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Valéry Ridde, Bonnie Campbell & Andréanne Martel

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## VIEWPOINT

### **Mining revenue and access to health care in Africa: could the revenue drawn from well-managed mining sectors finance exemption from payment for health?**

Valéry Ridde\*, Bonnie Campbell, and Andréanne Martel

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Various reforms undertaken during the 1980s significantly reduced the capacity of states to regulate health systems. Of the many policies implemented since then to increase access to health care, policies of exemption from direct payment are among the most important. These can be very effective in a well-funded and managed context. Beyond political will, are African states unable to afford policies of exemption from payment for health care? Our analysis, based mostly but not exclusively on research carried out in West Africa, leads us to suggest the importance of a well-managed extractive sector in Africa as a potential source to finance policies of exemption from payment for health care. This could come about if all actors concerned, whether from the private sector or the donor community, were required to follow the same rules and requirements of transparency and accountability being asked of the countries concerned.

Diverses réformes entreprises durant les années 1980 ont considérablement réduit la capacité des États à réglementer les systèmes de santé. Sur les nombreuses politiques mises en œuvre depuis pour accroître l'accès aux soins de santé, les politiques d'exemption de paiement direct figurent parmi les plus importantes. Elles peuvent se révéler très efficaces dans un contexte bien financé et bien géré. Au-delà de la volonté politique, les États africains n'ont-ils pas les moyens d'adopter des politiques d'exemption de paiement pour les soins de santé ? Notre analyse, qui se base principalement, mais pas exclusivement, sur des recherches menées en Afrique de l'Ouest, nous font suggérer l'importance d'un secteur extractif bien géré en Afrique comme source potentielle de financement des politiques d'exemption de paiement pour les soins médicaux. Cela pourrait se matérialiser si tous les acteurs concernés, qu'ils soient issus du secteur privé ou de la communauté des bailleurs de fonds, étaient priés de suivre les mêmes règles et exigences de transparence et de redevabilité que celles imposées aux pays concernés.

Las reformas de salud impulsadas durante la década de los ochenta del siglo pasado disminuyeron la capacidad gubernamental de regular los sistemas de salud. Entre las muchas políticas orientadas a elevar el acceso a la asistencia en salud implementadas desde aquella época, aquellas encaminadas a exentar el pago directo por este servicio figuran entre las más importantes. En un contexto de abundante financiamiento y de buena administración, dichas políticas pueden llegar a ser muy eficaces. Más allá de su voluntad política, ¿los Estados africanos son incapaces de financiar las políticas de exención de pago para la asistencia en salud? El análisis realizado por las autoras, apoyado en gran parte aunque no exclusivamente en sus investigaciones en África Occidental, sugiere que, siempre que sea bien administrado, el sector extractivo de África puede ser una posible e importante fuente de financiamiento que posibilite las políticas de exención de pago en lo que refiere a

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\*Corresponding author. Email: [valery.ridde@umontreal.ca](mailto:valery.ridde@umontreal.ca)

la asistencia en salud. Esta opción podría implementarse si a todos los actores implicados — sean del sector privado o bien de la comunidad de donantes— se les exigiera cumplir con las mismas normas y exigencias de transparencia y de rendición de cuentas demandadas a los países afectados.

**Keywords:** Aid – Aid effectiveness; Development policies; Globalisation (inc trade; private sector); Governance and public policy; Social sector – Health; Sub-Saharan Africa

