Public consultation: improving commercial foods for infants and young children

September 2024

Poor diet contributes as much as 50% of the total burden from coronary heart disease in Australia (AIHW, 2021). The Heart Foundation is concerned that current regulations in Australia permit food manufacturers to produce and sell commercial foods that are high in energy yet low in nutrients, and overall do not support good cardiovascular health. This is particularly concerning with regards to commercial foods for infants and young children, who have high nutrient needs for healthy growth and development.

Studies into the nutrition quality of commercial foods for infants and young children available in Australia have shown these food and drink products are high in kilojoules, sugar, saturated fats and sodium. The nutrition composition of these products may promote excess weight gain, high blood pressure and elevated cholesterol levels in children, elevating their risk for cardiovascular disease later in life (Mikkila et al, 2005; Nadeau et al, 2011; Te Morenga et al, 2012; Meng et al, 2024). Furthermore, parents and caregivers in Australia are subjected to misleading marketing strategies, such as nutrition and health claims that do not accurately describe these food products (Scully et al, 2023).

The Heart Foundation supports efforts to impose greater regulations on the composition and labelling of commercial infant and toddler foods in Australia. The use of commercial food and drink products for infants and toddlers is becoming increasingly common, offering a convenient way to feed children at home and on the go (Brunacci et al 2023). Parents and caregivers should be able to rely on these foods to provide good nutrition to their children, and to make informed food choices based on clear and transparent package labelling.

In August 2024, the Department of Health and Aged Care announced a public consultation on the topic of improving commercial foods for infants and young children. The objective of this work was to improve the composition, labelling and texture of commercial foods for infants and young children so they better align with Australian and New Zealand infant and toddler feeding guidelines. A consultation paper was prepared to canvass policy options, including maintaining the status quo, non-regulatory approaches and regulatory approaches (Department of Health and Aged Care, 2024). Public consultation took place via online survey. The Heart Foundation's response to the public consultation survey is detailed in this document.

The Heart Foundation welcomes the opportunity to make a submission to this public consultation on improving commercial foods for infants and young children, being undertaken by the Department of Health and Aged Care. The Heart Foundation is Australia's largest charity focused on the heart health of people in Australia. Our mission is to reduce heart disease and improve the heart health and quality of life of all people across Australia through our work in Research, Risk Reduction, Support and Care.

Your Views

QUESTION 6 – Do you agree with the proposed objective of this work? If not, what is your proposed alternative? (Yes/No)

Proposed Objective: *'To improve the composition, labelling and texture of commercial foods for infants and young children to better align with the recommendations in the Australian and New Zealand infant and toddler feeding guidelines'.*

No

We strongly agree with the objective of ensuring that commercial foods for infants and young children align with the Australian and New Zealand infant and toddler feeding guidelines. We further believe that the objective should emphasise not just achieving 'better alignment' but fully aligning with these guidelines. To enhance clarity, we recommend modifying the language to include the term 'marketing' alongside 'labelling,' as industry practices encompass various marketing strategies beyond labelling.

Furthermore, it is important to recognise that the current Australian and New Zealand guidelines provide limited specific guidance on commercial foods. For example, the Australian Infant Feeding Guidelines state that 'Special complementary foods or milks for toddlers are not required for healthy children' (NHMRC, 2013). Furthermore, the Healthy Eating Guidelines for New Zealand babies and toddlers note that 'Commercial baby foods are a convenient alternative to home-made baby food, but an over-reliance on these products may reduce the variety of flavours and textures in a baby's diet' (Ministry of Health, 2021).

Given the limited detail on commercial foods within these guidelines, we advocate for integrating international best practices into the reform process. Specifically, we suggest referencing the World Health Organization European Office's Nutrition Profile and Promotion Model (NPPM) to guide the development and evaluation of commercial foods (WHO, 2022).

While we support the objective, we propose that the reforms should ensure full alignment with both the Australian and New Zealand guidelines and international best practices (such as the NPPM) to comprehensively improve the quality of commercial foods for infants and young children.

QUESTION 7 – Are there additional policy options that should be considered? Please provide a rationale and the benefits and risks of your suggested option. (Yes/No)

No

Option 1: Status Quo

QUESTION 8 – Are the risks and limitations associated with the status quo described appropriately? (Yes/No)

No

The consultation paper identifies some risks and limitations of maintaining the status quo but does not adequately convey the gravity of the situation if no action is taken.

Currently, many commercial foods for infants and young children do not meet the standards necessary to support optimal health, growth and development. These products often fall short of international best practices for nutritional content and fail to comply with global standards for labelling and promotion (Scully et al, 2024). If Option 1 is implemented, these concerns will continue unaddressed, perpetuating the current problems.

Reporting from the Royal Children's Hospital National Child Health Poll shows that one in three children in Australia are eating commercial foods for infants and toddlers at least once per week, and one in five are consuming these foods daily (2022). To safeguard the health of infants and young children in Australia, it is crucial to implement comprehensive reforms in the composition, labelling, and texture of commercial foods. These reforms must be mandatory, with stringent monitoring and enforcement to ensure compliance and effectiveness.

