

# Interim Advertising Council

Meeting 6  
20 February 2004  
8.30 am – 4.30 pm

The Stamford Hotel, Mascot, Sydney

## DRAFT Minutes

### 1. Attendance

Mr Mike Codd (Chair)	
Ms Marilyn Anderson	Medsafe
Ms Jenny Bergin	Pharmacy representative (Aust and NZ)
Mr Pio Cesarin	Therapeutic Goods Administration
Mr Mike Cocks	Australian advertising industry representative
Ms Pam Davis	Medical devices industry representative (Aust and NZ)
Ms Jean Drage	Consumer representative (NZ)
Mr Colin Harcourt	Australian media industry representative
Mr Jeremy Irwin	Association of New Zealand Advertisers (NZ)
Ms Val Johanson	Complementary Healthcare Council of Australia (CHC)
Mr Raymond Khoury	Natural healthcare professional (Aust and NZ)
Mr Tony Miller	New Zealand Self-medication Industry (SMI)
Dr Robyn Napier	Medical profession representative (Aust and NZ)
Mr Kieran Schneemann	Medicines Australia (Aust and NZ)
Ms Juliet Seifert	Australian Self-medication Industry (ASMI)
Mr Rob Shaw	Dietary supplements industry (NZ)
Dr Derek Weir	Consumer representative (Aust)
Mr Glen Wiggs	Advertising Standards Authority Inc. (NZ)
Ms Christianna Cobbold	Director, Trans Tasman Group, Therapeutic Goods Administration
Dr Fiona Cumming	Therapeutic Goods Administration and Executive Secretary, IAC Support Group
Ms Judith Brimer	Secretary, IAC Support Group
Ms Sharyn McGregor	IAC Support Group

### Apologies

Ms Susan Martindale	Medsafe
Mr James Hart	Natural healthcare profession

### 2. Welcome

The Chairman welcomed new members Mr Colin Harcourt (Australian media representative), Ms Pam Davis (alternate medical devices industry representative), Mr Rob Shaw, (dietary supplements industry NZ representative), and alternate members

Mr Raymond Khoury (alternate Australia / New Zealand natural healthcare professional representative) and Ms Marilyn Anderson (alternate Medsafe representative) to the meeting and noted the expanded membership of the Interim Advertising Council (IAC).

### **3. Minutes of the meeting held 8 December 2003**

The minutes of the meeting held on 8 December 2003 in Auckland, New Zealand, were adopted unanimously.

### **4. Matters arising from the minutes**

#### ***4.1 Attendance of approvals officers at meetings of the Advertising Board.***

Because of the value of their input by virtue of continually working at the ‘coal face’, it was suggested that a mechanism should be found to enable the presence of Australian approvals officers and New Zealand adjudicators at meetings of the proposed Advertising Board. It was noted that, if the system of delegated authorities were to be introduced, it would be appropriate for the Australian central approvals manager and the New Zealand chief adjudicator to attend.

The Chairman suggested that a consultation process between the Advertising Board and delegated authorities through the Australian central approvals manager and the New Zealand chief adjudicator could be devised to facilitate the inclusion of such expertise.

### **5. Agenda item 1A - membership of the Advertising Board**

In formally welcoming representatives from the media, medical devices industry and the New Zealand dietary supplements industry to the Interim Advertising Council (IAC), the Chairman noted that the IAC membership now numbers 18. As well, it was noted that correspondence had been received from the Researched Medicines Industry association (New Zealand) and from Mediherb Pty Ltd (Australia) seeking additional membership for the addition of an RMI representative and a separate Australian healthcare practitioner representative, respectively. In the letter nominating a representative of the Australian media to the IAC, the Australian Publishers Bureau, Commercial Television Australia and Commercial Radio Australia also sought separate representation on the proposed Advertising Board.

The AMA representative expressed the view that expert input on safety and efficacy is essential for decisions on policy and, therefore, the final composition of the Advertising Board should include at least one medical practitioner.

The ANZA representative said that as the IAC’s role is to develop a common advertising code, the ultimate composition of the Advertising Board should be fully representative of the industries it is to serve, i.e. including the advertising industry.

The pharmacy representative expressed the view that health practitioners are best placed to recognise the public health implications implicit in some decisions and advertising policy determinations and it was, therefore, important that they be

represented on the Advertising Board. The need for balanced representation on the Advertising Board was also emphasised.

