

**Tax justice for universal public sector
health systems in
East and Southern Africa**



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**in the
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Executive Summary

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 public health services as well as delivering on health care rights and state duties. Yet net financial outflows from east and southern Africa (ESA), due to tax avoidance, illicit financial flows, tax waivers and exemptions and other financial leakages, are reported to contribute to significant loss of public revenue, including for health budgets.

The Training and Research Support Centre (TARSC) in the Regional Network for Equity in Health in East and Southern Africa (EQUINET) and Tax Justice Network Africa (TJNA) have thus jointly implemented work to outline and analyse evidence and issues related to tax justice and universal public sector health systems in the ESA region. Evidence was obtained and analysed on health financing and tax measures for the most recent year where data was available for all ESA countries covered. While there are limitations in data noted in the paper, the estimates indicate the scale of both the health financing and tax gap and are argued to be sufficiently robust to justify the policy messages drawn from the findings. With the most recent data coming from 2018/9 prior to the COVID-19 pandemic, the estimates are judged to be conservative.

This paper outlines performance on key dimensions of public sector health financing: the size of the funding 'gap' in relation to basic health service needs; population entitlements; and state duties to health care; with brief discussion on the negative implications for equity of meeting this gap through out of pocket (OOP) spending and privatisation of health services. With tax revenues the most progressive source of health financing for universal health coverage (UHC), it examines the level, sources and drivers of lost tax revenue in ESA countries, and relates the public sector health system funding gap to the sources of lost tax revenue.

By 2018/9, while five ESA countries were found to fund their public sectors above the estimated per capita expenditure requirements needed for a comprehensive health system, for other ESA countries the financing gap ranged from an average of US\$28– 84/capita, using various WHO and regional estimates of funding needs.

Some ESA countries are exploring expanding private sector funding and services to meet this shortfall, but with cautions on how the shorter term profit focus of private for-profit services undermines equity reinforcing the need to focus on domestic financing that does not segment and verticalize systems or deepen aid dependency. 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, which turns attention to losses in taxes and thus in public revenue.

Tax revenue as a share of gross domestic product (GDP) is referred to as the tax capacity. Using an approach applied by the United Nations Economic Commission for Africa (UNECA), comparing a conservative estimate of the average African country tax capacity of 20% against the region's average tax capacity of 18% yields an estimated tax gap of 2%, or an annual lost tax revenue of US\$34.2/capita. 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. Excluding Seychelles and Mauritius, with their low populations, indicates an average per capita loss from these two commercial tax practices of US\$13.8/capita/year.

The paper points to how the current global tax framework and its unfair allocation of taxing rights benefits high income countries to the significant detriment of low- and middle-income countries. Despite promises of reforms by some larger high income countries, those that have been proposed fail to address this tax injustice. The current Separate Entity principle, or even the new Organisation for Economic Co-operation and Development (OECD) proposals of a two-pillar solution significantly and unfairly disadvantage low-income countries, leading to significant tax

losses from the ESA region, and indeed, Africa as a whole. In contrast, the paper estimates that if a fairer Minimum Effective Tax Rate (METR) of 25% were applied in all countries to avoid incentivising the shifting of declared incomes to low tax countries or tax havens, the ESA region would gain US\$26.2/capita annually in additional tax collection.

Comparing the total annual tax loss with the shortfalls in public sector health financing, the total of US\$34bn would come close to completely financing the region's US\$36bn shortfall in public sector health financing for a comprehensive health system, including, using estimates from WHO, a minimally adequate set of interventions and the infrastructure to deliver them. Even individual areas of tax loss from shortfalls on tax capacities and unfair global tax rules identified in the paper, ranging from US\$26–34/capita in the region, could fund estimates of public sector health financing shortfalls for essential or basic services ranging from US\$28–32/capita.

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. With the public health and economic implications of COVID-19 having drawn socio-political 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 demonstrate the public health value of addressing these critical tax losses to increase public revenues for health. This calls for joint engagement in national, regional and global processes by ESA health and finance sectors and civil society, including those working on health equity and economic justice, to articulate policy needs, negotiate and build measures to achieve this, by:

- a. Making clear the funding demands in ESA countries and the region to address the right to health care, commitment to UHC and equity and to other health-related SDGs, including measures for pandemic preparedness and health security, and for the services needed to manage the current and projected demands from rising non-communicable diseases (NCDs).
- b. Articulating and ensuring socio-political and cross sectoral 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 a costing of the 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 as substantial sources of revenue, and by increasing transparency in and blocking illicit outflows, such as through beneficial ownership transparency registries.
- d. Establishing steps to link tax funding with other sources of financing in pooled funding for national health insurance to overcome segmentation of health financing, to enable risk and income cross subsidies, and ensure that OOP spending does not exceed the 20% of total health spending indicated by WHO to be catastrophic health spending.
- e. Working across countries at regional level and with the African Tax Administration Forum (ATAF) to reduce tax competition between ESA countries and reduce tax incentives and exemptions for corporates that lessen ESA countries' capacity to mobilise tax revenue.
- f. Adding health evidence to ongoing negotiations and the case made by African finance ministers for a fairer global tax system at international level, 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 SDG commitments and achieve UHC and health security.

Notwithstanding the multiplicity of global health funders, the paper further argues that there is a gap in the global architecture, with no UN global counterpart on tax financing to the WHO. Both the health and finance sectors have a joint interest in adding to existing pressures for the establishment of a more inclusive, democratic mechanism, such as a United Nations Tax body, to make the necessary changes to ensure progressive taxation as the core source of funds for an equitable, universal health system.

1. Introduction

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 public health services as well as delivering on health care rights and state duties (Lethbridge, 2016). Without a robust public and community health infrastructure owned and managed by the state, it becomes next to impossible to implement effective interventions to keep the population adequately healthy.

Despite this, the privatisation of health care is expanding across ESA countries, from commercialisation within public health systems, through to various forms of public–private partnerships (PPPs) and the expansion of for-profit financing and service provision, intensified by the COVID-19 pandemic (Chanda-Kapata, 2020). Private sector proponents argue that they can meet funding gaps for Universal Health Coverage (UHC), particularly given inadequate domestic public sector funding and limitations on aid financing (IFC, 2016). The underfunding and low prioritisation of public services, including in not meeting the Abuja commitment of 15% domestic government funding in health is, however, argued to contribute to a funding gap (Chitah, 2022).

In the context of neoliberal globalisation, states are exposed to trade, tax and other rules set outside ESA countries that underlie or contribute to this situation, and to net outflows from the region due to tax-related practices that undermine both public resources and public sector power, even in fast-growing ESA economies. Tax losses due to tax avoidance, illicit financial flows, tax waivers and exemptions and other financial leakages and outflows, are reported to contribute to significant loss of public revenue, including that for health budgets (Ndajiwo, 2020). Delivery of the right to health, health equity, and strengthening universal public sector health services must thus address the issue of public revenues and the rules, systems and practices that undermine it.

The Training and Research Support Centre (TARSC) in the Regional Network for Equity in Health in East and Southern Africa (EQUINET) and Tax Justice Network Africa (TJNA) have thus jointly implemented work to outline and analyse evidence and issues related to tax justice and universal public sector health systems in the seventeen countries of the East and Southern Africa (ESA) region (viz: Angola, Botswana, the DRC, Eswatini, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Mauritius, Namibia, Seychelles, South Africa, Tanzania, Uganda, Zimbabwe, Zambia).

This joint paper uses an equity lens to outline performance in key dimensions of public sector health financing and to identify the size of the funding gap in relation to basic health service needs, population entitlements and state health care duties. It briefly discusses the implications for equity of meeting this gap through out of pocket (OOP) spending and privatisation of health services. Recognising tax revenue as the most progressive source of health financing for UHC, it examines taxation systems in ESA countries, estimating the level, sources and drivers of lost tax revenue. The paper links the public sector health system funding gap to the losses to tax revenue. It presents the implications for public revenue should tax capacities improve and proposals for fairer global tax rules made by states and civil society in Africa be adopted. Drawing on this evidence we recommend key areas of policy dialogue and action as an information resource for follow up dialogue, advocacy and engagement at various levels.

2. Methods

The paper drew on a range of secondary sources of evidence. The evidence on rights and duties in relation to health and health care, trends in privatisation and the health equity impacts of service trends was drawn from searches in online libraries and databases and institutional websites. Only materials in English were included, so there is a limitation in potential exclusion of evidence from the two lusophone and one francophone countries in the region. Prior work by TARSC, EQUINET and TJNA in 2021/2, had also accessed relevant grey literature from online

media reports, country specific websites, blogs, international organisation briefs as well as from key informants, so this was also integrated into the evidence gathered, citing the source reports. A structured template was used to capture and organise the evidence from these sources.

For the evidence on key dimensions of public health financing, specific indicators were analysed for the most recent year where data was available for the seventeen ESA countries from the World Health Organization (WHO) Global Health Expenditure database (WHO, 2022), with the most recent year for this being 2018/19. Within countries, national health accounts data could be usefully used for deeper evidence of public health financing in relation to sources such as tax financing. However, given the wider regional cross country lens of this paper and the need for comparable data across countries, we have used the WHO database. While there are multiple options for assessing public sector health financing, specific indicators of particular dimensions of health financing were used. Measures of the adequacy and prioritisation of domestic financing evidence used to inform the size of the financing gap were:

- a. The percentage of government spending allocated to the health sector, noting the Abuja Declaration commitment of 15% of domestic budget spending on the health sector (AU, 2001).
- b. The percentage of Gross Domestic Product (GDP) spent on health, given that countries performing better in advancing towards UHC spend above 5% of their GDP on health (McIntyre 2012).
- c. The level of per capita public financing against WHO recommended and ESA budget per capita for health system funding.
- d. The share of private expenditure in total health expenditure.

The level of financial protection as a key measure of equity was assessed in terms of the share of OOP spending as a percentage of total health expenditure.

Evidence was obtained on tax measures and GDP for 2019, or the most recent year where data was available for the seventeen ESA countries. The tax measures gathered included:

- 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.

The paper specifically focuses on the revenue raised by government from **taxes** and does not include revenues from royalties, fees, aid grants and other sources. Resource revenue data, as levies on resource extraction, is an area that merits further work on the sums collected, but is not included here.. With few exceptions, the evidence presented is for ESA countries rather than the continent as a whole. The tax, GDP and population data was obtained from online databases available from the Organisation for Economic Cooperation and Development (OECD), World Bank and Tax Justice Network. While OECD data may derive from co-operation with the African Tax Administration Forum (ATAF), the paper drew data directly from the OECD database and thus cites this as the source.

