

## **FOOD LABELLING ISSUES:**

### **Qualitative research on participants' perceptions and use of nutrition, health and related claims on packaged foods and associated advertising material**

**EVALUATION REPORT SERIES NO. 12**

**FOOD STANDARDS AUSTRALIA NEW ZEALAND**

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**QUALITATIVE RESEARCH ON  
PARTICIPANTS' PERCEPTIONS AND  
USE OF NUTRITION, HEALTH AND  
RELATED CLAIMS ON PACKAGED  
FOODS AND ASSOCIATED  
ADVERTISING MATERIAL**

A RESEARCH REPORT

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## Executive Summary

### 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 health-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<sup>1</sup> (dietary supplements) labels.

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<sup>1</sup> 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.

## METHODOLOGY

The research was conducted with participants in both Australia and New Zealand, via 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. 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; and/or

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 appropriate 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 (eg 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 [eg 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<sup>2</sup>, 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). 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.

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<sup>2</sup> *Food Labelling Issues: Qualitative consumer study related to nutrition content claims on food labels. July 2003*

## ***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, and no participant appeared 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
- 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.

## **BACKGROUND & OBJECTIVES**

# 1. Background and Research Objectives

## 1.1. Background

Food Standards Australia New Zealand (FSANZ) is an independent, bi-national, government-funded organisation that has the role, in collaboration with other organisations, to protect the health and safety of the people in Australia and New Zealand through the maintenance of a safe food supply. In developing food standards FSANZ also aims to provide for consumer information and prevent misleading or deceptive conduct.

FSANZ evaluates the impact of key changes to the Food Standards Code on stakeholders in order to assess how well the regulatory arrangements are working and to inform decision-making for future standards development.

The development of a standard for nutrition, health and related claims is a major area of work for FSANZ during 2004–2005, and has been identified as a key issue for inclusion in the broader Evaluation Strategy. Health and related claims are described in Proposal P293<sup>3</sup> as ‘all claims referring to nutrient content, nutrient function, enhanced function, reduction of disease risk or maintenance of normal health’. Claims are classified in ministerial policy guidance provided to FSANZ as two broad categories: general level claims and high level claims. The proposed classification of a claim is based on the degree to which the potential health benefits arising from the use of nutrition, health and related claims are balanced against the potential risks of an adverse outcome arising from the misinterpretation of the claim or an inappropriate use of the claim.

This research project collected *baseline data* from participants before the standard is finalised, and is to be used both for the development of the standard itself and for future evaluation purposes.

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<sup>3</sup> [http://www.foodstandards.gov.au/\\_srcfiles/Full\\_report\\_IARandattachments.pdf](http://www.foodstandards.gov.au/_srcfiles/Full_report_IARandattachments.pdf)

## 1.2. Research objectives

Research was required to collect baseline data from participants on how nutrition, health and related claims are perceived, and the extent to which currently available claims are used by participants in making food choices in the context of their regular diet.

The research brief outlined specific objectives for both a qualitative and quantitative research component. The purpose of this qualitative research study was to explore participants' perceptions and understanding of nutrition, health and related claims, to assist in the development of a quantitative survey. Specifically, the study aimed to:

1. Explore participants' assessments of the degree of expected health benefit and the impact on intended purchase associated with different types of claims for comparison with the classification of claims given in the policy guidance
2. Determine how participants view endorsements, cause-related marketing activity, implied claims, wellbeing and performance claims, biomarker claims, whole of diet claims, slimming claims and therapeutic claims, all on product packs, in the context of the claims identified in the Claims Classification Framework
3. Explore participants' understanding of graphics that may be used in a variety of health claims
4. Examine participants' reactions to a variety of message devices designed to enhance communication
5. Investigate participants' perceptions of health claims on food labels compared to health claims in advertisements
6. Briefly investigate participants' perceptions of health claims on food labels compared to health claims on complementary medicine/ dietary supplements labels

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

- assessing claims (relates to objectives 1 and 2)
- understanding implied health claims (related to objective 3)
- enhancing communication effectiveness (relates to objective 4)
- health claims on food labels compared to advertisements (relates to objective 5)
- health claims on food labels compared to those on complementary medicines (relates to objective 6).

These topics were outlined in greater detail in the brief, and are addressed further in the Methodology section (3) of this document. The brief also specified a need for quantitative research, to be based on the findings of the qualitative research that is reported here. To this end, this report provides preliminary recommendations for issues that should be included in the quantitative survey to follow (Section 11).

## **METHODOLOGY**

## 2. Methodology

This research was entirely qualitative in nature and consisted of a total of **n=69 personal (face-to-face) depth interviews**, stratified across the five topic areas and relevant demographic variables. In-depth interviews (as opposed to focus groups) were considered to be more appropriate for the following reasons:

- The distraction of multiple opinions and the group process was likely to be counter-productive and work against the research objectives.
- As the study is mostly concerned with individual reactions and interpretation of written material (label information), more depth and detail could be gained from personal one on one interviews, where the researchers have sufficient ‘access’ to individual thoughts, cognitive processes and reasoning.
- Labels are rarely assessed in group settings and so the depth interview better mimics a consumer’s information and decision process.

Given the volume and depth of topics that needed to be included in the study, each interview covered just one or some of the topics. The number of subjects selected for each protocol were chosen on the basis of time constraints and considered adequacy for providing suitable information, including sufficient variety in responses, on which to base subsequent qualitative research. This approach was considered to provide sufficient numbers of subjects to ascertain the potential variety of responses. The following structure was used:

Number of Interviews (total = 69)	Interview Protocol	Topics
15	<u>Protocol 1</u> Topic A	9 claims (calcium/osteoporosis examples) Healthy diet concepts Sources of information
15	<u>Protocol 2</u> Topic A	7 claims (omega-6 fatty acids/heart health) Slimming claim Healthy diet concepts Role of government
19	<u>Protocol 3</u> Topics B, D and E	6 implied claims Advertising Complementary medicines
20	<u>Protocol 4</u> Topic C	Message devices

## 2.1. Sampling

Adult participants aged 18 years and over were eligible for the research. The interview composition and structure ensured that the sample was inclusive of a mix of gender, age, education and ethnicity, levels of health consciousness and both users and non-users of complementary medicines.

In defining and ascribing levels of health consciousness, the same categories were used as in the FSANZ 2002 survey of participants' awareness and use of food label elements<sup>4</sup>. However, given the very small incidence of those *not at all concerned about the health or nutritional value of the foods that they choose* (3%) in that previous study, participants were stratified according to only two levels of health consciousness:

- highly health conscious (always or regularly choose the healthy alternative)
- moderately/not at all health-conscious (usually do not worry about the health or nutritional value of foods or sometimes like to choose healthy or nutritious foods, depending on cost and convenience, or not at all concerned about the health or nutritional value of foods).

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<sup>4</sup>Food Labelling Issues: Quantitative Research with Participants ( FSANZ Evaluation Report Series No 4)  
January 2005

## 2.2. Composition and structure of interviews

The total number of n=69 interviews were conducted in Australia and New Zealand as follows:

- Auckland (n=24)
- Sydney (n=28)
- Melbourne (n=15)
- Canberra (n=2).

Using the protocol described in 2.1 two further Canberra subjects were recruited for 'make up' interviews to replace two Sydney interviews that did not occur due to participant no-show in the last days of the Sydney fieldwork. Return to Sydney to re-schedule these interviews would have resulted in unnecessary travel costs.

A summary of the interview structure is presented below.

	Number of interviews = 69				
	TOTAL	Gender	Age	Education	Health-conscious
<u>Protocol 1</u> Biomarkers 9 claims (calcium) Healthy diet concepts Information sources	<b>15</b> (5 NZ, 10 Aus)	25/75 Male/female	3 x 18-24 5 x 25-40 5 x 40-55 2 x 55+	40/60 High/Low	50/50 Highly/ mod'ly
<u>Protocol 2</u> Biomarkers 8 claims (omega-6 + slimming) Healthy diet concepts Role of government	<b>15</b> (5 NZ, 10 Aus)	25/75 Male/female	3 x 18-24 5 x 25-40 5 x 40-55 2 x 55+	40/60 High/Low	50/50 Highly/ mod'ly
<u>Protocol 3</u> Biomarkers 6 implied claims Advertising Complementary medicines	<b>19</b> (7 NZ, 12 Aus)	25/75 Male/female	4 x 18-24 6 x 25-40 5 x 40-55 4 x 55+	40/60 High/Low	50/50 Highly/ mod'ly
<u>Protocol 4</u> Biomarkers Message devices	<b>20</b> (7 NZ, 13 Aus)	25/75 Male/female	4 x 18-24 6 x 25-40 6 x 40-55 4 x 55+	40/60 High/Low	50/50 Highly/ mod'ly

### ***Ethnicity***

It was agreed that the inclusion of the views of people from different ethnic backgrounds could be achieved by the natural occurrence of this during recruitment. For this reason, the Sydney and Melbourne interviews were recruited from a range of different metropolitan and fringe metro areas, which resulted in a mix of ethnic backgrounds being represented. All of these participants were English speaking, but some had low English literacy. In Auckland, five participants were known to be Maori or Pacific Islander, while several others were married to a Maori or Pacific Islander.

### ***Use of complementary medicines***

Approximately one-third of the sample used complementary medicines. Users were identified through the recruitment screener questionnaire, where they were asked if they had deliberately purchased a vitamin or mineral supplement (e.g. multi-vitamin tablets) or an herbal medicine (e.g. Echinacea) in the last six months.

## **2.3. Recruitment**

To ensure quality recruitment services and compliance with privacy legislation, all participants were recruited using IQCA accredited recruitment companies. In Melbourne, the interviews were all conducted at TNS's depth interview facility room with client viewing facilities. In Sydney, the interviews were spread between the TNS depth interview facility room and community library facilities in both Parramatta and Granville. In Canberra, the interviews were held at the TNS Social Research office in Griffith. In Auckland, interviews were held in the PFI recruitment interview facility in Remuera, or at a community facility room nearby.

Interviews were held throughout the day and evening, so as to ensure the inclusion of working and non-working participants. Interviews ran for one hour (on average), and participants were paid \$60 for their out-of-pocket expenses and for their contribution to the research.

## **2.4. Interview procedure**

The interviews were semi-structured and covered the range of topics outlined in Section 4.2. A copy of the Interview Protocols is included in Appendix B. The first three interviews adhering to each protocol were used to confirm that the guide, stimulus materials and label mock-ups were appropriate, and that the range of topics and exercises could be covered in the time available. These interviews confirmed the suitability of all materials, and that there was sufficient time to include an additional word association exercise on a range of biomarker terms for all except Interview Protocol 4 (message devices). From then onwards, Interview Protocols 1 to 3 began with this word association exercise.

Most of the interview enquiry focused on asking the participant to read and interpret a series of different types (levels) of health claims. In particular, participants were asked to discuss their perceptions about the health benefit being suggested by the claim (if there was a health benefit at all) and its impact on their intention to purchase the product. Claims were firstly assessed individually (either in rotated order or in a prescribed sequence, depending on the exercise) and were then compared through a card sort exercise and subsequent discussion. To assess the perceived credibility of the various claims, participants were asked to rate from 1 to 10 *'how certain they were that by consuming the product they would receive the benefit it suggested'*, and then participants were asked to explain why they had rated the claim as they had.

The rating exercise was used as a qualitative technique rather than a quantitative one, to force participants to differentiate the claims in terms of perceived credibility and then to understand these differences through discussion. The emphasis was on understanding relative differences or similarities in perceived certainty about the claims, and for this reason actual scores have not been reported. Instead, conclusions have been made about how various claims 'stack up' against each other in terms of participants' perceived certainty about the health benefit they believe the claim offers.

The interviews relied on the use of a range of different stimulus materials:

- 9 x label mock-ups for milk featuring claims about calcium
- 7 x label mock-ups for sunflower oil featuring claims about omega-6 fatty acids
- 6 x label mock-ups featuring implied health claims (milk, two canned tomatoes, chewing gum, protein bar, night time tea) and a slimming claim (chocolate milkshake).
- a range of photographs and advertisements of products featuring health claims and implied health claims
- 6 x cereal and 6 x bread label mock-ups featuring health claims and message devices.

These materials were developed by FSANZ for research purposes only, to assess consumer perceptions' of likely use of a range of different types of claims. These materials were designed to test differences between claims (potential claims as well as existing claims) and were not necessarily intended to reflect the types of claims that industry may use in practice. For this reason, the labels were not screened by industry prior to their inclusion in the study.

It should be noted that for the purposes of this report, the term 'health claims' is used as short-hand to represent the full term 'nutrition, health and related claims'.

### 3. Study Limitations

- Although the study involved a reasonably large number of participants (n = 69) for qualitative research, the results were not intended to be extrapolated to the general population. This is because participants recruited for the qualitative research were drawn from large participant databases, rather than being randomly drawn from the total population of Australian and New Zealand households. The participants interviewed were stratified on only two levels of health consciousness; highly (always or regularly choose the healthy alternative) and moderately/not at all (sometimes like to choose healthy or nutritious foods, depending on cost and convenience or usually do not worry about the health or nutritional value of foods, or not at all concerned about the health or nutritional value of foods).
- Care should also be taken when using these results for each of the five topical components of the research as stand-alone findings. The qualitative study was designed as preliminary research in its own right, and to inform the development of a follow-up quantitative survey. The number of interviews conducted per topic were limited due to the large number of issues to be addressed and available budget. For some topics there was insufficient consistency in the findings for the results to be conclusive due to a high degree of variability in participants' reactions and reasoning. These topics are indicated as such in the report.
- Specific limitations to note with respect of provision of information and further decision making:
  - Difference between advertising and provision of information – This topic proved difficult to investigate effectively due to limitations in the materials used and the time available. If this topic is to be investigated further, the focus and objectives should be narrowed and appropriate materials developed.
  - Due to the breadth of issues being investigated the two sets of health claims tested in the study differed from each other in a number of ways, which has contributed to a larger degree of variability in responses. As a result it is difficult to isolate explanations because participants were responding to a number of differences that influenced their reactions in different ways.
  - The use of the word 'may' in several types of claims (higher level claims) triggered polarised reactions, for many, the word 'may' eroded the credibility of the claim, while others found it reassuring. This aspect should be controlled for in the quantitative study.

- The type of example products (eg. milk, sunflower oil, tea, boost bars) used in the interviews to assess consumer perceptions of claims also influenced how participants responded. Some found it difficult to separate their reactions to the example product and claim from their own views about that type of product or product category. For example, participants who had never used sunflower oil felt it necessary to qualify their responses by stating this was a product they were not familiar with or were not likely to use; and may have increased the variability in responses. In the quantitative survey, it is therefore recommended that respondents be given the option of selecting from a small range of products, so they can choose the one they are more likely to consider purchasing.
- Inherent in qualitative methodology (either in-depth interviews or focus groups) the claim and product assessments did not reflect real life, as participants most likely took considerably more time to study and assess the labels than they would normally in a shopping setting. Therefore, time exposure is also an area that should be controlled in the quantitative survey.
- It is difficult to interpret the findings in isolation, as consumers take a number of factors into account when making purchasing decisions eg price, brand, taste, general appeal, novelty.
- Only 1-2 examples were tested in each exercise, and thus cannot be representative of the wide range of products and advertising in the market place

## RESULTS

## 4. Assessing Claims

Thirty interviews addressed the topic of assessing different levels of claims and related issues. This topic aimed to address objectives 1 and 2 of the study, which were concerned with:

- assessing the degree of expected health benefit associated with the claim; and
- 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). Thus, 15 interviews were conducted using the milk/calcium examples and 15 interviews were conducted using the omega-6 fatty acids/sunflower oil set. Before participants were taken through the claims assessment, particular attention was paid to the careful introduction of the nutrient featured in the examples they were about to be shown. It was explained that the words and images were about calcium or omega-6 fatty acids, and the researcher probed to gain an understanding of the participant's prior knowledge about calcium or omega-6 fatty acids.

Existing knowledge of each of the nutrients proved to strongly influence participants' understanding and interpretation of the various types of health claims, in terms of wording and/or length preference, perceived health benefit offered by the claim, and following from that, their self-reported purchase intention regarding the example product. A summary of participants' awareness and understanding of each nutrient is provided below.

### **Calcium**

Awareness of calcium was extremely high. All but one participant had heard of calcium, and the participant who had not heard of calcium was a Tongan woman (Auckland interview) who had very low English literacy. All those who were aware of the term 'calcium' were also familiar with its main benefits, with most mentioning a link to bones or bone strength/density, teeth or osteoporosis. Several also mentioned good sources of calcium (dairy foods, milk, yoghurt). It was felt that calcium was most important for women; however, several also mentioned older people, children or 'everyone' in their responses.

### **Omega-6 fatty acids**

Compared to calcium, participants in the omega-6 fatty acids interviews had far less awareness and knowledge. Even though about two-thirds had heard of the term 'omega-6 fatty acids', very few knew any more about it. Most assumed that omega-6 fatty acids were 'good for you' and thus important, but they did not know why. A few were confused between omega-6 fatty acids and omega-3, which they had also heard about. After some consideration, about one-quarter of those participants interviewed mentioned a possible link between omega-6 fatty acids and heart-related health ("*good for your heart*", "*good for your arteries*", "*reduces cholesterol*"); however, most participants, when pressed, mentioned food source associations, such as fish, eggs, bread and olive oil, rather than functional benefits.

## 4.1. Perceived health benefits of claims

Before this claims assessment exercise was introduced, the researcher confirmed for the participant that they did not need to know anything about calcium or omega-6 fatty acids to complete the exercises that followed.

Nine calcium claims and seven omega-6 fatty acids claims were used, each labelled A-I (or G).

### Calcium claims

Code	Type of claim	Claim
A	content claim	Good source of calcium
B	function claim	This food is high in calcium and when eaten as part of a balanced diet helps maintain strong bones
C	Enhanced function claim	This food is high in calcium and when consumed as part of a health diet helps to improve bone strength
D	Biomarker maintenance claim	This food is high in calcium and when consumed as part of a healthy balanced diet helps to maintain bone density.
E	Biomarker enhancement claim	This food is high in calcium and when consumed as part of a healthy diet may help improve bone density
F	Risk reduction for serious disease	This food is high in calcium and when consumed as part of the total diet may help reduce the risk of developing osteoporosis.
G	Endorsement	This food is high in calcium and when consumed as part of a balanced diet helps to build strong bones – logo of Royal Society for Osteoporosis
H	Therapeutic claim	This food is high in calcium and when consumed as part of the total diet improves bone strength. Used in the prevention of osteoporosis.
I	Cause related marketing claim	Proceeds from the sale of this product will be donated to the Royal Society for Osteoporosis

### Omega-6 fatty acids claims

Code	Type of claim	Claim
A	content claim	Rich in omega fatty acids
B	function claim	This food is rich in Omega-6 fatty acids and when eaten as part of a healthy diet is essential for healthy skin.
C	Enhanced function claim	Contains Omega-6 fatty acids. A diet rich in Omega-6 fatty acids is beneficial for a healthy heart and general well-being.
D	Biomarker enhancement claim	This food is high in omega-6 fatty acids and when consumed as part of a healthy, balanced diet may help to reduce blood

		cholesterol.
E	Risk reduction for serious disease	This food is high in Omega-6 fatty acids and when consumed as part of a healthy diet may help reduce blood cholesterol and reduce the risk of heart disease.
F	Endorsement	Rich in Omega-6 fatty acids. The Society for a Healthy Heart endorses this product – logo for Society
G	Cause related marketing claim	Proceeds from the sale of this food will go towards research being undertaken by the Centre for Cancer Prevention.

As the claims sequentially provided more information or explanation, they were deliberately exposed in the same order each time. Copies of the stimulus materials shown to participants (presented as A4 size pictures) for this section are included throughout the following discussion of findings. Whilst discussion around some types of claims was lengthier than others, for each claim the following key questions were addressed:

- What are the words saying about the product?
- Is there a health benefit suggested by the words on the product? (If so, what is it?)
- How certain are you that by consuming the product they would receive this benefit? (Assessed via a scoring exercise from 1 to 10 and a discussion, but reported via commentary regarding relative certainty – to other claims – rather than reporting scores, as this was not a quantitative study.)
- Is this claim different to the others? How is it different?

