



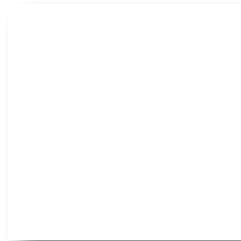
Hypothecated taxation and the NHS

India Keable-Elliott

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Acknowledgements

The author would like to thank Tom Papworth, Toby Fenwick, Harriet Davison, Tom Frostick and Russell Eagling at CentreForum for their input and editorial support. The content of this report, and any errors, are the author's responsibility alone.

Published December 2014 CentreForum

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‘Hypothecating tax revenue is not inherently right or wrong. It depends crucially on whether citizens trust its government to spend tax revenues wisely or not’

Doetinchem (2010)

■ Introduction

The National Health Service (NHS) is facing a funding shortfall. Estimates suggest that by 2020/21, the cumulative health budget deficit could approach £30 billion (NHS England 2014). This has sparked widespread debate about how the funding gap could be mitigated, and has catalysed renewed interest in hypothecating taxation for the NHS.

Hypothecation is not a new idea. Numerous papers have been written on the subject, and since the 1990s, the notion has been intermittently praised and spurned by academics and politicians alike. Now the issue is being aired once again, with members of all political parties expressing support for hypothecating taxation for the NHS.¹

This paper seeks to clarify the advantages and weaknesses of hypothecation, with a particular focus on health spending, and compares the cases made for it by proponents of different political persuasions. We contend that a strongly hypothecated tax for the NHS has some merits. However, these are outweighed by the fact that it makes health expenditure dependent on macroeconomic shocks and cycles, rather than health 'need' or 'demand'. Weak hypothecation has significant disadvantages.

In section 1 we discuss the NHS funding gap. In section 2 we outline the current funding sources of the health service. In section 3 we define two types of hypothecation, strong and weak, and offer some UK examples. In sections 4 and 5 we outline the cases for and against hypothecation. Finally, in section 6 we discuss the arguments put forward by the left and right in favour of hypothecation, namely raising revenue and rethinking spending.

1 For Labour and Conservatives, see: Helm (2014a)
For Liberal Democrats, see: Boffey (2014)

1 - The NHS funding shortfall

The Nuffield Trust has estimated that by the end of this financial year, the NHS will face a £1.5 to £2 billion gap between the actual costs of running the service and day-to-day income (McKeon et al 2014). Current trends point to continued growth in demand for NHS provision. This will be driven by factors such as an ageing society, and a consequent increase in the incidence of long-term conditions; as well as the expectation that new and more complex treatments will be provided by the NHS. Meanwhile, on the supply side, the cost of providing care continues to rise, productivity gains remain limited and public resources are constrained (NHS England 2013). The King's Fund note that since 2010/11, spending growth for the NHS has faced an unprecedented and sustained slowdown (Murray et al 2014).

If demand continues to grow and is not met by further annual efficiencies or real term increases in funding, the NHS could face an annual funding gap of £30 billion by 2020/21 (NHS England 2014). According to the recent NHS England *Five Year Forward View*, even if the NHS achieved strong efficiency gains of 1.5 per cent a year, by 2020/21 there would still be a mismatch between resources and patient needs of nearly £16 billion per annum (NHS England 2014).²

The three main political parties have all acknowledged the need for NHS funding increases. In the 2014 Autumn Statement, Chancellor George Osborne announced £2 billion of additional funding would be made available in 2015/16 to support the day-to-day work done by doctors and nurses, including a £200 million 'transformation fund' to kick-start the NHS *Five Year Forward View* (HM Treasury 2014). Labour Party leader Ed Miliband promised £2.5 billion to pay for 20,000 nurses, 8,000 GPs, 5,000 care workers and 3,000 midwives. Meanwhile, the Liberal Democrats committed to real increases of £1 billion each year until 2017/18, with £500 million promised for mental health services (King's Fund 2014). In this time of continued austerity, it is important to question where additional funding would come from.

