

The Union

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Tuberculosis and Lung Disease
Health solutions for the poor

Sustainable Funding Models for Tobacco Control: a Discussion Paper

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KEY MESSAGES

The Union has issued this background paper based on a careful review of the literature and international experiences to date in the development of sustainable funding models for tobacco control.

The 177 signatories of the WHO FCTC have pledged to take action to reduce the impact of tobacco in their countries and the Union is committed to providing knowledge, training and support to assist in doing so.

Sustainable funding for tobacco control is critical if the projected harms caused by tobacco use are to be curbed. There are compelling reasons to act now.

All countries, even the poorest, have the means to reduce tobacco use if tobacco taxes are increased and funds are applied to fund comprehensive tobacco control programmes.

Establishing a semi-autonomous foundation to administer funds and spearhead the fight against tobacco has been shown to be effective in a number of countries.

While a number of countries have established tobacco control foundations, no two are the same and no 'one size fits all'. The model must be adapted to suit the country, taking into account the health priorities as well as the economic, social and political environment.

Countries wishing to address the projected increase in death and disability from NCDs, which is expected to occur over the next 10 years, may wish to establish a health promotion foundation with a broader remit than that of a tobacco control foundation. Alternatively, they may elect to start by tackling tobacco and later extend to an all-encompassing health promotion model.

Any approach to create sustainable funding for tobacco control and a foundation to administer it must complement and enhance government initiatives and strategies; it must also bring together government, non-government and community sectors, and stakeholders to work together in the fight against tobacco.

1 INTRODUCTION

1.1 Why are sustainable funding models for Tobacco Control needed?

Tobacco remains the largest preventable cause of death and disease globally. The impact of tobacco is devastating and responsible for more than 6 million deaths every year^(1,2). Tobacco accounts for the greatest burden among non-communicable diseases (NCDs), contributing more to morbidity and mortality globally than all other health risk factors combined⁽³⁾. Low- and middle-income countries (LMICs) are most affected by the tobacco epidemic, accounting for more than 80% of these highly preventable deaths⁽¹⁾. This corresponds to an enormous healthcare and economic burden, along with the social and emotional costs associated with suffering and premature death. In addition, tobacco use imposes financial costs on national health systems and the population⁷. Estimates from the World Bank indicate that tobacco use accounts for between 6 and 15% of the overall annual cost of healthcare in high-income countries⁽⁴⁾. Whilst comparable figures are not currently available for LMICs, the high rates of tobacco use prevalence in many LMICs suggest that tobacco will account for an increasing health burden in these countries that can least afford it.

Reducing tobacco use is one of the most effective strategies to help countries achieve the global targets set forth by the UN General Assembly in 2011 to propel the prevention and control of NCDs. Indeed, tobacco use has been described as the most policy-responsive NCD risk factor⁽³⁾. For many countries, the commitment to respond to the World Health Organization's Framework Convention on Tobacco Control (WHO FCTC)⁽⁵⁾ has accelerated efforts to curb tobacco use. However, fully implementing all of the tobacco control measures advocated within the framework requires dedicated sustained funding. It also requires investment in building the capacity of organisations and a workforce to undertake tobacco control⁽⁶⁾. This is particularly challenging for LMICs. While WHO and philanthropies such as the Bloomberg Initiative to Reduce Tobacco Use and the Bill and Melinda Gates Foundation have contributed significantly to building tobacco control capacity in many countries, sustainable models for tobacco control are critically needed.

There is now a vast evidence-base confirming that tobacco control efforts need to be comprehensive and long-term in order to be effective, hence the mounting case for developing and guaranteeing sustainable funding to support the complex behavioural, environmental and policy changes required. Sustainable funding is also urgently needed for tobacco control to counter tobacco industry interference in government efforts to reduce tobacco use.

Tobacco control activity and effectiveness is left vulnerable if its funding is dependent on short-term funding pledges, be they from government, philanthropic or other sources. Many nations have health budgets which are already stretched to cope with the rising health care costs of treatment and curative care as well as the burden of the NCD epidemic. The reality is that in the budget process, health promotion and prevention tend to miss out because of urgent and compelling claims from the treatment and curative components of the health industry. Moreover, the fiscal burden of tobacco-related health and social costs is already large and increasingly unaffordable in many LMICs. Contributions from international organisations to tobacco control are not guaranteed and may diminish

once countries in theory have mechanisms to implement the WHO FCTC, including funding their own tobacco control activities from taxes or surcharges. Hence the necessary financial resources must be generated internally to be sustainable.

Taxes are a powerful tool, particularly if directed into a funding mechanism for tobacco control

Raising tobacco taxes and applying all or some (at least one percent) of the additional funds raised to tobacco control is one approach to meeting this challenge in a way which is fair, logical and cost effective. Moreover, as noted in a paper published in *The Lancet*⁽⁷⁾, raising tobacco taxes can serve a dual purpose, enabling countries to curb tobacco consumption whilst also mobilising financial resources to fund tobacco control and other health promotion measures. By increasing tobacco taxes and directing funds to tobacco control through the establishment of a foundation or similar entity, a number of WHO FCTC obligations can also be addressed⁽⁵⁾. In particular, it can facilitate the directing of funds generated by price and taxation measures⁽⁸⁾ to the implementation of education, communication and intervention strategies⁽⁵⁾ and more broadly, support the building of tobacco control capacity in the workforce. This can be particularly advantageous in LMICs that may otherwise struggle to fund public health campaigns and other aspects of tobacco control advocated by the WHO FCTC.

The Union has been working with LMICs on tobacco control for nearly two decades. This paper aims to assist the governments of these countries by encouraging them to establish sustainable and effective tobacco control funding models. If these governments can urgently and successfully address the underfunding of tobacco control, they can help their countries be healthier and more prosperous.

Case Study: Vietnam

Tobacco imposes a significant health and economic burden in Vietnam, which has one of the highest smoking rates in the world. 47.4% of men and 1.4% of women smoke. Overall, 23.8% of the population (15.3 million adults), currently uses tobacco (GATS, 2010). The cost of tobacco use imposes a heavy burden on the country. For example, the costs associated with three diseases attributable to tobacco use—lung cancer, ischaemic heart disease, and chronic obstructive pulmonary disease (COPD)—were estimated to be in excess of VND 1,100 billion (about US\$75 million) in 2005. The price of tobacco products in Vietnam remains low and it is an easily affordable commodity.

The continuing increase in the health and economic burden posed by tobacco has caused Vietnam's government to make progressive efforts to reduce tobacco use and tackle its serious consequences. In doing so, it became clear that this would require a sound legislative base, sustainable funding and an infrastructure to deliver comprehensive tobacco control programmes. The move to address the harms caused by tobacco was spearheaded by the Vietnam Steering Committee on Smoking and Health (VINACOSH). In the past 10 years, Vietnam has achieved many goals, including becoming a signatory to the WHO FCTC in 2004. Subsequently, it ratified an action plan to guide the development and promulgation of legislation to meet the requirements of the WHO FCTC in 2009.

The National Assembly passed the Law on the Prevention and Control of Tobacco Harms in 2012. This was followed by the Prime Minister's decision on the National Strategy on Tobacco Control, which included provisions to develop a model for a tobacco control fund that would be appropriate for Vietnam. The following year, 2013, saw the establishment of the Vietnam Tobacco Control Fund (VNTCF) together with the regulations for its infrastructure and operation.

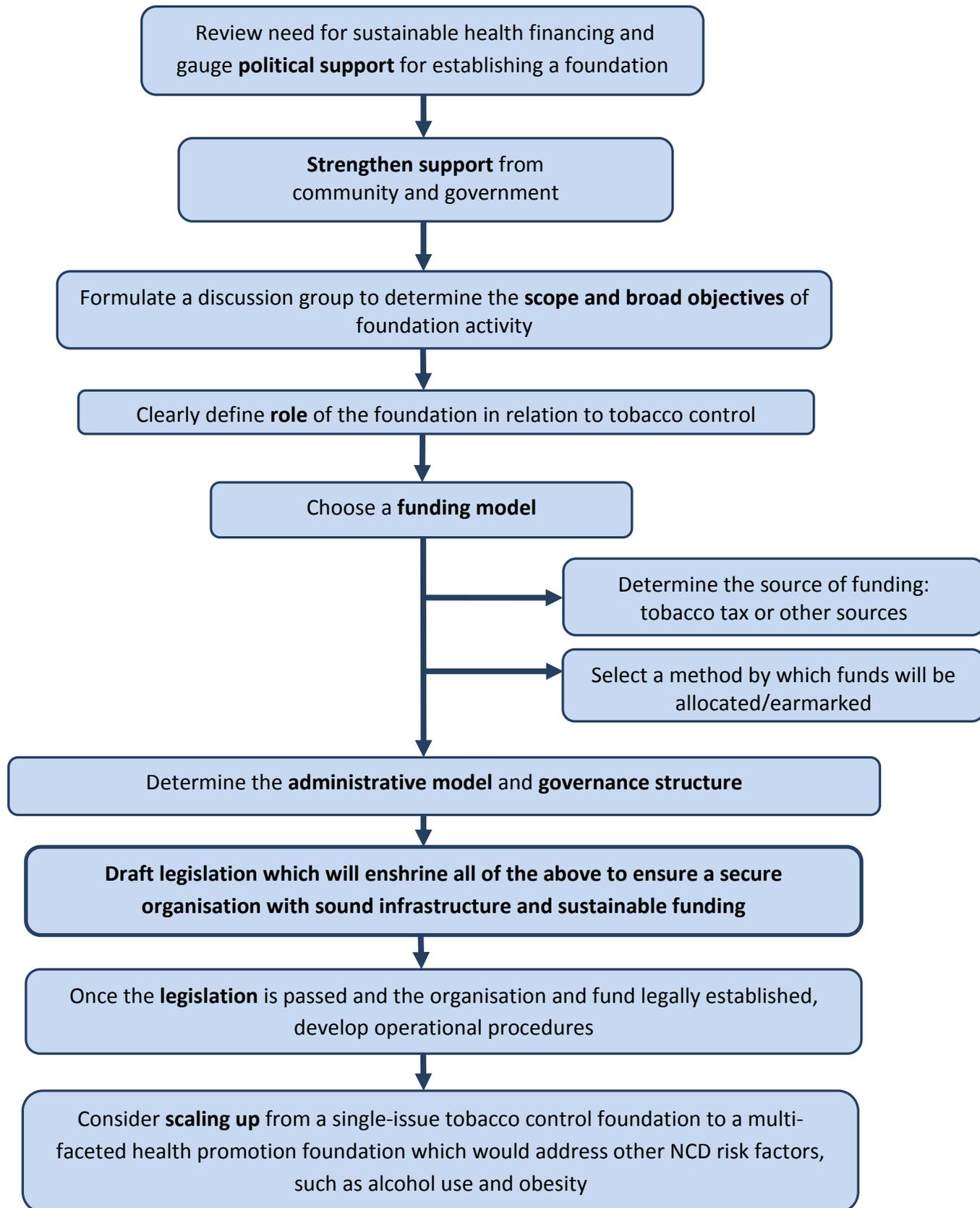
Fundamental to this process was the acknowledgement by the government of the enormous healthcare and economic burden, along with the social costs, associated with the suffering and premature death caused by tobacco use in Vietnam. This was coupled with the recognition that sustainable funding would be required to support the long-term comprehensive programmes needed to reduce the harms caused by tobacco.

1.2 Structure of this position paper

This paper draws on approaches that have been used around the world in securing more sustainable funding for tobacco control (Section 2), with a particular focus on the use of funds generated through tobacco taxation to establish dedicated organisations (hereafter referred to as 'foundations') that can support tobacco control activity and capacity building. The paper also touches on examples of foundations that have a broader health promotion remit than tobacco, and some that derive funds from sources other than tobacco tax. It also addresses how similar models can be established to invest in health promotion via taxes on other health-compromising goods and where the underlying principles for establishing and operating such an organisation are the same. Section 3 discusses the types of funding models that exist. It outlines key characteristics and activities of foundations and emphasises that while there are common elements, there is no one-size-fits-all model; foundations need to be developed to reflect the contextual circumstances of tobacco control in a given country. In Section 4, the importance of comprehensive legislation to underpin the establishment of a foundation is stressed and the various administrative models of foundations are explored with the advantages and disadvantages of each highlighted. The challenges experienced and reported by established foundations are described in Section 5. These are issues of which fledgling foundations should be aware, so that steps can be taken to minimise their impacts. Section 6 discusses the scope of foundations to scale up from tobacco control to address other NCDs and to source alternative public health taxation revenue. This paper concludes by summarising the benefits and importance of countries acting to tackle tobacco and of doing so *now*. Vietnam has recently established the Vietnam Tobacco Control Fund (VNTCF) and this paper uses the experiences of Vietnam to highlight and illustrate the key messages in each chapter of the paper.

