Benchmarking Food Environments:

Experts' Assessments of Policy Gaps and Priorities for the New Zealand Government



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Further information on INFORMAS and the Food-EPI is available at: **www.informas.org**

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Executive Summary

New Zealand has an unacceptably high prevalence of overweight and obesity. Two in three adults and one in three children are overweight or obese. Diet-related non-communicable diseases (NCDs), such as diabetes, cardiovascular diseases and many cancers are the biggest cause of death and ill-health in New Zealand and they are preventable.

Effective government policies and actions are essential to increase the healthiness of food environments[1] and to reduce these very high levels of obesity, NCDs, and their related inequalities. Internationally, there is wide recognition of this major public health issue. It is critical that the New Zealand Government implements preventive policies and actions to match the magnitude of the burden that unhealthy diets are creating. Monitoring the degree of implementation of the policies and actions recommended by the World Health Organisation (WHO) is an important part of ensuring progress towards better nutritional health for New Zealanders.

Approach

This report presents the results of a study, using the Food Environments Policy Index (Food-EPI), which assessed the New Zealand Government's level of implementation of policies and infrastructure support against international best practice for improving the healthiness of food environments. The Food-EPI is an initiative of INFORMAS (International Network for Food and Obesity / NCDs Research, Monitoring and Action Support) and was conducted in New Zealand with an Expert Panel of over 50 independent public health experts and representatives from medical associations and non-governmental organisations (NGOs).

The Expert Panel rated the extent of implementation of policies on food environments and infrastructure support systems by the New Zealand Government against international best practice. They also identified and prioritised actions needed to address critical gaps in government policies and infrastructure support. These priority actions are needed to improve the healthiness of food environments as these environments are major drivers of unhealthy diets and obesity.

Assessment results

The assessment of the implementation levels of priority policies and infrastructure support showed some areas of strength. New Zealand and Australia have set the international benchmark in one area by applying a nutrient profiling system to prevent unhealthy foods carrying health claims. New Zealand is also at world standard, along with many other high income countries, in requiring nutrition information panels on packaged foods, having good monitoring systems for NCDs and their risk factors, and having high levels of transparency in policy development and access to government information. Several other initiatives are underway such as reducing trans fats in foods, implementing food-based dietary guidelines, developing systems-based actions with communities (Healthy Families NZ), and establishing an interpretive front-of-pack labelling system (Health Star Ratings).

However, of major concern was the high number of food policies which were rated as having 'very little, if any, implementation'. This was especially apparent in the areas of reducing the marketing of unhealthy foods to children, using fiscal policies to support healthy food choices, supporting local communities to limit the density of unhealthy food outlets in their communities (for example, around schools and early childhood education (ECE) services), and ensuring that trade and investment agreements do not negatively affect population nutrition and health.

An enormous gap in New Zealand is the lack of a comprehensive national action plan to address unhealthy food environments and to reduce obesity and NCDs. The Healthy Eating Healthy Action implementation plan was prematurely terminated along with its funding and evaluation in 2010 and no plans have been announced to replace it. New Zealand will be expected to report to WHO in 2015 that it has a fully funded, comprehensive plan to reduce NCDs. This must be the highest priority for action.

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1 Food environments are defined as the collective physical, economic, policy and socio-cultural surroundings, opportunities and conditions that influence people's food and beverage choices and nutritional status. New Zealand's high levels of obesity and diet-related NCDs are related to the food environments in which New Zealanders live. Unhealthy food environments lead to unhealthy diets and excess energy intake which have detrimental consequences on morbidity and mortality. Dietary risk factors (high salt intake, high saturated fat intake and low fruit and vegetable intake) and excess energy intake (high body mass index) account for 11.4% of health loss in New Zealand.

New Zealand will also be expected to report on progress on reducing marketing of unhealthy food products to children and the reduction of saturated fatty acids in the food supply because these are two of the 25 core indicators in the WHO NCD Monitoring Framework. The absence of government action in protecting children from commercial exploitation will not be considered acceptable progress for a high income, high capacity country with one of the highest rates of childhood obesity in the world.

Priority recommendations

The Expert Panel recommended 34 actions, prioritising 7 for immediate action. They are to:

1. Implement a comprehensive national action plan for obesity and NCD prevention.
2. Set priorities in Statements of Intent and set targets for
   a. reducing childhood and adolescent obesity
   b. reducing salt, sugar and saturated fat intake
   c. food composition (salt and saturated fat) in key food groups
3. Increase funding for population nutrition promotion, doubling it to at least $70m/year.
4. Reduce the promotion of unhealthy foods to children and adolescents by
   a. restricting the marketing of unhealthy foods to children and adolescents through broadcast and non-broadcast media.
   b. ensuring schools and ECE services are free from commercial promotion of unhealthy foods.
5. Ensure that foods provided in or sold by schools and ECE services meet dietary guidelines.
6. Implement the front-of-pack Health Star Rating labelling system.
7. Introduce an excise tax of at least 20% on sugar-sweetened beverages.

The New Zealand Government is strongly urged to act on these recommendations to improve the diets of New Zealanders, reduce health care costs and bring New Zealand towards the progressive, innovative and world leader of public health that it can be.

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1. Why do we need to improve New Zealand's food environments?

New Zealand has very high levels of obesity with adults having the third highest rate of obesity within OECD countries, behind the United States and Mexico (1). Overall, in 2012, nearly two thirds of New Zealand adults were either overweight (34%) or obese (31%) with higher rates for Māori adults (48%) and Pacific adults (68%), and in those with greatest levels of deprivation (2). New Zealand children also have high rates of obesity, their rates are higher than those for children in Australia and in almost all Western European countries (1). In 2012, 11.1% of children aged 2 to 14 years were obese which had increased from 8.4% in 2006 (2).

Unhealthy diets and excess energy intake are modifiable factors that contribute to disease and disability in New Zealand.[2] Recent analysis shows that, collectively, dietary risk factors (high salt intake, high saturated fat intake, low vegetable and fruit intake) and excess energy intake (high body mass index, BMI) account for 11.4% of health loss in New Zealand (3). This is greater than the estimated 9.1% of health loss from tobacco use. The main diet-related diseases include cardiovascular diseases, diabetes and many cancers. These diseases are the main killers of New Zealanders (3, 4) and the health costs they incur are rising rapidly. For example, it has been calculated that overweight and obesity directly cost the health system $624M or 4.4% of New Zealand's total health care expenditure in 2006, in addition to $225 million in lost productivity (calculated using the Human Capital Approach) (5). The health care costs and lost productivity are now probably about $1 billion annually.

Currently, food environments[3] in New Zealand are characterised by highly accessible and heavily promoted energy-dense, often nutrient-poor, food products with high levels of salt, saturated fats and sugars. These environments are major drivers of unhealthy diets and energy overconsumption (6, 7) and are shaped by governmental, food industry and societal mechanisms (Figure 1).

Who can help improve the healthiness of food environments and population diets?

National governments and the food industry are the two major stakeholders groups with the greatest capacity to modify food environments and population diets. Effective government policies and actions are essential to increase the healthiness of food environments and to reduce obesity, diet-related non-communicable diseases (NCDs), and their related inequalities (8).

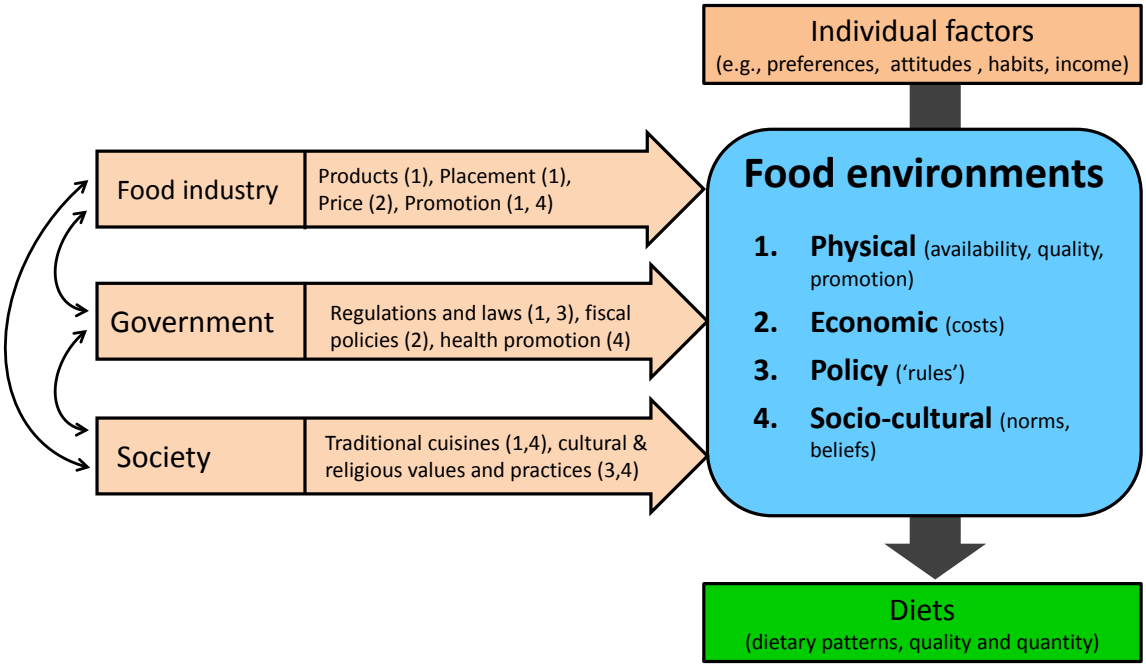
Despite wide recognition of this major public health issue internationally, slow and insufficient action by governments and the food industry to improve food environments continues to fuel rising levels of obesity and diet-related NCDs. This is in part due to the pressure of the food industry on governments (9-11) as well as other factors, such as the challenges of providing robust evidence on policy effectiveness before its introduction and competition for resources between prevention efforts and health services delivery (12).

However, some governments internationally have demonstrated leadership and taken action to improve food environments, and these can serve as best practice exemplars or benchmarks for other countries. (The evidence summary, Appendix 2, lists examples of best practice internationally and related references.)

2 Low physical activity is also an important modifiable risk contributing to health loss in New Zealand, however, the focus of this report is food environments, population diets and diet-related NCDs.

3 Food environments are defined as the collective physical, economic, policy and socio-cultural surroundings, opportunities and conditions that influence people's food and beverage choices and nutritional status and they include things as such as food composition, food labelling, food promotion, food prices, food provision in schools and other settings, food availability and trade policies affecting food availability, price and quality.

Figure 1: Food environments' components and the main influences on those environments



This report presents the results of an assessment by New Zealand experts of the level of implementation of government policies and infrastructure support considered good practice for improving food environments and population diets. Recommendations for government actions needed to address the gaps in policy and infrastructure support to reduce obesity and diet-related NCDs were also identified and prioritised.

2. How was the level of implementation of government policies and infrastructure support assessed?

Who conducted the assessment?

The study is an initiative of INFORMAS (International Network for Food and Obesity / NCDs Research, Monitoring and Action Support) (7) and it was conducted with a New Zealand-based Expert Panel of independent public health experts and representatives from medical associations and non-governmental organisations (NGOs).

INFORMAS was recently founded by universities and global NGOs to monitor and benchmark food environments, government policies and private sector actions and practices in order to reduce obesity and diet-related NCDs and their related inequalities. INFORMAS aims to complement existing monitoring efforts of the World Health Organization (WHO), such as the global NCD monitoring framework, which does not focus on food environment and policy indicators (13). (Refer to Appendix 1 for a more detailed description of INFORMAS's aims and objectives.)



What tool was used to measure the level of implementation?

An index developed by INFORMAS (called the 'Healthy Food Environment Policy Index' [Food-EPI]) was used to assess the extent of implementation by government of good practice policies and infrastructure support in New Zealand. The Food-EPI tool and process were designed to answer the question – How much progress has the government made towards good practice in improving food environments and implementing obesity/NCDs prevention policies and actions? (14,15)

The Food-EPI was developed to monitor and benchmark governments' policies and actions on creating healthier food environments. It is consistent with, and supportive of, the list of proposed policy options and actions for Member States included in the WHO's Global Action Plan for the Prevention and Control of Non-Communicable Diseases (2013–2020) (13) and the World Cancer Research Fund (WCRF) International NOURISHING Food Policy Framework for Healthy Diets (8, 16). The Food-EPI tool comprises a 'policy' component with seven domains on specific aspects of food environments and an 'infrastructure support' component originally with seven domains (subsequently reduced to six) to strengthen obesity and NCD prevention systems. Good practice indicators contained in these domains encompass policies and infrastructure support necessary to improve the healthiness of food environments and to help prevent obesity and diet-related NCDs (Figure 2).

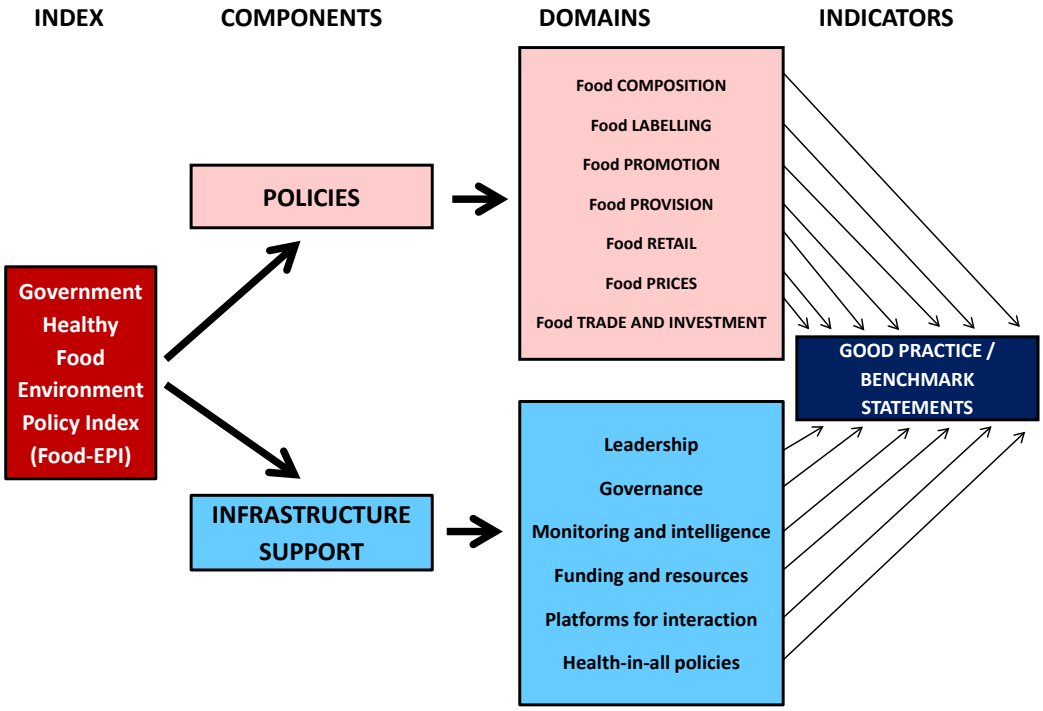
The Food-EPI tool and process have been through several phases of development including an initial development based on a review of policy documents, subsequent revision by a group of international experts, from low, middle and high income countries, (14) and pilot testing in New Zealand in 2013 (15). The refined tool was used in the baseline assessment of New Zealand's policies and infrastructure support in relation to international best practice (refer to Appendix 1 for more detail).

What processes were used to rate the level of implementation?

The processes used to rate the extent of implementation of policies and infrastructure support in New Zealand (more fully described in Appendix 1) involved 52 members of the Expert Panel (listed in Appendix 5) rating the New Zealand Government against international best practice benchmarks of policies and actions for creating healthier food environments. The Expert Panel's ratings were informed by extensive documented evidence, validated by government officials, of current implementation in New Zealand (refer to Appendix 2 for the evidence summary). A week before participating in the workshops, the experts were provided with the documented evidence with examples of international best practice benchmarks.

The Expert Panel rated a total of 42 indicators (19 of which related to policy and 23 of which related to infrastructure support) using likert scales (1 to 5) within a workshop setting. Before rating each indicator, the evidence on the extent of implementation in New Zealand and the international benchmarks were shown to the Expert Panel in a PowerPoint presentation, with opportunities for discussion and clarification. The mean rating for each indicator was used to categorise the level of implementation as 'high', 'medium', 'low' or 'very little, if any'. (Refer to Appendix 3 for a list of all the indicators.)

Figure 2: Components and domains of the 'Healthy Food Environment Policy Index' (Food-EPI)



3.How were the recommended actions identified and prioritised?

Concrete actions were proposed by the Expert Panel after assessing the 'implementation gap' from the rating distributions for each good practice indicator. Actions were recommended for 34 of the 42 good practice indicators. These actions were identified as having the potential, in concert with other actions, to improve the healthiness of food environments and population nutrition and reduce obesity and diet-related NCDs in New Zealand. (Refer to Appendix 4 for the list of recommended actions and related good practice statements).

The actions were prioritised in a separate process after the workshops. Experts participating in the workshops (and others unable to attend the workshops) were provided with the implementation rating results and the recommended actions within an Excel spreadsheet (sent by email). Policy and Infrastructure Support actions were prioritised separately[4].

The Expert Panel members were asked to prioritise the importance of the each action (taking into account the relative need, impact, effects on equity, and any other positive and negative effects of the action) within the group of 15 recommended policy actions by allocating 75 points across the 15 actions. They were also asked to prioritise the likely achievability of the recommended actions (taking into account the relative feasibility, acceptability, affordability, and efficiency of the action) by allocating another 75 points across the 15 actions. Expert Panel members were then asked to prioritise the 19 infrastructure actions using the same method. This meant allocating 95 points across the 19 infrastructure actions, first for importance and then for achievability. Participants were given the opportunity to differentially weight the importance and achievability criteria. The weights chosen by each expert were applied to their individual scores and their scores for importance and achievability were summed.



4 Hence the scores obtained for the Policy actions are not able to be compared with those for the Infrastructure Support actions and vice versa.

4. How well is the New Zealand Government performing compared with international best practice?

New Zealand rated well against international benchmarks for several infrastructure support indicators (Figure 3). These included having policies and procedures in place for ensuring transparency in the development of food policies; the public having access to nutrition information and key documents; and regular monitoring of body mass index (BMI) and the prevalence of NCD risk factors and occurrence rates for the main diet-related NCDs. New Zealand also rated well for policies regulating the provision of ingredient lists and nutrient declarations on packaged foods and for those regulating health claims on packaged foods.

However, over half (60%) of all the good practice indicators were rated as having 'low' or 'very little, if any' implementation compared with international benchmarks. This was not spread evenly across infrastructure support and policy indicators, with half (48%) the infrastructure indicators and three-quarters (74%) of the policy indicators rated as having 'low' or 'very little, if any' implementation in New Zealand.

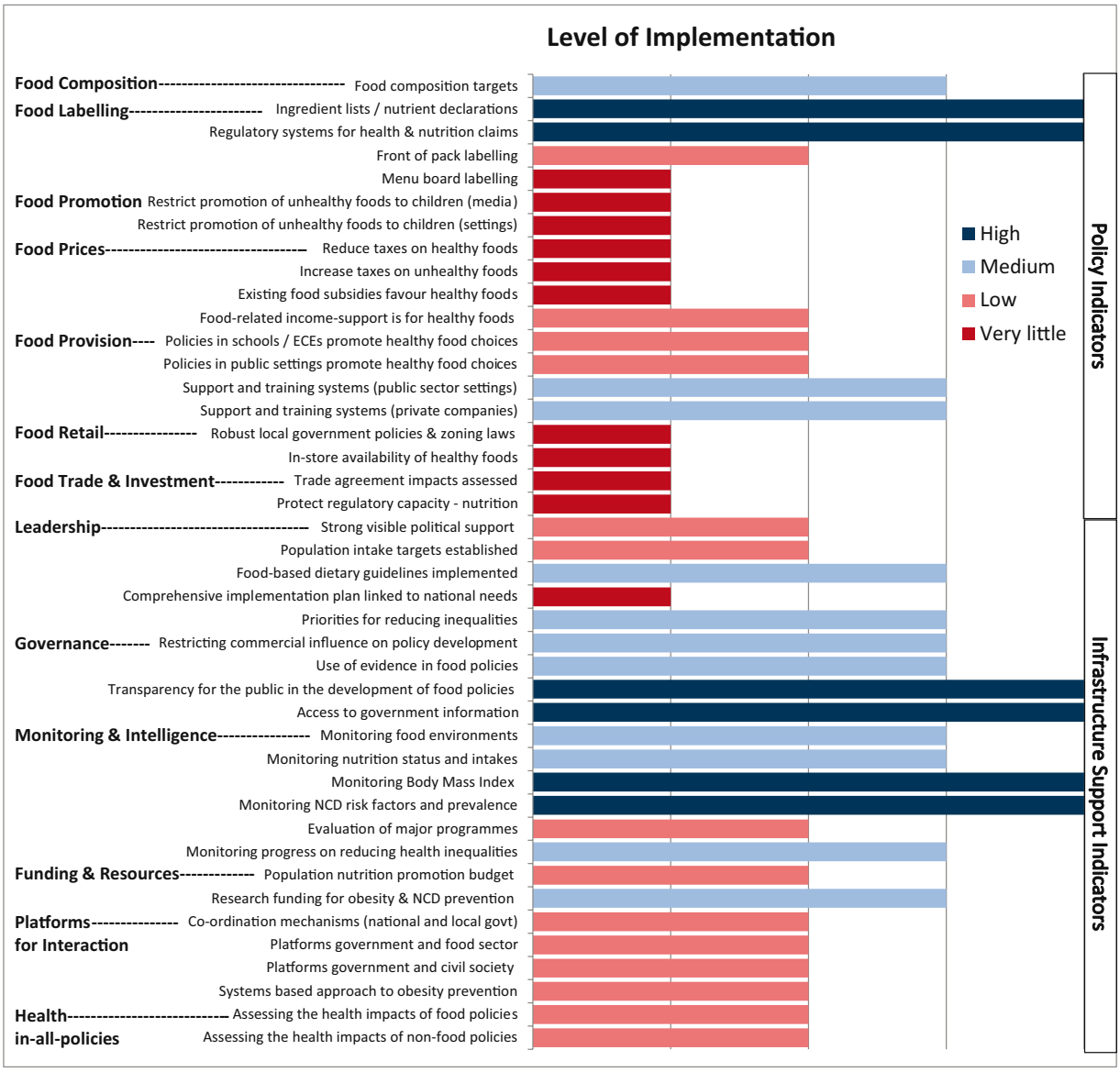
Several critical gaps were identified relating to government infrastructure support for obesity and diet-related NCD prevention. These highlighted a lack of government leadership. Obesity and population diet are not included as health priorities and there is no comprehensive and co-ordinated plan of action to address food environments, obesity and diet-related NCDs in New Zealand, despite the increasing prevalence of overweight and obesity and diet-related NCDs. To address the complexity of the multiple influences on population dietary behaviours and health outcomes, a comprehensive plan is needed and it should include a range of policy and programme strategies at national and local levels and social marketing for public awareness.

Related to the lack of an overarching plan were the relatively low levels of funding for population nutrition promotion and the absence of formal interaction platforms to co-ordinate action and maintain links between the government and key stakeholders working in this field. Funding for population nutrition promotion has reduced considerably over the past seven years which means that it is currently insufficient to improve food environments and population nutrition and to reduce obesity and diet related NCDs. For example, funding in 2012/13, for population nutrition promotion was $29 million compared with the $67 million budget for the Healthy Eating Healthy Action (HEHA) strategy in 2006/07[5]. Funding of $29 million (0.21% of total vote health) is relatively small compared with the health care costs attributable to overweight and obesity. In 2006, this was $624 million, 4.4% of total health care expenditure (5).

Major implementation gaps were also identified within government policy relating to the promotion, provision, availability and relative pricing of unhealthy versus healthy foods. Policies restricting the promotion of unhealthy foods to children through broadcast and non-broadcast media and within children's settings were areas that were rated as having very little, if any, implementation. Similarly, results showed the lack of policies aimed at making healthy food affordable and accessible for the population through measures that influence the relative pricing of healthy and unhealthy foods (17).

5 Note that the Healthy Eating Healthy Action budget included funding for physical activity initiatives.

Figure 3: Level of implementation of food environment policies and infrastructure support by the New Zealand Government



Food trade and investment agreements are an area of increasing concern as these have the potential to radically influence the food supply within countries (18, 19) and, therefore, which foods are available, accessible and affordable for the population. There was little, if any, implementation of policies which ensured that international trade and investment agreements are assessed for any direct and indirect impacts on food environments and population nutrition and health. Similarly, ratings indicated there was very little, if any, adoption of measures to manage foreign investment agreements and protect New Zealand's public health regulatory capacity to act to protect and promote public health nutrition.

Food retail environments are increasingly considered influential in determining dietary behaviours and health outcomes (20), however, ratings indicated that there was very little, if any, policy relating to community food environments (e.g., type, availability and accessibility of food outlets) or consumer food environments (e.g., in-store availability, prices, promotion and nutritional quality of foods). For example, there was little, if any, implementation of policies which would allow local governments and communities to make decisions about the density of outlets selling unhealthy foods within their communities, especially their proximity to schools and early childhood education (ECE) services. Similarly, there was little, if any, implementation of support systems encouraging food stores to promote the in-store availability of healthy food and limit the in-store availability of unhealthy foods.

5. Which actions did the Expert Panel prioritise for implementation by the New Zealand Government?

Four infrastructure support actions and six policy actions (condensed to 7 recommendations) were identified as having the highest priority for implementation by the New Zealand Government. In summary, these recommendations are to:

1. Implement a comprehensive national action plan for obesity and NCD prevention.
2. Set priorities in Statements of Intent and set targets for
   a. reducing childhood and adolescent obesity.
   b. reducing salt, sugar and saturated fat intake.
   c. food composition (salt and saturated fat) in key food groups.
3. Increase funding for population nutrition promotion, doubling it to at least $70m/year[6].
4. Reduce the promotion of unhealthy foods to children and adolescents by
   a. restricting the marketing of unhealthy foods to children and adolescents through broadcast and non-broadcast media.
   b. ensuring schools and ECE services are free from commercial promotion of unhealthy foods.
5. Ensure that foods provided in or sold by schools and ECE services meet dietary guidelines.
6. Implement the front-of-pack Health Star Rating labelling system.
7. Introduce an excise tax of at least 20% on sugar-sweetened beverages.

The top ranked policy and infrastructure support action recommendations are detailed further in Tables 1 and 2. The full set of recommendations identified by the Expert Panel is listed in Appendix 4.

Implement a comprehensive national action plan for obesity and NCD prevention

Improving the healthiness of food environments and reducing obesity and diet-related NCDs requires integrated action by government across a number of policy areas and infrastructure support systems. New Zealand will need to report to WHO in 2015 about whether it has a comprehensive national action plan for NCDs in place. This should include targets relating to obesity, nutrient intakes and food composition. The availability, affordability, accessibility and acceptability of foods are the critical determinants of dietary intake and measures will need to be included in the plan to increase these for healthy foods AND decrease these for unhealthy foods.

New Zealand has previously shown leadership in this area. For example, the Healthy Eating Healthy Action (HEHA) strategy and its associated implementation plan were comprehensive in their approach and had actions to address the main drivers of unhealthy diets and excessive energy intake. Action focused on priority populations including Māori, Pacific peoples, children and their families, and lower socioeconomic groups. Implementation of priority programmes was funded, as was an integrated research, evaluation and monitoring component.

Increase population nutrition promotion funding to at least $70M per year

Sufficient funding for policies, programmes and their evaluation is also required. Current levels of funding are only one twentieth of the health care costs of overweight and obesity in 2006. Funding for population nutrition promotion should be to least at the level of previous HEHA funding.

6 Approximately $67 million was allocated to the Healthy Eating Healthy Action strategy budget in 2008/09.

Table 1: Top four Infrastructure Support actions – ranked by score

1. To demonstrate a national commitment, the NZ Government:
   - Prioritises **improving nutrition and reducing childhood obesity** by:
     - Including clear support for these priorities in the government **Statements of Intent** (especially for the Ministry of Health (MoH)).
     - **Setting a target** to reduce the prevalence of childhood and adolescent obesity (for example, by 5% over the next six years) as part of the Better Public Service challenge targets.
2. To ensure that sufficient resources are available to improve population nutrition, the NZ Government:
   - **Increases funding** for population nutrition promotion to at least **$70M per year** (equivalent to about 10% of the health care costs of overweight/obesity and on a par with previous investments in prevention).
3. To convert its commitments to WHO's Global Action Plan to Reduce NCDs into the national context, the NZ Government:
   - Develops, funds and implements a comprehensive national action plan to prevent NCDs.
4. To demonstrate commitment and to measure progress, the NZ Government:
   - Specifies clear targets for the reduction of salt, sugar and saturated fat intake of the population based on WHO recommendations and the global NCD action plan (e.g., salt intake 5g/day, saturated fat intake less than 10% of energy, and free sugar less than 10% of energy).

