



# Dedicated tobacco taxes - Experiences and arguments

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This paper is one of two reports written as part of research commissioned by the Smokefree Coalition on the subject of Tobacco Taxation. The other paper is titled *Tobacco Taxation in New Zealand*.

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## Summary

After a short period in the later 1970s when a dedicated tobacco tax was used in New Zealand, there were a number of efforts to regain such a tax in the 1980s and 1990s. Treasury has been a persistent and major opponent of dedicated taxes in general, but has not always been successful. Currently there are three health-related dedicated taxes (for alcohol, accident and gambling control), as well as others outside the health sector.

Elsewhere, there are at least 10 countries and six US states with a dedicated tobacco tax. In addition, Canada has a tobacco company profit surtax, part of which is nominally dedicated to tobacco control.

The steps to achieving a dedicated tobacco tax include demonstrating to the public and policymakers that:

- The present funding system has not worked for tobacco control in New Zealand. Tobacco control is chronically under-funded (on a comparative cost-efficiency basis) and a dedicated tax is the most practical long-term answer to this under-funding.
- The present funding system extracts tobacco tax revenue from Māori (as a group) and from low-income households disproportionately, without using that revenue to help ensure equal health outcomes for Māori and non-Māori, and for households of all incomes. This is contrary to general government policy on health inequalities.
- A tobacco tax rise that is dedicated to tobacco control is far more likely to get public and smoker support, than one that is not.
- There are equity and ethical issues around the use of a lethal, addictive substance to raise government revenues that need addressing, and a dedicated tobacco tax will help to do this.

Introducing a dedicated tobacco tax for New Zealand will require wide and strong alliances, (reaching out beyond the health sector), and a clear vision of the nature of the system desired. Advocates need to ensure that the dedicated funding system they seek is such that the revenue cannot be diverted or eroded, and that the revenue is effectively used.

Because of chronic under-funding of tobacco control in New Zealand, we recommend, as part of a tobacco tax strategy:

1. That an increasing portion of the tobacco tax revenue be dedicated to tobacco control activities encouraging and assisting smokers to cease smoking and deterring non-smokers from starting smoking.
2. That the initial amount of dedicated tax revenue should be at least \$100 million, (compared to current spending on these activities of about \$40 million), and should be targeted initially to increase to at least \$200 million within five years.
3. That the objective of this dedication of revenue to tobacco control, together with the real increases in tobacco taxation advocated elsewhere in this report, should be to reduce smoking prevalence (including that of Māori and Pacific peoples) to less than ten per cent within 10 years, and less than one percent for all groups within twenty years.
4. That the administration of the dedicated revenue be structured to ensure that the revenue is:
  - 'Ring-fenced' for use in tobacco control and not diverted to other uses nor eroded in value.
  - Used effectively, with continued evaluation of results against objectives.

- Sufficiently and effectively devolved to regional and local tobacco control efforts.
- Used so that tobacco-related inequalities are reduced, and so that power and resources are devolved to Māori and other disadvantaged groups.

# 1. Introduction.

This part of the report examines the arguments for a dedicated<sup>1</sup> tobacco tax, and covers some of the background on such taxes. It seeks to answer two questions:

1. Should all or part of tobacco tax revenue be used for particular purposes (eg, tobacco control, health sector budgets)?
2. What is the experience of New Zealand and other jurisdictions in gaining, keeping, and using dedicated tobacco taxes?

This part first gives some of the New Zealand background (sections 1.1-1.4), then discusses the related experience elsewhere (section 2). Section 3 examines the arguments for and against dedicated tobacco taxes, and section 4 the practicalities of getting and using such a system. Some conclusions and recommendations are given in the final sections.

This report does not deal with the question of what the whole of tobacco control policy should be, and this section only deals with what should be done with tobacco tax revenue. Thus it does not discuss the necessary changes to legislation, health promotion, cessation and other areas that would be necessary to make the most effective use of dedicated tobacco tax revenue. Decreasing smoking prevalence to the levels in Recommendation 3 above will depend on other changes besides the adoption of a dedicated tobacco tax.

## 1.1 The history of dedicated taxes and efforts for dedicated tobacco taxes in New Zealand.

New Zealand had a dedicated tobacco tax from 1978 until the early 1980s. A small extra excise duty (ie. a tax) on tobacco and alcohol was introduced, and the revenue was used specifically for community health purposes, under the control of the Department of Health. The dedicated status of the tax on tobacco was removed by 1982, and the control of the extra revenue removed from the Minister of Health.

During 1984-1986, ASH NZ organised a campaign for a tied tobacco tax. In 1984, a National Research Bureau survey found that 75% of those polled supported the use of tobacco tax revenue for tobacco control education. In February 1986, ASH asked the government to set aside one cent per pack for children's education on tobacco.<sup>1,2</sup> Health Minister Michael Bassett supported the request, and was quoted as saying 'this is an attractive idea – even though the principle of tied tax does not appeal to Treasury'.<sup>3,4</sup> However, the tied tax was not implemented.

A Ministerial Review of tobacco and alcohol excise taxes in 1988 commented that '*substantial funding may be needed to ensure success in reducing smoking. Such funding could be raised from the excise tax from those continuing to smoke.*'<sup>5 p.5,8</sup> The government ignored the suggestion.

The concept of using a portion of tobacco tax revenue for health or tobacco control purposes re-emerged in 1989 with the need to replace the sponsorship from the tobacco industry. As the Australian state of Victoria had just introduced a dedicated tobacco tax to fund a health promotion and sponsorship agency, that model was at the forefront of the options considered. The Coalition against Tobacco Advertising and Promotion suggested a plan for a New Zealand Health Promotion Authority, which would have been funded by an extra amount of tobacco taxation.

The Department of Health was reported to have argued that *it* should administer any such fund, with the help of the Hillary Commission.<sup>6 p.38</sup> When the *Smoke-free Environments Bill* was being prepared in 1989-90, clauses were drafted for the Bill that would have created a dedicated tax, but not accepted by Cabinet. In December 1989, Helen Clark announced that 'funding for the sponsorship fund would come from the existing tobacco excise tax'<sup>6 p.50</sup> but this meant the existing *general* revenue.

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<sup>1</sup> Other terms used to describe a dedicated tax include 'earmarked', 'tied' and 'hypothecated'.

In 1991 the possibility of a dedicated tax to fund tobacco sponsorship replacement was again floated. At least one of the National Party enthusiasts for the Victoria model, the Chairperson of the Health Select Committee, Bill English MP, appears to have soon had his enthusiasm eroded by the use of arguments against the dedicated road fuel tax.<sup>7</sup>

The next official mention of a dedicated tax was by the Public Health Commission, in its discussion document on tobacco taxation in March 1995.<sup>8</sup> In this document it was argued that the level of continuous media and education spending needed to significantly reduce smoking prevalence required sustained funding. Tying a portion of tobacco tax revenue to this task provided a tax source that was considered more publicly acceptable than general taxation.

The most recent comprehensive review of health funding (finished in 2002, released in 2004) devotes a small section to dedicated taxes in general, and very briefly mentions dedicated tobacco taxation.<sup>9</sup> The arguments given in the review on dedicated taxes (particularly those on pp.28-29) are discussed in sections 3.I and 3.J below.

