Joint response of the International Obesity TaskForce and the European Association for the Study of Obesity to the Commission of the European Communities Green Paper "Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases".

The International Obesity TaskForce is the research, policy and advocacy arm of the International Association for the Study of Obesity, which represents the medical and scientific research professions concerned with obesity worldwide. The European Association for the Study of Obesity represents more than 2,500 members in 27 countries.

We welcome this opportunity to respond to the Commission's Green Paper, which raises a number of important questions and invites those involved in developing policies in this area to consider carefully those social and environment determinants which have developed over many decades and which need to be addressed if prevention strategies are to be successful.

We recognise that many of the remedial actions required depend upon national responsibilities; nevertheless we wish to emphasise the crucial role which the EC must play in stemming and then reversing the epidemic of childhood and adult obesity. There is also a need to consider how to counteract the other major deleterious effects on health of the current inappropriate nutritional quality of European diets for most of the population.

SETTING THE CHALLENGE IN PERSPECTIVE

The current obesity epidemic has by definition developed as a result of a wide range of changes in the environment, which have reduced the levels of physical activity in the population. Identifying the causes of this decline in activity does not necessarily then provide the basis for reversing the progressive levels of inactivity, because the advanced automation of the workplace and the home, together with the computerisation of so many societal activities, cannot be reversed. Therefore novel approaches to enhancing physical activity have to be developed now that few groups in the population are to be required to be very physically active in order to earn their living.

The markedly reduced need for physical activity means that there is also a much lower need for high energy containing foods. The entire population needs to reduce its overall energy intake on a routine daily basis. Estimates vary but the reduction in the average energy intake needed to maintain, in our modern circumstances, reasonably healthy body weights might be as much as 500-750 kcal less for the population in contrast to the needs for the more physically demanding work half a century ago. There is no longer a need in Europe to be concerned about under-nutrition and general food insecurity, which dominated the thinking post-war and led to the original development of the highly successful Common Agricultural Policy.

The behavioural changes in food patterns over the last half century have been remarkable in part because the human brain has a robust, albeit imperfect set of mechanisms for cutting down energy intake. So we have witnessed a pan-European social change in eating habits from the frequent large meals taken three or four times a day to smaller meals, very modest sized breakfasts, when they are eaten at all, and the acceptance that lunch is also a light meal.

These major social changes, based on remarkable industrial developments, have been accompanied by other equally successful industrial changes, which, unfortunately, have exacerbated the stress on the human brain's ability to maintain our body fat stores at an evolutionarily appropriate level. Thus, after the Second World War, the ability of countries to grow their own food was recognised as a matter of national security and became almost the exclusive basis for European Union funding as part of the original Common Agricultural Policy. This policy involved sustained major European funding focused on the concepts of the nutritional value of meat, milk, butter and additional sources of energy such as oils and sugar. By sustaining a large agricultural research portfolio providing detailed advice to farmers, subsidies, which could amount to 50-100% of capital investments, and with guaranteed prices for these key food products, the nature of farming in the Community was transformed. The farming community thereby prospered so that many farmers became major contributors to the economy instead of being subsistence farmers with modest amounts to sell. The aim of markedly reducing the retail cost of these commodities so that even the poor could afford them was also achieved.

In association with this agricultural revolution, the food and retail industry was also transformed with the recognition that food could be transported across the Community at relatively modest cost, so that the seasonal variation in the availability of food was eliminated. Food companies produced a range of new products based, very reasonably, on the results of taste panels and marketing experience which, as expected from our current knowledge, appealed to the primeval intense drives for particular fatty acids, sweetness and salt. These nutritional components were, in evolutionary terms, rare commodities which were significant for survival.

Given the further increasing recognition by governments and industry of the value of recruiting women into the workforce, there has also been a huge demand for convenient ready-to-serve meals and a transformation in eating habits with a far greater proportion of food eaten outside the home. This in turn has led in the intensively competitive free market in food, a range of marketing initiatives which have recognised the fundamental commercial value of considering the three basic features which determine their company's success: a) lower prices for high quality goods, b) pervasive availability of the products for consumers throughout the day and c) marketing to emphasise the particular value of the food brand. This has in turn led to larger portion sizes, intense competition to ensure products are conveniently located in the major centres of activity whether in canteens, shops, fast food outlets or in vending machines in schools, workplaces and city centres. Industry in general has also recognised the value of having children targeted because they become regular consumers and influence family purchases.