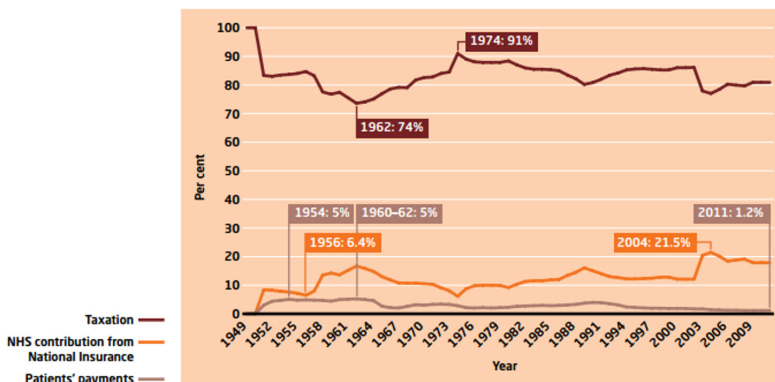
² Current Office for Budget Responsibility (OBR) estimates put net NHS efficiency gains at 0.8% a year in the long run

2 - Current funding of the NHS

The National Health Service was established in 1948 to provide a comprehensive range of health services to UK citizens, free at the point of use. Within the UK, each country has chosen to structure its NHS differently. Heads of department in England, Scotland, Wales and Northern Ireland are ultimately in control of delivering their health services (Harker et al 2012).

Figure 1 shows NHS finance sources from 1949 to 2011, including financing highs and lows as a percentage of NHS income. The vast majority of NHS funding comes from central (UK) taxation; each devolved administration is given a block grant based on the Barnett formula and can decide how much to spend on their NHS. Additional finance sources include prescription and dentistry charges, as well as various other patient payments.

Figure 1: NHS Sources of finance from 1949 – 2011



Source: Barker Commission (2014a)

General tax funding

General taxation has funded around 80 per cent of the NHS since 1951, ranging from a low of 74 per cent in 1962 to a high of 91 per cent in 1974 (Barker Commission 2014a). General taxation includes income, corporation and inheritance taxes, VAT and various other duties. In this instance it excludes National Insurance contributions (NICs).

National Insurance

National Insurance (NI) is the second largest funding source of the NHS. It has made up between 6.4 and 21.5 per cent of NHS income (Barker Commission 2014a). As some NICs are earmarked for health services, and the tax is at the centre of recent proposals regarding hypothecation, it is worth dwelling briefly on the relationship between NI and the NHS.

NICs are payable by employers, employees and the self-employed. Unlike income tax which is charged on total income, NI is a tax on earned incomes. It is not, for example, charged on savings and investment income, state and occupational pensions or earnings-replacement benefits. Individuals working in the UK who are over the age of 16 and under the state pension age are liable to pay NICs. The majority of receipts from contributions go into the National Insurance Fund, but a small proportion are allocated to the NHS.

In 2002, Gordon Brown announced that he would increase NI rates by 1 per cent for employers, employees and the self-employed, and earmark the additional revenue for health spending.³ Taken together, it was estimated that these changes would bring in £7.9 billion in 2003/04 (Seely 2014). Overall, Brown's decision was popular, perhaps in part because '[d]espite decades of politicians bellowing at voters that NICs are a tax, taxpayers continue to disagree' (Field 2014).

In 2013/14, for those paying Class 1 contributions, the NHS allocation was 2.05 per cent of earnings between the primary threshold and the Upper Earnings Limit (UEL), and 1 per cent of earnings above the UEL. The Government Actuary's Department estimates that in 2014/15 NICs will amount to £106 billion, of which £21 billion would go to the NHS (Government Actuary's Department 2014).

3 'For employees the rate of NICs rose by 1 percentage point to a rate of 11% on all earnings between the primary threshold and the UEL – and a new 1% rate was charged on earnings above the UEL. For employers the rate of NICs rose by 1 percentage point to a rate of 12.8% on earnings above the secondary threshold. For the self-employed the rate of NICs rose by 1 percentage point to a rate of 8% on all earnings between the lower profits limit and the upper profits limit – and a new 1% rate was introduced on earnings above the upper profits limit.' (Seely 2014)

Patient payments

The NHS is primarily free at the point of use, but does raise some income from patient charges (also known as ‘co-payments’ or ‘patients’ payments’ on the graph). The levels of these are set individually by the devolved administrations (Harker et al 2012).

Prescription charging

Since 1952, patients in England have been charged for prescription medication (Hawe and Cockcroft 2013).⁴ In 2013/14, prescriptions were charged at £7.85 and raised around £470 million (Department of Health 2014). Exemptions from the charge are extensive, with only around 40 per cent of the population liable to pay (Barker Commission 2014b).⁵ Of those exempt are several of the heaviest users of prescriptions (such as children, over 60s and those with specified medical conditions), meaning that, in practice, 90.6 per cent of prescriptions are dispensed free (Barker Commission 2014b).

Prescriptions have been free in Scotland since April 2011, in Wales since April 2007 and in Northern Ireland since April 2010 (Hawe and Cockcroft 2013).