#### 4.1.1 Calcium content claim (A)

- There was no perceived health benefit interpreted from the calcium content claim. The message was viewed as straight forward and understood to mean that it ‘contains calcium’. Participants were consistent in assuming there was no direct health benefit being communicated as part of this claim.
- However, there was an inherent awareness amongst almost all participants that calcium is important for good health (i.e. strong bones) and thus this message may *indirectly* communicate an associative health message.
- A few participants asserted that knowledge underpins the interpretation of the health message, and were concerned that if someone did not know that calcium was good for them, they would miss the indirect health message. However, the researchers did not see any evidence of a lack of awareness of the importance of calcium, other than in one participant who could not read English (a Tongan person) and another participant with poor spoken English and low education.



- Almost all participants were very certain that consuming the milk labelled with a content claim would deliver the benefit it promised (containing calcium, rather than an implied health benefit) – a few were less certain because they did not consider milk to be the sole source of calcium for humans.
- However, no participant believed that milk labelled in this way had more calcium than any other milk (without such a claim). Although very little was mentioned or made of how much calcium would be in this product, if anything there was a general assumption that the calcium was naturally occurring, rather than having been added or enriched. This is contradictory to the 'rich in' content claim below.

#### 4.1.2 Omega-6 fatty acids content claim (A)

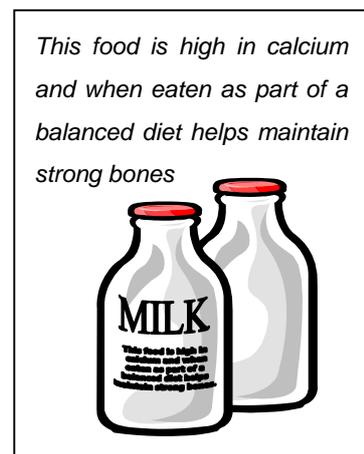
- In contrast to the calcium content claim, participants were less certain as to whether or not this claim communicated a health benefit, with most eventually assuming that it did. This is because participants were generally less informed about omega-6 fatty acids and therefore assumed there must be some health benefit, otherwise it would not be mentioned. However, most interpreted this claim as a simple statement that could be useful if you were interested in health rather than a persuasive health message.
- In their assessment, many participants distinguished between the words 'omega-6' and 'fatty acids', focusing on one or the other, and did not associate these terms together.
- Even though omega-6 fatty acids had widespread positive associations, there were some negative associations with fatty acids (fatty/fats = 'unhealthy' or 'bad for you'), which was thus confusing. participants who gave negative associations with fatty acids found it difficult to ascertain whether or not there was a health benefit communicated by this claim (as well as by the other types of claims featuring omega-6 fatty acids). (*"Sounds like it's loaded with fat!"*)
- A few participants became wholly concerned with trying to resolve their confusion over the perceived contrast between omega-6 fatty acids (assumed to be 'good') and fatty acids (assumed to be 'bad'). Some completely lost sight of the fact that they were assessing a type of oil (which is fat itself) and wanted to check the NIP to determine how much fat it contained and ensure that they would not be consuming too much fat from this product.
- Those who had heard of omega-6 fatty acids (or omega-3 fatty acids) inferred health benefits associated with the heart.



- The words 'rich in' were understood to mean 'good' or 'high' or 'lots of' ("A nicer way of saying lots of"), and a number of people assumed that the omega-6 fatty acids were fortified (and thus not naturally occurring). There was no concern raised if the omega-6 fatty acids were added. Generally, the term 'rich in' had more positive connotations than 'contains' (although it is important to note that these terms were not directly compared), and was also perceived to be more healthy than 'good source of' because it meant there was more of the nutrient present in the product – although most did not know why this would be better/healthier.
- Most participants were certain that consuming an oil labelled with a content claim would deliver the benefit it promised – those who were less certain wanted more information, including how much omega-6 fatty acids were in the product (as a %) – i.e. how much constitutes 'rich', whether and how omega-6 fatty acids is good for you, and how omega-6 fatty acids is derived (is it a natural product?).

#### 4.1.3 Calcium function claim (B)

- This claim was unanimously regarded as a health claim, as it clearly linked calcium (cause) to bone strength (benefit), and it provided more information than the content claim.
- The key words were 'maintains strong bones'; however, not all participants acknowledged or recognised the impact of the word 'maintains' and a few interpreted the benefit as 'increasing' bone strength. This claim could mean different things to different participants who do not distinguish between the subtleties of maintains vs increases. In their own words, a few participants interpreted the claim to mean "helps with bone strength" or "keeps your bones strong".
- This milk was regarded as a 'better' milk – better for you than the one with the content claim. However, a few objected to the word 'eaten' when referring to milk, and felt another word would be more appropriate (such as 'consumed').
- A number of intended audiences for this product/claim were mentioned. Whilst most said 'everyone', some groups were singled out, most commonly women, older people and younger children (for growing bones). Through the discussion it was apparent that some participants understood that there are multiple benefits of calcium (keeping bones strong for adults and older people, and building strong bones for children).
- Almost all participants were certain that consuming the milk labelled with this function claim would deliver the benefit it promised.



#### 4.1.4 Omega-6 fatty acids function claim (B)

- Participants generally viewed this claim as a health claim. All correctly interpreted that the health benefit being promised was healthy skin. For the majority who were uncertain about what omega-6 fatty acids does, this type of claim was viewed as being more useful than the content claim because it provided more information.
- However, others did not believe this claim, either because they had never heard of a link between omega oils and healthy skin, or because they did not believe that any one product could give you healthy skin. The most sceptical participants related stories of people with beautiful skin who did not eat omega-6 fatty acids and people with terrible skin who would be using omega-6 fatty acids already if it worked.
- 'Healthy skin' was understood to mean both 'inside and outside', and frequent mentions included "clear, no pimples", "free from blemishes", "glowing skin", "soft skin", as well as "healthy on the inside too".
- A few participants were sceptical about how oil could be linked to healthy skin, and they questioned whether consuming the oil would make your skin oilier or give you pimples.
- One participant who had initially but tentatively associated omega-6 fatty acids with reducing cholesterol second-guessed her assumption when she saw this claim, and believed that she must have been wrong about linking omega-6 fatty acids to cholesterol reduction.
- Participants had mixed reactions to the word 'essential' – it was consistently perceived to have positive connotations and usually meant 'necessary'. However, very few believed this claim and several found it concerning because they felt it was possible to have healthy skin without consuming this product. Whilst most participants could rationalise that it was the omega-6 fatty acids that was a contributor to healthy skin (not the oil in general), there were a number who felt the product's manufacturer was trying to 'force' them to buy it and felt that it was a marketing ploy.
- The words 'total diet' were considered unnecessary by most and confusing by some. A few interpreted the claim to mean that consuming the oil can make an unhealthy diet healthy.
- Compared to their certainty about the calcium function claim, participants were generally *much less* certain that consuming the oil labelled with this function claim example would deliver the benefit it promised – most disbelieved the claim or would seek to verify it before believing it completely.

*This food is rich in omega-6 fatty acids and when eaten as part of the total diet is essential for healthy skin*



#### 4.1.5 Calcium enhanced function claim (C)

- Generally participants did not see a great deal of difference between this claim and the previous calcium function claim – in terms of overall health benefit. Few participants noticed the wording difference between ‘maintains’ and ‘improves’ without prompting from the researcher.
- When prompted, the difference between the two terms was understood by most, but not all. Most interpreted ‘improve’ to mean this product would be useful if you have a problem with bone strength, and ‘maintain’ to mean that you need this product now/all the time. Some (not the majority) felt that the enhanced function claim promised more, as it would improve the bone strength.
- A few participants were thrown by the term ‘bone strength’ and did not know what it meant – they preferred the expression ‘strong bones’.
- Again, most felt that this claim was relevant for all ages; however, some assumed that it was targeted at older people because it could help improve what they did not have rather than only maintaining their poor bone strength.
- One participant felt that this was a false claim – as “no one can improve your bone strength”.
- In terms of certainty in the health benefit promised, this claim was rated the same as the previous function claim.

*This food is high in calcium and when consumed as part of a healthy diet helps to improve bone strength*



#### 4.1.6 Omega-6 fatty acids function/wellbeing claim (C)

- This claim was universally favoured over the function claim related to healthy skin, because it was deemed more believable and useful. It was also favoured over D below (biomarker enhancement) because heart health was generally considered more important (to more people) than cholesterol-related benefits (and some believed that heart health included low blood cholesterol).
- Most felt that the key benefit was a healthy heart (the key word in the claim), and many considered this very important. It was particularly relevant for those who had a heart condition or who were conscious of their or their family’s heart health.

*Contains omega-6 fatty acids. A diet rich in omega-6 fatty acids is beneficial for a healthy heart and general wellbeing*



- 'Healthy heart' was associated with clean arteries. The emphasis was not on improved performance of the heart, but on maintaining current functioning, and the key aspects included:
  - a heart that beats
  - one that works
  - a heart that is not fatty
  - one that is free of disease
  - a normal heart.
- There were a few participants who felt this claim was a 'big claim' or an over-claim, and a few could not reconcile having 'fatty acids' (bad) and 'healthy heart' (good) in the same sentence.
- 'Wellbeing' was understood to infer that the product was beneficial for everyone, and meant you would be healthy inside and out. However, this word was not integral to the usefulness and appeal of the claim, and the biomarker word association exercise demonstrated that most people associate wellbeing with holistic, spiritual health, as well as physical good health (see Biomarkers, Section 5).
- The term 'beneficial' was preferred to 'essential' (function claim); however, some participants wanted more information to ascertain how much of the product one needed to consume to receive the benefit, and whether one can have too much.
- Some participants, particularly younger ones, felt that this claim was aimed at older people.
- Many participants were certain about the health benefit offered by this claim, because it provided them with the information they needed to know (i.e. the benefits of fatty acids) and did not indicate that it was 'essential' as was highlighted in previous function claim.

#### 4.1.7 Calcium biomarker maintenance claim (D)

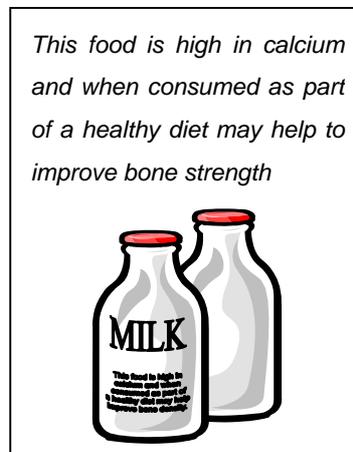
- This claim was viewed to be similar to the function and enhanced function claims, only using different words.
- The key health benefit was perceived to be maintenance of bone density. However, quite a few participants felt that 'bone density' was a more (and unnecessarily) complicated term than 'bone strength', and that given they mean the same thing there was little need for the more complicated wording. This observation was confirmed by a couple of participants of non-English speaking background who referred to this claim as a 'more educated' one.
- The perceived degree of certainty (in the health benefit) was similar to function claims.

*This food is high in calcium and when consumed as part of a balanced diet helps to maintain bone density*



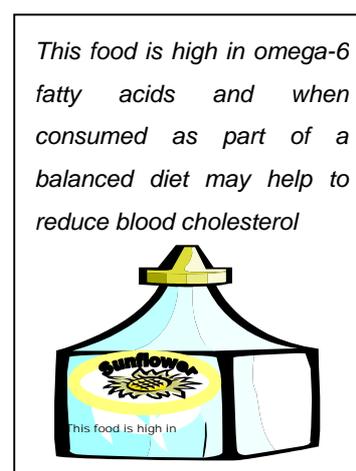
#### 4.1.8 Calcium biomarker enhancement claim (E)

- Although the health benefit expressed through this claim was perceived to be almost the same as the biomarker maintenance claim (D), participants were less certain about this claim and viewed it less favourably than the maintenance claim because of the word ‘may’.
- Some participants strongly objected to the use of the word ‘may’ and this dominated their reaction to the claim overall, resulting in them dismissing it on the grounds of low or questionable credibility. Most participants felt that this word reduced the veracity of the claim and softened up what it was trying to say – when describing their lack of confidence in this claim one participant referred to it as “a lottery”.
- Some participants proposed that manufacturers needed to use the word ‘may’ to avoid being sued; however, they did not like the use of this word, particularly when comparing to claims that had previously been shown (that did not use the word ‘may’).
- Because of the strong reactions to the word ‘may’ and the distraction it caused, there was little spontaneous or prompted reaction to the differences between the terms ‘improves’ and ‘maintains’.
- Participants were far less certain about this claim compared to those assessed prior to it.



#### 4.1.9 Omega-6 fatty acids biomarker enhancement claim (D)

- As with the calcium biomarker enhancement claim, reactions to this claim were dominated by the word ‘may’. However, opinion towards the inclusion of this word was more variable. A substantial number of participants felt that the word eroded the certainty to the claim and did not feel that a claim with this word should be allowed. A few compared the words ‘may help’ (uncertain) to the word ‘beneficial’, which they interpreted to mean ‘should help’. However, others favoured the use of the word ‘may’ because they felt it was realistic, and not over-claiming – accounting for individual differences and left it open to one’s own interpretation.



- Most indicated that the key health benefit of this claim was that it reduced blood cholesterol levels. Even though many understood the benefits of reducing blood cholesterol levels, there were some that were not sure what the benefits of this reduction would be. The expression of this claim (other than the words 'may help') was favoured over the function claim (but not the function/well being claim) because it was more specific and heart-related.
- Some participants indicated they would want more information in order to make a decision about whether to buy this product – information regarding how much omega-6 fatty acids is optimal to receive the benefit, the RDI for omega-6 fatty acids and %RDI in the product, sources of omega-6 fatty acids and whether it was naturally occurring in the product or artificially added.
- Some indicated they felt this claim was targeted at older people because of the reference to blood cholesterol, which some considered to be an older person's illness. A few referred to it as being a 'men's problem'.
- Some participants felt that the previous claim was better (function/wellbeing), as it used the term 'healthy heart' as opposed to 'blood cholesterol', which they felt some participants might not understand.
- The inclusion of the term 'balanced diet' was perceived positively, suggesting to some that one needed a balanced diet in order to reduce cholesterol, which made the claim more realistic.

Overall, participants considered biomarker claims as a form of health-related claim, but did not provide consistency in comparisons (i.e. 'similar' or 'different') with other types of claims. Some favoured biomarker claims over earlier claims because of the specificity of the information they gave, and thus the amount of certainty one had about the benefit. It would be of interest to further explore in a quantitative study whether consumers consider biomarker claims similarly to other claims, and if so, to which type eg function/ enhanced function/ risk reduction claims.

#### 4.1.10 Calcium risk reduction for serious disease (F)

- The key perceived benefit was that this milk would reduce the effects of osteoporosis or help the person avoid this illness. This was the first time that most participants spontaneously mentioned 'osteoporosis' when interpreting the claims, indicating there needs to be an explicit reference to the disease for this inference to be made while reading a claim.
- Most felt that this claim was promising considerably more than claim E, even though the word 'may' is still in this claim. This could be because the scientific or medical nature of the term 'osteoporosis', was seen as a stronger term than 'bone strength'. This claim was generally viewed as credible and important.
- Overall, this claim was not viewed as being particularly different to E (biomarker enhancement) or C (enhanced function); however, it was deemed to be giving a more preventative message.
- Even though a few participants felt that the word 'osteoporosis' was too complex and were concerned that many participants would not understand what it means, a lack of understanding was not observed in many participants. Others felt that this term was more relevant to older audiences and as a result would turn off younger participants from choosing this milk.
- Most participants felt that improving bone density and reducing the risk of osteoporosis were closely related, and that one was not more important than the other. However, very few made this link between osteoporosis and bone strength in the previous claims.

*This food is high in calcium and when consumed as part of the total diet may help reduce the risk of developing osteoporosis*



#### 4.1.11 Omega-6 fatty acids risk reduction for serious disease (E)

- There were very positive reactions to this claim. The claim was perceived to offer two benefits – reducing cholesterol and heart disease – and the product was viewed by some as healthier than previous claims. This claim was seen to be a combination of C (function/wellbeing) and D (biomarker enhancement), but participants were divided on their views about this. Some interpreted the claim to offer twice the benefit, while others felt that the claim was stating the same thing twice and that the benefits were similar enough to only need stating once.

*This food is high in omega-6 fatty acids and when consumed as part of a healthy diet may help reduce blood cholesterol and reduce the risk of heart disease*

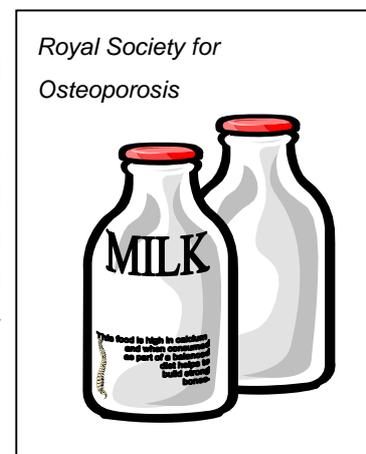


- The word ‘may’ elicited similar reactions to previous claims, with some people favouring it, but most finding it frustrating – wanting to know ‘does it or doesn’t it?’ Even though this difference in reaction came down to personal preference, generally the use of the word ‘may’ did not appear to erode the credibility of the claim to the same extent it did in other claims, perhaps because, as a couple of participants indicated, the two benefits balanced any erosion of credibility from the word ‘may’.
- A few participants spontaneously indicated that they liked the reference to ‘healthy diet’, as this reinforced there were other factors that needed to be considered to lower blood cholesterol, such as diet, exercise and genetics. However, in contrast one participant indicated that this reference would “*turn him off*” this oil, as he felt that he did not have a healthy diet and therefore would not receive any benefits – the reference implied that you had to have a healthy diet to receive the benefit.

The word ‘may’ eroded confidence in the claim (for some) and led to a greater number and range of requests for further information.

#### 4.1.12 Calcium endorsement (G)

- Reactions to this type of claim were polarised, but not evenly. Most responded favourably, perceiving the claim to be more credible and trustworthy than other claims (such as C, E and F), because of the endorsement by the society and the symbol. In combination (endorsement, symbol + words “this food is high in calcium and when consumed as part of a balanced diet helps to build strong bones”) this type of claim was perceived to be very effective, and greater health benefit was attributed to this claim compared to other claims.
- In contrast, a smaller proportion of participants did not react favourably to the endorsement. These participants, from both countries, were suspicious of this kind of endorsement because of information that they had received about other endorsements (e.g. the Heart Foundation tick), or they were inherently suspicious of endorsements. Some felt that this kind of endorsement can be bought and that this reduces the veracity of the claim.
- Some participants felt that this picture of a spinal cord was better at getting the information across quickly and simply. They indicated that they did not want to have to read all the information on the package and that the picture would give them a quick and easy understanding that this milk was good for their bones – which is all they needed to know.



- A few participants felt that this claim applied more to younger people because it promised to build bone strength, which was considered to be more relevant to younger participants.

Positive reactions and accelerated trust attributed to this claim were confirmed in the card sort (refer 4.2), when this claim was usually ranked in the top 1-3 for health benefit.

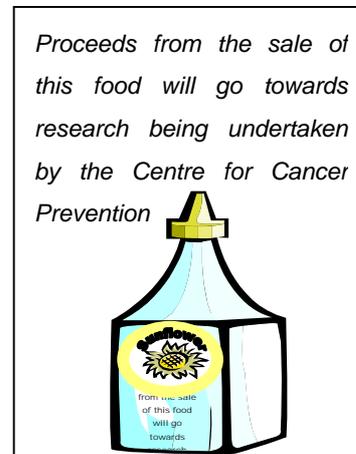
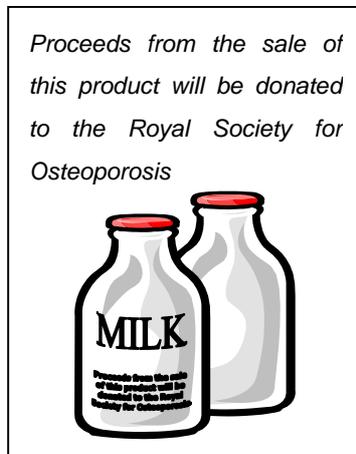
#### 4.1.13 Omega-6 fatty acids endorsement (F)

- Reactions to this endorsement claim were also polarised. There were a few participants who felt that this claim did not communicate any functional benefit from consuming the product (as opposed to the calcium example) and thus if one did not have heart problems in the family one would not be likely to pay attention to the endorsement.
- Most participants indicated that the key health benefit of this was a reduction in blood cholesterol levels, or that the more general benefit was that this oil would not harm your heart like other oils could/did.
- Participants' degree of certainty in this claim varied, depending on whether 'the society' (nominated in the label) was linked to the Heart Foundation or not (certainty was higher if one could know this).



Common to both the calcium and the omega-6 fatty acid endorsement claims was participants' belief that the endorsing society would substantiate the claim and would have undertaken relevant tests to prove the claim. Endorsements from known organisations (such as the Heart Foundation) carried more weight, 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.

