

Innovative Financing from Tobacco Taxation for Health Promotion

Report of the Expert Group Meeting
SEARO, New Delhi, 13-14 June 2011

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1. Introduction and rationale

Studies have shown that tobacco taxes are the most cost-effective way to reduce tobacco consumption. Increasing taxes on tobacco products reduces consumption, especially among the low-income group and the youth. Article 6 of the WHO Framework Convention on Tobacco Control, “Price and tax measures to reduce the demand for tobacco”, states that price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, particularly young persons. WHO has provided technical support to its Member States for implementation of tax and price measures to reduce demand for tobacco.

Further to that, in the WHO South-East Asia Region earmarked taxes from tobacco have been dedicated to health promotion, particularly tobacco and alcohol control. In Thailand, health tax is being applied to all sticks of manufactured and imported cigarettes since 2001, which is 2% of the excise tax revenue. The Thai Health Promotion Foundation (ThaiHealth) was established in 2001 as a health promotion funding mechanism that draws a 2% surcharge levied on alcohol and tobacco excise tax, generating approximately US \$ 50 million to 60 million a year. In 2001, the Cabinet passed the Thai Health Promotion Foundation Act, B.E. 2544, to establish a progressive financial mechanism for health promotion. This foundation works as a catalytic funding agency for civil movements that lead to the improvement in the well-being of Thai citizens. In 2008, about 23% of the tobacco revenue for ThaiHealth was spent for tobacco control.

The Government of India levies several different dedicated taxes on the production of *bidi* and cigarette products. The Beedi Workers’ Welfare Cess (BWWC) was introduced in 1976 and is one of the earliest examples of such a dedicated tax in India. The revenue from the BWWC is consolidated into a single fund which is administered by the Ministry of Labour and Employment. The funds are used to meet expenditures of various schemes that support the welfare of *bidi* workers in key areas such as health, social security, education, housing, recreation and water supply. The BWWC is currently applied at a rate of Rs 4 per 1000 sticks, which

represents 29% of the total excise rate (Rs 14 per 1000 sticks) levied on *bidi* and cigarettes.

The National Calamity Contingent Duty (NCCD) was introduced in 2001 following a major earthquake in the state of Gujarat, and has been institutionalized nationally as an earmarked levy to provide calamity relief to states. The revenue collected from the NCCD is transferred to a single fund maintained by the Central Government, and transfers to meet the calamity relief expenditures of individual state governments are made on the recommendation of the National Centre for Calamity Management. The NCCD is applied to all tobacco products including smokeless forms but 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 *hookah* and *gutkha*.

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 although with the notable exception of *bidis*. The HC rate also varies according to products, although it is by only a small amount in comparison with the NCCD (e.g. it accounts for 8% – 9% of the total excise on cigarettes and about 12% of the excise rate on *hookah* and *gutkha*). The revenue from this levy is used to help finance the expenditures of the National Rural Health Mission (NRHM) which was established by the Government in order to improve health infrastructure and to strengthen health systems in India's rural areas.

Therefore, there is a need to identify opportunities and challenges of such initiatives (ThaiHealth, NCCD, BWWC) and explore innovative ways of health financing through earmarking tobacco taxation for health promotion incorporating prevention and control of NCDs. NCDs are the leading cause of death in the Region accounting for 55% of all deaths. The rapidly rising trend of NCDs threatens poverty alleviation efforts and economic growth in the Region. Tobacco use, improper diet, physical inactivity, and harmful use of alcohol are the four major modifiable risk factors of NCDs. Tobacco control measures should be integrated with prevention and control of NCDs. It is also urgently required to identify innovative ways of financing for NCD prevention and control as Member States have done in the area of tobacco control. It is aimed that the discussions and recommendations from the consultation will serve as sources for a policy paper to be used as an advocating tool for earmarking part of the tobacco tax for NCDs.

Against this background, the Expert Group Meeting on Innovative Financing from Tobacco Taxation for Health Promotion was organized at the WHO Regional Office for South-East Asia, New Delhi, from 13 to 14 June 2011. It was attended by ten experts from Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand, as well as WHO staff from the Country Office for India. The background, objectives, agenda, list of participants and the policy document are attached in the Annexures.

The meeting consisted of presentations, panel discussions and group work. This report presents the highlights of the discussions and summarizes the outcomes of the meeting. It chronicles the output of the group work and panel discussions, the policy paper and the conclusions and recommendations that ensued.

