Tobacco Taxation and Innovative Health-care Financing

World Health Organization
Regional Office for South-East Asia

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Foreword

The introduction of excise taxes on products that pose risks to health have long been seen as one of the key mechanisms by which additional government revenues may be secured and used for health programmes. These "sin taxes" are certainly not new or innovative because they already exist in most countries of the world for tobacco and alcohol. WHO has steadily advocated for the introduction of an earmarked or dedicated tax on tobacco and alcohol to generate additional revenue for health, especially for health promotion including prevention and control of priority noncommunicable diseases (NCDs). The idea of a dedicated taxation on tobacco and alcohol products for health promotion has been prevalent for some decades in many countries around the world.

Tobacco taxes are earmarked by a number of governments. Countries earmark tobacco tax revenues for different purposes, such as health, education, sports, recreation, tobacco control activities, and the welfare of those involved in tobacco production, etc. Evidence shows that earmarked taxes have succeeded in reducing the use of health damaging products and raising additional funds for health promotion programmes.

An analysis undertaken by the WHO Task Force on Innovative Health Financing in 2009 estimated that low-income countries would need to spend an average of US$ 54 per capita in order to have a fully functioning health system covering a basis package of services. The average health expenditure level for low-income countries is only US$ 27 per capita. The current level and profile of spending on health promotion and disease prevention does not match up to the increasing burden from NCDs. In the light of this, the magnitude and profile of public and private spending on health promotion, disease prevention, and public health services are vital for policy-makers to respond appropriately.

There are various examples of financing health from tobacco taxation. In the WHO South-East Asia Region, India, Nepal and Thailand have established mechanisms to use tobacco taxes for health purposes. Thailand has been progressively taking advanced steps towards innovative financing for health promotion, while tobacco legislation in Nepal adopted in 2011 has more specific provisions for a health tax fund. India has levied a 10% health cess and other tobacco taxes are earmarked for rural health, relief in calamities and the welfare of *bidi* workers.

Globally, countries are looking into more innovative ways of financing health from tobacco taxation. I hope this document serves as a competent reference as well as advocacy tool for decision-makers in their efforts to finance health programmes through tobacco taxation.

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1 Introduction

This paper draws upon secondary sources of information such as existing literature, secondary level data and other empirical evidence to examine cases of how tobacco taxes have been used to finance health-care initiatives within and outside the WHO South-East Asia (SEA) Region. The draft paper was presented to the "Expert Group Meeting on Innovative Financing from Tobacco Taxation for Health Promotion", held in the WHO Regional Office for South-East Asia, on 13-14 June 2011. The paper incorporates the inputs from and recommendations of the Expert Group Meeting.

1.1 Prevalence of tobacco use in Member States of the WHO SEA Region

The prevalence of smoking of tobacco in the Member States of the WHO South-East Asia Region varies from 24.3% in India to 63.1% in Indonesia among adult men, and from 0.4% in Sri Lanka to 15% in Nepal among adult women. Due to the low levels of social acceptance of smoking by women, the use of smokeless tobacco is higher among women than smoking prevalence. It varies between 4.6% in Nepal and 27.9% in Bangladesh. The prevalence of smokeless tobacco use among men varies from 1.3% in Thailand to 51.4% in Myanmar. Although the overall tobacco use among males is high compared with females

in all SEA Region countries, tobacco use among women is on the rise because of the aggressive marketing tactics of the tobacco industry (Regional Profile on implementation of WHO FCTC).

Table 1: *Prevalence of tobacco use, by sex, in select Member States of the Region*

Member States	Age	Smoking (%)		Smokeless (%)	
		Male	Female	Male	Female
Bangladesh	15+	44.7	1.5	26.4	27.9
India	15+	24.3	2.9	32.9	18.4
Indonesia	15+	63.1	4.5	N.A	N.A
Maldives	25-64	37.5	11.8	N.A	N.A
Myanmar	15-64	44.7	7.8	51.4	16.1
Nepal	15-64	34.5	15.9	31.2	4.6
Sri Lanka	15-64	29.8	0.4	24.9	6.9
Thailand	15+	45.6	3.1	1.3	6.3

Source: Bangladesh GATS 2009, India GATS 2009, Indonesia National Socioeconomic Survey 2004, Maldives STEPS Survey 2004, Myanmar STEPS Survey 2009, Nepal Noncommunicable Disease Risk Factor Survey 2008, Sri Lanka STEPS Survey 2006, Thailand GATS 2009.

Findings from the Global Youth Tobacco Survey (GYTS) show that the current use of any form of tobacco among students aged 13–15 years ranges from 8.5% (Maldives) to 54.5% (Timor-Leste) among boys and from 3.4% (Maldives) to 29.8% (Timor-Leste) among girls.

2

Tobacco taxation

2.1 Purposes of tobacco taxation

Taxation of tobacco products is one of the most common sources of government revenue around the world. Three primary purposes for imposing tobacco taxes are (i) raising revenue, (ii) correct for externalities, and (iii) discourage the use of tobacco products *(Gruber J, Sen A, et al 2003)*.

Raising revenue

Tobacco taxes are considered to be an efficient instrument entailing low administrative costs for raising revenue. In the case of the United States, an increase in the Federal cigarette tax was used to finance the Civil War in 1864 and the Korean War in 1951. Before 1960, taxes on cigarettes were enacted and raised to generate revenue rather than to discourage consumption. In Finland, a major increase in cigarette price (a 60% increase in a seven-month period during 1975 - 1976) was intended mainly to increase state revenue *(Teh-Wei Hu 1997)*.

Revenues from tobacco taxes can be substantial in a number of countries and can provide important resources for health, particularly in low-income countries where resources are scarce. WHO estimates show that current

revenues (2008 data) from excise taxes can represent more than 50% of government health expenditures in countries such as the Democratic Republic of Congo, Pakistan or Viet Nam. In 2008, cigarette excise tax revenues generated by a 50% excise tax increase were equivalent to 31% and 26% of government health expenditures in Pakistan and Viet Nam respectively (WHO, 2010).

Correct for externalities

The tobacco tax is expected to correct for the externality tobacco consumption imposes on non-smoking members of society. There are clear negative externalities arising out of tobacco use, given the well documented health consequences of exposure to second-hand smoke (USDHHS 2006). When a person is uninsured, as is the case for most of the population in many low-income countries, the costs for his/her treatment are borne primarily by the family and also to a large extent by the public health-care system. The taxpayers' money spent through the public health-care providers is counted as external cost to society attributable to smoking. Tobacco tax is meant to correct for all these negative externalities to society as a whole.

