HEALTH FINANCING OPTIONS PAPER

Financing Universal Health Coverage in the Republic of Congo: Opportunities for Domestic and External Resource Mobilization

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1 Background

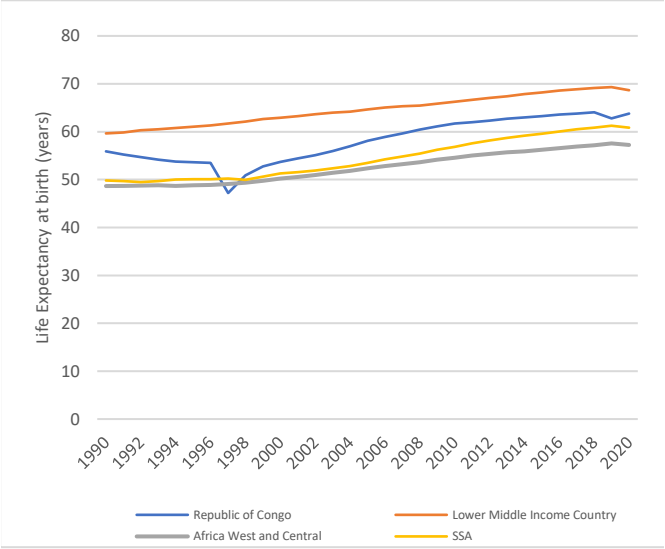
Attaining the Sustainable Development Goals (SDGs) and making progress towards Universal Health Coverage (UHC) are at the core of the Government of Congo's concerns. While the goals are ambitious, the means are limited resulting in an acute financing gap. The Government has committed to dedicating an increased share of the national budget (13 percent) to the health sector, acknowledging that successful progression to sustainable financing for health will have a positive impact on Congo's overall development. With a United Nations Human Development Index (HDI) of 0.571 in 2021, the country currently ranks 153rd out of the 188 countries[1]. Scoring 0.42 on the World Bank's Human Capital Index, under current conditions, a child in Congo will only reach 42 percent of its productivity compared to if they had enjoyed complete education and full health. This exacerbates a situation where three quarters (75.9 percent) of the active population have jobs that already qualify them as vulnerable to economic shocks. Social and gender inequalities remain a concern and the recent contraction of the Congolese economy by 2.2 percent in 2021 driven by the fall in oil production led to a 1.8 percentage point increase in poverty rates[2] from 50.2 percent in 2020 to 52.0 percent in 2021. The economic, food, and health crises and their socioeconomic consequences further exacerbate this social precariousness and intensify inequalities.

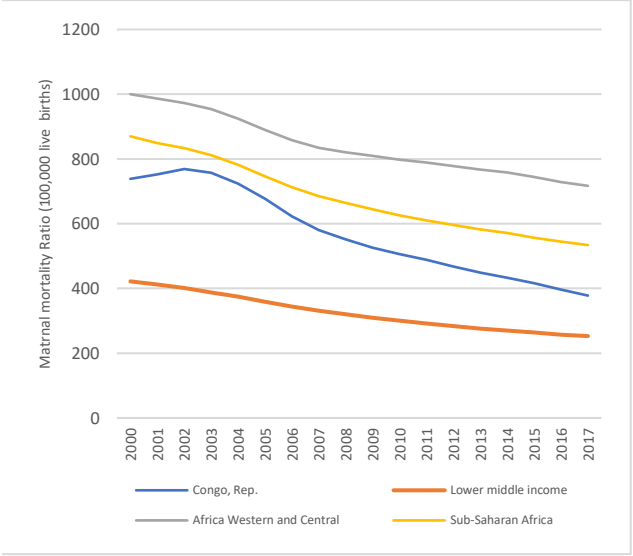
Congo, as most countries in Sub-Saharan Africa (SSA), has been undergoing a slow demographic transition – or shift from high to low mortality and fertility rates since the late 1970s, representing the country's first transition in health[5]. There has been a population increase while fertility and mortality are declining at a very slow rate. On average, a woman will have 4.4 children (Multiple Indicator Cluster Surveys, MICS 2015) and the adolescent fertility rate is among the highest in Africa: at the national level, there are 147 births per 1,000 women between 15-19 years of age. It is much lower in the urban centers of Brazzaville (74 births per 1,000 women) and Pointe-Noire (88 births per 1,000 women) than in rural areas. In Bouenza, Cuvette-Ouest, and Plateaux, more than 7.5 percent of young women ages 15- to 19-year-old gave birth to their first child before turning 15 years old. One consequence of the slow decline in fertility is that the population of Congo is very young, with about two people out of five now below 15 years of age.

The country subsequently began an epidemiological transition with some communicable diseases being vanquished or controlled and a decrease in deaths still caused by communicable diseases, maternal, prenatal, and nutrition conditions from 59 percent in 2008 to 45 percent in 2018[3]. However, on average, Congo's overall health performance in terms of mortality and disability still ranks below that of lower middle-income countries for communicable diseases such as HIV and AIDS, tuberculosis, malaria, as well as noncommunicable diseases including diabetes, and road traffic injuries. Malaria places an enormous burden on the Congolese healthcare system and remains the leading cause of consultations (54 percent), hospitalization (40 percent), and mortality (42 percent). The maternal mortality ratio increased from 378 per 100, 000 live births in 2017 to 445 per 100, 000 live births in 2021[4]. In 2017, this rate was already higher than the average for LMICs estimated at 253. Under-five mortality is also high at 43 per 1000 live-births (2021), compared to the Sustainable Development Goals (SDG) target of 25 per 1000 live births, but has declined from 68 per 1000 in 2011 (Demographic and Health Survey, DHS 2012). Infant mortality at 32 per 1000 live births (2021) is equally on a slightly downward trajectory from 41 per 1000 live births in 2012. Similarly, life expectancy at birth, estimated at 64 years in 2020, is 5 years below the average for countries in this income group for the same year (69) (Figure 1). This epidemiological transition will require greater fiscal capacity to tackle non-communicable diseases.

[1] https://hdr.undp.org/system/files/documents/global-report-document/hdr2021-22overviewenpdf.pdf
[2] Based on the 1.90 $ a day poverty line
[3] Institute for Health Metrics - Global Burden of Disease. https://vizhub.healthdata.org/gbd-compare/
[4] 2021 WHO (national estimate)

Figure 1: Comparative trends of life expectancy at birth (years) and maternal mortality rates (per 100,000 live births) in Congo with regional and income group averages (1990-2020 & 2000-2017)





Source: WDI

In a context of unequal access to healthcare services, one of the greatest challenges that Congo will have to tackle is how to successfully undergo the third transition in health[5]: financing universal health coverage (The Lancet, 2012). The policy choices that the Government of Congo has made in its commitment to sustainable development require the allocation of a significant amount of resources to the health system. Sustainable financing for better population and service coverage and quality is therefore a concern, particularly since financial investments in health have not so far translated into commensurate improvements in the population's health status. Further, demographic projections indicate that the country's population will grow at an accelerated rate with financial needs expanding. To sustain the level of health supply and establish an environment that is conducive to promoting health and development, additional resources must be mobilized. These resources will help the country to meet the strategic objectives under the national development plan, including improving health and financial coverage, and reducing inequalities.

As a lower middle-income country, Congo must prepare itself to bear the responsibility of financing the largest share of its transition to UHC. This options paper provides the evidence and guidance on policy choices Congo can make. It was prepared as an umbrella policy note consolidating the findings of a series of exploratory studies and a health financing situational analysis, conducted between 2019 and 2022. The studies focused on the efficiency, fiscal space, equity, and political economy of health financing, and were undertaken to provide an initial assessment of the state of financing in the Republic of Congo, as well as future challenges the country may face. The results allowed for the identification of a range of strategies that may improve the country's potential to cover the growing health needs.

[5] The global Universal Health Coverage movement follows two other great transitions in health. The first was the demographic transition that brough public health improvements, including basic sewerage and sanitation, which helped to reduce premature deaths; and the second was the epidemiological transition as disease burdens progress from predominantly communicable to non-communicable even in low and middle-income countries.

This Options Paper and three supporting policy notes[6] will form the basis of the Government's new National Health Sector Financing Strategy. As the country embarks upon a broad governance and service delivery reform agenda, there is a renewed commitment to achieve sustainable health system financing. A key priority for this will be to mobilize additional domestic resources for the sector and improve the quality of public health expenditures by using available resources more efficiently and effectively. Some consideration is also give to establishing an effective universal health insurance scheme. In line with the Government's National Development Plan (2018-2022), National Health Policy (2018-2030), and third National Health Development Plan (2018-2022), the importance of reinforcing the national health system is emphasized. The financing of the health sector draws on several functions, namely the generation and mobilization of available resources, pooling of these resources and lastly, their distribution for service delivery purchase. The function that mobilizes the resources needed to cover the health sector's expenditures operates by collecting funds from different sources of income. The Government will need to ensure a compact is established to allow for harmonizing of interventions across health system partners and actors to build a resilient health system.

Limitations: *Challenges around health data scarcity, namely data quantity, quality, and age, are a notable constraint in assessing health financing in the Republic of Congo. The last household consumption survey (ECOM) was carried out in 2005 and data have been extrapolated since then. A Demographic and Health Survey (DHS) to update the one undertaken in 2012 has been planned but not yet conducted. Similarly, the most recent Multiple Indicator Cluster Survey (MICS) was conducted in 2015 and therefore outdated making it difficult to provide accurate analyses based on recent data.*

2. Health System Performance

A perfect storm of fragility, weak governance and institutions, underfunding and neglect have left Congo's health system unable to adequately perform its functions. Despite its lower middle-income status, health system inputs do not lead to achieving health system outcomes, or goals as the country still has numerous challenges characteristic of low-income countries. These will need to be overcome to improve the state of the population's health.

