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*Committee on Development*

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# **DRAFT REPORT**

on health care systems in sub-Saharan Africa and global health  
(2010/2070(INI))

Committee on Development

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## CONTENTS

	<b>Page</b>
MOTION FOR A EUROPEAN PARLIAMENT RESOLUTION .....	3
EXPLANATORY STATEMENT .....	9

## MOTION FOR A EUROPEAN PARLIAMENT RESOLUTION

### on health care systems in sub-Saharan Africa and global health (2010/2070(INI))

*The European Parliament,*

- having regard to Article 25 of the Universal Declaration of Human Rights, which recognises health as a fundamental right,
- having regard to the right of every individual to enjoy the best possible state of physical or mental health he or she is capable of attaining,
- having regard to the 1987 Bamako initiative and its objective of 'Health for All by 2000',
- having regard to the Alma-Ata Declaration of 1978 defining the notion of primary health care,
- having regard to the Ottawa Charter for Health Promotion of 1986,
- having regard to the proposal from the International Children's Emergency Fund, endorsed by the WHO in 1987, seeking to revive the policy of primary health care and combat child mortality,
- having regard to the 1988 Abidjan Platform on 'Strategies to support mutual health organisations in Africa',
- having regard to the United Nations Millennium Development Goals (MDG) of 2000, concerning in particular human development (health and education), water and energy, rural development, agriculture and food security, and, more specifically, goals 1, 4, 5, 6 and 8,
- having regard to the Cotonou Agreement of 23 June 2000, revised on 25 June 2005,
- having regard to the European Union's priorities as defined in December 2005 in the 'European Consensus on Development',
- having regard to the Ouagadougou international conference of 2008 on primary health care and health systems in Africa and the undertaking given by the Heads of State present to increase the resources allocated to health to a minimum level of 15% of national budgets,
- having regard to the declarations by the West African Economic and Monetary Union (UEMOA) seeking to introduce universal sickness insurance for the region's populations and its regulation (No 7/2009) of 26 June 2009 regulating social mutual schemes in the UEMOA region,
- having regard to the 10th European Development Fund for the period 2008-2013 and the Council decision of December 2005,

- having regard to the Declaration of Paris of March 2007 following the 'Consortium' Conference (G8, ILO, WHO, WB, IMF, OECD) on health insurance cover,
- having regard to the priorities of the EU-Africa Fiduciary Fund laid down in April 2007 and, in particular, those relating to the development of infrastructure networks in Africa,
- having regard to the global initiative for an 'International Health Partnership' launched in London on 5 September 2007, seeking to improve coordination of external aid at bilateral and multilateral level,
- having regard to the G8 Summit of June 2007 and the launch of the initiative 'Providing for health' for the development of sustainable, equitable and 'pro-poor' health financing systems with universal coverage,
- having regard to the European Union's new financing instrument for development cooperation (DCI),
- having regard to the special report of the Court of Auditors of the European Union (10/2008) on EC development assistance to health services in sub-Saharan Africa,
- having regard to the African Union/European Union joint strategy on health, drawn up in Lisbon in December 2007,
- having regard to the Presidency/Commission unofficial joint document adopted at the informal meeting of development ministers of September 2008 in Bordeaux on sickness insurance cover and the financing of health systems in the developing countries,
- having regard to the 2008 Algiers Declaration on health research,
- having regard to the 2008 Ethekewini Declaration on hygiene and sanitation,
- having regard to the Libreville Declaration of August 2008 on health and the environment in Africa,
- having regard to the 2008 Bali Declaration on waste management for human health,
- having regard to the objectives laid down by EuropAID for the period 2009-2013,
- having regard to the declaration of the 'Association internationale de la mutualité' (June 2009) on the role of mutual provision in universal health care systems,
- having regard to the work undertaken by the STEP I and II programme (Strategies and tools against social exclusion and poverty) of the International Labour Office, seeking to combat social exclusion, reduce poverty and promote decent work through innovative strategies to extend social protection,
- having regard to the Yaoundé Declaration of September 2009, approved by the members of the Concertation between actors in the development of mutual health organisations in Africa, expressing the view that mutual health organisations are an appropriate response for achieving the goal of universal coverage in low- and middle-income countries,

