MALAWI MEDICAL JOURNAL

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November 2014

Weblink to this article: http://www.medcol.mw/mmj/?p=2018

Health spending, illicit financial flows and tax incentives in Malawi

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Abstract

This analysis examines the gaps in health care financing in Malawi and how foregone taxes could fill these gaps. It begins with an assessment of the disease burden and government health expenditure. Then it analyses the tax revenues foregone by the government of Malawi by two main routes:

- Illicit financial flows (IFF) from the country
- Tax incentives.

We find that there are significant financing gaps in the health sector; for example, government expenditure is United States Dollars (USD) 177 million for 2013/2014 while projected donor contribution in 2013/2014 is USD 207 million and the total cost for the minimal health package is USD 535 million. Thus the funding gap between the government budget for health and the required spending to provide the minimal package for 2013/2014 is USD 358 million. On the other hand we estimate that almost USD 400 million is lost through IFF and corporate utilization of tax incentives each year.

The revenues foregone plus the current government health spending would be sufficient to cover the minimal public health package for all Malawians and would help tackle Malawi's disease burden. Every effort must be made, including improving transparency and revising laws, to curtail IFF and moderate tax incentives.

Abbreviations

USD United States Dollar
MK Malawian Kwacha
MDGS Malawian Development and Growth Strategy
HIV Human Immunodeficiency Virus
AIDS Acquired Immunodeficiency Virus
SD Standard Deviation
TB Tuberculosis
EHP Essential Health Package
MDGS II Malawian Development and Growth Strategy 2011-2016
USAID United States of America International Development
DFID – Department for International Development (UK)
GDP Gross Domestic Product
IMF International Development Fund
UN United Nations

Introduction

Malawians suffer a markedly high disease burden and levels of mortality. This is largely due to poverty, inadequate financing of health care services and a weak health system. Malawi is one of the poorest countries in the world with 62 per cent of its 15.9 million population living on USD 1.25 a day or less.[1] It is the poor who are disproportionately affected by the disease burden and mortality.[2] Further, the health sector is poorly financed owing to low domestic resource mobilization.[3] Increasing the domestic resources available to promote health (and development in general) remains a critical policy focus for low income countries in Africa such as Malawi.

The disease burden, health system and health spending in Malawi

The disease burden

Common to other sub-Saharan African countries, Malawi's population suffers from a significant disease burden, made up of illness, impairment and mortality to which diseases including tuberculosis, malaria and HIV contribute substantially. The HIV prevalence is among the highest in the world: around one in ten people aged 15-49 – around a million people – live with HIV/AIDS, 60 per cent of whom are women. HIV/AIDS was identified as the leading contributor to disease burden. While the rollout of antiretroviral therapy has transformed the public health landscape in the last few years the health consequences of widespread HIV infection for the population remain substantial. One third of children, and two-thirds of adults, who need antiretroviral treatment for HIV are receiving it[4,5] and a huge and continuing effort to extend this and other interventions are needed. In 2008, the leading causes of disease among children under-five were lower respiratory infections, diarrhoea and malaria.[6] By 2010 around half of all under-fives were stunted (low height for age) and just over 1 in 10 were underweight (low weight for age, < -2SD)[7]; serial nutritional surveys indicate little change in rates of child malnutrition over several decades.

Alongside these problems there is evidence of a growing burden of non-communicable diseases, with 33 per cent of adults having hypertension.[8] According to the World Bank, around 8,000 Malawians die every year from diarrhoea, almost all of which is due to poor water, sanitation and hygiene.[9] The maternal mortality rate is among the highest in Africa, with estimates around 460 per 100,000 live births, remaining largely unchanged over recent years. By contrast the under-five mortality rate has steadily fallen from 180/1,000 births in 1999 to 133 in 2004 and to 83 in 2012; yet absolute child mortality rates remain high: more than one in nine Malawian children die before reaching their fifth birthday. According to the WHO, the most common causes of deaths among children under five are pneumonia, HIV/AIDS and malaria – which each account for 13-14 per cent of deaths.[10]