## 1.2 Treasury arguments and efforts on dedicated taxes

There has been a persistent resistance by Treasury to the tying of tobacco taxes to smoke-free promotion and other tobacco control initiatives.<sup>6 p.50, 8 p.5, 10 p.180</sup> The tying of revenue to particular spending has been inconsistent with Treasury's desire to have all spending based on the same criteria. Treasury advice has been based on the wish to make government spending more rationally based.

The arguments used by Treasury are that dedicated taxes '*would restrict the Government's ability to adjust fiscal policy as required or to ensure that competing claims for resources are accessed on an equal basis*'.<sup>11</sup> If the funding went into activities which included '*media health advertising, health initiatives and research promoting health or preventing disease*' Treasury argued that '*there is nothing about the areas ... that singles them out from other types of Government expenditure funded through the consolidated fund ... tied taxes offer protection from the normal expenditure scrutiny process*'.<sup>11</sup> These arguments appear to be predicated by the view that the allocation of resources and expenditure scrutiny are fair and rational processes.

Treasury have also argued that to entangle the level of the tobacco tax with tobacco control expenditures risks:

- '*Preventing the tobacco excise being set at a level appropriate to its function as an instrument of health policy....*
- '*Increasing or restraining the budget for anti-smoking expenditures independently of the worth of those expenditures; and*
- '*Serving as a precedent for ad hoc increases of particular taxes to avoid expenditure-control rules.*'<sup>12</sup>

Again, Treasury and the Ministry of Commerce have argued that:

*Tied taxes reduce the Government's ability to move resources from low- priority areas to high priority areas. The general principle is that Government raises tax revenue in the most efficient manner, and then allocates that revenue across spending proposals consistently with its overall strategy.*<sup>13 p.5</sup>

Treasury also wants to avoid further precedents for dedicated taxes.<sup>6 p.20,11,14 p.12</sup> Treasury has also raised the general objections that a dedicated tax might outlive the purpose for which it is made, and that such taxes were thought to create additional administration costs.<sup>11</sup>

The arguments against this stance are given in section 2.J below.

### 1.3 Other dedicated taxes in New Zealand

Parts of the alcohol, petrol, and vehicle registration levies or charges have been tied to specific uses for a number of years, with three dedicated taxes currently used for health-related purposes outside of tobacco control. The Alcohol Advisory Council has been funded from a levy on alcohol since 1976.<sup>15</sup> This is a direct precedent for a tax on a health-damaging product that is allocated to appropriate health promotion activities. The Accident Compensation scheme is funded by a separate compulsory levy on wages, self-employed earnings and other sources.

In 2004, a levy was set up under the Gambling Act 2003, to supply funds for the government program on problem gambling. The funds and the program are controlled by the Ministry of Health. The levy is 'collected on the profits of New Zealand's four main gambling operators: gaming machines in pubs and clubs; casinos; the New Zealand Racing Board and the New Zealand Lotteries Commission.'<sup>17</sup> The policy advice leading to this decision noted that the existing funding for the problem gambling services was 'unstable' and suggested that a dedicated tax would provide a more stable revenue stream.<sup>18</sup>

Outside of the core health sector, the Fire Service is funded partly by compulsory levies on insurance. Land Transport New Zealand, (and its predecessor agencies which funded roading), is partly funded by taxes on petrol, road user charges, and motor vehicle registration and license fees.<sup>16</sup> Both these services have large health implications, and Land Transport New Zealand is directly responsible for reducing road accidents.

In addition, many central or local government services and products are charged for directly or indirectly, tying the income stream directly or largely to the provision of the service or product. Examples include water (in some local authorities) and access to some National Park facilities.

### 1.4 Past and current links between tobacco taxation and tobacco control

Currently, government funded tobacco control in New Zealand is funded from general revenue, as part of the government budget for the Ministry of Health. However, since the late 1990s, there has been some implicit or explicit linkage between tobacco taxes and tobacco control funding.

In 1997, a Ministry of Health (MoH) briefing to Associate Health Minister Neil Kirton appeared to emphasise the presentational aspects of the links between tobacco tax revenue and health spending. The Ministry suggested that:

*Public support for increases in tobacco excise is more likely to be achieved where any tax increases are clearly linked with health promotion initiatives. The Ministry has in the past considered that ideally tobacco should be a "tied tax" ... The disadvantages of this option are that tied taxes are not currently Government policy and Treasury's advice to Government has consistently opposed this principle. .... Linkage publicly with increased funding (for tobacco control) ... provides ample argument against criticisms that tax on tobacco is simply a revenue gathering measure or that it is a measure that impacts in an iniquitous manner.*<sup>19 pp.9,20</sup>

The MoH appear to have managed to get some of its proposals on the presentation of the tobacco tax increase into the July 1997 joint paper with Treasury. The paper noted that:

*Linkage of the excise increase (by way of a communications strategy) with increased spending on smoking reduction outputs would make the increase more acceptable to the public, and enhance the likely impact on smoking behaviour.*<sup>13 p.5</sup>

In November 1997 the Minister of Health, Bill English, was reported as saying that money from a tobacco tax increase could be used to fund:

*'anti-smoking programmes'.... 'a proposal was before him to increase the tobacco excise, but he thought the rise would be unacceptable to the public unless "a good proportion" of the extra revenue went into trying to reduce smoking'.<sup>20</sup>*

In a radio interview he said that:

*there wouldn't be any point in increasing the excise tax and I think it would be unacceptable to people unless [a] good proportion of it was used in trying to reduce smoking.<sup>21</sup>*

When in March 1998 the Cabinet made the decision to raise the tobacco tax rate, it:

*noted that consideration might be given to using a small proportion of the additional revenue from the increase in the tobacco excise for additional funding for the Health Sponsorship Council's smokefree programmes.<sup>22</sup>*

For the tobacco tax rise in 2000 (the most recent non-indexed rise), there also appears to have been some linkage, at least at a political level, between the tax rise and new tobacco control spending. As the Labour-Alliance coalition was a minority government, the support of the Green Party was necessary for the tobacco tax rise. The Green Party appear to have negotiated an extra commitment of funds for smoking cessation support, as a *quid pro quo* for its support.<sup>23, 24</sup>

## 2. The experience elsewhere of dedicated tobacco taxes.

### 2.1 Current and past dedicated tobacco taxes

A WHO study in 2004<sup>25</sup> lists eight countries and three US states where part of tobacco tax revenue is dedicated to tobacco control. Five of the countries are in Europe (Finland, Estonia, Poland, Slovenia, Iceland) and three in Asia (Thailand, Korea and Qatar). The American states are California, Arizona and Massachusetts.

