ATTACHMENT 4

EXECUTIVE SUMMARY

CONSUMER RESEARCH – TNS RESEARCH

LABEL MONITORING SURVEY – AGRIQUALITY

Research on consumers' perceptions and use of nutrition, health and related claims on packaged foods and associated advertising material

A research report prepared for FSANZ by TNS Consultants

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Executive summary – Phase 1

PURPOSE OF THE RESEARCH

This study was conducted as the first of a two-part project to collect *baseline data* from consumers on how nutrition, health and related claims (refer Appendix A) are perceived, and the extent to which currently available claims are used in making food choices in the context of their whole diet. The component of the study reported here is the preliminary qualitative research. This research project is intended to provide useful information for the development of standards for nutrition, health and related claims as well as provide baseline data for future evaluation purposes. As health claims are currently not permitted (except for a folate/neural tube defect claim), and there may be nutrition claims used in the future that are not currently seen in the market place, all subsequent reference to nutrition and heath-related claims should therefore be taken as referring to both current and potential claims.

The specific objectives were to:

1. Explore consumers' assessment of the degree of expected health benefit and impact on intended purchase associated with different types of claims.
2. Determine how consumers view endorsements, cause-related marketing activity, implied claims, well-being and performance claims, biomarker claims, whole of diet claims, slimming claims and therapeutic claims on product packs in the context of the claims identified in the Claims Classification Framework.
3. Explore consumers' understanding of graphics that may be used in a variety of health claims.
4. Examine consumers' reactions to a variety of message devices designed to enhance communication.
5. Investigate consumers' perceptions of health claims on food labels compared to health claims in advertisements.
6. Briefly investigate consumers' perceptions of health claims on food labels compared to health claims on complementary medicines[1] (dietary supplements) labels.

METHODOLOGY

The research was conducted with participants in both Australia and New Zealand, through a total of 69 one-hour individual in-depth interviews. Participants were selected on the basis of their level of health consciousness, as determined by their food buying habits, as well as demographic and geographic characteristics.

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[1] *Note that dietary supplements/ complementary medicines are currently regulated in different ways in Australia, as therapeutic products by the Therapeutic Goods Administration, and in New Zealand, under separate dietary supplement regulations.*

The results are not designed to be extrapolated to the general population, as sampling was not random or representative of the total population.

The brief specified five main areas (broad topics) to be covered in the study:

- assessing nutrition, health and related claims, and encompassing issues (covered in 30 interviews)
- understanding implied health claims (covered in 15 interviews)
- enhancing communication effectiveness of nutrition, health and related claims (covered in 20 interviews)
- comparing health claims on food labels compared to advertisements (covered in 20 interviews)
- comparing health claims on food labels compared to complementary medicines (covered in 20 interviews).

Care should be taken in interpretation of the results from this study noting that it was designed for qualitative purposes only in order to provide indicative findings and guidance for further research, rather than categorical outcomes. A short list of study limitations has been outlined in Section 3 and notes aspects such as: inconclusiveness in some areas due to wide variation of responses; limited sample sizes; impact of personal relevance (or lack of) of the examples chosen; limited number of examples; and research conditions not being representative of actual shopping conditions. It should also be noted that a number of the claims, graphics and products used in the study were developed by FSANZ for the purposes of this research and were fictitious in nature. Therefore, they may not actually reflect claims and product relationships that may occur in the future.

RESULTS

The key results are presented in the following sections.

Assessment of health claims

This topic aimed to address objectives 1 and 2 of the study, which were concerned with assessing firstly the degree of expected health benefit associated with a range of different health claims, and secondly their impact on intended purchase. Each participant assessed one of two sets of claims (as described in the methodology) – each set featuring a particular nutrient (calcium in the milk examples, and omega-6 fatty acids in the sunflower oil examples). Claims were assessed individually (in a specified sequence) and then comparatively, through a sorting exercise and discussion.

Existing knowledge of each of the nutrients studied (i.e. calcium and omega-6 fatty acids) strongly influenced participants' understanding and interpretation of the various types of health claims, examined in terms of wording and/or length preference, perceived health benefit offered by the claim, and following from that, their self-reported purchase intention of the example product.

Expected health benefit

As a result of considerable variability in the findings for this topic (see Section 4.2), it is difficult to generalise about participants' understanding of the expected health benefit of the different types of claims.

