https://doi.org/10.1142/9781800612396_0012

Special Focus 3

Managing the Politics of Earmarked Health Taxes

Katherine Smith* **and Mark Hellowell†**

SF 3.1. Introduction

The public health interest in health taxes has largely focused on their ability to raise the cost of manufacturing, distributing, selling and/or consuming such products, reducing their consumption. However, there is increasing interest in using such taxes to mobilise additional government revenues to fund investments and programmes that contribute to health systems goals. For example, a recent report by the World Bank found that the large financing gap for Universal Health Coverage (UHC) in low- and lower-middle-income countries (LMICs) (now exacerbated by the economic effects of the COVID-19 pandemic), could be mitigated by tax increases on tobacco, alcohol, and sugar-sweetened beverages (SSBs).[1] The World Bank authors estimate that tax increases that raise the retail prices of these products by 50% could generate additional revenues of approximately $24.7 billion in 54 LMICs by 2030. If allocated to the health sector at a level of 50%, the excise tax increases would lower the estimated financing gap by $2.9 billion in

* University of Strathclyde, UK.

† University of Edinburgh, UK.

low-income countries and $6.6 billion in lower-middle-income countries (as well as reducing future costs by curbing the growth of non-communicable disease (NCD) burdens). However, this effect depends on the taxes being 'earmarked' – that is, allocated to specific purposes, a process alternatively called 'hypothecation'.

Our starting point in this contribution is to recognise that public support for new or increased consumption taxes is generally low, and yet, to be initiated and sustained over time, new health tax policies require sufficient support from citizens, policymakers and other stakeholders. Research across multiple contexts, and multiple specific taxes, suggests that the level of support is often higher when credible commitments are made to earmark the related funds for activities that are highly valued by the population.[2] Building on this understanding, we consider how the process of earmarking can impact, and has impacted, on the political feasibility and sustainability of health tax policies. Specifically, we seek to understand the perspectives of a range of stakeholders on health taxes and how these might be influenced by earmarking. In addition to members of the general public, who can be offered opportunities to engage with policy discussions about new tax proposals via consultations – or even, in some cases, direct votes on proposals – there exist multiple non-governmental and commercial sector actors with strong views about, and interests in, health taxes generally and, more specifically, the earmarking of such taxes. As this contribution shows, these actors often work hard to ensure that political and media discussions are influenced by their views and interests (see Refs.[2,3]). Finally, where cross-government support for earmarking is required, it is important to consider the views of policymakers beyond health and finance on earmarking health taxes (a rather smaller literature – see Ref.[2]).

Since it would be impossible to thoroughly review the available research literatures on the range of perspectives with respect to the earmarking of health taxes, this section identifies key insights regarding the views and interests of: (i) members of the public; (ii) policymakers and (iii) commercial sector actors. The third section focuses primarily on tobacco industry actors

since these activities are most comprehensively covered in the literature, but it also touches on the more limited literature examining the views of food, beverage and alcohol industry actors. It is notable that this contribution does not explore the views of civil society actors on earmarking in any detail. The reasons for this are that, although existing literature explores the role of these groups in efforts to promote the use of health taxes (which, as Chapter 13 sets out, can be crucial), there is a dearth of research exploring the perspectives of civil society actors on earmarking health taxes. In the contribution conclusion, we reflect on the potential reasons for, and importance of, this current knowledge gap.

SF 3.2. Public support for 'earmarked' health taxes

While public preferences vary by context and by specific tax proposal (e.g. while there is some evidence that the public can be supportive of SSB taxes in some contexts, support for new or increased consumption taxes in general is low – see Refs.[4–7]). However, there is remarkably consistent evidence that public support, across contexts, is higher when credible commitments are made to earmark funds for specified health objectives and related activities, such as subsidising healthier foods,[7] targeting child obesity,[8] providing support to smokers who want to quit,[9] and expanding access to free or subsidised health care in contexts where UHC has not been achieved.[10] Indeed, studies of proposals to raise tobacco taxes have found that public support tends to increase when such proposals include a commitment to earmark tobacco tax increases for health-related spending – evidence here comes from Germany,[11] Greece,[12] Indonesia,[13] New Zealand,[14] the Philippines,[10] the United Kingdom,[15] the United States[16,17] and Taiwan,[18] among others.

