Strategic Investment of Tobacco Tax Revenue

Article 6 of the WHO Framework Convention on Tobacco Control (FCTC) and its guidelines for implementation recommend that countries dedicate revenue to fund tobacco control and other health promotion activities.[1] In addition, Article 26 of the FCTC requires all Parties to secure and provide financial support for the implementation of various tobacco control programs and activities that meet the objectives of the Convention.[2] Tobacco excise taxes have also been identified as a revenue stream for financing the Sustainable Development Goals [3]

Dedicated Tobacco Tax Revenue for Strategic Special Purposes

Dedicating the revenue derived from tobacco excise taxes for a special purpose, instead of funneling it directly to the general consolidated budget allows more transparency in how taxes are used; in this case, for health priorities and programs. "Earmarking" is the term often used to describe this practice. While earmarking tobacco taxes is possible in some countries, in other countries it may be prohibited by law. For these countries, another option for securing revenue is to impose an additional levy on the value of tobacco production or sales.

It should be noted, however, that the imposition of an additional levy is not advisable where dedicating a portion of the excise tax revenue is possible under law. This is because, in addition to adding complexity to the tax system, determining the tax base for the levy can be difficult in countries with low administrative capacity, providing the opportunity for producers or manufacturers to avoid the levy by misreporting the tax base.

Whether through tobacco excise taxation or a special levy, the dedicated use of tax revenue should be viewed as a "strategic investment." Indeed, when revenue is used to improve health—directly via health care or indirectly via prevention programs and research—to support tobacco workers, it is, in effect, a form of investment to facilitate healthy behaviors, better health and a stronger economic workforce in the future.

To date a significant minority of all countries have dedicated some or all of the tax revenue collected from tobacco taxation to increased funding for new or existing health priorities such as health care, health promotion, and tobacco control. We identify 41 countries that make explicit and systematic use of tobacco tax revenue towards health related promotion program (***Table 1***).*

Importantly there is no single formula for establishing a dedicated fund. Each country's political, economic, and social context is different and their experience unique. For instance, allocating the revenue derived from tobacco taxation to health may be more feasible or desirable in countries that have robust and stable fiscal budgets.

There are several reasons why countries should seriously consider strategic investment of tax revenue. Above all, health care is often underfunded, especially in developing countries. Tobacco control is also largely underfunded, with only 0.4 percent of total global tobacco tax revenue allocated to it. Moreover, about 95 percent of what is allocated is spent by high-income countries. This is true despite the fact that tobacco kills more than 7 million people each year.[1]

Governments collect more than US$ 250 billion in tobacco excise tax revenues each year globally but spend only around US$ 1 billion on tobacco control, with 95 percent spent by high-income countries (HICs).

*Among the 41 countries, 38 countries are reported in the 2015 WHO Report on the Global Tobacco Epidemic (29 countries) or the 2017 report (33 countries). Botswana, France, and Kenya's earmarking practices were obtained from other sources.

Table 1. Use of earmarked tobacco taxes in countries that reported earmarking parts of their excise taxes or excise tax revenues for health purposes [1]

