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## **Second Conference of the African Health Economics and Policy Association (AfHEA)**

**15<sup>th</sup> to 19<sup>th</sup> March 2011, Dakar, Senegal**

**Promoting universal access to health services in post-conflict situations: what role can large scale cash transfer programmes play for better outcomes?**

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### **ABSTRACT**

Making well-informed decisions about how best to achieve MDGs depends on the ability of public policy makers in accessing the best available evidence about what is known to work and what could be potential benefits, and ways to integrate solutions into complex and often under-resourced health systems. Conditional cash transfer programmes have been largely explored as a policy for improving the education and health outcomes of poor children in developing countries as well as a tool for long-term poverty alleviation; but needs to be appropriate to the context and both fiscally and politically affordable. In DRC, the crisis and conflicts of the past decades severely affected the health status of the population and degraded the health system. Consequently, efforts in reducing infant and under-five morbidity and mortality are seriously hampered by widespread poverty and economic deregulation.

The aim of this paper is to question the feasibility and affordability of cash transfer compared to 2 alternatives: an outreach health and nutrition programme with a behavioral change communication component and the elimination of basic health care user fees. The results show that children health outcomes may instead be driven by the equal distribution of quality services through outreach health and nutrition programmes (20% to real GDP) than a large scale health-oriented conditional cash transfer (25.9% to real GDP). A number of issues is outlined with regard to the country's socio-economic and political context : (i) health-oriented conditional cash transfer cannot operate in DRC due to supply-side constraints and lack of health supply strategy, logistics and engineering ; (ii) targeting is somewhat time consuming and irrelevant in such context with a headcount averaging 77% ; (iii) outcomes of a geographic focused cash transfer programme could be expected on improvement of nutritional status, but less on the rise of health demand and would be difficult to scale-up.

# 1. Introduction

The challenges relating to the realization of child rights in the DRC are enormous. According to the World Bank, over 70% of the population lives below the international poverty line of \$1 per capita per day<sup>1</sup>. A recent study revealed that poverty is overwhelmingly affecting children more than adults and reports that nearly 77% of the children in the country live below the poverty line<sup>2</sup>. The national poverty line has been set back to \$ 0.72 per person per day and the proportion of children living in poverty is still very high (56.6%). Despite the national economic growth estimated at 12% in 2008, the average income per capita remains as low as US\$ 102.<sup>3</sup>

Children are disproportionately represented among the income-poor and many suffer from severe deprivation. Also, the resources devoted to the social sector remain inadequate and do not fit in a long-term perspective despite the fact that the country adopted a Poverty Reduction Strategy Paper (PRSP, 2006) together with a four years Medium-Term Expenditure Framework (2007 – 2010). The DRC ranks 167 out of 177 on the Human Development Index (HDI). The problematic and highly vulnerable position of children is further reflected in their lack of access to health services, quality education, and their exposure to physical and psychological violence. They are paying a heavy tribute as they are the most vulnerable to widespread poverty, deterioration in the quality of life, high unemployment, rising food prices, and grave inequity in access to basic social services.

With a low State budget allocation to health care and the low demand from the population due to extreme poverty (both monetary and non monetary), the country continues to face major difficulties as the levels of morbidity and mortality remain high. It is not surprising that reducing infant and under-five (U5) mortality is seriously hampered under this condition. In the past six years, the under-five mortality rate (U5MR) declined, but by not more than 4%<sup>4</sup>. Even though the recently completed Demographic Health Survey (DHS, 2007) confirms a new U5MR of 148 out of 1,000 live births, the reduction of the mortality rate will not be enough for DRC to be on course for achieving the MDGs by 2015.

These morbidity and mortality rates are exacerbated by the appearance of new challenges facing the health sector: (i) strong proliferation of HIV / AIDS whose prevalence is estimated at 5.5% in 2007 (DHS, 2007) and affects primarily the portion of the population living in poor conditions, (ii) resurgence of tuberculosis, which usually accompanies HIV/AIDS, (iii) persistence of malaria, which currently accounts for 40 to 50% of consultations and 28% of hospitalizations, (iv) low coverage of obstetric care, marked by increased maternal and neonatal mortalities. These situations are likely to increase the risk of mortality, especially among children and women with low nutritional status. On the other hand, the population's inaccessibility to basic health care services affects both social and economic activities by reducing their performance and ability to work. This leads to an economic loss of the potential labor force, both in terms of gross volume and productivity and, consequently, economic growth as it has been clearly demonstrated by Sen (1995) in his human capital theory.

