

Financing universal public sectors through tax justice in east and southern Africa

This brief presents evidence on key dimensions of adequacy and equity in public sector health financing in East and Southern Africa. It identifies the size of the funding 'gap' in relation to basic health service needs; entitlements; and state duties. Efforts to meet funding gaps from service privatisation and out of pocket spending carry negative implications for equity. Tax revenues are the most sustainable source of health financing for universal health coverage (UHC). Various innovative financing measures being explored provide some health funding, but the size of the financing gap calls for a wider focus on progressive tax financing. The brief thus presents losses from shortfalls in tax capacity, from global tax rules and illicit financial flows as three key areas of losses to public revenue in ESA countries. Addressing these tax losses could address the public sector health system funding gap. With COVID-19 having drawn attention to the need for investment in public sector health systems, there is an opportunity for a more ambitious alliance between the health and finance sectors to address these critical tax losses to increase public revenues for health.

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Financing universal public-sector health services

States are bound by national and international laws to meet rights to health and health care, as stated in many constitutions of east and southern African (ESA) countries and as outlined in the International Convention on Economic and Social Rights and General Comment 14, ratified by all ESA states. The World Health Organization (WHO) has unequivocally stated that universal healthcare services funded through taxation and free at the point of access are the most effective, equitable ways of funding and delivering health services.

The adequacy and prioritisation of domestic financing for health in the seventeen countries of the ESA region can be assessed through evidence from global databases on

- a. Delivery on the 2001 Abuja Declaration head of states commitment of 15% of domestic budget spending on the health sector.
- b. The percentage of Gross Domestic Product (GDP) spent on health, with countries spending above 5% of GDP on health performing better in advancing towards UHC.
- c. The level of per capita public financing vs recommended levels of annual per capita health system financing.

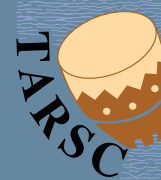
- d. The level of financial protection, as a key measure of equity, assessed in terms of the share of out-of-pocket (OOP) spending as a percentage of total health expenditure.

While the most recent data at the time of the assessment was for 2018/19, the pandemic and its impact post 2019 placed even higher demands for public health spending.

In 2018, no ESA country had attained the 15% Abuja commitment. Some countries (Lesotho, South Africa and Botswana) were close to it, but seven ESA countries spent half or less than the 15% committed to by heads of state. Between 2000 and 2019, five countries (the DRC, Seychelles, South Africa, Botswana, and Mauritius) consistently increased their share of health spending in budgets, but others showed declining or fluctuating spending. Post 2019, the COVID-19 pandemic led many ESA countries to rapidly mobilise public funding above the Abuja commitment for COVID-related interventions. This may not, however, have benefited other health service areas. It also raises a question of whether more adequate past funding of key prevention and care services would have ensured greater pandemic preparedness.

The share of current health spending in GDP from all sources exceeded 5% in eleven ESA countries, noting that this combines resources from public, private and household sources.

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In terms of the adequacy of public sector health financing, there was wide variability in spending on health in the public sector across the ESA region, from US\$3 per capita in the DRC, to US\$620 per capita in Seychelles.

Per capita public sector health spending was at or below US\$16/ capita in six ESA countries (DRC, Uganda, Madagascar, Mozambique, Malawi and Tanzania).

A number of estimates have been made of the amount of funds needed for health system functioning.

In 2012, WHO estimated that US\$44/capita as the minimum spending annually to provide basic, life-saving services. Adjusted for inflation, this translates to US\$48 per capita in 2018. The funding needed for a comprehensive health system, including a minimal set of interventions and the infrastructure to deliver them was estimated by WHO in 2001 as US\$80/capita per year, which adjusted for inflation is US\$114 in 2018. Government estimates from Zambia and Uganda in 2018 estimated the cost of an essential health benefit package for public sector services to be an average annual cost of US\$52 per capita.

