



# INVESTING IN UNIVERSAL HEALTH COVERAGE

## Opportunities and Challenges for Health Financing in the Democratic Republic of Congo

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2014 Health Public Expenditure Review



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# ACRONYMNS AND ABBREVIATIONS

AIMP	Aid and Investment Management Platform	HRH	Human Resources for Health
ARI	Acute Respiratory Infection	IMF	International Monetary Fund
CDF	Democratic Republic of Congo francs	MDG	Millennium Development Goal
CIDA	Canadian International Development Agency	MICS	Multi-Indicator Cluster Survey
DFID	UK Department for International Development	MoPH	Ministry of Public Health
DGCMF	Public Procurement Audit Division (Direction Générale pour le Contrôle des Marchés Publics)	MTEF	Medium-Term Expenditure Framework
DHS	Demographic and Health Survey	NHA	National Health Accounts
DPS	Provincial Health Divisions (Divisions Provinciales de la Santé)	NHDP	National Health Development Plan
DRC	Democratic Republic of Congo	NSI	National Statistics Institute
ETD	Local Entities (Entités Territoriales Décentralisées)	PESS	Health Facility Enhancement Program (Programme d'Équipement des Structures Sanitaires)
FEDECAME	Federation of Central Medical Stores (Fédération des Centrales d'Achat de Médicaments Essentiels)	SNAME	National System for Procurement of Essential Medicines (Système National d'Approvisionnement en Médicaments Essentiels)
GAVI	Global Alliance for Vaccines and Immunization	UHC	Universal Health Coverage
GDP	Gross Domestic Product	UNDP	United Nations Development Programme
GHNDR	Health, Nutrition and Population Global Practice	UNICEF	United Nations Children's Fund
HGR	District Hospital	USAID	United States Agency for International Development
HIV/AIDS	Human Immunodeficiency Virus	VAT	Value-Added Tax
		WDI	World Development Indicators
		WHO	World Health Organization

# OVERVIEW

## Background and Policy Recommendations

The Democratic Republic of Congo (DRC) is preparing to adopt a historic bill on Universal Health Coverage (UHC). Yet the government is questioning how effectively health financing reforms will improve coverage and financial protection of children and the rest of the population—three-fifths of children with respiratory infections, diarrhea, and fever are not treated for these conditions.

International aid and households' direct payments finance 80 percent of the health sector (half each), the government less than the remaining 20 percent. This pattern must be reversed, as it is neither sustainable (aid is likely to be reduced by 2020–2030) nor equitable (direct payments affect the poorest more). Unless the central government spends more than its current one dollar a year per capita on health, it will make no serious progress toward UHC. The health budget envelope should move out of its current, almost forgotten, state (4 percent of the overall budget); a doubling of the budget is a must to have the necessary critical mass.

Such doubling is possible, as DRC has considerable fiscal potential. Tapping into this potential could allow the country to generate substantial additional revenues and invest more for UHC. Whereas other countries in sub-Saharan Africa can mobilize 1 or 2 extra percentage points of gross domestic product (GDP), DRC should be able to manage more than 8 percentage points of GDP. New taxes are not needed, but a more effective tax collection system—particularly in mining—is. By increasing revenues from 13 to 21 percent of GDP by 2020, the state would then have the domestic resources to invest more in priority interventions for universal coverage.

When a dollar is allocated to health, only 40 cents are actually spent and 20 cents are, rightly, targeted at priority interventions. To progress toward UHC, it is essential to make health spending more effective and efficient—generating more “bang for the buck”—an agenda item be advanced in parallel to the suggested increase in budget. Inefficiencies have emerged within and outside the health sector. A set of Public Finance Management measures shall be accelerated as well as sector-specific actions be implemented to free up health resources. One key sector-specific measure is to refocus efforts on strengthening the availability and performance of primary and community care services, which are vital for efficiency but also for coverage expansion, especially of the poorest. The Global Financing Facility (GFF) can help underpin this full overhaul of health sector priority allocations and support the scaling up of key high-impact interventions.

Equity and financial protection are likely to be improved if the country moves from a user fee-based system that really only just finances the “bare bones” functioning of facilities while deterring use of services and accelerating catastrophic spending. As a way to transitioning toward more equitable and harmonized health financing, provincial resource pooling should be explored over the medium term as decentralization is consolidated and, it is hoped, transfers from central government to provinces as well as local revenues are strengthened. For these changes to be effective, retrocessions must accelerate to near the constitutional objective of 40 percent, earmarked transfers to provinces must be high enough for these jurisdictions to exercise their core mandate of implementing health financing, and fiscal and budgetary capacities at decentralized level must be firmed up.



Nationwide prepayment mechanisms such as mandatory health insurance may well be advisable over the longer term. In the short and medium term, however, defining and then implementing a quality care package alongside in-depth reform of provider payment systems (based on experiences from the country's performance-based financing mechanism since 2004) could be a more doable alternative to extend coverage and move effectively toward UHC in the medium term.

## Key Findings

### *Macroeconomic and Fiscal Environment—Strong Growth, but for What?*

The DRC economy over 2009–2013 enjoyed strong growth at an annual average of 7.4 percent, driven by a booming mining sector which, over 2010–2013, accounted for more than 20 percent of GDP growth. Yet the central government has not managed to tap into this upturn in national wealth by raising its revenues.

Although domestic revenues shot up from 2004 to 2012 they have stagnated since then—worse, at 13 percent of GDP they are actually sliding back due to low collection of indirect taxes and revenues from the natural resources sector. This revenue downturn has had a knock-on effect on expenditure, capping it at 12 percent of GDP since 2011–2012. This raises the question of how to fund the investment needed to achieve the government's aim of becoming a middle-income economy by 2030.

One avenue will be tapping the strong potential for local revenue generation in several mineral-rich provinces. Another will be decentralization, which has already given the country a new governance and tax order. In accord with the 2006 Constitution, provinces over the last few years have received greater political, administrative, and fiscal powers. The interprovincial redistribution system being set up, gradually, is smoothing revenue inequalities across provinces and paving the way for a new sense of national solidarity.

### *Health System and Results—Some Encouraging Outcomes Against a Backdrop of Poor Infrastructure and a Fragmented System*

In the mid-2000s, the country launched a deep reform of the health sector as a pillar of socioeconomic reconstruction. Dispensing with the emergency approach that prevailed in the late 1990s during the war, the government has paved the way for longer-term development of the health system. Some progress has been made, but the organization of the health care and service delivery system remains relatively fragmented and fragile.

The health system is no exception to the country's twin infrastructure deficit—quantity and quality. Geographic coverage has improved at primary health care level but the dearth of referral operations is still a major problem, while the quality of infrastructure and equipment is highly problematic—less than 30 percent of health facilities are considered operational.

Still, there are multiple signs for hope: service coverage rose for a number of interventions essential to maternal health. Over 2001–2014 for example, antenatal care coverage climbed from 68 percent to 88 percent and the skilled birth attendance rate from 61 percent to 80 percent. The use of insecticide-treated nets soared from 6 percent in 2007 to 56 percent in 2014. Coverage of essential treatments for children is, however, reported to have regressed slightly over the period, especially for fever and acute respiratory infection (ARI). Similarly, the proportion of fully vaccinated children apparently fell from 53 percent to 46 percent from 2010 to 2013–2014. Cost is a major barrier to access, though poor service quality also constricts demand.

Other encouraging data are that, after a slow start in the early 2000s, the reduction in child mortality started gathering pace after 2010, and infant mortality, estimated at over 90 per 1,000 over 1997–2007, fell sharply by 2013–2014 (to 58). Less happily, malnutrition still affects 43 percent of children, with nearly half of them suffering from severe malnutrition. Finally, following a sharp upturn in maternal

mortality due to conflicts in the late 1990s, the rate fell steadily to 846 deaths per 100,000 births over 2007–2014, though the rate remains higher than the regional average of 510.

#### *Health Financing—Minimal Spending and Heavy Reliance on External Aid and Out-of-Pocket Expenditure*

At USD 13 per capita, DRC spends less than one-tenth the average of the rest of sub-Saharan Africa on health. Health expenditure as a share of GDP fell from 4.6 percent in 2008 to 3.8 percent in 2011–2012.

External assistance is the leading source of health financing, accounting for an average 40 percent of total health financing sources over 2008–2013. Household funds are the second largest (averaging 39.3 percent over the period). Out-of-pocket payments accounted for more than 90 percent of household health expenditure.

At less than 15 percent of total health expenditure, the government’s share of health financing is minimal. Health accounted for an average of 4 percent of the central government budget, excluding debt and financial expenses, over 2007–2013.

Still, actual government expenditure on health averaged less than USD 1 per capita over 2007–2013, climbing to 0.7 percent of GDP only in 2013. Health as a share of total government spending averaged 3.95 percent over 2007–2013.

Since 2011, however, implementation of decentralization has led to more government financing for health through earmarked transfers to the provinces. These new transfers amounted to 150 percent of the MoPH budget in 2013 and appear to point to a new model of resource allocation to decentralized level.

#### *Payroll—A Heavy Burden for the Budget with Unsatisfactory Results for Personnel and Patients*

Despite a growing stock of human resources for health (HRH), the population does not have adequate access to qualified health professionals nationwide. Poor distribution of human resources is such that a large majority of primary-level facilities do not have

the staff needed to be fully operational, especially in rural areas. While Kinshasa has 1.3 physicians per 10,000, most of the other provinces post half of this ratio. Loose regulation of public sector employment in the health sector accelerates the imbalances and results in a growing stock of personnel in the capital and other urban areas.

The health labor market is relatively saturated. HRH supply is rising faster than demand, mainly due to increased production of medical personnel from private institutions on one side—over 2,000 trained physicians every year—and the public sector’s limited absorption capacity on the other side. Due to structural and cyclical rigidities the public sector can only enroll and pay a salary to 31 percent of the total stock of personnel.

Against a background of a shrinking share for (nonpersonnel) operating and capital expenditure, personnel spending is worrisome, doubling from 42 percent in 2007 to more than 80 percent of total government health expenditure after 2010. The increase in total payroll is due mainly to large pay raises in the civil service (more than 140 percent from 2009 to 2013).

The increase in the payroll raises questions about the medium-term financial sustainability of this expenditure. Allocations for personnel costs are to be doubled to just cover wages and bonuses of current staff, amounting to one and half times the MoPH budget for 2013. In particular, sustainability of the “risk bonus”—providing 85 percent of government paychecks for physicians and rose by 236 percent from 2009 to 2013—is a valid question for the government.

#### *Additional Fiscal Space for Health—Prospects Show Good Potential*

Recent estimates of the per capita health financing gap—USD 18 to USD 33—highlight the vast needs that must be met to achieve universal coverage of health care services in the country. While the level of funding is a critical issue for DRC, these estimates shall not be taken as definite spending “targets” and be an impediment for pursuing expenditure and efficiency-oriented reforms.

The country seems to have several possibilities for increasing the fiscal space for health. The central government could, as said, increase its revenue by 8 percentage points of GDP over the long term, by collecting more from the natural resources sector and by improving existing domestic revenue collection. All other factors being equal, greater central government revenue collection could generate up to 0.4 percentage points of GDP more for health.

Giving health a greater priority in the central government budget (up to 8 percent of government expenditure) could increase the health budget by 0.6 percentage points of GDP. Equally important, improved execution of health expenditure, as well as efficiency, would be needed so as to raise health sector performance and free up resources for the sector. All in all, it is expected that more than one additional point of GDP could be generated from domestic resources over the medium term to finance progress toward UHC.

Prospects from external assistance are less clear. The latest outlook for external assistance is gloomy. This source—equivalent to 5.6 percent of GDP in 2013—is forecast to shrink to 1.3 percent by 2030, for about USD 5 per capita in the short term (2015–2016), but declining over 2018–2020. Although no projections of external aid for health exist for DRC, it is probable that aid to the sector will follow the same pattern as that of total external assistance, as the country transitions to having greater political stability and becoming a middle-income economy.

#### *Health Expenditure Performance—Poor Financial Protection; Equity and Efficiency Are Concerns*

More than 80 percent of household expenditure takes the form of out-of-pocket expenditure, such that financial protection against illness is almost nonexistent. The poorest—spending more of their income on health than the rich—are hit hardest, as they are by catastrophic health expenditure, which overall affects more than 10 percent of the population.

Disparities in child health outcomes are large, but appear to be narrowing among income groups, as

they are between provinces. Prevalence of malnutrition, however, as estimated by the number of underweight children, is increasing among the poorest and in rural areas.

Major income-related disparities are reported in use of services, but some of these are narrowing, including use of antenatal care and skilled birth attendance (though a quarter of the poorest women do not receive any antenatal care, against just 8 percent of the richest). The use of services for treating childhood diarrhea has improved for all quintiles, notably for the poorest children, using community-based delivery mechanisms. Conversely, ARI and malaria treatment coverage, which government facilities provide for free, has decreased.

Government health expenditure is highly focused on hospitals (87 percent), which are used more by the richest quintile, pointing to inequitable access. All operating expenditure, modest though it is, goes virtually exclusively to hospitals. As hospitals are more used by the richest, the poorest quintile receives only 16 percent of total public subsidies. The distribution of health expenditure among provinces is also imbalanced, at a ratio of 5 (the capital) to 1 (the rest).

For the same level of expenditure, DRC's performance is much poorer than the rest of the region's infant and under-five mortality. Performance also largely varies across provinces with the same level of inputs, suggesting high technical efficiencies. Raising the quality of pre- and on-the-job training for rural personnel seems essential to improve efficiency.

#### *Impact of Decentralization on Health Financing—Opportunities Must Be Seized*

Decentralization has the potential to change the volume and execution of health financing. A larger share of government funds for health is likely to now transit through the provinces. The government's priorities mean that budget allocations to the provinces for these sectors have increased since 2010–2011, but execution of transfers remains poor.

As with the central government, external assistance is the biggest health financing source for the provinces. In 2013, amounts provided to the provinces by

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external partners were nearly three times as high as total government funds allocated for health. Central government funds account for the majority of provincial public funding. Except for Katanga, funds raised by the provinces from their own resources to finance health are extremely small (perhaps US 10 cents per capita).

Provincial budgets allocate only a tiny share to health—an average of 4 percent of their all resources to the health sector in 2010–2014. Central and

provincial public resources are primarily used in the provinces to cover personnel expenditure to top up or compensate extra personnel, not paid by the central level. Only a few provinces use internal resources purely for capital spending.

Finishing and aligning decentralization with UHC goals is central for the sector. Decentralization is a funding and governance opportunity that must be seized by health policy makers for the success of the UHC agenda.

# INTRODUCTION: COUNTRY CHARACTERISTICS AND STUDY PRESENTATION

## Country Overview

### *Political and Economic Environment*

**In 2007–2008, following two decades of war, the Democratic Republic of Congo (DRC) entered a phase of political and institutional consolidation.**

The signing of peace agreements in 2002 put an end to the second war in DRC that had contributed to the deaths of over 4.5 million people. However, security remains uncertain, especially in the east: despite a military victory won by the government army over the M23 rebellion in November 2013, some 40 armed groups remain at large in the Nord and Sud Kivu provinces. As the 2016 presidential elections near, tensions are rising in the capital again over whether the current president will run for a third term.

**The 2006 adoption of a new Constitution granting substantial powers to 26 new provinces stands as a strong symbol of national consolidation.** The Constitution also targets five priority sectors for decentralization: health, education, agriculture, rural development, and infrastructure. This process is gradually introducing earmarked fiscal transfers to the decentralized levels.

**The country has posted strong economic performance for five years (2009–2013) with economic growth at 8.5 percent in 2013, higher than the regional average of 5 percent.** It also showed marked improvements in development policies and institutions (Country Policy and Institutional Assessment [CPIA], 2014).<sup>1</sup> The good macroeco-

<sup>1</sup> The CPIA score for DRC was raised from 2.7 to 2.9 in 2014 in recognition of the introduction of public finance reforms and rigorous macro-economic management.

omic performance is due mainly to the buoyancy of the mining sector on high world prices for minerals, and of trade and services.

**In 2010, the government undertook to conduct extensive reforms to improve macroeconomic and tax stability.** The major reforms relate to public finance, economic governance, the business climate, use of banking services, and the dedollarization of the economy. Although all of these reforms have been launched, outcomes are partial. Considerable progress has been made on fiscal consolidation, enabling the central government to bring down its budget deficit. Inflation has fallen significantly.

### *Sociodemographic and Human Development Situation*

**DRC is the third most populous country in sub-Saharan Africa with over 70 million inhabitants and a population growth rate estimated at 3.1 percent in 2014.**<sup>2</sup> With half the population under 16 years old, there is a great deal of pressure on the labor market as over 33 million individuals would like to find work. The country remains mainly rural (61.2 percent), with the capital, Kinshasa, accounting for 11.7 percent of the population and standing out for its high share of households with a female head (25.6 percent).

<sup>2</sup> The absence of any recent population census (the latest dates back to 1984 and the next one is being prepared) and massive population mobility due to the conflicts make it hard to estimate the population in any detail. The latest estimates available place the population at 77.4 million inhabitants (National Statistics Institute [NSI], 2014).

**Poverty has been reduced.** Over 2005–2012 poverty was rolled back 8 percentage points from 71.3 percent to 63.4 percent (NSI, 2013). The drop was even sharper in rural areas where the incidence of monetary poverty fell 10 percentage points (65.2 percent in 2012). However, four provinces still have an incidence of over 70 percent: Kasai Oriental (78.6 percent), Equateur (77 percent), Kasai Occidental (74.9 percent), and Bandundu (74.6 percent). Access to basic infrastructure, especially water and electricity, remains very low with just 1 percent of rural households having electricity and running water (NSI, 2013).

**DRC has a high rate of literacy with over 73 percent of the population able to read and write in 2012.** A full 62 percent of the population reports having been to school. However, the net primary enrollment rate is 68 percent, pointing to late school enrollment and massive repetition. The net secondary enrollment rate plunges to 36 percent for the 12- to 17-year-old age bracket. Female school enrollment has improved hugely, and has caught up with the male rate.

**Maternal and child health has improved, but access to quality health care services remains problematic.** Under-five mortality fell steadily over the decade to 104 per 1,000 in 2013/2014. Yet 60 percent of children under five years old nationwide are not covered by basic treatment services for diarrhea, fever, and respiratory infections. Maternal health also remains a major concern. It is falling more slowly than in other countries and is one of the highest in the region with 846 deaths per 100,000 births. Despite relatively satisfactory antenatal care coverage, there is a lack of emergency obstetric care. At this rate, Millennium Development Goal (MDG) 4 (60 deaths per 1,000 births) and MDG 5 (332 deaths per 100,000 births) will not be achieved by either 2015 (the MDG end date) or 2020 (the national goal).

**DRC scores are second to last in the 2013 UNDP Human Development Report ranking with an index of 0.338.** Still, it appears to be catching up with the region's performances with annual index

growth of 1.64 percent, consistently higher than the regional average since 2000. Life expectancy at birth remains among the lowest in the world at 50 years in 2012.

## Rationale and Study's Objectives

**DRC is at a turning point in developing its health system.** The completion of the second National Health Development Plan (2011–2015) marks the end of a period of extensive health system reconstruction following two decades of war. The government has put real effort into improving coverage, assisted by development partners, with virtual universal coverage of primary health care operations. A vast government initiative, the Health Facility Enhancement Program (PESS), was launched in 2011 (becoming effective in 2013) to upgrade health centers, and district, provincial, and tertiary hospitals. In 2015 a consolidation phase will be launched to improve the quality of and financial access to health care. The strategic definition of the third National Health Development Plan (2016–2020) is expected to calibrate DRC's new post-millennium health system targets.

**Health is a pillar of decentralization.** In 2010, DRC launched a political, administrative, and tax decentralization process granting greater powers to the provinces and other local entities (ETDs). Health is among the sectors top of the agenda for this transfer of responsibilities. The process is expected to improve the response to needs by strengthening local governance. However, the real implications for health sector financing and governance are relatively uncharted.

**The health financing system is also undergoing a phase of transition and strategic redefinition.** During the war and immediate postwar years, the sector was financed largely by users and international aid in the form of emergency programs. Where users had access to health facilities, they paid out of their own pockets for their treatment under a cost-recovery mechanism set up in the 1990s. External assistance financed most of the capital and operating

costs. Through the mid-2000s, government funds invested in health care barely reached USD 50 cents per capita a year. Since 2010, with action scaled up in 2012–2013, the government’s commitment to several priority sectors including health has seen a sharp increase in allocations. Government funding, in various forms, has focused on upgrading supply.

**Universal Health Coverage (UHC) is on DRC’s political agenda.** Taking up this priority as a core objective of the current government’s roadmap,<sup>3</sup> authorities are set to progress toward UHC by 2020. The administration is therefore preparing a new health financing strategy with a view to passing a historic bill in 2015. Yet the absence of an up-to-date diagnosis of health sector financing and the scarcity of data makes it a difficult exercise.

**The purpose of this study is to establish a diagnosis of the health sector’s national and provincial financing in order to assist DRC with its transition to UHC.** The study’s specific objectives are to:

- Measure the availability of financial resources for health and analyze financing trends for 2007–2013;
- Analyze the prospects for increasing available resources for health in the macroeconomic and fiscal midterm environment;
- Assess the nature and performance of health spending in terms of coverage, financial protection, equity, and efficiency; and
- Investigate the impact of decentralization on the health sector’s financing.

The main guiding tool used to conduct this study is the World Bank Group’s analytical framework for public expenditure reviews for human development, and the health sector in particular.<sup>4</sup> This framework proposes an analysis of health financing based on three main parameters: health finance sources; actual sector expenditure by finance source, with a focus on government expenditure; and health expenditure performance in terms of equity and efficiency. The

Review also draws on the recently published health financing analysis guidance developed by WHO<sup>5</sup> and the tools developed jointly by the World Bank and WHO to measure progress toward UHC.<sup>6</sup>

## Methodology

The study analyzes both the central and the provincial level with a sample of six provinces selected non-randomly: Bandundu, Equateur, Katanga, Maniema, Province Orientale, and Sud Kivu. The analysis is based on primary and secondary data sources available for DRC (Table 1) in the second quarter of 2014 with respect to:

- The macroeconomic and fiscal environment;
- Health sector resources and expenditure from the government, households, and external sources;
- Health system and health expenditure performance—coverage, financial protection, efficiency, and equity; and
- Health outcomes.

The provincial analysis is based on the primary and secondary data available for Katanga, Sud Kivu, and Province Orientale for the first quarter of 2014, and for Bandundu, Equateur, and Maniema for the second quarter of that year. The main sources include fiscal data for each province and the state of total and sector government expenditure, along with data drawn from household surveys (Demographic and Health Surveys, Multi-Indicator Cluster Surveys [MICS], and 1-2-3 surveys on employment, the informal sector, and household consumption).

The central data were collected and compiled by a World Bank team from April to September 2014. Provincial data were collected in Bandundu, Maniema, and Equateur by a World Bank team in September 2014. Data collection in Katanga, Province Orientale, and Sud Kivu was conducted by a UNICEF team from January to March 2014.

<sup>3</sup> “Universal health coverage for mothers and children is a top national priority to be achieved by 2020,” H.E. the Minister of Health, National Health Steering Committee, Kinshasa, December 2014.

<sup>4</sup> <http://siteresources.worldbank.org/EXTPERGUIDE/Resources/PER-Complete.pdf>

<sup>5</sup> [http://www.who.int/health\\_financing/tools/hf\\_for\\_uhc\\_situation\\_analysis\\_v1.0.pdf?ua=1](http://www.who.int/health_financing/tools/hf_for_uhc_situation_analysis_v1.0.pdf?ua=1)

<sup>6</sup> [http://apps.who.int/iris/bitstream/10665/112824/1/WHO\\_HIS\\_HIA\\_14.1\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/112824/1/WHO_HIS_HIA_14.1_eng.pdf?ua=1)

## 2014 HEALTH PUBLIC EXPENDITURE REVIEW

A World Bank team conducted the analysis from September to December 2014.

Broad-based consultations were held throughout the study with all the central government authorities (ministries of health, the budget, economic planning, economy and finance) and provincial authorities (provincial ministries of health and governorate) along with development partners (Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI, UNICEF, IMF, DFID, USAID, and CIDA) in the form

of the GIBS sub-financing commission and individual interviews.

The study's preliminary findings were presented at a training workshop on UHC in Matadi (Bas Congo) in December 2014. Its main recommendations were presented at the highest level to H.E. the Ministers of Finance, Public Service, and Health in Kinshasa in December 2014 and April 2015. A final consultation workshop was held in Kinshasa in April 2015 with government and development partners.

**TABLE I** Summary of Data Sources

Type of data	Source	Origin	Period covered
<b>Fiscal data</b>	Macroeconomic framework and Medium Term Expenditure Framework	Ministries of Finance, of Budget, and of Economic Planning	2009–2014
	General budget (Budget Act)	Ministry of Budget	2007–2013
	Expenditure chain	Ministry of Economy and Finance	2007–2013
	National Health Accounts (NHA)	Ministry of Public Health	2008–2013
	Budget execution statements	Ministry of Budget	2010–2014
<b>Data on the state of health, coverage and financial protection</b>	National Survey on the Situation of Women and Children (ENSEF)	National Statistics Institute, Ministry of Economic Planning	1997
	Multiple Indicator Cluster Survey 2 (MICS 2)	Ministry of Economic Planning	2001 and 2010
	Demographic and Health Survey (DHS)	Ministry of Economic Planning	2007 and 2013/2014
	1-2-3 Household survey (poverty and service use)	National Statistics Institute	2013
	Annual reports (national and provincial) of the National Health Information System	Ministry of Public Health	2007–2014
<b>Data on household expenditure</b>	1-2-3 Household survey (household consumption and financial protection)	National Statistics Institute, Ministry of Economic Planning	2013
<b>Data on external expenditure</b>	Aid and Investment Management Platform (AIMP)	Ministry of Economic Planning	2014
	NHA	Ministry of Public Health	2008–2013
<b>Provincial fiscal data</b>	Macroeconomic framework per province and provincial Medium-Term Expenditure Framework (MTEF) (where such exists)	Ministry of Economic Planning, Ministry of Public Health Provincial Governments	2013–2014
	Statement of provincial revenues	Provincial Governments	2012–2014
	Statement of revenue retrocessions (to the provinces)	State Audit Office (Cour des Comptes)	2014
	Provincial budget provisions	Provincial Governments	2011–2014 (depending on the province)
	Provincial government expenditure monitoring	Provincial Governments	2011–2014 (depending on province)



## Report Structure

The report contains eight chapters. Chapter 1 leads off with the main macroeconomic and fiscal determinants to understand the general health financing situation in DRC. Its sections 1 and 2 provide a brief overview of the country's macroeconomic and fiscal environment. Section 3 sheds new light on decentralization—a core health issue—and focuses on the fiscal implications of decentralization. Section 4 offers a brief analysis of the management of public finance, a key element for the effectiveness and quality of expenditure, especially in health.

Outlining the DRC health system, Chapter 2 starts with a brief overview of the main objectives and analyzes its organization and governance, with a focus on health care delivery. It then presents a detailed analysis of the availability and distribution of inputs, especially infrastructure and equipment (Section 2), health personnel (Section 3), and pharmaceuticals (Section 4).

Chapter 3 discusses the performance of the main health system's outputs and outcomes. Section 1 analyzes major changes in health outcomes based on different household surveys. Section 2 addresses service coverage with a focus on mother and child services. Section 3 explores service quality issues.

In a detailed analysis of health financing sources, Chapter 4 looks at changes in public, external, and private sources over 2008–2013 (Section 1). Section 2 analyzes the adequacy of government funding for health financing needs, and assesses the prospects for expanding fiscal space for health.

Chapter 5 examines government funds mobilized for health, both allocated in the budget and executed (or

actuals). Government resources for health are taken to mean all domestic financing sources allocated to the Ministry of Public Health and other health entities. Section 1 examines changes in the health budget envelope over 2007–2013, while section 2 focuses on actual spending. Section 3 analyzes government executed expenditure by nature and Section 4 reviews trends and types of personnel expenditure—the largest share of government health expenditure.

Chapter 6 focuses on health expenditure performance in the light of three main parameters: financial protection; equity; and efficiency. Section 1 analyzes financial protection using standard indicators (share of out-of-pocket payments, catastrophic expenditure, and impoverishing expenditure). Section 2 scrutinizes health outcomes and service use disparities/inequalities based on income, gender, and place of residence. The last section presents an overview of the efficiency of health expenditure in DRC, primarily in comparison to its peer countries.

Chapter 7 analyzes health financing from the point of view of the provinces, the new “entitled” authorities for the health sector, drawing on a survey of financial and fiscal data from six provinces. Section 1 presents an overview of health financing flows after decentralization. Section 2 focuses on financing sources for the health sector at the provincial level, examining provincial government funds, external assistance, and central government transfers. The chapter ends with an analysis of the volume and type of decentralized government health expenditure.

The report concludes in a brief Chapter 8 with a series of recommendations to improve short- and medium-term health sector financing and performance.



# MACROECONOMIC AND FISCAL ENVIRONMENT

# 1

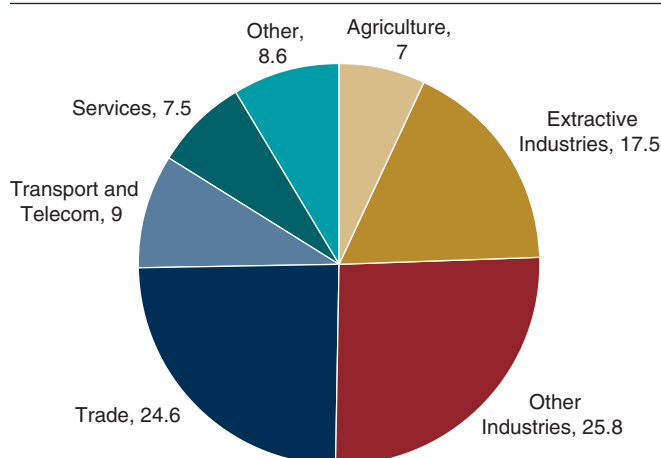
## Section I. Macroeconomic Environment

**DRC has enjoyed a period of strong, sustainable economic growth over 2009–2013, averaging 7.4 percent a year.** In 2013, DRC posted one of the highest real growth rates in the region at 8.5 percent compared with a regional average of 5 percent. The growth rate is forecast to have reached 9 percent in 2014, posting an average of 8.7 percent over 2014–2019 (World Bank, 2015). This good economic performance is due to an upturn in public and private investment in an environment of relative security and political stability. However, DRC’s per capita GDP (USD 445 in 2013) remains one of the region’s lowest.

**The booming mining sector is driving growth up,** accounting for around 20 percent of GDP growth over 2010–2013 (Figure 1). The mining sector’s value-added grew 10.5 percent on average over the period as investments made the previous decade came onstream. Preliminary data point to a 28 percent increase in the mining sector’s value added in 2013, while the general mining production index rose 17 percent. Copper production alone grew 52 percent, which largely offset a 7.4 percent price drop observed in 2013 (World Bank, 2015).