Discourage the use of tobacco products

Tobacco taxes discourage consumption, most particularly among the poor, the young and new tobacco users, by raising the price of tobacco products (*WHO* 2011). Increasing tobacco prices through higher taxes is the most effective intervention to reduce tobacco use and encourage smokers to quit (*WHO 2008*). Tobacco taxes are generally well accepted and even supported by many smokers, because most people understand that tobacco use is harmful *(WHO 2009)*.

A tax increase can produce a progressive impact because the rich decrease their smoking only slightly in response to a price increase while the poor decrease substantially as they are highly price sensitive. Demand for tobacco products is more responsive to price in low-and middle-income countries than it is in high-income countries. The vast majority of studies estimate price elasticities in the range from -0.25 to -0.5, with most of them clustered around -0.4. This number means that if price was increased by 10% consumption would decrease by 4%. Several studies have modeled and evaluated the addictive nature of tobacco use, finding that demand is more responsive to price in the long run than in the short run *(WHO 2010)*.

2.2 Types of tobacco taxes

Excise and value added tax (VAT) are the most common forms of domestic consumption taxation levied on tobacco products. About 90 per cent of countries levy excise on cigarettes and nearly as many countries levy a VAT *(WHO 2010)*.

Excises

Excise is imposed primarily to raise revenue. Additionally they serve as supplementary taxes on goods the consumption of which governments wish to discourage, for example for health (tobacco, alcohol) or environmental reasons. Excise is easier to administer than broad-based consumption taxes or direct taxes on income.

There are two types of excise taxes: specific and ad valorem. A specific tax is a monetary value per quantity (e.g, pack, weight, carton and piece) of tobacco products. An ad valorem excise tax is levied as a percentage of the value of the tobacco products.

Value added taxes

The purpose of a value added tax (VAT) is to raise revenue from domestic consumption. The trend in the world is for countries to reduce their reliance on import duties and increase their reliance on a broad-based consumption tax *(Sunley EM 2009)*.

In general, VAT is applied as a single rate and on a broad range of goods and services. In principle, VAT is a general tax on consumption of goods and services, leaving relative prices unaffected, and as such has great practical appeal for revenue generation *(WHO 2010)*. It minimizes the amount of detailed information needed for tax administration as only the total value of sales needs to be recorded. Only 30 countries do not levy any VAT tax on tobacco products *(WHO 2010)*.

Import duties

An import duty is a tax on a selected commodity imported in a country and destined for domestic consumption. In general, import duties are collected from the importer at the point of entry into the country.

The main economic functions of import duties are to protect domestic production and raise revenue. As these taxes have lower administrative costs than domestic taxes, countries constrained by the limited resources and a lack of qualified personnel resort to import duties as a straightforward way to raise revenue. Countries with no substantial cigarette production or no excise taxes have a tendency to levy higher import duties on cigarettes for revenue purposes.

2.3 Issues regarding tobacco taxes

The appropriate level of taxation

WHO recommends that tobacco excise tax levels account for at least 70 per cent of the retail prices for tobacco products *(WHO 2010)*.

There is a lack of consensus on the exact nature of the excise burden on cigarettes. As discussed earlier, cigarette taxes are often justified in terms of charging for the external costs of smoking, which would include the direct externalities experienced by other individuals such as health hazards and public nuisance caused by passive smoking, and the collectively borne costs of publicly funded medical treatment for smoking related conditions *(Cnossen 2009)*. Some empirical studies have concluded that tobacco taxes exceed the external costs to society *(Gravelle J and Zimmerman D 1994)*. In controversy, other studies have concluded that tobacco taxes do not cover external costs to society *(Sloan F, et al 2004)*.

Gruber and K. Szegi (2008) conclude that tobacco taxes should exceed the level of pure externalities because failures of individual self control lead to excessive smoking relative to the desired levels. Tobacco taxes can combat failures of self control due to addiction. Given the problems of quantifying the various social costs and offsets, particularly for developing countries with limited data, the World Bank urged that countries which want to adopt comprehensive tobacco control policies, should use, as a yardstick, a rule that tax should account for two thirds to four fifths (67% – 80%) of the retail price of a pack of cigarettes (World Bank 1999, WHO 2011). This yardstick is widely used in discussions of tobacco control.

However, the World Bank's yardstick refers to total taxes and not excise. An excise yardstick would be preferred because cigarette excise raises the price of cigarettes relative to the prices of other consumer goods. In contrast, a general consumption tax at a standard rate does not change relative prices and will thus have a minimal effect on smoking.

Affordability

Various measures of affordability of cigarettes are an alternative to the World Bank's yardstick. These measures take into account income and the price of cigarettes. The two most common measures of affordability are: (i) median minutes of labour to purchase a pack of cigarettes, and (ii) the percentage of per capita GDP required to purchase purchasing 100 packs of cigarettes *(Blecher E, van Walbeek C. 2008, Sunley EM 2009)*.

In general, if tobacco products become more affordable in a country, which has been the pattern in many developing countries, it may suggest that tobacco excises have been sufficiently raised to outweigh the positive effect of income growth.

Specific vs. Ad Valorem excise regimes

Excise on cigarettes can be specific levies or ad valorem levies. Most specific excise is levied per cigarette or per 1000 sticks of cigarettes. Ad valorem excise can be based on the ex-factory price the wholesale price or the retail price. When the excise is levied on the ex-factory price, the rate is usually a tax-exclusive rate, i.e. the base does not include the tax.[1] When the excise is levied on the retail price, the rate may be a tax-inclusive rate (the base includes the tax) or the rate may be a tax-exclusive rate.

A strong case can be made for countries adopting a specific tax regime for cigarettes. First, if the primary purpose of the cigarette excise, in addition to raising revenue, is to discourage consumption, the tax should be levied on the characteristic to be discouraged; that is, the number of cigarettes consumed. Second, an ad valorem excise has a multiplier effect, which leads to larger price differentials between high- and low-priced cigarettes, which in turn encourages brand switching to cheaper brands whenever the ad valorem rate is increased *(Sunley EM 2009)*.

