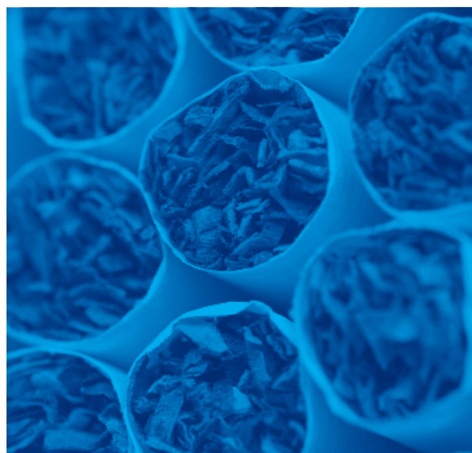
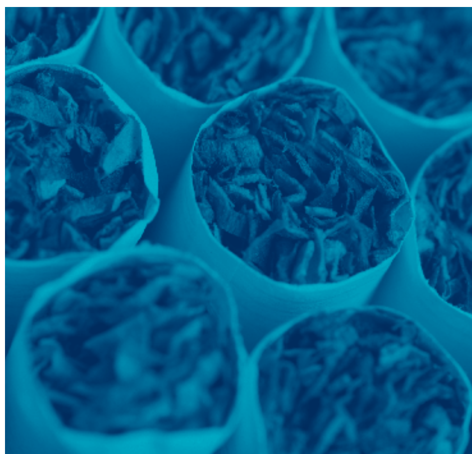
# EARMARKED TOBACCO TAXES

*lessons learnt from nine countries*





World Health Organization

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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*).

# 3. Earmarking practices in nine countries

The nine national governments and their political contexts are diverse, which could complicate comparisons of their taxation systems and mechanisms and how revenues are reallocated and expended. This section focuses on the common and unique features and issues that might have implications for adoption of this type of fiscal policy by other countries in different levels of development and with different tobacco consumption and tax systems. Table 1 provides information about the tobacco problem (adult smoking prevalence), tobacco taxation (excise taxes, cigarette prices and affordability), population size and gross domestic product (GDP) in each of the nine countries.

**Table 1.** Smoking prevalence, cigarette prices and excise taxes in nine countries in the six WHO regions

| Country | Smoking prevalence (current adult smokers) (%) 2013* | Retail price of a pack of 20 cigarettes (premium (P) and cheapest (C)) 2014 (US$) | Excise tax (% of price) | Percentage of GDP per capita to purchase 100 packs of most sold brand (affordability) | Total population (thousands) 2013 | GDP per capita, current prices 2013 (US$) |
|---|---|---|---|---|---|---|
| Botswana | NA | 3.08 (P)<br>NA | 51.97 | 3.98 | 2 021 | 7 117.74 |
| Egypt | 23.8 | 2.80 (P)<br>1.12 (C) | 73.13 | 3.35 | 85 378 | 3 204.57 |
| Iceland | 17.5 | 10.59 (P)<br>9.11 (C) | 36.08 | 2.12 | 321 | 47 630.03 |
| Panama | 7.4 | 4.50 (P)<br>3.50 (C) | 43.48 | 3.60 | 3 864 | 10 489.60 |
| Philippines | 26.7 | 1.27 (P)<br>NA | 63.55 | 2.11 | 98 394 | 2 790.88 |
| Poland | 29.4 | 4.73 (P)<br>3.20 (C) | 61.59 | 3.07 | 38 533 | 13 820.17 |
| Romania | 30.5 | 4.48 (P)<br>3.85 (C) | 56.06 | 4.32 | 20 020 | 9 001.05 |
| Thailand | 21.5 | 2.81 (P)<br>1.00 (C) | 66.59 | 3.66 | 67 011 | 5 670.13 |
| Viet Nam | 23.7 | 1.07 (P)<br>0.26 (C) | 32.50 | 4.25 | 91 680 | 1 901.70 |

Sources: GDP from reference *10* and the remaining information from references *1* and *11*.
NA, not available
* Age-standardized estimates

The nine countries have all regulated tobacco use and tobacco taxation by law. While all have specific statutes for earmarking tobacco taxes and for their collection, not all are operational (Table 2). Poland, the exception, 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, the new Public Health Act dissolved the initial tobacco control programme and incorporated tobacco control activities into the National Health Programme, which will now be financed from the State budget, therefore terminating the earmarking of revenues specifically for tobacco control. The introduction of earmarked taxes and the estimated annual total funds in each country are listed in Table 2, which shows that the earmarked taxes represent small amounts (except for the Philippines) and would therefore not introduce budget rigidity.

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

| Country | Year earmarking tobacco tax established | Funding source | 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 | 30% of production cost of tobacco products | 2014–2015: BWP 4 million (US$ 0.48 million) | NA | 3.1% |
| Egypt | 1992 | 10 piastres on each pack of 20 cigarettes | 2013–2014: EGP 392 million (US$ 52.06 million)<br><br>Earmarked taxes only 1.8% of total taxes on cigarettes | 1.086% | 2.1% |
| Iceland | 1972<br><br>1977 (suspended)<br><br>1985 (reintroduced)<br><br>1996 (amended)<br><br>2001 (amended) | 0.2% of gross tobacco sales value (1972)<br><br>0.7% of gross tobacco sales value (1996)<br><br>0.9% of gross tobacco sales value (2001) | 2014: ISK 108.3 million (US$ 0.89 million) | 0.083% | 7.0% |
| Panama | 2009 | 50% of selective consumption tax on cigarettes and other tobacco products<br><br>The level of the selective consumption tax was 32.5% of price declared by the wholesaler/importer in 1995 and it was increased to 50% in September 2009 and 100% in November 2009 | 2014: US$ 27.8 million | 1.322% | 5.2% |

| | | | | | |
|---|---|---|---|---|---|
| Philippines | 1997 (RA 8240) and 2004 (RA 9334)<br><br>Tobacco and alcohol excise tax reform in 2012 (RA 10351 or the "Sin Tax Reform Law of 2012") | More than 85% of incremental revenue from excise on tobacco and alcohol products | 2014 incremental revenue: PHP 50.23 billion (US$ 1.13 billion)<br><br>Earmarked amount to the Department of Health PHP 44.72 billion (US$ 1.01 billion)<br><br>Allocated amount for the Department of Health in 2014 PHP 30.49 billion (US$ 0.69 billion) | 36.4% * | 1.4% |
| Poland | 2000 (terminated in 2015) | State budget (0.5% of the value of the excise tax on tobacco products) | 2013: PLN 1 million (US$ 0.316 million) from general budget<br><br>Earmarked tobacco tax not allocated to the Ministry of Health | 0.001% | 4.6% |
| Romania | 2005 | Earmarked tax on tobacco and alcohol<br><br>10 €/1000 cigarettes, 10 €/1000 cigars, cigarillos and other tobacco products for smoking, 13 €/kg of smoking tobacco | 2014: Lei 1.1 million (US$ 0.33 million); 14.4% of total health budget | 0.004% | 4.2% |
| Thailand | 2001 | 2% surcharge tax on tobacco and alcohol | 2014: THB 4064.74 million (US$ 125.15 million) 1.78% of Ministry of Health budget and 1.84% of National Health Security Fund | 0.932% | 3.7% |
| Viet Nam | 2012 | Compulsory contribution by tobacco manufacturers and importers to Viet Nam Tobacco Control Fund: 1% of factory price effective from 1 May 2013, 1.5% from 1 May 2016 and 2% from 1 May 2019 | 2014: VND 299.171 billion (US$ 13.91 million) 0.5% of national health budget | 0.335% | 2.5% |

*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.

## 3.1 Process and strategies for achieving legislative change

The process for establishing earmarked taxes for the health sector has often been associated with tobacco control advocacy and health policy. For instance, in Iceland, discussion on earmarking tobacco taxes began as early as 1969. Some of the common campaign features for the introduction of earmarked tobacco taxes are summarized below.

### Finding the policy opportunity

The impetus for sustainable funding was usually the international political context or a national initiative to introduce tobacco control (particularly in recent years by Parties to the WHO FCTC). A common component of each country's campaign for earmarked taxes for health programmes was framing the taxes as both a fiscal and health benefit for the country. While most countries sought to introduce more comprehensive tobacco control measures, in Egypt, the Ministry of Health proposed an earmarked tax on cigarette sales to supplement the budget for student health insurance fees. The policy opportunities identified in each country are listed in Table 3.

**Table 3.** Policy opportunities used to introduce earmarked tobacco taxes

| Country | Year earmarking tobacco tax established | Law | Policy opportunity |
|---|---|---|---|
| Botswana | 2014 | Tobacco Levy 2014 by Presidential Directive<br>Control of Smoking Act CSA92 1992<br>Tobacco Control Bill (2015) | Strong political commitment to public health<br>Revision of the tobacco law for compliance with the WHO FCTC<br>Concern about young people smoking |
| Egypt | 1992 | Ministry of Finance Resolution No. 99 1992 | Additional funds to cover the cost of extended student health insurance |
| Iceland | 1972<br>1977 (suspended)<br>1985 (reintroduced) | Alcohol and tobacco laws (1972)<br>Tobacco Control Law (1985) | A comprehensive tobacco control law included reintroduction of earmarked tobacco taxes in 1985 |
| Panama | 2009 | Act No. 69 | Increases in selective consumption taxes and ratification of the WHO FCTC |
| Philippines | 1997 and 2004 with reform in 2012 | Republic Act 9334 (2004)<br><br>Republic Act 10351 (2012) on restructuring the excise tax on alcohol and tobacco products | Reform of the national Internal Revenue code, including large tax increase on tobacco products<br><br>Structural weaknesses in application of tobacco excise taxes |
| Poland | 2000 | Protection of Public Health against the Effects of Tobacco Use 1995 Regulations 1999, came into force in 2000 | A proposed amendment to the tobacco control law |

| | | | |
|---|---|---|---|
| Romania | 2005 | Law for health reform (No. 95/2005) | Two European Union directives on tobacco products and signing of the WHO FCTC |
| Thailand | 2001 | Health Promotion Foundation Act 2001 (BE 2544) | Inclusion of a health promotion fund and health insurance fund in the fiscal and financial master plan (1997–2001) |
| Viet Nam | 2012 | Prevention and Control of Tobacco Harms law | Ratification of the WHO FCTC in 2004 |

### Presenting a sound rationale and evidence

In each country, the rationale for earmarking tobacco (and alcohol) excise taxes was usually to improve public health. It was also funded from a tax increase, therefore tapping into new resources, rather than on existing ones. Evidence for the validity of this argument, often with evidence of an increase in fiscal revenue, generally persuaded legislators. The case for reform in the Philippines was that an earmarked tax would significantly increase both the budget for health and the general level of taxation, thus extending the overall fiscal space. In both cases, the political momentum or readiness to increase excise taxes largely came from understanding that the increased tax would be used for a defined policy outcome or priority. In Thailand and Viet Nam, the argument used in their campaigns for earmarking tobacco taxes was for a continuous, regular source of revenue for underfunded preventive public health programmes.

### Policy synergies and building consensus between finance and health sectors

Another common strategy was building collaboration between the financial and the health sectors for joint advocacy on earmarking taxes for health. Often, only a Ministry of Finance can decide to increase taxes. Earmarked taxes give ministers of health an incentive to support their finance ministers, hence creating synergy between the two portfolios. Limited funding for health and low tax revenues led to policy synergies between the two sectors in most countries. The earmarking of tobacco (and alcohol in some countries) taxes was a politically saleable means for meeting two objectives; the win–win policy measure protects both public health and the revenue requirements of a country. For example, the Fiscal and Financial Master Plan (1997–2001) of Thailand's Ministry of Finance made it possible to earmark tobacco and alcohol taxes for a health promotion fund.

### Strategic partnerships and leadership

Strategic partnerships between policy-makers, health professionals, researchers, advocates, civil society and the media were essential for achieving earmarked taxes for health. Many countries now recognize the importance of ministries of health in innovative partnerships, particularly with finance, to generate a sustainable source of revenue for health-related prevention programmes and treatment. For instance, a partnership between the ministries of Health and Finance was the basis for establishing the Viet Nam Tobacco Control Fund. The process was initiated by a group of health professionals and tobacco control advocates, led by the Steering Committee on Smoking and Health. Many partnerships were required to achieve the desired outcome, with coordination across government, civil society, the media, local leaders, special interest groups and donors.

## 3.2 Fund management and use of earmarked taxes

Earmarked tobacco taxes and revenues (in some countries combined with earmarked alcohol taxes) are usually attributed to the Ministry of Health for allocation, as in Iceland (where at one time there was a separate fund manager), Panama, the Philippines and Romania. The Ministry of Health in Poland, who was responsible for the tobacco control programme and fund, did not apply for or receive the earmarked taxes, whereas Thailand established an autonomous fund manager and Viet Nam a semi-autonomous fund manager. There are strategic trade-offs in each case, but avoidance of political interference is essential. It is equally important to ensure due diligence in accounting for use of the funds to Parliament. See Table 3.

### The Ministry of Health as fund manager

In most of the nine countries, the Ministry of Health is the fund manager. While this can be considered an efficient approach, safeguards must be present against pooling of earmarked funds with general revenue, which could result in diversion of funds from their intended purpose due to the fungibility of general budgetary allocations. The Ministry of Health is the fund manager in Botswana, Iceland, Panama, the Philippines and Romania, although the management and nature of expenditure varies. In Egypt, the General Authority for Health Insurance is the fund manager.

### Autonomous fund manager

The Thai Health Promotion Foundation is a statutory authority (outside any ministry) with an independent board of 21 members under the supervision of the Prime Minister. The Foundation's governance board monitors operations, while an independent board evaluates the overall performance of the Foundation and submits a performance and financial report annually to the Cabinet and to both houses of Parliament.

### Semi-autonomous fund manager

In Viet Nam, the earmarked tobacco tax is directed to the Tobacco Control Fund within the Ministry of Health. The Fund functions semi-autonomously, to retain flexibility in disbursement while subject to financial management by the Ministry of Finance. The Ministry of Health is responsible for reporting annually to the Government on the performance and use of the funds and also reports biannually to the National Assembly on the results of operations and management of the fund.

**Table 3.** Fund management and expenditure of earmarked taxes in eight countries in 2014*

| | Botswana | Egypt | Iceland | Panama | Philippines | Romania | Thailand | Viet Nam |
|---|---|---|---|---|---|---|---|---|
| Fund manager | Ministry of Health<br><br>The Tobacco Levy Fund Board provides oversight and accounts to the Minister of Health on use of the fund.<br><br>A Levy Implementation Committee provides technical guidance and supervision to the Department of Public Health, which is the implementing structure within the Ministry. | The General Authority of Health Insurance<br><br>Revenue collected by both the Sales Tax Department and Customs and deposited in a special account for student health insurance. | Directorate of Health<br><br>Tobacco and alcohol earmarked funds pooled into a public health fund managed by the Directorate of Health.<br><br>The Directorate appoints a board for the fund, comprising members of specialist tobacco and alcohol committees and others. | Ministry of Health<br><br>Act No. 69 of 2009 apportions funds to health and customs under the management of the Ministry of Health. | Department of Health<br><br>RA 10351 requires the Department of Health to "identify the annual funding requirements for financial risk protection, medical assistance, health enhancement facilities programme and other health programmes".<br><br>The Development Budget Coordination Committee, including the Department of Budget and Management and the Department of Finance, reviews the medium-term expenditure programme, which is the basis for annual allocation of the incremental revenue for universal health care, medical assistance and health enhancement facilities. | Ministry of Health<br><br>In accordance with Law 95/2005. | Thai Health Promotion Foundation (ThaiHealth) with autonomous fund manager supervised by the Prime Minister.<br><br>ThaiHealth has two governing bodies: a multi-sectoral Board of Governance (21 members) and an Evaluation Board with 7 members. The Board of Governors is chaired by the Prime Minister, the Minister of Public Health (first Vice-chair) and an independent expert appointed by the cabinet (second Vice-chair). Nine members are representatives from different ministries, and another eight are independent experts in various disciplines with no political affiliations. | Ministry of Health and Tobacco Control Fund, in accordance with law on Prevention and Control of Tobacco Harms (2012).<br><br>Semi-autonomous, with Inter-sectoral Management Board, chaired by the Minister of Health with members from Ministry of Finance (Vice-chair), Ministry of Industry and Trade, Ministry of Education and Training, Ministry of Information and Communication, the Labour Union and others. |

| | Botswana | Egypt | Iceland | Panama | Philippines | Romania | Thailand | Viet Nam |
|---|---|---|---|---|---|---|---|---|
| Expenditure | Funds are yet to be expended but will be used for health promotion, including tobacco cessation, rehabilitation and public education. | For preventive health and rehabilitation services for primary and secondary students by providing:<br>• a comprehensive medical examination at the beginning of each stage of education;<br>• vaccination;<br>• specific regular medical examination and in health emergencies;<br>• medical recommendations to the educational authority to provide the necessary services necessary to maintain environment health;<br>• examination of students practising various activities to determine their fitness for the activities;<br>• health awareness; and<br>• supervision of nutrition. | At least 0.9% of gross tobacco sales is allocated to tobacco control.<br><br>2011 (estimates)<br><br>• 20% of total spent on specific tobacco control activities; and<br>• 80% on general health promotion.<br><br>65% of funds are allocated to programmes run by or in conjunction with the Directorate of Health and 35% are granted to specific projects by application.<br><br>Settings include schools and communities. | 50% of tobacco excise revenues for health purposes.<br><br>The earmarked amount is distributed as follows:<br><br>About 40% to the National Cancer Institute for improving treatment and facilities.<br><br>40% to the Ministry of Health, which, in 2010–2011, expended:<br>• 70% to promote health, diagnosis and support cessation, with 20.1% to health promotion; 30.9% for diagnosis in primary health care; and 19% for smoking cessation and treatment of chronic diseases<br>• 23.4 % for WHO FCTC implementation and monitoring<br>• 4.9% for diagnostic support (laboratory services); and<br>• 1.7% for building capacity.<br><br>20% to the National Customs Authority (no data available from Customs). | More than 85% of incremental tax revenues go into health programmes, which include:<br>• universal health care under the National Health Insurance Programme,<br>• attainment of the health-related Millennium Development Goals,<br>• health awareness programmes, medical assistance and<br>• health enhancement facilities.<br><br>15% to alternative livelihood programmes for tobacco farmers (and economic projects in tobacco-growing provinces). | 10 € per 1000 cigarettes and 13 € per kg loose tobacco are dedicated to health<br><br>The Ministry of Health funds:<br>• the health system infrastructure; and<br>• national public health programmes (including for tobacco control) and other health-related services, such as an emergency system. | In accordance with the Foundation's strategic plans in 14 areas:<br><br>• 90% spent on 14 action plans. with 36% of funding within the plans to decrease the main health risks (tobacco and alcohol consumption and unsafe driving) and to increase physical activity and healthy eating<br>• 5% for administrative overheads. | In 2015:<br>• 47% of the total budget allocated to raise awareness among policy-makers and the public on the harm of tobacco and the tobacco control law;<br>• 36% for disseminating smoke-free models in State agencies and localities;<br>• 6% to improve and strengthen tobacco cessation services, the quitline and consultancy services in all health settings;<br>• 2% planned for capacity-building in the network of tobacco control collaborators and the Fund's Executive Board;<br>• 2% for research on the harm of tobacco, intervention programmes and their socioeconomic impact;<br>• 3% for building the capacity of the network of inspectors to monitor and enforce the tobacco control law; and<br>• 4% for administration and performance of the Fund. |

*Poland is excluded from table, as revenue was not transferred to a specific fund.

## 3.3 Contribution to health programmes and health outcomes

In the countries in which the earmarked tobacco taxes are allocated specifically to the health sector, they constitute new revenue for health programmes (see Table 2), and significant policy implementation has been undertaken and/or commenced. To measure the impact of the earmarked tobacco tax revenue policy on health outcomes, all the other economic and political factors that could have influenced health must also be taken into account. While no clear association can be demonstrated, improvements in health outcomes have been seen in the past few decades in the countries studied (Table 4).

**Table 4.** Health outcomes since establishment of earmarked tax revenue

| Country | Health outcomes (association not proven) |
|---|---|
| Botswana | Being established |
| Egypt | NA |
| Iceland | Adult daily smoking rate now < 15%<br>Study of the well-being of Icelanders in 2012 showed that more than half of the population had never smoked or had quit smoking.<br>Between 1981 and 2006, the death rate from coronary heart disease decreased for 25–74-year-olds, and that for lung cancer was increasing between 1980 and 2009 but has now plateaued. |
| Panama | Between 2007 and 2013, tobacco use decreased from 9.4% to 6.4%, the lowest recorded rate in the Americas at that time, due to a number of factors, including taxation.<br>Evidence of:<br>• a reduction in smoking prevalence,<br>• a reduction in the relative risk for acute myocardial infarction and<br>• a decrease in mortality from diseases associated with tobacco use from 16.4% in 2005 to 12.1% in 2012<br>Reduced affordability had a regulating effect on smuggling. |
| Philippines | A significant reduction in smoking prevalence, from 31% in 2008 to 25.4% in 2013[a] (the first year of implementation of the sin tax). |
| Poland | A significant reduction in daily smoking among people aged ≥ 15, from 33% in 1999 to 24% in 2015 |
| Romania | A reduction in the prevalence of daily smoking from 30.9% in 2008 to 24.3% in 2011<br>The emergency service system is partially funded by earmarked taxes. |
| Thailand | Prevalence of smoking among adults (> 15 years) decreased from 25.47% in 2001 to 20.7% in 2009 due to tobacco control, including taxation.<br>A similar reduction was reported in alcohol consumption, from 9.1% in 2004 to 7.3% in 2009.<br>The death rate from vehicle accidents decreased from 22.9 per 100 000 in 2003 to 16.82 per 100 000 in 2010.<br>The total number of Thai people who reported exercising regularly increased from 29% in 2003 to 29.6% in 2007.[b] |
| Viet Nam | Being established |

[a] The prevalence in 2013 in this table is different from that reported in Table 1 because they are derived from different datasets. In Table 1, an age-standardized number was used to compare countries. In this table, the number is the actual prevalence, which is comparable with the prevalence reported in 2008 and therefore over time.

[b] Vathesatogkit P, Ritthiphakdee B. The impact of the tobacco tax policy. Presented at a workshop on regional experience in tobacco tax, 5 July 2013, Halong, Quang Ninh, Viet Nam.

NA, Not Available

# 4. Challenges and lessons learnt

The nine countries studied all developed and coordinated a campaign with clear understanding of how the tobacco tax was to be used. The challenges and lessons of the nine countries are remarkably similar.

All the nine countries that enacted legislation for earmarking taxes for promoting health and funding tobacco control strategies experienced opposition and delays to legislative reform, essentially from two areas: normative fiscal policy beliefs and tobacco industry influence. One lesson learnt is that the process for establishing an earmarked tax should be short, so that the opposition has less time to counter the policy momentum (*12*).

