Reconceptualising healthy eating for improved nutrition policy

Policy Evidence Brief

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ahpc AUSTRALIAN HEALTH POLICY COLLABORATION

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Acknowledgement of Country

Victoria University acknowledges, recognises, and respects the Ancestors, Elders, and families of the Boonwurrung, Wadawurrung, and Wurundjeri of the Kulin who are the traditional owners of University land in Victoria. The Traditional Custodians of lands throughout Australia on which the contributors to this report live and work are acknowledged and honoured.

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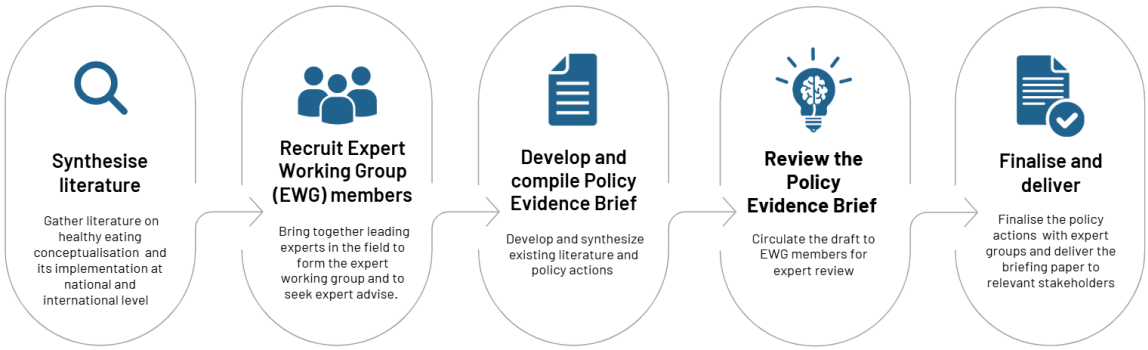

Disclaimer

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Glossary

Anorexia nervosa: An eating disorder usually characterised by significant low body weight due to restriction of energy intake relative to requirements, an intense fear of gaining weight, and persistent behaviours that interfere with weight gain[1,2]. Individuals with anorexia also exhibit misperceptions of their body shape, weight and image [1,2].

Bulimia nervosa: An eating disorder that involves recurrent episodes of binge eating followed by inappropriate compensatory behaviours to prevent weight gain and control body weight [2,3]. A binge eating episode is characterised by ingesting a comparably large amount of food over a discrete time period (e.g. within any 2-hour period) and feeling a loss of control regarding eating behaviour during the episode [4,5]. Inappropriate compensatory behaviours are grouped into two categories: purging behaviours (e.g. self-induced vomiting; misuse of laxatives or diuretics) and non-purging behaviours (e.g. fasting or excessive exercise) [6].

Binge eating disorder: An eating disorder characterised by recurrent episodes of binge eating without the presence of inappropriate compensatory behaviours [4,5].

Disordered eating: Sits on a spectrum between healthy eating and a clinically diagnosable eating disorder and often includes characteristics or behaviours of eating disorders, but at a lesser frequency or lower level of severity[7]. Disordered eating behaviours include fasting, dieting, skipping meals, binge eating, and restricting particular food groups, as well as compensatory behaviours such as self-induced vomiting, excessive exercise, and inappropriate use of laxatives or diuretics[8].

Foods of minimal nutritional value: Foods and drinks that are not essential to meeting nutritional requirements, also known as energy-dense, nutrient-poor foods or foods of minimal nutritional value. Foods of minimal nutritional value are energy dense and high in at least one of: saturated fats, sugars, salt, and/or alcohol [9]. Despite not being essential to a healthy diet, foods of minimal nutritional value can contribute to the overall enjoyment of eating, often in the context of social activities and family or cultural celebrations[10,11].

Eating disorders: Mental health disorders characterised by significant disruptions in eating habits as well as thoughts and emotions related to body weight, body shape, and/or food and eating[12,13].

Free sugars: Any sugars that are added to foods and drinks during the manufacturing, preparation or consumption processes (i.e. added sugars), plus the naturally occurring sugars present in honey, syrups, fruit juice and fruit juice concentrates[14].