1 Thailand is an exception; it levies a tax inclusive rate on the ex-factory price.

3

Earmarking of tobacco taxes

Earmarking – assigning revenues from designated sources to finance designated expenditures – is a long-standing and popular practice in many countries around the world *(Bird RM 1998, Sunley EM 2009)*.[1]

Earmarking can be *substantive* or *symbolic*. Earmarking is *substantive* when the earmarked revenues flow into a special fund and are the sole, or at least at the margin the incremental, source of funding for a particular expenditure item. The revenue directly affect expenditures: an increase in revenue means an increase in expenditure on the linked service and a decrease in revenue means a decrease in expenditure. Substantive earmarking is characterized by specificity and strong revenue-expenditure linkage *(Bird RM 1998, Bird RM and Joosung J 2005)*. The *strong* or *tight* link implies that all or most of the revenue goes towards financing a particular expenditure, and that the expenditure does not benefit (significantly) from other financing sources (e.g. the general fund) *(WHO 2010)*.

Symbolic earmarking on the other hand is "irrelevant" in economic terms. The earmarking is strictly "window dressing". Certain types of taxes (or charges) are designated to help pay for particular government services, but the revenues

1 Earmarking also may be defined more widely to encompass such practices as the requirement to spend a specified dollar amount (for example, from a conditional grant) or a given percentage of the budget on particular activities, or the hiving off of some aspects of government activity into special funds or separately financed agencies or enterprises or territorially based jurisdictions (Bird 1997).

from these taxes flow into a general (or consolidated revenue) fund and finances only a portion of the government service in question. At best, there is in such cases only a very loose connection between the growth of earmarked revenues and higher levels of government spending in the designated area.

No close link exists between the amount of earmarked revenues and the volume of services to which the earmarked revenues are nominally tied. The amount of earmarked revenues may rise (or fall) while the level of associated services that are provided remains the same. In contrast to substantive earmarking, the marginal expenditure decision thus remains firmly in the hands of the budgetary authorities *(Bird RM 1998, Bird RM and Joosung J 2005)*. Thus in case of symbolic earmarking the revenue-expenditure linkage is *weak* or *loose*. This implies that only a portion of the proceeds of the tax finances the expenditure in question, and/or the expenditure benefits (significantly) from other financing sources *(WHO 2010)*.

Furthermore, the earmarking can be *specific/narrow* or *broad/wide* (e.g. social security, education). There may or may not be an identifiable benefit rationale *(Bird RM 1998, Bird RM and Joosung J 2005)*. Bird (1997) categorizes eight distinct types of earmarking with reference to three different aspects of the way in which taxes and expenditures are connected: (i) the degree of specificity of the expenditures involved; (ii) the strength and nature of the linkage between the earmarked revenues and the expenditure; and (iii) whether or not there is an identifiable benefit rationale for the linkage. The earmarking for tobacco taxes is classified as Type D earmarking. There is a conceivable group "benefit" connection, but the connection between the taxes collected and the expenditures made in the broad area for which the revenues are earmarked is quite loose.

4

Uses of earmarked tobacco taxes

The idea of dedicated taxation for health promotion has been introduced for some decades in countries around the world. WHO has steadily advocated and has recently strengthened its efforts aimed at the introduction of earmarked or dedicated taxes on tobacco and alcohol to reduce consumption of these products and to generate additional revenue for health, especially for health promotion, including prevention and control of priority noncommunicable diseases.

Tobacco taxes are earmarked by a number of governments. Early examples of earmarking tobacco taxes include India's Bidi Workers' Welfare Cess (1976), and dedicated tobacco taxes in New Zealand between 1978 and early 1980s. Some countries that earmark tobacco tax revenues include Argentina, Australia, Costa Rica, Ecuador, Egypt, Estonia, Finland, Iceland, India, Korea, Philippines, Nepal, Thailand, Taiwan, the United States, the United Kingdom. Jamaica, Panama, Mongolia, Qatar, Iceland *(WHO 2009c, WHO 2010, Thomson G. 2007),* Guatemala and Djibouti. All these countries earmark all their revenues from tobacco taxes to health. Mongolia, Thailand and Qatar devote 2% and Bulgaria 1%, of tobacco tax revenues to health. In Tuvalu, a specific amount of two cents per cigarette is allocated for the health sector *(Sloan F, et al 2004)*.

The countries earmark tobacco tax revenues for different purposes: health, education, sports, recreation, tobacco control activities, the welfare of those

involved in tobacco production, etc. For example, Argentina uses earmarked tobacco taxes to address the economic and social problems of tobacco growing areas through the Special Tobacco Fund.

A WHO study in 2004 lists eight countries and three American states where part of the tobacco tax revenue is dedicated to tobacco control. Five of the countries are in Europe (Finland, Estonia, Poland, Slovenia and Iceland) and three in Asia (Thailand, Korea and Qatar). The American states are California, Arizona and Massachusetts (*Carol A 2004 and Thomson G. 2007*). A later study by WHO in 2009 found that earmarking tobacco taxes for health purposes is practised by more than 20 countries around the world (*WHO, 2009c*).

In California, 57% of the excise tax funds the Children and Families First Trust Fund, 29% is spent on health education, hospital services, physician services and research, and another 2% of the excise tax funds the Breast Cancer Fund. In the light of the success of an earmarked tobacco tax in California, similar earmarking of part of the state excise on cigarettes also takes place in Kentucky (mainly on cancer research), Louisiana (primarily for tobacco prevention), Massachusetts (mainly on health insurance) and Oregon (mainly for the health fund). Studies from California found, for example, that cigarette consumption has been reduced as a result of increases in both taxes and tobacco control activities funded by the tax increase.

Other types of funded activities include programmes for the protection of children, the elderly and disabled populations in (Costa Rica), education (Costa Rica, Iceland, Korea, India), emergency care (El Salvador, Paraguay), and sports activities (Colombia, Estonia and Australia) (*WHO 2010*).

In Egypt a fixed amount of levy of 10 piastres per pack of 20 cigarettes has since 1992 been used by the government to provide health insurance to students. It was to reduce the insurance burden on the government. This, however, has not been revised to keep in line with the inflation rate. As a result, the real value of these taxes has been falling over time (*WHO 2006, Hanafy et al 2010*). In July 2010, Egypt increased taxes on tobacco substantially. However, the earmarked "health" tax applied to all brands remained at 10 piastres.

