



Submission from the Cancer Society of New Zealand

On the: *Review of Food Labelling Law and Policy*

The Cancer Society of New Zealand

The Cancer Society of New Zealand is a not for profit organisation funded by caring New Zealanders. Our mission is: To improve community well-being by reducing the incidence and impact of cancer. The evidence of increased risk of cancer associated with Overweight and Obesity is strong. The Cancer Society welcomes the decision by the Australian and New Zealand Food Regulation Ministerial Council to undertake a comprehensive review of food labelling law and policy which will consider options to reduce the regulatory burden in food labelling without compromising public health and safety.

Recommendations:

The food labelling law and policy should:

- support consumers to select healthier foods with a Front of Pack (FoP) Traffic Light (TL) labelling scheme that is introduced with a public education campaign.
- be strictly enforced to prevent industry non-compliance, to minimise consumer confusion and to ensure compliant companies and food service organisations are not disadvantaged relative to non-compliant companies. The system must:
 - be mandatory, not voluntary to eliminate loopholes, maximise impact, reduce inequities within industry and better ensure consistency;
 - be supported by appropriate penalties to encourage compliance; and
 - be actively enforced;
- be closely monitored and evaluated against its specified goals and objectives. If necessary, be adjusted over time in order to best meet the objective of empowering consumers to make healthier food choices and encouraging industry to improve the quality of the food supply;
- be part of a broader framework for addressing obesity and chronic disease involving consumer education and policy and legislative initiatives;
- be given priority so the system is introduced reasonably quickly;
- not be delayed or derailed by industry stakeholders with vested interests ie those who market unhealthy foods which would be highlighted by the system;

- have a time limitation on the sale of unlabelled existing shelf stock; and
- ensure the costs of mandatory labelling are the responsibility of the industry and not passed onto consumers.

Evidence to support these recommendations

Burden of Disease Related to Obesity

Obesity is regarded as a risk factor for cancer, as well as many other chronic diseases, such as cardiovascular disease (heart disease and stroke) and type 2 diabetes.

The World Health Organization now describes the prevalence of obesity as an epidemic. There's been a rise in obesity in New Zealand in recent decades - from 9% (males) and 11% (females) in 1977 to 20% and 22% respectively in 2003 (Ministry of Health 2008).

The 2006/07 New Zealand Health Survey found that:

- one in three adults was overweight (36.3%) and one in four obese (26.5%).
- one in five children aged 2 to 14 years were overweight (20.9%) and one in twelve was obese (8.3%) (Ministry of Health 2008).

In New Zealand an estimate of the impact of higher than optimal BMI on cancer mortality put the figure at four percent of all cancer deaths. However, the authors note this is likely to be an underestimate since only colorectal and post menopausal breast cancers were included in the calculation and the risk coefficients used were conservative (Ministry of Health & University of Auckland 2003).

Breast cancer is the leading cause of death in females, accounting for almost 20 percent of all cancer deaths in women. Over 80 percent of breast cancer deaths are post-menopausal. It is estimated that approximately 15-20 percent of post-menopausal breast cancer deaths in 1997 could be attributed to 'high' BMI.

Approximately 15 percent of colorectal cancer was attributable to 'high' BMI in older age groups of New Zealanders (65 years and older), when the most colorectal cancer deaths occur (Ministry of Health & University of Auckland 2003).

In 2004, colorectal and breast cancer, which are two of the three leading cancer registrations and causes of death in New Zealand, have convincing evidence of BMI being a risk factor (New Zealand Cancer Registrations).

Obesity and Cancer Prevention: Epidemiological Evidence

In 2007 the World Cancer Research Fund and the American Institute of Cancer Research (WCRF/AIRC) released a comprehensive report on food and the prevention of cancer. The report found *convincing* evidence that excess body fat is a risk factor for cancers of the colon, kidney, pancreas, oesophagus, endometrium and post-menopausal breast cancer. It also found that excess body fat *probably* increased the risk of gallbladder cancer and there was *limited suggestive* evidence that excess body fat increased the risk of liver cancer. However, excess body fat was also found to *probably* decrease the risk of pre-menopausal breast cancer (WCRF/AIRC 2007).

The WCRF/AIRC found that abdominal fatness was *convincingly* associated with an increased risk of colorectal cancer, and *probably* increased the risk of cancer of the pancreas, endometrium and breast (in post-menopausal women). The report also stated that weight gain in adulthood *probably* increases the risk of post-menopausal breast cancer.⁷

Table 1 describes the proportion of cancer attributable to overweight and obesity factors (Calle et al,2003, Boyle et al, 2003 & Calle & Kaaks,2004).

