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Effects of Administrative Structure on Policy Performance

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Abstract: ***Burundi is currently implementing two health policies: the user fees exemption and medical assistance card (CAM) to enable vulnerable groups of people inlcuding children, pregnant women and aging people to have access to basic health care with the aim of reaching in the long-term universal health care coverage. The government reimburses health centers that implement these two policies for health care services provided to beneficiaries. Despite the fact that all the four health centers surveyed have some pending bills waiting to be paid by government and that they are facing budget deficits challenges, they have not experienced shortages of drugs in their respective stores. This is because non-beneficiaries of these two policies pay in cash all the health care services they receive. The process to fill in the order forms and to purchase drugs is decentralized at the health center and health district levels. This paper analyses the effects of local health care administrative structure on the performance of these two health care policies. The paper argues that health care administrative structure has no negative effects on the procedures of buying drugs at the district pharmacy that can affect the performance of these policies.***

Keywords: Primary health care, Organizational structure, administrative procedures

1. Introduction

The government has made efforts to cover full cost of user fees for children under five years of age and pregnant women, and to cover part of the cost of user fees for CAM patients from government budget. However, the government is not reimbursing the total cost of health care services provided to beneficiaries on regular basis. All the four health centers surveyed have pending bills yet to be paid and in general, they are all facing budget deficits. As results, the quality of the health care services suffers and beneficiaries are likely to face unconcerned personnel and deteriorating equipment. These health centers surveyed purchase drugs from the district pharmacy once per month. They need three signatures (the head of the health center, the head of the pharmacy and the representative of local community) to sign on the order forms. There are no administrative burdens since, one day is enough to get all order forms signed and only maximum of two to three hours to fill in all five order forms. The drugs are available at district pharmacy and it rarely happens that health centers received less drugs than they have ordered. The health center of Gitaza can purchase on average drugs equivalent BIF 4 000,000 BIF (=$2259.88) per month*(Exchange rate was $1=BIF 1770 when we conducted our study in July 2018).* According to available statistics, the money spent on purchasing drugs increased since 2010 till 2014. But in 2015 there was a decrease of 18.34% (BIF 4,832,425). And these amounts increased again in 2016 by 34.46% (BIF 7,519,122) and in 2017 the increase reached 8.05% (BIF 2,364,171). And finally up until November 2018 the health center purchased drugs amounting BIF 21193514. There will be a decrease of amount spent this year (2018) on drugs comparing to the last year 2017. In total, there is a pending bill of BIF 41024544 (=$23,177.7) to be reimbursed to the health center of Gitaza for health care services provided to beneficiaries of CAM. And only BIF 6842509 representing 2.35% of the total cost of health care services provided to beneficiaries of user fees exemption policy is yet to be reimbursed.

When the health center of Mubanga begun functioning in December 2017, it had spent in total BIF 1 500 000(=$847.45) while it purchased drugs equivalent BIF 5,550,000 (=$3,135.59) till November 2018. On average, the health center purchases drugs equivalent BIF 504,545.45 per month. However, it is not yet clear why this last amount reduced to less than half per month compared to BIF 1,500,000 provided by the head of this health center as one month spending on drugs when the health center begun functioning. The government has not reimbursed BIF 8,950,580 (=$5,056.95) for health care services the health center has provided to both beneficiaries. For example, for the one year of existing of this health center, the government has already reimbursed 95.82% (BIF 125840102) while only 4.17% (BIF 5478223) is the pending bill waiting to be paid for health care services provided to children under five years and pregnant women beneficiaries of user fees exemption policy. And also for the year 2018, the health center provided health care to CAM patients equivalent BIF 5764180. The pending bill waiting to be reimbursed is equivalent 60.24% (BIF 3472580).

The health center of Muhuta can purchase drugs equivalent to 2 500 000 BIF (=$1412.42) per month. The health center had spent BIF 24000000 (=$13559.32) in purchasing drugs until November of the year 2018. On average, the health center purchase drugs equivalent BIF 2 181 818.181 (=$1232.66) per month this year. However, the head of the health center was not able to provide figures for previous years. The government has not reimbursed for services the health center has provided to beneficiaries of user fees exemption. And till November 2018, the health center had a pending bill waiting to be paid equivalent BIF 10,578,852 (=$5976.72). The head of the health center provided figures for only the year 2018 and the total cost of these health care services was equivalent BIF 39,087,531 (=$22,083.35) out of which about 70.75% (BIF 27,656,857) has been reimbursed. The health center provided health care services to CAM beneficiaries equivalent BIF 25 956 998 (=$14664.97) out of which 80.71% (BIF

20950746=$11,836.57) is the pending bill yet to be reimbursed.

