T20 INDONESIA 2022 THINK

Policy Brief

EARMARKING HEALTH TAX FOR SUSTAINABLE UHC FINANCING IN G20 DEVELOPING COUNTRIES

Task Force 6
Global Health Security and COVID-19

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Abstract

Sustaining global health partnership remains challenging as some countries are still threatened by multiple public health issues. Hence, there should be strong incentives for political leaders to participate in sustaining global and domestic health securities including which is finding alternative funding to sustain country's Universal Health Coverage (UHC). We propose earmarking the health tax to finance the UHC in G20 developing countries as public health challenges in developing countries are mainly attributed to non-communicable diseases (NCD) risk factors. Health tax is expected to decrease the NCD risk factors while also increasing the government revenue to finance the development agenda.

Challenges

COVID-19 shows that international cooperation accelerates global post-pandemic recovery. Despite this, each country's recovery's speed relies on its initial health system condition and its ability to provide equitable universal healthcare. Owing to country-specific health challenges, global health possesses risk of increasing regional health disparity as countries recover at different paces. The underlying public health threats are further exacerbated by financing challenges raised from underfunded Universal Health Coverage (UHC) and the public health sector.

Challenge 1: Underfunded UHC and emerging burden of diseases

Underfunded UHC remains one of main national public health challenges for many countries. Despite the emerging burden of diseases, low- and middle-income countries are struggling to find alternative sources of financing, resulting in over 40% of out-of-pocket health expenditure (Langlois et al., 2020; Scheil-Adlung, 2020). G20 countries like South Africa are even dealing with quadruple burden of diseases whereby non-communicable and communicable diseases coexisted alongside maternal-child mortality and injuries (Modjadji, 2021). Brazil, India, China, and Indonesia – representing nearly 30% of the world's population – are also facing substantial burden of non-communicable diseases (majorly catastrophic diseases) burdening the already underfunded countries' UHC (Agustina et al., 2019; Marten et al., 2014). The continuing high proportion of out-of-pocket expenditure and underfunded UHC has increased risk for poor people to access health services. Considerable UHC deficit requires each country to seek alternative funding sources (Mahendradhata, et.al, 2017; Kumar, 2020).

Challenge 2: Fragmented funding and inequitable primary care services

Fragmented healthcare system lead to siloed financing and shift the focus from addressing primary health-care (PHC) functions (Lal et al., 2021). The strictly divided Global Health Security and national UHC have been exercised by many low- and middle-income countries (LMICs) globally. With this fragmentation, LMICs are majorly dependent on international aids while leaving personal health and PHC under UHC underfinanced (Erondu et al., 2018). Health system fragmentation also applies at national level, especially in countries with decentralized healthcare system. Domestic healthcare system fragmentation results in ineffective service delivery, health workforce, and health financing (Rakmawati et al., 2019). Consequently, a unified healthcare system – requiring alternative funding sources – will constitute uniformed national and international commitments in achieving common public and personal health goals (Erondu et al., 2018).

Challenge 3: Global health disparity

Achieving good health and well-being has been stipulated as goal number 3 in Sustainable Development Goals (SDGs). However, many countries are still lagging in even the most basic health indicators. Table 1 below compares different basic health indicators across countries' income group categories, showing concerning global health disparity.

Table 1 Comparison of Basic Health Indicators Between World Bank Income Group Category, latest data available

Indicator	High-Income	Upper Middle-Income	Lower Middle-Income	Low-Income
Life expectancy at birth, total (years)[a]	81.08	76.10	69.29	64.05
Maternal mortality ratio (modelled estimate, per 100,000 live births) [b]	11	41	253	460
Infant mortality rate (per 1,000 live births) [c]	4.1	9.1	33.9	47

Source: [a]World Bank (2022a), latest data available is 2021; [b]World Bank (2022b), latest data available is 2017; [c]World Bank (2022c), latest data available is 2021.

Under resourced healthcare system exacerbates existing global health disparity. While each country prioritises its interest, international resource mobilisation corroborated by strong domestic capital investment is needed to minimise the gap.

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Proposal

The three challenges above could be addressed by specifically finding alternative financing sources to extend the UHC funding, create unified healthcare system, and finally mobilizing financial resources to secure the GHS and close the between-countries health indicators gap. We propose health tax as a sustainable and solid healthcare financing means, especially in G20 developing countries. Health tax is defined as tax levied on products that have negative public health impact, e.g., tobacco, alcohol, and sugar-sweetened beverages (SSBs) (WHO, 2022). Growing number of developing countries are disproportionately threatened by increasing burden of NCDs epidemics (Islam et al., 2014).

Increasing risk of NCDs is attributed to consumption of NCDs risk factors (tobacco products, SSBs, alcohol, or saturated fat content). Hence, controlling for consumption of NCDs risk factors – through health tax – could subsequently lead to decreasing consumption of the respective products (Sánchez-Romero et al., 2020; Shankar et al., 2018). In addition, it is also followed by reducing incidence of harms associated to these products' consumption (Elder et al., 2010; Ho et al., 2018). Therefore, it is urgent to decrease the NCDs' risk factors in G20 developing countries. Health tax has been proven as one of the most effective policy measures to increase price and decrease consumption of harmful health products. In the long-term, imposing health tax is expected to reduce countries' health expenditure on NCDs and catastrophic diseases treatment. Hence, government health expenditure could be allocated for other spending purposes, including which is mobilizing the financial resources to secure GHS.

