



**Innovate for health:
Earmarking sin tax to support
Malaysia's NCD response**

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Abstract

Sin taxes are defined as state-sponsored excise taxes added to products or services that are seen as vices, such as alcohol, tobacco and gambling. Revenue from excise duty imposed on cigarettes, tobacco products and alcohol imported, manufactured and sold in Malaysia have increased steadily over the past half-decade. There has been no move yet to earmark the revenue collected for the purpose of health, specifically and directly funding non-communicable disease (NCD) prevention, control and treatment.

Earmarking has long been a tool to advance and sustain a national health priority. Many countries, including those in South East Asia, earmark sin taxes for public health purposes, usually for health promotion. In Ghana and the Philippines, earmarking for health has made it possible to launch or expand a national health insurance program. South Africa used this to mobilize an effective domestic response to the HIV epidemic. At least 80 countries earmark for health. More than 30 utilise tobacco tax for this purpose.

There is consensus about the strong potential role of earmarked taxes on tobacco and alcohol in financing health programmes. Not only does it generate more resources to health promotion and disease prevention programmes, it also deters demand for

tobacco and alcohol leading to possible improvements in health outcomes. The World Health Organisation recommends earmarking for health programmes.

In the context of Malaysia, the intention is not to argue for more new taxes but rather earmarking existing revenue from the collection of sin taxes already imposed on cigarettes, tobacco products and alcohol. The current practice of imposing excise duties on these products is intended to reduce consumption and increase government revenue through indirect taxation. It is not directly earmarked and linked to healthcare funding.

Therefore as a pilot programme, this paper recommends imposing an earmark of 5 percent to be applied to the collected sin tax revenue. An estimated RM 290 million can potentially be earmarked for health. For this initial phase, the utilisation of these funds would go towards strengthening NCD health promotion and treatment, specifically of diabetes and cancer. They should act as additional or supplementary funding, necessary to support upscaling of innovative programmes or fund crucial lifesaving medicines and treatment.

Key Messages

- The commitment and implementation of health policies to prevent and control NCDs are part of a political process
- Revenue from excise taxes/ sin taxes should be earmarked for health programmes
- The decision to earmark should be made in support of a specific health policy framework (e.g. Framework Convention on Tobacco Control (FCTC))
- A strong multi-sectoral partnership should be formed with civil society, with multi-ministerial policy alignment and coherence to secure support
- A percentage of revenue from tobacco and alcohol excise duties has the potential to generate significant additional or supplementary funding which is sustainable and multi-year
- Earmarking sin tax for health can be used to support upscaling of innovative programmes or fund crucial lifesaving medicines and treatment.

Background

Non-communicable diseases (NCDs) are estimated to kill around 38 million people per year, accounting for 68 percent of all deaths worldwide. The main NCDs namely cardiovascular diseases, cancers, chronic respiratory disease and diabetes are among the top 10 leading causes of death.

Strategy A4 of the 11th Malaysia Plan 2016-2020 focuses on measures which will be undertaken to reduce communicable diseases and non-communicable diseases (NCD). This includes the provision of preventive healthcare services and the promotion of a healthy lifestyle.

There is an estimated 3.6 million adult Malaysians living with diabetes, 6.1 million with hypertension, 9.6 million with hypercholesterolemia and 3.3 million with obesity. One in four Malaysians is estimated to be living with cancer.

Malaysia will need more action and commitment to meet and move beyond the Sustainable Development Goal (SDGs) NCD related targets under the United Nations' 2030 Agenda for Sustainable Development adopted at the Summit on Sustainable Development in September 2015. These targets include:

- Reducing by one third premature mortality from NCDs
- Strengthening implementation of the WHO Framework Convention on Tobacco Control (FCTC)
- Strengthening responses to reduce the harmful use of alcohol
- Providing access to affordable essential medicines and vaccines for NCDs
- Supporting the research and development of vaccines and medicines for NCDs

Malaysia has the highest rate of diabetes in Asia and one of the highest in the world. Almost one in five Malaysians is currently living with diabetes, beating the Ministry of Health's 2014 projections which predicted that this level would only be reached in 2020. The prevalence of Type 2 diabetes (T2D) has escalated to 20.8 percent in adults above the age of 30, affecting 2.8 million individuals.

Cancer is currently the 4th most common cause of death in Malaysia, contributing to 12.6 percent of all deaths in government hospitals and 26.7 percent in private hospitals. Approximately 37,000 cases are reported annually and this is estimated to rise to more than 55,000 newly diagnosed cases by 2030.

Interventions to prevent and treat diabetes and cancer must address a challenging context which includes an ageing population, rapid urbanization, inactivity and sedentary lifestyles, and unhealthy diets. It will require strong and adequately funded national plans which emphasize prevention and provides treatment access for all. Operationalising such plans and producing successful health outcomes require committed resources which are ideally, sustained over a multi-year period.

Excise taxes on alcohol and tobacco have long been a dependable and significant revenue source in many

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countries. Governments use earmarking as a mechanism to mobilize fiscal resources specifically for the health sector, to finance progress toward universal health coverage, or to fund other health priorities, such as control of NCDs. Currently, at least 80 countries earmark for health. At least 30, earmark tobacco tax for this purpose.

