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Health Taxes in the Polycrisis Era

KATHERINE KLEMPERER · PETE BAKER

Abstract

In 2019, the Task Force on Fiscal Policy for Health concluded that taxes on tobacco, alcohol, and sugar-sweetened beverages were a highly effective but greatly underused policy tool to reduce consumption, save lives, and raise domestic resources. The Task Force estimated that if all countries increased their excise taxes to raise prices by 50 percent, over 50 million premature deaths could be averted worldwide over the next 50 years while raising over USD 20 trillion of additional revenue. Since the Task Force first convened, the world has faced a "polycrisis," including a global pandemic, an economic recession, and the outbreak of wars in Europe and the Middle East. Against this backdrop, the world has also experienced prolonged health and fiscal crises. Health systems, weakened by the COVID-19 pandemic, lack sufficient financing to rebuild and respond to the surging non-communicable diseases epidemic caused by uncontrolled risk factors such as tobacco, alcohol, and sugar consumption. Opportunities to raise domestic resources are limited and debt burdens have squeezed budgets. The period from 2019 to 2027 risks becoming a "lost decade" for health and social policies, with 110 countries facing little prospect of any ability to raise government revenues beyond current levels. In this paper, we describe the current health and fiscal crises and review the contribution that health taxes could make in turning around this dire situation. We conclude that taxes on tobacco, alcohol, and sugar-sweetened beverages are an ideal policy solution—good for the budget and good for health. These taxes are relatively quick to implement, and, unlike other taxes, do not put economic growth at risk—a vital benefit in the current era.

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Introduction

The first Task Force on Fiscal Policy for Health was launched in 2019. Since then, the world has entered into a "polycrisis era,"—where "disparate crises interact such that the overall impact far exceeds the sum of each part" (Whiting & Park, 2023). These crises include both health and fiscal shocks.

The most dramatic health crisis was the COVID-19 pandemic, which directly resulted in significant mortality and morbidity, especially for those living with obesity or other non-communicable diseases (NCDs). The pandemic also led to substantial health system disruptions, including missed vaccinations, diagnoses, and treatments, which will have lasting consequences for the health of populations. To tackle the immediate threat of COVID, countries reduced their focus on other health challenges. The UN has stated that, halfway to the deadline for achieving the SDGs, we are "woefully off track" (UN News, 2023), with only 16 percent of targets, and none of the goals, on track to be met (Sachs et al., 2024). Targets related to hunger, sustainable diets, and health outcomes are particularly off-track (*The SDG Index and Dashboards*, n.d.). Increased resources will be needed to get health goals back on track, as well as fund increased pandemic preparedness. Yet COVID-19 is not the only health crisis countries have faced; this short-term crisis came on top of—and exacerbated—a chronic crisis of rising NCDs, especially in low- and middle-income countries (LMICs). By 2030, it is predicted that NCDs will account for 75 percent of all deaths (European Commission, 2018). This has led to a sizable—and rapidly rising—financial burden on countries, both in terms of treatment cost and lost economic productivity.

Concurrent economic and fiscal crises have restricted LMICs' ability to raise resources to tackle these health crises. The post-COVID economy is marked by low growth rates and high inflation. For example, middle-income countries (MICs) are expected to see lower Gross Domestic Product (GDP) growth in 2024–2028 than in all five-year periods since 2009 (Gourinchas, 2023). The global economy is set for the slowest half-decade of GDP growth for 30 years (World Bank, 2024). This lack of growth means it is more challenging to raise sufficient government revenue, squeezing the fiscal space for government health spending. The economic situation has worsened as a result of the war in Ukraine which triggered higher food and fuel prices and exacerbated the high inflation post-COVID. The conflict in the Middle East may put further pressures on inflation. High inflation has led central banks in high-income countries (HICs) to increase interest rates. These rising interest rates are particularly problematic as the high levels of borrowing by LMICs in response to the COVID pandemic has left a legacy of large debts. The proportion of low-income countries (LICs) experiencing or at high risk of "debt distress" has doubled to 60 percent since 2015 (IMF, 2022).

Relative to the situation in 2019, these crises, in combination, have significantly worsened population health and fiscal space. This paper seeks to describe the current health and fiscal crises and reviews the extent to which health taxes may offer a policy solution. Complementary papers will follow later this year to provide a review of progress on health tax policy since 2019, to estimate the short-term

revenue raising potential of expanding these taxes, and to explore opportunities to expand health taxes beyond SSBs to ultra-processed foods. These will be integrated into a 2024 Task Force report.

