BIDIS: A CURSE FOR THE POOR

A choice between Death and a Debt Trap

EXECUTIVE SUMMARY

Bidis are regarded as a poor person's pleasure and has traditionally been outside the radar of policymakers and regulators in India. Each successive government rationalised the reasons for not increasing the costs or taxing bidis as socially and economically weaker people, including tribals,who form a significant electoral constituent, smoke it or are engaged in its production. Hence, attempts at reducing its consumption or production through taxation or otherwise have not seen significant political will or determination.

The economic reasons given by the government to keep bidis at a low cost have been that any increase in taxes would lead to a large potential loss of economic activities and employment, due to reduced consumption or production brought about by higher taxes or any state led increase in input costs.

Tax collection from bidis is insignificant and hence, does not get adequate attention from a fiscal collection point of view and is ignored at each budget citing reasons that it would affect the livelihood of millions, who depend on the trade.

This report strongly advocates a radical shift in India's approach and, contrary to what many may perceive as a politically and economically incorrect position to take, it argues that bidis are the bane of the poor and not taxing it heavily to reduce its consumption is ANTI-POOR!

Some facts about bidi smoking in India include:

- Bidis are the most commonly consumed tobacco product in India, especially by the poor, and constitutes ₹ 53,780 crores or US $ 8.8 billion in value. It is also the cheapest due to cheap and exploited labour, artificially depressed costs of major inputs and low taxes.
- Bidi smoking, along with all tobacco products, is a modifiable risk factor for non-communicable diseases (NCDs) like cancer, cardio vascular diseases (CVD) and chronic obstructive pulmonary disorders (COPD), leading to loss of productivity and premature death.
- About 4 million deaths are likely to occur in India due to NCDs caused by modifiable risk factors, including tobacco consumption[1].
- A WHO report says that the risk factor for morbidity, associated with smoking has increased in India, from 13.9% in 2011 to 15% in 2014.
- 45.4% of all cancer cases in men and 16.8% of all cancers in women are associated with tobacco use[2].
- The economic cost of diseases attributable to tobacco use in India is ₹ 104,500 crores or USD 22 billion (for people in the age group of 35-69 years), according to a 2014 study by Public Health Foundation of India (PHFI). This is about 1.16% of India's current GDP[3].
- Cancer care costs ₹ 37,000, on an average, for treatment up to radio therapy, at AIIMS-Delhi[4]. Surgery or chemotherapy would raise it to ₹ 100,000-150,000 and critical care would shoot up the cost to ₹ 700,000. Considering that the minimum wage in Delhi ranges from ₹8,600 – ₹ 10,500 per month, the economic burden on the poor is stupendous.
- High healthcare cost accounts for more than half of Indian households falling into poverty, with about 39 million Indian people being pushed into poverty every year, according to Lancet (2011)[5].

1 A World Economic Forum and Harvard University study of November 2014: Non-Communicable Diseases in India.
2 http://www.ncrpindia.org/ALL_NCRP_REPORTS/HBCR_REPORT_2007_2011/ALL_CONTENT/PDF_Printed_Version/Chapter3_Printed.pdf - Consolidated Report of Hospital Based Cancer Registries 2007-2011
3 Economic Burden of Tobacco Related Diseases in India" (May 2014), PHFI, supported by MoHFW and the WHO Country Office for India
4 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3841486/
5 Lancet article, India: Towards Universal Health Coverage, January 2011

- About 1.4 – 2 million Indians experienced catastrophic spending in 2004 and 600,000 to 800,000 people were impoverished by the cost of caring for CVDs and cancer[6]. These costs were met from private savings or borrowing from money lenders, driving families to destitution.
- Loss of productivity due to tobacco-related hospitalisation and outpatient visits accounted for USD 411 million for India in 2004[7]. At current costs and given the growing population this will be over USD 1.2 billion
- Government expenditure on healthcare progressively increases with rising tobacco-related morbidity, adversely affecting poverty eradication efforts and overall economic development.

These facts are disturbing and convey a clear and strong message:

Bidis should be made unaffordable for the poor.

The argument, that increasing taxes on bidis will deprive the poor of their sole source of luxury and relaxation is fallacious. It is, in fact, driving the poor Indian to destitution and poverty.