Access to essential reproductive maternal and child health services for instance, is often inadequate and does not necessarily translate into good outcomes due to the poor quality of care. Only 77 percent of infants (aged 12-23 months) had received three doses of the pentavalent vaccine that protects against five major diseases: diphtheria, tetanus, pertussis (whooping cough), hepatitis B and Haemophilus influenzae type b (Gavi, the Vaccine Alliance, 2021). With more than half of Congo's population living in its two largest cities of Brazzaville and Pointe-Noire, potential for maternal and child health service coverage is high. However, Brazzaville is the region with the highest prevalence of children who failed to receive any routine vaccination (zero-dosed children). In addition, data on facility deliveries is limited and incomplete. The 2015 MICS suggests 92 percent of deliveries occurred at health facilities, 94 percent of births were attended by skilled birth attendants, and 79 percent of pregnant women attended four or more antenatal care visits (MICS 2015), while the high maternal mortality rate points to a need for more granular data to understand the extent of referral and quality-of-care challenges. This further alludes to hesitancy in the use of the public health system as access is deferred, with 89 percent of maternal deaths linked to the third delay – occurring upon arrival at the health facility (delays in receiving care).[7] Maternal death audit reports also reveal that many deaths could be prevented if the quality, organization, and provision of care services were optimized, with access to critical essential medicines and medical supplies for women guaranteed.

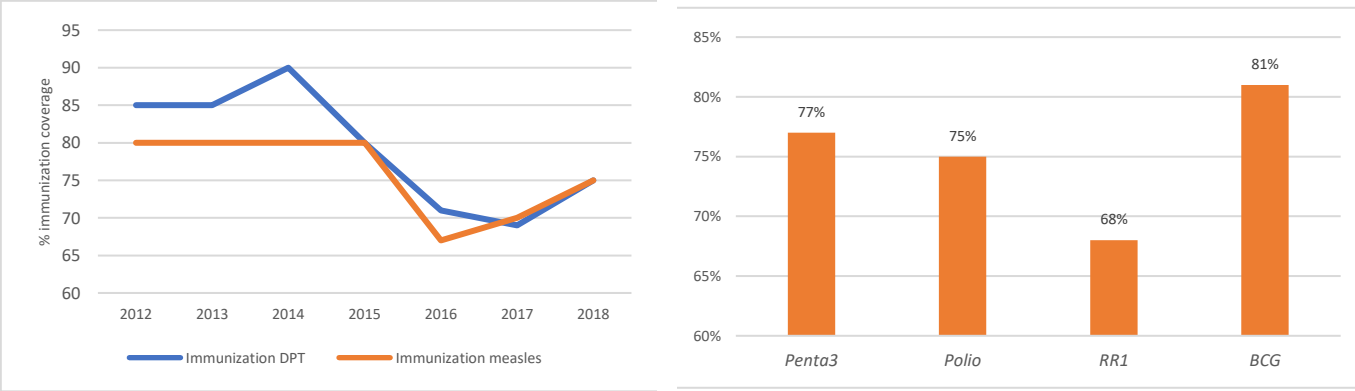
[6] (i)Budget Execution rate in the Health Sector: Status, challenges and opportunities for improvement; (ii) Health Financing Policy Note: Public Financial Management (PFM) in the Health Sector; (iii) Technical Guidance Note: Human Resources for Health: Status and Challenges),

[7] Maternal Health surveillance report, 2018

Coverage of basic services such as immunization is also impacted by frequent stock-outs of routine vaccines and essential medicines. A 2023 study on vaccine equity showed that immunization services were offered in only 49 percent of health facilities largely due to shortages of key antigens, with Ndayambaje already highlighting in 2016 that 1 out of 5 (21 percent) of facilities providing these such services belonged to the private sector. Immunization coverage therefore remains well below the country's national target of 90 percent (Gavi, the Vaccine Alliance, 2023). This has led to the rise of vaccine preventable diseases among 0-15 year old children; namely polio, yellow fever, diphtheria, tetanus and measles. The graph below shows core vaccines coverage for children aged 0-15 was below the 90 percent national target in 2021 (Figure 2). Shortages of essential medicines often occur at Government facilities and while medicines are more readily accessible in the private sector, margins applied to wholesale and retail medicines are high, between 12-41 percent and between 15-58 percent, respectively. The average price paid by patients for generic drugs was four times higher than the international reference price (WHO, 2014).

Service delivery coverage is poor in some areas as not all health centers are able to offer the full Minimum Package of Activities (MPA), which includes immunization services. The latter remains below pre-crisis (pre-2015) levels due to frequent stock-outs of routine vaccines. A 2016 study by Ndayambaje already showed that immunization services were offered in 89 percent of health facilities, among which 1 out of 5 (21 percent) belonged to the private sector. Only 1 in 20 (5 percent) of children are vaccinated during outreach and mobile clinic activities, which is particularly low. A review of service delivery gaps highlighted a low level of implementation of the Expanded Program on Immunization (EPI) activities, with 40 percent of the planned outreach activities and 84 percent of mobile strategy ones left unimplemented for lack of resources. The present situation has remains mostly unchanged: according to a recent study on vaccine equity, immunization coverage remains below the country's national target of 90 percent (Gavi, 2023). This has led to the rise of vaccine preventable diseases among 0-15 year old children; namely polio, yellow fever, diphtheria, tetanus and measles. The graph below shows core vaccines coverage for children aged 0-15 was below the 90 percent national target in 2021.

Figure 2: Trend in Immunization Coverage, 2012-2018 (left) and Coverage by Antigen, 2021 (right)



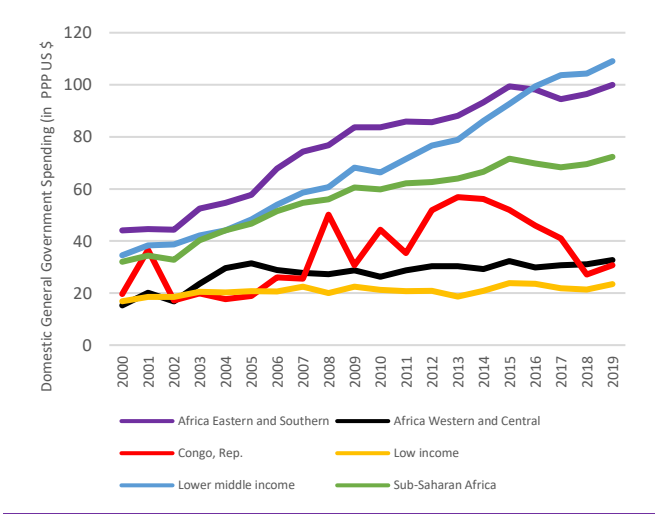
Source: WDI & GAVI

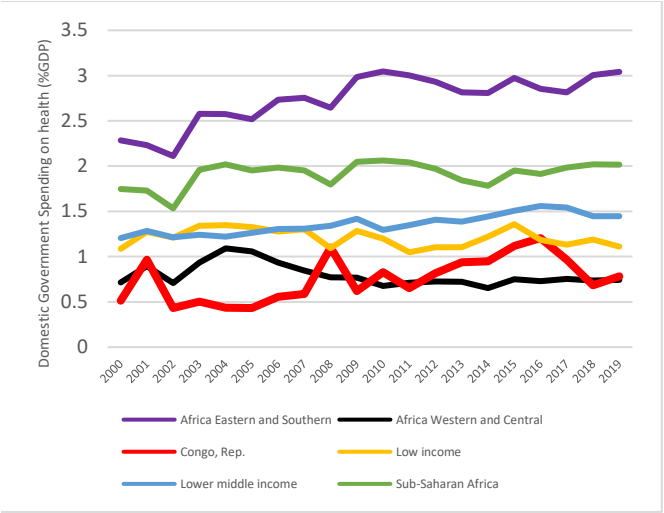
Poor service delivery is compounded by limited access to basic services such as clean water and electricity, and limited environmental health services such as waste management. Some policies seem to have worked: between 2019 and 2020, the reported incidence of malaria decreased by 54 percent and the mortality rate by 28 percent. However, these gains may be due to underreporting and changes in health seeking behavior during the COVID-19 pandemic. Further, any gains remain fragile in the context of an epidemiological profile that is evolving in complexity. In 2019, non-communicable diseases constituted 6 of the 10 leading causes of disability (estimated on the basis of the baseline indicator of years weighted by disability or Years Lived with Disability [YLDs]) (Global Burden of Disease).

3. Sources and Composition of Current Health Expenditure

Domestic Government Health Expenditure (GHE) per capita in Congo is low. On average the Government of Congo spends one-third less on health per capita as compared to its SSA Lower Middle-Income peer countries[8]. Domestic GHE per capita in Congo decreased by half from US$34.3 in 2014 to US$ 25.8 in 2019, whereas SSA has had a more stable spending curve of around US$30 since 2010. Since 2000, GHE spending per capita in Congo has been below the SSA, LMIC and even LIC averages for most years. The average per capita domestic GHE for LMIC stands at US$37.73 per capita or below for the majority of SSA LMICs: Zimbabwe (US$18.17); Tanzania (US$16.49); Senegal (US$14.79); Nigeria (US$11.40), Cameroon (US$1.81) and Benin (US$6.60). Over the past three years, domestic government spending covered under half (on average 37 percent) of the national health system's funding needs. Domestic general government health spending has been below 1.2 percent of GDP since 2000. In 20189, the share of 0.67 percent10 of GDP was less than the SSA average11 of 1.83 percent12, the LMIC13 average (1.28 percent) and even the LIC14 average of 1.16 percent.

