Tax Working Group
Te Awheawhe Tāke

Tax Working Group Public Submissions Information Release

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SUBMISSION TO THE TAX WORKING GROUP

SUGAR TAX

How our tax system can save lives, improve life quality, and shave millions off our national health costs

Submission by

diabetes new zealand

30 April 2018

Sir Michael Cullen,
Chair of the Tax Working Group,
Tax Working Group Secretariat
PO Box 3724
Wellington 6140

Dear Sir Michael,

How the tax system can save lives, improve life quality, and shave millions off our national health costs

Diabetes New Zealand is at the forefront of New Zealand's greatest health issue, diabetes. The incidence of diabetes in New Zealanders is at epidemic proportions and rising. Diabetes is a chronic illness with significant morbidity and mortality burdens.

Obesity is a primary factor leading to Type 2 diabetes. The 2017 OECD Obesity Index analysis that New Zealand has the third most obese population out of 35 member countries is both shameful and unacceptable. This is an indictment on our country and the poor health of our people. The OECD report represents an emphatic call to action. The Rt Hon Helen Clark has described the OECD's finding as "shocking" and has vigorously implored that "*whoever's in government needs to implement strong policy to stop this epidemic now".*

For decades, Diabetes New Zealand through its hard-working staff and volunteers has fought the war on diabetes across the whole country, deploying enormous resources to support and help countless thousands of people deal with their health problems and improve their lives. Raising awareness and prevention consumes a large part of the organisation's resources. From all this involvement, effort and informed experience at New Zealand's diabetes coal face, Diabetes New Zealand is ideally placed with this submission.

The bottom line is that despite many governmental programmes to address the problem, the incidence of diabetes in New Zealand is increasing, as is the rate of obesity. Something much more is needed to stem this fatal tide. Diabetes New Zealand earnestly believes that this 'something' is a Sugar Tax.

This submission carefully analyses the evidence and arguments surrounding the case for a Sugar Tax. We recommend this submission by Diabetes New Zealand to you, and its conclusion that a Sugar Tax will create a bow wave to behaviour change beyond any other governmental measure thus far.

As Patrons of Diabetes New Zealand, we appeal to you to follow the example of other nations in deploying the levers of taxation to intervene in this runaway health epidemic.

You have a unique opportunity to play a critical role in the health, well-being and longer lives of hundreds of thousands of current and future generation New Zealanders.

Yours sincerely,
[1]

Sir Eion Edgar KNZM
Lady Beattie fully supports this letter but is unable to sign due to having suffered a stroke
Patrons of Diabetes New Zealand

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Contents

1. Executive Summary

2. What is the purpose of tax?

3. The New Zealand Obesity & Diabetes Epidemic

- Type 2 diabetes is largely preventable

4. The impact of sugary drinks on obesity and Type 2 diabetes

- Key positions relating to sugar sweetened beverages (SSBs)
- Summary

5. What is diabetes and obesity costing our health system?

- Costs of Type 2 diabetes
- Costs of obesity
- These costs threaten to overrun our health system

6. Tougher government intervention is necessary

- Snapshot of major government and ministry actions

7. The effectiveness of a Sugar Tax

- The 'sugar tax' precedent trending with other countries can't be ignored
- Strong example with tobacco taxes
- What type of 'sugar tax'?
- Creating a 'bow wave' to change behaviours
- Need for political will-power
- Industry responses

8. Fiscally positive dual effect of revenue raising and cost savings

Appendix – About Diabetes New Zealand

1. Executive Summary

The key essential messages within this submission by Diabetes New Zealand (DNZ) are:

1.1 New Zealand is an obese nation and this has a direct and significant correlation to the incidence of Type 2 diabetes, and all its chronic downstream illnesses. One in three New Zealanders are obese. This country ranks as the third most obese nation out of a 35 nation analysis by the OECD. As at 31 December 2016, a massive 217,000 New Zealanders had Type 2 diabetes. Ministry of Health estimates that a further 100,000 New Zealanders are 'pre-diabetic', or at risk of developing diabetes. This represents a staggering 6.74% of all New Zealanders, and with 40 people newly diagnosed with diabetes each and every day, this health crisis is escalating. This is why diabetes is a towering health problem for this country.

1.2 The flow-on health complications that arise from diabetes are serious, and fatal. Diabetes is a major contributor to many diseases, including: blindness; cardiovascular disease; kidney failure; nerve damage (neuropathies); ketoacidosis; and amputations.

1.3 Type 2 diabetes is largely preventable through lifestyle, diet and weight loss. Obesity is symptomatic with unhealthy diets and lack of exercise.

1.4 Today's food shelves contain heightened levels of added sugar and fat, and this extends to many processed and convenience foods. The standout culprit of todays mass-marketed high sugar intake foods are sugary drinks, known as sugar sweetened beverages ("SSBs"). This is a global phenomenon.

1.5 Substantial evidence links the intake of sugar to increased body mass and chronic non-communicable diseases including heart disease, Type 2 diabetes, gout and fatty liver disease. The lack of nutritional value combined with their excess calorific content puts sugary drinks in the spotlight amongst a range of health damaging foods and drinks. This is exacerbated by sugary drinks being cheap, readily available and accessible with widely advertised content.

1.6 New Zealand consumes excess amounts of soft drink. Consistent with global analysis, this is prevalent amongst teenagers. In the UK and USA, sugary drinks (sugar sweetened beverages, or SSBs) are the top calorie source of sugar for 11 to 18-year-olds.

1.7 Scientific and nutritional studies overwhelmingly show causal links exist between sugar sweetened beverages and the prevalence of obesity and Type 2 diabetes.

1.8 MoH states that diabetes has high health costs because it is a long-term condition with the potential for severe complications. The Ministry calculates that the total direct health care costs for a person with diabetes are approximately three times those for people without diabetes.

The cost to our health system of treating diabetes and obesity related illnesses is enormous. A PwC report commissioned by DNZ modelled the total health costs of treating diabetes at service levels in 2008 could be $1.310 billion by 2016/17, with projections to blow out to $1.770 billion by 2021/22. These figures place the country's health spend on Type 2 diabetes at some 8.1% of the total Crown Health budget spend for 2016/17.

The costs of obesity are of similar proportions. Added to this is the economic cost of lost productivity. A NZIER review found that the impacts of obesity have a wider social cost (the impact of obesity on economic, social, cultural and environmental well-being) that are much greater than the health costs.

1.9 Given the sheer scale of New Zealand's diabetes and obesity population, the increasing year-on-year numbers who develop these long-term conditions, and the massive health care and social and economic impact costs, the call for tougher governmental action has never been stronger, as has been urged by the Rt Hon. Helen Clark.

1.10 Government policies to combat obesity and Type 2 diabetes have to date varied from healthy food and better nutritional encouragement, to health sector offerings, to sports and greater activity incentives across national levels, and also targeted community groups.

The distinctive feature of the above government led health programmes is the absence of any hard-hitting regulatory or legislative intervention or penalty impost such as a taxation. The policies touched on may be described as a faciliatory approach which seek to "influence" rather than "prescribe" a change in individual poor health behaviours.

1.11 However, we are still confronting a growing, rather than a reversing trend in population obesity and Type 2 diabetes which brings into question the overall effectiveness of education and information campaigns. This is reflected by Camilla Cavendish, author of Soft Drinks Industry Levy, as former head of policy under David Cameron who stated, *"making things more expensive does change people's behaviour in a way that I'm afraid all the leaflets we have all read over the years and all the newspaper articles fundamentally don't".*

1.12 The 'sugar tax' trending with other countries can't be ignored. The UK / Ireland Sugar Tax provides a strong case example for New Zealand. Following many years of political resistance to introduce a sugar tax (with politicians claiming insufficient evidence existed around the effectiveness of a sugar tax), these governments boldly stepped forward in 2016 with a 'profound move' to introduce a Soft Drinks Industry Levy.

1.14 DNZ believes that the example set by these other nations is incontrovertible and that the TWG simply must give credence to the growing trend in favour of governmental intervention in the form of a Sugar Tax.

In short, the scale of the problem is now too great to ignore, and sharper measures in the form of a Sugar Tax are essential if this country is serious about promoting the good health and welfare of New Zealanders.

1.15 The success with New Zealand's campaign to stop smoking with tobacco taxes is a demonstrable example of how interventionalist fiscal policy can change consumer behaviours. It is also a strong precedent about the influence of price increases on reducing consumer demand for health poor products.

1.16 Given that SSB's have been identified as the single biggest contributor to obesity and Type 2 type 2 diabetes, it seems clear that these can and should be targeted by way of a rifle-shot taxation approach.

