Commission on Taxation & Welfare
An Coimisiún um Chánachas ↄ Leas

Briefing Paper

# Public Health, taxation and welfare

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**Key Points**

- Public health is the science of protecting and improving the health of people and their communities.
- This paper examines the various taxation measures that are aimed at public health and the public health policy rationale behind these measures.
- 'Sin taxes' are employed as a key component of public health policy focused on discouraging and reducing consumption of products considered harmful to public health as well as a source of revenue.
- The public health implications of obesity are of growing concern in Ireland with rates of obesity and overweight as a proportion of the population increasing. Rising obesity is driving increases in health issues such as cancer, high blood pressure and diabetes.
- Social protection policies play an important role in public health outcomes. The public health issues contributing to chronic conditions and accompanying lifestyle factors are strongly influenced by socio-economic status, level of education, employment and housing which social protection in a broad sense can influence.

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# 1. Introduction

The purpose of this paper is to provide an overview of the tax and welfare measures relating to public health in Ireland. Public Health by definition is "the art and science of preventing disease, prolonging life and promoting health through the organised efforts of society".[1] A unifying principle of public health is its essentially "public" nature and the fact that it is mainly focused on the health of the whole population. Public health can be understood as a key aspect of the wider health system and can play an important role in improving the effectiveness and efficiency of health system delivery.

This paper will examine the various taxation measures that are aimed at public health and the public health policy rationale behind these measures.

Along with other public health interventions, tax is considered an important instrument which can be used in pursing public health goals. Excise duties or 'sin taxes' are levied in such a way as to discourage people from purchasing harmful products and to change their behaviour by placing a higher tax burden on goods or services which harm the environment. These tax measures also as provide a source of revenue for the Exchequer. However public health challenges place an enormous cost on not only the Exchequer but also the economy and wider society. Expenditure on health comprises the second largest component of public expenditure in Ireland, after social protection and is expected to rise considerably over the coming years due to our growing and ageing population. Chronic diseases are major drivers of healthcare costs, as well as associated economic losses.

This paper also examines the role of social protection in public health and in particular examines issues such as health inequalities, deprivation and public health outcomes.

# 2. Executive summary

Public health is the science of protecting and improving the health of people and their communities.

Public Health policy in Ireland is focused on many of the factors that influence public health outcomes. Public policy in recent decades has focused on health promotion, education and a number of direct interventions, particularly in taxation.

Evidence of improving public health in Ireland in recent decades can be seen through various health data indicators such as the increase in life expectancy. However, chronic illnesses and deaths arising

[1] Rechel B., McKee M. *Facets of Public Health in Europe. European Observatory on Health Systems and Policies Series.* Open University Press; Maidenhead, UK: 2014.

from the relatively high consumption of tobacco and alcohol and the deteriorating situation regarding obesity in Ireland pose considerable on-going challenges.

While life expectancy in Ireland has and continues to improve in general terms in Ireland, those living in deprived communities, with low levels of education, and from an unskilled social class have a much lower life expectancy at birth for than for the rest of the population.

'Sin taxes' are focused on discouraging and reducing consumption of products considered harmful to public health. These include high rates of excise duties on tobacco and alcohol which contribute to some of the leading causes of public health issues and mortality such as cancer, respiratory diseases and high blood pressure.

Tobacco smoking is the biggest single cause of ill health and death in Ireland, accounting for nearly 6,000 deaths annually, while alcohol contributes to over 1000 deaths annually.

The health implications arising from obesity is of growing concern in Ireland with the state having the second highest rate of obesity in Europe, with 60 percent of adults and over one in five children and young people living with overweight and obesity. Obesity is estimated to cost the exchequer in excess of €1 billion annually. Sugar Sweetened Drinks Tax has been introduced in recent years in order to target sugar intake by adults and children.

Social protection policies play an important role in public health outcomes. The public health issues contributing to chronic conditions and accompanying lifestyle factors are strongly influenced by socio-economic status, level of education, employment and housing which social protection in a broad sense can influence.

# 3. Public Health in Ireland

Public health has been defined as "the science and art of preventing disease", prolonging life and improving quality of life for people and their communities through organised efforts and informed choices of society, and individuals.[2]

General improvements in public health in Ireland in recent decades has seen life-expectancy increase by 2 years for women and 3 years for men since 2008: women living to 84 years and men to 80 years in 2018.[3] However this contrasts with life expectancy gains of 4.5 years for men and 4 years for women between the years 2000 and 2010. This recent slowdown in life expectancy in many EU countries is due to the slowdown in the reduction in death rates from circulatory diseases, which was previously the main driver of life expectancy gains.[4] Life expectancy at age 65 has risen strongly between 1926 and 2016. Life expectancy for men at age 65 was 12.8 years in 1926 but by 2016 it had increased 5.5 years to 18.3 years. For women, life expectancy at age 65 rose from 13.4 years to 21.0 years over the same time period, a gain of 7.6 years.[5] These increases have a significant demographic impact leading to growth in the number of people aged over 65. Currently each year this cohort increases by almost 20,000 people. This trend is set to continue and will have implications for future planning and health service delivery. The number of people aged 65 and over is expected to grow from one-fifth to over one-third of the working population over the next two decades which will have implications on how health services are funded and delivered.[6]

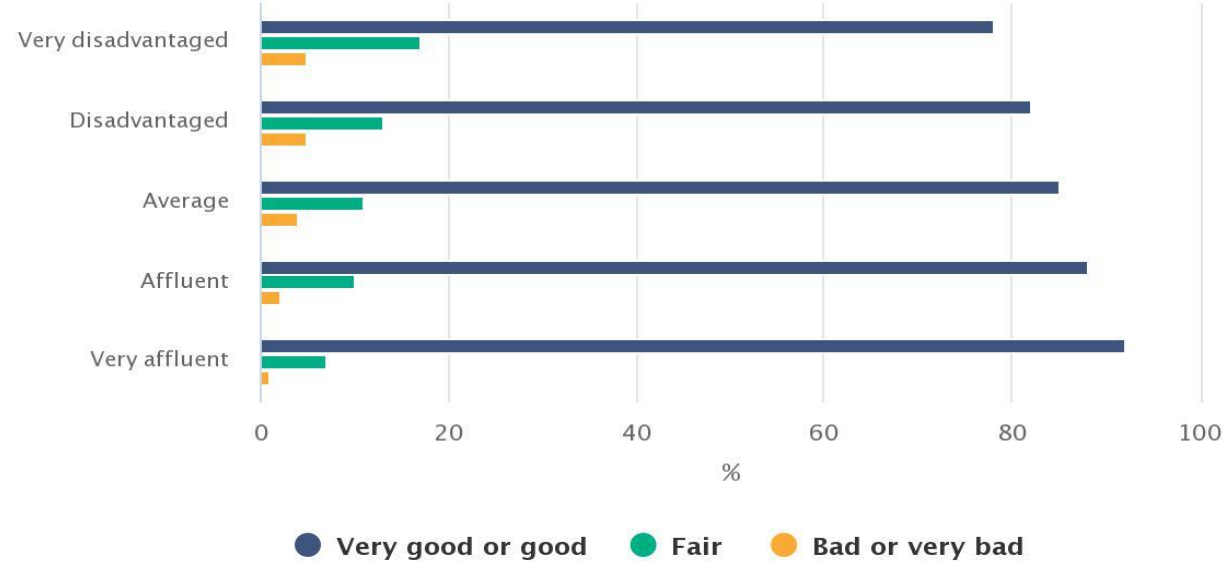
Despite overall improvements in life expectancy in Ireland, poor life expectancy remains an issue and is related to many factors such as deprivation, social class and education level. CSO data shows that life expectancy at birth for those with limited or low levels of education, those living in deprived communities, and those from an unskilled social class is much lower than for the rest of the population with professionals and those with a third-level education living longer. These non-medical factors that influence health outcomes are known as social health determinants which include income and social protection, education, socio-economic status, gender, age, and employment amongst others. Low income is also associated with less control over individual lifestyle factors that affect health. For example, the diet of those in the lowest socio-economic groups is likely to include insufficient fruit

[2] Public Health Ireland
[3] Irish Population Health: life expectancy and mortality, P. Malone, 2020
[4] OECD (2018) Health at a Glance: Europe 2018: State of Health in the EU Cycle [Online]
[5] CSO Life Expectancy Data
[6] Health Key Trend 2019

and vegetables. They are more likely to smoke and less likely to exercise regularly than people with higher incomes.[7]

The impact of income inequality on health can be further seen through self-perceived health status data with fewer low income earners reporting good health both in Ireland and across the EU. Ireland has however the highest self-perceived health status in the EU, with 85 percent of persons rating their health as good or very good. The number of people reporting a chronic illness or health problem is also better than the EU average, at around 27.7 percent of the population[8].