Option 2: Non-regulatory Approaches

QUESTION 9(a) – Are the risks and limitations associated with Option 2 described appropriately? (Yes/No)

No

The consultation paper underestimates the risks and limitations associated with Option 2, which relies on voluntary industry initiatives. This approach is problematic as it places too much trust in industry to act against its own interests. Experience and evidence, including the study 'Part of the Solution: Food Corporation Strategies for Regulatory Capture and Legitimacy,' show that relying on industry self-regulation is often ineffective (Lacy-Nichols & Williams, 2021). The rights of children to nutritious food and the rights of parents to accurate information should outweigh industry costs.

There is no substantial evidence, either in Australia or internationally, supporting the effectiveness of non-regulatory approaches in improving the nutritional quality and labelling of commercial foods for infants and young children. The consultation paper's suggestion that targeted voluntary initiatives might be successful is particularly concerning given the lack of evidence supporting such claims. This is a high-risk strategy for one of the most vulnerable populations.

Educational resources, while important, cannot replace the need for regulatory measures. Parents should have confidence that the foods they purchase for their children adhere to rigorous health and nutrition standards. As noted in the consultation paper, regulatory approaches ensure that foods align with infant and toddler feeding guidelines, a goal that cannot be achieved through education alone. Non-regulatory approaches are inequitable and may disadvantage vulnerable populations, particularly if not sufficiently funded. Education should complement, not replace, regulatory measures.

We also disagree with the paper's assertion that non-regulatory approaches can address a broader range of issues than regulatory approaches. Regulatory frameworks can comprehensively address issues related to the composition, labelling, marketing, and texture of foods for infants and young children.

Furthermore, the potential benefits of working with industry to increase knowledge and dissemination of feeding guidelines are already available under the status quo and do not constitute strengths of Option 2.

QUESTION 9(b) – Are there particular approaches in this option that should be further considered? (Yes/No)

No

We do not support any voluntary industry approaches. There is no evidence to suggest that such approaches will achieve the necessary improvements in nutrition and responsible marketing and labelling of foods for infants and young children.

QUESTION 9(c) – Food manufacturers- How likely are you to be involved in a voluntary reformulation or labelling program? What would be a suitable time frame for this option to be implemented in your organisation?

We do not support voluntary industry approaches. Experience from previous programs, such as the Health Star Rating scheme, indicates that voluntary participation by food manufacturers is often limited (Bablani et al, 2020). Relying on the industry's goodwill is insufficient to ensure that commercial foods for infants and young children meet nutritional standards and are marketed and labelled responsibly.

QUESTION 9(d) – What kinds of voluntary measures could be introduced to maximise industry uptake?

We do not support any voluntary industry measures. Evidence shows that voluntary approaches are unlikely to produce the necessary improvements in nutrition and responsible marketing and labelling of foods for infants and young children (Bablani et al, 2020; Jones et al, 2024).

QUESTION 9(e) – What implementation issues need to be considered for this option?

We do not support voluntary industry approaches.

Option 3: Regulatory Approaches

QUESTION 10(a) – Are the risks and limitations associated with Option 3 described appropriately? (Yes/No)

No

The Heart Foundation feels that the description of risks and limitations offered for Option 3 does not fully capture the potential impacts of inadequate regulation. Should regulation fail to establish adequate limits for composition, labelling and texture, this would allow Australian standards to continue falling short of international best practice and dietary guidelines. We strongly recommend that the government take swift and comprehensive action to overhaul the market for infant and young child foods to ensure alignment with international best practice and dietary guidelines.

The risks and limitations described in the consultation paper imply that regulatory approaches are difficult and will take a long time. We disagree, as the timeline is ultimately determined by the government and will only be extended if the government allows it. Comprehensive regulatory interventions to protect infant and child health should not be limited by concerns regarding implementation duration.

We strongly recommend that the implementation period for regulatory approaches is two years. Several regulatory proposals, including P1041 (Country-of-Origin Labelling), P242 (Food for special medical purposes), P1003 (Mandatory Iodine Fortification) and P295 (Mandatory Fortification with Folic Acid), show precedent for this timeframe. We note further that industry constantly reformulates and repacks foods for infants and toddlers within this time frame for their own purposes.

It is also important to note that while regulatory implementations will be of longer duration than non-regulatory ones, regulatory approaches will allow for a guaranteed result whereas voluntary approaches are unlikely to result in any significant changes (see our response to Question 9(a) above for further details).

We disagree that work to create relevant sub-categories is a limitation. The World Health Organization has already done extensive work to sub-categorise products

and prescribe detailed definitions and their specifications (WHO, 2022). Analysis of Australian and New Zealand products against this model shows products in this market can be sub-categorised using this model and the definitions and specifications are relevant and applicable (Scully et al, 2024).

The consultation paper states that challenges with consumer understanding would be a limitation of labelling changes. We disagree that labelling changes would be difficult for consumers to understand, as the appropriate changes to product labelling would ensure accurate, clear and transparent messaging. When compared to the status quo, implementing appropriate labelling requirements on infant and toddler food products would prevent the use of misleading nutrition claims that can be difficult to interpret, reducing associated risks. Regulations for the labelling of these products will simplify the customer experience and enhance overall product transparency.

