FSANZ Amendment (Forum on Food Regulation and Other Measures) Bill 2015

Public Health Association
AUSTRALIA

Public Health Association of Australia

Submission on the Food Standards Australia New Zealand Amendment (Forum on Food Regulation and Other Measures) Bill 2015

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Executive Summary

The Public Health Association of Australia Incorporated (PHAA) believes that protecting public health and safety is the primary objective that FSANZ must take into account in decision-making. This review of the FSANZ legislation provides an opportunity to reaffirm the capacity of FSANZ to uphold this objective.

However, PHAA also believes that the proposed amendments would result in diminishing the capacity of FSANZ to uphold this primary objective rather than pursuing it. The proposed amendments also add to the potential for perceptions of conflict of interests affecting the Board decisions.

The PHAA:

- **does not support** omitting the NHMRC nominee to the Board
- **does not support** any reduction in the number of designated Public health/ science positions on the Board
- **does not support** the proposed amendment to omit notification of proposed amendments "in a generally circulating newspaper, in each State or Territory and in New Zealand" , and to substitute "on the Authority's website"
- **does not support** the proposed amendment to require the inclusion of a Regulation Impact Statement (RIS) only 'if applicable'

Details regarding these positions are included in our submission.

Introduction

The Public Health Association of Australia

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles. PHAA is a national organisation comprising around 1900 individual members and representing over 40 professional groups.

The PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and public events and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a close involvement in the development of policies. In addition to these groups the Australian and New Zealand Journal of Public Health (ANZJPH) draws on individuals from within PHAA who provide editorial advice, and review and edit the Journal.

In recent years PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all levels of Government and agencies, and promoting key policies and advocacy goals through the media, public events and other means.

Vision for a healthy population

The PHAA has a vision for a healthy region, a healthy nation, healthy people: Living in a healthy society and a sustaining environment, improving and promoting health for all

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PHAA's Mission

Is to be the leading public health advocacy group, to drive better health outcomes through health equity and sound, population-based policy and vigorous advocacy

Priorities for 2014 and beyond

Key roles of the organisation include capacity building, advocacy and the development of policy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. The aims of the PHAA include a commitment to:

- Advance a caring, generous and equitable Australian society with particular respect for Aboriginal and Torres Strait Islanders as the first peoples of the nation
- Promote and strengthen public health research, knowledge, training and practice
- Promote a healthy and ecologically sustaining human society across Australia, including tackling global warming, environmental change and a sustainable population
- Promote universally accessible people centred and health promoting primary health care and hospital services that are complemented by health and community workforce training and development
- Promote universal health literacy as part of comprehensive health care
- Support health promoting settings, including the home, as the norm
- Assist other countries in our region to protect the health of their populations, and to advocate for trade policies that enable them to do so.
- Promote the PHAA as a vibrant living model of its vision and aims

Preamble

PHAA welcomes the opportunity to provide input to the Standing Committee on Community Affairs with regard to the *Food Standards Australia New Zealand Amendment (Forum on Food Regulation and Other Measures) Bill 2015*. 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 reducing health inequities. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Health Equity

As outlined in the Public Health Association of Australia's objectives:

Health is a human right, a vital resource for everyday life, and a key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions of society that underpin people's health. The health status of all people is impacted by the social, political, and 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.

The PHAA notes that:

- health inequity differs from health inequality. A health inequality arises when two or more groups are compared on some aspect of health and found to differ. Whether this inequality (disparity) is inequitable, however, requires a judgement (based on a concept of social justice) that the inequality is

unfair and/or unjust and/or avoidable. Inequity is a political concept while inequality refers to measurable differences between (or among, or within) groups.

- Health inequity occurs as a result of unfair, unjust social treatment – by governments, organisations and people, resulting in macro politico-economic structures and policies that create living and working conditions that are harmful to health, distribute essential health and other public services unequally and unfairly, preventing some communities and people from participating fully in the cultural, social or community life of society.

Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

The determinants of health inequities are largely outside the health system and relate to the inequitable distribution of social, economic and cultural resources and opportunities. Health inequities are the result of the interaction of a range of factors including: macro politico-economic structures and policy; living and working conditions; cultural, social and community influences; and individual lifestyle factors.

