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Implementing social security health care

The experience of the Mutual Benefit Society for Public Employees

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1. Introduction

Burundi has an area of 27,834 square kilometers and a population of 7,200,000, equivalent to a population density of 258 per square kilometer. It forms an enclave between Rwanda to the north, Tanzania to the east and south and the Democratic Republic of Congo (Congo Kinshasa) to the west. Of all Burundians employed in the three chief sectors of the economy, 93 per cent work in the primary sector, 2 per cent in the secondary sector and 4 per cent in the tertiary sector.

Population indicators include a gender breakdown of 46.76 per cent men and 53.24 per cent women. Urban dwellers are estimated to be 8 per cent compared with a rural population of 92 per cent. The literacy rate is around 37.5 per cent whilst life expectancy at birth is 44 years for men and 48 for women. The leading causes of morbidity in Burundi are malaria, respiratory infections and parasitic intestinal diseases. The leading causes of mortality are malaria, respiratory infections, malnutrition and AIDS.

Elderly persons (aged 65 and over) make up around 3.2 per cent of the country's total population. Children under 10 years account for 31.53 per cent.

Persons insured by the Mutual Benefit Society for Public Employees (*Mutuelle de la fonction publique* (MFP)) account for roughly 21.53 per cent of the economically active population. The latter group, in the age range 14 to 65, forms 56.1 per cent of the total population of Burundi.

Burundi has four mechanisms for funding the cost of health care provision: a compulsory health insurance scheme for public servants and equivalent personnel, an employer-funded scheme for employees in the formal private sector, a pre-payment scheme for the self-employed and rural population and a system of social welfare for those without means.

Health expenditure is about 3.6 per cent of the gross domestic product (GDP).

2. Description of the scheme

Access to health care in Burundi has always varied according to the socio-professional category of the population group concerned. These groups fall into one of two major sectors, namely the formal economy and the informal economy.

Formal employment encompasses categories of people who are covered either by specific terms of employment (civil service, magistracy, police, armed forces, etc.) or the provisions of the labour code (workers in public- and private-sector enterprises, persons under contract to the government). The informal sector covers the self-employed and rural population.

The development of health insurance systems in Burundi spans over two main periods: that prior to August 1980 and that following August 1980. In 1980 a compulsory health insurance scheme for public servants was set up as part of the overall social security system, and, as will be seen in the following paragraphs, this measure marked a dynamic new step in the funding of health care in Burundi.

2.1. Background to health insurance in Burundi

2.1.1. Prior to August 1980

2.1.1.1. Formal employment sector

Up to July 1980 persons employed under a range of specific public service employment regulations, namely civil servants, magistrates, officials of the judiciary, members of the various branches of the police and armed forces and retired civil servants, received free health care paid for by the State, making only a very modest out-of-pocket contribution themselves. Persons under contract to the government, however, as government employees governed by the provisions of the labour code, were not entitled to free health care on the same basis as permanent government employees and had to fund their own health care.

Persons working for public- and private-sector enterprises had their health care costs paid by their employers, as stipulated by the labour code, making no contribution themselves. But on reaching retirement age, these persons too had to fund their health care themselves.

2.1.1.2. Informal employment sector

Persons working in the informal sector - the self-employed and rural population - had to meet the full cost of their health care themselves.

2.1.2. After August 1980

2.1.2.1. Formal employment sector

As indicated earlier, 1980 marked a turning point in the funding of health care in Burundi, with the establishment of a health insurance scheme for public servants and equivalent personnel, representing a significant innovation in the field of social security.

It became mandatory for all persons covered by the various public service employment regulations to be enrolled in this scheme. As a result persons under contract to the government received the same benefits as permanent public servants and were likewise

covered by the health insurance scheme. Also enrolled in the compulsory insurance scheme for public servants were persons working for public-sector enterprises, students in higher education, local government employees and retired officials governed by the provisions of the labour code.

Only employees of private-sector enterprises continued to benefit from the system of free employer-funded health care. But this system proved inept and hard to apply and the revised labour code of 1983 decided on health insurance as the system of health care funding for this sector. Until such time as health insurance for the private sector becomes a reality, the system of employer-funded free health care remains in effect.

