



**Submission from the Dietitians Association of Australia on the
Nutrient Reference Values in the
Australia New Zealand Food Standards Code – Potential Revision
July 2010**

The Dietitians Association of Australia (DAA) is pleased to provide FSANZ with feedback on this consultation. DAA supports the need to revise regulatory Nutrient Reference Values (rNRVS) in the Code to be consistent with the 2006 Nutrient Reference Values¹ and with consideration of latest international approaches.

This consultation paper provides an opportunity:

1. To enable alignment between current scientific data (the 2006 NRVs)¹ which is being used by health professionals and research institutions when dealing with clients and population health promotion messages.
2. To enable consumers to more easily interpret their food requirements based on current scientific data rather than out of date RDI data.

DAA wishes to make the following comments on the Consultation Paper:

4.0 Approach – Underlying Principles

The DAA supports the FSANZ proposed underlying principles.

However, DAA recommends strongly that FSANZ acknowledges its first and most important statutory objective and give it the highest priority in this review. i.e. the requirement to consider and protect public health. DAA notes that public health is not mentioned in the underlying principles. DAA recommends that FSANZ add as a priority principle the protection of public health, and filter all its deliberations accordingly.

6. Potential Approaches to the Revision of the rNRVs for Current Nutrients in the Code

6.1 Selection of 2006 NRVs for a subset of nutrients – nutrient adequacy or reduction of chronic disease risk?

DAA supports FSANZ preferred approach to revise the basis of the rNRV from rESADDI to regulatory AI. This will allow consistency with domestic NRVs rather than using values taken from overseas.

This is consistent with the approach currently taken for the majority of nutrients. It will cause the least confusion for key stakeholders including consumers, health professionals and food industry. Our understanding of the relationship between nutrients and chronic disease risk is still evolving and should not be used as a basis for establishing NRVs at this point in time.

6.2 Selection of 2006 NRVs for protein, vitamins and minerals

6.2.1 Which measure of nutrient adequacy – EAR or RDI?

DAA supports FSANZ preferred approach 1 in adopting the RDI as the basis for the rNRV as it provides a population-coverage approach where the nutrient reference value is equal to or exceeds the true or undetermined nutrient requirement for nearly all individuals in the population group.

DAA believes that FSANZ needs to consider the effect on overall intake if RDIs are changed and greater absolute amounts of certain nutrients that can be added to food. To ensure upper levels are not exceeded, FSANZ needs to ensure the permissions to add a proportion of the RDI are still appropriate, and whether these need to be reduced based on current consumption data.

6.3 Calculation methods for rNRVs for protein, vitamins and minerals, dietary fibre

Although the different methods for calculating the actual figure for each NRV give varying results, the choice of either RDI or EAR has a much greater bearing on the final figure reached. DAA therefore supports FSANZ's preferred approach, which is the simplest and most easily understood. DAA also notes this is consistent with the CODEX approach.

6.4 Selection of reference energy value

DAA supports the preferred option 2 to review the energy reference value for the general population. Basing an energy reference value on current intakes, or on current average population weight will potentially overestimate the energy requirements to maintain a healthy weight and could encourage continued overconsumption and further increase overweight and obesity in the community. Hence the new energy reference value should be based on a mid-range healthy weight, that is a BMI of 22kg/m² and light PAL. Further consideration needs to be given for children and children-specific products.

Furthermore, for energy reference values to be more easily interpreted and meaningful to consumers, it would be useful to designate these by gender. Gender-specific energy values are specified on food labels in some countries such as the United States. However FSANZ need to consider how gender specific energy requirements would be incorporated to prevent overly complicated food labels.

DAA is not aware of any recent data on physical activity levels on which to base the energy calculations but agrees that the activity levels used should reflect the sedentary activity level of the general population. The upcoming Australian Health Survey may be a potential source of appropriate physical activity data to support the derivation of the reference energy value.

6.5 Selection of 2006 NRVs for carbohydrates and most fats

DAA understands that the preferred rNRV for protein is based on the 2006 RDI (10-12% energy) which in turn means that the rNRVs for carbohydrates and total fat will be based at a point along their respective AMDRs (expressed in terms of percentage energy).