A significant public sector health financing gap: Hence while five ESA countries, (Namibia, Mauritius, South Africa, Botswana and Seychelles) fund their public sectors above all of these recommended per capita levels, the annual public sector financing gap for the others ranged in 2018 from an average of US\$28 per capita for the most conservative estimate of system needs, to US\$84 per capita for a more comprehensive system, or a total annual shortfall in public financing ranging from \$10.5bn to US\$31.4bn. For all 17 ESA countries the total annual shortfall was US\$36.8bn. This is a significant gap in public financing, whether for the minimum level required, and particularly for a comprehensive health system to meet UHC commitments.

Some ESA countries are exploring expanding private sector funding and services to meet this gap, but with caution on how the shorter term profit focus of private for-profit services undermines equity. With nine ESA countries at a level of out-of-pocket spending on health above the 20% share of current health spending that WHO warns to signal 'catastrophic' or impoverishing spending, this caution is merited. Various innovative financing measures and levies being explored provide some health funding, but fall short of the size of the financing gap.

Taxation as a source of health financing in the region

Particularly during this era of global uncertainty, taxes offer the most sustainable form of financing to attain developmental commitments in the region, including for UHC. Taxes, particularly direct taxes, are generally progressive sources for health financing as they raise revenues equitably, redistribute income and wealth; reprice goods and services and recognize citizen representation as tax-payers. Mandatory national health insurance can also be regarded as a form of taxation.

Evidence was obtained on tax measures and GDP for 2018/19 for the seventeen ESA countries, including:

- a. Taxes from various sources as a share of total taxes.
- b. Tax to GDP ratios as a measure of tax capacity.
- c. Annual tax losses due to illicit flows.
- d. Potential tax revenue gains from applying unitary taxation.

African country tax to GDP ratios have increased by 1.8 percentage points over the past decade, primarily driven by VAT receipts and personal income taxes. The lower share of taxes on corporate profits in the region suggests weaker tax collection from this source, related in part to global tax rules and profit outflows. Despite this growth, there is a shortfall in tax revenue as a share of GDP, or tax capacity. Using an approach applied by the United Nations Economic Commission for Africa, a conservative estimate of the average African country tax capacity of 20% compared with the ESA region's average tax capacity of 18% yields an estimated tax gap of 2%. This translates to an annual loss of US\$34.2/capita in tax revenue in the region.



Further tax losses arise due to global tax rules and profit outflows. In 2017, the region lost US\$124.7/capita in tax revenue annually due to commercial practices reducing revenue and taxable income, termed 'base erosion', and shifting profits to other lower tax countries. The ESA region lost US\$7.6 billion annually in tax revenue in 2017 due to such global practices of base erosion and profit shifting. Excluding Seychelles and Mauritius, with their low populations, the average per capita loss from these two commercial tax practices was found to be US\$13.8 per capita annually. This is a conservative estimate as it excludes losses due to other sources of IFFs and losses due to limited taxation of natural resource depletion of extractive activities.

The current global tax framework applies a *separate entity principle*, where multinational companies operating as a common group with common ownership can treat their branches in different countries as separate and independent entities. This enables companies to reduce their revenue and taxable income, termed 'base erosion', and to shift profits to lower tax countries, both of which affect tax collection.' In 2016, the Organisation for Economic Co-operation and Development (OECD) proposed a *two pillar solution*. Pillar 1 apportions profits of multinationals earning more than US\$21bn and a profit margin above 10% to the different states they operate in, within a *unitary taxation approach*. This falls short of expectations for a fairer tax system in various ways. It covers less than 100 companies globally, biases towards consumption in high income countries and would require

African countries to forego digital taxes from all companies.

The new OECD proposal of a two-pillar solution significantly and unfairly disadvantages low-income countries, leading to significant tax losses from the ESA region, and indeed, Africa as a whole. Under Pillar 2, if a fairer Minimum Effective Tax Rate (METR) of 25%, as opposed to the proposed METR of 15% were applied in all countries, this would minimize the incentive to shift declared incomes to low tax countries or tax havens. If applied, the ESA region would gain US\$26.2/capita annually in additional tax collection.

