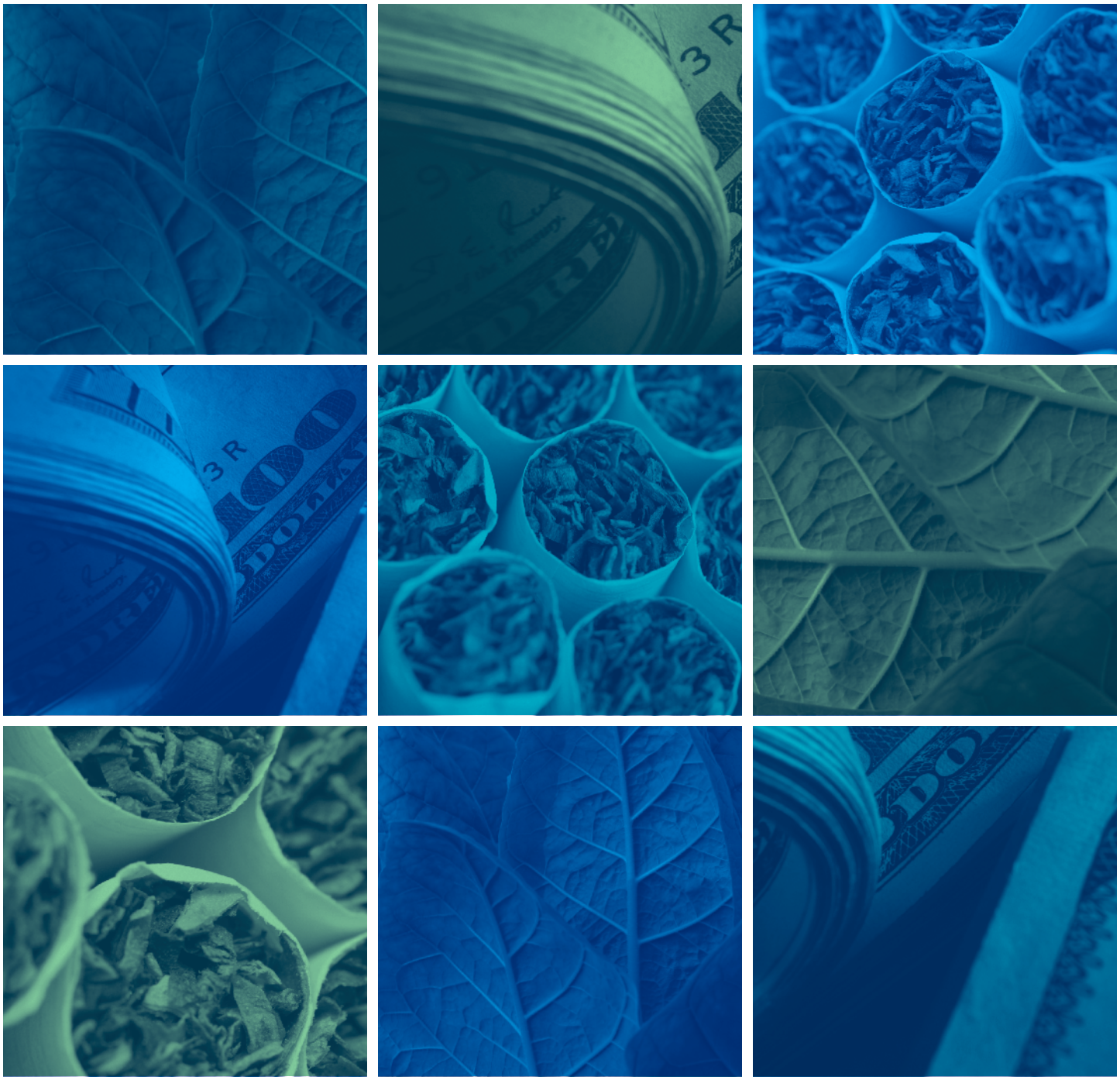
EARMARKED TOBACCO TAXES

lessons learnt from nine countries



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1. Introduction

Globally, and particularly in low- and middle-income countries, health budgets are under strain to meet the challenge of preventing the growing prevalence of noncommunicable diseases (NCDs).

Many countries have developed fiscal mechanisms to help finance the health sector and health programmes, including raising tobacco excise taxes and dedicating some of the revenue to a specific fund. Raising tobacco taxes high enough, through a well-designed, well-administered tax policy system, and thus raising the prices of all tobacco products, is one of the most cost-effective, efficient measures for reducing tobacco use and tobacco-related morbidity and mortality (*1*).