COUNTRY	REPORTED USE OF EARMARKED TOBACCO TAX REVENUE
Algeria	Revenues from an additional tax on cigarettes support an emergency fund and medical care.
Argentina	An additional emergency tax of 7% of the retail price of cigarettes is directed to social and/or health programs.
Bangladesh	A Health Development Surcharge of 1% of the Maximum Retail Price of tobacco products.
Cabo Verde	All excise revenues are used for sports and health.
Colombia	The total proceeds from the ad valorem excise tax (10% of retail price) are directed to health in the country's departments (sub-national units). Additionally, 16% of the specific excise tax on tobacco products funds sports.
Comoros	A portion of the 5% extra tax on tobacco is directed to the Ministry of Sports and another portion to hospital emergencies.
Congo	Proceeds of the specific excise tax are directed to health insurance and to sports.
Cook Islands [2]	50% of excise revenues are distributed to the Ministry of Health for non-communicable disease programs.
Costa Rica	All revenues from the specific excise tax are used to fund programs for the prevention and treatment of diseases related to tobacco use, cancer treatment, harmful use of alcohol, and sports.
Côte d'Ivoire	Proceeds of an additional tax are directed to the AIDS program and for tobacco control; proceeds of another additional tax are directed to sports.
Egypt	A portion of tax revenues funds health insurance.
El Salvador	35% of revenues from taxes on tobacco, alcohol and firearms, ammunition and explosives fund FOSALUD (the solidarity fund for health).
Estonia [2]	3.5% of excise revenues is earmarked to Cultural Endowment of Estonia, including 0.5% transferred to the physical fitness and sport endowment.
France [3]	A new additional levy on tobacco retailers goes entirely to tobacco control (effective Jan 1, 2017).
Guatemala	All revenues from the ad valorem excise tax on tobacco are used for health programs.
Iceland	At least 0.9% of gross tobacco sales is allocated to tobacco control.
India [4]	Specific amount for all tobacco products (varies by product), except bidis, goes to the Health Cessation Fund and an amount levied on bidis goes to the Bidi Workers' Welfare Fund, which also includes medical care to workers involved in the bidi industry.
Indonesia [4]	10% surcharge imposed on tobacco excise; at least 50% of its proceeds are allocated for health program and law enforcement at the regional level. 2% of tobacco tax revenues are allocated to regional governments of which a proportion should be used for health.
Iran	Up to 2% of taxes collected on tobacco are used to support tobacco control activities.
Ireland [2]	A tobacco levy of €168 million is directly transferred from Revenue to the Health Service Executive annually.
Jamaica	20 per cent of the revenues from the Special Consumption Tax on cigarettes is directed to the National Health Fund.
Kenya [5]	2% of the proceeds from tobacco production go to the national health fund.
Lithuania [2]	1% of revenues from tobacco excise are used to finance a Physical Education and Sport Support Fund.
Macedonia [4]	Amount of 0.053 denars per piece (cigarette) allocated to fund drugs for rare diseases.
Madagascar	6 ariary per pack are directed to finance the National Fund for the Promotion and Development of Youth, Sports and Recreation.
Mauritania [2]	Revenues from an additional tax of 7% of the declared import value of cigarette are dedicated to anti-cancer research.
Mauritius [2]	A portion of tax revenues funds the treatment of health problems associated with cigarettes consumption.
Mongolia [4]	A proportion of tobacco (2%) and alcohol (1%) excise tax revenues is allocated to the Health Promotion Foundation.
Morocco [2]	5.4% of the total excise tax revenue is allocated to the social cohesion fund which finances, among other activities, health care for the poor and physically handicapped.
Nepal	Tobacco excise revenues are directed to a Health Tax Fund.
Palau [2]	10% of the annual tobacco excise tax revenues are allocated to fund healthcare coverage subscription costs for citizens who are not working and are at least sixty (60) years of age or disabled, and 10% of taxes on alcohol and tobacco are allocated to non-communicable disease prevention.
Panama	Fifty percent (50%) of tobacco tax revenues collected are directed to the National Institute of Oncology, the Ministry of Health for cessation services and Customs to fight illicit trade in tobacco products.
Philippines	80% of the incremental revenues (after deducting allocations for the tobacco farmers) are allocated to universal health care programs while 20% are allocated nationwide to medical assistance and health facilities enhancement.
Poland [6]	0.5% of the excise duty levied on tobacco products funds a program to reduce tobacco consumption.
Republic of Korea	An amount of 841 KRW per pack is directed to a Health Promotion Fund which finances health promotion research and projects including tobacco control.
Romania [4]	10 euros per 1,000 cigarettes and 13 euros per kilogram of loose tobacco are dedicated to health. Additionally, 1% of the budget from the excise on cigarettes is used to finance sports.
Switzerland	A contribution from the excise tax on cigarettes is directed to the Tobacco Prevention fund.
Thailand	2% of excise on tobacco and alcohol are directed to the Thaihealth fund.
United States of America [4]	Varies by state. Amount per pack funds different types of activities, mainly health activities.
Viet Nam [2]	A surcharge of 1.5% of the excise tax base finances a Fund for Prevention and Control of Tobacco Harms.

