Detention of insolvent patients in Burundian hospitals

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Between February and June 2006, Human Rights Watch and the Association for the Promotion of Human Rights and Detained Persons conducted an investigation into the detention of insolvent hospital patients in Burundi. Of 11 hospitals visited, nine were found to be holding former patients in detention for being unable to pay their hospital bills. Thirty-seven detained patients, and key informants in government, hospital administration and health services, were interviewed. The detention of insolvent hospital patients was described as a routine practice, dating from the 1990s. Conditions of detention included overcrowding, insufficient food and water, and withholding of further medical treatment. Seventy-two per cent of patients interviewed had been detained for 1 month or longer at the time of interview. Mechanisms designed to exempt or reimburse the health fees of low-income and indigent people failed to protect patients from becoming detained. The detention of insolvent patients is a clear violation of rights established under international law, including the right not to be arbitrarily detained or detained as debtors and the right to accessible health care. The abolition of user fees for women giving birth and for small children in May 2006 has reduced the number of detained patients, but in June 2006 we visited two hospitals and found 77 detained men, older children and women with other health problems. Burundi, with the support of the international community, must immediately stop the detention of patients and address the urgent financing needs of health facilities.

Keywords Burundi, user fees, detention, cost-recovery, equity, access, human rights

KEY MESSAGES

- Hospitals in Burundi have been routinely detaining insolvent patients in violation of international law.
- Insurance and user fee exemption programmes have failed to protect poor patients from being detained.
- Government initiatives, such as the ad-hoc ‘charitable’ releases of detained patients and the abolition of user fees for women giving birth and for children under five, have reduced but not eliminated the detention of patients and fail to address the underlying problem of inadequate health resources.

Introduction

Burundi has been embroiled in civil war for over a decade but has recently undergone a process of political transition. Elections held in August 2005 were widely seen as a new starting point for this war-torn country. However, Burundi is one of the least developed countries in the world, ranking 169 of 177 on the 2006 United Nations Development Programme’s Human Development Index (UNDP 2006). In 2004 life...
expectancy was 45 years (WHO 2006), and in 2000 the maternal mortality ratio was estimated to be 1000 deaths per 100,000 live births (UNICEF 2006).

The government of Burundi devoted 2.7% of its national budget to health in 2005 (République du Burundi, Ministère de la Santé 2005). Per capita government expenditure on health in 2005 was US$1 and per capita total health expenditure was US$3 (WHO undated). The health system lacks trained staff and resources to pay them, medications and modern equipment (Niyongabo 2005). Skilled medical personnel leave the public sector for better-paid jobs both inside Burundi and in neighbouring Rwanda.

A local human rights organization, the Burundian Association for the Promotion of Human Rights and Detained Persons (Association pour la Protection des Droits Humains et des Personnes Dénues) (APRODH), contacted Human Rights Watch (HRW) in 2005 to raise the problem of hospitals detaining insolvent patients for failing to pay their hospital bills, and to discuss strategies to combat this practice. Consequently, HRW, together with APRODH, conducted an investigation to determine the nature and extent of the detentions and whether the rights of patients were being violated.

Methods

Of 35 public hospitals in Burundi, 11 were selected for investigation, prioritizing public tertiary care institutions with the highest numbers of patient visits and broad regional representation. All three public hospitals in the capital were chosen, as well as hospitals in Ngozi and Gitenga, the second- and third-largest cities. Ngozi is in the north and Gitenga in central Burundi. Six additional hospitals in four other provinces were selected. These included Muramvya, Karuzi and Muyinga Hospitals, and Bururi, Rumonge and Matana Hospitals in Bururi Province (Figure 1).

Interviews were conducted over a 5-month period between February and June 2006. Researchers from HRW and APRODH conducted the research jointly. Before the researchers arrived at each hospital, a Burundian research assistant obtained permission from hospital officials to conduct interviews and briefed the staff about the study. When the researchers arrived, social workers and nurses were asked to approach individuals who were being detained and to invite them to be interviewed. If numbers were too great to interview all detained patients, the researchers asked the staff to identify people according to two criteria, those detained the longest and people from different wards in order to represent a range of medical problems.

