RECLAIMING HEALTH:

REVERSAL, REMISSION & REWIRING.

UNDERSTANDING & ADDRESSING THE PRIMARY DRIVERS OF NEW ZEALAND'S METABOLIC & MENTAL HEALTH CRISIS (JANUARY, 2026). FULL REPORT

THE PHYSICIANS AND SCIENTISTS FOR GLOBAL RESPONSIBILITY NEW ZEALAND CHARITABLE TRUST (PSGRNZ).

3 PAGE SUMMARY + CHAPTER 12: RECOMMENDATIONS FOR REFORM.

PART I. LAYING THE GROUND: THE EXPLOSION IN METABOLIC ILLNESS.

Summary (pp. 1-41)

Part I establishes the scientific and ethical foundations of the report by arguing that New Zealand's escalating burden of chronic disease is best understood as a metabolic crisis expressed through multimorbidity, rather than as a collection of discrete illnesses.

Drawing on global burden-of-disease data, the section shows that diabetes, anxiety, depression, cardiovascular disease, and neurocognitive disorders have all risen sharply in parallel, particularly since 2010. These trends are increasingly evident at younger ages and are most pronounced in socio-economically deprived populations. Multimorbidity, multiple interacting conditions, has become the dominant clinical reality, with costs that are super-additive rather than incremental.

The report argues that dietary patterns sit upstream of this cascade, particularly:

- sustained exposure to high cumulative carbohydrate intakes,
- widespread reliance on ultra-processed foods, and
- micronutrient insufficiency affecting metabolic, immune, and neurological function.

Central to the analysis is the carbohydrate-insulin pathway, in which repeated glycaemic spikes drive hyperinsulinaemia, insulin resistance, elevated triglycerides, inflammation, and mitochondrial stress. These processes precede and promote type 2 diabetes, cardiovascular disease, fatty liver disease, periodontal disease, and a range of brain-related conditions.

Importantly, obesity is not treated as the primary cause but as one possible downstream manifestation.

Part I also integrates evidence from nutritional psychiatry and gut–brain research, showing that metabolic dysfunction is consistently associated with depression, anxiety, psychosis, and neurodegeneration. In many cases, metabolic impairment appears before psychiatric diagnosis, raising concerns that symptoms of poor nutrition and metabolic instability are being misclassified as primary mental illness.

A further driver examined is the carbohydrate-dopamine cycle, whereby refined carbohydrates and certain ultra-processed foods stimulate reward pathways in ways analogous to addictive substances, undermining satiety and long-term dietary adherence.

The section highlights a profound ethical failure: children, adolescents, and low-income communities bear the greatest burden of preventable metabolic disease, while existing policy frameworks largely ignore individual biological vulnerability, early metabolic markers, and food addiction dynamics.

Part I concludes that prevailing dietary guidelines and health policies remain misaligned with contemporary metabolic science, this sets the

stage for Part II's analysis of institutional and regulatory failure, and Part III's reform agenda grounded in human biology.

KEY POINTS: THE METABOLIC PATHWAY TO CHRONIC ILLNESS:

1. A single systemic metabolic & mental health crisis reframes many diseases as one metabolic failure.
2. Glycaemic and insulin stability underpin metabolic health & reflect core physiological regulation.
3. Insulin & inflammation as metabolic mediators. Displacing the single disease-specific approach.
4. Multimorbidity as signal, not just coincidence. Conditions share common upstream drivers.
5. Cumulative processed & refined carbohydrate exposure. Not just sugar, not just calories.
6. Nutrition & diet guidelines developed to avoid deficiency, not assure functional sufficiency.
7. Macronutrient hierarchy inverted. Carbohydrates structurally privileged over fat and protein groups.
8. Insulin as primary risk biomarker overturns cholesterol primacy.

PART II. GOVERNMENT AGENCIES 'DRAFT OUT' INDIVIDUAL BIOLOGY & MULTIMORBIDITY.