**The manufacturing and tertiary sectors also showed buoyancy.** Growth in manufacturing posted an estimated average 11.4 percent over 2010–2013, and 21.4 percent in 2013. Manufacturing reportedly provided 25.8 percent of total growth over the four-year period. The most buoyant manufacturing

**FIGURE 1** Contribution of the Main Economic Sectors to Growth (% of GDP), 2010–2013



Source: Adapted from World Bank, 2015.

subsector was the food industry. The tertiary sector—including trade, services, transport, telecommunications and other services—grew 9 percent on average over 2010–2013, although growth in 2013 was only 4.4 percent. The tertiary sector is estimated to have provided nearly 46 percent of total growth over 2010–2013. The tertiary sector’s strongest performance was in trade, reflecting the general recovery bolstered by stabilized prices and exchange rates in 2010–2011 (World Bank, 2014).

**Half of DRC’s economic activity still comes from the informal sector:** 97 percent in agriculture, 86 percent in manufacturing, and over 40 percent in mining and tertiary industries.

**Despite strong economic growth, the labor market shows tensions.** If the extended unemployment rate is taken to include jobseekers who have stopped looking for work due to a lack of vacancies, unemployment could be as high as 17.7 percent of the population, with 31 percent of them in urban areas, and 39 percent in Kinshasa alone. Youth unemployment is a huge concern, at 28 percent of the under-24s in the labor force. Nearly four in 10 of those out of work hope to find a job soon. All in all, it is estimated that over 33.6 million individuals want to find work. The informal sector outweighs all the other sectors with 88.6 percent of employed workers nationwide, ranging from 62.7 percent in the capital to 94.8 percent in rural areas.

**After peaking at over 40 percent in 2009, inflation has remained below 2 percent since 2012.** In 2013, it came in at 0.8 percent following fiscal restraint, control of monetary aggregates, and an absence of major import price shocks. The deceleration of inflation has coincided with a slowdown in the growth of the money supply, which has fallen from over 50 percent in 2008 and 2009 to around 20 percent since 2011. The reduction in the budget deficit and the consequent restriction of monetary financing of central government expenditure have helped contain inflation.

DRC's external debt has fallen sharply since 2010 when the country reached the completion point for the Heavily Indebted Poor Countries Initiative (HIPC). The public external debt ratio fell from 75 percent in 2009 to 18 percent in 2013, after substantial debt relief in 2010 (IMF, 2014).

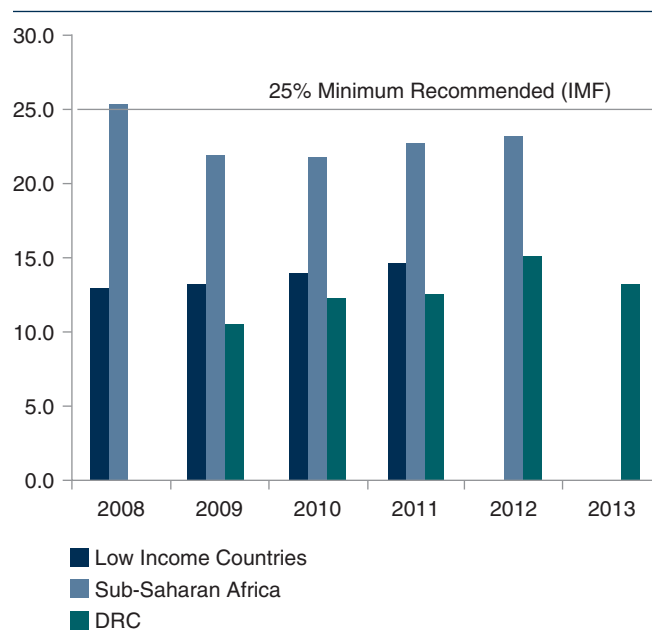
## Section 2. Fiscal Environment

**Despite strong growth, the central government has not managed to tap into the upturn in national wealth and raise its revenue.** Domestic revenue grew faster than GDP over 2004–2012, with an elasticity of 1.45, but has stagnated since 2012. In 2013, central government revenue was 13 percent of GDP, down on the 14.9 percent of 2012, mainly due to low indirect taxes—value-added tax

(VAT)—which fell from 30 percent to 27 percent of domestic revenue from 2012 to 2013, and low revenue collected from the natural resources sector (IMF, 2014; World Bank, 2014). This revenue ratio places DRC far behind its peers posting revenues of 23 percent of GDP on average in sub-Saharan Africa over 2008–2012, and 15 percent in the least developed countries over 2009–2010 (excluding grants) (Figure 2).

**The downturn in revenues has had a knock-on effect on the expenditure to bring the budget deficit under control.** Domestic government expenditure has stagnated at 12 percent of GDP since 2011–2012; its share in GDP rose from 6.4 percent in 2004 to 13.2 percent in 2011 before sliding back to 12.1 percent in 2012 and 12.5 percent in 2013. The government has reduced the level of public expenditure since 2011, mainly by introducing caps on fiscal commitments, in a move to sustain a positive domestic fiscal balance (0.5 percent in 2013, excluding payment of arrears).

**FIGURE 2** Share of National Revenues (excluding grants) in GDP in DRC, Low-Income Countries and Sub-Saharan Africa



Source: Authors' calculations, based on World Development Indicators (WDI, 2014) and IMF (2013).

**The recent downturn in revenues had put the burden of fiscal consolidation on expenditure and has accentuated the problems of financing development.** Fiscal consolidation has mainly hit capital expenditure, transfers, and expenditure on goods and services. Domestically financed capital expenditure reached a low 1.2 percent of GDP, before recovering to around 2 percent in 2013. Expenditure on goods and services has leveled off at 2.4 percent (World Bank, 2015). Payroll has continued to rise from 3.7 percent of GDP in 2009 to 5.0 percent of GDP in 2013, but remains moderate relative to the average of sub-Saharan Africa (8.5 percent). Extraordinary expenditure has increased sharply, from less than 0.5 percent of GDP in 2008 to more than 1.6 percent in 2012, reflecting a substantial rise in security expenditure over 2008–2012.

**Government expenditure is concentrated largely on current expenditure, to the detriment of capital expenditure.** Current (personnel and operating) expenditure accounted for an average 86 percent of government expenditure over 2009–2013. At 41 percent of the total, the largest share of government expenditure goes on government employee wages, a share that has increased at the rate of 30 percent a year on average over the last 10 years (World Bank, 2015). Expenditure on goods and services accounts for one-third of total expenditure, with a sharper increase posted in transfers to the provinces.

### Section 3. Decentralization: A New Tax Order

**The new Constitution gives the provinces their own fiscal and tax powers.** The provinces and local entities (ETDs) have been granted autonomy and free administration of their resource management (Article 3 of the Constitution). Act N.11/011 of July 13, 2011 confirms the provinces' fiscal autonomy and stipulates distinct fiscal authority: the central government budget is governed by the Budget Act, provincial budgets by provincial budget edicts, and local entities' budgets by budget "decisions." The legislation also grants provinces and

local entities authority to tax. Provincial resources comprise three main sources: local tax resources;<sup>7</sup> resources from national revenue allocated to the provinces; and extraordinary resources.

**Decentralization implies in principle an increase in allocations, especially in the social sectors for which responsibility has been transferred.** The 2006 Constitution stipulates that 40 percent of national tax revenue collected in the provinces is to be passed on to the provincial authorities in the form of revenue retrocessions to increase their fiscal capacity. The Constitution also lays down the principle of equalization across provinces in the form of an additional 10 percent allocation. Adding together personnel compensation, operating subsidies, and investment subsidies for the five priority sectors combined, expenditure earmarked for the provinces is estimated at approximately one-third (32.8 percent) of fiscal allocations in 2014 (as opposed to half in 2009).

**Since 2007, the retrocession system (being set up) has passed on only a small proportion of the revenue collected in the provinces.**<sup>8</sup> Tax revenue retrocessions form a relatively new source of provincial budget financing, and more than CDF 100 billion has been transferred annually since 2008.<sup>9</sup> However, retrocessions remain below the 40 percent threshold set by the Constitution: over 2007–2010, an average of 15.7 percent of national revenue collected was estimated to have been transferred back to the provinces (Table 2). Other sources estimate even lower rates of actual retrocession, ranging from 7.2 percent in 2010 to 11.4 percent in 2008 (IMF, 2014).

<sup>7</sup> Own resources include provincial taxes and levies (including real property taxes), public utility taxes and fees, and taxes specific to each province.

<sup>8</sup> The Constitution provides for revenue to be "retained at the source," but this does not happen in practice. Revenues from State-controlled entities are paid into the Public Treasury. Central government then calculates budgets for the provinces ("retrocessions") and retains a share to pay for the costs of the responsibilities not yet transferred to the provinces.

<sup>9</sup> Over 2003–2006, the exchange rate was in a range of CDF 400–468 for USD 1. Since 2010, the rate has been higher than CDF 900 per USD 1 (CDF 919 in 2013).

**TABLE 2** Growth in National Revenue Collected and Revenue Retrocessions, in CDF billions, 2007–2010

	Revenue* collected	Revenue retrocessions	Actual retrocession rate (%)
<b>2007</b>	358.7	50.0	13.9
<b>2008</b>	608.5	112.4	18.5
<b>2009</b>	790.2	134.1	17.0
<b>2010</b>	1,034.8	143.2	13.8
<b>Total 2007–2010</b>	2,792.1	439.7	<b>15.7</b>

Source: Authors' calculations based on State Audit Office data, 2013.

\* National revenue, except oil revenue.

**Local revenues collected by the provinces are highly imbalanced across the provinces and are generally low despite the considerable tax potential of certain areas.** For example, Maniema collected CDF 534 million in 2013, or less than USD 0.27 per inhabitant. Katanga, a mineral-rich province, collected roughly CDF 32 billion that year, which is still only USD 2.90 per capita (Table 3). These small provincial revenues are such that some provincial governments today find themselves with very little fiscal leeway despite their greater sector responsibilities.

**Decentralization has introduced an interprovincial redistribution system that could tend to smooth inequalities among provinces.** Although three provinces (Katanga, Kinshasa, and Bas Congo) collect 88 percent of national revenue (Figure 3, right

**TABLE 3** Local Revenues Collected by a Sample of Four Provinces (excluding revenue retrocessions), 2013

Provinces	Total local revenues (CDF millions)	Local revenues per capita (2013 current USD)
<b>Katanga</b>	32,489	2.94
<b>P. Orientale</b>	5,640	1.08
<b>Sud Kivu</b>	5,275	0.72
<b>Maniema</b>	534	0.27

Source: Authors' calculations, based on Provincial Government data, 2014.

Note: The sample was defined based on data available in the last quarter of 2014.

panel), they only receive 40 percent of total revenue retrocessions (Figure 3, left panel—although Katanga and Bas Congo receive the largest shares of total revenue retrocessions, at 17 percent and 13 percent respectively). According to State Audit Office data, the adjustment would mean that these three high revenue-collecting provinces receive proportionally fewer retrocessions—6–8 percent of the sums collected. Conversely, the revenue retrocession rates for Bandundu, Equateur, and Maniema—the three provinces with the highest incidence of poverty—stand at around 600–1,250 percent (Table 4).

## Section 4. Public Finance Management

**Despite recent changes, shortcomings in public finance management continue to undermine the volume and quality of government expenditure in DRC.** The country has launched a far-reaching public finance modernization campaign starting with the adoption of a vast program of public finance reforms via the establishment of COREF<sup>10</sup> (2009), the adoption of a Strategic Public Finance Reform Plan (2010), the revision of the Public Procurement Code (2010), and the passing of a new Public Finance Act (the LOFIP) in 2011.<sup>11</sup> These reforms cover the entire budgetary process as well as the administration and accounts management of expenditure.<sup>12</sup> These reforms aim to deconcentrate the budget and finance ministry payment process to the line ministries. The Administrative and Financial Divisions (AFDs), scheduled to be set up in each ministry in 2015, are the latest part of this reform. However, fiscal management performance remains suboptimal at best.

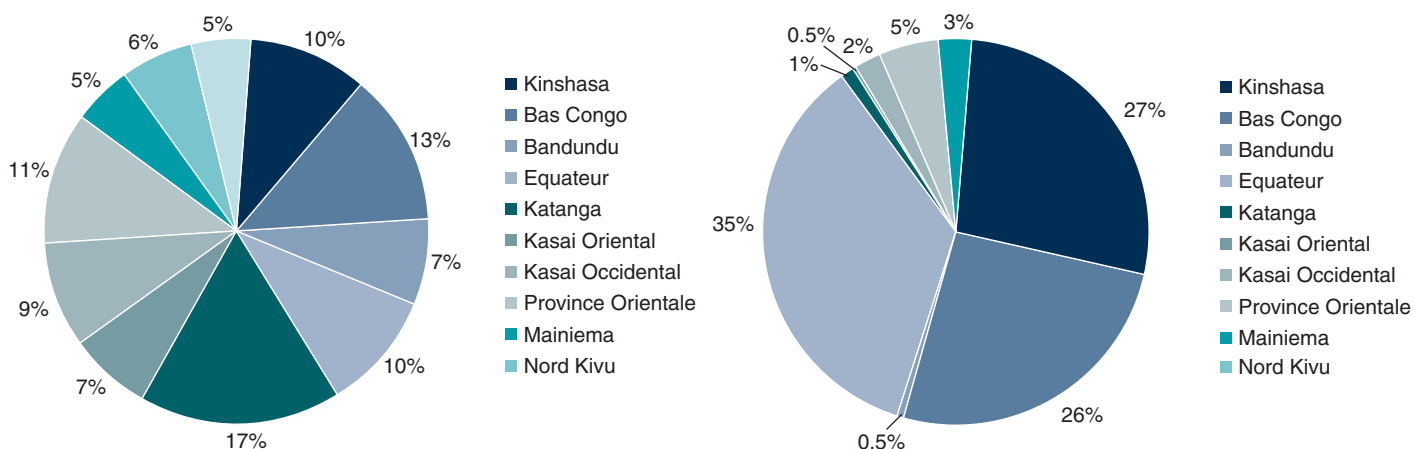
<sup>10</sup> The Public Finance Reform Steering Committee (Comité d'Orientation des Réformes des Finances Publiques) is the body in charge of steering the implementation of the public finance reform.

<sup>11</sup> Act N.11/2011 of July 13, 2011.

<sup>12</sup> The pillars of the reform are to reform the tax system to modernize the tax instruments and tax administration; streamline the management of government expenditure by improving budget procedures; improve the accounting system and cash-flow management; and improve the public finance auditing system via technical and institutional support to the audit bodies.

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**FIGURE 3** Distribution of National Revenue Collected per Province and Distribution of National Revenue Retrocessions per Province, 2010



Source: Authors' calculations, based on State Audit Office data, 2013.

**TABLE 4** Breakdown of Revenues Collected and Revenue Retrocessions per Province (total 2007–2010, in CDF billion) and Actual Revenue Retrocession Rate (%)

Province	Revenue collected (% of total)	Revenue retrocessions (% of total)	Actual revenue retrocession rate (%)
<b>Kinshasa</b>	27	10.1	5.9
<b>Bas Congo</b>	26.4	13.3	7.9
<b>Bandundu</b>	0.1	7	1,257.2
<b>Equateur</b>	0.3	9.9	604.7
<b>Katanga</b>	34.6	17.4	7.9
<b>Kasai Oriental</b>	0.6	7.4	200.2
<b>Kasai Occidental</b>	0.4	8.4	338.1
<b>Orientale</b>	1.9	10.7	90
<b>Maniéma</b>	0.1	4.4	583.7
<b>Nord Kivu</b>	5.1	6.1	18.7
<b>Sud Kivu</b>	3.6	5.3	23.3
<b>Total</b>	100	100	15.7

Source: Authors' calculations, based on State Audit Office data, 2013.

**Budget preparation still shows little standardization or systematization.** The introduction of general “steering” tools—the Medium-Term Fiscal Framework (MTFF) and budget preparation by program—has, to a certain extent, improved the predictability of the expected volume of revenue and expenditure and improved the budget’s clarity and credibility. The introduction of the Medium-Term

Sector Expenditure Framework (MTSEF) for the sectors was also expected to improve the predictability of budget allocations in the priority sectors (health, education, agriculture, rural development, and infrastructure). An MTSEF has been prepared for the health sector since 2011. Although the tool has been an effective training and information vehicle on budget preparation technique at the Ministry of Public Health (MoPH), it has done little to improve the predictability of budget allocations and choices.

**Although expenditure channels have been systematized, obstacles still hamper sound execution, especially for social allocations.** The current execution procedure has been improved with four standard expenditure steps (Table 5). The Budget Commitment Plans—introduced to keep expenditure in line with cash flow and restrict slippage (multitude of emergency procedures,<sup>13</sup> overruns, and initiation from outside the expenditure chain)—have limitations in practice, like delays, no connection to the original allocation, unsuitable timeframes, and meager commitments. Although the actual transfers generally match these plans, expenditure validation and payment orders are more problematic. These

<sup>13</sup> The Extraordinary Expenditure Procedure (EEP) rolls the first three procedures into one (commitment, validation and payment order). It is used for emergency expenditure and extraordinary expenditure (ministerial orders N.291/CAB/Min/Finances/2008 and 039/Min/Budget/2008).

**TABLE 5** Analysis of Budget Execution Delays and Impact on Sector Expenditure Effectiveness

Expenditure steps	Responsible administration	Problems identified
<b>Commitment</b>	Budget	Delays issuing the quarterly Budget Commitment Plans. Disconnect between these plans and the sector budget. Limitation of sums available for commitment (liquidity).
	Technical ministry	Delays/errors in the preparation (departments; sub-managers), signature (Minister) and submission (sub-manager) of the commitment voucher in accordance with the Budget Commitment Plan.
<b>Validation of expenditure</b>	Budget	Delays in the signature (charged to the following quarter; loss of quarterly transfers for the MoPH). Long processing delays/standstills. Highly manual procedures.
<b>Payment order</b>	Finance	Payment orders can take two to three months to sign (loss of quarterly transfers). Carryover transfers. Manual procedure.
<b>Payment</b>	Treasury	Delays/errors in authorization for payment and the bank transfer. Significant lag between opening the dossier (requisition) and releasing the payment.

Source: Authors; Ministry of Budget 2014; World Bank 2012; World Bank 2015.

Note: A commitment is the act by which the state creates or recognizes an obligation on the state from which a charge will arise. Validation of expenditure checks that the debt exists and calculates the exact amount of the outlay. A payment order is an administrative act by which, in accordance with the results of the validation calculations, the order is given to the cashier to pay the state's debt. Payment is the act by which the state is released from its debt.

two steps remain highly manual and, although lead-times have been reduced, overdue payments are still the norm and carryover transfers are frequent (World Bank, 2012).

**The low level of government expenditure execution across all resources has fallen further in recent years, whereas allocations have generally been raised.** Execution has fallen across the entire budget and for the social sectors in particular. The total expenditure execution rate tumbled from 77 percent in 2008 to 52 percent in 2011 before picking up to 56 percent in 2013 (World Bank, 2015). Expenditure execution of total resources fell even more sharply for the social sectors and infrastructure from 77 percent in 2008 to 35 percent in 2012–2013. The low level of execution for the social sectors, especially health, is due mainly to the overestimation of allocations from external resources and nonexecution of transfers to the provinces (Chapter 5).

**Since 2010, the expenditure chain has been reformulated.** The aim of reforms to the computerized expenditure monitoring base was to improve readability (reduce duplication), bring it into line with the budget classification and introduce new special modules (for payment in particular). The next step will be to set up an integrated information system for all ministries to consolidate monitoring of all government expenditure.

**A reform of the public procurement system was launched in 2010 on account of its importance in expenditure.** A Public Procurement Regulatory Authority, Public Procurement Audit Division (DGCMP), and management units in the departments were set up. Operating resources remain low, however. Its 12-step process involves validation by nonobjection at each step, but selection alone can take three or four months. With external assistance, several bodies have been set up to smooth purchasing and investment in health when done via public procurement (World Bank, 2015).



# HEALTH SYSTEM: ORGANIZATION AND RESOURCES

## 2

### Section I. Health System Objectives and Organization

**Health is one of the pillars of DRC's socioeconomic reconstruction.** The war has had a considerable impact on the health system and the population's state of health. After two decades of conflict estimated to have cost over 4.5 million lives, the government is aware of the need to build its human capital for future development. The second Growth and Poverty Reduction Strategy (GPRS 2, 2011–2015) adopted in 2011 prioritizes access to basic social services (Pillar III). The strategy is designed to contribute to poverty reduction mainly by improving the population's health and nutrition. The government adopted the second National Health Development Plan (NHDP II) in 2011 with its timeline aligned with that of the GPRS 2. This plan aims to consolidate the health system to better meet the population's health needs.

**Since the mid-2000s, the country has engaged in major reforms of health sector governance.** Moving from the emergency approach of the late 1990s, the government has paved the way for longer-term development, despite emergency operations in the eastern part of the country especially. The strong political will to set a long-term strategic vision for the health sector can be seen from the multiple strategies developed since 2010 (Table 6). Program tools have also been set up to improve monitoring of the sector's core outputs and performance, such as an outcomes framework for the NHDP (2011) and a

national Operational Action Plan. (Provincial operational action plans have also been written.)

**Consolidation of the health system calls for improving the health districts (zones de santé) that form the mainstay of the system's peripheral governance.** This focus should scale up access to quality primary health care by having local management geared to needs. It should also reduce the system's fragmentation by furthering the integration of vertical health programs. The health district is the basic health care planning and primary health care delivery unit, and its activities are coordinated by a Management Team. A health district covers some 100,000–200,000 inhabitants, with 10 health centers and one district hospital (Hôpital Général de Référence, or HGR). The Minimum Care Package provided by health centers covers first-referral curative, preventive, promotional, and assistance activities. The Supplementary Care Package covers the clinical services of internal medicine, surgery, gynecology-obstetrics, and pediatrics in district hospitals.

**Over the last few years, more responsibility has been shifted to the provinces.** In keeping with the 2006 Constitution, governance of the health sector, now the exclusive reserve of the provinces, has seen a redefinition of responsibilities between the health administration's central and decentralized levels (Table 7). The MoPH now has a regulatory and normative role (Article 202 of the Constitution) with responsibility for policy implementation at the province level (Article 204). The 26 Provincial

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**TABLE 6** Summary of Main Strategic Health Goals

Date of adoption	Strategy document	Main objectives or strategic goals
2013	National malnutrition reduction strategy	Reduce acute and severe malnutrition
2011	Growth and Poverty Reduction Strategy (GPRS 2, 2011–2015)	Improve access to basic social services to improve the population's state of health and nutrition
2011	National Health Development Plan II (NHDP II 2011–2015)	Develop the health district Improve sector leadership and governance Improve intersector cooperation
2010	Health System Strengthening Strategy (HSSS)	Correct distortions due to vertical programs Reorganize the central and intermediate level Develop human resources for health Reform the drugs sector Reform health financing Scale up intersector collaboration
2010	National Human Resources for Health Development Plan (2011–2015)	Improve careers management (rational management and use of HRH) Improve HR retention Increase the output of health professionals Take forward in-service training
2005	Health Financing Strategy	Increase sector financing Increase the predictability of internal and external government expenditure Scale up prepaid mechanisms (community-based insurance and other forms of insurance) Reduce the fragmentation of international aid for health Improve the populations' financial accessibility to quality health care
2000	Adoption of national health standards	Definition of quantitative and qualitative standards for the health care package Minimum Care Package Supplementary Care Package

**TABLE 7** New Governance of the Health System in DRC

	Administrative organization	Health organization
Central level	Minister of Health's staff Secretariat General for Health Central divisions and programs	Tertiary-level national hospital
Provincial level	Provincial MoPH Provincial Health Divisions Provincial Health Inspectorates	Secondary-level provincial hospital
Operational level	Central Health District Office	District hospital Health center Health post

Source: Authors, based on information from the MoPH, 2014.

Health Divisions (Divisions Provinciales de la Santé, DPS) established in December 2014, reporting to Provincial Minister of Health, have been tasked with managing and overseeing provincial health administration. Nevertheless, deconcentrated Provincial Health Inspectorates (Inspections Provinciales de Santé, IPS) are to continue supervising and monitoring at the provincial level with central ministry oversight. The old health care district has disappeared and District Manager Offices (Bureaux chef de Zones, BCZs) oversee the primary-level health facilities (district hospitals, health centers, and health posts).

**The nonprofit private sector has always played a dominant role in care delivery and health system structure.** Through 1991, 62 percent of health districts were managed by churches (Murru and Pavignani, 2013). It is estimated that the nonprofit private sector was managing over one-third of the health facilities in 2013, either on its own account

**BOX 1** Role of Faith-Based Organizations in the Health System in DRC

Some 35–40 percent of health districts are managed or comanaged by networks of faith-based organizations; an estimated 40–50 percent of health facilities are managed by such bodies. Their delivery of care is well integrated into the government system, without any real split or separate duties. They form part of service delivery considered public (with or without a government contract), rather than strictly “private.”

Health facilities managed by faith-based bodies may be owned either by a church or the state. The Catholic Church, for example, estimates that it works in 50 percent of health districts and supports 27 percent of health facilities fully and 67 percent partially. The MoPH pays the wages of some staff working in health facilities run by faith-based outfits. An estimated 65 percent of staff working in health facilities supported by the Catholic Church are registered as health personnel with the MoPH, and 30 percent are on MoPH payment registers.

What makes the situation in DRC different from other countries is that, beyond playing a major role in providing services in the community, health centers, and hospitals, faith-based networks also help manage or comanage health districts. Diocesan Offices are heavily involved in managing districts.

Source: Adapted from NHDP II, 2011 and DFID, 2010.

or delegated on behalf of the central government. An estimated 35 percent of district hospitals are managed by faith-based organizations (Box 1), 60 percent by central government, and 6 percent by the for-profit private sector (MoPH, 2010, NHDP). Recent years have seen the exponential growth of the for-profit private sector, especially primary-level

operations, due mainly to an increase in the output of medical personnel. This used to be a characteristic of the health districts in urban areas, but is now seen increasingly in rural areas (NHDP, 2011).

## Section 2. Health Care Infrastructure and Equipment Availability

**The health sector is no exception to the country’s infrastructure deficit.** DRC had a recorded 8,266 health centers, 393 district hospitals, and 5 provincial hospitals in 2013. The ratio of infrastructure coverage to national targets was 95 percent for primary level, 76 percent for district hospitals, and 19 percent for secondary level. Although geographic coverage has improved over the last decade, especially at primary level where it has reached the standard of one center for every 10,000 inhabitants, there is a dearth of referral operations with less than one district hospital for every 200,000 inhabitants nationwide. Secondary referral hospitals (or provincial hospitals) and tertiary (or national) hospitals remain scarce in the public health system given a 30-year absence of any strategy or financial policy for them.

**Less than 30 percent of primary- and secondary-level facilities are operational (Table 8).** Most health care operations/services offer patchy coverage capacity due to failings tied to aging infrastructure and lack of equipment. A 2013 MoPH study reports that only 31 percent of primary health centers are considered operational and capable of delivering the expected care package. Two-thirds are reported to have been built using materials not made to last. A

**TABLE 8** Availability and Operational Status of the Health Care Infrastructure in DRC, 2013

	Target	Actual	Operational	Percentage operational of total	Ratio (to population)	DRC standard
<b>Health centers</b>	8,628	8,266	2,588	0.31	1.08 per 10,000	1 per 10,000
<b>District hospitals</b>	516	393	31	0.08	0.49 per 100,000	1 per 100,000
<b>Provincial hospitals</b>	26	5	N/A	N/A	N/A	N/A

Source: MoPH, 2013; authors’ calculations.

mere 8 percent of district hospitals are considered capable of delivering the supplementary care package. Nationwide, 22 percent of the hospitals have electricity and 32 percent have running water, drinking or otherwise. Just 1 percent have full laboratory equipment. The majority of hospitals (59 percent) were built and equipped before independence, and little investment has been made since. Fewer than 10 hospitals were built over 1960–2010.

**Referral infrastructure is concentrated in urban areas.** Most district hospitals are in or around provincial capitals, leaving the majority of the population without direct access to a referral establishment. For example, the three urban health districts in Sud Kivu province each has three district hospitals, yet one-third of the rural health districts do not have a single hospital. In Province Orientale, 29 rural health districts have no referral establishments whereas the city of Kisangani has three. Some provinces suffer from a greater lack of hospitals than others: Maniema for example has just nine district hospitals, Katanga 59. The distribution of district

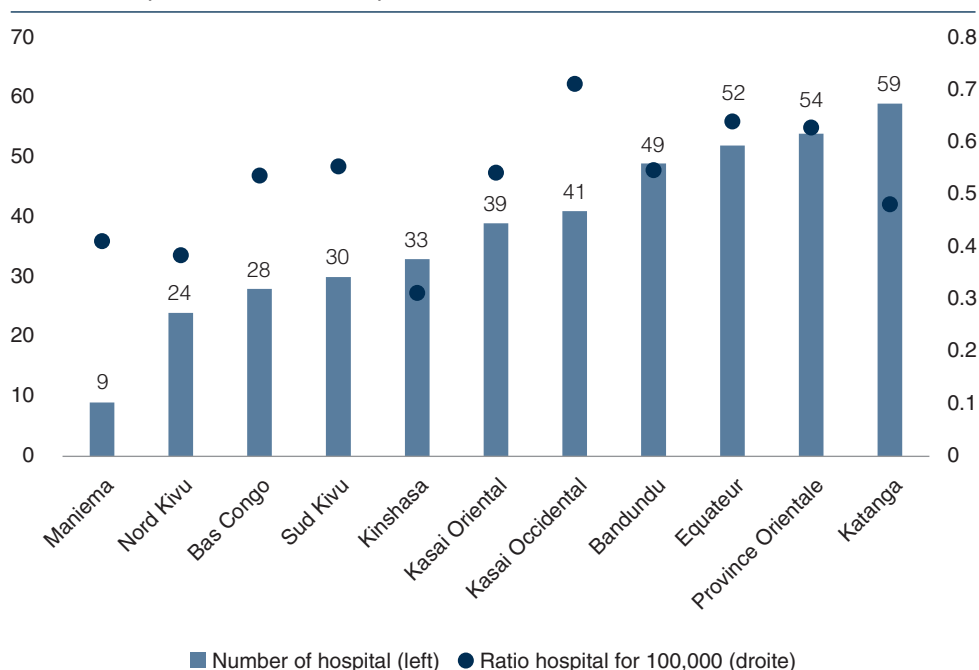
hospitals ranges from 0.33 hospitals per 100,000 inhabitants in Province Orientale to 0.71 in Kasai Occidental. Although the province of Kinshasa has a population of over 10 million, it is not the best covered province with just 33 district hospitals—or 0.31 hospitals per 100,000 inhabitants (or 1 hospital per 322,000 inhabitants) (Figure 4).

