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REGIONAL STRATEGY FOR HEALTH PROMOTION FOLLOW-UP OF THE SIXTH GLOBAL CONFERENCE ON HEALTH PROMOTION

HEALTH PROMOTION AND DEDICATED TAXES

This paper was originally prepared for review and discussion at the Regional Consultation on Regional Strategy for Health Promotion for South-East Asia, held from 26-29 June 2006, in Chiang Mai, Thailand.

Contents

Introduction

1. Over the years, the burden of chronic noncommunicable diseases (NCD) has been steadily increasing globally. Generally, NCD include chronic diseases such as cardiovascular diseases (CVD), cancer, diabetes, obesity and chronic respiratory diseases. These diseases are sometimes referred to as diseases of lifestyle, considering that behaviour is the basic determinant.

2. Of the deaths due to the above chronic diseases, 80% occur in low and middle income countries, where most of the world's poor people live. This has major adverse effects on the quality of life of the affected individuals, and also has an economic impact on families, communities and on society in general. Chronic diseases account for 54% of all deaths. WHO projects that 89 million people in the South-East Asia Region will die from a chronic disease over the next 10 years. An estimated USD 220 billion could be lost from the national income over the next 10 years in India alone, as a result of premature deaths caused by heart disease, stroke and diabetes.

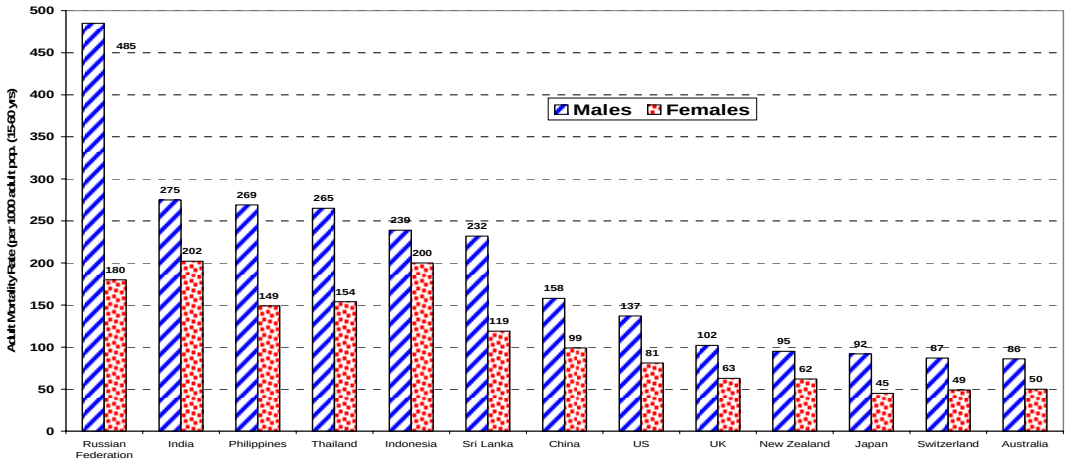
3. Actually, many of the deaths and disability caused by these diseases are due to a few modifiable risk factors that include: (a) use of tobacco and tobacco products; (b) high blood pressure; (c) high concentration of cholesterol in the blood; (d) being overweight or obese; (e) lack of or insufficient physical activity, and (f) inadequate intake of fruit and vegetables or an unhealthy diet. Enough knowledge is available to effectively address these risk factors. The application of proper knowledge and information with mass involvement of people in preventing and controlling chronic diseases could lead to a rapid improvement in life expectancy and the quality of life, especially among the middle-aged and older people in several countries.

4. There is enough evidence that deaths due to CVD, diabetes and cancer among people aged 30 years and above in Australia, Canada, UK and USA have reduced dramatically in the last two-three decades. This reduction in mortality and morbidity was realized largely as a result of implementing comprehensive and integrated NCD prevention and control programmes, directed at the whole population, with the focus on reducing common risk factors like tobacco, imbalanced diet and physical inactivity. It is estimated that around 14 million deaths have been averted in USA alone within the past three decades. The UK also averted three million deaths during the same period.

