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The sudden removal of user fees: the perspective of a frontline manager in Burundi

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In May 2006, the President of Burundi announced the removal of user fees in all health centres and hospitals for children under 5 and women giving birth. As other studies also point out, the policy was adopted extremely suddenly, without much reflection on its ultimate aims and on the operational dimension of its implementation. From the perspective of a frontline manager, this paper provides a descriptive case study of the abolition of user fees in the Muramvya District and a first-hand account of the effects of the sudden reform in the management of a district and a district hospital. The analysis highlights the challenges that the district and hospital teams faced. The main issues were: the reduction of financial flows, which prevented the possibility of investments and caused frequent drugs stock-outs; the reduced quality of the services and the disruption of the referral system; the motivation of the health staff who saw the administrative workload increase (not necessarily because of increased utilization) and faced 'ethical dilemmas' caused by the imprecise targeting of the reform. Undoubtedly, the removal of user fees for certain groups was an equitable and necessary measure in an extremely poor country such as Burundi. However, the suddenness of the decision and the lack of preparation had critical and long-lasting consequences for the entire health system. This analysis, performed from the frontline perspective, clarifies the importance of a rigorous planning of any reform, as well as of involving peripheral actors and understanding the complex challenges that they face.

Keywords User fees removal, Burundi, frontline manager, peripheral level perspective

KEY MESSAGES

- While removing user fees for some vulnerable groups is necessary to help reduce inequities and improve population health, a radical reform that proposes the introduction of exemptions should be carefully planned and implemented to avoid long-lasting, disrupting effects on the health system.
- Political leaders in Burundi and elsewhere should better involve technicians and frontline actors in the preparation of such radical reforms. Peripheral actors usually have information on system functioning and health facility management that can effectively guide the implementation of the reform.
- An 'insider' view from a peripheral-level perspective is valuable in providing a first-hand account of events following the introduction of a new policy and can effectively complement a central-level analysis performed by an external researcher.

Introduction

Access to high-quality health services for all is an objective far from being achieved in the majority of the countries and in particular in sub-Saharan Africa. However, if we are to attain targets set by the international community, such as the health-related Millennium Development Goals (MDGs), and to improve the equity of health systems worldwide, much has to be done to move towards the elimination of all barriers that prevent access to care and, at the same time, to increase the quality of the services provided. The removal of user fees, which are charged to patients as they access health services, has been recently promoted in some countries and by some international actors as one of the key reforms to advance towards this goal (see for example, Pearson 2004; Save the Children 2005). As an increasing number of countries in sub-Saharan Africa are implementing this measure, a growing body of literature tries to evaluate the reform (see for example, Lagarde and Palmer 2008; Ridde and Morestin 2009; Ridde *et al*. 2010; Ridde and Morestin 2011). Some studies adopt a quantitative approach to analyse the impact of the reform, while others focus on the policy-making and implementation processes. As the debate evolves, attention is shifted from a narrow focus on the user fees abolition itself to the larger health systems, i.e. how this reform has been implemented and how it is integrated within the larger set of reforms taking place in a country (Yates 2009). These issues are found critical for the success or the failure of the policy (James *et al.* 2006).

This paper looks in the same direction, analysing the effects of user fees removal. It aims to draw lessons from the case study presented, not only looking at data on service utilization (new outpatient visits for children under 5 and assisted deliveries) from eight health providers in a district, but also including testimonies from insiders. Indeed, while most studies describe how the policy was conceived and implemented from the eyes of the central-level policy makers, this study adopts the point of view of a frontline manager of the Muramvya district hospital in Burundi, who directly witnessed the impact of the reform on a peripheral health structure. Some of the issues that emerge are similar to the ones in other analyses performed, but others have a specific 'insider' aspect that could help policy makers and researchers in the international community relate to the reality of the field experience.

Background

Burundi is a small, land-locked country of Central Africa. The population numbers around 8 million and resides predominantly in rural areas. Since independence, Burundi experienced continuing waves of conflict and instability, and from 1993 until recent times the country was essentially in a state of civil war. As a result, Burundi is one of the poorest countries in the world with an estimated Gross Domestic Product (GDP) per capita of US$144 in 2008 (Government of Burundi 2009). The health status of the population is one of the worst in Africa. The under-5 mortality rate is estimated at 181 deaths per 1000 births, while maternal mortality is as high as 1100 deaths per 100 000 live births (WHO 2008).

