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RESEARCH ARTICLE

EFFECTS OF THE USE OF MEDICAL ASSISTANCE CARD (CAM) ON RURAL HOUSEHOLDS HEALTH SPENDING.

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Abstract

This government measure of financing health through subsidies aim at a long-term objective of "health for all" in particular rural people who are normally poor and financially excluded from healthcare services. The cost of one CAM is BIF 3000 (=$1.69) and is bought by household. The government pays subsidies to health centers according to the quantity of patients received. The beneficiaries of medical assistance card (CAM) are divided in two categories of people: (i) children aged between 5 years to 13 years old and from 14 years and above. Outpatient for the first category pays BIF 800 (=$0.45) while outpatient for the second category pays BIF 500 (=$0.25). And admitted patients for the two categories pays BIF 1000 (=$0.56) per day. And the government reimburses BIF 3200 (=$1.80) to health centers for health care services provided to a patient aged between 5 years and 13 years and BIF 2000 (=$1.12) for a patient aged from 14 years and above. With regards to admitted patients, the government reimburses BIF 360 (=$0.20) per day. This paper empirically evaluates the effects of the use of medical assistance card (CAM) on households health spending. The paper argues that CAM holders are paying higher cost on drugs in the private sector while the government reimburses health centers for services not provided to beneficiaries.

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Introduction:-

This government measure of financing health through subsidies aims at a long-term objective of "health for all" in particular rural people who are normally poor and financially excluded from healthcare services. The government introduced then the medical assistance card (CAM) as a solution to this health care issue. Though the CAM is sold at cheapest price ($1.69), its benefits are huge. The patients who possess CAM pays only BIF 800 (=$0.45) when he/she is aged between 5 years and 13 years old and BIF 500 (=$0.25) when the patient is aged from 14 years old and above. In case of admission, the beneficiary pays BIF 1000 (=$0.56) per day. The government reimburses to health facilities that implement the policy BIF 3200 (=$1.80) for outpatients aged between 5 years and 13 years old, BIF 2000 (=$1.12) for outpatients aged from 14 years and above while it also reimburses BIF 260 (=$0.14) per day of admission for both categories.

The results of our study show that the purchase of CAM is not dependent on household's monthly income. For example, of the 200 rural households surveyed, 67% have purchased CAM. The majority of households (90.29%)

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that possessed CAM have an income comprised between $0 and $20. This number decreases from households that have a monthly income above $20 per month. And of the 200 rural hoseholds, 33% did not purchase CAM. Of the 66 households that did not purchase CAM, 95.44% have a monthly income comprised between $5 and $25. The number of households decreases from those with $ 30 as their monthly income. However, out of 134 households that possessed a CAM, 43 households representing 32.08% had no income or at least had uncertain monthly income while of the 66 households that did not possess a CAM during out study, 22 households representing 33.33% had no or at least had unercertain income.

The results also show that beneficiaries who get curative consultations done at government health centers doubt its quality and for the same sickness, 24% of patients consult different health care providers including prayer rooms and traditional doctors.

Of the 200 households surveyed, 182 (91%) patients prefer to get their prescribed medicines from local government health center's pharmacies because it is cheaper. And of the 182 patients, 71.97% were beneficiaries while 28.02% were not. However, we have found that government pharmacies were not able to satisfy the demand of drugs from at least 156 patients: And among them, 131 patients had CAM while 25 others had not.

This is also to say that out of 156 patients who went to buy medicies at their local government health center's pharmacies, 150 (96.15%) were not able to get them as prescribed by nurses. And out of 66 households without CAM, 41 (62.12%) households prefer to go directly to buy medicines at private pharmacies because they believe government pharmacies make no difference in terms of availability of medicines while 25 (37.87%) prefer to begin at government pharmacies because the cost is much cleaper than in private pharmacy where they only go to buy the balance not found at government pharmacies. Thus, 14 (56%) patients without CAM who did not receive all prescribed medicines at local government pharmcies were able to afford the market prices and bought them at private pharmacies while 11 (44%) patients without CAM have bought all their priscribed medicines at private pharmacy because they did not get any medicines at government pharmacies.

We have found that 60 (45.8%) were patients who could get a portion of their prescribed medicines at government pharmacies but also who were able to afford the private pharmacies prices to complete their medicines. And 4 (3.05%) patients who possessed CAM did not receive all prescribed medicines at local public health center's parmacies and went to buy some medicines at private pharmacies, but were not able to buy all prescribe medicines. We have also find that 54 (41.22%) patients with CAM who did not receive any medicines at their local government health centers' pharmacies; at least, they were able to afford the market prices and have bought them all at private pharmacies. And other 7 (5.34%) patients with CAM who did not receive any medicines at their local public health center's pharmacies were also unable to get money to buy them at private pharcies. In fact, only 6 (4.58%) out of 131 CAM patients have received all prescribed medicines at govenment health centers's pharmacies.

The results also show that of the 99 CAM patients, only 12 (12.12%) were treated at official cost while 87 (87.87%) were treated at higher cost than what they were supposed to pay. The total amount that outpatients holders of CAM have paid is $1292.89. At the official cost the total amout that was pais is $4.06%. According to how the policy is to be implemented, there was $1288.83 that the government had reimbursed whereas it includes the official cost already paid by patients.