1.17 The more visible the tax impact is on the shelf price, the greater will be the response in consumer behaviour. To this end the International Diabetes Federation in conjunction with WHO recommend that taxation is required at levels that result in price rises by at least 20% to be effective in changing buying behaviours and materially reducing SSB consumption.

1.18 DNZ also believe that the Tax Working Group should give close consideration to a two-pronged approach, with some tax measure that offers thin subsidies to price reduce healthy alternatives, such as water. Evidence supports that this dual approach will have greater success on consumer behaviours over a sole Sugar Tax approach, by drawing consumers to discounted healthy substitutes over less healthy other sugar substitute options. The combination of a Sugar Tax and thin subsidies represents a powerful 'push me, pull me' effect that doubles the buyer influence for greater impact.

1.19 Working with the Food and Drinks Industry to develop and promote healthy products is an important program. However, DNZ has reservations about this voluntary and industry dependent approach being sufficiently productive, given the very obvious profit conflict inherent here, and also the historic delays in progress since the Nation Accord with the Food Industry Group back in 2004.

DNZ considers that the UK experience with the introduction of the Soft Drinks Levy Tax offers lessons to the parallel New Zealand position. The UK experience reveals a period of doubts and reticence toward the introduction of a Sugar Tax until a final realisation that the dire health evidence within the UK with obesity and Type 2 diabetes was just too overwhelming to ignore. Of particular relevance here, Camilla Cavendish, author of Soft Drinks Industry Levy, as former head of policy under David Cameron commented:

"There was an onslaught from the companies – every company said they couldn't possibly reformulate it. It would be impossible to change their ingredients, it would be impossible to take the sugar out. Here we are, three months before the tax comes in, and every single company, except one, has already reformulated its drink to avoid the tax. I think this is a huge success".

1.20 The missing and very salient point here is that little evidence exists that New Zealand's history of non-tax strategies for reducing Type 2 diabetes and obesity is making tangible inroads to that goal, and that something more is needed.

We believe that a Sugar Tax will constitute a political 'bow wave' that will strike more directly at reducing consumption of SSBs and the corresponding harmful effects, and will also infuse much needed attention to healthier dietary choices by the public at large. As with the UK, such a measure would send out a loud message about the seriousness with which Government is tackling better health outcomes to industry, and the broader public.

1.21 The Tax Working Group will be extremely mindful of the dual effect of a Sugar Tax, and the benefits this yields for Government and taxpayers more generally. A Sugar Tax will raise revenue. This revenue can be deployed in promoting other health campaigns (the UK is using its tax receipts to fund the promotion of sport in primary schools). The other fiscal benefit comes from a reduction to this country's massive and increasing health cost burden in treating diabetes and obesity related illnesses as positive outcomes emerge from changing current poor health options amongst our population.

This dual fiscal effect represents a rare outcome from regulatory intervention that economically underpins the case for action.

1.22 The complex nature of diabetes requires a comprehensive and sustained approach across many fronts to turn this rising tide. DNZ continues to advocate the need for multi-faceted actions across a wide-range of initiatives. However, the gap in New Zealand's arsenal for combatting the Type 2 diabetes and obesity epidemic is a Sugar Tax, and as a no cost (revenue positive) measure DNZ strongly recommend that the lead taken by 30 territories with such a tax is one that this country should follow.

1.23 For the reasons above, and more expansively outlined in the body of this submission, DNZ believe that a highly compelling case exists to justify the introduction of a Sugar Tax in New Zealand. We sincerely and earnestly encourage the TWG to strongly consider the merits of a Sugar Tax.

2. What is the purpose of Tax?

2.1 The Tax Working Group ("TWG") pose a very poignant question. Should we have a simple tax system, or should our tax system do more to incentivise or discourage behaviours?

Diabetes New Zealand ("DNZ") do recognise and support the strong tax framework that New Zealand has developed over the past 30 years, and its simplicity. Further, we believe that taxes that target behavioural change be on an exception-only basis.

2.2 We believe that a 'Sugar Tax' is a justified exception. Within this submission, we explain the basis for this exception from the appalling human and social poor health outcomes across New Zealand for which sugar sweetened beverages ("SSBs") is a major contributor, to the rising health costs to the nation of treating and dealing with an increasingly obese and diabetes affected population.

2.3 We also believe that consideration be given to 'subsidies' over healthier alternatives as a measure that would incentivise consumer choices away from high sugar SSBs in favour of alternative healthier options. This thin subsidy approach could be funded from revenue raised from a Sugar Tax.

2.4 DNZ has always advocated that a multi-faceted approach is essential to combat Type 2 diabetes and its complications, with actions across many fronts on an awareness, better information and educative footing. These non-tax strategies have dominated New Zealand's campaigns against obesity and Type 2 diabetes, however we believe that a Sugar Tax is a sharp tool that is missing from the arsenal that can create a powerful 'bow wave' to change poor consumption behaviours and send a necessary message to the beverage and food industry.

2.5 The growing trends and precedent from other nations with sugar taxes, and in particular the recent UK Soft Drinks Industry Levy, warrants considerable attention by the TWG. These countries have demonstrated considerable political will-power to tackle the increasing health epidemic from Type 2 diabetes and obesity. These government interventions using the blunt instrument of taxation exemplify what is necessary by New Zealand.

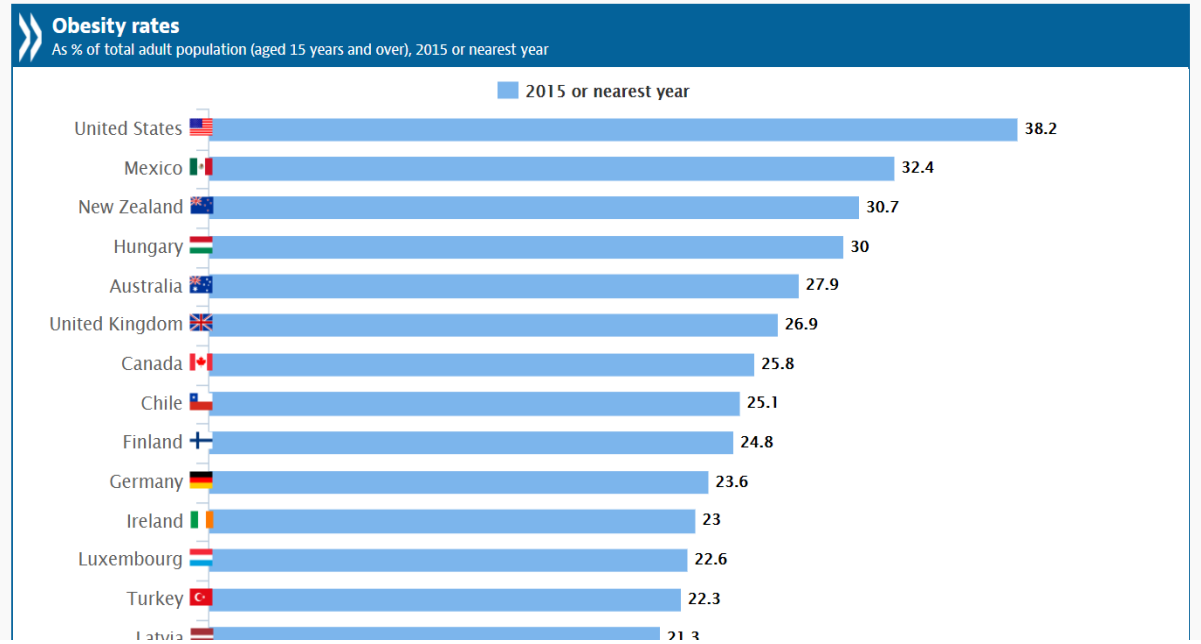
2.6 DNZ urge the TWG to closely consider the benefits of this country's commitment to aggressively taxing tobacco as a proven example of how leveraging the taxation system can generate better health outcomes for New Zealanders.

2.7 You have a unique opportunity to play a critical role in the health, well-being and longer lives of hundreds of thousands of current and future generation New Zealanders.

3. The New Zealand Obesity and Diabetes Epidemic

3.1 The OECD's 2017 Obesity Update ranking of New Zealand as the third most obese country out of a 35 country analysis is a shocking indictment of this nation. This was immediately recognised by the Rt Hon Helen Clark who pleaded that *"whoever's in government needs to implement strong policy to stop this epidemic now".*

3.2 The OECD analysis is a reflection of the MoH's own findings[1] that basically 1 in 3 New Zealanders are obese. The rate of obesity of this nation at 30.7% has been a continuously climbing rate since 2007 (26.5%), and this is expected to increase further over the next decade.