Table 1: Proportion of cancers attributable to overweight and obesity

Cancer Type	Proportion of incidence attributable to overweight or obesity	Aspects of the association between overweight or obesity and cancer
Endometrial cancer	39%	Women with a BMI of >25 have a two- to three-fold increase in risk Limited evidence suggests risk is similar in pre- and post-menopausal women Risk is greater with upper body obesity
Oesophageal adenocarcinoma	37%	Strong association between being overweight and adenocarcinomas of the lower oesophagus and the gastric cardia, with a two-fold increase in risk in individuals with a BMI of >25 Association seems greater in men than women
Renal (kidney) cancer	25%	Individuals with a BMI of >30 have a two- to three-fold increase in risk compared to those below 25 The effect is similar in men and women
Gallbladder cancer	24%	Limited evidence available but there is a suggestion of almost a two-fold risk, especially in women
Colon cancer	11%	Association seems greater in men than women Risk not dependent on whether person has been overweight in early adulthood or later in life
Post-menopausal breast cancer	9%	Increase in risk of 30% in women with a BMI >28 compared to those with a BMI of <21

Nutrition labels are an important part of a supportive environment that can assist people to make healthy food choices. Improving their ease of use and understanding has the potential to promote healthier food choices (Ni Mhurchu and Gorton 2007).

Role of government in the regulation of food labelling

Principles that should guide decisions about government regulatory intervention

The Cancer Society believes the role of government is central to the regulation of food labelling. Food labels can assist consumers to make healthy food choices. The following three principles should guide government decisions:

A commitment to improving health outcomes

First and foremost government must be guided by a commitment to improve health outcomes which is not swayed by industry interests. Food Standards Australia New Zealand's vision is a *safe food supply which supports the health of people in Australia and New Zealand*.

The Terms of Reference for the Review of Food Labelling Law and Policy acknowledge there are different policy drivers impacting on food labelling laws. The Cancer Society believes the focus must be on supporting the health of Australian and New Zealander people. Food sales are an important and essential part of the economies of New Zealand and Australia. However, the costs of obesity to the government are very real and like obesity growing. In 1991 the direct costs of obesity to New Zealand's health care system were conservatively estimated at \$135 million per year, or 2.5 percent of health expenditure for that year. On this basis the figure for 2000/01 would have been at least \$247.1 million, and it will be higher today (Report of the Health Committee 2007).

A commitment to reducing inequalities in health outcomes

Public health principles must be central to the role of government in the regulation of food labelling. There are large disparities in the determinants of health between different groups within the population.

Any regulatory intervention must consider those population groups that currently have the poorest health. In New Zealand these groups include Maori, Pacific people and people with low incomes. A system that works for these groups will also work for the general population, however, the reverse is not true. Too often decisions are made based on meeting the needs of the 'general population'. These decisions often further disadvantage the population groups that have the least choices and resources.

A commitment to evidence-based decision making

Consumers want access to unbiased information that enables them to make healthy food choices. While nutrient content information is important it is not sufficient in itself for most consumers to answer the question 'is this a healthy food?' Consumers require information that comes from a sound scientific base, is simple to understand and translates easily into informed food choices.

There is a large body of evidence showing that food labelling does have an impact on consumer choice. There is an equally large body of evidence showing that consumers are confused by current food labelling (Cowburn and Stockley 2005). Any regulatory system should be based on evidence of effectiveness.

Policies and mechanisms to ensure government plays its optimum role

One policy

The Cancer Society believes there should be an overarching policy to encompass all aspects of food labelling. The current arrangement where separate policy guidelines for different aspects of food policy are developed, such as for front of pack labelling, and nutrition and health claims, is cumbersome, difficult to navigate and fails to provide a clear direction for the promotion of public health. The development of an overarching food labelling policy would ensure that the fundamental principles of public health and consumer protection are maintained and increased.

One mandatory labelling system

One mandatory labelling system is required that ensures consumers receive clear and consistent messages. The system must be based on full disclosure of information. This avoids the current system where manufacturers can selectively promote via nutrition content claims certain nutritional characteristics of their products. Currently these claims can be interpreted as the food providing health benefits (such as high calcium content, low fat content or the presence of certain vitamins or minerals), while failing to disclose (other than on the NIP) other characteristics of their product which make them unhealthy overall, such as high sugar or high fat content.