Across both the calcium and omega-6 fatty acids sets of claims, there were two types of claims that were consistently sorted in the same 'position' (in terms of expected health benefit) by most participants, and these appeared at the extreme ends of the 'most/least' health benefit scale:

- The endorsement claim was always ranked towards or at the top of the scale – participants understood this claim to be offering much more of a health benefit than most other types of claims.
- The cause-related marketing claim was always ranked towards the bottom or at the bottom of the scale – participants understood this claim to be offering much less or the least amount of health benefit than the other types of claims.

There was no consistent pattern in the way that the remaining claims were sorted on health benefit.

Key aspects of claims that appeared to influence participants' belief that a product had greater health benefits than a product with different claims or information included:

- detailed information on the benefits of a nutrient for the body, or use of scientific type, but familiar, information – specifically, references to osteoporosis; or
- a clear link between consumption and the benefit – in plain language, such as healthy heart/lower blood cholesterol; or
- a simple message – easy to read if limited time.

It is important to note that it did not appear necessary for a claim to meet all of the above criteria in order to have greater than expected health benefit, the degree of simplicity, brevity or disease/medicalisation of the wording in the claim that effectively communicated health benefit depended on the personal relevance of the claim, and prior knowledge about the key nutrient or diet/disease relationship.

Key aspects of claims of lower ranked health benefit included:

- a lack of information in the claim about the benefits of the omega-6 fatty acids or calcium
- information that was considered to be untrue by some participants – such as the link between consumption of omega-6 fatty acids or an oil product and healthy skin.

Use or absence of the word 'may' in the claim (e.g. calcium may assist in …') caused a mixed response:

no use of word 'may'

- less doubt and uncertainty about the claim; or alternatively

- less trust in a global statement about benefits.

use of the word 'may'

- reduction in confidence in the claim due to lack of certainty; or alternatively
- enhanced confidence in the claim because it was realistic and not making a global claim about benefits.

Impact on purchase intention

After the sort on health benefit, the claims were again sorted and assessed comparatively with respect to the purchase intentions. For each of the examples (calcium and omega-6 fatty acids), most participants ranked claims according to perceived health benefit, basing their purchase decision on their perceived health benefit of the product and its health claim. This was particularly the case for health-informed or health-conscious participants, or those who shop with particular health conditions in mind, and was also a general trend for less informed participants. There were however a number of participants, almost exclusively men, who moved the cause-related marketing claim much higher up their hierarchy when assessing the claims according to purchase intention (see cause related marketing claim section over the page). This occurred more often for the calcium claims than the omega-6 fatty acids claims. It was also apparent during this exercise that price, brand and fat content also influenced the purchase intention.

Many participants acknowledged that some general level claims offered more information than others, and were thus more useful or credible than others, and that some high level claims offered more information again, in terms of a causal link between the nutrient and a health benefit, than did general level claims. However, there was no consistent pattern to the way in which participants made such distinctions, with a high degree of *individuality* in the way participants attributed relative health benefits to each type of claim, and no continuum was asserted to exist between content and other general level claims and high level claims.

The value/importance placed on claim information depended on the level of *prior knowledge* a participant had about the link between the nutrient and potential the health benefits. Participants who were health-conscious and/or regular label readers were also more informed about key nutrients and thus implied greater health benefits from simple claims than moderately/ not at all health-conscious participants.

Three types of claims were of particular interest to FSANZ: endorsement claims, biomarker claims and cause-related marketing claims.

Endorsement claims

Common to both the calcium and omega-6 fatty acids claims on products, participants believed that endorsement claims confirmed the endorsing society would substantiate the claim after having undertaken relevant tests to prove the claim. Endorsements from known health organisations (such as the Heart Foundation) carried more weight than the fictitious ones used in this exercise, but very few participants dismissed the two claim examples on the grounds of credibility, even though none claimed to have heard of the two societies before.

Biomarker claims

Overall, biomarker claims were interpreted as health claims but there was no consistency in the way in which participants differentiated them from function claims (or enhanced or function/well being claims).

Often they were favoured over general level claims because of the specificity of the information they gave, and thus the amount of certainty one had about the health benefit. However, use of the word 'may' eroded confidence in the claim (for some) and led to a greater number and range of requests for further information than for other claims.

In order to further investigate participants' understanding of biomarkers more fully, a word association exercise was undertaken where the researcher read out a list of seven biomarkers and recorded the words that came to a participant's mind as they spoke. Participants tended to associate words that related to the health impact of the biomarker (disease or consequence), or to the risk factor *("cause")* of incurring the biomarker, which was usually either diet- or exercise-related. Others (also) nominated associations that related to specific food sources that they knew to be disease risk factors [e.g. fat in diet, in response to blood cholesterol] or they associated lifestyle prevention factors, such as fitness and exercise.

