Public Health Association of Australia submission to the 5 year review of the Health Star Rating System

Contact for recipient:
Health Star Rating (HSR) Advisory Committee
Department of Health
E: frontofpack@health.gov.au

Contact for PHAA:
Michael Moore – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: phaa@phaa.net.au T: (02) 6285 2373
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Introduction

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia. The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.
Preamble

PHAA welcomes the opportunity to provide input to the 5 yearly review of the Health Star Rating system. The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. The Australian Government, in collaboration with the States/Territories, should outline a comprehensive national cross-government framework on promoting a healthy ecosystem and reducing social and health inequities. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

PHAA supports the implementation of a reformed, government-led HSR as the single, mandated front-of-pack labelling system to help promote healthy eating.

- A front-of-pack labelling system can potentially be a constructive intervention, but its effectiveness depends on it being a component of a comprehensive national nutrition policy
- There is a risk that the HSR could undermine the ADGs by giving an undeserved health halo to some discretionary foods
- This submission provides suggestions for reforming a number of flaws with the current HSR.

In our work to help ensure a more effective Health Star Rating System (HSR) that is better aligned with the Australian Dietary Guidelines (ADGs), PHAA will:

- Advocate for an overarching Australian National Nutrition Policy that includes a reformed, government-led, single, mandated HSR to encourage consumption of the healthy five food groups, in line with the ADGs
- Continue to work closely with government to strengthen HSR’s effectiveness as a public health intervention and protect it from inappropriate commercial influence
- Advocate for immediate implementation of reforms to governance, design, implementation, monitoring and independent evaluation and review of HSR to ensure it is more consistent with the recommendations of the ADGs

We provide responses to the specific review questions consistent with these objectives below.

PHAA Response to the consultation questions

HSR system

1. Are there any significant barriers or limitations to including the HSR system on packaged foods? If yes, please describe and provide examples.

The main barriers to including HSR on packaged foods are: (1) lack of consumer trust in the system, it is voluntary rather than mandatory, (2) the presence of multiple health rating devices on pack, and (3) issues with governance, the scoring system, and communication.

PHAA recommends the HSR is made mandatory across all foods (with the recommended reforms) to improve utility for consumers and establish a level playing field for industry, and make the lower limit of the HSR zero.

The current voluntary nature of HSR is a clear limitation to widespread uptake. As noted in the 2 year progress review, industry may be motivated to implement a voluntary label where they see a benefit to their products, brand and company, and perceived alignment with organizational values 1. Where these factors are not present, costs involved in changing a label confer little ‘first-mover advantage’.
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Other barriers identified by those not yet implementing HSR include a lack of clarity in the Guidance Materials (for example rules for ‘as prepared’); packaging and labelling costs (which may be reduced through adopting improvements at a time when other changes are being made, such as the Country of Origin Labelling changes required by June 2018); perceived or real lack of consumer trust (which may be overcome through improved consumer education and awareness, and improved consistency with the recommendations of the Australian Dietary Guidelines).

2. Thinking about making comparisons between products in the supermarket, how appropriately are consumers using the HSR system? Please provide comments.

As the HSR is not mandated across all foods, it is difficult to determine how appropriately consumers are using the system in practice. Most initial research was conducted using choice experiments to assess the potential of FoPL systems. Mhurchu et al (2017) stated that “various types of nutrition labels and point-of-purchase information have been studied to determine their ability to attract consumers’ attention, be well understood and promote healthy food choices...however, the evidence regarding the effects of interpretive FOP nutrition labels on real-world consumer food choices has been insufficient and complex”.

While it is encouraging that consumer awareness of HSR is growing, unprompted awareness of the system remains relatively low (reported as between 13-26% in Australia; 9% in NZ in mid-2016) despite HSR being in operation for three years. This is particularly concerning given that HSR seems to be the only public health nutrition population-based initiative currently operating to address poor diet and high body mass index, which are the leading causes of the Australian disease burden.

Among those who are aware of the system (prompted and unprompted 59-67% in Australia; 61% in NZ), Australian Pollinate research findings are promising: around one third self-report buying a new product because of its higher HSR, and of those, most report continuing to purchase the product. This suggests improved awareness could increase positive behaviour change.