Figure 3: Trend in Domestic General Government Spending (in PPP USD and % of GDP)





Source : WDI

Households have borne a large share of the health financing burden for four consecutive years (2016-2019), with an average of 46.5 percent. In 2018, more than half of the health system's expenditures were financed through out-of-pocket payments (45.9 percent in 2019). External funds from development

[8] These are: Angola, Benin, Côte d'Ivoire, Cabo Verde, Cameroon, Republic of Congo, Comoros, Eswatini, Ghana, Kenya, Lesotho, Mauritania, Nigeria, Sao Tomé & Principe, Senegal, Tanzania, Zambia, Zimbabwe.

[9] 2018 represents the year of the latest official release of the country's National Health Accounts, the 2019-2021 still awaiting validation

[10] Recent estimates from 2020 (WHO GHED) suggest that domestic government spending on health as a share of GDP more than doubled between 2018 and 2019 from 0.78% to 1.9%.

[11] It is to be noted that the WHO SSA classification is different from the World Bank mainly for Algeria (in SSA according to the WHO), Somalia and Sudan (not in SSA according to the WHO). We used the 2018 World Bank Classification for income groups.

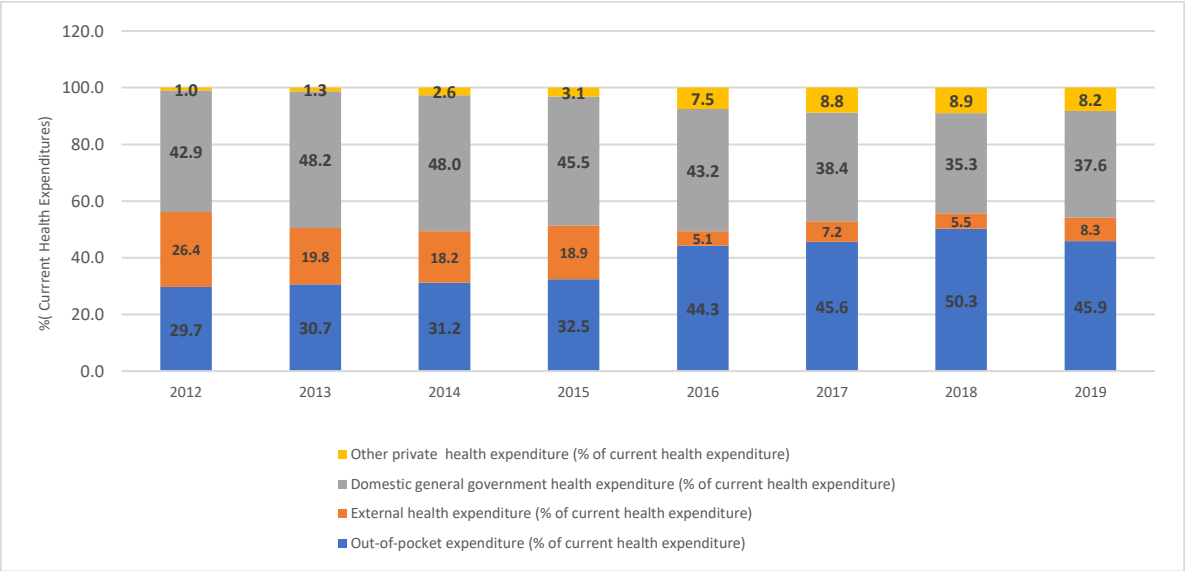
[12] This is the ratio between the population weighted average of the SSA domestic general government health expenditures and the weighted SSA average of the GDP per capita in constant 2018 US$ reported in the 2018 WHO GEHD. This computational approach is also valid for LMIC and LIC averages and the one used by the WDI team to compute regional and income group averages.

[13] As defined by the WHO in 2018

[14] As defined by the WHO in 2018

partners, at 8.3 percent of CHE in 2019, are the health system's third source of financing and have been shrinking since 2014 from US$11.6 per capita in 2014 to only US$4 per capita in 2018. Mutual funds mobilized through private businesses represent a very small contribution to health financing, with an average of 5.2 percent since 2012, with the lowest share of 1 percent recorded in 2012.

Figure 4: Trends of the distribution of health financing by sources, 2012-2019



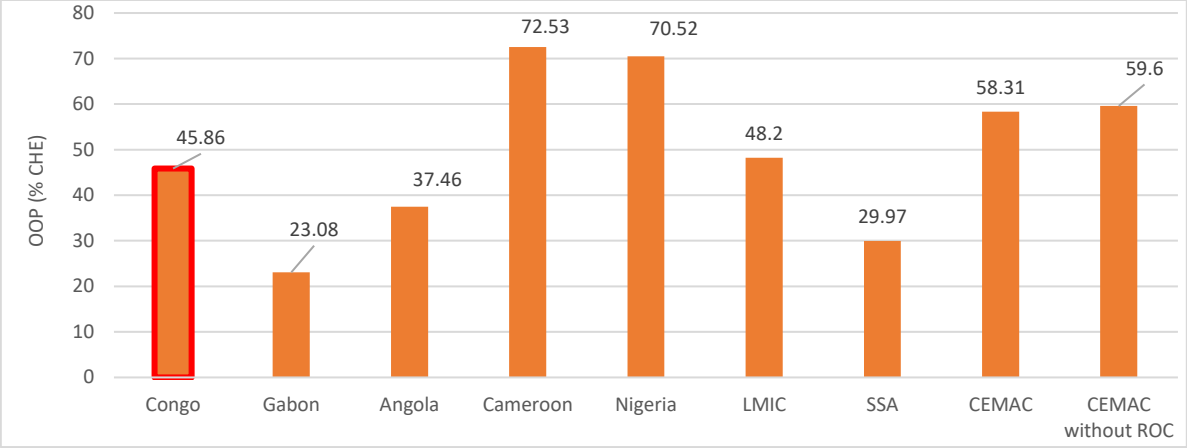
The share of household OOP expenditure against total CHE remains well above the 20 percent threshold and above regional (mainly SSA) averages. This is despite a recent drop from 50.5 percent in 2018 to 29.1 percent[15,16] in 2020. Evidence suggests that households tend to face greater catastrophic expenditures when OOPs is above 15 percent of total current health expenditure[17]. Households are increasingly bearing the burden of medicines and health treatments through higher medical bills, a consequence of inadequate and insufficient domestic government health spending. OOPS per capita has remained relatively stagnant around US$ 20-25 with an average of US$23.63 per capita (in current US$) since 2010 but significantly increased as a percentage of total current health expenditure from 29.73 percent in 2012 to almost 52.3 percent in 2018; roughly 19 percentage points higher than the SSA average in 2018 (33.3 percent). Such an increase sheds light on the robustness of financial safety nets at the household level. The reliance on user-fees for health facility income, the non-application of free healthcare policies (applicable to malaria, cesarean section, HIV AIDS) and non-operationalization of the health insurance scheme are some of the core drivers of high OOPs for households. The dependence on this method of financing is inequitable and inefficient.

Figure 5: OOP % CHE across country comparators and regions

[15] Provisional figure from the latest 2019-2021 NHA of Congo

[16] As these data are extrapolated from cross-sectional data for the single year 2011, from the latest household survey ECOM 2011, it is suggested that this may actually be largely underestimated (Thana Tchana F., 2015).

[17] WHO/Diane McIntyre and Joseph Kutzin (2016). *Health financing country diagnostic: a foundation for national strategy development*, Chapter 7, p.32-6, Health financing guidance N°1, WHO.



Source: 2021 WHO Global health Expenditures Database

Reliance on household contributions as the second main source of revenue poses equity challenges. The poor are particularly impacted by the national health system's failure to guarantee universal, affordable, and quality access to health services. In the absence of more recent household budget survey data, data from a 2011 survey (ECOM 2011) highlight that at 4.6 percent, Congo records the third highest rate of catastrophic expenditures in SSA after Benin (10.9 percent) and Niger (6.6 percent) (at the 10 percent threshold18). This is despite the drop in the incidence from 12.6 percent in 2005. The 2016-2018 National Health Accounts (NHA) suggest that the bulk (50.3 percent) of household current health expenditures (OOP) was directed not only to private retailers and other providers of medical goods, but also to public hospitals as direct payments on a fee-for-service basis (32 percent). Using the same data from 2011, the incidence of health expenditures showed that 1 in 5 households was likely to incur catastrophic expenditures. Maintaining an equivalent incidence rate throughout the 2018-2022 period, the lack of financial protection for health would have entailed that an annual average of approximately 221,607 people would have to incur catastrophic health expenditure. In addition, the risk of catastrophic health expenditure is twice as high among the poorest, with an incidence of 26 percent against 14 percent among the wealthiest population. The average OOP expenditure borne by a household amount to approximately XAF 33,000. The median is estimated at XAF 130,000, pointing to social inequalities.