Source: OECD Health Statistics 2017 (Forthcoming in June 2017)

3.3 The MoH Obesity Statistics show:

i. Around 1 in 3 adults (aged 15 years and over) were obese, 32%
ii. A further 34% of adults were overweight but not obese
iii. 50% of Maori adults were obese
iv. 69% of Pacific island adults were obese
v. Adults living in deprived areas were 1.5 times as likely to be obese
vi. Around 1 in 8 children (aged 2 to 14 years) were obese, 12%
vii. A further 21% of children were overweight, but not obese
viii. 18% of Maori children were obese
ix. 29% of pacific Island children were obese
x. Children living in deprived areas were 2.5 times as likely to be obese

[1] Refer, https://www.health.govt.nz/nz-health-statistics/health-statistics-and.../obesity-statistics - The **New Zealand** Health Survey 2016/17, and also, Obesity and diabetes in New Zealand; Parliamentary Library Research Paper 2014/04

3.4 Obesity is a primary risk factor for Type 2 diabetes[2], which is the maturity onset condition and which at close to 90% of all diabetes cases dominates this population. Type 2 diabetes is a progressive disease, which means it gets slowly worse with time.

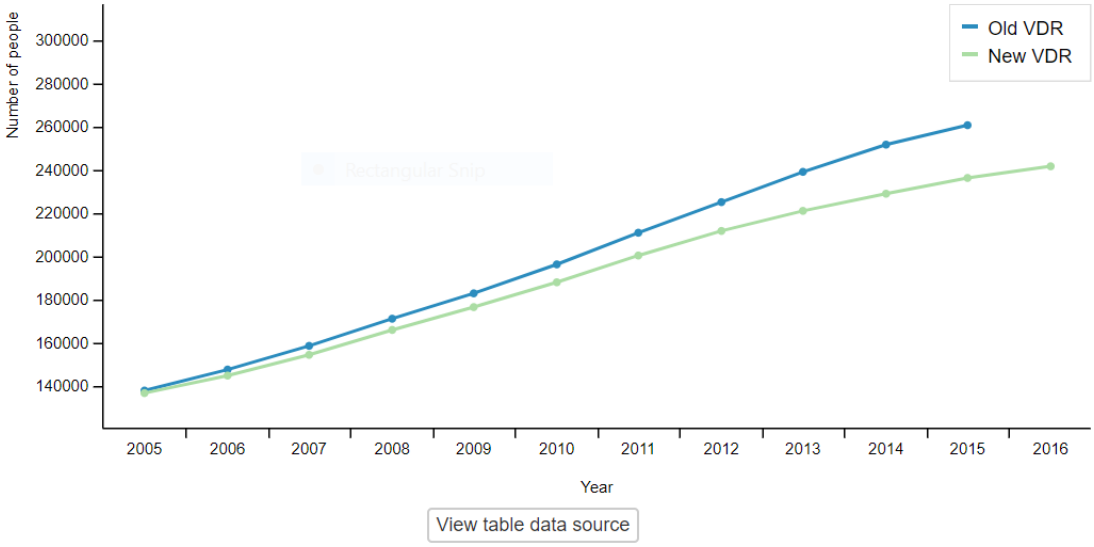
Using the latest MoH figures out of the revised Virtual Diabetes Register (VDR)[3], some 241,000 New Zealanders suffered from diabetes at 31 December 2016. By simple extrapolation at 90%, some 217,000 were people with Type 2 diabetes, which is relevant here for reasons above that overweight and poor nutrition is a leading contributor to this condition. In addition, MoH figures estimate that some 100,000 people are 'at-risk' of developing diabetes but as yet undiagnosed[4].

3.5 The combined current diabetes population (5.13%), together with the pre-diabetic population therefore represents a staggering 7.26% of all New Zealanders[5], with the Type 2 population representing some 6.74% of New Zealanders. This is a very significant portion of the nation's population and represents a more prevalent condition than any other health disease, particularly long-term conditions.

Put in contrast, these numbers are more than the total combined populations of Blenheim, Whangarei, Taupo, Queenstown, Nelson, Napier, Masterton and Kaitaia.

3.6 Figures reveal the growing incidence of diabetes within New Zealand, as illustrated by this graph taken from the MoH VDR.

Number of people suspected as having diabetes, on the old VDR and the new VDR, 2005–2016



[2] Type 2 diabetes is adult-onset diabetes mellitus, where the body becomes insulin resistant and unable to metabolise glucose, or blood sugars. It is distinguishable from Type 1 diabetes which is insulin-dependent diabetes mellitus that is an auto-immune failure of the pancreas. Type 2 diabetes is the dominant condition and accounts for approximately 90 of diabetes cases worldwide.

[3] The VDR contains data about people suspected as having diabetes, identified through their use of diabetes health services. The VDR uses an algorithm in data extracted from inpatient, outpatient, laboratory test and pharmaceutical dispensing databases.

[4] Refer - https://www.health.govt.nz/your-health/conditions-and-treatments/diseases.../diabetes, but this could be higher, refer https://www.health.govt.nz/system/.../pre-diabetes-risk-factor-management-nov16.doc

[5] Using 2016 population figures of 4.7 million, comparable with the timing of MoH VDR figures.

Year-end	2010	2011	2012	2013	2014	2015	2016
VDR figures	187,860	200,235	211,590	220,870	228,790	236,070	241,460
% yearly increase	-	6.6%	5.7%	4.4%	3.9%	3.2%	2.3%
% total increase							28.5%

3.7 Pacific island peoples have a significantly higher prevalence of diabetes than all other ethnic groups. The rates of diabetes within Indian populations is also close to that of Pacific Islanders. A recent NZIER Report[6] stated: *There are major ethnic and socio-economic disparities in the prevalence of diabetes and long-term outcomes for people with diabetes. Maori and Pacific people develop diabetes 10 to 20 years earlier than Europeans, and experience worse outcomes. These groups are also more likely to be heavy consumers of sugar-sweetened beverages.*

This data, together with an increased rate of diabetes within deprived communities, sees many parallels between diabetes and obesity.

3.8 Diabetes has been termed the '*silent assassin'*. The MoH figures predict that nearly 100,000 people are pre-diabetic and this group will already be suffering irreparable harm with the gradual damage to their health as elevated blood-glucose levels cause deterioration in vital health functions such as vision, kidney function, cardiovascular disease, and nerve damage.

3.9 What is seen here is that diabetes represents a large, deadly health-lake, from which morbidity[7] estuaries flow. Diabetes is cataclysmic as a major contributor to many diseases. It is the leading cause of adult blindness; the leading cause of kidney failure; a major cause of cardiovascular disease (heat attacks and strokes); and a causal factor with the development of nerve damage (neuropathies), ketoacidosis and amputations. The flow-on health complications that arise from diabetes are serious, and fatal.

3.10 While huge numbers of people die from diabetes, the vast majority are recorded as dying from their immediate and proximal medical cause of death, such as stroke and heart attack, kidney/renal failure, causal operation complications (eg. amputations), and other conditions. As a percentage of the national mortality profile, diabetes is mis-represented. A study in the US[8] concluded that while 3.3% of deaths of 30-to-84 year-olds from 1997 to 2011 recorded diabetes as the underlying cause of death, a much higher percentage closer to 12% could actually be attributable to diabetes.

3.11 The data above is dire, and explains why diabetes is described as an epidemic, indeed a pandemic health situation.

[6] Sugar taxes – a review of the evidence, NZIER report to Ministry of Health, August 2017

[7] Morbidity being the incidence of disease, disability and ill-health

[8] The disease that may be a leading cause of death; Data from the National Health Interview Survey (NHIS) and the National Health and Nutrition Examination Survey (NHANES) ; Article from Diabetes in Control, News and Information for Medical Professionals; 4th February 2017

Type 2 diabetes is largely preventable

3.12 Unlike Type 1 diabetes[9], Type 2 diabetes which is the prevailing condition in approximately 90% of cases can be prevented. The escalating prevalence in Type 2 diabetes has been attributed to personal and environmental factors that conspire to drive this epidemic. A segment of people who maybe genetically disposed to Type 2 diabetes may not prevent its onset. However, the majority of at-risk people can adopt lifestyle changes that will delay or prevent its onset.

3.13 Lifestyle changes from weight loss, improved dietary changes, and exercise are the keys to prevention. Fundamental here is healthy eating and good diet (portions and choices). Actions relating to healthy food promotion, advertising and labelling will all play a part in curbing bad food choices and encouraging healthier supermarket trolleys.

3.14 However, the introduction of a Sugar Tax represents a powerful weapon to drive better food choices and improve our nation's diet. This measure will strike at beverage manufacturers and distributors as well as the consumer population in general. This is a double edge sword, and as such a tougher and more direct measure that will add materially to the actions needed to drive changes in our health outcomes.

