



March 2006

Submission from the Dietitians Association of Australia

Proposal P293 – Nutrition, Health and Related Claims

The Dietitians Association of Australia (DAA) supports FSANZ's preferred option (Option 3) to introduce a new Standard (1.2.7) for Health, Nutrition and Related Claims.

There is evidence that the current system, with some of the requirements for nutrition, health and related claims in the Standard, and all of the nutrition content claims in the Code of Practice, is not working. A recent survey by Gately and Barclay (University of Sydney, 2006) of 4,171 foods in a Sydney supermarket determined that 62.6 % of all foods carried some kind of nutrition, health or related claim, and that 872 (33.3 %) of these foods carried a claim that did not comply with either the Food Standards Code or Code of Practice on Nutrient Claims. DAA therefore believes it is necessary for all nutrition, health and related claims to appear in the Food Standard Code as recommended under Option 3.

As well as providing food companies with a new range of marketing tools to influence consumer purchases, there may be some advantage to consumers in learning of the health benefits of specific foods. However there is still a risk that nutrition, health or related claims could be used inappropriately. The new legislation should regulate existing and future claims more effectively than the current legislation, and therefore, it should provide greater protection for all Australians and New Zealanders.

Adequate monitoring, enforcement, regular review of scientific evidence, and a comprehensive education program is essential to help consumers understand how to make sense of the new labelling claims and components of the regulatory framework and must not be overlooked. DAA has expertise in a number of these areas, and would like to work further with FSANZ to ensure an optimal management system is put into place.

DAA believes the draft legislation is a major improvement on the existing situation, however there are some key issues that must still be addressed. To help FSANZ formulate the final draft to go to the Ministerial Council, DAA would like to make the following suggestions:

Page 94, second paragraph, first sentence under heading "Purpose".

The clause "for sale" is repeated.

DAA believes appropriate health professional associations that are recognised internationally for their expertise in food and nutrition e.g. DAA, the New Zealand Dietitians Association and the Nutrition Society of Australia, should be included in the list of organisations to which the Standard does not apply. As such, we would recommend the following amendment:

“It does not apply the requirements of the Code to other types of activities, for example, government health promotional campaigns or public health materials published by community based organizations or appropriate health professional associations that are recognised experts in food and nutrition.”

DAA is seeking confirmation from FSANZ on the following:

- That DAA endorsement of nutrition education materials and nutrition education campaigns under DAA’s endorsement policy are exempt from the standard.
- That DAA nutrition communications for health professionals or consumers which are supported by branded products are not classified as advertising.
- That DAA can provide health professionals with detailed nutrition education materials, including product information.

DAA is seeking clarification of:

- The impact of the proposed standard on information that food companies currently provide to health professionals.

Please refer to Appendix [1] for further information.

Page 95, under heading “Interpretation” → biomarker.

It is not clear if this definition includes being overweight. To achieve optimum health, the median Body Mass Index (BMI) for the adult population should be in the range 21-23 kg/m² (Diet, nutrition, and the prevention of chronic disease. WHO Technical Report Series 916, 2003). Ipso facto, individuals that are overweight are at increased risk of developing chronic diseases like obesity, type 2 diabetes, cardiovascular diseases, and certain cancers. To make it clear that overweight is a biomarker for serious disease, DAA recommends that the definition is amended as follows:

“**biomarker** means a measurable biological parameter, which, when present at an abnormal level in the human body, is predictive of the risk of a serious disease. This includes being overweight, but not obese (which is a serious disease)”

DAA recommends that overweight be defined as having a BMI ≥ 25 and ≤ 30 kg/m² or waist circumference ≥ 80 cm in women and ≥ 94 cm in men and obesity be defined as BMI > 30 kg/m².

Page 95, under heading “Interpretation” → dietary information.

This definition may provide an unexpected loophole for manufacturers to make high level health claims due to the ambiguous wording of the last clause. DAA recommends that FSANZ amends the definition of dietary information to:

“**dietary information** means general dietary information, and includes information from national nutrition guidelines, but does not include information that refers to a specific brand of food and the effect of that brand of food on health.”

Page 95, under editorial note.

There are two (c)'s due to the insertion of the Dietary Guidelines for Older Australians (DGOA).