Public expenditure has proven largely insufficient to cover emerging needs, which hinders the likelihood of achieving UHC. Overall, the funding gap associated with the 2018-2022 five-year health development plan was nearly 34.8 percent of the total funding requirement, *i.e.* an overall shortfall of approximately XAF 381 billion (US$600 million equivalent). The biggest gap is estimated at 69 percent and pertains to the funding required to achieve equitable access to essential and quality service packages – which are aspects that are inherent to UHC.

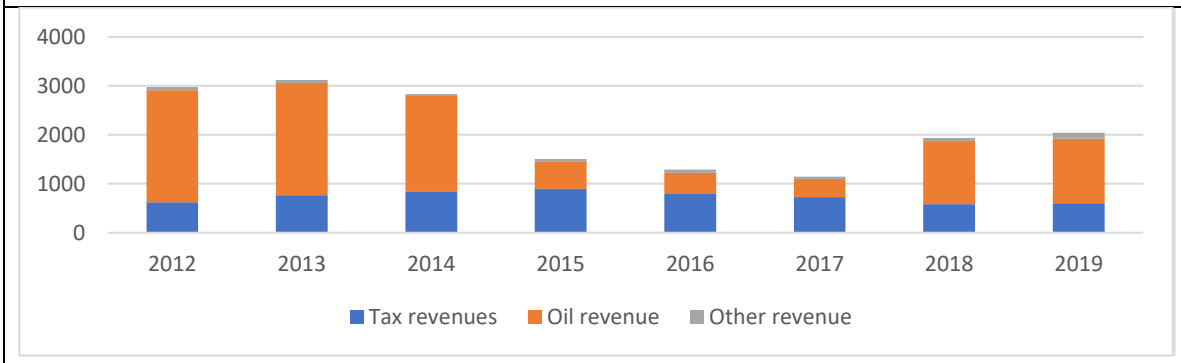
2 Health Financing Policy Options

Overall, the capacity for Congo to mobilize significant domestic resources for health is low, due to an overreliance on a volatile oil sector, inefficient tax revenue collection, and limited alternative options. The total government revenue for 2020 was 30 percent of GDP of which over 60 percent was from the oil sector and the rest from non-oil revenue collection. The amount of oil revenues declined significantly in 2015-2017 but has since slightly recovered. Tax revenues, which improved during the crisis period, remain low at

[18] whose amount would absorb more than 10 percent of the annual household income

only 8.9 percent of GDP in 2020 compared to SSA peers average of 16 percent, the African Union convergence criterion of 20 percent of GDP[19], and the IMF estimated "take-off" rate of 15 percent of GDP (see Figure 6). RoC also lags behind SSA and low- and middle-income countries on tax collection as a percentage of GDP.

Figure 6: Revenue composition in ROC, 2012-2019 (million CFA)



Congo's potential avenues for generating additional resources for the health sector are explored in more detail against five standard options presented below. These mechanisms for creating fiscal space and mobilizing resources include: (i) generating additional resources based on economic growth through favorable conditions in the national economy; (ii) use of specific domestic resources from taxation; (iii) prioritization of health in public budget expenditures; (iv) improving the efficiency of spending (enhanced public financial management, technical and allocative efficiency, and human resources); and (v) use of external resources from development partners. This range of options and strategic directions were explored, with some scenarios providing fewer levers and others being more promising.

2.1 Domestic Resources

2.1.1 Option 1: Economic Growth

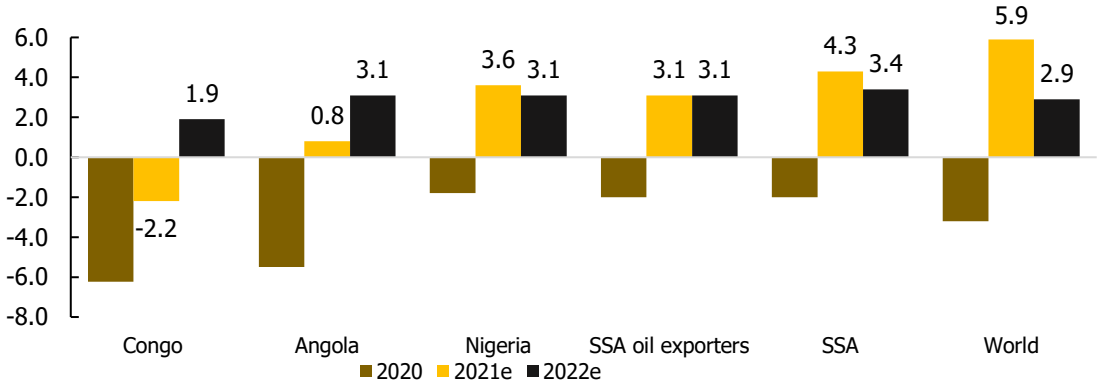
Congo is the third–largest crude oil producer in Sub–Saharan Africa after Nigeria and Angola and is heavily dependent on oil production and oil exports. Congo is endowed with abundant natural resources, however the economy is heavily dependent on oil production, which accounted for 45 percent of GDP, 75 percent of government revenue, and 95 percent of exports of goods during the height of oil prices (2010-14). Besides crude oil, Congo is has a wealth of mineral resources, including reserves of potash, phosphate, iron, and copper, which remain largely untapped. Much of the country is covered with tropical forests of softwoods and hardwoods (over 65 percent of the country's total surface area), a fragile ecosystem that removes carbon from the atmosphere and stores it, thus helping to slow global warming (World Bank, 2022).

While Congo's economy has yet to recover from the economic fallout of the COVID-19 pandemic, economic activity improved in 2022. Following a sharp economic contraction in 2020 due to the pandemic, output in many countries rebounded in 2021, however Congo's economy is estimated to have contracted further in 2021 (Figure 7). In 2021, growth was held back by reduced oil production while the non-oil sector recorded its first year of positive growth since 2014. Congo's economy is expected to rebound in the near future, with GDP growth projected at 1.9 percent in 2022 and an average of 4.1 percent in 2023-24. This growth

[19] https://au.int/sites/default/files/newsevents/workingdocuments/38223-wd-comments_on_the_macroeconomic_convergence_criteria_for_aacb_eng.docx

is driven primarily by the resumption of investments by oil companies and the continued clearance of government arrears to domestic firms.

Figure 7: GDP growth in Congo and selected peer countries, 2019-2021



Source: Congo Economic Update #9, World Bank, 2023

Macroeconomic prospects in Congo are improving, however, this is unlikely to generate substantial resources for health as the debt crisis looms. The Government is facing budget deficits accumulated from a period of economic contraction and Congo's public debt is classified as in distress, although debt is now assessed as sustainable. Higher oil prices, improved debt management, and debt restructuring agreements with two of Congo's three largest oil traders, helped restore debt sustainability in 2021. Furthermore, public debt fell sharply from 113.2 percent of GDP in 2020 to 102.2 percent of GDP in 2021 driven by high external debt amortization payments tied to oil prices and the increase in nominal GDP. With real GDP per capita falling by an estimated 2.2 percent in 2021, the poverty rate is estimated to have further increased, reaching 52.0 percent in 2021. It is estimated that the poverty rate will decline slightly to an average of 51.7 percent over the 2022–2024.

2.1.2 Option 2: Tax Revenue Expansion

In the Republic of Congo, optimizing the taxation system could be an effective means of mobilizing additional domestic funds. Tax revenue remains below 10 percent of GDP for 2021, which is one of the lowest rates across SSA. This modest performance is driven by a low tax base and limited taxpayer compliance on the side of the taxpayers and low tax effort by the government. Tax effort, measured as the ratio of tax collected to GDP, was 9.9 percent in 2020 compared to the SSA average of 16 percent. Congo ranks 185th out of 189 countries in 2017 in terms of overall taxation. The country therefore substantial leeway and could substantially expand its fiscal space through the taxation channel. At equal tax burden, improving this outlook would facilitate the mobilization of new resources for the health and social sectors.

A decade ago, the country chose to embark on an ambitious reform of its tax system, with the special aim of reinforcing its competitiveness. Whereas the option is complex, and any revision of taxation must abide by the criteria of relevance, efficiency, and equity, several scenarios are under consideration. The respective revenue generation potential of each scenario identified through simulation exercises intended to open the debate and guide any decisions relating to modifying tax collection, monitoring, and management systems or ultimately revising the tax burden and broadening the tax base. Potential scenarios tested include an estimation of the revenue amounts that can be mobilized from the revision of certain exemptions, the reinforcement of targeted taxation (especially on products with negative externalities on health), or simply the

effective payment of certain existing taxes. When deciding to revise the tax system, it is important to carefully assess the efficiency of new tax practices to guard against distortions and unfair or inefficient taxes.

Specific forms of taxation may additionally be appropriate, accompanied by revisions to areas that are currently under-taxed or exempt from tax. In this area, the taxes on goods and services are an asset for supplying revenue to priority spending sectors, including health. Out of the seven special accounts that "legally existed" in 2017, one was dedicated to the health insurance scheme, with a forecast budget for health matters estimated at XAF 4 billion. The contributions that can be mobilized from the revenue from domestic taxation on beverages and tobacco, and on electricity pylons would allow for supporting the health insurance scheme and purchase of generic drugs in the form of earmarked funds. In addition, regarding certain taxes levied in the country's main lines of business such as the oil industry or forest economy, reallocating part of the revenue to health or better implementing the taxation in force would provide further opportunities for generating additional resources, without the need to levy new taxes.