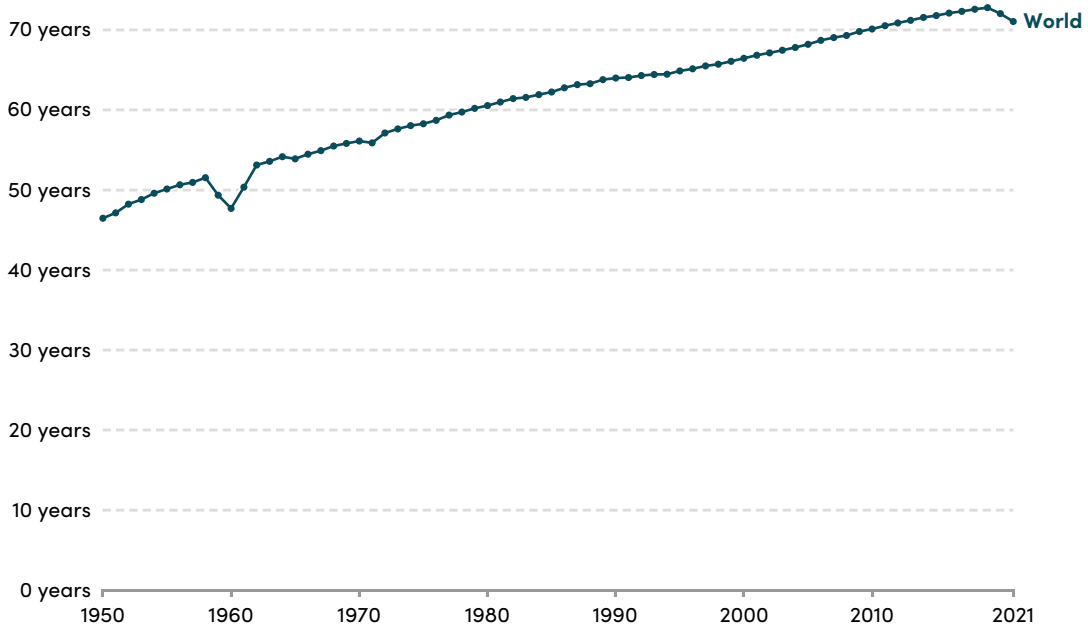
Section 1: The current health crisis

Health systems around the world are struggling with a dual crisis: a slow recovery from the shock of COVID-19 and a long-term crisis of rising non-communicable diseases. In this section we will explore how COVID-19 exacerbated the NCD crises, increasing mortality and disrupting NCD care. We then conclude with a review of deteriorating NCD trends that countries must now tackle if they are to make progress on their health system goals.

COVID-19: a devastating shock to global health, particularly for those with NCDs

Before COVID-19, there had been long-term progress in life expectancy, which increased from 46.5 years in 1950 to 72.8 years in 2019 (Dattani et al., 2023; see Figure 1). This progress was especially significant in LMICs. However, COVID-19 reversed this trend. 184 countries saw their life expectancy at birth decrease from 2019 to 2021; of these, 25 countries saw a decrease of more than three years, 24 saw a decrease of 2–3 years, 58 saw a decrease of 1–2 years, and 77 saw a decrease of less than one year (Cao et al., 2023). Only a handful of HICs did not see life expectancy declines in 2020; many continued to see declines in 2021, and as of 2022, the mortality shock from COVID was still ongoing (Schöley et al., 2022).

FIGURE 1. Global average life expectancy at birth in a given year, 1950–2021



Source: Dattani et al., 2023.

COVID-19 was particularly severe for people living with NCDs and those with high alcohol and tobacco consumption. For example, current and former smokers have 30 to 50 percent excess risk of COVID-19 progression, compared to never-smokers—and are significantly more likely to die from COVID-19 than non-smokers (Gallus et al., 2023). Severe outcomes from COVID-19 were more likely among individuals with increased body mass index, even within the healthy range (Gao et al., 2021), and obesity increases the risk of COVID-19-related hospitalisation and death (Sawadogo et al., 2022). The overall result was higher COVID-19 mortality rates in countries with higher NCDs (Azarpazhooh et al., 2020; Bollyky et al., 2021; Oshakbayev et al., 2022). People with NCDs are also more at risk of other respiratory infections, such as Middle East respiratory syndrome, suggesting that controlling NCDs is necessary both for population health and as a key element of future pandemic preparedness (He et al., 2021).

COVID-19 disrupted health systems and interrupted NCD care

Beyond the immediate loss of life, COVID-19 worsened health through widespread disruption on health system functioning, from which countries are still recovering. For example, it led to the worst backsliding in vaccination coverage in 30 years. There was an almost 40 percent increase in the number of unvaccinated children globally between 2019 and 2021, with coverage dropping to 2005 levels (World Health Organization et al., 2023). 25 million children under five missed at least one routine immunisation in 2021, more than the number of children who missed vaccines in either 2019 or 2020, demonstrating the lasting disruptions to health care systems. Three quarters of those 25 million children lived in one of 20 LMICs (*Global Partners Announce a New Effort – "The Big Catch-up" – to Vaccinate Millions of Children and Restore Immunization Progress Lost during the Pandemic*, 2023). The impact of the millions of missed measles vaccines is already evident, with a 43 percent increase in global measles deaths between 2021 and 2022 (Minta et al., 2023).

Essential services, routine procedures, and attendance at medical clinics were also disrupted. In 2021, the World Health Organization (WHO) reported that essential services were disrupted in 92 percent of countries; in 2022, there were still disruptions in 84 percent of countries (World Health Organization, 2023e). Elective treatment and outpatient attendance remains below pre-pandemic levels in many countries, and many people had referrals cancelled during the pandemic (van Ginneken et al., 2022). A review of the impacts in Africa found extremely high numbers of people missing out on health care during the pandemic, some of which, such as services to prevent mother-to-child transmission of HIV, will have long-lasting effects (Tessema et al., 2021). For example, in Ethiopia, there were substantial declines in tuberculosis diagnosis and management services and a decline in service utilisation of up to 50 percent for antenatal care attendance; in South Africa, there was a 36 to 50 percent reduction in the rate of child health care visits.

Individuals with NCDs were some of the most vulnerable to secondary disruptions of care due to COVID-19. In Brazil, Ecuador, Mexico, and Peru, hospitalisation for conditions amenable to health care declined by 28 percent between March 2020 and December 2021, as compared to pre-pandemic

years (Bernal Lara et al., 2023). This was not due to reduced disease burden, since mortality for these conditions increased by 28 percent in the same period—with NCDs accounting for 89 percent of the mortality increase (Bernal Lara et al., 2023). Despite this, insufficient consideration was made for NCD patients, especially in LMICs. Only 42 percent of LICs included NCD programmes in their readiness and responses plans for COVID, compared to 72 percent of HICs (Okereke et al., 2021)—and the resulting missed treatments may have serious implications for long-term health outcomes for NCD patients in LICs. Therefore, we expect many more problems to occur in the future—a "hidden backlog."

The relationship between COVID-19 harms and NCD harms was bi-directional—in that—the COVID-19 pandemic worsened NCD outcomes, but also, the underlying NCD burden worsened the outcome of the pandemic. This was both through individual-level effects, with NCDs increasing COVID-19 risk, and through population level-effects, as a significant burden of chronic conditions reduced available health care capacity, compounding the pandemic's burden on health systems (Kostova et al., 2021).