Purging: The forceful removal of food or calories from the body, typically aimed at controlling body weight or shape. Purging behaviours (e.g. self-induced vomiting) are common symptoms of various eating disorders, including bulimia and anorexia nervosa[15].

1 Purpose and scope

The purpose of this policy evidence brief is to:

- Highlight the deficiencies in how 'healthy eating' is currently defined and conceptualised within Australian health policy and national nutrition guidelines;
- promote a shift towards to a more holistic, comprehensive and multidimensional conceptualisation of healthy eating; and
- present a new conceptual framework for healthy eating that will help inform the development of future food and nutrition policy in Australia.

Current definitions and understanding of 'healthy eating' in Australian health policy and national nutrition guidelines are narrowly focused on dietary intake (i.e. what we eat). This brief posits that healthy eating is more than just a nutritionally adequate dietary intake, and that how we conceptualise and understand healthy eating in Australia should be expanded to also encompass positive dietary behaviours (i.e., how we eat) and attitudes (i.e., what we think and feel about food and eating), and having a healthy relationship with food.

Dietary intakes, behaviours and attitudes are all significantly influenced by a range of social, cultural, economic, and food environment factors. The authors acknowledge the critical importance of policy action to address these influencing factors, especially those concerning food insecurity and access barriers to healthy eating. However, a comprehensive review of the literature and/or analysis of specific interventions regarding these factors was considered beyond the scope and primary purpose of this brief and elsewhere [(see, for example, 16]. Instead, we focus on the evidence and justification for the proposed new conceptual framework of healthy eating.

We also acknowledge that there are various dietary risk factors and diet-related health outcomes associated with poor quality diets that are not discussed in this brief. Micronutrient deficiencies, malnutrition (other than in the context of eating disorders) and intake of trans fats were all considered out of scope due to their relatively small contribution to Australia's overall burden of disease, compared to the most prevalent diet related conditions (e.g., diabetes; eating disorders/disordered eating) and most common dietary risk factors (e.g. high dietary intake of salt, sugar and saturated fat.)

2 What is the problem?

2.1 Healthy eating is narrowly defined in Australian food and nutrition policy

Food and nutrition policy in Australia aims to play a crucial role in guiding dietary choices and supporting good health across the population. Therefore, it is vitally important that it accurately reflects and incorporates contemporary understanding, evidence, and lived experience. National dietary guidelines and other government-issued nutrition resources and advice are largely reflective of the best available evidence regarding diet quality and dietary intake. However, they incorporate a narrow conceptualisation of 'healthy eating.' [17–19].

The way that healthy eating is currently defined and conceptualised in Australian health policy fails to comprehensively capture the full spectrum of factors that affect diets and the

complexity of how the interact Australian policy initiatives, national guidelines, and public health messaging more broadly, tend to frame healthy eating through a narrow lens of dietary intake, nutritional adequacy and weight management[18,20]. This framing neglects the behavioural and psychological aspects of food and eating and fails to acknowledge the strong bi-directional relationship between diet and emotional wellbeing [21]. It also largely ignores the complex, interconnected web of social, cultural, economic, and food environment factors (e.g. availability and accessibility) that shape people's dietary beliefs, attitudes, behaviours, choices, and intakes. Examples of these 'influencing factors' include experiences of socioeconomic disadvantage and/or food insecurity, social contexts of eating and physical settings of food consumption, and cultural significance of food and accessibility of culturally appropriate foods.

As a result of these limitations, current conceptualisations of healthy eating are not comprehensive or sufficient for addressing the diverse needs and experiences of the Australian population.

