UN INTERAGENCY TASK FORCE ON NCDs

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Strengthening taxes on unhealthy products in the Gulf States

A synthesis of six Gulf Cooperation Council country reports

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Table of contents

Executive summary

Background

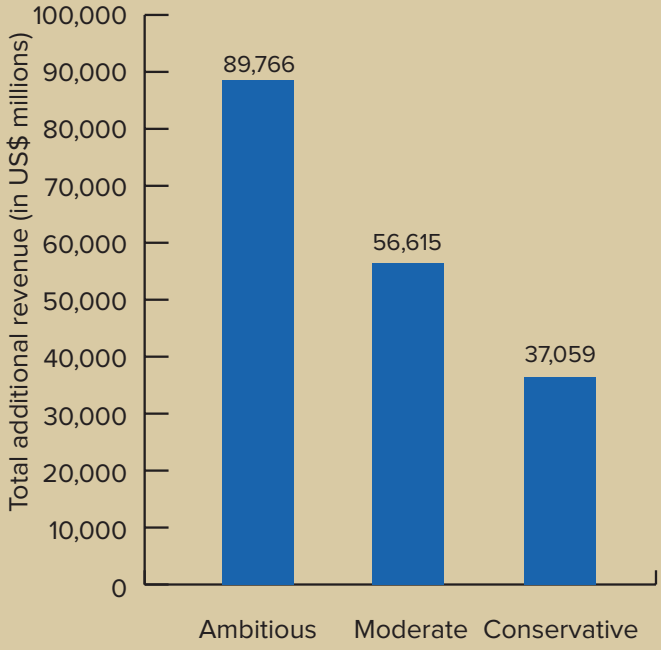
Strong, well-designed taxes on products harmful to health are among the most effective policy measures to save lives and avoid healthcare spending. By preventing death and disability, 'health taxes' contribute to a healthier, more productive workforce, that is a key part of a vibrant, growing economy. Beyond contributing to improved fiscal space by averting some NCD-related health spending, health taxes can represent a relatively stable and substantial source of tax revenue.

As part of a broader programme of support to Gulf Cooperation Council (GCC) countries to respond to the challenge of NCDs, the Gulf Health Council (GHC), the United Nations Development Programme (UNDP), the UN Inter-Agency Task Force on the Prevention and Control of NCDs (UNIATF), and the World Health Organization (WHO) cooperated to conduct economic forecasts of the additional government revenue to be gained from increasing taxes on tobacco, sugar-sweetened beverages and – where relevant – alcoholic beverages, in six GCC countries.

Key findings

The following highlights key findings under a moderate scenario increase in excise taxes that lead to consumer price increases of 20 percent on alcohol and SSBs, and 50 percent increases on cigarettes. Under a moderate scenario, for the period 2025-2029, increasing taxes on cigarettes, alcohol and sugar-sweetened beverages in six GCC countries would increase government tax revenue by an estimated US$90 billion under an ambitious scenario, US$57 billion under a moderate scenario, and US$37 billion under a conservative scenario.[1,2]

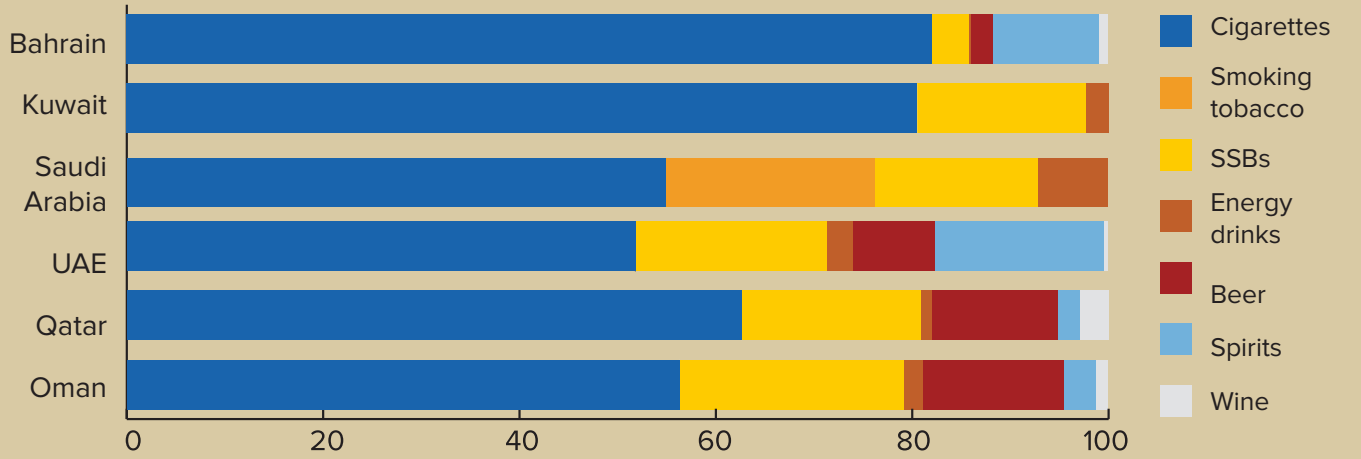
Projected additional tax revenue under three tax increase scenarios over 5-years (excise tax and VAT)



1 Assuming continuation of current trends in consumption throughout the time horizon of the analysis, adjusted for tax-induced decreases in consumption.

2 An ambitious scenario would entail tax increases resulting in consumer prices that are 50 percent higher on alcohol and SSBs, and 70 percent higher on cigarettes; a moderate scenario entails price increases of 20 and 50 percent; and a conservative scenario entails price increases of 10 and 30 percent on the same products, respectively.

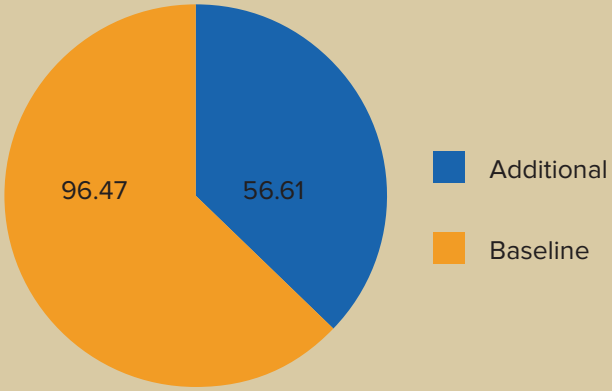
Of the products modelled, cigarettes represent the largest source of additional revenue at 65 percent of all revenue across the GCC countries, followed by SSBs at 16 percent, and energy drinks at 2.6 percent. In countries where alcohol consumption and sales are legal, beer represents the largest source of revenue at 9.6 percent, followed by spirits at 8.4 percent and wine at 1.4 percent.



For the first year of tax increases in 2025, additional government revenue would amount to between US$5.4 billion and US$14.1 billion, depending on the scenario. Additional revenue would range between 1.2 and 15.4 percent of all tax revenue for the region, and would be the equivalent of between 3.7 and 13.3 percent of total healthcare expenditures in the region.

Increasing taxes under a moderate scenario would result in US$57 billion in additional government revenue between 2025-2029. This represents an increase of 59 percent in comparison to baseline scenario.

Additional and baseline health tax revenue, 2025-2029 (in billions of US$)



Due to the increase in taxes, smokers across the six countries are expected to smoke on average 4 fewer cigarettes per day. Likewise, countries can expect a daily reduction in sugar consumption of about 3 grams per capita, and in the countries where alcohol is sold, an annual reduction in alcohol consumption of 2.3 litres of beer and 1.3 litres of wine and 1.5 litres of spirits per capita.*

*Above 15 years of age.

Conclusion and recommendations

Increasing taxes on unhealthy products has the potential to significantly increase government revenue in the GCC countries, supporting GCC countries' explicit goals of diversifying government revenue. Furthermore, health taxes would significantly reduce consumption of health-harming products, reducing the incidence of NCDs, improving population health and strengthening the resilience of health care systems in the GCC region. The six GCC countries can look towards the following to optimize their health-tax regimes:

Increase and restructure taxes on tobacco, alcohol and SSBs. Key reforms include:

- Introduce specific excise taxes on tobacco, alcohol and SSBs,[3] reviewing tax rates and product prices against income growth and raising taxes accordingly to prevent increasing affordability.
- Increase the overall total tax share of tobacco products to at least 75 percent, inclusive of an excise tax component of at least 70 percent of retail price.
- Ban or limit the utilization of direct and indirect price promotions, discounted sales, and reduce or ban duty-free sales.

Align health taxes with broader multisectoral efforts to prevent disease and promote healthy lifestyles.

GCC countries can integrate health taxes with initiatives, strategies and programmes on, for example, nutrition labeling and restrictions on beverages in kids meals and schools; restrictions on advertising, promotion and sponsorship of unhealthy products; educational programmes and awareness raising campaigns; improving access to screening, physician counseling and rehabilitation; fully implementing the WHO Framework Convention on Tobacco Control.

Reinvest tax revenue to support sustainable economic growth and improve population health.

Revenue from increased health taxes would become an additional source of funding for current universal healthcare system and health system reforms to scale up prevention and control of NCDs as well as help reduce the financial burden of out-of-pocket health expenditures. Further, transparency in how additional revenue will be spent is proven to increase public support for health taxes.

3 Designed differently based on product. See full recommendations and discussion in the report for more detail.

2. Introduction and overview

Approach

Strong, well-designed taxes on products that are harmful to health, or 'health taxes', are among the most effective policy measures to save lives and avoid healthcare spending. By preventing death and disability, health taxes contribute to a healthier, more productive workforce that is a key part of a vibrant, growing economy. Beyond contributing to improved fiscal space by averting some NCD-related health spending, health taxes can represent a relatively stable and substantial source of tax revenue. Indeed, the Addis Ababa Action Agenda on Financing for Development recognizes tobacco taxes as an important revenue stream for financing development [2]. Countries are realizing that the same logic applies to taxes on other health-harming products such as alcohol and sugar.