NCDs: uncontrolled and continuing to rise

COVID-19 has brought renewed focus on the urgency to correct the global failure to control NCDs and their causative risk factors. NCDs, including cancer, heart disease, stroke, lung disease, and diabetes, have risen sharply in all regions of the world. NCDs are projected to account for 75 percent of all deaths in 2030—up from 63 percent in 2013 (European Commission, 2018). 85 percent of the more than 15 million premature deaths among individuals aged 30 to 69 from NCDs occur in LMICs (World Health Organization, 2023b). This puts increasing pressure on health systems and creates significant economic costs—both for individuals and the wider health care system. The proportion of the population facing catastrophic or impoverishing out-of-pocket health spending has increased continuously since 2000 (World Health Organization and the International Bank for Reconstruction and Development/The World Bank, 2023). Today, about two billion people face such catastrophic spending. The high costs of NCDs—which are often life-long conditions requiring expensive and long-term treatment—could worsen this situation. For example, renal dialysis alone could potentially consume between 15 and 55 percent of total domestic governmental health expenditure in some African countries (Crosby et al., 2020). NCDs also impose costs through negative impacts on human capital and productivity loss. Overall, the leading five NCDs (cardiovascular disease, chronic respiratory disease, cancer, diabetes, and mental health conditions) are estimated to cost more than USD 2 trillion per year, globally (*Financing NCDs*, 2015). LMICs will shoulder a significant portion of this burden; for example, by 2030 they will account for 45 percent of diabetes cases—with an estimated direct treatment cost of USD 300 billion (Ndubuisi, 2021).

Given the well-known disease pathways leading to many NCDs, minimising risk factors is a reliable way to reduce future burden and health care costs. These risk factors are driven by the commercial determinants of health—the "systems, practices, and pathways through which commercial actors drive health and equity" (The Lancet, 2023). That is, ill health is triggered by our own personal

consumption behaviours, which are in turn encouraged by our environment, created by powerful industries in these sectors, and shaped by how we regulate the goods we trade and consume. However, despite this awareness, rates of obesity continue to rise, and levels of tobacco, alcohol, and SSB consumption remain high.

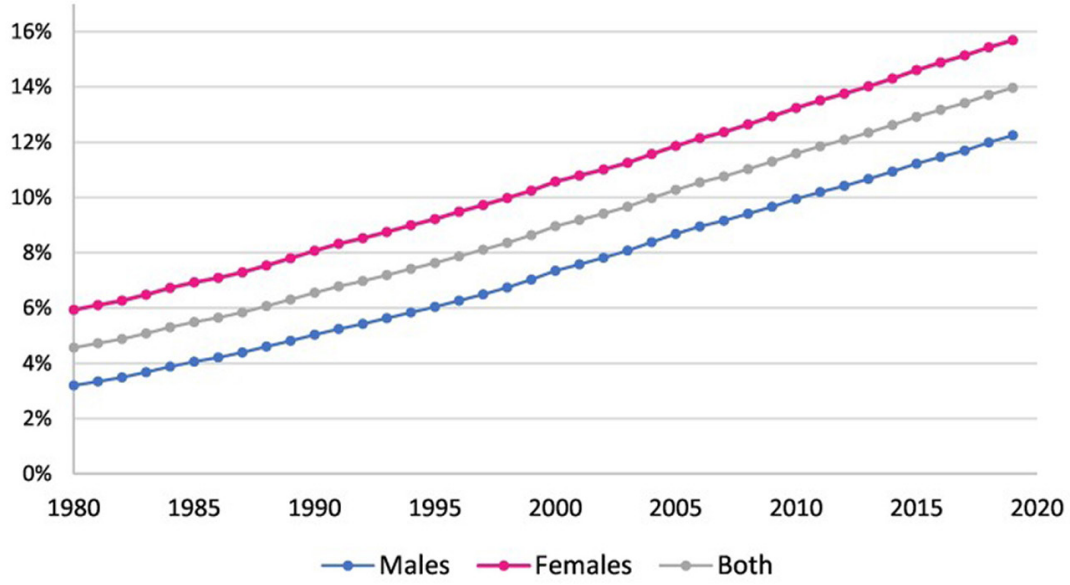
Tobacco leads to more than 8 million premature deaths each year (World Health Organization, 2023d). Tobacco use also results in significant costs, both in terms of treating tobacco-related illnesses and productivity losses. For example, in 2020, the United States lost USD 436.7 billion (2.1 percent of US GDP) as a result of cigarette use (Nargis et al., 2022). From 2017 to 2018, the cost of tobacco use in India amounted to 1 percent of its GDP; the direct medical costs alone accounted for 5.3 percent of total health expenditure (John et al., 2021). While the global prevalence of regular smoking has decreased steadily since 1990, there are still over 1.2 billion global tobacco users (World Health Organization, 2024). Moreover, six countries have seen increased prevalence of tobacco use, and population change means the absolute number of smokers in the African and Eastern Mediterranean regions is predicted to continue to increase. About 80 percent of global smokers now live in LMICs (World Health Organization, 2023d); therefore tackling tobacco use could bring major health and economic benefits to these countries.

Similarly, harmful use of alcohol results in 2.6 million deaths each year (World Health Organization, 2019), as well as disabilities and poor health for millions more—equivalent to 4.6 percent of the global burden of disease as measured in Disability-Adjusted Life Years (DALYs). One paper estimated the economic cost of alcohol consumption at 2.6 percent of GDP, with around one third of these costs relating to direct costs and two thirds relating to productivity loss (Manthey et al., 2021). Another found that alcohol consumption resulted in additional health care costs equivalent to 2.4 percent of the total health care expenditure in OECD countries. Across 52 OECD, EU, and G20 countries, USD 138 billion will be spent annually to treat alcohol-related diseases—equivalent to the current health spending in Australia (Goryakin et al., 2021). While average global alcohol consumption decreased from 2015 to 2019—following an increase from 2005 to 2010 and then a plateau until 2015 (World Health Organization, 2023a)—the COVID pandemic may have led to increased consumption. For example, in the US, alcohol sales rose by nearly 3 percent in 2020, the largest increase in over 50 years (National Institutes of Health, 2023) and alcohol-related deaths increased by 25 percent from 2019 to 2020 (in comparison with all other causes of death which increased by 16 percent) (White et al., 2022). Additionally, global trends masked regional differences: while alcohol use decreased in Europe and Africa, South East Asia and the Western Pacific regions saw substantial increased in alcohol consumption between 2000 and 2019. More needs to be done to tackle harmful alcohol use—which could have a substantial impact on reducing both mortality and health care costs.

