Employees’ perceptions regarding social health insurance: A case of Kinshasa, Democratic Republic of Congo

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Accepted 30 December, 2010

Sustaining splendid health has always been a wish for every employee of any formal organisation. If health is not excellent, employees are likely not to function as expected hence it is imperative to have social health insurance. This article reports on the findings derived from a research conducted in Kinshasa, Democratic Republic of Congo. The researcher personally distributed structured questionnaires among employees in 15 organisations. Findings show that the majority of the respondents experience problems in organizing their health care where it emerged that, 1) the majority of the employees from public sector are not assisted in organizing their health care, 2) they use out-of-pocket financing means for their health care, 3) in general, employees from public sector are not aware of health insurance and interestingly employees from mix companies and private sector are knowledgeable on health insurance, 4) respondents with post matric qualifications prefer to use private hospital when they are sick, 5) employees choose health facility based on good quality service provided. In general, it emerged from the findings that there is willingness to pay contribution should the social health insurance be introduced.

Key words: Social health insurance, Health financing systems, Democratic Republic of Congo (DRC), Out-of-pocket, Mixed —company.

INTRODUCTION

Good health status is imperative for the good life, well-being and development of nations. If health is not excellent, workers cannot do their jobs properly, children can not go to school and in fact, this situation will affect the whole family even more if no social insurance is in place. Furthermore, good health is needed for economic and social development.

An efficient and equitable health care system is therefore an important intervention in breaking the vicious cycle of poverty, vulnerability and ill health caused by non-provision of social health insurance (Jutting, 2005).

Developed countries often use social health insurance (SHI) to mobilise funds and pool risks, but low- and middle-income countries rarely use this approach and rely mostly on general revenues and direct out-of-pocket payments as sources of health care financing (Hsiao et al., 2007).

As mentioned by the World Health Organisation (WHO) (2007), the most common ways of financing health care are:

1. Tax funding, where the money to pay for health services comes from the general revenue of the government (sales taxes, income taxes, import and export taxes). Tax is usually imposed on public health facilities, but also increasingly on private provision. Taxes may be progressive (the better-off pay more than the poor) or regressive (favouring the better-off).
2. SHI, where members pay a contribution based on their income to a health insurance agency, which purchases health services from either public or private facilities. The contribution is proportional to income, so that within the

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pool of SHI members, the better-off subsidise lower income groups. Also, the healthy and young subsidise the sick and elderly. To avoid a high-risk pool, SHI is usually compulsory.

3. Private health insurance, where people buy health insurance for themselves from private, for-profit insurance companies. These companies pay providers of health services for their members and charge their members’ premiums according to their health risk status. As a consequence, the poor usually cannot afford private health insurance.

4. Community-based health insurance entails local insurance schemes that raise money from their members to pay for their health services.

5. Out-of-pocket spending is not a health financing scheme in itself but rather the way money is spent on health in the absence of a system. In this case, people buy health services straight from health providers and pay the full price for the services.

Out-of-pocket spending is very problematic as it causes people to fall into poverty because of medical expenses. SHI pools the health risks of its members and the contributions of organisations. The contributions from the households and organisations are normally based on income and government contributions are financed mostly through taxes (Carrin, 2002).

In principle, SHI involves compulsory membership for all formal workers, and in this way, it clears the assumption of voluntarism. SHI depends on the economy of the country. The more people are employed, the higher the contributions will be from the members of the insurance.

There are a number of reasons for compulsory participation. Firstly, it actually avoids the exclusion of certain population groups, such as the poorest and most vulnerable. Exclusion in a voluntary scheme can arise due to lack of political interest in vulnerable groups. The rationale is that the poorest may simply not be interested in opting for membership due to a lack of capacity to pay the proposed health insurance contributions. Secondly, compulsory insurance by its nature inhibits adverse selection. The latter occurs in a voluntary framework when people in good health judge health insurance as too expensive, and therefore opt not to join the scheme.

According to Carrin (2002), SHI is recognised to be a very powerful measure for granting the population access to health services in an equitable manner. For the implementation of SHI to be effective, the scheme should assure their members that they will receive the promised health insurance benefits.