2.1.2.2. Informal employment sector

One of the essential aims in establishing the health insurance scheme for public servants was to free the State from the burden of having to provide free health care for civil servants and thus enable it to use the resources thereby made available to improve health care provision for rural populations and the self-employed. In pursuit of this objective, a "health card" was introduced on 20 March 1984 entitling the holder and his/her family to receive care and medicines free of charge in State-run health facilities. An out-of-pocket charge of 20 per cent of the cost of care was introduced from May 1996. A three-tier charge was set for this card: tier one for persons earning their livelihood from farming, stockbreeding and subsistence fishing; tier two for artisans and small traders, and tier three for businessmen and other categories of self-employed persons. Under Article 5 of the relevant ordinance, the full cost of health care for persons without means is borne by the State. Since 2003 that cost has been split between the central government (80 per cent) and local government (20 per cent).

2.2. Health insurance scheme for public servants and equivalent personnel

The health insurance scheme for public servants and equivalent personnel was set up under Decree Law No. 1/28 of 27 June 1980 and is administered by the Mutual Benefit Society for Public Employees, established on the same date by Decree Law No. 100/107.

It had finally been realized that the system of free health care for certain public servants, a relic of colonial times, was placing an increasingly heavy burden on the State, leading to inequalities of treatment between different sections of the population and even between different categories of public servants.

In setting up a contributory and compulsory scheme of health insurance for its officials the Government of Burundi hoped, on the one hand, to end these inequalities and, on the other hand, to free up resources which could be used to improve health care for the self-employed and rural population once it was relieved of the burden of providing free care for public servants. The government also wanted to make public servants share the burden of social responsibility by making them contribute to the costs and involving them in the management of a reliable and financially sound venture based on solidarity.

2.2.1. Organization

2.2.1.1. Coverage

The Mutual Benefit Society for Public Employees progressively extended the scope of its health insurance cover as follows:

August 1980	Civil servants; Magistrates; Police; Officials of the judiciary; Persons drawing a civil service pension.
1981	Armed forces; Employees of public-sector enterprises; Students in higher education.
1984	Local government officials.
1986	Persons drawing a pension from the National Social Security Institute (*Institut national de sécurité sociale*) (former officials governed by the labour code).

All these persons are insured, along with their statutory dependants. Together with their families they now make up about 13 per cent of the total population of the country and 21.53 per cent of the economically active population.

2.2.1.2. Risks and benefits covered

The Mutual Benefit Society for Public Employees covers health benefits in kind, more specifically the following maternity-related costs - treatment costs for natural illness, pregnancy, childbirth and follow-up care. The Mutual Benefit Society for Public Employees meets the cost of curative health care provided exclusively within the country, not abroad.

The items entitling reimbursement have also evolved gradually. From 1980 to 1985, the only costs reimbursed were those of medicines and drugs, but from 1986 onwards reimbursement was extended to include other expenses as well (medical acts, in-patient treatment, paraclinical investigations).

2.2.1.3. Eligibility for reimbursement

In order to qualify for benefits from the Mutual, members must first be enrolled, must hold a member's insurance card and be able to demonstrate that they pay monthly contributions out of their earnings. They are eligible for benefits after paying one month's contributions and remain entitled to benefits for three months after their insurance ceases.

The system for providing benefits takes two forms: indirect distribution for medical acts, in-patient treatment and paraclinical investigations, and a hybrid system (direct and indirect) for medicines and drugs.

The system of reimbursement used is direct settlement. The cost of medical acts, in-patient treatment and paraclinical investigations are reimbursed at a flat rate of 80 per cent, whilst

medicines and drugs are reimbursed at rates differentiated in relation to the cost of generic drugs. Thus generic drugs are reimbursed at a rate of 80 per cent and proprietary drugs for which no generic equivalent is available are reimbursed at 70 per cent. If the beneficiary opts for a proprietary drug when a generic equivalent is available, the Mutual Benefit Society for Public Employees reimburses 80 per cent of the cost of the generic drug and the patient will, in addition to his/her 20 per cent out-of-pocket contribution, pay the difference between this and the cost of the proprietary drug. Medicines and drugs for chronic medical conditions are reimbursed at a rate of 90 per cent for generic drugs, 80 per cent for proprietary drugs with no generic equivalent and 90 per cent of the rate for the generic drug if an equivalent generic drug is available but the patient opts for a proprietary drug.

The reimbursement system also makes reference to a scale of fees for medical acts, in-patient treatment and paraclinical investigations and a schedule of approved drugs. The former are reimbursed on the basis of official fees set by law and the cost of drugs is reimbursed on the basis of tariffs agreed between the Mutual Benefit Society for Public Employees and its partners.