All health and tax data was captured in Excel spreadsheets, from which charts and tables were generated. As for the health data, using the global databases for the tax data allowed for comparable evidence across countries.

As **limitations**, the selected indicators do not represent the full spectrum of measures of equity in health financing, nor the full spectrum of tax losses. For example, how far different sources of financing are pooled to enable income and risk cross-subsidies is also important for equity and universality (Mills 2012, Kutzin 2013). The data used for the most recent year in global databases does not cover the pandemic period of 2020/1, when overall public spending on health systems increased significantly, albeit in particular areas of pandemic response, possibly leaving other areas with reduced funding (Chitah, 2022). We also recognise that there are variances in the same indicator in different cross-country databases and with evidence collected in country. By consistently using intergovernmental databases, we sought to maintain consistency but we

suggest that country-specific work triangulates data with national sources, such as national health accounts data.

Notwithstanding these limitations, the data shows evidence of key dimensions of adequacy of public financing and can be used to assess the financing gap, when measured against the financing levels estimated necessary for core services. It can be assumed that these are conservative estimates and that investment for improved prevention of and preparedness for pandemics would generate higher spending demands. With the analyses on outflows and the possible gains from application of a unitary system potentially under-estimating real levels, the potential contribution for improved tax revenue to meet the health financing gap may be greater than that shown. The addition of further evidence on resource revenues in follow up work, beyond the tax revenue addressed here, adds an additional potential opportunity for improved domestic revenue. Noting this, we consider the data applied to be sufficiently robust to justify the key policy messages drawn from the findings.

3. Delivering on equitable health financing in the ESA region

3.1 Rights and duties in relation to health care

States are bound by national and international laws to meet the rights to health and health care, as stated in many ESA country constitutions and as outlined in the International Convention on Economic and Social Rights and General Comment 14, ratified by all ESA states. The African Commission on Human and People's Rights has similarly called on states to use all appropriate measures to meet their obligations in relation to the full realisation of the right to health, including through tackling the constraints and damage that result from health privatisation, although the Commission is still in the process of developing standards that would guide implementation and adherence (ACPHR, 2019; Sehoole 2020). While many ESA countries protect the right to health care in their constitutions and include duties on all actors, including corporations, to prevent harm to health, most ESA countries do not have adequate legislation on private health insurance and have gaps or face implementation challenges in laws governing their private sectors (Doherty 2013).

Immediate post-independence redistributive equity policies and areas of state intervention to overcome colonial inequalities delivered on these rights. However, from the late 1980s, this normative and policy framework was undermined by the adoption of neoliberal policies in many ESA countries, first through structural adjustment programmes and then through wider neoliberal reforms, which led to reduced public funding for social services and declining public sector performance (Williams et al., 2021).

As public funding declined, states faced a challenge in delivering on rights to health and health care, limiting services to minimum packages focusing on high prevalence diseases and on what is affordable (Doherty 2011). Invoking the principle of 'progressive realisation' of rights within available resources placed a constitutional burden on affected populations and institutions to demonstrate the feasibility of rights claims (Sehoole 2020). Economic actors, including finance ministries, have resisted public health regulation that is seen to threaten investment, particularly when powerful corporate actors threaten disinvestment, withdrawal or even litigation against perceived controls. In the face of regulatory capture, civil society has litigated rights claims or demanded accountability from public sectors to deliver on existing rights and their duties (Murethi, 2021; Loewenson et al, 2021; Williams et al, 2021).

In summary, the right to health, and particularly to health care, is provided for by national law, and by continental African and international law and treaties. However, these rights have been limited in practice by neoliberal economic reforms, subjugating rights to resource availability, and to competing interests and power relations among society, corporates and states.

3.2 Delivery on, and deficits in, equitable public sector health financing

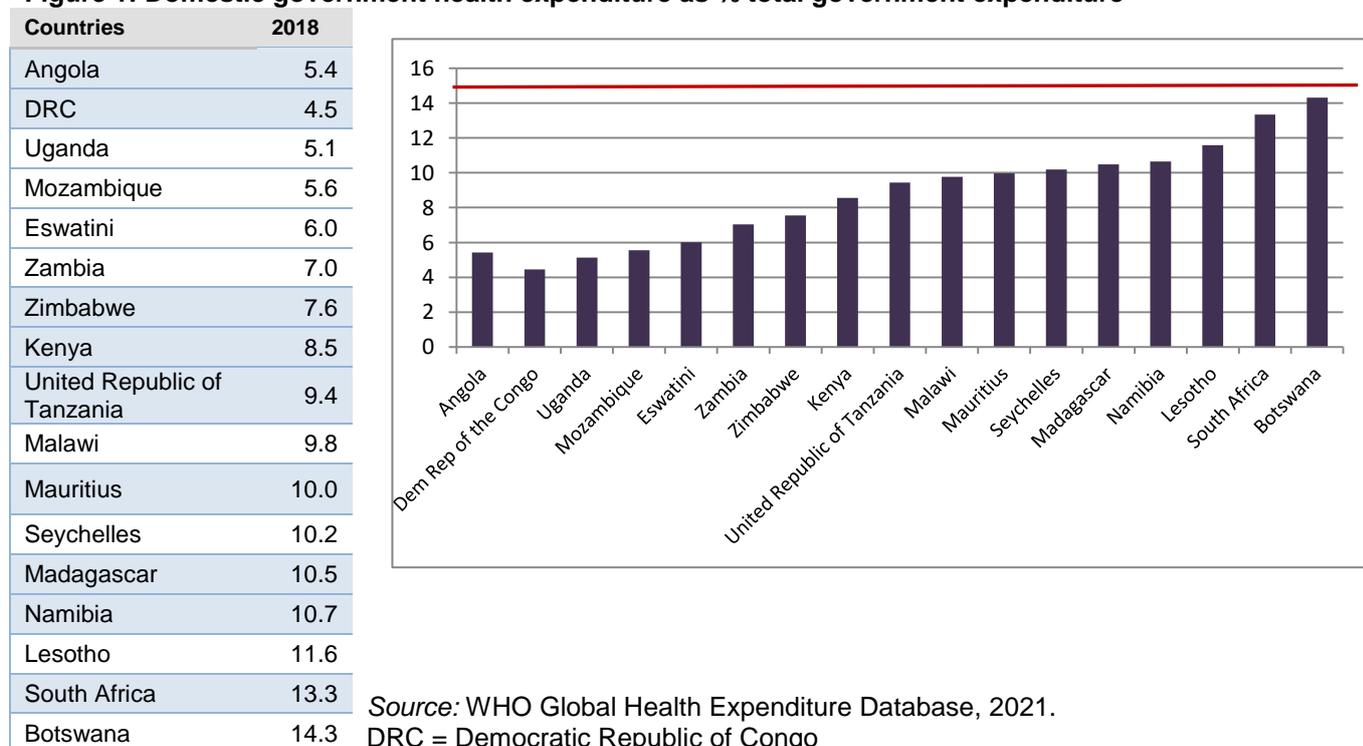
As a context for health financing, it is relevant to note that the ESA region is economically diverse, with GDP per capita levels in 2020 ranging from the lowest in Mozambique (US\$449) and the DRC (US\$557); to 10 times higher in Botswana (US\$6,711) and South Africa (US\$5,091). Countries like South Africa with high GDPs also have high inequality, however, with the highest Gini coefficient (63%) in the region, while many of the countries with lower GDP/capita have Gini coefficients of less than 45%. Inflation and external debt appear to have been relatively stable in ESA countries in the decade prior to 2019, but this does not reflect the impact of the pandemic, where both inflation and debt are reported to have risen (Chitah, 2022).

Government spending on the health sector

Figure 1 shows the level of current health expenditure as a share of total government expenditure by 2018, as a reflection of the priority governments give to health in their spending. With public funding for public health services, paid from general taxation and provided universally, free at the point of access considered the most effective in redistributing resources from high to low income groups and contributing to improvements in health, the priority given to health in public sector budgets is an important measure of overall equity and the adequacy of health financing. While the Abuja commitment was triggered by the demands of HIV, TB and malaria, the demands from rising noncommunicable diseases (NCDs), emerging and re-emerging epidemic outbreaks and pandemics, climate related health shocks and the commitment to UHC suggest that the Abuja commitment remains as relevant today as when it was made in 2001.

Figure 1 shows that in 2018, no country had attained the 15%, although some countries (Lesotho, South Africa and Botswana) were close to it. Seven ESA countries spend 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 either declines or fluctuating spending (Chitah, 2022). While it can be argued that other sectors also contribute to health, the allocation committed to in Abuja was regarded as a share that would reflect adequacy and prioritisation for the health sector to play its own role including within the whole of government approaches.

Figure 1: Domestic government health expenditure as % total government expenditure