### Section 3. Human Resources for Health

#### Availability of Health Personnel: Understaffing versus Overstaffing

**The issue of availability of qualified health personnel in DRC is thorny.** By international standards, DRC has an acute health personnel crisis (WHO, 2009). In 2013, the country was estimated to have just under 6,000 physicians and 72,000 nurses, i.e., 11 qualified health personnel per 10,000 inhabitants—according to WHO standards, the country should more than double its medical staff to 23. With only 0.7 physicians per 10,000 inhabitants

**FIGURE 4** Distribution of the Health Care Infrastructure by Province: Number of Hospitals per Province and Ratio per 100,000 Inhabitants



Source: Authors' calculations, based on MoPH data, 2011.

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**TABLE 9** Health Personnel by Professional Category in DRC (2013) and Sub-Saharan Africa (most recent available data)

	Physicians	Nurses and midwives	Total health personnel	Administrative personnel
<b>DRC</b>				
<b>Staff (2013)</b>	5,719	71,472	89,557	52,202
<b>Ratio per 10,000 (2013)</b>	0.7	8.9	11.1	6.5
<b>International comparisons (per 10,000 inhabitants)</b>				
<b>Sub-Saharan Africa (2009)</b>	0.3	1.7	2.0	N/A
<b>World (2009)</b>	1.4	2.8	4.1	N/A
<b>Standards (per 10,000 inhabitants)</b>				
<b>DRC standard</b>	0.3	4.8	1.3	N/A
<b>WHO standard</b>	N/A	N/A	23	N/A

Source: Authors' calculations based on MoPH data (2013) for DRC and WHO for other countries. <http://apps.who.int/gho/data/view.main.92000>

in 2013, DRC has one of the lowest physician ratios in the world.

**Yet the MoPH paints a picture of overstaffing in Human Resources for Health (HRH).** National standards—below WHO standards—classify the country as overstaffed. In particular, nursing staff and midwives (8.9 practicing per 10,000 inhabitants) are estimated at nearly double national standards (4.8 per 10,000) (Table 9). Although precise numbers of practicing personnel are subject to discussion absent a comprehensive up-to-date census, this estimate is corroborated by anecdotal evidence, especially in the hospitals and for certain categories of unskilled personnel, reportedly forcing some people to work on a monthly roster basis due to low workloads.

**In fact, despite a growing stock of HRH, the population does not have adequate access to qualified health professionals nationwide.** Poor distribution of human resources is such that a large majority of primary-level facilities do not have the staff they need to be fully operational, especially in rural areas. Although some urban operations may well be overstaffed, an analysis by province suggests that most of the health facilities, especially at lower levels of the health care pyramid and in rural areas,

remain chronically understaffed (World Bank and University of Kinshasa, forthcoming).

**The health labor market is relatively saturated.** HRH supply is rising faster than demand, mainly due to increased production of medical personnel on the one hand, and the public sector's limited absorption capacity on the other.

**The country has seen surging production of medical personnel.** Such production across all disciplines has boomed in the last decade with the expansion of universities and provincial schools. The number of medical schools shot up from three in 1998 to 61 in 2013.<sup>14</sup> The number of paramedical training schools doubled over 1998–2013. Potentially over 2,000 physicians and 4,000 nurses can graduate from the country's schools and faculties every year. The increase in graduate production has had a positive effect on the total density of working personnel, which soared from 0.1 to 0.7 physicians per 10,000 inhabitants over 2006–2013. The increase in the production of nursing graduates also appears to have driven up the number of nurses

<sup>14</sup> The 2009 MoPH assessment and the 2013 HRH directory count 406 technical institutes of medicine as opposed to 255 in 1998, 100 higher technical institutes of medicine as opposed to 53 in 1998, and 61 medical schools as opposed to 3 in 1998.

working in the country, with 8.9 nurses per 10,000 inhabitants in 2013.

**But growth in graduate production has come at the expense of skill levels.** The development of schools and training institutes in the provinces has become a lucrative business, with the emphasis on the quantity rather than quality: two-thirds of new training centers have no technical facilities for medical students to practice what they learn (MoPH, 2013). Without a solid accreditation system, the increase in production of medical personnel does nothing to raise the availability of skilled personnel.

**The supply of trained staff is larger than the public sector's absorption capacity.** DRC's higher education system turns out over 2,000 trained physicians every year, more than one-third of the number of public sector physicians in 2013.<sup>15</sup> This is too much for the civil service to absorb given its structural (budget constraints) and cyclical (flow management) rigidities. Yet despite the public sector's limited recruitment capacity, there is little regulation of personnel flows resulting in the majority of the public workforce being unpaid by the central government.

**There is little regulation of what used to be virtually automatic entry into the public sector.** Before the early 2000s, entry into the public sector was almost automatic.<sup>16</sup> Nearly all medical graduates were assured of a position in the civil service, at central or provincial level, from the moment they were registered with the Order of Physicians. Over the last decade, entry has been regulated more, due to civil service caps on government employee numbers. A freeze on wage earners among medical personnel was introduced in

2012–2013, but seems not to have put any real brake on entry into service, especially at the decentralized level, due to flexible implementation of recruitment/commissioning rules (estimated by the Civil Service Ministry in 2014). Entry continued to rise sharply over 2009–2013, especially for physicians. Today, the sector has 20 percent unregistered “new units” (35 percent on average across the entire civil service).

**It is hard to exit the civil service because it does not offer decent pensions.** Thus many staff who have reached retirement age remain in service and/or part of official staff numbers. Over 10 percent of staff registered by the MoPH are estimated due for retirement, but stay on the payroll. In 2013, a request was sent to the Civil Service Ministry for approval to retire 9,182 health employees—4 percent of all retirements to be brought in by end-2015 (among a total of 244,198 estimated by the Civil Service Ministry in 2014).

**Capacity for registration<sup>17</sup> and compensation are constrained, resulting in nearly half the workforce being effectively informal and unpaid.** Just 31 percent of the workforce is registered and receives a formal monthly salary from the civil service. Of the personnel working, 49 percent are registered, but not on the payroll<sup>18</sup> (Figure 5).

**Public sector constraints prompt a high brain drain from the health labor market.** Over 1995–2005, an estimated 9–13 percent of physicians and 12 percent of nurses emigrated (Clemens and Pettersson, 2007). The main destinations were other countries in the region (79 percent to South Africa, Zambia, Rwanda and, for the eastern part of the country, Uganda and Angola), followed by Europe (15 percent). On graduating, an estimated half of all graduates seek work in the private for-profit or nonprofit sector. Nongovernmental organizations alone reportedly take on over 30 percent of new medical graduates.

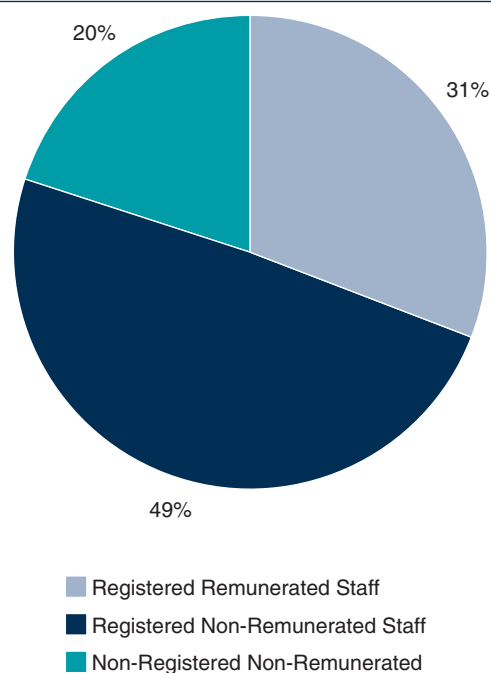
<sup>15</sup> Figures vary by source, but usually tally: 8,597 graduates from institutes of medical technology (ITMs) and institutes of medical education (IEMs) over 2001–2005 and roughly 8,000 over 2007–2009 (NHDP II); 3,424 graduates from all courses for the 403 ITMs/IEMs (MoPH, Annual Report, January 2014).

<sup>16</sup> At the central level, a medical graduate duly registered with the Order of Physicians used to receive a letter of commission (right to practice in a health facility) following a central assignment committee meeting (MoPH Secretary General authority). The MoPH virtually never refused registration. The provinces used to be able to issue a letter of assignment/commission, which was then sent to the Secretary General for approval.

<sup>17</sup> Registration (*immatriculation*) is the official recognition of staff by the Civil Service. It is equivalent to tenure.

<sup>18</sup> A recent study on the availability of HRH in four provinces (Bandundu, Equateur, Katanga and Sud-Kivu) shows that the rate of paid staff is even lower at 21 percent of the sample (across 1,771 staff interviewed). Mechanization is lower at primary level due to the absence of physicians on the staff.

**FIGURE 5** Registration and Compensation of Health Personnel in the Public Sector, DRC



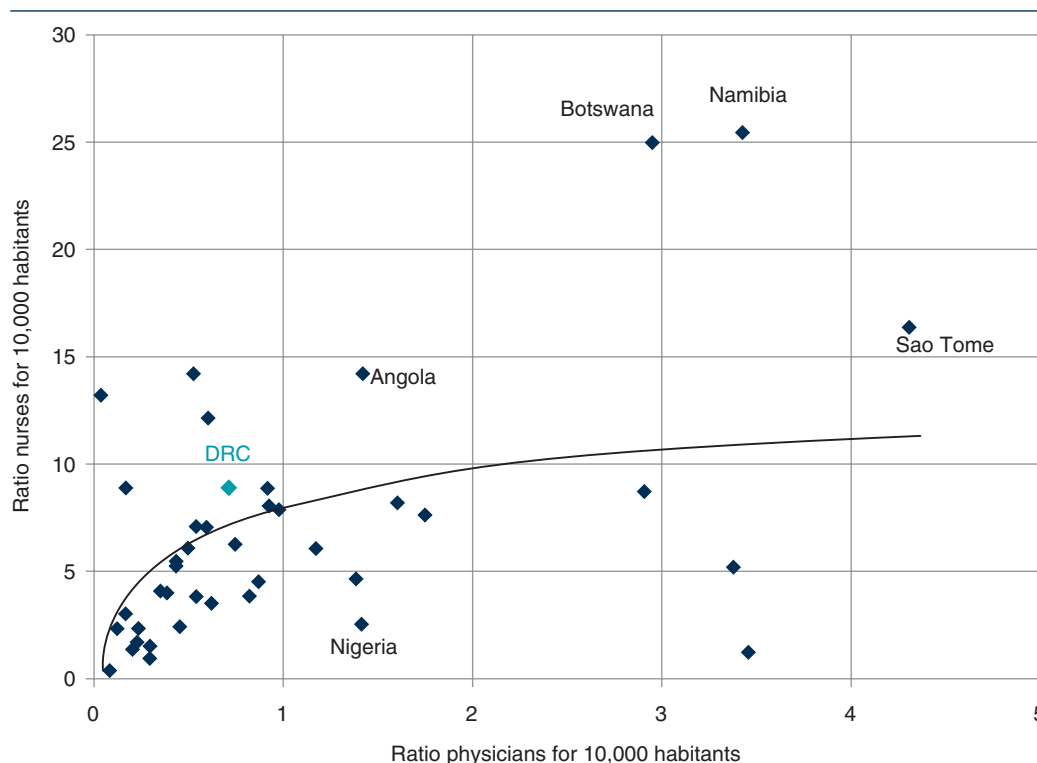
Source: Authors' calculations, based on MoPH data 2013.

*Distribution of Health Personnel*

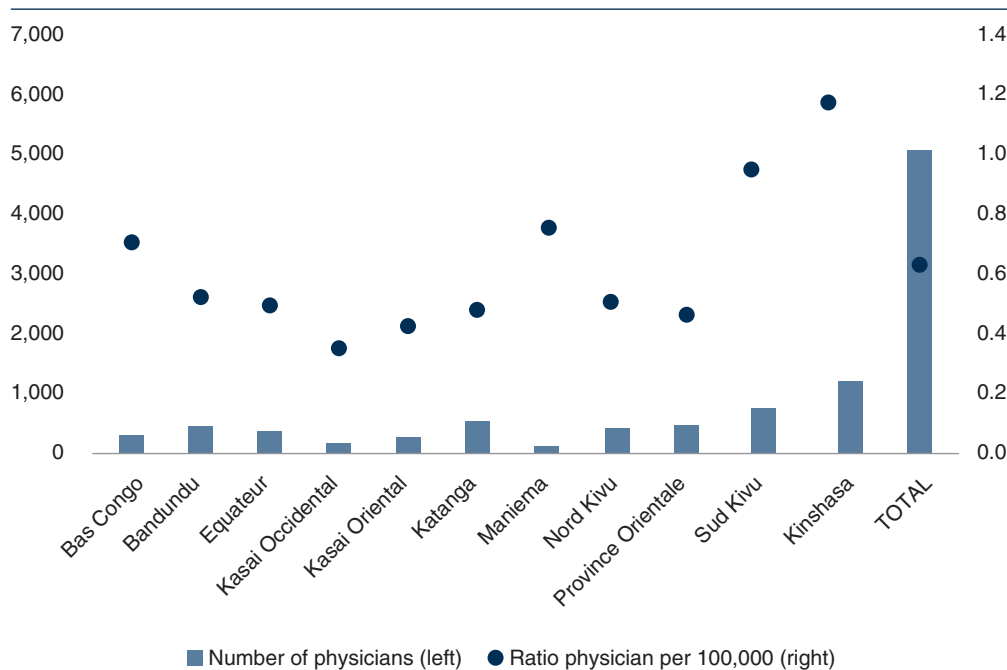
**Nurses features disproportionately among HRH.** With 8.9 nurses working for every 10,000 inhabitants, paramedical tasks would appear to be largely covered in DRC. The inverse physician/nurse ratio, with over 12 nurses to 1 physician (Figure 6), as opposed to 1 to 2.04 worldwide, confirms the shortage of physicians but also reflects a disproportionately high percentage of practicing nurses. This situation is due to the systematic delegation of clinical tasks to nurses at the primary level, met by a growing output of nursing graduates in the provinces.

**The geographic distribution of HRH shows large disparities between Kinshasa and the rest of the country, especially for physicians.** Kinshasa has 1.3 physicians per 10,000 inhabitants, while most of the other provinces post half this ratio (Equateur, Bandundu, the two Kasai, and Province Orientale).

**FIGURE 6** Ratios of Physicians to Nurses per 10,000 Inhabitants in DRC and Sub-Saharan Africa (all income levels)



Source: Authors, based on MoPH data for DRC and WHO, 2014 or latest available data.

**FIGURE 7** Geographic Distribution of Physicians per Province

Source: Authors' calculations, based on MoPH (2013) and Equateur DPS (2014) data.

The only exception is Sud Kivu with a ratio of 1.1 (Figure 7). The reverse is true for nurses: Bandundu and Equateur seem better off than Kinshasa with over 13,000 nurses each against Kinshasa's fewer than 4,000 (4 per 10,000) (Figure 8).

**The distribution of HRH is also problematic within provinces, with rural areas losing out.** Across a sample of four provinces, the facilities lacking staff are mainly in rural areas (Table 10). Rural health centers are mainly short of nurses (*infirmiers*) and administrators/managers.<sup>19</sup> As an example, Equateur's rural areas lack physicians (*médecins*), administrators, and pharmacists. Acute shortages are reported at district hospital level, while the stock of personnel is closer to national norms in urban areas. The main deficit overall is among physicians and technicians, especially pharmacists.

<sup>19</sup> National standards do not provide for physicians at health centers.

## Section 4. Availability and Funding of Pharmaceuticals

### Availability

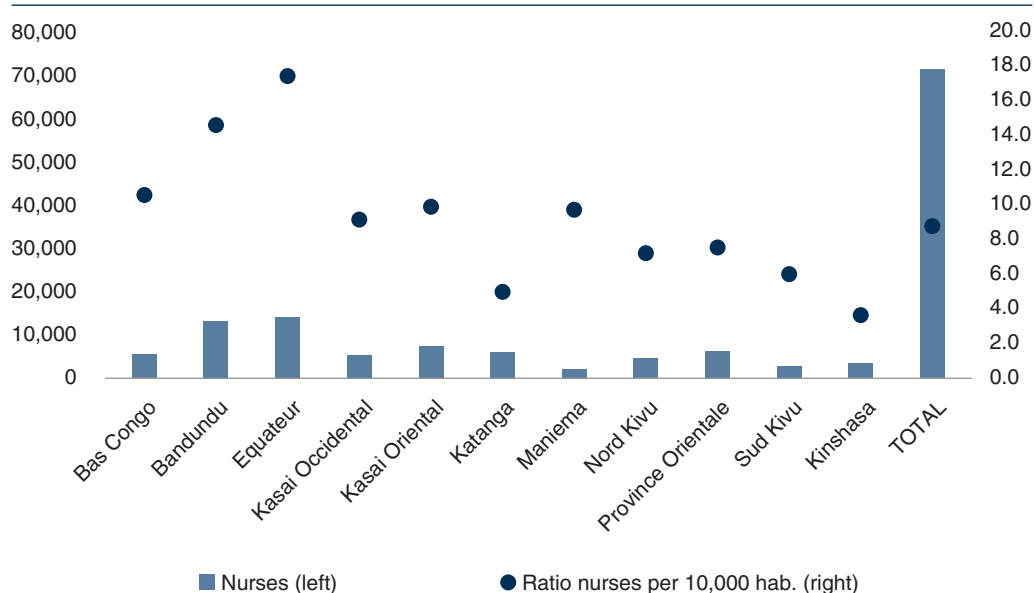
**Poor availability of essential drugs in health establishments is one of the major bottlenecks to quality health care provision.** In 2010, just 15 percent of tracer drugs were reportedly available in district hospitals (MoPH, 2011). The SARA survey conducted from 2012 to 2013 put average availability of tracer drugs at around 20 percent across the more than 1,000 health facilities in its sample (Figure 9). None of the health facilities has all the essential drugs. Oral rehydration salts—an essential treatment for diarrhea in children—are found in just 2 percent of health facilities. Access to essential drugs is almost nonexistent in certain provinces: five provinces have less than 20 percent availability of tracer drugs. Maniema, for example, has less than 13 percent of the drugs (1 in 17) on average.

**Lack of development and fragmentation of the supply system is restricting access to**



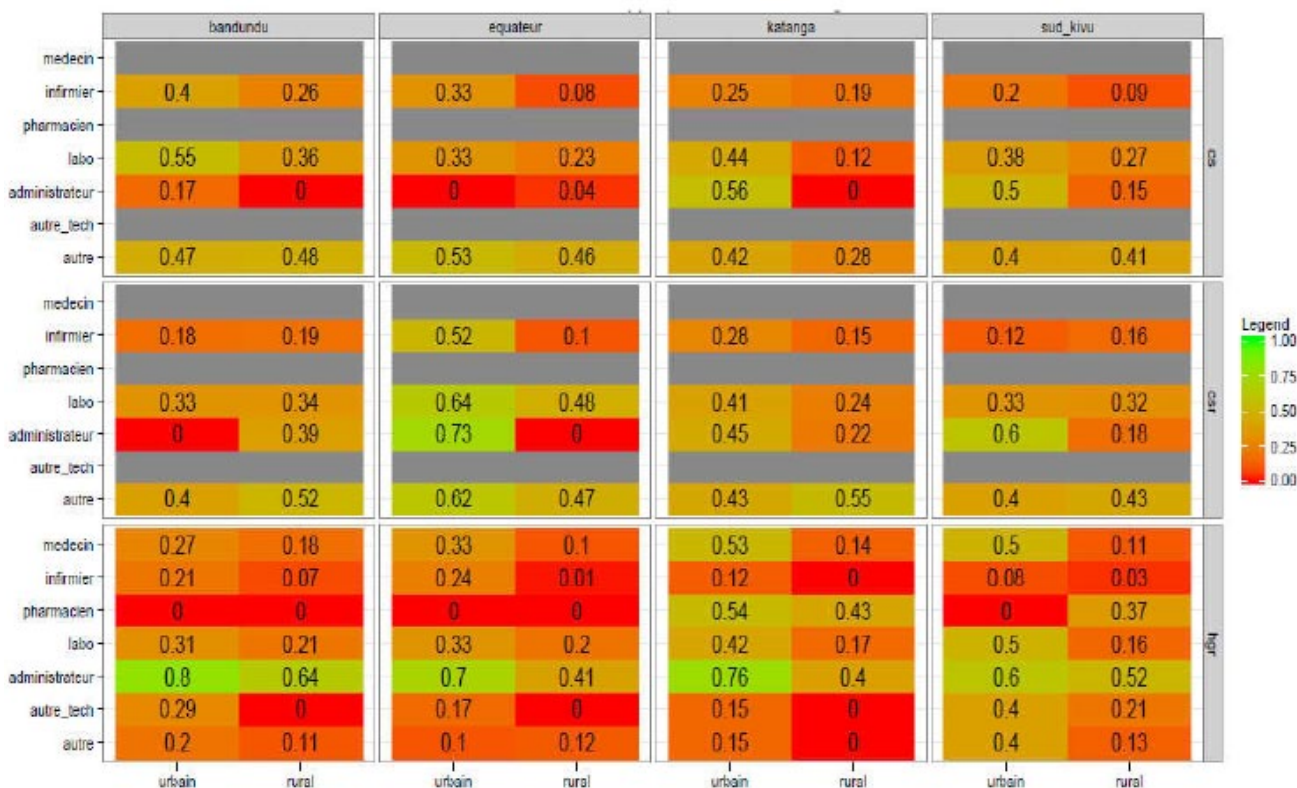
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**FIGURE 8** Geographic Distribution of Nurses/Midwives per Province



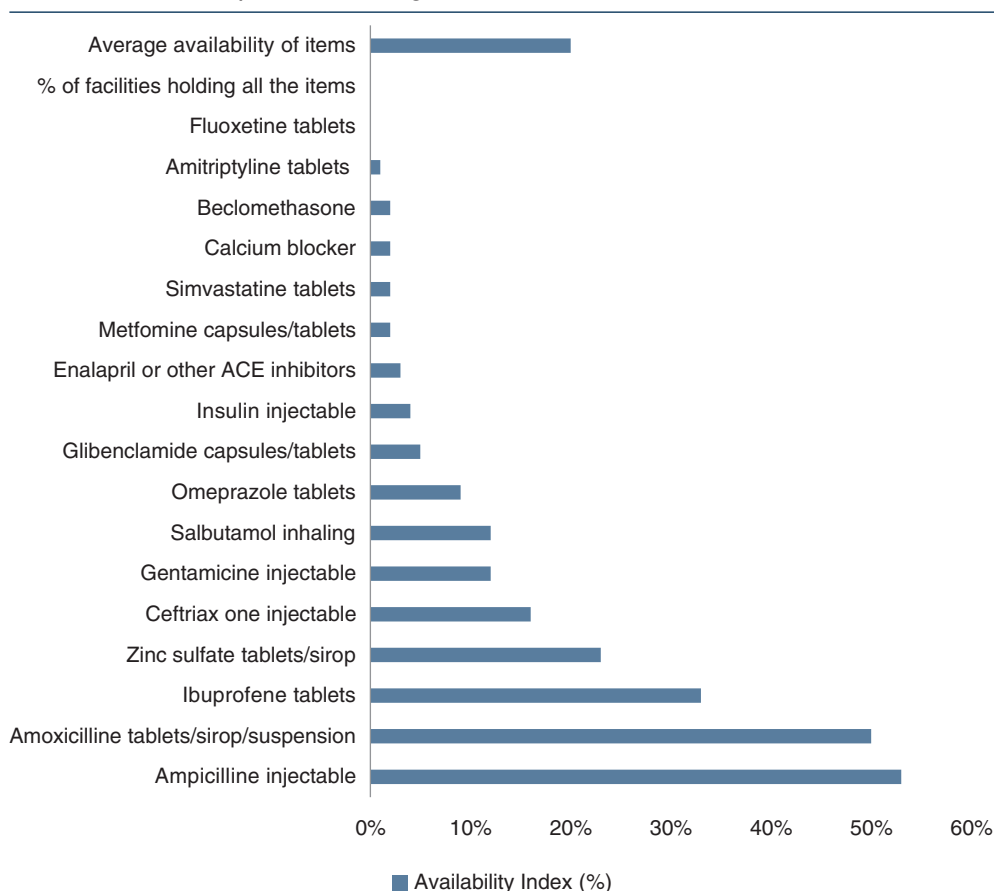
Source: Authors' calculations, based on MoPH (2013) and Equateur DPS (2014) data.

**TABLE 10** Proportion of Health Facilities Meeting National Standards per Category, Type of Health Facility and Location, 2014



Source: World Bank and University of Kinshasa, forthcoming.

Note: The number in each cell is the proportion (maximum = 1) of health facilities meeting the health standards. A red cell means that the standards are met by a small number of health facilities and that there are not enough health personnel in this category, province, type of facility, and district. An orange or green cell is a sign of an increase in the proportion of health facilities meeting national standards. "Autre = other."

**FIGURE 9** Availability of Essential Drugs

Source: SARA survey, MoPH, forthcoming.

**quality drugs.** A National System for Procurement of Essential Medicines (SNAME) set up in 2002 has done little to improve access to drugs. Drugs storage and distribution is decentralized through a network of 15 regional medical stores (Centrales de Distribution Régionales), but their performance remains poor and many health districts do not have one. Further, the quantification of needs is not very reliable and is affected by vertical programs working in “silos.” Logistical capacities remain poor, while certain regions are relatively inaccessible (e.g. province of Equateur). Transport is extremely expensive, weighing heavily on drugs budgets and making it impossible to place small emergency orders.

**Frequent stockouts mean that health facilities and patients turn to the private sector for medical supplies.** Yet this sector is poorly regulated, and

the effect on the quality of the drugs circulated is disastrous. Most private importers and wholesalers operate outside of the rules of best pharmaceutical distribution practices. The private sector is not regulated and the quality of the drugs circulating is a problem. A small-sample study in Kinshasa province in 2011 found that over 60 percent of drugs in circulation were unfit for consumption (expired, fake, or counterfeit) (MoPH, 2011).

**When the drug required is available, it is not always well managed and used.** The Register on the Use of Essential Drugs and Revenues is not in widespread use and is sometimes based on archaic tools. In terms of use, a recent analysis of medical prescriptions reveals a strong tendency to overprescribe with an average of four drugs per prescription (antibiotics in over 60 percent of cases). Overprescribing is

likely associated with the provider payment system in all facilities, including primary care level, which typically relies on itemized (fee-for-service) billing.

### Funding

**Drugs are funded largely by users.** A cost recovery system is in place in DRC based on the Bamako initiative. It was supposed to provide health facilities with financial autonomy and guarantee financially sustainable drugs renewal. In practice, in DRC as in other countries in the region, cost recovery has not prevented stockouts. Yet the cost recovery system has reportedly made substantial proceeds, which have not all been systematically reinvested in purchasing drugs. A study conducted in Sud Kivu finds a small share of proceeds reinvested in health establishments and drugs availability in particular (DCC, 2014). For example, annual Federation of Central Medical Stores (FEDECAME) orders are estimated to total one-tenth of the amounts disbursed by households for drugs at the point of use of the services.

**External assistance is another important source of drug funding.** Donors are estimated to have spent over USD 96 million on drugs in 2013. These drugs are distributed through two channels: centralized purchases by the national FEDECAME network and supplies (the majority of distribution) through each partner's own channels, which then handle distribution through to the health facilities. A 2010 WHO study finds more than 19 supply agencies

**TABLE 11** Estimate of Drug Expenditure, 2013

Funding source	USD (2013)
<b>Households*</b>	159,542,594
<b>External assistance**</b>	96,729,682
<b>Public sector***</b>	2,378,868

Source: Authors' calculations, based on MoPH data.

\* Estimate based on the NHA (2012 data).

\*\* Amount disbursed in 2013, as reported by the development partners and published by the MoPH Research and Planning Division, 2014.

\*\*\* Estimate based on predicted expenditure for the PESS program drugs line in 2013, the main drug expenditure item using government funds.

and 99 distribution channels involving over 50 different partners. This fragmentation undermines the system's efficiency at all stages of the supply cycle (selection, quantification, procurement, and information management) and creates huge disparities in drug accessibility between provinces (WHO, 2010).

**Government funds invested in drugs are paltry.** Before the launch of the Health Facility Enhancement Program (PESS)—a vast national initiative—government expenditure on drugs was virtually nonexistent (Table 11). This program now provides for the government to support the supply of targeted health districts with essential drugs and other consumables from its own resources. Likewise, the government has undertaken to finance part of the purchase of vaccines from its own resources (the 2015 allocation is USD 11 million).

# HEALTH SYSTEM PERFORMANCE

# 3

## Section I. Health Outcomes

### Demographic Issues

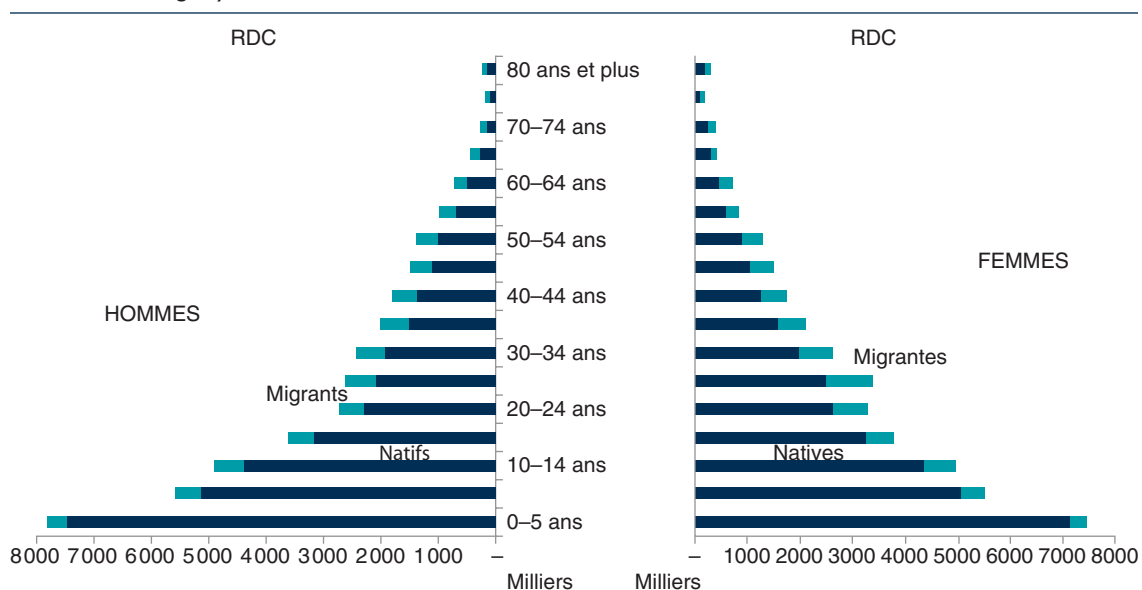
#### DRC faces immense demographic challenges.