The health center of Rutongo can purchase drugs equivalent to 1,500 000 BIF(=$847.45) per month. The health center of Rutongo had spent in 2015 BIF 10,543,500 (=$5,956.77 at official rate when the study was carried out), it has spent BIF 12,846,000 ($=7,257.62) in 2016 while in 2017 it spent BIF 13,200,000 (=$7,457.62) and till November 2018, the health center has spent BIF 18,000,000 (=$10,169.49) to purchase drugs from the district pharmacy. The money spent on purchasing drugs increased by 21.83% in 2016 while it sharply dropped in 2017 and reached 2.75%. And till November 2018, there was an increase of 36.36%. The head of the health center was not able to provide figures for previous years. The government has not reimbursed the money for services the health center has provided to beneficiaries of user fees exemption. And till November 2018, the health center had a pending bill waiting to be paid equivalent BIF 10,578,852 (=$5976.72). The head of the health center provided figures for only the year 2018 and the total cost of these health care services was equivalent BIF 39,087,531 (=$22,083.35) out of which about 70.75% (BIF 27,656,857) has not yet been reimbursed. The health center provided health care services to CAM beneficiaries equivalent BIF 25 956 998 (=$14664.97) out of which 80.71% (BIF 20950746=$11,836.57) is the pending bill yet to be reimbursed.

We have found that at the health center and district levels, health administrative structure has no negative effects on the procedures to order drugs and on the performance of these two policies. Non-beneficiary patients, pay user fees and this explains why the heads of these health centers say they never (in theory) experienced shortages of drugs in their stores even though it happens sometimes that the district pharmacy supplies fewer drugs than ordered by the health center. Pending bills of health care services provided to beneficiaries have not yet produced significant impacts on the activities of the health centers because the government can sometimes reimburse small money. This creates however, contradictions with the problems of shortages of drugs raised by rural populations surveyed, in particular CAM patients who are obliged to pay high prices on drugs in the private sector and exempted patients of user fees who also are requested to pay some money in government health centers.

2. Data and Methods

The data on health administrative structure and procedures were collected from four government health centers: the health center of Gitaza, the health center of Mubanga, the health center of Muhuta and the health center of Rutongo of the hill rural area of Muhuta commune, in the Province of Rumonge. We used a questionnaire with open questions that we distributed to each health center and was filled in by the head of the health center. The permission was officially asked and received from the Head of the health district of Bugarama who covers these four health centers. We have assured them that the information that will be collected will be used for academic use only. All questions were written in the local language of Kirundi and were also answered in the same language. We have empirically analyzed the information collected and then we drew conclusions. The study for this part was carried out in November 2018 and the head of these health centers were not able to provide detailed financial information since the implementation of these two policies in 2006 for User fee exemption and at least since the same year for CAM policy (because this has been in place before 2006).

3. Previous Studies

3.1 Primary Health Care

The concept of primary health care (PHC) was defined by WHO in the Alma Ata declaration as “essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally available to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.”

All countries saw primary care as an integral, permanent, and pervasive part of the form of health care system or as the means by which optimization of health and equity in distributing resources are balanced. Primary care addresses the most common problems in the community by providing preventive, curative, and rehabilitative services to maximize health and well-being. It also integrates care when more than health problem exists, and deals with the context in which illness exists and influences people’s responses to their health problems. It is finally care that organizes and nationalizes the deployment of basic and specialized resources directed at promoting, maintaining, and improving health.

In developing and transition country contexts and health systems, primary health care (PHC) was defined in terms of the basic or essential set of health interventions enshrined in the Alma-Ata Declaration. It was also equated with selective vertical programmes or an essential package of services used partly as a financing tool but also to meet the disease burden of predominantly communicable disease, perinatal and maternal deaths (HEN Report 2004; Atun R. 2004).

The 1978 Alma-Ata Declaration had defined essential elements of primary health care which include: (i) universal coverage according to the needs; (ii) participation of the population in planning, working and evaluating health care; (iii) emphasize the role of other actors and importance of other domains and sectors in health activities. The objective of the declaration was to attain universal health coverage by the year 2000 which was put on the agenda of World Health Organization (WHO) in 1981. However, in 2000 this objective had critically failed because health inequity persisted in most African countries. During the 1980s and 1990s, the health of the populations had critically degraded whereas health progress already achieved few years back were put into question in their various aspects be it in the North or the South of the Globe.

Protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care whereas governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures.