The health system

The government of Malawi identifies public health as a key priority area in its flagship development plan – the Malawi Growth and Development Strategy 2011-2016.[11] Since 2002, the government has been promoting an Essential Health Package (EHP).[12] This is delivered at the community, primary and secondary levels, is free of charge and is designed to address the most common causes of morbidity and mortality, focusing mainly on HIV, TB and maternal and neonatal conditions.[13] The health system in Malawi is challenged at all levels as noted by the WHO country office: "The health system in Malawi continues to experience challenges in human resource shortage, weak health information systems and shrinking funding for district health service delivery".[4] There are two doctors and 38 nurses per 100,000 population,[14] but these cadres are supported by 22/100,000 non physician clinicians.[15]

However the human resources are insufficient to meet basic health care needs. A recent analysis notes that key constraints to the successful implementation of the EHP in Malawi include a widespread shortage of staff. For example only half of expected person-days of clinical staff were available, with unfilled posts and workshops accounting for the days missed. Despite the frequent absences due to training, healthcare workers remain poorly trained with only 50% knowing that it is important to count the respiratory rate in children with a lower respiratory tract infection.[12] Supervision is inadequate and job satisfaction is very low because of low salaries and poor working conditions.[12] However, in order to improve staff retention a top up of 52% of gross pay, amounting to 25-41% after tax was introduced in 2005. This resulted in an increase in students applying for training in the health sector but the impact on retention has not been assessed.[16] However, this experience does demonstrate that an injection of revenue can increase the number of students interested in training to be a health care worker. Health system weakness is also a major constraint, for example in commodity supply, only one quarter of health centres having a supply of basic antibiotics.[12]

Health spending

The government's annual budget allocation to health is given in Table 1. Malawi's budget is aligned to its second Malawian Growth and Development Strategy (MGDS II).[17] Around 70% of the total budget is allocated to the priorities of the MGDS II and 12% of the total budget is allocated to public health, sanitation, malaria and HIV management. The allocations and projected allocations in USD are shown in Table 1 for the years 2011 to 2016. Donors contribute significantly to health financing in Malawi; however the estimated transaction costs range from 32% of the total (USAID) to 8% (DFID) and unpredictability complicates planning. It has been estimated by the Government of Malawi that on average 19% of pledged donor funds do not reach the health sector but are consumed by overheads and transaction costs.[11] Eighty per cent of the Ministry's budget is allocated to salaries and other recurrent costs, with 16 per cent allocated to medical supplies and expenses.[18]

Table 1: Budget allocation to public health in USD

	2011/12	2012/13	2013/14	2014/15 Projections	2015/16 Projections
In USD millions*[18,32]	263	167	177	161	167
Donor contributions[11]	274	271	207	244	243
Total required to provide EHP	502	518	535	553	571

* Exchange rate from the Reserve Bank of Malawi. On 31/12/13 rate was MK435.23 = 1 USD, on 31/12/12 rate was MK335.13, on 31/12/11 rate was MK163.75

One way to assess the adequacy of health spending is to utilize a measure of per capita expenditure. The WHO Commission on Health and Macroeconomics have estimated the cost for the provision of minimal services to be US$34 per capita in 2007 and US$38 per capita in 2015. The estimated resources required to achieve the goals set out in the EHP in Malawi in 2011 were US$33.4 per capita.[11] The capital required to provide the EHP for each person in Malawi has been estimated using the population for that year and is shown in Table 1.[19] The WHO notes that Malawi's per capita health spending has always been low and not enough to cover the EHP.[4] Using the figures above, Malawi's public health spending of USD 167 million plus donor expenditure in 2012/13 amounted to per capita expenditure of USD 28.20. These per capita spending figures do not capture private spending on health; the World Bank estimates that in 2011, per capita total expenditure on health in the country was USD 77. [20]

Tax, IFF and tax incentives in low income countries

Tax and development

Taxes are the most important, sustainable and predictable source of finance for governments in low income countries. They provide revenues for the provision of essential social services including health, sanitation and education. The United Nations estimates that if the world's Least Developed Countries raised at least 20 per cent of their Gross Domestic Product (GDP) from taxes, they could achieve the Millennium Development Goals (MDGs).[21] However, Malawi raises around 20 per cent of its GDP in taxes,[22] but is "off track" to reach most of the MDG except for reduction in under-five mortality.[23] Malawi's revenues from taxes are derived mostly form Valued Added Tax (VAT) and Pay as You Earn (PAYE), see Table 2.