The health sector has a lack of qualified and well-trained health workers and has been chronically underfunded. In 2007, a few months after the removal of user fees, the Government of Burundi's funds allocated to the health sector represented only 4% of the total budget (MOH-Burundi 2009), well below the 15% level set by the Abuja Declaration (OAU 2001). The total health expenditure per capita was only US$17.4 in 2007. Of this, only 17% (almost US$3) was contributed by the government, while external aid accounted for 40% (almost US$7). The rest of the health expenditures are paid by households, mainly through out-of-pocket payments, which account for 38% of the total health expenditure (US$6.5) (MOH-Burundi 2009). The heavy reliance on out-of-pocket expenditures from households is clearly a problematic and inequitable aspect of the health system, especially in the light of the extreme poverty of the majority of Burundian households. Despite some efforts to introduce exemption schemes for the poor by the Government (*Carte d'Assistance Maladie*, CAM) and by some Non-Governmental Organizations (NGOs) in the provinces (for example, Médecins Sans Frontières in Karuzi), serious concerns about the effectiveness of these schemes remained (Save the Children 2003; Lambert-Evans 2009). Some actors have begun to perceive this high financial burden for health care on the shoulders of families as both a barrier to access to care and a breach of fundamental human rights (MSF Belgium 2004; Human Rights Watch 2006). The issue became even more obvious due to the frequent 'hospital detention' of insolvent patients (Kippenberg 2008). Along with other international partners, Médecins Sans Frontières and Human Rights Watch pressured for the removal of user fees, at least for some groups (an exemption policy). The President of Burundi became personally involved and took political leadership of the decision and the reform. In May 2006, he announced that services for children under 5 and women giving birth were to be free.

As Burundi was one of the six countries reviewed by the UNICEF multi-country review (see Meessen *et al*. 2011, this issue), a description and evaluation of the events has been carried out already by an external researcher (Noirhomme 2008). The UNICEF report describes the main issues from a central-level perspective. As shown for other countries, 'political will is not enough' (Ridde and Morestin 2011: 8). Before the President's announcement, little if no preparatory work was done to think over the aims of the policy and the operational dimension of its implementation. First of all, the policy to remove user fees was formulated in a hasty and incomplete way with little attention to: the ultimate objectives (whether equity in general or the promotion of the MDGs), the existing situation (no baseline study was undertaken) and the available financial resources. In this regard, no economic assessment of the impact of the reform was performed. The assumption was that the funds available from the Highly Indebted Poor Countries (HIPC) Initiative could cover all incremental costs. However, these funds ended within a few months, and a budgetary revision, as well as in-kind support from international donors, was required to keep the reform going. Secondly, the reform was announced before any accompanying measures were defined. The Ministry of Health (MOH) worked (and still works) to put in place the necessary structures and directives step by step, but these efforts are hardly enough. In particular,

a key issue is the reimbursement system, which was based on the submission of itemized bills to the MOH, which performed a first check before sending them to the Ministry of Finance for payment. This process was cumbersome (especially for health workers and administrators of health centres), lengthy (the delay in reimbursement could be up to 8 months) and prone to misreporting (checks were arithmetic, while there was no control on the real utilization of the billed items). Moreover, after several months, it was realized that this system entailed a double payment for drugs. They were given for free to the health centres (via the Provincial Health Bureaus) by the international partners, but also included in the reimbursements. Finally, the removal of user fees was not adequately monitored and evaluated, and there were no comprehensive analyses available of the impact of the reform (e.g. changes in utilization rates, perceived quality of services, drug stock-outs, costs, etc.) at country level.

This paper aims to shed light on the Burundian experience by complementing these findings with the perspective of a frontline manager. The analysis focuses on the health district of Muramvya. This district is one of two that compose the province of Muramvya, in central Burundi and covers a population of about 200 000. There is one referral hospital with 158 beds and 11 health centres (of which eight are public and three private not-for-profit). We next present an explanation of the study methods. The reform and its effects are then described from the peripheral level, with a narrative of the events as well as quantitative data on the effects on utilization within the district of analysis. Finally, these findings are discussed and conclusions are drawn in the last section.

