



BACKGROUND NOTE

Health Policy Decision-making Around Taxes on Alcohol, Tobacco, and Unhealthy Foods in the Covid-19 Era

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HEALTH POLICY DECISION-MAKING AROUND TAXES ON ALCOHOL, TOBACCO, AND UNHEALTHY FOODS IN THE COVID-19 ERA

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I. INTRODUCTION

1. The late stage of the coronavirus disease (COVID-19) pandemic in 2021 has seen renewed calls for enhanced spending to shore up public health defenses against future pandemics and to refocus on the preventive and curative capacity of health systems. As examples of such calls, the High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response of the Group of Twenty (G20) has called for a minimum of United States (US) \$15 billion per year in new international financing for the years 2022–2025 (G20 HLIP 2021). The World Health Organization (WHO) Council on the Economics of Health For All (CEHFA) has also called for “more finance and better finance” for health, emphasizing that increased funding must flow through reformed governance mechanisms directing the investments, enabled by expanding the available fiscal space (WHO 2021a). These exhortations apply the rationale that health systems have been historically disadvantaged in the allocation of domestic and multilateral resources, especially in terms of gaps in strengthening their core functions of preventing destructive epidemics, saving lives when these occur, and meeting the considerable needs of other communicable and noncommunicable diseases that are still burdening societies, without causing out-of-pocket hardship for households. Both G20 and WHO reports envisage that mostly domestic tax-based resources as well as the financing from international finance institutions (IFIs) such as the multilateral development banks will contribute to this surge in funding for health systems, compared to private sources such as households, firms, and philanthropy. According to the G20 and WHO reports, governments and IFIs should coordinate with these latter sources, but should not depend on them.

2. This background note is concerned with government decision-making around domestic tax-based resources that may contribute to the new calls for enhanced spending on health. It compares possible viewpoints on increased tax-based financing from both the government health sector (ostensibly in favor of increased spending) and from the finance/industrial development sectors (ostensibly more nuanced views on taxation). It is likely that such public sector financing for health will be cofinanced with resources from IFIs, which, in terms of new lending from multilateral development banks, will itself in the long term be satisfied from future domestic resources. Specifically, this note considers the decision-making and cross-sectoral viewpoints around taxation of the so-called “public health bads”¹—tobacco,² alcohol, and certain unhealthy foods—in the context of the renewed calls for enhanced spending on health systems from public sources. These taxes have also been called “health taxes” (TFFPH 2019). This terminology is not used in this note because of its ambiguity. While the topic of taxing such products is not new and has an extensive literature exploring its fiscal potential and overall pros and cons,³ reconsidering the political economy of such taxation in the context of COVID-19 may add to ongoing global discussion and be useful for readers of the *Asian Development Outlook 2022* Theme Chapter: Strengthening Taxes for Sustainable Development.

¹ Called “bads”—in opposition to standard “goods”—since their consumption contributes to downstream ill-health, especially because of noncommunicable diseases. These taxes are also referred to often as “sin taxes”.

² Tobacco taxation policies now also cover inhaled nicotine-delivery products, such as vapor and e-cigarettes.

³ Refer to the *Asian Development Outlook 2022* background paper: ADB. 2021. *Asian Development Outlook 2022: Meeting Health Challenges in Developing Asia with Corrective Taxes on Alcohol, Tobacco, and Unhealthy Foods*. Manila.

3. Before getting into the discussion on taxation of certain products, two characteristics of the recent calls for enhanced health sector funding are important to review. First, the proponents argue that the resources be “net new”, i.e., additive to existing funding for global health and for development in general. Second, they propose that the net new resources be mobilized soon, since the costs of inaction related to unrealized gains from higher investment are too high. A corollary of the need for rapid increase in health-related resource mobilization is that this may indicate “a rising tide lifting all boats”—overall economic growth and increase in general tax revenue driving social spending—may be too slow, except in a few economies, to derive the necessary boost. Third, a variety of sources are mentioned in these calls as contributing the necessary fiscal space, and direct/indirect taxation is only one of them. Other sources mentioned include redirecting domestic bank credit, negotiated debt relief from private lender consortia, changes to the sovereign credit ratings system, and increased IFI funding (WHO 2021a).

