



Method of Payment and Accessibility to Healthcare in Urban Areas: Case of the Health District of Kisanga in the Democratic Republic of Congo

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Abstract

Introduction: Improving health conditions in poor countries should be a priority in development policies, not only because health problems are an integral dimension of poverty, but also because there is no access to development without work and no longer to a work without health. **Method:** We carried out a cross-section on accessibility to care in the Kisanga health zone with the aim of improving access to health care. Our data was collected based on a questionnaire as well as an interview. We used the Epi Info software for analysis and data recording. **Results:** Regarding the gender of heads of household, we observed a predominance of women (52.7%); the Protestant religion was in the majority (29%); households spent an average of \$170 for care; payment for care as well as discrimination were the determinants of access to care ($P < 0.0001$). **Conclusion:** It is imperative to organize the health service and institute risk sharing in terms of third-party payment to promote access to health care, which is a condition for the emergence of any nation.

Subject Areas

Health Policy, Public Health

Keywords

Health Care, Accessibility, Mode of Payment, Kisanga

1. Introduction

Continuity of care implies that the resources for the services that provide them, including financial resources, are permanently available. To this end, the financing of health care services should be predictable, stable, and sufficiently [1].

The use of basic health services is one of the key factors promoting better health of populations [2].

The payment of health care is supported by arguments of ethics and professional conduct, political philosophy (role of the state) and economics, for the sustainability of services [1]. The payment of care by their users or beneficiaries is of paramount necessity. On the one hand, it makes it possible to empower them, and on the other hand, it makes it possible to collect or collect the income necessary to finance health services. In Africa, the payment of healthcare by users is based on the reform plan called the Bamako initiative [1].

In fact, towards the 1980s after the departure of most of the colonizers from African countries, they who brought progress and resources by ensuring free health care, the state coffers were empty, the hope of health development tended to disappear, structural weaknesses were coming to light, and health structures had been left to their own devices, without drugs and with unpaid staff [1].

To “save” and revitalize the primary health care (PHC) strategy, two major events were held in 1987. First, an interregional meeting of the world health organization (WHO) was held in Harare (Zimbabwe) where African countries subscribed to the health district approach as a model for implementing PHC. A month later, the 37th session of the WHO regional committee was held in Bamako, Mali, at which African health ministers launched a reform plan called the “Bamako Initiative” (IB), in the presence of the Director-General of WHO and the Executive Director of UNICEF [1]. The IB aimed at a sustainable solution to the provision of financial resources to health services, relying, among other things, on the financial participation of the population to finance the health services and in the management of the services intended for them.

The objectives of establishing this financing system (IB) for health services include cost recovery, user empowerment, continuity, integration, accessibility, rationalization and relative autonomy of care and health facilities [1].

There are multiple financing systems, the criteria of which are the net income of users, the ease of setting up the system, the effects on care services, the effects on equity, and the effects on community participation [3].

In Developing Countries in general and in particular the health district of Kinsanga, accessibility to the health care system, especially basic and of high quality, poses enormous problems and difficulties and needs to be addressed a major concern of both national and provincial government.

The use of basic health services is one of the key factors promoting the better health of populations. The literature indicates that the analysis of the determinants of demand for care is extremely important for the formulation of policies and strategies in the health sector but also to ensure effective use of services and

to improve the quality of services. It is also important for designing strategies capable of ensuring the sustainability of the financing of a health program [4]. As in most African countries, from the end of the 1970s with the debt crisis and during the 1980s, which were characterized by weak progress in health indicators, the idea was established that the decentralization of care could be part of the solution. This is how Rwanda adopted the primary health care strategy to promote the health of its population [2]. In 1995, with the aim of promoting quality, acceptable and accessible health care to the population, the country reformed the health system, in accordance with the Lusaka Declaration, which was adopted by the Government of National Union in 1996 [5].

WHO says that each year, more than 150 million people in 44 million households face catastrophic expenses when seeking treatment [6].

In Rwanda, in order to ensure the access of the Rwandan people to a healthy life and enable them to be socially and economically productive, the government has put in place the policy and continues to promote mutualist initiatives in order to guarantee equity in the distribution of health care and services, community solidarity, ipso facto financial accessibility to health care [7].

In Togo, new health and social protection policies were initiated between 2011 and 2015 with a view to solving the problem of catastrophic health spending. However, despite its initiatives and efforts, the contribution of households to the financing of health care remains substantial in this country. A survey conducted in 2015 of 2400 households on the ability to pay and total household expenditure shows that 7% (threshold of 40%) of households have made catastrophic expenditure measured against non-food expenditure. This study maintains that at this threshold, Togolese households at risk allocate 60% of their total monthly expenditure to health care [8].