**Figure 1: Self-perceived health status of persons aged 15 and over by income quintile, 2019**




*Source: CSO*

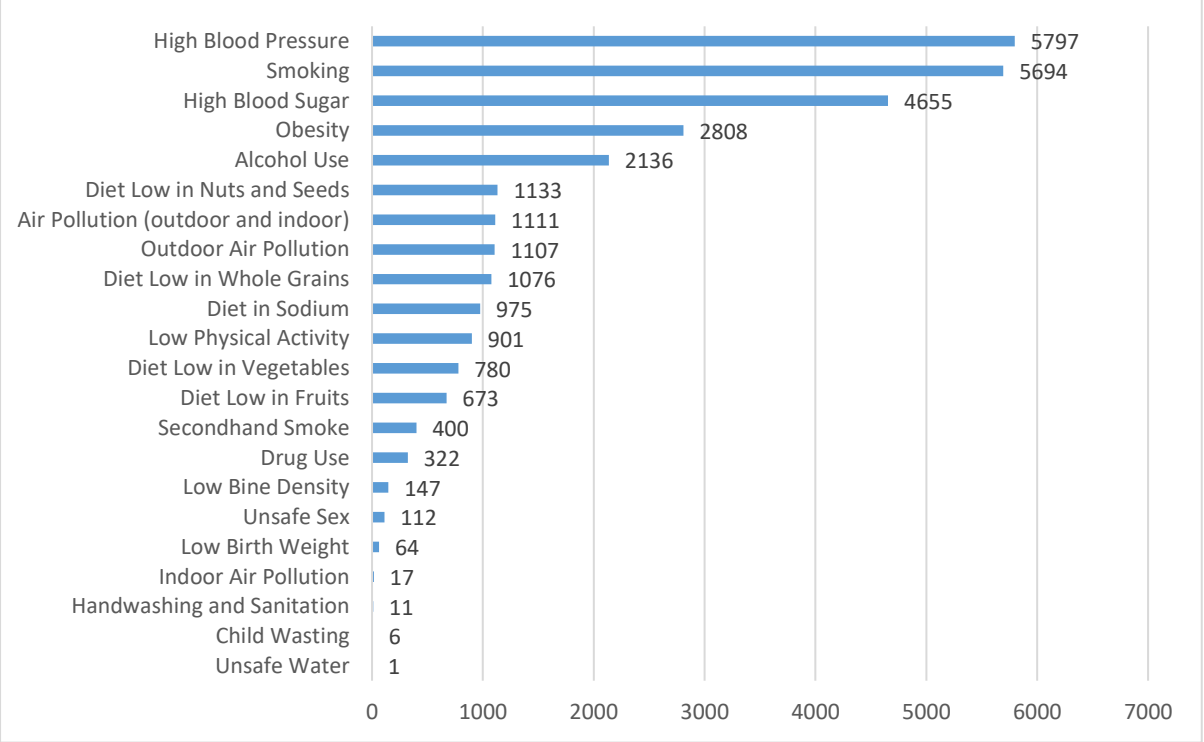
In Ireland and throughout the EU a social gradient in health status exists where people with lower education, a lower occupational class or lower income tend to die younger and have a higher incidence of most types of health problems. Inequality in life expectancy and public health outcomes represents a loss in terms of human health with consequent losses of productivity and costs to the social protection system. Therefore a core aim of public health is giving everyone a chance to reach their potential to live a healthier life and the benefits to society that emanate.

In terms of mortality, cancer is a leading cause of death in Ireland, causing some 9,000 deaths in 2018 followed by diseases of the circulatory system and respiratory diseases.[9] Chronic diseases are major drivers of healthcare costs as well as exacting a huge human toll. Ninety per cent of our total

[7] Ruth Barrington, Poverty is Bad for your Health, 2004
[8] Health in Ireland Key Trends 2019
[9] Malone, 2020

healthcare costs are spent on the 30 percent of the population with chronic diseases. Many of these diseases are caused or worsened by risk factors such as tobacco use, overweight and obesity, alcohol consumption and physical inactivity. Prevalence of chronic conditions and accompanying lifestyle factors are also strongly influenced by socio-economic status, level of education, employment and housing.[10]

**Figure 2: Number of deaths by risk factor in Ireland, 2017 (all ages and genders)**




*Source: IHME, Global Burden of Disease.*

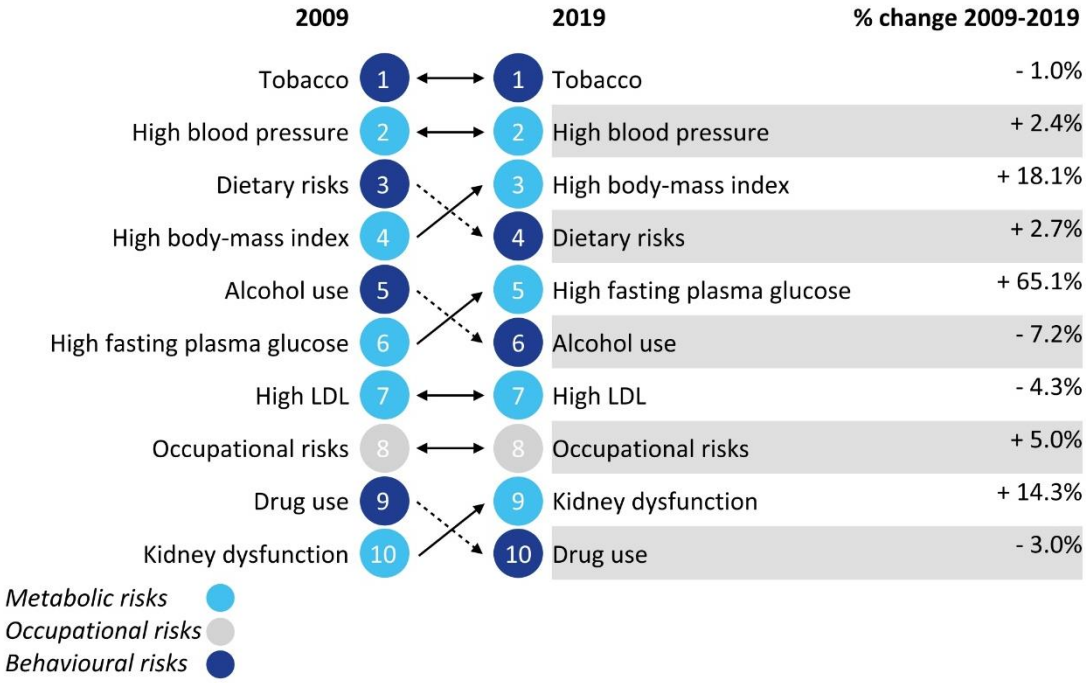
Public health policy has been focused on tackling the drivers causing these chronic diseases including taxation measures with excise duties on tobacco and alcohol in particular and more recently on sugar in sugar sweetened drinks.