In 1987 the Victorian Health Promotion Foundation (VicHealth) in Australia was established with the passing of the Victorian Tobacco Act. It is funded from government-collected tobacco taxes and is mandated to promote health in the State of Victoria, Australia. Since its establishment while continuing to focus on strengthening tobacco control initiatives, VicHealth has broadened its activities to include healthy lifestyles, prevention and early detection of

disease, and research and development (VicHealth 2010). A 5% tax was levied on the sale of tobacco products in 1987 to finance health promotion *(Galbally R, ed 1995)*.

The opinion over earmarking of taxes is divided. The main argument against earmarking is that it may introduce rigidities in the budgetary process that limit the use of funds for alternative purposes, discouraging the optimal allocation of resources and hence reducing social welfare (*Bird 2010*). New Zealand had a dedicated tobacco tax from 1978 until the early 1980s. A small extra excise duty for tobacco and alcohol was introduced, and the revenue was used specifically for community health purposes under the control of the Department of Health. The dedicated status of the tax on tobacco was removed by 1982, and the control over the extra revenue was removed from the Ministry of Health. There were a number of efforts made to regain such a tax in the 1980s and 1990s. The treasury has persistently opposed dedicated taxes in general. There are, however, three health-related dedicated taxes (for alcohol, accident and gambling control), as well as others outside the health sector. Advocacy for introducing a dedicated tobacco tax for tobacco control activities continues. Currently, government funded tobacco control in New Zealand is provided for general revenue as part of the government's budget for the Ministry of Health. Those in favour of earmarking point out that tobacco control is under-funded. They claim that any tobacco tax hike that is dedicated to tobacco control is far more likely to get the support of the public and smokers than one that is not (*Thomson G. 2007*).

The arguments in favour of earmarking include insulating health spending from competition from other competing needs, particularly when government health spending is low or unstable. An earmarked tax could increase and stabilize resources. Earmarked tobacco taxes can promote equity. For instance, many publicly provided health insurance programmes target lower-income populations when a portion of the taxes is used for poor populations particularly when smoking rates among the poor are high. Tobacco farmers and those employed in tobacco manufacturing bear part of the burden of adjustments resulting from higher tobacco taxes. In the short run, earmarking part of the new revenues from a tobacco tax for crop-substitution and retraining programmes can significantly reduce any impact on tobacco growers and producers.

5

Global Solidarity Tobacco Levy (STL): A recent development

Global Solidarity Tobacco Levy (STL), a global levy on tobacco products, is currently under discussion as an innovative financing tool for health, particularly for NCDs and tobacco control. WHO tabled it during the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control held in Moscow in April 2011. It emerged from the 2009 recommendations of the High-Level Task Force on Innovative Financing (WHO 2011).

The STL proposes a micro-levy on tobacco products in all G 20[1] Plus countries and to use the additional proceeds in totality or as a proportion generated for international health financing purposes through a pooled funding system. It is proposed that the STL will be dedicated to NCDs and tobacco control in low/lower middle income countries.

WHO calculates that in excess of US$ 7 billion could be raised each year if STL were to be fully applied in all G 20 Plus countries and hence represent a significant new source of additional funding for health. A small increase in tax can create significant revenue either for national use or contributions to the pooled mechanism:

1 The G-20 Plus countries include the 19 G-20 countries, the 23 Member States of the European Union which are not members of the G-20, as well as Chile and Norway, a total of 44 countries.

- Additional US$ 0.05 applied in high-income G 20 Plus countries would raise US$ 4.3 billion.
- Additional US$ 0.03 applied in upper-middle income G 20 Plus countries would raise US$ 1.7 billion.
- Additional US$ 0.01 applied in the G 20 Plus lower-middle income countries would raise US$ 1.6 billion.

In an earlier study for WHO, Stenberg et al (2010) estimated that a 50% increase in tobacco taxes would generate US$ 1.42 billion in additional funds in 22 low-income countries. If all of this were allocated to health, it would allow government health spending to increase by more than 25% in several countries, and at the extreme, by 50%. The study used data for 22 of the 49 countries classified as "low-income" (in 2009) by the World Bank and price elasticity of demand estimate of -0.6. This implies that an increase in price of 10% will lead to a decrease in consumption of 6%, which is in the mid-range of published estimates for low-and middle-income country settings. In countries such as the Lao People's Democratic Republic, Madagascar and Viet Nam, the extra revenue could represent 10% and more of the total expenditure on health. In countries such as Congo, the Lao People's Democratic Republic or Viet Nam, the extra revenue would be equivalent to an increase in current government health expenditure by more than 25%. In the South-East Asia Region, studies show that cumulative revenue gains from increasing tobacco prices by 5% in real terms annually could bring in an extra US$ 440 million in Nepal, US$ 725 million in Sri Lanka and US$ 994 million in Bangladesh (estimates for 2010) (World Bank and WHO 2003).

The modalities on allocation and management of STL are still under discussion. The concept needs to be discussed further by Member States with respect to political feasibility, management and investment of funds (WHO 2011).

The concept of solidarity levies is not new. Solidarity levies have been used in different contexts. The Leading Group on Innovative Financing for Development[2] was established in 2006 with the aim of promoting innovative financing to fund development through solidarity levies, particularly on airline tickets. Since the founding conference in Paris in 2006, the Leading Group has expanded by gathering 63 countries, international organizations, foundations and NGOs[3]. For example, France committed to allocating 90 per cent of the total

2 www.leadinggroup.org/rubrique177.html
3 www.leadinggroup.org/rubrique173.html

revenue to UNITAID and 10 per cent to the International Finance Facility for Immunization, or IFFIm (Leading Group 2010, Brookings Institution 2007).

The air ticket solidarity levy is charged to passengers taking off from airports in the countries implementing the scheme. Transit passengers are exempted from paying the levy. A unit tax (a fixed amount, not a percentage) is added to the price of a ticket, with the amount depending on destination and class of service.

Rates can vary for domestic and international flights, flight distance and the travel class. The fee enabled France to generate an extra €160 million in conventional aid in 2009, of which 90% was dedicated to UNITAID's international purchasing facility (Leading Group 2010).

Airline companies are responsible for collecting the contribution which is added to the fees and charges that are already part of the plane ticket final price. Collecting costs are minimal. Such a flat contribution, provided it is non-discriminatory, is in line with the Chicago Convention, bilateral treaties and agreements, European regulations and WTO agreements. The mechanism is based on territoriality, not nationality. All airline companies, whatever their nationality, have to levy the contribution if departing from an airport located in a participating country (Leading Group 2010).

