

Italian Task Force for a National Plan of Dietary Prevention and against Sedentariety

1. Background

In the last 40 years important evidences have arisen suggesting that diet significantly affects the onset of chronic–degenerative pathologies, pain of the developed world.

Association between diet and cancer was studied over a long period and research has now reached a critical turning point. Ecological studies of the 60's, many case–control studies started in the 70's, large perspective studies that begun in the 80's with dietary surveys and bio–banks and, finally, the dietary campaigns of the 90's all contribute to the conclusion that over one third of cancers could theoretically be preventable through changes of eating habits.

Other important evidences in the fields of cardiovascular and degenerative diseases led to the implementation, in some areas of the world, of public health plans on dietary prevention.

2. Italian Task Force for a National Plan of Dietary Prevention and against Sedentariety

Italian Epidemiologists and researchers are working to define a general plan for prevention for all chronic–degenerative diseases where dietary prevention is considered a key action.

This plan looks with interest at the Mediterranean diet as a protective dietary style.

The Task Force should not miss to coordinate with other similar events on dietary prevention in Europe in order to help the creation of a European strategy in the fight against Cancer and Chronic–degenerative Pathologies. The European Public Health Projects EUROCISS, on Cardiovascular diseases, and EUROCHIP, on Cancer, offer the expertise of their members and their Networks to centralize the work related to the proposal.

One of the activity performed by the Task Force is to provide an homogeneous reply to the green book prepared by the European Commission. This reply is here presented.

3. Linked Projects

3.1 EUROCHIP and I TUMORI IN ITALIA

The project **EUROCHIP–1**, funded in 2002–2003 by the EC within “Health Monitoring Programme” (HMP), has contributed to the development of a cancer surveillance system in Europe. HMP was implemented to produce an European public Health Data Bank and EUROCHIP–1 has contributed to this by proposing a list of Cancer Indicators for the development of an information system amongst the European Countries.

EUROCHIP–1's results provided the basis for EUROCHIP–2 The action. The project has enlarged the information network, improves access to cancer information and knowledge in all European Countries and promotes actions to improve health control in the fight against inequalities. Through National Consensus Conferences, **EUROCHIP–2** identifies the cancer–control deficient areas in each country where a public health action is desired and promotes actions characterised by a strong European imprimatur. EUROCHIP–2 helps the relationship between the world of knowledge and the world of decisions.

The project “**I Tumori in Italia**” is the Italian link to the project EUROCHIP–2, and it is aimed to develop a cancer information system through a Portal of Cancer Epidemiology (www.tumori.net) The Italian Cancer Research Institutes, the Institute of Health and the major Italian Cancer Networks are involved. The project gives access to data for the epidemiological description of cancer at national and regional level, provides information on control delays and data for health plans on cancer prevention, early diagnosis and care.

"I Tumori in Italia" have provided incidence estimates and projections for all cancer sites. Projections suggest that incidence levels of the Southern Italian regions will reach the levels of Northern Italian Regions. Cancer epidemiology geography will then be completely modified: Southern regions would lose the origin protection in comparison with the rest of the Italian regions.

Estimates of Lombardy (Northern region characterised by the highest cancer mortality level and one of the highest incidence levels) and Campania (Southern region) show that in 2010 incidence rates for males will be higher in Campania than in Lombardy, and for females the risk will be equal.

It is possible to assume that one of the determinants of risk increment in the Southern Italy are the dietary changes that are progressively taking place. The substitution of the Mediterranean diet with a more northern diet, associated to oncological risk, may be amongst the causes of this important phenomenon. The promotion of primary prevention programmes both on national and regional level would be necessary to slow the increasing trend of cancer incidence. I

3.2 EUROCISS and CUORE

The **EUROCISS** project (European Cardiovascular Surveillance Set) was set up in 2000 by a partnership of EU countries and financed by the European Commission as part of the Health Monitoring Programme with the aim of developing health indicators and recommendations for monitoring the distribution and impact of cardiovascular diseases (CVD) in Europe.

The project was structured in two consecutive phases: the first one between 2000 and 2003 and the actual one which will end in 2007.

The main objectives of EUROCISS phase I were:

To identify which CVD are of importance in public health. The choice was based on two criteria: high prevalence of disease in terms of mortality, morbidity and disability and the possibility of prevention, in terms of modifiable risk factors.

Therefore, diseases included in the project were: acute myocardial infarction/acute coronary syndrome, ischaemic heart diseases, heart failure, cerebrovascular accidents and other cardiovascular diseases of atherosclerotic origin.