If the health services cannot be delivered as promised, the trust of the covered population could easily fade away and this may lead to members no longer paying the contributions as expected.

The other important issue is that sometimes the services are available, but the service providers as appointed to deliver the services simply do not comply with the SHI principles. This could be as a result of the service providers being uncertain about their expected incomes. In the Democratic Republic of Congo (DRC), during the colonial period in 1885 to 1960, health financing was supported by the colonial government, civil societies (religious professional societies) and the private sector. Of these three groups, the colonial government played an important role, which led to the control of several illnesses such as variola (DRC, Ministère de la Santé, 1999:3). Since independence, this organisation has been ravaged by political troubles, socio-economic crises and an interruption of bilateral cooperation within the country (DRC, Ministère de la Santé, 1999).

Financing of the health sector in the DRC was led by three principal actors:

1. The government by means of the budget (DRC, Ministère de la Santé, 1999).
2. The Institut National Securité Sociale (INSS), or National Institute of Social Security (DRC, Ministère de la Santé, 1999), which deals with health affairs of workers in the formal sector related to illness and accidents concerning professionals.
3. The public and private enterprises, where public enterprises are allowed to deal with the health mission (DRC, Ministère de la Santé, 1999:5) and private enterprises are obliged to organise health services for their employees (DRC, Ministère de la Santé, 1999).

In striving to improve the health sector, DRC authorities adopted the objective of “health for everybody for 2000”. This objective involved primary health care as a strategy, where the financing of health would allow equity, quality and efficiency (DRC, Ministère de la Santé, 1999).

Despite adherence to the principles and requirements of the “health for everybody” objective, the widespread socio-economic crises and reduced commitment of government led to the diminution of the resources allocated to the health sector and deterioration of health indicators. The following illustrates this situation (WHO, 2008):

3. Infant mortality for every 1,000 live births: 129 (2006)
4. Proportion of population with sustainable access to an improved water source: 46% (2004)
7. When compared to the colonial period, the role of public authority decreased.

Currently, the DRC context has changed significantly, with several years of civil war and ongoing conflict in some provinces within the country which have worsened the health indicators. In addition, as stated in the foregoing, the public and private enterprises which are supposed to provide health care for their employees do
not in practice accomplish this mission (Dibwe et al., 2005).

In November 2005, in the DRC, the government created the National Programme of Social Protection (DRC, Cabinet du président de la République, 2005). The original intention was that the programme would involve nine projects, including compulsory health insurance (DRC, Cabinet du président de la République, 2005). However, this initiative has not been implemented yet. This paper intends to explore the employees’ perceptions regarding the introduction of SHI.

Based on the information in the foregoing, this paper specifically addresses the issue of the feasibility of SHI and determines the challenges faced by employees in formal organisations regarding non-provision of SHI in Kinshasa, in terms of their sector of employment and qualifications. Suggestions are also offered for improving the current situation.

**Specific objectives**

1. To determine how employees organise and feel about their health care.
2. To determine the challenges experienced by employees in the formal sector.
3. To recommend possible ways of addressing the challenges.

**RESEARCH DESIGN AND METHODS**

In this study, the quantitative approach was used with the intention to identify the current situation of health care sponsorship of employees in Kinshasa (DRC) and to determine the factors that can explain the choice of SHI by employees. In order to achieve this, a survey was conducted among employees in Kinshasa. As the objective of the study was to get opinions about SHI, this survey method was regarded as appropriate.

The population of this study consisted of employees working in the formal sector within Kinshasa, as this was where most of the government departments and companies are situated. The researcher personally distributed questionnaires to 312 employees, representing 15 companies/organisations. A simple random sampling was used, where each individual in the population has an equal chance of being selected to be a part of the study (Creswell, 2003).

Ethical consideration

Prior to data collection, the researcher obtained permission from each institution selected in Kinshasa and was aware of their code of ethics. Informed consent was obtained from the participants by means of an information leaflet outlining the purpose of the study. The participants were further informed of their rights that they had a right to participate and that if they were not interested, they were at liberty to inform the researcher of their intentions. Participants were also informed that anonymity would be maintained as no personal identifiers were used in the research.