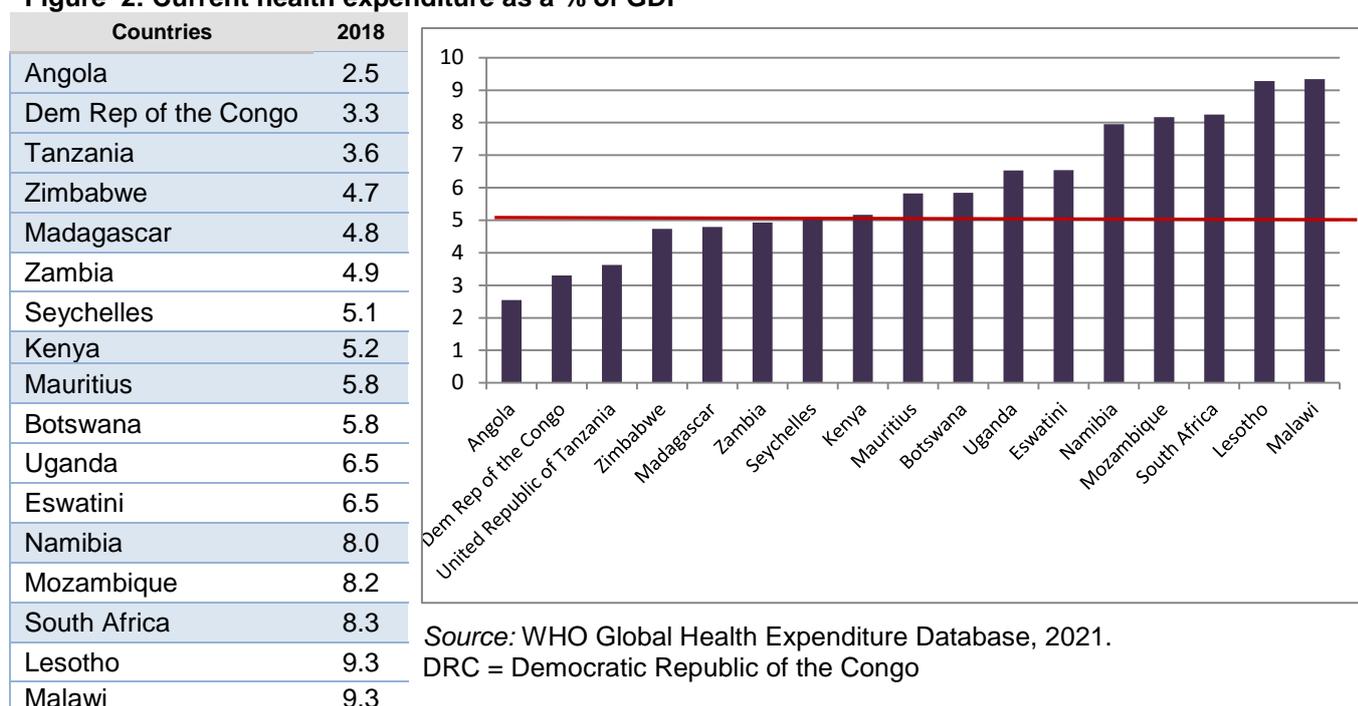


The figures for 2020–2021 are not yet available but anecdotal evidence and a case study from Zambia (Chitah, 2022) suggest that the massive mobilisation of funds to meet the demands of the COVID-19 pandemic, in the context of an underfunded health system, led many governments to rapidly mobilise health sector funds above the Abuja commitment of 15%, especially for prevention, testing, surveillance and contact tracing and, more recently, delivery of vaccination programmes. While recognising the positive responses made by ESA countries to control the pandemic, had the key prevention and service areas been more adequately funded in the past, it can be questioned whether this would have ensured greater preparedness.

The share of GDP spent on health

As noted earlier, countries performing better in advancing towards UHC spend above 5% of their GDP on health (McIntyre 2012). *Figure 2* shows current health expenditure as a percentage of GDP for 2018, for ESA countries.

Figure 2: Current health expenditure as a % of GDP

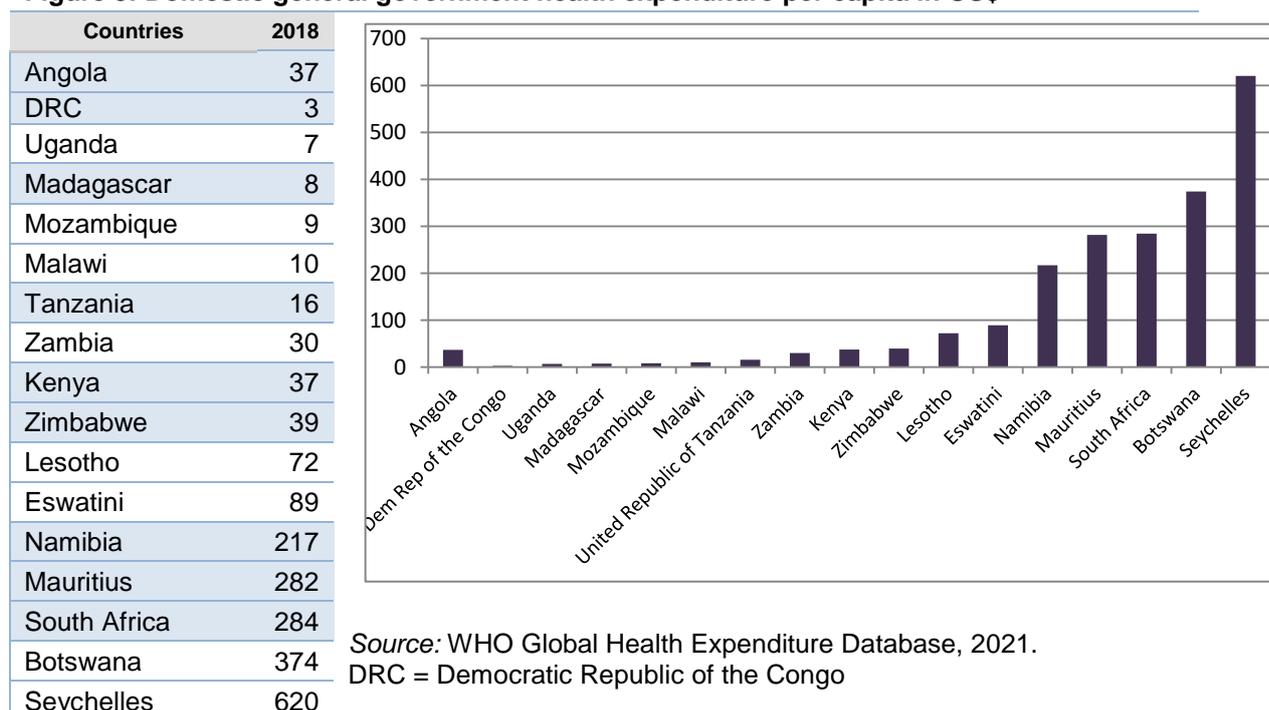


For 11 ESA countries, the share of current health spending in GDP from all sources exceeded 5%. Other financial analyses indicate that between 2000 and 2019, it has only consistently increased in four of these countries, namely Lesotho, Mauritius, Mozambique and South Africa. While this suggests widening mobilisation of health sector resources in these countries, it is noted that this combines resources from public, private and household sources. The evidence of public spending levels in *Figure 1* and the trends 2000–2019 suggest that public sector leadership of this rising health expenditure may have been greater in fewer countries, and more notable in Mauritius and South Africa.

The level of per capita public financing

The overall adequacy of public sector health financing can be assessed from the per capita government expenditure on health in US\$. *Figure 3* overleaf provides this data and shows the wide variability in spending on health in the public sector across the ESA region, and the very low levels of per capita spending in six ESA countries. Countries with smaller populations and higher overall GDP appear to fare better.

Figure 3: Domestic general government health expenditure per capita in US\$



A number of estimates have been made of the amount of funds needed for health system functioning. In this paper we use two WHO estimates and one from country costings of essential health benefit packages, and apply these as costs per capita for the public sector to deliver its health system obligations.

In 2012, the WHO estimated that the **minimum spending per person per year** needed to provide basic, life-saving services was US\$44, which, adjusted for inflation, translates to US\$48 per capita in 2018, and US\$54 per capita in 2022. As *Figure 3* shows, ten ESA countries spent below this 2018 level, while only countries with small populations and high incomes spent above it. The average funding gap for those spending below the basic threshold was US\$28 per capita, ranging from US\$9 in Zimbabwe to US\$45 in the DRC.

In 2018, a review of the cost calculated for an essential health benefit (EHB) delivered by the public sector and covering essential health services was implemented by selected governments. For the three countries that assessed total costs shown in *Table 1* below, the 2018 per capita cost ranged from US\$52 to US\$560.

Table 1: Estimated US\$ cost per capita for EHBs (public sector): most recent data

Service level	ZAMBIA		UGANDA		ESWATINI	
	US\$/capita	Year	US\$/capita	Year	US\$/capita	Year
Total (including MoH and ancillary) in year shown	37.70(*)	2003	47.90	2012	519.00	2013
Total (including MoH and ancillary) in 2018 (**)	51.47(*)	2018	52.41	2018	559.71	2018
Total (including MoH and ancillary) in 2022 (**)	58.13(*)	2022	59.19	2022	632.08	2022

Source: Loewenson et al, 2018. All \$ figures in US dollars based on conversion using exchange rate at year of costing; N/A = not available; (*) including HIV interventions (**) the last two rows present the figure adjusted by inflation as calculated by the authors of this paper using the [US\\$ inflation calculator](#).

The figure of US\$560/capita in Eswatini reflects the small population as an outlier. For the majority of the countries in the region, it is reasonable to take the common US\$52 found for the two other countries, one in east Africa and one in southern Africa as a proxy. Using this, as shown in *Figure 3*, ten ESA countries spent below this 2018 level, and the average funding gap for those spending below that basic threshold was US\$32 per capita, ranging from US\$13 in Zimbabwe to US\$49 in the DRC.

The estimates in *Table 1* are a conservative minimum. The 2000 World Health Report estimated that US\$60 per capita was needed for a comprehensive health system, including a minimal set of interventions and the infrastructure to deliver them. In 2001, this estimate was revised to US\$80 per capita per year (Govender et al 2008). Adjusting for inflation, this translates to US\$114 per capita in 2018 and US\$128 per capita in 2022. As *Figure 3* shows, twelve ESA countries spent below this 2018 level. The average funding gap for those spending below that basic threshold was US\$84 per capita, ranging from US\$25 in Eswatini to US\$111 in DRC.

Hence while five ESA countries, (Namibia, Mauritius, South Africa, Botswana and Seychelles) fund their public sectors above all of these recommended per capita expenditures, the public sector financing gap for the others, ranges from an average level of US\$28 per capita for the most conservative estimate of system needs, to US\$84 per capita for a more comprehensive system. The remaining ESA countries are Angola, DRC, Uganda, Madagascar, Mozambique, Malawi, Tanzania, Zambia, Kenya, Zimbabwe, Lesotho, and Eswatini, with a combined population of 374.2million (World Bank, 2022).

The total shortfall in public financing for these countries using 2018 data thus ranged from US\$10 478 972 000 (\$10.5bn) to US\$31 436 916 000 (US\$31,4bn). This is a significant shortfall in public financing for even the minimum level required for the health system to deliver the minimum health service package, and even more so for a comprehensive health system.