#### 4.1.14 Cause-related marketing claims (I and G)



- When properly considered, almost all participants felt there was no health claim made by these statements. However, a few acknowledged that at first glance, in the usually busy and fast shopping environment, it was possible that they would initially believe there to be a health-related benefit. However, most regarded it as marketing with a cause and not an independent endorsement of the product, and while they considered a donation to a worthy cause to be commendable, they did not feel there was any health benefit offered in this claim.
- In the card sorts, these claims were consistently ranked low (or bottom) on health benefit (see 4.2); however, on impact on purchase intention (see 4.3) quite a few participants shifted this claim closer to the top in terms of their likelihood to buy the product with this claim for other reasons (more so for milk than oil). These were participants who 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.
- More so than the calcium example, there were a couple of participants who linked the cause-related claim for omega-6 fatty acids to a reduction in cancer. These participants indicated that the health benefit for them was a reduction in their chances of getting cancer. A couple of others felt that the product must in some way be linked to reducing the risk of cancer (they were not sure how), but assumed there must be some (even small) connection, otherwise the claim would not be there.
- There was one comment that the sunflower picture appeared to be healthy, and this was suggestive that the product itself was healthy – this comment was not made for any other type of claim, even though a picture of sunflowers was on all the other products.
- Participants were also highly uncertain about the veracity of this type of claim in terms how much of the sale would actually be provided to the Society.

#### 4.1.15 Calcium therapeutic claim (H)

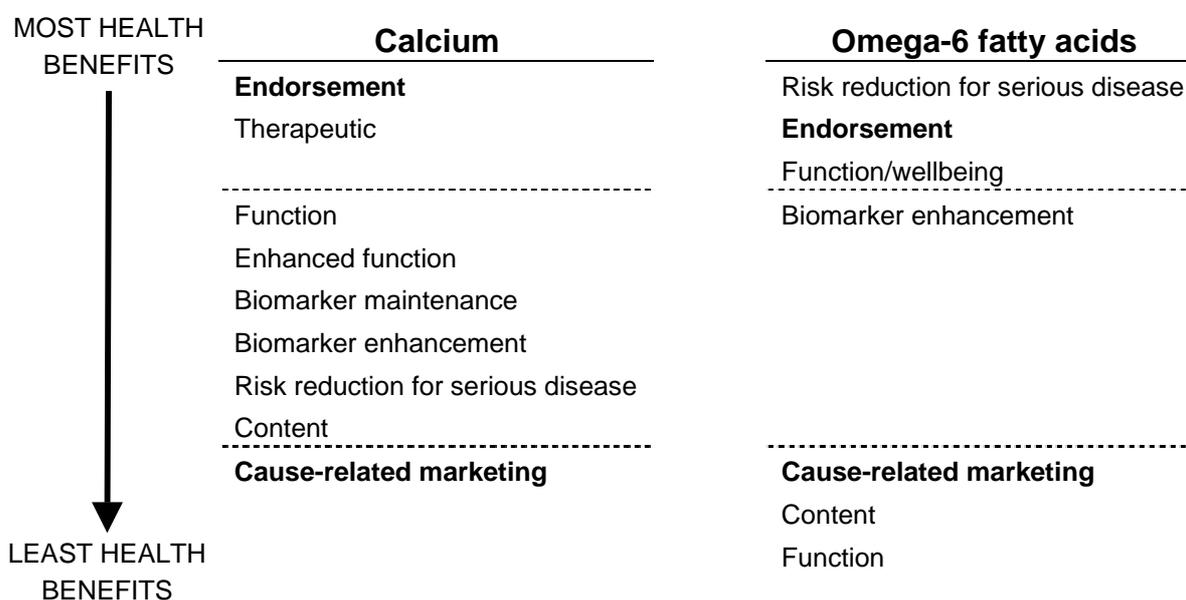
- Most participants felt this was a very effective claim because it made the link between osteoporosis and bone strength that had not been in previous claims.
- Generally, the key health benefit of this claim was that the risk of osteoporosis would be reduced by building strong bones – a double benefit.
- Most participants felt that this was better than previous claims because:
  - of the link between the disease and bone strength
  - of applicability to old and young people (osteoporosis and strong bones)
  - it does not alienate those who do not know what osteoporosis is.

*This food is high in calcium and when consumed as part of the total diet improves bone strength. Used in the prevention of Osteoporosis*



## 4.2. Grouping of claims on perceived health benefits

After assessing the calcium or omega-6 fatty acids claims individually, participants were asked to undertake two sorting exercises. In the first exercise participants were asked to sort the claims (either calcium or omega-6 fatty acids) according to those they felt would give the most and least health benefits. Participants were instructed to sort the claims in any way they liked (grouped or ranked), and to assume that they bought the product featured (milk or sunflower oil). The findings are summarised in the diagram below, which is a simplistic representation and should be carefully considered in conjunction with the explanatory notes that follow.



There was considerable variability in the way in which participants sorted the claims based on perceived health benefits, both in terms of:

- how they approached categorising the claims (some sorted into a number of groups of ‘like’ claims and others ranked them instead of grouping); and
- the rationale for positioning claims as they did.

As a result, we cannot generalise about claims, in terms of participants’ understanding of the expected health benefits. 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’ by most participants, and these appeared at the extreme ends of the ‘most/least’ 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 placement of this claim towards the top was not simply because of the absence of the word ‘may’ but because it was seen to be offering more.
- The cause-related marketing claim was always ranked towards the bottom of the scale – participants understood this claim to be offering much less health benefit than most other types of claims.

There was no consistent pattern in the way the remaining claims were sorted, with a range of explanatory issues accounting for a high degree of *individuality* in the way participants attributed relative health benefits to each type of claim

Key aspects of claims that appeared to influence participants’ belief that a product had greater health benefits 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; or
- less doubt and uncertainty (no use of word ‘may’).

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 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 that were considered to have lesser health benefits included:

- a lack of information on the benefits of the omega-6 fatty acids or calcium
- information that was considered to be untrue – such as the reference to healthy skin, which some participants felt could not be influenced by oil
- use of the word ‘may’ – many felt this reduced their confidence in the claim.

There are a number of issues that explain the high degree of variability in the way participants sorted the claims on perceived health benefits:

- Claims were differentiated by *how much information* (or how many health benefits) they provided and whether they were perceived to be offering more explanation of the link between consuming the key nutrient and the health benefits, compared to other claims, or only restating the same benefit by using different words (telling them what they already know). This assessment came down to personal preference, partly influenced by their apparent education and literacy levels.
- Overall, there was a preference for claims that communicated a '*clear link between consuming the product and the health benefit*', and the link had to be causative and unequivocal. However, even though most participants felt the word 'may' reduced the efficacy (strength/trustworthiness) of the claim, there were a few who liked the use of this word. Those who liked the use of 'may' believed it strengthened the believability of the claim – made it more trustworthy because the manufacturer was not trying to over-claim or promise something that was impossible to deliver. This was the view of participants who were generally sceptical of labelling and advertising or who did not believe any one food could deliver a health benefit on its own.

The value/importance placed on claim information (over and above the content claim) depended on the level of *prior knowledge* a participant had about the link between the nutrient and potential the health benefits (generally greater for calcium than omega-6 fatty acids).

Therefore, some participants regarded short and simple claims (such as content and function claims) as offering more health benefits because these types of claims inferred un-stated health benefits from their prior knowledge. For example

- For the omega-6 fatty acids claims, those that were perceived as communicating greater health benefits were those providing more information on the effects of fatty acids, where the consumption of the product could be clearly linked to a positive health effect. Generally, claims that linked fatty acids to a healthy heart or lower blood cholesterol were considered to have high health benefits. This was because fewer participants (almost none) understood why omega-6 fatty acids are beneficial, and therefore needed the claim to make a clear link between omega-6 fatty acids and the health benefits.
- This was not necessarily the case for the calcium claims. In the calcium exercise there was a greater proportion of participants with prior understanding of the benefits of the key nutrient (calcium and its link to bone strength) and thus calcium function/content claims were ranked higher, compared to the participants that ranked the similar omega-6 fatty acids claims. In some cases those who ranked the calcium content claims higher (i.e. most health benefits) than omega-6 fatty acid content claims did so because it was '*simple*' and allowed the participant to use their own knowledge about milk (or omega-6 fatty acids) to infer the benefits. This claim was only put forward by those who had a higher degree of knowledge of the health benefits of calcium or omega-6 fatty acids.

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.

- For the calcium claims (only), information that was considered to be 'more scientific' was also generally placed higher in terms of health benefits. In this exercise, the claims that specifically mentioned 'osteoporosis' were rated higher in terms of their health benefits, compared to those that only mentioned 'bone strength' or 'bone density'. This finding was consistent across the interviews, despite the fact that during the individual assessments, participants did not necessarily favour claims with the word 'osteoporosis', and others unfavourably described the term 'bone density' as being 'too educated or scientific' compared to the term 'strong bones'.

Clearly, the way in which participants arrive at their understanding of the relative health benefits of each type of claim is based upon the interplay of a combination of rational and motivational issues. One example that illustrates this interplay is the value placed on the word 'osteoporosis' in the calcium exercise:

- It is worth noting that the endorsement claim was most often ranked highest in terms of health benefits, even though the word 'osteoporosis' occurs in the endorsement rather than the wording of the claim. However, the word 'osteoporosis' also occurs in the risk reduction for serious disease claim, where it was ranked much lower – this may be due to the word 'may', which appears to have eroded the effectiveness/certainty of this claim. The word 'osteoporosis' also appears in the cause-related marketing claim; however, all participants were able to discern that this was not a health claim.

#### 4.2.1 Sort on calcium content

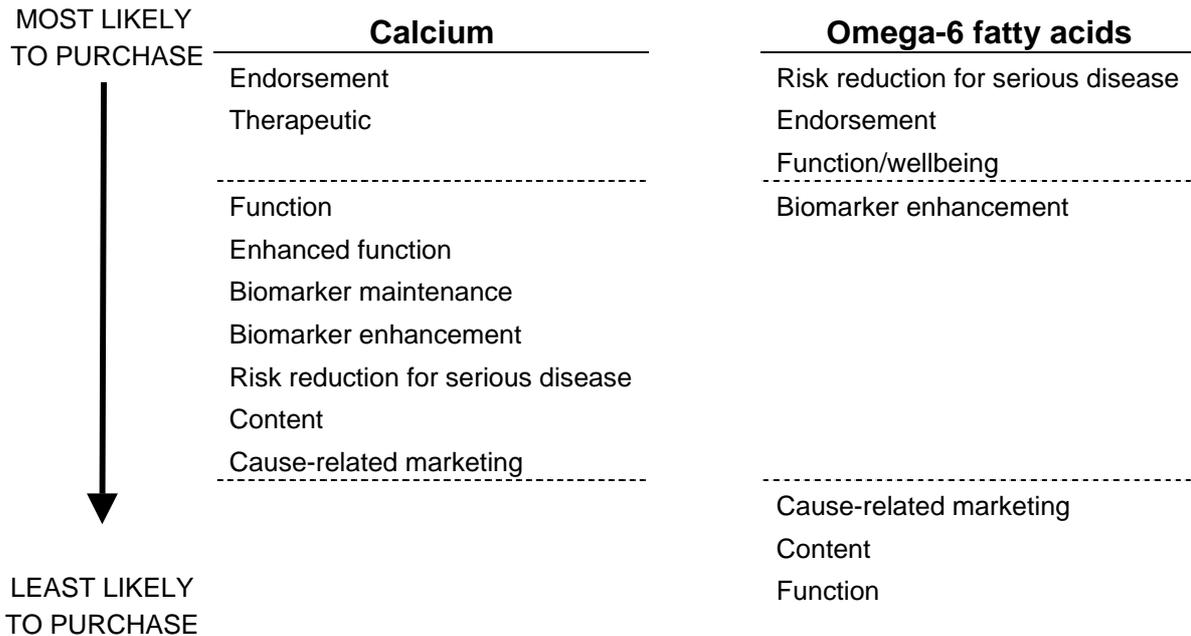
All of the participants who undertook the calcium claim sort (n=15) were also asked to nominate those claims they felt indicated the milk product had more or less calcium than others. Almost all participants considered that the milk claims all had the *same level* of calcium. There was little difference in participants' understanding of 'high in' and 'good source' – all were perceived to mean roughly the same thing.

There were three key reasons for this:

- participants already had a good knowledge of calcium and milk, and the relation between the two
- no claim overtly stated that there were higher levels of calcium
- participants were not able to look at the NIP, with all indicating they would to verify calcium content.

### 4.3. Grouping of claims on purchase intention

After the sorting exercise on health benefits, the claims were shuffled and participants were asked to re-sort them based on whether or not they would buy each one. Again, participants were encouraged to sort the claims, by grouping or ranking them the way that made sense to them.



Most participants made little change to how they had sorted the claims based on health benefits, confirming that their purchase decision was based on their perceived health benefits of the product. This was particularly the case for the health-informed or health-conscious participants, or those who shop with particular health conditions in mind, but was also a general trend for less informed participants.

There were 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. This occurred more often in the calcium claims than the omega-6 fatty acids claims. These participants indicated that they did not buy milk for health reasons (particularly) and that they felt better that their purchase would contribute to a 'worthy' cause. The assumption was that the donation would contribute to research or helping people. Some qualified their ranking with an intention to find out exactly how much money was being donated.

Even though it appears (from this exercise) that participants generally purchase based on health benefits, many participants indicated they would need to first verify the price, the brand and the fat content before making a decision to purchase. Many indicated that the fat content would be the overriding factor that would influence their intent to purchase both the milk and oil. Some also indicated they would want to know the kJ content of the oil.

Most participants also indicated they would be willing to switch from their current brand to another brand that used one of these claims – if all other aspects remained the same (e.g. price and fat content). They felt that the health claim information was important and that milk/oils with these details would generally be preferred. Some participants also indicated that whilst they currently don't use much oil or do not use sunflower oil, a claim such as this (their preference) would encourage them to purchase this product, as it clearly had health benefits.

#### 4.4. Slimming claim

After the assessment of the omega-6 fatty acids claims, a slimming claim was introduced and assessed through similar questions to the omega-6 claim set:

- 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. Perhaps this latter reaction was relative to the health benefits that had been discussed previously (e.g. heart health, lowering cholesterol).
- 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. When encouraged by the researcher, they were likely to make a highly critical assessment.
- One participant indicated that she felt the only reason this product would work is because you have to consume it as part of a balanced diet and that if you had a balanced diet you would not need to manage your weight.
- The remainder were either slightly interested or neutral, and put more effort into their comments.
- Many had doubts or were confused about what exactly the product was offering, and wanted more information to be provided about:
  - kJ, sugar and fat content – which would be verified using the NIP
  - how exactly the product would work to achieve its claim
  - what was meant by 'weight management' – clarification of whether this meant weight loss, maintaining current weight, or weight gain (this term was not well understood by any participant)
  - how the product is prepared and whether it is a meal replacement or is consumed in addition to usual diet
  - what the unique substance *chromium picolinate* is, how it works and whether it is a naturally occurring or artificially made substance
  - flavour.
- Most assumed this was a short-term weight loss product that would be used by overweight people (however, they felt this was not clear enough from the claim and packaging).



- 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 allowance, including:
  - remove the word 'may assist' and not allow unless there is proven evidence that it has worked, and who it has worked for
  - information about the unique ingredient
  - not for sale in the supermarket
  - advise to use in conjunction with exercise (one person).
- However, a few participants felt that this sort of claim should be more heavily regulated against, because this claim could cause harm. One participant commented that the picture of the milkshake represented milk and as everyone knows that milk is a healthy product, the implied message from the label is that this product is healthy.
- The majority of participants did not believe that a health benefit was offered in the claim.

As part of the consideration of consumers understanding of slimming claims the mis-conception of 'negative energy' was also briefly investigated i.e. a product 'uses up' more energy (kJ) than it provides however, no participant made any reference to this concept. Many indicated they would look at the NIP for fat levels and sugar levels and would need more information on the additive before they would purchase this product.

## 4.5. Concept of a healthy/balanced/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'.

There was variation in what was understood by these terms, both between each term and within each term. The findings are presented below.

### 4.5.1 Concept of a 'healthy diet' (vs 'balanced' and 'total')

- This term was most preferred – the word 'healthy' resonated more quickly and strongly with participants, and everyone appeared to have a similar shared understanding of what it meant:
  - only good foods
  - good food and plenty of exercise
  - only vegetables – 'rabbit food'.
- When included in claims, a few participants commented that the term 'healthy' caused them to think/question the content of their diet or the product in question and its contribution to their overall diet (more so than 'balanced').

#### 4.5.2 Concept of a 'balanced diet' (vs 'healthy' and 'total')

- This term was preferred over 'total diet' (but not as much as 'healthy') because it was more meaningful to participants, and there was less reported variation in what it meant (although still some different interpretations). The most common understandings were:
  - one serving from each food group every day – the food pyramid
  - exercise and diet – a little of both
  - good and bad things each day – good outweighing bad
  - a mix of mostly good foods with some treats (in moderation)

but

- could be really unhealthy – a balanced diet of McDonalds
- a few didn't know what this word meant.

#### 4.5.3 Concept of a 'total diet' (vs 'healthy' and 'balanced')

- This was the least preferred of all three concepts because it was considered too vague or abstract and was most open to wide-ranging interpretation:
  - strict, regimented diet of only 'good' foods – fruit, vegetables, etc.
  - inclusive of anything and everything that you eat, good and bad – too non-specific
  - exercise and diet – no bad foods at all and a lot of activity
  - just what you eat in a day – no actual diet, only the daily diet.
- 'Total' diet was not understood to necessarily mean a 'healthy' diet – it is most definitely perceived as different to the term 'healthy' or 'balanced' diet.

A number of participants suggested (and preferred) a combined term: 'healthy, balanced diet', which they felt was more meaningful. It is therefore recommended that relative preferences between 'healthy diet', 'balanced diet' and 'healthy, balanced diet' be tested quantitatively to be conclusive in this finding.

**Summary:**

In assessing the various types of health claims (previous exercise), reactions to these concepts varied between participants. A few completely ignored or overlooked it, with other key words in the claim attracting their attention instead (either the health benefit key word or the word 'may'). Others commented spontaneously on the term (as opposed to having to be prompted by the researcher), particularly the term 'total diet', which almost everyone disliked because they did not understand its meaning or relevance.

Most participants felt there was a need for this kind of concept to be included in the claims. Indeed, many felt it was necessary because, for example, only consuming the milk did not ensure that one developed strong bones or prevented osteoporosis. Most felt that if such words were not included with the claims, it would imply that all someone had to do was consume the product to obtain the benefit. However, there were a few participants (a minority) who felt that such a statement was unnecessary and made the claim too wordy.

**4.5.4 Concept of wellbeing**

This concept was associated most strongly with a holistic sense of good health – 'mind, body and spirit' – encapsulating good (healthy, balanced) diet, regular exercise, contented, happy and healthy lifestyle. Further analysis of this concept is reported in Section 5 (Biomarkers).

## 4.6. Role of government

The research also aimed to include discussion on participants' views of the role that government is presently undertaking in regulating claims, the role that participants believe the government should be playing in terms of their expectations of the degree of certainty of scientific evidence to back-up claims, and the level of regulation required for these types of claims. The extent to which these objectives could be explored was limited by the time available in the interview, after other higher priority objectives had been covered. Fifteen interviews addressed this objective, and key findings follow.

Almost all participants indicated there was a clear role for government in the management of these kinds of health claims. They felt there was a need to have an impartial review of the claim to ensure that it was legitimate and correct. Many felt that this government involvement would ensure they could trust the claim and would prevent the public from being misled by manufacturers.

In most cases, participants felt this was the responsibility of the government rather than manufacturers; however, they did not feel it had to be managed by a government department *per se*, but an appropriate trustworthy body that was empowered by government. Participants indicated that manufacturers were responsible for marketing and selling their product and were not considered to be independent.

Most participants felt there needed to be some form of scientific evaluation of the claim, and that this evaluation needed to be conducted by the government. Specifically, they felt that where a claim implied that it had a clear health benefit there needed to be some scientific evidence that this claim was actually correct. Scientific evaluation could take the form of testing of the claim or, if the claim was well known and understood, this only needed to be highlighted on the package.

Some participants suggested that the package could contain an endorsement or symbol that indicated that the government had reviewed and endorsed the claim. They felt that this endorsement would be trusted more than other endorsements, as the government could ensure impartiality and the symbol could not be bought by a manufacturer. It was very important that any such endorsement was not available for purchase, as the National Heart Foundation's "tick" was known to be by quite a few participants.

