

Health, Nutrition and Population Global Practice

HEALTH EARMARKS AND HEALTH TAXES: WHAT DO WE KNOW?

*Ceren Ozer, Danielle Bloom, Adolfo Martinez Valle,
Eduardo Banzon, Kate Mandeville, Jeremias Paul,
Evan Blecher, Susan Sparkes, and Sheena Chhabra**

December 2020



KEY MESSAGES:

- Earmarking means taking all or a portion of total revenue from a tax or group of taxes and setting it aside or “protecting” it for a designated expenditure purpose. Earmarking practices vary from “hard” to “soft,” and are associated with different levels of fiscal risk.
- At least 80, and likely more, countries earmark for health. However, earmarking is unlikely to bring a sustained net increase in revenue due to offsetting, and can create rigidities and inefficiencies.
- If allocations fail to match priorities or if a tax can make the priority more politically acceptable, soft earmarks that are closer to standard budget processes may be useful in the short term.
- The primary intent of “health taxes” is to curb unhealthy behaviors that affect population health and can strain health systems. Health taxes can generate revenue without compromising equity, and their revenues can be earmarked, but they do not by design net more money for health.
- In the context of fiscal constraints (e.g., with COVID-19), health taxes may provide an overall source of revenue for governments, and help manage disease burden and fiscal pressure on the health system by reducing risk factors for COVID-19. Soft earmarks on health taxes may also help inject short-term funding into the health sector, if the appropriate public financial management safeguards are in place.

INTRODUCTION

It is estimated that 85 percent of countries around the world will experience a GDP contraction as a result of the economic impact of COVID-19, amplifying fiscal constraints in general and for the health sector in particular (Tandon 2020). Recent studies conducted by World Bank experts find that in the last two decades, over half of the increase in per capita public spending on health has been the result of economic growth, underscoring the need to manage reforms within countries’ macrofiscal context (Tandon et al. 2018, 2020).

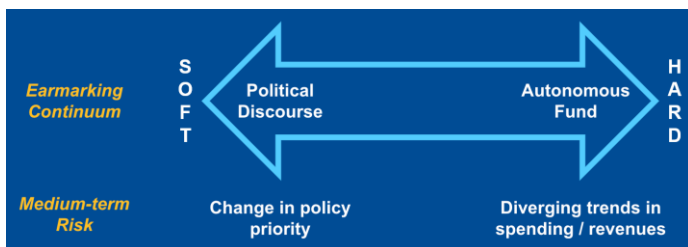
Keeping tax revenues above 15 percent of GDP is a key ingredient for economic growth, for funding health and social sectors, and ultimately, poverty reduction and human capital development. However, about half of developing countries were below this mark even before the pandemic hit. COVID-19 will lower tax to GDP ratios globally as a result of reduced revenue from taxes relative to other public revenue sources—so much so that attention may shift from achievement of well-established goals like the Sustainable Development Goals (SDGs) to simply staying afloat (Global Economic Prospects 2020). Countries now need to explore smart health financing policies that will help them to rebuild better following

COVID-19. This brief will review the concepts of earmarking and health taxes, global evidence using these polices, and their potential role in building more resilient health systems under COVID-19.

WHAT IS EARMARKING FOR HEALTH?

Earmarking means taking all or a portion of total revenue from a tax or group of taxes and setting it aside or “protecting” it for a designated expenditure purpose. In practice, earmarking gives visibility to a *revenue and expenditure package*—creating a transparent link between a funding source and exactly what it is spent on—and is driven by an implicit understanding that, all else being equal, the package requested will be sufficient to meet articulated expenditure needs. All earmarking policies have various revenue and expenditure characteristics that dictate how they are set: (i) They can dictate what proportion of a revenue source should be allocated to the health sector or a target program, population, or service within the sector; (ii) They can mandate the proportion of funds that should be spent on a specific target; or (iii) They can spell out a benefit rationale—connecting individuals with direct gains from their contributions. Additionally, the adoption and implementation process, including how earmarked funds flow and accountability mechanisms are established, can also impact how effective an earmark is and the results it might generate.