This paper empirically evaluates the effects of medical assistance card (CAM) on household's health spending in order to improve universal coverage. The paper concludes that beneficiaries of the medical assistance card are paying higher prices in the private sector while the government reimburses health facilities for services not provided to beneficiaries and for which patients have already paid.

Data and Methods:-

The data on CAM holders and health spending were collected in the hill rural area of Muhuta commune, in the Province of Rumonge in Burundi. The core sample of villages was randomly selected from 4 zones of the commune with probability of proportional to the number of villages. The number of 200 households was drawn in four parts. The first part represented a core sample of 89 households selected objectively from zone Gitaza with probability proportional to the number of households. The second part represented a core sample of 34 households also selected objectively from zone Rutongo with probability proportional to the number of households. The third part represented a core sample of 32 households all selected objectively from zone Busenge with probability proportional

to the number of households. The fourth part represented a core sample of 45 households selected objectively from zone Muhuta with probability proportional to the number of households. Households were randomly selected and surveyed. They were small rural farmers and uneducated people whose income is uncertain, unstable and weak because it depends mainly on the generosity of the climate and soil. They were asked whether they have or have not a CAM and their experiences when they visit local health care facilities.

All questionnaires were schedule questionnaires and were filled in by survey agents who climbed mountains to meet them in their villages. The survey agents were well trained to record exactly in the same wording the responses and without influencing the respondents. The respondents were assured of anonymity and confidentiality of their responses. All households were unable to remember the exact amount they spend every year on their health because they don't keep any record on regular basis. The raw data collected was captured and statistically analyzed in order to draw conclusions on the outcomes of how the policy is being implemented on the ground. The field research was conducted in the month of July 2018 and questions covered the period from July 2017 to July 2018. Responses were asked and answered in the local language Kirundi.

Previous Studies

Universal Health Coverage

Fragmentation refers to many small insurance schemes and a wide range of health care providers paid from different funding pools. Fragmentation reduces the possibilities for income and risk cross-subsidies in the overall health system. The aim is to achieve universal coverage through pooling risk to the greatest extent possible, an equitable health system where ability-to-pay determines financing contributions and the use of services is on the basis of need for care. In this context, user charges and other out-of-pocket payments are reduced and the level of prepayment is increased in a way that maximizes the size of risk pool. Though the 2005 World Health Assembly called for universal coverage in health systems, health sector reforms have increased inequities in access to affordable health care in many African and other low- and middle-income countries. The poor were and are still disadvantaged by a health care provided by privately organized care on the basis of ability-to-pay (Diane Mc. et al. 2008). Universal health coverage is the single most powerful concept that public health has to offer, as a way to reduce financial impoverishment caused by health spending and increase access to key health services (Gina L. et al. 2012).

The introduction of risk sharing strategies through community-based health insurance have fuelled health system fragmentation, with over a hundred individual medical schemes in South Africa and, similarly for CBHI, in Ghana even though they covered a small proportion of the population (Diane Mc. et al. 2008; Gina L. et al. 2012; Wright et al. 2016).

Out-of-pocket payments represent the most extreme form of fragmentation as they place the burden of health-care funding on an individual and translate into health service use, and hence benefits, being distributed according to ability-to-pay rather than need for health care.

However, the relatively high share of out-of-pocket expenditures as a percentage of total expenditure on health severely limits the potential for universal coverage by excluding the poorest with the greatest health risks. Of course, national health insurance is not the only way that countries can work towards universal coverage. For instance India has launched both the Rashtriya Swasthya Bima Yojna (national health insurance program: RSBY), that relies on private insurers and mainly private hospitals to deliver fully subsidized inpatient care to poor people, and the National Rural Health Mission, that provides budget support to expand and improve free primary care in public clinics.

Community-based health insurance (CBHI) is often included in the universal health coverage strategies of low- and middle-income countries because of its perceived comparative advantage in targeting and enrolling underserved, uninsured, and largely informal-sector populations into risk-pooling schemes. However, due to the fact that enrollment to CBHI is often voluntary or not enforced; they became vulnerable to adverse selection, where disproportionate enrollment by high-risk individuals accompanies non-participation by low-risk individuals.

Some few examples of private health insurers and private CBHI schemes targeting lower-income households or workers in the informal sector exist in some countries but in general, this model does not contribute significantly to population coverage in countries with small formal sectors (Diane Mc. et al. 2008; Gina L. et al. 2012; Wright et al. 2016).

Medical Assistance Card (CAM)

Under the first republic in the 1980s, health care services were free in Burundi. But due to lack of financial means, the government was unable to provide primary health care services to its population and medical consultation payment was introduced. The medical insurance card as was called at that time was bought by households and its holder was provided with free health services. By 1988, the ministry of public health introduced a new reform and decentralization policy that emphasized (i) increase of the contribution of local communities to health services income through the payment of medical consultation, (ii) gradual implementation of user fees mechanism in all health structures, (iii) establishment of autonomy in management for all health structures at the provincial level, and (iv) creation of structures at local level which would facilitate dialogue and high collaboration between provincial and community levels. And this continued to be applied up until in 1999 when a joint circular note from both the ministry of public health and ministry of finance announced the modification for the prepayment system and the introduction of payment at consultation.

A circular note also issued in 2002 by the ministry of public health indicated that the World Bank (WB) has donated a fund in the frame of emergency and rehabilitation loan to the entire provincial office and it intimated to start implementing a user fees system.

