Submission
No 24

INQUIRY INTO INQUIRY INTO CHILDHOOD OVERWEIGHT AND OBESITY

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NCOSS Submission

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NSW Council of Social Service

About NCOSS

The NSW Council of Social Service (NCOSS) works with and for people experiencing poverty and disadvantage to see positive change in our communities.

When rates of poverty and inequality are low, everyone in NSW benefits. With 80 years of knowledge and experience informing our vision, NCOSS is uniquely placed to bring together civil society to work with government and business to ensure communities in NSW are strong for everyone.

As the peak body for health and community services in NSW we support the sector to deliver innovative services that grow and evolve as needs and circumstances evolve.

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Recommendations

1. The NSW Government should ensure the Premier's Priority of tackling childhood obesity has a sub-target focussed on reducing overweight and obesity in children from low income households.
2. NSW Health should direct additional resources towards Local Health Districts to mobilise a whole-of-community approach to reducing childhood overweight and obesity in low socioeconomic areas.
3. NSW Health should lead cross-agency efforts to develop the tailored strategies needed to support children from particularly vulnerable backgrounds across the State to be of healthy weight. This should involve coordination and co-design with the non-government sector as well as close consultation with children and young people themselves.
4. The NSW Government should invest an additional $25 million per annum in the state-wide rollout of nurse-led home visiting programs for vulnerable families with children age 0-2.
5. The NSW Government should investigate the potential to embed home-based early intervention programs such as Healthy Beginnings in nurse-led home visiting programs such as Sustaining NSW Families.
6. The NSW Government should support the recommendations made by the Australian Council of Social Service (ACOSS) in relation to the payments system including indexing family payments to wage movements; increasing the Family Tax Benefit Part A rate for families with children over 5 years by $30 per week; and replacing Family Tax Benefit Part B for single parent families with a Sole Parent Supplement set at the level of the current Part B payment for younger child.
7. The NSW Government should support initiatives designed to improve access to affordable healthy food for low-income families, children and young people, such as school breakfast programs, food vans and community gardens.
8. The NSW Government should investigate and implement initiatives to ensure free or low-cost sports activities are available to children and young people from low-socio-economic backgrounds.
9. The NSW Government should include health and well-being as an objective in the *Environmental, Planning and Assessment Act 1993*.
10. Health impact assessments should be required for all major new developments.
11. The NSW Department of Planning and Environment, in collaboration with local councils, should conduct a mapping exercise documenting the quantity, quality and accessibility of green spaces across Greater Metropolitan Sydney, and invest additional resources to create or improve green spaces where required.
12. The NSW Government should scale up preventative efforts, emphasising the common risk factor approach to health promotion which will bring about benefits across the whole health system.
13. The NSW Government should champion efforts to protect children from unhealthy food marketing through COAG.
14. The NSW Government should advocate for the introduction of a tax on sugar sweetened beverages.

Introduction

Children from low-income and disadvantaged backgrounds are at much greater risk of being overweight or obese. This can have a profound and enduring impact on their lives, further entrenching health and social inequities.

Children who are overweight or obese are more likely to suffer from a range of health problems.[1] They are often socially marginalised and have lower self-esteem. [2] They miss school more frequently, and as a result have poorer educational outcomes.[3] Overweight children are more likely to be overweight as adults[4], and will continue to experience social, educational and financial disadvantage. They will be predisposed to a range of health conditions including diabetes and heart disease [5], and ultimately, will have a shorter life expectancy.[6]

We therefore welcome the current focus on reducing overweight and obesity rates of children, and the inclusion of a 5% reduction on current rates as one of the NSW Premier's priorities.[7] It is imperative that efforts aimed at achieving this target focus on low-income and vulnerable children. Failure to take the unique circumstances of those children into account will mean that the solutions we invest in will fail to benefit the most vulnerable, and will risk widening existing health inequities.

For this reason, this submission addresses the Inquiry's Terms of Reference from an equity perspective. Where relevant we highlight how factors that contribute to childhood overweight and obesity impact differently – and often more strongly - on children from low-income and disadvantaged families, and focus on the strategies needed to address these factors. In doing so, we draw on a discussion paper on childhood obesity we published earlier this year,[8] and a roundtable event we hosted involving key stakeholders from the community sector and academia.

