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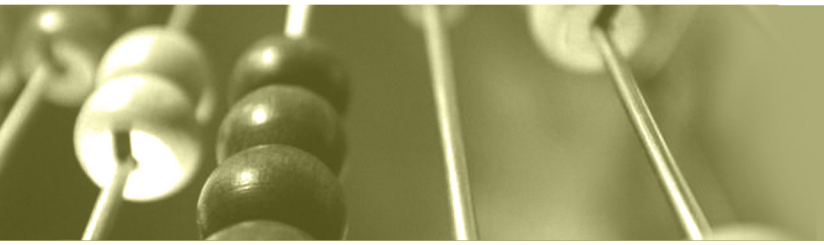


HEALTH REFORM NOTE 14

AUGUST 2011

Funding the NHI - Earmarked Tax

This note investigates the ANC proposal of funding the additional expenditure required for a NHI system with an earmarked tax. Since it would represent only a small proportion of the NHI budget (and be a so-called weak earmarked tax), we find that it does not seem to support the main rationale proposed in the discussion document.[1] *Hence, there does not seem to be a strong argument for implementing an earmarked tax rather than using general taxation. Next we discuss the implications of the increase in taxes, which is likely to be highly progressive and to have severe implications for families paying personal income tax (i.e. largely the medical schemes members).*

1 Introduction

Although general taxation is intended to be the main source of funding for the NHI, according to the ANC discussion document a number of options are currently being examined to supplement general taxation. These options include a surcharge on taxable income, payroll taxes for employees and/or employers, an increase in value-added tax (VAT) and the removal of the existing tax subsidy for medical aids. These supplementary funds would be reserved for the NHI.

The favoured option seems to be a progressive earmarked tax in the form of a mandatory payroll-related contribution, which would presumably have to raise the additional revenue to fund the NHI, projected to be around R9 billion in 2012.[2] According to the ANC discussion document[3] the main rationale for a progressive earmarked tax would be to establish a link between contributions that individuals make and the health benefits that they receive. A further rationale put forward in the document is that a progressive earmarked tax would provide a mechanism for cementing social solidarity in the health system.

2 Earmarked Taxes

Earmarked (or hypothecated) taxes are taxes of which the revenues are reserved solely for a specific programme or purpose.

This research note forms part of a series of notes dealing with issues of health reform in South Africa. In the interest of constructively contributing to the NHI debate, the Hospital Association of South Africa (HASA) has commissioned this series of research notes which can be accessed on the Econex website: www.econex.co.za.

1. *ANC. 2010. "National Health Insurance." ANC National General Council: Additional Discussion Documents*
2. *See footnote 1.*
3. *See footnote 1*

This contrasts with funding from general taxation, where expenditures are financed from consolidated receipts. Examples of earmarked taxes include fuel taxes reserved for the transportation sector and carbon taxes reserved for environmental protection funds.[4]

Globally, healthcare often receives earmarked taxes in the form of sin taxes on alcohol and tobacco. The Australian state of Victoria implemented the first earmarked tax on tobacco for healthcare in 1987. The revenue was used to fund an independent health promotion foundation called VicHealth.[5] A part of the tax revenue from the sale of cigarettes is also earmarked for healthcare in Belgium and the United Kingdom.[6]

Earmarked income taxes for healthcare, similar to those currently proposed in South Africa, partially contribute to financing the health systems in France and Italy. In Ghana the National Health Insurance Levy is an earmarked tax reserved for the health sector. Yet, in general, earmarked taxes represent a relatively modest contribution to healthcare financing.[7]

2.1 Earmarked taxes – some theoretical considerations

The use of earmarked taxes has always been a contentious issue, with the same arguments often used for and against earmarking. For instance, proponents often argue that earmarking can limit wasteful government spending, while opponents argue that they limit flexibility in expenditure in times of need. Clearly these arguments depend on one's view of the role of government.[8]

2.1.1 Earmarking to constrain overall public spending

Public choice models assume that government bureaucracies are self-interested and that voters, with differing preferences, attempt to arrive at a consensus to support alternative public spending programmes. According to these theories, earmarking provides an accountability mechanism that constrains public spending and can also work as a commitment device to solve time-inconsistency problems in tax policy. This is because the amount of public spending is constrained by the size of the earmarked tax revenue. These mechanisms can foster trust between the government and taxpayers, which can be especially relevant in developing countries with weak democracies.[9]