There are multiple reasons why 'earmarking' might increase public support for health taxes (although understanding people's rationales for favouring health taxes that are earmarked is much less well researched).

In the absence of earmarking, there is an inherent disconnection between the payment of taxes and the allocation of funds to specific objectives and activities, which can create or exacerbate concerns that public spending priorities are misaligned with public preferences. Earmarking can provide a way of addressing such concerns by ensuring that funds are allocated towards activities that command broad public support, thereby increasing a sense among countries' citizens that they 'have a say' in decisions about how public money is spent,[18] and strengthening the ethical case for taxation (e.g. an argument that it is right for consumers of health-damaging products to contribute more tax to support health care was effectively deployed by officials of the Romanian Ministry of Health to support an earmarked tobacco tax increase – see Ref.[19]). Earmarking health taxes can also enable policymakers to respond to considerable public concerns about the regressive nature of consumption taxes that pertains in many country contexts (i.e. the possibility that they will increase the tax burden of those on low incomes) (e.g. Refs.[20–24]), via commitments to direct spending towards those most affected by the health effects of the taxed product, or towards the poorest, and/or other vulnerable social groups.[22,25]

On the other hand, while earmarking can generate a strong signal to the public that new or increased taxes will be used to fund activities in accordance with public preferences, in practice, funds may not always be earmarked to the extent that was initially claimed, leading to a loss of trust in and public support for the tax.[26,27] Because money is 'fungible' (i.e. any unit of a given currency is ultimately substitutable for any other), it is difficult to trace the connection between specific revenue streams and specific activities. Unless a specific revenue stream is the *only* source of funding for a specific area of expenditure (which is neither feasible nor desirable in most cases – see Ref.[10]), increased revenues from a specific source can be offset by reducing revenues from other sources, leading to no overall increase. We call this the accountability problem. Where steps are not taken to address this problem (e.g. through assiduous monitoring – ideally by an independent entity such as a supreme audit institution),

actors opposed to the tax may use such lacunae in financial accountability to undermine public support.[3]

Moreover, it is important to note that decisions to earmark revenues from a proposed tax or tax increase do not *guarantee* a high level of public support, since this form of accountability is far from the only factor shaping public opinion (mass media coverage and counter-lobbying by corporate interests being notable others – see, e.g. Refs.[27–29]). There may also, in some contexts, be institutional factors that offset, or outweigh, the political benefits of earmarking health taxes. For example, in recent years, a number of city authorities in California have run referenda on new SSB taxes. One of the challenges faced by advocates of such taxes is that while new taxes can pass with a simple majority, earmarked commitments require a two-thirds majority.[30] In such cases, the political analysis of earmarking becomes more complicated, and less favourable overall. In other words, while advocates of SSB taxes might believe that earmarking will increase public support for the SSB tax, for reasons described previously, they may be unclear as to whether this increase will be sufficient to achieve the two-thirds majority required for an earmarked tax proposal to pass. Empirically, the result has differed across Californian cities; in some cases leading to new SSB taxes being passed, while in others proposals have been rejected.[30]

SF 3.3. Government support for 'earmarked' health taxes

The literature exploring policymakers' perspectives on the earmarking of health taxes is more limited and there are contrasting conclusions. Research suggests that government officials are often wary about the idea of earmarking health taxes for specific spending purposes. In addition, policymakers may be subject to formal restrictions on earmarking (e.g. Ref.[17]) or may simply believe that policy buy-in would be too low to warrant pursuing. An interview-based study in Saudi Arabia, for example, found that neither

policy officials from the health or finance sectors felt there was any appetite for earmarking the revenue from a new SSB tax for health-related spending, attributing this to the lack of precedent for earmarking.[31] Similarly, a study of Israeli policy stakeholders on the prospect of new taxes on SSBs and unhealthy snacks revealed strong opposition to earmarking among Ministry of Finance officials, to the extent that many other stakeholders believed earmarking was not a realistic prospect.[32] Likewise, a US study of efforts to pass a new alcohol tax in three states found that, although legislators acknowledged that public support was likely to increase if commitments were made to earmarking revenues for health spending, their clear preference was for the revenue to go to the general budget.[33]

