CENTER FOR GLOBAL DEVELOPMENT

# Health Taxes in the Asian Development Bank Portfolio

## A 15-YEAR REVIEW

Jayati Nigam and Ainhoa Petri-Hidalgo

## Abstract

Noncommunicable diseases (NCDs) account for a rising share of deaths in Asia and the Pacific and are driven in part by consumption of unhealthy products such as alcohol, tobacco, and sugar-sweetened beverages (SSBs). Health excise taxes on tobacco, alcohol, and SSBs offer the opportunity to reduce consumption and increase public revenue, with the potential to channel this revenue to universal health coverage efforts. This paper reviews the engagement of the Asian Development Bank (ADB) on health taxes from 2010 to 2025, in terms of policy advice, technical assistance, and lending programs. Health taxes lie at the intersection of health policy and domestic resource mobilization, two areas that ADB strategically prioritizes across countries. The analysis reviewed 1,179 sovereign projects in relevant sectors and found that health taxes are a very minor focus (only 45 projects, or 3.8%, mention health taxes). ADB's engagement with health taxes is limited. Where loans or grants do address them, most include measurable health-tax commitments, but fewer than half track them in results frameworks. Health taxes have also been largely framed in fiscal rather than health terms across projects. Mention of health taxes has been incidental more than strategic, with no clear trends emerging on engagement patterns, consistent with ADB's overall sporadic approach. ADB engagement varied across ADB regions, and the results-framework indicators related to health-tax measures demonstrated a greater focus on fiscal than health outcomes, which is consistent with the mix of health and public sector specialists on ADB project teams. There is opportunity for a systematic and strategic engagement on health taxes across ADB regions, which could advance domestic resource mobilization efforts and improve health outcomes across Asia and the Pacific.

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## Health Taxes in the Asian Development Bank Portfolio: A 15-Year Review

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# Introduction

Global spending on health increased during COVID-19 and has since fallen back to or below its long-term trend in most country income groups.[1] In fact, in some countries across Asia and the Pacific, government spending on health as a percentage of GDP has decreased,[2] and remains well below the benchmark of 4–5% of GDP on health, predominantly from public sources, set in the World Health Organization's (WHO's) 2010–2015 regional health financing strategy.[3,a] At the same time, the global burden of disease has shifted—in Asia and the Pacific, many countries are experiencing a dual burden of communicable and noncommunicable diseases (NCDs). The Global Burden of Disease estimates indicate that, compared with global averages, the Pacific, Central Asia, Southeast Asia, and South Asia have higher age-standardized disability-adjusted life-year (DALY) rates from NCDs, while East Asia's is lower; South Asia and the Pacific also continue to have much higher rates of communicable diseases.[4] NCDs are driven by several modifiable risk factors—tobacco use, harmful alcohol use, unhealthy diets, and physical inactivity—of which the first three are directly amenable to health taxes and are the focus of this paper. Excise taxes on goods such as tobacco, alcohol, and sugar-sweetened beverages (SSBs) are an effective mechanism to generate public sector revenue and improve health outcomes.

Health taxes on consumption products that are harmful to health offer dual benefits: a reduction in consumption of harmful products and an increase in public revenue. Revenues generated from health-tax policies can also be channeled to improve health systems, among other social services, yielding even greater dividends for developing countries, where resources are strained for public service provision. The case for health taxes is as strong as ever—the 2024 report of the Task Force on Fiscal Policy for Health, for which the Center for Global Development (CGD) serves as the secretariat, found that globally, there are more than 10 million deaths per year with economic costs above $4 trillion due to tobacco, alcohol, and SSBs. The potential additional revenue for low- and middle-income countries from excise taxes on tobacco, alcohol, and SSBs was estimated at $2.1 trillion over five years, with 50 million averted premature deaths globally over 50 years if prices were increased by 50%.[5] Tax administration remains a crucial factor to determine the success of health-tax policies, which require robust monitoring and accountability for tax collection.

The Asian Development Bank (ADB) has the potential to play a major role in supporting countries to raise health taxes, as it is a major financier and has strong connections with finance and health ministries. However, the extent of ADB's engagement on health taxes is not known. This paper reviews ADB's engagement on health taxes over a 15-year period from January 1, 2010, to December 31, 2025. ADB provides health sector and public taxation guidance to its developing member countries (DMCs) through policy advice channeled through technical assistance (TA)

a The WHO strategy refers to public financing of health, including tax financing and social health insurance; its proposed target is total health expenditure of at least 4–5% of GDP. For a proposed target of government spending on health of at least 5% of GDP, see McIntyre et al. (2017).

and lending programs (Box 1). The focus will be on how ADB's advice on health taxes to member countries has evolved over time and whether clear trends have emerged across regions.

In Section I, the paper will outline the disease burden in Asia and the Pacific. In Section II, the motivation for health-tax policies and country experience with implementation will be explored. In Section III, ADB's policy advice and lending operations on health taxes will be explored, and in Section IV, the paper will take a closer look at outcome measurements of ADB programs as they relate to health outcomes, revenue generation, or both, and at the teams behind them. Finally, Section V will summarize the key findings and their implications for ADB's future engagement.

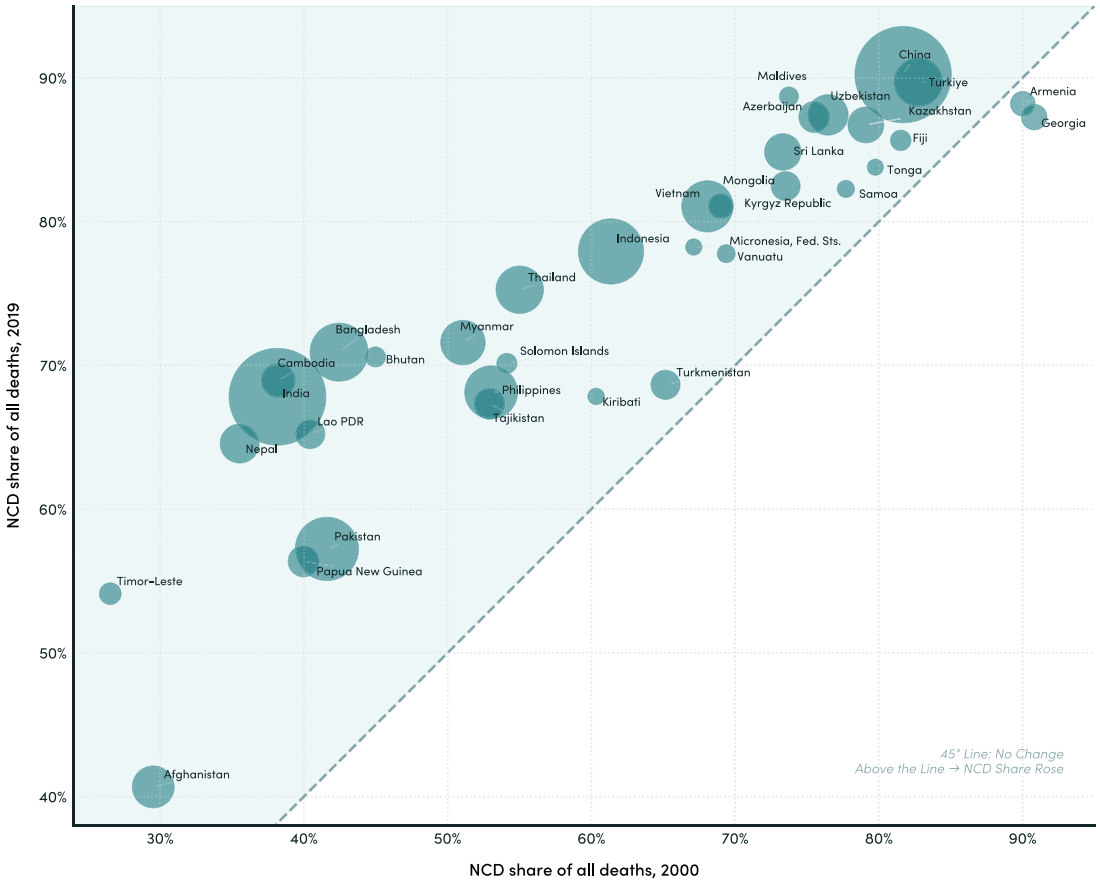
## I. NCDs in Asia and the Pacific

NCDs accounted for 43 million deaths in 2021, which was 75% of non-pandemic-related deaths globally.[6] Across Asia and the Pacific, there has been an increase in the share of deaths from NCDs since 2000; in Bangladesh, the share of deaths from NCDs increased from 42.5% in 2000 to 70.9% in 2019, and in Nepal it rose from 35.5% in 2000 to 64.6% in 2019 (see Figure 1). NCDs require long-term treatment, often leading to high costs to individuals and households, especially in low- and middle-income countries, where there are high out-of-pocket costs.[7]

The rising share of deaths from NCDs signals a shift toward chronic disease, which raises health care costs and undercuts productivity.[8] Tobacco use has declined over the years, which WHO credits to countries' tobacco control efforts.[9] Of the measures WHO recommends, such as graphic health warnings, comprehensive bans on tobacco advertising, smoke-free areas, and higher taxes, raising taxes is the most effective but also the least adopted: in 2022, only 12% of the world's population lived in countries where taxes made up at least 75% of the price of the most popular cigarette brand.[10] Alcohol excise taxes are also low, averaging about 17% of the price of alcohol compared with 42% for tobacco, and have generally not kept pace with inflation or income growth.[11] SSB taxes have spread to 41 more countries since 2018 but remain less common in the region: as of 2022, fewer than half of the countries in the WHO South-East Asia and Western Pacific regions applied excise taxes to sugar-sweetened carbonated beverages.[12,b]

b As of July 2022, 45.5% of countries in the WHO South-East Asia Region and 44.4% in the Western Pacific Region applied excise taxes to sugar-sweetened carbonated beverages.

**FIGURE 1. Almost every country's NCD share rose between 2000 and 2019**
Noncommunicable share of all deaths in Asia and the Pacific
(larger bubbles = larger population)




*Notes:* World Bank WDI (SH.DTH.NCOM.ZS). 33 of 35 countries sit above the 45° line, so their noncommunicable (NCD) share of deaths rose between 2000 and 2019; the exceptions are Armenia and Georgia, which were already near 90% in 2000 and fell by 1.8 and 3.5 points. A low NCD share (e.g., Afghanistan, bottom-left) does not signal lower mortality—it reflects a high competing burden of communicable, maternal, and perinatal disease (an earlier stage of the epidemiological transition). Shares are composition of deaths only, not absolute death rates.
*Source:* World Bank, World Development Indicators (SH.DTH.NCOM.ZS).

## II. Health taxes: Rationale and country experience

Curbing consumption of tobacco, alcohol, and SSBs through effective tax policies is one way to reduce the incidence of chronic conditions. In the longer term, increased excise taxes on these health-harming products can reduce consumption. In addition, while tobacco and alcohol are relatively inelastic goods, evidence still suggests that price increases do lead to a decrease in consumption.[13,c]

c The Task Force notes that demand for tobacco and alcohol is "quite inelastic" but estimates that taxes raising prices by 50% would cut tobacco consumption by nearly a quarter and alcohol consumption by 30%. WHO reports that, on average, a 10% increase in tobacco prices reduces consumption by 5–8% in low- and middle-income countries.

