

FISCAL POLICIES FOR FOOD AND BEVERAGES

Background Paper

This paper provides background information to the PHAA Fiscal Policies for Food and Beverages Policy Position Statement, providing evidence and justification for the public health policy position adopted by Public Health Association of Australia and for use by other organisations, including governments and the general public.

Summary

Most Australians have eating patterns that are inconsistent with the recommendations of the Australian Dietary Guidelines. A significant driver of these low-quality eating patterns is a food environment dominated by easily accessible, intensively advertised, low cost, highly processed, discretionary foods and beverages.

Evidence indicates that regulatory and legislative reforms are likely to be the most effective and cost-effective policy actions for managing and preventing diet-related chronic diseases, including providing substantial savings to the health-care system. Consequently, fiscal policies are proposed to incentivise purchases of foods and beverages in line with the dietary guidelines.

The main fiscal policies that have been recommended by public health organisations, include levies on sugar sweetened beverages (SSBs) and discretionary foods, and subsidies on healthy foods, mainly fruits and vegetables. Repurposing agricultural subsidies to ensure fairly priced fresh, minimally processed foods and beverages, and restrictions on price promotions (discounts) on discretionary foods, have also been proposed.

Table of Contents

FISCAL POLICIES FOR FOOD AND BEVERAGES.....	1
Background Paper	1
Summary.....	1
Public health issue	3
Background and priority.....	4
Current situation	5
Australia.....	5
Other countries.....	6
Policy options	7
Recommended action.....	8
References.....	9

Note: This background paper, and the policy position statement it relates to, focuses on fiscal policies other than taxation of sugar sweetened beverages, as this is covered in a separate policy position statement ('Health Levy on Sugar Sweetened Beverages').

Public health issue

1. Healthy eating patterns are important for good health, contributing to the maintenance of a healthy weight, protection against infection and reduction of non-communicable disease (NCD) risk¹. However, few Australians have eating patterns consistent with the Australian Dietary Guidelines.
2. In 2020–21, most Australians (94%) did not eat the recommended amount of fruit and vegetables² and 38% of energy was consumed from foods and drinks high in energy, saturated fat, added sugars, added salt and/or alcohol (known as 'discretionary foods and beverages')³.
3. In 2017–18, two-thirds of Australian adults, and a quarter of Australian children and adolescents, were experiencing overweight or obesity⁴. In 2015, the economic impact of obesity in Australia was significant, with an estimated cost of \$8.6 billion⁵. This figure included both direct costs to the healthcare system, amounting to \$3.8 billion, and indirect costs, primarily through reduced workforce productivity, amounting to \$4.8 billion. It was also projected that if steps were not taken to address the rising rates of obesity, Australia could face an additional cost of \$87.7 billion between 2016-2025⁵. Conversely, if Australia were to meet the World Health Organization (WHO) target of reducing obesity rates to 2010 levels, a benefit of \$10.3 billion was estimated over this same period⁶.
4. The drivers of overweight and obesity are complex with multiple factors at play. It is a public health problem that cannot be solved by education and personal responsibility alone and people experiencing overweight and obesity require support to achieve better health.
5. There are substantial inequities in dietary quality and obesity in Australia, with lower dietary quality and higher rates of obesity among those in lower socioeconomic groups^{1, 4}.
6. A significant driver of low quality eating patterns in high-income countries is food environments dominated by easily accessible, intensively advertised, low cost, highly processed, discretionary foods and beverages.⁷
7. The price of nutritious foods and beverages is also commonly reported as a barrier to healthy eating patterns⁸. Several studies, conducted in various parts of Australia, indicate that while healthy diets can be less expensive than current (unhealthy) diets, they remain unaffordable (i.e., cost more than 30% of income) for some population groups, such as those living below the poverty line, those in rural and remote communities, and some Aboriginal and Torres Strait Islander communities⁹⁻¹¹.
8. In Australia, price promotions (discounts) are a common and effective marketing technique used to increase purchases and therefore, are likely to increase consumption of the foods and beverages that are discounted¹²⁻¹⁴. A higher proportion of price promotions in Australia are for unhealthy foods and beverages, compared with healthy options^{15, 16}. A food environment that encourages the purchase of unhealthy foods and beverages is likely to contribute to the consumption of unhealthy eating patterns. Thus, price promotions on discretionary foods may undermine other price-related policies (e.g., levies on the same products).