Tax financing of the public sector health financing gap

ESA countries are facing a significant demand on their health and social protection systems, in part due to demands raised by pandemics and other emergencies, but also due to rising levels of chronic diseases and the health impacts of precarious employment, living and working conditions. This and the unpredictable nature of development aid has raised the demand to shift away from the dependency that has grown in the health sector on external funds, towards progressive and predictable forms of domestic financing. The commitment to meet UHC and other global goals has added impetus to this. It is thus pertinent to compare the total tax financing that can be raised by addressing the three areas of tax losses discussed in the previous section with the shortfalls to be met in public sector health financing, shown in *Table 1*.

Table 1: Annual total and per capita US\$ public sector financing gap and lost tax revenue

Area	For ESA countries		Year of data
	US\$ total billion	US\$ /capita	
Public health financing gap			
Cost of an essential health benefit in ESA	14.0	32.0	2018
Minimum annual spending to provide basic, life-saving services	12.3	28.0	2012
Comprehensive health system, including a minimally adequate set of interventions and the infrastructure to deliver them (*)	36.8	84.0	2018
Taxes lost to public revenue			
Tax losses due to actual collections vs tax capacity	15.0	34.2	2019
Tax losses due to non-application of a unitary taxation METR	11.5	26.2	2016
Tax losses from global tax abuse (base erosion and profit shifting)	7.6	17.4	2017

Source: Loewenson and Mukumba, 2022

(*) Original year figure adjusted using the [US\\$ inflation calculator](#); total population for the per capita figure.



Reversing tax losses to meet the health funding gap: Comparing the total annual tax loss with the shortfalls in public sector health financing, addressing the total annual tax loss of US\$34bn could come close to financing the US\$36.8bn shortfall in public sector health financing for a comprehensive health system in the ESA region, including a minimally adequate set of interventions and the infrastructure to deliver them. Even individual areas of tax loss, particularly from shortfalls on tax capacities and unfair global tax rules, could fund estimated shortfalls in public sector health financing for essential or basic services ranging from US\$28–32/capita.

Recommendations for policy and action

This evidence indicates that it is possible to meet the health financing gap for public sector health systems in the region through adequate funding from progressive taxation. It calls for joint engagement in national, regional and global processes by ESA health and finance sectors, civil society and others, including those working on health equity and economic justice. Key areas for such joint engagement include:

- a. Making clear the funding demands in individual ESA countries to address the right to health care, and the commitment to UHC, equity, to meet demands for pandemic preparedness, and for the services needed to manage the current and projected demands from rising non-communicable diseases.
- b. Articulating and ensuring understanding that these demands call for a public sector health system that is domestically financed above 5% of GDP and 15% of government budgets, with funding for the costed services and system infrastructure required; and that the current health financing gap can, and should be, most sustainably, equitably and adequately met through progressive taxation.
- c. Redoubling efforts at national level to address the tax gap by building domestic capacity within revenue authorities, expanding the tax base through the expansion of wealth and other progressive taxes, and by increasing transparency in and blocking illicit outflows, such as through beneficial ownership transparency registries.
- d. Linking tax and other sources of financing in pooled national health insurance to overcome segmentation of health financing, to enable risk and income cross subsidies, and ensuring that OOP spending does not exceed 20% of total health spending.

- e. Working across countries at regional level and with the African Tax Administration Forum (ATAF) to reduce tax competition between ESA countries, such as through corporate tax exemptions, that lessen ESA countries' capacity to mobilise tax revenue.
- f. Adding health evidence to the case made by African finance ministers in negotiating for a fairer global tax system, showing both the need for and the opportunity to obtain public revenue by applying fairer tax measures, such as a unitary taxation METR, to meet public revenue demands to overcome the health financing gap, meet commitments to global goals and achieve UHC and health security. Both the health and finance sectors also have a joint interest in advocating for a more inclusive, democratic mechanism, such as a United Nations Tax body, to make the changes towards a fairer global system for progressive taxation.

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