Please note that the NH&MRC has very recently rescinded the DGOA.

Page 96, under heading “Interpretation” → food group

Although not officially a food group under the Australian Guide to Healthy Eating or New Zealand Food and Nutrition Guidelines, fats and oils are a part of most Australian and New Zealanders' diets. Additionally, Nutrition, Health and Related Claims can be found on a significant proportion (70%) of fats and oils sold in Australian supermarkets, and the situation is likely to be similar in New Zealand.

Similarly, while humans only need fresh water to drink, other beverages are an important component of most Australian and New Zealanders' diets.

DAA therefore recommends that the following two groups are added to the food group definition:

(e) fats and oils.

(f) beverages

Page 97, under heading “Interpretation” → meal/main dish product

To prevent foods high in added fat from being classified as a meal, DAA recommends that FSANZ amends the definition to exclude fats and oils:

(b) at least two ingredients (including compound ingredients) from at least two different food groups, except (e) fats and oils, of at least 40g each.

Page 97, under heading “Interpretation” → serious disease.

To clarify the status of overweight and obesity, DAA recommends that this definition is amended as follows:

serious disease means a disease, ailment, defect or condition that is not appropriate to diagnose, treat or manage without consultation with or supervision by a health care professional, and includes obesity, but does not include overweight (which is a biomarker).

Page 97, under heading “Application” → Clause (1)(b).

FSANZ should give consideration to including Australia's 'Go for 2 + 5 veg' and NZ '5+ a day' endorsement programs in the list of pre-existing programs for exemption from the Standard.

Page 98, under heading “3 Claims, endorsements and statement prohibition” → Clause (3) A claim must not compare a food and a therapeutic good.

Neither the Therapeutic Goods Act 1989 or the Therapeutic Goods Advertising Code (2005) prohibit the comparison of supplements with food. Anecdotally, dietary supplements, which in Australia are regulated as therapeutic goods, are frequently compared to foods in advertising. Recent examples include probiotics in capsules with those found naturally in yoghurt, and vitamin C in tablets/lozenges with that found in oranges. In order to provide a level playing field, both the Therapeutic Goods Act and Code should be amended to prohibit these comparisons and associated claims, or this clause should be dropped from Standard 1.2.7.

Page 99 under heading “5 Conditions for general level claims”, section (2) (a)

DAA foresees several major problems with the proposed generic exclusion criteria set out in this part of the Standard.

Firstly, Australia and New Zealand does not have prescribed serve sizes for foods and beverages, so manufacturers will be able to manipulate the recommended serve sizes of their products so they can make claims. Australia and New Zealand would be the only two countries in the world to implement a nutrition and health claim system where standard serve sizes are not legislated. If FSANZ is to continue to base exclusion criteria on serve sizes, DAA recommends that standard serve sizes should be developed in consultation with key stakeholders and incorporated into Standard 1.2.7 to avoid potential consumer confusion and/or deception. Consideration should be given to the use and extension of the ‘reference quantities’ stipulated in Standard 1.3.2 (Table to clause 3).

Secondly, DAA has modelled the proposed generic disqualifying criteria on a database of over 9000 generic (AusNut) and brand-name foods. While the disqualifying criteria do successfully identify several thousand healthier food items, they also allow foods that most dietitians would consider to be less healthful such as many biscuits, cakes, table sugar and many sugar-based confectioneries to make claims. The sugars criteria will also exclude some very nutritious foods like pears, bananas and mangos, because nature packages them in larger serve sizes. Similarly, many breads and canned legumes will not be able to make claims due to their moderate sodium levels, despite being highly nutritious foods. Surprisingly, the generic criteria will allow foods low in sugar yet high in total fat and kilojoules, like butter, to make claims, because of their small serve size. Appendices 2 & 3 (see attached) list specific examples of foods that meet/fail to meet the proposed disqualifying criteria.

One of the major reasons for the lack of specificity in the disqualifying criteria is that they are not based on food groups. DAA recognises the need to have a simple set of criteria from an enforcement perspective. Unfortunately, the proposed system is just too simplistic, and as a consequence, no way near specific enough. DAA believes that the lack of specificity will only create more confusion in the mind of the consumer.