Summary (pp. 60–89)

Part II argues that New Zealand's health governance frameworks have progressively drafted out individual biology, metabolic vulnerability, and multimorbidity, resulting in systemic policy failure rather than isolated shortcomings. While nutritional, metabolic, and biomedical science has advanced, government agencies continue to rely on legacy assumptions, narrow biomarkers, and harmonised international guidance that do not reflect current evidence.

The section critiques dietary and macronutrient recommendations that are framed primarily around preventing overt deficiency rather than supporting optimal physiological function. Official guidelines focus on avoiding acute deficiency states but provide limited guidance on nutrient adequacy for metabolic resilience, brain health, immune function, or life-stage needs. This deficiency-based approach is inadequate for preventing chronic metabolic and mental illness and cannot assure population health in food environments dominated by refined and ultra-processed foods.

Policy papers frequently claim to address health but rarely include explicit nutrition guidance, instead referring back to legacy dietary guidelines. The section shows that agencies often draft policy content to align with pre-formed objectives rather than undertaking regular, transparent, and independent reviews of the scientific literature. As a result, important evidence remains unexamined. For example, Ministry of Health agencies do not routinely assess the cost of multimorbidity by age and gender, nor the parallel rise in polypharmacy across the life course.

These gaps raise ethical concerns: informed consent is undermined when carbohydrate–insulin biology, micronutrient sufficiency, inflammation, and individual metabolic risk are marginalised, while cholesterol-centred risk models and pharmaceutical interventions dominate policy responses. Real-world consequences include the promotion of high-carbohydrate dietary patterns, such as recent revisions to school lunch programmes.

From a constitutional and public-law perspective, Part II frames health as a core public interest and a fundamental right. Despite Vote Health being the Government's largest area of expenditure, current arrangements are not fulfilling this function. Rising multimorbidity, increased medication use, pressure on hospital systems, and mounting fiscal costs are indicators of governance failure, not improved care.

The report describes how institutional lock-in is reinforced through procedural norms, guideline rigidity, regulatory settings, and limited public-good

research capacity. Nutrition education remains marginal in medical training, and clinicians who depart from guideline orthodoxy, particularly through dietary or nutritional approaches, have historically faced professional sanction. This suppresses upstream prevention and delays integration of emerging science.

Part II concludes that addressing proximate policy failures is insufficient. Root-cause change requires structural governance reform, re-orienting health policy away from deficiency avoidance and downstream treatment, and back towards biology, prevention, and population resilience.

PART III. REFORM. FOCUS ON HUMAN BIOLOGY. Summary (pp. 89–106)

Part III moves the report from analysis to practical action, providing case studies which show that dietary clinical interventions based on clinic and community support and education have demonstrable real-world outcomes that can explicitly benefit many of the groups that are historically at risk for the worst health outcomes. Based on published data and outcomes from clinical practice, the core message is optimistic: rising metabolic and mental illness is not inevitable, and meaningful improvement is already being achieved in clinics and communities when dietary and nutritional exposures are tracked alongside relevant biomarkers.

This section focuses on reversal and remission, outlining how dietary change can stabilise, improve, and in many cases reverse chronic illness. Evidence shows that reducing refined and ultra-processed carbohydrates, alongside improving nutritional quality, can normalise insulin signalling, reduce chronic inflammation, support mitochondrial function, and correct nutrient insufficiency. Improvements are often seen across multiple conditions simultaneously, helping explain why remission of multimorbidity is increasingly reported across age groups.

Part III integrates a growing body of food addiction research, recognising that some ultra-processed and refined carbohydrate-rich foods activate reward pathways in ways that parallel substance addiction. This helps explain persistent difficulties with dietary adherence and repeated relapse. Dietary approaches that reduce glycaemic volatility and prioritise satiating foods are shown to weaken addictive cycles, restore appetite regulation, and support sustained change.

