

1. REVERSE THE CHRONIC DISEASE CRISIS

Repivot fiscal policy for metabolic disease prevention within an integrated framework spanning dietary guideline reform, school lunch provision, and advertising regulation.

Dietary Guideline Reform: A balanced whole food, macronutrient approach Page 4.

- Explicit guidance to reduce intake of refined carbohydrates & prioritise nutrient dense foods.
- Restore macronutrient healthy fats and proteins dietary guideline recommendations.
- Recognise that different people have different tolerances to carbohydrates.

Fix Food Taxes. Current taxation is upside down. Let's fix it! Page 6.

- Remove GST from a defined basket of minimally processed staple foods that support metabolically healthy diets.
- Introduce a 20% excise tax on sugar-sweetened beverages & an excise tax on non-essential carbohydrate-rich ultra-processed packaged foods, using an administratively simple threshold of ≥ 275 kcal per 100 g.

Restore Ka Ora, Ka Ako School Lunches in Low Decile Schools Page 8.

- Restore the programme in the low-decile schools it was originally designed to serve, with a renewed emphasis on nutritional quality and minimally processed foods.

Food Marketing & Advertising: Reducing Exposure Without Burdening Users Page 8.

- Approaches in digital environments must place responsibility on systems and intermediaries, platforms, advertisers, and data brokers, rather than on individuals to verify their age.

2. PUT PREVENTION BACK AT THE HEART OF HEALTHCARE

Implement an integrative system to support and empower healthcare professionals to identify root causes of illness (multimorbidity) and optimise nutritional interventions for optimal health at all ages.

Metabolic Health Strategy: Screening for unwell populations Page 5.

- Upgrade and extend screening to improve metabolic health parameter testing for: Standard lipids - add apoB; Glucose/HbA1c - add fasting insulin or TyG logic; hs-CRP and uric acid; vitamin D, vitamin B12, folate, iron (ferritin + transferrin saturation), magnesium, zinc, and selenium; and testing to assess functional methylation impairment on presentation of complex chronic and brain-related conditions.

Implement Health Coaching for a Nutritional Upgrade (10 year plan) Page 6.

- Prioritise: Individuals diagnosed with prediabetes or type 2 diabetes, obesity with self-reported food addiction, or those receiving mental health and addiction services.

- Purpose: Support stabilisation of blood glucose, promote healthier insulin signalling, improve diet quality, and reduce systemic inflammation through practical lifestyle and nutritional strategies.
- Programme: GP oversight, nutrition-focussed health coach integration across primary care, mental health, addiction services with community and peer support components and digital tools (e.g. continuous glucose monitoring devices) to monitor outcomes.

Mental Health: Multinutrient Supplementation as a First-Line Intervention Page 7.

- Establish a first-line or early-stage intervention option for vulnerable populations, particularly where current treatments carry significant side-effect burdens or are poorly tolerated.
- Priority populations include children and adolescents with ADHD or mood dysregulation, pregnant women experiencing anxiety or depression, individuals with treatment resistant mental health conditions, and those experiencing side effects from psychiatric medication.

Helping Doctors and Clinicians Page 9.

- This policy overlaps with other policies to support system-wide change: apply nutrition therapeutically at levels that optimise health; ensure scientific information is up to date and research institutions can support nutritional approaches; integrate health coaching; reform guidelines; strengthen nutrition education; and reduce doctors' administrative burden.

3. EMBED NUTRITION FROM SCHOOL TO UNIVERSITY

Introduce physiological and nutritional concepts early and revisit to deepen understanding, so students move beyond description to causal reasoning. By adolescence, students can connect dietary patterns to metabolic and brain processes, and can assess real-world influences on health.

Primary and Secondary Years. Pages 4 and 22-26

Staged, age-appropriate health education first builds from basic concepts of energy and body systems (ages 8–10); second, deepens understanding to integrate metabolism, brain function and nutrient roles (ages 11–15); and third, culminates in senior students (15–18) applying mechanistic knowledge to analyse food environments, evaluate health issues, and design biologically grounded programmes.