Currently a "Global Solidarity Levy (GSL)" on currency transactions is under discussion to fund this gap which was exacerbated by the recent global financial crisis that is undermining governments' ability to meet their pre-existing commitments. The proceeds of the GSL would be paid into a proposed Global Solidarity Fund, a financing facility for global public goods (Leading Group 2010).

6

Earmarking of tobacco taxes in the WHO South-East Asia Region

6.1 India

The Indian market for smoking tobacco is dominated by *bidis* (also known as *beedis* and *biris*). Roughly eight *bidis* are consumed for each cigarette (Sunley 2009).

India imposes specific excises (per 1000 sticks) on both bidis and cigarettes. For bidis, the rates depend on whether the bidis are handmade or machine-made – almost all bidis are handmade. Bidis produced by manufacturers producing less than two million sticks a year without machines are exempt from the excise. Tax compliance is low in the bidi sector, as there are thousands of bidi manufactures and the manufacturing is highly fragmented *(Sunley EM 2009)*.

For cigarettes, the excise rates vary by the length of the cigarette. Prior to 2008, the excise rates were lower for non-filter cigarettes than for filter cigarettes. The 2008 Finance Bill raised the rate on non-filter cigarettes to

be on par with the rates on filters of the same length. Under this reform, the rate on micro non-filter cigarettes (≤60 mm in length) was increased 387 per cent and the rate on regular non-filter cigarettes (>70mm-70mm in length) was increased 142 per cent. The rates on filter cigarettes and bidis were not increased *(Sunley EM 2009)*.

The excises on bidis and cigarettes are imposed under India's Central Value-Added Tax (CENVAT). Bidis and cigarettes are not subject to the 8% standard rate that applies to most manufactured goods[1]. The CENVAT is a VAT-like levy that applies only through the manufacturing stage. States also levy a VAT on goods through the retail level, but cigarettes are not taxed at the state-level (Sunley 2009)[2].

The excise duty on cigarettes comprises four parts: (i) Basic Excise Duty (BED), (ii) National Calamity Contingent Duty (NCCD), (iii) the Health Cess (HC), (iv) 3% Cess.

Beedi Workers Welfare Cess

The *Beedi* Workers Welfare Cess (BWWC) was introduced in 1976 under the *Beedi* Workers' Welfare Fund Act, 1976. The revenue from the BWWC is consolidated into a single fund which is administered by the Ministry of Labour and Employment. The Ministry of Labour and Employment is administering five welfare funds for *bidi*, cine and certain categories of non-coal mine workers (Ministry of Labour and Employment, 2010)[3].

The funds are used for various welfare schemes for *bidi* workers in areas such as health, education, housing and recreation. Since 1 April 2006, the BWWC is Rs 5 per 1000 sticks.

National Calamity Contingent Duty

The National Calamity Contingent Duty (NCCD) was introduced in 2001 following a major earthquake in the state of Gujarat. The NCCD is a surcharge by way of duty or excise levied on goods specified in the Seventh Schedule of the Finance Act of 2001. The goods subject to NCCD include tobacco products,

1 The CENVAT rate was reduced from 14% to 10% in December 2008 and to 8% in February 2009, as part of stimulus packages adopted to fight the world-wide fiscal crisis. (Sunley 2009)

2 In the budget speech for the 2009-10 (July 6, 2009), the Government of India did not increase the excise rates on cigarettes or bidis, in part, because the government adopted an expansionary fiscal policy to stimulate economic growth.

3 http://labour.nic.in/annrep/

petroleum products, high-tenacity yarn of polyester, and motor vehicles (Sunley 2007). It is earmarked for relief to states affected by calamities. The revenue collected from the NCCD is transferred to a single fund maintained by the Central Government. The Central Government transfers to state governments on the basis of recommendations of the National Centre for Calamity Management.

The NCCD is applied on all tobacco products, including smokeless forms, at varying rates. For example, the NCCD accounts for 7% of the total excise on bidis, 11-12% of total excise on cigarettes, and 19% of total excise on smokeless products such as *gutkha*[4].

Health Cess (HC)

In 2005-2006 the Government of India introduced a new dedicated levy called the Health Cess (HC). This HC applies to most smoked and smokeless tobacco products. Health Cess is an additional excise duty of approximately 10% on basic excise duty. In the 2005 Budget Speech[5] in Parliament it was proposed that the specific rate on cigarettes would be increased by about 10 per cent and a surcharge of 10 per cent on ad valorem duties on other tobacco products including *gutkha*, chewing tobacco, snuff and *paan masala* would be imposed. *Bidis* are exempt (Government of India, 2005). The revenue from this levy is used to help finance the expenditures of the National Rural Health Mission (NRHM). The contribution to the NRHM is part of the regular NRHM budget. There is no Act mandating that the Health Cess be used for NRHM as in the case of the *Beedi* Workers Welfare Cess.

6.2 Indonesia

Indonesia is the leading producer of sweet-smelling clove-flavoured *kretek* cigarettes, which comprise over 90% of the domestic cigarette market. About 40% are handmade and 60% machine-made. Indonesia differentiates its excises on cigarettes based on the producer's annual production. In 2009 Indonesia initiated a reform process to simplify its cigarette excise regime *(Sunley EM 2009)*.

Law no. 39/2007 on excise duty stipulates that the government allocate 2% of its total national revenues from tobacco excise for health programmes,

4 http://www.searo.who.int/LinkFiles/TFI_tax-NRHM.pdf
5 Paragraph 136. Budget Speech 2005-2006

social welfare, tobacco control, as well as law enforcement for smuggling.[6] This arrangement has been implemented since 2008. However, this allocation, known as the Profit Sharing Fund from Tobacco Excise (DBH CHT), only goes to excise-producing provinces and/or tobacco-producing provinces. In 2011 with the amount of IDR 1.2 trillion (approximately US$ 141045842), it covered 341 municipalities within 20 provinces out of the 33 in Indonesia. This fund is allocated to the provincial and municipality governments for administering through the transfer mechanism from the Central Government.