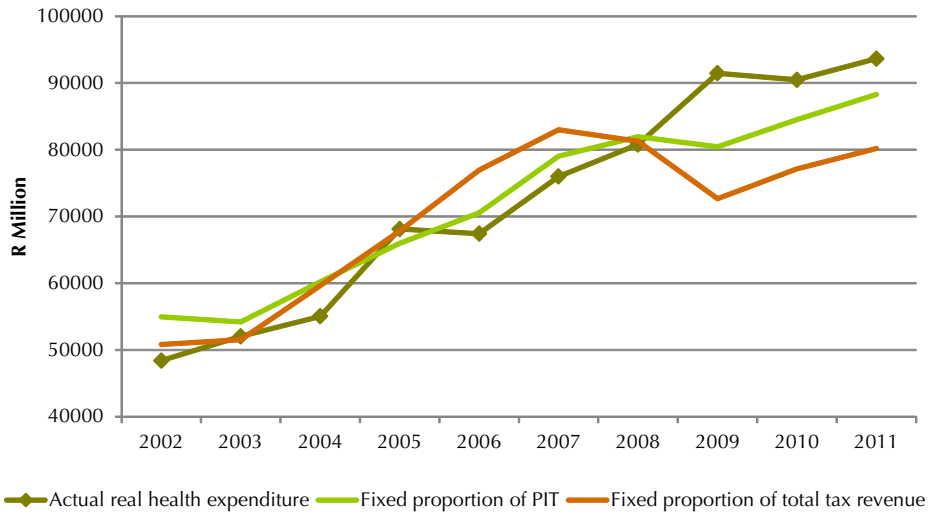
Because the level of spending is directly tied to the amount of taxes paid, earmarking can inform taxpayers of the cost of particular services. In a seminal paper[10], Buchanan argued that earmarking allows voters to choose the prices and quantities of public services that should be provided. In this case, there will be a simultaneous choice of the level of taxation and expenditure on each public service, as opposed to the two-step decision process of general taxation, where decisions on the aggregate level of taxation and expenditure are made separately. In other

4. *Chen, B. L. and Lee, S. F. 2008. "General Fund Financing, Earmarking, Economic Stabilization And Welfare."Munich Personal RePEc Archive: Paper No. 27666*
5. *Doetinchem, O. 2010. "Earmarking of Tax Revenue for Health." World Health Report: Background Paper No. 51.*
6. *Mossialos, E., Dixon, A., Figueras, J. and Kutzin, J. 2002. "Funding Health Care: Options for Europe." European Observatory on Health Care Systems Series, World Health Organisation.*
7. *Savedoff, W. 2004. "Tax-Based Financing for Health Systems: Options and Experiences."World Health Organization: Discussion Paper, No.*
8. *See footnote 5.*
9. *See footnote 4.*
10. *Quoted in Wilkinson (footnote 12)*

words, there would be a real link between revenue and expenditure and taxpayers should be able to make more informed private decisions about each public service by comparing their costs with their benefits.[11] Traditional public finance theory, on the other hand, rejects the role of earmarked taxes. These theoretical models typically assume that government takes the form of a benevolent social planner, attempting to maximise a well-defined social welfare function. Public finance theorists usually argue that public expenditure should not be determined by the amount of revenue raised from a specific revenue source, but by policy decisions.[12] In other words, earmarking reduces the flexibility of public spending.

Tax revenues are heavily dependent on the overall performance of the economy and tend to fluctuate with the business cycle. Since revenues rise and fall over the economic cycle, the constraint on government discretion would lead to pro-cyclical budgets and spending. Funding levels would not be determined by the requirements of the population, but by unrelated macroeconomic circumstances.[13] In this case, any specific earmarked tax to fund the NHI could become hostage to economic cycles with the threat of under-funding during economic downturns.[14] Moreover, tax revenue and spending requirements may coincide at the beginning of a programme, but over time they may drift apart.[15]

Figure 1: Pro-cyclical tax revenues compared to actual health expenditure (Real R millions)



Source: Econex calculations

Figure 1 illustrates the pro-cyclical nature of tax revenues and the pro-cyclical spending that would have resulted. We compare the actual real health expenditure to two hypothetical expenditure scenarios based on earmarked taxes. For these two scenarios we assume that a constant percentage (equal to the average over the last ten years) of either personal income tax or total tax revenue would have been allocated to healthcare. If we assume that actual health expenditure was the correct amount, there would have been large over-funding in expansionary phase before 2008, with large under-funding thereafter.