This reflects resistance among public officials to proposals for earmarking taxes (more broadly) on the basis that it deprives public officials of crucial flexibility in public spending.[34] Indeed, while policymakers working within ministries and departments focusing on health may support earmarking taxes for health spending, officials within finance ministries are generally likely to oppose such commitments and their impacts on the flexibility of budgetary arrangements.[35] However, research exploring such perspectives on proposals to implement SSB taxes in the United States (which were subject to voter ballots) found that most respondents viewed commitments to reinvest accrued revenues into health-related activities as a persuasive argument in favour of such taxes.[36] In addition, the majority of respondents believed public support would be lower when policymakers failed to specify how revenues from proposed health taxes would be spent.[36] Overall, this suggests that, where there is both (a) a precedent for earmarking health taxes and (b) high levels of citizen engagement in decisions about the taxes (e.g. via consultation or even voting), policymakers that support such taxes should view earmarking as strategically attractive (or even necessary).

The earmarking of health taxes has also been identified as a promising mechanism for increasing the degree of cross-departmental government support in some contexts.[2] For example, a tax on unhealthy food products introduced in French Polynesia in 2002 enjoyed extremely broad ministerial

support, a finding attributed to the use of the tax to co-finance a broad range of public health and cultural, educational and youth-focused initiatives, which benefitted 7 of the 17 ministers in government.[37] In addition, our work with country governments in several LMICs has shown how Ministries of Finance often seek guarantees from other ministries that new revenue streams have been identified before new intervention areas and activities will be supported. For instance, to obtain support from Ministries of Finance for new (or expanded) National Health Insurance Funds (often a key part of UHC efforts in LMICs), ministries that support such proposals are often required to identify a specific revenue stream that will be used to fund or co-fund the necessary budgetary commitments. In such cases, earmarked health taxes are often viewed by Ministries of Finance as feasible and a more economically desirable option than potential alternatives such as (highly distortionary) taxes on payroll/salaries.

The combination of (a) the strategic value (for attracting public support) of *claiming* that the revenue from new health taxes/tax increases will be dedicated to health spending with (b) the accountability problem and (c) strong pressures to 'flex' public spending allocations over the political and economic cycles, helps explain the existence of several cases in which commitments to earmarking health taxes for specific purposes have been made but not honoured. Indeed, there are multiple case studies in the literature on US state-level tobacco tax increases which were passed by public ballot on the basis that the revenue would be used for particular purposes but for which evidence suggests revenues were subsequently diverted (e.g. Refs.[38–40]). Similarly, an analysis of a Scottish Government tax on large retailers selling alcohol and tobacco found that, despite efforts by policymakers to frame the new tax as one that would be dedicated to health-related purposes, in fact 'the revenue raised from the Supplement was not meaningfully hypothecated – and indeed it seems likely that there was never any intention to formally hypothecate for health purposes' (Ref.[26], p. 825). Where divergences between stated revenue-spending intentions and actual

revenue spending occur, this may undermine public support for existing or future health taxes, and create lobbying opportunities for interests opposed to the implementation or maintenance of such taxes.[3,27]

SF 3.4. Commercial sector opposition to 'earmarked' health taxes

As Chapter 12 sets out, multiple commercial sector actors have a potential interest in proposals to earmark health taxes, including those whose profits may be impacted by the taxes (e.g. unhealthy commodity industries, such as tobacco, alcohol and ultra-processed food manufacturers and retailers) and those who may benefit from commitments to invest accrued revenues on health (e.g. health and social care providers and pharmaceutical companies). In this section, we focus on the available literature concerning the perspectives of actors working for unhealthy commodity industries on health taxes. This is a rather imbalanced literature which, until recently, was dominated by analyses of transnational tobacco company perspectives. This reflects the fact that litigation cases in the United States have require tobacco companies to place some of their internal documents into the public domain, providing a resource to researchers seeking to analyse and understand commercial sector perspectives on a wide range of policy issues.[41]