Table 2: Top six Policy actions – ranked by score

1. To improve food composition, the NZ Government:
   - Sets **sodium targets** for the food groups which are major contributors to sodium intake, based on international best practice targets.
   - Establishes a food standard to minimise the unhealthy fatty acid content of **commercial deep frying fats**.
   - Examines **other opportunities** to reduce the amount of salt, sugar and saturated fat in foods and beverages.
2. To reduce unhealthy food promotion to children, the NZ Government:
   - Introduces regulations to **restrict the marketing of unhealthy foods**, as defined by the nutrient profiling scoring criterion, to children and adolescents (e.g., younger than 16 years) through:
     - broadcast media, with initial priorities for restriction of advertising through television, and
     - non-broadcast media, with initial priorities for restriction of advertising through sports sponsorship, food packaging and point of sale advertising.
3. To reduce unhealthy food promotion to children, the NZ Government:
   - Implements policies to ensure that **schools and early childhood education and care services, are free of commercial promotion** of unhealthy foods, as defined by the MoH Food and Beverage Classification System
4. To ensure that children's settings provide healthy food, the NZ Government:
   - Enacts policies that ensure **schools and early childhood education and care services provide or sell foods which meet the food and nutrition guidelines** as outlined in the Food and Beverage Classification System.
5. To improve food labelling (consumer-friendly nutrition quality labels), the NZ Government.
   - Endorses the **Health Star rating system** for implementation from 2014 on a voluntary basis with provision to move to regulations if there is not wide coverage within 2 years.
6. To discourage the consumption of unhealthy foods and beverages, the NZ Government:
   - Introduces a significant (at least 20%) **excise tax on sugar-sweetened beverages**; and explores how the tax revenue could be applied to create healthy food environments and promote healthy diets.

Set targets for reducing obesity, reducing salt, saturated fat and sugar intakes, modifying food composition (salt and saturated fat)

Setting targets is increasingly seen as an effective way of focusing and mobilising resources to address public health issues. However, although the New Zealand Government uses Statements of Intent and setting targets as policy mechanisms, it has not developed targets for obesity, food composition or population intakes of salt, sugar, and saturated fats. Internationally, several countries include targets for obesity and NCDs in their national action plans. For example, South Africa's strategic plan for the prevention and control of NCDs has a target for reducing the percentage of people who are obese and/or overweight by 10% by 2020 and reducing premature mortality from NCDs of those aged under 60 years by at least 25% (21). The Brazilian Strategic Action Plan for Confronting NCDs 2011-2022 also specifies national targets, such as halving the prevalence of obesity in children and adolescents by 2022 and halting the rise in obesity in adults (22). Many countries have set population intake targets for salt and reformulation targets for sodium in food products. For example, Argentina and South Africa have specified, in law, mandatory maximum levels of sodium in a range of food categories (23). The UK salt reduction programme, initiated in 2003/04 has led to reductions in the salt content of many processed foods and a significant (15%) reduction in urinary sodium levels (24). The World Health Organisation's NCD action plan also specifies a target to reduce population salt intake to 5g/day (25).



Restrict the marketing of unhealthy foods to children and adolescents through all media

Restricting the high levels of marketing of unhealthy foods to children and adolescents is another critical action to begin addressing increasing levels of obesity in New Zealand's children and adolescents. Children's food preferences, purchase requests, and consumption patterns are influenced by food marketing (e.g., (26-28)). Self-regulation by industry has not led to any reduction in the exposure of children to unhealthy food marketing. Experts consider restricting marketing through broadcast and non-broadcast media as well as removing commercial promotion of unhealthy foods in schools and ECE services settings particularly important. Internationally, a range of countries and regions have restricted marketing of unhealthy foods to children and adolescents. For example, in 1980, Quebec banned all advertising to children under the age of 13. In South Korea, television advertising of specific categories of food is prohibited between 5 and 7pm and before, during, and after other children's programmes. In this instance, children are defined as those aged under 18 years. The restriction also applies to advertising targeting children (e.g., where free toys are included). In Ireland, advertising and other forms of commercial promotion of unhealthy foods (as defined by a nutrient profiling model) are prohibited during children's television and radio programmes (that is, where over 50% of the audience is aged under 18 years). Laws also prohibit food advertising to children under 15 years that features celebrities (23). Other countries such as Spain, Chile, Peru and Brazil have passed legislation to restrict food advertising to children.

Ensure schools and ECE services provide or sell foods which meet food and nutrition guidelines

Making sure healthy food choices are available within school and ECE services is also a priority identified by the Expert Panel. They consider that the government should enact policies that ensured schools and ECE services provide or sell foods which meet the food and nutrition guidelines as outlined in the New Zealand Food and Beverage Classification System.

Implement the front-of-pack Health Star Rating labelling system

To better inform consumers about the healthiness of packaged foods, the Expert Panel prioritised the introduction of the Health Star Rating system that has been introduced into Australia. This follows other countries such as the United Kingdom and Ecuador who have introduced an interpretive, evidence-based front of pack labelling system. New Zealand has since announced that it will introduce the Health Star Rating system but on a voluntary basis. The Expert Panel recommended that New Zealand follow Australia's lead in making it mandatory if there is not widespread uptake by industry.



Introduce an excise tax of at least 20% on sugar-sweetened beverages

Discouraging consumption of sugar-sweetened beverages by increasing the price through an excise tax was also prioritised by the experts. Research has shown that such a tax is likely to improve health and probably reduce health inequalities (29). A 20% tax on carbonated drinks was estimated to reduce daily energy intakes by 0.2% (20kJ/day) and avert or postpone 67 (95% CI, 60 to 73) deaths from cardiovascular disease, diabetes and diet-related cancers, which equates to 0.2% of all deaths in New Zealand per year. Other research showed that increasing the price of sugar sweetened beverages led to a significant reduction in purchases of those beverages but did not significantly affect purchases in other beverage or snack food categories (30). A tax on sugar sweetened beverages with the funding used for health promotion was also recommended by the New Zealand Beverage Guidance Panel in their six-point policy brief (31). A range of other countries globally (e.g., Mexico, Tonga, France, Hungary, French Polynesia) introduced taxes on sugar-sweetened beverages and several use the revenue for improving population health (e.g., Mexico, Hungary, French Polynesia) (23) .

6. Conclusions

Effective government policies and actions are essential to increase the healthiness of food environments and to reduce the high levels of obesity, diet-related NCDs, and their related inequalities (8). Internationally, there is wide recognition of this major public health issue and New Zealand is lagging behind other nations in implementing policies to improve food environments and reduce levels of obesity and diet-related NCDs.

New Zealand has set the international benchmark in one area by applying a nutrient profiling system to prevent unhealthy foods carrying health claims. New Zealand is also at world standard in other areas such as nutrition information panels and monitoring systems for NCDs and their risk factors. Several initiatives are showing good progress, such as reducing trans fats in foods, and others, such as the Health Star Rating system and community-based efforts (for example, Healthy Families NZ) although currently rated at a low level of implementation, will be implemented in the near future.

Of major concern were the large gaps in implementation, especially the lack of a comprehensive plan and specific regulatory or fiscal policies, for instance, the restriction of marketing of unhealthy foods to children and taxes on sugar sweetened beverages. The Healthy Eating Healthy Action plan was prematurely terminated along with its funding and evaluation in 2010 and no plans have been announced to replace it. New Zealand will be expected to report to the WHO in 2015 that it has a fully funded, comprehensive plan for NCDs. This must be the highest priority for action.

In addition, New Zealand will be expected to report on progress on reducing the marketing of unhealthy food products to children because this is one of the 25 core indicators in WHO NCD Monitoring Framework. The lack of government action in protecting children from this commercial exploitation will not be considered acceptable for a high income, high capacity country with one of the highest rates of childhood obesity in the world.

New Zealand has an excellent opportunity to take the prevention of obesity and diet-related NCDs seriously and invest in highly cost-effective policies and programs to become a leader in the field. It will require a much greater government effort than has recently been evident. The top priority actions are recommended by the Expert Panel for immediate implementation but all 34 recommended actions are achievable with sufficient government commitment.

The Food-EPI will be conducted every three years towards the end of each government's term of office to measure progress made towards improving food environments over that term. The Expert Panel hopes that substantial progress will be made by 2017 to bring New Zealand towards the progressive, innovative and world leader in public health that it can be.

"Let me remind you. Not one single country has managed to turn around its obesity epidemic in all age groups. This is not a failure of individual will-power. This is a failure of political will to take on big business"

Dr Margaret Chan, Director General, World Health Organisation, June 2013

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8. Appendix 1: Research approach and methods

The International Network for Food and Obesity/NCDs Research, Monitoring and Action Support (INFORMAS) (7) was recently founded to monitor and benchmark food environments, government policies and private sector actions and practices globally.

INFORMAS aims to:

1. Develop a global network of public-interest organisations and researchers to monitor, benchmark and support efforts to create healthy food environments and reduce obesity, non-communicable diseases (NCDs) and their related inequalities;
2. Collect, collate and analyse data on public and private sector policies and actions, food environments, population diets, obesity and NCDs:
3. Compare and communicate the progress on improving food environments against good practice benchmarks between countries and over time;
4. Use the results to strengthen public health efforts, particularly by supporting the translation of relevant evidence into public and private sector actions.

INFORMAS complements existing monitoring efforts of the World Health Organization (WHO), such as the global NCD monitoring framework, which does not focus on food environment indicators (13).

INFORMAS produces evidence that is highly policy-relevant in order to help increase the accountability of governments and the private sector through the provision of regular direct evidence on their levels of action or inaction and the healthiness of food environments.

Methods overview

The purpose of the Healthy Food Environment Policy Index (Food-EPI) tool and process is to monitor and benchmark public sector (national government) policies and actions. It aims to answer the overarching question – How much progress have governments made towards good practice in improving food environments and implementing obesity/NCD prevention policies and actions?

A mixed methods design was used to obtain the ratings of the level of implementation of good practice policies and infrastructure support and to identify and prioritise actions. The methods used to obtain the rating followed the steps outlined in Figure 4 with the exception of weighting the scores outlined in step 6. Unweighted rating results are presented as appropriate weights for the good practice domains and their indicators are in development.

In New Zealand, an Expert Panel was formed by invitations being sent to a wide range of independent public health experts and representatives from medical associations and NGOs.

Figure 4: Process for assessing the policies and actions of governments for creating healthy food environments



Development of the Healthy Food Environment Policy Index (Food-EPI)

The Food-EPI was based on a review of the evidence and policy documents and revised by a group of international experts, including experts from low, middle and high income countries as well as senior representatives from the World Health Organisation (WHO) and the Food and Agriculture Organisation (FAO). Evidence-based or expert committee reports from international agencies such as WHO and FAO, national government agencies, non-governmental organisations, professional societies and expert advisory groups were reviewed for their recommendations for improving food environments and population diets (14). The WHO approach to strengthening healthy systems (32) was adapted for incorporation into the infrastructure support component of the tool. The structure of the Food-EPI tool is provided in the body of the report (Figure 2) and the process that was used to implement the tool in New Zealand is outlined below.

Piloting and refining the Food-EPI tool and process

The Food-EPI tool and processes were pilot tested and revised for New Zealand and international implementation in 2013. The main elements of the piloting process were to:

- Collect evidence on the extent of government implementation of different policies and infrastructure support systems in New Zealand and validated with government officials.
- Present the evidence to informed independent public health experts and NGO representatives in a workshop setting.
- Ask experts participating in the workshop to rate the performance of their government on the good practice statements covering the policy and infrastructure support domains.
- Ask experts participating in the workshop to evaluate.
    - The level of difficulty of rating each indicator.
    - The appropriateness and completeness of the evidence presented.

For the pilot study, two whole-day workshops were convened. Thirty-nine independent public health experts and NGO representatives rated the good practice statements within the 7 policy and 7 infrastructure support domains. The difficulty of rating the indicators and the comprehensiveness of the evidence base was also assessed by the experts. Based on their assessments and comments and the inter-rater reliability scores (overall score of 0.85, CI=0.81-0.88), the main changes to the Food-EPI tool included strengthening the leadership domain, removing the workforce development domain (because professional training was mainly outside the government jurisdiction), strengthening the equity focus, and adding community-based programs and government funding for research on obesity and NCD prevention as good practice indicators. The modified tool and the revised good practice statements and evidence were used in the baseline study in April-May 2014.

Baseline study – rating the levels of implementation in New Zealand

Similar to the pilot study, two workshops were convened to obtain ratings for the level of implementation for each good practice indicator. Prior to the rating workshops, the experts were provided with a written summary of New Zealand evidence on the extent of implementation of good practice policies and infrastructure support and international benchmarks for each indicator. The evidence summary was compiled from policy documents and budgets retrieved from websites and through official information requests. The evidence was comprehensively documented and returned to government officials to verify its completeness and accuracy. International best practice exemplars were extracted from the World Cancer Research Funding NOURISHING framework and from other sources detailed in Appendix 2.

Fifty-two New Zealand-based public health experts and representatives from medical associations and NGOs independently scored the degree of implementation of policy and infrastructure support in New Zealand against international best practice. A total of 42 indicators were rated using likert scales (1 to 5) comprising 19 policy indicators and 23 infrastructure support indicators (refer to Appendix 3 for a full list of the statements).

Before rating each indicator, the evidence and international benchmarks were briefly summarised in a PowerPoint presentation with opportunities for comment and clarification. Experts in the Auckland and Wellington workshops were able to comment on the evidence and benchmarks before rating the indicator. They also provided feedback on the completeness and accuracy of the evidence document. The evidence document was revised where inaccuracies were noted. Representatives from the Ministry of Health and/or the Ministry of Primary Industries were present as observers and were invited to make comments on any of the evidence presented.

The mean rating for each indicator was used to determine an overall percentage level of implementation. These ratings were then categorised into High, Medium, Low, or Very Little, if any levels of implementation based on the following cut-points: >75% = High; 51 to 75% = Medium; 26 to 50% = Low; <25% = Very little, if any.

Identifying and prioritising actions for implementation in New Zealand

Concrete actions were identified in the workshops' plenary discussions after all the indicators had been rated. Experts participating in the workshops were presented with the distribution of the rating score for each indicator. They discussed the need for any action in relation to the indicator and, if they considered there was a need, identified actions required to improve food environments and population nutrition and reduce NCDs in New Zealand.

Actions were proposed for 34 of the 42 good practice indicators. These 34 actions were identified as having the potential, in concert with other actions, to help improve food environments and population nutrition and reduce obesity and diet-related NCDs in New Zealand. (Refer to Appendix 4 for a complete list of indicators and their related actions).

The 15 recommended policy actions and 19 recommended infrastructure support actions were prioritised in a separate process. Experts who participated in the workshops (and others unable to attend the workshop) were provided with the summary results of the ratings on the implementation gaps and the recommended actions within an Excel spreadsheet (sent by email). They were asked to complete and return the spreadsheets with their individual prioritisation scores. Policy and Infrastructure support actions were prioritised separately.

Within the set of 15 recommended policy actions, the experts were asked to prioritise the *importance* of the action (taking into account the relative need, impact, effects on equity, other positive and negative effects of the action) by allocating 75 points across the 15 actions (Refer to Table 3 for a description of the criteria). They were also asked to prioritise the likely *achievability* of the 15 policy actions (taking into account the relative feasibility, acceptability, affordability and efficiency of the action) by allocating 75 points across the actions. The experts were then asked to prioritise the 19 infrastructure actions. This meant allocating a 95 points across the 19 infrastructure actions, first for importance and then for achievability.

Table 3: Criteria for prioritising the recommended actions: Importance and Achievability

Importance	Achievability
Need The size of the implementation gap	**Feasibility** How easy or hard the action is to implement
Impact The effectiveness of the action on improving food environments and diets (including reach and effect size)	**Acceptability** The level of support from key stakeholders including government, the public, public health, and industry
Equity Progressive / regressive effects on reducing food/ diet-related health inequalities	**Affordability** The cost of implementing the action
Other positive effects (e.g., on protecting rights of children and consumers)	**Efficiency** The cost-effectiveness of the action
Other negative effects (e.g., regressive effects on household income, infringement of personal liberties)	

9. Appendix 2: Evidence summary provided to the Expert Panel

New Zealand Healthy Food Environment Policy Index (Food-Epi): Evidence for Raters Distributed to Participants in the Food-Epi Workshops held in Auckland and Wellington in 2014

Definitions

Benchmark: A standard or point of reference against which aspects of food environments or policies can be assessed and compared.

Civil society: The aggregate of non-governmental organizations, institutions and individuals that manifest interests and will of citizens (academia, professional organizations, public-interest NGOs and citizens)

Diet-related non-communicable diseases (NCDs): Type 2 diabetes, cardiovascular diseases and nutrition-related cancers, excluding micronutrient deficiencies, undernutrition, stunting, osteoporosis, mental health and gastrointestinal diseases

Food environments: The collective physical, economic, policy and sociocultural surroundings, opportunities and conditions that influence people's food and beverage choices and nutritional status

Government: National and local government, including councils, district health boards and public health units

Government-funded settings: Government departments and agencies, publicly funded schools, publicly funded early childhood education services, elderly homes, hospitals and prisons

Government implementation: refers to the intentions and plans of the government, government funding for implementation of actions undertaken by non-governmental organisations, and actions and policies implemented by the government.

Healthy foods: Foods recommended in national food-based dietary guidelines, dietary guidelines or food-based standards

Healthy food environments: Environments in which the foods, beverages and meals that contribute to a population diet meeting national dietary guidelines are widely available, affordably priced and widely promoted

Nutrients of concern: salt, fat, saturated fat, *trans* fat, added sugar

Platforms: Formal government mechanisms (e.g. standing committees, ad hoc committees, advisory groups, taskforces, boards, joint appointments) for interaction on particular issues

Population nutrition promotion: The investments in population promotion of healthy eating and healthy food environments for the prevention of obesity and diet-related NCDs, excluding all one-on-one promotion (primary care, antenatal services, maternal and child nursing services etc.), food safety, micronutrient deficiencies (e.g. folate fortification) and undernutrition

Unhealthy foods: processed foods or non-alcoholic beverages high in saturated fats, *trans* fats, added sugars, and/or salt

Important information

If 'foods' are mentioned, it means 'foods and non-alcoholic beverages'. Alcohol is excluded from the framework.

The time frame is the last three years (governing period), although the monitoring domain needs to take a longer view (5 years).

Text in italic in the tables serves as background information only.

Abbreviations

ASA: Advertising Standards Authority; DHB: District Health Board; ECE Early Childhood Education; ERO Education Review Office; FIG: Food Industry Group; FSANZ: Food Standards Australia New Zealand; GRAS: Generally recognized as safe; GST: Goods and Services Tax; HeartSafe: Sodium Advisory & Food Evaluation; HBC: Heartbeat Challenge; HEHA: Healthy Eating Healthy Action; HPA: Health Promotion Agency; HPS: Health Promoting Schools; HSR: Health Star Rating; INFORMAS: International Network for Food and Obesity/NCDs Research, Monitoring and Action Support; MBIE: Ministry of Business, Innovation and Employment; MFAT: Ministry of Foreign Affairs and Trade; MoH: Ministry of Health; MPI: Ministry for Primary Industries; NAG: National Administration Guideline; NCDs: Non-communicable diseases; NHF: National Heart Foundation; NHMRC: National Health and Medical Research Council; NIP: Nutrition Information Panel; NPSC: Nutrient Profiling Scoring Criterion; NZFSA: New Zealand Food Safety Authority; NZFCD: New Zealand Food Composition Database; SD: Standard Deviation; SNAP: Supplemental Nutrition Assistance Program; SPEAR: Social Policy Evaluation and Research; SSC: State Services Commission; WIC: Special Supplemental Nutrition Program for Women, Infants, and Children; WHO: World Health Organisation; WTO: World Trade Organization

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Evidence collected for the good practice statements within the 7 FOOD POLICY domains (as at 29/04/2014)

1 FOOD COMPOSITION: There are government systems implemented to ensure that, where practicable, processed foods minimise the energy density and the nutrients of concern

Q2 COMP 1: **Food composition targets/standards have been established by the government for the content of the nutrients of concern in certain foods or food groups if they are major contributors to population intakes of these nutrients of concern (*trans* fats and added sugars in processed foods, salt in bread, saturated fat in commercial frying fats)**

Evidence:

- There are no food composition targets specified by the Ministry of Health (MoH) or the Ministry for Primary Industries (MPI) for the nutrients of concern.
- *Major contributors to New Zealand sodium intakes are: bread (26%), processed meats (10%), and sauces (6%). Mean (SD) sodium contents of these processed foods are: 447 (125) mg/100 g, 1,169 (444) mg/100 g, and 1,046 (1,235) mg/100 g, respectively. Food categories with the lowest percentage of products meeting corresponding UK Food Standards Agency targets are: sausages/hot dogs and sliced meat (0%); salami/cured meat (2%); liquid meal-based sauces (4%); and multigrain bread (14%). Mean sodium contents of NZ products were found to be higher than for similar products in the UK. These data were collected over a one-month period between December 2010 and January 2011 in New Zealand. Key opportunities identified for sodium reduction were: white bread, sausages and hot dogs, and salami/cured meat[1].*
- There are a range of initiatives in New Zealand aimed at reducing levels of salt (mainly) and saturated fats in processed foods and reducing portion sizes: The National Heart Foundation (NHF)'s food reformulation programme (HeartSafe (Sodium Advisory & Food Evaluation)) was developed in 2010 to facilitate industry-led, cross-category sodium reduction in New Zealand, based on voluntary collaboration between food companies, industry bodies and the government. HeartSafe is coordinated by the NHF, **under a contract from the MoH**. It aims to support food companies to reduce salt levels in packaged food products (particularly lower-cost high-volume packaged foods). Reformulation work largely focuses on salt reduction. Some of the more recent categories have other factors included (e.g. pies - saturated fat, soups – portion size). The programme involves the setting of best practice sodium guidelines for packaged foods, in partnership with the food industry and then supports and encourages food companies to reduce sodium levels to these guidelines. The objective of the programme is to achieve at least 80% of the market share (by sales volume) to meet the targets. In 2007, the NHF started the voluntary strategy, first with bread manufacturers. It aimed to reduce the sodium content of bread, particularly low cost and high volume breads, to less than 450mg/100g[2]. Currently bread companies are exploring the feasibility of a 400mg guideline (personal communication Dave Monro, NHF). The best practice guidelines for sodium reduction in a range of food products (for bread, breakfast cereals, processed meats, savoury pies) and current industry commitments for sodium and saturated fat reduction in foods within HeartSAFE can be found online on the website of the NHF [3]. The NHF is also in the process of setting new sodium reduction guidelines for cheese, butter/oil based spreads and soups. These guidelines are largely to encourage reformulation in outlier products as a number of the bigger companies have done work in these categories to bring sodium levels down (personal communication Dave Monro, NHF). Currently in the majority of categories where guidelines have been set, over 80% of the volume market share met the sodium targets (personal communication Dave Monro, NHF). The reformulation work has been carried out in the absence of any consumer awareness campaign. This "behind the scenes" approach was implemented in order to minimise risk to market leading companies who owften do not want to communicate to their customers that iconic brands have been reformulated. It also avoids cross-over with the NHF's Tick signposting programme and avoids consumer confusion that the NHF is endorsing less healthy foods (e.g. processed meats, white bread) that have lowered levels of salt. The approach aimed to prioritise categories based on highest sodium contribution and targeted high volume, low cost foods (including private label products). Despite this programme being on a voluntary basis the effect of the programme on the New Zealand food supply has been significant, with over 210 tonnes of salt per annum removed from the food categories that have been targeted (personal communication Dave Monro, NHF).

Food category	Contribution to sodium intake[4]	Target set and timeframe	Outcomes
Bread	25.7%	Bread pilot project started in 2007 (Project Target 450: 450 mg/100g)	• **Over 80% market share of category meet target**. • **150 tonnes of salt removed from food supply** over one year period as result of bread companies reformulating down from levels around 500-600mg. • Industry exploring the viability of going below 450mg as the new target. This has been done already in some leading stock keeping units (e.g. largest selling white bread in NZ at 410mg).
Processed Meats	10.3%	HeartSAFE target **set in 2010** with the timeframe of the end of 2013 (targets: sausages 800 mg/100g, bacon and ham 1200 mg/100g)	• Currently 69% market share meets the guidelines. By **March 2014 it will rise to over 80% of market share meeting the targets**. • **34 tonnes of salt removed from the food supply per annum**. • Reductions of around a third in some high volume stock keeping units. • Processed meat progress particularly pleasing in light of research conducted in 2010 - 2011 that showed levels in NZ higher than UK and Australia.
Breakfast Cereals	5.8%	HeartSAFE target **set in 2010** with the timeframe of the end of 2014 (targets: Puffed Rice & Corn Flakes 600 mg/100g, Oat based Muesli & Porridge 200 mg/100g, biscuits 300mg/100g, and others 400 mg/100g)	• **Over 80% market share of category meet targets**. • **19 tonnes of salt per annum** removed from the food supply based on the change in levels from 2006-2007 to 2013. • Large companies had reformulation in train prior to setting targets; HeartSAFE targets have been more effective in supporting change in private label and smaller companies. • Major reformulation activity has centred on cornflake and rice bubble- styled cereals, with some products having sodium levels reduced by a third.
Butter/ margarine (Proposed)	3.8%	HeartSAFE guideline setting/ industry roundtable in Feb 2014 (no target on website yet)	
Savoury pies	3.1%	HeartSAFE target set in **2012** -timeframe for sodium in March 2014 and saturated fat in November 2014) Target for sodium: 400 mg/100g by 2014 and 350 mg/100g by 2016 Target for saturated fat: mince/steak 5 g/100 g by 2014, while Mince & Cheese/Steak & Cheese 5 g/100g by 2016	• **Around 40% market share meet targets**. • One supplier who produces more than 12 million pies annually has reduced the salt levels by around 40 percent across its pie range to meet the target. • **10 tonnes of salt re moved per annum** from this category.
Cheese	2.8%	HeartSAFE guideline setting/ industry roundtable Feb 2014 (no target on website yet)	
Soups	1.7%	HeartSAFE guideline set Feb 2014 with timeframe of Feb 2016 (wet soups: 290mg/100g; dry soups: 300mg/100g).	

- The Chip Group initiative aims to improve the nutritional quality of deep-fried chips served by New Zealand foodservice by reducing fat (total and saturated) and salt content. It is funded by both food industry and the MoH, approximately 50% from industry and 50% from government (85000 NZD per annum from MoH) (personal communication Glenda Gourley, Chairperson The Chip Group). The NHF provides support to the Chip group through expertise, resources and time. The Chip Group sets Industry Standards that are scientifically robust and achievable, including chip size, serving size, cooking oil temperature, salt addition, and oil type [5]. The standards for deep-frying are: Maximum 28% saturated fat, max 3% linolenic acid and max 1% trans fat. The Chip Group oil logo, for use on approved oil packaging and point-of-sale, was developed in 2010. There are currently 11 registered approved oils – including blends and new variety oils - marketed by Bakels, Integro (division of Goodman Fielder), Cookright, Peerless, NZ Sugar/Wilmar. The Chip Group runs the Best Chip Shop Competition every second year to find the best of the best operators. Only one gets the Grand National title and six are awarded as regional winners. If their chips were under 9% fats they receive a highly commended award.
- Food Standards Australia New Zealand (FSANZ) concluded based on reviews of the status of *trans* fats in the New Zealand and Australian food supply in 2007 and 2009 that regulatory intervention and targets were not required and that national non-regulatory approaches to further reduce the levels of *trans* fats in the Australia and New Zealand food supply would be the most appropriate action for risk management. This was, because average total *trans* fat intakes from both ruminant and manufactured sources in New Zealand were below the World Health Organization (WHO) population goal of contributing less than 1% to total energy intake. The survey report indicated as well that the quick service restaurants (19 participating) and their stakeholders made positive changes resulting in lower *trans* fat products. These results were self-reported. The 2009 review report and supporting documents (including survey reports of progress of voluntary initiatives, Round table on Trans Fats in the Quick Service Restaurant Industry) are available on the FSANZ website[6].

