



Australian Medical Association
Pre-Budget Submission
2023–24

Chapter 4: A health system for all

CHAPTER 4: A HEALTH SYSTEM FOR ALL

Overview

This chapter of the *AMA Pre-Budget Submission 2023–24* draws on the AMA research report [A tax on sugar-sweetened beverages: Modelled impacts on sugar consumption and government revenue](#) with some of the modelling adapted and extended to give estimates between 2022–23 and 2025–26.

Note: some of the costings in this budget submission are estimates from 2022–23 to 2025–26 to align with the costings outlined in the related AMA research reports.

Problem statement

There is an obesity crisis in Australia which is getting worse. In Australia, 31 per cent of adults and 8 per cent of children are obese. When including those who are overweight this increases to 67 per cent of adults and 25 per cent of children.¹ The prevalence of obesity in Australia is expected to continue to increase, with a third (33 per cent) of the projected adult population will be obese by 2025.² Obesity is a major risk factor for chronic and preventable conditions including type 2 diabetes, heart disease, hypertension, stroke, gall bladder disease, osteoarthritis, sleep apnoea and respiratory problems, mental health disorders and some cancers.

Sugar-sweetened beverages (SSBs) are a major contributor to the obesity crisis and provide almost no nutritional benefit. SSBs are drinks containing large amounts of 'free sugars' such as sucrose, high-fructose corn syrup or fruit juice. They deliver a high number of liquid calories but provide almost no nutritional benefit, with 8–12 teaspoons (33–50 grams) of sugar in the average 375 millilitre can of soft drink.³ Despite the high sugar content, Australians are consuming SSBs in huge volumes.⁴ In 2019–20, Australians consumed on average 70 grams of free sugar a day, with more than a quarter (18g) of this coming from sugary drinks.⁴ The AMA estimates that Australians drink 2.4 billion litres of SSBs per year.⁵

Policy proposals

The AMA recommends implementing an excise tax based on sugar content on selected SSBs, at a rate of around \$0.40/100g sugar, to reduce consumption, improve health outcomes, and lower the financial burden on the healthcare system. SSBs are a logical target for a public health intervention, given the high level of consumption of these products, which provide almost no nutritional benefit but make a major contribution to the obesity crisis, and to poor dental health, through high levels of free sugar.

A tax can deliver both a clear message for consumers that the product is unhealthy, and a tangible deterrent in the form of higher prices. An appropriately designed tax can also incentivise manufacturers to reduce the sugar content in their products. SSBs are also a practical target for a tax, as they are a discreet category that is easily identifiable.

SSBs subject to tax

This category of beverage typically includes carbonated and non-carbonated fruit, dairy/milk, sport, energy and cordial drinks containing free sugars, and excludes alcoholic and artificially-sweetened (diet) drinks. The AMA's proposal is to tax a subset of SSBs — all non-alcoholic drinks containing free sugars, excluding 100 per cent fruit juice, milk-based and cordial drinks. The focus is on drinks that provide no nutritional benefit.

Design of tax

The AMA recommends a sugar content tax, which is a sliding scale where the tax increases as the sugar content increases. A sugar content tax is the most logical option, given that harm is caused proportionate to the sugar content, not the value or the liquid volume. It is the only option that creates an incentive for manufacturers to lower the sugar content of their products, and therefore is the option most targeted at reducing sugar consumption.

Target of tax

The AMA recommends the tax be applied to domestic and international manufacturers of SSBs. The tax should be targeted at the manufacturer in order to incentivise reformulation. An excise (and customs) tax is the most logical option to do this.

Scale of tax

The AMA recommends a tax rate of \$0.40/100g sugar. The World Health Organization's recommendation is that a tax on SSBs would need to raise the retail price by at least 20 per cent in order to have a meaningful health effect.⁶ The proposed rate would have the effect of increasing the price of the average supermarket SSB by at least 20 per cent. SSB tax rates vary around the world. Several comparable countries to Australia have implemented sugar content taxes, some of which are set at a similar rate to that which is proposed. The tax would raise the price of a 375ml can of coke (which contains 40g sugar) by \$0.16 (see Table 1 in the [research report](#)).⁷



Risks and implementation

Public support

Australian surveys have consistently shown majority support for a tax on SSBs.⁸ Public support is even higher if tax revenue is hypothecated to fund initiatives to tackle obesity.⁹ A nationally representative survey undertaken in 2017 found 60 per cent of Australians support a tax on sugary drinks. This increased to 77 per cent support if the proceeds were used to fund obesity prevention.¹⁰