Within this context, the section acknowledges a shift in macronutrient emphasis, away from low-fat paradigms and towards diets that adequately include fat and protein, including low-carbohydrate and ketogenic dietary patterns. These approaches reduce insulin demand, support metabolic flexibility, enhance satiety, and stabilise energy intake, and have been associated with improved metabolic markers and reduced reliance on pharmacological management.

Crucially, Part III highlights real-world clinical success, including clinics that treat low-carbohydrate approaches as legitimate interventions supported by education, coaching, and peer support. Reported outcomes include remission of type 2 diabetes, reduced prescribing, improved cardiovascular risk markers, and better mental wellbeing.

The section also points to New Zealand-based evidence, including work by Carolyn Zinn, Grant Schofield, Glen Davies, and colleagues, showing improvements in glycaemic control, metabolic markers, and patient-reported outcomes. These findings reinforce international evidence that insulin sensitivity and metabolic flexibility can be restored even in established disease.

Part III emphasises that reform does not require waiting for new technology or perfect consensus. The tools already exist, including screening for insulin resistance and inflammation, recognising nutrient insufficiency, and integrating mechanistic, clinical, and cohort evidence. Community programmes, health coaching, and peer support are identified as essential to sustaining change beyond the consulting room.

This section is optimistic. Reform is framed not as radical overhaul, but as a return to foundational public health principles: prevention, biological realism, and empowering people to regain health.

RECLAIMING HEALTH EXTRACT: CHAPTER 12. Pp.110-115.

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12.WHOLE OF SYSTEM REFORM: IN BRIEF

PSGRNZ's proposals for reform involves the implementation of high-level strategic science, regulatory and science system shifts, in addition to community and practitioner led wrap-around policies that directly support people in the short-term to pivot long-term to dietary habits that support metabolic health.

PSGRNZ broadly supports Professor Grant Schofield's proposal:[1]

- Investing in prevention: A minimum 15% of the health budget will be allocated to chronic disease prevention and 5% to mental health services.
- Reforming food policy: Stronger nutrition labelling, reduced unhealthy food marketing, and ultraprocessed food tax measures.
- Reducing medication reliance: Encouraging 'social prescribing' so GPs can refer patients to exercise, nutrition support, and mental health therapy before medication.
- Expanding public health workforce: Training more health coaches and lifestyle medicine experts to support behaviour change.
- Ensuring accountability: A National Health Reform Taskforce with executive powers will monitor progress, report on key health indicators, and adjust strategies as needed

In addition to the Schofield Proposal, PSGRNZ propose the following:

[I] DIET FIRST APPROACHES IN LOCAL COMMUNITIES.

Implement practitioner and community-led dietary approaches that recognise individual susceptibility to hyperglycaemia and hyperinsulinemia in response to high-glycaemic and refined carbohydrate intake (cumulative carbohydrate burden), and that address the challenge of food addiction, which may co-occur with and reinforce chronic high refined carbohydrate intakes.

1. **Formal recognition that so-called prediabetes (HbA1c 39–46 mmol/mol; 5.7–6.4%) is more accurately described as early type 2 diabetes mellitus** (Zinn, 2025). HbA1c values in this range reflect impaired blood glucose regulation and represent a precursor state to metabolic syndrome, conferring increased long-term health risk.

2. **The right to information on the dietary carbohydrate and consequent blood glucose burden for that individual.** From childhood onwards, New Zealanders have the right to be informed of the combinatory role of free sugars and dietary carbohydrates in creating the metabolic conditions which underlie prediabetes, diabetes and which are associated with common chronic metabolic and brain-related conditions. That individual has the right to regular testing to assess that individual's unique predisposition to the risk of unstable blood glucose, elevated triglycerides and elevated insulin.