In some countries, it was not difficult to achieve consensus between fiscal and health officials; however, in most cases, understanding had to be built of the twin benefits of increasing excise or consumption taxes on harmful products and earmarking a proportion for a range of health programmes.

Lobbying of decision-makers by the tobacco industry was seen in most countries. In Poland, the tobacco industry lobby appears to have been very persuasive, as there was little political commitment to implementing the earmarking finance mechanism.

The Philippines faced a different dilemma. With a sudden increase in the budget for universal health coverage, the Directorate of Health had to spend the new resources, while it had limited absorptive capacity for the new programme expectations.

While there is no single formula for addressing these challenges, the campaign and implementation programmes of each country show some common and some unique lessons that are illustrative for others, as listed below.

### *Present a consistent, evidence-based rationale that is persuasive for decision-makers.*

A strong, effective argument used during public debates by officials of the Romanian Ministry of Health was the ethical aspect of the measure: smokers have to pay more to the public health system, as they are more frequent users of medical services. In return, the Ministry would support them in giving up smoking by financing a programme for tobacco control.

### *Specify the financing mechanism and use of the funds.*

The simpler the mechanism for collecting and transferring earmarked revenue, the greater the administrative efficiency and the smaller the likelihood of political interference. For example, the Panamanian Ministry of the Economy and Finance

collects the selective consumption tax, and their Revenue Department notifies the National Bank of the amount of the tax, which is transferred to the sub-account for tobacco control of the Ministry of Health account. This money is not routed through the national budget and has no impact on the budget lines of any other source or entity.

### *Pay close attention to implementation.*

How the earmarked tax is to be used, the type of funding mechanism and also the administrative structures for managing and allocating the funds must be clearly stated in the legislation (*12*).

### *Form partnerships in all sectors of society for the establishment of an earmarked fund and to counter opposition.*

A campaign to advocate for an earmarked fund requires only a small group of dedicated people. Their influence will grow by building strategic alliances. Important relationships are those with the government health and fiscal departments to ensure agreement on the funding mechanism, its administration and the amount of earmarked funds.

### *Build strong political support, and use political champions.*

Before initiating a campaign, ensure that there is a positive political environment. Timing is essential (*12*).

### *Be patient and persistent, and identify opportunities for policy change.*

The time it takes to implement new legislation varies; therefore, a campaign for earmarked taxes for health will require both a short- and a long- term strategy.

### *Think globally while acting locally.*

Networking and partnering should extend beyond national boundaries, not only to support the tobacco control lobby but also to obtain intra-disciplinary support from taxation specialists and health policy-makers and administrators. Decision-makers who are aware of successful legislative models in other countries gain confidence that they can be adapted to their context.

# 5. Present and future opportunities for advocacy on earmarked taxes

The establishment and use of earmarking taxes for tobacco control and other health programmes in the nine countries reviewed is now in the past. New opportunities are now available for advocacy for earmarking funds for tobacco control or health promotion:

- Specific guidelines for dedicating revenue from tobacco tax for tobacco control is given in Article 6 of the WHO FCTC. In mid-2015, less than one fifth of countries had dedicated tax revenues for tobacco control (*1*).

- Economic analysis of health financing shows that insufficient funds are available from international development aid and national domestic budgeting for health, especially for NCDs (*13*). Even when funds are available, both development aid and domestic allocations for tobacco control are often unsustainable, irregular and too low to fund comprehensive tobacco control programmes (*14*).

- The political declaration of the high-level meeting on NCDs in 2011 recommended that implementation of the WHO FCTC be accelerated and that predictable, sustainable resources be found through innovative financing mechanisms (*15*). Tobacco use is a central risk factor for NCDs, which represent the greatest disease burden worldwide and 80% of that in low- and middle-income countries (*16*).

- Adoption of the 2030 United Nations Agenda for Sustainable Development in 2015 by 193 world leaders committed them to achieving 17 Sustainable Development Goals (SDGs) with 169 targets to end extreme poverty, fight inequality and injustice, improve health and well-being and protect the planet over the next 15 years. The WHO FCTC is one of the four means for meeting the targets of SDG 3 on health, which pledges governments to ensure healthy lives and promote well-being for all at all ages. Tobacco taxation is also referred to in the 2015 Addis Ababa Action Agenda, a framework adopted to catalyse domestic, multilateral and private investment for achieving the SDGs, including policy commitments to increase financing for addressing NCDs.

For low- and middle-income countries in which funding for NCDs is not available through normal budgetary mechanisms, earmarked tobacco taxes are a compelling choice for ensuring full implementation of the provisions of the WHO FCTC.

# 6. Conclusions

The countries studied earmark tobacco tax revenues for the health sector. While no clear association has yet been identified between a tobacco tax earmarked for health and actual health outcomes, the earmarked taxes (after a tax increase) have increased tobacco prices and generated funds for tobacco control programmes. Political acceptance of earmarking tobacco revenues for health programmes in these countries lends support to the introduction of such measures when revenues for tobacco control programmes are minimal. Although all the factors that might be responsible have not been analysed rigorously, the consistency of the results is important. Positive outcomes have also been reported when the funds have been used for other health programmes and infrastructure.

The case for earmarking tobacco (and alcohol) taxes for health programmes (particularly tobacco control) is supported by the experience of eight of the countries studied. All saw benefits in having a predictable, secure source of funds for long-term interventions. The fact that the fund in each country represents only a small fraction of the total health budget and efficient use of the funds and clear reporting and accountability mechanisms made it easy to address traditional arguments against earmarking taxes. The small fraction of the general health budget earmarked for preventive programmes like tobacco control did not disrupt fiscal discipline or create undue rigidity.

While each government will have to weigh the advantages and disadvantages of applying an earmarked tax on tobacco or alcohol products, the case studies show that, when sufficient revenue is generated to fund national health promotion programmes, they will ultimately reduce the impact of NCDs.

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# Annex 1.
# Reported use of earmarked tobacco taxes

| Country | Reported use |
|---|---|
| Algeria | 6 dinars per pack of cigarettes for the emergency fund and medical care; 2 dinars per pack for cancer control |
| Argentina | Additional emergency tax of 7% of retail price to finance social and/or health programmes of the rural change programme and the social–agricultural programme |
| Bangladesh | Additional excise of 1% of the retail price to the Ministry of Health |
| Cape Verde | All excise tax revenues used for sports and health |
| Colombia | 16% of the specific excise tax on tobacco products used for sports and all revenues from ad valorem excise for health |
| Comoros | Part of the 5% of tax on tobacco to the Ministry of Sports and to hospital emergency departments |
| Congo | Half of the specific excise tax per pack (40 XOF) to health insurance and half to sports |
| Costa Rica | All revenues from the specific excise tax are used to fund programmes for the prevention and treatment of diseases related to tobacco use, cancer treatment, harmful use of alcohol and sports |
| Côte d'Ivoire | An extra tax of 5% goes to the AIDS solidarity fund and another 2% to sports |
| Egypt | An extra tax of 10 piastres per pack is used to fund student health insurance |
| El Salvador | 35% of revenues from taxes on tobacco, alcohol and firearms, ammunition and explosives (or a minimum of US$ 20 million per year) fund the solidarity fund for health |
| Guatemala | All revenues from the ad valorem excise tax on tobacco used for health programmes |
| Iceland | At least 0.9% of gross tobacco sales is allocated to tobacco control |
| India | 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 |
| Indonesia | 10% surcharge imposed on tobacco excise; at least 50% allocated for health programmes and law enforcement at regional level and 2% of tobacco tax revenues allocated to regional governments, of which a proportion should be used for health |
| Iran (Islamic Republic of) | Up to 2% of taxes collected on tobacco products are used to support tobacco control activities |
| Jamaica | 20% of the special consumption tax on tobacco and another 5% of the tax on all products including tobacco to the National Health Fund |
| Madagascar | 6 ariary per pack to fund the National Fund for the Promotion and Development of Youth, Sports and Recreation |
| Nepal | All tobacco tax revenues go to the Health Tax Fund to finance mainly prevention and treatment of NCDs |
| Panama | 50% of tobacco tax revenues collected go to the National Institute of Oncology, the Ministry of Health for cessation services and Customs to fight illicit trade in tobacco products. The Ministry of Health also uses the funds for regional activities on tobacco control. |

| Philippines | After the tax increase in 2012, more than 85% of incremental revenue goes to health programmes. Of this, 80% is allocated for universal health care, the health-related MDGs and health awareness, with 20% nationwide for medical assistance and health enhancement facilities |
|---|---|
| Poland | 0.5% of the excise duty funds a programme to reduce tobacco product consumption (never implemented and terminated in 2015) |
| Republic of Korea | 354 won per pack goes to the Health Promotion Fund, which finances health promotion research and projects |
| Romania | 10 € per 100 cigarettes and 13 €/kg of loose tobacco are dedicated for health. Additionally, 1% of the excise on cigarettes is used to finance sports. |
| Switzerland | 0.26 CHF per pack of cigarettes goes to the Tobacco Prevention Fund |
| Thailand | Surcharge of 2% on tobacco and alcohol excise goes to the ThaiHealth Fund |
| The former Yugoslav Republic of Macedonia | 0.053 denars per piece (cigarette) allocated to fund drugs for rare diseases |
| United States of America | Amount per pack varies by state and funds different types of activity, mainly for health |
| Viet Nam | An additional ad valorem compulsory contribution (1% of producer or imported price) goes to the Tobacco Control Fund |

# Annex 2. Country case studies of experience with tobacco tax earmarking

## BOTSWANA

### 1. Description of the earmarked tax

Botswana has a long history of political commitment to the principles of primary health care, including protecting public health from vested interests and other threats. The country promulgated its first tobacco law, the Control of Smoking Act (CSA92), in 1992; it is under repeal and is about to be replaced by a law that complies with the WHO Framework Convention on Tobacco Control (WHO FCTC). The Tobacco Control Act is currently awaiting Cabinet and Parliamentary approval. CSA92 is the primary current legislation covering tobacco control, with the Presidential directive that introduced a tobacco levy of 30% of unit cost in February 2014 that has so far accrued US$ 4 million. The money is collected by the Botswana Unified Revenue Services of the Ministry of Finance and Development Planning and deposited in a central account managed by the Ministry of Health, in recognition of the impact of tobacco use on the health sector, which deals with the morbidity and mortality caused by tobacco.

The levy funds are therefore earmarked for general health promotion activities, with a focus on the prevention and control of noncommunicable diseases (NCDs) and the social ills caused by tobacco. Botswana's NCD and tobacco profiles show that 20% of cancers are related to tobacco use and that 14.3% of young people aged 13–15 years are current smokers. These and other statistics drove the country's leaders to introduce the levy, which is to be increased annually until tobacco products become unaffordable to young people and expensive enough for adult consumers. The increases will follow the principle of reaching 75% of unit cost.

The funds accrued by the levy will be used to fund health promoting activities, including aid for tobacco use cessation, rehabilitation and public education. The Department of Public Health will report to and be guided by an intersectoral board, which reports to the Minister of Health, who in turn reports to Parliament and the Office of the President.

The Botswana Revenue Services (Ministry of Finance and Development Planning) collect the revenue and deposit it into a dedicated account accessible by the Ministry of Health. For proper

management of the funds, the Tobacco Levy Fund Board will be trained to provide oversight and be accountable to the Minister of Health. The Levy Implementation Committee will also be trained to provide technical guidance and supervision to the Department of Public Health, which is the implementing structure in the ministry. The Levy Implementation Committee will approve proposals for funding from interested parties, including the Ministry of Health itself. Once approved, projects and activities will be funded by disbursing approved budget amounts to the accounts of the implementing agencies, which will be expected to provide quarterly and end-of-project reports, so that their progress, efficiency and impact can be monitored.

## 2. Process that led to adoption of the law

The Ministry of Health and its partners have led education of the public about the ill effects of tobacco and countering the influence of the tobacco industry. Botswana law outlaws tobacco advertising, promotion and sponsorship. Research and surveillance on tobacco use has tended to focus on young people. Studies such as the 2005 Global Student Health Survey and the 2008 Global Youth Tobacco survey showed that about 14% of Botswana students were current smokers. The 2007 STEPS survey[1] is currently the only source of credible data on smoking among adults, and the results of the 2014 STEPS survey will shed further light on this group.

Parents and traditional, religious and political leaders saw that smoking patterns and behaviour were eroding social norms and harming public health, as had alcohol use, and therefore decided to act by supporting the work of the Ministry of Health. As was to be expected, the tobacco industry went on the offensive and engaged in a protracted media campaign to protect their products and attempt to prove that the problem was not their products but the consumers. They signed memoranda of understanding with strategic Government sectors, ostensibly to support research, action against illicit trade and other activities. The industry was able to influence traders in the informal sector to a certain extent, inciting them to complain about interference with their livelihoods. Finally, one Government department that had signed a memorandum of understanding with the industry was helped to annul it, while another is maintaining the relationship in spite of advice to end it. Public education and advocacy with strategic structures such as Parliament overcame complaints and issues from small businesses. Imposition of the Tobacco Levy Order succeeded because it had the approval of the Head of State and because evidence showed a worrying trend of use among young people.

## 3. Statistics of the earmarked funds

After 1 year of collection, the amount accrued is US$ 4 million, giving an idea of what the annual trend will be. No funds have yet been disbursed, as the management structures and implementation modalities are still being organized.

1 The WHO STEPwise approach to Surveillance (STEPS) is a simple, standardized method for collecting, analysing and disseminating data in WHO member countries: http://www.who.int/chp/steps/en/

## 4. Impact of the tax

As the modalities are still being organized, the only discernible impact is an increase in the unit cost of tobacco products. Other effects may appear over time.

## 5. Current implementation

The only challenge observed is a delay in finalizing the implementation modalities. This is due partly to recent changes in the Government, one consequence of which is that a permanent director has not yet been assigned to the Department of Public Health, which is in charge of implementing the new policy.

# EGYPT

## 1. Description of the earmarked tax

Egypt's general budget depends on taxes and sovereign fees, which represent more than 70% of the State resources. Most State resources from taxes, whether direct or indirect, go to the Ministry of Finance, which disburses funds to various areas of expenditure, such as for education and health. There are limited exceptions, such as students' health insurance, imposed by law no. 99 of 1992, which covers students in all schools before university (from preschool to secondary school); university students are not covered. The law stipulates a tax of 10 piastres (US$ 0.012[2]) on every 20 cigarettes sold in the domestic market, whether they are local or foreign, for students' health insurance. Subscriptions are also collected from students, augmented from the State treasury, donations, subsidies and grants for this purpose. The law stipulates that a special account be opened for students' health insurance and payment of all services by the General Authority for Health Insurance. Law no. 99 stipulates that the tax for students' health insurance be imposed on locally produced cigarettes sold in the domestic market and be collected by the Sales Tax Department, with the general sales tax; the Customs Department collects the tax for students' health insurance along with customs duties on imported cigarettes.

The General Authority for Health Insurance is committed by the law to provide the following preventive health services to students:

- a comprehensive medical examination at the beginning of each stage of education;
- vaccination;
- specific medical examinations, both regularly and in health emergencies;
- recommendations to the educational authorities to ensure the health interventions deemed necessary to maintain environmental health;
- examinations to determine fitness for specific activities;
- health awareness-raising; and
- supervision of nutrition.

The General Authority is also committed to provide services in cases of illness and accidents, including:

- medical services by general practitioners at specific stages of treatment;
- medical services by specialists, including dental specialists;
- scanning, laboratory tests and other medical examinations;
- treatment and stays in hospitals, clinics and medical and specialized centres, surgical operations and other types of treatment;
- medicines; and
- all prosthetic devices, including eyeglasses.

2 Exchange rate as of end February 2016

Schools providing basic education (primary to preparatory) and pre-university technical schools, which are affiliated to the Ministry of Education (Al Azhar Al Sharif and Al Kifaya Al Entajiya ) and the Ministry of Health and Population are committed by law to establish medical clinics, in addition to hospitals affiliated to the General Authority for Health Insurance, that provide therapeutic services for students and to send all statistical data to the General Authority for Health Insurance. These services are provided subject to a very small membership fee paid annually by students (4 Egyptian pounds per year, equivalent to US$ 0.50). Students also pay one third of the cost of medicines outside hospitals (in clinics). The insurance is no longer available when the student finishes high school.

At its inception in 1992, the insurance plan covered 12 million students; it now covers about 20.6 million. As the revenues earmarked from the tobacco tax are not sufficient to cover all the services, the Government covers the deficit from other sources.

As the General Authority for Health Insurance is responsible for the expenditures of the students' health insurance according to the law and for providing insurance coverage to third parties, it must separate the revenues and expenses.

## 2. Process that led to adoption of the law

The Ministry of Health prepared the draft law and related studies to be submitted to the Cabinet for approval before forwarding them to the Parliament for endorsement. Preparation of the law took nearly 2 years, and the Government presented the draft to Parliament in October 1991. At that time, it did not include a tax on cigarettes; therefore, the health insurance system was financed only by subscriptions collected from students and the State treasury. The Parliament returned the draft to the Government for further study of the cost of insurance coverage and a request to reduce students' contributions by imposing a tax on cigarettes to cover health insurance.

The studies carried out to estimate the initial cost of the system and the contributions to be borne by students included the number of students to be covered by insurance (12 million) and the health interventions to be covered, including detection and treatment of acute and chronic diseases, surgery, provision of prosthetic devices, adaptation of clinics and establishment of new ones in underserved areas.

The Government presented a second draft law to the Parliament in July 1992, which included a tax of 5 piastres on each pack of 20 cigarettes. Parliament Members asked for better coverage of students with regard to the cost of treatment, the types of diseases to be covered and a reduction in the subscription. They finally raised the tax for health insurance to 10 piastres.

A number of arguments were raised against the draft law to impose a tax on cigarettes. It was pointed out that the tax would increase the price of cigarettes and therefore increase average household expenditure on tobacco products from the current 5% to 7%, which would affect expenditure on other needs. The Eastern Company, which markets all local and foreign

cigarettes in Egypt, argued that it would be negatively affected by reduced consumption. The Government refuted these challenges by stating that smoking is detrimental to health and that a tax on cigarettes would have only beneficial effects: The increase in prices would reduce consumption and thus improve citizens' health, and the tax on cigarettes would increase the resources for students' health insurance, which would increase insurance coverage.

The main reasons for maintaining the tax for health insurance and increasing it from 5 to 10 piastres were the requests of many Members of Parliament to extend insurance coverage to more students, increase the percentage contribution to the costs of treatment, operations and medicines and reduce students' subscriptions. This nevertheless requires more, dependable resources.

## 3. Statistics of the earmarked funds

The tax on cigarettes in Egypt has been raised four times in the past 5 years, but consumption has remained stable. The tax allocated to students' health insurance is a fixed amount on every 20 cigarettes, which has not changed since promulgation of the law on 22 July 1992; therefore, the revenue from the tax has been relatively stable, as shown below:

Revenues from the earmarked tax

| Fiscal year | Egyptian pounds (millions) | US$ equivalent (February 2016) |
|---|---|---|
| 2009–2010 | 427 | 54.53 |
| 2010–2011 | 395 | 50.44 |
| 2011–2012 | 376 | 48.01 |
| 2012–2013 | 398 | 50.82 |
| 2013–2014 | 392 | 50.06 |

These amounts comprise only a small part of the tax imposed on cigarettes, as the total tax revenue from cigarettes in the fiscal year 2013–2014 exceeded 21 billion Egyptian pounds (US$ 2.61 billion). The tax represents only 1.8% of all health insurance revenues in the same year (392 million pounds; US$ 48.77 million). The remainder of the tax on cigarettes is spent by the Ministry of Finance in accordance with the state general budget and is not allocated.

## 4. Conclusion

The Ministry of Health has asked several times for the amount of the tax to be raised to 50 piastres, and the Ministry of Finance issued resolution no. 120 on 23 February 2015 to that effect; however, the resolution was withdrawn the following day on the grounds that it violated the law that provided for only 10 piastres, which does not permit or authorize any minister to increase the fee.

# ICELAND

## 1. History and description of the earmarked tax

The tax earmarked for tobacco control in Iceland dates to 1972. It was implemented by the Government at a time when the prevalence of smoking was increasing rapidly and the harmfulness of smoking was becoming known. Subsequent to the findings of Sir Richard Doll (*1*) in 1950, the Professor of Medicine at the University of Iceland, Dr Níels Dungal, published a paper on the harmful effects of smoking on health (*2*). Tobacco consumption in Iceland was similar to that in neighbouring countries, tobacco being advertised even in medical journals; there was a high smoking prevalence, and wholesale distribution of tobacco throughout the country was monopolized by the State Alcohol and Tobacco Company by law. Both professional and political interest in tobacco control began to be expressed.

The first formal proposals to ban advertising of tobacco in Iceland were brought before the Parliament in December 1964 and again in 1967, but neither was passed into law because of lack of political support (*3, 4*). In 1969, an independent law was passed regarding the organization of the State Alcohol and Tobacco Company (*5*), which included an article requiring health warning messages on cigarette packages. This was the first formal legislative provision in Iceland aimed to reduce smoking and one of the first examples of warning labels worldwide (*6*). The text to be put on packages was: "*Viðvörun*: *Vindlingareykingar geta valdið krabbameini í lungum og hjartasjúkdómum*", which can be translated as: Warning: Cigarette smoking can cause cancer of the lungs and heart disease. Use of an earmarked tobacco tax for tobacco control was first proposed in Parliament, and, in 1970, Parliament Member Jón Ármann Héðinsson proposed changes to laws on alcohol and tobacco to ban all advertising of tobacco in newspapers, radio and television and on outdoor billboards, on the basis of professional advice from the Chief Medical Officer at that time, Dr Bjarni Bjarnason. Mr Héðinsson found no support from his colleagues in Parliament, but, with support from society, public discussions and petitions, the proposal was passed. An additional proposal led to replacement of the warning labels on tobacco products by an earmarked tobacco tax amounting to 0.2% of gross nationwide tobacco sales (*7*). The rationale was that warning labels were not effectively reaching young people and children, the target population for prevention. The funds were to be allocated directly to tobacco control organized by a newly appointed national tobacco control committee. The law entered into force on 1 January 1972. One member of the committee was appointed by the State Alcohol and Tobacco Company, one by the Icelandic Cancer Society and one by the Icelandic Heart Association. An office for tobacco control was established at the Reykjavik Cancer Society. The focus of preventive activities from the beginning was educating children and students about the harmful effects of smoking on health, sending the same message through the mass media and newspaper advertisements. The funding available at that time

for tobacco control was similar to that for labelling cigarette packages, and this was used as the rationale for the tax in discussions in Parliament. These events marked the beginning of nationwide organized tobacco control in Iceland.