Due to the relatively large amount of evidence linking saturated fat, and sodium with disease risk, few would debate that foods high in these nutrients should be limited. However, the use of sugars as a disqualifying criteria is not considered appropriate by DAA. The assertion on page 44 of Appendix 5 of P293 that “...both total and added sugars both contribute to energy intake, and are digested, absorbed and processed by the body through the same mechanism.”

is incorrect and misleading. There are significant differences in the way monosaccharides are digested compared to disaccharides. In relation to absorption, some monosaccharides are actively transported across the intestinal lumen while others are passively absorbed. Finally, the pentose fructose is metabolized via a different mechanism than hexoses like glucose. The net effect of the differences in digestion, absorption and metabolism of the various sugars can be quantified physiologically by the glycemic index, as recommended by the World Health Organisation/Food and Agriculture Organisation (Carbohydrates in human nutrition. 1998. Report of a Joint FAO/WHO Expert Consultation. FAO Food and Nutrition Paper – 66.).

Fruits, milks and their derivatives are naturally high in sugars, and the majority of the sugars in these products are low glycemic index. On the other hand moderate to high glycemic sugars like sucrose and glucose are not found naturally in large quantities, but are usually added by food manufacturers to improve a foods texture and taste. It is the refined added sugar that is by definition contributing “empty kilojoules” to the diet, not the naturally occurring sugars, and it is these added sugars that have a greater glycemic impact. Therefore, if any criterion was to be set for sugars it should be for added sugars only.

The only disease associated with high sugar consumption independent of energy intake is tooth decay. While tooth decay is still a serious health problem for a significant proportion of the population it should not be the sole rationale for setting a sugar disqualifying criteria, particularly because it is strongly related to frequency of consumption rather than just total amount consumed. From a total energy intake perspective, a disqualifying criterion for kilojoules is the most logical alternative, as energy density is much more strongly correlated with total body weight. DAA does not understand why FSANZ is recommending the use of a surrogate when the causal factor is readily known, and the information is equally available on nutrition panels?

In order to overcome these particular limitations, DAA recommends that separate criteria are developed for the food groups as defined under section 1 Interpretation (page 96), plus one set of criteria for foods not listed in section 1 (Note that while nuts and seeds have been placed in category (e) along with fats and oils, for the sake of simplicity, we are in no way implying that they are part of this food group as defined in Section 1 Interpretation on page 96). Detailed modelling by DAA has suggested the following cut-offs would be appropriate to promote foods consistent with the recommendations in the Dietary Guidelines for Australian Adults and Dietary Guidelines for Children and adolescents in Australia:

(a) bread and other cereal products (Breakfast cereals, Cakes, Biscuits, Noodles, Pasta, Rice, Savoury biscuits, and Snack foods);

≤ 1600 kJ per 100 g; saturated fat ≤ 3 g per 100g; Sodium ≤ 500 mg per 100 g

(b) fruit and vegetables (fresh, frozen and pickled)

≤ 1100 kJ per 100 g; saturated fat ≤ 3 g per 100g; Sodium ≤ 300mg per 100 g

(c) milk, milk products and alternatives (cheese, yoghurts, milk and soy based drinks, etc....with a min of 50% dairy or ingredients);

Cheese – saturated fat ≤ 18g per 100 g; Sodium ≤ 600mg per 100 g;

Other milk, milk products and alternatives - ≤ 500 kJ per 100 g; saturated fat ≤ 2 g per 100 g; calcium > 100 mg per 100 g.

(d) meat, fish, eggs, and legumes (including fresh and processed meat, poultry and seafood, with minimum 50% meat/poultry/seafood);

≤ 800 kJ per 100 g; saturated fat ≤ 4 g per 100g; Sodium ≤ 450 mg per 100g

(e) fats, oils, edible oil spreads, cream, dressings, nuts, seeds and their spreads

$\leq 3,700$ kJ per 100 g; saturated fat ≤ 20 g per 100g; Sodium ≤ 450 mg per 100g

(f) All other foods (not covered by (a) – (e))

≤ 1000 kJ per 100 g saturated fat ≤ 2 g per 100g; Sodium ≤ 300 mg per 100 g

(g) Beverages (cordials, soft drinks, fruit and vegetable juices, and dairy drinks with $< 50\%$ dairy)

≤ 175 kJ per 100 g; Sodium ≤ 150 mg per 100g

For meal/main dish products we recommend the following criteria:

≤ 800 kJ per 100 g; saturated fat ≤ 4 g per 100g; Sodium ≤ 450 mg per 100 g

Detailed modelling suggests that these category-specific disqualifying criteria will not be overly restrictive for food industry, and experience with existing endorsement programs would suggest that they will promote industry innovation. However, DAA would be happy to discuss the rationale and further development/refinement of these criteria with FSANZ.