In the recent years, a number of strategies have been explored in order to enhance human capital accumulation and impact household welfare in view of breaking intergenerational transmission of poverty. An illustration of this is the approach of social risk management advocated by the World Bank (social contracts) including direct cash transfers and approaches seeking complementarities between public (social security) and community systems (palliative systems), health insurance and health mutuals. This paper attempts to analyze the potential impact of a child-focused cash transfer programme with a health-oriented conditionality in reducing physical vulnerability (with a focus on child malnutrition) among the under-five to meet 2 objectives: (i) one that directly offsets the income effect of the shock through transfer of an amount of cash per child under-five in each household and ; (ii) one that seeks to mitigate the consequences of vulnerabilities on human development outcomes such as nutrition status of children. Our analysis therefore aims to answer 2 essential questions: (i) Is a universal or targeted cash transfer to reduce child morbidity and mortality fiscally and administratively affordable for the DRC given its actual macroeconomic context? (ii) Is a child-focused health-oriented universal cash transfer program the most

<sup>1</sup> DRC Public Expenditure Review, World Bank report 42167 ZR, December 2007

<sup>2</sup> Pauvreté des enfants et disparités en RDC, UNICEF RDC, Kinshasa juillet 2008

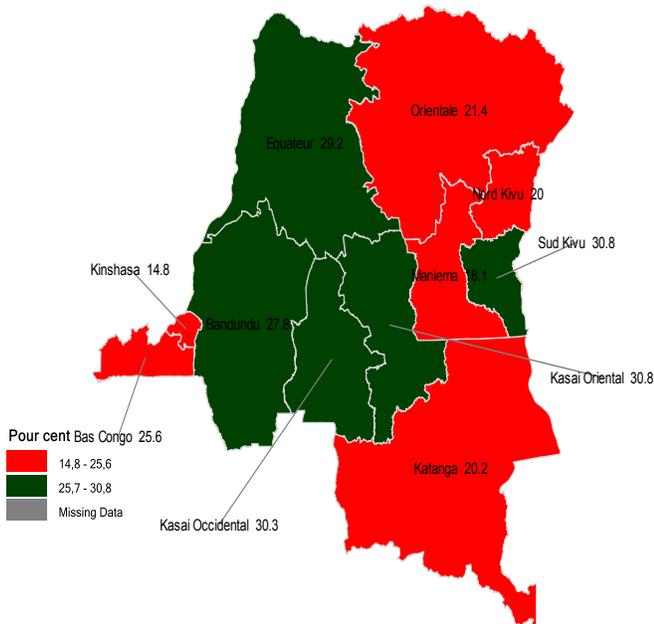
<sup>3</sup> Democratic Republic of Congo, Economic report: Fall 2008, Worldbank.

<sup>4</sup> UNICEF MICS 2001, UNICEF SOWC 2008

appropriate and cost-effective way to meet universal access to basic health care especially in this post-conflict situation?

## 2. Problem identification: Child and Infant Morbidity and Mortality

Graph 1: Underweight distribution by province (DHS, 2007)



The crisis and conflicts of the past decades severely affected the health status of the population of DRC, especially in such fragile environment conducive to health system degradation. As a result, the overall coverage of the basic health services along with the utilization of these services were highly affected.

The main health sector-related MDG indicators remain very poor although there have been some improvements since the end of major conflicts, but the Country is still struggling to reach the pre-1990 levels. Under-five mortality during the period 2002-2006 is estimated from the 2007 Demographic and Health Survey at 148 per 1,000 live births (figure 3), among the highest in the African region.