The *borgarlæknir*, the district medical officer in Reykjavik, surveyed the prevalence of smoking among adolescents aged 14–16 years old in 1975 (*8*) and found that about half of this age group smoked. Extensive education in Reykjavik elementary schools about the harmfulness of smoking on health and prevention measures were initiated by the Reykjavik Cancer Society, with rapid effects. At the same time, Þorvarður Örnólfsson, the Managing Director of the Reykjavik Cancer Society, was employed to manage all tobacco control projects and funding (*9*).

Over the next few years, several legislative changes were made, and the earmarked tobacco tax was dropped in 1977 (*10*). Nevertheless, changes were made to laws related to tobacco control, and the stated political aim was to preserve or increase funding for tobacco control, although this was not documented in the State budget. The changes included a ban on advertising of tobacco in the media, cinemas and outdoors and giving the Minister of Health the authority to publish regulations on smoke-free areas in public buildings and to appoint the Tobacco Control Committee. Thus, the State Alcohol and Tobacco Company no longer had a representative on the Committee and its role was broadened to conduct more extensive tobacco control programmes. Funding for tobacco control was not earmarked between 1977 and 1984, and both funding and activities decreased during this period (*11*). The Committee organized the first smoke-free day in Iceland on 23 January 1979.

The Icelandic Parliament passed the first comprehensive tobacco control law in 1984, which entered into force on 1 January 1985 (*12*). The law banned sale of tobacco to minors under 16 years of age and banned smoking in public places, schools, health care facilities, public transport, domestic flights and workplaces. The ban on advertising was more explicit than before, and a regulation called for graphic health warnings on cigarette packages (*5*). The Government, guided by the work of a committee at the Ministry of Health, made a political decision to restore the earmarked tax of 0.2% on tobacco sales, to be used to support implementation of projects proposed by the Tobacco Control Committee. There was no political support for a regular budget for tobacco control.

In 1991, Parliament adopted the National Health Policy 1991–2000 (*13*). Continuing support for tobacco prevention in Parliament was shown by revision of the tobacco control law passed in 1996 (*14*) to double the earmarked tax from 0.2% to 0.4%; however, during discussions, the tax was raised to 0.7% based not on a formal assessment of budget needs but on political support in Parliament for greater tobacco control. Several other changes were introduced when European Union regulations on tobacco were adopted, banning snuff and *snus* and sales to minors under 18 years. The Tobacco Control Committee was still appointed by the Minister of Health, with nominations from the Icelandic Cancer Society and the Icelandic Heart Association. An increase in the budget for tobacco control in 1996 made a huge difference. Two full-time staff were hired to work on tobacco control nationwide, a "train the trainer" programme was set up, and new educational material was published. During the next few years, "outreach" projects

were introduced, such as "Quit and win – don´t start" (*15*) and a "Smoke-free class" competition (*16*), which has been a nationwide project held annually since 1998. A quit-line for smoking cessation (*16*) was established in 2000 in collaboration with the Thingeyjarsyslur Health Centre and with specialist training from the Swedish quit-line. A considerable increase in mass media campaigns was seen, and public and professional discussions on tobacco control were supported, in collaboration with various organizations in sports, schools and municipalities and with health professionals.

In 2001, the Parliament adopted the second National Health Policy, for 2001–2010 (*18*), and the tobacco control law was revised for the third time (*19*), with a memorandum that unconventional methods of tobacco control would be required to achieve the goals for tobacco use in the National Health Policy. The major changes were a ban on displays of tobacco at points of sale, a ban on media coverage of tobacco other than warnings of its harmful effects, mandatory licensing of all tobacco sales and an increase in the earmarked tobacco tax to 0.9% of gross sales. The Office of Tobacco Control was still jointly run by the Icelandic Cancer Society and the Reykjavik Cancer Society, and the Tobacco Control Committee was still appointed by the Minister of Health every 4 years to allocate funds to projects. By this time, all indoor public places, transport, schools and sporting events were smoke-free, and it was time to seek new frontiers. The ban on displays at points of sale was met by legal action from the tobacco industry (*20*). A media campaign was released, and licensing of sales of tobacco led to a reduction in the number of retail outlets for tobacco.[3]

The next major change in the legal framework of tobacco control in Iceland was the founding of the Public Health Institute in 2003, which brought together several Government health promotion and prevention units (*21*), including nutrition, alcohol, drugs and tobacco. Prevention of both alcohol[4] and tobacco use was funded by earmarked taxes, which were included in the budget of the new institute, which financed tobacco control projects. When the Office of Tobacco Control was transferred to the Public Health Institute, the projects continued, and new programmes were started for general health promotion, in collaboration with schools (*22*). Between 1970 and 1975, the national tobacco committee was responsible for allocating the budget; when the State Alcohol and Tobacco Company was responsible, their projects were mainly mass media campaigns on the harm caused by smoking; between 1976 and 2003, the Tobacco Control Committee was responsible for the budget and allocated it to the Icelandic Cancer Society and the Reykjavik Cancer Society.[5]

In May 2011, the Public Health Institute was merged with the Directorate of Health (*23*), and committees on prevention in specific areas, such as tobacco and alcohol, appointed by the Directorate, replaced the independent Tobacco Control Committee. All earmarked funding for prevention of tobacco and alcohol use was subsumed in a new Public Health Fund, managed by the Directorate of Health in accordance with a regulation of the Ministry of Health (*24*). The board members include participants from the Directorate committees. In the current regulation,

3 Unpublished data from the Directorate of Health in Iceland, Embætti landlæknis, Reykjavík, 2015.
4 The earmarked tax for alcohol is promulgated in a separate law.
5 Unpublished data from the Directorate of Health, Embætti landlæknis, Reykjavík, 2015.

65% of the funds are allocated to programmes run by or in conjunction with the Directorate and 35% to specific projects by application (see Table 1). The Office of Tobacco Control was also transferred and continued the annual projects such as World No Tobacco day and the Smoke-free Class Competition. In response to increasing use of smokeless tobacco by young Icelandic men, the latter was changed to the Tobacco-free Class Competition in 2011. Health promotion projects were extended, with formal implementation in elementary and secondary schools; they are now also beginning at community level, with participation from the pioneer community, Mosfellsbær (*25*) and Reykjavík City (*26*).

**Table 1.** Total annual earmarked tobacco tax (million ISK), 2004–2014

| Year | Gross tobacco sales | Earmarked tax (0.9%) | Public Health Institute budget | Directorate of Health committee for tobacco control (65%) | Public Health Fund (35%) |
|---|---|---|---|---|---|
| 2004 | 12 815.00 | 115.3 | 115.30 | NA | NA |
| 2005 | 13 188.50 | 118.7 | 118.70 | NA | NA |
| 2006 | 13 152.80 | 118.4 | 118.40 | NA | NA |
| 2007 | 12 905.00 | 116.1 | 116.10 | NA | NA |
| 2008 | 12 728.80 | 114.5 | 114.50 | NA | NA |
| 2009 | 12 829.80 | 115.5 | 115.50 | NA | NA |
| 2010 | 12 360.50 | 111.2 | 111.20 | NA | NA |
| 2011 | 12 090.50 | 108.8 | NA | 70.70 | 38.10 |
| 2012 | 11 817.30 | 106.4 | NA | 69.10 | 37.20 |
| 2013 | 11 915.50 | 107.2 | NA | 69.70 | 37.50 |
| 2014 | 12 032.50 | 108.3 | NA | 70.40 | 37.90 |

Unpublished data from the Directorate of Health in Iceland, Embætti landlæknis, Reykjavík, 2015
All values are adjusted to the Icelandic Consumer Price Index from January of the respective year to January 2015.
NA, not applicable

The goal of the National Health Policy for 2010 to reduce daily smoking among adults to less than 15% was met. On ratification of the WHO FCTC, the national authorities assumed the obligation to integrate tobacco control into various policies, laws and regulations. The Government legislated a policy direction in 2010, called "Iceland 2020" (*27*), which included health promotion for the prevention of alcohol and drug use and to improve nutrition, physical activity, sexual health and mental well-being. In 2012, a new National Health Policy to 2020 was introduced in Parliament but was not passed (*28*). On the following World No Tobacco Day, in 2013, the Minister of Health launched work on a public policy for national tobacco control in Iceland to 2020, in response to changes in tobacco and nicotine consumption and based on collaborative work on the National Health Policy by the Ministry of Welfare, the Ministry of Finance and Economic Affairs, the Ministry of Education, Science and Culture, the Directorate of Health, the National Association of Municipalities and others (*29*).

Iceland ratified the WHO FCTC in June 2004 (*30*). It had already implemented the Tobacco Products Directive of the European Union when it entered into the European Economic Area

agreement in 1993. Recently, there has been increased formal and informal collaboration among the Nordic countries to become tobacco free by 2040, in accordance with the public health agenda of the Nordic Council of Ministers (*31*).

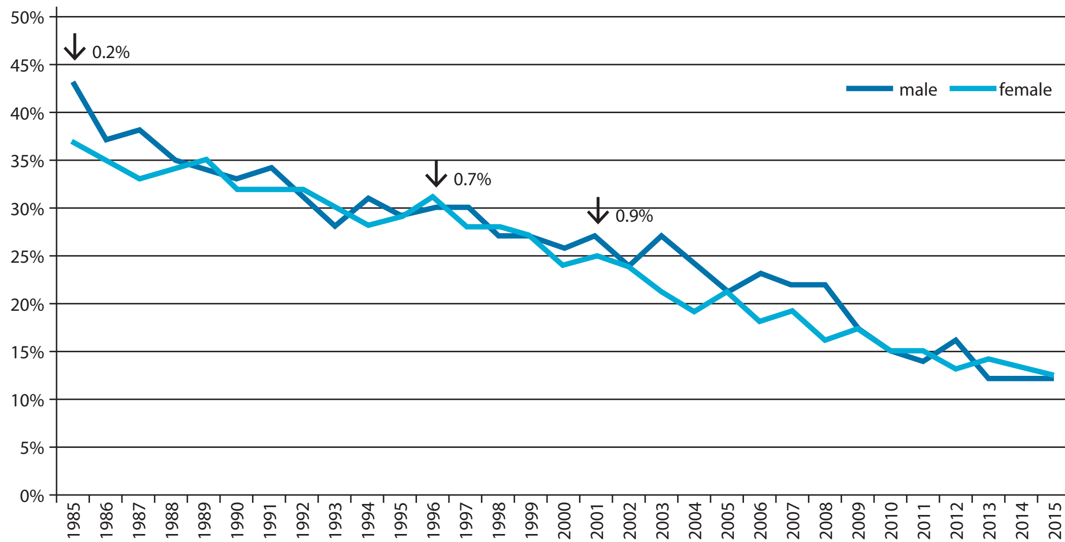
## 2. Statistics of earmarked funds

Earmarked taxes have been the main source of financing for tobacco control from the beginning. The revenue flow of earmarked tax has been delivered annually on the basis of an estimate and reviewed against actual sales figures. There is no separate analysis of the amounts budgeted and used for specific projects before 2004, and, in view of intermittent inflation in the Icelandic economy, they would not be comparable over time. The Minister of Health provided a formal report for 2004–2007 in response to a question in Parliament on how the funds were spent (*32*). In 2004–2007, 84% of earmarked funding was used specifically for tobacco use prevention and health promotion and 16% for the overheads of the Public Health Institute. After its transfer to the Directorate of Health, 65% of the earmarked tax went to the Directorate, which continues to finance national tobacco control programmes, and 35% to the Public Health Fund. The board of the Public Health Fund requires regular reporting and monitoring of the effectiveness of the projects funded. The Public Health Fund has financed various health promotion projects in schools and the community, including tobacco control activities. A rough estimate indicates that 20% of its funds go to specific tobacco control projects and 80% to more general health promotion projects.

The Icelandic health care system is a centralized, publicly financed system with universal coverage, based on residence in the country. The primary care health centres throughout the country are the main points of care, although access to specialist care in Reykjavik is also widely available. The health care system is financed mainly by general taxation, and the health expenditure as a share of gross domestic product was similar to that of Denmark and Norway until 2008; subsequently, it dipped below that of the other countries, mainly due to increases in other countries (*33*). The health budget for NCDs is not available.

The trends in the prevalence of daily smoking by adults in Iceland over the past 30 years is shown in Fig. 1. The prevalence decreased over time, with minor differences between men and women. A national survey in 2007–2012, "Well-being of Icelanders", showed a decreasing trend in smoking by both sexes and in all socioeconomic groups in all parts of the country (*34*). Iceland can be considered to be in stages III–IV of the tobacco epidemic (*35*); the prevalence of daily smoking is up to three times higher in people with lower education than those with university education, but the difference between rural and urban areas is smaller. As shown in Fig. 1, the increases in earmarked tax were followed by slightly steeper decreases in prevalence than before; however, other changes were made to the tobacco control law each time.

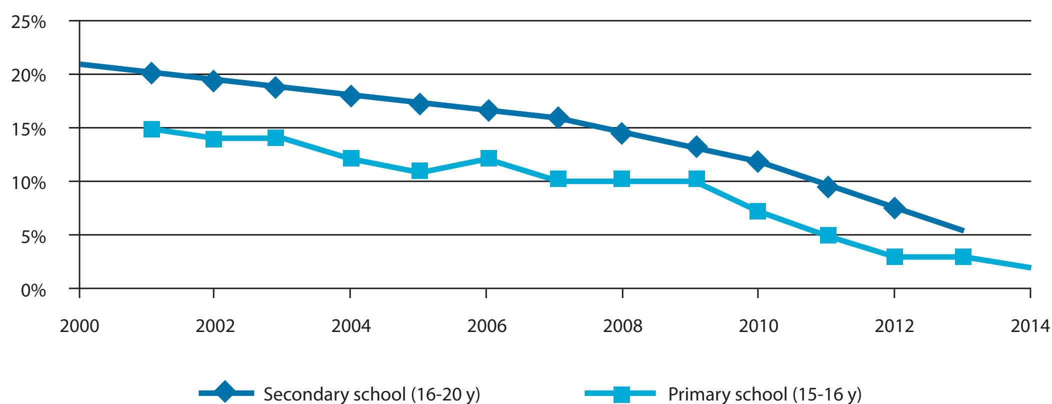
**Fig. 1.** Prevalence of daily smoking by Icelanders aged 18–69 years, 1985–2015, with major milestones of earmarked tax for tobacco control




From reference *36*

The smoking prevalence among Icelanders aged 14–16 years has changed considerably since the first survey in 1975, when half of them smoked, to the situation in the new millennium, when only 15–21% smoked daily (Fig. 2). The decrease in smoking in this age group is very promising. The nationwide study of the Directorate of Health, "Well-being of Icelanders" in 2012 found for the first time that more than half the population of Iceland had never smoked or had quit smoking (*34*). There is reason for concern, however, with regard to the youngest age groups, as young men are increasingly using smokeless tobacco; furthermore, this appears to be additional to smoking and not a substitute.

**Fig. 2.** Prevalence of daily smoking among Icelanders aged 15–20 years in primary and secondary school, 2000–2014




From references *37* and *38*

The effectiveness of tobacco control over time can be seen in research on the trends in mortality from diseases caused by smoking, such as in ischaemic heart disease. The death rates from coronary heart disease decreased between 1981 and 2006 among people aged 25–74 years, by 79% for men and 82% for women. According to Aspelund et al. (*39*), over 70% of the decrease was attributable to reductions in population risk factors; reduced smoking prevalence contributed 22% of the decrease. The death rate from lung cancer increased between 1980 and 2009, by 50% for men and 20% for women, although the rate appears to have reached a plateau in the past 5 years (*40*). The combined number of deaths due to smoking in Iceland is estimated to have decreased by about a third in the past 20 years.[6]

## 3. Summary and conclusions

Organized tobacco control in Iceland began in 1970 and received strong support for interventions in schools 5 years later as a reaction to the high prevalence of smoking among adolescents. At first, the work was led by doctors and lawyers collaborating with politicians, supported by many, diverse nongovernmental organizations (NGOs), which brought about changes to the tobacco control laws. The contributions of the Reykjavik Cancer Society, the Icelandic Cancer Society and the Icelandic Heart Association were important and resulted in a more multidisciplinary approach to tobacco control over time.

The earmarked tax on tobacco products in Iceland has supported independent tobacco control projects for decades, mainly to support the legal framework, tobacco control at community level and regulatory actions for primary prevention. Changes to the tobacco control law often took years, including targeted actions supported by the goals of the National Health Policy. Iceland was among the first countries to ratify the WHO FCTC and had been planning tobacco control legislation that met the official WHO recommendations long before that time (*41*). This was important for a small country with limited resources. Additional support was provided by collaboration at European level and among the Nordic countries.

The most highly prized asset for tobacco control in Iceland is the support of the people, who want to protect children and young adults from the use of tobacco; awareness of the effect of smoking on bystanders has also increased. Discussion of legislative action in the public arena has been made visible in the media, with petitions to support the suggested changes. Tobacco control legislation in Iceland scores high on the European Tobacco Control Scale. It provides its people with an almost smoke-free society for those who do not smoke and has also affected the private space; many people have declared their homes smoke-free as well. One limitation is that people in Iceland who still smoke or use tobacco do not have as good access to cessation support as people in many other European countries. The earmarked tax has been used to only a small extent to support such activities.

6 Fjöldi látinna árlega vegna reykinga, óbirt áætlun [Number of deaths caused by smoking], unpublished estimate. Kópavogur: Icelandic Heart Association; 2012.

The earmarked tobacco tax in Iceland has made an important contribution to tobacco control. When it was withdrawn, organized activity decreased, despite political support for increased funding. Reintroduction of a higher tax changed the situation markedly. As tobacco sales decrease when consumption decreases, the earmarked tax must be increased to secure revenue for tobacco control.

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# PANAMA

## 1. Introduction

Since the mid-2000s, Panama has made significant progress in controlling tobacco use, especially on non-tax measures since 2008 and on tax measures since 2009. Not only has the tax on tobacco increased, but for the first time 50% of the tax revenue has been divided between the health sector and the customs authorities, making Panama one of the few countries in the Americas to use this method of channelling resources directly to tobacco control activities. In addition, this has proved to be one of the most effective of all health initiatives (*1*, *2*).

Between 2009 and 2014, incremental tax revenue more than doubled, from US$ 12.3 million to US$ 27.8 million, i.e. an average annual increase of 17.6%, while the rate of tobacco use fell from 9.4% in 2007 to 6.4% in 2013, currently the lowest recorded rate anywhere in the Americas. This demonstrates the cost-effectiveness of fiscal measures in addition to non-tax measures (*3*,*4*).

Most of this revenue has been used to promote health and support diagnosis and tobacco cessation treatment (70% of the earmarked resources). Only 11% has been earmarked for other areas, such as capacity-building for tobacco control, strengthening surveillance and control under the WHO FCTC and strengthening national legislation (*5*).

The resources have been crucially important for sustained pursuit of the MPOWER package policies of the WHO, namely **M**onitoring tobacco use and prevention policies, **P**rotecting people from tobacco smoke, **O**ffering help to quit tobacco use, **W**arning of the damage caused by tobacco, **E**nforcing bans on advertising, promotion and sponsorship of tobacco products, and **R**aising taxes on tobacco (*6*, *7*).

In the short term, there are plans to use another financing mechanism, in this case revenue from licences to sell tobacco products, 30% of which will go to the Ministry of Health, 30% to the Gorgas Commemorative Institute for Health Research to study NCDs associated with tobacco use and 40% to civil society organizations such as the Panamanian Coalition against Tobacco Use (30%) and the National Cancer Association (10%) (*8*, *9*).

## 2. Background

Panama has increased its selective consumption tax rates on cigarettes and other tobacco-derived products from 32.5% to 100% of the price declared by the wholesale importer. Act No. 69 of 2009 is the most recent legal instrument for apportioning financial resources to the health sector and the customs authorities, under the management of the Ministry of Health.

The legislation specifies that 20% of the selective consumption tax shall be paid to the Ministry, 20% to the National Cancer Institute and 10% to the National Customs Authority (*10*).

The Ministry of the Economy and Finance collects the selective consumption tax, and the Revenue Department notifies the National Bank of the amount of the tax, which is transferred to the tobacco sub-account of the Ministry of Health account. The money is not routed through the national budget, as it is a financial account. The same procedure is followed for the National Cancer Institute and the Customs Authority.[7]

As it is not part of the budget, the tax has no impact on the budget lines of any other source or entity. The money is therefore not forfeited at the end of the fiscal year. Yet it complies with all prior and post-auditing procedures of the Panamanian National Audit Office. In respect of the tobacco funds received by the Ministry of Health, a technical cooperation agreement operates with the WHO Country Office up to a transferable amount of US$ 2 million for the development of tobacco control activities, endorsable by the National Audit Office.

Each entity manages the funds it receives from the selective consumption tax, which must be spent exclusively on activities associated with tobacco use. These are various activities in line with the MPOWER package and the WHO FCTC, i.e. monitoring, protecting people from tobacco smoke, offering help to quit tobacco use, warning of the dangers of tobacco, enforcing bans on advertising, promotion and sponsorship of tobacco products, and raising taxes on tobacco (*6*). A report on the authorized and planned activities for which the funds will be used is submitted annually in respect of the allocation made to each entity (*5*).

The activities also include research, outreach and purchase of equipment. For example, the Panama Global Adult Tobacco Survey was financed with support from Ministry of Health tobacco funds, as were regional meetings and workshops on illicit trade, taxation and prohibition of advertising, promotion and sponsorship. These resources have been the most important source of funding for activities required to comply with the WHO FCTC (*11*).

The money has also been used to purchase kits for monitoring tobacco smoke (SIDEPAQ) and other contaminants, e.g. products of combustion of solid wastes at refuse dumps in the metropolitan area. Vehicles have been acquired for tobacco control-related activities and provided to all Ministry of Health regional offices; they are also used for other justified health-sector activities. Likewise, spirometers have been procured to diagnose respiratory illnesses not caused by tobacco use, as is the laboratory support equipment for diagnosis of respiratory diseases not attributable to tobacco use.

To sum up, these funds complement the resources allocated under the national health budget. This method of financing is especially recommended for developing countries such as Panama (*12*).

7 Ballesteros VHH. Entrevista a la Dra Reina Roa. Directora de Planificación del Ministerio de Salud [Interview with Dr Reina Roa, Director of Planning at the Ministry of Health]; 2015.

## 3. Process that led to adoption of Act No. 69/2009 establishing the selective consumption tax

In 1995, under the leadership of the Ministry of Health, the first steps were taken to increase taxation on tobacco and to use the revenue to fund the health sector. In that year, the selected consumption tax was fixed at 32.5% of the price declared by the wholesale importer (*13*). In 2001, value-added tax (VAT) was increased from 10% to 15%, and 5% was earmarked for the National Cancer Institute (*14*). In 2004, Panama ratified the WHO FCTC, and this was used as justification for increasing the selective consumption tax to 100% in 2009, in keeping with the recommendations of the MPOWER initiative (*10*, *15*).