Submission re the FSANZ Amendment (Forum on Food Regulation and Other Measures) Bill 2015

The Public Health Association of Australia (PHAA) welcomes the opportunity to comment on the proposed amendments to the Food Standards Australian and New Zealand (FSANZ) Act. Our comments are based on the principles of community engagement in the policy development processes and ensuring that the FSANZ Board members possess the necessary expertise and experience to enable sound judgements in line with the FSANZ Section 18 Objectives of protecting public health and safety through considering short-term and long-term risks and evidence based approaches, and enabling consumers to make informed decisions.

As outlined in the PHAA Food, Nutrition and Health Policy statement, and supported by the World Health Organization's Expert Committee on Diet, Nutrition and the Prevention of Chronic Disease, there is a strong link between food and beverage intake and a variety of chronic diseases including cardiovascular disease, type 2 diabetes, various cancers and risk factors such as obesity. Dietary factors present the greatest burden of disease in Australia.

Reviewing and setting food regulations in Australia and New Zealand plays a significant role in shaping our health and food supply, from determining levels of agricultural chemicals allowed, assessing new food-related technologies and considering food labelling and packaging. This responsibility exerts significant influence over public health outcomes, both short term and long term, as is acknowledged in FSANZ's own statement on its public health role.

The PHAA Food, Nutrition and Health Policy Position is included as an attachment provided at the end of this submission.

No Justification for the proposed changes to the composition of the FSANZ Board

The decision-makers within FSANZ, the Board members, play a critical role in influencing the food supplies in Australia and New Zealand, and hence are key decision-makers in relation to public health. It is therefore essential that Board members have strong backgrounds in public health and nutrition. Any changes that may potentially reduce the public health expertise of the Board decision-making processes should be avoided.

PHAA does not support omitting the NHMRC nominee as this is likely to reduce expertise relating to conduct of trials, scientific rigour, the quality of evidence, and a level of independence and objectivity. Choosing a Board member with a science qualification or background or current work within a commercial laboratory is unlikely to cover the independent expertise from a NHMRC nominee.

A NHMRC representative also can provide important cross links with nutrition policy guidelines (as identified in policy statement for food fortification as well as nutrition and health claims) and in particular would provide essential links with NHMRC policies such as the Dietary Guidelines for Australians.

PHAA does not support any reduction in the number of Public health/ science positions. Such people are the 'bread and butter' of the Board and should be increased, not decreased. PHAA would support two Board members with public health expertise and two actively working in science. Public and commercial confidence in the food regulatory processes depends on the Board being able to make, and being perceived to be able to make, objective, evidence-based decisions.

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The new proposed wording of – *7 members, with at least one from consumer, one from science and one from PH* provides greater flexibility to the Minister, potentially without consulting the Forum until after his/her decision, to have minimal Board membership for Public Health and Consumer (1 each of consumer, public health and science) and potentially up to 4 of the 7 Board members from industry. The science nominee also could come from an industry position, eg a food technologist in a food company. Science generically defined may not reflect that range of science matters before the Board and if the nominated Board member with a science background is from the food industry, it creates the public impression of food industry bias, thus undermining the authoritative role of the FSANZ Board and its deliberations.

We appreciate that the juggling of expertise is always a challenge, but this level of flexibility in selecting Board members has the potential to

1) Have a large number of members with strong industry ties;
2) Diminish the public health perspectives; and
3) Decrease the independence / objective scrutiny of the quality of the science.

Collectively these can lead to public perceptions of vested interests influencing Board decisions, or worse, the Board not having the rigour and objectively to make good evidence-based decisions that incorporate short term *and* long term health considerations.

Public notification of proposed changes to the Food Standards Code (Subsection 96(6)

PHAA does not support the proposed amendment to omit notification of proposed amendments "in a generally circulating newspaper, in each State or Territory and in New Zealand", and to substitute "on the Authority's website".

FSANZ has made efforts to establish circulation lists of interested parties who are notified about proposed changes to the Food Standards Code. However, withdrawing the requirement of notification in public newspapers and using only the Authority's website places the burden on the interested community, public health or food industry person to proactively seek the information. This requires the person to be aware of any proposed change and also the time frame involved so they can actively seek the information from the website. This may not be an issue for those who are in employed positions that support their time to monitor and seek such information on proposed changes, but disadvantages community members who lack such time and support. The result of the proposed change may skew the range of comments that are submitted and limit the effectiveness of the consultation process.