4. The rest of this note is in terms of four sections. The next section discusses the significance of net new revenue from taxes imposed on the three public health “bads” in the context of recent calls for enhanced health sector funding. The third section considers the perspectives of the government health sector for such taxation, across a “corrective tax” lens and the fiscal lens (terms discussed in paragraphs 13 and 14, and the potential linkage of these perspectives. The fourth section considers the perspective around such taxation of the government sectors concerned with revenue raising and industrial development. In all sections, additional considerations specific for developing member countries (DMCs) of the Asian Development Bank (ADB) are provided.

II. CAN TAXES ON PUBLIC HEALTH “BADS” CONTRIBUTE ENOUGH, AND SOON?

5. This note will not critically examine the requirement for enhanced funding from the domestic public and multilateral sources for the health sector as seen in recent global advocacy, nor the stipulation that such funding be net new, rapid, and less dependent on the private sector. This can be examined by other institutions and by national governments, who determine their own strategic, long-term financing priorities. This section of the note is concerned with whether such increase in domestic government spending for health as heard in recent calls is feasible based on the literature, if from a specific resource mobilization channel of taxes levied on alcoholic beverages, tobacco products, and certain unhealthy foods such as sugary beverages. An important implication of an answer “yes” to the question “is it feasible” would be that some of the other, potentially more complex sources, including debt relief, change to sovereign credit ratings, directed credit policies, and changes to corporate tax rates (WHO 2021a), may not be needed, or will be less significant.

6. A focus on taxation of the three product categories for their role in the fiscal space for health discussion is defensible, as multiple recent reports have highlighted their revenue-raising potential. The table summarizes recent multi-country estimates presented by the 2019 report of the Task Force on Fiscal Policy for Health (TFFPH 2019) based on a simulation study (Summan et al. 2020).

7. **Sufficiency for net new needs:** At present discounted value (2018 US dollars), additional excise taxation that raised prices by 20% would raise US\$6.84 trillion (range: 6.24–7.40) in tax revenue over 50 years in low- and middle-income countries. Of this, 75% would be driven by alcohol taxes, 17% by tobacco, and the rest from sugary beverages. Given that the G20 High Level Independent Panel (HLIP) report wants to raise US\$5 billion per year for net new health resources over 2022–2025 globally, i.e., US\$75 billion; this level of additional taxation of alcohol, tobacco, and sugary beverage products would seem to be more than sufficient, as it would raise 9 times (range 8–10) as much as the requirement. By extension, a smaller tax-driven price increase (<20%) across the three product groups or focusing tax changes on the bigger revenue earners of alcohol and tobacco, could still be sufficient to raise the required net new funding.

Additional Revenue from Taxes on Alcohol, tobacco, and Sugary Beverage Products

Tax Type and Level	Average Additional Revenue (US\$ billion)	Notes
Excise: 1. Raising prices by 20%	By income group, per economy, per year <ul style="list-style-type: none"> Low-income: 0.1 (0.1 – 0.13) Lower middle-income: 1.0 (0.9 – 1.04) Upper middle-income: 1.5 (1.3 – 1.6) 	In 2018 United States dollars. Based on 50-year simulation. Values in brackets show 95% confidence interval. Per economy results calculated using study results and counts for 2018 as follows: 31 low-income, 47 lower middle-income, and 87 upper middle-income economies.
2. Raising prices by 50%	<ul style="list-style-type: none"> Low-income: 0.19 (0.14 – 0.23) Lower middle-income: 1.8 (1.5 – 2.1) Upper middle-income: 2.7 (2.2 – 3.2) 	

Note: As used in the study, income level classifications are based on World Bank data.

Source: Summan et al. 2020.

