

Industry narratives on health taxes — and what the evidence says

Ministers and parliamentarians who support health tax reform consistently encounter a familiar set of industry counter-arguments. The same claims surface in nearly every country that has debated tobacco, alcohol or sugar-sweetened-beverage (SSB) taxes — and there is now substantial peer-reviewed evidence that these claims range from misleading to demonstrably false. This brief provides short, evidence-backed responses to each, drawing on African and global experience.

Myth 1. “Health taxes destroy jobs.”

Reality. A 2025 interrupted time-series analysis of South Africa’s Health Promotion Levy, using 11 years of national Quarterly Labour Force Survey data, found **no significant employment loss** in any sugar-related industry following a large increase in soda taxation. Macro-economic simulations of alcohol tax increases in five US states found a small net *gain* in employment, because consumer spending shifts to other sectors and government re-spends the revenue in labor-intensive services. The pattern of “no significant net job loss” is consistent across the global evidence base.

Source: Tshehla E, et al. The association between the health promotion levy and employment in South Africa: an interrupted time series analysis. BMC Nutrition (2025). Wada R, et al. Employment impacts of alcohol taxes. Prev Med (2017).

Myth 2. “Higher tobacco taxes will trigger an explosion of illicit trade.”

Reality. Illicit trade is primarily driven by **gaps in enforcement, not tax rates**. A systematic review of tobacco-industry claims of illicit-trade volumes found that industry inflated figures in 31 of 35 estimates examined. Kenya’s experience underscores the point: its digital tax stamp system was associated with a 76% rise in legitimate cigarette and cigar sales between 2013 and 2016, even as taxes rose. Stronger tax administration — not lower taxes — is the proven effective response.

Source: Gallagher AWA, Evans-Reeves K, Hatchard JL, Gilmore AB. Tobacco industry data on illicit tobacco trade: a systematic review. Tob Control (2019). Ross H. Tracking and tracing tobacco products in Kenya. WHO FCTC Knowledge Hub policy brief (2017).

Myth 3. “Health taxes are regressive — they hurt the poor most.”

Reality. Distributional analyses of South Africa’s Health Promotion Levy show that although lower-income households pay a slightly higher share of their income on the tax, they **benefit the most** through averted diabetes deaths, lower out-of-pocket medical costs, and productivity gains, making the policy **progressive in net welfare terms**. The same pattern holds across the global review of tobacco, alcohol and SSB tax evidence: the health and economic benefits accrue disproportionately to lower-income households. Health taxes are even more pro-poor if they fund services such as expanded access to primary health care and clean water.

Source: Saxena A, Stacey N, Puech PDR, Mudara C, Hofman K, Verguet S. The distributional impact of taxing sugar-sweetened beverages. BMJ Global Health (2019). Paraje GR, Jha P, Savedoff W, Fuchs A. Taxation of tobacco, alcohol, and SSBs: reviewing the evidence and dispelling the myths. BMJ Global Health (2023).

Myth 4. “Tobacco taxes will devastate our smallholder farmers.”

Reality. Multi-country research across African tobacco-growing economies — including Malawi, Kenya and Zambia — finds that **most smallholder tobacco farmers operate at a net loss** once unpaid family labor is properly accounted for, and that a substantial share are locked into contract-farming debt cycles with leaf-buying companies. The current arrangements, not the tax, are already failing them. **Article 17 of the WHO FCTC** explicitly supports the transition of tobacco growers to economically sustainable alternative livelihoods — alternative crops and broader rural enterprise development — rather than locking farmers into a single dependent value chain. Health-tax revenue can help finance that transition.

Source: Goma F, Drope J, Zulu R, et al. The economics of tobacco farming in Zambia. University of Zambia / American Cancer Society (2016). Appau A, et al. Explaining why farmers grow tobacco: evidence from Malawi, Kenya, and Zambia. Nicotine Tob Res (2019).

Myth 5. “Cross-border smuggling will eat up the revenue gains.”

Reality. Cross-border smuggling is a real concern, but it is driven by **enforcement gaps and price differentials with neighboring jurisdictions**, not by absolute tax levels. The proven response is a combination of regional coordination — for example through SADC, EAC, or ECOWAS — together with a non-industry-aligned digital tax stamp system. Several African countries are have adopted digital tax stamps for precisely this reason; the WHO FCTC Protocol to Eliminate Illicit Trade in Tobacco Products provides the international framework.

Source: WHO FCTC Protocol to Eliminate Illicit Trade in Tobacco Products (in force 2018). Ross H. Tracking and tracing tobacco products in Kenya. WHO FCTC Knowledge Hub policy brief (2017).

Myth 6. “Alcohol taxes will close bars, restaurants, and the tourism sector.”

Reality. Macro-economic simulations of alcohol tax increases across five US states produced a **small net gain in employment**, because consumers redirect spending to other sectors and governments re-spend revenue in labor-intensive services. There is no peer-reviewed evidence that alcohol excise increases have caused systemic hospitality job losses anywhere they have been studied.

Source: Wada R, Chaloupka FJ, Powell LM, Jernigan DH. Employment impacts of alcohol taxes. Prev Med (2017). Wagenaar AC, Tobler AL, Komro KA. Effects of alcohol tax and price policies on morbidity and mortality: a systematic review. Am J Public Health (2010).

Myth 7. “Push the rate too high and revenue will fall.”

Reality. Demand for cigarettes, alcohol and SSBs is relatively **price-inelastic**: consumption falls when prices rise, but proportionally less than the price increase, so revenue keeps growing. Countries with effective enforcement — the Philippines, South Africa, and Colombia — have shown gains in revenue and reductions in consumption.

Source: Kidane A, Mduma J, Naho A, Ngeh ET, Hu T-W. The demand for cigarettes in Tanzania and implications for tobacco taxation policy. PMC (2016). WHO Regional Office for Africa. Raising taxes on tobacco: good for health, good for economies (TaXSiM application, Tanzania, 2017).

Myth 8. *“This is just nanny-state government overreach.”*

Reality. Taxpayers and the public health system bear the substantial healthcare and lost-productivity costs of tobacco-, alcohol- and SSB-related disease. Excise pricing addresses these social costs while leaving consumers entirely free to choose. This application of taxation is endorsed by the World Bank, IMF and WHO. In fact, the person most associated with the birth of capitalism, Adam Smith, wrote in his 1776 book, The Wealth of Nations: *“Sugar, rum, and tobacco are commodities which are nowhere necessities of life, which are become objects of almost universal consumption, and which are therefore extremely proper subjects of taxation.”*

Source: Paraje GR, Jha P, Savedoff W, Fuchs A. Taxation of tobacco, alcohol, and SSBs: reviewing the evidence and dispelling the myths. BMJ Global Health (2023). Jha P, Chaloupka FJ. Curbing the epidemic: governments and the economics of tobacco control. World Bank (1999).