



Healthy Revenues

**How the extractives industry can support
Universal Health Coverage in Sierra Leone**

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How the extractives industry can support Universal Health Coverage in Sierra Leone

Written by Natalie Sharples with additional input from Sarah Edwards, Regina Bash-Taqi and Melissa Whitney-Long. With thanks to Regina Keith, Cara International Consulting Ltd, Budget Advocacy Network Sierra Leone and Mark Curtis, Curtis Research. This report is funded by WHO.

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Cover image: Sierra Leone January 2011, Mothers queue with their babies to receive pneumococcal vaccine at a peripheral health unit in Pujehun District.
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**Health Poverty Action works to
strengthen poor and marginalised
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Executive Summary

The people of Sierra Leone are being denied their right to health.

In the absence of strong health systems, the current emergence of Ebola in West Africa has become an epidemic. Even before the Ebola crisis, Sierra Leone had some of the worst health indicators in the world. Ebola has plunged the country into a spiralling health crisis. Whilst over 3,908 people to date have died directly of Ebola,ⁱ many others are dying of unrelated conditions and diseases such as malaria, as public health work grinds to a halt and weak health systems teeter on the brink of collapse, incapable of meeting the needs of their population. The lack of adequate, sustainable funding for the health system means the people of Sierra Leone are dying needlessly.

Meanwhile, Sierra Leone is losing huge sums in untapped tax revenue each year. New research conducted for this report estimates that the country could gain an additional \$94ⁱⁱ million through reductions in just three tax incentives over the next few years.ⁱⁱⁱ Another estimate, from the Budget Advocacy Network and National Advocacy Coalition on Extractives in Sierra Leone, suggests that the country has lost \$199 million a year in recent years due to tax incentives,¹ over three times the health budget for 2015.

On top of this Sierra Leone is losing revenues from illicit capital flight – unrecorded financial outflows, some a result of tax evasion and avoidance. These amount to an average of around \$71 million each year over the past decade.² These are vast sums, much of which could and should be used to promote the health of Sierra Leone's people.

Sierra Leone ranks 183 of 187 countries on the Human Development Index,³ has an infant mortality rate of 107 per 1000 live births,⁴ the world's highest maternal mortality ratio⁵ at 1165 maternal deaths per 100,000 live births, and two doctors for every 100,000 people.⁶

Mistrust in the poorly functioning health system is increasing the spread of Ebola.^{7,8} Over forty years of underinvestment in health and high user fees – charges levied on individuals in order to access health services – have forced people to resort to alternative methods to manage illness. Responding to Ebola is not just about controlling infections. An effective response, and prevention of future crises, requires a strong and efficient health system, accessible to and trusted by the people.

The current Ebola crisis has thrust Sierra Leone firmly back into the humanitarian spotlight. There are fears this will fade once the epidemic is under control, only to return with the next crisis. Yet there is an alternative to this pattern. Sierra Leone's emergence from this crisis will provide a critical opportunity to channel the renewed energy and resources into sustainable solutions for the country. With the necessary national and international political will, a strong health system can emerge from this tragedy; a system that will provide a barrier to health crises and protect the health of its people.

For many UHC is literally a life or death issue

**World Health Organization,
Arguing for Universal Health Coverage**

Globally, Universal Health Coverage – providing people with access to quality health services they need without incurring financial hardship – is gaining unprecedented momentum. Ultimately, Universal Health Coverage (UHC) is about the right to health. The Government of Sierra Leone is committed to achieving UHC in line with its commitments made at the 2005 World Health Assembly, and the UN Secretary General's Global Strategy for Women and Children's Health.⁹

i. WHO reported deaths up to 24 May 2015

ii. All figures are in US dollars.

iii. Since our research was undertaken mining activities have seen major setbacks, due mostly to a drop in iron ore prices. Two companies – African Minerals and London Mining – have gone into administration and it is currently unclear whether the new owners of the iron ore mines will receive the same tax concessions, hence our figures are illustrative only.



Five-month-old Mohamed Kamara is about to get his second dose of pneumococcal conjugate vaccine.

In 2010 the Government took an important step towards UHC by introducing the Free Healthcare Initiative: this provides free healthcare to pregnant and lactating women and children under five. Whilst this initiative has contributed to a number of positive indicators for maternal and child health outcomes, it is heavily reliant on donor funding.

Health coverage under the Free Healthcare Initiative does not extend to the remainder of the population who face high and often prohibitive user fees. This means that essential health care is out of reach of many Sierra Leoneans who die from preventable and treatable illnesses.

Strong health systems require sustainable investment. While there are a number of ways to increase finance for health systems, tax financing has played a dominant role in all UHC success stories,¹⁰ and is key to ensuring equitable access. In recent years Sierra Leone's National Revenue Authority has made good progress in increasing collection of tax revenues, but the country is still giving a lot away in tax incentives, especially to mining companies.

It is estimated that low income countries need to spend a minimum of \$86 per person, per year to fund universal primary health care services.¹¹ In Sierra Leone, this would mean the Government spending around \$524 million a year on health.

Whilst Sierra Leone is clearly a long way from this figure, there are a number of shorter term steps it can take in this direction. Sierra Leone will need donor support for the foreseeable future, but there is also an urgent need for a vast increase in the mobilisation of domestic resources, to achieve the ultimate long-term goal of sustainably funded Universal Health Coverage. This report looks at the scope for increasing revenues from the extractive industries to contribute to filling this and other health financing gaps.

It draws on research carried out in Freetown between January and April 2014 using a mix of desk-based analysis, reviews of primary and secondary documentation and interviews with stakeholders. It also uses analysis from Sierra Leone's Budget Advocacy Network and National Advocacy Coalition on Extractives.

We conclude that five things are needed: urgent strengthening of the health system; reduction in current tax incentives for the extractives industry; strengthening national capacity for tax collection; increased transparency in mining agreements; prioritisation of healthcare financing from the domestic tax base.

As 2015 welcomes the successor framework to the Millennium Development Goals, it is imperative that the agendas of Universal Health Coverage and tax justice are brought together to secure the right to health for the people of Sierra Leone.

1. The health system in Sierra Leone

Sierra Leone gained independence from Britain in April 1961. During the 1980s the country was subject to the World Bank and International Monetary Fund's (IMF) structural adjustment policies¹² which contributed to reduced funding of health and education and increased inflation and devaluation of the national currency.¹³ These policies are even cited as one factor which may have contributed to the political chaos which culminated in the civil war.¹⁴ Control of natural resources was at the heart of this conflict. Between 1991 and 2002 50,000-75,000 people were killed and more than half the population (2 million) displaced.¹⁵ War devastated Sierra Leone's economy and the health system. By 1996 only 16% of health centres were still functioning.¹⁶ It is estimated that by the end of the war, average income was reduced by 50%. Whilst Sierra Leone is no longer considered a fragile state, the after-effects of the conflict are still evident.¹⁷

Many health workers migrated during the war. Others migrated due to poor working conditions as a result of the weak health system. Of the 203 Medical Officers that were present in the country in 1993, only 67 remained in 2005 and only 152 of the 623 State Registered Nurses.¹⁸ This laid the ground for the current critical health worker shortages.