"It's all about healthier option taking"

[9] Type 1 diabetes is insulin-dependent diabetes mellitus that is an auto-immune failure of the pancreas

4. The impact of sugary drinks on obesity and Type 2 diabetes

4.1 Obesity is symptomatic with unhealthy diets and lack of exercise. It is non-contentious that today's food shelves contain heightened levels of added sugar and fat, and this extends to many processed and convenience foods – cereals, ice cream varieties, yoghurts, breads, cookies, nutrition bars, fruit juices, etc. The standout culprit of today's mass marketed high sugar intake foods are sugary drinks, known as sugar-sweetened beverages ('**SSB**').

Fuelled by industry mass-marketing and promotional campaigns, including aggressive pricing techniques, the consumption of SSB's has escalated. This is a global phenomenon.

4.2 The following summary positions will inform readers of key facts about SSB's, and the adverse causal outcomes. These positions are well documented internationally, including New Zealand based literature.

Key positions relating to SSB's

- SSB's include those beverages that have added sugar such as carbonated or fizzy drinks, sports drinks, fruit drinks and juices, powdered drinks, cordial and flavoured drinks;
- A 600ml bottle of soft drink contains approximately 16 teaspoons of sugar. A 375ml can of soft drink contains approximately 10 teaspoons of sugar[10].
- The World Health Organisation recommends that the total daily sugar intake for adults and children should be reduced to less than 10% of their daily energy intake, which is equivalent to around 12 teaspoons of sugar for adults[11]. The UK Scientific Advisory Committee on Nutrition halved this (previous) recommendation and advised that to achieve good health the average population intake of sugar should not exceed 5% of total dietary energy[12].
- In both the UK and USA, SSB's are the top calorie source for teenager's diets[13]. In the UK, as the largest single source of sugar for 11 to 18 year olds, consumption of SSB's equates to one can individually each and every day. Soft drinks provide close to 30% of daily sugar intake, on average, for this age group.
- In the UK, it is estimated that the sugar intake of school aged children and teenagers is up to 15.7%, and for adults is over 12% on average[14].
- Back in 2002, New Zealand was ranked 9th out of 18 developed countries consuming 84.2 million litres of soft drink[15].

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[10] Taxes on sugary drinks: Why do it? apps.who.int/iris/bitstream/10665/260253/1/WHO-NMH-PND-16.5Rev.1-eng.pdf; World Health Organisation 2017; and also, Rethink sugary drink key messages for professionals. At http:/www.rethinksugary-drink.org.au/for-professionals#key-messages

[11] Taxes on sugary drinks: Why do it? apps.who.int/iris/bitstream/10665/260253/1/WHO-NMH-PND-16.5Rev.1-eng.pdf

[12] The Scientific Advisory Committee on Nutrition. (2015) Carbohydrates and Health. Online. Available from: https://www.gov.uk/government/groups/scientific-advisory-committee-on-nutrition

[13] Sugar Reduction: The evidence for action. Review by Public Health England, October 2015; "The Nutrition Source: Sugary Drinks". *Harvard T.H. Chan School of Public Health*. Harvard School of Public Health.

[14] Taxes on sugary drinks: Why do it? Ibid

[15] Studies referenced by *Curbing the Consumption of Soft Drinks in New Zealand: Is Tax the Solution?;* Lin Mei Tan - Senior Lecturer School of Accountancy, Massey University, and James Xun Liu Accountancy intern Bank of China; New Zealand Journal of Taxation and Policy (2014) 20 NZJTLP 203.

- New Zealand is the worst country behind the UK, Australia and Canada for its proportion of sugar laden drinks according to a University of Waikato study.[16]
- SSB's have little, if any, nutritional value. In this way, they contribute empty calories. They are also highly acidic[17].
- Substantial evidence links the intake of sugar to increased body mass and chronic non-communicable diseases including heart disease, Type 2 diabetes, gout and fatty liver disease, as well as dental caries[18]. People who consume sugary drinks regularly – 1 to 2 cans a day or more – have a 26% greater risk of developing Type 2 diabetes than people who rarely consume such drinks[19]
- The lack of nutritional value combined with their excess calorific content puts sugary drinks in the spotlight amongst a range of health damaging foods and drinks. This is exacerbated by sugary drinks being cheap, readily available and accessible with widely advertised content.
- A University of Cambridge Study predicted that under current trends nearly 80,000 new cases of Type 2 diabetes will develop in the UK over the next 10 years as a direct result of SSB's[20]. This research does not suggest that all cases of Type 2 diabetes are triggered by the consumption of SSB's, but the regular intake off SSB's will increase the likelihood of Type 2 diabetes.
- Research at the Queen Mary University of London assess that the reduction of sugar in soft drinks by 40% over five years could prevent 1.5 million cases of obesity, and 300,000 cases of obesity related Type 2 diabetes in the UK[21]. The reduction in calories from this measure was estimated to lead to an average body weight reduction of 1.2kg.
- A common finding amongst studies and health reports is that high sugar intake, and excess SSB consumption is associated with low socio-economic groups[22]. This correlates to statistical data that records obesity and Type 2 diabetes as most prevalent within these same groups[23].

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[16] Sugary drinks: NZ worse than Canada, UK and Australia, study finds; article by Ruby Nyika; Stuff; 16 January 2018; https://www.stuff.co.nz/.../Sugary-drinks-NZ-worse-than-Canada-UK-and-Australia-stud...

[17] Consensus Statement on Sugary Drinks; New Zealand Dental Association; 2016

[18] Te Morenga L, Mallard S, Mann J. *Dietary sugars and body weight: systematic review and meta-analyses of randomised controlled trials and cohort studies.* BMJ 2013; 346: e7492. [PubMed]

[19] *Sugar sweetened beverages and risk of metabolic syndrome and type 2 diabetes: a meta-analysis*; Malik VS Popkin, Bray GA, Despres JP, Willett WC, Hu FB; Diabetes Care, 2010;33;2477-83

[20] *Consumption of sugar sweetened beverages, artificially sweetened beverages, and fruit juice and incidence of type 2 diabetes: systematic review, meta-analysis, and estimation of population attributable fraction. The BMJ 21 July 2015.* This international team of researchers led by the MRC Epidemiology Unit at the University of Cambridge set out to assess whether or not habitual consumption of sugar sweetened drinks, artificially sweetened drinks, or fruit juice was associated with the incidence of type 2 diabetes – and to estimate the 10-year risk attributable to sugar sweetened drinks in the USA and UK.

[21] Gradual reduction of sugar in soft drinks without substitution as a strategy to reduce overweight, obesity, and type 2 diabetes: a modelling study'. Yuan Ma, Feng J He, Yunjian Yin, Kawther M Hashem, Prof Graham A MacGregor. *The Lancet Diabetes & Endocrinology* 2015.

[22] Refer Alasdair Gardiner, *Implications of a Sugar Tax in New Zealand: Incidence and Effectiveness*; New Zealand Treasury Working Paper 16/09; November 2016; and, Sugar taxes: A review of the evidence; NZIER Report to Ministry of Health; August 2016; and, Sugar Reduction: The evidence for action; Public Health England; October 2015.

[23] *"Living Well with Diabetes – A plan for people at high risk of or living with diabetes 2015-2020*", the NZ Ministry of Health

Summary

4.3 The above positional statements underpin the conclusion that SSB's lack any nutritional value which combined with their excess calorific content puts sugary drinks in the spotlight amongst a range of health damaging foods and drinks. This is exacerbated by sugary drinks being cheap, readily available and accessible with widely advertised content.

4.4 The scientific and nutritional studies overwhelmingly show causal links exist between SSB's and the prevalence of obesity and Type 2 diabetes.

5. What is obesity and diabetes costing our health system?

5.1 The cost to our health system of treating diabetes and obesity related illnesses is enormous. Not only is it an enormous health cost but it is also a disproportionately higher one than the costs of treating other health conditions. In its health plan to manage the country's diabetes problem, the MoH states: "*Diabetes, because it is a long-term condition with the potential for severe complications, has high health costs. For example, the total direct health care costs for a person with diabetes are approximately three times those for people without diabetes*"[24].

5.2 These costs represent a very heavy burden on the country's health budget, and, indirectly on all taxpayers. Importantly, the cost burden of obesity and Type 2 diabetes also needs to be considered from a broader non-fiscal perspective, involving economic, social, cultural, and environmental well-being factors.

5.3 A fundamental and compelling message here is that the costs on preventative intervention will deliver significant cost savings across our health sector[25].

5.4 In addition, the increasing cost and resource burden on our health system from the growing demands of health care for obesity and Type 2 diabetes, and the associated complications, has adverse repercussions for the general health care of the public in general. This 'squeeze-out effect' threatens an already under pressure health system to have sufficient resources and budget to deliver full health services required by the country at large[26].

