POLICY BRIEF

EMPOWERING WOMEN THROUGH HEALTH TAXES

A POWERFUL FISCAL TOOL FOR ACCELERATING JUST, EQUITABLE AND SUSTAINABLE DEVELOPMENT

MARCH 2025

Key points:

- Women experience differential negative impacts as a result of the use of sugar-sweetened beverage (SSB), alcohol, and tobacco products.
- Health taxes are a proven, evidence-based approach to reducing use of these products, mitigating harms on women while raising significant government revenue.
- Health taxes are underutilized, especially in low- and middle-income countries. There is significant scope to increase and strengthen health taxes as an enabler and accelerator of SDG 5 (gender equality) and beyond.
- Health taxes can be designed to bring significant benefits to poor people, including women.
- Compared with other tax types, health taxes are easier to administer and can raise significant revenues quickly, making them particularly well suited for countries with limited tax administration capacity and fiscal space.

1. Introduction

The world remains far from achieving gender equality. Only 15 percent of the 14 indicators for Sustainable Development Goal (SDG) 5 (achieve gender equality and empower all women and girls) are on track, and nearly a quarter of them are "far or very far off track".[1] 'The Global Gender Gap Report 2024' revealed that achieving full gender equality would take 134 years at the current pace of progress.[2]

The slow progress comes with high economic costs, in addition to the high social costs. The World Bank projects that the world is losing an estimated US$160 trillion in human capital wealth due to gender pay gaps,[3] a figure exceeding the world's total gross domestic product (GDP).[4]

On the other hand, McKinsey Global Institute estimated that advancing women's equality could add up to $28 trillion to the global economy annually.[5] Improving women's health alone is projected to inject over $1 trillion into the global economy and boost economic productivity by as much as $400 billion.[6]

As the 2030 deadline for the SDGs approaches, the world must adopt novel and effective strategies to accelerate women's empowerment and reduce gender disparities, as emphasized in the United Nations Development Programme (UNDP) Strategic Plan 2022-2025[7] and its HIV and Health Strategy.[8] These strategies will be crucial in mitigating economic losses and driving inclusive, equitable development as envisioned by the 2030 Agenda for Sustainable Development. One such novel strategy is the strategic utilization of health taxes.

2. Health taxes

2.1. Definition

Health taxes refer to a form of excise duties (i.e. taxes on specific goods or services)[9] levied on products harmful to health.[10] Examples of health-harming products include sugar-sweetened beverage (SSB), alcohol and tobacco products, ultra-processed foods, and foods high in certain ingredients, such as sugar, salt and fats.

Excise taxes are considered the most effective in reducing the consumption of health-harming products. This is primarily because excise taxes are levied specifically on these products and can be increased easily.[11] A more comprehensive definition of health taxes may also include

taxes on a wide range of goods, such as fossil fuels (and also the removal of fossil fuel subsidies) due to their adverse health impacts through air pollution.[12]

2.2. Benefits of health taxes

Health taxes are often considered a 'triple win' for governments. This is because health taxes: (1) improve public health; (2) potentially reduce long-term health care costs; and (3) generate revenue.[13] Health taxes also reduce the economic costs, such as lost productivity.[14] This policy brief proposes an additional win, which is to advance women's empowerment.

Over the past decade, a growing number of countries have introduced, increased or expanded the use of health taxes, including among low- and middle-income countries (LMICs). The World Health Organization's (WHO) 'Health Taxes: Policies and Practice'[15] describes certain unique attributes of health taxes that help policymakers make a compelling argument to secure broader political and societal endorsement—a crucial factor for the adoption and execution of these fiscal measures.

First, health taxes, especially from a development perspective, bring a broad spectrum of individual and societal benefits. This fact helps understand the effects of health taxes on efficient resource allocation and distribute the political costs of implementing such taxes across various sectors and stakeholders.

Second, health taxes encounter fewer trade-offs than other public policies because they offer broad societal benefits while also generating revenue. This dual advantage helps minimize stakeholder conflict and enhances political acceptability.

Third, health taxes, while generating broad cross-sectoral benefits, require lesser coordination among different government sectors, making them an attractive and low-cost development policy instrument.

Moreover, health taxes are progressive and equity-enhancing, benefiting lower-income populations in particular, as described in 'Health Taxes in the Polycrisis Era' by the Center for Global Development[16] and highlighted in tobacco control investment cases by UNDP and the Secretariat of the WHO Framework Convention on Tobacco Control.[17] Health taxes, compared with other forms of taxation, also do not hinder economic growth due to their non-distortionary[a] nature on the supply side, and, in aggregate, they do not exert negative influences on labour markets or growth.[18]

Health taxes are attractive particularly for LMICs, as they are less complex to administer than other forms of taxation[b] and enable revenue generation relatively quickly.[19] The SSB, alcohol and tobacco markets are primarily dominated by a handful of producers, which manufacture products that are easily categorized and widely used.[20,c]

In other words, health taxes are particularly well suited to LMICs, which are often challenged by limited tax administration capacity and small income tax bases due to a large informal economy.[21]

Finally, as this brief will demonstrate, health taxes significantly benefit and empower women.

For the purposes of this brief, the term 'gender' is specifically used to refer to women. However, it is important to acknowledge that this term also encompasses men and individuals of other gender identities.[22]

2.3. Scope of health taxes in this brief

This policy brief focuses solely on the taxation of SSB, alcohol and tobacco products when referring to health taxes. The reasons are as follows.

First, these taxes have been proven to be cost-effective and feasible development measures. The WHO defines tobacco and alcohol excise taxes as 'best buys' for the prevention of non-communicable diseases (NCDs)—i.e. an average cost-effectiveness ratio of ≤ I$100 per Disability-Adjusted Life Year (DALY) averted in LMICs, which means that you gain a year of healthy life for less than US$100 PPP (**Box 1**) — and SSB taxes as a 'good buy' (i.e. > I$100 per DALY averted in LMICs).[23]

Second, research and evidence on the impacts of excise taxes on other health-harming products such as salt and fat, particularly their gender impacts, are currently limited.

Third, although not a direct reason, Adam Smith, known as the father of economics, argued that "[S]ugar, rum, and tobacco are commodities which are nowhere necessaries of life, which are become objects of almost universal consumption, and which are therefore extremely proper subjects of taxation."[24] Their historical trajectory as health taxes thus involves the use of the term with a definition that resonates with most readers.

BOX 1.

Disability-Adjusted Life Years (DALYs)[25]

DALY is a metric used to measure the overall burden of disease. It combines two components:

(1) Years of Life Lost (YLL): This is the number of years lost due to premature death. If a person dies earlier than the average life expectancy, the difference is counted as YLL.

(2) Years Lived with Disability (YLD): This is the number of years lived with a disability, illness or injury, adjusted for the severity of the condition.

The formula for calculating DALY is **DALY = YLL + YLD**

a "A tax is called distortionary if the amount due from an agent depends on his[/her] actions. If an activity is subject to a distortionary tax, then by avoiding the activity the agent can avoid the tax, which distorts his[/her] incentive to engage in this activity." Source: Grochulski, Borys, 2009, 'Distortionary taxation for efficient redistribution', *Economic Quarterly*, Federal Reserve Bank of Richmond, vol. 95(Sum), https://www.richmondfed.org/-/media/RichmondFedOrg/publications/research/economic_quarterly/2009/summer/pdf/grochulski.pdf.

b However, this may depend on the design. If a country has a mixed tax structure for alcohol, for example, and the government must monitor alcohol volumes and prices, it may become complex.

c The International Monetary Fund (IMF) states that "[f]or developing countries, these excises can have special appeal as concentrated production and high import shares make administration relatively easy." Source: International Monetary Fund, 'G-20 Note on Alternative Options for Revenue Mobilization', IMF, Washington, DC, 2024, https://www.imf.org/external/np/g20/pdf/2024/062424.pdf.

In simple terms, DALY is a way to count both the years people lose because they die young and the years they live with poor health.

For example, if someone dies 20 years before the average life expectancy at birth, that is 20 YLL.

If someone lives for 10 years with a disability that makes their life only half as healthy as it could be, that is 5 YLD (10 years × 0.5).

Therefore, if a person dies 20 years early and has lived 10 years with a disability, DALY would be:

DALY = 20(YLL) + 5(YLD) = 25

The WHO 'best buy' example above (≤ I$100/DALY averted) means that a year of unhealthy life can be averted for every ≤ I$100 invested in the implementation and administration of tobacco and alcohol excise taxes.

3. Impact of SSB, alcohol and tobacco products on women

Leveraging fiscal policy to address the gender-differential impacts of health-harming products represents a powerful, yet underutilized, strategy to advance women's empowerment and promote equitable development.

Health taxes have profound gender implications. Health taxes not only generate substantial tax revenue for governments but also reduce the consumption of SSB, alcohol and tobacco products. Although women generally consume these products at lower rates than men, men's usage poses risks of adverse impacts for women.