5. Figure 1 below shows the difference between developed and developing nations with regard to the Adult Mortality Rate (probability of dying per 1000 adults between ages 15-60 years) for 2004. Nations which have adopted comprehensive NCD prevention and control policies have a far better status than others. The challenge is how other countries, especially developing ones, follow suit. The WHO Global Report on Chronic Diseases, 2005, has also highlighted that if developing countries adopt the basic policy and strategic framework for the prevention and control of chronic noncommunicable diseases, there is a possibility of reducing the death rates from all chronic diseases by 2 per cent per year, over and above the existing trends during the next 10 years. If, and when this goal is realized, around 36 million lives could be saved by 2015. In the South-East Asia Region, this means 8 million people. Almost half of these averted deaths would be men and women below 70 years of age.

6. The strategies for prevention and control for a nation-wide programme require the adoption of proper mechanisms for planning and implementation. The choice depends on which low-cost, high-impact interventions are implemented step-wise with available resources. Governments need to allocate adequate resources and provide leadership to address the problem of low funding for health promotion.

Figure 1: ***Adult Mortality Rate (Probability of dying per 1000 adults between ages 15-60 years)***



(Source: World Health Report 2006)

Funds for Health Promotion

7. For over 20 years, OECD countries (such as USA, European and East Asian countries) have adopted different forms of earmarked or dedicated taxes, to be realized from a certain proportion of general tax revenue usually from the taxes (*sin-tax*)[1] levied on tobacco, alcohol, and/or gambling. While the main purpose of the sin tax is to increase the general revenue to be used for general public expenditure, it has been, in some cases, earmarked with the additional aim of reducing or eliminating the consumption of a particular consumer product. The revenue thus collected is usually spent on social welfare activities.

8. In some countries, through legislation, a portion of taxes has been earmarked for health promotion programmes with particular focus on prevention and control of chronic diseases. Such dedicated taxes are imposed with the understanding that excessive consumption of harmful products is not only detrimental to one's self, but also incurs additional budgetary expenses for families, the government and for society as a whole, in taking care of the ensuing problems. Some argue that dedicated taxes place an extra burden on the poor rather than helping them. There is also some disagreement that tax revenue collected on harmful products

[1] *Sin-tax* is the tax levied on items, which are culturally disfavoured but are nonetheless legal and widely consumed. In many countries it is almost exclusively referred to taxes levied on tobacco, alcohol and gambling. Attempts to expand the taxable items to include unhealthy food or firearms, have failed.

like tobacco or alcohol should be used exclusively for health purposes. In many cases, ministries of finance are reluctant to earmark taxes for a particular purpose.[2]

9. However, since the mid-1980s, many developed nations have introduced the sin-tax, earmarked for specific purposes like tobacco or alcohol control or for general health promotion activities. WHO has steadily advocated for introduction of sin-tax or dedicated tax to generate additional revenue for health, especially for health promotion and prevention and control of priority diseases.[3] The WHO Framework Convention on Tobacco Control (FCTC)[4] also contains a number of obligatory measures that are directly addressed to dedicated taxes. For example:

- *Price and tax measures (Article 6, 2 (a))*: implementing tax policies and, where appropriate, price policies so as to contribute to the health objectives aimed at reducing tobacco consumption.

10. WHO Member States, as contracting Parties to the Convention, have to fulfill these legal obligations. Such actions actually require substantial resources. This paper aims to provide a short glimpse of the history and scope of the use of dedicated taxes for health promotion with selected countries' experiences, and to guide other countries to formulate their national policy to introduce such measures.

11. During medium-term development planning or the annual budget process for the health sector, health promotion and primary prevention activities tend to miss out due to urgent and compelling claims from hospitals and health centres, mainly for curative care. Many of the health promotion activities also go beyond the health sector and they tend to be left for negotiation with those sectors and thus, lead to less financing. Funds generated from dedicated taxes or an earmarked expenditure could separate the budget and expenditure from the main health budget, and also provide some autonomy for managing such funds by a separate body. The following health promotion initiatives can be supported from such funding sources:

- General health promotion programmes, addressing major communicable and noncommunicable diseases;
- Tobacco, alcohol and other substance-abuse control, including use of mass media, advocacy, education and legal reforms; replacement of advertising; and health research;
- Sponsoring sports and art exhibitions and promotion; and,
- School and youth education including development of lifeskills.