With a natural increase rate estimated at 3.1 percent in 2014, forecasts suggest that the population will double by 2050 and could approximate 150 million (Box 2). Currently, nearly half of the population is under 16 years old and 20 million people are aged 15 to 30 (Figure 10).

#### DRC's fertility rate is one of the highest in the region, at 6.6 children per woman (Figure 11).

Fertility reportedly rose slowly from 6.2 children per woman in 2007 to 6.3 in 2010 and 6.6 in 2014. When this rate is disaggregated at provincial level, marked differences are found between urban areas (5.4 children per woman) and rural areas (7.6). Adolescent pregnancies have also increased, especially in rural areas, from 24 percent in 2007 to 27 percent in 2013–2014 among women aged

**FIGURE 10** Age Pyramid, 2013



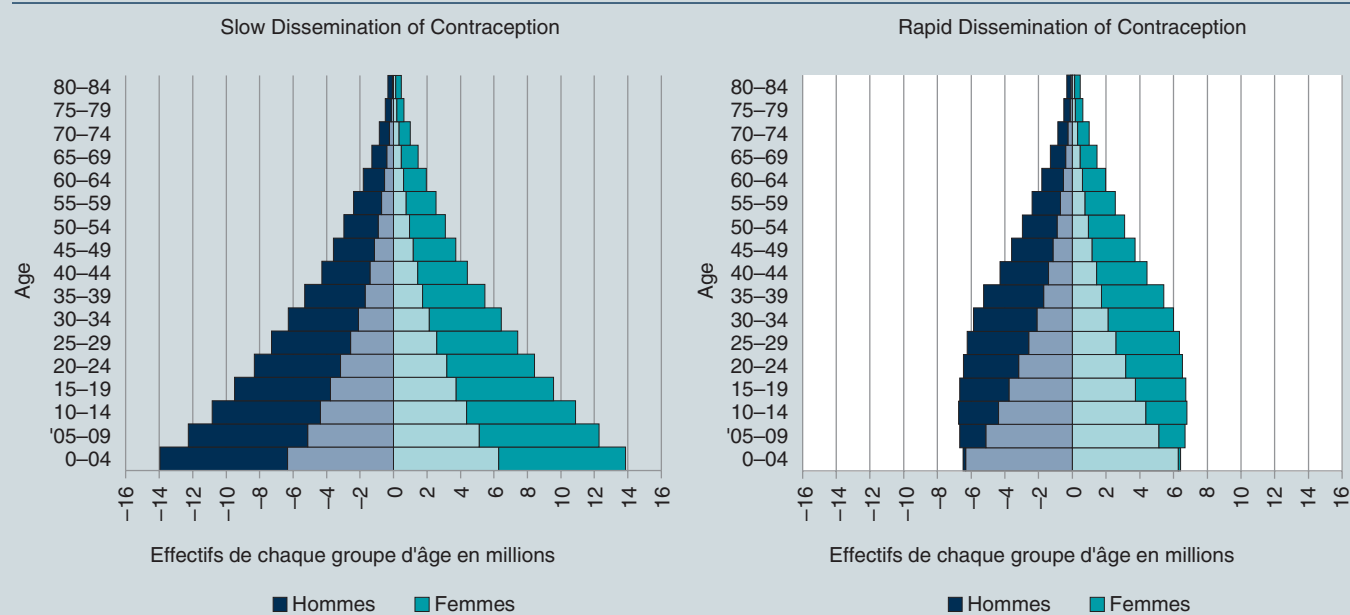
Source: NSI, 2013.

Note: Hommes = men; femmes = women; milliers = thousands; ans = years.

**BOX 2** Demographic Scenarios for 2050

Demographic projections show that it is possible to intervene on the demographic variable, through accelerating contraceptive use. Three scenarios of dissemination of contraception have been formulated: slow, with an increase in prevalence of modern contraception of 1.0 percentage point a year from 2014; rapid, with an increase of 1.5 points a year; and very fast, with an increase of 2.0 points a year. These scenarios lead to a decrease in the fertility rate of about 6.5 children per woman today to respectively to 4.4, 3.1, and 2.2 children per woman in 2050. But irrespective of hypothesis, the population of the DRC will be at least 100 million by 2030, and in 2050 could be 140 million for the very fast scenario, double today's, and 185 on the slow scenario. Current high fertility and the many young people of child-bearing age will therefore mean that the DRC's population will continue growing strongly in 2050 and beyond.

The essential difference between these assumptions lies in the age structure of the DRC's population in 2050. On the slow scenario, young people under 15 and those aged 15–24 are in 2050 twice as numerous as in 2014. On the very fast scenario, the number of young people under the age of 15 are stabilizing and the 15–24 age group are less numerous than before. This scenario also sees a shift in the population growth rate from 3 percent to 1 percent in 2050 (2.4 percent in the slow scenario), which would lead to a more rapid increase of GDP per capita. In emerging countries, the elimination of the costs attributable to a continued increase in numbers of pregnancies, births, and young people has generated a tax gain that has allowed them generally to better respond to social demands in health and education, and to implement policies that benefit from the demographic dividend.

**BOX FIGURE** Age Pyramids in 2014 and 2050 with Two Hypotheses of Slow and Rapid Dissemination of Contraception

Source: Guengant J-P. et al. 2014 : Population, développement et dividende démographique en République Démocratique du Congo.

15–19. In rural areas, nearly one-third of women under 19 were mothers in 2013–2014.

**Use of modern contraceptives remains scant.**

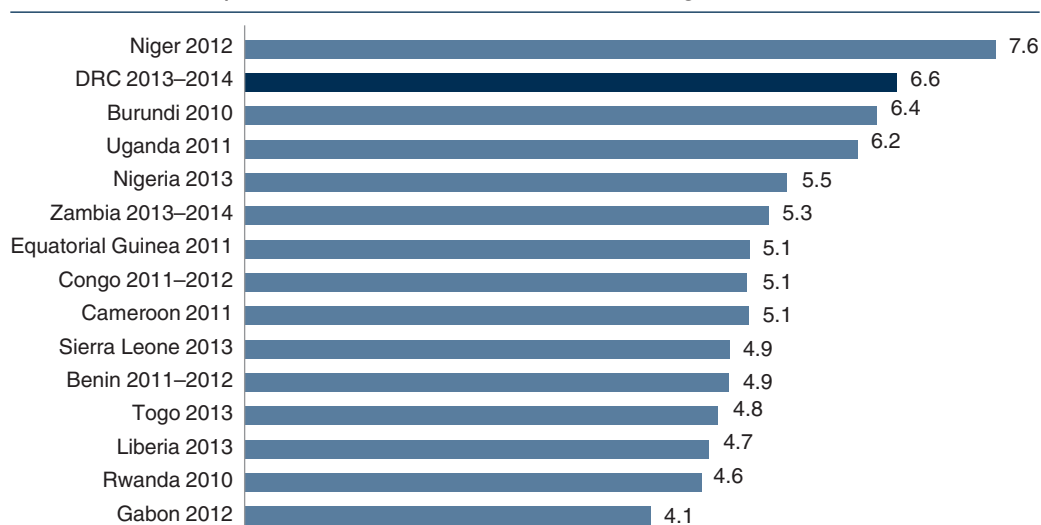
This is despite a slight upturn from 6 percent to 8 percent among women aged 15–49 over 2007–2013/2014 (as opposed to 15 percent in 1995), which places DRC behind peer countries (Figure 12).

**Main Causes of Death among Adults**

**The main causes of illness and death have changed little, with communicable diseases accounting for a large proportion.** (Malaria comes first followed by respiratory infections, diarrhea, malnutrition and HIV/AIDS). Adult mortality among those aged 15–49 is 5.4 per 1,000 (for women) and 5.2

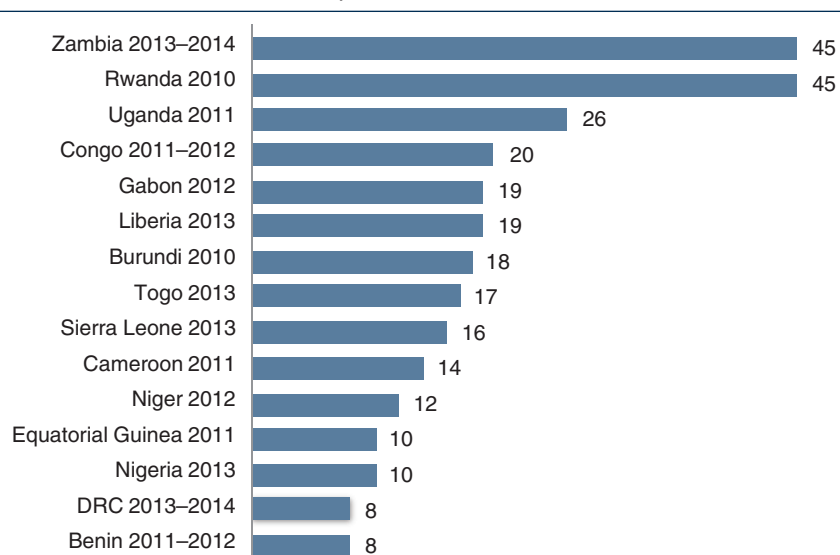
## 2014 HEALTH PUBLIC EXPENDITURE REVIEW

**FIGURE 11** Fertility Rates in DRC and Other Countries in the Region



Source: DHSs, date depending on national data availability.

**FIGURE 12** Use of Modern Contraceptive Methods in DRC and Other Countries in the Region



Source: DHSs, date depending on national data availability.

(for men). The trend rises with age for women from 4 per 1,000 at ages 15–19 to 7 at ages 45–49; for men the equivalent figures are just under 4 and 10.

**DRC has one of the highest incidences of malaria in the region.** Malaria remains rampant with 23 percent of under-fives testing positive by thick smear. Prevalence rates are higher in Province Orientale (38 percent), Katanaga (32 percent), and

Maniema (34 percent). Malaria continues to account for over 40 percent of the causes of infant mortality and is the number one reason for consultations nationwide.

**The HIV/AIDS epidemic appears to have been brought under control with a prevalence of 1.2 percent among adults in 2013, down from 5 percent in 1990 (and 1.3 percent in 2007).** Still,

HIV/AIDS is the fifth most common cause of number of years of life lost (YLLs), accounting for 5.4 percent of all YLLs. Seroprevalence among pregnant women fell from 4.3 percent in 2008 to 3.4 percent in 2011. However, the epidemic remains more widespread among women, as 1.6 percent of women aged 15–49 are HIV positive against 0.6 percent of men. HIV prevalence is very high among widows (7.9 percent) and divorced/separated women (2.9 percent). A large proportion of the total population (68 percent) has never taken an HIV test, suggesting that national prevalence is underestimated.

**Tuberculosis prevalence started a downward trend in 1990.** The rate dropped from 160 per 100,000 in 2003 to 94 in 2012. However, annual incidence remains high at 384 cases per 100,000 due to the increase in coinfections. DRC still ranks among 22 countries the hardest hit by tuberculosis worldwide, and number five in Africa.

**Neglected tropical diseases (NTDs) contribute significantly to the burden of disease.** Two conditions in DRC—leprosy and Human African Trypanosomiasis (HAT)—are estimated to have the highest prevalence of any NTDs globally. Seventy-five percent of the global HAT cases are in DRC, and 50 percent of all cases in DRC come from one district (Mai-Ndombe in Bandundu province). In

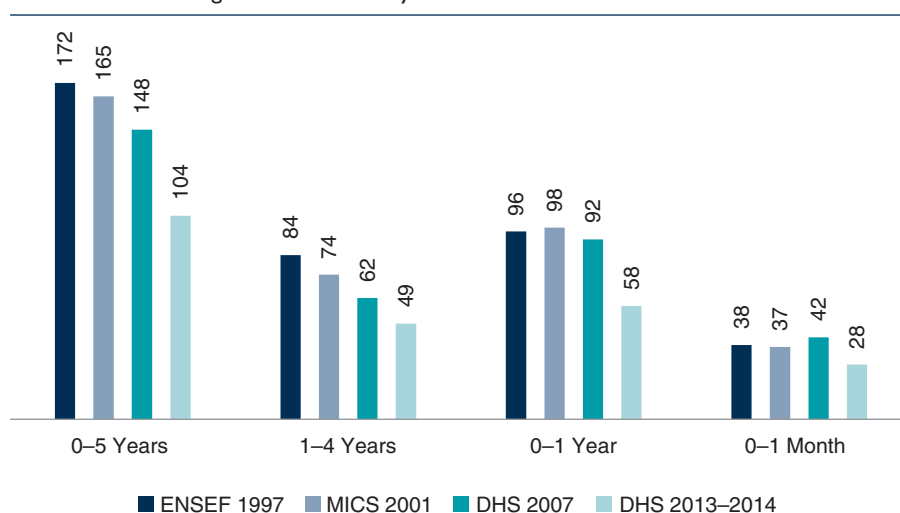
addition, Schistosomiasis, hookworm infection, Ascariasis, Trichuriasis, and Lymphatic Filariasis are also prevalent, and likely to be some of the underlying factors contributing to the burden of disease linked to malnutrition in DRC. The HAT program is in transition, with changes such as a new rapid test and new oral treatment to be launched by end-2015. There are regular outbreaks of cholera and the Ebola virus in DRC. In 2014, the country recorded 8,700 cases of cholera with 249 deaths. The province of Katanga was the hardest hit. There were an estimated 66 reported cases of Ebola causing 49 deaths in September 2014 (with the outbreak starting in Jeera county).

### Mother and Child Health

**After a slow start in the early 2000s, the reduction in child mortality started gathering pace in 2010.** Infant mortality (below 1 year old), estimated at over 90 per 1,000 over 1997–2007, fell steeply by 2013–2014 (to 58). Under-five mortality has also seen distinct progress in recent years, falling from 172 per 1,000 in 1997 to 148 in 2007 and then 104 in 2013–2014 (Figure 13).

**Malnutrition continued to affect 43 percent of children in 2013–2014, with nearly half of them suffering from severe malnutrition.** The prevalence

**FIGURE 13** Change in Child Mortality from 1997 to 2013–2014



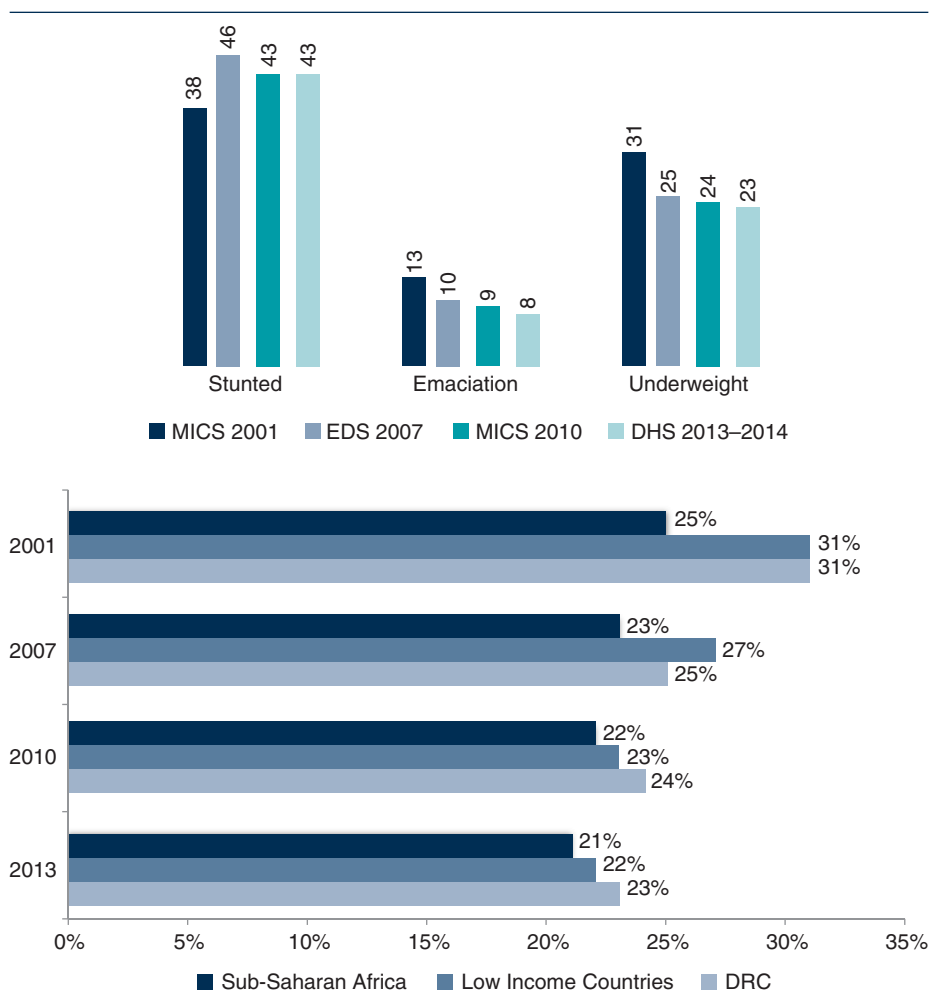
Source: ENSEF (1997), MICS (2001 and 2010), DHS (2007 and 2013/2014).

of malnutrition has not changed much since 2010 and there have even been significant upturns in the eastern regions (> 40 percent). The rate of stunting rose to 43 percent of children in 2014 from 38 percent in 2001. No significant progress was made with wasting (8 percent) or underweight children (23 percent) from 2007 to 2013–2014 (Figure 14).

**Following a sharp upturn due to the conflicts in the late 1990s, maternal mortality may have fallen steadily to 846 deaths per 100,000 live births over 2007–2014 (with 2010 the point**

**year of estimation).** However, maternal mortality estimates vary by source. The 2007 DHS estimates maternal mortality at 543 deaths per 100,000 births while the 2013–2014 DHS sets mortality at roughly 800 deaths. The maternal mortality rate, which stood at more than 1,000 maternal deaths per 100,000 births prior to 2000, fell to some 900 around 2005 and then to 800 or so around 2010 (Figure 15). Continuation of this trend would place the maternal mortality rate at around 700 in 2014. Maternal deaths account for 35 percent of all deaths of women aged 15–49.

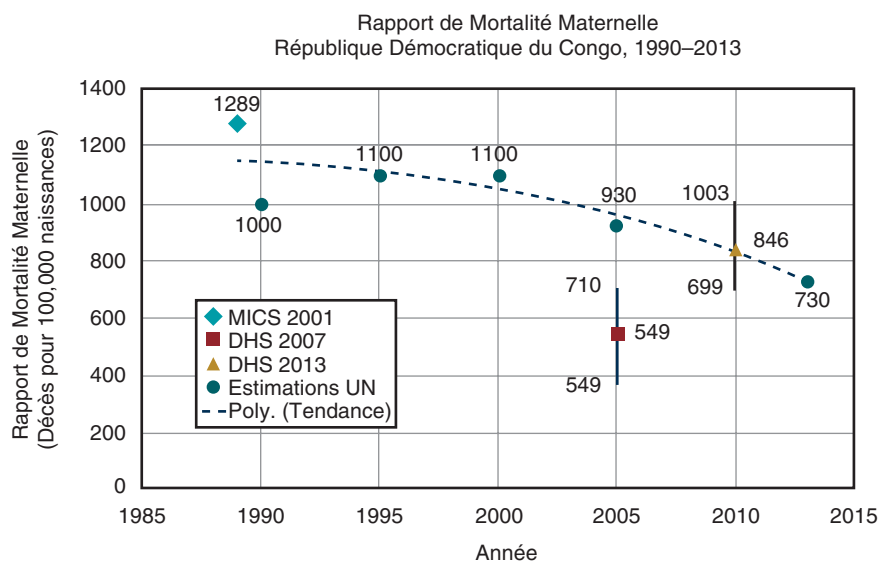
**FIGURE 14** Change in Child Malnutrition in DRC and Underweight Children in DRC and Peer Countries



Source: ENSEF (1997), MICS (2001 and 2010), and DHS (2007 and 2013/2014) for DRC and WDI for other countries.



**FIGURE 15** Change in Maternal Mortality, DRC, 1990–2014



Source: ENSEF (1997), MICS (2001 and 2010), DHS (2007 and 2013/2014).

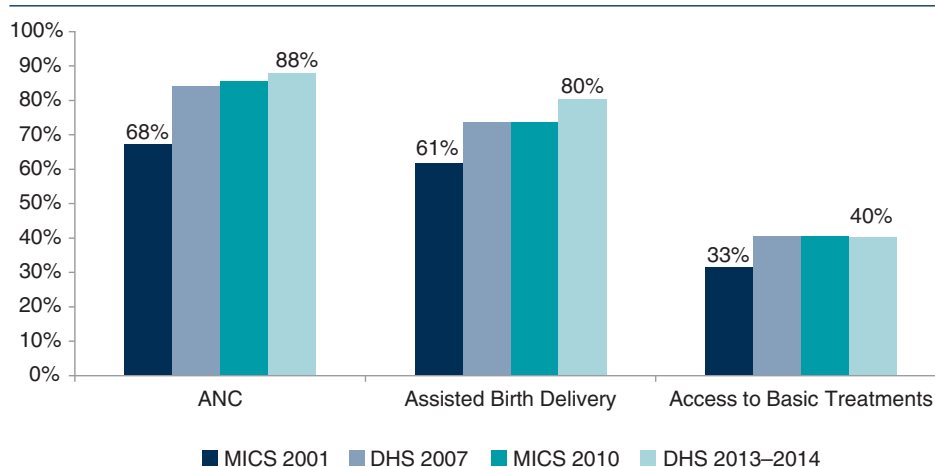
## Section 2. Service Coverage

**Service coverage rose for a number of interventions essential to maternal health.** Over 2001–2014, antenatal care coverage rose from 68 percent to 88 percent and skilled birth attendance from 61 percent to 80 percent (Figure 16). This gave to DRC antenatal care coverage rates higher than those in peer countries for these two interventions (Figure 17). A sharp upturn in the use

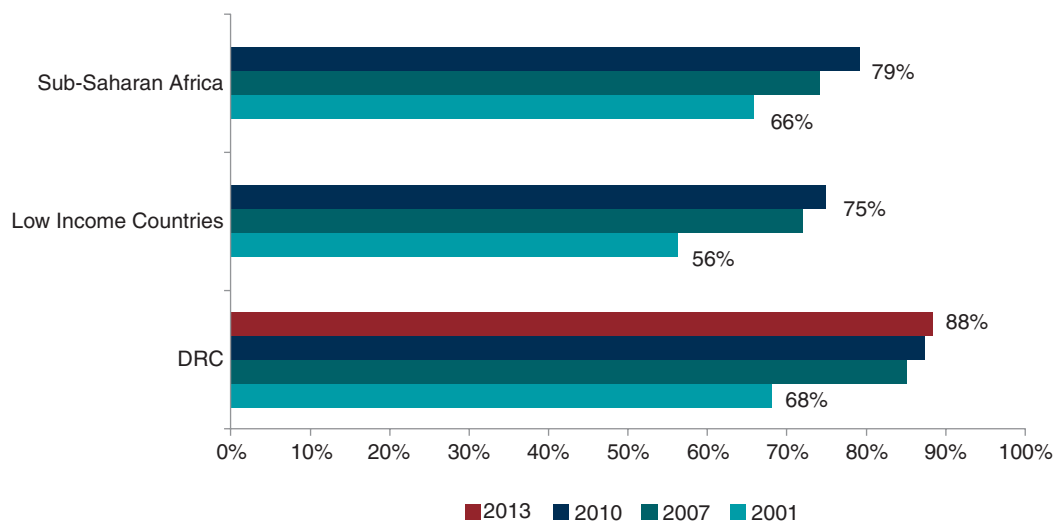
of insecticide-treated nets represents an important advance for maternal health. The majority of pregnant women sleep under such nets (56 percent in 2014), but only 6 percent did so in 2007.

**Although the generic index of access to essential treatments for children (ARI, diarrhea, and fever) has risen, an analysis by treatment reveals backsliding coverage.** In particular, the share of children with respiratory infections who receive

**FIGURE 16** Coverage for Antenatal Care, Skilled Birth Attendance and Basic Treatment for Children in DRC and Peer Countries, 2001–2014



Source: MICS 2001, DHS 2007, MICS 2010, DHS 2013/2014.

**FIGURE 17** Antenatal Care Coverage in DRC and Peer Countries, 2007–2013

Source: MICS 2001, DHS 2007, MICS 2010, DHS 2013/2014 and WDI for other countries.

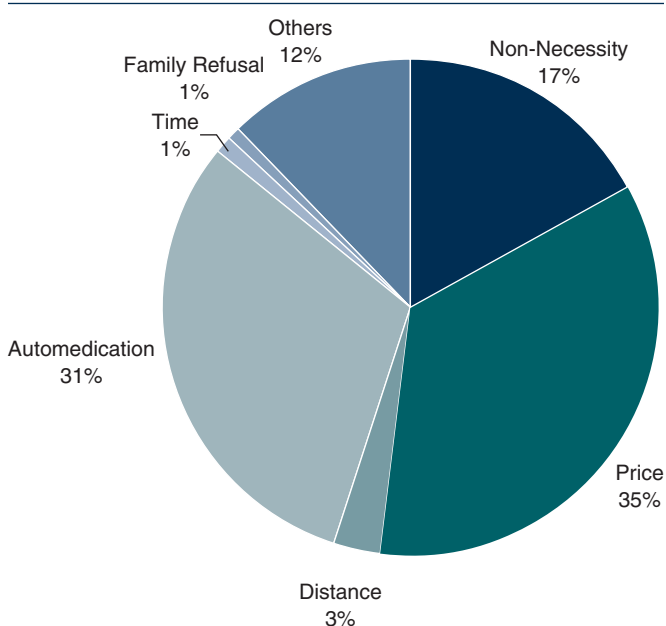
treatment is reported to have fallen from 42 percent to 35 percent since 2007. The number of children treated with anti-malarial drugs is also estimated to have fallen, from 45 percent to 40 percent over 2007–2014, when treatment for fever posted a downturn from 31 percent to 20 percent. Conversely, access to treatment for diarrhea is reported to have improved from 32 percent to 39 percent of children with diarrhea.

**Immunization coverage has slipped over the last few years.** Although coverage doubled over 2001–2010 (from 23 percent to 45 percent fully vaccinated children), the proportion of fully vaccinated children is estimated to have fallen from 53 percent to 46 percent from 2010 to 2013–2014. Immunization coverage remains behind peer and neighboring countries (with Rwanda at 90 percent, Burundi 83 percent, and Cameroon 53 percent). In particular, little progress has been made with BCG coverage over the last four years (down slightly from 84 percent to 83 percent) and Pentavalent-3 coverage (unchanged from the 2010 coverage of 61 percent) despite encouraging efforts from 2001 to 2007.

**Out-of-pocket payment by users acts as a barrier to access to health care.** The health care services depend on cost recovery in the form of having users pay at the point of use. Price is the number one reported reason for nonuse of health care and forms a barrier for 35 percent of people interviewed (Figure 18), and 40 percent among the poorest (NSI, 2013). Consequently, the national rate of service use is very low, estimated at around 0.4 consultations per person a year.

### Section 3. Service Quality

**Service quality is largely affected by the poor availability of amenities and equipment required for good quality consultations.** Only 64 percent of health facilities on average have a private room for consultations to respect patients' privacy. Availability of other amenities and conveniences is also low at less than 50 percent for sanitary facilities (41 percent), improved water sources (37 percent), communication equipment (28 percent), a vehicle in working order with fuel (12 percent), power source

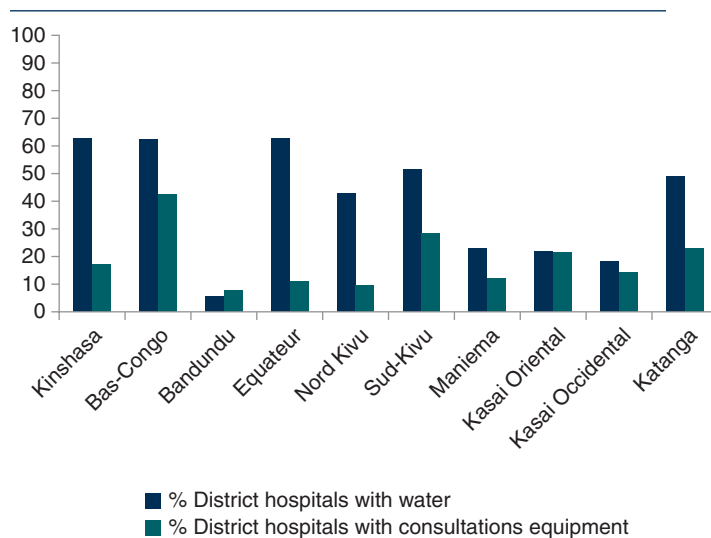
**FIGURE 18** Main Reasons for Nonuse of Health Care, DRC, 2013

Source: Authors' calculations based on I-2-3 Survey data, NSI, 2013.

(9 percent), and computers and Internet connection (2 percent) (MoPH, forthcoming a). Only less than 17 percent of the health facilities tested in Bandundu and 19 percent in Kasai Occidental have the level of amenities and equipment required for curative consultations. Five provinces post an average availability of 25 percent or less (MoPH, forthcoming a).

**The quality of hospital infrastructure and equipment is, in particular, very poor.** In Bandundu and Equateur, just 5–7 percent of district hospitals have running water and less than 10 percent have full consultation amenities (Figure 19). The health facilities in the province of Kinshasa are somewhat better equipped but are still not fully operational (just 62 percent of the district hospitals in that province have running water). Only the province of Bas Congo has over 40 percent of its district hospitals fully equipped for consultations.

**Diagnosis capabilities are also poor (personnel, equipment, and analysis).** Although there is a relatively good nationwide availability of means to diagnose malaria (84 percent), just 40 percent

**FIGURE 19** Operational Level of Hospitals by Province: Running Water and Facilities for Consultations (% of hospitals)

Source: Authors' calculations, based on MoPH data, 2011.

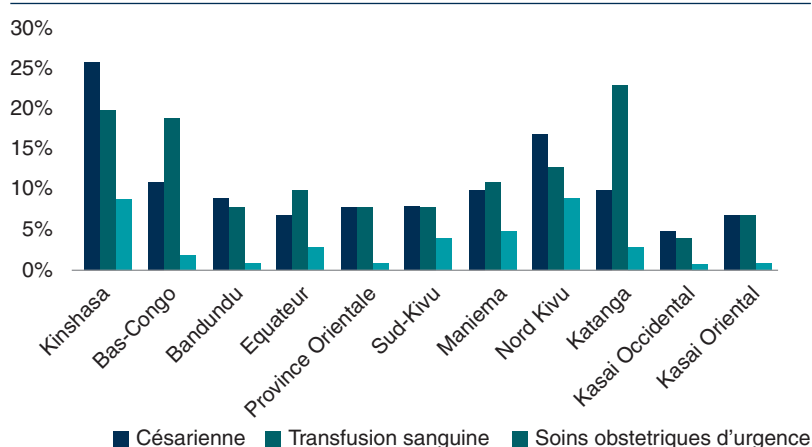
of the health facilities have a urine pregnancy test. Availability of the other basic tests (blood sugar type) is less than 20 percent. Only 21 percent of health facilities have adequate means to diagnose HIV/AIDS, mainly because HIV/AIDS prevention and treatment services have not been incorporated into the health system. Services to prevent mother-to-child transmission also remain thin on the ground, at 15 percent nationwide.