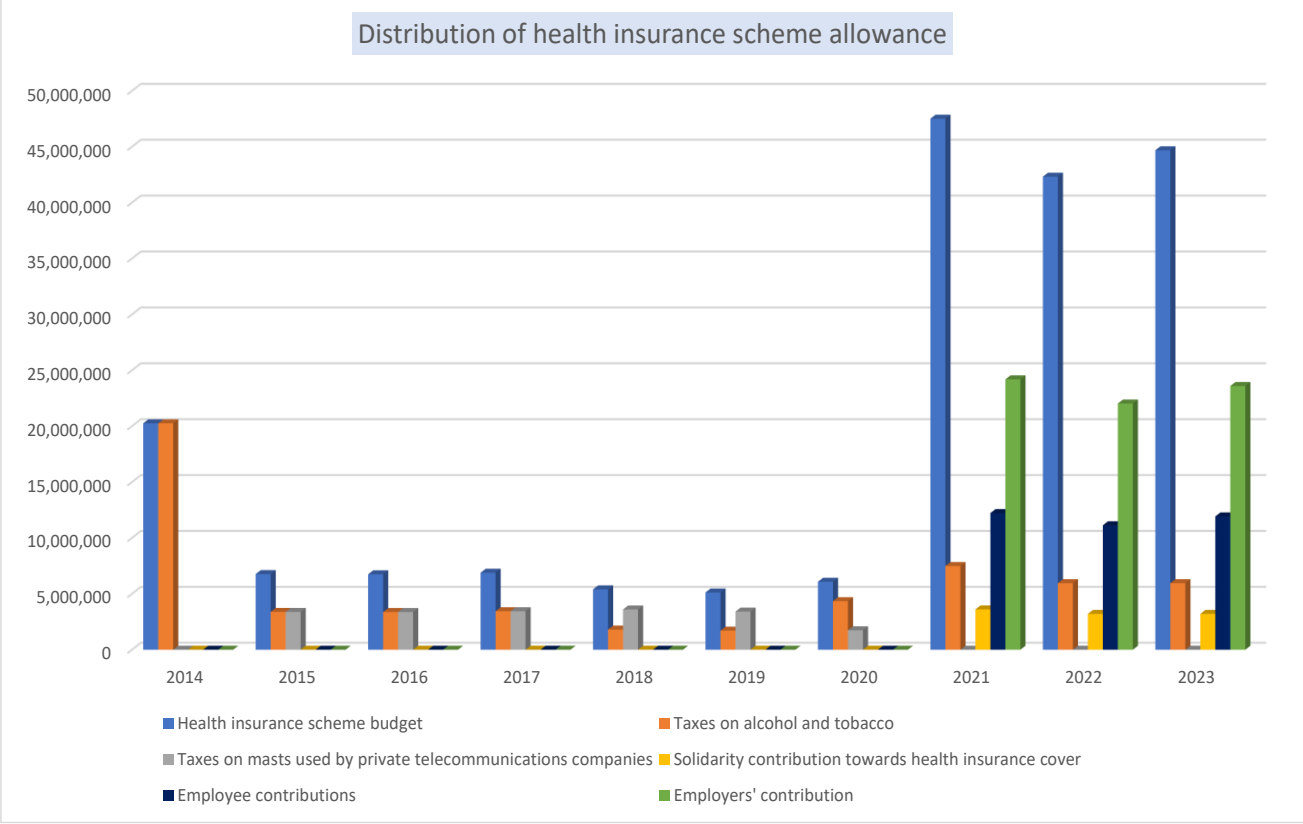
There seems to be little room for increasing domestic value-added tax (VAT) as this item already represents a substantial relative share both of indirect tax on consumption (i.e. 52.4 percent in 2016) and of total tax revenue (i.e. 54.5 percent in 2016). The windfall could come from an increase in the tax burden on imports, which account for 6.8 percent of revenue for the category of indirect tax on consumption. Excise duties account proportionally for a negligible share, at 1.1 percent of the total for this tax category. However, specific taxation on products with negative externalities for health is a more than interesting channel for the health sector. A hypothetical increase in revenue of 1 percent in these two items could be mobilize an estimated additional XAF 1 billion based on figures communicated for 2016. Several scenarios could thus be explored in order, on the one hand, to specify the extent of the needs to be covered by each of these additional revenue sources and, on the other hand, to assess the impact of a change in the tax burden.

Box 1.

Tax-based funding of the National Health Insurance Scheme (Caisse d'Assurance Maladie Universelle, CAMU)
Literature shows that an increase in the share of total health expenditures channeled through social security funds and other government agencies could significantly lower the incidence of catastrophic health expenditures (Wagstaff et al. 2018). However, medical insurance or social protection programs cover less than 10 percent of Congo's population and were financed through the collection of social charges (social contributions on income). The tax system therefore is an important channel for supporting future health reforms. For the country, there is a vital role that prepayments, resource pooling, and a solid financial protection system can play in mitigating health-related risks if spent equitably.

A targeted health fund was established in 2014 as one of the public Treasury's special accounts. According to the forecasts, during this period, a tax on alcohol and tobacco is collected in varying amounts with a total of more than US$57 million within the 10-year period 2014-2023 (Figure 1). The tax on the pylons used by communications companies has not been earmarked to fund the health insurance scheme in 2014, 2021-2023. On the other hand, the employee and employer contributions and the solidarity contributions for the health insurance fund only fed the health insurance scheme during the last three years of the period. The amounts vary from year to year, regardless of the wording of the resource line, and the largest allocation is for 2021, at US$47.5 million, also the largest contribution in the series is made by employers up to US$24 million for the same year with the total of US$69 million between 2021 and 2023. The total amount allocated to health insurance scheme since 2014 is more than US$191 million.

Figure 1: Distribution of health insurance scheme financing, 2014-2023



Source : National budget (2014-2023); Amending budgets 2014, 2016, 2017, 2021, 2022

2.1.3 Option 3: Prioritizing Health in the Government Budget

With a commitment estimated at about 14 percent of the overall Government budget, defense is currently allocated a budget share higher than that of health and much higher than that of social protection. Health - through public financing to the Ministry of Health at 13.1 percent - comes in third position behind the sub-sectors of basic, higher and vocational education (21.5 percent) and national defense (14.4 percent). The Ministries in charge of social affairs and social security was allocated respectively 2.3 percent and 1.9 percent of the total for the projected period, on average.

Government could choose to allocate an additional percent of GDP to priority expenditures such as expanded coverage of essential health services. In 2018[20], the share of domestic general government health spending was 0.78 percent[21]. In theory and according to 2022 forecasts, allocating an additional percent of GDP to health could bring gains of nearly XAF 16 billion for the sector. Prospects for generating substantial resources for health over the years to come are estimated to be extremely limited given that the economy is strongly influenced by oil market's fluctuations and impacted by the lack of economic diversification. Although the economy is experiencing a modest upturn, the situation remains precarious and prospects of increasing public spending remain negligible. Congo could develop its capacity to take advance actions to effectively mitigate the effects of unfavorable macroeconomic environment by making strategic investments in good times. It would also need to seek solid alternatives to address the underfunding of the health sector. As such, although several efforts were provided to prevent budgets from decreasing during the post-crisis period, the trend noted shows that the country is relatively unable to sustainably convert public revenue (oil windfall) into fiscal space for enhancing the population's health.

The health budget[22] follows the seesaw curve of the national budget. The level of commitment is inconsistent and sometimes procyclical as the years of budgetary effort are followed by years of nearly equal budgetary decline. The trends noted over the 2011-2021 period considered may not allow for establishing that a constant investment effort has been made into the sector. In FYs 2012-15, the national budget doubled from USD 3.5 billion to USD 6-7 billion. A windfall in oil revenues and growing expectations from citizens converged to freeing up resources in health, promises mainly included the *2012 initiative* that declared 2012 the Year of Health, the presidential commitment *Le chemin d'avenir 2009-16* (Walk into the future) that included the construction of 12 HGs and more rural dispensaries and the free health care(*gratuité*) policies). Disaster relief after the unexpected 2012 Brazzaville arms dump blast required also exceptional resources augmenting the budget. During that same period, the health budget reached a peak of USD500-600 million (FYs 2014-15) - an increase from 6 to 10% of the national budget.

Despite fiscal capacity and periods of high domestic revenues, RoC has not reached the 15 percent Abuja target. The average share of the national budget is estimated at 9 percent over the 2011-2021 10-year period. FYs 2020-21 seem to approach that target but this is mainly because of exceptional spending to respond to the COVID-19 pandemic and less ambitious national budget sizes estimated at USD 2.7 billion against an average budget of USD 4 billion (2011-21). In 2014, the country massively invested in the health sector following the presidential initiative to build 12 general hospitals (1 hospital per department). Investments in the health sector were therefore largely allocated to construction and, to a lesser extent, to the improvement

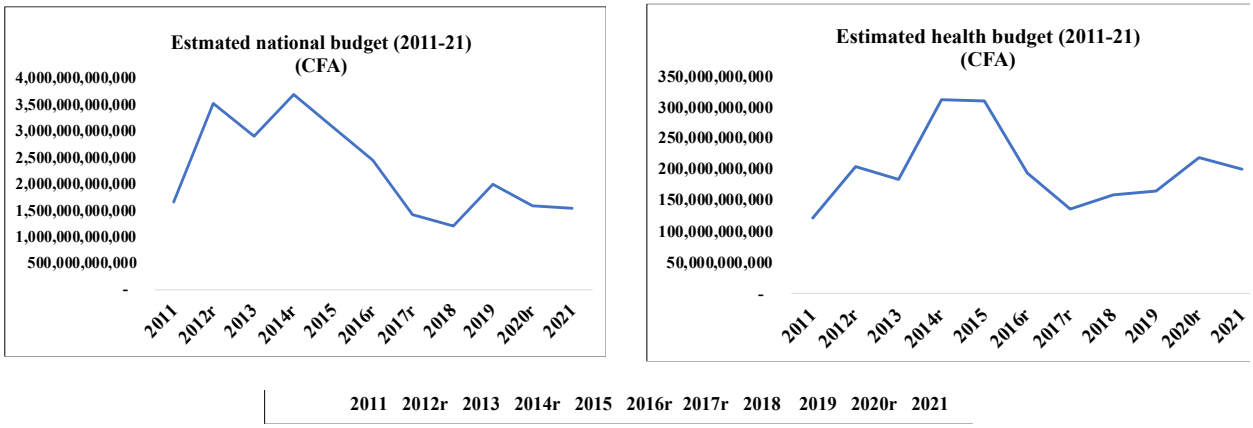
[20] 2018 represents the year of the latest official release of the country's National Health Accounts, the 2019-2021 still awaiting validation

[21] Recent estimates from 2020 (WHO GHED) suggest that domestic government spending on health as a share of GDP more than doubled between 2018 and 2019 from 0.78% to 1.9%.