9. Evidence indicates that regulatory and legislative reforms are likely to be the most effective and cost-effective obesity prevention policy actions, including providing substantial savings to the health-care system¹⁷.
10. The excess consumption of discretionary foods and beverages creates economic costs to governments and society that are not incorporated into the costs borne by producers or by customers at the point of sale¹⁸. Discretionary foods and beverages can be inexpensive to produce and purchase but are associated with increased risk of NCDs, and therefore incur a very high cost to society over the long term^{18, 19}. Thus, there is market failure which justifies government fiscal intervention to increase the price of such products, thereby reducing demand¹⁸.
11. As a consequence of the market failure associated with excessive consumption of such products, a number of countries have implemented fiscal interventions such as taxing sugar sweetened beverages (SSBs) and other discretionary foods.^{20, 21} The World Health Organization (WHO) has recommended “there is reasonable and increasing evidence that appropriately designed taxes on sugar-sweetened beverages result in proportional reductions in consumption, especially if they raise the retail price by 20% or more”²⁰.

Background and priority

12. Fiscal policies refer to governments’ revenue and spending policies. In the context of promoting healthy diets, these typically include levies on discretionary foods and beverages and subsidies on healthy foods and beverages²⁰
13. Fiscal policies are primarily proposed to promote healthy diets by disincentivising customer purchases of discretionary foods and beverages (i.e., by raising their prices) and incentivising customer purchasing of healthy foods and beverages (i.e., by lowering their prices)²⁰. Fiscal policies may also promote healthy eating due to the financial implications of changes in purchasing for producers, which may provide an incentive for producers to reformulate their products, decrease production of discretionary foods and beverages, and/or increase production of healthy foods and beverages²⁰. The revenue generated from taxes on discretionary foods and beverages can also be used to fund other health promoting activities^{20, 22}.
14. Fiscal policies to promote healthy eating have been repeatedly recommended or suggested as a policy option, including, but not limited to:
 - by the UN Special Rapporteur on the right to food, who recommended in 2014 that “States should... Impose taxes on soft drinks (sodas), and on HFSS foods [foods high in fat, sugar or salt], in order to subsidize access to fruits and vegetables and educational campaigns on healthy diets”²³.
 - by the WHO Commission on Ending Childhood Obesity, which in 2016 recommended the implementation of effective taxes on SSBs and noted that “Some countries may consider taxes on other unhealthy foods, such as those high in fats and sugar”²⁴.
 - in the Australian National Obesity Strategy 2022–2032, which includes “explor[ing] and implement[ing] use of economic tools to shift consumer purchases towards healthier food and drink options” among its strategies²⁵
 - in the draft WHO guideline on fiscal policies to promote healthy diets, released in 2022, which recommended taxation of SSBs and suggested taxation of discretionary foods and subsidisation of healthy foods²⁶.

15. Public health policymakers seek to develop and implement fiscal policies that improve health via healthier eating patterns, while finance policymakers are more focused on increasing revenue and decreasing spending²⁷. Policymakers from both sectors are concerned with earmarking revenue (dedicating revenue to a specific sector or intervention) and the potential financial regressivity of taxes (i.e., when taxes place a larger financial burden on those receiving lower incomes)²⁷. As such, collaboration between policymakers in both the finance and health sectors is important for effecting such policies^{27, 28}.
16. The main fiscal policies that have been proposed for promoting healthy diets are levies on SSBs and other discretionary foods, and subsidies on healthy foods, mainly fruits and vegetables²⁰. Furthermore, there is growing evidence for the effectiveness of combining discretionary food and beverage taxation with healthy food subsidies²⁰.
17. The Food and Agriculture Organisation (FAO) has also called for the repurposing of agricultural fiscal policies to ensure fresh and minimally processed, staple foods and beverages are fairly priced²⁹.
18. A key modelling study in Australia³⁰ suggests a combined levy (on sugar, SSBs, salt and saturated fat) and subsidy (on fruits and vegetables) package would be an advantageous public health nutrition strategy. Simulations estimated a combined levy and subsidy package would help encourage the public to purchase healthier options and avert as many as 470,000 DALYs in a population of 22 million, providing a net cost saving of \$3.4 billion to the health sector³⁰.
19. Despite the considerable evidence of the public health benefits of fiscal policies, they often receive considerable pushback from industry stakeholders even though there is no evidence they affect employment and profitability in these sectors^{31, 32}.