The arguments for setting a threshold of 50% of the selective consumption tax are contained in Act No. 40 of 2004 and Act No. 13 of 2008, which impose upon the Ministry of Health a series of tasks, including control of smuggling. As far as the Ministry of Health is concerned, these are commitments under the WHO FCTC. For the National Customs Authority, Article 15 of the WHO FCTC imposes monitoring and control of illicit trade, for which resources are required. Funds were allocated to the National Cancer Institute because the treatment of diseases associated with tobacco use (such as cancer) is expensive, and treatment costs can be reduced by limiting the impact of tobacco use (*11*).

Strategic partnerships between the Ministry of Health, the National Assembly, the Ministry of Economy and Finance and civil society organizations such as the Panamanian Anti-smoking Coalition, the National Cancer Association and Fundácancer were crucially important in bringing about the increase in the selective consumption tax. A media communications plan was prepared to react to attacks by the tobacco industry, especially with regard to smuggling. The anti-tobacco tactics include free radio and television spots, interviews, dissemination of evidence to journalists sympathetic to tobacco control, organizing forums for journalists and developing a media relations guide in cooperation with the most representative, credible civil society groups. The support of Government and opposition lawmakers has been a key factor in ensuring political balance in negotiation of the tax (*16*).

Hard data are also important: a study of the demand for tobacco in Panama between 2009 and 2012 demonstrated that, by increasing the selective consumption tax, fiscal revenue would increase and prevalence would decrease (*17*, *18*). This evidence was key in allaying the concerns of the Ministry of Economy and Finance that the revenue stream from the selective consumption tax might decrease. The tax was initially increased to 50% in September 2009 and subsequently to 100% in November the same year, because it was considered that the tax receipts were not at all commensurate with the hospital costs occasioned by tobacco-related diseases. This argument played well with the National Assembly (*10*).

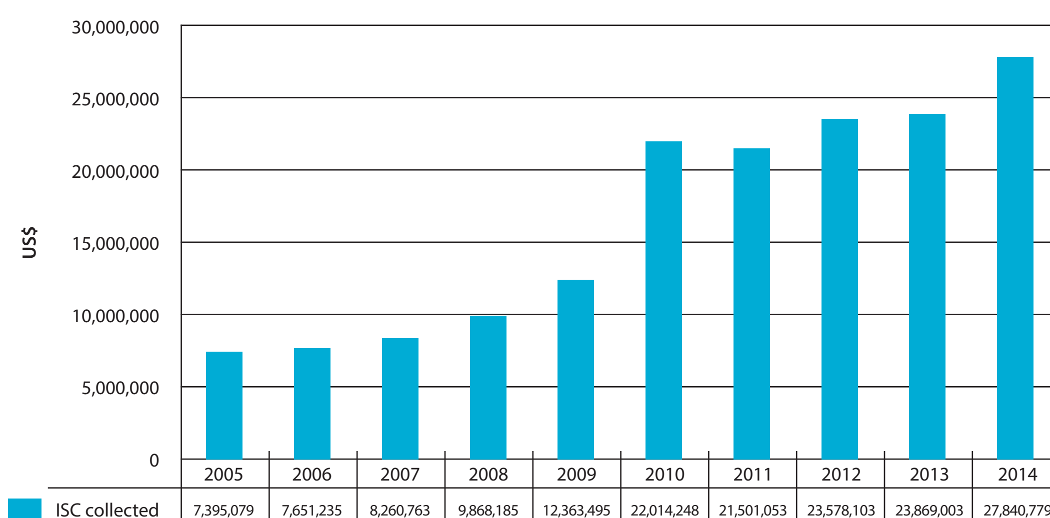
Some of the main factors in getting the law adopted were: convincing the Ministry of Economy and Finance by technical studies and ad hoc meetings at the highest level (Deputy Minister and revenue director), strategic lobbying of lawmakers on the Board of Trade before the first

reading, targeted action by civil society stakeholders in the media and garnering the support of sympathetic journalists. Another important factor was the political situation and the tax reform of 2010, whereby the Government in power sought higher taxes to finance subsidy programmes and infrastructure projects, by increasing VAT from 5% to 7% for example. The year 2009, the government's first year in power, was therefore the right time to propose a further increase in the selective consumption tax.

## 4. Collection of the selective consumption tax and use of the revenue

After entry into force of the WHO FCTC, revenue from the selective consumption tax began to increase significantly. This occurred well before November 2009, when the rate of 100% was introduced. Since 2010, receipts have continued to increase, as borne out by the findings of the studies of tobacco demand in 2009 and 2012 (see Fig. 1) (*5*, *18*). Likewise, in view of the increase in per capita income, the affordability criterion is still significant. Between 2009 and 2014, the average rate of increase in per capita GDP was 6.5%, which suggests that selective consumption tax revenue will continue to grow in the longer term, Panama being one of the most thriving economies in the region (*19*, *20*).

**Fig. 1**. Annual selective consumption tax (ISC) revenue in US$



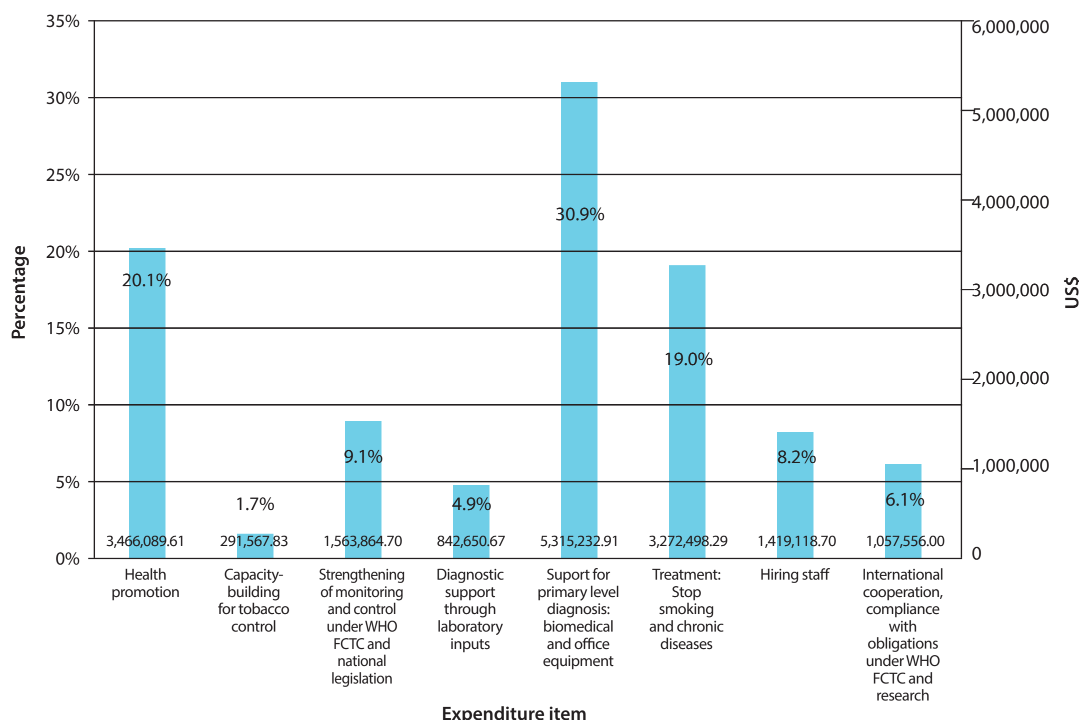

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|---|
| ISC collected | 7,395,079 | 7,651,235 | 8,260,763 | 9,868,185 | 12,363,495 | 22,014,248 | 21,501,053 | 23,578,103 | 23,869,003 | 27,840,779 |

Source: Revenue Department.

In accordance with the earmarking scheme specified in Act No. 69, of the total revenue of US$ 59 401 644.05 in the period 2009–2014, the Ministry of Health was allocated US$ 23 638 254.30, the National Cancer Association US$ 23 638 254.30 and the National Customs Authority US$ 12 125 135.45. Under the MPOWER work, the Ministry of Health as the regulatory body is responsible for using the funds to promote tobacco control policies; Fig. 2 and Table 1 show the breakdown of the figures.

Fig. 2 shows how the selective consumption tax receipts are distributed; the most significant expenditure items are health promotion (20.1%), support for diagnosis at primary health care level (30.9%), smoking cessation treatment and the treatment of chronic diseases (19%). These represent 70% of the total expenditure. The second tier of activities includes strengthening monitoring and control functions under the WHO FCTC and national legislation (9.1%) and hiring staff to carry out these functions (8.2%). International cooperation as called for under the WHO FCTC accounts for 6.1%, diagnostic support by laboratories for 4.9% and capacity-building for 1.7%.

**Fig. 2.** Allocation (%) of earmarked funds from selective consumption tax revenue, 2010–2013




Source: National Commission for the Study of Tobacco Use in Panama, Ministry of Health

Table 1 gives a breakdown of the specific areas in which investments have been made, with 75% for procuring equipment for treating outpatients (item 1), mobile equipment to monitor environmental health (items 2 and 3) and IT equipment to support tobacco inspections (item 5).

**Table 1.** Expenditure, Ministry of Health tobacco funds, 2015

| No. | Item | US$ |
|---|---|---|
| 1 | Biomedical equipment for outpatient treatment | 300 000.00 |
| 2 | Off-road motorcycles for environmental health inspections in 14 regions | 92 000.00 |
| 3 | On-road motorcycles for environmental health inspections in 14 regions | 69 000.00 |
| 4 | Recording videos to promote Act No. 13, smoking cessation clinics and treatment | 20 000.00 |
| 5 | 275 computers for tobacco inspections in 14 regions | 142 175.00 |
| 6 | 15 laptop computers to measure fine particles in each region and environmental sub-department | 12 015.00 |
| 7 | Printing the national and health regional Global Youth Tobacco Survey and Global Adult Tobacco Survey and national and international dissemination | 30 000.00 |
| 8 | Printing of recommendations for smoking cessation | 20 000.00 |
| 9 | Transfer of funds to Santo Tomás Hospital for a smoking cessation clinic | 20 000.00 |
| 10 | Strengthening the information system for monitoring and control of NCDs, other diseases associated with tobacco use and the national cancer registry | 45 000.00 |
| 11 | Two SPSS 20.0 software licences and complementary modules | 22 000.00 |
| 12 | Per diem allowances for health regions to comply with tobacco control directives | 34 831.24 |
| 13 | Total | 807 021.24 |

Source: National Commission for the Study of Tobacco Use in Panama, Ministry of Health

The money has been spent mainly on tobacco control equipment and capacity-building, and the information system for monitoring NCDs received 6% of the funds directly.

Table 2 shows the annual breakdown of expenditure of the funds allocated to the National Cancer Institute, a total of US$ 14 227 642.60 in 2015. The money was used to maintain facilities and treat cancer patients. Funding has increased by about 30% every year.

**Table 2.** Expenditure, National Cancer Institute tobacco fund, cumulative total 2015

| Year | Expenditure (US$) |
|---|---|
| 2010 | 1 922 129.24 |
| 2011 | 4 631 860.82 |
| 2012 | 3 374 091.44 |
| 2013 | 4 299 561.10 |
| Total | 14 227 642.60 |

Source: National Cancer Institute

Before the advent of selective consumption tax revenues, no money was allocated for tobacco control activities at the Ministry of Health, the National Cancer Institute or the National Customs Authority. All these entities have played a part in implementing the MPOWER policies (although the National Customs Authority did not provide data, despite a formal request on 11 June 2015). Part of the funds are decentralized to the Ministry of Health regions, to train health workers and establish health promotion and activities to reduce chronic NCDs. The Ministry of Health is strengthening surveillance and enforcement of control measures, research, and treatment and smoking cessation campaigns, among other projects. Since 2012, international and regional cooperation has been stepped up, in addition to cooperation with the WHO FCTC

secretariat to implement international agreements on tobacco control and reduction of chronic diseases associated with tobacco use; a cumulative total of US$ 2 million has been spent in this area. To date, US$ 1.6 million has been spent on national or regional tobacco control activities to comply with WHO FCTC or Act No. 13 and its objectives. The remaining US$ 400 000 will be allocated to activities for chronic diseases. All expenditure is reviewed in accordance with guidelines of the Regional Office for the Americas and subsequently audited by the National Audit Office. Of the total of US$ 2 million, US$ 1.4 million has already been transferred and US$ 600 000 is pending transfer.[8]

In the period since 2010, a total of US$ 23 130 479.42 has been received, and an outstanding amount of US$ 157 053.63 has still to be executed. The funds are made available as the selective consumption tax is collected and earmarked for each body as established by law.

## 5. Impact of the selective consumption tax on tobacco control

The impact of the selective consumption tax was documented by a study on tobacco demand in Panama between 2009 and 2012, which shows that increasing the tax rate to 100% doubled tax receipts while reducing prevalence. The National Health and Quality of Life Survey conducted in 2007 indicated a prevalence rate of 9.4%, while the Global Adult Tobacco Survey conducted in 2013 gave a prevalence rate of 6.4% (smoked and non-smoked tobacco), the lowest rate thus far recorded in the Americas. Data from the Global Youth Tobacco Surveys of 2002, 2008 and 2012 indicate tobacco use prevalence rates of 18.3%, 8.3% and 9.5%, respectively, although these findings reflect tobacco use among young people before the introduction of new products such as electronic cigarettes (*21–23*). These findings are borne out by public health research, which shows, for example, a reduction in the relative risk for acute myocardial infarction and a decrease in mortality due to diseases associated with tobacco use from 16.4% in 2005 to 12.1% in 2012 (*1*, *24*).

Moreover, the evidence shows that the increase in the selective consumption tax reduced affordability and had a regulating effect on smuggling. Faced with the falling prevalence rate, the tobacco industry adapted its tactics by distributing its legal and illegal brands in both segments. This did not, however, expand the market, as both legal and illegal brands of tobacco have become more expensive. This indicates the cost-effectiveness of the increase in the selective consumption tax (*17*,*18*,*25*,*26*).

Further increases in the selective consumption tax should be envisaged, given that it is a continuous mechanism for making financial resources available to offset the negative aspects of tobacco use.

8 See previous footnote.

## 6. New tax policy initiatives and challenges

Since 2015, initiatives have been launched to channel resources from other taxes to the health sector; the most significant are contained in draft acts No. 176 and No. 136. The principal initiatives are the criminalization of illicit trade in tobacco, licensing the sale of tobacco products and introducing plain packaging, subject to ratification of the WHO FCTC Protocol to Eliminate Illicit Trade in Tobacco Products (*8*, *9*, *15*).

The revenue derived from special licensing taxes and fines will be distributed as follows:

- 30% will be earmarked for the Ministry of Health via the tobacco focal point, for surveillance and monitoring of implementation of the WHO FCTC and enforcing the provisions of Act No. 13 of 13 August 2008.
- 30% will be earmarked for the Panamanian Anti-smoking Coalition, for prevention, education, promotion and monitoring of its objectives at national level.
- 30% will be earmarked for the Gorgas Commemorative Institute to conduct research on tobacco use and associated NCDs.
- 10% will be earmarked for the National Cancer Association to support prevention, promotion and stop smoking programmes.

This initiative seeks to impose tighter control on illicit trade and make resources available not only to the public health sector but also to civil society, with a view to strengthening its role (*8*, *9*).

There remains, however, institutional resistance in some quarters, such as the National Customs Authority, which has not yet made use of the earmarked resources from the selective consumption tax, and lack of leadership in the fight against illicit trade in tobacco products, for example in the Panamanian Board of Trade and Industry, which on occasion unintentionally adopts positions favourable to the tobacco industry (*27*).

The lack of a comprehensive policy on the use of tobacco products continues to be the main stumbling block in areas such as consumer protection, trademark registration, international trade treaties and criminal law, because these matters give rise to regulatory conflicts and require harmonization of health standards, thus leaving the tobacco industry considerable room for manoeuvre as it takes advantage of institutional failings.

## 7. Conclusions

Panama is one of the few countries in the region that uses tobacco tax revenue to fund the MPOWER policies derived from articles of the WHO FCTC. This is the principal source of funding for all activities to control tobacco use, including national contributions to international cooperation.

The funds are used mainly for health promotion, diagnostic support at the primary health care level and smoking cessation treatment. Specifically, the money is used to procure biomedical

equipment, vehicles for monitoring and computer equipment to carry out inspections in the 14 health regions under the Ministry of Health, the authority that oversees tobacco control policy in Panama.

The impact of the tax on fiscal receipts and health has been tracked. The public sector (health and customs) received US$ 59 401 644.05 between 2009 and 2014 following the increase in the basic rate of the selective consumption tax from 32.5% to 100% and the subsequent doubling of tax revenue. There has since been a reduction in the prevalence rate of tobacco use to 6.4%.

These findings demonstrate that the increase in the selective consumption tax has been cost-effective. Affordability has been increasing along with per capita income increases; therefore, further tax increases should be considered to ensure the complementarity of fiscal and non-fiscal measures (*17*, *18*, *25*). Tax increases are a continuous process ; therefore, indexation with the general rate of inflation is recommended (*28*) to ensure that the health sector continues to receive financial resources and can therefore pursue the MPOWER initiative and activities to control NCDs in the long term. Increases in the selective consumption tax continue to be one of the principal strategic considerations for the future. Given the current problems facing the national budget, channelling tax revenues to the health sector is extremely important.

Another important consideration is the need to make of the MPOWER package and the normative tools that support it a complementary instrument that operates in tandem with other legal provisions, such as for a trademarks registry, consumer protection and control of illicit trade. There is still considerable institutional resistance to implementation of various aspects of the WHO FCTC; consequently, greater efforts must be made in convergence, by supplying data on our progress, and awareness-raising in order to launch new tobacco control initiatives, as they will require strategic political partnerships. These will include Government bodies such as the Ministry of Trade and Industry, the National Assembly, the Ministry of Health, the National Customs Authority, the Ministry of Government and Justice and the Consumer Protection and Defence of Competition Authority and civil society associations such as the Panamanian Anti-smoking Coalition and the National Cancer Association, the most important stakeholders at local level, as well as partnerships with international scientific and technical bodies.

A significant problem for the author of this article was the difficulty in obtaining complete, standardized data, especially from the National Cancer Institute and from the National Customs Authority. It was therefore difficult to assess the overall impact of the tax as a complement to health budgets. This kind of information should be systematically approved for release to allow construction of baseline indicators for determining the scope and effectiveness of selective consumption tax revenues in implementing the WHO FCTC.

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# PHILIPPINES

## 1. Introduction

The reform of the tobacco and alcohol excise tax system, Republic Act (RA) 10351, in the Philippines in 2012 has been an unqualified success, in terms of both the law's progressive and innovative features and its immediate, dramatic outcomes. The indications are that the gains will be sustained in the longer term, although Congress will review the law in the third quarter of 2016, with the accession of a new administration.

## 2. Background

The landmark 2012 legislation on tobacco and alcohol taxation, popularly known as "sin taxes", corrected the fundamental weaknesses of the old law embodied in the National Internal Revenue Code. It took 15 long years to reform the law enacted in 1997 as part of the comprehensive tax reform programme. The old law permitted a change in the excise tax on tobacco from an ad valorem tax to a specific tax, in order to check the abuses committed under the ad valorem system. In that system, the leading tobacco manufacturer resorted to transfer pricing by underpricing cigarettes at the factory gate before they were sold to dummy wholesale entities. It was a creative way of evading taxes. Pursuing a tax evasion case was difficult, given the strong political connections of the tobacco manufacturer, and a regulatory solution was used.

The shift to a specific tax turned out, however, to be a cosmetic change. The 1997 law, and amendments made in July 2004 (RA 9334), contained several egregious provisions:

- The price classification freeze benefited "legacy" brands that were on the market before enactment of the 1997 law, as their price classification for tax rates was rigidly fixed on the basis of 1996 net retail prices. Thus, their tax rate classification remained the same, although the increase in their prices should have led to a higher price classification and therefore higher tax rates. New brands were taxed on the basis of their actual (current) net retail price and thus at the highest tax rate bracket (see below).

- The complex tax structure consisted of four price classifications for machine-packed cigarettes with correspondingly low tax rates. In 2011, the excise tax rates for machine-packed cigarettes were as follows:
    - PHP 2.72 (US$ 0.063[9]) for cigarettes with a net retail price (i.e. excluding VAT and the excise tax) < PHP 5.00 (US$ 0.12 per pack,

9 Exchange rates used are annual averages from the central bank of the Philippines

- PHP 7.56 (US$ 0.17) for cigarettes with a net retail price of PHP 5.00 but not exceeding PHP 6.50 (US$ 0.15) per pack,
- PHP 12.00 (US$ 0.28) for cigarettes with a net retail price > PHP 6.50 but not exceeding PHP 10.00 (US$ 0.23) per pack and
- PHP 28.30 (US$ 0.65) for cigarettes with a net retail price > PHP 10.00 per pack.

Note, however, that the original price classification of "legacy" brands was retained, even though their actual prices, without the price classification freeze, would have led to an upward re-bracketing of price classification. In fact, even brands classified as low-priced and medium-price (with tax rates of PHP 2.72 and PHP 7.56, respectively) should have been paying the premium tax rate of PHP 28.30 if they had not been protected by the price classification freeze.

- Real revenue was eroded by non-adjustment of taxes to inflation rates.

RA 10351 in 2012 contained the following essential reforms with respect to tobacco taxation:

- The price classification freeze was removed and steps were taken towards a simple, unitary tax system, which will take effect fully on 1 January 2017.

- The excise tax rates were raised significantly:
  - A tax rate of PHP 12.00 (US$ 0.28) - from the low of PHP 2.72 - per pack for machine-packed cigarettes with a net retail price of ≤ PHP 11.50 (US$ 0.27), effective on 1 January 2013, followed by annual increases in the tax rate of up to PHP 30 (US$ 0.71) per pack on 1 January 2017. Despite attempts by some tobacco firms to depress prices artificially, the effect was to increase the price per stick of the most popular brand from PHP 0.80 (US$ 0.02) at the end of 2012 to PHP 1.40 (US$ 0.03) per stick in June 2014, representing a 75% increase (data from the National Statistics Office); and
  - A tax rate of PHP 25.00 (US$ 0.59) per pack for machine-packed cigarettes with a net retail price > PHP 11.50, effective 1 January 2013, to be followed by an annual increase of up to PHP 30 per pack on 1 January 2017.

- An automatic adjustment of the tax rate to inflation by increasing the tax rate by 4% every year thereafter (based on the past average inflation rate in the Philippines), effective on 1 January 2018.