As Europe has developed so successfully with increasingly standardized rules for trade, there has been an astonishingly effective multidimensional integration of the whole of the food chain. Thus it was discovered by the Scientific Steering Committee in DG SANCO when investigating the potential flow of food products across Europe, as part of its analyses of BSE, that feed from the UK could be fed to an animal in France, but the bulk products might be handled in two other countries before being processed in a third and then distributed to six further countries within the Community. This emphasises the fundamental importance of considering the food chain on a Community and not a national basis. It is also important to accept that the food manufacturing, catering, distribution and retailing sector of the economy is by far the largest industrial sector in the Community. It is therefore in the interest of the Community as a whole that it is seen to continue to prosper and cope with international competition in the agricultural and food as well as retail sectors. DG SANCO in turn therefore has a dual task of ensuring the wellbeing of the European population whilst at the same time convincing the other DGs and Commissioners of the importance of the underlying industrially related forces which currently have ill-health as a by-product of their activities. The challenge is how best to maintain the industrial food sectors without incurring the major disadvantages of dietary ill-health.

This response to the Green Paper is based on the preceding perspective of the Commission's responsibilities.

IV 3 Health Across EU Policies

> **"What are the concrete contributions which Community policies, if any, should make towards the promotion of healthy diets and physical activity, and towards creating environments which make healthy choices easy choices?"**

We take the term "promotion" of healthy diets to mean the full range of measures required to help consumers choose a healthy diet. This term should not refer solely to those health or nutrition educational measures, which are always being cited as the primary mechanism for changing people's behaviour; current evidence shows that nutritional change in response to advice even if given by doctors has an extremely small effect on consumer behaviour because of the pervasive pressures to consume inappropriate diets and undertake minimum activity.

Health Impact Assessments should be undertaken on the full range of EU activities, and Community policies should be re-evaluated to assess their contribution towards an environment which promotes healthy diets and activity. Equitable access to healthier diets for all EU citizens can be encouraged by removing present market distortions associated with support for the production of oils, fats and sugars, and a transfer of support to stimulate both growth in capacity and the supply of fruits and vegetables to enable EU citizens to achieve recommended dietary goals. The EU should support member states in developing sustainable distribution, particularly to those areas which are poorly served or have poor access to fresh produce.

Research should focus on the modelling of the 'upstream' influences of food and activity choices, e.g. prices, investment incentives, externalised transport costs, road design, marketing and labelling.

IV4 Public Health Action Programme

> **How can the availability and comparability of data on obesity be improved, in particular with a view to determining the precise geographical and socioeconomic distribution of this condition?**

A. ESTABLISH A PROPER EU HEALTH MONITORING SYSTEM

The capacity of DG SANCO to evaluate the health effects of current Community policies is limited, despite this being an accepted requirement specified by member states. The IOTF and its members have for many years been involved in attempting to estimate the burden of disease in Europe relating to excess weight and the other nutritional problems, which fundamentally underlie the huge health burden of diet related diseases such as heart disease, strokes, many cancers, most cases of diabetes in the Community, kidney failure, bone diseases such as arthritis and osteoporosis and obesity all of which are fundamentally caused by inappropriate diets and low physical activity levels. It is ironic that the outstanding research which revealed the major dietary and physical inactivity basis for heart disease, strokes, several cancers, obesity and the prevention of type 2 diabetes originated in Europe, yet we still do not have a system for monitoring the health, dietary and physical activity patterns of the population of the Community. This is even more bizarre given the fact that the majority of funding throughout the history of the European Union has been based on massive food chain subsidies, amounting to many billions of Euros over the years.

WHO will announce in April 2006 the first set of standards of children's growth for universal use. These standards are based on European data, as well as data from elsewhere in the world, providing the most compelling evidence of the uniform natural growth patterns of optimally fed children in their first five years of life, illustrating vividly that support for exclusive and continued breastfeeding is the best nutritional strategy for the healthy development of infants and young children. The WHO data present enormous challenges, because they imply we have been substantially underestimating the problem of early childhood overweight in Europe. European experts in the IOTF are currently evaluating, which European data sets – perhaps Czech or Netherlands data - should be used temporarily to extend this standard to older children.

