

---

# The Future of Health Taxes: Helping It Happen

Angeli Vigo\*, Jeremy A Lauer†, Franco Sassi‡, and Agnes Soucat§

## 13.1. How this book can be used, and by whom

This book has been designed to meet the needs of a diverse audience, serving two main purposes. The first is to help those who wish to establish a case for health taxes, providing economic arguments and empirical evidence in support of their adoption. The second purpose is to set out key considerations in the design and implementation of health taxes, conveying sufficient technical knowledge to inform key choices faced by decision-makers in policy development.

An important message of this book is that not any tax, and not even any consumption tax, can be a health tax, that is, a tax designed to improve health. If health ministries have one exclusive prerogative in the field of health taxes, this is the entitlement to claim a health rationale for a fiscal policy. Health ministries should apply that claim sparingly and should set the bar high in granting their seal of approval for taxation measures. Not only a poorly or

---

\* World Health Organization, Switzerland.

† University of Strathclyde, UK (formerly World Health Organization, Switzerland).

‡ Imperial College London, UK.

§ Agence Française de Développement, France (formerly World Health Organization, Switzerland).

unsuitably designed tax will bring no health benefits, but also it will be counterproductive for the cause of public health and for health taxes more widely. In this final chapter, we reiterate and summarise what a health tax is, and what it is not, bringing together arguments that have been developed throughout the book. We summarise the guiding principles of the design of health taxes and the political economy considerations that can determine the success, or failure, of health taxes. Finally, we look at the future of health taxes and how they can become a mainstream policy tool in countries worldwide.

### **13.2. Understanding what health taxes are; when taxes are not health taxes**

Consumption is a key driving force in the growth model of most modern economies. Social welfare returns on increasing consumption, however, have been diminishing, with greater negative externalities being generated, especially to the detriment of the natural environment, and also greater negative long-term impacts on health, largely unaccounted for in people's consumption choices. Even essential consumption, such as food consumption, a key enabler of human development and well-being, has developed in ways that make it a leading cause of environmental degradation and depletion of natural resources, as well as a leading cause of disease burden worldwide.

A very large share of consumption by households and individuals, in many countries the majority of it, has impacts on health. This includes both consumption that has direct and immediate health impacts, such as the consumption of tobacco and alcohol products, as well as the consumption of goods and services ranging from food to energy, from housing to transport, that has less immediate or less direct, but no less important, health impacts. Consumers are aware of, and understand, only a small part of the health impacts generated by the above forms of consumption, and well-documented cognitive biases prevent them from coherently balancing present benefits and future consequences, resulting in consumption choices that are typically inconsistent with long-term individual and social welfare.

In the current context, the idea that consumption taxes should cause the least distortion to consumer choices, sounds, at best, like a missed opportunity. In fact, the practice of consumption taxation is rife with deviations from the 'least distortion' principle and consumption tax rates are often differentiated across products in alignment with policy goals, including health in some instances, but mostly in response to externalities and income inequalities. However, governments throughout the world have shown an increasing interest in using consumption taxes to address a wider range of the spill-over impacts of consumption. This trend strengthens the case for health taxes, that is for aligning the differentiation of consumption tax rates with health goals.

Health taxes are fundamentally fiscal policies aimed at addressing the negative health spill-overs of people's consumption choices, including spill-overs affecting other people (externalities), those affecting the same consumers or their households in the future (internalities), as well as future generations more widely (e.g. in terms of health system sustainability).

A key goal of health taxes is to incentivise consumers to make healthier choices through the differentiation of consumption tax rates. In most instances so far, health taxes have been designed as excise taxes, adding to general consumption taxes like value-added taxes. Nonetheless, even general consumption taxes can qualify as health taxes if their rates and bases are suitably differentiated to serve health goals. In other words, what makes a consumption tax a health tax is its health rationale.

A health rationale cannot be claimed when taxes are not designed to achieve a meaningful reduction of the detrimental health spill-over effects of specific forms of consumption.