As a result, it only makes sense to use earmarked taxes to fund liabilities which fluctuate with the business cycle, i.e. where benefits are tied to contributions. Because general taxes fluctuate less in relation to the benefits promised, they

11. *See footnote 9.*
12. *Wilkinson, M. 1994. "Paying for Public Spending: Is There a Role for Earmarked Taxes?"Fiscal Studies, Vol. 15, No. 4 (119-35).*
13. *See footnote 5.*
14. *Twine, T. 2010. "The National Health Insurance Scheme: Re-allocating Finite Resources." Consumer Market Trends, Vol. 9610/1006.*
15. *See footnote 5.*

are most efficient when benefits are not related to contributory status and liabilities must be financed regardless of the decrease in revenue.[16]

2.1.2 Classification of earmarked taxes

Wilkinson (1994)[17] provides a useful classification of earmarked taxes, by distinguishing between strong (or substantive) earmarking and weak (or nominal) earmarking on the one hand, and narrow and wide earmarking on the other.

In the strong case, tax revenues must equal public expenditure on the programme, while referendums may be held on the tax rate and the amount of spending. In the weak case, earmarking is undertaken to make the system more transparent and to inform the taxpayer of the cost of the service, but expenditures do not match revenues. Wide earmarking covers a whole spending programme, whereas narrow earmarking covers a specific project within a programme. According to this classification, the ANC's proposed earmarked tax to supplement the funding of the NHI would amount to weak, wide earmarking.

Many proponents of earmarked taxes appear to refer either explicitly or implicitly to strong earmarking. Otherwise many of the arguments in favour of earmarked taxes are weakened substantially or fall away completely. For instance, strong earmarking, with no subsidies from to general taxation, is necessary to realise the benefits of accountability and trust.[18]

With weak earmarking, taxpayers have no control over total expenditure on the public service for which the additional revenues are earmarked and governments could spend much more than earmarked taxes by increasing spending from general tax revenues. Conversely, since government revenues are fungible, earmarked taxes may simply be offset by cutbacks in other general sources. In other words, an increase in funds from earmarked taxes can easily be offset by a decrease in the rest of the health budget. The effect would be to impose a constraint on the minimum level of expenditure on the public service, while overall spending would be at government's discretion.[19]

Weak earmarking would only constrain public expenditure decisions in very narrow cases, where earmarked funds contributed to some specific project within a general public service programme.[20] Some critics argue that when the revenue from

16. *Van den Heever, A. 2011. "Introduction to Health economics and Systems: Financing Health Care." Graduate School of Public and Development Management.*
17. *See footnote 9.*
18. *See footnote 5.*
19. *See footnote 7.*
20. *See footnote 14.*

an earmarked tax does not determine the amount of spending on the programme it pays for, any further earmarking would only mislead taxpayers into thinking that their payments controlled government spending.[21]

During recessions, tax revenue tends to decrease whereas the demand for healthcare tends to increase, as illustrated in the last three years in Figure 1. The earmarked tax could be supplemented from general taxation during times of recession, whereas earmarked tax revenues could be raided for other types of spending in expansionary periods. In either case, with weak earmarking, there would be no real link between revenue and spending, undermining the argument in favour of earmarking.[22]

Over time many earmarked taxes have become less strong due to these considerations. For instance, in the VicHealth example, earmarked taxes were replaced by general taxation. This is probably due to their lack of fiscal flexibility and the fact that these taxes often do not raise the exact amount needed, which may be exacerbated over time.[23]

2.1.3 Political support

Proponents claim that a move towards earmarking will increase tax revenue by increasing taxpayers' willingness to pay. If taxpayers are more aware of the destination of their taxes, they can express their willingness to pay more clearly, by altering their work effort and private consumption. Earmarking can then generate public support for taxes to fund popular services, such as healthcare and education. For example, a separate entry on tax returns for an NHI tax might make the tax less objectionable.

Due to public support for healthcare spending, health departments are usually in favour of earmarked taxes. Earmarking provides them with a reliable and predictable source of funding, but also allows them to protect their resources from competing political interests and in some cases to avoid budgetary constraints.[25] In contrast, finance departments are rarely in favour of earmarking, as it undermines their discretion in budgetary allocation. Earmarked tax revenues are usually exempt from the periodic review and control, and may be captured by special interest groups.[26] Because earmarked taxes require the government to track and account for revenues separately, this usually increases tax administration and compliance costs.[27]