And in 2003 indigent card was introduced. This indigent card helps orphans, very old people, and persons without any piece of land, beggars, and sometime people without any family member to get free healthcare services. And by end of 2005, the government, through the national commission for reintegration of people affected by the 1993 political conflict provided vouchers to internal displaced persons (IDPs) and returned refugees (MSF 2004).

Burundi health coverage system comprises public and private mechanisms. The public sector include: The mutual insurance (MFP), the national institute for social security (INSS) and health assistance card (CAM). Health pre-payment mechanisms are only concerned with 10 per cent of the population.

The Health Assistance Card (CAM=Carte d'Assistance Médicale) was initiated by the Government of Burundi in 1984, for the benefit of farmers, artisans and small business persons with low-income. The CAM allows coverage of 80 per cent of the cost of lab tests, consultations and hospitalizations. However, the beneficiary had to pay for both the medications and the remaining 20 per cent balance. The primary difficulties lied in the lack of reimbursement by the government to certain providers which caused a reticence to offer care to persons with CAM. In the long-term, this situation has discredited this means of payment and has also constituted a disincentive for the population.

The 1996 amendment restricted the CAM to the self-employed and set differential premiums according to strata within this group: 500 Fbu (Burundian francs = $2.25) a year for farmers, pastors and fishermen; 1,500 Fbu ($4.5) a year for artisans, retailers and shopkeepers not registered with the tax services; and 3,000 Fbu ($13.5) a year for artisans, retailers, shopkeepers and other self-employed registered with the tax services (at 1996 exchange rates). Since 2012, the CAM cost is fixed at 3000 Fbu (=$0.28 (today's rate: $1=BIF 1770)) and the province of Bujumbura where was located my commune of interest was covered at only 5.6 per cent which represented the lowest coverage in the country.

Despite its apparent attractiveness, the CAM never reached more than 10-25 per cent of the population. By 1999, the CAM was interrupted by lack of public resources and escalating needs. And in 2006, one out of three (1/3) Burundians did not seek healthcare when in need, of which eight out of ten (8/10) because they could not financially afford it (PNDS 2011; WHO Report 2010). The Carte d'Assurance Médicale was changed into Carte d'Assistance Médicale in May 2012.

The population had difficulties to access health care due to high health care services tariffs and weak purchasing power especially populations in rural and urban areas who were not insured or without any solidarity mechanism permitting them share health care services cost. The CAM policy was formulated and implemented by the government initially to enable noninsured population to have financial access to health care services. The CAM contributed 0.4 per cent of the total health expenses. Health financing with CAM mechanism did not last longer and was later abandoned due to lack of finances and some difficulties related to its use. In principle, indigents had the right to free health care services but in reality local community authorities that were supposed to deliver indigent certificates to exempt them from paying, were not sensitized enough to do so, and were tempted to deny delivering them. This lack of sensitization was motivated by the fact that communes were to cover (20%) of health care

services cost of the indigent patients. Corruption was also another barrier to the successful implantation of the CAM policy. Other problems included insufficient medicines; lack of sufficient competent and motivated personnel; poor healthcare quality; very low healthcare tariffs with regards to the real healthcare production cost, delays or sometimes no payment at all of bills by communes, the government or MFP. The other difficulties come from the fact that cost recovery policies at the level of health care centers and the right of autonomy of management given to hospitals had led to big problems related to health care access for the majority of the population (NHDP 2006-2010; MSF 2004; PRSP I, HRW 2006).

Results:-

Income and Possession of CAM

The measure of the government to introduce CAM for children ageed between 5 years and 13 years old and children from 14 years and adults intendes to assist poor people to access health care facilities and services. Local government sells one CAM at BIF 3000 (=$1.69). This part analyses if the possession CAM depends on how much a household is earning per month.

The results of our study show that of the 200 rural households surveyed, 67% have purchased CAM. The table below indicates that the majority of households (90.29%) that possessed CAM have an income comprised between $0 and $20. This number decreases from households that have a monthly income above $20 per month. Of the 134 surveyed households who possed CAM, 32.08% are those who declared to have zero income. When compared to non CAM holders, we found that there are 87.87% households within the same income interval of $0 to $20. However, out of 134 households that possessed a CAM, 43 households representing 32.08% had no income or at least had uncertain monthly income while of the 66 households that did not possess a CAM during out study, 22 households representing 33.33% had no or at least had unercertain income. The possession of CAM is not dependent on the household's income because we found only a slight difference of 1.25% (33.33%-32.08%) between having a CAM and the households monthly income.

Table 1:-Income And the Possession of CAM

INCOME $	POSSESS CAM	PERCENT	NOT POSSESS CAM	PERCENT
0 - 5	53	39.55	26	39.39
5 - 10	26	19.4	16	24.24
10 - 15	24	17.91	14	21.21
15 - 20	18	13.43	2	3.03
20 - 25	5	3.73	5	7.57
25 - 30	4	2.98	1	1.51
30 - 35	1	0.74	1	1.51
35 - 40	2	1.49	0	0
40 - 45	1	0.74	1	1.51
45 - 50	0	0	0	0
50 - 55	0	0	0	0
55 - 60	0	0	0	0
60 - 65	0	0	0	0
65 - 70	0	0	0	0
70 - 75	0	0	0	0
75 - 80	0	0	0	0
80 - 85	0	0	0	0
85 - 90	0	0	0	0
90 - 95	0	0	0	0
100	0	0	0	0

Source: My field research

CAM Holders and Households Health Spending

CAM Outpatients Spending

With regards to CAM policy, outpatients children aged between 5 years and 13 years old pay BIF 800 (=$0.45) per day and those from 14 years and above pay BIF 500 (=$0.28) per day(official rate was $1=BIF1770). The results of our study show that 73.88% of CAM outpatients who visited a local public health center have paid out-of-pocket

money for their curative consultations and treatment. This part analyses health spending by CAM outpatients at local health centers.