Methods

Methodologically, this paper could be categorized as a 'case study' describing the impact of sudden user fee removal on the daily management of a district hospital and a health district, as reported by an insider using routine data and qualitative information he has access to due to his position.

The first step of the research was to collect data and information. The first part of the findings amounts to a narrative description of the events that occurred at health facility level after the introduction of the exemptions. It is based on the direct observation of one of the authors (MN) who happened to be the director of the district hospital in Muramvya at the time of the reform. The second part presents quantitative data collected in Myramvya on utilization rates for specific health services. The information collected focuses only on one district and it is not representative of the country as a whole. However, it is a useful supplement to the 'policy story'. In particular, the data refer to seven of the district's health centres (two of which are faith-based providers) and the district hospital. This sample represents the entirety of the district providers with the exception of: one health centre that is close to the hospital (therefore, all deliveries are systematically referred there), two health centres that were not open in 2006, and one private health centre that never applied the exemptions for the target groups. These data were collected directly at the health providers' level in 2009. The method of data collection and the source (the registries of the facilities) are the same for the length of the series. Because there was no incentive for the facilities' staff to over- or under-report the number of patients in the registries, the use of this source limits the possible detection bias. Although more reliable than the national health information system, we acknowledge that the quality of the data at facility level can be questioned.

In our analysis, we want to be clear about what Walt *et al.* (2008) call the question of 'positionality' of the researcher. Both authors of the study are 'insiders', although to different extents. The first author (MN) was the director of the Muramvya hospital from December 2004 to August 2008 and was therefore at this post when user fees were abolished. Subsequently, he pursued a Master in Public Health abroad, where he was able to reflect on these issues from a more objective perspective. The second author was in Burundi between 2007 and 2009, working directly within the MOH at central level, thus being an outsider turned into a 'temporary insider'. We do not consider ourselves 'objective' or 'independent' (Walt *et al.* 2008: 315), but we intend to carry out an analysis in the most rigorous way possible. We recognize our advantage of being 'insiders' and participant-observers, in terms of 'easy access, the ability to ask more meaningful questions [...], to be able to project a more truthful, authentic understanding of the culture under study' (Merriam *et al.* 2001: 411) and in bringing out another point of view. On the other hand, we are aware of the intrinsic tension between our role in the policy implementation and our role in its evaluation—indeed, we are both players and referees. However, this policy has already been evaluated by other external 'referees' (such as Noirhomme 2008), and 4 years after its announcement, it has been widely discussed both in Burundi and outside. We feel confident of being able to provide an interesting standpoint that brings a new perspective to the analysis, while at the same time being sufficiently rigorous. Although our conclusions may not be externally valid and are unavoidably context-specific (possibly limited to the Health District of analysis), we believe some lessons could be applied to other contexts, whether in other countries or regarding the implementation of reforms different from the removal of user fees.

The 'policy story': what happened at peripheral level after removal of user fees

The improvisation and unpreparedness of the reform implementation that we described at national level was reflected by what happened at peripheral level.

In mid-April 2006, the first author of this paper (MN) attended a meeting of all the directors of District Hospitals at the MOH. During the meeting, unexpectedly, the following news came: all providers (public and faith-based) were to provide health care services for free to children under 5 and women giving birth. Hospital directors eagerly waited for more details and explanations, but in vain. MN's first reaction was one of relief, being now able to free some of the insolvent patients who, though healed, occupied hospital beds needed by other patients. Indeed, many of the detained patients were women unable to pay the fees after a caesarean section. The new policy

might help in solving this absurd situation and partially avoid for the future what had been too often witnessed: households falling into debt when they had to pay for health care services. Although worried about the lack of support and explanation of the implementation by the MOH, he left the capital city enthusiastic about the historical reform they were about to begin for the benefit of the population. Back in Muramvya he met with a Government delegation from outside the health sector that was visiting the province and he was the first to report the news—not even they knew about it.

This immediate enthusiasm concealed the real, practical problems that were to be faced very soon by the hospital managers. After 2 weeks, on May 1, 2006, the President announced the reform to the population. The announcement was included in the broadcast speech given by the President to celebrate the public holiday and did not contain any details regarding the implementation procedures. From May 1, hospital staff began providing free health services and drugs to women giving birth and children under 5, but soon realized that they were running out of medicines. The hospital management team also realised that, because of the delays in reimbursement of the services provided for free, the hospital's debt with the pharmacies was becoming unmanageable.