**Although there is relatively good availability of antenatal care, the quality emergency obstetric care that is so important to a mother's survival is lacking.** Antenatal care is available in nearly 78 percent of health facilities, yet less than 5 percent of health facilities can offer quality emergency obstetric services. In Bandundu, Province Orientale, and the two Kasai provinces, over 99 percent of health facilities can provide no quality emergency obstetric services for want of equipment or trained personnel (Figure 20).

**In 2011 the central government launched the PESS, which came into effect in 2013.** The program has two major phases: to improve 1,000 health centers and 200 district hospitals, and to target secondary and tertiary levels (Box 3).

## 2014 HEALTH PUBLIC EXPENDITURE REVIEW

**FIGURE 20** Availability of Full Obstetric Services for Mothers, Average Score per Province, 2012–2013



Source: Authors' calculations, based on MoPH, forthcoming a.

### BOX 3 A Unique Initiative Funded by Domestic Resources: The PESS

In December 2011, the prime minister officially launched the PESS, funded entirely by the government. This off-budget program is designed to roll out in two major phases. The first, PESS-Primary Network (PESS-RP) phase, for a total of CDF 80 billion (USD 85 million) is to renovate, equip, provide training for, and supply essential drugs to 1,000 health centers and 200 district hospitals in the 11 provinces. The second, PESS-Secondary and Tertiary Network (PESS-RST) phase, being developed, might well be able to mobilize a large amount (USD 90 million) to fit out provincial and tertiary hospitals.

The PESS-RP was initially planned as a four-phase program for a sum of CDF 20 billion (USD 21 million), with each phase designed to renovate, equip, provide training for, and supply essential drugs to 66 district hospitals and 330 health centers in the 11 provinces. UNICEF was placed in charge of purchasing the health care equipment (for an earmarked USD 50.8 million), with essential drugs to be supplied by the FEDECAME by means of financing facilities opened in the regional medical stores for the establishments concerned (USD 6 million) and renovation/building work assigned to BCeCO (the National Coordination Body for External Aid). In addition, USD 4.9 million was earmarked for capacity building.

At June 30, 2014, the Public Treasury had disbursed USD 65 million, allocated to: (i) the purchase by UNICEF of equipment for all the targeted establishments (the equipment for the first two phases was distributed in September 2014 or is being distributed); (ii) the design of standard plans for the health centers to be built, the renovation of two district hospitals and eight health centers in Kinshasa, the launch of building work for 34 health centers in keeping with the standard plans in the 11 provinces (work is scheduled for completion in mid-2015), and the preparation of operations for the next phase (the funds initially earmarked for the first phase were redirected to building fewer establishments following the standard plans); and (iii) the opening of financing facilities in the regional medical stores for 132 district hospitals and 660 health centers, as well as the purchase of contraceptives (through UNFPA). The financing facility set up for capacity building had been entirely used up at this date, used, for example, on provincial training workshops, provision of management tools, a BCeCo study, and program monitoring and monitoring assignments in the provinces.

Source: Authors, based on information provided by the MoPH.

# HEALTH FINANCING

# 4

## Section I. Health Financing Sources

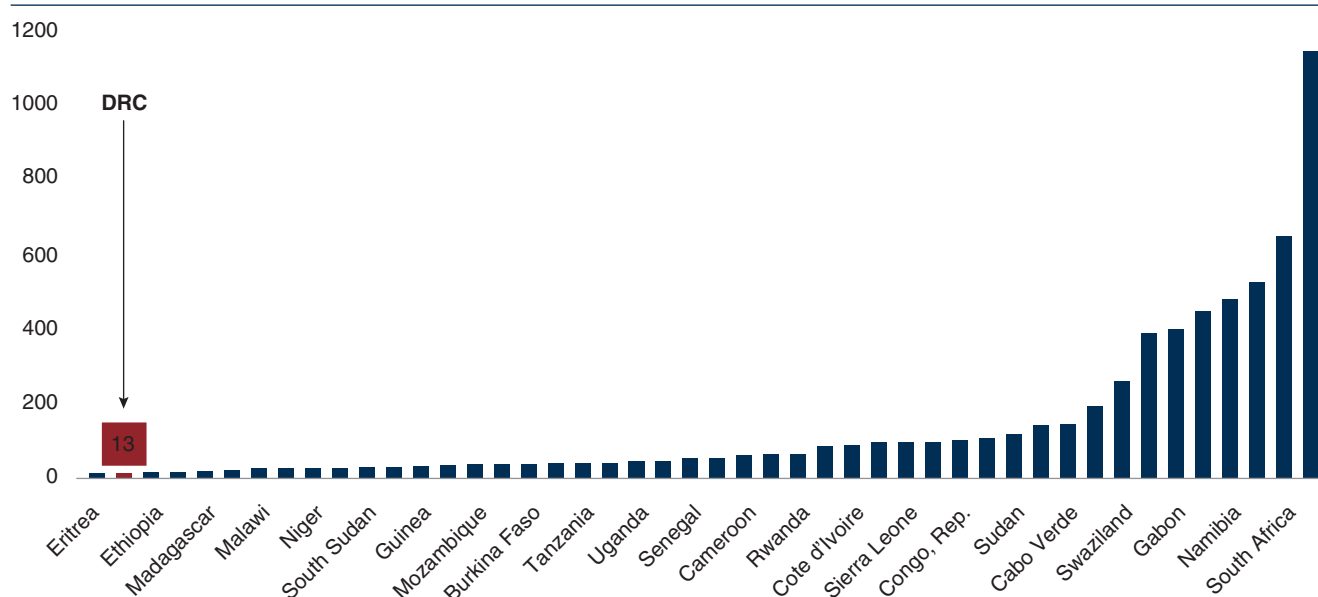
**TABLE 12** Main Health Financing Indicators, 2008–2013

	2008	2009	2010	2011	2012	2013
Nominal GDP (from SNA 93) (CDF millions)	10,741,806	14,788,935	18,592,321	21,912,978	25,249,857	27,596,000
Nominal exchange rate (CDF/USD)	563.19	816.78	906.96	918.02	918.74	919.48
Population (NSI) (thousands)	68,076	70,991	72,784	75,259	77,817	80,462
Total health expenditure (USD thousands)	869,831	893,363	891,955	904,187	1,031,802	1,249,836
Total health expenditure (% of GDP)	4.6	4.9	4.4	3.8	3.8	4.5
Total health expenditure per capita (USD)	12.8	12.6	12.3	12.0	13.3	15.53
Government health expenditure (USD thousands) <sup>a</sup>	129,263	127,971	94,712	108,064	160,559	224,103
Government health expenditure (% of total health expenditure)	14.9	14.3	10.6	12.0	15.6	17.9
Government health expenditure (% of GDP)	0.7	0.7	0.5	0.5	0.6	0.8
Household health expenditure (USD thousands)	366,738	374,073	329,214	339,297	405,399	475,483
Household health expenditure (% of total health expenditure)	42.2	41.9	36.9	37.5	39.3	38.0
Household health expenditure (% of GDP)	1.9	2.1	1.6	1.4	1.5	1.7
Household per capita health expenditure (USD)	5.4	5.3	4.5	4.5	5.2	5.9
Out-of-pocket payments for healthcare (USD thousands)	366,408	272,974	308,432	327,446	343,053	459,418
Out-of-pocket payments (% of household spending)	99.9	72.9	93.7	96.5	84.6	96.6
Out-of-pocket payments for health care (% of total health expenditure)	42.1	30.6	34.6	36.2	33.2	36.7
Out-of-pocket payments for healthcare per capita (USD)	5.4	3.8	4.2	4.4	4.4	5.7
External health expenditure (USD thousands)	291,478	297,307	423,435	423,671	423,868	462,665
External health expenditure (% of total health expenditure)	33.5	33.3	47.5	46.9	41.1	37.0
External health expenditure (% of GDP)	1.5	1.6	2.1	1.8	1.5	1.6
External health expenditure per capita (USD)	4.3	4.2	5.8	5.6	5.4	5.7

Source: Authors' calculations based on the 2013 NHA and the Ministry of the Economy.

a. All expenditure by government entities active in the health field (MoPH and other ministries, Social Security), at every level using internal and external resources.

Note: The findings based on the health financing indicators, as shown in this table, differ from those based on the 2013 NHA Program. The main reasons for this difference are that the updated GDP figure from the new SNA 93 classification is used and the population is greater per the latest (2013) estimates from the NSI.

**FIGURE 21** Total Health Expenditure per Capita in DRC and the Rest of Sub-Saharan Africa, 2012 (USD)

Source: Authors, based on the NHA.

**DRC's health expenditure per capita is less than one-tenth that in the rest of Africa.** DRC spent USD 13 per capita on health in 2012 (Table 12), compared with more than USD 140 on average in the rest of the region and USD 31 in low-income countries (Figure 21). Total health expenditure per capita showed little growth over most of the period, ranging between USD 12–13.30, but climbing in 2013 to USD 15.53.

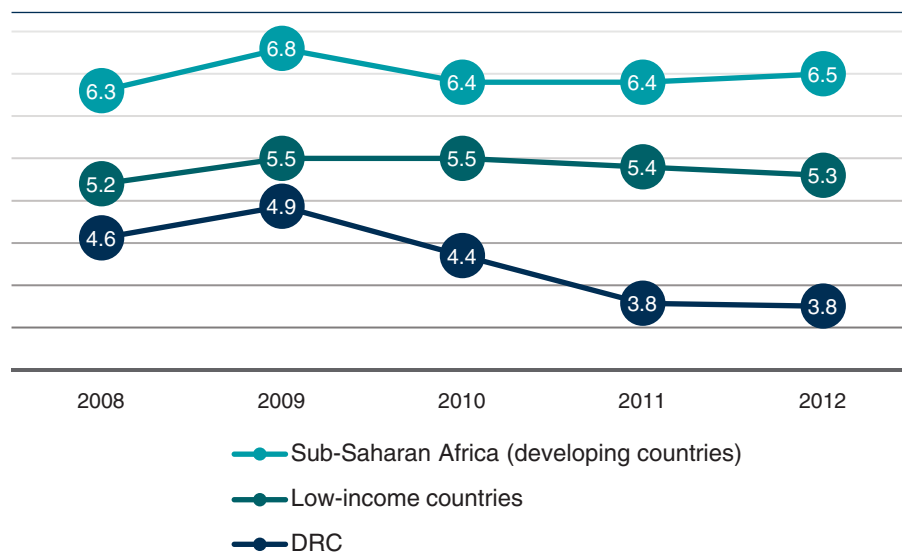
**Health expenditure as a share of GDP has shown a falling trend since 2008.** Total nominal health expenditure was stagnant over 2008–2011 at less than USD 900 million, rising to USD 1.2 billion in 2013. Health expenditure as a share of GDP declined after a big jump in GDP from 2008. It fell from 4.6 percent of GDP in 2008 to 3.8 percent in 2011–2012, versus 6.5 percent in the rest of the region and 5.3 percent in low-income countries (Figure 22). Health expenditure rose to 4.5 percent of GDP in 2013.

**External assistance is the leading source of health financing in DRC.** External assistance accounted for 40 percent of total health financing over 2008–2013, rising from 33 percent in 2008 to 37 percent in

2013, peaking at more than 47 percent in 2010. This share is equivalent to around 1.7 percent of GDP on average over the period. Even though estimates vary by source, all sources indicate a big jump in the last few years. The NHA show an increase from USD 291 million in 2008 to USD 462 million in 2013; the International Assistance Management Platform has external assistance doubling over 2007–2013 from USD 255 million to USD 530 million; and the OECD Development Assistance Committee shows that health/population assistance climbed from USD 169 million in 2006 to USD 363 million in 2009.

**Despite this growth, per capita external assistance for health was still lower than in the rest of the region.** It stood at USD 5.7 in 2013 according to the NHA (half the amount of other countries in sub-Saharan Africa, which average USD 11) and at USD 7 according to the International Assistance Management Platform. Assistance for all sectors is still low in DRC, at USD 23 per capita.

**Even though the per capita amounts for health are lower than for the rest of the region, health is one of the partners' priority areas.** In 2012, 26 percent of total assistance to DRC was for health,

**FIGURE 22** Total Health Expenditure as Percentage of GDP in DRC and the Rest of Sub-Saharan Africa, 2008–2012

Source: Authors, based on the NHA.

up from 15 percent in 2007. External assistance for health is tightly concentrated by source, with five main donors accounting for more than 70 percent of it over 2007–2012. By contributions, these five donors are the Global Fund (21.5 percent), USAID (15.6 percent), World Bank (14.4 percent), the Government of Belgium (10.3 percent), and GAVI (9.6 percent). Much support from partners is extrabudgetary, and the central government budget amounts to only a very small share of the funds from donors (roughly 10 percent). The execution rate varies: 83 percent of 2012’s commitments and 42 percent of 2013’s (MoPH—Research and Planning Division, 2014).

**External assistance is still focused primarily on financing for treatment of communicable diseases (HIV/AIDS, malaria, and tuberculosis), totaling nearly USD 150 million in 2012.** Support for vaccination accounts for the second-largest share. At nearly USD 50 million, support for the health system that is not related to specific diseases accounts for the fourth largest share of external assistance expenditure (malaria is the third) (Figure 23).

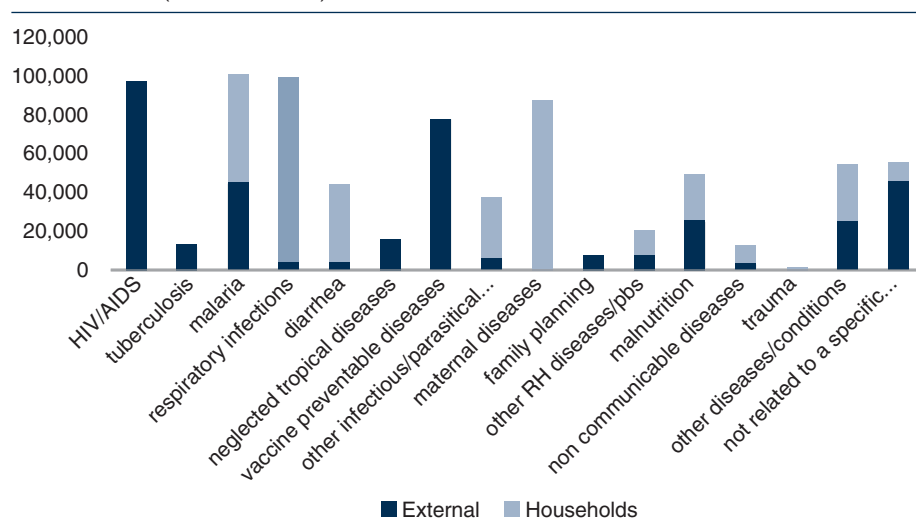
**External assistance finances the bulk of health investment (construction and facilities).** In 2012, it financed 89 percent of capital expenditure.

Current expenditure, which accounted for nearly 95 percent of total expenditure over 2010–2012, was covered in 2012 almost equally by external assistance (39 percent) and households (41 percent). External assistance in 2013 financed primarily drugs and specific inputs (34 percent of total expenditure reported to the MoPH, or CDF 96 million). Other large expenditure items were services (15 percent of total expenditure) and infrastructure and equipment (12 percent).

**Household funds are the second largest source of health financing, just behind external assistance.** Households accounted for an average of 39.3 percent of total health expenditure over 2008–2013. Their share of expenditure declined slightly from 42 percent in 2008 to 38 percent in 2013, reflecting the increase in external health assistance in real terms. Household health expenditure averaged USD 5 per capita, in the range of USD 4.50–5.90 over the period. The private sector’s share of total health expenditure stood at 4 percent in 2012, consisting of direct payments of health costs by some employers in the formal economy.

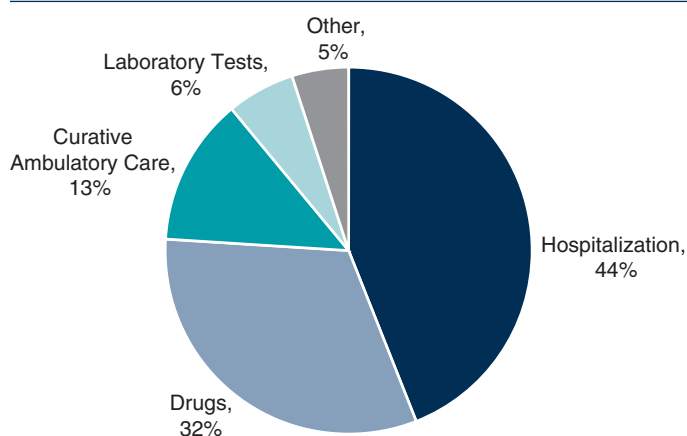
**Out-of-pocket payments account for more than 90 percent of household health expenditure.** In a fee-for-service system, users cover the total costs of

**FIGURE 23** External Financing and Household Expenditure by Disease, DRC, 2012, (USD thousands)



Source: Authors' calculations, based on the 2012 NHA.

**FIGURE 24** Household Health Expenditure, DRC, 2012



Source: Authors' calculations, based on the 2011 NHA.

office visits, house calls, and drugs, except in a few districts that have recently introduced a subsidized flat-rate payment. Drugs (32 percent) and primary care (13 percent) account for nearly half the out-of-pocket payments by users. Forty-four percent is mainly to cover hospitalization costs (secondary and tertiary) (Figure 24). Household expenditure is used to cover the costs of maternal health (childbirth and postnatal care) and child health (mainly respiratory infections and malaria).

**At less than 15 percent of total financing sources over 2008–2013 (average of 14.2 percent), the**

**government's share of health financing is limited.**<sup>20</sup> The central government, via the MoPH and other ministries indirectly involved in health, accounted for 15 percent of financing in 2008, a share that decreased to 11 percent in 2010, but then picked up to 17.9 percent in 2013. Government funds cover most payroll costs (Chapter 5).

**There is no pooling system at the national level.** A system of voluntary insurance plans has developed sporadically, but coverage (1–2 percent of the population) and financial protection are weak. The two most developed insurance networks are in Bwamanda (since 1986) and Sud Kivu (since 1997). The first has more than 130,000 voluntary members and the second 20,000–30,000 in 16 insurance plans. Both networks offer identical coverage, including curative care in health centers and general hospitals. They impose copayments of 20–50 percent of cost. The yearly individual premium is USD 1.50 in Bwamanda and USD 3.00–USD 6.00 in Sud Kivu. Coverage is delivered through a network of faith-based establishments directly linked to the insurance

<sup>20</sup> This figure is based on the NHA definition and includes government expenditure using internal and external resources. The breakdown provided in Chapter 4 is based on government expenditure using internal resources only, which explains the difference between the two estimates of “government health expenditure.”



organization. Some evidence shows an increase in the use of services by the insured, but limited financial protection. The reduction in out-of-pocket payments for care is about 10 percent over five years among the enrolled population (Soglohoun 2012). A compulsory insurance plan for teachers was recently introduced with mandatory membership and premiums.

## Section 2. Adequacy of Government Financing for Health and Fiscal Space

**Achieving universal coverage of essential health services requires substantial funding.** Closing the financial gap—estimates range from USD 18 to USD 33 per capita—would require a tripling of current health financing (MoPH 2011, Integrated Healthcare Technology Package method).<sup>21</sup> With government expenditure of about USD 1 per capita (see Table 16), financing needs will not be met unless fiscal space is expanded, especially as external assistance from donors may decline in the medium to long term (IMF, 2014).

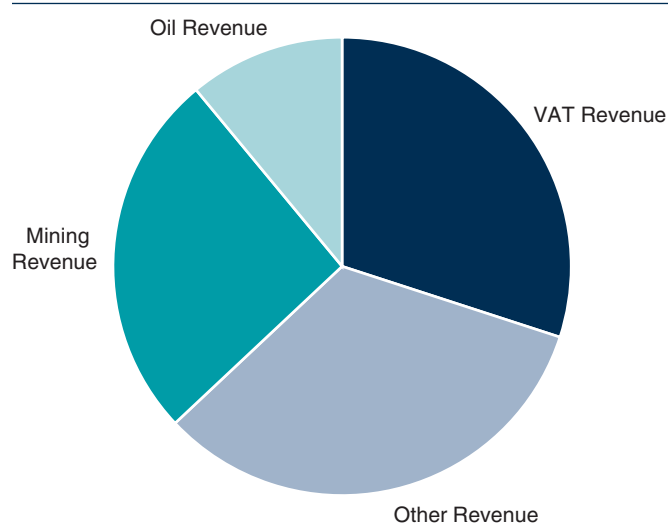
**There are multiple possibilities for increasing fiscal space.** The medium-term macroeconomic projections for DRC are reassuring. Real GDP growth is expected to reach an average of 8.9 percent growth from 2015 to 2017. Inflation, which was less than 1 percent in 2013, is expected to rise again to an average of 4.3 percent in the medium term. The fiscal deficit was small in 2013, but could increase in the medium term to 3 percent of GDP, reflecting the expected stagnation in assistance from donors (IMF, 2014).

**Mining industry revenue falls short of its potential.**<sup>22</sup> The growth of the mining industry over 2010–2013, and the doubling of mining exports over

<sup>21</sup> A joint study by the World Bank and the Government in 2015 should make accurate estimates of the financial requirements for universal coverage of maternal and child health care by 2030 as part of the Global Financing Facility.

<sup>22</sup> DRC has identified deposits of some 50 minerals, including copper, cobalt, uranium, diamonds, gold, and coltan. It has the second-largest reserves of copper in the world and the largest reserves of cobalt—an essential component of electronic circuits. It also produces oil.

**FIGURE 25** Structure of Domestic Revenue (% of total revenue), 2011



Source: Adapted from World Bank, 2015.

2009–2013 as copper production increased sharply with high international prices, have not lifted related revenue. Poor revenue collection, stemming from organizational inefficiencies in the tax administration and tax breaks for the mining industry, mean that the effective tax rate for the mining industry is around 13.9 percent,<sup>23</sup> while tax revenue from the petroleum industry is estimated to be worth up to 53.6 percent of the value of oil exports. Ultimately, mining contributes to a quarter of total revenue in 2011 (Figure 25).

**Tax revenue from other sectors also seems to fall short of its potential.** The revenue share from other sectors (i.e. excluding extractive industries and donors) was 9.4 percent of GDP in 2012, against 22.9 percent in the region.<sup>24</sup> The share of tax revenue

<sup>23</sup> The mining tax system is under review. The government is exploring options for increasing royalties and for introducing a resource tax rent. Exemptions to the tax regime in the natural resource sector as a whole were also under review in 2015.

<sup>24</sup> Note: Boundaries between tax, non-tax and mining revenue are blurry in the context of DRC. Part of the non-tax revenues are in fact revenues from the mining and oil industry, while part of direct and indirect taxes also originate from the mining sector. Double counting and mis-classification frequently occur. For this reason, tax and non-tax mining revenue was not distinguished in the present analysis. Further classification and analytical work is ongoing by the World Bank and the Government.

**TABLE 13** Expanding Fiscal Space, 2014–2019

Percentage of GDP	2013	2014–2015, short-term	2016–2017, medium-term	2018–2019, long-term
<b>Domestic revenue</b>	13	14.9	14.9	21
<b>Expenditure using domestic revenue</b>	12.5	14.6	15.4	20.5

Source: Adapted from IMF, 2014 and World Bank, 2015.

in total revenue has improved in recent years to 8.7 percent of GDP in 2012. The VAT amounted to 4.5 percent and is a key indirect tax and source of country revenue. It has though posted a poor performance since 2013, with a drop in revenue equivalent to 1 percentage point of GDP, following an increase in tax credits granted to the private sector and changes in accounting methods relating to VAT refunds.

**The central government should be able to increase its revenue by 8 percentage points of GDP in the long term.** The IMF estimates that all categories of revenue fall short of their potential, sales tax aside. This means that revenue could increase from 13 percent of GDP in 2013 to 21 percent in 2019 and government expenditure could increase from 12 percent in 2013 to 20.5 percent in 2019 (Table 13). The IMF argues that full tax potential could be achieved by collecting more revenue from the natural resources sector and by strengthening administration and collection of existing (and future) domestic revenue.

**There are different options for expanding a country's fiscal space for health.** The literature and empirical evidence reveal four main types of mechanisms that can be used to increase resources for health: (i) economic growth, if it leads to more central government revenue, can automatically increase the size of the health budget; (ii) prioritization of the overall budget can give a larger share of the central government budget to the health sector; (iii) raising new resources earmarked for the health sector (assistance from donors, excises) can increase the resources available; and (iv) efficiency gains made through improved expenditure execution and utilization can free up resources for the health sector (Tandon and Cashin 2010; Mathonnat 2010).

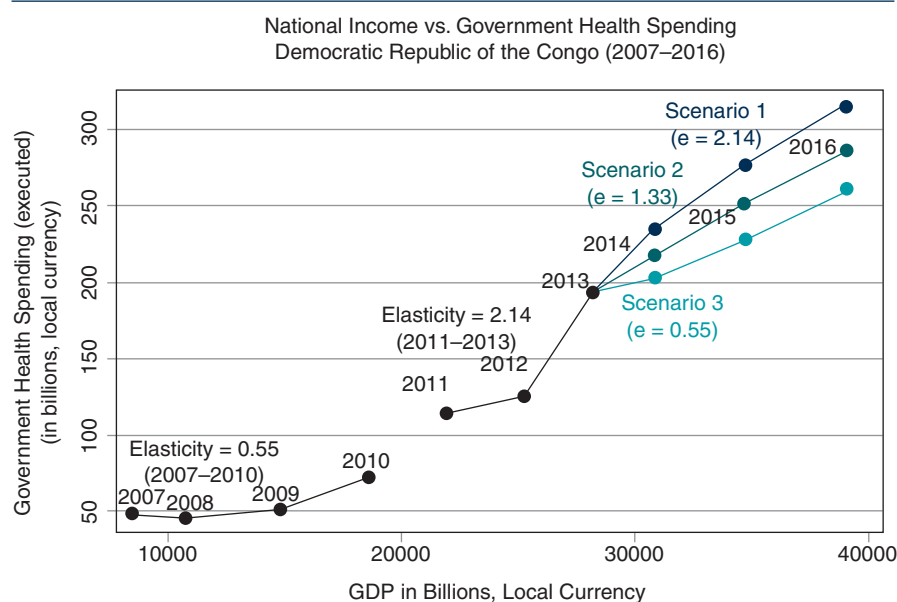
**There is room for expansion in the medium term through improved macroeconomic performance.** Government funds for the health sector from domestic sources could be increased by at least 1 percentage point of GDP. By linking health expenditure to national income growth, the resources raised can be used to meet some of the health sector needs in the medium term. Government health expenditure started tracking growth with greater elasticity in 2011–2012 ( $e = 2.14$  over 2011–2013, up from  $e = 0.55$  over 2007–2010). If this trend ( $e > 2$ ) were sustained until 2016, government health financing could reach CDF 300 billion, up from CDF 186 billion in 2013 at current prices (Figure 26). Similarly, overall domestic financing including “the investment grants to provinces and local entities” could increase from CDF 463 billion to CDF 830 billion.

**Greater revenue collection would generate up to 0.4 percentage points of GDP more for health, all else equal (Scenario 1—Table 14).** This scenario, which is backed up by the IMF Article IV projections and World Bank PEMFAR, seems plausible. In the medium term, central government revenue collection could increase by 8 percentage points of GDP from 13 percent to 21 percent. Achieving this increase depends on improving collection capacities for existing taxes and a reform of the collection system. An improved business climate and better control of natural resources are also needed to lead to effective increase in fiscal space.

**Health could be given greater priority in the central government budget (up to 8 percent of government expenditure) and increase by 0.6 percentage points of GDP, all else equal (Scenario 2).** However, it remains to be seen whether this scenario is politically and technically

## 2014 HEALTH PUBLIC EXPENDITURE REVIEW

**FIGURE 26** GDP Elasticity of Government Health Expenditure, DRC, 2007–2016



Source: Authors, based on government payment data and World Bank projections (2014).

**TABLE 14** Summary of Potential Long-Term Increases in Fiscal Space for Health

	Gov't. health exp. (% of GDP)	Total gov't. exp.	Gov't. health exp. (% of total gov't. exp.)	Conditions
<b>Baseline Scenario (2013)</b>	0.7	12.5	5.3	
<b>Scenario 1</b>	1.1	20.5	5.3	Increase in central government revenue from 13% to 21% of GDP and subsequent increase in gov't expenditure
<b>Scenario 2</b>	1.0	12.5	8.0	Increase in health expenditure from 5.3% to 8.0% of central government budget
<b>Scenario 3</b>	1.3	12.5	10.3	Improved spending effectiveness through better execution of health budget (to 80% of allocations)
<b>Combined Scenario</b>	1.7	17.0	10.0	Increase in central government expenditure to 17% of GDP; increase in health expenditure as a percentage of central government budget (2 points) and in the execution of budget allocations (2 points)

Source: Authors.

feasible. The current cuts in government expenditure stemming from lower revenue do not augur well for increased budgets for line ministries (Chapter 5). The budget surplus of 0.5 percent (excluding payments in arrears) results from fiscal consolidation relying on compression in priority expenditures, including capital and social spending. Similarly, the share of expenditure using domestic sources (12.5 percent) is

low and leaves little room for reallocation between sectors. The 2015 budget outlook seems to support this hypothesis, with a 5 percent cut expected in the health budget from 2014. This cut would mainly affect the matching funds from the government, the PESS, and the operating budgets of provinces and health facilities—the core functioning of the health system beyond wages.

**Improved execution of health expenditure would be an effective way to free up additional resources (Scenario 3).** By increasing execution up to 80 percent, government expenditure could reach 1.3 percent of GDP, all else equal. However, execution of government expenditure using domestic sources (excluding current expenditure) is closely linked to the ineffectiveness of transfers to the provinces. The improved execution of these transfers lies outside the MoPH's remit (Chapter 5).

The potential gains from more efficient expenditure cannot be quantified exactly, but could also be quite large (Chapter 6).

**Decentralization could also be an opportunity for health financing.** In addition to central government budget transfers to the provinces, three types of domestic financing sources can now be used: revenue retrocessions, investment subsidies, and local resources. The introduction of revenue retrocessions has been very valuable politically and is expected to lead to an overall increase in transfers for provinces. Investment grants earmarked for such priorities as health may be a new source of health financing at the local level, as long as the transfers are executed (Chapter 7). On the strength of their broader mandate for implementing health policy, provinces could also raise more local revenue, especially from natural resources industries.

