Aligning donors: a way to reducing inefficiencies in the health sector in the DR Congo

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National context evolution

1. Prior 1990s DRC as pioneer of district health model in Africa ("zones de santé")
2. Three decades of lack of governance and armed conflicts that led to collapse of state in 1990s
3. In 1990s, the Government withdraws from health financing which become totally dependent of out-of-pocket payment and international aid
4. Up to 195 projects and programmes externally funded and international aid is essentially based on humanitarian assistance
5. 15 steering committees, management units and multiple parallel systems;
6. Theses led to Increasing inefficiencies in the health sector
Inefficiencies and their manifestations

1. Disproportionate management costs
2. Waste and duplications due to fragmentation;
3. Organizational and managerial inefficiencies;
4. Inefficient workforce deployment
5. Duplication of supply chains.
1. Disproportionate management costs

- The management cost including international technical assistance: up to 40% of the total budget of the project;
- Under the 9th European Development Fund: 38% of the total budget of 80 million euro to management cost and technical assistance: 30.5 million euro;
- To put this in perspective, the government spent 30 million euro to fully equip 660 HC and 132 DH in 2013.
3. Organizational and managerial inefficiencies

1. National standards
   1. HC offers basic services package;
   2. DH offers hospitalization and referral services.
   3. The costs to the HC and DH to deliver services are respectively $91,300 and $1,200,000 per year.
   4. It is expected that each health facility plays its rôle;

2. HC received resources from Global Initiatives

3. To get some resources from Global Initiatives, DH started competing with the HC offering basic services package

4. This led to a waste of resources allocated to DH
4. Inefficient workforce deployment

• National standards,
  – 5 nurses for a HC (10 000 people)
  – 7 to 10 MD for a DH (100 beds hospital or 100 000 people);

• What happened in urban areas:
  – 30 nurses for a HC with 5 outpatients a day
  – 15 MD for 22 beds hospital (each MD works one day a week, but all of them receive full salary every month from the government);

• Very high number of fictitious and double payment between health workers
5. Duplication of supply chains

- Existence of a national Procurement System & supply
- More than 100 projects using their own procurement agencies, warehouses and distribution channels
- 99 distributions channels in 2009 including the GFATM channels;
- The suffocation of the national procurement system becomes unavoidable
Consequences of inefficiencies (1)

1. Missing opportunities: waste of money that could have been spent better and make the Health System more effective (1, 2, 4);

75% Health Areas, out of 8 000
Consequences of inefficiencies (2)

2. Organisationnel, managerial inefficiencies and Fragmentation:

- Deterioration of the ability of the District Hospitals to deliver quality second line services
- Declining health care and services quality;
- Frustrations of health workers and erosion of professional identities;
- Users lost confidence in the health system;
- Multiplication of private for profit dispensaries.
- Risk of institutional memory to disappear.
Consequences of inefficiencies (3)

3. Duplication of supply chains;
   - Out of Stock of medicines and health products in some facilities while other received more than they need and see medicines and health products expire;
   - A number of Regional Distribution Centers of medicines and health products went into bankruptcy due to competitions from parallel systems;
   - The Bandundu Regional Distribution Center lost 10% of its Turnover volume in 2013

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Inefficiencies and their causes

1. Disproportionate management costs
2. Waste and duplication due to fragmentation
3. Organisational and managerial inefficiencies
4. Inefficient workforce deployment
5. Duplication of supply chain

Collapse of state due to lack of governance and armed conflicts

1. Government withdraws from health financing
2. Lack of regulation in the health sector
3. Donor dependency and implementation of parallel systems
2005: SRSS

1. SRSS is a set of reforms to:
   - Build national leadership in the health sector;
   - Improve health sector effectiveness in terms of services delivery and access
   - Overcome inefficiencies in the health sector
   - Manage donors

2. Concretes measures needed to be taken to translate the reform into practice in order to reduce inefficiencies
1. This corresponds to savings of 56,000,000 USD from 2009 to 2014;
2. To date, 30% of external funding (GAVI, EU and GFATM) are channelled through the new mechanism. It is expected that the reform become the main channel for international aid in 2015 (WB and Belgium decided to join the reform)
Overcoming duplications and wastes

- Results:
  - All partners aligned with the reform and provide technical and financial support;
  - Fragmentation reduced;
  - More complementarity and synergies between different sources of funding;
  - Reducing of the demand on the time of health district team to attend seminars and to write reports;
  - More time to deliver health care and services at the district level.
Eliminating double payment and payment to fictitious employees

Investments in the health sector

Banking payroll  Reduce ficticious  Public finance reform

Governement purchases equipment with UNICEF procurement support
GAI and GFATM decided to do the same
Overcoming managerial and organizational inefficiencies

- Redefine the role and functions of health center and District hospital
- Establish flat fee to reinforce continuity of care
- Establish prepayment system to avoid hospital to deliver basic services package

Kisantu DH: Referred patients

- Year 2008: 80% (20% of total)
- Year 2009: 50% (50% of total)
Reducing duplication of supply chains

- Ownership and alignment with national systems in 2014:
  - Government uses national warehouse and distribution channels
  - GAVI and GFATM (government grants recipients) have aligned with national procurement, warehouse and distribution channels
  - Grants from GAVI and GFATM to improve national warehouse capacity

Trend of business volume of SNAME in million USD

HSS Grants from GAVI and GFATM have been contributing to increase national warehouse capacity and distribution channel. It is expected an important reduction of duplications of supply chains.
Unexpected results

1. Fragmentation of the management unit: partners insisted having staff that would respond to them directly in the management unit;
2. Mismanagement and conflicts of interests: management unit accumulated technical, financial and procurement responsibilities

To date, management unit is only responsible of financial management. Technical responsibilities have returned to programmes and directions and a procurement unit will be put in place
Lessons learnt

1. The pressure of rapids and visibles results leads often to the multiplication of parallel systems and waste of resources at the country level;

2. Resources wasted in terms of inefficiencies are very important in some cases. They create a missing opportunities for building a sustainable and effective health system in the beneficiary countries;

3. The direct causes of inefficiencies in the context of collapse of state are often very complex. So there is no magic solution to address them. We need to test measures, to improve, to redesign and to adapt them as circumstances changed
Lessons learnt

4. There is no effective alignment of donors (beyond the declaration of intents) at national strategies and systems without a strong leadership at the country level;

5. To breaking early the vicious circle of alignment is essential to reducing the risk of inefficiencies in the health sector:
   – Financial Partners expect a certain level or performance of national systems to align. In the same time, countries cannot improve their systems if they do not have access to the funds from partners.
   – This is a vicious circle that can maintain inefficiencies for a long time and create missing opportunities for building sustainable health systems

6. A strong ownership is catalytic to alignment