8. **Real-world test:** According to the study, the additional tax revenue across the three product categories shown in the table, for a 50% price increase, would be equivalent to about 1.00%, 1.24%, and 0.70% of 2018 gross domestic product (GDP) for low-, lower middle-, and upper middle-income economies, respectively (Summan et al. 2020).⁴ How plausible is this, and by extension, the sufficiency finding in the previous paragraph? As per a recent survey using data for the latest available year, tobacco excise taxes at their current national rates accounted for at least 0.5% of GDP in 18 of ADB's DMCs out of 39 with data, with the highest values in the Pacific region. Most of these are middle-income countries. Alcohol tax collections varied more significantly, given some DMCs strictly restrict sales. Where they are collected, they were significant, ranging from 0.1% of GDP at the low end (e.g., Kazakhstan, Malaysia) to 1.0%–1.2% at the high end (e.g., Bhutan, India, Thailand). Therefore, at least as far as scale is concerned, the figures in the table and their implication for sufficiency to meet new global health funding requirements seem plausible.

9. **Is there room to collect more?** On average, taxes on cigarette packs as a percent of pack price in developing Asia are below 50% in 2020, except in the Central Asia region (WHO 2021b). This leaves significant room to maneuver up to the WHO-recommended level of 75% tax share of the price of the most common brand in a country (WHO 2013). While there are no recommended levels of taxes on alcoholic beverages and products, there is huge variability in tax rates and design applied to alcohol products across developing Asia, in countries where alcoholic products are not strictly controlled. Hence, standardization of tax policy applying to alcohol and a movement to higher rates as seen regionally, e.g., in the Philippines after its recent policy approval;⁵ and standardization of rates to higher levels within a country where subnational jurisdictions set rates, as seen in India, are both possible pathways to higher revenue collection overall. Finally, few ADB DMCs beyond the Pacific region have excise taxes on sugary beverages—exception being Malaysia, the Philippines, and Thailand—which implies there is room to collect more if a tax is adopted.

10. **How soon can revenues rise?** Unlike excise taxes on sugary beverages, the taxation of alcohol and tobacco products is a part of established fiscal structures in most ADB DMCs and globally. There is wide variation in excise revenue across middle-income countries, and rising from the median to the 75th percentile in this regard could mean significant additional revenues (Lane, Glassman, and Smitham 2021).

⁴ Values for additional revenues as a share of GDP from tax increases that raised prices by 20% were not presented in the study or its supplementary materials.

⁵ As per Republic Act No. 11467, in effect from 1 January 2020, the excise tax rates on alcohol were increased. For example, the rate is 22% ad valorem plus ₱42 specific tax per proof liter on distilled spirits, with specific tax value to increase further every year.

Under existing legislation, the executives in most jurisdictions can issue new rates on these products for the next tax year. Recently, Indonesia has adopted a new tax law that introduces such flexibility.⁶ As such, making incremental changes as well as tweaking the tax design (moving from ad valorem to specific taxes, or adopting both) to enhance revenue as well as public health benefits can happen in a time frame relevant to recent calls from the G20 HLIP and the WHO CEHFA.

11. Whether governments will increase taxes on alcohol and/or tobacco, and introduce them on sugary beverages, and do so in an urgent timeframe; and whether such tax revenue will be allocated for the types of spending envisaged in these G20 and WHO reports, is discussed in the sections III and IV.

III. PERSPECTIVE OF THE GOVERNMENT HEALTH SECTOR ON INCREASING TAXES ON HEALTH “BADS”

12. **Classical motivations of the government health sector for taxes on health “bads”.** Historically, ministries of health have supported such taxes for two major reasons: (i) to modify population-level behavior, i.e., for these taxes to be “corrective”; and (ii) to increase their budget allocation. Under the first reason, the behavior-changing potential of taxes that raise the price of the product has been well documented and there are pros and cons. The second reason is derived from the belief, firmly rooted in practice, that the revenue from such taxes will be partially or wholly earmarked to the health budget for use in meeting needs specific to the possible health harms (e.g., for tobacco use cessation programs) or general health sector needs. General needs could include pandemic preparedness, health system strengthening, and combating antimicrobial resistance, as raised by the G20 HLIP and WHO CEHFA.