## Introduction

Access to health care systems for African populations in general, and particularly for the poorest in those populations, has been impeded for a long time by numerous obstacles (Andersen 1995). Since the 1980s, the health policies that were implemented, and notably the generalisation of the principle of paying at the point of service (Gilson 1997; Foley 2010), have not improved access to health systems (Gilson and Mills 1995). Moreover, the various reforms undertaken during this period have significantly reduced the capacity of states to regulate health systems and, despite there being a myriad of health care providers in Africa, quality is not always guaranteed (Turshen 1999; Mills et al. 2001). In this context, following the leading role that South Africa played in 1994, several African countries have adopted policies of exemption from direct payment (Ridde and Morestin 2011). In contrast to the earlier reforms of the 1980s, most of these policies were introduced by national authorities, often for political reasons and without the support necessary or due to the influence of international actors (Meessen et al. 2011). Policy-makers hoped to increase access to health care to improve their citizens' health and financial security by eliminating part of the financial barrier, in order to ensure that going to a health centre would not be a source of impoverishment, two of the main objectives of universal health coverage (Kutzin 2013). When well-prepared and implemented, these exemption policies proved very effective and frequently equitable (Lagarde and Palmer 2011; Ridde and Morestin 2011; Dzakpasu, Powell-Jackson, and Campbell 2014); however, when demagogic, ill prepared, or insufficiently financed, or when lacking accompanying measures to ensure that the health system would be able to withstand the resulting increase in demand, they sometimes aggravated pre-existing problems (Walker and Gilson 2004; Meessen et al. 2011; Olivier de Sardan and Ridde 2014). Furthermore, they exacerbated debates on the capacity of states to fund such policies. For example, in Niger, only 50% of the budget required to finance the public policy to exempt children under five from health care payments was voted by Members of Parliament (Olivier de Sardan and Ridde 2014). In Senegal, less than 30% of the funds necessary for the country's policy to exempt people over 60 from making health care payments was allocated (Mbaye, Kâ, and Ridde 2013). In the Ivory Coast, only 23% of the 2011 emergency funds intended for free health care measures was provided. While Ghana had the necessary funds during the first years of its policy of exemption from childbirth payments, this no longer seems to be the case (Witter, Garshong, and Ridde 2013). In Sudan, state funding of the policy of exemption from payment for children under five and pregnant women covered a mere 7% of actual needs (Witter et al. 2012). However, such insufficient financing for the implementation of adopted policies is not the norm. In Burkina Faso, for instance, Parliament voted to fully deliver the funds required to carry out its childbirth subsidy policy from 2006 to 2015 (Meessen et al. 2011).

Despite this, there is cause for concern. Beyond political will, are African states able to afford policies of exemption from payment for health care? After all, abolishing payments for the demand is simply not enough: sufficient financing must be in place for the supply to meet it. In the context of the development of national health insurance, there are concerns about the scarcity of resources (Preker et al. 2013). This article aims to draw attention to a funding source that is available but rarely proposed in public health reviews: extractive industry resources and more

specifically, mining revenue. For example, in its 2013 appeal addressed to states urging them to invest more domestic funds in the health sector, the Regional Office for Africa of the World Health Organization (WHO 2013), did not mention mining revenues at all, but only petroleum products from Kenya. Three years before, in its 2010 annual report specifically devoted to financing of health systems, WHO had drawn attention to the need for innovative domestic funding solutions within states. In its analysis of the various options, the initiative presented as having the greatest potential for mobilising resources concerned a special “*levy on large and profitable companies*”. However the report does not raise the potential of the mining sector in Africa and only refers to the exemption policies of Australia which did in fact introduce such a levy on mining companies. Rather, WHO preferred to highlight the potential sources of funding from taxes on tobacco and alcohol rather than from the mining industry.

### Finding resources by improving health system efficiency

While it is true that public health officials have often written about the capacity to mobilise more resources for the health system, few have made reference to the resources that could be mobilised through the development of activities in the extractive sector. As is well known, the continent has enormous mineral wealth potential (UNECA and African Union 2011) and liberalisation strategies to encourage its speedy development were introduced specifically with the promise of mobilising internal revenues (World Bank 1992). While there have been mining company initiatives regarding HIV/AIDS prevention programmes for their workers (Heywood 1996; Campbell and Williams 1999) and recent work published on public–private partnerships regarding HIV/AIDS service provision involving the mining industry (World Economic Forum 2008; Rispel et al. 2010), such programmes do not address the broader and crucial issue of the access to health of the populations in the mineral-rich countries of the continent. In this regard, the contribution of the extractive sector to social and economic development has proven quite disappointing in many mining countries (UNIDO 2005). Moreover, when emphasis is placed on the extractive sector as a source of funding more generally, anticipated results have not always been forthcoming. For example, even though the Nigerian government does use oil revenues to finance its health system, that financing amounts to just 5.9% of its budget (Preker et al. 2013).

Until now, health experts have focused above all on the inefficiency of health systems, a factor which remains significant, but chiefly because these systems are seldom used when direct payment is in effect (Lagarde and Palmer 2011; Marchall and Flessa 2011). WHO estimates that between 20% and 40% of global health spending is wasted because of inefficient health systems (WHO 2010). In addition, few countries are fulfilling their commitment to allocating 15% – an arbitrary standard though it may be – of their national budget to the health sector (Elovainio and Evans 2013; Witter, Jones, and Ensor 2013). For instance, the average for the Economic Community of West African States (ECOWAS) is 8%, while the average for the WHO African region is slightly less than 10% (Witter, Jones, and Ensor 2013). Internal resources could therefore be mobilised more efficiently. Increasing cigarette taxes in lower middle-income countries (LMICs), for example, could allow the latter to increase their health budget by 25% (Elovainio and Evans 2013). The absorption capacities of external funds can also help explain the loss of resources. For instance, in Mali, 31 billion CFA francs (US\$62.5 million) from aid could not be used for health in 2009 (Paul 2011). Likewise, 120 billion CFA francs (US\$242 million) released (as subsidies) by the government of Burkina Faso to help its poorest citizens during the 2008 “high cost of living” crisis mainly benefited the rich (Arze del Granado and Adenauer 2011), when the money could have been applied to health policies such as free health care. Based on the experience of Sudan, Yates (2014) argues that subsidies

which are given to buy gas should instead be used to finance access to health care and the provision of free medicine.