Another concerning trend is the rising levels of obesity in LMICs. Global overweight and obesity rates have nearly tripled since 1975 and are predicted to continue to increase—from 38 percent of the population aged five or over in 2020 to 51 percent in 2035 (World Obesity Federation, 2023;

see Figure 2). While the increase has been slowing in HICs, the rise in obesity rates has been greater in LMICs (Abay et al., 2022). About 70 percent of overweight or obese people live in LMICs—equating to nearly 2 billion people (Shekar & Popkin, 2020). Being overweight or obese is a key risk factor for many diseases—indeed, body mass index (BMI) is a strong predictor for overall mortality (Djalalinia et al., 2015) and being overweight reduces life expectancy by an average of 2.7 years in OECD countries ("Overweight and Obesity among Adults," 2021). In 2017, 4.7 million people were estimated to have died prematurely due to high BMI (Powell & Blecher, 2024). In line with increasing rates of obesity, the number of high BMI-related DALYs lost more than doubled between 1990 and 2019 (Dai et al., 2020). This results in significant medical costs for both individuals and the health care system. As of 2020, high BMI accounted for 13 percent of global health care expenditure (Lobstein & Brinsden, 2020). In the next 15 years, the overall annual cost of overweight and obesity in LMICs is projected to reach about USD 7 trillion (Shekar & Popkin, 2020). Tackling drivers of obesity is therefore of paramount importance for public health strategies and for minimising health care costs.

FIGURE 2. Global trends in obesity among adults over 20 years old



Source: Boutari & Mantzoros, 2022, using data from the Global Burden of Disease Study. Reproduced with permission.

Recovery from COVID-19 requires increased focus on NCD prevention and increased health financing

The interaction of the COVID pandemic with a longer-term NCD crisis has resulted in a significant burden on health systems. Given this context, all LMICs will need to reduce pressure on health systems. This will require both a renewed effort to control NCD risk factors and a commitment to increase levels of health financing and rebuild health systems. This is challenging, however, as the economic impacts of the polycrisis era have resulted in LMICs facing a simultaneous crisis in health financing, to which we now turn.

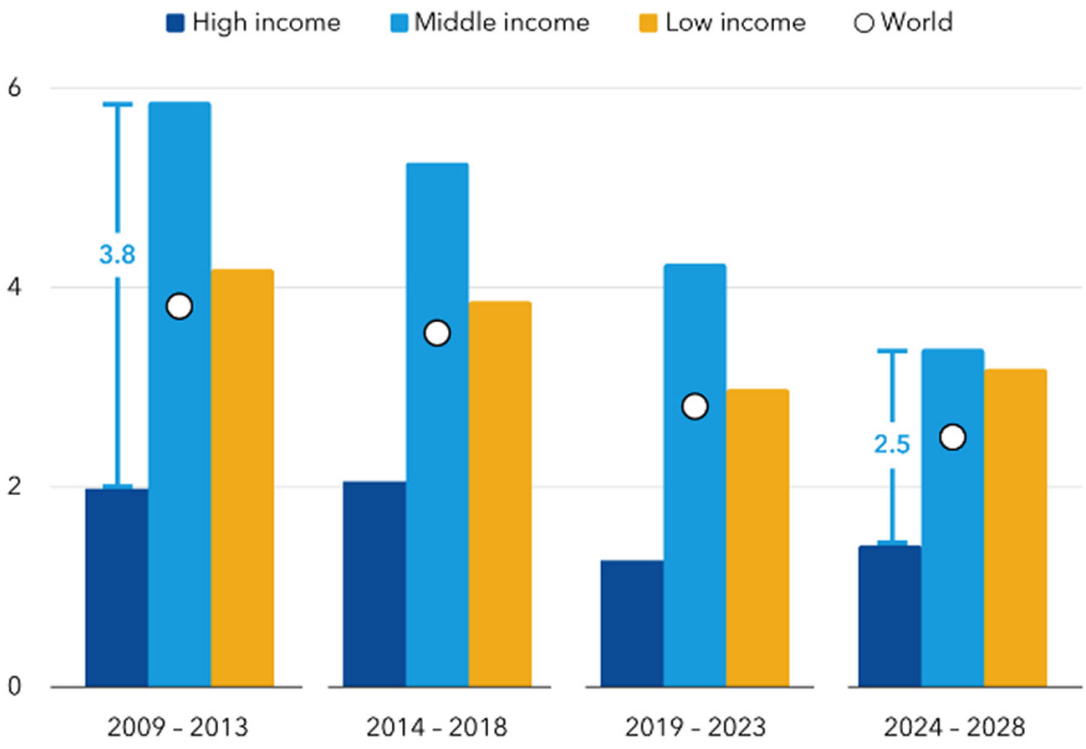
Section 2: The current fiscal crisis and health financing trends

In this section we review how low economic growth, high inflation, and high debt repayment levels are limiting government expenditure on health and other social sectors.