Table 2: Malawi tax revenues, 2011/12[18]

	Percent of total
VAT (import and domestic)	32.6
PAYE	24
Company (corporate income) tax	13.3
Excise duties	12
Import duty	9.6
Withholding tax	8.7
Tax refunds	2.7
Other taxes	2.4
Total Tax	**100%**

Countries can raise significant amounts of money from businesses and individuals if they collect the taxes due. However, substantial tax revenues are lost through two mechanisms which are illicit financial flows (IFF) and tax incentives.

Illicit financial flows

Illicit financial flows are funds that are illegally transferred, illegally earned, or illegally utilized and cover all unrecorded private financial outflows that drive the accumulation of foreign assets by residents in contravention of applicable laws.[24] They involve the transfer of money earned through tax evasion, corruption and other criminal activities.[25] As these flows are illicit and therefore difficult to quantify, researchers have had to use proxy measures to estimate them.[26] Global Financial Integrity, a research and advocacy organization estimates that between 1970 – 2008, illicit financial flows from Africa amounted to a USD 854 billion.[27] There is little doubt that loss of capital from poor countries negatively impacts their development and should be curtailed.[25] Boyce and Ndikumana estimate that USD 814 billion flowed from SSA between 1970 to 2010.[28] Table 3 provides estimates of illicit financial flows from Malawi, using data from Global Financial Integrity. Overall, the equivalent of USD 4.7 billion has left Malawi in the ten years 2001-10, representing an average of USD 469 million per year.

Table 3: Illicit financial flows from Malawi, 2001-10 (USD million)[24]

2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total	Average
357	112	210	159	494	458	453	1,013	751	684	4,691	469

These illicit financial flows translate into substantial lost tax revenues for the Malawian people since illicit flows are, by definition, untaxed. Corporate income tax is 30 per cent for Malawian companies and 35 per cent for branches of foreign companies in Malawi, so a middle figure of 32.5 per cent is reasonable to assess lost tax revenues. Using this figure, illicit financial flows have resulted in lost tax revenues of USD1.52 billion during 2001-10, or an average of USD 152 million a year. However, the illicit flows for the three most recent years for which data are available – 2008-10 – are much higher, amounting to an average of USD 846 million annually. This has resulted in estimated loss of tax revenues of USD 275 million per year. These figures amount to a substantial proportion of Malawi's revenue. For the period 1980-2009, Malawi lost an average of around 12 per cent of GDP in illicit financial flows.[25] Table 4 shows that illicit financial flows amount to an average of 18.1 per cent of GDP in the three years 2008-10.

Table 4: Illicit financial flows and lost tax revenues as percentage of GDP

	2008	2009	2010	Average
Malawian GDP (USD million)*[21,31]	4,255	4,682	5,039	4,659
Illicit financial flows (USD million)[24]	1,103	751	684	846
Illicit financial flows as % of GDP	25.9	16.0	13.6	18.1
Estimated lost tax revenues (USD million)	359	244	222	275

*GDP Exchange rates converted as per rate prevailing on 1 July that year (MK141/USD in 2008; MK140/USD in 2009; MK151/USD in 2010)

It is unclear what proportion of taxes is paid by companies in Malawi as the data in Table 2 do not disaggregate company and individual tax payments. The extractives sector is increasingly important with the expectation that mining companies will pay significant amounts in tax in the coming years. However, this is not yet the case. Although mining exports were worth USD 114 million in 2010, equivalent to 10 per cent of all exports and USD 123 million in 2011[29], mining currently contributes little in taxes. Data on the country's total revenues from mining are not regularly available. The only revenue figure provided by the government is 'slightly over 2 billion Malawian Kwacha (MK)' in 2010, which amounted to 0.76 per cent of government tax revenues.[29]

Projections are that, without remedial action by the government, Malawi will continue to lose significant potential tax revenues from illicit financial flows. Using International Monetary Fund (IMF) figures for projected GDP and assuming that tax revenue losses from illicit financial flows will remain at 5.9 per cent (the same as the average for 2008-10), Malawi will lose USD 1.98 billion in the seven years 2011-17. This would be an average of USD 283 million a year.