SOURCES: 2015 and 2017 WHO Reports of the Global Tobacco Epidemic (GTCR). 33 countries were included in 2017 report.

NOTES: 1. Only countries that have reported earmarking some portion tobacco taxes or tobacco tax revenues for a specific health purpose are listed in this table. Examples from other countries which direct or use tobacco tax funds in a similar manner are not recorded if data was not provided or was not verifiable for the purposes of this report. Additionally, some countries reported earmarking tobacco taxes, but for purposes other than health and are therefore not included in this table. **2**. Countries added in the 2017 WHO report, but not reported in the 2015 WHO report. **3**. Droit des Non-Fumeurs (DNF). Law 2016 – 742 DC. **4**. Countries in the 2017 WHO report but not reported in the 2015 WHO report. **5**. Kenya Revenue Authority. **6**. Poland had a statute (Protection of Public Health against the Effects of Tobacco Use Act 1995, Article 4) that included earmarking, but there was no regulation for the funds to be allocated to the Ministry of Health. In September 2015, a new Public Health Act dissolved the initial tobacco control program and incorporated tobacco control activities into the National Health Program, which is now be financed from the (general) State budget, effectively terminating the earmarking of revenues specifically for tobacco control (WHO, 2016).

The rationale for earmarking tax revenue derived from taxes on the sale of harmful products such as tobacco or alcohol to health and prevention programs is much stronger than the rationale for earmarking the revenue derived from other types of taxes (e.g., payroll tax). The costs of smoking are enormous for governments, and it serves the government's interest to use tobacco tax revenue to fund tobacco control. Reducing smoking and the negative health and economic effects of smoking benefit the population, the economy, and the government.

There are several strong reasons for earmarking tobacco taxes[2,3]:

- **Revenue protection:** Dedicating tobacco taxes can ensure funding for a specific program or service while also protecting it from competing political interests and poaching due to budgetary constraints.
- **Efficiency:** Linking tobacco taxation more closely to benefits such as the treatment of tobacco related diseases or more general health programs can increase the efficiency of public spending for tobacco control because it directly affects the health of the population.
- **Public support:** Linking tobacco taxation more closely to benefits can soften public resistance to taxation because taxpayers (tobacco users and tobacco producers) generate revenue to compensate for the costs of tobacco production and use.
- **Accountability:** Linking tobacco taxation more closely to benefits can increase accountability because the allocation of the revenue is easier to track, making tax administration more transparent.
- **Cost awareness:** Communicating about dedicated tobacco taxes can help educate the public about the costs and dangers of tobacco use.
- **Progressivity:** In the case of tobacco, the tax itself may put a disproportionate burden on the poor, who spend a larger share of their income on cigarettes than the wealthy. However this regressive effect can be mitigated if the dedicated revenue is directed toward programs that disproportionately benefit the poor and disproportionately reduce their future health risks.
- **Symbolic:** Requiring users of tobacco products to pay taxes that are dedicated to tobacco control serves as an additional reminder of the paramount importance of controlling tobacco use.

Despite non-communicable diseases (NCDs) accounting for 67 percent of all deaths in low- and middle-income countries (LMICs), only 1 percent of all global health funding goes toward preventing NCDs.[1]

Addressing Arguments Against Earmarking Tobacco Tax Revenue for Tobacco Control and Health Programs

Opponents of dedicating tobacco excise taxes to specific purposes general cite four justifications:

1. **Budget rigidity** or a reduction in the government's capacity to allocate budget resources to highest impact use;
2. **Economic distortion** or the possibility that the earmark will produce an adverse impact that defeats the overall goal of the earmark;
3. **Decreased equity** for example, when access to the benefits of a tax is narrowly defined and some segments of the population are precluded from access without any additional benefits; and
4. **Susceptibility to special interests** or the possibility that fund administrators will disburse funds preferentially in response to pressure from groups with a stake in how the fund operates.