Low economic growth

In 2020, the COVID-19 pandemic and resultant economic disruptions led to global GDP falling by 3.4 percent (Dyvik, 2023)—the deepest recession since the Second World War (World Bank, 2020). In 2022, the invasion of Ukraine led to dramatic spikes in food and oil prices and was one of the main factors which led to the decrease in global economic growth from the predicted 5 percent to 3.1 percent in 2022 (Jenkins, 2023). Both of these shocks have left a lasting legacy on the economic outlook. The International Monetary Fund's (IMF) 2023 World Economic Outlook has predicted short-term growth for LMICs, but this is still less than was previously estimated, and there are concerns about long-term trends (Gourinchas, 2023). GDP growth across MICs is likely to be lower in 2024–2028 than in all five-year periods since 2009 (see Figure 3). In one third of LICs, per capita incomes in 2024 will be lower than in 2019 (World Bank, 2023a). For the third year in a row, global economic growth will continue to slow in 2024—marking the slowest half-decade of GDP growth in 30 years (World Bank, 2024).

FIGURE 3. Five-year per capita GDP growth (Purchasing Power Parity-GDP weighted averages; percentage points)



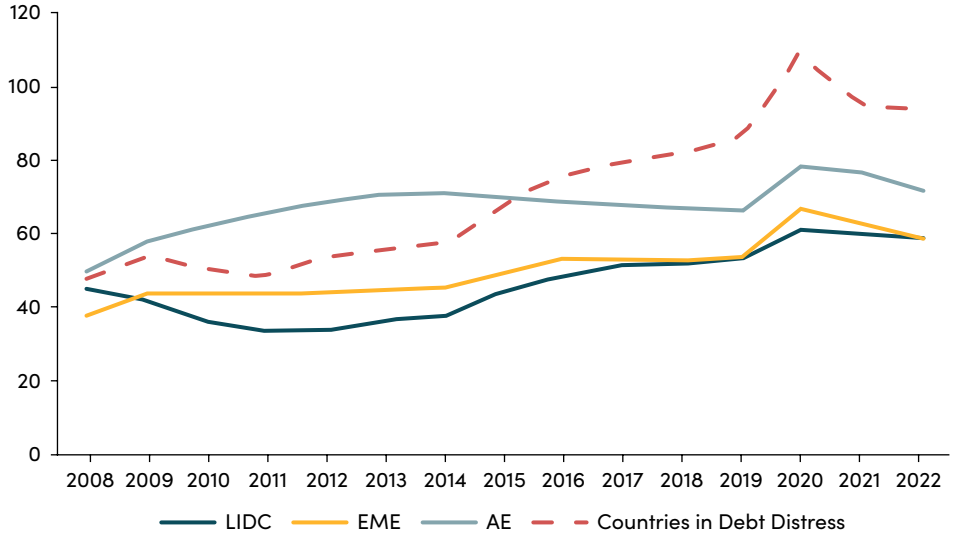
Source: Gourinchas, 2023.

Low government expenditure

In accordance with low growth, estimates of general government expenditure trends look weak. In 41 countries, the World Bank projects general government expenditure may be lower in 2027 than it was in 2019 (Kurowski et al., 2022). In a further 69 countries, spending may stagnate, barely rising above 2019 levels. Only 67 "spending expansion" countries are expected to increase general government expenditure between now and 2027. This suggests we could be in the middle of a "lost decade" in government financing of social objectives in 110 countries (Kurowski et al., 2022).

Debt repayments are further restricting fiscal space—for health and for other social sectors. After high levels of borrowing during the pandemic (with overall global borrowing jumping 28 percentage points to 256 percent of GDP in 2020 (IMF, 2022)), levels of government debt are now extremely high (see Figure 4). There was a sharp spike in deficits across all country income groups in 2020. Public debt has increased more than fourfold since 2000—reaching a record USD 97 trillion in 2023 (UNCTAD, 2024)—in comparison to GDP increasing threefold (UNCTAD, 2023). African countries alone owed USD 644.9 billion to external creditors as of 2021 (Harcourt et al., 2023).

FIGURE 4. General government gross debt (percentage of GDP)



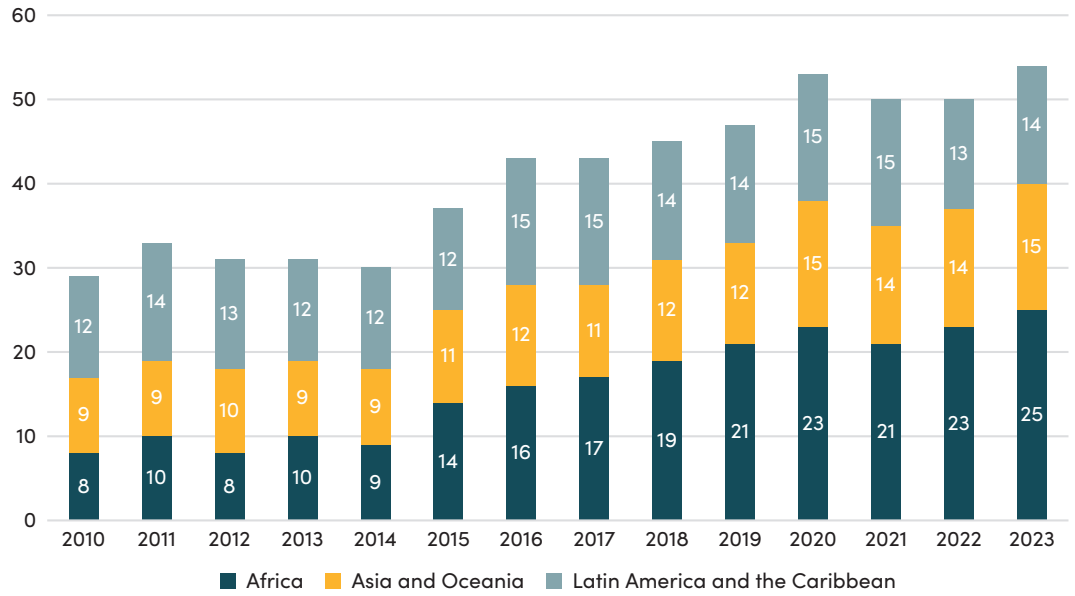
Note: Countries are aggregated by income level, where LIDC = low-income developing countries, EME = emerging market economies, and AE = advanced economies. Countries in debt distress = Republic of the Congo, Ghana, Grenada, Lao P.D.R., Malawi, Mozambique, Somalia, Sudan, São Tomé and Príncipe, Zambia, and Zimbabwe.