Arguably, one of the most effective ways to make bidis unaffordable is by raising taxes. As a 2010 research, "The Economics of Tobacco and Tobacco Taxation in India" points out, raising tax makes immense sense. It says, "Raising bidi taxes to ₹ 98 per 1000 bidi sticks from the existing low level of ₹ 14 per 1000 would raise over ₹ 36.9 billion (USD 0.77 billion) in new revenues. By increasing prices up 52.8% from their current levels, the higher tax would also significantly reduce bidi consumption, and prevent 15.5 million premature deaths among current and future bidi smokers". It adds, "10% increase in bidi prices could reduce bidi consumption by 9.2%"[8].

Experts have been arguing for long that India should raise prices and taxes to discourage bidi consumption. Reductions in tobacco use after tax increases will occur slowly allowing tobacco cultivators, tendu leaf pickers and bidi rollers to transition to other industries which are healthier both for workers and for the economy overall. The government can assist in this transition through alternative livelihood programs.

The report suggests a three-pronged approach:
- Recognise that not taxing bidis is actually being anti-poor, and as WHO recommends, tax them at a rate high enough to significantly reduce bidi consumption;
- Raise input costs significantly, in particular, cost of unmanufactured bidi tobacco; and
- Setting up a regulatory mechanism that controls bidi production and distribution, and related input costs, from a taxation and health perspective.

For tobacco taxation to work as a deterrent against tobacco consumption, the tax regime needs to ultimately be uniform across all tobacco products.The benefits are many:
- Reduced burden of disease on consumers and government;
- Improved life expectancy, labour productivity, earning capacity and purchasing power of tobacco consumers; and
- Better economic development.

India needs to check the bidi menace without further loss of life and productivity. A healthy and productive citizen will contribute more to nation building and help in realising India's dream of becoming a world economic power.

6 Quoted in "NON-COMMUNICABLE DISEASES AND POVERTY IN INDIA", from Ministry of Statistics and Program Implementation, Health Care and Condition of the Aged. Report No. 507 (60/25.0/1), Government of India NSSO, New Delhi, 2006. (Available at http://healthbridge.ca/Fact_sheet_NCDs_&_Poverty2.pdf
7 Economic cost of tobacco use in India, 2004 R M John, H-Y Sung, W Max
8 Economics of Tobacco and Tobacco Taxation in India by John RM, RK Rao, MG Rao, J Moore, RS Deshpande, J Sengupta, S Selvaraj, FJ Chaloupka, Prabhat Jha, 2010

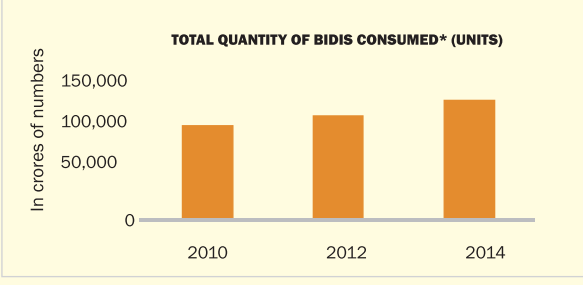
A CHOICE BETWEEN DEATH AND DEBT TRAP

Bidis and chewing tobacco are the most consumed tobacco products in India. Bidis are the cheapest, and, therefore, attractive to the financially and socially backward and is often called the 'poor man's cigarette'. According to the National Sample Survey data, approximately, 1,123 billion sticks (or 64% of all tobacco consumption) were consumed in 2012[9]. Bidi making is a labour intensive process consisting of cutting and drying of tendu leaf, stuffing tobacco into a tendu leaf roll, tying the roll with thread and packing it in bundles of 20-25.

The size of the beast

More than 300 million Indians are estimated to be using tobacco in some form. This is derived from the following:

- The Global Adult Tobacco Survey (GATS) India, 2009-10[10], estimates that 34.6 % of all adults in India consume tobacco in some form (adults have been defined as individuals of the age of 15 years and above);
- The Global Youth Tobacco Survey (GYTS) India, 2009[11], estimates that 14.6% of students aged 13-15 years currently use tobacco;
- Among these 130 million are tobacco smokers (80 million bidi smokers and 50 million cigarette smokers).



**2010 and 2012 based on actual consumption of bidis extracted from National Sample Survey 66th and 68th round estimates*

The high prevalence and growth of bidi consumption is ascribed mainly to its low cost. The low cost is fundamentally driven by cheap labour, comprising mostly of women and children who roll bidis in their homes and get paid a pittance, and low taxation. Bidi making is largely a cottage industry and unorganised, with little regulation. A growing population and growing disposable incomes in rural and semi-urban areas,combined with the low cost of bidis is likely to lead to an explosion in bidi consumption in the near future.