The two year review report also suggests that most people (72% of Australians and 67% of New Zealanders) find HSR easy to understand and use. Pollinate research, as well as that done by CHOICE suggest most Australians want HSR on more (or all) products. In randomised trials conducted in both Australia and New Zealand, consumers preferred HSR to alternative label conditions, including the Nutrient Information Panel (NIP), Daily Intake Guide (DIG) and Multiple Traffic Light (MLT) system. At the relatively low levels of use observed in these studies, none of the labelling conditions (except for a fictional warning/endorsement condition in the Australian study) demonstrated a significant effect on food purchases. Shoppers using the HSR system in New Zealand found it to be significantly more useful and easier to understand than nutrition information panels.

Several papers by Talati and Pettigrew et al provide support for HSR’s ability to allow consumers to make appropriate comparisons between foods. These findings are consistent between adults and children, and among socio-economic and linguistically diverse groups.

Taken together, these findings support HSR as an appropriate labelling system at a population level, and also that it is preferred by consumers over both the MTL and the industry-preferred DIG.

Despite this growing body of support, existing research also provides insight on areas where HSR understanding could be improved:

- Findings on awareness suggest this could be greatly improved;
- Only one in four Australians report seeing the HSR campaign, with lower results in regional areas and among those with high BMI, who may be most at risk from diet-related disease;
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- There remains confusion about who is behind the campaign: at least a quarter of surveyed Pollinate respondents could not correctly identify this. Future communications must reinforce HSR is government led;
- There also appears to be confusion about key campaign messages, with a concerning proportion of consumers agreeing it communicates messages including ‘you should only buy food with a Health Star Rating’, ‘you should buy packaged instead of unpackaged foods’ and ‘buy more packaged foods’. These results are particularly concerning to PHAA for their inconsistency with the objectives of a FoPL within broader strategies to promote healthier diets.
- Confusion also remains about whether HSR can be used within or across categories. The current guidance for the system is that it should be used to compare products within a category only, rather than between categories. However, consumers do not always know exactly which category a product fits into, and intuitively do compare throughout a supermarket as they shop. A good example of the confusion is between yoghurts (HSR category 2D) and dairy desserts (HSR category 2). Currently, these products are in different categories, resulting in lower scores for some yoghurts than less healthy dessert products. This anomaly is easily identified because of the usual close proximity of the products on supermarket shelves. However, the same contradiction is identified by shoppers when they have products from different categories in their basket or cupboard at home. These differences may not be immediately apparent at the supermarket shelf, but undermine the credibility of the system when such inconsistencies are readily apparent to consumers, such as when products sit next to each other on their kitchen or dining room table.

PHAA has three specific recommendations:

- the HSR education campaign be revised to promote messages consistent with the ADGs and how to utilise FoPL to improve food literacy, awareness and understanding, particularly for population groups vulnerable to poor nutrition
- develop a HSR system and algorithm that supports accurate messaging across categories (such as applying the “the more stars the healthier” message to emphasise comparison of the HSR across food categories, instead of only within categories)
- the algorithms be adjusted to ensure that, as far as possible, products are comparable both between and within categories, to more accurately inform and reflect consumer behaviour and provide more consistent and comparable information.

3. Has stakeholder engagement to date been effective in providing information about the system and addressing stakeholder implementation issues? Please describe how, including examples where appropriate.

PHAA appreciates that a number of stakeholder workshops have been held, both at the introduction of the system and more recently in response to requests. Ongoing efforts to ensure broad consultation, transparency and responsive and timely improvements are essential for the success of the HSR.

We note that, compared to stakeholder events in New Zealand, the majority of Australian workshops have targeted a general audience. Further targeted consultations with public health and consumer stakeholders in Australia present an ideal opportunity to gather experience and feedback from those with most in-depth knowledge about the development and implementation of existing policies (including the ADGs).

It is important that all stakeholders feel feedback from stakeholder workshops has been valued and will lead to a timely and effective response. We particularly support further actions noted in response to feedback in 2016 that HSRAC has agreed to further consider, inter alia, whether HSR is adequately aligned
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with the ADGs, the development of additional campaign materials, and to revisit the proposal to make the scheme mandatory.

While ‘fixes’ to all issues may not be able to be implemented immediately, PHAA notes that the concerns regarding Milo and other application of “As Prepared” rules were raised in one of the early workshops at the system launch stage, and remain in the ‘to be addressed’ column. While it is now recognised as a priority, the time taken to get to this point means that the 5 year review itself now risks further delaying implementation of a response. We believe the ‘As Prepared’ issue provides an ideal opportunity for HSRAC to demonstrate leadership and responsiveness to stakeholder feedback by both addressing and resolving the matter as soon as possible.

PHAA believes that leaving review of the system to a 5-year interval is too long, increases distrust in the system, and leads to negative media attention.

