Tax Working Group
Te Awheawhe Tāke

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Submission to the Tax Working Group on the Future of Tax

From:

SHORE and Whariki Research Centre, Massey University

The SHORE & Whariki Research Centre is a full cost-recovery research centre within the College of Health, Massey University. The research team has expertise in a number of fields including alcohol and other drugs, Maori health research, effects of place on health, identity, mental health and resilience, vulnerable populations, youth mental health, nutrition, body image, sexual violence and housing. The team's methodological expertise is wide ranging and includes the design and implementation of social survey research, formative, process and outcome evaluation, community action research, GIS, Kaupapa Māori research and a number of qualitative methodologies.

WHO Collaborating Centre

The Research Centre is designated as a WHO Collaborating Centre in Research and Training in Alcohol and Drug Abuse, one of four WHO Collaborating Centres in New Zealand. SHORE was re-designated in 2016.

This submission was prepared by **Professor Sally Casswell**, PhD, FRSNZ, ONZM, Co- director SHORE & Whariki Research Centre

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We have read and support the overall thrust of the submission made by the Department of Public Health, University of Otago, Wellington, particularly regarding the need for New Zealand to move towards social wellbeing being the 'paramount aim of tax and social policy in order to reduce inequality, achieve social justice, and attempt to avert environmental disaster'.

This submission is confined to discussion and recommendation about the use of excise tax on hazardous products (alcohol, tobacco and sugar) as a contribution to these overall objectives. In the global health community, there is currently an increased focus on excise tax on hazardous products for two purposes: first, to increase health and wellbeing and reduce health inequity and second to enable funding for financing of prevention and control of non-communicable diseases (eg heart disease, cancers) and health services in general. The use of excise tax has been explored in many contexts recently including the Lancet Taskforce on NCDs and Economics (Summers, 2018) and the Bloomberg Commission on Fiscal Policy for Health (Bloomberg Philanthropies, 2018).

One of the issues thoroughly covered in the research literature is that of regressivity, since this is an argument frequently raised in opposition to the use of excise tax on hazardous products. However, when the health benefits are taken into account these contribute to increasing equity as the adverse health effects, which are reduced, fall disproportionally on lower socio-economic people. Equitable outcomes can also be enhanced by the use to which taxation is put, for example, increasing health

services to support reductions in consumption and enhanced health services (Summers, 2018) or to reduce other regressive taxes (Whitehead, 2010). People generally support excise taxes more if they believe there will be an improvement in related services (Parry et al., 2017).

The remainder of this brief submission will focus on alcohol excise tax.

NZ's alcohol excise tax was reformed in the mid-1980s. There was a suggestion, supported by the alcohol industry that alcohol should not be subject to any specific tax. However, as Easton (2005) says: 'Fiscal prudence, political realities, and the vigour of the alcohol control lobby resulted in the imposition of a excise duty based on the quantity of absolute alcohol, so that wine and beer face the same tax for the same quantity of absolute alcohol.' Spirits are taxed at a higher rate reflecting the lower costs involved in their production resulting in a tax system in which the price reflects, approximately, the absolute alcohol in the beverage. A positive aspect of the New Zealand tax system is that every six months duty levels are automatically increased by the same amount as consumer prices. This means the government does not have to face criticism by passing legislation and it prevents the real value of the taxes falling. However, despite this, affordability of alcohol, particularly that of wine, was shown to increase 1988 - 2011 (Wall & Casswell, 2013) and again 2012 – 2017 (Health Promotion Agency, 2018) because the increases in price have not kept pace with increasing incomes. Off license sales (accounting for more than 70% of alcohol sales) are the cheapest way to buy alcohol and the HPA report points out it took less *time* in 2017 than in 1999 to earn enough to buy an averagely priced drink of beer, whisky or cask wine from a supermarket or liquor store. Wine sold in a cask is the most affordable type of alcohol. In 2017, it took only 2.1 minutes for a person on a median income to earn enough for an averagely priced drink of cask wine.

The issue of alcohol taxation was addressed in the context of reforming alcohol policy in 2009 -10 but no action was taken. The New Zealand Law Commission in their review of alcohol harm in New Zealand and in the process of deciding on evidence based and effective policy changes commissioned a review by an Australian consultancy (Marsden Jacobs Associates, 2010). This was described as 'a valuable contribution' by NZ Treasury who described alcohol excise tax, as a tax with relatively low welfare losses. The NZ Law Commission recommended a 50% increase in alcohol excise tax, which would result in a 10% increase in price but this was not implemented by government.

The establishment of a Working Group on Taxation in New Zealand provides a new opportunity for public health voices to enter the debate on the appropriate level of alcohol taxation.

There is strong evidence of the benefits of increased price of alcohol, most commonly achieved by excise taxes. alcohol taxation has been proven to be a singularly cost effective way to reduce consumption and harm (Anderson et al., 2009).

Globally researchers estimate that every 10 percent increase in the price of alcohol decreases consumption by between four and five percent, the same relationship as found with tobacco (Wagenaar et al., 2009; U.S. National Cancer Institute and World Health Organization, 2016).

The evidence shows heavy drinkers reduce their drinking (Chaloupka et al., 2002) and there is a clear relationship with harm which, in Finland, was found to impact more on people of lower socio-

economic status (Herttua et al., 2008). In addition the initiation of drinking/heavy use by younger people is delayed (Cook, 2012). In New Zealand evidence shows heavier drinkers (Casswell et al., 2014) and the heaviest younger drinkers choose lower prices (Wall & Casswell, 2017).

An argument often made (especially by lobbyists on behalf of the alcohol industry) is that excise taxes are inappropriate because they will impact on the moderate drinker. In fact, simply because the 'moderate drinker' purchases so much less than the heavier drinker the tax burden falls on the heavier drinker to a much greater extent. An increase in excise tax on alcohol might therefore be seen as increasing fairness to the extent this contributes to the externalities of alcohol use which otherwise are met by other forms of taxation including those paid by the moderate drinker. The argument regarding 'moderate drinkers' is also influenced by beliefs about health benefits of moderate drinking. However, while there is evidence of low levels of consumption reducing ischemic heart disease low levels also have detrimental effects, for example there is no threshold for breast cancer (Rehm et al., 2017), and this benefit should not influence policy aiming to reduce harm any more than the benefit of reduced Parkinson's disease from tobacco use (Hernán et al., 2002).

The arguments raised by alcohol industry lobbyist against excise taxation (and other effective policies) should be interpreted in the light of their conflict of interest. Research evidence, from the NZ arm of the International Alcohol (IAC) study, showed that 40% of their sales in New Zealand are consumed in harmful drinking occasions (based on measure of typical drinking per occasion of 8 plus drinks for men and 6 plus for women) (Casswell et al., 2016). For this reasons effective policies which reduce harmful drinking, such as alcohol taxation, are consistently opposed.

Data from the IAC study has also explored the proportion of the retail price of alcohol which is made up of excise tax in New Zealand. This is based on the prices paid by New Zealanders (and has been validated (Casswell, et al., 2014). It showed that less than 30% of the alcohol retail prices paid was made up of excise tax (Wall et al., 2017). This can be contrasted with the 70+% of tobacco price which WHO recommends should be contributed by excise tax and which New Zealand has achieved.

In conclusion it is recommended an increase in alcohol excise tax of 100% would be appropriate along with ongoing monitoring of retail prices in case other complementary approaches to control pricing are required.

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