Women, for example, are disproportionately affected by second-hand smoke, alcohol-induced intimate partner violence, and the burden of caretaking for family members with diseases related to SSB, alcohol or tobacco product use, as described later in this brief. Thus, introducing, increasing or expanding health taxes offers numerous benefits for women.

By mitigating the health, economic and development burdens these products impose on women (and also men), health taxes present a promising strategy to address the gendered dimensions of the NCD epidemic.

NCDs, including cardiovascular diseases, cancer, diabetes and chronic respiratory diseases, kill 41 million people every year, accounting for 74 percent of global deaths.[26] The proportion of premature deaths (i.e. death before age 70 that could potentially be avoided)[27] due to NCDs among women increased from 44 percent in 1999 to 61 percent in 2019.[28] LMICs account for 77 percent of all NCD deaths and 86 percent of premature deaths.[29]

While men experience a higher overall mortality rate from NCDs,[30] this brief focuses on the differential impact on women, as women often face systemic barriers. Understanding the diverse ways in which these products impact development outcomes for women is crucial for effective policymaking.

The following sections illustrate how SSB, alcohol and tobacco products impact women.

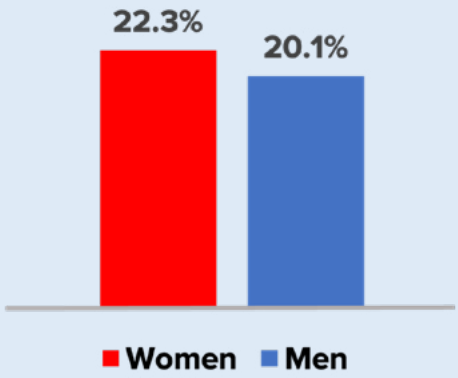
3.1. Sugar-sweetened beverage (SSB) products

In 2018, SSB product consumption was slightly higher among men, consuming on average 2.8 servings (one serving is 8 oz or 227 ml) a week compared to women's 2.6 servings. Still, both men and women are consuming more than half a litre of SSBs every week. Notably the overall average amount of SSBs consumed was much higher in Latin America and sub-Saharan Africa (7.8 servings and 6.6 servings, respectively). Women are consuming 1.5–2 litres of SSBs per week in these regions.[31]

Between 2000 and 2019, SSB product use among women increased by 22.3 percent, slightly higher than the corresponding figure for men of 20.1 percent. **(Figure 1)**.[32]

FIGURE 1.

Slightly higher rate of increase in SSB intake among women, 2000-2019



Source: The Lancet (2020)

Studies have also found that women SSB consumers presented higher risk of stroke compared with their male counterparts.[33,34] There is a robust body of scientific evidence indicating that reducing SSB product intake will decrease the prevalence of obesity and its associated health issues.[35]

3.1.1. SSB products and obesity among women

SSB product consumption leads to weight gain and obesity.[d] [36,37] Increased body weight and SSB product intake have been linked to the risks of related chronic health conditions such as type 2 diabetes, cardiovascular disease and cancer.[38,39,40]

Over 1 billion people are estimated to be living with obesity across the world.[41] The estimated global economic costs attributable to obesity are approximately $2 trillion per year, which represents around 2.8 percent of the world's GDP.[42]

A comprehensive meta-analysis examining nearly 300 studies encompassing over 2.6 million individuals found

d According to the WHO classification, a body mass index (BMI) value greater than or equal to 25 is considered overweight, while a BMI greater than or equal to 30 is defined as obesity. BMI is a widely used metric to classify overweight and obesity status in adult populations. It is calculated by dividing an individual's weight in kilogrammes by the square of their height in metres (kg/m^2). Source: World Health Organization, https://www.who.int/news-room/facts-in-pictures/detail/6-facts-on-obesity.

that women were 2.7 times more likely to develop obesity compared with men, regardless of age.[43] Furthermore, the data indicate that women with obesity were more than twice as likely to also suffer from hypertension and type 2 diabetes as women without obesity.[44]

Distinct from many other health risks, obesity prevalence is higher among adult women than men across nearly all countries and ages.[45,46] In 2022, there were roughly 504 million women (18.5 percent of the population) living with obesity, compared with 374 million men (14 percent).[47] The age-adjusted[e] obesity prevalence increased substantially across many countries between 1975 and 2022, rising by over 20 percentage points in 49 nations (25 percent) for women, compared with 24 countries (12 percent) for men.[48]

3.1.2. SSB taxation

These findings underscore the gender disparities in the burden of obesity and associated chronic health conditions, highlighting the critical need for gender-responsive policies and interventions to address this widening global challenge. In recent years, the implementation of SSB taxes has emerged as an increasingly prominent policy intervention to address the challenges posed by obesity and related NCDs.

This fiscal measure has drawn growing attention from policymakers as an effective tool for reducing SSB product intake and mitigating the substantial health, economic and societal costs, including the disproportionate burdens on women. Starting in 2016, the WHO began to include SSB taxation in its comprehensive menu of recommended interventions for addressing the growing NCD burden globally.[49]

At least 108 countries around the world implemented SSB excise taxes as of 2023.[50] The impacts of SSB taxes have been thoroughly investigated, with findings showing clear evidence of effectiveness in reducing SSB product purchase and sugar intake, incentivizing product reformulation with lower sugar content,[51] and facilitating positive behaviour change such as increased water consumption.[52]

Empirical evidence suggests that the implementation of SSB taxes is associated with a decline in the purchase and consumption of SSB products.[53] An estimated price elasticity of demandfor SSB products, a measure of how sensitive the quantity demanded of these products is to changes in their prices, ranges between -0.8 and -1.59 (i.e. a 10 percent increase in SSB price would decrease consumption by 8–15.9 percent), with LMICs being at the higher end.[54] This means the demand for SSB products is more price-sensitive (i.e. elastic) than for alcohol and tobacco products (See Sections 3.2.3 and 3.3.4). Studies also indicate that people with lower incomes are more sensitive to SSB product price increases than those with higher incomes.[55]

The WHO recommends that governments implement SSB taxes that increase retail prices by at least 20 percent to achieve observable results.[56] According to recent analysis in Indonesia, a 20 percent SSB price increase as a result of a tax increase would reduce SSB product demand by 17.5 percent.[57] Moreover, it would generate additional government revenue of about $239 million annually, equivalent to 0.2 percent of the country's total tax revenue in 2022.

Studies have been conducted to estimate how SSB taxes could reduce obesity and other health-related issues.[58,59,60,61,62] For example, analysis in the Philippines estimated that even a 13 percent SSB tax increase would avert nearly 6,000 deaths due to diabetes and over 18,000 deaths from cardiovascular diseases over 20 years, with an additional benefit of averting approximately 14,000 cases of catastrophic[f] health expenditure.[63]

SSB taxes appear to offer greater health benefits for women in certain areas, although conflicting findings also exist.[64] A study examining the health impact of SSB taxes on adolescents in three US cities found reductions in a body mass index (BMI), with a more significant effect observed among women.[65] Research in South Africa projected that a 20 percent SSB tax would avert more cases of type 2 diabetes among women (106,000 cases) than men (54,000 cases) after 20 years.[66]

The greater tax impact on women appears to be primarily attributable to women's higher mean BMI compared to men.[67] A study in Brazil observed similar findings.[68] Women and the low-income population, in which women tend to be disproportionately represented,[69] are likely to benefit the most from increased SSB taxes.[70,71,72,73,74]

3.2. Alcohol products

Worldwide, there are nearly 900 million women current[g] alcohol drinkers,[75,76,77] amounting to approximately 30 percent[h] of the population of women aged 20 and above. Alcohol product consumption killed 600,000 women in 2019.[78]

A significantly higher proportion of men than women drink alcohol: 52.5 percent of men and 35.4 percent of women in 2019.[79] However, the gender gap is narrowing globally.[80] While alcohol product consumption has been declining in HICs,[81] it is on the rise in many LMICs,[82,83,84] including among women.[85,86,87]

The alcohol industry has been targeting women worldwide, particularly in LMICs,[88] by both "perpetuating and challenging gender stereotypes".[89] The industry's female-targeted marketing includes feminization of products (e.g. fruit beers, low calorie/low alcohol products, slimmer cans,

e An age-standardized/adjusted indicator is a way to compare a health condition in different groups of people while ensuring age differences do not affect the results. For example, if you are comparing two cities, one with more older people than the other, and you want to see which city has more people with diabetes, you need to account for the fact that more older people might have this condition. Age adjustment or 'age standardization' in technical terms helps make a fair comparison by imagining both cities have the same age distribution. This way, you can see if diabetes is truly more common in one city or if it is just because the first city has more older people. See: Pan American Health Organization, 'Standardization: A Classic Epidemiological Method for the Comparison of Rates', *Epidemiological Bulletin* 2002; 23 (3), September, https://www3.paho.org/english/sha/be_v23n3-standardization.htm.

f The WHO defines catastrophic health expenditures as "out-of-pocket payments greater than 40% of capacity to pay for health care. Capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs (food, housing and utilities)." Source: World Health Organization, 'Households with out-of-pocket payments greater than 40% of capacity to pay for health care (food, housing and utilities approach - developed by WHO/Europe)', WHO, n.d., https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4989.

g WHO defines current drinkers as "those who have consumed a drink containing alcohol in the last 12 months". Source: World Health Organization, https://www.who.int/data/gho/indicator-metadata-registry/imr-details/3680#:~:text=Definition%3A,in%20the%20last%2012%20months.

h Calculated based on data from the World Bank Gender Data Portal, https://genderdata.worldbank.org/en/topics/population.