### **13.3. Designing effective taxes, mitigating unintended impacts**

Effective health taxes are designed to create both demand-side and supply-side incentives by changing market prices and profit margins for taxed products. In principle, price increases will incentivise consumers to reduce their consumption of taxed products, while shrinking profit margins will

incentivise manufacturers to change their products, where possible, in ways that would prevent the application of the tax or mitigate its impact. In practice, we have seen in this book that both consumers' and manufacturers' responses may offset some, or all, of the benefits of health taxes. Consumers may substitute taxed products with others that have similar or worse health impacts; manufacturers may adopt strategies to limit the transfer of taxes onto prices faced by consumers, while minimising impacts on their profits. Designing effective health taxes requires awareness of such potential responses and the ability to prevent them by adopting smart tax-design solutions.

Health taxes are meant to provide incentives for behaviour change, so they must be sufficiently large to motivate change and impact affordability. While official (WHO) recommendations exist, at least for tobacco products, on the size of total taxes as a proportion of retail prices, the appropriate size of each health tax needs to be determined with reference to the specific context in which the tax is to be implemented and to the health goals the government is pursuing.

When faced with price hikes caused by taxation, consumers typically will first seek substitutes within the same product category and then consider wider substitutions. Ideally, prices should be aligned with potential health impacts, especially within product categories. Higher prices should correspond to the least healthy products. The reality is different, and much more complex; for example, in some product markets price is seen by consumers as a signal of quality. Taxes cannot ensure that prices are aligned with health impacts, but they can influence prices and reduce price differentials, where they exist, between cheap unhealthy options and more expensive and healthier options, increasing the relative affordability of the latter. For this purpose, specific excises are often recommended over ad valorem taxes, and taxation according to the quantity of an unhealthy component in a product (e.g. ethanol for alcohol beverages) is preferred over taxation by the quantity of product.

With the exception of tobacco products, the principle of using taxation to incentivise reductions in the unhealthy components in products by

manufacturers has been increasingly applied in the design of health taxes. Most health taxes can incentivise manufacturers to change their products, but some do so more than others. Tiered taxes based on sugar content, for instance, have been effective in incentivising soft drink reformulation when appropriately designed. But the responses health taxes can elicit from manufacturers are also driven by structural factors and market competition, all of which need to be foreseen and accounted for in tax design.

### **13.4. Understanding and managing the political economy of health taxes**

Health taxes are fundamentally different from other public health policies. Taxes can increase prices for consumers and decrease profits for suppliers. Health taxes involve different benefits as well as different costs for various stakeholders, and this triggers complex, and often divisive, political economy dynamics. Many consumers loathe having to pay more for products they value, and whose risks they do not fully perceive. Manufacturers often find the stigmatisation of their products, marked as unhealthy by the levying of health taxes, as even less acceptable than the economic losses caused by taxation. Goals and views often diverge within governments too. The proponents of health taxes face formidable challenges, for which they need to be well prepared, however strong their case may be. This book illustrates such political economy challenges and provides tools and examples that proponents of health taxes may use to navigate the complexity of adopting, designing and implementing health taxes.

### **13.5. Taxes can be used to promote health**

The evidence shows that health taxes are effective fiscal measures for reducing the harmful consumption of products such as tobacco, alcohol and SSBs and are an important tool for reducing the burden of non-communicable diseases and other consumption-related adverse outcomes.

The pathway for change is described in detail in *Chapter 3: Protecting and promoting health through taxation: Evidence and gaps*. Health taxes change relative prices of taxed versus untaxed products which, in turn, affect consumption behaviours. The reduced consumption of these products translates into improvements in health: evidence shows that higher cigarette prices and taxes are associated with lower levels of cancer and respiratory disease and lower overall mortality and higher prices/taxes for alcoholic beverages are associated with reduced health risks (e.g. liver cirrhosis) and reduced risks of other harms (e.g. accidents, violence). There is also emerging evidence that links sugary beverages and other unhealthy food prices/taxes to negative health outcomes, and there are some studies that have demonstrated associations with reduced body mass index.

It is important to note that the change in consumer behaviour varies depending on demographic and socioeconomic status (SES). For instance, in the case of tobacco, SSBs and other selected foods, the evidence suggests that lower-income populations are relatively more price sensitive compared to their higher-income counterparts. Finally, the chapter also explains how substitution and tax avoidance behaviours may affect the net impact of the taxes.