Figure 1: Continuum of Hard to Soft Earmarking



Source: Prady, 2020

The way that earmarks are set can also place them on a continuum from “hard” to “soft,” terms that are associated with varying levels of fiscal risk (Figure 1). In hard earmarking, all revenue is allocated based on rules that may bypass the budget process and are specific to that earmark; for instance, a legislated amount of revenue may be connected to a narrow expenditure purpose, which may be associated with an autonomous fund. This creates fiscal risk by limiting oversight and the ability of governments to shift resources to align to spending needs and realities, including in response to fiscal crisis. In soft earmarking, practices are aligned to the budgeting process and political discourse.¹ Soft earmarking gives visibility to a political priority, is aligned to a standard budget process, and links revenue less tightly: it can be

diverted to other purposes, or other funds can be allocated to the earmarked priority—while subject to shifts in politics, it is generally a much less risky process and recommended over hard earmarks (Cashin, Sparkes, and Bloom 2017; Cashin 2020; Prady 2020).

TO EARMARK OR NOT TO EARMARK

Debates about earmarking can be polarizing. On the negative side, earmarks are said to introduce budget rigidity, economic distortion, limit the ability of governments to put in place countercyclical policies, increase fragmentation, decrease solidarity and increase regressivity, and be susceptible to special interest groups (Cashin, Sparkes, and Bloom 2017).

On the positive side, there are many reasons that countries may choose to explore an earmark. Some objectives are *financial*—linked to directing revenue toward a particular expenditure purpose, such as the health sector overall or a specific health program. Others may be *technical*, such as increases in efficiency, accountability, cost awareness, or flexibility. Still other objectives may be *political*; for instance, a country may wish to gain public support, increase the acceptability of a tax increase or reform to show political commitment to a popular program or initiative, or to improve transparency in how funds are allocated. Earmarking may also be used to further *social objectives* such as improved equity by targeting expansion of coverage to poor populations, or by curbing consumption of unhealthy products (Cashin, Sparkes, and Bloom 2017).

In general, if a budget process works well and health is well prioritized, then earmarking should not be needed. However, if the budget process fails to generate allocations that match priorities or if a tax can make the priority more politically acceptable, soft earmarking—when complemented by supporting analysis, such as the Extended Cost Benefit Analysis (ECBA)²—may be useful in the short term.

COUNTRY EXPERIENCES EARMARKING FOR HEALTH

As of 2017, at least 80 countries earmarked different revenue or expenditure sources for health. Figure 2 below is organized by the predominant types of revenue sources that have been used in health earmarking. Of these, the most common source of earmarked revenues for the health sector are payroll taxes to finance health care, despite findings that these may increase inequality, unnecessarily fragment the health system, and may not generate sufficient revenues (Cashin, Sparkes, and Bloom 2017; Yazbeck et al. 2020).

Figure 2: Countries Using Earmarking for Health



Source: Cashin, Sparkes and Bloom 2017

Cashin, Sparkes, and Bloom (2017) also presented experiences from across a set of six case study countries (Estonia, Ghana, Indonesia, the Philippines, South Africa and Viet Nam) that earmark across a set of sources including general revenue, payroll, value-added tax (VAT), social security contributions, and health tax revenues. Looking at this source and other evidence, a number of lessons emerge:

- **Short-term revenue gains from earmarked funds are often lost due to longer-term reductions of other revenue sources.** This loss is due to the ability to offset or shift funds to other priorities (fungibility) and reprioritization of general government revenue for health. In some cases, this leads to a net decrease in revenue going to health, for instance, in Gabon, Ghana, and Estonia (Cashin, Sparkes, and Bloom 2017).
- **The expenditure purpose should be narrow enough to be enforceable and link funding to priorities, but not create rigidities.** The link between revenue and expenditure should also be flexible enough so that the amount of money available alone doesn't drive spending, or that expenditure is allowed to proceed unchecked. For instance, national health insurance or HIV/AIDS are specific purposes where funding flows can be tracked, but priorities within programs can be adjusted. In Indonesia, having subnational transfers earmarked broadly for health provided challenges in enforcement and accountability and increased rigidity, limiting central governments' discretion over resource allocation (World Bank 2020a; Cashin, Sparkes, and Bloom 2017).