QUESTION 10(b) – Are there particular approaches in this option that should be further considered? (Yes/No)

Yes

According to the Royal Children's Hospital National Child Health Poll, 53% of parents falsely believe that ready-made infant and toddler foods are strictly regulated by the Australian Government to ensure they are healthy and nutritious for this age group (2022). In reality, current regulations in Australia allow food manufacturers to sell food and drinks targeted at this age group that are high in energy and low in nutrients. Regulatory interventions could meet caregivers' expectations by ensuring products meet appropriate minimum standards for composition, labelling and texture, resulting in food products that caregivers can rely on to support child health and development.

In relation to the regulatory approaches noted in the consultation paper, we have some comments.

1. COMPOSITION

1.1 IRON

We do not support the extension of minimum iron levels to further categories of foods targeted to infants and young children.

We appreciate the particular importance of iron in the diets of infants and toddlers. However, mandatory levels of iron in infant and toddler foods will provide food manufacturers with the opportunity to place labelling on the products to advertise the fortification. Evidence from Latin America and Nepal has shown that micronutrient fortification of ultra-processed foods can lead to a 'health halo' effect, wherein consumers believe the item is 'healthy' simply due to fortification (Fanzo et al, 2023). This presents the potential for food items of otherwise low nutrient value being marketed and perceived as a healthy product, and possibly displacing nutrient-rich

whole foods. We continue to support the minimum iron levels as set out in the Food Standards Code.

1.2 ADDED SUGARS AND SWEETENERS

The Heart Foundation is concerned with the extensive use of sugar and sweeteners in foods for infants and young children in the form of added sugar, concentrated fruit ingredients, fruit and non-sugar sweeteners. The World Health Organization (WHO) European Office recommends that free sugars make up less than 10% of total energy intake in adults and children, and further recommends that foods for infants and children not have any free sugars added to them (WHO Europe, 2019). The WHO Guideline on Sugars intake in adults and children states 'free sugars include monosaccharides and disaccharides added to foods and beverages by the manufacturer, cook or consumer, and sugars naturally present in honey, syrups, fruit juices and fruit juice concentrates' (2015). Despite this recommendation, there is currently no regulation in place that limits the addition of free sugars to infant and toddler foods in Australia. In fact, a 2022 study from Cancer Council Victoria found that 9 out of 10 commercial infant and toddler food products contained added sugar, according to Public Health England's definition of 'free sugars' (Scully et al, 2023).

Children's intake of dietary sugar, especially from sugary drinks and added sugars, has been associated with elevated daily energy consumption, as well as excess weight gain and increased risk of obesity – key cardiovascular disease risk factors (Nadeau et al, 2011; Te Morenga et al, 2012). Children display a preference for sweet foods, and early introduction of such foods in the form of added sugars in the diet may promote a preference for sweet taste (Vos et al, 2017). What is particularly concerning is that evidence suggests the dietary choices established in childhood can be carried into adulthood (Mikkila et al, 2005).

The excess use of sugar and the sweetness of foods for infants and toddlers must be addressed with a comprehensive regulatory approach that goes beyond simply setting maximum sugar content thresholds for sub-categories. We strongly recommend:

Prohibit the use of added sugars (as defined in the Food Standards Code) in all foods for infants and young children up to 36 months.

Prohibit the use of concentrated fruit ingredients in all foods for infants and young children. Concentrated fruit ingredients include: all fruit ingredients other than pureed fruit and whole, cut or chopped dried fruit, including but not limited to fruit juice, fruit paste, fruit gel, fruit powder, fruit pulp, concentrated fruit puree, a blend or combination of any two or more ingredients listed above (note: this definition excludes concentrated fruit juice and deionized fruit juice as these are considered Added Sugars and would be prohibited under the Added Sugar prohibition above). Note, these concentrated fruit ingredients are all considered 'free sugars' under Public Health England's definition (Swan et al, 2018).

Limits on the use of fruit to sweeten foods for infants and young children - we recommend using the NPPM guidelines which limit fruit in savoury foods, dairy products, cereal and snacks (WHO, 2022). Fruit includes whole, dried, or pureed fruit (does not include any Concentrated Fruit Products).

Prohibit the use of non-sugar sweeteners in foods intended for infants and young children. This is important because restrictions on sugar, concentrated fruit ingredients, and fruit could lead the food industry to seek alternative sweetening methods. Non-sugar sweeteners are also referred to as high intensity sweeteners, low or no calorie sweeteners, non-nutritive sweeteners, non-caloric sweeteners and sugar-substitutes (WHO, 2023).

Foods that are high in total sugar should not be marketed as suitable for infants and young children. To ensure this, we recommend a maximum limit for total sugar as a percentage of total energy and a maximum total sugar threshold for foods for infants and young children. We recommend following the World Health Organization guidelines for this requirement (WHO, 2022).

Prohibit any drinks, other than those regulated by Standards 2.9.2 and 2.9.3 of the Food Standards Code, for infants and young children, aside from water and unflavoured milk (*Australia New Zealand Food Standards Code - Standard 2.9 Special purpose foods*, 2023)

1.3 SODIUM

We strongly recommend the introduction of maximum sodium limits for foods for young children in line with international best practice as set out in the NPPM (WHO, 2022).