Despite Malaysia already imposing significant excise duties to tax the consumption of products such as tobacco and alcohol, these are primarily punitive in nature and intended for control and decreasing uptake. The tax collected is consolidated with other government revenue. There has been no move yet to earmark the revenue collected for the purpose of health, specifically and directly funding NCD prevention, control and treatment.

This paper is aimed primarily at exploring the possibility of earmarking sin taxes for the use of preventing and treating non-communicable diseases, specifically diabetes and cancer.

Excise Duties and Sin Taxes

Definitions

An **excise duty** (also known as an excise tax) is a type of tax imposed on certain goods imported into or manufactured in Malaysia.

According to the Royal Customs Malaysia, the following selected goods are subjected to excise duty: liquor (includes brandy, whisky, rum and tafia, gin, rice wine, mead, beer and cider), cigarettes, tobacco and tobacco products, motor vehicles, motorcycles, playing cards and mahjong (classic Chinese tile-based game) tiles.

A "**sin tax**", a non-technical economics term, is defined as an excise tax levied on commodities, products or services that are seen as vices (e.g. gambling) or adversely affects the health of a person such as tobacco and alcohol. In the context of the latter, it is also referred to as a public health tax.

Three main arguments are usually utilised to justify the existence of these taxes: reduces consumption through increased prices; increases monetary resources for health; and provides compensation for increased health system costs usually attributed to treatment of non-communicable diseases as a result of said consumption.

A common criticism is that sin taxes can be regressive if mostly people of lower income are disproportionately affected, while those who are better off are able to enjoy healthy alternatives and tax breaks.

For the purposes of this paper, the discussion and reference to sin taxes will be limited to excise duties imposed on cigarettes and tobacco products, and alcoholic beverages only.

Sin tax revenue (2012 – 2017)

Sin tax revenue from cigarettes, tobacco products and alcohol imported, manufactured and sold in Malaysia increased steadily over the past half-decade.

From 2012 to 2017, a combined total of RM 30.6 billion was collected. Annual collection also increased by a total of RM 1.165 billion during the same period. An increase of almost 10 percent (RM523 million) occurred from 2016 to 2017. An

annual average of RM 5.1 billion was collected from 2012 – 2017.

Sin tax represented 49.7 percent of all excise duties collected and 10 percent of indirect taxes totalling RM 60.5 billion in 2017. All revenue from payment of these taxes is henceforth channeled into the Federal Government's Consolidated Fund.

Excise Duties	Year					
	2012	2013	2014	2015	2016	2017
Total Excise Duty Revenue						
Total excise duty revenue (RM, Millions)	12,187	12,193	12,925	11,890	11,705	11,806
Annual increase (%)	5.82	0.05	6.00	-8.01	-1.56	0.90
Total Sin Tax Revenue						
Total sin tax collected (RM, Millions)	4,698	4,795	4,917	4,953	5,340	5,863
Annual increase (%)	1.25	2.06	2.54	0.73	7.81	9.79
Sin tax against total excise duties (%)	38.55	39.33	38.04	41.66	45.62	49.66

Table 1: Total excise duty revenue and sin tax collected (2012 – 2017)

Proportion of sin taxes against total excise duty revenue has increased steadily

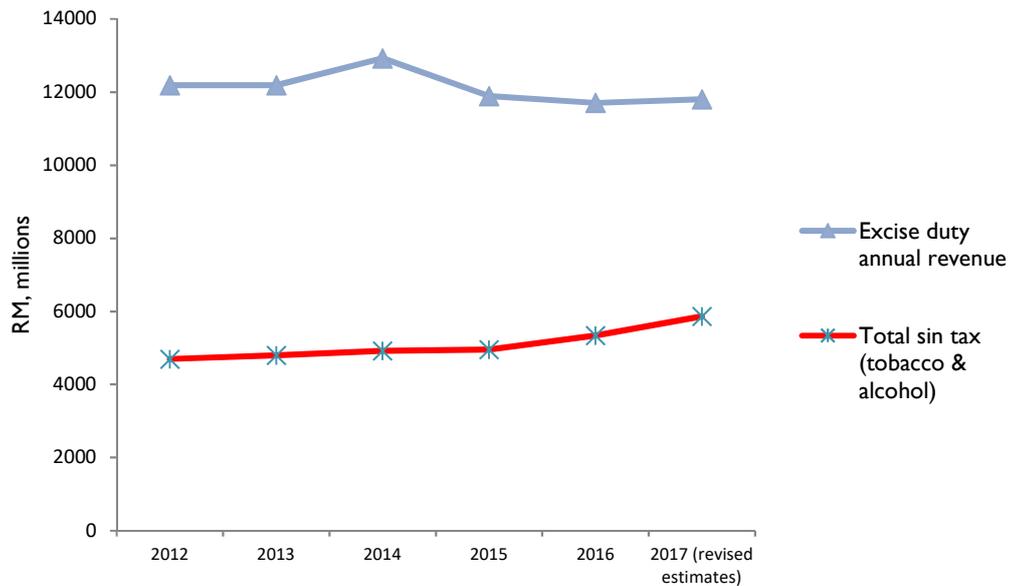


Figure 1: Total excise duty and sin tax revenue from 2012 to 2017

At 67 percent, the proportion of duties on cigarettes and tobacco products represented a larger contribution to sin tax compared to that of alcoholic beverages. Despite a slight dip in revenue in 2015 largely attributed to the significant jump in levied duties that year, collection from the former increased by more than 10 percent in 2017 compared to the previous year.