Detained patients were told who the researchers were, how the information was going to be used, and that their confidentiality would be maintained. Researchers explained that they had no money to pay the detainees’ bills. Patients were asked if they were willing to be interviewed; all who were approached agreed to participate.

Interviews were conducted using a uniform set of broad questions as a guide. In addition to interviews with detained patients, key informants were interviewed, including hospital staff (hospital directors, financial and administrative directors, doctors, nurses and social workers), representatives of local and international organizations working in the health care sector, public health experts, representatives of donor governments and agencies, and officials of the Ministry of Public Health and the Ministry of National Solidarity, Human Rights and Gender.

Detained patients were interviewed in Kirundi with translation into French by an HRW translator or staff member from APRODH. Interviews with key informants were conducted in French.

In addition to the qualitative data gathered in the interviews, researchers asked the managers in all the hospitals for quantitative documentation, and such data were collected from nine hospitals. Researchers were able to collect information such as the number of patients who were unable to pay their bills, the number of patients detained and loss of income from insolvent patients. However, the type of information, format and detail of the reports varied significantly by hospital.

Further information on methods, including dates and identities of specific key informants interviewed, and transcribed testimony of detained patients, is available as part of a previously published report (HRW and APRODH 2006).

Results

Unpaid hospital bills

Data from seven hospitals in Burundi documented 1076 patients who were unable to pay their bills (insolvent patients) in 2005 (Table 1). The number of insolvent patients per hospital varied from 36 at Bururi and Rumonge hospitals to 422 at Roi Khaled Hospital in Bujumbura.

Key informants reported that the frequency of patients being unable to pay their hospital bills has increased since 2001. Hospital records from Prince Louis Rwagasore Clinic in Bujumbura indicated an increase from 11 insolvent patients in 2001 to 39 in 2005. Over the same period, the total of unpaid bills at Roi Khaled Hospital more than doubled (Table 2). At Prince Régent Charles Hospital the number of bills recorded as paid by benefactors rose from 44 in the 3 years 2001–03 to 352 in 2005.

Data from four hospitals show that two-thirds of insolvent patient in 2005 were admitted for surgery. The remaining one-third were mostly from internal medicine (16%) and paediatrics (10%) wards. Overall, 35% of insolvent patients were women who had delivered their babies by caesarean section. Hospitals characterized these women in multiple categories including gynaecology/obstetrics, surgery and operating theatre (Table 3).

Detention of patients

Nine of the 11 hospitals visited were found to have former patients in detention for being unable to pay their hospital bills. Official hospital records did not systematically document the number of patients who were detained. Rather, hospitals typically recorded information such as the total financial loss incurred, the number of insolvent patients, how many bills were left unpaid, and information about benefactors who paid bills. Thus it was impossible from hospital records to estimate the overall number of patients who were detained over any time period.

However, interviews with key informants confirmed that the detention of insolvent patients was routine and not a new or ad-hoc measure, and that hospitals began detaining patients
unable to pay their bills in the 1990s. Detained patients identified the moment when hospital staff handed patients their bills as the transition from hospital treatment to hospital detention, however patients also reported being turned away from emergency care for being unable to pay admitting fees (Table 4). Hospital staff—mostly nurses and doctors—turned away patients and imposed the detention, and attempted to justify these actions to patients. Hospital managers—medical doctors as well as administrators—also justified these acts.

Interviews with detained patients indicated that the length of detention varied greatly, depending in part on whether the patient could find a benefactor to pay the bill or find a way to escape. Most patients interviewed were detained for a period of several weeks or months, but a few were kept for as long as a year. Of 32 people interviewed for whom complete information was gathered, at the time of the interview two (6%) had been detained for less than 2 weeks, seven (22%) had been detained for between 2 to 4 weeks, 20 (63%) had been detained for 5–8 weeks, and three (9%) had been detained for more then 8 weeks.

The size of hospital bills of detained patients also varied greatly, but even relatively small amounts could lead to detention. For example, one detained patient interviewed was a 17-year-old widow who was also an orphan and who was unable to pay the US$9 fee for her baby’s malaria treatment.

**Conditions of detention**

In most hospitals, detained patients were able to move around the building but were prevented from leaving the premises by security guards from private security companies contracted

![Figure 1 Map of Burundi indicating cities where hospital staff (H) and hospital staff and patients (HP) were interviewed](image-url)
by the hospitals. Patients reported that security guards generally knew their names and faces, and several said guards followed them around even within the hospital premises.