Appendix 3 of the WHO Global Action Plan for the Prevention and Control of NCDs contains a menu of cost-effective affordable policies and interventions to prevent and control NCDs [84]. Among the most highly cost-effective interventions listed are excise taxes on tobacco and alcohol, as well as taxation on SSBs as part of comprehensive fiscal policies to promote healthy diets. Indeed, taxation of unhealthy products has been proven time and again to be among the most cost-effective measures in improving population health while reducing healthcare expenditures and widening fiscal space to strengthen health systems. Therefore, the GHC initiated a project in cooperation with the UN to estimate the revenue impacts of different scenarios of health tax increases.

Tobacco, alcohol and sugar-sweetened beverages claim more than 27,000 lives in the Gulf region every year [3]. While health taxes hold great potential to reduce consumption of such health-harming products, they remain under-utilized in some jurisdictions and could be optimized to enhance resulting health and economic benefits. In 2016, the Gulf countries signed an excise tax agreement that included implementing and harmonizing excise taxes on health-harming products. However, not all countries have advanced in implementing these. The Gulf countries all stress in their national development and financing strategies the need for diversifying their fiscal revenue sources. Health taxes not only can serve as a tool in achieving diversification, but can support progress toward achieving the SDGs more broadly. As discussed above, health-taxes improve population health (SDG 3), and revenues can be reinvested into not only the health sector, but other basic services and productive sectors, contributing to SDG 11 (Sustainable Cities and Communities), as well SDG 8 (Decent Work and Economic Growth), for example.

This synthesis report compares findings across the six GCC country heath tax briefs – from present consumption and health burden of unhealthy products, through existing taxation measures, national fiscal contexts, to modeled interventions scenarios. The report presents conclusions and key recommendations, including nuances at the policy level.

Background

Since 2018, the Gulf Health Council (GHC), United Nations Development Programme (UNDP), the UN Inter-Agency Task Force on the Prevention and Control of NCDs (UNIATF), and the World Health Organization (WHO) have been cooperating with Ministries of Health (MOH) to strengthen the economic evidence base around population health, healthcare delivery and reform.

Tobacco, alcohol and sugar-sweetened beverages claim more than 27,000 lives in the Gulf region every year [3]. While health taxes hold great potential to reduce consumption of such health-harming products, they remain under-utilized in some jurisdictions and could be optimized to enhance resulting health and economic benefits.

The cooperation was initiated to address the rising incidence and prevalence of NCDs in the Gulf Cooperation Council (GCC) region, attributable to an increased life expectancy and lifestyle changes associated with increases in high-calorie and processed-food diets, reduction of physical activity and tobacco consumption along with specific environmental factors contributing to the rising NCD burden (UNDP and WHO, 2022). Addressing the health and economic burden of NCDs in GCC countries will require whole-of-government and whole-of-society approaches, as well as targeted investments to scale-up cost-effective clinical and population-based interventions, enhancing efficiency in the health sector and overall public sector fiscal sustainability.

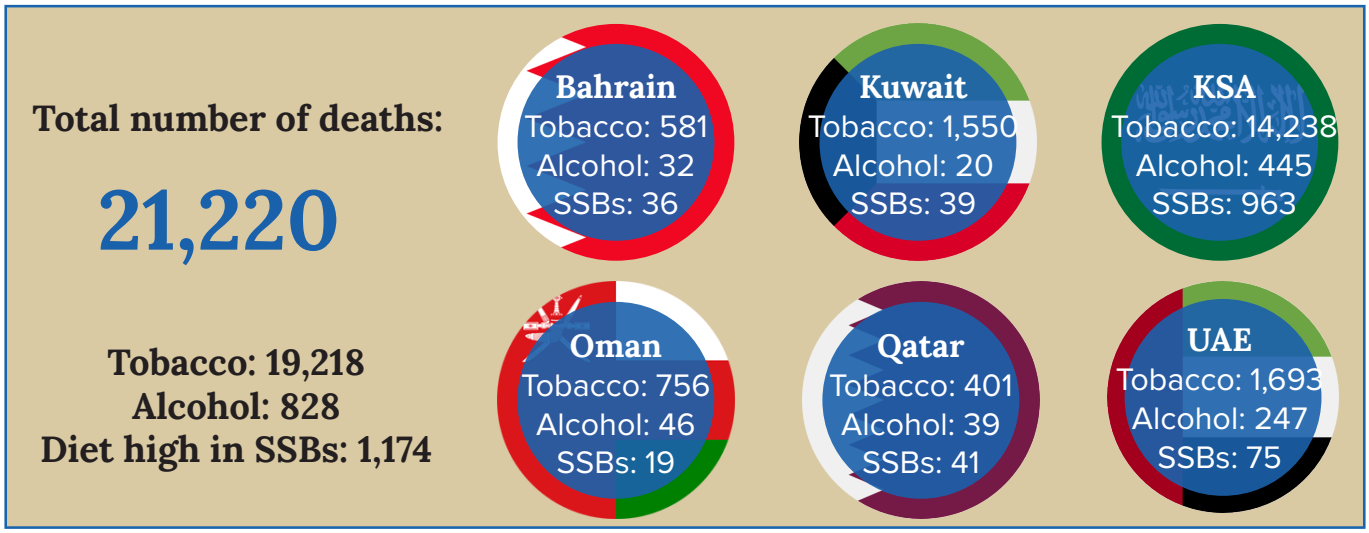
Under this collaboration, the GHC initiated and led – along with Ministries of Health and UN partners – the development of investment cases for the prevention and control of NCDs. Investment cases quantify the toll of poor health and its drivers—the impact on people's lives, the strains on the health sector and the ripple effects on the economy. The cases also measure the benefits that would come from targeted investments and policy change, identifying political barriers and opportunities for progress. Aggregate findings across the NCD investment cases indicate that nearly **43,000** people die in the GCC every year from the four major NCDs (cancer, cardiovascular diseases, diabetes and chronic respiratory diseases) causing **43 percent** of all deaths [1]. Further, the premature death, morbidity and disability associated with NCDs have a substantial negative impact on socioeconomic development, costing the GCC economies **US$50 billion** each year, equivalent to **3 percent** of their 2019 GDP [1].

The health and economic burden of NCDs is similar across the six GCC countries, accounting for between 41 and 65 percent of all deaths and ranging in economic losses between 2.7 to 3.9 percent of GDP [1]. Among the 28 WHO NCD best buy interventions – i.e. the most effective interventions to tackle NCDs – taxation of tobacco, alcohol and SSBs belong to measures with the highest cost-benefit ratio [1]. As a follow-up to the investment cases, government focal points at the Ministries of Health were interviewed to identify priority demands for further research and main barriers to scaling-up cost-effective measures to reducing the burden of NCDs. Exploring the potential of taxes on unhealthy products to improve public health was frequently cited as a key area of research.

3. Consumption and health burden of unhealthy products in GCC countries

Unhealthy diets, tobacco use and alcohol consumption are leading NCD risk factors, contributing to a very large health and economic burden in the GCC countries. According to the Global Burden of Disease study, consumption of the unhealthy products that were modelled under this study cause more than 21,000 deaths in GCC countries every year. To mitigate this growing burden, GCC countries have introduced several policies including an excise tax on goods harmful to human health. This section discusses consumption of the unhealthy products modelled under the health tax case, while the next section discusses GCC taxation of these products in more detail.

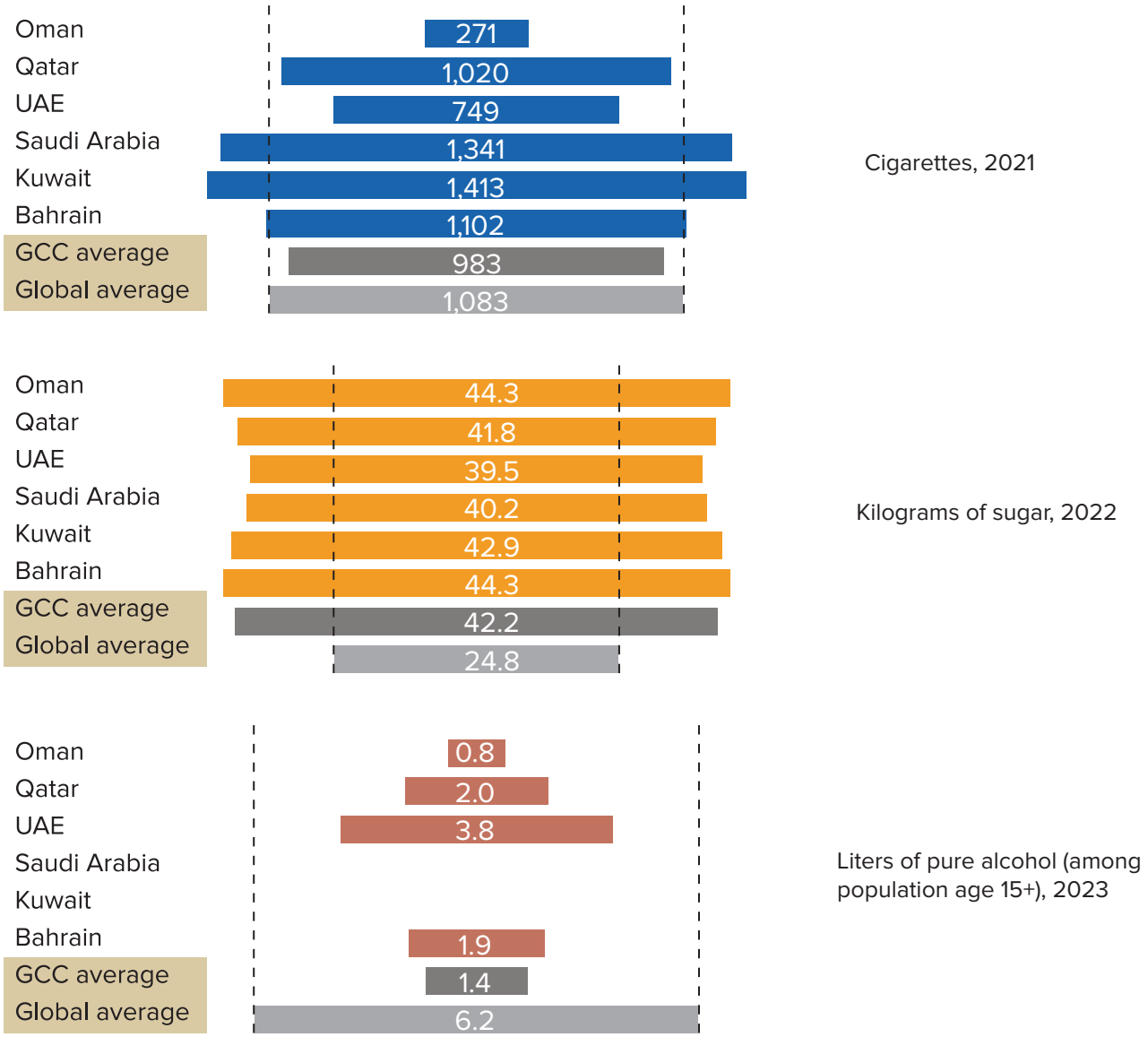
Fig. 1: Annual deaths causes by tobacco, alcohol and SSBs in the GCC region