It was noted by the Chairman that the replacement of the broadly representative Therapeutic Goods Advertising Code Council (TGACC) in Australia by the Interim Advertising Board may need to be considered as part of the transition from the current to the new regulatory arrangements. The TGACC has responsibility for the consideration of submissions for the use of restricted representations, requiring the application of the public interest criteria, and, should this replacement occur, the constitution of the IAC would need to reflect that function.

In recognition of the wish of many stakeholders for direct input to the proposed Advertising Board and, on the other hand, of the need for the Board to be able to progress its work in an efficient and timely manner, the Chairman put forward a 'hybrid' proposition for composition of the Advertising Board to the meeting, as follows:

1. The establishment of a broadly representative Advertising Board, which would meet twice per year. Its function would be to consider and endorse matters relating to the policy of regulating advertising of therapeutic products, and changes to the Advertising Code.
2. The establishment of a small committee, drawn from the Advertising Board, which would meet six times per year. This group would function as an executive committee, holding the responsibility for taking short-term decisions on finance, hiring and firing, providing direction for training and education, monitoring and evaluation and overseeing approvals and complaints operations.
3. Some functions involving the requirement for expert advice, such as the consideration of submissions for the use of restricted representations, could be addressed by delegation to an appropriately constituted, supplementary committee.

For such a proposition to work effectively, it would be necessary for all papers and outcomes from consideration of matters by the executive committee to be provided to members of the Advertising Board, giving the Advertising Board members the opportunity for input into the deliberations of the executive committee; and strongly dissenting views able to be reflected in advice put forward to the Advertising Board.

Matters raised by members in the discussion included:

- (a) The constitution of the executive committee. It was suggested that, firstly, principles underpinning appropriate representation should be identified and then applied in determining the actual membership of the committee. These principles could include the function of the committee and that its membership should reflect those whom the system is to serve and the providers of the funding through cost recovery.
- (b) Unambiguous parameters should be set for the power of the executive committee.
- (c) Matters that require the approval of the Advertising Board must be clearly articulated.

- (d) A central support unit would need to be established, to implement the decisions made by the Advertising Board and the executive committee in four operational areas, i.e. approvals, complaints, education/training, and evaluation/monitoring. The executive committee would oversee these operations.
- (e) The twice yearly meetings of the Advertising Board could be coordinated with the legislative timetable, providing consistency and reliability.
- (f) The value of including representation of the Researched Medicines Industry association and an Australian healthcare practitioner in the next meeting of the IAC was noted.

Brief consideration was given to a possible model for the composition of the executive committee as follows:

- Independent chair
- 2 consumer representatives (Australia and New Zealand)
- 3 industry representatives from New Zealand
- 3 industry representatives from Australia
- 1 joint Australia/New Zealand representative from the devices industry
- 1 joint agency representative

Not all members agreed that this was an appropriate construct but it was agreed that the IAC Support Group review the discussion paper so that this option is included in the draft report. The pharmacy representative was strongly opposed to this model unless membership of the Advertising Board and the administrative sub-committee included expertise in practicing pharmacy.

**There was in-principle support from most members for including the option of establishing a broadly representative Advertising Board and a small executive committee in the draft report.**

**The IAC agreed to recommend to the TGA and Medsafe that the Researched Medicines Industry association and an Australian complementary healthcare practitioner should be invited to nominate a representative to be appointed to the IAC.**

## **6. Agenda item 1B Workplan update**

1. It is anticipated that the draft report on the proposed advertising system could be circulated to members by mid June. Members will then be invited to submit constructive comments and editorial suggestions for inclusion in a marked up version, which will be considered at the July IAC meeting. Agreed amendments and dissenting views from this meeting will be included in the final report to be forwarded to the TGA and Medsafe later in July 2004.
2. It was suggested that the final version of the Advertising Code needs to be accepted very soon, to enable the education process to begin.
3. There was considerable discussion on the legislation timetable for the trans Tasman agency legislation and on the value and appropriate length of a transition

period for the new advertising regulatory model. While it was suggested that the transition period should accommodate a full year of product advertising, members accepted this may not be possible if the trans Tasman joint agency commences from July 2005. The expectation that a major review of the advertising regulatory system will be undertaken after a period of twelve months of operation was noted, and that this review would be ongoing annually with a report provided to the Ministerial Council. The period from now to July 2005 was seen as an opportunity to test parts of the proposed system before all of the legislative arrangements were in place.