International success

SSB taxes in other countries have been successful in reducing consumption and incentivising reformulation of SSBs. Almost 60 jurisdictions across the world have implemented SSB taxes.^{11,12} There has been confirmed success already in a number of countries, including the United Kingdom (2018), Mexico (2014), France (2012), Chile (2014), Catalonia, Spain (2016) and in some US jurisdictions (Portland 1991; Cleveland 2003; Berkeley 2015), where robust evaluations have shown a drop in consumption following the tax.¹³

Pass-through of tax

There is no guarantee that an excise tax will be fully passed on to the consumer, as the retailer, wholesaler or manufacturer may choose to absorb it in part or in full. However, the international experience is that the SSB tax pass-through is sufficient to have an impact on consumption.¹⁴ The government also has a range of options to influence tax pass-through such as raising the tax over time.

Impact on obesity and healthcare expenditure

Reduced sugar consumption and improved diet would likely lead to a reduction in the prevalence of obesity and substantial healthcare savings. According to previous Australian modelling, an SSB tax that increases the retail price by 20 per cent would lead to a reduction in the prevalence of obesity of around 2 per cent, and healthcare expenditure savings of \$609 million to \$1.73 billion (over the lifetime of the population modelled).¹⁵

Impact on vulnerable groups

A flat tax will inevitably have a greater impact on lower income consumers of the taxed product, as a proportion of their expenditure/income. This regressive effect is reduced if there is an untaxed substitute that consumers can easily switch to.¹⁶ In the case of SSBs, healthy substitutes such as water are readily available and affordable to most people, and consumers can avoid the tax, as well as improving their health, by making this change.

When viewed holistically, an SSB tax could be considered a progressive measure, as lower socioeconomic groups, who are more likely to have poorer diets and be overweight and obese,¹⁷ would theoretically experience a disproportionate health benefit in response to the tax. There is also potential to use the revenue from the tax to implement initiatives that would produce a benefit for lower socioeconomic groups, such as targeted subsidies on healthy foods.

It must be recognised that price signals do not have the same relevance in remote communities where the water supply is unsafe and/or unstable, as there is no safe and affordable source of hydration to switch to. The impact of price rises in these areas must therefore be considered to avoid creating further disadvantage, with particular attention paid to the safety and availability of drinking water, and the price of bottled water. The AMA recommends implementing the tax alongside measures to ensure reliable, safe access to water and affordable hydration beyond SSBs.

Impact on sugar industry

There would be minimal impact on Australia's sugar industry as around 80 per cent of Australia's domestic sugar production is exported (averaged over the past decade),¹⁸ and only 5.3 per cent of total domestic production goes towards domestic SSB manufacture.¹⁹ The estimated change in SSB consumption due to the proposed tax is 12 to 18 per cent (scenario 1 in the [research paper](#)), which translates to a 0.64 to 1.01 per cent drop in demand for domestic sugar production. The domestic sugar market has a much greater level of volatility than this change.²⁰ The impact on the sugar industry is therefore anticipated to be minimal and does not appear to warrant a government assistance package. Government may wish to consider whether there are any specific small farmers that mainly supply the domestic market, who may warrant an assistance package (which could be funded from the tax revenue).

The risks of not taking action

There is a strong association between SSB consumption and increased energy intake, weight gain and obesity.²¹ Conversely, reduced consumption of SSBs is significantly associated with weight loss.²² People living with obesity have healthcare costs that are approximately 30 per cent greater than their healthy weight peers.²³ Many of these healthcare costs are borne by the government, with the AMA estimating that if no action is taken to stem the obesity crisis, by 2025 governments will have footed a further \$29.5 billion for the direct healthcare costs of obesity (over four years to 2024–25).²⁴



Timeframes and costing over four years

Original modelling by the AMA indicates a tax on select SSBs would reduce sugar consumption by 21 per cent in 2022–23 to 31 per cent by 2025–26. It would raise annual government revenue of \$740 million in 2022–23, falling to \$678 million in 2025–26.

Over four years, this would translate to government revenue of \$2,839 million between 2022–23 and 2025–26. More importantly, it would result in the reduction of 3.15 kilograms of sugar per person per year consumed through SSBs.

The rate of tax per 100g of sugar is indexed at an assumed 2 per cent between 2022–23 and 2025–26.