2. Opening session

Dr Athula Kahandaliyanage, Acting Regional Director, welcomed the participants. He stated that although health promotion is widely recognized as a cost-effective way to reduce the burden of disease and to improve health, financial resources for health promotion are still inadequate in both developed and developing countries. He pointed out that only about 3% of the total health expenditure on an average is allocated to health promotion programmes even in Member countries of Organization for Economic Cooperation and Development (OECD).

The Acting Regional Director suggested that innovative financing mechanisms need to be identified and encouraged in the wake of the increasing financial constraints. He said that earmarked or dedicated taxes have proved to be a successful tool to generate funds for health promotion, and evidence shows that these taxes have succeeded in reducing the use of health damaging products in addition to raising funds for health promotion. He stated that in the South-East Asia Region, earmarked taxes from tobacco have been successfully dedicated to health promotion, particularly in the area of tobacco and alcohol control in the countries such as Thailand and India.

Dr Athula Kahandaliyanage also said that the meeting would basically focus on earmarking tobacco taxation as a means to health financing and identify other innovative ways of generating funds for health promotion. Also, the deliberations were expected to throw up inputs to the policy

document that is under development. The Acting Regional Director expressed the hope that the meeting would come up with comprehensive recommendations for future directions on tobacco taxation.

3. Business session

Dr D.C. Jain, Deputy Director-General, Department of Health and Family Welfare, Government of India, was nominated as the Chair of the meeting. Dr Shilpa Modi Pandav was nominated rapporteur.

Dr Nyo Nyo Kyaing, Regional Adviser, Tobacco Free Initiative, WHO-SEARO, presented the background and objectives of the meeting (See Background and Objectives in Annexure 1 and 2).

4. Panel discussions

4.1 Tobacco taxation in the WHO South-East Asia Region

Dr Nyo Nyo Kyaing, Regional Adviser, Tobacco Free Initiative, WHO-SEARO, made a presentation on "Tobacco taxation in the South-East Asia Region". She briefly dwelled upon the current situation of tobacco use in the Region and stressed on the complexity of tobacco use, which imposes a formidable challenge to tobacco taxation in the Region. She said that more than three-fourths of all smokers in India, Thailand and Myanmar use indigenous tobacco products such as *bidi*, *cheroots* and *kreteks*. A variety of smokeless tobacco products are also consumed in the Region. The prevalence of tobacco products among men varies from 1.3% in Thailand to 32.9% in India and 51.4% in Myanmar.

In her presentation, she discussed briefly about the status of national tobacco control legislation in Member States. She said that ten out of eleven Member States of the Region have ratified the WHO Framework Convention on Tobacco Control, nine countries have comprehensive tobacco control laws in line with the Framework Convention in place, and the remaining two countries have some regulations in force for tobacco control.

Dr Nyo Nyo Kyaing also stated that Article 6 of the WHO Framework Convention has provisions for implementing tax policies and price policies on tobacco products to contribute to the health objectives aimed at reducing tobacco consumption. She stressed that taxation of tobacco products is an important tobacco control measure since increasing the price of tobacco through higher taxes has been found to be the single most-effective way to decrease consumption and encourage tobacco users to quit. Scientific evidence shows that a 70% increase in the price of tobacco could prevent up to a quarter of all smoking-related deaths worldwide. Findings from 1999 published in a World Bank study show that a 10% increase in the price of cigarettes through higher taxation would reduce their use by about 4% in developed countries and by about 8% in low and middle income countries.

She then presented the status of taxation on cigarettes in the South-East Asia Region. She explained that tax differentiation among different tobacco products is high and this reduces the potential health benefits of tobacco taxation and can undermine other tobacco control interventions. There exists a wide disparity between the taxes levied on cigarettes and on indigenous products in the Region. Indigenous products have low taxes or not taxed at all compared with cigarettes. For instance, in India, the tax on *bidis* is trivial compared with that on cigarettes, even though 10 *bidis* are smoked for every cigarette.

