

SUBMISSION ON THE PUBLIC HEALTH BILL

To the Health Select Committee,

This submission is from the Executive Committee of the New Zealand Society for the Study of Diabetes (NZSSD). NZSSD is the leading professional and scientific organisation for healthcare professionals in diabetes in New Zealand. We represent over 300 members. Our aims are as follows:

1. To advance and foster the study of diabetes in New Zealand and Oceania
2. To encourage, support and enable high quality research in all aspects of diabetes
3. Provide a national source of scientific and clinical expertise, reference and advocacy for:
 - a. The condition of diabetes mellitus, its prevention and its complications
 - b. The care of people with diabetes

We wish to appear before the committee to speak to our submission. The following people wish to appear: Associate Professor Patrick Manning, Dr Stephanie Farrand.

The contact details are noted in the footer below.

Summary

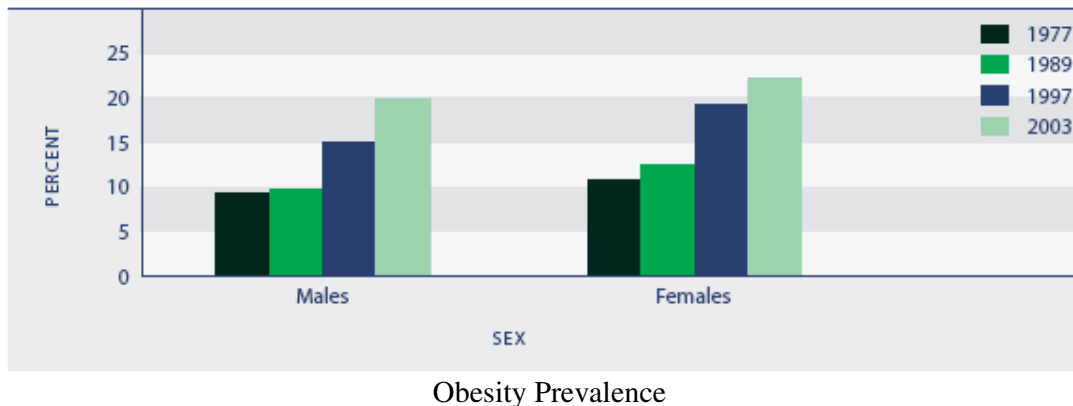
We support the intent of the bill for the following reasons:

- Non-communicable diseases are recognised as a significant threat to public health - this includes obesity and diabetes – see Section 79
- The Director-General must take into account the importance of – (a) improving and enhancing the health of communities by addressing broad determinants of health, including, in particular, risk factors: [risk factor defined as a thing or substance that, on its own or together with other things or substances or conditions, may, whether immediately or over time, give rise to, or increase the incidence of, non-communicable diseases in the general population.....]. This indicates that the Director-General must address those risk factors in society that increase the risk of obesity and diabetes.
- Section 374(x) allows the Director General of health introduce regulations to reduce or assist in reducing risk factors associated with the development of non-communicable disease (obesity and diabetes).

Specific Comments:

1. The prevalence of both obesity and diabetes is increasing at an alarming rate in New Zealand.

- In 2003, 21 percent of adults aged 15 years and over were obese, an increase from 17 percent in 1997.
- In 2002, 10 percent of children aged 5–14 years were obese. Therefore at least 50% of obese individuals are already obese during childhood.
- The prevalence of obesity (BMI > 30) is steadily increasing in New Zealand just as it is in other westernised societies.



<http://www.socialreport.msd.govt.nz/health/obesity.html>

2. Obesity increases the risk for future medical disorders including diabetes.

- Obesity increases the risk of multiple co-morbidities including diabetes, cardiovascular disease, hypertension, gout, sleep apnoea, osteoarthritis.
- Obesity is associated with an increase in mortality and cancer
- Lifestyle intervention reduces the risk of overweight individuals developing diabetes

3. The increase in obesity is largely due to lifestyle changes

What has led to this increase in obesity? Obesity is a complex disorder. Undoubtedly genetics play a role and there is a strong familial tendency to develop obesity. However changes to the genetic background of the New Zealand population cannot account for the observed increase in obesity. It is clear that the predominant force has been a change in lifestyle.

4. The obesogenic environment

The factors contributing to an increased risk of obesity include:

- Low cost energy dense food
- High cost to healthy food choices such as fruit and vegetables
- Town planning that encourages motorised transport
- Lack of appropriate facilities for physical activity

The most illustrative case for the effect of the environment on the risk of obesity is that of Pacific Island and Asian individuals who come to live in New Zealand. By entering an environment which is higher in fat intake and reduced physical activity their risk of obesity increases substantially.

Obesity is strongly linked to low socioeconomic class. This may be due to lack of education with respect to healthy lifestyle but probably is more indicative of the low cost of unhealthy food.

5. Prevention versus Treatment of Obesity

Once established obesity is extremely difficult to reverse. Even intensive lifestyle interventions and pharmacologic interventions are only modestly successful at producing weight loss. Unfortunately most studies indicate that the majority of individuals eventually regain the lost weight. Given that treatment is difficult and in many cases ineffective, there has been a strong emphasis on attempting to prevention of obesity. Since obesity develops at a young age, strategies that are likely to be effective must initially be aimed at altering the obesogenic environment of this stage in life. Instilling healthy lifestyle attitudes from the outset is likely to be more effect than attempting to reverse established adult obesity.

6. Can Obesity be Prevented?

There is evidence that modifying the environment can have beneficial effects on consumption of energy dense foods and carbonated drinks¹.

In addition a number of simple school based intervention programmes have shown effectiveness at reducing weight gain²

However, no one approach has been successful in the prevention of obesity and it is clear that being over-reliant on a single approach is destined to fail. Changing the obesogenic environment is a longterm commitment. Certain changes will take a long time, for example making exercise-friendly communities. However, others such as access to healthy food at school and increasing physical activity in schools need to be implemented with some urgency. It is clear that multiple parallel interventions are likely required to have any useful effect.

¹ James J. [BMJ](#). 2004 May 22;328(7450):1237.

² Brown T. Prevention of obesity: a review of interventions March 2007 - Vol. 8 Issue s1 Page 127

7. The role of Regulation

One of the important lessons from efforts to reduce smoking is the lag time between research and action, whether among individuals, in terms of behaviour change or at a population level in terms of public health interventions. Controls on smoking provide an interesting case study with respect to the acceptability of different types of interventions. Over the last 50 years, policymakers have moved from the basic provision of information and advice, through the facilitation of healthier options (e.g. through use of nicotine replacement), active discouragement of the unhealthy behaviour (e.g. taxation, advertising restrictions) and onto regulatory action (e.g. bans on smoking in public places).

It would appear that certain beneficial changes are taking place in New Zealand at the present time without the necessity for regulation. For example, removal of vending machines from schools and improvement in healthy food options in school canteens. However, while these changes affect healthy behaviour at school they have little impact outside the school environment.

Parental education and guidance promoting healthy living to their children is imperative. However, it is difficult for parents to deliver these important messages when their children are facing a barrage of advertising for unhealthy food choices in the media.

The NZSSD Executive believes that the government should have the ability to introduce regulation that results in a less obesogenic environment. This may not be necessary if those institutions who have the capacity to make appropriate changes do so. Unfortunately, at present there do not appear to be signs that this is happening.