- having regard to the adoption in April 2009 by the United Nations Chief Executives Board of the global initiative for a 'social protection floor', based on a coherent and structured set of essential social transfers and basic social services, including health, to which all citizens should have access,
  - having regard to the work of the ACP-EU Joint Parliamentary Assembly of 3 December 2009 and in particular its resolution on agricultural problems and climate change which can only have an adverse effect on public health, and to the Climate For Development in Africa initiative,
  - having regard to the Commission communication of 31 March 2010 on the EU role in global health (COM(2010)0128),
  - having regard to the conclusions of the 3011th meeting of the Council of Foreign Affairs Ministers of 10 May 2010 on the role of the European Union in global health,
  - having regard to Rule 48 of its Rules of Procedure,
  - having regard to the report of the Committee on Development (A7-0000/2010),
- A. whereas vertical health funds have succeeded in reducing the mortality rates from major diseases such as tuberculosis, malaria, and others, and whereas these efforts must be continued,
  - B. whereas the international community, including the EU, must focus its efforts on the implementation of this national policy,
  - C. whereas basic health systems must tackle all health problems and whereas, therefore, both the horizontal and vertical approaches are necessary and complementary,
  - D. whereas, under a properly structured horizontal approach, insurance systems can be developed (mutual health organisations, micro-health insurance, etc.) where beneficiaries become actors in their own health,
  - E. whereas, in Africa as elsewhere, health is not a commodity and whereas non-profit making approaches to health insurance should be pursued based on the values of solidarity and democracy,
  - F. whereas many initiatives seeking to establish sickness insurance schemes emerged in Africa during the 1990s and the social dynamic they reflect must be supported,
    1. Points out that health is a reflection of the socio-economic level, democracy and good governance of states;
    2. Points to the importance to the economy of the sub-Saharan countries of external factors such as international market rules, cooperation policies, the financial crisis, climate change, and the policies pursued by major pharmaceutical companies and major international financial institutions;
    3. Stresses that these external factors can radically reduce the margin for manoeuvre of states

wishing to provide good governance and can have a profound effect on the health of their populations;

4. Points out that the universal right to health is a transversal right which cuts across various legal areas, such as health and welfare law, labour law and civil law;
5. Points out that women have the right to exercise full control over matters relating to their reproductive health, as regards procreation, contraception, abortion or sexually transmitted diseases; points to the fact that they are still subject to genital mutilation and extreme violence, while rape remains a weapon of war;
6. Is concerned that private organisations receiving European funding and providing health care services for African populations may, under the influence of religious movements, restrict certain types of reproductive health care and preventive treatment;
7. Condemns the proliferation of sects which exploit the credulity of the most vulnerable populations to provide pseudo-health care, while the authorities do nothing to intervene;
8. Is alarmed at the growing commoditisation of health care and the emergence of a two-speed medical system in countries experiencing political difficulties and shortcomings as regards good governance;
9. Supports the often admirable work done by non-governmental organisations working in conflict-torn regions, but points out that emergency efforts of this kind cannot be a lasting solution and are no substitute for sustainable health and insurance systems;
10. Notes that a large part of the population of sub-Saharan Africa, particularly in rural areas, is unable to afford health care or drugs, even of the generic kind;
11. Welcomes the fact that, despite the humanitarian, economic and political difficulties they face, many sub-Saharan countries are attempting to introduce policies that will improve or allow access to health care for their populations, albeit of a basic type;
12. Considers it necessary for states to organise functional health services which are socially efficient and affordable, while also dealing with health care demand issues and thus the role of mutual health organisations within the health system;
13. Welcomes the success achieved by vertical funds in proving attractive to donors and the progress made in combating major pathologies such as AIDS, tuberculosis, malaria, poliomyelitis and other serious diseases; stresses, however, that this vertical approach can under no circumstances be a substitute for a sustainable horizontal approach to basic health care;
14. Points out that a horizontal approach to basic health systems, with the participation of the public authorities, but also numerous other actors, is the only way of producing a long-term and sustainable improvement in the living and health conditions of populations;
15. Stresses that it is unlikely in the short term that these states will be able to fund national health care systems from their tax revenues alone and that a mixed funding system must

be found;