A systematic review of the literature concerning tobacco industry efforts to influence tobacco tax policies found that tobacco companies work hard to prevent significant tobacco excise increases – and that they are particularly aggressive in opposing proposals for taxes that are 'earmarked' for tobacco control or spending on other health-related objectives or activities.[3] The review identified 17 studies, all focusing on the United States, concerning proposals for tax increases in which officials had made commitments to earmark the revenue for health-related programmes. In all cases, tobacco companies worked to oppose these proposals (most of which involved

direct public ballots/votes), often successfully. The review found that such actors make use of the accountability problem outlined previously. Indeed, the most commonly identified industry argument in these studies was that earmarked funds would be used in ways which the public did not support and/or which differed from those described in the original proposal.[3] Specifically in the US context, the industry has argued that tobacco taxes would be misused to subsidise healthcare for poorer groups, which the industry sometimes framed as a diversion of funds to 'greedy' doctors, hospitals, healthcare companies, insurers and/or community health activists. Such efforts were helped by the fact that healthcare and health insurance organisations often *wanted* to divert the funds and by the fact the tobacco industry sometimes worked with such actors to try to *achieve* such diversions (e.g. Refs.[38–40]). This not only limited the availability of resources for tobacco control efforts (for which funds had originally been earmarked) but also provided evidence to support the tobacco industry's arguments that earmarking commitments would not be honoured.

There has recently been an increase in studies exploring the perspectives of food and beverage company actors on health taxes, in the context of widespread policy experimentation with SSB and food taxes (see Ref.[2] and Chapter 13 in this book). However, while this literature charts strong food and beverage company opposition to proposals for taxes on their products (see Ref.[42]), we could not identify any specific analysis of perspectives on, or responses to, proposals for earmarking such taxes. The literature exploring alcohol industry perspectives on health taxes is even more limited. This suggests we currently know very little about broader commercial perspectives on earmarking health taxes. However, given the evidence (discussed in this contribution) that earmarking increases public support for health taxes, combined with the extensive evidence of unhealthy commodity industry opposition to health taxes (as set out in Chapter 13), it would be not be surprising to find that the tobacco industry's opposition to earmarking extended to other unhealthy commodity industries.

SF 3.5. Conclusion

Existing literature shows that commitments to earmarking health taxes for specific purposes (especially health purposes, such as funding UHC, health system strengthening or preventive public health services), can increase public and political support for such policies.[4,37,43,44] For precisely this reason, tobacco industry actors have actively opposed earmarking principles and questioned the legitimacy of the associated commitments. In doing so, such actors have aimed to undermine the degree of public and political support by raising the connection between taxes paid and the socially valuable interventions and activities that they enable. For these reasons, we argue that earmarking is a process that should command the interest and support of the public health community (e.g. non-governmental organisations, researchers and practitioners). Yet, the dearth of research exploring the views of public health actors on earmarking health taxes, combined with at least two case studies in which the absence of public health support has been noted as a factor in the failure of the taxes to be sustained,[27,29] suggests efforts are needed to encourage and facilitate such engagement.

Earmarking is something that can help to offset and counter the influence of industry interests with regard to the initiation and sustainability of health taxes. However, this is only the case where governments are able to set out credible mechanisms for abiding by their earmarking commitments once these taxes have been implemented. Failure to do so has provided a lobbying focus for commercial actors (and others) opposed to health taxes, undermining public and political support for them. The public health community may therefore wish to both promote earmarking in principle, and also advocate to ensure that commitments to earmarking health taxes are feasible and honoured in practice. There is currently little evidence of such support. Meanwhile, as we outline in this contribution, analyses of US tobacco tax increases found that some health and medical actors had even worked with commercial actors to divert the revenue of tobacco tax

increases away from original commitments, unwittingly providing evidence to undermine public confidence in future proposals for earmarked health taxes.