In working towards ensuring responses to child overweight and obesity benefit children from low-income and disadvantage backgrounds, we begin by recommending that an equity sub-target be established to guide efforts towards achieving the Premier's Priority of reducing overweight and obesity rates of children in NSW.

Recommendation 1: The NSW Government should ensure the Premier's Priority of tackling childhood obesity has a sub-target focussed on reducing overweight and obesity in children from low income households.

[1] World Health Organization (2016) Report of the commission on ending childhood obesity.
[2] Sahoo K, "Childhood obesity: causes and consequences", (2015)J Family Med Prim Care. 2015 Apr-Jun; 4(2): 187–192.
[3] [3]Schwimmer JB (2003), note 27.
[4] Simmonds et al (2016) "Predicting adult obesity from childhood obesity: a systematic review and meta-analysis", *Obesity Reviews*, 17: 95–107.
[5] Australian National Health Prevention Agency, (2014), *Obesity Prevalence Trends In Australia: Evidence Brief*.
[6] Ibid.
[7] NSW Government (2015) *Making It Happen: Tackling Childhood Obesity*.
[8] NCOSS (2014) *Childhood Obesity: An Equity Perspective*.

Section 1: Inquiry Terms of Reference A, E and F.

- *(a) Current approaches to reduce childhood overweight and obesity in NSW*
- *(e) Coordination between NSW Government agencies to reduce childhood overweight and obesity*
- *(f) The potential for collaboration on strategies to reduce childhood overweight and obesity with the non-government and private sectors*

The NSW Government's current approach to reducing childhood overweight and obesity in NSW is articulated in the NSW Healthy Eating Active Living Strategy 2013-2018. This strategy recognises that the causes of overweight and obesity are complex; that there is no one solution; and that NSW Health cannot achieve change alone. Yet while the need for cross-agency, cross-sectoral efforts have been acknowledged, it is difficult to see how efforts targeted at those children at greatest risk of being overweight are being effectively coordinated.

We believe that a successful response to child obesity will not only require coordination at the State level, but also at the local level, and that additional resources are required to achieve this. These resources should be targeted to areas of concentrated disadvantage, with strong evidence that whole-of-community approaches that address multiple risk factors are most effective at reducing obesity for people from lower socioeconomic backgrounds. [9] Locally-based coordinators could facilitate a collective impact approach involving government agencies across all three tiers of government as well as the non-government and private sectors.

Locally coordinated whole-of-community approaches have been implemented in numerous jurisdictions both in Australia and internationally, and are exemplified in the EPODE, *Together Let's Prevent Childhood Obesity* method implemented in 500 European communities since 2004.[10] This type of approach can be designed to complement state-wide strategies: Healthy Together Victoria, for example, operates at a state-wide level as well as resourcing local government to lead concentrated community-level efforts in 12 Healthy Together Communities.

Additional resources targeted to lower socio-economic areas would support:

1. A coordinated cross-sectoral approach to addressing local level needs and priorities. An example of this type of approach can been seen in the Western Sydney Diabetes Prevention and Management Initiative which brings a diverse range of partners together in a whole-of-district approach.
2. Capacity-building for services operating in low-socioeconomic areas to support implementation of the state-wide initiatives outlined in the Healthy Eating Active Living Strategy. This is similar to the approach taken by the Good for Kids, Good for Life program in the Hunter New England Local Health District, which resulted in an average annual rate of decline in the prevalence of overweight and obesity for all children in the region of approximately 1% per year.[11]
3. The development and implementation of additional localised responses to meet community needs. This would involve a community level needs assessment, a prioritisation process, and the subsequent development and implementation of appropriate initiatives. Examples of the types of initiatives that could be implemented in response to particular needs are provided at Attachment A.