Current situation

Australia

20. Although food-related fiscal policy is largely yet to be actively considered or implemented in Australia, an existing measure that does meet international best practice and should be retained is the goods and services tax (GST) exemption for fresh and minimally processed, staple foods³³. Estimates demonstrate that introducing a 10% GST on fruit and vegetables would decrease consumption by 5%, which given current consumption in Australia, would render vegetable intake to virtually zero^{34, 35}. The public health consequences of this have been estimated at an additional 90,000 cases of heart disease, stroke and cancer, with at least a 1 billion dollar health care price tag³⁵. Further, those already most affected by diet-related diseases, such as Aboriginal and Torres Strait Islander peoples, people on low incomes and people living in rural and remote areas, would be most adversely affected by a 10% GST on fruits and vegetables. This is contrary to any taxation policy imperative to ensure reforms are equitable³⁶.
21. Agricultural subsidies in Australia are among the lowest in the world, and mostly consist of government funding for research and development and risk management tools for Australia's variable climactic conditions³⁷. Despite this, some products such as rice, sugar, sunflower, meat and dairy attract greater support than other commodities. Although directed at environmental outcomes, farmers in the sugar industry are directly subsidised by an average of 2.6%. While it is unlikely this situation will change in the near or medium term, future fiscal policies should be

repurposed to support the affordability and accessibility of healthy food and beverages as recommended by the FAO²⁹.

Other countries

22. While many other countries have implemented food-related fiscal interventions, evaluations of their effectiveness are relatively scarce and thus, the current evidence is largely based on small-scale intervention studies and modelling²⁰. Nevertheless, the following countries provide examples on both successful and unsuccessful fiscal interventions, and lessons for future practice.
23. A systematic review of food and beverage levies and subsidies commissioned by the WHO in 2022 found consistent evidence that food taxes increased prices and reduced purchases of taxed products^{31, 38}. The evidence on the effect of food taxes on purchases of untaxed products, however, was mixed and few studies have reported on longer-term outcomes, such as BMI, highlighting the importance of policy evaluation. Meta-analysis showed that fruit and vegetable subsidies were associated with increased purchases of fruit and vegetables. While there was no significant change in fruit and vegetable consumption, these studies were fewer in number and of lower quality³¹.
24. In 2015 Mexico ranked first in mortality and morbidity related to SSB consumption and in 2011 had the highest consumption of SSB per capita³⁹. In 2012, 70% of the consumption of added sugar came from SSB and 23% from energy dense foods^{20, 40}. In January 2014, Mexico introduced an excise tax of 1Peso/L (\$0.064/L AUD) on SSBs (approximately 10%) and an 8% sales tax on energy dense foods containing more than 275kcal/100g (1155kJ/100g)³⁹. Evaluation of the SSB tax found a 12% overall reduction in purchases by the end of 2014 across the population⁴¹. However, reductions were highest amongst households with low incomes, where there was a 9-17% decline in SSB purchases^{20, 39}. A follow up cohort study in 2020 found these improvements had been sustained several years later⁴⁰.
25. An evaluation of Mexico's tax on energy-dense, non-essential foods, found that the volume of taxed foods purchased was 5.1% lower in 2014 than what would have been expected based on pre-tax trends, with no corresponding change in purchases of untaxed foods⁴². The reduction in volume of taxed foods purchased was greater for lower socioeconomic households (10.2% lower than expected based on pre-tax trends) than medium (5.8% lower) or high (no change) socioeconomic households⁴².
26. In 2011, Denmark introduced a tax on saturated fat, where foods containing more than 2.3g saturated fat/100g were taxed 16 DKK/kg saturated fat (\$3.37AUD/kg)²⁰. These were primarily meat, dairy, butter, margarine, spreads, oils and rendered or extracted animal fat products⁴³. Although this tax was proposed in relation to WHO's Global Action Plan for the Prevention and Control of Noncommunicable Diseases⁴⁴, the primary aim was part of a larger reform to reduce income tax⁴³. Pre-implementation, the saturated fat tax was heavily criticised by the food industry, retailers, farmers and trade organisations^{20, 43, 45} however, the WHO suggest using strong scientific evidence, building a multisectoral coalition of support, developing a comprehensive advocacy strategy, and strategically framing a tax as means of countering such opposition⁴⁶. Evaluations found that saturated fat intake in Denmark reduced by 4% and that consumption of oil, butter and similar fats reduced by 10-15%^{43, 47}. The saturated fat tax was, however, repealed in 2012 as it lacked strong proponents and, as noted above, had many adversaries^{43, 45}.