The EU should now establish a health monitoring system, involving member states, to assess both children and adults.

The following monitoring systems are required:

a) **Birth weights -** so that the impact of the epidemic of overweight in young women entering pregnancy can be monitored. The more overweight women are before pregnancy, the more likely they are to become diabetic during pregnancy and have bigger babies, which appear to then be predisposed to an intergenerational propensity to obesity and earlier onset of diabetes.

b) **Monitoring of breast feeding rates and the determinants of poor compliance.** This is important now that WHO is producing new growth standards which have remarkably uniform results for babies who are breast fed. Some of the Scandinavian countries have an excellent record for enhancing breast feeding rates through public policies, which include medical and employment policies together with the mobilisation of the civil society sector. This contrasts with other countries such as the UK where breast feeding rates are disgracefully low. It is important that all EU policies and practices support the WHO Global Strategy on Infant and Young Child Feeding**.**

c) **Monitoring of children -** in their pre-school years and on entry to primary and secondary school for their heights, weights together with some appropriate index of dietary and activity patterns. The Commission has already received a report on the appropriate health indicators for monitoring the health and well-being of babies and children so it should institute an appropriate set of procedures based on this evidence.[i]

d) **Monitoring of adult indices of health** - with particular emphasis on height, weight, waist circumference and with measures of their principal risk factors e.g. smoking, blood pressure and blood cholesterol levels, as well as indices in appropriate groups of diet and activity; sets of data should be obtained from nationally representative surveys, undertaken by suitably qualified research groups.

e) **Disease patterns** - relating to the principal diseases which account for the major burden of disease and premature deaths in the Community.

f) **Special groups** - particular attention should be given to special groups i.e. ethnic minority and socially disadvantaged groups. There is clear evidence that Asians are far more susceptible to the impact of modest weight gains and seem to have a 2-5 fold increased risk of developing diabetes compared with Europeans of equivalent weight. Obesity is also more common amongst the disadvantaged, so this group needs to be properly assessed and their health considered as a separate issue in reporting procedures.

How can the programme contribute to raising the awareness of the potential which healthy dietary habits and physical activity have for reducing the risk for chronic diseases amongst decision makers, health professionals, the media and the public at large? Which are the most appropriate dissemination channels for the existing evidence? (IV 4.3)

B - REGULAR REPORTING TO THE EUROPEAN PARLIAMENT OF THE HEALTH BURDEN FROM DIET, SMOKING AND INACTIVITY AND THE POLICY IMPLICATIONS.

These data obtained by EU-wide monitoring, and their implications, should be reported not only to the rest of the Commission, but formally to the European Parliament on a regular basis – preferably annually. This can inform the Commission, the Council and Parliament's discussions and decision making, and will attract considerable professional, media and public interest. It will help to overcome the tendency to consider the problem of obesity, heart disease, cancers and diabetes as essentially an individual education issue or simply a national health service provision issue which is not fundamentally linked with European wide policies.

C. PROMOTE THE DEVELOPMENT OF A NETWORK OF NATIONAL PUBLIC HEALTH INSTITUTES CAPABLE OF APPROPRIATE INTERACTIONS AND WITH THE RESPONSIBILITY TO REPORT TO DG SANCO ON A REGULAR BASIS ON CURRENT MAJOR PUBLIC HEALTH ISSUES

This is important because currently public health in Europe is being neglected. Some countries e.g. in Scandinavia have an enviable system for monitoring, evaluating and then dealing with public health issues but this feature is uncommon in many EU countries. European experience shows that without this independent public sector and civil society component of analysis and evaluation, the response of governments will be far too slow in considering the far slower and broader public health issues. Ministries of Health are typically locked into the huge problems of managing overburdened health services and have little time or motivation for anticipating problems which can be dealt with by suitable preventive procedures. This is particularly so when the remedies are usually the responsibilities of other government departments. DG SANCO should therefore view the establishment of Public Health Institutes not as a secondary entity for monitoring and policy analysis, but as a mechanism to boost its own ability to argue within the Commission for policy changes conducive to health.