Participants indicated that claims that could be detrimental to someone's health needed to be regulated more strictly. These included claims that related to weight management (slimming) and claims where additives had been added to food that would otherwise not be contained in the food.

## 4.7. Sources of information

Sources of information used by participants on what constitutes a 'healthy diet', and the credibility and trustworthiness of these different sources, were also explored in the research. This objective was only covered in fifteen interviews and was considered to be a lower priority.

The most frequently mentioned sources of information included:

- NIP panel – generally people were looking for fat, sugar and salt content on this NIP panel.
- recipe books – information on how to cook in a healthy way
- word-of-mouth – information from other mothers, friends on how to eat well, what foods were good and what were bad
- TV – current affairs, cooking shows, lifestyle shows and ads
- newspapers
- magazines – women's
- doctors
- advertising in the supermarket – aisles and on the packets themselves
- schools and through their children
- Internet
- endorsements, such as the NHF tick.

Most trusted information generally related to the veracity of the source of the information. Specifically, any information that was given by a health professional was considered to be more trusted than information from other sources, even though information sourced via supermarkets and magazines was deemed more accessible.

Most trusted sources of information included:

- doctors/health professions: particularly with allergies and food additives etc
- friends
- current affairs and TV.

## 5. Biomarkers

In an effort to further understand how participants might interpret biomarkers, an additional topic was included in the research (subsequent to finalisation of the Brief). This topic explored what other words or concepts participants associated with certain hypothetical biomarkers, using a word association exercise where the researcher read out a rotated list of seven biomarkers and recorded the words that came to a participant’s mind as they spoke (a ‘free association’ technique). This exercise was undertaken at the start of the interview, before the guided discussion that included some of these biomarkers. Between 45 and 50 participants were asked to complete this task (depending on the amount of time available and the content of the interview<sup>5</sup>).

The biomarkers and their most frequently mentioned associations are presented below. Similar word associations have been grouped together, and fall naturally into one of several different themes that describe the way participants cognitively processed the biomarker term.

### Blood Cholesterol

First mentions	Next mentions	Last mentions (infrequent)
<b>Risk factors:</b> Fats/fat levels Fat in diet/fatty food	Bad Unhealthy	Big/chubby Too much alcohol No exercise/fitness Salt
<b>Disease/consequence:</b> Arteries/clogged arteries Restrict blood flow Heart attack High blood pressure Stroke	<b>Risk factors:</b> Diet Bad food Over-eating	Genetics Worry Obesity Specific foods (specified) Doctor

<sup>5</sup> The word association exercise was not included for Interview Protocol 4 (message devices).

### Blood Pressure

First mentions	Next mentions	Last mentions (infrequent)
<b>Risk factors:</b> Stress/anxiety <hr/> <b>Disease/consequence:</b> Heart disease Stroke Heart attack Constriction of arteries Measuring blood pressure (cuff)/tests	<b>Lifestyle:</b> Exercise Eating wrong food	Anger/temper Passing out Doctors/hospitals Tablets Smoking Cholesterol Fizzy drinks/Coca cola Death

### Blood Glucose

First mentions	Next mentions	Last mentions (infrequent)
<b>Risk factors/cause:</b> Sugar/too much sugar Blood sugar <hr/> <b>Disease/consequence:</b> Diabetes Insulin Heart disease High blood pressure Tiredness	<b>Food sources:</b> Foods Biscuits Sweets/lollies	Not enough fibre, iron Unhealthy Not right diet Too much carbohydrate Energy drinks Children Finger prick Exercise Adults Energy Looking after yourself

### Bone Density

First mentions	Next mentions	Last mentions (infrequent)
<b>Risk factors/cause:</b> Calcium / lack of calcium <hr/> Bones – strong/strength Brittle/frail bones Thick bones Fractures	<b>Disease:</b> Osteoporosis <hr/> <b>Risk factor:</b> Old age 70+	Drink milk/milk/cheese/dairy Bone marrow Women Elderly men Medical Chemist Vitamins Illness Menopause

### Obesity

First mentions	Next mentions	Last mentions (infrequent)
Overweight Obese Large/big people	<b>Food sources (fat):</b> Takeaways Biscuits Cake Fatty food Sugar	Habitual eating/eating problems Can not control appetite Horrible Cholesterol Weakness Unattractive
<b>Risk factors:</b> Eating wrong foods/poor diet Over-eating Too much fat/fatty foods Not enough exercise	<b>Lifestyle solution:</b> Dieting Reduce fat More exercise	Can not buy clothes Hereditary problem Weight Watchers Meat Watching TV Early death
	<b>Consequence:</b> Unhealthy Health risk Heart attack Cholesterol Depression	Lazy/sluggish Uncomfortable Miserable

### Wellbeing

First mentions	Next mentions	Last mentions (infrequent)
Health/healthy General good health Absence of illness	<b>Lifestyle:</b> Exercise Fit Energetic Walking	Sleeping/enough rest Food supplements Nutrition Timeout Fruit and vegetables Healthy relationships
<b>Lifestyle:</b> Happiness Peace of mind Spiritual, mental Not stressed Satisfied Can cope with the day Feeling good about yourself	<b>Lifestyle prevention:</b> Eat right Balanced diet	Believe in your goals Holistic Relaxation

**Health**

First mentions	Next mentions	Last mentions (infrequent)
<p><b>Risk factor:</b>            Diet – fruit and vegetables            Diet – eat right foods            Balanced diet/good diet</p>	<p><b>Risk factors:</b>            Low cholesterol            Low blood pressure</p>	<p>More natural            Able to cope            Relaxed            Doctor/hospitals            Personal responsibilities</p>
<p>Not sick            Feeling good            Able            Happy            Enjoying life</p>	<p><b>Lifestyle prevention:</b>            Exercise regularly            Fitness</p>	<p>Pills/medicine            Radio/newspaper            No smoking            Wellbeing/wellness            Cancer            Low sugar/low fat            Maintenance</p>

**Summary:**

Overall, participants tended to associate words that related to the health impact of the biomarker (disease or consequence) 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 [eg fat in diet, in response to blood cholesterol] or they associated lifestyle prevention factors, such as fitness and exercise.

The term ‘wellbeing’ drew associations well beyond physical wellbeing, with many participants nominating words around the theme of spiritual wellbeing.

## 6. Understanding Implied Health Claims

Twenty interviews addressed the topic of assessing implied claims, which relates to objective three of the study. Seven different implied claim mock-ups were introduced in rotated order and the following key questions were addressed:

- What are these words (images) saying about this product?
- Is it suggesting a health benefit? What is the health benefit that it is suggesting?
- How certain are they that by consuming the product they would receive this benefit? These were assessed via a scoring exercise (1-10) and discussion, but reported via commentary regarding relative certainty (to other claims) rather than reporting scores, as this was not a quantitative study.
- Whether other information is needed to help interpret these claims, and if so what information?

The results for each type of claim are presented in the following section. Copies of the stimulus materials shown to participants (presented as A4 size pictures) for this section are included in the following discussion of findings. No other text was provided on the graphics.

### 6.1. Heart symbol with words ‘healthy heart’

#### *What is it saying?*

- Most participants understood that the implied benefit of the product was about being ‘good for the heart’. This view was mostly driven by the heart image, rather than the words.
- ‘Good for the heart’ meant that the product might be low in fat, low in salt, low in sugar, pure tomatoes with nothing added – i.e. it was more likely to have an absence of ‘bad’ nutrients or ingredients rather than have something added to make it healthy.
- While most participants understood the implication of the claim, there was some doubt as to its veracity:
  - In part, this was driven by their knowledge that tomatoes are good for you (anyway), having no cholesterol or fat normally, and confusion as to how these particular tomatoes would be any different or healthier.
  - For others this was driven by their overriding scepticism of labels and a lack of believability in this particular claim – *“it’s ‘implying’ it is healthy, it’s not necessarily so”*.
- Some participants doubted the claim simply because they prefer to purchase fresh tomatoes over canned ones.
- Quite a few participants said they would look for the NHF tick, which they normally associated with products that are good for the heart, and some would use the NHF tick to help them decide if the claim was credible.



- The heart graphic was eye-catching, and one participant said that if they were rushing it would get their attention – only as they thought about the product further did they become more sceptical.

#### **What would you check?**

- Many participants said they would check the product for further information. The most common things looked for were:
  - the NIP, to verify sugar, salt and fat assumptions
  - the ingredients list, to verify salt content, and whether the product included any additives
  - a statement or further explanation on why these tomatoes are particularly good for the heart.

## **6.2. Heart symbol with an ECG graphic**

#### **What is it saying?**

- This product attracted more variability in responses, driven by the ECG graphic. Most participants did not immediately know what the ECG graphic was, although most were able to work it out after giving it some thought.
- Initially, the ECG graphic was described as:
  - an electricity line
  - bad teeth, a scary smile
  - broken heart
  - lightening
  - jaws
  - radar
  - danger – look out, beware
  - a grinning monster
  - sharp, compared with the soft heart.
- Once participants understood the graphic to be an ECG line, they mostly viewed it *negatively*. The heartbeat was seen to be unhealthy, too dramatic, too variable and with very high peaks and very low troughs (representing extremes that seemed dangerous).
- Those who had negative reactions to the ECG graphic thought they would avoid the product.
- As with the previous tomato implied health claim, this label implied to participants that it was 'good for the heart', and participants had similar reactions to the non-ECG tomato label by questioning what it was about this product that made it superior to other tomatoes not labelled in this way.
- Similarly, some participants assumed that it would be healthy for the heart by having the absence of unhealthy nutrients, such as fat and salt. However, this time others speculated that it was because the product had something in particular added to it.



- The NHF tick was again brought-up, with participants reporting they would prefer to see the tick, and that this would improve the product's credibility.
- Generally, it was agreed that the ECG graphic made the product label more eye-catching than the version without the ECG graphic, and those who saw the tomatoes without the ECG after seeing them with the ECG felt that the can without the ECG was very plain and boring to look at.

#### ***What would you check?***

- Again, participants wanted to check the contents for salt, preservatives and vinegar, and whether the product included any pureed tomatoes or any extenders.
- The NIP would be used to verify sugar, fat, salt and cholesterol assumptions.

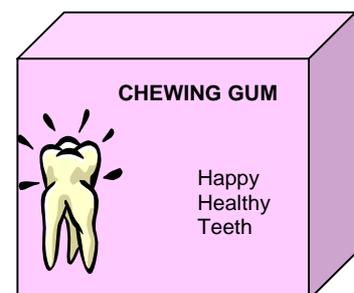
#### **Comparing A (no ECG) and B (with ECG):**

- Generally, B was seen as bolder and more attention grabbing than A. Product A was seen as passive and softer, while B was seen as active.
- However, most participants said they were less likely to buy B than A, because of negative reactions to the ECG graphic. Because the ECG graphic was 'scary', participants felt that product B was not as friendly and therefore not as trustworthy.
- Opinions were mixed as to which version was healthier – there was no consistent preference.

### **6.3. Healthy teeth chewing gum**

#### ***What is it saying?***

- Most participants understood that the implied claim in this label was that the product was 'good for teeth'. However, there was a great deal of scepticism about whether the product could achieve this claim.
- 'Good for teeth' meant keeping them clean, somehow adding something to them, removing plaque, making gums healthier, and for one participant, making them strong.
- One participant thought the product implied it could be used instead of brushing. Another felt it was designed for children, and would keep their teeth healthy.
- For those who believed the claim, they inferred additional benefits in the gum that were not stated on the label, reporting that the gum could achieve 'healthy teeth' by being low or free of sugar, requiring chewing and thus producing saliva, or possibly by containing fluoride.



- The picture attracted a great deal of attention, but was mostly received negatively because participants thought the tooth was:
  - ugly
  - yellow or discoloured
  - extracted, so obviously rotten
  - painful, throbbing or under stress (the lines around the tooth).
- Some participants suggested they would have preferred a picture of a healthy tooth or a smiling mouth full of teeth.
- One participant suggested the packaging looked unsophisticated, implying for him that the product was from questionable origins.

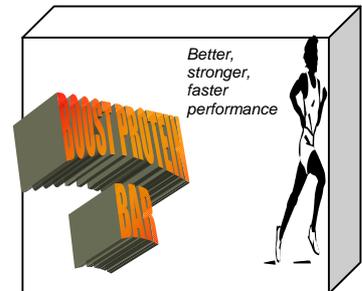
#### ***What would they check?***

- Most participants believed they would look to verify the sugar content on the reverse of the package. Generally, participants expected the product to contain little or no sugar, or a sugar substitute.
- Only one participant expected the sugar content to be high, because the product is confectionery.
- One participant reported that they would check the flavourings to try to avoid any synthetic flavourings, while another participant would check to see how long the flavour was going to last.
- Several participants were looking for a statement about why the product is good for teeth, and one said they would look for the *'magic ingredient'*.
- Several participants said that normally products state 'sugar free' on the front as a benefit, and questioned why this product did not do so.

## 6.4. Boost protein bar

### *What is it saying?*

- The most common health benefit implied from this label was energy, which meant not feeling lethargic, but feeling young, sporty or like running.
- Some participants felt the product would achieve this by giving the user a quick sugar fix, thus being high in sugar. The word ‘boost’ seemed to imply a quick fix and quick, easily consumed energy, suggesting that the product is a snack food. However, this product was believed to be different to ‘ordinary’ muesli bars.
- The word ‘protein’, on the other hand, implied a longer term performance benefit and seemed to be more related to people in training, athletes, people going to the gym, walkers, etc. This assumption was supported by the running graphic, suggesting sport, young people, fitness and activity. A few also inferred muscle benefit, and that the product was suitable for people who wanted to be stronger.
- One participant felt that the picture implied the user would be “*successful*”.



### *What would you check?*

- Participants were only likely to want more information about this product if they felt they personally would benefit from the product (and thus be likely to use it). Personal relevance depended partly on whether a participant was responding to the words ‘boost’ or the words ‘better performance’.
- Most wanted to check the nutritional content, and the most common nutrient of interest was sugar, followed by fat and salt. Some participants who already consumed energy drinks and other protein products were aware that these products are often high in salt, and would therefore check sodium content.
- There was an expectation that this product would be high in calories so that it would be able to achieve its aim of boosting performance or energy.
- Several participants wanted to know more about the protein contained in the product, and wanted to know where it came from and how much there is. Several participants understood that protein is an animal product, and thus would also check cholesterol content. One participant said he would check with his doctor, in magazines or with his wife (who was more knowledgeable on the topic) about what the protein might be.
- Several participants would look for information on recommended serving sizes, and would want to know how many bars they needed to optimise the health benefit and whether the product would be fattening if they ate too many.

## 6.5. Night Time Tea

### *What is it saying?*

- Participants noted this product as one of the most credible of those shown.
- The benefit of this product was understood by most participants to be that it helps you to relax and to sleep. However, only a couple of participants regarded this as a *health* benefit, of needing sleep for good health.
- The words used to describe the benefits of this product were many, and included 'night-time', 'relaxing', 'happy', 'more energy', 'nodding off', 'appealing', 'sleepy tea', 'comfort' and 'niceness'.
- The picture was highly appealing and conveyed most of the message on its own. The moon in particular was associated with happiness, comfort and relaxation.
- One participant felt the benefit of the product was psychological, making you think you can sleep better, which would probably be successful. This participant felt the tea would do no harm and would not be fattening. Participants consistently felt that this product was a low risk product, with no harm being likely from consuming it, and thus they were more likely to feel that they would 'give it a go'.
- A small number of participants did not believe the claim, because tea before bedtime means they have to get up during the night.



### *What would you check?*

- Several participants wanted to know what the ingredient was that would make you sleep – most thought it was an herb of some sort.
- Some would check whether all the ingredients were herbal or organic, and whether the product contained any caffeine or impurities.
- Several wanted to know serving information, such as whether the product was loose-leaf tea or tea bags, and what time of day or night you would take it.

## 6.6. OsteoFix milk

### *What is it saying?*

It is noted that the participants viewing this material had not been exposed to, and therefore were not influenced by, the earlier stimulus materials.

This product received a wide variation in comments:

- Most participants understood that the product was 'good for bones' by giving you calcium. To most this meant strong bones, while a small number also mentioned bone density.
- Some participants also inferred benefits for the teeth.
- Other participants felt the product would make bones stronger, some felt it was aimed at children with growing bones, while some felt it was for those with osteoporosis and would either prevent or fix this condition.
- The word 'OsteoFix' implied the product would fix a condition, most commonly nominated as osteoporosis, but there was some scepticism and disbelief about this claim.
- More than half the participants felt that the product had additional or fortified calcium, and the remainder felt it was only normal milk with a normal level of calcium (which they understood to be quite high anyway).
- It was more common in New Zealand for participants to feel the product was designed for children, while in Australia it was more common for participants to say the product was for older people, particularly menopausal and post-menopausal women.
- The skeleton picture built the understanding that the product was for bones, and one participant said that without the picture the product would sound like a medicine. The skeleton received a mixed reception, with some seeing the skeleton as cheerful and happy, and others seeing it as gruesome (one participant saying the skull reminded her of death).
- There was some speculation about whether the product was full fat or reduced fat milk, with some participants saying that products with added calcium were usually lower in fat. Others felt that the product would be full cream milk, particularly for those who thought it was intended for children.



**What would you check?**

- Most participants said they would look to check the calcium content, but many were unsure how much the product should contain. Very few said they would compare the calcium content to that of other products.
- Others would also check (in addition to calcium) fat, salt, sugar and carbohydrate content. One participant also confirmed she would look for vitamin B12.
- One participant said they would look for the recommended daily intake for calcium, and whether you could “overload” on the product.

**Summary:**

Pictures and key words appeared to have a major impact on participants, both in initially attracting attention and in conveying health benefits. Pictures implied a great deal more to participants than words alone and, in some cases, the pictures inferred much more or different benefits than equivalent written health claims (in the health claims assessment exercise).

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 verified claims personally relevant to them by using the 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.

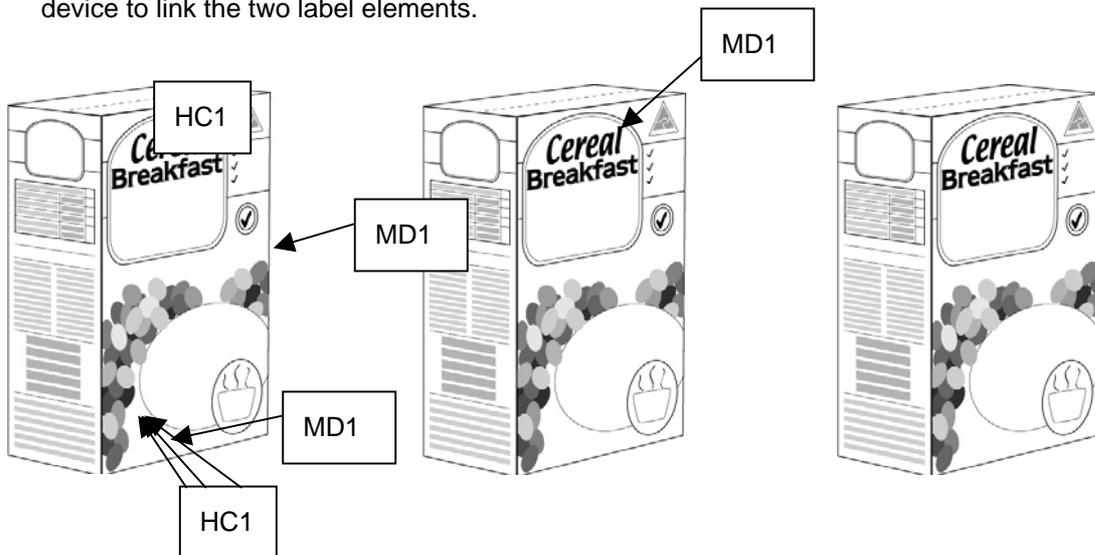
Perceived certainty about these implied claim examples seems to also be linked to the level of perceived risk a consumer attributes to consuming the product. Risk includes both potential dangers (safety), and potential health risks, including putting on weight. Claims where more information was given were more trusted than claims that were not very detailed.