13. **Summary of the “corrective” lens from a government health sector perspective.** Ministries of health perceive clear advantages from such taxes that reduce consumption, related to: improved overall population health and saved lives via reduced future ill-health because of noncommunicable diseases; reduced productivity losses for the economy because of death and disability of workers; reduced household burden because of the out-of-pocket costs of medical care that could have ensued; and potentially reduced social harms associated with these products’ consumption and the related licit and illicit markets.⁷ In this context of “correction”, the government health sector may perceive two main disadvantages. First, there is a likelihood that tax introduction or increase will produce insufficient reduction in consumption because of the nature of demand, which would lower desirable effects. Second, the taxes would be regressive, i.e., relatively more burdensome for poorer consumers. To what extent either of these two concerns weigh on a specific ministry of health’s calculus for pushing for the taxes is difficult to gauge, as it will depend on (i) whether evidence has been collected specific to the economy in question, understanding that analyses are complex and data sometimes scarce; (ii) whether the ministry perceives any short-term distributional issues of taxation (i.e., in terms of any preponderance of financial effects of the tax on the poor and vulnerable) as

⁶ Law No. 71: Harmonization of Tax Regulations (2021), under chapter 7, article 14, gives the executive the power to propose additions or subtractions to the list of products subject to excise under the annual central budgeting exercise. While a tax on sugary beverages was expected, it did not materialize under the law.

⁷ In economic terms, public health “bads” often exhibit negative externalities, where consumption by an individual causes harms to others (e.g., second-hand smoke). Alcohol, tobacco, and sugary beverages do not cause the same type or quantum of externalities. Analysis of the value of these externalities in a specific economy is a complex exercise. These products also cause harms to the individual (internalities) that they do not realize fully and have not thought through (e.g., lacking information on risks to organs from excess consumption, or discounting future ill-health). Here, taxation of such products can be increased so that prices rise and consumption falls to a point where the marginal social benefits are equal to the marginal social cost (considering both externalities and internalities). A common shorthand to this analysis is to calculate aggregate monetary value of the losses (health, productivity, social) and compare it to tax revenue as a social benefit. This makes assumptions that economic transfers from consumers to government in this way are value- and equity-neutral. We can ask if governments always spend new revenue well, or if the value of the health gains and reduced medical spending of the poor outweighs the financial burden of taxes.

under its remit; or (iii) consideration that negative effects will be ameliorated by other policy or directed use of tax revenue. In the decision-making of some ministries of health, the global body of evidence will matter in making a case within policy circles. Here, advocates of higher taxation of alcohol, tobacco, and sugary beverages have produced strong evidence to suggest that the pros outweigh the cons in terms of health, distributional and overall economic outcomes, and that intelligent tax design can reduce negative effects; evidence which has been reviewed elsewhere.⁸ However, to the extent that changing tax policy is a weighty exercise and there may be headwinds from the non-health parts of the government sector, ministries of health must be responsive to non-tax methods to reduce consumption of public health “bads”, especially ways that substantially cut externalities, e.g., by banning smoking in public spaces.

14. **Summary of the budgetary lens from a government health sector perspective.** The use of revenue from taxes on alcohol, tobacco, and sugary beverages has been highlighted as a way to close broad government revenue gaps that arose during the COVID-19 pandemic, mainly as economic activity suffered because of preventive lockdowns and decline in demand (Lane, Glassman and Smitham 2021). An extension to this is applying these tax revenues to higher levels of health sector spending required by the gaps exposed by COVID-19, though this has not been brought out explicitly in the recent calls for increased funding (G20 HLIP, WHO CEHFA). Before these implications related to COVID-19, there were two channels for applying these revenue streams to health. First, revenues should be used to benefit those who are most affected: consumers of health “bads” and those impacted by negative externalities. This implied that, if tobacco tax revenues were earmarked to the health sector budget, they would be substantially spent on tobacco cessation programs, including advertising and awareness activities. Second, such tax revenues should be applied to the health sector to support pro-poor programs, including financing primary care (as in Indonesia) or paying premiums for government-supported health insurance schemes (as in the Philippines). Both these channels have multiple examples in the Asia and Pacific region. Taken together, these ways to spend the funds are defended as an aggregate modality through which the transfer of financial resources from consumers to the government is overall reducing inequality, potentially addressing concerns around regressivity (if any exists) of such consumption taxes. Ministries may also have two major questions about use of such taxes in the health sector, regardless of whether they are used very specifically to benefit certain groups or broadly in terms of pro-poor health policies:

- (i) **Are such taxes a long-term source of financing for the health sector?** Since the “corrective lens” on such taxes intends that taxes should drive down consumption significantly, and this has significant benefits to society and individuals, the associated revenue cannot logically be significant for long. Therefore, linking such revenue to long-lasting government schemes and policies, such as efforts to achieve universal health insurance (e.g., financing health insurance subsidies) raises questions of what other sources will substitute for the taxes when demand falls, especially in an era of rising needs from the public sector budget.⁹ Ministries may also be concerned whether gains via such taxes may be offset by reductions in allocations from general government revenue, as part of the overall budget process (Ozer, et al. 2020).

⁸ How quickly consumption shifts in response to price increases in these products is an important consideration, which derives from the price elasticity of demand. On this, there is significant empirical evidence for most of these product groups, though not equally and not for every economy. If demand falls swiftly across all income groups, the welfare gain is large because of avoided negative externalities and internalities, but revenue gains will be transitory. If demand is “inelastic”, especially for the poor, because of addiction among heavier users or incorrect tax design (loopholes that mean certain brands/product types incur less tax as a share of the price), then either the tax will be regressive or ineffective in meeting health and social goals, or both.

⁹ As an example of dependency, in the Philippines, the Department of Finance data suggest that baseline budgetary allocation to the Department of Health was flat in value and declining as a share of total budgetary allocations to the Department of Health and PhilHealth over 2013–2019. In the same period, earmarked taxes allocated to the health sector rose in value and as a share of total budgetary allocations from 37% to 55% (Habitan 2020).

- (ii) **Are such taxes sustainable in economic downturns?** Some research suggests that consumption tax revenue in richer countries from sources like value-added tax (VAT), previously stable, have since become more susceptible to downturns since the 2008–2009 crisis (Simon and Harding 2020). In middle-income settings, a popular view sees the consumption of alcohol, tobacco, and sugary beverages as discretionary for households, and likely to fall faster than necessities or other spending heads. If this were true, and the indirect taxes on these products were held constant (or even increased, as seen in some economies), revenue would reduce or at best remain constant. If ministry of health budgets were dependent on such revenue, then during a health-related crisis such as COVID-19, this would mean significant budgetary trouble. In the Philippines, comparing the first halves of 2020 and 2019, while overall national government revenues fell 6.1%, excise collections fell by 19.0%, and revenues for tobacco and alcohol fell even more, by 27.6% and 26.4%, respectively (Habitan 2020).

15. **Intertemporal considerations for government health actors in increased taxation of health “bads”.** The summaries above suggest that ministries of health should balance longer-term considerations in approaching such taxes. Based on global evidence, it is definitive that these taxes can assist in maximizing long-term health outcomes (e.g., total quality-adjusted life years) and minimizing unnecessary health spending (e.g., related to tobacco-induced lung diseases, alcohol- and sugar-induced noncommunicable diseases). However, if such taxes become a primary source of financing critical health sector policies related to achieving universal health coverage, then they may introduce vulnerabilities, such as exacerbating the historically procyclical nature of health budgets. This may mean such taxes should be accompanied by overall fiscal policies and IFI financing that support the social sector, i.e., for achieving the Sustainable Development Goals, captured in commitments. These may better guarantee long-term budget stability for the health sector.

IV. PERSPECTIVE OF NON-HEALTH GOVERNMENT SECTOR ON INCREASING TAXES ON HEALTH “BADS”

16. **Hypothesized motivations of the non-health government sector related to taxes on alcohol, tobacco, and some unhealthy foods.** Two main voices in the government policy-setting mechanism are discussed here: of ministries related to industrial production, and those related to finance. While their goals can be hypothesized to be overlapped, they are not entirely the same. Ministries related to industries, whether specific sectors or overall, may want to protect production and investment, and/or employment, in the context of taxation. Ministries of finance oversee revenue collection and allocation via budgetary frameworks and may be concerned with monetary and fiscal stability, where these must serve national goals. During a period of revenue contraction accompanied by major new spending as seen during COVID-19, central ministries of finance and departments of revenue at subnational levels may favor enhanced taxation of consumption, if they believe these offer better prospects than greater taxation of income.