Population nutrition is a major focus of various national policies, strategies, programs, and other government initiatives in Australia. Relevant current policy initiatives, along with their year of publication or timeline for implementation, are listed below:

- Australian Dietary Guidelines (2013)[18]
- Australian Guide to Healthy Eating (2013)[19]
- National Preventive Health Strategy 2021-2030 [22]
- National Men's and Women's Health Strategies 2020-2030 [23,24]
- National Obesity Strategy 2022-2032 [20]
- Health Star Rating System (2014)[17]
- Healthy Food Partnership (2015)[25]
- National Eating Disorders Strategy 2023-2033 [26]

The majority of these national strategies and other policy initiatives and tools almost exclusively focus on dietary intake and individual choice when they discuss healthy eating, with minimal acknowledgment of the importance of dietary behaviours and attitudes and limited discussion around the broader environmental, social, economic, and cultural factors that influence eating[18,22,25,27].

For example, the Australian Dietary Guidelines (ADG) are a set of high-level, evidence-based recommendations regarding the composition of a 'healthy diet'[28]. They provide general information and advice about the types and amounts of foods and food groups that should be consumed to meet nutrition requirements and promote health and wellbeing[28]. However, in the most recent iteration of the ADG (last updated in 2013), the summarised guidelines make no mention of dietary behaviours and attitudes or broader social, economic, cultural, and environmental factors that influence eating [18]. Moreover, its explicit reference to weight (see guideline 1., below) is problematic as 'healthy weight' is an ambiguous and contentious term and can vary widely across individuals. The five high-level guidelines included in the 2013 iteration are:

1. Achieving and maintaining a healthy weight through nutritious food choices and physical activity

2. Enjoying a wide variety of foods from five key food groups daily
3. Limiting intake of saturated fats, added salt, added sugars, and alcohol
4. Encouraging breastfeeding
5. Ensuring safe food preparation and storage[18,28]

Furthermore, despite healthy diets being a central focus of many of the strategies, policy initiatives, and policy tools outlined above, most were designed, developed, and are being implemented as separate, siloed activities. There is minimal coordination, misaligned objectives, and in some instances, direct contradictions, between different initiatives (e.g., inconsistent terminology and definitions of key terms across different national strategies and government resources). There is currently no overarching national framework to support the coordination of these different strategies and other policy initiatives, with the only comprehensive national nutrition strategy in Australia published in 1992.

2.2 Unhealthy eating is associated with significant harms

Despite several decades of national dietary guidelines and widespread public health information about the importance of a healthy diet, the average Australian diet continues to exceed the recommended intake for salt, free sugars, and saturated fat, and does not meet the recommendations for daily consumption of fruits and vegetables and fibre [29,30]. Diets that are high in salt, sugars, and saturated fat are associated with a variety of harms including cardiovascular disease, stroke, type 2 diabetes, poor oral health, and various cancers [31].

The Australian Institute of Health and Welfare (AIHW) places dietary risk factors as the third leading preventable cause of illness and premature death in Australia. The AIHW estimates that between 30-50% of the total disease burden related to coronary heart disease, type 2 diabetes, stroke, and bowel cancer is attributable to diets high in salt, sugar, and saturated fat[31]. The prevalence of diet-related chronic disease continues to increase in Australia, with the number of people living with type 2 diabetes increasing almost 300% between 2000 to 2021[32].

At the same time, unhealthy behaviours and attitudes towards food, eating, and body image are also increasingly contributing to poor health and other negative outcomes. A 2024 report by Deloitte Access Economics estimated that, in Australia in 2023, there were:

- approximately 1.1 million Australians living with an eating disorder;
- 1,273 annual deaths attributable to eating disorders; and
- a total economic burden of almost $67 billion per year attributable to eating disorders[33].

In addition to the significant number of Australians living with eating disorders, there is a much larger cohort of the population who may not meet the threshold for a clinical diagnosis, but who exhibit harmful disordered eating behaviours[34]. Disordered eating behaviours include fasting, dieting, skipping meals, and restricting particular food groups, as well as compensatory behaviours like self-induced vomiting, excessive exercise, and inappropriate use of laxatives or diuretics[8].