In addition to this list, Taiwan,<sup>26</sup> Egypt<sup>27</sup> and a further at least three American states (Oregon, Colorado, Montana)<sup>28, 29, 30</sup> also have dedicated tobacco taxes. Three Australian states and the Australian Capital Territory had dedicated tobacco taxes until 1997, when a court ruled that they could not collect tobacco tax.<sup>25 Appendix A</sup>

From 1994, Canada has had a surtax on tobacco company profits, which was intended to be used for tobacco control. The rate was first set at 40%, and increased to 50% in 2001<sup>31 p.22</sup>. However, while the initial intention was to allocate about \$C60 million annually to tobacco control,<sup>32</sup> it appears that by 1998, only \$C20m (out of \$C94m) was allocated this way.<sup>33</sup>

The amount of revenue to tobacco control from a dedicated tax depends on both the proportion of the tax that is allocated, and the size of the tobacco tax revenue stream. The nominal proportion of the tobacco tax revenue that goes to tobacco control in different places ranges from 23% in Arizona, to 0.45% in Finland. In Egypt, 10 piastres per cigarette pack goes to a student medical insurance fund. Inflation has decreased the effect of this dedicated tax since its inception in 1992.<sup>27</sup>

Internationally, there has been a growth in the use of relatively independent health promotion agencies to use dedicated tobacco taxes for health promotion. They occurred formerly in Australia, and currently include those in Estonia and Thailand.<sup>25</sup> These agencies are marked by having focus primarily on health promotion, have long-term funding security, relatively independent governing boards, and acceptance by a wide range of political and other stakeholders.

### 2.2 Getting dedicated tobacco taxes

#### Research evidence

Research evidence in the United States and elsewhere indicates that tobacco tax rises are more acceptable if the revenue is used for tobacco control. A survey in 1990, across four US states (Texas, Michigan, Arizona, and Pennsylvania) found that 63% of interviewees (and about 41% of smokers) agreed with tobacco tax rises if the revenue was used for tobacco control.<sup>34</sup> In Victoria, Australia, a 1987 survey indicated that only 47% of the public supported a tobacco tax increase, but 84% supported an increase when part of the revenue was dedicated for health purposes.<sup>35</sup> Surveys in Thailand showed a similar result.<sup>25 p.17</sup>

In surveys in Massachusetts between 1993 and 1998, support by the public for tobacco tax increases was 'strongly related' to whether the tax was dedicated for health purposes. Support was 81% for a dedicated tax for tobacco control, compared to 74% for a wider health purpose, and 31% for any government purpose.<sup>36</sup> Smokers in particular were much more likely to support the increases if the tax was dedicated for tobacco control. The Massachusetts surveys also found that smokers with children under 18 were more likely to support a dedicated tax compared to other smokers (but this was not the case for a non-dedicated tax).<sup>36</sup>

#### Voting results

However, survey results may differ from actual votes by the public on these issues, partly because the survey sample can be different from the pattern of those who actually vote. The difference can also be because voters may not sufficiently believe that the funds will be used for the purpose intended. There may also be a different public perception of the issues at the time of voting

(compared to perceptions at the time of survey), due to the intense efforts of opponents such as the tobacco industry to discredit the tax initiative and persuade the public against the dedicated tax.<sup>36</sup>

In the at least ten US states where there have been efforts to raise tobacco taxes through state level binding referendum ballots, the experience is that these efforts are more likely to succeed when at least part of the tax is allocated to tobacco or health-related use. Out of the nine states where the efforts have succeeded, at least six have dedicated taxes (California, Arizona, Massachusetts, Oregon, Colorado, and Montana).<sup>29, 30, 36</sup>

The experience from state referendums includes:

- A high degree of opposition from the tobacco industry to the initiatives (usually through front groups).
- The need to try at least twice in several of the cases of eventual success.
- The need to include a wide variety of groups in a coalition seeking to get a new policy. Where potentially influential groups (eg, returned servicemen) are not included in the coalition, it is important to know any concerns they have about the new policy sought.

The efforts of the tobacco industry are demonstrated by surveys before and after the 1996 vote in Oregon to dedicate the revenue from a rise in tobacco tax to the state health insurance plan (90%) and tobacco control (10%). While 68% of survey interviewees said they would support the rise before the vote, in the vote only 56% of voters supported the tax rise.

In the post-vote survey, of those who did support the tax rise, 66% of those surveyed put their primary reason as 'to discourage tobacco consumption', and 27% as 'to expand the health plan'. For those who did *not* support the tax rise, 47% gave as the primary reason 'tobacco users should not be forced to pay a disproportionate share of health costs', and 36% gave the reason that the tax rise would 'lead to wasteful spending by the government'. These latter issues had featured in the campaign by the tax initiatives opponents.<sup>37</sup>

This experience is similar to that in Montana, where a dedicated tobacco tax was defeated in 1990 (although an initiative in 2004 was won).<sup>30</sup> In the 1990 defeat, the opponents' campaign emphasised the themes of opposition to new taxes and to a larger state bureaucracy.

The strategic lessons from the Oregon surveys and the 1990 Montana vote appear to include:

- The greater the proportion of a tobacco tax rise going to tobacco control, the greater is support for the rise. In the 1996 Oregon case, the 90% of the tax rise going to the health insurance plan rather than to tobacco control appears to have been a significant reason for voters to *not* support the rise.
- That if the dedicated tax revenue goes to an independent body that is perceived to be able to spend the revenue effectively, then there could be less adverse reaction by voters because of the potential for 'wasteful government spending'. While Oregon and Montana voters may be even more sceptical than those in New Zealand about this potential, there is a strong thread of comment about 'waste' in government within the New Zealand media and by New Zealand politicians.<sup>38, 39</sup>
- That unless the public can be convinced that an appropriate proportion of the tobacco tax will go to tobacco control, and will be effectively used for such, then opponents will use these issues to persuade a substantial proportion of voters against the initiative.

Tactical lessons from the experience in the USA include:

- The usefulness of preliminary survey or other research to help identify the type of policy that is most likely to get public support (including the proportion of tobacco tax revenue going to tobacco control or other work). Surveys and other research can also help identify which arguments for the policy change will best work. For instance, a 2004 Oklahoma survey identified support for three different levels of tax rise (50 cents, \$1,

\$1.50) used for either general or specifically health purposes, ie, six different levels of support, depending on the policy combination.<sup>40 p.41</sup>

### 3. Why dedicate tobacco tax in New Zealand?

This section first discusses reasons for dedicating tobacco taxes (A-H), and then discusses arguments against such dedication of the revenue (I-J).

#### A) To get support for tobacco tax increases

There is some indication that the New Zealand public and smokers are more likely to support tobacco tax rises, if the whole of the rise, or a significant part, is used for tobacco control. This appears to be the perception of officials and politicians in the period of 1996-2000, when two such rises were being considered and negotiated (see section 1.4 above).

As seen in section 2.2, in other jurisdictions, there is a consistent theme in the research about tobacco tax rises of greater public support for the rises if some of the extra revenue is used for tobacco control or health purposes.<sup>36,34,40 p.40</sup> Smokers in particular have been more likely to support the rises if the revenue was used for tobacco control (eg. smoking cessation).

Thus dedicated tobacco taxes can help achieve health goals (through lower tobacco consumption and a lower smoking prevalence) in a more politically acceptable way.