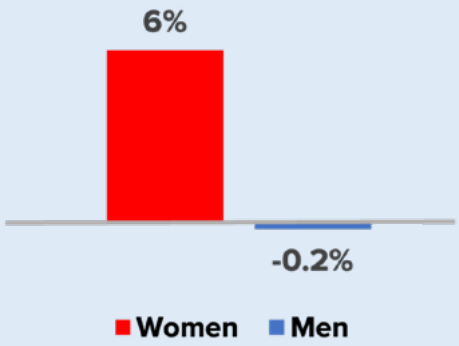
the pinking of products); offers of free feminine accessories with alcohol purchases (e.g. make-up); and gender-stereotyped messaging (e.g. slimness, all-female friendships, motherhood) combined with messages of empowerment and an impression of alcohol product use as a gender equalizer.[90,91,92,93]

Under these circumstances, in some countries, the proportion of drinkers among women has caught up to or even surpassed that among men, particularly among young women[94] and even girls.[95]

In the United States, for example, from 2000 to 2016, the proportion of women aged 18 and above who drink grew by 6 percent each year, in contrast to a 0.2 percent reduction for men **(Figure 2)**. The number of women who engage in binge drinking rose by 14 percent, while the rate of increase for men was 0.5 percent.[96] Also in the United States, female high-school and college students are more likely than male counterparts to drink alcohol and to binge drink.[97,98]

FIGURE 2.

Growth of 18+ women alcohol drinkers in the US beween 2000 and 2016 compared to men



Source: White (2020)

Statistics illustrate the adverse impacts of increasing alcohol product consumption on women. From 2009 to 2019 in the United States, for instance, the incidence of alcohol use disorder (AUD)[i] in women rose by 84 percent, more than twice the rate of increase in men (35 percent), although men had a much higher AUD prevalence (16.7 percent) than women (9 percent).[99] In 2020, AUD was found in 9 percent of women in general and 17 percent of young women aged 18–25 years.[100] Women with AUD are at a greater risk than their male counterparts for developing liver problems associated with alcohol, including cirrhosis and hepatitis, despite women typically drinking less alcohol and having a shorter history of use.[101]

Furthermore, the rate of alcohol-induced deaths is increasing more rapidly among women than among men. A US study found that between 2000 and 2016, the annual increase in alcohol-induced deaths was 3.1 percent for women, over twice as high as the rate for men (1.4 percent).[102] While women accounted for 23.7 percent of all alcohol-attributable deaths in 2000, the figure grew to 27.7 percent in 2016.[103] The National Institute on Alcohol Abuse and Alcoholism reported that from 1999 to 2017, the number of alcohol-related deaths among women in the United States increased by 85 percent, compared to 35 percent among men.[104]

Women are also vulnerable to greater harms from alcohol compared with men. Studies indicate that women are more susceptible than men to a range of alcohol-induced health conditions, with worse outcomes, even with lower alcohol intake.[105,106,107,108,109,110] They include liver injury, heart disease, memory blackouts, mental disorders and some cancers.

Women experience different physiological responses to alcohol consumption compared to men. Women have lower levels of certain enzymes responsible for metabolizing alcohol, resulting in a slower breakdown process.[111] The immediate intoxicating effects of alcohol typically manifest more rapidly and last longer in women than men.[112] Prolonged exposure to alcohol can increase the risk of organ damage.

Additionally, women have a lower percentage of body water than men, leading to a higher concentration of alcohol in their systems even when being the same weight.[113] Consequently, women generally experience higher blood alcohol concentrations than men after consuming the same amount of alcohol. The higher concentration can amplify the effects of alcohol and potentially increase its harmful impacts.[114]

3.2.1. Alcohol-induced violence against women

Violence against women is a leading cause of premature death in women worldwide.[115] The WHO estimates that nearly one in every three women worldwide has been the victim of violence.[116] Intimate partner violence (IPV) killed nearly 86,500 women in 2019.[117] IPV also increases women's risk of acquiring sexually transmitted infections, including HIV.[118,119,120] IPV was accountable for 11 percent of DALYs due to depression and 13.9 percent of DALYs due to HIV among women.[121]

Women who have experienced IPV further suffer from an increased risk of mental disorders. According to the WHO's 'World Mental Health Report', women with severe mental disorders are significantly more likely to have experienced domestic and sexual violence throughout their lives compared with other women.[122]

A recent study revealed that women who had experienced IPV were three times more likely to have attempted suicide in the past year compared with non-victimized women.[123] Furthermore, the risk of suicide attempts was seven times higher for women sexually assaulted by intimate partners.

António Guterres, the United Nations Secretary-General, calls violence against women "a horrific violation of human rights, a public health crisis, and a major obstacle to sustainable development".[124]

Alcohol products play a significant role in IPV. Alcohol use by male partners was estimated to increase violence against women by 2.6 times in a study of 23 LMICs.[125] The risk for women increased six-fold when their male partners had drinking problems.[126] Another study found an alarmingly high incidence of IPV within the last six months perpetrated

i AUD is defined as "a medical condition characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences". Source: National Institute on Alcohol Abuse and Alcoholism, https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-alcohol-use-disorder#:~:text=Alcohol%20use%20disorder%20(AUD)%20is,%2C%20occupational%2C%20or%20health%20consequences.

by male partners with AUD; 90 percent of them committed physical and psychological violence, and 76.7 percent committed sexual violence.[127]

Research indicates that alcoholic beverage use by women increases the likelihood of experiencing sexual intimate partner violence by 2.2 times.[128]

As the evidence illustrates, alcoholic beverages play a direct role in violence against women, with significant mental health impacts. Coupled with women's greater susceptibility to alcohol-related psychological distress,[129,130] alcohol product consumption exacerbates the disturbing gender inequity demonstrated by the fact that women are 50 percent more likely than men to suffer from depressive and anxiety disorders over the course of their lives.[131]

A chain of harms for women triggered by alcohol product use extends even further. Another negative impact of violence against women is increased financial risk due to divorce. A study estimates that married women experiencing partner violence had a 1.7–5.7 times greater likelihood of divorce compared with those without such experience.[132]

Many abused women are trapped: on the one hand, if they are financially dependent on the abusive partner and lack qualifications for entering the job market, they may have no choice but to stay in the relationship. On the other hand, even when they are able to leave the abusive relationship, financial challenges may perpetuate their suffering: divorce can bring women a significant decline in income[133] and assets[134] and increased poverty risk.[135]

3.2.2. Alcohol-attributable road traffic accidents and their impacts on women

Globally, road traffic accidents are a significant concern, with nearly 1.2 million fatalities each year.[136] Alcohol product consumption is one of the main factors contributing to road traffic accidents.[137] Alcohol product use is estimated to contribute to approximately 5–35 percent of road traffic fatalities globally, with a weighted average of 22 percent.[138] A multi-country study found that the risk of road traffic accidents is increased fivefold by alcohol product consumption.[139]

Although the vast majority of drunk drivers and individuals injured in road crashes are men,[140,141,142] women are affected differently by alcohol-related traffic accidents.

Women have a higher likelihood of sustaining injuries or fatalities compared with men in road crashes of equivalent or similar severity.[143] For example, when a woman is involved in a car crash, she is 47 percent more likely than a male counterpart to sustain serious injuries. Her likelihood of fatality is 17 percent higher than a male counterpart even after accounting for variables such as seatbelt usage and crash intensity. These discrepancies are attributable to vehicle designs and safety measures, which are tailored primarily to the male physique,[144,145] although recent design improvements have reduced the fatality gap.[146]

Furthermore, women frequently shoulder a disproportionate share of the consequences of traffic accidents.[147] Women often end up undertaking additional work and greater financial and other responsibilities after a crash, including caregiving duties. Their higher likelihood of financial dependence places many women, particularly from low-income households, at heightened risk of falling into poverty when a male family member, who may be the main income earner, passes away or becomes incapacitated due to a road traffic accident.