Regulation Impact Statement

PHAA does not support the proposed amendment to require the inclusion of a Regulation Impact Statement (RIS) only 'if applicable'.

The development of a Regulation Impact Statement is an important external (to FSANZ) review process to consider wider implications of any changes to the Food Standards Code. Primarily the Regulation Impact Statement (RIS) has a focus on impacts on industry and economic burdens. However, in light of the primary objectives of FSANZ and the intent of food regulations to protect public health and safety, if anything, the RIS should be expanded to consider wider impacts of food standards, such as on biological, social and environmental indices.

In relation to the proposed amendment, the criteria to determine when 'if applicable' applies is not clear and the absence of a RIS on a recommended amendment may provide grounds for the Ministerial Forum to reject a Board decision to amend the Food Standards Code. If this proposed amendment is accepted, it should be accompanied by clear criteria for when 'if applicable' will or will not be relevant.

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Conclusion

The PHAA notes the primarily administrative changes in the Amendment Bill but does not support the changes that may impact on the science and public health expertise and independence of Board members, nor does it support a diminution of public notification of proposed changes to the Food Standards Code.

We hope that our perspectives contribute to the decision making process of what is right in relation to the proposed amendments to the FSANZ Act. We are more than happy to provide further details on topics or to discuss issues over the phone or in person.

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Chief Executive Officer
Public Health Association of Australia

30 October 2015

Appendix A.

PHAA Food, Nutrition and Health Policy

Policy-at-a-glance –Food, Nutrition and Health Policy

Key message:

PHAA recommends that Australian Governments –

1. Take the primary steering role in developing food and nutrition policies and provide leadership for coordinating and facilitating consistent action by other departments and government agencies such as agriculture, education, urban planning, transport and welfare;

2. Continue to review and promote guides for the population such as Dietary Guidelines for Australians and the Australian Guide to Health Eating that provide consistent, coherent, simple and clear healthy eating messages that can be conveyed by a range of organizations to improve nutrition literacy; and

3. Ensure that the major priority in all food legislation is ensuring that the food and beverages produced by the food industry are ones associated with good health.

Summary: PHAA's vision is for a safe, affordable, secure and environmentally sustainable food system accessible to all Australians for health, wellbeing and prosperity now and into the future. All Australians should have access to healthy, affordable and acceptable food. Food and nutrition policies ensuring health goals as a top priority should be developed at local, state/territory and national levels and these policies should integrate agricultural, economic, food production and distribution, social, educational, and environmental factors. There is urgent need for a National Food and Nutrition Policy similar to the 1992 Australian Food and Nutrition Policy to direct action towards healthier foods across all sectors. This policy seeks to outline a series of principles and tangible actions designed to achieve these goals.

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Audience:	Australian, State and Territory Governments; National Health and Medical Research Council; Food Standards Australia and New Zealand; policy makers and program managers.
Responsibility:	PHAA's Food and Nutrition Special Interest Group (SIG)
Date policy adopted:	September 2012
Contact:	Helen Vidgen & Simone Braithwaite, Co-Convenors, Food & Nutrition SIG – h.vidgen@qut.edu.au; skbraithwaite@gmail.com

Food, Nutrition and Health Policy

The intention of this document is to state the Public Health Association of Australia's overall position on food and nutrition and to serve as the food and nutrition umbrella policy to support, and be supported by further detail in other PHAA policy statements:

- Food and Nutrition monitoring and surveillance in Australia
- Food Security for Aboriginal and Torres Strait Islander Peoples
- Marketing of food and beverages to children
- Promoting Healthy Weight: Prevention and management of overweight and obesity
- Genetically modified foods
- Health claims on food

The Public Health Association of Australia notes that:

1. Food is a human right. "Everyone has the right to a decent life, including enough food, clothing, housing, medical care and social services. Society should help those that are unable to work because they are unemployed, sick, disabled or too old to work. Mothers and young children are entitled to special care and assistance" (Universal Declaration of Human Rights, 1948).