Dental charging

In 2013/14, NHS England raised around £683 million in dental charges (Department of Health 2014). The service is partially financed through public funds and there are numerous exemption. Those liable to pay for dentistry are charged between £18.50 and £219 depending on the complexity of the treatment. In Wales, patients pay between £13 and £180.90,⁶ and in Scotland and Northern Ireland patients are required to pay 80 per cent of the cost of their NHS dental treatment, up to a maximum of £384 per course of treatment.⁷

4 Except for the period between February 1965 and June 1968

5 Current prescription charge exemptions are: being 60 or over, under 16, between 16 and 18 and in full-time education, pregnant or having had a baby in the previous 12 months, having a specified medical condition, having a continuing physical disability that prevents you from going out without help from another person, holding a valid war pension exemption certificate, being an NHS inpatient, having an NHS tax credit exemption certificate or a valid HC2 certificate, or receiving Income Support, Income-based Jobseeker’s Allowance, Income-related Employment and Support Allowance, or Pension Credit Guarantee Credit

6 Full details of Welsh NHS dental charges available: www.wales.nhs.uk/ourservices/findannhsdentist/nhsdentalcharges

7 Full details of Scottish NHS dental charges available: www.scottishdental.org/index.aspx?o=1923 and Northern Irish available: www.nidirect.gov.uk/health-service-dental-charges

Other sources

NHS hospital trusts can raise additional incomes through charges for hospital car parking, television and telephones, and premium rate phone lines (Blow 2014). They can also earn income through treating patients privately, or charging overseas visitors and their insurers for NHS treatments (Harker et al 2012).

3: Hypothecation - some definitions

The hypothecation of a tax is the dedication or earmarking of revenue raised from a specific tax for a particular programme or service. The literature distinguishes between two kinds of hypothecation: strong and weak.⁸

1. If hypothecation is **strong**, revenues from the tax concerned are only used to fund a particular programme or service, and there is no other source of tax funding for that programme.
2. If hypothecation is **weak**, either or both of the conditions for strong hypothecation do not hold. That is, either the hypothecated tax revenue is used to fund a service other than the one for which it was earmarked, or the programme receives tax funding from a source other than the hypothecated tax (or both) (Le Grand 2003).

The differences between the two types of hypothecation are set out in Figure 2 (overleaf). The distinction is significant because it affects the substance of the arguments for and against hypothecated taxes.

UK examples of hypothecation

The House of Commons Library Standard Note *Hypothecated Taxation* states that ‘hypothecation has never been a central feature of the UK tax system and governments have opposed its adoption on the grounds that spending priorities should not be determined by the way in which money is raised’ (Seely 2011). However, there have been a few instances of hypothecation in the UK.

The TV licence is a current example of hypothecation, as the revenue raised is earmarked for the BBC. Gordon Brown’s decision in 1999 to allocate additional revenue raised from real increases in tobacco duties to health expenditure is an example of weak hypothecation (Seely 2011). Similarly, Brown stated in his November 1999 Pre-Budget statement that ‘revenues from any real terms increases in fuel duties will, in future, go

⁸ A distinction can also be made between wide and narrow hypothecation, where wide hypothecation refers to tax revenues being used to fund an entire public service, and narrow hypothecation refers to the funding of a specific programme within an area of expenditure.

straight into a ring-fenced fund for improving public transport and modernising the road network’.

National Insurance Fund

The National Insurance Fund (NIF) is the most prominent example of type 3 weak hypothecation. The majority of National Insurance contributions are paid into the NIF, and it is notionally used to fund contributory benefits. However, the Institute for Fiscal Studies stresses that ‘in years when the Fund was not sufficient to finance benefits, it was topped up from general taxation revenues, and in years when contributions substantially exceed outlays (as they have every year since the mid-1990s), the Fund builds up a surplus, largely invested in gilts: the government is simply lending itself money’ (Browne and Roantree 2012).

Figure 2: Types of hypothecation

		Do citizens know what the tax revenue is spent on?	
		Yes	No
Do citizens know which tax revenue funds the service?	Yes	<p>Strong hypothecation</p> <p>All of the hypothecated tax revenue is spent on the specified service.</p> <p>The hypothecated tax revenue is the only source of funding for the specified service.</p>	<p>Weak hypothecation (type 1)</p> <p>Surplus tax revenue is spent on other programmes or services.</p> <p>The hypothecated tax revenue is the only source of funding for the specified service.</p>
	No	<p>Weak hypothecation (type 2)</p> <p>All of the hypothecated tax revenue is spent on the specified service.</p> <p>Expenditure on the specified service is supplemented by other sources of tax funding.</p>	<p>Weak hypothecation (type 3) OR no hypothecation</p> <p>Surplus tax revenue is spent on other programmes or services.</p> <p>Expenditure on the specified service is supplemented by other sources of tax funding.</p>

4 - Arguments for hypothecated taxes

‘Lots of reputable people believe in it, and I think there is a lot to be said for it’

Lord Finkelstein (2014)

Transparency

The strongest arguments in favour of hypothecation are that it increases transparency, accountability and trust (Le Grand 2003; Doetinchem 2010).