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[9] Boelsen-Robinson, T. et al(2015), A systematic review of the effectiveness of whole-of-community interventions by socioeconomic position. *Obesity Reviews*, 16: 806–816. Beauchamp, A., Backholer, K., Magliano, D. and Peeters, A. (2014)," The effect of obesity prevention interventions according to socioeconomic position: a systematic review". *Obesity Reviews*, 15: 541–554.

[10] Borys, J.-M.,et al (2012), EPODE approach for childhood obesity prevention: methods, progress and international development. *Obesity Reviews,* 13: 299–315.

[11] Good for Kids, Good for Life 2006-2010: Evaluation Report, NSW Health.

4. Building the commitment, momentum and capacity needed to shape healthier neighbourhoods. The importance of the built environment in relation to the health of children and young people from low-socio-economic backgrounds is described in more detail below.

Recommendation 2: NSW Health should direct additional resources towards Local Health Districts to mobilise a whole-of-community approach to reducing childhood overweight and obesity in low socioeconomic areas.

In addition to targeting responses to low-income families via a geographic focus on low socio-economic communities, the NSW Government should ensure tailored strategies are developed to support children from particularly vulnerable backgrounds across the State to be of healthy weight. Cohorts where close attention is needed include:

1. **Aboriginal and Torres Strait Islander children:** Aboriginal and Torres Strait children are 6% more likely than other children to be overweight or obese. And recent research shows the gap in weight status between Aboriginal and non-Indigenous children is widening.[12]

2. **Children and young people in out of home care:** Overseas studies have shown that children in out of home care are more likely to be overweight or obese,[13] and while there is a lack of rigorous Australian research in relation to prevalence rates of overweight and obesity in children in out-of-home care this is also likely to be the case here.[14]

3. **Children in the juvenile justice system:** Overweight and obesity is prevalent among young people in custody and being in custody exacerbates obesity. A study using data 2009 NSW Young People in Custody Health Survey[15] found that:

   - At baseline, nearly half of the 303 detainees surveyed (47.9%) were overweight or obese;
   - On follow-up measurement, three-quarters of young people reported weight gain since being incarcerated, and those who spent a longer time in custody were more likely to report weight gain or be overweight or obese.[16]

   Although being in custody led to improvements in diet and exercise, this was counterbalanced by food environments in which multiple portions were offered, and energy-dense food was available as rewards. Additionally, the physical activity offered is low intensity.[17]

Developing and implementing targeted strategies should involve coordination and co-design with the non-government sector – which in many cases has existing relationships with children and young people who are otherwise hard to reach – as well as close consultation with children and young people themselves. And as part of this process, existing programs should be examined for their potential for broader roll-out.

One initiative we recommend be rolled out across the State is nurse-led home visiting programs for vulnerable families with children age 0-2. There is strong evidence that these programs bring about a range of substantial benefits for vulnerable children and their families, including supporting mothers to breastfeed for longer which

[12] Hardy, LL, O'Hara, BJ, Hector, D, Engelen, L, & Eades, S.J (2014) Temporal trends in weight and current weight-related behaviour of Australian Aboriginal school-aged children. *Med J Aust,* 200 (11): 667-671.

[13] Hadfield, S. C., & Preece, P. M. (2008). Obesity in looked after children: Is foster care protective from the dangers of obesity? *Child: care, health and development*,34, 710-712

[14] Skouteris, H et al (2011) "**Obesity** in Children in Out-of-home Care: A Review of the Literature" *Australian Social Work,* 64:4, 475-486.

[15] Indig D et al. (2011) 2009 NSW Young People in Custody Health Survey: full report. Sydney: Justice Health and Juvenile Justice.

[16] Haysom et al (2013) Prevalence and perceptions of overweight and obesity in Aboriginal and non-Aboriginal young people in custody, *Med J Aust* 2013; 199 (4): 266-270.

[17] Ibid.

is an important protector against obesity.[18] We estimate that the state-wide roll-out of the Sustaining NSW Families program would require investment of an additional $25 million per annum. There is also evidence that home-based early intervention programs such as Healthy Beginnings[19] can reduce family and behavioural risk factors for childhood obesity, with the potential to embed these programs into the nurse home visiting model.