The main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice. It was argued that PHC forms an integral part of both the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system by bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

The Alma-Ata conference on PHC called for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference called on all the aforementioned to collaborate in introducing, developing and maintaining primary health care of this Declaration. The World Health Organization (WHO) formalized its commitment to PHC in 1978, when it was identified as central to the achievement of the goal of "health for All" and as key instrument for improving health throughout the world (WHO, 1978). Primary health care approach emphasizes accountability as a core element in implementing health reform and improving system performance.

Health reforms, in particular, have aimed at streamlining health care financing and decentralizing authority for planning and implementation. However, not all of these reforms have strengthened PHC, nor have they uniformly contributed to improving health or equity in its distribution. The changing health challenges in the developing countries and the widespread dissatisfaction with the status quo have generated interest in a renewed and reinvigorated approach to health systems development based on PHC. All approaches adopted by developing countries to getting their health systems to perform better by downsizing, privatization, competition in service delivery, performance measurement and indicators, and citizen participation have failed to sustain sufficient financing for health care (James M. et al. 2009; Ekman B. 2004).

3.2 The Bamako Initiative 1987

The idea of health care reforms came on the policy agenda ten years after the Alma-Ata Conference when the characteristics and performance of the health sector varied tremendously among developing countries. In most cases, however, the sector faces three main problems. And each of these problems was due in part to the efforts of governments to cover the full costs of health care for everyone from general public revenues during the welfare state era. These problems include:

(i) Insufficient spending allocation on cost-effective health activities. On the one hand, the government spending alone, even if it were better allocated, would not be sufficient to fully finance for everyone a minimum package of cost-effective health activities, including both the truly "public" health programs and basis curative care and referral services. On the other hand, although nongovernment spending on health was substantial, not enough of it went for basic cost-effective health services. As a result, the growth of important health activities was slowed despite the great need of fast-growing populations, urbanization and the apparent willingness of households to pay at least some of the cost of health care.

(ii) All developing countries faced internal inefficiency of public programs and policies. These inefficiencies included nonsalary, recurrent expenditures for drugs, fuel, and maintenance. They were chronically underfunded and have created a situation that often reduced dramatically the effectiveness of health staff. For instance, many physicians could not accommodate their patient loads, yet other trained staff was not productively employed. There was underuse of lower-level facilities while central outpatient clinics and hospitals were overcrowded. Other problems that affected public programs were related to logistical problems which were pervasive in the distribution of services, equipment, and drugs. Public health care facilities had often poor quality of health services; clients faced unconcerned or harried personnel, shortages of drugs, and deteriorating personnel and equipment.

(iii) Finally, there was inequity in the distribution of benefits from health services. Investment in expensive modern technologies to serve the rich continued to grow while simple low-cost interventions for the masses were underfunded. The rich in most countries have better access both to nongovernment services, because they could afford them, and to government services because they lived in urban areas and know how to use the system. The rural poor benefited little from tax-funded subsidies to urban hospitals, yet often paid high prices for drugs and traditional care in the private sector. The World Bank strongly believed that the reform of financing deserved serious consideration as one part of an overall renewed effort to improve the health status of the populations in developing countries. But however, since these reforms did not tackle the real problems of the sector they have in the contrast created more problems to the sector than they resolved (Valérie; Ludovic Q. & Yamba K. 2009).

3.3 Health Administrative Structure

The Burundi health care system is organized on four levels: i) a national level, ii) provincial level, iii) district level, and iv) at facility level through the primary health care centers. And treatment programs that include TB, malarial and immunizations are conducted through an integrated minimum services package at facility level and coordinated by the provincial or district offices. Most of the public facilities ranging from primary care centers to hospitals are financially autonomous since 2002 and rely on user contributions/charges and international aid. Private medical clinics are also available in Bujumbura where there are moderately better health facilities for an increased cost (WHO accessed on October 2017).

3.3.1 Central level

The central level includes the Office of the Minister and other central administrative services:

a) Directorate of Services and Health Programs;
b) Directorate for Health Promotion, Hygiene and Sanitation;
c) Directorate for Pharmacy, Drugs and Laboratories;
d) Provincial and Municipal Bureaus of Health;
e) Directorate General of Resources;
f) Directorate for Human Resources;
g) Directorate for Health Infrastructure and Equipment;
h) Directorate for Budget and Supplies.

The central level is charged primarily with formulating health policy, strategic intervention and planning and, formulation and evaluation of quality of health services norms.

3.3.2. Intermediate level

The intermediate level is comprised of 18 provincial bureaus for health and fight against HIV/Aids (BPSLS). The provincial health bureaus are charged with coordinating all activities of health and fight against HIV/Aids at the provincial level.

