

Health Taxation for the Prevention of Noncommunicable Diseases: Evidence, Design and Policy Priorities

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Received: Mar. 13, 2026; Revised: Apr. 11, 2026; Accepted: May. 04, 2026; Published: June. 30, 2026

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Abstract: Background: Tobacco, alcohol and sugar-sweetened beverages contribute substantially to preventable disease, premature mortality, household expenditure and health-system costs. Health taxes—excise taxes designed to increase the price and reduce the affordability of products that harm health—are among the most cost-effective population-level interventions. Their potential application is expanding to include high-sugar foods, ultra-processed products and environmentally harmful commodities. **Objective:** This narrative review critically examines the rationale, evidence, design and distributional implications of health taxation, with particular emphasis on sugar-sweetened beverage taxes and the Indian policy context. **Key findings:** Tobacco taxation has the strongest and longest-established evidence base, particularly when tax increases are large, recurrent and applied uniformly across products. Alcohol taxes reduce consumption and alcohol-related harms, but effectiveness is weakened by inflation, product substitution, unrecorded alcohol and tax systems based on beverage price rather than ethanol content. Implemented sugar-sweetened beverage taxes consistently increase retail prices and reduce purchases, while tiered sugar-content taxes can stimulate product reformulation. Evidence of effects on obesity and diabetes is emerging but remains less mature because these outcomes require longer follow-up and are influenced by the wider diet. Health taxes are sometimes described as financially regressive because lower-income households spend a larger share of income on consumption taxes. This interpretation is incomplete: lower-income groups are generally more price-responsive and bear a disproportionate burden of tobacco-, alcohol- and diet-related disease, making the overall health and financial-protection effects potentially progressive. India increased GST on specified sweetened and flavoured beverages to 40% in September 2025, but its broader health-tax system remains fragmented across products and jurisdictions. **Conclusion:** Well-designed health taxation should use product-specific excises, protect against inflation and income growth, minimize substitution, cover emerging products and be supported by administration, surveillance and conflict-of-interest safeguards. Revenue use should be transparent and preferably reinforce universal health coverage, nutrition, cessation and social-protection programmes.

Keywords: Health taxes; sugar-sweetened beverages; tobacco taxation; alcohol taxation; noncommunicable diseases; India

INTRODUCTION

Noncommunicable diseases are shaped not only by individual behaviour but also by the price, availability, marketing and commercial production of health-harming commodities. Tobacco, alcohol and sugar-sweetened beverages are inexpensive to manufacture, heavily promoted and associated with costs that are not fully reflected in their market prices. These costs include health-care expenditure, disability, premature mortality, lost productivity, road injury, violence, second-hand smoke exposure and harms to family members.

Health taxes are levies placed on products that adversely affect population health. The term most commonly refers to excise taxes on tobacco, alcoholic beverages and sugar-sweetened beverages (SSBs).

Unlike general sales taxes, which apply broadly across goods and primarily raise revenue, health taxes are designed to increase the price and reduce the affordability of specific harmful products. Excises can be applied per unit of product, per quantity of a harmful ingredient, or as a percentage of price.

The World Health Organization (WHO) describes health taxes as “win-win-win” policies because they can reduce consumption, prevent disease and mobilize public revenue.[1] In 2025, WHO launched the “3 by 35” initiative, encouraging countries to use taxation to increase the real prices of tobacco, alcohol and sugary drinks by at least 50% by 2035.[2] The initiative reflects a renewed interest in domestic revenue mobilization at a time when noncommunicable disease burdens, health-system costs and public debt are increasing.

Yet the simple statement that taxation improves health conceals difficult policy choices. A nominal tax may be too small to influence purchasing, may decline in real value with inflation or may apply only to a narrow product category. Consumers can switch to cheaper brands, untaxed products, informal alcohol or different forms of tobacco. Producers may reformulate products beneficially, absorb part of the tax, reduce package sizes or intensify marketing. A credible assessment must therefore examine tax structure, administration, behavioural response, equity and the wider regulatory environment.

Economic and Public Health Rationale

Health taxes are justified by both externalities and internalities. Externalities are costs imposed on others, such as second-hand smoke, alcohol-related violence, road injuries and publicly financed medical care. Internalities arise when people underestimate or do not fully account for harms to their future selves because of addiction, limited information, aggressive marketing, present bias or decisions initiated during childhood and adolescence.