Recommendation 3: NSW Health should lead cross-agency efforts to develop the tailored strategies needed to support children from particularly vulnerable backgrounds across the State to be of healthy weight. This should involve coordination and co-design with the non-government sector as well as close consultation with children and young people themselves.

Recommendation 4: The NSW Government should invest an additional $25 million per annum in the state-wide rollout of nurse-led home visiting programs for vulnerable families with children age 0-2.

Recommendation 5: The NSW Government should investigate the potential to embed home-based early intervention programs such as Healthy Beginnings in nurse-led home visiting program such as Sustaining NSW Families.

[18] Owen CG et al. Effect on infant feeding on the risk of obesity across the life course: a quantitative review of published evidence. *Pediatrics*. 2005;115:1367-1377.
[19] http://www.healthybeginnings.net.au

Section 2: Inquiry Terms of Reference B and C.

- *(b) strategies to assist parents and carers in enabling their children to make healthier food and beverage choices and be active, including by participating in sport*
- *(c) measures to support 13 to 18 year olds to make healthier food and beverage choices and be active, including by participating in sport*

Strategies to assist parents, carers, and young people themselves to make healthier food and beverage choices and be active must first consider *why* poor eating habits and sedentary behavior may have developed. Below, we outline some of the key factors that impact the choices made by people experiencing poverty and disadvantage, and provide recommendations that go towards addressing these factors.

The affordability of healthy food

Families with little disposable income can find it very difficult to afford a healthy diet, with 6.8% of disadvantaged households with children under the age of 15 experiencing food insecurity in NSW in 2014.[20] The risk of obesity is 20 to 40% higher in individuals who are food insecure.[21]

The inadequacy of income support allowances and the high cost of housing[22] are two major causes of strain on many household budgets. This can impact a family's ability to afford healthy food, with rent or housing repayments taking priority in the family budget, and groceries being one of the only 'discretionary' items.

On a limited budget, a healthy diet may simply be unaffordable.[23] The NSW Cancer Council Healthy Food Basket Survey found that families in the lowest quintile would need to spend 56% of their average weekly income on food to afford a healthy food basket.[24] Families in this situation may either skip meals, or cope by substituting cheaper, more energy dense foods such as refined grains, added sugars, and added fats for healthy food options which generally cost more.[25] Healthy food can also be more expensive in remote areas[26], and in some areas with low-socioeconomic status. [27]

In assessing the affordability of healthy food, the following must also be considered:

- The time-cost associated with accessing, purchasing and preparation of healthy food. In many low-income families parents are time-poor. They may live further from work, work longer, less sociable hours, and be unable to afford home-help. They therefore have less time to prepare healthy meals.[28]
- The ability to store healthy food. Very low-income families may not have access to refrigeration.[29]

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[20] Health Statistics NSW (2013) *Food insecurity, persons aged 16 years and over, NSW 2002 to 2012.* Data from NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.
[21] Vic Health (2004) A review of the literature describing the link between poverty, food insecurity and obesity with specific reference to Australia
[22] SCRGSP (Steering Committee for the Review of Government Service Provision), Report on Government Services 2016, vol. G, Housing and Homelessness, Productivity Commission, Canberra.
[23] Drewnowski, A., & Darmon, N. (2005). The economics of obesity: dietary energy density and energy cost. *The American Journal of Clinical Nutrition*, *82*(1), 265S-273S.
[24] The Cancer Council NSW. NSW Healthy Food Basket Cost, Availability and Quality Survey. Sydney 2007. Available at http://www.cancercouncil.com.au/foodbasket, p10
[25] Anglicare (2013) '*Going Without in a Time of Plenty: A Study of Food Security in NSW and the ACT*'.
[26] Burns CM, et al. Food cost and availability in a rural setting in Australia. *Rural and Remote Health* 2004; **4**: 311. Available: http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=311 (Accessed 4 April 2016)
[27] Tsang A, et al. Adelaide healthy food basket: a survey on food cost, availability and affordability in five local government areas in metropolitan Adelaide, South Australia. *Nutrition and Dietetics* 2007; 64:241-7
[28] Nogrady, B (2015) 'Time and Money: Why we need both to be healthy'
[29] In Anglicare's national study of people accessing Emergency Relief, 9% reported being limited in their choice of food because they did not have a fridge, while 7% did not have the power connected. Anglicare (2013) Hard Choices: Going Without in a Time of Plenty

- The cost of small portions versus buying in bulk. People on low-incomes may be unable to afford a weekly grocery shop, but purchase food in small amounts when money is available, adding to the overall cost of food.