17. **Summary of perspectives of ministries of industry or similar on such taxation.** Inasmuch as these ministries want industrial development to continue and production in their sectors of oversight to grow, their views on increased taxation may be negative, through the channel of reduced demand leading to reduced production with lag, which reduces future investment and employment. However, this suggests a simplified calculus, which would be better understood as two-stage analysis.

- (i) The first stage analysis may involve ministries extrapolating the incidence of these taxes on producers versus consumers, which depends primarily on the tax design and,

secondarily, on market dynamics. Excise taxes, which are the commonest way¹⁰ to achieve demand-corrective as well as budgetary goals, may be specific (related to per unit of quantity, weight, volume, potency) and/or ad valorem (linked to the price), and can be collected at different points.¹¹ For excise taxes, for taxes to impact prices, they should be passed on to consumers. Such pass-through is likely, but not certain, and the level depends on each manufacturer's objectives across demand- or profit-maximization. For tobacco taxes, evidence suggests a variety of industry responses and objectives (Sheikh, Branston, and Gilmore 2021). These objectives can shift over time as market levels of competition and demand (especially tastes) shift. Therefore, ministries of industry may link their reaction to taxation based on the anticipated or observed industry reaction. If pass-through into consumer prices is certain and significant, then at this stage, ministries may also attempt to understand impact on demand. Whether taxes impact prices significantly and if this reduces demand, and to what extent, is an empirical issue, on which significant evidence related to the price elasticity of demand exists from varied settings for tobacco, alcohol, and sugary beverages. These "bads" are not similarly elastic or inelastic, and the elasticity may vary across income groups and product type. Summarizing this evidence is beyond the scope of this note. Without access to specific modeling data, ministries will be challenged to predict industrial responses and impact.

- (ii) The second stage of study may begin if the excise (or a specific VAT rate) is likely to affect prices and impact demand. Here, ministries of industry may look for studies that model the likely response of industry across manufacturers, packers, distributors, and retailers. The response may involve shifts in volume, in preponderance of certain product types in production or retail, and exit of certain producers from the market. Across these complex shifts, which link to market actors' objectives and incentives, it will be hard to anticipate the future shape of the industry, given additional complexities. These include (a) the possibility of demand substitution, where consumers shift away from the more taxed products to similar products in the same market or another sector, e.g., from sugary to diet beverages, from cigarettes to vapor products (if available and not taxed), or from hard liquor to beer (if the excise is specific to alcohol content). The likelihood of illicit goods increasingly entering the taxed market could also complicate the situation. (b) Nature of the taxed industry, especially ownership and labor structure, may need to be considered. For example, some tobacco and alcohol producers in developing Asia are state-owned or parastatal enterprises whose reaction to taxes may carry inordinate weight. Employment may be large in tobacco-producing countries, and relatively concentrated in vulnerable communities. It could be assumed that, as production or investment is cut, so will the workforce. (c) There is also the potential for directed policies that provide relief to the affected sectors and entities, including through the use of part of the tax revenues.
- (iii) Though it is often stated that these concerns, e.g., on employment (TFFPH 2019), are overstated, in fact little definitive evidence from Asia and the Pacific exists for all the considerations above, and the evidence can vary across regions. Whether ministries of industry seek to maximize output, investment (more likely in growing sectors), and/or employment will determine how they view the net effect across the first and second stages of analysis for an increase or introduction of indirect tax on health "bads". In the context of COVID-19, where sales may have been depressed because of reduced income among consumers, as well as non-tax-related price increases (such as supply chain-related

¹⁰ An increase in the general VAT rate to achieve overall fiscal goals is common. Being generally standardized, VAT is less likely to be a focus of corrective taxation related to social ills. A lower VAT rate imposed for necessities such as health care services or products is more likely and also seen. However, the more such rate differences, the more the tax code is considered to be overly complex.