[22] National and health budget data differ from one source to another. Inconsistencies remain largely unexplained because of unreferenced data or the way totals are calculated. This makes a technical reading of budget sizes a challenging exercise and affects the quality of multi-year comparisons and percentage calculations. In the 2021 PER, We applied a uniform and straight-forward approach. National budget sizes were calculated as (assumed) contributions to national development. Hence, The size of the domestic health budget (2011-2021) has been aggregated from various sources: The Loi de finances (Finance Act), budget-related (but fragmented) documents (period 2011-20) collected in dribs and drabs from the MSP (DEP, IGS) and the Treasury (*crédits définitifs*) plus the NHAs provided complementary data and insight

of the country's existing health infrastructure, or the provision of services[23]. The 10.2 percent share of health in the national budget for that period should therefore be put into perspective.

Figure 8: Trends in the health and National Budget and share of health in the national budget



Source: 2021 PER using *Loi des Finances* & MoH data

Even without additional allocations, under this Option, a significant achievement would be for the Government to materialize its commitment to maintain the health sector's share in the overall State budget at 13 percent. Although this political ambition appears promising, it's implementation must be tracked annually to ensure public spending allocated to the health sector is reflected in the national budget. There are two limiting factors that call for attention in this regard. First, even if the level of prioritization of health is maintained, the size of the budget allocated to the sector is directly determined by the economic situation. Secondly, real public expenditure on health has been on a marked and continuous downward trend since 2014.

2.1.4 Option 4: Improve the Efficiency of Public Health Spending (Public Financial Management, Technical & Allocative Efficiency)

The efficiency of government spending, as measured by the percentage of budget receipts that go into actual service provision, is low especially for the ministries charged with improving human capital. Only 27 percent of the entire government budget is allocated to the education, health and social protection sectors. For the ministry of health, 72.2 percent of its budget goes to service provision while only 22.8 percent of the allocation to the ministry of primary education goes to service provision. This legacy of underinvestment in human and physical capital can be reversed through more effective spending in service provision in addition to allocation of more resources to the critical sectors of education and health.

Improving the efficiency of the public health spending has become much needed in the context of resource scarcity. Identifying and eliminating inefficiencies observed in resource allocation and distribution, and in public finance management would provide the sector with a significant lever and is an important strategic option for the country. Currently, despite some progress, providing quality care and services to the population is a constant challenge. The performance of Congo's health system ranks lower than that of other countries in its income group. These underperformances observed at the national level translate into unsatisfactory social outcomes in terms of life expectancy, maternal mortality, and infant mortality. More

[23] In FYs 2014-15 (FY 2014 is the kick-off for the HG construction works) investment surges to a high 70% of the total health budget raising fundamental questions however about relevance

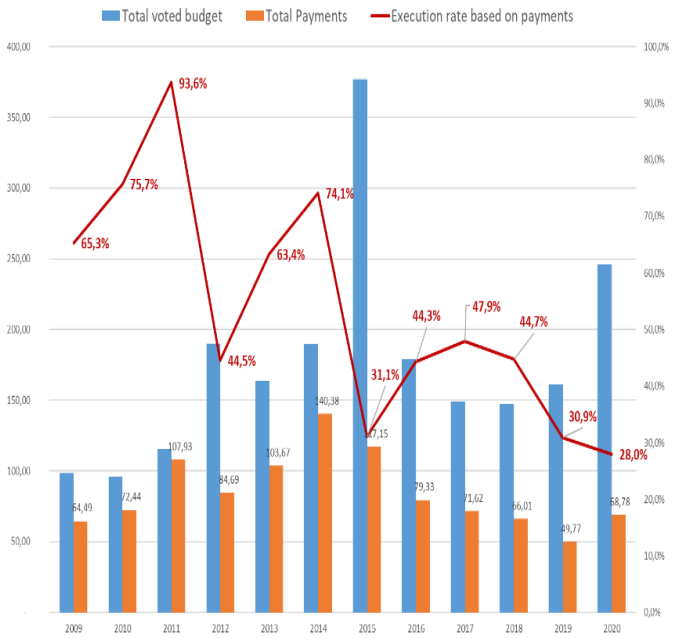
generally, the country's low health coverage rate, estimated at 38 percent (WHO global report on UHC, 2020), ranks below regional scores and far behind the performance of regional peers such as Equatorial Guinea (45 percent), Gabon (52 percent) or aspirational peers such as Morocco (65 percent). Unsatisfactory outcomes on the spectrum of sustainable development goals underscore the need to put in place measures to optimize efficiency in public health expenditure. A funding performance improvement strategy would greatly benefit the health sector.

Public Financial Management (PFM):

Understanding approaches to enhance the effectiveness of public financial management, streamlining and adapting the budgetary process to operational realities, and strengthening transparency are key to enhancing efficiency. The general level of governance negatively impacts on the health sector. Despite previous efforts made in PFM reforms, progress on expenditure management has lagged behind as some fundamentals of annual budget preparation are not yet in place. This has led to gaps between budgets and spending due to poor revenue forecasts and the absence of control of commitments. A remaining key concern is budget credibility, driven by unreliable revenue forecasts and politically motivated allocations, and the resulting volatility in budget execution.

Despite recent efforts from the government to devote more resources to the health sector, the budget execution rate remains low. Between 2009 and 2014, budget execution rates in the health sector were generally above 60%, reaching 93.6% in 2011, but started falling below 50% post 2015, collapsing to as low as 28% in 2020. The main cause of this situation, which is not solely controlled by the Ministry of Finance, is the country's heavy dependence on oil resources. This situation is compounded by budget forecasts which are not adapted to the country's genuine financial capacities. Finally, the country's budgetary governance and the resulting crowding-out effects are additional drivers of the low budget execution rates in the health sector. However, budget execution rates tend to vary substantially by category of expenditures. For instance, budget execution rates for salaries are generally almost 100% whereas the level of budget execution rates for other categories of health expenditures excluding salaries was only 65.7% based on commitments, 61.3% based on authorizations, and 16% based on payments/disbursements for 2020. These figures highlight a major cause of the low budget execution rate in Congo: liquidity challenges mean Treasury is unable to pay all commitments and when funds are available there are often delays in processing payments.

Figure 2: Ratio MoH budget/National budget



The characteristic poor predictability of financing and challenges around the budget cycle that lead to low execution are on the one hand the result of the lack of dialogue and management within and between the Ministry of Health and other responsible Ministries. There is also the lack of coordination and respect of some norms and standards associated with the Ministry of Health and finance ministries. These include weak budgetary and financial management capacities of departments within the Ministry of Health; the absence of budget management tools, mainly procedural manuals; the lack of communication between departments within the MoH and the prospective and studies division of the same ministry ; the lack of management dialogue between the Ministry of Health and the administrations of the Ministry of Finance (Treasury) and the Ministry of Planning.

Further avenues to explore include setting up mechanisms for monitoring general and specific health expenditures, developing good governance practices, and regular internal and independent auditing. Reinforcing the sectoral authorities' responsibility for health and social and financial protection matters is another potential important avenue. Also, a form of budgetary process upgrading and administrative decentralization to the entities having jurisdiction on health would allow for reducing the complexity of financial flows and optimizing disbursements at destination. Securing the funds allocated to the health priorities defined in the sector's strategic development plan has already been mentioned earlier. To meet the health sector's new financing needs and bridge the particularly large financing gap on certain lines of intervention, it would be good for the country to initiate an in-depth reflection and operationalize mechanisms for securing available resources.