The introduction of user fees proved debilitating for the country. These are charges for health services at the point of access, and often featured as a condition of structural adjustment loans in the 1980s. As the economic environment and the war increased poverty, vulnerable populations were pulled further into poverty through paying for health care, or stopped using it altogether. Delays in seeking health care resulted in high maternal and child death rates, giving Sierra Leone the unenviable distinction of being the worst place to be born or have a child for over a decade.¹⁹ In 2000 the World Health Organization ranked the health system of Sierra Leone as the least efficient in the world.²⁰

Today the health system in Sierra Leone is a dual system comprising government and donor provision alongside private contributions. For those patients not targeted by the Free Healthcare Initiative for maternal and child health, health services are only available for high user fees.

Despite progress, the health system faces complex challenges. This includes a lack of trust in the sector due to insufficient quality treatment and a lack of preventative measures for major diseases. The top causes of mortality in Sierra Leone are nutritional deficiencies, pneumonia, diarrheal diseases, anaemia, malaria, tuberculosis and HIV/AIDS.²¹ This means that most deaths in Sierra Leone are preventable, yet currently Sierra Leone has an infant mortality rate of 107 per 1000 live births²² and the world's highest maternal mortality ratio at 1165 maternal deaths per 100,000 live births.²³ Sierra Leone provides a key example of the extent of global health inequalities. A child in Sierra Leone is 90 times more likely to die before his/her fifth birthday than a child in Luxembourg.²⁴ A stronger health system would save lives.

Health worker shortages

The shortage of health workers in Sierra Leone provides a major barrier to providing effective healthcare. With one doctor for every 45,625 people,²⁵ it is in the bottom 10 countries for overall health worker density for physicians, nurses and midwives 2000–2010.²⁶ The WHO states that a threshold of 230 doctors, nurses and midwives per 10,000 people is the minimum needed to deliver essential maternal and child health services.²⁷ 58% of doctors, 62% of nurses and 66% of midwives work in the public sector while 15% of doctors, 16% of nurses and 16% of midwives work in Faith Based organisations and the remainder in the for-profit sector.²⁸

Like many countries with health worker shortages, it is not just the overall shortages that impact on care, but their maldistribution and lack of certain specialist cadres. Almost all districts in Sierra Leone have insufficient staff and most of Sierra Leone's health workers are concentrated in the Western Area.²⁹ At the worst end of the spectrum Kailahun District has one midwife for every 17,415 births and one midwife for every 4,627 deliveries in a health facility.³⁰ These shortages are despite the fact that many women do not deliver in health centres.

Sierra Leone's subsidy to UK health services

Despite having only 136 doctors in 2010, a further 27 doctors that trained in Sierra Leone are currently in the UK.ⁱ

The data does not record the level at which they are working. It costs the NHS £269,527 to train a junior Doctor (Foundation 1).ⁱⁱ If we assume all 27 are junior doctors this would represent a subsidy of £7.3 million to UK health services. If those doctors are working as GPs that figure would be £13.5 million and as consultants it would almost double to £15.2 million.ⁱⁱⁱ

Sierra Leone had 1,017 nurses in 2010. The UK Nursery and Midwifery Council register lists 103 nurses that were trained in Sierra Leone.^{iv}

It costs £70,000 to train a nurse in the UK.^v This would be a contribution of £7.2 million to UK health services. Altogether this suggests the subsidy Sierra Leone is currently providing to UK health services could be as high as £22.4 million.

- i. GMC, personal correspondence
- ii. British Medical Association, Press briefing, How much does it cost to train a doctor in the United Kingdom?, January 2013
- iii. Ibid.
- iv. International Development Committee, 02 October 2014, 6th Report – Recovery and Development in Sierra Leone <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmintdev/247/24706.htm>
- v. Health Education England, 28 May 2013 New education and training measures to improve patient care, accessed 08/12/14 <http://hee.nhs.uk/2013/05/28/new-education-and-training-measures-to-improve-patient-care/>

Sierra Leone's health worker shortages have been exacerbated by migration. It is one of five African countries with an expatriation rate of over 50%, meaning that more than half the doctors born in Sierra Leone are now working in OECD countries.³¹ This means that Sierra Leone is effectively providing a subsidy to the world's wealthiest countries.

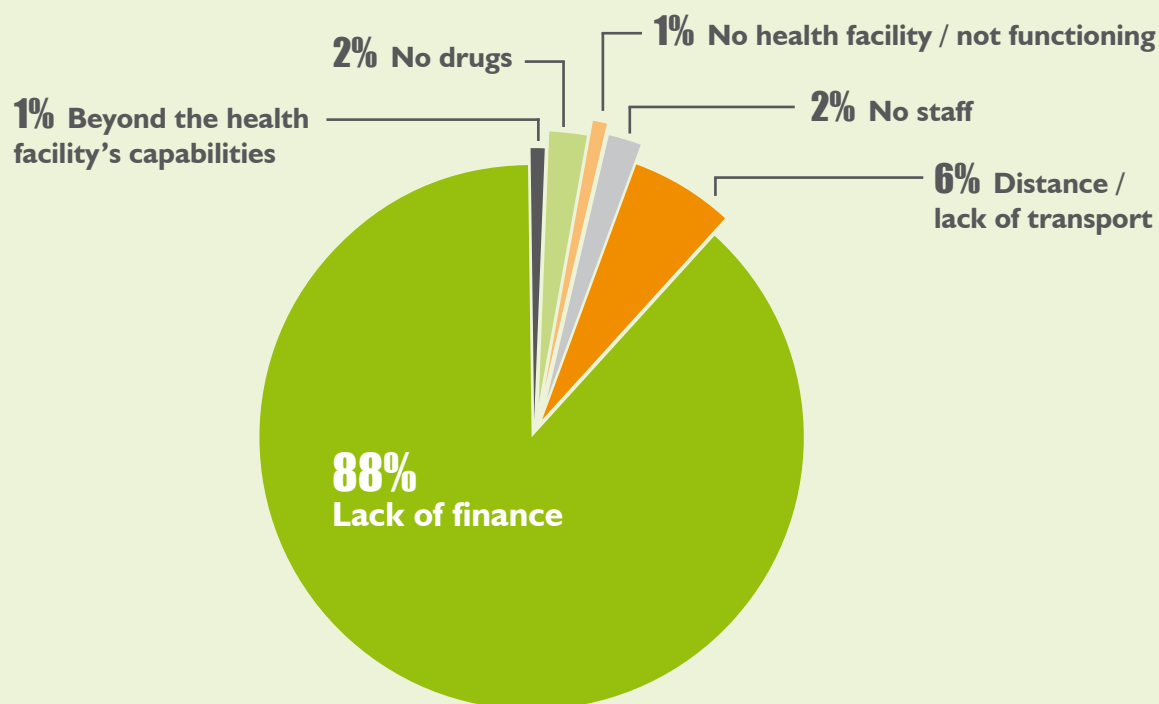
User fees

Many of Sierra Leone's population are forced to pay user fees to access care. User fees are now widely acknowledged as both an inequitable and inefficient means of funding health services,³² with estimates that 40–60% of funds raised are lost through administration costs.³³ For the poorest people, user fees mean that essential healthcare is a 'luxury' they simply cannot afford. Others face

'catastrophic healthcare costs' with 100 million dragged into poverty to pay for healthcare each year, the equivalent of three people every second.³⁴

In Sierra Leone, 88% of respondents to the 2008 National Service Delivery Perception Survey identified lack of finance as a barrier to accessing health care.³⁵

In 2008 the NGO, Médecins Sans Frontières found that 66% of people using the health service in Sierra Leone had been forced into debt as a result of healthcare costs.³⁶ A five year study³⁷ conducted by Save the Children showed that on average 30% of the population, the poorest, do not seek care, while the middle 30% are plunged into poverty as a result of selling finite assets like animals, harvests or land to pay for health care. User fees lock people into a cycle of poverty and poor health from which they may never recover.