Furthermore, the government is in the process of revising the legislation to bring more specificity to the nature of activities that can be funded.[7]

It is proposed that the initial focus of the reform will be on government tax revenue, and over time greater weight will be given to health concerns. In 2009 Parliament passed Law No. 28/2009 concerning local taxes and charges regulating an additional tobacco tax, called the Cigarette Tax, which will be equal to 10% and is to be levied on the current cigarette excises collected by the government. It will be effective from 1 January 2014. At least 50% of the revenues from the cigarette tax shall be earmarked to fund public health services and law enforcement by authorized officials *(Sunley EM 2009)*.[8]

6.3 Nepal

Nepal has raised the excise duty on tobacco, beer and alcohol for the past several years. In 1993, Nepal introduced a one paise health tax per stick of manufactured cigarette (domestic or imported) and cigar. It was raised to 2 paise in 2003-2004 on cigarette and cigar only but not on chewing tobacco. This was discontinued after 2005.[9] The revenue generated was deposited in a separate public account, called the Health Tax Fund, for financing activities relating to prevention and treatment of cancer, tuberculosis, and other diseases. The major proportion of the fund (more than 65%) was actually used for supporting the B.P. Koirala Memorial Cancer Hospital, and 20% was used for supporting the Nepal Cancer Relief Society and other community zonal hospitals. The remaining balance of the fund was used for supporting the activities of the National Health Education, Information and Communication Centre of the Ministry of Health. The percentage share of health tax collected in total tax revenue, however, constituted only 0.3% in 2006.

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6 Ministry of Finance Regulation (PMK) No. 84/PMK.07/2008, amended PMK No.20/PMK.07/2008 further elaborate upon activities/programs that can be funded from the earmarked tobacco excise. (Personal Communication with Mr Aan Prianto on June 26 2011);

7 Personal communications with Dr Lily Sulistyowati

8 Law No.28/2009 (Personal Communication with Mr Aan Prianto on June 26 2011)

9 Communication with Director, NHEICC, Nepal

Although the taxes on tobacco have been revised every Nepali fiscal year including the introduction of 13% VAT, since 1994 the health tax has remained the same. Initially 75% of the health tax revenues were earmarked for cancer programmes and 25% for health promotion activities. Currently, the funds are disbursed to government and nongovernmental institutions for preventive, promotive and curative services for communicable and noncommunicable diseases based on the recommendations of National Planning Commission and Ministry of Health and Population[10].

Section 22 of the recently adopted "Tobacco Product (Control and Regulatory) Act 2010" is on the Health Tax Fund. It states the following:

(1) The Government of Nepal shall establish a Health Tax Fund for controlling smoking and tobacco products consumption and the prevention and control of diseases caused by the consumption of such products.

(2) In the fund established under sub-Section (1), the fund as prescribed shall be deposited in addition to the annual fund allocated by the Government of Nepal.

(3) No amount allocated pursuant to sub-Section (2) shall be less than the amount allocated in the previous year.

(4) The amount deposited in this fund under this Section shall be spent as prescribed.

6.4 Thailand

In Thailand 85% of ad valorem excise on cigarettes is levied at a single rate. Thailand has increased its cigarette excise more rapidly than inflation. In January 1992, the rate was set at 55% of the ex-factory price. The excise has increased by over 365% between 1992 and 2009 (Sunley 2009).

Thailand is one of the pioneers among ASEAN nations to implement innovative financing for health promotion by utilizing dedicated taxation on tobacco and alcohol products, after more than a decade of effort towards legislation. Two comprehensive tobacco control laws were enacted in 1992. There were low-budget interventions on tobacco control and requests for more budgets through the conventional method were unsuccessful. The budget was

10 http://www.nep.searo.who.int/EN/Section4/Section48.htm

decreasing despite increased revenue from tax increases, even though the government is endorsing tobacco control policy.[11]

The Royal Government of Thailand enacted the Health Promotion Foundation Act in 2001 and established the Thai Health Promotion Foundation (Thai Health) as an autonomous public agency under the direct control of the Prime Minister and having to report annually to Parliament.

The two main features in the Act include (i) a regular and sustainable funding source (a surcharge tax), and (ii) an autonomous health promotion agency.

Thai Health has 21 members appointed by the Cabinet. It is chaired by the Prime Minister with the Health Minister as the First Vice-Chairman and an expert as the Second Vice-Chairman. There are nine high-ranking officials from eight ministries such as Finance, Transport, Interior, Labour and Education, and one from the National Economic and Social Development and eight highly independent experts from a multidisciplinary mix in the fields of health promotion, community development, mass communication, education, sports and culture, law, as well as adminstration. Its main objective is to advocate, stimulate, support and provide funding to various public and private organizations for health promotion activities with a view to reducing cases of infirmity and premature deaths from noncommunicable diseases.

The source of funding is a 2% dedicated tax on tobacco products and alcoholic beverages over and above the existing taxation. This is popularly known as "Sin Tax". The funding from Thai Health had been used for supporting over 700 projects, which include engaging civil society for massive community mobilization on tobacco and alcohol control, injury prevention, mainly road traffic injuries, health promotion for elderly, and community capacity strengthening.

Currently, Thai Health is supporting 13 plans: Tobacco Consumption Control; Alcohol Consumption Control; Traffic Injuries and Disasters Prevention; Health Risk Factors Control; Health of Specific Group of Population; Health Promotion in Community; Children Youth and Family Health; Health Promotion in Organizations; Physical Activities and Sports for Health; Social Marketing and Communication; Open Grants and Innovative Projects; Health Promotion through Health Service Systems; Supportive Systems and Mechanisms; and Development for Health Promotion. In 2010 Thai Health spent 5.3% (US$ 5.3

11 Powerpoint presentation by Prof Prakit Vathesatogkit at the forum *Partners for Health in SEA, 2011*.

million) of its total revenue of US$ 100 million on tobacco control activities (Thai Health, Vathesatogkit 2011).

The reason behind advocating for a surcharged (dedicated) tax and not the General Budget was to ensure a regular and sustainable budget. A dedicated/ specific source of funding provides a predictable and more stable amount of budget and is less susceptible to diversion of funding for other purposes.

7

Discussions

At a meeting organized by the International Agency for Research on Cancer (IARC) in Lyon, France, in May 2010, a group of 20 international experts on economics, epidemiology, public policy and tobacco control recommended that governments should dedicate tobacco tax revenues for comprehensive tobacco control programmes and health promotion activities so that these initiatives can lead to further reduction in tobacco use and improvements in public health *(Chaloupka FJ and Straif K, Leon ME 2011)*.