2.1.4 Benefit principle

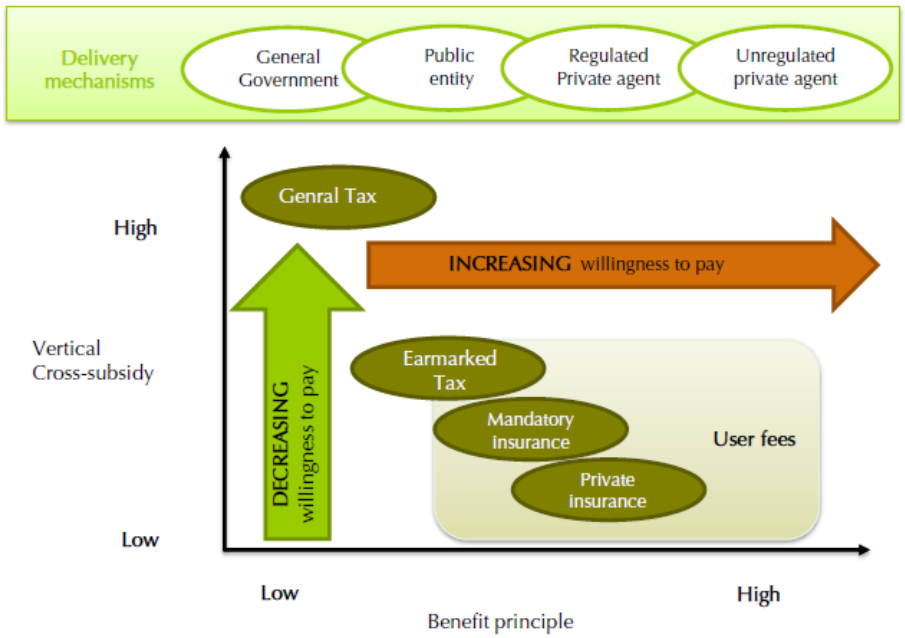
According to the ANC discussion[28] document the main rationale for a progressive earmarked tax would be to establish a link between contributions that individuals make and the health benefits that they receive. In other words, according to this benefit principle, the tax should be paid by those that benefit more directly. This will increase taxpayers' willingness to pay, because it will be seen less as a tax. The stronger the benefit

21. *See footnote 9.*
22. *British Medical Association. 2004. "Could a Hypothecated Tax Close the Gap?" Available at: http://www.bma.org.uk/Archive/healthcarefundingreview.jsp?page=18&media=print*
23. *See footnote 5.*
24. *Duncan, A. And Jones, A. 2003. "Economic Incentives and Tax Hypothecation."Department of Economics and Related Studies, University of York: Heslington, York.*
25. *See footnote 5.*
26. *Mossialos, E., Dixon, A., Figueras, J. and Kutzin, J. 2002. "Funding Health Care: Options for Europe"European Observatory on Health Care Systems Series, World Health Organisation.*
27. *Michael, J. 2008. "Earmarking State Tax Revenues." Minnesota House of Representatives: Policy Brief.*
28. *See footnote 1.*

principle the better the case for earmarked taxes, in the form of payroll taxes or mandatory contributions, since benefits are tied to contributions. In this case the source of finance will be able to sustainably match the benefits promised.[29] Figure 2 illustrates these principles.

In contrast , the NHI will not have a strong benefit principle, especially if funded by highly progressive taxes. This is because the taxpayers that fund an NHI system are unlikely to switch to the public sector on a large scale (especially not in the short term), given the strong demand for private sector healthcare (see Note 11). As we argue below, it is likely that any tax to fund the NHI will be highly progressive, with the tax payer not receiving benefits to the same value as taxes paid. Large redistributive taxes are typically associated with targeted and universal benefits, with the aim of poverty alleviation. Thus, NHI systems correspond to the top left of Figure 2, with large vertical cross-subsidies. As vertical cross-subsidies increase there will be a decreasing willingness to pay. In this case general taxes are most efficient, since benefits are not directly related to contributions.[30]

Figure 2: Financing principles with institutional implications



Source: Van den Heever (2011)

2.1.5 Social solidarity

A further rationale put forward in the ANC discussion document[31] is that a progressive earmarked tax would provide a mechanism for cementing social solidarity in the health system through income-related contributions to a single pool of funds that will benefit all. However, this rationale seems to contradict the first rationale, namely establishing a link between contributions that individuals make and the health benefits that they receive.

In fact, general taxes could be argued to cement social solidarity, since there are only 5.5 million registered tax payers and they are all aware that a large component of their taxes is redistributed to the poor. In contrast then, earmarking would probably serve to undermine social solidarity.[32]

Hence, there does not seem to be a strong argument for implementing earmarked rather than general taxation to fund additional expenditure on the NHI.