Taxing products that have a negative impact on individual health can increase the fiscal space available for human capital investments. Surveys in several countries, including India and Malaysia, show majority public support for raising health taxes, and support tends to be higher when the revenue is earmarked for popular programs such as health.[14,d]

Three country experiences illustrate how health-tax reforms differ in design, fiscal objectives, and observable health effects.

**Thailand:** Thailand introduced a tiered SSB excise tax in 2017, combining ad valorem rates with specific rates based on sugar content. The specific rates were scheduled to rise in steps, giving manufacturers time to reformulate, and surveys found lower sugar content in domestically produced beverages in March 2018, six months after the tax took effect, than in March 2015. ThaiHealth, Thailand's health promotion foundation, supported evidence generation for the reform; it is financed by a 2% surcharge on tobacco and alcohol excise taxes rather than by SSB revenue.[15,e]

**Vietnam:** Vietnam's tobacco taxes have historically been among the lowest in the Association of Southeast Asian Nations, at just over a third of the retail price in 2022, and the increases of 2016 and 2019 barely reduced consumption because rising incomes kept cigarettes affordable. A law adopted in June 2025 adds a specific tax rising to VND 10,000 per pack by 2031, but total taxes are projected to reach just under 59% of the retail price, below WHO's recommended 75%.[16,f] Adult smoking prevalence declined only modestly, from 23.8% in 2010 (Global Adult Tobacco Survey) to 20.8% in 2021 (WHO STEPS survey).[17] WHO modeling suggests the reform could help 2.1 million people quit or avoid smoking by 2031, but these projected effects have yet to be observed or attributed to the reform.[18]

**Philippines:** The 2012 Sin Tax Reform Act restructured tobacco and alcohol excises into simpler, mostly specific rates, with further increases legislated through 2020, and soft-earmarked the incremental revenue mainly for health, chiefly premium subsidies for poor and near-poor households through PhilHealth, the national health insurer. Tobacco excise collections rose nearly fivefold in nominal terms between 2012 and 2022, and adult smoking prevalence fell from 28.3% in 2009 to 18.5% in 2021. The World Bank noted in 2016, however, that smoking was already declining before the reform and cautioned that part of the early post-reform decline may reflect that

d In 2012, 70% of Malaysians favored raising tobacco taxes, and in a 2021–2022 Gallup survey, 59–63% of respondents in India supported raising taxes on tobacco, alcohol, and high-sugar drinks.

e Table 4 and annex 3 of the WHO report list the nine countries that earmarked SSB excise revenue for health programs as of July 2022; Thailand is not among them.

f The projection of nearly 59% by 2031 and the limited effect of the 2016 and 2019 tax increases are from the Campaign for Tobacco-Free Kids case study.

longer-term trend.[19,g] Over the same period, the inflation-adjusted price of a pack of 20 cigarettes rose from PHP 29.60 (about $0.60) in 2009 to PHP 107.80 (about $2.19) in 2021.[20,h]

### BOX 1. ADB core activities

The Asian Development Bank (ADB) provides financial assistance to developing member countries (DMCs) across Asia and the Pacific, through loans, grants, and technical assistance (TA) for development needs. ADB collaborates with DMCs to design and implement effective policies related to health, public sector governance, and tax administration, while strengthening institutional governance through lending and capacity-building initiatives. There are five regional departments in ADB: East Asia, South Asia, Southeast Asia, the Pacific, and Central and West Asia departments.

**Financial assistance:** ADB lends to DMCs on a range of health, education, transport, urban development, and public sector governance issues. Lending modalities include project loans, ADB's most commonly used modality, and policy-based loans (PBLs), which are loans tied to conditionalities of policy reforms by recipient governments. Another modality is results-based lending (RBL), tied to disbursement-linked indicators; none of the health-tax operations reviewed here used it.

**Technical assistance and grants:** ADB supports sustainable development and long-term policy development in DMCs through TAs. TAs are aimed at strengthening institutional capacity through training and enhanced knowledge; policy development through regulatory frameworks and governance improvements; and research and knowledge sharing. Grants, mainly from the Asian Development Fund for ADB's poorest and most vulnerable members, are used for financial assistance, including social sector support, pilot projects, emergency response, and policy-based support; because grants in the Pacific often finance the same policy-based operations that loans finance elsewhere, this paper groups grants with loans (Annex 2, Section A2.1).

**Capacity building and policy support:** ADB uses TA for training, capacity building, institutional strengthening, and policy advice, which can support longer-term engagement and the implementation of projects and institutional reforms.

In terms of health systems strengthening, ADB supports a wide range of investments, including infrastructure development, policy and capacity development, health information systems, vaccines and access to medicines, and health financing mechanisms.

g Tobacco excise collections were PHP 32.16 billion in 2012 (Bureau of Internal Revenue data, as reported by Agence France-Presse) and PHP 160.55 billion in 2022 (as reported by *the Philippine Star*).

h Prices are in constant 2021 pesos as reported by the Global Adult Tobacco Survey, which adjusted the 2009 value for inflation. US dollar equivalents are converted at the World Bank official period-average exchange rate for 2021.

# III. How ADB engages on health taxes

## Methodology

This study reviews ADB documents over a 15-year time period from January 1, 2010, to December 31, 2025. We review the extent and depth of ADB engagement on health taxes through a review of the Asian Development Outlooks (ADOs), loan, TA, and grant documents, publicly available for active and closed projects. Regional results are presented based on ADB country classifications within regional departments: South Asia (SARD), East Asia (EARD), Central and West Asia (CWRD), the Pacific (PARD), and Southeast Asia (SERD). Figures 4, 5, 6, and 7 also show a "Regional" group: seven multicountry TA projects, which we do not assign to a single regional department (two of them, led by the Pacific Department, cover only Pacific countries).

We constructed a dataset of publicly disclosed ADB project documents. ADOs over the 15-year time period were also assessed to understand ADB's institutional prioritization and emphasis on health taxes in DMCs. The corpus included reports and recommendations of the President, completion reports, TA reports, consultants' reports, and related project documents for sovereign projects classified under public sector management, health, or multisector. Each document was screened for references to health taxes, including tobacco, alcohol, SSB, and broader excise or "sin tax" measures, and classified according to whether the reference represented a general mention (C1), engagement through TA (C2), engagement through a loan or grant (C3), or a measurable health-tax commitment or outcome indicator (C4) formally incorporated into a supported operation.

We then used a two-stage Python-based text extraction and classification process, followed by manual validation. The automated scan identified relevant health-tax references and distinguished descriptive background mentions from ADB-supported policy actions based on document context, such as policy matrices, reform matrices, design and monitoring frameworks (DMFs), and results frameworks. The classification rules—keyword anchors, contextual exclusions, and project-level admit-deny overrides—were developed iteratively with the assistance of Claude Code, with every rule change and edge-case adjudication reviewed by the authors against the source documents. All in-scope classifications were then reviewed manually against the source PDFs, with corrections applied where needed. The final dataset includes 45 in-scope projects with 130 distinct documents from the screened corpus; during validation, we also consulted linked ADB documents, such as policy design and monitoring frameworks (PDMFs) and loan and grant agreements. Together these were used to construct a weighted index capturing the depth of ADB engagement across countries, regions, and projects.

Products are reported at two levels: those a project's ADB documents mention and those covered by its qualifying engagement (C2, C3, or C4), attributed only where ADB's documents name them; product attribution does not affect the index (Annex 2, Section A2.3).

## Findings on health taxes across ADOs, TAs, and loans in ADB DMCs

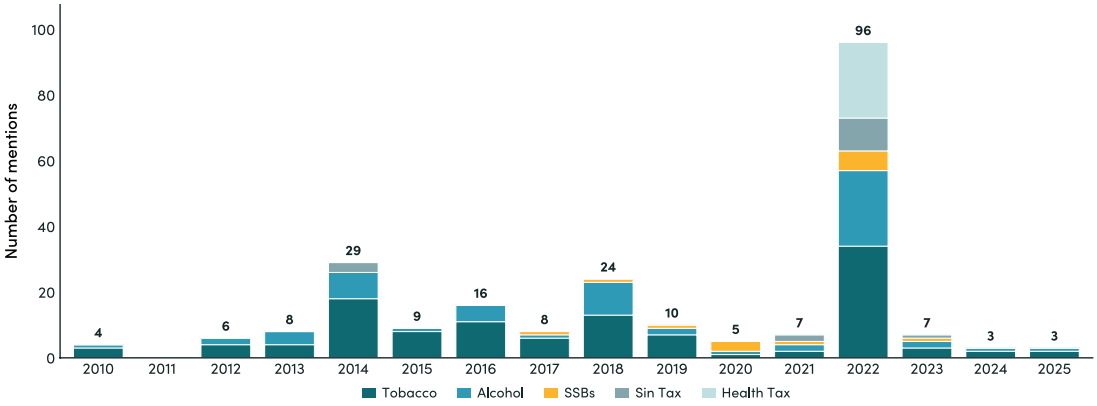
### *Review of Asian Development Outlooks: 2010–2025*

ADB's annual flagship report, the Asian Development Outlook, reveals a clear pattern over 15 years: substantive attention to tobacco and alcohol excise taxes in 2014 and to tobacco, alcohol, and SSB excise taxes in 2022, and mostly brief or descriptive references in other years (see Figure 2). Counts alone do not capture depth: outside 2014 and 2022, most mentions simply report individual countries' tax changes. We reviewed 65 ADO publications (main editions, updates, and supplements) during the 15-year time horizon from 2010 to 2025.

The 2014 edition, focused on fiscal policy for inclusive growth, made a general case for tobacco and alcohol excise tax increases around four objectives: increasing government revenues, channeling more revenue to health services, improving public health outcomes, and increasing equity.[21] In contrast, the 2018 editions mentioned tobacco, alcohol, and SSB excise taxes only descriptively, summarizing individual countries' recent or planned tax increases and their effects on inflation and revenue rather than recommending rate increases.[22] Between 2018 and 2022, ADB's policy messages on health taxes were brief: the 2020 Update noted that sugary-drink taxes can guide consumers toward better diets, and the 2021 edition listed tobacco and alcohol taxes among options for financing a sustainable recovery.[23]

The 2022 edition was a defining report with the strongest and most comprehensive approach to alcohol, tobacco, and SSB excise taxes. A central feature was domestic resource mobilization, with a focus on mobilizing taxes for development because of the immense pressure that COVID-19 put on government budgets, the gap in revenues faced by Asia and the Pacific to meet the Sustainable Development Goals by 2030, and Asia's aging population, which would require pension and health services. A full section of the report's theme chapter, "Green and Health Taxes Strengthen Revenue and Development," made a strong dual case for health taxes, addressing the rising burden of NCDs across the region while noting that, as a short-term benchmark for low- and middle-income economies, higher taxes on alcohol, tobacco, and SSBs could raise up to 0.6–0.7% of GDP in additional revenue.[24] However, this momentum was not sustained in subsequent ADOs: mentions of health taxes dropped significantly in 2023–2025, and where there were references, they were limited to individual countries' fiscal policy actions rather than substantive recommendations or analysis. ADB's most comprehensive engagement occurred in 2014 and 2022, which were two isolated cases in an otherwise lean record of substantive analysis in flagship reports.