Source: Global Burden of Disease Study [3]

Figure 2 provides an overview of consumption levels in the six GCC countries. Annual per capita cigarette consumption is higher than the global average in three of the GCC countries. Sugar consumption from SSBs in the GCC region averages 42kg per capita annually, far above the global average of around 25kg per capita per year. Diets high in free sugars are linked to a range of diseases and metabolic risk factors including impaired fasting glucose and obesity. Per capita alcohol consumption is quite low in the region when compared to the global average, with much of the alcohol consumed by tourists.

Fig. 2: Annual per capita consumption of unhealthy products in the GCC countries (years vary)



Sources: *For cigarettes:* Tobacco Atlas. Available at: https://tobaccoatlas.org/. *For sugar:* World Population Review. Available at: https://worldpopulationreview.com/country-rankings/sugar-consumption-by-country. *For alcohol:* World Health Organization, Global Health Observatory Data Repository. Available at: https://www.who.int/data/gho

Tobacco

Tobacco consumption is common across all six GCC countries, with more men consuming tobacco than women. The latest consumption rates range from 7.6 percent of adults reporting being current tobacco users in Oman [4] to 21 percent in Kuwait [5]. In the UAE and Saudi Arabia, men are around 7 times more likely to be current smokers than women (15.7 vs 2.4 percent and 28 vs 3.7 percent respectively) [6], [7].

Youth in the GCC countries are using tobacco at alarming rates. Notably the gender gap in tobacco consumption seems to be shrinking as girls are outpacing the consumption rates of previous generations of women. In Qatar, the latest GYTS showed that 12.1 percent of students use tobacco (15.7 percent of boys and 8.7 percent of girls) [8].

While cigarettes tend to be the most common form of tobacco used, shisha or waterpipe and medwakh usage is also common in the region. In the UAE, the majority of current smokers use manufactured cigarettes (70 percent), followed by shisha (9 percent), medwakh (6.6 percent), tobacco pipes (0.8 percent) [6]. In Bahrain, around one third of tobacco users smoke shisha (28 percent) with more than half of women smokers (54 percent) using shisha [9]. A 2021 study in Qatar reported that nearly half of tobacco users smoked waterpipe or medwakh (48 percent) [10].

The use of e-cigarettes is also a concern in the GCC countries. In Qatar, tobacco users use e-cigarettes and heated tobacco (11.3 and 3.0 percent of tobacco users respectively) [10]. Even those who do not use tobacco are not immune to its negative effects. In all countries, people of all ages are exposed to second-hand smoke which can lead to severe illness including heart disease and cancers. In Oman, around 18 percent of adults [4] and 11.9 percent of youth [11] are exposed to second-hand smoke at home. Outside of the home, individuals are also exposed. More than half (58 percent) of youth in Kuwait are exposed to second-hand smoke inside enclosed public places [12].

Sugar-sweetened beverages

Over-consumption of sugar is a main contributor of obesity, diabetes and tooth decay, with sugar-sweetened beverages (SSBs) being a leading source of excessive sugar consumption [13]. Throughout the GCC countries, consumption of SSBs is prevalent, along with prevalence of obesity and diabetes. According to the WHO Global Health Observatory, nearly one-third of the adult population across the region is living with obesity, ranging from 27 percent in Oman to 37.9 percent in Kuwait [14], which is between two to three times the global average of 13 percent [15]. In 2021, nearly a quarter of adults 20 to 79 years old were living with diabetes (11.3 percent in Bahrain to 25 percent in Kuwait), higher than the global average of 10.5 percent [16].

Examples of SSBs include but are not limited to: carbonated soft drinks; juices; flavoured milks; energy drinks; vitamin waters; sweetened teas; sweetened coffee drinks, fruit-flavoured drinks; and sports drinks[1] [17]. Consuming SSBs is common in the GCC countries, with some of the highest consumption rates globally. The mean intake in the Middle East/North Africa Region is higher than the global average [18] and SSBs appear to be a popular beverage choice among youth in the GCC countries, where in the UAE, SSBs are the most consumed beverage among children and adolescents [19]. In Oman, more than half of adolescents in schools drink at least one SSB per day [20].

Alcohol

Religious principles and cultural values across the six GCC countries are reflected in policies related to alcohol consumption as well as the existing tax rates on alcoholic beverages. Alcohol consumption is illegal in Kuwait and Saudi Arabia and there are restrictive policies to limit consumption in Oman, Bahrain, the UAE and Qatar. Alcohol consumption in the GCC countries is much lower than the global average. Annual alcohol consumption rates ranges from 0 in Kuwait to 3.9 liters of pure alcohol per capita in the UAE [21], well below the global average of 6.2 liters [22]. Nearly all respondents of the Oman 2017 STEPS Survey reported being lifetime abstainers

1 This is in accordance with the WHO definition which defines SSBs as “all types of beverages containing free sugars, and these include carbonated or non-carbonated soft drinks, fruit/vegetable juices and drinks, liquid and powder concentrates, flavoured water, energy and sports drinks, ready-to-drink tea, ready-to-drink coffee and flavoured milk drinks” [13].

from alcohol (97 percent) [4]. In the UAE, alcohol consumption is slightly more common with 2.5 percent of adults (ages 18-69) reporting being current drinkers (3.7 percent of men and 1.2 percent of women) [6].

Given the unique context in the region, there is limited information available on alcohol consumption in the population. Nevertheless, the health and societal consequences of harmful use of alcohol are a public health concern. Harmful use of alcohol can result in domestic violence, putting women at great risk for intimate partner violence [23], as well as road traffic injuries and fatalities [24]. A study analysing the misuse of alcohol and other substances when investigating emergency room activity from 2019 to 2020 in Qatar, shows that the greatest substance of abuse resulting in emergency room activity was alcohol, with 98 percent of these cases being substance abuse among men and 70 percent of this group being non-GCC nationals [25].

4. Taxation of unhealthy products in GCC countries

Tobacco

Prior to the introduction of other taxes on tobacco, the GCC countries levied only import duties on tobacco products. In 2016, however, the GCC agreed as part of the *Common Excise Agreement of the States of the GCC* to implement a unified ad-valorem excise tax of 100 percent on all tobacco products [26].[2] The KSA was the first to implement the ad-valorem tax on tobacco products in 2017, with Bahrain and the UAE following within the same year. In 2019, the agreed taxation was adopted by Qatar and Oman, with only Kuwait still to implement it.

All countries apply import duties on tobacco of 100 percent of cost, insurance and freight (CIF) value [27]–[31]. In addition, Oman and the UAE impose a VAT of 5 percent [32], [33], Bahrain of 10 percent and KSA of 15 percent [34], [35]. Kuwait does not currently impose VAT [36], and Qatar is expected to introduce VAT in 2024 [37].

While the total tax share in the final retail price of cigarettes is very close to the WHO recommended 75 percent in most GCC countries, the excise tax share remains substantially below the WHO recommended 70 percent of final retail price (see **Table 1**). When taken all together, by 2022, total tobacco excise taxes as a share of the final consumer retail price paid by consumers averaged 40.3 percent across the GCC.[3]

2 Applied on retail price excluding VAT and the excise tax itself.
3 Removing Kuwait with a 0 percent ad valorem excise tax rate from the calculation increases the average to 48.3 percent.

Table 1. Taxes as a percentage of retail price of the most sold brand of cigarettes in GCC countries, 2022

	Specific Excise	Ad Valorem Excise	Total Excise Tax	Value Added Tax/Sales Tax	Import Duties	Total Tax
Bahrain	0	47.62	47.62	4.76	17.39	73.38
Kuwait	0	0	0	0	24.02	24.02
Oman	0	48.78	48.78	4.76	12.50	66.04
Qatar	0	50.00	50.00	0	18.18	68.18
Saudi Arabia	0	46.51	46.51	13.04	14.29	73.84
United Arab Emirates	0	48.78	48.78	4.76	18.18	71.72
WHO best-practice level			**70**			**75**

Source: *WHO, 2023* [39]

Sugar-sweetened beverages

As part of the Common Excise Agreement of the States of the GCC, GCC countries collectively agreed to introduce ad valorem tax on sodas (defined as a drink with carbon dioxide, with or without sugar) of 50 percent as well as the tax on energy drinks of 100 percent [39]. The Kingdom of Saudi Arabia was the first nation to implement these measures (June 2017), followed by the UAE (October 2017), Bahrain (December 2017), Qatar (January 2019) and Oman (June 2019), with Kuwait still to implement the measure [39]. In addition, the same VAT standard rates apply on SSBs as on tobacco: 5 percent in Oman and UAE, 10 percent in Bahrain and 15 percent in KSA, with Qatar expected to introduce the VAT in 2024.

