

# **For the Public's Health: Investing in a Healthier Future**

**Committee on Public Health Strategies to Improve Health**

**Board on Population Health and Public Health Practice**

**INSTITUTE OF MEDICINE**  
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- (1) There should be a relationship between the source(s) and public health use;
- (2) The amount of funds that could be raised should be large enough (e.g., commensurate with the magnitude of preventable disease burden the activities are designed to address) and sustainable; and
- (3) Allocation from any given source cannot have substantial deleterious economic effects.

The committee reviewed a wide range of potential sources, and discussed the advantages, disadvantages, and barriers to their use (see Table 4-1, and Sessions, 2011 in Appendix D, for additional discussion of revenue sources). Although a single funding source was viewed by the committee as desirable in that it would reduce the level of complexity involved in establishing a funding mechanism and structures for accountability, the combination of several funding sources may for pragmatic reasons, merit consideration.

As discussed in the committee's report on law and policy (IOM, 2011b), policy tools such as taxes and fees may be formulated to serve dual purposes, for example, to raise funds and to spur more health-promoting behavior (e.g., decrease in consumption alcohol or of sugar-sweetened beverages). Options differ widely on the above criteria as well as their political palatability and on other aspects of feasibility.

**TABLE 4-1** Options for Funding Public Health<sup>15</sup>

<b>Mechanism/Source</b>	<b>Fundraising Potential</b>	<b>Advantages (including meeting the criteria outlined above) and Disadvantages or Barriers</b>
Estate tax: a tax imposed on the transfer of the estate of a deceased person	\$70 billion in 2020 (and \$50 billion annually by 2020) if extended in its current form (according to a Congressional Budget Office estimate)	Stable, and could support education or other factors known to contribute to better health outcomes, it would not have a large negative effect on the economy
Excise taxes: paid at the time of purchase of specific goods	1 cent per ounce of sugar-sweetened beverage would raise \$1.8 billion annually in California and \$1 billion in New York, Florida, and Texas  A national excise tax of 3 cents per 12 ounces of sugary beverage would yield \$50 billion over 10 years (Sussman, 2011)  Standardizing federal taxes on alcoholic beverages to 25 cents per	Could be linked explicitly to public health and may have additional effects on risk behaviors Although alcohol and other "sin" taxes may affect certain vulnerable populations disproportionately (Commonwealth Fund, 2007), some of those groups often bear the heaviest burden of the negative effects of the product

<sup>15</sup> This table is not comprehensive as there are other possible funding options (see also Appendix D). For example using general tax revenues to finance government services allows the government to raise money efficiently (while minimizing distortions caused by taxes). Also, the government could use funds raised by Medicare payroll taxes to support public health activities, particularly those aimed at preventing chronic diseases that will cost Medicare billions of dollars to treat in the future (this would require Congressional action, as well as clear evidence of potential savings but does meet the committee's criteria for reciprocity and reliance).

	ounce of alcohol would increase revenue by \$60 billion over 10 years	being taxed.
Value-added taxes: a form of consumption tax (common in other industrialized countries); it is similar to a sales tax although it is paid at all levels of production on the value added at each level	Wide-ranging	See Appendix D (Sessions, 2011) for additional discussion.
Sales taxes	Taxes imposed by states and localities may range from 1 to 10 percent Tax on remote sales (e.g., Internet) could raise as much as \$22 billion annually in funds currently owed but not collected Another source provides an estimate of \$33.7 billion in revenues lost as a result of online sale taxes not being collected (Brunori, 2007).	See Appendix D
Taxes on medical care, including a transaction tax on health care services, surcharges on health insurance, etc. (health care transaction tax)	Approximately \$50 billion could be raised with a 2 percent transaction tax	This is a broad-based tax to benefit a common good—the services of public health departments. Small increases can generate substantial revenue (Wicks, 2008 ). While there could be objections that the tax increases health care costs, it has the potential to reduce the need for clinical care.
Property tax	Property tax is levied in all 50 states (with a tax rate range of 0.65% in Alabama to 2.57% in Texas in 2007). They are a large source of local government revenue (generate approximately 72 percent of local tax revenues, or 26 percent of total local government revenue). The per capita property tax amount in the US in 2007 at the state level was \$42.21, and \$1,236.00 at the local level [Tax Foundation, 2009]. If the local per capita tax were increased by 5.25 percent (\$65), that could help raise \$20 billion for public	Highly visible tax. Not related to public health. Funds already allocated to other areas so would need to increase the tax to avoid adverse effects.