Some concerns were raised as to the scope of review, the basis of the legislation, ‘grandfathering’ of certain parts of the system, including the validity of current two year approvals, and the importance of industry being fully aware of any degree of risk involved in their commercial planning.

It was suggested that, as had been the case with the implementation of the current Therapeutic Goods Advertising Code (TGAC) in Australia from the 1999 review, the standard applied at approval and complaint would be the new trans Tasman Advertising Code, from the date of it being brought into operation. The complaints bodies could have discretion in taking into consideration the code under which an advertisement had been approved. A similar procedure is applied in New Zealand with the introduction or review of codes, even after relatively short notice to stakeholders and this is thought to be effective. The New Zealand representatives were of the view that it is unnecessary to consider any notion of ‘grandfathering’ in relation to introduction of the new Advertising Code.

Members agreed that, should there be no ‘grandfathering’ of advertisements approved in Australia at the commencement of the new legislation, then sufficient advance notice of any changes must continue to be given to stakeholders. The Support Group and the Director of the Trans Tasman Group were asked by members to note that as much notice as possible should be given to industry.

In the first instance, virtually all of the elements of the broader trans-Tasman regulatory scheme will be contained in the Rules, which will be amendable by the Ministerial Council, rather than the Act, which will be as minimal as possible. It was noted that there is scope for input into the transition arrangements for the joint Agency.

It was explained to members by the Director of the Trans Tasman Group that the legislation is unlikely to be debated in the Australian Parliament until the spring session and possibly later in New Zealand. With the likelihood of elections being called around that time in both Australia and New Zealand it is not possible to predict with any certainty the introduction of the legislative components of the proposed advertising controls in Australia ahead of the commencement of the joint agency.

While recognising the potential legal difficulties of introducing parts of the scheme before July 2005, consideration was given to the possibility of amending the existing Australian Therapeutic Goods Advertising Code either to align with, or be replaced by, the proposed Australia New Zealand Advertising Code, and

retaining the Therapeutic Goods Advertising Code Council during the transition period to 1 July 2005. Under this proposal, the IAC or a subsequent body could focus on overseeing the implementation of the proposed education program and the work undertaken on costs and compliance.

The Chairman summarised the discussion as follows:

**A recommendation is to be made to the Therapeutic Goods Administration that:**

- **Version 8 of the draft Australia New Zealand Therapeutic Products Advertising Code for Therapeutic Products be embodied in the Australian Therapeutic Goods Advertising Code, as far as possible; and**
- **The TGA consider an early announcement about the application of the Australia New Zealand Therapeutic Products Advertising Code in Australia to approvals and at complaint and any associated period of ‘grace’ with respect to compliance.**

**The NZ representatives gave an undertaking to consider a similar process.**

## **7. Agenda Item 1C – Consultancy services**

The Support Group tabled copies of a briefing invitation for submissions on the costing project for the Trans Tasman joint agency, including the costs of the advertising regulatory arrangements, and copies of a draft brief for submissions to undertake the work on relative compliance of advertisements disseminated in ‘above the line’ and ‘below the line’ material (i.e. comparing the level of compliance and volume of approved with unapproved material).

There was concern expressed at the process that had been adopted for provision of the costing consultancy brief without prior provision to IAC members for comment, as it was suggested that there were some shortcomings in the briefing document.

It was explained that the purpose of the document was to identify the most appropriate supplier of these services and that any comment on the brief would be appreciated and incorporated into the refined, final schedule forming the contract with the successful tenderer. It was noted that the consultants will be meeting with all stakeholders and that this consultation process will provide the opportunity to ensure that all views and information are considered.

**Members were invited to provide any suggestions on the briefing documents to the Support Group as soon as possible.**

## **8. Agenda Item 2 – Correspondence received**

Letters had been received by the Support Group from the Chair of the Complaints Resolution Committee (CRC), the Researched Medicines Industry (New Zealand) (RMI) and the Chief Executive Officer of MediHerb. The letter from the CRC chair stated his belief that the present complaint handling system in Australia works well

and raised concerns about the proposed system of handling of complaints in relation to charging of fees, not accepting anonymous complaints and the role of the self-regulatory complaints panels. The letters from RMI and Mediherb each sought separate representation on the Interim Advertising Council from the RMI and the Australian natural healthcare professional sector, respectively.

### ***8.1 Discussion on fees and charges, and anonymous complaints***

In considering the comments on introducing fees and charges for the handling of complaints, it was noted that concerns on this matter have been expressed from a range of quarters. These concerns include the view that charging of fees would act as a disincentive to complaint by small industry players and that this would be unacceptable as the complaints system is the most powerful process for ensuring the quality of the system.