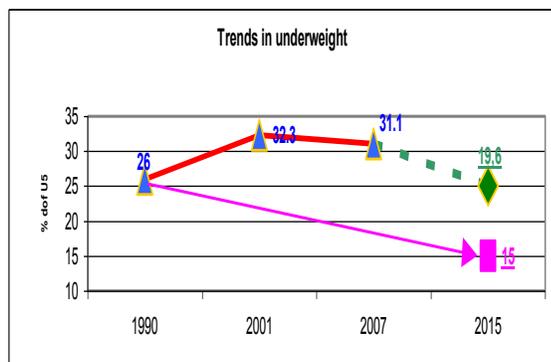
Data from DHS survey indicate some improvement over the past few years. The estimate for the period 1998-2001 is 165 per 1,000 live births, against 172 in 1993-97. However, most of the improvement is concentrated among ages 1-4 years, likely reflecting better care since the end of the civil war, while infant mortality, thought more sensitive to health care services, hardly changed. At the same time, chronic malnutrition among under-five children estimated at 31.1 % in 2007 (figure 2) may have increased. Consistent with this very poor nutritional situation, 48% of children aged 6-59 months had moderate or severe anemia in 2007, while the prevalence was 18% among women aged 15-49 years.

Using underweight as a proxy for socio-economic conditions, figure 2 illustrates how the prevalence of malnutrition among children were dramatically deteriorated during the period of war as well as the increase in child and infant mortality (figure 3). The projections towards the 2015 MDGs horizon suggest that the country would not be able to achieve health-related MDGs and could only reach the pre-conflict figures<sup>5</sup>, far from the expected benchmarks (“*halve, between 1990 and 2015, the proportion of people living extreme poverty and hunger*”). Even with such assumptions, the indicators hide disparities between poorest (1<sup>st</sup> quintile: Q1) and better-offs (5<sup>th</sup> quintile: Q5), and between rural and urban areas. These also lead to large differences in health outcomes between different socio-economic groups and areas. While 52% of children under-five in rural areas were chronically-malnourished (stunted) in 2007, prevalence was 36% in urban areas. Reflective of the very poor nutritional situation, 50% of children aged 6-59 months in rural areas had moderate or severe anemia in 2007, compared to 45% in urban areas.

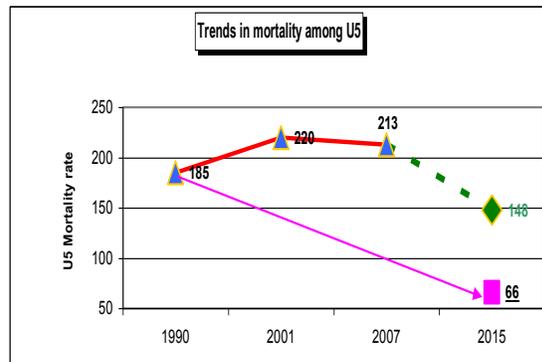
Malaria is also highly endemic and contributes a great deal to child morbidity and mortality. The disease is widespread and reported to account for over half of outpatient visits, one-third of hospital admissions, and 25-30% of child mortality (UNICEF, 2008). Population-representative survey data have similarly shown that fever is associated with 40% of child deaths (IRC, 2004, cited by UNICEF, 2008).

<sup>5</sup> These figures represent the levels at which the country was before the outbreak of hostilities. Further efforts are therefore needed to reach the levels obtained during the commitments to the MDGs (1990)

**Graph 2 :** Trends in underweight among children aged 6-59 months



**Graph 3 :** Trends in child and infant mortality (children aged 6-59 months)



**Legend :**

Red = Actual evolution of the indicator ;  
 Green = projection towards the MDGs horizon (2015) and ;  
 Orange = Projection expected as per MDGs to the benchmark  
 Sources: DHS 1990, MICS 2001, DHS 2007.

Based on epidemiological evidences, the causal relationship between highest prevalence as stunting, iodine and iron deficiencies, and inadequate cognitive and social-emotional stimulation was determined (Grantham-McGregor *et al.*, 2007; Heckman *et al.*, 2006; Berlinski *et al.*, 2006). Also, it is a known fact that the course of infectious diseases such as malaria and HIV/AIDS is much more detrimental for undernourished than for other categories. Therefore, programmes that promote child development through preventing or improving child nutrition and health (in an overall morbidity reduction perspective) reduce the effects of social, environmental, and infectious risks of morbidity and mortality especially among the under-five. This leads, in a medium term, to consistent cognitive and socio-emotional outcomes and, in a long term to educational performance, employment improvement, and disruption of intergenerational cycle of poverty.