Overall, this position paper provides a rationale and methodology for governments to address the issue of reducing the harms caused by tobacco. While it outlines key considerations in establishing a foundation for sustainable tobacco control and canvasses ways in which the model may be adapted to suit different contexts and countries, it is not designed as a blueprint for setting up a foundation. Rather, its purpose is to stimulate interest in and commitment to developing sustainable funding models for tackling tobacco with the knowledge that all countries can take action and in fact must do so as a matter of urgency.

Establishing a Tobacco Control Foundation: A Stepwise Approach



2 MODELS FOR SUSTAINABLE FUNDING OF TOBACCO CONTROL

2.1 Existing funding models

Over the past two decades, a growing number of countries have already recognised the need to bolster traditionally established funding sources or establish new and more sustainable funding mechanisms for tobacco control. Countries need to determine the most appropriate model to secure the adequate resources needed to fund tobacco control and perhaps other health promotion initiatives. This requires thinking strategically about innovative funding mechanisms and infrastructures that will support the national tobacco control agenda over the long term. Appendix 1 summarises the types of models that exist in different countries and illustrates how the source of funds and process of allocation can vary. Some observed advantages and disadvantages of the different models are also summarised in this Appendix. Two major considerations in selecting a funding model approach are the source of the funds and the method of funding allocation and these are discussed below.

2.2 Sources of funds

Determining the most appropriate source of sustainable funding for tobacco control can be challenging and needs to take into account a range of contextual factors for the country in question. When investigating options, it is vital to consider the regulatory, political and economic factors which may influence a decision as well as the country's social norms. While there may be compelling reasons to use tobacco tax as a means to garner the necessary capital, it is important that all options are canvassed and the advantages and disadvantages of each are considered. This paper mainly focuses on tobacco tax as a major source of revenue for tobacco control programmes; however, there are a number of other potential options which may include funds from one or more of the following sources:

- Taxes from tobacco;
- Taxes on other 'health-damaging goods', e.g. alcohol or fast food;
- A treasury appropriation;
- Value added tax (VAT);
- Health/sickness or universal health cover insurance levy;
- Philanthropic donations;
- Other private, corporate and donor sources;
- Funds collected through penalties for violations of legislation (as occurs in India⁹).

Tobacco tax is the most common and most logically justified source of funds for tobacco control. Moreover, increasing the price of tobacco via tobacco taxation is recognised internationally as one of, if not the, most effective strategy to reduce tobacco use (see Box 2.1). Hence allocating tobacco taxes to tobacco control programmes can powerfully extend the impact of tobacco taxation as an effective mechanism for tobacco control. Additionally, dedicating earmarked funds from tobacco taxes (where the income stream remains separate from the main health budget) means that the funds are more likely to remain untouched, even in a recession when there may be 'across the board' budget cuts.

Box 2.1 Why increase tobacco taxes?

Raising tobacco taxes can have the dual benefit of curbing tobacco consumption as well as mobilising financial resources for tobacco control and/or health promotion⁽⁷⁾. Revenue raised from tobacco can be applied to tobacco control efforts and/or to offset the costs to the healthcare system of treating tobacco-related diseases.

The implementation of tax policies on tobacco products is one of the most efficient and effective measures for reducing global tobacco consumption^(5,8,10). It is estimated, for example that a price increase of 33% would result in between 22-65 million smoking-attributable deaths being averted worldwide, with up to 90% of these averted deaths in LMICs⁽¹¹⁾.

Tax increases that substantially raise the retail price of cigarettes are the most effective measures to reduce tobacco demand and consumption⁽¹²⁾. Higher prices decrease prevalence by increasing interest in quitting, quit attempts and successful cessation⁽¹²⁾. Higher prices can also reduce consumption among remaining smokers by reducing consumption by daily smokers⁽¹²⁾.

Children, adolescents and people on low incomes are most responsive to increases in price, so the impact of the measure is greatest among these vulnerable population groups⁽¹³⁾.

If tax increases can prompt cessation or reduced consumption amongst the poor, it can release scarce resources for other essential items. For example, data suggests that as much as 9-22% of household income is spent on tobacco among the poorest families in Mexico⁽¹⁴⁾.

2.2.1 Countering the critics of tobacco tax increases

Opponents of tobacco tax increases generally tend to make strident but not well-grounded arguments to support their views, and these arguments are often promulgated, even when it is proposed to invest the tax raised in health or tobacco control. Tax experts stress the importance of adhering to evidence-based best practices in tobacco taxation administration to counter such opposition, as well as to improve both the collection of government revenue and the health benefits gained by reducing tobacco use. (The WHO Technical Manual on tobacco tax administration is a comprehensive and useful guide to this⁽¹⁵⁾).

It is clear from the experiences of countries that have proposed or implemented tobacco tax increases that the commonly touted arguments against this are often based on myths or misconceptions^(16,17). Table 2.2 describes common myths and how they may be countered.

Table 2.2 Myths and realities	
Myth	Reality
Lost Revenue Tobacco tax increases will result in lost	When cigarette taxes are increased, declines in demand do not exceed gains in revenue. Evidence from around the world clearly shows that excise taxes are a proven and effective tool for generating higher

revenue (i.e. due to fall in demand and sales due to price increase).	revenues ⁽¹⁵⁾ . It has been estimated that a 10% increase in tobacco taxes globally would raise the revenue generated by tobacco by nearly 7%, even accounting for tax impacts on tobacco consumption ⁽¹⁸⁾ .
Job losses If the demand for tobacco falls, there will be permanent job losses in many countries.	Job losses would not occur overnight and new job opportunities would emerge as ex-smokers divert their spending to other goods and services ⁽¹⁹⁾ . Even if tax increases were introduced right away, the decline in smoking and jobs would be gradual and the economy would have time to adjust.
Promotes smuggling Higher cigarette taxes will result in more cigarette smuggling.	Smuggling is a serious problem that requires strict implemented regulation but is often raised as a distracting objection to increased taxes. Even when smuggling occurs there is evidence that tax increases bring greater revenues and reduce consumption. Improving tax administration, law enforcement and closing tax loopholes are the most effective measures for reducing tax avoidance and evasion ⁽¹⁵⁾ .
Penalises the poor Poor people are penalised more by increased tobacco taxes.	People on low incomes are usually more responsive to price increases, therefore their consumption of cigarettes will fall more sharply following a tax increase and their relative financial burdens will correspondingly be reduced ^(13,20) . There is also evidence that tobacco control measures can help reduce social inequality; for example, research in China found that reducing expenditure on tobacco freed up household funds to spend on food, housing, and other goods that can help improve living standards ⁽²¹⁾ .
Politically unpopular with the community Increasing tobacco taxes will be unpopular with people who generally do not support tax increases.	This is a myth designed to make governments feel nervous and therefore reluctant to change. Evidence shows that support can be generated if the tax increase is tied to funding tobacco control or health promotion programmes ^{(22),(11)} . Surveys carried out in Australia and Thailand prior to introducing legislation to raise tobacco taxes confirms this view, with public opinion surveys demonstrating that the percentage of people approving an increase in tobacco tax rose when they were told that part of the tax was to be used for health promotion and health research ^(23,24) . This approach means a win for government and a win for health promotion/tobacco control.

2.3 Methods of funding allocation

The method by which funds are allocated can also vary. The main funding allocation approaches used in tobacco control internationally are summarised in Appendix 2. In most cases the funding allocation is undertaken by government and the key ways this can be done warrants further explanation.

Earmarked funds are those revenues from designated sources used to finance designated expenditures. Earmarking is a long-standing and popular practice in many countries around the world^(25,26) and is either substantive or symbolic. Although earmarking may be opposed in principle by some economists, it has been recognised as a valuable tool for addressing political and other opposition to increasing tobacco taxes⁽¹¹⁾. As argued by Jha et al, earmarking tobacco taxes can be justified on the grounds that the funds

will be used to *benefit* those who pay⁽¹¹⁾ (e.g. users of tobacco who need help to quit or who have health care costs).

Substantive earmarked funds typically comprise revenues from taxes, fees, licenses, or other sources designated constitutionally, statutorily, or by the requirements of law to be spent for specific programmes or purposes. This approach is generally enshrined in legislation which identifies the source, the method of collection and the amount. While tobacco taxes have been the dominant source of earmarked funds for tobacco control and other programmes, potential exists for taxes on a range of substances and activities, e.g. alcohol, unhealthy food and drinks and gambling.

Symbolic earmarking of funds describes where certain types of taxes (or charges) are designated and help pay for particular government services. The revenues from these taxes flow into consolidated revenue and is used to fund only a part of the government service in question. This means that there is a very loose connection between the growth of earmarked revenues and higher levels of government spending in the designated area⁽²⁷⁾. This method has also been described as *committed funding* i.e. where an amount is committed in legislation to support specific purposes, such as tobacco control. Such funds will come from consolidated revenue which may include, but are not exclusively from, tobacco or alcohol tax⁽²⁸⁾.

Earmarking is the most commonly observed type of funding for sustainable tobacco control to date. Other variations include **special funding**, which refers to a provision to set aside funds from consolidated revenue for a specific purpose such as tobacco control but differs from committed funding in that the amount or method of appropriation is not necessarily specified in legislation⁽²⁸⁾. **Application based** funding by contrast comes from general revenue; the amount is not stipulated in legislation, therefore not assured. This differs from *special funding* in that there is no base level of funding; it is allocated on the basis of an application from the administering organisation to government.

It should be noted that funds appropriated by special or application based means do not offer the security of earmarked funds, whether substantive or symbolic. Ideally, those wishing to create a fund for tobacco control on sustainable and solid financial footing would be well advised to aim for one of the *earmarked* methods which require strong legislative support and state explicit amounts which should be modified to reflect the Consumer Price Index (CPI).

2.4 Which source and method of allocation is applicable?

In determining which source of funding and method of funding allocation is most applicable or feasible, it is important to note that some countries have encountered obstacles in their efforts to increase taxes and secure at least part for tobacco control/health promotion⁽²⁹⁻³¹⁾. Below are some of the issues that may pose challenges or form the basis of opposition:

- Cultural and religious mores which may preclude using tax from ‘health damaging goods’ for health promotion (as experienced in Malaysia);
- State or government ownership or investment in the tobacco industry;

- Economic reliance on tobacco growing, manufacturing, marketing or export of tobacco;
- Legal impediments, e.g. where the government is not permitted to redirect tax to be administered by a specific organisation;
- Concern that the tax base may not be adequately secure to make financial commitments (i.e. too much variability and uncertainty in the amounts derived from taxes in any given year);
- Concern that if tax is allocated to a worthy cause like tobacco control, the floodgates may open to demands from other commendable causes.

Despite such obstacles, powerful and evidence-based arguments can be mounted in support of using a portion of tobacco tax to address the growing health and social issues stemming from tobacco use.

2.5 Importance of maintaining a sustainable funding level

While the appropriation of taxes for public health has been widely recommended, such revenue must be protected using appropriate legislative mechanisms to ensure that a foundation's funding does not get redirected should other priorities arise.

Legislation should also include a mechanism to ensure that the funding is linked to CPI so that the 'real' value of funds invested in tobacco control does not diminish. Ensuring that the tax revenue and 'real price' of tobacco does not drop is also an essential part of an evidence-based approach to reducing demand for tobacco products. One of the key policies advocated by WHO is to raise tobacco tax and to do so incrementally on a regular basis to at least match the rate of income growth and ensure that cigarettes do not become more affordable⁽³²⁾. Evidence from a number of countries demonstrates that cessation attempts increase significantly when the price of tobacco increases^(24,33-36). However, studies also suggest that whilst cessation attempts increase immediately following tax increases, this is not necessarily sustained, adding weight to the need for regular tax increases⁽³⁷⁾. Therefore, increases need to be frequent and large enough to help maintain the frequency of serious quitting attempts by remaining smokers.

To optimise the benefits of tobacco tax increases, they need to be complemented by other elements of a comprehensive tobacco control strategy, e.g. media campaigns and access to cessation services and products. In fact, this is one of the benefits of using tobacco-derived funds to strategically invest in tobacco control activities, as newly generated funds can complement and expand the suite of comprehensive tobacco control measures in a given country or state.

Case Study: Vietnam

After canvassing the range of available options, it was decided that earmarked tobacco tax would be the most appropriate source of funding for the VNTCF. The amount and method of collection of the tax was stipulated in the Law on the Prevention and Control of Tobacco Harms, which states that the amount is to be calculated on a percentage of the excise tax liable prices. This is specified as 1% from May 2013,

1.5% from May 2016 and 2% from May 2019. In terms of the method of collection of the compulsory contributions, the legislation states that they will be registered, calculated and paid to the fund by the tobacco manufacturers or importers at the same time as the tobacco excise tax is paid. In practice, this process occurs monthly and is overseen by the Ministry of Finance. In the first year, roughly US\$7 million in revenue was raised and allocated to fund the annual plans and programmes of the VNTCF. While a number of jurisdictions use tobacco taxes to fund their health promotion/tobacco control programmes, no two countries operate in the same way. Vietnam employs a unique method of collection of the funds which fits its regulatory, political and economic environment as well as the social norms of the country.