Examples of Health Promotion Funds or Foundations

12. Since the early 1980s, as part of the health promotion movement, governments in a number of countries or state authorities mostly in the developed world have established funds

[2] EP Mach & B. Abel-Smith, *Planning the finances of the health sector - A Manual for Developing Countries,* WHO Geneva, 1983

[3] B. Abel-Smith, *Health Financing in Myanmar,* Assignment Report, October 1994, WHO SEARO (SEA/Econ/12)

[4] FCTC is the first international framework convention adopted by the 56th World Health Assembly in May 2002 for the purpose of tobacco control. By January 2006, 147 Member States had ratified the Convention.

for health promotion including dedicated taxes for tobacco and alcohol. (See details in the table at pages 9-11). There are different modalities for the establishment of authorities or funding mechanisms for health promotion.

13. One of the earliest legislative actions for health promotion in 1983 was by the ***State Government of Western Australia,*** which introduced the tobacco tax to provide additional money for implementing general health promotion activities with an emphasis on tobacco control and also partially addressing the issue of sponsorships by tobacco companies for sports and recreation. The Western Australian Health Promotion Foundation (Healthway) was formally established in 1991 through the Tobacco Control Act of 1990. The 15% increase in tobacco tax resulted in a 10% additional fund for health promotion. Out of the revenue of AU$ 17 million annually from tobacco tax, 30% each is spent on health promotion, research, and sports, and the rest goes for the promotion of arts.[5] In 1987, the ***State Government of Victoria in Australia*** passed a Tobacco Act that led to earmarked tobacco taxes being directed to health promotion including tobacco control programmes. The funds were managed through a specific organization, called the "Victorian Health Promotion Foundation" or "VicHealth"[6] which is an independent statutory public body. It is funded by a dedicated 5% tax that is levied on sales of tobacco products, amounting annually to around USD 25 million. Thus, 40% of the funds collected were used for promotion of community and school health; 30% for sponsoring sports; 20% for health research and the balance for administration. A few other States, ***South Australia*** in 1988 and the ***Australian Capital Territory*** in 1989, followed suit. In 1997, the Australian High Court ruled that the dedicated tobacco tax is un-constitutional. Now, health promotion activities are funded totally by a direct allocation from consolidated government revenue, and it turns out that the level of funding has increased.

14. The ***State of California, USA*** has levied, since 1988, an additional 25 cents per package of cigarettes, and a quarter of such dedicated tax (collected overall) was earmarked for anti-smoking education and tobacco-related research. Similarly, a number of other States (Maine, Mississippi, Minnesota, Maryland, Arkansas, Arizona, Massachusetts, etc.) levied increased tobacco tax through legislation to utilize the funds for effective tobacco control.

15. ***New Zealand***, in 1976, introduced a levy on alcohol produced or imported for sales in the country through its Alcohol Advisory Council Act, with annual tax revenue of USD 8 million. The funds have been used to reduce harm from alcohol use, mainly through education and research. The country further adopted the Smoke-free Environment Act in 1990, through consolidated revenue, initially to buy out tobacco sponsorship and later used for tobacco control, sun safety and injury prevention activities.

16. The ***Republic of Korea*** (ROK) adopted a National Health Promotion Act in 1995, to establish a National Health Promotion Fund (NHPF), using funds levied from tobacco products. The Ministry of Health and Welfare was mandated to collect 150 Won (approx. 0.15 US$) for every pack of 20 cigarettes in 2000. This was increased to 500 Won by the end of 2004. The fund, around 15 million Won (USD 1.5 million) collected annually, is used to promote health

[5] Western Australian Health Promotion Foundation (*Healthway*), Core Business (URL address: http:// www.healthway.wa.gov.au/)

[6] Victorian Health Promotion Foundation: An overview. *Internet Journal of Health Promotion,* 1998, URL: http://www. rhpeo.org/ijhp-articles/1998/9/index.htm

education and anti-smoking campaigns, and to limit advertisement of cigarettes and alcohol. The fund is managed by the Korea Institute for Health and Social Affairs (KISHA), affiliated to the Ministry of Health.[7]