Earmarking taxes for particular services makes the link between taxation and government spending more transparent, which can help to reconnect voters with the purpose of taxation. Hypothecation gives the electorate a sense of what a particular service costs and how much is being spent on it (Barker Commission 2014b). Le Grand (2003) notes that information is ‘an essential element to being an active and autonomous citizen and hypothecation is a way of ensuring that a key part of that information is available’.

Hypothecation enables taxpayers to make more informed decisions about the balance between the tax burden and spending on a service (Doetinchem 2010). In the context of health, increased transparency could spark a debate about how much the electorate are willing to pay for the service.

Accountability and trust

Hypothecated taxes reduce flexibility in government spending, restricting the power of government relative to the power of its citizens. Governments cannot spend earmarked tax revenues any way that they want; they have to allocate those resources in a pre-specified way (Le Grand 2003). Consequently, hypothecation provides taxpayers with in-built accountability for government spending (Doetinchem 2010).

Hypothecating taxation may be particularly advantageous at times when government is not trusted to spend revenues wisely, or when its priorities are not aligned with those of the public. Earmarking could ensure that funds are spent the way the electorate want them to be.

Public support

Earmarking tax revenues for a popular service, such as health, can reduce the electorate's resistance to a tax rise, or even generate public support for increased taxation (Fabian Commission 2000; Le Grand 2003; Doetinchem 2010). A July 2014 poll by firm ComRes⁹ found that 49 per cent of people would be prepared to pay more tax to help fund the health service, 33 per cent would not be ready to do so, and 18 per cent did not know. In a Guardian/ICM poll¹⁰ from the same month, 48 per cent of respondents said they favoured tax-funded spending increases in the NHS. However, a September 2014 Populus poll¹¹ commissioned by think tank Reform found that two-thirds of Britons would be unwilling to pay higher rates of income tax to fund more spending on the NHS.

Protecting resources

Strong hypothecation is a way of ring-fencing tax revenue for a specific purpose. Thus earmarking taxes can be viewed as protecting resources from competing political interests. As health expenditure is a relatively popular area of public spending, hypothecation could help to protect the health budget (Doetinchem 2010).

9 D Campbell, 'Half of voters happy to pay more tax to fund NHS – poll', Observer, 15 August 2014 www.theguardian.com/society/2014/aug/15/voters-tax-fund-nhs-poll

10 T Clark, 'Poll shows support for raising taxes to sustain NHS', The Guardian, 16th July 2014, Available: www.theguardian.com/society/2014/jul/16/poll-raise-taxes-nhs-funding

11 P Wintour, 'Labour considers staking all on saving the NHS', The Guardian, 16th September 2014, Available: www.theguardian.com/politics/2014/sep/16/labour-staking-all-saving-nhs

5 - Arguments against hypothecated taxes

Strong hypothecation

‘For a hypothecated tax to succeed, the hypothecation must be strong’

Le Grand (2003)

A strongly hypothecated tax is one where the revenue funds a particular program or service solely and entirely. The arguments against such a tax are discussed individually below.

Inappropriate funding levels

Critics argue that health spending should be determined by ‘need’ or ‘demand’ for a service, rather than how much a tax raises (Doetinchem 2010). Strong hypothecation ties spending to a single tax revenue, and would thus make health expenditure dependent on macroeconomic performance.

Spending on health would be exposed to macroeconomic shocks that have nothing to do with the health of the population. Furthermore, tax revenues would fluctuate over the economic cycle, which risks insufficient funding for health services during economic downturns, and wasteful spending during booms. The Barker Commission (2014b) notes ‘demands on the health service may well rise in times of recession (as unemployment produces an increase in anxiety and depression), just when revenues are falling. It makes no sense to spend more on health... in boom times just because revenues are higher.’

Stabilisation fund

One solution is the creation of a stabilisation fund. Extra revenue would be paid into the fund during boom years, and used to supplement revenues during economic downturns. However, such a fund has problems of its own.