3 RATIONALE FOR ESTABLISHING A DEDICATED FOUNDATION TO ADMINISTER FUNDS FOR SUSTAINABLE TOBACCO CONTROL

3.1 Evolution of the foundation model approach in tobacco control

Health Promotion Foundations (HPFs) evolved as a solution to the dilemma of sustainable funding for tobacco control. Indeed they have been described as an ‘invention designed to solve a health problem which was also a political problem’⁽³⁸⁾. A health promotion foundation can generally be defined as *an autonomous or semi-autonomous statutory body which has, as its major purpose, the promotion of health*⁽³⁹⁾. The actual titles may vary and not refer to a ‘foundation’ per se, for example in Malaysia there is a Health Promotion Board while Vietnam has the VNTCF.

The first instances of these were established in the 1980s and early 1990s in four Australian states (sub-national jurisdictions) after tobacco sponsorship was banned under state legislation. The concept of using tobacco tax to promote health and tobacco control activities was first introduced in 1987 when the Victorian State Government in Australia passed the Tobacco Act. The Act increased tobacco taxes in that state and decreed that a percentage of those taxes were to be directed to health promotion and tobacco control programmes. The levy on tobacco taxes funded the buy-out of tobacco sponsorships and advertising. The Act also created a new independent statutory organisation, the Victorian Health Promotion Foundation (VicHealth), to administer the funds. Subsequently, this innovative approach to funding for tobacco control and health promotion was followed by Western Australia, leading to the establishment of the West Australian Health Promotion Foundation (Healthway), and was then taken up in a number of countries around the world, particularly in the Asian and European regions.

The successes of the early foundations like ThaiHealth and VicHealth have encouraged a range of countries like Mongolia, Tonga, and Malaysia and, most recently, Vietnam to adopt the foundation model and adapt it to suit their needs. Other countries such as Samoa and Vanuatu are currently contemplating this approach. The International Network of Health Promotion Foundations (INHPF)⁽⁴⁰⁾ was established in 1999 to enhance the performance of existing HPFs and to support the development of new ones⁽⁴⁰⁾. The growth of these bodies has also been nurtured by the Western Pacific Regional Office (WPRO) of WHO, with leadership training and capacity building being offered through the health promotion leadership programme, PROLEAD⁽⁴¹⁾.

Appendix 1 provides an overview of countries to date that have established an entity along the lines of an HPF. As evident in Appendix 1, while the founding principles are similar, no two foundations are the same; they have different names, scopes and budgets (see Sections 4 and 5 for further discussion of these variations).

3.2 Benefits of a separate foundation to administer funds for tobacco control

Existing foundations have contributed to a rapid diffusion of health promotion messages, programmes and structural changes in the countries in which they are established. For example in its tobacco control stream, Healthway has supported a range of programmes and research grants, a youth smoking prevention campaign, interventions to discourage smoking in the home and it requires all funded organisations to implement a smoke-free policy. Such rapid ‘successes’, particularly in areas of policy and legislation (e.g. in alcohol, tobacco) are relatively unparalleled, with public health movements in many countries battling for decades to achieve changes of this kind.

What sets the foundation model apart is the relative independence from government and ability to make self-directed decisions about programmes, policies and the allocation of funding. These should naturally reflect and support any national policies and priorities which have been identified. Generally, the government will maintain some control, for example by making appointments to the board and approving budgets while the organisation reports annually to the government on achievements, challenges and emerging issues.

From the observed experience of countries that have dedicated or committed some or all of the tobacco taxes raised to fund educational and public awareness programmes on tobacco control, there are a number of other flow-on benefits summarised in Box 3.1 below:

Box 3.1 Benefits of a Foundation model	
Long term security and outlook	Foundations can plan and implement long-term programmes with confidence because the funding is committed and protected by legislation, ensuring there are political and administrative barriers to changing either the organisation or its funding source.
Does not have to compete for scarce health resources	Ministry of Health budgets are generally stretched with demands from the hospital and treatment sectors of the health system. Hence, health promotion and prevention, while seen as important, tend not to receive adequate funding. This problem can be overcome by setting up an entity which does not participate in the normal budget process because it has its own separate allocation of funds protected by legislation (and if the funds are raised through tobacco tax or other sources, it does not compete with other health priorities for funds from the core health budget).
Transparency and accountability	As usually established through legislation, there are requirements for transparent and open financial accounting systems which must be independently audited and periodically reviewed in order to assess the effectiveness of the foundation in relation to its objectives.

Box 3.1 Benefits of a Foundation model	
Independence	The foundation model is generally designed to operate at arm's length from government whilst supporting and reinforcing government priorities and directions for health promotion/tobacco control. This independence can allow foundations to distance themselves from tobacco industry influence.
Flexibility	Foundations can respond quickly to emerging issues; they operate openly, equitably, accountably and quickly with fewer bureaucratic constraints than if part of a ministry. Foundations have been instrumental in trialling innovative programmes which, if effective, can be easily adopted and implemented on a country-wide basis.
Advocacy	They can use the expertise and influence of a broad range of people including board and committee members to advocate in relation to tobacco control/health promotion policy.
Intersectoral involvement	Foundations aim to work across all government and community sectors, using different environments and settings while establishing partnerships and networks to engage in tobacco control/health promotion programmes.
Lowers tobacco consumption	Increasing tobacco tax and applying some or all of this to the work of a foundation has the simultaneous effect of reducing tobacco consumption, given that price is one of the most effective measures to encourage cessation and reduce use.

As foundation models have become more common around the world, acceptance of this approach has also grown. However, the proposal to establish a self-governing or semi-autonomous body to administer the funds for tobacco control may still receive criticism from industry sources who may feel threatened by the establishment of a well-resourced single-focus entity. Other critics may include politicians, bureaucrats and even members of the general public whose concerns are generally based on myths that a separate entity would:

- Be more costly to run;
- Have the potential to be corrupt or corrupted;
- Dilute the impact of the Ministry of Health;
- Compete with the Ministry or related NGOs for scarce funds;
- Duplicate the programmes of other relevant agencies;
- Open the floodgates to other special interest groups wishing to establish a separate autonomous organisation.

Such myths can, however, be countered by the established foundations, which can refute the above arguments and demonstrate their multiple benefits ⁽²⁸⁾.

Case Study: Vietnam

A comprehensive range of strategies was employed to determine the kind of organisation that would be appropriate to lead the fight to curb the harms caused by tobacco in Vietnam. A range of international donors and sponsors as well as the Tobacco Control Working Group (TCWG) comprising in-country partners supported this groundwork. For example, Bloomberg Philanthropies contributed to the development of Vietnam's tobacco control capacity with grants totalling more than US\$3.2 million during the period from 2007 to the time of writing.

The strategies included:

- A review of options for sustainable funding for health promotion and tobacco control in Vietnam so that an informed decision could be made about the kind of infrastructure that was needed;
- A national capacity assessment on the effectiveness of tobacco control policy which was carried out by a group of national and international experts. They identified underfunding of tobacco control activities and programmes as a major barrier to Vietnam reducing the harms caused by tobacco. A key recommendation was the establishment of a National Fund for Prevention and Control of Tobacco Harms which would, in time, become the Vietnam Tobacco Control Fund (VNTCF);
- A number of delegations representing the Ministry of Health, Ministry of Finance, the Department of Tax Policy, and the Government Office and National Assembly visited foundations within the region to examine funding models, infrastructures and governance structures. The aim was to acquire first-hand experience of the work they were doing and to assess impact;
- Within Vietnam, steps were also taken to educate policy makers, government officials, stakeholders, journalists and the community about the importance and methods of tackling tobacco control as well as issues around tobacco tax. This not only placed tobacco control on the national agenda but also supported the advocacy effort;
- Evidence-based documents on the importance of sustainable funding for health promotion and tobacco control were developed to support advocacy, communication and education strategies;
- A regional Workshop on Tobacco Tax and Health Promotion Foundations in Hanoi was attended by government officials to raise awareness and support.

Recognising that tobacco causes a significant health and economic burden, the government decided to establish the VNTCF as a semi-autonomous body with secure funding from tobacco tax. This followed a careful examination of a range of possible options, and took into account the social, political and cultural milieu of the country. The decision was facilitated through a targeted programme of education, study tours, and advocacy which was supported by the work of both internal and external coalitions of partners in tobacco control.

4 CHARACTERISTICS AND ACTIVITIES OF FOUNDATIONS

Although foundations may differ in name, size, scope of activity and administrative and legislative structure, generally a tobacco control foundation can be defined as follows:

An organisation established by legislation to fund and implement comprehensive tobacco programmes—including prevention and control as well as policy-driven research in order to advance tobacco control policies in the country.

The INHPF has identified a number of common characteristics which apply to HPFs as depicted in box 4.2⁽⁴⁰⁾, and these are equally applicable to foundations that may be set up with a focus solely on tobacco control.

Box 4.2 Characteristics of Health Promotion Foundations

- Involved primarily in funding health promotion activities (tobacco control or broader);
- Established according to some form of legislation such as an Act of Parliament and typically reports to a government minister;
- Governed by an independent board that includes stakeholder representation and is not involved in the day to day running of the organisation;
- Able to exercise a high level of autonomous decision making and use transparent and equitable allocation procedures;
- Not aligned with any political group and encourage support from across the political spectrum;
- Provided with a long-term and recurrent budget supported by legislation for the purposes of health promotion/tobacco control;
- Promotes health by working with and across many sectors and levels of society.

In establishing a foundation there is no **‘one size fits all’** model to follow, as what is right for a particular country or jurisdiction will depend on a range of factors including:

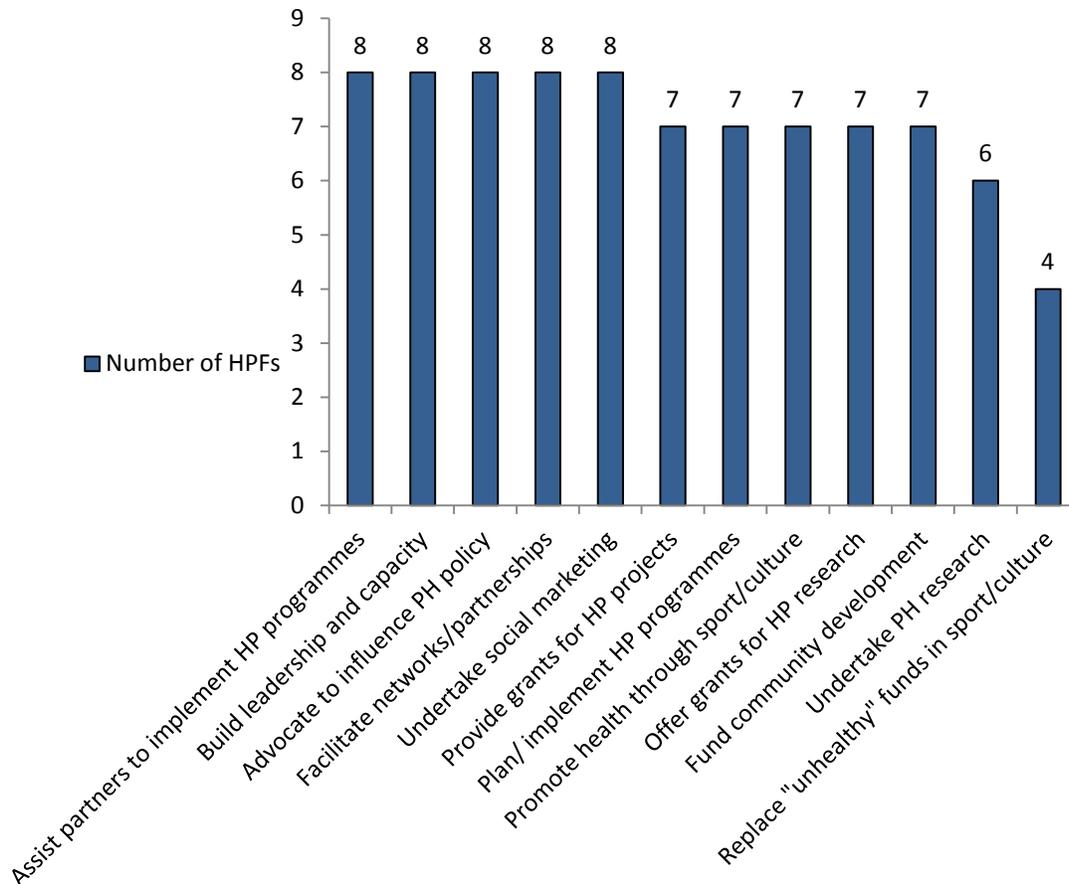
- National health priorities and policies;
- The objectives of the foundation as set out in the enabling legislation;
- The capacity of the personnel employed by the foundation;
- The capacity of potential grant recipients to deliver programmes;
- The priority areas identified in national and organisational strategic plans;
- Political imperatives.