D. DEVELOP A SERIES OF ECONOMIC ANALYSES OF THE ECONOMIC IMPACT OF OBESITY AND ITS CO-MORBIDITIES IN THE EU

Economic analyses, which include not only the health care costs, but also the impact of disability, time off work and reduced economic productivity due to illness, are clearly needed if DG SANCO is to strengthen its arguments with the other sectors of the Commission. These analyses should be done on a common basis – otherwise Ministers of Health will argue some special circumstances to explain country and regional differences. The uniform method is particularly needed if DG SANCO has to argue its case in general policy making terms with the rest of the Commission.

E. HEALTH IMPACT ASSESSMENT OF OTHER COMMUNITY POLICIES

Although the need for the health impact assessment of EU policies was incorporated into EU responsibilities with the Amsterdam Treaty, there is little evidence that this has been followed up effectively by the Commission. The experience and skills needed are unusual, but it is clear that many aspects of economic policy making also include some components of the required analyses.

The Danish Economic Research Institute in Copenhagen already has detailed price elasticities of different foods in relation to the socioeconomic status of adult individuals and families from weekly surveys covering more than four years. These clearly reveal the potential for helping people to overcome the current European based distortions in food prices and more intriguingly show that manipulating the prices of food ingredients e.g. the fat content is a more effective method than taxing or subsidising the product itself. Doubtless there are many other groups in Europe undertaking these analyses and it is well known that the supermarkets – with up to 40 carefully monitored subgroups of consumers have an extremely sophisticated understanding of not only the immediate impact of price changes on their consumers responses, but also the long term impact of a temporary price promotions in converting customers to sustained purchases of their products.

DG SANCO should explore how they might obtain a reasonable view of these commercial market analyses, which are of course of intense competitive importance to industry. Retailers contributing to the current DG SANCO Platform also have an extremely sophisticated understanding of the purchasing responses to increases in portion size and to the availability and marketing of their products. Availability includes the location of retail outlets within our outside a town centre, and the detailed display of different items – including the precise positioning of products in the middle or end of shelves at different height.

There is a need to relate the price elasticity data, in relation to the economic status of the consumer, with the health impact of consequent changes in diet. Given that there are already good data, accepted by WHO in its recent global analyses, on some food components e.g. fruit and vegetables[ii], it is comparatively straight forward for the Commission to model the price elasticity equations with their health impact. It should also be relatively straightforward to provide assessments of the effects of saturated fats, trans fatty acids, free sugars and salt on disease promotion, as well as the overall impact of energy density on the development of obesity. In this way it would be perfectly possible to begin to undertake a Health Impact Assessment of all the policy initiatives of, for example, DG Agriculture.

As noted at the beginning, the priority given to promoting the motor car at the expense of other forms of transport, together with the dramatically different approaches of EU nations to town planning and traffic policies, has led to remarkably different developments of cities. Thus several Danish cities, much of the Netherlands and some other cities, e.g. Barcelona, have developed pedestrian and cycling friendly policies which are very different from those found in many European national capitals and cities. The EU should contribute to an analysis of the relative merits of different approaches to town planning and traffic policies, because these have on the whole been developed on a national basis often with very little understanding of the benefits of best practice apparent across the EU. This is therefore a role which DG SANCO could play.

Health Impact Assessments should include the implications of the relaxation of standards in the TV Without Frontiers directive.

V.1.2 Consumer Information, Marketing and Advertising

When providing nutrition information to the consumer, what are the major nutrients, and categories of products, to be considered and why? Which kind of education is required in order to enable consumers to fully understand the information given on food labels, and who should provide it?

The recent UK Food Standards Agency scheme for simplified front of pack nutrition labelling (traffic lights) will:

- provide separate information on fat, saturated fat, sugar and salt
- use red, amber or green colour coding to indicate whether levels of these nutrients are high, medium or low
- use nutritional criteria developed by the FSA to determine the colour code
- give information on the levels of nutrients per portion of product.