¹¹ For example, collected at import (if foreign), on sale by manufacturer (to distributors or directly to retailers), on sale by a retailer, or on use by an intermediate actor (e.g., a packer).

scarcity in 2021) there may be further reluctance in the non-health ministries to consider indirect taxation that will add to prices till there is a broad-based demand recovery.

18. Summary of perspectives of ministries/departments of finance or similar on such taxation.

Ministries or departments of finance at national and subnational levels have economy-wide concerns and, as such, the issues of correcting future health impacts and reducing unnecessary health expenditures may not be high on their policy agenda. Though, this can be influenced, especially through advocacy and the role of the political leadership. Mainly, these entities' perspectives on taxes on certain health "bads" may focus on their impact on medium-term fiscal and budgetary concerns and on the distributional nature of the overall tax structure.

- (i) **As a solution to financing the regular budget for the health sector.** Because such taxes may be originated and/or increased with a specific policy intent to support the health sector, ministries of finance may be supportive of them within a framework of soft revenue earmarking.¹² However, since earmarking (or hypothecating) these taxes reduces fiscal flexibility, there could be additional considerations. (a) If legislation requires a certain share of the overall budget to be allocated to the health sector,¹³ then revenue earmarking of taxes on some health "bads" is one way to meet this requirement. However, there could be problems in the way revenue and expenditure here are linked in policy. In the context of a strong link to expenditure, if revenues from earmarked taxes on tobacco, alcohol, or sugary beverages (any combination) are growing faster than the rest of the economy and even the government budget, this could reduce fiscal flexibility and introduce risk. (b) Another consideration is if any expenditure earmarking is possible, and how, given the expected duration of the revenue stream. If analysis suggests a durable stream, then an expenditure earmark to recurrent needs such as for paying subsidies, buying certain commodities, and even covering salaries may be more meaningful. If the revenue may dry up fast (in conditions of high demand elasticity), then an investment project may be an earmarked use. The political acceptability of one or the other use, and the wider policy context of the taxation (e.g., perspectives of other non-health ministries), could constrain the flexibility of the ministry of finance in assigning such use of the revenue, and hence affect their posture towards the tax.
- (ii) **As a solution to new, expanded requirements for the health sector.** In the context of the calls for higher post-COVID-19 funding for health, the acceptability of increasing or introducing taxes on health "bads" may be more complicated. Some have argued that, given fiscal consolidation is likely in the post-COVID-19 era after a period of high countercyclical spending and constrained revenue, future government health budgets will need to be prioritized, and revenue-earmarking from taxes on health "bads" is a protective pathway (Ozer, et al. 2020). Even without considering the G20 HLIP or WHO CEHFA calls, this is arguably so because other sources of health expenditure that are not out-of-pocket, such as employer contributions, have declined in the pandemic or will decline because of rising informality, changing nature of work, and a desired move away from payroll taxes (Yazbeck, et al. 2020). In this context, ministries of finance can ask: will the expanded funding requirement be durable and, if so, are the proposed earmarked sources from new/increased taxes a sustainable financing source?

¹² Such characterization of earmarks should be seen as a continuum, where the softest designs link revenue to an expenditure purpose (such as within the health sector) relatively loosely and potentially without legal protection. Hard earmarks may have a legal basis, circumvent the annual budgeting negotiation, and be held in a ring-fenced fund. For an introduction to earmarking of taxes on specific health "bads", refer to Ozer et al. (2020).

¹³ For example, Indonesia requires 5% of the central government budget, where the denominator is defined in a particular way, to be allocated to health. For a discussion of these policies, refer to Dutta et al. (2020).