To realize an inventory of available indicators in partner countries, which has led to the identification of specific indicators available for single specific diseases or for groups of cardiovascular diseases and to compare data collection methods used in the different countries.

To develop recommendations for collection and harmonization of indicators. The specific indicators were divided into: (1) actually available, (2) those obtainable by matching several indicators, which then require further elaboration to be reliable and available in short time. For example, attack rates, which are collected through population-based registers, are obtained by matching mortality and hospital discharge data for acute events; (3) those which need long periods of time and more resources to be implemented and then validated.

The II phase of EUROCISS foresees the following objectives:

To update the inventory of available indicators in Member States (MS)

To prepare the manual of operations for the implementation of population-based registers of acute myocardial infarction/acute coronary syndrome and stroke in countries lacking these surveillance systems starting from the experience of those countries which have them running in order to assess the attack rate/incidence of CVD;

To prepare the manual of operations for the implementation of CVD surveys on the basis of standardized procedures for assessing the prevalence of CVD in MS.

To create a network of Member States with expertise in chronic diseases surveillance to foster the collection of valid, reliable and comparable indicators in order to improve the surveillance and the prevention of CVD.

The **Cuore** Project - epidemiology and prevention of ischaemic heart diseases - launched in 1998, is financed by 1% of the National Health Fund and is coordinated by the Istituto Superiore di Sanità. The aims of the project were to:

1. estimate the impact of cardiovascular diseases in the general population;
2. evaluate the distribution of cardiovascular risk factors in representative samples of the Italian population;
3. evaluate the cardiovascular risk in the Italian population.

The first objective has been achieved through the implementation of the national register of coronary and cerebrovascular events involving individuals ages 35-74 in eight representative areas of the country (Brianza, Caltanissetta, Firenze, Friuli-Venezia Giulia, Modena, Napoli, Roma and Veneto) to estimate the frequency of acute coronary and cerebrovascular events. The registers allows to produce reliable attack, incidence and mortality rates of acute coronary and cerebrovascular events occurring all over the country.

The second objective has been achieved through the setting up of the Osservatorio Epidemiologico Cardiovascolare, resulting from the collaboration between the Istituto Superiore di Sanità (ISS) and the Associazione Nazionale Medici Cardiologi Ospedalieri (ANMCO). The OEC has as its main objectives: the description of the distribution of cardiovascular risk factors in the Italian population; the assessment of the prevalence of high risk conditions, that is hypertension, hypercholesterolemia, smoking habit, physical inactivity, obesity, diabetes; the assessment of the prevalence of cardiovascular diseases of arteriosclerotic origin, such as angina pectoris, myocardial infarction, TIA (Trans Ischaemic Attack), stroke, intermittent claudication and atrial fibrillation.

The third objective has been achieved through the risk chart tables and the calculation of the Italian cardiovascular risk score. The cardiovascular risk chart is a simple and objective way of assessing the likelihood of experiencing a first major cardiovascular event (myocardial infarction or stroke) over the following ten years, when the values of six risk factors - gender, history of diabetes, smoking, age, systolic blood pressure and total serum cholesterol – are known.

The individual risk score takes also into account serum HDL cholesterol and the prescription of anti-hypertensive medications.

The CUORE Project, allowing the identification of cardiovascular risk factors, promotes a targeted action toward those modifiable risk factors: smoking habit, diet and sedentariness. Since high cardiovascular risk is strongly related to these factors, the adoption of an healthy lifestyle, giving up smoking, consuming healthy food and making physical activity, is an extremely effective preventive tool .

Replies to the GREEN PAPER

"Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases"

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?

Proposed by Dr. A. Micheli – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

Health is a shared value and must be promoted. Dietary lifestyles are associated with a set of factors: economy, agriculture, education, etc. The European Union could acknowledge that healthy diet and correct lifestyle should be central elements of different health plans in various European countries.

Proposed by Dr. R. Tumino – Ragusa Cancer Registry

Regional healthy dietary cultures (based on local food availability) have to be promoted, in opposition to “food–globalization” trends.

In other words, nutritional and dietary recommendations have to be based also on dietary culture. This way healthy choices could be easy choices.

For example in Sicily (in principle in small provinces as Ragusa) persons (also young people) maintain the use to consume wild vegetables, that are rich of antioxidants.

Two articles are published on this matter:

- Salvatore S, Pellegrini N, Brenna OV, Del Rio D, Frasca G, Brighenti F, Tumino R. Antioxidant Characterization of Some Sicilian Edible Wild Greens. J Agric Food Chem. 2005; 53:9465–71.
- Tumino R, Frasca G, Giurdanella MC, Lauria C, Krogh V. Consumption of wild vegetables in the EPIC cohort of Ragusa (Sicily). IARC Sci Publ. 2002;156:115–6.