RA 10351 has another important feature, which goes beyond correcting the structural weakness of the old law on tobacco and alcohol excise taxation. This is a provision on earmarking the bulk of the incremental revenue from excise taxes on alcohol and tobacco products to health programmes.[10]

10 Incremental revenue, as defined in the Implementing Rules and Regulations of R. 10351, "shall be computed as the difference between the total actual excise collections from alcohol and tobacco products for the year under consideration with Reform Implementation under R.A. 10351, and the Baseline Excise Collections (Without R.A. 10351) for the same year." The Implementing Rules and Regulations define baseline excise collections (without RA 10351) "as the pertinent excise collections under the 2012 structure," as provided by the old law (RA 9334).

## 3. Description of the earmarked tax

RA 10351 states that the remainder of the incremental revenue, after deduction of the earmarked allocations from the tobacco excise taxes to the alternative livelihoods programme for tobacco farmers and other economic projects in tobacco-growing provinces,[11] be dedicated to health expenditures. As the amount earmarked for tobacco farmers and tobacco-growing areas is equivalent to 15%, the annual allocation for health programmes is equivalent to 85% of the incremental revenue collected from tobacco (and 100% from alcohol) excise taxes in the preceding year. Thus, although the intention of the 2012 law is to use all the incremental revenue from the increase in tobacco and alcohol tax rates to finance universal health care, the full amount cannot be allocated.[12]

Since the amount for the earmarking (equivalent to 15 percent of the incremental revenue) that benefits the tobacco-growing local government units is already defined by the two laws, it is first deducted from the total. The remainder of the net amount or the bulk of the incremental revenue is then allocated to health programs.

RA 10351 specifies that the areas to be funded by the incremental revenue are universal health care under the National Health Insurance Program, attainment of the health-related Millennium Development Goals, health awareness programmes, medical assistance and health enhancement facilities. The allocation of the incremental revenue is distributed with 80% (68% of total incremental revenue[13]) allotted to finance universal health coverage, the Millennium Development Goals for health and health awareness and the remaining 20% for health expenditure (17% of total incremental revenue[14]) for medical assistance and health enhancement facilities in various political and district subdivisions.

The original goal was to generate financing that would at least finance health insurance for the poorest 40% of Philippine households, but the revenue projection was conservative, as the model assumed a higher price elasticity coefficient. The actual additional revenue is greater than the estimate and will carry through in succeeding years. Although the net or incremental revenue per year varies (probably with an annual reduction), the amount is cumulative over time, and the Government can expect additional revenue for health programmes, although less each year. For example, the incremental revenue was PHP 51.17 billion (US$ 1.21 billion) in 2013, the first year of implementation of the "sin tax", and PHP 50.23 billion (US$ 1.13 billion)

11 Earmarking of a portion of tobacco excise taxes for tobacco farmers and tobacco-growing provinces is stipulated in two laws: RA 7171 and RA 8240 (and reaffirmed in RA 9334). RA 7171 (An Act to Promote the Development of the Farmer in the Virginia Tobacco-producing Provinces) states: "The financial support given by the National Government for the beneficiary provinces shall be constituted and collected from the proceeds of fifteen percent (15%) of the excise taxes on locally manufactured Virginia type of cigarettes." RA 8240 states: "Fifteen percent (15%) of the incremental revenue collected from the excise tax on tobacco products under this Act shall be allocated and divided among the provinces producing burley and native tobacco in accordance with the volume of tobacco leaf production".

12 See previous footnote.

13 That is, four-fifth of the 85 percent of the total incremental revenue from the tobacco and alcohol taxes, or .8 x .85 = .68

14 That is, one-fifth of the 85 percent of the total incremental revenue from the tobacco and alcohol taxes, or .2 x .85 = .17

the following year. The amount earmarked for health programmes did not decrease by PHP 1 billion; rather an additional PHP 50.23 billion was allocated for universal health care and related programs in 2014. Thus, health programmes funded through the sin tax are protected, unless the Government or the Department of Health shifts priorities.

Earmarking sin taxes for health is not unique, as the old law (RA 9334, passed in 2004) had a similar provision, whereby 2.5%of the incremental revenue from the tobacco and alcohol excise taxes was allocated to the Philippine Health Insurance Corporation to meet the goal of universal coverage and another 2.5%of the incremental revenue to the Department of Health as a trust fund for disease prevention. However, unlike the new law, which has no time limit (unless it is amended), sin taxes were earmarked for health for only 5 years, from January 2005. The amount earmarked was only 5%, which pales to insignificance as compared with the equivalent of 85% in the new law. Furthermore, the earmarking of taxes for health in the old law did not actually translate into new spending for health during the 5 years that it was in effect, as the incremental revenue could not be used for new spending or new programmes of the Department of Health. In practice, the incremental revenue was mixed with general revenue and became a subset of the health budget that would have been provided via the General Appropriations Act. In the new law, attribution to new programmes and new spending is clear. The Implementing Rules and Regulations for RA 10351 require the Department of Health to "identify the annual funding requirements for financial risk protection, medical assistance, health enhancement facilities program and other health programs."

The Department of Finance determines the actual incremental revenue and submits the projected incremental revenue for the year immediately preceding the budget year to the Department of Budget and Management. If the actual incremental revenue exceeds that projected, the surplus is carried over to the following budget year. The Bureau of Internal Revenue and the Bureau of Customs, both under the Department of Finance, collect the excise taxes and certify the incremental revenue collected. The Department then endorses the certification to the Department of Budget and Management.

The Department of Health submits a medium-term expenditure program for universal health coverage to the Department of Budget and Management and, every November, also submits "a list of projects and programs to be implemented for universal health coverage, including funding requirements and guidelines for prioritization", as input for the preparation of forward estimates. In addition, the Department of Health and its agencies, including the Philippine Health Insurance Corporation, submit reports and financial statements, including a special budget, for the release of the earmarked funds. In turn, the Development Budget Coordination Committee, which includes the Department of Budget and Management and the Department of Finance review the Department of Health's medium-term expenditure programme, which is the basis for yearly allocation. Each concerned agency submits a detailed report on expenditure and use of the earmarked incremental revenue to the Oversight Committee, and the reports are published on the *Official Gazette* and on the websites of the agencies.

Earmarking the incremental revenue from tobacco (and alcohol) excise taxes is thus unique:

- The largest proportion, about 85%, goes to health programmes, especially universal health coverage.
- Earmarking is continuous.
- The implementing rules and regulations for earmarking are well defined in terms of attribution, transparency and accountability.

Earmarking the bulk of the incremental revenue for health spending was an essential part of making health the principal objective of the tobacco and alcohol excise tax reforms. The twin goals for health are to reduce smoking (particularly prevalence) and excessive alcohol drinking and to use the revenue for health programmes. Use of the sin tax as a health measure, with generation of substantial revenue, explains the success of the reforms. Nevertheless, we should answer the question often raised by economists that earmarking, no matter how good the intention, is prone to rigidity and inefficiency.

The revenue from an earmarked tax is used exclusively for a specific purpose or a programme. Tax revenue is part of general appropriations, which are then allocated to various government programmes, while earmarking is imposed for economic, social or political reasons. Such taxes constitute only a small percentage of total taxes. The main criticism of earmarking is that it constrains the choice of allocation or spending, whereas the funds could have been used for more deserving programmes or projects, or that the earmarking is overfunded, resulting in huge opportunity costs.

Sin tax earmarking for health is, however, sound, notwithstanding these theoretical issues. Funding of the country's universal health coverage does not depend on tobacco and alcohol excise taxes: the incremental revenue fills the gap left after general appropriations and health insurance premiums. For example, before the sin tax reform, the Philippine Government was unable to subsidize health insurance for the second quintile of poor families and assigned allocation of resources for health insurance for this quintile to local government units. These units complained, however, that they could not both provide health services and raise additional funds for health insurance. With the sin tax reform, health insurance has become universal, and the Government sponsors the poorest 40% of families. The entire general population benefits from earmarking for health. Health spending is a public good and the support of the people and their representatives in Congress for health spending makes earmarking acceptable.

Earmarking was also a political act or even a political imperative. It would have been much more difficult to pass the sin tax law without broad support generated by the appeal of earmarking for health, in light of the intense and powerful lobby of vested interests. Ultimately, the earmarked tax not only significantly increased the budget for health but also contributed to the general level of taxation, thus expanding the overall fiscal space. Passage of the bill in 2012 led to a series of credit upgrades, and the country attained two notches above investment grade for the first time.

## 4. Impact of the tax

The Philippine sin tax reform is now hailed as a global good, or best, practice. For its achievement in passing a bold law in 2012, the Philippine Government received the 2015 Award for Global Tobacco Control from Bloomberg Philanthropies. In the first year of implementation of the law, the revenue from the sin tax increased from PHP 56.32 billion (US$ 1.38 billion) at the end of 2012 (enhanced by front-loading of volume removal to avoid the steep increase in tax rates that took effect in January 2013) to PHP 103.38 billion (US$ 2.43 billion at the end of 2013), an increase of 77%. Total revenue from the sin tax continued to increase in 2014, by 10.3% in 2014 and further increased by 24.4% in 2015 (Table 1).

**Table 1:** Sin Tax Collection as % of total Bureau of Internal Revenue collection and as % of GDP

| Year | Sin Tax Collections (in PHP billions) | Growth Rate | As % of Total Bureau of Internal Revenue collection | As % of GDP |
|---|---|---|---|---|
| 2009 | 49.43 | | 6.59% | 0.55% |
| 2010 | 57.10 | 15.52% | 6.94% | 0.59% |
| 2011 | 51.18 | -10.37% | 5.54% | 0.53% |
| 2012 | 58.32 | 13.95% | 5.51% | 0.55% |
| 2013 | 103.38 | 77.26% | 8.50% | 0.87% |
| 2014* | 114.02 | 10.29% | 8.54% | 0.90% |
| 2015 | 141.84 | 24.40% | 9.84% | 1.07% |

* includes the Bureau of Customs collections amounting to PHP 44.85 million

Furthermore, since implementation of the law, the actual increase in incremental revenue has surpassed that projected. In 2013, the actual incremental revenue from tobacco excise taxation was PHP 41.84 billion (US$ 0.99 billion), whereas that projected was PHP 23.40 billion (US$ 0.55 billion); in 2014, these figures were PHP 39.39 billion (US$ 0.89 billion) and PHP 29.56 billion (US$ 0.67 billion), respectively. The actual annual incremental revenue from alcohol excise taxes was slightly below the target in 2013 and 2014. Overall, the total incremental revenue from tobacco and alcohol excise taxation was PHP 51.17 billion (US$ 1.21 billion), PHP 50.23 billion (US$ 1.13 billion) and PHP 73.09 billion (US$ 1.61 billion) in 2013, 2014 and 2015, respectively (Table 2).

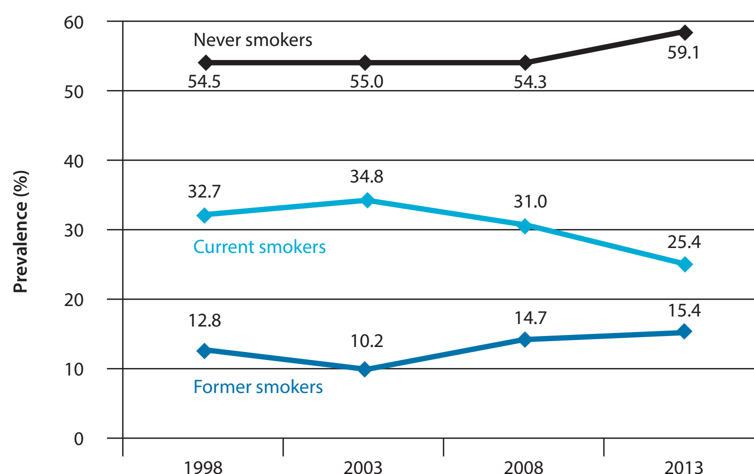
**Table 2:** Tobacco and alcohol sin tax revenue, exceeding target and increasing year-on-year

| Year/Product | Projected Incremental Revenue (In PHP Billion) | Actual Incremental Revenue (In PHP Billion) |
|---|---|---|
| 1st Year – 2013 | | |
| Tobacco | **23.40** | **41.84** |
| Alcohol | 10.56 | 9. 33 |
| Total | 33.96 | 51.17 |
| 2nd Year – 2014 | | |
| Tobacco | **29.56** | **39.39** |
| Alcohol | 13.30 | 10.83 |
| Total | 42.86 | 50.23 |

| 3rd Year – 2015 | | |
|---|---|---|
| Tobacco | **33.52** | **55.74** |
| Alcohol | 17.11 | 17.34 |
| Total | 50.63 | 73.09 |

The steep increase in tobacco taxation during the first year of implementation has had a considerable impact. A drop has been seen in volume removal (a proxy for consumption) of cigarette packs of 15.55% was seen in 2013 (from 5.76 billion packs in 2012 to 4.87 billion packs in 2013) and 19.55% in 2014 (from 4.87 billion packs in 2013 to 3.92 billion packs in 2014). The strongest evidence for a health impact is the significant reduction in smoking prevalence, from 31% in 2008 to 25.4% in 2013 (the first year of implementation of the sin tax). The main explanation, as suggested by Fig. 1, is the deterring effect of the steep tax rate increase on would-be smokers, particularly among the young and the poor.

**Figure 1:** Reduction in smoking prevalence




Source: National Nutrition and Health Survey (NNHeS); and Antonio Dans M.D.
Note: Prevalence of Never, Current, and Former Smokers, Philippines, NNHeS, 1998 to 2013

The health impact should also be measured in terms of the budgetary increase for specific programmes, as the sin tax law defines the health programmes to be funded. For example, between 2013 and 2014, funding for financial risk protection increased by 180% (from 12.63 in 2013 to PHP 35.34 billion in 2014).

Since the start of implementation of the law in 2013, the budget of the Department of Health increased from PHP 53.23 billion (US$ 1.25 billion) to PHP 83.72 billion (US$ 1.89 billion) in 2014 (a year-on-year increase of 57.3%) and PHP 86.97 billion (US$ 1.91 billion) in 2015 (3.9% increase). The approved budget in 2016 is PHP 122.63 billion (US$ 2.7 billion) (41.0% increase).

The greatest impact of incremental revenue from the sin tax on health spending is health insurance coverage of the poorest 40% of families. Between 2012 and 2014 the sponsored

programme increased Philippine Health Insurance Corporation coverage of the poor from 4.61 million members to 14.71 million members, or an increase of 219% during the 2-year period, and total membership increased from 80.92 million to 86.22 million between 2012 and 2014. The sin tax incremental revenue is also the source of funding for mandatory coverage of all Filipino citizens living in the Philippines aged ≥ 60 years who are not indigent or are not sponsored members or have no qualifying contributions to be entitled to Health Insurance benefits. These "senior citizens" are entitled to many benefits, including primary care and the no-balance billing policy (only in accredited Government health care facilities).

## 5. Challenges and conclusions

The sudden increase in the budget for universal health coverage posed new, complex challenges. The Department of Health has perennially faced the problem of absorptive capacity, and the influx of new money has exacerbated the problem of under-spending. The Department has fragmented programmes, putting into question efficient use of the additional resources. Further, the shortage of health care providers and the inadequacy of health facilities jeopardize provision of services for which funds have been augmented by the dramatic increase in the budget. This problem can be addressed mainly by allocating a larger budget from the sin tax revenue to human resources.

The sin tax revenue has made it possible for the Philippine Health Insurance Corporation to finance membership of 40% of the poorest Philippine households and to extend some benefits. It is critical that the members, and especially the poor, use the benefits. There has been an increase in benefit use by different segments of the population, although the rich still access services more than the poor. The Insurance Corporation is putting in place safeguard systems, including accreditation of health providers and electronic recording, to check abuses in the use of benefits.

A sensitive issue with respect to universal health coverage is setting programme priorities, in view of trade-offs, cost-effectiveness and equity. The Philippines has a vibrant civil society, which accounts not only for the success of the sin tax reform but enables stakeholders to engage Government officials in policy debate or dialogue.

The Philippine tobacco and alcohol excise tax reform of 2012 offers rich lessons. The design of the law to restructure the system and make health the primary objective was a crucial factor in its successful outcomes. The twin goals of better health outcomes and generating revenue have been met. Furthermore, the tax reform is the main explanation for the increase in tax effort, resulting in a series of credit upgrades and thereby boosting investor confidence. The generation of revenues is robust, with yearly tax rate increases until 2017, when the unitary tax takes effects; thereafter, the tax rate will increase automatically by 4% annually to correct for inflation.

Health has also benefitted. Smoking consumption and prevalence have been significantly reduced, and the bulk of the incremental revenue is allocated to health programs, especially

for universal health coverage. The increase in the health budget is dramatic, and health expenditure has grown consistently every year since passage of the law. Despite the reservations of economic theory, earmarking is acceptable on the grounds of both efficiency and the political imperative. Allocation of the revenue for health benefits the entire population. The programmes and projects that benefit from the incremental revenue are identified, and attribution of funds is ascertained. The rules for allocation of the revenue ensure transparency and accountability. The revenue earmarked for universal health coverage is robust and sustainable, unless the law is amended. The incremental revenue is computed on the basis of the 2012 baseline, and the tax will be automatically indexed to inflation by 2017. In view of the price inelasticity of tobacco and alcohol products, additional revenue can be expected every year.

Once the law consolidates in 2017, a new round of tax rate increases will be necessary to address issues of affordability and extension of health expenditure. With the momentum and lessons of the 2012 reform, the Government and civil society are well positioned to achieve the objectives. The Philippine experience and insights into the sin tax reform deserve further scrutiny and recognition.

# POLAND

## 1. Description of the earmarked tax

Funding of tobacco control activities is based on Article 4 of the Act on the Protection of Public Health against the Effects of Tobacco Use of 9 November 1995 (*1*). The Act establishes a programme to reduce the health consequences of tobacco smoking (in Polish, Program Ograniczania Zdrowotnych Następstw Palenia Tytoniu). Funding for the programme was provided only in 1999, when regulations were enacted that came into force from 1 January 2000, which state that the programme is to be financed from the State budget at a level of 0.5% of the excise tax on tobacco products. In 2014, the amount was 89.5 million PLN (US$ 22.35 million[15]), representing 0.5% of 17.9 billion PLN (US$ 4.47 billion) income from excise tax.

Under Polish law, the Council of Ministers was responsible for creating the programme. The Council authorized the Ministry of Health to manage the programme, which in 2006 authorized the State Sanitary Inspectorate to lead it. The procedure for transfer of revenues from excise tax to the Ministry of Health was not established. In 2000, the Ministry of Finance added an extra 21 million PLN to the Ministry of Health budget for the new task, on the premise that the Minister of Health would set a budget based on 0.5% of the excise tax for the programme. The Ministry of Health has not, however, fulfilled this obligation (*2*), with no administrative or personal consequences. In an interview, a retired employee of the Ministry of Health concluded that there was no political will to fund the programme.

The strategic aim of the programme for 2014–2018 (*3*) was to reduce exposure of Polish society to tobacco smoke (active and passive smoking). The detailed aims are to:

- prevent an increase in the number of people who start smoking;
- prevent increased exposure to tobacco smoke in public places;
- create regulations to ensure an effective tobacco control policy;
- increase understanding of the dangers of smoking tobacco among children and adolescents;
- change attitudes towards smoking, with the aim of marginalizing its use in society; and
- increase the number of people who quit smoking.

15 Exchange rate as of end February 2016.

This will be accomplished by:

- monitoring tobacco use and tobacco growing,
- effective protection from tobacco smoke,
- providing help in treating dependence on tobacco,
- providing information and warnings about the health risks associated with tobacco use,
- eliminating marketing tactics that violate the ban on advertisement and promotion of tobacco products and
- using economic and administrative incentives to reduce consumption of tobacco products.

These aims have not been met. The Supreme Audit Office reported that the State Sanitary Inspectorate has not conducted reliable monitoring or evaluation of the effects of the programme and has not developed a method for assessing implementation of either the strategic or most of the detailed aims. The law stipulates that the Council of Ministers shall submit a report on implementation of the programme to the Parliament by 30 April each year, although the format of the report is not specified; however, the report has never been prepared on time. The Supreme Audit Office noted that the reports contained descriptions of actions taken but without linking them to their intended purpose and no evaluation of achieved results.

The funds are used according to a 5-year plan, the latest being for 2014–2018; however the document did not include a budget.

## 2. Process that led to adoption of the law[16]

In May 1998, the Parliamentary Commission on Health proposed an amendment to the tobacco control law to ban advertising of tobacco products. The Ministry of Health added a proposal to describe how the tobacco control programme should be financed. The new law was enacted in November 1999 and came into force on 1 January 2000. The Ministry used experience gained during work on the Act of 1995, including cooperation with the Institute and Health Promotion Foundation at the Warsaw Oncology Centre, directed by Professor Witold Zatoński, to prepare a strategy, which included providing advocacy materials to members of the Polish Parliament, individual meetings, participation in meetings of the Commission on Health and assistance to members of Parliament in drafting the text of the amendment.

No analyses were conducted on earmarked taxes. The budget required for the programme was calculated on the basis of the amount of excise tax. Although the Senate proposed a tax of 1.5%, this proposition was not passed. The discussions on financing the tobacco control programme also included imposing a direct tax on the tobacco industry; finally, however, an excise tax was agreed upon on the basis that it represents social justice and a stable source of financing.

16 Based on an interview with Tadeusz Parchimowicz, retired senior officer responsible for tobacco control issues in the Ministry of Health

The real challenge was not the amount of the budget, as it was easy to show how the money could be spent, but the financing mechanism. The Ministry of Health proposed the creation of a special fund to be financed by direct transfer of the tobacco excise tax. The Parliamentary Commission on Health agreed, but the Minister of Finance was radically opposed, on the basis that budget incomes should not be disposed of before they are collected (i.e. during the fiscal year). He considered that special-purpose funds should be eliminated, as they limit the effectiveness and flexibility of the management of the national budget (with rigid expenditure for about 80% of the budget); the only source of funding for the programme should be the budget itself. The Ministry of Finance resisted all counterarguments and threatened not to support the amendment, which would have resulted in its withdrawal. An established fund based on a specific value was proposed, with a link to tax revenues, which appeared safer to the Ministry, as it would grow or shrink in line with changes in tax revenue.

In the first year, 2000, the new legislation was considered a success, as the Ministry of Health spent 21 million PLN; however, spending dropped dramatically subsequently.

## 3. Statistics on earmarked funds

The total amounts collected per year between 2000 and 2014 are shown in Table 1.