In addition to increasing the effectiveness of excise tax systems to increase revenues, governments are encouraged to consider using fiscal policies to reduce consumption of harmful goods such as tobacco. Further, a number of countries have channelled some of the increased tax revenue into increased funding for health programmes. This fiscal policy is also aligned with Article 6 of the WHO Framework Convention on Tobacco Control (WHO FCTC), "Price and tax measures to reduce demand for tobacco", and its guidelines for implementation, which recommend that countries dedicate revenue to fund tobacco control and other health promotion activities (*2*). Article 26 of the WHO FCTC requires all Parties to secure and provide financial support for the implementation of various tobacco control programmes and activities to meet the objectives of the Convention. Tobacco excise taxes have also been identified as a revenue stream for financing the post-2015 Sustainable Development Goals (3).

This document describes the challenges, set-backs and achievements of nine countries in the six WHO regions (Botswana, Egypt, Iceland, Panama, the Philippines, Poland, Romania, Thailand and Viet Nam) that have introduced laws for earmarking tax revenues on tobacco (and in some instances alcohol) for spending on public health programmes. The studies of the nine countries indicate that there is no single formula for establishing an earmarked fund but that that some advocacy strategies are more likely to result in the desired policy changes and longer-term outcomes. Although each country's political and social context is different and their experience unique, common lessons can be applied in other contexts.

It is hoped that this analysis will be a useful resource for policy-makers and tobacco control advocates who are considering establishing sustainable funding for health programmes in general or for tobacco control programmes specifically from earmarked excise taxes.

2. "Earmarking" taxes for health

During the past two decades, a number of countries and subnational states have dedicated part of their tax revenues to health care and health promotion, including tobacco control. This measure has been described as "hypothecated", "dedicated", "earmarked" or "tagged" taxation. A simple way of understanding the measure is that revenue is assigned for special purposes. As it is not part of general consolidated revenue, the system allows more transparent, dedicated allocation of taxes to health programmes.

There may be several rationales for earmarking tobacco taxes for the health sector:

- to promote better health by investing in sanitation and hygiene, making preventive health care available and educating the public about healthy lifestyles;
- to ensure that health care is affordable, exempt from taxes or guaranteed as a legal right;
- to support initiatives in education, agriculture, housing and energy that affect health indirectly; and
- to support research and development on health care products and services (*4*).

The main advantage of earmarking tobacco tax revenues for tobacco control or health promotion is that they can be expected to ensure a continuous, regular source of funding for programmes that is not subject to annual budgetary review. If managed effectively, they are expected to further reduce health burdens and offset longer-term health costs.

Taxes on tobacco products are already an important source of revenue for most governments. Tobacco excise tax is particularly amenable to earmarking, as people in general are more likely to support tax increases when the proceeds are used for health programmes (*1*).

Opponents of earmarking revenues for specific programmes argue that they are prone to rigidity and inefficiency. The main criticism is that earmarking constrains the choice of allocation or spending by governments and hampers budgetary control (*5*). For instance, the earmarked funds might have been used for more deserving programmes or projects that are outside the scope of the current law, or earmarking could result in overfunding, creating significant opportunity costs. Public finance theorists also argue that public spending should be determined by policy decisions and not by the amount of revenue that is raised by an earmarked tax (*6*). An interesting case of flexibility is that of India, where the Ministry of Finance collects a health cess on all tobacco products (excepts *bidis*)[1] and makes it available for funding health programmes. As the cess is collected by the Ministry of Finance as part of the national exchequer, however, the Ministry of Health must make a proposal to receive the funds. If the Ministry of Health cannot plan and budget for the full amount collected, the Ministry of Finance uses the amount to support programmes outside the health sector.

1 See information on India in Annex 1.

Concern has also been expressed that earmarking revenues is inherently pro-cyclical and therefore susceptible to "booms" and "busts". For example, financing for a particular service such as national health insurance or an educational initiative could decrease in the event of an economic downturn. Furthermore, revenues from earmarked taxes on unhealthy products can be expected to decrease in the long term as consumption of the products decreases after implementation of dissuasive policies. Earmarking may also increase fragmentation of the budgeting process. In health financing, separating revenue sources for health could fragment pooling, and separating health from other areas of public spending could lead to a lack of integration of health policy with other sectors that are also important for improving population health. Opponents also argue that this type of revenue is particularly susceptible to the influence of interest groups and professional lobbies (*7*), which could channel the resources directly for their own benefit. Another concern is that earmarked funds might not actually be additive, either because they are diverted to other activities or because they are offset by reductions from other domestic sources (*8*).

Earmarking is seen by many as infringing on their discretion: by reducing the command of the executive and legislative branches over the allocation of resources, it builds some rigidity into the system and reduces flexibility (*9*).