17. ***Switzerland,*** through its 1996 Sickness Insurance Act has collected a certain proportion (SF 2.4 per annum) of insurance fund for every insured person to support health promotion activities, including tobacco control. The fund is managed by Health Promotion Switzerland. The total annual revenue collected is around USD 12 million.[8]

18. The Thai Health Promotion Foundation (ThaiHealth)[9] was established by the Royal Government of ***Thailand*** by virtue of the Thai Health Promotion Act of 2001. It is an autonomous State Agency functioning directly under the control of the Prime Minister. The main aim of ThaiHealth is to advocate, stimulate, support and provide funding to various organizations in the community for health promotion activities, with a view to reducing infirmity and premature deaths. The source of funding for ThaiHealth is a 2% tax imposed on tobacco products and alcohol (estimated annual revenue of over 1000 million Baht).

19. Similarly, in addition to many European countries like Austria, Estonia, Poland, and Iceland, countries in Asia such as New Zealand, Qatar and Malaysia have established health promotion foundations and funds. Details of the establishment and use of dedicated taxes for health can also be reviewed in the document entitled, "The Establishment and Use of Dedicated Taxes for Health", produced by the WHO Regional Office for the Western Pacific.[10] Legislation for establishment of a National Authority on Tobacco and Alcohol in Sri Lanka is being considered by Parliament.

Organization and Management

Taxation policy

20. There are a number of reasons for imposing tax on alcohol and tobacco products. Introduction of a dedicated tax began with the awareness of very high smoking prevalence with increasing trends and heavy burden of social and economic loss from tobacco-related diseases and conditions. According to a study in 2004 by the American Lung Association, 23% of high school students and 10% of middle school students in the USA smoke. The CDC-USA estimated that each pack of cigarettes sold in the United States cost the country US$ 7.0 in medical costs and loss in productivity.11

21. Various studies have shown that increasing taxes that substantially increase the retail price of these products (whether tobacco or alcohol) are effective means to reduce demand and accessibility. The greatest impact of such measures is the reduction in the use of tobacco and

[7] National Health Promotion Foundation, Republic of Korea (http://healthguide.kihasa.re.kr/ eng/)
[8] Health Promotion Switzerland: (http://www.gesundheitsfoerderung.ch/en)
[9] ThaiHealth, *The Birth of The ThaiHealth Fund*, Second Edition (2003) p21
[10] WHO WPRO, *The Establishment and Use of Dedicated Taxes for Health*, Manila (2004)
[11] American Lung Association, *State of Tobacco Control 2003 Fact Sheet*, http://www.lingsa.org

alcohol products among children, adolescents and people from low income groups. [12, 13] It was estimated that a 10% price increase reduces overall consumption by 4% in developed countries and 8% in developing countries.

22. As described earlier, many governments have introduced a progressive increase in taxation for tobacco and alcohol products. Only a few countries, a majority being from the developed world, have introduced earmarked or dedicated tax on tobacco and alcohol products, a portion of which is used for health promotion programmes to address health and social issues stemming from the use of such harmful products. Some have earmarked contributions from insurance funds or set aside a certain proportion from the general tax revenue. Governments have created various types of management bodies either within the government structure or outside as autonomous agencies to oversee the programmes.

Different models of management

23. *Health Promotion Foundation or Fund* (Model 1): For the last 20 years, a number of countries or states within a country have established various forms of "Health Promotion Foundation or Fund" as independent statutory bodies with autonomous management. Financial support for these institutions comes from a wide range of sources, including dedicated tax from alcohol and tobacco. A majority of them are financed by the "sin-tax". Originally, the main task was to fund the "buy-out" of tobacco and alcohol sponsorships and advertising, and later, covering a wide range of health promoting activities. An International Network of Health Promotion Foundations was established in 1999 to enhance the performance of such national health promotion foundations and support the establishment of new ones.