The ability to raise tobacco taxes in a more politically acceptable way would also enable government to better meet its obligations as a signatory to the Framework Convention on Tobacco Control (FCTC). There is a FCTC obligation to implement tax policies to contribute to tobacco control objectives (Article 6a). New Zealand (and other signatories to the treaty):

'should take account of its national health objectives concerning

*tobacco control and adopt or maintain, as appropriate, measures which may include: ... implementing tax policies and, where appropriate, price policies, on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption.*<sup>41</sup>

#### B) To address the ethical and equity issues of using a lethal, addictive substance to raise general government revenue

The dedication of at least some tobacco tax revenue to effective tobacco control programs can reduce the ethical problems of raising revenue through taxes on tobacco. The ethical problems arise both from the addictive and commonly lethal nature of tobacco, and from the regressive nature of tobacco taxation.<sup>42</sup>

At present in New Zealand, the general public benefits from the revenue produced by an addictive activity that has great costs to smokers and their households. Only 3% of the nearly \$1 billion tax revenue from tobacco is allocated to helping smokers quit or to helping minimise smoking uptake.<sup>43</sup> This scale of disproportion has existed for the decades that the government has known that nicotine addiction occurs very quickly and relatively permanently from tobacco smoking. While the nature of nicotine addiction has been debated, there has been considerable evidence for over 15 years that addiction often occurs after only a few cigarettes, and that the need for nicotine then is prolonged, usually lifelong.<sup>44-47</sup>

It can be argued that, having allowed a situation where there has been and still is a relatively easy supply of tobacco to children, that successive New Zealand governments are responsible, along with the tobacco industry, for the mass nicotine addiction that has occurred. Government has had research evidence of the risks of youth taking up smoking since 1961 or before.<sup>48, 49</sup> There are over half a million nicotine addicts in New Zealand, strongly handicapped from stopping smoking when they wish to. Surveys in a number of countries indicate that over 90% of smokers regret starting smoking.<sup>50</sup> To allow this situation, and then use that addicted population as a captive means to raise revenue, without proportionate effort to prevent smoking uptake and to free smokers from their addiction, appears to be deliberately using a dangerous addictive substance for revenue raising.

In addition, most New Zealand smokers start smoking before finishing year 10 at school, when only 14-15 years old (ie the smoking prevalence for that age group has been consistently over 75% of the rate for the 15-24 age group).<sup>51 p.11, 52 pp.3,5,6</sup> Furthermore, Māori Year 10 students are much more likely to be daily smokers than others. This difference has increased during 1999-2004.<sup>53</sup> Nicotine addiction generally occurs at an age when youth are unable to make truly informed decisions about whether or not to smoke. This is due to insufficient knowledge or understanding of the speed and irreversibility of nicotine addiction,<sup>54-56</sup> and of the enormity of the implications for their future health, and a lack of maturity and decision-making skills.<sup>57</sup> It can therefore be argued that due to the addictive nature of nicotine and the young age at which smoking generally starts, smokers cannot be held wholly responsible for their behaviour. Therefore a government which allows this situation to continue has an ethical responsibility to do all that it can to prevent smokers starting, and encouraging and helping them to quit.

If any particular *other* group, apart from government, should be responsible (and thus pay for the costs of smoking) it would appear to be businesses who profit from the sale of tobacco. Tobacco manufacturers have been aware of both the pharmacologically addictive and commonly lethal nature of tobacco for over 50 years, and have continued to actively market and (until very recently) deny the harm.<sup>58-61</sup>

At present, smokers, and their households and families, bear very large costs from tobacco use, including death and severe sickness. They suffer these costs at an earlier age than the community at large. Thus there is a double inequity, in that the public at large benefit from the tobacco tax revenue, and the tobacco-related costs in life and health are born by only some (generally - households with smokers). The inequity is directly contrary to stated government policy, which is that '*reducing inequalities in health is a key government policy.*'<sup>62</sup>

On a population basis for the last thirty years, government has gained almost twice the amount of tobacco tax revenue per head from Māori, due to the almost double prevalence of smoking for Māori compared to non-Māori.<sup>52</sup> Spending on tobacco by addicted smokers contributes to the unequal socio-economic status of Māori.<sup>63</sup> Because of their greater smoking prevalence, Māori have a much greater risk of preventable death from active and second-hand smoke.<sup>64-66</sup> However, because of the under-funding of tobacco control, government have not met their Treaty of Waitangi obligations to ensure equal health outcomes for Māori and non-Māori. Again, this is directly contrary to stated government policy.<sup>62</sup>

While some in government may argue that smoking reduces net state expenditure on pensions, due to the death of smokers at a younger age, this saving is contested, particularly in the context of tobacco tax increases.<sup>67-71</sup> However, even if there was a reduction in net state spending, such an approach is not ethically defensible. Households with smokers are much more likely to be in the bottom 30% of incomes than those without smokers, and smoking is more likely to contribute to early mortality for Māori and those with low formal educational qualifications.<sup>72-75</sup>

In practice it means that government allows underprivileged groups (eg, low income and Māori) to die earlier, in order to save money. Generally, those who are more advantaged benefit from a tax levied on those who are less advantaged.

One way to put the issue is that a dedicated tobacco tax is a *fairer return to smokers*. It will ensure that money raised through tobacco taxation is spent on supporting smoking cessation, and since smoking occurs disproportionately among disadvantaged groups it should benefit disadvantaged groups more, provided the resources are targeted appropriately.

### C) To improve the comparatively low level of funding for tobacco control.

Tobacco control, compared to the funding of many other New Zealand Government programs to avoid preventable deaths and sickness, is under-funded. For instance, over the last five years the annual funding for both cancer screening and meningococcal immunisation has been far greater

than for tobacco control, despite the small potential numbers of lives to be saved, compared to tobacco control. National tobacco control health promotion campaigns appear to be funded at a *fiftieth* or less of the rate per life saved, compared to the funding for road safety campaigns.<sup>76</sup> New Zealand tobacco control is also under-funded in comparison to best practice guidelines.<sup>77</sup>

As an illustration of the disparity of focus, Table 1 shows the investment in policy staff by the Ministry of Health in three different areas of work, for the period 2001-2005. In terms of staff per preventable deaths that could be avoided, tobacco control has less than a *hundredth* of the policy staff investment, compared to cancer screening and meningococcal immunisation.

**Table 1: Ministry of Health policy staff investment in three areas; 2001-2005**

	Potential lives saved/year	Average policy staff	Potential lives saved/year/staff
<b>Tobacco control</b>	4700	5	<b>940</b>
<b>Meningococcal immunisation</b>	Under 20	11	<b>2</b>
<b>Cancer screening</b>	Under 250 (breast, cervical)	30	<b>8</b>

Source: Based on information from the Ministry of Health<sup>78</sup> and from Dr Nick Wilson

This relative under-funding of tobacco control is because health sector funding is rarely allocated on the basis of cost-effectiveness, but more as a reaction to public concern as perceived by politicians (often in response to repeated and emotive coverage of a topic in the media). Over the last 20 years, the Ministry of Health has not been able to persuade governments that tobacco control was a more effective use of funds in reducing preventable deaths and sickness, compared to other uses of funds.

The lack of tobacco control funding is in spite of the reduction of smoking being at the top of the government's 13 population health objectives in the *New Zealand Health Strategy*.<sup>79</sup> The experience of tobacco control under-funding demonstrates how New Zealand governments persistently fail to allocate funding in accordance with their own priorities. That is, governments have persistently failed to 'to ensure that competing claims for resources are accessed on an equal basis' - the criteria suggested by Treasury as necessary for government policy.<sup>11</sup> Thus dedicated tobacco taxes are a way of ensuring that the government *does* allocate money to the highest priority areas like tobacco control, and are a *necessary* protection from the usual expenditure allocation process which has persistently failed to allocate resources commensurate to need.