According to one hospital administrator the private security company guarding the hospital premises maintained surveillance on non-paying patients until someone paid the bill, and if patients fled, the company had to pay a fine to the hospital.

Detained patients at one hospital were held in a separate room with a guard at the door and were not allowed out of the room. When researchers visited, about 20 people were in the room, including a dozen mothers with newborn babies plus some family members who were assisting or visiting them.

A filthy toilet and shower constituted the sanitary facilities for all the detainees and visitors. According to those guarding the room, most of the detainees at the hospital were women who had had birth complications.

Sometimes patients were refused further treatment once they became unable to pay for their medical care. Patients described how they were locked in rooms where doctors and nurses never entered; how staff refused to treat sick newborns when mothers were detained after delivery; and how staff refused to remove stitches or to carry out surgical treatments on patients unable to pay the costs. One woman being detained had become unable to walk because she was denied the surgery she needed.

Almost all detained patients complained of hunger. Hospitals in Burundi generally do not provide meals to patients. Family members, charities or benefactors must provide food and drink; even clean water must be purchased. Detained patients sometimes had to vacate their beds for patients who could pay. Patients reported sleeping on thin mats or directly on the cement floor.

Children were detained as well as adults. Mothers stayed with babies and small children while older children were sometimes held by themselves, with little or no support from the hospital. Four of the detained patients interviewed were school-aged children. None were permitted to attend school while being detained.

Some detained patients expressed fear of losing access to health care for themselves or their children in the future if they attempted to escape. They preferred to remain detained than to risk being refused hospitalization during their next illness.

Patients and key informants reported that when medical bills were not settled by families after patients died, hospitals typically refused to release the bodies to family members. Bodies were often held in the morgue for long periods.

### Table 1 Number and total amount of unpaid bills at seven hospitals in Burundi, 2005

<table>
<thead>
<tr>
<th>Hospital</th>
<th>No. patients unpaid</th>
<th>Total amount unpaid (FBU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roi Khaled, Bujumbura</td>
<td>422</td>
<td>47 769 382</td>
</tr>
<tr>
<td>Prince Régent Charles, Bujumbura</td>
<td>267</td>
<td>24 498 992</td>
</tr>
<tr>
<td>Ngozi, Ngozi province</td>
<td>217</td>
<td>9 492 170</td>
</tr>
<tr>
<td>Bururi, Bururi province</td>
<td>36</td>
<td>1 115 050</td>
</tr>
<tr>
<td>Rumonge, Bururi province</td>
<td>36</td>
<td>2 174 350</td>
</tr>
<tr>
<td>Matana, Bururi province</td>
<td>51</td>
<td>460 540</td>
</tr>
<tr>
<td>Muramvya, Muramvya province</td>
<td>47</td>
<td>2 270 351</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1076</strong></td>
<td></td>
</tr>
</tbody>
</table>

1 000 000 FBU = approximately US$1000 (August 2006).

*Data for the month of April are missing.

*Data for the month of December are missing. The figure is based on lists of unpaid bills by escaped patients.

### Table 2 Unpaid bills at two health care facilities in Bujumbura, 2001–05

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Roi Khaled Hospital</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unpaid bills (FBU)</td>
<td>23 334 446</td>
<td>64 150 549</td>
<td>34 297 612</td>
<td>25 666 425</td>
<td>47 769 382</td>
</tr>
<tr>
<td><strong>Prince Louis Rwagasore Clinic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. insolvent patients</td>
<td>11</td>
<td>18</td>
<td>16</td>
<td>16</td>
<td>39</td>
</tr>
<tr>
<td>Bills owed by insolvent patients (FBU)</td>
<td>1 716 744</td>
<td>1 753 456</td>
<td>2 568 408</td>
<td>2 586 682</td>
<td>7 629 331</td>
</tr>
</tbody>
</table>

1 000 000 FBU = approximately US$1000 (August 2006).