Price influences consumption through several pathways. Some people do not initiate use, some delay initiation, current users reduce consumption, and others stop. Young people and lower-income consumers are generally more sensitive to price because they have less disposable income. For addictive products, price effects may be smaller in the short term but increase over time as initiation declines and cessation accumulates.

The relevant objective is reduced affordability rather than a one-time nominal price rise. If tax rates remain fixed while incomes and inflation increase, harmful products become more affordable despite apparently high taxation. Specific excise rates therefore need automatic or regular adjustment for inflation and income growth.

Taxes also signal that a product creates societal harm. However, taxation should not be framed as punishment of consumers, many of whom are affected by addiction, stressful living conditions and commercial targeting. Fiscal policy should operate alongside cessation services, treatment, product regulation and supportive environments.

Tobacco Taxation

Tobacco taxation has the strongest evidence base among health taxes. Cigarette prices influence initiation, consumption and cessation, and tax increases are particularly effective among young people and lower-income groups. WHO recommends that total taxes constitute at least 75% of the retail price of cigarettes. Nevertheless, only a minority of countries meet this benchmark, and the average tax share remains markedly lower in low-income than in high-income countries.[3]

The design of tobacco taxes is crucial. A uniform specific excise—levied per cigarette, pack or defined quantity—raises the price of inexpensive and premium brands by the same absolute amount and reduces the opportunity to “trade down” to cheaper products. Ad valorem taxes, calculated as a percentage of price, automatically capture price increases but can widen price gaps and allow low-priced brands to remain affordable. Many countries use a mixed system.

Complex tiered structures based on cigarette length, filter type, price or production scale can encourage manufacturers to modify products to qualify for lower rates. Taxes should cover bidis, smokeless tobacco, water-pipe tobacco, heated products and nicotine products where relevant. Large differentials between product categories encourage substitution rather than cessation.

Industry claims that higher taxes inevitably cause illicit trade are overstated. Illicit markets are influenced by governance, corruption, enforcement, supply-chain security and proximity to low-tax jurisdictions, not tax rates alone. Track-and-trace systems, licensing, tax stamps, enforcement against organized smuggling and international cooperation are required. Excessive focus on small-scale consumers can distract from large commercial supply chains.

Health gains from tobacco taxation often exceed the immediate burden of higher prices. Lower-income households experience a disproportionate burden of tobacco-related disease and are more responsive to price changes. When consumption falls, households may redirect expenditure towards food, housing and education and avoid catastrophic treatment costs. The long-term distributional impact is therefore frequently progressive even when the tax payment itself appears regressive.

Alcohol Taxation and Pricing

Alcohol differs from tobacco because patterns, beverage types and contexts of use are highly variable. Alcohol contributes to liver disease, cancers, cardiovascular conditions, mental illness, dependence, injuries, violence and fetal harm. Costs are imposed not only on drinkers but on families, road users and communities.

Alcohol excise taxes reduce consumption and alcohol-related harm, especially when they generate substantial increases in the price of inexpensive alcohol. Tax systems based on litres of beverage rather than the quantity of ethanol may tax products inconsistently. A litre of strong spirits contains substantially more alcohol than a litre of beer; taxation should therefore reflect pure alcohol content and, where feasible, rise progressively with strength.[4]

Ad valorem taxes can leave inexpensive high-strength products relatively affordable. Volumetric excises—charged per gram or litre of pure alcohol—more closely target the harmful ingredient. Minimum unit pricing is a related but distinct policy: it establishes a floor price per unit of alcohol. Unlike tax revenue, the additional margin from minimum pricing may remain with producers or retailers unless combined with taxation. Minimum pricing can target very cheap products favoured by heavy consumers, while excise taxation generates government revenue and affects the wider market.

Alcohol taxes must be adjusted for inflation and income. WHO's 2025 assessment found that alcoholic beverages had become increasingly affordable in many countries because taxes had not kept pace with economic change.[4] Exemptions for wine or traditional beverages weaken health objectives and may reflect political influence rather than differences in health risk.