A similar argument was promulgated with respect to the accepting of anonymous complaints, in that requiring a complainant's identity to be revealed could act as a disincentive to complainants, which could result in precluding consideration of a number of complaints with potential public health and safety issues. Members were reminded that public anonymity could be retained by withholding the identity of a complainant from the other party to the complaint and from publication. It was suggested, however, that some small companies fear disclosure of their identity and, were identification to be required, some competitor complainants would simply act in a misleading way by masquerading as consumers.

It was noted that while the Australian Competition and Consumer Commission (ACCC), for the reasons outlined above, supports the view that no fees should apply to the making of a complaint and that anonymous complaints should be accepted;

- neither Medicines Australia nor the Australia Medical Association accept anonymous complaints; and that
- in New Zealand anonymous complaints are not allowed and fees apply in some circumstances for lodging a complaint.

On the one hand, because there are so many advertisements that appear in both Australia and New Zealand, it may be argued that there should be consistency of approach and that the same system should apply in both countries. On the other hand, the majority felt that in Australia there should be no charges for complaints, and anonymous complaints should be allowed.

**The Chairman noted that the consultancy outcomes will provide information on revenue raising and costs that will assist in decisions relating to different systems operating in Australia and New Zealand.**

### ***8.2 Discussion on membership of the Central Complaints Panel***

Although this issue had been discussed at previous meetings, some members reiterated the view that legal and healthcare practitioner expertise on the Central Complaints Panel is essential. The reasons given included:

1. Healthcare practitioners involved at the coal face of community reaction to advertising would be better placed to provide advice than an ‘academic’ healthcare professional;
2. It is difficult, and at times not possible, to assess the need for such expertise before consideration of a complaint;
3. Provision of such advice on an ad hoc basis could be time consuming and costly, resulting in delays that would not be in consumers’ interest;
4. An important reason for the existence of the co-regulatory system is to preclude the necessity of prolonged and expensive court action. To achieve that, an environment of legal protection must be built in to the process to ensure natural justice and provide confidence in the system for industry; and
5. By having legal expertise at the table for the consideration of complaints, the likelihood of appeal could be reduced.

**It was generally agreed by members that the Chair of the Central Complaints Panel should be a medical, or other, healthcare professional , preferably with public health expertise, and that representation on the Central Complaints Panel should include a legal person with comprehensive trade practices expertise.**

**The final report will canvass both the option of inclusion of a legal person as a full Panel member and the option of attendance by such a person on an “invitation only” basis.**

**The correspondence was noted.**

## **9. Agenda Item 3 - Feedback from the Therapeutic Goods Advertising Code Council (TGACC) meeting held on 12 February 2004.**

The Executive Officer of the TGACC reported on the following matters relevant to IAC issues that were considered at the TGACC meeting held on 12 February 2004.

### ***9.1. IT issues***

TGACC members suggested that consideration needs to be given to having an IT system capable of supporting harmonisation between Australia and New Zealand for approvals and complaints. For example, if a problem advertisement has been dealt with in New Zealand, the delegated authorities in Australia are able to be made aware of the decision and the advertisement to which it relates, but that such information should not be made public. It is suggested that the system needs to support intra-systems’ transfer of information to enable a harmonised system and, as well, needs to take into account material that can be released publicly for reporting and for educational purposes.

***The suggestions were noted.***

### ***9.2. Samples***

Issues relating to the advertising for the provision of samples, giveaways and competitions have been a subject of consideration by the TGACC for some time. A recommendation has been made to the TGA for removal of clause 4.6 (refer (i)

below), which precludes the advertising of provision of samples, with (as happens in practice) reliance on strengthened clauses 4.1.2(c) and (f) (as per (ii) below). Consultation has taken place with the National Coordinating Committee for Therapeutic Goods and provisional advice has been given that the proposal for removing clause 4.6 is not supported. When this issue has been finalised by the TGACC, there may be a need for consideration by the IAC as to whether or not the advertising of samples should be allowed.

**(i) 4.6 Samples**

An advertisement for therapeutic goods (other than therapeutic devices and sun screening preparations) must not contain an offer of a sample.