27. Hungary introduced its public health product tax (PHPT) in 2011²⁰. The PHPT is an excise tax on non-staple foods i.e., pre-packaged foods, high in saturated/trans-fat, sugar and salt including SSBs, sugar sweetened cocoa powder, energy drinks, flavoured alcoholic beverages, condiments, fruit jams, syrups and salty snacks. The main objectives of the PHPT were to encourage healthy habits by improving the accessibility of healthy options, encourage reformulation of unhealthy products, and increase public health funding⁴⁸. Evidence from impact assessments found that most people reduced their intake of the target foods; there were improvements in health literacy and awareness of discretionary items; the majority of people who made substitutions opted for healthier alternatives (e.g. water, fruits and vegetables, herbs and spices) and individuals experiencing overweight or obesity were twice as likely to change their consumption than those in the healthy or underweight body mass index (BMI) range^{20, 21, 48}. Revenue generated in the first four years of implementation of the PHPT was used to subsidise the wages of 95 000 health workers^{20, 21, 48}.
28. Food and beverage taxation has been studied to a lesser extent in Pacific Island countries, however, there is some evidence for food-related fiscal policy in Tonga⁴⁹. In 2016, in addition to taxes previously applied to SSBs, several tax types were applied to foods with high fat content including turkey tails, mutton flaps, chicken leg quarters, mayonnaise and lard⁵⁰. One observational study found there was a 5-22% reduction in soft drink purchases in 2016, with greatest declines among households receiving low incomes⁴⁹. A formal evaluation of the effects of food taxation has not been conducted, however, findings from one report suggest both retailers and customers found the tax to be ineffective and insensitive to the needs of people on low incomes and cultural practices and traditions⁵⁰. The importance of culture and religion in behaviour change was highlighted as a future priority in order to improve public support⁵⁰.
29. In Latvia, a reduction in the value added tax (VAT) rate for some fresh fruit and vegetables in 2018 was followed by a decrease in retail prices⁵¹.
30. In 2023, the UK government plans to implement legislation to restrict large and medium retailers from offering volume-based price promotions (e.g., 'buy-one-get-one-free' specials) for foods and beverages high in fat, sugar, or salt. Modelling shows that, if restrictions on price promotions of discretionary foods were to be implemented in Australia, it would likely result in improvements in the quality of eating patterns and be a highly cost-effective policy option⁵².

Policy options

31. The GST-exemption for fresh, minimally processed and staple food categories in Australia, should be retained to ensure the positive public health impacts of this policy are maintained.
32. As per PHAA's policy on a Health Levy on Sugar Sweetened Beverages in Australia and WHO recommendations⁴⁶, a levy of 20% or more should be applied to SSBs as part of a comprehensive package to address existing and prevent further diet-related diseases.
33. A levy should be applied to discretionary foods to reduce dietary risks associated with obesity, chronic disease and related health care costs, and any revenue generated should be used to fund other public health nutrition initiatives and/or health promoting activities.
34. Review existing agricultural subsidies to ensure they are aligned with promoting public health.
35. To offset the potentially fiscally regressive effect of taxation on foods and beverages, healthy food

subsidies and improved income support/targeted subsidies for households receiving low incomes should be considered.

36. Restrictions on the use of price promotions (discounts) on discretionary foods should be mandated. Such price promotions are highly prevalent, incentivise the consumption of discretionary foods, and may undermine other price-related policies (such as levies and subsidies).
37. As part of such fiscal measures, a model that is line with Australian Dietary Guidelines should be adopted or developed for use in classifying foods (e.g., determining foods and beverages to be levied or subsidised).