**FIGURE 2. Health-tax mentions in ADB's Asian Development Outlook, 2010–2025**
Annual count of health-tax keyword mentions in ADO reports, by mention type




*Notes:* Each mention is a keyword hit from an automated scan of the full text of ADB's Asian Development Outlook (ADO), so counts are approximate; a sentence naming more than one product counts once per product. A single edition can contribute many mentions, and ADB publishes multiple editions per year (the April outlook plus mid-year updates/supplements), so counts partly reflect coverage volume as well as salience. Tobacco, alcohol, and SSBs are product-specific; "sin tax" and "health tax" are generic umbrella references. No health-tax mentions were detected in 2011.

## *Depth of ADB engagement, 2010–2025*

A review of ADB documents reveals inconsistent trends in the mention of health taxes across 2010–2025. Of the 1,179 projects reviewed (2,055 distinct project documents screened), only 45 projects, or 3.8%, have any mention of health taxes (see Figure 3; Table A1 lists all 45 projects). An index comprising four criteria has been used to assess the depth and comprehensiveness of ADB's engagement, building on an earlier CGD review of the International Monetary Fund's (IMF's) engagement on health taxes.[25,i] The criteria (and weighting) used are as follows: C1: Any mention of health taxes (0.5); C2: TA intervention on health taxes (1.0); C3: Loan or grant intervention on health taxes (2.5); and C4: Measurable health-tax commitment or outcome indicator (1.0).[j] To understand the depth of engagement, we also took into consideration whether projects that had health-tax interventions (C2 or C3) had a measurable health-tax commitment or indicator formally incorporated into the operation, such as an excise increase of a stated amount, an excise-revenue target, or a health-related indicator.

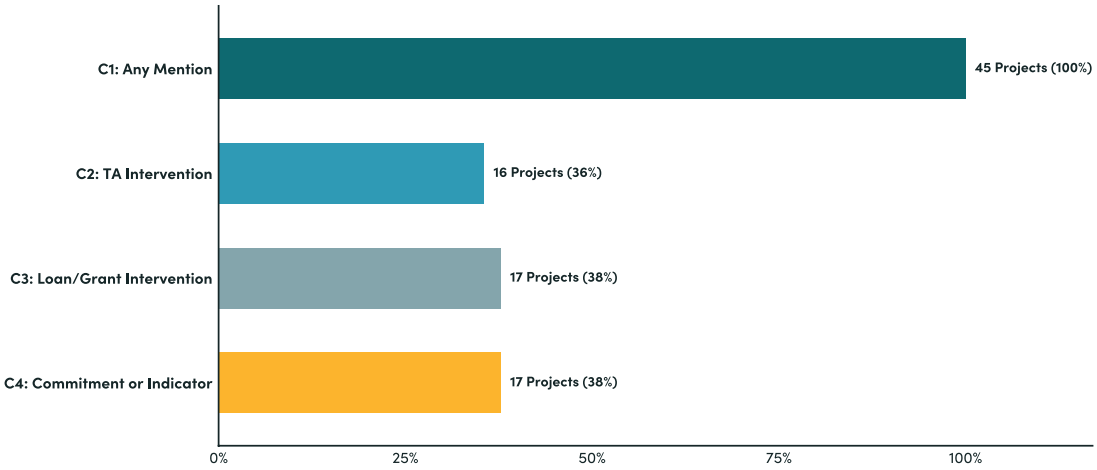
Of the 45 projects with health-tax mentions, 36% include TA support and 38% include a loan or grant intervention. Of the 17 projects incorporating health-tax measures into loans or grants, 16 include a measurable health-tax commitment or indicator (C4), as does one further project, the second subprogram of the Build Universal Health Care Program (discussed below). Figure 3 traces ADB-funded projects from broad mention to measurable health-tax commitments or indicators. TA interventions overlap with loan and grant interventions, and there are nine projects that feature

i The IMF review used a country-level index with four equally weighted components; the index in this paper scores individual ADB projects on four criteria and weights them unequally.

j A higher weight was given to a loan or grant intervention because of the higher potential for impact of loan and grant modalities through financial conditionality, such as prior actions and tranche conditions.

both a loan or grant intervention and a TA intervention, indicating technical support accompanied by financial commitments, although in six of them the TA is credited for supporting the operation's broader health-tax reform package rather than a named product tax (Annex 2, Section A2.3). All 17 projects with a measurable health-tax commitment or indicator are loans or grants.

**FIGURE 3. ADB health-tax engagement by tier (C1–C4)**
Share of projects reaching each tier




*Notes:* C2 and C3 are not mutually exclusive; nine projects have both TA and loan/grant intervention. C4 = a measurable health-tax commitment or outcome indicator formally incorporated in the operation; it records the commitment, not its implementation or results. Of the 17 loan/grant interventions, 16 include one, but only seven have a results-framework indicator: one health-outcome target, for tobacco-use prevalence, which the program documents do not attribute to the tax, three revenue indicators, and three implementation indicators; the other nine are policy-matrix commitments, seven of them completed prior or policy actions and two prospective commitments that the documents reviewed do not show as implemented. One further project, Build Universal Health Care subprogram 2, reaches C4 without a loan or grant health-tax measure: it meets C2 through technical assistance and C4 through its own tobacco-prevalence target.

Twenty-one projects contained references to health taxation but did not meet C2, C3, or C4. These references ranged from background discussion and descriptions of earlier reforms to prospective policy topics and broader fiscal-policy engagement (Table A1 describes each).

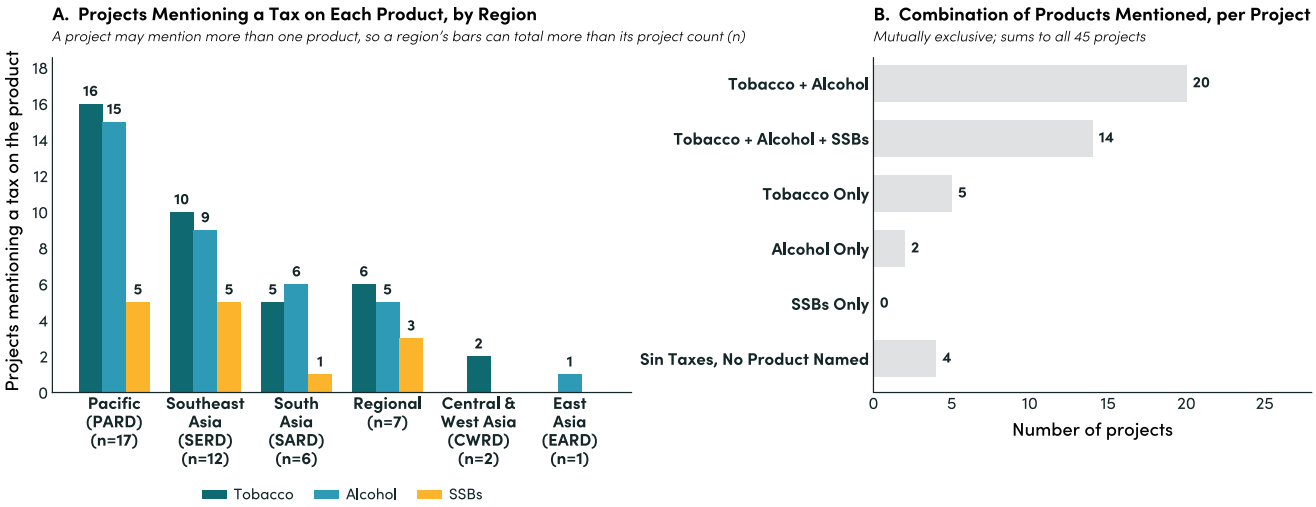
## *Product composition: Tobacco, alcohol, or SSBs?*

There is a major focus on tobacco and alcohol taxes across ADB projects, in both mentions and engagement, but far fewer projects engage on each product than mention it. Taxes on tobacco, alcohol, and SSBs are mentioned in 39, 36, and 14 projects, respectively (Figure 4). Tobacco and alcohol often appear together: 20 projects mention tobacco and alcohol taxes only. In mentions, SSBs do not appear alone and are always mentioned together with tobacco and alcohol. A mention may be background, however, and does not by itself show that ADB supported a tax on that product. Counting only the products that ADB's TA (C2) or loan or grant measures (C3) covered, 17 projects engage on tobacco taxes, 16 on alcohol taxes, and 9 on SSB taxes (Figure 5). A measurable commitment or indicator covering the product itself (C4) is found in 14 of those on tobacco, 13 of those

on alcohol, and 5 of those on SSB taxes. Results-framework indicators are rarer, covering tobacco and alcohol in five projects each and SSBs in two (Annex 2, Section A2.3).

Engagement on SSB taxes is mostly, but not always, bundled with tobacco and alcohol. Six of the nine projects that engage on SSB taxes also engage on both tobacco and alcohol taxes. The other three engage on SSBs without alcohol; in Solomon Islands, a 2022 ADB program supported an SSB tax without tobacco or alcohol measures (Annex 2, Section A2.4, describes all nine). These are different models of engagement; the data describe them but do not show their relative costs or benefits, which depend on country context and government acceptability. SSB excise taxes are also relevant to nutrition interventions related to healthy food environments, product reformulation, and social and behavioral change.

## FIGURE 4. Health-tax products mentioned in ADB projects

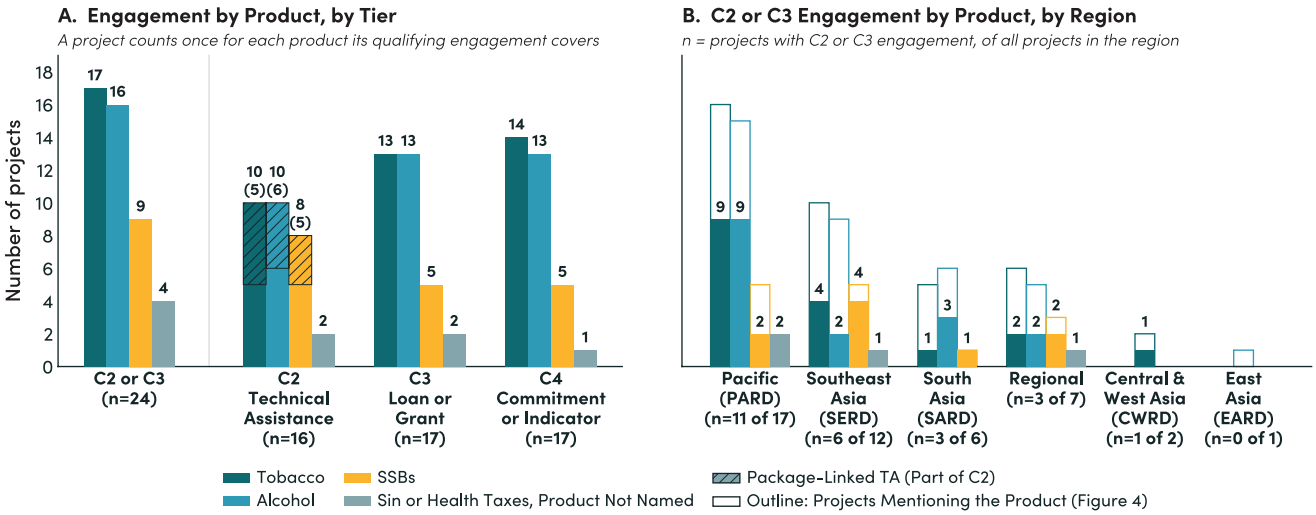



*Notes:* Products are those whose taxes a project's ADB documents mention, including background references. A mention does not by itself indicate ADB support for a tax on that product; Figure 5 shows engagement. Projects that mention only sin taxes, without naming a product, appear in no Panel A bar. Panel B places each project in one combination, so its bars sum to all 45 projects. Regions assigned by country (Mongolia under East Asia/EARD; Pakistan under Central and West Asia/CWRD).