4. How effective has the implementation of the HSR system to date been in meeting the overarching objective of the HSR system?

The objectives of the HSR system have 3 key themes: guiding healthier choices, aligning with other advice, and improving incentives for reformulation.

Guide consumers towards healthier choices

Evidence suggests that consumers find the HSR easy to understand, supporting this objective. However, with the scheme being voluntary the HSR is appearing on those products obtaining higher scores first (mean HSR 4.0 in the 2-year review).

PHAA are encouraged that HSRAC reports rapidly increasing uptake (7000 products by 140 companies in April 2017), and support the decision of Coles and Woolworths to put HSR on all private label products. However, although Industry appears supportive of the scheme, it is unlikely to fully commit across all product ranges. Current uptake is still likely to constitute a relatively small proportion of the supermarket. For example, although Sanitarium and Woolworths committed to supporting the scheme in 2014, by 2017 the rating is not yet across all products.

Community perception is that government control or regulation of food labelling is important. For example, 95% of the West Australian population in 2012 believed that government regulation of a health rating on food products was important.

Making HSR mandatory as soon as possible would increase both awareness of the system and its ability to guide consumer choice. Further details of this proposal are outlined in Question 14 and 16 below.

Alignment with other food regulation, public health policies, and authoritative sources of dietary advice such as the Australian Dietary Guidelines (ADGs)

In order to achieve its public health and consumer choice objectives, it is essential HSR is aligned with existing evidence-based policies and policy tools in both Australia and New Zealand. PHAA believes significant focus is warranted to ensure that HSR is aligned with the ADGs in particular.

The ADGs are a policy tool that classify foods based on rigorous graded evidence of association between their consumption and health outcomes and/or risks of ill-health outcomes, whereas, the HSR system classifies foods predominantly on selected features including nutrient criteria/ cut-offs, which are only broadly related to health outcomes.
According to the current HSR Guide to Industry an ‘anomaly’ occurs within HSR when a star rating is inconsistent with the ADG, or when used to make comparisons within a food category or across comparable food categories that would mislead consumers (HSRAC takes both factors into account as part of its considerations). Work done by NSW Health examined how well the HSR aligned with the ADG, examining 11,500 products across 30 food categories. Using a HSR cut-off of ≥3.5 that work found:

- 79% of ADG Five Food Group (FFG) foods achieved a HSR of ≥3.5
- 86% of discretionary foods achieved an HSR of <3.5
- There was a significant difference in the mean (FFG = 3.7 stars, discretionary foods = 1.9 stars)

While this alignment was judged as generally better than the existing MTL scheme utilised in NSW School Canteens, it also suggests that the current HSR algorithm misclassified one in five FFG foods, and one in seven discretionary foods. In the context of a typical supermarket selling 30,000 packaged foods, the level of demarcation between FFG and discretionary foods found in this research is concerning, especially with the proven need to increase consumption of FFG foods and decrease discretionary foods.

Half of the new discretionary products launched onto the Australian market between April and December 2016 displayed ≥3 HSR stars and another study found that 95% of 215 high market share ultra-processed foods contained added sugars (described in 34 different ways), 55% carried a HSR, and 55% achieved a HSR of ≥3.5.

The significant number of outliers identified in research to date suggests there is too great a disconnect between the HSR system and the ADG, in that the HSR system does not adequately encourage consumption of foods, food groups and dietary patterns consistent with the recommendations of the ADG, such as “enjoy a wide variety of nutritious foods from the five food groups every day” which are often unpackaged. One of the factors is that the system was specifically designed for packaged food. This creates potential for HSR to undermine evidence-based dietary advice, by creating a food environment that contributes to consumer misinformation; potentially decreasing consumer trust in the system. Further, the current system could inadvertently encourage the packaging of fresh produce such as vegetables and fruit in order for them to be promoted with high star ratings, which can increase the carbon footprint and contribute to the environmental unsustainability of the food supply.

While emphasising the need for greater alignment, PHAA also recognises sustained, 100% alignment between HSR and the ADGs may never occur, for two major reasons. Firstly, the two systems should be subject to regular evaluation and refinement informed by the scientific evidence-base around food, diet and health relationships. From this, there will inevitably be improvements in both. This means alignment will be constantly changing. Secondly, the two systems are very different in their approach and philosophy, with one being an objective measure of selected nutrient content and arbitrary cut-off levels and the other on the evidence-base of specific food, dietary patterns and health relationships informed by systematic reviews.