Recommended action

38. The Commonwealth, State and Territory governments should retain the GST-exemption for fresh, minimally processed and staple food categories in Australia.
39. The Commonwealth, State and Territory governments should use WHO guidance⁴⁶ to implement a levy of 20% or more on SSBs as part of a comprehensive package to address existing and prevent further diet-related diseases in Australia.
40. The Commonwealth, State and Territory governments should also levy discretionary foods to reduce dietary risks associated with obesity, chronic disease and related health care costs, as well as review existing agricultural subsidies to ensure they are aligned with promoting public health as recommended by the FAO²⁹.
41. Any revenue generated by such fiscal measures, should be used to fund other public health nutrition initiatives and/or health promoting activities.
42. The Commonwealth, State and Territory governments should also investigate the use of healthy food subsidies and improved income support/targeted subsidies for households receiving low incomes, in order to offset the fiscally regressive effect of taxation on discretionary foods and beverages.
43. Commonwealth, State and Territory governments should mandate restrictions on the use of price promotions (discounts) on discretionary foods to avoid the undermining of other price-related policies (such as levies and subsidies).
44. The Commonwealth, State and Territory governments should adopt a model that is line with Australian Dietary Guidelines for use in classifying foods to be levied or subsidised.
45. Any food fiscal policy should be monitored and evaluated to ensure dietary, health and fiscal goals are met or where necessary adjust strategies to better align with desired outcomes.

ADOPTED September 2023

References

1. Australian Institute of Health and Welfare. Nutrition across the life stages. Cat. no. PHE 227. Canberra: AIHW; 2018.
2. Australian Bureau of Statistics. National Health Survey - Dietary Behaviour. Canberra: ABS; 2022. Available from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/dietary-behaviour/latest-release>.
3. Australian Bureau of Statistics. Apparent Consumption of Selected Foodstuffs, Australia. Canberra: ABS; 2022. Available from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/apparent-consumption-selected-foodstuffs-australia/latest-release>.
4. Australian Institute of Health and Welfare. Overweight and Obesity. Canberra: AIHW; 2022 [updated 16 August 2022]. Available from: <https://www.aihw.gov.au/reports/australias-health/overweight-and-obesity>.
5. Roberto CA, Swinburn B, Hawkes C, Huang TTK, Costa SA, Ashe M, et al. Patchy progress on obesity prevention: emerging examples, entrenched barriers, and new thinking. *The Lancet*. 2015;385(9985):2400-9.
6. PricewaterhouseCoopers. Weighing the Cost of Obesity: A Case for Action. Australia: PwC; 2015.
7. Swinburn BA, Sacks G, Hall KD, McPherson K, Finegood DT, Moodie ML, et al. The global obesity pandemic: shaped by global drivers and local environments. *The Lancet*. 2011;378(9793):804-14.
8. Zorbas C, Palermo C, Chung A, Iguacel I, Peeters A, Bennett R, et al. Factors perceived to influence healthy eating: a systematic review and meta-ethnographic synthesis of the literature. *Nutrition Reviews*. 2018;76(12):861-74.
9. Lee A, Lewis M. Testing the Price of Healthy and Current Diets in Remote Aboriginal Communities to Improve Food Security: Development of the Aboriginal and Torres Strait Islander Healthy Diets ASAP (Australian Standardised Affordability and Pricing) Methods. *International Journal of Environmental Research and Public Health* [Internet]. 2018; 15(12). Available from: <https://www.mdpi.com/1660-4601/15/12/2912>.
10. Love P, Whelan J, Bell C, Grainger F, Russell C, Lewis M, et al. Healthy Diets in Rural Victoria-Cheaper than Unhealthy Alternatives, Yet Unaffordable. *Int J Environ Res Public Health*. 2018;15(11).
11. Zorbas C, Brooks R, Bennett R, Lee A, Marshall J, Naughton S, et al. Costing recommended (healthy) and current (unhealthy) diets in urban and inner regional areas of Australia using remote price collection methods. *Public Health Nutrition*. 2022;25(3):528-37.
12. Bennett R, Zorbas C, Huse O, Peeters A, Cameron AJ, Sacks G, et al. Prevalence of healthy and unhealthy food and beverage price promotions and their potential influence on shopper purchasing behaviour: A systematic review of the literature. *Obesity Reviews*. 2020;21(1):e12948.
13. Hawkes C. Sales promotions and food consumption. *Nutr Rev*. 2009;67(6):333-42.
14. Martin L, Bauld L, Angus K. Rapid evidence review: The impact of promotions on high fat, sugar and salt (HFSS) food and drink on consumer purchasing and consumption behaviour and the effectiveness of retail environment interventions. NHS Health Scotland; 2017.
15. Grigsby-Duffy L, Schultz S, Orellana L, Robinson E, Cameron AJ, Marshall J, et al. The Healthiness of Food and Beverages on Price Promotion at Promotional Displays: A Cross-Sectional Audit of Australian Supermarkets. *International Journal of Environmental Research and Public Health*. 2020;17(23):9026.
16. Riesenber D, Backholer K, Zorbas C, Sacks G, Paix A, Marshall J, et al. Price Promotions by Food Category and Product Healthiness in an Australian Supermarket Chain, 2017–2018. *American Journal of Public Health*. 2019;109(10):1434-9.
17. Ananthapavan J, Sacks G, Brown V, Moodie M, Nguyen P, Veerman L, et al. Priority-setting for obesity prevention—The Assessing Cost-Effectiveness of obesity prevention policies in Australia (ACE-Obesity Policy) study. *PLOS ONE*. 2020;15(6):e0234804.
18. Duckett S, Swerissen H, Wiltshire T. A sugary drinks tax: recovering the community costs of obesity. Victoria: Grattan Institute; 2016.
19. Karnani A, McFerran B, Mukhopadhyay A. The Obesity Crisis as Market Failure: An Analysis of Systemic Causes and Corrective Mechanisms. University of Chicago Press,. 2016;1(3):445-70.
20. World Health Organization. Fiscal Policies for Diet and Prevention of Noncommunicable Diseases. Geneva: World Health Organization; 2016.