Cause related marketing claim

Most participants regarded this type of claim as marketing with a cause and while they considered a donation to a worthy cause commendable they did not feel there was any health benefit offered in this claim.

When participants sorted the claims (on health benefit and purchase intention) the cause related marketing claim was consistently ranked low (or bottom) on perceived health benefit, however, quite a few participants shifted this claim closer to the top in terms of their likelihood to buy the product with this claim (more so for the milk example than the oil example). These participants tended to be male and were not buying milk/oil explicitly for health benefits ('milk is milk') and thus they felt that they might as well buy milk that had money going to a worthy cause.

Slimming claim

This claim was assessed independently of the calcium and omega-6 fatty acid claims. Most participants indicated they did not consider this claim to suggest a health benefit, partly because of the inclusion of the words 'may assist' (which was equated with 'may not assist') and partly because weight management/loss was not readily associated with a health benefit. About half the participants dismissed the claim as irrelevant to them, perceiving it to be about weight loss, which they were neither interested in, nor in need of, and thus they were not motivated to provide any useful feedback on the claim. Most participants felt that this product should be allowed on the market (for those who might want it); however, a few put conditions on this, such as removing the word 'may assist' and disallowing it unless there is proven evidence that it has worked, and for whom, and providing additional label information about the unique ingredient (thus explaining how the product works).

Concept of a 'healthy diet' vs. 'balanced diet' vs. 'total diet'

The research also explored what the concept of a 'healthy diet' means to participants, as part of understanding the context in which participants use claims to make food choices. In addition, the understanding of two alternate concepts 'total diet' and 'balanced diet' was explored, as were reactions to the concept of 'wellbeing'.

The terms 'healthy diet' and 'balanced diet' were preferred over 'total diet'. A number of participants suggested (and preferred) a phrase that combined 'healthy, balanced diet', and felt that this was more meaningful. Most participants felt there was a need for this kind of statement to be included in the claims, and that if these words were not included in the claims, it would imply that all someone had to do was consume the product to get the benefit. However there were a few participants (a minority) who felt that such a statement was unnecessary, and made the claim too wordy.

When asked about sources of information that participants use or rely on to determine what constitutes a 'healthy diet', they indicated that the most trusted sources of information included: doctors/health professionals, friends; and current affairs and TV shows.

Role of government

Almost all participants endorsed a role for government in the setting of standards for the use of claims by manufacturers and the distinction of disclaimer-type label information as coming from an authoritative source (other than the manufacturer). Some participants suggested that the government-prescribed labelling element, such as a message device, could contain an endorsement or symbol that indicated that the government had reviewed and endorsed the claim.

Implied health claims

In order to explore and understand participants' understanding of graphics likely to be used in a variety of health claims, seven different implied claim mock-ups were introduced in rotated order and participants were asked about their interpretation of the claim, with particular attention paid to any suggested health benefit, certainty about any suggested benefit, and what other supporting information might be needed to interpret the claim.

Pictures and key words appeared to have a major impact on participants, both in initially attracting attention to a given product, but also in conveying health benefit. Pictures implied a great deal more to participants than words alone and, in some cases, the pictures implied much more or different benefits than equivalent text-based health claims. It was felt by participants that the impact of the implied health claim examples used in this study is likely to be greater when there is little rather than considerable time available to pay attention to the graphic and words– such as seeing it for the first time on a supermarket shelf during a busy shopping trip. Health-conscious participants said they verified claims personally relevant to them by using the Nutrition Information Panel (NIP) and ingredients list, but for non health-conscious participants, and at times where the participant is shopping in a rush, the implied claim examples were likely to be accepted and trusted. The example products (with implied claims) that consumers would most consider trying were those that have lower perceived risk associated with them.

Perceived credibility or certainty about the implied claim examples was linked to the perceived risk a consumer attributed to consuming the product, more so than the text-based claims in the earlier part of the study. Risk included both potential dangers (safety) and potential risks to health, including putting on weight (e.g. Boost Bar). Implied claim labels where more text information was given were more trusted than claims that were not very detailed, which may be because participant's had less prior knowledge about the products and their claims, compared to the calcium claims for example.

Message devices

Message devices are statements that provide additional information to the claim and include disclaimers, disclosures and advisory statements. In order to address objective four (examining participants' reactions to a variety of message devices designed to enhance communication) each participant undertook four comparison exercises (using either bread or cereal label mock-ups, see Section 7) that explored effectiveness, interpretation and preferences between the content and positioning of different message devices.