## 4. Problem analysis

### 4.1. Structural causes of child morbidity and mortality

Though the deterioration of the key health indicators in the DRC comes from a conjectural situation, it is also fair to acknowledge that several structural factors stand to be the direct causes of child morbidity and mortality: (i) the country’s poor health policies, (ii) a multitude of supply constraints, (iii) the recent food crisis and, (iv) the loss by several households of their livelihood.

After a long period of structural adjustment marked by “belt-tightening” measures combined with poor governance and disappearance of the Welfare State, the Government spending on social sectors failed to keep up with population growth and to adequately respond to increasing health needs and demands. Care has become less and less affordable for a growing number of people, especially for the poorest. Concurrently, the ideas of “cost-sharing” and “community financing” (Bamako Initiative, 1987) adopted by the country and operationalised through formal and informal direct payments imposed on the users of public health care services (= user fees) have been detrimental to a large proportion of the population, especially for the poorest. However, to a large extent, these schemes have failed to meet expectations with respect to additional resource generation, improvement of quality of services and the predicted increase of health service utilization. On the contrary, a dramatic and sustained drop in the use of services was observed, given that non-creditworthy remained *de facto* excluded from the system.

At the opposite of the strong health need and demand, the health services supply remain poor, especially in rural areas due to numerous disruptions, lower-than-projected production growth, and small inventories operating illegally. This situation has worsened considerably, leading the informal service providers to play a significant

role on household-level utilization of health services without any guarantee on their quality. The 2001 MICS found that more than 25% of children with fever received care from drug sellers.

The estimated annual requirements to develop and support health services shown in the medium term expenditure framework are in the range of US\$ 430 million in the period 2008-2010. This is around US\$ 6.50 per capita annually, a level of public spending on health care that would be consistent with a country with an annual GDP per capita of around US\$ 200, but still in an unrealistic range.

Regarding social protection scheme, DRC like most sub-Saharan African countries has no explicit policy with regard to national solidarity and redistribution of wealth. The vast majority of the population, estimated at 95% (ILO, 2001), has no social security coverage. The option taken by policymakers was to restrict the coverage to public sector employees under the labor code, registered and able to pay regular contributions. The informal sector, rural people, self employed and unemployed were excluded from the public system, which makes the need to strengthen social safety nets in assisting poor families to cope with declining income without sacrificing the expenses related to school and health care more than necessary.

On another level, the social affairs sector has experienced a paltry budget, with a record of US \$ 33 million in 2008 (see figure 5), equivalent to US \$ 0.6 per capita. On this line of public spending, nearly half (48%) is devoted to the central administration costs. Thus, the amount budgeted is not necessarily spent and, therefore, is likely to overestimate the social protection expenditure as % of GDP.

A fact that deserves to be stressed is that conflicts have repeatedly led to spontaneous changes due to multiple displacements (DRC abounds more than half of IDPs in the sub-region), the loss of speed, vulnerability in a context of general insecurity. Households are therefore struggling daily to ensure their livelihood mainly based on small-scale agricultural activities and livestock. The continuing fragility of the ecosystem due to inadequate rainfall, the increase in food prices due to the dual financial and food crisis are all factors that explain the negative effects on food sovereignty with visible consequences on child nutrition and health.

As a result, the living conditions of the poorest households are deteriorating, with an increase in the level of household indebtedness and a reduction in the quality and frequency of meals, thus increasing food insecurity and malnutrition. For example, the price of imported rice in DRC in July 2008 was more than double its level a year earlier. Similarly, cooking oil and fresh vegetables have increased by over 16 percent. This is greatly limiting accessibility to nutritious food for rural and urban households (especially those headed by women or children). These crises, if left unattended, have the potential to undo the progress of the last 10 years and put the Country right back at pre-1990 levels. Malnutrition is known to have long-term cognitive and productivity effects on the children involved and may generate cumulative economic costs, up to 3% of GDP annually. This outweighs any short-term fiscal savings from direct nutrition action to prevent malnutrition and promote adequate growth in young children.