*Figure 3* show recent trends in the Ireland's top 10 risks risk factors driving the most death and disability from 2009 to 2019. Tobacco remains the top risk factor while showing a slight decline, with alcohol also declining. However, of particular public health concern is the rise in other risk factors often associated with obesity and poor diet and lifestyles, such as high body mass index, blood glucose and blood pressure. For example, the number of deaths from diabetes rose from 514 in 2010 to 564 in 2017, an increase of 10 percent. Of the 564 deaths in 2017, 57 percent were male.[11]

[10] Royal College of Physicians, 2017

[11] CSO: Ireland's UN SDGs 2019 - Report on Indicators for Goal 3 Good Health and Well-Being

**Figure 3: Ireland Top 10 risks contributing to total number of DALYs in 2019 & % change 2009–2019**




*Source: Healthdata.org (DALY: Disability adjusted life years: The disability-adjusted life year is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.*

# 4. Taxation and Public Health

Taxes that target public health are imposed on products that have a negative public health impact, including tobacco, alcohol and sugar-sweetened beverages. In Ireland such products are targeted through the application of excise taxes. With the completion of the Single Market of the EU in 1993 and the widespread adoption of value added tax across the EU much of Ireland's excise duties were eliminated with tobacco, alcohol, energy products and vehicles remaining as the primary subjects of excise taxation. In Ireland the primary aim of excise duties is to raise revenue for the Exchequer and they were not originally designed with the primary objective of promoting good public health. However, in recent years these excise taxes have been adopted as a means of deterring the consumption of harmful products reflecting the cost placed on society arising from the consumption of such products. As the effectiveness of excise on alcohol and tobacco products is well known and endorsed by the WHO, using excise as a means of tackling the over-consumption of sugar and the growing problems arising from obesity led to a sugar sweetened drinks tax being designed as an excise tax and introduced in Ireland in recent years (as noted ahead).

Other public health measures in taxation implemented in recent years include the introduction of a Nitrogen oxide (NOx) surcharge into the VRT regime. The surcharge reflects the detrimental effect of these emissions on our environment and, in particular, impacts of older polluting diesel cars. Research shows a causal link between exposure to pollutants (NOx, PM, SOx, etc.) emitted from vehicles – particularly diesel vehicles - and a number of chronic conditions including respiratory, cardiac disorders and cancer.[12] In August 2021 the Irish Medical Journal published researched focusing on the impact of COVID-19 lockdown restriction on ambient NO2 (nitrogen dioxide levels) and asthma hospital admissions. The study by the HSE, UCC and the EPA, examined the impact of the transport restrictions on ambient nitrogen dioxide (NO2) concentrations and hospital admissions for asthma across Ireland. The study provides evidence of an association between population exposure to ambient air pollution and aggravation or exacerbation of asthma episodes that warrant acute hospital admissions. The results showed falling numbers of hospital admissions which corresponded with a decrease in annual average NO2 levels.[13]

[12] Department of Finance: Climate Action and Tax Tax Strategy Group TSG 19/04

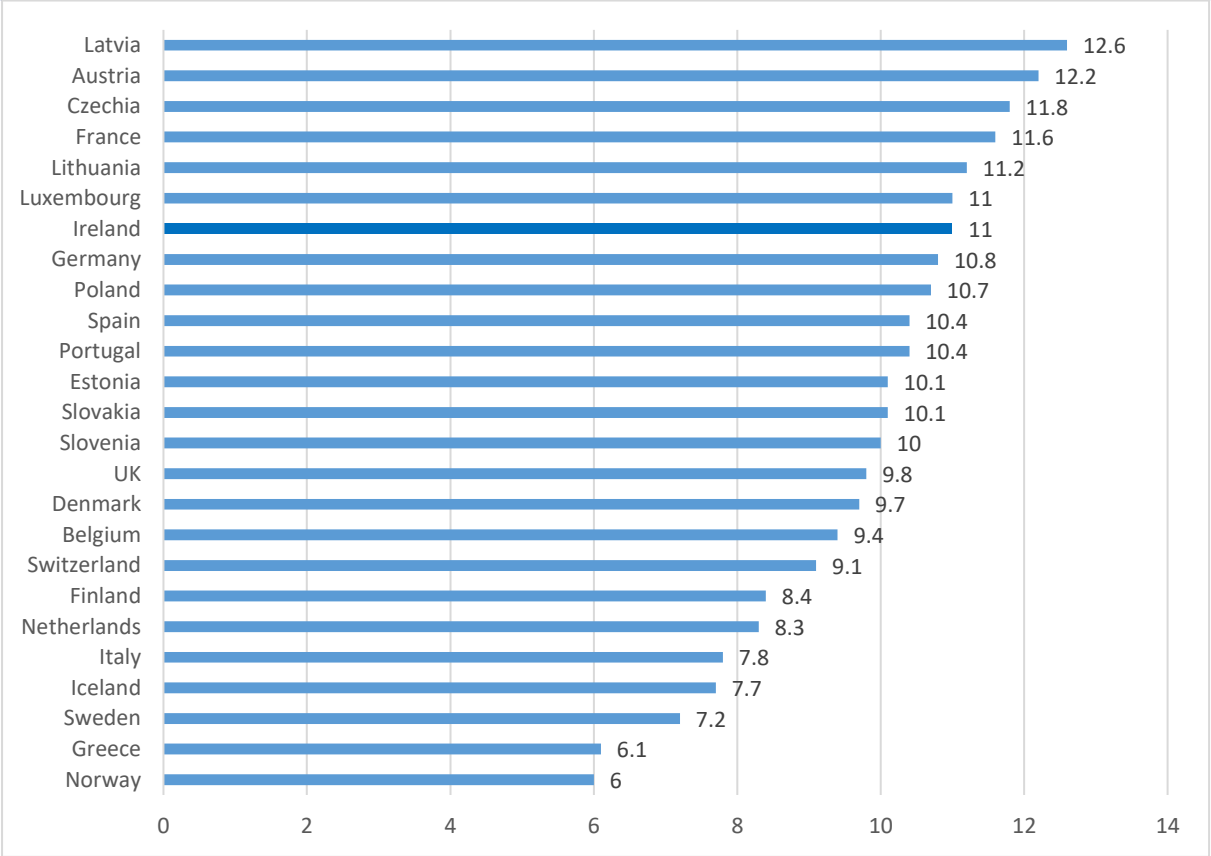
[13] Quintyne, Kelly, Sheridan, Kenny and O'Dwyer (2021) *Impact of COVID-19 Lockdown Restrictions: Ambient NO2 and Asthma Hospital Admissions*, Issue: Ir Med J; Vol 114; No. 7; P413

## 4.1 Taxation of Alcohol

### 4.1.1 Alcohol and Public Health Policy

Alcohol consumption, in particular problematic drinking behaviours, is a major social problem and places considerable pressure on healthcare systems. By international standards, Ireland has a high rate of per capita consumption of alcohol. The most recent per capita alcohol consumption figures available for 25 European countries are presented in Figure 3. Ireland has the seventh highest per capita alcohol consumption rate of these countries (based on 2018 data). Ireland's consumption is 13.4% higher than per capita consumption in the UK.[14]

**Figure 4: Alcohol consumption total litres per capita (aged 15 and over) 2018**




*OECD (2021), Alcohol consumption (indicator). doi: 10.1787/e6895909-en (Accessed on 30 June 2021)*

Between 1989 and 2001, there was a general upward trend in alcohol consumption, with per capita consumption increasing from 10.5 litres in 1989 to 14.3 litres in 2001. The steepest increase took place between 1994 and 2001, the era of the 'Celtic Tiger', whereby alcohol became more affordable due to increased disposable income combined with no increases in excise duty on alcohol. Consumption

[14] O'Dwyer C, Mongan D, Doyle A and Galvin B (2021) Alcohol consumption, alcohol-related harm and alcohol policy in Ireland. HRB Overview Series 11. Dublin: Health Research Board.

decreased in 2003 following an increase in excise duty, and remained stable until 2007 and decreased by 16.7% between 2007 and 2009 as Ireland experienced an economic downturn. In December 2009, excise duty on all alcohol products was reduced by 20–21%, halting the decline in consumption. In 2010, per capita alcohol consumption increased by 5.5% to 11.6 litres. In December 2012, excise duty on alcohol products was increased by 37–62%, which likely contributed to the 8.7% decrease in alcohol consumption in 2013. In October 2013, excise duty on alcohol products was further increased. The last excise duty changes were made in 2014.[15] Between 2013 and 2019, consumption has remained relatively stable, rising just 2.9% from 10.5 litres to 10.8 litres over that period. According to the Health Research Board the 2012 and 2013 increases in excise duty may have prevented the sharp spike in alcohol sales witnessed during Ireland's last period of economic growth.[16] No changes in excise duties on alcohol have been implemented since 2014.