Figure 1: Reasons for not accessing assistance from health facility

Source: National Service Delivery Perception Survey, 2008

Free Healthcare Initiative

In September 2009, Sierra Leone was one of six African countries to take steps to address the damage inflicted by user fees: with support from the international community it committed to abolish user fees for pregnant women, lactating mothers, and children under five. The Free Health Care Initiative (FHI) was enacted in April 2010 removing cost-related barriers to healthcare access for around 460,000 pregnant and lactating women and one million children under five, whilst also seeking to improve the delivery of Sierra Leone's health care.³⁸

Inevitably, abolishing user fees increases the numbers accessing health services, increasing pressure on existing staff and provision. The government and its donors recognised the importance of addressing supply side issues to meet demand and introduced a range of initiatives. These include strengthening human resources for health in the FHI, creating

At the start of free health care we thought it was a lie that it was free, but now that I have been, I know it's true. Thank God.

Mother, Stella Limba Chiefdom

substantial salary increases for health workers in technical positions, a mobile recruitment programme to bring in new health workers and removing 'ghost' workers from the payroll. A range of other schemes have been implemented since, aimed at improving attendance, performance, and coverage in rural areas. Despite these initiatives, momentum on human resources for health is reported to have diminished since 2010.³⁹



© Robert Yates / DFID

Sierra Leone's Free Health care Initiative: A mother and child wait at 8am along with 200 others for a children's hospital to open.

There has so far been no independent evaluation of the FHI,^{iv} however a report⁴⁰ from DFID highlights some promising results from the Health Management Information System including:

- 2.9 million under 5 consultations, a tripling compared to the previous year;
- 1.3 million of these young children received life saving treatment for malaria;
- 126,477 women delivered their babies in a health facility, 39,100 more women than the year before;
- 20,135 maternity complications were managed in health facilities with a 60% drop in the fatality rate in these cases;
- 140% increase in the number of new users of modern family planning.

Despite its successes, the FHI has also exposed weaknesses in the system.⁴¹ These include continued charging of some eligible patients and poor drug supply and distribution. The Free Healthcare Initiative does not include faith based hospitals in

Sierra Leone, so pregnant and lactating women and children under the age of five still pay for services at these institutions. For example, the faith based Kamakwie Wesleyan Hospital is the only hospital that can be accessed by communities in Northern Bombali where HPA works, and the free government hospital in Makeni is too far for people to reach in emergencies, for example in the case of obstetric emergency. As Kamakwie Wesleyan Hospital is the only tertiary hospital in Northern Bombali, mothers and children here do not have access to free tertiary level healthcare. It also does not extend to the remainder of the population who face high user fees.

Free Health Care helps to save lives, whereas before even a minor illness would lead to death.

Mother, Sanda Loko Chiefdom

iv. One is currently being conducted by DFID

The current Ebola crisis

The first confirmed case of Ebola in Sierra Leone was on 24 May 2014. As of 24 May 2015, Sierra Leone had been hit by 12706 cases of Ebola of which 3908 people had died.⁴² There is currently no cure for Ebola, but early basic interventions can significantly improve the chances of survival.⁴³ Despite this, Ebola was not contained but spread exponentially, before transmissions finally slowed in recent months.

Nothing can be done in an epidemic like Ebola if there is no trust.

Peter Piot, scientist who co-discovered the Ebola virus.

A major problem in countering Ebola has been lack of trust in the authorities and in Sierra Leone's health system.⁴⁴ This means that people may distrust official information and are reluctant to present themselves at health centres. One survey found that a third of respondents believed that Ebola was airborne.⁴⁵ With a 70% death rate from Ebola, health facilities are perceived as places where one catches the disease rather than recovers.⁴⁶

The crisis has had devastating ripple effects across an already weak health system. As of 17 February 2015, 221 health workers had died⁴⁷ of Ebola since the beginning of the crisis and others had gone on strike due to a backlog in pay and conditions.

The beleaguered health system is largely unable to treat non-Ebola related conditions and immunisations and many other public health activities were put on hold. Between May and July 2014 the proportion of children receiving oral rehydration solution and zinc treatment for diarrhoea within the first 24 hours of contracting the illness fell by 33%.⁴⁸ In the same period the proportion of women attending health services to deliver their babies fell by 16%,⁴⁹ prompting NGOs to warn that across the three countries hit by the epidemic an additional one in seven women could die in pregnancy or childbirth.⁵⁰

This health crisis has also had wider economic impacts across the whole country due to the restriction of commercial activity as a result of containment measures combined with the fear of contagion.⁵¹ The World Bank states that in the recent history of infectious disease outbreaks, behavioural affects are responsible for 80-90% of the economic impact.⁵² The most serious current economic impacts on Sierra Leone from Ebola are that government revenues are falling and economic growth is slowing. The government said in the budget speech in November 2014 that domestic revenue collection was expected to fall by Le390 billion (\$90 million) in 2014.⁵³ Sierra Leone was on a trajectory to achieve real GDP growth of 15.2 and 20.2% in 2012 and 2013. For 2015, GDP growth rates have been revised down to -13% and -2% excluding iron ore.⁵⁴



Ebola prevention poster.



Community members attend a briefing by a social mobilization team in Lester Road, Freetown.

Economic benefits of investing in health

Investing in health systems is essential to securing the right to health. It also makes economic sense. The Lancet Commission on Investing in Health argues that the economic benefits of investing in health are realised through increased educational attainment, worker productivity and access to foreign investment through the control of disease.

Rather than just measurement by GDP, the Commission proposed a “full income” measurement of the benefits of health which combines growth in national income (GDP) with the value people place on increased life expectancy to also calculate the intrinsic value of better health. Using this approach the Commission found the benefits exceed costs by a factor of 9-20.⁵⁵ This measure, in the context of the Ebola crisis, highlights just how huge is the need for sustainable – and thus we would argue, tax-based – investment in Sierra Leone’s health system.

The enormous economic cost of the current outbreak to the affected countries and the world could likely have been avoided by prudent ongoing investment in such health system strengthening.