Table 13: Impact of implementing an excise tax on select SSBs

	2021–22 (baseline)	2022–23	2023–24	2024–25	2025–26	Total
Sugar per person from SSBs (kg/person)	8.90	6.91	6.54	6.10	5.75	-
Excise rate per 100g sugar (\$)	0	0.40	0.41	0.42	0.42	-
SSB revenue (\$m)	0	740	724	697	678	2,839
Estimated cost of administration to Australian Taxation Office (\$m)	-	2	0.5	0.5	0.5	3.5
Net revenue to government (\$m)	-	738	723.5	696.5	677.5	2,835.5

Revenue estimates have been derived using the more conservative price elasticity (in revenue terms) from the paper, derived from real-world impact evaluations of SSB taxes around the world (-1.00).²⁵

Consumption of SSBs would drop the most when the tax is first introduced. An assumption in this modelling is that manufacturers would reformulate their products to reduce the impact of the tax and to align with an accelerated consumer preference for healthier beverages. These two factors cause the revenue raised from the tax to fall over time. The rate of reformulation has been assumed to match a similar reduction in sugar per beverage (34 per cent) to what was seen in the UK following introduction of a similar tax, but across a longer timeframe of 5 years, whereas this occurred in the UK within 3 years.

In this modelling, the impact of the tax is compared to and built upon a 'no tax' scenario. In the no tax scenario, there is assumed to be growth in underlying beverage consumption due to Australian population growth, in line with flat consumption per person. There is also assumed to be a gradual move toward no and low sugar beverages at the rate of a 1 per cent increase in market share of those products each year, in line with the aggregate industry trend.²⁶

It is anticipated the government would use the existing ATO policies and processes responsible for excise and excise equivalent goods to administer the new SSB tax. It is assumed there would be an initial cost to set up new internal processes — an indicative estimate is given of \$2 million set-up cost and \$0.5 million per year thereafter for the ATO's ongoing compliance duties.



Other policy priorities

Preventive health

Investing in preventive health helps mitigate the onset of chronic illness, affords people longer and healthier lives, and reduces pressure on the health system. Prevention must become a foundation of healthcare planning and design. The AMA is calling for implementation of the National Preventive Health Strategy 2021–2030, including the commitment to allocate five per cent of health expenditure to prevention activities in the life of the strategy.

Aboriginal and Torres Strait Islander health

The AMA supports the National Agreement on Closing the Gap. This partnership gives Aboriginal and Torres Strait Islander leaders an equal seat at the table with all governments, and is designed to ensure Indigenous voices are prioritised in policy, budget and direction setting for policy across a broad range of areas.

Even so — the health gap remains persistent, and more effort is needed to ensure equity of access to culturally safe, response, affordable and accessible healthcare for Aboriginal and Torres Strait Islander peoples including:

- funding for Aboriginal and Torres Strait Islander health services is allocated according to need and under the advice of Aboriginal and Torres Strait Islander expertise
- expanding and investing in successful community-controlled health service delivery models, to allow Aboriginal and Torres Strait Islander organisations to deliver culturally safe and appropriate health services to their own communities
- investing in evidence-based strategies to grow the Aboriginal and Torres Strait Islander medical workforce
- ensuring cultural safety training is embedded across the medical profession.

Mental health

Three years into the pandemic, we have seen an increase in prevalence of mental ill-health to now impact almost one in four Australians at some point in their lifetime. We have also seen an increase in mental ill-health amongst young people who have been isolated from the normal freedoms and opportunities that define this significant time in life.

A comprehensive government response is needed over the long term to rebuild and reshape the Australian mental health system, and respond to a growing demand for services in the years to come, including:

- investment in mental health services delivered through general practice, offering comprehensive care to patients, and reducing fragmentation of care. This includes mental health nurses, social workers and other support services embedded within general practices to provide responsive mental healthcare
- increased MBS rebates for GPs providing mental healthcare to have parity with other chronic illness consultations
- expanding community mental health services to take pressure off other parts of the health system including emergency departments

Climate change

The health sector makes a significant contribution to Australia's carbon emissions — around 7 per cent each year. The AMA is committed to a net zero target for the healthcare sector by 2040, with an interim target of 80 per cent by 2030.