Regionally, Pacific and Southeast Asia projects drive tobacco and alcohol mentions (Figure 4), but engagement differs. Pacific projects account for the most engagement on tobacco and alcohol taxes, nine projects each, but only two engage on SSB taxes (Figure 5). Southeast Asia projects engage on tobacco and alcohol taxes in only four and two projects, respectively, but on SSB taxes in four. South Asia projects are more alcohol-heavy, driven by India's state excise reforms. SSBs, interestingly, have no presence in East Asia or Central and West Asia projects. There is little evidence of established trends in engagement by product type over the years, though it is clear that ADB has provided the most documented engagement on tobacco taxation, followed by alcohol, with less frequent engagement on SSB taxation: 17, 16, and 9 projects, respectively. SSB engagement first appeared in 2016 and rose from three projects approved in 2015–2019 to six in 2020–2025, partly reflecting

indicative commitments for later subprograms rather than implemented tax reforms (Annex 2, Section A2.4). Projects engaging on any health tax also rose, from 8 to 12, and the last period covers six years rather than five; with such small numbers, this should not be read as an established trend (Figure A1 shows product mentions over time). The predominance of tobacco and alcohol is consistent with global patterns: more countries apply excise taxes to tobacco (183) and alcohol (149) than to SSBs (132), and tobacco and alcohol taxes are estimated to offer more additional revenue.[26,k]

**FIGURE 5. Health-tax engagement by product in ADB projects**




*Notes:* Figure 4 counts products a project's documents mention; this figure counts only the products covered by the engagement that qualifies a project at each tier: technical assistance (C2), a loan or grant measure, including indicative actions for a later subprogram (C3), and every qualifying measurable commitment or indicator (C4). Tiers are separate criteria, not stages: Build UHC subprogram 2 meets C2 through technical assistance and C4 through its own tobacco-prevalence target, without C3, and Vanuatu reaches C3 without C4. Hatched: technical assistance credited for supporting the operation's health-tax reform package and attributed the products of that package's measure; bracketed figures exclude these cases, and Panel B is unchanged without them. "Product Not Named": sin or health taxes with no product named, never assigned to a product; Solomon Islands (2022) counts both here and for SSBs. Results-framework indicators cover tobacco in 5, alcohol in 5, and SSBs in 2 projects. Regions assigned by country.

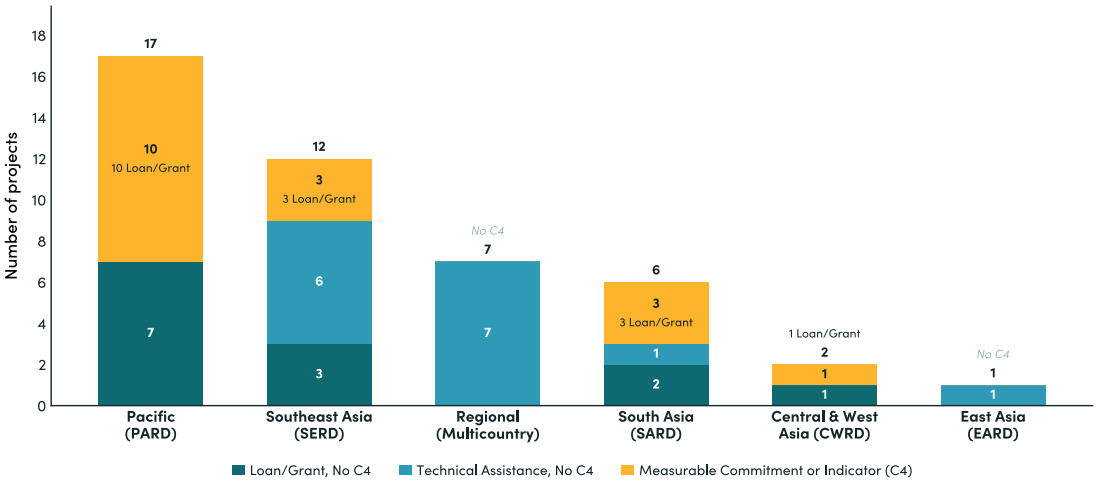
## *Geographic trends*

Regional variations of health-tax engagement are significant. The Pacific regional department has the most loan or grant interventions on health taxes and the highest frequency of projects with a measurable health-tax commitment or indicator (C4), 10 of its 17, or 59% (Figure 7). Seven of these rest on policy-matrix commitments; only three Pacific projects, or 18%, carry a results-framework indicator. Southeast Asia has the second-largest number of projects, 12, but only 3, or 25%, have a measurable commitment or indicator, all three with a results-framework indicator. In contrast, while South Asia has fewer projects, six, half of them have a measurable commitment or indicator, two through results-framework indicators and one through a prospective commitment. The Central

k In 2019, countries raised, on average, revenue equal to 0.6% of GDP from tobacco taxes and 0.3% of GDP from alcohol taxes. The Task Force estimates that excise taxes raising prices by 50% would generate additional revenue globally over five years of $1 trillion from tobacco and $2.4 trillion from alcohol, compared with $328 billion from sugary beverages.

and West Asia and the East Asia regional departments have the fewest projects on health taxes, and neither has a results-framework indicator.

**FIGURE 6. Health-tax engagement across ADB regions**
Project volume by ADB regional department, split by modality and C4 status



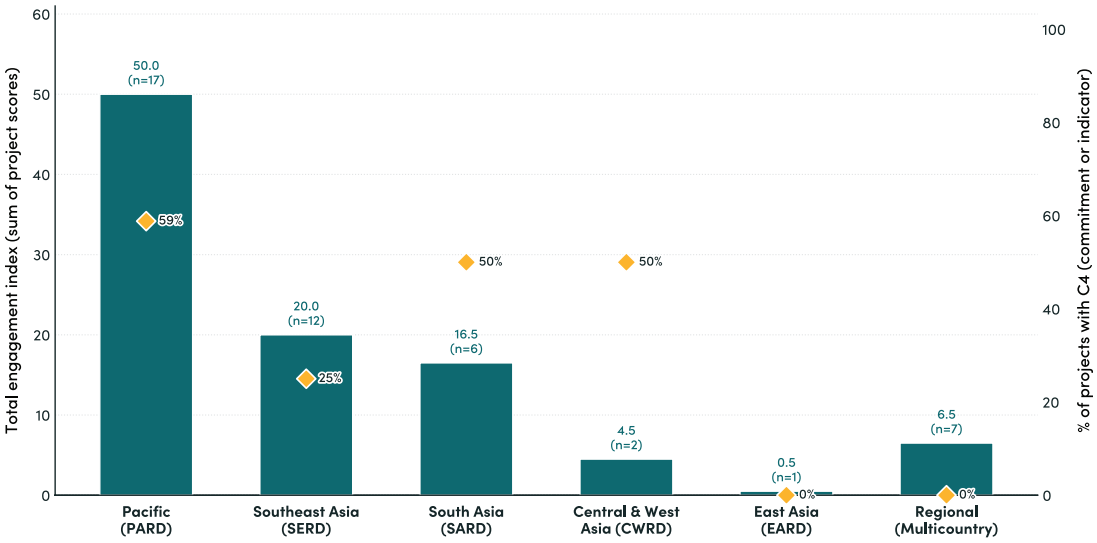

*Notes:* The 45 health-tax projects by ADB regional department (plus a "Regional" bucket for multicountry work), stacked by modality and C4 status: loans or grants without C4, technical assistance without C4, and projects with a measurable health-tax commitment or outcome indicator (C4). Smaller text on each gold segment gives the loan/grant/technical-assistance (TA) composition of that region's C4 projects. Of the 17 C4 projects, all are loan/grant operations; 8 of them have a results-framework indicator, and the rest are policy-matrix commitments. Bars count projects by financing modality, not by criterion: of the 30 loan/grant operations, 17 incorporate a health-tax measure (C3), 11 of them in the Pacific, and 13 do not: 12 only mention health taxes and 1 (Build Universal Health Care subprogram 2) meets C2 through technical assistance and C4 through its own results-framework indicator.

Regional variations reveal that more projects emerged from the Pacific than from any other regional department, along with the most C4 projects (see Figure 6). The East Asia and the Central and West Asia departments have the fewest projects and only one C4 project, in Pakistan, resting on a completed approval condition rather than a results-framework indicator.[27] In South Asia, while there are fewer projects than in Southeast Asia (6 vs. 12), the C4 share is twice as high (50%, 3 of 6 projects, compared with 25% in Southeast Asia, 3 of 12). Therefore, although projects in Southeast Asia engage more frequently, the depth of engagement is lower, largely attributable to more TA projects with health-tax mentions, but few corresponding measurable commitments or indicators (see Figure 6). Although South Asia's engagement is smaller in volume of projects, it is more comprehensive in terms of depth. Overall, the volume of projects and the depth of engagement differ, with Southeast Asia demonstrating this difference clearly with its high project count but low project depth. South Asia, on the other hand, has had a lower engagement index than Southeast Asia (16.5 vs. 20.0; Figure 7), but has a stronger track record of translating project interventions into measurable commitments or indicators: all three of its projects with C2 or C3 engagement reach C4, against three of the six in Southeast Asia (Figures 5 and 6). The Pacific fares well on both counts, although most of its

C4 projects rest on policy commitments rather than results-framework indicators. Figure 7 brings breadth and depth together by region: the Pacific's engagement index, 50.0, is two and a half times Southeast Asia's, and 59% of its projects reach C4, while the seven multicountry TA projects add 6.5 to the index without any reaching C4.

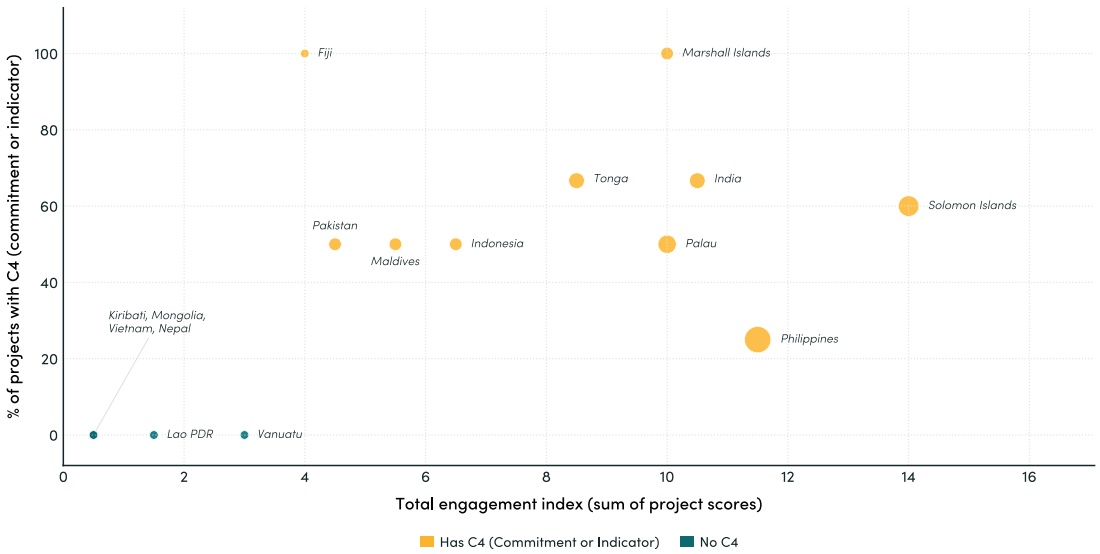
Figure 8 unmasks the regional aggregation shown in Figure 7 to show ADB engagement across individual countries. The most important quadrant is the upper right, with a high engagement index and a high share of projects reaching C4: Solomon Islands, India, Marshall Islands, and Tonga show this pattern of both volume and depth, and Palau sits on the margin. Solomon Islands has the highest engagement index of any single country, and three of its five projects reach C4, although only one carries a results-framework indicator. Marshall Islands and Palau each have two C4 projects that rest on policy commitments rather than results-framework indicators; in Marshall Islands, the tax legislation carrying the alcohol and tobacco excises was still pending in Parliament in 2014. The Philippines is the outlier: the largest bubble in the dataset, with the most projects of any single country, eight, and the second-highest engagement index, 11.5, but only two reaching C4, indicating high breadth and relatively low depth. In contrast, while countries such as Fiji, Indonesia, Maldives, and Pakistan have had fewer projects on health taxes, the depth of engagement has been higher. On the other hand, countries such as Vietnam, Lao PDR, Mongolia, Kiribati, and Nepal have had a limited number of projects and low engagement.