World Bank, September 2014⁵⁶

2. Health for all?

Universal Health Coverage

Universal Health Coverage is firmly rooted in the WHO Constitution of 1948 declaring health to be a fundamental human right and in the Health for All agenda set by the Alma-Ata declaration in 1978. As defined by the WHO, Universal Health Coverage requires that: all people obtain the health services they need without suffering financial hardship when paying for them.⁵⁷

UHC is about far more than universal coverage of services. It embodies three related objectives: equity in access to health services, meaning that services needed – including promotion, prevention, treatment, rehabilitation and palliation – are available to all, not just those with the means to pay; quality of health services is sufficient to improve the health of those receiving them; and financial-risk protection – ensuring

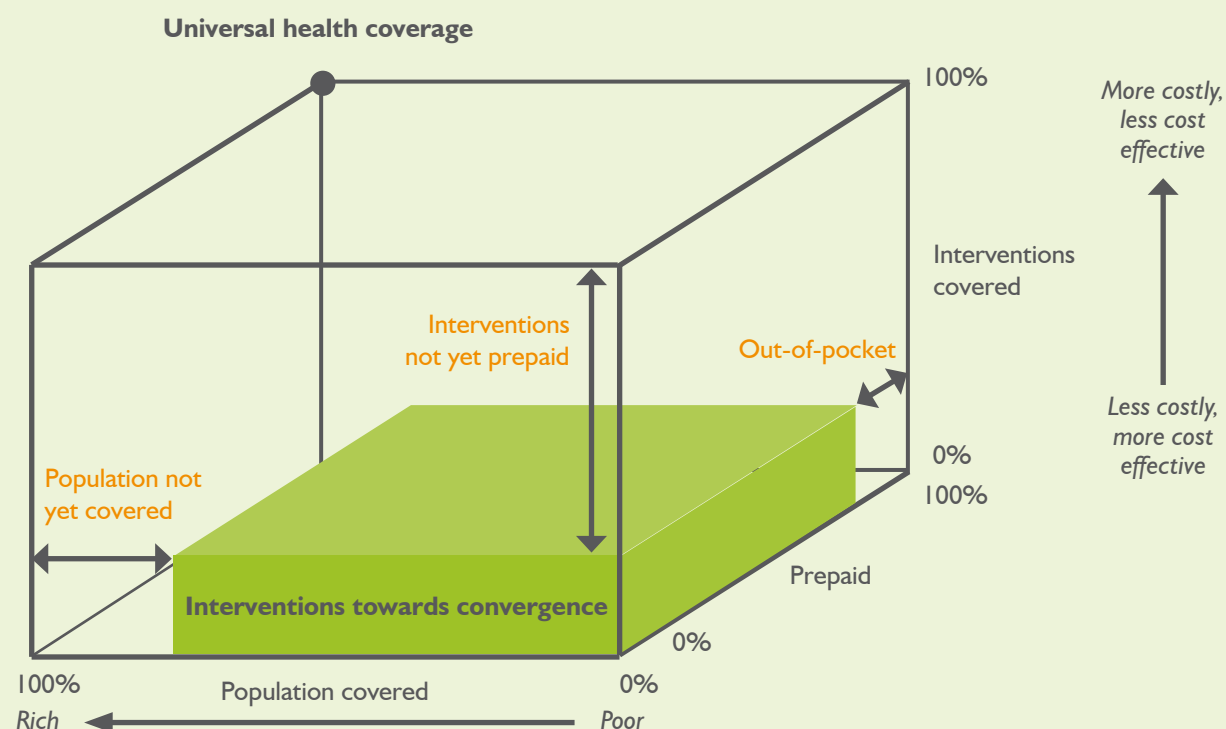
that people do not experience financial hardship in order to access care.⁵⁸

This is captured in the ‘UHC cube’ outlined in the 2010 World Health Report (reproduced below) with progress towards UHC progressively filling the cube.

The concept of equity is fundamental to Universal Health Coverage. It recognises that health is a right, not a privilege for those who can afford to pay for it. Reducing inequality is therefore both an outcome of UHC and must be explicitly built into its design.

The WHO outlines a number of key ways to finance UHC: reduce out of pocket payments; maximize mandatory pre-payment for health; reduce the number of risk pools (evenly spreading the risks across a range of contributors); and provide protection from additional costs (transport/accommodation etc) for those who cannot afford to pay.⁵⁹

Figure 2: Pathways towards Universal Health Coverage



Source: The World Health Report: *Health systems financing: the path to universal coverage*. Geneva: World Health Organization; 2010

It is increasingly recognised that the most effective and equitable way to finance pre-payment is through compulsory public financing, predominantly general taxation.^v This has been demonstrated by a number of countries including Sri Lanka, Malaysia, and Brazil, which fund healthcare from tax revenues. Other countries such as Thailand, Mexico and Kyrgyzstan have pooled taxation with insurance contributions from those in salaried employment for coverage for the whole population.⁶⁰

Financing healthcare in Sierra Leone

Financing universal healthcare requires high and consistent resource flows. In 2012 Total Health Expenditure in Sierra Leone amounted to \$96 per person.⁶¹ Whilst this is more than wealthier countries such as Ghana, it is important to note that Total Health Expenditure includes government, donor and private expenditure such as user fees. In Ghana over half of health expenditure (56.6%) is met by the government, whereas in Sierra Leone the Government's contribution is very low, just \$16 in 2012, 16.6% of overall health expenditure.⁶²

This is supplemented by donor resources. Private insurance plays a minimal role in Sierra Leone, whereas traditional healers and alternative medicine play a strong role, partly as a result of the high costs of healthcare.

Spending on healthcare is split into two parts. The Government pays a basic salary to all health workers, a large number of nurses and small number of doctors. The payroll contains more than

10,000 employees, who receive on average around \$200 a month, amounting to approximately \$20 million for 2012.⁶³ Under half of this is paid by the Government, with major donors such as DFID and the Global Fund paying the rest.⁶⁴

The Government also provides funds for some of the costs of service delivery and administrative and support services such as fuel, electricity, water and travel. Some of the remaining costs are met by user fees. Similarly, drugs are sold on a cost recovery basis. Services provided and costs generated as part of the Free Healthcare Initiative detailed below, are not funded by user fees.^{vi} This includes the provision of free drugs for most common conditions, medical equipment, salary top up for health workers based on additional work done, as well as technical and logistical support.^{vii}

Health spending as a total of the government budget

In 2001 African governments pledged to increase spending on health to 15% of their national budgets, known as the Abuja target.⁶⁵ Sierra Leone's Agenda for Prosperity (AfP)⁶⁶ and the National Health Sector Strategic Plan⁶⁷ both acknowledge that healthcare is a priority both for growth and poverty reduction. Despite this, whilst government spending on health has fluctuated, it only allocated 6.8% of the national budget to health in 2012 and 7.5% in 2013.⁶⁸ The government health budget in 2015 is \$61.3 million, 9.7% of the overall government budget.^{vii} Meeting the Abuja target therefore requires a further (\$33.6 million).^{ix}

v. See for example Oxfam, 09 October 2013, Universal Health Coverage, Why Health Insurance Schemes are Leaving the poor Behind, http://www.oxfam.org/sites/www.oxfam.org/files/bp176-universal-health-coverage-091013-en_.pdf or Yates, R, 24 February 2014, Public Financing – The Key to Universal Health Coverage <http://www.medact.org/medact-blog/robert-yates-public-financing-key-universal-health-coverage/>

vi. Although in theory there should be no user fees for these groups, there have been reports of malpractices, where users have been asked to pay fees. About 5% of FHI patients have been paying for services that were meant to be free, according to a report from 2012. Monitoring Report: Community Monitoring of the Free Health Care Services 2012, Health for all Coalition Sierra Leone, published 2013. <http://healthforallcoalition.org/wp-content/media/Monitoring-of-the-FHCI-Second-Edition-Report-FINAL-REPORT.doc>

vii. The FHI benefits package is based on the Basic Emergency Obstetric and Newborn Care (BEMONC) package.

viii. 2015 budget is 263 billion using the exchange rate at January 2015 <http://mofed.gov.sl/PUBLICATIONS/Budget%20Profile%20GPD.pdf> Annex 6a

ix. 15% would be Le 405 billion. Therefore the spending gap is Le 142 billion (\$33.6 million)



Universal access to essential services

The ultimate long-term target must be for the Government of Sierra Leone to fund Universal Health Coverage. Yet currently the FHI depends heavily on unsustainable donor resources, and the amount the Government spends on health is insufficient for an essential package of services. In reality individuals still have to pay the major burden of health care costs as discussed in the section on user fees above. It is estimated that it costs \$86 per capita, to fund universal coverage for health essential services. In 2012 the Government of Sierra Leone spent just \$16.^x

Mobilising domestic revenue

Sierra Leone has struggled to mobilise domestic revenue,⁶⁹ but the picture above demonstrates that the country must do so if it is to achieve the long-term goal of Universal Health Coverage.