The Region faces many challenges in the area of tobacco taxation, some of which include the intense lobbying by the tobacco industry and multinational companies, the relatively low tax rates, the absence of a mechanism for inflation and income-adjustment in the tax rate, tax evasions, and weak administrative enforcement of tax regimens. Dr Nyo Nyo emphasized that net tax imposed exclusively on manufactured cigarettes is a major challenge posed by the strong lobby of the *bidi* industry and this prevents governments from imposing higher taxes on *bidis*. She also discussed that cigarettes are becoming more affordable since inflation has not been taken into account in their price analysis when governments have raised taxes on them over the years. With inflation and increased consumer purchasing power, cigarettes are becoming relatively more affordable even in countries where the tax accounts for a large proportion of the purchase price.

4.2 Financing for health through taxation of tobacco: The Thai experience

Mr Supakon Busai and Ms Thantida Wongprasong from the Thai Health Promotion Foundation made a presentation on the Thai experience. They emphasized that health promotion goes beyond the mere perception of health education, which indeed requires thinking out of the box. Between 1990 and 1995, tobacco control had low budget for interventions and even requests for more budget through the conventional method did not yield results.

The budget for tobacco control was decreasing despite increasing revenue from periodic tax hikes and despite the fact that the government was endorsing the tobacco control policy. The idea of setting up a "health promotion fund" originally arose from the want of secure funding for supporting tobacco control activities. Back then, Thailand was facing high morbidity and mortality from preventable causes, including tobacco, despite the commitment of the MoPH and the rising cost of health care. It was found that there was no point in putting an additional 1% in the general budget of the Ministry of Public Health, whose average growth was 13% between 2002 and 2007.

The Thai Health Promotion Foundation Act 2001 mandates establishing the Thai Health Promotion Fund as an autonomous state agency, requiring 2% of all taxes on alcohol and tobacco to go to this fund. The funding is used for tobacco and alcohol control programmes as well as health promotion activities. Two main features of the Thai Health Promotion Foundation Act are (i) regular and sustainable funding source, and (ii) an autonomous health promotion agency.

The Thai Health Governing Board consists of 21 members appointed by the Cabinet. The Prime Minister is the Chairperson of the Board and the Minister of Public Health the First Vice Chair. There are nine high-ranking officials from eight ministries such as finance, transport, interior, labour, education and one from National Economic and Social Development. It also comprises eight distinguished members from multidisciplinary backgrounds such as academics, community leaders and NGOs.

In 2009, the budget of the Thai Health Fund was 1.6% of the budget of the MoPH and 0.6% of the total health expenditure. After the establishment of Thai Health and the multisectoral network, nine national

alcohol policies had been adopted within four years and incidence of traffic accidents has been on a decline. There was also a decline in the economic burden of smoking-related diseases including lung cancer, coronary heart disease and chronic obstructive pulmonary diseases.

4.3 Taxation Policies on Tobacco Products in Thailand

Dr Isra Sarntisart from the Centre for Development Policy Studies, Bangkok, discussed the taxation policies on tobacco products in Thailand. He said that the elasticity of the demand for cigarettes in Thailand was most sensitive to income than own and cross price. [Own price: - 0.3925; income: 0.7049 and cross price: -0.0047 to 0.0012]. However, price elasticity did not show much difference within various age groups. There are two types of tax rates in Thailand: Exclusive rate (T_o), which is based on the pre-tax price; and inclusive rate (T) which is based on the post-tax price or the price that includes the tax.

Relationship between T_o and T is $T_o = T / (1-T)$

E.g. if $T = 80\%$ (or 0.8), $T_o = 0.8/0.2 = 4$ (or 400%).

In Thailand, the inclusive rate (T) has been applied. Moreover, the official factory price is the price that includes the excise tax. It is not the factory price that is generally defined. In his presentation, Dr Isra Sarntisart explained about the hypothetical price changes, average shares of basic price, industry margin and all taxes on the retail price and the nominal and real marginal cost of cigarette production.

It was discussed that the ideal situation would be to have a higher total tax with lower industry margin that would discourage the production and increase the tax revenue. For other tobacco products, the excise tax rate has been fixed at 0.1%. Between 1992 and 2007, while there was a ten-fold increase in cigarette excise tax from 55% to 85% there was no change in the excise rate for hand-rolled tobacco products. It was also found that the rate of excise tax on cigarettes has no significant impact on the prices of hand-rolled tobacco products. Thus, the effectiveness of cigarette price policy to control smoking has been partly offset by the low prices of other tobacco products.