3. **Right to information and informed consent:** Patients must be provided with clear, comprehensive information about the likely progression of common medication pathways

[1] Schofield, G. (March 2025). Health Reform in New Zealand. https://prekure.com/petition/#proposal

associated with metabolic syndrome, inclusive of diabetes. Informed consent should be explicitly strengthened to ensure that patients understand the potential for a progressive cascade into multimorbidity following diagnoses such as prediabetes and diabetes. This requires that patients are fully briefed on the side effects of medications that are likely to be co-prescribed over the course of treatment for metabolic and psychiatric conditions, including the risks of drug–drug interactions.

4. **Expand health coaching across general practice, integrating a three-pronged approach** (Zinn et al. 2025[2])**:** Whole food, carbohydrate reduction; a health coach, behaviour-change-based delivery approach; and community- or peer-based initiatives to reduce hyperglycaemia and hyperinsulinemia. Health coaches combine holistic and flexible individual- and community-based nutrition education to support patient dietary transitions away from patterns that provoke hyperglycaemia and hyperinsulinemia. Health coaches incorporate food addiction education and counselling to support patients to adopt behavioural and psychological strategies to optimise nutrient intake and health outcomes.
    a. Recent New Zealand findings corroborate with international evidence that the three-pronged health coach model results in meaningful patient outcomes, improves health equity, and reduces medical prescribing. A small number of early-adopter New Zealand primary care practices have integrated qualified health coaches, a model that can be expanded.[3] [4]
    b. Expand PHO health coach services to integrate the three-pronged approach.
    c. Refer all patients with HbA1c 39–46 mmol/mol+ for health coaching to support long-term reduction in chronic elevated blood glucose levels.
5. **Offer subsidised, Pharmac funded continuous glucose monitors (and training) for young people under 25 after diagnosis of prediabetes or diabetes, including T2DM.** Automatic provision for the under 25 age group with the choice of access to a CGM device for an initial six-month period.
6. **Expand care of dental and general practitioner services to young people under 25** (this aligns with the NZDA's call to increase affordability of access to dental care). PSGRNZ echo select proposals by the New Zealand Dental Association (NZDA), *Roadmap Towards Better Oral Health* report which recommended expanding care to young adults and the implementation of dental service models to meet the needs of local communities and high-need population groups.
    a. Free doctors and dental visits to young people under the age of 25.
    b. That pharmacy charges to patients for prescriptions issued by a dentist should be the same as those for prescriptions issued by a medical practitioner in primary care.
    c. That patients attending a dentist should have access to funded laboratory services for histology and routine blood tests on the same basis as primary care.

[2] See also discussion Part III, above.
[3] E.g. Health Coaches Australia and New Zealand Association (HCANZA).
[4] Zinn C, Campbell JL, Fraser L. *et al*. (2025) Carbohydrate Reduction and a Holistic Model of Care in Diabetes Management: Insights from a Retrospective Multi-Year Audit in New Zealand. *Nutrients*.17(24):3953.

7. **Offer high-dose multinutrient supplementation as an option as an adjunctive, first-line treatment for a spectrum of psychiatric conditions that would automatically be diagnosed as requiring prescription drugs and health coaching as an integrative wrap-around support framework.** The Hardy DEN product, and future similarly structured products is sufficiently safe to be offered for retail sale as a general nutrient by healthcare practitioners. (Pharmac funding for the under-25 age group and for individuals who receive work and income benefits).

    a. Automatically enrol people eligible for high-dose multinutrient supplementation, in health coaching as wrap-around, clinician led and community enhanced integrative support framework to enhance nutrient intake, address food addiction, and support the remission of metabolic and brain-related parameters for a period of two years.

8. **Re-establish the original Ka Ora, Ka Ako programme.** Ensure that meals are locally produced by community contractors. Amendments may include:

    a. Review of lunch menus to: (i) ensure meals support optimal brain health; and (ii) substantially reduce high-glycaemic carbohydrate portions, given the strong likelihood that carbohydrates will dominate other meals and snacks throughout the day because they are the most affordable macronutrient.

    b. Greater focus on waste reduction and management: implementation of recyclable or compostable packaging options and practices; utilizing more biodegradable packaging materials; improving communication around appropriate waste disposal methods; and enhancing provider's recommendations for sustainable practices (Dey, 2025, p.244).

