



PUBLIC HEALTH ASSOCIATION
OF AUSTRALIA

HEALTH CLAIMS ON FOOD

The Public Health Association of Australia notes the following:

1. Fundamental public health nutrition principles include:
 - the reduction in risk for disease is affected by the total diet and lifestyle pattern, not by use of an individual food;
 - individual foods by themselves do not prevent or cause a disease;
 - all chronic diseases in which diet has been implicated to play a causative and/or preventative role and for which labelling and advertising claims could be anticipated, are multi-factorial in nature as to the aetiology and progression;
 - The precise role of diet for many such diseases remains to be determined; and
 - The role of diet for each individual cannot be predicted because of marked individual variability resulting mainly from hereditary and life-style factors.¹

2. Historically, food regulation policy based on prohibiting health claims was introduced in Australia and New Zealand in response to certain food manufacturers' marketing abuses. The prohibition policy has effectively prevented many food marketing abuses that attempted unscientifically to promote individual food products as having disease prevention and/or health promoting properties and thereby helped serve to protect public health in Australia and New Zealand since the early 1900s. The removal of this general prohibition puts at risk the secure foundation for protecting public health and safety afforded by this important public health policy.

The Australia New Zealand Food Regulation Ministerial Council (ANZFRMC) requested in July 2001, a policy on health and related claims be developed to guide the setting of food regulations in this area. A Consultation Paper on Health and Related Claims was developed by the Food Regulation Standing Committee and underwent limited consultation with selected stakeholder groups prior to consideration by the ANZFRMC in May 2002. In 2003, the ANZFRMC directed FSANZ to develop a Standard to regulate nutrition, health and related claims. In 2007, FSANZ released a Preliminary Final Assessment Report for public comment (Food Standards Australia New Zealand, 2007, *Preliminary Final Assessment Report, Proposal P293: Nutrition, Health and Related Claims*, FSANZ, Canberra). It is anticipated that by mid-2008 food Standard 1.2.7 – Nutrition, Health and Related Claims will be accepted by the ANZFRMC and included into the Food Standards Code

3. Lack of consistency of interpretation and enforcement of regulations on labelling of foods, especially health and related claims, is a continuing problem.
4. Health claims is a vexatious and divisive public health policy issue. Broader public health nutrition policy currently does not provide guidance as to the role of claims on foods to support the provision of information or education regarding priority public health nutrition issues. Public debate has been absent regarding the role of such claims on food labels – whether they are primarily supporting food marketing perspectives; their role in public health education; the benefits or dangers of using health related claims to promote specific brands of foods or food items versus a whole of diet approach.
5. Regulations are of little value in the absence of competent enforcement.
6. Certain food companies are prepared to undertake the risk of receiving a disproportionately small fine to achieve the marketing gains of implementing aggressive marketing strategies that include health claims.
7. The PHAA believes that the decision to proceed with some form of health claims on food will have a major impact on the food supply, the food industry, nutrition education, the work of health professionals and consumers.² For example, the PHAA believes that health claims will promote an understanding of individual foods as drugs - that is a ‘magic bullet’ effect, which is unrealistic and misleading for most diet-related diseases. Furthermore, this ‘medicalisation’ of food distorts the importance of balance, variety and moderation in food selection and other public health nutrition messages.
8. The PHAA remains opposed to the introduction of health claims. The evidence that health claims either inform consumers and improve food choices, beyond promoting specific products, or promote public health³ is inconclusive at best. Moreover, the use of the Folate Health Claims Pilot as an example of success of health claims in Australia⁴ is not valid for the following reasons:
 - the nutrient-disease relationship for folate is not representative of most nutrient/food and health relationships;
 - the evidence that was used to support claims of a successful intervention were based on an inappropriately short time period (approximately 6 months) for the duration of the Pilot and the period of evaluation.
 - an 8 year follow up monitoring research project found just two food products in the marketplace were implementing the folate health claim⁵

Indeed the impact evaluation of the Folate Health Claims Pilot in Australia, concluded that written educational material, rather than food labelling, was the preferred mechanism for conveying information to consumers about folate and neural tube defects.⁶

9. The PHAA notes the research suggesting that consumers want simple and reliable information on food labels.^{7,8} The PHAA supports the use of some

food labelling, e.g. nutrition labelling, which is factual rather than speculative and has been demonstrated to be effective in assisting healthy food choices.⁹

10. Proliferation of manufacturer – led claims on foods may act to increase consumer scepticism of information on food labels¹⁰ and act to undermine other important public health initiatives such as, allergen labelling or provision of nutrition information.