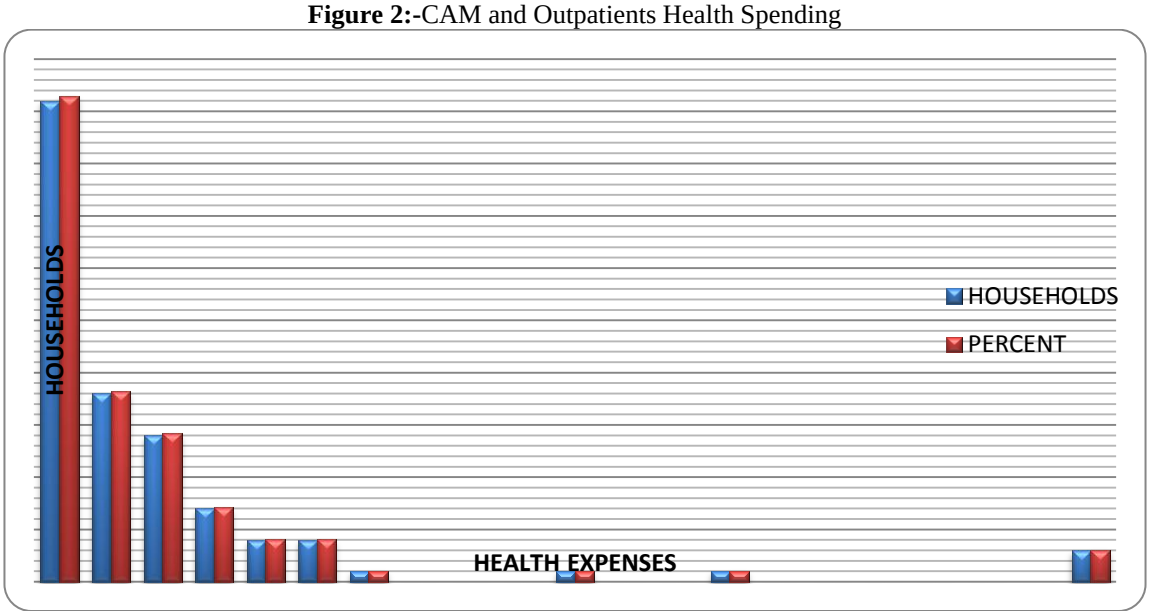
The results from the data we collected indicated that of the 99 CAM outpatients, only 12 (12.12%) were treated at official cost while 87 (87.87%) were treated at higher cost. The total amount that outpatients holders of CAM have payed equals $1292.89 (BIF 2288430). At the official tarrifs the total amout that was paid is $4.06. According to how the policy is to be implemented, there was $1288.83 that the government had reimbursed and which included the official cost already paid by CAM patients who paid more than official tarrifs set by the government.

Table 2:-CAM and Outpatients Health Spending

EXPENSES $	HOUSEHOLDS	PERCENT
0 - 5	46	46.46
5 - 10	18	18.18
10 - 15	14	14.14
15 - 20	7	7.07
20 - 25	4	4.04
25 - 30	4	4.04
30 - 35	1	1.01
35 - 40	0	0
40 - 45	0	0
45 - 50	0	0
50 - 55	1	1.01
55 - 60	0	0
60 - 65	0	0
65 - 70	1	1.01
70 - 75	0	0
75 - 80	0	0
80 - 85	0	0
85 - 90	0	0
90 - 95	0	0
95 - 100	0	0
>100	3	3.03

It is important to note that of the 46.46% CAM patients who paid between $0 to $5, there were also those who were consulted and given medicines at official tarrifs set by the government.

Figure 2:-CAM and Outpatients Health Spending



Source: My field research

Biggest Out-of-Pockect Money Payment by CAM holders

The households surveyed are uneducated and they don't keep records of their health spending on regular basis. But due to negative impacts big amounts cause to their households, they were at least able to remember the bigest amount they have spent at once as health spending and as CAM holders at public or private health centers. The results of our study show that 63% have paid out-of-pocket money at local health centers. And of the 126 CAM patients who were affected by spending such a big amount at once, 112 (88..88%) CAM holders have paid out-of-pocket money at their local goverment health centers while 14 (11.11%) have paid big out-of- pocket money at local private health centers. And 104 (92.85%) paid more than they were supposed to pay and we also found that 1(0.89) patient has paid an amount comprised between BIF 500 and BIF 800 which is also the rates not set by the government. The total amount they had illegally paid at is $2 318.65. The total amount at official tarrifs that was paid is $2.14. Though, 7 (6.25%) patients have paid the official tarrifs, they were negatively affected because some rural population have uncertain incomes.