From these evidences, restaurants of the province of Ragusa were invited to introduce wild vegetables in their food lists. The initiative was favourably accepted by the restaurants.

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Dr. P. Baili – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

Organization of a European “healthy lifestyle and physical activity day” to promote good nutrition behaviours by arranging events on local food and sport events in order to discuss about the relevance of these topics for human health.

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

Messages on good lifestyles have to reach teenagers and schools. Health education and prevention should be mandatory subjects within specific lectures in the European schools.

Which kind of Community or national measures could contribute towards improving the attractiveness, availability, accessibility and affordability of fruits and vegetables?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

After giving a complete information on fruit and vegetables consumption, it is necessary to grant quality control on products and to promote price policies to make products more affordable.

Proposed by Dr. A. Micheli – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

Dr. C. Amati – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

Dr. P. Baili – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

- In Milan, once a year, the council promotes the offer of 5 kg of fruit and vegetable at low cost in the fruit & vegetables district markets.
- National directives to promote “Fruit & Vegetable Saving Days”. Every day of the week supermarkets and street shops should apply a 20% reduction on a different item of fruit and vegetables. The list of items should be decided by directive for the entire calendar year.
- Funding of local productions and favourable conditions for local product importation

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

Fruit & vegetables marketing and advertising should be regulated. It is vital to reduce prices of fruit & vegetables to avoid that “healthy diet” could be too expensive.

On which areas related to nutrition, physical activity, the development of tools for the analysis of related disorders, and consumer behaviour is more research needed?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Analysis of consumer behaviour.

Proposed by Dr. A. Micheli – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

Studies on interventions and their efficacy to modify dietary behaviour

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

Research on dietary behaviours in childhood and teenagers.

The 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?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

It could be interesting to focus attention on nursery schools as proxy indicating the way families deal with diet and physical activity.

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

School is the best source to obtain comparable data on young-age-obesity.

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?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Promote estimates of the number of avoidable deaths that would emerge if a correct dietary behaviour was adopted in the European countries.

Which are the most appropriate dissemination channels for the existing evidence?

Proposed by Dr. P. Baili – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

Supermarkets. Little book dedicated to consumers (for example with correct definition of portions) to prepare for supermarket diffusion.

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Dr. F. Bellù – Alto Adige Cancer Registry

Schools. A structural programme to reach population and families from off-spring early ages.

Consumer information, advertising and marketing

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?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Different colouring of the self-regulated area of packaging in order to allow easy understanding of fat (red), minerals (light blue), vitamin (green) content.

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

Labels should be clearer, with clear characters (magnifying glass should not be needed to read labels)

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?

Proposed by Dr. A. Micheli – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

Dr. F. Bellù – Alto Adige Cancer Registry

Alternatives could include taxation or other economical incentives/disincentives.

How can effectiveness in self-regulation be defined, implemented and monitored? 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?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Surveys to evaluate dietary changes in population

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

The European Union has to approve an ethical code for advertising and marketing.

Consumer education

How can consumers best be enabled to make informed choices and take effective action?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Dr. A. Micheli – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

It is important to standardize as much as possible information that reach consumers.

Promotion of Projects to connect information sources (newspapers, magazines, TV, internet sites, etc)

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

Spread correct information in schools at all costs. “Correct information” also means contrast bad habits.

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?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Mass media communications, public discussions, brochures, etc prepared by public health personnel with scientific knowledge have to underline community advantages (for example less illness means reduction of health expenditure) and personal advantages (for example peaceful elderly age).

Proposed by Dr. P. Baili – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

- 1) TV programs promoting physical activity. E.g. in Italy following to the showing of TV program “Ballando con le stelle” (“Dance and with the Stars”), Dancing Schools gained popularity
- 2) Fruit & vegetable consumption promotion in the episodes of national TV series.
- 3) Reality shows as “Big brother” to offer free fruit & vegetables for participants and to ban smoking.
- 4) Supermarkets’ Saving Programmes to prise consumers for fruit and vegetables purchase with double (green) points.
- 5) Supermarkets’ Saving Programmes to grant discounts on fruit and vegetables after a given level of (green) points reached by consumers

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

- 1) Health education and prevention should be mandatory subjects of specific lectures in European schools.
- 2) Coherent and strong messages could be given by all Health Ministers of the European Countries

A focus on children and young people

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

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Private Catering Services in Schools to be checked by a multidisciplinary committee (e.g. teachers, parents, nutritionists,) with planning and monitoring tasks to promote healthy diet and adequate physical activity and control meals preparation and conservation.