The results clearly demonstrated that message devices must be expressed more overtly, i.e. the inherent message must be far more obvious, in order to achieve the communication objective. Participants in this study appeared to value as important those message devices that they associated with potential risk. When there was high perceived risk, participants wanted the health claim and the message device to be positioned sufficiently together, on the front of the package, so that both messages are obviously linked and so that the message device will not be missed. The findings also demonstrated that participants will read information that is spaced out (but clearly linked), but may pass over a message device that is part of the same paragraph as the claim. It is also clear from the research that most participants would miss health information on the back or non-NIP side of the package, while only health-conscious participants would see information on the NIP side.

Confirming the findings of other Food Standards Australia New Zealand research[2], the NIP is used by health-conscious participants to verify nutrition or health claim information. However, it cannot be assumed that all health-conscious participants know how to verify all claims, because it seemed that most of these participants were only adept at assessing the nutritional content of one or at the most two significant nutrients that are important to them.

Health claims on food labels compared to advertisements

The purpose of these exercises was to gain a better understanding of how, if at all, participants distinguish between information on food labels compared to information in different types of food advertisements, including public education type information. Impact on perceived health benefits and purchase intention were investigated. The products and advertisements used in this section were for illustrative purposes only.

The findings highly variable and therefore inconclusive for this topic. Although there were some indications that the advertising information that included health claims did not appear to substantially influence the perceived health benefit or purchase intention of the two products examined (yoghurt/soy milks).

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[2] *Food Labelling Issues: Qualitative consumer study related to nutrition content claims on food labels. July 2003*

This finding was inconsistent with the earlier claim assessment exercises. However, advertising and product labels that detailed product benefits were viewed as more credible than less detailed versions, as was noted with implied health claims.

It was somewhat clearer (but again not conclusive) that participants felt that sponsorship or branding of advertisements or product labels by reputable health organisations (such as a Dietitians Association or National Heart Foundation) lends credibility and authenticity to claims. Greater trust is afforded, irrespective of whether the health organisation is a sole advertiser or is sponsoring in partnership with a brand. Nonetheless, advertising from any source was regarded to be promoting an agenda, albeit a more altruistic agenda by health advertisers, that is in the public's health interests. Comments received during the interviews also suggested an assumption by some participants that advertisers are regulated in what they can claim.

Health claims on food labels compared to complementary medicines

In order to assess how participants discern between health claims on food labels and health claims on complementary medicines (objective six), participants were asked to look at a tea product (food) and a capsule product (complementary medicine), in rotated order. Both products featured St John's Wort and claims about its benefits.

The active ingredient (St John's Wort) was viewed as being equally appropriate presented in either form (tea or capsules). Neither form was deemed to be healthier or more appropriate than the other, nor did any participant appear to be concerned about the general safety or potential danger of including St John's Wort in the products. For this specific example the food form (tea) was seen as cheaper, safer and faster acting, and equally as reliable as the capsule.

Summary

This report concludes by presenting an overview of findings that can be drawn across the five major topical areas of study (see Section 10), and a list of recommendations for consideration during the design of the quantitative survey (see Section 11).

Topics and issues where there was greater consistency included:

- greater assumed knowledge about the health benefits of calcium than for omega-6 fatty acids;
- relative understanding of the health benefits of endorsement and cause-related type health claims, compared to other types and levels of claims;
- endorsement of the role for government in the setting of standards for the use of claims by manufacturers;
- the distinction of disclaimer-type label information coming from an authoritative source (other than the manufacturer);

- the powerful influence of images and pictures on what participants inferred about the health benefits of a product, resulting in the inference of health benefits beyond those stated through text-based claims – however, the way in which images influenced participants was highly variable;

- agreement about the preferred positioning of message devices in relation to the position of the health claim; and

- claims and devices from which participants infer that there was a potential health risk as a result of consuming the product, were generally paid more attention and were taken more seriously.

Executive summary – Phase 2

PURPOSE OF THE RESEARCH

This research project collected baseline data from consumers before Standard P293 for nutrition, health and related claims was finalised and will be useful both for the development of the standard and for future evaluation purposes.

The purpose of developing quantitative research on consumers' perceptions and use of nutrition, health and related claims was to:

- gather baseline data on key issues identified in the qualitative research relating to consumers' perceptions and understanding of nutrition, health and related claims and the impact of such claims on intended purchase;
- explore, in a controlled setting, the communication effectiveness of disclosure statements;
- collect data on the proportion of consumers that use the Nutrition Information Panel (NIP) to verify claim information on labels; and
- gather baseline data on how consumers currently view nutrition and health claims for comparison to data collected in future surveys. The various claim types explored in this research are summarised in the Table below.