Tobacco taxes are earmarked for different purposes: health, education, sports, recreation, tobacco control activities, the welfare of those involved in tobacco production, etc. Internationally, there has been a growth of health promotion agencies primarily funded by earmarked tobacco taxes such as the Thai Health Promotion Foundation (Thai Health) and Victorian Health Promotion Foundation (VicHealth). These agencies have primarily focused on health issues. These are characterized by long-term funding security, relatively independent governing boards, and acceptance by a wide range of political and other stakeholders (Thomson G. 2007).

Currently, only nine of the 53 countries in the WHO's European Region earmark taxes for tobacco control and other public health measures. The average level of allocation is less than 5% of total tax revenue (WHO, 2009c). Within the SEA Region the proportion of earmarked tax going for tobacco control

measures is negligible. In 2010 Thai Health spent 5.3% (US$ 5.3 million) of its total revenue of US$ 100 million on tobacco control activities. It is not clear what percentage of BWWC and Health Cess funds in India has been allocated for tobacco control activities.

The recently adopted "Tobacco Products (Control and Regulatory) Act, 2010" of Nepal states that a Health Tax Fund will be established for controlling smoking and tobacco products consumption and to aid the prevention and control of diseases caused by consumption of such products. The law clearly indicates that the amount deposited in the Health Tax Fund shall be spent as prescribed.

Regarding earmarked taxes the following should be considered and reviewed:

(1) ***Inflation***: In SEA Region countries earmarked taxes have not kept in pace with inflation with the exception of Thailand. Since 1 April 2006 the *Beedi* Workers Welfare Cess (BWWC) in India remains at Rs 5 per 1000 sticks. The health tax of 2 paisa per stick in Nepal has not been revised since 2004 even though taxes on tobacco have been revised every Nepali fiscal year. Meanwhile, Thailand has increased its cigarette excise more rapidly than inflation. In January 1992, the rate was set at 55% percent of the ex-factory price. The excise has increased by over 365% between 1992 and 2009.

(2) **Impact of earmarked tobacco taxes:** There is a lack of analysis of the actual functionality and impact of earmarking of tobacco taxes. Within the SEA Region neither has any evaluation of the *Beedi* Workers Welfare Fund in India or the Sin Tax in Thailand been undertaken.

(3) **Diversion of earmarked funds:** The implementation of a dedicated/ earmarked tax may be as important as its establishment. Unless the revenue for tobacco control is allocated to a separate administrative body, there is a proven danger that the funds will be diverted to other uses.

(4) **Intersectoral coordination:** Intersectoral coordination is essential for successful implementation of earmarked taxes. ThaiHealth builds on the strong collaboration between different ministries which meet regularly.

(5) **Revenue-expenditure link:** An analysis undertaken by WHO (2010) found an overall weak revenue-expenditure link (Annex Table 1).

This indicates that earmarked tobacco taxes finance only a portion of the earmarked expenditure and the expenditure in question benefits from other financing sources. This in turn implies that much of the tobacco earmarking is "symbolic" rather than "substantive". A *strong* or *tight* link implies that all or most of the revenue goes towards financing a particular expenditure, and that the expenditure does not benefit (significantly) from other financing sources. In contrast, a weak revenue-expenditure linkage implies that only a portion of the proceeds of the tax finances the expenditure in question, and/or the expenditure benefits (significantly) from other financing sources (*Bird 1997, Bird and Jun 2005, WHO 2010*). In the SEARO Region the *Beedi* Workers Welfare Cess (BWWC) in India and Sin Tax in Thailand offer examples of strong linkages (Annex Table 2).

(6) **Mandatory contribution of earmarked tobacco taxes:** The Thai Health Promotion Foundation (ThaiHealth) was established under the Health Promotion Foundation Act 2001 and the *Beedi* Workers Welfare Cess (BWWC) was established under the *Beedi* Workers' Welfare Fund Act, 1976. This led to a flow of earmarked taxes to these on a sustained basis. However, there is no clarity on the funds that NRHM received from the Health Cess. It is not mandatory for the Ministry of Finance to allocate the funds from the Health Cess to NRHM under any Act.

Additional questions that need to be answered prior to earmarking (*Bird and Jun 2005*) include the following:

(1) Is the earmarking for a fixed time-period or indefinite?

(2) Is the rate of the earmarked tax fixed or subject to change as part of the normal budgetary process (in which case the "earmarking" has no real significance)?

(3) Must the earmarked revenues be spent in the period in which they are received?

Additionally, it is important to take feasibility, tax administration costs and accompanying issues such as increase in tax evasion, switching to cheaper substitutes, etc. into account when proposing increase in the earmarking of taxes.

8

Recommendations and way forward

8.1 Determining funding gaps

It is important to ascertain funding gaps for tobacco control initiatives. As a starting point, countries should conduct assessments on adequacy of current funding for tobacco control and health promotion in relation to the measures required to address the tobacco burden.

8.2 Use of earmarked funds to strengthen tobacco control measures and health

Renewed emphasis needs to be placed on the use of earmarked tobacco taxes for tobacco control activities. The need for it gets highlighted from the fact that only a small number of countries use earmarked tobacco taxes for tobacco control and public health.

In this context the following areas need to be taken into consideration:

(1) Evaluating earmarking of tobacco taxes: It is important to assess the impact and functionality of proposed mechanisms. Evaluation of the *Beedi* Workers Welfare Fund in India and Sin Tax in Thailand can be a starting point.

(2) Having safeguards in place to prevent diversion of earmarked funds.

(3) Keeping pace with inflation.

(4) Building strong intersectoral coordination for successful implementation of earmarked taxes. The Ministry of Finance should be involved when exploring the introduction of these taxes.

(5) Making contribution for earmarked taxes mandatory: Contribution of earmarked taxes to be used for specified purposes should be made mandatory through legislation.

8.3 Promoting agencies focusing on health promotion

Agencies such as VicHealth and Thaihealth should be promoted for financing health promotion, including tobacco control. The following parameters should be met for promoting such kind of foundations (*Thomson G. 2007*):

- long-term funding security,
- relatively independent governing boards, and
- acceptance by a wide range of political and other stakeholders.