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Big spenders <sup>7</sup> /luxury goods taxes (higher taxes on items not considered essential or to purchases over a certain dollar amount)	As an example, the luxury tax applied in Arizona on tobacco and liquor yielded \$477 million in fiscal year 2007-2008.	A national luxury tax was implemented in 1990 but was not successful and repealed two years later because the revenues were disappointing. Buyers of luxury items with the higher taxes looked to purchase other items instead. The tax also had a negative impact on sales of luxury items.
Industry taxes for externalities (for example, forcing market participants to pay the additional social costs of their products)	NRC, 2010 reported the following social costs imposed by externalities related to power generation: <ul style="list-style-type: none"> <li>• Coal—70 percent of its market price</li> <li>• Petroleum—¼ of cost of gasoline</li> </ul>	Taxing gasoline for pollutants emitted, sugar for related health care costs, firearm manufacturers for the cost violent crime imposes on society
Tax life insurance proceeds and other things that transfer at death—at state level	In 2010 \$58 billion was paid to life insurance beneficiaries (ACLI, 2012). A 1% tax would yield \$580 million, a 1.5% tax would yield \$870 million, and a 2% tax would yield 1.16 billion annually.	Related to health in that the funds would be used for population health interventions to prolong and improve quality of life.
Intangibles tax: A tax imposed by states or localities on the value of assets such as stocks, bonds, money market funds, and annuities	Varies by state. Only ten states implement an intangible property tax <sup>16</sup> . Only four states have an intangibles tax on business and personal property that also apply to intangible property (such as funds on deposit, promissory notes, rights of court judgments, stock certificates, and bonds) (Tax Foundation, 2008).	Not related to public health and not widely used in the US. Some consider this an “anti-growth” tax because of its effect on businesses if they hold large amounts of their own, or other companies, stock.
Hospital Community–benefit (recently updated IRS requirement that non-profit hospital use their tax exemption to return benefit to their communities) <sup>17</sup>	This could raise up to \$13 billion (Goodman, 2009). “A 2009 IRS study showed that not-for-profit hospitals spent an average of 9% of their total revenues on community benefits.” “The study also	Community-based, could serve as basis for linkages between public health and clinical care, hospitals can reap benefits from investing in healthier communities;

<sup>16</sup> Padgitt, 2010 Index, p. 27-28.

<sup>17</sup> Hospital Community Benefit refers to the Internal Revenue Service requirement—dating back to 1969 (amended by the IRS in 1983) and updated by the Affordable Care Act—that not-for-profit hospitals provide certain services to benefit the communities they serve (such as emergency room care to everyone—even those who cannot pay) and in return receive tax exemption from the federal government. Hospitals are expected to provide to their communities

	<p>found that 58% of the not-for-profit hospitals spent 5% or less of their total revenues on charity care and that slightly more than one-fifth of the hospitals spent less than 2% of their total revenues on community benefits.” Uncompensated care was the largest spending category. Hospital annual revenues in the study ranges from under \$25 Million to over \$500 Million (IRS, 2009).</p>	<p>hospitals may prefer to use the funds differently, the IRS does not at this time require that hospitals partner with public health departments (only that they receive a public health input). However, the final IRS guidance on Community Benefit has yet to be published. See Appendix B for a discussion of the potential implications of the community benefit provision to public health practice (Rosenbaum, 2011). The considerable strength of this potential funding source is its close relevance and relationship to population health. Local support of public health as part of an Accountable Care Organization (ACO) or health home (KFF, 2011) is one of the options being discussed for channeling Community Benefit funds.</p>
<p>Social investment bonds (SIB)—a new tool through which government pays after results are achieved by collaborating public and private actors (including</p>	<p>Wide range is possible. For the 2012 budget the White House proposed up to \$100 million in SIB pilots.</p>	<p>Addresses political challenge of government investments with long-term yields (hard for CBO to calculate), leverages resources of philanthropies and other private sector investors<sup>18</sup></p>

benefits commensurate with the tax exemption they enjoy. The IRS has not detailed the specific composition of what constitutes community benefits and what a hospital must provide to maintain its tax exempt status (CBO, 2006), however states can develop their own standards. ACA (Section 9007) expanded and clarified what is required of hospitals to maintain their tax-exempt status: “give increased attention to working with others to determine community health needs and take action to meet those needs” and “implement financial assistance and billing and collection policies that protect consumers” (Folkemer et al., 2011). Under these new requirements hospitals are obligated to collaborate with public health agencies, and align payment requirements with patient financial capacity. The IRS has published draft guidelines to be implemented in 2012 and requested public comment. The importance to hospitals of community benefit funds may increase as Medicaid Disproportionate Share Hospital (DSH) funding currently allocated to hospitals for services to uninsured and Medicaid patients is phased out beginning in 2014 (Academy Health, 2011). DSH funding totaled \$17.15 billion, including \$7.5 in state and local government funds (NAPH, 2009). This may make it more difficult for public health to claim some of those funds.