### Table 3 Number of patients unable to pay their bills by medical department, 2005

<table>
<thead>
<tr>
<th></th>
<th>Roi Khaled Hospital, Bujumbura</th>
<th>Prince Louis Rwagasore Clinic, Bujumbura</th>
<th>Prince Régent Charles Hospital, Bujumbura</th>
<th>Muramvya Hospital, Muramvya province</th>
<th>Total for each ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total for each hospital</td>
<td>422</td>
<td>267</td>
<td>47</td>
<td>775</td>
<td></td>
</tr>
<tr>
<td>Gynaecology/obstetrics</td>
<td>91</td>
<td>15</td>
<td>12</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>100</td>
<td>13</td>
<td>16</td>
<td>166</td>
<td></td>
</tr>
<tr>
<td>Internal medicine</td>
<td>64</td>
<td>14</td>
<td>14</td>
<td>121</td>
<td></td>
</tr>
<tr>
<td>Paediatric</td>
<td>48</td>
<td>3</td>
<td>5</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Intensive care and emergency</td>
<td>46</td>
<td>6</td>
<td>0</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Operating theatre (anaesthetics etc.)</td>
<td>64</td>
<td>2</td>
<td>2</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>0</td>
<td>8</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

1 000 000 FBU = approximately US$1000 (August 2006).
Table 4  Illustrative testimony of insolvent patients detained by hospitals

<table>
<thead>
<tr>
<th>Patient</th>
<th>Excerpt</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-year-old woman held with her baby at Louis Rwagasore Clinic, Bujumbura</td>
<td>I had to come to hospital because I needed a caesarean delivery. When I got the bill, the doctor said to me, ‘Since you have not paid, we will keep you here’. Life here is difficult. I don’t have permission to leave with my baby. We are often hungry here. I cannot stand this situation any longer.</td>
</tr>
<tr>
<td>22-year-old man who had a car accident, held at Prince Regent Charles Hospital, Bujumbura</td>
<td>One day, I tried to get out of the hospital and I was stopped because I had not paid my bill yet. When I see a doctor, I always ask to leave, since I am not getting any medical treatment. The guards threaten me. Whenever I come near the exit, they tell me that I cannot leave because I have not settled the bill.</td>
</tr>
<tr>
<td>20-year-old woman, detained for 1 month after she got her bill, Prince Régent Charles Hospital, Bujumbura</td>
<td>I went to Roi Khaled Hospital but they refused to admit me because I had no money to pay the admission fee...I went to Prince Régent Charles Hospital. They, too, refused me because I had no money. I thought to myself, ‘There is nothing else I can do. If I have to die, I will die.’ I left, but then the doctor ran after me and said, ‘I will do it’</td>
</tr>
<tr>
<td>13-year-old boy, detained at Prince Régent Charles Hospital for over a year, after having already spent a year there for treatment for injuries suffered when hit by a car</td>
<td>I was in seventh grade in school but now I am not going to school any more. Now I am healed, there is just one small injury left. My family cannot pay the bill. I have been told that I cannot leave unless the bill is paid.</td>
</tr>
</tbody>
</table>

One hospital nurse reported that if bodies remained at the morgue for a very long time eventually the hospital would bury them.

Insurance and exemption systems
To mitigate the impact of user fees, the government of Burundi has developed three insurance and exemption systems, with different eligibility criteria and benefits. An insurance card (carte d’assurance maladie, CAM) is available to all Burundians. It can be bought for an annual fee of about US$0.50 and reduces the medical bill by 80%. An indigence card (carte d’indigence) waives health fees for impoverished individuals determined to be unable to purchase the CAM. And a voucher (bon de commande) waives health fees for internally displaced Burundians.

Information on insurance and social welfare coverage was obtained for 34 patients. Twenty of 34 (59%) detained patients had the insurance card (CAM) but still ended up in hospital detention. Many had obtained the CAM when they were hospitalized but cards purchased at this late date were rejected by the hospital. Large hospitals also excluded medical equipment and supplies from coverage by insurance. Some provincial hospitals accepted or promoted the CAM but detained patients if they could not pay the remaining 20% of their costs.

Most respondents not only did not have an indigence card but had not even heard about it. Detainees who had or tried to obtain the indigence card encountered difficulties. One hospital director said that the indigence card was not accepted because there was no reimbursement by the state and that vouchers were no longer available. Obtaining vouchers was described as so burdensome and complex that few eligible recipients completed the process.