8.4 Identification of innovative financing from tobacco taxation other than earmarked tax

Innovative financing mechanisms such as the following measures should be explored and piloted:

- Global Solidarity Tobacco Levy (STL).
- Tapping corporate tax exempted for corporate social responsibilities of tobacco companies (Note: Guidelines for Article 13 of the WHO FCTC recommends prohibition of corporate social responsibilities of tobacco product companies).

- Taxing duty-free tobacco products.
- Oil tax for tobacco control, involving OPEC.
- Taxing junk food/soft drinks.
- Taxing currency transactions.
- Engaging large business conglomerates and big entrepreneurs.

8.5 Allocating funds for research on innovative financing for tobacco control and health promotion

- Evaluation of existing institutions and impact of earmarking of tobacco tax within the SEA Region to gather evidence in support of introduction of innovative financing through tobacco taxation in the remaining SEA Region countries.
- Exploring sources of innovative financing through tobacco taxation in these countries using cost-effectiveness analysis.
- Integrating country-specific research on innovative financing through tobacco taxation with the tobacco control and health policy research of that country.

9

Conclusion

Earmarked or dedicated taxes have been shown as a successful tool to finance health promotion. The advantage of this instrument is that the funds cannot be taken away easily by competing programmes. They raise additional source of funding for health programmes, supplement the budget and assure stable and secured source of funding if made into a mandatory contribution by law. Earmarked taxes act as an alternative source for specific causes and usually target the poor.

Earmarked taxes may have some disadvantages as well. The funds can formally not be used for other programmes even when prioritized, thus limiting the government's discretion to use funds. When separate institutions are founded, health system fragmentation and duplication of efforts may occur. Issues of fairness, extracosts for separate transaction and administration, distortion of incentives and cumbersome financial management are some of the disadvantages identified by experts.

However, evidence shows that earmarked taxes have succeeded in reducing the use of health damaging products and in raising additional funds for health promotion programmes in various countries. Health Promotion Foundations over the world have been implementing successful programmes. The number of countries adopting their models in their own setting is growing.

The paper has looked into earmarked tobacco taxes in the South-East Asia Region. It shows that strong political commitment and multisectoral coordination are keys to the sustainability and effective use of funds generated from earmarked taxes. Mandatory contribution of earmarked tax for a designated purpose by legislation is vital to achieve the desired results and to ensure a stable source of funding.

More research is needed to explore the feasibility of recent developments such as the Global Solidarity Tobacco Levy.

WHO would continue to support the Member States to advocate with policy-makers on an harmonious increase of taxes on all forms of tobacco products in accordance with the provisions of WHO FCTC. Health impact studies and studies on tobacco economics should be supported for being carried out in all Member States. These studies will support advocacy for the urgent need to enhance tobacco control in the Region.

10

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Annex

Table 1: *Link between tax and spending programmes in countries earmarking tobacco tax revenues by Region:*

Region/ country	Number of countries/ states	Link between tax and spending programme	Type of spending programme
Africa	3	Weak	Broad spending examples: youth, sports and recreation (Madagascar),University hospital of Brazzaville (Congo), health (Comoros).
Central and South America	9	Weak	Broad spending examples: health (El Salvador, Guatemala, Jamaica), education, social and old age security (Costa Rica), sports (Colombia), debt cancelling and Anti-Cancer Commission (Uruguay), agriculture, including subsidies to tobacco producers (Argentina), emergency relief (Paraguay). Narrow spending examples: oncology institute (Panama).

Region/ country	Number of countries/ states	Link between tax and spending programme	Type of spending programme
Europe	10	Weak	Broad spending examples: health, social security, culture. Narrow spending examples: smoking prevention, treatment of tobacco-related diseases (Finland, Iceland, Poland, Serbia and Switzerland).
United States Of America (Federal and states)	36	Weak	Federal: Broad (Children's health insurance policy) States: Broad in all States. Often revenues are shared among spending programmes according to predetermined percentages. Spending examples: health, education, sports and recreational activities.
North Africa and West Asia	7	Weak	Broad: High Council for the Youth (Jordan), Solidarity National Fund (Tunisia). Narrow: tobacco control and treatment of tobacco diseases (Yemen), tobacco control (Djibouti, Iran and Qatar), health insurance for students (Egypt).
South-East Asia	3	Weak	Broad: health (India, Nepal, Thailand), social security (India).
Western Pacific	6	Weak	Broad: health (Korea, Mongolia, Philippines), education (Marshall Islands), railways and forest special service accounts (Japan) Narrow: tobacco control (Tuvalu).

Source: Countries Earmarking Tobacco Tax Revenues by Region WHO (2010)

Notes: WHO data collection through the GTCR questionnaire and personal communication. This table is not exhaustive, and relies on publicly available information from government websites. 1/ "Weak": Tobacco revenues are partially earmarked, or spending benefits from earmarked revenues also benefits from other financing sources (e.g. General Fund). "Tight": All revenues are earmarked and the spending programme is exclusively financed by earmarked revenues. 2/ "Broad": Spending programme is broadly defined (e.g. health, education). "Narrow": Spending programme is narrowly defined or specific (e.g. smoking prevention).

Table 2: *Link between tax and spending programmes in the countries earmarking tobacco tax revenues in the SEA Region that earmark tobacco tax revenues*

Country	Programme	Link between tax and spending program	Type of spending programme
India	The *Beedi* Workers Welfare Cess (BWWC)	Strong	Health, education, housing and recreation.
	The National Calamity Contingent Duty	Weak	Relief to states facing calamities.
	Health Cess	Weak	Finance expenditures of the National Rural Health Mission (NRHM).
Thailand	Sin Tax (2% surcharge levied on alcohol and tobacco)	Strong	Funds Thai Health Promotion Foundation (ThaiHealth).

Health-care financing continues to be a contentious issue in most Member States of the WHO South-East Asia Region. While making an effort to address the concerns about health services delivery and accessibility, matters regarding mechanisms of financing and budgeting must also be taken into account. To this end, a collaborative and consultative Expert Group Meeting aiming at fostering ideas and exchanging thoughts was organized at WHO SEARO, New Delhi, India, on 13-14 June 2011.

Following this meeting, the document titled *Tobacco Taxation and Innovative Health-care Financing* was developed. It highlights the empirical evidence and existing literature on tobacco taxation, the practices of earmarking taxes for specific projects or programmes in Member States, and innovative methods of financing health-care.

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