### **Why it is important to invest mineral wealth in other forms of capital, especially human capital to promote social and economic development**

If the strategy of using revenue from the mining sector to support the financing of health systems is to be considered as a serious option as proposed here, there are important preconditions to be taken into consideration. Among these is the need to revisit the role which the mining sector has played so far in the development of mineral-rich countries of Africa, as well as recognising the potential such a renewal could have on the transformation of non-renewable natural capital (minerals) into other forms of lasting capital such as human, social, and physical capital which are the basis for sustained development and economic transformation. These considerations are in fact, as will be seen, at the centre of recent policy discussions among African decision-makers.

At the origin of the African Mining Vision (AMV), adopted in 2009 by the Heads of State and Government of the African Union, which calls for “*Transparent, equitable and optimal exploitation of mineral resources to underpin broad-based sustainable growth and socio-economic development*”, is the recognition that minerals are non-renewable natural capital which can only promote development if they are invested in other forms of capital that outlast the duration of mining. At present, most of Africa’s minerals are exported as ores, concentrates, or metals, without significant value-addition. There is however a huge potential on the continent for mineral beneficiation, which entails local transformation such as refining to promote value addition of minerals whether for export or domestic use. Such transformation depends, as the AMV points out and details, on the formulation and implementation of resource-based development and industrialisation strategies. As in the experience of the Scandinavian countries, such strategies depend in turn on the existence of a shared strategic vision, deliberate and proactive government-led collective action, timely interventions, and coordination of public, private, and community interests at all levels. Among the conditions required, as the AMV also underlines, are that:

“where there is underdeveloped human, knowledge, physical and institutional capital, as well as governance deficiencies, insufficient innovation systems, low rates of technology awareness and progress, and inefficient economic and business organization, it is impossible to turn initial factor endowment into a platform to build successful clusters and diversified economies.” (African Union 2009)

None of these conditions will be realised however, in the absence not only of trained but healthy human resources; to repeat a truism, only healthy populations can build prosperous nations.

In this regard, it should be noted that within the community of those responsible for the development of mineral resources on the continent and notably among the Ministers Responsible for Mineral Resource Development, there is a growing recognition (UNECA and African Union 2011) that better management of the mineral resources sector and consequently of human resources, can indeed contribute to greater domestic resource mobilisation. The development of mineral resources is therefore seen as a key to developing lasting human capital (African Union and UNECA 2011).

### ***Mining resources could also be mobilised through better sector management by the state***

Paradoxically, in view of the above, the mobilisation of mining resources is rarely addressed in public health documents even though half of the countries on the continent view the mining

sector as an important area of economic activity and produce ore for the international market, outside Africa (African Union and UNECA 2011).

Nevertheless, in recent years, it is in countries where the extractive industries have been subject to large-scale development that we have seen policies of exemption from payment for health care implemented (WHO 2013). On numerous occasions, however, these policies were underfinanced or the list of exempted services was reduced on the grounds of state financial limitations (Richard et al. 2013; Ridde and Olivier de Sardan 2013). Aside from the case of the Democratic Republic of Congo (DRC), where the abundance of mining resources and the little consideration given to health have long been common knowledge (Van Reybrouck and Rosselin 2012), several much poorer countries, such as those in the Sahel, have recently experienced a mining boom (e.g. Burkina Faso, Mali, and Niger).