Chapter 3 emphasises that behavioural changes are triggered when the prices of taxed goods increase relative to untaxed goods. Thus, it is important to determine whether the taxes are absorbed by the manufacturer, or whether these are passed on to the consumers. The commercial responses of the taxed industries are explored in *Chapter 4: Supply-side responses to health taxes*. Empirical studies show that taxes on tobacco, alcohol and SSBs are usually passed on to consumers, sometimes exceeding the amount of the tax. The extent of tax pass-through can vary widely, depending on factors such as type of product, package size, brand characteristics, store type, market structure and others. The same chapter also describes how taxes can encourage manufacturers to reformulate their products in response to the tax.

While the focus of much of this book is on taxes on tobacco, alcohol and SSBs, *Chapter 7: Expanding health taxation to other unhealthy behaviours*

*and harmful activities* explores taxation of other activities that may have a negative health impact. The chapter describes the challenges and advantages of using taxes as a way to address the negative health effects caused by air pollution, land use, gambling and farming practices.

### **13.6. Health taxes can have economic benefits**

Economic impacts are not the principal objective of health taxes, but they are nevertheless socially important outcomes that policymakers need to consider. Indeed, many arguments advanced against health taxes do not attempt to rebut their positive health impacts but rather to convince policymakers that the negative economic impacts of health taxes outweigh their health benefits.

Policymakers often grapple with the question: if taxes on these products are designed with a health goal in mind, can these measures be relied upon to generate stable revenue for countries? The revenue-raising potential of health taxes is explored in *Chapter 2: The place for health taxes in the wider fiscal system*. The chapter explains that taxes on tobacco and alcohol have a long history and raise significant amounts of revenues across countries. On average, health tax revenues account for 0.8% of GDP. Empirical evidence shows that increasing health tax rates is expected to increase tax revenues since in many countries, the tax rates are very likely not set at their revenue maximising point. In addition to increasing health tax rates, there might be substantial revenue potential from extending health taxes to other products that generate negative externalities linked to health. Scope exists to enhance the role of health taxes, but health tax reform needs to be embedded within the design and functioning of the broader tax system.

Apart from revenue impacts, policymakers also need to consider how health taxes may affect the labour market. Opponents of health taxes claim that these measures will result in negative labour impacts and economic downturn, particularly in lower-income contexts. *Chapter 5: The labour market impact of health taxes* explains how these claims are based on

studies that use inappropriate methodology, thus showing only the partial, gross impacts. While affected industries might incur job losses from reduced consumption, and the economy will incur transient restructuring costs, consumer spending on other goods and services and spending of increased government tax revenue can drive a sectoral shift that results in either minimal, neutral job losses or even gains. Furthermore, the implementation of health taxes can help reverse the indirect costs to an economy from productivity losses attributable to morbidity and mortality from consumption of tobacco, alcohol and SSBs/energy dense foods.

### **13.7. Health taxes can support the achievement of broader development goals**

The reduction in consumption of harmful products triggered by increases in health taxes has effects in multiple development dimensions beyond the health and economic impacts described in the previous chapters. *Chapter 6: Impacts of health taxes on the attainment of the SDGs* looks at the broader societal impacts of these measures. Most of the literature on health taxes and sustainable development has focused on the effect these taxes have on income inequalities and the discussion about their progressive or regressive nature. The chapter shows that the effects extend beyond income inequalities; in general, health taxes positively affect the three systems that sustain human life, namely, the global society, the earth's physical system and the world's economy.

### **13.8. To reap the benefits of health taxes, tax design and implementation require careful consideration**

Apart from considering health taxes within the broader fiscal framework, the technical aspects of tax design must also be thoughtfully studied.

As explained in *Chapter 8: The design of effective health taxes*, in designing a health tax policymakers must consider: the type of tax to be



applied; what products are to be taxed (i.e. the tax base); the tax structure (i.e. how the products are taxed); and the tax rate to be applied. The chapter discusses the current state of evidence regarding the implications of tax structure.

To further maximise the benefits of health taxes, the design and implementation of these measures should also be analysed within the context of countries' overall tax and governance systems.