2. World Health Organizations' (WHO) Expert Consultation on Diet, Nutrition and the Prevention of Chronic Disease in 2003 examined the evidence of the relationships between food and beverage intakes and physical activity and the major nutrition-related chronic diseases. The report documented the strong link between food and beverage intake and a variety of diseases like cardiovascular disease, various types of cancers and Type 2 diabetes, as well as a link to risk factors such as obesity. Type 2 diabetes is expected to become the leading case of disease burden by 2030 (Australian Institute of Health and Welfare, 2012). Food and beverage intakes based on predominantly relatively unprocessed vegetables, fruits, and grains with small amounts of nutrient dense dairy products, meat and fish support good health. Large consumption of high-energy (kilojoules) foods and foods high in saturated fat, added sugars and salt contribute to non-communicable diseases.

3. Food and beverages are composed of a complex array of constituents including individual nutrients. Improving health outcomes by isolating individual nutrients has not been replicated by clinical trials using dietary supplements. The health benefits of nutrients cannot be delivered in isolation and may even cause adverse effects (Jacobs, Gross & Tapsell, 2009). Food and beverages must be the focus of food and nutrition policy decisions including dietary guidelines and research in this area.

4. Food and beverage requirements vary across stages of the lifecycle, genders and physical activity levels. Not only will food and beverage choices affect health but also consideration must be given to the portion sizes of meals and snacks and the frequency of consumption.

5. Australians have a right to expect to be food secure i.e. to have access to nutritionally adequate, affordable and acceptable food acquired in socially appropriate ways. The major determinants of food security are a nutritionally adequate, accessible and affordable local food supply. Factors specific to individuals are important; income, physical access and individual resources such as nutrition knowledge, budgeting and food preparation skills.

6. The provision of nutritious, affordable, accessible and acceptable food should take into consideration the sustainability of natural resources both in Australia and in the countries from which we import food.

7. Unlike other developed economies there has been no recent systematic public health assessment of the current food supply with particular reference to the production and availability of both nutritious foods and energy dense, nutrient poor foods. The most recent ABS data 1997-1998 food balance sheet assessment of the nutritional adequacy of the Australian food supply, showed that with the exceptions of thiamin and calcium, sufficient energy and all the nutrients were available to meet nutritional needs of all Australians (ABS 2000).

8. The Australian Government's Preventative Health Taskforce has outlined ten specific Key Action Areas for the prevention of obesity. The Key Action Areas identified by the Taskforce are supported by the Public Health Association of Australia as part of the broader framework for food, nutrition and health policy in Australia (National Preventative Health Taskforce, 2009).

The Public Health Association of Australia confirms that in relation to nutritious foods and beverages for health:

9. Food and beverage intake in Australia contributes substantially to burden of disease as measured by disability adjusted life years (DALYs) (Begg et al, 2007). The summative contribution of selected food and drink related risk factors measured contributed a greater proportion of the burden of disease than did tobacco or alcohol (Australian Institute of Health and Welfare (AIHW), 2012).

10. Overweight and obesity continue to be major risk factors for disease in adults and children in Australia and present a major public health challenge. People of all ages and backgrounds face this

risk. The 2007-08 National Health Survey measured body mass index (weight/height$_2$) and found that 25% of adults were obese and 73% were overweight (ABS, 2009). This was in total 68% of men and 55% of women. One quarter (25%) of children aged between 5 and 17 were overweight or obese (17% overweight and 7.8% obese). Overweight and obesity develops because of an energy imbalance between physical activity and energy (kilojoules) consumed. Excess energy intakes are the major determinant to this energy imbalance (Stubbs and Lee, 2004: WHO, 2003). The 1995 National Nutrition Survey demonstrated that both adults and children over consumed at two to four times the recommended limits of non-core (unhealthy) foods and that these contributed excessively to energy (36% adults and 41% children) and fat (41% adults and 47% children) intakes (Rangan et al 2008a and Rangan et al 2008b).

11. Large proportions of Australian adults and children do not consume the recommended amounts of fruits and vegetables for good health despite some improvements in national and state *Go for 2 & 5* campaigns. (ABS, 1997, Pollard et al 2008). Younger people tend to have lower intakes than older people.