Worldwide, there are a number of reasons for tobacco control under-funding. These include the comparative lack of visibility of the resulting deaths and sickness (for instance compared to road accident deaths), the lag time for some of the effects, the very strong opposition from commercial interests, and the lack of realisation that tobacco use is a business and economic problem.<sup>80</sup> To some degree, the under-funding is also because of the pressures to fund treatments rather than the prevention of illness. Writing generally of health budgets worldwide, Carol writes:

*The reality is that, in the budget process, the prevention and promotion areas tend to miss out because of urgent and compelling claims from the hospital and treatment services side of the health industry. However, with dedicated taxes, the income stream is separate from the main health budget, and so those dedicated taxes are more likely to remain untouched, even in a recession when there may be 'across-the-board' budget cuts.*<sup>25 p.14</sup>

Better funding for tobacco control would enable government to better meet its FCTC obligations for tobacco control health promotion. In particular, the obligation in Article 12 to:

'promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate.'<sup>41</sup>

## D) To provide more stable and predictable funding for tobacco control

Because of the long term nature of tobacco control, where persistent effort is needed over long periods (over a generation) and where results from interventions can come significant periods after the interventions (eg, 10-15 years for the effect of parental example on adult quitting<sup>81</sup>), there needs to be a stable, long term revenue base. Tobacco control staffing and funding in New Zealand has had long periods of neglect,<sup>82, 83</sup> and a dedicated tax is one way to avoid such periods in future. It would also help avoid repetition of perverse policies such as the reduction in promotion of Quitline services in the period following the introduction of the SEAA (2003).

## E) Because tobacco control is a very effective use of funds, with a high return on investment (for health status, reducing health inequalities and for the economy)

There is evidence to show how comparatively cost-effective various population-level tobacco control interventions are, compared with a range of other health sector spending.<sup>84, 85</sup> In particular, there is evidence for mass media campaigns,<sup>68, 86, 87</sup> and cessation help<sup>88-92</sup>. Interventions such as tobacco tax increases and smoke-free policies are low-cost (principally needing policy staff, legal drafting and parliamentary resources) with very high health and economic benefits.<sup>84</sup>

## F) As a politically acceptable way to provide extra tax revenue

Seen from the point of view of politicians who would like to provide extra government services, a dedicated tobacco tax can provide *extra* revenue that has a relatively high public support (including among smokers). This is compared to both a non-dedicated tobacco tax, and general revenue gathering such as income taxes and GST.

## G) To help reduce the risk of future litigation against government from those affected by smoking

A transfer of tobacco tax revenue to tobacco control funds would help decrease the government's exposure to future litigation by smokers and their families. The litigation could be on the basis of the inequity of the disproportion between the revenue from the tobacco tax, and the funding of tobacco control. This inequity is exacerbated by the deliberate use of a dangerous addictive substance for revenue raising, as detailed in B above.

## H) As part of a planned approach to moving from the use of tobacco revenue

As well as the ethical considerations detailed above, there are practical reasons for government to have a planned approach to moving from a dependence on tobacco taxation for general revenue by government.

Even without a dedicated tobacco tax, government aims to reduce tobacco use. If such reduction occurs, government tobacco tax revenue will eventually decline, even with increases in the rate of taxation. However, it is difficult to predict at what point the eventual decline in tobacco tax revenue will occur. A staged and planned reduction of the dependence on tobacco taxation for general revenue by government, would reduce the chance of unpredicted revenue shortfalls. Gradually increasing the proportion of tobacco tax revenue that is dedicated to tobacco control appears to be an optimal system for such a planned reduction of the dependence.

## I) What are the arguments against a dedicated tobacco tax?

The arguments against a policy where some or all of tobacco tax is dedicated to a particular purpose include those mentioned above:

- That smokers and their families should bear most or all of the costs of smoking (both the costs to the state, and the costs to them and their families)
- The alleged savings to the state from the earlier deaths of smokers.

The answers to these arguments are given above in section 3.B.

In addition, other arguments that opponents may use include:

1. That the fixed allocation of a funding stream to one purpose removes the ability of government to move funding to where it can be most effectively and appropriately used. The effect of this handicap can increase over time, as the need for tobacco control may diminish compared to other increasing needs.
2. That a dedicated tax will prevent the use of tobacco taxation as an instrument of health policy (ie. the use of price levels to lower consumption and promote quitting).
3. The precedent: If a dedicated tobacco tax is adopted, then other 'special interests' will demand that users of particular services or products pay more directly to address resulting costs.<sup>93</sup>
4. The stream of dedicated revenue may decrease, as tobacco control becomes more effective and tobacco consumption decreases. If tobacco control depended on a dedicated tax, this could limit the ability of government to fund tobacco control.
5. An agency depending on a dedicated tobacco tax could have an incentive for the consumption of tobacco to continue, in order for the revenue to continue. They would have an incentive to not be effective in tobacco control, as if tobacco consumption declines as government intends (without the dedicated tax going up to compensate for the decline), then the agency would have less money.
6. The responsibility for funding tobacco control (and paying other costs relating to tobacco) should lie with the tobacco industry. As tobacco harm can be seen as an externality from the industry (a cost on others which the industry does not sufficiently pay for), then they should pay all costs relating to the harm. Smokers should not have to pay for fix the problem.

A particular comment of the Ministry of Health's 2002 report, *Future Funding of Health and Disability Services in New Zealand*, is that 'at present the amount raised by the tobacco excise is far in excess of the treatment costs of smoking related diseases.' This statement may imply that the present amount spent by government on tobacco-related treatment is sufficient, and at the least, appears to ignore the very large shortfall in cessation treatment. This shortfall is discussed in section 4.5 below.

## J) Answers to concerns about dedicated tobacco taxes

This section provides answers to the six points listed above.

### 1) Removal of the ability of government to allocate funding rationally according to priorities and needs.

**Answer:** Government and government agencies are often subject to strong temptations to spend revenues on 'immediate' needs, especially when subject to public and media criticism for failing to do that. One of the tasks of government, however, is to give adequate weight to longer-term considerations. Government can be helped in this objective by the occasional use of 'ring-fencing' of

allocated funds (as for example in recent years with mental health funding and some public health funding to District Health Boards), or by the use of dedicated taxes.

The record of policy-making by the New Zealand Government suggests that irrational spending decisions, counter to stated objectives, will persist. Governments make spending decisions that are based on many different and contradictory criteria. Examples include local government contracting, international agreements and health structures.<sup>94-96</sup> There is evidence that policy-making in similar settings is also chronically inconsistent. Rather, policy-making is characterised by ‘muddling through’ and decision making that has fundamental irrational elements.<sup>97 pp.7,22, 98-101</sup>

The track record of government spending on tobacco cessation support, media campaigns etc., for example the failure to fund Quitline adequately to meet demand following the SEAA (2003) suggests that a tied tax is exactly what is needed to ensure that rational funding decisions are taken on tobacco control in the future.

In the area of health, different criteria have been used by the New Zealand Government for the allocation of spending on immunisation, cervical and breast cancer screening, the prevention of meningococcal infections and tobacco control (see Figure 1). Treasury’s wish for a rational, consistent policy process is admirable, but preventing a dedicated tobacco tax is unlikely to deal with the chronically irrational quality of funding decisions for tobacco control. A dedicated tobacco tax provides an overriding mechanism that makes at least some correction for this.