- **Earmarks work best when the objectives of health and finance stakeholders are aligned** and can help garner political support and unlock stalemates. In Ghana, the Ministry of Finance (MoF) faced issues increasing the VAT rate until it was tied to funding the National Health Insurance Scheme (Cashin, Sparkes, and Bloom 2017).
- **Sunset clauses or periodic review can help ensure that earmarks are still meeting their intended purpose**, as earmarks often only provide for short-term increases in fiscal space for health. For instance, South African parliamentary expenditure earmarks are subject to review each year, while treasury earmarks can be revised at any time (Cashin, Sparkes, and Bloom 2017).
- **Earmarks can limit flexibility to adapt to changing conditions**, including demographics and labor markets, presenting challenges. For example, after years of effort, Estonia was finally able to decrease funding from payroll taxes in lieu of increased general revenue financing for its National Health Insurance Fund, responding to changes driven by population aging (Cashin, Sparkes, and Bloom 2017; Thomson et al. 2011).
- **While the first best option is an open and transparent budget that prioritizes health, soft earmarks that are closer to standard budget processes may be considered**, allowing for a balance between flexibility in the budget and reliability of some sort of commitment. In the Philippines, earmarked revenue goes to the General Fund and throughout the regular budgetary process—while the Department of Health (DoH) is assured funds, its expenditure program must be approved. (Cashin, Sparkes, and Bloom 2017; Paul 2020).

From these country experiences, it is possible to conclude that in general, if earmarks must be used they work best if implemented as a part of a comprehensive package of policies aligned to health and finance objectives, and are established as flexible, soft earmarks that align to standard budget processes.

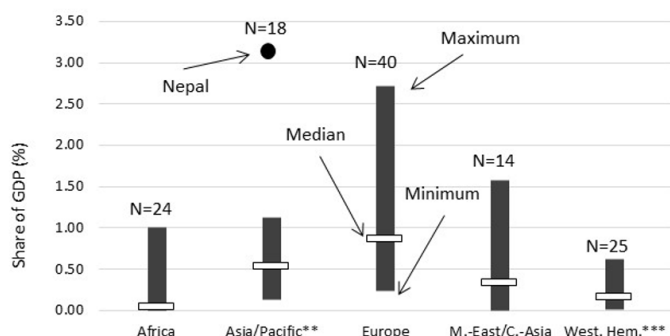
THE ROLE OF "HEALTH TAXES"

"Health taxes," sometimes known as "sin taxes," are taxes imposed on products that have a negative public health impact, such as taxes on tobacco, alcohol, or sugar-sweetened beverages (SSB). They can even extend to environmental taxes on pollutants that damage health (fossil fuels) or social security contributions that are levied in relation to health. The primary objective of introducing a health tax is to improve population health through reduced consumption of unhealthy products. The

secondary objective is to raise *overall* government revenues. Importantly, while 54 countries earmark some form of health tax, a health tax does not necessitate that related revenue is earmarked for the health sector (Cashin, Sparkes and Bloom, 2017).

The calculation of health tax potential needs to take into account the local administrative capacities and conditions, and overall prioritization of health within government budgets (Petit 2018). However, in countries that have instituted or increased health taxes—particularly tobacco excise taxes—revenue gains are nontrivial (Figure 3).

Figure 3: Tobacco Taxes and GDP Min, Max and Median (2013)*



Source: Petit, 2018

Notes: *IMF and WHO data. Excise only, and excluding revenue from state enterprises

** including Nepal (3.19%). The second highest is Solomon Islands (1.12%)

*** Excluding notably Canada, USA and Brazil. Many Caribbean Islands rely on import duties

The Task Force on Fiscal Policy for Health –select fiscal policy, development and health leaders from around the globe with Mike Bloomberg and Larry Summers as co-chairs—also estimated the impact of one-time health tax increases that would result in a 20 to 50 percent increase in prices over a 50-year period and provide commensurate estimates of value for money (Figure 4-Bloomberg et al. 2020).