**For provincial fiscal space to develop in the long term, the heavy reliance transfers from central government must give way to revenue raised locally.** An analysis of the types of revenue in provinces with strong economic capital, such as Katanga, reveals the low levels of revenue raised locally, given their potential for raising tax revenue. Almost half (48.8 percent) the revenue in Katanga's 2013 budget came from revenue retrocessions. Local tax revenue was tiny and totaled only 0.11 percent of the revenue that the province collected in 2013. The local tax system is highly fragmented, with more than 50

different local taxes that produce little and are inefficient. Local mining revenue, which is categorized as “extraordinary revenue,” accounts for a small share of total local revenue at only 8 percent of the total reported. The effective tax rate from the mining sector is less than 2 percent: for a combined output of coltan, copper, and zinc of USD 2.17 billion in Katanga, revenue collected was only USD 52.3 million (2012) (Provincial Government data, 2013).

**External assistance will be unable to sustain a lasting increase in fiscal space for health.** It accounted for 4.4 percent of GDP in 2013 (excluding 1.4 percent as loans). In the medium term, the share is forecast to stabilize at 4.5 percent in 2017, but to decline to 1.3 percent by 2030 (IMF 2014). There are no reliable data on external assistance for health in DRC, which makes it impossible to assess the sustainability of this financing accurately, or its future potential. However, estimates call for external assistance—the main financing source for health—to stabilize at about USD 5 per capita in the medium term (2015), then decline over 2018–2020. Off-budget assistance is expected to decrease as funds for humanitarian assistance shrink. In-budget assistance could, however, rise, particularly with the creation of the Global Financing Facility (GFF) for maternal and child health. HIPC funds were a major source of government revenue for health, accounting for 83.6 percent of the MoPH's internal resources in 2007. The residual funds are now used to finance the health sector, accounting for 8.9 percent of financing in 2013. These funds are expected to dry up in the medium term as the country pays off its debt. Finally, a “harmonized contract” at provincial level would increase fiscal space for health by enhancing the efficiency of external assistance, through better coordination and harmonization. (Such a contract was adopted in December 2014 to replace some of the multiple contracts in use, improve coordination of external assistance, and allow for more predictable financing.)

# GOVERNMENT FINANCING FOR HEALTH

# 5

**BOX 4** Priority Recommendations for the Health Sector from the First Public Expenditure Review, DRC, 2008

**Government Budget and Disbursement Process:**

1) Improve the credibility and usefulness of the budget by introducing a transparent prioritization process within a realistic total envelop and involving the provinces in the budget process. 2) Establish a system to collect and compile data on external assistance for health. 3) Improve budget execution of nonsalary allocations. 4) Curtail the use of exceptional payment procedures for MoPH expenditures.

**Human resources:** Establish an accounting of civil servants and nonregularized personnel in each province.

**Decentralization:** Lead a consultative and policy development process for decentralization in the health sector.

Source: World Bank, 2008.

## Section I. Health Budget

**In real terms, allocations for health, excluding external funds, increased fourfold over 2007–2013 and increased 10-fold in nominal terms over 10 years.** The MoPH’s budget from domestic resources increased 4.8 times in nominal terms

over 2007–2013, from CDF 39 billion to CDF 186 billion. However, given inflation and the devaluation of the currency over 2007–2013,<sup>25</sup> the MoPH’s budget allocation barely doubled at constant 2007 prices, rising from CDF 39 billion to CDF 74 billion.

**The central government devoted 4.2 percent of its budget to health, equivalent to 0.7 percent of GDP in 2013 (Figure 27).** Health’s share of the central government budget is tiny and much smaller than the average for the region. The MoPH averaged 3.7 percent of the central government budget over 2007–2013, on a downward trend since 2003.<sup>26</sup> The education budget had the opposite trend, rising over 10 years to 9 percent in 2013.

**The health budget closely tracks the total central government budget, which is pro-cyclical.**

<sup>25</sup> Over 2003–2006, the exchange rate was in a range of CDF 400–468 for USD 1. Since 2010, the rate has been higher than CDF 900 per USD 1 (CDF 919 in 2013).

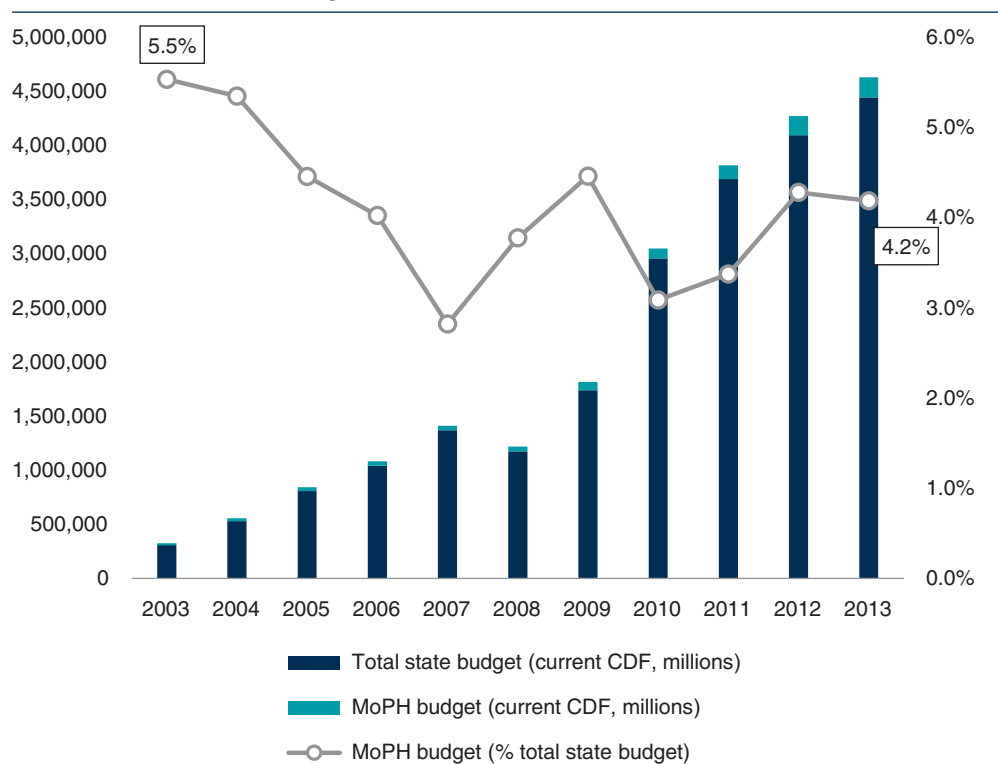
<sup>26</sup> During the period covered by the first Public Expenditure Review, health accounted for an average of 4.6 percent of the central government budget from 2003 to 2006. However, this figure included external financing and is not comparable to the 2007–2013 average, which excluded external funds and was based exclusively on internal resources.

**TABLE 15** Budget Allocations, MoPH Budget, 2007–2013

	2007	2008	2009	2010	2011	2012	2013
<b>MoPH budget (current CDF millions)</b>	38,663	44,287	77,597	91,354	124,649	175,472	186,145
<b>MoPH budget (% of total budget)*</b>	2.8	3.8	4.5	3.1	3.4	4.3	4.2
<b>MoPH budget (% of GDP)</b>	0.5	0.4	0.5	0.5	0.6	0.7	0.7

Source: Authors’ calculations based on disbursement data and 2013 GDP under SNA 93, IMF 2014.

\* Excluding debt and financial expenses.

**FIGURE 27** DRC Health Budget, 2003–2013

Source: Authors' calculations based on MoPH data (2008–2013) and the 2008 Public Health Expenditure Review (2003–2007).

The health budget was never a priority over 2003–2013. A fall in revenue led to slower growth of the central government budget and automatically to slower growth of the health budget. The government's policy largely consisted of adjusting expenditure to match the revenue available to curb the fiscal deficit. The main burden of adjustment fell on financing for social and infrastructure expenditures (IMF, 2014).

**The health budget is volatile from one year to the next and is strongly linked to the total budget.** The budget posted large annual variations, with steep nominal increases in 2009 (75 percent), 2011 (36 percent), and 2012 (41 percent), and more moderate increases in 2008, 2010, and 2013 (6–18 percent). Hence the budget was unpredictable. The recent introduction of health budget guidelines—Health Medium-Term Expenditure Framework (MTEF)—has not been effective at stabilizing the health budget or making it more predictable (Box 5).

**Since 2011, decentralization as implemented has led to more government financing for health through earmarked transfers to the provinces (called “investment subsidies to provinces and local entities”).**<sup>27</sup> These new transfers amounted to 125 percent of the MoPH budget in 2012 and 150 percent in 2013. They came to CDF 43 million in 2011 and exceeded CDF 277 million in 2013. They increased the health budget as a share of the

<sup>27</sup> At first, in 2011, these transfers were recorded in a specific section (Section 88) by province, but without specifying the field. Starting in 2012, these transfers were specified in Section 88 “investment subsidies to provinces and local entities” under the expenditure heading “Provinces and Local Entities/Health—Chapter 88100” and then broken down by province and nature of expenditure. These transfers are for areas where the provinces have sole jurisdiction. These are projects that are defined by the provinces and/or coordinated with the provinces, and then executed by central government on behalf of the provinces. This will continue as long as the provinces' public procurement systems are not operating in compliance with the public procurement code (see Memorandum of Understanding on procedures for using investment transfers in sectors that are the sole jurisdiction of the provinces, March 2013).

**BOX 5** Using the Health MTEF to Improve the Budget Process

From 2011 the Research and Planning Division at the MoPH has run a program to improve the budget process via a results-oriented management concept that uses the MTEF as a tool. Since 2012, the national MoPH and provincial ministries have compiled a national and provincial MTEF each year. This tool is featured in the roadmap for government expenditure reform initiated by the Ministry of Economy and Finance, making the health sector a trailblazer for a reform to be extended to all other sectors.

The benefits are twofold. First, results-based management practices are picked up by provincial planning and budgeting teams. These teams will play a central role in future allocations of resources for health. Second, the tool makes it easier to develop arguments in defense of the health budget when choices are being made for the annual budget. In 2014, sound arguments helped the MoPH obtain a 20 percent increase in the budget initially announced for nonwage expenditure. This represents an additional USD 10 million in the health allocation.

However, the unpredictability of external resources and uncertainty surrounding decentralization makes the medium-term budget process an especially delicate exercise that often has little link to macroeconomic realities. The MTEFs are developed using incomplete and patchy data: the provinces have no clear idea of the domestic and external resources that they will receive the following year. Therefore, MTEFs are hardly ever used to manage resources and are more of a theoretical exercise. The MoPH's efforts to improve the budget process are hampered by the uncertainty surrounding decentralization and the fragmentation of external financing. The MoPH's financing strategy should enable the government to set out its official vision of the health financing and decentralization architecture, which will improve the budget process.

Source: World Bank/CIDA Project, 2014.

budget by 6 percentage points in 2013, from 4.2 percent (excluding earmarked transfers) to 10.4 percent (including earmarked transfers). The new budget transfers seem to be leading to a refined model of resource allocation for the sector.

## Section 2. Government Health Expenditure—Low and Volatile

**Central government expenditure using domestic resources for health averaged less than 1 dollar (USD 0.84) per capita over 2007–2013 (Table 16)—among the lowest in the world.**

**Even though government health expenditure rose by around half in real terms over 2007–2013, it showed a declining trend as a share of total government expenditure (see Table 16).** Health expenditure as a share of total government expenditure averaged 3.95 percent over 2007–2013, but was on a declining trend, especially over 2007–2009. Over the period, government health expenditure as a share of GDP ranged between 0.3 percent (2009) and 0.7 percent (2013).

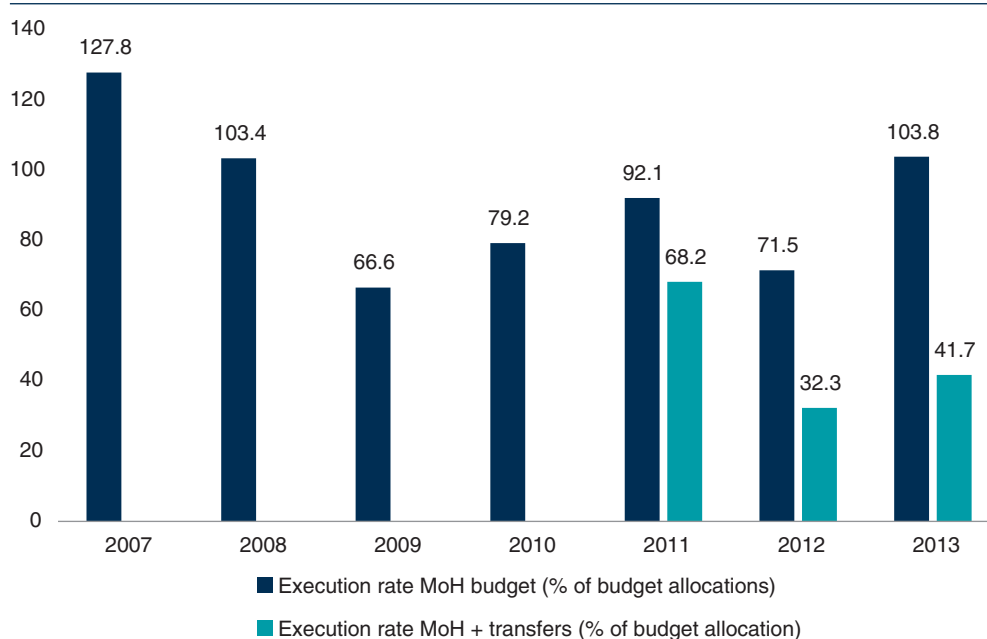
**The earmarked transfers to the provinces increased the health budget, but had little effect on actual health expenditure.** Despite the sharply higher budget allocations for transfers to the provinces (especially in 2012 and 2013—see previous section), the transfers increased the MoPH's actual expenditure by only 2 percent in 2012 and 0.1 percent in 2013.

**Execution of government health expenditure is volatile and has declined since 2011.** The average execution rate for MoPH expenditure and transfers

**TABLE 16** Government Health Expenditure (Execution), 2007–2013

	2007	2008	2009	2010	2011	2012	2013
<b>MoPH expenditure (constant 2007 CDF millions)</b>	49,415	39,025	30,123	34,177	46,916	50,253	76,522
<b>MoPH expenditure + transfers (constant 2007 CDF millions)</b>	49,415	39,025	30,123	34,177	46,916	51,119	76,614
<b>Central government health expenditure (% of total government expenditure)</b>	6.8	3.9	3.3	3.3	4.2	4.3	5.3
<b>Central government health expenditure (% of GDP)</b>	0.6	0.4	0.3	0.4	0.5	0.5	0.7
<b>Central government health expenditure per capita (constant 2007 USD)</b>	1.5	1.0	0.5	0.5	0.7	0.7	1.0

Source: Authors' calculations based on disbursement data (2014).

**FIGURE 28** Execution of Health Expenditure Using Internal Resources (MoPH and Earmarked Transfers), 2007–2013

Source: Authors, based on MoPH data.

Note: Earmarked transfers were only made from 2011.

stood at 74 percent over 2007–2013, better than in 2004–2007<sup>28</sup> but with sharp annual variations. Execution slipped sharply after 2011, including transfers to 32 percent in 2012 and 41 percent in 2013. In contrast, expenditure exceeded the budget transfers by 127 percent in 2007 and 103 percent in 2008. Expenditure was erratic, with a decline until 2010 followed by annual increases ranging from 7 percent to more than 50 percent.

#### **The declining execution rate for government health expenditure since 2011 stems primarily from nonexecution of transfers to the provinces.**

These transfers undermine the effectiveness of the health budget and cut the execution rate in half—in 2013 from 103 percent (excluding transfers) to 41 percent (including transfers). In 2011, no payments were made on these budget items. In 2012, only 1 percent of the budgeted amount was executed and in 2013 only 0.1 percent (Figure 28).

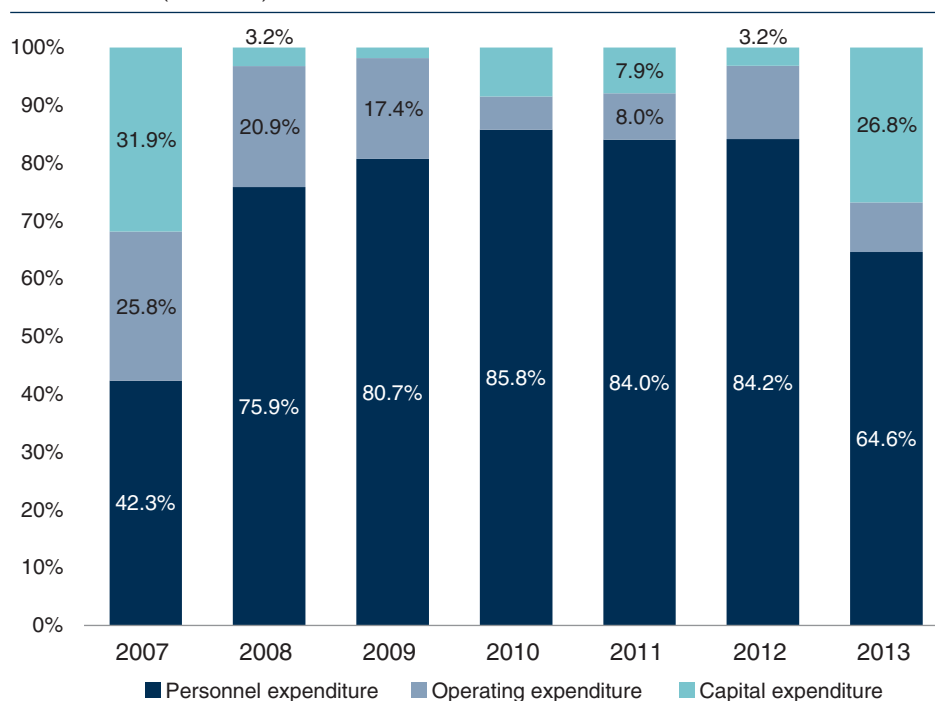
<sup>28</sup> The 2008 Government Health Expenditure Review reported that the execution rate for government health expenditure ranged from 55 percent to 65 percent (World Bank, 2008).

### **Section 3. Government Health Expenditure by Type**

**The economic classification of government health expenditure shows changes in recent years, with a shrinking share for operating and capital expenditure.** Current expenditure accounts for an average of nearly 90 percent of government health expenditure using internal resources. As a share of the total, personnel spending doubled from 42 percent in 2007 to more than 80 percent over 2009–2012 (against around 90 percent for education). The share of operating expenditure steadily declined from around 26 percent in 2007 to 8 percent in 2013. The share of capital expenditure also declined from around 32 percent in 2007 to 3 percent in 2012, but it then jumped to 27 percent in 2013 after the start of the PESS and the recognition of related expenditure in the accounts of the MoPH (Figure 29).<sup>29</sup>

<sup>29</sup> All of the 2013 PESS expenditure (CDF 20 billion) was attributed to the MoPH as “investment using internal resources,” even though the MoPH did not set aside provisions in its budget for these operations.



**FIGURE 29** Economic Classification of Government Health Expenditure, 2007–2013  
(% of total)

Source: Disbursement data and World Bank calculations, 2014.

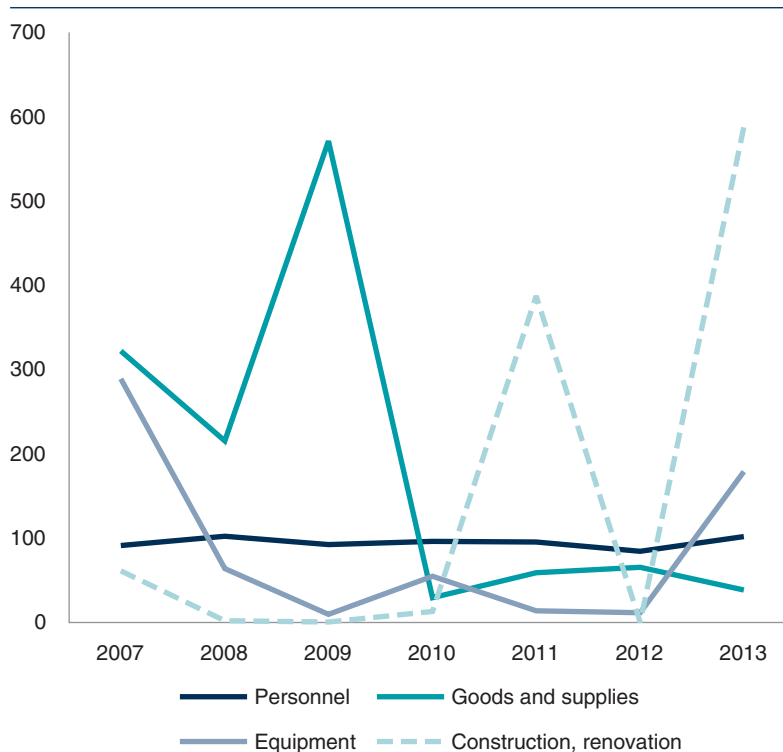
**Analysis of expenditure by function was difficult because of inaccurate reporting of some expenditure items.** Government expenditure is most directed to health promotion activities, public health campaigns, and programs that deal with major diseases. Together these accounted for 42 percent of total government health expenditure, or CDF 91.5 billion, in 2013. Expenditure on operating health facilities, pharmaceutical products, and vaccines was small at only 5 percent of the total that year.

**Personnel expenditure has maintained a steady share while execution of other types of expenditure varied widely (Figure 30).** When personnel expenditure is stripped out, no clear trends emerge in expenditure execution. Personnel expenditure execution tended to be in line with allocations, with execution rates ranging from 84 percent in 2012 to 102 percent in 2008. Conversely, other operating expenditure was far over budget from 2007 to 2009, but with average execution rates of less than 50 percent after that. Capital expenditure for equipment,

construction, and renovation seems to follow an implementation and execution pattern that has no relation to the budget allocations for these items.

**A detailed analysis of the budget execution process shows that the main problems lie with the MoPH (commitments) and the Ministry of Economy and Finance (payments).** Over 2011–2013, expenditure commitments on equipment, services, and transfers by the MoPH came to 14 percent, 21 percent, and 59 percent of the allocations received. Expenditure commitments are more in line with the allocations received for personnel expenditure (94 percent), goods and services (116 percent), but less so for construction (67 percent). The second problem lies with payments. Payments come to only 55 percent of the transfers for goods and equipment and 40 percent of the transfers for construction (Table 17). On the whole, it seems that much less use was made of exceptional procedures, which represent less than 10 percent of total allocations.

**FIGURE 30** Execution of Government Health Expenditure by Type of Expenditure (% of allocations), 2007–2013



Source: Authors, based on disbursement data (2014).

**TABLE 17** Analysis of the Government Health Expenditure Execution Chain for All Resources, 2011–2013

	Total allocations in current CDF billions (2011–2013)	Expenditure commitments (% of allocations)	Validations (%)	Payment orders (%)	Payments (%)
<b>Personnel</b>	351.5	94.1	94.1	94.0	93.6
<b>Goods and equipment</b>	45.8	116.0	115.0	63.8	54.5
<b>Services</b>	5.5	20.9	20.2	18.3	18.1
<b>Transfers</b>	35.7	58.7	58.5	45.1	41.2
<b>Equipment</b>	597.5	14.4	14.4	14.1	13.5
<b>Construction, rebuilding, renovations</b>	59.9	67.0	49.2	59.5	39.5

Source: Authors, based on consolidated data from the MoPH Research and Planning Division, Ministry of Budget and Ministry of Economy and Finance 2014.

## Section 4. Expenditure for Health Personnel

**Health personnel expenditure has shot up since 2007.** The total payroll using internal resources increased nearly sixfold over 2007–2013, from CDF 21 billion to CDF 125 billion. The increase over

2009–2013 was around 200 percent (Table 18). Most of the increase stems from large pay rises in the civil service, since the number of employees on the payroll increased by only 25 percent. Average civil service pay increased by more than 140 percent, from CDF 340,457 in 2009 to CDF 816,192 (USD 380) in 2013. Bonuses rose by 236 percent,

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**TABLE 18** Wage Expenditure, 2009–2013

	2009	2013	Increase (%)
<b>Total compensation of government employees (current CDF billions)</b>	41.6	124.9	200
Wages	14.54	33.80	132
Bonuses	27.14	91.18	236
Number of wage-earning employees	32,450	40,626	25
Number of bonus-earning employees	90,000	112,507	25

Source: Authors' calculations based on MoPH data, 2013.

the average rising from CDF 301,633 in 2009 to CDF 810,474. The larger bonuses primarily benefited physicians more than nurses, averaging USD 660–806 (USD 138 for nurses). The “hazard bonus” started as top-up pay and an incentive; it is now the main component of civil service pay. The bonus accounted for more than 85 percent of government paychecks for physicians and 73 percent of personnel expenditure in 2013, up from 65 percent in 2009.

**The increase in personnel expenditure stems from better coverage of health personnel working in or for the civil service.** Government efforts have provided some form of compensation, including bonuses, for nearly 80 percent of health personnel (112,507 out of a total of 141,759 in 2014), even if a salary is the norm for only 31 percent of the whole staff. Further, wage increases have brought physicians' pay into line with that in neighboring countries. The system for depositing employees' pay directly into their bank accounts has been in place since end-2013, making payments more secure.

**The increase in payrolls raises questions about the medium-term financial sustainability of this expenditure.** It is estimated that the allocations for personnel costs will need to be more than doubled (CDF 250 billion) to only cover wages and bonuses for all of the employees recognized by the MoPH in 2014. This amount represents one and half times the MoPH's total budget in 2013 (CDF 186 billion). Paying bonuses made a large increase

**TABLE 19** Government Compensation of Health Personnel, 2013

	Average by rank, official pay scale (constant 2013 US dollars)		
	Maximum	Minimum	Risk bonus (%)
<b>Medical director</b>	806	727	86
<b>Junior doctor</b>	660		85
<b>Head nurse</b>	190	155	39
<b>Nurse</b>	138	125	24
<b>Manager</b>	117	101	21

Source: MoPH 2013 and authors' calculations.

in compensation for health employees possible, but systematic use of bonuses, which now account for around 85 percent of physicians' compensation from the government (Table 19), raises problems for the medium and long term: bonuses are not included in base pay; there are no financial incentive schemes; and bonuses are not taken into consideration when calculating retirement pensions.

**Wages account for only a minor share of total compensation of health personnel, as seen.** A recent survey<sup>30</sup> shows that compensation from government sources (wages and bonuses) account for a small part of total compensation for most health personnel, even though it accounts for a larger share of physicians' compensation (42 percent). In contrast, users' out-of-pocket payments based on covering costs are the main source of compensation for all personnel in health facilities (except for central and provincial administration staff). External assistance, in the form of wage supplements (per diems, bonuses, and incentives) is the main source of income for the executives supervising the health district, but it accounts for a smaller share for other personnel, from 27 percent for nurses to 11 percent for physicians. Income from activities outside the health field account for around 20 percent of total income of health personnel and this share is proportionately higher for unskilled personnel (28 percent) and for pharmacists (27 percent).

<sup>30</sup> World Bank and University of Kinshasa, forthcoming.

# HEALTH EXPENDITURE PERFORMANCE

## 6

### Section I. Financial Protection

That 90 percent of total health expenditure is household out-of-pocket expenditure is a primary indicator of the poor financial protection provided by the health financing system in DRC. Prepaid systems from voluntary insurance plans cover only a tiny proportion of the population. Furthermore, access to insurance plans is linked to income: 0.7 percent of men and 1 percent of women in the poorest quintile reported that they had insurance, whereas 12 percent of men and 15.3 percent of women in the richest quintile have insurance (DHS, 2013/2014).

**Financing health through households' out-of-pocket expenditure disadvantages the poorest, who spend a larger proportion of their income for their health.** The share of health in household expenditure increases with poverty. Health absorbs 6.48 percent of household nonfood expenditure for the population as a whole, from 11.44 percent (poorest quintile) to 4.48 percent (richest quintile) (Table 20).

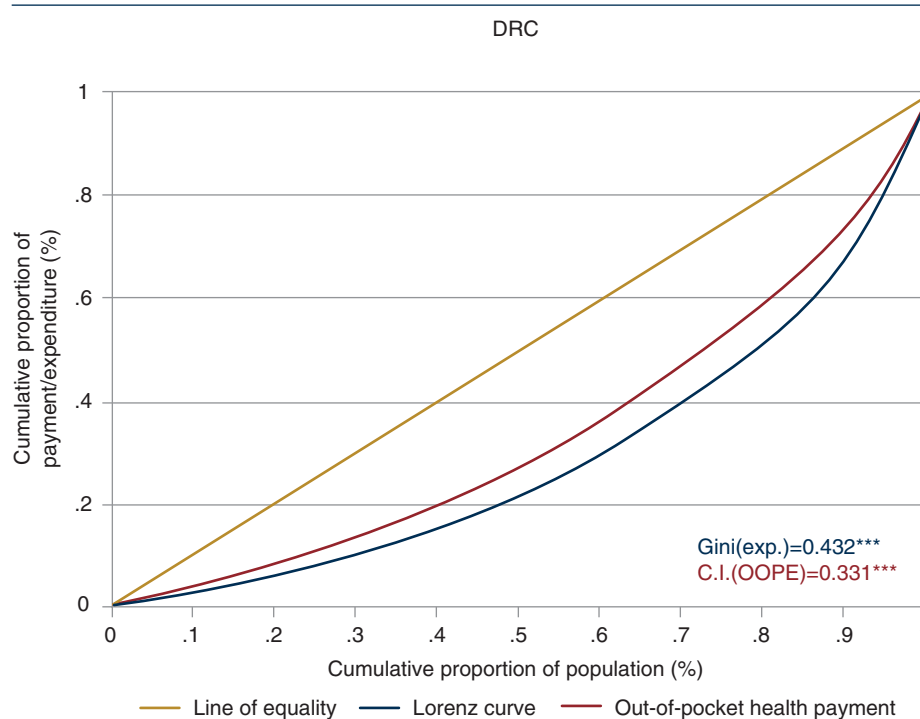
The concentration curve of out-of-pocket expenditure lies below the line of equality, which shows that the richest spend less on health than the poorest (Gini=0.432). Furthermore, out-of-pocket payments exceed households' ability to pay, since the concentration curve of payments lies below the Lorenz curve. The poor spend proportionally more than their ability to pay than the richest (Figure 31).