Impact on health and economic consequences

Tobacco use is one of the key risk factors associated with non-communicable diseases (NCD), viz., cancer, cardio vascular diseases (CVD) and chronic obstructive pulmonary diseases (COPD). Daily smoking increases the risk of contracting an NCD. This risk has increased from 13.9% in 2011 to 15% in 2014, according to a WHO report[12].

A World Economic Forum and Harvard University study of November 2014, titled “Economics of Non-Communicable Diseases in India” (WEF-Harvard study), says CVD, cancer, chronic respiratory diseases and other NCDs account for more than 60% of all deaths in India. According to the study, about 4 million deaths are likely to occur due to NCDs caused by modifiable risk factors that include tobacco consumption and the probability of dying of one of the four main NCDs during the most productive years (30-70 years) is as high as 26%.

The report further says that due to risks associated with NCDs, India stands to lose USD 4.58 trillion (₹ 2,15,26,000 crores) before 2030 - CVDs accounting for USD 2.17 trillion (₹ 1,01,99,000 crores), cancer USD 0.25 (₹ 11,75,000 crores) and chronic respiratory disease USD 0.98 trillion (₹ 46,06,000 crores). This represents lost economic output over the 18 year period from 2012 to 2030. Such risks get multiplied if the person is a user of tobacco.

9 As per National Sample Survey-NSS 66th round data (for 2012), published by the Government of India

10 GATS India was conducted by the International Institute for Population Sciences, Mumbai in behalf of the Ministry of Health and Family Welfare, GoI, with technical support from the US Centres for Disease Control and Prevention (CDC), the World Health Organisation, the Johns Hopkins Bloomberg School of Public Health and the RTI International. Available at: http://www.who.int/tobacco/surveillance/en_tfi_india_gats_fact_sheet.pdf

11 GYTS India 2009 available at http://cbhidghs.nic.in/writereaddata/mainlinkFile/Health%20Status%20Indicators-2013.pdf and http://www.la-press.com/a-survey-of-24-000-students-aged-13ndash15-years-in-india-global-youth-article-a2267 *

12 http://www.who.int/nmh/countries/ind_en.pdf?ua=1

The prevalence of NCDs in India, (most of which are caused by modifiable risk factors, including tobacco consumption), and the related loss of disability adjusted life years (DALY) is tabulated below:

NCD	DALYs	%age of total DALYs	Deaths	%age of total deaths
CVD	487,93,600	9.4	20,95,930	21.1
Chronic respiratory disease, including asthma, chronic obstructive pulmonary disease-COPD, etc.	358,80,300	7	11,76,740	11.8
Cancer	190,94,000	3.7	6.63,032	6.7

Source: 2014, WEF-Harvard study- Table 1: Prevalent NCDs in India, 2010

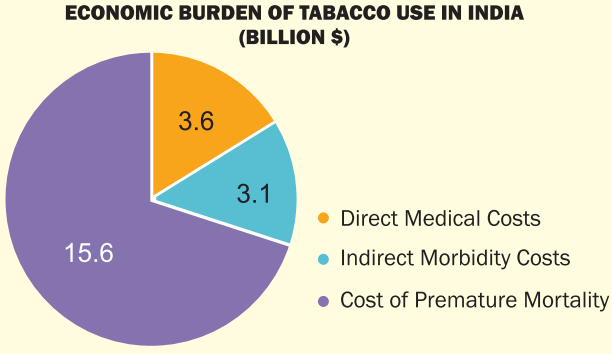
There are several other studies and reports which reflect the adverse health and economic impacts of bidi consumption (it being the most consumed tobacco product). The National Cancer Registry Programme in India, which collects data on magnitude and patterns of cancer in the country, reports that in all its registries in India, 45.4% of all cancers in men and 16.8% of all cancers in women are associated with tobacco use[13].

Burden of Disease

An article in the Indian Journal of Critical Care Medicine estimates cancer care costs to be ₹37,000,on an average, for a course of treatment up to radiotherapy at AIIIMS-Delhi[14]. Additional requirements of surgery or chemotherapy would raise the cost to around ₹100,000-150,000 for a period of 1.5 months and critical care would shoot up the cost to about ₹ 700,000 for the same period. Considering that the minimum wage in Delhi ranges from₹ 8,600 to ₹ 10,500 a month for un-skilled to skilled labour, the economic burden on the poor is simply stupendous.