24. The general characteristics of these foundations are:

- The institution is primarily responsible for health promotion.
- It has been established through national/state legislation, which also prescribes a long-term and recurrent financial support.
- The institution is governed by an independent management board representing all levels of stakeholders. The Board and its Executive Director are responsible for the day-to-day management of the institution.
- The institution exercises a high-level of autonomous policy-making, decision-making, and fund allocation including the use of transparent and equitable allocation procedures.
- The institution is non-aligned with any political group and encourages support across the political spectrum.
- Its main focus of work is to promote health of the people from all walks of life, across many sectors and levels of society.
- The source of funds is from the dedicated tax collected from taxation of tobacco and alcohol and, in some cases, of gambling.

[12] World Bank, *Curbing the epidemic: Governments and the economics of tobacco control*, Development in Practice Series, 76.77 (1999)
[13] WHO, *Global Status Report: Alcohol Policy*, Geneva 2004, p57

25. Since all resources are from the national or state budget, the government would like to maintain its strong control on the use of these funds, including appointment of board members, and approving policies and controlling decisions. The legislative framework adopted by the highest level (either national or state parliament) also provides for government control.

26. There are a few examples of such foundations or funds in Asia and the Pacific Region, such as the Thai Health Promotion Foundation (ThaiHealth) and the Victorian Health Promotion Foundation (VicHealth). In Thailand, the Governing Board of the Thai Health Promotion Foundation consists of the Prime Minister as Chairperson and other members representing various sectoral ministries, political advocates, community organizations and public media. The governing board of the foundation etc. is directly linked to the National Parliament where the annual report is presented. The main advantages of an autonomous body are:

- Many foundations can carry out their work by commissioning specific health promotion projects or research activities, through a competitive, transparent funding mechanism. In 2005, ThaiHealth supported over 700 projects, one-third of which were on tobacco, alcohol and prevention of road traffic injuries. The other activities also covered strengthening community capacity and health promotion of specific populations.
- Since these foundations/funds are autonomous, they have more flexibility as compared to public bodies, especially in working in partnership with non-governmental and community-based organizations by enabling and empowering them to carry out health promotion activities and initiatives. They can operate independently of public organizations while supporting the government's priorities and directions in health promotion.
- With multi-stakeholder ownership, the work of the institutions receives support from all political fronts.
- Health promotion activities can be planned and implemented with a long-term vision and with annual budgeted plans due to the long-term commitment enshrined in the legislation, which is guaranteed.
- Being an independent body, it can implement many innovative programmes that could be risky or politically sensitive and possibly be controlled by commercial interests and are unlikely to be undertaken by any public agencies.
- The institution can operate openly, equitably, and with accountability without any bureaucratic constraints.

27. There are however, a few disadvantages. For example, it may not be possible to redirect funds being guaranteed through legislation to other health issues in times of national budgetary constraints or cutbacks. This could affect other health programmes. Another possible disadvantage is that the institution, being an autonomous body, could dissociate itself from the health and commerce ministries. Having appropriate government representation on the governing board could minimize the duplication of efforts and allow close links to generally enable national priorities being followed.

28. Organization as part of a Ministry (Model 2): Some country may prefer to set up a separate agency or unit or centre or an institute like the Health Promotion Development Centre (HPDC) in the Republic of Korea, which operates within the Korean Institute of Health and Social Affairs.

A new Sri Lanka Bill on National Authority on Tobacco and Alcohol[14] is also aimed at the prevention and control of the harmful use of tobacco and alcohol, with the establishment of a national authority formed under the President. The advantages of establishing a unit within a ministry or a separate government agency, with dedicated, delegated and autonomous authority, are:

- The Unit/Department/Institute/Centre/Authority can fully support and implement the national policies and priorities due to its closed relation and integration with other units/sections/departments within the ministry.
- It can directly influence the policy and programme directions, and also reduce duplication of efforts.
- The disadvantages of having such a unit within a ministry are:
- Having direct ministerial control could reduce its potential for independence and flexibility.
- There is a likelihood of implementing programmes and priorities based on political and other pressures rather than addressing actual needs. There could also be political influence in relation to decisions about grants and sponsorships.
- There could be competition from within the ministry for resources and internal pressure could redirect funds to other activities.
- Being a public agency, there could be some inflexibility to work, especially in relation to sponsorships and grants, which are related to the commercial milieu.