Source: World Economic Outlook 2023, via Clemens, Gupta, and Khamidova 2023.

Repayments on these debts are a significant burden, particularly given recent jumps in interest rates—the biggest surge in interest rates in four decades (World Bank, 2023b). For example, interest payments on the total external debt stock of IDA-eligible countries have quadrupled since 2012, and across all developing countries, debt-service payments on public and publicly guaranteed debt are estimated to increase by 10 percent over the 2023–24 period (World Bank, 2023b). For LICs, this increase is estimated at nearly 40 percent (World Bank, 2023b). Figure 5 shows the growing number

of developing countries with interest payments exceeding 10 percent of revenue. Since 2015, the proportion of LICs in, or at high risk of, debt distress[1] has doubled to 60 percent, including 21 LICs in Africa (IMF, 2022). These debt repayments put pressure on government spending. The result is that 3.3 billion people live in countries which spend more on interest payments than they do on health or education (UNCTAD, 2023). In the medium term, the situation may even get worse. Across all country income groups, interest payments per capita are projected to increase through 2027 (Kurowski et al., 2022).

FIGURE 5. Number of developing countries with interest expenditures exceeding 10% of revenues



Note: Net interest payments of the general government refer to the total amount of domestic and external interest expenses incurred from loans and other forms of borrowing, minus any interest income received.

Source: UN Global Crisis Response Group—technical team calculations based on International Monetary Fund (IMF) World Economic Outlook (April 2024), via UNCTAD, 2024.

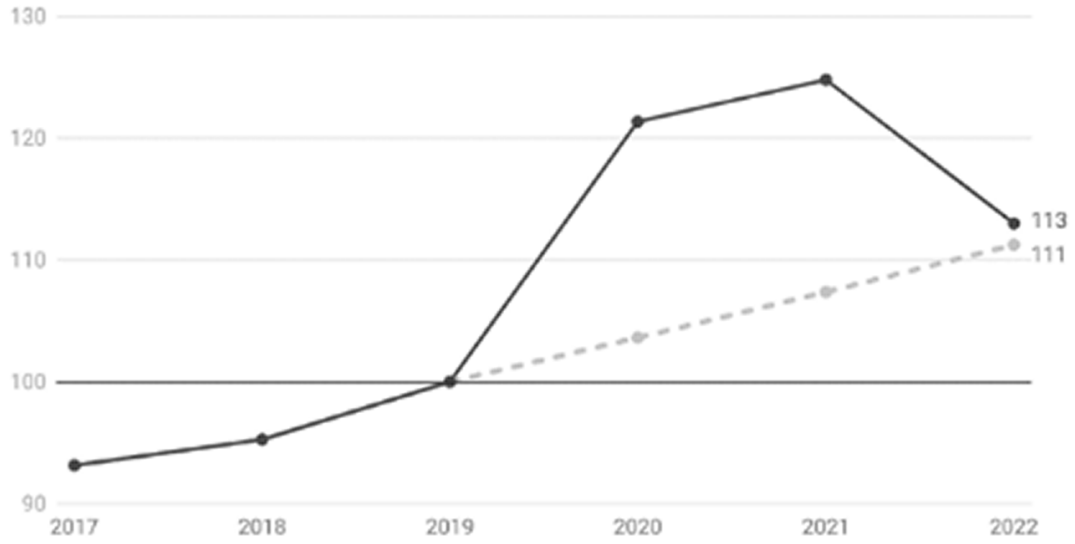
Low health expenditure—an "acute-on-chronic" crisis

The combination of weak economic growth, stagnant or decreasing government spending in most countries, and increasing debt repayments, is likely to trigger an acute health financing crisis. Direct evidence on how health spending has been affected by the polycrisis is limited, however, as the most robust database (the Global Health Expenditure Database compiled by the WHO) only tracks up until 2021. (This was the in midst of the COVID-19 crisis when most countries exhibited increased levels of health spending to manage the pandemic, making it a misleading guide to project future spend.) The World Bank has produced more up-to-date estimates, using budgetary data from 78 countries, which show that by 2022, health financing had reduced to match the pre-pandemic trend (see Figure 6).

1 Countries in debt distress are those unable to fulfil their financial obligations and needing debt restructuring.

This reflective of government prioritisation of health[2] which has dropped back down to pre-pandemic levels by 2022 (Kurowski et al., 2023).

FIGURE 6. Average Central Government Health Spending (CGHS) Index, Actual and Pre-Pandemic Trend Counterfactual, 2017–2022 (2019 = 100)



Note: The counterfactual assumes that pre-pandemic real per capita CGHS growth from 2017–2019 continued between 2019 and 2022.

Source: Kurowski et al., 2023.

Given what we know about weak economic growth and rising debt repayments, these projections may seem optimistic; and individual country examples suggest a more serious health financing crisis may be underway. For example, in Kenya the health sector budget for 2023–24 was cut by 5.6 billion Kenyan shillings (over USD 36 million) (Saya, 2023). In Nepal, the health sector allocation for 2023–24 was nearly 20 percent less than for the previous fiscal year (Poudel, 2023).

This acute crisis is particularly challenging because it comes on top of a chronic crisis of underfunding of LMIC health services. For example, at 80 percent population coverage, the annual cost of a limited package of essential universal health coverage services (UHC) is estimated at USD 87 per capita (in 2021 dollars) in LICs (Watkins et al., 2020). However, the Institute for Health Metrics and Evaluation (IHME) predicts government health expenditure in LICs will only reach USD 15.8 per capita by 2050 (in 2021 dollars) (IHME, 2023). A similar package of essential UHC services in lower-middle-income countries would require USD 143 per capita, but IHME predicts government health expenditure in these countries will only reach USD 98.8 by 2050. Other analysis suggests that countries should aim to spend at least 5 percent of GDP on health in order to progress towards UHC (Mcintyre et al., 2017; Savedoff, 2007). Yet LMIC health spending is not predicted to reach these levels even by 2050. Additionally, compared to pre-pandemic estimates, up to 95 million more people fell

2 Defined as the percentage of government expenditure spent on health.

into extreme poverty (Gerszon Mahler et al., 2022), and hunger returned to 2005 levels (*Goal 2: Zero Hunger*, 2023). These challenges will necessitate increased government funding.

