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Is trade policy being effectively used to curb drinking and smoking? Evidence from ASEAN

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Highlights

- ASEAN tariffs on alcohol and tobacco are above the world averages (38.2% vs world average of 8.8% on alcohol, and 36.9% vs world average of 12.0% on tobacco).
- Alcohol is part of the "General Exception List" of the ASEAN Free Trade Area, meaning it is excluded from duty free provisions, and there are calls to add tobacco to that list.
- In 2014, none of the ASEAN members had excise taxes higher than 75% of cigarette retail price (the minimum level recommended by WHO).
- At the same time, consumption of alcohol is 4.29 litres per capita, lower than the world average of 6.2 litres, and smoking prevalence is 22.8% of adult population, higher than the world average of approximately 15%.

The evidence is mixed, suggesting that while some countries indeed use trade policy for public health concerns, there are indications that in other cases it may potentially be a disguised protectionist policy.

Introduction

Among ASEAN members, alcohol and tobacco are estimated to contribute annually to nearly 350,000[1] and 500,000 deaths, respectively (SEATCA, 2015; WHO, 2014). As such, an important public health priority is discouraging consumption of alcohol and tobacco. Raising consumer prices is widely recognized to be the most effective public health policy. Price increases can be achieved through conventional excise taxes, as well as through trade policy through, for example, tariffs. However, trade policy under the guise of public health concerns may also be used to protect domestic producers from foreign competition. This commentary examines the prevailing trade policies in ASEAN and looks at its efficacy at reducing alcohol and tobacco consumption. The findings are mixed, suggesting that both public health concerns and protection of local industries are evident.

[1] ESCAP calculations based on the World Health Organization statistics.

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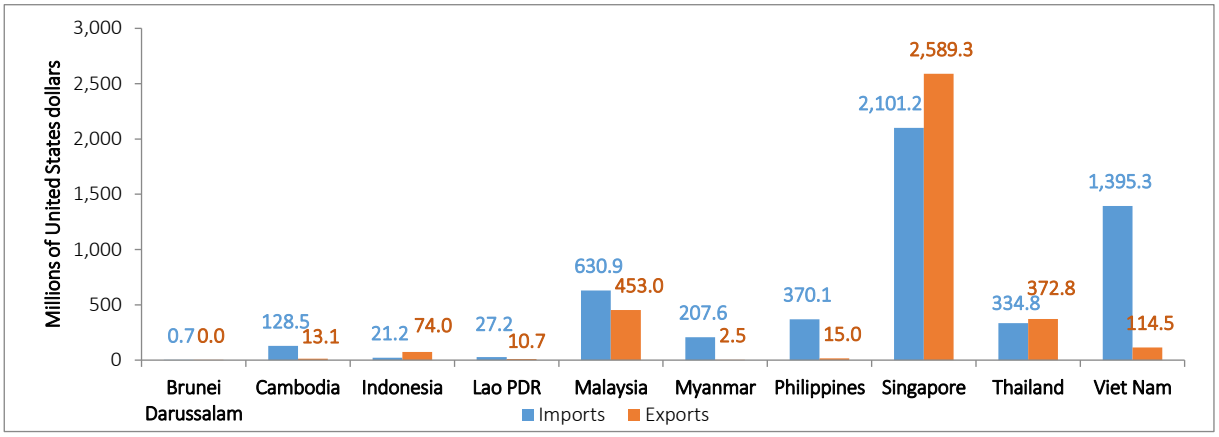
Trade in tobacco and alcohol in ASEAN

In 2016, imports of alcoholic beverages of ASEAN members reached $5,217 million (6.0% of world imports) while exports attained $3,644 million (4.3% of world exports).[2] As shown in figure 1, Singapore was by far the biggest importer and exporter of alcohol in ASEAN. Viet Nam, Malaysia and Thailand were also major importers and/or exporters in the region. These four countries represented 85.5% of ASEAN imports of alcohol and 96.9% of exports.