Data collection and analysis

Primary data for the study were collected by means of a structured questionnaire. The researcher developed the questionnaire as there was no existing relevant questionnaire that could be used for this particular study. The steps used by Muheki (1998) were adopted and adjusted to be in line with the objectives of this particular research. The questionnaire was self-administered and contained closed questions. The questionnaire was constructed in English and translated into French, which is the official language in DRC. It was divided into four sections. The first section comprised questions relating to the biographical details of the respondents. The second section contained questions associated with the sector of employment. The third section included questions concerning health care behaviours and household. In the first three sections, respondents were asked to choose their answers from different statements. The fourth section included 23 questions regarding the SHI plan, where a 5-point Likert scale was used, ranging from “strongly agree”, “agree”, “uncertain” and “disagree” to “strongly disagree”. Respondents were requested to provide their answer to each statement concerning the SHI plan by selecting one of the five choices. However, the researcher collected the data for a period of two months, and no follow-up research was done due to the fact that most of the questionnaires were returned.

The collected data were analysed by using SPSS. Descriptive statistics, which present quantitative descriptions of data in manageable form (Babbie, 2007), were used. Furthermore, these quantitative data were analysed at an inferential statistical level with a computation of chi-square tests to ascertain variations in terms of educational qualification and sector of employment in relation to various statements on SHI.

**Validity and reliability**

To ensure reliability and validity of the instrument, Cronbach’s alpha test was employed. This is a measure of internal reliability for multi-item summated rating scales. According to Kent (2001), the coefficient varies between zero for no reliability to unity for maximum reliability and it is recommended that a value of 0.7 is achieved. It is assumed that if the alpha for any scale is greater than 0.7, it reflects an acceptable directive. For this specific research, the Cronbach’s alpha coefficient yielded 0.895, which reflects high reliability of the measuring instrument used for the research.

**FINDINGS**

Sample realisation

The results were analysed and interpreted based on the 240 returned questionnaires out of the 312 questionnaires that were distributed to the public and private sector employees. This constitutes a response rate of 77.2%. The overall number of respondents in the survey consisted of 192 males (80%) and 48 females (20%). Some 20.7% of the respondents were in the age group of 24 to 34 years, 34.0% ranged from 35 to 45 years, 31.1% were in the age group of 46 to 56 years and 14.1% were in the age group of 57 years and more. Furthermore, of the 240 responses, 49.2% of the respondents had a bachelor’s degree or postgraduate qualification, 27.5% had a national diploma, 22.9% had a matric qualification and only 0.4% had primary school education. In terms of the sector of employment, 66.5% of the respondents were in the public sector, which is a major provider of employment, 30.1% were in the private sector and only 3.3% were in mixed companies.
Table 1. Highest educational qualification distribution by statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Primary school level (%)</th>
<th>Matric level (%)</th>
<th>National diploma (%)</th>
<th>Bachelor's/Post-graduate degree (%)</th>
<th>Chi square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice of service provider when sick</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Private hospitals</td>
<td>0.0</td>
<td>41.2</td>
<td>51.6</td>
<td>68.0</td>
<td></td>
</tr>
<tr>
<td>2 Public hospitals</td>
<td>0.0</td>
<td>37.2</td>
<td>31.3</td>
<td>17.4</td>
<td></td>
</tr>
<tr>
<td>3 Traditional healers</td>
<td>0.0</td>
<td>2.0</td>
<td>1.6</td>
<td>0.0</td>
<td>0.005</td>
</tr>
<tr>
<td>4 Self-medication practice</td>
<td>0.0</td>
<td>9.8</td>
<td>10.9</td>
<td>2.8</td>
<td></td>
</tr>
<tr>
<td>5 Church/missionary</td>
<td>100*</td>
<td>9.8</td>
<td>4.6</td>
<td>13.6</td>
<td></td>
</tr>
<tr>
<td>Reason for choosing service provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.000</td>
</tr>
<tr>
<td>1 Cheaper price</td>
<td>0.0</td>
<td>45.1</td>
<td>22.2</td>
<td>10.2</td>
<td></td>
</tr>
<tr>
<td>2 Good quality of service</td>
<td>100.0*</td>
<td>45.1</td>
<td>42.9</td>
<td>57.4</td>
<td></td>
</tr>
<tr>
<td>3 My culture/behaviour</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>7.4</td>
<td></td>
</tr>
<tr>
<td>4 Reputation of the service provider</td>
<td>0.0</td>
<td>5.9</td>
<td>22.2</td>
<td>11.1</td>
<td></td>
</tr>
<tr>
<td>5 Other</td>
<td>0.0</td>
<td>3.9</td>
<td>12.75</td>
<td>13.9</td>
<td></td>
</tr>
<tr>
<td>Means of payment of medical bills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.004</td>
</tr>
<tr>
<td>1 The company/organisation pays</td>
<td>0.0</td>
<td>13.0</td>
<td>28.1</td>
<td>41.1</td>
<td></td>
</tr>
<tr>
<td>2 Out-of-pocket</td>
<td>100.0*</td>
<td>87.0</td>
<td>67.2</td>
<td>51.4</td>
<td></td>
</tr>
<tr>
<td>3 Medical insurance pays</td>
<td>0.0</td>
<td>0.0</td>
<td>1.6</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>4 Other</td>
<td>0.0</td>
<td>0.0</td>
<td>3.1</td>
<td>6.5</td>
<td></td>
</tr>
<tr>
<td>Knowledge about health insurance plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.000</td>
</tr>
<tr>
<td>1 Yes</td>
<td>0.0</td>
<td>19.6</td>
<td>53.1</td>
<td>68.7</td>
<td></td>
</tr>
<tr>
<td>2 No</td>
<td>100.0*</td>
<td>67.4</td>
<td>23.4</td>
<td>17.4</td>
<td></td>
</tr>
<tr>
<td>3 Somewhat</td>
<td>0.0</td>
<td>13.0</td>
<td>23.4</td>
<td>13.9</td>
<td></td>
</tr>
</tbody>
</table>