Most hospitals in Burundi receive a small annual budget from the MOH, sometimes coupled with contributions (financial or in kind) by donors, and are allowed to retain the totality of user fees collected. Fees are charged separately for consultations, laboratory examinations and imagery services, treatment and prescribed drugs. All funds are managed by the hospitals themselves, which are autonomous. This includes buying pharmaceuticals and commodities either at the *Central d'Achat de Médicaments* or at private pharmacies. After the introduction of the exemptions, funds did not suffice to buy all the drugs needed and the management team at Muramvya Hospital decided that children under 5 simply could not be offered free care at the hospital outpatient clinic. This same decision was taken also by other hospitals in Burundi, in order to cope with the delays in reimbursements and with the fact that the MOH and international donors focused on providing free drugs and kits only to the health centres (and not to hospitals). Therefore, these financial issues did not allow for the provision of drugs for free to ambulatory patients under 5, although this was included in the announced reform.

This slowness in the reimbursement flow was caused, on the one hand, by the problems faced at hospital level to prepare the required documentation. For this reason, the Muramvya hospital manager decided to hire an accountant to speed up the procedure. On the other hand, however, the slowness at central level (Ministries of Health and of Finance) remained. The debt of the Government to the Muramvya hospital was US$53 000, US$59 000, US$32 000 and US$76 000 at the end of 2006, 2007, 2008 and 2009, respectively, amounts that were paid back with a delay of 12 months initially, which was reduced to 3–9 months from 2007 onwards.

The sudden decrease in the flow of funds also hindered the possibility of implementing the hospital's investment plan (such as new laboratory equipment, computers, etc.). Investments were, in fact, the first item to be cut off from the priority list. Moreover, even the normal management of the recurrent expenditures became critical: hygiene and cleaning equipment, petrol, paper and other consumables became increasingly difficult to purchase. Ironically, paper, ink cartridges and photocopy machines were the materials most needed to be able to produce the invoices to be sent to the MOH for reimbursement. In practice, in the months following the reform, the hospital was forced to limit its expenditure to drugs only.

The sudden reform also had a profound impact on human resources. Staff at the Muramvya hospital were initially supportive of the reform. The exemptions seemed a promising measure to favour vulnerable groups of the population and reduce the number of detained and impoverished patients, an issue that personnel was often forced to sadly witness without the possibility of addressing it. However, the first few weeks were sufficient to change their opinion, as the practical challenges became clear. The personnel of the hospital, whether providing health care or administrative services, saw their workload increase almost hour by hour. The reason was not only the increased utilization rates (see next section). As mentioned above, the complex billing procedure necessary to claim the reimbursements forced the hospital to hire another accountant at the expense of the hospital. The administrative workload was even more burdensome in the health centres, where staff are less numerous and (in most cases) there is no one exclusively charged with accounting. Often the health centre manager has to do it himself, taking out precious time from the provision of health care services.

For the health care personnel, the initial enthusiasm soon waned. Staff got tired of the new situation and in particular the chaos regarding the implementation procedures, which caused some 'ethical dilemmas'. Firstly, the law requires a set of identification papers (see Table 1) to be provided by the parents to prove that the child is under 5 years of age. But in cases where these documents were not all present, what should the staff do? Should the child be excluded from the user fee exemption? What about the children of single mothers (who cannot produce a 'family certificate')? With regard to deliveries, should a woman who comes to the hospital earlier in order to be already at the facility when the time of giving birth comes, be cared for free of charge until the delivery? And at the same time, how can payment be demanded from someone who returns to the hospital sometime after delivering her baby, suffering from post-partum complications?

Many critical decisions were taken by the management team at the Muramvya hospital with regard to these issues: some varied from case to case, but others were made for all cases. As mentioned above, drugs for outpatient services for children under 5 were not provided for free. To avoid complaints, sometimes the hospital staff declared these drugs were simply not available within the hospital and parents were required to buy them from private pharmacies. At the same time, the hospital team decided to consider the poor as beneficiaries of the measure (although they are not among the target groups if they are not under 5 years of age or not coming for a delivery) and to provide them with services free of charge. The alternative would have been to detain them within the hospital. The exemptions, therefore, only partially solved the problem of insolvent patients, as some other vulnerable groups remained excluded.