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?

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?

Proposed by Dr. I. Casella – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

- 1) A cartoon promoting fruit & vegetables
- 2) A computer game on “Healthy cooking”

Proposed by Dr. C. Amati – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

Circulate amongst the youngsters models of superheroes whose power benefits from fruit& vegs consumption (e.g. Popeye).

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?

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

Employers offering healthy choices at workplace canteens to receive incentives.

What measures would encourage and facilitate the practice of physical activity during breaks, and on the way to and from work?

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

Employers encouraging and facilitating physical activity at workplace to receive economical incentives .

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?

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

Each Health service to be prompted to focus the attention on promotion of healthy diets and physical activity.

Addressing the obesogenic environment

In which ways can public policies contribute to ensure that physical activity be “built into” daily routines?

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

Public policies to encourage employers with economical incentives to facilitate physical activity at workplace.

Which measures are needed to foster the development of environments that are conducive to physical activity?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Dr. F. Bellù – Alto Adige Cancer Registry

It is necessary to limit the use of cars increasing number of pedestrian and cycling paths in metropolitan areas.

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?

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?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Dr. A. Micheli – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

Dr. F. Bellù – Alto Adige Cancer Registry

It is really important to take in consideration that healthy diet and adequate physical activity:

- have economic benefits to entire healthcare system
- have direct benefits to people's quality (and duration) of life

It is moreover vital to consider that over-national directives are successful only if :

- they are rational and shared
- they are comprehensible
- they are translated in specific directives for local realities.

Which role at national and at Community level?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Dr. A. Micheli – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

Dr. F. Bellù – Alto Adige Cancer Registry

It is really important to avoid clashes with local dietary traditions.

If these traditions should be abandoned due to unhealthiness, it is essential this is explained clearly

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?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Dr. A. Micheli – Istituto Nazionale per lo Studio e la Cura dei Tumori – Milan

Dr. F. Bellù – Alto Adige Cancer Registry

Promoting specific dietary behaviour of some local areas as examples of healthy diet.

As mentioned above, it is really important to not create clashes with local dietary traditions.

How can the gaps between proposed nutrient targets and actual consumption patterns be overcome?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

To give information about the risks of an hypercaloric diet in absence of a good physical activity.

This requires a long period of evidence-based strategy.

How can dietary guidelines be communicated to consumers?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

General practitioners and paediatrician could be the first communicators.

In which way could nutrient profile scoring systems such as developed recently in UK contribute to such developments?

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?

Other issues

Which of the issues addressed in the present Green paper should receive first priority, and which may be considered less pressing?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

Physical and dietary education in schools

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

All aspects considered in the green paper have similar priority.

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?

Proposed by Dr. E. Stagnaro – Istituto Ricerca sul Cancro – Genoa

To discuss about the risk of overweight and not only about obesity.

Focus on the quality of physical activity and not only on the quantity.

Proposed by Dr. F. Bellù – Alto Adige Cancer Registry

Focus on alcohol abuse as cause of eating disorders.

Proposed by Sergio Mariotti, Istituto Superiore di Sanità

Claudio Paretti, Andrea Fianza, Ente per Nuove tecnologie, Energia e Ambiente

It is felt by the writers of the present short report, that two main issues are not adequately dealt with in the Green Paper.

The first issue concerns the problem of **evaluating the dimension of prevention as an issue** promoted by the Green paper. In facing a difficult prevention problem, the first task should be to highlight how big the problem is, especially since there are striking differences in the distribution of health in the EU, more so now that the EU includes 25 member states. The Green Paper, quoting paragraph II.2, states: “*An analysis made by the Swedish Institute of Public Health concludes that in the EU, 4.5% of disability-adjusted life years (DALYs) are lost due to poor nutrition, with an additional 3.7% and 1.4% due to obesity and physical inactivity – a total of 9.6%, compared with 9% due to smoking*”. It is dubious if these estimates for the whole of EU should be trusted, when the Green Paper declares in other parts that the available measures of obesity are not well enough defined to be reliable and certainly they are not uniform across all 25 members states. If this is true for obesity, an even bigger problem arises for the measures of daily physical activity, both at work place and at home, which are recognised to involve several difficulties.

The situation is still worse for data relative to dietary habits, which differ widely among the 25 member states, while no dietary surveys in a representative sample of the whole population exist in

most states. In spite of the warnings above, an approximate evaluation for the whole of EU can be still attempted, basing the estimates on few countries with more available data, and with the acknowledged risk of large possible errors, building on the philosophy that an approximate estimate is still better than no estimate at all. But what about the internal variance of an estimate of this type inside EU member states?