12. The 2007 National Child Nutrition and Physical Activity survey demonstrated that children still do not achieve recommended intakes of healthy foods like fruits and vegetables for good health and continue to consume higher than recommended intakes of noncore foods such as soft drink, chips, biscuits and lollies (Commonwealth Department of Health & Ageing, 2008).

13. There are significant economic costs associated with unhealthy food and drink choices (Crowley et al 1992). These costs affect not only the direct cost of running Australia's health care system but also indirect and intangible costs to individuals and society. Access Economics has calculated that the total cost of obesity in 2008 was $58.2 billion. There are significant savings to be made to the health care system and society by the provision of consistent funding for large scale and local public health nutrition programs (Marks, Coyne & Pang, 2001, Marks et al 2001).

14. Increasingly Australians are consuming foods prepared outside the home with 28% of total food expenditure made on food from restaurants, cafes, takeaway or fast food outlets (ABS 2006). From the most recent 1995 National Nutrition Survey (ABS 1997), a high consumption of foods prepared outside the home is associated with high intakes of saturated fat, sugar, salt, alcohol (in women) and low intakes of iron, fibre and calcium (Burns et al, 2002). Changes in social and economic conditions within Australia drive the continued demand for convenience or fast foods. It is important that the choice of foods in out-of-home settings include foods that are nutritious and affordable. There should be regular monitoring of the cost and nutritional contents of convenience foods as part of a comprehensive nutrition surveillance system for Australia.

The Public Health Association of Australia confirms that in relation to the accessibility of healthy food:

15. In remote areas, the supply of healthy foods continues to be poor. In rural areas food access may be compromised (Burns et al 2004). In urban areas, provided individuals have access to transport, a nutritionally adequate diet is accessible and available (Turrell et al, 2004, Winkler, Turrell & Paterson, 2006, Burns & Inglis, 2005). However, those who do not own a car and are dependent on

public transport may be food insecure due to lack of access (Burns & Inglis, 2005; Burns et al 2011). Physical barriers may also compromise access for individuals with a disability (Sutherland, Couch & Iacono 2002) and the elderly (Russell, Hill & Basser, 1998). It is important that rural development and urban planning take into account the ease of food access for all residents.

16. Many studies, both overseas and in Australia, have investigated the possibility of *food deserts (*poor food availability in socio-economically disadvantaged areas). The results to date from two geographical areas in Australia do not indicate that poorer neighbourhoods have inferior food availability (Turrell et al 2004, Winkler, Turrell & Paterson, 2006). Research in South Australia has established lower availability of supermarkets in poorer areas, but food intake was more likely to be limited in households that did not have independent access to shops (Coveney & O'Dwyer, 2009). It is likely that blanket statements about area level socio-economic disadvantage cannot be made and the assessment of community food security in individual cities, towns and neighbourhoods is necessary.

The Public Health Association of Australia confirms that in relation to affordable healthy food:

17. Food and non-alcoholic beverages were the largest single category of household expenditure (17% of household expenditure on goods and services) in the 2003-04 Household Expenditure Survey (HES) (ABS, 2006). HES data consistently demonstrates that low-income households spend a greater proportion of income on food than high-income households (20% vs. 15% in the 2003-04 HES).

18. Increasing amounts of disposable income results in increased expenditure on food items, which at least for low-income households has been associated with improved nutritional dietary quality and a greater proportion of diets meeting minimal acceptable levels of intake for various dietary constituents (Karp, Cheung & Meyers, 2005). It is important that government welfare and pension payments enable the purchase of healthy foods to meet dietary requirements.

19. Income and lack of financial resources are a major determinant of food security. Poverty is a real issue in Australia. The current estimates for poverty in Australia range from 4.1 million to 1.5 million (The Commonwealth Government recently published the Report on Poverty and Hardship 2004 – "A hand up not a hand out" (Commonwealth of Australia 2004). Analysis of poverty trends from 1990 to 2000 indicated that in all but one study poverty rates in Australia did not decrease over the decade, in spite of the nation's economic growth (Brotherhood of St Laurence 2002 (www.bsl.org.au).