During the years 1990-2005, the proportion of people living below the poverty line rose from 80% in 2001 to 70.8% in 2005 (Table 1; ref. PRSP, 2006); the influence of insufficient resources on access to health care has impacted on the lower level of child mortality. Given these factors, changes in the mortality of children under 5 years can be explained by differences in access to care due to the situation of parents who are not remedied by programs addressing poverty and disparities. Furthermore, the probability for a child to die before his 5th birthday decrease as the educational level of mothers increases. Thus, infant mortality increased from 135 ‰ in children whose mothers have not studied at 67 ‰ in those whose mothers have reached the level of higher education.

The largest part of GDP comes from agriculture (especially cash crops) and industry 31.3% and 29.7% in 1990, and 39.8% and 22.3% in 2005 respectively. The share of services remains close to 31%. This means in a long run that improving the situation of children does not automatically come from a change in the structure of the economy or increase in real income, but rather on fair social service offer.

### 3. Policies options to overcome child morbidity and mortality

To identify the optimal option in terms of cost-benefit and cost-effectiveness on the reduction of child morbidity and mortality, we considered 3 different approaches/alternatives which are in fact non exclusive : (i) a health-oriented large scale cash transfer programme with a monthly growth monitoring for children under two (and a quarterly visit for those from 3 to 5) at a therapeutic feeding center, nutrition education for mothers, and the provision of vitamin A supplements and deworming; (ii) an outreach health and nutrition programme with a behavioral change communication component given the deterioration of the health system and the per capita allocation to health care (2% of the total government expenditure); (iii) the mobilization of resources from the government to support the elimination of basic health care user fees.

The first approach relies on a rights-based approach to emphasize not only the consequences of the program but also the process through which these are achieved with multiple objectives, namely: the alleviation of current poverty through targeted cash transfers, and the generation of a sustained decrease in poverty by conditioning these transfers on the accumulation of human capital (i.e. nutrition and health status) by households. Two other approaches which have gained prominence over the last decade are the *basic needs* (Streeten *et al.*, 1981) and *capabilities approach* (Sen, 1985; Sen, 1987). Both of these approaches distinguish between income as a "mean" or as an "end", and highlight the commonly observed lack of strong correlation between income and other outcomes that enter into one's concept of development.

### 4. Methodology and data

The objective is to determine whether potential health-oriented cash transfer program, targeted or universal, is economical and cost effective, taking into account the direct and administrative costs to implement such a programme. The costs of alternatives have been calculated based on public expenditure rather than budget allocations. As the cost-benefit analysis requires calculating the opportunity cost of spending an equivalent amount on other programs, the question is whether the marginal benefit of an additional dollar spent more effectively on a program of cash transfer compared to the marginal benefit of an extra dollar raised to the elimination of user fees in the health sector. We have chosen to make calculations based on quantitative techniques to measure the cost of a potential cash transfer programme and determine whether it is economical and cost-effective in order to reduce poverty and accumulate human capital.

The data used in our calculations are those from the general population Census projections (1984), i.e. well before the conflicts started. High levels of mortality for the period 1990-2000, population displacement and various migrations make these values unreliable. However, in the absence of recent and relevant data, the figures are in fact considered as being official. From a simulation based on informal sector and poverty survey (1-2-3), we estimated a US \$ 10 per child per month for the least interesting scenario and US \$ 15 per child per month for the better one, the direct costs of the transfer. Administrative costs have been difficult to determine because such programme in DRC should be multi-sectoral involving several administrations (as no administration has the formal institutional competency to deliver such a social programme alone). To simplify our calculations, an administrative cost of 12% of the delivering costs of the program would be reasonable, even if it seems high compared to other experiments in which these costs were approximately 5%. Because of poor governance and administrative malfunction, leakages will also be high (estimated at about 30%).