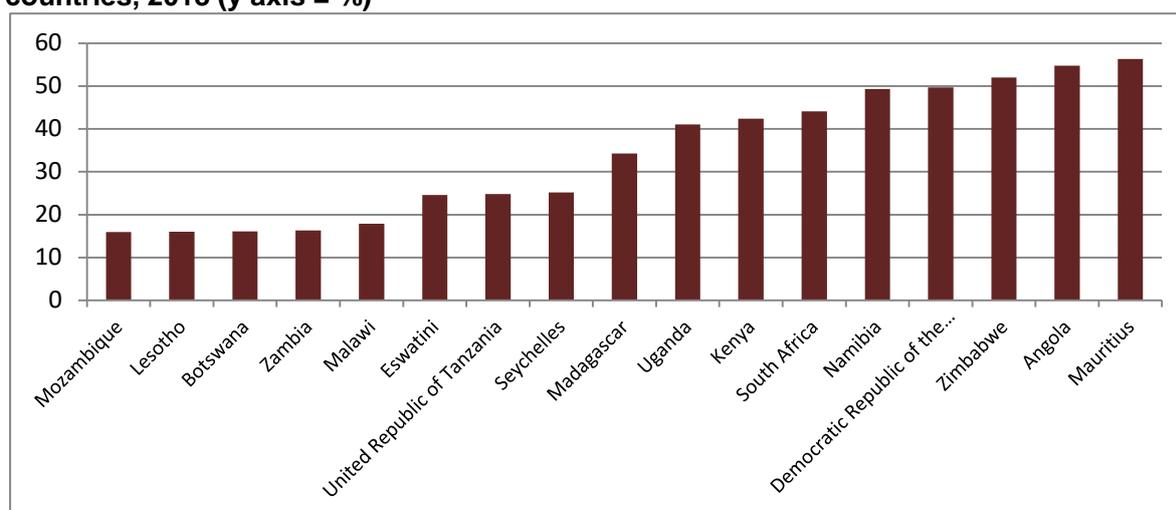
The share of private expenditure in total health expenditure

It is useful to distinguish between private financing and private health service provision, given that publicly-provided services may be privately financed through out-of-pocket (OOP) payments or private health insurance, and private services may also receive direct and indirect public financing, in the latter case such as tax subsidies (Foster, 2012). Private service providers may be for-profit facilities and practitioners, as well as related services such as laboratories, pharmacies and traditional health sector providers, that are formal or informal/unregulated. Not-for-profit private providers include local and international non-governmental organisations (NGOs) and faith-based organisations (FBOs) that are often more integrated with public funding and services (Foster, 2012).

Private spending is mainly in the form of voluntary health insurance and OOP expenditure. In most ESA countries, voluntary insurance extends cover for elites, with limited pro-poor benefit, especially in the context of a weakly regulated for-profit private sector (Doherty, 2019). Voluntary insurance schemes largely fund private-for-profit services that may be unaffordable for lower income communities unless private spending is pooled with public funds in national health insurance funding and thus also funds public services. Only one country (South Africa) currently plans a form of overall pooling, in which all members of the population would be enrolled through pooling tax and non-contributory and contributory financing (Doherty, 2019). A number of ESA countries do, however, also include public and not-for-profit services in the funds reimbursed by voluntary insurance schemes.

Domestic private expenditure as a share of current expenditure varies widely across ESA countries, from 16% in Mozambique, Malawi, Botswana and Zambia, to over 50% in the DRC, Zimbabwe, Angola and Mauritius (*Figure 4*). In part, the share of private expenditure rises, not only when private financing rises, but also when public financing falls.

Figure 4: Domestic private health expenditure as a % of current health expenditure, ESA countries, 2018 (y axis = %)



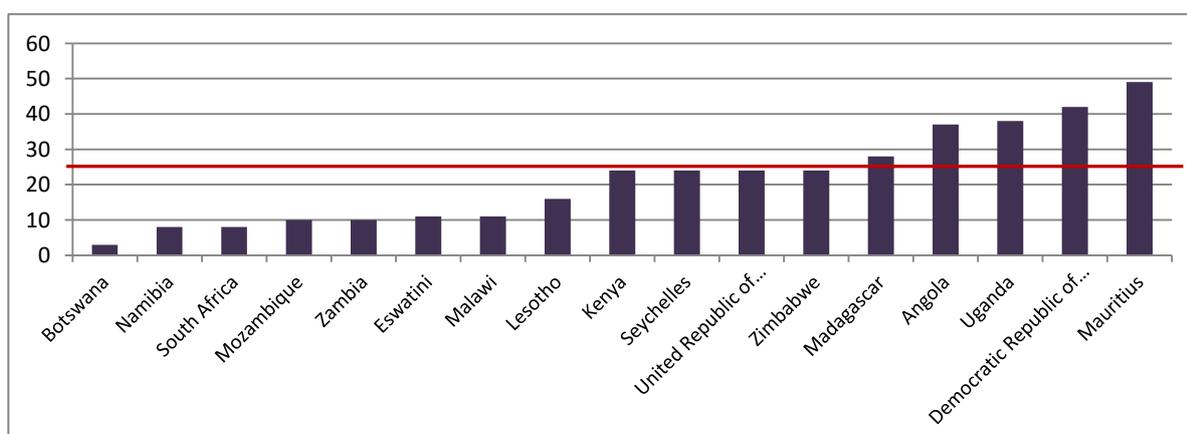
Source: WHO Global Health Expenditure Database, 2021

Notwithstanding the diversity in levels of private financing, the private sector is expanding in the region. Private health has become the fifth most promoted sector in Africa after tourism, hotels and restaurants, energy and computer services (UNCTAD, 2005). While the for-profit sector in many ESA countries often takes the form of informal retail of medicines and local informal providers, some governments (Kenya, South Africa, the DRC and others) are also experimenting with contracting out primary care services to the private sector, while some are also expanding public-private partnerships (PPPs) based on contracts (Doherty, 2011). While discussed elsewhere than in this paper, the debate around the benefit of these private arrangements to the public sector and communities and their implications for equity need to be acknowledged, particularly where PPPs incur substantial subsidies from public to private services (DAWN 2021).

The level of financial protection

One area of private spending and a key equity issue is the share of OOP spending as a percentage of total health expenditure. When OOP spending rises above the 20% WHO describes as a threshold for catastrophic expenditure, it has significant consequences for impoverishment and inequity. *Figure 5* shows the level of OOP spending as a share of total current health expenditure, in public and private sectors combined.

Figure 5: OOP health expenditure as a % current health expenditure, ESA countries, 2018 (y axis = %)



Source: WHO Global Health Expenditure Database, 2021

Countries with a low share of private health expenditure also tend to have low OOP spending and vice versa, but this is not always the case. For example South Africa and Zimbabwe with higher levels of voluntary insurance, have lower shares of OOP spending than might be expected from their overall share of private spending. Uganda, in contrast, has a higher level than might be expected, suggesting fee charges for public services and weak insurance coverage.

Figure 5 shows that in 2018, nine ESA countries had a level of OOP spending on health that exceeded the 20% share of current health spending indicated by WHO as catastrophic. While this may be unequally distributed between social groups within these countries, it suggests that for a majority of ESA countries, fee charges continue to be a barrier to care and a source of potential impoverishment. Households facing difficulties with rising food prices and falling incomes during the pandemic, who also faced such fee charges, may have been more likely to fall out of health services. While most ESA countries have policies of free services for particular levels of care or services, such as maternal and child health care, fee charges persist. In public services, informal charges may be levied when public funding does not cover the cost of care, or may arise when people use services at higher referral levels where fees are charged, or use private services due to poor quality provisioning at lower levels. Such outcomes are more likely when public sector services are inadequately funded and represent an inequitable shift in the burden from states and businesses, to households.

3.3 Delivery on public sector health care and trends in privatisation

Equitable health systems provide relevant, holistic, comprehensive promotion, prevention and care in response to need, as a social right and a state duty. In contrast, market-driven services treat health as a commodity, broken into discrete saleable units with the patient as 'a customer' or consumer. The latter objective of private-for-profit services drives a focus largely on curative services, given the low individual profits from preventive care, except in the not-for-profit non state sector (Loewenson, 2022).

While falling public financing and service quality and rising OOP spending can drive people to use private sector services for needs not met in the public sector, the private-for-profit sector has a mixed record in terms of quality of care, particularly for services used by lower income groups. Private sector services have been reported to include over-prescribing; limited reach beyond higher income groups; barriers to access due to user charges; and fragmentation of risk pools, all of which limit access and effective coverage among lower income groups (Ruiters and Scott, 2009; Ngangom and Aneja 2016). Widening private-for-profit provisioning is associated with rising levels of OOP spending or generally regressive forms of voluntary private insurance with limited pooling of income or risk cross subsidies across them, unless pooled with public financing (McIntyre, 2012). In Kenya, for example, private sector prices have been rising by 20% annually due to the collapse of agreements on pricing guidelines, with the introduction of new co-payments or a reduction in benefits used to manage cost escalation (Doherty, 2011). In South Africa even those covered by private voluntary insurance have complained about rising prices and declining benefits, paying still more out of pocket when they need care (McIntyre, 2010).

The links between falling public revenues and the drivers of rising service privatisation is not only in terms of service quality and access; there are also indirect effects, such as from falling real incomes among health workers and their migration from public services, further exacerbated by the higher workload for those remaining (Vermuyten, 2017). For example, in Uganda, a decline in public financing, including in external resources and public health infrastructure triggered the emigration of many health workers, with the service gap filled by a rising number of private sector services, including many illegal clinics and unregistered medical practices (Sserwanga, 2013; CEHURD, 2019; Ssenyonjo et al., 2018). Hence, while the policy literature often refers to complementarity and partnership between the public and private sectors in health, a strong private sector can permanently undermine efforts to build a strong public sector by siphoning off skilled personnel, fragmenting the risk pool and consequently, limiting opportunities for cross-subsidisation) and building power blocs resistant to regulation (Doherty, 2011). These equity

concerns have also been raised by WHO AFRO (WHO AFRO, 2018). The COVID-19 pandemic demonstrated that, while the private sector made important contributions to laboratory, curative and health technology inputs, it also faced significant challenges in ensuring wider service continuity and population health interventions in low income communities, with this and co-ordination of private inputs for wider social benefit depending on public sector leadership and services (Chanda-Kapata, 2021).