Firstly, a stabilisation fund would weaken the direct link between revenues raised and expenditure each year, thereby reducing transparency, one of the main benefits of hypothecation. Secondly, there would need to be strict laws preventing the government from using general tax revenues

to top up the fund, or from redirecting (e.g. borrowing) any surplus revenue, as in the case of National Insurance contributions. Without these stipulations, hypothecation would be weak, and fall prey to the criticisms of weak hypothecation.

Thirdly, a stabilisation fund would require surplus revenues in years when the economy is performing well. Demand for healthcare is widely regarded as being income-elastic; it rises by proportionately more than income (Le Grand 2003; Barker Commission 2014a). Consequently, pressure could be put on the government to spend more during booms, which would negate any benefits of a stabilisation fund. To prevent this from happening, a mechanism would be required to decide how much 'needs' to be spent on health in any given year (Barker Commission 2014b).

Independent body

The Barker Commission (2014b) suggests that an independent body could be created to fulfil this role. Such a body could be 'charged with assessing demand or need within the overall entitlements set by the government of the day, making a judgement on what efficiencies health and social care might reasonably be expected to achieve in any given year, and setting the budget, with the power to vary tax rates to keep the fund in balance' (Barker Commission 2014b). Regardless of whether funds are hypothecated, a mechanism to determine resource allocation is especially important for health care that is free at the point of use, because demand is typically characterised as having no (imminent) upper limit.

Stabilisation role of government

Le Grand (2003) notes strong hypothecation could constrain government's ability to stabilise the economy over the business cycle. During a recession, tax revenues decrease. Consequently, government would have to increase the rate of the hypothecated tax (to maintain spending), or cut expenditure on the designated service (in line with falling tax revenues). Either action would exacerbate a recession, particularly if the area of spending was substantial, as in the case of health. Similarly, in a boom, taxes may have to be cut or spending increased in line with tax revenues, either of which would fuel the boom.

In response to this argument, Le Grand (2003) contends that 'the use of fiscal tools as an instrument of macroeconomic stabilisation... is no longer thought to be as important as it once was, [so] the price might not be all that great'. In any case, a stabilisation fund used to smooth

spending on the service could help to resolve this issue. However, as noted above, stabilisation funds can be problematic.

Tax policy

Just as spending on a service should not be determined by how much revenue a particular tax raises, tax policy should not be designed based on the spending requirements of a particular service. Using a single tax to fund a particular service in its entirety may not be the most efficient or equitable way of funding that service.

Strongly hypothecating a tax for health would require government to do one of two things: create a new tax with revenues earmarked for the health service, or hypothecate the revenues of an existing tax.

Hypothecating a new tax

A new tax could alter income distribution in a way that society deems to be less equitable, though it is worth noting that ‘fairness’ means different things to different people (Heady 1993; Bird and Zolt 2003). Most new taxes have economic costs, which include the cost to government of administering and enforcing a tax, and the cost to individuals and businesses of complying with it. New taxes may also increase economic inefficiency by altering the behaviour of individuals and businesses.¹² The World Bank explains that most taxes:

‘give rise to what economists call “deadweight” or “distortion” costs. Almost every tax may alter decisions made by businesses and individuals as the relative prices they confront are changed. The resulting changes in behavior likely reduce the efficiency with which resources are used and hence lower the output and potential well being of the country. No matter how well the government uses the resources acquired through taxation, governments need to limit the negative consequences of tax-induced changes in behavior’ (Bird and Zolt 2003)

12 The main exception is a lump-sum tax, where the tax burden is the same regardless of any behavioural responses by taxpayers. Lump-sum taxes fall equally on the rich and the poor, and so place a greater relative burden on the latter. For those who believe in assessing tax on the basis of ‘ability to pay’, lump-sum taxes can be unfair (Bird and Zolt 2003). Indeed, Margaret Thatcher’s introduction of a lump-sum tax (the community charge or ‘poll tax’) in 1989 was deeply unpopular, and contributed to her political demise (Mankiw et al 2009).

These costs are not insurmountable, and in any case, proponents of hypothecation may argue the benefits outweigh these problems. However, a new tax should not be considered without pause for concern about its costs to society, both economically and in terms of fairness.

Hypothecating an existing tax

The Barker Commission (2014b) note that the £110 billion income from National Insurance contributions, alongside tobacco, wine and spirit duties, would broadly match current combined health and social care expenditure. Paul Kirby (2014) suggests that NICs alone could be hypothecated for health and renamed 'NHS Insurance'. However, to maintain the current level of NHS funding, NI or 'NHS Insurance' rates would have to be increased.

