WHY INDIA'S CENTRALISED CIGARETTE CESS ALONE WILL NOT DELIVER TOBACCO CESSATION

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India’s recent overhaul of cigarette and tobacco taxation—removing the GST compensation cess and introducing a mix of GST, excise duties, and a new “National Health Security Cess Act, 2025”—has been presented as a public health win. Evidence shows that higher prices can discourage tobacco use. However, helping users quit cessation requires more than price increases. According to GATS-2 (2016–17), 55 per cent of smokers and 50 per cent of smokeless tobacco users expressed a willingness to quit tobacco; however, the actual quit rate remains low, underscoring the gap between intent and actual access to cessation support.

Closing this gap requires comprehensive, well-funded interventions including counselling and behavioural programmes, quitlines, nicotine replacement therapies and prescription medications, awareness campaigns, smoke-free environments, and systemic follow-up to prevent relapse. Without such structured support, many addicted users may struggle to quit despite higher costs.

As policymakers celebrate revenue collections, they risk ignoring the stark reality that cessation services in India are chronically underfunded and poorly resourced.

Cessation Services: A Fraction of Revenue

Each year, India collects over 75,000 crores in tobacco taxes (Ministry of Finance, 2016-24). Yet, when it comes to funding actual cessation support, the numbers are staggeringly low. Between 2014–15 and 2022–23, Union budgetary allocations for tobacco control, including cessation programmes, ranged from ₹13 crore to ₹84 crore per annum, cumulatively amounting to approximately ₹463 crore over eight years. This represents less than 0.07 per cent of annual tobacco tax revenues, underscoring the extent of fiscal imbalance between revenue generation and health investment. In several years, allocations were negligible relative to tobacco tax receipts. Since 2023, tobacco control expenditures have ceased to be itemised in Union budget documents and are instead subsumed under broader health budget heads, further constraining transparency, expenditure tracking, and outcome-based accountability.

This pattern reflects a structural misalignment in policy. While a portion of tobacco taxation is designated as a “health cess,” the proceeds are neither legally earmarked nor institutionally ring-fenced for tobacco control or cessation activities, nor are they systematically tracked through budgetary or programme-level reporting frameworks. As a result, tobacco taxation primarily serves as a revenue instrument rather than a coherent public health financing mechanism aligned with cessation objectives.

Cessation Services Are Limited and Uneven

The National Tobacco Control Programme (NTCP) is India’s flagship anti-tobacco effort, including cessation. It has established over 675 tobacco cessation centres in district hospitals and operates the National Tobacco Quitline Service (NTQLS), which provides counselling in multiple languages. In 2023-24 alone, more than 1.35 million counselling sessions were delivered through these channels. This percentage translates to less than 0.5 per cent of the 274 million tobacco users who availed of cessation services. Among those availing cessation services, the quit rate remains low, estimated at 6-12.5 per cent, depending on the interventions.

However, these quit rates, being primarily self-reported, are also not very reliable. Without biochemical verification or standardised follow-up, self-reports tend to overestimate true cessation rates and fail to capture relapses, limiting their validity as indicators of programme effectiveness. Additionally, the current infrastructure is limited and often urban-centric, leaving vast rural and underserved populations without access to support. To effectively reduce tobacco use, cessation programmes must be strengthened in terms of reach, accessibility, and cultural responsiveness.

Central Tax Collection Weakens State Autonomy

Tobacco users need support close to home through clinics, community health centres, and even household outreach. State and local control over cessation funding is therefore critical to ensure services meet local needs.

However, the new cigarette cess remains a central tax, collected and pooled at the national level. States and urban local bodies responsible for delivering most health services have no guaranteed share of this revenue for cessation support or workforce expansion. Without fiscal decentralisation, states are left to fund cessation out of general health budgets, often competing with priorities such as maternal health, immunisation, and non-communicable disease programmes.

High tobacco taxes alone cannot bridge the gap between quit attempts and quit success. Cessation support counselling, medications, community outreach, and quit lines require predictable, long-term funding that matches local demand. If the government's intent is genuinely health-oriented rather than revenue-oriented, a few key reforms are essential:

1. **Dedicated Funding:** Allocate at least 10 per cent of tobacco tax revenues to expand access to cessation tools and services, and another 10 per cent to modernise tobacco production, enhancing worker safety, tracking outcomes, and supporting viable livelihood alternatives for farmers and beedi workers. These funds should be transferred directly to states, proportionate to local tobacco burden and service demand.

2. **Integration with Existing Health Programmes:** Embed cessation support into non-communicable disease clinics, reproductive and child health programmes, and school health initiatives.

3. **Tailored Interventions by Product:** Design product-specific cessation protocols, recognising that SLT users may require different behavioural and pharmacological interventions than smokers, based on local patterns of use.

4. **Capacity and Resources:** Equip clinics with trained personnel, culturally sensitive counselling materials, and essential pharmacological aids, such as Nicotine Replacement Therapy (NRT), patches, gum, and lozenges.

Finally, implementing robust follow-up mechanisms and leveraging community health workers (ASHAs, ANMs) to improve programme uptake and adherence are particularly important in underserved areas. Only then can price deterrence be matched with sustained support for people fighting addiction. Higher taxes can prompt people to consider quitting. But only investment in cessation makes quitting actual.

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