A 2014 PHFI[15] report estimates the economic burden of diseases attributable to tobacco use across India to be ₹ 104,500 crores or USD 22 billion for persons in the age group 35 to 69 years. Considering bidis are the most common form of tobacco used in the country, a large proportion of these costs will be due to bidi use.

The burden of disease works out to be approximately 1.16% of the total GDP of the country and 12% more than the combined health expenditure of the central and state governments for 2011-12.



The PHFI study however coversonly adult consumers of tobacco in the age group of 35-69 years. The economic cost due to illness and premature mortality would be much higher, if it covered all tobacco consumers above the age of 13, as well as bidi rollers engaged in bidi manufacture.

Bidi Consumption: Poor man's luxury or poor man's blight?

The rapid rise in NCDs and consequent government spending on healthcare is bound to impede poverty reduction initiatives in a low-income country like India. Vulnerable and socially disadvantaged people are at a greater risk of being exposed to harmful products like tobacco, making them more susceptible to NCDs. NCDs can quickly drain low-income households of precious economic resources, including the loss of bread winners. It drives millions of people into poverty in a country like India where healthcare is a high-cost service. Such a situation may stifle development and threaten achievement of the UN Millennium Development Goals. (WHO Fact sheet, 2013)

13 http://www.ncrpindia.org/ALL_NCRP_REPORTS/HBCR_REPORT_2007_2011/ALL_CONTENT/PDF_Printed_Version/Chapter3_Printed.pdf - Consolidated Report of Hospital Based Cancer Registries 2007-2011

14 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3841486/

15 "Economic Burden of Tobacco Related Diseases in India" (May 2014), PHFI, supported by MoHFW and the WHO Country Office for India

A CHOICE BETWEEN DEATH AND DEBT TRAP

According to WHO:[16]

- In India, the risk of distress borrowing and distress selling of assets was not ably higher for hospitalised patients who are smokers; and
- From 2005 to 2015, India was projected to lose International $ (I$)[17] 237 billion (1.5% of the GDP) as a result of heart disease, strokes and diabetes.

A fact sheet prepared by Health Bridge India finds that:[18]

- Loss of productivity and income on account of NCDs cause a double burden on poor households, leading to loss of savings and assets, reduced opportunities for children's education and malnutrition;
- High treatment costs combined with likely loss of jobs and lost incomes of affected individuals and care givers put a heavy economic burden, driving them to destitution;
- An estimated 1.4 million to 2 million Indians experienced catastrophic spending in 2004 (catastrophic expenditure implies healthcare expenditure exceeding 40% of a household's ability to pay);
- 25% of Indian families with a member with (CVD) experience catastrophic expenditure. The treatment cost increases with cancer- 50% of households experience catastrophic spending, which drives 25% of them to poverty;
- 600,000 to 800,000 people were impoverished by the cost of caring for CVDs and cancers alone; and
- Living close to the poverty line, these households face a much higher risk of falling into the poverty trap from treatment expenditure.

A 2004 study, "Economic Cost of Tobacco Use in India", estimated the loss of productivity for the year, i.e., total value of lost income from tobacco related hospitalisation and outpatient visits, to be USD 411.4 million, including USD 313.8 million for male smokers, USD 14.5 million for female smokers, USD 67.8 million for male smokeless tobacco users and USD 15.3 million for female smokeless tobacco users[19].

Bidis, due to their low cost, are largely consumed by the poor who are then forced to seek prohibitive healthcare in the private sector in the absence of a robust public health caresystem. In a 2014 WEF study, 90% of Indian respondents said they depended on borrowings from family and others for financing their treatment. Out of pocket (OOP) expenditure constitutes nearly 98% of private health care expenditure here.

According to the National Sample Survey Organisation, urban hospitalisation costs increased by 126% between 1995-96 and 2003-04, while rural hospitalisation costs increased by 78%. Independent Commission on Development and Health in India (ICDHI) noted that one-fifth of the population that is just above the poverty line will automatically slip into poverty if they face even one serious health crisis.