Page 101, under heading “Conditions for high level claims” → Table to clause 6.

Clause (b) of the two High Level calcium claims are different from the other High Level claims in that they do not state that “the food must comply with the conditions for a general level claim other than a nutrition content claim”.

DAA recommends that foods with High Level calcium claims should meet the “conditions for general level claims other than a nutrition content claim” to be consistent and therefore not provide unfair market advantage.

Page 101, under heading “Conditions for small packages”

With respect to nutrition, health and related claims, DAA doesn't support any exemptions from small package legislation. If a package itself is too small, manufacturers are able to provide additional information in the form of a shelf talker, neck tie, or fold out label.

Page 104, under heading “Conditions for making general level claims” → Table to clause 11.

DAA has the following suggestions:

Cholesterol – DAA would recommend that all cholesterol claims are prohibited as saturated and trans fats are more significant dietary issues in Australia, and cholesterol free claims obfuscate this fact. However, if at final assessment, FSANZ decides that they are to be permitted, then DAA strongly recommends that they are limited to animal-based foods only. It is misleading to claim cholesterol free on products that never contained any in the first place.

Dietary fibre – DAA does not support increasing the level at which ‘source’ and ‘good source’ claims can be made for fibre, as there is no evidence that increasing the levels at which claims can be made will achieve an increase in dietary fibre intake. On the contrary, DAA is concerned that increasing the levels of fibre to make claims could have the opposite effect, as many products in the market will have to either downgrade their claims for fibre or remove them all together. This will only make it harder for consumers to identify foods that are a source or good source of fibre.

For example, a serving of regular wholemeal bread (2 slices, 60g) or wholegrain wheat breakfast biscuits (2 biscuits, 30g) which can currently claim to be 'high in fibre' will only meet criteria for 'source of fibre' under the proposed new guidelines. In addition, using a standard serve size of 150g for fruits as outlined in the Australian Guide to Healthy Eating, will mean that bananas, pears and oranges will only qualify for a 'source of fibre' claim under the proposed new standards (providing 3-3.5g fibre per serve), whereas they qualify for a 'high fibre' claim under the current Code of Practice guidelines. These foods are generally promoted as good sources of fibre in the Australian diet

DAA questions the quality of the scientific evidence and rationale on which the increased claims are based, and urges FSANZ to consider the potential negative consequences of reducing or removing fibre claims from foods that are currently available and important contributors to overall dietary fibre intakes.

Glycemic Index or Load – DAA recommends that FSANZ adopts the definitions used in the Australian Standard on Glycemic Index testing so that the descriptors “Low”, “Medium” and “High” GI can be used in association with GI Claims.

Saturated fatty acid – DAA recommends that in addition to the current criterion, that an alternative of 28% or less of total fats as saturates plus trans be included. This will permit the foods with higher levels of ‘good fats’ such as oily fish, vegetable oils, salad dressings made with unsaturated oils, nuts, avocados, etc... to highlight their relatively low saturated fat content to encourage healthier choices.

Protein – DAA recommends that in order to be consistent with other content claims, different criteria for solid and liquid protein foods are developed.

Page 112, under heading “ [5] Standard 1.2.8 of the Australia New Zealand Food Standards Code is varied by –“

While DAA recommends that only foods and beverages that meet the category-specific disqualifying criteria should be able to make any nutrition, health or related claims, we do believe that the Nutrition Information Panel (NIP) should be able to include non-mandated nutrients, which themselves should be exempt from disqualifying criteria, but still be required to meet qualifying criteria. This will enable consumers to still identify foods that are high in non-mandated NIP nutrients like dietary fibre and calcium, that wouldn't be able to make stronger marketing claims due to their high kilojoule, saturated fat or sodium level(s). For example, a high fat and salt cheese should still be able to list its Calcium content in its NIP.