In addition to these programmes there is a compulsory medical insurance programme for civil servants run by the state. However, as of June 2006, the programme owed hospitals large amounts of money. Key informants reported that insurance payments to hospitals for the programme were regular in the beginning of the year but generally stop by mid-year.

Alternatives to detention
According to key informants, some hospitals found ways other than detention to assure payment of bills. Measures included keeping patients’ identity cards or bicycles. Some facilities supported by international NGOs operated different models of health financing: patients paid a percentage of the costs or a flat fee (MSF 2004). Detention of patients was unusual in these hospitals. At a hospital that charged 300 FBU (US$0.30) for out-patient treatment and 500 FBU (US$0.50) for hospitalization, there were no detainees at the time of the visit by the research team. According to the financial and administrative director, there were patients who could not pay the flat fee, but they were treated nevertheless. In another province, a donor agency provided medicine and fees for medical consultations for indigent patients. This hospital had no detained patients.

Responses by key informants in authority
Senior government officials and hospital staff alike often denied the characterization of patients being held against their will as detention, or minimized the problem. According to the chief of staff in the Ministry of Health: ‘In my opinion, this is not detention or imprisonment. It is a long waiting period. If people cannot pay at all, they are [eventually] allowed to go. They might overstay 2 to 3 days or a week.’

Government and hospital officials also attempted to justify hospital detentions. For example, the chief of staff in the Ministry of National Solidarity, as well as several hospital managers, pointed out that hospitals would have to close if they lacked the funds to operate. Others suggested the alternative was to refuse treatment. Even when government and hospital officials presented the issue as deplorable, they refused to take responsibility for it.

Evolving government policies
In December 2005, the Ministry of National Solidarity—at the initiative of the President of Burundi—ordered the release of patients and announced it would pay their bills. While the
ad-hoc ‘charitable’ release of detainees provided good publicity for the government, it did nothing to solve the real problem. Shortly after Christmas 2005, hospitals were again filling up with insolvent patients in detention. In addition, the government did not reimburse the bills for those patients released, as promised, and by May 2006 the government owed four hospitals over US$50 000.

On 1 May 2006, President Nkurunziza declared that all maternal health care and treatment for children under 5 years old would henceforth be free of charge. He also announced pay raises for public service employees, and the creation of an anti-corruption brigade (IRIN 2006a).

Some observers have noted that increased pressure regarding the detention of hospital patients might have played into the decision to provide free care. Prior to the announcement of the reform, the Burundian government and the World Bank were discussing how to best use the US$10 million gained from debt relief, and the release of detained patients was one of the issues that arose.

While the directive on free maternal and child health has the potential of significantly improving access to health care, in practice it has been poorly implemented. During the first days of May 2006, thousands of pregnant women and parents of sick children made their way to the nearest hospital to benefit from the reform (MSF 2006). As hospitals were overstretched, patients were denied treatment and hospitals rapidly ran out of supplies and medicines. Patients have also complained that free medicine is only provided for hospitalized mothers and small children, not outpatients (IRIN 2006b).

The 1 May reform may have reduced by about one-third the number of persons being detained in hospitals. In June 2006, for example, there were no women with birth complications or children under five among the 77 patients detained in the two hospitals visited by the research team. However, the programme is not funded in the national budget, and as of August 2006, hospitals had not yet been reimbursed by the state for the care they had provided to pregnant women and small children.

Discussion
Breaches of human rights law
The detention of insolvent hospital patients violates a number of human rights that are established in international law, including the right to liberty, freedom from arbitrary detention, and for some, access to education and health care. According to the International Covenant on Civil and Political Rights (ICCPR), people have a right not to be arbitrarily detained or detained as debtors and a right not to be mistreated while in detention (United Nations 1966a).

In addition, health is a fundamental human right enshrined in numerous international human rights instruments. The International Covenant on Economic, Social and Cultural Rights (ICESCR) specifies that everyone has a right ‘to the enjoyment of the highest attainable standard of physical and mental health’ (United Nations 1966b). Each state that is party to the ICESCR agrees ‘to take steps…to the maximum of its available resources’ to achieve the full realization of the right to health, including availability, accessibility, acceptability and quality of care (United Nations 1966b; CESCR 2000).