**FIGURE 7. Health-tax engagement index by region**
Bars = total engagement (sum of project scores, left)
Gold diamonds = share of projects with C4, a measurable commitment or indicator (right)




*Notes:* Engagement index = sum of project scores per region, each project scoring 0.5·C1 + 1.0·C2 + 2.5·C3 + 1.0·C4 (max 5.0). Bars show "how much" total engagement (rewards both depth and number of projects); gold diamonds show "how deep"—the share of the region's projects with a measurable health-tax commitment or outcome indicator (C4). All mention projects (C1 = 1). "Regional" = multicountry projects.

**FIGURE 8. Country engagement: Breadth vs. depth**
Total engagement index (how much) vs. share of projects with C4 (how deep)




*Notes:* Each bubble is a country; bubble size = number of country-specific mention projects. X = total engagement index (sum of project scores, 0.5·C1 + 1.0·C2 + 2.5·C3 + 1.0·C4). Y = share of that country's projects with a measurable health-tax commitment or outcome indicator (C4); a policy-matrix commitment such as an excise increase counts, so C4 does not imply results-framework monitoring. Multicountry "Regional" projects excluded. ADB-financed projects only; does not capture health-tax work by governments or other partners, or countries' own monitoring of their reforms.

## *Does ADB engagement target countries with the greatest tobacco tax gaps?*

WHO recommends tobacco taxes reach at least 75% of the retail price.[28] In 2024, only 2 of the 16 DMCs with an ADB health-tax project reached the threshold: Indonesia and Palau (see Panel A in Figure 9). Indonesia crossed it through tobacco excise increases, which ADB's 2025 program records among the completed prior actions of its first subprogram;[29] Palau crossed it mainly through a general goods and services tax in its ADB-supported 2021 reform, not a higher tobacco tax. The other high-engagement countries—Solomon Islands, the Philippines, India, Marshall Islands, and Tonga—all fall below the WHO-recommended threshold (Tonga only narrowly), so ADB is engaging where there is still need for advocacy and engagement. Yet, this remains inconsistent and may not point to intentional country targeting efforts by ADB, since countries that receive the least ADB attention on health taxes sit, on average, even further below the WHO-recommended threshold (i.e., Lao PDR, Vietnam, Kiribati, Mongolia, and Nepal). Tobacco excise revenue shows no uniform relationship with ADB engagement (see Panel B in Figure 9). The least-engaged countries all collect less than 0.5% of GDP, but so does India, the third most-engaged country, at about 0.1% of GDP (cigarette excise in fiscal year 2015/16, the latest WHO figure), while Vanuatu, with one project, collects more than 1%. The index measures documented ADB engagement with health taxation, not the effectiveness of tax policy, and the revenue data refer to different years, so these patterns describe where ADB has

engaged rather than whether that engagement raised revenue. This points to a clear opportunity for ADB to benchmark data more systematically to target health-tax engagement toward countries with the largest gaps, taking into account the support that other partners already provide.

**FIGURE 9. Tobacco tax burden, excise revenue, and ADB engagement**
Tobacco tax design (left) and revenue yield (right) by ADB DMC, with the WHO 75% reference point




*Notes:* Only 2 of the 16 DMCs with an ADB health-tax project (Indonesia and Palau) reach the WHO 75% tobacco-tax threshold. Panel A counts all taxes on cigarettes, including excises, value-added or goods and services taxes, and import duties, so it can rise without a higher tobacco excise: Palau crossed 75% mainly through the goods and services tax introduced under its 2021 tax reform, while its per-pack tax on tobacco was not raised. Tobacco-excise revenue (Panel B) is below 0.5% of GDP in 7 of 14 DMCs with data. DMCs without an ADB health-tax project are not shown. Tobacco-use prevalence rates are not taken into account in the analysis, nor the presence or intensity of other partner engagement.

*Sources:* Panel A – WHO Global Health Observatory, total taxes as a share of the retail price of the most-sold cigarette brand (TOBACCO_MPOWER_R_TAX), 2024. Panel B – WHO MPOWER tobacco excise revenue ÷ World Bank nominal GDP in local currency for the same (fiscal) year; revenue covers cigarettes only for India, Indonesia, Kiribati, Lao PDR, Pakistan, and the Philippines, and the latest revenue year ranges from 2015/16 (India) to 2024.

# IV. How ADB measures and staffs its health-tax work

## Are ADB projects measuring outcomes sufficiently?

Measurable outcome indicators in loan and grant projects make it possible to track the longer-term impact of ADB projects at the policy and institutional level. Of the 17 projects incorporating health-tax measures into loans or grants, 16 include measurable health-tax commitments or indicators, but only 7 include a health-tax-related indicator in their results frameworks. In the other nine, the measure appears only as a policy commitment: seven are completed prior or policy actions or approval conditions, such as excise increases on tobacco and alcohol in Fiji, and two are prospective commitments, in Marshall Islands and Maldives, that the documents reviewed do not show as implemented (Table A1 gives each). Measurable commitments in the ADB health-tax projects largely refer to fiscal or administrative events such as a law passed, a rate increase, or licenses issued for a compliance system; some are steps short of an enacted reform, such as a bill introduced, and none of the nine commitment-only operations includes a results-framework indicator that tracks the measure's implementation or effects.

The results-framework indicators vary in focus, tracking health outcomes, revenue, or implementation. The Build Universal Health Care Program (Subprograms 1 and 2) has health-outcome indicators related to the reduction in prevalence of current tobacco use, which the approval documents do not link to the excise increases.[30] Two programs in West Bengal, India, tracked state excise revenue, levied on alcohol, and QR-code holograms on liquor bottles;[31] Indonesia's Domestic Resource Mobilization Program targets extending excise taxes beyond tobacco and alcohol;[32] and a subprogram series in Tonga has outcome indicators related to increases in excise-duty revenue as a proportion of GDP, a measure that also includes fuel.[33] However, other projects do not demonstrate quantitative measurable indicators so explicitly, and instead include policy measures as results-framework targets. For example, the results framework of a Solomon Islands fiscal sustainability program lists the enactment of excise increases on alcohol and tobacco, which took effect before the grant was approved, rather than a quantified indicator of the excises' health or fiscal effects.[34]

Of the eight projects with a results-framework indicator, including the second Build Universal Health Care subprogram, two measure health outcomes, three measure revenue, and three track implementation; none measures both health and fiscal effects, and none attributes a change in health outcomes to the tax. Among the loan and grant operations, the link between health taxes and health financing is rare and only seen in the Philippines' Build Universal Health Care Program[35,l] and

l The government's earmarking of excise revenue from alcohol, tobacco, and sweetened beverages for universal health care was a Subprogram 1 prior action; the Subprogram 2 Report and Recommendation of the President notes the allocation to universal health care of tax revenues from tobacco and alcohol. Subprogram 2 is credited with technical assistance through TA 6832-PHI, which was attached to Subprogram 1 but also directed at Subprogram 2, and whose approved activities include tracking the funds earmarked from the tobacco, alcohol, and sweetened-beverage excises; the documents reviewed show this tracking as approved, not as delivered.

Indonesia's Domestic Resource Mobilization Program,[36,m] suggesting a fiscally oriented approach to health taxes at ADB. This review did not assess the measured effects of ADB-supported reforms on revenue, affordability, consumption, or prevalence.

Long-term project impact may depend on the types of loan modalities employed for health-tax interventions. A review of the 17 loan and grant operations with a health-tax measure reveals that all were policy-based loans or grants (PBLs), with or without programmatic approaches, wherein health taxes were not a central focus. This is likely because PBLs allow for time-bound policy-based actions, which are an important mechanism to implement health-tax policies and keep governments accountable. However, other modalities, such as results-based lending (RBL), can measure outcome achievement based on a set of disbursement-linked indicators, and could be used to pursue similar results for health-tax interventions. Revenue or health-outcome indicators that have disbursements tied to them can be a promising way for governments to implement and increase excise taxes. More than half of the loan and grant operations with a health-tax measure and a measurable commitment or indicator, 9 of 16, have no health-tax indicator in their results frameworks. Pairing health-tax policy actions with at least one performance indicator that tracks their implementation or effects would strengthen monitoring, although it would require agreeing on indicators, baselines, and data sources with governments. The option to use other modalities for health-tax interventions should be adequately explored in future ADB projects since RBL programs, which run about five years on average,[37] typically last longer than single-tranche PBLs and link disbursements to agreed results over that period, which may suit reforms that need an incremental approach.