20. Data from Queensland's Healthy Food Access Basket (HFAB) surveys conducted biennially since 1998 indicates that the cost of the Healthy Food Basket continues to be considerably higher in rural and remote locations in Queensland. Since 2000, the annualized per cent increase in the cost of the HFAB has been higher than the increase in the Consumer Price Index for food in Brisbane (Harrison et al 2007; Queensland Health, 2011). Consumers, particularly those in very remote areas need to pay substantially more for healthy foods. Conversely, some less nutritious foods such as sweetened carbonated beverages are now relatively more affordable. Data from the Northern Territory also confirms that high energy density foods are generally cheaper to purchase (Brimblecombe & O'Dea, 2009). Victorian research on healthy food baskets (VHFB) did not demonstrate the same issues with

remoteness but did demonstrate that fruits and vegetables were the most expensive component of the VHFB to purchase (Palmero et al 2008). The Illawarra Healthy Food Basket surveys from 2000 to 2007 demonstrated that the greatest increases in prices were for vegetables and fruits (Williams, Hull & Kontos, 2009). Relatively higher prices of healthy foods are a key barrier to acquiring food for good health among the socio-economically disadvantaged and other vulnerable groups.

21. There needs to be further investigation into the causes and effects of the increasing cost of basic healthy food compared to less nutritious alternatives. There should be regular and national monitoring of food cost as part of a comprehensive nutrition surveillance system for Australia. The regular monitoring of food costs would enable the determination of dietary budget standards for households of varying size and composition (Saunders 1998). It is important to develop these as benchmarks for social and public health policy.

22. In the 1995 National Nutrition Survey of adults 16 years and over 5% of Australians reported being food insecure i.e. in the previous year they had ran out of food and did not have enough money to buy more (ABS 1997). The frequency rose to 9% of persons in the areas of most disadvantage, 13 % of persons on low income and 16.5% of persons on low income who were aged 16-24 years. More recent studies using complex measurements have found food insecurity as high as 21% in Sydney suburbs (Nolan et al, 2006). Food insecurity is associated with the consumption of a poor variety of foods (particularly plant foods), and a lower intake of major food groups required for health (Wood et al, 2001). While subgroups of the Australian population are at risk of malnutrition as a consequence of food insecurity, the literature also indicates a paradoxical link between food insecurity and obesity in women (Burns 2004).

23. There is limited evidence to decide whether socially disadvantaged individuals and families do not eat a nutritious diet because of a lack of knowledge or education (Burns 2004). Yet it must be noted that there is currently a lack of knowledge about food, cooking and budgetary skills among Australians from all social strata (Worsley 2002). These food related skills should be accepted and promoted as necessary life skills. It is important that children, adolescents and young adults be supported in acquiring knowledge about food and food skills like cooking through community programs like school kitchen gardens.

The Public Health Association of Australia confirms in relation to the acceptability of healthy foods that:

24. Australia's traditional Aboriginal and Torres Strait Islander peoples recognized the diversity of native flora and fauna as providing a healthy intake and many of these foods are culturally valued today and where possible should be promoted as part of a healthy food supply (Lee et al 2009).

25. Australia continues to increase in cultural diversity, particularly through schemes such as the Humanitarian Entrant Program that has increased the number of persons from different descents now residing in Australia. The top five countries of birth for refugee visas for 2007-08 were Burma/Myanmar, Iraq, Afghanistan, Sudan and Liberia (Commonwealth Department of Immigration and Citizenship, 2008). It is important that all peoples be able to access nutritious food that is culturally acceptable.

26. New migrants and refugees need to be supported by community programs that help them acquire healthy, culturally acceptable foods and prevent them from becoming food insecure. Refugees may choose to consume cheaper high kilojoule foods and this will have a potential impact on health (Renahzo and Burns, 2003).

27. Good nutrition programs need to consider the literacy levels, local culture and communication barriers for a variety of sub groups in the Australian population, such as Aboriginal and Torres Strait Islander groups.