**Table 1.** Total amounts collected per year and trends over time

| Year | Income from excise tax (PLN)* | 0.5% of excise tax (PLN) | Expenditure for tobacco control (PLN)** |
|---|---|---|---|
| 2000 | 6 355 981 600 | 31 779 908 | 21 000 000 |
| 2001 | 7 305 174 300 | 36 525 872 | 3 000 000 |
| 2002 | 7 927 208 100 | 39 636 041 | 500 000 |
| 2003 | 8 456 473 600 | 42 282 368 | 500 000 |
| 2004 | 9 275 760 600 | 46 378 803 | 652 557 |
| 2005 | 9 819 728 000 | 49 098 640 | 700 000 |
| 2006 | 11 247 981 500 | 56 239 908 | 1 618 000 |
| 2007 | 13 483 026 000 | 67 415 130 | 1 001 664 |
| 2008 | 13 460 100 000 | 67 300 500 | 1 227 150 |
| 2009 | 16 057 800 000 | 80 289 000 | 1 264 000 |
| 2010 | 17 436 300 000 | 87 181 500 | 1 044 967 |
| 2011 | 18 264 200 000 | 91 321 000 | 915 532 |
| 2012 | 18 578 700 000 | 92 893 500 | 1 011 196 |
| 2013 | 18 205 600 000 | 91 028 000 | 1 008 463 |
| 2014 | 17 922 709 000 | 89 613 545 | |

* Data from reports on State budget implementation, Ministry of Finance
** Data from annual reports of the Programme for Reducing the Health Consequences of Tobacco Smoking

The earmarked tax was not transferred directly. The value of 0.5% of the excise tax was used only as a guideline by the Ministry of Health to decide how much to allocate for the tobacco control programme, and the earmarked money was spent on other programmes by the Ministry of Health.

Table 2 shows the breakdown of expenditure by type of activity in the tobacco control programme in 2013, and Table 3 shows expenditure in the total health budget.

**Table 2.** Expenditure (in PLN) by type of activity in the tobacco control programme*

| Activity | Chief Sanitary Inspectorate | Local sanitary inspectorates | Other partners | Ministry of Internal Affairs | Ministry of Defence |
|---|---|---|---|---|---|
| Conferences, events, World No Tobacco Day and Smoke Out Day | 102 370 | 99 474 | 154 061 | | |
| Educational programmes for children and young people | 148 775 | 66 554 | 198 449 | | |
| Smoke-free workplace activities | 40 000 | 9 209 | 17 862 | | |
| Other expenses | 26 858 | | | | |
| Smoking cessation programmes | | | | 56 247 | 90 600 |

* Data from the report on implementation of the tobacco control programme, 2013

**Table 3.** Comparison of the funds in total health budget or other relevant reference (2013)*

| Type of expenditure | Amount (PLN) |
|---|---|
| Total for health from the State budget | 4 317 544 000 |
| Health policy programmes from the State budget | 882 851 000 |
| Tobacco control programme | 1 008 463 |
| Colon cancer screening programme (excluding medical services) | 17 941 995 |
| Primary cancer prevention programme | 1 800 000 |
| Cervical cancer and breast cancer screening programme (excluding medical services) | 20 294 660 |

* Data from the reports on implementation of the State budget and the national cancer control programme, 2013

## 4. Impact of the earmarked tax

Although Poland achieved a significant reduction in the prevalence of daily smoking among people aged ≥ 15, from 33% in 1999 to 24% in 2015,[17] no detailed analysis has been conducted of the contribution of the tax. A recent report from the Supreme Audit Office (*2*) concluded that funding of the programme from earmarked tax was not responsible for changing the smoking rate (*4*) and that the change was negative in relation to the age structure of smokers. The Audit Office also pointed that that the programme cannot be assessed because of the lack of reliable monitoring and evaluation of its aims and activities and lack of proper management and coordination. These weaknesses are due mainly to the fact that neither the financing mechanism nor the programme were defined in the law and that the Ministry of Finance did

17 Data from TNS Polska SA surveys (http://tnsglobal.pl/)

not accept queries from the Ministry of Health about transferring funds.[18] At the same time, the Ministry of Health did not consider itself responsible for providing funds from its budget, because of competing priorities.[19]

Unfortunately, the tobacco control programme has not had strong support from any minister of health since 2000. The programme is thus low on the agenda, and ministers have given up on having it financed according to the law. Additionally, the Ministry knows there would be no serious political or legal consequences of not financing the programme. In the Ministry, only one person has been responsible for the daily management of tobacco control issues. Opposition parties were not interested in using reports from the tobacco control programme to attack the Government, and the mass media found the issue uninteresting.

## 5. Current implementation process

In March 2015, the Ministry of Health presented the Public Health Act, which contains a proposal to create a special Public Health Fund that would consist of 0.5% of the excise tax on tobacco, 1% of the excise tax on alcohol and 3% of income from subsidies for gambling from the State.

The Ministry of Finance did not agree to this proposal, and in fact the Public Health Act enacted in September 2015 ended the tobacco control programme, as described in the Act on the Protection of Public Health against the Effects of Tobacco Use. It now incorporates tobacco control activities into the National Health Programme, which will be financed from the State budget. The level of financing has not yet been established.

## References


1. Art. 4 paragraph. 2 of the Act of 9 November 1995. Health protection against the consequences of tobacco use and tobacco products (Dz. U. z 1996 r. Nr 10, poz. 55, z późn. zm).
2. Supreme Audit Office. Information on the result of audit no. 145/2013/P/12/137/LKA: realization of the regulations of the Act on the Protection of Public Health against the Effects of Tobacco Use. Warsaw: 2013.
3. Programme on Reducing Health Consequences of Tobacco Smoking. Aims and task for years 2014–2018 (http://www2.mz.gov.pl/wwwfiles/ma_struktura/docs/projekt_tyton_11032014_poppp.pdf).
4. Postawy wobec palenia papierosów [Attitudes towards tobacco smoking] (komunikat z badań BS/70/2011). Warsaw: Centrum Badania Opinii Społecznej; 2011.


18 Letter from the Undersecretary of State in the Ministry of Finance, Jacek Kapica, dated 18 December 2009 (CA4/8870/285/09/1331BMI8KOM).
19 Letter from the Ministry of Health to the Supreme Audit Office dated 29 January 2013 (MZ-DNM-073-17539-5/KCZ/13).

# ROMANIA

## 1. Description of the earmarked tax

The official designation of the earmarked tax on tobacco is the "contribution for health applied on tobacco and alcohol products", known popularly as the "tax on vice". It was introduced in 2005 by the law for health reform (Law no. 95/ 2005) to "combat excessive use of tobacco and alcohol products and funding of health costs". Implementation began in 2006. The tax is calculated as a fixed amount per unit of tobacco product: 10 € per 1000 cigarettes, cigars, cigarillos and other tobacco products or 13 € per kg of smoking tobacco. Tobacco products for oral use are banned, and the electronic cigarettes are not yet regulated.

The tax is paid every month by the legal entity responsible for the trade of tobacco products (importation or manufacture) in Romania, on the basis of the quantity sold in the previous month. The payment is made in the national currency (leu) into an account for the Ministry of Health at the County Public Finance Treasury. Thus, all revenue from the earmarked tax on tobacco is transferred directly to the Ministry, which manages and uses the funds, with no interference in allocating funds but according to Law 95/ 2005: investments in health system infrastructure, national public health programmes (including for tobacco control) and other health-related services.

The earmarked tax is only part of the tax on tobacco products and the legal entity pays the difference between excise owed and earmarked tax into another account, also opened at the County Public Finance Treasury but belonging to the Ministry of Finance. The method for calculating the exchange rate between the euro and the leu is the same as that used to calculate the excise value, which has been modified over time:

- During 2006–2013, the tax was fixed and varied only subject to changes in the exchange rate between the euro and the lei published in the *Official Journal* of the European Union every 1 October;

- From 2014, all excises and taxes are calculated directly in lei and are not influenced by the exchange rate. They are, however, adjusted to inflation (the annual average of the index of consumer prices) at the beginning of each year, in the framework of a law that changed the entire excise system (all excise is now adjusted yearly to inflation).

As the earmarked tax on tobacco and the excise are paid monthly by the importer or manufacturer at the same time and in the same place but in two different accounts to two ministries, the revenue flows are predictable and regular and are not influenced by other interventions.

The revenues from the earmarked tax are fungible and are used according to the priorities established by the Ministry of Health. The precise activities and programmes funded from these revenues, their budgets and their reporting and monitoring requirements cannot, however, be identified. The earmarked funds go into the pool of "specific (own) revenues", with the revenue from the "clawback" tax[20] (until 2011; since 2012, this tax is paid to the Health Assurance House), earmarked tax on alcohol and various administrative taxes. This pool is separate from the State budget. Thus, the Ministry of Health funds consist of the pool of own revenues plus the State budget, in distinct accounts, with different rules for spending the money. For example, funds from the State must be spent during one fiscal year (1 January–31 December); any unspent funds are returned to the State budget, whereas "own" funds can be used the following year.

## 2. Process that led to adoption of the earmarked tax

The process of establishing an earmarked tax on tobacco products was led by the Ministry of Health as part of health sector reform starting in 2004 and was fully implemented and operational in 2006. The process was facilitated by a favourable context for tobacco control measures, both nationally (two European Union directives with regard to tobacco products) and internationally (ratification of the WHO FCTC). Thus, a specific strategy or research was unnecessary, as long as there was consensus between the ministers of finance and health.

The initial proposal for the amount of the tax was maintained throughout the process, but there was some discussion about inclusion of the earmarked tax into total excise. In the initial proposal, the earmarked tax was not part of the excise but was levied from the final price (after exclusion of VAT) for the benefit of public health, because it increased the final price. The solution adopted was to levy the tax from the excise under the provisions of the European Union Tobacco Taxation Directive. The main challenge was to define the administrative pathway for collection of the tax and to channel the funds directly to the Ministry of Health, without an excessive administrative burden on local fiscal authorities.

Resistance was put up by tobacco product manufacturers and importers, sustained by the mass media, as there was no ban of advertising in printed media and no major actions or campaigns were run to provide correct information about tobacco control. Wide "fear-appeal" tactics were used, with forecasts of increased illicit trade and smuggling and a decreased State budget, with compassion for smokers who were being urged to quit. The only arguments against mass media offensive were based on the few international data showing a beneficial impact of increased price on smoking prevalence, as no national data were available. During the Parliamentary debate on the law, the best argument was the expected increase in revenue for the Ministry of Health, which could be used to improve the health infrastructure and services.

20 The "clawback" tax represents an agreement between a company or organization and the Government, in which the company agrees to repay Government benefits at a higher tax at a later date. In Romania, this tax was paid by pharmaceutical companies producing drugs that are reimbursed by public health insurance (reimbursement varies between 20% and 100%) and by the Ministry of Health through national programmes, in which all drugs are reimbursed 100%. As part of the clawback tax on medicines, the producers paid a quarterly contribution for compensated drugs, which was calculated by applying a percentage to the value of the sales of each producer.

A strong, effective argument used during public debates by officials of the Ministry of Health was the ethical aspect of the measure: smokers would have to pay more to the public health system as they use medical services more frequently. In return, the Ministry would support them in giving up smoking.

The three main reasons for adoption of the law were:

1. the international political momentum: As Romania was preparing to join the European Union and to ratify the WHO FCTC; "tobacco control" was on the mainstream political agenda.
2. political consensus between the Minister of Finance and the Minister of Health: The fact that both ministers were expert economists was an important advantage, as they were able to focus on facing resistance and obstacles.
3. the national context necessity to reform the health system: As supplementary funds were required for new health infrastructure and new medical services, revenues from tobacco product use appeared both ethical and efficient.

## 3. Statistics on the earmarked funds and their use

The amounts collected between 2006 and 2014 varied according to the euro/leu exchange rate and the number of tobacco product units sold (Table 1). The proportion of the funds in total health budget is presented in Table 1. The ratio between the earmarked revenues and the state budget allocated to the Ministry of Health is quite constant, demonstrating that the introduction of the earmarked tax did not decrease the amount allocated by the governments for the health sector. By contrary, in 2013 and 2014 these allocations were bigger because of increasing of expenses due to some internal particularities. Thus, the tobacco tax was additive to the parts of the health budget coming directly from governmental sources.

**Table 1.** Revenues of the Ministry of Health according to source, 2006–2014

| Year | Total budget (million lei) | Revenue from State budget (billion lei) | "Own" revenue (billion lei) | Revenue from ear-marked tax (billion lei) | Proportion of earmarked tax in total budget (%) | Earmarked tax divided by revenue from State budget (%) | Exchange rate euro/leu |
|---|---|---|---|---|---|---|---|
| 2014 | 7.96 | 3.11 | 1.32 | 1.14 | 14.4 | 0.37 | 4.74 |
| 2013 | 9.998 | 2.75 | 1.45 | 1.09 | 10.9 | 0.40 | 4.52 |
| 2012 | 4.60 | 2.20 | 1.84 | 1.14 | 24.8 | 0.50 | 4.30 |
| 2011 | 4.41 | 2.61 | 1.63 | 1.08 | 24.5 | 0.41 | 4.27 |
| 2010 | 7.16 | 2.13 | 1.77 | 0.92 | 12.9 | 0.43 | 4.27 |
| 2009 | 4.04 | 2.09 | 1.88 | 1.16 | 28.6 | 0.55 | 3.74 |
| 2008 | 4.47 | 2.43 | 1.86 | 1.11 | 24.9 | 0.46 | 3.36 |
| 2007 | 3.94 | 2.66 | 1.51 | 1.15 | 29.3 | 0.51 | 3.54 |
| 2006 | 2.46 | 1.38 | 0.97 | 0.59 | 24.2 | 0.43 | Variable |
| 2005 | 1.33 | 1.33 | 0 | 0 | 0 | 0 | 0 |

Source: Ministry of Health

The overall health budget comprises funds from the national health insurance and the budget of the Ministry of Health. The national health insurance budget is derived from health insurance paid by individuals and legal entities and a State budget allocation to cover expenditure. The Ministry of Health budget is constituted of funds allocated by the State budget, the Ministry's "own" revenues and other resources, such as external funds. The specific (own) revenues of the Ministry of Health comprise the earmarked tax on tobacco products, the earmarked tax on alcohol products, the earmarked tax on advertising for tobacco and alcohol products, the clawback tax (until 2011) and other specific revenue, like taxes.

The activities implemented by the Ministry of Health are financed from the two main budget lines, the State budget and own revenues, according to the main category of expense (personnel, services, goods, capital and financial expenses) and not by type of activity. Although it is impossible to specify the amount budgeted or expended from earmarked tax by type of activity, more than 50% of total specific revenue comes from the tobacco tax. As the specific revenues are spent mainly on infrastructure for the health system and for health programmes (including new drugs and methods for diagnosis and treatment of patients), it can be concluded that the earmarked tax on tobacco products is used for the modernization and expansion of the health system.

One of the most important advantages of the funds obtained from tobacco taxation is their flexibility. Thus, the Ministry of Health can finance innovative programmes (such as human papillomavirus vaccination of young adolescents, fertilization in vitro, screening for cervix cancer), new techniques (such as interventional radiology, minimal invasive robotic surgery, minimal surgical therapy for resistant epilepsy) and social programmes (covering 90% of the cost of medications for people with an income below the minimal national salary). These programmes were financed for one or more years and, depending on their efficiency, were transferred to the National Health Insurance House for funding.

Another advantage of these funds is their availability: their collection and transfer are continuous and relatively predictable, as they are independent of political influence. Thus, the funds can be used when a health priority occurs. For instance, the past 3 years of explosive development in organ transplant, including stem cells, was due to increased funding for these activities from specific revenues (Table 2).

**Table 2.** Budget allocations for transplant activities, 2011–2013, according to budget source

| Year | Specific budget, including earmarked tax (million lei) | State budget (million lei) |
|---|---|---|
| 2013 | 45.95 | 44.25 |
| 2012 | 28.94 | 49.34 |
| 2011 | 71.04 | 8.78 |

Source: reference *1*

These funds were also the main source for financing the emergency system from the beginning of collection of the earmarked tax, as the infrastructure developed each year (Table 3). Since 2012, almost all costs are covered from this budget line. Today, the Romanian emergency system is very effective and is an example of good practice.

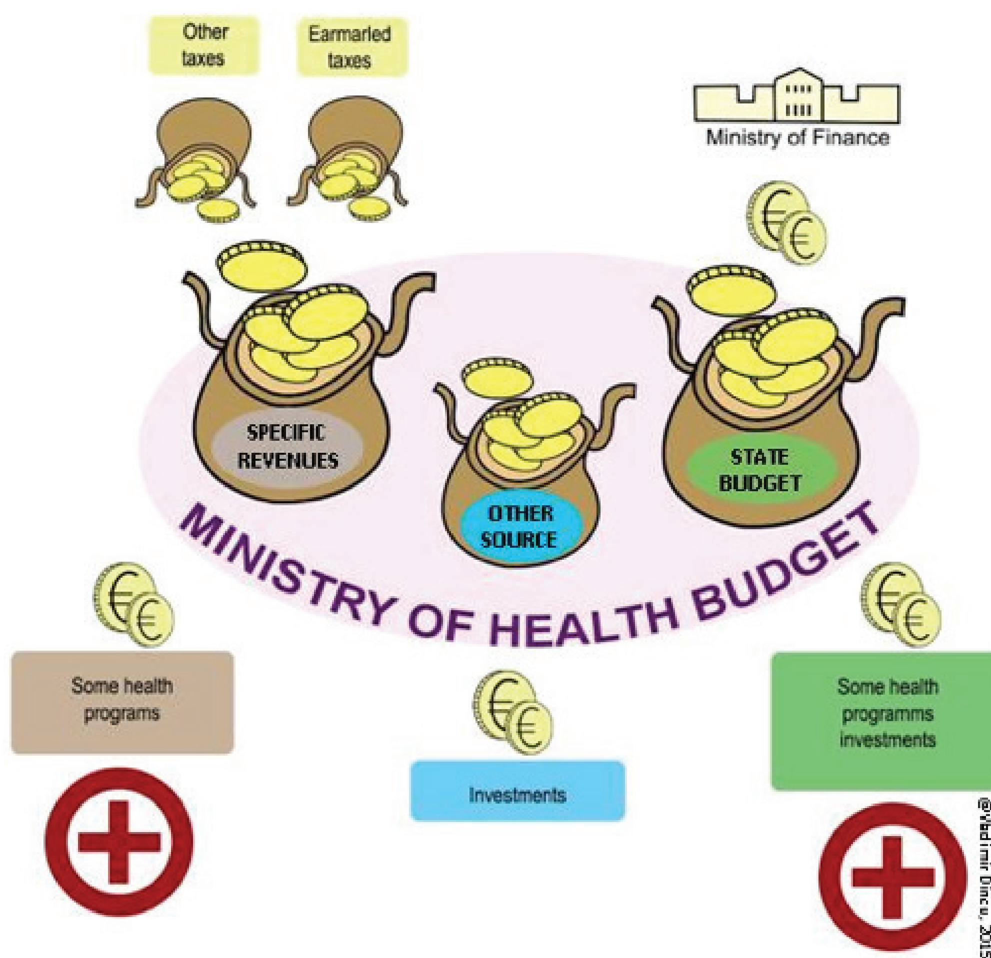
**Table 3.** Budget and certain acquisitions of the emergency system

| Year | Pre-hospital expenses (lei) | No. of ambulances | No. of helicopters |
|---|---|---|---|
| 2013 | 7 400 | 132 | 3 |
| 2012 | 487 200 | 54 | 2 |
| 2011 | 102 400 | 203 | 1 |

Source: reference *1*

The sources of funding and the expenditures of the Ministry of Health are illustrated in Fig. 1.

**Fig. 1.** Sources of funding and expenditures of the Ministry of Health



## 4. Impact of the tax

By financing modern treatment of myocardial infarction (percutaneous coronary interventions), the earmarked tobacco tax contributed to a decrease in overall in-hospital mortality from this condition from 13.5% in 2009 to 9.93% in 2011 The reduction was more evident in centres with percutaneous coronary facilities (7.28% mortality rate) than in those without (14.2%) (*2*). Unpublished estimates[21] show better results for overall in-hospital mortality in 2013: 8% at national level and 4–4.5%% in specialized clinics. The treatment has been funded since 2010, but, since 2013, it has been funded exclusively from specific revenues (Table 4) through a national programme that covers all the necessary instruments; national health insurance covers the cost of medical services.

**Table 4.** Budget allocation for cardiovascular programme, 2011–2013, according to budget source

| Year | Specific budget (million lei) | State budget (million lei) |
|---|---|---|
| 2013 | 124.05 | 0 |
| 2012 | 59.79 | 23.957 |
| 2011 | 41.66 | 34.54 |

Source: Reference *1*

Many tobacco control measures were implemented in 2007–2008, but the only measure taken by the Government after 2009 was a permanent increase in the level of excise tax adopted to comply with the provisions of the Tobacco Products Taxation directive. This increase in the price of tobacco products (also encouraged by the earmarked tax) affected the prevalence of daily smoking, which decreased from 30.9% in 2008 to 24.3% in 2011 (3). The European Commission study on the attitudes of Europeans to tobacco use (4) also showed a decrease in the prevalence but different values were estimated. Results reported a decrease of daily smoking from 30% in 2012 to 27% in 2014. The difference in results can be explained by the difference in methodology used in comparison with the Global Adult Tobacco Survey (reference 3).

## 5. Challenges in implementation of the policy

The earmarking policy is the victim of its own success: as the number of smokers decreases, the number of packs of tobacco sold legally also decreases, as eventually does the revenue from the earmarked tobacco tax, despite adjustment for inflation. Taxes will have to be increased further in order to compensate for the decrease in the number of tobacco users.

Another challenge is the increased administrative workload, as the institutions financed by the Ministry of Health receive funds from two different budgets. Additionally, as smokers and the mass media know that part of the excise is transferred to the Ministry of Health, they are expecting clarifications about how the money is spent. The workload of the

21 http://ampress.ro/sanatate/alerta-medicala-infarctul-la-tineri-a-devenit-regula-in-romania-pericolul-care-ii-pandeste-pe-copii/

communications department is therefore also increased. This also increases accountability and transparency for good implementation of the earmarked tax.

The way in which the earmarked tax is calculated makes it easy to collect and to monitor transfer to the Ministry of Health. The transparency in allocation of the funds and the sums allocated to tobacco control programmes could be improved, which would foster public support for increasing the tax. As the tax is part of excise, however, the Ministry of Finance is reluctant to increasing the amount.

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3. Global Adult Tobacco Survey (GATS), Romania 2011. (GATS report: http://www.who.int/tobacco/surveillance/survey/gats/gats_romania_report_2011.pdf)
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# THAILAND

## 1. Background

Although stronger tobacco control policies were developed and implemented in early 1990s, the health budget for health promotion and tobacco control was not only limited but also showed a decreasing trend. This led to a movement to secure more stable, regular, sustainable funding for health promotion. A health promotion fund was proposed simultaneously with the idea of setting up a universal health insurance fund, and a study on a health financing model from a dedicated excise tax under the control of an autonomous agency established by the State was initiated. After eight years (1993–2001) of planning, strategy and cooperation among the stakeholders and partners, and with strong support from the tobacco control movement, the Thailand Health Promotion Foundation (ThaiHealth) was formed in 2001 and enacted as an independent organization under the Health Promotion Foundation Act (BE 2544) (*1*).