High blood pressure is a leading risk factor for cardiovascular disease in Australia, with almost 1 in 4 adults measuring high blood pressure (ABS, 2023). Cardiovascular disease risk factors are also becoming increasingly prevalent in children. Data from the 2011-12 Australian National Health Survey shows that 12.6% of children aged 5—17 years had either high-normal blood pressure or hypertension (Larkins et al, 2018). There is strong evidence that links elevated blood pressure in childhood and adolescence with adult hypertension, vascular aging, cardiac damage and cardiovascular disease in adulthood (Meng et al, 2024).

In adults, about 21% of the burden from high blood pressure in Australia in 2015 was due to a diet high in sodium (AIHW, 2019). The literature shows that when sodium intake is decreased through the diet, this results in lowered blood pressure in adults. Some evidence has shown similar results from reduced sodium intake in infants, children and adolescents as well, concluding that reducing sodium consumption in this population may improve their blood pressure management (Meng et al, 2024; WHO, 2012).

As noted in the Food Regulation Standing Committee's Issues Paper, one third of young children are estimated to exceed the recommended upper limit for dietary sodium intake (*Issues Paper: Commercial foods for infants and young children,* 2023). The most important source of sodium in the diets of people in Australia include processed food products such as cereal products, cereal-based items like biscuits and pizza (FSANZ, 2023a). While there is no evidence that has examined the contribution of commercial foods targeted at infants and toddlers to their total sodium intake, these items are often highly processed and have potential to exceed NPPM guidelines. A study from Cancer Council found that 93% of infant foods assessed were compliant with NPPM sodium guidelines as they are subject to compositional sodium limits set out in the Food Standards Code. However, the study found that only 38% of toddler foods, which are not subject to compositional limits on sodium, were compliant with NPPM guidelines for sodium (Scully et al, 2023).

As compositional limits for sodium have proven to have a significant impact on the sodium content of infant foods in Australia, we strongly recommend extending compositional limits for sodium to toddler foods. Furthermore, maximum sodium limits in foods for infants and young children should align with international best practice as set out in the NPPM (WHO, 2022).

1.4 IN ADDITION TO COMPOSITIONAL ELEMENTS, WE ALSO RECOMMEND:

1.4.1 SNACK FOODS ARE ADDRESSED: Snack foods account for 35% of the food products marketed for infants and young children (Scully et al, 2024). What is of great concern is that snack foods that are high in energy and low in nutrients are increasing in prevalence, and such discretionary foods are not recommended for this age group (Scully et al, 2022).

Limits to sugar and sodium composition will not be sufficient in ensuring that these food items offer good nutrition to infants and young children. While sugar and sodium may be regulated, this would not address the high proportion of infant and toddler snack foods that are energy-dense, highly processed, high in refined flours, oils and flavourings, with little other nutritional value. Infants and young children have high nutrient needs, and as such there is no place for low-nutrient, energy-dense items as part of a healthy infant and toddler diet.

Regulatory measures in addition to sugar and sodium limits will be needed to ensure snacks support the growth and development of infants and young children. We suggest implementing maximum energy density limits in line with the NPPM, and regulation of portion sizes, oils, flavourings, additives, powders, refined flours and fortification (WHO, 2022).

1.4.2 MAXIMUM SATURATED FAT levels are set for foods for infants and toddlers and prohibition on the use of TRANS FAT in foods for infants and toddlers, as recommended in the NPPM (WHO, 2022). Extensive evidence has found that a diet high in saturated and trans fats is associated with elevated cholesterol levels in

adults, one of the most important cardiovascular disease risk factors (National Heart Foundation of Australia, 2023; Commonwealth of Australia, 2023). In children, elevated levels of low-density lipoprotein (LDL) cholesterol have been associated with preclinical signs of atherosclerosis (Berenson et al, 1992). It is estimated that excess intake of saturated and trans fat in childhood can increase the risk of cardiovascular disease in adulthood due to the longer exposure time to a high fat diet (Law, 2000). While infants and children require intake of saturated fat as part of healthy and normal development, evidence shows that reducing saturated and trans fat intake does not pose any risk to child health, and significantly reduces total and LDL-cholesterol levels as well as diastolic blood pressure (Te Morenga & Montez, 2017).

This additional upper limit for saturated and trans fats is important because restrictions on sodium, sugar, concentrated fruit ingredients and fruit could lead food manufacturers to use these alternative ingredients. Any increase in trans and/or saturated fats in foods for infants and young children would not be in their best interests.

1.4.3 MINIMUM TOTAL PROTEIN and protein weight requirements are set for commercial infant and toddler meal products. We recommend these align with NPPM guidelines (WHO, 2022). It should also be noted that protein sources in meals must be from whole foods, not protein fortification.

1.4.4 MAXIMUM/MINIMUM ENERGY DENSITY LIMITS The consultation paper noted concerns with the energy density of commercial foods for infants and young children, however no policy options were proposed to address this. We strongly recommend the adoption of policy options reflecting the energy density guidelines in the NPPM (WHO, 2022). These include maximum energy density limits for snacks and minimum energy density thresholds for most other food categories to ensure they are nutritionally dense and do not contain excess water or stock.

1.4.5 MAXIMUM SERVE SIZE LIMITS The consultation paper identified an issue with the serving sizes of many commercial foods for infants and young children but fails to provide any options to address this. To meet the goal of improving commercial foods for infants and toddlers, we strongly recommend that policy options to address the serving size are included as this work progresses.