The possibility that dedicated tobacco tax revenue may with time prevent the funding of other activity, that would be even more effective in providing health, can be allowed for by periodic reviews of the policy or by a sunset clause.

## **2) A dedicated tax would prevent the use of tobacco taxation to raise tobacco prices at a sufficient rate to lower consumption and promote quitting.**

**Answer:** This argument appears to assume that if *all* tobacco tax revenue is dedicated to a particular purpose or purposes, then the tobacco tax rate could not be lifted because there might be too much or not enough revenue (a price increase could reduce overall tobacco tax revenue). This situation can be avoided by either augmenting the revenue (if it was insufficient) or by dedicating only part of the revenue (if it was considered too much). In fact our recommendations are for dedication of only a part of current tobacco taxation revenue. Amounts of \$60 to \$120 million would be roughly 6 to twelve percent of current tobacco tax revenues.

## **3) Arguments about any precedent from the establishment of a dedicated tobacco tax.**

There are at least two types of reply to this argument. One is that *even* if there is a precedent that could be used by other interest groups, then the arguments for a dedicated tobacco tax are so strong as to substantially override this consideration. (And in any case tied taxes might equally well be justified in some other instances.)

Secondly, it can be argued that the revenue from tobacco taxation is unique, in that it is on an activity that is addictive for *all* or nearly all those who smoke regularly.<sup>102-104</sup> This is contrast to alcohol or gambling tax revenue. Tobacco tax revenue could be argued to be not part of *normal* government income because of the unique combination of addictiveness and danger from the product taxed. Because of this unique nature, a dedicated tobacco tax could be argued to not set a precedent for other dedicated taxes.

## **4) The stream of revenue may decrease.**

**Answer:** As the *overall* income from tobacco taxes decreases with declining consumption, the *proportion* of revenue going to tobacco control could be increased. This increased proportion could be guided by a set absolute minimum funding (indexed to inflation), or (ideally) could be guided by evidence of the effectiveness of the current and potential spending uses in tobacco control. As long as the interventions proposed were more cost-effective (by current government criteria such as life-years saved) than interventions that are intended to meet those criteria, there would be an argument

for maintaining or increasing the funding. Eventually, when tobacco consumption reached very low levels, government could also fund part of tobacco control out of general revenue, as it does for the control of the relatively small volumes of highly addictive and dangerous illicit drugs.

**5) There would be an incentive for tobacco use to continue.**

Such an argument depends on the governance and management of the agencies funded by a dedicated tobacco tax being oriented to continue the status quo, rather than to achieve success. This can be avoided by the appointment and reappointment of governance body members and management on the basis of an orientation to success, and a record of success in reducing tobacco harm. More generally, poor performance by an agency can be avoided by transparent processes, and by strong overview by groups funded to do so (eg Parliament, the Auditor General, and the Ombudsman).

**6) The tobacco industry should pay for tobacco control, not smokers.**

Any method of recovering tobacco-related costs from the tobacco industry would result in the costs being passed on to smokers, in the form of higher tobacco prices, unless government forced price controls. Such price controls could result in the exit of tobacco companies from the market, if they did not make sufficient profits. So money taken from tobacco companies by litigation, by legislated penalties for particular behaviour, or by surtaxes, would in effect be taxes on smokers. However, if tobacco control costs ARE recovered from the tobacco companies, then there is a strong case for such funds to be used to support tobacco control efforts.

## 4. *How to get a dedicated tax: Gaining, keeping, and using a dedicated tobacco tax.*

### 4.1 Getting a dedicated tax system.

The international experience is that, in order to persuade policymakers that a dedicated tax is not just worthwhile, but is feasible and without major political risks, advocates need to present a clear vision on the way in which dedicated funds are governed, administered and spent.

The success in getting a dedicated tax can be due to well-prepared officials and advocates taking advantage of a political window of opportunity, or can be the result of long term planning and work (over 10 years in the cases of Thailand).<sup>25 p.11</sup>

### 4.2 Elements in getting a dedicated tax.

#### **Wide and strong alliances.**

Two ways to increase and strengthen alliances to get a dedicated tobacco tax are to:

- Widen the interest in tobacco use reduction to outside the health sector (because of the social and economic benefits of reduced tobacco use).
- Widen the benefits of the tax dedication from tobacco control to a wider area of health promotion.

However, if dedicated tobacco tax revenue is used for purposes other than to reduce smoking prevalence and uptake, then there are both the dangers of a lack of focus on tobacco control, and the ethical problems of using revenue from a highly addictive, lethal substance in ways that are not directly related to reducing tobacco harm. In particular, a health promotion agency that depends on tobacco consumption for its revenue, and has other missions besides tobacco control, would have incentives to not focus on tobacco control because reduced consumption could erode revenue for non-tobacco control purposes.

#### **Demonstrate public opinion.**

In addition to surveys that show support for tobacco taxes and tax rises (eg, for New Zealand<sup>105, 106</sup>), surveys can show public support for dedicated taxes (see section 2.2 above). In particular, increased public support can be shown for tobacco taxes, when part of the revenue is dedicated.

#### **Provide draft legislation.**

Draft legislation provides a model for policymakers to work with, and allows advocates to outline in a relatively precise way the objectives, timetables, methods and implementation processes that they want adopted. Such documents provide detail for the media, and help prevent the development of myths by those opposing dedicated taxes.

Clarity is required for a number of areas, which include:

- The aims and objectives of the dedicated tax (eg, an aim could be to rapidly lower smoking prevalence to under one per cent, objectives could include; to provide more adequate and stable funding, and to make tobacco taxation more ethical).
- The proportion or absolute amount of the tax revenue, or tax increase, that is to be dedicated.
- The areas for which the dedicated revenue is to be used (this requires considerable definition).
- Who is to administer and spend the revenue.

- The means and timetable for any increases in the proportion or absolute amount of revenue dedicated. To ensure that tobacco control funding does not decline, there should be explicit provisions to ensure this.
- The mechanism for monitoring and evaluation of the impact of the tobacco control interventions which the dedicated tax funds.

### **Linking the start of a dedicated tax with a tobacco tax rise.**

Generally, dedicated tobacco taxes have been established by increasing the tax *rate* at the time of the establishment of the dedicated tax. This allows the present flow of funds to governments for general purposes to be maintained or increased, while allowing part or all of the increased revenue to be allocated to tobacco control.