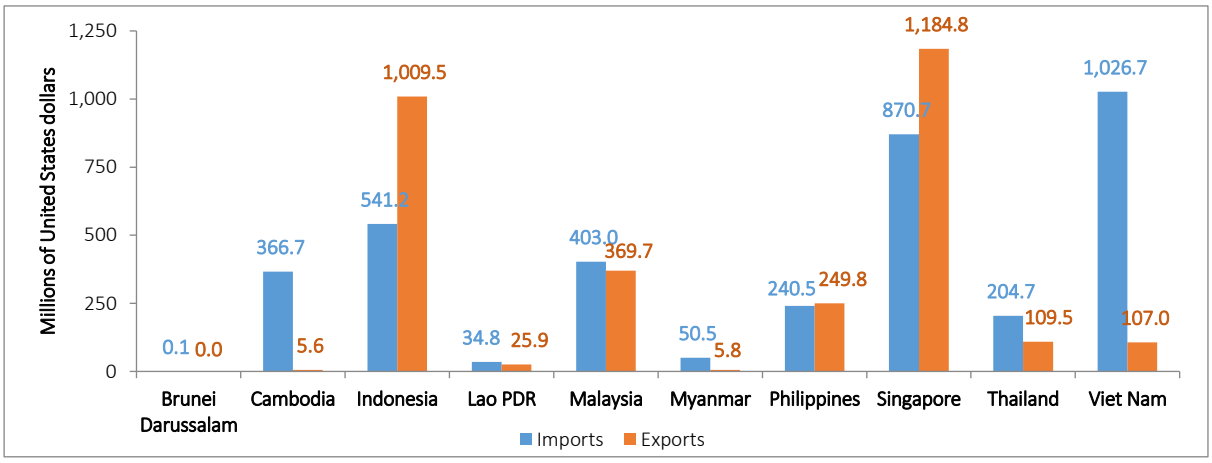
Figure 1: Imports and exports of alcoholic beverages in ASEAN in 2016



Sources: UN COMTRADE & ITC. Data used for Cambodia, Lao PDR, Myanmar and Vietnam are mirror data.

At the same time, imports of tobacco and manufactured tobacco substitutes of ASEAN countries amounted $3,739 million (8.6% of world imports) while exports totalled $3,067 million (7.4% of world exports). Here too, Singapore was the biggest exporter (figure 2). Given the fact that Singapore does not dedicate any land area to tobacco crops, it means that these exports are manufactured tobacco deriving from foreign tobacco leaves, and some of its imports are re-exported. The other key economies of ASEAN, namely Indonesia, Malaysia and Vietnam are also important players. Overall, alcoholic beverages and tobacco represented 0.8% of ASEAN total imports (0.47% and 0.33%, respectively) and 0.56% of ASEAN total exports (0.3% and 0.26%, respectively) in 2016.

Figure 2: Imports and exports of tobacco in ASEAN in 2016



Sources: UN COMTRADE & ITC. Data used for Cambodia, Lao PDR, Myanmar and Vietnam are mirror data.