For context 10.8 litres of pure alcohol equates to:

- 40 bottles of vodka (700 ml)
- 113 bottles of wine (750 ml), or
- 436 pints of beer (568 ml).

Considering that 24% of the population abstains from alcohol, when abstainers are excluded (n=939,024), alcohol consumption among those who have consumed alcohol in the past year increases to 14.2 litres of pure alcohol per drinker aged 15 years and over.[17]

The relationship between alcohol consumption and its impact on health is complex. Harm from alcohol is determined not only by the volume of alcohol consumed, but also by patterns of drinking, in particular occasions of heavy episodic drinking. Adding further to this complexity are the multiple mechanisms through which alcohol use affects health such as the toxic effects on organs and tissues through alcohol consumption, acute intoxication leading to poisoning or injuries and alcohol dependence leading to impairments in behaviour.

In 2013, there were 1,055 deaths, which is an average of 88 deaths per month or three deaths per day.[18] The relationship between the excise duty on alcohol and consumption is well known. Generally an increase in excise duty rates leads to reduced alcohol sales, higher excise receipts and lower

[15] Tax Strategy Group 20-08 General Excise
[16] Health Research Board, 2021
[17] O'Dwyer C, Mongan D, Doyle A and Galvin B (2021) Alcohol consumption, alcohol-related harm and alcohol policy in Ireland. HRB Overview Series 11. Dublin: Health Research Board
[18] Mongan D and Long J (2016) Overview of alcohol consumption, alcohol-related harm and alcohol policy in Ireland. HRB Overview Series 10. Dublin: Health Research Board.

consumption. The World Health Organisation[19] has noted that there is "indisputable evidence that the price of alcohol matters. If the price of alcohol goes up, alcohol-related harm goes down" (WHO, 2009). The example of Finland illustrates the clear link between tax, price and consumption. In 2004 the Finnish government reduced alcohol excise duty by an average of 33% in order to reduce the number of cheap imports. The result was an immediate 10% increase in consumption and a 17% increase in alcohol-related mortality, equivalent to approximately eight additional alcohol-related deaths per week.[20]

Alcohol mortality data from the National Drugs Related Death Index (NDRDI) analysed for 2008–2017 showed 10,803 alcohol-related deaths recorded, accounting for 3.7% of all deaths in Ireland during this time, there were 1,094 deaths in 2017. In terms of gender of the 10.803 deaths, 8,000 male and 2,803 female deaths were recorded, accounting for 5.4% of all male deaths and 2.0% of all female deaths in Ireland during this time period. The 50–64-year-old age group consistently accounted for the highest number of alcohol-related deaths each year, with two in five (39.1%) alcohol-related deaths between 2008 and 2017 occurring in this age group. Deaths among those aged 65 years and over have shown an upward trend over time, increasing by 22.6% between 2008 and 2017. Overall, seven in ten deaths (70.3%) occurred in persons aged under 65 years, highlighting the level of premature mortality associated with alcohol (Health Research Board, 2021).

The Department of Health previously published the following estimates of alcohol related costs:

- alcohol-related illness cost the healthcare system €793 million, alcohol related crime cost an estimated €686 million and alcohol related road accidents cost an estimated €258 million in 2013;
- the cost of lost economic output due to alcohol was estimated to be €641 million in 2013 (e.g. €195 million due to absenteeism, €185 million due to accidents at work, €169 million due to suicide and €65 million due to premature mortality).

Alcohol-related harm is a major public health concern in the EU. In 2016, cancer was the leading cause of alcohol-attributable deaths with a share of 29%, followed by liver cirrhosis (20%), cardiovascular diseases (19%) and injuries (18%).[21]

[19] WHO (2009) Evidence for the Effectiveness and Cost-Effectiveness of Interventions to Reduce Alcohol-Related Harm

[20] Mongan D and Long J (2016) Overview of alcohol consumption, alcohol-related harm and alcohol policy in Ireland. HRB Overview Series 10. Dublin: Health Research Board.

[21] EU Cancer Plan

Tackling harmful alcohol consumption is a target set by the UN Sustainable Development Goals. Future developments in this area at EU level are expected as the EU Commission is reviewing EU legislation on the taxation of alcohol and on cross-border purchases of alcohol by private individuals.

### 4.1.2 The Public Health (Alcohol) Act

The Public Health (Alcohol) Act was enacted on 17th October 2018. The primary policy objectives of the Act are to:

- reduce alcohol consumption to 9.1 litres of pure alcohol per person per annum by 2020,
- delay the initiation of alcohol consumption by children and young people,
- reduce the harms caused by the misuse of alcohol, and
- regulate the supply and price of alcohol in order to minimise the possibility and incidence of alcohol related harm.

The Public Health (Alcohol) Bill Regulatory Impact Analysis[22] contained the following measures amongst a number of other policy initiatives with particular emphasis on increasing the price of alcohol over the medium term to ensure that alcohol becomes less affordable. In relation to Excise Duties the Regulatory Impact Analysis contained the following:

- maintain excise rates at high levels;
- further increase excise rates for higher alcohol content products;
- increase the differential between excise rates applied to alcohol content levels in each alcohol product category; and
- increase the annual excise fee for the renewal of off-licences.

### 4.1.3 Minimum Unit Pricing

Minimum Unit Pricing is intended to address the health harms associated with harmful alcohol consumption by preventing the sale of very low priced alcohol. The Government Decision in 2013 approved the implementation of a minimum unit pricing regime for alcohol products under the Public Health (Alcohol) Bill to be subject to a similar provision being introduced simultaneously in Northern Ireland. Section 11 (1) of the Public Health (Alcohol) Act, which is subject to a commencement order, sets out the minimum price per gram of alcohol at €0.10. The MUP raises the price of certain alcohol products, it does not result in any excise increase.

[22] Regulatory Impact Analysis supporting Public Health (Alcohol) Bill

The Minister for Health has put forward a draft memo requesting the Government to agree to the proposed implementation of a minimum price for alcohol products through the commencement of section 11 of the Public Health (Alcohol) Act 2018. A recent announcement by the Minister for Health in Northern Ireland has indicated that the introduction of MUP will not happen during his mandate, consequently the Department of Health do not anticipate any introduction of MUP in the North until at least 2023. The introduction of MUP in the Republic without a simultaneous introduction in Northern Ireland will pose challenges for cross border trade flows in relation to alcohol products and may create a significant risk to the Exchequer without the desired reduction in alcohol consumption.

### 4.1.4 Alcohol Products Tax (APT) Excise Yields

Excise duty on alcohol and alcohol products is known as the Alcohol Products Tax (APT). Various rates apply and the tax can be charged on both businesses and individuals. Excise receipts from alcohol makes a significant contribution to the Exchequer, consistently raising over €1.2 billion in recent years in addition alcohol sales also raise significant VAT receipts for the Exchequer.