Removal of user fees must be complimented by a scaling up of pre-payment mechanisms to fund health care. In countries regarded as having achieved universal coverage, mandatory pre-payment provides well over 60% (and often over 70%) of all health service funding.⁷⁰

In the next section we look at the extractives industry and consider the potential additional contribution it could make to fill the health financing gaps.

It should be noted that disbursement of funds is an issue in Sierra Leone. There are discrepancies between health funds budgeted and those actually spent. In some years disbursement of funds to the Ministry of Health has been reported to be more than double that budgeted,^{xi} in other cases the amount disbursed appears much less than the budget. This is something that needs to be addressed in order to achieve sustainable health financing.

x. \$86 is based on 2012 figures. See the Chatham House, March 2014, Fiscal Space for Domestic Funding of Health and Other Services. Per capita health expenditure is from the WHO, Global Health Expenditure Database, <http://apps.who.int/nha/database> (accessed 21 January 2015) With a population of just over six million the government of Sierra Leone needs \$524 million to fund universal access to primary health services.⁷

xi. See Budget Advocacy Network et al, Sierra Leone, Health and Sanitation Budget Tracking 2012, http://www.savethechildren.org.uk/sites/default/files/docs/Sierra_Leone_Health_and_Sanitation_Budget_Tracking_2012.pdf

Health insurance

The evidence is clear: if developing countries want to achieve UHC, they should replace private voluntary financing with compulsory public systems and use mostly tax financing to cover informal sectors.

Rob Yates, Senior health economist, WHO.ⁱ

Insurance schemes are one option introduced by some countries as an attempt to finance UHC. These can take a range of forms from private to community based insurance and can be voluntary or mandatory. The failures of voluntary schemes are widely recognised, and the WHO has been explicit that “no country in the world has managed to come close to UHC by using voluntary insurance as its primary financing mechanism.”ⁱⁱ

However, mandatory schemes can also have shortcomings. For example they may not cover the informal sector but even when they do, if the premiums are unaffordable they become, in effect voluntary. Even schemes expressly targeting the poor such as community based health insurance can suffer from low enrolment rates, small risk pools, regressive flat-rate premiums and generate low levels of revenue. Ten years after the introduction of social health insurance schemes in Tanzania, population coverage reached only 17% of people. Ghana’s mandatory insurance scheme subsidises premiums for informal sector workers and includes a levy on VAT, yet after 10 years only 36% of the population remain covered.ⁱⁱⁱ

Any scheme that does not cover the whole population will only exacerbate inequality. There is also a risk that an insurance scheme may drain funds away from the health service. The government of Tanzania spent \$33m on employer contributions in 2009/10; equivalent to \$83 per employee – six times more than it spent per person, per year on health for the general population.

Realising UHC requires cross subsidies based both on risk (from healthy to less healthy) and ability to pay (rich to poor). This requires large risk pools to maximise opportunities for cross subsidisation and provide equitable access to health care.^v

- i. Yates, R, Only public funding can guarantee universal health coverage, Wednesday 9 October 2013, The Guardian <http://www.theguardian.com/global-development/poverty-matters/2013/oct/09/public-funding-universal-health-coverage>
- ii. WHO, 2013, Arguing for Universal Health Coverage
- iii. Oxfam, 09 October 2013, Universal Health Coverage, Why Health Insurance Schemes are Leaving the poor Behind, http://www.oxfam.org/sites/www.oxfam.org/files/bp176-universal-health-coverage-091013-en_.pdf
- iv. Ibid.
- v. Regional Network for Equity in Health in East and Southern Africa (EQUINET) 2012, Discussion Paper 95, <http://equinetafrica.org/bibl/docs/Diss%20paper%2095%20UHC%20Dec2012.pdf>



Oteka mine in Kono

3. Revenues from extractives

Overview of the extractive industries

Until recently, Sierra Leone had witnessed a surge of activity in the extractive industries. Most famous historically for its diamonds, the country's largest export has become iron ore, with large-scale mining operations in diamonds, rutile and bauxite and continued small-scale and artisanal mining of gold and diamonds. Further mining leases have recently been granted to two large-scale gold producers and an iron-ore producer. Current exploration activity also indicates the potential for commercially viable supplies of petroleum offshore. This increased activity led to predictions of significantly increased revenues with the potential to help Sierra Leone achieve middle-income status by 2035.⁷¹

In recent months, however, mining activities have seen major setbacks, with two companies – African Minerals and London Mining – going

into administration in early 2015 – largely due to dramatic falls in the international price of iron ore. British company African Minerals, which bought London Mining when it fell into administration, was itself subsequently bought in April 2015 by Chinese firm Shandong Iron & Steel. The section below examines mining tax revenue prospects between 2014 and 2020, focusing on the revenues from the five large-scale companies operating in 2014 (African Minerals, Sierra Rutile, London Mining, Oteka Mining Limited and Sierra Minerals Holding Limited). It is currently unclear whether the new owners of the iron ore mines in Sierra Leone will receive the same or different tax concessions, hence our figures below are illustrative only.

Actual revenues since 2010

Revenues from the extractive industries have increased significantly in the last few years, making a growing contribution to domestic revenue.^{xii}

xii. Revenue data from 2010 to 2012 supplied by the National Revenue Authority Data on revenues in 2013 obtained from <http://mofed.gov.sl/publications/2013%20Mines%20Revenue%20i.pdf>. \$/SLL conversions use the official GoSL exchange rate for 2010 of 3,978; 2011 of 4,349; 2012 of 4,334; and 2013 of 4,331