Unrecorded and informally produced alcohol presents a genuine challenge. Very high price differentials can encourage substitution to illicit products where enforcement and consumer protection are weak. The appropriate response is not to abandon taxation, but to combine it with licensing, quality control, measures against industrial-scale illicit production and affordable treatment for alcohol-use disorders.

India presents a particularly complex alcohol-tax environment. Alcohol for human consumption lies outside the national GST framework and is taxed primarily by states through excise duties, licence fees and related charges. Rates and systems vary substantially, creating differences in affordability and incentives for cross-border purchasing. Public-health objectives may compete with states' dependence on alcohol revenue. A national technical framework based on ethanol content, affordability and health impact could improve consistency while respecting constitutional responsibilities.

Sugar-Sweetened Beverage Taxes

SSBs include carbonated soft drinks, energy drinks, sports drinks, sweetened waters, fruit-flavoured beverages and other drinks containing added sugars. Some tax systems also include concentrates, syrups, sweetened milk beverages or non-sugar sweeteners; others exclude important categories.

SSBs are suitable taxation targets because they provide rapidly absorbed sugar with limited satiety and little nutritional benefit. Frequent consumption is associated with weight gain, type 2 diabetes, dental caries and cardiometabolic disease. Taxation can reduce intake directly and encourage manufacturers to lower sugar content.

A systematic review and meta-analysis of implemented SSB taxes found that taxes were associated with higher prices and lower sales of taxed beverages. On average, the taxes were largely passed through to retail prices, and purchases declined in the expected direction.[5] A later evaluation across five large US cities similarly found substantial and sustained reductions in purchases following tax-related price increases.[6] These studies provide strong evidence for effects on price and purchasing, though evidence for body weight, diabetes and cardiovascular outcomes is less developed.

The absence of immediate measurable changes in obesity should not be interpreted as policy failure. Obesity is influenced by the entire diet, physical activity, sleep, medication and socioeconomic conditions. SSB taxes generally remove only a fraction of daily energy intake, and health effects accumulate over years. Population taxes should be evaluated through intermediate outcomes—price, purchases, sugar sold and reformulation—as well as long-term disease trends.

Tax design

SSB taxes can be ad valorem, volume-based or sugar-content-based. A flat tax per litre is simple and raises the price of all taxed beverages, but it treats drinks containing 5 g and 12 g of sugar per 100 mL identically. A sugar-content tax more closely aligns liability with potential harm and gives producers an incentive to reformulate.

Tiered systems impose higher rates above specified sugar thresholds. The United Kingdom's Soft Drinks Industry Levy demonstrated that a tax announced in advance can stimulate reformulation before implementation. However, threshold-based systems may encourage products to cluster just below the cut-off rather than progressively reduce sugar. A continuous tax per gram of added sugar offers a more direct incentive but may be administratively demanding.

Tax bases should be broad enough to minimize substitution. Exempting sweetened juices, powders, syrups or milk-based drinks can shift consumption rather than reduce sugar intake. At the same time, definitions must distinguish products such as unsweetened milk or oral rehydration solutions with legitimate nutritional or clinical roles.

WHO reported that SSB tax adoption had expanded globally, but many taxes remained too low or narrowly designed to produce major health effects.[7] A frequently used benchmark is a tax expected to increase retail prices by at least 20%, although effectiveness depends on baseline prices, pass-through and consumer responsiveness.

Substitution and reformulation

Consumers may switch from taxed SSBs to water, unsweetened drinks or lower-sugar products, which is beneficial. Substitution to untaxed sugary products, confectionery or large quantities of artificially sweetened beverages may reduce expected gains. Tax evaluation should therefore examine the total diet rather than taxed sales alone.

Reformulation is one of the most important advantages of ingredient-based taxation. A small reduction in sugar across products consumed by millions can produce large population benefits without requiring active individual decision-making. Yet manufacturers may replace sugar with non-sugar sweeteners, whose long-term population effects remain debated. Taxes should form part of a broader nutrition policy including front-of-pack labelling, marketing restrictions, school-food standards and access to safe drinking water.

Beyond the Traditional “Big Three”

Health-tax proposals increasingly include products high in salt, saturated fat or added sugar; ultra-processed foods; cannabis products; gambling; fossil fuels; and pollutants. The logic is strongest where a clearly measurable product or harmful ingredient is causally related to disease and where consumers and producers can respond to price.