**Beyond the ADGs**

The FoPL Policy Statement reference to other ‘authoritative sources of dietary advice’ can also invoke updated guidance from WHO, including the increased mandate for mandatory FoPL in the updated Appendix III of ‘Best Buy’ policies in the Global Action Plan on NCD, and the Implementation Plan of the WHO Commission on Ending Childhood Obesity in 2017. Renewed focus of WHO on added (of ‘free’) sugar intake in the 2015 Guidelines on Sugars Intake for adults and children create additional impetus for this to be included in review of the algorithm (see further at Question 6 below).
Providing incentives for reformulation

There is consistent evidence that mandatory labelling requirements can incentivise positive improvements to the food supply by encouraging positive reformulation. For example, mandatory labelling of trans-fats and high-salt content in other jurisdictions led to positive reformulation, with small changes across many products leading to significant public health impact.

Improvements to the food supply are likely to deliver benefits equitably, including among those least likely to read labels, who are also most likely to be at highest risk of diet-related disease.

There are early signs that HSR is stimulating some reformulation. The two year Australian review contains anecdotal evidence of favourable reformulation. Data from New Zealand, (while on a small product sample), suggests favourable changes in energy, sodium and fibre contents compared with product composition prior to adoption of HSR. Reformulation of HSR labelled products was at a higher rate than that of non-HSR labelled products over the same time period.

Evidence from national salt reduction schemes elsewhere suggest even small changes can deliver benefits across population. Reformulation is likely to be further incentivised by increasing the sensitivity of the algorithm to those nutrients of most consumer concern (e.g. added sugars, sodium).

To ensure reformulation is of genuine public health benefit, it is important to ensure the algorithm is primarily focused on reducing risk nutrients, and cannot be unduly manipulated or offset by addition of substances that do not deliver genuine health benefit (e.g. inulin for fibre points, superfluous protein or components derived from concentrated FVNL such as fruit juice concentrate). Incentive to reformulate may also be improved by including added sugars in the algorithm, as outlined further in Question 6 below.

HSR Calculator

5. Do you think the HSR currently scores foods appropriately? Please provide evidence to support your response.

As noted above, a variety of studies have sought to address the performance of the HSR algorithm. While large datasets suggest a reasonably high degree of alignment with the ADG concepts of ‘five food groups’ and ‘discretionary’ foods and drinks, several studies highlight a concerning number of outliers, particularly in discretionary items currently electing to display HSR.

PHAA believes the major change needed is to distinguish between FFG foods and discretionary products. This is basic to fulfilling the goal of helping Australians to improve their food choices.

Potential ‘outliers’ or ‘anomalies’ warrant further attention for multiple reasons:

- If guidance provided by HSR is incorrect but is followed by consumers, adverse public health outcomes could result; and
- Even if consumers do not follow the HSR guidance, inappropriate scores jeopardise trust in, and the integrity and sustainability of, the system overall.

Areas of concern have been extensively documented elsewhere, but broadly include:

- Products that appear to contain high levels of a single harmful nutrient that are scoring relatively well (e.g. breakfast cereals high in added sugars)
- Products that are obtaining the benefit of displaying HSR on basis of preparation with other healthy, whole foods (e.g. Milo, seasoning mixes)
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- Products that may be manipulating their formulation to obtain maximum benefit from nutrients that do not provide a health benefit (e.g. ultra-processed protein bars, cereals with laboratory-sourced ingredients added to boost protein or fibre levels)
- Products that have been found to be associated strongly (above level B evidence) with positive health benefits such as weight control, diabetes and cardiovascular disease, are scoring relatively poorly, such as unsweetened milk and yoghurt regardless of fat content (NHMRC 2013).

6. Can you suggest how the algorithm and/or the generation of a star rating might be improved?

We welcome the creation of a multi-stakeholder Technical Advisory Group (TAG) to review the HSR algorithm and suggest ways in which it could be improved.

PHAA believes that changes which most enhance the ability and effectiveness of the HSR to achieve its public health objectives should be prioritised first. Changes which will have significant impact on public perception of and trust in the HSR system are also high priority, since that is fundamental to the system achieving its objectives.

The PHAA recommends reforming the HSR algorithm and adopting a policy position to: demarcate FFG and discretionary foods; minimise ingredients with minimal health benefits; increase ‘free’ sugar penalties and labelling; and address the ‘as prepared’ loophole.