Over the last decade, several Sahelian countries have witnessed a significant increase in the production and export of ores, especially gold, due to the combined effect of the introduction of regulatory frameworks which are very conducive to investment, increasing demand from countries such as China and India, and rising metal prices. For example, the production of gold has doubled in Burkina Faso since 2008 and the commodity has become the country's second most exported product, after cotton (ITIE 2012). In 1997, the contribution of gold to Mali's gross domestic product (GDP) replaced that of cotton (Campbell 2009), then gold became the leading exported good in 1999, exceeding cotton and livestock (Belem 2009; ITIE 2012). At present, the average yearly production of gold in the country is more than 50 tons. According to the Central Bank of the West African States, in the first quarter of 2008 it accounted for a little over 75% of export revenues (MEF 2009). For 2006–08, payments made to the government, including royalty payments, corporate income taxes, and dividend payments on state shareholdings, averaged 2.5% of GDP and 15% of total central government revenue (International Monetary Fund 2010). In addition to producing gold, countries in the Sahel region have become important exporters of other products from the extractive sector. In 2012, Niger was the world's fourth leading producer of uranium. Moreover, the country has also been producing gold, coal, salt and, since 2011, oil. Interestingly, according to EITI figures for 2010, government received \$140 million from extractive companies, representing just under 10% of total revenues (Revenue Watch Institute 2013a). According to the African Regional Health Report (WHO 2014), WHO acknowledges that in the case of Niger, the "*potential for raising taxes from mining has not yet been tapped*". Despite the significant market shares of these Sahelian countries in the industry, they remain at the very bottom of the Human Development Index (with Niger next to last in 2013, and Mali and Burkina Faso ranking 176th and 183rd respectively for the same year, to use these three countries as examples).

### ***As in the case of health, mining sector reforms have undermined institutional capacities***

In similar fashion to the health sector (Turshen 1999; Mills et al. 2001), the African mining sector also suffered heavily as a result of state reforms that required public budget cuts and the transfer of public responsibilities to private actors. Institutional capacities were thus undermined and weakened in terms of access to information, negotiation, monitoring, auditing, and the application of related public policy (Campbell 2009; UNECA and African Union 2011). Until very recently, Ghana exemplified such a lack of essential monitoring and control of a mining sector development that benefits the population and contributes to the recovery of resources, especially for the health sector. As the continent's second leading producer of gold, it experienced a significant liberalisation of its mining sector that began in 1986, prompting massive foreign investments under extremely advantageous terms that were supposed to stimulate growth and reduce poverty (Akabzaa 2009). Twenty years later, in 2006, the government of Ghana was relying on

figures provided by private companies to calculate its mining revenues, whether with regard to the quantity and quality of ore produced, the price of gold, figures which are then used to calculate royalties, and also with regard to capital investment allowances – data the government was unable to verify (Murphy 2007). Such a situation obviously makes it very difficult, if not impossible, to monitor the sector (the most important in Ghana's economy) and verify royalty calculations. As a result, the possibility of holding the government accountable towards its population is inevitably reduced.

The problem is not limited to Ghana or the mining sector. Between 2002 and 2006, practices of transfer mispricing in Mali and the DRC, characterised by price manipulation, notably in the form of deliberate import overbilling and export under billing (for tax evasion purposes), cost these countries 25% of their yearly non-grant government revenue. This amounts to a loss of US\$200 million per year for Mali and US\$375 million for the DRC. During the same period, it is estimated that these practices cost developing countries as a whole more than US\$100 billion per year (Hollingshead 2010). The United Nations Development Programme (UNDP) estimates that, between 1990 and 2008, the 48 countries that the United Nations categorised as the "least developed" – 33 of which are located in Sub-Saharan Africa – lost a total of US\$246 billion from illicit capital flows in its overall sectors (UNDP 2011). Six of the ten countries most affected by these cumulative illicit flows were located in Africa, and each one had a significant extractive sector. These figures can be examined in light of France's announcement that it would allocate 30 million euros (US\$39.7 million) over a three-year period (2013–15) to policies of exemption from payment for health care for children in six countries of the Sahel, funding raised through taxes on financial transactions in France (Ministère des Affaires étrangères 2013).

In the extractive sector, and especially in the mining sector, capital flight and illicit transfers, including transfer mispricing, are responsible for the financial ruin many African countries are facing. In only five transactions, the DRC incurred an estimated loss of US\$1 billion in tax revenues as a result of undervaluation and foreign companies selling mining assets to their subsidiaries (Africa Progress Panel 2013). These losses amount to more than twice the DRC's health and education budget. In Angola, approximately US\$4.2 billion are said to be missing from the coffers of the state-owned oil company (Africa Progress Panel 2013). Overall, it is estimated that between 2008 and 2010, US\$38 billion was lost every year through these illicit transfers, "*more than all of the bilateral aid received from OECD donors*" (Africa Progress Panel 2013).

An increasing proportion of exports from West African countries consists of extractive products, and often the entire production from this sector is exported; all of Mali's average yearly output of 54 tons of gold is destined for export (ITIE 2012). Nonetheless, mining revenues sometimes represent an insignificant percentage of the national economy. In Niger, 70% of the country's exports are dependent on the extractive sector, but the latter only made up 5.8% of the national economy in 2010 (Revenue Watch Institute 2013a). The same year, in Guinea, mining products accounted for more than 50% of exports and represented 17% of the GDP (Revenue Watch Institute 2013b).