This means that local government health centers had illegally collected both user fees paid at least by 95 (84.82%) CAM patients and the subsidies from the government budget. Since the patients don't keep records of their health expenses on regular basis, these results consitute good indicators that over the one year of our studies, local government health centers had collected huge amount of money from beneficiaries of CAM policy.

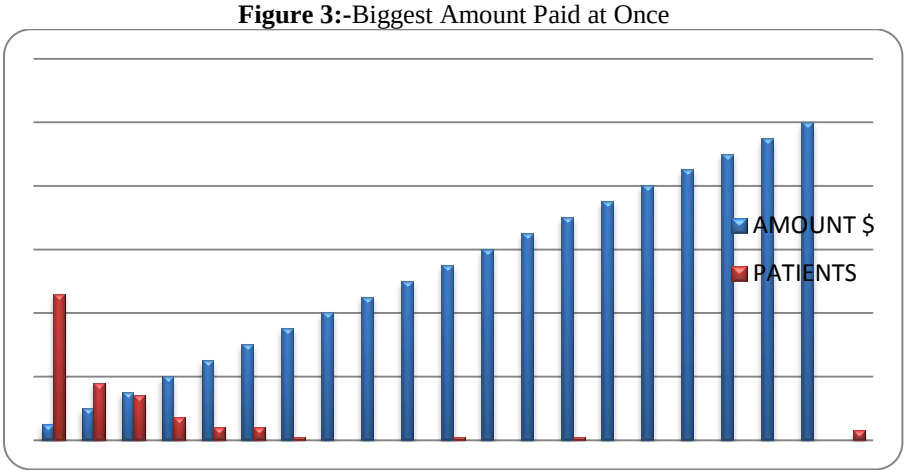
Table 3:-Biggest Amount Paid at Once

AMOUNT $	PATIENTS	%
0 - 5	38	33.92
5 - 10	17	15.17
10 - 15	21	18.75
15 - 20	8	7.14
20 - 25	7	6.25
25 - 30	4	3.57
30 - 35	1	0.89
35 - 40	3	2.67
40 - 45	0	0
45 - 50	3	2.67
50 - 55	1	0.89
55 - 60	1	0.89
60 - 65	0	0

65 - 70	0	0
70 - 75	0	0
75 - 80	0	0
80 - 85	1	0.89
85 - 90	0	0
90 - 95	0	0
95 - 100	1	0.89
>100	6	5.35

Source: My field research

Figure 3:-Biggest Amount Paid at Once



Source: My field research

CAM Holder and Health Spending on Admission

With regards to CAM policy, admitted patients at health facilities that implement the policy pay only BIF 1000 (=$0.56) per day. However, the results of our study show that none of inpatients have paid official trarrifs and that 3 patients have spend more than $100 as their admission fees till they were discharged. The lowest amount was BIF 1300 (=$0.73) whereas the largest amount was BIF 340000 (=$192.09). The table below shows the number of inpatients and the amount they have spend on their admission. However, even in the interval of $0 to $5, all the 14 patients have spend more than BIF 1000 (=$0.56).

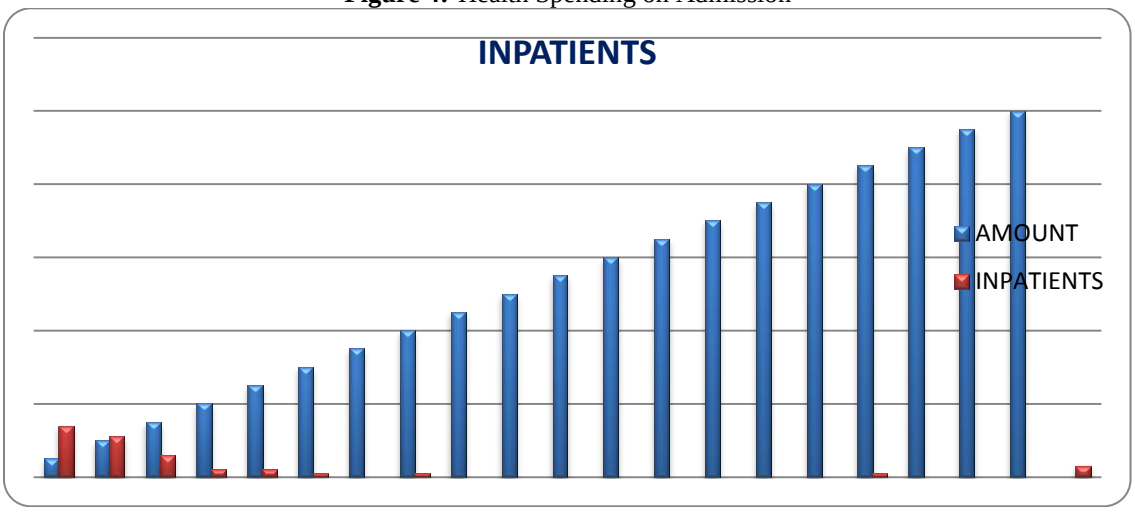
Table 4:-Health Spending on Admission

AMOUNT $	INPATIENTS	PERCENT
0 - 5	14	34.14
5 - 10	11	26.82
10 - 15	6	14.63
15 - 20	2	4.87
20 - 25	2	4.87
25 - 30	1	2.43
30 - 35	0	0
25 - 40	1	2.43
40 - 45	0	0
45 - 50	0	0
50 - 55	0	0
55- 60	0	0
60 - 65	0	0
65 - 70	0	0
70 - 75	0	0
75 - 80	0	0
80 - 85	1	2.43