The criteria for the 50 percent "soda" tax have evolved differently for countries over the years, with some countries specifying that this applies to beverages with or without sugar. For example, in Qatar, the tax applies to "any aerated beverage except unflavored aerated water" meaning it is applicable to carbonated water with added sugar, other sweeteners, flavors, concentrates, powder, gel and or extracts which are used to make an aerated beverage [40]. In Bahrain, sugar-sweetened beverages, as well as sugar-free, diet and flavored sparkling waters with no sugar are subject to the tax [41]. In 2020, Oman expanded the scope of the excise tax to include sports drinks, fruit drinks, and barley drinks [42]. KSA also extended the scope of the tax to both carbonated and non-carbonated SSBs [43]. With different criteria to determine which drinks are taxable in each country, it is challenging to compare the health impacts of these taxes.

Alcohol

Considering the illegality of alcohol consumption in Saudi Arabia and Kuwait, this removes the necessity for taxation in these countries. Oman and Qatar levy an ad-valorem excise tax on all alcoholic beverages of 100 percent of the retail price (VAT and excise tax itself exclusive). Both countries also impose customs duties equal to 100 percent of the CIF on imported beverages. Oman applies in addition its standard VAT of 5 percent. Bahrain does not currently apply any excise tax on alcohol and applies only the import duty of 125 percent of the CIF and its standard VAT (10 percent). The UAE has the largest per capita consumption of alcoholic beverages within the GCC and imposes a number of different taxes on alcohol. First, the country imposes customs duties on alcohol of 50 percent of CIF. Depending on the port of entry, a logistics tax of 30 percent may be charged (imposed on the sum of CIF and customs duties). Furthermore, Abu Dhabi and Dubai apply a 30 percent municipal tax on off-trade sales (e.g., sales of alcohol in retail stores and supermarkets). However, in 2023, Dubai revoked this duty, with plans to reinstate it after a year. The overall excise tax rate levied in the country is estimated to be around 50 percent of the final retail price.[4] In addition, the standard 5 percent VAT is charged to sales of all alcoholic beverages.

5. Fiscal context

Prior to the COVID-19 pandemic, the six GCC countries saw an average annual GDP growth of 0.5-1.85 percent (2018-2019) compared to the OECD average of 1.7-2.4 percent [44]. In 2020, all six countries experienced a decline in annual GDP growth (from –3.4 percent in Oman to –8.9 percent in Kuwait), in line with the OECD average of –4.2 percent [44]. However, in 2021 and 2022 there has been a return to increases in GDP growth, from 1.3 percent in Kuwait in 2021 to 8.7 percent in Saudi Arabia in 2022 [44]. Additional tax revenue would help make strides in diversifying fiscal space. Moreover, excise taxes exhibit weaker reactions to fluctuations in GDP, and can serve as a stabilizer of public revenues in the face of economic shocks [45]–[48].

A high share of nominal GDP among GCC countries stems from the oil sector, from 19.2 percent in Bahrain to 44.9 percent in Kuwait in 2021 [49] with concomitant high levels of government revenue from the oil sector. At the high range, 75 percent of Bahrain and Oman's government revenue stemmed from the oil sector, with 42 percent of Qatar's revenue from the oil sector at the low range among GCC countries [49].

Four of the GCC countries can be counted among the top 25 fossil fuel subsidizers in the world, in terms of subsidies as a percent of GDP, with Saudi Arabia providing US$41 billion in subsidies in 2021, equivalent to 6 percent of its GDP, accompanied by UAE (US$17 billion, or 5 percent of GDP), Kuwait (US$8 billion, or 5 percent of GDP) and Qatar (US$6 billion, or 4 percent of GDP) [50].

The GCC countries have stated that diversification in government revenues is a priority [49]. However, building economic diversification through the development of sectors that are independent from hydrocarbons is both a short- and long-term challenge. However, in the past 15 years, GCC countries have increased their "ease of starting a business" ranking (as per the World Bank Ease of Doing Business Index), included economic diversification within their national vision plans, are aiming for better integration of the private sector into economic activities, have established support for small-

4 Tax rates in the UAE require confirmation from UAE officials in order to arrive at an exact percentage.

and medium-sized enterprises, and have looked to educational reforms to provide vocational skills in support of market needs [51].

Historically, the GCC has had low to no taxes. As a percentage of GDP, regional tax revenue is estimated to have doubled (to 5.2 percent of GDP) between 2016-2019 [52]. Although supportive of diversification efforts, tax revenue remains low across the region, from less than 2 percent of GDP in Kuwait to just under 8 percent in Oman, compared to a low and middle-income benchmark of 15 percent, and an OECD average of 34 percent [53], [54].

While government health expenditure varies across the GCC countries as share of GDP and as part of total health expenditure, all six countries see 8-11 percent of total government expenditure going towards health (see **Table 2** below). Moreover, health expenditures are expected to rise together with the increase in prevalence of NCDs in the region, necessitating the need for additional sustainable revenue sources. The fiscal incentives to exploring increasing taxes on health harming products lie then in generating sustainable revenue while benefitting population health, thereby avoiding future healthcare expenditures as well as economic losses due to death and disability caused by consumption of unhealthy products.

Table 2. Government health expenditure for GCC countries, 2020 [55]

	Bahrain	Kuwait	Oman	Qatar	Saudi Arabia	UAE
Government health expenditure as % of current health expenditure	63	90	90	79	70	61
Government health expenditure as % of GDP	3	6	5	3	4	3
Government health expenditure as % of general government expenditure	8	9	10	10	11	10

6. Methods

The approach used in the health tax briefs builds on previous efforts to quantify excise tax revenues in a static context and is outlined below [56]. Further details about the methodology such as the formulas and assumptions of the model can be requested from the authors and will be published soon.

1

Data collection and desk review

Extensive research is conducted to gather the data needed for the modeling, encompassing a broad spectrum of details about each country (detailed information is available in the country data request sheets, available upon request). Key data used in the model comprises recent and projected estimates of national GDP, population numbers, inflation rates, current healthcare spending, government tax revenues, and details on the consumption and sales of health-harming products. The desk review also identifies key information regarding regional collaboration, the policy and fiscal landscape, as well as country- and region-specific behavioral responses to tax changes, among others.

2

Estimate baseline consumption and the retail price

For each data input, data from at least two sources are used wherever possible. The data are triangulated to smooth potential data discrepancies. Depending on the data structure and availability, various methods are used to estimate baseline consumption levels.

The model constructs minimum, median, maximum, and geometric mean consumption levels for each product and forecasts baseline consumption for the modelled period. The calculation accounts for the future growth path of multiple input variables, including expected sales volume growth, expected growth in per capita consumption, population growth, consumer price index for each product and GDP growth.

The retail price of each product tends to be drawn from at least two different sources, to account for any variability. For cigarettes, the price of the most sold brand is used. For SSBs, due to the heterogeneity of the market and a lack of detailed market data for GCC countries, the model extrapolates prices for products based on a typical carbonated soft drink with 12g of sugar per 100ml. For alcoholic beverages, the model calculates the average retail prices of the most sold type of beer, spirit and wine.

3

Identifying the price on which the excise tax is applied

Employing the data gained on the current retail price and the current tax structure, which can vary across countries, the model extrapolates tax base, i.e. price on which the excise tax rate is applicable.

4

Identifying the price on which the excise tax is applied

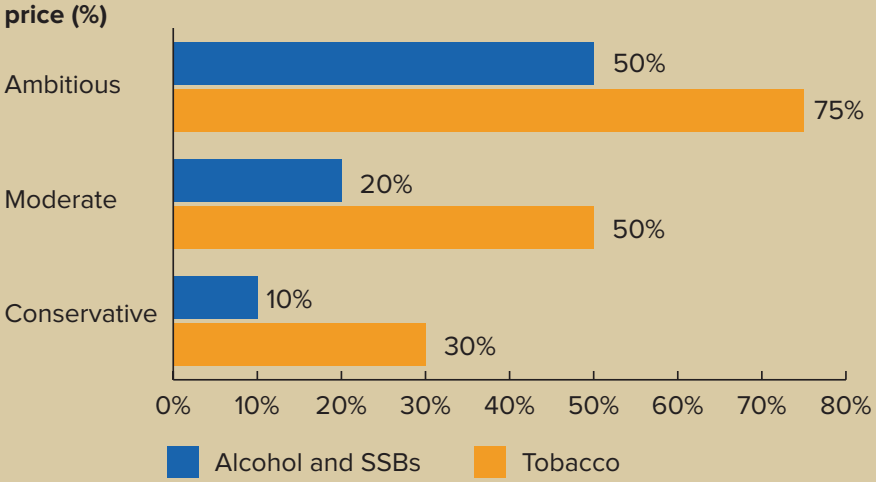
Using the median consumption level, the estimated base price and current applicable tax rates, baseline government tax revenue is estimated for the 5-year period (both excise tax and VAT revenue where applicable).

5

Identifying the price on which the excise tax is applied

Estimates of the expected additional tax revenues from increasing health taxes are based on tax increases calculated using maximum retail price increase constraints for three different scenarios: high, moderate, and conservative, as shown in **Figure 3** below.

Fig. 3: Ambitious, moderate and conservative scenarios, expected target increase in retail price (%)



The three scenarios were selected following the categorisation done by Davis et al. (2019) [56], and based on consultations with the GHC and GCC countries, as well as pilot modelling of different scenarios to ascertain final consumer prices. Within the briefs themselves, emphasis is drawn to results from the moderate scenario which strikes a balance between ambitious scaled-up action on health-harming products and political feasibility.