## 7. Enhancing Communication Effectiveness – Message Devices

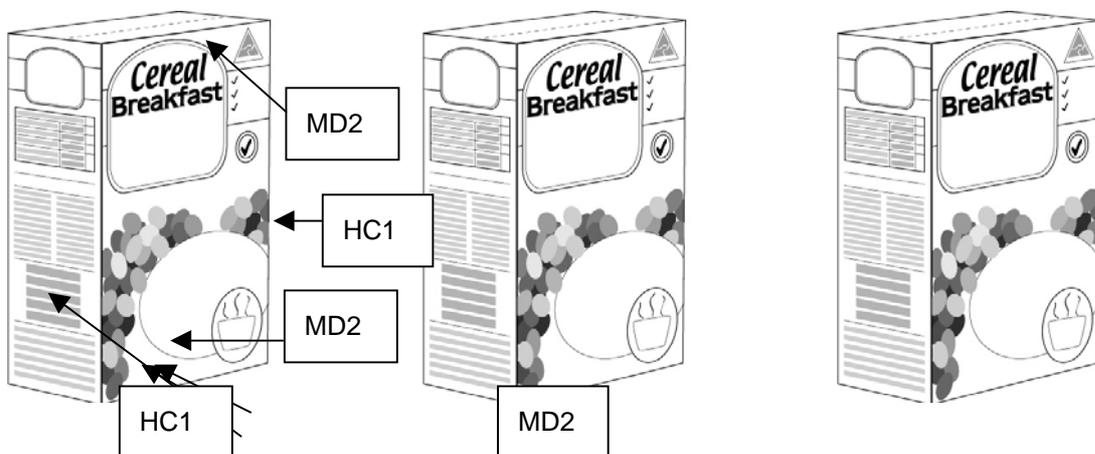
Twenty interviews were dedicated to addressing objective four – examining participants' reactions to a variety of message devices designed to enhance communication. These devices (disclaimers, disclosures, advisory statements, etc.) could be required in food regulation for certain types of claims with the intention of improving participants' understanding of the promised health benefits. This exercise also compared the effectiveness of 1) a health claim and short message device to a health claim with a longer message device; and 2) a closely positioned health claim and message device with a split health claim (i.e. on front of the pack) and message device on the back; and 3) assessed the impact on consumer use of the message stemming from the position per se of the health claim and message device ie front, back or side of package.

Four comparison exercises were undertaken, using either bread or breakfast cereal as the product example. Participants were given actual products (a box of breakfast cereal or a loaf of bread) to look at, where the labels on the food packets had been modified for the purpose of this exercise. The diagrams below are not replicas of the actual products used but indicate the various positions of the message devices that were tested. The label mock-ups were developed by FSANZ to present the following types of claims:

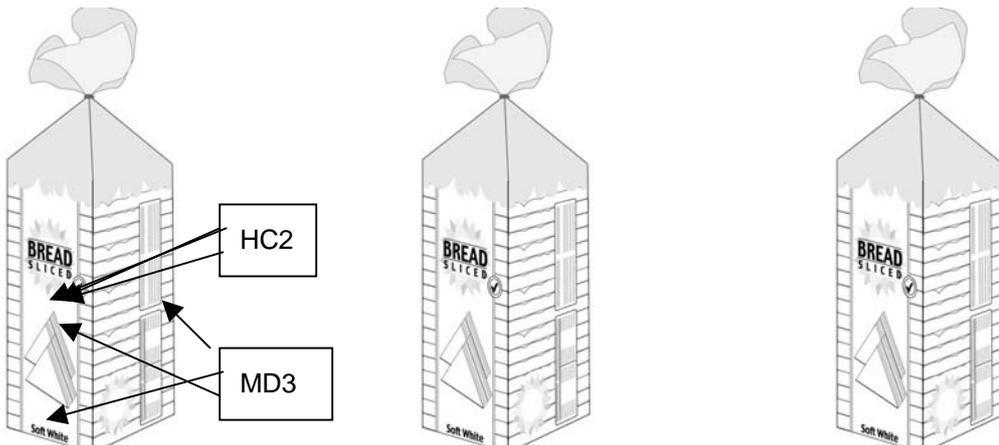
- First cereal with the health claim (**HC1**) “A diet low in saturated fat may help reduce the risk of heart disease. This product is low in saturated fat”, and short message device (**MD1**) “see nutritional information for sugar content” to direct consumers to the NIP. The sugar content for the cereal was relatively high for a cereal. Even though the health claim was always located on the front bottom of the box, the message device was located in one of three different positions (front, together with health claim; front, at top of box, separate to health claim; or on the side, separate to the health claim). An asterisk was positioned at the end of the claim and beginning of the message device to link the two label elements.



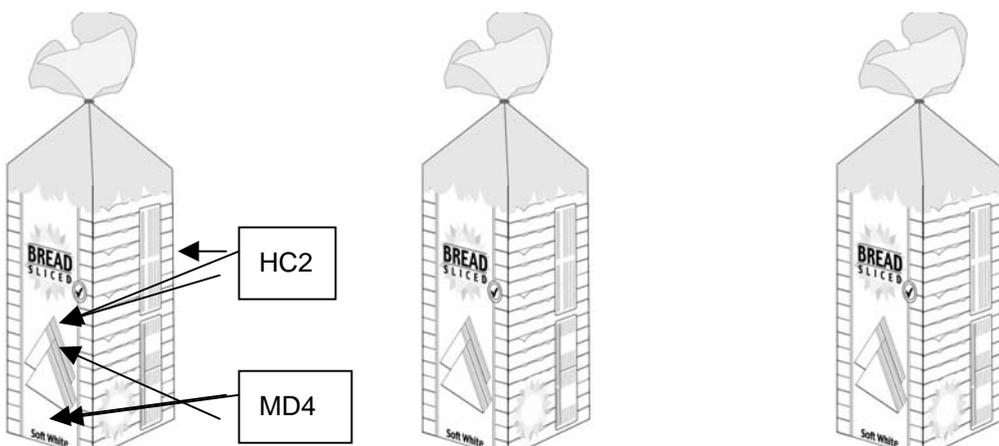
- Second cereal with the same health claim (**HC1**) as above and longer message device (**MD2**) “many factors, such as family history of heart disease, increased blood and LDL cholesterol levels, high blood pressure, cigarette smoking, diabetes and being overweight, contribute to heart disease” – The health claim was either located on the front bottom or the side of the box, and the message device was located in one of three different positions (front, together with health claim; front, at top of box, separate to health claim; or on the other side, separate to the health claim).



- First bread with the health claim (**HC2**) “Zellosan<sup>6</sup> may assist in weight loss by blocking absorption of fat” and message device (**MD3**) “consume no more than three servings per day” – While the health claim was always located on the front in the middle of the pack, the message device was located in one of three different positions (front, together with health claim; front, at the bottom of the pack, separated from the health claim by a graphic; or on the back, separate to the health claim).



- Second bread with the health claim (**HC2**) “Zellosan may assist in weight loss by blocking absorption of fat” and message device (**MD4**) “this product is not recommended for infants, children and pregnant or lactating women unless under medical supervision” – The health claim was either located on the front in the middle of the pack or on the back, and the message device was located in one of two different positions (front, together with health claim; or front, at the bottom of the pack).



<sup>6</sup> Note this was a fictional ingredient.

## 7.1. Understanding of claims and devices

### 7.1.1 Health benefit

- Participants understood most of the health benefits implied by the products' packaging. Importantly, it was not only the text health claim and message device that communicated health information, but content and other types of claims, such as those on the side of the cereal box, also effectively communicated health benefits.
- The cereal was perceived generally to be a 'health food'. This impression was formed from the imagery on the front of the box, which was a combination of the photo of the bowl of cereal (featuring fresh fruit) and the product name, Apple Flakes. The inferred benefits from these elements alone were that the product is high in calcium, vitamins and minerals, and is low in fat.
- Of the two cereal message devices, the one directing participants to the NIP for sugar content was clearest and most effective in terms of causing participants to act upon the message (i.e. turn over and refer to the NIP). However, the device resulted in different interpretations regarding its intent and meaning, possibly as a result of participants' level of knowledge or specific health concerns (as noted earlier):
  - Some felt it implied the product was low in sugar and that the manufacturer wanted to impress participants with this fact. Participants who held this impression were also of the view that anything labelled on the front of the pack is positioned there at the manufacturer's will, and thus would not be there unless it presented the product advantageously.
  - In contrast, a smaller proportion of other participants felt that this device implied the product may be high in sugar and that shoppers were being encouraged to find out from the NIP exactly how high it was.
  - A smaller number of other participants could not ascertain either way the implication of the device (i.e. that the cereal was likely to be high or low in sugar), and when pressed guessed that it must be low.
  - The majority of participants assumed that this message was intended for sugar-conscious people, such as diabetics or participants who were particularly health-conscious. It was not viewed as a general health message for everyone.
- For a few participants, the word 'may' in a health claim absolved manufacturers from having to clarify their claim, as it meant the claim was not categorical and that the device was therefore unnecessary. However, this was not a commonly held view.

- The use of an asterisk in the cereal message device for checking the NIP was not effective, as many participants did not notice the asterisk (because it was small). The asterisk was also redundant when the claim and the device were together. When spotted, an asterisk is understood to be referring the consumer to the bottom of the page/package or to turn over to the back.
- The least useful or relevant message device was the second cereal example<sup>7</sup> that referred at length to risk factors for heart disease. This information was deemed to be common knowledge by most participants and not important enough to warrant positioning on the front of the package – it was information that was ‘*nice for some people to know*’ but most people felt it was out of place on a cereal box, and many drew parallels with warnings on cigarette packets. Some felt it had a negative impact and was off-putting because it was information overload. Almost no one linked the relevance of this message device to the saturated fat health claim.
- In the bread examples, there was a lack of understanding of what *Zellosan* is and what it can do. There was a great deal of confusion about this ingredient, with no way of resolving the confusion because of the lack of information provided on the package. Some participants looked for an explanation of this ingredient on the reverse side of the packaging, looking for information about its source, how it functions and whether it was a natural product.
- The mention of absorption of fat on the bread products made some participants speculate that the bread itself would be low in fat, and some were confused whether the product blocked the fat in the bread itself (during consumption) or if it blocked all the fat consumed that day.

### 7.1.2 Serving information (bread examples)

#### ***“Consume no more than three servings per day”***

- There was inconsistency in the understanding of serving sizes for the bread products. Assumptions (before clarification using the NIP) were split between those who believed one slice of bread equated to one serve, and those who felt that two slices (a sandwich) was one serve. The pictures on the products, which differed between the mock-ups, were partly leading participants to make different conclusions about serve size, with one version having a picture of three slices and another having a picture of two slices. Clearly, the influence of pictures should not be underestimated in terms of influencing how participants interpret text information.
- When asked to check and confirm their judgement about serve size, most participants checked the back of the package for serving information, and once they found it in the NIP almost all were able to work out the recommended serving size (although some took a long time and it remains questionable whether they would have spent as long in a supermarket).

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<sup>7</sup> “Many factors, such as family history of heart disease, increased blood and LDL cholesterol levels, high blood pressure, cigarette smoking, diabetes and being overweight, contribute to heart disease”

- Several participants objected to the word 'serving' and felt it was ambiguous. It was suggested that instead of using the term 'servings', it would be preferable to use the most commonly understood unit, 'slice' (i.e. *consume no more than six slices per day*). This point was argued strongly by the few participants from multicultural backgrounds who, either themselves or their family members, had poor English literacy.
- There was a lack of clarity about why there would be a recommended number of serves, with a number of different hypotheses offered (in the absence of explanation on the label). A few participants felt that consumption had to be limited so as to minimise one's intake of bread in general (because you should not have too much of one product). Others felt it was because the potential benefits of the product would be undone, with possibly an opposite effect resulting (such as weight gain). Even though there was a general lack of understanding of any potential danger from consuming too many serves, the consumption message was taken reasonably seriously (see below section 7.5). Indeed, some participants referred to the serving device as a message about 'dosage', as would be found on a medicine bottle.

### 7.1.3 Seriousness of devices

- Whether people read and take notice of devices depends on their personal relevance and the perceived risks arising from consuming the product. Both the message devices on the bread examples were interpreted as much more 'medical' type recommendations, and were described by the majority of participants as 'warnings'. In contrast, the cereal message device referring consumers to the NIP was taken much less seriously, and would be attended to only if sugar was a significant nutrient for an individual or family member. The cereal/heart disease message device was dismissed as irrelevant, or 'nice to know' but of little personal consequence unless one had heart or cholesterol concerns (although the content of the message was perceived as entirely credible).
- The device referring to pregnant and lactating women (bread) was viewed as serious, but not personally relevant to most participants who did not qualify as part of the mentioned groups. However, there was a general consensus that participants would abide by the device if they lived with someone in those groups, and as a consequence some participants who were mothers of young children would instead opt not to buy the product if the main bread-participants in their family could not eat it. *"This bread looks like trouble, it has a medical exclusion."*
- In both of the bread examples, the devices provoked an assessment of the personal risk of consuming the product, with many participants wanting further information about why this product was not suitable for some groups, or why you could not consume too much of it. After some consideration of the message device, most participants presumed that it related to the health claim (about *Zellosan*), and thus linked the two pieces of information, but initially participants were engaged more by the message device than the health claim.

- Nonetheless there was a *minority* view that participants did not have to pay too much concern to such messages, because there was an expectation that the health effects for the mentioned groups would not be severe, otherwise the product would not be available. This emanates from an underlying assumption (found in other FSANZ research conducted by TNS Social Research<sup>8</sup>) that the food supply in Australia and New Zealand is highly regulated and safe

## 7.2. Likely impact of the claim and NIP device

- For the cereal message device referring consumers to the NIP, many participants, particularly those for whom sugar is a significant nutrient, thought they would check sugar content. However, most admitted that they would not be able to evaluate whether the cereal was high or low in sugar, and most had no benchmark with which to compare the sugar content of the cereal in question. No participant automatically converted the amount of sugar in a 100g serving to a percentage, and when assisted to do so most were not greatly concerned by the sugar content (i.e. approx 25%).
- However, without the device very few would check the sugar content of the product in the first place, because the overriding perception about the cereal product from the image and product name was that it is healthy.
- The majority of participants would follow the device recommendations in the bread examples. These devices were interpreted as 'warnings', were taken seriously, and are relatively easy to act upon (see Section 7.1.3).

### Summary:

If the intention of the cereal message device referring consumers to the NIP is to alert people for whom sugar is a dietary concern or risk factor, the device is effective (assuming these people know how much sugar they should consume). However, if the intent is to draw attention to the fact that cereal may be 'healthy' in one way (low in fat), but potentially 'unhealthy' in another (high in sugar), the device has not achieved its objective. It was clear from this exercise that subtle or indirect messages that attempted to lead participants to consider the relative levels of particular nutrients did not work, and that such messages need to be much more straightforward. Participants are looking for messages that describe the food as 'high', 'medium' or 'low' in particular nutrients, and in this study most did not have the knowledge or skills to make such assessments on their own.

<sup>8</sup> Food Labelling Issues: Qualitative consumer study related to nutrition content claims on food labels. July 2003  
Food Labelling Issues: Qualitative Research with Consumers. December 2001

### 7.3. Preferred format and location for information

- Overwhelmingly, it was preferred by the participants for this protocol that both the health claim and the message device are both situated on the *front* of the package, and that they are obviously linked. However, linkage via an asterisk was not effective. The majority of participants felt it would be pointless to locate the message device referring consumers to the NIP anywhere but on the front. In the examples where the device was located on the front but very distant from the health claim (e.g. top of cereal box) or on the side, participants took much longer to find and link the two pieces of information and unanimously [chk ALL?] objected to the fact that they were so separate (distant).
- The way in which the health claim and message are linked can vary somewhat and still be effective. Linkage can be physical (such as two sentences that follow each other) or linkage can be suggested in other ways, such as through close but separate positioning with common graphics, colour, font style, etc that are unique to the claim and the device; or they can be closely situated but separated by a graphic (such as the bread examples).
- It was important that the combination of the health claim and the device does not produce a message that is too long or wordy, as the impact of the device is eroded because the latter part of the information is not read attentively in the usual 'glance and scan' process a shopper uses to assess products in the supermarket. This was demonstrated through the cereal and bread examples that offered varying distance between the claim and the device:
  - In both bread examples, the split between the claim and the device by putting a graphic between the lines was seen as enough of a space and far more effective than locating the two sentences back to back. Only a very small number of participants felt there was too much of a space.
  - In the first cereal example (heart disease claim and short message device about the NIP), participants overwhelmingly preferred the example position where the claim and device were reasonably close together (following on from each other), to the alternate position where the device was located some distance away at the top of the box.
  - In the second cereal example (heart disease claim and long message device about heart disease risk factors), many participants said they would be unlikely to read both the claim and the device as the information ran together, and that they preferred the information to be separated slightly. *"It separates each fact ... they are different points ... that [example with HC and MD together] looks like it's all about the same thing, but they've got two different reasons here [example with HC and MD separate]."* Additionally, more participants preferred the location of this device on the side of the box, compared to the number that preferred this position in the first cereal device example (NIP message). This was because they did not believe it sufficiently important to position it on the front.

- The font size and colour combination of claim and device text and backgrounds also played a significant role in determining how closely linked the two are perceived to be, and how easy they are to notice and read. These design elements were not deliberately manipulated for this research however further consideration will need to be given in the quantitative research to ensure design elements such as these do not significantly confound the results. It was clear that the preferred position would be rendered ineffective if the font colour or size means the device is difficult to read.
- It was also clear that for health claims and devices to be noticed (and linked), they must be positioned such that they follow the natural direction (for the majority of Australians and New Zealanders - note this depend on ethnicity and first language) that the consumer's eye travels during product assessment in a supermarket. For this reason, if a device is located separately to the health claim (but still on the front, as these findings recommend), then indications are it should potentially be located somewhere below (or parallel) to the health claim for it to be noticed. Similarly, locating either message above the brand name would mean it is likely to be missed altogether (because all participants began reading the product label at the brand name and worked downwards).
- Several participants objected to the word 'serving' and felt it was ambiguous. It was suggested that instead of using the term 'servings', it would be preferable to use the most commonly understood unit, 'slice' (i.e. *consume no more than six slices per day*). This point was argued strongly by the few participants from multicultural backgrounds who, either themselves or their family members, had poor English literacy.
- There was a lack of clarity about why there would be a recommended number of serves, with a number of different hypotheses offered (in the absence of explanation on the label). A few participants felt that consumption had to be limited so as to minimise one's intake of bread in general (because you should not have too much of one product). Others felt it was because the potential benefits of the product would be undone, with possibly an opposite effect resulting (such as weight gain). Even though there was a general lack of understanding of any potential danger from consuming too many serves, the consumption message was taken reasonably seriously (see below section 7.5). Indeed, some participants referred to the serving device as a message about 'dosage', as would be found on a medicine bottle.

## 7.4. Using the NIP

- Many participants used the NIP to verify claims, but to varying degrees.
- Health-conscious participants were much more likely to use the NIP to verify claims, and sometimes compared products to other similar products. In some of these cases, they knew an acceptable level for each of their significant nutrients, and compared against this.
- Participants who were moderately or not health-conscious were less likely to use the NIP to verify claims, and did not look often, other than for new product categories. These participants were less likely to compare to other products and less likely to have an understanding of an acceptable level (of fat or sugar generally).
- In the bread examples, participants wanted to find out more about *Zellosan* and tended to search for a statement about it rather than use the NIP or ingredients list. However, in the absence of such a statement, persistent participants searched the NIP and ingredients for reference to *Zellosan*. The NIP was used to verify the fat content of the bread, driven by an expectation by some that it would be low in fat as a result of the health claim.

### **Overall Summary:**

The communication objective of message devices must be expressed much more explicitly if it is to be understood by participants. Participants in this study appeared to value as important those message devices they associated with perceived potential risk. The two different bread devices achieved their objective and were taken very seriously. However, the cereal message device referring consumers to the NIP was not effective for two reasons: firstly it was not interpreted as relating to health risk or a health trade-off; and secondly, most participants were not sufficiently educated in order to assess the cereal as being high in sugar once they checked the NIP. The cereal heart disease risk factor message device was valued lowest in terms of importance and risk, and participants did not understand the true intent of the message.

When there is high perceived risk participants want 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. Participants will read information that is spaced apart (but clearly linked), but may pass over a device that is part of the same paragraph as the claim. Placing health information (health claims and/or message devices) on the non-NIP side of the package would be missed by most participants, while information on the NIP side of the package would be seen by health-conscious participants only.

The serving size recommendation in the message device (bread examples) was confusing for participants, who would prefer the specific unit information, such as the number of slices of bread.