One of the important issues policymakers face is how to utilise the revenue from health taxes, and countries have adopted various ways of earmarking health taxes. From a political economy perspective, soft earmarking has helped to advance the adoption of new health taxes in some settings. *Chapter 9: Public governance and financing, and earmarking health taxes* explains these points, as well as other considerations related to public financial management in further detail.

The systematic monitoring of health taxes is also a key component in the effective implementation of health taxes. It is important to monitor health taxes to ensure that they are achieving the goal of decreasing the affordability of the taxed products. In many LMICs, alcohol and SSBs are becoming dramatically more affordable due to rapidly growing incomes and progress on reducing the affordability of tobacco is insufficient. Monitoring can help identify weaknesses in the tax scheme and will inform decisions for further action. *Chapter 10: Monitoring and measuring health taxes* not only explains the importance of monitoring health taxes but also proposes an approach for monitoring taxes on alcohol and SSBs adapting the WHO methodology for collecting data on tobacco taxation.

### **13.9. Challenges to the implementation of health taxes**

Health taxes, like any government policies, require a careful examination of the political economy landscape of the country. The industry sectors involved in the production, distribution and promotion of tobacco, alcohol, unhealthy foods and SSBs have historically opposed health taxes

because they can decrease the demand for their products and reduce profits. However, industry is by no means the only source of challenges to health taxes.

Challenges may even come from outside the country. Trade law arguments are sometimes used to dissuade countries from implementing health taxes. Opponents of health taxes have claimed that increasing taxes would contravene countries' obligations under international trade law, since these result in discriminatory effects for imported products. However, as explained in *Chapter 11: Health taxes and trade law*, even where a health tax has the effect of favouring domestic products, it may still be lawful under trade agreements, so long as that effect is justifiable in terms of protecting human health.

However, there are also many other stakeholders involved constructively in the development and implementation of health taxes, including government agencies, non-governmental organisations, civil society groups, public health professionals, and the scientific community. Thus, while health-tax advocates face powerful foes, they can find allies in other sectors.

To achieve this goal, there is a need to build coalitions at the local, national and international levels capable of working collaboratively in the interests of public health. *Chapter 12: A political economy analysis of health taxes* provides a useful resource for policymakers by providing a description of the relevant actors, strategies employed to oppose taxes and recommendations for engaging with these different groups.

### 13.10. The future of health taxes

Our current understanding of health taxes has extended beyond the concept of a collection of excise taxes on a limited number of consumption goods. The emerging conception of health taxes encompasses the potential for the development of an innovative agenda based on centring health in fiscal policy, in line with the principle that health taxes are fiscal policies aimed at addressing the negative health spill-overs of consumption choices, including spill-overs affecting other people, those affecting consumers or their

households in the future, as well as those affecting future generations. Our confidence in the innovative potential of the health-taxes agenda stems from three facts. First, for purely fiscal reasons differentiated consumption taxes are likely to become an increasingly important part of public policy. Second, the linkage of health taxes with the broader goals of public policy, that is, not those required merely for the purposes of financing the state but also for the sake of preserving both human health and the planetary environment, is inevitable. Third, the increasing need to demonstrate the political legitimacy of the public sector, including the ability to link, both conceptually and in practice, the revenue and expenditure sides of the fiscal system, both complements and reinforces the trend towards centring health in fiscal policy.

### **13.10.1. Health taxes in three key domains (tobacco, alcohol, SSBs)**

Despite their demonstrated positive impact on health, public finance and broader development objectives, health taxes are underutilised globally. In particular, taxes on tobacco, alcohol and SSBs show substantial potential for further extension and development. At global scale, health goals cannot be said to be always at 'the centre' of existing taxation of tobacco, alcohol and SSBs, although there may be exceptions for some products in some jurisdictions (e.g. tobacco taxes in Australia). That said, it is likely that, even in a hypothetical future of optimal health taxation of tobacco, alcohol and SSBs, tax design and rates will differ across jurisdictions in order to take account of product- and market-specific characteristics, as well as differing health goals according to product and burden of disease.