Table 3 indicates the baseline and alternative excise tax rates modelled in each country, under a moderate scenario. For countries in which alcoholic beverages are banned, no tax increases were modelled.

	Cigarettes/Tobacco		SSBs		Energy drinks		Alcoholic beverages	
	Baseline	Alternative	Baseline	Alternative	Baseline	Alternative	Baseline	Alternative
Oman	100	200	50	80	100	140	100	140
Qatar	100	200	50	80	100	140	100	140
UAE	100	200	50	80	100	140	50*	80
KSA	100	200	50	80	100	140	N/A	N/A
Kuwait	0	50	0	20	0	20	N/A	N/A
Bahrain	100	200	50	80	100	140	0	20

*The overall tax rate imposed on alcohol is estimated to be 50 percent of retail price, on average, in the country. This value remains to be confirmed by officials.

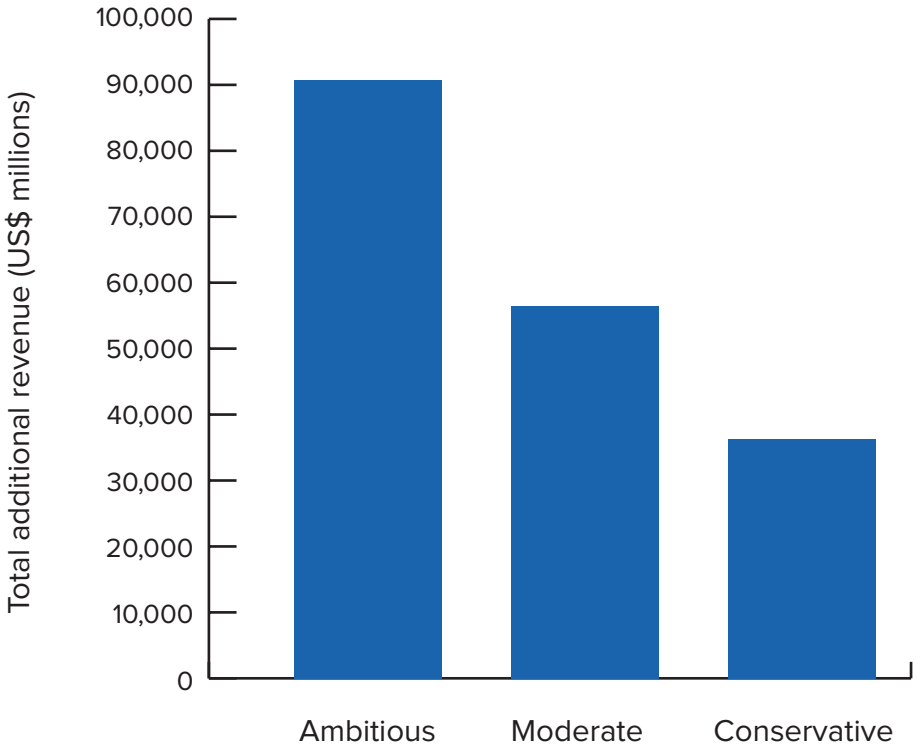
6 Estimate alternative consumption levels and alternative tax revenue from tax increases

The model uses price elasticity of demand to estimate changes in consumption. This reflects the expected change in consumption for a given change in price. The model employs national estimates of price elasticities where possible and otherwise, employs regional or country-level proxies from neighbouring or similar countries. The model calculates total and percent changes in consumption for all goods modelled, which is normalized as per-capita consumption. For SSBs, the model calculated both the decrease in litres of SSBs consumed as well as in grams of sugar. Using the new estimated level of consumption, i.e. units consumed, the alternative tax rates are applied on the base price, and alternative government tax revenue is calculated. Finally, the model assumes a full pass-through of the taxes to consumers.

7. Main findings

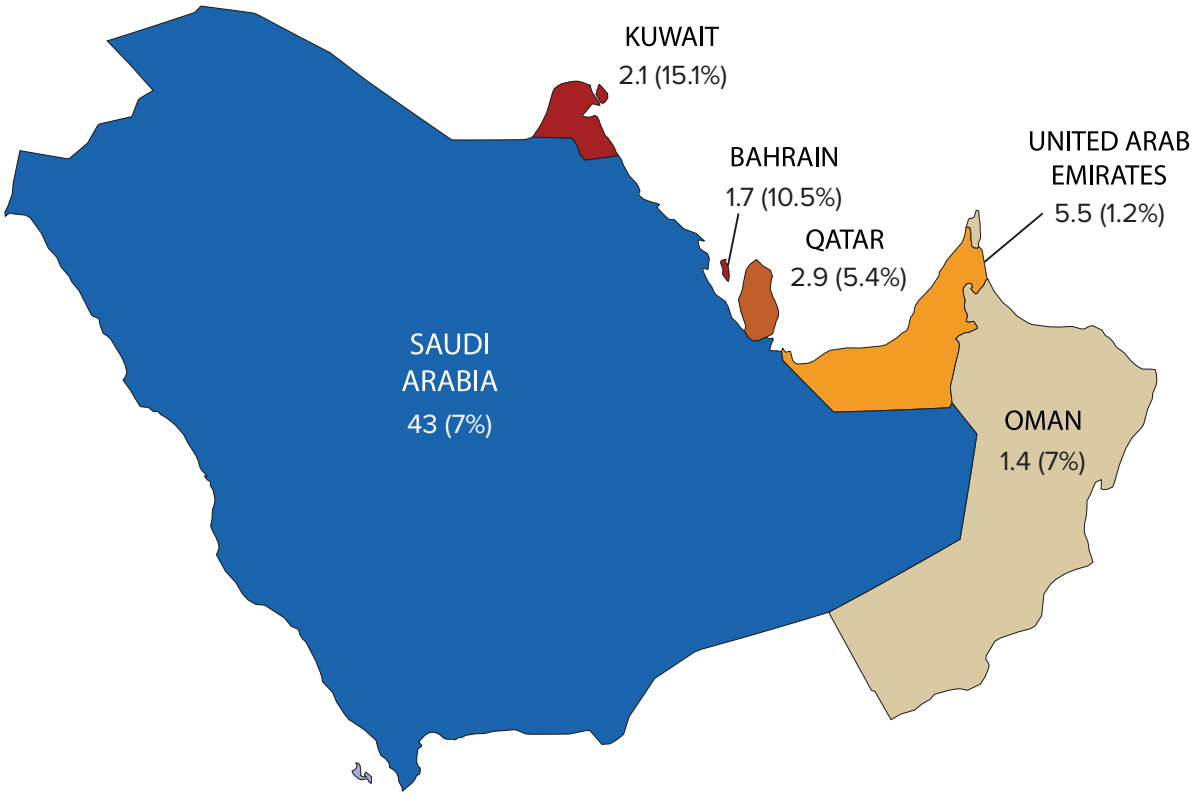
Figure 4 below illustrates the projected additional tax revenue over 5 years from 2025-2029, aggregated across all six GCC countries. As shown, the ambitious scenario would lead to around US$90 billion in additional government tax revenue. Projected additional tax revenue is substantially lower under the moderate scenario, where the model projects total additional government tax revenue of US$57 billion, and still lower under the conservative scenario at a projected US$37 billion of additional revenue.

Fig. 4: Projected additional tax revenue under three tax increase scenarios over 5-years



As illustrated in **Figure 5** below, the additional government revenue projected to be raised from increased tax rates on health-harming products over the five-year period ranges from US$1.4 billion in Oman to nearly US$43 billion in Saudi Arabia. The additional tax revenue expected to be gained represents an average of 7.7 percent of all projected total tax revenue in the region, ranging from 1.2 percent in the UAE to 15.1 percent in Kuwait.

Fig. 5: Projected additional tax revenue over 5 years, under the moderate scenario, absolute values (in US$ billions) and as a share of total projected tax revenue



On average, projected additional tax revenue is equivalent to 0.3% of forecasted GDP and 6.4% of forecasted health care costs

Table 4 compares the expected additional tax revenue from higher health taxes under a moderate tax increase scenario for a single year (2025) with current healthcare expenditures. Expected additional tax revenue would represent, on average, 6.5 percent of government healthcare expenditures, 43.7 percent of all out-of-pocket expenditures and 6.4 percent of total healthcare expenditures across the region.

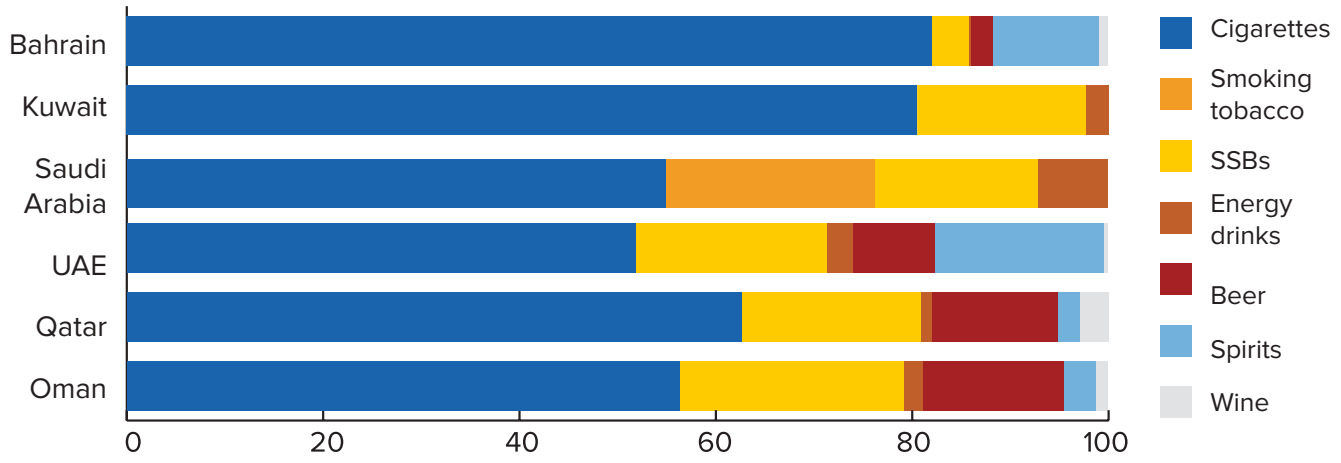
Table 4. Projected additional revenue as a percentage of healthcare spending, 2025