METHODOLOGY

The research was conducted with main or joint household shoppers in Australia and New Zealand, with a total of n=1044 respondents completing an online survey (635 in Australia and 409 in New Zealand).

As part of the refinement of the research objectives and the project design process, nine hypotheses were formulated by FSANZ for exploration as part of the project (see Appendix 1). These represented five priority areas of investigation and the questionnaire was divided into modules that reflected these areas (see 2.3.1 Questionnaire Framework). The study included a range of label mock-ups and 'test' products.

Table 3.1: Health and Nutrition Claims		
General level claims (do not reference a biomarker or serious disease)		High level claims (reference a biomarker or serious disease)
Content claims	General level health claims	
Examples: Absolute content claim Describe or indicate the presence or absence of a component in the food (nutrient, energy or biologically active substance). For example, 'this food is high in calcium'; 'this food is low in fat' Comparative content claim Describe or indicate the presence of a component in a food in comparison to other similar foods For example, ' reduced fat'	Examples: Function Claim 'This food is a source of calcium and when consumed as part of a healthy diet is good for strong bones and teeth' Enhanced Function claim ' Exercise and a diet high in calcium and calcium containing foods like this product contributes to stronger bones' Risk Reduction (ref to non-serious disease) 'This yoghurt contains acidophilus. Foods high in acidophilus as part of a healthy diet may reduce your risk of stomach upsets'	Examples: Biomarker maintenance claim 'This food is high in Omega-6 fatty acids which may help to maintain normal blood cholesterol' Biomarker enhancement claim 'This food is high in Omega-6 fatty acids which may help to reduce blood cholesterol levels' Risk reduction (ref a serious disease) claim The potential for a food or component to assist in controlling, reducing the risk of, or improving, a serious disease or condition. For example, 'this food is high in Omega-6 fatty acids, which as part of a diet low in saturated fat and high in soluble fibre may reduce the risk of developing heart disease'

A short list of study limitations has been outlined in Section 2, which discusses the potential impact on the results of the selection of label mock-ups used to depict the various claim types. As a result of using particular products, it should be kept in mind that consumers infer a range of different beliefs and assumptions about the health and nutritional value of different foods, based on their individual knowledge and life experiences. Such assumptions may have some bearing on the research results.

RESULTS

The description of the findings in this executive summary concentrates on the support or otherwise, of the hypothesis and the associated findings. For detailed statistical results on the hypotheses, please see the relevant sections of the report.

Awareness and use of specific nutrition and health claims and intent to purchase

In order to establish a baseline measure of nutrition and health claim familiarity, respondents were asked to indicate their awareness and past use of six specific claims, representing different claim types (see Table 1a). Specifically, **module 2** of the questionnaire (i.e. Q's 2.1 to 2.3) was designed to measure respondent's current awareness of, and past experiences with, different types of health claims. It is intended to use these same questions in future surveys to track consumers' awareness and use of nutrition and health claims over a period of time. For this reason some of the questions referred to the type of claims that are not currently permitted but are expected to be permitted under the new standard.

Awareness of health claims

There was clear evidence to suggest that respondents were more likely to be aware of general level claims than high level claims. The most frequently seen type of claim was the function claim (90%), followed by the content claim (84%), and the biomarker maintenance* claim (82%). Significantly fewer respondents had seen the biomarker enhancement claim*, the (folate/NTD) risk reduction claim on the cereal or the risk reduction claim[3] on the frozen fruit and vegetables, although the numbers claiming to have seen such claims were high.

Respondents were significantly less likely to have seen the permitted serious risk reduction claim on cereal or the whole of diet risk reduction claim on frozen vegetables* compared to other claims, although reported awareness levels were still reasonably high (46% in both cases).

Respondents may have reported seeing claims that were not expressly permitted in the Code (marked with an *) due to confusion of the claims with other claims, confusion of the claims with other nutritional information, responses reflecting intent to purchase rather than actual behaviour and the inappropriate use of some claims currently.

Past use of health claims

While the content claim on the baked beans - high in fibre, low in fat - was one of the claims most seen by respondents (see above), past use of this claim when buying products was significantly lower (59% used), when compared to the:

- function claim on the milk (67% used this type of claim);
- biomarker enhancement claim* on the simmer sauce (65% used this type of claim); and
- biomarker maintenance claim* on the margarine (63% used this type of claim).

Nutrition and health claims influence on intent to purchase

The research showed that two high level claims – the whole of diet risk reduction claim and the biomarker maintenance claim, even though not currently permitted, had the most influence on intent to purchase, when compared to other claims.