5.5 Therefore, greater and more effective measures to tackle and reduce New Zealand's obesity and diabetes crisis should directly benefit the government's fiscal purse, free up more health services to cater for other general public health treatment and contribute to better health outcomes for New Zealanders.

5.6 In this regard, DNZ strongly advocate the introduction of a Sugar Tax as just such a measure.

Costs of Type 2 diabetes

5.7 Several studies and Treasury's own health care cost-benefit tool substantiate the enormity of health service costs expended in treating diabetes and obesity related illnesses.

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[24] "Living Well with Diabetes – A plan for people at high risk of or living with diabetes 2015-2020", the New Zealand Ministry of Health

[25] This fundamental message was at the core of the PwC Report "Type 2 Diabetes: Managing for Better Health Outcomes" that concluded, *that there is potential to make significant savings through increased expenditure on prevention and early detection…..an increased investment of $60 million a year (in 2008 dollars) in prevention, self-management and early detection services for Type 2 diabetes has the potential to reduce the government's health expenditure by as much as $260 million in 2022. As well as this reduced cost to the taxpayer, at the same time there will be increased services focused on improving the health and well-being of New Zealanders.*

[26] This threat is acknowledged by the MoH. In its 5 year plan, "Living Well with Diabetes – A plan for people at high risk of or living with diabetes 2015-2020", the MoH state, *The increasing prevalence of diabetes in New Zealand will have a major impact on the health system. This is because more people will need to access secondary and tertiary health services for treatment of the complications associated with primary health care support to help manage their disease, as well as diabetes*.

5.8 PWC was commissioned by DNZ to undertake a report – *Type 2 Diabetes: Managing for Better Health Outcomes* in 2001, which provided modelling of government health costs for Type 2 diabetes services. This model was updated in 2007[27], and again in 2008, where the costs for public health services for people with Type 2 diabetes was modelled then (2008) at $600 million per annum.

The model also projected that based on then current services and treatments, these costs could be expected to reach $1.310 billion per annum by 2016/17 (based on MoH prevalence data), growing further to $1.770 billion per annum by 2021/22.

The PwC 2008 updated model costs closely approximate another Study on the health care costs analysed from obesity related illnesses in 2006, which allocated $526m to the treatment of Type 2 diabetes[28].

5.9 While it is accepted that differences and mis-matches will exist in the figures, this extrapolated model of the country's health spend on Type 2 diabetes represents some **8.1%** of the total Crown Health budget spend for the same 2016/17 period of $16.2 billion[29]. By any measure, this is a very disturbing proportion of the country's total health budget.

5.10 A further study conducted in 2008 concludes that cardiovascular disease and diabetes accounted for a substantial and disproportionate share of health care expenditure by the Counties-Manakau District Health Board[30]. The following Table from that report is demonstrable.

Table 5. Age standardised health care cost per year for people with CVD or DM compared to people without CVD or diabetes (aged 15 or above) in 2008.

Age standardised cost per person	Hospital, Pharmaceutical Laboratory cost
Person with CVD or DM	$3,054
Person without CVD or diabetes	$673
Person with CVD or DM in the year prior to death	$21,600
Person without CVD or diabetes in the year prior to death	$11,800

5.11 The 2017 Treasury healthcare cost-benefit analysis[31] draws on the above CMDHB Study and applies adaptations to update the associated healthcare costs as follows:

[27] diabetes.squiz.co.nz/__data/assets/pdf_file/0016/11806/OutcomesModelUpdate.pdf (PWC's Report and Outcomes Model Update, is the most commonly cited reference of costs of diabetes in New Zealand)

[28] Refer *Health care and lost productivity costs of overweight and obesity in New Zealand*; Australia and New Zealand Journal of Public Health; 2012, Vol.36, No.5; https://www.ncbi.nlm.nih.gov/pubmed/23216496

[29] https://treasury.govt.nz/information-and-services/interest-areas/health. Being here $1.310/$16.200

[30] Health care costs related to cardiovascular disease and diabetes in CMDHB in 2008; W Cheuk Chan, G Jackson, D Papa, January 2010. www.countiesmanukau.health.nz/...and.../health.../2008-health-care-cost-related-cardi...

[31] www.treasury.govt.nz/publications/guide/cbax-spreadsheet-model; Refer Impacts Database, Rows 107-112

Healthcare per person Diabetes/CVD	Value (Healthcare costs evaluated)
Per-person with Diabetes	**$4,249**
Per-person without Diabetes	**$918**
Marginal value in avoiding Diabetes	**$3,331**
Per-person with CVD	**$7,402**
Per-person without CVD	**$918**
Marginal value of avoiding CVD	**$6,484**

5.12 The Treasury cost-benefit impact analysis lends credibility to the 2008 data and starkly demonstrates just how costly it is to treat and care for diabetes related health issues. The MoH health plan for managing diabetes 2015-2020 reflects the figures above that the total direct health costs for a person with diabetes are approximately three times those for a person without diabetes.

Costs of obesity

5.13 In the same vein, the cost burden of overweight and obesity in New Zealand is considerable. In a 2006 study[32], health care costs attributable to overweight and obesity were estimated to be $624 million, or 4.4% of New Zealand's total health care expenditure in 2006. Added to this, the study estimated that an additional $100 million to $225 million was costed to lost productivity. The combined upper end costs of health care and lost productivity from the incidence of (high) obesity in New Zealand was nearly $850 million.

This study examined health care costs from hospital (inpatient /outpatient) services, allied health professional costs, G.P. visits, residential aged care, pharmaceuticals and laboratory tests across co-morbidities, such as Type 2 diabetes, stroke, ischemic heart disease, osteoarthritis, colorectal cancer, postmenopausal breast cancer, uterine cancer, and kidney cancer. As such, some overlap of costings exists with these figures and those above for Type 2 diabetes health care costs.

5.14 In addition to these hard health care costs of obesity, there are a range of substantial non-health impacts of obesity that have a wider social cost. A review of the impact obesity has on New Zealand's economic, social, cultural, and environmental well-being was undertaken in 2014/15 by NZ IER for Superu[33].This review concluded that "*obese people experience a range of non-health impacts and some evidence suggest that these impacts are much greater than the health costs most commonly associated with obesity".*

[32] Refer *Health care and lost productivity costs of overweight and obesity in New Zealand*; Australia and New Zealand Journal of Public Health; 2012, Vol.36, No.5; https://www.ncbi.nlm.nih.gov/pubmed/23216496

[33] superu.govt.nz/costsofobesity

These costs threaten to overrun the health system

5.15 The Mexican Health Secretary Jose Cordova said that diabetes will bankrupt his country's health system in the next decade if nothing is done to improve the situation. The PwC Report referred to above has projected that the cost for our healthcare services to treat people with Type 2 diabetes will reach a staggering $1.8 billion by 2021/22.

5.16 As has been the case in the majority of countries, the costs to the health budgets are blowing out in dealing with Type 2 diabetes and its complications. These costs are creating considerable pressure on our hospitals and District Health Boards that run to constrained governmental budgets. The risk here, and a real one at that, is that the treatment of Type 2 diabetes and all its complications will squeeze out the funds and resources available for wider health services.

5.17 In this regard, the New Zealand *Parliamentary Inquiry into Obesity and Type 2 Diabetes in New Zealand in 2007*[34] stated: "*Diabetes services throughout the country are overloaded and delivery is inconsistent across District Health Boards (DHBs). Hospital dietetic services are not available for all patients who need dietary advice, and outpatient support service for those with obesity or diabetes is available in some districts only for patients with co-morbidities".*

5.18 DNZ itself confronts a "tsunami" of needs from our country's vast population with diabetes and despite the enormous input, efforts and goodwill of all our staff and many volunteers in improving the health and wellbeing of many thousands of affected New Zealanders, we lack the necessary resources and funds to make a difference in the lives of far too many people.

[34] https://www.parliament.nz/resource/0000026433

6. Tougher government intervention is necessary

6.1 Given the sheer scale of New Zealand's diabetes and obesity population, the increasing year-on-year numbers who develop these long-term conditions, and the massive health care and social and economic impact costs, the call to governmental action has never been stronger.

6.2 Since 2002 successive government and ministry initiatives have been put in place to tackle obesity and diabetes in New Zealand.

The New Zealand *Parliamentary Inquiry into Obesity and Type 2 Diabetes in New Zealand in 2007*[35] represents a comprehensive review of these labelled 'epidemics' that concluded that the severity of the problem demanded an urgent, concerted, and sustained public-health approach to manage the issues. This conclusion is just as germane today.