85 - 90	0	0
90 - 95	0	0
95 - 100	0	0
>100	3	7.31

Source: My field research

Figure 4:-Health Spending on Admission

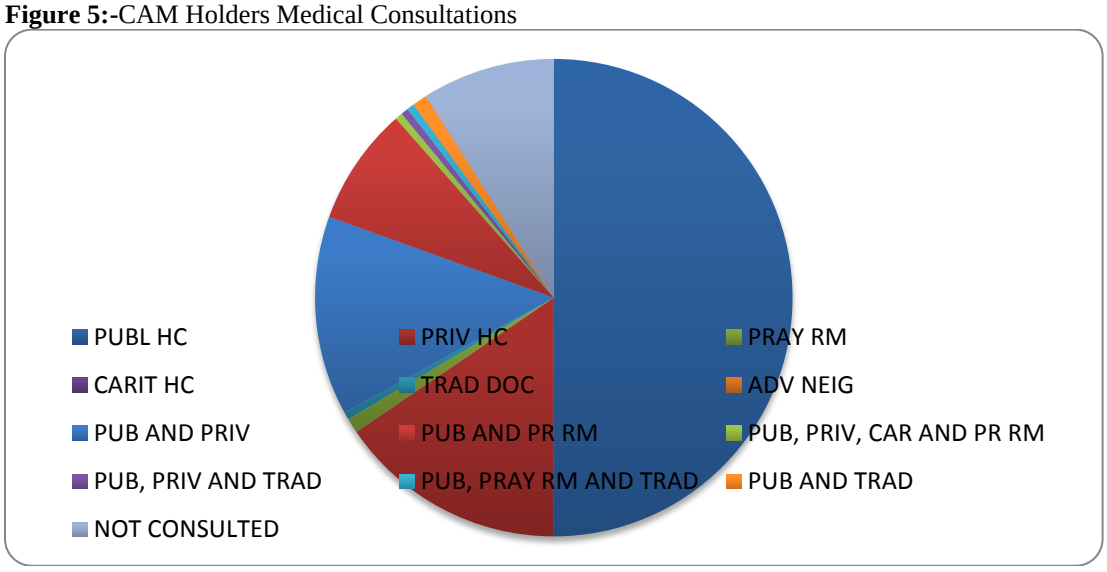


Source: My field research

CAM Holders and Medical Consultations

Analysis of where rural populations holders of CAM get their medical consultations done was a good indication of the quality of consultation. Government health centers get a share of 50% of all consultations while private health centers get a share of 15.5% of all consultations; Prayer room gets a share of 1% whereas traditional healer gets only 0.5% of consultations. The results also show that 24% are mix-consultations e.i. some patients get consulted at different health care providers and for the same sickness. During the period of our study July 2017 till July 2018, 9% of CAM patients did not consult any health care providers.

Figure 5:-CAM Holders Medical Consultations



Source: My field research

PUBL HC= Public health center ; PRIV HC= Private health center ; PRAY RM= Prayer room ; CARIT HC= Caritative health care ; TRAD DOC= Traditional doctor ; ADV NEIG= Advisor from neighbor ; PUB AND PRIV=

Public and private health center ; PUB AND PR RM= Public health center and prayer room ; PUB, PRIV, CAR AND PR RM= Public, private, caritative and prayer room; PUB, PRIV AND TRAD= Public and private health centers and traditional doctor ; PUB, PRAY RM AND TRAD= Public health center, prayer room and traditonal doctor ; PUB AND TRAD= Public health center and traditional doctor.

Availability of Medicines at Local Public Health Center's Pharmacies

The table below indicate the availability of medicines at local public health center's pharmacies. All patients possessing CAM are entitled to receive all prescribed medicines at their local health center's pharmacies. The results of our study show that 182 (91%) patients prefer to get their prescribed medicines from local government health center's pharmacies. Of the 182 patients, 71.97% of households were in possession of CAM while 28.02% were households which did not possess and use CAM. The table below also shows the distribution of medicines between patients at government pharmacies.

Table 5:-Availability of Medicines at Government Pharmarcies

NO	PATIENTS	PERCENT
TOTAL PATIENTS	182	91
CAM PATIENTS	131	71.97
ALL MEDICINES	73	55.72
PORTION OF MEDICNES	58	44.27
NON CAM HOLDER PATIENTS	51	28.02
ALL MEDINES	31	60.78
PORTION OF MEDICNES	20	39.21

Reaction of Patients on Stock-Outs of Drugs

The table above indicates that patients who visited government pharmacies to get their medicines are not able to receive as much as they need as per their medical prescriptions. The results of our study show how beneficiaries and nonbeneficiaries of CAM policy manage to get the medicines they did not get at government pharmacies. Of the 182 patients who visited government pharmacies, we have got the reactions of 156 patients who were able to talk about how they manage to complete their prescribed medicnes. And of the 156 partients, 131 patients were CAM beneficiaries while 25 others were not.