Confirming the findings of previous FSANZ research<sup>9</sup>, the NIP is used by health-conscious participants to verify nutrient or health claim information. However, it cannot be assumed that all health-conscious participants know how to verify all claims, as it seems that most of these participants tend to assess just the nutritional content of one or two significant nutrients that are most important to them. It is important for FSANZ to clarify whether message devices, such as those pertaining to fat and sugar content, are intended as general cautions for all participants, or whether they are specifically targeted at the at risk groups, such as those with heart disease or diabetes. If such devices are aimed at these at risk groups, the location of the device on the front of the panel remains important, because not all at risk participants are using the NIP to verify the content of nutritional risk factors.

The power of product names and images in creating sub-text messages about the health benefit of the product should not be underestimated. Many participants commented on the inherent health benefit of the Apple Flakes cereal, which was implied to them from the product name and the picture of the cereal bowl with fresh fruit on the front of the package.

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<sup>9</sup> *Food Labelling Issues: Qualitative consumer study related to nutrition content claims on food labels. July 2003*  
*Food Labelling Issues: Qualitative Research with Consumers. December 2001*

## 8. Health Claims on Food Labels Compared to Advertisements

In order to address objective five of the study, 20 participants were asked to comment on three different information and advertising comparison exercises:

- Comparison between the front panel of a 'regular' **yoghurt** product, a same-brand yoghurt with an implied claim, and a print advertisement with a health claim for the yoghurt with the implied claim.
- Comparison between the front panel of a 'regular' carton of **soy milk** and a print advertisement for soy milk that includes a health claim, supported by a photo of a celebrity figure.
- Comparison between the above print advertisements and a '5 a day' public education style information leaflet.

The products and advertisements used in these exercises were chosen for illustrative purposes only. They were introduced to participants on the basis that they were 'just one example of a yoghurt/soy milk', and it was explained that they were selected for no reason in particular.

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 findings for each comparison, followed by an overall summary are presented below.

### 8.1. Yoghurt comparison

#### ***'Regular' label – no claims***

- This product was generally viewed as an overall healthy food, as are most yoghurts. Many participants were drawn to the statement about probiotics at the bottom of the package (*"Contains Acidophilus Bifidus Casei...these friendly bacteria may assist in digestion and maintaining good health..."*) and were able to understand the benefit of this for digestion. Those who were unfamiliar with these cultures said that the words were *"big words"* and confusing, but inferred that it *"must be good for you"*.
- There was some confusion about the intended meaning of the word 'natural'. Some understood the word 'natural' to mean organic, while others felt that even though this was what was suggested, it could not be true, because otherwise the word 'organic' would have been used.
- The words 'genuine Leben' suggested to participants that the product was European or using a European method, and that it would probably taste good as a result.
- Many said they would check the manufacturers' ticks (barely visible on the side of the package from the photograph provided) to see what else was in the product.

**Label with implied health claim**

- Generally, this product was received much more positively than the previous product, and inferred many more health benefits than they had in the first yoghurt product label – *“It gives you the full story, a very effective label”*. The combination of the product name (ProHeart), the picture of the body and heart ECG line, and the reference to omega-3 and vitamins collectively contributed to this view. Many participants said that the more they read about the product (on the label), the better it sounded.
- Compared to the previous product, the label of this product was seen to be clear, *“in plain English”* and easy to understand.
- The name ProHeart made a significant positive impression, which when supported by the graphic of the man with the heartbeat, implied to all that this product was beneficial for your heart. For those familiar with omega-3, this message was further reinforced by the reference to this content. There appeared to be greater familiarity with omega-3 and association with heart health than there was with the omega-6 fatty acids benefits in the health claims assessment exercise.
- Unlike the relevant tomatoes product (implied claims exercise), this ECG line was seen to be healthy and strong.
- Many participants also thought the product would be naturally high in calcium, and therefore good for bones and teeth. Many also identified folate on the label and were aware of its advantages during pregnancy. The vitamins were also seen as a positive, even though few could nominate the specific benefits of each.
- It was generally agreed that this product was a lot healthier than the previous yoghurt, although some were concerned that it might not taste as good. The inclusion of blueberry flavouring was seen as desirable (though very few thought it was real fruit), especially for persuading children to eat the product. However, there was a small amount of concern that the inclusion of omega 3 would make the product taste *“fishy”* or *“oily”*.
- Some participants confirmed they would look for the NHF tick, and were sceptical about the heart benefits of the product without the tick.
- There was also some concern about the level of processing the product had gone through, with most participants believing at least the vitamins, and likely the omega 3, had been added to the product and were not naturally occurring.
- Many participants said they would check the fat content of the product, although several of those said it was unlikely that it was a full fat product (because it had heart health benefits). Also, many were looking for a statement about live probiotics and confirmed they would therefore check the pack for these as well. As probiotics is a major reason for participants purchasing yoghurt, this was a major ingredient seemingly missing from the front label.

**Print advertisement**

A one page promotional leaflet for the same yoghurt product (with implied health claim on the label) was introduced. The leaflet contained textual information below a picture of the product, which included an additional health claim. The purpose of this assessment was to explore how participants treated this kind of information (compared to the stand-alone product with no advertising support) and what impact this type of advertisement had on perceived health benefit and purchase intention.

- Most participants skimmed the text in the advertisement, and picked up key words. The words that resonated most were '98% fat free' and the statement about live probiotics – many participants felt this should be on the front of the package, and that they were more likely to purchase the product now they knew this.
- Other than these two statements, the advertising did not seem to add a lot to the attractiveness or desirability of the product, as most other benefits were picked up from the front label in the previous example.
- The inclusion of omega-3 was viewed as beneficial, and several participants said they would like to know the RDI for a benefit from this nutrient.
- Most felt that the product was enriched and fortified, and that none of the advertised nutrients were naturally occurring, except perhaps the live cultures.
- Again, participants would look for the NHF tick to validate the claims about benefits for the heart.
- The picture behind this yoghurt (salad and dessert) also conveyed a message that this product was healthier than other yoghurts, and that it would taste good.

**Summary:**

The most effective information in this exercise was the yoghurt product alone only showing the front label (including the implied health claim). There was no consistent finding that the combination of product and print advertisement indicated to participants that the product was healthier or had additional health benefits that the product alone did not have. The main advantage of the advertising copy was that it clarified for participants the fat content of the product (98% fat free) and provided information about live probiotics, and knowing this further reinforced the existing desirability of the product.

## 8.2. Soy milk comparison

### *'Regular' label – no claims*

Reactions to this product were highly positive in terms of perceived health benefit. Furthermore, the brand featured was seen to have a good reputation, and thus the believability of the inferred health benefits was high:

- Most participants stated the health benefits of soy milk as given on the label, with some saying that soy milk is “automatically better for you than cow’s milk”. All participants assumed the usual health benefits of milk, based on the content statements on the front panel.
- ‘No animal fat’ was seen to have advantages for people dieting, as well as for those with allergies or intolerances.
- Several participants noted that they would look for the NHF tick to verify heart claims before making a decision to purchase this milk.

### *Print advertisement (2 page)*

The two page print advertisement featured a picture of the product in use (pouring on top of cereal), a celebrity endorsing the product, and textual information about the product that included a health claim. The brand for the product was removed from the advertisement. The purpose of this assessment was to explore how participants treated this kind of information (compared to the stand-alone product with no advertising support) and what impact this type of advertisement had on perceived health benefit and purchase intention.

- On first impressions the advertisement was seen to be advertising a branded product, with some participants noting that the size and attractiveness of the advertisement meant, “It must have been paid for”.
- Most skimmed or read the information, although several said they would not have read it in a magazine because the size and colour of the font made it difficult to read. Some found this celebrity type advertisement unappealing or irrelevant to them and would not have paid it much attention when reading the magazine in which it was featured.
- Once read, most participants changed their mind and assumed that the advertisement was for a generic soy milk (or all soy milk), with several asking the researchers which product they should buy. Many said at this point that the advertisement was only advertising soy milk as a category, which was seen as reasonable because “soy milk is soy milk”. However, other participants would have preferred to see a clear brand name, so that they knew which brand of soy milk to buy (assuming some were better than others).

- For those who are interested in advertising information as part of their product decision process, the information in the advertisement was appealing because it explained the health advantages of the major nutrients. For example, participants liked that the text explained bone strength and osteoporosis rather than only confirming that the product contained calcium.
- The health benefits were understood to be improving bone density, preventing osteoporosis, improving cholesterol levels, and generally improving health and an overall sense of wellbeing.
- There was some criticism that the use of a celebrity in this advertisement was attempting to infer that the celebrity drinks soy milk “to look like that”, whereas many thought it was likely she also exercised and ate well.
- Several said they would check the cholesterol and fat content of the product.
- Participants were asked how their views about the advertisement might change, if at all, if the advertisement was branded with different well-known brands. This changed some perceptions, and the perceived credibility of the advertisement varied with the brand – some brands were afforded more credibility than others.
- Participants were also asked about their impressions of the advertisement if it were branded or sponsored by a health/professional organisation, such as the Australian or New Zealand Dietitians Association. Several participants commented that the health/professional organisation made the information more credible and gave strength to health claims. This was because, whilst all advertising was seen to have a purpose and an agenda, the professional organisation was seen to have a different kind of agenda (a more altruistic one). It was presumed by many that the organisation would not endorse a product that was “shonky” and that all advertisers are regulated in what they can claim. Some more trusted brands were perceived to have similar credibility to the Dietitians Association, while other less trusted brands were not.
- It was also believed unlikely that an association would have a double page spread in a magazine, with a famous celebrity.

### ***Comparing the yoghurt advertisement, soy milk advertisement and the ‘5 a day’ leaflet***

Participants were asked to compare three nutrition related advertisements (the yoghurt and soy milk advertisement used earlier, and a ‘5 a day’ public health information leaflet produced jointly by United Fresh and NZ Supermarkets (see <http://www.5aday.co.nz/homepage.html>))

- When asked to compare three materials most acknowledged that they were all advertising materials, but that the 5 a day leaflet gave more information and was therefore more trustworthy. It was difficult to ascertain whether the more positive reactions to the ‘5 a day’ leaflet emanated from the information source or from the greater amount of information provided (compared to the specific food advertisements).

- If anything, packaging and advertising with more information was viewed as more trustworthy than those without a great deal of information; however, this finding is inconclusive because participants varied so widely in their views. For example, some participants simply prefer short-text, 'straight to the point' advertising information (while others prefer as much detail as possible); some participants are interested in nutrition information (while others are not); and some people are users of the example products (and others are not).
- The appeal of the leaflet was that it gave information on how to be healthy, rather than product information only.
- Most, when pressed by the researcher, drew a line between information and advertising on the basis of the presence or absence of a brand. When the information is branded or refers to a branded product, or when it includes celebrities or icons it was more readily determined to be 'advertising' (as opposed to public health information).
- Some participants believed they would read the leaflet "*cover to cover*".

**Summary:**

The results of this component of the research are less clear than other for other topics, due to the limited number of interviews on these particular topics, the variability between the advertising materials about which comparisons were made, and the variability in participants' interest in buying the featured product (yoghurt or soy milk). These factors should all be controlled in any subsequent quantitative study.

In these exercises, the advertising information that included health claims did not appear to substantially influence the perceived health benefit or purchase intention of the two product examples (yoghurt/soy milks). This contradicts the findings of the claims assessment earlier in the report. However, advertising and product labels that detail product benefits were viewed as more credible than less detailed versions.

It was somewhat clearer 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 appeared to be afforded, irrespective of whether the health organisation is a sole advertiser or is sponsoring in partnership with a brand.

Nonetheless, it was clear that 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. It was also assumed by participants that advertisers are regulated in what they can claim.

Generally, participants were not highly discerning between advertising information that did and did not include biomarker and disease terms, such as 'osteoporosis' and 'bone density'. This finding is somewhat counter to the results in the health claims assessment exercise, where reactions to such terms carried more weight in influencing perceived health benefits and purchase intentions. This may be in part a factor of the circumstances of this exercise and the test examples, where trust afforded to particular brands and their advertising may have influenced perceptions (the health claims examples were unbranded), and also because in the context of an advertisement (with more words), less attention could be paid to individual words and terms – some participants talked of reading advertisements by seeking out the general gist of the information rather than focusing on particular words.

Further qualitative and quantitative work is required to measure the effects of advertising on purchase intention and perceived health benefit.

## 9. Health Claims on Food Labels Compared to Complementary Medicine Labels

In order to assess how participants discern between health claims on food labels and health claims on complementary medicines (objective six), 20 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. A summary of the individual assessment of these products, and a comparison between them is provided below.

### 9.1. St John's Wort tea

The St John's Wort tea was a 'natural' looking product, in brown paper bag packaging. The label included product information that included the following health claim; *"Traditional recipe to support the normal function of the Nervous System. Supports the body's response to stress, anxiety & mild depression and the healthy physiological function of the nerves. Helps to maintain normal energy levels and balances moods."*

- This product was perceived to offer health benefits. Participants quickly interpreted the health benefits of the tea as relaxing, easing stress, calming, removing anxiety, balancing moods and maintaining energy.
- The product was seen as natural, possibly organic, not over-processed, using a traditional recipe, and containing no caffeine or anything artificial.
- The statement about the product being safe for children implied it was generally a safe product, which was noted by almost all participants.
- The packaging was seen as more descriptive than that on the capsule bottle, and therefore more trustworthy.
- The claims were generally viewed as believable, and not seen as outrageous – participants had a high degree of confidence in the efficacy of the claim. The words 'supports' and 'helps' were predominantly driving this belief.
- The only concerns about this product were that it required effort to make and that it may "*taste bad*".

## 9.2. St John's Wort capsules

The St John's Wort capsules were packaged in a glass jar. The label included product information that included the following health claim; *"High potency natural mood enhancer. Scientific research has shown that extracts of the herb St John's Wort with high Hyperforin activity are effective for the relief of restlessness, anxiety and nervous tension, and beneficial in times of stress."*

- The capsules were perceived to offer similar health benefits, such as enhancing mood and being calming and relaxing. Even though the 'natural' claim countered some concerns about the product being a 'medicine' instead of safer 'herbs', a few were still concerned about the product purely because of its capsule form, such as *"tablets have a fix-it type attitude"*.
- One participant noted that people are conditioned to believe tablets will help them, and that he felt that this brand should have to prove (more than it did on the label) what he called *"airy fairy claims"*. This participant did not make the same observation about the tea product.
- Several participants felt that the claim of scientific research was comforting, although a few others noted that there was no proof of this research.

## 9.3. Comparing St John's Wort tea and capsules

Overall, participants felt that the food and the complementary medicine were equally as beneficial (in terms of health benefit), and no participant indicated concern about the inclusion of St John's Wort in either product. The general consensus about the inclusion of St John's Wort in a food was that it was a matter of consumer choice – no concerns about safety or the proliferation of active ingredients from complementary medicines into the wider food supply were spontaneously mentioned.

When participants were probed specifically about the comparative effectiveness of the two products, the following differences were observed:

- The tea was seen to be the most effective form of the treatment. Overall, the tea was perceived to act faster, as it was believed that the liquid form could be absorbed faster by the body than the capsule form.
- It was also felt the tea would be cheaper, because it did not have the high processing and packaging costs of the capsules; however, the tea was thought to be less readily available. Some participants could not say which product they thought would be cheaper without working out the number of serves/dosages in each package.

- Across all the interviews, neither product was seen to be more reliable than the other. Those that were of the view that capsules would be more reliable believed that the information on the capsules was more credible (than the tea label information); whereas those that believed that the tea was more reliable did so because of their concerns about risk, stating that the tea was '*safer*' or '*natural*'.
- Some participants were concerned that the capsules would be more dangerous, because it would be easier to take too many of these compared to the tea. Also, the capsules have a warning on them, which made some feel unsafe. Yet others were reassured by this, believing that the tea should have the same warning. There was also some concern that a tea serving would not be a reliable amount, whereas the capsules were consistent.

**Summary:**

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

However, the results of this single example should not be interpreted as inferring that people generally perceive food forms of an active ingredient as equally as reliable or safe as complementary medicines. It is suspected that the inclusion of medicinal herbs in teas is a more familiar and accepted food for the addition of active ingredients, compared to other potential foods, and thus was seen as an equally acceptable form as complementary medicines.

## 10. Observations and conclusions across all study topics

This study has produced considerable variability in responses for particular issues, and we have attempted to hypothesise reasons for this throughout this report. However, there are a number of common findings that underpin participants' responses and behaviours across the whole study (five topics) and these are listed below:

- Existing knowledge about specific nutrients led to potential health benefits being better understood in content claims. A calcium content claim was recognised by participants as being a claim about content rather than health, but many participants nonetheless understood calcium was 'good for bones', while almost no health benefit was understood from the omega-6 fatty acids content claim because much less was known about it.
- Perceived risk vs perceived benefit – Claims with higher perceived risk (or possibly less personal knowledge of) were taken more seriously and seen to be more credible than those with lower perceived risk. Risk was determined by existing knowledge about the active component (e.g. *Zellosan*) or the product (e.g. night time tea) (high risk = low knowledge), the use of particular language (e.g. 'not recommended'), or the exclusion of specific population groups. When a claim was believed to have a high perceived benefit, the product was also assessed in terms of potential risk on a broader basis (e.g. it may be low in saturated fat, but someone with sodium as their significant nutrient assessed the product using the NIP for sodium content in order to evaluate the potential risk of the product for them).
- Linked to the assessment of risk was the concept of personal relevance. Either a product was personally irrelevant (e.g. "*I don't buy canned tomatoes*"), or the claim was personally irrelevant (e.g. "*I don't care about sugar content*"). Claims or devices were dismissed if they were either not personally relevant or seen to be potentially high risk. A longer term health risk, such as heart disease, was seen to be lower risk and less relevant than immediate or short-term health risk, such as cholesterol lowering or the *Zellosan* examples.
- Fat was perceived differently to other nutrients, and dominated consumer thinking. In the assessment of the message device referring consumers to the NIP (see nutrition information for sugar content) and for implied claims that made no mention of fat, participants wanted to verify the fat content of the product. Fat intake was equated with high health risk – any mention of fat in a claim or device (including fatty acids) made participants concerned about or wanting to check the fat content of the product.
- New information or terms were treated differently to old (known and accepted) ones. Participants were more cautious about new terms, with more time spent assessing new terms, such as *Zellosan*, omega-6 fatty acids and chromium picolinate.

- The most common approach to seeking further information was to check the NIP, the ingredients list or to look for special statement on the back of the product. All participants expected to find further information on the back of the product. Even though checking the NIP was the most common information-seeking pathway, most participants were not skilled at using the NIP to assess whether the product was a suitable choice for them, unless they had already been educated to do so for their own personally 'significant' nutrient. When seeking out serve information on the NIP, some participants commented that the writing was too small to find this quickly (or without reading glasses).
- More vs less information – Participants wanted specific information, or the claim to directly communicate cause and effect. It seems that less words could be used if specific, universally understood terms are included (e.g. 'osteoporosis'). Participants tolerated more words or information in claims or messages that were personally relevant (see previous point) – e.g. the cereal heart disease device was deemed to be 'too wordy' in cases where it was 'not relevant'.
- The value of the word 'may' varied by participant rather than by the type of claim or message, but also varied depending on the rest of the wording of the claim. Generally, the word 'may' reduced the credibility of the claim and disengaged some participants who were intolerant of this term and felt words that follow 'may' should be taken 'with a grain of salt' or should not be there (and thus are only taking up space). Yet there was a small proportion that was more sceptical of labeling and claims and therefore liked the word 'may', as it was an example of a manufacturer being more realistic about what the product could achieve. In some cases, the word 'may' alleviated the need for a message device (e.g. cereal heart disease). Furthermore, attention and value placed on the word 'may' varied depending on the wording of the rest of the claim, and whether other terms grabbed and held the attention, in which case the word 'may' was not noticed or not paid as much attention.
- Words that distinguish some types of claims by subtle semantic differences (such as 'maintains' vs 'increases') were not noticed by many participants, and many of those who did notice such differences during the exercise felt that they would not have done so while shopping, when they are usually in a hurry or distracted by noise, traffic or children. Similarly, it seemed that message devices that do not explicitly state their intent are lost on many participants. For example, when the intent of the NIP device was explained fully (by the researcher), many participants responded with *"Well, why doesn't it just say 'high in sugar'?"*
- Participants did not distinguish or even infer distinction between manufacturer's messages and this study's fictitious health authority/government messages, particularly when the information was on the front of the package. The only exception to this was the National Heart Foundation tick, which many participants were aware of and recognised. As found in previous research studies, the front of the pack is unquestionably the manufacturer's domain, and it was assumed that messages on the front were included to entice the shopper to buy the product. Thus, the information was assumed to be presenting benefits or advantages (not cautions or disadvantages).

