Auckland Women's Health Council

Submission of the Auckland Women's Health Council
Proposed changes to the promotion and provision of healthy drinks in schools

Background to the Auckland Women's Health Council

The AWHC was founded 33 years ago (July 1988) and has a special interest in patient rights, informed consent and decision-making in health care, health consumer advocacy, the Code of Health and Disability Services Consumers' Rights ('Code of Rights'), consumer voice and representation, medical ethics, and the social and commercial determinants of health.

The AWHC has had a long and sustained interest in advocacy and consumer representation; our goal is to provide an independent feminist voice focused on women's and family/whānau health and health services. Over the last three decades we have been active in advocating for upholding patient/ consumer rights, including making formal submissions on a wide range of health topics, such as the legislation and regulations governing various health and disability services, and in consumer representation roles relating to health and disability services.

Our priorities include: that women have the right to make informed decisions regarding their own health care and treatment; that women participate in all decision-making processes for health care services; and that women have accessible, affordable, available, and accountable health care services.

In the context of the "Proposed changes to the promotion and provision of healthy drinks in schools" we are not a school, nor do we have any role or responsibilities to or in any schools. However, all Executive Committee members are parents and do have or have had parental roles in the dietary choices of their children. In as much as we have an ongoing advocacy role in the health and well-being of Auckland women, we believe that a healthy diet is critical for health, well-being and longevity.

AWHC beliefs regarding healthy food and drink:

We believe that:

The vast majority of children/tamariki not only survive but thrive only on breastmilk and water as a first option, and properly formulated alternative infant and toddler milks and water as a second option. Drinks that are not water or milk, such as juices, fruit drinks, cordials, soft drinks and other sweetened drinks, are not necessary for the growth health and well-being of children/tamariki.

A child's diet should predominantly comprise fresh foods, cooked/created at home with a focus on a plant-based diet plus quality animal protein or complex plant proteins. Highly processed foods, foods high in sugar and additives should be avoided or provided as occasional foods only.

The consumption of healthy food should be modelled and encouraged from a young age and children/tamariki should be taught about what their bodies need to thrive and be healthy from a young age.

Schools/kura have a role in modelling and teaching children/tamariki and young people/rangatahi at primary and secondary schools about healthy food and nutrition.

Schools/kura should not be making unhealthy food available except for special occasions such as school events (social events, fund-raising fairs, etc.). Unhealthy food should not be available to children/tamariki in schools/kura through school tuck shops and lunch buying programmes.

Children/tamariki are better able to learn when provided with healthy, nutritious food, and are not hungry. Children/tamariki learn better and behave better and are more focused in school/kura when they do not have access to sweetened drinks.

Nutrition and Health

We are concerned that the discussion document focuses only on the contribution that sugar sweetened beverages makes to high rates of decayed, missing or filled teeth in children/tamariki in Aotearoa New Zealand (Problem definition/opportunity – Question 2). We agree that there is a significant problem with oral health in New Zealand children/tamariki; at the same time we believe that there are additional important long term health issues that should be considered as well when discussing the role of healthy food and drink in schools/kura. To omit healthy food from this discussion and to ignore long-term health issues is a missed opportunity to make a significant difference to the health of our children/tamariki well into their futures.

Unhealthy food and drink are major contributors to numerous health issues.

According to a Ministry of Health report[1] on health loss in Aotearoa New Zealand:

Across all condition groups, cancers and vascular and blood disorders (including coronary heart disease) are the equal leading causes of health loss at 17.5% of total DALYs[2] each. Diabetes and other endocrine disorders is 9th with 4.1% of total DALYs; diabetes alone accounts for 3% of total DALYs. Coronary heart disease is by far the leading specific cause of health loss accounting for 9.3% of DALYs

In addition, diabetes is a risk factor for coronary heart disease, ischaemic stroke, and dementia, and so indirectly contributes to the burden of other diseases. "Furthermore, a raised blood glucose or glycated haemoglobin (HbA1c) level below the diagnostic threshold for diabetes (sometimes called pre-diabetes) also increases the risk of these conditions."[1] On this basis, the total burden of diabetes and pre-diabetes, including both direct and indirect burdens, is estimated to be 4.7% of total DALYs.

Collectively, dietary risk factors and excess energy intake (high BMI) account for 11.4% of health loss. The MoH report acknowledges that the impact of diet as a risk factor is "likely to underestimate diet-related health loss because it is based on only three dietary components: high sodium intake, low vegetable and fruit intake, and high saturated fat intake"[1], and doesn't include other dietary influences, such as sugar consumption/high blood glucose. However, high BMI can be included along with the dietary risk because it reflects dietary energy intake in excess of energy expenditure requirements.

1 MoH, 2013: Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016. Wellington: Ministry of Health.

2 Disability adjusted life years. DALY combines information on both fatal outcomes (early death) and non-fatal outcomes (illness or disability).

Among individual risk factors, high BMI (7.9%) was the second greatest risk to health.

High BMI, blood glucose, sodium intake, and saturated fat intake and low vegetable and fruit intake all contribute to vascular disease (including coronary heart disease) and most contribute to diabetes, while obesity, sodium intake and low fruit and vegetable intake contribute to the burden of cancer.