## 2. Process that led to adoption of the Health Promotion Foundation Act

The movement to find innovative funding for health promotion was initiated by two dedicated health advocates, Dr Prakit Vathesatogkit and Dr Supakorn Buasaiin late 1995. The Fiscal and Financial Master Plan (1997–2001) of the Ministry of Finance included proposals for both a health insurance scheme and a health promotion fund. These were accepted with the proviso that a fund should also be established to promote health in the general public and another to provide medical welfare in line with the concept of fiscal and financial policy for social development promoted by the Ministry of Finance. To support the proposals, a working group was set up to establish a private or public health promotion institute and a health promotion and a health insurance scheme or fund on 9 August 1996.

The health promotion movement was supported by various ministries, including those of Finance and Public Health, Government organizations (the Health System Research Institute), NGOs (e.g. Action on Smoking and Health Foundation), academia, WHO, health professionals and the public. Advocates used various strategies to convince policy-makers and to mobilize support from diverse groups for a health promotion foundation with sustainable funding. The activities included organizing a series of scientific conferences and meetings, consultations, public fora with various stakeholders and participating in regional and international conferences on health promotion. Study tours with leading advocates for health promotion were important for gaining the support of high-ranking policy-makers at the ministries of Finance and Public Health, the Finance and Fiscal Bureau and the Health System Research Institute. A study tour was also organized to the Victorian Health Promotion Foundation, Australia, and

the Health Sponsorship Council, New Zealand, to learn about organizational structure, operations, problems, limitations and sources of revenue, particularly the use of "sin taxes" for health promotion. Another strategy was to ask experts from the Victorian Health Promotion Foundation to share their experience and to make a courtesy call to the Minister of Finance and other policy-makers for discussions on health promotion.

The Health System Research Institute compiled and synthesized local and international evidence for advocacy messages for the health promotion foundation. It also supported and undertook joint research among researchers, academics and leading advocates on the fiscal and health impacts of a tax increase, price elasticity and demand analysis, health care costs, the health impact of smoking, a desk review of foreign legislation on health promotion funds, a health financing model from dedicated excise tax, a benefit–cost analysis of establishing a Thai health promotion foundation, the evolution of tobacco consumption control, a public poll to support use of "surcharge sin taxes" for health promotion and lessons learnt and experience from other health promotion foundations.

The initial bill proposed to establish the ThaiHealth Office funded by a dedicated tax was not endorsed by the Ministry of Finance, which objected to an earmarked tax. At the same time, however, a bill on a Campaign Fund for Cessation of Alcohol and Tobacco Consumption was proposed by the Excise Department, which authorized the Ministry of Finance to collect revenue from producers and importers of alcohol beverages and tobacco. The bill was drafted after the Cabinet liberalized the alcohol trade. Concern was raised about the impact of such policy and whether a mechanism was required to reduce alcohol consumption by imposing an alcohol tax. The Deputy Minister of Finance proposed that the two bills be combined into one ThaiHealth bill, which had a clear organizational structure, function and management with the source of funding yet to be decided, while the other bill has a funding source but lacked operational details.

In the early years of advocacy (1995–1998), it was suggested that the new health promotion agency receive approximately 1% of the public health budget annually, corresponding to about 700 million baht (US$ 19.5 million[22]), representing about 2.5% of the cigarette excise tax at that time. This was based on the premise that the Government would invest 1% of the Ministry of Health budget for health promotion. In 1999, when the Deputy Finance Minister expressed support for the combined bill, the proposed budget was 2 billion (US$ 0.06 billion) rather than 700 million baht, on the premise that ThaiHealth should receive the same amount as the AIDS unit of the Ministry of Public Health, as it covered more health promotion issues than AIDS. In addition, the estimated economic loss due to tobacco and alcohol consumption and traffic accidents was a further 200 billion baht (US$ 5.58 billion) annually. If 2 billion baht were invested in health promotion and reduced the problem by 10%, 10% of economic losses would be saved, resulting in about 20 billion baht (US$ 0.56 billion) total loss. The proposed 2 billion baht budget for the new agency is equivalent to 2% of the surcharge taxes on tobacco and alcohol; therefore, that rate has been used for advocacy.

22 Exchange rate as of end February 2016.

During advocacy for a 2% surcharge tax for health promotion, strong challenges were raise, particularly from the Ministry of Finance, which raised concern about the cost–effectiveness of the investment and the legitimacy of using tax revenues from alcohol and tobacco to support programmes and activities that are unrelated to these products. They also argued that the funds from the tax would be misused for other purposes or result in corruption and that a surcharge tax would set a precedent and may disrupt the country's "financial discipline" if replicated. The Deputy Minister of Finance requested an official search to determine whether any law prohibited a surcharge tax. As none was found, the proposal for a surcharge tax was presented for consideration by Parliament as a useful investment for the country.

The Ministry of Public Health proposed that the health promotion foundation be placed under its jurisdiction but was concerned that it might duplicate its Division of Health Promotion. Those concerns were addressed by evidence from local and international studies and the positive experience of other health promotion foundations that a health promotion programme under a Ministry of Health is service based, while the new health promotion agency would conduct population-based activities. Frequent changes in Government leadership, Cabinet ministers and Government officials meant that the proposals stalled for a while and were reviewed intermittently. It is interesting to note that there was less resistance from the tobacco industry on the proposal to use the surcharge tax for the ThaiHealth Foundation, as it replaced the proposal for a tobacco tax increase; this also helped to dampen opposition from the Ministry of Finance, as the tobacco industry would pay more on tax if the tobacco tax increased by more than the 2% surcharge tax. Another argument was that the main reason for setting up a health promotion fund was to improve health in various areas. There was poor understanding of the overall objectives and actual work of ThaiHealth.

The draft Royal Decree for establishment of the Thai health promotion agency under the Public Organization Act 1999 was approved by the Thai Cabinet on 19 October 1999 and made into law by His Majesty the King on 30 June 2000. Simultaneously, a bill to set up a dedicated fund for cigarette and alcohol taxes as a regular, sustainable source of revenue for the agency was proposed. It was approved by Parliament on 26 September 2001 and came into force on 8 November 2001. This gave birth to the ThaiHealth Foundation with a 2% dedicated surcharge tax on tobacco and alcohol. In all, it took about 2 years from the time the bill was submitted to Parliament to adoption of the Health Promotion Foundation Act in 2001.

The ThaiHealth office was first operated under Public Organization Act BE 2542 (1999), while awaiting the coming into force of legislative processes for the health promotion bill based on surcharge taxes. An estimated 150 million baht were allocated for ThaiHealth's first year of operation, but only a fraction was spent, as the ThaiHealth office wasbusy drafting the funding mechanism and other regulations in the early stages of its establishment.

It took about 7 years (1995–2001) of consolidated effort to get the adoption of the Act, due to the work of highly committed and determined individuals who are respected for their integrity and hold prominent positions in society, with access to key policy-makers. Continuous support from other advocates, civil society and policy allies at various stages of the process also

helped to overcome obstacles. The Health System Research Institute played a significant role in knowledge management, including compiling, generating, synthesizing and disseminating resources for policy advocacy, knowledge transfer and awareness-raising among policy-makers and the general public. The main principle of the surcharge tax is that tobacco and alcohol producers pay an additional 2% excise tax for the health promotion foundation as a new funding mechanism that is not restricted by financial or other legislation in Thailand.

## 3. The ThaiHealth Promotion Foundation

The Health Promotion Foundation Act (BE 2544) (*2*) legally founded ThaiHealth as an autonomous State agency outside the formal structures of Government. Thus, ThaiHealth is not managed by the bureaucratic system of the Ministry of Public Health and is under the supervision of the Prime Minister. As an autonomous agency, ThaiHealth can work with various ministries and with agencies in both the public and private sectors. It is therefore not bogged down by bureaucratic processes and is free of interference from ministers and ministry officials.

ThaiHealth has two governing arms: the multi-sector Board of Governance and the Evaluation Board. The Board of Governance comprises 21 members. It is chaired by the Prime Minister; the Minister of Public Health is the first Vice-Chairman, and an independent expert appointed by the Cabinet is the second Vice-Chairman. Of the remaining Board members, nine are representatives from ministries and another eight are independent experts in various disciplines who have no political affiliation but are chosen as qualified honorary members from the community. The Board sets policies, regulations, strategies and the overall budget and oversees the management and other guidelines for ThaiHealth. The Board takes also advice from a series of expert advisory committees. The Evaluation Board has seven members, who are experts in health promotion, finance and evaluation, and are responsible for evaluating the overall performance in policy-making, activities and operations, in order to ensure accountability, transparency and efficiency. The two boards, which are appointed by the Executive Cabinet, have equal standing. ThaiHealth is guided by a Chief Executive Officer, who is a member of the Board and also act as the secretary (*3–5*).

### 3.1 Funding mechanism and management[23]

The Act entitled ThaiHealth to collect a 2% surcharge on the tax levied on alcohol and tobacco. Thus, tobacco and alcohol producers are required to pay an additional tax on top of the excise tax, which is dedication to the health promotion fund. This type of legislated funding mechanism may be the most effective means for securing sustainable long-term funding for health promotion, because tobacco and alcohol taxes are a highly predictable, reliable source of revenue. The mechanism provides sustainable funding by a Parliamentary Act, which safeguards the fund from easy abolishment by the industry. As the surcharge tax is used to support health promotion projects to improve public well-being, a politician or Government official who plans to abolish the fund will not be respected by the public.

23 Raungarreerat K. Overview of ThaiHealth. Presented during study the visit of the Viet Nam Tobacco Control Fund Team to ThaiHealth Foundation, Bangkok, 15–16 December 2014.

In practice, the Excise and Customs departments are responsible for invoicing the levy, which is remitted directly to the Foundation without going through the Ministry of Finance. The dedicated revenue is thus transferred directly to the ThaiHealth bank account (at Krung Thai Bank PCL) and is administered by the financial and accounting unit. The fund is not subjected to normal budgetary processes.

The Governance Board has the power and duty to control the transparency and accountability of the fund flow and distribution and to supervise the operation of the foundation. A finance sub-committee assists in managing and supervising financial issues. Generally, ThaiHealth is governed by an independent board and is audited by a designated Government agency, the Auditor General of Thailand. It is required to submit a report on performance and a financial summary annually to the Cabinet and to both houses of Parliament (the House of Representatives and the Senate). It is supported by a number of expert advisory committees. At project level, all ThaiHealth's grantees are subjected to financial and accounting audits by a certified public accountant.

Funds are allocated for proactive and open grants, with some allocation for unplanned or emerging health promotion issues, such as adolescent pregnancy. Such projects must obtain approval for funding from the ThaiHealth Governance Board, chaired by the Prime Minister.

In 2014, the ThaiHealth annual investment in promoting health was 4 064.74 million baht (US$ 125.15 million), equivalent to 1.8% of the combined budget of the Ministry of Public Health and the National Health Security Fund combined (*6*, *7*).

### 3.2 Collection and distribution of the ThaiHealth fund

Since establishment of the ThaiHealth Foundation in late 2001 (fiscal year 2002), the funding generated from the 2% surcharge tax on tobacco and alcohol has increased steadily as a result of increases in the taxes on tobacco and alcohol products each year. The annual revenue increased from 1.92 billion baht (US$ 0.06 billion) in 2003 to 4.06 billion baht (US$ 0.14 billion) in 2014. The tax increases are made mainly with the intention of collecting more revenue to fill the Government's treasury. ThaiHealth's relentless campaigns to de-normalize tobacco and alcohol products have raised public awareness, so that there has been less public outcry over the tax increases, despite strong opposition from the tobacco and alcohol industries.

ThaiHealth funds projects to address health risks, such as from tobacco and alcohol use, traffic accidents and inadequate physical activity, including research, community programmes, advocacy and mass media campaigns. The Ministry of Public Health does not receive a budget for these activities. The ThaiHealth fund is distributed in 14 plans, covering tobacco and alcohol control, health promotion in communities, social marketing and system support. A healthy community strengthening plan and a plan for a healthy media system and promotion of a spiritual health pathway were given highest the budget allocations of 683.71 million baht (14.5%) and 672.84 million Baht (14.3%), respectively, although the actual disbursement was only 11% and 11.7% of the estimated budget, respectively. The total budget allocation for prevention programmes on the three major health risk factors increased from 264.7 to 308.9 million baht

(5.6% to 6.7%) for tobacco control, from 272.7 to 369.6 million baht (5.8% to 8.1%) for alcohol and substance abuse control and from 189.4 to 262.7 million baht (4% to 5.7%) for road safety and disaster management. Similar trends were seen for promotion of healthy children, young people and families, which increased from 261.3 to 280.7 million baht (5.6% to 6.1%), promotion of healthy food, from 169.9 to 262.9 million baht (3.6% to 5.7%), and a health learning centre, from 118 to 154.6 million Baht (2.5% to 3.4%). The total budget distribution for innovative health promotion and open grants rose from 241.3 to 311.5 million baht (5.1% to 6.8%).

The health promotion work of ThaiHealth does not duplicate that of the Ministry of Public Health. The ThaiHealth programmes are population-based and conducted mainly in collaboration with the non-health sector and NGOs, while the programmes and activities of the ministry are provided nationwide at health service centres by various agencies. They include health education, counselling, vaccination, rehabilitation and health education, with some campaigns on a healthy diet and exercise but no mass media campaign due to limited resources. The Ministry of Public Health does not fund project-based programmes and cannot fund NGOs for related health promotion programmes. The budgetary allocations of the ministry and of the health promotion division at the Department of Health are unchanged, and they continue to operate as they did before ThaiHealth was set up. The health promotion division at the ministry received less than 60 million (US$ 2 million) baht in 2003, while ThaiHealth's budget was about 1.9 billion baht (US$ 0.06 billion). ThaiHealth funds many Ministry projects that failed to obtain funding from the regular budget and also provides funds to the tobacco and alcohol office. ThaiHealth's programmes and projects focus on advocacy for the adoption of public health regulations and laws, while the ministry can advocate for policy change only with political approval and may be influenced by groups with vested interests.

ThaiHealth and the ministry collaborate on tobacco and alcohol control, ThaiHealth funding mass media campaigns on physical activity, diet, traffic accidents, research, capacity-building in health promotion and policy advocacy. ThaiHealth also provides funding for health promotion in communities, schools and workplaces.

## 4. Tax implications

ThaiHealth plays a significant role in health beyond that of the ministry by contributing to funding the prevention and control of NCDs. The use of tobacco, alcohol and other harmful substances has decreased over the years. Cigarette excise taxes were increased about 10 times between 1991 and 2011, which resulted in a significant gain in revenue, from 15.898 million baht (US$ 530 million) in 1991 to 59.914 million baht (US$ 1.997 million) in 2011, and a decreasing trend in smoking prevalence among adults (> 15 years), from 25.47% in 2001 to 20.7% in 2009 (*8*).[24] Thus, ThaiHealth's revenue increased with the reduction in smoking prevalence. The "SimSmoke" model (*9*) shows that, by 2006, tobacco control policies implemented between 1991 and 2006 had already decreased smoking prevalence by 25% as compared with what it

24 Vathesatogkit P, Ritthiphakdee B. Thailand presentation on impact of tobacco tax policy. Presented at the workshop on the regional experience on tobacco tax, 5 July 2013, Halong, Quang Ninh, Viet Nam.

would have been in the absence of the policies. Tax increases on cigarettes and advertising bans had the greatest impact, followed by anti-smoking media campaigns, clean air laws and health warnings. It was estimated that the policies saved 31 867 lives by 2006 and will have saved 319 456 lives by 2026 (*9*). A similar reduction rate was reported in alcohol consumption, from 9.1% in 2004 to 7.3% in 2009; the death rate from vehicle accidents decreased from 22.9 per 100 000 in 2003 to 16.82 per 100 000 in 2010. The number of Thai people who exercised regularly increased from 29% in 2003 to 29.6% in 2007 (*10*).

Moreover, the social return of ThaiHealth's investment in tobacco consumption control (2001–2010) was 18 times, with a return of 18 baht for every baht spent. This calculation is based on the total direct and indirect cost of 1 433 million baht (US$ 47.8 million) and overall outcomes estimated at 189.359 million baht (US$ 6 312 million). A higher return, of 130 baht for every baht spent on road traffic accident prevention, is derived from a total expenditure of 1 454 million baht (US$ 48.5 million) and an estimated benefit of 26 289 million baht (US$ 876.3 million) (*11*).

ThaiHealth supports a number of national and provincial policies and programmes to promote the well-being of the Thai people. Major legislative changes have been made, such as extension of smoke-free areas in public places, such as open-air markets, restaurants, pubs and bars, increasing the number and size of pictorial health warnings, printing the national quit-line number (1600) on all cigarette packs, banning tobacco advertising at points of sale and prohibiting designations such as "low tar" or "light" on packs. Support for quitting smoking and reducing alcohol consumption was set up in 2008, comprising telephone consultations and therapy, supported by the Government, the private sector and communities. Other developments are an increase in the number of alcohol policies, liability for damage in the Unsafe Product Act, a toy control system, television programme ratings, establishment of an independent public broadcasting television from earmarked tobacco and alcohol excise taxes, prohibiting use of mobile phones while driving without an accessory, a safe, clean Internet cafe policy and prohibition on adding sugar to infant formula. Several institutions have been established to support health promotion programmes, including the Tobacco Control Research and Knowledge Management Centre, the national quit-line, the Quality Learning Foundation and the Social Enterprise Promotion Office. ThaiHealth can support nationwide mass campaigns and community mobilization. Nationwide campaigns have been conducted for the general population and specific groups to introduce a culture of no smoking in public, particularly in urban areas and also in hospitals; 80% of hospitals were smoke-free in 2011.

ThaiHealth fund was used mainly for health promotion programs that were not supported by Ministry of Public Health or not within their budget line. ThaiHealth's role would complement MOPH that focuses on service-oriented curative treatment. Thus, it's clear that the earmarked revenue for ThaiHealth would not offset any of the national health budgets. Thailand's national health budget comprises the budgets of the Ministry of Public Health, National Health Security Fund and the health budgets of all other Government agencies, including health care for Government employees and social security for workers, and universities, the military, the police and Bangkok Metropolis Hospital. The annual budget of ThaiHealth represented 1.78–1.84% of that of the Ministry of Public Health and the National Health Security Fund between 2012

and 2014 (Table 1), equivalent to only 1% of the total national health budget. Although the ThaiHealth budget for health promotion is smaller than the total national health budget, it supports many health promotion programmes and activities, which have a significant impact on the health status of Thai people. The funding mechanism itself is a powerful health promotion intervention.

**Table 1.** Annual budget for health (in million baht), 2010–2014

| Fiscal year | ThaiHealth | Ministry of Public Health | National Health Security Fund | Ministry of Public Health plus National Health Security Fund | Proportion represented by ThaiHealth (%) |
|---|---|---|---|---|---|
| 2010 | 3110.30 | 71 625.40 | 89 384.80 | 161 010.20 | 1.93 |
| 2011 | 3391.77 | 86 904.50 | 101 057.90 | 187 962.40 | 1.80 |
| 2012 | 3561.27 | 91 996.80 | 107 814.10 | 199 810.90 | 1.78 |
| 2013 | 3811.55 | 99 788.20 | 108 744.50 | 208 532.70 | 1.83 |
| 2014 | 4064.74 | 106 102.90 | 115 176.70 | 221 279.60 | 1.84 |

Sources: References 6 and 7

## 4.1 Programme priorities and granting mechanism[25]

In order to prioritize health promotion and disease prevention to ensure a healthy, sustainable environment for Thai society, the plans and strategies of ThaiHealth are aligned with the national health strategy and priorities. ThaiHealth also acts as catalyst to accelerate commitment and implementation of health promotion programmes identified in national policies and plans for health. It also creates and coordinates health promotion in related sectors, mainly through policy advocacy and social mobilization.

Its reliable funding allows ThaiHealth to continue supporting and implementing many short-, medium- and long-term health promotion programmes and innovative projects throughout the country. The fund is distributed to 14 master plans: for issues (tobacco and alcohol control, traffic injuries and disaster management, physical exercise and sports for health, healthy food and diet and control of health risk factors, settings (health of disadvantaged groups, health promotion in the community; child, adolescent and family health and health promotion in organizations; and the health system (social marketing and communication, health promotion in health service systems and a health learning centre. supportive systems and mechanisms and open grants and innovations). The plans being supported have evolved over time, from only seven in 2002. In 2014, about 90% of the budget was spent on these 14 plans and 5% for administrative expenditure; most disbursements (36%) were on activities to decrease the main health risks (tobacco and alcohol consumption, unsafe driving) and increase physical activity and food safety programmes. ThaiHealth has established a broad geographical reach among diverse population groups and sectors for major risk factor reduction programmes.

25 Raungarreerat K. ThaiHealth's strategic plan and partners. Presented during study visit of Viet Nam Tobacco Control Fund Team to ThaiHealth Foundation, Bangkok, 15–16 December 2014.

Implementation of the plans is supported by two types of granting scheme: proactive and open grants. The proactive (strategic) grants are accorded to major health promotion projects initiated by ThaiHealth but implemented by others. ThaiHealth sets the agenda in the framework of the master plan. The grants are based on goal, strategy and partners. An estimated 4 281.79 million Baht (US$ 133.8 million) (93.2%) were spent in 2014 on proactive grants. Open or reactive grants are available for any organization and provide opportunities for public participation in health promotion and innovations. These received the remaining 311.49 million baht (US$ 9.73 million) or 6.8% of the implementation fund allocation in 2014.

The strategies used to implement the plans include research, awareness and education, social mobilization, capacity-building and policy development for issues, settings, areas and target populations. The approaches and health promotion strategies of ThaiHealth are based on capacity-building, in accordance with the Health Promotion Foundation Act, to foster the capacity and ability to plan, develop and implement health promotion programmes for communities, Government and NGOs, private and public interest organizations, State enterprises and other State agencies.

ThaiHealth supports and complements rather than replacing existing structures and agencies and has extensive strategic partnerships and collaboration with all sectors of society, ranging from national to grassroots networks. Strong partnerships have been formed with diverse population groups, communities, organizations, ministries, Government agencies, private organizations, temples, educational institutions and others. ThaiHealth invested about US$ 140 million in 1 937 health promoting projects and activities in 2013 and has established networks among 12 480 organizations and individuals nationwide more a decade after its inception. The National Health Security Bill, which was proposed simultaneously with the Health Promotion Bill to establish universal health insurance for Thais, was promulgated into law in 2002. It meets the primary goal of providing health security and health promotion.