International or national good/best practice:

1. **In Argentina in 2013, the government adopted a law on mandatory maximum levels of sodium permitted in meat products and their derivatives, breads and farinaceous products, soups, seasoning mixes and tinned foods (law no. 26.905 on Maximum Levels of Sodium Consumption). Large companies have to meet the sodium targets by December 2014, small and medium sized companies by June 2015. Infringements by producers and importers may be sanctioned, the most severe penalties being fines of up to one million pesos, in case of repeat infringements up to ten million pesos, and the closing of the business for up to five years[7]**
2. **In 2013, the South African Department of Health adopted targets for salt reduction in 13 food categories by means of regulation (Foodstuffs, Cosmetics and Disinfectants Act). There is a stepped approach with food manufacturers given until June 2016 to meet one set of category-based targets and another three years until June 2019 to meet the next[7]**
3. **The UK salt reduction programme was a successful comprehensive voluntary approach [8]; The approach was voluntary, but with threat of legislation. Since the salt reduction programme started in 2003/2004, significant progress has been made as demonstrated by the reductions in salt content in many processed foods and a 15% reduction in 24-h urinary sodium over 7 years (from 9.5 to 8.1 g per day, $P<0.05$). In March 2006 the Food Standards Agency published the original voluntary salt reduction targets for 85 categories of foods. The updated reduction targets for 2010-2012[9] and those for 2017[10] can be found online.**
4. **In 2009, New York City established voluntary salt guidelines for various restaurant and store-bought foods. In 2010, this city initiative evolved into the National Salt Reduction Initiative that encouraged nationwide partnerships among food manufacturers and restaurants involving more than 100 city and state health authorities to reduce excess sodium by 25% in packaged and restaurant foods and by 20% among the population by 2014.The National Salt Reduction Initiative has worked with the food industry to establish salt reduction targets for 62 packaged foods and 25 restaurant food categories for 2012 and 2014 [11, 12].**
5. **In Denmark a law introduced in 2003 prohibits the sale of products containing *trans* fats, a move that effectively bans its use in products destined for sale on the Danish market[7]**
6. **In New York City, *trans* fats were banned in chain restaurant meals to less than 0.5 g per serving in 2006. The pre- and post- *trans* fat monitoring showed substantial declines compared to other US cities where no bans or legislation was enacted to establish mandatory food labeling standards[13].**

2 FOOD LABELLING: There is a regulatory system implemented by the government for consumer-oriented labelling on food packaging and menu boards in restaurants to enable consumers to easily make informed food choices and to prevent misleading claims

Q3 LABEL1: **Ingredient lists and nutrient declarations in line with Codex recommendations are present on the labels of all packaged foods**

Evidence:

- New Zealand meets CODEX standards and regulation is in place to ensure compliance. The MPI manages New Zealand's participation in Codex and sets strategic priorities which ensure that Codex standards have the widest possible application.
- The labelling regulation is outlined in the Australia New Zealand Food Standards Code [14, 15]. The MPI is responsible for implementation of the Food Standards Code, which has been in force since 2002. Previously there were 2 separate codes: a regular one and one combined with the AU code, which were agreed in 1995 and have been in force since 1996. Labels must include among others the ingredient list. Ingredients must be declared in the statement of ingredients in descending order of ingoing weight.
- The nutritional information panel (NIP) must be set out specifically as shown below and is required on most packaged food products.
- Where average quantities or minimum/maximum quantities are given this must be indicated in the NIP (standard example shown below)

NUTRITION INFORMATION Servings per package: (insert number of servings) Serving size: g (or mL or other units as appropriate)		
	Quantity per Serving	Quantity per 100g (or 100mL)
Energy	kJ (Cal)	kJ (Cal)
Protein	g	g
Fat, total	g	g
- saturated	g	g
Carbohydrate	g	g
sugars	g	g
Sodium	mg (mmol)	mg (mmol)
(insert any other nutrient or biologically active substance to be declared)	g, mg, µg (or other units as appropriate)	g, mg, µg (or other units as appropriate)

- In 2009, Australian and New Zealand food regulation ministers agreed to a comprehensive independent review of food labelling law and policy. An expert panel, chaired by Dr Neal Blewett, undertook the review and the panel's final report, called Labelling Logic, was publicly released on 28 January 2011 and included 61 recommendations[16]. The role of food labels in communicating preventative health messages and informing healthy food purchasing decisions by consumers was a key focus of Labelling Logic. The Legislative and Governance Forum on Food Regulation provided a detailed response to the recommendations from the Labelling Logic report [17]. Under policy drivers of food labelling it was recommended in Labelling Logic that the *Food Standards Australia New Zealand Act 1991* be amended to include a definition of public health to the effect that: 'Public Health is the organised response by society to protect and promote health, and to prevent illness, injury and disability' (recommendation 1). To address this, in the first instance a Ministerial Policy Guideline will be developed detailing the expectations of FSANZ in relation to the role of food standards in supporting public health objectives.
- Currently, FSANZ is undertaking a number of projects arising from the Legislative and Governance Forum on Food Regulation response to Labelling Logic [18]. One of the projects relates to Recommendation 13, which states that mandatory declaration of all *trans* fats above an agreed threshold be introduced in the NIP if manufactured *trans* fats have not been phased out of the food supply by January 2013. FSANZ has been asked to provide technical evaluation and advice to the Forum on this issue. Further progress will be provided on an indicated online web page[19].

Other projects include providing technical advice on:

- recommendation 14 - declaration of total and naturally occurring fiber content to be considered as a mandatory requirement in the NIP
- recommendation 26 – that the energy content be displayed on the labels of all alcoholic beverages consistent with the requirements for other foods. FSANZ has been requested to undertake a cost benefit analysis for this recommendation
- providing technical advice on recommendation 12 - where sugars, fats or vegetable oils are added as separate ingredients in a food, the terms 'added sugars' and 'added fats' and/or 'added vegetable oils' be used in the ingredient list as the generic term, followed by a bracketed list (e.g., added sugars (fructose, glucose syrup, honey), added fats (palm oil, milk fat) or added vegetable oils (sunflower oil, palm oil);

Over the next 12 months FSANZ will start work on:

- considering removal of the mandatory requirement for the 'per serve' column in the NIP unless a daily intake claim is made in response to recommendation 17;

International or national good/best practice:

1. **In a range of countries around the world, including New Zealand, producers and retailers are required by law to provide a nutrient list on pre-packaged food products (with limited exceptions), even in the absence of a nutrition or health claim. The rules define which nutrients must be listed and on what basis (e.g. per 100g/per serving). [7]**

2. **In Finland national legislation regarding the compulsory use of warning labels on high-salt foods has been in place since 1993. The legislation is applied to all the food categories that make a substantial contribution to the salt intake of the Finnish population. Foods that are high in salt are required to carry a "high salt content" warning. A "high salt content" must be labelled, if the salt content is more than 1.3% in bread, 1.8% in sausages, 1.4% in cheese, 2.0% in butter, and 1.7% in breakfast cereals or crisp bread. [7]**

3. **In 2012, the Chilean government approved a "Law of Food Labeling and Advertising" which included a provision for the development of "warning labels" on foods high in energy, sugar, saturated fat and sodium. In 2013, the government issued a further statement defining the products to which the warning label applies. It also defines the criteria for the presentation and location of the warning. Although the rules have been adopted, the warning labels have not yet been implemented. [7]**

4. **The US Food and Drug Administration has proposed updates to the Nutrition Facts label on food packages[20] to reflect the latest scientific information, including the link between diet and chronic diseases such as obesity and heart disease. The proposed label also would replace out-of-date serving sizes to better align with how much people really eat, and it would feature a fresh design to highlight key parts of the label such as calories and serving sizes. Information on the amount of added sugars would be included on the label, serving size requirements to reflect the amounts people currently eat would be updated, and "dual column" labels would be presented to indicate both "per serving" and "per package" calorie and nutrition information.**

5. **The US Food and Drug Administration made disclosures of *trans* fats mandatory on the 'Nutrition Facts' panel[21, 22]. In November 2013, the Food and Drug Administration issued a Federal Register notice with its preliminary determination that *trans* fats are no longer "generally recognized as safe".**

2 FOOD LABELLING: There is a regulatory system implemented by the government for consumer-oriented labelling on food packaging and menu boards in restaurants to enable consumers to easily make informed food choices and to prevent misleading claims

Q4 LABEL2: **Robust, evidence-based regulatory systems are in place for approving/reviewing claims on foods, so that consumers are protected against unsubstantiated and misleading nutrition and health claims**

Evidence:

- A new food standard to regulate nutrition content claims and health claims on food labels and in advertisements became law on 18 January 2013. From this date food businesses in Australia and New Zealand have three years to meet the requirements of the new Standard (Standard 1.2.7 - Nutrition, Health and Related Claims [23]). Food businesses wanting to make general level health claims will be able to base their claims on one of the more than 200 pre-approved food-health relationships in the Standard or self-substantiate a food-health relationship in accordance with detailed requirements set out in the Standard. Standard 1.2.7 requires a person to notify FSANZ of a relationship between a food or property of food and a health effect (food-health relationship) which has been established by a process of systematic review. Notification must be made before making a general level health claim based on the food-health relationship. High level health claims (referring to a serious disease or a biomarker of a serious disease) must be based on a food-health relationship pre-approved by FSANZ. There are currently 13 pre-approved food-health relationships for high level health claims listed in the Standard. For example: Diets high in calcium may reduce the risk of osteoporosis in people 65 years and over. An example of a biomarker health claim is: Phytosterols may reduce blood cholesterol.

- Health claims will only be permitted on foods that meet the nutrient profiling scoring criterion (NPSC)[24]. Final Score = baseline points (based on average energy, saturated fat, total sugar and sodium content per 100 g or 100ml) – (fruit and vegetable points) – (protein points) – (fibre points). An online calculator is available to help food businesses determine a food's nutrient profiling score[25]. New Zealand is one of the few countries having a nutrient profiling scheme in place.

- A Health Claims Scientific Advisory Group has been established to provide scientific and technical advice to FSANZ, when requested by FSANZ, in relation to: health claims; and matters relevant to Standard 1.2.7- Nutrition, Health and Related Claims. The role of the High Level Health Claims Committee is to consider and provide recommendations to FSANZ in relation to draft high level health claim variations and/or the application or proposals that resulted in that draft variation.

- A nutrition content claim that meets the conditions to use the descriptor diet must not use another descriptor that directly or indirectly refers to slimming or a synonym for slimming. A nutrition content claim using the descriptor diet is a comparative claim if it meets the conditions for making that claim by having at least 40% less energy than the same quantity of reference food. Although nutrition content claims need to meet certain criteria set out in the Standard, there are no generalized nutritional criteria that restrict their use on "unhealthy" foods. The NPSC does not apply to nutrition content claims.
- The MPI will undertake a baseline survey this year, identifying claims which are currently made on food products available on the domestic market. This information will be used to identify areas which require additional guidance information, to remind industry on the transitional process and associated deadlines, develop regulatory tools with regard to the interpretation of the Standard and to also evaluate the impact of Standard in the future (response MPI to official information request).
- Other MPI work programme activities associated with Standard 1.2.7 include: provision of consumer and industry information on the Standard, liaison with industry on the development of dossiers and the development of internal procedures to assess dossiers.
- The enforcement mechanism specific to this Standard is under development. However, it is likely to be similar to that of other legislative requirements, where non-compliances of a public health concern are treated as issues for priority action by Food Act Officers. With regard to self-substantiated claims, MPI plans to review all dossiers associated with the initial notifications from New Zealand food manufacturers. MPI will then establish criteria for selecting dossiers associated with notifications. Dossiers will contain commercially sensitive information and therefore will not be available in the public domain. Industry will hold these dossiers. MPI, as the regulatory body, has access to these dossiers, so that compliance can be assessed against Standard 1.2.7. (response MPI to official information request)
- Laws that protect the consumer in NZ include the fair trading act and the consumer guarantees act[26]. It is stated that 'goods must meet the guarantees of acceptable quality, and matching description'. The Ministry of Consumer Affairs prepared a consumer guide to explain the consumer's rights related to the guarantees act[27].

International or national good/best practice:

1. **A law (Standard 1.2.7)[23, 24] approved in 2013 regulates the use of nutrition content and health claims on food labels and in advertisements in Australia and New Zealand. Health claims must be based on pre-approved food-health relationships or self-substantiated according to government requirements. Health claims are only permitted on foods that meet nutritional criteria, as defined by a nutrient profiling model. Few countries have such a nutrient profiling model in place. Although nutrition content claims need to meet certain criteria set out in the Standard, there are no generalized nutritional criteria that restrict their use on "unhealthy" foods.**
2. **Regulation 1924/2006 establishes EU-wide rules on the use of specified nutrient content and comparative claims (i.e. levels of fat for a low fat claim). Nutrition claims can only be used on foods defined as "healthy" by a nutrient profile (nutrient profile not yet defined). This regulation applies in Iceland and Norway as members of the European Free Trade Agreement participating in the European single market[7].**

2 FOOD LABELLING: There is a regulatory system implemented by the government for consumer-oriented labelling on food packaging and menu boards in restaurants to enable consumers to easily make informed food choices and to prevent misleading claims

Q5 LABEL3: **A single, consistent, interpretive, evidence-informed front-of-pack supplementary nutrition information system, which readily allows consumers to assess a product's healthiness, is applied to all packaged foods.**

Evidence:

- There is currently no mandatory or voluntary front-of-pack labelling system implemented by the government in NZ.
- The Blewett labelling logic report[16], commissioned by the Australian and New Zealand food regulation ministers, contained several recommendations related to front-of-pack nutrition labelling:

  Recommendation 50: That an interpretative front-of-pack labelling system be developed that is reflective of a comprehensive Nutrition Policy and agreed public health priorities.

  Recommendation 51: That a multiple traffic lights front-of-pack labelling system be introduced. Such a system has to be voluntary in the first instance, except where general or high level health claims are made or equivalent endorsements/ trade names/marks appear on the label, in which case it should be mandatory.

  Recommendation 52: That government advice and support be provided to producers adopting the multiple traffic lights system and that its introduction be accompanied by comprehensive consumer education to explain and support the system.

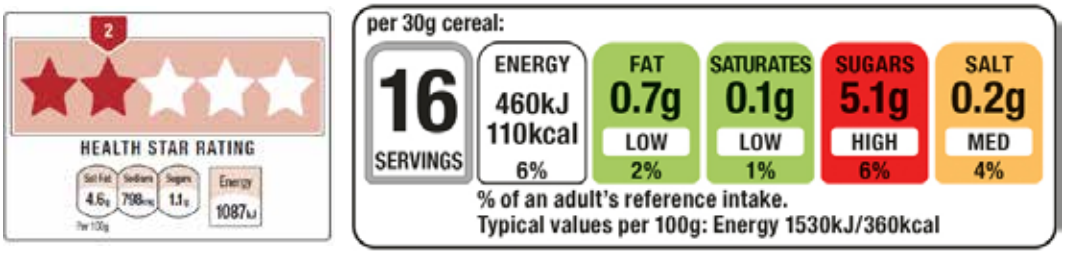
  Recommendation 53: That on-going monitoring and evaluation of the multiple traffic lights system be undertaken to assess industry compliance and the effectiveness of the system in improving the food supply and influencing consumers' food choices.

Recommendation 50 was supported by the government and the others are on hold dependent on the outcome of recommendation 50[17].

- Under the leadership of the MPI an expert advisory group, composed of industry, government and public health stakeholders, has been working on development of a voluntary approach to front-of-pack labelling in NZ. On 14/06/2013 the Health Star Rating (HSR) system was approved by Australian government [28]. The preferred implementation option at this stage is a voluntary system, subject to consistent and widespread uptake of the system by industry. If, following evaluation after two years, a voluntary implementation is found to be unsuccessful, a mandatory approach will be considered. In the meantime, the Calculator for the HSR system has been approved and consumer research has been done. In June 2014 the Legislative and Governance Forum on Food Regulation will consider the HSR label design, and any processes to address anomalies that may be identified within the HSR calculator[29]. An example of the health star rating label is printed below. New Zealand intends to align as much as possible with what is happening in Australia and has supported a voluntary interpretive FOPL system. The traffic light system is not being considered in New Zealand or Australia. Research in New Zealand has shown however that Māori populations prefer the multiple traffic light labelling system, but the research did not yet take into account the HSR system [30]. New Zealand is still working through any areas of difference from the proposed Australian system, in particular the proposed exemptions.
  Research to study the health star rating system in isolation, looking at how this system might be perceived and understood in New Zealand, has been announced in November 2013[31].

International or national good/best practice:

1. **In the UK a new consistent system of front-of-pack food labelling has been introduced: A combination of colour coding and nutritional information is used to show how much fat, salt and sugar and how many calories are in each product. It is estimated that about 60% of foods will be covered by the system because it will remain voluntary. In 2013, the government published national guidance for voluntary 'traffic light' labelling for use on the front of pre-packaged products. The label uses green, amber and red to identify whether products contain low, medium or high levels of energy, fat, saturated fat, salt and sugar.**
2. **In Ecuador, mandatory multiple traffic light front-of-pack labelling has been approved by government, but not yet implemented. A regulation of the Ministry of Health published in 2013 will require packaged foods to carry "traffic light" labels with red, orange and green signals in Ecuador [7].**
3. **Australia is in the final stages of implementing a Health Star Rating system which will be voluntary but become mandatory if insufficient uptake by industry.**



2 FOOD LABELLING: There is a regulatory system implemented by the government for consumer-oriented labelling on food packaging and menu boards in restaurants to enable consumers to easily make informed food choices and to prevent misleading claims

Q6 LABEL4: A consistent, single, simple, clearly-visible system of labelling the menu boards of all quick service restaurants (i.e. fast food chains) is applied by the government, which allows consumers to interpret the nutrient quality and energy content of foods and meals on sale

Evidence:

- The Labelling logic report[16], commissioned by Australian and New Zealand food regulation ministers, recommended that declaration of energy content of standardised food items on the menu/menu boards or in close proximity to the food display or menu should be mandatory in chain food service outlets and on vending machines. Further, information equivalent to that provided by the Nutrition Information Panel (NIP) should be available in a readily accessible form in chain food service outlets (recommendation 18). Chain food service outlets across Australia and New Zealand should be encouraged to display the multiple traffic lights system on menus/menu boards. Such a system should be mandatory where general or high level health claims are made or equivalent endorsements/trade names/marks are used (recommendation 54).
- There is no government-initiated mandatory or voluntary labelling of foods and meals in any restaurants or outlets across New Zealand. In some chains voluntary information is available.
- The government is supportive of the voluntary industry-led initiatives currently being implemented and will consider the evaluation of these initiatives prior to considering regulatory measures of this nature being adopted through the Food Standards Code [17].

International or national good/best practice:

1. **Since 2010, in South Korea, the Special Act on Safety Control of Children's Dietary Life has required all chain restaurants with 100 or more establishments to display nutrient information on menus including energy, total sugars, protein, saturated fat and sodium on menus from 2010[7].**
2. **In the UK as part of the government's Responsibility Deal, 49 companies/retailers have agreed to provide calorie information on menus and display boards. Although voluntary, the label must follow a standard government model[7].**
3. **In the US the Patient Protection and Affordable Care Act (2010) requires that all chain restaurants with 20 or more establishments display energy information on menus. The Food and Drug Administration has yet to issue the implementing rules. Four states (e.g. California), five countries (e.g. King County, Washington State) and three municipalities (e.g. New York City) already have regulations requiring chain restaurants (often chains with more than a given number of outlets) to display calorie information on menu and display boards. These regulations will be pre-empted by the national law once implemented[7].**
4. **Australia has mandated kJ menu board labelling for chain fast food outlets in New South Wales, South Australia and Australian Central Territory.**

3 FOOD PROMOTION: There is a comprehensive policy implemented by the government to reduce the impact (exposure and power) of promotion of unhealthy foods to children (<16years) across all media

Q7 PROMO1: Effective policies are implemented by the government to restrict exposure and power of promotion of unhealthy foods to children through all forms of media, including broadcast (TV, radio) and non-broadcast media (e.g. Internet, social media, point-of-purchase, product placement, packaging, sponsorship, outdoor advertising)

Evidence:

- There are no government regulations in place to restrict unhealthy food promotion to children through TV, radio, internet, social media, packaging, product placement, magazines, outdoor advertising, sponsorship and point-of-purchase. *If food marketing to children via the media were to become regulated other than through the current self-regulatory regime, the Ministry for Culture and Heritage would be likely to be the Ministry responsible for regulation because it is currently the department responsible for media regulation. There is no Ministry of Broadcasting in New Zealand (only a Minister). The extent to which other departments may be involved in regulation would depend on the nature of any food marketing regulatory regime.*

- *There is industry self-regulation of food marketing in NZ. Advertising rules are governed by the Advertising Standards Authority (ASA), which is an industry body. ASA has a number of codes, two of which are relevant to food advertising to children. ASA, aiming to self-regulate advertising in NZ, established a new code in 2010: the Children's Code for Advertising Food 2010. All advertisements for food and beverages that influence children, whether contained in children's media or otherwise, shall adhere to the Principles and Guidelines set out in this Code. This Code defines the age of a child as under 14 in line with the Children, Young Persons and their Families Act 1989 and aligns with the Broadcasting Standards Authority definition of a child [32]. It is stated that: "Food and Nutrition Guidelines" are the current version of the Food and Nutrition Guidelines for Healthy Children (aged 2-12 years) of the Ministry of Health. Food advertisements should not undermine the food and nutrition policies of Government, the Ministry of Health Food and Nutrition Guidelines nor the health and wellbeing of children. Advertisements for nutritious foods important for a healthy diet are encouraged to help increase the consumption of such foods. However, advertisements should not encourage over-consumption of any food. Children's viewing times are determined by the individual television broadcasters. Another code, the Code for Advertising Food, applies to food advertising to persons 14 years and over. Advertisers are required to exercise a particular duty of care for food advertisements directed at young people aged 14 to 17 years of age [33]. Also relevant to TV advertising is the NZ Television Broadcasters code: getting it right for children (this covers the main free-to-air broadcasters) [34]. There are policies included on: 1. No Advertising in Pre-school Television Programming Times, 2. Limited Advertising in School-age Children's Television Programming Times, 3. Compliance with Television Advertising Codes of Practice, 4. Separation of Programmes and Advertising, 5. Repetition, 6. Programme Issues, 7. Sponsorships and 8. 0900 Numbers and Text Responses. In 2008 a new advertising classification – CF (Children's Food) was introduced, to be applied during school-age children's programming times only. It is based on the NZ food and beverage classification system. Evidence suggests that there was no decline in children's exposure to advertising of unhealthy food between 1997 and 2006 [35], based on content analysis of free-to-air television advertising to children [36, 37].*

International or national good/best practice:

1. Norway and Sweden banned all food advertising targeting children aged younger than 12 years since 1990
2. Quebec has banned all advertising to children under the age of 13 since 1980[38]
3. In Ireland advertising and other forms of commercial communication of unhealthy foods, as defined by a nutrient profiling model, are prohibited during children's TV and radio programmes where over 50% of audience are under-18. Content rules also apply to commercial communications for unhealthy foods broadcast outside of children's programmes but which are directed at children. The 2005 Children's Advertising Code states that food advertising to children under the age of 15 must not feature celebrities [7].
4. In South Korea TV advertising is prohibited for specific categories of food before, during and after programmes shown between 5-7pm and during other children's programmes. Children are defined as younger than 18 years of age. The restriction also applies to communication that is assumed to target children (e.g. where free toys are included). The regulation of TV advertisements also applies to the Internet [7].
5. In November 2006, following an extended period of analysis and consultation, Ofcom, an independent communications regulator in the UK, announced a ban on television advertising of products high in fat, salt or sugar during children's airtime and around programmes with a disproportionately high child audience. Advertising of unhealthy foods, as defined by a nutrient profiling model, is prohibited during TV and radio programmes that have 20% more viewers under 16 years old relative to the general viewing population (includes sponsorship of TV programmes). Ofcom's principal aim was to reduce the exposure of children to advertising of unhealthy foods. Unhealthy products were defined by reference to a nutrient profiling model developed by the Food Standards Agency (FSA). The final phase came into force on 1 January 2009, when all advertising for products high in fat, salt or sugar (HFSS) was banned from children's channels (terrestrial as well as cable and satellite channels). In the UK, the data show a 51% reduction in exposure (impacts) to TV advertisements high in fats, sugars or salt during the period 2007–2010 for children aged 5–9 years, and a reduction of 23% for children aged 10–15 years in a wide segment of TV programming. While the number of HFSS advertisements (spots) shown during children's programming fell from 0.3 m in Q1 2005 to virtually zero in 2009, the numbers of advertisements for HFSS foods shown in non-child programming (but still seen by children) rose in the same period[39].
6. In 2013, the "Promoting Healthy Food for Children Act" was passed into law in Peru. The law includes a range of provisions designed to discouraged unhealthy diets, including food advertising. The law states that advertising that is directed to children and adolescents under 16 years old and is disseminated through any format or media, should not stimulate the consumption of food and non-alcoholic drinks, with "trans" fat, high content of sugar, sodium and saturated fats. The law requires implementing regulations in order to be applied[7].
7. Conanda (National Council for the Rights of Children and Adolescents), a government agency attached to the Department of Human Rights of Brazil, has passed a resolution, with the force of law, banning advertising towards children in Brazil. Although there is uncertainty as to how this resolution will be enforced, it marks a landmark shift in Brazil for marketing to children. The resolution states that "the practice of directing advertising and marketing communication to children with the intention of persuading them to consume any product or service" is abusive and, therefore, illegal as per the Consumer Defence Code. With the resolution, starting immediately, the following methods of marketing to children is considered prohibited: print ads, television, commercials, radio sports, banners and sites, packaging, promotions, merchandising, actions on shows, and point-of-sale presentations directed at children[40].

3 FOOD PROMOTION: There is a comprehensive policy implemented by the government to reduce the impact (exposure and power) of promotion of unhealthy foods to children (<16years) across all media

Q8 PROMO2: **Effective policies are implemented by the government to ensure that unhealthy foods are not commercially promoted to children in settings where children gather (e.g. preschools, schools, sport and cultural events)**

Evidence:

- No such policy in place in New Zealand, for any of the settings
- There are guidelines on the Ministry of Education's website for schools to develop policies relating to the food environment in their school[41]. Within the section 'developing a food and nutrition policy framework' the following recommendation is included: 'It is recommended to critically review the promotion of foods and beverages to children and young people including through sponsored curriculum materials, advertisements, fundraisers, and sponsorship'.

International or national good/best practice:

1. **In 2007, the state of Maine in the US passed a law prohibiting brand-specific advertising of certain unhealthy foods and beverages on school grounds, at any time. The ban applies to "foods of minimum nutritional value" as defined by federal law[7].**
2. **In 2011 the Spanish Parliament approved a Law on Nutrition and Food Safety, which stated that kindergartens and schools should be free from advertising. Implementation, which is reportedly not enforced, is at the discretion of regional authorities[7].**
3. **Conanda (National Council for the Rights of Children and Adolescents), a government agency attached to the Department of Human Rights of Brazil, has passed a resolution, with the force of law, banning advertising towards children in Brazil. The text of the resolution also considers abusive any advertising and market communication in day care centres and nurseries, as well as elementary schools, including advertising on school uniforms and classroom material[40].**

4 FOOD PRICES: Food pricing policies (e.g., taxes and subsidies) are aligned with health outcomes by helping to make the healthy eating choices the easier, cheaper choices

Q9 PRICES1: Taxes on healthy foods are minimised to encourage healthy food choices where possible (e.g. low or no sales tax, excise, value-added or import duties on fruit and vegetables)

Evidence:

- Goods and services tax (GST) applies equally to all foods in NZ. There is no reduction of taxes on healthy foods in NZ, never actively considered by the government due to complexity and potential revenue shortfall. The current government policy is not in favour of introducing exemptions.

International or national good/best practice:

1. **GST exemption exists for basic foods (including fresh fruits and vegetables) in Australia**
2. **In Tonga in 2013, as part of a broader package of fiscal measures, import duties were lowered from 20% to 5% for imported fresh, tinned or frozen fish in order to increase affordability and promote healthier diets[7].**
3. **All unprocessed food stuffs are zero-rated value-added tax in the UK. A range of unhealthy foods have standard-rated value-added tax[42]**

4 FOOD PRICES: Food pricing policies (e.g., taxes and subsidies) are aligned with health outcomes by helping to make the healthy eating choices the easier, cheaper choices

Q10 PRICES2: Taxes on unhealthy foods (e.g. sugar-sweetened beverages, foods high in nutrients of concern) are in place to discourage unhealthy food choices where possible, and these taxes are reinvested to improve population health

Evidence:

- No increase of taxes on unhealthy foods in NZ. The current government policy is not in favour of introducing taxes on specific foods.