16. Welcomes the diagonal approach adopted by some vertical funds, which have decided to devote part of their resources to consolidating the health care systems of the countries affected by the pathologies targeted;
17. Believes that the introduction of a health insurance scheme can help to place a health system on a sound financial footing and that every effort should be made to structure such schemes effectively at local level;
18. Considers that health insurance schemes must be based on solidarity and tailored to the cultural, social and political context in which they operate; accordingly, they should not be a mere transposition of an imported model or an unchanged colonial legacy;
19. Considers that health insurance schemes must provide universal access to health care and must be non-profit making and participatory;
20. Considers that a health insurance scheme can help to guide and influence the health policy of the state in which it operates, to the advantage of its beneficiaries;
21. Considers that mutual schemes are the best way of creating a social dynamic based on the values of solidarity and providing universal access to health care;
22. Considers that mutual schemes play an important role in improving social cohesion and in facilitating advocacy of quality health care access and genuine public participation in the planning and implementation of health policies, while combining well with formal social protection schemes;
23. Notes that the mutual approach has been able to tailor insurance provision to the socio-economic characteristics of populations in an informal economy which remain excluded from formal schemes and commercial insurance and that as a result it is an appropriate solution for achieving the goal of universal coverage in low- and middle-income countries;
24. Notes that the main objective of mutual organisations is not to take the place of the state but to offer an alternative, enabling the obstacles to health care access to be overcome and providing improved access to quality health care for all citizens regardless of their income, while encouraging the state to reinvest in this area;
25. Notes that various countries such as Burundi, Burkina Faso, Cape Verde, Senegal, Benin, Rwanda, Tanzania, Ghana, Nigeria, Guinea and Cameroon are introducing systems which sometimes differ widely, but which are bearing fruit;
26. Expresses the need for systems to adjust to the values of solidarity and to African culture, the concept of family being widespread in Africa, something which raises the question of the number of beneficiaries to be covered by mutual aid schemes if they are organised on western lines;
27. Stresses the need for interdependency between insurance schemes and the way in which

horizontal health care is structured, as populations will not see the value of paying contributions unless access to health care and medicines is guaranteed;

28. Firmly believes that populations need to be informed about insurance through appropriate awareness campaigns.
29. Calls for the Commission's programmes to continue to place emphasis on specific projects targeting socio-economic health determinants in the form of drinking water, road infrastructure, food security and measures to combat climate change;
30. Calls on the Commission to provide transparent financial health indicators for the different countries, including the disease burden, child and maternal mortality rates, population size, income levels, etc.;
31. Calls on the Commission to support the horizontal health model and to include in its health policy principles the role to be played by mutual systems as a health protection mechanism in combination with other methods in helping to extend health cover;
32. Calls on the Commission to adopt a firm stance at the meeting of the Global Fund to Fight AIDS, Tuberculosis and Malaria to be held in New York in October 2010 and to embark on specific projects for the period 2011-2013;
33. Calls on the Commission to supplement its aid for vertical funds with recommendations designed to encourage 'diagonal' measures to support basic health care in the countries concerned;
34. Calls on the European Union to make the most of the potential offered by the mutualist movement for organising health demand and to support the many existing mutualist initiatives designed to promote access to health care;
35. Calls on the Commission to ensure that European policies on reproductive health are properly promoted among all associations receiving European funds;
36. Calls on the Council to remind the Member States of their financial commitments in the area of cooperation assistance;
37. Calls on the Commission to comply with the remarks and recommendations addressed to it by the Court of Auditors (Report 10/2008) with regard to the development aid it provides for health services in sub-Saharan Africa as part of its commitments aimed at achieving the Millennium Goals;
38. Instructs its President to forward this resolution to the Council and the Commission.

## EXPLANATORY STATEMENT

The health problems existing in sub-Saharan Africa are a severe test of the solidarity between North and South. The fact that the life expectancy of an African or a European can differ by 30 or 40 years can only be seen as striking. This disparity reflects the problems faced by an entire continent still marked by its colonial past when it comes to making progress today. Bad governance in some countries, the drastic effects of the financial crisis, climate change, natural disasters, extreme poverty, wars, tax havens draining the continent's resources, the ultra capitalism practised by the big multinationals, ethnic conflicts, the greed inspired by extraordinary natural resources, the major epidemics such as aids - all these factors combine and interact to create a complex situation.