One way to improve the affordability of healthy food would be to increase incomes, specifically Government allowances. To this end, we recommend that the NSW Government supports the recommendations made by the Australian Council of Social Service (ACOSS) in relation to the payments system.[30]

In addition, the NSW Government should support initiatives designed to improve access to affordable healthy food for low-income families such as school breakfast programs, food vans and community gardens. We consider these would be best delivered through the whole-of-community approach recommended above.

Recommendation 6: The NSW Government should support the recommendations made by the Australian Council of Social Service (ACOSS) in relation to the payments system including indexing family payments to wage movements; increasing the Family Tax Benefit Part A rate for families with children over 5 years by $30 per week; and replacing Family Tax Benefit Part B for single parent families with a Sole Parent Supplement set at the level of the current Part B payment for younger child.

Recommendation 7: The NSW Government should support initiatives designed to improve access to affordable healthy food for low-income families, children and young people such as school breakfast programs, food vans and community gardens.

The affordability of organised sport and dancing

We know that children from low socio-economic backgrounds are less likely to be involved in organised sport or dancing, with children from unemployed single parent families the least likely to participate. [31] The cost of these activities– including the cost of travel, membership fees and uniforms – is a persistent barrier to participation. We therefore recommend that the NSW Government continues to investigate and implement initiatives to ensure free or low-cost sports activities are available to children and young people from low-socio-economic backgrounds.

Recommendation 8: The NSW Government should investigate and implement initiatives to ensure free or low-cost sports activities are available to children and young people from low-socio-economic backgrounds.

Obesogenic environments

Differences in physical activity based on socioeconomic status are even greater for non-organised physical activity than for organised activity,[32] pointing to the important role the built environment plays in supporting people to lead physically active lifestyles.

We know that low-income neighbourhoods often have fewer parks, green spaces, and recreational facilities than higher income neighbourhoods[33], making it more challenging for children and families living in these areas to

[30] ACOSS (2015) *Budget Priorities Statement 2016-17*.
[31] Australian Bureau of Statistics (2012) *Australian Social Trends June 2012*
[32] Australian Bureau of Statistics (2014) 'Stats & Facts: Sport And Physical Recreation - Differentials In Participation'
[33] Astell-Burt, T., Feng, X., Mavoa, S., Badland, H.M., & Giles-Corti, B. (2013) Do low-income neighbourhoods have the least green space? A cross-sectional study of Australia's most populous cities. *BMC Public Health,* 14:292.

lead physically active lifestyles. Limited access to such resources is a risk factor for obesity,[34] with recent research demonstrating that for boys in particular, the presence of neighbourhood green space is linked to increased physical activity and a reduction in television viewing.[35]

We also know that for people on low-incomes it can be challenging, if not impossible, to incorporate active transport into their daily lives. Many low-income families are car-dependent because lower-cost housing is rarely close to jobs and services and is poorly serviced by public transport. In addition, a child or young person's ability to walk or cycle to school depends on neighbourhood characteristics such as the presence of infrastructure, neighbourhood amenability, and safety – characteristics that are lacking in many disadvantaged communities.

Low socio-economic areas also tend to have a higher concentration of fast-food outlets[36] and poorer access to healthy food[37], factors that have a significant impact on the risk of obesity.[38,39] Barriers to accessing healthy food are compounded in very low-income households that are less likely to have and use their own vehicle for regular food shopping than more advantaged households,[40] making it harder to compensate for the lack of access to fresh fruit and vegetables nearby.