International or national good/best practice:

1. In December 2013, the Mexican legislature passed two new taxes as part of the national strategy for the prevention of overweight, obesity and diabetes. An excise duty of 1 peso ($0.80) per litre applies to sugary drinks. Sugary drinks are defined under the new law as all drinks with added sugar, excluding milks or yoghurts. This is expected to increase the price of sugary drinks by around 10%. An ad valorem excise duty of 8% applies to foods with high caloric density, defined as equal to or more than 275 calories per 100 grams. The food product categories that are affected by the tax include chips and snacks; confectionary; chocolate and cacao based products; puddings; peanut and hazelnut butters. The taxes entered into force on 1 January 2014[7]. The aim is for the revenue of taxes to be reinvested in population health, namely providing safe drinking water in schools.
2. In France in 2012, the government introduced an excise duty on drinks with added sugar and artificial sweeteners, including sodas, fruit drinks, flavoured waters and 'light' drinks. The tax is around 11 euro cents per 1.5 litres of soda and used to raise revenue for the general budget[7].
3. In French Polynesia a domestic excise duty on sweetened drinks, beer, confectionary and ice cream has been in place since 2002. The tax aims to raise funds for prevention-oriented health programmes, as well as discourage consumption. The tax is around $0.44 per litre on domestically-produced drinks[7].
4. In Hungary a "public health tax" adopted in 2012 is applied on the salt, sugar and caffeine content of various categories of ready-to-eat foods, including soft drinks (both sugar- and artificially-sweetened), energy drinks, pre-packaged sugar-sweetened products. The tax is applied at varying rates. Soft drinks, for example, are taxed at $0.24 per litre, and other sweetened products at $0.47 per litre[7].
5. In Tonga, as of 2013, soft drinks containing sugar or sweeteners are taxed at $0.50 per litre. Animal fat products (e.g. lard and drippings) are taxed at $1 per kilogram[7].

4 FOOD PRICES: Food pricing policies (e.g., taxes and subsidies) are aligned with health outcomes by helping to make the healthy eating choices the easier, cheaper choices

Q11 PRICES3: The intent of existing subsidies on foods, including infrastructure funding support (e.g. research and development, supporting markets or transport systems), is to favour healthy rather than unhealthy foods

Evidence:

- Subsidies on foods in New Zealand, compared to other countries (e.g. agricultural subsidies in the United States), are quite small. In the US In addition to making grains cheap, subsidies have led to an artificially low cost of meat (corn and soy are the central constituents of animal feed) and allowed the food industry to inexpensively sweeten a variety of foods with high fructose corn syrup.
- The National Science Challenge on high value nutrition drives functional food development towards foods on which health claims can be made. In the recent request for proposals it was written that the objective of this science challenge is to develop high-value foods with validated health benefits to drive economic growth. Health targets are to be identified that are amenable to a science evidence-based food solution to drive economic growth. Profitable high-value food products are to be produced and marketed, backed by scientifically validated health claims. The major aim of all the 10 National Science Challenges is to identify big science-based issues for New Zealand that, if addressed, will contribute significantly to the wellbeing of the nation, including through economic growth[43].
- Councils can approve and encourage applications for farmers markets on Council owned land, remove any stall fees and charges at farmers markets, regional councils can ensure appropriate transport links are available to markets and other fruit and vegetable outlets, cycle pathways, lighting etc. for night markets (personal communication Sarah Stevenson Public Health Service Tauranga). Councils usually support farmers markets by land allocation and bus routes. Support for farmers markets is quite common by NZ Councils. To our knowledge, no councils to date boost support for fresh fruits and vegetables at produce markets, by such measures as providing free stall space.

International or national good/best practice:

1. **In Singapore as part of the Healthier Hawker programme, manufacturers are able to tap into non-health related government funding for productivity and innovation to improve logistics and efficiency in supply of healthier oils and healthier staples, with a view to making prices competitive [7].**
2. **The New York City Health Department District Public Health Offices distribute 'Health Bucks' to farmers' markets. When customers use income support (e.g. Food Stamps) to purchase food at famers' markets, they receive $2 back in 'Health Bucks', which can then be used to purchase fresh fruits and vegetables[7].**

4 FOOD PRICES: Food pricing policies (e.g., taxes and subsidies) are aligned with health outcomes by helping to make the healthy eating choices the easier, cheaper choices

Q12 PRICES4: The government ensures that food-related income support programs are for healthy foods

Evidence:

- Food-related income support is not tied to criteria related to the nutritional quality of foods in New Zealand
- KickStart Breakfast is the only school breakfast programme of its kind within New Zealand. Sanitarium provides the Weet-Bix, Fonterra the Anchor milk and it's the school that is responsible for delivering the programme. There are no nutrition requirements set for this programme by the Ministry of Social Development, any decisions around nutritional requirements are matters for the individual schools (info on nutritional requirements retrieved through official information request). The Prime Minister announced, as part of Government's commitment to optimal outcomes for children and young people, funding of $9.5 million over the next five years, to expand Fonterra and Sanitarium's KickStart Breakfast programme. KickStart Breakfast, now in its fifth year, currently provides breakfasts of Anchor Milk and Weet-Bix twice a week to children in more than 570 decile one to four schools around New Zealand (At 1 July 2013, there were about 1016 decile 1-4 schools in NZ). This amounts to 48,000 breakfasts every week, with almost 5 million breakfasts served to date. The Government support will initially enable Fonterra and Sanitarium to extend the current programme from two days a week to five days a week for the schools that currently participate and offer the KickStart Breakfast programme to any other decile one to decile four schools.
- The Government funds the Fruit in Schools programme, which all decile one and two primary and intermediate schools are able to opt into. In 2012, around 480 decile one and two schools participated, seeing around 96,806 children receiving one piece of fruit per day. At July 2013, there were about 521 decile 1-2 schools in NZ.
- There are special needs grants to beneficiaries on a case-by-case basis. The Ministry of Social Development, through Work and Income, can provide recoverable or non-recoverable financial assistance to people to meet an immediate need for essential items such as food, health costs, power and other costs. These payments are available to any person as long as they meet the income and asset test, and they are unable to meet the cost from any other source. This form of support is not tied to any nutritional requirements.

International or national good/best practice:

1. **In 2009, the U.S. Department of Agriculture's implemented revisions to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to improve the composition and quantities of WIC-provided foods from a health perspective. The revisions include: Increase the dollar amount for purchases of fruits and vegetables, expand whole-grain options, allow for yoghurt as a partial milk substitute, allow parents of older infants to buy fresh produce instead of jarred infant food and give states and local WIC agencies more flexibility in meeting the nutritional and cultural needs of WIC participants[7]**
2. **The WIC Farmers' Market Nutrition Program (FMNP) is associated with the Special Supplemental Nutrition Program for Women, Infants and Children, popularly known as WIC. The WIC FMNP was established by Congress in 1992, to provide fresh, unprepared, locally grown fruits and vegetables to WIC participants, and to expand the awareness, use of, and sales at farmers' markets. Women, infants (over 4 months old) and children that have been certified to receive WIC program benefits or who are on a waiting list for WIC certification are eligible to participate in the WIC FMNP. State agencies may serve some or all of these categories. A variety of fresh, nutritious, unprepared, locally grown fruits, vegetables and herbs may be purchased with FMNP coupons. State agencies can limit sales to specific foods grown within State borders to encourage FMNP recipients to support the farmers in their own States[44].**
3. **The Senior Farmers' Market Nutrition Program (SFMNP) awards grants to States, U.S. Territories, and federally recognized Indian tribal governments to provide low-income seniors with coupons that can be exchanged for eligible foods (fruits, vegetables, honey, and fresh-cut herbs) at farmers' markets, roadside stands, and community-supported agriculture programs[45].**
4. **In 2012, the USDA piloted a "Healthy Incentives Pilot" as part of the Supplemental Nutrition Assistance Program (SNAP, formerly "food stamps").**
5. **Participants received an incentive of 30 cents per US$ spent on targeted fruit and vegetables (transferred back onto their SNAP card)[7].**
6. **The New York City Health Department District Public Health Offices distribute 'Health Bucks' to farmers' markets. When customers use income support (e.g. Food Stamps) to purchase food at famers' markets, they receive $2 back in 'Health Bucks', which can then be used to purchase fresh fruits and vegetables[7].**

5 FOOD PROVISION: The government ensures that there are healthy food service policies implemented in government-funded settings to ensure that food provision encourages healthy food choices, and the government actively encourages and supports private companies to implement similar policies

Q13 PROV1: **The government ensures that there are clear, consistent policies (including nutrition standards) implemented in schools and early childhood education services for food service activities (canteens, food at events, fundraising, promotions, vending machines etc.) to provide and promote healthy food choices**

Evidence:

- The National Administration Guidelines (NAG) for school administration set out statements of desirable principles of conduct or administration for specified personnel or bodies. The NAG 5 [46] states that each board of trustees is required to promote healthy food and nutrition for all students. From June 2008 to February 2009 there was an additional clause that schools should only sell healthy food on their premises. The Education Review Office (ERO) evaluated schools ability to meet this requirement [47]. In February 2009, the National Government removed the Directive that school canteens sell healthy food to the children in their care. There is now no minimum nutritional standard for school canteens in New Zealand. Currently, a school board of trustees is obliged to comply with the requirement to "promote healthy food and nutrition for all students" in its school. The responsibility for complying with that requirement rests with the board of trustees, not with ERO or the Ministry of Education. ERO does not have any powers other than its ability to publish reports, and any powers of 'enforcement' would be through the Ministry. Where a school board fails to comply with its legal obligations to any significant extent, the Ministry can consider an intervention under Part 7A of the Education Act 1989. As part of ERO's general education review process, which is described in ERO's publication Framework for School Reviews, ERO uses the Guidelines of Board Assurance Statement and Self-Audit Checklists in which a board is asked to attest to comply with a considerable number of legal obligations in six areas – Board Administration, Curriculum, Health, Safety and Welfare, Personnel, Financial, and Asset Management – before ERO's review of the school commences. ERO then does not review those matters attested to, but takes that attestation on trust. ERO does however check on items related in particular to student safety because they have a potentially high impact on student achievement. The compliance obligation to meet the NAG 5 requirement for food and nutrition rests with the board of trustees. If a parent of a student had concerns about the school's response to the NAG 5 requirement, then the parent would take their concern directly to the board. Prior to the removal of the directive, in June 2008 and January 2009 ERO completed two national reports on the NAG 5 requirements, and published these on its website but has not reported on NAG 5 since that time. (Personal communication Marc Canning Education Review Office).
- The Early Childhood Education (ECE) Services Regulations 2008 mention: 46 Health and safety practices standard: general is the standard that requires every licensed service provider to whom this regulation applies to take all reasonable steps to promote the good health and safety of children enrolled in the service
- There are guidelines on the Ministry of Education's website for schools to develop policies related to the food environment in their school[41].
- The Children's Commissioner published Guidelines for School Food Programmes: Best Practice Guidance For Your School (February 2014)[48]. The guideline principles are that school food programmes should be child-centred, inclusive, and nutritionally sound, take a whole-school approach, sustainable and evidence-based. The guidelines include examples of successful school food programmes in appendix 1 of that document.

International or national good/best practice:

1. **In Australia five states or territories have implemented mandatory standards in schools based on either the national voluntary guidelines or nutrient and food criteria defined by the state. 'Red category' foods are either completely banned in schools or heavily restricted.**
2. **In 2006, the Latvian government implemented legislation that prohibited the sale/availability of soft drinks, drinks with added colours, sweeteners, preservatives and caffeine on all school premises. Food served in educational institutions, hospitals and long-term social care institutions may not exceed 1.25g of salt per 100g of food product; fish products may contain up to 1.5g of salt per 100g of product [7].**
3. **England and Scotland have mandatory nutritional standards for school food, that also apply to food provided in schools other than school lunches. These standards apply to all state schools and restrict foods high in fat, salt and sugar, as well as low quality reformed or reconstituted foods[7].**
4. **As part of the Public Health Act (2004) in France, there is a ban on vending machines in all schools. Fruit and bottled water are made available[7].**
5. **Brazil has one of the largest school feeding programs in the world. Not only nutrition standards are set, but also the law requires schools to buy locally grown or manufactured products, supporting small farmers and stimulating the local economy. The law, approved in 2001, requires that 70% of the food served to children in school meal programs be unprocessed and another law, approved in 2009, that 30% of the program budget should be used to purchase fresh foods directly from family farms and their cooperatives.**

5 FOOD PROVISION: The government ensures that there are healthy food service policies implemented in government-funded settings to ensure that food provision encourages healthy food choices, and the government actively encourages and supports private companies to implement similar policies

Q14 PROV2: The government ensures that there are clear, consistent policies in other public sector settings for food service activities (canteens, food at events, fundraising, promotions, vending machines, public procurement standards etc.) to provide and promote healthy food choices

Evidence:

- Overall, the government does not specify any requirements for consistent policies across public sector settings in NZ or for specific public sector settings in particular.
- Nearly all District Health Boards (DHBs) do have healthy eating guidelines. Most DHBs also have policies and apply a set of criteria to DHB owned and operated staff cafes and stocking vending machines and add a nutrition clause in new contracts. A list of non-exhaustive examples follows. The Auckland District Health Board applies the following criteria to DHB owned and operated staff cafes and stocking vending machines: no sugar sweetened beverages, no confectionary or snack foods exceeding 800 kJ per packet and no deep fried foods. This applies for vendors leasing space at DHB as well and a nutrition clause is included in the contracts for new vendors. The clause is tailored to the type of vendor and focuses on limiting portion sizes and ensuring that vegetables, fruits and whole grains dominate the menus. The same applies for contracts with NGO providers. The Northland DHB healthy food policy specifies that the healthy food options in cafeterias must be promoted by methods such as: placing these products at eye level, subsidizing healthier options by increasing the price of less healthy items, highlighting the healthier options etc. All vending machines must adhere to the Northland DHB beverage guidelines. Red beverages (sugar-sweetened beverages) are not permitted to be sold. In terms of processed and packaged foods, at least 50% of the items for sale must meet the better choice nutrition criteria (<800 kJ per packet, <1.5 g/100g saturated fat and <450mg/100g sodium). Confectionary items (including sugar-free ones) are excluded from the better choice criteria such as lollies, marshmallows, liquorice, chocolate, carob or chewing gum. Before the start of any new catering contract, the contractor shall provide Lakes DHB contractor manager with a nutritional analysis of all hot and cold foods they intend to provide, using the Crop and Food Database. In Wairarapa DHB vending machines are not permitted on the premises.
- A working group has been established with representatives from the three metro Auckland DHBs and Auckland Regional Public Health Service including dieticians, food service managers and public health specialists. This Group is working on a set of agreed nutrition criteria with the intention that these will be consistently applied across the three DHBs and will also be promoted to other public sector settings e.g. Auckland Council, tertiary institutions etc. Removal of sugar sweetened beverages is a key component of this work and there is also a focus on limiting portion sizes and ensuring vegetables, fruit and wholegrain foods dominate the menu.
- The Department of Corrections states that meals provided to prisoners are in line with the guidelines for food and nutrition set by the MoH. The Department's prison operations manual sets out performance standards surrounding catering, menus and responsibilities relating to prisoners with health issues, such as diabetes (personal communication Department of Corrections). In 2008-2009 Regional Public Health Wellington undertook a review of the Corrections menu[49], following a request from the Department of Corrections, to assess whether prison menus meets the minimum nutritional requirements set out by the Ministry of Health, and Corrections are considering a review again this year. It was found that overall; these menus provide an adequate variety of food in appropriate amounts for both males and females. Energy intake would be suitable to meet the needs of sedentary prisoners. The overall recommendations for further improvements to the menu to ensure nutrient adequacy are listed in the report[49] .
- All rest homes and aged residential care facilities are certified and audited to ensure they provide safe, appropriate care for their residents and meet the standards set out in the Health and Disability Services (Safety) Act 2001[50]. Overall, there are 50 standards and 101 criteria within the standards that can be used for the audits. It is stated that food, fluid and nutritional needs of consumers are provided in line with recognized nutritional guidelines appropriate for the consumer group.

International or national good/best practice:

1. **In 2007, New York City (NYC) began developing a nutrition policy for all foods purchased, served, or contracted for by City agencies[51]. A Food Procurement Workgroup was created with representatives from all City agencies that engaged in food purchasing or service, and the NYC Health Department served as technical advisor. The NYC Standards for Meals/Snacks Purchased and Served (Standards) became a citywide policy in 2008. The first of its kind, the Standards apply to more than 3000 programs run by 12 City agencies. New York City has an Executive Order setting nutritional standards for all food purchased or served by city agencies, which applies to prisons, hospitals and senior care centres.**
2. **Vending machines dispensing crisps, chocolate and sugary drinks are prohibited in National Health Service hospitals in Wales. Guidance issued by the Welsh government defines what is allowed and not allowed, and has liaised with major vending providers to find ways to introduce healthier food and drink options[7].**
3. **In 2008, the Scottish government issued guidelines to National Health Service chief executives on the provision of competitively priced fruit and vegetables in hospital settings and the removal of all soft drinks with a sugar content greater than 0.5g per 100ml (pure fruit juice is exempt)[7].**
4. **Los Angeles county has used health impact assessments relating to healthy food to inform public procurement bid specifications[7].**

5 FOOD PROVISION: The government ensures that there are healthy food service policies implemented in government-funded settings to ensure that food provision encourages healthy food choices, and the government actively encourages and supports private companies to implement similar policies

Q15 PROV3: The government ensures that there are good support and training systems to help schools and other public sector organisations and their caterers meet the healthy food service policies and guidelines

Evidence:

Support and training systems for schools and early childhood education (ECE) services

- The Ministry of Education has developed resources [52] in consultation with the MoH to assist schools and ECE services in their focus on this area: 'Food and Nutrition for Healthy Confident Kids' guidelines (2007) [41] and 'Food and Nutrition for Healthy Confident Kids' toolkit containing some resources to support the guidelines. These guidelines are supported by the MoH's food and beverage classification system. These have not been updated by MoH since 2007 but are still available for use. The 'Food and Nutrition for Healthy Confident Kids' guidelines are still very much used by schools and considered the key nutrition source for schools (statement from the Ministry of Education). The Food and Beverage Classification System (FBCS) is now managed by the NHF (rebranded as Fuelled4life) and is a collaborative initiative that involves the education, health and food industry sectors working together to make it easier to have healthier food in schools and early childhood education (ECE) services in NZ. This is voluntary [53, 54]. Fuelled4life includes food buyers guides for schools and ECE services.
- Also available at http://healthylifestyles.tki.org.nz are case studies from schools around New Zealand successfully working to improve nutrition, physical activity levels and general wellbeing[41].
- There are guidelines on the Ministry of Education's website for schools to develop policies relating to the food environment in their school[41].
- The Children's Commissioner published Guidelines for School Food Programmes in 2014: Best Practice Guidance For Your School (February 2014)[48].
- The Healthy Heart Award is an established, free programme coordinated by the NHF and partially funded by the MoH. It assists ECE services to create an environment promoting healthy eating and physical activity to under 5s and their families. There are three award levels[55].
- HEART START Toitoi Manawa is a free curriculum-linked programme, partially funded by the MoH. It is offered to all schools across New Zealand. The programme fits with schools existing work and helps build a heart healthy environment[56].
- The NHF has several other resources available for schools and ECE services on the website related to ECE menu development and school canteen menu development.
- Another training program from the NHF is the HEAT nutrition training course, a level 3 unit standard qualification in nutrition available for food preparers. The course is ideal for chefs, caterers, teachers, menu planners, supervisors and students with an interest in catering[57].

Health Promoting Schools (HPS) is an approach (initiative of MoH) where the whole school community works together to address the health and wellbeing of students, staff and their community. The initiative is broader than nutrition only (e.g. sun-safe and smoke-free schools, kiwi sport, fruit in schools, 5+ A Day School Competition) and it is funded by the MoH. The HPS National Strategic Framework supports school communities to identify and address their prioritised health needs and take actions that utilise their strengths and build capability. The framework empowers school communities to develop solutions for their own transformation in partnership with health, education and social services. The inquiry-based approach is outcomes focused and sustainable as it builds on what schools already do and integrates the actions and outcomes into schools' planning and reporting mechanisms. Many schools have joined HPS over the years. In 2009, around 67% of schools were part of the programme. There is a goal for HPS to have75% of decile 1-4 schools included by 2014. They are supported by advisors from public health units, district health boards or local government, who are contracted by the MoH to support HPS. The December 2013 database shows that: 474 decile 1-4 schools (out of 1016), 126 decile 5-7 schools, 54 decile 8-10 schools are adopting the HPS framework in New Zealand . The December 2013 database shows that 37% of schools engaged in HPS undertake nutrition-related work. The December 2013 biannual survey shows 52.36 FTEs spread across 178 staff are working on HPS framework across the country (information received trough Janet Chen, Senior Portfolio Manager, MoH). An overview of the themes and activities covered by HPS in relation to nutrition is printed below.

Key areas:	Activities
Partnerships across health, education and social services	Enviro-schools, Fruit in Schools, 5+ a Day, Heart Foundation, Cancer Society.
Government priorities: • Healthy eating • Physical activity • Rheumatic Fever • Mental health • Smokefree	Hear start, Milk in Schools, Fruit in Schools, KidsCan, 5+ a Day, Food for Thought, Food stuffs, Fonterra and Sanitarium Breakfast Clubs
Plans and charter	Nutrition/ Water only Policy review as part of review cycle. Resulting plans for change.
Student engagement	• Student involvement in building, planting and maintaining gardens and using produce • Cultural festivals and healthy eating options
Family/whānau engagement	• Parent involvement in building, planting and maintaining gardens and using produce • Breakfast Club • Cultural festivals and healthy eating options.
Individual and school community knowledge, skills, attitudes and behaviours	Cooking(developed NCEA programme Chch), Nutrition lessons/ workshops for students and parents Oral health Matariki celebrations
Physical, social and cultural environment	Gardens- herb, garden to plate, seed to plate, plant to plate. Planting orchard Keeping chickens/ bees Worm farms
School policies	Healthy eating and nutrition policy Healthy lunches Tuck shop Water only

Support and training systems for other settings

- Heartbeat Challenge (HBC) is a workplace health and wellbeing programme which focuses on strengthening the environment that supports and improves health for all employees. The programme framework enables and empowers employees to help drive the programme and contribute to the content. Emphasis is placed on encouraging environmental change within the workplace such as in the provision of healthy food options in cafeterias, encouraging incidental exercise, providing bike racks, shower facilities, supporting smoking cessation programmes and harm reduction from alcohol and other drugs. Workplaces that meet the Heartbeat Challenge criteria (factories, disability support services, government departments, call centres, rest homes, local councils and district health boards) are supported by a Workplace Health Promoter to work towards a Heartbeat Challenge Award. This is attained by achieving a set number of changes in each of the chronic disease risk factor elements. The award is renewed every two years to ensure sustainability. Heartbeat Challenge was originally developed by the NHF. Since 2003 HBC has been further developed and delivered by the Auckland regional public health service and is funded by the MoH. HBC is active in over 110 workplaces in the wider Auckland Region [58].
- The Health Promotion Agency (HPA) recently developed a guide to providing healthier beverage options for workplaces[59] . These guidelines explain how to improve the range of beverages available to staff in workplaces. They are designed to help gain the support of management and staff to improve the quality of available beverages as part of workplace health, safety and wellness responsibilities. These guidelines are for workplaces looking to take steps to improve the health and wellbeing of employees. The guidelines can be used to improve the quality of beverages supplied in vending machines, cafeterias and at staff functions.
- For the development of a workplace healthy eating programme or policy, the following toolkits may be useful: WorkWell for Healthy Eating Toolkit[60], Auckland Regional Public Health Service Heartbeat Challenge[61], the sample workplace food and nutrition policy template from The Heart Foundation[62]. The Well@Work initiative initiated as part of the Healthy Eating Healthy Action (HEHA) and Mission-On initiatives developed tools for workplaces to use to create healthy workplaces and focused on healthy eating and physical activity within workplaces.

International or national good/best practice:

1. **In May 2009, President Obama tasked the Office of Personnel Management with developing wellness best practices and a plan for the federal workforce. In addition, the White House Offices of Management and Budget and Health Reform began working with federal agencies to provide healthier food choices to federal employees. This effort to improve food choices at federal facilities was led by the U.S. General Services Administration (GSA). Health and Human services (HHS) and USDA joined the effort in late 2009. In 2010, CDC formed the federal food service guidelines team (HHS (CDC, FDA, NIH, ASA, ASPE), GSA, and USDA), which translated the Dietary Guidelines for Americans and evidence-based sustainability recommendations into institutional food service practices to create the HHS and GSA Health and Sustainability Guidelines for Federal Concessions and Vending Operations HHS/GSA Guidelines, released in March, 2011. The goal of the HHS/GSA Guidelines is to assist in increasing healthy food and beverage choices and sustainable practices wherever people buy or are served food[63].**
2. **Many New South Wales public schools provide a canteen service for their students. School canteens can be run by Parents and Citizens' Associations, by schools themselves or leased to private companies. The Fresh Tastes NSW Healthy School Canteen Strategy requires all NSW government schools to provide a healthy, nutritious canteen menu in line with the Australian Dietary Guidelines for Children and Adolescents. The Canteen Menu Planning Guide with Communication Kit, the Fresh Tastes Tool Kit, the Fresh Ideas for a Healthy School Canteen recipe file and the 'Come into my Canteen' DVD have been developed to assist schools in implementing the Strategy[64].**

5 FOOD PROVISION: The government ensures that there are healthy food service policies implemented in government-funded settings to ensure that food provision encourages healthy food choices, and the government actively encourages and supports private companies to implement similar policies

Q16 PROV4: Government actively encourages and supports private companies to provide and promote healthy foods and meals in their workplaces

Evidence:

- The Health Promotion Agency (HPA) recently developed a guide to providing healthier beverage options for workplaces[59] . These guidelines explain how to improve the range of beverages available to staff in workplaces. They are designed to help gain the support of management and staff to improve the quality of available beverages as part of workplace health, safety and wellness responsibilities. These guidelines are for workplaces looking to take steps to improve the health and wellbeing of employees. The guidelines can be used to improve the quality of beverages supplied in vending machines, cafeterias and at staff functions.

- For the development of a workplace healthy eating programme or policy, the following toolkits may be useful: WorkWell for Healthy Eating Toolkit[60], Auckland Regional Public Health Service Heartbeat Challenge[61], the sample workplace food and nutrition policy template from The Heart Foundation[62]. In New Zealand local public health service units oversee the WorkWell programme, including a focus on healthy eating, and provide toolkits for companies to use. Under the WorkWell programme The Public Health Unit Toi Te Ora is currently working with 23 businesses who have identified healthy eating as a priority. Each of these businesses is currently implementing their relevant action plans. The smaller businesses have tended to opt for the development of a generic wellbeing policy rather than a specific healthy eating policy. However, the policies of each of the 23 businesses have a commitment to healthy eating. Toi Te Ora provides support to the workplaces in the development on their healthy eating action plans, ensuring they consider actions across organisational, environmental and individual levels.
  There is a healthy eating toolkit which provides examples and support material.
  There are currently 41 businesses enrolled in Workwell in that area covering a total of 11321 employees. Workwell targets businesses employing high numbers of Māori, Pacific and low skilled staff.