Accurate, population-level prevalence data on disordered eating in Australia is limited. However, a recent systematic review and meta-analysis of 32 studies of 63,181 children and adolescents aged 6-18 years from 16 countries found that 22% exhibited disordered eating behaviours[36]. A study focused on Australian adolescents estimated disordered eating

prevalence in this population to be above 30%[37]. Moreover, emerging evidence suggests that disordered eating may be higher in particular priority population groups, including Aboriginal and Torres Strait Islanders [38] or LGBTIQA+ individuals [39]

Disordered eating is a significant risk factor for developing an eating disorder[8,35]. Moreover, there is evidence that disordered eating is associated with a range of negative outcomes over the short and long-term[8,37,40]. These include physical health symptoms (e.g., fatigue, headaches, and gastrointestinal issues), mental health outcomes (e.g., depressive and anxiety symptoms, increased risk of substance abuse, and other mental health disorders), and socioeconomic outcomes (e.g., higher rates of socioeconomic disadvantage and housing insecurity, and lower educational attainment)[8,40–42]. Emerging evidence suggests that the relationship is causal. A longitudinal study concluded that intuitive eating, defined as eating according to internal hunger and satiety cues, predicted better psychological health and lower use of disordered eating behaviours [43]

Finally, body dissatisfaction and weight-based discrimination are key contributors to the development of eating disorders, increase the risk of other mental health conditions such as depression, anxiety, and self-harm, and negatively affect physical health and overall quality of life [44]. A recent report by the Butterfly Foundation estimated that the annual economic and social costs of body dissatisfaction and weight-based discrimination were $36.6 billion and $27.6 billion, respectively [45].

3 Healthy eating conceptual framework: shifting the paradigm

In this policy evidence brief, we propose that healthy eating comprises three interrelated dimensions, rather than just dietary intake, and that all three of these dimensions are significantly influenced by an array of factors, including the broader food environment and various social, cultural, and economic factors. The three-dimension definition of healthy eating builds on existing research that discusses healthy eating as a multidimensional concept that extends beyond just 'what we eat' [46–48]. This includes a recent study that arrived at a three-component definition of healthy eating through a Delphi consensus-based process with a range of leading global experts in nutrition policy, weight science, eating disorders, and weight stigma[46].

We provide the following healthy eating conceptual framework to provide a visual representation of the three dimensions of healthy eating and the interconnected ecosystem of factors that comprise and influence healthy eating. Please note that the outer circle in this figure represents the range of additional contributing and contextual factors and that the figure is not meant to be a social-ecological model of healthy eating.

Figure 1: Healthy eating conceptual framework

3.1 Dimensions of healthy eating

What we eat

This dimension aligns with what is generally referred to in Australian health policy, government nutrition guidelines, and public discourse more broadly, as 'healthy eating'[18,23,24,30], but which we will refer to as a healthy diet. It is focussed solely on dietary intake (i.e., the actual food and drink consumed by an individual) and the nutritional quality/adequacy of that intake. A healthy diet is one that provides the body with energy, fluids, and essential nutrients (e.g., protein, carbohydrate, healthy fats, fibre, vitamins and minerals) to meet the body's nutritional requirements and support physical and mental health [47,49]. There is an abundance of evidence and almost universal acceptance by nutrition experts that a healthy, high-quality, balanced diet should comprise a variety of foods from across the five key food groups (i.e., (1) vegetables; (2) fruit; (3) grain (cereal) foods – mostly wholegrain and/or high cereal fibre varieties; (4) lean meats and poultry, fish, eggs, tofu, nuts and seeds, and legumes/beans; and (5) milk, yoghurt, cheese and/or alternatives – mostly reduced fat)[50]. A healthy diet also involves consuming appropriate portion sizes relative to specific energy requirements and limiting the intake of salt, sugar, saturated fats and trans fats as these are known to cause diet-related harm[51].