The PHAA believes the following are the highest priorities to ensure that the system achieves its maximum public health impact:

- Better demarcate FFG and discretionary foods to improve alignment with the ADGs
  - As noted above, it is a priority of PHAA advocacy to ensure better demarcation between five food group foods (to encourage consumption) and discretionary foods and drinks (to discourage consumption) to align with Australian and New Zealand Dietary Guidelines. Five food group foods should get more stars than discretionary foods.
  - One option to achieve this would be to make Five Food Group foods eligible for 2.5 – 5 stars, while limiting discretionary choices to 0 – 2 stars, implementing a policy decision to cap scores within these ranges

- Include added or ‘free’ sugars in the algorithm:
  - Consumption of added sugars is associated with risk of cardiovascular disease mortality
  - Most ultra-processed packaged foods contain added sugars, but many currently score an HSR of 3 or more
  - Recent modelling by the George Institute over 34,000 products suggests 87% of discretionary foods contain added sugars
  - Of all the nutrients used in the current algorithm, this modelling found total sugars had the greatest capacity to discriminate between core and discretionary foods, but that added sugar would perform even better, increasing alignment with the ADGs
  - Given high consumer interest, inclusion of added sugars in the algorithm could increase incentive for industry reformulation
  - The Forum on Food Regulation is currently considering the inclusion of added sugars on the NIP, which would provide an opportunity to have an introduction of added sugars to the HSR coincide. We encourage parallel adoption of both measures to improve transparency, but also note that (like FVNL currently) inclusion of added sugars in the algorithm is not reliant on its inclusion in the NIP
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- Since development of the algorithm, the WHO has issued revised recommendations on added (or ‘free’) sugars. Data from the Australian Health Survey suggest most Australians are far exceeding these recommendations, making this matter ripe for reconsideration.
- PHAA believes the WHO definition of added (also called ‘free’) sugars should be used and made clear in the style guide for industry. This includes monosaccharides (such as glucose, fructose) and disaccharides (such as sucrose or table sugar) and sugars naturally present in honey, syrups, fruit juices and fruit juice concentrates.

- Resolve the ‘as prepared’ issue as soon as possible:
  - PHAA supports the process for determining a solution to the ‘as prepared’ anomaly, with public consultation and stakeholder workshops in 2017.
  - While any change is likely to impact a small number of products, the issue is garnering much negative public attention and harming the integrity and sustainability of HSR system overall.
  - A solution could be found in amendments to the Style Guide rather than the algorithm itself. This could be implemented relatively easily and prior to the five-year approach to the HSR algorithm, similar to previous amendments to the Style Guide.

- Simplify the algorithm to allow comparison across categories:
  - As noted in Pollinate’s research, there remains significant confusion among consumers about whether HSR applies within or across categories. This confusion is understandable, given the intuitive appeal of a system that operates to allow reasonable comparisons across all products in a supermarket. Confusion is not only likely among consumers, but also manufacturers using HSR Guidance materials – the published log of clarifications about which foods fall within/outside certain dairy categories suggests this is the case.
  - The example of scores granted to yoghurts and dairy desserts on the same shelf provide one good example of this much wider issue.
  - While modelling is needed to recalibrate and re-scale, we believe further attempts are necessary to investigate the potential of a single HSR system that works for all products.

- Remove protein from the HSR calculator:
  - The objectives of HSR are outlined in relevant policy documents, and include: Enabling comparison between individual foods that, within the overall diet, may contribute to risk factors of various diet-related chronic diseases; and that HSR should be based on elements that inform choice on balance by assessing both health-benefit and health-risk associated food components;
  - Inclusion of protein may not be necessary to meet these goals. Data from the Australian Health Survey suggests Australians already consume a sufficient (and increasing) amount of protein, creating little public health benefit from incentivising further uptake.
  - The belief (whether real or perceived) that food manufacturers are ‘gaming’ the system by adding protein to all kinds of products (e.g. breakfast cereals) to attain a higher HSR warrants further review.

- Ensure nutrient definitions do not allow addition of ingredients with negligible health benefit:
  - We suggest revisiting definitions to ensure HSR encourages only positive reformulation.
  - This could include for example only applying FVNL to ‘intact’ FVNL, preventing the inclusion of inulin powder in fibre points, or soy isolate or gluten for protein points, and preventing ingredients such as fruit juice concentrates, coconut ‘flour’ or coconut ‘sugar’ being added to breakfast cereals, muesli bars, children’s snack foods and various discretionary products to garner extra stars.
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7. Is the HSR Calculator easy for industry to use? If not, why not?
No PHAA response

8. Are there process and guidance documents for the HSR system (HSR system Style Guide, Guide for Industry to the HSR Calculator, artwork file, anomaly process and dispute process) adequate and do they provide clear guidance?