A 2011 Lancet article, titled "India: Towards Universal Health Coverage", says that high health expenditures account for more than half of Indian households falling into poverty, with about 39 million Indians being pushed into poverty every year. This estimate does not take into account the effects on people already living below the poverty line who are pushed further into poverty or those groups who are forced to forego health care as a result of the costs.[20]

The message is quite clear. Bidis should be made unaffordable for the poor and arguably, one of the most effective ways to achieve this is to raise taxes. In fact, not taxing bidis will actually be anti-poor. The exorbitant out of pocket private healthcare expenditure will drive the poor smoker to debt and destitution.

16 http://www.who.int/nmh/publications/ncd_report_chapter2.pdf
17 An international dollar is a hypothetical currency that is used as a means of translating and comparing costs from one country to another using a common reference point, the US dollar. An international dollar has the same purchasing power as the US dollar has in the United States.
18 Quoted in "NON-COMMUNICABLE DISEASES AND POVERTY IN INDIA", from Ministry of Statistics and Program Implementation, Health Care and Condition of the Aged. Report No. 507 (60/25.0/1), Government of India NSSO, New Delhi, 2006. (Available at http://healthbridge.ca/Fact_sheet_NCDs_&_Poverty2.pdf)
19 Economic cost of tobacco use in India, 2004 R M John, H-Y Sung, W Max
20 Lancet article, India: Towards Universal Health Coverage, January 2011

BIDI PRICING:TAX REGIME AND RELATED ANOMALIES

Compared to cigarettes, bidis are cheap in India and attractthe lowest, almost negligible, tax(central excise or state VAT).Increasing taxis a WHO recommended 'best buy' and also widely considered by experts to be an effective means of reducing tobacco use.

However, while 64% of all tobacco products consumed in India are bidis, its contribution to total excise collections is almost negligible. Cigarettes alone contribute about 71% of total excise duty collections from all tobacco products, while their consumption is significantly lower than that of bidis. Bidis, on the other hand, contribute a mere 3% of the total excise duty collections from tobacco products or just 0.3% of total central excise collections.

	Products	*Excise duty collected (in ₹crores)	Tax per stick (₹)
1.	Cigarettes	10,454	1.57
2.	Chewing tobacco	1,074	
3.	Bidis	377	0.003
4.	Others including Gutkha	2,899	
	Total	**14,804**	

*Provisional collection data for financial year 2011-12 up to January 2012. Total excise duty collection during this period being ₹114,046 crore.[21]

This contrast is primarily due to the policymakers' reluctance to increase taxes on bidis. The main argument against raising taxes is the huge potential loss of livelihoods and employment of millions of bidi growers, rollers and tendu/kendu leaf pickers, due to reduced consumption. This is not without reason. According to Central Tobacco Research Institute (CTRI) about 4.4 million people are engaged in bidi rolling. Another 2.2 million, mainlytribals and landless people in some of the poorest districts of India, are engaged in collecting tendu leaves.

The 2014 budget raised basic excise duty on regular length cigarettes by 11-21%, while for smaller sized cigarettes of 64mm length the duty was increased to 72%.[22] In contrast, current excise duty on bidis (which have not significantly changed over the years) is:

Bidis-Description	₹ per 1000 sticks (effective March 2012)	₹ per 1000 sticks (old rate)
Hand-rolled	10	8
Machine-rolled	21	19

In addition to the low and differential rates, bidi units producing less than 2 million sticks a year without machines are exempt from excise duty.

With the increase in excise on cigarettes in 2014, the excise duty on hand-rolled bidis (which constitute a majority of the bidis sold in the country) is less than 1% (on a per stick basis) of that on cigarettes (non-filter not exceeding 65mm). The distinction made between hand-rolled and machine-rolled bidis discourages mechanisation in the industry and acts as an incentive for hand-rolled bidi manufacturers. Such incentives need to be removed.

Unmanufactured tobacco is another grey area that needs attention. In the 2014 budget, basic excise duty on unmanufactured tobacco was raised from 50% to 55%. However, usually unmanufactured tobacco sold by a tobacco processor/blender to the bidi manufacturer in India is, for the most part, not branded (unmanufactured tobacco is defined to mean unmanufactured tobacco bearing a brand name and comes under tariff heading 2401 of the First Schedule to the Tariff Act.[23] Under the Central Excise Act of 1944, unmanufactured tobacco, bearing a brand name, manufactured with the aid of packing machine and packed in pouches is declared as a 'notified good').Thus, the effective tax rate on such products is actually nil.