Page 113, under heading “Percentage intake information”.

DAA is deeply concerned with the proposal to use a declaration of how much a food contributes towards the percentage Recommended Daily Intake of kilojoules for adults as a surrogate for appropriate disqualifying criteria for nutrition content claims.

Firstly, nutrition content claims are the most common type of claim found on food labels in Australia. For example, a survey of 4,171 foods was conducted in a major suburban supermarket in mid 2005 (Ms Nicole Gately, University of Sydney M Sc research project and Mr Alan Barclay, Supervisor) covering most major food categories (breads, cereals, dairy foods, meats, vegetables, fats/oils, snacks, desserts, and convenience foods). The survey found that 63 % of all food labels carry some kind of nutrition claim and that the vast majority of those foods (89.4 %) carried nutrition content claims.

Secondly, FSANZ's recent consumer research (Attachment 4, page 4) found that other than endorsements and cause-related marketing statements, *“There was no consistent pattern in the way that the remaining claims were sorted on health benefit.”* In other words, consumers believe a content claim promises similar health benefits to a high level health claim. Furthermore, *“It was clear from the results that there was little difference on intent to purchase for the product with a high level claim compared to the product with a general level claim (either content or function).”* (ibid, page 13)

Thirdly, Australia and New Zealand's food regulation ministerial council policy guideline proposal on nutrition, health and related claims state very clearly that *“Consideration should be given during the FSANZ standard development process for including the criteria for making each level of claim and any parameters (eg. qualifying and disqualifying criteria, or exclusions for certain categories of food, such as alcohol and baby foods) should be specifically stated in the standard. **These parameters will be particularly important to the monitoring and enforcement of nutrient content claims**”*. While the majority of content claims in FSANZ's proposal have adequate qualifying criteria, the draft Standard fails to provide adequate disqualifying criteria.

Fourthly, as soon as the new Nutrient Reference Values have been ratified by Australia and New Zealand's respective government authorities, the figure of 8,700 kJ for the typical androgynous adult will be changing, along with the values for the macro and micronutrients, and no consideration has been given at all to the needs of children and adolescents. Again, this will lead to considerable confusion for consumers.

Finally, armed with the knowledge that nutrition content claims can be just as effective as higher level claims at persuading consumers of their health benefits, and having a similar effect on consumers' intent to purchase, and with no system in place to prevent manufacturers from placing such claims on less healthy foods, it seems inevitable that such claims will remain dominant in the market place, to the detriment of consumer understanding and choice, unless a more balanced system is put in place.

Therefore, DAA strongly recommends that content claims are also required to meet the same disqualifying criteria as other general level claims. Not only would this be more consistent with the Ministerial Council's policy guideline, it would also directly address the results of FSANZ's consumer research. Furthermore, this approach would overcome the problems of gender and age that are an inherent weakness of FSANZ's proposed model.

Page 111, under heading “Conditions for making specific general level claims, other than nutrition content claims ” → Table to clause 12.

DAA does not support the provision of any claims about weight loss. No single food or beverage can safely facilitate weight loss, and by only allowing foods that meet the definition for low joule, consumers will be misled into thinking they need to eat a range of non-core foods that in reality they could successfully manage without. Furthermore, the criteria for low joule foods prevent most of the core foods that are the important part of a weight loss diet from making such claims.

However, if the results of this present round of stakeholder consultation demonstrates majority support for the use of weight loss or maintenance claims, DAA would recommend that foods from the Core Food Groups categories (a) to (d) as defined in Clause 1 of the draft Standard are also able to make weight management claims provided they meet the category specific disqualifying criteria to ensure a more balanced portrayal of a healthy diet. Furthermore, those low joule foods and beverages that are eligible to make weight loss or maintenance claims should also meet their category-specific disqualifying criteria for saturated fat and sodium, to ensure there is a level playing field for all nutrition, health and related claims.

Compliance and enforcement

DAA considers the success of this proposed standard is predicated on the appropriate enforcement of the legislation, both to protect public health and protect consumers from making ill-informed choices. DAA is concerned that proposed approach to enforcement may not be effective in ensuring food manufacturers comply and misleading claims and advertisements could proliferate in the marketplace.