29. *Mixed Model* (Model 3): This is a hybrid of the above two models, taking the best elements. New Zealand has adopted this composite model through a contract between the Health Sponsorship Council and the Ministry of Health to deliver health outcomes. The Ministry determines the budget and health priorities for the Council to carry out. Funding is not tied to tobacco taxes although 75% of the budget is used for tobacco control.15

30. Management of funds: An appropriate management mechanism for collection of funds, adequate and sustainable financing for health promotion activities, including sponsorships, and the establishment of independent monitoring and evaluation are important managerial issues to be considered. While many health promotion funds or foundations are devoted almost totally to tobacco and alcohol control, some have expanded their span of work to cover school education, general public health awareness, sports and arts promotion.

31. India has recently adopted a new tax (surcharge on pan masala and certain specified tobacco products, to finance the National Rural Health Mission) as part of national budget for 2006-2007. This additional duty will be charged at prescribed specific rates on cigarettes, and at a rate equal to 10% of the aggregate of normal rates of excise duties payable on *pan masala* and other tobacco products. This surcharge does not include levies of bidis.[16]

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[14] *Draft Bill on National Authority on Tobacco and Alcohol*, The Gazette of the Democratic Socialist Republic of Sri Lanka, November 2005

[15] New Zealand Health Sponsorship Council (http://www.healthsponsorship.co.nz)

[16] New Excise for Budget 2006-2007 for India (http://indiabudget.nic.in) Note: India has launched a nation-wide public health initiative, called "National Rural Health Mission, 2005-2012", with the objective of promoting health of the poor

How should others do it?

32. The idea of introducing dedicated taxation for health promotion, including alcohol and tobacco control has always led to reactions and resistance. Powerful arguments, advocacy and lobbying are required to initiate appropriate legislation and implementation. It took Thailand and Malaysia, which legislated for dedicated taxation in 2001 and 2005 respectively, about 10 years of hard work to reach the final stage of processing.

Strategic steps and keys for success

- ***Policy advocacy*** : Need for initial development of concept paper or debate for policy, strategies and programmes, good policy climate;
- ***Evidence*** : vital for generating knowledge and facts for argument; be clear about how to use the funds;
- ***Prime movers and shakers*** : very knowledgeable, political affiliation, bipartisan support, networks at community levels, leadership, coalition partners;
- ***Lobbyists*** (coalition of partners involving opposition groups) : active campaigns; public interests,
- ***Public opinion*** : opinion surveys; politicians; market research; parliament; public debates;
- ***Publicity and awareness campaigns*** (mass doers) : press; radio; TV; newspapers; journals/periodicals; celebrities;
- ***Act and Counteract for opposition forces*** : Parliament; Public debates,
- ***Maintain and sustain high morale*** : dramatize; constant lobby;
- Need ***short time-frame*** for advocacy and legal action.

33. By 2030, it is estimated that one in six adults will die due to diseases caused by the use of tobacco or alcohol, amounting to 10 million people per year. Firm and speedy action is necessary for effective control of tobacco use, by introducing straightforward legislation and also by adopting healthy public policy.

Further reading

1. WHO, Framework Convention on Tobacco Control (FCTC), Geneva (2005)
2. ThaiHealth, The Birth of The ThaiHealth Fund, Second Edition (2003)
3. WHO, WPRO, The Establishment and Use of Dedicated Taxes for Health (2004)
4. WHO, Preventing Chronic Diseases: A vital investment, Geneva (2005), URL http://www.who.int/chp/ chronic-_disease_report/en/

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through wide use of effective interventions, health volunteers and upgraded health centers at remote places, and the details of NRHM can be accessed at http://mohfw.nic.in/national_rural_health_mission.htm.