4.1 Activities of foundations

There is also no **‘one size fits all’** model for the scope of activities undertaken and/or funded by a foundation, but common themes are evident among foundations around the world. A survey of eleven HPFs undertaken in 2010⁽²⁸⁾ identified a range of roles and functions which were common to the

respondents (see Figure 4.1 below). As is apparent from the list of activities reported, foundations typically provide grants to external organisations to undertake health promotion activities, but some are also directly involved in developing or implementing programmes or workforce training (this is discussed further in Section 5).

Figure 4.1 Roles and functions of Health Promotion Foundations



It is important to note also that the scope of a foundation’s role and activities may change over time. For instance, it may begin with a tobacco control focus but expand to address other priority health promotion issues. Or it may assume some roles itself initially (such as mass media awareness raising campaigns or health promotion workforce training), but as the capacity of other organisations to undertake health promotion develops, the foundation can step back and simply play a funding role. Alternatively, a foundation may initially provide some grant funding to government agencies or other organisations to support them becoming smoke-free, but once these policies are established, they can be absorbed into the core policies of those organisations and not require ongoing foundation support.

4.2 Foundation-funded activity as a complement to global and national tobacco control strategies

Increasing tobacco taxes and directing funds to tobacco control through the establishment of a foundation provides a mechanism to complement and add to existing tobacco control activity and capacity in a given country.

Where a strategic plan for tobacco control already exists at either a national or jurisdictional level, it is important to assess how a foundation can support attainment of the objectives and goals of the plan in a way that ‘adds value’, while not duplicating the roles of existing programmes and organisations. A foundation will need to develop its own strategic plan, and ideally this will reflect how its role and activity will complement the country’s overarching tobacco control strategy. In Vietnam, for example, the VNTCF developed a strategic plan as well as a monitoring and evaluation framework designed to operationalise the objectives set forth in the national tobacco strategy for Vietnam. In those countries which do not yet have a robust and wide-ranging tobacco strategy, the foundation may be required to take the lead to ensure that all components of a comprehensive tobacco control programme are fully implemented.

Globally, there are also a number of frameworks for effective tobacco control and foundations can also play an important role in facilitating implementation of these. For example, the (MPOWER) package—released by the WHO to guide countries—details measures designed to fight the epidemic of chronic disease caused by tobacco use. Foundations can address each of the MPOWER measures by either taking direct action or funding external groups to do so, as illustrated in Appendix 3. Note these are examples only, drawn from a range of foundations. It is not an exhaustive list, nor necessarily applicable in all countries (for example in those where this activity already occurs).

Case Study: Vietnam

As decreed in the enabling legislation, the VNTCF focuses only on tobacco control. The act and the regulations governing it clearly state the responsibilities of the organisation, which include:

- Developing pilot models of smoke-free communities, agencies and organizations; expanding and multiplying effective models;
- Organizing community-based campaigns and initiatives on prevention and control of tobacco harms;
- Developing and implementing a smoking cessation service;
- Implementing research to provide evidence for the prevention and control of tobacco harms;
- Building the capacity of the network of collaborators working on the prevention and control of tobacco harms.

The regulations also stipulate that the VNTCF is to operate a grants scheme where tobacco control activities are mainly undertaken by external organisations. The role of the VNTCF is to allocate funds to, as well as monitor and supervise, the grants programme.

In conjunction with the legislation and accompanying regulations, Vietnam's National Strategy on Tobacco Control provides a framework as well as guidance for the practical operation of the VNTCF. Based on these documents, a strategic plan has been developed which sets specific objectives, identifies priorities and focuses resources for the first five years.

5 ESTABLISHING A TOBACCO CONTROL FOUNDATION: FUNDAMENTAL CONSIDERATIONS

While learning from the approach of others, each country planning to establish a foundation to support sustainable tobacco control needs to modify and refine the model to suit the national setting and circumstances. This is apparent in the variations evident across the foundations that have been established around the world to date (Appendix 1). This spans from establishing entirely new entities with a degree of autonomy (the VNTCF) to embedding a dedicated unit within the Ministry of Health (the Taiwan Health Promotion Administration). Section 5.4 discusses options for administrative structures more fully.

Notwithstanding the importance of tailoring a foundation model to suit the needs and circumstances of each country, there are a number of common considerations that can be drawn from the experience of establishing foundations. These are discussed below.

5.1 Legislation and supporting regulations

The important role that legislation plays in creating a secure organisation with sound infrastructure and sustainable finance has already been stressed. While the content and format of the various acts of Parliament to establish foundations differ from country to country, there are key common and essential elements which include:

- The objectives of the organisation;
- The means of administering and governing the organisation, including specifying the relationship with the relevant minister or ministry;
- Functions and powers of the organisation;
- Accounting and reporting measures;
- Sources and methods of collection and disbursement of funds.

All of these elements must be addressed in legislation to ensure the foundation's security, transparency, accountability, effectiveness and sustainability. Such legislation often contains a provision for a review of the act and the foundation within a certain number of years to determine how well they are operating.

While it is critical to draw up legislation which guarantees the security, sustainability and efficiency of the organisation, it is vital that it is not so prescriptive that the foundation is destined to become unworkable. For example, the introduction of a many-tiered board/committee structure to oversee

decisions may render the organisation ineffectual as it struggles with its internal bureaucracy. Furthermore, while the legislation may decree a limited budget for administration to ensure that the funds are allocated to programmes and projects rather than generous remuneration for staff and board members, there must be adequate provision for the organisation to be well-resourced and staffed with the necessary high level of expertise required to carry out its work.

5.2 Enlisting support of the community and non-government organisations

NGOs as well as the community can play a vital role in supporting legislation establishing a foundation. There are major benefits and incentives for the broader community in doing so. These include the creation of a healthier nation where, for example, the harms caused by tobacco are reduced, and the enhanced ability of NGOs and community groups to apply for grants to promote healthier lifestyles. It is also important to introduce the concept of a foundation to the wider public to engender support for it. This should be a relatively easy concept to sell, given that the entire community stands to benefit through enjoying better health in the long-term.

In situations where there is scant political support for tobacco control initiatives (or the industry is scaremongering about the implications of taxation increases), it is vital to stimulate community and intersectorial support. In a number of countries, NGOS and community groups have played a critical role in spearheading well-planned advocacy campaigns to build support for tobacco control legislation and the associated establishment of a foundation. This can include:

- Generating awareness and support for tobacco control in general and a foundation in particular;
- Demonstrating support for the government to prioritise tobacco control;
- Increasing awareness that the tobacco industry has acted and continues to act irresponsibly and needs to be countered;
- Countering tobacco industry opposition to legislation or establishment of a foundation.

Such campaigns require much patient preparation and planning. The evolution of ThaiHealth demonstrates the need to take a long-term approach to advocacy. In describing the evolution of ThaiHealth, which was initiated by a coalition of supporters, the timeline is described thus: “We did not sit around idly, waiting for miracles to happen. The whole process took 8 years altogether, from 1993 to 2001, not including the deliberations that took place before that”⁽⁴²⁾.

5.3 Determining the scope of foundation activity

In establishing a tobacco control foundation, two critical decisions about scope need to be made. The first pertains to whether the foundation will focus solely on tobacco as is the case with the VNTCF, African Tobacco Control Alliance and Canadian Council for Tobacco Control—or whether it will have a broader focus on health promotion such as ThaiHealth, VicHealth or Healthway. Key considerations for determining the scope of a new foundation are summarised below in Table 5.1 while options for scaling up the latter are discussed in Section 6.

Assessment of the current status of tobacco control and health promotion in the country	Examining the existing programmes and activity levels in each area. Such an assessment would include the programmes of all health agencies including the Ministry of Health, NGOs, aid organisations and any other stakeholders. By considering the roles and responsibilities of all relevant agencies, gaps can be easily identified and duplication of effort avoided.
The funding source	If the funding comes from tobacco tax there may be an obligation to focus on tobacco, particularly if, in making a case to increase tobacco tax, a commitment was given to use some or all of the funds to reduce the harms caused by tobacco.
The amount of funding which is allocated to the foundation	If there is a minimal amount of funding, it may be more effective if assigned to address one risk factor such as tobacco use. If funds are stretched over a number of risk factors, a broader health promotion approach would be required to encompass a wide range of programme areas with the necessary supporting infrastructure and staff.
Timing	Where there is a short lead time between passing the establishing legislation and when the fund is expected to be operational, it may be more pragmatic to focus on a single issue such as tobacco control in the first instance rather than to span across a wide range of areas.
Existing capacity to deliver the proposed programmes	There is a need to appraise the existing capacity, infrastructure and workforce that can undertake tobacco control activity, as well as the capacity of other ministries and sectors needed to support the foundation's work (e.g., tax collection, board representation, etc.). In any new setup it will be essential to develop strategies to strengthen capacity in all of these areas. However, this will take time and requires financial and human resources. Where capacity is limited, it may be judicious to begin with a narrower focus and build the competencies and capabilities of the various groups and networks over time.

If tobacco is the decided focus, the second set of decisions relates to the scope of activity and role of the foundation in relation to tobacco control. Foremost, foundations should aim to fund the most effective tobacco control strategies which fall within their guidelines and areas of influence. Foundations are encouraged to complement existing tobacco control activity and national strategies within their country as well as help build capacity to address key elements of effective tobacco control as advocated by global strategic frameworks such as the WHO FCTC and MPOWER^(5,32). In some countries, determining the focus of a prospective foundation's activity will require considering a number of features germane to the local health system and environment.

5.4 Models of administration

An examination of the administrative/structural set-ups of existing foundations reveals that there are a number of models in use⁽²⁸⁾⁽³⁹⁾⁽⁴³⁾. For example, some operate as Quasi-Governmental Organisations,

which are agencies of the government who act independently from the government. These agencies receive their funding from the government but may also have their own means of collecting funds (e.g. ThaiHealth, Healthway and Tonga Health). Other examples include those that are government agencies or instrumentalities which operate within the infrastructure of government (such as the Korean Health Promotion Development Centre, Taiwan Health Promotion Administration and Lao PDR Health Tobacco Control Fund) and those which combine both administrative systems (e.g. Singapore Health Promotion Board, the Malaysian Health Promotion Board and the Mongolian Health Promotion Foundation).

The three main types of administrative models adopted by foundations are:

- i. A self-governing (sometimes referred to as autonomous) statutory body overseen by an independent board;
- ii. A unit within the relevant ministry;
- iii. A semi-autonomous body.

Each of these and key associated advantages and potential disadvantages are described below in Table 5.2.

Table 5.2 Models of Administration	
<i>Model 1 - A self-governing statutory body</i>	
Key Features: Typically, this type of foundation is:	
<ul style="list-style-type: none"> ▪ Set up by legislation which provides a long-term and recurrent budget for health promotion or tobacco control purposes; ▪ Governed by a board that comprises of broad stakeholder representation. Board governs the fund and oversees transparent and equitable allocation procedures; ▪ Independent from government and generates support across the political spectrum; promoting health by working across many sectors and levels of society. 	
Advantages	Disadvantages
<ul style="list-style-type: none"> ▪ Operates independently while still able to support government priorities; ▪ Can plan and implements long-term programmes due to secure funding and infrastructure; ▪ Safeguards health promotion programmes from cancellation due to political interference; ▪ Advocates for health promotion policy; ▪ Pilots innovative or politically sensitive programmes that may be unlikely to be undertaken by government directly; ▪ Operates transparently, equitably, accountably and swiftly without bureaucratic constraints; ▪ Involves and empowers a range of partners, collaborators and sectors. 	<ul style="list-style-type: none"> ▪ May incur opposition relating to earmarking and quarantining of its funds which some economists and governments object to; ▪ Duplication may occur if more than one agency sees itself as having a lead role in tobacco control. This can be mitigated by having appropriate government representation on the governing body and consulting with relevant departments.