In summary, the combination of stagnant general government expenditure and rising debt repayments means LMIC governments are struggling with insufficient fiscal space for spending on key government services. Moreover, the fact that health financing levels in LMICs have been chronically insufficient, and there are no signs of an increase in prioritisation of health, means an acute-on-chronic crisis is likely. Therefore, in the midst of the current economic and fiscal crisis, governments need to find ways to reduce health care costs, minimise strains on the health care system, and raise additional revenue to fund key government services, including health care. This is where health taxes can play a vital role.

Section 3: Health taxes as a solution

Excise taxes on tobacco, alcohol, and sugar-sweetened beverages (SSBs) are a win-win policy solution for this era of dual health and fiscal crises—improving health (and thereby reducing future health care burden and costs) and raising revenues. With sufficient political will to overcome entrenched industry interests, they are relatively quick to implement; and, unlike other taxes, they do not put economic growth at risk. Moreover, when factoring in consumption changes, the impacts of these taxes are progressive, disproportionately benefiting lower-income groups (Chaloupka et al., 2019; Pan American Health Organization, n.d.), and are therefore a win from an equity point of view.

Impact of health taxes on health and health services

As discussed in Section 1, tobacco, alcohol consumption, and unhealthy diets are significant drivers of the global NCD epidemic. While tobacco, alcohol, and sugar are, to varying degrees, addictive, consumption is also affected by price. Estimates suggest that in LMICs, increasing price by 10 percent would lead to 5 percent decline in tobacco consumption (U.S. National Cancer Institute & World Health Organization, 2016), and a 6 percent decline in alcohol consumption (Sornpaisarn et al., 2013). Sugary beverage consumption is found to be elastic and thus especially sensitive to price, with a price increase of 10 percent resulting in a 16 percent decline in consumption (Andreyeva et al., 2022). This makes taxes a powerful tool for health promotion. Indeed, increasing excise taxes such that tobacco, alcohol, and SSBs prices increase by 50 percent would avert 27.2 million, 21.9 million, and 2.2 million premature deaths, respectively, over the next 50 years (The Task Force on Fiscal Policy for Health, 2019). Reducing tobacco, alcohol, and sugar consumption also improves quality of life, for example by eliminating or reducing years lived on oxygen tanks, coping with injuries from violence and accidents, or suffering amputations. Reductions in alcohol and tobacco consumption can also produce short-term benefits for health services by, for example, reducing admissions due to harmful drinking, road traffic accidents, and heart attacks, thus freeing resources to restore services following the COVID-19 pandemic (Maharaj et al., 2023; Sims et al., 2010).

Impact of health taxes on government revenue and economic growth

LMIC governments currently spend 3 percent of GDP on health services (World Bank, 2023c), two percentage points lower than the estimated 5 percent of GDP needed to achieve UHC (Mcintyre et al., 2017). The short-term revenue-raising potential of health taxes is estimated to be 0.6–0.7 percent of GDP (Lane et al., 2021)[3], meaning, if the revenue was channelled to UHC, health taxes could narrow the gap in UHC financing by a third.

Given the current economic crisis, policy makers will want to consider how health taxes compare against alternative mechanisms to raise revenue and pay for social goals. The IMF recently reviewed options available to countries and found a nine percentage-point increase in tax to GDP ratio is achievable through increasing and optimising VAT, excises, personal and corporate income tax, modernizing taxation to include digital services, and improving tax capacity and administration (Benitez et al., 2023). Policy makers may see this as an opportunity to raise resources to achieve social objectives, but they may also be reluctant to implement them due to concerns that they could be distortionary, prevent growth, or be administratively challenging and slow to implement (Abdel-Kader & de Mooij, 2020). With current weak growth rates post-COVID and substantial increases in extreme poverty worldwide, these arguments have additional political salience.

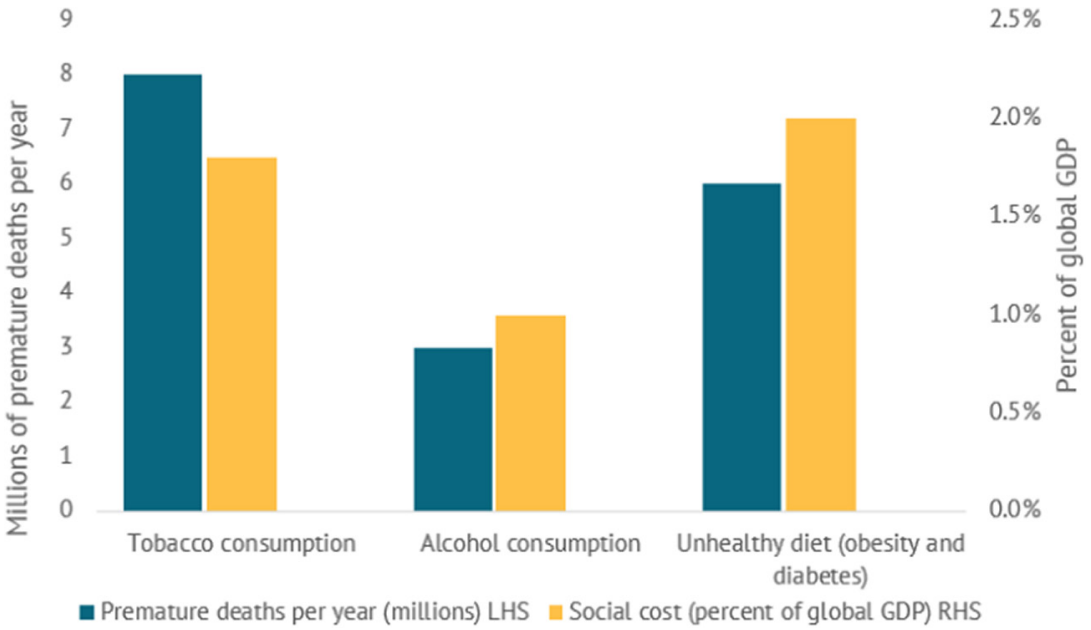
Compared to other taxes, the economic case for health taxes is clear. They are non-distortionary (on the supply side), and on aggregate, they do not negatively impact labour markets or growth. This was recognised as far back as 1776 when Adam Smith wrote *"sugar, rum, and tobacco are commodities which are nowhere necessaries of life, which have become objects of almost universal consumption, and which are therefore extremely proper subjects of taxation."* (Cited in Paraje et al., 2023). The economic case for health taxes is based on the view that the prices of tobacco, alcohol, and sugar are too low and do not fully represent their true social costs. This is because they cause additional costs—in the form of "internalities" on consumers themselves and "externalities" borne by others in society—that are not captured in their price. Externalities arise, for example, through secondhand smoke, road traffic accidents, and large publicly funded health care costs; internalities arise due to the inappropriate assessment by consumers of the long-term risk of consumption against the perceived short-term benefits. Thus, taxes on these items may be corrective in a "Pigouvian sense," bringing consumption and the economy closer to a social welfare optimum (Allcott et al., 2019).

