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MNZH MAKE NEW ZEALAND HEALTHY

Reverse the Chronic Disease Crisis. In Brief.

THE PROBLEM: New Zealand's dietary guidelines have largely followed global convention, resulting in a decades-long consensus-based approach that has entrenched existing strategies while under-examining conflicting evidence and methodological limitations. This has contributed to a persistent under-emphasis on the role of nutrient-dense fats and proteins, despite their importance for satiety, metabolic regulation, and overall diet quality. While guidance has promoted fruit and vegetable intake, it has not adequately addressed the need for balanced macronutrient intake across fats, proteins, and carbohydrates.

At the same time, New Zealand is unusual in applying a 15% GST to nearly all foods, including basic healthy foods, during a period of rising food prices. This sits alongside a food environment in which ultra-processed foods (UPFs) remain relatively inexpensive.

Chronic disease reflects a departure from the body's normal state of health, arising from one or more underlying causes. Identifying and addressing these root causes is central to both prevention and treatment, even where medication plays an important role in managing a given condition.

Health plays a foundational role for individuals, society, business, and the nation. The underlying drivers of ill health are not specific to any one disease category, and our chronic disease crisis is not just an ageing problem. Children and young people are experiencing diet-related illness at earlier ages. Current dietary guidance and food-tax settings do not adequately support access to nutrient-dense whole foods, nor do they sufficiently discourage diets high in UPFs dominated by refined sugars and starches. These diets are typically low in essential micronutrients and key macronutrients, contributing to poor diet quality.

The result is a growing burden of metabolic dysfunction, including unstable blood glucose, elevated triglycerides, insulin dysregulation, and increased risk of diabetes, cardiovascular disease, systemic inflammation, and related neurological conditions.

UPFs now constitute a substantial proportion of dietary intake internationally. Estimates suggest they provide approximately 45–60% of total energy intake in countries such as Canada, the United Kingdom, and Australia, with the highest consumption among younger age groups. New Zealand data are limited, but available evidence indicates that UPFs contributed around 42–51% of total energy intake by age five, over a decade ago.

Addressing the Underlying Causes. The Scientific Case for a Metabolic Approach:

A substantial body of literature demonstrates that:

a. Diets high in refined carbohydrates and ultra-processed foods are associated with dysregulated glucose and insulin signalling, contributing to metabolic syndrome, type 2 diabetes, systemic inflammation and a host of other physical and brain-related conditions.
b. Total carbohydrate load and quality, not only free sugars, influence glycaemic control and downstream metabolic outcomes.

c. Adequate protein intake, including sufficient essential amino acids, supports satiety regulation, lean mass maintenance, and metabolic stability, and is critical during periods of growth, development, and pregnancy.
d. Evidence on dietary fats indicates that health effects are context-dependent, and that whole-food sources of fat cannot be equated with industrial trans fats.
e. Diet quality is more accurately captured by nutrient density and degree of processing, rather than isolated nutrient thresholds.
f. Emerging evidence indicates that ultra-processed foods may elicit addiction-like responses in some individuals, including craving, loss of control, and continued consumption despite harm.

THE SOLUTION: A coordinated set of policy reforms that realign dietary guidance, food pricing, and the wider food environment to reduce exposure to refined carbohydrate-dominant ultra-processed foods and improve access to nutrient-dense whole foods. Together, these measures address the systemic drivers of metabolic disease by reshaping the food environment.

1) Dietary Guideline Reform: A balanced whole food, macronutrient approach.

Refined carbohydrate reduction: Explicit guidance to reduce intake of refined carbohydrates, including refined starches and sugars to lower blood glucose levels and protect patients from elevated insulin levels and recognition of glycaemic load and metabolic impact as relevant considerations.

Macronutrient balance: Inclusion of guidance on adequate protein intake across the life course; Recognition of the role of whole-food dietary fats within healthy dietary patterns; Removal of implicit or explicit bias toward high-carbohydrate dietary patterns.

Fat quality clarification: Clear distinction between industrial trans fats (to be avoided) and whole-food sources of dietary fat and the avoidance of blanket restrictions that conflate these categories.

2) Fix Food Taxes. Current taxation is upside down. Let's fix it!

Remove GST from core staple foods. GST should be removed from a defined basket of minimally processed staple foods that support metabolically healthy diets. The exemption would apply to minimally processed foods with limited ingredients and certain savoury culinary ingredients.

Impose a 20% tax on sugar sweetened beverages and non-essential carbohydrate-rich ultra-processed packaged foods using an administratively simple threshold of ≥275 kcal per 100 grams.

3) Restore Ka Ora, Ka Ako School Lunches in Low Decile Schools.

Ensure reliable access to nutritious school meals as an effective public-health intervention for improving child nutrition and reducing health inequalities, with a renewed emphasis on nutritional quality and minimally processed foods

4) Food Marketing & Advertising: Reducing Exposure Without Burdening Users.

Apply a comprehensive regulatory framework across outdoor and public spaces, broadcast media, retail environments, to digital and cross-platform marketing (without imposing user age identification requirements) and limit sponsorship and brand exposure in environments where children live, learn and play.