2. LABELLING

We strongly support the review and enhancement of labelling requirements for commercial foods for infants and young children. Regarding the regulatory approaches discussed in the consultation paper, we note the following:

2.1 REVIEW OF NUTRITION INFORMATION PANELS (NIP)

We do not support the declaration of iron content on the NIP, nor any other changes to the NIP specifically for foods for infants and young children. Please see our

response regarding iron above. More generally, we believe that the information on the NIP should be useful and relevant for all ages. By the age of 12 months, the Australian Dietary Guidelines recommend young children should be eating family foods (NHMRC, 2013).

2.2 REVIEW OF CLAIM PERMISSIONS

We strongly support regulation to address issues with claims on foods for infants and young children. As stated in the NPPM, promotion of health and development during this stage of life is of critical importance, and because of this, specialised labelling regulations should be in place for foods targeted at infants and young children (WHO, 2022). The consultation paper points out that multiple claims on products have the potential to cause consumer confusion about the appropriateness of the product in the diets of infants and young children. Evidence also shows that parents and caregivers use simple health-related cues, such as health claims, images of fruit or endorsement logos found on food packaging, to judge the item's healthiness (Ares et al, 2022). Because of this, labelling on infant and toddler foods should offer accurate and clear guidance on the nutrition content of foods so that parents and caregivers can make informed choices.

The World Health Organization recommends no health, nutrition, or marketing claims on these foods (with limited exceptions), and we strongly recommend this approach should be mandated in Australia (WHO, 2017).

In relation to specific categories of claims we note as follows:

2.2.1 NUTRITION CONTENT AND HEALTH CLAIMS: Nutrition content claims for foods in section 4—3 (Standard 1.2.7—12) and health claims (Standard 1.2.7—Division 5) exist for making certain health and nutrition claims on packaged foods. These criteria have been developed at a population level and do not consider the specific nutritional needs of infants and children, and therefore have the potential to lead to misleading nutrition content and health claims on foods for this age group. As noted in the consultation paper, infant formula products are not permitted to carry nutrition content or health claims, and we strongly recommend this restriction be extended to foods for infants and children (*Australia New Zealand Food Standards Code - Standard 1.2.7 - Nutrition, health and related claims*, 2018).

An example to show the need to reform the Food Standards Code criteria for nutrition content claims would be the recent changes to the 'no added sugar' claims resulting from P1062 (FSANZ, 2024a). The threshold for this claim has been set too high, resulting in criteria that does not sufficiently address sugars in foods for infants and toddlers. This is concerning, given that the claim 'no added sugar' is not always well understood by consumers. A rapid review from FSANZ found that across seven studies, between 4—60% of consumers believed this claim meant that the food product could not contain any sugar (FSANZ, 2023b). Furthermore, this claim is highly influential, with polling results in Australia showing that 91% of parents were at

least ‘somewhat likely’ to choose to buy a particular food product based on the claim of ‘no added sugar’ (The Royal Children’s Hospital National Child Health Poll, 2022). We strongly recommend that this nutrient content claim is not permitted to be used on commercial infant and toddler foods, in line with guidance from the NPPM (WHO, 2019).

Furthermore, nutrition content claims about properties of food not regulated under Schedule 4—3 of the Food Standards Code (Standard 1.2.7-13) enables food manufacturers to use misleading claims on their packages (*Australia New Zealand Food Standards Code - Standard 1.2.7 - Nutrition, health and related claims*, 2018).

We note for example:

FREE FROM ‘preservatives’, ‘flavours’, ‘colour’ claims*:* recent research has shown these claims are the most influential to parents and carers and promote the perception these items are healthier for children, as well as promote intention to purchase (Dixon et al, 2024). We strongly recommend that claims about what is not in a food cannot be used on foods for infants and young children.

ALLERGEN CLAIMS: we strongly recommend that allergy labelling on foods for infants and young children is only permitted as per the new requirements of Proposal P1044 – Plain English Allergen Labelling (FSANZ, 2024b). These ensure that caregivers can access allergen information when needed, and there is no reason for additional claims about allergens.

MARKETING PUFFERY: claims that are not at all regulated by the Food Standards Code. These ‘unregulated claims’ have been found to be more common than regulated claims in Australia (McCann et al, 2021). A variety of unregulated claims can be found in the market, covering a range of topics including health related ingredient claims (for example ‘no added preservatives’), child-specific messages (such as ‘first flavours’, ‘ideal finger food’, naturalness (for example ‘made with natural ingredients’), environmental (such as ‘BPA free’). Policy options to regulate some other claims should be considered, for example:

ORGANIC claims: we recommend that organic claims are only permitted as described in the NPPM - within the ingredients list only (such as ‘organic carrots’). The same rule should apply to all descriptive claims, consistent with the NPPM. For example, ‘wholegrain flour’ in the ingredients list only and no claims such as ‘made with wholegrains’ elsewhere on the packaging (WHO, 2022).

TEXTURE claims: we strongly recommend prohibiting claims about texture that imply smoother products are the ideal option for young children (for example ‘smooth’, ‘no bits/chunks’, ‘easy-to-swallow texture that is great for helping your little one as they start to explore solid foods’), or a product’s dissolvable nature (for example ‘melt in your mouth’, ‘softens in mouths’).