A focus in the for profit sector on more easily costed curative and personal care interventions impacts on health outcomes in terms of the level of prevention of risk, and outreach to those most exposed to risk, including of epidemics and infectious disease. This raises future health costs for households, countries and intergenerationally, including through children's exposure to environmental toxins and chronic conditions (Loewenson et al, 2021; Chanda Kapata, 2020). In a study of 37 African countries, rising fee charges and OOP spending were significantly associated with increased under-five mortality, with user fees influencing the health seeking behaviours of these children's families (Karungi et al., 2005). Data from 44 middle- and low-income countries show that the focus on curative care and exclusion of wider public health initiatives in the for-profit sector excludes poor people and, particularly women, from positive health outcomes (Doherty, 2011). The specific implications of a rising share of private spending for health sector preparedness for COVID-19 would need to be explored at country level. However, in the context where the pandemic had further strained already stretched health systems, a regional review of public and private sector responses to COVID-19 found that the public sector role was 'critical and responsible in ensuring a co-ordinated, equitable and comprehensive response across all sectors, and for regulating and accrediting private sector activities' (Chanda-Kapata, 2021:2).

Health profiles and need vary across ESA countries. In all, health outcomes have, however, been associated with income, residence, quality of living and working conditions and social exclusion and disability. Many countries now face the challenges of rising levels of chronic conditions, including mental ill health, and the added demands of pandemics and climate-related emergencies. Early, proactive screening and upstream action on the conditions that lead to these challenges is critical, to avoid unaffordable costs to countries, health sectors and households. While not-for-profit private services have a long tradition of co-operation and some level of integration with public services in the region, this section indicates that the shorter term profit-focus of private for-profit services undermines equity in a number of ways. This reinforces the WHO's unequivocal backing for a public sector health service as critical to ensure equity, universality and the longer term planning needed to respond to current and projected health challenges. The challenge that must thus be squarely faced, and that is indeed a focus of policy dialogue and public advocacy in the region is how to reverse the decades of under-financing and to sustainably and domestically fund public health systems in ways that do not further segment and verticalize systems or deepen aid dependency.

4. Taxation as a source of health financing in the region

4.1 Taxes as a source of revenue for health

Tax revenues are the proceeds collected by governments from taxes on income and profits, social security contributions, taxes levied on goods and services, payroll taxes, on the ownership and transfer of property, and other taxes (OECD, n.d.). As noted in *Section 2*, this paper is focused on tax revenue and is not examining other resource revenues that are often captured in separate statistics and merit separate investigation. The focus on taxes in this paper is however merited as have been recognised as a backbone of and the most sustainable source of income for any economy.

Particularly during this era of global uncertainty, taxes offer the most sustainable form of financing to attain the ESA region's developmental objectives. Tax revenues play four different roles in an economy; defined as the '4Rs'. They:

- a. **Raise revenues equitably** from all sources, through various types of taxation. A good tax system treats all taxpayers in the same situation equally. It taxes local and multinational enterprises at similar rates, and taxes all sources of income equally, thus creating a level playing field.
- b. **Redistribute income and wealth to address poverty and inequality:** Tax systems redistribute income and wealth by employing progressive tax rates, so that wealthier groups in society pay a higher percentage of their income in taxes.
- c. **Reprice goods and services**, especially critical in health and climate problems. Tax systems recognise and incentivise resources and practices that might otherwise be neglected, and conversely, that may be used to create disincentives for activities that are discouraged. Hence, for example, targeted tax and expenditure measures can be used to protect natural resources or to stimulate particular areas of economic and social activity. Conversely, tax measures have been used to discourage the consumption of sweetened beverages and alcohol.
- d. Enable **representation of taxpayers as citizens:** Tax systems indicate the central role that citizens play in funding public revenue. The long-standing call, 'no taxation without representation', has driven democratic change and advocacy from various social groups on the basis of their rights as taxpayers. History has shown that unjust tax systems create tax resistance and non-compliance and that equitable tax systems only emerge through tax bargaining between the concerned parties. Representation and citizenship are key, but also often missing ingredients, in good tax policy (TJNA, 2011).

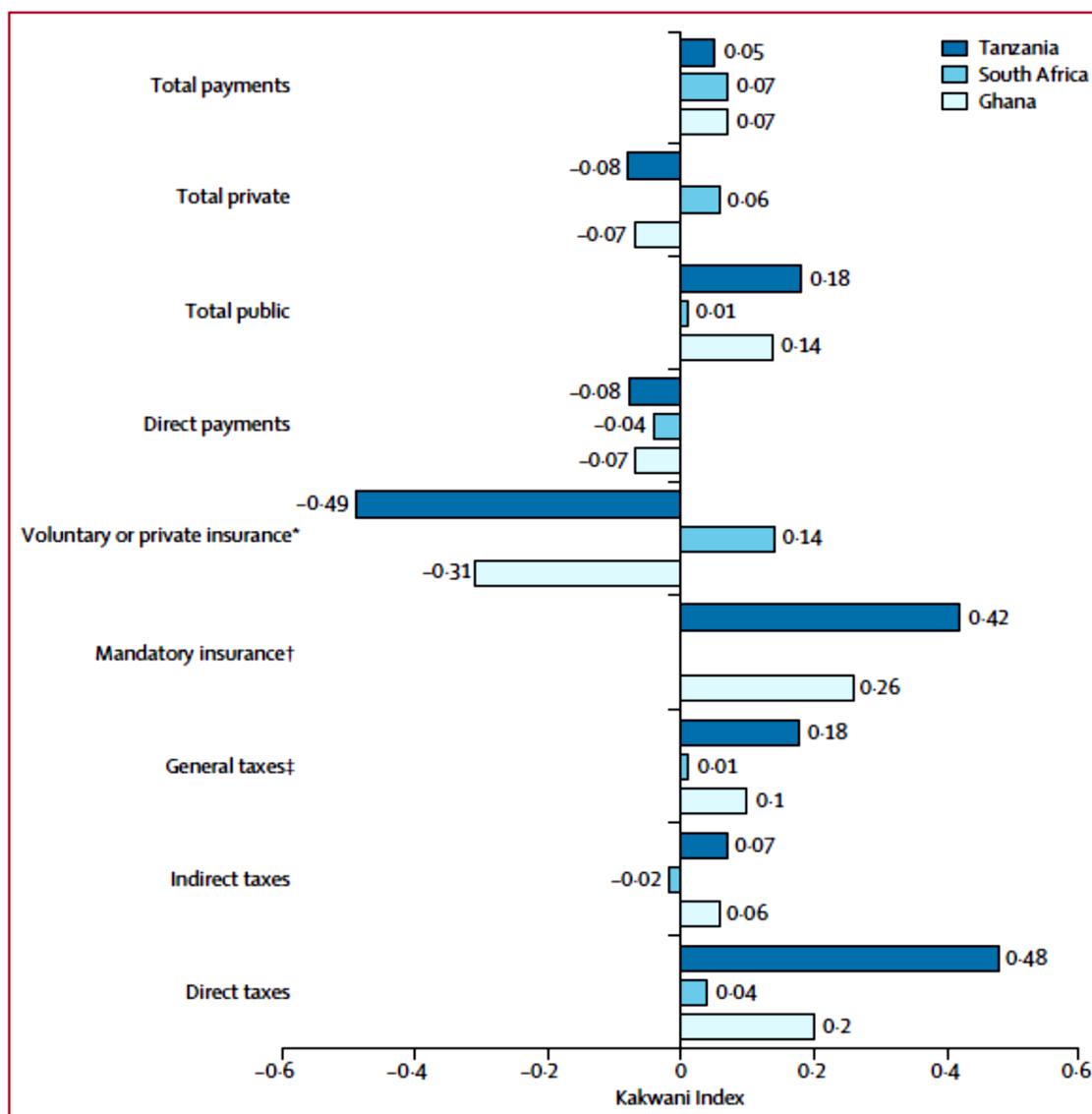
Taxes can be divided into direct and indirect taxes. Direct taxes are those that can be adjusted to the individual characteristics of a taxpayer and are levied directly on the taxpayer. Indirect taxes are those levied on transactions irrespective of the circumstances of the buyer or seller (Atkinson, 1977). An example of a direct tax is the income tax levied on an individual's income, while taxes levied on goods like fuel, or a professional service, are examples of indirect taxes.

Different revenue sources are more or less progressive, with significant impact on equity and financial protection. *Figure 6* shows, for example, the progressiveness of the various tax and other sources of health financing, for three African countries.

In relation to health financing, **direct taxes** are the most progressive source of revenue and can generate large funding pools but they may be affected by economic downturns and be difficult to collect where informal employment is high. In some countries, health financing is also sourced from **indirect excise taxes**, such as those on tobacco and alcohol. If these goods are consumed to a greater degree by wealthier social groups, they may be progressive, as are wealth taxes, windfall taxes on super-profits and taxes on large, profitable companies. Earmarking a surcharge on company or income tax, as applied in Zimbabwe's 'AIDS levy', or earmarking a portion of Value Added Tax (VAT), as applied in Ghana, to fund its national insurance, are further taxation opportunities for health. New tax collections for innovative health financing are seen as more acceptable if they are progressive, easy to collect, and can show a link to health needs or impacts (Doherty, 2019).

In many ESA countries value-added tax on consumption of goods and services is charged at a flat rate across all income groups. VAT has been identified as regressive when applied to goods purchased by poor people. However, an assessment of health care financing progressivity in Tanzania found that VAT, excise tax and import duty were all progressive, with rich people paying more than poor, although less so than in income taxes. Excise tax was found to be progressive overall, but more so for tax on alcoholic drinks and fuel, and less so for taxes on cigarettes and kerosene (EQUINET, 2012). In South Africa, income tax was also found to be progressive, but VAT, excise taxes and the fuel levy were found to be regressive (Ataguba and McIntyre 2012b). Ghana's health insurance fund draws from a 2.5% VAT on selected goods and services, but a range of goods and services consumed mainly by the poor were then exempted (Akazili 2010).

Figure 6: Progressiveness* of different sources of health financing in African countries



Source: Mills et al, 2012. (*) Based on Kakwani indices for financing sources. A negative index shows a regressive mechanism and a positive index a progressive mechanism.