[II] EDUCATIONAL REFORM

9. **Expand nutrition education across medical training:** Encompassing functional nutrition (including the role of macro- and micronutrients in biological function, metabolic regulation, and the maintenance of cellular and neurobiological systems), including the role of nutrition not only in preventing deficiency, but in supporting health, and in reducing and reversing the biological and inflammatory drivers of chronic metabolic and brain-related illness.
    a. Undergraduate level – with core, assessable nutrition competencies embedded within medical curricula.
    b. Postgraduate level – including structured nutrition education within vocational training programmes and specialist colleges.
    c. Professional organisations – increase the visibility and status of nutrition within professional bodies such as the Royal Colleges, including through formal competencies, accreditation standards, and continuing professional development (CPD) requirements.

10. **Embed nutrition education throughout the school curricula. Improve the quality of nutrition education, incorporating recognition of the carbohydrate-insulin pathway, the specific role of micronutrients in human biological systems and in particular, brain health, and provide food addiction education and counselling alongside other forms of counselling services.**

    a. *Preschool* – food preparation and eating.

b. *Primary* – Embed stepwise nutrition education across health, science and wellbeing curricula so that students can gain an appreciation of nutrition's role at the level of the mitochondria, the cell, an organ system, the gut microbiome and the brain. Educate children on the difference between craving refined sugars and starches and real (homeostatic) hunger, and the role of protein, fat and fibre in satiety.

c. *Secondary* – revise curriculums across biology, science and health so that the role of nutrition in sustaining and protecting animal/plant/human health is weighted at least as equivalently as genetic factors. Reintroduce compulsory nutrition and cooking education for years 7-9. Educate children on the difference between craving refined sugars and starches and real (homeostatic) hunger, and the role of protein, fat and fibre in satiety.

d. *Tertiary* – Increase content quality and pathways for research across health, medical and agricultural sciences. Course content to emphasise the role of nutrients in biological processes from the mitochondria, to cellular, to organ systems and the metabolism. For example, for psychology, nutrition may focus on brain health, for agriculture nutrition may focus on soil health, productivity and fertility, for health sciences and medicine nutrition can consider biochemical pathways to disease and health and the role of dietary nutrition in preventing mental and metabolic disease.

[III] INSTITUTIONAL & REGULATORY REFORM.

11. **Alignment with some aspects of the *Rebalancing our food system* May 2024 report by the Public Health Advisory Committee (PHAC).**[5] This supports increasing access to healthy foods. However, this report aligns with government dietary guidelines. Without a substantial policy shift it is likely that any policy shifts could prioritise access to healthy meat protein and healthy fats.

12. **Expand access to laboratory testing services:** New Zealand's relatively small population size has resulted in a small group of laboratories who undertake the bulk of testing and privately funded testing must not be unduly restricted.

    a. Expand publicly funded nutritional status testing for high-risk groups: vitamin D, vitamin B12, folate (B9), vitamin B6, copper and selenium. This includes the following categories of people diagnosed with a psychiatric and/or neurodegenerative condition: (i) under-25 year olds; and (ii) preconception and pregnant mothers; and (iii) Those with treatment resistant psychiatric illness; - diagnosed with depression, anxiety, schizophrenia, obsessive compulsive disorder, bipolar and/or ADHD; (iii) People diagnosed with dementia/neurodegenerative conditions.

    b. Where a specific clinical pathway exists, expand testing for: (i) MTHFR polymorphism, (ii) CYP450 panel; (iii) Broader HLA safety screening; (iv) Monogenic diabetes (MODY) genetic testing.