### 5. Results and discussion

#### 5.1. Design and structure of transfers: size, conditionality and coverage

Social transfers constitute subsidies in cash or kind to households or individuals for the purpose of supplementing their income or consumption. In this context, they are primarily an instrument for poverty and vulnerability reduction of the under-fives. Also, transfer sizes related to health and nutrition conditions are

generally lump sum. There have been a number of different approaches to the design of the transfer. In most cases, the amount of the health/nutrition transfer represents the difference between the consumption of an average extreme poor household and the food poverty line, with some variations (i.e., the per capita poverty gap for children under 6 only). The goal of this type of transfer is to – on average - move households living in indigence to a minimum consumption level. In addition to a basic needs and political issue, minimum consumption is seen as a pre-requisite to human capital investment. Another approach is to base the transfer amount on the opportunity costs of accessing health care, which has resulted in a lower average monthly transfer. For the purposes of the present paper, it is important to note that the health and nutrition grant lump sum structure favors smaller families.

The determination of the size of the transfer is consistent with the country context marked by a significant increase in food prices and experiences in neighboring countries where the size of the transfer was averaging US\$ 12 per child per month, although some countries have transferred more than US\$ 25 per child per month as is the case in Lesotho and South Africa. Taking into account the government provisions in the Medium Term Expenditure Framework for the year 2010 (which takes into account the level of growth and the inflation rate at its current level), the real GDP was estimated at US\$ 12.2 billion. We opted for a transfer to cover the food basket for a child per month in urban areas (US\$ 10) and with non foods (US\$ 15). Declination to urban / rural was not deemed necessary in our analysis because the most relevant data were lacking. It is clear that a transfer of US\$ 15 per child per month would have more impact with positive externalities in terms of access to basic health care and basic education.

In order to receive the month-to-month conditional cash transfer, beneficiary households must comply with a set of conditions related to the use of preventive health services and attendance to a monthly growth monitoring for children under two (and a quarterly visit for those from 3 to 5) at a therapeutic feeding center, nutrition education for mothers, and the provision of vitamin A supplements and deworming. This package of services will enable the country not only to cope with the challenging issues of child malnutrition, but also to contribute to the African strategy for child survival and development (SASDE), a strategy that the country is preparing to implement.

The nutrition outcome is expected to result from the combination of the increased income from the transfers, the growth monitoring and the nutrition knowledge provided to caregivers. Since therapeutic feeding centers are not located in all health zones in the country, a pilot experience in areas where such centers could be used is needed, but the scaling-up of such programme will remain a major challenge. The behavior change communication strategy focuses on infant and young child feeding practices as recommended by WHO and UNICEF, disease preventive measures, home-based care, recognition of danger signs, and care seeking for sick children and incorporates not only mothers but also other influential caregivers such as grandmothers. In addition, the management of acute malnutrition which includes the use therapeutic foods has to be strengthened in all the intervention areas.

## ***5.2. Universal or targeted programme?***

The issue of children in situations of vulnerability is a complex type in an environment such as the DRC. It is the consequence of a heterogeneous group of children whose common point is to live in an environment unfavorable to their socio-emotional development: street children, abused children, children separated from their parents, children in conflict with the law, exploited children, refugee children, disabled children, etc. It should be noted that these subgroups are not exclusive. It is possible for a child to be both disabled and on the street or on the street and abused, etc. This further complicates any targeting. It is therefore difficult to project a reduction of child poverty and vulnerability by acting exclusively on family structures as it is the case in Latin American countries. Interventions of this nature can only touch a group of children (living in households). A good class of children said Orphans and Vulnerable Children - OVC living outside a structured household will not be affected by the cash transfer programme even though they culminate worst poverty and vulnerability.

Tackling child poverty reduction and vulnerability will be effective if it develops a balanced mix of universal (at the household level) and targeted services (specific groups), including outreach (social treatment on streets, career sites exploiting children, legal protection, etc.), and preventive measures (to combat the risk of social exclusion)

for children from disadvantaged situations in many ways. Can we really talk about targeting in a context where 77% of the population lives below the poverty line? Even relying on the existing social systems, targeting in this context aim to strengthen the social divide and increase administrative costs and leakages. The cash transfer can not be selective in a post-conflict environment like DRC because it will not help riding the targeted groups. Cash transfer directed to U5 caregivers is already a criterion of discrimination in the allocation of subsidies. Thus, going for a universal programme is worthwhile as it will normally reach a theoretical maximum of 3 children per household, without limiting the number of children that can benefit. Also, it should be made easier for migrants and IDPs to enroll in the programme and draw benefits in their new areas of residence. Clearly, that requires the establishment of an integrated management information system for civil registration, but that is an investment that would be well worth making to improve the efficiency and security of the whole civil registration system, as well as to make it more flexible and convenient for citizens who move residence.