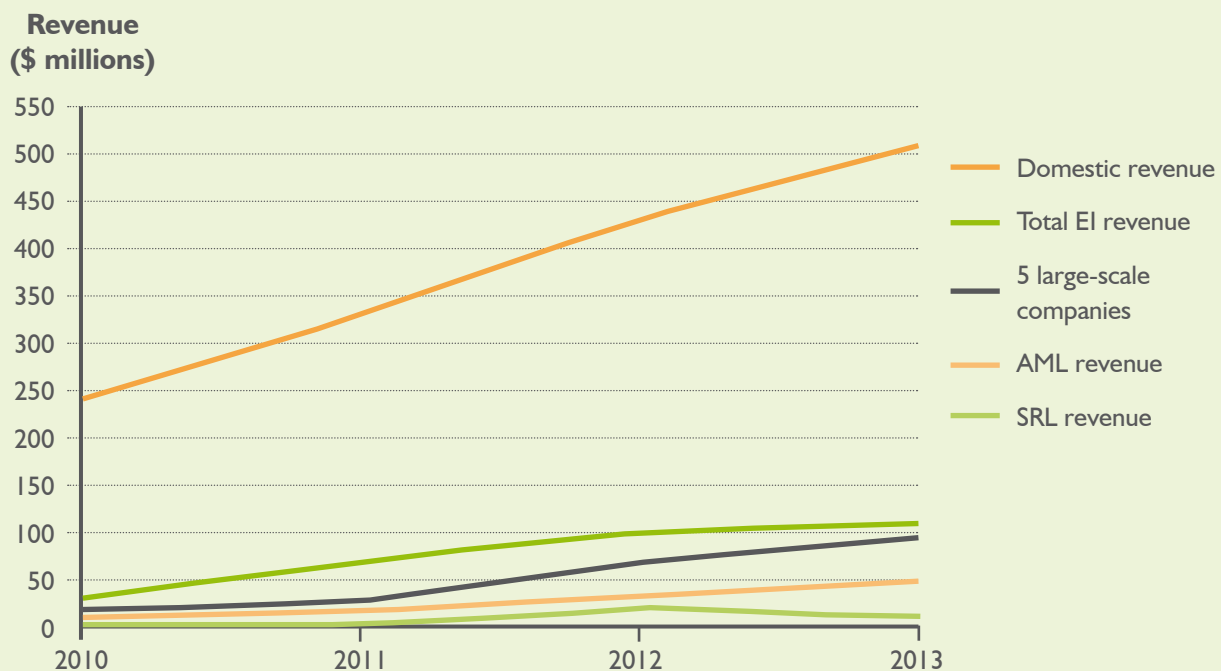
Extractive industry revenues of \$109 million made up 21% of the domestic revenue collected by the National Revenue Authority (NRA) in 2013, compared to 11.8% in 2010, even with substantial growth in non-extractive industry revenue over this period. Some of this has come from petroleum exploration companies (as a result of their one-off payments of signature bonuses), but the five large-scale companies involved in mining operations in 2014 were by far the greatest contributors: they generated \$93 million of revenue in 2013. African Minerals Limited, on its own, contributed 9.4% of the revenue collected by the NRA in 2013.^{xiii}

Tax exemptions

The mining sector in Sierra Leone is regulated by the Mines and Minerals Act 2009 (MMA), which provides the legal basis for the fiscal regime along with the Income Tax Acts, the Finance Acts up to 2013 and the Goods and Services Tax Act 2009.

However, mining companies have signed individual mining agreements with the Government which give them more favorable fiscal terms than in existing legislation. Mining agreements have been signed with companies including African Minerals, Sierra Rutile, London Mining, Octea Mining and Sierra Mineral Holdings.^{xiv}

Figure 3: Total domestic, extractive industry (EI), & selected company revenues



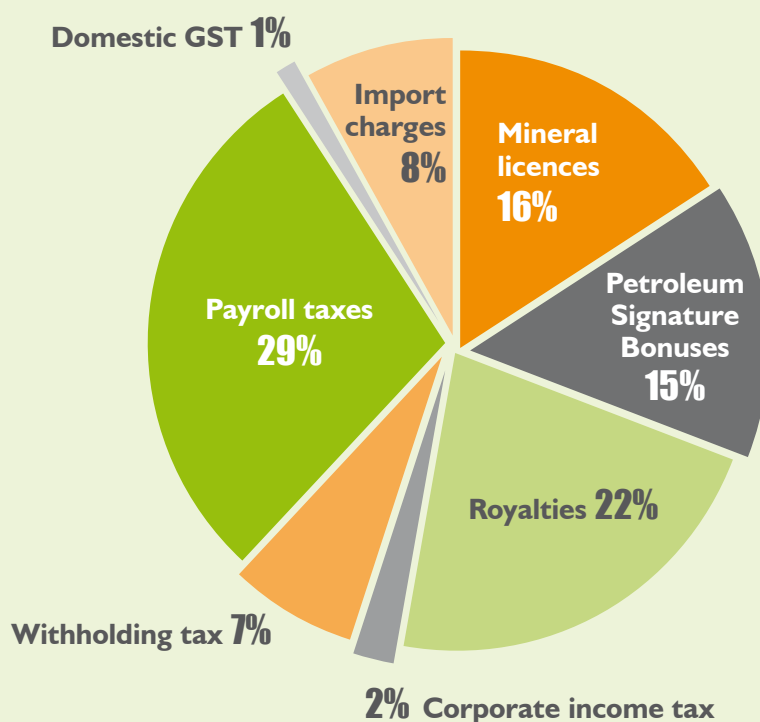
Source: Data on revenues in 2010-12 provided by National Revenue Authority on 15 February 2014.

Data on revenues in 2013 obtained from <http://mofed.gov.sl/publications/2013%20Mines%20Revenue%20i.pdf>.

\$/SLL conversions use the official GoSL exchange rate for 2010 of 3,978; 2011 of 4,349; 2012 of 4,334; and 2013 of 4,331.

xiii. Data on revenues in 2010-12 provided by National Revenue Authority on 15 February 2014. Data on revenues in 2013 obtained from <http://mofed.gov.sl/publications/2013%20Mines%20Revenue%20i.pdf>

xiv. The texts of some of these agreements can be found here – <http://slminerals.org/contracts/>

Figure 4: Breakdown of extractives revenues in 2010-13 by revenue stream

Source: Data on revenues in 2010-12 provided by National Revenue Authority on 15 February 2014.

Data on revenues in 2013 obtained from <http://mofed.gov.sl/publications/2013%20Mines%20Revenue%20i.pdf>.

These mining agreements provide tax incentives in addition to those already granted by law. The Government provides incentives to attract investors to Sierra Leone⁷² and to ensure earlier profitability with the expectation that both will lead to higher revenues. However, the benefit of negotiable fiscal terms has been questioned even by the IMF⁷³ and the tax incentives provided by the Government have been widely criticised by civil society.⁷⁴

The fiscal regimes of African Minerals and Sierra Rutile^{xv}

African Minerals' previous mining agreement with the Government, signed in 2010, gave the company a corporate income tax rate of 25%; zero or low rates of withholding tax; and exemption from all duties and taxes on a wide range of imports. The agreement signed between Sierra Rutile and the Government in 2004 also provided large concessions, including an extremely low royalty rate of just 0.5% and a turnover tax of only 0.5%.⁷⁵ This agreement was set to expire at the end of 2014, at which point the fiscal regime should revert back to an original agreement signed in 2002.

xv. Only revenue streams that are paid to central government are included here as revenue streams paid to local government and other entities, e.g. surface rent, do not have a direct influence on healthcare expenditure by government.

Table 1: Selection of fiscal terms included in the mining agreements of AML and SRL

	General Legislation	AML 2010	SRL 2002	SRL 2004 Amendment
Lease Rent Paid to give a company the exclusive right to carry out mining activities in the approved area	\$500,000	As in law	\$400 in 1989 and adjusted annually by 5%	\$400 in 1989 and adjusted annually by 5%
Royalty Paid on the sale/export of a mineral	Precious stones: 6.5% Precious metals: 5% Other minerals: 3%	As in law	3.5/4%	0.5%
Corporate Income Tax Paid on the profit made in a fiscal year (after losses from previous years have been recouped)	30%	25%	37.5% or as in law if lower	Exempt
Turnover Tax Paid on the revenue made in a fiscal year	-	-	3.50%	0.5%
Contractor Withholding Tax (CWT) Paid on the value of payments made to contractors	Residents: 5%; Non-residents: 10%	Exempt	Exempt	Exempt
Dividend Withholding Tax (DWT) Paid on the value of dividends given to shareholders	10%	5%	As in law	Exempt
Interest Withholding Tax (IWT) Paid on the value of interest paid on debt	15%	Exempt	10%	Exempt
Management Fees Withholding Tax (MWT) Paid on the value of fees paid for affiliates' services	Residents: 5%; Non-residents: 10%	5%	10%	10%
Duties & Taxes on Capital Imports and Consumables Paid on the value of imports	Variable rates but minimum of 5%	Exempt	Maximum of 5%	Exempt