Undergraduate Health & Biomedical Studies. Pages 4 and 26-30.

Re-anchor the curriculum around first principles of physiology and system regulation, position nutrition and nutrient sufficiency as foundational biological inputs, integrated vertically across years and disciplines, so that macronutrients and micronutrient cofactors are consistently recognised as drivers of metabolic, neurological, and endocrine function.

Embed clinical translation from the outset, and align institutional signals, examinations, clinical supervision, and teaching materials to support this model.





4. PAUSE THE MEDICAL PRODUCTS BILL

Cease drafting and place a temporary moratorium on the legislative process. Return to broad, transparent public consultation that extends beyond undisclosed officials, to establish an evidence-based policy foundation prior to Bill drafting.

Key issues that require resolution prior to drafting a future bill include: Pages 4-5

- Declaration of officials and advisors, including relevant expertise, informing policy and legislation.
- Substantive, evidence-based review of biologic medicines and their distinct risk profiles.
- Clear statutory principles for regulatory decision-making.
- Evaluation of international best practice in medicines regulation and clinical trial design.
- Systemic challenges in adverse-event reporting, including under-reporting and the exclusion of non-serious but clinically meaningful harms.
- Evaluation of polypharmacy and interaction risk, including harms arising from two-drug combinations.
- Streamlined access to Pharmac funding for nutrients with a long history of safe use.
- Development of an appropriate regulatory framework for natural health products.
- Consideration of risk-based classification models for nutrients.
- Assessment of disproportionate penalties applied to low-risk substances.



5. GUARANTEE SCIENTIFIC INTEGRITY IN INFORMED CONSENT

A scientifically and ethically appropriate informed consent framework must convey both therapeutic benefit and potential for serious harm in absolute, comprehensible, and population-relevant terms.

To meet a reasonable public-interest standard, consent materials must include: Pages 4-7

- **Routine screening for key nutrient insufficiencies and metabolic markers** where clinically relevant before initiating long-term pharmacotherapy. Integrate nutrition as a first line strategy where appropriate.
- **Require mandatory disclosure of absolute benefit and harm data.** This information must be age- and sex-stratified (numbers needed to treat and numbers needed to harm).
- **Ensure that national formularies and Medsafe data sheets include:** Original trial citations (with DOIs), study durations and population characteristics; clear disclosure of evidence gaps; and linked access to systematic reviews and regulatory evaluations.
- **Provide doctors with trial decoding tools:** Publicly verifiable tables showing absolute event counts and study-level metadata to understand risk or benefit by age, gender and health status.
- **Implement a statutory Five-Year Evidence Reappraisal Cycle** for all medicines listed on the Pharmaceutical Schedule.
- **Systematic evidence integration that assimilates data for best evidence** including regulatory assessment reports (e.g., FDA, EMA, TGA, Medsafe, NICE, Health Canada); clinical study reports, trial registries and post-marketing data; pharmacovigilance databases, including spontaneous reports and cohort analyses; and peer-reviewed literature and meta-analyses.



6. REMOVE PHARMAC BARRIERS TO RECOGNISED SAFE NUTRIENTS

Stop government agencies categorising a nutrient formulation as a medicine solely because marketing or consumer information describes that formulation as influencing physiological processes, irrespective of dose or intrinsic risk.

Reform nutrient regulation to assess biologically essential, low-risk nutrients through a proportionate nutrition and food-law lens, rather than being swept into medicines controls through overly broad functional triggers. **Pages 3-6.**

Establish a Tiered, Risk-Proportionate Regulatory Framework: Align regulatory control with dose, exposure, and demonstrated risk and replace the current system, which can escalate substances into medicines regulation based on physiological effect alone, with a tiered model.

Remove Automatic Medicines Classification Based on Physiological Function: Nutrients that support, influence, or restore normal physiological function must not, in themselves, trigger medicines classification.

Use Upper Intake Levels as Scientific Risk Benchmarks Only: Upper intake levels should be treated strictly as scientific risk reference points, not regulatory thresholds that trigger reclassification as a medicine.