- In most of the message devices examples, all participants assumed that both the claim and the device were from the manufacturer and designed to position the product positively. This was another reason why the message device referring consumers to the NIP was interpreted by many to suggest that the product is low in sugar (when it was in fact relatively high in sugar). Because this message device example was perceived to be of low risk through its association with the word 'sugar', it was not viewed as a 'warning'. In contrast, the message devices on the bread examples were most definitely interpreted as 'warnings' because the product, as a result of the message device, was interpreted to carry high potential risk that warranted further investigation or verification in order to abide by it.
- Participants believed that risk-related message devices were important, however, to be interpreted as important cautions that are to be taken seriously, they need to be far easier to identify as such – through use of a symbol or endorsement that is well recognised (as has been achieved by the National Heart Foundation tick) or through language that is taken seriously (such as the words "*not recommended*" in the bread examples).
- Participants appeared to infer much from the claims, on many occasions substantially more than was explicitly stated. This was done *via* pictures (implied claims and advertising), as well as from key words as presented in the message devices and health claims assessment exercises. More was inferred from words or concepts that had greater familiarity, assumed understanding and broader meaning (depending on one's personal interests and health needs).

## 11. Recommendations for Quantitative Survey

The following broad topics and issues have been identified for consideration in the design of a follow-up quantitative survey questionnaire:

- Perceptions/understanding of health claims, e.g. which are most useful and least useful and the reasons why. Reactions to claims are possibly better tested in pair sets, where each comparison includes only *one* difference, such as the word 'may' (or not), the word 'maintain' vs 'increase', or the term 'healthy diet' vs 'balanced diet' (see Sections 7 and 10).
- The existing number of claims will be too large for quantitative testing to be done thoroughly and therefore should be prioritised so that a limited number are included in the survey. It will be of particular interest to compare content claims against other types of claims; general level claims against high level claims; and biomarker claims against other claims.
- The sorting exercise (on health benefit and purchase intention) should be included to bring clarity to the qualitative findings. It is recommended that these exercises prescribe the sorting method that will be used by survey respondents, so that all respondents are sorting in the same way. It would be most useful if the task requires sorting against three levels only (e.g. most or high health benefit, least or low health benefit, and all others).
- For questions and sorting about purchase intention, respondents should be able to base their assessment on a product that they regularly use (e.g. either milk or oil, or some other food).
- A question (or sequence of questions) should be included to test preferences around the terms 'healthy diet', 'balanced diet' and 'healthy, balanced diet' – relative preferences and how each term influences the value of this kind of statement included within a claim.
- Exercises that confirm consumer preferences for the position of message devices (relative to the health claim) and the best format of devices that allow respondents to clearly identify devices as government information (or at least information not from the manufacturer), e.g. a symbol. The use of the cereal 2 device (heart disease risk factors) could be omitted, as the findings for this device were clear in the qualitative study. The development of the device examples can be improved based on the qualitative findings, for example omitting positions that were not effective (such as placing the device at the top of the product package, or placing the claim and the device together as one paragraph).
- Refinement and testing of the wording of devices. In particular, devices like the NIP cereal device should be tested against more blatant or explicit messages once the intention of the device is clarified (i.e. public health message or targeted at specific at risk groups).

- Quantify the proportion of respondents who use the NIP to verify claim information. This could include those who turn the package over (or recording what components of the label are read or clicked on), but should possibly also include the proportion who can correctly interpret the NIP, who feel confident that they could assess the NIP and make a correct decision, and assessment of which nutrients in the NIP are checked.
- Questions about purchase intention need to stipulate brand and price information (e.g. specify that comparison products are the same brand as a participant would usually buy, and are the same price), and also recognise the influence of prior knowledge about the key content nutrient.
- Quantify the effect of potential risk (i.e. does risk affect how much of the device or claim is noticed and read; whether the device should be on front or back; and whether participants act upon the device). This could be achieved through comparisons between a product with significant or immediate risk (e.g. the *Zellosan* and caution against use when pregnant [bread] example) and a product with a longer-term risk (e.g. heart disease). In assessing potential risk, the study would need to control for prior knowledge, medical history and whether a participant has any nutrients of personal significance.
- If the advertising and health claim topic is to be tested quantitatively, items that could be measured include a comparison between 'light' and 'heavy' information on labels and advertisements; advertisements that differ only in terms of the extent of the health claim (e.g. function claim vs risk reduction for disease claim); and advertisements that are clearly 'sponsored' by different types of advertisers (product manufacturers, government departments, well-known non-government organisations). Exercises like these could also be used to further test and confirm the influence of 'scientific' information, medical-type wording, or immediate and long term disease terms (such as osteoporosis, cholesterol, heart disease)

**APPENDIX A:  
GLOSSARY OF TERMS**

## GLOSSARY

<b>Health Claim</b>	In relation to the FSANZ Conceptual Framework, a health claim is a claim, other than a therapeutic claim, that describes or indicates the relationship between the consumption of a food, a category of food or one of its constituents and health. FSANZ considers that a health claim may be a type of general level claim or a high level claim. (Refer to subsection 5.5.2 of the Initial Assessment Report). A health claim does not include nutrition content claims.
<b>Nutrition content</b>	A nutrition content claim refers to the presence or absence of energy, nutrients or biologically active substances in a food. For example, 'low fat', 'high fibre', 'reduced in sugar' and '97% fat free'.
<b>Nutrition, health &amp; related claim</b>	In the context of Proposal P293, this is a collective term for any claim which makes reference to nutrients, nutrition or diet and health.
<b>Therapeutic Claim</b>	'is a claim [outside the context of the total diet] which refers to the prevention, treatment, alleviation or cure of a disease, ailment, defect or injury'. For example, 'Eating this food protects you from getting bowel cancer'.
<b>Function Claim</b>	'is a general level claim which describes [explicitly or implicitly] the biological role of a food or energy or a nutrient [or a biologically active substance] in [normal] growth, development, maintenance and other like functions of the body. For example, 'Calcium is good for strong bones and teeth. This food is high in calcium'.
<b>Enhanced Function Claim</b>	'is a general level claim which describes [explicitly/ implicitly] the biological role of a food or energy or a nutrient [or a biologically active substance] beyond [normal] growth, development, maintenance and other like functions of the body. For example, 'A diet high in calcium may help in the development of stronger bones and teeth. This food is high in calcium'.

**Risk Reduction Claim referencing a non-serious disease** 'is a general level claim which describes [explicitly/ implicitly] the biological role of a food or energy or a nutrient [or a biologically active substance] in [significantly] reducing the risk of developing a non serious disease or condition'. For example, 'This food is high in fibre which may reduce constipation'.

**Biomarker Maintenance Claim** 'is a high level claim which describes [explicitly or implicitly] the biological role of a food or energy or a nutrient [or a biologically active substance] in maintaining a normal level of a [recognised] biomarker. For example, 'This food is low in saturated fat, which as part of a diet low in saturated fat, may help to maintain a healthy blood cholesterol level'.

**Biomarker Enhancement Claim** 'is a high level claim which describes [explicitly or implicitly] the biological role of a food, energy or a nutrient [or a biologically active substance] in reducing or increasing the level of a [recognised] biomarker'. For example, 'This food is high in calcium which helps improve bone density when eaten as part of a varied diet high in calcium'.

**Risk reduction claim referencing a serious disease** 'is a high level claim which describes [explicitly or implicitly] the biological role of a food or energy or a nutrient [or a biologically active substance] in [significantly] reducing the risk of developing a serious disease or condition'. For example, 'A healthy diet that may lower the risk of certain cancers is one that is low in fats and includes fibre from a number of sources including a variety of fruits and vegetables, and wholegrain bran and cereals. This food is high in dietary fibre.'

<b>Whole of diet claim</b>	Messages about food in the context of a healthy diet. These claims are based on the Australian Dietary Guidelines or the New Zealand Food and Nutrition Guidelines. For example, 'A healthy, balanced diet that includes dietary fibre from a number of sources is one that can help reduce your risk of constipation'.
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<b>Wellbeing claim</b>	a claim that describes the role of a food or a component in a food in terms of the specific benefits related to general wellbeing. For example, 'St John's Wort herb has natural soothing mood mending properties, which can help reduce anxiety and uplift your general mental spirit'.
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**Performance claim** a claim that describes the role of a food or component of a food in enhancing the performance of the body or an organ or system within

the body. For example, 'This product is fortified with Pharmaceutical grade L-Glutamine for muscle protection and faster recovery'.

**Slimming claim**

a claim that describes the role of a food or component of a food in a diet to assist in weight reduction. For example, 'Whey protein is a natural appetite suppressant and contains properties, which help speed the body's metabolism and therefore assists in weight loss. This product is pure whey protein concentrate'.

**Endorsement**

A message or pictorial representation indicating endorsement of an organisation on a particular food. For example, the Heart Foundation of Australia's 'Tick Programme'.

**Cause-related marketing**

A message or pictorial representation indicating that the manufacturer will donate a proportion of the money from the sale of a product to a charity or non profit organisation. For example, a product label that promises to donate 50c to the Cystic Fibrosis Association of New Zealand for every product sold.

**APPENDIX B:  
INTERVIEW PROTOCOLS**

# INTERVIEW PROTOCOL 1

<b>1</b>	<b>WELCOME &amp; INTRODUCTION</b>	<b>(5 MINS)</b>
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- Introduce self.
- Explain purpose of interview – topic is food labels and information on labels about nutrition and health.
- Don't need to know anything about nutrition and health. No right or wrong answers.
- Mix of activities and talking, informal.
- Housekeeping issues – toilets, mobile phones off, confidentiality & taping (audio).

**WARM UP**

Ask about particular shopping habits/patterns and whether have any special dietary needs that influence what food products they buy.

Food allergy .....	01
Asthma.....	02
Weight loss .....	03
Medical condition (diabetes, heart disease, health concerns such as high blood pressure or cholesterol, digestive concerns such as coeliac disease, Irritable Bowel Syndrome) .....	04
Other conditions (migraine, pregnancy and breast feeding) .....	05
Lifestyle (Vegetarian / vegan, religious / ethical beliefs, training for sports etc) .....	06
General health .....	07
Other ( <b>CODE &amp; WRITE IN</b> ) .....	08
<hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>	
No, none .....	09

Relevant participant information:	

## 2 ASSESSING NUTRITION AND HEALTH CLAIMS

(40 MINS)

For this section, the Researcher has 9 picture cards, each depicting milk with different nutrition and health claims regarding calcium.

Introduce the exercise with: *"I'm going to show you a range of different words and images that you might find on various food products in the supermarket now or in the future. Each example is slightly different, but they are all about calcium. The words will mean different things to different people, I'm interested in what they mean to you. There are no right or wrong answers".*

### 2A: First ask

*Firstly, what if anything do you know about calcium – have you heard of that term before?*

**Record using record sheet.** Using probing, establish if participant has heard of calcium before, what they know about it, and also establish if they consider calcium to be important and why. In particular, probe for whether they associate positive, negative or neutral benefits with consuming calcium. Also record if they spontaneously mention an association between calcium and bone/teeth strength, bone density and the prevention of osteoporosis.

Then say: *You do not have to know anything about calcium for the following exercises.*

### 2B: Individual assessment of claims. (20 minutes)

Show cards in order A-I. Spend approximately 2 minutes on each card, using the following prompts:

#### Claim A - Content

- What are these words saying about this product?
- Is there a health benefit suggested by the words on this product? If yes, what is it?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**showcard 2B**)

#### Claim B

- What are these words saying about this product? What words are most useful / important?
- Is there a health benefit suggested by the words on this product? If yes, what is it? (Probe fully. If participant says 'strong bones' probe – if this relevant for adult males adult females, children or some/all.)
- Is the perceived health benefit only maintenance of strong bones or do consumers link the claim to osteoporosis?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**showcard 2B**)

#### Claim C

- Is there a health benefit suggested by the words on this product? If yes, what is it? (Probe fully. If participant says 'strong bones' probe – if this relevant for adult males adult females, children or some/all.)
- Does claim C mean something different from claim B or promise more than claim B?
- How do consumers interpret 'helps maintain' (claim B) vs 'helps improve' (claim C)?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**showcard 2B**)

#### Claim D

- Clarify health benefit.
- Do consumers perceive any difference between the health benefit expressed in claims B, C & D?
- Does this claim promise more than B and C? How or what?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**showcard 2B**)

#### Claim E

- Clarify health benefit, if any.
- Does claim E mean something different from claim D or promise more than claim D? What or how?
- How do consumers interpret 'helps maintain' vs 'helps improve'?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**showcard 2B**)

#### Claim F

- Clarify health benefit, if any.
- Does following the advice of claim F promise more to the consumer than E?
- Do consumers consider that reducing a risk of osteoporosis is more serious or important than improving bone density?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive the health benefit? (**showcard 2B**)

#### Claim G

- Clarify health benefit if any.
- Does the endorsement suggest to the consumer that the food may reduce the risk of osteoporosis? Does this claim suggest more than claims B, C, D or E?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive the health benefit? (**showcard 2B**)

#### Claim H

- Does claim H mean something different from claim F?
- Does it promise more than claim F?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive the health benefit? (**showcard 2B**)

#### Claim I

- Is there a health benefit suggested by the words on this product? If yes, what is it?
- Do consumers perceive that consumption of this food will alleviate/prevent/reduce the risk of osteoporosis?
- Do they recognise it only as a fundraising statement?
- How, if at all, is it different to G.

### **2C: Relative comparison of cards (claims)**

Spread all 9 cards in front of participant (face up), in random order.

#### **Exercise 1A - Sort on health benefit** (10 minutes)

*Now imagine we had 9 different brands of milk, each making one of these different claims about calcium. I'd like you to sort these cards based on which milk (claim) you think would give you the greatest health benefit if you included it as part of your whole diet, down to which milk (claim) you think would give you the least health benefit (cards may be sorted in rank order, grouped into piles, or all grouped together if there is no difference).*

Researcher note and **record** how the cards were sorted. Then probe:

- Was it hard to decide? Why have you grouped the claims as you have done?
- PROBE as to why particular claims have been grouped together or apart. How are they similar or different? What words or attributes or implied meaning makes them so?
- Which are the claims that they feel will give greater health benefit? Why? PROBE for words, length, graphics etc.

#### **Exercise 1B - Sort on link to Osteoporosis** (3 minutes)

Which claims are more closely linked to Osteoporosis? Get respondent to **rank order**, and **record** using recording sheet.

## **Exercise 2 - Sort on impact on intended purchase** (10 minutes)

Shuffle cards and lay in front of participant, in different but random order.

*Next I'd like you to think about what influence these words or claims would have on which or all of these 9 products you would buy. Please sort these cards based on which milk (claim) you think you would be most likely to buy if you saw it in the supermarket, down to which milk (claim) you think you would be least likely to buy. If calcium is not important to you, could you please imagine that it is in order to do this exercise. (cards may be sorted in rank order, grouped into piles, or all grouped together if there is no difference).*

Researcher note and **record** how the cards were sorted. Then probe:

- Clarify which ones the participant would and wouldn't buy, and why.
- Was it hard to decide? Why have you grouped the claims as you have done?
- PROBE as to why particular claims have been grouped together or apart. How are they similar or different? What words or attributes or implied meaning makes them so?
- How likely are you to buy the milk with the claim(s) you favour, compared to a milk without any of these claims (assume that you have to buy milk)? (very likely, somewhat likely, not very likely, not at all likely, don't know). Probe as to WHY?
- If not ranked top or bottom, PROBE about placement of biomarker, cause-related marketing and endorsement claims and reasons why placed where they were.
- What other information might you use on the food label to help you make a choice? Probe as to WHY? (If NIP mentioned, probe further to ascertain what parts/information and why)

## **3 –CONCEPT OF A 'HEALTHY/BALANCED/TOTAL DIET' (5 MINS)**

This section may have already come up spontaneously in Section 2. Explore to the extent that this has not been covered adequately.

*Some of these claims include the words 'healthy diet', 'balanced diet', 'total diet'.*

Refer and point to specific claims that mention 'healthy / balanced / total diet'.

- What does that expression 'as part of a healthy diet' mean to you when you read these claims?
- Why do you think this particular claim includes that expression 'as part of a healthy diet'?
- Should these words 'healthy diet' be included or not? Why/why not? How would this claim be different if those words were excluded – would the meaning change?
- Do other terms like 'as part of a balanced diet' or 'as part of the total diet' mean the same thing? Are they different from a 'healthy diet'? If so, which expression do you prefer?

#### 4 SOURCES OF INFORMATION ABOUT 'HEALTHY BALANCED/TOTAL DIET' (5 MINS)

*Think back to how you formed your opinion of what is meant by a 'healthy/balanced/total diet'.*

- What information did you use to decide? (**write in or tick on prompt sheet 4**)
- Where do you get this information?

**SHOW PROMPT LIST**, INCLUDING PARTICIPANT'S MENTIONS FROM ABOVE.

- What are the best sources of information about 'healthy/balanced/total diets'? What do you trust most? What would you trust least?

(RECORD)

#### 5 WORD ASSOCIATION (5 MINS, IF TIME AVAILABLE)

To finish with we're going to do something very different, and it should be quite fun. I'm going to read out a number of different items, and I want you to tell me the words that come immediately to mind for you. Don't hold back or think too hard, just say whatever comes to your mind. You can say as many things as possible. There are no right or wrong answers.

First, we'll do a practice:

1. wheelchair

*Now we'll do some words that you may see on food labels.*

Read out one at a time (rotate order), record all mentions for each. For each word, probe "anything else?" once only.

1. **Blood cholesterol**
2. **Blood pressure**
3. **Blood glucose**

THANK AND CLOSE

Your views will assist FSANZ in their work on developing food labelling standards

PROVIDE INCENTIVE.

# INTERVIEW PROTOCOL 2

## 1 WELCOME & INTRODUCTION (5 MINS)

- Introduce self.
- Explain purpose of interview – topic is food labels and information on labels about nutrition and health.
- Don't need to know anything about nutrition and health. No right or wrong answers.
- Mix of activities and talking, informal.
- Housekeeping issues – toilets, mobile phones off, confidentiality & taping (audio).

### WARM UP

Ask about particular shopping habits/patterns and whether have any special dietary needs that influence what food products they buy.

Food allergy ..... 01  
Asthma..... 02  
Weight loss ..... 03  
Medical condition (diabetes, heart disease, health concerns such as high blood pressure or cholesterol, digestive concerns such as coeliac disease, Irritable Bowel Syndrome) ..... 04  
Other conditions (migraine, pregnancy and breast feeding) ..... 05  
Lifestyle (Vegetarian / vegan, religious / ethical beliefs, training for sports etc) ..... 06  
General health ..... 07  
Other (**CODE & WRITE IN**) ..... 08  
\_\_\_\_\_  
No, none ..... 09

Relevant participant information:	

## 2 ASSESSING NUTRITION AND HEALTH CLAIMS

(40 MINS)

For this section, the Researcher has 7 picture cards, each depicting sunflower oil with a different health claim regarding omega-6 fatty acids.

Rotate order in which cards are shown. Introduce the exercise with: *"I'm going to show you a range of different words and images that you might find on various food products in the supermarket now or in the future. Each example is slightly different, but they are all about omega-6 fatty acids. The words will mean different things to different people, I'm interested in what they mean to you. There are no right or wrong answers"*.

### 2A: First ask

*Firstly, what if anything do you know about omega-6 fatty acids – have you heard of that term before?*

**Record using record sheet**. Using probing, establish if participant has heard of omega-6 fatty acids before, what they know about it, and also establish if they consider them to be important and why. In particular, probe for whether they associate positive, negative or neutral benefits with consuming omega-6 fatty acids. Also record if they spontaneously mention an association between omega-6 fatty acids and heart health.