Low literacy levels and limited work experience hinder some women's ability to enrol in or claim insurance benefits and compensation they may be entitled to following a road traffic accident. Households affected or impoverished by road traffic accidents, many of which may be led by women, face significant challenges in their recovery.[148]

3.2.3. Alcohol taxation

A report by the WHO and UNDP, 'Action for health taxes from policy development to implementation: making the case for alcohol taxes', argues that "of all the health taxes now in common use, alcohol probably has the most untapped potential".[149]

The significant alcohol-related harms for women highlight the need for effective interventions to reduce alcohol product use and abuse. One evidence-based intervention is increasing alcohol excise taxes, which is considered one of the most cost-effective policy options, or a WHO 'best buy'. A systematic study on the relationship between alcohol tax/price and consumption with over 1,000 estimates from 112 studies concluded that alcohol tax and price increases effectively reduce overall alcoholic beverage consumption, with larger effects than other prevention measures.[150]

A meta-analysis on the price elasticity of alcohol demand in LMICs found an average elasticity of -0.64, suggesting that a 10 percent increase in price would reduce alcohol product consumption by 6.4 percent.[151] Increasing the price of alcoholic beverages through higher tax rates has been consistently shown to contribute to reductions in harmful outcomes associated with alcohol product consumption.[152]

A comprehensive review based on 50 studies estimated that a doubling of alcohol excise taxes could decrease fatalities from traffic crashes by 11 percent, sexually transmitted diseases by 6 percent, and violence by 2 percent.[153] These findings suggest the potential benefits for women (and men) that could be achieved through impactful fiscal interventions targeting the affordability of alcohol products.

However, unlike tobacco, there is currently no recommended level of alcohol tax rates, nor is there an international agreement for alcohol control. Furthermore, only 26 percent of the countries implementing alcohol excise taxation adjust their tax rates for inflation.[154] This limitation significantly undermines the potential of these taxes to effectively reduce alcohol affordability, consumption and related harms for women.

3.3. Tobacco products

An estimated 231 million women used tobacco products globally in 2020.[155] Tobacco product use killed 1.6 million women in 2021, accounting for 5.2 percent of all deaths among women.[156] Additionally, in the same year, nearly 700,000 women died due to second-hand smoke, which is more than men, representing 53.4 percent of all deaths due to second-hand smoke.[157]

In Viet Nam, where 47.1 percent of adult men but only 2.7 percent of women smoke,[158] tobacco-related causes account for over 6.5 percent of deaths among women.[159] A meta-analysis encompassing 55 studies revealed that women married to smokers faced a 27 percent higher risk of

developing lung cancer compared with women married to non-smokers.[160]

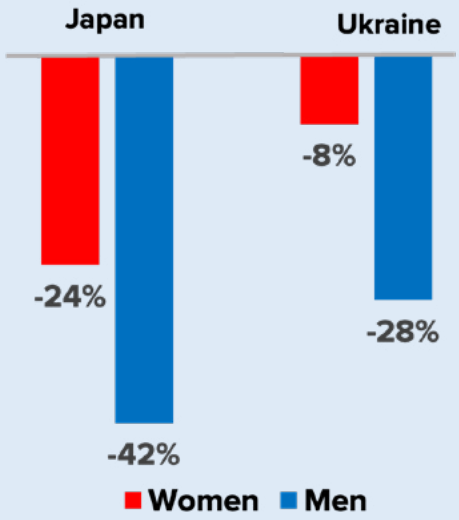
The number of tobacco product users and tobacco-attributable deaths is much larger among men than women. However, the rate of increase in deaths between 2010 and 2019 is higher for women than men for tobacco product use,[161] smokeless tobacco product use[162] and exposure to second-hand smoke.[163]

Additionally, tobacco control efforts may not be reaching women as effectively as men in certain regions. At the global level, women fared better in terms of the change in age-standardized smoking prevalence between 1990 and 2019, with a 38 percent decline compared with a 28 percent reduction among men.[164] However, a closer examination reveals that nearly 40 percent, or 76 countries, recorded a lower reduction rate for women than men.

For instance, during the same period, smoking prevalence in Japan declined by 42 percent among men, but by only 24 percent among women. Similarly, the corresponding rates in Ukraine were 28 percent for men and 8 percent for women **(Figure 3)**.

FIGURE 3.

Women's smoking prevalence decreased much less than men's in Japan and Ukraine, 1990-2019



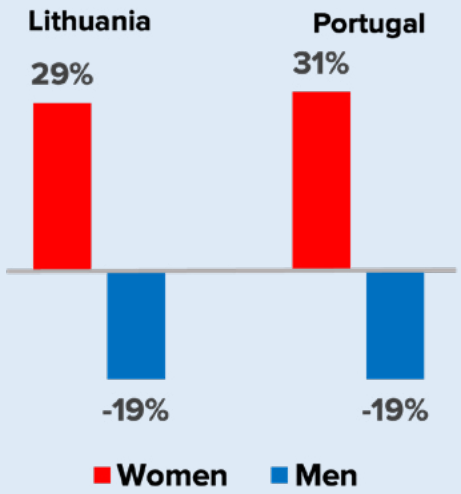
Source: Institute for Health Matrix and Evaluation (2023)

Furthermore, the prevalence of smoking among men aged 15 and older saw a significant drop in 135 countries (66 percent) between 1990 and 2019, while a similar significant decline among women occurred in just 68 countries (33 percent).[165]

During the same period, 21 countries even saw an increase in women's smoking prevalence, while the corresponding men's rates in these countries declined. In Lithuania and Portugal, for instance, although the smoking prevalence among men dropped by 19 percent, it increased by nearly 29 percent and 31 percent, respectively, among women **(Figure 4)**.[166]

FIGURE 4.

Women's smoking prevalence increased while men's decreased in Lithuania and Portugal, 1990-2019



Source: Institute for Health Matrix and Evaluation (2023)

Over 100 million women currently use smokeless tobacco products globally.[167] In 2019, 83 percent of global deaths due to smokeless tobacco products occurred in South Asia.[168] In Bangladesh, the prevalence of smokeless tobacco use is higher among women than men (24.8 vs. 16.2 percent).[169] The same pattern is observed in countries such as Lao PDR (8.6 percent for women vs. 0.5 percent for men) and Cambodia (6.5 vs. 0.3 percent).[170]

The use of e-cigarette products is gaining in popularity worldwide, particularly among youth.[171] While e-cigarette use is generally higher among boys,[172] some countries present the reverse trend, such as England (10 percent for girls and 7 percent for boys in 2021)[173] and New Zealand (15 percent for girls and 11 percent for boys in 2022).[174]

Evidence shows that youth who have not previously used tobacco and begin using e-cigarette products may face an increased risk of eventually starting to smoke traditional cigarettes.[175,176] Also, some women concerned about stigma or health risks associated with cigarette smoking during pregnancy switch to e-cigarettes. However, many of these women end up using both tobacco cigarette and e-cigarette products concurrently throughout their pregnancy.[177]

Women and girls in LMICs have been identified as a promising market.[178] The tobacco industry has long marketed feminine brands, such as lipstick- and perfume-shaped packaging[179] and slim sticks with a smaller diameter, to target women, particularly young women, who perceive slim sticks as more attractive and less harmful.[180]

Targeted marketing by the tobacco industry is preying on women and girls by abusing their vulnerabilities and linking tobacco products with women's desires to advance, attractiveness, stress management and weight control.[181,182,183] Exploiting women's concern about weight, some tobacco companies even added appetite-suppressing substances to cigarettes in the past.[184] Predatory marketing may have contributed to sustained tobacco product use and

its stagnant reduction among women and girls in some countries.

3.3.1. Heightened health risks for women

Women face gender-specific risks from tobacco product use. Compared with men, women become addicted to tobacco products in a shorter period and experience greater difficulty in achieving tobacco cessation and abstinence.[185,186,187] The study authors attributed these heightened risks to women's different physiological responses to nicotine, restrained access to tobacco cessation support due to stigma attached to female smoking, and a tendency to use tobacco products to manage stress.[188]

Research also indicates that the health hazards of tobacco products may affect women disproportionately.[189,190,191] For example, a recent study estimated that women lose approximately 22 minutes of life for each cigarette smoked, which exceeds the 17-minute reduction estimated for men, although the study does not fully explain the reasons for this difference.[192]

Also, the risk of coronary heart disease is 25 percent higher for women smokers than men smokers, for the same level of tobacco product use.[193,194] Pre-menopausal women exposed to second-hand smoke are three times more likely to develop osteoporosis and 2.6 times more likely to sustain a non-spine fracture than non-smokers who are not exposed to such smoke.[195]

Tobacco products not only damage women's physical health but also adversely affect their mental well-being. Throughout their lives and across the world, women are more vulnerable to mental health conditions such as depression and anxiety disorders than men.[196,197,198,199] Tobacco product use and exposure to second-hand smoke, including emissions from e-cigarettes,[200] exacerbate women's already heightened mental health risks.[201]