Technical and Allocative Efficiency:

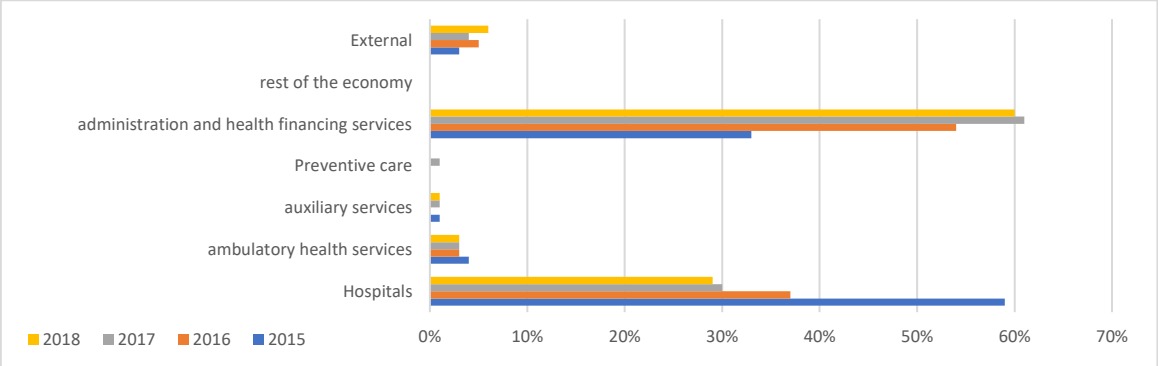
The findings of a recent study indicate that African countries would benefit from an average efficiency improvement margin estimated at 25 percent. In 2018, an international comparative study ranked countries of the Africa region among the least efficient countries in terms of public spending on health (Herrera Aguilera and Ouedraogo, 2018). The calculations, based on a non-parametric approach applied to the health sector, identified a non-negligible efficiency gain and therefore a considerable growth potential, at an unchanged level of expenditures. On average, African countries would gain from improving their efficiency by a margin estimated at 25 percent. If we look at the global average, the potential gain amounts to 10 percent. This

evidence suggests that Congo could derive a comparatively very attractive increase in fiscal space via this mechanism (compared to the four other fiscal expansion mechanisms available to the country's authorities). Indeed, at an equivalent level of input, the health sector would only realize three quarters of its health benefit potential, compared to the most efficient health systems of the world. The latter is a finding made by the European Commission during a past field mission (reports produced after the end of the Commission's interventions).

Congo was part of another study by Novignon and Nonvignon (2015) focused on 45 countries in SSA which showed that in 2011, it could make savings on health expenditures per capita amounting up to 0.10 percent and 0.08 percent of GDP per capita for the single and multiple input specifications (*i.e.* under the assumptions considered), respectively. The Stochastic Frontier Analysis model (SFA) indicates a higher average, with a potential saving equivalent to approximately 0.75 percent of GDP per capita on health expenditure. More specifically, depending on the evaluation technique used, Congo recorded a potential saving on health expenditure ranging from 0.04 percent (Data envelopment analysis methods) to 0.34 percent (SFA method) of GDP per capita, respectively. The results of the regression analysis demonstrated a generally significant relationship between health expenditure efficiency, health expenditures, and health outcomes. The relationship between the efficiency variable and the health expenditure variable was stronger. This suggests that improving efficiency might have a greater impact on health outcomes than a simple increase in health expenditures. These results support the argument that the actions undertaken by governments should go beyond increasing healthcare expenditures to ensuring the effective use of resources. Resources being scarce, reducing their waste is imperative, and a demonstrated necessity for the Congo's health sector. Knowledge provided by the literature on this area provides an evidence base that can be used to encourage the Government of Congo to further its efforts to improve the efficiency of health financing.

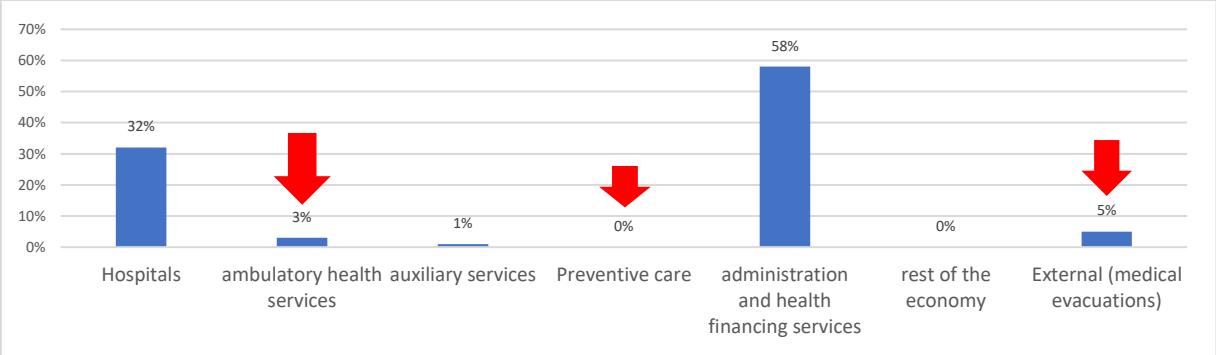
There is strong evidence of allocative inefficiency of health expenditure in Congo. The health system is hospital centric, with more funding going to tertiary level hospitals (curative care: 35 percent) and health system governance (58 percent) rather than preventive care (6 percent) between 2016-2018 (Figure 9). Over the period of 2016-2018, the country mobilized more funds for medical evacuations (5% of current government health expenditure) than for primary health care through ambulatory health services (3%) and preventive care (0%) (Figure 10). The highest burden of disease is from preventable causes that can be addressed by focusing on Primary Health Care (PHC) investments (infectious diseases, maternal and child health). Spending on primary healthcare however, remains below regional benchmarks and country comparators (Figure 11).

Figure 9: Share of current health expenditures by service providers



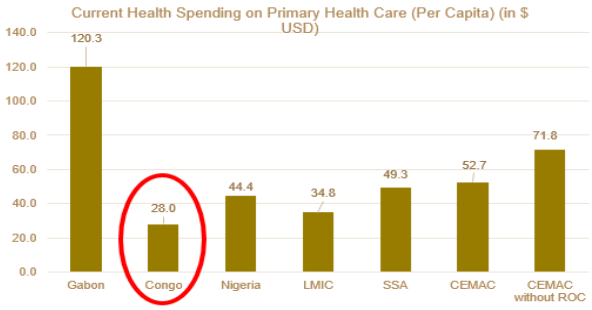
Source: 2015-2018 National Health Account

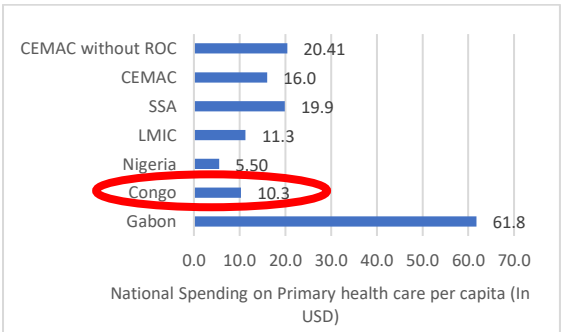
Figure 10: Share of current health expenditures by service type



Source: 2015-2018 National Health Account

Figure 11: Primary Health Care Spending in Congo and Comparator Countries.





Source: 2015-2018 National Health Account

Several health facilities in Brazzaville are overstaffed but critically understaffed elsewhere in the country. There is an unequal health workforce distribution nationwide with the majority of health workers concentrated in urban areas, namely the country's largest cities of Brazzaville and Pointe Noire. In those two cities, staff in place largely exceed the minimum Human Resource for Health norms. For instance, the *Blanche Gomes* and *Talangai* hospitals based in Brazzaville require 13 midwives based on norms, but respectively employ 75 and 56 midwifes. Outside of Brazzaville, there is a need to recruit more than 40% of health workers. Recent data (2018) indicate that physicians (87%), nurses (66%) and midwives (61%) are mainly concentrated in the *Brazzaville* and *Pointe Noire* urban departments where 56% of the RoC population lives. *Brazzaville* alone (with 37% of the population) hosts half of all physicians. Some rural departments, such as *Cuvette*, appear privileged and have twice as many physicians as, for instance, *Bouenza* that has a population twice as large.

The proportion of health workers on payroll versus those not on payroll varies greatly and salary scales differ significantly. Site visits outside Brazzaville reveals that about 45% of staff may not be on the payroll, of which a high number of CHWs. In Brazzaville, health facilities tend to portray an inverse trend with a (much) smaller proportion of agents on term contracts (34% at the general hospital of *Blanche Gomes*, 11% at the Base Hospital of *Talangai*, and 5% at the base hospital of *Moukondo*). This is mainly due to the proximity with relevant ministries that can speed up the process of registering staff on the government payroll. In principle, agents on term contracts (who are locally recruited) cannot be put on the payroll until they acquire a civil servant status. Salary scales may also differ significantly and privilege a minority whereas most staff not on payroll do not earn the minimum wage. Part of the health workforce is privileged. For instance, entities under the MoH supervision located in Brazzaville (such as Teaching Hospitals, the National Pubilc Health Laboratory, and the National Blood Transfusion Center) receive quarterly operating grants also called subsidies which top up the salaries of health workers working as civil servants in those entities.

2.2 Option 5: External Resource Mobilization

Unlike other countries in the Sub-Saharan Africa sub-region, RoC has a history of relatively 'low dependence' on external aid, below 30 percent of total CHE since 2000 and below 10 percent over the 2016-2018 period24. External funds from development partners are the health system's third source of financing and have been shrinking since 2014 from US$11.6 per capita in 2014 to only US$4 per capita in 2018. The share of external funds on total CHE has been below 30 percent since 2000 and less than 10 percent over the 2016-2019 period. The drop in donor aid over the recent years as the country graduates from receiving support due to its income level resulted in a modest drop in the total health budget. However, this is not necessarily problematic as primacy must be placed on mobilizing adequate domestic resources and utilizing these strategically to buffer the modest impact of decline external resources.