Taxes on foods high in sugar, salt or saturated fat are more difficult to design than beverage taxes because foods contain multiple nutrients, serve different dietary functions and may be essential sources of energy for low-income populations. Broad taxes based only on an “ultra-processed” classification may cover heterogeneous products and create administrative disputes.

Nutrient-profile models can identify products exceeding defined thresholds, but industry reformulation may manipulate one nutrient while leaving overall quality poor. Food taxes should therefore be tested carefully, paired with subsidies or social support for fruits, vegetables, pulses and other nutritious foods, and monitored for unintended effects on food security.

Environmental taxes also have health effects. Carbon pricing, fossil-fuel taxation and congestion charges can reduce air pollution, injuries and climate-related disease. They are not traditionally described as health taxes, but they demonstrate that fiscal policy can generate substantial health co-benefits.

Equity: Are Health Taxes Regressive?

The criticism that health taxes are regressive usually refers to the proportion of household income spent on the tax. If consumption did not change, poorer households would bear a greater relative financial burden. This static calculation ignores behavioural and health effects.

Lower-income consumers are commonly more price-responsive. They are therefore more likely to reduce consumption and receive larger health gains. Because tobacco-, alcohol- and diet-related diseases disproportionately affect disadvantaged groups, reduced consumption can prevent medical expenditure, income loss and premature death. World Bank distributional analyses indicate that when health and financial-protection effects are included, health taxes can be progressive over the longer term.[8]

Table 1. Major Health Taxes: Design, Evidence and Implementation Priorities

Product or tax domain	Preferred tax base	Principal expected effects	Evidence and limitations	Key design and implementation priorities
Manufactured cigarettes	Uniform specific excise, supplemented where appropriate by ad valorem tax	Reduced initiation and consumption, increased cessation and higher revenue	Strong causal evidence; substitution and illicit trade can weaken effects	Reach or exceed 75% total tax share, narrow price gaps, index rates and strengthen track-and-trace systems
Bidis and smokeless tobacco	Tax per stick or standardized weight at rates comparable with cigarettes	Reduced use and prevention of switching to cheaper tobacco	Evidence supports price responsiveness, but informal production complicates collection	Tax all products consistently, license producers and simplify fragmented tiers
Electronic cigarettes and heated products	Specific tax based on liquid volume, nicotine content or standardized product unit	Prevent youth uptake and maintain price advantage of cessation over continued nicotine use	Long-term harm and substitution effects remain uncertain	Avoid very low rates that attract youth while preserving coherent cessation policy
Alcohol	Specific excise per quantity of pure ethanol, increasing with strength	Reduced consumption, heavy drinking, injury and chronic disease	Strong evidence for price effects; unrecorded alcohol and cross-border purchasing require monitoring	Adjust for inflation and income, cover all beverage types and combine with licensing and drink-driving measures
Sugar-sweetened beverages	Specific tax per litre or, preferably, per gram of added sugar	Higher prices, lower purchases and reformulation	Strong evidence for price and sales effects; long-term anthropometric evidence is emerging	Cover a broad range of beverages, ensure meaningful price increase, tax concentrates and provide safe water
Energy drinks	SSB tax with possible additional caffeine-related provisions	Reduced sugar and high-caffeine exposure among adolescents	Product-specific health evidence is less extensive	Include within SSB base and regulate marketing and school sales
High-sugar, high-salt or high-fat foods	Nutrient-threshold or nutrient-content tax	Reformulation and reduced consumption of targeted products	Modelling is favourable but real-world evidence is less mature than for SSBs	Use validated nutrient profiles and protect access to nutritious foods
Fossil fuels and carbon emissions	Carbon content, fuel quantity or pollution intensity	Reduced emissions, air pollution and climate-related health harms	Strong evidence for environmental effects; distribution depends on revenue use	Protect energy access for poor households and invest in clean transport and energy
Gambling and related digital products	Stakes, gross gaming revenue or product-risk classification	Reduced harmful participation and funding for prevention	Behavioural substitution and online markets complicate policy	Coordinate taxation with product regulation, age safeguards and treatment

Revenue allocation	General revenue or transparent earmarking for health and social purposes	Greater political support and potential equity gains	Earmarking may improve acceptability but can reduce budget flexibility	Publish revenue and expenditure, supplement rather than displace existing health budgets
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Equity nevertheless depends on design. A tax can harm low-income households if healthy alternatives are unavailable, addiction treatment is inaccessible or revenue replaces rather than expands social spending. Governments should ensure safe drinking water, cessation services, substance-use treatment and affordable nutritious foods.