The AMA welcomes the Commonwealth governments \$3.4 million commitment to establishing a National Health Sustainability and Climate Unit, and looks forward to working with government to ensure that the unit is an enduring long-term function that:

- enables all health departments across Australia to work together to reduce emissions and elevate sustainable practices in health care
- implements a national strategy
- incorporates waste reduction strategies as a requirement in hospital accreditation.

Child health

Climate change, poverty, a poor diet, and unstable housing can have a huge impact on a child's health. Social determinants have a direct impact on health and wellbeing, and the AMA believes that a commitment to equity must underpin fiscal, social, and economic policy. The AMA, along with other expert peak organisations, are calling for the establishment of a child health taskforce.



Other policy priorities

Matching the medical workforce to community needs

To avoiding the boom-bust cycle that has characterised medical workforce planning, we must ensure that medical school intakes are linked to workforce planning and community need. While we have seen an explosion in medical student numbers in Australia since 2004, this has not solved problems of maldistribution and specialty shortages.

The growth in full fee-paying student places encourages medical graduates to pursue specialty areas that are better remunerated, and these are typically areas of subspecialist practice located in large metropolitan centres.

We need to see a better system where there is regulation of all medical school places, including domestic and overseas full fee-paying places, so that medical school intakes are matched to community need, with clear limits on the number of full fee-paying students.

Investing in the rural medical training pipeline

To improve access to medical care for regional/rural areas and disadvantaged communities, we need to develop clear training pathways and solutions to rural medical workforce needs and distribution. This requires an increased focus on generalism within the specialist workforce, improved access to specialist services in rural Australia, and development of a rural training pipeline which takes students all the way through to the completion of specialist fellowship training. To achieve this we need to see:

- the expansion of the Commonwealth Government’s Specialist Training Program (STP) to 1700 places over the next term, giving priority to rural areas, generalist training and specialties that are under-supplied
- investment in regional teaching hospitals to ensure they have sufficient capacity to host STP-funded non-GP specialist registrars
- implement the National Rural Generalist Pathway nationally, and a commitment to ongoing funding
- encouragement of end-to-end rural medical training programs, with a view to ensuring they provide positive rural exposure and lead to retention of rural medical practitioners
- expansion of capacity for remote learning (training and educational opportunities, especially for trainees in regional/rural sites, and potential remote supervision)
- promotion of regional training and research teaching hospital hubs to grow non-GP specialist capacity outside metropolitan areas.