The Public Health Association of Australia affirms that:

28. A safe, affordable, secure and environmentally sustainable food system accessible to all Australians for health, wellbeing and prosperity now and into the future is vital. A national food and nutrition policy is required with the objectives of enabling Australians to understand, choose, consume and enjoy a high quality diet comprised of safe, nutritious, affordable and environmentally sustainable food from a prosperous food system whilst preventing diet-related ill health.
29. Food and nutrition policies ensuring health goals as a top priority should be developed at local, state and national levels and that these policies should integrate agricultural, economic, food production and distribution, social, educational, and environmental factors. There is urgent need for a National Food and Nutrition Policy similar to the 1992 Australian Food and Nutrition Policy to direct action towards healthier foods across all sectors. (http://www.foodsecretariat.health.gov.au/internet/main/publishing.nsf/Content/phd-nutrition-fnp-1992). WHO's 2004 Global Strategy on Diet, Physical Activity and Health calls for the formulation of national policies, strategies and action plans to improve food and beverage intake (WHO, 2004).

30. .A national food and nutrition surveillance system is required to monitor health and include regular national monitoring of the cost and accessibility of both health enhancing and less beneficial food and beverages.

31. Agricultural policies, taxation and subsidies should support the affordability and accessibility of healthy food and beverages.

32. All Australians should have education to ensure that they have knowledge about healthy foods, food budgeting and food preparation, such as cooking skills.

33. There are considerable challenges in promoting healthy foods in Australia's food and nutrition system that will require the reduced production of unhealthy foods and beverages and this will produce conflict between health and other sectors within the food and nutrition system.

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The Public Health Association of Australia believes that given the intersectorial factors impacting on the food and nutrition system for Australians the following actions should be supported by the Council of Australian Governments (COAG) and Food Standards Australia and New Zealand (FSANZ):

34. Determine optimum levels of nutrient intake and explore the distribution of these levels amongst different socioeconomic groups and how this is translated into food and beverage recommendations, particular for dietary guidelines.

35. Monitor health behaviours and the long-term effects of regular food access and food consumption patterns on health outcomes.

36. Continue to support research into the extent and nature of the relationship between diet related health issues and inequity in Australia. A research priority should be the development of national, state and local public health interventions to ensure both community and individual food security.

The Public Health Association of Australia believes the following actions should be taken by Commonwealth, State, Territory and Local Governments:

37. Provide the primary steering role in developing food and nutrition policies and the leadership for coordinating and facilitating other departments and government agencies such as agriculture, education, urban planning, transport and welfare.

38. Direct action at all levels to use their purchasing power in the market to ensure that the food supply under their control offers affordable and acceptable nutritious food. This includes government catering organisations, hospitals, schools, day-care centres, welfare services and workplaces.

39. Continue to review and promote guides for the population such as Dietary Guidelines for Australians and the Australian Guide to Health Eating that provide consistent, coherent, simple and clear healthy eating messages that can be conveyed by a range of organizations to improve nutrition literacy.

40. Encourage the development of education programs incorporating knowledge and skill development about food in schools, in the community, in institutions and in the food industry that motivate people to prepare and consume healthy food.

41. Ensure that the major priority in all food legislation is ensuring that the food and beverages produced by the food industry are ones associated with good health.

42. Enable food labelling to provide accurate, standardized and comprehensible information on the front of pack and back of pack to allow Australians to make quick, easy and healthy food choices at the point of purchase and to ensure foods do not carry misleading claims.

43. Ensure that current food safety standards are enforced and reviewed at five yearly intervals.

44. Reduce marketing, advertising, sponsorship and promotion messages that encourage unhealthy food and beverage choices, portion size and frequency of consumption, particularly the marketing and advertising directed at children via television, websites, magazines and sporting organizations.

45. Introduce a national food and nutrition monitoring and surveillance system incorporating all facets of the food and nutrition system including the regular monitoring nationally of regular food access and the cost of healthy foods and foods that are less health enhancing.

The Public Health Association of Australia resolves that:

46. The National Office will present this agenda for action to the appropriate Minister(s) of the Commonwealth government and Branches should approach State Ministers.

47. The National Office will approach the Council of Australian Governments (COAG), National Health and Medical Research Council (NHMRC) Food Standards Australia and New Zealand (FSANZ) to seek support for research identified in this policy.

ADOPTED 2006, REVISED AND RE-ENDORSED IN 2009 AND 2012

First adopted at the Annual General Meeting of the Public Health Association of Australia 2006. Revised and re-endorsed in 2009 and 2012.

Other PHAA supporting policy statements

- Ecological Sustainable Development Policy

References

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