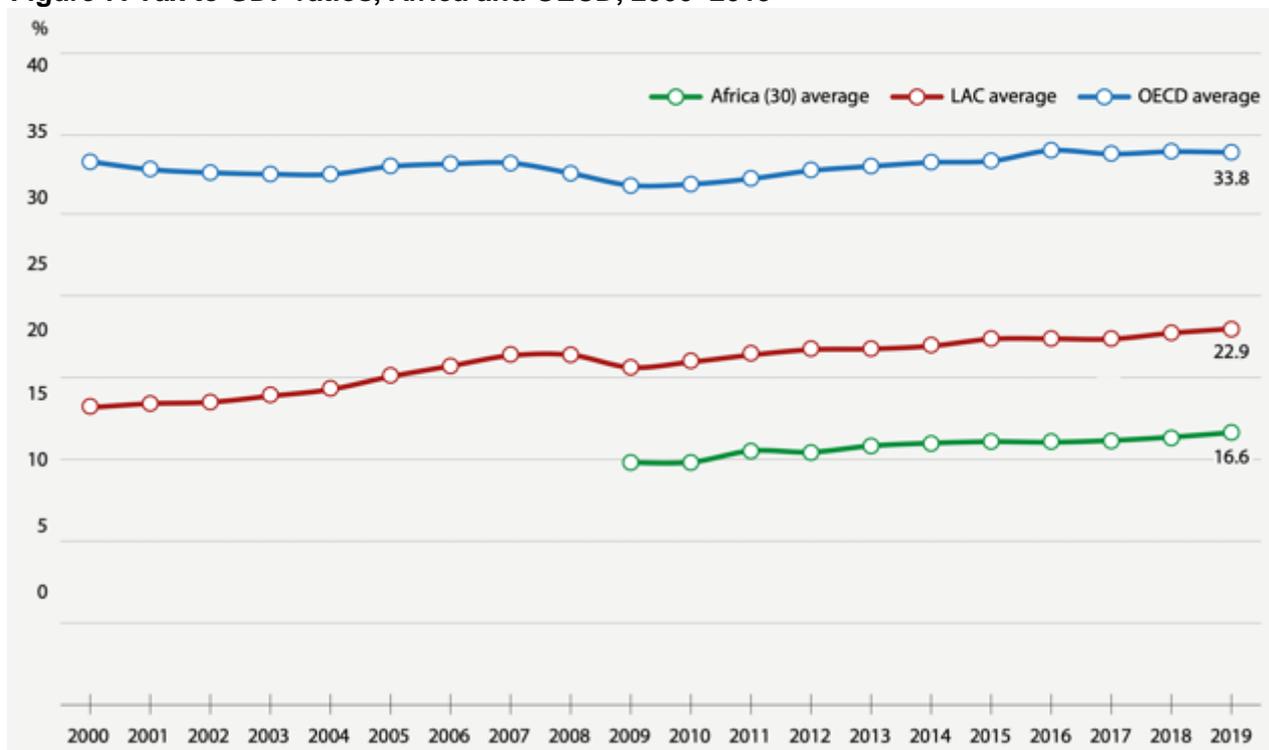
It appears, as suggested in *Figure 6*, that VAT, which contributes a significant amount to tax revenue in ESA countries, can be a progressive source of funds for health where there is a large informal sector, provided it covers commodities consumed more by high income groups, and if VAT collection thresholds protect small businesses (EQUINET, 2012).

Mandatory contributory payments (national health insurance), such as South Africa's national health insurance, are a form of taxation and is progressive, when levied on income rather than as a flat rate contribution and pooled with other tax funding, to cover services for all income and risk groups (EQUINET, 2012). Surcharges on income tax, such as Zimbabwe's AIDS levy, provide significant additional resources for specific purposes and rise progressively along with the tax to which they are applied. In contrast, more limited application of social health insurance (SHI) for specific groups varies in terms of equity, efficiency, sustainability and adequacy unless blended into a single financing system, if not a single pool, with tax funds and with common entitlements across the system (Doherty, 2019).

Private voluntary health insurance may be regressive and impact negatively on efforts to achieve universalism, especially in the context of a weakly regulated for-profit private sector (Doherty, 2019).

Despite the importance of tax revenue, the overall share of tax revenues in relation to African countries' GDP, is one of the lowest in the world (See *Figure 7*).

Figure 7: Tax to GDP ratios, Africa and OECD, 2000–2019



Source: OECD, AUC, ATAF, 2021.

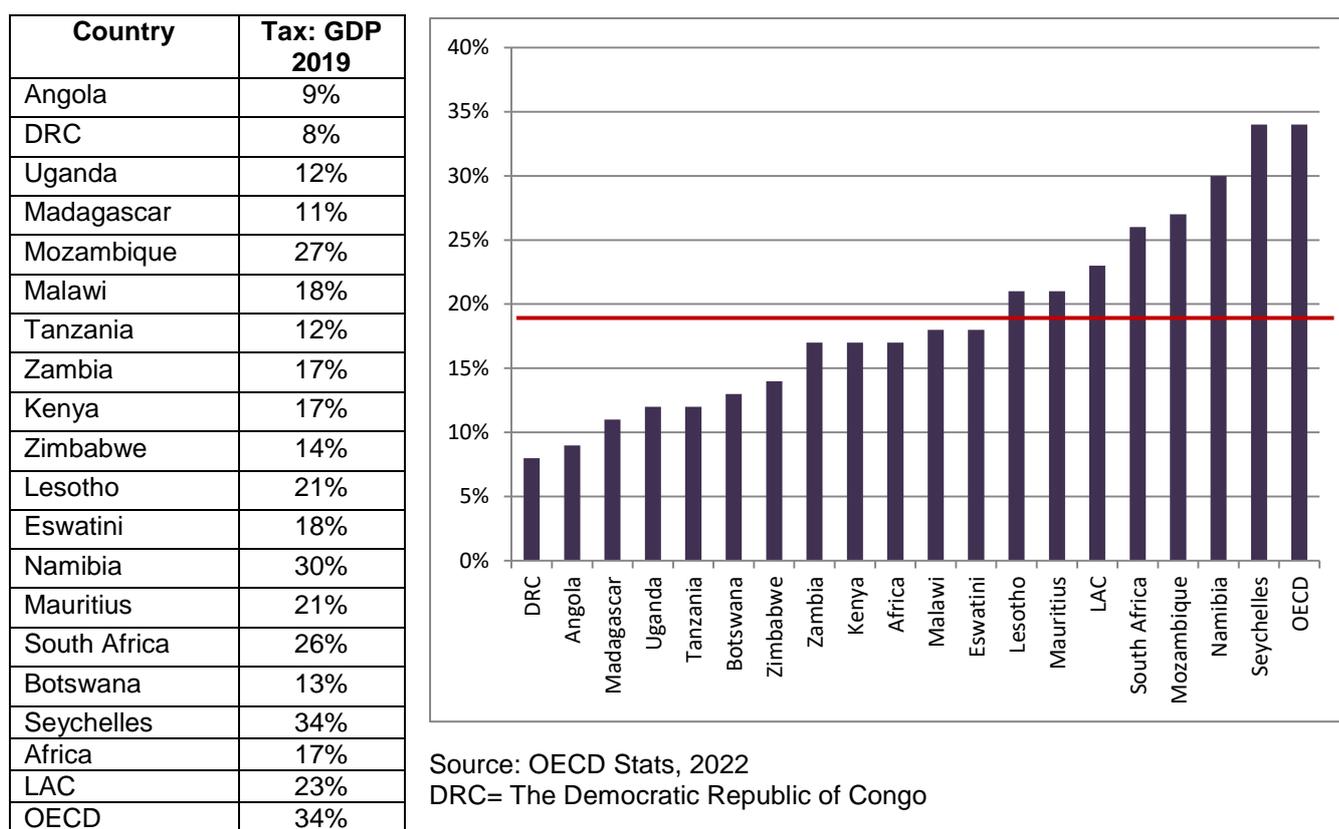
The tax to GDP ratio represents the total tax revenue, including compulsory social security contributions, as a percentage of GDP. As noted earlier, this does not include non-tax revenues such as resource rents/royalties, or fees and income from state-owned companies; we make clear the intergovernmental database used in the sources cited.

For African countries, the figure of 16.6% is below the averages of Asia Pacific countries (21%) Latin America and the Caribbean (22.9%) and OECD countries (33.8%) (OECD et al., 2021). For ESA countries, the average tax to GDP ratio, at 18.1%, is slightly higher than that for African countries, but still lower than for countries in other regions (See *Figure 8* overleaf).

There is wide variation between ESA countries in their tax to GDP ratio from ratios of below 10% in Angola and the DRC (countries with high levels of oil and mineral wealth), to ratios of above 25% in South Africa, Seychelles, South Africa, Mozambique and Namibia, with seven countries having above average tax to GDP ratios for the region.

As discussed later, each country has an optimum tax revenue as a share of GDP – referred to as its tax capacity. In sub-Saharan Africa, this tax capacity is conservatively estimated to be 20% (UN ECA, 2019). The gap between this and actual tax capacities in the region represents the lost tax revenue.

Figure 8: Tax to GDP ratio in ESA countries, 2019



The 'tax gap' is the difference between the amount of tax paid and the amount that should have been paid in a given year. Measuring the tax gap is fraught with difficulties due to the multitude of tax types and national tax systems (UNECA 2019). Each country has an optimum tax revenue as a share of GDP, referred to as its tax capacity. Sub-Saharan Africa's tax capacity is estimated using an approach by UNECA in 2019 to have the lowest tax capacity at 20%, noting that this is a conservative estimate. Using the 20% as a conservative estimate of the tax capacity in Africa, and Africa's average tax revenue to GDP ratio of 17% for 2000–2018, yields an estimated tax gap of 3% of GDP, or approximately \$72 billion in foregone revenue (UNECA 2019).

Similarly, for ESA countries alone, using a conservative tax capacity estimate of 20% and the region's average tax capacity of 18%, yields an estimated tax gap of 2% of ESA GDP, using a GDP figure of US\$773 billion. This indicates lost tax revenue of US\$15 billion, or, given a combined population of 438mm (World Bank, 2022) a tax loss of US\$34.2 per capita. Applying less conservative estimates of tax capacity would yield even higher levels of tax gap.

Despite their low levels, African country tax to GDP ratios have increased by 1.8 percentage points over the past decade. This growth was primarily driven by VAT receipts, which rose by one percentage point to reach 4.9% of GDP in 2019. Income taxes were the second-largest driver of the increase in the tax-to-GDP ratio between 2010 and 2019, increasing by 0.6 percentage points to 6.3% of GDP in 2019. The increase in this source was primarily driven by a growth in personal income tax, which comprised 51% of total income tax revenue (OECD et al., 2021).

The **share of tax revenue from different sources** for ESA countries is shown in *Figure 9*. For African countries overall, indirect taxes, particularly on goods and services, are the most

significant contributor to tax revenues and accounted for 52% of total tax revenue. This was followed by taxes on income and profits at 38% of tax revenue, VAT, at 29% of tax revenue, taxes on profits at 19% and tariffs on income at 18% (OECD et al., 2021). Here too, the the ESA region differs somewhat, with taxes on goods and services, taxes on income, and on profits and capital gains, contributing similar shares of 47% and 46% respectively. VAT in the ESA region accounted for 27% of total tax revenue, higher than the 22% from taxes on income and the 15% from taxes on profit (OECD, 2022).