Table 1 Documents necessary to have access to free health care services

Type of document	Delay in issuing document	Fee charged
Children under 5		
Identity card of one of the parents	2–3 days	–
Family certificate	2–3 days	0.8 US$
Vaccination card	1 day	–
Mutuelle de la fonction publique (MFP) card for civil servants; or *attestation de service* (proof of work) for the privately employed	MFP card can take between 3–6 months to obtain after employment	–
Women giving birth		
Identity card or passport	2–3 days	–
Form for antenatal consultation	–	–
Mutuelle de la fonction publique (MFP) card for civil servants; or *attestation de service* (proof of work) for the privately employed	MFP card can take between 3–6 months to obtain after employment	–

In August 2008, when MN left his post of Director at Muramvya Hopital, the situation had hardly changed. The procedures to reimburse the services provided for free were somewhat accelerated by the creation of a verification team at MOH level (rather than at the Ministry of Finance), but the financial flows were still slow and insufficient to compensate for the lost revenues. The reimbursement mechanism remained the same. A more radical reform, with the introduction of reimbursements based on performance, was implemented since April 2010.

While still facing these issues and slowly trying to address them at country level, we were also interested to know how the 2006 user fee removal policy affected health care utilization by the target groups.

Quantitative data from health care providers

The data presented in this section refer to the period from January 2005 to December 2009, and therefore show a 'before and after' picture of the removal of user fees for the target groups (May 2006).

Some limitations of the quantitative data should be considered. As mentioned before, because they refer to a long period that extends well before the data collection (data from 2005 to 2009 were collected between mid-2009 and 2010), the validity of these data could be challenged. The analysis conducted is based on before–after observation, without control groups. The advantage of this type of quasi-experimental evaluation is that it uses the same information as the source of counterfactual inference (the same as the information used to assess the situation after the intervention). However, this is also a threat to internal validity, because of the possibility that changes that occurred between the two points of observation are the result of events other than intervention (history bias), or the natural evolution of the phenomena under consideration (maturation bias) (Haddad *et al*. 2008). The handling of the data does not take into account these potential biases, nor other biases found in longitudinal data analysis, such as non-stationarity, seasonality and autocorrelation (Lagarde 2011).

In Figure 1, denominators are used to take into account the change in population during the 5-year period of analysis and are calculated based on the population covered as indicated by the facilities. The graph shows a wide variation in attendance of health centres and district hospital for deliveries and no clear effects (or no effects) of the policy. Some of the variability can be explained by the issues we highlighted before, such as the sudden drug stock ruptures, the operational difficulties and the fact that exemptions were suspended when funds were lacking, which happened without a clear temporal pattern. Clearly, faith-based providers are utilized far more than public providers, due to their better quality and the fact that there is a widespread trust in faith-related organizations. Faith-based providers register a slight decline after 2007. One of the reasons for this is that most private not-for-profit providers in the country, after initially complying with the free health care policy, refused to continue doing so, as the reimbursements were arriving too late.[1] Both Bukeye and Shombo health centres reintroduced user fees for all services starting in 2007.

Figure 2 provides information on new outpatient visits for children under 5. The trend and pattern in variability here is even more difficult to identify, and there has been no widespread sharp rise in outpatient visits. In addition to the issues discussed above, the reasons for this may lie in the difficulties and costs that families faced in providing all the documentation required for children under 5. In particular, the necessary 'birth certificate' could be obtained for free only from 2008 onwards, while the 'family certificate' is impossible to obtain for single mothers. Moreover, the fact that drugs for children under 5 were to be purchased in the private pharmacies when the health centre was out of stock (which happened often) may have contributed to a rather limited increase in utilization.

Figure 3 shows the evolution of admission rates at the paediatric ward of the district hospital in Muramvya. Although constantly very low, admissions increase over time. The rising trend seems similar, though, before and after the removal of user fees. It can be noted that the increase was more evident in 2009, which can be explained by the improvement of the administrative reimbursement procedures. Contrary to deliveries, paediatric admissions often require drug prescriptions.