Figure 4: The Task Force on Fiscal Policy for Health

	2018 US\$ billions of excise tax revenue		Years of life gained (1000s)		Value for money: years of life/revenue	
	20% increase	50% increase	20% increase	50% increase	20% increase	50% increase
Tobacco	1,987	3,625	160,724	401,836	80,888	110,851
Alcohol	9,428	17,778	227,421	546,745	24,122	30,754
SSB	724	952	24,355	59,762	33,640	62,775

Note: SSB= Sugar-sweetened beverages

Opponents of health taxes have argued that they cost jobs, harm business, and slow the economy; that they can encourage illicit trade and harm a country’s Doing Business rating; and even that they are discriminatory, unconstitutional, or illegal. However, evidence against many of these claims render them unfounded (Hattersley et al. 2020a, b). Indeed, evidence on regressivity shows that when medical expenses and gains in working life are taken into account, health taxes are generally progressive in the long term (Fuchs, Gonzalez Icaza, and Paz 2019).

Further, in **South Africa**, it has been reported that industry overstates estimates of illicit trade, compared to independent studies, creating a narrative that it is growing at an alarming rate or as the result of a recent tax increase (Blecher 2010; Eriksen et al. 2015). South Africa is an example of a country that has implemented excise taxes on tobacco, alcohol, and sugar-sweetened beverages, It has raised rates on tobacco and alcohol dramatically since the early 1990s. For tobacco and alcohol, this has served to reduce sales volumes while still leading to large increases in tax revenue (R 14.5 billion and 31.5 billion, respectively). For sugar-sweetened beverages, the innovative structure of the reform creates an incentive for producers to reformulate their products to reduce sugar volumes but does not make as substantial a contribution to the fiscus (R 2.9 billion). South Africa *does not earmark* any of the tax revenue in line with broader fiscal policy processes in the budget (Blecher 2020).

EARMARKING OF HEALTH TAXES

If health taxes are earmarked, they require the same considerations as other earmarked sources—with soft earmarks aligned to the standard budget processes as preferable—and face the same challenge as other earmarked revenue sources: they sometimes generate additional revenue for health, as can be seen through country examples - but do not by design necessitate a net increase in revenue due to fungibility and revenue becoming a ceiling for expenditure.

In the **Philippines**, earmarking for health came about as a result of a political promise during the Aquino administration to move toward universal health coverage (UHC) without introducing new taxes. As a result, the 2012 Sin Tax Reform introduced soft earmarks for UHC funded from incremental revenues generated by reforming the tax structures and increasing rates on alcohol and tobacco taxes (about 85 percent of incremental revenues). Approximately 80 percent of the 85 percent earmarked for health goes to National Health Insurance subsidies, with the balance going to health facility upgrades. The reforms continued under the Duterte administration when in 2018, the Tax Reform for

Acceleration and Inclusion Law (TRAIN) imposed taxes on sugar-sweetened beverages and earmarked 30 percent of incremental revenue from SSB to fund social mitigating measures including investment in health and targeted nutrition programs. Under the UHC Law passed in 2019, the national government share from the income of the Philippine Gaming Corporation (50 percent) and the Philippine Charity Sweepstakes Office (40 percent) were earmarked for UHC. Furthermore, the base of earmarks was changed in 2019 from incremental revenues to total revenues, such that by 2020 the corresponding shares earmarked for health are as follows: alcohol (100 percent), tobacco (50 percent), sugar-sweetened beverages (50 percent), heated tobacco (100 percent), and vaping products (100 percent). The earmarks have provided not only a sustained but significant source of revenue, tripling resources for health in a period of 5 years (2013–18). The earmarks have also helped to decrease smoking prevalence and improve equity by expanding coverage and paying for health insurance for the poor (See Figure 5- Banzon 2020; Paul 2020).

Figure 5: Expansion to Fund Premiums for Poor



Source: Paul 2020

Finally, **Thailand** presents an example of a *hard earmark* on revenue from health taxes. Since 2001, there has been a 2 percent surcharge on the base of excise taxes imposed on sales from alcohol and tobacco products for the ThaiHealth Promotion Foundation. The revenue was remitted directly to an extrabudgetary fund that is managed by ThaiHealth. ThaiHealth is an independent organization with a governing board that includes the Prime Minister, Ministry for Public Health, and an independent expert. The board sets ThaiHealth’s policies, strategies, and budget, and funds are directly expended on projects that improve health in collaboration with nongovernmental organizations. Over one-third of the funds are dedicated to prevention of three primary risk factors: tobacco use, unsafe alcohol use, and unsafe driving. The budget is approximately US\$120 million per year, representing only 0.9 percent of government expenditure on health. While there is no major opposition

to the earmark, there is pressure to cap the amounts (Galbally et al. 2012; Paul 2020; Pongutta et al. 2019).