Then say: *You do not have to know anything about omega-6 fatty acids for the following exercises.*

### 2B: Individual assessment of claims. (15 of 40 minutes)

Show cards in order A-G. Spend approximately 2 minutes on each card, using the following prompts:

#### Claim A - Content

- What are these words saying about this product?
- Is there a health benefit suggested by the words on this product? If yes, what is it?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**showcard 2B**)

#### Claim B

- What are these words saying about this product?
- Is there a health benefit suggested by the words on this product? If yes, what is it? (Probe fully. If participant says 'healthy skin' probe – what does 'healthy skin' mean?)
- What does 'essential' mean?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**showcard 2B**)

#### Claim C

- Is there a health benefit suggested by the words on this product? If yes, what is it? (Probe fully. If participant says 'healthy heart' probe – what that means.)
- What does 'healthy heart' and 'general well being' mean? Does this sound authentic?
- If you saw this claim on one product and claim B on another, what does it mean? How are they different?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**showcard 2B**)

#### Claim D

- Clarify health benefit.
- What is the difference between 'high in this claim and 'rich' in Claim C?
- Who is this claim useful for? (Probe to clarify if it applies to everyone, or just people with high blood cholesterol).
- What is the difference between this claim and Claim C?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**showcard 2B**)

#### Claim E

- Clarify health benefit.
- What is the difference between this and Claims C and D?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**showcard 2B**)

#### Claim F

- Clarify health benefit, if any.
- What difference does the logo make as to the authenticity of the claim?
- Is this claim better (healthier) than any of the other claims?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive the health benefit? (**showcard 2B**)

#### Claim G

- What health benefit, if any might be associated with the product?
- Is the product more likely to have characteristics that relate to cancer?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive the health benefit? (**showcard 2B**)

## **2C: Relative comparison of cards (claims) (20 of 40 minutes)**

Spread all 7 cards in front of participant (face up), in random order.

### **Exercise 1 - Sort on health benefit (10 of 20 minutes)**

*Now imagine we had 7 different oils, each making one of these different claims about omega-6 fatty acids. I'd like you to sort these cards based on which oil (claim) you think would give you the greatest health benefit if you included it as part of your whole diet, down to which oil (claim) you think would give you the least health benefit (cards may be sorted in rank order, grouped into piles, or all grouped together if there is no difference).*

Researcher note and **record** how the cards were sorted. Then probe:

- Was it hard to decide? Why have you grouped the claims as you have done?
- PROBE as to why particular claims have been grouped together or apart. How are they similar or different? What words or attributes or implied meaning makes them so?
- Which are the claims that they feel will give greater health benefit? Why? PROBE for words, length, graphics etc.

### **Exercise 2 - Sort on impact on intended purchase (10 of 20 minutes)**

Shuffle cards and lay in front of participant, in different but random order.

*Next I'd like you to think about what influence these words or claims would have on which or all of these 7 products you would buy. Please sort these cards based on which oil (claim) you think would be most likely to buy if you saw it in the supermarket, down to which oil (claim) you think would be least likely to buy. If omega-6 fatty acids are not important to you, could you please imagine that they are in order to do this exercise. . (Cards may be sorted in rank order, grouped into piles, or all grouped together if there is no difference).*

Researcher note and **record** greatest and least impact on purchase. Then probe:

- Clarify which ones the participant would and wouldn't buy, and why.
- Was it hard to decide? Why have you grouped the claims as you have done?
- PROBE as to why particular claims have been grouped together or apart. How are they similar or different? What words or attributes or implied meaning makes them so?
- How likely are you to buy the oil with the claim(s) you favour, compared to an oil without any of these claims (assume that you have to buy oil)? (very likely, somewhat likely, not very likely, not at all likely, don't know). Probe as to WHY?
- If not ranked top or bottom, PROBE about placement of biomarker, cause-related marketing and endorsement claims and reasons why placed where they were.
- What other information might you use on the food label to help you make a choice? Probe as to WHY? (If NIP mentioned, probe further to ascertain what parts/information and why)

## 2D: Slimming Claim (5 minutes)

Introduce picture card with slimming claim (Chocolate flavoured milkshake with the claim “The natural substance chromium picolinate may assist in weight management”.)

- What is this product suggesting?
- What benefit is it offering? AFTER response, PROBE whether this is perceived as a health benefit vs other benefit.
- NOTE and record if participant asks about how can a food with kJ make you lose weight (ie give you negative energy).
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**show card**)
- What other information might you use on the food label to help you make a choice or be more certain? Probe as to WHY? (If NIP mentioned, probe further to ascertain what parts/information and why)
- Should this type of claim be allowed on food products? Should they be allowed under any particular conditions, or with any other information / restrictions?

## 3 CONCEPT OF A ‘HEALTHY/BALANCED/TOTAL DIET’ (5 MINS)

This section may have already come up spontaneously in Section 2. Explore to the extent that this has not been covered adequately.

*Some of these claims include the words ‘healthy diet’, ‘balanced diet’, ‘total diet’.*

Refer and point to specific claims that mention ‘healthy / balanced / total diet’.

- What does that expression ‘as part of a healthy diet’ mean to you when you read these claims?
- Why do you think this particular claim includes that expression ‘as part of a healthy diet’?
- Should these words ‘healthy diet’ be included or not? Why/why not? How would this claim be different if those words were excluded – would the meaning change?
- Do other terms like ‘as part of a balanced diet’ or ‘as part of the total diet’ mean the same thing? Are they different from a ‘healthy diet’? If so, which expression do you prefer?

## 4 ROLE OF GOVERNMENT

(10 MINS)

Refer back to picture cards (section 2 claims) for this section.

- Now that you've seen a range of potential health claims, how do you feel about the use of these sorts of claims by food manufacturers? [probe to assess level of concern or favour, and whether need for regulation comes up]
- Do you think any limitations or regulations should be placed around the use of these claims? Why / why not?
- Probe for degree of certainty of scientific evidence needed to back up claims. How would this be collected / managed/ communicated?
- Do some claims need more regulation than others? Which ones? Why / why not? [Probe for each, or for those different from others]
- Whose responsibility do you think it is to regulate the use of these claims (government, food manufacturer?)
- What role do you think the government currently plays? What role should it play?
- How could you be reassured that government was playing an active role in regulating these claims? (eg through education, or some other means?)
- How can consumers be advised or reassured that that government is regulating the claims. (If say's "TV" PROBE for other ways as TV not viable).

## 5 WORD ASSOCIATION

(5 MINS, IF TIME AVAILABLE)

To finish with we're going to do something very different, and it should be quite fun. I'm going to read out a number of different items, and I want you to tell me the words that come immediately to mind for you. Don't hold back or think too hard, just say what ever comes to your mind. You can say as many things as possible. There are no right or wrong answers.

First, we'll do a practice:

- a. wheelchair

*Now we'll do some words that you may see on food labels.*

Read out one at a time (rotate order), record all mentions for each. For each word, probe "anything else?" once only.

1. **Blood pressure**
2. **Blood glucose**
3. **Bone density**

THANK AND CLOSE

Your views will assist FSANZ in their work on developing food labelling standards

# INTERVIEW PROTOCOL 3

## 1 WELCOME & INTRODUCTION (5 MINS)

- Introduce self.
- Explain purpose of interview – topic is food labels and health information.
- Don't need to know anything about health. No right or wrong answers.
- Mix of activities and talking, informal.
- Housekeeping issues – toilets, mobile phones off, confidentiality & taping (audio).

### WARM UP

Ask about particular shopping habits/patterns and whether have any special dietary needs that influence what food products they buy.

Food allergy ..... 01  
Asthma..... 02  
Weight loss ..... 03  
Medical condition (diabetes, heart disease, health concerns such as high blood pressure or cholesterol, digestive concerns such as coeliac disease, Irritable Bowel Syndrome) ..... 04  
Other conditions (migraine, pregnancy and breast feeding) ..... 05  
Lifestyle (Vegetarian / vegan, religious / ethical beliefs, training for sports etc) ..... 06  
General health ..... 07  
Other (**CODE & WRITE IN**) ..... 08  
\_\_\_\_\_  
No, none ..... 09

Relevant participant information:	

## 2 ASSESSING IMPLIED HEALTH CLAIMS

(20 MINS)

For this section, the Researcher has 6 picture cards, each depicting a different implied health claim in graphic/symbol format.

The implied claims are:

- A. Implied claim (heart logo on tomatoes)
- B. Implied claim (heart logo with ECG tracing on tomatoes)
- C. Implied claim for dental health (Chewing gum - 'happy, healthy teeth')
- D. Implied claim for sport performance (Boost protein bar - 'better, stronger, faster performance')
- E. Night time tea ('sleep easy')

### 11.1.1 Osteofix and graphic of skeleton

#### 2A – Assessing claims individually (18 of 20 minutes)

Rotate order in which cards are shown. Introduce the exercise with: *“I’m going to show you a range of different words and images that you might find on various food products in the supermarket. Each example is slightly different, and they will mean different things to different people, I’m interested in what they mean to you. There are no right or wrong answers”.*

Spend approximately 3 minutes on each card, using the following prompts:

- What are these words (images) saying about this product? .
- What else? [Exhaust fully before probing elicit and clarify if implied or explicit, and influence of graphic/symbol/words? Note extent to which you had to prompt on this.]
- Is it suggesting a health benefit? What is the health benefit that it is suggesting?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**show card**)
- Is this type of representation more or less credible/believable than just words?
- Do you need other information to help you interpret these claims? What information do you need and where would you obtain it?

#### 2B – Comparing claims (2 of 20 minutes)

Refer to the two heart examples.

- Are these two claims conveying the same message or a different message?
- Is this type of representation more or less credible/believable than just words?
- Which of these two claims do you prefer? Why? (PROBE fully)
- Is one more trustworthy / credible than the other?
- Which is more likely to get your attention? Why?
- Do you need other information to help you interpret these claims? What information do you need and where would you obtain it?

PROBE to clarify what difference the 'ECG' type symbol makes.

### **3 RELATIVE IMPACT OF CLAIMS ON PRODUCTS VS ADVERTISING (25 MINS)**

#### **3A: Yogurt (10 of 25 mins)**

Introduce stimulus material A [Jalna yoghurt with no health claim].

- Here is one brand of yogurt. It doesn't make any particular health claims, but what if any health benefits do you think it may have— take your time to read the label and tell me what you think. [reinforce it's ok to say 'don't know' or 'no particular benefit']

Then show stimulus material B [Jalna yoghurt with implied health claim] or C [advertising material featuring Jalna yogurt with health claim and additional text about health benefits of consuming the product]. Rotate order but ask both.

#### **B: Yogurt with implied claim**

- What do you make of the health claim – what do you see and what does it mean to you?
- What does this product offer that the first yogurt didn't? [probe for health benefit and also likelihood of purchase]

#### **C: Advertising material:**

Here is some information/advertising material produced by the yoghurt manufacturer

- What do you make of this material – what do you see and what does it mean to you?
- What does this product appear to offer that the first yogurt didn't? [probe for health benefit and also likelihood of purchase]
- What words or sentences suggested that this product has a health benefit that the first product didn't?
- Is the advertising material more or less credible/trustworthy than the information on the food label of the yoghurt making a claim?

Comparing the yogurt with no health claim (A) to the yogurt with the claim (B), what influence might the advertising material (C) have on how you feel about that product? [probe on trust and also purchase intention]. Does seeing the ad make you feel differently (positive or negative) about the 2 yogurt products?

#### **3B Soy Milk (10 of 25 mins)**

Introduce stimulus material A [soy milk product with no health claim].

- Here is one brand of soy milk. It doesn't make any particular health claims, but what if any health benefits do you think it may have– take your time to read the label and tell me what you think. [reinforce it's ok to say 'don't know' or 'no particular benefit']

Then introduce stimulus material B [magazine ad for soy milk – no brand].

- What do you make of this material – what do you see and what does it mean to you?
- What does this product appear to offer that the soy milk product didn't? [probe for health benefit and also likelihood of purchase compared to product with no claim].]
- What words or sentences suggested that this product has a health benefit that the first product didn't?
- What difference would it make if this ad was branded *Sanitarium*? (i.e. same brand as soy milk product). Would you feel differently about the soy milk? How? Why? [probe for influence on trust and also purchase intention].]
- What difference would it make if this ad was branded *Dietitians Association of Australia*? (i.e. same brand as soy milk product). Would you feel differently about the soy milk? How? Why? [probe for influence on trust/credibility and also purchase intention].]

### 3C Comparing the yogurt and soy milk advertising (5 of 25 minutes)

In the yogurt example, the health benefit was claimed for that particular brand of yogurt, where as in the soy milk advertisement, there is no particular brand being advertised.

- Is one approach better than the other? Does a brand (or endorsement by a trusted organisation like DAA) make a difference to how you view the 'health' or 'scientific' information being given? How?
- When does scientific or health information become 'advertising'? How do you make a distinction between the two?

## 4 COMPLEMENTARY MEDICINES

(10 MINS)

Use two example products as references (St Johns Wort tea and capsules).

### 4A: Individual assessment of one product.

Rotate order. Introduce either tea product or capsules.

*This product makes a claim about a health benefit.*

- What are these words (images) saying about this product?
- What is the health benefit that it is suggesting?
- On a scale of 1 to 10, how certain would you be that by consuming this product you would receive this benefit? (**showcard**)
- What words are most useful / important?

#### **4B: Relative comparison of both products**

Introduce second product.

*This product makes the same health claim.*

- Comparing both products, are the claims different in any way?
- Although both products claim to offer the same thing, would you expect the health benefit to be different in any way between the products? If so, is one better than the other?
- Would you expect the health benefit from one product to be more effective than another, or would you might expect them to be the same? What about in terms of:
  - Act faster – quicker results
  - Healthier / better for you
  - Cheaper
  - More reliable
  - Dangerous
  - Safer
- Is the claim more fitting or appropriate on one product more than another, or is it equally fitting in both?

THANK AND CLOSE

Your views will assist FSANZ in their work on developing food labelling standards

## INTERVIEW PROTOCOL 4

This discussion guide is intended as an outline only. There will be considerable scope within the discussion for exploring issues as they arise. Questions are indicative only of subject matter to be covered and are not word for word descriptions of the moderator's questions.

<b>1</b>	<b>WELCOME &amp; INTRODUCTION</b>	<b>(5 MINS)</b>
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- Introduce self.
- Explain purpose of group interview – topic is food labels and health information.
- Don't need to know anything about health. No right or wrong answers.
- Mix of written activities and talking, informal
- Housekeeping issues – toilets, mobile phones off, refreshments, confidentiality & taping (audio).

**WARM UP**

Ask about particular shopping habits/patterns and whether have any special dietary needs that influence what food products they buy.

Food allergy .....	01
Asthma.....	02
Weight loss .....	03
Medical condition (diabetes, heart disease, health concerns such as high blood pressure or cholesterol, digestive concerns such as coeliac disease, Irritable Bowel Syndrome) .....	04
Other conditions (migraine, pregnancy and breast feeding) .....	05
Lifestyle (Vegetarian / vegan, religious / ethical beliefs, training for sports etc) .....	06
General health .....	07
Other ( <b>CODE &amp; WRITE IN</b> ) .....	08
<hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>	
No, none .....	09

Relevant participant information:	

## 2 WORD ASSOCIATION

(10 MINS)

We're going to do something that should be quite fun. I'm going to read out a number of different items, and I want you to tell me the words that come immediately to mind for you. Don't hold back or think too hard, just say whatever comes to your mind. You can say as many things as possible. There are no right or wrong answers.

First, we'll do a practice:

1. wheelchair

*Now we'll do some words that may be seen on food labels.*

Read out one at a time (rotate order), **record** all mentions for each using record sheet. For each word, probe "anything else?" once only.

1. **Blood cholesterol**
  2. **Blood pressure**
  3. **Blood glucose**
  4. **Bone density**
  5. **Obesity**
  6. **Well being**
  7. **Health**
-

### 3 MESSAGE DEVICES

(45 MINS)

For this section, the Researcher has 4 sets of 3 different mock-up products bearing differing message device scenarios to work through. A message device refers to information that supplements the health claim. Ideally you will be testing 4 message devices, however you are likely to only have time for 3. The four devices are listed below, the three priority ones are in bold (1,3,4):

- 1. See nutrition information for sugar content**
2. Many factors, such as a family history of heart disease, increased blood pressure and LDL cholesterol levels, cigarette smoking, diabetes and being overweight contribute to heart disease
- 3. Consume no more than 3 servings per day**
- 4. Not recommended for infants, children and pregnant or lactating women unless under medical supervision**

There are 2 sets of cereal and 2 sets of bread

**Set 1, cereal A – message device 1, health claim 1**

Set 2, cereal B – message device 2, health claim 1

**Set 3, bread A – message device 3, health claim 2**

**Set 4, bread B – message device 4, health claim 2**

Different positions of the message devices are also being measured., each involving 3 picture cards that show different message positions.

Within each set of products, the message devices are positioned in three different ways – a, b, c (12 mock-ups in all):

- a) in close proximity to the health claim
- b) separated from the health claim, but on the same panel
- c) separated from the health claim but on a different panel

Always show the three positions A-C within the one set at the same time (random order). Introduce the exercise with: *“I’m going to show you a range of different words and images that you might find on various food products in the supermarket. Each example is slightly different, and they will mean different things to different people, I’m interested in what they mean to you. There are no right or wrong answers”.*

### **3A: Assessing first health claim, message device 1 (20 minutes)**

Introduce Cereal A (3 mock ups) picture cards and ask:

- Are any of these products making any sort of claim about a health benefit you would get by consuming it? What is the health benefit that it is suggesting? (is response correct?)
- Can you identify where the health information is on each of these products? (get participant to point to information, and **record**).

Clarify for the participant that each product is making the same health claim, and point out the critical difference between the 3 products in terms of position of the message device. Allow participant to familiarise themselves with each.

Note extent to which participant can see the linkage between the health claim and the message device.

- What does this additional information suggest that you should/ shouldn't do?
- Would you take notice of this advice? Does the device encourage you to read the NIP?
- How likely would you be to act on this message (i.e. read the NIP)
- Do any of these versions work better? Do you have a preference?
- Why do you prefer the claim information to be in your preferred format? Exhaust fully before probing for detail and depth (related to visibility / comprehension vs clutter vs perceived distinction between front of product = "advertising" and side of product = "facts".)
- Probe for advantages and disadvantages of linked claim and device vs split health claim and message device, particularly in regards to ability to interpret, verify or believe the claim.
- Which version makes it easier for you to make a decision about which product is a better choice for a healthy diet? Which is more user / reader / shopper friendly?

### **Rotate order of presenting 3B and 3C.**

### **3B: Assessing the second health claim, message device 3 (15 minutes)**

Introduce set of 3 mock ups (Bread A):

- Are any of these products making any sort of claim about a health benefit you would get by consuming it? What is the health benefit that it is suggesting? (is response correct?)
- Can you identify where the health information is on each of these products? (get participant to point to information, and **record**).

Clarify for the participant the health claim that each product is making the same health claim (different to the cereal), but that the additional information (device) has changed. Allow participant to familiarise themselves with the claim and device in each of the 3 positions.

- What does this additional information suggest that you should/ shouldn't do?
- Would you take notice of this advice?
- Is the message device interpreted as 'guidance' or as a 'rule' that must be followed?
- Do any of these versions work better? Do you have a preference?
- Why do you prefer the claim information to be in your preferred format? Exhaust fully before probing for detail and depth (related to visibility / comprehension vs clutter vs perceived distinction between front of product = "advertising" and side of product = "facts".)
- Probe for advantages and disadvantages of linked claim and device vs split health claim and message device, particularly in regards to ability to interpret, verify or believe the claim.
- Which version makes it easier for you to make a decision about which product is a better choice for a healthy diet? Which is more user / reader / shopper friendly?
- What will happen if someone eats more or less than the recommended 3 servings?
- What do you think is meant by 'serving'?

### **3C Assessing second health claim, message device 4 (10 minutes)**

Introduce set of 3 mock ups (Bread B):

Clarify for the participant the health claim that each product is making the same health claim as the previous bread example, but that the additional information (device) has changed. If necessary, point out the critical difference between the 3 products in terms of position. Allow participant to familiarise themselves with the claim and device in each of the 3 positions. .

- What does this additional information suggest that you should/ shouldn't do?
- Is the message device interpreted as 'guidance' or as a 'rule' that must be followed?
- Would you take notice of this advice? Why/not? (do they pay attention if they are not one of the groups mentioned?)
- How would you use this information? (to limit or control usage of the product??)
- Do any of these versions work better? Do you have a preference?
- Why do you prefer the claim information to be in your preferred format? Exhaust fully before probing for detail and depth (related to visibility / comprehension vs clutter vs perceived distinction between front of product = "advertising" and side of product = "facts".)
- Probe for advantages and disadvantages of linked claim and device vs split health claim and message device.
- Which version makes it easier for you to make a decision about which product is a better choice for a healthy diet? Which is more user / reader / shopper friendly?

**OPTIONAL:**

**3D: Assessing first health claim, message device 2 (10 minutes)**

Introduce the other cereal example (message device 2) **only if time left**. Use same question format, plus:

- Is this message too long?
- How, if at all, does it assist the consumer to verify or understand the claim?
- Is this message relevant? Useful? Necessary?
- Does this message make the health claim more or less credible?
- Did you know this information before reading it now?

**THANK AND CLOSE:**

- Your views will assist FSANZ in their work on developing food standards.