Retrospective study of health spending using data obtained from household surveys reveals that globally, 808 million people in 2010 incurred catastrophic health expenditure [9]. With regard to our study, our research purpose is to find out whether households in the Kisanga health District face catastrophic health expenditure while using health services.

2. Methodology

We conducted a cross-sectional study over the period from January to June 2018.

This study was carried out in the health district of Kisanga in the Democratic Republic of Congo in the province of Haut Katanga in the Democratic Republic of the Congo.

This health district has 11 health areas with an estimated population of 239,290 inhabitants in 2018. This population lives mainly from petty trade and agriculture. The most common illnesses include malaria, tuberculosis, HIV-AIDS infection, acute respiratory infections, and simple diarrhea. On a technical level, this ZS had a General Reference Hospital and around 75 public and mostly pri-

vate first-line health facilities. The study population is made up of heads of households.

Sampling: The level of use of curative care services considered normal is 50 new cases/inhabitants per year, according to the health standards in force in the DRC [10]. We used Non-Probability Sampling and 501 households were chosen for our study.

Data collection: a pre-tested questionnaire was sent to each household.

Data analysis: The data and encoded in Excel then analyzed on correctly completed questionnaires were analyzed and coded. Data entry was performed by an entry operator in an entry mask created in Excel 2013. Statistical analysis of the data was carried out using Epi Info 7.6.2.2 and Excel 2013 software.

Conflict of Interest: No conflict of interest has been declared.

3. Results

The female sex was predominantly represented with 52.7%, the age group between 20 and 34 years was in the majority and the maximum expenditure was between 12.5 and 25 USD (Table 1).

Among the respondents, the liberal profession was in the majority (49.09%) and the Protestant religion was in the majority (58.18%) (Table 2).

Table 1. Socio-demographic characteristics.

Variables	Frequency	Percentage
Sex		
Male	237	47.3
Female	264	52.7
Age		
≤19	11	2.2
20 - 34	212	42.32
35 - 49	197	39.32
50 - 64	71	14.17
65 - 73	10	2
Expenses (USD)		
<12.5	86	17.2
12.5 - 25	170	33.9
26 - 37.5	98	19.6
38 - 50	52	10.4
>51	95	19
Total	501	100

Figure 1 indicates that 438 or 87.4% of our respondents had access to curative care against 63 or 12.6% had access to other care.

Figure 2 shows us that 219 or 43.81% of our respondents had attested that the reception of nursing staff was good. Less expensive health care follow up with 165 or 32.99%.

Figure 3 indicates that in 74.1% of cases the households used the direct payment method our respondents. Their method of payment was direct and against indirect method of payment 25.9%.

Table 3 shows the result about who pays for health care in the household.

Table 4 shows that there is a statistically significant association between the method of payment, negative discrimination and accessibility to care (P-value < 0.05) while there is none between accessibility to care and equality of care (P-value > 0.05).

Table 2. Socio-demographic characteristics (Continued).

Variables	Frequency	Percentage
the main activity of the head of household		
Employer	108	21.82
State worker	68	13.64
Independent	23	4.55
Liberal	246	49.09
Private employee	37	7.27
Without occupation	18	3.64
Religion		
Catholic	159	31.82
Revival Church	18	3.64
Muslim	9	1.82
Protestant	292	58.18
Jehovah's Witness	23	4.55
Total	501	100

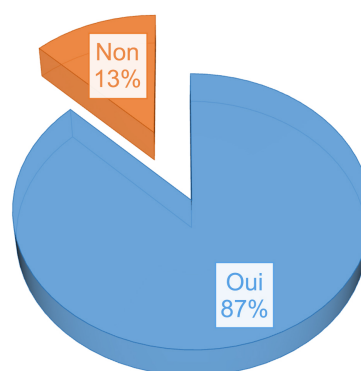


Figure 1. Accessibility to curative care.

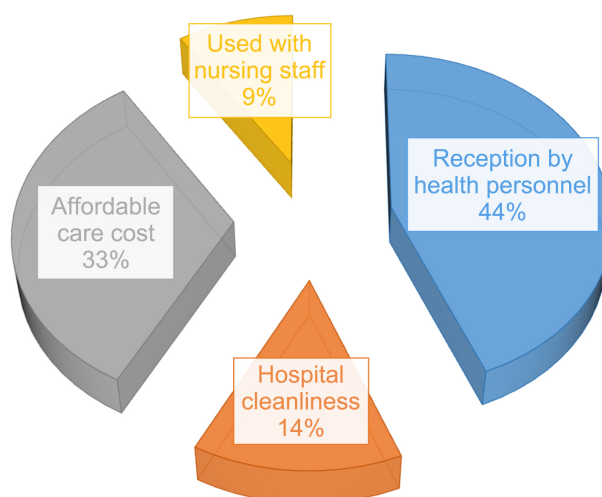
Table 3. Distribution of respondents according to the person paying for health care in the household.