### 5.3. Costs and potential benefits

To inform decisions about those options, it is important to look at some cost comparisons, financial affordability, and political feasibility. The number of children estimated to qualify for the program is 12.6 million and reinforces the idea that this type of program is difficult to implement in a post-conflict context with widespread poverty. Giving a monthly direct cash transfer of US\$ 15 to each child under age 5, would cost US\$ 1.75 billion per year, while refining the transfer to US\$ 10, would cost 1.52 billion per year. The total cost of the program is likely to be in the range of US\$ 2.1 billion to US\$ 3.2 billion based on delivery costs which includes the cost of the transfers, the administrative costs and leakages. The evaluation of costs should also take into account the costs of the program in the broader context of social protection if the implementation is universal. Simulations based on both scenarios and calculation of costs as indicated in Table 2 reported that the programme is not affordable for the government because that would mean 17.7% to 25.9% of its real GDP in 2010 and the entire budget of the Ministry of Social Affairs (investments + current expenditures), while it is known that for Social affairs, current expenditure in absolute terms do not exceed 52%.

Table 2: Costing of the programme using the 2 different scenarios

	Nb. of population	\$US 10/month/child	\$US 15/month/child
Population	63226000		
Estimated number of U5	12645200		
Estimated Nb of beneficiaries per households	12645200		
Average number of U5 per households	3		
Average monthly monetary benefit per household		45	45
Average monthly transfer		126452000	189678000
<b>Average Annual Transfer</b>		<b>1517424000</b>	<b>2276136000</b>
Average transfer as a % Poverty line*		1168416480	1752624720
Pre-Transfer Household Consumption		9104544	9104544
Administrative cost (12%) <sup>†</sup>		182090880	210314966.4
Leakages (30%) <sup>†</sup>		455227200	682840800
Extra-programme costs		637318080	893155766.4
<b>Total annual cost (incl. admin costs and leakages)</b>		<b>2154742080</b>	<b>3169291766</b>
Total as % to real GDP (2010)**		17.70%	25.90%
Total as % to Social affairs expenditure		64.13%	94.32%

\* National poverty line actually rank at US\$ 0.72 per person per day

\*\* 2010 real GDP as per national MTEF

<sup>†</sup> As percentage of the delivery cost

#### *5.4. Discussions*

Given the challenges, it is not surprising that children's health outcomes may instead be driven by the equal distribution of quality services through outreach health and nutrition programmes (20% to real GDP) than a conditional cash transfer (25.9% to real GDP) assuming that all alternatives lead to the same benefits in term of life quality gained. This raises the following question: is a large-scale cash transfer programme financially and administratively affordable and feasible in DRC given its actual socio-economic and political situation? While both supply and demand side factors are likely to be important, without up front analysis, it is difficult to determine which policy or what combination of policies is most cost-effective for DRC government investment without a descriptive and bivariate analysis on expected outcomes.

The estimated annual requirements to develop and support health services as planned in the MTEF are in the range of US\$ 430 million in the period 2008-2010, around US\$ 6.50 per capita annually, a level of public spending on health care that would be consistent with countries with an annual GDP per capita of around US\$ 200. The achievement of health-related MDGs therefore suggests an exponential increase in resource levels and requires annual public spending of US\$ 16 to US\$ 22 per capita, rising to US\$ 30 to US\$ 40. By this standard, current estimated total domestic and international public spending of around US\$ 5 to US\$ 6 in DRC implies a minimum annual gap of US\$ 10 per capita, or US\$ 600 million additional required resources.

The deterioration of the macroeconomic balances and the dollarization of the economy are seriously jeopardizing the ability of the government to use the traditional monetary instruments, translating any domestic borrowing immediately to inflation and exchange rate depreciation. Precariously low official reserves (equivalent of only 4 weeks of non aid-related imports at end-2007) also meant that the authorities had little margin of maneuver to ensure high and shared growth and create fiscal space for carrying out poverty-fighting programs. Potential availability of funding is therefore not enough to ensure the successful introduction of cash transfers as a national programme. This also requires a favorable political and social climate, with proponents who will advocate for the necessary share of the budget. Beside, at the institutional level, there are many ingredients to achieve these objectives: improved fiduciary control over revenue collection and public expenditures, decentralization, reforms to create professional and accountable civil service, transparent natural resource management, to mention a few.