### **13.10.2. New avenues for health taxes**

Although the main focus of this book has been taxes on tobacco, alcohol and SSBs, we have also touched on other potential areas for the application of health taxes, in particular on the (health) taxation of fossil fuels as

a primary source of urban air pollution (Chapter 7). Though there is no substitute for socially optimal carbon pricing, differentiated taxes on the major sources of microscopic particulate matter and of other noxious pollutants, particularly in urban areas, is a promising avenue for the development of health taxes. Health taxes on fossil fuels not only have obvious synergies with limiting the adverse effects of climate change, but they also make salient to individuals the concrete benefit of improved health, in addition to the more remote (both conceptually and in time) benefits people legitimately care about when thinking exclusively of planetary health.

Through the lens of planetary health, it is obvious that a number of areas of traditional environmental concern also have major health implications. An important area in which synergistic fiscal incentives can be created to promote both human and planetary health is food. Food and diet are key determinants of health and major sources of greenhouse gas emissions and depletion of natural resources such as land and water. Fiscal policies have shown great promise when applied to SSBs. Using SSB taxes as a proof of concept, a case can be built for the wider use of consumption tax rate differentiation on food and non-alcoholic beverages, which would complement and reinforce other policies aimed at incentivising consumers towards food and dietary choices that are conducive to health and environmental sustainability.

### **13.10.3. Towards a more holistic approach to health taxes**

A more holistic approach to health taxes seems possible, though this goes beyond the traditional definition of health taxes as corrective taxes as set out previously. The development of such a programme, however, would depend on advances in economic theory about which we can only speculate.

The following seems probable in outline: there will be extensions to optimal tax theory as we now know it. Though there are technical difficulties to be surmounted, the avenues of development might involve:

- i. relaxing the usual assumption of complete and perfect markets underlying the indirect (i.e. income-mediated) utility models on which existing optimal tax theory rests,
- ii. inferring the internal 'market' dynamics of individuals' optimising behaviour regarding investment in and/or consumption of health capital versus other forms of investment and consumption, and
- iii. internalising in a shadow-pricing system the major sources of externalities (e.g. hyperbolic discounting, uncertainty, incomplete and asymmetric information, myopia and other recognised sources of irrational decision-making).

Extending these thoughts somewhat, health capital can be thought of as an idealised asset that jointly determines longevity and wage income. As noted in the introductory chapter, there is no ready metric of prospective and intrinsic health status (i.e. of 'health capital') rather only retrospective measures of health-capital realisations (e.g. outcomes such as longevity and wages). The further study of health capital, therefore, seems a promising avenue for reframing, and to a certain extent, rethinking health taxes: since internal 'market failures' exist (whence the term 'externalities'), it is doubtful whether individuals can even in principle optimise their investment and consumption choices regarding an idealised asset that cannot be directly observed. What sort of 'tax policy' would render health capital salient for individuals?

Another avenue for reconceptualisation would be to go beyond the traditional welfarist emphasis on benefits realised by individuals (as it were, in isolation). When 'centring health in fiscal policy', there thus seems scope for giving increased attention to the production and consumption of emergent and/or collective goods, especially those with the potential for network effects (such as communities of various kinds). Many such goods can be understood as public goods in the neoclassical tradition (e.g. when their production is not guaranteed without collective action), but others might be better described as common goods (e.g. when overuse is guaranteed in the absence of collective action). Both public and common

goods present coordination problems, and in the absence of emergent collective action, they require the appointment of an agent to act on behalf of those who will benefit from enhanced coordination in the use of the resource. In the present context of fiscal measures for health, the agent is the state.

Nevertheless, with the progressive loss of credibility and opportunity for both the social theory of the state (i.e. one emphasising collective mechanisms of protection against life-course risks faced by all members of society) and the more minimalistic neoliberal theory of the state (i.e. emphasising the liberty of the individual in the context of a collective that serves primarily to protect individual property rights), a more compelling conception of the social contract has yet to emerge. One promising formulation proposes the state as the provider and protector of Common Goods for Health.<sup>1</sup> In the sense used in that publication, ‘common goods’ encompasses both goods and services economists have traditionally called public goods (i.e. with supply failures), as well as common goods per se (i.e. with demand failures). The notion of ‘common goods for health’ is defined as ‘population-based functions or interventions that require public financing’, including:

- Policy and coordination
- Regulation and legislation
- Taxes and subsidies
- Information collection, analysis and communication and
- Population services

Recent failures of collective action in global health can be attributed in part to the attrition, over decades, of state-sponsored mechanisms for the financing and provision of common goods for health, which has operated either under the banner of austerity or in the name of a radical reconceptualisation of the social theory of the state along neoliberal lines.