Model 2 (A separate unit within a government department/ministry)	
Key Features: <ul style="list-style-type: none"> Typically set up as a health promotion or tobacco control division established within a government agency such as the Ministry of Health; Has a separate budget (usually appropriated funding) and specific functions as enshrined in legislation while being under the direction of the relevant minister; May appeal to authorities who are resistant to committing large sums of money to an organisation that is close to the government. 	
Advantages	Disadvantages
<ul style="list-style-type: none"> Can support and complement other public health policies, priorities; Easier direct access to government through the minister and departmental director (enabling the foundation to influence policy and direction for health promotion); Minimises the potential for duplication within government; Easily accesses the expertise and resources of a range of other departmental units. 	<ul style="list-style-type: none"> Direct ministerial control may limit independence or freedom to be more innovative; May encounter political pressure to fund programmes that are not high priority Less scope to collaborate with civil society, NGOs, private sector; May be competing with other government priorities for resources; Existing within a bureaucracy may limit capacity to respond quickly to new opportunities or health issues.
Model 3 (semi-autonomous)	
Key features: This model is a hybrid of models 1 and 2: <ul style="list-style-type: none"> Attached to but not under the direction of the relevant ministry; Has separate funding and is governed by an independent board; Submits a budget request which is approved and allocated through the Ministry of Health, who determines the priority action areas for the foundation; The independent board determines how funds are assigned and which are implemented to address priority areas. 	
Advantages and disadvantages <ul style="list-style-type: none"> Optimises many of the advantages of Models 1 and 2 whilst minimising some of the disadvantages associated with being a totally independent body; May appeal to governments that don't want to give a foundation total independence, whilst still enabling it to have flexibility and autonomy in decision making. 	

5.5 Governance

Corporate governance refers to the system of structures, rights, duties and obligations by which organisations are directed and controlled⁽⁴⁴⁾, and it is critical to get good governance structures and procedures in place from the outset. Governance is important for all organisations, but particularly so in the case of a foundation that will be administering funds derived from the collection of taxes. Good governance is also critical to ensure that the organisation has the accountability and procedures that are above the reproach of any tobacco industry criticism or political interference.

Self-governing and semi-autonomous foundations are typically governed by Boards of Directors. The governance structure specifies the rights and responsibilities of different participants in the

organisation, such as board members, managers, auditors, regulators and other stakeholders. Governance also provides the structure through which foundations set and pursue their objectives as well as monitor the actions, policies and decisions of the Board. Important considerations when appointing board members are the selection method of members, the skills and interests that they will represent and whether parliamentarians are included.

Parliamentary representation on foundations varies from jurisdiction to jurisdiction. For example, the ThaiHealth board is chaired by the Prime Minister and the Vice Chair is the Minister for Health. Conversely, in Western Australia the Healthway Board has no parliamentary delegates and goes to great lengths to remove any possibility or perception of political interference. Members of Parliament may not be associated with any payments made by the organisation and their photographs are excluded from appearing in any of the organisation's publications.

However the governing body is appointed and structured, it should be able to operate equitably, independently and without fear or favour. As well as a governing board, most foundations have the ability to appoint advisory committees comprised of experts whose roles may include:

- Making recommendations to the board regarding the awarding of grants;
- Advising on priorities and policies for the foundation;
- Advising on the development of a strategic plan;
- Overseeing financial and audit matters.

Other foundations have other governance structures that correspond to conventional practice in that country, for example the Board of Controllers for the VNTCF.

5.6 Operational roles

Foundations have various ways of operating. Their legislative mandates and the contexts in which they operate (cultural, demographic and geographic) all combine to shape the foundation and its culture, goals and objectives, structures and scope of activity. A **delivery model** refers to the methods and strategies the foundation will use in order to meet its objectives. This requires having a clear vision of what the organisation wants to achieve as well as a realistic understanding of the capacity of available personnel and organisations, both internal and external, to deliver. A strategic plan which expands on objectives and highlights priorities for a given period will also inform and govern the most appropriate delivery model for the organisation.

Foundations operate in modes which may be described as 'internal' or 'external'. Some plan and deliver entire health promotion/ tobacco control programmes including social marketing (internal) while others provide grants to external organisations to deliver programmes. Furthermore, some carry out research internally while others outsource it to external organisations. Foundations may also use an 'open grants' approach for which an appropriate organisation may apply for funding to tackle a priority health issue. Alternatively, some foundations use a 'proactive grants' approach which means that priority programmes and projects are commissioned, initiated or developed by the foundation but implemented by others. Or as is the case with many foundations, they fund a combination of open and proactive grants.

5.7 Research and evaluation

There is increasing recognition globally within public health of the critical imperative to strengthen data collection and have monitoring mechanisms that enable tracking trends in chronic disease risk factors, morbidity and mortality, and the associated economic costs of disease burden⁽⁷⁾. Just as critical is the need for research and evaluation to build the evidence-base for effective tobacco control, particularly regarding ‘what works’ in LMICs. Likewise, it is essential that foundations plan for and invest in evaluating the ‘impact’ of the foundation itself. Being able to demonstrate the effectiveness and success of a foundation is vital given the opposition it may encounter from the tobacco industry or from political or community groups that are sceptical about its merits. However, it is also vital that foundations recognise up front the difficulty of fully isolating their impact from other factors, thus the need to have rigorous evaluation processes and be cautious about not overstating successes. In Thailand, for example, there was a reduction in road deaths following ThaiHealth’s high-profile road safety and alcohol campaigns, but other factors such as improved roads and law enforcement may also have contributed to the reported decrease in road deaths⁽⁴⁵⁾.

Comprehensive evaluation should encompass:

- (i) Clearly defined evaluation processes and measures that align to the foundation’s strategic priorities and objectives;
- (ii) Monitoring of project and programme implementation and effectiveness (within the organisation as well as of the activity other external groups are funded to undertake);
- (iii) Monitoring of impact on tobacco control and other capacity building initiatives among funded groups and in the community more broadly;
- (iv) Collection of data and feedback to inform continual learning and improvement.

Foundations can also choose to play an important role in helping build research capacity within a country. Many foundations, for instance, have established a research grants programme. This can support a mix of investigator-led research, strategic research and evaluation research to build evidence for public health investments. By supporting excellent research, improving the overall skills of researchers, providing networking opportunities for researchers and connecting research to policy and practice, foundations can increase the impact of tobacco control. Funding research can also play an important role in building the local evidence-base for investing in tobacco control.

Investing in research and evaluation can also have valuable flow on benefits to public health more broadly (e.g. via raising awareness of the importance of routine data collection, facilitating infrastructure development to support research and workforce training in evaluation). In Western Australia for example, past recipients of Healthway PhD scholarships, postdoctoral fellowships and research grants have often gone on to work in various areas of public health, including occupying significant leadership roles in government and NGOs.

5.8 Capacity building of tobacco control workforce and networks

Health Promotion capacity building involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners, the expansion of support and infrastructure for health promotion in organisations, and the development of cohesiveness and partnerships for health in communities⁽⁴⁶⁾. The WHO has noted that the ultimate goal of capacity building in tobacco control is to enable governments and non-governmental organisations to develop, implement and sustain effective strategies to combat the harmful effects of tobacco use⁽⁴⁷⁾.

The establishment of a foundation and legislating for sustainable funding for tobacco control are of themselves highly recommended strategies for capacity building advocated by the WHO⁽⁴⁷⁾. But just as importantly, a tobacco control foundation needs to see the development of capacity as a core building block underpinning its processes, approach to funding, and way of working with others.

This includes building the capacity of:

- Organisations and groups specifically engaged in tobacco control;
- Tobacco control and public health workforces;
- Government and non-government agencies outside of the health field that are in a position to facilitate tobacco control and/or health promotion outcomes;
- Civil society groups;
- Community groups and community champions;
- Universities and research organisations, NGOs, religious or faith groups.

As recognised in the Bangkok Charter on Health Promotion, communities and civil society can play a significant role in initiating, shaping and undertaking health promotion⁽⁴⁸⁾. Countries vary, however, in the extent to which tobacco control is prioritised or incorporated into the role of civil society groups, NGOs and government agencies outside of health. **Hence when a tobacco control foundation is first established, it is vital to litmus test the current state of tobacco control capacity and workforce within that country.** In some LMIC countries, for example, there are already civil society groups or non-government organisations that are already playing a role in tobacco control, hence this is existing capacity that can be tapped into and further developed. In Vietnam, unions such as the Women's Union and the Youth Union are seen as valuable groups for the VNTCF to engage with in tobacco control as they have wide-reaching networks across the country and a core commitment to citizen wellbeing that can be harnessed. In Thailand, there are many grass-roots community groups that have become involved in health promotion through grants and capacity building supported by ThaiHealth.

Government should be a major collaborator with any foundation at all levels (local, provincial and national). The departments involved may include health, social development, transport and traffic, planning, community services and education as well as finance and tax policy. At the local level in China,

for example, an academic research team at Peking Union Medical College collaborated with local government officials to focus on the development and implementation of smoke-free policies in schools, government buildings and hospitals⁽⁴⁹⁾.

Foundations are also in a unique position to facilitate the development of networks and collaborators among stakeholders. A key role of a foundation should be to support, foster and connect other organisations and individuals to work more effectively to promote the health and wellbeing of the community. Fostering the links and collaborative activity of key players in tobacco control is more sustainable if it is spearheaded by a foundation that has its own sustainable funding: in Indonesia and the Philippines, for example, grant funding from The Union and Bloomberg Initiative has seen considerable strengthening of collaborative tobacco control activity among government and non-government organisations in recent years. However, reliance on external funding is not sustainable.

In LMICs, regional and national networks are particularly crucial for information exchange necessary for tobacco control researchers to maximise their country's available resources⁽⁴⁹⁾. The Global Tobacco Research Network is one such network that aims to consolidate institutions and researchers in order to build and sustain international tobacco control efforts⁽⁵⁰⁾. Its focus is on knowledge sharing and management and educational partnerships. A selling point for the foundation model is that it can contribute to these networks, building organisation and workforce capacity that have flow on benefits to public health and the community and country more broadly.

Those foundations which have a commitment to developing capacity through innovation-specific activities, such as policy and structural change, or general capacity building such as workforce skill development and commitments to allocating resources to health promoting activities will ensure that health gains are not only multiplied but also sustained over the long term. Box 5.1 summarises examples of capacity building that has ensued from the establishment of foundations.

Box 5.1 Capacity building benefits flowing from foundations	
Tobacco control capacity	Broader capacity building
Building tobacco control capacity within the health sector and increasing scope for prevention efforts around tobacco (for example, hospitals offering cessation advice instead of only treating tobacco diseases).	Utilising existing domestic infrastructure at district and local levels to ensure broad reach of programme activities.
Developing skills and abilities of external organisations and groups to implement tobacco control (for example to enforce laws and implement smoke-free policy).	Building public health workforce capacity in project management, grant applications and evaluation.
Contributing to a national multi-sectorial approach for tobacco control policy and program development.	Building capacity of external organisations to apply for funds and manage projects.
Contributing to a system of monitoring and evaluation of tobacco control policies and programmes.	Facilitating networks and collaborations among groups and organisations that may not otherwise have worked together.

Embedding a systemic approach to capacity building into the way that a foundation operates can both ensure sustainability over the longer term, and multiply the return on investment for tobacco control.

Case Study: Vietnam

As has already been stated, the legislation and its supporting regulations clearly outline the role and responsibilities of the VNTCF as well as the **scope of its activity**. In limiting the scope of the VNTCF to tobacco control at this point in time, it was considered that tobacco-related diseases were the leading health problem in Vietnam and that funding was urgently needed to mount a comprehensive tobacco control programme. There were also concerns about the potential for duplication and the perception that a single-issue foundation would be more palatable to government.

In terms of its **model of administration**, the VNTCF is best described as a semi-autonomous body. It has separate, secure funding and is governed by a nine-member board that approves the strategic directions and programme expenditure. Eight of the nine members are ministry officials and the ninth is a representative of the General Confederation of Labour. The Chairperson is the Minister of Health and the Deputy Chair is the head of the Ministry of Finance. The board composition differs from that of most other similar foundations that tend to combine personnel from government and non-government organisations as well as other relevant professions.

A **governance structure** specifies the rights and responsibilities of different participants in the organisation. In the case of the VNTCF, these are clearly specified for board and committee members as well as the executive team, auditors and regulators. As an example of a governance structure designed to conform to the norm of its country, the structure of the VNTCF includes a Board of Controllers who reports to the Board of Management and whose role is to oversee legislative compliance and supervise and monitor financial activities.

The **operational roles** of the VNTCF as outlined in the enabling legislation emphasise that it is a granting organisation rather than one which is to deliver the entire tobacco control programme. The exception to this is that the VNTCF is responsible for a mass communications campaign using local, provincial and nationally-based media. This will provide important awareness-raising about the VNTCF's work as well as begin to challenge and shift social norms around tobacco use. In the first round of the grants programme, the fund used a more proactive approach where four priority areas were identified, and applicants were restricted to the key organisations with which VINACOSH had existing partnerships. As capacity grows, the VNTCF will fund a combination of open and proactive grants.