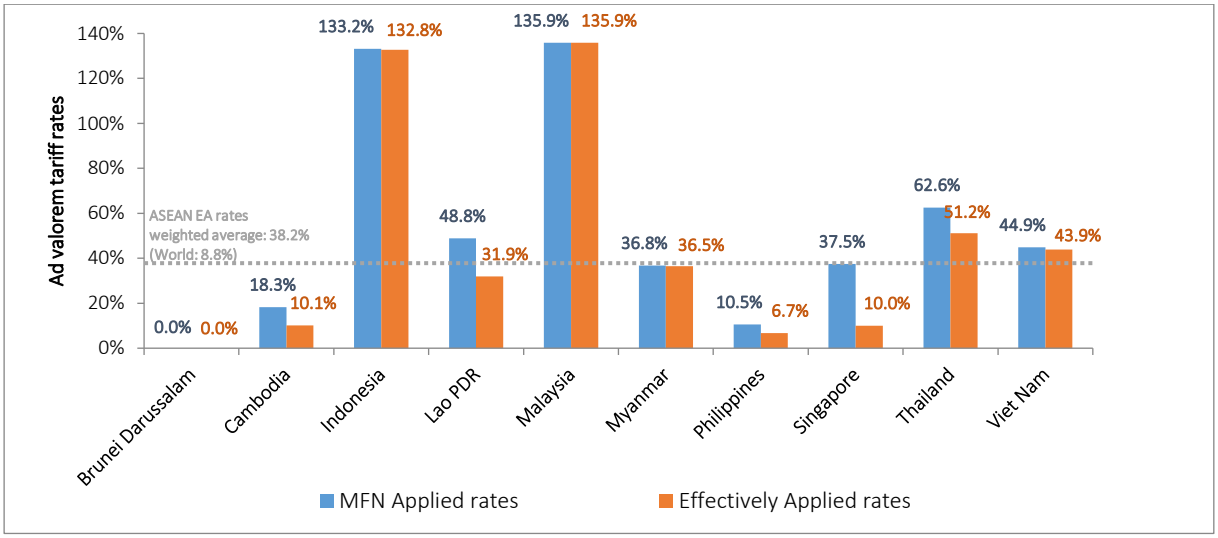
[2] For comparison, ASEAN's total share of world exports and imports in 2016 was 7.3% and 6.9%, respectively.

Alcohol and tobacco trade policies in ASEAN

Similar to other countries, ASEAN members use a combination of trade policy measures and other domestic policies to regulate consumption of alcohol and tobacco, mostly driven by public health concerns. Despite several statements recalling that "reduction of tobacco consumption and harmful use of alcohol" is a health priority in ASEAN, there is no common and concrete policy in this area.

Looking at trade policy specifically, as shown in figure 3, tariff rates applied to alcohol products in most recent years by ASEAN members vary considerably, but Indonesia and Malaysia lead with tariff rates of 132.8% and 135.9%, respectively. Indeed, MFN (most favoured nation) and effectively applied tariffs rates (weighted averages) on alcohol in these two countries are far higher than in other ASEAN members: 0.0% in Brunei Darussalam, 6.7% in Philippines, 10.0% in Singapore, 10.1% in Cambodia, 31.9% in Lao PDR, 36.5% in Myanmar, 43.9% in Viet Nam, 51.2% in Thailand. Driven largely by Malaysia and Indonesia, ASEAN effectively applied average rate on alcohol is also significantly higher than the global average (38.2% in ASEAN vs 8.8% worldwide).