Snapshot of major Government and Ministry actions

6.3 The following is a snapshot of major initiatives undertaken under successive governments in response to the growing diabetes and obesity crisis. These actions are revealing for the non-tax strategies deployed.

- 2000 NZ Health Strategy - improving nutrition as a way to reduce obesity
- The 2002 launch of "Healthy Action – Healthy Eating", targeted at more at risk and disadvantaged groups such as the poor and Maori.
- Free annual consultations were provided to people with diabetes under the 'Get Checked' programme
- In 2004, the Government signed the Health of our Nation Accord, an industry led 'agreement' with the Food Industry Group to work toward healthier eating in a bid to reduce obesity[36].
- The 2005 initiated Fruit in Schools programme (for 114 low decile schools).
- The 2007 launch of the B4 School programme aimed at compulsory health checks for four-year olds, including weight measurement.
- Healthy eating guidelines were introduced by Labour and then scrapped by National.
- Physical activity became a focus in 2008 with the Kiwisport initiative.
- In 2014, MoH dropped its Get Checked programme in favour of a new Diabetes Care Improvement Package - a community and primary care-based programme, building on core diabetes services
- In 2014 Healthy Families NZ was an anti-obesity initiative from Australia, which backed community-led efforts to encourage healthy eating and exercise.
- The Health Star Rating system is a 2014 trans-Tasman Government led initiative for food companies to (voluntarily) rate packaging on basis of nutritional value.
- In 2015 the Childhood Obesity Plan introduced initiatives to identify, help and prevent obese Kiwi kids and stop others from becoming overweight.

[35] https://www.parliament.nz/resource/0000026433

[36] Of note from this is the Voluntary Schools Beverage Agreement (VSA) in 2009 which heralded NZ's two major company's Coca-Cola Amatil New Zealand, and Frucor Beverages withdraw the direct supply of full sugar carbonated soft drinks from all New Zealand schools.

6.4 As seen from above, government policies have varied from healthy food and better nutritional encouragement, to health sector offerings, to sports and greater activity incentives across national levels, and also targeted community groups.

6.5 The distinctive feature of the above government led health programmes is the absence of any hard-hitting regulatory or legislative intervention or penalty impost such as a taxation. The policies touched on may be described as a faciliatory approach which seek to “influence” rather than “prescribe” a change in individual poor health behaviours.

6.6 By comparison, a more prescriptive approach is evident in the government’s war on tobacco, which DNZ regards as compelling precedent how to change habits and behaviours that have chronic health outcomes. Using high tax and price inflating measures was shown as being a blunt tool which had direct and impactful consequences in reducing smoking.

6.7 DNZ considers that the policies above are necessary since tackling the obesity and Type 2 diabetes epidemic requires a multi-faceted approach, as was clearly identified in the 2007 Parliamentary Inquiry. However, DNZ believe that given the extent of the bad health obesity and Type 2 diabetes crises that a sharper and more direct intervention with a Sugar Tax is a necessary addition to the overall combative arsenal.

7. The effectiveness of a Sugar Tax

7.1 Camilla Cavendish, author of Soft Drinks Industry Levy, as former head of policy under David Cameron has stated, *"making things more expensive does change people's behaviour in a way that I'm afraid all the leaflets we have all read over the years and all the newspaper articles fundamentally don't".*

DNZ considers that this statement is an accurate reflection of just where New Zealand is at following many years of non-tax strategies to combat unhealthy behaviours leading to our obesity and Type 2 diabetes epidemic. We are still confronting a growing, rather than a reversing trend in population obesity and Type 2 diabetes which brings into question the overall effectiveness of education and information campaigns alone.

7.2 DNZ contends that blunter government intervention in the form of taxation is necessary.

In this respect there is ample evidence of the effect of excise taxes and price increases from the success of the New Zealand governments' war on tobacco and cigarette consumption. In addition, there is a growing trend by many countries to introduce a Sugar Tax (in some form), and the recent introduction of the Soft Drinks Industry Levy in the United Kingdom and Ireland deserve particular attention by the TWG.

7.3 There is a growing body of research and literature about the effectiveness of a Sugar Tax, both in terms of whether it results in a marked reduction in the consumption of SSB's, and also of the improved health benefits. While these reports do vary in the conclusions reached, one thing remains clear and that is the decisiveness of a great many countries to put a stake in the ground and declare their resolve to tackle the enormous health crisis from obesity and Type 2 diabetes.

The 'sugar tax' precedent trending with other countries can't be ignored

7.4 Nearly 30 nations have introduced some measure of taxation in the form of a Sugar Tax all with the combined aim of countering the increasing prevalence of obesity and Type 2 diabetes and reducing the dire health consequences of the nation. More countries are actively considering their position.

Notable amongst these nations are Mexico (2013/14), France (2012), Hungary (2011), Norway (increased level of tax 2017), UAE (2017), South Africa (2018), United Kingdom (2018), Ireland (2018), USA City Taxes (incl. Berkeley, San Francisco, Philadelphia, Oakland, Boulder, Seattle).

7.5 The UK / Ireland Sugar Tax provides a good case example for New Zealand. Following many years of political resistance to introduce a sugar tax (with politicians claiming insufficient evidence existed around the effectiveness of a sugar tax), these governments boldly stepped forward in 2016 with a 'profound move' to introduce a Soft Drinks Industry Levy.

The then Chancellor of the Exchequer, George Osborne, stated in his budget address announcing the Soft Drinks Levy – *"I am not prepared to look back on my time here in this Parliament, doing my job and say to my children's generation 'I'm*

sorry. We knew there was a problem with sugary drinks. We knew it caused disease. But we ducked the difficult decisions and we did nothing."

7.6 DNZ believes that the 30 or so jurisdictions that have introduced some form of Sugar Tax have a genuine concern for this health crisis and are committed to act decisively by regulation. These 30 examples lend considerable weight to the viability and effectiveness of sugar taxes and the TWG must take note of this level of credibility about the use of taxation to drive affirmative health outcomes.

In short, the scale of the problem is now too great to ignore, and sharper measures in the form of a Sugar Tax are essential if this country is serious about promoting the good health and welfare of New Zealanders.

Strong precedent with tobacco taxes

7.7 New Zealand has a smoke free target by 2025. Since 1997, the smoking rate amongst New Zealanders has dropped nearly 10%[37]. This success must be attributed to considerable political will-power and decisive actions with a range of campaigns, most notably the government's aggressive taxation increases on cigarettes and tobacco.

This is a demonstrable example of how interventionalist fiscal policy can change consumer behaviours. It is also a strong precedent about the influence of price increases on reducing consumer demand for health poor products.

7.8 We accept that differences exist with a tobacco tax and a sugar tax. Most notably, people can live entirely without tobacco, they can't live entirely without sugar. But, people can live without added sugars, and foods overly-rich in sugar content.

7.9 Given that SSB's have been identified as the single biggest contributor to obesity and Type 2 type 2 diabetes, it seems reasonably clear that these can and should be targeted by way of a rifle-shot taxation approach.

In its message to world leaders to tax sugar to reduce obesity and Type 2 diabetes rates, the International Diabetes Federation has stated[38] – *"It is well established that heavy taxation on tobacco and relentless reinforcement of the message that tobacco is unhealthy has had a very good effect. It is time now that we adopted a similar approach with sugar".*

7.10 DNZ urge the TWG to closely consider the benefits of this country's political commitment to aggressively taxing tobacco as a proven example of how leveraging the taxation system can generate better health outcome for New Zealanders.

[37] Refer, Facts & Figures, Health Promotion Agency, Smokefree.org.nz. Smoking rates are now less than 16%.
[38] International Diabetes Federation message to the Group of 20 (G20) of the world's major advanced and emerging economies, who are meeting in Turkey on 15th-16th November 2015.

What type of 'sugar tax'?

7.11 It is beyond the scope of this submission to examine the taxation options with any sort of Sugar Tax. However, the following brief observations have relevance to DNZ's stance here.

7.12 Differing approaches to taxing sugary drinks exist. Commonly, such taxes are imposed as excise taxes in the form of a sales tax at the point of sale to public consumers (on a basis proportional to the level of calorific or sugar content).

An excellent research report on the types of tax impost used by countries is contained in *Curbing the Consumption of Soft Drinks in New Zealand: Is Tax the Solution?*[39]

7.13 The UK and Ireland Soft Drinks Industry Levy is imposed at the manufacturer and distributor level on bands of total sugar content (First, at 5gms per 100ml; second for drinks over 8gms per 100ml). The expectation is that the price per litre unit of SSB's at the lower level would rise by 18p, and that of the higher level by 24p[40].