International or national good/best practice:

1. **Government funding for health promotion (including nutrition) in workplaces has been made available along with guides and tools to promote health and wellbeing in the workplace as part of the National Partnership Agreement on Preventive Health in Australia[65].**

2. **The UK responsibility deal includes collective pledges on health at work, which set out the specific actions that partners agree to take in support of the core commitments. One of the pledges is on healthier staff restaurants, with 165 signatories to date[66]**

6 FOOD RETAIL: The government has the power to implement policies and programs to support the availability of healthy foods and limit the availability of unhealthy foods in communities (outlet density and locations) and in-store (product placement)

Q17 RETAIL1: Zoning laws and policies are robust enough and are being used, where needed, by local governments to place limits on the density or placement of quick serve restaurants or other outlets selling mainly unhealthy foods in communities

Evidence:

- *Zones have a set of rules (e.g. permitted activity lists) that are reflective of their anticipated land use, so for a commercial zone retailing, commercial enterprises, takeaways etc. are all permitted activities that can be undertaken without need for Council consent. Permitted activities for each zone are set by the District Council through the District plans. Council does not regulate the type of commercial activity unless it is impacted by other regulations such as the Hazardous Substances legislation that limits the amount and type of some goods that can be stored. Council does have the ability to regulate other activities using bylaws / policies such as the Trading in Public Places Bylaw. This is primarily to regulate temporary mobile vendors to keep them out of commercial zones so they do not impact on the trading of the existing, lawfully established businesses.*

- Historically, the public health role of the Councils focused on sanitation and food safety and the control of infectious diseases by having a healthy physical environment. However, the Health Act 1956 imposes on Councils a general duty to improve, promote and protect public health. Councils bylaw making power is covered in the Local Government Act 2002. A territorial authority may make bylaws for its district for 1 or more of the following purposes: (b) protecting, promoting, and maintaining public health and safety. The four well-beings (social, economic, environmental and cultural) as a purpose of local government have recently been removed from the Local Government Act however.

- No NZ Council has specific rules for regulating the number and location of food outlets. If a Council was to develop a policy on this it would need to undertake a process using the Special Consultative Procedure under the Local Government Act 2002. Alternatively there could be new "takeaway" rules developed to be given effect through the District Plan which would require a Plan Change Process under the Resource Management Act 1991. Both involve considerable research and consultation. The real difference between the 2 processes is that Council's decisions on Plan Changes can be appealed to the Environment Court which can drag the process out considerably. Policy decisions developed under the Local Government Act can't be appealed but the process can be challenged to a Judicial Review to see if the process followed was sufficiently robust.

- In 2009 regional public health (Wellington region) funded research to examine the food environment of Eastern Porirua. This work quantified the poor availability of healthy and affordable foods and high density of unhealthy food outlets within this region. Presentations were made to the Porirua City Council to raise awareness and potential solutions including zoning policies and community markets to promote fruit and vegetable availability. Since this time, a monthly summer market has been commenced.
  In 2012 the public health dietician wrote submissions for each of councils long term plans (upper hut, lower hutt, wellington, porirua and kapiti), including raising awareness on increase in healthy food availability and access through development and maintenance of community markets and gardens and mapping density of food outlets especially in more deprived areas, work on solutions to improve access to healthier and more affordable foods and explore regulation or incentives to restrict fast food outlets near schools and limit density within neighbourhoods.

- The Auckland Public Health Unit has made submissions on a cap for density of fast food outlets to the draft plan of the Council. No New Zealand councils expressed interest in pursuing work around zoning policies to date.

International or national good/best practice:

1. **In 2008, the Los Angeles City Council, in the United States (USA), approved a 1-year moratorium on the opening of new fast food establishments in several south Los Angeles neighbourhoods with high fast food density and high obesity[67].**
2. **In Detroit, USA, the zoning code prohibits the building of fast food restaurants within 500 ft. of all elementary, junior and senior high schools[67].**
3. **In South Korea the Act establishes 'Green Food Zones', banning the sale of fast foods and soda within 200 metres of schools. The law was implemented in 2009-2010[68].**

6 FOOD RETAIL: The government has the power to implement policies and programs to support the availability of healthy foods and limit the availability of unhealthy foods in communities (outlet density and locations) and in-store (product placement)

Q18 RETAIL2: **There are existing support systems to encourage food stores to promote the in-store availability of healthy foods and to limit the in-store availability of unhealthy foods**

Evidence:

- Toolkit developed by Toi Te Ora- Public Health Service in Tauranga[69] with options for local government regarding ways they can assist in improving the food security of their communities through supporting improvements in healthy food access and the environment through advocacy, support, planning and policy. This toolkit contains a collection of possible strategies, advocacy opportunities and policies targeting local government action to improve their community's food security. The toolkit is divided into four main sections that represent the four spheres of influence to improve food security: Collaboration, Community Capacity, Supportive Environments and Advocacy. Through the toolkit councils are encouraged to take practical steps to encourage and facilitate farmers markets.

- Toi Te Ora- Public Health Service in Tauranga has done some work with fruit and vegetable retailers to increase fruit and vegetable sales by offering a weekly ordering system that offers customers convenience and good value, it is called "Kai@The Right Price". This was originally a Waikato public health unit initiative that has been implemented across three locations (Western Heights in Rotorua, Mangakino and Opotiki). Once a vendor agrees to be involved, support is provided over a 13 week trial period, a communications strategy is developed and the advertisement of the project is funded. T-shirts and aprons for the staff to promote the initiative in store, eco-bags to package the produce, ordering of resources to include with the produce (including recipes and tips what to do with the produce), evaluation of the trial and any other support required are funded. Funding is obtained to support the roll out of 2 new Kai@The Right Price projects with businesses per financial year[70]. The aim is to trial the programme in Whakatane this year and then to support Food Policy councils to undertake it in the future.

- Taranaki DHB: During 2006-2009 a pink feet food retailer project took place within a defined geographical community with a focus on healthy school lunches. Pink feet led the customers to the healthy choices which were highlighted with shelf-talkers, in one outlet. This expanded to 3-4 outlets. During 2012-2013, in another community, green feet was organised. The green Feet project is a collaborative project between the Taranaki DHB Public Health Unit and local food retailer 4 Square 45, and is currently running within the small coastal community of Opunake.
  The Green Feet project uses social marketing techniques to promote healthier lunchbox items for children. Green Feet run along the floor; bypassing isles containing unhealthy food choices and leading people to the healthier food choices. Shelf-talkers also point out food choices. The feet and the shelf-talkers lead the customers to the green, healthy choices. Cheap and easy recipes were readily available. This project included supermarket tours and label reading, budget cooking demonstrations and taste-testing and remains in place.

- The Tairawhiti DHB has worked with one shopping area to promote low fat milk, whole grain bread and increased consumption vegetables and fruits. They are planning "Tips on chips" workshops with local food outlets in the next 6 months.

International or national good/best practice:

1. **The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) requires WIC authorised stores to stock certain healthier products (e.g. wholegrain bread)[7].**

2. **In England's responsibility deal, although voluntary, the government sets clear expectations for retailers, for example to remove prominently displayed sweets and chocolate from checkouts or setting up a scheme that would have given customers rewards for buying healthy food such as fruit and vegetables**

3. **The Change4Life Convenience Stores programme is a partnership between the UK Department of Health and the Association of Convenience Stores to increase the availability of fresh fruit and vegetables in convenience stores in deprived, urban areas in England with poor existing retail access to fresh fruits and vegetables [7]. It was introduced in 2008 and aimed to increase retail access to fresh fruit and vegetables in deprived, urban areas by providing existing convenience stores with a range of support and branded point-of-sale materials and equipment.**

7 FOOD TRADE AND INVESTMENT: The government ensures that trade and investment agreements protect food sovereignty, favour healthy food environments, are linked with domestic health and agricultural policies in ways that are consistent with health objectives, and do not promote unhealthy food environments

Q19 TRADE1: The direct and indirect impacts of international trade and investment agreements on food environments and population nutrition and health are assessed and considered

Evidence:

- A list of all New Zealand's trade agreements (both in force and under negotiation) can be found online [71]. Trade agreements between two or more countries can be known as either a Free Trade Agreement (FTA), Closer Economic Partnership (CEP), or Strategic Economic Partnership (SEP). International trade accounts for around two-thirds of New Zealand's total economic activity. The site includes useful information on each of the agreements, including form of the agreement, countries involved and time since entry into force. Trade agreements often cover: Trade in Goods (Market Access, Rules of Origin, Customs Procedures, Chapters on institutional and legal matters, Trade Remedies, Sanitary and Phytosanitary Measures, Technical Barriers to Trade), Trade in Services (Market Access, Movement of Natural Persons), Investment, Intellectual Property, Government Procurement, Competition and Consumer Policy, Cooperation, Trade and Labour and Trade and Environment. On the site the full text of each concluded agreement can be found, as well as the National Interest Analysis for each agreement[71]. Both the statement of intent 2013-2016[72] and the annual report[73] of the Ministry of Trade and Foreign Affairs do not include any assessment of the impact of trade agreements on food environments, population nutrition or national nutrition and health policies. For the trade agreements in force, a search for the key words 'nutrition', and 'food' in the text of the agreement as well as any national interest analysis for the agreement did not deliver any relevant results. We found no evidence available from public sources from the Ministry of Foreign Affairs and Trade (MFAT) or MoH or MPI, the Ministry of Business, Innovation and Employment (MBIE), treasury or other relevant government agencies that potential impacts on nutrition and health are assessed in the negotiation of agreements (other than relying on the standard WTO clauses which have a very high bar for evidence of negative impacts on health).

- Information on stated purposes of legislative proposals relating to food was sought from examining the Food Bill, introduced in 2010. This states among other things that the purpose of the act is to achieve the safety and suitability of food for sale and provide for risk-based measures that minimise and manage risks to public health; and protect and promote public health'(cl 4). While a reference to protecting and promoting public health is positive, there is little in the act that would implement this aspect of the Act's purpose in a broad way going beyond traditional food safety concerns. For instance, the Bill states the primary duty of persons who trade in food is to 'ensure that it is safe and suitable'. Concepts of safe and suitable are defined in the Bill, but in rather limited ways. It is also to be noted that a report on submissions to the Food Bill is due in May 2014 [74].

International or national good/best practice:

1. **European commission launches online public consultation on provisions and investor protection in Transatlantic Trade and Investment Partnership[75]**

2. **There has been very little systematic monitoring of the impacts of trade agreements from any perspective, and nothing from a food environment/obesity perspective. There is some ex-post evidence of the direct impacts of the North American Free Trade Agreement (NAFTA) agreement on agricultural and food product imports/exports between US and Mexico, as well as indirect impacts on Mexico's food industry and domestic agricultural production. The flow of several key products between the United States and Mexico was plotted over the 14-year NAFTA period (1994-2008). Directly and indirectly, the United States has exported increasing amounts of corn, soybeans, sugar, snack foods, and meat products into Mexico over the last two decades. Facilitated by NAFTA, these exports are one important way in which US agriculture and trade policy influences Mexico's food system. Because of significant US agribusiness investment in Mexico across the full spectrum of the latter's food supply chain, from production and processing to distribution and retail, the Mexican food system increasingly looks like the industrialized food system of the United States[76].**

7 FOOD TRADE AND INVESTMENT: The government ensures that trade and investment agreements protect food sovereignty, favour healthy food environments, are linked with domestic health and agricultural policies in ways that are consistent with health objectives, and do not promote unhealthy food environments

Q20 TRADE2: **The government adopts measures to manage investment and protect their regulatory capacity with respect to public health nutrition.**

Evidence:

- International investment agreements have the potential to restrict a country's regulatory capacity with respect to public health nutrition. A range of proactive measures have been proposed to manage investment and protect public health nutrition regulatory capacity. For NZ it is uncertain whether trade negotiations include evaluation on whether granting incentives that lower production costs may jeopardize public health by making unhealthy products more affordable, no assurance that investment contracts do not tie the hands of regulators in ways likely to undermine health, no introduction of a clarification that a foreign investor cannot legitimately expect the host country not to issue nutrition measures and no clarification of terms and general exceptions and the meaning of indirect expropriation and of fair and equitable treatment.

International or national good/best practice:

1. **Ghana has set standards to limit the level of fats in beef, pork, mutton and poultry in response to rising imports of low quality meat following liberalization of trade. The relevant standards establish maximum percentage fat content for de-boned carcasses/cuts for beef (<25%), pork (<25%) and mutton (<25% or <30% where back fat is not removed), and maximum percentage fat content for dressed poultry and/or poultry parts (<15%)[7].**
2. **Pacific Island countries have been innovative in developing trade-related policy approaches to create a less obesogenic food environment. Taxation-based approaches that affect pricing in the region include increased import and excise tariffs on sugared beverages and other high-sugar products, monosodium glutamate, and palm oil and lowered tariffs on fruits and vegetables. The bans on high-fat turkey tails and mutton flaps highlight the politics, trade agreements and donor influences that can be significant barriers to the pursuit of policy options. Countries that are not signatories to trade agreements may have more policy space for innovative action. However, potential effectiveness and practicality require consideration. The health sector's active engagement in the negotiation of trade agreements is a key way to support healthier trade in the region[77].**

Evidence collected for the good practice statements within the 7 INFRASTRUCTURE SUPPORT domains (as at 29/04/2014)

8 LEADERSHIP: The political leadership ensures that there is strong support for the vision, planning, communication, implementation and evaluation of policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities

Q21 LEAD1: **There is strong, visible, political support (at the Head of State / Cabinet level) for improving food environments, population nutrition, diet-related NCDs and their related inequalities**

Evidence:

- The statements of intent of the Ministry of Health are available online and provided on a yearly basis [78-83]. Nutrition does not figure at all in the latest statement of intent [78] and is not part of the latest health targets 2013/2014 either [84]. The current health targets are: shorter stays in emergency departments, improved access to elective surgery, shorter waits for cancer treatments, increased immunization, better help for smokers to quit and more heart and diabetes checks. In the latest statement of intent, the only item that is mentioned under impact 7 (The public is supported to manage their health and maintain their independence) is 'develop policy options for incentives for self-care, healthy lifestyles and responsible use of health services; and provide operational policy and technical advice on nutrition and physical issues'. The only preventative measures covered are: increasing immunisation, better support for youth mental health services and more smoking reduction programmes [78].

- The New Zealand Government adopted the voluntary global NCD action plan from the World Health Organization, including 9 targets and 25 indicators for reducing premature mortality due to non-communicable diseases by 25% by 2025.

- The Health Promotion Agency (HPA) has an overall function to lead and support activities to: promote health and wellbeing and encourage healthy lifestyles, prevent disease, illness and injury, enable environments which support health, wellbeing and healthy lifestyles, and reduce personal, social and economic harm. The HPA undertakes work on a wide range of health issues, including: alcohol, gambling harm, health education, immunisation, mental health, nutrition and physical activity, sun safety and tobacco[85]. In the statement of intent it is specifically stated that HPA will specifically contribute to the health targets of: increased immunisation, better help for smokers to quit and more heart and diabetes checks. Nutrition does not figure as a priority in the statement of intent. Until recently, HPA's nutrition and physical activity work has focused on increasing breakfast eating among school aged children and some activities to support this work will continue into 2013/14. They will also be undertaking new work to improve infant and maternal nutrition and physical activity. Appropriate impact measures for the new work will be developed during 2013/14 as HPA's contribution to improving infant and maternal nutrition and physical activity is further defined.

- In 2012 the Health and Independence Report[86] (the Director-General of Health's Annual Report on the State of Public Health) was published as part of the Ministry's Annual Report for the Year Ended 30 June 2012. The Health and Independence Report provides an overview of the current state of public health in three main sections: health status, factors that influence New Zealanders' health and health system performance.

- Media releases[87] and news items[88] from the MoH were investigated for the period 2012 and 2013 and 2014 (until 01/04/2014). Of the 60 media releases by the MoH [87], 1 was on the results of the Health Survey, 1 was about cancer statistics for NZ, 1 was about release of new food and nutrition guidelines, 1 was about physical activity guidelines for elderly, 1 was on the systematic assessment of health loss for New Zealand and 1 was about vitamin D and sun exposure. Of the 66 news items published by the MoH [88], there was one news item about the new food and nutrition guidelines for young people and one on the healthy survey results 2012-2013. On the website of Health Minister Tony Ryall [89] speeches, releases, features and newsletters were searched for the period 2012-2013-2014 (until 01/04/2013).

- Of the 365 items posted, there were 6 on the Healthy Families New Zealand programme, 1 on the Energize project, 1 on the fruit in schools initiative, 3 items on infant and maternal nutrition, 2 items on the promotion of physical activity, 2 items on diabetes and heart disease with prevention focus, 1 item on world health day, 1 item on reporting progress towards the national health targets, 1 item on extra money for school kids' preventative health and 1 speech for the Cardiac Society containing few lines on support for prevention. A search for the key words 'nutrition' and 'obesity' on the government website www.beehive.govt.nz for 2012-2014 (until 01/04/2013) resulted in 78 items. Of those, only the following were somewhat relevant: Under 5 Energize off to a rolling start, Healthy Families: $1.46 million to give South Auckland families a healthy start , $1.1M giving young families a healthy start, Healthy Families NZ: texting Auckland mums for a healthy start, 2011/12 NZ Health Survey regional data released , New food health labelling a win for consumers and exporters , Launch of the revised Code of Practice for the Marketing of Infant Formula in New Zealand, New food health labelling a win for consumers and exporters, Exercise still the best medicine – green prescriptions increase, 2011/12 NZ Health Survey regional data released, Breakfast programme part of the solution, Green Prescriptions going global, Massey University College of Health Opening, Opening of RNZCGP Quality Symposium, Opening Australia New Zealand Obesity Society (ANZOS) Annual Scientific Meeting: preventative actions by government

mentioned, Minister commends Milk for Schools programme, Decision paves the way for innovative foods for health: new trans-Tasman rules for health and nutrition claims on food labels, Minister welcomes Pacific Health Chart Book: including call for better preventative actions, Health equity – in search of Narnia, Board appointed for new Health Promotion Agency.

- As part of the theme of the auditor general Office's work in 2012/13 – Our future needs – is the public sector ready? –a performance audit to understand the public sector's approach to combating child obesity was carried out. The performance audit intended to concentrate on the Ministries of Health and Education and Sport New Zealand (formally SPARC), because historically these three agencies had a leadership role that focused on physical activity and nutrition[90]. It was found that the Ministry of Education and Sport New Zealand no longer focused on obesity to the extent they had in the past. The Ministry is considering how its current range of health promotion-based programmes can be complemented by introducing an emphasis on interventions that target critical periods of human development to achieve the greatest effect. For example, the Ministry said that it might implement an obesity prevention programme with, for example, a strong emphasis on maternal and infant services. This would mean supporting women to achieve a healthy weight during and after pregnancy, and a focus on child nutrition in the first few years to potentially prevent obesity developing in childhood and later in life. In the meantime, the Ministry is continuing with its range of existing interventions and Health Target initiatives, such as screening people for type II diabetes[90].

- The New Zealand Government has announced the Healthy Families New Zealand (HFNZ) programme, which is a community-based programme in 10 more deprived communities in New Zealand. HFNZ will support local leaders to implement voluntary initiatives that encourage families to live healthy, active lives.

- The public health bill aims to update New Zealand's fragmented and outdated legislation for public health, and is the primary public health statute. It aims to replace the Health Act 1956 and the Tuberculosis Act 1948[91, 92]. It is important to note that it has been stalled since 2006/07. The bill continues the traditional public health focus on communicable disease control (such as tuberculosis and HIV/AIDs) and environmental health (such as sewerage and insanitary dwellings). The bill includes new guideline provisions aimed at reducing risks of non-communicable disease (risk factors such as those that can lead to diabetes). The Bill provides for the Director-General of Health to issue non-binding codes of practice or guidelines about NCD risk factors. Guidelines could, for example, be issued on the location of vending machines in venues frequented by children. The Bill provides for statements about goods, substances or services that comply with these codes or guidelines to be included in any promotional or communication material and the Bill permits regulations to be made that would reduce or assist in reducing risk factors associated with NCDs. The Bill provides for a 'legislative review and report back' to the House of Representatives three years after enactment, on possible further measures to address NCDs[91, 92]. The Public Health Bill states: 'Reducing the impact of non-communicable diseases in the population requires intervention at a number of levels, as well as co-ordinated efforts across key sectors and settings that can support outcomes such as improved nutrition and physical activity. Legislation alone is not the answer, but, as experience with tobacco control has shown, appropriate legislative provisions can support effective public health action in a way that also reduces inequalities.' The Bill includes principles and provisions for the making of codes or guidelines to address non-communicable disease risk factors. The Director-General will be able to make non-binding codes and guidelines to promote public health, for example, in relation to:
  - exposure to, or access or use by, the public generally or specific groups in respect of products and services relevant to non-communicable disease risk factors
  - matters relevant to the advertising, sponsorship, or marketing (direct or indirect) of products and services with an impact on non-communicable disease risk factors
  - performance, composition, contents, additives, design and construction of goods or services or processes that impact on non-communicable disease risk factors.

  The Bill requires the Minister of Health to report to the House of Representatives on options and proposals for addressing non-communicable disease issues within 3 years from enactment (with an option to extend this period).

International or national good/best practice:

1. **on a city level: Michael Bloomberg (New York)**
2. **on a state level: David Davis Victoria Melbourne for the implementation of the Healthy Together Victoria systems-based approach**
3. **Michelle Obama**
4. **South Africa's strategic plan for the prevention and control of non-communicable diseases includes a target on reducing the percentage of people who are obese and/or overweight by 10% by 2020 and reduce by at least 25% the relative premature mortality (under 60 years of age) from non-communicable diseases by 2020[93]**
5. **The Brazilian Strategic Action Plan for Confronting NCDs in Brazil, 2011-2022 specifies national targets, including: reduction of the prevalence of obesity in children 5-9 years old from 16.6 % to 8.0 % in boys and from 11.8% to 5.1 % in girls between 2008 and 2022, reduction of the prevalence of obesity in male adolescents 10-19 years old from 5.9 % to 3.2 % and in female adolescents from 4.0 % to 2.7 % between 2008 and 2022, halting the rise of obesity in adults, increasing adequate consumption of fruits and vegetables, from 18.2% to 24.3 % between 2010 and 2022 and reduction of the average salt intake of 12 g to 5 g, between 2010 and 2022[94].**

8 LEADERSHIP: The political leadership ensures that there is strong support for the vision, planning, communication, implementation and evaluation of policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities

Q22 LEAD2: Clear population intake targets have been established by the government for the nutrients of concern to meet WHO and national recommended dietary intake levels

Evidence:

- There are no intake targets specified by the Ministry of Health (MoH) or the Ministry for Primary Industries (MPI) for the nutrients of concern. *The National Heart Foundation (NHF) specified in 2010 that meeting the upper recommended level of sodium intake (2300 mg/day) requires a one-third reduction in sodium consumed from both manufactured or pre-prepared food and discretionary salt added at the table or during cooking* [2].
- New Zealand adopted the voluntary non-communicable diseases (NCD) action plan and global monitoring framework of the World Health Organisation in May 2013, including a target to reduce population salt intake to 5 g of salt per person per day. The Ministry of Health is looking at the implications of the NCD resolution, including New Zealand's reporting obligations to the WHO, and will ensure it is ready to report to the WHO from 2016 onwards. The Ministry will continue to work with key stakeholders and partners, and support effective strategies and actions to address the burden of NCDs in New Zealand (response of MoH to official information request).
- The adequate intake and upper intake level of sodium, including some recommendations and advice for the public to decrease sodium intakes, have been updated by MoH for 2-18 year olds in July 2012 [95], for 0-2 year olds in December 2012 [96], for adults in 2003 [97], for the elderly in January 2013 [98], and for pregnant and lactating women in 2006 [99]. Adequate intake and upper intake level of fats, saturated fatty acids and added sugar were also specified in the dietary guidelines for the specific age groups, and some practical advice for the public to reduce intakes was included as well [95, 97]. It was specified that the sum of saturated and *trans* fat intakes should be lower than 10% of energy [95, 99].

International or national good/best practice:

1. **The "Strategic Action Plan for Confronting NCDs in Brazil, 2011-2022 specifies a target of increasing adequate consumption of fruits and vegetables, from 18.2% to 24.3 % between 2010 and 2022 and reduction of the average salt intake of 12 g to 5 g, between 2010 and 2022[94].**
2. **Health Canada established a multi-stakeholder Sodium Working Group, which agreed a Sodium Reduction Strategy for Canada in July 2010. The Strategy sets an interim goal of reducing daily sodium intake from 3400 mg to 2300 mg by the year 2016[7].**
3. **On January 23, 2014 the Dutch Ministry of Health, Welfare and Sport signed an agreement with trade organisations representing food manufacturers, supermarkets, hotel, restaurant and caterers to lower the levels of salt, saturated fat and calories in food products. Under the agreement, the aim is to reduce the mean salt intake from 9g to a maximum of 6g a day by 2020[7].**
4. **The South African plan for the prevention and control of non-communicable diseases includes a target on reducing mean population intake of salt to <5 grams per day by 2020[93]**

8 LEADERSHIP: The political leadership ensures that there is strong support for the vision, planning, communication, implementation and evaluation of policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities

Q23 LEAD3: Clear, interpretive, evidence-informed food-based dietary guidelines have been established and implemented

Evidence:

- There have no healthy visual food guides been developed and implemented in New Zealand. *The NHF developed a 'Healthy Heart' visual food guide [98].* There are food-based dietary guidelines[100] available for adults (updated February 2013), breastfeeding mothers (updated February 2013), for babies and toddlers (updated April 2013) and for older people (updated August 2012), all based on the Ministry of Health food and nutrition guidelines. There is an existing food and beverage classification system[54] developed by the Ministry of Health in 2007 and now rebranded as Fuelled4life by the NHF.
- The contracts with the Ministry of Health include a clause that all messages have to be in line with the food and nutrition guidelines of the MoH.
- The Ministry of Health is currently translating the food-based dietary guidelines into a set of short statements for the public.

International or national good/best practice:

1. **The Australian Dietary Guidelines use the best available scientific evidence to provide information on the types and amounts of foods, food groups and dietary patterns that aim to: promote health and wellbeing, reduce the risk of diet-related conditions and reduce the risk of chronic disease. The Guidelines are for use by health professionals, policy makers, educators, food manufacturers, food retailers and researchers. They have recently been updated [101].**
2. **Brazil has issued new dietary guidelines in 2014. Brazilian health officials designed the guidelines to help protect against undernutrition, which is already declining sharply in Brazil, but also to prevent the health consequences of overweight and obesity, which are sharply increasing in that country. The guidelines are remarkable in that they are based on foods that Brazilians of all social classes eat every day, and consider the social, cultural, economic and environmental implications of food choices. There are three golden rules: • Make foods and freshly prepared dishes and meals the basis of your diet, • Be sure oils, fats, sugar and salt are used in moderation in culinary preparations, and • Limit the intake of ready-to-consume products and avoid those that are ultra-processed[102].**

8 LEADERSHIP: The political leadership ensures that there is strong support for the vision, planning, communication, implementation and evaluation of policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities

Q24 LEAD4: There is a comprehensive, transparent, up-to-date implementation plan (including priority policy and program strategies, social marketing for public awareness and threat of legislation for voluntary approaches) linked to national needs and priorities, to improve food environments, reduce the intake of the nutrients of concern to meet WHO and national recommended dietary intake levels, and reduce diet-related NCDs

Evidence:

- There is currently no such plan in NZ. The previous comprehensive plan (Healthy Eating Healthy Action strategic framework, developed in 2003) has been abandoned.
- The New Zealand Food Safety Authority had a Nutrition Strategy 2009-12 with its associated work programme included the intention of reducing sodium intake in the diet and improving the nutritional quality of fat in the food supply

International or national good/best practice:

1. **The previous Healthy Eating Health Action New Zealand strategic framework was a comprehensive plan with priorities on lower socio-economic groups, children, young people and their families, environments, communication and workforce [103]. The strategy and associated implementation plan was a comprehensive approach to achieving its goals of improving nutrition, increasing physical activity and reducing obesity. It incorporated a series of objectives and actions aimed at building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; reorienting health services; monitoring environments and the population, researching underlying issues and evaluating policies and programmes; communicating HEHA messages; and addressing workforce capacity and capability.**
2. **One of the first tools that the UK Food Standards Agency devised to help prompt discussions with the food industry in the UK on salt reduction was the salt model. This was a theoretical model which demonstrated one way in which the 6g intake target could be achieved through both reductions in levels of salt in foods and consumers' discretionary intake of salt[104]. A clear salt reduction strategy and action framework (including public health campaigns) were developed by the UK Food Standards Agency which included the threat of legislation in case the voluntary approach would not be successful[8]**

8 LEADERSHIP: The political leadership ensures that there is strong support for the vision, planning, communication, implementation and evaluation of policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities

Q25 LEAD5: Government priorities have been established to reduce inequalities in relation to diet, nutrition, obesity and NCDs

Evidence:

- The New Zealand Public Health and Disability Act 2000, which the statement of intent refers to[78] sets the strategic direction and goals for health and disability services in New Zealand, including improving the health of Māori and other specific population groups.
- Protecting vulnerable children is stated as a government priority in the latest statement of intent[78]. In addition, delivering better health services for Māori and the Pacific community is mentioned. To achieve this the Ministry will administer and monitor the Māori Provider Development Scheme to develop more accessible and effective Māori health and disability service providers and the Māori Health Innovation Fund (Te Ao Auahatanga Hauora Māori) to support innovation in health services for Māori and administer and monitor the Pacific Provider Development Scheme to achieve Government's goals for viable Pacific provider infrastructure.
- Government and the Ministry of Health have made it a key priority to reduce the health inequalities that affect Māori through the updated Māori health strategy and action plan[105].
- There is a good institutionalisation of the Treaty of Waitangi within central and local government (e.g. certain provisions included in the Local Government Act)
- The MoH reports the estimates derived from health surveys and nutrition surveys by four subpopulation groups including age group, gender, ethnic group and an area level deprivation index [106, 107]. Similarly, estimates derived from other data types (e.g. mortality) are presented by these subpopulation groups.
- The contracts between MoH and NGOs or other institutions include a section on Māori Health and state: "An overarching aim of the health and disability sector is the improvement of Māori health outcomes and the reduction of Māori health inequalities. You must comply with any: a) Māori specific service requirements, b) Māori specific quality requirements and c) Māori specific monitoring requirements". In addition, the provider quality specifications for public health services include specific requirements for Māori:" C1 Services meet needs of Māori, C2 Māori participation at all levels of strategic and service planning, development and implementation within organisation at governance, management and service delivery levels, C3: support for Māori accessing services". In the specific contract between the Ministry of Health and Agencies for Nutrition Action the first clause is on Māori Health: "you must comply with any Māori specific service requirements, Māori specific quality requirements and Māori specific monitoring requirements contained in the Service specifications to this agreement".
- There were more than 300 contracts funded from the budget of MoH over the past five years related to nutrition and physical activity. The Ministry has not examined every single contract (extensive work involved), but considered it unlikely that an explicit objective to reduce health-related inequalities would have been included as part of contracts, as an outcome, rather than an input, it is unlikely to have been explicitly contracted for. However, programmes developed over the period were clearly designed with the intentions of meeting the diverse needs of New Zealand population. Contracts were undertaken with Māori NGOs (for example Autaki Kaipaipa – smoking cessation, Rangatahi physical activity programmes and Māori public health leadership). Programmes were also contracted with a focus on improving health outcomes of Pacific peoples living in low decile areas. The Government funded Fruit in schools targets decile 1 and 2 primary and intermediate schools (answer MoH on official information request).
- It has been announced that the Healthy Families NZ will be carried out specifically in lower income communities: East Cape; Far North District; Invercargill City; Lower Hutt City; Rotorua District; Whanganui District; Manukau Ward; Manurewa-Papakura Ward; Spreydon-Heathcote Ward; and Waitakere Ward. The 10 communities come from areas with higher-than-average rates of preventable chronic diseases (such as diabetes), higher-than-average rates of risk factors for these diseases (such as smoking), and/or high levels of deprivation. The 10 communities are geographically spread and are a mixture of urban and rural areas, so the healthy families NZ programme will be able to provide valuable evidence on what works for a diverse range of communities[108].
- The Science Challenges have a strong focus on reducing health inequalities.