2.3 IN ADDITION TO THE LABELLING ELEMENTS NOTED IN OPTION 3 WE ALSO RECOMMEND

That section 2.9.2-7(2) of the Food Standards Code is amended to change '4 months' to '6 months' (*Australia New Zealand Food Standards Code - Standard 2.9 Special purpose foods*, 2023). The consultation paper clearly sets out the dietary guidelines' recommendations in relation to the introduction of solids – foods should be introduced from around 6 months (NHMRC, 2013). However, 15% of infant foods in Australia are marketed to infants younger than 6 months of age (Scully, 2023). The proposed amendment would ensure that no foods are permitted to be marketed as suitable for children under 6 months of age, consistent with international best practice as set out in the NPPM, infant feeding guidelines and dietary guidelines in both Australia and New Zealand (WHO, 2022; NHMRC, 2013).

That section 2.9.2-8(1)(a) is amended to require that the percentage of ingredients listed in that section (milk, eggs, cheese, fish, meat (including poultry), nuts or legumes) are required to be declared regardless of whether reference is made to that ingredient in the label; and include fruits, vegetables, cereals, water and stock in the list of ingredients in that section for which the percentage of that ingredient must be declared (*Australia New Zealand Food Standards Code - Standard 2.9 Special purpose foods*, 2023). This is consistent with international best practice, as set out in the NPPM (WHO, 2022).

2.4 REVIEW NAMING REQUIREMENTS

We strongly support regulation to address issues with the use of inaccurate and misleading names of foods for infants and toddlers.

The World Health Organization recommends product name clarity whereby contents are listed in descending order and sweet tastes and high fruit content are not hidden (WHO, 2022). Any regulation introduced in Australia should follow this recommendation for all commercial infant and toddler foods.

We also strongly recommend that fruits and vegetables should not be permitted in the name of foods where fruits and vegetables are not in the product in their whole form or in their whole form do not make up a significant portion of the product.

2.5 REVIEW MARKETING ASPECTS

Industry has been found to use a number of child-directed marketing features on food packages, including but not limited to: characters or cartoons; celebrities; sports sponsorships; toys & prizes (Obesity Evidence Hub, 2022).

We strongly recommend that no child-directed marketing be permitted on foods for infants and young children. We further recommend this should be part of the policy reforms to improve foods for infants and young children and not as part of the Food Regulatory System workplan work on reducing children's exposure to unhealthy food

and drink marketing, or as part of the response to the feasibility study on options to restrict marketing of discretionary foods to children.

We also strongly recommend that images of fruits and vegetables should not be permitted on packaging where fruits and vegetables are not in the product in their whole form, or in their whole form do not make up a significant portion of the product.

3. TEXTURE

The consultation paper speaks generally about texture for oro-motor skills but does not highlight their importance or the critical developmental window when infants need exposure to complex textures. It also omits details on how inadequate texture exposure is associated with later risk of picky eating, lower intakes of fruit and vegetables later in childhood up to 7 years of age (Coulthard, 2009).

Feeding and swallowing development is complex, starting before birth and continuing through early childhood. The appropriate introduction of varied textures is crucial to this development, and will permit children to take part in regular table food with their peers and family, while gaining exposure to a larger variety of foods (Delaney & Arvedson, 2008).

We strongly recommend that from 9 months of age snack foods must be chewable and not of a dissolvable texture.

4. POUCH PRODUCTS

Products in pouches with spouts have been found to result in a number of unfavourable outcomes for infants and young children, such as inappropriate textures for most age groups and the potential for overconsumption (Brunacci et al, 2023). Food pouches are a popular choice partly due to the ability for young children to feed themselves by consuming directly from the pouch's spout. This method of consumption poses a risk of excessive energy intake whereby the smooth texture of the pouch contents, as well as the squeezing and sucking action used by the child, can each promote rapid food intake. What is most concerning is that commercial infant food pouches in Australia are found to have high levels of saturated fats, free sugars and kilojoules, and a single pouch can contain several serve sizes. This means that frequent use of pouches may contribute to excessive energy intake (Brunacci et al, 2023; FSANZ 2020 . The energy density of a meal is associated with excessive weight gain in young children (Brunacci et al, 2023). Weight gain in this age group has been shown to predict elevated blood pressure and waist circumference later in life – key cardiovascular disease risk factors (Nummela et al, 2022). We strongly recommend that pouches with spouts are phased out in products targeted at children aged 9 months and over.

For pouches with spouts designed for infants aged 6—9 months, we recommend clear FRONT-OF-PACK instructions indicating that the food should not be consumed

directly from the package (spout), and should be decanted into a bowl or onto a spoon prior to consumption.

QUESTION 10(c) – Food manufacturers - please provide information on the impact of potential composition options. What would be a suitable time frame for these options to be implemented in your organisation.

We recommend a two-year implementation period. Industry practices show that reformulating products within this timeframe is feasible, and delays could have adverse health impacts on children.

QUESTION 10(d) – Food manufacturers - please provide information on the impact of potential labelling options. What would be a suitable time frame for these options to be implemented in your organisation.

Similar to composition changes, a two-year implementation period is appropriate for labelling changes. Industry is capable of adapting within this timeframe.

QUESTION 10(e) – What implementation issues need to be considered for this option?

Implementation Period: A two-year period is recommended, consistent with past regulatory precedents. Delays could exacerbate health risks for infants and young children.