Require Case-by-Case, Contextual Assessment: Make regulatory decisions on a case-by-case basis, taking into account dose, chemical form, route of exposure, population context, and total cumulative intake.

Modernise and Implement Weight-of-Evidence Scientific Method: Strategically review mechanistic biology, clinical trials, observational and cohort data, case reports and biomarker and physiological data.

Recognise Biological Function as a Foundational Regulatory Principle: Ensure legislation explicitly recognises that nutrients are endogenous and biologically essential and that physiological roles are expected.

Proportionate Decision-Making Under Uncertainty: Introduce a statutory principle where regulatory frameworks distinguish between theoretical hazards, mechanistic plausibility and demonstrated clinical harm.

Immediate Alignment of Clearly Outdated Thresholds. Immediately update secondary legislation where existing thresholds are demonstrably conservative and not grounded in contemporary scientific risk assessment.

Mandatory Scientific Transparency and Expertise Disclosure. Require committees to include appropriate expertise in nutrition science, physiology and nutritional toxicology. All names and conflicts of interest must be disclosed.

Establish a Dedicated Nutrient Assessment Pathway. Independent evaluation with iterative evidence development, as a practical route for low-risk, non-patentable substances to be assessed and accessed.



7. REDUCE THE ADMINISTRATIVE BURDEN AND RESTORE PROFESSIONAL AUTONOMY IN GENERAL PRACTICE

Implement integrated reforms that protect clinical judgement and patient autonomy; expand access to evidence, including through AI platforms that incorporate physiological, nutritional and toxicological drivers of disease; and strengthen access to pharmaceutical, nutritional and integrative evidence and professional development.

Introduce ten governing principles that support practitioner decision-making. Page 5.

This permits emerging evidence and different therapeutic approaches to be considered within a common structure, while preserving clinical judgement, patient autonomy and accountability.

Introduce a Primary Care Therapeutic Decision Matrix. Page 7.

Practical framework that supports systematic clinical reasoning without prescribing a single therapeutic pathway. Symptoms and diagnoses may arise from interacting metabolic, nutritional, inflammatory, endocrine, behavioural, psychosocial and environmental factors. Their expression and response to treatment can vary according to genetics, developmental history, life-course exposures, comorbidities and other circumstances.

Working with AI: Integrate first principles into clinical inquiry. Page 9.

Ensure AI-supported clinical search systems routinely bring relevant physiology, biochemistry and underlying biological and functional factors into clinical inquiry, broadening the knowledge available to GPs while preserving professional judgement and autonomy. This is because ‘clinical information’ is itself shaped by the boundaries of established guidelines, databases and search systems.

Education & Professional Development. Page 11.

Expand professional development and strengthen knowledge across nutrition and lifestyle medicine, behavioural and psychological health, informed consent, integrative approaches and social prescribing, while preserving and extending core medical expertise.

Health System Indicators & Whole-of-Government Accountability. Page 12.

Expand indicators and targets to encompass glycaemic control and remission, central adiposity, polypharmacy burden, blood pressure distribution, mental health function, and early-life metabolic health.

Reduce GP Burdens & Restore Capacity for Primary Care. Page 13.

Redesign primary-care workflows, reporting requirements and funding by systematically reviewing non-clinical demands on General Practice, separating clinical from clerical and administrative work, reducing reporting, compliance and information-processing burdens, using bounded digital systems to reduce administrative burden and expanding team-based prevention and health coaching.

Prioritise Primary Care & Patient Partnership for Long-Term Health. Page 14.

Align primary care incentives with health outcomes to structure workforce design and clinical systems as an integrative primary-care model that rewards improved health and continuity of care, and strengthen the capacity of patients and surrounding communities to participate as informed partners in preventive, individualised and longitudinal care.



8. REQUIRE THE NZ EPA TO USE THE BEST AVAILABLE EVIDENCE

Build a public-good, transparent and integrated system for monitoring, analysing and making regulatory judgements that protects human and environmental health in practice, not merely in principle.