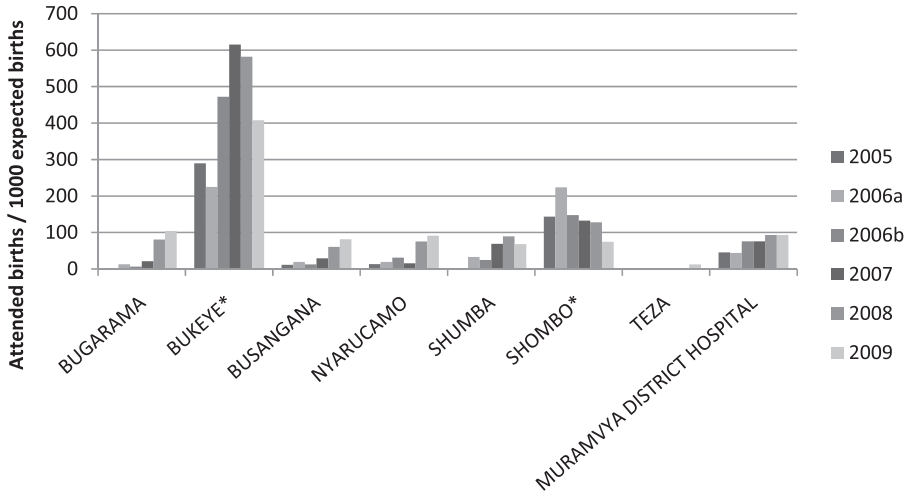

Figure 1 Number of assisted deliveries per 1000 people in health centres and district hospital, Muramvya District, Burundi, 2005–2009
Notes: *Faith-based (private not-for-profit) health centres. 2006a = before May 2006 (when user fees were removed). 2006b = after May 2006. (Data for 2006a and 2006b are extrapolated to an annual period.)

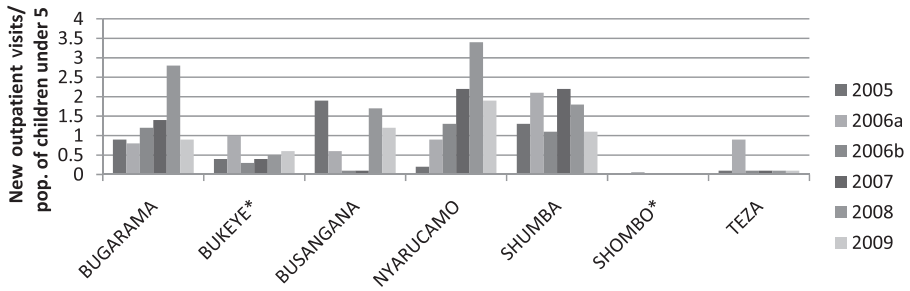

Figure 2 Utilization rates for outpatient visits by under-5s in health centres, Muramvya District, 2005–2009
Notes: *Faith-based (private not-for-profit) health centres. 2006a = before May 2006 (when user fees were removed). 2006b = after May 2006. (Data for 2006a and 2006b are extrapolated to an annual period.)

Initially, these drugs were bought outside the hospital at the patients' expense, but they have been provided for free since 2009, thus promoting the use of the health services.

In conclusion, it seems that the data and figures above provide no clear indication of any changes induced by the policy. They cannot be interpreted without referring to the narrative, for which they are a useful complement that confirms the issues that the 'policy story' highlights.

Discussion

In spite of the initial appreciation and enthusiasm for the reform among the population and health care workers, the impact of fee removal is mixed. Notwithstanding their limitations, the data show no clear impact on services utilization, and the narrative description of the 'policy story' helps explain some of the reasons for the mixed picture. Indeed, when assessing the reform against the 18 'good practices' identified in *Removing User Fees in the Health Sector in Low Income Countries: A Policy Guidance Note for Programme Managers* (Meessen 2009), Burundi has a very low score, as practically none of the recommendations contained in the guide were followed (see Meessen *et al.* 2011, this issue, for a comparison with the five other countries).

Here we consider further the experience against the four broad categories indicated in chapter 3 of the Guidance Note: (1) the policy process that leads to the adoption of the reform (agenda setting), (2) the importance of setting clear objectives and (3) of accurate targeting, and (4) the economic consequences of abolishing user fees (Meessen 2009: 11–16).