Industry Adaptation: Industry practices demonstrate that changes can be made within two years, highlighting that swift action is both necessary and feasible.

We advocate for rapid action so as not to delay implementation, which would allow current standards to continue impacting the health and development of infants and young children.

Effectiveness of the proposed Options

QUESTION 11 – Do you agree with the analysis of how well the proposed options would achieve the proposed objective? If not, please describe why and provide references with your response. (Yes/No)

No

1. Option 2

We disagree with the current assessment in Table 3 of the consultation paper that Option 2 (non-regulatory approaches) be rated ‘orange’ or has ‘some potential to meet the objective’ for each component (composition, labelling, texture, and feasibility). We argue that Option 2 is unlikely to significantly change the current position and therefore should be rated as ‘red’ or ‘unlikely to meet the objective’ for each component.

RATIONALE

Composition: Non-regulatory approaches, such as voluntary industry guidelines or consumer education campaigns, lack the enforceability to ensure consistent improvements in the composition of foods for infants and young children. Without regulatory mandates, industry may not be incentivised to make meaningful changes, particularly if such changes involve increased costs or modifications to established practices.

Labelling: Voluntary labelling changes and educational initiatives may not be sufficient to address the complexities and ambiguities in current food labelling practices. Without regulatory requirements, there is no guarantee that food manufacturers will adhere to higher standards of transparency and accuracy.

Texture: Addressing texture issues through non-regulatory means is particularly challenging, as it involves altering manufacturing processes and product formulations. Industry-driven changes are unlikely to prioritise or uniformly address these concerns across the board.

Feasibility: Non-regulatory approaches may lack the necessary coordination and oversight to effectively implement widespread changes, particularly given the diverse and fragmented nature of the food industry.

Evidence from similar initiatives in other sectors has shown that voluntary guidelines alone are often insufficient in driving significant improvements (e.g., voluntary nutrition labelling programs in various countries) (Jones et al, 2024). The lack of enforceability and accountability in non-regulatory approaches has been well-documented in public health literature, highlighting the need for binding regulations to ensure compliance and effectiveness.

2. Option 3

We agree with the assessment that Option 3 (regulatory approaches) has the potential to achieve strong and widespread improvements. If all proposed measures are implemented, this option offers a comprehensive framework for addressing the issues identified in the consultation paper.

While Option 3 presents a robust approach, we acknowledge that significant gaps remain. The proposed measures in the consultation paper address only selected issues related to composition, labelling, and texture. To fully meet the proposed objective, a more comprehensive set of reforms is needed. See our response for our recommendations to ensure a comprehensive regulatory approach.

QUESTION 12 – Which issues in this paper do you consider are more suitable to regulatory and non-regulatory approaches?

We believe that all the issues discussed in the consultation paper are more appropriately addressed through regulatory approaches rather than non-regulatory ones. Evidence suggests that non-regulatory approaches, such as voluntary industry

guidelines or consumer education campaigns, often lack the necessary impact and enforcement to drive significant and widespread improvements.

Ensuring that proposed measures are feasible and effectively implemented requires a coordinated approach with oversight and compliance mechanisms. Regulatory approaches can provide the structure needed to support industry compliance and ensure practical application.

Non-regulatory approaches would be limited by inefficient resource utilisation. Such approaches, including voluntary industry guidelines or consumer education, often lack the authority to enforce changes and may lead to inconsistent implementation across the industry. Non-regulatory approaches frequently fall short in achieving substantial and uniform improvements (e.g., voluntary nutrition labelling programs (Bablani et al, 2020).

QUESTION 13(a) – Do you agree with the description of the possible benefits associated with the proposed options? (Yes/No)

No

Benefits to the community: We disagree that Option 2 will effectively reduce total sugar content or enhance the iron content in commercial foods for infants and young children. Evidence supporting the widespread adoption of voluntary measures is lacking, making these anticipated benefits unlikely.

Benefits to industry: Option 1 offers industry the advantage of avoiding additional costs. However, it allows the continued sale of products that do not necessarily promote the optimal growth and development of infants and young children.

Benefits to government: Option 1 may provide short-term financial relief for governments by avoiding the costs associated with implementing voluntary or regulatory changes. However, this temporary benefit is outweighed by the long-term health costs related to the consumption of inadequate foods by infants and young children.

Health system savings: We strongly disagree with the assertion that Option 2 will generate savings for the health system. The ability of voluntary approaches to drive significant, widespread improvements is questionable, thus their potential to positively impact the health system's finances is minimal.

QUESTION 13(b) – Are there additional benefits associated with all or some of the proposed options that have not been captured? Please provide data and references for your response.

BENEFITS TO COMMUNITY

Option 3 is the only proposed option that guarantees improvements in the quality of commercial foods for infants and young children. Comprehensive reforms under Option 3 would yield several significant benefits:

Enhanced growth and development: Caregivers would be assured that commercial foods would support the healthy growth and development of their children.

Clarity and transparency: Caregivers would benefit from clearer, more accurate labelling and marketing, reducing confusion and potential misinformation regarding food products.

Health benefits: Improved food standards under Option 3 could prevent issues such as tooth decay, oro-motor development problems, and other health concerns related to inadequate food quality.