The emergency aid provided by NGOs funded by the EU and the international community as a whole is a very piecemeal response to this complex situation. It makes it possible to deal with the most urgent cases and provide free care for those most in need. Yet not everyone is lucky enough to benefit from such aid, which does not offer a sustainable model for the future. On the contrary, in some regions it acts, paradoxically, as a brake preventing responsibility for health care being assumed by the state, by complementary structures or even other alternatives operating on the basis of solidarity. Health indicators in Africa are so alarming that health care privatisation can only increase these blatant disparities.

That is why this report calls for sustainable health systems, even if it is unlikely, according to the World Bank, that developing countries will be able in the near future to finance their own national systems from their tax revenue. Non-profit-making systems with mixed financing from state resources, international support and public participation are the best way to meet the immense challenge posed by health care in sub-Saharan Africa. In 2006, international aid covered 0.25 to 0.5% of health budgets in this region. Yet, even with this level of aid, the problem remains vast. First of all, because the global financial crisis does not encourage European countries to keep their promises, in other words to give at least 0.7% of GDP in development assistance by 2010. Secondly, because traditionally health is not a priority. For example, aid for health amounts to only half of the amount allocated to education. While the importance of this latter sector should not be underestimated, this disparity tells its own story. Finally, because the problem still remains of how funding is to be targeted.

Recent decades have seen a growing prevalence of so called 'vertical' funds targeting specific diseases - AIDS, Tuberculosis, Malaria, Poliomyelitis, etc. siphoning resources away from international aid and private initiatives. The result in terms of research, vaccination and prevention has been remarkable, yet it has had the perverse effect of weakening aid for basic 'horizontal' health care systems. These horizontal systems relate to general health: access to treatment and medicines for the entire population without discrimination, the challenges posed by child and maternal mortality, commonplace yet fatal diseases such as dysentery, often caused by poverty, lack of hygiene, absence of drinking water, etc. The variety of health systems existing - or striving to exist - in Africa can be endlessly analysed. This very general term includes basic infrastructure, health actors, care provision, drugs and the pharmaceutical companies which sell them, the international community, NGOs, churches, sometimes sects ... and ordinary citizens, whether sick or healthy. As a donor, it may seem safer and simpler to

finance clear targets and this is one of the reasons that vertical funds have proved attractive. However, the growing criticism from health experts concerned at the financial imbalance between vertical and horizontal systems is leading to a solution whereby some vertical funds now opt for what is known as a diagonal policy. They devote part of their funding to supporting basic health systems. These efforts should be encouraged and popularised. These vertical funds need to support full and integrated health systems rather than undermining them. Yet the weakness of basic health systems leads to other perverse effects. The many scourges and conflicts experienced by Africa have led to the spread of emergency care provided free of charge by NGOs or churches, which do admirable work yet with little continuity. This emergency care is vital but is no substitute for a sustainable health policy.

However, one aspect of this partial funding of health systems is of great interest, namely the participation of civil society and the assuming of responsibility for health by citizens in original forms based on solidarity. Since the 1990s, Africa has seen the emergence and gradual growth of a wide variety of mutual health structures, including community organisations, or organisations of farmers, young people and women with trade union- or mutual- style structures<sup>1</sup> Micro-insurance<sup>2</sup> has aroused growing interest and efforts to develop mutual structures, in some cases encouraged by governments, have started to develop.

These efforts call for participatory governance, since listening to and assessing the needs of the people are at the heart of the process. They also require a legislative framework and wide-ranging efforts to educate the public authorities, medical practitioners and citizens<sup>3</sup> Yet they are attempting, in a variety of different ways closely linked to local circumstances to promote access to quality health care based on solidarity, non-exclusion, democracy and non-profit-making. We have seen both public and private initiatives, with churches, non-denominational philosophical and political networks, and other associations entering the fray.

There are, however, many obstacles:

- to be able and willing to pay for health insurance, populations need to have a modicum of resources. The poorest cannot afford it;
- the necessary infrastructures and medical practitioners must be available. There is no point taking out insurance if there is no doctor, no dispensary, no hospital, no pharmacy Basic health infrastructures are a precondition for any mutual health system. In urban areas, and even more so in rural ones, those who cannot afford to attend health centres turn to traditional healers and buy medicines from markets or from itinerant drug sellers. Yet even where such infrastructures exist, health centre attendance rates are very low (0.24 per year in Mali ,0.34 in Burkina Faso and 0.30 in Benin);
- political stability is also required, since alternative models and specific infrastructures are needed in times of conflicts, violence and war;
- finally, types of insurance and mutual systems must be found which are tailored to local African conditions and values and do not attempt to transpose a western model to the

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<sup>1</sup> COHEUR Alain (2009) Structures mutualistes en Afrique. Les mutuelles de santé, actrices de changement social, *Politique*, HS13, November 2009,27-29.