International or national good/best practice:

1. **No benchmarks have been collected so far for this statement. The Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau strategy prioritised Māori, Pacific peoples, children and lower income groups.**

9 GOVERNANCE: Governments have structures in place to ensure transparency and accountability, and encourage broad community participation and inclusion when formulating and implementing policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities

Q26 GOVER1: There are robust procedures to restrict commercial influences on the development of policies related to food environments where they have conflicts of interest with improving population nutrition

Evidence:

- New Zealand is No 1 ranking in Transparency International's Corruption Perceptions Index 2013, together with Denmark, obtaining a score of 91% on a total of 177 countries included [109]. The last report on New Zealand's national integrity system was published in 2003[110] and acknowledged that New Zealand scores very highly by international standards in terms of the absence of public sector corruption (defined as the misuse of public power for private gain). However, the instruments used to measure corruption are not well suited to exploring more subtle issues of quality of governance. Some emergent findings of the 2013 survey were published [111] prior to the final report. The final report includes two recommendations that relate more broadly to government systems including to 3. Strengthen the transparency, integrity and accountability systems, of Parliament, the political executive (cabinet) and local government.4 Strengthen the role of the permanent public sector with respect to public procurement, integrity and accountability systems, and public policy processes.

- There are legal expectations with regard to lobbying and commercial influences, contained in legislation including the Crimes Act[112], Electoral Act[113], Secret Commissions Act[114] and others (communication Leo Stothart State Services Commission (SSC)). New Zealand does not have a legislated lobbying regime. There are no lobbying registers available in New Zealand. Before Parliament was the Lobbying Disclosure Bill which seeks to regulate lobbying in New Zealand. The following link contains information on the Bill including submissions made to Select Committee[115]. This has been rejected.

- Submissions from stakeholders to policy documents are generally publically disclosed in New Zealand.

- The State Services Commission (SSC) in New Zealand has published Best Practice Guidelines for Departments Responsible for Regulatory Processes with Significant Commercial Implications [116]. They cover the development and operation of a regulatory process. They also include specific references to principles around stakeholder relationship management and departmental dealings with former staff who may be employed by, or from, stakeholders. CSS has the power to set minimum standards of conduct for many of the agencies which make up the State Services, and to apply those standards by way of a code or codes of conduct.

- A discussion document was prepared in 2005 to identify integrity provisions which may already be in place, and explore whether setting additional standards may contribute to increased trust in government and confidence in the State Services [117].

- Representatives of the processed foods industry and their lobby group (New Zealand Food and Grocery Council) sit on key government committees or boards (e.g. food labelling committee, Health Promotion New Zealand) who make decisions on food policy and public health nutrition. Appointments of members to sit on working groups, committees, advisory groups and standing committees are made in accordance with any relevant legislation, the body's terms of reference and the State Services Commission's Board Appointment and Induction Guidelines. The precise appointment process adopted will depend on a number of factors (intended duration, complexity of work, need for specialist skills, level of public interest in the subject matter etc.) (response MoH to official information request).According to MPI the process for selecting members for a particular group is usually outlined in the terms of reference (or equivalent document) for that group. The working group on front-of-pack labelling in New Zealand mainly includes industry members, and only one academic specialised in public health nutrition policy.

- Within the WHO compliance Panel all panel members on appointment sign a conflict of interest declaration from to declare whether or not they have any actual or potential financial, professional or personal conflicts of interest, and if so, the details of these actual or potential conflicts of interest. A conflict of interest register is kept for current members and conflict of interest is a standard agenda item when the compliance panel is considering complaints. The procedure for dealing with conflicts of interest is outlined in the compliance panel's terms of reference[118]. Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. When members believe they have a conflict of interest on a complaint, they must declare that conflict of interest and the chair will decide what that person can contribute to the discussion and/or activity around the consideration of that complaint.

International or national good/best practice:

1. **To our knowledge, there are currently no governments restricting participation of the food industry during development of policies**

9 GOVERNANCE: Governments have structures in place to ensure transparency and accountability, and encourage broad community participation and inclusion when formulating and implementing policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities

Q27 GOVER2: Policies and procedures are implemented for using evidence in the development of food policies

Evidence:

- A recent report by Sir Peter Gluckman[119], requested by government to improve decision-making, found that there is a wide and rather inconsistent range of practices and attitudes with respect to understanding and application of robust evidence for policy formation and the evaluation of policy implementation across government agencies. The variability suggests that a more systematic approach would be desirable. The key recommendations from the report include: Develop a standard set of protocols across government regarding obtaining expert scientific advice; 2. Extend the use of Departmental Science Advisors (DSAs) more broadly across government; 3. Use the community of DSAs and the Chief Science Advisor to assist central agencies with longer-term planning, risk assessment and evaluation; 4. Improve and make more explicit the use of government funds for research to assist policy formation; 5. Provide greater transparency regarding the use of research-informed data (or its absence) with respect to complex and controversial areas of decision-making where the public is directly or indirectly consulted.
- In 1999 the SSC reviewed the quality of policy advice within the Public Sector and identified areas for improvement. The SSC produced advice for central government agencies on the basis of this review which included advice about the use of accurate information/evidence and steps to ensure its availability when needed [120]. A more recent document was produced in 2008 by the SSC on measuring [121].
- The policy advice produced by a number of government agencies including the MoH is regularly reviewed by The NZ Institute of Economic Research[122]
- FSANZ includes evidence in their regulatory impact assessments

International or national good/best practice:

1. **No benchmarks have been collected so far for this statement**

9 GOVERNANCE: Governments have structures in place to ensure transparency and accountability, and encourage broad community participation and inclusion when formulating and implementing policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities

Q28 GOVER3: Policies and procedures are implemented for ensuring transparency in the development of food policies

Evidence:

- The State Services Commission (SSC) reviews each government department each year on performance and these reports are available online through the SSC website. The latest review report for the MoH and for MPI can be found online[123]. FSANZ publishes all material related to processes and outcomes online. Public consultation on standards is possible at several occasions. Submissions from stakeholders are publically disclosed.
- According to the latest report from Transparency International [111] there is a high level of fiscal transparency in NZ at the level of international best practice, scoring 93 out of 100 on the open budget index 2012 and being ranked first among 100 countries.

International or national good/best practice:

1. **New Zealand is No 1 ranking in Transparency International's Corruption Perceptions Index 2013, together with Denmark, obtaining a score of 91% on a total of 177 countries included [109].**

9 GOVERNANCE: Governments have structures in place to ensure transparency and accountability, and encourage broad community participation and inclusion when formulating and implementing policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities

Q29 GOVER4: The government ensures access to comprehensive nutrition information and key documents (e.g. budget documents, annual performance reviews and health indicators) for the public

Evidence:

- Key budget documents (e.g. Vote Health), annual performance reviews of the different government departments and reports on nutrition guidelines and survey results are available for download online through the library of the MoH. In addition in NZ the public can request specific information through the Official Information Act.
- Through the official information act 1982, information on budgets spent on population nutrition promotion by MoH, MPI, the Health Promotion Agency and DHBs and PHUs were easily obtained.
- The general approach is that information formally generated by the MoH is published on the web. Decisions about work programmes and funded priorities are published through the Ministry's statement of intent and output plan, both of which are on the web. Decisions about publication of material on the web or through publications are usually made by business unit producing that information, but there are no formal policies covering what is published (information obtained from MoH through official information request). MPI publishes most reports on its website. In cases where reports are withheld from publication, it is because of commercial or other sensitivities.

International or national good/best practice:

1. **New Zealand ranks first on the Social Progress Index, second on the component of access to basic knowledge, and seventh on the component of access to information and communications[124]**

10 MONITORING AND INTELLIGENCE: The government's monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans

Q30 MONIT1: Monitoring systems, implemented by the government, are in place to regularly monitor food environments (especially for food composition for nutrients of concern, food promotion to children, and nutritional quality of food in schools and other public sector settings), against codes/guidelines/standards/targets.

Evidence:

Food composition

- Levels of sodium in foods were assessed in the 2003/04 New Zealand Total Diet Survey [125] and the one in 2009 [126], funded by the MPI. This survey is carried out approximately every five years and monitors concentration levels in foods and dietary intake of contaminants and some key elements (including sodium) from a simulated NZ diet for key population groups. *The survey has been undertaken 7 times since the first study in the mid-1970s. The most recent study was in 2009. The first 5 were carried out by the MoH, but when the NZFSA was established in 2002, responsibility for the survey was transferred. The survey is now the responsibility of MPI.* The 2009 Total Diet Study consisted of 123 foods and represented those foods most commonly consumed in New Zealand. The next Total Diet Study is planned to go into the field in 2014 (personal communication Jenny Reid MPI).
- In 2009, Food Standards Australia New Zealand (FSANZ) found that *trans* fat levels in foods decreased and *trans* fat intakes from manufactured sources decreased in Australia and NZ by 25-45% or 0.1% of energy since 2007[127, 128]. MPI is currently repeating a similar survey on *trans* fats in foods and the results will become publically available late 2014 or early 2015 (personal communication Jenny Reid MPI).
- National surveys on commercial frying fats[129], funded by MoH, were conducted in 1999, 2007 and 2011. Tallow/hydrogenated fat use reduced from 87% (1999) to 64% (2007, 2011). Palm increased in 2007 survey and decreased somewhat in 2011 survey. Saturated fat (as % of total fat) significantly decreased from 53% (1999, 2007) to 49% (2011) (personal communication Judith Morley-John).
- The New Zealand Institute for Plant & Food Research Limited and the MoH jointly own the New Zealand Food Composition Database (NZFCD) which is a comprehensive collection of nutrient data in New Zealand. It contains nutrient information on more than 2600 foods. The nutrients sodium, fat, saturated fat, *trans* fatty acids, sugars and total fibre are included. Accredited laboratories in New Zealand and Australia are used to analyse these nutrients in the foods. The output products of the NZFCD are available in three forms: New Zealand Food files, the concise New Zealand food composition tables and New Zealand food composition data for Nutrition Information Panel. An updated version of the New Zealand FOODfiles is released regularly and a new edition of the Concise New Zealand Food Composition Tables is

published every 2-3 years. Approximately 65 Food Records are updated annually as new foods or replacements for foods with values older than 10 years old or sourced from other databases [130]. There are two versions of the data files in the New Zealand FOODfiles 2012: 1. A standard version that contains information for 76 components of >2600 foods. Because the list of core components has changed over time, some foods do not have data for all 76 components.2. An unabridged version that contains information for 342 food components of > 2600 foods listed in the standard version. Most foods do not have data for all 342 components[131]. The following food groups are included: bakery products, alcoholic beverages, non-alcoholic beverages, breakfast cereals, cereals and pseudo-cereals, dairy, eggs, fast foods, fats and oils, finfishes, fruits, meats, meat products, miscellaneous, nuts and seeds, recipes, sauces and condiments, shellfishes, snack foods, soups, sugar, confectionary and sweet spreads, vegetables, and infant formulas and baby foods[131].

- The Nutritrack database, funded partly by MPI and by grants from the Health Research Council, currently contains the nutritional content of more than 16,000 packaged and fast foods (from major fast food outlets with ≥20 stores nationwide).[1, 132] From 2013, photographs of foods are being collected, and recently, a smartphone application, *FoodSwitch,* was launched to help consumers make healthier food choices, but also allowing them to contribute new products to the database. The app has been downloaded more than 28,000 times and users crowdsourced more than 5,000 new products.
- The Manufactured Food Database was discontinued mid-June 2012. However, a contract to supply a new food composition database has been awarded to the University of Auckland. The database will contain ingredient data and Nutrition Information Panel (NIP) data for manufactured foods regulated under the Australia New Zealand Food Standard Code. MPIs interest in the composition of foods is mainly from a safety point of view, but it means there will be a searchable database with package, nutrient, and ingredient information entered. It is important to note that nutrition information panel data might be wrong in some cases.

Food promotion

- No monitoring of food promotion in place in New Zealand. Some research has been done in the area, but not nation-wide and not across all types of media.

Food provision

- Both in 2007 and 2009 a School and Early Childhood Education (ECE) Services Food and Nutrition Environment Survey was organised in a representative sample of Schools and ECE across New Zealand[133]. Those surveys aimed to collect information on key baseline indicators, follow-up indicators and experiences of key stakeholders in relation to the implementation of Healthy Eating Healthy Action (HEHA) and Mission-On initiatives within school and ECE services. The initial 2007 Survey aimed to collect baseline information on the availability, supply and sale of food and beverage types and described the prevalence and content of food and nutrition policies and procedures in schools and ECE services. The survey was repeated in 2009. The survey was funded and managed by the MoH.
- No monitoring of food environments in other public sector settings by the NZ Government.

International or national good/best practice:

1. **The Food Standards Australia New Zealand regularly conducts a Total Diet Survey which reports on sodium levels in foods. Sodium levels were identified in the surveys in 2003/04 and 2009 and it is anticipated that they will be in the 2014 survey[134]. A separate review of trans fatty acids in Australian and New Zealand population diets was conducted in 2007 and 2009 and is planned for 2014 [127].**
2. **The UK regularly monitors sodium levels in foods against the Food Standards Agency targets[135].**
3. **Many countries do have food composition databases available[136]**
4. **Currently no country has a comprehensive program to monitor food marketing, to our knowledge. Most countries' policies are reactive, and are based on consumer complaints rather than active monitoring.**
5. **Australia has good data on food promotion through different media, mostly funded through the New South Wales government, and some other state governments in Queensland and South Australia. But it is ad hoc and not a monitoring system, and nor is it linked to enforcement of policies.**
6. **Previously as part of HEHA monitoring and evaluation in New Zealand, a method was developed and tested which aimed to monitor advertising of higher fat, salt and sugar products / foods and lower fat, salt sugar products / foods on television.**
7. **In England in October 2005, the School Food Trust ('the Trust'; now called the Children's Food Trust) was established to provide independent support and advice to schools, caterers, manufacturers and others on improving the standard of school meals. They perform annual surveys, including the latest information on how many children are having school meals in England, how much they cost and how they're being provided. Each year a survey of local authorities in England is conducted to collect data on take up of school lunches and to find out about factors affecting take up. The survey also gathers contextual information about school lunch provision.[137]**

10 MONITORING AND INTELLIGENCE: The government's monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans

Q31 MONIT2: There is regular monitoring of adult and childhood nutrition status and population intakes against specified intake targets or recommended daily intake levels

Evidence:

- The latest nation-wide adult nutrition survey was carried out from October 2008-October 2009 (4721 adults aged 15+ years participated) [138]. Results were presented separately for Pacific people (n=757) and Māori people (n=1040) [106]. The results included information on energy and macronutrient intake, dietary habits, measured body mass index, measured waist circumference, blood pressure, cholesterol and diabetes [107]. In the latest national nutrition survey sodium intake was not estimated due to concerns about the reliability of sodium data in the NZFCD. The survey included separate estimates for sucrose, fructose, lactose and total sugar intake, as well as for saturated and total fat intake. No estimate was provided for intake of *trans* fats. The latest nation-wide survey on children was conducted in 2002. The former survey was performed in 1997 and no new separate nutrition surveys will be organised in the future. From April 2011, the Health Survey and the various other surveys (including the Adult and Child Nutrition Surveys, Tobacco, Alcohol and Drug Use Surveys, Te Rau Hinengaro – the New Zealand Mental Health Survey, and the Oral Health Survey) were integrated into a single survey, which is now in continuous operation. Each year, the survey collects data from a representative sample of about 13000 adults and 4000 children. The survey contains some core questions and measurements that are repeated each year, as well as a series of modules that change each year. The core questions and measurements cover all key health domains, including health status, long term conditions, health risks and behaviours, health service utilisation and socio-demographic factors. The core measurements of the New Zealand Health Survey include self-reported fruit and vegetable intake (adults) and self-reported fruit and vegetable intake, breakfast consumption, fizzy drink consumption and fast food consumption among children. Planning for future modules is currently underway. Key health domains that yet to be covered in a module are mental health, oral health, nutrition and physical activity. The tentative plan is to include a nutrition module for both adults and children in 2017/18 to coincide with another round of biomedical testing. The scope and frequency of any future nutrition module has yet to be determined.
- The Food and Nutrition Monitoring report was published in 2006, which covered information from a range of sources about the food supply in New Zealand [139]. In addition, a national survey of physical activity, sedentary behaviours and dietary habits in 5–24 year-olds was organised in New Zealand[140]. The Survey was commissioned by SPARC together with the Ministries of Health, Education and Youth Development to support the Mission-On initiative. Face-to-face interviews with follow-up telephone calls were conducted with a nationally representative sample of 2503 participants from September 2008 to May 2009. As part of an evaluation of iodine fortification, MPI undertook a survey using 24-hour urine samples in which sodium intake was measured as well for 300 adults in Dunedin and Wellington[141].

International or national good/best practice:

- **The National Health and Nutrition Examination Survey (NHANES) is a program of studies designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and physical examinations[142]. The NHANES program began in the early 1960s and has been conducted as a series of surveys focusing on different population groups or health topics. In 1999, the survey became a continuous program that has a changing focus on a variety of health and nutrition measurements to meet emerging needs. The survey examines a nationally representative sample of about 5,000 persons each year. These persons are located in counties across the country, 15 of which are visited each year.**
- **Other countries (Japan, US, The Netherlands) also have continuous surveys in place**

10 MONITORING AND INTELLIGENCE: The government's monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans

Q32 MONIT3: There is regular monitoring of adult and childhood overweight and obesity prevalence using anthropometric measurements

Evidence:

- Both nutrition and health surveys contain information on obesity and overweight rates. Weight and height are measured. The most recent update of the information from the New Zealand Health Survey was the 2012/13 update. The latest New Zealand Health Survey was performed in 2011/2012 [143, 144] (4921 children aged from birth to 14 years and 12,488 adults aged 15 years and over). Prior to introduction of annual surveys, five years surveys were conducted in 2006/07, 2002/03 and 1996/97. The questionnaire gathers information on key questions on nutrition, general health; anthropometry, NCDs. The health surveys also measure waist circumference among children and adults. A report on 'tracking the obesity epidemic' was published by the MoH and included data from 4 national surveys up to 2003[145]
- The B4 School Check[146] is a nationwide programme offering a free health and development check for four year olds. B4 School Checks were rolled out nationwide in September 2008. For 2011/12, the target across the country for B4 School Checks was 52,144 children. The B4 School Check includes the measurement of height and weight for recording in the Well Child health book and B4 School Check database. The target was achieved. The Ministry of Health prepared a document on the Access, Use and Disclosure Policy for B4 School Check Information System Users[147].

International or national good/best practice:

1. **England's National Child Measurement Programme was established in 2006 and aims to measure all children in England in the first (4-5 years) and last years (10-11 years) of primary school. In 2011-2012, 565,662 children at reception and 491,118 children 10-11 years were measured[148].**

10 MONITORING AND INTELLIGENCE: The government's monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans

Q33 MONIT4: There is regular monitoring of the prevalence of NCD risk factors and occurrence rates (e.g. prevalence, incidence, mortality) for the main diet-related NCDs

Evidence:

- NCD prevalence is measured in NZ health surveys [149, 150].
- Blood pressure is measured among adults in NZ health surveys[144], 'Doctor-diagnosed' Heart disease, stroke, diabetes, asthma, arthritis, mental health conditions, chronic pain, high blood pressure, high blood cholesterol are self-reported.
- The Mortality Collection (MORT) classifies the underlying cause of death for all deaths registered in New Zealand, and all registerable stillbirths (foetal deaths), using the ICD-10-AM 6th Edition and the WHO Rules and Guidelines for Mortality Coding. Deaths registered in New Zealand from 1988 onwards are held in the Mortality database[151]. The National Minimum Dataset (NMDS) is a national collection of public and private hospital discharge information, including coded clinical data for inpatients and day patients. Data has been submitted electronically in an agreed format by public hospitals since 1993[152].
- The New Zealand Cancer Registry (NZCR) is a population-based register of all primary malignant diseases diagnosed in New Zealand, excluding squamous and basal cell skin cancers[153].
- The New Zealand Burden of Disease, Injury and Risk Study 2006-2016 (NZBD)[154] is a systematic analysis of health loss by cause for New Zealanders of all ages, both sexes and both major ethnic groups. It includes estimates of fatal and nonfatal health losses from 217 diseases and injuries and 31 biological and behavioural risk factors. This information is intended to support health policy and planning. It includes estimates of health loss due to diet and high BMI.
- There is a virtual national diabetes and cardiovascular disease register based on data from primary care.

International or national good/best practice:

1. **NZ and most OECD countries: Have regular and robust prevalence data for the main diet-related NCDs and NCD risk factors**

10 MONITORING AND INTELLIGENCE: The government's monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans

Q34 MONIT5: There is sufficient evaluation of major programs and policies to assess effectiveness and contribution to achieving the goals of the nutrition and health plans

Evidence:

- No comprehensive nutrition and health plan exist in New Zealand. *Previously The Healthy Eating Healthy Action Strategy, (2003)[155], its associated implementation plan[103] and the report on progress of implementation[156] set out the programme of work. A comprehensive research, evaluation and monitoring framework was associated with the strategy. However the strategy and many associated programmes were disestablished in 2009.*

International or national good/best practice:

1. **During 2007/2008 there was 7 million NZD foreseen in HEHA New Zealand for research, monitoring and evaluation, both at national as well as at local level (a bit less than 10% of the total HEHA budget). During previous years, this budget was a lower (3-4 million NZD)**
2. **National Institutes for Health (NIH) in the US provide funding for rapid assessments of natural experiments. The funding establishes an accelerated review/award process to support time-sensitive research to evaluate a new policy or program expected to influence obesity related behaviours (e.g., dietary intake, physical activity, or sedentary behaviour) and/or weight outcomes in an effort to prevent or reduce obesity[157].**

10 MONITORING AND INTELLIGENCE: The government's monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans

Q35 MONIT6: Progress towards reducing health inequalities and societal and economic determinants of health are regularly monitored

Evidence:

- All Ministry of Health surveys (including the more recent nutrition and health surveys) report on estimates for different population groups in particular by ethnicity (including Māori and Pacific peoples), by age, by sex and by NZDep).
- Ministry of Health contracts include a section on Māori Health and state: "An overarching aim of the health and disability sector is the improvement of Māori health outcomes and the reduction of Māori health inequalities. You must comply with any: a) Māori specific service requirements, b) Māori specific quality requirements and c) Māori specific monitoring requirements."

International or national good/best practice:

1. **New Zealand: All Ministry of Health Surveys report estimates by subpopulations in particular by ethnicity (including Māori and Pacific peoples), by age, by gender, and by NZDep**

11 FUNDING AND RESOURCES: Sufficient funding is invested in 'Population Nutrition Promotion' to create healthy food environments, improved population nutrition, reductions in obesity, diet-related NCDs and their related inequalities

Q36 FUND1: The 'Population Nutrition Promotion' budget, as a proportion of total health spending and/or in relation to the diet-related NCD burden is sufficient to reduce diet-related NCDs.

Evidence:

- Through the official information act 1982, information on budgets spent on population nutrition promotion by MoH, MPI, the Health Promotion Agency and DHBs and PHUs were easily obtained.
- The Health promotion agency budget was $1.1 million on population nutrition promotion in 2012/2013 (Info Health Promotion Agency).
- MPI budget was $98000 in 2012/2013(0.113% of the Vote) for salt and energy reduction and the nutrition labelling working group. This has not been included in the overall estimate as it is not considered to be part of population nutrition promotion (monitoring and labelling are considered in other parts of the framework).
- The MoH budget was $24 million on population nutrition promotion (0.9% of vote health operational budget and 0.17% of total vote health) compared to $67 million during 2008/09 HEHA period. The budget for physical activity is included as well, as nutrition and physical activity could not be separated. Health care costs attributable to overweight and obesity were estimated to be NZ$624m or 4.4% of New Zealand's total health care expenditure in 2006. The costs of lost productivity using the Friction Cost Approach were estimated to be NZ$98m and NZ$225m using the Human Capital Approach. The combined costs of health care and lost productivity using the FCA were $784m and $911m using the HCA[158].
- The spending of the Ministry of Education on Population Nutrition Promotion is difficult to retrieve and would be a huge overestimation and has not been included either. They mainly develop a series of online resources on a website in view of the administration guideline on health and physical education, they provide learning and facilitation for teachers in the area of health and physical education and they provide funding for some networks and associations of teachers in the areas of health & PE.
- The Ministry of Māori development (Te Puni Kokiri) does not have a specific budget allocation for nutrition promotion or for the delivery of services aimed to prevent obesity and diet-related non-communicable diseases. Community groups are supported through the Mara Kai programme to boost the level of involvement by Māori in community gardening projects (including marae, schools and community organisations) to produce health, financial and social benefits. Through the Mara Kai small one-off funding grants are available of up to $2000 for marae, kohanga reo, schools and Māori communities to meet the set up and operational costs of gardens. A total of more than $500000 was allocated for 278 Mara Kai in 2009/10 and a further $500000 was budgeted for 2010/11. To date the Māori Economic Task force has supported the establishment of more than 460 Mara Kai, with more planned. The amount of funding for the Māra kai programme for the year 2012/13 was $731,000. Under Te Puni Kokiri's contestable funding, there are time-to-time supported projects which promote sustainable communities in a general sense but not specifically to encourage better nutrition or obesity prevention. This funding has been excluded from the full figure.
- Contracts between MoH and DHBs were active during the time that the HEHA Strategy was being implemented with each DHB receiving funding from the MOH to deliver a range of nutrition and physical activity (N&PA) services. When HEHA funding was reduced after 2008/2009, N&PA health promotion services were no longer able to be funded unless the understanding is that DHBs no longer delivered any N&PA health promotion services. However, some DHBs may still fund some health promotion services using their baseline funding which they receive directly from the MOH. For 2012/13 this was about 4million dollars (including all DHBs).
- In summary, the total funding for population nutrition promotion was estimated at about 29 million dollars or 0.21% of the total of vote health (while dietary risk factors account for 11.4% of health loss in NZ). In terms of comparison, 300 million dollars was spent during the Rugby World Cup by the government [142].