Independent research suggests that consumers want a consistent approach endorsed by an authoritative, independent and trusted body such as the FSA. The use of traffic light colours is key to helping people understand whether a food has high, medium or low levels of fat, saturated fat, sugar and salt. This form of "consumer education" provides straightforward clarity, in contrast to the impenetrable small print labelling which is current practice. The traffic lights approach was recommended in the IOTF submission to the EU on nutrition labelling and its position paper on Obesity in Europe in 2003.

Are voluntary codes ("self-regulation") an adequate tool for limiting the advertising and marketing of energy-dense and micronutrient-poor foods? What would be the alternatives to be considered if self-regulation fails? (V 1.2)

Evidence from the USA suggests that voluntary codes, in existence over many decades, fail to regulate advertising and marketing to children effectively. Repeated violations of the code result from short-run campaigns which are over by the time the self-regulation mechanisms can be applied. There is little indication of any effective reduction in marketing and advertising to children within the EU, even with undertakings by major brands and trade groups not to promote to children under 12. These children are regularly exposed to all forms of promotion aimed at older children and adults. In addition new forms of marketing, via the internet, mobile telephone messaging and "viral" marketing techniques evade any limitations placed on television advertising. A coherent and enforceable European regulatory code governing all forms of marketing is needed to ensure compliance, not only from those voluntarily accepting the need for standards to protect children, but from those who do not comply.

Which measures should be taken towards ensuring that the credulity and lacking media literacy of vulnerable consumers are not exploited by advertising, marketing and promotion activities? (V 1.2)

Existing advertising codes pay lip service to the recognition that children are vulnerable because they are not equipped, developmentally, to view advertising and marketing approaches from a critical perspective. The concept of "media literacy" assumes that children, who are not equipped to cope with commercial communications, nevertheless can be educated to understand and beware of the purpose of advertising. The most effective measure to protect children throughout the EU, particularly

where existing national regulations are thwarted by cross-border broadcasting, is to adopt a single EU standard to prohibit marketing to children.

V. 2 Consumer Education

How can consumers best be enabled to make informed choices and take effective action? What contributions can public-private partnerships make toward consumer education? In the field of nutrition and physical activity, which should be the key messages to give to consumers, how and by whom should they be delivered?

Consumers obtain most of their nutritional health information from commercial sources. They are often exposed to conflicting claims and dietary advice which may misinform the consumer. The EU should establish common standards throughout the market. A traffic-light labelling scheme would be a major step towards enabling consumers to make better choices.

Any commercial support for "consumer education" should be channelled through a "blind trust" system to avoid undue influence. The key messages are well known and awareness of these messages has had little impact on consumers, except when reinforced by doctors treating a related condition.

V.3 A focus on children and young people

What are good examples for improving the nutritional value of school meals? How can parents be informed on how to improve the nutritional value of home meals?

Recent initiatives to encourage schools to eliminate 'fast food', and provide healthier menus offer promise for the future if sustained. Municipal initiatives, which emphasize the sourcing of locally grown produce in Italy, the UK and elsewhere, offer examples of ways to stimulate local horticultural economies and achieve greater availability of fresh fruit and vegetables. Removing the option of confectionery, calorie dense snacks and soft drinks will also improve the nutritional value of school meals.

Parents often lack any understanding of the nutritional needs of their children or themselves. Evidence from experimental programmes to introduce children to a range of fresh fruit and vegetables suggests that children take home newly acquired appetites and tastes for items parents automatically assume they will dislike.

Independently validated advice on improved nutrition could be made available prominently by retailers, with stocking policies to make low-nutritional energy high products less accessible or appealing to children.

What is good practice for the provision of physical activity in schools on a regular basis? What is good practice for fostering healthy dietary choices at schools, especially as regards the excessive intake of energy-dense snacks and sugar-sweetened soft drinks?

Physical activity in schools may be encouraged in many ways depending on local settings. A car free zone around schools should lead to the requirement for all children to walk at least a minimum distance to school. Schools should have ample recreational areas to enable children to exercise their natural inclination to be active. Activity can be integrated in curriculum planning in novel ways.

Children should move from lesson to lesson, rather than remain in a single classroom throughout the day. Over emphasis on sport may be counter-productive whilst other forms of activity, including dancing, and even gardening, also contribute to improving activity levels.