## Which ADB teams engage most on health taxes? Is expertise sufficiently leveraged across teams?

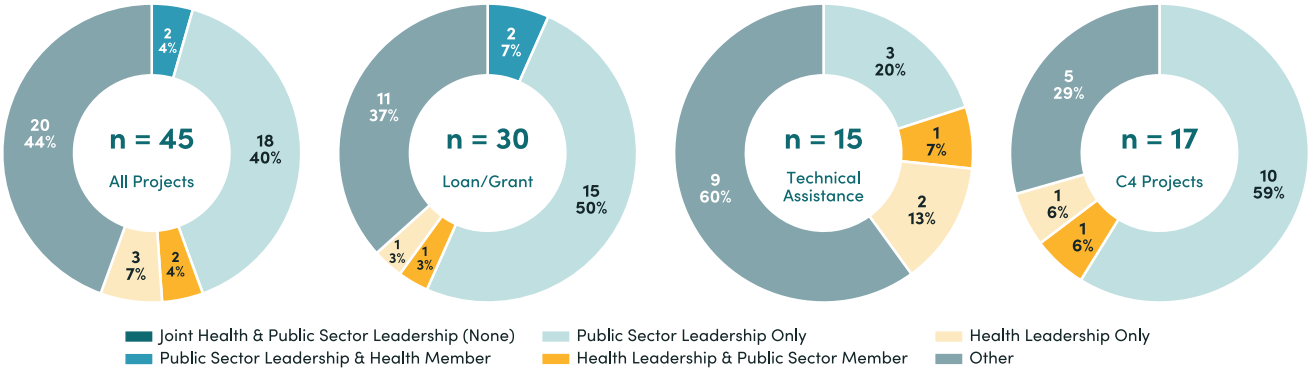
Health taxes are an inherently multisectoral intervention and have implications for health and fiscal policy. Close coordination with ministries of health and ministries of finance is needed for effective policy implementation. Health and fiscal outcome measures are essential to capture the effects of the policy as well. Reductions in tobacco prevalence rates, per capita alcohol consumption rates, or increased public revenue due to excise increases are examples of indicators that can measure the longer-term outcomes of health-tax policies. The review reveals that there are no projects that have joint team leadership between health and public sector management specialists in ADB (see Figure 10). These specialists are responsible for health and fiscal policy interventions in ADB projects, respectively, across ADB DMCs. Of the 30 loans and grants, 50% are led by public sector specialists, while another 7% are led by public sector specialists with a health team member (a total of 57% led by public sector specialists, with or without a health team member). Another 37% of loans and grants are led by staff from other sectors, such as economists or country specialists. The remaining 7% (2 loans)

m The program's prior actions included regulations setting out how a share of tobacco excise revenue is earmarked for subnational governments to finance promotive and preventive health programs.

are led by health specialists. Therefore about 13% of loans and grants have health membership present in some capacity in the team composition (Figure 11). Notably, the only two operations among the eight with results-framework indicators to include a health-outcome target, the two subprograms of the Build Universal Health Care Program, are both health-led, suggesting an association between health expertise on the team and the inclusion of health-outcome indicators, although both belong to the same health-sector program. The absence of joint team leadership and the limited health membership point to missed opportunities to capture the effects of the intervention across sectors and ensure that outcome indicators accurately reflect both health and revenue benefits. This is consistent with the outcomes measurement review, where fiscal and administrative indicators were the most commonly measured, which may be partially explained by the heavier fiscal staffing on loan and grant programs.

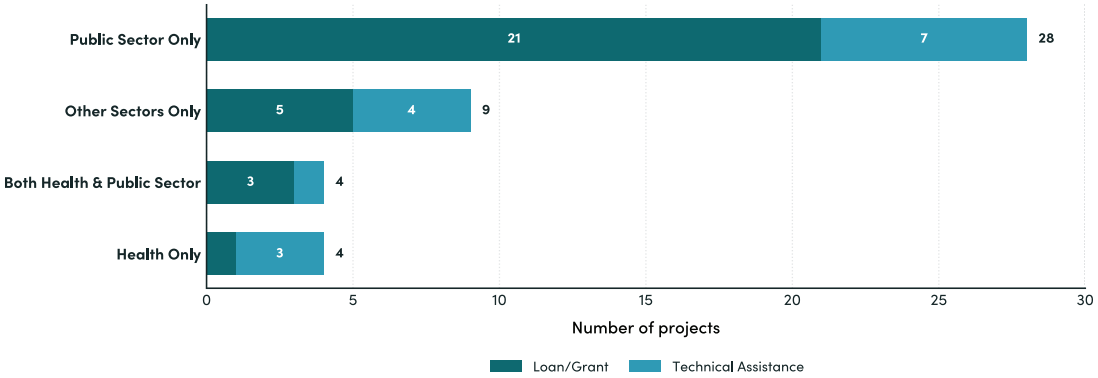
For TAs, the health sector is involved in 27% of TA projects. TAs do not produce measurable health-tax indicators in their DMFs and therefore do not have trackable health-tax outcomes: no TA project reaches C4. There are no loan or TA projects that have had joint team leadership across health and public sectors. Closing the fiscal-health gap will require bringing health specialists into loan design, as co-team leaders or team members, to ensure that DMF measurement outcomes capture health benefits. This is largely missing across ADB projects and regional departments: no project is jointly led, and health specialists sit on only 4 of the 30 loan and grant teams.

**FIGURE 10. Leadership composition of ADB health-tax project teams**
Share of projects by lead sector tag, with cross-functional team-member breakdown




*Notes:* Each donut shows the share of projects by team-leader sector tag, split further by whether the team includes a cross-functional member. "Joint Health & Public Sector" requires the team leaders to include both health and public-sector expertise. "Health" counts a member tagged Health or titled a Social Sector specialist; gender and general social-development specialists are not counted as health. Of the 20 "Other" projects, most are led by Economists (14) or Social Development/Gender specialists (3), with the remaining 3 led by two country specialists and a financial sector specialist. The fourth donut restricts to C4 projects (n = 17). Health presence is near-absent in "Other"-led teams: of the 20 "Other"-led projects (11 loans/grants + 9 TAs), only 1 had a health or social-sector team member (43263-012, a TA); the other 19 had none.

**FIGURE 11. Sector mix of ADB health-tax project teams**
Most project teams include public sector specialists but no health-sector member




*Notes:* Working team (team leaders + members; peer reviewers excluded) of the 45 health-tax projects. "Public Sector" = a member tagged Public Finance/Tax or Public Sector/Governance. "Health" = a member tagged Health or titled a Social Sector specialist; gender and general social-development specialists are not counted as health (counting them would raise health presence from 8 to 26 of 45). Categories are mutually exclusive; bars split loan/grant vs. technical assistance (All = loan/grant + TAs = 45). "Other Sectors Only" (9) comprises 5 projects led by Economics-tagged staff, 3 by Social Development/Gender staff, and 1 by a country specialist; Economics is a distinct tag, not Public Sector. Sensitivity: peer reviewers raise Public Sector 28→33.

# V. Conclusions and discussion

Health taxes on tobacco, alcohol, and SSBs are an underutilized policy lever for governments. They reduce consumption and premature deaths and generate revenue that can be used toward health systems strengthening and financing efforts. However, ADB engagement with health taxes has been incidental and opportunistic, geographically concentrated and not clearly targeted to need, and largely fiscal in its framing rather than health outcome oriented.

Across the 1,179 screened projects, ADB engagement on tobacco, alcohol, and SSB excise taxes has been limited, concentrating in the Pacific on policy-based loans and grants (mostly programmatic series) that drive most of the measurable commitments or indicators, and predominantly measuring indicators that are fiscal or administrative in nature. When ADB does intervene through loans and grants, it almost always incorporates measurable health-tax commitments or indicators (16 of 17 such operations), but explicit monitoring of health-tax implementation and outcomes remains considerably less common: only 7 of those 16 include health-tax-related indicators in their results frameworks. Moving from simple engagement to measurable commitments or indicators is seen only across loans and grants rather than TAs, and staffing composition, with no jointly led project and few teams with a health member, points to the potential

value of joint team membership. Most projects lack health team representation, a pattern associated with less emphasis on measurable health outcomes. Engagement on SSB taxes is the least common. SSB engagement presents a strong opportunity for ADB to engage further with countries, while simultaneously engaging on tobacco and alcohol excise taxes. The review of 2010–2025 points to a missed opportunity and the lack of a clear strategy to engage more deeply across countries and regions on health taxes, with sporadic and opportunistic engagement, rather than systematic and organized. Several opportunities arise from this analysis, in terms of future strategy to further enhance and establish ADB's role as a regional partner on health taxes, including its comparative advantages of regional knowledge sharing and peer-learning networks. These opportunities are set out in the accompanying policy brief, *Asian Development Bank Health Tax Engagement: Looking Ahead*, on ADB's strategic role in advancing the health-tax agenda.[38]

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# Annex 1. ADB health-tax projects, 2010–2025

### TABLE A1. ADB health-tax projects: Products mentioned and engaged, and measurable health-tax commitments or indicators (n = 45)

| Project (No. – Country: Name) | Approval Year | Products Mentioned; Engaged (C2–C4) | C4: Measurable Commitment or Indicator |
|---|---|---|---|
| **Loans and Grants (n = 30)** | | | |
| 43186-012 – Solomon Islands: Economic Recovery Support Program (Subprogram 1) | 2010 | Mentioned: Tobacco, alcohol<br>Engaged: Tobacco, alcohol | C4, completed prior action (no results-framework indicator): Prior action 1.4.2: ministerial orders raising import duties, excises, and fees on luxury goods, alcohol, and tobacco (single-tranche condition; reported as adopted in the February 2010 RRP, para. 48; marked completed March 2010 in the completion report) |
| 43321-013 – Marshall Islands: Public Sector Program (Subprogram 1) | 2010 | Mentioned: Tobacco, alcohol<br>Engaged: Tobacco, alcohol | C4, prospective commitment (no results-framework indicator): Policy action 3.2 (SP1 tranche condition, met): Cabinet endorsement of time-bound actions to be performed by FY2015, including adoption of excises on alcohol, tobacco, motor vehicles, and fuels; the tax legislation to effect these reforms (7 bills), introduced in Parliament in 2012, was still pending in September 2014 (program completion report, 43321-023) |
| 43321-023 – Marshall Islands: Public Sector Program (Subprogram 2) | 2012 | Mentioned: Tobacco, alcohol<br>Engaged: Tobacco, alcohol | C4, completed policy action (no results-framework indicator): Policy action 3.1 (SP2 tranche condition, met): implementation of the SP1 time-bound tax actions evidenced by introduction of the tax legislation (7 bills) into Parliament in August 2012; SP1 action 3.2 defines those actions to include adoption of excises on alcohol and tobacco; the legislation was still pending in September 2014 (program completion report) |
| 44453-014 – India: West Bengal Development Finance Program | 2012 | Mentioned: Tobacco, alcohol<br>Engaged: Alcohol | C4, results-framework indicator: Revenue: increase in state excise revenue of at least 25% a year (an output-level target; state excise is levied on liquor) |
| 44253-013 – Philippines: Local Government Finance and Fiscal Decentralization Reform Program (Subprogram 1) | 2014 | Mentioned: Tobacco, alcohol | No C4: Mention only (C1). Background: the Sin Tax Law (in effect from January 1, 2013) cited in the risk table |
| 45288-002 – India: Punjab Development Finance Program | 2014 | Mentioned: Tobacco, alcohol | No C4: Mention only (C1). Background: state excise in completion-report revenue tables, projections, and narrative (on liquor); a VAT levied mainly on petroleum products, liquor, and tobacco; and an education cess levied on liquor to fund a schools program |
| 47314-001 – Kiribati: Strengthening Fiscal Stability Program | 2014 | Mentioned: Tobacco, alcohol | No C4: Mention only (C1). Government excise increase reported in the completion report under a general post-program revenue item |