BUILDING RESILIENCE DURING COVID-19

COVID-19 has kicked off a deep global economic contraction and highlighted the interplay between the health of citizens and the economy. Latest estimates indicate that per capita economic growth rates will decline on average by almost 7 percent globally, and between 4 to-8 percent across low- and lower-middle income countries. Exacerbated by the fact that many countries did not enter this recession in a favorable economic condition, and carried other risk factors like poor external integration, the impact will be severe (Tandon 2020).

Countries may choose to explore health taxes as a way to help rebuild better: to curb unhealthy behaviors that contribute to conditions like diabetes or obesity and act as risk factors for COVID-19, to reduce burden on the health system, and to generate revenue for a country. However, without reprioritization, public financing for health will stagnate or decline in many countries, meaning that a clear case will need to be made to increase allocations for health during annual budget submissions, especially as countries are able to take a step back to examine the fiscal impacts of their response (Tandon 2020). For instance, while COVID-19 gives clear momentum to help strengthen and channel resources toward health systems, some countries have reduced, deferred, or temporarily covered health insurance contributions (Thomson, Habicht, and Evetovits 2020), and the repercussions these decisions is yet to be seen. Indeed, as fiscal space shrinks, there is a risk that human capital investments across the board will decline, and in the coming months, countries will have difficult expenditure choices to make.

The question then arises as to whether earmarking can be used in tandem with a health tax to help channel and prioritize resources toward health during COVID-19.

Already, some countries have begun to explore this practice. In **India**, the National Calamity Contingent Duty on Tobacco, Fuel, and Motor Vehicles represents a hard earmark for the National Disaster Response Fund (NDRF). In March 2020, the Indian central government made 35 percent of its resources for fiscal year 2019–20 available for medical supplies needed for COVID-19. As of today, US\$700 million has been made available to the State Disaster Response Funds. Additionally, at least 16 states in India significantly increased taxes and excise duty on alcohol to mobilize additional revenue post-COVID, including: a) increase of excise duty on alcohol ranging from 6 percent in Karnataka to about 75 percent Andhra Pradesh; b) 25 percent increase in cess on

alcohol in Assam, Arunachal Pradesh, and Meghalaya; c) 14 cents to US \$3 increase in the price of liquor per bottle in Uttar Pradesh and Uttarakhand; and d) levying a new “COVID fee” on maximum retail price ranging from 11 percent in Karnataka to 50 percent in Odisha (Chhabra 2020; Paul 2020).

In **Mexico**, there are three health taxes in place: taxes on alcoholic beverages; cigarettes, cigars, and other tobacco products; and sugar sweetened beverages—although only the first two are currently earmarked for health. However, there is political will to allocate more resources to health through earmarked taxes due to COVID-19. Congress is now discussing options, especially as other sources of revenue seem unfeasible due to the current state of the economy (Martinez Valle 2020).

Still, there may be secondary impacts of other social policies during COVID and of the revenue potential of health taxes. During the COVID-19 lockdown, **South Africa** banned sales of tobacco and alcohol, thereby forgoing the tax revenue. In April 2020 alone it was estimated that this loss amounted to R35 million daily.²

Conclusion

In terms of health taxes, the time is now: health taxes that improve health outcomes and raise revenue can also help rebuild better and ultimately decrease health system impact in future waves of the pandemic or other health shocks. If a budget process works well and health is prioritized, then earmarking of health tax revenue or other sources may not be needed. However, if there is a failure to generate allocations that match priorities or if a tax can help improve political support, soft earmarking may be useful in the short term. Emphasis on soft earmarks with clear time horizons is important to avoid rigidity, fragmentation, and ensure alignment with the standard budget process, while also maintaining transparency. It is also important to analyze if a health tax and earmarking policy proposal is pro-poor. Further, where earmarks of health taxes are channeled to the health sector, the ability to sustainably fund, manage, and monitor the impacts of an earmark should all be clearly assessed at the outset (Cashin, Sparkes, and Bloom 2017). Further research might explore the operational considerations behind how earmarks are managed and operated. As with all practices, earmarks should be pursued with safeguards and an understanding of local conditions and impacts.