Earmarking revenue for health, education or nutrition can increase public acceptability and reinforce equity, but formal earmarking is not always administratively desirable. At minimum, governments should transparently report revenue and demonstrate that health taxes are accompanied by meaningful investment in public services.

Commercial Determinants and Industry Responses

Health-tax debates involve powerful commercial actors. Common industry strategies include disputing causal evidence, emphasizing personal choice, predicting job losses, framing taxes as attacks on small businesses, funding favourable research and promoting voluntary measures.

Employment claims require examination across the entire economy. Money not spent on tobacco, alcohol or SSBs is generally spent on other goods and services, creating employment elsewhere. Local effects on specific producers or retailers may occur and should be anticipated, particularly where livelihoods depend on a single crop or industry. Transition support is preferable to allowing commercial dependence to block health policy.

Tax avoidance may include product redesign, reclassification, package downsizing, shifting profits, promotional discounts and lobbying for exemptions. Legislation must define products clearly and authorize regular adjustment. Government engagement with industry should be transparent and protected from conflicts of interest, particularly in tobacco control, where the WHO Framework Convention on Tobacco Control requires protection of policy from tobacco-industry interests.

Public Health Significance

Health taxation operates across an entire population and does not depend on repeated clinical contact. It can prevent initiation among adolescents, reduce exposure among current consumers and generate revenue immediately. In countries with limited capacity for long-term treatment of diabetes, cancer and cardiovascular disease, prevention through fiscal policy is especially important.

Taxation also changes markets. Unlike educational campaigns, which ask each individual to resist highly promoted products, taxes modify the economic environment in which choices occur. Ingredient-based taxes can influence manufacturers before products reach consumers.

Taxes are not sufficient alone. Tobacco taxation is strengthened by smoke-free laws, advertising bans, warnings and cessation support. Alcohol taxes require licensing, drink-driving enforcement and marketing controls. SSB taxes work best with nutrition labelling, school standards and availability of free water. Fiscal and regulatory interventions should be understood as complementary rather than competing strategies.

Indian Perspective

India faces a large burden of tobacco use, alcohol-related harm, diabetes, obesity and dental disease, while its fiscal arrangements differ across products. Tobacco taxation combines GST with central excise and other levies, and historically varies by product type. Lower-priced bidis and smokeless tobacco products can provide substitutes when cigarette prices rise. Simplifying tax structures and reducing differentials across tobacco products are therefore major priorities.

Alcohol is taxed by states and excluded from GST. This gives states regulatory flexibility but produces substantial variation in rates, retail systems and affordability. Revenue dependence may discourage public-health-oriented reform. A nationally agreed technical framework could encourage taxation according to ethanol content and regular affordability adjustment without displacing state authority.

India initially placed aerated drinks containing added sugar or flavouring in the highest GST slab with an additional compensation cess. In September 2025, the GST Council recommended a 40% GST rate for specified goods under tariff heading 2202 containing added sugar, sweetening matter or flavouring, effective from September 22, 2025.[9] This represented a substantial nominal tax but remained based primarily on product classification rather than grams of sugar.

The health effect will depend on which beverages are covered, actual pass-through to retail prices and substitution towards untaxed juices, powders, sweetened dairy drinks or inexpensive local products. A high percentage tax on price may also leave low-cost products affordable and provides less incentive for gradual sugar reduction than an ingredient-based levy.

India should consider converting beverage taxation into a tiered or continuous sugar-content excise applied across a comprehensive set of sweetened beverages. Such a reform could preserve revenue while creating incentives for reformulation. Exemptions should be limited and based on nutritional or medical justification, not lobbying power.

National and state governments should jointly monitor prices, sales, sugar content, household purchases and industry reformulation. Health-tax data should be linked with dietary, tobacco and alcohol surveillance. Revenue could reinforce primary prevention, safe drinking-water provision, tobacco cessation, treatment of substance-use disorders and nutrition programmes.