**(Continued)**

**TABLE A1. (Continued)**

| Project (No. – Country: Name) | Approval Year | Products Mentioned; Engaged (C2–C4) | C4: Measurable Commitment or Indicator |
|---|---|---|---|
| 48458-001 – Philippines: Expanding Private Participation in Infrastructure Program (Subprogram 1) | 2015 | Mentioned: Sin taxes, no product named | No C4: Mention only (C1). Background: the Sin Tax among past revenue reforms |
| 48361-001 – Tonga: Building Macroeconomic Resilience Program (Subprogram 1) | 2016 | Mentioned: Tobacco, alcohol, SSB<br>Engaged: Tobacco, alcohol | C4, results-framework indicator: Revenue: excise-duty revenue to at least 4.7% of GDP (total excise, base includes fuel) |
| 48361-002 – Tonga: Building Macroeconomic Resilience Program (Subprogram 2) | 2017 | Mentioned: Tobacco, alcohol, SSB<br>Engaged: Tobacco, alcohol, SSB | C4, results-framework indicator: Revenue: excise-duty revenue to at least 4.8% of GDP (total excise, base includes fuel) |
| 49209-001 – India: Second West Bengal Development Finance Program | 2017 | Mentioned: Alcohol<br>Engaged: Alcohol | C4, results-framework indicator: Implementation: QR-code-based holograms on liquor bottles (Excise Directorate), 40% to 100% of bottles |
| 52074-001 – Solomon Islands: Improved Fiscal Sustainability Reform Program | 2018 | Mentioned: Tobacco, alcohol<br>Engaged: Tobacco, alcohol | C4, results-framework indicator: Implementation: alcohol and tobacco excise increases, with an automatic annual increase mechanism, enacted (restates a policy action already in force at approval: in force October 1, 2018, Board approval November 26, 2018) |
| 48361-003 – Tonga: Building Macroeconomic Resilience Program (Subprogram 3) | 2019 | Mentioned: Tobacco, alcohol, SSB | No C4: Mention only (C1). Describes excise measures adopted under earlier subprograms (48361-001/-002); its own actions are revenue-administration and customs bills |
| 53247-001 – Pakistan: Economic Stabilization Program | 2019 | Mentioned: Tobacco<br>Engaged: Tobacco | C4, completed policy action (condition for Board approval; no results-framework indicator): Policy action 8 (RRP, Table 2): the Federal Board of Revenue issued licenses for the implementation of the track-and-trace system for the cigarette excise |
| 54193-001 – Pakistan: COVID-19 Active Response and Expenditure Support Program | 2020 | Mentioned: Tobacco | No C4: Mention only (C1). Lists the cigarette track-and-trace licensing supported under 53247-001 among government fiscal reforms |
| 54245-001 – Palau: Health Expenditure and Livelihoods Support Program | 2020 | Mentioned: Tobacco | No C4: Mention only (C1). Background: Government tobacco-tax increases, FY2015–FY2019 |
| 53305-001 – Solomon Islands: Domestic Resource Mobilization Project | 2021 | Mentioned: Tobacco, alcohol | No C4: Mention only (C1). Background: the customs department collects tobacco and alcohol excises |

**(Continued)**

**TABLE A1. (Continued)**

| Project (No. – Country: Name) | Approval Year | Products Mentioned; Engaged (C2–C4) | C4: Measurable Commitment or Indicator |
|---|---|---|---|
| 54284-001 – Palau: Recovery through Improved Systems and Expenditure Support Program (Subprogram 1) | 2021 | Mentioned: Tobacco, alcohol<br><br>Engaged: Tobacco, alcohol | C4, completed prior action (no results-framework indicator): Prior action 2.1: President's transmittal to Congress (OEK) of a tax reform bill replacing alcohol and tobacco import duties with an excise; the package was enacted on September 29, 2021 under Subprogram 2 |
| 55105-001 – Philippines: Build Universal Health Care Program (Subprogram 1) | 2021 | Mentioned: Tobacco, alcohol, SSB<br><br>Engaged: Tobacco, alcohol, SSB | C4, results-framework indicator: Health outcome: tobacco-use prevalence (age 15+) target of 20.0% by 2024 (2018 baseline 24.3%), which the program documents do not attribute to the tax; for products, prior action 1.2 (earmarking of the tobacco, alcohol, and sweetened-beverage excises for universal health care) also independently meets the C4 test |
| 54284-002 – Palau: Recovery through Improved Systems and Expenditure Support Program (Subprogram 2) | 2022 | Mentioned: Tobacco, alcohol<br><br>Engaged: Tobacco, alcohol | C4, completed prior action (no results-framework indicator): Prior action 2.3.1: the OEK passed the tax reform package, signed into law by the President on September 29, 2021; the same policy-matrix row (SP1 action 1.3) defines the package as replacing import duties on alcohol and tobacco with an excise that also applies to local production |
| 55011-001 – Solomon Islands: Supporting Fiscal and Economic Recovery Program (Subprogram 1) | 2022 | Mentioned: Tobacco, alcohol, SSB<br><br>Engaged: SSB; sin taxes, no product named | C4, completed prior action (no results-framework indicator): Prior action 1.4.1: new tax on sugar and sugary drinks (Customs and Excise (Import Duties) (Amendment) Orders 2021); indicative SP2 action 2.4 (extend health taxes to at least one more product) was replaced in Subprogram 2 by a nickel royalty (SP2 RRP, 2024) |
| 55003-001 – Maldives: Strengthening Fiscal Management and Sustainability Program (Subprogram 1) | 2023 | Mentioned: Tobacco, alcohol, SSB<br><br>Engaged: Tobacco, alcohol, SSB | C4, prospective commitment (no results-framework indicator): SP2 policy action 2.4 (due by August 2025): Cabinet to approve and submit to Parliament legislation to formalize and raise excise rates for goods with negative externalities (the RRP lists alcoholic beverages, sugary soft drinks, and tobacco products among them); Subprogram 2 had not been approved by the end of 2025 |
| 55105-003 – Philippines: Build Universal Health Care Program (Subprogram 2) | 2023 | Mentioned: Tobacco, alcohol, SSB<br><br>Engaged: Tobacco, alcohol, SSB | C4, results-framework indicator: Health outcome: tobacco-use prevalence target (16% by 2026; SP2 PDMF indicator h), which the program documents do not attribute to the tax; meets C2 through TA 6832-PHI (approved to track the excise earmark), without C3; C4 rests on this target |
| 56288-001 – Philippines: Domestic Resource Mobilization Program (Subprogram 1) | 2023 | Mentioned: Tobacco, alcohol, SSB | No C4: Mention only (C1). Background: TRAIN-law excise increases; its own excise is on plastic bags |

**(Continued)**

**TABLE A1. (Continued)**

| Project (No. – Country: Name) | Approval Year | Products Mentioned; Engaged (C2–C4) | C4: Measurable Commitment or Indicator |
|---|---|---|---|
| 55011-002 – Solomon Islands: Supporting Fiscal and Economic Recovery Program (Subprogram 2) | 2024 | Mentioned: Tobacco, alcohol, SSB | No C4: Mention only (C1). Describes Subprogram 1's tax on sugar and sugary drinks and the 2018 excise increase; its own actions include no health-tax measure (the indicative health-tax action was replaced by a nickel royalty) |
| 57121-001 – Palau: Strengthening Fiscal Resilience for Sustainable Development Program (Subprogram 1) | 2024 | Mentioned: Tobacco, alcohol | No C4: Mention only (C1). Describes the earlier excise reform (supported under 54284-001/-002); its own actions concern other taxes and tax administration |
| 57264-001 – Fiji: Sustainable and Resilient Growth Program (Subprogram 1) | 2024 | Mentioned: Tobacco, alcohol<br>Engaged: Tobacco, alcohol | C4, completed prior action (no results-framework indicator): Prior action 1.1.4: Excise Act amendments in the FY2024 Budget raising the duty on unhealthy goods, including 5% increases on tobacco and alcohol products |
| 57337-001 – Nepal: Green, Resilient, and Inclusive Development Program (Subprogram 1) | 2024 | Mentioned: Tobacco, alcohol | No C4: Mention only (C1). Background: government excise increases on alcohol and tobacco |
| 56257-001 – Indonesia: Domestic Resource Mobilization Program (Subprogram 1) | 2025 | Mentioned: Tobacco, alcohol, SSB<br>Engaged: Tobacco, SSB | C4, results-framework indicator: Implementation: excise extended to at least 4 product types; for products, completed prior action 1.10 (tobacco excise increases) also meets the C4 test |
| 58547-001 – Vanuatu: Enduring Fiscal Position Program | 2025 | Mentioned: Sin taxes, no product named<br>Engaged: Sin taxes, no product named | No C4: Loan or grant measure (C3) without a measurable commitment |
| **Technical Assistance (n = 15)** | | | |
| 43263-012 – Philippines: Support for Social Protection Reform (formerly MDG Acceleration and Poverty Reduction) | 2010 | Mentioned: Tobacco, alcohol | No C4: Mention only (C1). Background: sin-tax revenue earmarked for PhilHealth, described in a consultant's report |
| 46429-001 – Philippines: Supporting Capacity Development for the Bureau of Internal Revenue (BIR) | 2013 | Mentioned: Tobacco, alcohol | No C4: Mention only (C1). Background: the government's recent tobacco and alcohol excise reforms |
| 47150-001 – Maldives: Enhancing Tax Administration Capacity | 2013 | Mentioned: Tobacco, alcohol | No C4: Mention only (C1). Background: government tobacco and liquor duty increases, in a consultant's report |
| 47342-001 – Regional: Pacific Economic Management (Phase 2) | 2013 | Mentioned: Tobacco, alcohol | No C4: Mention only (C1). Background: alcohol and tobacco duties as an inflation factor (Cook Islands report) |

**(Continued)**

**TABLE A1. (Continued)**

| Project (No. – Country: Name) | Approval Year | Products Mentioned; Engaged (C2–C4) | C4: Measurable Commitment or Indicator |
|---|---|---|---|
| 48294-001 – Indonesia: Tax Revenue Administration Modernization and Policy Improvement in Local Governments | 2015 | Mentioned: Tobacco<br>Engaged: Tobacco | No C4: Technical assistance (C2) |
| 49156-001 – Regional: Enhancing Governance and Capacity Development as Driver of Change | 2015 | Mentioned: Tobacco | No C4: Mention only (C1). Background: excise increases on beverages and cigarettes as an inflation factor (Armenia report) |
| 50093-001 – Mongolia: Gender-Responsive Sector and Local Development Policies and Actions | 2016 | Mentioned: Alcohol | No C4: Mention only (C1). Background: alcohol tax revenue in a gender analysis (Mongolia) |
| 50139-002 – Vietnam: Strengthening the Policy and Institutional Framework of Social Health Insurance | 2016 | Mentioned: Tobacco, alcohol | No C4: Mention only (C1). Issues section: tobacco and alcohol taxes cited as possible financing; not among the TA's outputs |
| 50331-001 – Philippines: Strengthening Tax and Fiscal Policy Capacity for Inclusive Growth | 2016 | Mentioned: Tobacco, alcohol, SSB<br>Engaged: SSB | No C4: Technical assistance (C2) |
| 50375-001 – Regional: Strategies for Financing Social Protection to Achieve Sustainable Development Goals in Developing Member Countries | 2017 | Mentioned: Tobacco, alcohol, SSB<br>Engaged: Tobacco, alcohol, SSB | No C4: Technical assistance (C2) |
| 52012-001 – Regional: Enhancing ADB's Support for Social Protection to Achieve the Sustainable Development Goals | 2018 | Mentioned: Tobacco, alcohol | No C4: Mention only (C1). Background: country reports note tobacco duty increases |
| 55130-001 – Regional: Fiscal Policy for Green and Inclusive Development | 2021 | Mentioned: Sin taxes, no product named<br>Engaged: Sin taxes, no product named | No C4: Technical assistance (C2) |
| 56072-001 – Regional: Strengthening Integrated Primary Health Care Management of Noncommunicable Diseases | 2023 | Mentioned: Tobacco, alcohol, SSB | No C4: Mention only (C1). A delivered report suggests tax-based financing and lists tobacco-tax options in passing |