How we eat

This dimension encompasses all observable actions and habits related to food consumption, often referred to as 'dietary behaviours'[52,53]. These behaviours include meal timing, snacking habits, food preparation methods, and the context in which food is consumed (e.g., whether a person eats alone or with others, eating out frequency, screen time during meals, eating while on the go, etc.)[54–56]. Dietary behaviours are influenced by a range of social, cultural, and economic factors and the surrounding food environment, as well as interpersonal factors related to emotional state and underlying beliefs and attitudes[57]. 'How we eat' is an integral component of healthy eating, as suboptimal dietary behaviours – such as skipping meals or reliance on convenient food items – can undermine nutritional health and increase the risk of diet-related disease [57]. Positive dietary behaviours (e.g., adopting regular mealtimes, eating with others, limiting screen time during meals) are associated with better diet quality, and in some instances have also been shown to contribute to improved social and emotional wellbeing[58–61] as well as being protective against eating disorders and disordered eating [62]. For some groups, accommodations or extra support may be required to improve dietary behaviours.

What we think and feel about food and eating

This dimension encompasses the psychological and emotional aspects of healthy eating, including a person's beliefs, values, perceptions, and attitudes towards food and eating. This includes how people view eating, their level of concern about nutrition, beliefs about the health effects of certain foods, and emotional associations with eating (e.g., guilt, shame, or pleasure). This dimension of healthy eating also encompasses cultivating a positive relationship with food, enjoying a wide variety of foods without using dichotomous framings (e.g., good vs bad; healthy vs unhealthy)[63,64], and understanding the role of food in nourishing the body, supporting overall wellbeing, and fostering social and cultural connections[65].

Dietary attitudes and other psychological or emotional factors are closely intertwined with dietary behaviours, all of which can significantly influence dietary intake[66,67]. While attitudes can drive behaviours, they do not always align, as individuals may have a healthy mindset and beliefs regarding food but still engage in unhealthy eating behaviours due to time pressures, stress, or other external influencing factors [66,68].

Negative attitudes and perceptions surrounding food, fuelled by societal norms, cultural influences, and media messages, can lead to guilt, shame, or anxiety related to eating choices[66]. Misinformation, diet culture, and conflicting dietary advice contribute to confusion and unrealistic expectations about food and nutrition, further perpetuating unhealthy relationships with eating and poor body image[67,69].

3.2 The broader food environment and social, cultural, and economic contexts

The multidimensional reconceptualisation of healthy eating proposed in this brief also recognises the broader food environment and social, cultural, and economic factors that influence dietary behaviours, attitudes, and intakes. A brief discussion of each is provided below. Any nutrition policy that seeks to advance healthy eating must include consideration of these key factors.

The food environment

The food environment encompasses various factors that significantly influence dietary choices, eating behaviours, and perceptions about food[70]. These include food security and the availability, accessibility, affordability, and marketing of food[71–74]. When nutritious foods (e.g., fruit; vegetables; wholegrain products) are readily available and affordable, individuals are more likely to engage in healthy eating[63]. Conversely, environments in which foods of minimal nutritional value are highly accessible tend to promote suboptimal dietary behaviours and make healthy eating more difficult.

Marketing, food labelling, and portion sizes also influence perceptions of what is 'normal' or desirable to eat, shaping attitudes toward food over time. In addition, cultural norms, urban planning, and the presence of food outlets (e.g., supermarkets vs. fast food restaurants) create a context that either supports or undermines healthy eating. These food environment factors interact with individual preferences and socioeconomic conditions to influence not only what people eat, but also how they eat and what they think about food and eating[70].

Misaligned nutrition interventions may overlook vulnerable groups such as Aboriginal and Torres Strait Islanders, socioeconomically disadvantaged, LGBTIQA+ and culturally diverse populations, which can widen health disparities and reduce the effectiveness of national population-wide initiatives [75]. Moreover, interventions that don't reflect lived realities – such as affordability, cultural preferences, and access – risk being ignored or ineffective [76].

Contemporary food environments are often designed to make foods of minimal nutritional value more attractive, convenient, and affordable. In Australia, such foods are easily accessible from fast-food outlets and at supermarket checkouts, service stations, and sporting venues[77]. Aggressive marketing of such foods, particularly those targeting vulnerable groups such as children, plays a significant role in promoting these types of foods [78,79]

Social and cultural factors

Other people exert a powerful influence on what, how and why we eat[80]. Family and social networks are major contributors to individual food preferences and eating behaviours and attitudes[81–85]. This influence extends to parents' attitudes towards eating and body image, which have been shown to significantly influence associated perceptions and behaviours in their children[86–88].