The voluntary percentage daily intake (%DI) labelling scheme entered into by some food manufacturers is failing to protect consumers from potentially misleading or deceptive food packaging and labelling. These misleading labelling practices confuse consumers and contribute to the problems of obesity and overweight

Voluntary systems do not protect the interests of consumers. They are confusing potentially misleading and create unfair commercial advantage. Following their comprehensive evaluation of the evidence relating to food labelling schemes, the World Cancer Research Fund and the American Institute for Cancer Research recommended that governments should “ensure accuracy, uniformity, and availability of product information in all advertising and promotion and on food labels”. They further stated that:

“As with advertising and marketing of processed foods, voluntary codes are evidently not effective in leading to adequate or universally applied labelling systems. The main action here needs to be taken by governments” (WCRF/AICR 2009 p.124).

The principles and approaches to achieve compliance with labelling requirements and appropriate consistent enforcement

Compliance with any legislation requires appropriate and consistent enforcement. Non-compliance requires penalties that signal to industry the importance of this legislation.

Compliance and enforcement of mandatory labelling legislation should be undertaken as an active process and not left to a complaints process to identify non-compliant products.

Improve food labelling law and policy

Mandatory Traffic Light Labelling system

There is strong New Zealand research which indicates the most at risk populations, Maori, Pacific and low Socio Economic Status (SES) consumers (Signal et al 2008), fail to understand the information already on food labels and that simple interpretive labels are more easily understood (Maubach and Hoek 2008). International, New Zealand and Australian research supports the introduction of colour coded interpretive front of pack labelling (FOPL).

A recent Australian study tested different FOPL systems including the Percentage Daily Intake (%DI) system and the Traffic Light (TL) system which uses colour-coding to indicate nutrient levels. Using the TL system, participants were five times more likely to identify healthier foods compared with the Monochrome %DI system [odds ratio (OR) = 5.18; $p < 0.001$], and three times more likely compared with the Colour-Coded %DI system (OR = 3.01; $p < 0.05$). The authors concluded the TL system was the most effective in assisting consumers to identify healthier foods and recommended mandatory TL labelling regulations to assist consumers in making healthy food choices (Kelly et al 2009).

Similarly a recent European study clearly indicated that labels helped to identify healthier foods better than un-labelled food. As with the Australian study this study compared different labelling systems. This study found the multiple traffic light (MTL) system showed the best performance. For most of the pair-wise comparisons the MTL format showed the highest percentage of correct choices, and also the overall number of correct decisions was highest with this labelling format (Borgmeier and Westenhoefer 2009).

Consumers prefer, and are better able to understand, the Traffic Light Labelling which assists them to identify healthier food products at point of sale. Non-interpretive systems, such as %DI, are not understood by many consumers and especially by those in the most disadvantaged groups in which chronic diseases are more prevalent. The %DI is too difficult for consumers with low literacy and numeracy skills. NB the background paper (Information prepared by the 2007/08 Food Regulation Standing Committee (FRSC) Front of Pack Labelling (FOPL) Working group) noted that in the United Kingdom around half of the population did not understand percentages.

The Cancer Society believes Multiple Traffic Light (MTL) Front of Pack (FoP) Labelling should be the only scheme allowed to be used in New Zealand. If other types of FOP Labelling are used as well it is likely to lead to confusion. The MTL FPO Labelling scheme would provide simple clear information which can be interpreted quickly in the supermarket and the nutrition information panel (NIP), in its present form, will continue to provide the additional information needed.

Consumer education would be necessary at the introduction of the Multiple Traffic Light Labelling scheme but it is a much simpler concept to get across than the other options and should therefore require less resource. This education would need to be effective for groups that do not presently use and/or understand food labels. New Zealand literature (Signal et al 2008) suggests Maori and Pacific groups do not use food labelling information at present.

Long term benefits in improved nutrition and health will only occur if the labelling system is easy for all consumers to understand. Improved nutrition status could potentially result in substantial cost savings in health care costs and productivity.

The Cancer Society recommends a Multi Traffic Light system which includes a colour coded (red, amber & green) interpretive labelling for important individual nutrients for each food groups, eg. sugars, fats and fibre combined with an overall interpretive rating for the whole food product.

Health and nutrition content claims

The Cancer Society strongly supports the regulation of health and nutrition content claims and understands that FSANZ is continuing to consider issues raised by the Ministerial Council about the regulation of health and nutrition content claims. Appropriate eligibility/disqualifying criteria for nutrition content claims are required so that unhealthy foods are not permitted to make potentially misleading or selective nutrition claims. A lack of disqualifying criteria means that foods that are unhealthy overall may nevertheless be permitted to highlight a single beneficial nutrition characteristic without disclosing the overall unhealthiness of a product.