Person who pays for care in case of illness	Frequency	Percentage
Head of household	114	22.8
Other	387	77.2
Total	501	100

Table 4. Association between discrimination, payment method, equality and accessibility to curative care.

Variables d'étude	Accessibility			
	Oui	Non	OR (CI 95%)	p
Discrimination				
Yes	429 (88.8)	54 (11.2)	7.9 (3.0 - 20.9)	0.0000002*
No	9 (50.0)	9 (50.0)		
Payment method				
Direct payment	336 (90.6)	35 (9.4)	2.6 (1.5 - 4.5)	0.000342*
Indirect payment	102 (79.7)	28 (20.3)		
Equal care				
No	427 (87.7)	60 (12.3)	1.9 (0.5 - 7.2)	0.31088**
Yes	11 (78.6)	3 (21.4)		

*: Significant association; **: Association not significant.

**Figure 2.** Respondents and factors influencing access to curative care.

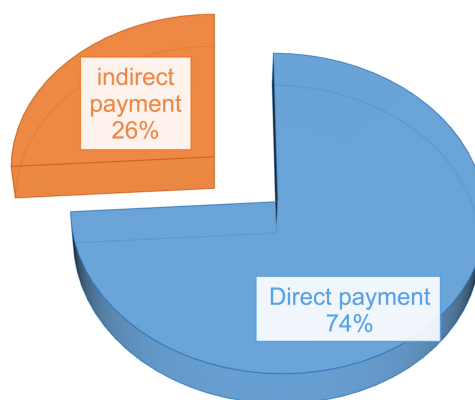


Figure 3. Distribution of respondents according to the method of payment for health care.

4. Discussion

4.1. Socio-Demographic Characteristics

In 49.1% of cases (**Table 2**), the heads of households occupied liberal functions versus those who were without occupation (3.6%); Protestants were in the majority (58.2%) against Muslims (1.8%). In some studies on the factors determining access to health care, farmers were in the majority [11].

4.2. Improving Accessibility to Curative Care

We observed that 219 or 43.81% of our respondents had attested that the reception of nursing staff was good, followed by less expensive health care with 165 or 32.99% (**Figure 2**). Some authors believe that the improving access to healthcare also requires the establishment of a clear, uniform and appropriate pricing system [12].

4.3. Method of Payment for Health Care

In 74.1% of cases, households used the direct payment method our respondents, their payment method was direct as shown in **Figure 3**. In the DRC, only 2.4% of the working populations enjoy social security coverage, moreover, partial and 82% of the populations say they are unable to pay for their health care [13]. In many OECD countries, the progressivity of these indirect payments is, in reality, more than enough to compensate for the degeneration of direct payments. [14].

4.4. Source of Payment for Health Care in the Household

In 77.2% of cases, the managers were not able to pay for their care and they were honoured by third parties (family member, church, neighbours, etc.). Our results do not match those of Mashini Ngongo and Kabya Ilunga who found that housewives contribute more than 70% to health care [15] [16].

4.5. Determinants of Accessibility to Curative Care

Discrimination, as well as the method of payment determine access to healthcare

in Kisanga ($P < 0.001$) while equality of care had no statistically significant link with access to healthcare ($P > 0.001$). In the DRC, household income is one of the criteria used by the populations to define the choice of their health care [11]. Thus, households with a higher income will seek care in private structures, and people with a low income will seek care in public structures [17]. Some authors have found that household financial income is a factor in access to health care, but not in the decision to join the mutual insurance company [18] [19].

5. Conclusions

We observed that in socio-demographic terms, female heads of household were in the majority (52.7%). The age group between 20 and 34 years was the majority, *i.e.* 212 (33.9%) and most households spent between \$12.5 and \$25 per illness episode (33.9%); while 438 or 87.4% of our respondents had access to curative care against 63 or 12.6% had access to other care.

Since health is not a right, access to health care is required by universal health coverage and the politico-administrative authorities as well as civil society must activate the lever so that every citizen has access to care. Health when he needs it and without suffering from his pocket.

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Conflicts of Interest

The authors declare no conflicts of interest.

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