<sup>18</sup>Social Investment Bonds (SIBs) are an innovative instrument developed and implemented in the UK, “allowing government to engage private capital to fund ... preventive programs and incur public benefit” (Greenblatt, 2011). In addition to garnering investment in social outcomes, SIBs require success in order to give a return on shareholder investment. The federal government is pilot-testing SIBs under a \$100 million program, and the state of Massachusetts has released a request for information on its own SIB program.<sup>18</sup> SIBs may be one cure for the

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Community Development Financial Institutions (CDFIs)	In 2007, CDFIs leveraged \$621 million in private investments that led to the creation of jobs, development of livable housing, etc.	By definition, CDFIs have a focus on disparities and disadvantaged communities that are typically at greater health risk; dependent on multi-sector collaboration; can be used to advance health in all policies initiatives.
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The last three of the potential funding sources described in Table 4-1 are somewhat different from the rest because they represent public-private funding mechanisms, leveraging government funding or government's financial interest to raise private sector funds or bringing other private sector resources to bear on population health improvement. See Box 4-2 for a discussion of an international public-private model of funding public health, or specifically in this case, health promotion.

**BOX 4-2**

**A Different Model for Funding Public Health/Health Promotion**

An additional model to fund population health activities is found in the not-for-profit or quasi-government health promotion foundations formed by several different countries, including Australian states of Victoria and Western Australia, Canada, Switzerland, Thailand, Scotland, and the Chagnon Foundation in France. The mechanisms used by those countries include

- government-based approach within ministry
- public bodies closely linked to government
- health promotion foundations
- private foundations (International Network of Health Promotion Foundations), 2011.

Extrapolated to the population of the United States, the amounts of funding raised by the Australian states or by Switzerland, which are comparable to the United States in the level of wealth and development, are only a few billion dollars. However the activities of the health promotion foundations represent a fairly narrow set of population-based interventions rather than the full gamut of public health activities in a country. The fundraising models provided by health promotion foundations includes: dedicated excise taxes on alcohol or tobacco (ThaiHealth), a value added tax (Austria), specific appropriations from Treasury budgets (Australian health promotion foundations and the Malaysian Health Promotion Board), and a levy on health insurance (Switzerland).

After considering this extensive range of options, the committee favors a transaction tax on all clinical services because of its pertinence to population health (the first criterion), its ability to raise an adequate level of funds, and the low likelihood of deleterious economic effects. The feasibility of the tax has been demonstrated in Minnesota and Vermont, where funds raised by the tax are used to expand access to medical care (Pacific Health Policy Group, 2012; Wicks, 2008). This tax is known as a "provider tax," "fee," or "assessment" and is implemented through

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political process' aversion to or impatience about investments that yield fruit in the long-term, such as prevention programs in different areas of society, ranging from health to criminal justice.

“a state law that authorizes collecting revenue from specified categories of providers” (NCSL, 2011). In fact, federal law allows the collection of “health care-related taxes” from 19 different classes of health care providers or services (Pacific Health Policy Group, 2012, p. 1). Such taxes have been used to generate state funds for federal Medicaid matching, but states may “designate or earmark the revenue for any state purpose” (NCSL, 2011). They have been used to “raise provider rates, fund other costs of the Medicaid program or be used for other non-Medicaid purposes, such as depositing the funds into the state’s general treasury” (Pacific Health Policy Group, 2012, p. 1).

Among other public health purposes, the tax could be used to strengthen the efforts of public health departments to support their clinical care counterparts in becoming more efficient and effective, and also to further public understanding of and expectations for clinical care. Most states have some type of provider tax, and 30 states tax more than one category of providers (Wicks, 2008), this is generally used to raise provider reimbursement rates (by adding to funds available for this purpose) or expand coverage. The committee believes that using such a tax for the purpose of raising funds to support public health is reasonable, given the need to improve the balance of spending, especially by government, on clinical care and public health.