Good dietary choices may be promoted by creating a healthy food environment in schools. The evidence from the USA indicates that the availability of energy dense snacks and sugary drinks, so called competitive foods, undermines efforts to achieve minimum nutritional standards in school lunches. The French legal standard requiring the removal of vending machines from schools should be adopted throughout the EU. Similarly school tuck shops should meet nutritional standards and not supply energy dense snacks and drinks.

How can the media, health services, civil society and relevant sectors of industry support health education efforts made by schools? What role can public-private partnerships play in this regard? V.3.2

The success of efforts to improve dietary health and physical activity depend significantly on changes in the environment. Much of the effort may be wasted if outside school, children are surrounded by conflicting messages, ubiquitous promotion of easily obtained food and drinks of low nutritional value, and sustained campaigns to encourage consumption. Therefore the media, civil society and industrial sectors should acknowledge their responsibility to support efforts to improve the health of children. Public-private partnerships may contribute to awareness if they are guided by independent authorities to support initiatives which are not commercially based.

V.4 Food availability, physical activity and health education at the work place

How can employers succeed in offering healthy choices at workplace canteens, and in improving the nutritional value of canteen meals? What measures would encourage and facilitate the practice of physical activity during breaks, and on the way to and from work?

Employers should encourage their workforces to take meal breaks, and where provision is made, ensure that canteens and staff restaurants offer healthy menus; the provision of free vegetables or salads with a workplace meal is one successful approach adopted in Finland. Employers could also provide fruit on a similar basis. In appropriate settings employers could provide exercise and recreation areas. Distancing car parks from offices and workplaces can also help to generate 'invisible' activity, necessitating additional walking. Employers should place less emphasis on the provision of cars as benefits, make ample provision for cyclists, with incentives for employees using cycles at work.

V.5 Building overweight and obesity prevention and treatment into health services

Which measures, and at what level, are needed to ensure a stronger integration aiming at promoting healthy diets and physical activity into health services?

Health services are major employers throughout the EU, and therefore should provide models of best practice to other employers. Health services should ensure highest nutritional standards are maintained and should avoid measures which may undermine health advocacy, such as the sale of energy dense, low nutritional value foods and drinks on their premises including hospitals and other facilities.

A European Network of Centres of Excellence should be established focused on obesity education, prevention, treatment and research, integrating the IASO/IOTF and EASO SCOPE programme for certification of obesity professional education for both medical and non-medical health professionals engaged in this area.

V.6 Addressing the obesogenic environment

In which ways can public policies contribute to ensure that physical activity be "built into" daily routines? Which measures are needed to foster the development of environments that are conducive to physical activity?

A strategic transport priority, both at Community and national level, must be to improve public transport and safe provision for cyclists and pedestrians. Deterrents to car use should be incorporated where appropriate, with urban congestion charging schemes and restrictions on car access in cities, which in turn may promote greater use of public transport, cycling and walking. Cycle lanes should be structured to protect cyclists and prevent vehicular intrusion as found in Denmark. Adverse environments, with traffic congestion and pollution, inhibit people wishing to be physically active. Similarly unsafe streets, where the risk of crime is great, act as deterrents to activity. Ensuring the safety of roads and recreational areas is an important step which can be taken at municipal level, often at minimal expense.

V.7 Socio-economic inequalities

Which measures, and at what level, would promote healthy diets and physical activity towards population groups and households belonging to certain socioeconomic categories, and enable these groups to adopt healthier lifestyles? How can the "clustering of unhealthy habits" that has frequently been demonstrated for certain socio-economic groups be addressed?

Overweight and obesity often reflect social inequalities, with higher proportions of populations in certain categories adversely affected. There are often long term physiological effects of socio-economic deprivation which can be inter-generational and are not easily addressed by promoting the idea of improved diet and activity. In some poorer urban and rural areas it may be difficult to obtain sufficient fruit and vegetables to meet recommended dietary levels. The predominance of large supermarkets, accessible only by car, may lead to market concentrations with limited and more expensive options in local community shops for those dependent on public transport. The preferential distribution of fruit and vegetables at prices attractive to local conditions could be one approach to addressing this problem in specific communities. Addressing "clustering" may require community focused initiatives, particularly addressing childhood obesity, but directed at improving those environmental factors.