**Equity in household expenditure varies by province and by place of residence.** The difference between urban areas (11.0 percent) and rural areas (4.7 percent) stems from the lower use of services in rural areas, especially costlier hospital services. The provinces of Maniema, Nord Kivu, and Sud Kivu are where private health expenditure is proportionally the highest (11 percent of nonfood expenditure). Bandundu and Katanga are the two provinces where the distribution favors the rich the most, whereas Sud Kivu has the least inequitable distribution of out-of-pocket health payments. In four provinces (Bandundu, Equateur, Maniema, and Province Orientale) health payments are equivalent

**TABLE 20** Share of Health in Household Expenditure by Income Quintile, DRC

	Q1	Q2	Q3	Q4	Q5	Mean
<b>Total private health expenditure per household (current CDF)</b>	20,341	28,265	35,185	40,344	59,188	<b>39,270</b>
<b>Share of health in household total expenditure (%)</b>	3.39	2.97	2.80	2.48	2.02	<b>2.41</b>
<b>Share of health in household nonfood expenditure (%)</b>	11.44	10.97	9.83	7.78	4.48	<b>6.48</b>

Source: Authors, based on I-2-3 Survey data, NSI 2013.

**FIGURE 31** Concentration Curves and Lorenz Curves for Out-of-Pocket Payments, DRC

Source: Authors, based on I-2-3 Survey data, NSI 2013.  
\*\*\*p < 0.001

to the ability to pay (the concentration curves and the Lorenz curves meet). In the other provinces, payments are regressive.

**With no reliable data from the last decade, it is hard to estimate real changes in financial protection.** According to WHO, the household share of health expenditure fell from 90 percent in 2002 to 50 percent in 2012. There are questions about the reliability of these figures, however. Failure to include data on external assistance could result in overestimation of households' expenditure as a share of health financing in the early 2000s. The high estimate of household expenditure in 2002, at 90 percent of total health expenditure, could lead us to think that the share of household expenditure decreased substantially from 2002 to 2008, whereas this expenditure seems to have stagnated at a level equivalent to the regional average of around 50 percent.

**The incidence of catastrophic health expenditure, estimated at 10 percent of household**

**total expenditure, probably affected nearly 13 percent of the population in 2013 (Table 21).** However, another commonly used measure for estimating catastrophic expenditure—health expenditure of at least 40 percent of household nonfood expenditure—gives a lower estimate of incidence of catastrophic expenditure, affecting 3.84 percent of the population. Catastrophic expenditure affects the poor more: using an intermediate measure of 20 percent of nonfood expenditure, 16.3 percent of the poorest spend more than this share on health, but only 10.5 percent of the nonpoor.

**TABLE 21** Estimated Incidence of Catastrophic Health Expenditure, DRC, 2013

Household health expenditure (share of total household nonfood expenditure)	>40%
Share in the total population (%)	3.84
Household health expenditure (share of total household expenditure)	>10%
Share in the total population (%)	12.91

Source: Authors, based on NSI data, 2013.

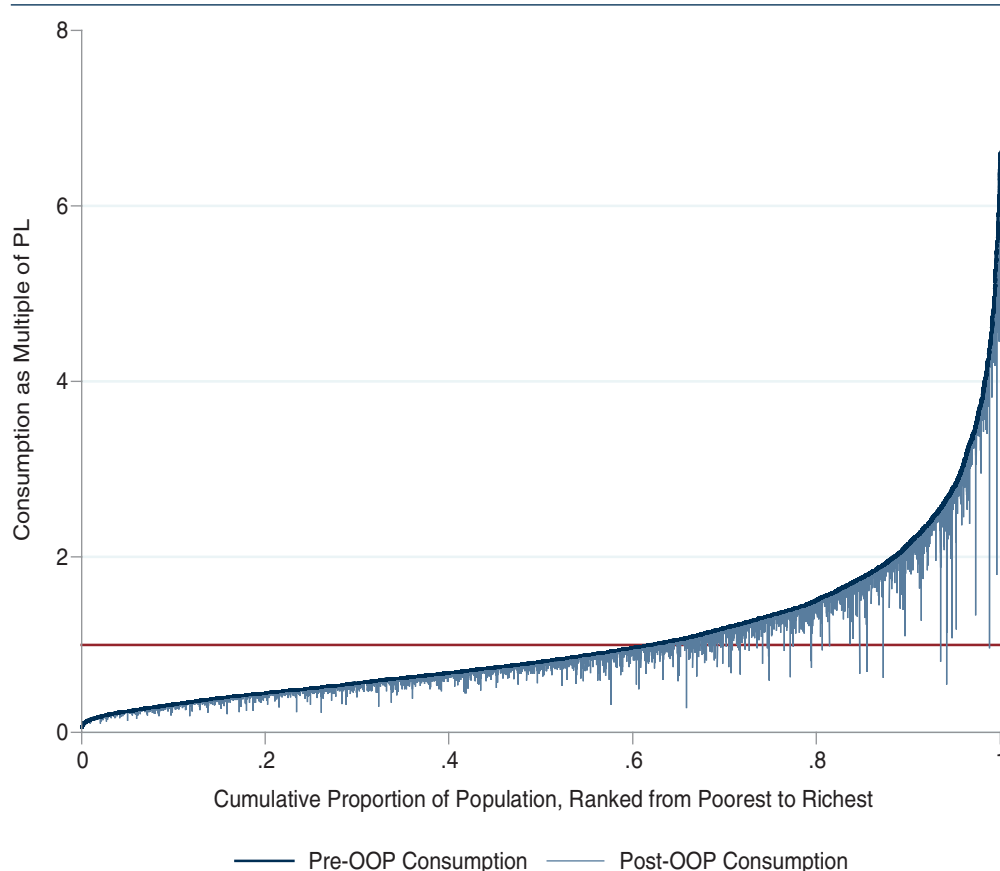
**Impoverishing expenditure is estimated to affect roughly 1 percent of the national population and 2 percent of the rural population.** In Pen's Parade, all the households in the first to third income quintiles have impoverishing health expenditure. Despite their low health expenditure, it keeps them below the poverty line. The situation is different for the richer households in the fourth and fifth income quintiles. Still, it seems that a large proportion of households are pushed below the poverty line by major health expenditure (Figure 32). For some households, impoverishing health expenditure amounts to half their disposable income.

## Section 2. Equity

### *Poverty and Place of Residence*

**Despite the fall seen in incidence of poverty over 2005–2012, disparities between provinces and between the provinces and Kinshasa are still very stark.** Nationally, the incidence of poverty fell by 8 percentage points, from 71.3 percent in 2005 to 63.4 percent in 2012, but it is still greater than 70 percent in four provinces (Kasaï Occidental and Oriental, Equateur, and Bandundu). The regional poverty incidence is lowest in Kinshasa at 36.8 percent, or equal to half the Kasaï Occidental. Over

**FIGURE 32** Effects of Health Expenditure on the Pen's Parade Curve of Household Consumption



Source: Adept Survey, MoPH 2014b, based on data from MICS and NHA 2010.

Note: The figure shows Pen's Parade for household unadjusted consumption and out-of-pocket health expenditure. Household consumption is expressed as a curve starting below the extreme poverty line based on minimum food requirements set at a threshold of USD 1.08. The "paint drip" shows how much subtracting out-of-pocket health payments reduces consumption for each household. If the drip falls below the poverty line, the household is not classified as poor on the basis of its unadjusted consumption, but is poor based on its net consumption.

2005–2012, half the provinces saw declines in poverty incidence of more than 13 percentage points, while Kasai Occidental and Oriental as well as Maniema recorded higher incidence. The decline in incidence was greatest in rural areas, where it fell by 10.6 percentage points, against only 1.4 points in urban areas (NSI, 2013).

### *Inequalities in Health Outcomes*

**Infant and child mortality is concentrated in the poorest population groups, but the disparities narrowed over 2007–2014.** In 2007, nearly 12 percent of children born to the poorest households died before their first birthday, against 6 percent in richer households. Seven years later, infant mortality rates were more uniform between the income quintiles at 6 percent (richest) and 7 percent (poorest). Infant and child mortality rates also improved faster for the poorest, falling from 18 percent to 13 percent, against a decline from 11 percent to 9 percent for the richest. Concentration indicators show that the gaps for infant mortality narrowed from  $-0.11$  to  $-0.03$ , while those for infant and child mortality narrowed from  $-0.09$  to  $-0.06$  (MoPH, forthcoming b; Table 22).

**Child health disparities exist between the provinces, but they have narrowed over time.** Bandundu is the only province that posted infant and under-five mortality rates that were always below the national average for the last 15 years, whereas Sud Kivu, Province Orientale, and Katanga have always had rates higher than the national average. Children born into the poorest households are

significantly more likely to die before their first birthday in Bandundu or their fifth birthday in Equateur. However, the degree of inequality declined over 2007–2013.

**There has also been notable progress on infant and child mortality in rural areas over 2007–2013.** Infant mortality fell from 12 percent to 7 percent in rural areas and from 8 percent to 6 percent in urban areas. Infant and child mortality rates fell from 18 percent to 13 percent in rural areas and from 12 percent to 10 percent in urban areas (MoPH, forthcoming b).

**The prevalence of childhood diseases is higher in the poorest population groups.** The prevalence of acute respiratory infection (ARI) is much lower for children of mothers with a higher education, 3 percent, versus 6 percent for mothers with a secondary education, 7 percent for mothers with a primary education, and 8 percent for mothers with no education. The variations according to the index of economic well-being are minor, even though children from households in the highest quintile suffer less from ARI, with a prevalence of 5 percent, versus an average of 7 percent for the other quintiles. In addition to social and demographic factors, the prevalence of childhood diarrhea also varies by province, with one out of five children suffering from diarrhea in Sud Kivu and Kasai Oriental, versus less than one in 10 in Maniema. It appears that access to improved latrines does not have a significant impact on the prevalence of diarrhea among the children surveyed (DHS, 2013/2014).

**TABLE 22** Concentration Indicators, Infant and Under-5 Mortality by Province (sample) and National Indicator, 2007–2013

	Bandundu	Equateur	Katanga	Maniema	K. Oriental	Sud-Kivu	National
<b>Under-5 mortality</b>							
<b>2007</b>	-0.0642	-0.0789	-0.1226**	-0.0728	-0.0270	-0.1653**	-0.1206**
<b>2013</b>	-0.0322	0.0237	-0.1028**	0.0068	0.0328	-0.0915**	-0.0265
<b>Infant mortality</b>							
<b>2007</b>	-0.0972**	-0.0607**	-0.1730	-0.0175	0.0575	-0.1935	-0.1104
<b>2013</b>	0.0004	0.0352	-0.0615	0.0110	0.0569	-0.0286	-0.0174

Source: Authors, based on 2007 and 2013–2014 DHS.

**The prevalence of malnutrition, as estimated by the number of underweight children, is increasing among the poorest.** It rose from 27 percent to 31 percent for children from the poorest households but declined from 15 percent to 8 percent for children from the richest households. All provinces are seriously affected by malnutrition, with prevalence of more than 20 percent, apart from Kinshasa, where prevalence was 5 percent in 2013–2014. Maniema, where 33 percent of children are underweight, is by far the most seriously affected. The decrease in malnutrition was smaller in rural areas, where prevalence fell from 29 percent to 27 percent over 2007–2014, than in urban areas, where it fell from 20 percent to 14 percent. The same pattern is found for stunting, which is decreasing less rapidly in urban areas.

**The figures broken down by province show that childhood malnutrition increased in Bas Congo and Maniema, whereas it decreased or remained the same in the rest of the country.** In Maniema, the prevalence of underweight children is estimated to have increased by 11 percentage points over 2007–2014. In Bas Congo it increased from 26 percent to 28 percent. In contrast, prevalence in Kinshasa fell by two-thirds to 5 percent in 2013. The same pattern is found for stunting, which increased by some 2 percentage points in Bas Congo, Maniema, and Kasai Occidental, but decreased in all other provinces.

### *Inequalities in Use of Services*<sup>31</sup>

**The most recent data show major inequalities in coverage of maternal health services based on income and place of residence.** One-quarter of the poorest women do not receive any antenatal care, whereas only 8 percent of the richest women do not receive any. Nine percent of the women living in Kinshasa do not receive any antenatal care, whereas the figures are more than 20 percent in Katanga, Kasai Occidental, and Kasai Oriental.

<sup>31</sup> This subsection draws on analysis carried out for this report and a separate Equity Analysis conducted using Adept software.

The distribution of mothers' use of services is significantly more favorable to the rich in Bandundu, Equateur, and Province Orientale.

**The increase in the use of antenatal care and skilled birth attendance favored the poorest households.** The use of these services is still concentrated among the richest, but the scale of inequality narrowed gradually over 2007–2014, with concentration indexes falling from 0.087 to 0.058 for four antenatal visits. The disparities are still stark between the provinces and Kinshasa, where 76 percent of women receive full antenatal care; in eight out of 11 provinces, fewer than half receive such care.

**The use of modern contraception is still strongly an urban phenomenon slanted toward the richest—17 percent of women—versus 6 percent in rural areas.** In Kinshasa and Bas Congo, 21 percent of married women report that they use a modern contraception method, whereas most of the other provinces fall below the national average of 8 percent. The differences between rich and poor are wide: only 4 percent of the poorest women use a modern contraceptive method, against 20 percent of the richest.

**The use of services for treating childhood diarrhea improved for all quintiles, including the poorest.** A significant increase of 10 percentage points, from 21 percent to 31 percent, was seen in access to treatment for diarrhea for the poorest children. The increase was sharper in the provinces than in Kinshasa. Provinces such as Kasai Occidental and Oriental as well as Province Orientale saw increases of more than 10 percentage points. With 31 percent and 32 percent of children having access to treatment for diarrhea, Equateur and Province Orientale fall below the national average of 39 percent.

**Access to treatment for ARI and for malaria, which government facilities provide for free, decreased, especially among the richest.** Access to ARI treatment fell for all children, but the decrease was sharper for the richest households at 15 percentage points than among the poorest households at 6 percentage points. Access is still very restricted



for all quintiles, at 39 percent for the richest and 33 percent for the poorest. In Province Orientale and Nord Kivu, access to this treatment fell by half to less than 25 percent in 2013–2014. Access to treatment for ARI also fell sharply in urban areas from 46 percent to 35 percent of children infected, matching the level of treatment for rural children. Access to malaria drugs also fell, particularly for the richest households, from 63 percent to 43 percent. This decline may stem from less use by the richest quintiles of government health centers that distribute free malaria treatments. On the other hand, access to means of prevention and, more specifically, access to insecticide-treated nets that are distributed free in local communities is fairly equitable, with little differences in use between the income quintiles and places of residence.

**The decrease in vaccination coverage is estimated to have affected the poorest more severely**, with a decline of 6 percentage points over 2010–2014, whereas the coverage rate increased by 9 percentage points for the richest households. Provinces such as Bandundu, Katanga, and Kasai

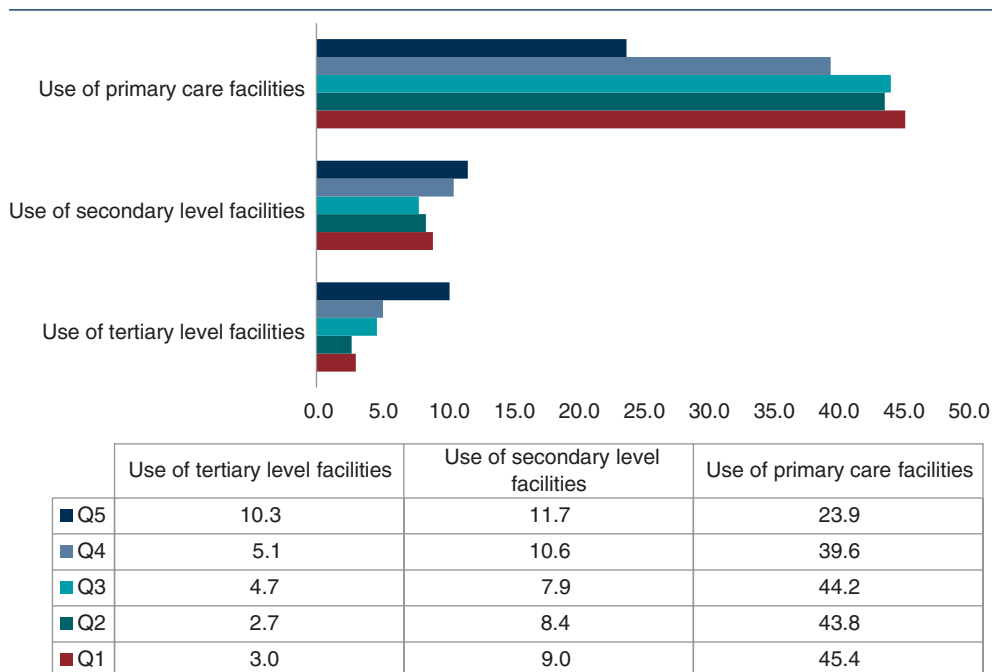
Oriental saw their coverage rates fall below 40 percent and below the national average of 46 percent. Even though coverage rates increased in Equateur and Province Orientale, these two provinces still have the lowest vaccination coverage rates, with 33 percent and 31 percent of their children fully vaccinated.

**The use of secondary level health facilities shows a fairly equal distribution between the income quintiles, but access to tertiary health facilities is still slanted toward the richest quintile.** In contrast, only 24 percent of the top quintile use primary health facilities, compared with 45 percent of the poorest (Figure 33). The use of private health services is concentrated in urban areas, accounting for 46 percent of the care consumed, against 13 percent in rural areas.

*Benefits of Government Financing*

**Government health expenditure benefits hospitals more.** Operating expenditure, modest though it is, goes virtually exclusively to hospitals. Further,

**FIGURE 33** Inequalities in the Use of Services by Income and by Service Level, DRC, 2013



Source: Authors, based on I-2-3 Survey data, NSI 2013.

as of 2013, new fixed grants for district hospitals' operating costs were introduced. Government expenditure on health centers, in the form of operating subsidies, is virtually nonexistent. Yet if we consider all the current expenditure, including wages, the distribution may be slightly more balanced, even though the majority of qualified personnel are employed by hospitals. However, the breakdown of expenditure by level of health facility is difficult to estimate because of the lack of detail in the classification. In addition, the primary level of health facilities encompasses health centers and district hospitals, which makes the cut-off between levels even vaguer.

**Government health expenditure appears rather inequitable.** The richest quintiles use hospital services more than the poorest (Figure 34), but it seems that current expenditure benefits higher levels of health facilities more than primary health facilities. While 87 percent of government expenditure goes to government hospitals—with 70 percent for hospitalization services and 17 percent for ambulatory care—only 13 percent goes to ambulatory care in health centers. Under the proportional cost assumption, government expenditure favors the top quintile, which accounts for 22 percent of the total. The poorest quintile receives 16 percent of total public

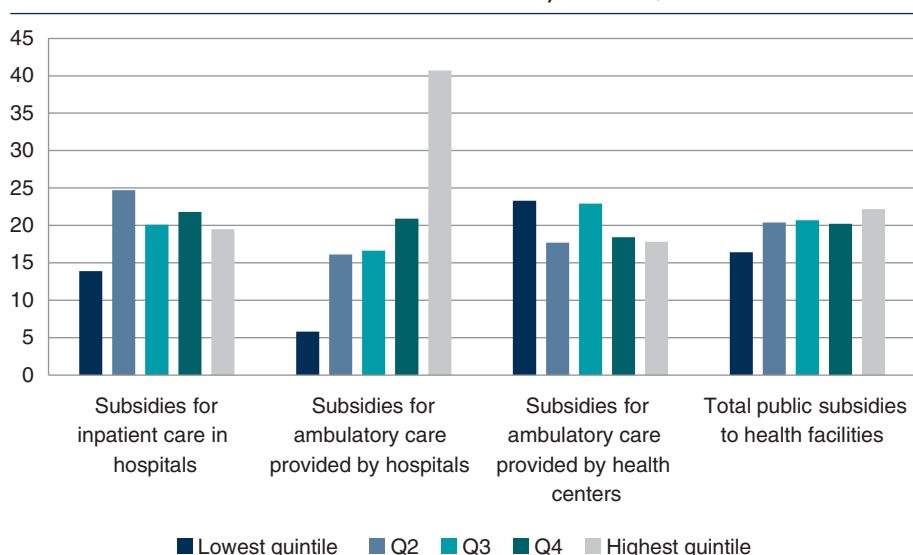
subsidies. Subsidies for ambulatory care in government hospitals are used more by the richest quintile. These are the most inequitable subsidies, bringing very little benefit to the poorest quintile, which receives 5.8 percent, as opposed to the top quintile, which receives 40.7 percent (MoPH, forthcoming b).

**The geographic distribution of government expenditure is inequitable.** The majority of government expenditure is inversely related to local income. Kinshasa receives CDF 2,431 per capita a year, whereas the other provinces, except Bas Congo, receive less than half that. The ratio between the capital and the province receiving the lowest amount per capita is 5 to 1 (Figure 35).

### Section 3. Technical and Allocative Efficiency

**For the same level of health expenditure, health outcomes in DRC fall short of those of peer countries.** Government expenditure on maternal health in DRC seems to be more efficient and provides antenatal care and skilled birth attendance coverage that is higher than the regional average (Figure 36). However, the maternal mortality rate is much higher than the regional average, which hints

**FIGURE 34** Distribution of Government Subsidies by Income Quintile, DRC

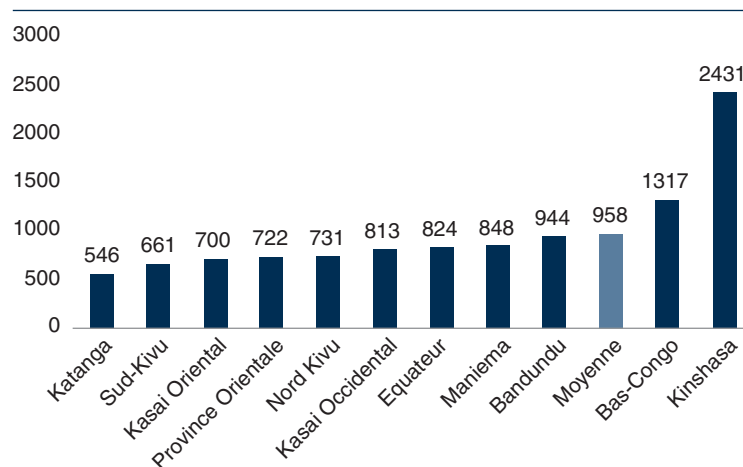


Source: Authors, based on NHA and MICS data, 2010.

Note: Calculations under the proportional cost assumption.

## 2014 HEALTH PUBLIC EXPENDITURE REVIEW

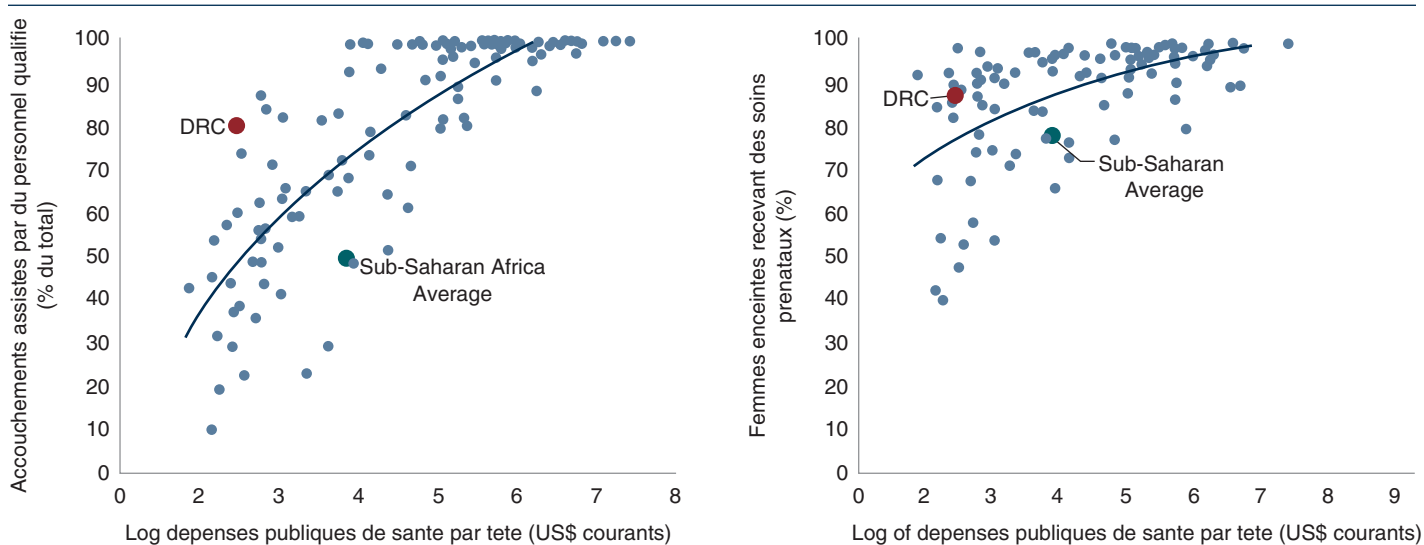
**FIGURE 35** Geographic Distribution of Government Expenditure per Capita, 2013 (CDF)



Source: Authors, based on disbursement data (2013).

Note: For the sake of accuracy, the geographic distribution of government expenditure is calculated on the basis of personnel expenditure in each province. Estimated on the basis of personnel expenditure.

**FIGURE 36** Rate of Skilled Birth Attendance (left) and Antenatal Care (right) vs. Government Health Expenditure per Capita and Peer Countries (2013 or most recent available data)



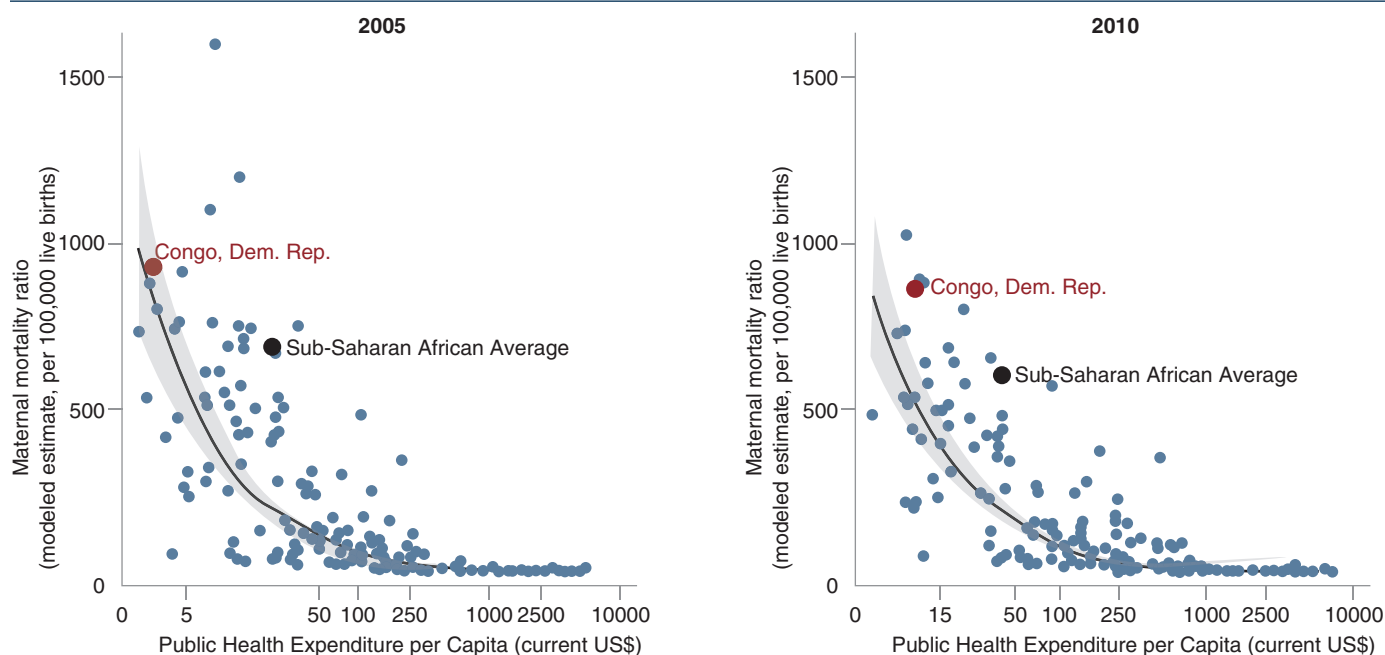
Source: Authors, based on WDI data.

Note: Skilled birth attendance rate is percentage of total births). Antenatal care is percentage of pregnant women.

Log of government health expenditure per capita in current USD.

at major problems with the quality and effectiveness of services (Figure 37). For the same level of expenditure, DRC's performance is also much poorer than the rest of the region for infant mortality and under-five mortality (Figure 38).

**Government health expenditure by province does not seem to be linked to priorities for action or to health outcomes.** For example, Maniema has higher government health expenditure per capita than the other provinces, but it has

**FIGURE 37** Maternal Mortality vs. Government Health Expenditure per Capita, 2005 and 2010

Source: Authors, based on WDI data.

Note: x-axis log scale. Gray area indicated 95% confidence interval for the fitted line.

not achieved better coverage for health services. The allocations for Bandundu, Equateur, and Province Orientale are fairly similar, but Bandundu shows better outcomes on vaccination coverage and skilled birth attendance. The priority on allocations for hospitals also makes it harder to improve the performance of primary care and the health system as a whole (Chapter 6, Section 2).