A process for advancing a Vietnam **tobacco research agenda** is currently being undertaken at time of writing; there is recognition of the importance of building tobacco research capacity in-country and preliminary work has been done on identifying priority areas. Strategies to do this are being developed. Although it is early in its establishment phase, the VNTCF already has a comprehensive monitoring and evaluation framework in place to ensure that the effectiveness of the organisation and its programs can be measured.

Capacity building of the tobacco control workforce and network is seen as crucial to the success of the organisation. VINACOSH, the forerunner of the VNTCF, has a strong history of working with different sectors, organisations and community and civil society groups. This will not only continue but be amplified with the new organisation and increased funding levels. A blueprint for building capacity and increasing the numbers involved in the tobacco control network is outlined in the strategic plan. The first group targeted for training are those involved in the tobacco control law's enforcement and monitoring.

6 CHALLENGES FOR FOUNDATIONS

Since foundations have now been established in a variety of country contexts, future foundations can benefit from the lessons of hindsight and anticipate potential challenges. Earlier sections of this paper discussed some of the challenges that may be faced, but there are a number of other potential challenges identified in a survey of HPFs undertaken in 2010⁽²⁸⁾. This section synthesises these issues (Box 6.1) so that those planning a foundation are aware of potential challenges ahead and can take steps to avoid them, minimise their impact and/or tackle them.

It is pertinent to note that new foundations face particular challenges because they must start a new organisation from scratch. This, coupled with the need to act very quickly to disburse funds under the scrutiny of the parliament, media and other interested stakeholders may put the fledgling foundation, its board and its staff under enormous pressure.

Box 6.1 Challenges facing foundations and potential strategies to address them	
Finding the right approach to tobacco control given no 'one size fits all' solution	Countries must tailor the approach, organisation, funding, etc. of a foundation to enable them to address health priorities as well as to suit their political, social, and economic environments.
Risk anticipation, assessment and mitigation strategies	Foundations are generally high-profile organisations with complex business models funded from the public purse. They receive a high level of scrutiny from government and media as well as the public. To maintain integrity and the support of key stakeholders, foundations must develop risk management strategies to minimise the risk of events occurring that will impact adversely on the objectives of the foundation and its reputation.
Encouraging sustainability in projects funded	There is a dilemma between not abandoning successful projects yet still having funds for new and innovative ones ⁴⁴ . Providing recurring funding for existing projects erodes the funds available for new initiatives and can foster a culture of dependence on foundation funding. This can be addressed by requiring applicants for grants to provide some funding or other support to implement the project and to discuss strategies for sustaining the work in their application.
Spreading too thin	While there is much to commend foundations for the wide and varied range of activity in which they engage, there is some risk that they may try to do too much with their limited resources, particularly those who seek to

	address a range of health issues and not just tobacco. HPFs are increasingly recognising the need to prioritise particular areas of funding within each strategic planning cycle to optimise the effectiveness of its investment in tobacco control.
Diminishing health promotion gains over time	Early rapid gains in adoption of healthier behaviours often slow down or plateau ⁴⁷ , with those still engaging in the unhealthy behaviour often more resistant to change or hindered by circumstances that make behavioural change more difficult. It is important for foundations to anticipate that initial dramatic impacts (e.g. reduced prevalence, changes in social norms regarding smoking) may level off at some point, and to know that this is not necessarily a reflection on the effectiveness of their programmes or strategies.
Freedom from political interference	Foundations can be easy targets for politicians and others wishing to access extra funds or favours to support their portfolios, electorates and spheres of interest. Despite having legislative parameters which provide for a degree of independence as well as political and administrative barriers to minimise interference in foundation activity, this issue continues to be challenging for some foundations. Robust administrative policies and strong support from the board can reduce the potential for interference to occur.
Commercial interests may be anti-foundation	The fear of impacted profits or over-regulation may precipitate commercial interests (such as tobacco retailers) trying to destabilise foundations by actively lobbying against them and undermining the work they do. It is important that foundations and advocates counter-lobby to ensure that decision-makers are aware of the harmful effects of such products and the ways they are promoted. Foundations must also raise awareness of the ways they are benefiting the health of the community to instil community support.
Measuring and demonstrating effectiveness	Evidence of changing behaviours and tobacco-related illness cannot be collated in the short-term, and foundations are vulnerable until they can start to demonstrate effectiveness and impact. This underscores the importance of investment in monitoring and evaluation and setting appropriate strategic objectives and performance indicators from the outset.

Case Study: Vietnam

The challenges that have the potential to harm foundations have been well documented and the VNTCF is clearly aware of them. One identified risk is for a country to replicate exactly what has been successful elsewhere, while it is widely recognised that there is ‘no one size fits all’ approach! In Vietnam, this risk has been mitigated by tailoring the approach, infrastructure and funding mechanism to enable the VNTCF to address its tobacco control priorities as well as suit the political, social, and economic environment.

Another important initiative—and one which will be envied by some of the more mature foundations—is that the VNTCF has already developed a monitoring and evaluation programme and set strategic

objectives and performance indicators. By being equipped to measure and demonstrate effectiveness, the VNTCF will be less vulnerable to criticism and question, particularly in the short-term when significant behaviour changes are yet to be recorded.

While the VNTCF has already taken steps to address potential challenges, the new organisation may face some additional trials unique to its own circumstances.

Examples include:

- Administrative costs have been capped at 5% of the total budget, which may limit the ability of the VNTCF to employ adequate staff to undertake the necessary work. Understandably, legislators are keen to ensure that funds get allocated to the programmes and activities of the organisation rather than to salaries and administrative costs. However, it is important to ensure that the organisation is adequately resourced to meet its objectives and implement programmes.
- A multi-level committee structure and lack of clarity around the roles of the various committees may create a bureaucratic structure that may impede efficiency and effectiveness.
- The tobacco industry in Vietnam is a state-owned enterprise which may be influential within government but which can be moderated by the implementation of a comprehensive conflict of interest policy.
- The VNTCF's management board includes the heads of the key ministries as well as the Confederation of Labour. The Advisory Board also consists of high-level government officials. As these are people pressed for time, the challenge is to ensure involvement in and ownership of the VNTCF by the boards and committees, and to engage them in capacity building/training activities.

The VNTCF has developed a risk register which identifies potential risks and their causes, as well as prospective strategies to address them. By being mindful of possible risks and challenges, the VNTCF is well placed to reduce potential impact should challenges arise.

7 SCALING UP – FROM TOBACCO CONTROL TO HEALTH PROMOTION

7.1 Tobacco as part of a broader NCD agenda

Countries who choose to start with a single-issue tobacco control foundation should be aware that the programme base may have to be expanded as the increase in NCD deaths in the next decade is realised, and as momentum gains around the world to address NCDs in an integrated way^(3,7). The WHO projects that the total number of deaths from NCDs will increase by 15% globally between 2010 and 2020, with greatest growth projected for Africa, the Eastern Mediterranean and South-East Asia⁽²⁾. Targeting tobacco use can contribute substantially to the attainment of global targets for reductions in NCDs and their risk factors⁽³⁾ and may be a good starting point for LMICs that have limited capacity and resources to tackle all NCDs simultaneously. There are also synergies and lessons learnt from tobacco control that

can be transferred to addressing other NCD risk factors. Furthermore, as noted earlier, foundations can help to build workforce and research capacity that benefits public health more broadly.

Given the mounting global imperative to address NCDs in a more integrated way, one option is to consider scaling up from a single issue organisation (such as a tobacco control foundation) to an HPF that covers a range of health promotion issues. As reflected in Appendix 1, some foundations were established with this broader health promotion remit, albeit often with funds derived primarily from tobacco taxes. HPFs with a broader health promotion focus typically align their activity to the key preventable health issues of their country (for example alcohol use, physical activity, road safety and mental health promotion), whilst countries such as Thailand have added more local priorities such as road safety. Such a foundation is also geared to respond to emerging issues as they arise. For example, the Australian Health Promotion Foundations are now active in the fight against obesity and in promoting mental health, issues which were barely on the agenda when the foundations were established some 20 years ago⁽⁵²⁾.

One of the potential benefits of opting for a broader health promotion focus is that the foundation may meet with less opposition from the tobacco industry lobby and other vested interest groups who perceive such a foundation as a direct threat to their interest and existence⁽⁵³⁾. However, there is a risk that in tackling a breadth of issues, a foundation spreads itself too thinly⁽⁴⁵⁾ and tobacco control effectiveness may be diluted. As discussed in Section 5.3, there are range of considerations that each country should appraise in determining the scope of activity that best suits its context and circumstances.

7.2 Taxing goods other than tobacco to fund health promotion

Whilst tobacco has been the most widely taxed product used to support public health efforts in the past, many of the same arguments which were applied to the use of tobacco tax are now being used to increase and allocate taxes on other health-compromising goods. For example, increases in taxes on alcohol and unhealthy foods can be used to reduce the harms they cause. ThaiHealth is an example of a foundation that derives its funding from both alcohol and tobacco tax, and the recent 'sin tax' in the Philippines similarly collects revenue from alcohol and tobacco. Other countries like Vietnam and Australia have commenced with a tax on tobacco and are contemplating the same approach to other consumables such as a tax on sugar-based drinks.

It is important to recognise that while there are some similarities between tobacco taxation and the rationale and methods for increasing taxes on other health comprising goods, there are also some important differences to consider. For example, other products may not have the same price elasticity as tobacco, and the availability of 'substitute' products is more problematic in the case of food and beverages. The argument for tobacco taxation can also be clearly founded on the fact that there is no safe level of tobacco use, whereas the same categorical case cannot be made for alcohol or unhealthy goods. Notwithstanding these differences, NCD prevention has much to gain from the lessons learnt from tobacco control regarding the need for sustainable funding and the merits of reducing demand for

unhealthy products. A brief précis of the other types of taxes being applied on unhealthy products other than tobacco is provided below.

Alcohol

There is sufficient evidence internationally that taxation and price measures are among the most efficient and cost-effective in reducing alcohol consumption and alcohol-related harms⁽⁵⁴⁾. Importantly, implementing taxes is believed to reduce alcohol consumption and alcohol abuse among young people. To date, Thailand is the only country that has specifically earmarked alcohol taxes for health promotion⁽⁴³⁾; however, the illegal alcohol market in other countries may reduce the impact of such measures⁽⁵⁵⁾.

Taxing high-fat or high sugar-foods

Many countries are experiencing rising rates of obesity and diabetes that are contributing significantly to the NCD burden. There is growing recognition that the relative affordability of less healthy foods contributes to this, with little economic incentive to consume a healthy diet. For example, in some LMICs, sugar-sweetened beverages are less expensive than healthier choices such as milk or water⁽⁵⁶⁾.

Taxing high-fat or high-sugar foods has gained some momentum in recent years⁽²⁰⁾ and last year's UN high-level meeting on NCDs recognised the important role of food taxes⁽⁵⁷⁾. Denmark has introduced a 'fat tax',⁽⁵⁸⁾ France has taxed sweetened drinks⁽⁵⁹⁾ and Peru has announced plans to tax junk food⁽⁶⁰⁾. Several arguments are used to support calls for such taxes. The first is that it can potentially reduce consumption directly if price is raised sufficiently enough to become a purchase deterrent. Secondly, implementing a fat or sugar tax can send a message to consumers that the product is unhealthy. Thirdly, the revenue generated can be invested in preventive health programmes, including those targeting obesity⁽⁶¹⁾. It is critical, however, to ensure that the funds generated are directed back into health promotion and that fat or sugar taxes are properly administered in order to have the desired impact on public health outcomes⁽⁶³⁾. For example, currently 33 states in America tax sugar-based beverages, however only small consumption reductions have been observed⁽⁶⁴⁾. Therefore, it is argued that the revenue generated by the taxes could be more effectively directed to health-related and obesity-specific campaigns.

One argument against fat, junk food or sugar taxes is that they are a form of regressive taxation that will particularly burden those on lower incomes who may be greater consumers of such products and least able to absorb price increases. However, the counter argument that has held true in tobacco control is that low-income groups are more sensitive to price increases, so hopefully their unhealthy food intake will decline⁽⁶²⁾. Another argument is that whilst fat or sugar taxes may yield substantial revenue, they are unlikely to reduce obesity and diabetes rates; for unlike tobacco, there will be many other foods that influence obesity and diabetes other than those to which the tax is applied⁽⁵⁶⁾. It is also contended that to influence the consumption and weight of at-risk populations, the tax excise would need to be high, but this is less likely to be politically palatable or sustainable⁽⁵⁶⁾.

An alternative to merely imposing taxes on unhealthy foods is to look at pricing policies that comprise both taxes on unhealthy food/beverage and subsidies on healthier options. This would have the dual impact of discouraging key unwanted behaviours and encouraging desirable, healthier behaviours⁽⁶⁵⁾.