3.3.3. Peripheral level

The peripheral level is comprised of 46 health districts. This comprises a team framework of district (ECD) within the Health and Fight against HIV/Aids District Bureau (BDSLS). They have the responsibility of ensure decentralized planning, provision of quality health care and good functioning of Health Centers (CDS), associative structure to fight against HIV/Aids and, promotion of health and the District Hospitals (HD).

District Hospitals are also ensuring the implication of communities in management and control. Health Centers are entitled to provide a well defined population of an area under their responsibility the minimum package of activities (PMA) according to the norms of the Ministry of Public Health. District Hospitals are entitled to provide a complementary package of activities to the CDS activities (PCA).

The health district is the operational unit of the health care system. It includes the community level, health centers, and the district hospital which is the hospital of first reference. The communities are involved in the health care system through the management of health centers, by implementing health committees and health center management. They are also represented by the community liaisons that provide the interface between the health center and the community through awareness messages, treatment, monitoring and support for patients.

3.4 Organization of the Care Network

The operation of the care network is based on three levels: the basic level, the first reference level and the national reference level. A minimum package of activities is defined for each level covering treatment, prevention, promotion and rehabilitation. The health center is the point of entry into the health care system. There are 955 health centers, 546 of which are public, 122 are approved religious facilities and 278 are private facilities. Each health center must offer a minimum package of activities, including treatment and prevention consultation services, laboratory, pharmacy, health promotion and health education services as well as in-patient observation. Technical actions that may be involved are births, minor surgery and nursing care (PNS 2016-2018).

3.4.1 First Reference

According to health standards, each District Hospital (HDS) offers outpatient consultation, emergency services, hospitalization, specialized techniques, diagnosis and support services. Outpatient Consultation services at the district hospital only receive new cases that were referred by the health center. There are 73 public hospitals, 44 are public, 9 are religious and 20 are private. In the field, this patient loop is not respected. So the District Hospitals offer both the minimum package of activities and the supplemental package, which is often incomplete. This causes a high level of use of hospital services and under-utilization of health center services. In spite of this subdivision that is intended to bring care to the population, 9 districts out of 45 do not have hospitals. Even in those that do have them, the PCA is not provided in full. Certain hospitals are not sufficiently equipped to serve as reference hospitals (PNS 2016-2018).

3.4.2 Second Reference

There is currently three (3) second-reference hospitals located in Ngozi, Bururi and Gitega. They supplement the package of activities by offering certain specialized care. This level lacks the legal framework for operation and even their package of care is not well defined. Their status will be defined and they will be strengthened to play their true role as reference facilities.

3.4.3 Third Reference Level

The national reference level is comprised of specialized hospitals that offer care that is not provided at other levels, such as specialized exams and treatment. This level specifically comprises the University Hospital of Kamenge (CHUK), Prince Regent Charles Hospital (HPRC), the Kamenge Military Hospital (HMK), the Prince Louis Rwagasore Clinic (CPLR), plus the specialized hospitals, such as the Kamenge Neuro-Psychiatric Center (CNPK), the National Multi-drug Resistant Tuberculosis Center (the former Kibumbu Sanatorium), and the National Brace and

Rehabilitation Center (CNAR) at Gitega. The patient loop is not well structured, because all the hospitals provide all packages, without differentiation. The districts of the Municipality of Bujumbura do not have 1st reference hospitals. So, patients have a tendency to go directly to the National Hospitals, requiring them to offer the minimum package of activities, which nevertheless is available from the Health Centers (CDS).

3.4.4 Geographic access to health care services

The Ministry of Public Health and Fighting AIDS has initiated certain structural reforms to improve access to care from the geographic point of view, by implementing health districts. Geographic accessibility is satisfactory since the population in general (80%) can access a health center less than 5 km away, although there are geographical disparities, primarily in favor of urban centers. Connections are also provided over roads. Most of the health facilities (in excess of 90%) are accessible by road, even if they are sometimes defective. This means of connection plays an important role in the reference and counter-reference system. Regarding financial accessibility, the majority of Burundi households have access to direct payment to finance their health expenses. With low buying power, this method of payment limits access to care by the population.

3.4.5 Human Resources Management

The management of human resources is marked by excessive centralization of management activities for personnel at the level of the central administration, which leads to situations that often handicap the correct operation of health facilities in the field. The lack of job descriptions and career plans for agents and the absence of benefits management are determining factors that contribute to the poor management of human resources. The Government has implemented motivational measures, including subsidizing the health care of personnel and generalizing the performance-based financing approach in health care facilities (NHDP 2011-2015; MSPLS; PNS 2016-2018; SCOMS 2016-2018).

