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*Better Health & Social Care: How are Co-ops & Mutuals Boosting Innovation & Access Worldwide?*
An International survey of co-ops and mutuals at work in the health and social care sector (CMHSC14)
Volume 2: National Cases



For the research framework, the analysis of the national cases, and other research components, including a description of the research team members, refer to Volume 1: Report.

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# BURUNDI

2014

## HEALTH SYSTEM

Burundi's mechanism of insurance covered only 17.9 % of the population in 2012-2013, according to a "Survey on Demography and Health" carried out across the country as part of a government programme for social protection.[1] Delivery of health insurance occurred through several means: the Medical Assistance Card (CAM),[2] the Public Service Mutual Health Organization (MFP), community MHOs, and certificates of indigence. It may however have increased slightly since the survey was completed, due to government efforts to promote CAM enrollment.

According to the Burundi Ministry of Public Health and the Fight Against AIDS, 23% of the population are currently CAM members. However, future growth in membership could be discouraged by long waits for the reimbursement of health service expenditures. According to a second survey in 2012-2013, the CAM suffers from weaknesses in design and implementation.

The CAM is a bold initiative to extend Medicare beyond the formal sector to the mass of the people dependent on family agriculture. But its introduction in 2012 without preliminary technical studies seems to have put the efficiency and sustainability of the entire mechanism at risk. Evidently, the annual membership fee of $1.96 USD (3,000 BIF) per household was not determined based on a calculation of the cost of services, the ability of households to pay, and/or the potential level of public subsidy.

**Population** (in thousands): 9,850

**Population median age** (years): 17.64

**Population under 15** (%): 44.2

**Population over 60** (%): 3.87

**Total expenditure on health** as a % of Gross Domestic Product: 8.1

**General government expenditure on health** as a % of total government expenditure: 13.7

**Private expenditure on health** as a % of total expenditure: 40.5

As a result, the CAM is underfunded. This is the reason for the long delays for reimbursement and the accumulation of debts by health units. Furthermore, the MFP, which provides health insurance to public sector employees, covers a small fraction of the population (3.4%). The same goes for community MHOs. Their coverage rate is also extremely low: a mere 1.3% of the population.

## MUTUAL HEALTH ORGANIZATIONS

Despite the government's decision to subsidize 100% of the cost of health care for pregnant mothers and for children under five, access to health care for Burundi's rural population in general and the most vulnerable remains low. According to data provided by the Strategic Framework for Growth and the Fight Against Poverty (CSLP), 17.4 % of patients do not have financial access to health care, while 82% of patients in rural areas are forced to borrow or sell part of their property to pay their treatment. The government plans to solve this problem with the introduction of MHOs[3] in the rural sector in accordance with the policy of the Department of Public Health and the CSLP.

The National Policy on Social Protection designs MHOs based on family membership. Every householder would pay a single fee for dependents to a maximum of six people. The family premium per 6-person household would be around $6.48 USD (10,000 BIF). This amount would cover benefits only. Support from the government and its development partners would cover the additional dues. These supports may total at least $3.24 USD (5,000 BIF). The World Health Organization (WHO) estimates that the cost of primary health care in Burundi is about $2.00 USD per capita per year. The desired outcome is 100% adherence of the rural population to community MHOs in accordance with the "Burundi Vision 2025."[4]

Civil society has already taken steps in this direction; for example, the MHOs initiated in the Catholic diocese of Gitega and Muyinga. The producer associations grouped under the National Confederation of Associations of Coffee Producers (CNAC-Murimarusangi) have an MHO and are supported by the Association for the Support of Integral Development and Solidarity in the Hills (ADISCO). Another initiative is that of the Union for Co-operation and Development (UCODE) which established MHOs in the provinces of Ngozi, Kirundo, Muyinga, and Kayanza with funds provided by the NGO Louvain Coopération. Other MHOs are those supervised by SOS Médecin in certain parts of rural Bujumbura,

those of the Family to Defeat AIDS (FVS), and those framed by MEMISA Belgium and Health Net TPO.

Studies conducted by CORDAID Health Plus and Health Net TPO show that people deeply appreciate MHOs. With their membership cards, they are no longer forced to sell their land or crops for treatment. Some of them testify that before becoming MHO members, they were unhealthy because they repeatedly took incomplete cures for lack of means or they resorted to street drugs. MHOs have allowed them to heal properly, receiving full doses of the proper pharmaceuticals.[5]

Poverty in Burundi continues to increase. The decline in the price of coffee (the main source of income for most people) and the decline in agricultural production due to the fragmentation of land ownership are all factors that make people struggle to pay their contributions regularly or to renew their memberships. Complementary services were established to improve people's ability to contribute. These include microcredit in support of activities that enable a household to generate more income.[6]

## Case Study

Burundi is recovering gradually from more than a decade of civil war. This prolonged crisis has weakened the economy, destroyed the social fabric, and reduced the population. According to a 2012 UNDP report, more than 70% of Burundians live below the poverty line on less than $1 USD per day.[7]

Under these conditions, access to basic needs (food, education, quality health care, etc.) has become a real challenge.

Fortunately, for more than two years, initiatives have been taken, especially in the field of health, to alleviate the suffering of the population. In 2006, the government decreed free care for children under five and for pregnant mothers. At the same time, existing farmer organizations decided to invest collectively in the establishment of MHOs in order to improve access to quality care.