National Insurance is a tax on workers; it applies to employers and employees under the state pension age. If earmarked for health, NI 'would overwhelmingly switch the burden of paying for the additional costs of health...on to the working population' (Barker Commission 2014b). The older generation, who currently consume roughly two fifths of healthcare, would pay nothing towards increased spending on the health service because they do not pay NI. This is concerning from an intergenerational fairness point of view and prompts questions about who should bear the brunt of tax increases for the NHS.

National Insurance is a more socially regressive tax than, for example, income tax (Barker Commission 2014a). The Upper Earnings Limit (UEL) caps the level of salary on which workers have to pay NI, so that overall those on high incomes pay a lower percentage of their basic salary in tax. Additionally, because NI is levied on earned income, it disproportionately affects those without unearned incomes such as asset wealth or a pension. Harrop (2014) comments 'even if you buy the case for a hypothecated tax rise, National Insurance is the wrong choice for new funding for the NHS'.

An alternative tax, such as income tax, could be hypothecated for the NHS. However, Senior Fellow at the Adam Smith Institute Tim Worstall (2014) stresses that if 'there is no connection... between how much we can raise from one specific tax and how much we want to spend on one particular activity... [then] we shouldn't link one specific tax with one specific area of spending'.

Effects on other taxes

Sections of the public could clamour to opt out of a health tax (Wilby 2014). Strong hypothecation makes it possible to identify individuals'

payments towards healthcare, and thus the amount of tax that they could, at least in principle, opt out of. While government would not be required to provide such an opt-out mechanism, there could be increased pressure to do so.

A health tax would draw more attention to the individual costs of public healthcare, including relative to the (private) alternatives. This could cause renewed calls for an opt-out from those already in favour (e.g. those with private health insurance), as well as additional support for an opt-out from those who might stand to benefit (e.g. individuals without private health care who felt they would be better off opting out of a health tax and purchasing private insurance).

In addition, if health spending were strongly hypothecated, there could be calls for hypothecation in other areas of expenditure. Opposition to taxation for 'less popular' services such as welfare benefits or defence, or to general taxation, could intensify (Wilby 2014).

Public support for tax increases

The notion that hypothecation would increase public support for tax rises if the revenue went to health spending is time and context specific (Le Grand 2003). Some polls indicate public resistance to tax increases would fall if the revenue was earmarked for health, whilst others, such as the September 2014 Populus poll, suggests the contrary.

Le Grand (2003) labels this line of reasoning in support of hypothecation 'unprincipled'. He argues that it 'simply assumes that raising spending is a good thing and hence anything that furthers that end has also to be good. But there can be no presumption that, at all times and in all situations, raising public spending is desirable'. For example, between 2001 and 2005 funding for the NHS increased significantly, yet NHS productivity fell by 2 per cent a year (Peñaloza et al 2010).

Health crises

Widespread medical emergencies, such as the 2009 swine flu pandemic, could make strong hypothecation for health unviable politically. To ensure that the health service had sufficient funds to deal with unexpected health crises, an emergency fund would need to be built in to the health budget. Given the unpredictable nature of health crises, it is likely that this fund would either be too large (and thus an inefficient use of resources), or too small to finance an adequate response. In the case of the latter, it would be politically unviable for any government to not provide the funds necessary to cope with a widespread medical emergency. But, if

government were to top up health expenditure, hypothecation would be weak, not strong.

Alternatively, government could raise the hypothecated tax rate so as to increase the revenue available to the health service. However, there would be a time lag in the availability of such funds,¹³ which would likely make this option politically unfeasible as well.

Evaluation

The strongest objection to this kind of hypothecation is that it would make health spending dependent on macroeconomic shocks and the economic cycle, rather than the health needs or demands of the public. A stabilisation fund could be adopted but would bring with it several problems including weakening transparency, arguably one of the greatest benefits of strong hypothecation.

Public pressure to be able to ‘opt out’ of a health tax is a concern for anyone who doesn’t want to see severe cuts to the health service. Lord Finkelstein (2014) comments that there is ‘the suggestion that people might seek to opt out of [a health tax], which can be answered simply by saying that indeed they might, but they wouldn’t be allowed to’. However, he may well be underestimating the public and political will behind such a move. Furthermore, whether strong hypothecation would be politically viable should additional health funds be immediately required is questionable.

Finally, the economic costs generated by new (or varied) taxes should not be disregarded or downplayed. This is especially pertinent when considering hypothecating NICs for health spending.