REFERENCES

- ¹ Australian Bureau of Statistics (2018). *National Health Survey: State and Territory Findings, 2017-18*. Retrieved 29/06/2021 from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-state-and-territory-findings/latest-release>
- ² PwC Australia (2015). *Weighing the cost of obesity: A case for action*. pp4-5, 61-63. Retrieved 22/12/2020 from: <https://www.pwc.com.au/pdf/weighing-the-cost-of-obesity-final.pdf>
- ³ Miller, C., Wakefield, M., Braunack-Mayer, A., Roder, D., O’Dea, K., Ettridge, K. & Dono, J. (2019). Who drinks sugar sweetened beverages and juice? An Australian population study of behaviour, awareness and attitudes. *BMC Obesity* 5(1). Doi: 10.1186/s40608-018-0224-2
- ⁴ Australian Bureau of Statistics (2020). *Apparent Consumption of Selected Foodstuffs, Australia*. Retrieved 03/08/2021 from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/apparent-consumption-selected-foodstuffs-australia/2019-20>; World Health Organization (2015). *Guideline: Sugars intake for adults and children*. Geneva: World Health Organization. Retrieved 18/02/2021 from: <https://www.who.int/publications/i/item/9789241549028>
- ⁵ See full paper for explanation of how this was calculated: Australian Medical Association (2021). *A tax on sugar-sweetened beverages: Modelled impacts on sugar consumption and government revenue*. Retrieved 03/08/2021 from: <https://www.ama.com.au/articles/tax-sugar-sweetened-beverages-what-modelling-shows>
- ⁶ World Health Organization (2016). *Fiscal policies for diet and prevention of noncommunicable diseases*. Technical Meeting Report. 5-6 May 2015, Geneva, Switzerland. WHO: Geneva. pp9, 24. Retrieved 18/02/2021 from: <https://apps.who.int/iris/bitstream/handle/10665/250131/9789241511247-eng.pdf?sequence=1>
- ⁷ Rethink Sugary Drink. *‘How much sugar is in...?’* Retrieved 02/02/2021 from: <https://www.rethinksugarydrink.org.au/how-much-sugar>
- ⁸ Miller, C.L., Dono, J., Wakefield, M.A., Pettigrew, S., Coveney, J., Roder, D., ... & Ettridge, K.A. (2019). Are Australians ready for warning labels, marketing bans and sugary drink taxes? Two cross-sectional surveys measuring support for policy responses to sugar-sweetened beverages. *BMJ Open* 9, e027962. Doi: 10.1136/bmjopen-2018-027962; Sainsbury, E., Hendy, C., Magnusson, R. & Colagiuri, S. (2018). Public support for government regulatory interventions for overweight and obesity in Australia. *BMC Public Health* 18, 513. Doi: 10.1186/s12889-0185455-0; Morley, B., Martin, J., Niven, P. & Wakefield, M. (2012). Public opinion on food-related obesity prevention policy initiatives. *Health Promotion Journal of Australia* 23(2), 86-91.
- ⁹ Miller, C.L., Dono, J., Wakefield, M.A., Pettigrew, S., Coveney, J., Roder, D., ... & Ettridge, K.A. (2019). Are Australians ready for warning labels, marketing bans and sugary drink taxes? Two cross-sectional surveys measuring support for policy responses to sugar-sweetened beverages. *BMJ Open* 9, e027962. Doi: 10.1136/bmjopen-2018-027962; Sainsbury, E., Hendy, C., Magnusson, R. & Colagiuri, S. (2018). Public support for government regulatory interventions for overweight and obesity in Australia. *BMC Public Health* 18, 513. Doi: 10.1186/s12889-0185455-0.
- ¹⁰ Miller, C.L., Dono, J., Wakefield, M.A., Pettigrew, S., Coveney, J., Roder, D., ... & Ettridge, K.A. (2019). Are Australians ready for warning labels, marketing bans and sugary drink taxes? Two cross-sectional surveys measuring support for policy responses to sugar-sweetened beverages. *BMJ Open* 9, e027962. Doi: 10.1136/bmjopen-2018-027962
- ¹¹ Popkin, B.M. & Ng, S.W. (2021). Sugar-sweetened beverage taxes: Lessons to date and the future of taxation. *PLoS Med* 18(1), e1003412. Doi: 10.1371/journal.pmed.1003412
- ¹² Obesity Evidence Hub. (2021, August 17). *Countries that have taxes on sugar-sweetened beverages (SSBs)*. Retrieved 27/01/2022 from: <https://www.obesityevidencehub.org.au/collections/prevention/countries-that-have-implemented-taxes-on-sugar-sweetened-beverages-ssbs>
- ¹³ Teng, A.M., Jones, A.C., Mizdrak, A., Signal, L., Genc, M. & Wilson, N. (2019). Impact of sugar-sweetened beverage taxes on purchases and dietary intake: Systematic review and meta-analysis. *Obesity Reviews* 20, 1187-1204. Doi: 10.1111/obr.12868; Bandy, L.K., Scarborough, P., Harrington, R.A., Rayner, M. & Jebb, S.A. (2020). Reductions in sugar sales from soft drinks in the UK from 2015 to 2018. *BMC Medicine* 18. Doi:10.1186/s12916-019-1477-4
- ¹⁴ See Teng, A.M., Jones, A.C., Mizdrak, A., Signal, L., Genc, M. & Wilson, N. (2019). Impact of sugar-sweetened beverage taxes on purchases and dietary intake: Systematic review and meta-analysis. *Obesity Reviews* 20, 1187-1204. doi 10.1111/obr.12868
- ¹⁵ Veerman, J.L., Sacks, G., Antonopoulos, N. & Martin, J. (2016). The impact of a tax on sugar-sweetened beverages on health and health care costs: A modelling study. *PLoS ONE* 11(4), e0151460. Doi: 10.1371/journal.pone.0151460
- ¹⁶ Thow, A.M., Downs, S. & Jan, S. (2014). A systematic review of the effectiveness of food taxes and subsidies to improve diets: Understanding the recent evidence. *Nutrition Reviews* 72(9), 551-565. Doi: 10.1111/nure.12123
- ¹⁷ Backholer, K. & Baker, P. (2018). Sugar-sweetened beverage taxes: The potential for cardiovascular health. *Current Cardiovascular Risk Reports* 12. Doi: 10.1007/s12170-018-0593-6





January 2023

39 Brisbane Avenue Barton ACT 2600

Telephone: 02 6270 5400

www.ama.com.au