Figure 3: Tariff rates and imports per capita of alcoholic beverages in ASEAN

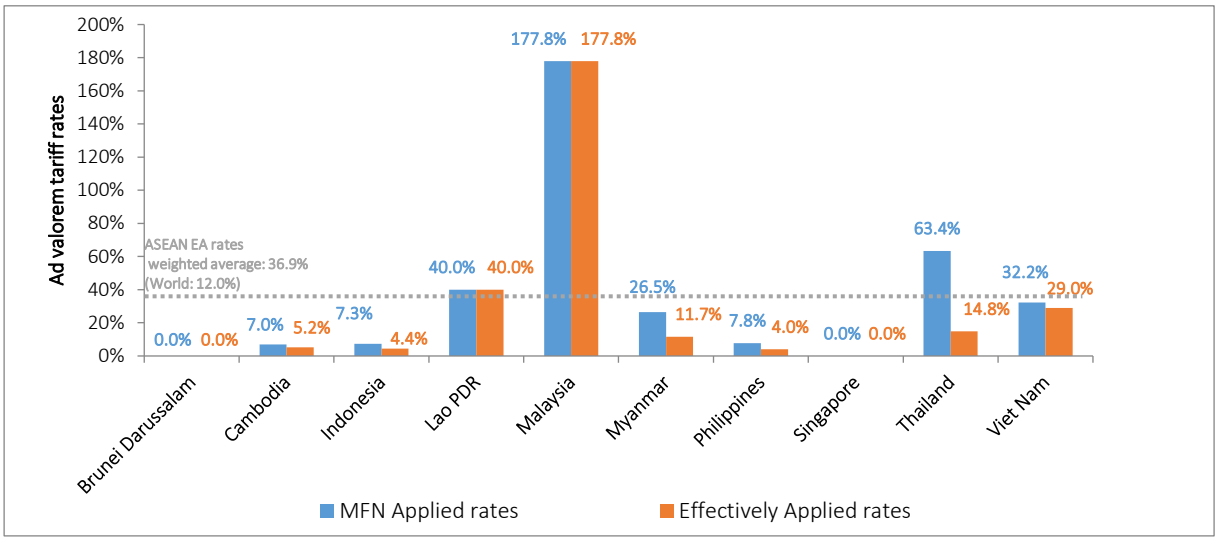


Sources: WITS. Year chosen is the last available year: 2013 for Indonesia, Malaysia and Philippines, 2014 for Brunei Darussalam and Viet Nam, 2015 for Cambodia, Lao PDR, Myanmar, Singapore and Thailand.

Furthermore, Malaysian and Indonesia MFN applied rates are very close to the effectively applied rates. This is because these two countries almost always exclude alcoholic beverages from liberalization under the trade agreements that they sign (bilaterally or in the framework of ASEAN negotiations). Disparities among the tariff rates applied by countries exist in ASEAN because alcoholic beverages are part of a "General Exception List" which holds products permanently excluded from the Free Trade Area duty free provisions. According to Indonesian former Trade Minister Thomas Lembong, who supported this exception, the objective is to "protect Indonesian culture and moral values from the negative impact of alcoholic beverages". Protection of public health and related concerns (cirrhosis, violence, drunk driving, etc.) are also put forward as reasons for the restrictive trade policy.

Looking at the trade policy on tobacco and manufactured tobacco substitutes in ASEAN countries, similar variability of tariff rates is observed (figure 4, the most recent available year). Indeed, Malaysia's tariffs stand out: its effectively applied tariff rate (weighted average) is 177.8% while other countries' rates are much lower, ranging from 0.0% in Brunei Darussalam and Singapore, 4.0% in Philippines, 4.4% in Indonesia, 5.2% in Cambodia, 11.7% in Myanmar, 14.8% in Thailand, to 29.0% in Viet Nam and 40.0% in Lao PDR. Similarly to the case of alcoholic beverages, ASEAN average rate is considerably higher than the world average (36.9% in ASEAN, 12.0% worldwide).

Figure 4: Tariff rates and imports per capita of tobacco in ASEAN



Sources: WITS. Year chosen is the last available year: 2013 for Indonesia, Malaysia and Philippines, 2014 for Brunei Darussalam, 2015 for Cambodia, Lao PDR, Myanmar, Singapore, Thailand and Viet Nam.

Contrary to alcohol, tobacco and manufactured tobacco substitutes are not part of a "General Exception List". However, South East Asia Tobacco Control Alliance (SEATCA) – an organisation established to support ASEAN countries in developing and putting in place tobacco control policies – called to exclude tobacco products from free trade agreements.[3] Tobacco is a major preventable cause of death among the populations of ASEAN member States (Barraclough & Morrow, 2010). Several studies have also proved that the liberalisation of tobacco trade represents an important threat to tobacco control policies, especially in low and middle-income countries (Chaloupka & Nair, 2000; Callard, Chitanondh & Weissman, 2001; Shaffer, Brenner & Houston, 2005).

The analysis of trade peaks provides further evidence on the restrictiveness of trade policy when it comes to these two sectors (table 1). There are two types of tariffs peaks: international peaks which refer to duties over 15%, and domestic peaks signalling duties over three times the average of domestic tariff structure.

Table 1: Tariff peaks in ASEAN

		Brunei Darussalam	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philippines	Singapore	Thailand	Viet Nam
Alcoholic beverages	Domestic Peaks (EA rates)	0	0	500	30	707	140	0	210	748	447
	International Peaks (EA rates)	0	293	500	122	707	140	0	210	748	460
Tobacco & substitutes	Domestic Peaks (EA rates)	0	0	90	19	293	1	0	0	175	40
	International Peaks (EA rates)	0	2	90	19	319	6	0	0	175	198

Source: WITS. Year chosen is the last available year: 2013 for Indonesia, Malaysia and Philippines, 2014 for Brunei Darussalam, 2015 for Cambodia, Lao PDR, Myanmar, Singapore, Thailand and Viet Nam.
Note: There are two types of tariff peaks: international peaks when duties are over 15% and national peaks when duties are over three times the average of the tariff structure. They are both signs of protecting trade policy.