We have found that 45.8% were patients who could get a portion of their prescribed medicines at government pharmacies but also who were able to afford the private pharmacies prices to complete their medicines. And 3.05% patients who possessed CAM did not receive all prescribed medicines at local government health center's parmacies and went to buy some medicines at private pharmacies, but they were not able to buy all prescribe medicines. We have also find that 41.22% patients with CAM who did not receive any medicines at their local government health centers' pharmacies; at least, they were able to afford the market prices and have bought them all at private pharmacies. And other 5.34% patients with CAM who did not receive any medicines at their local public health center's pharmacies were unable to get money to buy them at private pharcies. In fact, only 4.58% of CAM patients have received all prescribed medicines at govenment health centers's pharmacies.

This is also to say that out of 156 patients who went to buy medicies at their local government health center's pharmacies, 96.15% were not able to get them as prescribed by the nurses. And of the 66 households without CAM, 62.12% households prefer to go directly to buy medicines at private pharmacies because they believe government pharmacies make no difference in terms of availability of medicines while 37.87% prefer to begin with government pharmacies because the cost is much cleaper than in private pharmacy and they only go to buy the balance not found at government pharmacies. Thus, 56% of patients without CAM who did not receive all prescribed medicines at local government pharmcies were able to afford the market prices and have bought them at private pharmacies while 44% patients without CAM have bought all their priscribed medicines at private pharmacy because they did not get any medicines at government pharmacies.

Table 6:-Reactions of Patients on Stock-Outs of Drugs

	HOUSEHOLDS	PERCENT
TOTAL HOUSEHOLDS	156	78
HOUSEHOLDS WITH CAM	131	83.97

HOUSEHOLDS WITHOUT CAM	25	16.02
ABLE TO COMPLETE FROM PUB AND PRIV	60	45.8
UNABLE TO COMPLETE FROM PUB AND PRIV	4	3.05
ALL MEDICINES FROM PRIV PHARMA	54	41.22
UNABLE TO COMPLETE FROM PRIVATE	7	5.34
RECEIVED ALL MEDICINES AT PUB PHARMA	6	4.58
ABLE TO COMPLETE FROM PUB AND PRIV WITH NO CAM	14	56
NO MEDICINE AT PUB AND COMPLETE FROM PRIV PHARMA	11	44

Source: My field research

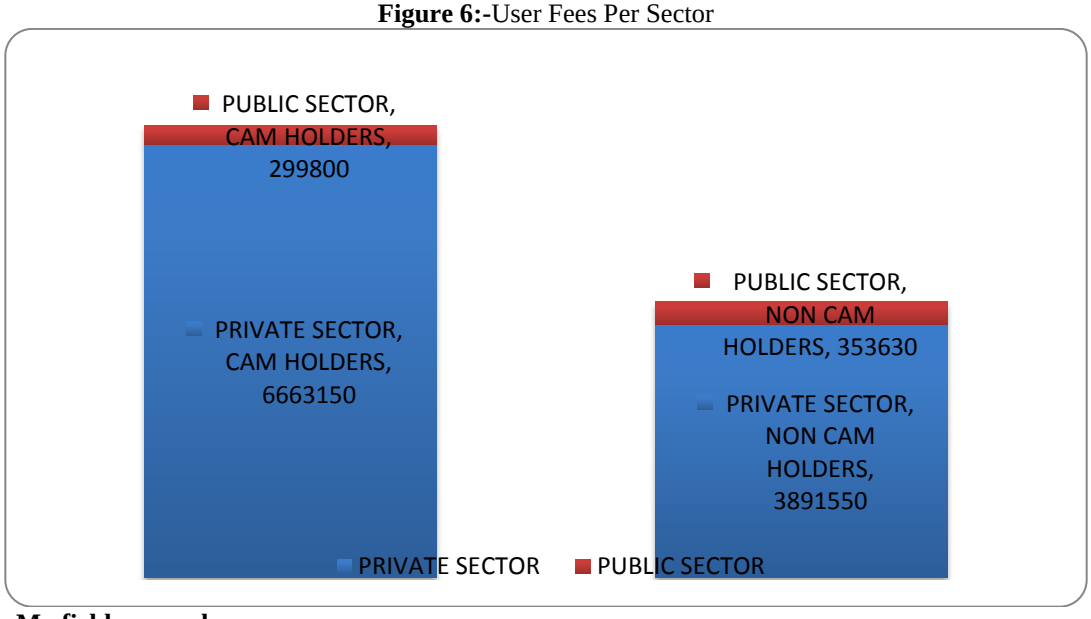
CAM Patients Health Spending in the Public and Private Sectors

The results of our study show that patients beneficiaries of the CAM policies are spending more money on drugs in the private sector. The results also show that there is a slight difference between the amount spent by non CAM beneficiaries in the public and private sector. For the policy beneficiaries, when they don't find the basic health care services at their local government health centers, they go to seeck them at private health care providers at high cost. And for the non beneficiaries of CAM policy, it is much cleaper at government heath centers when they pay 100% than in the private sector. For example, while CAM holders patients have spent BIF 299800 (=$169.37) in the public sector, they have spent BIF 6663150 (=$3764.49) in the private sector. And whereas non CAM holders patients have spent BIF 353630 (=$199.79) in the public sector, they have spent BIF 3891550 (=$2198.61) in the private sector. We found that non CAM beneficiaries prefer to consult and buy a portiton of medicines available at government health centers before going to private health care providers.