First, in Burundi, the decision to introduce the reform was taken at the highest possible political level, with little involvement of technicians at the MOH (at central level) and no involvement of health staff at peripheral level. The agenda-setting process is often regarded as an intrinsically political stage that involves only the central level and it tends to be entrusted to politicians rather than technicians. However, it is also recognized that, notwithstanding this common practice, 'a top-down process can be a frustrating experience for technicians' (Meessen 2009: 11) and can lead to multiple challenges in the implementation stage. As noted in other countries (Kajula *et al*. 2004; Walker and Gilson 2004; Witter and Adjei 2007; Witter 2007a; Witter 2007b), a more participatory approach and wider discussion with all actors, including those in the field, would have been highly beneficial to better plan the reform and its implementation. This is even more true in the case of Burundi, where, because of the lack of an effective health information system, the information available

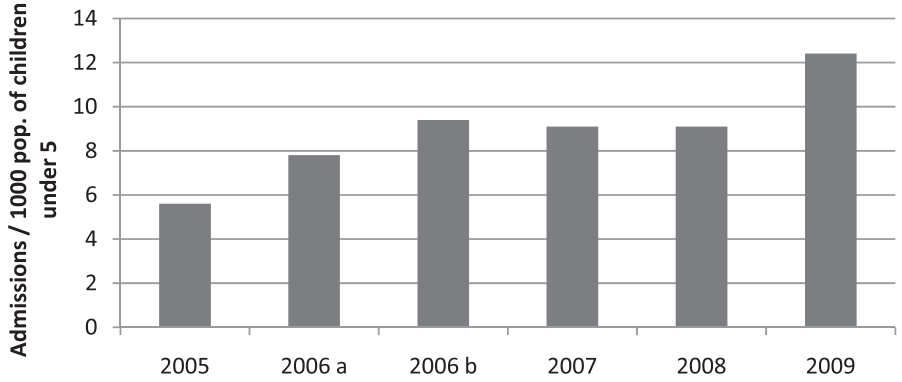

Figure 3 Admission rates at the paediatric ward of the district hospital in Myramvya, Burundi, 2005–2009
Notes: 2006a = before May 2006 (when user fees were removed). 2006b = after May 2006. (Data for 2006a and 2006b are extrapolated to an annual period.)

at central and peripheral levels sharply differs. In general, actors in the field have more detailed information on the applied protocols and the real beneficiaries of the measures in comparison to the central level, and could thus have effectively guided the implementation of the policy.

Secondly, the objectives of the user fees removal in Burundi were not sufficiently clearly established. The only reference to them occurred in the Presidential Decree that vaguely referred to the 'reduction of inequities in the access to healthcare services' (cited in Noirhomme 2008: 15). Also Médecins Sans Frontières, one of the supporters of the reform, argued that, '. . . strategies, such as free care for everyone or targeted groups such as the under-5s and pregnant women [. . .] are needed to ensure increased access to effective health services for the poor' (Lambert-Evans *et al*. 2009). However, if equity was indeed the objective, as the discourse seemed to imply, there was no careful consideration of some related and very important issues. First of all, inequities affect not only women giving birth and children under 5, but also other vulnerable categories (e.g. the poor, the elderly, widows and handicapped people) that were not considered in the policy. This resulted in frontline managers autonomously deciding to exempt some additional patients from payment, instead of detaining them within the health facilities. In addition, in Burundi as in other African countries (Hjortsberg 2003; Richard 2004; Gilson and McIntyre 2005; Kruk *et al.* 2008), user fees represent only one of the barriers that hinder access to health care. Other barriers, whether financial (costs of travel, drugs, required documentation, food, etc., plus indirect costs) or cultural or quality-related, continue to exist (James *et al.* 2006) and should be carefully addressed by establishing clear objectives and targets, if the ultimate aim is an effective reduction of inequities in access to health care.

Moreover, the lack of attention to the objectives of the reform did not permit a real discussion on the side effects of the removal of user fees for some groups, in particular on issues regarding the quality of services and the effects on the public and private not-for-profit sectors. At peripheral level, this had significant repercussions. Quality of services decreased, as shown by the frequent drugs stock-outs, the longer waiting times and the decreased duration of patients' contacts with health staff, while the private not-for-profit sector refused to comply with the law and managed to keep higher standards of quality (thus becoming more appealing to the population than public providers). Another effect concerned the functioning of the so-called 'pyramid of health care'. Contrary to other countries (such as Uganda and Madagascar; see Nabyonga *et al.* 2005 and Cholet *et al*. 2008), the specified services in Burundi were made free across levels (health centres and hospitals). This resulted in patients accessing hospitals directly without real need, disrupting the correct referral system and creating frustrating situations for the health workers.