As part of ongoing advocacy in ensuring the country’s continued adherence to the World Health Organisation’s Framework Convention on Tobacco Control (FCTC), cigarettes and tobacco products experienced back-to-back increases to their imposed tax rates at 14 percent, 12 percent and a significant jump of 36 percent in 2013, 2014 and 2015 respectively. Malaysia became a Party to the WHO FCTC on 15 December 2005.

The National Health and Morbidity Survey (NHMS) 2016 estimates that five million Malaysians or 22.8 percent of the population are smokers.

This is an increase of 6 percent from the 4.7 million reported by the Global Adult Tobacco Survey Malaysia in 2011. It has also been estimated that 6 out of every 10 cigarettes sold in Malaysia are now from the illicit market, resulting in a loss of sin tax revenue of at least RM 5 billion annually.

It is interesting to note that alcoholic drinks experienced moderate growth over the past couple

of years. In 2015, per capita alcohol consumption in Malaysia amounted to approximately 1.7 litres per annum, a modest amount compared to the global average per capita at 6.2 litres. Prevalence of alcohol consumption is at 7.7 percent.

An average of RM3.464 billion was collected from the duties on cigarettes and tobacco products from 2012 - 2017, as opposed to RM1.63 billion by alcoholic beverages in that same period.

Notwithstanding the imposition of the GST (Goods and Services Tax) and adjustments to excise tax rates in 2015 and 2016 respectively, demand for alcoholic drinks ensured that the proportion of revenue collected from these products is slightly less than a third of all sin tax collected.

Excise duty on beer in Malaysia is the second highest in Asia and third highest in the world (Singapore is second highest). 2016 saw a major change in how sin tax was levied on these products, which is now

determined by alcohol content. That year saw the excise duty for beer being replaced to RM175 per 100 percent volume per litre.

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- 2017, as opposed to RM1.63 billion by alcoholic beverages in that same period.

Refer to *Appendix* for a detailed breakdown of excise duties for cigarettes and tobacco products and, alcoholic beverages (as of March 2018).

Sin Taxes	Year					
	2012	2013	2014	2015	2016	2017
Sin tax on cigarettes and tobacco products						
Cigarettes and tobacco products (RM, in millions)	3,281	3,275	3,417	3,318	3,554	3,941
Annual Increase (%)	3.08	-0.18	4.34	-2.90	7.11	10.89
Percentage of contribution to total sin tax (%)	69.84	68.30	69.49	66.99	66.55	67.22
Sin tax on alcoholic beverages						
Alcoholic beverages (RM, in millions)	1,417	1,520	1,500	1,635	1,786	1,922
Annual increase (%)	-2.75	7.27	-1.32	9.00	9.24	7.61
Percentage of contribution to total sin tax (%)	30.16	31.70	30.51	33.01	33.45	32.78

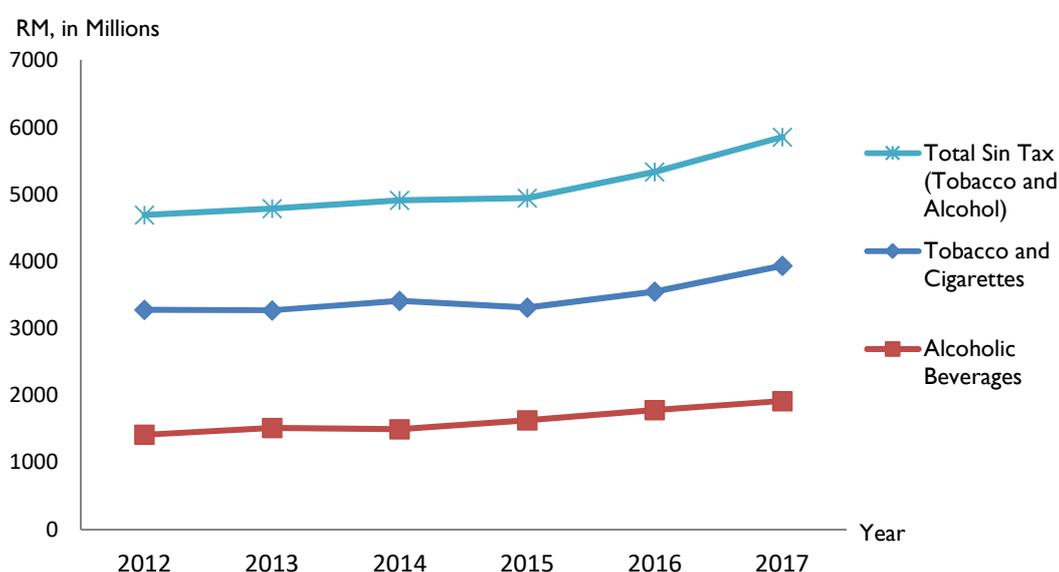


Table and Figure2: Breakdown of sin tax revenue (2012 – 2017)

Estimates for 2018

In 2018, excise duties are forecast by the Ministry of Finance to grow to RM12.33 billion, up 4.5 percent from last year's RM11.81 billion. Notwithstanding the repeal of the GST and re-imposition of the Sales Service Tax (SST) from 1 September 2018 onwards, at least RM 4.1 billion is expected to be collected

from excise duties on the production and sale of cigarettes and tobacco products, while revenue from alcoholic beverages is estimated to be around RM 2 billion. This represents an estimated increase of 4.1 percent in revenue for 2018.