Where the tax rise and the establishment of the dedicated tax have not been at the same time, as in Thailand in 2000-2001, the tax rise preceded the dedicated tax, and helped to facilitate the discussions on the dedicated tax.<sup>25 p.11, 107</sup>

## **4.3 What sort of body or administrative system should use the dedicated tax?**

The factors to consider in the structure and design of a funding and administrative body or system include:

- What can be shown to be the most effective *form* of body or system to achieve the stated objectives? For example, Land Transport New Zealand (a small single-mission agency leading the drive for road safety), has been more effective in preventing deaths and injuries than larger, less-focused agencies. Alternatively, if a large agency can demonstrate it would be more effective in achieving the objectives, it would need to be considered.
- What system can most transparently and effectively be evaluated, so that policymakers and the public can be satisfied that the funding is used effectively?
- What will best protect the funding from erosion and misuse? The mechanisms for this include the means for the appointment of and criteria for the governance body, limits on the ability of government to direct the agency, and the transparency and extent of decision-making, accounting and evaluation of outcomes. Much of this is detailed by Carol.<sup>25 pp.31-33,41-50</sup>
- What design will best ensure that tobacco control effectiveness remains the objective? For instance, provisions about the appointment and reappointment of governance body members and management on the basis of their proven intentions and record of success in reducing tobacco harm.
- What powers the agency would have (eg, would it lead the advice to government on tobacco taxation)?
- How will the system devolve power and resources to regional and local tobacco control efforts?
- How effective will the design be for reducing inequalities and devolving power to Māori and other disadvantaged groups?
- The breadth of the Ministry of Health's mission, and the many demands on their management and other resources, means that it is difficult for them to give sufficient priority to tobacco control over more immediate operational needs. Tobacco control is by its nature a long-term investment, which is not suited to a large organisation subject to short-term investment pressures.

A single purpose agency may be one of the better options for the control of the dedicated tobacco tax revenue. One reaction to the idea of 'yet another agency' may be that this will mean further bureaucracy, extra staff, and duplication of resources. A single purpose agency is justified when there is an extraordinary problem such as widespread nicotine dependency. When an organisation has a single aim:

- It is able to concentrate on that mission, without competing objectives.
- Such focus means that all the arrangements within the organisation are designed to enable the carrying out of that mission. Information systems, human resources and recruitment, public relations, management systems, - all these can be orientated to one objective.
- It has particular advantages where a major new policy initiative is sought – insofar as a new, single-issue body can more easily evolve an institutional climate appropriate for that initiative.

Evidence from New Zealand tobacco industry documents indicate that relatively focused and independent agencies such as the Public Health Commission (PHC) of 1993-1995 are seen by them as more of a threat than the Ministry of Health. The PHC was a threat because it was able to bring very strong tobacco control ideas and arguments into the public arena. A July 1995 fax from Jim Burns of Wills NZ reads:

*...The death of the PHC at least removes an independent, extremely well funded loose cannon from the anti-tobacco debate although having its former chief as deputy chief of the Health Ministry is not helpful. However, at least [PHC head Dr Durham] is now obliged to operate within the confines of the Civil Service – which was our second objective – the first to see the PHC disbanded.<sup>108</sup>*

Independence for an agency from short-term interference by politicians could in New Zealand be partly achieved by having 'entrenched' legislation, and by having the appointment of the agencies governance partly controlled by civil society. Thus independent agencies such as the Medical Association and the Public Health Association could nominate part of the governance board.

### **Desirable models for dedicated tobacco taxes.**

The elements that tobacco control advocates can seek in a dedicated tobacco tax framework include:

1. Ensuring that the allocated tax revenue is not diverted or eroded.
2. Ensuring that the allocated tax revenue is used effectively, with continued evaluation of the results against objectives.
3. Ensuring that tobacco tax revenue is not seen as the only funding for tobacco control, and is not seen as a substitute for cost recovery from the tobacco industry.
4. Ensuring consistency with long term aims. For instance, these aims may include a strategy of regular significant tobacco prices increases from tax increases, beyond the rate of increase of tobacco affordability. Thus a framework may need a legislative basis that requires such tax rises, or the power of a health agency to require the rises when necessary.
5. Ensuring that power and resources are sufficiently and effectively devolved to regional and local tobacco control efforts.
6. Ensuring that inequalities are reduced, and that power and resources are devolved to Māori and other disadvantaged groups.

Internationally, possible models for an agency for tobacco control include the Office of Tobacco Control (Ireland),<sup>109</sup> and the Thai Health Promotion Foundation (ThaiHealth).<sup>110</sup>

Another possible model (and one of the longest running) is the use of dedicated tobacco tax revenue through the California Department of Health and California Department of Education. Since 1989, dedicated revenue in California has gone to the Cigarette and Tobacco Products Surtax Fund, which has six separate accounts for specific purposes. The accounts are for tobacco control health education (20%), health services for low-income, uninsured patients (45%), tobacco control research (5%), environmental work (5%), and for any of these areas (25%).<sup>111</sup> Short term state legislation made specific allocations for the health education section, to: (i) Mass media campaigns; (ii) City and county health departments (the amounts based on population), (iii) School districts for 'non-classroom' tobacco control work, for non-profit groups, and for programs 'aimed at the state's ethnic and racial minorities'; (iv) School-based work; (v) Administration; and (vi) A program for children in low-income families. Later legislation changed this allocation somewhat.<sup>112</sup>

In 2000-01, California spent \$US45.2 million on the tobacco control media campaign from the Cigarette and Tobacco Products Surtax Fund. Other funding meant that the total California spending on tobacco control was \$US134.5 million.<sup>113</sup>

The California research funding from the dedicated tax (the Tobacco-Related Disease Research Program) has become the one of the top three tobacco control research funds in the USA. To 2006, it had given over \$US 365 million for this research.<sup>114</sup> It is run by the University of California.

The effect of *even* this type of dedicated revenue structure, where only 25% of the dedicated funds go to tobacco control in some way (and as low as 11% during periods of fund diversion)<sup>112</sup> can be seen by the drop in smoking prevalence during 1988-1993 that was much faster than for the rest of the USA (1.1%/year compared to 0.6%.<sup>115</sup>). In 2002, the adult smoking prevalence for California was 16%,<sup>116</sup> compared to 20% in 1990.

#### 4.4 The dangers of diversion and erosion of funds.

The implementation of a dedicated tax may be as important as the establishment of it. Unless the revenue for tobacco control is allocated to a separate administrative body, there is a proven danger that the funds will be diverted to other uses. In at least three of the American states, there has been temporary or permanent erosion of the funds reaching tobacco control.<sup>28, 117-119</sup> In Massachusetts, the dedicated funds were used to fund non-tobacco control work, and to supplant funding for pre-existing programmes, which was explicitly prohibited by the relevant Massachusetts referendum on tobacco tax.<sup>119</sup>

Even where funds are available for tobacco control, political hostility or other forces can erode the effectiveness of the *use* of the dedicated revenue. In California, the effectiveness of aggressive tobacco control campaigns that started to move the focus of tobacco control from the smoker to the tobacco industry were eroded, requiring efforts from advocates and others to limit this erosion.<sup>118, 120</sup>

#### 4.5 How much of the tobacco tax revenue should be dedicated?

Tobacco-related deaths and sickness, and the accompanying social costs, are *entirely* preventable, using current knowledge and practices.<sup>84</sup> Thus tobacco control starts with an advantage over some other areas of the prevention of premature death, in that a combination of spending and policy changes can result in a future situation of *no* or minute costs to government or society from the problem.

Four of the considerations in deciding an optimum level of funding for tobacco control from a dedicated tobacco tax are (i) the best practice spending levels in other New Zealand health promotion and prevention areas, (ii) the cost-effectiveness of tobacco control spending, (iii) the ability of the health sector to cope with new funding, and (iv) the past and current shortfall in the funding needed to remove smoking as a significant health problem.