**(ii) 4.1.2 An advertisement for therapeutic goods *must not*:**

- (c) Mislead, or be likely to mislead, directly or by implication or through emphasis, comparisons, contrasts or omissions;
- (f) Encourage, or be likely to encourage, inappropriate or excessive use;

**9.3. The definition of ‘serious’**

TGACC members agreed to a commonsense proposal to incorporate the term ‘manage’ in the definition of ‘serious’ so that those conditions for which the term ‘treatment’ does not apply are captured.

**IAC members agreed to include the term ‘manage’ in the definition of ‘serious’, as follows:**

*“Serious” means forms of diseases, conditions, ailments or defects which are:*

- *generally accepted not to be appropriate to be diagnosed, treated and/or managed without consulting a suitably qualified healthcare professional, and/or*
- *generally accepted to be beyond the ability of the average consumer to evaluate accurately and to treat or manage safely without regular supervision by a qualified healthcare professional.*

**9.4. Proposed amendment to clause 4.5, Testimonials, of the TGAC**

It was noted that a recommendation from the TGACC has been forwarded to the TGA for an amendment to clause 4.5 of the TGAC to require testimonials to be typical. This is in line with the approach taken in the draft trans Tasman Advertising Code.

**10. Agenda item 4 – MDARG report on advertising of medical devices**

The medical devices representative introduced this item by noting the intrinsic differences between medical devices and medicines.

**10.1. Risk-based dividing line for the approval of advertisements for medical devices**

The proposed risk-based dividing line for the requirement of approval for advertisements for medical devices was presented by the medical devices representative, with reference to the matrix at Attachment B of the draft Advertising Code. It was explained that the proposed dividing line depends on the classification of the medical device into one of five risk based categories, , whether it may be administered or used by the consumer or only through a healthcare practitioner and the nature of the claim. It is expected that where no approval is requirement, advertisements would, nevertheless, be required to comply with the Advertising Code.

There were some issues raised, and comments made, by members during the discussion, including:

1. The difference between advertising a device and advertising a service that uses a device. It was noted that clarification on this issue is a work in progress. Some members voiced concern at promotions involving laser surgery and whole body scanning, while recognising that this type of advertising involves issues of professional practice which are not regulated by the Australian Commonwealth
2. The public interest criteria were felt by some members to be flawed, in that by applying to the advertisement rather than to the ‘serious’ condition they appear to protect the practitioner rather than the consumer. It was felt that this approach may not necessarily be in the public interest and it was agreed that further comments would be provided by IAC members to MDARG detailing these concerns;
3. It was noted that the media-based dividing line would be neither suitable or acceptable for the advertising of medical devices;
4. There were serious concerns that the proposal did not appear to include a requirement for approval of advertisements for certain devices that are sold directly to consumers, for example, magnetic therapy products;
5. It was suggested that, should a product be found at market entry to be unsuitable for a minority group within the population, approval should be required;
6. It is inappropriate to use the preapproval process for managing the safety of devices, as this is a market entry issue. Any factor compromising safety should be on the therapeutic products database;
7. Advertised therapeutic claims must be consistent with the purpose of use on the therapeutic products database;
8. After the introduction of new medical device legislation in October 2004, many some alternative medical devices are likely have difficulty in complying with the regulatory requirements for supply to the Australian market;
9. This system must be consistent with the global classification system of medical devices;
10. It was suggested that if at the time of product licensing a risk is identified in relation to the safe use of the device, it could be made a condition of licence that the advertising would require preapproval.

**In summary, the meeting agreed that the risk-based approval dividing line approach is appropriate for medical devices advertising, the table should be refined to identify where products are able to be sold directly to consumers and**

**that there should be a link between the product licensing process, establishing where there is a risk and the requirement for approval.**

## ***10.2. Other aspects of the MDARG Report***

### ***Approval personnel***

The paper recommended a suitably qualified approvals officer for the approval of advertisements for medical devices. Members were of the view that an approval officer would not necessarily have to be a person from the medical device industry but that any person approving such advertisements would need to have met the requirements set down for authority to approve advertisements, including for this sector, familiarity with the medical device industry, devices regulation and sources of relevant information.

### ***Approval delegations***

The Chairman reminded members of the proposal for a central approvals office in Australia, which would have responsibility for training and standards as well as approval if a delegation were withdrawn. He referred to the expectation that, unlike the current system, the delegation would be given to an individual rather than to an association.