The very narrow definition of anomaly has meant that weaknesses in the system have not been able to be quickly addressed. For example, the ‘as prepared’ issue has remained unresolved for the first three years. PHAA recommends that the definition of an anomaly which can be resolved quickly and easily by the HSR Advisory Committee and Technical Advisory Group be expanded to include consumer and public health concerns, as well as the currently allowable technical anomalies, which are more of interest to industry.

There has been inconsistency in the interpretation of some of the material in the Guide, resulting in differences in the way the ‘as prepared’ issue has been applied, including some choosing not to display the HSR due to the lack of clarity. There are concerns here that the current guidance may not be consistent with provisions of Australian Competition and Consumer Law. PHAA recommends the updating of this be given high priority.

HSR Graphic and Informative Elements

9. Do you think the informative elements provide additional useful information to consumers? If not, why not? Please provide evidence to support your response.

The primary benefit of a front of pack labelling system is in a single, at a glance symbol. It is confusing for consumers to see both the HSR and DIG on one label. We recommend that given that the HSR system has been in operation for over 3 years, there is no need for the DIG to be used on packaging.

10. Is the HSR graphic easy to understand for all consumers, including people from a non-English speaking background and those with low levels of literacy? If not, why not?

The HSR has been found to be easier to understand and better able to assist consumers to correctly identify healthier foods, than other common front of pack labelling systems such as multiple traffic lights or daily intake guides. The HSR is consistently preferred to other systems by both men, women and children, and those of higher and lower socioeconomic status.

Where the labelling is less intuitive, such as with the current ‘as prepared’ provisions, the system becomes much more difficult to understand and interpret, diminishing its effectiveness and potentially being misleading.

11. Is the HSR graphic easy for food manufacturers to implement on packaging? If not, why not?

PHAA understands that changing labels to incorporate the HSR, or indeed to incorporate changes to the HSR, represents a cost for industry. We note that mandatory application of new country of origin labelling means all foods have to change labels by July 2018, which presents an ideal opportunity for simultaneous application of changes to the HSR to improve the business case for a label change.
Communication

12. How effectively are the key messages of the HSR system communicated to different stakeholders (consumers, industry, government and public health groups)? Please clearly outline whether your response relates to the Australian or New Zealand campaign.

The PHAA response to this item relates to Australia only.

With problems to the overall alignment of the HSR to the ADG, as discussed in Q4, and therefore public perception and trust of the system in decline, there are issues regarding the messaging which must be improved if the system is to survive and help achieve its aim of improving food choices. The number of foods for which the HSR is not currently useful to achieve the basic aim of encouraging the public to choose foods according to the ADGs has the potential to damage the entire system. This requires several responses:

- Consumers are consistently interpreting the system as being capable of comparison across categories, and the algorithm should be changed to incorporate this as far as possible. Appropriate messaging to consumers is then required.
- Industry have interpreted issues such as the ‘as prepared’ to their commercial advantage rather than in keeping with the public health objectives of the system. Messaging to industry should remind them that the public health objectives are the foundation and basis for the system, and that interpretations of the guide material must not undermine this.
- Government must take a lead role in the messaging to ensure that their central role in the system and its public health objectives are clear.
- Public health groups need to be better engaged with the system and see improvements (such as fixing the ‘as prepared’ issue) made in a timely way, in order to more cohesively support the system.

13. Are the government communication resources and materials for the HSR system useful and meaningful i.e. campaign material, stakeholder kit, website, fact sheets etc.? Please note whether these resources are part of the marketing campaign in Australia, New Zealand or both.

The PHAA has found the social media material useful and has been retweeting and posting on Facebook, where appropriate.

Monitoring and governance

14. Do you think there are additional opportunities to monitor the HSR system? If so, please provide examples of what the opportunities are, and how additional monitoring may be conducted.

There are a number of areas where additional monitoring of the HSR could be beneficial.

More information about HSR’s alignment with the ADGs (i.e. its ability to distinguish between FFG foods and discretionary choices) is essential and all monitoring should address this issue.

Greater clarity could be provided about positive reformulation occurring in Australia to improve the healthiness of the food supply in alignment with the ADGs. Further systematic analysis of food composition since HSR’s implementation would be useful in this regard.

The HSR website could also be expanded to include a publicly searchable database of all individual products carrying the HSR by product name, type and category. Healthier alternatives could be included, similar to previous information of this type provided by third parties.
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There should also be a more comprehensive and easy-to-find complaints process, initially through the HSR website, to allow consumers and public health stakeholders to voice reasonable concerns about the ratings of individual products. This would not only provide consumers with a clear voice, but also provide Government and stakeholders with information about consumer concerns to guide ongoing education and awareness.