Regarding alcoholic beverages, Thailand has the highest number of peaks (748 domestic and 748 international), followed by Malaysia (707 and 707) and Indonesia (500 and 500). Similarly, Malaysia has the highest number of tariff peaks for tobacco (293 domestic and 319 international) followed by Thailand (175 and 175) and Viet Nam (40 and 198).

[3] Sarntisart, I. (2006). Asean Regional Summary Report: AFTA and Tobacco. *Southeast Asia Tobacco Control Alliance (SEATCA)*

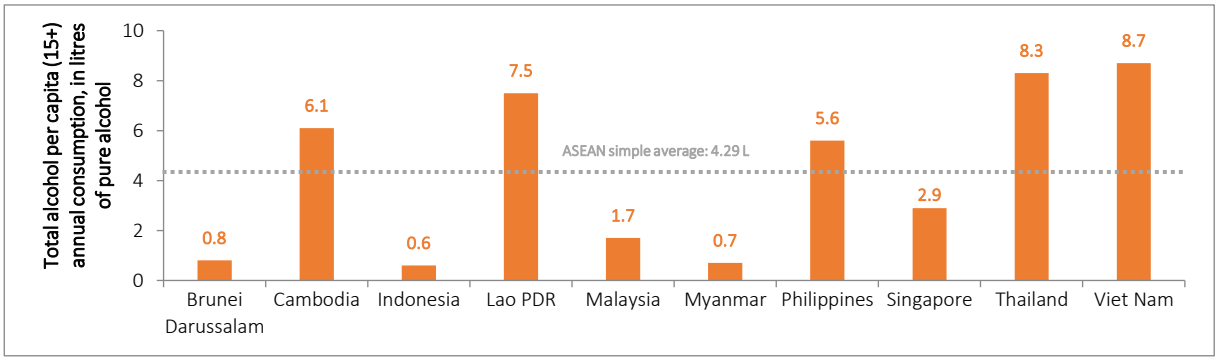
There are other trade instruments applied on alcohol and tobacco in ASEAN. For example, Viet Nam imposes quotas for some tobacco products. The Government of Malaysia requires retailers to obtain a license to sell and serve alcohol. Brunei Darussalam bans personal imports of alcohol for Muslims. Furthermore, Brunei Darussalam and Singapore do not provide duty-free allowances for tobacco for international travellers (SEATCA, 2015). ASEAN member States also apply sanitary and phytosanitary measures, technical barriers to trade, pre-shipment inspections, contingent trade protective measures or price controls.[4]

Therefore, it appears that Malaysia restricts imports of alcoholic beverages and tobacco, while Indonesia limits imports of alcoholic beverages much more than other ASEAN countries do. Also, although Brunei Darussalam appears to be open for imports of foreign alcohol and tobacco (average tariffs are at zero with no tariff peaks), the sale of alcohol and its public consumption is prohibited by law.

Consumption of alcohol and tobacco among ASEAN member States

The study of alcohol consumption in ASEAN countries (figure 5) demonstrates that countries can be classified in two groups: one comprising countries with a low alcohol consumption per capita (from 0.6 to 2.9 litres per year) – Indonesia, Myanmar, Brunei Darussalam, Malaysia, Singapore – and a second one bringing together countries with a consumption per capita higher than 5.6 litres – the Philippines, Cambodia, the Lao PDR, Thailand, Viet Nam.