DAA also notes that FSANZ has not determined the energy percentages for the macronutrients in this paper, as these decisions need to be made in tandem with decision on the reference energy values and protein rNRV.

6.6 Calculation methods for rNRVs for carbohydrate and most fats

DAA supports the FSANZ preferred approach for protein, total and saturated fat and total carbohydrates, but not for sugars.

Protein

The current approach results in a protein figure of around 10-12.5% (depending on EER selected), which is somewhat less than the lower end of the AMDR range for protein, however, protein is well-represented in the Australian diet and Australians easily achieve required levels.

Fat

DAA contends it is inappropriate to recommend a lower level of 20% energy for fat as it is insufficient for meeting essential fatty acids requirements. The lower percentage needs to be reviewed by FSANZ.

DAA notes that trans fat has been included but prefers that the level be no greater than 8% total energy and that the upper limit of 10% total energy be reviewed in line with the Heart Foundation Position Statement on dietary fats and cardiovascular health ¹.

Carbohydrate – total and added sugars

DAA proposes the upper limit of 65% be reviewed and be decreased to 60% to account for the increase in the energy percentage from total fats from 20% to more i.e. 27-28%.

The NRVs did not allocate an AMDR for either added or total sugars as there was insufficient evidence. However, it is noted that “The WHO together with a number of countries such as the UK and Germany recommended equal or less than 10% of energy from added sugars, whilst the Food and Nutrition Board: Institute of Medicine sets the limit at 25% of energy for added sugars.”² The American Heart Foundation recommends that added sugars should contribute less than 420KJ/day for women and 630KJ/day for men. DAA recommends that the rNRV for sugars is set at 10% of energy from added sugars.

DAA also contends that the majority of carbohydrate be from low GI and low energy dense food sources. This message should form part of any education strategy.

6.7 Selection of 2006 NRVs for Sodium

DAA agrees that the upper limit value for sodium should not be used as the basis for a future rNRV. DAA supports the FSANZ preferred approach to use the SDT value for sodium as the rNRV value for sodium if the rNRVs in the Code are revised.

The current rNRV is 2300mg which is the adult UL. Sodium is acknowledged to be different from most other nutrients in that it is the only one with both an AI and an SDT and for which the population intake generally exceeds the SDT. The FSANZ approach is to adopt the SDT of 1600mg as a more reachable rNRV. That is 4 g salt per day.

DAA wishes to acknowledge the food industry’s commitment to salt reduction programs via voluntary internal policy, the work of AWASH, and more recently the Food and Health

Dialogue. With targets to reduce consumer intake of salt to 6g by 2012 as part of population health promotion messages, implementing the SDT reflects this.

7.0 Others Matters relating to Current Nutrients in the Code

7.1 Units for Niacin

DAA notes FSANZ's concern that the proposed change to niacin equivalents results in a 50% increase in the rNRV value, with foods of differing protein levels being differently affected. While DAA is generally supportive of the change to niacin equivalents to better reflect the true niacin content of foods, we believe an assessment of the likely impact of higher levels of added niacin in lower protein foods is required. Modelling these potential changes to the food supply against the UL for niacin set by the NHMRC to ensure safe levels of niacin in the food supply should be undertaken.

7.2 Units for folate

DAA supports the preferred approach of basing the rNRV for folate on dietary folate equivalents. With a growing number of products being fortified with folic acid, and the difference in bioavailability with folate, it is appropriate to ensure consistency and provide a single unit to give consumers a better indication of the total folate available.

7.3 Dietary fibre

DAA supports FSANZ preferred approach 2 to adopt the 2006 NRVs for dietary fibre, and to update the code to include resistant starch in the definition of dietary fibre. DAA understands this approach is also supported by Go Grains, a leading independent organisation for grain foods and legumes in health and nutrition, as it would assist industry with opportunities to increase the dietary fibre in foods, and provide consumers and health professionals with better information with which to identify food sources for dietary fibre requirements.