V.8 Fostering an integrated and comprehensive approach towards the promotion of healthy diets and physical activity

Which are the most important elements of an integrated and comprehensive approach towards the promotion of healthy diets and physical activity? Which role at national and at Community level?

Introducing changes in long established unhealthy habits requires a supportive environment. Recent moves in some EU member states to prohibit smoking in public places have demonstrated the effectiveness of providing a regulatory framework within which to advance public health policies. Promoting healthy diets requires that preference be given to making easily available and affordable those foods which contribute to a healthy diet, and removing the marketing pressures and incentives to consume less appropriate diets. Therefore ensuring suitable advantageous pricing and provision of healthy foods is an important and essential component of an integrated approach.

The promotion of unhealthy alternatives should be addressed by clear labelling indicating the nutritional disadvantages of a product, pricing schemes which make these less attractive, and controls on promotion, marketing and advertising of unhealthy alternatives.

Controls over marketing to children should reflect the precautionary principle. No marketing and advertising should be directed to schoolchildren either in school or via the full range of media available including television and the internet. Pre-existing national laws regarding children and broadcasting in Sweden, for example, should be adopted on a Community basis, while new laws implemented in France requiring advertising of certain products to include a health warning should be considered an interesting model for adoption at Community level.

Physical activity is addressed in response to V.6

V.9 Recommendations for nutrient intakes and for the development of food-based dietary guidelines

In which way could social and cultural variations and different regional and national dietary habits be taken into account in food-based dietary guidelines at a European level? How can the gaps between proposed nutrient targets and actual consumption patterns be overcome? How can dietary guidelines be communicated to consumers? In which way could nutrient profile scoring systems such as developed recently in UK contribute to such developments?

Dietary guidance sets targets to aim for at a population level, but this allows for regional, local and individual variations in practice.

Differences between goals and actual consumption depend not only on personal preferences and socio-cultural variations, but on the irregular pricing mechanisms of the EU market. To move towards goals in reducing consumption of sugar, fats and oils, agricultural support for their production for human consumption should be eliminated. Alternative uses for these products, for example in bio-fuels, should be explored. Increasing the production and distribution of fruit and vegetables should be given priority, along with pricing mechanisms to ensure affordability to even the poorest.

Communicating dietary guidelines may be achieved through the signposting system referred to in response to V.1.2. This provides clarity in enabling those with little comprehension of dietary requirements to understand simply coded indications of whether a product meets dietary requirements.

V.10. Cooperation beyond the European Union

Under which conditions should the Community engage in exchanging experience and identifying best practice between the EU and non-EU countries? If so, through which means?

Best practice should be assessed systematically through research and independent evaluation. However once the EU has had an opportunity to genuinely establish improved standards for dietary health and activity, this should be promoted as international norms. Non-EU countries, seeking economic advantage by maintaining sub-standard health provisions, should be encouraged to adopt best practices. This may require the introduction of health impact assessments as a pre-requisite in international trade negotiations.

V.11 Other issues

Are there issues not addressed in the present Green paper which need consideration when looking at the European dimension of the promotion of diet, physical activity and health? Which of the issues addressed in the present Green paper should receive first priority, and which may be considered less pressing?

The increasingly concentrated retail sector has increasing influence in determining product ranges, pricing and promotion. The EU should work with major retailers to establish European standards for retail presentation, which would shift the balance to healthy foods, and reduce the emphasis on the promotion of less healthy foods, particularly to children.

Restructuring agricultural production to support the needs of healthy EU citizens should be considered an immediate priority, since this may take another generation to achieve. Meanwhile childhood obesity is rising in the EU at the rate of 300,000 children each year, and adult obesity levels continue to increase remorselessly with consequences for diet-related diseases such as diabetes, heart diseases and some forms of cancer.

It should be noted that general efforts to improve diet, physical activity and health can have a broad impact on the development of chronic diseases. It is therefore important that the value of this approach is understood and can be integrated as part of a comprehensive population strategy for the prevention of obesity and related chronic disease.

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[i] Kohler L, Rigby M Indicators of children's development: consideration when constructing a set of national child health indicators for the European Union Child Care, Health and Development 2003; 29(6) 551/558

[ii] Lock et al WHO Global Burden book