### **Best practice spending levels.**

The best practice spending levels for health promotion include the over \$31 million per year spend on road safety information and promotion (2002-2003 year). This is approximately \$69,000 per preventable death per year.<sup>121</sup> In contrast, for 2003–2004, less than \$7 million was invested in tobacco control health promotion by government through the two main national agencies: the Health Sponsorship Council and the Quit Group (personal communication, J Muschamp, 2004).<sup>122</sup> This national-level tobacco control health promotion spending to prevent deaths is under \$1400/death/year, about a fiftieth of the rate of spending for road safety.

If national-level tobacco control health promotion was funded at the level of road safety health promotion, at least \$276 million per year would currently be allocated. In fact in 2005/2006 the total Ministry of Health expenditure on tobacco services was \$29.7 million, GST excluded, plus a further approximate \$200,000 on tobacco-related policy advice, and a further \$1 million for tobacco research and evaluation, made available from the funding for the cancer control strategy.

### **The cost-effectiveness of tobacco control spending.**

The cost-effectiveness of tobacco control depends to some degree on the extent to which years of life (or quality of life) are valued. However, even using tangible costs, tobacco control programs provide considerably greater benefits than the costs of the program investment.

The research most relevant to New Zealand includes that on Australian benefits from tobacco control programs by Girgis and Ward,<sup>123</sup> and Collins and Lapsley.<sup>124</sup> The latter suggest that for New South Wales (with a similar population to New Zealand), a annual real expenditure of \$278 million a year would be justified for 20 years, if it reduced smoking prevalence there to 13.1% (from the current approximately 20%). This calculation assumes that a real social rate of return on investment of at 10% a year is required. Further arguments on the return on investments in tobacco control are found in the publication *Tobacco Control: A Blue Chip Investment in Public Health*.<sup>85</sup>

### **The ability to cope with new funding.**

There are a number of factors which indicate that large increases in tobacco control spending could be effectively spent. They include the ability shown in at least three occasions to effectively use large increases in funding. In 1991, funding increased from under \$2 million dollars a year to over \$6 million dollars, most of it going to the new Health Sponsorship Council. In 1997-98 the funding increased under \$8 million to over \$11 million dollars, and in 2000-2001 funding increased from under \$13 million to over \$27 million (in both cases, the increases largely were for cessation help).

Another factor is that current mass media campaigns could be quickly made much more effective by extra spending. This is because the current types of TV campaigns could be shown at times when there are more viewers. There is strong evidence that mass media campaigns (as part of comprehensive tobacco control programs) are very cost-effective in decreasing smoking prevalence.<sup>84</sup>

### **The past and current shortfall in funding.**

Further arguments for much greater funding of tobacco control include the need to make up the past shortfall in spending. For instance the total spending on tobacco control during 1984-2001 was less than \$150 million, in 1995 dollars. This was less than 0.7 percent of the retail spending on tobacco during the period, and less than 1.5 percent of the tobacco tax revenue.<sup>51 p.24, 125</sup> The low level of past spending, and the inadequate policy interventions,<sup>82, 126-128</sup> mean that there is a very large group of addicted smokers, and strong social norm of smoking for many groups.

The size of the current shortfall in funding can be gauged by the chronic situation in New Zealand over the last 15 years where over 23% of the adult population (about 700,000 smokers) continue to smoke, despite about 90% of smokers wanting to quit.<sup>50</sup> Another way to gauge the shortfall is to

estimate the cost of cessation services that would result in at least half of all smokers wanting to quit becoming continually smoke-free within a year.

At present less than \$15 million a year is spent on smoking cessation help. During July 2001-October 2006, 211,597 smokers phoned the government funded Quitline (Personal communication, M Grigg, 2006). There appear to be less than 10,000 other smokers treated by government funded cessation services in this period. Thus less than a third of the 750,000 current smokers contacted cessation services in the last five years. A proportion of those calling are likely also to be repeat callers.

Using current data on the cost of using the Quitline programme to get a smoker to quit permanently (between \$3,198 and \$7,120),<sup>130</sup> then the cost of getting even 100,000 smokers to quit would be at least \$319,800,000. To ensure that cessation help was effective many smokers may require a much more intense and costly level of treatment, more on the scale of that given to heroin addicts.

### **Summary of considerations for an optimum level of funding for tobacco control**

There is some evidence that the health sector can absorb large increases in funding for tobacco control, with an historical record of several doublings of tobacco control budgets. Media spending provides a quick way of increasing effective spending.

The best practice spending levels in other New Zealand health promotion and prevention areas, the cost-effectiveness of tobacco control spending, and the past and current shortfall in the funding indicate that at a minimum, an initial annual budget of over \$250 million could be considered.

Whatever amount is budgeted, a substantial proportion needs to be devoted to control of smoking among Māori. The Māori ethnic group population aged 15 and over numbered 635,400 for the year 2005, or 12.8 percent of the total resident population aged 15 and over. At the reported Māori smoking prevalence (AC Nielsen survey) of 50.9 percent, Māori ethnic group smokers aged 15 and over numbered 209,000, or 27.6 percent – over a quarter - of the total of 757,000 smokers of all ethnicities.

## 5. Conclusions.

- Tobacco control measures in New Zealand are currently under-funded, both on a comparative cost-effectiveness basis, and in the light of the government's stated health priorities. There is evidence that policy makers find it difficult to allocate funding to preventive services and programmes, particularly where the benefits are not clearly tangible and are in the long term, and particularly in the face of competing pressures from immediate health care deficiencies and resource shortfalls.
- One option for helping ensure that government's stated priority on tobacco control is matched by adequate funding, is to have part or all of tobacco tax revenue dedicated to tobacco control spending.
- There are a number of precedents for such dedicated tax revenue in New Zealand and elsewhere. Research indicates that there is far greater support for dedicating tobacco tax revenue when the revenue is spent on tobacco control efforts.
- Dedicating tobacco tax revenue for tobacco control helps to address the ethical and equity issues of using a lethal, addictive substance to raise general government revenue and the economic hardship potentially caused low-income smokers.
- If tobacco tax revenue is dedicated for tobacco control, consideration needs to be given to:
  - The amount of the funding
  - Annual adjustments in the amount of funding, and how these adjustments might be linked to changes in overall tobacco tax revenues.
  - The structure and degree of autonomy of the agency administering the funding
  - Ways of ensuring uses of the fund which meet the criteria commonly applied to health-care funding decisions, including cost-effectiveness and improving the equity of health outcomes.

## 6. Recommendations.

- 1 That an increasing portion of the tobacco tax revenue be dedicated to tobacco control activities encouraging and assisting smokers to cease smoking and deterring non-smokers from starting smoking.
- 2 That the initial amount of dedicated tax revenue should be at least \$100 million, (compared to current spending on these activities of about \$40 million), and should be targeted initially to increase to at least \$200 million within five years.
- 3 That the objective of this dedication of revenue should be to reduce the smoking prevalence (including that by Māori and Pacific) to less than one per cent within 20 years, and less than 10% for all groups within ten years.
- 4 That the administration of the dedicated revenue be structured to ensure that the revenue is:
  - Not diverted or eroded.
  - Used effectively, with continued evaluation of results against objectives.
  - Sufficiently and effectively devolved to regional and local tobacco control efforts.
  - Used so that tobacco-related inequalities are reduced, and so that power and resources are devolved to Māori and other disadvantaged groups.

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