3.4.6 Drugs and Health Care Supplies

The supply chain of drugs was not mastered because of the presence of many players in the sector. The availability and access to drugs remained problematic in all health structures. And this situation had led to the development of informal providers of drugs and auto-medication practices (PNDS 2011). However, there are significant improvements in drug and medical consumable supply. The supply chain of medical products in the public sector is made of central of purchase at national level (CAMEBU) and 46 district pharmacies which supply health structures. There are 2 secondary warehouses that were funded by the World Fund. Alignment on national circuit is obligatory except for subsidized drugs.

The private sector accounts for 25 whole sellers of drugs, 228 pharmacies with branches and uses 80 percent of the 125 pharmacists of the country. The availability rate of drugs was 42 percent for all sectors in 2014 and costs of drugs were globally inaccessible for the majority of population. Though the store size of the CAMEBU tripled in 2013, shortages of essential drugs supply are observed, leading district pharmacies and health structures to purchase them in private pharmacies out of any competition mechanism and documented transparency. The public sector accounts for 42.8 percent while the private sector accounts 42 percent of drugs availability and 42.9 percent in the confessional sector. There is only one factory that manufactures generic drugs in the country and enjoys thereby the monopoly of the local market (CCS-BDI-2016-2018).

4. Results

4.1 Administrative Procedures For Drug Supply

4.1.1 Health Center of Gitaza

The four local health centers surveyed purchase drugs from the district pharmacy once per month. The health center of Gitaza can purchase drugs equivalent to 4 000,000 BIF(=$2259.88) per month. To order drugs, the health center needs to fill in five papers and it can take about two hours. Then three authorities have to sign on these papers and these include the head of health center, the head of pharmacy and a representative of local community. One day is enough to have all papers signed. And when it happens that the health center receives fewer drugs than it has ordered, it cannot buy them out the district pharmacy because the district remains its sole supply source. While this health center has its pharmacy, there are also five more private pharmacies at Gitaza shopping center. However, the health center is mainly challenged with budget deficit since the government is the main fund provider. The tables below indicate the amounts the health center have spend to purchase drugs, the cost of services provided to user fees exemption and CAM beneficiaries and the amount the government has not yet reimbursed.

4.1.1.1 Annual Spending on Drugs

The table below indicates that the money spent on purchasing drugs by the health center of Gitaza went on increasing since 2010 up until 2014. But in 2015 there was a decrease of BIF 4,832,425 (18.34%) as compared to 2014. And these amounts increased again in 2016 by BIF 7,519,122 (34.46%) and in 2017 the increase reached BIF 2,364,171 (8.05%). And finally up until November 2018 the health center purchased drugs amounting BIF 21,193,514. There will be decrease of amount spent in 2018 on drugs comparing to the last year 2017.

Table 1: Annual Spending on Drugs at Gitaza Health Center

YEAR	AMOUNT IN BIF
2007	0
2008	0
2009	0
2010	17604403
2011	18697426
2012	18684219
2013	23195947
2014	26347915
2015	21815490
2016	29334612
2017	31698783
2018	21193514

Source: My field research

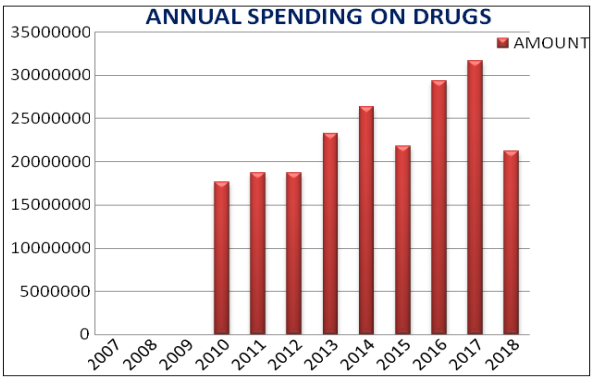

Figure 1: Annual Spending on Drugs at Gitaza Health Center

Source: My field research

4.1.1.2 Annual Pending Bills on Health Care Services

The government has not reimbursed the money for services the health center of Gitaza has provided to CAM beneficiaries from 2014 up until November 2018 when this research was carried out. The table 2 and figure 2 below indicate that in 2014, 76.76% of the annual cost of health care services provided to CAM beneficiaries was not reimbursed while for the years 2015, 2016 and 2018 there was no reimbursement at all. However, in 2017 the government has to reimburse a balance of 22.89% of the total annual cost of services provided to CAM patients. In total, there is a pending bill of BIF 41024544 (=$23,177.7) to be reimbursed to the health center of Gitaza for health care services provided to beneficiaries of CAM.