21 http://www.pib.nic.in/newsite/erelease.aspx?relid=81803
22 http://www.cbec.gov.in/ub1415/do-ltr-jstru1.pdf
23 Rule 2 (Definitions) of the "CHEWING TOBACCO AND UNMANUFACTURED TOBACCO PACKING MACHINES (CAPACITY DETERMINATION AND COLLECTION OF DUTY) RULES, 2010[Notification No. 11/2010-C.E.(N.T.), dated 27.02.2010]

Summary

Raising taxes makes immense sense, for more than one reason. A 2010 research study, "The Economics of Tobacco and Tobacco Taxation in India" says, "Raising bidi taxes to ₹ 98 per 1000 bidi sticks from the existing low level of ₹ 14 per 1000 would raise over ₹ 36.9 billion (USD 0.77 billion) in new tax revenues. By increasing prices up 52.8% from their current levels, the higher tax would also significantly reduce bidi consumption, and prevent 15.5 million premature deaths among current and future bidi smokers". It adds, "10% increase in bidi prices could reduce bidi consumption by 9.2%".[24]

The issue of anomalies in the tobacco tax structure can be addressed by adopting WHO recommendations[25], calling for a simple and unified excise duty system by treating all tobacco products at par. Accordingly, the following steps can be initiated:

- Taxing branded bidis, at ₹ 98 per 1000 sticks, up from the current rate of ₹ 21 per 1000 sticks;
- Removing the distinction between hand-rolled and machined-rolled bidisand related incentives;
- Banning unbranded bidis;
- Raising input costs – i.e. cost of unmanufactured bidi tobacco; and
- Ultimately, bringing all tobacco products under the purview of GST.

Such measures will lead to more effective tax administration and higher revenues. WHO says, that a unit-rate excise duty system would reduce incentives for substitution among different brands (or tobacco products), reduce non-compliance and eliminate incentives for various pricing strategies by manufacturers to reduce their tax liability.

It is a health issue, not merely a fiscal one

According to the 2014 OECD Economic Survey-India report, "Increasing taxes on tobacco; reducing the use of solid fuels in cooking; reducing salt intake and improving road safety can all play a major role in increasing the life expectancy of the poor."[26]

Article 6 of the WHO Framework Convention on Tobacco Control (FCTC) commits to treat tobacco taxation as a health measure rather than a solely a fiscal measure. India has ratified the convention.

Therefore, India has to initiate all such measures that will improve the health of its citizens and reduce the economic burden of tobacco consumption. Such measures include uniform tax rates across all categories of tobacco products, which would mean bringing bidis at par with other products for taxation purposes, streamlining tax levies and improving overall enforcement. Implementation of GST and including tobacco within its purview will be the right way to go about this.

Bidi production: Controlling supply

The bidi industry is significantly un-regulated, with little controls over growing of the plant, manufacture of tobacco- cut/ blend etc. in an intermediary form and its rolling into a final product. A majority of the units engaged in manufacturing bidis are home-based factories or small scale industries(SSI), which are exempt from tax under various statutes of the Indian Parliament. Furthermore, there is no provable nexus between such units and large manufacturers.

The excise duty of 55% on un-manufactured tobacco, as explained earlier, in reality is rarely invoked, as nearly all un-manufactured bidi tobacco is unbranded and is home or SSI made. These are then supplied to the bidi roller by the SSI to avoid any connection with a large manufacturer.

24 Economics of Tobacco and Tobacco Taxation in India by John RM, RK Rao, MG Rao, J Moore, RS Deshpande, J Sengupta, S Selvaraj, FJ Chaloupka, Prabhat Jha, 2010
25 http://www.who.int/tobacco/publications/en_tfi_tob_tax_chapter2.pdf
26 OECD Economic Surveys – India (November 2014)

Consequently, effective and efficient tax collection, proper healthcare of workers, as well as enforcement of other laws including those related to labour welfare become challenging.

Therefore it is recommended that a body oversee and regulate the growing, manufacture and output of bidis for effectively administering taxes.