ThaiHealth encourages interested organizations to apply for open grants for innovative projects and provides stable financial support to long-term projects that meet its objectives. The Foundation also supports programmes for changing public values, lifestyle and the social environment to promote health and well-being. It complements other bodies working in health promotion. It shared its experience and provided mentorship to Mongolia in setting up a health promotion fund, and collaborated with the Southeast Asia Tobacco Control Alliance in mentoring Viet Nam and the Lao People's Democratic Republic in establishing a tobacco control fund based on a surcharge tax. ThaiHealth is becoming a referral point for study visits and has run several capacity-building workshops to share its experience in using tobacco taxes. ThaiHealth has also provided funding, e.g. to the Lao People's Democratic Republic, for capacity-building on health promotion. Since 2011, ThaiHealth has served as the secretariat for the International Network for Health Promotion Foundation and provided in-kind support for its activities.

### 4.2 Monitoring and reporting system

ThaiHealth finances many short- and long-term programmes and relies on strategic partnerships to initiate, design and implement its programmes to meet its objectives; it also has a

project monitoring and reporting system to ensure that projects are progressing in accordance with their objectives and the time-bound deliverables. As mentioned above, 14 master plans are funded, with various programmes, each of which is administered by a "plan administering committee" comprising 7–15 external expert representatives of Government, NGOs, academic and other interest groups, including two Board members. They manage and administer the master plans, oversee the progress of projects and appoint a programme manager for each plan. ThaiHealth also funds an internal plan manager to oversee and monitor each plan and external work plan managers to oversee the work of one or more plans.

Each program is supported through the implementation of a series of projects as the lowest-level operational unit by an external organization. ThaiHealth acts as a facilitator and does not actually implement projects. Monitoring is built into each project, and progress is self-assessed by the grantees who are required in the signed contract to submit a financial and progress report to ThaiHealth at the end of each phase. Once the report is approved, subsequent financial support is released for the next stage of project activities. If the work plan or budget streams change, the steering committee can approve only a 10% budget adjustment during the same phase. For large projects, the plan administrative committee establishes a steering committee to supervise and report back to the administrative committee. The frequency of supervision for each cycle varies but may be every 3–12 months. Currently, ThaiHealth can estimate the benefit of granting support on the basis of the real outputs and outcomes of each project. In addition, an in-depth evaluation is made. Internal evaluations are carried out for projects costing 10 million baht (US$ 0.33 million) or more, in which a project manager is required to report to the plan administrative committee. For the projects costing more than 20 million baht (US$ 0.67 million), an external evaluation is carried out by each section and reported to the plan administrative committee. ThaiHealth uses independent external evaluators or groups for each project or programme to provide advice and support. For projects on major risk factors, evaluators work closely with the plan administrative committee and the project manager from the outset.

## 5. Conclusions

A decade after its establishment, ThaiHealth is still learning to strengthen its programmes to meet its mission and vision. As a new financial mechanism was used, with a dedicated tax, awareness about ThaiHealth's philosophy, governance and operational structures is still lacking. The tobacco and alcohol industries try to undermine the credibility of research findings and health promotion campaigns launched by ThaiHealth. Furthermore, the health promotion professionals and staff still have insufficient capability for health promotion and operational aspects, and their capacity must be strengthened continually. Inevitably, ThaiHealth sometimes encounters weak political support from the nine board members, most of whom are high-ranking officials in ministries that may have some political influence and also faces opposition from certain industries and businesses with vested interests. Despite these challenges, ThaiHealth continues to expand its scope of interest to respond to emerging health problems across Thailand with effective policies and programmes.

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# VIET NAM

## 1. Background

An escalating trend in NCDs and tobacco consumption among the Vietnamese during the past decades raised growing concern. Although the harmful effects of smoking are well known and scientifically proven, the habit continues to spread, with a current adult smoking prevalence of 23.8% (15.3 million), with 47.4% among men and 1.4% among women (*1*), the overall prevalence being one of the highest in the world. This has resulted in substantial health, economic and social costs to the Government. The total direct and indirect health care cost for five diseases attributable to tobacco use (lung cancer, cancers of the upper respiratory tract, chronic obstructive pulmonary disease, ischaemic heart disease and stroke) among smokers was estimated to be VND 23 139.2 billion (about US$ 1 113.7 million) in 2011.[26] As the price of tobacco products is still low, they are relatively affordable.

The magnitude of the problem outweighs the health promotion and preventive measures taken by the Viet Nam Government because of a limited national health budget. Tobacco use has always been perceived as of low priority on the health agenda, and only a fraction of funding is allocated for smoking prevention programs. Thus, 90% of the resources for the tobacco control movement initiatives have been from international donors since the early 1990s. However, the contributions from these international donors were not guaranteed or regular (*2*).

The limited national budget for tobacco control and a diminishing flow of international funding make it difficult for Viet Nam to effectively implement comprehensive tobacco control measures in accordance with the WHO FCTC, which it ratified in 2004. This realization triggered an urgent call to the Government to secure more regular, stable, sustainable funding to deliver comprehensive tobacco control programmes across the country.

Inspired by Australia (the Victorian Health Promotion Foundation) and Thailand, Viet Nam obtained funding through a dedicated tax from 1987. This was, however, ruled by the High Court as unconstitutional in 1997, and tobacco control has received funds from the national budget ever since). A group of health professionals and tobacco control advocates was formed, which is spearheaded by the Viet Nam Steering Committee on Smoking and Health (VINACOSH), the tobacco control unit in the Ministry of Health. The Steering Committee has been advocating for a tobacco control fund in Viet Nam since 2008. An intensive movement to garner both political and public support for the establishment of a tobacco control fund began the following

26 Pham Thi Hoang Anh, Le Thi Thu. Health costs attributable to smoking in Vietnam. Unpublished report submitted to the International Development Research Centre, Canada, 2012.

year, with the drafting of a tobacco control law. The importance of establishing a sustainable funding mechanism was recognized as essential for ensuring a primary and long-term stream of funding for advancing tobacco control policies in Viet Nam (*2*).

Strategic partnerships and multi-sector collaboration between the Government and nongovernment agencies in the health and fiscal sectors led to establishment of the Viet Nam Tobacco Control Fund (VNTCF) as a self-sustaining internal financial resource from taxes on tobacco products. This was achieved by enactment of the country's first comprehensive tobacco control law with provision of a dedicated fund. The law was adopted by the National Assembly on 18 June 2012 and took effect on 1 May 2013 (*3*).

## 2. Process that led to adoption of the Viet Nam Tobacco Control Fund

The Viet Nam Government ratified the WHO FCTC in 2004. Three years later, the tobacco control law was proposed for inclusion on the National Assembly agenda; however, it was not considered a priority at that time. In 2010, it made its way onto the official agenda, paving the way for establishment of the VNTCF and a tobacco control law. After a series of consultations and revisions to the overall structure and wording of the draft law and incorporation of recommendations from various ministries in order to gain their support, it was submitted to the National Assembly for review in August 2011. After two rounds of hearings in November 2011 and May 2012, the tobacco control law was adopted on 18 June 2012by the National Assembly.

The Ministry of Health, and particularly VINACOSH and the Department of Legislation, spearheaded the process of adoption of the law. The strategic partnership between the Ministry of Health and the Ministry of Finance was the determining factor in establishing a tobacco control fund based on an earmarked tax. VINACOSH contacted various ministries, such as of Justice, Finance, Education and Training, Public Security and Industry and Trade; National Assembly committees, such as for Social Affairs, Legislation and Budget and Finance); public organizations (Labour Union, Women and Youth Union, Fatherland Front); civil society (NGOs, HealthBridge Viet Nam, Community Development Service Centre, the Hanoi School of Public Health and the Public Health Association); local leaders and National Assembly delegates in some localities; the Tobacco Control Working Group, WHO, international donors and the mass media. They received technical and financial support from regional and international partners, including Bloomberg Philanthropies, the International Union against Tuberculosis and Lung Disease (the Union) and the Campaign for Tobacco-free Kids, Atlantic Philanthropies, Viet Nam–Sweden Health Cooperation, WHO and the Southeast Asia Tobacco Control Alliance.

VINACOSH was at the forefront of preparation of the tobacco control law and in advocating for its enactment. The Committee took various approaches and strategies, with partners including WHO, HealthBridge and local NGOs, to strengthen collaboration and gain support from key stakeholders for the tobacco control fund. They consulted with officials in relevant Government agencies to obtain their commitment, gain access to high-ranking officials and build contacts with Vietnamese agencies with similar funding mechanisms. Workshops, technical meetings,

unofficial face-to-face discussions and follow-up phone calls were used. Bilateral study tours are another means for policy-makers to learn from countries and regions with experience in tobacco control measures, particularly Australia (Victorian Health Promotion Foundation), Hong Kong (China) (Council on Smoking and Health), Malaysia (Malaysia Health Promotion Board), Singapore (Health Promotion Board) and Thailand (ThaiHealth). High-ranking officials in the National Assembly and the ministries of Finance, Justice and Health participated in the study tours to gain better understanding of different tobacco tax systems, financing tobacco control through taxes and controls on cigarette smuggling and to gain support for strengthening Viet Nam's tobacco tax policy and ideas for sustainable funding that could be adapted for Viet Nam. Regional and international experts served as resources for the workshops, technical meetings and briefings with high-ranking officials to inform them about tobacco control laws and a tobacco control fund. The programmes received technical and financial support from WHO, the Southeast Asia Tobacco Control Alliance, the Union and the Campaign for Tobacco-free Kids. The use of evidence-based resource materials (PowerPoint presentations, leaflets, fact sheets, booklets) on tobacco taxation and health promotion facilitated effective discussions on issues, particularly among policy-makers, the public and the media. Local and international evidence-based materials were compiled and synthesized as a basis for messages to support passage of the tobacco control law, including the Global Youth Tobacco Surveys in 2003 and 2007, the Global Adult Tobacco Survey in 2010, studies on health care costs, tobacco affordability and the impact of a tobacco tax, tobacco prices, tobacco and poverty, tobacco and employment, desk reviews of health promotion models including lessons learnt from regional and international health promotion foundations, graphic health warnings and smoke-free best practices.

The original proposal was for a compulsory contribution of 2% of the taxable price per pack for all cigarette brands produced locally or imported for local consumption to be channelled into the VNTCF. The rate was based on the ThaiHealth model, in which a 2% surcharge tax on tobacco and alcohol is collected. A gradual increase in the percentage of the compulsory contribution from the tobacco industry for VNTCF was proposed, after consultation with the National Assembly (particularly the Committee of Budget and Finance, the Government Office and related ministries). The proposal was for a gradual increase 3 years after the tobacco control law came into force, including 1% from 1 May 2013 and thence an increase to 1.5% from 1 May 2016 and to 2% from 1 May 2019. The proposed gradual increase took into account experience from other health promotion funds, which indicated that the fund needs time to build and strengthen its capacity and should therefore start with a small amount and gradually increase it. The proposed rates were adopted by law.

Inevitably, some challenges were encountered during advocacy for the law and inclusion of a tobacco control fund. Initially, there was opposition and reservations about inclusion of a tobacco control fund in the law and also about other important features, such as graphic health warnings, smoke-free tobacco sponsorship and kiddie packs (packs of small size) that are attractive to children. It was clear that there was little awareness among policy-makers, who raised concern about effective use of the fund, corruption and the governance and structure of the VNTCF. Some ministers proposed that the VNTCF be placed under the Minister of Health in order to minimize administrative costs and avoid fund abuse and corruption. Compulsory

contribution is a new tax mechanism for Viet Nam, and it was challenged by some of the members of the National Assembly and ministries. The tobacco industry raised the argument that a tobacco control fund would affect their profit, as it would increase the price of cigarettes, which would reduce tobacco consumption.

VINACOSH, in collaboration with its partners, prepared a series of evidence-based advocacy materials containing arguments and messages to counter the opposition from the tobacco industry. It also attempted to gain support from the Ministry of Justice and related ministries. The key arguments included those listed below:

- A similar model with a surcharge tax has been used in various countries. Professor Dr Prakit Vathesatogkit summarized 16 health promotion and tobacco control funds around the globe.
- The health promotion fund is an effective way of generating sustainable revenue for long-term investment. A study in the United States showed that investment of US$ 1 in tobacco control can generate a return of US$ 5 by reducing hospitalizations for heart disease, stroke, respiratory disease and cancer due to tobacco use (*4*).
- The funds would be collected from users of these harmful products, instead of taking them from the pockets of the entire population through the State budget and taxes.
- The health promotion fund could be managed effectively, as seen in the health promotion models used by ThaiHealth, the Victorian Health Promotion Foundation, the Singapore Health Promotion Board and others.
- Some countries in the Association of Southeast Asian Nations have established or are establishing a tobacco control fund or a health promotion fund, including the Lao People's Democratic Republic, Malaysia, Singapore and Thailand.
- The 2% tax for the tobacco control fund would have a minor impact on the price of tobacco products, as it will add only 1% to the factory price. Therefore, the actual cost to the tobacco industry and to individual consumers of the proposed surcharge tax would be negligible, whereas the revenue gain from the tax would be significant for tobacco control and health promotion.

Workshops, meetings with stakeholders and study tours to countries that have established health promotion foundations or similar funding mechanisms were used to raise awareness and for information. Consultations were also held with the Tobacco Control Working Group and international partners, including the Southeast Asia Tobacco Control Alliance, WHO, the Union and the Campaign for Tobacco-free Kids for advice on strategies for tobacco control, and their international experts were used as resources for the workshops. Other measures included mobilizing public support through an online public poll, a communications campaign, dissemination of materials on tobacco control issues and support for the law.

More than a decade of consolidated efforts by various partners resulted in enactment of the tobacco control law and establishment of the tobacco control fund in 2012. Strong support from the Tobacco Control Working Group, high-level political leadership and commitment by policy-makers, including the Minister of Health, the Minister of Finance and the Prime Minister

and also the leader of the Social Affair Committee and the Chairman of the National Assembly, resulted in establishment of the tobacco control fund.

VINACOSH and partners used comprehensive strategies for advocacy and drafting of the law and raised awareness among policy-makers and the public on the harmful effects of tobacco use and tobacco control. With technical and financial support from the donors and other partners listed above, a local evidence base was accumulated to formulate tobacco control policies and an effective communication campaign. Information, education, communication, lessons learnt, common challenges and best practices in health promotion fund initiatives and mechanisms were disseminated to target groups to garner support and coordinate all stakeholders working towards establishing the fund. A strong partnership was built on the basis of shared goals and trust for tobacco control policy reform.

## 3. The Viet Nam Tobacco Control Fund

The creation of the VNTCF under the Tobacco Control Law is a historic milestone in tobacco control in Viet Nam, as it is a semi-autonomous body with regular, predictable funding from compulsory contributions from the tobacco industry for an earmarked tobacco tax. The funding mechanism was developed by the ministries of Finance and Health and enacted in the tobacco control law. The funding is a separate stream and does not offset any Government budget. The total budget of the VNTCF in the first 18 months (between May 2013 and December 2014) was estimated to be VND 299.17 billion (US$ 13.91 million), equivalent to 0.5% of the national health budget in 2014 (*5*). This complements the national health budget fund, which is used mainly for curative services. The VNTCF supports diverse tobacco control and intervention programmes on a national scale, which replace the pilot projects carried out in selected provincial cities before inception of the Fund.

### 3.1 Funding mechanism and management (*6, 7*)

The funding for the VNTCF is based on compulsory contributions calculated as a percentage of the excise tax. Thus, since 1 May 2013, tobacco manufacturers and importers have been required to contribute 1% of the factory prices of all cigarette packs. This tax will be increased to 1.5% from 1 May 2016 and to 2% from 1 May 2019. The fund is also open to voluntary contributions from national and international organizations and individuals, although other funds have not yet been received. The tobacco companies pay the excise tax to the Department of Taxation each month and an additional 1% is collected for the VNTCF account, with a monthly report to VNTCF. The planning and finance division of the Fund cross-checks with the bank and documents the financial statement with a data management softwareto document the process.

The organization and operation of the Fund are defined in the law, as decided by the Prime Minister. It is administered by an intersectoral management board, which comprises an advisory board, a comptroller board and the executive board. The management board is chaired by the Minister of Health, with a representative from the Ministry of Finance as the Vice-chair and representatives from the ministries of Industry and Trade, Education and Training and Information and Communication, the Labour Union and other relevant agencies.

VNTCF is under the Ministry of Health and is subject to State financial management by the Ministry of Finance. The Ministry of Health reports to the Government on the performance management and the use of funds annually and reports to the National Assembly on the results of operations and management of the fund biannually. The two main organizational structures, the Executive Board and the Board of Comptrollers, ensure the transparency and accountability of the funding flow and distribution, and the Fund is audited annually by an independent audit agency and a State audit agency. A report is submitted to the Management Board and the ministries of Health and Finance on all expenditure in each fiscal year. Independent bodies, such as academic institutions, conduct impact evaluations and cost–benefit analyses of the VNTCF plan and programmes as its activities continue to expand. A guideline for monitoring and internal evaluation of grants has been prepared in line with the monitoring and evaluation framework, to assess progress in achieving the Fund's mandate and to identify areas for improvement and future directions.

### 3.2 Collection and distribution of the VNTCF

The earmarked revenue is used strictly to support tobacco control programmes and strengthen implementation of the tobacco control law. As the Fund functions as a semi-autonomous entity, it retains flexibility in disbursement, and grantees can request additional funding for unplanned activities by revising their original proposal and resubmitting it to the VNTCF for further review and consideration. The Management Board, which convenes only biannually, has the sole authority to grant final approval of any adjustment made to the original proposal.

## 4. Tax implications

### 4.1 Programme priorities and granting mechanism

The VNTCF provides a long-term, recurrent budget to support short-, medium- and long-term strategies and other activities to prevent and control the harm of tobacco nationwide. The priorities are set in accordance with its mission, as stated in the law, emphasizing policy, capacity and research development and implementation of tobacco control programmes. These include:

- communication and community campaigns on the harmful effects of tobacco use and other prevention and control strategies for different target groups;
- pilot models of smoke-free communities, agencies and organizations;
- community-based smoking cessation services;
- evidence generation through research and capacity-building in a network of collaborators;
- educational materials on the harm of tobacco and on tobacco control programmes; and
- alternative occupations for tobacco growers and workers in raw material processing and manufacture.

As the VNTCF is still in the early stages of operation, only some priorities have been funded. An annual tobacco control plan will be prepared in line with the areas of interest submitted by partners at provincial and national levels. All plans are reviewed by both the Board of Comptrollers and the Advisory Board to ensure that the projects match the priorities stipulated in the law.

At present, funding is given only for proposals submitted by ministries, popular organizations (Labour Union, Women and Youth Union, Fatherland Front) and the people's committees of provinces and cities. Open grant will be funded in the coming years.

An estimated VND 299.171 billion (US$ 13.94 million) earmarked revenue had been generated for the Fund by the end of 2014, which was equally distributed among the different objectives. In 2015, 47% of the total budget was allocated for awareness-raising among policy-makers and the public about the harm of tobacco use and the tobacco control law. Another 36% was used to disseminate smoke-free models in State, provincial and municipal agencies; 6% was allocated to strengthen tobacco cessation services, the quit-line and consultancy services in all health settings; 2% was used for capacity-building in the network of collaborators and the VNTCF Executive Board, 2% to conduct research on intervention programmes and their socio-economic impact, 3% to build the capacity of inspectors to monitor and enforce the tobacco control law and 4% for the administration and management of the VNTCF.

In the first 6 months of operation (July–December 2014), the VNTCF funded proposals from 11 provinces or cities, six ministries and the Labour Union, with a total disbursement of VND 16.853 billion (US$ 0.8 million). After 8 months of operation, in 2015, 92 grantees were funded, for a total of VND 200 billion distributed among 20 ministries, popular organizations, 63 provinces or cities and six hospitals. The projects were mainly communication campaigns on prevention and control of tobacco use, smoke-free areas, enforcement of the law and capacity-building programmes (*8*).

The funds received represent a huge increase over the US$ 50 000 per year that was allocated from the Government budget for tobacco control to VINACOSH before inception of the VNTCF (apart from international grants). Once the Fund is fully operational, the relatively small amount allocated from the Ministry of Health budget for VINACOSH to conduct tobacco control activities will no longer be needed.

To ensure effective implementation of its programmes, the VNTCF and the Steering Committee have strategically fostered a multi-sector partnerships and collaboration with Government and NGOs, public and private interest organizations, communities and other agencies. They have established strong partnerships with 20 ministries and popular organizations and reached out to 63 provinces and cities.

### 4.2 Programme and project monitoring and reporting system

The VNTCF prepared both a strategic plan and a monitoring and evaluation framework to operationalize the objectives of the national policy on tobacco harm prevention and control. The monitoring component is built into project implementation, and grantees include this aspect from the start; if it is not mentioned in the proposal, the activity is not considered for funding, even if it is approved initially. Publications and any resource materials must be submitted to the VNTCF for review before they are finalized for printing and dissemination. Internal project monitoring is conducted by a focal point from the monitoring and evaluation unit of the VNTCF, involving a site visit or regular participation in the project. Grantees are required to submit a progress report to the monitoring and evaluation department not later

than 20 days after the end of each quarter. Most reporting on activities is observational. The quarterly progress report is reviewed within 3 working days to provide feedback and seek clarification if needed. Subsequently, a proportion of the funding is released to the grantee to support project implementation in the following quarter. In addition, an independent agency evaluates the performance of the VNTCF and determines the effectiveness of each project or programme after 2 years (until the end of 2015). None of the grantees is allowed to receive sponsorship from the tobacco industry. All training courses and workshops must be conducted in a smoke-free setting.

## 5. Conclusions

Several problems were identified in the initial stages of operations of the Fund. One is the frequent change in leadership at ministerial level, which could affect the Fund, as most of the members of the three boards are from ministries. Furthermore, most board members contribute on a part-time basis. The absence of well-trained human resources at the VNTCF for operational and project management and inadequate capacity and experience in tobacco control issues also limit effective work. Grantees also lack skills in planning, proposing and managing projects, and most provincial officials lack experience and knowledge in tobacco control fund management. These are challenges to ensuring effective use of funds. There has also been interference from the tobacco industry, particularly the Viet Nam Tobacco Association, which requested funding to control smuggling; their proposal was refused, as smuggling control is not one of the tasks or functions of the Fund.

As the VNTCF has been in operation for less than 2 years, it is premature to measure any impact of the projects that have been funded. The Fund is still learning to improve the effectiveness of its funded projects. Much work remains before the Fund can be fully used to meet its objectives, and concerted, multi-sectoral effort is required at central and provincial levels to ensure effective use of the Fund to improve people's health and meet its public health objectives.

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