Table 2: Annual Pending Bills on CAM Health Care Services

Year	Pending Bill For Cam Patients BIF	Cost Of Services BIF	Percent
2006	0	0	0
2007	0	0	0
2008	0	0	0
2009	0	0	0
2010	0	0	0
2011	0	0	0
2012	0	380720	0
2013	0	8045537	0
2014	7466604	9726800	76.76
2015	5549180	5549180	100
2016	10889160	10889160	100
2017	3551440	15514240	22.89
2018	13568160	13568160	100

Source: My field research

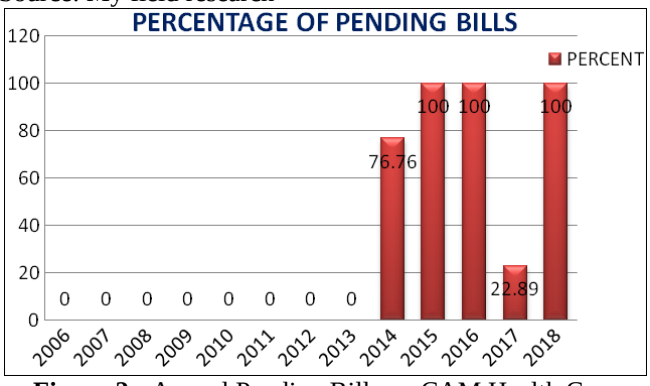

Figure 2: Annual Pending Bills on CAM Health Care Services

Source: My field research

4.1.1.3 Annual Cost of Health Care Services For User Fees Exemption

Though the cost of health care services provided to user fees exempted patients has increased in 2011 and from 2013 to 2017, the health center of Gitaza has a pending bill of only 2.35% (BIF 6842509 =$3865.82) because the government has already reimbursed, since 2010 about 97.64% (BIF 283231758=$160017.94) of the total cost of health care services. The annual cost of health care services in 2013 totaled BIF 59532864 and remains the highest until 2018 when the study was carried out. The head of this health center was not able to provide figures for the previous years (2006-2009).

Table 3: Annual Cost of Health Care Services For User Fees Exemption

Year	Cost Of Services BIF	Percentage Of Increase BIF
2006	0	0
2007	0	0
2008	0	0
2009	0	0
2010	18919000	100
2011	22810225	20.56
2012	2017933	-739.87
2013	59532864	2858.19
2014	48259837	18.93
2015	32387180	32.88
2016	35694540	10.21
2017	37799315	5.89
2018	32653373	-13.61
Total	290074267	

Source: My field research

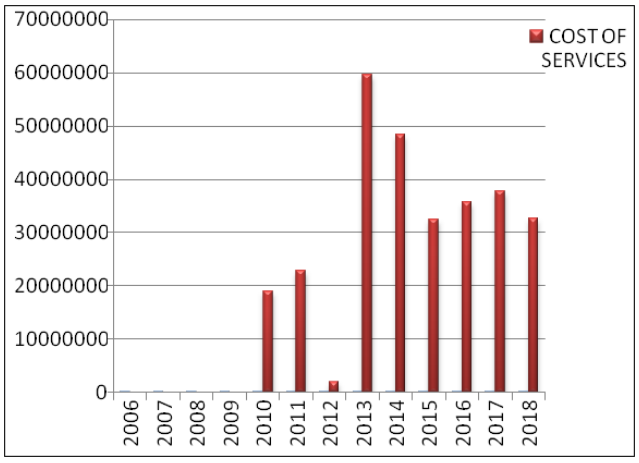

Figure 3: Annual Cost of Health Care Services For User Fees Exemption

Source: My field research

4.1.2 Health center of Mubanga

The four local health centers surveyed purchase drugs from the district pharmacy and once per month. The health center of Mubanga begun to function in 2017 and the following year 2018, it was able to purchase drugs equivalent 1 200 000 BIF(=$677.96) per month. To order drugs, the health center needs to fill in five forms and it can take about three hours. Then three authorities have to sign on these forms which include the head of health center, the head of pharmacy and a representative of the local community. One day is enough to get all the forms signed. And when it happens that the health center receives fewer drugs than it

has ordered, it cannot purchase them from private pharmacies. This health center is located in the hilly area surrounding Gitaza shopping center and it has its pharmacy. But, it geographic location has no negative impact on availability of drugs since they head of the health center can easily hire local people to carry the boxes of drugs at lower cost. Though the health center is new, there is also a new operational private pharmacy in that area. However, the health center is mainly challenged with budget deficit which does not currently affect the availability of drugs since non-beneficiaries pay in cash at market tariffs.