Indeed, the wider social costs of NCDs such as heart disease, cancer, obesity, and diabetes, are very large—they are estimated at over 5 percent of global GDP (The Task Force on Fiscal Policy for Health, 2019, p8; see Figure 7). This is in part because they cause premature deaths in the working

3 The revenue potential of tobacco taxes was estimated as the revenue from raising tobacco excise taxes to the WHO-recommended level of 70 percent of retail price, capped at a 50 percent price increase. The revenue potential of alcohol taxes was estimated as the revenue for a country moving from the 25th percentile of alcohol excise revenue to GDP to the 75th percentile. The revenue potential of SSB taxes was estimated based on case studies in four countries.

age population, leading to significant economic productivity losses. The economic costs of smoking and alcohol alone have been estimated as 1.8 percent of global GDP (i.e., USD 2 trillion in 2024) and 2.6 percent of global GDP (i.e., USD 2.8 trillion in 2024), respectively (Manthey et al., 2021; Vulovic, 2019). A study of 25 LMICs estimated that health taxes could be three times higher than they currently are and they would still be considered corrective (Lane & Bhardwaj, 2021). Studies have also shown that health taxes do not harm labour markets in aggregate. For instance, evaluations in north America, Europe, Africa, and Asia have shown that while tobacco tax rises do result in job losses specific to that industry, consumer spending moves to other sectors which are often more labour intensive. The result is either no impact or a slight gain in overall aggregate employment (Chaloupka et al., 2019). Thus, for politicians who wish to keep taxes low, it may be better to tax "bads" such as tobacco, alcohol, and sugary beverages, and not "goods" such as labour and overall consumption (Summers, 2018).

FIGURE 7. Global estimates of premature deaths and social costs of tobacco, alcohol, and unhealthy diets



Source: The Task Force on Fiscal Policy for Health, 2019, via Lane & Smitham, 2021.

Conclusion: A rapid solution for a fast-changing polycrisis era

The ongoing polycrisis means countries need urgently to prepare for future health threats and reduce the rising burden of chronic diseases. This requires simple and fast sources of revenue. Compared to other tax options, health taxes can be implemented quickly and easily in most countries. Almost all countries have an excise tax system and thus the systems and experience to include health taxes. 87 percent of the world's population lives in a country which already has tobacco taxes, even though they are often too low, suggesting considerable room and capabilities to increase

existing tax rates and broaden them to include alcohol and SSBs (Ghebreyesus & Clark, 2023). Clear guidance is available from the WHO, World Bank, and IMF, and technical assistance providers are available to support interested countries optimise their tax design.

Despite this ease, and the convincing arguments in favour of health taxes, there has been insufficient progress since the start of the COVID-19 pandemic. For example, while there was significant improvement in tobacco taxation policies between 2018 and 2020, as measured by Tobacconomics (Chaloupka et al., 2021), progress between 2020 and 2022 was uneven, with a significant number of countries backsliding. Insufficient action is likely due to fierce industry opposition and tactics. Many companies in these industries are large, powerful, multinational corporations—just five firms account for nearly 80 percent of cigarettes sold worldwide (Collin & Hill, 2019).

The recent inflationary environment has made this limited policy progress worse and reduced the efficacy of most existing health taxes. More than 70 percent of countries have specific excises on cigarettes, and 58 percent of countries with SSB taxes have specific taxes. These taxes have a nominal value, meaning their impact would be reduced by inflation if not indexed to a measure of income or the consumer price index (Lane, 2022). While automatic indexation could address the risk of tax erosion, only 26 percent of countries have such a system for tobacco taxes. Therefore, renewed and more strategic progress on health taxes, with the goal of increasing taxes substantially above growth and inflation levels is an urgent priority in the current polycrisis era. These taxes should be part of a coherent multi-sectoral policy approach to reduce consumption, and, in the case of tobacco, aligned with the principles of the WHO Framework Convention on Tobacco Control (World Health Organization, 2003). This includes demand and supply side measures, for example, restricting availability, banning advertising, eliminating subsidies, promoting public awareness, and restricting and increasing transparency of all interaction between government and industry.

The challenge is not administrative or technical, nor is it a lack of public support which is broadly in favour (World Health Organization, 2023c); the challenge is leadership and developing the political coalitions that can confront industrial interests and lobbying. Policy makers would be wise to harness the imperative of the current economic crises, and the dire need to raise revenue wisely, to overcome industry pressure and deliver a win for the budget and a win for health in the form of optimised health taxes.

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