Figure 5: Alcohol per capita consumption in ASEAN (2015, projection)



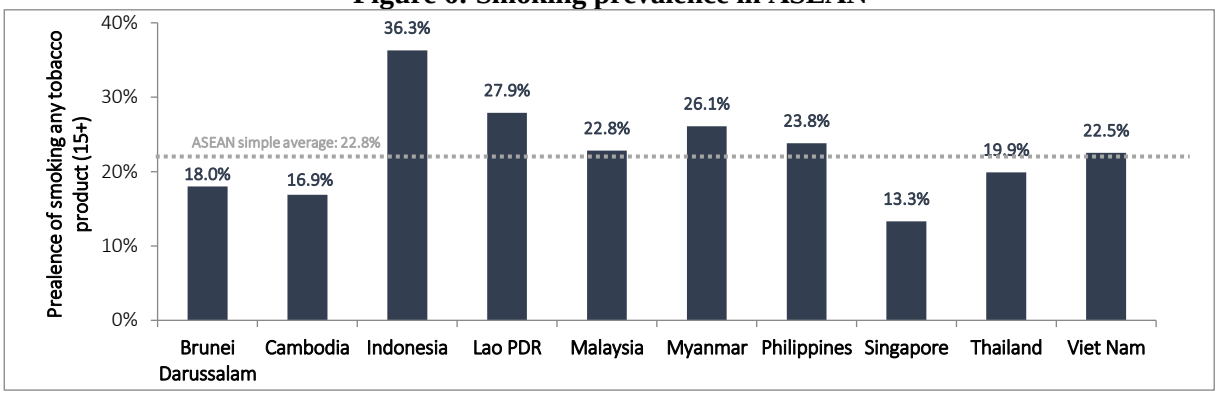
Source: Global status report on alcohol and health 2014, WHO

Smoking prevalence in ASEAN (the last available years are used) appears to be more homogeneous (figure 6), averaging to 22.8% across the countries. In comparison, the global average is approximately 15% (WHO, 2015). Rates range from 13.3% (Singapore) to 36.3% (Indonesia). As the biggest tobacco consumer in the region, Indonesia has also one of the highest rates of children smoking in the world (22.3%).[5] In addition, men have significantly higher smoking rates than women in ASEAN (for example, 2.1% for females, in comparison to 64.9% for males in Indonesia).

[4] More information is available on TRAINS, the global database on Non-Tariff Measures, http://i-tip.unctad.org/

[5] In Indonesia, 41% of boys (13-15) and 3.5% of girls (13-15) are using tobacco daily (WHO report on the global tobacco epidemic 2013)

Figure 6: Smoking prevalence in ASEAN



Source: ASEAN Tobacco Tax Report Card, SEATCA (November 2016), latest available years: 2013 for Indonesia and Singapore, 2014 for Brunei Darussalam, Cambodia and Myanmar, 2015 for Lao PDR, Philippines, Thailand and Viet Nam.

Effect of trade policy on consumption of alcohol and tobacco in ASEAN

While there are many other factors and policies influencing the consumption of alcohol and tobacco, this commentary aims to observe whether there is an association between stringency of trade policy and achievement of public health goals.

It has been shown that tariff rates on alcohol and tobacco across ASEAN countries differ significantly, with Indonesia and Malaysia having more restrictive policies than other countries. Higher tariffs and no tax exemptions should result in higher retail prices of these items sufficiently to discourage consumption, despite a notoriously low price elasticity of demand when it comes to items linked to addicted behaviour (Hu & Mao, 2002; Tian & Liu, 2011; Chaloupka, Yurekli & Fong, 2012).

Alcohol seems to be a good example. In Indonesia and in Malaysia (two countries who implemented high tariffs on alcoholic beverages), alcohol consumption was among the lowest in the region in 2015 according to WHO estimates (figure 3). Even though it is difficult to claim that there is a causal relationship, it is likely that high tariff rates on alcohol are an incentive to limit alcohol consumption. Conversely, Cambodia, the Lao PDR, the Philippines and Viet Nam, the four countries which have the highest prevalence of alcohol dependence rates among ASEAN members have lower tariffs on alcoholic beverages.