Standard serving sizes

Furthermore the Cancer Society supports criteria for the levels of key nutrients should be based on 100g or 100mL of the food or beverage product to avoid deceptive serving size manipulation by manufacturers and for easy comparison for consumers. On a recent supermarket visit the Obesity Action Coalition found breakfast cereals with serving sizes of 30g, 40g, 45g and 55g. This makes product comparisons complicated.

A further complication with breakfast cereals is that some provide nutrition information including milk (usually trim rather than whole milk as it makes the nutrient profile look better) while others provide information for the cereal alone.

Summary

In summary the food labelling law and policy should;

- support consumers to select healthier foods with a Front of Pack (FoP) Traffic Light (TL) labelling scheme that is introduced with a public education campaign.
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- have a time limitation on the sale of unlabelled existing shelf stock; and
- ensure the costs of mandatory labelling are the responsibility of the industry and not passed onto consumers.

The Cancer Society of New Zealand looks forward to the results of this review in anticipation that the outcome will protect consumers from potentially misleading food labelling and ensure healthy food choices are easy to make.

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Kathy Chapman, Cancer Council Australia & Leigh Sturgiss, Obesity Action Coalition

Contact details:

For further information contact

Dr Jan Pearson
Health Promotion Manager
Cancer Society of New Zealand
P O Box 12700,
Wellington, New Zealand

References

Borgmeier I and Westenhoefer J. Impact of different food label formats on healthiness evaluation and food choice of consumers: a randomized-controlled study. *BMC Public Health* 2009;9:184.

Boyle P, Autier P, Bartelink H, Baselga J, Boffetta P, Burn J *et al.* European Code Against Cancer and scientific justification: third version (2003). *Ann Oncol.* 2003; 14(7): 973-1005.

Calle EE, Rodriguez C, Walker-Thurmond K, Thun MJ. Overweight, obesity, and mortality from cancer in a prospectively studied cohort of U.S. adults. *N Engl J Med.* 2003; 348(17): 1625-1638.

Calle EE, Kaaks R. Overweight, obesity and cancer: epidemiological evidence and proposed mechanisms. *Nat Rev Cancer.* 2004; 4(8): 579-591.

Cowburn G, Stockley L. Consumer understanding and use of nutrition labelling: a systematic review. *Public Health Nutrition* 2005;8:21-8.

Kelly B, Hughes C, Chapman K *et al.* Consumer testing of the acceptability and effectiveness of front-of-pack food labelling systems for the Australian grocery market. *Health Promot Int* 2009;24(2):120-9.

Maubach N and Hoek J. The effect of alternative nutrition information formats on consumers evaluations of a children's breakfast cereal, Proceedings of the EPartnerships, Proof and Practice. International Non-profit and Social Marketing Conference 2008, University of Wollongong, 15-16 July 2008; <http://ro.uow.edu.au/insm08/1>

Ministry of Health and the University of Auckland. (2003) Nutrition and the Burden of Disease: New Zealand 1997-2011. Wellington: Ministry of Health.

Ministry of Health (2008) A Portrait of Health: Key results of the 2006-07 New Zealand Health Survey. Wellington: Ministry of Health.

Ministry of Health (2003) Nutrition and the Burden of Disease. Wellington: Ministry of Health.

New Zealand Cancer Registrations. www.nzhis.govt.nz/.nsf/pagesns/500

Ni Mhurchu C and Gorton D. Nutrition labels and claims in New Zealand and Australia: a review of use and understanding. *Australia New Zealand Journal of Public Health* 2007; 31(2): 105-112.

Signal L, Lanumata T, Robinson J et al. Perceptions of New Zealand nutrition labels by Māori, Pacific and low-income shoppers. *Public Health Nutrition*, 2008. DOI: 10.1017/S1368980007001395, Published online by Cambridge University Press 02 Jan 2008.

Report of the Health Committee. Inquiry into Obesity and Type 2 Diabetes in New Zealand. Presented to the House of Representatives. August 2007.

WCRF and AIRC (2007) Food, nutrition, physical activity and the prevention of cancer: a global perspective. Washington DC: AICR.

WCRF and AIRC. (2009) Policy and Action for Cancer Prevention - Food, Nutrition, and Physical Activity: a Global Perspective. 2009.