Notwithstanding these failures (or because of them), according to the IMF’s Fiscal Monitor, since early 2020 and as of September 2021 additional amounts equivalent to US\$ 17 trillion in public expenditure (accounting for more than 20% of annual gross world output) had been disbursed in direct

and indirect economic support ('stimulus') as a result of the pandemic. Given that health taxes are not only 'common goods for health' in their own right by the above definition but can in addition be used to finance other common goods for health on the list given above, there would seem to be substantial scope to broaden both the theoretical and practical basis of our understanding of health taxes.

#### **13.10.4. Need for coordination with other fiscal measures**

Some of the controversy surrounding health taxes has been fostered by the tendency for health taxes (or for that matter environmental taxes) to be seen in isolation, rather than as merely one component of a complex fiscal system. Any tax in isolation should not be judged as regressive or progressive without consideration of the entire range of fiscal measures in place, including expenditure measures.

Admittedly, certain elements of the fiscal system have the advantage (or misfortune) of being more 'visible', either to consumers or to producers. The visibility of fiscal measures functions effectively as a form of (conceptual) concentration, of either the benefits or costs of such measures. Excise taxes are highly visible; as noted earlier in this chapter, they could not be called health taxes without this feature. Yet many of the least transparent (i.e. least visible) fiscal measures also deserve attention in the context of centring health in fiscal policies. For example, tax expenditures (i.e. deferrals, deductions, credits, exemptions and concessionary tax rates) make up more than half of the effective subsidies of fossil fuels (i.e. excluding unpriced externality costs, which might also be considered a subsidy).<sup>2</sup>

Although tax expenditures, which are foregone government revenues, act similarly in economic terms to actual government expenditures, they do not appear in the balance sheet, and they are not subject to any regular budgetary or appropriations discipline; they are usually, therefore, implemented in the complete absence of any of the basic principles of public financial management.

### 13.11. Health taxes in the immediate post-pandemic era

At the time of writing, the near-to-medium-term future threatens to be increasingly multi-polar and unstable. The words of the Chief Economist of the IMF, quoted in the introductory chapter to this book, seem, with a few nuances, as relevant now as when they were written.

Whatever disruptions have so far been experienced along the lines of those foreshadowed by the IMF in 2020 are, moreover, merely a foretaste of the scale of upheavals to the social fabric and to social cohesion, of the chaotic incoordination and too-little-too-late responses that have characterised national attempts to address supranational issues, and of the social and political polarisation that will be witnessed when the effects of the climate emergency become generalised and severe.

Health taxes by themselves are insufficient to address such problems, or even to achieve the totality of the Sustainable Development Goals, but they can play an important role as an enabler and facilitator of related policy goals, such as the SDG commitments to Universal Health Coverage. Earlier in this chapter, we recalled that work presented in Chapter 2 showed, globally and on average, that 0.8% of GDP was being collected in the form of health taxes. In 2020, world output stood at approximately US\$ 85 trillion, implying that health taxes were generating revenues in the order of US\$ 680 billion per year. For comparison, achieving Universal Health Coverage in 67 low- and middle-income countries has been estimated to require resources in the order of 1.2% of gross world product, according to WHO estimates.<sup>3</sup> Without much effort, therefore, health taxes can (and, in our view, must) play an important role in financing key components of the SDGs.

#### References

1. Financing common goods for health. Geneva: World Health Organization, 2021.
2. International Monetary Fund. Fossil fuel subsidies [<https://www.imf.org/en/Topics/climate-change/energy-subsidies>]. International Monetary Fund, 2021.
3. Stenberg K, Hanssen O, Edejer T, Bertram M, Brindley C, Meshreky A. et al. Financing transformative health systems towards achievement of the health sustainable development goals: a model for projected resource needs in 67 low-income and middle-income countries. *Lancet Global Health*. 2017; 5: 875–887.