Recent Advances

The most important recent development is a shift from taxing product value to taxing the harmful ingredient. Sugar-density taxes and ethanol-based alcohol taxes better align payment with health risk and encourage reformulation or lower-strength products.

WHO's 3 by 35 initiative has placed affordability, rather than nominal tax rates, at the centre of global policy.[2] This is essential because rapidly growing incomes can neutralize taxes. Countries increasingly use automatic indexation and multi-year tax escalators to prevent products becoming cheaper over time.

Digital tax stamps, track-and-trace platforms and electronic invoicing are strengthening administration. These systems can reduce evasion but require independent governance and must not be controlled by industries subject to regulation.

Research is also moving from average effects towards distributional outcomes. Studies increasingly examine responses by income, age, baseline consumption and neighbourhood deprivation. Such analysis is important because a policy with a modest average effect may produce major gains among high-risk populations.

Another advance is evaluation of reformulation. Measuring sales volume alone can miss substantial reductions in sugar or alcohol content. Future monitoring should quantify the total harmful ingredient sold into the market.

Challenges and Limitations

Most health-tax evaluations use natural experiments rather than randomized trials. Comparison regions may differ, policies may coincide with other interventions and industry responses may begin before implementation. Nevertheless, consistency across jurisdictions strengthens causal inference for price and purchasing outcomes.

Long-term health outcomes are more difficult to measure. Diabetes, cancer and cardiovascular disease develop over years, and taxes may change repeatedly. Modelling studies are necessary but depend on assumptions about price elasticity, substitution and disease risk.

Cross-border shopping is important for local taxes but generally less relevant for national policies. Informal production and illicit trade are more serious for tobacco and alcohol than for packaged SSBs. Administrative capacity must be incorporated into design rather than treated as an afterthought.

Public opposition may arise when taxes are introduced without explaining their health purpose or when revenue use is opaque. Poor communication allows industry narratives about government intrusion to dominate.

Taxes also risk being symbolic. A small levy can permit governments to claim action while prices remain affordable. The policy indicator should be the change in real retail price and consumption, not simply whether a tax exists.

Future Directions

Countries should adopt comprehensive health-tax strategies covering tobacco, alcohol and SSBs, with common principles of affordability reduction, automatic adjustment and transparent evaluation. Research should compare specific, ad valorem and ingredient-based designs using actual market data. Evaluations should include product reformulation, substitution, household welfare, disease outcomes and industry conduct.

India requires an independent health-tax observatory bringing together finance, health, GST, state excise, nutrition, economics and civil-society expertise. It should publish annual reports on prices, affordability, tax share, consumption and revenue.

SSB taxation should evolve towards a sugar-content-based national excise. Tobacco taxes should reduce price gaps between cigarettes, bidis and smokeless products, while alcohol taxation should increasingly reflect ethanol content.

Revenue policy should be transparent. Even where formal earmarking is not adopted, annual budgets should disclose revenue from health-harming products and corresponding investment in prevention, treatment and social protection.

Finally, health taxation should be framed as part of a broader social contract. People should not be asked to pay more for harmful products while healthy food, clean water, treatment and public transport remain inaccessible. Fiscal policy is most legitimate when it expands genuine healthy choices.

CONCLUSION

Health taxation is one of the most powerful but underused instruments for preventing noncommunicable disease. Its strength lies in changing prices, discouraging initiation, reducing consumption, encouraging product reformulation and generating revenue.

The evidence is strongest for tobacco taxes and substantial for alcohol and SSB taxes. Implemented SSB taxes consistently increase prices and reduce purchases, although their long-term effects on obesity and diabetes require continued evaluation. Ingredient-based designs are generally better aligned with health objectives than simple taxes on product value.

Claims that health taxes are inherently regressive ignore the unequal distribution of disease, medical expenditure and responsiveness to price. Well-designed taxes, combined with accessible alternatives and transparent use of revenue, can improve health equity.

India has made an important move by raising GST on specified sweetened beverages to 40%, but the next step should be a coherent health-tax strategy rather than isolated product classifications. Tobacco, alcohol and SSB taxes should be simplified, regularly adjusted, broadly applied and evaluated by their effect on affordability and health.

Health taxation is not a substitute for regulation, health care or social policy. It is a means of aligning market prices more closely with societal costs and ensuring that commercial profitability does not continue to depend on preventable disease.

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