The Public Health Association of Australia affirms the following:

11. The PHAA believes that regulatory provisions to allow health claims on food are a contradiction to the following public health nutrition principles (as stated in Point 1):
 - the reduction in risk for disease is affected by the total diet and lifestyle pattern, not by use of an individual food;
 - individual foods by themselves do not prevent or cause a disease;
 - all chronic diseases in which diet has been implicated to play a causative and/or preventative role and for which labelling and advertising claims could be anticipated, are multi-factoral in nature as to the aetiology and progression;
 - The precise role of diet for many such diseases remains to be determined; and
 - The role of diet for each individual cannot be predicted because of marked individual variability resulting mainly from hereditary and life-style factors.¹
12. In lieu of the inconsistencies with public health nutrition principles, health claims are a potential risk to public health nutrition by creating further consumer confusion about food and health relationships and distorting dietary intake patterns.
13. The present approach to health claims appears to be driven by a long standing need by industry to use such claims to differentiate their products for marketing purposes.¹¹ It is not driven by, or even within the context of, public health initiatives to promote better nutrition education for consumers.
14. The primary drivers for a health claims regulatory framework are the highly processed food industry and/or large food manufacturers and less local food producers of primary and core foods. Experience from those countries that do permit health claims suggests that this situation presents public health nutrition risks from biological (dietary imbalances), social (more expensive foods tend to display claims) and environmental (use of resources in processing) dimensions.
15. Within the current considerations of health claims by food regulators there is an overly simplistic view about so-called ‘maximising opportunities’ for health gain provided by the advertising budgets for food products. Advertising budgets for food products are designed to increase sales of specific products,

not increase consumer understandings of healthy diets. Not surprisingly, research suggests that health claims promote only product-specific knowledge; there is no evidence that health claims educate consumers to make healthy food choices.⁸

The Public Health Association of Australia makes the following recommendations:

While opposing the concept of health claims on the grounds that they are inconsistent with fundamental public health nutrition principles and that evidence is lacking that health claims will benefit public health, the PHAA acknowledges that the ANZFRMC have stated that it supports the setting of Standard 1.2.7 – Nutrition, Health and Related claims to permit the introduction of certain health claims and that the gazettal of this standard is imminent. Faced with this outcome, the PHAA recommends:

16. Government policy on the role of information and education to promote public health should be based on sound evidence. Currently evidence is lacking that health claims provide a role in the nutrition education of consumers and thereby benefit the public's health.
17. Research efforts should be directed at determining the most effective mechanisms for health information dissemination, particularly in relation to food choices.
18. Complementary nutrition education and monitoring and evaluation strategies be coordinated and implemented by the Commonwealth Department of Health and Ageing to complement the proposed revised food label format.
19. Nutritionists and other educators should be able to use disease claims as a corollary (a disease claim relates certain individual foods to increasing the risk of certain diseases, eg high sugar containing foods and dental caries).
20. Evidence should be provided that there is no harm to individuals or the population, especially disadvantaged groups.
21. Surveillance of food labels and advertising by the food regulatory system for compliance to food regulations needs to be enhanced considerably. Fines for contraventions should be increased substantially.
22. The PHAA also believes that in isolation and unless managed with strong regulation, health claims will be counterproductive to public health in Australia. In particular, they will have potential to undermine public health nutrition principles, to create consumer confusion and to divert limited public resources to the servicing of a program, the implementation of which will preferentially benefit vested commercial interests and certain scientists associated with these commercial interests.

The Public Health Association of Australia resolves to undertake the following actions:

23. The Food and Nutrition Special Interest Group, with the backing of the Board, Branches and other Special Interest Groups, will campaign vigorously for the recommendations outlined in this policy statement to be enacted.
24. The Food and Nutrition Special Interest Group will monitor the process and evaluation of any action taken in response to changes to current legislation on health and related claims, with particular focus on the potential for conflicts of interest to arise among commercial, scientific and government bureaucratic interest groups.
25. The Food and Nutrition Special Interest Group will, with the Board's endorsement, collaborate with other health and consumer groups to share information, campaign jointly and lobby for further research into health claims on food and their public health impact and to keep a watching brief on regulatory processes associated with health claims to expose those processes that are non-transparent and subject to conflict of interest concerns.
26. The Food and Nutrition Special Interest Group will maintain and update the PHAA's information base on health claims and their public health impact.
27. The Food and Nutrition Special Interest Group will advocate for any liberalisation of the existing general prohibition on health claims to be complemented with equal emphasis towards permitting claims that link individual foods with increased risk of disease outcomes.

References:

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