13 The assumption – implicit in strong hypothecation – that government raises tax revenue first and then spends the funds on services (causing a time lag between tax increases and spending rises) is contested. In the chicken and egg scenario of spending and taxation, arguably spending, in practice, occurs before revenue is raised; the government borrows or increases money supply to meet any shortfalls in revenue (Murphy 2014).

Weak hypothecation

'A promise of hypothecated tax increases to pay for new NHS spending is a sham that would simply spell more cuts elsewhere'

Harrop (2014)

Figure 2 (see page 12) demonstrates the various ways in which hypothecation can be weak. Surplus revenues from the hypothecated tax could be used to fund a programme other than the one for which it was earmarked (type 1); expenditure on the service could be supplemented by tax revenues from sources other than the hypothecated tax (type 2); or both could occur (type 3).

Transparency, accountability and trust

Under type 1 weak hypothecation, earmarked tax revenues may not be used for their intended purpose. Accordingly, the link between the hypothecated tax and the level of public spending is less clear. Since the earmarked revenues can, in reality, be used to fund any programme government wishes (with some clever accounting), this type of hypothecation does not constrain the power of government or provide accountability for government spending. As Le Grand (2003) notes, 'individuals can no longer be sure that the money they pay through the earmarked tax will be used in exactly the way they have been told it will; and, once that certainty is gone, the trust that the hypothecation is meant to cement between individuals and government will disappear'.

Under type 2 weak hypothecation, government is able to top up spending on a service where it sees fit. This makes the link between hypothecated taxation and government spending far less transparent. Government flexibility in spending is not curbed. Instead, government has the power to increase (or cut) spending on a service by more than the electorate may have intended, weakening accountability and trust.

Protecting resources

Neither type of weak hypothecation guarantees budgets are protected. This is best demonstrated when considering the effect of an increase in the rate of an earmarked tax. In the case of type 1 weak hypothecation, government could divert additional revenue towards (or 'borrow' it for) other programmes, leaving expenditure on the service it was earmarked for unchanged. With type 2 weak hypothecation, government could vary the service's tax funding from other sources so as to counteract any additional revenue raised by the earmarked tax. Neither type guarantees

that an increase in a hypothecated tax rate would lead to an increase in spending on the designated service.

Even if government did ensure that a hypothecated tax rise led to increased expenditure on the service in year one, it is difficult to show how the extra revenue would affect spending in subsequent years. If the budget had already been agreed before the decision to hypothecate a tax increase, identifying the total amount being spent on health would be straightforward. You would simply add the revenue raised through the hypothecated tax increase to the previously agreed budget. That would then allow the government to say that the hypothecated tax resulted in an X% increase in spending on the health service.

Conversely, if the health budget had not been agreed before the hypothecated tax increase was brought in, it would be difficult to make such a claim. If nobody knew what the allocation would have been prior to the decision to earmark a tax increase for health expenditure, then no government could say that the hypothecated tax resulted in X amount of additional spending on the health service. Indeed, the additional funds from the tax increase would more than likely be taken into consideration when setting the budget, rather than viewed as additional to the budget.

Evaluation

Weak hypothecation does not protect budgets, or guarantee that additional revenue increases spending. The Barker Commission (2014b) notes that weak hypothecation is 'a soft form of the idea, and one that may rapidly become a lie'.

In fact, weak hypothecation negates all of the benefits of hypothecation discussed earlier, with the possible exception of public support for tax increases. However, this argument falls prey to all of the criticisms noted in the strong hypothecation section.

6 - Political motivations

‘The idea [of hypothecated taxes] has been seized on both by those who want to defend the public sector who think it would make taxation popular and by those who want to cut public spending who expect the opposite effect’

Wilkinson (1994)

A 1994 paper for the journal *Fiscal Studies* noted the positive interest hypothecation was receiving from politicians on both the left and the libertarian right. Today support for the idea has been similarly cross-party. While the left have focused on weak hypothecation (in particular, earmarked tax rises) and the right on strong hypothecation, both sides have argued that it could play a role in solving the NHS funding crisis. Yet there appear to be differing political motives on each side. Proponents on the left support hypothecation as a means of raising revenue for the NHS, whereas some on the right consider it an opportunity to rethink how far health care should be made free at the point of use.