Regarding the type of employment status in the company/organisation, 96.2% of the respondents had full-time or permanent employment and 2.5% had part-time or casual employment.

DISCUSSION

Here, this study focuses on the discussion of the two tables which present the statements relating to SHI and inferential statistics for highest qualifications and sector of employment. Table 1 reflects the percentages of respondents relating to their highest educational qualification by statements and the chi-square P-value of statements. The findings from Table 1, regarding the choice of service provider when sick, showed that 68.0% of the respondents with a bachelor's degree/postgraduate qualification went to private hospitals when they were sick and 100% with primary school level education went to church/missionary hospitals. The chi-square P-value associated with this statement yielded 0.005.

In terms of service provider, the respondents attested that they made their choices on the basis of good quality of the service provided. This represents 57.4% of respondents with a bachelor's degree/postgraduate qualification and 100% of
Table 2. Sector of employment by statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Public sector (%)</th>
<th>Mixed companies (%)</th>
<th>Private sector (%)</th>
<th>Chi square (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Means of payment of medical bills</td>
<td></td>
<td></td>
<td></td>
<td>0.000</td>
</tr>
<tr>
<td>1 The company pays</td>
<td>10.6</td>
<td>62.5</td>
<td>71.2</td>
<td></td>
</tr>
<tr>
<td>2 Out-of-pocket</td>
<td>83.4</td>
<td>37.5</td>
<td>25.8</td>
<td></td>
</tr>
<tr>
<td>3 Medical insurance pays</td>
<td>0.7</td>
<td>0.0</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>4 Other</td>
<td>5.3</td>
<td>0.0</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Knowledge about health insurance plan</td>
<td></td>
<td></td>
<td></td>
<td>0.001</td>
</tr>
<tr>
<td>1 Yes</td>
<td>44.5</td>
<td>75.0</td>
<td>70.0</td>
<td></td>
</tr>
<tr>
<td>2 No</td>
<td>37.7</td>
<td>25.0</td>
<td>12.9</td>
<td></td>
</tr>
<tr>
<td>3 Somewhat</td>
<td>17.8</td>
<td>0.0</td>
<td>17.1</td>
<td></td>
</tr>
</tbody>
</table>

The results show that despite the level of qualification of respondents, the majority used out-of-pocket financing as a way to pay their medical bills. Of these, 100% had primary school level education, 87% did matriculation, 67.2% had a national diploma and 51.4% had a bachelor’s degree/postgraduate qualification.