References

1. World Bank Group. *High-Performance Health Financing for Universal Health Coverage: Driving Sustainable, Inclusive Growth in the 21st Century,* 2019, https://openknowledge.worldbank.org/handle/10986/31930.
2. Wright A, Smith KE, Hellowell M. Policy lessons from health taxes: a systematic review of empirical studies. *BMC Public Health.* 2017; 17: 583.
3. Smith KE, Savell E, Gilmore AB. What is known about tobacco industry efforts to influence tobacco tax? A systematic review of empirical studies. *Tobacco Control.* 2013; 22(2): 144–153.
4. Barry C, Niederdeppe J, Gollust S. Taxes on sugar-sweetened beverages: Results from a 2011 national public opinion survey. *American Journal of Preventative Medicine.* 2013; 44: 158–163.
5. Beeken R, Wardle J. Public beliefs about the causes of obesity and attitudes towards policy initiatives in Great Britain. *Public Health Nutrition.* 2013; 16: 2132–2137.
6. González-Zapata LI, Alvarez-Dardet C, Millstone E, Clemente-Gómez V, Holdsworth M, Ortiz-Moncada R, et al. The potential role of taxes and subsidies on food in the prevention of obesity in Europe. *Journal of Epidemiology and Community Health.* 2010; 64: 696–704.
7. Morley B, Martin J, Niven P, Wakefield M. Public opinion of food-related obesity prevention policy initiatives. *Health Promotion Journal of Australia.* 2012; 23: 86–91.
8. Donaldson EA, Cohen JE, Rutkow L, Villanti AC, Kanarek NF, Barry CL. Public support for a sugar-sweetened beverage tax and pro-tax messages in a Mid-Atlantic US state. *Public Health Nutrition,* 2015; 18: 2263–2273.
9. Chaloupka F. *Tobacco Control Lessons Learned: The Impact of State and Local Policies.* Research Paper Series, No. 38, ImpacTeen, University of Illinois at Chicago: Chicago, USA; 2010.
10. Cashin C, Sparkes S, Bloom D. *Earmarking for Health: From Theory to Practice*. Department of Health Systems Governance and Financing Health Systems and Innovation, World Health Organization. Geneva, Switzerland; 2017. https://apps.who.int/iris/bitstream/handle/10665/255004/9789241512206-eng.pdf.
11. Hanewinkel R, Isensee B. Opinion on tobacco tax increase: factors associated with individuals' support in Germany. *Health Policy.* 2008; 86(2–3): 234–238.
12. Vardavas CI, Filippidis FT, Agaku IT, et al. Tobacco taxation: The importance of earmarking the revenue to health care and tobacco control. *Tobacco Induced Diseases.* 2012; 10: 21.
13. Thabrany H, Laborahima Z. People's support on sin tax to finance UHC in Indonesia. *Journal Ekonomi Kesehatan.* 2016; 1: 1.

14. Wilson N, Weerasekera D, Edwards R, Thomson G, Devlin M, Gifford H. Characteristics of smoker support for increasing a dedicated tobacco tax: National survey data from New Zealand. *Nicotine & Tobacco Research.* 2010; 12(2): 168–173.
15. Sussex J, Burge P, Lu H, Exley J, King S. Public acceptability of health and social care funding options. The Health Foundation, 01/05/22. https://www.health.org.uk/sites/default/files/upload/publications/2019/Public%20acceptability%20of%20health%20and%20social%20care%20funding%20options_0.pdf.
16. Nicholl J. Tobacco tax initiatives to prevent tobacco use. *Cancer.* 1998; 83: 2666–2679.
17. Chainani AA. *Sugar-Sweetened Beverage Taxes: Learning from Passage and Failure in California Cities.* University of the Sciences in Philadelphia, ProQuest Dissertations Publishing, 2019. 13859719.
18. Lin T-F, Chan Y-S, Chen J. Awareness of tobacco tax policy and public opinion on tobacco tax reform in Taiwan. *Asian Pacific Journal of Health Economics and Policy* 2020; 3: 2–14.
19. WHO. *Earmarked Tobacco Taxes: Lessons Learnt from Nine Countries.* Geneva: WHO; 2016, https://apps.who.int/iris/bitstream/handle/10665/206007/9789241510424_eng.pdf#.
20. Allais O, Bertail P, Nichle V. The effects of a fat tax on French households' purchases: A nutritional approach. *American Journal of Agricultural Economics.* 2010; 92: 228–245.
21. ECORYS. *Food Taxes and Their Impact on Competitiveness in the Agri-Food Sector: Final Report.* Rotterdam: ECORYS; 2014.
22. Hirono KT, Smith KE. Australia's $40 per pack cigarette tax plans: The need to consider equity, *Tobacco Control.* 2018; 27: 229–233.
23. Hoek J, Smith K. A qualitative analysis of low income smokers' responses to tobacco excise tax increases. *International Journal of Drug Policy.* 2016; 37: 82–89.
24. Shill J, Mavoa H, Allender S, Lawrence M, Sacks G, Peeters A, et al. Government regulation to promote healthy food environments – A view from inside state governments. *Obesity Reviews.* 2012; 13: 162–173.
25. Madden, D. The poverty effects of a "fat-tax" in Ireland. *Health Economics.* 2015; 24: 104–121.
26. IARC (International Agency for Research on Cancer). *IARC Handbooks of Cancer Prevention Volume 14: Tobacco Control: Effectiveness of Tax and Price Policies for Tobacco Control.* Lyon: World Health Organization; 2011.
27. Hellowell M, Smith KE, Wright A. Hard to avoid but difficult to sustain: Scotland's innovative health tax on large retailers selling tobacco and alcohol. *Milbank Quarterly.* 2016; 94: 800–831.
28. Bodker M, Pisinger C, Toft U, Jorgensen T. The rise and fall of the world's first fat tax. *Health Policy.* 2015; 119: 737–742.
29. Vallgårda S, Holm L, Jensen JD. The Danish tax on saturated fat: Why it did not survive. *European Journal of Clinical Nutrition.* 2015; 69: 223–226.
30. Marriott R, Price Dillard J. Sweet talk for voters: A survey of persuasive messaging in ten U. S. sugar-sweetened beverage tax referendums. *Critical Public Health.* 2021; 31(4): 477–486.