<sup>2</sup> Micro-insurance brings together a number of health care funding mechanisms including mutual health organisations, pre-payment systems, solidarity funds, credit/health combinations.

<sup>3</sup> MARIKO Lamine (2009). Burkina Faso. La mutualité, un pas vers la protection sociale. Les mutuelles de santé, actrices de changement social. Regards Nord-Sud. *Politique*, HS 13, November 2009, pp25-26.

continent.

Various African countries have launched promising initiatives with the help of the international community. For example, Burkina Faso, Senegal, Burundi, the Democratic Republic of the Congo and Cape Verde have embarked on a programme supported by an NGO. This ambitious programme is entitled 'The Right to Health'. It gives priority to a community-based approach and involves 153 community organisations in the countries concerned. It also works in combination with other programmes, such as 'Decent Work, Decent Life' and 'Food Security and Sovereignty', since health cannot be divorced from the need to eradicate poverty, and combat hunger and social inequalities. Its key idea is a system of networking where various mutual organisations support and sustain each other at local, national and international level. In this way, not only are they able to act more effectively at their respective levels, but they can also influence social security and health policies in the countries where they operate.

In Burkina Faso, the government has studied a project for universal sickness insurance. In Burundi, the plans to develop mutual structures are backed up by a highly-structured system from bottom to top. The country's National Confederation of Coffee-Growers brings together more than 100 000 producers and the goal is to establish 25 mutual health organisations, divided into 5 unions with a national federation. In the Democratic Republic of the Congo, mutual structures such as the Musaru Mutual Health Organisation in East Congo are struggling to survive in the face of competition from NGOs providing free services, particularly in conflict zones. In this region, however, it is churches which are a driving force behind the development of mutual structures, operating through a well-established and efficient network.

A number of essential questions underlie the debate on mutual health structures in Africa. What role do such structures play compared to the efforts pursued by states seeking to establish health care structures? What role do mutual structures play in relation to NGOs providing a full range of services free of charge? To what extent can African mutual organisations, of which there are hundreds of different models, be something more than a corporate, religious or even ethnic sideline and emerge as a social movement? How can the international community play a supporting role, or even take initiatives, while allowing the African structures to develop autonomy and take responsibility for themselves? The mutual model offers an alternative to the efforts of the state, but requires solidarity on the part of its members. It may be that it needs wealthy members too. The West African Economic and Monetary Union recently adopted a supra-national regulation on mutual health organisations and several countries are attempting to introduce a compulsory sickness insurance scheme. Will it be possible to maintain the values of solidarity, dynamism and a flexibility which should guide African mutual organisations, which are developing against a background of highly complex circumstances? It seems that we are now at a crossroads.

A sustainable mutual model should possess different qualities. It should be based on solidarity - between north and south and among its members - but in the long term should aim to gain its autonomy and become self-financing. It should be flexible and adapt to different circumstances. It should aim for equality, not in the individual's contribution to its economic survival, but in the access to health care it provides. It should be participatory and embody a social dynamic, so as to be able to influence and even guide health policies and bring pressure

to bear on governments. It should not therefore depend directly on the government in office, otherwise it might commit the same errors or even be guilty of the same shortcomings. Finally, it must link the actors on the ground and involve them in the health care process. It must be economically viable in the long-term, based on solidarity, flexible, dynamic and participatory. It is a lot to ask, but the initiatives described above are moving in this direction.

The European Union has a role to play in the introduction of health structures based on solidarity. First by working to ensure that the pre-conditions for mutual systems are met, by providing advice, guidance and funding of basic health care systems, together with access to drugs, without which no health insurance system can develop. It must provide the countries of sub-Saharan Africa with transparent funding based on health indicators reflecting the needs of the population. It must support programmes to educate the population in prevention and early diagnosis of diseases, since the low attendance at health centres where they do exist, points to a problem which is undoubtedly more than financial. Lastly, it must support international solidarity programmes to develop initiatives and exchanges which will allow the creation of mutual networks that can bring about social transformation. Europe demands that health care should not be commoditized and that must be the rule for Africa too.