[3] *Not expressly permitted by the Food Standards Code*

At least half of those who had used each type of claim when buying a product indicated that it had a 'very strong' or 'strong' influence on their intention to purchase, clearly showing the influence that claims have on consumers' intent to purchase.

Regulation of nutrition and health claims

High level claim influence

One of the aims of the research was to evaluate the impact that various types of nutrition and health claims could have on consumers' perceptions of a product's health benefits and their likely intent to purchase it. In particular, the survey investigated how influential high level health claims are compared to general level claims and no claim at all on a product in terms of their ability to communicate greater health information and their impact on intended purchase.

Respondents were shown four variations of a packet of bread in random order, displaying one of three types of claim (general level claim (nutrition content), general level claim (function claim), high level claim) and one with no claim.

The questions in **module 3/4** of the questionnaire relate to hypotheses 1a and 1b below:

- **Hypothesis 1a:** That a product with a high level claim is not perceived by consumers to communicate greater health benefits about a product, than a product with a function and nutrition content claim, a product with a nutrition content claim or a product with no claim at all.

- **Hypothesis 1b:** That a product with a high level claim is not perceived by consumers to have a greater impact on intent to purchase, than a product with a function and nutrition content claim, a product with a nutrition content claim or a product with no claim at all.

Most of the findings from the research **did not support hypothesis 1a**, meaning that there was a difference in consumers' perceptions of the different products studied**.** Overall, the results suggested that there is a trend for high level claims to communicate greater health benefits compared to general level claims, particularly when compared to a content (general level) claim.

The findings from the research **partially support hypothesis 1b**, which assumed that a product with a high level claim did not influence intent to purchase more than a product with a function claim, a content claim or a product with no claim.

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). This particular finding supported the hypothesis, however, other findings did not.

There was also evidence that there was a difference between intent to purchase between a product with a high level claim and one without a claim. Respondents indicated that they would be more likely to purchase the product with a high level and function claim, when compared to the product without a claim. This was also the case for both the function claim and the content claim compared to no claim at all.

Endorsement claim influence

Another of the key objectives of the research was to investigate the influence of endorsements on respondents' perceptions in relation to the health benefits of the product (**module 5 of the questionnaire**).

Respondents were shown four variations of a tinned salmon product in random order, each with a different type of claim (non-specific endorsement, non-specific general level claim, specific general level claim and high level claim) on the label.

Questions in this module related to hypothesis 2a, hypothesis 2b and hypothesis 2c as follows:

- **Hypothesis 2a:** That an endorsement (non-specific) is not perceived by consumers as having greater credibility than a non-specific general level claim (e.g. whole of diet claim), an equivalent specific general level claim or an equivalent high level claim.

- **Hypothesis 2b:** That an endorsement (non-specific and classified as a general level claim) is not perceived by consumers to communicate greater health benefits than a non-specific general level claim (e.g. whole of diet claim), an equivalent specific general level claim or an equivalent high level claim.

- **Hypothesis 2c:** That an endorsement (non-specific and classified as a general level claim) is not perceived by consumers to have a greater impact on intent to purchase than a non-specific general level claim (e.g. whole of diet claim), an equivalent specific general level claim or an equivalent high level claim.

The findings from the research **indicated that hypothesis 2a was not supported**, meaning that consumers did perceive a difference in credibility between the different products studied. The results indicated that respondents were significantly more likely to consider a product with a non-specific endorsement to be credible (i.e. trust what it says completely), when compared to a product with a non-specific general level claim, a product with a specific general level claim or a product with a high level claim. However, it is important to note that this is likely to have been influenced by the particular endorsement used in this research, which was the National Heart Foundation (NHF) tick.

There were findings both for and against **hypothesis 2b**, which assumed there would be no difference in consumers' perceptions of the health benefits of consuming a product with an endorsement compared to products with different written claims. When examining results from a question relating to perceived benefits, it was found that the NHF endorsement was perceived to be similar to a high level claim (in terms of 'a reduced risk of heart disease') and similar to a specific general level claim (in terms of 'assistance with heart health'). The endorsement lacked specificity, and as a result consumers appeared to have assigned many meanings to it. On the other hand, respondents were less likely to attribute specific health benefits to the non-specific claim than the endorsement; although the endorsement was non-specific it did have a level of 'specific' understanding associated with it (i.e. endorsement by the NHF). From a regulatory point of view, these findings suggest that non-specific endorsements could be difficult to classify within the claims classification framework.