Cultural factors are also an important influence on what, how, and why we eat. This includes what foods are traditionally eaten and how they are prepared, meal structure and timing, the social meaning of food, and religious and ethical beliefs[89–93].

The growing prevalence of social media's influence raises concerns about its impact on food choices. Much of the content that is promoted as health-related on such platforms is unreliable[94]. Research also suggests that peer pressure, mainly from social media, can trigger body image issues and disordered eating behaviours/eating disorder symptoms[95,96].

Economic factors

Factors such as socioeconomic status and community affluence can significantly influence access and availability to healthy food, dietary behaviours, food purchasing decisions, and attitudes or beliefs related to food and eating. Food costs can be a major barrier to accessing

nutritious food options and contribute to poor diet quality and increased health risks. Additionally, time constraints and the need or preference for convenience can also influence food choices, as people may opt for readily available but often less nutritious alternatives[97–99].

Due to structural and systemic inequities, Australians who live in more affluent areas or in major cities tend to consume healthier diets and experience lower rates of most diet-related chronic disease. Conversely, people from a lower socioeconomic status or living in areas of greater disadvantage, or in remote/rural locations, are more likely to have poorer diet quality and suffer from diet-related diseases[18,71].

4 Evidence for expanding the conceptualisation of healthy eating

4.1 The benefits of a multidimensional definition

What we eat, how we eat, and how we think and feel about food and eating) are deeply interconnected and should all be considered critical aspects of healthy eating[100,101]. There is evidence that interventions that target multiple dimensions of healthy eating are associated with greater health benefits than those exclusively focused solely on dietary intake. For example, a systematic review of obesity prevention programs for adolescents found that the 'energy-balance interventions', which focused only on 'what we eat', did not result in reduced or maintained weight, improved diet, or increased physical activity[102]. In contrast, preventive programs that focussed on 'shared risk factors for obesity and eating disorders' and looked to address multiple dimensions of healthy eating simultaneously, were associated with reduced body dissatisfaction, decreased disordered eating behaviours, and improved weight maintenance[102].

Intuitive eating, an adaptive style of eating that incorporates all three components of healthy eating, has been shown to contribute to improved diet quality[100,101] as well as various positive physical and mental health outcomes, including lower rates of cardiovascular disease, type 2 diabetes and depression; reduced prevalence of disordered eating behaviours; and improved self-esteem and body image[64,103,104]. Intuitive eating encourages individuals to trust their body's internal cues around hunger, fullness, and satisfaction, while embracing gentle nutrition to make food choices that support health and well-being without guilt or restriction. Importantly, a recent study found that intuitive eating predicts (rather than is just correlated with) better mental health and lower levels of disordered eating behaviours[43].

Targeting the full spectrum of healthy eating with multifaceted policy interventions, rather than addressing each dimension separately and in isolation, also has inherent implications for improved efficiency and effectiveness in addressing eating-related harms.

There is emerging evidence indicating that nutrition interventions that target dietary behaviours and attitudes, in addition to dietary intake, can have the greatest scope to improve diet quality; however, more long-term research with larger sample sizes is needed[105–107].

This proposed conceptualisation of healthy eating may also avoid inadvertently increasing risk factors for disordered eating as a result of public health efforts to reduce rates of overweight and obesity[108,109]. A systematic review of the effects of anti-obesity public health messages on

risk factors for disordered eating concluded that messages were stigmatising towards people with higher weight; exacerbated thin ideals and aspirations for thinness, which have been linked to increased risk of disordered eating and body dissatisfaction [110]; and that messages promoting smaller meals may be potential triggers for disordered eating, although the authors pointed out the shortage of high-quality studies[108].

Finally, this broader conceptualisation of healthy eating would help to ensure that public health messaging and policy efforts related to improving dietary intakes were aligned and coordinated.