4.1.2.1 Annual Spending on Drugs

When the health center of Mubanga begun functioning in December 2017, it had spent in total BIF 1 500 000(=$847) while it purchased drugs equivalent BIF 5,550,000 (=$3,135.59) till November 2018. On average, the health center purchase drugs equivalent BIF 504,545.45 per month. However, it is not yet clear why this last amount reduced to less than half per month compared to BIF 1,500,000 provided by the head of this health center as one month spending on drugs when the health center begun functioning.

4.1.2.2 Annual Pending Bills For Health Care Services Provided

The government has not reimbursed BIF 8,950,803 (=$5,056.95) for health care services the health center has provided to both beneficiaries. And for the one year of existing of this health center, the government has already reimbursed 95.82% (BIF 125840102) while only 4.17% (BIF 5478223) is the pending bill waiting to be paid for health care services provided to children under five years and pregnant women beneficiaries of user fees exemption policy. And also for the year 2018, the health center provided health care to CAM patients equivalent BIF 5764180. The pending bill waiting to be reimbursed is equivalent 60.24% (BIF 3472580).

Table 4: Annual Pending Bills For Health Care Services Provided

Beneficiary	*Cost Of Services Bif*	*Reimbursed*	*%*	*Pending Bills BIF*	*%*
User fees exemption	131318325	125840102	95.82	5478223	4.17
CAM	5764180	2291600	39.76	3472580	60.24

4.1.3 Health center of Muhuta

The health center of Muhuta we surveyed also purchases drugs from the district pharmacy once per month. The health center can purchase drugs equivalent to 2500 000 BIF(=$1412.42) per month. To order drugs, the health center needs to fill in five forms and it can take about one day. Then three authorities have to sign on these forms and these include the head of health center, the manager of the pharmacy and a representative of the local community. One day is enough to get all the papers signed. And when it happens that the health center receives fewer drugs than it has ordered, it relies only on what it has in the store because the district remains its only supply source. The location of the health center in the hilly areas of the commune has no negative impact on carrying boxes of drugs from the main road. And while it has its pharmacy, there are also two private pharmacies in that area. Though, the health center is mainly challenged with budget deficit we found that this has not yet produced direct impact on the availability of drugs because non-beneficiaries pay in cash at market tariffs.

4.1.3.1 Annual Spending on Drugs

The health center of Muhuta had spent BIF 24000000 (=$13559.32) in purchasing drugs for the year 2018. On average, the health center purchase drugs equivalent BIF 2000 000 (=$1129.94) per month this year. However, the head of the health center was not able to provide figures for previous years.

4.1.3.2 Annual Pending Bills for Health Care Services Provided

The government has not reimbursed the money for services the health center has provided to beneficiaries of user fees exemption. And till November 2018, the health center had a pending bill waiting to be paid equivalent BIF 10,578,852 (=$5976.72). The head of the health center provided figures for only the year 2018 and the total cost of these health care services was equivalent BIF 39,087,531 (=$22,083.35) out of which 70.75% (BIF 27,656,857) has not yet been reimbursed. The health center provided health care services to CAM beneficiaries equivalent BIF 25 956 998 (=$14664.97) out of which 80.71% (BIF 20950746=$11,836.57) is the pending bill yet to be reimbursed.

4.1.3 Health Center of Rutongo

The health center also purchases drugs from the district pharmacy once per month. The health center of Rutongo can purchase drugs equivalent 1,500 000 BIF(=$847.45) per month. To order drugs, the health center needs to fill in five order forms and it can take some hours. Then three authorities have to sign on these forms and these authorities include the head of health center, the manager of the pharmacy and a representative of the local community. One day is enough to get all the forms signed. And when it happens that the health center receives fewer drugs than it has ordered, it is not allowed to purchase them from private providers. This health center is located in the hilly areas of the commune and it has its pharmacy. There is also one private pharmacy in that area. However, the geographic location and budget deficit have not yet produced direct negative impacts on the availability of drugs. First, cheap private transport is available to carry the boxes of drugs from the main road to the health center. Second because non-beneficiaries pay in cash and at market tariffs.

4.1.3.1 Annual Spending on Drugs

The health center of Rutongo had spent in 2015 BIF 10,543,500 (=$5,956.77 at official rate when the study was carried out), it has spent BIF 12,846,000 ($=7,257.62) in 2016 while in 2017 it spent BIF 13,200,000 (=$7,457.62) and till November 2018, the health center has spent BIF 18,000,000 (=$10,169.49) on purchasing drugs from the district pharmacy. The money spent on purchasing drugs increased by 21.83% in 2016 while it sharply dropped in 2017 and reached 2.75%. And till November 2018, there was an increase of 36.36%. The head of the health center was not able to provide figures for previous years.