Earmarking

Hypothecation, also commonly known as 'earmarking', is the term used by economists to describe the process of separating all or a portion of total revenue, or revenue from a tax or group of taxes, and setting it aside for a designated purpose. There are many forms or versions of earmarks, depending on the source of revenue and the intended purpose of the designated funds.

In countries transiting from dependence on aid or donor funding, or those working to achieve health system goals such as universal healthcare, earmarking has been an essential tool in a government's policy toolbox to identify and mobilise domestic resources. It has also increasingly been used as an instrument of public health policy.

Pros and cons

The arguments for and against the practice of earmarking are dependent on the type of earmarked being imposed, the programme being funded or supported, and occasionally who is being taxed for the revenue.

A common example is the use of tobacco excise duties collected to fund anti-tobacco initiatives as well as cancer prevention and control programmes. Smokers, who are the consumers being taxed, would therefore be funding or subsidising programmes intended to curb smoking which would benefit the larger population. This could be viewed positively.

On the other hand, earmarked payroll taxes (such as contributions to employment schemes) could be viewed negatively as it is applied much broadly and reduces disposable income levels for lower income households. It is interesting to note that governments in general, tend to view the practice of earmarking sceptically.

Pro

- Secures or ring-fences funding for a stated government priority. May also protect revenues from competing political interests and from constraints and limitations imposed by the Ministry of Finance.
- Improves efficiency of public expenditure allocation by linking taxes to received benefits. Revenue is collected from those who use specific services to fund that

service. Example: contributing to social health insurance to fund individual health coverage

- Reduces public resistance to taxation, particularly if it is linked to areas such as health, education or welfare. Increases accountability as it links taxes to public spending and delivery of services
- Helps educate the public about the cost of a specific programme or service.
- Contributes towards public health interventions which aim to discourage consumption of taxed products such as the imposition of sin taxes, whose revenue is directed to health promotion and disease prevention programmes

In countries transiting from dependence on aid or donor funding, or those working to achieve health system goals such as universal healthcare, earmarking has been an essential tool in a government's policy toolbox to identify and mobilise domestic resources. It has also increasingly been used as an instrument of public health policy.

Cons

- The budget process may become rigid. The programme dependent on earmarks may become vulnerable to funding restrictions which are unable to accommodate or recognise future needs for more funds, or becomes underfunded (it becomes a revenue ceiling).

- Creates distortions or inefficiencies in the economy. Earmarked payroll taxes (i.e. monthly deductions) intended for programmes such as national health insurance, may act as a deterrent for individuals to join the formal labour force. Increases informal economy.
- Revenues which are earmarked may be significantly vulnerable to fluctuations in the specific sector of the economy. For example, if a country earmarks sin tax for cancer programmes, depending on the size of the earmark, even a 0.5 percent reduction in the number of smokers purchasing legal cigarettes might have a significant impact on the available public health funding for cancer prevention programmes. The revenues may actually even reduce over time, as a result.
- May cause fragmentation in the budget process by creating a separate revenue source for a particular programme. This may result in the latter being disjointed, disproportionate and become less integrated with other parts of public policy.
- Earmarked funds might be used to offset reductions or funding cuts to existing allocations, rather than being auxiliary to or act as additional funding, necessary to support upscaling of pilot programmes or strengthening of systems.

Pros	Cons
<ul style="list-style-type: none"> • Protects and secures funding for a specific budget item or priority, particularly if they are underfunded • Directly links taxes to received benefits • Public more supportive of tax increases when clearly indicated for use of targeted social programmes, increases accountability • Educates the public about the cost of a specific programme or service • Contributes towards public health interventions which aim to discourage consumption of taxed products 	<ul style="list-style-type: none"> • The budget process may become rigid and inefficient causing the programme to become vulnerable to funding restrictions; unable to adapt • Creates distortions or inefficiencies in the economy • Revenues which are earmarked may be significantly vulnerable to fluctuations in the specific economy • May cause fragmentation in the budget process by creating a separate revenue source for a particular programme • Earmarked funds might be used to offset reductions or funding cuts to existing allocations

Table 3: Pros and cons for earmarking

Earmarking for health

Globally, governments collect nearly US\$ 270 billion in tobacco excise tax revenues each year, but spend around US\$ 1 billion combined on tobacco control. Much of that spending is by high-income countries.

In 2015, beverage alcohol excise taxes in the United Kingdom accounted for 3.1 percent (US\$ 12 billion) of government revenue while in the United States, it amounted to US\$ 9.64 billion or 9.8 percent of all excise revenue. 95 percent of countries have taxes on alcohol, with increasing prices acting as to influence alcohol consumption and associated social problems. However, in most cases, despite covering around 6.5 billion people, those taxes are primarily to raise government revenues and not necessarily to improve health.