When it comes to tobacco consumption, the relationship between its consumption and applied trade policies is less clear. Whereas tariffs in Malaysia on tobacco and manufactured tobacco substitutes are by far the highest in ASEAN, the Malaysian rate of smoking prevalence is equal to the average rate in ASEAN on a whole (22.8%).[6] In contrast, Cambodian and Thai smoking prevalence are some of the lowest in ASEAN (16.9% and 19.9%), while their effectively applied tariffs on tobacco are, respectively, 34 and 12 times smaller than the Malaysian tariff.

This unclear relation between tariff policy and consumption can be explained by the fact that tobacco consumption (but alcohol consumption as well) depends significantly on additional factors: sociodemographic determinants, national production, culture, prevention and others taxes. For example, public spaces (healthcare and government facilities, universities, offices, restaurants, pubs, bars, public transport) are not smoke-free in Malaysia, while they are in Cambodia and Thailand. Moreover, pictorial health warnings (PHWs) only cover 50% of the front of cigarette packages in Malaysia while they cover 85% of them in Thailand (table 2).

[6] 22.8% is a simple average; weighted average rate of the ASEAN on a whole is 28.2%. Simple average has been chosen because of the role of Indonesia, the biggest tobacco consumer and the most populated country in ASEAN.

Excise taxes are arguably a more significant determinant of prices. The Philippines, for instance increased taxes on cigarettes more than fourfold in 2012. Consequently, between 2010 and 2015, smoking prevalence (male adults) fell from 47.6% to 43.0%.[7] However, in 2014 there was not any country in ASEAN that was applying an excise tax higher than 75% of cigarette retail price (the minimum level recommended by WHO).[8]

Table 2: Taxes on cigarettes, pictorial health warnings and smoke-free places in ASEAN in 2014

	Brunei Darussalam	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philippines	Singapore	Thailand	Viet Nam
Tax rates (% of price of the most sold brand of cigarettes)	61.7	22.2	53.4	17.3	55.4	50	74.3	66.2	73.1	41.6
Smokefree places										
Health-care facilitie	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Government facilities	Yes	Yes	No	No	No	Yes	Yes	No	Yes	Yes
Education facilities	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Universities	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Indoor offices	Yes	Yes	No	No	No	Yes	No	No	Yes	Yes
Restaurants	Yes	No	No	No	No	Yes	No	Yes	Yes	Yes
Pubs and bars	Yes	Yes	No	No	No	No	No	Smoking rooms	Yes	No
Public transport	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No
Pictorial health warnings, front of cigarette packages	75%	30%	40%	30%	50%	Not specified	50%	50%	85%	50%

Source: WHO

Tariffs for public health reasons – protectionism in disguise?

Tariffs on tobacco and alcohol imports can be an important determinant of alcohol and tobacco consumption rates among ASEAN member States because they create pecuniary disincentives to alter consumers' behaviour. However, imposing high tariffs on imports is also a biased policy lever because they create distortions with respect to relative prices of foreign versus domestic goods and may cause a substitution from consumption of foreign to consumption of domestically produced alcohol and tobacco.

Although comparison of statistics of the volumes of imports and tariff rates over the last decade shows that trade policy had only a marginal effect on consumption of foreign produced alcohol and tobacco in Indonesia and Malaysia,[9] sceptics may see the use of trade policy as just another deterrent of entry of foreign competition rather that a legitimate instrument to defend public policy goals. As an example, table 3 shows the land area dedicated to tobacco crops and compares it to effectively applied tariff rates on tobacco in ASEAN. Considering that every ASEAN member State is producing tobacco (except Brunei Darussalam and Singapore), and that in Thailand and Viet Nam, the Governments have full or partial control of tobacco manufacturing and distribution, it is conceivable that some countries may use tariffs as a means to protect their local tobacco industry.

Lao PDR – which applies the second highest tariff rates on tobacco in ASEAN (40.0%) – has the highest amount of land to tobacco crop per capita (9.2 m^2) and implemented the lowest tax rate on cigarettes in the region (17.3%, ASEAN simple average is 51.5%). This suggests that the Government is much more open to local than foreign tobacco, a policy which may be difficult to juxtapose in terms of protection of public health.