By all accounts, bidis are harmful and cause death. There are no available studies that highlight any benefit that arises from its consumption. Therefore, stringent government control is needed on their production and use, through a regulatory body, which can oversee production and distribution of bidi tobacco, and can also oversee the governance of the bidi industry, with a focus on taxation and healthcare. Its functions should include:

- Regulating bidi production, the bidi tobacco purchasing process and tendu leaf procurement process in coordination with State Governments and respective Forest Departments;
- Mandatory registration of bidi tobacco purchases and periodic filing of purchase data to facilitate effective monitoring of bidi production as well as for tax administration;
- Ensuring branding of all bidi bundles sold in the market, to ensure effective tax administration;
- Ensuring fair and remunerative wages to tendu leaf collectors and bidi rollers;
- Regulating the contract nature and piecework method of wages for bidi rolling;
- Recommending minimum procurement prices for tendu leaves;
- Encouraging or funding research on alternative crops and uses of tendu leaves and
- Coordination with relevant authorities/ ministries/state departments for skill development and education of tribals and backward classes engaged in the industry.

WAY FORWARD & CONCLUSION

Various tobacco control initiatives have been carried out in India, including increasing tax on cigarettes, banning smoking in public places, banning advertising and other measures such as pictorial warnings on cigarette packets, public interest advertisements, health education etc. However, little has been done to control bidi consumption which continues to grow.

Any tobacco control measure that ignores growing bidi consumption and the resultant disease burden will be anti-poor, given that a large and growing population consuming it comes from the socially and economically backward sections.

As a 2010 report "Tobacco Taxes in India" points out, increasing bidi taxes from ₹14 to ₹98 per 1000 bidi sticks (i.e. from 9% to 40% of retail price) will increase government revenue by ₹36.9 billion ($0.8 billion) and avert 15.5 million premature deaths.

More than revenue, it is the prevention of premature death that should engage the Indian government. It needs to adopt a three-pronged approach to reduce bidi consumption:

- Recognise that not taxing bidis is actually anti-poor, and taxing branded bidis, at ₹ 98 per 1000 sticks, up from the current rate of ₹ 21 per 1000 sticks;
- Increase input costs of bidisby regulating production and sale of unmanufactured bidi tobacco; and
- Setting up a regulatory body that will control bidi production and distribution, and related input costs, to ensure effective tax administration and control over bidi consumption.

For tobacco taxation to work as a deterrent against tobacco consumption, all forms of tobacco and tobacco products should ultimately attract uniform tax. The benefits are many as drastic cuts in consumption will improve life expectancy, labour productivity, earning capacity and purchasing power of tobacco consumers. It will reduce the economic burden on the consumer and government and save resources for funding growth and development.

Recommendations

In order to close the gap between taxation and public healththe following steps are recommended:

- Eliminate differential taxation on bidis (hand-rolled and machine-rolled);
- Remove exemption to manufacturers of less than 2 million hand-rolled bidis;
- Gradual elimination of differential rates of tax between bidis and cigarettes;
- Control bidi tobacco farming;
- Increase input costs – regulating prices of unmanufactured tobacco, increasing wages of tendu leaf pickers and bidi roller, increasing minimum procurement price of tendu leaves;
- Banning unbranded bidis and effective implementation of branding/pictorial displays on packaging to facilitate identification of manufacturers and tax collection;
- Including tobacco under the proposed Goods and Services Tax (GST);
- Allocating additional taxes generated to reduce NCDs caused by tobacco consumption; and
- Establishing clear linkages between fiscal measures, national health programmes, labour welfare, development, research, environment and tobacco control measures.

Needless to say, a healthy and productive citizen will contribute more to the economy and help in realising India's stride towards becoming a world economic power.

ABOUT TARI

Thought Arbitrage Research Institute (TARI) is a not for profit multi-disciplinary research think tank, set up under section 25 of the Indian Companies Act, with 200+ person-years' experience in defining public policies and their implementation.

TARI's mandate is to develop intellectual capital for the country in the areas of corporate governance, sustainability, economics and public policy. Research in such areas today is usually funded by the government, bilateral agencies or foreign universities; there is very little privately funded research that puts forth an unbiased point of view of the business world.

TARI attempts to bridge this gap in the area of thought development. This research will help reduce the country risk and ultimately contribute to reducing the cost of capital for India as more business decisions will be based on researched facts rather than opinions.

Tomorrow's arbitrage will not be on labour, cost or capital – but on knowledge, ideas and thought. Countries that are at the forefront in these areas will control the course of global economic power.

TARI works with all stakeholders to leverage that thought arbitrage for the society and country.

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