International or national good/best practice:

1. **The budget of MoH was $67 million during 2008/09 HEHA period.**

11 FUNDING AND RESOURCES: Sufficient funding is invested in 'Population Nutrition Promotion' to create healthy food environments, improved population nutrition, reductions in obesity, diet-related NCDs and their related inequalities

Q37 FUND2: Government funded research is targeted for improving food environments, reducing obesity, NCDs and their related inequalities

Evidence:

- All funding recipients of 2012 and 2013 funding from the Marsden Fund and the Health Research Council New Zealand were evaluated. For Marsden, both in 2012 (total budget=$54,960,000) and 2013 (total budget=$58,965,214) there was no funding for projects related to population nutrition or prevention of obesity and non-communicable diseases. For the Health Research Council, in 2012 11.4% (total budget=$69,960,192) and in 2013 10.6% (total budget=$70,964,459) was spent on population nutrition and/or prevention of obesity and non-communicable diseases.
- The funding programmes from MPI relate to Agriculture, Forestry, Environment and Natural Resources, Biosecurity and animal welfare and are not considered relevant.

International or national good/best practice:

1. **In January 2009, recent funds allocated by major medical research funding bodies to obesity in children were investigated in Australia. Websites from the National Health and Medical Research Council (NHMRC), Australian Research Council, Diabetes Australia Research Trust and National Heart Foundation (NHF) were explored to identify outcomes of funding rounds since 2005. A limitation of the approach is that fellowship, scholarship and travel grants were not included. Of the total 2809 project grants of NHMRC funded since 2005, just 0.5% (almost $7 million) were directed towards childhood obesity[159]. The NHMRC's December 2008 statement indicated that 33 (total $18 040 675) of 688 (total $355 872 646) project grants funded for 2009 were related to obesity [160].**
2. **NZ: In 2012, 11.4% of the HRC's total budget of $70M and, in 2013, 10.6% of the HRC's total budget of $71M was spent on population nutrition and/or prevention of obesity and non-communicable diseases**

12 PLATFORMS FOR INTERACTION: There are coordination platforms and opportunities for synergies across government departments, levels of government, and other sectors (NGOs, private sector, and academia) such that policies and actions in food and nutrition are coherent, efficient and effective in improving food environments, population nutrition, diet-related NCDs and their related inequalities

Q38 PLATF1: **There are robust coordination mechanisms across departments and levels of government (national and local)) to ensure policy coherence, alignment, and integration of food, obesity and diet-related NCD prevention policies across governments**

Evidence:

- Delivering better public services within tight financial constraints is one of the Government's four priorities for this term. The Better Public Services (BPS) programme aims to increase alignment of policy by working across agencies. Changes are also being made to core State sector legislation which places obligations of stewardship on chief executives of State sector agencies to look to the long term interests of the Crown and departments. This statement from The Treasury elaborates on some of the changes being made to facilitate policy alignment[161].
- In the Statement of Intent 2012-2015 of the Minister of Health the following paragraph is included: 'The health and wellbeing of a population require coordinated action across government. Children's health, for example, is influenced by their household's living conditions, income and education levels. As well as fostering collaboration across the health sector, the Ministry of Health works collaboratively with other government agencies to implement the government's agenda. This involves finding better ways to organise integrated and streamlined public services, in order to deliver more effective, accessible and convenient services for New Zealanders.
- There used to be a memorandum of understanding between Sparc, MoH and Ministry of Education as part of the Mission-On initiative which was supported at ministerial, agency and implementation levels. The arrangement was disestablished with Mission-On and HEHA...There are no formal or mandated links between health and other departments relating specifically to nutrition and physical activity.
- The Government set 10 challenging results for the public sector to achieve over the next five years. There are 10 result actions within five areas (none of which relate to nutrition or obesity) which are collective responsibility to be achieved over the next 5 years[162].
- The Government has set 10 challenging results for the public sector to achieve over the next five years. There are 10 result actions within five areas (nothing in this space) which are collective responsibility to be achieved over the next 5 years[162].
- The Social Policy Evaluation and Research (SPEaR) Committee is a cross-agency group established by the New Zealand Government in 2001 to oversee the government's investment in social policy research and evaluation. "We use our unique cross-agency mandate to monitor social research and evaluation activity. We work to strengthen connections between public, private and tertiary sector providers and users of information. We do this to increase the capacity and capability of the social sector to deliver evidence-informed advice in a timely manner. We advocate for the provision of social research and evaluation to decision makers. SPEaR was established with 17 member agencies." The committee was supported by the SPEaR Secretariat[163] but has not had a chair since 2010.
- Whānau Ora is an inclusive interagency approach to providing health and social services to build the capacity of all New Zealand families in need. It empowers whānau as a whole rather than focusing separately on individual family members and their problems[164].

International or national good/best practice:

1. **The ministerial, agency and operational cross-sectorial teams supporting the Mission-On initiative during HEHA and the associated memorandums of understanding can be considered a good practice example**

12 PLATFORMS FOR INTERACTION: There are coordination platforms and opportunities for synergies across government departments, levels of government, and other sectors (NGOs, private sector, and academia) such that policies and actions in food and nutrition are coherent, efficient and effective in improving food environments, population nutrition, diet-related NCDs and their related inequalities

Q39 PLATF2: **There are formal platforms between government and the commercial food sector to implement healthy food policies**

Evidence:

- The Front of Pack Labelling advisory group was established to provide advice on an approach to voluntary interpretive front of pack labelling in New Zealand. This committee has wide representation and includes the commercial food sector.
- A NZ food industry group (FIG) arose out of the formation of the Food Industry Accord, which was launched in 2004 by the former Minister of Health. Membership is voluntary and members believe in the principle of industry self-regulation. Nothing on salt, fat or sugar reduction was included in the latest FIG annual report of 2011-2012 [165, 166]. The Chip Group™ is made up of a range of players in the food service industry, such as potato growers, chip manufacturers, oil suppliers, equipment suppliers and media. The group is supported by The Ministry of Health. The overriding goal is to improve the nutritional status of deep-fried chips served by New Zealand foodservice by reducing fat (total and saturated) and salt content[167]. The Chip group is funded by both government (50%) and industry (50%).
- In 2007, the National Heart Foundation (NHF), under a contract from MoH, started a voluntary strategy with bread manufacturers. It aimed to reduce the sodium content of bread, particularly low cost and high volume breads, to less than 450mg/100g. Currently bread companies are exploring the feasibility of a 400mg guideline (personal communication Dave Monro, NHF). The best practice guidelines for sodium reduction in a range of food products (for bread, breakfast cereals, processed meats, savoury pies) and current industry commitments for sodium and saturated fat reduction in foods within HeartSAFE[168] can be found online on the website of the NHF. However, this is a service delivery approach rather than a direct engagement platform.
- An important document in the conflicts of interest sphere is the Office of the Auditor-General's 'Managing conflicts of interest: Guidance for public entities [169]. In relation to conflicts of interest, State servants are bound by the 'Standards of Integrity and Conduct' ('The Code') which sets out the standards expected of State servants. The Code includes the statement 'we must ensure our actions are not affected by our personal interests or relationships.' A breach of this (or any aspect) of the Code may be grounds for disciplinary action[170].
- The SSC in New Zealand has published Best Practice Guidelines for Departments Responsible for Regulatory Processes with Significant Commercial Implications [116]. These guidelines cover a section on managing conflict of interest issues in different government departments as well. As a principle it is stated that Departments should have clear, effective and robust processes in place for identifying and addressing potential conflicts of interest[116]. Two useful resources are the State Services Commission resource kit "Walking the Line: Managing Conflicts of Interest" (published June 2003 and updated in 2005)[171] as well as an SSC report "Report for State Services Commissioner on Civil Aviation Authority Policies Procedures and Practices Relating to Conflicts of Interest and Conduct of Special Purpose Inspections and Investigations" (published December 2003) that describes the application of these principles to an example of a regulatory process.
- There are conflict of interest registers available for senior management staff by each department. Board members have duties under the Crown Entities act (much stricter for boards than committees). The conflicts of interest are looked after through the crown ownership unit at the treasury. HPA manages conflicts of interest (declaration of interests was received) in accordance with the provisions of the Crown Entities Act 2004 and advice provided to the state sector from the Office of the Auditor General and the State Services Commission. Once board members are appointed, the following HPA procedures apply: A register of interests, regularly updated, in accordance with policy. Identification and noting of interests in preparing agenda Interest disclosure to be first item at each meeting. Affected member leaves room for discussion/decision (Official Information Request Health Promotion Agency).
- The Treasury's guideline for public private partnerships in New Zealand (2009) refers to public private initiatives as being direct agreements between the crown and the private sector. The Ministry does not have any direct agreements with the Private Sector for nutrition initiatives.
  However, the Ministry has a small number of contracts with NGOs who have either memorandum of understandings or other formal arrangements with the private sector; or the Ministry funds NGOs who also receive separate funding from the private sector for different services. These are managed separately by the NGO. The two nutrition-related Ministry funded joint public private initiatives are as follows:
  - Chip Group: To improve the nutrient profile of food service deep-fried chips, including reductions in total fat, saturated fatty acids, trans fatty acids and sodium (85000 NZD excluding GST annually)
  - New Zealand Heart Foundation: Food for thought programme which takes children into supermarkets where they put theory into action by purchasing food and then preparing a class lunch for their parents after a classroom session on healthy eating and nutrition (100000 NZD excluding GST annually)

International or national good/best practice:

1. **Consensus Action for Salt and Health (CASH) in the UK[172]**
2. **Australian Health Star Rating Advisory Committee has wide representation**
3. **New Zealand: Front of Pack Labelling advisory committee has wide representation**

12 PLATFORMS FOR INTERACTION: There are coordination platforms and opportunities for synergies across government departments, levels of government, and other sectors (NGOs, private sector, and academia) such that policies and actions in food and nutrition are coherent, efficient and effective in improving food environments, population nutrition, diet-related NCDs and their related inequalities

Q40 PLATF3: **There are formal platforms for regular interactions between government and civil society on food policies and other strategies to improve population nutrition**

Evidence:

- MPI has had contracts with Otago University Nutrition Department for providing advice on a range of nutrition related issues. They also had a range of academics on the Academy, which was disbanded earlier last year. The Academy was a group of academics that met once a year and were able to be contacted during the year to provide advice on food safety related issues. Three academics were considered nutrition experts. They also had academics as members of the Front of Pack labelling working group. This group has just been reconvened and there are two nutrition academics in this group (Information from MPI through the Official Information Act request). A range of organisations is involved in consultations for policies or standards, regular meetings with consumer groups and advisory groups etc.
- The MoH currently does not have any standing committees or formal platforms for dialogue between Government officials and academia on general nutrition issues. Several advisory committees have been disestablished due to restrictions on the budget. External advice is obtained on an individual project basis as and where necessary. For example, the Ministry has: led the development of a consensus statement on vitamin D and sun exposure, a WHO code of marketing of breast milk substitutes compliance panel, a joint project with the department of health and ageing in Australia to review nutrient reference values, funded the health promotion agency to convene a technical advisory group, including academics, to provide strategic advice to inform their nutrition and physical activity work programme (Information from MoH through the Official Information Act request). A list of all food-and nutrition related advisory groups, working groups and committees over the last 5 years, including topics dealt with; list of conflicts of interest declared is attached as Annex 1. The only committees currently active are the WHO code compliance panel (meeting up to four times a year) and the technical advisory group for the eating and activity guidelines (has met once in November 2013 and expected to meet up to four times a year).
- FSANZ encourages input of consumers through the consumer and health dialogue
- The National Health Committee (NHC) provides the Minister of Health with independent advice on a broad spectrum of health and disability issues.
  The NHC incorporates the Public Health Advisory Committee, which provides the Minister with public health advice.
- Some NGOs in NZ receive MoH funding, for example, the National Heart Foundation is funded to develop salt reduction strategies with industry.
- MoH contracts with NGOs do not allow NGOs to spend their MoH funding on advocacy for healthy food environments although the relevant clauses may be absent from contracts with smaller NGOs who receive the majority of their funding from other sources. The contract between the Ministry of Health and Agencies for Nutrition Action was received for the period June 2012-June 2015. Service requirements include: to support the facilitation of a nationally coordinated approach to the implementation of public health prevention services, to support the implementation of evidence-based nutrition and physical activity policies and programmes and to promote the building of healthy public policies that enhance wellbeing and disease prevention related to nutrition, physical activity and healthy weight. The following clause is included: "Neither of us may during or after this agreement either directly or indirectly criticise the other publicly, without first fully discussing the matters of concern with the other in good faith and in a co-operative and constructive manner. Nothing in this clause prevents either of us from discussing any matters of concern with our respective staff, subcontractors, agents or advisors. In the service specifications under activities not funded by the Ministry of Health: advocate for a comprehensive environmental approach to prevent obesity and encourage healthy eating and physical activity".
- Civil society is encouraged to participate in public submissions in certain aspects of food policy development (eg to Parliamentary Inquiries, Select Committees)

International or national good/best practice:

1. **In Brazil the National Council of Food and Nutrition Security (CONSEA) is a body made up of civil society and government representatives, which advises the President's office on matters involving food and nutrition security. Through the presidential advisory body CONSEA, a cross-government, cross-sector, participatory instrument for designing or suggesting, implementing and evaluating food and nutritional security policy, civil society has been able to influence policy directions more directly. CONSEA supported Congress to pass a bill obliging local governments to buy at least 30 per cent of the food destined for school meals from small-scale farmers.**

12 PLATFORMS FOR INTERACTION: There are coordination platforms and opportunities for synergies across government departments, levels of government, and other sectors (NGOs, private sector, and academia) such that policies and actions in food and nutrition are coherent, efficient and effective in improving food environments, population nutrition, diet-related NCDs and their related inequalities

Q41 PLATF4: The government leads a broad, effective and sustainable systems-based approach with local organisations to improve the healthiness of food environments at a national level

Evidence:

- The only program currently running in New Zealand is project Energize in the Waikato region[173]. Project Energize began in 2005 and is funded by Waikato District Health Board. Partners in the project include Sport Waikato and AUT University, University of Waikato, Waikato Institute of Technology, Sport and Recreation NZ, National Health Foundation. Programme delivery partners are Māori and Pacific health providers Te Kohao Health, Te Korowai Hauora O Hauraki, Nga Miro Health and South Waikato Pacific Islands Health Committee. A total of 44,000 primary and intermediate schoolchildren are now part of Project Energize through 244 Waikato schools. Vital to the success of Project Energize are the 27 "Energizers" who work with schools, teachers and parents, giving physical fitness and nutritional advice and helping implement health and fitness programmes. The budget for the program Energize is increasing over the years since 2004. Other areas are looking into implementing Energize. In New Zealand, a 2011 evaluation of Project Energize (Waikato) found that 'Energize' children had: smaller waist circumferences and lower body-mass index than Waikato children of the same age measured in 2004 and 2006, obesity rates three percent less than the national level and faster running times over 550m compared to national data[174].

- The Government recently announced[108] it would launch a 'healthy families NZ' community-based programme, similar to the Healthy together Victoria programme in Australia. Healthy Families New Zealand is a new initiative that aims to improve people's health where they live, learn, work and play in order to prevent chronic disease. The Ministry of Health is leading the establishment of HFNZ communities in 10 locations across New Zealand. HFNZ will support local leaders to implement voluntary initiatives that encourage families to live healthy, active lives. Through investment in community partnerships and a skilled health promotion workforce, these communities will find local solutions to local needs, supporting healthy living. Activities will initially focus on the settings where people live, learn, work, and play. The 10 HFNZ communities come from areas with higher-than-average rates of preventable chronic diseases (such as diabetes), higher-than-average rates of risk factors for these diseases (such as smoking), and/or high levels of deprivation. It is expected that HFNZ communities will reach approximately 900,000 New Zealanders. The design for Healthy Families NZ communities draws on evidence from the Be Active Eat Well pilot (Colac, Australia), EPODE pilots (France) and Project Energize (New Zealand), which have been associated with a number of measurable improvements that will support the health and wellbeing of children. The process for establishing HFNZ began with the release of a Registration of Interest (ROI) process on 14 March 2014. The purpose of the ROI is to identify and short-list organisations who could act as Local Lead Providers for the implementation of HFNZ in the communities selected. The funding for HFNZ will allow providers to:
    - establish and build a local health promotion workforce
    - support communities to find local solutions to local needs
    - roll out a range of programmes that provide skills and support for families to achieve better health
    - support prevention partnerships within their communities (e.g. with government, non-government organisations, businesses and community members)
    - support health promoting early childhood services, schools, workplaces and communities
    - tailor health messaging to local circumstances and needs
    - contribute to research and evaluation.

International or national good/best practice:

1. **Healthy Together Victoria[175] in Australia aims to improve people's health where they live, learn, work and play. It focuses on addressing the underlying causes of poor health in children's settings, workplaces and communities by encouraging healthy eating and physical activity, and reducing smoking and harmful alcohol use. Healthy Together Victoria incorporates policies and strategies to support good health across Victoria, as well as locally-led Healthy Together Communities. The initiative is jointly funded by the State Government of Victoria and the Australian Government through the National Partnership Agreement on Preventive Health (NPAPH).**

13 HEALTH IN ALL POLICIES: Processes are in place to ensure policy coherence and alignment, and that population health impacts are explicitly considered in the development of government policies

Q42 HIAP1: There are processes in place to ensure that population nutrition, health outcomes and reducing health inequalities are considered and prioritised in the development of all government policies relating to food

Evidence:

- FSANZ does not undertake health impact assessments. However, their standards development process (which is based on the Codex risk analysis model) incorporates key elements, including assessment of issues (including health impacts, if relevant) and consultation. Their process also includes a regulatory impact analysis, and a Regulation Impact Statement (RIS) may be prepared to inform this process. Regulatory impact assessments usually compare several scenarios: no regulation, voluntary regulation and mandatory regulation (1 or 2 different scenarios), but this is not considered a health impact assessment.

- MPI performs safety assessments for agricultural policies

International or national good/best practice:

1. **Republic of Slovenia assessed the health effects of agricultural policy at a national level[176]. The HIA has basically followed a six-stage process: policy analysis; rapid appraisal workshops with stakeholders from a range of backgrounds; review of research evidence relevant to the agricultural policy; analysis of Slovenian data for key health-related indicators; a report on the findings to a key cross-government group; and evaluation. The experience in Slovenia shows that the HIA process has been a useful mechanism for raising broader public health issues on the agricultural policy agenda, and it has already had positive results for policy formation[176].**

13 HEALTH IN ALL POLICIES: Processes are in place to ensure policy coherence and alignment, and that population health impacts are explicitly considered in the development of government policies

Q43 HIAP2: There are processes (e.g. health impact assessments) to assess and consider health impacts during the development of other non-food policies

Evidence:

- Policy-level Health Impact Assessment (HIA) guidelines were published in 2004 by the Public Health Advisory Committee (PHAC), a subcommittee of the National Health Committee [177]. The MoH released additional HIA guidelines in 2007 that provided greater focus on whānau ora (health and well-being for Māori, their families and communities)[178].

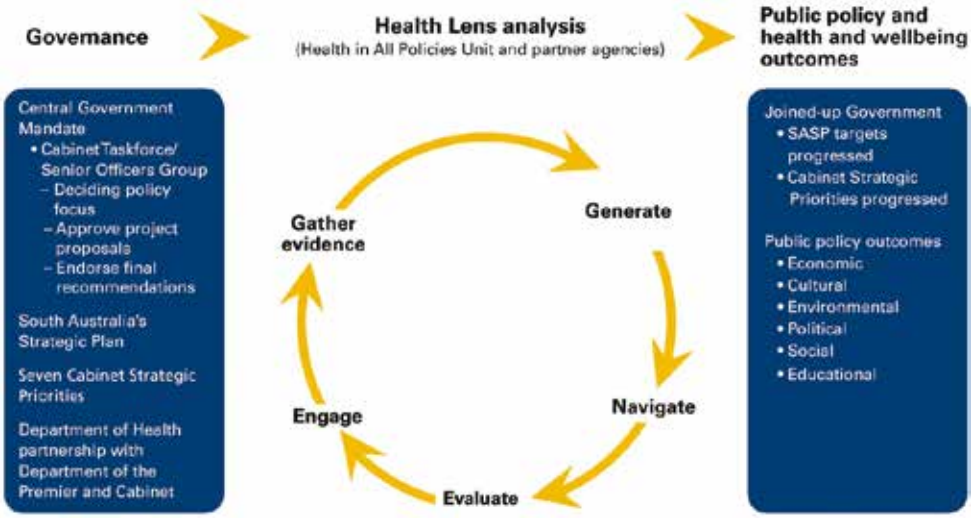
- The NZ Cabinet agreed in 2006 to establish a national HIA support unit within the MoH with four years of funding. Since October 2012 there is no HIA support anymore at the MoH since both of the people working in that unit left and were not replaced. Currently the central government is not anymore prioritizing HIA. HIA is much stronger at local level in New Zealand but actions are slowing down due to lack of support from central government. Most DHB public health units have undertaken HIAs. Reasons for this include permission given to them by the MoH through funding contracts; allocation of staff and funding by DHB management; workforce development, resulting in a trained HIA staff member in all public health units in 2009;[179] and the willingness of staff to take a new approach to protecting and promoting public health. There appears to be increasing acceptance amongst public health staff that HIA is 'business-as-usual'. Local government has also been a key player in the development of HIA in NZ. Several HIAs have been led by local government agencies and many other HIAs have involved strong collaboration between public health and local government staff. It seems likely that the legislative requirement on local government to consider community well-being has been an important motivator for them in adopting HIA. HIA values and processes appear to resonate with some local government staff and politicians. Building support and leadership for HIA in local government is a continuing focus in NZ. An evaluation of health impact assessments in New Zealand was performed in a report in 2010 [180]. An overview of HIA in New Zealand to date can be found in the book chapter by Rob Quigley and Louise Signal[181]. In late 2011 47 HIAs were completed, or in progress in NZ, at the local level. They cover a wide range of health determinants at a range of levels. All of the HIAs were voluntary as there is no legislative requirement for them to be undertaken. A 'Learning by Doing Fund' provided financial support to nearly half the HIAs undertaken in NZ. The fund, now ceased, likely increased the number of HIAs that occurred, and may have ensured better quality. There is a now a substantial body of work in NZ demonstrating the value of HIA at the local-level including how HIA can strengthen health, well-being and equity in strategies, policies, programmes and plans. This work has included building HIA workforce capacity, increasing the evidence about the impacts of policy on health, and evaluating the benefits of HIA. Further there has been progress on embedding HIA as 'business-as-usual' in public health and in some areas of local government. Progress has slowed since 2009 reflecting reprioritization of resources by successive centre-right governments. For instance, efforts to provide a legal framework for HIA under new public health legislation have stalled and the Learning by Doing Fund is no longer available[181].

- Health in All Policies (HiAP) is defined as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity." There is nothing happening at central government level on this. A diversity of ways of incorporating health and equity into urban planning was explored in a report in 2011 by the University of Auckland financed by the Ministry of Health. [182] Nobody was sent from the Ministry to the Health Promotion Conference in Helsinki in June 2013 (topic=health in all policies). The only good local example is the health-in-all policies approach from Canterbury launched in 2009. Christchurch City Council, Canterbury District Health Board, the Regional Council (Environment Canterbury) and Pegasus Health work in this partnership to embed a health perspective within their organisations. These four partner organisations operated a Steering Group [SG], with a Memorandum of Understanding [MoU] and Terms of Reference [ToR] to oversee the project, and jointly funded a fulltime Project Officer. In addition, Community and Public Health and the Christchurch City Council jointly funded a Public Health Specialist position to lead the Health In All Policies approach. The focus is to educate and re-orientate the health and other sectors around a health determinants focus. Evaluation of this HiAP is done at a regular basis.

International or national good/best practice:

1. Two initiatives with healthy public policy goals were recently implemented in Canada and are designed to better coordinate public policies in multiple sectors of government activity so as to improve health outcomes[183]. Those initiatives are the strategies surrounding section 54 of Québec's Public Health Act and ActNow British Columbia (BC). ActNow BC, for its part, is aimed at coordinating all the provincial ministries, as well as various municipal public agencies and private partners—that is, non-governmental organizations and corporations. This initiative can thus best be described in terms of the concept of "whole-of-government." ActNow BC is an initiative that was publicly launched in 2006 by the office of the Premier of British Columbia. The intention was to take advantage of the renown and the nature of the Olympic Games (which, in 2003, the City of Vancouver was chosen to host), using them as a jumping off point and a catalyzer for efforts to meet certain public health objectives. This initiative was thus conceived of as a government platform; that is, a grouping of principles and proposals defining the framework of a public policy initiative, with targets having a limited time frame. The platform was structured around three objectives. First, the overall goal was, through the platform, "to make BC the healthiest jurisdiction to host the Winter Olympic and Paralympic Games". Second, the initiative aimed more specifically "to inspire commitment to create a BC that makes the healthy lifestyle choice the easy choice for everyone". Finally, ActNow BC aimed to improve the health of British Columbians by encouraging, specifically, "healthier eating, increased physical activity, a healthy body weight, the reduction, cessation or avoidance of tobacco use, and healthy choices in pregnancy". In section 54 of QUÉBEC'S public health act which took effect in June 2002, the government affirmed its desire to take into account, in its legislative process, the effects of all its public policies on the population's health and welfare. The initiative is conceived of in horizontal terms. Section 54, in fact, provides a legal basis for the task of promoting healthy public policy, and its purpose is to prompt interministerial action and responsibility for the purpose of establishing healthy public policies. The following provisions are included in this section of the law: 1) The Minister is by virtue of his or her office the advisor of the Government on any public health issue. The Minister shall give the other ministers any advice he or she considers advisable for health promotion and the adoption of policies capable of fostering the enhancement of the health and welfare of the population. 2) In the Minister's capacity as government advisor, the Minister shall be consulted in relation to the development of the measures provided for in an Act or regulation that could have significant impact on the health of the population (Québec, 2005)[183].

2. The South Australian HiAP model includes two key elements: central governance and accountability and a Health Lens analysis process. The model captures the interactive and fluid nature of the approach. Beginning with clear governance and accountability it moves through a flexible Health Lens analysis process, leading to improved policy or social determinants of health outcomes. The governance structure provides a mandate for horizontal collaboration and joined-up policy making, which underpins the HiAP work. The model seeks agreement on the policy focus and utilises robust methods of assessment and analysis to explore the links between the policy area and health and wellbeing of the population[184]. A background document and practical guide have been published [185]. An overview is given in the Figure below.