	Total current healthcare expenditures (in %)	Out-of-pocket healthcare expenditures (in %)	Government healthcare financing schemes (in %)
Oman	4.3	217.5	4.6
Qatar	3.5	20.7	4.5
UAE	4.4	52.6	11.7
Saudi Arabia	8.1	53.0	10.8
Kuwait	3.7	50.3	4.0
Bahrain	13.3	44.6	23.8
Average	6.2	73.11	9.9

Source for healthcare expenditures: *WHO global health expenditures database*. Available at: https://apps.who.int/nha/database/Selecst/Indicators/en

Of all products modelled, cigarettes contribute the majority of additional expected tax revenue, ranging from 51.8 percent in the UAE to 82 percent of additional revenue in Bahrain (see **Figure 6** below). SSBs constitute in all cases the second largest generator of revenue, ranging from 3.7 to 22.9 percent of revenue across all the products in Bahrain and Oman, respectively. The only exception is Saudi Arabia, where second largest sources of revenue would be generated by loose tobacco. Where alcohol was modeled, tax revenue to be expected from sales of spirits is notably higher in the UAE and Bahrain than other alcoholic beverages, while revenue from sales of beer ranks highest among the alcoholic drinks in Oman and Qatar.

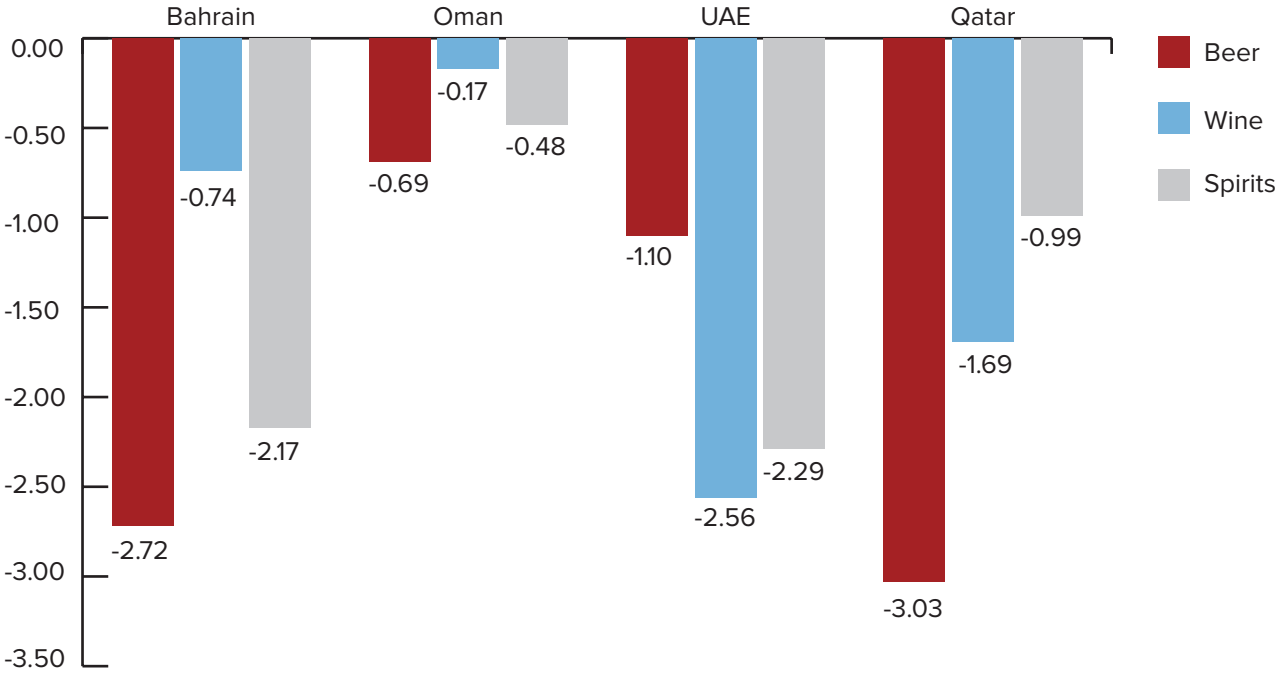
Fig. 6: Share of total expected additional government tax revenue, by product category



Increases in prices for each product will also lead to expected decreases in consumption for those products. Smokers across the six countries are expected to smoke on average 4 fewer cigarettes per day. Naturally, however, reductions will not be distributed evenly among the population, as some individuals will be more likely to quit or take up cessation, while others will be less likely to start consuming tobacco following price increases. A 2012 study by the US Centers for Disease Control and Prevention reviewing 116 studies found that a ten percent increase in price of tobacco products would reduce adult tobacco use prevalence by two percent, increase adult cessation by almost four percent, and reduce youth initiation by more than four percent [94]. This merely represents one of the most comprehensive meta-analyses, but more recent studies corroborate these findings as well. In addition, countries can expect a daily reduction in sugar consumption of about 3 grams per capita. This could bring GCC closer to reducing daily per capita consumption in line with WHO guidelines to reduce sugar consumption to less than 25 grams per day [57]. Revenue from loose-leaf (smoking tobacco) was only calculated for Saudi Arabia due to significant volumes consumed with respect to cigarettes and represents a substantial 22.2 percent of expected revenues in the country.

In addition, alcohol will be consumed less, with an average expected per capita[5] reduction in consumption over five years of 1.9 litres of beer and 1.3 liters of wine and 1.5 liters of spirits. Although data on alcohol consumption prevalence is not available, alcohol consumption prevalence is very likely substantially lower in GCC countries than the global average. Therefore, the average reduction in consumption per alcohol consumer will be significantly higher. **Figure 7** below illustrates the per-capita annual reduction of alcohol consumption across the six countries and types of alcoholic beverages.

Fig. 7: Reduction in consumption of alcoholic beverages, litres per capita



5 Above 15 years of age.

8. Discussion

Increasing taxes on tobacco, SSBs and alcoholic beverages has the potential to significantly increase government revenue in the GCC countries. Indeed, under the moderate scenario, increasing health taxes as modeled would result in additional tax revenue equivalent to between 1.2 percent in the UAE to 15.1 percent in Kuwait of all total government tax revenue from all sources, with an average of 6.7 percent across all six GCC countries. Increasing taxes on unhealthy products would therefore support GCC countries' explicit goals of diversifying government revenue. Oman, for instance, is targeting to increase the non-oil share of its economy from a current 61 percent of GDP to 91.6 percent of GDP in 2040 [58], while Saudi Arabia is striving to increase non-oil government revenue from SAR 163 billion to SAR 1 trillion by 2030 [59]. Increasing health taxes alone, as per this study, would raise additional revenue of SAR 155 billion by 2029.[6]

The model also projects tax revenue under a conservative and ambitious scenario. The conservative scenario would still result in additional government tax revenue equivalent to a substantial 2.5 percent of all government revenue in the region in 2025. Were the GCC to pursue a more ambitious scenario, the GCC would raise 6.7 percent of the average projected tax revenue for 2025.

Revenue from increased health taxes would help enable the creation of a less volatile source of funding for health system reforms to scale up prevention and control of NCDs, as well as help reduce the financial burden of OOP health expenditures. Further, GCC countries could use health tax revenues to invest in other sectors, diversifying their economies and promoting sustainable growth.

Despite erroneous arguments that health taxes are regressive, their reform actually reduces inequalities. This is principally attributable to the role of health taxes in reducing the incidence of NCDs, which disproportionately affect low-income groups. OOP expenditures on health represent a greater proportion of income for poorer households rendering them less able to afford quality care when it is needed most. Poorer households also are more likely to modify their behaviour in response to price changes as a result of increased health taxes and recent evidence confirms that health taxes bring net gains to lower-income households [60]–[65]. This pro-poor effect can be amplified by earmarking revenues from health taxes to programmes targeting lower-income groups.

More widely used tax instruments, such as VAT, actually do show a regressive character [66]–[68]. According to a study by the OECD, as VATs are mildly regressive in countries with broad-based VAT systems with few reduced rates or exemptions [69]. When VAT rates are reduced or eliminated for certain products, governments must ensure these measures do not amplify unhealthy behaviours.