**The performance of health personnel varies by province and could be greatly improved.** The lack of reliable data makes it impossible to assess productivity by output per person.<sup>32</sup> However, disparities in coverage indicators and health outcomes by province, compared with health human resources, suggest that the performance of health personnel could be improved appreciably. Bandundu and Province Orientale have the same level of qualified personnel, but their use rates vary by a factor of two in terms of coverage for child health care and infant

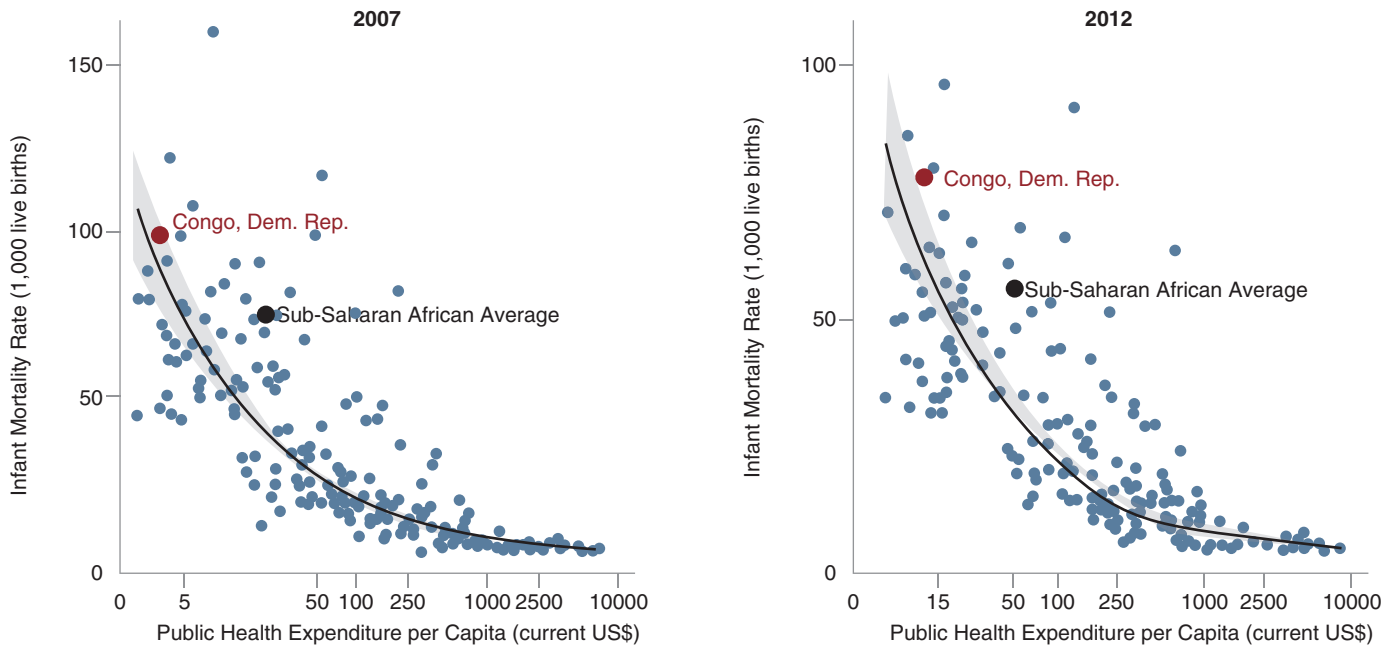
mortality (Figure 39). Coverage of antenatal care does not seem to vary according to the level of personnel available in each province, but skilled birth attendance does seem to be inversely linked to personnel density. Equateur, which has the most health personnel of the six provinces in the sample, seems to have the lowest rate of skilled birth attendance, at less than 20 percent.

**DRC introduced a performance-based financing mechanism (PBF) in 2004 (Box 6).** The mechanism was scaled up quickly to purchase services based on the performance of health facilities. In DRC, PBF is used to link financing to specific outcomes, and payment is only made once the expected results have been achieved and verified. In 2014, PBF was implemented in more than 120 health districts in the country, covering some 20 million people. Purchases of services included both the minimum care packages provided by health centers and the supplementary package provided by district hospitals and other facilities. An independent agency performs the care purchase function.

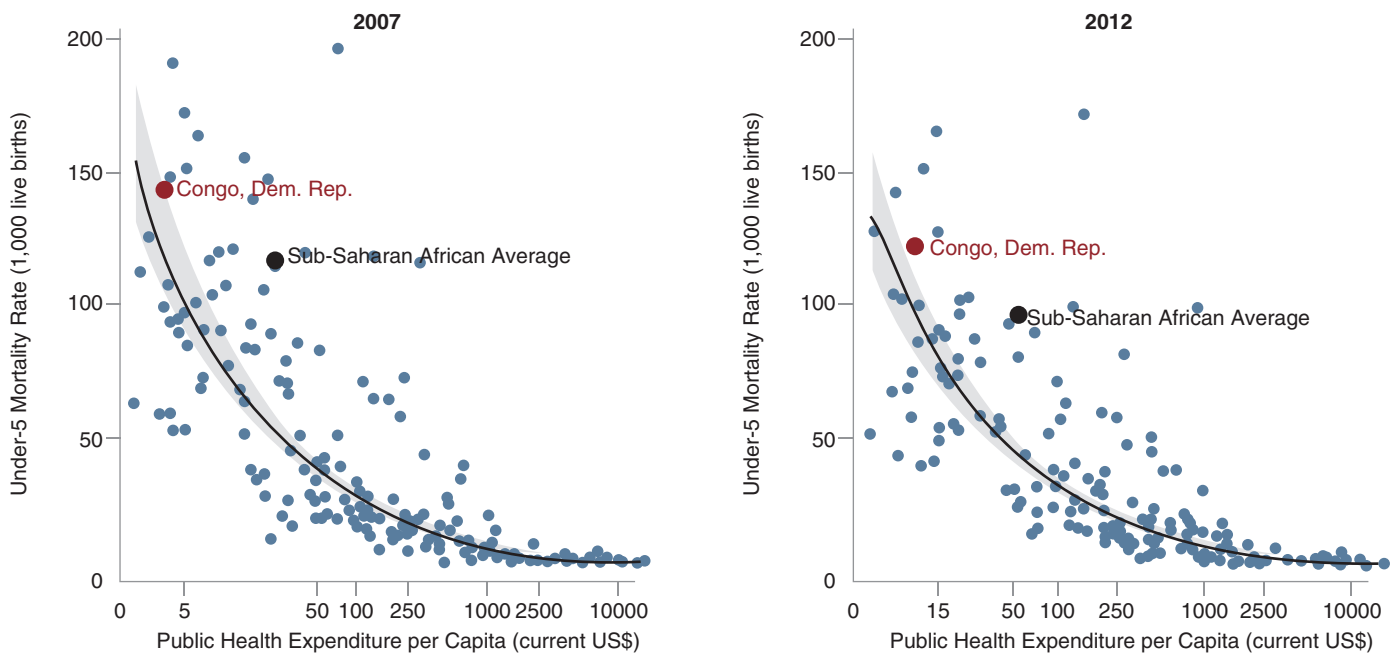
<sup>32</sup> A performance assessment of the health care delivery system will be carried out in 2015. It could shed light on personnel performance and service quality.

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**FIGURE 38** Infant (upper figures) and Under-5 (lower figures) Mortality Rates vs. Government Health Expenditure per Capita, 2007 and 2012



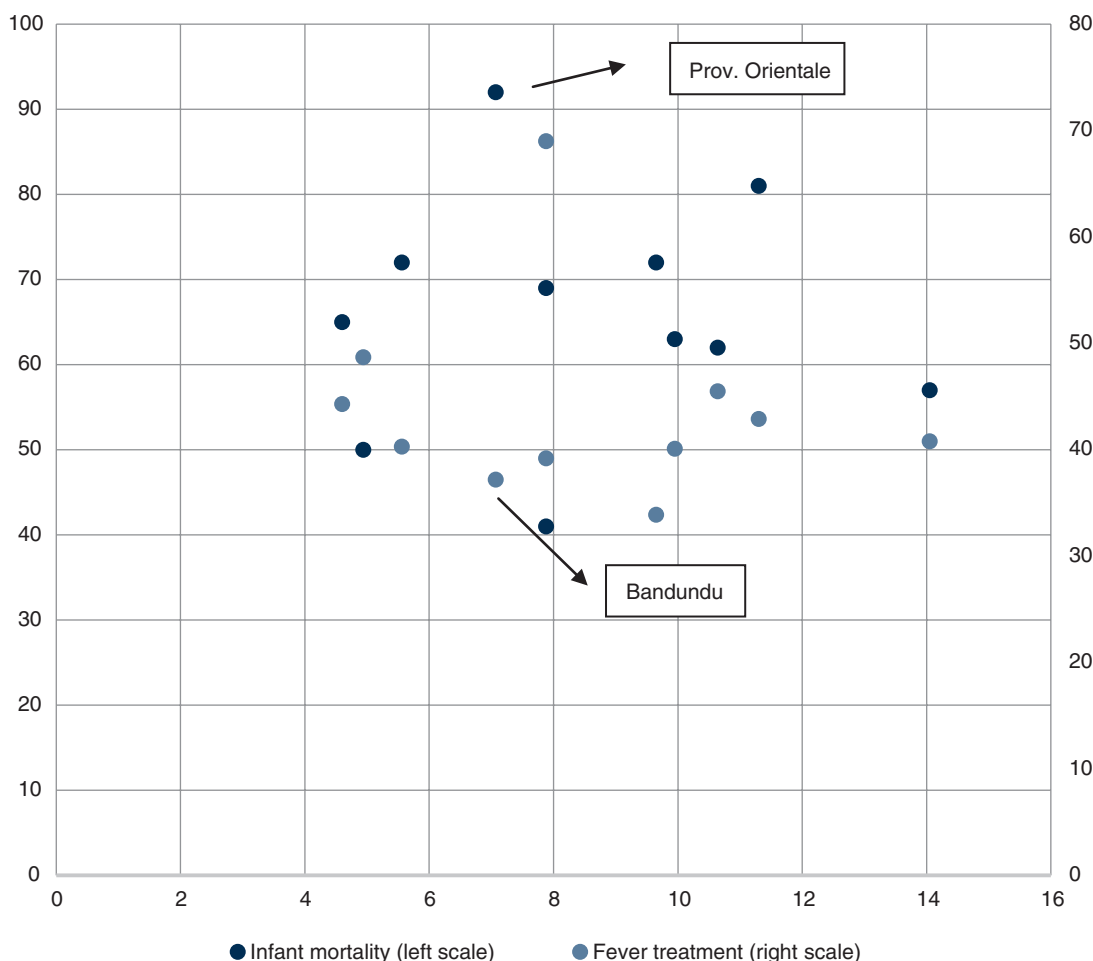
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Source: Authors, based on WDI data.

Note: x-axis log data. Gray area indicated 95% confidence interval for the fitted line.

**FIGURE 39** Availability of Qualified Personnel vs. Use of Services for Treating Fever and Infant Mortality



Source: Authors, based on MoPH data for personnel and DHS 2013/2014 for the other data.  
 Note: Each dot represents a province. The y-axis shows access to treatment of fever for children under five in light blue. Infant mortality is shown in dark blue. The x-axis shows the ratio of qualified personnel per 10,000 population.

**BOX 6** Performance-Based Financing: Findings of an Impact Study in Katanga

Haut-Katanga (population: 1.26 million) was part of the World Bank Health Sector Rehabilitation Support Program (HSRSP), which covered 83 health districts in five DRC provinces. An impact assessment was carried out in 98 health areas, which were assigned randomly to 2 groups: 48 districts received performance-based financing and the others received fixed payments.

The impact assessment in Haut-Katanga found that the PBF mechanism was effective in increasing the supply of targeted services. Personnel attendance was 14 percent higher in the PBF areas. The number of preventive health sessions was also greater, along with the number of community-based outreach

activities, indicating more motivated personnel. The mechanism did not lead to a reduction in the supply of nontargeted services and it did not have a negative impact on service quality (or a positive impact either). However, the study also shows that the test project did not lead to a significant increase in the use of services, despite lower costs for users. The use of services was similar between the PBF districts and the other districts. The main obstacle that households reported to account for nonuse of services was a lack of confidence about the benefits of the care provided.

Source: Huillery and Seban, 2014.

# DECENTRALIZATION: IMPACT ON DEPLOYMENT AND USE OF HEALTH RESOURCES

## 7

### Section I. Financing Flows (excluding wages)

Provinces receive three types of earmarked transfers: investment (capital spending); operating; and fixed grants for deconcentrated services. However, a large share of government expenditure (excluding wages) is still executed at the central level on behalf of the provinces.

**Investment is the priority.** Total budgeted investment allocations more than doubled from 2010 to 2013, accounting for more than 75 percent of total allocations. However, the amounts executed are small, averaging for the six sampled provinces 26 percent over 2010–2013.

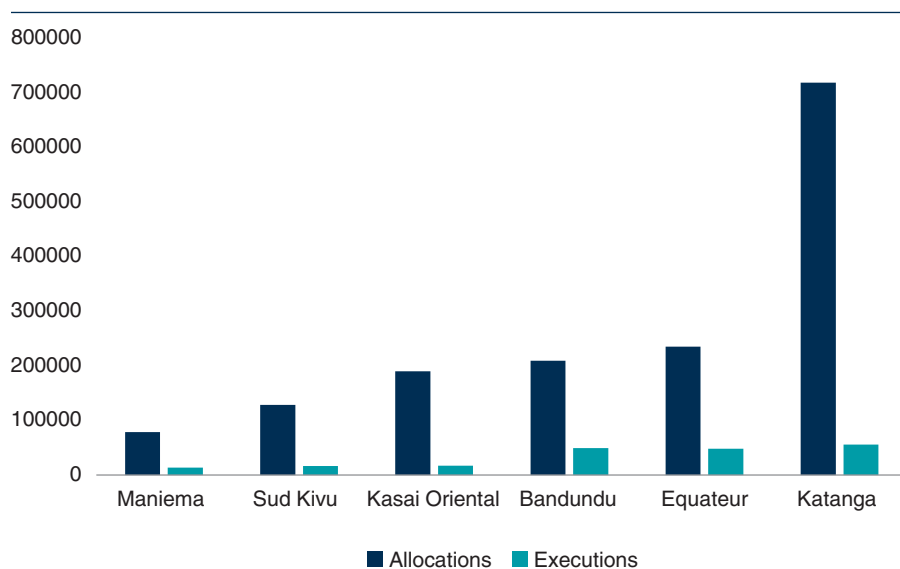
**Operating allocations are smaller,** at roughly one-quarter the size of investment allocations, and show little growth, though the central government is improving execution of transfers. The execution rate rose from 75 percent in 2010 to 94 percent in 2013, taking operating grants to half the transfers executed. Fixed grants for deconcentrated services, the third type of transfer, have minimal allocations, though on this tiny base they have quite high execution. They ultimately account for only 1 percent of actual transfers.

**The geographic distribution of transfers shows no discernible pattern and their execution is unpredictable.** Katanga receives the largest subsidy, which is 10 times as great than the subsidy for Maniema (Figure 40). However, the ratio is 5 to 1 in

terms of execution. Bandundu and Equateur receive more than twice the transfers budgeted, thus matching the amounts actually transferred to Katanga.

**Despite increased transfers, government expenditure is still mainly controlled and executed by the central government, which is a sign of incomplete decentralization.** Investment in the provinces is still largely controlled by the central government, in the absence of effective public procurement management in most provinces. The central government executes the PESS directly; no provisions are made for the program in the provincial budgets. The central government also continues to execute personnel expenditure and no guidance has been provided to date about transferring the payroll function to the provinces.

The provincial budget-making process is still in its infancy. A lack of reliable information and problems tracing revenue and expenditure hamper budget planning. Planning processes do not have adequate macroeconomic guidelines; the expected revenue and expenditure amounts are often out of step with the availability of local and central government resources, on the one hand, and disbursement capacities, on the other. Technical staff have little say in budget planning, which, despite a vote by the Provincial Assembly, is primarily a political process. The recent introduction of guidelines such as MTEF in the provinces have helped provide guidance for forecasting revenue and expenditure, but budget elaboration process remains perfectible. Further, the

**FIGURE 40** Investment Transfers Allocation and Execution, 2010–2013 Total by Province in CDF Million

Source: Authors, based on compilation of various central and provincial sources.

provincial budgets are presented using nonstandard formats that differ between provinces. Budgets are not broken down by administration; areas of jurisdiction are still vague and vary from one province to the next. This increases the lack of transparency in sector budgets.<sup>33</sup> Some budgets are also artificially inflated by incorrect recognition of resources and expenditure executed by the central government, such as wages.

## Section 2. Provincial Health Financing Resources

**As with the central government, external assistance is the leading health financing source for provinces.** Estimates of external assistance vary by source, and few provincial authorities are aware of them. Our analysis based on questionnaires filled in by development partners at national and provincial level show that external assistance is predominant

in health financing at provincial level: in 2013, the amounts provided to provinces by external partners were nearly three times as great as total government funds allocated for health (and executed rates were of course far lower). In some provinces, such as Maniema or Sud Kivu, external assistance is up to six times as high as central and provincial government funds (Figure 41). The majority partner in Sud Kivu, Katanga, and Kasai Oriental is USAID. In the three other provinces in the sample, the World Bank is the main donor through the Health Sector Rehabilitation Support Program (HSRSP).

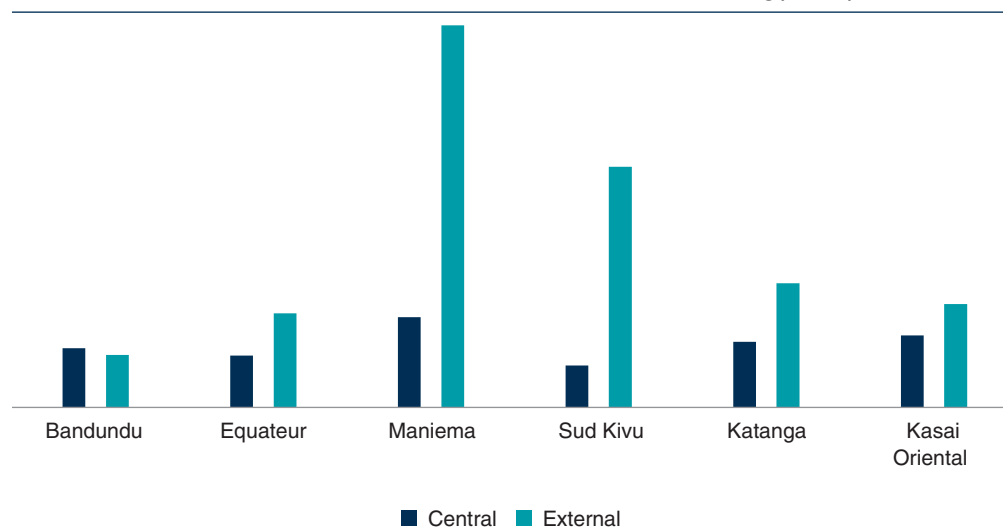
**Central government funds account for the majority of provincial government funding.** Katanga aside, funds raised by the provinces to finance health are small (Figure 42). In Kasai Oriental, Sud Kivu, Bandundu, and Equateur, provincial resources for health come to CDF 53 and CDF 97 per capita—less than USD 0.10. In Maniema, provincial funds are greater, but are still only one quarter that of central government health transfers. In Katanga, however, central government and provincial government funds seem to be in balance at about USD 0.60 per capita each.

<sup>33</sup> Bandundu: Ministries of Public Health, Social Affairs, Humanitarian Affairs, and of Youth and Sports; Equateur: Ministries of Public Health, of Social Affairs, and relations with Parliament; Maniema: Ministries of Public Health and of Social and Humanitarian Affairs.



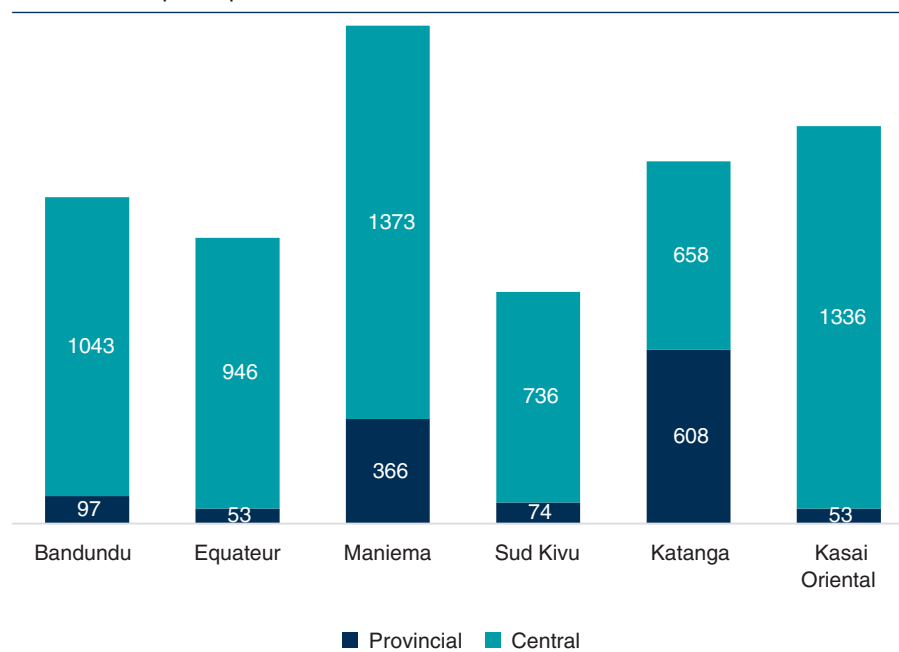
## 2014 HEALTH PUBLIC EXPENDITURE REVIEW

**FIGURE 41** External Assistance and Government Funds in Health Financing per Capita, CDF 2013



Source: Authors, based on data compiled from provincial authorities and development partners using questionnaires.

**FIGURE 42** Central and Provincial Government Funds for Financing Health Care per Capita, CDF, 2013



Source: Authors, based on national and provincial budget data.

**TABLE 23** Health Allocations as Percentage of Provincial Government Budgets, 2010–2014 (%)

Province	Health allocation (% of provincial budgets) <sup>a</sup>
Bandundu	5.0
Equateur	5.0
Maniema	7.3
Sud Kivu	2.0
Katanga	3.0
Kasaï Oriental	2.7

Source: Authors, based on provincial budget documents.

a. From internal resources and unearmarked transfers.

**Provincial budgets devote a tiny share of expenditure to health.** Excluding earmarked transfers, provinces allocate an average of 4 percent of their resources to health (Table 23).

**Decentralization efforts meant that expenditure financed by government funds increased more than expenditure funded by other financing sources.** Earmarked transfers from central government for health nearly doubled from 2011 to 2013 in the provinces in the sample, rising from CDF 3,476 to CDF 6,091 per capita. Provincial funds for health increased less rapidly, but still rose by around half.

External assistance, however, declined by 13 percent (Figure 43). Starting in 2010 there was a downwards trend in Bandundu, Equateur, Maniema and Katanga. Sud Kivu, which suffered from a succession of military and humanitarian crises, posted a significant increase in external assistance up until 2012, followed by a slight decline in 2013 (Figure 44).

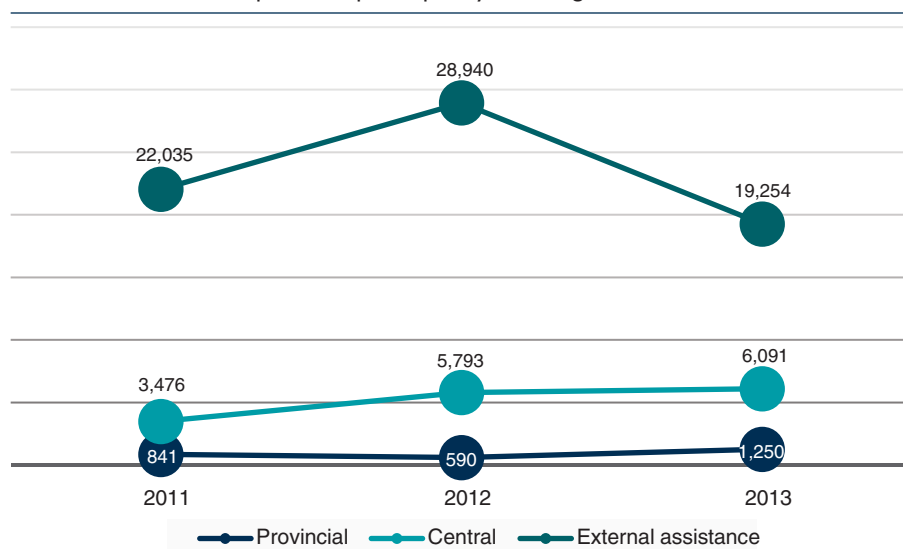
### Section 3. Provincial Government Health Expenditure

**Government health spending per capita is very low.** Among the six provinces, it varied little among them (except for Maniema), from CDF 809 to CDF 1,364 (USD 0.90 to USD 1.50) in 2013.

**Central and provincial government resources are primarily used in the provinces to cover personnel expenditure.**<sup>34</sup> Personnel expenditure is primarily paid by the central government, but some

<sup>34</sup> Apart from Katanga and Maniema, personnel expenditure accounted for more than 90 percent of total government expenditure executed in 2013: 92 percent in Bandundu, 97 percent in Kasaï Oriental, 99 percent in Sud Kivu, and 99 percent in Equateur. Maniema and Katanga were the closest to the national average, at 61 percent and 62 percent.

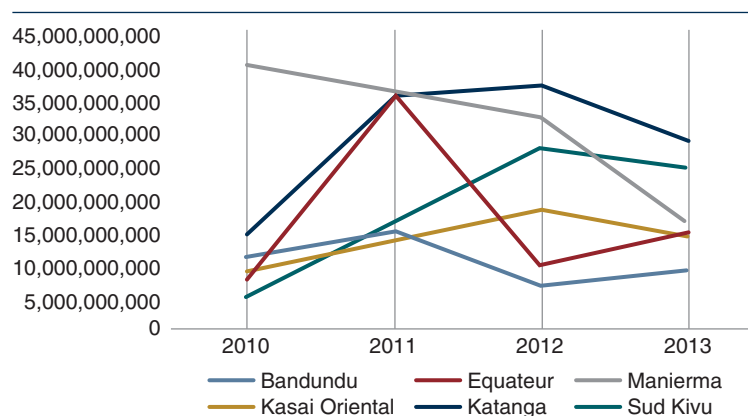
**FIGURE 43** Health Expenditure per Capita by Financing Source, 2011–2013



Source: Authors, based on data compiled from provincial authorities and development partners using questionnaires.

## 2014 HEALTH PUBLIC EXPENDITURE REVIEW

**FIGURE 44** External Assistance Disbursements by Province, CDF, 2010–2013



Source: Authors, based on data compiled from development partners using questionnaires (disbursements).

provinces top up wages with their own resources, such as Bandundu, Kasai Oriental, and Sud Kivu.

**A few provinces use internal resources purely on investment.** This is true for Katanga (100%, or more than 37 percent of total government resources spent on health) and Maniema (100% and 18 percent). Investment in other provinces was financed by the central government, but the amounts were very small at less than 1 percent Kasai Oriental as an example.

**Operating expenditure is the poor cousin in provincial government expenditure.** An average of less than 5 percent of expenditure of all central and provincial resources combined goes to operating health facilities and the health system in general in the provinces in the sample. However, larger “new” subsidies were awarded to district hospitals to cover operating costs, especially in Bandundu and Maniema, since 2013. These subsidies came to CDF 242 million in Maniema and CDF 309 million in Bandundu.

**External assistance was apparently used mainly to finance the operating expenditure of health facilities** and the associated management bodies

(office of the District Manager, district executives, provincial authorities). In a sample of three provinces (Katanga, Sud Kivu, and Kasai Oriental), operating expenditure accounted for half of the disbursements by external partners. The other main expenditure items are services (15 percent), equipment, goods, and supplies (18 percent), and personnel (13 percent) for bonuses and other wage supplements.

**Expenditure execution using provinces’ internal resources is fraught with problems.** The average execution rate for such expenditure in 2013 stood at 20 percent (Bandundu, 25 percent; Maniema, 24 percent and Sud Kivu, 19 percent). No significant improvement was seen from 2011 to 2013.

**There is a lack of monitoring and supervision of provincial expenditure.** A simplified expenditure chain is being introduced in the provinces, but it was not yet operational in most provinces in the sample in 2014. Expenditure monitoring is not computerized, or only partially computerized, as is the case in Katanga. Monitoring by the Ministries responsible for the budget is not comprehensive, or even nonexistent in Sud Kivu, at the commitment and/or validation stages.

# MAIN POLICY RECOMMENDATIONS AND ROADMAP FOR IMPLEMENTATION

## 8

Topics	Diagnosis	Recommendations	Timeline			Lead Authority
			Short term	Medium term	Long term	
I. Make natural-resources wealth more “healthy” to invest for UHC						
<b>Fiscal Space</b>	Government resources for health (USD 1 per capita) are inadequate to meet needs. There are feasible options for increasing fiscal space for health.	<p>1a) Increase the mobilization of domestic revenues from natural resources and improve the system for collecting and administering the existing revenues for a gain of up to 8 percentage points of GDP.</p> <p>1b) Revise the priority-setting exercise within the government budget and aim to double the health envelope (to 8 percent of the general budget).</p> <p>1c) Use the sectoral MTEF as an advocacy tool rather than a constraint to build up health budget credibility and gain power in budget negotiations.</p> <p>1d) Enhance the predictability and traceability of external health assistance through systematic collection of financial information for allocation, execution, and forecasts.</p>		X		Ministry of the Economy and the Budget, MoPH
				X		
			X		X	
2. Free up resources for priority interventions for UHC through better effectiveness and efficiency of health spending						
<b>Effectiveness and Efficiency</b>	The amount, nature, and distribution of government health expenditure are inequitable, and lack efficiency and effectiveness. The predictability, effectiveness, equity, and efficiency of government health expenditure can be improved.	<p>2a) Define a joint roadmap between the Ministry of Economy and Finance and MoPH to boost effectiveness of health expenditure and smooth rigidities and delays.</p> <p>2b) Enhance the expenditure-commitment procedure through capacity building at the MoPH level to avoid loss of budgeted allocations and improve the execution rate (up to 90 percent).</p>	X			MoPH, Ministry of Finance
			X			

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Topics	Diagnosis	Recommendations	Timeline			Lead Authority
			Short term	Medium term	Long term	
		2c) Conduct a complete overhaul of allocations within the health sector with the aim of refocusing efforts on priority preventive and primary care as well as priority, cost-effective interventions, with the support of the GFF.		X		
		2d) Speed up development of purchasing agents, ensuring a functioning purchaser/provider split and therefore greater efficiency of health spending.			X	
<b>3. Revise and enforce public sector employment, deployment and remuneration rules</b>						
<b>Personnel Expenditure</b>	Government personnel expenditure tripled over 2009–2013 and only covers one-third of personnel. Full compensation of registered personnel would help improve motivation and service quality. It would also stabilize staffing levels in the short term.	3a) Step up the census of active personnel (short term).	X			MoPH, Ministry of the Civil Service, College of Physicians
		3b) Stabilize the pay scale and staffing levels through stricter enforcement of civil service hiring and employment rules (short term).			X	
		3c) Finalize the system of direct bank deposit of wages and bonuses (short term).	X			
		3d) Run a cost simulation of the total payroll, including salaries and bonuses for all active personnel.	X			
		3e) Initiate rethinking of national health human resources standards and incentives policy in order to curb geographic and skills imbalances.			X	
		3f) Regulate quality of training through accreditation of training institutes.			X	
<b>Decentralization</b>	Decentralization has not been optimized or harmonized with sector funding and governance. Health resources for coverage expansion can be better mobilized and applied at decentralized levels.	4a) Improve execution of revenue retrocessions to bring it up to constitutional commitment (40 percent of national revenue collected).		X		MoPH, Provincial Governments
		4b) Clarify the roles and the division of labor for implementing health financing reforms between the central, provincial, and deconcentrated entities (in particular for expenditure and personnel management).		X		
		4c) Increase the collection of local revenues by consolidating and simplifying the provincial tax system and increasing revenues from natural resources.		X		

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Topics	Diagnosis	Recommendations	Timeline			Lead Authority
			Short term	Medium term	Long term	
		4d) Develop a budget tool kit to enhance budget preparation at provincial level and sensitize on health and UHC priorities to align allocations with goals.	X			
		4e) Pilot resource-pooling mechanisms at provincial level as a first step toward better alignment across different sources of funds (domestic, external, and private).		X		

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