In addition, women with existing mental health conditions are more likely to use tobacco products.[202] In other words, tobacco products can trigger a bi-directional and mutually reinforcing cascade of harm for women, although the causality (i.e. cause and effect) is not yet conclusive.[203,204]

3.3.2. Women's vulnerability in the tobacco sector

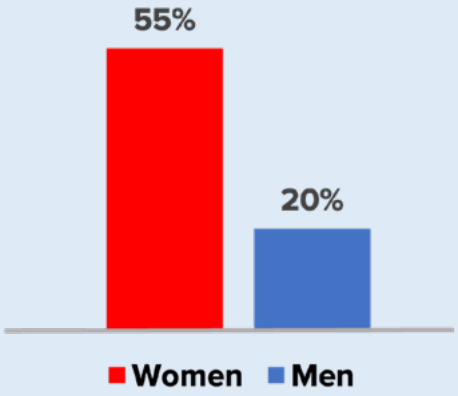
Women represent a substantial share of the labour force in the tobacco sector in many countries. In Indonesia, 66 percent of the workforce in the tobacco manufacturing sector are women, which represents the highest female proportion of all manufacturing industries in the country.[205] Women comprise 94 percent of workers in factories producing hand-rolled *Kretek*,[206] which are clove-flavored cigarettes unique to Indonesia.[207]

In India, over twice as many women as men work in the *bidi* (a small hand-rolled cigarette) industry.[208] In the region of Kushita, a major tobacco growing and processing area in Bangladesh, women constitute nearly 95 percent of the tobacco processing workforce.[209]

Women working in the tobacco industry are exposed to considerable health risks. Workers exposed to tobacco leaves are at risk of nicotine poisoning, commonly known as Green Tobacco Sickness (GTS).[210] Many studies found a significantly higher GTS prevalence among women.[211,212,213,214] In Brazil, for example, GTS was seen in 71.7 percent of women tobacco workers, compared with 35.3 percent of men workers.[215] In South Korea, the GTS prevalence in women was also more than double that of men (55 vs. 20 percent) **(Figure 5)**.[216]

FIGURE 5.

Higher GTS prevalence among women in South Korea



Source: Park et al. (2018)

A study in Malaysia[217] found significantly lower levels of personal protective equipment use among women tobacco farmers compared with male workers, including the use of facemasks, long boots and rubber gloves. The cultural convention that long boots are a masculine form of dress leads many women tobacco farmers to forgo this protective equipment. In addition to cultural factors making women susceptible to GTS, biological differences could also be at play. Research shows that women have a larger dermal area relative to their body volume compared to men, which could facilitate greater nicotine absorption.[218]

3.3.3. The hidden violence against women catalysed by tobacco product use

The harms inflicted on women by tobacco products extend far beyond physical and mental health. Tobacco product use is linked to violence against women—a link that is often overlooked. Research in Thailand revealed a 1.6-fold increased risk of domestic violence against women in families where tobacco products were used, compared with tobacco-free households.[219]

A study[220] found that women who smoke were over twice as likely to experience intimate partner violence compared to non-smokers. Evidence also illustrates a strong association between smoking and drinking, where non-alcohol users and non-binge drinkers have much lower rates of smoking.[221]

As mentioned above, women are disproportionately affected by second-hand smoke, which can be classified as a form of violence under the Philippines' Republic Act 9262 (Anti-Violence against Women Act 2004)[222] and Thailand's 2019 Promotion of Development and Protection of the Family Institution Act.[223,224]

An official from the Philippines' Department of Social Welfare and Development stated "[S]moking is the least explored among other forms of violence against women. Often,

domestic violence is attributed to excessive drinking or substance abuse, [and] smoking hardly comes up as a factor in cases of violence against women."[225]

Further, cigarette products, which are used predominantly by men, pose a significant financial burden on households. Research consistently demonstrates the crowding-out effect of tobacco product expenditure on essential household needs, such as health care, education, food, clothing and housing, which benefit all household members, including women and girls. [226,227,228,229,230]

For instance, a World Bank study found that in Indonesian households with a smoking father, tobacco products represented 22 percent of weekly per capita household expenditures.[231] This substantial allocation significantly reduced the budget available for food—a stark contrast to households where the father did not smoke.

Women generally prioritize allocating household income to family welfare.[232] This makes their male partners' tobacco spending particularly detrimental, negatively impacting women's well-being and restricting their control over family finances.[233] The situation can exacerbate existing intrahousehold gender inequality.

Furthermore, tobacco product use significantly contributes to long-term financial hardship for women. This may be attributable to the impoverishment of households following the premature death or illness-induced job loss of a smoker. Additionally, catastrophic health expenditures associated with tobacco-related diseases further strain household budgets. For example, tobacco-related expenditures were estimated to impoverish nearly 15 million people annually in India,[234] and pushed over 300,000 people into poverty in Viet Nam in 2018.[235]

Poverty plays a major role in the disempowerment of women and the persistence of gender inequality. Poverty is a significant contributor to inflicting harms on women and girls such as intimate partner violence,[236] forcing girls to marry,[237] human trafficking,[238] forced transactional sex,[239] female genital mutilation[240] and girl child school dropout.[241] Consequently, the financial strains, or 'financial violence', catalysed by tobacco product use are intricately linked to women's disempowerment.

3.3.4. Tobacco taxation

Increasing tobacco taxes can serve to mitigate the detrimental impacts of tobacco products on women's health, economic security and empowerment. The price elasticity of demand for tobacco products is estimated to be about -0.4 for high-income countries (HICs) and between -0.6 and -0.2 for LMICs.[242]

This means that a 10 percent increase in price would reduce consumption by 4 percent in HICs and by between 2 percent and 6 percent in LMICs. Reduced tobacco product consumption through higher taxes would mitigate some of the adverse impacts of tobacco product use on women described earlier.

Moreover, women smokers are more sensitive to tobacco price increases than men smokers[243,244] and would therefore directly benefit more than men from a tax hike. A US study found that women consumers were nearly twice as responsive to changes in cigarette taxes as their male counterparts.[245] Another study revealed that women-headed households responded to tobacco price changes nearly four times more than men-headed households.[246]

Studies consistently show that lower-income smokers are more responsive to price changes compared to high-income smokers.[247,248,249]

Consequently, a tax increase would lead to a more significant reduction in tobacco product consumption and greater health and other benefits among women, especially vulnerable groups, including those with low incomes.[250,251]

Notably, pregnant women who smoke are even more responsive to tobacco tax increases than women smokers overall.[252,253] A US study estimated that a 10 percent price increase would reduce smoking among pregnant women by 7 percent, which is three to four times higher than the corresponding figure for smoking adults.[254]

Furthermore, reduced cigarette product use and associated savings from household spending empower women. As most cigarette users are men, reduced household expenditure on these products effectively "enables an income transfer from male smokers to females".[255]

The impact of higher tobacco taxes on employment has been assessed to be minimal. A recent study in Lao PDR commissioned by UNDP found that cigarette production is typically manufacturing-intensive, meaning that reduced demand due to higher taxes is more likely to result in shorter shifts than job losses among tobacco sector workers.[256] Furthermore, many tobacco farmers cultivate various crops, making it unlikely that a reduction in tobacco demand would significantly threaten their livelihoods.[257]

Reduced purchasing of tobacco products due to higher tobacco taxes increases disposable income, which can be spent on other goods and services. Furthermore, increased tax revenue can expand fiscal space for greater public investments in other sectors of the economy. These pathways contribute to economic growth, new employment opportunities and economic diversification.[258,259,260]

In fact, some studies have found a net positive impact on employment resulting from tobacco tax increases.[261] In Indonesia, researchers estimated a net gain of over 84,000 jobs following a 30 percent tobacco tax increase.[262] A study from Viet Nam estimated a net gain of over 60,000 jobs as a result of a 20 percent increase in tobacco tax.[263]