Health is generally underfunded in many low- and middle-income countries. The World Health Organisation (WHO) encourages the use of sin taxes

for healthcare purposes, including financing of healthcare programmes, health education and tobacco or alcohol control efforts. It considers such measures being able to provide security for “long-term funding, relatively independent governing boards, and acceptance by a wide range of political and other stakeholders”.

Such financing mechanisms are perceived as innovative and governments are encouraged to fully or partially earmark sin tax, to fully or partially fund specific health expenditure.

The Australian state of Victoria implemented the first earmarked tax on tobacco for healthcare purposes in 1987. Used to fund an independent health promotion foundation called VicHealth, the world’s first health promotion foundation, the revenue was collected as part of the Tobacco Act 1987. It involved earmarking revenue from the 5 percent excise tax

for tobacco control efforts as well as for sports and arts programmes.

Today, that experiment has successfully resulted in VicHealth being involved in and sustaining a diversity of health initiatives including NCD prevention, mental health, health in the workplace and gender

based violence. Earmarking for health is currently considered a best practice.

At least 80 countries currently practice earmarking for health. More than 35 have earmarked sin tax revenues, specifically tobacco and alcohol taxes, for health purposes. Refer to *Country Cases* for examples of earmarking sin taxes for health.

NCDs	Tobacco control	Health Insurance/ Universal Healthcare	Other/more general health programmes
Algeria (<i>cancer control and other health programmes</i>) Costa Rica (<i>incl. tobacco control</i>) Nepal Panama (<i>incl. tobacco control</i>)	Iceland Iran Switzerland Viet Nam	Congo Egypt Philippines	Argentina, Bangladesh, Cape Verde, Colombia, Comoros, Côte d'Ivoire, El Salvador, Guatemala, India (<i>incl. tobacco control</i>), Indonesia, Jamaica, Madagascar, Republic of Korea, Romania, Thailand, Macedonia, USA

Table 4: Examples of countries earmarking tobacco tax revenue for health programmes

Advantages and disadvantages to earmarking for health

Governments have not only used sin taxes to improve public health, but also to pursue a variety of related policy goals such as economic and infrastructure development (e.g. funding street lighting in Cambodia to increase public safety).

Increasing health expenditure in developing countries, especially for the purpose of improving the health outcomes of low - income households, could contribute to achieving equity and increasing productivity.

Earmarking sin taxes for health expenditure can also insulate health spending from fluctuation and competition from other national needs, particularly when government or healthcare funds are low or unstable.

It is thus suitable to be allocated to specific areas of requiring high levels of investment over a long term period, such as the prevention and treatment of non-communicable diseases such as cancer.

In some instances, earmarking created new short-term fiscal space for health. In the Philippines, a large increase in the tobacco tax translated into a large increase in earmarked revenue for health, enabling roll-out of new services and coverage not previously possible.

In South Africa, it has raised additional funding for HIV treatment. In the Philippines and Ghana, earmarked revenues have increased health insurance coverage enabling increased access to health

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services, particularly for the lower income population.

However, businesses especially those whose goods and products are directly affected by the excise duties (i.e. cigarettes, tobacco products and alcohol), will generally be opposed to earmarking, particularly for health, as this would make people more amenable and less resistant to taxation.

This may present the possibility of further increases in excise duties.

The existence of a significant trust deficit between the government and the public might call into question the sincerity of earmarking funds for the purpose of strengthening healthcare.

It is a fact that governments actually do impose punitive excise duties on sin products and services such as alcohol, tobacco and gambling, but may use the revenue for other purposes, differing from the original stated intent.

The collection of sin tax could instead be utilised to increase general government revenue, make up for budgetary shortfalls or be diverted for vanity projects.

The lack of public transparency or accountability mechanisms to inform the public of the earmarking and its appropriate utilisation for health, could instead reduce support and acceptance for earmarked taxes.

Ingredients for success

- Secure political support for the proposal to earmark for health
- Earmarked tax revenue must be from an additional revenue source (i.e. excise taxes/ sin taxes)
- Position the decision to earmark taxes within and in support of a specific health policy framework (e.g. Framework Convention on Tobacco Control (FCTC))
- Ensure strong multi-sectoral partnerships (especially with civil society) and policy alignment and coherence (e.g. Ministry of Health, Ministry of Finance and Ministry of Domestic Trade and Consumer Affairs)
- Present evidence-driven and needs-based arguments in favour of earmarking
- Clearly define the parameters and quantum for the earmark (e.g. percentage of tobacco excise tax)
- Prepare and utilise a communications strategy to raise public awareness of the earmark, the objectives and intended beneficiaries (e.g. funding cancer treatment and research)
- Prepare counter arguments to address the concerns and issues raised by those opposed to earmarking excise duties for health, in particular tobacco and alcohol industries

A Proposal for Malaysia

Issue

Malaysia's expenditure for healthcare is 3 percent lower than WHO's recommendation and benchmark suitable for this upper-middle income country. The current level (2017) is 4.3 percent of the gross domestic product (GDP), out of which 2.3 and 2.1 percent are from the public purse and private spending respectively.

As more than 70 percent of the population access public healthcare, especially those from B40 households, the cold reality is that the government must spend more to provide quality care and adequate coverage.