The successful experiences of cash transfers as a policy option in Latin America, Asia or in some Eastern African countries have taken into account the ramifications and issues at the policy making level. This one advocates for a political solution with key players such as the Ministry of Finance and the Ministry of Planning, where the financial implications of the program should be sufficiently analyzed before opting for the programme or its alternatives. The establishment of such mechanism also requires a rather impressive logistics and engineering to render the system transparent and fair, this is what is still lacking in the ability of government to efficiently implement at a reasonable scale.

A number of health policies have focused on access to care for the poor with a central question: "how to increase demand of care for the poor?" There is an existing UNICEF, World Bank, WHO, initiative on maternal, new born and young child health, and DRC was selected to be one of the pilot countries at the beginning of 2006. The remaining question is how to identify the core minimum package which could be offered free of charge for under 5 children and pregnant women within that initiative? The partnership is also trying to produce a health financing strategy with an emphasis on improving the levels and management of public financing. It seeks to improve national government and donor financing rather than user fees (50.43% to real GDP).

Table 3: Policies alternatives and costs

<b>Policies alternatives</b>	<b>Estimated total cost (billion US\$)</b>	<b>% to real GDP (2010)</b>
Health-oriented universal cash transfer programme	3.17	25.90%
Outreach health and nutrition programme*	2.51**	20%
Elimination of basic health care user fees	6.33	50.43%

\* *The distribution of nutritional supplements is now integrated with Vit A and deworming*

\*\* *From the Health Sector MTEF, and does not take into account leakages (normally low)*

More work on estimating the cost of implementing the DRC health sector development strategy is needed. The health sector development strategy adopted in 2006 intends to phase support geographically, aiming at extending progressively the geographic coverage of a comprehensive package of services. Thus, the financial requirements to implement this strategy will depend on how geographic expansion targeting is defined. First, the package of health services to be supported requires costing. Second, realistic projections of expansion of the coverage of this package are needed. Further work on the MTEF will need to reflect such analysis at the same time as remaining realistic in terms of both the likely available resource envelope and absorption capacity.

User fees and drug costs raise significant barriers to access to care for the poor, and one of the aims of domestic and international public financing is to substitute for the current level of out-of-pocket payments in order to improve access for the poor. The 2007 target is already inoperative, as the health allocation in the 2007 budget represents 5.7% of the total (excluding debt payments). Given the budget execution record described previously, even this level of spending is unlikely to be achieved. If these targets were met (and assuming that total government expenditures are around 20% of GDP, which is consistent with recent years), then government health spending would be US\$ 150 million in the first year, US\$ 275 million in the second, and US\$ 325 million in the third.

## 6. Conclusion

Although the cash transfer and elimination of user fees are being debated, available resources would not allow public provision of basic health services free-of-charge to the entire population, even targeting the U5. Evidence of the severe impact on access to health services by poor populations in DRC during the conflict led to calls for elimination of user fees (MSF, 2001) and cash transfer conducive to human capital accumulation. Currently, the issue has been raised in the context of development programs. In any case, the paucity of available resources makes this debate somewhat moot: currently, it is neither possible to provide the basic package of health services free-of-charge to the entire population, nor is it to provide cash to households in such a post conflicts situation where the Country is struggling to stabilize its economy. Reducing financial barriers to utilization and the burden on households will require some combination of exemption policies and the provision of free or highly-subsidized selected high-impact services. Such strategies are, to some extent, already in place in DRC and they require strengthening in combination with the necessary external subsidies. This leads to the following conclusive remarks: (i) conditional cash transfer cannot operate in areas like DRC with supply-side constraints without a comprehensive health supply strategy, logistics and engineering to lower leakages administrative costs; (ii) In a context of generalized poverty (headcount = 77%), targeting is time consuming and irrelevant; (iii) The outcomes of a geographic focused cash transfer programme could be expected on improvement of nutritional status, but less on the rise for health demand and would be difficult to scale-up.

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