According to the Minnesota Department of Management and Budget, the state was expected to raise \$512.1 million in revenues from their 2 percent transaction tax (Michael, 2011; Wicks, 2008). Extrapolating from Minnesota’s population of 5.34 million to the US population of 311.6 million, one would expect to raise approximately \$29.9 billion.<sup>19</sup> In Vermont, the tax—which ranges from 0.14 to 6 percent depending on the provider class—is expected to raise \$129.7 million in 2012 (Pacific Health Policy Group, 2012).<sup>20,21</sup> Extrapolated to the current population of the United States and assuming similarly tiered assessments, approximately \$64 billion could be raised. A different way to estimate the total funds that could be raised by the tax is to calculate an assessment of 2 percent on the \$2.05 trillion personal health care line item of the nearly \$2.5 trillion in total national health expenditures (CMS, 2011), which would yield approximately \$40 billion.

Although it imposes a small amount of financial burden on the clinical encounter, a tax on medical care transactions is unlikely to have a substantial deleterious economic effect. And from the perspective of developing a health system that links its activities in clinical care and population-based strategies, a tax in the clinical care setting is a coherent approach for aligning the shared end goal of better health.

Access to medical care is one of the determinants of health. Expanding access is contributing to better population health in Minnesota and Vermont, but population-based efforts have the potential to do so more powerfully. For example, through the implementation of a range of effective tobacco control policies, new generations of Americans are born into a society where norms about smoking and the environmental conditions that surround this behavior have changed dramatically over nearly five decades.

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<sup>19</sup> The estimates extrapolating from Minnesota’s revenues are based entirely on population and do not consider how they might differ from the “average state” on factors that affect revenue—e.g., health care utilization, quality and funding of public health department.

<sup>20</sup> PHPG (2012) calculated that were the 6 percent tax assessed on all classes of providers, nearly \$178 million could be raised in 2013, \$40 million more than the estimated \$137 million expected in 2013.

<sup>21</sup> The estimates extrapolating from Vermont’s revenues are based entirely on population and do not consider how they might differ from the “average state” on factors that affect revenue—e.g., health care utilization, quality and funding of public health department.

The critical goal for both the public and private sectors is to bend the curve on the burden of preventable disease experienced by Americans. A tax that is designed to assist in doing so should seem sensible to employers and health plans that stand to reap the benefits of and savings realized from a healthier population. The funds raised by the tax would be used to meet health needs that clinical care alone cannot (prevention, and especially primordial prevention) and the tax therefore has the potential to be a win-win for insurers and payers. The clinical care system would benefit from contributing to the funding of population based interventions. Improving the healthfulness of physical and social environments is likely to have effects at different levels of prevention. Fewer individuals would enter the clinical care delivery system to receive care for preventable conditions. Transformed community conditions could also contribute to adherence to lifestyle and other factors that are linked to the environment, mitigating illnesses such as hypertension and diabetes. Policies and other interventions could also alter environmental factors to discourage distracted driving, thus affecting a growing cause of injuries and fatalities related to motor vehicles.

The committee believes that new and reliable sources of funding to support public health are needed. The nation's priorities regarding financing clinical care are crystal clear—there is a dedicated, stable, long-term, and vast outlay of funds. Public health practice and population health improvement activities deserve similarly adequate and dedicated funding to meet the nation's pressing health challenges.

**Recommendation 10: The committee recommends that Congress authorize a dedicated, stable, and long-term financing structure to generate the enhanced federal revenue required to deliver the *minimum package of public health services* in every community (see Recommendation 8 above).**

**Such a financing structure should be established by enacting a national tax on all medical care transactions to close the gap between currently available and needed federal funds. For optimal use of new funds, the Secretary of HHS should administer and be accountable for the federal share to increase the coherence of the public health system, support the establishment of accountabilities across the system, and ensure state and local co-financing.**

ACA mandates that only 15-20 percent of every premium dollar can be retained by the insurer to cover administrative, sales, marketing, profit, and other costs. One way to minimize potential negative effects of the tax for population health would be to consider it an allowable “care” expense included among expenditures that qualify toward medical loss ratio mandates. This would be similar to wellness and disease management, and other clinical care initiatives that can be part of the 80-85 cents for each dollar of premium collected by insurers or health plans. By supporting more robust public health action to prevent disease and disability in the population, the tax would deliver health value to beneficiaries.

## CONCLUDING OBSERVATIONS

In this chapter, the committee attempted to provide an answer to the report's central question: how much? Estimating the needs of US public health is a challenging and ultimately, at