Raising revenue

On the left, weak hypothecation has been proffered as a way of raising revenue to help save an NHS that is free at the point of use. The idea is based on the perceived loyalty of the electorate to the NHS, and in particular, their willingness to pay more in taxes as long as the extra revenue went towards health spending. Nick Pearce (2014a) contends ‘[d]espite continued efforts to dislodge them from their loyalty to the NHS, the British public remain resolutely supportive of it. So, if we want to be honest about the need for tax rises... [and] ensure that our health services are properly funded without placing untenable pressures on other services, a new NHS tax merits public consideration’. Similarly, Neal Lawson, chair of centre-left think tank Compass, argued a hypothecated tax for the NHS could provide ‘essential extra funding... [and] confidence that the one national institution people still believe in has a future’ (Helm 2014).

Shadow Chancellor Ed Balls has argued that Labour are ‘the only party with a plan to save and transform the NHS’. As part of their NHS funding

plans, Balls announced that Labour would earmark £1.2 billion from a 'mansion tax' for an NHS Time to Care Fund (Balls 2014). The policy is an example of weak hypothecation; the revenue raised from the mansion tax would fund only part of the NHS Time to Care Fund, itself a sub-section of overall NHS expenditure.

Frank Field MP has supported hypothecation in the form of an earmarked increase in National Insurance rates. In a submission to the Labour Policy Review, he proposes increasing NI by 1p for employees and employers, raising the Upper Earnings Limit on employee contributions and hypothecating the additional revenue for NHS spending. He estimates that this would raise around £15 billion by 2020/21 – half of the predicted 2020 cumulative health budget deficit (Field 2014). Nick Pearce argued that an NHS tax or increase in National Insurance could 'play a significant – and immediate – role in reducing the funding gap while maintaining quality of care and keeping the NHS free at the point of need' (Pearce 2014b).

Lord Warner, who previously advised Tony Blair on health reform, advocated higher hypothecated 'sin' taxes on alcohol, cigarettes, sugary foods, betting and gambling to increase the revenue available to the NHS (Warner and O'Sullivan 2014). Meanwhile former Labour Home Secretary Charles Clarke stated recently that he 'strongly support[s] the idea of a hypothecated health tax' (Helm 2014b).

Rethinking spending

On the right, proponents have argued strong hypothecation could spark a debate about how much of the NHS should be provided for free. The idea is that by making the cost of the NHS more visible, strong hypothecation would encourage the public to question what the balance between taxation and health provision should be. Conservative peer Lord Finkelstein stresses that under strong hypothecation it 'wouldn't be possible for the proportion of national income devoted to healthcare simply to drift upwards, without anyone realising. As the proportion rose, it would require a tax rise directly caused by it, which would force a debate about whether the increase was something we really wanted to pay for' (Finkelstein 2014).

Paul Kirby, former special adviser to 10 Downing Street, proposed that the NHS be entirely funded out of National Insurance contributions, renamed 'NHS insurance' (Kirby 2014). It is notable that Kirby's hypothecation suggestion sits alongside other proposals for the reform of the NHS that would move it away from its original ethos and towards a more privatised system. Further, Lord Finkelstein's emphasis on the role strong

hypothecation could play in forcing a debate on ‘how much healthcare we should offer people free at the point of use’ is an indication that the right’s solution to the NHS funding crisis may be at odds with the left’s.

■ Conclusion

The NHS funding shortfall has sparked renewed debate about the strengths and weaknesses of hypothecating taxation for the health service. We have argued that strong hypothecation, though flawed, does have some merits. Weak hypothecation has few, if any.

Strong hypothecation increases transparency, helping to reconnect the public to the purpose of taxation and facilitating debate about the desired balance between the tax burden and spending on a service. It curtails flexibility of public spending, which is an important attribute in times when government is not trusted to spend revenues wisely. However, the inflexibility in government spending it creates is perhaps its biggest flaw.

Strong hypothecation would make health spending dependent on macroeconomic shocks and cycles, rather than health 'needs' or 'demands'. A stabilisation fund could be used to mitigate this problem, but would weaken the benefits of transparency, accountability and trust. The possibility that citizens would clamour to 'opt out' of the tax is a real concern, and should emergency health funds be required, the political viability of strong hypothecation is questionable.

Weak hypothecation has few advantages. It is unlikely to improve transparency, accountability or trust. There is also no guarantee that tax rises (or cuts) would lead to increased (or decreased) spending on a service. In practice, weak hypothecation is little more than a cosmetic exercise.

Perhaps the only strength of weak hypothecation is that it might increase support for a tax rise, if the public were told the extra revenue would go towards health spending. However, since there is no guarantee that additional revenue from a tax rise would lead to increased expenditure on a designated service, weak hypothecation may well be 'little more than a lie' (Barker Commission 2014b).

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