Table: *List of Countries which use dedicated taxes collected from Tobacco and Alcohol Products, and Gambling, to be used for health promotion*[17]

No	Country (State)	Organization	Legislation	Funding Sources	Amount (USD)	Total Population	Purpose of Fund
1.	New Zealand	Alcohol Advisory Council	Alcohol Advisory Council Act, 1976	A levy on alcohol produced or imported	8.0 m	4 m	Reduce alcohol-related harm, mainly through education and research
		Health Sponsorship Council	Smokefree Environment Act, 1990	Consolidated revenue	4.5 m	- ditto -	Initially to buy out tobacco sponsorship, and later funding for tobacco control, sun safety and injury prevention
2.	Switzerland	Health Promotion Switzerland	Article 19 of Law of Sickness Insurance, 1996	Medical Insurance companies to contribute SF 2.40 per annum for every insured person	12 m	7 m	Focus on enpowerment, cooperation, health promotion policy and projects of Swiss cantons
3.	Australia (Victoria)	VicHealth	Tobacco Control Act, 1987	Consolidated revenue	16.2 m	4.6 m	Actively discourage the use of tobacco; health promotion and disease prevention
	Australia (Western A)	Healthway	Tobacco Control Act, 1990	Consolidated revenue	10.0 m	1.9 m	Actively discourage the use of tobacco; health promotion and disease prevention
	Australia (South A)	Depts of Human Services, Sports and Arts	Tobacco Products Regulation Act, 1997	Consolidated revenue	9.0 m	2.0 m	To promote the quality of life by creating healthy environments through sports, recreation, and arts settings, and to support health promotion, with a focus on tobacco

[17] Adapted from Appendix Tables of "The Establishment and Use of Dedicated Taxes for Health", WHO WPRO (2004)

No	Country (State)	Organization	Legislation	Funding Sources	Amount (USD)	Total Population	Purpose of Fund
	Australia (Capital)	Healthpact	Health Promotion Act, 1995	Consolidated revenue	1.4 m	300 000	Promotion of good health through sponsorship of sports, recreation, arts and cultural activities
4.	Austria	Austrian Health Promotion	Healthy Austria Health Promotion Act 1998	Consolidated revenue	7.9 m	8 m	Funding for maintaining, promoting and improving health
5.	Republic of Korea	National Health Promotion Fund	National Health Promotion Act, 1995	Tobacco tax (3% to NHP Fund, and 97% to Nat. Health Insurance)	8 m (NHPF)	4.25 m	To support health promotion activities, limit advertisements and to promote health education
6.	Finland	Government Agency	Act on the Measures for recreation of Tobacco Smoking Statute, 1976 (Amended 1999)	Tobacco tax, 0.45% per annum	-	5 m	Health promotion, including tobacco control
7.	Iceland	Tobacco Control Board	Tobacco Control Act, 1996	Tobacco tax (0.9%)	-	282 000	Tobacco control
8.	Poland	Council of Ministers	Tobacco Act, 1995 (amended 2003)	Tobacco tax (0.5%)	-	38 m	A programme outlining health, economic and social policies aimed at reducing tobacco use
9.	Astonia	Health Promotion Commission	Tobacco Act, 1994; Alcohol Tax 2000 & Health Insurance Tax 2002	Tobacco tax (35%) Alcohol (3.5%) Health Insurance Fund	-	1.4 m	Fund for Cultural Endowment as well as Health Promotion and Disease prevention
10.	Slovenia	Health Council	Restriction on the use of Tobacco Products, 2002	Tobacco tax	-	1.9 m	Public Health Initiatives against the harmful effects of tobacco products

No	Country (State)	Organization	Legislation	Funding Sources	Amount (USD)	Total Population	Purpose of Fund
11.	Thailand	Thai Health Promotion Foundation (ThaiHealth)	Health Promotion Foundation Act, 2001	Tobacco and alcohol tax 2% per annum	25m	64 m	Campaigns to reduce consumption of alcohol, tobacco and other harmful substances; health promotion projects and research
12.	Qatar	Ministry of Health (Model 2)	The Law of Tobacco Control, 2002	2% of overall Tobacco Sales Taxes	-	77 000	Health promotion
13.	USA (California)	California Tobacco Programme	California Revenue and Taxation Code, 1998	Tobacco tax	-	-	Tobacco-related school and community health education programmes and research
	USA (Arizona)	Health Department	Tobacco tax and Health Care Act	Tobacco tax (23 cents of every dollar)	-	-	Programmes for reduction of the use of tobacco, through public education, cessation and evaluation