Dr Isra also talked about illicit trade in tobacco products. He estimated that around 15.5% of imported cigarettes smoked in Thailand in 2001 were illegally imported. He argued that higher retail prices would not

necessarily reduce tobacco consumption because the industry can utilize the higher revenue and float a bigger share of produce to promote tobacco consumption that can actually offset the effect of higher retail price on cigarette demand. His findings showed that most of the time, the excise tax rate was increased only up to the point where official factory price (including excise tax) matched with the general consumer price level. Increases in excise tax rate did not raise the relative prices of cigarettes over those of other goods. There is no real effect of price on cigarette demand. To have a real effect, the cigarette retail prices should increase faster and higher than the inflation rate. This can be done by an increase in the excise tax rate as well as by making a serious verification of the declared basic prices of cigarettes that basically has to follow inflation.

4.4 Taxation Policies on Tobacco Products in India

Dr D.C.Jain, Deputy Director-General, Department of Health and Family Welfare, Government of India, made a presentation on tobacco taxation in India. He said India is the second largest tobacco growing and consuming country in the world. A plethora of tobacco products, both smoking and non-smoking, are available at a very cheap rate in India. Tobacco consumption is intricately interwoven into the social and cultural fabric of people's lives in India. Over a hundred varieties of tobacco are consumed and the pattern of use varies from state to state.

Cigarettes of various lengths are taxed at different specific rate per 1000 sticks. *Bidis* are taxed at specific rates depending upon machine-made or hand-made (per 1000 sticks). Types of taxes on tobacco levied by the Central Government include central excise, the National Calamity Contingency Fund (surcharges), special excise duty, ad valorem (levy of Additional Duty on *pan masala* and other tobacco products) and the Bidi Workers Welfare Cess.

States in India levy VAT (value-added tax) on all tobacco products. During the last Budget, some states have increased VAT across all tobacco products. Rajasthan increased VAT up to 40% on all tobacco products uniformly.

In 2005–2006, the Government of India introduced a new dedicated levy imposed on tobacco products called the Health Cess (HC). However, *bidis* are exempted from this cess. Revenue collected goes to the

Consolidated Fund of India (general pool of resources). The revenue from this Health Cess is used to help meet the expenditures of the National Rural Health Mission (NRHM).

Dr D.C. Jain said *bidis* are considered “poor man’s luxury” and therefore is taxed at a very low rate. He recommended that research specific to India be conducted to study the consequences of low taxation on certain tobacco products. A plethora of tobacco products coupled with non-uniform tax structure is known to encourage switching over from relatively expensive tobacco products to cheaper ones. He described that on an average, duties on cigarettes account for as much as 85% of the revenue generated from tobacco taxation even though they represent only 14% of tobacco consumption. Other tobacco products such as *bidis* and chewing tobacco account for 86% of total tobacco consumption but constitute only 15% of the revenue generated from tobacco tax. He projected that raising *bidi* taxes to Rs 98 per 1000 sticks would add Rs 36.9 billion to tax revenues and prevent 15.5 million current and future smokers from dying prematurely. Similarly, increasing cigarette taxes to Rs 3691 per 1000 sticks would further add Rs 146.3 billion to tax revenues and prevent 3.4 million premature deaths in India.

4.5 Innovative financing from tobacco taxation for health promotion

Dr Shilpa Modi Pandav, an economist who prepared the background policy paper, made a presentation on tobacco taxation and innovative health-care financing. First, she defined earmarking as assigning revenues from designated sources to finance designated expenditures. Earmarking can be described as of two categories: (i) substantive earmarking; and (ii) symbolic earmarking. Substantive earmarking is characterized by specificity and strong revenue-expenditure linkage whereas in symbolic earmarking revenue-expenditure linkage is weak. A strong or tight link implies that all or most of the revenue goes towards financing a particular expenditure and that expenditure does not benefit from other financing sources. In symbolic earmarking, only a portion of the proceeds of the tax finances the expenditure in question and expenditure benefits significantly from other financing sources.

The 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 impeding social welfare. Arguments in favour of earmarking include insulating health spending from other competing uses, particularly when government health spending is low or unstable.

Dr Shilpa described the earmarked taxes in India, Nepal and Thailand and the proposed earmarked taxes in Indonesia. In the South-East Asia Region, the Bidi Workers Welfare Cess (BWWC) in India and Sin Tax in Thailand offer good examples of earmarked taxes being implemented effectively. However, in the Region, earmarked taxes have not been keeping pace with inflation except for Thailand. Thailand has increased cigarette excise more rapidly than inflation. The excise has increased by over 365% between 1992 and 2009. The BWWC in India remains at rupees 5 per 1000 sticks since 2006.