**(Continued)**

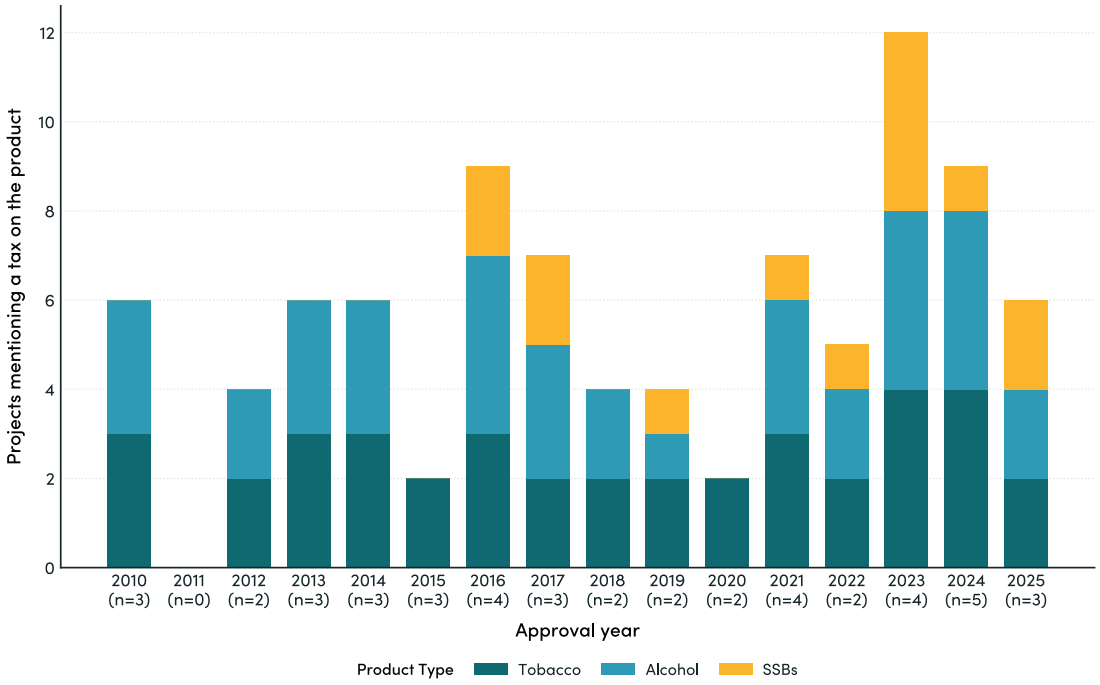
## TABLE A1. (Continued)

| Project (No. – Country: Name) | Approval Year | Products Mentioned; Engaged (C2–C4) | C4: Measurable Commitment or Indicator |
|---|---|---|---|
| 58193-001 – Lao PDR: Strengthening Public Finance and Investment Planning to Advance Climate Commitments | 2024 | Mentioned: Sin taxes, no product named<br><br>Engaged: Sin taxes, no product named | No C4: Technical assistance (C2) |
| 59281-001 – Regional: Developing Regional Universal Health Coverage Growth | 2025 | Mentioned: Tobacco, alcohol, SSB<br><br>Engaged: Tobacco, alcohol, SSB | No C4: Technical assistance (C2) |

*Notes:* All 45 in-scope ADB projects whose documents mention a health tax, 2010–2025, ordered with loans and grants first, then technical assistance. Products: "Mentioned" = products whose taxes the project's documents mention, including in background sections; "Engaged" = products covered by the project's qualifying technical assistance, loan or grant measure, or measurable commitment or indicator (C2–C4), shown only for projects above C1; "sin taxes, no product named" marks sin or health taxes for which the documents name no product; these are not assigned to any product. Last column: C4, a measurable health-tax commitment or outcome indicator formally incorporated into the operation; the column states whether it is a results-framework indicator or a policy-matrix commitment without one and, for a commitment, whether it was a completed prior or policy action or a prospective commitment. C4 records the commitment, not its implementation or results. For mention-only projects, the last column briefly describes the reference.

*Abbreviations:* PDMF = policy design and monitoring framework; RRP = report and recommendation of the President; SP1/SP2 = subprogram 1/2; BIR = Bureau of Internal Revenue (Philippines); OEK = Olbiil Era Kelulau (Palau's national congress); PhilHealth = Philippine Health Insurance Corporation; TRAIN = Tax Reform for Acceleration and Inclusion law (Philippines).

**FIGURE A1. Health-tax products mentioned in ADB projects over time**
Projects by approval year, counted once for each product whose tax their documents mention




*Notes:* Products are those whose taxes a project's ADB documents mention, including background references; a mention does not by itself indicate ADB support for a tax on that product (Figure 5 shows engagement). Each project is counted once for each product mentioned, in its approval year, so a year's bars can total more than its number of projects (n). Projects that mention only sin taxes, without naming a product, appear in no bar; no in-scope project was approved in 2011.

# Annex 2. Detailed methodology: Classification rules and product attribution

This annex sets out in full the methodology summarized in the main text: the coding criteria (A2.1), measurable commitments and indicators (A2.2), product attribution (A2.3), and the case-level detail behind the SSB findings (A2.4).

## A2.1. Coding criteria (C1 to C3)

The index measures ADB engagement with health taxation: technical advice and analysis, planning and policy commitments, implementation support, and the monitoring of health-tax measures and of the use of taxed products. Each in-scope project was coded on four criteria. C1, mention: an ADB project document explicitly mentions taxation of tobacco, alcohol, or sugar-sweetened beverages, or sin or health taxes, including in background sections; mentions of consumption, health risks, or nontax tobacco legislation alone do not qualify. C2, technical assistance: ADB technical assistance explicitly supports a health tax, or an identifiable reform package that includes a health-tax measure,

within its approved scope or planned deliverables, or through substantive health-tax work documented as delivered, for example in a completion report, even if it was not planned; background mentions, general program support without a documented connection to that reform, and support only for separate revenue reforms do not qualify. C3, loan or grant intervention: ADB's documents for a loan or grant, read together, place an identifiable tobacco, alcohol, or SSB tax measure, or sin or health taxes generally, within the object or documented scope of one of the operation's own commitments: a prior or policy action (including an indicative action for a later subprogram), a financing condition, a covenant, or an output or activity in its results framework. The tax need not be named in the action itself or be a new measure, but ADB's documents must establish that the supported activity encompasses it; broad administrative, customs, or financing reforms count only for the components that an ADB document places within their scope. Background references, a measure recounted from an earlier operation, a government's general commitment outside the supported actions, a retrospective listing against a generic revenue commitment, and a monitoring target alone do not qualify. Each separately approved subprogram is coded on its own commitments, on the same test. Grants, including policy-based grants, are grouped with loans because, in the Pacific, grants often finance the same policy-based operations that loans finance elsewhere. C2 and C3 are not mutually exclusive: a project carries both when it combines a loan or grant measure with genuinely related technical assistance.

## A2.2. Measurable commitments and indicators (C4)

C4, measurable health-tax commitment or outcome indicator: an operation that qualifies under C2 or C3 formally incorporates a concrete, verifiable health-tax policy commitment, implementation milestone, excise-revenue target, or health-related indicator in its results framework, design and monitoring framework, policy matrix, or equivalent monitoring plan. Examples are an excise increase of a stated amount or legislation by a specified date, a tax-stamp or track-and-trace milestone, an excise-revenue target, and a target for consumption of a taxed product. General fiscal targets without an identifiable health-tax component do not qualify. The operation's formal documents are read together: an action qualifies when they give it an identifiable health-tax component, and a consumption or prevalence target for a taxed product counts only in an operation that supports that product's taxation. A commitment counts whether it was completed as a prior action or financing condition or set for a later date, so C4 records the commitment, not its implementation or results. C4 is the primary measure throughout the paper. Because a C4 commitment need not be monitored, we also report separately whether the operation's results framework includes a performance indicator for the health-tax measure, its revenue, or the use of a taxed product; this narrower measure indicates explicit results-framework monitoring and does not enter the main index. As a robustness check, counting under C4 only the eight projects with a results-framework indicator leaves the top of the country ranking unchanged: Solomon Islands, the Philippines, and India remain the three highest-ranked countries.

## A2.3. Product attribution

Products are reported at two levels. Product mentions record whether a project's ADB documents mention a tax on tobacco, alcohol, or SSBs, including in background sections; they are recorded at C1, where four projects mention sin taxes without naming a product. Product-specific engagement records the products covered by the engagement that qualifies a project for each higher criterion: the technical assistance work for C2, the loan or grant measure for C3 (including indicative actions for a later subprogram), and every qualifying measurable commitment or indicator for C4, with results-framework indicators recorded separately. A product is attributed only where ADB's documents name it: engagement on sin or health taxes that names no product is recorded as unspecified and assigned to no product, and a list introduced by "including" or "such as" adds nothing beyond the products it names. Earmarking of a product's excise counts as a measure on that product; a consumption or prevalence indicator is attributed to the product it measures; an aggregate excise-revenue indicator is attributed to the products of the operation's own health-tax measures, not to every product the statistic covers; and products that appear only in background or in a related operation's documents are not attributed. In six projects, technical assistance qualifies because it supported the operation's broader health-tax reform package rather than a named product tax; we attribute to it the products of that package's health-tax measure and also report C2 counts without these six projects. Product attribution does not affect the index.

The overall product engagement counts (17, 16, and 9) do not depend on the six projects whose technical assistance is credited for supporting a broader reform package, since each also covers the same products through a loan or grant measure. For the first subprogram of the Build Universal Health Care Program, the product counts include its prior action earmarking the tobacco, alcohol, and sweetened-beverage excises, which independently meets the C4 test alongside its tobacco-prevalence target; the narrower results-framework measure counts only that target, so for this program it covers tobacco alone. The two results-framework indicators that cover SSBs are Indonesia's target to extend excise taxes to more product types—where packaged sweetened beverages are the only type beyond tobacco and alcohol that the program names—and Tonga's second-subprogram target for excise revenue as a share of GDP. The Tonga target is an aggregate measure that we attribute to the excise increase the subprogram supported, which included fizzy sweetened drinks.

## A2.4. SSB engagement: Cases and timing

Six of the nine projects that engage on SSB taxes also engage on both tobacco and alcohol taxes, through broad excise reforms, earmarking, or advisory work: Tonga's 2016 excise increases; Maldives' planned excise legislation; the two subprograms of the Philippines' Build Universal Health Care Program, the first counting the earmarking of tobacco, alcohol, and sweetened-beverage excise revenue for universal health care as a prior action and the second credited with technical assistance approved to track that earmark; and two regional technical assistance projects. The other three engage on SSBs without alcohol: the 2022 Solomon Islands program counted the government's new tax on sugar and sugary drinks as a completed prior action and set an indicative commitment to extend health taxes to at least one further, unnamed product; the Philippines' 2016 tax-policy technical assistance named the introduction of an SSB tax among its initial areas of advice; and Indonesia's 2025 program paired higher tobacco excises with an indicative extension of excise to packaged sweetened beverages.

SSB engagement by period: In 2015–2019, one operation's SSB engagement concerned a tax increase already in force (Tonga's 2016 excise order) and two were technical assistance. In 2020–2025, two concerned measures already adopted, Solomon Islands' new tax and the Philippines' earmarking of an existing SSB excise; two were indicative commitments for later subprograms, in Maldives and Indonesia; and two were technical assistance, one of them the Philippine earmark tracking credited to a second subprogram.