- 1. Build a permanently funded stewardship intelligence function.** Establish an internal unit responsible for continuous horizon scanning, systematic evidence review, uncertainty characterisation and data publication.
- 2. Re-orient reassessment towards New Zealand exposure reality.** Ensure that overseas regulatory conclusions and industry submissions are inputs to reassessment, not substitutes for it.
- 3. Appoint a Senior Integrated Pest Management & Resistance Ecology Adviser** (principal scientist level).
- 4. Hard-wire mixtures and cumulative exposure into routine practice.** Move beyond single substance assessment as the regulatory default. Incorporate class-based grouping, mixture prioritisation and cumulative-loading analysis into standard procedure.
- 5. Create an operational precaution framework under HSNO.** Publish a clear decision pathway showing how material uncertainty is to be handled.
- 6. Build monitoring-to-regulation feedback loops and reinstate Environmental Exposure Limits (EELs).**



9. RE-ESTABLISH SCIENCE FOR HEALTHY PEOPLE & HEALTHY SYSTEMS

Re-establish a coherent national science and research system to restore the foundational role of publicly funded research: generating the knowledge required to understand and steward the nation's human, environmental and productive systems.

- 1. Re-establish a dedicated Ministry of Research Science and Technology,** as the central public authority responsible for stewardship of the national research, science and technology system, replacing the current system where the science system is embedded inside the Ministry of Business, Innovation and Employment.
- 2. Establish a statutory Institute for Human and Environmental Health Research,** responsible for long-horizon interdisciplinary investigation into the biological, environmental and social determinants of human health and disease.
- 3. Affirm AgResearch in statute as a public-good agricultural science institution,** tasked with supporting the resilience, sustainability, and productivity of New Zealand's agricultural systems across pastoral farming, horticulture, arable systems, forestry and dryland agriculture.
- 4. Legally require the Ministry to maintain national scientific capability in essential domains** for the long-term wellbeing and resilience of New Zealand, including environmental health, agriculture, nutrition science, chronic disease causation, and the environmental drivers of human health and disease.
- 5. Provide for coordinated national monitoring and knowledge infrastructure,** enabling the research system to generate continuous scientific intelligence about the condition of the nation's key biological and environmental systems, including environmental pollutants, chemical exposures, soil systems, water systems, and population health determinants, while also informing the design, maintenance and long-term management of national assets.

6. Enact a Research, Science and Technology Stewardship Act to re-establish independent science as a core national capability serving the long-term wellbeing of people, ecosystems, productive systems and infrastructure. The inclusion of infrastructure stewardship within the purpose of a research and science statute reflects the historic role of public science in informing the design, maintenance and long-term management of national assets.



10. SUPPORT FARMERS & GROWERS THROUGH BETTER AG SCIENCE

Refocus and reorientate agricultural science to prioritise public-good, integrative research to support the agricultural sector with intelligent, informed and dynamic two-way feedback loops between scientific researchers and farmer and grower groups.

1. Establish a Guiding Principle. Science in New Zealand should be guided by kaitiakitanga: the stewardship and protection of soils, waters, ecosystems, and human wellbeing for present and future generations, through knowledge that sustains resilience, restores biological integrity, and supports enduring prosperity.

2. Ring-fence public-good systems science. Dedicated funding is needed for soil health, pest ecology, nutrient cycling, pasture resilience, nutrient density and climate variability adaptation: the biological infrastructure that underpins productivity.

3. Restore farmer and grower co-design with scientific communities. Structured participation ensures research priorities reflect field realities and enables early detection of systemic stress signals.

4. Rebuild extension as a two-way knowledge loop. Sustained extension capacity is essential to translate science into practice and to feed farmer observations back into research design.

5. Strengthen independent IPM and resistance research. Public research is needed to evaluate spraying thresholds, resistance management, and the real-world impacts of chemical mixtures.

6. Recognise resilience and durability as export infrastructure. Soil function, ecological stability and postharvest quality retention underpin market performance and long-term sector viability.