The proposed health claims watchdog, sitting under the Implementation Subcommittee (ISC), is largely a secretariat which functions to co-ordinate and report on complaints across all jurisdictions. Clearly, this approach will create a situation where monitoring and enforcement are not proactive, and will vary with both capacity and willingness to act in each jurisdiction. States where the bulk of manufacturing occurs will also be asked to carry the greatest burden in this area.

Timeliness of enforcement action is an essential part of ensuring the system is providing the public with information which is not misleading or inaccurate. If an advertising campaign contravenes the health claims standard, the campaign could be over by the time enforcement action is completed under the currently proposed mechanisms. Meanwhile, the marketing objective of the campaign has been achieved, although the message may have been misleading. Those enforcing the standard must have the capacity to stop an advertising campaign immediately.

An alternate approach could be that which is used by the Therapeutic Goods Administration's co-regulatory model for listed medicines. This would provide a Commonwealth-led approach with the ability to act proactively. The system should include appropriate penalties (for example fines, retractions, and corrective advertising) which would be less costly, more effective and a more timely deterrent against misleading practices than taking action through the courts at a jurisdictional level. Funding for this system could be achieved through an industry levy.

Information and education

In order to minimise confusion and maximise benefits, it is essential that the implementation of this new standard is coupled with an adequate education campaign for both consumers and health professionals. The objective of such a campaign should be to reinforce the key messages of the Australian Dietary Guidelines whilst improving consumer understanding of food labels in general and nutrition and health claims in particular.

Consumer-level education campaigns will be enhanced if health professionals are appropriately skilled in the area of the new nutrition and health claims. DAA has been communicating, and will continue to communicate with its members on the impact of the new standard. DAA would like to offer assistance to FSANZ in the education of other health professionals.

It is believed that website materials will not be sufficient unless there is also a coordinated education campaign. The development of educational materials (such as fact sheets and posters) by FSANZ similar to that developed for the food labels could be supplied to point of sale and would assist in supporting a comprehensive education campaign.. Funding for a comprehensive campaign which could include television and newspaper advertising could be in-part levied from the food industry, in return for the privilege of being able to make nutrition and health claims on their products.

Conclusion

The Dietitians Association of Australia strongly urges FSANZ to address these issues before finalisation of the Standard, in order to ensure that Australia will have the best possible system for managing nutrition, health and related claims in the future.

Appendixes 1 and 2 are separate pdf files.

Appendix 3

Health claims – Impact of health claims legislation on DAA’s role in nutrition education.

The Dietitians Association of Australia (DAA) currently plays a significant and expanding role in nutrition education of the public both independently and through joint activities with its corporate partnerships. Key activities are producing, endorsing and distributing nutrition education material aimed at promoting healthy eating for all Australians. This document outlines what activities DAA expects to be able to continue to do under the new nutrition, health and related claims legislation. The current DAA Endorsement Policy available on the DAA website www.daa.asn.au under About/Advertising/ Endorsement Policy and Application form. The Policy Statement is ‘DAA may endorse activities or initiatives such as campaigns, conferences and services; and literature or materials such as statements, patient education materials and practice guidelines. DAA’s endorsement signifies DAA’s agreement, advocacy or recommendation towards the action or subject it endorses. DAA will undertake an evaluation process before arriving at a decision to give DAA’s endorsement.’ The policy allows reference to branded food products within this context but does not permit direct endorsement of branded food products.

Current DAA nutrition education endorsement program

Nutrition education material – no reference to branded products

The health claims Policy Guideline defines ‘endorsement program’ as in the commercial sense – an advertising testimonial: an instance of public endorsement of a product for advertising purposes; and states that “Endorsement programs that state or imply a nutrition, health or related claim must comply with the principles and requirements of the relevant claim category. They will require a statement to explain why the endorsement has been granted (e.g. meets the nutrient criteria required by the endorsement program)’. The draft Standard defines endorsement as ‘a design used, or intended to be used, to distinguish food certified by an endorsing organisation in relation to its nutrition or health features from other foods not so certified, and includes a certification trade mark, but does not include – (a) a design that distinguishes food in relation to ethical, religious or environmental features including vegetarian, halal, kosher or organic designs; or (b) a design that includes a reference to a serious disease other than as part of the name of the endorsing organisation.