The MoH Report finds that "there is considerable scope for prevention, with tobacco, diet, physical activity, alcohol, obesity and diabetes all important potentially modifiable risks to health."[1]

The International Cancer Research Agency (IARC) lists diet and body weight/BMI as two of the five major lifestyle factors[3] that contribute to cancer. If all five were addressed one third of cancers could be prevented.[4, 5]

Reflecting the significant contribution that cancer makes to health loss, as reported in *Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study*[1], IARC reports that in 2020, Aotearoa New Zealand had the second highest incidence of cancer[6] in the world (second only to Australia).[7] Cancer is the leading cause of premature death in 30 to 69 year old New Zealanders;[7] approximately 25,000 people are diagnosed in this country each year.[7] Addressing the dietary contribution to cancer could save thousands of lives in this country in the future.

Unhealthy diet is the biggest contributor to type 2 diabetes.

The number of people diagnosed with diabetes in Aotearoa New Zealand has increased by over a third in the last decade to almost 280,000; that is one in every eighteen people.[8]

According to the MoH, "this increase is largely due to the growing prevalence of type 2 diabetes, which accounts for around 9 out of 10 diabetes cases. Growing levels of obesity are fuelling this increase which is predicted to reach between 390,000–430,000 people living with type 2 diabetes by 2040, one in every twelve people."

Additionally, "the incidence of type 2 diabetes mellitus in children and adolescents is increasing as the rates of childhood obesity have increased. Evidence suggests that this disease commonly progresses more rapidly in youth compared with adults and is associated with high rates of early microalbuminuria, hypertension, and dyslipidemia."[9] Young people with type 2 diabetes have a much shorter life expectancy than their peers with type 1 diabetes, due to the aggressive nature of their disease and associated comorbidities.[8]

High blood glucose (including diabetes and pre-diabetes) accounts for 6% of health loss in Aotearoa New Zealand, including health loss from both disability and premature mortality.[1]

3 The others are tobacco smoking, alcohol consumption and exercise.

4 WHO, 2022: Cancer Fact Sheet, World Health Organization, 3 February 2022

5 Wild CP, Weiderpass E, Stewart BW, editors, 2020: World Cancer Report: Cancer Research for Cancer Prevention. Lyon, France: International Agency for Research on Cancer.

6 All diagnoses for all cancer types/sites.

7 IARC: Data visualization tools for exploring the global cancer burden in 2020, World Health Organisation, International Agency for Research Cancer.

8 MoH, 2022: Draft Diabetes Action Plan 2022-2027, Ministry of Health, Wellington.

9 Narasimhan S & Weinstock RS, 2014: Youth-onset type 2 diabetes mellitus: lessons learned from the TODAY study. Mayo Clinic Proceedings, 2014 Jun;89(6):806-16.

Proposed changes to the promotion and provision of healthy drinks in schools

In light of the compelling evidence that unhealthy food is a major contributor to the burden of disease, including mortality, AWHC finds it quite bizarre that proposed changes focus on the promotion and provision of healthy drinks alone.

In terms of the options that are presented in the Discussion Document, we believe that there should be a fourth option:

> That the existing nutrition guidelines for schools are replaced with a regulation that all schools and kura ***promote healthy, nutritious food***, and a duty on ***all*** schools/kura (primary and secondary) ***to only provide healthy food and drinks***.

This would mean that all school tuck shops/cafeterias could only provide/sell healthy food and drinks, and that all schools must be teaching students about healthy food and drink.

The importance of this opportunity for schools/kura to influence the life-long health of our children/tamariki and young people/rangatahi cannot be overstated.

We do not believe that "regulating the provision of healthy drinks is simpler to implement" is an adequate or valid reason not to include healthy food in these regulations.

We believe that this should be implemented at both primary and secondary schools/kura, especially because secondary schools are more likely to have tuck shops.

We agree that there should be circumstances where the duty to provide only healthy food and drink may not apply, such as for school events and social events such as school fairs and other fundraising events, socials/dances/balls.

We also believe that, while students and whānau should be encouraged to bring only healthy food to school, strict regulation of this should not be imposed or prescribed. One of the greatest barriers to healthy eating is cost.

Equitable access to health and well-being is not just about enablers – e.g. promoting and providing healthy food and drink within schools – but also about dismantling barriers. Financial barriers to health and well-being are a significant issue for our most vulnerable communities. No amount of promotion and teaching will assist people living with high levels of deprivation and/or below the poverty line to buy healthy food when unhealthy, calorie dense food is cheaper. In the last year fresh fruit and vegetables have increased in price by 17%, almost three times the rate of inflation, already at a 30-year high. Regulations about promoting healthy food and drink, and education about healthy nutrition will not pay for healthy food, and the social and economic factors that influence poor health must also be addressed in order for families/whānau to be in a position to supply their children/tamariki and young people/rangatahi with healthy food for eating at school/kura.

In terms of the circumstance where schools/kura have an existing supply of, or contract to buy and supply unhealthy food and drink for sale or use at school events, a "sunset" clause of 12 months should be more than adequate to allow schools to exhaust that supply or end a contract for supply. Food and drink have a shelf life and it would be entirely possible for schools/kura to transition to compliance with the regulations in a 12 month period.