Source: IMF Fiscal Affairs Department⁷⁶

Research by Sierra Leone's Budget Advocacy Network in April 2014 estimated that Sierra Leone would lose \$131 million in the three years 2014-16 from corporate income tax incentives granted to five mining companies. Overall revenue losses from tax incentives were much higher – when exemptions on customs duty and the Goods and Services Tax (GST) are taken into account, Sierra Leone was estimated to lose an average of \$199 million a year during 2010-2012.⁷⁷ Assessing the amount of revenue foregone from other tax incentives, such as the concessional rates of withholding tax, is difficult given the information available.^{xvi} Research conducted for this report estimates the extra revenues that could be recouped by reducing other tax incentives. This research finds that the Government could raise the following from amendments to three different tax streams:

- Increasing African Mineral's rate of corporate income tax from 25% to 30% could raise \$30 million extra a year by 2020;
- Eradicating mining companies' exemptions to pay import charges (i.e. customs duties and the GST on imports) could raise nearly \$50 million more per year by 2016;
- Introducing a Resource Rent Tax, as proposed by the government in its Extractives Industries Revenue Bill, could increase revenues by \$45 million a year by 2020.

Combining these three sources could raise revenue of \$94 million in the next few years.^{xvii} These estimates, it should be noted, were made before the current Ebola crisis and whilst they do account for a drop in iron ore prices, based on last year's estimates by analysts,^{xviii} they do not account for the price plummets that have since occurred.

Linking extractives to healthcare

Clearly working towards Universal Health Coverage is not a short term goal. Achieving the figure of \$86 per capita^{xix} of public spending to fund universal primary health care services will be a significant challenge. The Government of Sierra Leone's spending on health amounted to only \$16 per capita in 2012.⁷⁸ That would mean to reach this target the Government would need to spend \$524 million. Therefore even if the Government was to channel the estimated extra \$94 million from amendments to the three taxes, or the \$199 million estimated by the Budget Advocacy Network, large gaps would remain.

It is important to bear in mind that Sierra Leone will need substantial donor support for some years ahead. Some \$1.1 billion has been pledged by donors just to tackle the impact of Ebola in Sierra Leone.⁷⁹ In addition, achieving Universal Health Coverage is also not just dependent on more funds, but on how these funds are spent. Several countries have achieved or made significant progress towards Universal Health Coverage with much lower levels of spending, for example Sri Lanka, whose tax-funded health system has been achieved with government spending of just \$39 per capita in 2011.⁸⁰

Whilst remaining conscious of the long term goal of UHC, there are a number of short to medium term targets that Sierra Leone should work towards. If we take the estimates both from research for this report, and recent research published by the Budget Advocacy Network and National Advocacy Coalition on Extractives, extra tax revenues from the extractives industry could raise somewhere between \$94 million to \$199 million.

xvi. The company financial statements that are publically available are presented on a consolidated basis, and therefore do not report, for example, interest payments made by the Sierra Leone subsidiary.

xvii. The combined revenue is not just a simple total of the three figures above as the different taxes would interact with each other; for example import charges impact on profitability, reducing revenue from corporate income tax which in turn impacts on the resource rent tax. Research conducted for this report gives an overall estimate based on calculations of these interactions.

xviii. See for example the IMF's World Economic Outlook Price Projections. <http://www.imf.org/external/np/res/commmod/CommodityPriceForecasts.xls>

xix. In 2012 terms.

How could this additional funding be channelled into health spending?

Financing the Free Healthcare Initiative:

With an annual additional financing need of at least \$22 million,⁸¹ even if donors were to withdraw some of their financial support after 2015, an additional revenue stream of between \$94 and \$199 million would cover the future costs of the FHI.

Financing the Abuja Target: Meeting the Abuja Target requires an estimated additional \$33.6 million in government revenues. Again, the estimated \$94 to \$199 million in tax revenues could more than cover this need.

Sierra Leone should therefore work towards increased domestic financing of the FHI and more broadly meeting the Abuja Target over the next five years, whilst looking ahead to the long term goal of financing Universal Health Coverage, so that every citizen in the country can begin to realise their right to health.

Other factors in raising revenues

Other changes are also needed to ensure that extra revenues from mining can be effectively absorbed by the health service.

Regular funding from the Ministry of Finance:

In order for the government to take full ownership of FHI with the Ministry of Health in a lead role, finance flows from the Ministry of Finance and Economic Development (MoFED) have to be reliable and regular, which has not always been the case.

Increased transparency: Transparency is a vital tool for government to negotiate better deals and monitor company activity and for civil society to hold governments to account.⁸² Yet lack of sufficient transparency continues to be an issue in Sierra Leone. Sierra Leone was accepted to the Extractive Industries Transparency Initiative (EITI) in 2008 and subsequently took a number of steps to become

compliant. These include the introduction of an Online Repository System, an online mining database publishing data on the extractives industry in 2012, the freedom of information law enacted on October 29 2013, and the establishment of the National Minerals Agency in 2013. Despite these actions, Sierra Leone was suspended from the EITI in 2013 following its first report (2008 – 2010), due to a failure to adequately document mining revenue and company payments. Following remedial measures it was readmitted in 2014, but civil society concerns about transparency remain. Sierra Leone's score is 39 out of 100 in the 2012 Open Budget index indicating that the Government provides the public with minimal information on the national government's budget and financial activities.⁸³

Capacity for tax collection: The Auditor-General's reports for 2011 and 2012⁸⁴ indicate that low capacity within the National Revenue Authority (NRA) is constraining its ability to independently audit company accounts and assess the information that it is provided. Work is ongoing to change this. For example, the NRA has been working with Crowne Agents to increase its capacity and a specialised unit is being set up within the NRA to build up a body of expertise on taxation of the extractive industries.⁸⁵ However, to date, none of the largest mining companies have been fully audited.⁸⁶

Global tax architecture: Whilst this report is concerned with generating taxation revenue from the extractives industry, achieving tax justice for all countries also requires changes in the global tax architecture. Vast sums of money are being lost in illicit financial flows (IFFs). In the last ten years Sierra Leone lost an average of \$71 million a year from illicit financial flows (IFFs).⁸⁷ IFFs are unrecorded financial outflows which consist of both 'illegal' capital flight due to corruption, theft and criminality; as well as 'legal' capital flight⁸⁸ driven by tax avoidance – clever accounting that whilst technically legal is morally questionable – and commercial transactions that exploit international trade and fiscal loopholes. Illicit financial flows are a global problem, and one that is underpinned by the network of tax havens.

Reasons for optimism

Despite these reservations there are a number of initiatives that may help to increase transparency and ensure the collection of increased taxation revenues in Sierra Leone.

Extractive Industries Revenue Bill (EIRB)

With support from donors, notably the IMF, the Government of Sierra Leone has drafted an Extractive Industries Revenue Bill (EIRB) and has sent this to Parliament. This consolidates the mining and petroleum fiscal regimes in one piece of legislation. The EIRB proposes a resource rent tax, something the current mining revenue regime lacks, and which is intended to “enable Government to derive additional tax revenues from these (mining) activities in the event that profits are above projections.”⁸⁹ However, existing mining agreements will not be covered by this proposal – a major gap. Nevertheless, at least three new mining agreements are currently being discussed;^{xx} the extent to which they conform to the EIRB will provide an indication of how serious the government is about making the EIRB’s fiscal terms non-negotiable.