DAA understands that its current endorsement program, which seeks to endorse nutrition education material and not branded products or services, does not fit into either the Policy Guideline or draft standard definitions. Therefore, the Association will be able to continue to endorse nutrition education material that does not refer to specific branded products, but that may be produced or supported by a company, and meets DAA requirements.

Nutrition education materials – with reference to branded products

DAA endorsement of nutrition education materials which are produced/supported by a branded product and/or may refer to a range of branded products in the copy.

Example 1 - Nutrition education material supported by a branded product. For example, DAA endorsement of a brochure on the benefits of breakfast supported by 'Breakfast cereal X' but that does not include any specific reference to any branded breakfast cereal within the brochure copy or significant product placement.

Example 2 – Nutrition education material that lists a range of branded products from a range of companies. These materials are commonly used by dietitians to help clients select appropriate products to meet their specific nutritional requirements. For example, DAA endorsement of a brochure on appropriate snack choices for people with hypercholesterolaemia, where the brochure lists branded and non-branded food products, from a variety of different food companies (e.g. 'Brand X muesli bar, Brand Y muesli bar, dried fruit etc).

DAA has previously endorsed a fact sheet developed by the DAA Victoria Branch Cardiology Interest Group on healthier snack ideas. The fact sheet was aimed at adults and listed a range of branded products identified as healthier snacks under a variety of headings (eg: bakery products, dry biscuits etc...).

Recipes

DAA has also worked at a campaign level with companies to endorse recipes that include branded ingredients. The best example of this is the Coles 7-a-day program which ran from 1999 to 2003 and promoted fruit and vegetables to Australians. As part of this campaign DAA endorsed recipes that included Coles branded ingredients (e.g. Coles potatoes) and met specified DAA criteria. DAA expects to work on similar campaigns in the future, and expects to be able to endorse recipes, that may include branded ingredients, at the Associations discretion.

DAA policy allows reference to branded ingredients within DAA-endorsed recipes on the Smart Eating section of the DAA website and in recipe books which DAA endorses. All recipes must meet DAA criteria. DAA wishes to refer to branded ingredients in these recipes as the recipes have been tested and analysed using specific ingredients and the quality, taste and nutritional value can not be guaranteed if these ingredients are substituted. DAA will include a disclaimer to explain that rationale and advise consumers that other branded ingredients may also be suitable and DAA does not endorse any branded product.

Benefits of DAA endorsement of nutrition education materials

DAA will continue to seek opportunities to produce and endorse accurate and practical nutrition information for the public to help promote the nutritional health of Australians. DAA endorsement provides the public with greater confidence in the material and offers DAA the opportunity to promote further information sources and encourage consultation with an Accredited Practising Dietitian for individual advice. Allowing branded products to support nutrition education material endorsed by DAA extends the reach of DAA nutrition information and increases the amount of good quality nutrition information available to Australians. Corporate information frequently undergoes significant revision as part of the DAA endorsement process.

In practice, dietitians regularly recommend branded products to their clients and need many more resources to support their work. DAA endorsement of nutrition education resources that list a range of branded products ensures that the products are nutritionally appropriate and that a wide range of products are represented.

It is appropriate for DAA to consider endorsement of nutrition education material that refers to branded products outside of the health claims Policy Guidelines and draft standard, as this is clearly nutrition education focussed and DAA is not advertising the product or seeking commercial gain from sales of the products. Similar materials from companies who benefit from sales of branded products is defined as advertising and would need to be regulated by the standard.

Other issues for clarification

DAA also seeks FSANZ clarification as to whether there will be a difference between the types of information organisations such as DAA can provide to health professionals. It is DAA's current understanding that detailed nutrition and medical information, including information about branded products, can be provided to health professionals because they can make a professional judgement about it. It is DAA's understanding that if DAA provides this information it is not seen as advertising, even if the information refers to branded products, as DAA is not seeking any commercial gain from the sale of the products. This is a key channel by which DAA communicates complex nutrition information to health professionals and members and the Association expects to be able to continue to do so outside the provisions of the new health claims legislation.

For example, DAA is currently managing a project to standardise the classification and description of texture modified diets in Australia in collaboration with Speech Pathology Australia. This project expects to identify brand name products (food and fluids) that fit within the standardised descriptions.