The findings from the research indicated that **hypothesis 2c was not supported,** meaning that the endorsement did have a greater impact on consumers' intent to purchase than the written claims**.** More respondents perceived the non-specific endorsement claim as having a 'very strong' effect on health compared to the specific general and high level claims. There was evidence to suggest that a non-specific endorsement claim had a positive impact on intent to purchase a product, when compared to products with general and high level claims. However, it is possible that the endorsement claim chosen for this research had an effect that other endorsement claims would not, due to the inherent credibility and acceptance of the NHF tick.

Implied claim influence

Another research objective was to review the influence of implied claims i.e. claims implied through the use of graphics or words such as a product name or branding, when compared to other claim types.

Respondents were shown, in random order, four different claim types featured on a yoghurt product (brand-implied claim, graphic-implied claim, explicit general level claim and high level claim).

Questions in this module (**module 6**) related directly to hypothesis 3a and 3b as follows:

- **Hypothesis 3a:** An implicit health claim, when expressed as either a graphic or as a brand name, is not perceived differently by consumers to an explicit general level or high level claim in relation to communication of health benefit.

- **Hypothesis 3b:** An implicit health claim, when expressed as either a graphic or as a brand name, is not perceived by consumers to have a greater impact on intent to purchase than an explicit general level or high level health claim.

Hypothesis 3a, which assumed consumers' perception of implied and explicit claims would be the same, **was partially supported.** While the high level claim communicated the message of 'a reduced risk of osteoporosis' more effectively than both of the implied claims, the majority of respondents nonetheless believed the implied claim would provide both benefits. Graphics and brand names are therefore potentially powerful mechanisms for inferring health benefits.

The evidence suggests that, while there were clear similarities in who would benefit from the product, between the three different products shown, it was also apparent that there were significant differences in the communication of health information between the brand-implied and the graphic-implied claim studied.

The findings from the research **supported hypothesis 3b**, meaning that consumers did not perceive a difference in their intent to purchase the products studied**.** The results suggested that implied claims [brand or graphic] were as effective as high level and general level claims in terms of respondents' intention to purchase a product. Half the respondents or more stated that they would buy any of the claimed yoghurts.

Disclosure statement influence

The research also sought to identify any differences in perceived health benefit between products with and without a disclosure statement (DS) and to compare products with a disclosure statement either supported or unsupported by further information, in this case, a guide to fat levels.

Respondents were shown three muesli bars, each with a nutrition content claim ('source of dietary fibre') and the nutrition information panel and either no additional information, a disclosure statement or a disclosure statement and a reference guide to fat levels.

Questions in this module (**module 7 in the questionnaire**) related directly to hypothesis 4 below:

- **Hypothesis** 4: That a nutrition content claim with a disclosure statement on the front of the food package is not perceived by consumers to communicate greater health information than:

  - a nutrition content claim with a disclosure statement (DS) and a reference guide; or
  - a nutrition content claim with no disclosure statement (DS).

The findings from the research **partially supported hypothesis 4.** The findings indicate that the disclosure statement (with and without the fat guide) did not improve respondents' assessment of the fat content of the food, nor did it alter their overall judgment of the healthiness of the food.

This finding, however, needs to be interpreted with caution, as there was some indication that the disclosure statement may be useful in directing consumers to the NIP but only half of the respondents made the correct judgment about the fat content of the food. In addition, the similarly high levels of 'healthiness' attributed to each example could also have been the result of an underlying belief that muesli bars in general are healthy. Furthermore, as was indicated in the qualitative research, the DS could equally well have been a signal to uninformed consumers for product healthiness as unhealthiness.

Cause related marketing influence

As a final question, respondents were asked to rate the perceived health benefits from two label variations on a can of baked beans, one with a cause related claim ('proceeds from this product will go to the Royal Society for Diabetes') and the other with no claim. This question is directly linked to hypothesis 5 below.

Hypothesis 5: That a product carrying a cause related marketing claim on its label is not perceived by consumers to be providing more of a health benefit than a product without a cause related marketing claim.

The findings **did not provide support for hypothesis 5**, meaning that consumers did perceive a difference in the two products. The results suggest that the product with a cause related claim was perceived to be significantly more beneficial to health than the product with no cause related claim.

ON-GOING FOOD LABEL MONITORING SURVEY IN AUSTRALIA AND NEW ZEALAND

Re-assessment of 2003 Labels for Nutrition, Health and Related Claims

Report by AgriQuality Pty Ltd, prepared for FSANZ
August 2005

Executive summary

There is currently a prohibition on health and related claims in the Australia New Zealand Food Standards Code (the Food Code), with the exception of claims relating to the benefit of maternal consumption of folate[4].