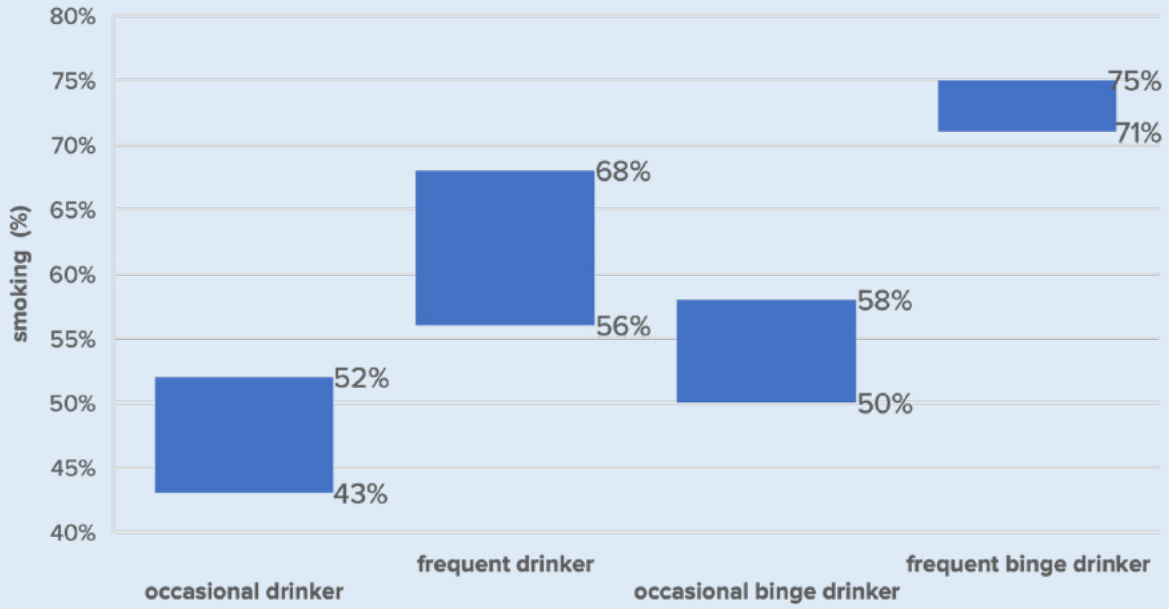
The World Bank concludes, "[s]tudies show that over time there is likely a net gain rather than a loss in employment in nearly all countries that raise tobacco excise rates."[264] While these studies did not analyse gender-specific impacts, it is reasonable to assume that women would benefit, both directly and indirectly, from increased employment opportunities in non-tobacco sectors as a result of tobacco tax increases.

3.4. Concurrent use of SSB, alcohol and tobacco products

Gender, financial and health harms of SSB, alcohol and tobacco product consumption are magnified when these products are used concurrently. Research indicates significant correlations, especially in the case of tobacco

FIGURE 6.

Heavy (frequent/binge) drinkers were more likely to smoke



Source: Jiang et al. (2014)

and alcohol product use, with a potential dose–response[j] relationship.[265]

For example, one US study investigating over 3,000 young adult bar patrons found that approximately 43–52 percent of occasional drinkers and 56–68 percent of frequent drinkers were smokers.[266] Similarly, 50–58 percent of occasional binge drinkers and 71–75 percent of frequent binge drinkers were smokers **(Figure 6)**. People who did not drink or binge drink were much less likely to be smokers, suggesting a strong relationship between smoking and drinking.[267]

Another study from India revealed that people who drink were over five times more likely to smoke than non-drinkers.[268] On the other hand, smokers had a 2.7 times greater likelihood of drinking than non-smokers.

Furthermore, women currently diagnosed with AUD were more likely than their male counterparts to be daily or occasional smokers.[269] An investigation of predictors of tobacco product use among women shows that the most significant predictor of high cigarette consumption was poor psychological health.[270] Women's impaired mental health is associated with alcohol product use,[271] cigarette smoking,[272] intimate partner violence,[273,274] and financial distress attributable to tobacco and alcohol product consumption.[275]

Regarding SSB products, while evidence is limited, a Chinese study examining more than 12,000 individuals (52.9 percent female) identified significant associations between SSB product intake and both smoking and past-year alcoholic beverage use.[276] Another US study analysing low-income overweight or obese pregnant women found that smokers were nearly four times more likely to consume SSB products than non-smokers.[277]

3.4.1. Adverse impacts on women

The dual use of tobacco and alcohol imposes a high cost at the household level, with significant gender implications. A study in India tracking 50,000 villages across 19 states observed that rural households on average spent 5 percent of their monthly expenditure on alcohol products and 7 percent on tobacco products.[278] Research in Mexico found that when tobacco spending increased, there was a proportional rise in alcohol expenditures.[279]

Higher alcohol and tobacco product expenditure, particularly observed in lower-income households, was associated with lower spending on food and education. In other words, households with dual use of tobacco and alcohol products allocated a considerable proportion of their limited monthly expenditures to these products primarily consumed by men. Dual use was more prevalent in poorer households.[280]

Consequently, dual use diverts more spending away from essential goods and services than in households that consume only either tobacco or alcohol products. It can exacerbate women's food insecurity, as food insecurity remains constantly higher among women than men across the world.[281]

This is particularly concerning as global food price inflation has remained elevated in recent years, often surpassing the overall inflation rate.[282] Coupled with the use of land for farming tobacco and alcohol-related crops and sugar cane instead of nutritious food crops, food price inflation can worsen food insecurity for many women by further limiting dual-use households' ability to afford sufficient and nutritious food.

Additionally, the use of tobacco and alcohol products is linked to gambling—a practice that is also much more

j A dose–response relationship describes how a change in the amount (dose) of something affects the intensity or occurrence of a certain response or effect. For example, if you are consuming alcohol, a higher/more frequent alcohol intake might cause a higher risk of tobacco use.

prevalent among men than women.[283,284,285] Research suggests that people who use tobacco and/or alcohol products are more likely to gamble than non-users, and increased use of these products correlates with higher gambling expenditures.[286] A study conducted in a middle-income country revealed that individuals who gambled spent between 5.4 percent and 20 percent of their household income on gambling.[287]

Gambling therefore represents another substantial drain on household finances connected to the use of tobacco and alcohol products.

3.5. Caregiving burdens on women

Most of the unpaid caregivers across the world are women. According to the International Labour Organization, 76 percent of the 16.4 billion hours per day of unpaid care work is performed by women.[288] This includes caregiving for people with an NCD,[289] for which SSB, alcohol and tobacco product use is a major risk factor.

Due to an increased risk of premature death, disease and disability associated with tobacco and alcohol product use,[290,291] many users of these products, primarily men, may end up requiring home care, which is predominantly provided by women, often at the expense of their own health and other needs.[292]

The demand for unpaid home care by women can be substantial, given the high number of male tobacco and alcohol product users: in 2019, there were at least 940 million male smokers and 6.6 million tobacco-related male deaths.[293] In 2016, there were 1.5 billion male consumers of alcohol products and 2.3 million alcohol-related deaths.[294]

A study involving over 10,000 women from 10 countries, most of which were LMICs, revealed that on average, 50 percent of the women were caregivers for a household member with an NCD.[295] Furthermore, 20 percent of these women had to quit their jobs or reduce their working hours to provide care.

A report by the Organisation for Economic Co-operation and Development (OECD) stresses that "[t]he gender inequalities in unpaid care work ... translate into higher gender gaps in labour outcomes".[296] Consequently, as research from the United States revealed, women who were caregivers faced a 2.5-fold risk of impoverishment compared with women without a caregiving role.[297]

4. Health tax contributions to SDG 5

SSB, alcohol and tobacco product consumption subjects women to a cascade of adverse effects, including an increased risk of diseases, mental distress, injuries, death, intimate partner violence, unpaid caregiving burdens and impoverishment, as examined in this brief. These factors collectively exacerbate existing gender inequities, perpetuating a cycle of disempowerment for women.

Low health taxes may be viewed as a subsidy for the consumption of harmful products. Given that men generally consume more SSB, alcohol and tobacco products and many women bear the societal costs (e.g. health care and caregiving) associated with the products they do not consume, such policies could be considered discriminatory against women.

By reducing the consumption of these harmful products, health taxation can play a significant role in promoting gender equality and empowering women, aligning with SDG 5, to achieve gender equality and empower all women and girls. This fiscal approach addresses multiple SDG 5 targets **(Box 2)**.

BOX 2.

Health taxes contributes to the following targes of SDG 5

- **Target 5.1:** End all forms of discrimination against all women and girls everywhere
- **Target 5.2:** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
- **Target 5.4:** Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate
- **Target 5.6:** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.
- **Target 5.A:** Undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws
- **Target 5.C:** Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.

In other words, health taxation is a potent vehicle for advancing women's empowerment and should be recognized as a key enabler and accelerator for achieving SDG 5. Health taxation should be part of a "concerted effort to dismantle gender barriers and empower all women and girls – because we cannot expect to achieve the [Sustainable Development] Goals without gender equality," as stressed by 'The Sustainable Development Goals Report 2024'.[298]

However, its potential may have been overlooked within women's empowerment movements and policies: its integration would offer a crucial opportunity to create a more equitable and just world for women and girls.