BENEFITS TO INDUSTRY

Option 1: Industry would continue to control the market for foods for infants and young children and maintain profitability from products that may not necessarily promote optimal growth and development.

Option 3: By aligning with international best practices, Option 3 would enhance the industry's reputation and export potential. This alignment would meet evolving international standards and create a level playing field domestically, particularly in competition with imported goods.

QUESTION 14(a) – Do you agree with the assessment of the costs associated with the proposed options? (Yes/No)

No

Costs to the community and to government: The consultation paper acknowledges that early nutrition and lifestyle significantly impact long-term health outcomes. However, the consequences associated with Options 1 and 2 are underestimated, failing to account for the substantial future costs of impacts to child health and development to both governments and communities.

Option 3: While there will be short-term costs for governments related to the development, administration, and enforcement of new regulations under Option 3, these are offset by the long-term benefits. The improved health and developmental outcomes for infants and young children will result in considerable future cost savings.

Costs to industry: We agree that Option 1 would incur no costs to industry. Conversely, we dispute the claim that Option 2 would impose costs on industry. The likelihood of significant voluntary implementation by industry under Option 2 is low, which diminishes the expected costs.

QUESTION 14(b) – Are there additional costs associated with all or some of the proposed options that have not been captured? Please provide data and explain your rationale and your calculations.

Costs to the community: Additional costs associated with Options 1 and 2 that have not been fully captured would be the impacts of ongoing misleading information

about commercial infant and toddler foods. Caregivers will continue to encounter misleading labelling and marketing practices. This misinformation can result in increased health care costs due to the potential adverse health effects of consuming poorly regulated foods, as well as additional financial burdens associated with addressing these health issues.

QUESTION 15 – What do you consider to be the preferred policy option(s) to recommend to Food Ministers? Please provide your rationale for your preference.

Option 3: Regulatory approach

QUESTION 16 - Please provide any other information on costs, timeframes, and feasibility for the options discussed in this consultation.

None

QUESTION 17 - Please provide any other comments or points for consideration that may not have been addressed in this consultation.

SWIFT AND COMPREHENSIVE REGULATORY ACTION IS NEEDED

The consultation paper emphasises the importance of government action to enhance health outcomes for children in Australia and New Zealand and to align commercial foods with current guidelines. To achieve these goals, a comprehensive regulatory approach is needed to address not only the composition but also the labelling, marketing, and texture of foods for infants and young children. While the consultation paper effectively identifies many key issues, it does not fully capture all the necessary aspects of food regulation for this age group. See our response to Question 10 for further details.

To safeguard the health of our youngest citizens, it is imperative that we implement mandatory policies that are strictly monitored and enforced, ensuring that commercial foods meet the highest standards.

PRODUCTS IN SCOPE

We support the proposed 'products in scope' as detailed on page 5 of the consultation paper. Given the subjective nature of some classifications, we recommend that products intended for older children be clearly labelled with an age indication (e.g., ‘suitable from 4 years’) on the front of the pack. This will enhance the effectiveness of product classification and prevent confusion between foods for infants and those for older children. This approach aligns with international best practices, such as those outlined in the NPPM (WHO, 2022).

Although toddler milks are currently excluded from this consultation, they warrant attention due to their significant marketing and health concerns. These products are often marketed as essential in young children’s diets, yet they are highly processed, high in sugar, and can displace healthier whole foods. We support their referral to the Food Regulation Standing Committee for further evaluation, including both nutritional

content and marketing practices. We recommend extending the prohibition on health and nutrition content claims, currently applied to infant formula, to toddler milks.

HEALTH STAR RATING SYSTEM

We acknowledge the summary of the Health Star Rating (HSR) System in the consultation paper. While infant foods are excluded from the HSR System under Standard 2.9.2 of the Food Standards Code, we recommend extending this exclusion to foods for children 12 months and over. As noted, the HSR System presents challenges for this category. However, if a mandatory HSR system is implemented, it must be carefully calibrated to ensure its effectiveness and relevance for foods intended for young children.

ULTRA-PROCESSED FOODS

The consultation paper does not fully address the growing body of evidence on the harms associated with ultra-processed foods, which constitute a significant portion of the diets of infants and young children. Research indicates that 85% of foods for young children in Australia are ultra-processed, and similar trends are observed in New Zealand (Fangupo et al, 2021). Ultra-processed diets are linked to various adverse health outcomes, including metabolic disorders, chronic diseases, and mental health issues (Lane et al, 2024). Given this evidence, it is crucial to consider reducing the market presence of ultra-processed foods and promoting diets aligned with dietary guidelines, focusing on fresh and minimally processed options.

WIDER CONTEXT OF EARLY CHILDHOOD NUTRITION

We recognise the broader context of early childhood nutrition and the additional efforts required to improve young children’s diets. We recommend that the government invest in:

Regular extensive surveys: conduct comprehensive infant and young child feeding surveys, including biomarkers, with consistent methodologies to enable longitudinal comparisons and flexible follow-up questions.

Updated dietary guidelines: develop updated dietary guidelines for infants and young children as part of the broader review of the Australian Dietary Guidelines.

Supportive resources: develop and distribute resources to assist in infant and young child feeding, such as the Grow&Go Toolbox.

Parental leave: ensure adequate parental leave to support breastfeeding and other essential early childhood nutrition practices.

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