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Appendix 3: List of good practice statements and experts' ratings

Table 4: Level of implementation for each policy and infrastructure support good practice statement: New Zealand 2014

Domain	Good practice statements:	RATING category	%
Leadership: The political leadership ensures that there is strong support for the vision, planning, communication, implementation and evaluation of policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities	**LEAD1:** There is strong, visible, political support (at the Head of State / Cabinet level) for improving food environments, population nutrition, diet-related NCDs and their related inequalities	Low	35
	LEAD2: Clear population intake targets have been established by the government for the nutrients of concern to meet WHO and national recommended dietary intake levels	Low	36
	LEAD3: Clear, interpretive, evidence-informed food-based dietary guidelines have been established and implemented	Medium	63
	LEAD4: There is a comprehensive, transparent, up-to-date implementation plan (including priority policy and program strategies, social marketing for public awareness and threat of legislation for voluntary approaches) linked to national needs and priorities, to improve food environments, reduce the intake of the nutrients of concern to meet WHO and national recommended dietary intake levels, and reduce diet-related NCDs	Very little	24
	LEAD5: Government priorities have been established to reduce inequalities in relation to diet, nutrition , obesity and NCDs	Medium	62
Governance: Governments have structures in place to ensure transparency and accountability, and encourage broad community participation and inclusion when formulating and implementing policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities	**GOVER1:** There are robust procedures to restrict commercial influences on the development of policies related to food environments where they have conflicts of interest with improving population nutrition	Medium	51
	GOVER2: Policies and procedures are implemented for using evidence in the development of food policies	Medium	59
	GOVER3: Policies and procedures are implemented for ensuring transparency in the development of food policies	High	83
	GOVER4: The government ensures access to comprehensive nutrition information and key documents (e.g. budget documents, annual performance reviews and health indicators) for the public	High	90

Domain	Good practice statements:	RATING category	%
Monitoring & Intelligence: The government's monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans	**MONIT1:** Monitoring systems, implemented by the government, are in place to regularly monitor food environments (especially for food composition for nutrients of concern, food promotion to children, and nutritional quality of food in schools and other public sector settings), against codes/guidelines/standards/targets.	Medium	53
	MONIT2: There is regular monitoring of adult and childhood nutrition status and population intakes against specified intake targets or recommended daily intake levels.	Medium	61
	MONIT3: There is regular monitoring of adult and childhood overweight and obesity prevalence using anthropometric measurements	High	76
	MONIT4: There is regular monitoring of the prevalence of NCD risk factors and occurrence rates (e.g. prevalence, incidence, mortality) for the main diet-related NCDs	High	86
	MONIT5: There is sufficient evaluation of major programs and policies to assess effectiveness and contribution to achieving the goals of the nutrition and health plans	Low	36
	MONIT6: Progress towards reducing health inequalities and social determinants of health are regularly monitored	Medium	74

Domain	Good practice statements:	RATING category	%
Funding & Resources: Sufficient funding is invested in 'Population Nutrition Promotion'(estimated from the investments in population promotion of healthy eating and healthy food environments for the prevention of obesity and diet-related NCDs, excluding all one-on-one promotion (primary care, antenatal services, maternal and child nursing services etc.), food safety, micronutrient deficiencies (e.g. folate fortification) and under-nutrition) to create healthy food environments, improved population nutrition, reductions in obesity, diet-related NCDs and their related inequalities	**FUND1:** The 'Population Nutrition Promotion' budget, as a proportion of total health spending and/or in relation to the diet-related NCD burden is sufficient to reduce diet-related NCDs	Low	34
	FUND2: Government funded research is targeted for improving food environments, reducing obesity, NCDs and their related inequalities	Medium	56
Platforms for Interaction: There are coordination platforms and opportunities for synergies across government departments, levels of government, and other sectors (NGOs, private sector, and academia) such that policies and actions in food and nutrition are coherent, efficient and effective in improving food environments, population nutrition, diet-related NCDs and their related inequalities	**PLATF1:** There are robust coordination mechanisms across departments and levels of government (national and local) to ensure policy coherence, alignment, and integration of food, obesity and diet-related NCD prevention policies across governments	Low	37
	PLATF2: There are formal platforms between government and the commercial food sector to implement healthy food policies	Low	47
	PLATF3: There are formal platforms for regular interactions between government and civil society on food policies and other strategies to improve population nutrition	Low	41
	PLATF4: The government leads a broad, effective and sustainable systems-based approach with local organisations to improve the healthiness of food environments at a national level	Low	43
Health-in-all-policies: Processes are in place to ensure policy coherence and alignment, and that population health impacts are explicitly considered in the development of government policies	**HIAP1:** There are processes in place to ensure that population nutrition, health outcomes and reducing health inequalities are considered and prioritised in the development of all government policies relating to food	Low	37
	HIAP2: There are processes (e.g. health impact assessments) to assess and consider health impacts during the development of other non-food policies	Low	28

Domain	Good practice statements:	RATING category	%
Food Composition: There are government systems implemented to ensure that, where practicable, processed foods minimise the energy density and the nutrients of concern (salt, fat, saturated fat, trans fat, added sugar)	**COMP 1:** Food composition targets/standards have been established by the government for the content of the nutrients of concern in certain foods or food groups if they are major contributors to population intakes of these nutrients of concern (trans fats and added sugars in processed foods, salt in bread, saturated fat in commercial frying fats)	Medium	51
Food Labelling: There is a regulatory system implemented by the government for consumer-oriented labelling on food packaging and menu boards in restaurants to enable consumers to easily make informed food choices and to prevent misleading claims	**LABEL1:** Ingredient lists and nutrient declarations in line with Codex recommendations are present on the labels of all packaged foods	High	86
	LABEL2: Robust, evidence-based regulatory systems are in place for approving/reviewing claims on foods, so that consumers are protected against unsubstantiated and misleading nutrition and health claims	High	76
	LABEL3: A single, consistent, interpretive, evidence-informed front-of-pack supplementary nutrition information system, which readily allows consumers to assess a product's healthiness, is applied to all packaged foods	Low	43
	LABEL4: A consistent, single, simple, clearly-visible system of labelling the menu boards of all quick service restaurants (i.e. fast food chains) is applied by the government, which allows consumers to interpret the nutrient quality and energy content of foods and meals on sale	Very little	25
Food Promotion: There is a comprehensive policy implemented by the government to reduce the impact (exposure and power) of promotion of unhealthy foods to children (<16years) across all media	**PROMO1:** Effective policies are implemented by the government to restrict exposure and power of promotion of unhealthy foods to children through all forms of media, including broadcast (TV, radio) and non-broadcast media (e.g. Internet, social media, point-of-purchase, product placement, packaging, sponsorship, outdoor advertising)	Very little	22
	PROMO2: Effective policies are implemented by the government to ensure that unhealthy foods are not commercially promoted to children in settings where children gather (e.g. preschools, schools, sport and cultural events)	Very little	25

Domain	Good practice statements:	RATING category	%
Food Prices: Food pricing policies (e.g., taxes and subsidies) are aligned with health outcomes by helping to make the healthy eating choices the easier, cheaper choices	**PRICES1:** Taxes on healthy foods are minimised to encourage healthy food choices where possible (e.g. low or no sales tax, excise, value-added or import duties on fruit and vegetables)	Very little	22
	PRICES2: Taxes on unhealthy foods (e.g. sugar-sweetened beverages, foods high in nutrients of concern) are in place to discourage unhealthy food choices where possible, and these taxes are reinvested to improve population health	Very little	22
	PRICES3: The intent of existing subsidies on foods, including infrastructure funding support (e.g. research and development, supporting markets or transport systems), is to favour healthy rather than unhealthy foods	Very little	23
	PRICES4: The government ensures that food-related income support programs are for healthy foods	Low	42
Food Provision: The government ensures that there are healthy food service policies implemented in government-funded settings to ensure that food provision encourages healthy food choices, and the government actively encourages and supports private companies to implement similar policies	**PROV1:** The government ensures that there are clear, consistent policies (including nutrition standards) implemented *in schools and early childhood education services* for food service activities (canteens, food at events, fundraising, promotions, vending machines etc.) to provide and promote healthy food choices	Low	35
	PROV2: The government ensures that there are clear, consistent policies *in other public sector settings* for food service activities (canteens, food at events, fundraising, promotions, vending machines, public procurement standards etc.) to provide and promote healthy food choices	Low	38
	PROV3: The government ensures that there are good support and training systems to help schools and other public sector organisations and their caterers meet the healthy food service policies and guidelines	Medium	55
	PROV4: Government actively encourages and supports private companies to provide and promote healthy foods and meals in their workplaces	Medium	52

Domain	Good practice statements:	RATING category	%
Food Retail: The government has the power to implement policies and programs to support the availability of healthy foods and limit the availability of unhealthy foods in communities (outlet density and locations) and in-store (product placement)	**RETAIL1:** Zoning laws and policies are robust enough and are being used, where needed, by local governments to place limits on the density or placement of quick serve restaurants or other outlets selling mainly unhealthy foods in communities	Very little	21
	RETAIL2: There are existing support systems to encourage food stores to promote the in-store availability of healthy foods and to limit the in-store availability of unhealthy foods	Very little	23
Food Trade & Investment: The government ensures that trade and investment agreements protect food sovereignty, favour healthy food environments, are linked with domestic health and agricultural policies in ways that are consistent with health objectives, and do not promote unhealthy food environments	**TRADE1:** The direct and indirect impacts of international trade and investment agreements on food environments and population nutrition and health are assessed and considered	Very little	22
	TRADE2: The government adopts measures to manage investment and protect their regulatory capacity with respect to public health nutrition	Very little	21

Appendix 4: Recommended actions prioritised by the Expert Panel

The following tables list the recommended actions that were prioritised by the experts. Note that the actions for 'Infrastructure Support' and 'Policies' were prioritised separately. As the number of actions differed between Infrastructure Support (19) and Policies (15), the scores cannot be compared across the two components. The scores provide the overall ranking of the action statements within each component.

Table 5: Recommended infrastructure support actions prioritised by the Expert Panel

Infrastructure support action	Infrastructure support good practice statement	Score (rank)
1. To demonstrate a national commitment, the NZ Government prioritises **improving nutrition and reducing childhood obesity** by: • including clear support for these priorities in the government **Statements of Intent** (especially for the Ministry of Health); • **setting a target** to reduce the prevalence of childhood and adolescent obesity (for example, by 5% over the next six years) as part of the Better Public Service challenge targets	LEADERSHIP **LEAD1:** There is strong, visible, political support (at the Head of State / Cabinet level) for improving food environments, population nutrition, diet-related NCDs and their related inequalities	390 (1)
2. To demonstrate commitment and to measure progress, the NZ Government specifies clear **targets for the reduction of salt, sugar and saturated fat intake** of the population based on WHO recommendations and the global NCD action plan (e.g., salt intake 5g/day, saturated fat intake less than 10% of energy, and free sugar less than 10% of energy)	**LEAD2:** Clear population intake targets have been established by the government for the nutrients of concern to meet WHO and national recommended dietary intake levels	317 (4)
3. To ensure the consistency of policies and messages on healthy diets, the NZ Government actively **implements its food-based dietary guidelines** including translating and promoting them to the public and to professional groups, industry groups, and relevant settings.	**LEAD3:** Clear, interpretive, evidence-informed food-based dietary guidelines have been established and implemented	282 (10)
4. To convert its commitments to WHO's Global Action Plan to Reduce Non-Communicable Diseases (NCDs) into the New Zealand context, the NZ Government develops, funds and implements a **comprehensive national action plan** to prevent NCDs	**LEAD4:** There is a comprehensive, transparent, up-to-date implementation plan (including priority policy and program strategies, social marketing for public awareness and threat of legislation for voluntary approaches) linked to national needs and priorities, to improve food environments, reduce the intake of the nutrients of concern to meet WHO and national recommended dietary intake levels, and reduce diet-related NCDs	324 (3)
5. To articulate the high priority to reduce health inequalities, the NZ Government embeds explicit objectives to reduce health inequalities throughout the comprehensive plan.	**LEAD5:** Government priorities have been established to reduce inequalities in relation to diet, nutrition , obesity and NCDs	302 (5)

Infrastructure support action	Infrastructure support good practice statement	Score (rank)
6. To minimise direct conflicts between commercial interests and the interests of public health nutrition, the NZ Government strengthens its **conflict of interest procedures** to ensure that food industry representatives with direct conflicts are not included in setting food-related policy objectives and principles (this does not apply to their participation in policy implementation).	GOVERNNANCE **GOVER1:** There are robust procedures to restrict commercial influences on the development of policies related to food environments where they have conflicts of interest with improving population nutrition	298 **(6)**
7. To track progress towards healthier food environments and to inform action, the NZ Government strengthens its **monitoring of food environments** by regularly: • monitoring of marketing unhealthy foods to children through broadcast and non-broadcast media; and • monitoring the nutritional quality of foods provided and sold in schools and early childhood education and care services.	MONITORING **MONIT1:** Monitoring systems, implemented by the government, are in place to regularly monitor food environments (especially for food composition for nutrients of concern, food promotion to children, and nutritional quality of food in schools and other public sector settings), against codes/guidelines/standards/targets.	292 (7)
8. To track progress towards healthier diets and to inform action, the NZ Government ensures that there are comprehensive regular (e.g., five yearly) **food consumption surveys** for adults and children, so that food and nutrient intakes and nutritional status can be assessed against nutritional and food-based guidelines and targets.	**MONIT2:** There is regular monitoring of adult and childhood nutrition status and population intakes against specified intake targets or recommended daily intake levels.	278 (12)
9. To track progress and to inform action at a local level, the NZ Government institutes a system to deliver regular 'fine-grained' **estimates of overweight and obesity prevalence** (especially for children and adolescents) at community levels for use by local communities.	**MONIT3:** There is regular monitoring of adult and childhood overweight and obesity prevalence using anthropometric measurements	228 (18)
10. To track progress on NCDs and their risk factors, the NZ Government continues to invest in **CVD and diabetes risk assessments** and investigates the inclusion of height and weight measurements and the use of the data for **population monitoring.**	**MONIT4:** There is regular monitoring of the prevalence of NCD risk factors and occurrence rates (e.g. prevalence, incidence, mortality) for the main diet-related NCDs	280 (11)
11. To ensure effectiveness and the efficient use of resources, the NZ Government includes robust **program evaluation in any major investment** in improving population nutrition with approximately 10% of program costs allocated for evaluation including outcome measures	**MONIT5:** There is sufficient evaluation of major programs and policies to assess effectiveness and contribution to achieving the goals of the nutrition and health plans	288 (8)

Infrastructure support action	Infrastructure support good practice statement	Score (rank)
12. To track progress and inform action on the underlying drivers of poor health and health inequalities, the NZ Government funds **regular monitoring reports on the underlying societal and economic determinants of health** and the related progress on the reduction of health inequalities.	**MONIT6:** Progress towards reducing health inequalities and social determinants of health are regularly monitored	288 **(9)**
13. To ensure that sufficient resources are available to improve population nutrition, the NZ **Government funding** for population nutrition promotion is increased to at least **$70M per year** (equivalent to about 10% of the health care costs of overweight/obesity and on a par with previous investments in prevention).	FUNDING **FUND1:** The 'Population Nutrition Promotion' budget, as a proportion of total health spending and/or in relation to the diet-related NCD burden is sufficient to reduce diet-related NCDs	339 (2)
14. To align research strategies with improving the healthiness of diets, the NZ Government ensures that the **Science Challenges** on Healthier Lives, Aging Well, and A Better Start **have a strong focus on research to improve nutrition.**	**FUND2:** Government funded research is targeted for improving food environments, reducing obesity, NCDs and their related inequalities	232 (17)
15. To facilitate whole-of-government approaches to improving population nutrition and obesity, the NZ Government establishes **cross-government mechanisms** (national to local and between ministries) to co-ordinate food-related prevention policies (e.g., through the introduction of a new Public Sector Challenge).	PLATFORMS FOR INTERACTION **PLATF1:** There are robust coordination mechanisms across departments and levels of government (national and local) to ensure policy coherence, alignment, and integration of food, obesity and diet-related NCD prevention policies across governments	264 (14)
16. To maximise the input and value from civil society, the NZ Government ensures there are **formal platforms** including a nutrition advisory committee and other mechanisms for civil society organisations (e.g., NGOs, academia) to be involved proactively in food policy and program development, implementation, and evaluation.	**PLATF3:** There are formal platforms for regular interactions between government and civil society on food policies and other strategies to improve population nutrition	264 (15)
17. To maximise the impact of community-based programs for obesity prevention, the NZ Government implements the **Healthy Families NZ** programme to at least the level of comprehensiveness, coverage and depth as the Healthy Together Victoria programme in Australia	**PLATF4:** The government leads a broad, effective and sustainable systems-based approach with local organisations to improve the healthiness of food environments at a national level	273 (13)

Infrastructure support action	Infrastructure support good practice statement	Score (rank)
18. To ensure that food policies are compatible with the objectives of improving population nutrition and reducing obesity and diet-related NCDs, the Ministry for Primary Industries and the Ministry of Business, Innovation, and Employment assess the wider **health impact of food policies** (not only from a safety point of view) on long-term population health.	HEALTH-IN-ALL-POLICIES **HIAP1:** There are processes in place to ensure that population nutrition, health outcomes and reducing health inequalities are considered and prioritised in the development of all government policies relating to food	246 (16)
19. To ensure that government policies in general are compatible with the objectives of improving health, the NZ Government establishes a **health impact assessment** (HIA) capacity, including funding for HIAs at the national and local level.	**HIAP2:** There are processes (e.g. health impact assessments) to assess and consider health impacts during the development of other non-food policies	227 (19)

Table 6: Recommended policy actions prioritised by the Expert Panel

Policy action	Policy good practice statement	Score (rank)
20. To improve food composition, the NZ Government: • sets **sodium targets** for the food groups which are major contributors to sodium intake, based on international best practice targets; • establishes a food standard to minimise the unhealthy fatty acid content of **commercial deep frying fats**; • examines **other opportunities** to reduce the amount of salt, sugar and saturated fat in foods and beverages.	FOOD COMPOSITION **COMP 1:** Food composition targets/standards have been established by the government for the content of the nutrients of concern in certain foods or food groups if they are major contributors to population intakes of these nutrients of concern (trans fats and added sugars in processed foods, salt in bread, saturated fat in commercial frying fats)	372 (1)
21. To improve food labelling (nutrient disclosure), the NZ Government: • requires **trans fats** to be added in the nutrition information panel where they exceed a particular level; and • examines the potential for including **'added sugars'** in the nutrition information panel.	FOOD LABELLING **LABEL1:** Ingredient lists and nutrient declarations in line with Codex recommendations are present on the labels of all packaged foods	260 (10)

Policy action	Policy good practice statement	Score (rank)
22. To improve food labelling (preventing misleading claims), the NZ Government investigates the application of the Nutrient Profiling Scoring Criterion to restrict the use of **nutrient content claims** on packaged unhealthy foods (especially 'irrelevant claims' such as 'no cholesterol' claims on plant-based foods).	**LABEL2:** Robust, evidence-based regulatory systems are in place for approving/reviewing claims on foods, so that consumers are protected against unsubstantiated and misleading nutrition and health claims	278 (8)
23. To improve food labelling (consumer-friendly nutrition quality labels), the NZ Government endorses the **Health Star Rating** system for implementation from 2014 on a voluntary basis with provision to move to regulations if there is not wide coverage within 2 years	**LABEL3:** A single, consistent, interpretive, evidence-informed front-of-pack supplementary nutrition information system, which readily allows consumers to assess a product's healthiness, is applied to all packaged foods	329 (5)
24. To improve food labelling (energy disclosure), the NZ Government requires all **quick service chain restaurants to display kJ labelling** (per serve as sold) on their menu boards.	**LABEL4:** A consistent, single, simple, clearly-visible system of labelling the menu boards of all quick service restaurants (i.e. fast food chains) is applied by the government, which allows consumers to interpret the nutrient quality and energy content of foods and meals on sale	242 (12)
25. To reduce unhealthy food promotion to children, the NZ Government introduces regulations to **restrict the marketing of unhealthy foods**, as defined by the nutrient profiling scoring criterion to children and adolescents (e.g., younger than 16 years) through: • broadcast media, with initial priorities for restriction of advertising through television; and • non-broadcast media, with initial priorities for restriction of advertising through sports sponsorship, food packaging and point of sale advertising.	FOOD PROMOTION **PROMO1:** Effective policies are implemented by the government to restrict exposure and power of promotion of unhealthy foods to children through all forms of media, including broadcast (TV, radio) and non-broadcast media (e.g. Internet, social media, point-of-purchase, product placement, packaging, sponsorship, outdoor advertising)	364 (2)
26. To reduce unhealthy food promotion to children, the NZ Government implements policies to ensure that **schools and early childhood education and care services, are free of commercial promotion** of unhealthy foods, as defined by the MoH food and beverage classification system	**PROMO2:** Effective policies are implemented by the government to ensure that unhealthy foods are not commercially promoted to children in settings where children gather (e.g. preschools, schools, sport and cultural events)	341 (3)
27. To discourage the consumption of unhealthy foods and beverages, the NZ Government: • introduces a significant (at least 20%) excise tax on sugar-sweetened beverages; and • explores how the tax revenue could be applied to create healthy food environments and promote healthy diets	FOOD PRICES **PRICES2:** Taxes on unhealthy foods (e.g. sugar-sweetened beverages, foods high in nutrients of concern) are in place to discourage unhealthy food choices where possible, and these taxes are reinvested to improve population health	320 (6)

Policy action	Policy good practice statement	Score (rank)
28. To ensure that taxpayer-funded food for children is healthy, the NZ Government requires all programs involving **subsidised or supplied food for children** (e.g., school breakfast programs) to meet the food and nutrition guidelines as outlined in the food and beverage classification system	**PRICES4:** The government ensures that food-related income support programs are for healthy foods	270 (9)
29. To ensure that children's settings provide healthy food, the NZ government enacts policies that ensure **schools and early childhood education and care services provide or sell foods which meet the food and nutrition guidelines** as outlined in the food and beverage classification system	FOOD PROVISION **PROV1:** The government ensures that there are clear, consistent policies (including nutrition standards) implemented **in schools and early childhood education services** for food service activities (canteens, food at events, fundraising, promotions, vending machines etc.) to provide and promote healthy food choices	330 (4)
30. To show national leadership, the NZ government develops and implements **healthy food service policies throughout the public health sector** (e.g. Ministry of Health, hospitals, DHBs, Public Health Units).	**PROV2:** The government ensures that there are clear, consistent policies **in other public sector settings** for food service activities (canteens, food at events, fundraising, promotions, vending machines, public procurement standards etc.) to provide and promote healthy food choices	284 (7)
31. To stimulate the uptake of healthy food service policies and actions, the NZ Government provides **support and training** systems for children's settings, government sector and private sector workplaces (particularly small to medium businesses).	**PROV3:** The government ensures that there are good support and training systems to help schools and other public sector organisations and their caterers meet the healthy food service policies and guidelines	236 (14)
32. To support local communities achieve healthy food environments for children, the NZ Government reviews the adequacy of the current **local government legislation** with a view to strengthening local governments' authority to create healthy food environments for children (e.g., ensuring 'green food zones' around schools to minimise unhealthy food outlets and advertising.	FOOD RETAIL **RETAIL1:** Zoning laws and policies are robust enough and are being used, where needed, by local governments to place limits on the density or placement of quick serve restaurants or other outlets selling mainly unhealthy foods in communities	254 (11)
33. To protect the health of New Zealanders, the NZ Government includes formal and explicit population **nutrition and health risk assessments** as part of their national interest analysis on trade and investment agreements	FOOD TRADE & INVESTMENT **TRADE1:** The direct and indirect impacts of international trade and investment agreements on food environments and population nutrition and health are assessed and considered	228 (15)
34. To avoid government exposure to being sued by transnational corporations, the NZ Government ensures that specific and explicit provisions are included in trade and investment agreements allowing the New Zealand Government to **preserve its regulatory capacity** to protect and promote public health	**TRADE2:** The government adopts measures to manage investment and protect their regulatory capacity with respect to public health nutrition	237 (13)

12. Appendix 5: List of New Zealand Experts

The following experts participated in the Food-EPI process at one or more of its stages: rating workshops; priority setting for the policy and infrastructure support actions; and the review of the final document. All took part on their own behalf and were not formally representing their employing organisation or other organisations to which they belong.

Title	Surname	First Name	Organisation	Location
Mr	Asghar	Joe	Diabetes New Zealand	Wellington
Dr	Baddock	Kate	New Zealand Medical Association	Auckland
Prof	Blakely	Tony	University of Otago	Dunedin
Prof	Bonita	Ruth	The University of Auckland	Auckland
Dr	Butts	Christine	The New Zealand Institute for Plant & Food Research Ltd	Palmerston North
Ms	Chilcott	Nicola	Agencies for Nutrition Action	Wellington
Assoc. Prof	Coad	Jane	Massey University	Palmerston North
Ms	Connor	Ellen	ProCare Health Ltd	Auckland
Ms	Cook	Lynley	Pegasus Health	Christchurch
Ms	Cutler	Liz	NuDe Food Consultants	Timaru
Mr	Ehau	Terry	Te Rōpū Mate Huka ō Aotearoa	Bay of Plenty
Ms	Field	Penny	University of Otago	Dunedin
Ms	Fitzpatrick	Jo	Diabetes New Zealand	Auckland
Dr	Foliaki	Sunia	Massey University	Wellington
Ms	Funaki-Tahifote	Mafi	Heart Foundation	Auckland
Ms	Gallagher	Jenifer	Eastern Bay Primary Health Alliance	Whakatane
Ms	Gorton	Delvina	Heart Foundation	Auckland
Ms	Gregan-Ford	Carmel	Kidney Health NZ	Christchurch
Ms	Head	Marilyn	The New Zealand Nurses Organisation	Wellington
Prof	Hoek	Janet	University of Otago	Dunedin
Prof	Jackson	Rod	The University of Auckland	Auckland
Dr	Jenkin	Gabrielle	University of Otago	Wellington
Ms	King	Bronwen	Pegasus Health (Charitable) Ltd	Christchurch
Dr	Krebs	Jeremy	Wellington Hospital	Wellington
Mr	Lindberg	Warren	Public Health Association of NZ	Wellington
Ms	Mackay	Sally	The University of Auckland	Nelson
Prof	Mann	Jim	University of Otago	Dunedin
Ms	Marshall	Hereni	Toi Tangata	Auckland
Ms	Matoe	Leonie	Te Hotu Manawa Māori	Auckland
Dr	McCool	Judith	University of Auckland	Auckland
Ms	McGregor	Maggie	Agencies for Nutrition Action	Auckland
Ms	McKerchar	Christina	University of Otago	Christchurch
Ms	McKey	Anne	Royal New Zealand Plunket Society	Auckland
Dr	McLean	Rachael	University of Otago	Dunedin
Ms	Morgan	Melanie	Te Rūnanga Ō Kirikiriroa	Hamilton
Ms	Muimuiheata	Soana	ProCare Health Ltd	Auckland
Ms	Ngatama	Raetea	Healthward Ltd	Auckland
Prof	Ni Mhurchu	Cliona	The University of Auckland	Auckland
Ms	Nitschke	Julie	Whanganui Regional Health Network	Whanganui

Continued...

Title	Surname	First Name	Organisation	Location
Ms	Outhwaite	Linda	Nutritionwise Ltd	Auckland
Ms	Nahi	Papatuanuku	Hapai Te Hauora Tapui	Auckland
Dr	Parackal	Sherly	The University of Auckland	Auckland
Dr	Paterson	Helen	The Royal Australian and New Zealand College of Obstetrics and Gynaecology	Wellington
Dr	Pearson	Jan	Cancer Society of New Zealand	Wellington
Dr	Pega	Frank	University of Otago	Wellington
Dr	Peterson	Mark	New Zealand Medical Association	Wellington
Ms	Pollard	Sue	New Zealand Nutrition Foundation	Auckland
Prof	Poppitt	Sally	The University of Auckland	Auckland
Ms	Radford	Tanya	Te Awakairangi Health Network	Lower Hutt
Ms	Robinson	Vicki	Dietitians NZ	Wellington
Ms	Rolston	Sharron	Te Rūnanga Ō Kirikiriroa	Hamilton
Ms	Rout	Julia	Stroke Foundation of New Zealand	Wellington
Prof	Rush	Elaine	AUT University	Auckland
Ms	Ryan	Louisa	Heart Foundation	Auckland
Prof	Schofield	Grant	AUT University	Auckland
Dr	Scott	Ian	Auckland PHO	Auckland
Mr	Simmons	Geoff	The Morgan Foundation	Wellington
Dr	Skeaff	Sheila	The Nutrition Society of New Zealand	Dunedin
Dr	Stuart	Marise	NZ Medical Students' Association	Wellington
Dr	Sundborn	Gerhard	Le Va	Auckland
Prof	Taylor	Barry	University of Otago	Dunedin
Assoc. Prof	Taylor	Rachael	University of Otago	Dunedin
Dr	Te Morenga	Lisa	University of Otago	Dunedin
Ms	Tester	Beth	Kimi Hauora Wairau- Marlborough Primary Health Organisation	Blenheim
Dr	Tolley	Hilary	The University of Auckland	Auckland
Dr	Toomath	Robyn	Fight the Obesity Epidemic	Auckland
Dr	Utter	Jennifer	The University of Auckland	Auckland
Dr	Von Hurst	Pamela	Massey University	Auckland
Dr	Wall	Clare	University of Auckland	Auckland
Dr	Weber	Janet	Massey University	Palmerston North
Dr	Wham	Carol	Massey University	Auckland
Mr	White	John	The University of Otago	Wellington

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