Non-communicable diseases (NCDs) currently account for more than 73 percent of total deaths.

Treating cancer, diabetes and cardiovascular diseases combined has cost Malaysians at least an estimated RM 11 billion annually, depleting public and private funds, and individual savings. Increasingly more people are experiencing financial hardship due to such chronic diseases. Annually, diabetes and cancer cost billions of RM both in terms of funding and lost productivity.

At least 63 percent of the population is at risk of at least one NCD which includes cardiovascular diseases, diabetes, cancer, obesity and hypertension. These have four shared risk factors namely tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol.

Treating cancer, diabetes and cardiovascular diseases combined have cost Malaysians at least an estimated RM 11 billion annually, depleting public and private funds, and individual savings. Increasingly more people are experiencing financial hardship due to such chronic diseases. Annually, diabetes and cancer cost billions of RM both in terms of funding and lost productivity.

The National Strategic Plan For Non-Communicable Disease 2016-2025 identified inadequate additional and dedicated funding as being possibly responsible for the limited progress under the previous national NCD strategy for the period 2010 - 2014. Only RM 4 million was approved under the MOH's Dasar Baru (New Policy) for the implementation of specific health promotion activities under MyNCDP-IM during that period.

Its successor, the KOMuniti Sihat PEmbina Negara (or KOSPEN), is the Ministry of Health's current primary initiative to address prevention and control of both communicable diseases and NCDs through a community-based intervention programme. Last year and in 2018, the allocations for this programme under the annual national budget were RM 80 million and RM 30 million respectively.

Generally, current investments in health promotion, NCD prevention and control activities are woefully inadequate. The public healthcare system is struggling under the overbearing escalating cost and burden of treatment for NCDs.

Public healthcare in Malaysia, like many other countries, is part of public services, and is usually funded from a single pot of money, in this case the federal government's Consolidated Revenue Account under the Consolidated Fund. With guidance and budget recommendations from the Ministry of Health, decisions over how to fund different services is determined and taken by the Ministry of Finance.

Additional funding must be found within the existing revenue framework and current budget limitations to supplement the existing allocations for health under the annual national budget.

Recommendation

It may not be necessary to enact new legislation to impose a tax or surcharge for this purpose. A framework of excise duties imposed on cigarettes, tobacco products and alcohol is already currently and conveniently in place. Existing anecdotal information and informal surveys conducted through social media seem to indicate that there is public support for the revenue from sin taxes to be used for health.

As a pilot programme, an earmark of 5 percent could be applied to the collected sin tax. Based on 2017 revenue figures, this would result in an estimated RM 290 million earmarked for health.

Assuming that current trends of duty-paid cigarettes, tobacco products and alcohol remain constant, this is the minimum amount which could be earmarked and collected annually.

For this initial phase, the utilisation of these funds would go towards strengthening NCD health promotion and treatment, specifically of diabetes and cancer.

They should act as additional or supplementary funding, necessary to support upscaling of innovative programmes or fund crucial lifesaving medicines and treatment.

The Ministry of Health, together with a multi-sectoral oversight committee, would then manage these funds. It is important that these earmarked funds are not used to offset reductions or funding cuts to existing allocations under the national budget.

As a pilot programme, an earmark of 5 percent could be applied to the collected sin tax.

Based on 2017 revenue figures, this would result in an estimated RM 290 million earmarked for health. Assuming that current trends of duty-paid cigarettes, tobacco products and alcohol remain constant, this is the minimum amount which could be earmarked and collected

Conclusions

In general, utilising sin taxes for the purposes of healthcare financing is perceived to be politically acceptable across many countries, including countries in South East Asia. Using such taxes to finance public health expenditures could be perceived by the public as 'taking away' from the 'bad' and doing 'good' with the proceeds, thus contributing to the social good. It provides the funding necessary to increase specific expenditures, especially in support of programmes which assist those from lower income households.

Generally, current investments in health promotion, NCD prevention and control activities in Malaysia are woefully inadequate. Annually, diabetes and cancer cost billions of RM both in terms of funding and lost productivity. As a result, the public healthcare system is struggling under the overbearing escalating cost and burden of care for the treatment of these diseases. An innovative approach must be found to address this problem and produce better health outcomes.

While utilising sin taxes for healthcare expenditure has received positive responses in other countries, there is a lack of information or available literature on the level of acceptance or support for earmarking

such funds for health in the Malaysian context. However, anecdotal information and social media surveys seem to indicate support for sin taxes to be used for health.

It is important to ensure that earmarking results in actual increases in spending. They should not be illusory, and not be used to offset reductions or funding cuts to existing allocations under the national budget.

The utilisation of these funds should go towards strengthening NCD health promotion and treatment, specifically of diabetes and cancer. Earmarked funds should act as additional or supplementary funding. They should be used to support upscaling of innovative programmes or fund crucial lifesaving medicines and treatment. Evidence indicates that doing so could mean the possibility of improved health outcomes.

It is important to ensure that earmarking results in actual increases in spending. They should not be illusory, and not be used to offset reductions or funding cuts to existing allocations under the national budget.

In order for Malaysia to replicate the success experienced by countries such as Australia and Thailand, in addition to the existing NCD control measures recommended by international standards already adopted, it must be willing to innovate and earmark sin tax collected from cigarettes, tobacco products and alcohol for the purposes of health.