Paul Hunt, the United Nations Special Rapporteur on the right to health, has further described the obligations of states in relation to the right to health and access to health care as follows: ‘the right to health can be understood as a right to an effective and integrated health system’, which is accessible to all. Hunt further explains that: ‘an effective health system is a core social institution, no less than a court system or political system’ (Commission on Human Rights 2006).

When Burundi became a party to both covenants in 1990, it became obligated to protect from detention and mistreatment debtors who cannot fulfill their contracts. Its minimum core obligations in terms of health care include assuring to citizens ‘the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups’ and ‘equitable distribution of all health facilities, goods, and services’ (CESCR 2000).

Ethical responsibilities of health professionals
The health professionals who participated in detaining patients also violated their own ethics and their conduct led to a breach of trust in a privileged relationship. All health professionals have a responsibility to care for their patients in an ethical manner. Doctors in Burundi take an oath as the basis of their ethics based upon the Geneva Declaration of the World Medical Association. Among other things, it says, ‘The health of my patients will be my first consideration;…I will not use my medical knowledge to violate human rights and civil liberties, even under threat’ (World Medical Association 1949).

Health policies in Burundi
Prior to the 1980s, health care services in Burundi were free of charge. In 1988 a prepayment system was introduced and management was decentralized to the provincial level (Phillips et al. 2004). As part of the change, hospitals continued to receive some state subsidy but were obliged to raise some funds themselves (République du Burundi, Ministère de la Santé 2005).

This prepayment system and the social welfare exemption systems subsequently implemented are now widely recognized as ineffective. The insurance card (CAM) is not accepted by some large hospitals and has been abolished in five of 17 provinces. The 2005 National Plan for Health Development for 2006–2010 seems to blame patients rather than the hospitals or the government for the collapse of the CAM: ‘the population does not have confidence in the illness insurance card (CAM) any more…This card is in the process of disappearing in most parts of the country’ (République du Burundi, Ministère de la Santé 2005). In one survey, only 1% of patients had the insurance card (MSF 2004).

Similarly, the voucher is currently accepted at only three hospitals, all in the capital. A study by Médecins Sans Frontières determined that where indigence cards and vouchers are still available, they are inappropriately targeted because qualification criteria are arbitrary and lack transparency (MSF 2004). Moreover, local communes are expected to cover the exempted costs but lack sufficient resources to do so.
The 2005 National Plan for Health Development began to address these problems by including a focus on improving maternal and infant health, subsidies for medicine for the poor, and health care for children under 5 years old (République du Burundi, Ministère de la Santé 2005). The Plan called for raising the health budget to 15% of the total annual budget, in line with the commitment made by African countries in 2001 (Organization of African Unity 2001).

Despite these commitments, our investigation found that the detention of insolvent hospital patients was routine and widespread, although not without exception. The government was not reimbursing hospitals for services provided under CAMs, indigence cards and vouchers, but at the same time it was pressuring them to recover their costs. Extracting payments by detaining patients has become an effective solution. In fact, the practice of debt payment by benefactors, whether private individuals or organizations, may have even encouraged hospitals to detain people by in effect rewarding them for the practice. According to numerous respondents, detention was a rational and acceptable policy that helped maintain the Burundi health care system financially, even though ethically, legally and in terms of human costs, it was not acceptable.

**International cost-recovery policy**

The situation in Burundi did not occur in a vacuum. In fact, it could be considered a logical result of over two decades of international health policy aimed at developing countries. Primary health care was free in many African countries in the 1970s and early 1980s, but in the 1980s the World Bank recommended structural adjustment programmes for low-income countries with large unpaid debts. Public spending for health and social programmes would be reduced and cost recovery mechanisms used to make up the loss (World Bank 1987; Hutton 2004). New funding was made available to countries but was contingent upon adherence to the new economic policies (Périn and Attarin 2003).

The Bamako Initiative, developed by the WHO and UNICEF and endorsed by African governments in 1987, reinforced the strategy. Under the initiative, communities were expected to establish cost recovery at the community level to increase health sector revenue, promote efficiency and equity, and improve quality. While cost recovery might include components such as user fees and community health insurance schemes, governments were expected to establish mechanisms to assure access to health care for people with no means to pay.