**Table 1: Alcohol receipts and consumption per year 2016-2020**

| Year | Wine Receipts | Wine Litres | Beer Receipts | Beer Litres Alcohol | Spirits | Spirits Litres Alcohol | Cider Receipts | Cider Litres | Total Receipts (€m) |
|---|---|---|---|---|---|---|---|---|---|
| **2016** | €380 | 92.7m | €430 | 19.2m | €338 | 8.0m | €59 | 63m | €1,207 |
| **2017** | €382 | 93.0m | €424 | 18.8m | €353 | 8.3m | €61 | 64m | €1,220 |
| **2018** | €376 | 91.2m | €430 | 19.3m | €372 | 8.7m | €61 | 64.3m | €1,239 |
| **2019** | €378 | 92.5m | €421 | 18.9m | €373 | 8.8m | €60 | 63.1m | €1,232 |
| **2020** | €425 | 103.6m | €351 | 15.6m | €374 | 8.9m | €53 | 55.9m | €1,203 |

*Source: Revenue Statistics*

**Table 2: Impact of rate changes on excise by product type, alcohol by volume (ABV)**

| | Beer (4.3% ABV Pint) | Sill Wine (12.5% ABV bottle) | Spirits (40% ABV glass) | Cider (4.5% ABV Pint) |
|---|---|---|---|---|
| **1993** | €0.45 | €1.94 | €0.39 | €0.22 |
| **1994** | €0.49 | €2.05 | €0.39 | €0.25 |
| **2002** | €0.49 | €2.05 | €0.39 | €0.47 |
| **2003** | €0.49 | €2.05 | €0.55 | €0.47 |
| **2009** | €0.49 | €2.46 | €0.55 | €0.47 |
| **2010** | €0.38 | €1.97 | €0.44 | €0.37 |
| **2013** | €0.47 | €2.78 | €0.52 | €0.46 |
| **2014** | €0.55 | €3.19 | €0.60 | €0.54 |

*Source: Department of Finance and Revenue*

## 4.2 Taxation of Tobacco

The current rates and structures of excise duty on tobacco products are harmonised across the European Union through Directive 2011/64/EU known as the Tobacco Products Tax Directive. The EU Council issued an outcome of proceedings in June 2020 stating that updates to the directive are needed for the proper functioning of the internal market and a high level of health protection across the EU.[23] The European Commission has identified the three key focus areas of its review of the Directive

1) minimum excise duty rates,
2) harmonization of the taxation of new products, and
3) the fight against contraband

The Commission has indicated a legislative proposal to revise the Directive could be presented in the fourth quarter of 2021.

### 4.2.1 Tobacco and Public Health Policy

Tobacco smoking is the biggest single cause of ill health and death in Ireland and according to data from the Global Burden of Disease study it remains the leading preventable cause of ill-health, disability and premature mortality in this country.[24] Similarly the Department of Health indicate that smoking remains the leading cause of preventable death in Ireland, accounting for nearly 6,000 deaths annually. It is estimated that one out of every two long-term smokers will die of a disease related to their tobacco use. The Programme for Partnership Government set a smoking prevalence target of less than 5% of the population smoking by 2025. The Healthy Ireland Survey 2019, showed that the prevalence of smoking in Ireland dropped from 23% in 2015 to 17% in 2019. There are now 165,000 less smokers in Ireland than there were 5 years ago. Smoking rates are higher in deprived areas (24%) compared to affluent areas (14%). Smoking rates are also higher for those who are unemployed (40%) and those with no third level education (20%), than they are for those in employment (18%) and those with degree level education (11%)[25].

Tobacco consumption continues to be the leading cause of preventable cancer, with 27% of all cancers attributed to tobacco use. By eliminating tobacco use, nine out every ten cases of lung cancer could

[23] https://www.consilium.europa.eu/media/44235/st08483-en20.pdf
[24] http://www.healthdata.org/ireland
[25] Healthy Ireland Summary Report 2019

be avoided.[26] Tobacco taxation is one of the most effective instruments to fight tobacco consumption, particularly in deterring young people from taking up smoking.

Tax increases that substantially increase the retail price of cigarettes have been described as the most effective measure to reduce tobacco demand (WHO, 2004)

### 4.2.2 Novel Tobacco Products

The Programme for Government includes a commitment to implement a targeted taxation measures to discourage "vaping" and e-cigarettes. E-cigarettes and other novel products are currently not included in the Tobacco Products Tax EU Directive, however as this issue is being reviewed at EU level with a view to updating the Directive, and having a harmonised EU approach. A national regime targeting novel products may pre-empt any measures introduced at EU level. E-cigarettes/vaping use has increased slightly over the past few years, from an estimated 3% of the population in 2015 to 5% in 2019 (Department of Finance, 2020). Health campaigners such as the Irish Heart Foundation are urging for the introduction of an excise tax of 6c per millilitre of e-cigarette liquid. Such as measure which would add in the region of 10-25 percent to the price of e-cigarettes. Focusing on e-cigarettes the WHO points out that scientific evidence on e-cigarettes as cessation aids is inconclusive and there is a lack of clarity as to whether these products have any role to play in smoking cessation. The WHO is concerned that such products have been linked to harmful health effects and are becoming increasingly popular among children.[27]

### 4.2.3 Tobacco Products Tax Rates and Yields

Ireland has some of the highest rates of duty on tobacco products in the EU. This reflects a long-standing government policy of levying high rates of excise duty on tobacco products to meet public health targets. The Programme for Government supports outlines further increases in excise duty on tobacco products in the coming years in an effort to further discourage smoking. Excise duty on tobacco products has increased consistently in every budget over the past twenty years, with the exception of Budgets 2005, 2006 and 2010. Rate increases of €0.50 on 20 pack cigarettes, which is the most popular price category, have been implemented in each of the last six budgets with pro rata or higher increases applied to roll-your-own tobacco (RYO). Recent increases in excise has resulted in the average price of tobacco increasing by about 20% between March 2017 and March 2020.[28]

[26] EU Cancer Plan
[27] WHO Quit tobacco to be a winner
[28] Tax Strategy Group 20-08 General Excise

**Table 3: Tobacco taxation receipts 2011-2020**

| Yearly Tobacco Receipts €m | |
|---|---|
| **2021** | 155.4 |
| **2020** | 1201.2 |
| **2019** | 1136.3 |
| **2018** | 748.8 |
| **2017** | 1397.3 |
| **2016** | 1097.7 |
| **2015** | 1082.3 |
| **2014** | 983.7 |
| **2013** | 1063.8 |
| **2012** | 1072.2 |
| **2011** | 1126.2 |

*Source: Department of Finance/Revenue Statistics*

The **Minimum Excise Duty (MED)** is a tax policy tool which can be useful in supporting public health objectives by tackling the cheapest cigarettes on the market and it can also support fiscal sustainability. By its nature increasing the MED would impact greatest on the heaviest smokers of the cheapest cigarettes. There is evidence that 'big box' cigarettes packs would be more affected by any increase in the MED as they are often the best value for money when measured on a per cigarette basis. For example in Budget 2021 the Minimum Excise Duty (MED) for cigarettes was raised to €414.24 per 1,000 cigarettes, with effect from 14 October 2020. This means that all packs of 20 cigarettes sold at, or below, €11.50 will be subject to €8.28 in Excise Duty.

## 4.3 Taxation and Obesity

Obesity is mainly the result of a continued excess of energy intake over expenditure. As countries develop economically, not only are incomes rising – allowing the consumption of more calories while expending less physical energy – but also diets shift from staple foods towards, for example, more animal products, fats and sugar, as well as more highly and ultra-processed and convenience foods. This culminates in "Western" diet characterised by higher intake of sugars, refined carbohydrates and animal-source foods and fats and is nutritionally imbalanced, as consumers tend to ingest excess calories and insufficient levels of nutrients.

The United Nations Human Rights Council has identified five priority actions for tackling obesity which includes taxing unhealthy products.

Body mass index (BMI) is the most widely accepted tool in epidemiological studies and clinical practice to diagnose excess body weight in both children and adults. It also is widely used as a risk factor for

the development of or the prevalence of several health issues. In addition, it is widely used in determining public health policies.