Taxation at the point of sale, or at the manufacturer/ distributor level, will ultimately bear on the consumer, although with the latter impost, this depends on the pass-through price rate to consumers. Camilla Cavendish, author of the UK Soft Drinks Industry Levy has said *"The sugar tax on drinks is not a tax on customers, it is a tax on manufacturers. The whole point of it was to get manufacturers to change the ingredients of the product".* The reality is that industry will pass on additional costs to their customers in some shape or form.

7.14 DNZ agrees with the World Health Organisation that the more visible the tax impact is on the shelf price, the greater the behavioural change made in response to it[41].

7.15 The response from the soft drink industry in the UK was swift and material. Between announcement date in 2016 and implementation date 6th April 2018, significant reformulation of soft drinks took place across the industry rendering considerably more SSB's with a sugar level below the 5% level, thus avoiding the tax (this despite industry protestations that it would be impossible to reformulate the ingredients). UK policy makers deemed this industry response an immediate success of the Soft Drinks Levy.

7.16 Both of the International Diabetes Federation and the World Health Organisation rely on evidential research in recommending that taxation is required at levels that results in price rises by at least 20% to be effective in changing behaviours and reducing SSB consumption materially[42]. This approach draws on the effectiveness of price increases with tobacco taxes. In this sense, product pricing is

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[39] *Curbing the Consumption of Soft Drinks in New Zealand: Is Tax the Solution?;* Lin Mei Tan - Senior Lecturer School of Accountancy, Massey University, and James Xun Liu Accountancy intern Bank of China; New Zealand Journal of Taxation and Policy (2014) 20 NZJTLP 203.

[40] The UK Soft Drinks Levy: what's the impact of the 2018 'sugar tax'? By Market Analyst Joshua Warner, of IG (IG Markets Limited, 27 February 2018.

[41] *Fiscal policy to improve diets and prevent noncommunicable diseases: from recommendations to action;* 20 December 2017 revised version; www.who.int/bulletin/volumes/96/3/17-195982/en/

[42] *Fiscal policy to improve diets and prevent noncommunicable diseases: from recommendations to action;* 20 December 2017 revised version; www.who.int/bulletin/volumes/96/3/17-195982/en/

seen as a potent way to discourage consumption and achieve healthier outcomes. The research piece *Curbing the Consumption of Soft Drinks in New Zealand: Is Tax the Solution?* references trialled studies on New Zealand supermarket pricing and consumer behaviour that the authors estimate that a 10% tax on SSBs could lead to a 13% decrease in population purchases of SSBs[43].

7.17 A common criticism of a Sugar Tax is that it is a regressive tax[44]. This criticism is that a Sugar Tax will have most impact on people with lower incomes who spend a higher proportion of their income on food and beverages, and this is seen as inequitable. However, contrary views exist which counter balance this criticism. Notably, that socio-economic deprived groups who typically consume high levels of SSBs would be highly impacted and so reduced consumption would have most effect[45]. Equally, it is thought that lower income groups are more price sensitive, and therefore resulting changes in buying patterns away from SSBs would offset the regressive nature of a Sugar Tax.

A tax impost approach (unlike a subsidy approach) to promote healthy outcomes will commonly have a degree of regressive inequality, however this should be justified where greater benefits are derived from those disadvantaged groups. This was, and is, clearly the case with tobacco taxes, and parallels exist with a Sugar Tax on SSBs.

7.18 Another form of tax leveraged intervention is the zero-rating or exemption from sales or value add taxes (such as our GST) for targeted healthy foods and drinks. This approach exists within Australia and the UK with concessions for healthy foods, such as fruits and vegetables. New Zealand's indirect Goods and Services Tax is a broad based, no exemptions system, that is regarded highly on an international scale. We understand that policy makers are steadfast on the existing no exemptions system rather than introducing a subsidy in the form of zero rating or exempting GST on selective drink and food items.

7.19 However, there is considerable logic to the 'push me / pull me' effect of tax pricing bad consumables while subsidising good consumables. To this extent, it has been forwarded[46] that a most impactful approach is a two-pronged one that taxes unhealthy drinks, and also offers thin subsidies to price reduce healthier alternatives, such as water. This could be tax neutral with the revenue from sugar taxes funding the thin subsidy.

7.20 DNZ believe there is considerable merit in this double-up, two-pronged taxation approach as one that can have greatest impact on changing consumer behaviours, and accordingly we urge the TWG to look at how a thin subsidy in the form of GST relief might be achievable.

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[43] There is much literature on the Price Elasticity (of supply and demand) of food and beverages, and the resulting changes in consumption. Refer here again to *Curbing the Consumption of Soft Drinks in New Zealand: Is Tax the Solution? Ibid.*

[44] "*Implications of a Sugar Tax in New Zealand" Incidence and Effectiveness";* Alasdair Gardiner; New Zealand Treasury Working Paper 16/09, November 2016

[45] In Mexico, two years after the introduction of a tax on sugary drinks, households with fewest resources reduced their spend on sugary drinks by 11.7%, compared to 7.6% for the general population; World Health Organisation paper – Taxes on sugary drinks" Why do it?; 2017, citing - Colchero, MZ RJ Popkin, BM, Ng SW.In Mexico, evidence of sustained consumer response two years after implementing a sugar-sweetened beverage tax. Health Aff 363(3):564-571;2017

[46] See for example *Curbing the Consumption of Soft Drinks in New Zealand: Is Tax the Solution; Ibid N.35*

Creating a 'bow wave' to change behaviours

7.21 As noted earlier, a Sugar Tax will represent a more 'prescriptive' approach from the current 'influential' approach and with this New Zealanders will receive a very loud message about reducing their SSB intake to improve their health. We consider that this messaging would likely have other upside benefits by encouraging wider healthy option taking behaviours from the public at large.

7.22 DNZ believe that a Sugar Tax will constitute a political 'bow wave' that will strike more directly at reducing consumption of SSBs and the harmful effects that arise. The 'bow wave' effect will build much needed attention to healthier dietary choices by the public, and inevitably turn buyer behaviours for the better.

7.23 Type 2 diabetes requires combative actions on a multi-faceted basis. DNZ has long-advocated that many viable actions are available and essential to build into a comprehensive yet integrated Type 2 diabetes prevention campaign, and that this is necessary to make meaningful inroads to reversing the prevalence trends[47]. In this regard, DNZ endorses the excellently crafted call to action recommendations of the Report of the Parliamentary Health Committee Inquiry into Obesity and Type 2 Diabetes in New Zealand, as well as recommendations of the International Diabetes Federation and World Health Organisation[48] for intervening to reverse the growing prevalence of obesity and Type 2 diabetes.

Need for 'political will-power'

7.24 The previous Minister of Health, Dr Jonathan Coleman dismissed calls for a sugar tax claiming that *"there is no evidence that a sugar tax decreases obesity rates".* This follows several New Zealand reports that looked at the evidence for introducing a Sugar Tax.

7.25 Alasdair Gardiner's 2016 Treasury Working Paper[49] stated that there was insufficient conclusiveness about the effectiveness of sugar taxes. That paper did acknowledge that the majority of studies (9 of 13) *provided evidence to show that a sugar tax could be effective in reducing obesity rates, [*and achieving better health outcomes*], when set at a sufficiently high rate, and when introduced as part of a broader policy package to tackle obesity.* However, Gardiner reported that limited evidence existed about the 'substitution effect', that is, whether consumers retreating from higher priced sugar drinks would substitute other unhealthy products, or healthier choices. (This point underpins our contention that a double-edged taxation

[47] These range from clearer and stronger food labelling on sugar content; guideline limits on food and beverage advertising and promotions; reinvigorated school campaigns about family health and eating options; healthy lifestyle awareness; water only schools; more city and town water fountains; government and community pressure on the Food and Beverage Industry to focus on healthier foods and drinks and de-focus less healthy alternatives, and more.

[48] *" Fiscal Policies for Diet and Prevention of Noncommunicable Diseases";* Technical Meeting report, World Health Organisation, 5th-6th May 2015, Geneva, Switzerland

[49] "*Implications of a Sugar Tax in New Zealand" Incidence and Effectiveness";* New Zealand Treasury Working Paper 16/09, November 2016,

and "thin subsidy" approach represents an optimal approach – refer para 7.18 – 7.20 above).

7.26 The NZIER 2017 report to the Ministry of Health[50] undertook a comprehensive review of the literature and from that review concluded that insufficient evidence exists that sugar taxes have an identifiable impact on better health outcomes. While this Report agreed that taxes are passed through to prices with reduced demand consequences, it found a lack of any conclusive real experience studies of any material reduction in sugar intake.