Any number of conclusions may be drawn from these figures. When they are compared with the cost of the policies of exemption from payment for health care for the same region, it is easy to understand how more effective management of mining resources could save lives if policies were properly implemented, as illustrated by the case of Niger (Amouzou et al. 2012). In Burkina Faso, the policy of exemption from childbirth payments costs 2 billion CFA francs per year, while the one planned for children under five would cost 8 billion CFA francs, the same amount as in Niger. In the Ivory Coast, the exemption of payment for children under five is budgeted at 5 billion CFA francs (US\$10 million). In Senegal, free health care for people over 60 costs 1 billion CFA francs (US\$2 million) per year. In Benin, the cost of free caesarean sections is estimated at 2 billion CFA francs (US\$4 million) per year. Admittedly, these examples are far from perfect, as they consider

only the cost of reimbursing free services conducted at health facilities and not all of the essential accompanying measures (Meessen et al. 2011), but they do show that financing these exemption policies through the better management of mining resources is not impossible. We do not believe therefore that the pretext of resource scarcity (Preker et al. 2013) can continue to justify the lack of investment in exemption policies, which can often be viewed as a first step on the path to universal health coverage (Kutzin 2013). As the Regional African Office of WHO (2013) suggested “*there is a need for the health ministry to be proactive in its approach to general government revenue generation*”.

## Conclusion

Beyond an increase in health system efficiency (WHO 2010), which is an essential pre-condition, this article has drawn attention to the proposal that as a first measure, resources derived from the extractive industry in Africa could be mobilised on a large scale (among other ways through better management of tax revenues, local transformation and value addition of resources, better control of illicit flows) to bolster state budgets and, consequently, finance policies of exemption from payment for health care (WHO 2013). As a second step, and without neglecting the importance of mobilising other internal resources, once faith in the health care system has been restored, citizens would no doubt be happy to see these same resources mobilised for universal coverage.

Nevertheless, the capacity to mobilise the revenues needed to implement health policies will not only depend on the presence of new mining resources. The development of the mining sector has not led to economic and social development beneficial to populations. On the contrary, most countries have lost some of their institutional capacities with respect to the monitoring and managing of the sector’s development, as the impetus and responsibility for, and control over, its development were put in the hands of the private sector. It is easy to draw a parallel with the health system since many countries are applying externally imposed reforms. This occurred in the 1980s, when the World Bank and UNICEF encouraged states to make it standard practice to introduce direct payment at the point of sale, and it continues to take place today with the World Bank financing these same countries to implement a performance-based financing system. The capacity and willingness of African states to refuse such incentives, which entail substantial budgetary outlays, is particularly indicative of governance shortcomings.

However, the strategic policy direction of what is needed on the health front has now been spelled out. So has the commitment of those responsible for the development of the continent’s mineral resources as the positions taken by the AU and UNECA make clear. The problem, as in all countries in the world, has been the failure to move from declarations to implementation. Perhaps an important stumbling block and one which needs to be addressed is that discussions on what constitute “optimal outcomes” in the extractive sector need to go beyond optimising revenue streams and include social considerations: better health for all and reduced health inequalities.

Not a month goes by without an announcement about new mining sector developments in the Sahel and in Africa more generally. History must not repeat itself without these potential resources being mobilised to benefit their populations. A well-managed mining sector in the mineral rich countries of Africa and more specifically in the Sahelian countries is possible. The mobilisation of internal resources could thus benefit health policies, notably through the exemption from payment for health care, and governments of the Sahel should be held accountable for their efficient implementation. However, such transformations will only be feasible if the private actors concerned and the donor community follow the same rules and requirements for transparency and accountability being asked of the countries concerned.

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No potential conflict of interest was reported by the authors.

## Notes on contributors

Valéry Ridde is Professor in the Department of Social and Preventive Medicine, School of Public Health, University of Montreal and Research Chair in Applied Public Health of the Canadian Institutes of Health Research (CIHR): [www.equitesante.org](http://www.equitesante.org).

Bonnie Campbell is a Professor in the Faculty of Political Science and Law, and Director of the Centre interdisciplinaire de recherche en développement international et société (CIRDIS), University of Quebec in Montreal: [www.cirdis.uqam.ca](http://www.cirdis.uqam.ca)

Andréanne Martel is a Senior Researcher at the Centre interdisciplinaire de recherche en développement international et société (CIRDIS), University of Quebec in Montreal.

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