Thirdly, the lack of clear operational guidance regarding the targeting of the reform and the procedural chaos that followed resulted in the 'ethical dilemmas' that health workers often faced. This issue clearly emerged at provider level and has been rarely highlighted by other evaluations. Health personnel were left to face important decisions regarding whether or not to provide services free of charge to groups that are vulnerable and represent borderline cases between the target groups and outside (as exemplified in the 'policy story'), such as children under 5 without the necessary documents, children over 5, as well as women during pregnancy and right after birth giving.

This impacted also on the motivation of the health workers. As in other countries (such as South Africa; Walker and Gilson 2004), health workers had an ambivalent reaction to the removal of user fees. On the one hand, they are professionally motivated as the policy allows them to treat patients for free and contribute to the health of the population. On the other, they are frustrated by the few patients who take advantage of the system (such as the women who arrive at the hospital 2 weeks before the due date), by the increased administrative workload and the reduction of financial resources available to purchase necessary items such as drugs, recurrent and capital equipment (see below).

Fourthly, the economic consequences of the removal of user fees were not carefully addressed. User fees represented an important source of income at peripheral level and their abolition was not accompanied by an efficient and timely reimbursement system. The effect was dramatic for the health care providers who found themselves with fewer resources both for investment needs (which became impossible to address), the daily management of the health facilities and for the purchase of essential, basic items, such as drugs (especially for hospitals that did not receive replacement stocks from the Provincial Health Bureaus or international donations). As found elsewhere (for example in Uganda; Nabyonga *et al*. 2008),

medicine stock-outs became a recurrent problem at hospital level and the only feasible solution was to apply a charge to prescriptions for under-5s' outpatient visits or to ask patients to purchase them outside of the hospital. These financial problems compromised the quality of the health care provided, decreased the motivation of the health personnel and raised questions about the equity of the reform and its potential to reach the most vulnerable, as the real poor seemed still to be excluded from the services.

Conclusion

In Burundi, the Presidential decision to remove user fees for some vulnerable groups was a necessary measure to reduce inequities and improve the health of children under 5 and their mothers. As 'insiders', we fully support the decision and, to our knowledge, there is a broad consensus in the country on the issue.

However, just like many other 'insiders', we have observed how the suddenness of the decision, the lack of preparation and of a carefully considered planning process had critical consequences for the entire health system. These long-lasting, disrupting effects still need to be addressed. As in other countries that have abolished user fees, a negative attitude towards the reform is unnecessary. Now is the time to be proactive in finding immediate and appropriate solutions to the issues identified and to complete the reform in order to reorganize the health care system.

It is also important to reflect on what has happened. Notwithstanding the limitations, the data we presented show no evidence of change in utilization after the introduction of the reform. We discussed the numerous issues that may have contributed to this insignificant effect. Moreover, our particular policy story is helpful in providing insight into the impact of reforms at peripheral level and into the daily management of health facilities. It can highlight lessons that are important for countries wishing to remove user fees or to implement other health sector reforms. These lessons are not new. Careful planning and phased implementation, assessment of the financial implications, evaluation of the efficacy of targeting, establishment of a monitoring system (ideally starting from a baseline survey before implementation), careful evaluation of the impact of the reform on the health system and of its interaction with already existing policies—all of these are critical for the success of a reform (see for example, James *et al*. 2006 and Meessen 2009). The observed effects of the sudden removal of user fees, as seen from the eyes of a frontline manager, should help clarify the necessity of involving peripheral actors in preparing such a radical reform. Moreover, they highlight the importance of understanding the complex challenges that peripheral staff face, which are often, and easily, overlooked when only a central-level approach is adopted.

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Conflict of interest

None declared.

Endnote

[1] Most faith-based providers in Burundi hold an agreement with the MOH and are subject to the same rules and regulations of the public sector, including the way services provided for free are to be reimbursed. Health centres so-called *agrées* initially complied with the policy on user fees removal. However, as it soon became clear that free services were very slow to be refunded, they refused to comply with the national law, claiming that the delays in reimbursements were disrupting the functioning of their structures.

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