29. *Van den Heever, A. 2011. "Introduction to Health economics and Systems: Financing Health Care." Graduate School of Public and Development Management.*
30. *See footnote 29.*
31. *See footnote 1.*
32. *See footnote 5.*

While general taxes are the most efficient in this case, they are subject to macroeconomic constraints. There is only so much that can be taxed without causing damage to the economy.[33]

3 Impact of an Increase in Earmarked Taxes

The economic impact of an increase in earmarked taxes would be equivalent to an increase in general taxation. The fact that the revenue would be reserved for a specific purpose would not change the fact that taxation increased as a whole, or alter the impact of such an increase, including also the negative implications, distortions and reduced incentives for productive activity that are usually associated with an increase in taxes.

Unless the extra expenditure on healthcare comes at the cost of expenditures elsewhere, it will have to be raised by additional taxes and the relative size of government will increase. While fiscal substitution is unlikely, the political power of the Department of Health will be tested against the relative power of the other departments, with each appealing to the National Treasury to secure its own slice of the tax revenue for its continuing political survival and prosperity.[34]

3.1 SA NHI Tax Proposals

The question that needs to be answered is how the required increase in health expenditure will be financed. According to the recent Budget Review[35] a range of possible funding sources are currently being considered which are similar to those mentioned in the ANC discussion document. These include the removal of tax subsidies for medical scheme contributions, a surcharge on taxable income, a mandatory payroll tax, and an increase in the VAT rate. In addition to the ANC proposal, the Budget Review stated that the feasibility and practicality of co-payments or user charges will also be explored. However, announcements about specific funding instruments will only be made in the 2012 Budget.

Clearly, each of the potential revenue sources has opportunities and threats associated with it. For example, VAT collections would be instantaneous to introduce, but would be regressive, affecting the poor more than the wealthy.[36] In our opinion an increase in the VAT rate therefore is unlikely. The favoured option seems to be a mandatory payroll-related contribution. According to the ANC proposal, the mandatory NHI payroll tax would be progressively structured, from less than 1% for the lowest income earners to a maximum of between 7% and 8% for the highest income earners.[37] The additional funding needs will to some extent be offset by the proposed removal of tax subsidies for medical scheme contributions. According to the Budget Review, the revenue foregone from tax-deductions for medical scheme contributions was approximately R 6.7 billion in 2008/09.[38] The plan is for these funds to be channelled to the NHI.

3.2 Impact of increased taxes on medical scheme members

As an example, OMAC[39] generated some scenarios to illustrate the possible impact

33. *Van den Heever, A. 2011. "Introduction to Health economics and Systems: Financing Health Care." Graduate School of Public and Development Management18. See footnote 22.*
34. *See footnote 11.*
35. *See footnote 33.*
36. *See footnote 11.*
37. *See footnote 1.*
38. *See footnote 33.*
39. *OMAC Actuaries and Consultants. 2010. "ANC's Proposal for National Health Insurance." Old Mutual Life Assurance.*

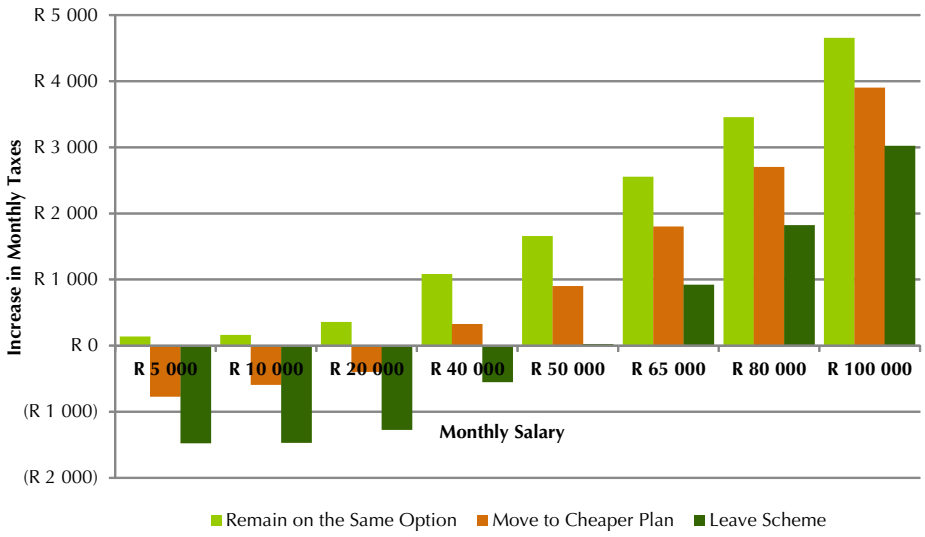
on medical scheme members of this progressive increase in income tax, as well as the removal of tax-deductions for medical scheme contributions. The tax brackets and the increase in marginal tax rates assumed, ranging from 0.5% to 6% are illustrated in Table 1.