Further, the placement of fast-food and takeaway outlets is of particular concern when it comes to influencing the health behaviours of children and young people, with both primary and secondary schools more likely to be in closer proximity to fast food restaurants in areas with higher levels of disadvantage.[41]

In working to address these issues, strategies are needed to ensure health and well-being becomes a key driver of planning decisions and processes. As a first step, we recommend that health and well-being be incorporated as an objective in the *Environmental, Planning and Assessment Act 1993* which is being reviewed later this year.[42] This would bring us into line with Queensland and Tasmania, with both states including a specific objective related to health in their planning laws. In addition, health impact assessments should be required for all major new developments to ensure new developments enhance the health of existing residents and facilitates the health of future residents.

We also recommend that a mapping exercise of green spaces across Greater Metropolitan Sydney be conducted. This should capture information about both the quality and accessibility of existing green spaces, and assist in identifying where further investment is required.

Recommendation 9: The NSW Government should include health and well-being as an objective in the *Environmental, Planning and Assessment Act 1993*.

Recommendation 10: Health impact assessments should be required for all major new developments

[34] Lachowycz, K. and Jones, A. P. (2011), Greenspace and obesity: a systematic review of the evidence. Obesity Reviews, 12: Dunton et al (2009), "Physical environmental correlates of childhood obesity: a systematic review", *Obesity Reviews*, 10: 393–402

[35] Sanders, T., Feng, X., Fahey, P., Lonsdale, C. and Astell-Burt, T. (2015) The influence of neighbourhood green space on children's physical activity and screen time: findings from the longitudinal study of Australian children. *International Journal of Behavioural Nutrition and Physical Activity,* 12: 126.

[36] Thornton, LE, Lamb, KE and Ball, K (2016). 'Fast food restaurant locations according to socioeconomic disadvantage, urban–regional locality, and schools within Victoria, Australia'. *SSM-Population Health*.

[37] Astell-Burt, T., Feng, X (2015) Geographic inequity in healthy food environment and type 2 diabetes: can we please turn off the tap? *The Medical Journal of Australia*, September 2015.

[38] Larson, N. I., Story, M. T., & Nelson, M. C. (2009). Neighborhood environments: disparities in access to healthy foods. *U.S. American Journal of Preventive Medicine,* 36(1), 74-81

[39] Bell, J., Mora, G., Hagan, E., Rubin, V., & Karpyn, A. (2013). Access to Healthy Food and Why It Matters: A Review of the Research. Available at: http://www.policylink.org/find-resources/library/access-to- healthy-food-and-why-it-matters. Accessed 10 June 2016.

[40] Food Research and Action Centre (2015) *Why Low-Income and Food Insecure People are Vulnerable to Obesity*

[41] Ibid.

[42] See *Legislative changes to simplify the planning system*.

Recommendation 11: The NSW Department of Planning and Environment, in collaboration with local councils, should conduct a mapping exercise documenting the quantity, quality and accessibility of green spaces across Greater Metropolitan Sydney, and invest additional resources to create or improve green spaces where required.

Education, awareness and exposure

Children are strongly influenced by their parent's dietary practices and food preferences, which are, in turn, influenced by factors including food affordability (discussed above) and nutritional knowledge and understanding. Advertising campaigns that promote healthy living, awareness-raising initiatives, and educational programs can therefore play an important role in equipping parents and carers to support their children to make healthier food choices. Similarly, they are crucial for young people who have not had the opportunity to acquire the skills and knowledge they need in order to be healthy. In order to succeed, health promotion initiatives must be tailored to specific audiences and take their needs and circumstances into account. As outlined above, we consider health promotion efforts should be targeted to low-income and vulnerable families, children and young people in two ways:

1. Via state-wide strategies tailored to particular vulnerable groups such as children and young people in out-of-home care or juvenile justice.
2. Via programs tailored to communities in particular locations, delivered through a place-based whole-of-community approach.

We also note that many of the factors that contribute to child overweight and obesity also contribute to poor oral health, and that like overweight and obesity, the result is a much greater burden of ill health on people experiencing poverty and disadvantage. We therefore recommend that the NSW Government scale up its preventative efforts, emphasising the common risk factor approach to health promotion, which will bring about benefits across the whole health system.