Country cases

Case Study I – Republic of Korea

The Republic of Korea introduced the National Health Promotion Act (No. 4914) in 1995 to utilise tobacco excise taxes to fund the Korea Health Promotion Fund (KHRF). The Health Promotion Fund was established by the Minister of Health and Welfare (MOHW) to ensure a source of revenue for national health promotion projects. The Republic of Korea now has one of the largest funds for health promotion globally.

The Korea Health Promotion Fund (KHRF) is a public institution involved in public health promotion by developing policies, implementing programs and conducting public awareness campaigns on topics defined as health promotion, such as healthy nutrition, physical activity, anti-tobacco and anti-alcohol projects.

Three government levels are in charge of the formulation of health promotion policies and implementation: National level, provincial level and local/district governments. The responsibilities, structures and initiatives of each level of governance are clearly-defined, which aids in efficient implementation.

The National level (MOHW) is responsible for drafting policies, guidelines, goals and objectives on the country's health promotion. It is also responsible for mandating provincial and local governments on implementation according to guidelines. Provincial and local governments are mainly responsible for developing action plans according to national guidelines and implementing plans for their governing area.

	National	Provincial	Local/District
Guidance documents for implementation	<ul style="list-style-type: none"> Health Plan 2010 (White paper) National Health Promotion Act (Legislation) 	<ul style="list-style-type: none"> Regional Health Promotion Plan (Action plans) 	<ul style="list-style-type: none"> Community Health Promotion Plans (Action plans)
Responsible body	MOHW	Provincial government	Public health centres
Key policy recommendations	<ul style="list-style-type: none"> National Health Plan: 14 goals and 38 objectives. 	<ul style="list-style-type: none"> Contains long-term work plans and province-specific action areas 	<ul style="list-style-type: none"> Contains work plans and city-specific action areas
Evaluation	Evaluation of Health Plan is not set (approx. every 5 years)	Yearly. Done by the Korea Health Promotion Fund	Yearly by provincial governments

Table 6: Responsibilities in Health Promotion (Republic of Korea)

According to the National Health Promotion Act, tobacco excise taxes are collected and utilised by the KHRF. However, funding from the KHRF is often transferred to and used by the National Health Insurance Corporation (NHIC). The NHIC provides universal healthcare for 97 percent of the population (citizens and non-citizens alike) and has been experiencing fiscal problems. In 2008, approximately 62 percent of earnings from tobacco excise taxes were transferred to the NHIC while 38 percent are spent on health promotion by the KHRF.

This has led to criticisms on the use of tobacco tax funds. Many criticise that channelling funds from the health promotion fund to health insurance cannot be justified on the basis of the original goals of the tobacco tax increase, which was to fund the KHRF.

Case Study 2 – Thailand

The surcharge of sin taxes for tobacco and alcohol has been used as a financial mechanism to sustainably fund the Thai Health Promotion Foundation (ThaiHealth). ThaiHealth is an autonomous government agency established by the Health Promotion Foundation Act (2001). It operates outside the bureaucratic system of the Ministry of Public Health and is administered by two governing bodies:

- *Board of Governance:* Oversees ThaiHealth's governance and operations, policy development, budget allocation and regulation enactment. Chaired by the Prime Minister, with the Minister of Public Health as the first Vice-Chairman and an independent expert as the Second Vice-Chairman. The board members comprise representatives from nine ministries and eight independent experts across a variety of disciplines.
- *Board of Evaluation:* Evaluates the overall performance of ThaiHealth's policies, activities and operations, as well as to assess and resolve conflicts of interest identified by the Board of Governance. Consists of seven independent experts appointed by the Cabinet according to the Ministry of Finance.

ThaiHealth defines health promotion as any action done to promote the physical, emotional and social health of people so they can enjoy a long and quality life. It not only aims to strengthen an individual's capacity to adopt a healthy lifestyle, but also to work on social structures and environment that enables healthier lifestyle choices.

The annual revenue of ThaiHealth draws from a 2 percent surcharge levied on alcohol and tobacco excise tax, which generates a sustainable funding source of approximately US\$ 120 million annually (US\$ 125 million in 2014). In 2017, the ThaiHealth bill was amended so that the organisation's funding from sin taxes would be capped at four billion baht a year (approximately US\$ 128 million).

While the amount of funding may appear to be large, it is limited in the scope of financial resources and capabilities when compared with other state agencies in health system. According to a summary document on ThaiHealth, its annual budget is 5 percent of the annual expense of the Ministry of Public Health, and only 0.73 percent of the total national health expense in 2012.

Given the large number of actors on public health in Thailand and ThaiHealth's limited funding and resources, ThaiHealth positions itself as a catalyst and innovative enabler of change, as opposed to an implementer, to promote considerably more impact. It utilises three key strategies: the creation of knowledge, social mobilization and policy advocacy.

An example of ThaiHealth serving as catalyst was during its inception. The use of sin taxes to fund the establishment of ThaiHealth was done via a triad of organizations: the Anti-Smoking Campaign Project of the Moh-Chao-Ban Foundation (Social Mobilization), the Office of Thai Trade Competition Commission, OTCC (Policy), and Health Systems Research Institute or HSRI (Knowledge).