Table 5: Annual Spending of Drugs

Year	Amount in BIF	Increase %
2007	0	0
2008	0	0
2009	0	0
2010	0	0
2011	0	0
2012	0	0
2013	0	0
2014	0	0
2015	10,543,500	0
2016	12,846,000	21.83
2017	13,200,000	2.75
2018	18,000,000	36.36

4.1.3.2 Annual Pending Bills for Health Care Services Provided

The government has not reimbursed the money for health care services the health center has provided to beneficiaries of user fees exemption policy. And till November 2018, the health center had a pending bill waiting to be paid equivalent BIF 10,578,852 (=$5976.72). The head of the health center provided figures for only the year 2018 and the total cost of these health care services was equivalent BIF 39,087,531 (=$22,083.35) out of which about 72.93% (BIF 28,508,679) has been reimbursed. The health center provided health care services to CAM beneficiaries equivalent BIF 25 956 998 (=$14664.97) out of which 80.71% (BIF 20950746=$11,836.57) is the pending bill yet to be reimbursed.

Table 6: Pending Bills for Health Care Services Provided

2018	Cost Of Services BIF	Reimbursed BIF	%	Pending Bill BIF	%
User Fee Exemption	39087531	28508679	72.93	10578852	27.06
CAM	25956998	5006252	19.28	20950746	80.71

5. Conclusion

The four health centers surveyed are all government owned. All the heads of these health centers are challenged by budget deficits. They have to purchase all drugs they need from the pharmacy of the district of Bugarama, in Rumonge Province. They are not authorized to purchase drugs from private pharmacies even when they don't have enough in their respective stores. It takes only some hours to fill in all the five order forms and they have no problems related to the delays in getting signatures of the three authorized signatories or in getting all the drugs they have ordered. Of the fours health centers surveyed, none of them was able to provide complete and detailed information on their spending on drugs and on the cost of health care services provided to beneficiaries since the implementation of these policies. Non-beneficiaries of these two policies pay in cash and at different prices all their health care services they receive. This explains the reason why, all these fours health centers had never had any problems related to shortages of drugs despite the fact that they all still have pending bills yet to be reimbursed by the government. This is in contradiction with the problems of shortages of drugs raised by rural populations surveyed, in particular CAM patients who are obliged to pay high prices on drugs in the private sector and exempted user fees patients who pay money in the government health centers. There are no administrative burdens at the health center and district levels due to administrative structure that would explain the regular stock-outs of drugs.

6. The Scope for Further Study

Of the fours health centers we surveyed, none of them was able to provide complete and detailed financial information on their spending on drugs and on the cost of health care services they have provided to beneficiaries of the two policies since their implementation until the date this study was carried out. Further study is needed to examine if the money government reimburses corresponds to quantity of health care services provided to beneficiaries. This study can also contribute to determine the amount of money these health centers have spent on purchasing drugs over the year of implementation of these policies and its final end.

There are some pending bills the government has not yet reimbursed. This will in the long run affect the functioning of these health centers. Further study is needed to examine the effects of continuous budget deficits on the performance and sustenance of these policies.

All the four health centers had no administrative burdens that could cause delays in purchasing drugs or that could explain regular shortages of drugs for CAM patients. Further study is needed to examine the management of drugs and the relationships between government and private pharmacists in rural areas.

References

[1] National Health Development Policy 2011-2015
[2] Ministère de la Santé Publique et de la Lutte contre le SIDA : www.minisate.bi
[3] World Health Organization: https://www.who.int (accessed on October 2017)
[4] Stratégie de coopération de l'OMS avec le Burundi, 2016-2018
[5] Politique Nationale de Santé 2016-2025
[6] Politique Nationale de Développement de la Sanitaire 2011
[7] Valéry Ridde, Ludovic Queuille et Yamba Kafando, Capitalisation de politiques publiques d'exemption du paiement des soins en Afrique de l'Ouest, 2009.
[8] James Macinko; Barbara Starfield and Temitope Erinosbo, The Impact of Primary Healthcare on Population Health in Low- and Middle-Income Countries, Vol. 32, No. 2.pp. 150-171, 2009
[9] Ekman B., Community-based health insurance in low-income countries: a systematic review of the evidence, Oxford University Press, 2004.
[10] World Health Organization, 1978
[11] Alma-Ata 1978 International Conference on Primary Health Care. CF/MST/1985/034/Anx 04/07.
[12] Atun R., *What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?* Copenhagen, WHO Regional Office for Europe. HEN Report January 2004