### 4.3.1 Obesity in Ireland in an international context

Obesity is a worldwide issue and countries vary in their strategic programmes and policies that aim to tackle the issue. Some have concentrated on limited but effective initiatives, notably taxing unhealthy food high in sugar, fat and salt; nutrition surveillance; and infant and child growth monitoring, public education campaigns or education and school programmes. Responsibility for implementing such programmes has tended to vary across sectors, and the success of such programmes has been largely dependent on leadership in the relevant sector and evidence of effectiveness of the action or programme.[29]

Ireland has one of the highest levels of obesity in Europe, with 60% of adults and over one in five children and young people living with overweight and obesity. Recent results from the European Health Interview Survey shows that Ireland has the second highest rate of obesity in the European Union as of 2019 with almost 26 percent of adults considered obese. This compares to the 2014 survey which showed an obesity rate of 18 percent.[30]

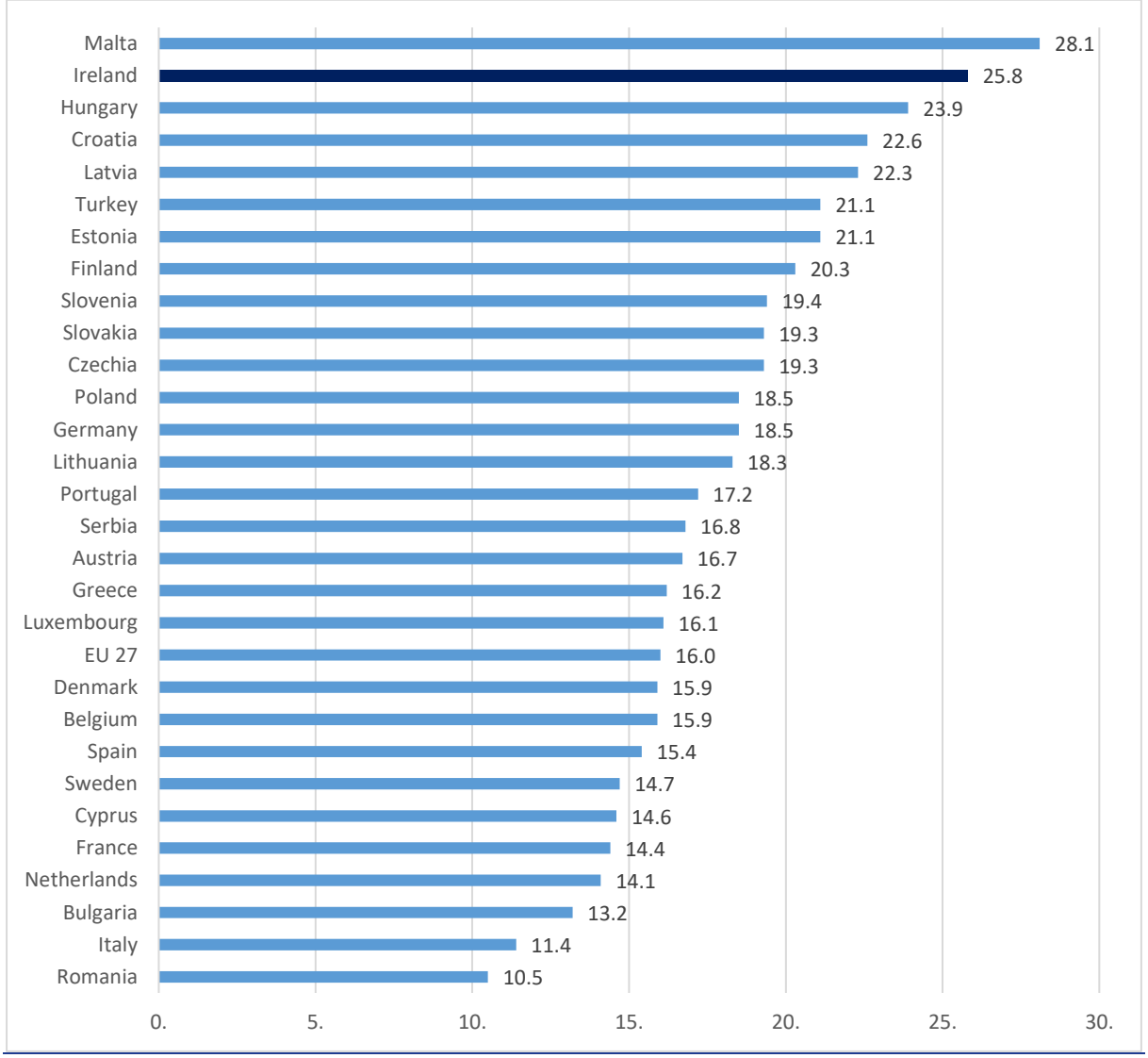
The availability, purchase and consumption of foods high in fat, sugars and salt and low in fibre (in particular ultra-processed foods) are linked to the high health and economic burden of non-communicable diseases, including cancer, in Europe.[31] Obesity is associated with chronic diseases such as diabetes, cardiovascular disease, respiratory disease, several types of cancer, pain and musculoskeletal disorders. Certain groups in the population have a high risk of excess weight gain leading to obesity, these include older people, women in pregnancy and post-natal, individuals with eating disorders, mental illness, intellectual and physical disabilities as well as socially excluded and disadvantaged groups.[32]

Childhood overweight and obesity tracks into adulthood for the majority of overweight or obese children. It is estimated that approximately 55% of obese children go on to be obese in adolescence, around 80% of obese adolescents will be obese in adulthood and around 70% will be obese over the

[29] A Healthy Weight for Ireland: Obesity Policy and Action Plan 2016 - 2025
[30] Eurostat
[31] Moz-Christofoletti MA, Wollgast J. Sugars, Salt, Saturated Fat and Fibre Purchased through Packaged Food and Soft Drinks in Europe 2015–2018: Are We Making Progress? Nutrients. 2021. https://doi.org/10.3390/nu13072416
[32] https://www.hse.ie/eng/about/who/cspd/ncps/obesity/

age of 30 (HSE, 2018). Rates of childhood overweight and obesity are socio-economically patterned, with those in lower socio-economic groups more likely to be overweight or obese.[33]

**Figure 4: European Health Interview Survey, Body mass index (BMI)**




*Source: Department of Finance/Revenue Statistics*

A recent report by the European Commission Joint Research Centre studied food consumption patterns across a number of European states including Ireland. The study focused on sugars, salt, saturated fat and fibre purchased through packaged food and soft drinks in Europe 2015-2018. Irish people consume more sugar from confectionery than anywhere else in Europe at 20g per day – up almost 0.5g compared to 2015 levels. The report found that consumers in Ireland have the third highest level of salt intake from savoury snacks like crisps at approximately 0.45g per day – which is up by 0.04g, the third highest rate of increase in Europe.

[33] HSE Submission to Oireachtas Health Committee 2018

The average consumption of saturated fats from processed meat and savoury snacks is increasing in Ireland

The research revealed that there was a 24 percent reduction in the levels of salt consumption from ready-made meals sold in Ireland between 2015 and 2018, while there was a 20 percent reduction in the consumption of saturated fat contained in sweet biscuits over the same period.34

The report concludes that overall, the amounts of sugars, saturated fat, salt and fibre being sold to European citizens through these products is not improving to an extent to meet public health objectives.

### 4.3.2 Public Health Costs of Obesity

The healthcare and economic burden associated with overweight and obesity is alarming. The estimated cost of overweight and obesity in Ireland was €1.13 billion in 2009, of which direct healthcare costs were almost €400m.[35]

The total lifetime costs of childhood obesity in Ireland are estimated to be €4.6 billion, with the direct healthcare associated costs estimated at €1.7 million. If body mass index (BMI) was reduced by 1% the lifetime cost of childhood overweight and obesity would be reduced by €270 million. A BMI reduction of 5% would reduce the lifetime costs by €1.1 billion.[36]

Internationally plans to tackle obesity and the associated public health issues have been or are being developed. The EU Cancer Plan for example will bring a focus on measures to make healthy foods more available as well as exploring with Member States tax incentives to increase their consumption, along with measures to improve consumer information and health literacy and address the marketing and advertising of products linked to cancer risks.