There is concern over the lack of evaluation of the impact and functionality of earmarked taxes. It was found that in 2010 Thai Health spent 5.3% of its total revenue of US \$ 100 million on tobacco activities. It was not clear what percentage of BWWC and Health Cess funds in India were allocated for tobacco activities. The recently adopted Tobacco Product (Control and Regulatory) Bill, 2010, on the Health Tax Fund in Nepal states that the fund will be established for controlling smoking and tobacco product consumption.

Dr Lily S. Sulistyowati, Head of the Centre for Health Promotion, Ministry of Health, Republic of Indonesia, also made a presentation on Utilization of Cigarette Excise for Health Promotion in Indonesia. She described that Decree No. 37 of 2007 mandates 2% of total tobacco excise revenue to return to the local government of regions (provinces and cities) that produce cigarettes and cultivate tobacco. This fund can be used for increasing tobacco leaf quality, promoting the cigarette industry, social welfare including local health promotion, pro-poor and pro-job programmes, dissemination of tobacco excise policy in local areas and law enforcement of tobacco excise policy in local areas. In 2008, the Central Java Province received funds from tobacco tax of about Rupiah 4.2 billion which has been managed by the Ministry of Health and used for implementing tobacco control activities. It has been proposed that 50% of the collectable cigarette tax will be earmarked for financing comprehensive health programmes and law enforcement. It has been proposed to utilize cigarette excises for health programmes through the Ministry of Finance Decree to cover promotive, preventive, curative and rehabilitative services.

4.6 Discussion points

The discussions highlighted:

- Discrepancies in the information were pointed out in the percentage of tobacco taxes compiled by WHO for Thailand, Myanmar, Indonesia, Nepal and Bangladesh. Myanmar and Indonesia have no ad valorem tax. The tax reported for Bangladesh was for the medium tier. A recent study that used weighted average daily consumption showed that taxes were lower than 50% (45% in 2010). Since India has a federal structure, the state tax structure should also be taken into account. In India, four states have introduced VAT on tobacco products. Rajasthan has introduced 40% VAT on both cigarettes and *bidis*.
- Effectiveness of the price policy to control smoking has been partly offset by the low prices of other tobacco products. Because of the increase in cigarette prices, cigarette smokers can switch from cigarettes to cheaper hand-rolled tobacco products to some degree. Thus the excise tax rates on other tobacco products should be increased to discourage that switch. Although there has been an argument that the tax increase in these tobacco products will harm poor smokers and poor producers in rural areas, these products are as dangerous as cigarettes.
- Tax increases, if not adjusted to inflation, will lead to increasing affordability of cigarettes in the Region. Basic prices of cigarettes need to follow inflation.
- Inadequate capacity of tobacco control advocates in the area of tobacco taxation is a big constraint in the Region.
- Renewed emphasis needs to be placed on the use of earmarked tobacco taxes for anti-tobacco activities such as media campaigns, prevention programmes, subsidization of tobacco cessation products and programmes and other activities to reduce tobacco use.

- The pros and cons of earmarked taxes should be discussed widely. Additional questions that need to be answered prior to earmarking include whether the earmarking is for a fixed or indefinite time-period. It is prudent to remain flexible while proposing for earmarked taxes because tax administration costs and accompanying issues such as increase in tax evasion and switching to cheaper substitutes need to be taken into account.
- There is the possibility of duplication of health promotion funds in the Region.
- “World Bank Yardstick”: WHO should exercise caution in promoting the World Bank Yardstick which refers to total taxes and not excise taxes. In fact, WHO has its own yardstick that suggests that excise tax should account for 70% of the retail price. This would be a better measure to promote for the Region.
- Production Index also needs to be monitored.
- There is a need to find a middle ground in regard to the formula for Optimal Tax and adopt a holistic approach to dealing with earmarking although it may be a challenge to implement it.
- It is important to calculate price elasticity. There are challenges posed by the availability and accessibility of relevant data. Cross-price elasticity should also be calculated because rises in taxes will lead to substitution to cheaper products.
- Thai Health promotes collaboration among different ministries. Even ThaiHealth is a new governance structure. It faces political pressure to use and disburse funds. During the parliamentary session, the Prime Minister attends all the meetings. The Board with representatives from different ministries meets regularly. It was pointed out that this will be a difficult model to follow in other countries such as India and Indonesia.
- It is important to sensitize different religious groups. In Thailand, some Buddhists and Muslims consider using sin tax as religiously unacceptable. In Indonesia too, one Muslim organization

declared consumption of tobacco to be a sin while the other maintains that it does not violate religion.