As part of a review of the regulatory framework with regard to the use of nutrition, health and related claims on food labels, a pilot label monitoring survey was undertaken. A total of 1262 Australian and New Zealand food labels were collected in 2003 and assessed according to their consistency with 12 label components. The purpose of the current project was to further assess these same labels to determine the proportion that carried nutrition, health and related claims.

The labelling provisions included in this survey were those provided in the Food Code, the Code of Practice on Nutrient Claims in Food Labels and Advertisements (CoPoNC), the New Zealand Dietary Supplements Regulations (NZDSR) and the fair trading legislation in both Australia and New Zealand.

The consistency of the claims with the above labelling provisions was determined as part of this survey.

The claims were also assessed against the classification framework for nutrition and health claims under development by Food Standards Australia New Zealand (FSANZ) as set out in Proposal 293.

Of the 1262 labels collected in 2003 in Australia and New Zealand, 43% carried nutrition claims or health claims. A greater proportion of the labels collected featured nutrition claims (42%), rather than health claims (11%).

Of the 542 labels that carried claims, the proportion that carried nutrition claims was the same in both Australia and New Zealand (99%). However, of the labels that carried claims, health claims featured on a greater proportion (33%) of labels from New Zealand than labels from Australia (20%).

Approximately 40% of health claims (66 claims) were National Heart Foundation endorsements, and 23% of health claims (38 claims) were function claims.

[4] *FSANZ has permitted a trial health claim on claims about the benefit of maternal consumption of folate, to prevent neural tube defects (eg. spina bifida) in developing foetuses and more than one hundred products have temporary permission to carry the claim.*

Labels were collected across 14 different food categories. Labels from the three largest categories (Mixed foods, Fruit and vegetables, and Bread and bakery products) made up 48% of all labels collected. Labels from the three smallest categories (Egg and egg products, Sugar, honey and related goods, and Food intended for particular dietary use) made up less that 5% of all labels collected.

Within each category, the number of labels with claims was expressed as a proportion of the total number of labels within each category. The categories with the highest proportion of labels featuring nutrition claims were Food intended for particular dietary use (96%), Edible oils and emulsions (70%), and Dairy products (69%). The categories with the lowest proportion of nutrition claims were Confectionary (17%), Sugar, honey and related products (17%) and Meat and meat products (22%).

The categories with the highest proportion of labels featuring health claims were Food intended for particular dietary use (52%), Edible oils and emulsions (30%), and Cereals and cereal products (24%). The categories with the lowest proportion of health claims were Sugar, honey and related products (0%), Confectionary (0%) and Meat and meat products (5%).

The majority of claims assessed were consistent with the requirements of the labelling provisions used for this survey.

A total of 85 claims on 73 labels were found to be inconsistent with the labelling provisions. Of these claims, the majority (60%) came from labels collected in Australia.

A total of 153 labels collected in Australia were identified as having 220 claims to be assessed against CoPoNC, providing an average of 1.4 CoPoNC claims per label.

After the labelling provisions of CoPoNC were applied to the 220 claims on labels, these were found to be consistent with labelling requirements in the majority (97%) of cases. Six labels were found to be inconsistent (5 for an incorrect 'fat free' claims and 1 for a missing reference to the whole class of the food).

Four high level health claims were assessed. Two of these were biomarker enhancement claims, and were consistent with the current labelling provisions. One, which referenced a serious disease and provided advice of a medical nature, was assessed as inconsistent with the labelling provisions. As the claim featured on a label collected in New Zealand, it was also found to be inconsistent with the provisions of the NZDSR. One high level health claim made reference to a non-serious disease, and one general level health claim referred to a physiological condition. Consequently both were inconsistent with the provisions of Standard 1.1A.2.

One general level health claim was also considered to be inconsistent with the provisions of both Standard 1.1A.2 and NZDSR, as it referred to a non-serious disease and provided prophylactic advice.

The category with the highest proportion of inconsistent claims was Ice cream and ice cream products (43%), followed by Meat and meat products (30%), and Dairy products (25%).

The categories of Egg and egg products, and Sugar, honey and related products did not have any inconsistent claims, while the Cereals and cereal products category had 6% inconsistent claims as a proportion of total number of labels with claims.

Whilst the labels collected in Australia were assessed against a greater number of provisions than those from New Zealand, the extra requirements of CoPoNC did not appear to be the cause of the higher number of inconsistent label claims for labels collected in Australia.

As the Label Monitoring Survey enters its second phase under the FSANZ Evaluation Strategy for 2004-2008, the 2003 information provided in this report will be a valuable benchmark for comparison with current nutrition, health or related claims.