21. World Health Organization. Using taxes to beat NCDs: success story in Hungary. World Health Organization,; 2017 [updated 17 Oct 2017]. Available from: <https://www.developmentaid.org/news-stream/post/8887/using-taxes-to-beat-ncds-success-story-in-hungary>.
22. World Cancer Research Fund International. Building momentum: lessons on implementing a robust sugar sweetened beverage tax. London: WCRFI; 2018.
23. United Nations General Assembly. Report of the Special Rapporteur on the right to food, Olivier De Schutter. Geneva: Human Rights Council, Twenty-fifth session, Agenda item 3, Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development; 2014.
24. World Health Organization. Report of the commission on ending childhood obesity. Geneva: WHO; 2016.
25. Commonwealth of Australia. The National Obesity Strategy 2022-2032. Canberra: Health Ministers Meeting; 2022. p. 1-87.
26. World Health Organization. Public consultation on the draft guideline: fiscal policies to promote healthy diets. Geneva: WHO; 2022. Available from: <https://www.who.int/news-room/articles-detail/public-consultation-on-the-draft-guideline-fiscal-policies-to-promote-healthy-diets>.
27. Thow A, Heywood P, Leeder S, Burns L. The global context for public health nutrition taxation. *Public Health Nutr.* 2010 Aug 16; 14(1):176-86.
28. Thow A, Downs S, Mayes C, Trevena H, Waganivalu T, Cawley J. Fiscal policy to improve diets and prevent noncommunicable diseases: from recommendations to action. *Bull World Health Organ.* 2018 Feb 5; 96(3):201-10.
29. FAO, IFAD, UNICEF, WFP, WHO. The State of Food Security and Nutrition in the World 2022. Repurposing food and agricultural policies to make healthy diets more affordable. Rome: FAO; 2022.
30. Cobiac L, Tam K, Veerman L, Blakely T. Taxes and Subsidies for Improving Diet and Population Health in Australia: A Cost-Effectiveness Modelling Study. *PLoS Med.* 2017;Feb 14:1-18.
31. Andreyeva T, Marple K, Moore TE, Powell LM. Evaluation of Economic and Health Outcomes Associated With Food Taxes and Subsidies: A Systematic Review and Meta-analysis. *JAMA Network Open.* 2022;5(6):e2214371-e.
32. Powell LM, Wada R, Persky JJ, Chaloupka FJ. Employment impact of sugar-sweetened beverage taxes. *Am J Public Health.* 2014;104(4):672-7.
33. Global Obesity Centre (GLOBE) and Australian Prevention Partnership Centre. Policies for tackling obesity and creating healthier food environments Scorecard and priority recommendations for Australian governments. Deakin University, Victoria: GLOBE and APPC; February 2017.
34. Australian Bureau of Statistics. National Health Survey: First Results, Australia 2017-18. ABS Catalogue no. 4364.0.55.001. Canberra: ABS; 2018.
35. Veerman L, Cobiac LJ. Removing the GST Exemption for Fresh Fruits and Vegetables Could Cost Lives. *Medical Journal of Australia.* 2013;199(8):534, 5.
36. Martin F. The case for specific exemptions from the goods and services tax: what should we do about food, health and housing? *eJournal of Tax Research.* 2020;18(1):99-123.
37. Greenville J. Analysis of government support for Australian agricultural producers. Canberra: Australian Bureau of Agricultural and Resource Economics and Sciences (ABARES) research report, Australian Government, Department of Agriculture, Water and The Environment; May 2020.
38. Andreyeva T, Marple K, Marinello S, Moore TE, Powell LM. Outcomes Following Taxation of Sugar-Sweetened Beverages: A Systematic Review and Meta-analysis. *JAMA Network Open.* 2022;5(6):e2215276-e.
39. Sanchez-Romero L, Canto-Orsorio F, Gonzalez-Morales R, Colchero M, Ng S, Ramirez-Palacios P, et al. Association between tax on sugar sweetened beverages and soft drink consumption in adults in Mexico: open cohort longitudinal analysis of Health Workers Cohort Study. *BMJ.* 2020 Mar 24(369):m1311.
40. Cuadrado C, Dunstan J, Silva-Illanes N, Mirelman A, Nakamura R, Suhrcke M. Effects of a sugar-sweetened beverage tax on prices and affordability of soft drinks in Chile: A time series analysis. *Soc Sci Med.* 2020 Jan(245):1-9.
41. Colchero MA, Popkin BM, Rivera JA, Ng SW. Beverage purchases from stores in Mexico under the excise tax on sugar sweetened beverages: observational study. *BMJ.* 2016;352:h6704.
42. Batis C, Rivera JA, Popkin BM, Taillie LS. First-Year Evaluation of Mexico's Tax on Nonessential Energy-Dense Foods: An Observational Study. *PLoS Medicine.* 2016;13(7): e1002057.