It emerged from the statement “knowledge about health insurance plan” that 100.0% of respondents with primary school education and those that did matriculation (67.4%) did not know about the health insurance plan. 68.9% of their counterparts with a bachelor’s degree/postgraduate qualification did know about the health insurance plan. The chi-square test P-value for this item is 0.000; this shows a highly significant association between this item and the highest qualification. The findings also show that a high percentage (100.0%) amongst the respondents with primary school level education preferred going to church missionary hospitals when they were sick.

The percentage of the respondents’ sector of employment jointly by statements and chi-square P-value is presented in Table 2.

In terms of the method of payment of medical bills, it emerged that a greater percentage (83.4%) of the respondents in the public sector used out-of-pocket financing to pay their medical bills. 71.2% of their counterparts in the private sector indicated that their companies/organisations paid their medical bills. The chi-square test P-value is 0.000, which shows a high statistically significant association between this item and the sector of employment.

Fundamentally, 75.0 and 70.0% of those in mixed companies and private companies knew about the health insurance plan, respectively, while only 44.5% of those in the public sector knew about it.

There seems to be less interest by public sector employees in SHI. The rationale could be that there is no hope that they would ever be given support by their organisations or even the government, in that the chi-square test P-value represents 0.001, which means a statistically significant association.

**Limitations of the research**

Since this research was conducted in Kinshasa only, this may limit the generalisability of the findings to other settings and populations. Thus, further research should attempt to replicate and extend these findings to different areas of the DRC.

**Conclusions**

The primary objective of this research was to address the issue of the feasibility of SHI and to determine the challenges faced by employees in formal organisations regarding non-provision of SHI in Kinshasa, DRC. The findings on which the article is based suggest that there are challenges faced by employees in the formal sector. These challenges are as follow:

1. Employees from the public sector are not assisted in organising their health care.

   Consequently, they use the out-of-pocket system to pay their health bills. This in fact leads to poverty and vulnerability of the society.

2. Employees (71.2%) in the private sector highlighted that their companies/organisations paid their medical bills.

3. The majority of employees indicated that when they were sick they preferred to go to private hospitals rather than public hospitals. This is as a result of better services provided by the private sector. Contrary to this, employees with primary school level education (100%) went to the church/missionary hospital when they were sick.

4. Employees choose the health facility based on good quality service provided.

5. There is a need to revitalise public hospitals so that
people will use them and thus SHI will be successful.
6. It noted that employees in mixed companies and private companies know about the health insurance plan; whilst on average, employees in the public sector have little knowledge about it.

RECOMMENDATIONS

The following recommendations are made:

1. It is imperative to improve the infrastructure of public hospitals. As shown in the findings, the majority of the respondents indicated that they opted for private hospitals when they were sick and that this choice was made on the basis of quality service provided by private hospitals.

2. It is recommended that the public sector should assist their workforce to pay their medical bills on a pro rata basis.

3. It is imperative to educate employees about the introduction of SHI across the workforce spectrum.

4. Once the scheme is implemented, it is essential to monitor it to ensure that there is no abuse of the system by both members and service providers and as such government should build managerial capacity amongst those who will be monitoring the system.

5. The DRC should consider implementing SHI to ensure that employees and their families’ health problems are addressed, especially since the surveyed employees indicated that if the scheme was introduced, they would be willing to pay their contributions.

6. Should the government consider introducing the social health system, it is essential to market the scheme so that every employee will be conversant with it, since the scheme would be compulsory.

The discussion in the article provides valuable information on which employers and the government can develop a way of addressing the realities of health care matters in the DRC to ensure that the livelihood of the employees and their families is improved.

Above all, the introduction of SHI would ensure accessibility to affordable and high quality health care for all Congolese communities, irrespective of their wealth status. In conclusion, based on the responses from participants, there is an indication of willingness to pay their contribution should SHI be introduced. Thus, the government of DRC should consider its position of “health for everybody for 2000” which was initiated in 2005. This can address the challenges the employees in the formal sector are experiencing, particularly those in the public sector, since they are using mainly their own funds to pay their medical expenses.

REFERENCES