A further important consideration is to reduce unintended consequences of taxes on unhealthy products, including the possibility of consumers substituting to other products. Well-designed taxes based on sugar and alcohol contents can avoid this pitfall, but substitution effects may be particularly harmful in the case of nicotine where other novel nicotine delivery systems (NNDS) such as vapes are rising in demand and displacing a substantial portion of cigarette and tobacco consumption. Governments should therefore ensure that taxes are increased uniformly across the whole spectrum of tobacco and nicotine delivery products, with a particular eye on NNDS,

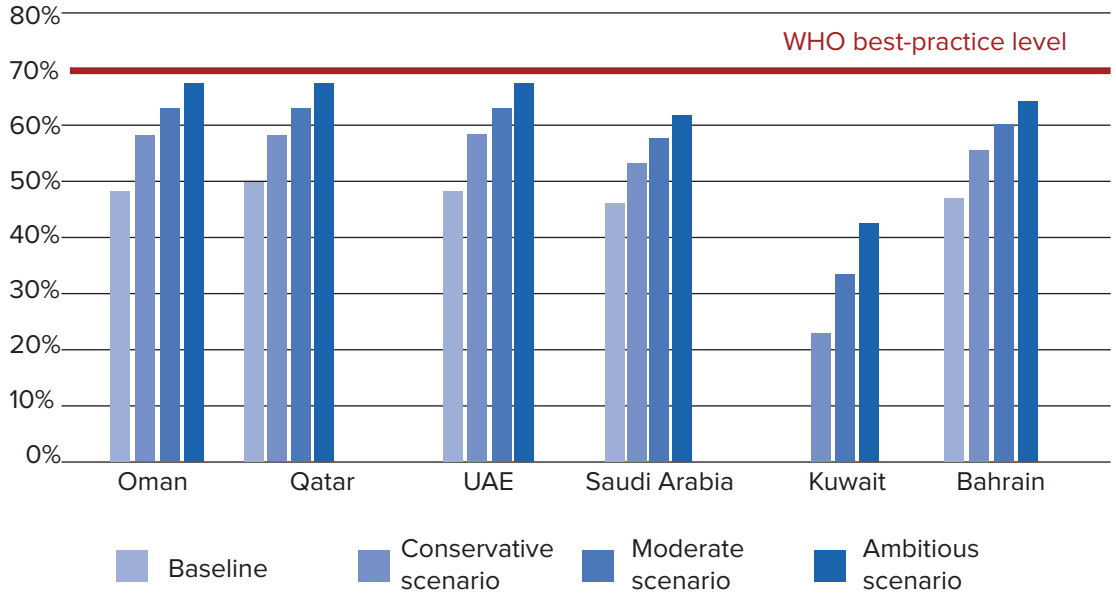
6 Includes additional revenue from excise tax and VAT.

ensuring effective high rates of taxation on all components of NNDS including devices, liquids, heat-sticks and on.

This report focuses on a moderate excise tax increase scenario, whereby consumers would face a 20 percent price increase for alcoholic and sugar-sweetened beverages, and a 50 percent increase for tobacco products. Higher rates for tobacco are justified based on the high prevalence of tobacco consumption, the large number of deaths caused by tobacco, and the legal obligations of GCC countries to implement Article 6 of the WHO FCTC around price and tax measures.

Though GCC countries are on average approaching the recommended 75 percent overall tax share of retail price, tobacco excise taxes in the GCC remain well below the WHO-recommended 70 percent of retail price [70]. In 2022, total tobacco excise taxes across the GCC averaged at 40.3 percent of the retail price of the most sold brand of cigarettes [38], placing the GCC 92nd globally in terms of tobacco excise tax rates. Even after the moderate scenario tax increases, none of the GCC countries would reach the 70 percent WHO recommended threshold as discussed and shown below. A more ambitious approach is therefore highly encouraged. Under the ambitious scenario, the total excise tax share of the retail price averaged across GCC countries would be 62.3 percent and nearly reaching 70 percent in Oman, Qatar, and the UAE, placing the GCC as a block 15th globally in terms of highest excise tax rates.[7]

Fig. 8: Share of excise tax expressed as percent of the final retail price of cigarettes under different modelling scenarios



While there are clear guidelines issued by the Parties to the WHO FCTC for taxation of tobacco, best practice recommendations exist for taxation of SSBs and alcoholic beverages. Using either specific excise taxes based on alcohol or sugar content, or mixed specific and ad-valorem excise tax regime with automatic mechanisms adjusting the specific rates for inflation and income growth to prevent increasing affordability is considered the best practice, depending on country context and its administrative capacities. While many of the GCC countries have already implemented high tax rates on both SSBs and alcohol, there is room to increase rates and improve the tax structure from a simple ad-valorem tax towards a specific excise tax based on sugar and alcohol content, respectively.

7 And 9th globally if excluding Kuwait from the calculated average.

Although tax increases do not have a history of garnering public support in the GCC region, increased transparency on tax policy and engagement with the public is suggested to increase public buy-in [71]. In Tbilisi, Georgia, where far more people use tobacco than in GCC countries, a 2014 survey on the partial tobacco-free policy found that 36 percent of respondents were in favour of increasing tobacco prices and taxes, and only 29 percent opposed the policy [72]. Findings from a systematic review by the University of Edinburgh revealed that earmarking revenue from health taxes for health spending such as improving health systems and obesity prevention interventions can help mobilize public and political support for taxes [73].

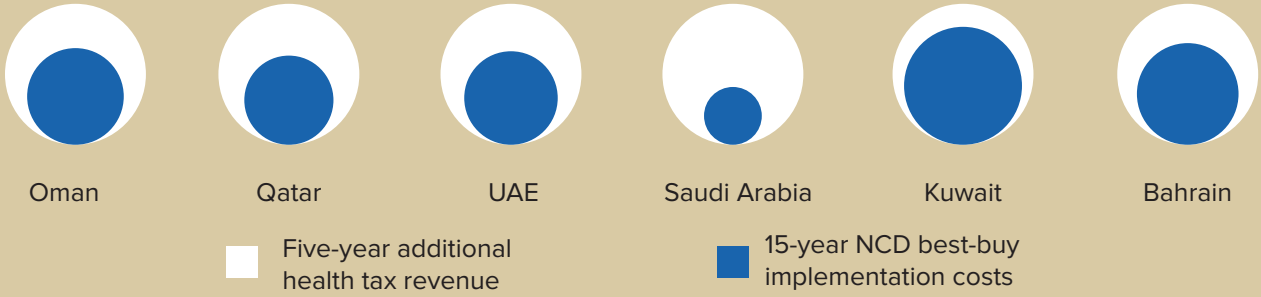
Indeed, reinvesting into the health sector more generally can advance population health while also supporting sustainable economic growth. Many countries have earmarked revenue from health taxes for health systems strengthening and/or the sustainable development goals. At least 35 countries earmark all or some of the revenue from tobacco taxes, 9 countries from alcohol taxes and 10 countries from other health harming goods (e.g. SSBs) [74]. Hungary and Portugal both impose excise taxes on SSBs and earmark the resulting revenue for their respective national health services [75]. The Philippines introduced soft earmarks on alcohol and tobacco to advance UHC in 2012 and expanded it to include SSBs in 2018. In 2019, the Government earmarked a 50 percent share of the Philippine Gaming Corporation and 40 percent of the Philippine Charity Sweepstakes Office for UHC. This resulted in the tripling of resources for health over a five-year period (2013-2018) in addition to advancing health and equity in the country [76].

Box 1. Implications for population health

The projected additional tax revenue generated under a moderate scenario in this study represents an opportunity to further improve population health by reinvesting the resulting revenue into the health sector. For example, as demonstrated in the synthesis report Scaling up Action on Non-communicable Diseases in the Cooperation Council for the Arab States of the Gulf [77], investing to scale-up highly cost-effective NCD prevention and control measures would save the region US$68.5 billion in economic losses (equivalent to 4 percent of the GCC's 2019 GDP) and more than 290,000 lives over 15 years.

Figure 9 compares the total costs to implement a package of WHO-recommended, cost-effective interventions, so-called "best-buys", to the total expected additional revenue resulting from a single year of increased tax rates on health-harming products under this study. It shows that the additional revenue to be gained over 5-years from increased health-taxes would cover the 15-year NCD best buy implementation costs ranging from US$666 million in Oman to US$7.2 billion in Saudi Arabia. Investing towards fully implementing the WHO-recommended best-buys in this way would save 1.5 million lives and US$50 billion in economic costs over 15-years.

Fig. 9: 15-year NCD best-buy implementation costs as share of 5-year additional health-tax revenue



Cross border harmonization

Cross-border tax coordination helps to ensure the effectiveness of health taxes by contributing to coordinating the prices and affordability of unhealthy products across neighbouring countries. Without such coordination, health taxes can be undermined through the import of lower-taxed products from neighbouring countries, tax avoidance, and cross-border smuggling. This may encourage consumption of unhealthy products purchased abroad, obstructing the goal of health taxes to reduce unhealthy consumption. If countries coordinate on cross-border tax regimes, there is less of an incentive to undercut tax rates, as countries have similar rates, and the efficacy of taxes is maximised [78].

Over the years, the GCC has demonstrated an increased commitment to ensure cross-border tax coordination. In the Gulf region, an agreement exists to address coordination of health taxes across borders – the Common Excise Tax Agreement of the States of the GCC of 2016 to adopt and impose excise taxes on goods that are deemed harmful to human health and the environment [79]. This decision embodied a first step away from a historical regime of only applying import duties on these products [80]. Although the GCC countries have levied new excise taxes as a regional bloc, each country levies different additional taxes on products, such as import duties and different rates of sales tax. Excise taxes on unhealthy goods are in place in most GCC countries and are set according to the GCC standard [81].

Box 2. Taxes and regulations on other health-harming products

A 2022 report submitted by the WHO Director General to the WHO executive board at its 150th session recommends fiscal and price policies “that emphasize the consumption of whole grains, legumes, nuts, vegetables and fruit and reduce the demand for products high in fats, sugars and salt/sodium” [82]. In line with this recommendation, some countries have imposed taxes on other health-harming products, based on different characterizations. For example, in 2014 Mexico enacted an 8 percent ad-valorem excise tax on foods considered “nonessential foods”, which were identified as those with more than 275 kcal per 100 grams. As a result of this , there was a decrease in the purchases of taxed foods in the first three years of implementation of the tax, particularly among lower socioeconomic households [83]. Similarly, Hungary enacted a Public Health Product Tax in 2011 which is applied to “ready-to-eat food and beverages with high salt, sugar or caffeine content, with rates varying depending on the product category”. Assessments of the tax found that following the introduction of the tax, purchases of processed food decreased, while purchases of unprocessed foods increased [83].