Each reason carries an internal logic, but in spite of the apparent soundness, the rationale behind each argument is much weaker than the rationale for investing tobacco tax revenue. Meanwhile, there is a growing body of evidence that investing tax revenue in tobacco control and health programs have contributed to improved heath and social welfare. There is little evidence supporting the inefficiencies, distortions or rigidities that opponents of earmarking often cite.[1]

Data in **Table 2** show that the earmarked taxes are small amounts (except for in the Philippines) and therefore do not introduce budget rigidity.

Surveys in several countries have shown that tax increases are more readily accepted by the public, and even among smokers, if at least some of the increased tax revenues are dedicated to health programs.

A study in the United States showed that investment of US$ 1 in tobacco control programs can generate a return of $5 by reducing hospitalizations for heart disease, stroke, respiratory disease and cancer due to tobacco use. This is a five-fold net return on every dollar raised from tobacco taxation and reinvested in health and prevention programs.

The experiences from countries that have dedicated tobacco tax revenue to specific programs show that doing so can be very effective and can contribute to the reduction in tobacco initiation and use. Country experiences also show that the most successful programs are those that:

1. **Ensure a well-designed and systematic mechanism** to funnel the funds from the revenue collector to the recipient;
2. **Seek policy opportunities to gain public support;**
3. Are based on tax policies that **dedicate revenue from *additional* excises** and do not affect how existing excise tax revenue is currently used of excise taxes;
4. **Feature strong inter-sectoral partnerships and synergies** (e.g., Finance and Health Ministries, Customs Authority, civil society);
5. **Carefully present arguments for dedicating revenue,** with evidence of the need and potential significant net benefits; and
6. **Effectively counter opponents' arguments** , which are often primarily from the tobacco industry and government sectors influenced by it.[6]

Table 2. Use of earmarked taxes for various health promotion programs, including tobacco control

COUNTRY	YEAR EARMARKING TOBACCO TAX ESTABLISHED	ESTIMATED ANNUAL TOTAL FUNDS FROM EARMARKED TAX	ANNUAL FUNDS FROM TOBACCO EARMARKED TAX AS PERCENTAGE OF GENERAL GOVERNMENT EXPENDITURE ON HEALTH (2013)	GENERAL GOVERNMENT EXPENDITURE ON HEALTH AS PERCENTAGE OF GDP (2013)
Botswana	2014	2014–2015: BWP 4 million (US$ 0.48 million)	NA	3.10%
Egypt	1992	2013–2014: EGP 392 million (US$52.06 million) Earmarked taxes only 1.8% of total taxes on cigarettes	1.09%	2.10%
Iceland	1972; 1977 (suspended); 1985 (reintroduced); 1996 and 2001 (amended)	2014: ISK 108.3 million (US$ 0.89 million)	0.08%	7.00%
Panama	2009	2014: US$ 27.8 million	1.32%	5.20%
Philippines	1997 (RA 8240) and 2004 (RA 9334) Tobacco and alcohol excise tax reform in 2012 (RA 10351 or the "Sin Tax Reform Law of 2012")	2014 incremental revenue: PHP 50.23 billion (US$ 1.13 billion) Earmarked amount to the Department of Health PHP 44.72 billion (US$ 1.01 billion) Allocated amount for the Department of Health in 2014 PHP 30.49 billion (US$0.69 billion)	36.4% [1]	1.40%
Poland [2]	2000 (terminated in 2015)	2013: PLN 1 million (US$ 0.316 million) from general budget; Earmarked tobacco tax not allocated to the Ministry of Health	0.00%	4.60%
Romania	2005	2014: Lei 1.1 million (US$ 0.33 million); 14.4% of total health budget	0.00%	4.20%
Thailand	2001	2014: THB 4064.74 million (US$ 125.15 million) 1.78% of Ministry of Health budget and 1.84% of National Health Security Fund	0.93%	3.70%
Viet Nam	2012	2014: VND 299.171 billion (US$ 13.91 million) 0.5% of national health budget	0.34%	2.50%