When the OTCC was unable to generate policy changes, the focus of work shifted to the HSRI in integrating knowledge that informs further action, with ThaiHealth linking the work between these organizations. This multi-faceted approach became the basis of ThaiHealth's working operations, which now moderates and conduct campaigns and programs facilitating various public health bodies and civil society.

ThaiHealth is widely regarded as a model for ensuring that health promotion activities receive adequate support. It has inspired models developed in other countries such as Viet Nam.

Case Study 3 – Iceland

Excise taxes imposed for alcohol and tobacco are specified in The Alcohol and Tobacco Levy Act No.96/1995. The Tobacco Control Act No. 6/2002 also sets out provisions to reduce damage to health caused by tobacco consumption. It is specified that 1 percent of alcohol tax (from The Alcohol and Tobacco Levy Act) and 0.9 percent of gross tobacco sales (from The Tobacco Control Act) would be earmarked into the health promotion and prevention programmes. Such activities are run by two key parties: the Directorate of Health and the Public Health Fund.

The Directorate of Health operates under the Ministry of Welfare in Iceland, whose responsibilities include supervising operations of healthcare services in the country. After merging with the Public Health Institute in 2011, the Directorate of Health became involved in public health measures and health promotion activities, such as sponsoring and organising public health initiatives, and improving public understanding of health.

Health promotion activities engaged by the Directorate of Health aim to support communities in creating conditions that promote their health and well-being. For example, drafting national public health guidelines, assisting schools and communities to create comprehensive health promotion policies, gathering and analysing data related

to public health and collaborating with school nurses and the Ministry of Education to introduce health education into curriculums.

The total budget allocated from sin taxes to health promotion and prevention activities by the Directorate of Health is not disclosed. However, it is known that for tobacco taxes, 65 percent are earmarked to the Directorate of Health for tobacco control annually, while 35 percent is channelled into the Public Health Fund. In 2014, this amounted to ISK70.4 million (approx. US\$ 71,000) for the Directorate of Health and ISK37.9 million (approx. US\$ 38,200) for the Public Health Fund.

For example, the Alcohol and Drug Abuse Prevention Council advises and aids the Directorate in strengthening measures to reduce intake and combat consequences of alcohol and drug intake, particularly among children and young people. The Tobacco Control Council advises and works on preventive measures against the use of tobacco.

The Public Health Fund provides grants for fund health promotion projects mainly in schools and communities. The Ministry of Welfare is in charge of the allocation of money from the fund.

A rough estimate indicates that 80 percent of funds from the Public Health Fund is channelled into general health promotion projects, including alcohol and drug control activities, while 20 percent is allocated for tobacco control projects. In 2014, this amounted to approximately ISK30.32 million (US\$ 30,600) for general health promotion projects and ISK7.58 million (US\$ 76,500) for tobacco control.

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Appendix

Excise Duty Increase for Tobacco Products (2012 – 2017)

Year	Cost per 1000 Sticks	Annual Percentage Hike	Cost Per Stick	RM Cost Per Pack (20 sticks)
2017	RM400	0%	RM0.40	RM8.00
2016	RM400	0%	RM0.40	RM8.00
2015	RM400	36%	RM0.40	RM8.00
2014	RM280+20%	12%	RM0.28	RM5.60
2013	RM250+20%	14%	RM0.25	RM5.00
2012	RM220+20%	N/A	RM0.22	RM4.40

Excise Duty Increase for Alcohol Products (2012, 2016, 2017)

Year	2012	2017 & 2016
Item	Original Data	RM per 100% vol per litre
Beer	7.40 + 15%	175
Sparkling wine	34 + 15%	450
Wine	12 + 15%	150
Vermouth	12 + 15%	150
Toddy	Bottled or Canned: 1.10 + 15% Others: 30 per 100% vol. per litre + 15%	40
Mead	4 + 15%	40
Fermented beverages, e.g. cider	1.50 + 15%	60
Wines obtained by fermentation of fruit juices, other than grapes	30 per 100% vol. per litre + 15%	60
Sake	22.50 per 100% vol per litre + 15%	60
Shandy	0.10 + 15% (Exceeding 0.5% but not exceeding 1.14% vol); 30 per 100% vol per litre + 15% (Others)	60
Ethyl Alcohol, or other spirits, denature, etc with alcohol content of 80% or higher	22.50 + 15%	22.50 + 15%
Exceeding 99% and/or Others		1.10 + 15%
Ethyl Alcohol, or other spirits, denature, etc with alcohol content of 80% or higher	30 + 15%	150
Spirits from distilling grape wine	30 + 15%	150
Gin and Geneva	30 + 15%	150
Vodka	30 + 15%	150
Rum and distillation from sugar cane products	30 + 15%	150
Whisky	30 + 15%	150
Brandy	30 + 15%	150
Liquers and Cordials	42.50 per 100% vol per litre and 15%	60
Arack or Pineapple Spirit	17 + 15%	60
Medicated Samsu	35 per 100% vol per litre and 15%	60
Bitters	9 + 15%	40
Alcoholic products which are below 1.14% alcoholic content	Not available	60

Note: Information on excise duty on alcohol products is only available for 2012, 2016 and 2017.

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