References

- Banzon, Eduardo. 2020. Presentation on Philippines for “Filling the Coffers Post-COVID through Pro-Health Taxes.” Domestic Resource Mobilization Collaborative, Joint Learning Network’s Health Financing Technical Initiative Webinar, July 2, 2020.
- Blecher, E. H. 2010. “A Mountain or a Molehill: Is the Illicit Trade in Cigarettes Undermining Tobacco Control Policy in South Africa?” *Trends in Organized Crime* 13 (4): 299–315.
- Blecher, E. 2020. Correspondence with author.
- Cashin, C., S. Sparkes, and D. Bloom. 2017. “Earmarking for Health: From Theory to Practice.” Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO.
- Cashin, C. 2020. Presentation for “Pro-Poor Earmarking of Health Taxes for Domestic Resource Mobilization.” Domestic Resource Mobilization Collaborative, Joint Learning Network’s Health Financing Technical Initiative Webinar, August 20, 2020.
- Chhabra, Sheena. 2020. Presentation on India for “Filling the Coffers Post-COVID through Pro-Health Taxes.” Domestic Resource Mobilization Collaborative, Joint Learning Network’s Health Financing Technical Initiative Webinar, July 2, 2020.
- Eriksen, M., J. Mackay, N. Schluger, and F. I. Gomeshtapeh. 2015. *The Tobacco Atlas*, 6th ed. Atlanta, GA: American Cancer Society.
- Fuchs, Alan, Fernanda Gonzalez Icaza, and Daniela Paz. 2019. “Distributional Effects of Tobacco Taxation: A Comparative Analysis.” Policy Research Working Paper No. 8805, World Bank, Washington DC.
- Galbally R, Fidler A, Chowdhury M, Tang KC, Good S, Tantivess S. 2012. “Ten-Year Review of Thai Health Promotion Foundation, Nov. 2001–Nov. 2011.” Bangkok: Thai Health Promotion Foundation.
- Hattersley, L., Fuchs A., Alberto Gonima, A., Silver L., and Kate Mandeville, K. 2020a. “Business, Employment, and Productivity Impacts of Sugar-Sweetened Beverages Taxes.” Health, Nutrition and Population Knowledge Brief, World Bank, Washington, DC. <https://openknowledge.worldbank.org/handle/10986/34082>.
- Hattersley, L., Fuchs A., Alberto Gonima, A., Silver L., and Kate Mandeville, K. 2020b. “Countering Common Arguments against Taxes on Sugary Drinks.” Health, Nutrition and Population Knowledge Brief, World Bank, Washington, DC. <https://openknowledge.worldbank.org/handle/10986/34361>.
- Martinez Valle, A. 2020. Presentation on Mexico for “Filling the Coffers Post-COVID through Pro-Health Taxes.” Domestic Resource Mobilization Collaborative, Joint Learning Network’s Health Financing Technical Initiative Webinar, July 2, 2020.
- Ozer, C, Mandeville, K., Blecher E., Borowitz, M. 2020. Presentation for “Filling the Coffers Post-COVID through Pro-

Health Taxes.” Domestic Resource Mobilization Collaborative, Joint Learning Network’s Health Financing Technical Initiative Webinar, July 2, 2020.

Paul, J. 2020. Presentation on India, Philippines, and Thailand for “Pro-Poor Earmarking of Health Taxes for Domestic Resource Mobilization.” Domestic Resource Mobilization Collaborative, Joint Learning Network’s Health Financing Technical Initiative Webinar, August 20, 2020.

Petit, P, and Nagy, J. 2016. “How to Design and Enforce Tobacco Taxes?” How to Notes 3, International Monetary Fund, Washington, DC.

Petit, P. 2018. “Excises and Health Financing”. Domestic Resource Mobilization Collaborative, Joint Learning Network’s Revisiting Health Financing Technical Initiative Meeting, April 16–17, 2018.