Case Study: Vietnam

There is an understanding that given the marked increase in death and disability worldwide caused by NCDs, Vietnam may need to scale-up to encompass a broader health promotion agenda in the future. For now, however, the focus remains on tobacco. If or when the time comes to expand the remit of the organisation, the VNTCF will have learned lessons from tobacco control that can be readily transferred to other NCD risk factors. There will also be a workforce and research capacity as well as networks competent to embrace a broader public health agenda.

8 CONCLUSION

Tobacco is the only product proven to kill more than half of its regular users. Finding ways to accelerate global reductions in tobacco use and tobacco-caused death is a matter of urgency. Without sustainable funding for tobacco control, tobacco deaths are predicted to escalate from the current level of more than six million deaths to an estimated eight million deaths annually by 2030, with the majority of preventable death and disease occurring in LMICs⁽⁶⁶⁾. The purpose of this paper is to demonstrate that there is a practical and economically viable way for governments to address the issue of tobacco control while generating a sustainable source of funding to support it.

The WHO FCTC provides a clear direction and set of measures for tackling tobacco but its success relies on its rapid and full implementation⁽¹¹⁾, which requires both financial and human capital. An evidence-based solution that has been effectively applied in a number of countries is raising tobacco taxes and applying part or all of the funds generated to tobacco control and/or health promotion programmes. This enables even the poorest of countries to meet its obligations in relation to the WHO FCTC and represents an investment that yields substantial savings in the medium to long-term by reducing the social and economic burden of tobacco.

Establishing a foundation to administer the tobacco control funds and associated programmes can:

- Provide a sustainable mechanism for financing, implementing and coordinating tobacco control/health promotion initiatives, thereby acting as an additional health financing option for governments;
- Bring together government, civil society and private sector stakeholders and experts;
- Complement and enhance government tobacco control/health promotion initiatives by working in parallel with government departments in their key focus areas;

- Strengthen the health system while, importantly, not competing for funds that have been set aside for treatment.

Strengths of foundations include low administrative costs, lack of bureaucratic impediments, quick turnaround and response time, inclusion of community inputs and the potential to shield governments from unpopular funding decisions.

The following recommendations are made In light of the compelling need to take urgent action to reduce tobacco use and the personal and societal burdens of tobacco-related disease and death.

It is recommended that:

- Governments which have not already done so commit to the tobacco control measures in the WHO FCTC to reduce the prevalence of tobacco use and exposure to tobacco smoke.
- Governments and civil society collaborate to strengthen tobacco control efforts by establishing a network across all levels of government as well the community. Such a coalition can assess the current situation including the cost of tobacco to the community as well as the funding required to comprehensively reduce its impact. The network can also be used to maintain awareness of issues before the public, refute tobacco industry claims, enhance community involvement and promote community buy-in and support, as well as educate policy makers and help to bring about policy change.
- Governments with civil society support act now to develop an effective national strategy or action plan for tobacco control. This may require an audit to determine which elements of a comprehensive programme currently exist and help identify gaps and focus areas.
- Steps are taken to develop a fully functioning and adequately financed infrastructure to ensure capacity to implement effective interventions. This will involve securing adequate and sustainable funding as well as establishing an appropriate administrative model.
- A capacity building programme is undertaken to ensure strong leadership and an adequate number of skilled staff is available to facilitate programme implementation and oversight, offer technical assistance and training as well as develop a research agenda.
- An evaluation framework is implemented to assess and report on performance, effectiveness and changing priorities that may occur with predicted increases in NCDs.

The Union has a long history of working with governments in LMICs, helping countries implement public health interventions since 1920. Beginning with their work in tuberculosis, The Union has provided technical assistance in dozens of countries at the request of governments, ministries and outside agencies. The infrastructure and lessons gained from the work in tuberculosis has been incorporated into the Tobacco Control Department, which has designed, supported, and administered tobacco

control initiatives for over twenty years. The Union provides technical assistance to LMICs, including helping set up tobacco tax-funded foundations. This paper offers a step-by-step guide for governments, and future resources will include a tool-kit and training courses.

The Union can help governments address the underfunding of tobacco control and establish their own health promotion foundation. For further technical advice and assistance, please contact the Tobacco Control Department of The Union at tobaccofreeunion@theunion.org or union@theunion.org.

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APPENDICES

Appendix 1 - An overview of countries to date that have established an entity along the lines of an HPF.

Appendix 2 – Global variations in funding allocation approaches for sustainable tobacco control

Appendix 3 – Potential actions that can be undertaken by foundations to complement tobacco control more broadly

Appendix 1 Health Promotion and Tobacco Control Foundations around the world

Name	Focus	Purpose (where stated)	Standing	Governance	Funding source and amount (where available)
African Tobacco Control Alliance (ATCA), 2008	Tobacco Control	<i>Not avail.</i>	Self-governing/ autonomous agency (non-profit, non-political)	ATCA Board, headed by Chair	Tobacco excise taxation (tax increase to 45% in Togo, Niger, Senegal)
Austrian Health Promotion Fund, 1998	Health Promotion	<i>Not avail.</i>	Self-governing/ autonomous agency	Board of Trustees chaired by Minister of Health	Value Added Tax distributed by the Ministry of Finance Annual budget: USD \$9.95 million (2013) ≈ (USD \$1.18/head) [#]
Brunei Health Promotion Centre (HPC), 2008	Health Promotion	<i>Not avail.</i>	Self-governing/ autonomous agency	General Director (MOH) and Head of HPC	National Health budget (no specific information on part reserved for Tobacco control)
Canadian Council for Tobacco Control (CCTC), 1974	Tobacco Control Fund	<i>Not avail.</i>	Semi-Autonomous	Non-governmental, Chair and Board of directors	Tobacco Tax and Corporate Sponsorship Tax Revenue: USD \$6.34 billion (2012-2013) ≈ (USD \$188.91/head) [#]
Croatian National Health Insurance Fund, 1993	Health promotion	<i>Not avail.</i>	Government agency	Director and Board of directors appointed by Minister of Health	Voluntary complementary Health insurance that cigarette taxation (As of 1 June 2014, tax increase to: USD \$0.66 per pack of cigarettes)
Estonia Health Promotion Commission, 1994	Health promotion including tobacco	Fund for cultural, endowment as well as health promotion and disease prevention	Self-governing/ autonomous agency	Ministry of Social Affairs, Health Insurance Fund and Health Care Board	Tobacco tax (3.5%) (Total Health Expenditure*: USD \$1.32 billion, 2012 ≈ USD \$1015/head) [#]

#USD per head is calculated based on available budget amount and current 2014 population statistics

*Total Health Expenditures based % of GDP spent in 2012 from World Bank data by country (data.worldbank.org)

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Name	Focus	Purpose (where stated)	Standing	Governance	Funding source and amount (where available)
Finland Health Promotion, 1999	Health promotion	<i>Not avail.</i>	Government Agency	Ministry of Social Affairs and Health	Tobacco tax, 0.45% per annum (Total Health Expenditure*: USD \$22.49 billion, 2012) ≈ (USD \$4165/head) #
Foundation Lucie et Andre Chagnon, Canada, 2000	Health Promotion	To contribute to the development and improvement of health through poverty and disease prevention by focusing primarily on children and their parents.	Autonomous	Non-governmental, Board of directors.	Charitable organisation which has a partnership with the Canadian government. The charitable trust fund commits an amount (\$15 million) that is matched by the Canadian Government USD \$17 million (2012) ≈ (USD \$2.10/head in Quebec) #
Iceland Tobacco Control Board, 1996	Tobacco Control	<i>Not avail.</i>	Government department	Tobacco control board (Ministry of Welfare)	Tobacco tax (0.9%)
Korea Health Promotion Foundation, 2011**	Health Promotion	1. To support developing the National Health Promotion Plan 2. To operate training programmes for health care professionals. 3. To plan and evaluate research regarding health promotion. 4. To carry out initiatives related to health promotion	Autonomous Agency under MOH	Board of Directors chaired by a president	Treasury Budget and donations (but mainly from the Ministry of Health and Welfare) USD \$10 million (2013) ≈ (USD \$0.20/head) #

#USD per head is calculated based on available budget amount and current 2014 population statistics

*Total Health Expenditures based % of GDP spent in 2012 from World Bank data by country (data.worldbank.org)

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Name	Focus	Purpose (where stated)	Standing	Governance	Funding source and amount (where available)
		programmemes assigned by the Ministry of Health and Welfare.			
Laos PDR Tobacco Control Fund, 2013	Tobacco Control Fund	<i>Not avail.</i>	Unit in MOH	Tobacco Control Fund Council (The National Committee on Tobacco Control)	Government budget and Tobacco tax (USD \$0.03 per pack) Annual revenue from taxes: USD \$2.19 million ≈ (USD \$0.33/head) #
Malaysian Health Promotion Board (MySihat). 2006**	Health Promotion	1. To develop the capacity of organizations (including health and community based) for health promotion. 2. To plan and implement health promotion programmemes and activities for the benefit of the community, with a particular focus on youth.	Semi- Autonomous Agency under MOH	Board of Directors and Chairman appointed by the Prime Minister upon the advice of the Minister of Health	Treasury Budget USD \$5 million (2011-2012) ≈ (USD \$0.17/head) #
Mongolian Health Promotion Foundation, 2007**	Health Promotion	<i>Not avail.</i>	Semi- Autonomous Agency and a unit in MOH	Foundation Council chaired by Minister of Health	Government Budget (2% of tobacco tax since 2005) USD \$210 380 (2010) ≈ USD \$0.075/head#

#USD per head is calculated based on available budget amount and current 2014 population statistics

*Total Health Expenditures based % of GDP spent in 2012 from World Bank data by country (data.worldbank.org)

** Member of INHPF (International Network of Health Promotion Foundations)

Name	Focus	Purpose (where stated)	Standing	Governance	Funding source and amount (where available)
Nepal's Smoking and Tobacco Control and Regulatory Committee,	Tobacco control	<i>Not avail.</i>	Semi-autonomous	Chaired by secretary of the Ministry of Health and Population	The Government levies excise tax on tobacco products annually ¹ Tax: 25% retail price (2008)
Qatar tobacco control, 2002	Health promotion	<i>Not avail.</i>	Government department	Ministry of Health, Department of Public Health	2% of overall Tobacco sales taxes
Singapore Health Promotion Board (HPB), 2001	Health Promotion	To help residents in attain optimal health through health promotion and disease prevention programmes. To promote health by forming sustainable partnerships with other government agencies, the community, private and corporate entities to implement programmes to all age groups. programmes encompass health promotion (in smoking control, nutrition, physical activity, mental health, non-	Semi-Autonomous Agency and in MOH	Chairman and Board of Directors	Government, Ministry of Health budget (tobacco excise duties) (USD \$0.31 excise per cigarette) USD \$55.22 million ≈ (USD \$10.42/head) #

#USD per head is calculated based on available budget amount and current 2014 population statistics

*Total Health Expenditures based % of GDP spent in 2012 from World Bank data by country (data.worldbank.org)

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Name	Focus	Purpose (where stated)	Standing	Governance	Funding source and amount (where available)
		communicable and communicable disease prevention and management), screening for chronic diseases (for adults), health screening for children, and immunisation.			
Switzerland Health Promotion, 1994	Health Promotion	To establish and maintain an institution which initiates, coordinates and evaluates measures for the promotion of health and prevention of diseases.	Semi- Autonomous Agency	Foundation council and independent chair	Health insurance (recurrent budget through health insurance levy of around USD\$2.60 per every insured person annually Annual budget: USD \$19.4 million (2012) ≈ (USD \$2.60/head) #
Taiwan Health Promotion Administration (HPA), 2001**	Health Promotion	<i>Not avail.</i>	Unit in Ministry of Health and Welfare (MOHW)	Director General (Chair of Governance Board)	Tobacco tax (USD \$0.61 tax) per standard pack USD \$153 million ≈ (USD \$6.58/head) #
Thai Health Promotion Foundation (ThaiHealth), 2001**	Health Promotion	1. To promote good health of Thai people according to National Public Health Policy. 2. To raise awareness of health issues through social marketing campaigns	Autonomous Agency	Board of Governance chaired by Prime Minister	2% surcharge levied on excise tax from alcohol and tobacco annually USD \$100 million revenue from surcharges on taxes ≈ (USD \$1.42/head) #

#USD per head is calculated based on available budget amount and current 2014 population statistics