15. Do you consider the operational structure of the HSR system, including the effectiveness of HSRAC and the New Zealand HSR Advisory Group and their associated working/sub groups appropriate?

While the HSRAC does contain representation from Government, industry, public health and consumers (through CHOICE), PHAA is concerned that representation (in raw numbers) and relative influence may be inequitable, and disproportionately favour commercial interests.

There is increasing recognition of the need to ensure transparency, rigor and public scrutiny of government food and nutrition policy, regulatory and norm-setting activities to ensure they are adequately protected from undue or inappropriate commercial interest.

The HSRAC, appointed by Food Ministers, includes representatives with commercial COI, notably the Acting Chief Executive Officer of the Australian Food and Grocery Council. The committee includes a three-way balance of government, industry and ‘public health and consumer’ stakeholders, where these two latter groups have been bundled together to account for one third of members. In the case of HSRAC this means three government representatives, two public health and one consumer representatives, three industry representatives and one representative from New Zealand. This is commensurate with a make-up of an initiative primarily designed to improve public health and consumer information.

PHAA recommends that representation on the HSRAC be formally equalised, including provisions for proxies so that when public health representatives (who tend to be less well funded than industry representatives) are unable to attend, a proxy can be sent to maintain equal representation at meetings and, that formally qualified public health nutritionists are represented on the HSRAC.

PHAA is also of the view there is insufficient, relevant public health nutrition expertise on the TAG. Required knowledge and skills include detailed knowledge and understanding of the ADG and underlying evidence-base and decision making processes including the six major sources of scientific information (including previous ADG; NRVs and daily nutrient requirements; modelling to identify serving sizes and minimum number of serves required to meet nutritional needs in Australia and inform the AGTHE; systematic, graded, literature reviews of the evidence on the links between foods/nutrients and health outcomes; current food and nutrient intakes and dietary patterns; and key authoritative reports, public and international consultations).

Finally, greater consideration could be given to HSRAC and working group involvement with governance structures in parallel initiatives to improve coordination and impact (e.g. Healthy Food Partnership, ADGs).

16. What options may be appropriate for the future governance and administrative arrangements for the HSR system?

PHAA believes and recommends that the HSR should be made mandatory as soon as possible to ensure its public health objectives are met. The reforms to the HSR need to be made for the system to be ready for mandating.
PHAA submission to the 5 year review of the Health Star Rating system

The initial intent of the scheme was to move to be mandatory within two years. The Australian government stated that the first two years of the system will be voluntary but that after the two years, a thorough assessment of the system would be done. If, at that point, the uptake of the system was minimal, the government may choose to legislate mandatory compliance. The constitutionality of mandatory FoPL requirements have been considered in detail elsewhere, suggesting the Commonwealth Government has the requisite jurisdiction to make the system mandatory, and should forego voluntary implementation in favour of a mandatory system.

Community perception is that government control or regulation of food labelling is important, for example, 95% of the West Australian population in 2012 believed that government regulation of a health rating on food products was important. There is good general community support for mandatory interpretive front-of-pack labelling (such as the HSR system), as a method of preventing obesity in children.

Where an immediate announcement to make mandatory is not politically viable, we call upon government to issue a public announcement that if HSR is not displayed on 90% of eligible products by a given date, this will trigger the system automatically being made mandatory on the date of its five-year anniversary. This kind of credible threat has been shown to increase adherence to voluntary initiatives (e.g. voluntary salt reduction programs in the UK) and was likely the intent of the initial two year voluntary caveat. This kind of announcement could drive further uptake by industry and improve consumer awareness and use. It would also be wholly compliant with prior decisions not to change certain HSR features prior to July 2019.

Public health intervention

17. To what extent do you agree that the HSR is, or has the potential to be, a successful public health intervention? If not, why not?

PHAA has supported the development and implementation of HSR on the basis of its potential contribution to a comprehensive strategy to improve Australian diets. However, there are several areas where immediate reform of aspects of the HSR is required to retain the primacy of its public health goals, and particularly its ability to enhance uptake of the ADGs.

Very few Australians regularly consume a diet that adheres to the ADGs. In 2010-11, less than 4% of Australians ate enough of the nutritious five food group (FFG) foods (fruits; vegetables and legumes; grain foods; lean meats, poultry, fish, eggs or legumes, nuts and seeds; and milk, yoghurt and cheese or plant-based alternatives). At least 35% of total daily energy intake of adults and at least 39% for children came from discretionary food and drinks, contributing to excess energy intake and unwanted weight gain, and displacing intakes of nutritious FFG foods from the diet. The HSR needs to assist in changing this serious imbalance in food choices. This is why PHAA supports restricting the number of stars available to discretionary products.