The change in cost to members was investigated under three scenarios: the member remained on the same benefit option, the member buys down to a cheaper plan, or the member leaves the medical scheme. The impact on the monthly cost to members is illustrated in Figure 3, by monthly salary, for a principal member only.

The results indicated that for a member earning R 40,000 per month, remaining on the same benefit option would cost around R 1,000 extra per month. This reflected the additional income tax and the removal of the tax subsidy. Members earning less than this would not be significantly affected. However, members earning more would be progressively disadvantaged.

When dependents were added, the cost of remaining on the same option would increase because of the larger tax subsidy that would be lost. If a member chose to move to a cheaper plan, part of the additional tax would be offset by the lower premiums. In this scenario the

Figure 3: Extra Tax to be paid by medical scheme member



Source: OMAC Actuaries and Consultants (2010)

cheaper plan, e.g. a Hospital Plan, would cost around R 700 less per member per month. Principal members earning more than R 33,000 per month would pay more than they currently do, while those earning less would save money. If a single member chose to leave the scheme, the breakeven point would be a monthly salary of around R 50,000.

As mentioned before, it is unlikely that a large proportion of scheme members would choose to leave their schemes entirely. It is probably more likely that members would either stay on their current plan or move to a cheaper plan, while utilising certain public sector facilities. Importantly, these scenarios assume that the NHI contributions purchase the same value/

Table 1: Personal Income Tax Brackets and the Increase in marginal tax rates

Personal Income Tax Brackets	Marginal Tax Rate	Increase in Marginal Rate for NHI
0 – 132,000	18%	0.5%
132,001 – 210,000	25%	1%
210,001 – 290,000	30%	2%
290,001 – 410,000	35%	3%
410,001 – 525,000	38%	4%
525,001	40%	6%

Source: OMAC Actuaries and Consultants (2010)

volume of goods, but possibly offered in the public sector or an accredited private provider. We have often mentioned the massive supply constraints faced by the South African public health sector and it is most unlikely that current service levels (on average) in public institutions are comparable on a Rand for Rand basis to the levels currently offered in the private sector.Therefiore, it will not be possible to fund a bennefit equivalent to what medical scheme members currently purchase with their own income.

At the same time, it is clear that taxes will be highly progressive so that those that can contribute will do so and presumably their contributions will then be evenly spread across the populace.The taxpayers that pay for the additional health spending will probably not leave their medical schemes for the public sector. As a consequence, the additional taxes will in all likelihood not generate an offset in the demand for private services and will amount to a substantial increase in their tax burden.[40]

In other words,while the mayority of South Africans should theoretically be better off and have improved access to quality care, the people that pay for the NHI will receive very little benefits and be worse off. This also contradicts the ANC's main rationale for a progressive earmarked tax, namely to establish a link between contributions that individuals make and the health benefits that they receive. This perceived unfairness could also lead to tax resistance and other unintended consequences.

4 Conclusion

In this note we investigated the proposal of funding the extra expenditure on the NHI system with an earmarked tax. We showed that the proposed weak earmarking of taxes would negate most of the arguments in favour of earmarking. If government were to increase the budget for public healthcare it could do so more efficiently through increases in general taxes, as benefits are not related to contributory status in an NHI. If there were a need to improve the progressivity of taxes, this could be achieved more simply through changes in general taxes.[41]

The additional taxes needed to fund the NHI are likely to be highly progressive and will probably amount to a substantial increase in the tax burden of medical scheme members. However, revenue options are always dependent on macroeconomic performance and it is important to consider not just funding options for the NHI but balancing the entire fiscal equation. As Twine[42] says, "discussing the apparent options available for funding the NHI is a little like contemplating the arrangement of deckchairs on an ocean liner instead of keeping an eye open for icebergs."

40. *Van den Heever, A. 2009. "NHI - What's Wrong With This Debate?" Health-e. Available at: http://www.amandlapublishers.co.za/special-features/the-nhi-debate/223-nhi-whats-wrong-with-this-debate*
41. *See footnote 43.*
42. *See footnote 11.*