Figure 9: Different taxes as a percentage of total tax



Source: OECD stats, 2022. *Zimbabwe not included due to insufficient data.

As Figure 9 indicates, here too there is wide variability within the ESA region. The lower share of taxes on corporate profits for both the continent and the ESA region suggests a possibility of weak tax collection from this source, related in part to global tax rule and profit outflows, discussed in the next subsections.

4.2 Losses to ESA tax revenue from global tax rules

Several reasons have contributed to the continent's low tax to GDP ratios observed in Section 4.1. The High Level Panel on Illicit Financial Flows from Africa (HLP) reports that poor governance, weak regulatory structures, harmful tax incentives and double taxation agreements contribute to lower levels of tax collection (AU and UNECA, 2015). Illicit financial flows are discussed further in the next subsection. Reduced tax collection can also be attributed to a global rule system that assigns tax collection to countries outside the region.

The rules of the current global tax framework unfairly disadvantage low-income countries and lead to significant tax losses from the ESA region and the continent. The current system applies a **separate entity principle**, modelled in line with the OECD transfer pricing guidelines. In this system, multinational companies that operate under a common group and common ownership with a common interest can treat their branches in different countries as separate and independent entities, with an expectation that they work at 'arms-length. This enables companies to employ strategies to both reduce their revenue and taxable income, termed 'base erosion', and to shift profits to other lower tax countries, both of which affect tax collection.'

In contrast, a formula can be used to apportion or allocate the overall profits of multinationals to the different states they operate in, within what is termed a 'unitary taxation' approach. This represents an improvement on the separate entity principle, as it shares the tax on value added more equitably, but this depends on the formula used. Many factors can be used in the allocation formula under this unitary taxation approach. Historically the formulae identified have used three main factors for country allocations, viz the share of payroll costs, sales, and physical assets (Ndajiwo, 2020). Given differentials in income, consumption and assets across countries, these factors adversely affect lower income countries and benefit high income countries.

In 2016, and in response to grievances raised around the inequity in the current global tax rules, the OECD proposed a **two pillar solution and inclusive framework** to address some of the issues raised. Pillar One of the proposed OECD two-pillar solution adopts new allocation rules that adapt the formula where some large multinationals pay taxes by apportioning tax liabilities on the basis of sales where final consumers are located. This falls short of expectations for a fairer tax system in various ways. The new tax solution applies only to companies with more than €20 billion (US\$21bn) in revenues and a profit margin above 10% (OECD, 2021). For those companies, only 25% of the profits above the 10% margin are taxed where final consumption occurs. Effectively, this definition covers less than 100 companies globally, maintaining the earlier formula and system for all other companies. Further given the high volume of export of African commodities, it biases towards consumption in high income countries. There are also concerns that implementing a global minimum tax deal would require African countries to forego their digital tax, undermining revenue mobilisation, and that while the global minimum tax will apply to only 100 countries, the digital tax removal will apply to companies in all countries.

Given this limited scope, the ATAF and many African countries consider the current OECD proposals insufficient to address the injustices inherent in the global tax system that undermine public revenue in African countries. In some degree of frustration at the lack of fair treatment and progress, African finance ministers noted at the 2020 Extraordinary Specialised Technical Committee on Finance, Monetary Affairs, Economic Planning and Integration that, “The Inclusive Framework negotiations have made it clear that developed countries are not listening to the concerns of developing countries and have no intention of redressing the balance of taxing rights in any significant way.” (African Union, 2020)

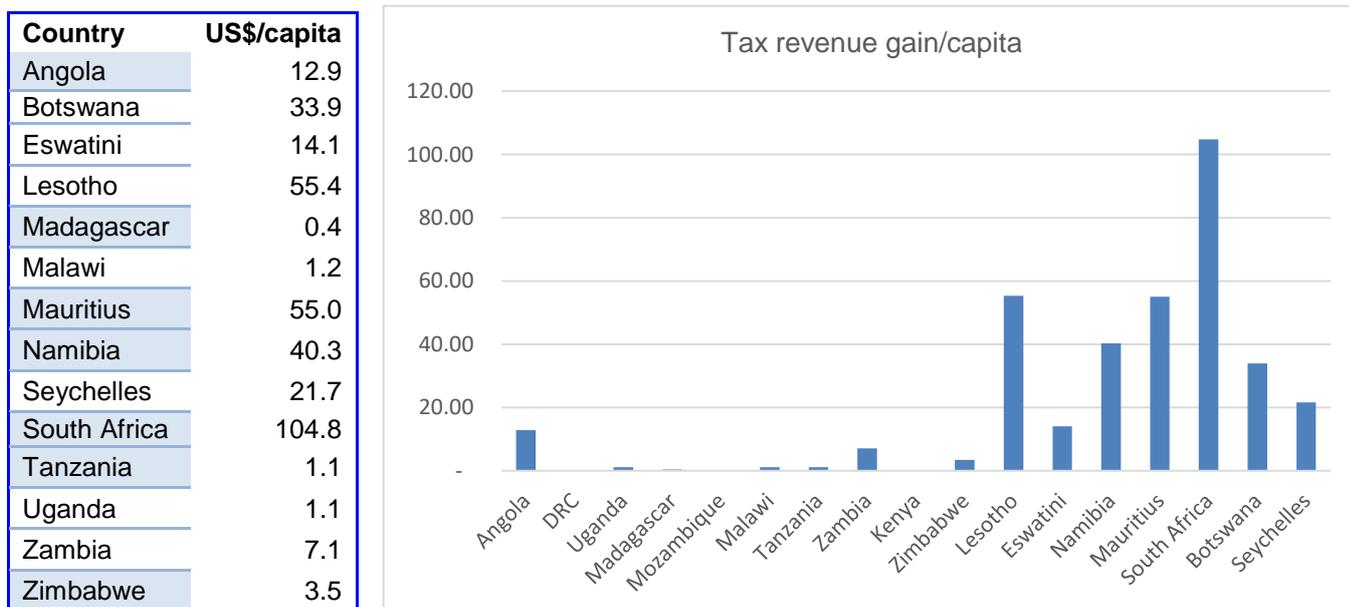
The current imbalance in the allocation of taxing rights and the unfair allocation of those rights in favour of residence jurisdictions that are often in high income countries where company headquarters are based, acts to the significant detriment of source jurisdictions, in low and middle income countries, where the income is sourced. This matter has not been addressed in global tax reforms, despite promises by some high income countries that this would be done (African Union, 2020). The demand for change towards a fairer global tax system has become even more pressing given the significant public expenditure needed to fund costs related to the COVID-19 pandemic and the increased deficits generated by the resultant trade and economic disruption.

Alternative approaches have been proposed. Cobham et al., (2021) show three ways in which the apportionment in the formulae for unitary taxation could be more fairly applied, demonstrating how much countries could lose or gain from application of each. A further option is a Minimum Effective Tax Rate (METR) approach. This is simpler than the OECD proposal and eliminates the unfairness in prioritising multinational home countries’ taxing rights in the OECD two pillar solution. It proposes that **all** countries apply a minimum effective tax rate. This avoids the incentive of shifting declared incomes to low tax countries or tax havens. A METR of 25% has been proposed by advocates of this approach as being closer to the average corporation tax rate in African countries of 28%, noting that the OECD proposal of 15% would still incentivise profit-shifting to OECD countries, given Africa’s higher average corporation tax rate in Africa (Tax Foundation, 2021).

As an example of the potential tax gain from a fairer global tax system, *Figure 10* shows how much ESA countries could gain by applying the evidence from Cobham et al., 2021, and the METR approach to the ESA region, using a globally weighted minimum effective tax rate of 25%.

The evidence in *Figure 10* indicates that all ESA countries will achieve some level of tax gain per capita from applying a METR approach, although some will benefit more than others. In total, South Africa’s population size means it stands to gain the most significant level of additional tax revenue at US\$6 billion, followed by Angola (US\$397 million) and Zambia (US\$123 million). On a per-capita basis, the most significant tax gain is for South Africa, Lesotho and Mauritius.

Figure 10: Annual tax revenue gain/capita using a weighted minimum effective tax rate of 25%



Source: Cobham et.al 2021).
Data not available for the DRC, Mozambique and Kenya.

Overall, and applying the data from Cobham et al., 2021, excluding the DRC, Kenya and Mozambique, for which data was not available, if a METR approach was applied in global tax rules, the ESA region would gain US\$7.2 billion in additional tax collection annually, or US\$26.2 per capita.

4.3 Losses to ESA revenue from illicit flows

As noted earlier, illicit financial flows contribute to losses in tax revenue. While there are various definitions of illicit financial flows (IFFs), the definition endorsed by the Inter-Agency and Expert Group on Agenda for Sustainable Development defines IFFs as “financial flows that are illicit in origin, transfer or use; that reflect an exchange of value (instead of a pure money transaction); and that cross country borders” (UNCTAD, 2020). The issue of IFFs from Africa was given attention in the 2015 Report of the High-Level Panel on Illicit Financial Flows out of Africa (AU and UNECA, 2015). This report highlighted that, over the last 50 years, Africa was estimated to have lost more than US\$1 trillion in IFFs, and US\$50 billion annually. The authors noted that this loss exceeded the annual inflow of overseas development aid (AU and UNECA, 2015). In 2020, the United Nations Conference on Trade and Development reported an annual outflow of financial resources from the continent of US\$88.6 billion, suggesting that IFFs have increased (UNCTAD, 2020).

Although corruption within the continent is often pointed to as a key source of IFFs, the larger share arises from commercial activities, accounting for 65% of the total, while those from Illegal activities and corruption account for 30% and 5% of IFFs respectively (AU and UNECA, 2015). Commercial IFFs stem from business-related activities such as transfer pricing, trade mispricing, mis-invoicing of services and intangibles and use of unequal contracts. This is reported to enable tax evasion (illegal), aggressive tax avoidance (legal), and illegal export of foreign exchange (AU and UN ECA, 2015). While tax evasion and foreign exchange export in excess of legal permissions are illegal, tax avoidance is not illegal and many of these multinational corporate practices are enabled by a global rules system that provides the legal loopholes to minimise their tax liabilities in African countries, as noted in the previous subsection. This includes their registration in and shifting of their profits to tax havens (AU and UN ECA, 2015).