- (iii) **As a way to influence the overall distributional impact of the tax structure.** In addition to being significant revenue sources overall, taxes on the health “bads” may also have major influence on the impact of taxation on inequality. Since COVID-19, concerns exist that inequality has risen because of unequal effects across socioeconomic groups of sickness-related morbidity and mortality, job losses, reduced economic activity, and most recently, goods scarcity and inflation (World Bank 2021). Within the context of all tax instruments, new taxes should not add majorly to distributional concerns, reflecting policymakers’ “inequality aversion”. Given that many economies have raised taxes during COVID-19, whether in the direct or indirect domains, any aspects of the tax structure that provide a positive distribution effect would be welcome from a ministry of finance perspective. In this context, a systematic review of evidence on distributional effects suggests that, given the value of future ill-health, medical and social costs that could be averted, in general, poorer households may have net benefits from higher tobacco and sugary beverage taxes (Jain, et al. 2020). Such evidence is helpful in policy decision-making, alongside holistic reviews of the links between tax structure and inequality before and after changes, including through aggregate indicators of income and wealth inequality (e.g., Gini coefficients, and the Kakwani Index).

V. SUMMARY

19. **Maximizing along multiple domains in decision-making on new taxation of health “bads”.**

The summaries in section IV suggest that non-health government actors face complex choices and considerations in evaluating the decision to impose new taxes, including on health “bads”. The governmental decision-making process for introducing or raising such taxes within a national-level cabinet, or a subnational executive setting, hence, involves multiple perspectives and choices. Based on sections III and IV, it can also not be assumed that the health sector is a natural proponent of new taxes on health “bads”, or that the ministry of finance is a natural opponent, as both have reasons to see pros and cons. The ministry of health especially would not like to become dependent for core pro-poor programming on taxes that would not provide a durable source, and could prefer these taxes as part of a package of overall commitments towards long-standing budgetary support to the sector. Another key takeaway should be that the “corrective” lens on such taxes (which aims to reduce harms on future health and the economy) and a “fiscal” lens are linked. This is both within the ministry of health analytical process as discussed and for a ministry of finance, where the latter has a prime directive to look at fiscal considerations while evaluating the distributional impact of the taxes, which derives significantly from their corrective value for consumption.

20. **Are new taxes on health “bads” the answer to post-COVID-19 calls to substantially raise health funding?**

The summary of evidence and decision-making processes in this note suggests that introducing or increasing indirect taxes may have significant and proven revenue potential at the global level. This may be up to or exceeding the levels of net new funding requested in recent calls, including to ameliorate pressures on health sector budgets in post-COVID-19 fiscal consolidation. Distributional impacts, at least for tobacco and sugary beverage taxation, are broadly positive in a variety of economies classed by income group. However, such funding is logically not sustainable at the tax rates advocates want since the intention is to make the products unaffordable and drive down consumption, steadily reducing revenue. Therefore, the social sector uses such tax sources are put to, i.e., via explicit earmarking, should be thought through. If the calls for increased health sector funding to improve health system capacity and resilience have a sunset clause, i.e., the net new resources are needed for a period only, then the taxes on health “bads” have something to offer.

21. **Should other sources for net new health funding be explored?** Brief No. 2 from WHO’s Council on the Economics of Health For All has suggested that governments with monetary sovereignty face no

real fiscal limits (WHO 2021a).¹⁴ If this were true, where such freedom to act exists, new taxes would not be needed. Unfortunately, limits on macroeconomic action likely do exist. Hence, the other prescriptions of the CEHFA include, among others, increasing deficit spending limits, expanding bank credit for health, debt relief, IFI actions including reallocations of the International Monetary Fund's special drawing rights, and standardizing corporate tax rates across economies. If taxes on health “bads” have the requisite potential to meet the net new needs, then the requirement to explore these other sources, which may require more negotiation and invite controversy, is lower. Here, economies may choose to “save their powder” for other battles, such as for climate change financing and meeting the entirety of the Sustainable Development Goals.

¹⁴ The WHO CEHFA brief acknowledges that countries may not have such sovereignty because of fiscal rules, whether internally or externally imposed. Where they do, then their freedom to act relates to tenets of “modern monetary theory”, which is a controversial paradigm among macroeconomists and not official policy for any government. In a simplified formulation, “modern monetary theory” suggests that governments that can issue currency can increase money supply (“print money”) to pay off future obligations, such as the debt used to finance current fiscal deficits.

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