However, research has shown that, overall, cost-recovery initiatives for health financing rarely had the desired impact (McPake 1993; Hutton 2004; James et al. 2006). Cost-recovery schemes in Africa have raised less revenue than expected. In 1992 user fees provided only 4% of the recurrent budget costs in Burundi (Pearson 2004). Introduction of user fees has been associated with decreased health care utilization, while elimination of fees is associated with increased utilization (Haddad and Fournier 1995; Mbugua et al. 1995; Mwabu et al. 1995; Wilkinson et al. 2001; Ridde 2003; Deininger and Mpuga 2004; Palmer et al. 2004; Ensor and Ronoh 2005).

User fees have not been shown to increase the efficiency of health care use in low-resource settings, particularly the reduction of unnecessary utilization and increased utilization of primary rather than tertiary care (Poletti 2004; Brikci and Philips 2007). Although it is difficult to document the direct effects of user fees on health status, some indirect associations have been made. For example, when user fees were introduced for obstetric care in Nigeria, the number of assisted deliveries dropped by 54%, yet the number of maternal deaths increased by 56% (Ekwempu 1990).

There is little evidence that equity can be achieved through cost recovery. Numerous studies document a strong association between measures such as user fees and reduced utilization by the poorest (McPake 1993; Haddad and Fournier 1995; Mbugua et al. 1995; Ensor 2004). Moreover, while equity is an expressed objective in most national health plans, the means for achieving it are rarely sufficiently funded or operationalized (Russell and Gilson 1997; Gilson et al. 2000).

The hope that increased revenue from user fees would be used to improve quality of care has been reported in some studies, even among the poor. However, this has not generally been found to occur (Vogel 1988; Litvack and Bodart 1993; Haddad and Fournier 1995; Ensor 2004).

Other out-of-pocket health care costs besides user fees, such as transportation, lost income and unofficial payments to providers, raise the cost of even free health care. Altogether these can impoverish families who lack a financial cushion (Killingsworth et al. 1999; McPake et al. 1999; Xu et al. 2003; Ensor and Ronoh 2005; van Doorslaer et al. 2006). Prepayment has become accepted as a better method of cost recovery than user fees (Bennett 2004; Palmer et al. 2004; Carrin et al. 2005). In countries with large rural populations and extensive informal economic sectors, community-based health insurance (CBHI) is seen by some as an alternative to formal medical insurance plans and has been shown to have modest success in providing access to health care, but not for the most vulnerable populations (Moens 1990; Criel et al. 1999; Ekman 2004). According to Ekman (2004), ‘there is little convincing evidence that voluntary CBHI can be a viable option for sustainable financing of primary health care in low-income countries’.

Given the preponderance of this evidence, the World Bank no longer promotes cost recovery as the sole option, and donors have moved to a more nuanced position (Pearson 2004). In October 2000 the United States Congress passed legislation prohibiting the US from supporting World Bank loans which include user fees for primary health or education, ‘including prevention and treatment efforts for HIV/AIDS, tuberculosis, and infant, child, and maternal well-being’ (Public Law 2001). Yet cost recovery continues to be a common health financing model in Africa and the detention of patients is not a problem limited to Burundi. Echoing the justifications of detention provided by government officials in Burundi, in a recent report which included information on detentions of women in maternity wards in Kenya, Karugu Ngatia of the National Coordinating Agency for Population and Development said: ‘The policy is that you should be able to pay your bills. [Patients are] not detained—just given time to tell relatives to organize themselves’ (Center for Reproductive Rights and Federation of Women Lawyers – Kenya 2007).

Many policymakers in both international donor organizations and in low-income countries continue to defend user fee
schemes, or insurance system was not working properly and proposed The 2005 National Plan acknowledged that the current medical governance issues: lack of financial transparency

The structural problems of the Burundi health care system contributed to the failure of the cost recovery system. Furthermore, these problems remain unresolved. Financing mechanisms are inadequate and irregular. Hospital management is uncertain of reimbursement by the state through the medical insurance and indigence card systems. Patients are unsure what costs they will have to pay. The government subsidy to public hospitals covers only a fraction of operating costs and salaries of health personnel are very low.