FOP systems work best when they initiate a food systems response. Making the system mandatory and increasing the sensitivity of the algorithm to nutrients of high consumer concern (e.g. added sugars) are likely to increase this outcome. Impact is likely to come not just from how the system is able to change consumer behaviour, but how it drives companies to positively improve their products, and/or remove the least healthy products from food supply. This improves the food environment for everyone, including those who may not read labels.

Industry commercial interests have the potential to inherently conflict with the public health objectives of the scheme. Therefore, while they may be necessarily involved in implementation, we recommend government ensure industry do not exercise undue influence in determining HSR’s terms and operation. The changes to the HSRAC and TAG suggested in Q15 would assist in this regard.
In addition to our specific recommendations for improving HSR, the system’s utility could be increased by furthering uptake and effective implementation of complementary policies. Adoption of a revised National Nutrition Policy would present an ideal opportunity to highlight roles and synergies of existing initiatives (including HSR, the ADGs and the Healthy Food Partnership) as well as providing a useful framework for future work (e.g. on fiscal policies including a tax on sugary drinks and effective controls on marketing to children).

18. Does the HSR graphic help consumers choose healthier foods? If not, why not?

There are some limits to the message the HSR currently sends, because it is only on packaged foods. These limits have been picked up in the Pollinate research to date 24. In reality, as the HSR website acknowledges: “A high Health Star Rating doesn’t mean that the food provides all of the essential nutrients which contribute to a balanced diet. The Health Star Ratings are one tool to assist you in following a healthy diet, and consideration should be given to other information such as the Australian Dietary Guidelines” and “The Health Star Ratings are one tool to assist you in following a healthy diet, and consideration should be given to eating a wide variety of nutritious foods, many of which may not be packaged”.

Extension to fresh foods, as well as an improved campaign may alleviate these concerns. Research indicates that consumers are motivated to use the HSR to make choices about every day foods as part of their daily meals, rather than for discretionary snacks or desserts 32. Currently, the system inhibits their ability to use the information in this way.

There is also evidence that the system could be used successfully for fast foods, which would increase its utility to consumers and build upon existing kilojoule labelling now common in this context to provide a consistent message across multiple points of food purchase 33.

The current algorithm working within categories rather than between them increases the chances that some discretionary foods are given inflated ratings within their own category. Amending the number of stars that can be scored by discretionary products and simplifying the algorithm to allow comparison across categories as far as possible would assist in more clearly differentiating between FFG (higher rating) and discretionary (lower rating) foods.

19. Do you think the HSR will encourage positive reformulation of foods by industry? Please provide evidence supporting your response.

As noted above in Question 2, we believe HSR has potential to incentivise positive reformulation. There is evidence from the commissioned two-year review of the HSR system that industry has made some effort to reformulate foods to achieve lower stars leading to the perception that the system has the potential to encourage this, but the current lack of monitoring and clear reporting on this does not assist.

Factors which may increase the incentive for positive reformulation include: Making the system mandatory; Inclusion of added sugar in the algorithm; Increasing the sensitivity of the algorithm to risk nutrients such as salt, saturated fat, added or total sugar; Ensuring only nutrients and substances with genuine public health benefits qualify for inclusion (i.e. review of the definition of fibre and inclusion of protein for purpose of gaining points).
Conclusion

PHAA supports the broad directions of the 5-year review of the HSR. However, we are keen to ensure that the integrity of the system is secured and its potential for benefiting public health fulfilled in line with this submission. We are particularly keen that the following points are highlighted:

- the system should be made mandatory
- the algorithm should be amended to allow comparison across categories as far as possible
- a solution to the ‘as prepared’ issue should be implemented as soon as possible
- to better align with the ADGs, added sugars should be included in the algorithm in place of total sugars and offsetting points should only be allowed for intact ingredients instead of isolated components of foods such as fruit juice concentrates or powdered protein or dietary fibres
- The system should ensure better differentiation of core and discretionary foods, aligning with the ADG by introducing a cap on the number of stars that can be assigned to discretionary products

The PHAA appreciates the opportunity to make this submission and the opportunity to contribute to the continual improvement of the HSR system. Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

Michael Moore BA, Dip Ed, MPH
Chief Executive Officer
Public Health Association of Australia

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References