[5] Public Health Advisory Committee. 2024. Rebalancing our food system. Wellington: Ministry of Health.

c. Expand high-sensitivity C-reactive protein (hs-CRP) testing. Hs-CRP (>3 mg/L) can be used in routine clinical practice to identify primary prevention individuals at increased inflammatory risk as long as the patient is not acutely ill.

d. Remove barriers to enable the general public to independently request and self-fund laboratory serum testing directly through their medical practitioner. Access to such testing should not require specialist referral for approval of individual tests or test panels, nor require disclosure of personal information to laboratories beyond that included in the clinician's test request.

13. **Provide Pharmac funding for high dose multinutrient supplements for the under-25 age group and low-income, at-risk groups.**

    a. MoH/Medsafe can reverse their general sale medicine decision for the Hardy's multinutrient product and that product can be generally available as a retail multinutrient supplement from health practitioners. Products with equivalent ingredients must not be classified as a general sale medicine.

    b. Pharmac can fund the Hardys DEN products under the multivitamin preparation category for (i) the under-25 age group; and (ii) preconception and pregnant mothers; and (iii) Treatment resistant psychiatric illness; - diagnosed with depression, anxiety, schizophrenia, obsessive compulsive disorder, bipolar and/or ADHD; (iii) doctors can have discretion to expand use of the DEN product to other categories including for the prevention or slowing of neurodegenerative disorders for a period of two years.

14. **Implement a pathway to regulatory reform that recognises that micronutrients have therapeutic potential and that they can be consumed at upper levels that are safe.** The Medicines Act 1981 does not permit micronutrients to have therapeutic potential. This is not supported by science. The role of higher dose micronutrients has been ignored in government policy. After thirty years of the status quo, a pathway to reform must ensure open and collegial scientific and health-based engagement prior to the Ministry of Health taking action to draft legislation. This is to ensure that future legislation does not automatically adopt a toxicological perspective which could then rule important considerations out of scope during select committee consultation processes.

    a. Regulations can be amended through Orders in Council (secondary legislation):

        i. The terminology in the Dietary Supplements Regulations 1985 can be amended to replace 'maximum daily dose' with 'recommended daily dose'.

        ii. The Medicines Regulations 1984 Schedule 1, Part 1 can be altered, removing lithium as an exclusively pharmaceutical medication.

15. **Guiding principles for all health legislation:**

    a. Primum non nocere – First do no harm.

    b. Evidence based. This includes (i) regular reviews and public reporting of the changing evidence base for safety and risk, (ii) Including evidence of safety and efficacy by age, gender and health status held by governments and industry and updates in the scientific literature; (iii) the obligation that all medical drug and

device information is linked to the trials information and data that are claimed to support the safety and efficacy of the medical drug or device.

c. Require signed informed consent.

d. Proportionate. Match regulation to the biological risk.

e. Prevention through empowerment. People can read and review studies to establish whether dietary changes, dietary supplements and medical drugs and devices are beneficial or risky for them.

[IV] SCIENCE SYSTEM REFORM

16. **Disestablish the Ministry of Business, Innovation and Employments' (MBIE) control over science and technology funding.** The decline of human and environmental health research, research to monitor and evaluate New Zealand resources and infrastructure, and the decline of basic research in agriculture, has mirrored the domestic pivot to prioritise innovation.

17. **Establish a Ministry of Science, Research and Technology.** Overarching principle for research funding revolves around the long-term stewardship, or kaitiakitanga, of New Zealand, her people and environment. Devote fully 50% of New Zealand's science, research and technology budget to public good research. This involves shifting research that demands an innovation output to instead reposition innovation as one element or outcome that is embedded within the research, science and technology platform, rather than the current situation which positions innovation as the north star of New Zealand's research architecture.

18. **Establish a multidisciplinary environmental health institution in a New Zealand region which is tasked to drive chronic disease prevention and remission through the advancement of knowledge relating to the dietary, nutritional and toxic drivers of metabolic and mental illness.** The institution board will include experts in nutrition, metabolism, nutritional psychiatry, nutrigenomics, endocrinology, inflammatory and biomarker assessment, epidemiology, toxicology and diet, who have a demonstrated research record in these sectors relating to chronic disease prevention.