- During the Indian presentation, lack of coordination with other ministries was identified as a key challenge. Health Cess is approximately a 10% surcharge on excise. The contribution to the NRHM is part of the regular NRHM budget. There is no clarity on the amount that the finance ministry receives as Health Cess and the amount that gets transferred to the Ministry of Health. This will form only a small percentage of the total NRHM budget.
- The study on taxation policies on tobacco products in Thailand presented by Dr Isra indicated that the ad valorem tax on ex-factory price translates into lower tax than originally intended.

5. Group work on advocating to policy-makers on innovative financing from tobacco taxation for health promotion

The participants were divided into two groups and worked on the following:

- Discussions/views/opinions on the pros and cons of earmarked/sin taxes.
- Identification of innovative financing from tobacco taxation other than earmarked tax: the national, regional and international experience.
- Discussion on recent developments such as solidarity tobacco levy.
- Add points/views to the background paper that will be included in the policy paper, in addition to inputs on earmarked tobacco taxes from respective countries.
- Pros and cons of earmarked taxes are as follows:

Pros	Cons
<ul style="list-style-type: none"> ➤ Additional source of funding. ➤ Budget supplementation. ➤ Assured/stable/sustainable/secured source of funding. ➤ Priority setting. ➤ Targeting the poor. ➤ Central-local government relationships/interface. ➤ Government latitude to use the fund for specific purpose. ➤ Alternative source for a specific cause. 	<ul style="list-style-type: none"> ➤ Fairness issues. ➤ Separate transaction/administrative costs. ➤ Distortion of incentive. ➤ Limits the government's discretion to use fund. ➤ May not use fund in the right cause and can be counterproductive. ➤ Financial management may become cumbersome—fund may not be channelled to the targeted use or pro-poor purposes.

- Intersectoral coordination and consultation was considered the key to garnering the support for raising the earmarked tax. However, there is a need to assess the impact of earmarked taxes in terms of how they are being used and the outcome of their investment. Addressing the issues of transparency, accountability and good governance may help organizations or institutions in managing the earmarked taxes effectively.
- Identification of innovative financing from tobacco taxation other than earmarked tax (national, regional and international experiences):
 - Tapping corporate tax exempted for corporate social responsibilities of tobacco companies.
 - Taxation on duty-free tobacco.
- 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. While discussing the innovative means of financing tobacco control programmes, considerable interest was generated around the solidarity tax. The idea of raising funds through a solidarity tax seemed possible but questions over the mechanism of tax collection, nature of contributions and defining beneficiaries would require further discussions at the national level.

- In addition to earmarked tax, building an endowment is another possibility of generating funds for tobacco control. An endowment in Hong Kong for the quality education fund is a good example where the government provided the initial seed money. Such a fund could be generated for a limited duration till a sufficient fund is secured through regular sources.
- However, there is growing concern that the government's excessive reliance on the tobacco tax may lead to a conflict of interest. This implies that overdependence may create a situation where the tobacco industry's interest would have to be taken into account just for the sake of revenue. In order to curb the likeliness of such a situation, first there should be an assessment of the proper costs and prioritization of tobacco control activities. Then the resources required to run the programmes could actually come from the general taxation, not necessarily from the tobacco tax.
- Some other innovative financing options are: Raising export and import duties in international trade of tobacco; engaging large business conglomerates and entrepreneurs; involving regional organizations such as SAARC, ASEAN, SAFTA, etc. in tobacco control; imposing tax on oil for tobacco control with the involvement of Organization of the Petroleum Exporting Countries (OPEC); taxing junk food/soft drinks; taxing air tickets and currency transactions.

6. Recommendations and inputs for the policy-makers on innovative financing from tobacco taxation for health promotion:

- Determining funding gaps: Undertake an assessment of adequacy of current funding for tobacco control in relation to the measures required to address the tobacco use prevalence.
- Evaluating earmarking of tobacco taxes: It is important to assess the impact and functionality of the proposed mechanisms.