Recommendation 12: The NSW Government should scale up preventative efforts, emphasising the common risk factor approach to health promotion, which will bring about benefits across the whole health system.

In addition to being influenced by their parents' dietary intake, a child's food preferences are shaped by their exposure to food and information about food in a variety of settings. Children from lower socioeconomic backgrounds not only live in neighbourhoods with a higher density of unhealthy food options, they also spend more time watching television – and are more likely to have a television in their bedrooms[43] - and are therefore more exposed to messages that promote the consumption of unhealthy food. Measures that restrict the advertising of unhealthy food products are therefore likely to disproportionately benefit children from low-income backgrounds. This approach was supported by the WHO Commission on Ending Childhood Obesity[44], and is likely to be highly cost effective, saving $38 for every dollar invested.[45] We recommend that the NSW Government champion efforts to protect children from unhealthy food marketing through COAG.

Another population level measure that would support both parents, carers and young people themselves to make healthier food choices is the introduction of a tax on sugar sweetened beverages (SSBs). Given that

[43] Hardy L, King L, Espinel P, Cosgrove C, Bauman A. (2010) NSW Schools Physical Activity and Nutrition Survey (SPANS) Full Report. Sydney: NSW Ministry of Health, p239.

[44] WHO Commission on Ending Childhood Obesity (2016) Final Report, Recommendation 1.3.

[45] Gortmaker, S.L., et al., *Cost Effectiveness of Childhood Obesity Interventions: Evidence and Methods for CHOICES.* Am J Prev Med, 2015. **49**(1): p. 102-11

families with less disposable income are more responsive to price signals, and children in such families consume a greater amount of soft drinks, this approach is likely to disproportionately benefit children and young people from low income backgrounds. Sugar taxes been introduced in a number of countries - including France, Hungary and Mexico – and will be introduced in the UK in 2018.[46] The evidence of their efficacy is strong:

- The first year of Mexico's 10% tax on sweetened beverages, purchases of taxed beverages declined by 12%. A decline was found across all socioeconomic groups, with reductions highest among lower socioeconomic households.[47]
- UK modelling predicted that a 20% tax on SSBs would lead to a 1.3% reduction in the prevalence of obesity with the greatest effects likely to be seen in young people.[48]

Again, this policy has been recommended by the WHO Commission on Ending Childhood Obesity[49] and is highly cost effective, with recent modelling from the US demonstrating that a tax on SSBs would save $55 for every dollar invested.[50] There is also considerable support for the introduction of a sugar tax: A recent poll of 400 people receiving Government benefits conducted by NCOSS found that 53% of respondents supported a tax on sugar-sweetened beverages.

Revenue raised from a sugar tax should be channeled towards health prevention and promotion initiatives.

Recommendation 13: The NSW Government should champion efforts to protect children from unhealthy food marketing through COAG.

Recommendation 14: The NSW Government should advocate for the introduction of a tax on sugar sweetened beverages.

Conclusion

We thank the Committee for taking time to examine this important and timely issue, and appreciate the opportunity to contribute to this process. We would welcome the opportunity to answer any questions in relation to this submission, including appearing at a hearing. We are also currently developing a more detailed report and recommendations in relation to ensuring responses to child obesity reach low-income and vulnerable children, and will provide this to the Committee on publication.

[46] Ibid.
[47] Obesity Policy Coalition (2015) *Policy Brief The Case for An Australian Tax on Sugar Sweetened Beverages*
[48] Andreyeva et al., (2011) above n 14; Chaloupka F et al (2011) 'Sweetened beverages and obesity: the potential impact of public policies' 30(3) *Journal of Policy Analysis and Management* 644–665.
[49] WHO Commission on Ending Childhood Obesity (2016) Final Report, recommendation 1.2.
[50] Gortmaker, S.L., et al., *Cost Effectiveness of Childhood Obesity Interventions: Evidence and Methods for CHOICES.* Am J Prev Med, 2015. **49**(1): p. 102-11