DAA supports FSANZ preferred approach to update the Code's analysis methods for dietary fibre. However, it is of concern to DAA that the preferred approach of selecting the average of the fibre AI for men and women, results in an rNRV for fibre of 27.5g, a decrease of 2.5g compared to the current rNRV. This is a retrograde step in an area where even higher fibre intakes are known to be protective, and many people don't reach the current modest level of 30g.

DAA recommends that FSANZ consider adopting the average SDT for men and women, which would be 33g (based on 28g for women and 38 for men). We consider this to be a more appropriate figure and a move in the desired direction for optimising public health outcomes.

8.0 Potential New Nutrients and New Age Categories in the Code

8.1 New nutrients

DAA supports the inclusion of rNRVs for the new nutrients: linoleic acid, α -linolenic acid, long chain omega 3 fat, choline, fluoride and potassium. In principle, DAA does not object to using these rNRVs as the basis for setting content claim criteria. Any existing fortification permissions or claim criteria (such as for omega 3 fatty acids) should be reviewed taking into account the new rNRV together with current consumption patterns to ensure excess intakes do not result.

8.2 Potential new age categories for labelling purposes

The DAA supports introducing new age categories in the Code.

Currently rNRVs for the general population apply to those aged 4 years and upwards. It would be useful to have further categories in children given adult energy and micronutrient values, especially sodium, are not appropriate for children. For practical purposes, only one additional group may be necessary: an average of values for boys and girls aged 4-13 years, given many food products aimed at children would likely be given across this age range.

The new age category should include values for energy and macro- and micronutrients, including sodium for the following reasons outlined below.

1. Maintaining a low sodium intake in children is particularly important given children's kidneys are still maturing and salt appetites are often established in childhood.
2. A growing number of foods are fortified with vitamins and minerals, and given the current rNRVs largely reflect adult requirements, the % daily intake (%DI) on products aimed predominantly at children provides a significant underestimate of the product's contribution to these consumers' requirements. This could lead to excessive intakes of micronutrients in children.
3. Childhood obesity is a significant issue in Australia and given the %DI for energy and macronutrients reflects higher adult values, care-givers are being misinformed about the contribution foods make to their child's requirements which could encourage overconsumption.

The new age rNRVs would be expected to be listed in the NIP on food products aimed at children such as certain snacks and breakfast cereals. It should be specified in the NIP to what population group the values refer.

The DAA does not think it is necessary to introduce into the Code a new life stage group for pregnant and lactating women. While the nutritional requirements for this group are different to non-pregnant women, there are very few products that would be aimed specifically at pregnant and lactating women and the inclusion of rNRVs for pregnant and lactating women on all products is likely to be excessive. Furthermore these women receive a relatively high amount of education from health professionals through antenatal education. If a new category were to be added to all products for the general population, it would be preferable to have separate categories for males and females.

Further Comments

Wholegrains

The DAA recommends the inclusion of an rNRV for wholegrains be established as a Daily Target Intake (DTI) of 48g as proposed by Go Grains.

Consumer Education

DAA believes that the most important issue for FSANZ to consider in revising the rNRVs in the Code is consumer education. A change to the rNRVs in the Code may lead to many changes to labels in the supermarket and could easily lead to consumer confusion. A comprehensive education campaign developed between FSANZ and the food industry is paramount to the success of the rNRV revision.

DAA strongly recommends that a comprehensive education strategy targeting consumers and also health professionals, such as dietitians, GPs and nurses, is developed and appropriately

resourced in order to communicate the changes. The likely impact on government would include the links to the review of labelling law and policy, funding an education strategy and the approach to phasing in any changes to the Code.

Finally, the DAA would be pleased to be involved in further discussions on the draft rNRVs or to clarify any of our comments above.

References

1. Heart Foundation. 2009. Position Statement Dietary fats and dietary sterols for cardiovascular health.
2. Department of Health and Ageing, the NHMRC and Ministry of Health. Nutrient Reference Values for Australia and New Zealand. Commonwealth of Australia. Canberra. 2006.