Lack of guidelines on how funds are to be used and lack of transparency facilitate mismanagement, fraud and corruption. According to key informants, hospital staff have been involved in financial mismanagement and corruption. In 2005, officials at the National Commission for the Reintegration of the Displaced found staff at one hospital submitting false vouchers and fabricating and selling documents attesting to poverty or returnee status. International agencies that pay hospital bills for some of their beneficiaries have complained of cases of false or inflated bills prepared by hospital staff.

Government plans for the future

The 2005 National Plan acknowledged that the current medical insurance system was not working properly and proposed abolishing it and replacing it with a system of voluntary CBHI schemes, or mutuelles. The Burundian government proposes to promote these for the large proportion of the population that is active in the informal urban or rural sectors of the economy. While CBHI is traditionally created and funded through the local community, the Burundian government is planning to subsidize the mutuelles (République du Burundi, Ministère de la Santé 2005). Studies have shown that low enrollment is a frequent problem of CBHI. If the government creates mutuelles, it must develop a strategy to address this problem and make the programme viable.

The national health plan concedes that there might be difficulties in extending CBHI schemes to the poor and proposes state subsidies to ‘protect the most vulnerable groups such as pregnant women, children under five years of age and indigents’ (République du Burundi, Ministère de la Santé 2005). While the government has, as already discussed, taken steps to improve access to health care for pregnant women and small children, it has not done so for indigents. The Ministry of Health attempted to create a fund for poor patients in December 2005, but its plan was rejected during budget debates.

The President’s 1 May 2006 policy of free health care for women giving birth and children under five has ended most, if not all, detentions among patients of this vulnerable group. But the policy was imposed without planning and consultation, and will fail unless the government ensures the programme’s sustainability and increases staff, equipment and medicine throughout the country. Furthermore, the government must embed the new change in the context of a larger health policy which addresses all detainees.

Under the Heavily Indebted Poor Countries Initiative, Burundi has qualified for the initial phase of interim debt relief, subject to meeting certain conditions. During this period, the funds must go towards education, health and agriculture (IMF 2005). As a result, the government has almost tripled the health budget from about US$5 million to about US$15 million. If Burundi finalizes its debt relief agreement and gets permanent status, it will be free to set its own spending priorities and not be required to fund key social sectors (World Bank 2006).

The detention of patients is the most visible evidence of a failed health care system. However, our investigation did not directly examine either the threat of detention as a deterrent to accessing care or the consequences of selling assets or borrowing money to pay for care. In a previous study in Burundi, over half of poorer households who paid for health care sold assets and 20% borrowed money from a friend or relative. The study concluded that these are ‘risks, irreversible strategies’ that are ‘potentially catastrophic’ for poor households (Save the Children UK 2005). A larger study found that more than 80% of the households surveyed paid for health care by incurring a debt, selling assets (cattle, land or harvest), or by taking on additional work. Selling income-generating resources draws people more deeply into poverty (MSF 2004).

Conclusion

Resolving the issue of detention of insolvent patients in Burundi requires measures both to protect individuals from human rights abuses and to establish effective, equitable and transparent methods of financing health care. In both cases it is the state’s responsibility to take action, but it is also incumbent upon the international community to apply pressure on the government of Burundi to do so, and to support efforts in that direction. In April 2002, the World Health Organization, in a report by its Commission for Macroeconomics and Health, estimated that a minimum level of financing needed to cover essential interventions was between US$30 to US$40 per capita (WHO 2002). Burundi, with US$3 in total public health spending per capita, remains far from reaching this level and in need of increased international assistance. However, international donors must also press for an end to the detention of patients and for improved access to health care for the poor, in accordance with Burundi’s human rights obligations.

Interventions to protect patients from detention should include the establishment of legislative and administrative prohibitions against detention, with appropriate sanctions, as well as systems to assure identification and prosecution of individual and institutional perpetrators. Laws and administrative policies must create transparent, accountable and adequately funded state agencies that are in dialogue with civil society representatives and responsive to citizen complaints. Success should inculcate in government and health care institutions a respect for the rights of individuals and a commitment to meeting the needs of citizens. Preventing detention also requires financing mechanisms that enable...
health facilities to provide efficient, equitable and accountable health care. There is no reason to think that replacing an acknowledged failed system of prepayment and waiver mechanisms (CAM, indigence cards and vouchers) with yet another prepayment mechanism, the mutuelles, will work without providing a strong framework of government and institutional support and accountability.

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References


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