Table 6:-User Fees Per Sector In BIF

SECTOR	**CAM HOLDERS**	NON CAM HOLDERS
PRIVATE	6663150	3891550
PUBLIC	299800	353630

Figure 6:-User Fees Per Sector

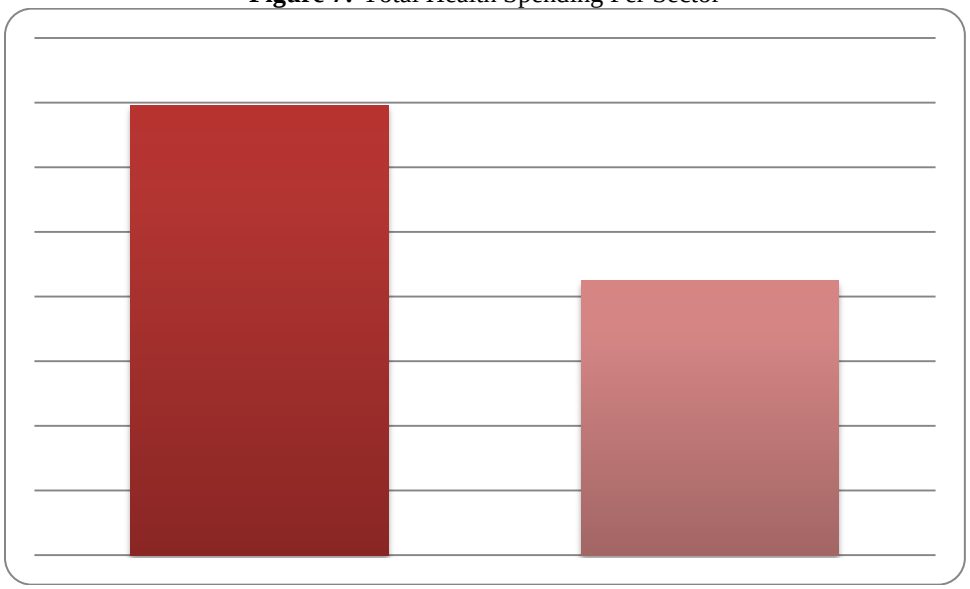


Source: My field research

The figure below shows that rural patients are spending more money at private sector than in the public sector. This is mainly due to the fact that patients both beneficiaries and non beneficiaries of CAM policy begin their medical consultations at government health centers and buy the available portion of their medicines but due to regular stock-outs problems in the public sector they go to buy the other portion in the private sector. And government nurses prefer non CAM holder patients to CAM holders because they pay cash and at a cost relatively higher than CAM

beneficiaires. In total, CAM holders have spent BIF 6962950 (=$3933.87) in the public and private sectors while non CAM holders have spent BIF 4245180(=$355 828.61) in the private and public sectors.

Figure 7:-Total Health Spending Per Sector



Source: My field research

Conclusion:-

This paper empirically evaluates the effects of medical assistance card (CAM) on households health spending. This policy was introduced with the aim to improve universal coverage. With regards to this policy: (i) children aged from 5 years to 13 years old pays BIF 800 (=$0.45) while outpatient aged from 14 years and above pay BIF 500 (=$0.25). And admitted patients for the two categories of beneficiaries pay BIF 1000 (=$0.56) per day. The government reimburses BIF 3200 (=$1.80) for outpatients aged between 5 years and 13 years old and BIF 2000 (=$1.12) for patients aged from 14 years old and above while it also reimburses BIF 260 (=$0.14) per day of admission for both categories.

The results of our study show that the implementation of this policy has produced unexpected effects on health spending. Beneficiaries who get curative consultations done at government health centers doubt its quality and for the same sickness, they consult different health care providers including prayer rooms and traditional doctors. Government nurses prefer non beneficiaries of the policy to beneficiaries because they pay cash and at higher prices. And the majority of patients is receiving a portion of prescribed medicines in the government pharmacies. And patients prefer to buy medicines at government pharmacies because they are cheaper. But due to shortages of medicines, some patients are obliged to complete the other portion in the private pharmacies at higher cost. This makes them spend more money in the private sector. And due to this, some beneficiaries who cannot afford the market prices decide to keep and take the portion of medicines available at government health centers. The government reimburses health centers that implement CAM policy for services not provided to beneficiaries while the health centers are making profits from both government subsidies and user fees from the patients.

This paper empirically evaluates the effects of medical assistance card (CAM) on household's health spending in order to improve universal coverage. The paper concludes that beneficiaries of the medical assistance card (CAM) policy are paying higher prices in the private sector while the government reimburses health facilities for services not provided to beneficiaries and for which patients have already paid.

Recommendations:-

The government reimburses health centers that provide health care services to CAM patients. But, rather than CAM beneficiaries to benefit from this policy, health centers are making profit from government subsidies and user fees from patients.

Consulting different healthcare providers for the same sickness may produce negative effects on the health of the populations. Further research is needed to determine these effects. This study can also help to examine health effects on patients who take only a portion of prescribed medicines due to stock-outs of drugs and lack of money to afford market prices of drugs.

Since uneducated rural populations don't keep records of their health expenses on regular basis, they had difficulties to know how much they spent on their health for a long period which means that they may be spending more money on their healthcare services and drugs. Further research is needed to determine how much money both the government and beneficiaries are losing per year and the final end of the money that is paid by beneficiaries to government health centers. This study can also contribute to determine the final end of medicines bought by government health centers because there are more private pharmacies in rural areas than government pharmacies.

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