An additional fiscal approach to promote a healthy diet is to remove taxes, such as VAT, on healthy foods, namely fruits and vegetables. In July 2016, the Government of Tonga followed this approach by exempting the 15 percent VAT on fruit, vegetables, eggs, water and yogurt. Similarly, the Government of Fiji lifted the 10 percent excise duty on imported vegetables, resulting in a substantial increase in their import [83]. Countries are recommended to go even further by subsidizing these healthy foods to promote their consumption [85]. While not a fiscal policy, the 2023 Updated Appendix 3 of the WHO Global NCD Action Plan 2013-2030 includes the recommended cost-effective intervention to reformulate food and beverages to be healthier through the elimination of trans-fatty acids [84]. The REPLACE action package provides technical guidance for countries to implement this intervention [85].

9. Conclusion and recommendations

Increase and restructure taxes on tobacco, alcohol and SSBs. Key reforms include:

- Introduce specific excise taxes on tobacco, alcohol and SSBs, reviewing tax rates and product prices against income growth and raising taxes accordingly to prevent increasing affordability.
- Increase the overall total tax share of tobacco products to at least 75 percent, inclusive of an excise tax component of at least 70 percent of retail price.
- Ban or limit the utilization of direct and indirect price promotions, discounted sales, and reduce or ban duty-free sales.

Tobacco

While the GCC countries have made progress in increasing taxes on tobacco products in recent years, there remains scope to increase and restructure taxes to further reduce consumption and substitution. To do so, the GCC could:

- Introduce a uniform specific excise tax on tobacco products to raise tobacco product prices and reduce the likelihood of consumers switching to cheaper products;
- Increase the overall total tax share of tobacco products to at least 75 percent, inclusive of an excise tax component of at least 70 percent of retail price [70], [86];
- Review tax rates and product prices against income growth on a regular basis (e.g. annually) and raise taxes accordingly to prevent increasing affordability of tobacco;
- Phase-out import duties on tobacco products which are liable to be subject to removal under future free-trade agreements, and shift the composition of tobacco taxes towards excise taxes;
- Introduce legislation requiring a minimum specific tax floor and banning price discounts and promotions for tobacco products; and
- Reduce or ban duty-free sales of tobacco products to further decrease their affordability, reduce consumption and increase tobacco tax revenues.

Decision makers can look to the experiences of countries with high tax rates and high cigarette prices, such as Australia or New Zealand, where the prices of cigarettes are higher than in the Gulf region (in international dollars at purchasing power parity). Australia and New Zealand both have high, specific excise tax rates which represent 69 and 65 percent, respectively of the retail price of the most sold brand in each country. Combined with regular price increases to adjust for inflation, these specific excise taxes lead to high consumer prices for tobacco products in those countries.

Alcohol

Despite the relatively low consumption of alcoholic beverages in the region, increasing taxes on alcohol can help reduce consumption and the associated health consequences, while also bringing economic and fiscal benefits. Furthermore, unifying tax rates across jurisdictions, and where possible, between GCC countries can prevent cross-border trade.

Similar to the approach with tobacco taxes, GCC countries in which alcohol is sold can take important steps to restructure taxes to further reduce consumption and substitution. Alcohol tax reform in the region can follow best-practice guidelines such as those outlined in detail under recent guidelines on how to design excise taxes on alcoholic beverages [89] and more generally, for instance under the WHO-led technical initiative to provide support to Member States in reducing the harmful use of alcohol [88] :

- Consider introducing specific excise taxes on alcohol alongside the existing ad-valorem excise tax component, and regularly review rates to outpace income growth and inflation to prevent increased affordability;
- Create a structured domestic tax system for alcohol, supported by a robust enforcement mechanism that considers the alcoholic content of the beverage;
- Ban or limit the utilization of direct and indirect price promotions, discounted sales, below-cost sales, and fixed rates for unrestricted alcohol consumption or other forms of volume-based sales;
- Reduce or ban duty-free sales of alcohol to further decrease their affordability, reduce consumption and increase alcohol tax revenues.

SSBs and energy drinks

The GCC countries can increase and modify their tax structure on SSBs to improve population health and increase government revenue. They should consider introducing taxes on non-sugar sweetened beverages (e.g. artificial sweeteners based on health grounds), as well as all beverages containing free sugar (e.g. 100 percent fruit juices). Although not modeled, they should shift from an excise tax based on the price alone to using a specific tax structure that is based on sugar content that is applicable to all types of SSBs.

The tax should be based on total sugar content as in South Africa, or based on thresholds as in the United Kingdom, which uses a two-tier tax on SSBs, which charges GBP £0.24 per litre for drinks with over 8 grams of sugar per 100 ml and £0.18 per litre for drinks with 5 to 8 grams of sugar per 100 ml [89]. This would influence consumer choice, encouraging individuals and households to choose smaller portions and/or lower-sugar beverages, if they do not choose to switch to water or other non-SSBs. A tiered, specific tax structure, in addition, motivates manufacturers to lower the sugar content in their products, also known as reformulation, to qualify their product into a lower tax tier. Overall, it is important that GCC countries ensure that all beverages containing sugar are taxed.

Align health taxes with broader multisectoral efforts to prevent disease and promote healthy lifestyles

GCC countries can integrate health taxes with initiatives, strategies and programmes on, for example, nutrition labeling and restrictions on beverages in kids meals and schools; restrictions on advertising, promotion and sponsorship of unhealthy products; educational programmes and awareness raising campaigns; improving access to screening, physician counseling and rehabilitation; fully implementing the WHO Framework Convention on Tobacco Control. The cause and effects of tobacco, alcohol and SSB consumption are not limited to health alone. A whole-of-government and whole-of-society approach is required for effective action to reduce the consumption of tobacco, alcohol and SSBs, and their multifaceted harms. Non-health sectors require clear guidance on their roles and responsibilities in tax administration as well as in promoting population health more broadly.

Moreover, integrating health taxes into broader national strategies and initiatives including those on NCDs and nutrition would enable countries to advance their respective health goals. Indeed, health taxes should be considered as part of wider efforts to reduce consumption. Alongside increasing taxes on alcohol for instance, other measures should be considered to reduce alcohol harms such as strengthening restrictions on availability, advancing and enforcing drink driving counter measures, improving access to screening, brief interventions and treatment, and enforcing bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion [88]. Similarly for tobacco, fully implementing and enforcing the tobacco control demand reduction measures of the WHO FCTC require coordinated multisectoral efforts [90]. Regarding nutrition-targeted taxation (e.g. SSBs) nutrition labelling, ingredient lists, restrictions on beverages with kids meals, advertisement bans and educational programmes are examples of critical policies and interventions that can support the administration and health impact of taxation on unhealthy foods and beverages. Broader health sector efforts to prevent disease and promote nutrition and healthy lifestyles should also be considered.

Raising public awareness about the significant harms of tobacco, alcohol and SSBs is vital to reduce their consumption and to garner public support for health taxes and other measures. Efforts should include raising awareness of the harm to others caused by tobacco and alcohol, particularly among vulnerable groups, including women, girls and low-income individuals. Specifically, highlighting the health consequences of secondhand smoke from tobacco and underscoring the connection between alcohol consumption, road injuries, and gender-based violence is imperative. In addition, ensuring equitable access to effective cessation and rehabilitation programmes for addictions of all kinds, should remain a priority for all GCC countries. However, initiatives must ensure to avoid stigmatization and discourage discrimination against people who consume or are addicted to these products.

The GCC can also consider awareness efforts specifically aimed at government officials. This should include sensitizing ministries across government on how the consumption of health-harming products such as tobacco, alcohol and SSBs has broad-ranging impacts that affect their mandates, in addition to key actions they can take to reduce avoidable harms and losses.

The GCC countries would also benefit from strengthening action to protect public health policy from industry interference. Implementing codes of conduct and transparency measures, among others, such as those required to meet WHO FCTC Article 5.3 obligations, could serve as a foundation to protect policy makers from industry interference.

Efforts to raise awareness among all public officials of the need to avoid conflicts of interest are encouraged and can be undertaken in collaboration with civil society groups. Implementing a code of conduct prescribing expected standards for all public officials, service providers, contractors and consultants involved in setting or implementing policies, especially around tobacco and alcohol should be considered.

Reinvest tax revenue to support sustainable economic growth and improve population health

Revenue from increased health taxes would become an additional source of funding for achieving the SDGs, including SDG 3 by representing a source of financing for expanding universal healthcare, supporting health system reforms to scale up prevention and control of NCDs, and reducing the financial burden of OOP health expenditures. By being invested in productive sectors or other basic services, health tax revenues would support SDG 8 on Decent Work and Economic Growth, as well as SDG 11 on Sustainable Cities and Communities.. Further, transparency in how additional revenue will be spent is proven to increase public support for health taxes. Health taxes are an efficient way for governments to diversify financially, while promoting population health and supporting sustainable development.

To create longer-term sustainable financing frameworks, governments should look to incorporate health tax revenue into overall tax revenue plans. Complementary to this, GCC countries would be well-placed to conduct comprehensive reviews of subsidy regimes currently in place, as a first step to removing harmful subsidies, while advancing those that benefit human health, the environment and the economy. In addition, GCC countries can remove taxes, such as VAT, on health-promoting products, such as fruits and vegetables. Even further, GCC countries can subsidize healthy foods like fruits and vegetables to promote their consumption.

GCC countries may also invest part of the additional revenue into other sectors, for instance to support development of the agriculture sector, which would promote a healthy sustainable food system, as well as contribute to economic diversification through the production of nutritious foods.

GCC countries can also increase public support for higher health taxes by informing the public on how additional tax revenue will be spent. For example, the Philippines announced in advance how tax revenues would be earmarked towards expanding universal health coverage (UHC), thereby gaining overwhelming public support for the tax increases. Earmarking revenue from excise taxation for health systems strengthening and/or the SDGs has been implemented in many countries. While the Philippines earmarked excise tax revenues towards UHC, Egypt allocated tax revenue from tobacco products to health insurance schemes for students [91].

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