Strengthening the tax base

In December 2014 the African Development Bank began a new project working across the National Revenue Authority, the National Minerals Agency, the Ministry of Mines and Mineral Resources, and the Ministry of Finance and Economic Development seeking to strengthen resource governance and revenue collection. The project includes the establishment of an Extractive Industries Revenue Unit within the National Revenue Authority to enhance the latter’s capacity to collect adequate revenue from the extractive industries. It will also establish a Natural Resource Charter (NRC) Benchmarking Framework for Sierra Leone that will promote good governance and accountability in the natural resources sector and conduct a study on the Harmonisation of Mineral Taxation Regimes across Liberia, Guinea, Cote d’Ivoire and Sierra Leone with the aim of harmonising their mineral

taxation and licences regimes to reduce the ‘race to the bottom’ in taxation rates and smuggling across borders.⁹⁰ This is a welcome step.

The Transformational Development Fund and health financing

Due to the projections of large revenue inflows, the Government (aided by the IMF) is planning to develop⁹¹ a fund – the Transformational Development Fund (TDF) – into which all extractive industry revenues will flow and a fiscal rule which will determine how much of the TDF can be spent in a given year and what it can be spent on. Funds of this nature are considered best practice for extractive industry revenues but may restrict financing FHI and healthcare in general for two reasons.

Firstly, the TDF currently identifies five spending areas of which healthcare is one. However, the current understanding is that the TDF will only finance capital projects, leaving FHI and other healthcare with limited funds as they mainly comprise recurrent expenditure.

Secondly, the TDF fiscal rule sets a limit on how much can be spent in a given year. This is determined by the level of *overall* domestic revenue in the previous year. If non-extractives industry domestic revenue is still low, even high revenues from the extractive revenues would not result in significantly increased spending on healthcare.

It will be important for health advocates to monitor developments with the proposed TDF carefully, and seek to argue the case for healthcare costs to be prioritised within its spending parameters.

Debt repayments

According to the World Bank, Sierra Leone’s external debt amounted to 31% of its Gross National Income in 2013.⁹² In the wake of Ebola the IMF has written off \$29.2 million of debt payments up to December 2016 – although new loans means its debt is increasing.⁹³

xx. With Baomahun Gold Ltd, Kingho Investment Company Ltd, and Nimini Mining Ltd.

4. Recommendations

The Government of Sierra Leone should do the following to achieve its commitment to Universal Health Coverage:

- Review the tax incentives it grants to the extractives industry, bringing them into line with general legislation.
- Make strengthening the health system an urgent political priority. This includes working toward the long term goal of Universal Health Coverage, with health services delivered free at the point of access and increasing funds from government revenues.
- Use increased revenues from the extractives industry to meet the Abuja Target for health spending. This requires increasing government spending on health to at least 15% of its annual budget.

These must be supported by action at the international level, to eliminate illicit financial flows.

Further recommendations are outlined below.

Strengthening the health system

The Government of Sierra Leone should:

- Develop short, medium and long-term plans for scaling up the provision of healthcare using increased tax revenues from the extractive industry, factored in to the new health sector strategy paper to be formulated during 2015. The Ministry of Health will need technical assistance to increase capacity in strategic planning and costing.
- Carry out a human resource analysis to ascertain the impact of Ebola on the health workforce. This should feed into a short, medium and long term strategy for increasing the number of skilled health workers, and improving their quality and distribution.
- Review its mining agreements with individual companies to bring them into line with general legislation.
- Ensure all future mining license agreements are in line with existing legislation and with the Extractive Industries Revenue Bill (EIRB), including the new agreement with Shandong Iron and Steel.
- Ensure the Revenue Management Bill includes necessary transparency measures including an annual, comprehensive public statement of tax expenditure and a cost benefit analysis of all incentives granted.
- Establish a task force including representatives of civil society to review the government's policy and legislation on tax incentives with a view to radically reducing them.
- Widen the remainder of the domestic tax base and improve enforcement and collection.

The Ministry of Health and Sanitation should:

- Continue to improve its performance and strengthen accountability and governance measures.
- Work with other ministries to ensure that determinants of health such as food security, water and sanitation are funded concurrently through public finances (augmented with international aid where necessary).
- Carry out District level Health Accounts and Public Expenditure Reviews annually to determine the effectiveness of financial management systems in the districts.
- Strengthen regulation capacity to ensure that tax avoidance and evasion is reduced by enhancing penalties and increasing the capacity of the National Revenue Authority (NRA) to conduct independent audits of the largest companies.

The Ministry of Finance should:

- Disburse Ministry of Health budget lines fully, regularly and on time. The National Health Accounts and Public Expenditure Reviews should be reviewed annually.
- Strengthen the capacity of the NRA to collect taxes and monitor and investigate companies.
- Provide a cost-benefit analysis of any tax incentive granted in new or renegotiated mining agreements, ensuring that Parliament is properly informed before ratifying these. This could be mandated in the Revenue Management Bill.

Parliament should:

- Ensure adequate scrutiny and ongoing debate of mining fiscal regimes.

Donors should:

- Review the funding gaps, for example in resourcing the Free Healthcare Initiative, and continue to provide long-term and predictable funding to support Sierra Leone in strengthening its health system.
- Continue to build Sierra Leone's tax and finance capacity, for example supporting the strengthening of the National Revenue Authority and district level production of District Health Accounts and public expenditure reviews.
- Contribute to short term solutions to the acute health worker shortage by making it easier for health professionals from the diaspora to return to Sierra Leone for limited periods and providing opportunities for foreign medical staff to volunteer.
- Donor countries that receive substantial subsidies from Sierra Leone as a result of health worker migration must provide financial compensation to Sierra Leone in addition to aid.

The IMF should:

- Write off all of Sierra Leone's debt.

OECD countries should:

Recognising that tax justice also requires eliminating illicit financial flows OECD countries should:

- Take much greater steps to reform the global tax architecture

5. Conclusion

There is no denying that achieving Universal Health Coverage in Sierra Leone will be a significant challenge. Yet the Ebola crisis provides a stark example of the urgent need to do so. In the wake of the crisis, the Government of Sierra Leone, with support from donors, must direct concerted energy into delivering a long term vision to enable all its citizens to achieve their right to health. In the shorter term it must take steps including providing sustainable financing for the Free Healthcare Initiative and meeting its commitment to the Abuja Target. Extractives

industry revenues can provide significant additional contributions to health financing, with estimates varying between \$94 and \$199 million per year, and the Government must look to this sector as a key source of revenue generation in the years ahead.

We also must not forget that tax justice requires international effort to eliminate the network of tax havens and legal loopholes which enable corporations and wealthy elites to avoid paying the taxes that are due to countries like Sierra Leone where they live or operate.

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Healthy Revenues

How the extractives industry can support Universal Health Coverage in Sierra Leone

Despite its wealth of natural resources, Sierra Leone has some of the worst health indicators in the world. This report explores how increased taxation revenue from the extractives industry can contribute to Sierra Leone's journey towards Universal Health Coverage.



Health Poverty Action works to strengthen poor and marginalised people in their struggle for health.

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