The ASMI representative flagged that this approach gives rise to issues around structure and framework for the approvals system that would potentially impact on the cost recovery model. An indication was given that, at this stage, ASMI is unable to support the granting of delegations to individuals and that for practical reasons delegations should be granted to associations. However, support was given to establishing a separately located office, with the responsibility for the employment and performance of suitably qualified staff held under the delegation of approval to industry.

**The recommendations in the executive summary to the MDARG Report were noted in the light of the discussion outlined above.**

## ***10.3. MIAA/MIANZ submission***

The medical devices representative noted that a two-stage approach is contemplated with the development of advertising self-regulatory processes for the medical devices industry in Australia. The first stage will deal with advertising directed to healthcare practitioners and the second stage is to involve the implementation of a complaints mechanism to deal with advertising to healthcare practitioners and other issues. A draft code of practice is under development for consultation with stakeholder groups. The New Zealand counterparts are keeping a watching brief to ensure trans Tasman harmonization.

Differing views were put forward as to the timing of the implementation of controls on the advertising of medical devices. It was felt by the devices sector that, because of the regulatory impact of the introduction of the system, there should be an extended transition period. Some IAC members were of the view that because of current problems encountered in the advertising of some medical devices, an early introduction of the controls is indicated.

The endorsement of the medical devices code of practice by the Advertising Board was seen as an important issue to be considered by that sector to ensure commonality of approach and universal application to the sector.

The meeting was reminded that the Medicines Australia code of practice applies to all sponsors of prescription medicines as a condition of registration and of the potential ability of the association to apply fines to non-members, as an alternative to referring matters of non-compliance to the regulator for further possible regulatory action. It was suggested that a similar arrangement for all sectors could remove both problems of consistency between sectors and the possibility of forum shopping.

It was suggested that the key goals are:

- to have a single industry code for each therapeutic product sector with consistency between these codes;
- to obtain endorsement for that code from the Advertising Board with a mechanism to require compliance by members and non-members alike; and
- to develop common codes of practice for each sector in Australia and New Zealand.

Some members were of the view that this would be very difficult to achieve.

**It was noted that several issues need to be addressed, including the uniformity of fines, appropriate levels of fines for different sectors of industry with differences in terms of size of business and resources, and the likely difference in approach between the application of fees for the lodging of competitor complaints in New Zealand and no application of such fees in Australia for complaints about advertisements directed to consumers**

## **11. Agenda item 5 – Version 7 of the draft Advertising Code**

The CHC representative noted that a recent meeting had taken place, which had been attended by members of the CHC, the alternate healthcare practitioner representative, Mediherb, the IAC Chairman, a member of the Support Group and the Director of the Trans Tasman Group. While it was evident that stakeholders from the complementary sector wished to revisit certain aspects of the Code, IAC members were reluctant to reopen discussion as they had already consulted with their stakeholders on agreed wording.

Several IAC members indicated that any fundamental change, such as amendment to the definition of ‘advertisement’, would raise difficulties and require further full consultation.

Generally members were of the view that the agreed wording of the definition of ‘advertisement’ should be retained but, for clarification, agreed to include brackets, as follows:

**Advertisement** means any communication which promotes or discourages the use, sale or supply of products (whether or not in conjunction with the supply of services, and whether or not the communication identifies particular products or services). (Refer A5)

Members considered Version 7 of the Advertising Code up to and including Requirement 4. Due to time constraints, members were asked to submit comments in writing on all other parts of Version 7 to the Support Group by Friday 27 February 2004, or as soon as possible after that date.

Version 7.1 (20 February 2004) of the Advertising Code, including coded changes and comments as a result of members' consideration of Version 7 and incorporating comments provided in writing by members, is to be found at Attachment A.

An outline of the amendments and reasons for the changes are provided at Attachment B.

### **12. Agenda item 6 – Definition of healthcare practitioner**

A discussion paper on a definition of 'healthcare practitioner' that could meet the needs of both Australia and New Zealand had been circulated with the agenda papers.

Members were invited to provide any comments in writing to the Support Group.

*The paper was noted.*

### **13. Agenda item 7 – Advertising of foods making therapeutic claims, including correspondence received**

This issue was discussed during consideration of the Advertising Code (refer Attachment B).

*The paper was accepted and the correspondence noted.*

### **14. Date of the next meeting**

It was agreed that the next IAC meeting is to be held over two days in Sydney on 8 and 9 July 2004, at a time and location to be advised.

Stakeholder consultation meetings are to be held in Sydney and in Auckland in mid June 2004, on a date to be confirmed.

The meeting ended at 4.30 pm.