- Intersectoral coordination: It is key to understanding and rolling out any newly proposed tax.
- Promoting agencies focusing on health promotion: In order to promote agencies such as VicHealth and Thaihealth, it is important to meet certain parameters such as long-term funding security, relatively independent governing boards and acceptance by a wide range of political and other stakeholders.
- Developing safeguards to prevent diversion of earmarked funds:
 - The implementation of an earmarked tax may be as important as its establishment as proposed in Nepal under Section 22 of the Tobacco Product (Control and Regulatory) Bill, 2010 on the Health Tax Fund.
 - Earmarked taxes should keep pace with inflation.
 - Making contributions for earmarked taxes mandatory: It is important to make it mandatory by legislation for earmarked taxes to be used for specified purposes.
 - Additional questions that need to be answered prior to earmarking include :
 - Is the earmarking for a fixed time period or indefinite?
 - 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)?
 - Must the earmarked revenues be spent during the period in which they are received?
 - Is it important to take into account other factors such as feasibility, tax administration costs, tax evasion, switching to cheaper substitutes and smuggling?
- Establishing a strong revenue-expenditure linkage.
- Promoting agencies focusing on health promotion.
- Exploring the feasibility of the Global Solidarity Tobacco Levy (STL) that is currently under discussion as an innovative financing tool for health, particularly NCDs and tobacco control.

7. Closing session

Dr Athula Kahandaliyanage, Acting Regional Director, delivered the closing remarks. He discussed all the recommendations made by the participants. He thanked all experts for their engaged participation and sharing of valuable experiences to make this meeting a successful one. He lauded the experts for their hard work and inputs that have contributed significantly to the development and refining of the policy paper. He hoped that there would be similar expert group meetings in the future as well to continue to explore innovative means for financing tobacco control in the Region.

Annex 1

Objectives

The objectives of the Expert Group Meeting on Innovative Financing from Tobacco Taxation for Health Promotion were:

- (1) To share information on health financing through earmarking tobacco taxation.
- (2) To identify the next steps on health financing for health promotion through innovative ways of tobacco taxation.
- (3) To provide inputs on the advocacy document intended for use by policy-makers in the Region, mainly on the subject of earmarking of the tobacco tax for health promotion, including prevention and control of NCDs and tobacco.

Annex 2

Agenda

The objectives of the Expert Group Meeting on Innovative Financing from Tobacco Taxation for Health Promotion were:

- (1) Opening session.
- (2) Panel discussions
 - Tobacco taxation in South-East Asia Region: Dr Nyo Nyo Kyaing.
 - Financing for health through taxation of tobacco: The Thai experience:
 - Ms Thantida Wongprasong.
 - Taxation policies on tobacco products in Thailand: Dr Isra Santisart.
 - Taxation policies on tobacco products in India: Dr D C Jain.
 - Innovative financing from tobacco taxation for health promotion: Dr Shilpa Modi Pandav.
- (3) Group work on advocating policy-makers for innovative financing from tobacco taxation for health promotion.
- (4) Recommendations for inputs for the policy paper: Dr Shilpa Modi Pandav.
- (5) Closing Session.

Annex 3

List of participants

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Annex 4

Message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region (Delivered by Dr Athula Kahandaliyanage, Acting Regional Director)

It is my pleasure to deliver the opening remarks at this Expert Group Meeting on Innovative Financing from Tobacco Taxation for Health Promotion. I would like to welcome you all.

Health promotion is a complex, multisectorial activity and only part of it is organized within the health system. It comprises governmental and non-governmental programmes that are disease-specific or focused on healthy lifestyle programmes in general. It also relates to global, national and local efforts to address the social determinants of health, including human rights, the redistribution of wealth and resources, as well as environmental issues.

Health promotion is widely recognized as a cost-effective way to reduce the burden of disease and to improve health. It also has proven to have resulted in cost savings for the health system. However, health promotion financing is still inadequate, both in developed and developing countries. Only 3% of total health expenditure on an average is dedicated to prevention and health promotion programmes in Organization for Economic Cooperation and Development (OECD) countries.