[7] *Source:* Global Health Observatory data repository (WHO)

[8] *Source:* World Health Organization

[9] Comparison between effectively applied tariff rates and imports of tobacco in Malaysia from 2003 to 2013, comparison between effectively applied tariff rates and imports of alcohol in Indonesia and Malaysia from 2003 to 2013

In contrast, Malaysia – which applies the highest tariff rates on tobacco in the region – is only dedicating 0.15m^2 per capita of land to tobacco crop (ASEAN simple average: 5.42m^2), which means that even if the country is clearly limiting imports of foreign tobacco, it is likely aimed at constraining smoking prevalence which is, as mentioned previoulsy, relatively high (22.8% of the population, equal to the average rate of the ASEAN on a whole).

Table 3: Harvested area of unmanufactured tobacco and tariff rates in ASEAN

	Brunei Darussalam	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philippines	Singapore	Thailand	Viet Nam
Area harvested (ha)	0	8404	209400	6250	435	28000	36082	0	24665	23215
Area harvested per capita (m2)	0.00	5.39	8.33	9.19	0.15	5.19	3.70	0.00	3.63	2.53
Effectively Applied rate	0.0%	5.2%	4.4%	40.0%	177.8%	11.7%	4.0%	0.0%	14.8%	29.0%

Sources: FAO for area harvested values. WITS for tariff rates. World Bank for population values. Years chosen are 2014 for area harvested and population and the last available years for tariff rates: 2013 for Indonesia, Malaysia and Philippines, 2014 for Brunei Darussalam, 2015 for Cambodia, Lao PDR, Myanmar, Singapore, Thailand and Viet Nam.

In the case of alcohol, even though Indonesia is applying one of the highest tariff rates in ASEAN, it does not seem that it is trying to protect its local beer industry. In fact, Indonesian production of beer per capita was comparatively low (1.14 tonne, the second lowest one – see table 4 below). Similarly, Cambodia – which is the second biggest producer of beer per capita in the region while applying a relative low tariff rate on it – is probably not protecting its local production either.

However, this may not be the case in Singapore and Thailand. These two countries are, respectively, the first and the third largest producers of beer per capita in ASEAN, while applying relatively high tariffs on imported beers (120.2% and 33.9%, respectively). These create distortions and may provide a disincentive to buy foreign beers. The fact that Singapore and Thailand are important beer producers suggests that the protection of local producers is probably surpassing public health objectives, at least to a certain extent.

Table 4: Production of beer and tariff rates in ASEAN

	Brunei Darussalam	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philippines	Singapore	Thailand	Viet Nam
Production (tonnes)	0	480000	280000	47720	295000	Not specified	1033000	120000	2237880	1308000
Production per capita (kg)	0.00	30.81	1.11	7.02	5.47	Not specified	10.59	21.66	32.93	14.26
Effectively Applied rate	0.0%	11.0%	129.4%	40.0%	147.6%	30.0%	1.2%	120.2%	33.9%	32.1%

Sources: FAO for production of beer. WITS for tariff rates. World Bank for population values. Years chosen are 2014 for production and population and the last available years for tariff rates: 2013 for Indonesia, Malaysia and Philippines, 2014 for Brunei Darussalam, 2015 for Cambodia, Lao PDR, Myanmar, Singapore, Thailand and Viet Nam.

Conclusion

Trade policy alone for public health reasons is arguably a rather blunt tool for the stated objective. Analysis presented in this commentary needs to be qualified since it has not rigorously estimated the effect of trade policy on tobacco and alcohol consumption. However, at least in some cases, there is evidence that restrictive trade policies targeting these commodities shelter domestic producers, which is against the spirit and objective of public health. A concerted public health policy approach that includes a wide range of policies, such as education and excise taxes that keep up with economic development, complimented with trade policy, may be a better alternative. A restrictive trade regime should be consistent with the equal treatment of domestic and imported goods and not create distortions. Perhaps countries that restrict imports for public health reasons may also consider examining their export patterns for the same reasons. Future research can examine this aspect rigorously at length.

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