5. Underutilization of health taxes

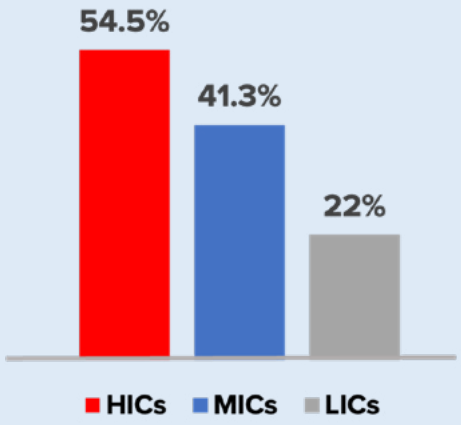
Health taxes have been underutilized, especially in LMICs.[299] This is a missed opportunity to reduce significant harms to women, advance gender equality and drive broader development gains. It is estimated that SSB, alcohol and

tobacco taxes must be increased by at least threefold just to offset the economic costs associated with their use.[300]

The WHO recommends that tobacco excise taxes should comprise at least 70 percent of the retail price.[301] However, on average, cigarette excise taxes make up less than 22 percent of the retail price in lower-income countries (LICs), 41.3 percent in middle-income countries (MICs) and 54.5 percent in HICs **(Figure 7)**.[302]

FIGURE 7.

Tobacco excise tax rates



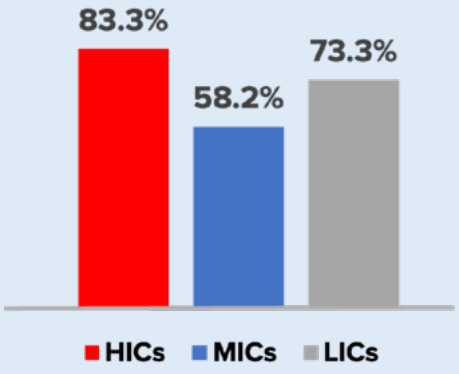
Source: Lauer et al. (2021)

Furthermore, tobacco tax policies have deteriorated in 76 countries in recent years. Approximately 87 percent of the world's 1 billion smokers, including millions of women, now reside in countries where cigarettes remain equally affordable or have become more affordable than they were in 2019.[303]

The global average share of excise taxes in the average price of the most sold brand of beer and spirits was 17.2 percent and 26.5 percent, respectively, in 2022.[304] The corresponding rate for SSB products was 6.6 percent.[305] SSB taxes are less prevalent in LMICs than in HICs **(Figure 8)**.[306]

FIGURE 8.

Proportion of countries with SSB taxes

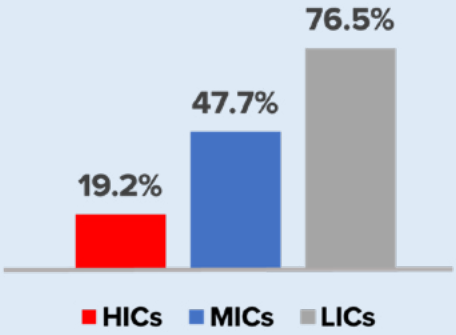


Source: WHO (2023)

On the other hand, a higher percentage of LMICs tax unsweetened bottled waters, even though water offers the healthiest alternative to SSB products **(Figure 9)**.[307] This is concerning also from a gender standpoint, because women, especially those with lower incomes, are more likely to consume bottled water than men.[308,309]

FIGURE 9.

LMICs are more likely to tax unsweetened bottled waters



Source: WHO (2023)

The Task Force on Fiscal Policy for Health estimates that a global health tax hike resulting in a 50 percent increase in the price of SSB, alcohol and tobacco products would generate $3.7 trillion in additional revenue over five years, with $2.1 trillion mobilized in LMICs.[310,311]

Significant economic, health and social benefits for women could also be anticipated from reduced use of these products by both men and women. Additional revenue and fiscal space from increased health taxes and reduced health care expenditures present an opportunity to prioritize and expand funding for gender equality initiatives.

A report by UN Trade and Development (UNCTAD) projects that achieving gender equality in 48 developing countries requires an annual investment of $6.4 trillion from 2023 to 2030, with a current funding gap of $360 billion per year.[312]

Mobilizing additional domestic financing is more critical for LMICs today than ever before, particularly when these countries are burdened with rising debt servicing costs, as global markets saw the largest increase in interest rates in four decades.[313] More than 3 billion people reside in countries where expenditure on interest payments exceeds that on education or health care.[314] UNDP estimates that debt servicing impoverished 165 million people between 2020 and 2023.[315]

Women are disproportionately affected by countries devoting their public funds to debt servicing.[316,317] It crowds out public expenditures and services that are vital for the well-being of many women. This includes sectors such as social protection and health care, and programmes assisting victims of domestic violence or human trafficking. Additionally, support for women's employment and shared family responsibilities may be undermined due to reduced investment in eldercare, childcare and education.

Increasing health taxes could present a viable policy option for mitigating the gendered impacts of debt servicing, mobilizing revenues that could go to these areas that are squeezed out to make debt payments, offering a unique approach to gender-responsive economic policies.

Given the evident and extensive advantages of raising health taxes, why are many LMICs not proactively implementing this policy? One of the major factors is industry interference in policymaking. For example, the WHO calls tobacco industry interference "the greatest obstacle to reducing tobacco use",[318] "particularly strong against efforts to increase tobacco taxes".[319]

Financial and national planning officials frequently regard the tobacco industry as a source of tax revenue, employment and economic growth, much like other industries. This perception is especially prevalent when policymakers lack awareness of the significant economic, gender and environmental harm inflicted by tobacco products and are repeatedly subjected to the industry's manipulative data and tactics that can even undermine political and legislative integrity.[320,321]

To address this issue, the WHO Framework Convention on Tobacco Control (FCTC) mandates the protection of tobacco control policies from industry interference (Article 5.3) **(Box 3)**. UNDP and the Secretariat of the WHO FCTC developed a model code of conduct against tobacco industry interference.[322]

BOX 3.

WHO FCTC Article 5.3

"In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law."

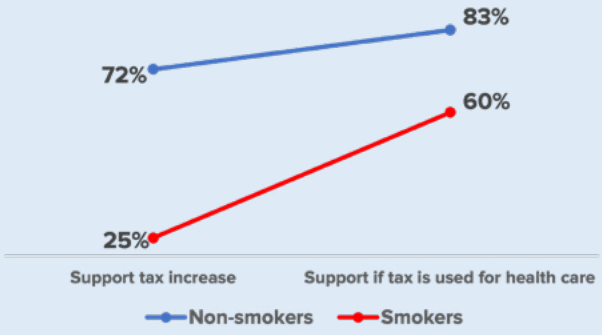
6. Lower political risk

Health taxes carry lower political risk than many other tax reforms. A 2022 Gallup poll shows that the majority of surveyed individuals across five countries support higher taxes on SSB (59 percent on average), alcohol (69 percent) and tobacco products (66 percent).[323,324] These findings align with other similar studies, with indications that the level of public support can grow even further if health tax revenues are allocated transparently to health and other social programmes,[325,326,327] which can particularly benefit women.

For instance, research in New York recorded 72 percent support for tobacco tax hikes among non-smokers and 25 percent among smokers.[328] Their support jumped to 83 percent and 60 percent, respectively, if the tax revenues were to be used for health care **(Figure 10)**.

FIGURE 10.

Public support for tobacco tax increases if revenue is used for health care



Source: Farley et al. (2015)

Similarly, in Western Australia, public support for increasing tobacco taxes grew from 60 percent for an unconditional increase to 88 percent if tobacco tax revenues were to be allocated for public health.[329]

Industries often alarm politicians, policymakers and the public by stating that health tax increases are regressive, harming poor people disproportionately. Contrary to the industry claims, a compelling body of evidence demonstrates that higher health taxes benefit especially people with lower incomes over time. This is because lower-income individuals are more likely than wealthy individuals to quit, reduce or avoid the use of harmful products in the first place in response to increased taxes and prices.[330,331]

Considering the evidence, the World Bank has concluded: "The bottom line is this: when we look at all the facts, tobacco taxes are not regressive, but highly progressive, as the full health and economic benefits of this measure far outweigh its relative cost."[332] The IMF's 'G-20 Note on Alternative Options for Revenue Mobilization' also reports that health taxes can be increased substantially in many countries without harming poor people.[333]

Given that women are disproportionately represented in and affected by poverty,[334] and the gender poverty gap is expected to widen by 2030,[335] the pro-poor attributes of health taxes can lead to substantial positive outcomes for women.

7. Use of health tax revenues for measures benefiting women

The pro-gender equality impact of health taxes can be amplified even further if health tax revenues are allocated to measures that particularly benefit women. These include universal health coverage (UHC) and support for tobacco and alcohol prevention and cessation programmes, reducing women's second-hand smoke exposure, for example.