Tax incentives

In addition to losing tax revenues from illicit financial flows, many low-income countries are foregoing revenues from the tax incentives – provided mainly to companies, especially mining companies. Tax incentives can be defined as 'a deduction, exclusion or exemption from a tax liability, offered as an enticement to engage in a specified activity such as investment in capital goods for a certain period'. These include different forms of tax holidays and low tax rates.

Tax incentives in Malawi are enshrined in the main tax legislation such as the Customs and Excise Act, the Income Act and the Export Processing Zones (EPZ) Act. Malawi provides tax incentives to foreign investors to encourage greater amounts of foreign direct investment. One recent estimate, following analysis of selected companies' financial reports, is that tax incentives have resulted in revenues foregone of a minimum of USD 588 million in the five years 2008-12, meaning an average of USD 117.6 million a year.

The health sector related opportunity costs of illicit flows and tax incentives

Principal findings

This analysis has demonstrated that the government of Malawi spends approximately USD 170 million on health for the population each year; donors contribute around USD 250 million. Together these do not reach the amount required to provide the minimal health package, which is estimated to require USD 530 million. Each year USD 275 million of government revenue is foregone in the form of potential taxes on flows of capital from the country and an additional USD 117 million is foregone due to tax lost through tax incentives. If these flows could be curtailed and tax incentives reduced, the country could pay for the minimal health package with domestically mobilized resources. This would have the advantage of decreasing the dependence on unpredictable donor pledges and would help with health systems planning; for example, it is challenging to hire healthcare workers if there is uncertainty about donor pledges. The decision on how to spend these additional, but still scarce, domestically mobilized resources should be made in a way which best meets the country's needs. We have used health expenditure in order to show the scale of the opportunities lost but the impact on health may be even greater if spent on other sectors such as infrastructure or education.

There is debate about the efficacy of tax incentives in attracting investment and whether the loss of tax outweighs the benefits from increased investment. There is a considerable literature suggesting that tax incentives are not needed to encourage investment and there is no evidence either in support of tax incentives or against tax incentives in the context of Malawi.[30] Tax incentives can be provided to support domestic companies, or deployed to help the poor, for example by reducing taxes on basic food items. However, the key

issue is to differentiate between tax incentives that serve a strategic purpose which benefits broader society or the economy, and those that favor individual companies and provide little or no benefit to the economy. Bilateral agreements signed with individual companies are especially open to criticism.

Conclusions and recommendations

On the issue of illicit financial flows, the government and international partners need to work on a variety of fronts to secure action to clamp down on the use of tax havens and to require much greater transparency and the automatic exchange of information on the activities of companies operating across borders. International developmental partners could play an important role, while continuing to support developmental efforts, which is treating the symptoms of poverty, they could also advocate to reduce the causes.[31] The Malawian government could add its voice to those calls for all transnational companies to report their financial accounts on a country-by-country basis, in order to scrutinize company financial flows and tax payments in each country in which they operate.

One policy area directly under the government's authority concerns transfer pricing. The government could strengthen its regulations to ensure that companies operating in Malawi are not able to reduce their taxable income by engaging in transfer pricing. It could increase the number and expertise of staff monitoring and scrutinizing company accounts and increase the penalties payable by companies if they are found to be engaged in illicit activities. Policy on tax incentives is also under the control of the government. The authorities could review the policy of tax incentives with a view to reducing or abolishing those incentives provided for the purposes of encouraging foreign direct investment. They could also promote much greater transparency on the issue, for example by publishing an annual figure on the extent of government tax incentives, to allow for adequate parliamentary, public and media debate on the subject.

While these issues may seem far removed from healthcare workers, this analysis demonstrates the opportunity costs in terms of the healthcare budget. We should individually and in our professional organizations advocate for legislation which will curtail illicit flows and tax preferences which do not benefit broader society.

Acknowledgements

Mr. Innocent Makuta for proof reading the final manuscript; Dr. Cameron Bowie for advice on health spending; Professor Will Stones for reviewing the final manuscript.

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