2.2.1.4. Financing

The major change to the financing of health care brought about by the health insurance scheme for public servants and equivalent personnel was undoubtedly the introduction of a system of shared contributions payable by both workers and employers. During the period 1980 to 1985, when the Mutual Benefit Society for Public Employees only covered the cost of medicines and drugs, the total contribution was 4 per cent of the worker's salary, paid in equal halves by the worker and his/her employer. When cover was extended in 1986 to include medical acts, in-patient treatment and paraclinical investigations, the total contribution was increased to 7.5 per cent of the worker's salary, 4.5 per cent of this payable by the employer and 3 per cent by the worker. From January 1999 it rose again, to 10 per cent broken down into 6 per cent for the employer and 4 per cent for the worker. The Mutual Benefit Society for Public Employees has never as yet received any subsidy from the State, though the law makes provision for its resources to include government funding.

2.2.1.5. Collection of contributions

The worker's contribution is deducted from his/her salary and is forwarded to the Mutual Benefit Society for Public Employees at the end of each month by the employer along with the employer's own contribution. The government and public-sector enterprises have always fulfilled their obligations regarding regular payment of the contribution. Collection is not always regular, however, from some public-sector services and local authorities which experience cash flow difficulties. As a result the collection rate for contributions is approximately 90 per cent.

2.2.2. Administration

The health insurance scheme for public servants and equivalent personnel is administered by the Mutual Benefit Society for Public Employees, an administrative public-sector establishment which is under the supervision of the minister responsible for the civil service. The Mutual Benefit Society for Public Employees has a seven-member board comprising three representatives of the government, three representatives of its enrolled members and one representative of the Mutual's staff. Day-to-day management of the Mutual Benefit Society for Public Employees is the responsibility of a director-general, assisted by three

directors: the administrative and financial director, the technical director and the director of pharmacies. Its accounts are scrutinized by two government-appointed auditors.

3. Issues and challenges

Since inception, the Mutual Benefit Society for Public Employees has faced a number of problems which have constantly threatened its financial equilibrium. These problems were due essentially to the Mutual's lone status as the only body in the country operating a reliable system of health insurance, in a situation where contributions received are not enough to cover the cost of benefits paid out, especially the cost of medicines and drugs.

3.1. Lone status of the Mutual

The Mutual Benefit Society for Public Employees covers only public servants and equivalent personnel, in other words a small section of the population which is only about 13 per cent of the total population of the country and 21.53 per cent of the economically active population. Due to this situation it has not only been unable to benefit from the law of large numbers - one of the important balancing factors for any insurance company - but it has also been vulnerable to all types of benefit frauds by people who have no health insurance or inadequate health insurance coverage.

In an effort to overcome the disadvantage of its lone status and fight benefit fraud, the Mutual Benefit Society for Public Employees has always sought to operate a number of controls on the acquisition of benefits and to monitor its members' consumption and the behaviour of health care providers. But the efficacy of these controls has remained fairly limited because no concrete measures have been taken to remedy the lack of cover, or its inadequacy, for the other sectors of the population, which is in fact the fundamental cause of this fraud. For this reason the Mutual Benefit Society for Public Employees has worked energetically to promote every activity conducive to the establishment of reliable health insurance systems for the other sectors of the population. The health insurance scheme for the formal private sector, introduced by a law promulgated in 2000, is part of this strategy, though it is not yet fully implemented.

3.2. Imbalance between contributions received and cost of services provided

The Mutual Benefit Society for Public Employees has struggled, and continues to struggle, with an ever-widening discrepancy between contributions received and the cost of benefits paid out, particularly for medicines and drugs. More than 90 per cent of these are imported from abroad and purchased in foreign currency, and the cost is reimbursed out of contributions calculated on the basis of public servants' salaries which, as is well known, are not all that quick to change. Continuing devaluation of Burundi's currency against the currencies in which imports have to be paid for is pushing drug prices to astronomical heights. The situation is complicated still further by other factors such as the AIDS pandemic.

The Mutual Benefit Society for Public Employees has adopted the following solutions in an attempt to cope with this imbalance between contributions and the cost of benefits:

- creation of mutual pharmacies;
- promotion of generic drugs;

- exemption of medicines and drugs from customs duties and sales tax;
- raising the rate of contributions.

Creation of mutual pharmacies

By putting money into providing benefits directly through its own pharmacies, the Mutual Benefit Society for Public Employees sought to make these the point of reference for keeping drug prices as low as possible and stable. It also sought to correct a number of imbalances in the geographical location of private pharmacies, because it was through its own pharmacies that the Mutual Benefit Society for Public Employees hoped to promote its policy of encouraging the uptake of generic drugs.