Health promotion programmes should pursue universal coverage and this can be done by ensuring necessary financial resources through different financing mechanisms. Innovative financing mechanisms need to be identified and encouraged. The Bali Call for Action in 2007 advocated Member States to increase budgetary allocations for health promotion by the health sector and other sectors. The Call for action of The Bangkok Charter for Health Promotion in a Globalized World 2005 requests the World Health Organization and its Member States, in collaboration with others, to allocate resources for health promotion, initiate plans of action and monitor performance through appropriate indicators and targets, and to report on progress at regular intervals.

Earmarked or dedicated taxes have been shown to be a successful tool to finance health promotion. Dedicated taxes are collected with the immediate aim to finance health promotion programmes. The advantage of this instrument is that the funds cannot be taken away easily by competing programmes. In several countries the resources are used to finance semi-autonomous institutions that implement health promotion programmes at the national or local level. Earmarked taxes may have some disadvantages as well. The funds can formally not be used for other programmes, even when prioritized, and when separate institutions are founded, health system fragmentation and duplication of efforts may occur. 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.

Tobacco control is an integral part of health promotion. Studies have shown that tobacco taxes are the most cost-effective way to reduce tobacco consumption, especially among the low income groups and the youth. The World Bank reviewed available evidence on the relationship between price and tobacco use in 1999 and concluded that a 10% increase in the price of cigarettes through higher taxation would reduce their use by about 4% in developed countries and by about 8% in low- and middle- income countries.

Article 6 of the WHO Framework Convention on Tobacco Control, “Price and tax measures to reduce the demand for tobacco”, stated that price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, young persons in particular. WHO has provided technical support to its Member States for implementation of tax and price measures to reduce demand for tobacco.

Further than that, in the South-East Asia Region, earmarked taxes from tobacco have been dedicated to health promotion, particularly tobacco and alcohol-tobacco control. In Thailand a health tax is being applied on all sticks of manufactured and imported cigarettes since 2001, which is 2% on the excise tax revenue. In 2001, the Cabinet issued the Thai Health Promotion Foundation Act, B.E. 2544, to establish a progressive financial mechanism for health promotion. This foundation works as a catalytic funding agency for civil movements that lead to the improvement in well-being of the Thai citizen. In 2008, about 23% of the tobacco revenue for ThaiHealth was spent for tobacco control. The Government of India levies several different dedicated taxes on the production of *bidi* and cigarette

products and have 10% health cess and other tobacco taxes for rural health, calamities and the welfare of *bidi* workers. Nepal has a service tax on cigarettes and alcohol (Health Tax Fund) earmarked for cancer treatment. The newly adopted tobacco control legislation of Nepal has more specific provisions for a health tax fund.

The objectives of this Expert Group Meeting are to share information on health financing through earmarking tobacco taxation, to identify the next steps on health financing for health promotion through innovative ways of tobacco taxation, and to provide inputs on the advocacy document intended for use by policy-makers in the Region, mainly on the subject of earmarking of the tobacco tax for health promotion, including prevention and control of NCDs and tobacco.

NCDs are the leading cause of death in the Region accounting for 54% of all deaths. The rapidly rising trend of NCDs threatens poverty alleviation efforts and economic growth in the Region. Tobacco use, improper diet, physical inactivity, and harmful use of alcohol are the four major modifiable risk factors of NCDs. Tobacco control measures should be integrated with prevention and control of NCDs. It is also urgently required to identify innovative ways of financing for NCD prevention and control as Member States have done in the area of tobacco control.

I believe the meeting will have very interactive and stimulating discussions. It is aimed that the discussions and recommendations from the consultation will serve as inputs for the policy paper to be used as an advocating tool for earmarking part of the tobacco tax for health promotion. I would like to urge all of you to share national as well as international experiences, discuss frankly on the pros and cons of sin tax or earmarked tax and other taxation policies on tobacco, and provide valuable inputs for the policy document.

I wish you all a fruitful meeting.

Thank you.

The “Expert Group Meeting on Innovative Financing from Tobacco Taxation for Health Promotion” was held at the WHO Regional Office for South-East Asia, New Delhi, on 13-14 June 2011. It provided a medium to voice the opinions of experts and researchers concerning novel methods of financing health promotion efforts. This document presents the discussions and outcomes of the meeting.

Progress on various health promotion projects, tobacco taxation and financing mechanisms for tobacco control in the Region is highlighted. The document contains the recommendations on innovative financing mechanisms put forward by experts, which would be useful to policy-makers, advocates and managers in Member countries to help mobilize resources and sustain the efforts for tobacco control.



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