In this context the EU Commission is developing proposals on VAT rates that will allow Member States to make more targeted use of rates, for instance to support the availability and affordability of healthy and nutritious food. In 2022, the Commission will publish a **study mapping fiscal measures and pricing policies** on sugars, soft drinks and alcoholic beverages. Following this, the Commission will look into the feasibility of proposing new tax measures on sugars and soft drinks.[37] Similarly, the WHO

[34] Moz-Christofoletti, Maria A., and Jan Wollgast. 2021. "Sugars, Salt, Saturated Fat and Fibre Purchased through Packaged Food and Soft Drinks in Europe 2015–2018: Are We Making Progress?" *Nutrients* 13. https://doi.org/10.3390/nu13072416

[35] Royal College of Physicians of Ireland (RCPI): Sugar Sweetened Drinks Tax Response to Department of Finance Public Consultation

[36] HSE Submission to Oireachtas Health Committee 2018

[37] Europe's Beating Cancer Plan

encourages the management of food taxes and subsidies to promote healthy diet as well as economic interventions to promote physical activity (taxes on motorized transport, subsidies on bicycles and sports equipment).[38]

In 2016, the UK launched a broad, structured sugar reduction programme to remove sugar from everyday products. All sectors of the food and drinks industry were challenged to reduce overall sugar across a range of products that contribute most to children's sugar intakes by at least 20 percent by 2020, including a 5% reduction in the first year of the programme. The overall reduction between 2015 -2018 (in total sugar per 100g) was -2.9 percent.[39] Only three food groups of the eight measured managed at least a 5 percent reduction in the first year: sweet spreads and sauces, yoghurts and fromage frais, and breakfast cereals. There has been no sugar reduction in biscuits and chocolate bars.[40] In contrast to this co-regulation, for products where the Soft Drinks Industry Levy applies over the same period a reduction in sugar of about 30% was found.[41] .

Drawing on the UK experience with sugar tax and subsequent research it is reasonable to conclude that fiscal policy may be a more effective method of encouraging the food industry to improve the healthiness of its product range. Progress reports on sugar reduction by Public Health England show there has been an increase in the proportion of sales of drinks with no levy attached.

The Soft Drinks Industry Levy ('SDIL') applies to the production and importation of soft drinks containing added sugar to the UK market. The tax was introduced in April 2018, and was applied to soft drinks which contain added sugar and have a total sugar content above certain thresholds.

The total sugar purchased per household from drinks subject to the SDIL has decreased across all socio-economic groups. The reduction is largest in Group C2 (those households where the main wage earner is in a skilled manual occupation) with 38.5 percent, and then is similar across all remaining socio-economic groups (between 32.7% and 35.1% reduction). The percentage decreases from the SDIL are also much greater than those seen for the food categories included in the voluntary sugar reduction programme.

[38] OECD The Heavy Burden of Obesity : The Economics of Prevention: Promoting healthier diets and active lifestyles: Policies and best practices
[39] Public Health England: Sugar reduction Report on progress between 2015 and 2019
[40] Public Health England: Sugar reduction Report on progress between 2015 and 2019
[41] Healthy Food Environment Policy Index, 2020

Taxes on sugar sweetened drinks are becoming increasingly popular in the European Union with taxes implemented in Finland, France, Hungary, Portugal, Belgium, Latvia and the Catalonia region of Spain.[42]

Denmark attempted to introduce a saturated fat tax on food and nutrient intake in 2011. Though 'fat tax' was repealed in 2012, the tax reduced the Danish consumption of taxed products by 10% to 15% in the first nine months, although the demand partially shifted from high price supermarkets to discount stores.[43] The failure of the tax was blamed on its unpopularity and the impact it was having on the Danish food industry in particular the administration of the tax. The 'experiment' does however show that fiscal policies on food consumption can have a positive impact.

In 2011 Hungary introduced a public health product tax (PHPT), aimed at reducing the consumption of food products that are regarded as harmful to public health to promote a healthy diet. The PHPT targeted eight different product groups, including sugar-sweetened cocoa powder, energy drinks, condiments, fruit jams, flavoured beer and alcoholic beverages, salty snacks, soft drinks and syrups. An assessment of the impact of the PHPT was conducted four years after its introduction and clearly showed not only that consumption of the taxed products had decreased but also that the reduction had generally been maintained. A total of €200 million was generated in tax revenue during the first four years of the Hungarian PHPT.[44]

Academic studies on the potential role of taxation in targeting highly processed foods have shown that an increase in taxes on highly processed foods[45], and thus the price difference between healthier and highly processed foods, could be an effective method to reduce obesity. Food taxes in general are generally considered regressive as they pose a disproportionate burden on poorer consumers. Taxes on broad food groups such as highly processed foods would be most effective at tackling obesity however they will also put a particularly heavy burden on the poor which will need to be factored any policies developed in this area.[46]

### 4.3.3 Sugar Sweetened Drinks Tax

The concept of a Sugar Sweetened Drinks Tax (SSDT) is rooted in the policy objective of reducing the problem of obesity in Irish society. The SSDT came into effect on 1 May 2018 and applies to water and

[42] European Commission, Annual Report on Taxation 2021, Review of taxation policies in the EU Member States
[43] OECD Health Policy in Denmark
[44] WHO Using taxes to beat NCDs: success story in Hungary
[45] NOVA 4 Highly processed food, see Appendix 1 for explanation of NOVA Food classification
[46] Boysen O, Boysen-Urban K, Bradford H, Jean B, *Taxing highly processed foods: What could be the impacts on obesity and underweight in sub-Saharan Africa?* 1 Jul 2019, World Development, 119:55-67

juice based drinks. The scope of the tax was extended with effect from 1 January 2019 to include certain drinks containing milk fats and plant protein drinks. The Sugar Sweetened Drinks Tax operates as an excise duty and is administered on a self-assessment basis.

SSDT applies on the first supply in the State of sugar sweetened drinks. The supplier is liable to account for and pay the tax. The tax applies to water and juice based drinks which have added sugar and a total sugar content of five grams or more per 100 millilitres and since 1 January 2019 SSDT also applies to certain categories of plant protein drinks and drinks containing milk fats. SSDT applies to these drinks if they do not have a calcium level of at least 119 milligrams per 100 millilitres. Products liable to the tax may be in ready to consume or in concentrated form.

Examples of ready to consume sugar sweetened drinks that fall under the scope of the tax include flavoured waters, carbonated drinks, energy drinks, and juice based drinks. Drinks containing milk fats or soya, cereal, seed or nut based drinks with less than 119 milligrams of calcium per 100 millilitres. Specific products falling which are excluded from liability include alcohol-free beers and wines products labelled as food supplements.

### 4.3.4 Rates and Yield

Sugar Sweetened Drinks Tax applies on a volumetric basis at one of the following rates which are dependent on the total sugar content of the 'ready to consume' form of the sugar sweetened drink.

- €16.26 per hectolitre on drinks with a total sugar content of five grams or more, but less than eight grams, per 100 millilitres.
- €24.39 per hectolitre on drinks with a total sugar content of eight grams or more per 100 millilitres.

**Table 4: Sugar Sweetened Drink Tax Receipts 2018-2019**

| Sugar Tax Net Receipts (€m) | |
|---|---|
| **2019** | 33.04 |
| **2018** | 16.30 |

*Source: Department of Finance/Revenue Statistics*

### 4.3.5 VAT on Food and Drink

There have been calls in recent years to review the VAT treatment for certain categories of food and drink from a public health perspective. Most basic foods in Ireland apply at the zero VAT rate under a historical derogation from normal VAT rules (including bread, butter, sugar etc.). Catered food primarily applies at the 13.5%/9% reduced rate, including hot beverages. Most drinks apply at the

standard VAT rate, including alcohol, soft drinks, bottled water and fruit juices[47]. There are wide ranging views on precisely which food products should apply at the zero rate and which should apply at the standard rate based on the nutritional value of the foods concerned.

Changes to VAT rates may be something which the Commission would like to consider further as part of its future work however it should be noted that changes are restricted by EU VAT rules. The Department of Finance advise that where the VAT rate on food or drink that currently applies at the zero rate were to be increased, it would not be possible to return that food or drink to the zero rate at a later date. In addition, it is not possible to apply the zero rate to any new food or drink that has not applied at that rate on and from 1 January 1991.

In relation to the different VAT rates that apply to catered food, one of the main principles of EU VAT law is also fiscal neutrality, which provides that different VAT rates cannot apply to goods that are considered the same. Therefore, the Department has also advised that it is not possible to apply different VAT rates to restaurant services based on the nutritional value of the food being served (e.g. fast food).