19. **The environmental health institution board will establish the policy and work programme for the institution.** Research, which can complement global research trajectories, will include anthropogenic exposure monitoring and assessment of risks from man-made chemicals, heavy metals and radiation. This includes occupational, household, industrial, urban and agricultural exposures, research to identify the additive and synergistic health risks from the food additives, plastics, electromagnetic field radiation, pesticides, common drugs and low levels of chemicals in drinking water. The work programme will include the review and assessment of optimum micronutrient levels by age, gender and developmental stage. Aims will target increased recognition of health harms from poor diets, improved consumer knowledge through better labelling[6], improved school

[6] Mackay S, Eyles H, Gontijo de Castro T, Young L, Ni Mhurchu C, et al. (2021) Which companies dominate the packaged food supply of New Zealand and how healthy are their products?. PLOS ONE 16(1): e0245225. DOI:10.1371/journal.pone.0245225

dietary choices[7] [8] and support the adoption of nutrient-dense diets across the population.[9] [10]

   a. The quality of research will be ensured by rigorous reviews of the independent scientific literature where authorship, research methods and raw data is disclosed; and which take into account human difference (complexity and uncertainty) and biology. Evidence for research and policy can be drawn from structure and function studies to single cases, cohort studies and controlled trials.

20. **The institution will be 50/50 funded by the health budget and the Ministry of Science.** Ministers and political appointees, including chief science advisors will not direct funding trajectories. This institution will be based in Hamilton or Christchurch and affiliated with research across relevant academic institutions.

21. **Environmental health institution to have independent powers to inform New Zealanders.** The Institute will be tasked to independently support and inform communities, hospitals, the education sector and clinical practice to incorporate evidence-based nutritional and dietary education to reduce ultraprocessed food intake, increase wholefood intake, and optimise mental and metabolic health.

22. **Innovation is recategorized as an element of research, not the key driver.** For example, research funding can be allocated to co-design and development of healthy formulated foods with industry, development of screening and assays to identify harmful or toxic formulations. This could drive trust and promote consumer confidence in domestic and export markets. As a part of a recent project to reconfigure ultraprocessed foods to optimise human functioning, a group of researchers proposed a 'Metabolic Matrix' as a principle-based pathway which would revolve around protecting the liver, feeding the gut and supporting the brain.[11]

Click on the link to go to Full Report: *Reclaiming Health: Reversal, Remission & Rewiring. Understanding & Addressing the Primary Drivers of New Zealand's Metabolic & Mental Health Crisis* (January 2026).

[7] Myers I (April 9, 2025). California Assembly committee advances bill to protect schoolchildren from harmful UPF. *EWG News*. https://www.ewg.org/news-insights/news-release/2025/04/california-assembly-committee-advances-bill-protect

[8] Trask S, Thornley S, Sundborn G. (2024). School-based learning about sugary drinks: possibilities and potential for curriculum approaches supporting health promotion in New Zealand. *Health Education Research,* 39(5)475–485. DOI: 39/5/475/7696174

[9] Starck, C.S.; Blumfield, M.; Keighley, T.; *et al.* (2021).Nutrient Dense, Low-Cost Foods Can Improve the Affordability and Quality of the New Zealand Diet—A Substitution Modeling Study. *Int. J. Environ. Res. Public Health18*:7950. DOI: 10.3390/ijerph18157950

[10] Young, L., Kidd, B., Shen, S. *et al.* (2024) Trends in the healthiness and nutrient composition of packaged products sold by major food and beverage companies in New Zealand 2015 to 2019. *BMC Med* **22**, DOI: 10.1186/s12916-024-03567-w

[11] Harlan TS, Gow RV, Kornstädt A, Alderson PW and Lustig RH (2023) The Metabolic Matrix: Re-engineering ultraprocessed foods to feed the gut, protect the liver, and support the brain. *Front. Nutr*. 10:1098453. doi: 10.3389/fnut.2023.1098453