Depending on the estimate, base erosions and profit shifting to tax havens alone, collectively cost governments between US\$500–600 billion annually in lost corporate tax revenue, a third of which was from low income countries (IMF, 2019). For ESA countries, where collections from tax on corporate profits constitute an important share of tax revenue, these losses may be significant, as indicated in *Table 2*, drawing on data for 2017 analysed by the global Tax Justice Network (TJN) (TJN, 2021).

Table 2: Annual tax loss USD millions from corporate base erosion and profit shifting, 2017

Country	Total annual tax loss, US\$ mmm	Tax loss per capita (US\$)
Angola	361	11.7
Botswana	13	5.8
DRC	639	7.6
Eswatini	15	13.2
Kenya	559	10.9
Lesotho	1	0.5
Madagascar	77	2.9
Malawi	60	3.3
Mauritius	451	356.5
Mozambique	334	11.3
Namibia	52	21.2
Seychelles	151	1,556.7
South Africa	3561	61.6
Tanzania	213	3.8
Uganda	383	9
Zambia	635	36.6
Zimbabwe	107	7.4

Source: TJN, 2021

Evidence thus suggests that the ESA region lost US\$7.6 billion annually in tax revenue in 2017 due to global practices of base erosion and profit shifting, or US\$124.7 per capita, equivalent to 1.6% of the region's GDP. Given that Seychelles and Mauritius with their low populations contribute to high per capita averages, even excluding these two countries suggests an average per capita loss from these two commercial tax practices alone, of US\$13.8 per capita per year. 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.

5. Financing public sector health systems in ESA countries

5.1 Relating health budget deficits to tax losses

As noted in Section 3, 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 NCDs and the health impacts of precarious employment, living and working conditions. This, and the unpredictable nature of external funding and development aid has raised 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 the global SDG commitment to ensure UHC has added impetus to this.

While various forms of innovative financing are being explored in ESA countries, the additional funds they bring can be small relative to the scale of demand. For equity and universality, the core of a public sector health system is funded by taxation or mandatory national insurance

(rather than voluntary or partial social insurance) as a form of taxation. The evidence in this paper thus focuses attention on the potential sources of substantial losses in tax revenue, as an area of policy attention for more sustainable and meaningful levels of health financing.

In line with this, and applying the evidence in *Sections 3 and 4*, the various estimates of the size of the public sector health financing gap based on whether it covers a minimum or comprehensive assessment, can be related to losses in public revenue due to the various dimensions of lost tax revenue that is in relation to:

- the tax revenue versus the tax capacity, or the optimum tax revenue as a share of GDP.
- the tax lost due to global rules that do not apply a unitary tax system.
- the revenue lost due to illicit financial flows.

To allow for this comparison, the figures presented in the previous sections are expressed in the table as annual per capita US\$ figures.. The results are shown in *Table 3*. The table does not show total public sector health financing or total tax revenue, but rather the public sector health financing **gap** and the **lost** tax revenue, to relate the deficit in public financing for health to the level of tax losses. The estimates for the totals in *Table 3* use the per capita rate multiplied by the total ESA population and vice versa. There may be some overlap in the estimates of tax losses in *Table 3*, such as in the reduced tax capacity enabling global tax abuses, but as noted in *Section 4*, these estimates limit tax avoidance to specific areas only and exclude wider sources of IFFs. Taking this into account it could be justified to combine tax losses to indicate a total annual tax loss to the region of US\$34.1bn, using the estimates shown in *Table 3*.

Table 3: Annual total and per capita US\$ public sector financing gap and lost tax revenue, 2019

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

(a) Loewenson et al, 2018; (b) WHO, 2012; (c) WHO in Govender et al, 2008; (d) UN ECA 2019; (e) Cobham et al. 2021; (f) TJN 2021.

(*) Original year figure adjusted by inflation using the [US\\$ inflation calculator](#), and applies the total population to the per capita figure.

(**) Per capita figure estimate excluded the DRC, Kenya and Mozambique but applied in this table to the total ESA population to estimate total tax loss to the region.

Comparing the total annual tax loss with the shortfalls in public sector health financing, the total 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, using WHO estimates. Even individual areas of tax loss, particularly from shortfalls on tax capacities and unfair global tax rules could fund estimates of shortfalls in public sector health financing of essential or basic services.

While the limitations of estimates are noted, the scale of the figures provide an indication of the significant contribution that addressing tax losses can make to meeting the gap in public sector financing of health services. *Section 3* noted the implications of the shortfalls in public health financing for meeting commitments to UHC, addressing demands for health security and preparedness for the now predictable emergencies and pandemics, and for critical measures to provide financial protection and comprehensive primary health care to address inequities in health. It also noted the limitations and potential inequity arising in meeting these demands with small additional segmented innovative financing pots, notwithstanding their useful contribution, nor with expanded private sector provisioning or segmented private funding. *Section 4* indicates the level of tax losses and, of importance, indicates that many of these are losses to taxes on wealth or on taxes being fairly collected within, rather than outside, ESA countries, suggesting that addressing these losses will not increase inequity by burdening poorer populations. Engaging these sources of lost tax thus presents an important avenue for equitable domestic health financing.

5.2 Recommendations for policy and action

As resources for the health sector have fluctuated or fallen, the interaction between health and finance ministries has often focused on improved efficiency and accountable use of funds, both of which are relevant concerns. Yet the financing gap for health systems, exposed by the challenges faced in meeting core services, reducing OOP spending and managing the additional demands during the COVID-19 pandemic, and the reliance in many countries on unpredictable external funding for core health services, indicate that it is equally critical to address issues of adequacy and equity. This implies shifting the dialogue between health and finance sectors to the joint discussion on what needs to be done to ensure adequate public revenue. This dialogue has commenced with the interactions on smaller pools of innovative tax financing, but with the size of the demand and the current health financing gap, projected to increase with rising NCDs, pandemics and climate-related challenges, it is timely to deepen this to joint advocacy on the tax gap and tax losses.

With the public health and economic implications of COVID-19 having raised sociopolitical attention on 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 in public revenues for health. There is also scope in follow up work to explore further potential contributions to health financing from other domestic revenue flows, such as the resource revenues noted earlier. The global engagement by African countries on the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) waiver, backed by health diplomacy, as well as African finance ministers' engagement on the global tax system indicate the potential when trade, health sectors, professionals and civil society engage on regional interests, including in challenging inequities in global systems that undermine responses within the region.

This paper provides evidence 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 thus calls for joint engagement in national, regional and global processes by ESA health and finance sectors and civil society, including those working on health equity and economic justice, to articulate policy, demand, negotiate and build measures to achieve this, by:

- a. Making clear the funding demands in ESA countries and in the region to address the right to health care, the commitment to UHC and equity and to other health-related SDGs in the public domain, including measures for pandemic preparedness and health security, and for the services needed to prevent and manage the current and projected demands from rising NCDs.

- b. Articulating and ensuring sociopolitical and cross sectoral 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 a costing of the 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, by expanding the tax base through expansion of wealth and other progressive taxes as substantial sources of revenue, and by increasing transparency in and blocking illicit outflows, such as through beneficial ownership transparency registries.
- d. Establishing steps to link tax funding with other sources of health financing in pooled funding for national health insurance to overcome segmentation of health financing, enable risk and income cross subsidies, and ensure that OOP spending does not exceed the 20% of total health spending indicated by WHO to be catastrophic health spending.
- e. Working across countries at regional level and with the ATAF to avoid tax competition between ESA countries, and to reduce tax incentives and exemptions for corporates, that reduce the capacities of ESA country to mobilise tax revenue.
- f. Adding health evidence to ongoing negotiations and the case made by African finance ministers at international level for a fairer global tax system, showing both the need 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 SDG commitments and achieve UHC and health security.

The WHO as an intergovernmental body on health has no UN global counterpart on tax financing, presenting a significant gap in the global dialogue on health financing, The OECD Inclusive Framework platform currently discussing proposed reforms to global tax rules and formulae is not inclusive. It excludes many African countries, with seven ESA countries (Uganda, Mozambique, Zimbabwe, Tanzania, Malawi, Madagascar, Lesotho) not members of the platform. Even those that are members do not participate at the same level as OECD member states.

The global architecture has developed a growing proliferation of global health funding bodies, mobilised in response to various health challenges, even while health systems in ESA countries have continued to be underfunded, with health financing remaining precarious and for many ESA countries, with high levels of dependency on overseas development aid. Health and finance sectors thus have a joint interest in adding to the existing pressures to establish a United Nations Tax body, and to have a more democratic and inclusive global mechanism to make the necessary changes to ensure progressive taxation as the core source of funds for an equitable, universal health system.

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Acronyms

ATAF	African Tax Administration Forum
EQUINET	Regional Network for Equity in Health in East and Southern Africa
ESA	Eastern and Southern African countries
CHE	Current Health Expenditure
COVID–19	Coronavirus Virus Disease
GDP	Gross Domestic Product
IFF	illicit financial flows
METR	Minimum Effective Tax Rate
MoH	Ministry of Health
NCDs	Non-communicable Diseases
NHA	National Health Accounts
NHI	National Health Insurance
OECD	Organisation for Economic Co-operation and Development
OOP	Out-Of-Pocket
PPPs	Public–Private Partnerships
TJNA	Tax Justice Network Africa
UHC	Universal Health Coverage
UNECA	United Nations Economic Commission for Africa
VAT	Value Added Tax
WHO	World Health Organization

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity-oriented interventions. EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

The Regional Network for Equity in health in east and southern Africa (EQUINET) implements work in a number of areas identified as central to health equity in east and southern Africa, including

- Cross cutting equity analysis, including on health in extractives
- Health rights and the law
- Fairly resourcing health systems
- Social empowerment for health, participatory research and
- Global engagement, trade and health and health diplomacy

The Tax Justice Network Africa (TJNA) is a pan-African organisation and a member of the Global Alliance for Tax Justice. TJNA promotes socially just, accountable and progressive taxation systems in Africa. It advocates for tax policies with pro-poor outcomes and tax systems that curb public resource leakages and enhance domestic resource mobilisation. TJNA engages in activities that are aimed at promoting public awareness regarding tax issues in Africa. Through networking among member organizations across Africa, TJNA seeks to raise awareness on the importance of taxation as a tool for development and democratic governance.

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