Pongutta, S., R. Suphanchaimat, W. Patcharanarumol, and V. Tangcharoensathien. 2019. “Lessons from the Thai Health Promotion Foundation.” *WHO Bulletin* 97 (3): 213–20.

Prady, D. 2020. Presentation for “Pro-Poor Earmarking of Health Taxes for Domestic Resource Mobilization.” Domestic Resource Mobilization Collaborative, Joint Learning Network’s Health Financing Technical Initiative Webinar, August 20, 2020.

Bloomberg, M., Summers, L., Ahmed, M., Aziz, Z., Basu, K., Cardenas, M., Chan, M.. 2020; “Health Taxes to Save Lives. Employing effective excise taxes on tobacco, alcohol and sugary beverages” Bloomberg-Summers Task Force on Fiscal Policy for Health, April 2019.

Tandon, A, Cain, J., Kurowski, C. and Postolovska, I. 2018. “Intertemporal Dynamics of Public Financing for Universal Health Coverage: Accounting for Fiscal Space Across Countries.” Health, Nutrition and Population Discussion Paper, World Bank, Washington, DC.

Tandon, A., J. Cain, J. Kurowski, A. Dozol, and I. Postolovska. 2020. “From Slippery Slopes to Steep Hills; Contrasting Landscapes of Economic Growth and Public Spending for Health.” *Social Science and Medicine* 259.

Tandon, A. 2020. Presentation on Economic Impact of COVID-19 on Fiscal Space for “Filling the Coffers Post-COVID.” Domestic Resource Mobilization Collaborative, Joint Learning Network, July 2020.

Thomson, S., T. Habicht, L. Roovali, T. Evetovits, and J. Habicht. 2011. “Responding to the Challenge of Financial Sustainability in Estonia's Health System: One Year on.” Copenhagen: World Health Organization Regional Office for Europe.

Thomson, S., T. Habicht, and T. Evetovits. 2020. “Strengthening the Health Financing Response to COVID-19 in Europe.” Health Financing Policy Paper, World Health Organization Regional Office for Europe, Barcelona, Spain.

World Bank, 2020a, “Indonesia Public Expenditure Review, Spending for Better Results.” World Bank, Washington, DC.

World Bank 2020b. “Taxes on Sugar-Sweetened Beverages: Summary of International Evidence and Experiences.” World Bank, Washington, DC.

WHO (World Health Organization). 2016. “A Global Analysis of Earmarked Tobacco Taxes and Lessons Learned from Nine Countries.” Geneva: WHO.

Yazbeck, A., W. D. Savedoff, W. C. Hsiao, J. Kutzin, A. Soucat, A. Tandon, A. Wagstaff, and W. Chi-Man Yop. 2020. “The Case against Labor-Tax Financed Social Health Insurance for Low and Low-Middle-Income Countries.” *Health Affairs* 39 (5).

ENDNOTES

1. An earmark is soft if tax revenues are designated for a specific purpose but do not determine the amount spent—there is no hard expenditure ceiling and transfers to and from general funds are possible. Defined in Cashin et al. 2017
2. A methodology that accounts for different behavioral responses to the health tax shock and subsequent price increases.
3. In South Africa there have been some estimates of lost revenue, but difficulty in doing so without a counterfactual. Treasury has reported totals for excise but that includes fuel (which was not banned, but sales are still depressed). Other estimates have focused on impact of tobacco tax revenues and may be used to gain an understanding of the magnitude of the impact: <https://africacheck.org/reports/up-in-smoke-roughly-r35-mil-in-tobacco-tax-revenues-lost-daily-during-south-africas-lockdown/>.

* This HNP Knowledge Brief provides an overview of published learnings from earmarking for health, building upon a webinar series hosted by the Domestic Resource Mobilization (DRM) Collaborative under the Joint Learning Network for Universal Health Coverage. Contributions from the DRM Collaborative team led by Ajay Tandon, country members of the DRM Collaborative, and from Michael Borowitz and other members of the Global Fund team as the co-organizers of the webinar series are gratefully acknowledged. The authors represent a mix of presenters, facilitators and authors of referenced publications.