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Name	Focus	Purpose (where stated)	Standing	Governance	Funding source and amount (where available)
		and sponsorship of sports, the arts and popular cultures.			
Tonga Health Promotion Foundation (TongaHealth), 2007 **	Health Promotion	To promote health and reduce harm from NCDs such as Diabetes, High Blood Pressure, Heart problems and smoking related illnesses.	Autonomous Agency	Board of Governance and Chair appointed by the Minister of Health	Governmental Treasury Budget, Secretariat Pacific Community and private donations USD \$500 000 (2012) ≈ (USD \$4.76/head) #
Victorian Health Promotion Foundation (VicHealth), 1987**	Health Promotion	1. To fund activity related to the promotion of good health, safety or the prevention of disease. 2. To increase awareness of programmemes for promoting good health in the community 3. To encourage healthy lifestyles and support activities involving participation in healthy pursuits. 4. To fund research and development	Autonomous Agency	Board of Governance and independent chair	Treasury Budget Annual budget: USD \$35.5 million (2012-2013) ≈ (USD \$6.19/ head) #

#USD per head is calculated based on available budget amount and current 2014 population statistics

*Total Health Expenditures based % of GDP spent in 2012 from World Bank data by country (data.worldbank.org)

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Name	Focus	Purpose (where stated)	Standing	Governance	Funding source and amount (where available)
		activities in support of these activities.			
Vietnam Tobacco Control Fund, 2013**	Tobacco Control Fund	<i>Not avail.</i>	Semi- Autonomous Agency and a unit in MOH	Intersectoral Management Board chaired by Minister of Health	A compulsory contribution equal to 1- 2% of factory price of all cigarette packs (2013-2016), USD \$4.3 million ≈ \$0.05/head [#] (2016-2019) \$6.5 million ≈ \$0.07/head [#] (2019 onward) \$8.5 million ≈ \$0.09/head [#]
Western Australian Health Promotion Foundation (Healthway), 1991**	Health Promotion	To provide grants and sponsorships to advance health promotion through health promotion programmes and research as well as sports and arts activities.	Autonomous Agency	Board of Governance and independent chair appointed by Minister of Health	Regulated annual transfer from Treasury Budget Annual budget: USD \$19.24 million (2013) ≈ (USD \$7.64/head in WA) [#]

[#]USD per head is calculated based on available budget amount and current 2014 population statistics

*Total Health Expenditures based % of GDP spent in 2012 from World Bank data by country (data.worldbank.org)

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Appendix 2 Sustainable Funding Options for Tobacco Control

Source of funding	Process of allocation	Examples	Advantages	Disadvantages
Tobacco taxes - Earmarked taxes (Substantive)	Treasury allocates proportion of tax revenue collected for health promotion/tobacco control	<p>ThaiHealth (tobacco and alcohol) (2% of all revenue from tobacco taxes)²</p> <p>Mongolian Health Promotion Foundation (part funded from tobacco tax) (2% of all revenue from tobacco taxes)²</p> <p>The Vietnamese Tobacco Control Fund</p> <p>Estonia Health Promotion Commission</p> <p>Finland health promotion</p> <p>Korea Health Promotion Foundation</p> <p>Nepal Cancer Relief Society (NCRS) and Smoking and Tobacco Control and Regulatory Committee- cigarette tax is earmarked for cancer control¹</p> <p>Qatar Tobacco control (2% of all revenue from tobacco taxes)²</p>	<p>Fund is separate from and not reliant on the general health budget. Hence does not compete directly with other health claims.</p> <p>Facilitates new initiatives at no cost to governments if tax is increased prior to being earmarked.</p> <p>Funds cannot be easily diverted for other priority or competing programmes.</p> <p>Used sparingly and for high priority initiatives e.g. tobacco control they provide a secure resource.</p> <p>Can increase and sustain resources by insulating health spending from competing demands, particularly where spending is low and volatile.</p> <p>Community generally supports earmarked taxes when applied to positive programmes. There is a perceived responsiveness of the tax system to the preferences of the taxpayer².</p>	<p>Funding source may be perceived to be vulnerable in the long term if use of tobacco (and therefore taxes from its sale) decrease.</p> <p>Could lead to fragmentation and duplication if not properly coordinated and managed.</p> <p>Multiple earmarked funds may lower the general budget available. Could render government resources/budget process less stable over time.</p>
Taxes on other health compromising goods Earmarked taxes (Substantive)	Treasury allocates proportion of tax revenue collected for health	<p>ThaiHealth</p> <p>Philippines</p>	Broadens funding base and legitimises focusing on health promotion areas other than tobacco alone.	Less evidence to date re efficacy of 'fat tax' impacting on behaviour.
Committed funds (symbolic earmarked)	Treasury allocate funds form consolidated revenue/ funds which	<p>Healthway (1996-2006)</p> <p>Laos PDR Tobacco Control Fund</p>	Funds received direct from Treasury gives the administering organisation greater autonomy and security than if dependent on approval of a	Continuity and amount of funding may be vulnerable to changes in Government that may precipitate review of legislative

Source of funding	Process of allocation	Examples	Advantages	Disadvantages
<p>funds)</p> <p>Committed in legislation to support specific purposes, such as tobacco control or health promotion.</p>	<p>may include, but are not exclusively from tobacco or other specific tax.</p>	<p>Iceland Tobacco Control Board</p>	<p>Minister based on an application.</p> <p>Reflects importance Government places on tobacco control/ health promotion.</p> <p>Security and stability of Fund enhanced because any change in the amount, or purpose of Fund requires legislative change.</p>	<p>commitment.</p> <p>Needs to be linked to CPI to ensure value of Fund keeps pace with inflation.</p>
<p>Special funds (allocated from consolidated revenue)</p>	<p>Appropriations /allocations from Government/ Treasury (amount/method of appropriation not specified in legislation)</p>	<p>Healthway (after 2006)</p>	<p>Convenient way for Governments to support new initiatives.</p> <p>Can be justified to reduce preventable health related death and disease as Investments to reduce tobacco related harms will produce future health care cost savings for tax payers.</p> <p>Since no legislative changes are required funding level can be readily increased.</p>	<p>Available consolidated revenue in LMICs may be limited.</p> <p>Competing demands for scarce resources may result in most resources being used for high cost tertiary care over health promotion programmes.</p> <p>Continuity and amount of funding may be vulnerable to changes in government policy.</p> <p>Since no legislative changes are required, funding level can be easily reduced. Fund may be insecure without legislative protection</p>
<p><i>VAT/fiscal adjustments</i> (a form of consumption tax which generates tax revenues for government)</p>	<p>May be earmarked or committed.</p>	<p>Austrian Health Promotion Foundation, African Tobacco Control Alliance Public Health England</p>	<p>Does not compete for other core government funding.</p> <p>Potential for increase if specified as a % of VAT.</p> <p>VAT has more revenue potential than most other instruments. Effective use of VAT requires expanding the base rather than increasing rates ²</p>	<p>May be subject to variation due to economic situation which may act negatively on amount of funds available.</p>

Source of funding	Process of allocation	Examples	Advantages	Disadvantages
Government Department funding	Not committed but based on periodic applications for funds.	Singapore Health Promotion Board New Zealand Health Promotion Agency Malaysian Health Promotion Board Tonga Health Promotion Foundation	Reinforces that health is the core focus of the organisation and reflects support of Government for tobacco control /health promotion.	Continuity and amount of funding may be vulnerable to changes in Government or government priorities. The amount allocated may be subject to political whim. The least secure of all of the appropriation methods. Uncertainty of funding if dependent on application process Organisation may not have sufficient degree of independence/ autonomy to achieve optimal results. Country-level capacity in tax policy analysis may be weak and a barrier to better design and ownership ²
Social Insurance payments (also described as personal Income tax. Raises revenue through mandated pay roll taxes)			Universal coverage enhances equity of access. Has the potential to provide health promotion / tobacco control to all. Is in effect a form of cross subsidization from the healthy to the more vulnerable.	Contributors to fund generally employed, hence subsidizes the unemployed. Has the potential to become inequitable if the funds are not used on a population basis e.g. if only used for those workforce (settings based), who contribute. If not committed, there is the potential for government to divert funds to health services rather than promotion and prevention.
Private health /	May be earmarked or	Health Promotion Switzerland	Potential to free up public health resources to	Insurers may consider tobacco control/

Source of funding	Process of allocation	Examples	Advantages	Disadvantages
<i>sickness insurance levy</i>	committed	(Mandatory that all those insured pay a contribution per person per year). Croatian National Health Insurance Fund- Voluntary complementary health insurance (contributes to cigarette taxation)	address other health services. Using these funds for prevention can reduce treatment costs, eventually leading to savings for health insurance funds.	health promotion as the core business of government and may be reluctant to contribute. Contributors are only those who can afford to, or who choose to participate in private health insurance schemes.
<i>External funding</i> (e.g. potential sources could be the World Bank or European Union).	Potential to allocate as grants or loans, based on applications.		Potential access to new finance if funds cannot be sourced through other means.	Burden of paying off debt may fall to future generations. Resources required to repay debt may result in inadequate funds for ongoing programmes. May be vulnerable to volatility in loan interest rates. .
<i>Donor Aid</i> – internal and external NGOs Non-government organization funding	Non-government organization funding	The Korea Health Promotion Foundation relies partly on private donors	Potential to access a range of finance sources	Donor priorities may not match national health priorities. Danger of not being able to implement priority programmes. Dependent on donor organisation for continuity - may not be secure and sustainable. May encourage governments to abrogate their financial responsibility for health promotion/ tobacco control.
<i>Philanthropic funding</i> (can be from organisations set up	Philanthropic donations (either as general	Lucie et André Chagnon Foundation (Quebec) has a partnership with	Can use the resources of philanthropic individuals.	Potential for priorities to be pushed by the donor rather than based on sound

Source of funding	Process of allocation	Examples	Advantages	Disadvantages
to administer philanthropic funds or received from individuals)	donation or via grant applications to philanthropic fund)	Government to fight poverty through education. Philanthropic Organisation – Bloomberg Initiative to Reduce Tobacco Use, Bill and Melinda Gates Foundation funding for tobacco control	Reduces dependence on Government funding. Encourages government funding if Government is required to match those of the donor as in this case.	epidemiological and other evidence. Economic factors may reduce the long term return on invested funds. Funding may be for limited period only.
<i>Corporations</i>		Canadian Council for Tobacco Control (has corporate sponsorship)	Corporations recognize the benefits of investing in their employees' health as a way of improving productivity, reducing absenteeism as well as promoting workplace safety.	May be difficult to convince corporations of the value of investing in tobacco control or health promotion activities where the impact on worker health may not be realized in the short term.
<i>Funds collected through penalties for violations of legislation</i>	Fines and court proceeding costs transferred to Fund to fight tobacco. Fines and penalties given to offenders are put back into preventative programmes.	India's Tobacco Control Cell (Ministry of Health and Family Welfare). ³	Potential to act as a strong deterrent to smokers, manufacturers, retailers, and advertiser who violate tobacco laws. Can raise money for awareness campaigns and tobacco control initiatives.	May be costly to administer.

1. Tandon A, et al. Assessing public expenditure on health from a fiscal space perspective. 2010.
2. Powell- Jackson T, et al. Fiscal Space for Health, A review of the literature. London School of Hygiene and Tropical Medicine, 2012.
3. Indian Ministry of Health. National Tobacco control programme India: Ministry of Health, 2012.

Appendix 3 - MPOWER elements and potential action that can be supported by Foundations

Monitoring tobacco use and prevention policies

Foundations can fund research or perform research which indicates

- The extent and cost of the tobacco epidemic and subgroups in need of tailored policies and programmes
- Public awareness of tobacco epidemic and attitudes towards tobacco control
- Changes in tobacco use following implementation of policies and programmes
- Enforcement and societal compliance with tobacco control policies
- Tobacco industry practices that counter tobacco control effectiveness

Protecting people from tobacco smoke

- Advocate for the introduction of comprehensive smoke free legislation
- Fund public awareness programmes/campaigns to promote the smoke free message
- Require grant funding to be conditional on organisations having 100% smoke free environments
- Support the training of enforcement for smoke-free policies

Offering help to quit tobacco use

- Support the design and implementation of effective programmes/campaigns to encourage cessation
- Promote best practice population based interventions to assist smokers to quit
- Encourage and offer training for health professionals to provide clear, strong, personalized advice about the risks of tobacco use and the importance of quitting

Warning about the dangers of tobacco

- Advocate for best practice health warnings on tobacco packs
- Fund campaigns to warn of the health risks of tobacco smoking
- Support anti-smoking education programmes in schools
- Engage and inform the media in relation to developments in tobacco control

Enforcing bans on tobacco advertising, promotion and sponsorship

- Advocate for updates to legislation to take account of innovations in industry tactics as well as media technology
- Provide funds for compliance monitoring and enforcement training
- Make the provision of grants to organisations conditional upon them having complete bans on the sale, advertising and promotion of tobacco

products.

Raising taxes on tobacco

- Advocate for the raising of taxes periodically
- Demonstrate by example and positive results the benefits of allocating tobacco taxes to Foundations and tobacco control programmes