Coffee producers were among the first to take this kind of initiative. More than 100,000 families live directly from the sale of coffee (nearly 800,000 people, 10% of the population). Their associative movement dates back to the 1990s.

At the national level, the various associations of coffee producers are topped by the National Confederation of Associations of Coffee Producers, CNAC.[8] For several years, the movement has enjoyed coaching from Inades/Formation/Burundi. In the aftermath of the war, however, this organization had no expertise to help coffee producers to develop a mutual health insurance scheme. The associations instead had to call for support from a specialized organization, **ADISCO** (Support for Integral Development and Solidarity in the Hills).[9] Over the past year or more the project has evolved favourably. It has already set up a dozen MHOs across the country. "Today we are at 13.6% of households but our goal is that at least 40% will adhere to a mutual health insurance scheme initiated around each coffee washing station," said Déogratias Nawaz, coordinator of the association.

The producers remain the pillars of each MHO. ADISCO helps only in training, monitoring, and control, and by providing governance documents. In its design phase, each MHO is indeed totally driven by coffee producers. They undertake the management, under the watchful eye of ADISCO.

To access the benefits of a mutual health insurance scheme, each family is requested to pay an annual contribution of $8.70 USD (13,500 BIF). "It is an amount affordable for all but realistic for a family of six people; beyond that, a household must add $1.62 USD (2,500 BIF) per additional person. If they are not eligible for the free care available for pregnant mothers and children under five, the contribution would amount to $18.20 USD (28,000 BIF)," explains Déo Nawaz. Once a household enrolls in the mutual health system, each family member is entitled to all the care available at a public health centre with a co-payment of 20% (or 40% in centres run by the Catholic Church) to a maximum of $19.50 USD (30,000 BIF).

To this point, the system seems to be safe and very promising. However, to prepare for any eventuality, provision has been made to initiate a guarantee fund to reimburse hospitals (if a MHO were to close its doors, for example). "For each member, support starts after two months of observation. Each new MHO offers its services after reaching a membership of 250. With a membership of 600, each MHO should be self-sustaining, which should happen in five years," concludes Déo Nawaz.

**MUSCABU** (Mutual Health Organization of Coffee Producers of Burundi) is considered the most important programme for the promotion of access to social protection in Burundi. By August 2012 it had managed to enroll 14,830 household members (31% of the members of coffee producer associations) and 79,896 beneficiaries. However, its revenues are unpredictable. Coffee producers are subject to cyclical instability due to the "vagaries of climate," with perverse repercussions on revenue projections.

Like its predecessor, the project is run both by the CNAC and ADISCO. While the first 3-year phase of the mutual health insurance scheme (2008-2010) launched a movement with 26 MHOs, five unions, and a national federation, the second phase (2011-2013)

aims to strengthen the partners, the MHOs, and their networks in terms of their vision, their competence, their network affiliations, and their resources. The CNAC is responsible for activities complementary to MHOs, while ADISCO is responsible for the mutuality component as well as the coordination of the programme.

As for the MHOs themselves, the programme is at the crossroads. There are certain mutual associations (+/-17) which have definitively taken off due to strong leadership which can adapt to difficult situations. Others continue to rely on ADISCO and CNAC. The challenge for the programme is to strengthen both those which have demonstrated dynamism, and those which still need assistance.

Up to 2013, MHOs have treated 45,000 people. These included 1,693 cases of hospitalization and nearly 700 serious cases which could have irreversibly impoverished a household. MHOs have responded well to this situation by stepping up controls and by increasing the levels of contribution.

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[2] The Medical Assistance Card (CAM) system started in May 2012. Like the Health Insurance Card which it replaced, the CAM is sold in the offices of 129 communes in Burundi. The $1.96 USD fee entitles the member to health care in health centres and hospitals in the district, and to drugs available on the market, but at only 20% of the going rate. The remaining 80% is paid by the State of Burundi (partly through revenue raised by the sale of the CAM). AGnews. 2012. "Burundi: A petits pas la Carte d'Assistance Médicale avance." *Burundi Agnews*. December 12. Retrieved August 18, 2014 (http://burundi-agnews.org/sports-and-games/?p=4116).

[3] Within this framework, MHOs are non-profit organizations observing the general ethics of social and solidarity economy organizations.

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[7] United Nations system in Burundi and Government of Burundi. 2013. *Summary: BURUNDI Millennium Development Goals Report*. Retrieved August 18, 2014 (http://www.bi.undp.org/content/dam/burundi/docs/publications/UNDP-bi-mdg-en-summary-2013.pdf).

[8] CNAC is the National Confederation of Coffee Producers Associations of Burundi. It was founded in 2004 and is organized at four levels: associations (hills), unions of associations, cooperatives, federations of producers, and national confederation. See Confédération Nationale des Associations des Caféiculteurs du Burundi. 2014. Website. Retrieved August 18, 2014 (http://www.cnacburundi.org/index.php/notreinsti/22-qui-sommes-nous).

[9] ADISCO is composed of members subscribing to the values of the association and its strategic analysis, and who demonstrate a commitment to solidarity and development. Appui au Développement Intégral et la Solidarité sur les Collines. 2014. Website. Retrieved August 18, 2014 (http://www.adisco.org/adisco.php).