43. Smed S, Scarborough P, Rayner M, Jensen D. The effects of the Danish saturated fat tax on food and nutrient intake and modelled health outcomes: an econometric and comparative risk assessment evaluation. *EJCN*. 2016 Apr 13;70(6):681-6.
44. World Health Organization. Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020. Geneva: World Health Organization; 2013.
45. Vallgarda S, Holm L, Jensen J. The Danish tax on saturated fat: why it did not survive. *EJCN*. 2014 Oct 29;69(2):223-6.
46. World Health Organization. WHO manual on sugar-sweetened beverage taxation policies to promote healthy diets. Geneva: WHO; 2022. Contract No.: Licence: CC BY-NC-SA 3.0 IGO.
47. Jensen JD, Smed S. The Danish tax on saturated fat – Short run effects on consumption, substitution patterns and consumer prices of fats. *Food Policy*. 2013;42:18-31.
48. World Health Organization. Assessment of the Impact of a Public Health Product Tax. Budapest: World Health Organization,; 2015.
49. Teng A, Buffiere B, Genc M, Latavao T, Puloka V, Signal L, et al. Equity of expenditure associated with a sweetened beverage tax in Tonga: repeated cross-sectional household surveys. *BMC*. 2021 Jan 18;21(149):1-13.
50. Food and Agriculture Organization of the United Nations. Effects of food taxation in Tonga: A snapshot. Fiji: FAO; 2017.
51. Nipers A, Upite I, Pilvere, Irina , Stalgiene A, Viira, Ants-Hannes. Effect of VAT Rate Reduction for Fruits and Vegetables on Prices in Latvia: Ex-Post Analysis. *Journal of Agricultural Science*. 2019;30(1):25-31.
52. Huse O, Ananthapavan J, Sacks G, Cameron AJ, Zorbas C, Peeters A, et al. The potential cost-effectiveness of mandatory restrictions on price promotions for sugar-sweetened beverages in Australia. *Int J Obes (Lond)*. 2020;44(5):1011-20.