Earmarking—the process of allocating a whole or a portion of tax revenue to specific purposes—is often debated, with some arguing that such earmarking may lead to inflexibility and distortions in fiscal planning and budgeting, resulting in an inefficient allocation of resources.[336] Despite the ongoing

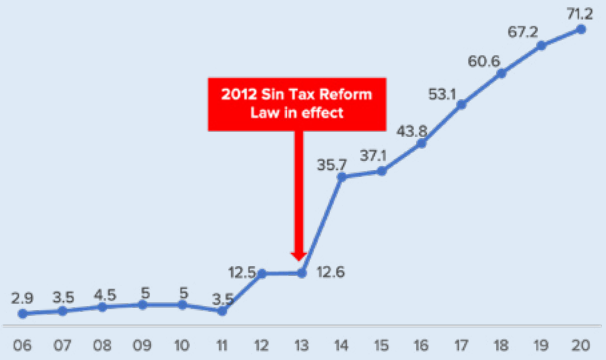
debate over earmarking, earmarking of health tax revenues in different countries has had significant positive impacts, on both health and wider development outcomes.[337]

The Philippines, for example, dedicates a substantial share of the growing excise tax revenues it collects from SSB, alcohol and tobacco products to advance UHC. These increases in tax revenues are a result of continuous tax hikes over the past decade, beginning with the Sin Tax Reform Law of 2012,[338,339,340] as detailed in the UNDP policy brief 'Pro-poor taxes for sustainable development financing: Tobacco taxation to accelerate the SDGs, equity, and sustainability in Asia and the Pacific'.[341]

Under the sin tax reform, the fiscal space for covering health insurance premiums for poor people in the Philippines as a result of earmarking excise taxes expanded significantly from PHP12.6 billion (approximately $250 million) in 2013 to PHP35.3 billion ($700 million) in 2014,[342] and grew continuously to PHP71.2 billion ($1.4 billion) in 2020[343] **(Figure 11)**.

FIGURE 11.

Growing fiscal space to subsidize health insurance premiums for poor people (in PHP billions)



Source: Based on Paul (n.d.) and World Bank (2020)

As a result, the number of poor and near-poor households with health insurance tripled in just three years, from 5.2 million in 2013 to 15.3 million households, or 45.4 million people, in 2015.[344]

Additionally, the extra tax revenues, which surpassed the initial projections by 44 percent in 2015,[345] enabled fully subsidized health coverage for all elderly citizens in the Philippines. These policies, enabled by health tax revenues, particularly benefit women, who are often more represented in low-income[346] and elderly[347] populations than men.

UHC increases the likelihood of women receiving annual health check-ups,[348] accessing facility-based deliveries[349] and escaping poverty.[350] Notably, women who are pregnant stand to benefit from UHC. From 2013 to 2022 in the Philippines, the percentage of live births delivered in a health facility rose from 61 percent to 88 percent.[351] The maternal mortality ratio in the Philippines declined by nearly 30 percent between 2011 and 2020, from 108 to 78 deaths per 100,000 live births.[352]

Improvements in women's overall health leads to their increased labour force participation and employment, and higher wages.[353,354] According to a US study,[355] a decrease in maternal mortality between 1920 and 1970 led to a 52 percent rise in labour force participation among women of reproductive age.

The IMF's 'Gender Notes 2024' also reports a range of economic benefits from higher female labour force participation, including increased tax revenues, pension contributions and GDP, as well as mitigating GDP losses caused by declining birth rates.[356] Moreover, increasing women's contribution to household income shifts family spending towards food, while decreasing the spending on alcohol and cigarettes.[357]

In the Philippines, poverty rates among women dropped from 23.9 percent in 2015 to 18.4 percent in 2021.[358] Although causality cannot be drawn from the health tax reforms to these values, these improvements in women's health and poverty occurred alongside the rapid expansion of UHC among poor people in the Philippines, made possible by increased health tax revenues.

8. Recommendations

Key recommendations for policymakers, development practitioners, civil society organizations and other stakeholders involved in advancing women's empowerment and the SDGs are outlined below.

Strengthen health taxes

Health taxes, as detailed in this brief, have been underutilized, particularly in LMICs. There is substantial scope to raise and strengthen taxes on SSB, alcohol and tobacco products, which should be automatically adjusted for inflation and income growth to ensure the desired outcomes of shifting people's consumption behaviour away from health-harming products.

Not only do health taxes provide significant benefits for women, but they also enable sustainable domestic resource mobilization alongside economic, health, social, environmental and other development gains for all. Health taxes can deliver these developments while benefiting poor populations in particular, in which women tend to be overrepresented, as well as accelerating the progress across multiple SDGs simultaneously.

Evidence is fundamental to the formulation of health tax policies. Investment cases are prime examples, as they help establish a solid evidence base and drive action for effective health taxation. Since 2015, UNDP, WHO, and partners have worked with 56 countries to develop 85 investment cases on key health issues. These efforts have led to 29 government actions to strengthen health taxes – which often show the highest return on investment when analyzed – alongside broader reforms in governance, financing, and health service access and delivery.

That includes the Philippines, which used its NCD investment case to strengthen excise taxes on tobacco and alcohol, earmarking revenue to expand universal health coverage.[359] (For more details, visit the Making the Case for Investment in Health site on UNDP's Data Futures Exchange (DFx) platform.[360])

Incorporate gender considerations when designing health tax policies

The differential adverse impacts of SSB, alcohol and tobacco product use on women, along with the gender-equalizing effects of health taxes, should be examined, quantified and reflected in health tax research and policy discourse.

Equally important is the acknowledgment that the harmful impacts on women may be lessened by decreasing tobacco and alcohol use among men—an outcome that can be facilitated through higher health taxes. Health taxes should be positioned as an integral part of gender-responsive fiscal policies.

Include health taxation as part of comprehensive gender equality strategies

Health taxes can provide a unique and additional rationale, vehicle and set of stakeholders to empower women. By presenting evidence on the significant impacts of SSB, alcohol and tobacco product use and health taxes on women, the Ministry of Finance—the steward of tax policy—the ministry responsible for women's issues, the Ministry of Health and women's civil society organizations could be engaged as active participants in promoting gender-responsive fiscal policies.

Such multisectoral collaboration can significantly enhance efforts to empower women by addressing gender disparities more comprehensively and effectively. This collaborative approach allows for the development of comprehensive strategies that consider the multifaceted nature of gender issues, leading to more impactful and sustainable outcomes.

Allocate health tax revenues to measures benefiting women

Given the significant adverse gender impacts of SSB, alcohol and tobacco product use, countries should consider reinvesting a portion of increased health tax revenues into development programmes. These programmes could encompass social protection measures, such as UHC and support for poor people and victims of intimate partner violence. The strategic investment of health tax revenue will help bridge the gender equality financing gap. It will also yield significant benefits for men and for society as a whole.

Integrate health taxes as part of essential national development policies

The impact of health taxes can be further amplified if implemented as part of wider development policy packages, including, for example, marketing regulations and poverty reduction. The tobacco and alcohol industries have consistently and significantly invested in associating tobacco and alcohol product use with women's empowerment and gender equality. As tobacco and alcohol product sales are declining in HICs, the industries have targeted women and girls in LMICs.

Act to prevent industry interference

The SSB, alcohol and tobacco industries have applied various tactics to oppose measures to reduce the use of their products.[361,362] Countries need robust governance systems to prevent industry interference in the development and implementation of health tax policies.

Some countries, including the Philippines[363] and Australia,[364] have developed a robust framework with a code of conduct aimed at preventing non-transparent and unnecessary interactions between public servants and the tobacco industry across all government sectors. This system may have played a pivotal role in enabling the Philippines to increase tobacco taxes successfully and substantially over the past decade, despite strong opposition from the tobacco industry.

To achieve significant outcomes for women through substantial health tax increases, countries are urged to implement such regulations and to extend them to include the alcohol, beverage and other relevant industries. A model code of conduct based on Article 5.3 of the WHO FCTC (mentioned above) can provide practical guidance.

9. Conclusion

The evidence presented in this policy brief makes a compelling case for leveraging health taxation as a potent tool for advancing women's empowerment. It reveals economic, health and broader development benefits that extend beyond addressing gender disparities and increasing tax revenue.

Despite their potential, health taxes remain underused, particularly in LMICs. This missed opportunity is concerning, given the slow progress towards achieving SDG 5 and the urgent need for innovative solutions to accelerate gender equality.

By recognizing the unique ways SSB, alcohol and tobacco products affect women, and by strategically designing and implementing health taxes, countries can significantly accelerate gender-responsive development.

Health taxes can not only mitigate the harmful impacts of these products on women's lives but also generate revenue that can be specifically invested in women's empowerment and gender equality. Health taxes offer a unique opportunity to open a novel gender policy pathway, engage new stakeholders for more robust multisectoral cooperation, and mobilize a sustainable source of domestic revenue.

This policy brief has demonstrated that health taxes are an innovative enabler and accelerator for advancing the empowerment of women. In turn, women's empowerment, health and well-being are essential for achieving better development outcomes for everyone.[365]

'The Pact for the Future', the outcome document of the UN Summit of the Future 2024, acknowledges that "gender equality and the empowerment of all women and girls is an essential prerequisite to sustainable development. We cannot achieve our shared ambitions for the future without addressing these challenges with urgency and renewed vigour."[366]

It is imperative to fully utilize the power of health taxes to unlock an equitable, just and sustainable future for women, and for all.

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