7.27 The current Minister, David Clark appears to have adopted the pre-existing same party line, and prefers an industry led self-regulating approach involving the voluntary reduction of sugar content by soft drink makers[51]. This approach mirrors the Health of our Nation Accord with the Food Industry Group back in 2004, which also had a backstop regulatory threat, but resulted in only modest progress toward healthier outcomes from the Food Industry until 2009, and then piecemeal moves thereafter.

7.28 DNZ again highlights the UK example which not unlike New Zealand reveals a long period of doubts and reticence toward the introduction of a Sugar Tax until the realisation that the dire health evidence within the UK with obesity and Type 2 diabetes was just too overwhelming to ignore. Of particular relevance here, Camilla Cavendish, author of Soft Drinks Industry Levy, as former head of policy under David Cameron commented *"There was an onslaught from the companies – every company said they couldn't possibly reformulate it. It would be impossible to change their ingredients, it would be impossible to take the sugar out. Here we are, three months before the tax comes in, and every single company, except one, has already reformulated its drink to avoid the tax. I think this is a huge success".*

(As noted below, DNZ has reservations about the motives of soft drink companies and related industry to fully commit to product changes that promote healthy outcomes).

7.29 The missing point to all this is that little evidence exists that the governmental non-tax strategies for reducing Type 2 diabetes and obesity is making tangible inroads to that goal. This salient point was at the forefront of a concerted appeal to Government by 74 expert health professors calling for a sugary drinks tax[52]. The signatories agree that the evidence supporting sugary drink taxes is stronger than the evidence for any of the 22 strategies in the government's childhood obesity action plan.

7.30 Finally, we draw on the wisdom of ex-Prime Minister the Rt Hon Helen Clark (who for some years was Minister of Health) with her response to this country's appalling obesity rates pleaded that *"whoever's in government needs to implement strong policy to stop this epidemic now".* DNZ contend that this message begs a regulatory response.

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[50] *"Sugar taxes – A review of the evidence";* NZIER report to the Ministry of Health; August 2017

[51] Refer Thomas Coughlan from Newsroom, 8 February 2018, and Rachel Thomas from Stuff Health 8th March 2018 (*The Sugar fix: Is it right to target sugary drinks?)*

[52] *An open letter to Cabinet Ministers from 74 health professors calling for a sugary drinks tax;* Convened by Professor Boyd Swinburn, University of Auckland, April 2016

Industry Reactions

7.31 The soft drink industry is confronting a rising tide of protest about the poor health consequences from its SSBs. As noted from the UK, this industry has only meaningfully begun to change its product mix to offer more lines of low and no sugar drinks with the introduction of sugar taxes by more and more countries.

In June 2017, Coca-Cola launched its new brand of 'Coke No Sugar', and other SSBs are being reformulated. While this signifies progress from the soft drink industry in terms of healthier choices, the jury remains out over the consumer impact in response to these new product lines in the absence of any price influence to substitute to low / no sugar content drinks.

7.32 We also note that a number of countries have introduced sugar taxes on both added sugar and artificial sweetener drinks[53]. Related to this, studies cast doubt on the healthier effects of artificially sweetened beverages (ASBs), one such observation[54] being - "*ASBs stimulate sweet taste receptors—which could theoretically increase appetite, induce preference for sweet taste, and modulate gut hormone secretion—or result in overconsumption of solid foods due to awareness of the low-calorie content of ASBs"*.

7.33 Like many, DNZ harbours serious reservations about a vested interest and conflicted soft drink industry advocating self-regulation of SSBs as part of its responsibility to promote public health. To this end we reiterate the relevance of comments by Camilla Cavendish[55], author of Soft Drinks Industry Levy, on industry responsiveness becoming truly active following the introduction of a tax (colloquially known as a 'stick over carrot approach').

[53] For example France and the Philippines

[54] "*Artificially Sweetened Beverages and the Response to the Global Obesity Crisis";* MC Borges; January 2017; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5207632/

[55] *"There was an onslaught from the companies – every company said they couldn't possibly reformulate it. It would be impossible to change their ingredients, it would be impossible to take the sugar out. Here we are, three months before the tax comes in, and every single company, except one, has already reformulated its drink to avoid the tax. I think this is a huge success".*

8. Fiscally positive dual effect of revenue raising and cost savings

8.1 The TWG will be extremely mindful of the positive fiscal results that a health driven Sugar Tax will generate.

8.2 Nations that implement a Sugar Tax typically appropriate the revenue raised from such a tax toward healthier action plans on several levels. The UK estimate of taxes raising £520 million a year be earmarked for increasing funding of sport in primary schools.

8.3 We acknowledge that as sugar taxes bite and cause a change in SSB contents to a lower sugar content, there will be a resulting drop in tax revenue gained (a successful outcome).

8.4 From a New Zealand perspective, Treasury are best placed to analyse the likely tax revenue gains from introducing a Sugar Tax. However, we do note that a sugary drinks tax was expected to raise $30 million to $40 million in New Zealand by a study by the University of Auckland[56]. Further, that finding advocated the use of this revenue to boost funding for obesity prevention programs.

8.5 There is of course a dual effect from sugar taxes that is fiscally positive also. That is the reduction to this country's massive and increasing health cost burden in treating diabetes and obesity related illnesses as positive outcomes emerge from changing current poor health options amongst our population. The cost savings that flow from positive health outcomes represents the dual advantage to the country's health costs that can be expected to yield from a Sugar Tax. (refer section 5 of this submission).

8.6 It has been suggested that over 10 years, a tax on sugary drinks of 1 cent per ounce in the United States of America would result in more than UD$17 billion in healthcare cost savings[57]. The DNZ commissioned PwC report[58] is clear on the financial benefits to future health care costs from the adoption of earlier preventative measures.

8.7 From the above, there is no financial barrier to New Zealand taking actions with a Sugar Tax. In fact, the evidence suggests that such an action would pay considerable dividends to our health budget, and taxpayers in general.

8.7 While these fiscal benefits are a significant factor in the case for a Sugar Tax, it goes without saying that the more important and compelling factor is the improvement in the health and wellbeing of New Zealanders.

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[56] Refer *An open letter to Cabinet Ministers from 74 health professors calling for a sugary drinks tax;* Convened by Professor Boyd Swinburn, University of Auckland, April 2016

[57] Refer Taxes on sugary drinks: Why do it?; article by World Health Organisation, 2017, quoting WangYC, Coxson P, Shen Y, Goldman L, Bibbins-Domingo K; *A penny-per-ounce tax on sugar-sweetened beverages would cut health and cost burdens of diabetes*. Health Affairs, 2014; 31, no 1:199-207

[58] Refer to para. of this Submission at 5.8.

Appendix – About Diabetes New Zealand

Diabetes New Zealand Inc is New Zealand's leading organisation representing and supporting all New Zealanders with diabetes. The organisation is a not-for-profit charity (CC11432) that has been working to improve the lives of people with diabetes for over 50 years.

We have a National Office in Wellington, and branches across the country with staff and volunteers. Diabetes New Zealand is affiliated with 168 country and territory organisations all over the world through its membership and representation to the International Diabetes Federation in Brussels.

The vision of the International Diabetes Federation is to promote diabetes care, prevention and a cure worldwide.

Diabetes New Zealand and its branches undertake the following work:

1. Leadership and Advocacy – at national level as the voice for people with diabetes with diverse representation to Government, Ministry of Health, Pharmac, and other agencies and organisations (such as NZSSD – the New Zealand Society for the Study of Diabetes), as well as pharmaceutical companies. At local levels, our branches liaise, lobby and advocate with District Health Boards, Primary Health Organisations, and many related health providers.

2. Education, Awareness and Profiling – this involves a full suite of initiatives, from web- based data about diabetes, to information brochures and resources, community based courses and presentations, workplace diabetes and wellness presentations, and mobile awareness services, the HOPE programme (Healthy Options Positive Eating), events and functions.

3. Support – to people with diabetes through support groups and meetings, education sessions, self-management assistance, help lines, a variety of shopping and nutritional courses, and more.

4. Youth – a sub-set of DNZ involves Diabetes Youth which is dedicated to Type 1 diabetes children, including newly diagnosed care and help, peer group social media, children camps and excursions, and other support activities.

5. Prevention – through education programmes to the wider community, mobile awareness van, the HOPE programme, diabetes risk assessments and testing, and information dissemination.

6. On-line Shop – providing information and a wide range of specific diabetes supplies.

7. Research – on a limited basis, funds are made available for projects that further the research and study into diabetes related causes.

Diabetes New Zealand is a not-for profit organisation that is reliant on funding from an assortment of generous grants, member subscriptions, self-fundraising events, donations and bequests, and some investment income. The organisation receives Ministry of Health funding for brochures and awareness campaigns but no government funding for the provision of the extensive support services it provides within the community.