4.2 Healthy eating in nutrition policy – international examples

Nutrition guidelines in several other countries go some way to recognising that healthy eating encompasses more than just a healthy diet. The *Canadian National Food Guide*, for example, includes discussion of behaviours and attitudes towards food and eating. This *guide* states that healthy eating is "more than the foods you eat. It is also about where, when, why, and how you eat"[111]. It also says that healthy eating is "about being mindful of your eating habits, taking time to eat, and noticing when you are hungry and when you are full". The *guide* emphasises the importance of cultural and traditional preferences, knowledge, and expectations of healthy eating; that eating with others enhances enjoyment; that healthy eating needs to be based on individual energy needs and be in balance with physical activity levels; that 'fad diets' can be harmful; and that food choices have environmental impacts.

The *Dietary Guidelines for the Brazilian Population* includes five 'shaping principles', which frame healthy eating as a multidimensional concept and make multiple references to the important social and cultural factors that influence diet[112]. The first shaping principle succinctly highlights this concept by stating that "diet is more than intake of nutrients" [112]. The Brazilian guidelines also emphasise the significance of "modes of eating", which encompass dietary behaviours related to convenience, with whom and where meals are consumed, and the importance of deriving pleasure from eating. The guidelines recommend eating regularly and carefully, eating in comfortable and calm environments, and eating and preparing meals with others [112].

The *Dietary Guidelines for Japanese* includes messages about enjoying meals, eating at regular times, and taking advantage of one's dietary culture [113]. Similarly, *the General Dietary Guidelines for Koreans* recommend avoiding binge eating and eating with family [114].

5 Policy implications

Current conceptualisations of healthy eating in Australian food and nutrition policy often miss the bigger picture – they narrowly focus on what is eaten, but not why, how, or who is eating it.

Australia has a strong history of providing evidence-informed nutritional advice to the population in the form of the *Australian Dietary Guidelines*, which now sit alongside multiple national strategies and other policy initiatives relevant to healthy diets. However, the *guidelines* have not been updated since 2013, and along with relevant national strategies and nutrition-related policy initiatives, fail to demonstrate a comprehensive understanding of healthy eating as a multidimensional, complex concept. These policy resources and activities risk being ineffective or inequitable if the psychological and behavioural dimensions of healthy eating, and the various social, cultural, economic, and environmental factors that influence dietary

intake and food choice, are not adequately considered and addressed. A comprehensive and coordinated approach is required for improving population nutrition, starting with an expansion of how 'healthy eating' is conceptualised in policy and public health messaging.

5.1 Recommendations

1. Adopt the expanded conceptualisation of healthy eating presented in this brief in all relevant national food and nutrition policies, resources, and guidelines.
    - Coordinate efforts to ensure consistency of understanding and application across multiple strategies, jurisdictions, and settings;
    - Develop supporting implementation resources in close collaboration with key stakeholders, including people representing diverse lived experiences.

2. Develop a contemporary national healthy eating and nutrition strategy to provide an overarching framework for the implementation of a long-term, comprehensive, multifaceted policy program aimed at reducing eating-related harms and improving population nutrition. An overarching national strategy would support coordination of existing strategies and nutrition policy initiatives currently being implemented. A contemporary national strategy should adopt the expanded conceptualisation of healthy eating proposed in this brief and feature a suite of initiatives, including:
    - development of evidence-based, comprehensive 'healthy eating guidelines' that address all three dimensions of healthy eating (i.e., dietary intake, behaviours, and attitudes) and all influencing factors of healthy eating (e.g., the food environment; cultural and social factors; economic factors);
    - whole-of-population public awareness campaigns emphasising the importance of eating behaviours and attitudes, as well as dietary intake, to overall health and wellbeing;
    - targeted investment and tailored programs aimed at reducing eating-related harm in at-risk and priority population groups;
    - other government-funded policy interventions focused on food and nutrition literacy and enabling healthier food environments;
    - development and ongoing monitoring over time at the population level of robust healthy eating metrics; and
    - establishment of appropriate evaluation measures and national healthy eating targets to measure the impact of the overarching national strategy over time and encourage long-term accountability.

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