Prospects for external fund mobilization appear limited with a lower middle-income country classification. On average, over the 2016-2018 period, Congo's Total Current Health Expenditure (CHE) was financed at an average of 10 percent by external funds, mainly from multilateral donors. About one third of the external support is transferred to the Government budget and managed under public administration. External support to the public budget decreased over the 2012-2015 period, dropping from XAF 40,443 million to XAF 30,808 million, with an estimated average of XAF 33,662. Overall, health aid is on a downward trend, with a contribution estimated at only USD 4 per capita in 2015, *i.e.* 8 USD less than in 2015. According to available estimates, the various foreign donors engaging with Congo committed a general average amount of USD 81.2 million over the 2015-2019 period, with substantial annual variations.

The country's institutional soundness, which has potential to support the health system, has been undermined by the political crisis that led to a withdrawal of institutional support for the development and reinforcement of the health sector. Although the use of development aid to support health will be maintained, this mechanism offers limited potential to cover the financing gap. Contrasting with these initial constraints, the political and strategic recognition of future public health challenges and need to expand the health coverage – two priorities included in the national health development plan (NHDP) - constitute a big upside in this complex picture. Any decline in aid should be tackled by seeking solutions through the establishment of a coordinated policy dialogue between the parties, supporting potential synergies and securing the Government's matching contribution.

3 Accompanying Implementation Monitoring Measures

Drawing on the analysis of the fiscal space expansion options, the Government will embark on collaboratively designing the new health financing strategy - and ultimately, materialize the options that are most relevant and realistic. The Options recognize that sustainable progress toward UHC requires that a country's health financing system routinely generates sufficient and largely domestic resources to expand and sustain access to high-quality health services with financial protection. Public resources are the most efficient and equitable way to fund health coverage, so UHC requires significant fiscal commitment from government. Policy measures—known collectively as strategic health purchasing—may be further applied to directing increased government health spending towards improved efficiency in order to advance UHC goals.

[24] The 2016–2018-time frame also corresponds to the period when RoC fell out of eligibility from GAVI and Global Fund support

In addition to due consideration of the options presented, the following accompanying measures must also be considered:

A) **Congo should continue to adopt UHC targets and benchmarks (allowing for cross-country comparison), but should additionaly define and make data available to monitor needed national targets.** The WHO Commission on Macroeconomics and Health (CMH) estimated the minimum annual spending on health at USD34 per capita to ensure a set of essential interventions, of which US$15 from domestic resources and US$19 from donor aid (CMH report, 2001). African Union member states committed to allocating at least 15% of annual national budgets to health sector improvement (Abuja Declaration, 2001, Art. 26). If both benchmarks allow measuring willingness to increase health resources, they also have their limitations. First, US$34 per capita does not differentiate local purchasing power, disease burden and systemic weaknesses that may significantly vary across countries[25]. In the same way, the 15% intrinsically depends on the size of the economy (GDP) and population: in other words, better-off countries do not face the same scope of challenges as poor ones. The figure also overlooks spending inefficiencies and the way health systems operate. Generic benchmarks are therefore best completed with country-specific targets. This is dependant on the timely availability of reliable health statistics, which are currently lacking.

B) **While all options should be given due consideration, in the immediate term, primacy must be placed on improving effiency.** This can be addressed by establishing routine and high-quality statistics that allow calculating relevant budgets, updating the health map (referral system) and reviewing the health workforce. Congo should ensure full, direct, timely and binding flows of operating grants to health facilities and local administrations (including a budget line for pharmaceuticals) to provide a basis for more autonomy and liability in the use of resources - including local income - and allow for building local capacity for transparent financial management (PFM). This is in line with the performance-based financing (PBF) model that seeks to establish decision-making autonomy on resource management and introduce responsible management practices. This will enhance the timely access to health services, optimize the referral system, improve the availability of essential health commodities, reduce user fees, and support the full implementation of the free healthcare policy (on condition operating grants flow regularly). The computerization of the expenditure process, which is supposed to strengthen the rationalization of engagement and control systems, is also not fully finalized due to deficiencies in accounting procedures. Strengthening planning and budget implementation procedures could assist in improving the allocative efficiency of public spending and service delivery in RoC.

Box 2. Budget Control Mechanisms

Overall budget control mechanisms must also be strengthened at all three levels. The three types of budget control include administrative control by the administration's internal bodies, parliamentary control exercised by Parliament, and jurisdictional control carried out by the Public Audit Office (*Cour des Comptes*). Administrative control operated by the financial controller at the origination phase of the spending process (engagement), and by the accountant at the payment phase (*paiement*) are important aspects of administrative control. Spending ministries, such as the Ministry of Health, should also have its internal control bodies. The Inspection Générale des Finances (IGF) is the control arm of the finance ministry, with a focus on deconcentrated government units and other entities benefiting from public funding. The control prerogatives of Parliament as defined by the Constitution, could also be leveraged as Parliament authorizes the use of public money by the executive branch through the vote of the initial budget law (*Loi des Finances Initiale*). The Public Audit Office (*Cour des Comptes*) is an independent jurisdiction from both the executive and legislative

[25] Chris Atim (2006). *Health financing in Africa - further thoughts on Abuja*. World Bank.

C) **Public Expenditure Tracking Surveys should be implemented regularly to improve budget creditbility and provide insight into budget availability at the frontline.** While the 13 percent of budget allocated to health in recent years can be lauded, reducing the opacity of the budget process compounded by a multiplicity of actors, is needed. Budget execution in health is complex with multiple ministries acting as spending authorities. The Ministry of Health (MOH) is the ordonator of expenditure for non-wage recurrent budgets for goods and service. The Ministry of Public Works largely administers the investment budget such as for the contruction of the 12 national public general hospitals. The Ministry of Defense oversees military hospitals, while the Ministry of Finance payment directorate manages the payroll and pays salaries directly into bank accounts. MOH therefore does not have the entire span of control over health-related budgets, as other Ministries implement and execute in different ways. The operating budgets of health facilities and local administrations - all of them frontline healthcare providers and essential to UHC - appear to be under the control of the Ministry of the Interior, not MOH. Multi-ministry management of the health budget is therefore also a matter of accountability where 'delegated' ordinators are legally (and morally) liable to MOH. The Treasury is at the heart of budget commitment and payment phases. All Ministries depend on the Treasury for budget execution. However, there is only limtied access to these data within government.

D) **A National Budget Conference should be organized to discuss the strategies presented in this Options Paper and validate the strategic directions and options, prior to national budget preparation.** This will include high-level governmental authorities and representatives of the Ministries in charge of executing the health budget. It should also include civil society (trade unions, employers, NGOs, etc.), along the health sector's technical and financial partners such as the World Bank, the World Health Organization, GAVI, UNICEF, UNFPA, the Global Fund or the Roll Back Malaria Partnership to End Malaria. In addition, this workshop will agree on the way forward for the development of the Congo's new health financing strategy and the introduction of a Treasury Special Purpose Account, to cover priority health needs.

E) **Fully implementing the national health insurance scheme (*CAMU*) may provide some additional contribution to financial protection in Congo.** However, it will be essential to finalize the *CAMU* strategy, taking into account equity dimensions and estimating the impact of the scheme on the national budget. Governance and transparency must be improved, and existing contributions accounted for. Plans for the digitalization of revenue collection and payments must also be finalized. Materializing the CAMU will also require deeper collaboration between the Ministries in charge of health and Ministry in charge of social security.

4 National Dialogue

Considering the strategic challenges that the health sector faces and the significant need for financing to cover requirements, it would be important for Government to take ownership of these strategic options. In so doing, the country would be initiating a profound and informed reform of its national health system. Efforts must be provided to identify the most suitable options, then develop and implement them to ultimately set up a secure and sustainable financing system that is adequate, ensures higher equity, and reduces exclusion. The technical assistance offered here gives a first impetus for informed decision-making. This is the first step of a long process that will lead up to effective implementation of a sustainable financing policy for universal health coverage in the Congo.

The findings of the various studies therefore call for several strong commitments from the country's high-level authorities. To implement this reform of the health system's financing, Congo will need to develop

a national strategy to mobilize domestic and external funds to ensure sustainable financing and the transition to universal health coverage. The country will also need to adopt a roadmap. After a first stage dedicated to laying the groundwork for this study, a second stage will support decision-making regarding health matters, ending with a consensus-building and advocacy workshop revolving around these topics. The country will be proposed a third stage during which the technical assistance may support the authorities in developing the technical, legal, and operational tools needed to implement the future financing strategy, according to the needs expressed.

As confirmed by a study on the political economy of health financing, the adequacy of health financing must be debated within the country's highest decision-making bodies. A survey conducted with 42 health key informants in March and April 2019, showed that three major actors (the President, Prime Minister and Vice-Prime Minister) had addressed the issue of financing in their official interventions and gave it a place that the sector deemed important. However, aside from these high-level authorities, it seems that other representatives and actors of the health sector do not perceive the subject as a major concern. Among the subjects addressed, universal health insurance was identified as a national priority, retaining the attention of only one quarter of the actors involved in health. Other topics, such as financing in its literal sense, which parliamentarians called the Government and the Minister in charge of health out on, received national attention but minimal ownership from the different health actors. Among the indicators informing health financing, the share of the health expenditure in GDP is the only indicator that seems to have caught the actors' attention. In general, there seems to be little knowledge as well as little to no use of key financing indicators among health actors. Consequently, the survey suggests that the decision-making process in the health sector is further based on political rather than technical motives and has a weak evidence base. It therefore appears that establishing an effective and informed decision-making process in Congo's health sector will remain challenging in the years to come.

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