The Mutual currently has 15 dispensaries, five in the capital Bujumbura and 10 in the provinces, where scheme members and the rest of the population can obtain quality drugs at reasonable prices. The Mutual's pharmacies thus form one of the country's largest groups in terms of the quantity of products imported and sold. But the ideal solution and the only way of ensuring that drugs are available and affordable which makes sense in the long term, both for the Mutual and for the country generally, lies in developing the national pharmaceuticals industry - a project which has not taken shape as yet.

Promotion of generic drugs

The modest level of resources generated by members' contributions made it unrealistic for the Mutual to continue reimbursing the cost of expensive products when less expensive but equally effective products were available. For this reason, from 1999, it has operated a system of differentiated reimbursement for medicines and drugs, paying out more generously for the uptake of generic drugs. This system is described in section 2.2.1.3 of this report.

Raising the rate of contributions

By 1998 the financial imbalance had reached a level where the viability and sustainability of the health insurance scheme were in doubt, and so from January 1999 the total contribution was increased from 7.5 per cent to 10 per cent, with the employer paying 6 per cent and the worker 4 per cent.

Exemption of medicines and drugs from customs duties and sales tax

One reason for the high cost of medicines and drugs in Burundi was the duties and taxes charged on them. The Mutual succeeded in convincing the government that by exempting medicines and drugs from the main duties and taxes, and thus making them more affordable and making health care in general more accessible, it stood to gain more than the value of the duties and taxes levied on these products, because a healthy and well looked-after population would also be a more productive population. So since January 2000, medicines and drugs have been exempt from customs duties and sales tax.

4. Recent and future health reforms

Burundi's Mutual Benefit Society for Public Employees cannot continue to be the country's sole provider of health insurance and if it is to be sustainable and viable in the long term it must extend the scope of its operations, offering, on the one hand, compulsory health insurance to workers in the private sector and to all self-employed persons demonstrably

earning a regular income and, on the other hand, encouraging and organizing the rural population with a view to the establishment of community-based mutual benefit societies. This is the thrust of the reforms currently under way in the country.

For its part the Mutual has introduced recent reforms which have increased the sums reimbursed for drugs to treat chronic medical conditions and have improved the accessibility of benefits and services by revising the fees charged for them.

The Mutual also plans to broaden the range of its services by reimbursing the costs of prescription optical products and antiretroviral drugs. A general and actuarial review of the health insurance scheme for public servants and equivalent personnel is already under way, with the aim not only of quantifying the financial implications of funding these new benefits but also of assessing the scheme's capacity for expansion and in order to draw up a five-year plan.

5. Conclusion

Burundi's Mutual Benefit Society for Public Employees has just celebrated a quarter of a century's existence. It has reached full maturity as an institution and has made its mark on the country's social sector.

Not only has it provided easy access to health insurance for public servants; it has also contributed significantly to the development of health care facilities. It has mobilized considerable resources in the form of contributions which it has fed into the financial circuit through its reimbursement of health care costs to health care facilities and pharmacies. Surplus revenues which have to be put into a range of statutory reserves have been invested as and when appropriate in the various sectors of the national economy in bank deposits and company equities. The Mutual has also put money into the direct provision of services, by setting up its own pharmacies.

In the course of its 25-year history, the Mutual has become part of the everyday language of the people of Burundi because it has become synonymous with value for money. Businesses which charge fair prices are referred to as "mutuals". When someone has secured a good deal on a purchase he will say "I paid a mutual price for this". And public-sector employees candidly admit that they stay in the job chiefly in order to retain their insurance cover with the Mutual. Job applicants always ask if the post in question carries eligibility for mutual benefits. All this just goes to show that the Mutual currently occupies a position of choice in the financial, social and cultural life of the nation.

Internationally, the experience of Burundi's Mutual Benefit Society for Public Employees has become a yardstick for measuring creativity and success in social security to the point where other African countries have already intimated that they will emulate it when they introduce health insurance into their own systems of social protection. The most striking example is the Rwandaise Health Care Insurance (*La Rwandaise d'assurance maladie* (RAMA)) in Rwanda, the health insurance scheme for government employees, which has been operational since 1 March 2001 and is modelled largely on the experience of Burundi's Mutual Benefit Society for Public Employees.

In view of the above, and despite all the difficulties described in this report, due essentially to the fact that Burundi is a poor country and has been in a situation of crisis for the last 10 years, it is evident that if Burundi's Mutual Benefit Society for Public Employees did not

exist the people of Burundi would have many reasons to invent it. But fortunately it already exists, and every effort must be made to safeguard it.

Safeguarding this institution will go a long way towards achieving the ultimate objective of all the endeavours in this country, namely the assurance of knowing that the people of Burundi can "live in the present without fear for the future, even if they fall ill".