31. Alsukait R, Bleich S, Wilde P, Singh G, Folta S. Sugary drink excise tax policy process and implementation: Case study from Saudi Arabia. *Food Policy.* 2020; 90: 101789.
32. Tamir O, Cohen-Yogev T, Furman-Assaf S, et al. Taxation of sugar sweetened beverages and unhealthy foods: A qualitative study of key opinion leaders' views. *Israel Journal of Health Policy Research.* 2018; 7: 43.
33. Ramirez RL, Jernigan DH. Increasing alcohol taxes: analysis of case studies from Illinois, Maryland, and Massachusetts. *Journal of Studies on Alcohol and Drugs.* 2017; 78(5): 763–769.
34. Stowers GN. Earmarking as a strategy against budgetary constraints: San Francisco's Children's Amendment. *Public Budgeting & Finance.* 1995; 15: 68–85.
35. Thow AM, Downs SM, Mayes C, Trevena H, Waqanivalu T, Cawley J. Fiscal policy to improve diets and prevent non-communicable diseases: From recommendations to action. *Bulletin of the World Health Organization.* 2018; 96(3): 201–210.
36. Jou J, Niederdeppe J, Barry CL, Gollust SE. Strategic messaging to promote taxation of sugar-sweetened beverages: Lessons from recent political campaigns. *American Journal of Public Health.* 2014; 104(5): 847–853.
37. Thow AM, Quested C, Juventin L, Kun R, Khan AN, Swinburn B. Taxing soft drinks in the Pacific: implementation lessons for improving health. *Health Promotion International.* 2011; 26: 55–64.
38. Balbach ED, Traynor MP, Glantz SA. The implementation of California's tobacco tax initiative: The critical role of outsider strategies in protecting proposition 99. *Journal of Health Politics, Policy and Law*. 2000; 25: 689–715.
39. Begay ME, Traynor M, Glantz SA. The tobacco industry, state-politics, and tobacco education in California. *American Journal of Public Health.* 1993; 83: 1214–1221.
40. Traynor MP, Glantz SA. California's tobacco tax initiative: The development and passage of Proposition 99. *Journal of Health Politics, Policy and Law.* 1996; 21: 543–585.
41. Collin J, Lee K, Gilmore AB. Unlocking the corporate documents of British American Tobacco: An invaluable global resource needs radically improved access. *Lancet.* 2004; 363: 1746–1747.
42. Du M, Tugendhaft A, Erzse A, Hofman KJ. Sugar-sweetened beverage taxes: Industry response and tactics. *The Yale Journal of Biology and Medicine,* 2018; 91(2): 185–190.
43. Julia C, Méjean C, Vicari F, Péneau S, Hercberg S. Public perception and characteristics related to acceptance of the sugar-sweetened beverage taxation launched in France in 2012. *Public Health Nutrition*. 2015; 18: 2679–2688.
44. Somerville C, Marteau TM, Kinmonth AL, Cohn S. Public attitudes towards pricing policies to change health-related behaviours: A UK focus group study. *European Journal of Public Health*. 2015; 25: 1058–64.