As referenced in section 4.3.2 above, the European Commission is developing proposals on VAT rates that will allow Member States to make more targeted use of rates which may make it easier to support the availability and affordability of healthy and nutritious food in the future.

Any potential VAT reforms aimed at addressing obesity could focus on using the NOVA classification system and cross-classifying NOVA with criteria related to nutrients or food uses.

## 4.4 Health Expenses / Private Health Insurance Tax Relief

Taxpayers who pay medical expenses that are not covered by the State or by private health insurance can claim tax relief on some of those expenses. Tax relief can be claimed on doctors and consultants' fees, medical treatments, treatment from a psychologist or psychotherapist, and specialised dental treatment amongst others. Tax relief is also available for certain prescribed medicines and medical equipment, appliances and treatments. Tax relief cannot be claimed for routine ophthalmic and dental care but certain dental expenses such as orthodontic treatments, crowns and root canal treatment do qualify. Tax relief is also available for premiums paid for health insurance and for long-term care insurance. The insurance company grants this tax relief at source.

[47] https://www.irishtaxation.ie/vat-rates-ireland/

Income tax relief is available on fees paid for nursing homes and can be claimed under the general scheme for tax relief on medical expenses

Tax relief for health expenses is given at the standard rate of tax (20%). Nursing home expenses are given at the highest rate of tax (up to 40%).

The National Economic and Social Council believes that tax expenditures with a social purpose (such as pension and health insurance tax relief) should be capped, as these expenditures are regressive.[48]

In the context of the implementation of Sláintecare[49], which aims to tackle unequal access to health care removing the need for large parts of the population to purchase private health insurance plans or pay fees to access primary health care, the appropriateness of such reliefs into the future should be questioned.

Tax reliefs on health expenses form part of a structure of healthcare that has an unusual degree of overlap between public and private provision not seen to the same extent in most developed countries. Private patients are treated in public hospitals, partly subsidised by the State through tax relief on private health insurance premiums while public patients are treated in private settings under the National Treatment Purchase Fund. Sláintecare aims to place greater separation between the public and private systems. In terms of private health insurance, it has been suggested that Sláintecare will reduce claims costs thereby reducing premiums (all things being equal) and the need for tax expenditures in this area. However, transition to Sláintecare may also impact overall levels of demand for private health insurance should waiting times across both public and private care converge, potentially increasing pressure and cost on the public system over time.[50]

[48] National Economic and Social Council: The Future of the Irish Social Welfare System: Participation and Protection, No.151, November 2020
[49] SLÁINTECARE Implementation Strategy 2018
[50] Sláintehealth and the public/private relationship

# 5. Social Protection and Public Health

Social protection policies play an important role in public health outcomes. A broad understanding of social protection includes access to services such as health, education, housing and childcare and not just income transfers. Where such services are comprehensive, universal and free, there is less reliance on income transfers to prevent and alleviate poverty, and provide an adequate standard of living. However, in Ireland, where these services are not necessarily comprehensive, universal or free, there is a greater reliance on income transfers.[51]

According to the WHO, well-resourced and comprehensive social protection systems are critical drivers of progress in promoting health and reducing health inequalities in all countries. Governments that invest in social protection and the welfare of the population also invest in health, manifesting in lower poverty rates, greater social cohesion, and better educational outcomes for children, a more productive workforce and higher levels of health attainment. Societies investing in social protection, including countercyclical measures, achieve greater health progress overall and can also more rapidly improve the health of the most vulnerable people (WHO 2020).

Evidence indicates that ill health reduces people's employment prospects and working hours and increases the likelihood of premature retirement and of experiencing poverty in old age. Likewise for children, poor family health correlates with lower performance in education, which in turn increases their risk of exclusion throughout adulthood.

Social protection systems support public health outcomes by providing social support for women, mothers-to-be and young families, in-work poverty prevention and unemployment protections amongst others. Good public health can in turn improve social protection and socio-economic outcomes by improving standards of living, reducing poverty, encouraging the development of healthy individuals, families and communities, and encouraging preventive health measures, good nutrition and healthy lifestyle.

## 5.1 Social Protection and Health Inequalities

The numerous social determinants that are likely to influence health directly or indirectly are also linked to a range of policy fields, including economic policies, social policies, labour market policies, school policies and many others. Most of these types of policies and programmes have primary goals

[51] NESC, 2020

in terms of economic growth, employment and unemployment rates, return to work, poverty rates and so forth.

Those on low incomes experience an accumulation of factors that undermine their health, reduce the priority they attach to protecting health and lessen their control over the factors that influence their health. The continuing stress associated with living on a low income manifests itself in changes that increase the risk of depression, infections, diabetes and cardiovascular disease.[52]

In Ireland, nearly half of the population (45 percent) rely on private health insurance to access the health system, while a similar percentage (43 percent) are entitled to free GP and/or hospital care through holding a means-tested medical card. The means-tested medical card, which is a secondary benefit of a social protection payment, can act as an obstacle to the transition from welfare to work for some people. Uncertainty around continued eligibility after the three year grace period, during which the medical card can be retained following return to employment, can discourage families with a chronic illness from returning to the workforce.[53]

Measures of income inequality do not take into account access to quality affordable services, such as housing, health and education. Clearly, there is a difference in quality of life and outcomes for a person on a low income in a country where they can benefit from extensive housing supports, free healthcare and free education, and a person living in a country where fewer, or none, of these services are provided. Where such services must be paid for, they reduce the amount of income available to spend on food, utilities and other items, thus effectively reducing available income. As Ireland prioritises cash transfers over service provision, NESC suggests that this means that the experience of poverty may be stronger than official data suggests.[54]

In terms of direct health related benefits the Department of Social Protection administer the Treatment Benefit Scheme which provides dental, optical and aural services to insured workers, the self-employed, retired people and their dependant spouse/partner who have the required number of social insurance (PRSI) contributions. The policy rationale behind the Treatment Benefit Scheme is that through the provision of these limited supports, insured contributors without medical cards have financial support to avail of treatments in an efficient and timely way. Furthermore it aims to support the health and well-being of insured contributors by maintaining good dental, optical and aural health.

[52] Ruth Barrington, Poverty is Bad for your Health, 2004
[53] NESC, 2020
[54] NESC, 2020

# 6. Proposals for the Commission – forward looking

As part of the next phase of work, the following topics are areas the Commission may wish to focus on:

- To what extent does the current tax regime meet desired the public health and other policy objectives and principles?
- Is the further scope for the taxation system to help tackle the issue of obesity in Ireland?

## Public consultation questions:

- How well do you think the taxation system supports good public health outcomes?
- Is there scope to develop the taxation system further to deliver good public health outcomes?

# Appendix 1

The NOVA system classifies food into the following four groups according to the nature, extent and purposes of the industrial processes they undergo:[55]

| GROUP | DEFINITION | EXAMPLES |
|---|---|---|
| **NOVA 1** | Unprocessed or minimally processed foods | Fresh, chilled, frozen, or dried fruit, vegetables, meat, poultry, fresh and pasteurised milk, plain yoghurt, herbs and spices. |
| **NOVA 2** | Processed culinary ingredients used to prepare, season and cook group 1 foods. | Starches, syrups, butter, vegetable oils and table salt |
| **NOVA 3** | Processed foods which often have been processed to increase their durability and are usually recognizable as the original food. | Canned vegetables, tinned fish preserved in oil, salted nuts, freshly made unpackaged breads and cheeses. |
| **NOVA 4** | Ultra-processed foods engineered by recombining ingredients created through extraction from and refinement of food and other organic sources through physical, biological and chemical processes. These are foods are made from low-cost ingredients are convenient and have a long shelf-life and are hyper-palatable products. | Ready-to-consume products such as carbonated drinks, snacks, chocolate, confectionery, ice-cream; packaged breads and buns, margarines, biscuits, pastries, cakes, breakfast cereals, fruit yoghurts.<br>Ready-to-cook products such as pizzas, chicken nuggets, burgers, pies, pastas, instant soups and noodles.<br>Infant formulas, meal replacement/slimming shakes and powders. |

[55] Food and Agriculture Organization of the United Nations, NOVA classification system