SOURCES: Cashin et al. (2017), and
1. Estimate for 2014 dividing allocation from the sin tax reform law by the total budget of the Department of Health in 2014. Sources: Nine country case studies (see Annex 2); reference 11 for general government expenditure on health (except for Philippines, data for the budget of the Department of Health was directly provided by contacts in the Ministry of Finance) and reference 10 for GDP data.
2. See note to Table 1.

List and Types of Earmarking in WHO Countries

As of 2016, 41 countries reported earmarking tobacco tax revenues for a health or prevention purpose. Among them, 9 were high-income countries, 29 were middle-income, and 3 were low-income (***Table 2***).[3,7]

Countries have chosen to dedicate revenue from taxes (or levies) on tobacco products in many different ways, including through:

- an additional amount per cigarette pack or stick (e.g., Algeria, France, Republic of Korea);
- an incremental proportional levy on excises (e.g., Thailand, Indonesia);
- a proportion or all of excise revenues (e.g., Egypt, Panama, Philippines); or
- a portion of the proceeds from tobacco production or sales (e.g., Kenya, Iceland).

Countries have chosen to earmark or invest tobacco tax revenue to targeted health and prevention efforts in different ways. These investments include funding for:

- tobacco control or prevention (e.g., Iceland, South Korea, Switzerland, France);
- a specific disease of public health importance (e.g., AIDS in the case of Côte d'Ivoire; cancer in the case of Nepal);
- health promotion programs (e.g., Thailand, Viet Nam);
- national health care programs (e.g., Egypt, France, the Philippines, Palau, Turkey);
- health insurance for students (e.g., Egypt);
- efforts that focus on specific population groups such as the poor and youth (e.g., Madagascar, Palau, Morocco;
- sports (e.g., Cabo Verde; Columbia; Lithuania);
- research related to tobacco prevention or health (e.g., Mauritania, South Korea);
- cultural or social programs around health education (e.g., Argentina, Estonia); and
- tackling illicit trade (e.g., Panama).

References

1. WHO Report on the Global Tobacco Epidemic, 2017: monitoring tobacco use and prevention policies. Geneva: Work Health Organization; 2017. **2**. Cashin C, S Sparkes, and D Bloom. 2017. "Earmarking for Health: From Theory to Practice." Health Financing Working Paper No. 5. World Health Organization. [WHO, EH 2017] **3**. Petit P, Nagy J. 2016. "How to design and enforce tobacco excises?" Fiscal Policy, International Monetary Fund, Fiscal Affairs Department. Washington. www.imf.org/external/pubs/ft/howtonotes/2016/howtonote1603.pdf. **4**. Vardavas CI, Filippidis FT, Agaku I, Mytaras V, Bertic M, Connolly GN, Tountas Y, and Behrakis P. 2012. "Tobacco taxation: the importance of earmarking the revenue to health care and tobacco control." Tobacco Induced Diseases, 10(21). **5**. Dilley JA, Harris JR, Boyson MJ, Reid TR. 2012. "Program, policy, and price interventions for tobacco control: quantifying the return on investment of a state tobacco control program." Am J Public Health, 102: e22–e28. **6**. World Health Organization. 2016. "Earmarked Tobacco Taxes: Lessons Learned from Nine Countries. [WHO, ETT 2016]. **7**. WHO Report on the Global Tobacco Epidemic, 2017: monitoring tobacco use and prevention policies. Geneva: Work Health Organization; 2015.