In addition to reducing consumption of NCDs risk factors, health tax will also increase government revenue and creates fiscal space to finance the development agenda (Miracolo et al., 2021). To specifically address the sustainable health financing, health tax should be earmarked to finance UHC – which in many cases of developing countries are still underfunded, leaving numbers of population uncovered and high proportion of out-of-pocket expenditure. Earmarking health tax for UHC financing should follow a clear roadmap/policy plan to create a sustainable financing means in developing countries. We propose following policy plans:

Proposal 1: Imposing complete health tax (e.g., on tobacco, alcohol, SSBs, and saturated fat content) in countries by developing and submitting comprehensive policy proposals to the national policy making process.

One of WHO's recommended strategies in controlling NCDs and their risk factors is to impose health taxes. This has been found to be a successful measure in many developing countries. In Mexico, during the first two years of the implementation of SSB tax, per capita sales of SSB dropped by 7.3% followed by an increase in per capita sales of plain water by 5.2% (Guerrero-Romero et al., 2016). The more recent study by Abdool Karim et al. (2020) in South Africa also found that the Health Promotion Levy introduced in 2018 has significantly reduced sugar consumption. Similarly, sin tax for tobacco and alcohol has been widely proven to be successful in various countries. The study by Javadinasab et al. (2019) comparing the implementation of sin tax in six different countries found that sin tax could provide sustainable health financing for the respective countries. All these studies agreed on the importance of price as a control instrument for commodities with adverse health effects. In the long-term, mitigating adverse health effects could help in cutting UHC deficits due to the major cost of catastrophic non-communicable diseases and premature mortality related to these diseases (Sánchez-Romero et al., 2020; Shankar et al., 2018). Hence, it is a costless alternative to sustainable UHC financing. In addition, some studies documented evidence on expansion of population coverage by earmarking sin taxes to fund UHC (Obermann et al., 2018; Tandon & Reddy, 2021). To intervene with the national policy making process, a comprehensive evidence-based policy proposal on complete health tax with country's specific context should be immediately submitted to the relevant key policymakers.

Proposal 2: Stating the earmarking 20% of health tax for sustainable UHC funding in the policy proposal.

Tax earmarking for health can take different forms with different characteristics. Hence, how and how many of tax would be allocated for health financing should be clearly stated in health tax policy proposal. Health tax earmarking is characterised as part of revenue earmarking instrument (rather than expenditure earmarking). In addition, taking tax as the earmarking instrument is usually linked with percentage/proportion of tax earmarking (rather than flat amount which usually is associated with external aid) (Cashin et al., 2017). We propose that at least 20% of health tax should be allocate for UHC funding. Country with specific earmarking framework which has specific expenditure purpose for health insurance from health taxes is Philippines (tobacco and alcohol taxes) (Cashin et al., 2017).

Proposal 3: Advocating the policy proposal for the public support by developing policy briefs and conducting public campaigns.

Policy initiation requires strong public support. Policy advocacies need to involve influential networks, opinion leaders, and ultimately, decision-makers take ownership of the ideas, evidence, and proposals and subsequently act upon them. Health taxes implementation in various countries have shown mixed reactions among public members and stakeholders. Hence, policy advocacy as a negotiation and mediation dialogue process to create one common goal among public members and stakeholders becomes an important instrument. Experience in implementing health tax in several countries, such as SSB tax in the UK, shows that there are groups that actively influence the content and the process of policymaking. Therefore, we propose an active policy advocacy process in providing complete information and persuasive and educative measures in pursuing health tax policy implementation. The policy advocacy can involve various actors such as academicians, experts, opinion leaders to ensure the widespread of information. We propose two strategies in policy advocacy:

- Distributing policy briefs and negotiation to influential networks, opinion leaders, and decision makers. The policy brief can contain information about the urgency of health tax, the benefit of health tax, the health tax mechanisms, and comparative study of health tax.
- Public campaign to disseminate information and motivational content to provide information about the benefit of health tax and why health tax matters to the society, especially younger generation.

Proposal 4: Preparing unified policy mechanism to implement health tax initiative among government agencies.

Each country needs to develop a basic policy for imposing this health tax following their respective standards. G20 leaders have an essential role to play in driving this policy. The G20 Health Working Group needs to support and increase discourse during the G20 meeting about the importance of health tax in all countries, especially in the G20 developing countries. Health tax requires two central cores: the financial aspect and the health aspect. In the financial aspect, it is necessary to identify actors to be able to draft the regulations on the imposition of health tax and 20% earmarks for UHC. As for the health aspect, relevant ministries need to continue to voice health promotion aspects and reduce consumption of risk factors such as tobacco, SSB, alcohol, and salt.

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