No evaluations exist of the DALYs lost in the individual member states, and no reliable quantitative assessment of the magnitude of the problem posed to the 25 states by obesity and physical inactivity has ever been undertaken.

For all reasons outlined above, it is clear that a quantitative assessment of the differences in dietary habits, physical activity and obesity among the 25 member states, with differences in risk factors leading to different potential DALYs lost, must be attempted, acknowledging that this is not an easy task. At least, a clear understanding of the order of magnitude of these differences is mandatory: if we want to start a large effort for the prevention of overweight, obesity, lack of sufficient physical activity and chronic diseases that derive from these, it is necessary to know to some extent in which one of the member states the problem is larger in order to differentiate and concentrate the preventive effort.

To this purpose, we propose that one of the tasks to be undertaken should be a large effort to collect the most reliable available measures and indicators related to the quantities of interest addressed by the Green Paper, basing these effort on the previous work carried on in the EU in such projects as ECHI and ECHIM. Once suitable measures or proxies or estimates are available, an accurate evaluation of the DALYs lost due to obesity, other nutrition-related risk factors and physical inactivity should be undertaken possibly for each of the 25 member states. Among the factors related to nutrition, special concerns should be reserved to the effects of bad nutritional habits on high blood pressure and high cholesterol, and to the unfavourable effects of low fruit and vegetable consumption.

Such analysis should follow the methods outlined in the recent WHO publication: “Comparative Quantification of Health Risks”.¹

A second issue concerns the recommendation of the Green Paper to focus prevention efforts on children and young people (paragraph V.3), since “*lifestyle choices pre-determining health risks at adult age are made during childhood and adolescence*”.

We certainly agree with this recommendation. However, we feel that a second category of people deserves special attention, because of their relative frailty, i.e. of their higher mortality risk: **the over 60, including the oldest-old, up to 85 years of age.**

It is now commonly recognised by most gerontologists that there is no age limit to an effective prevention action. Quoting a famous cardiologist, William B Kannel, the Head of the Framingham Heart Study: “*declines in coronary mortality rates in the US have included the elderly, justifying optimism about the efficacy of preventive measures. Most of the elderly have sufficient remaining*

life expectancy to warrant vigorous preventive management. Trials of risk factor modification in the elderly indicate that decades of exposure to modifiable risk factors can be countered by measures implemented late in life....." ². Another well-known scientist, James W Vaupel, remarks that, following unification of East and West Germany, mortality in the East declined toward prevailing levels in the West, especially among the elderly, providing strong evidence that, although conditions early in life do significantly influence human health and survival late in life, such effects are of less importance than changes in current conditions ³.

After recent research on aging has challenged the inevitability of the linkage of severe impairment with age, the fact that functional loss is no more considered as a necessary and nearly universal correlate of the aging process is demonstrated by the innumerable initiatives to promote physical activity among the elderly in the USA, Canada, UK and Australia.

In the US the governmental Agency for Healthcare Research and Quality (AHRQ) reports about all the activities to promote physical activity among the elderly on their site⁴.

Three important statements that can be found in the reports of the AHRQ are:

1. It's never too late to become physically active. No one is too old to enjoy the benefits of regular physical activity.
2. Investing a small amount of time in becoming more active can produce big dividends in better health. Spending at least 30 minutes in moderate activity, such as a brisk walk or raking leaves, on all or most days of the week has remarkable health benefits for older adults.
3. Research has identified a number of key strategies for what we can do, as individuals and in our communities, to help older people become more active.

A major national planning document for aging and physical activity was released in the US in 2001, to serve as a guide for multiple organizations, associations and agencies, to inform and support their planning work related to increasing physical activity among America's aging population: *The National Blueprint: Increasing Physical Activity Among Adults Aged 50 and Older* ⁵.

The document concludes that there is a substantial body of scientific evidence which indicates that regular physical activity can bring dramatic health benefits to people of all ages and abilities, and that this benefit extends over the entire life-course.

As a result of the Blueprint, the Active Aging Toolkit was developed by researchers to help healthcare providers prescribe physical activity programs for their older patients: *The First Step to Active Health* ⁶ provides an evidence-based, progressive activity program. The goal of the program is to improve health and functional ability, to promote independence, and to help prevent chronic disease and disability in adults over age 50. The program includes a step-by-step approach to improve physical abilities with a variety of simple activities, including cardio/aerobic, flexibility, strength, and balance activities.

Another instruction manual with similar purposes has been developed by the Center for Healthy Aging of the US National Council On The Aging ⁷, and a guide to physical exercise which includes a DVD or VHS video by the National Institute on Aging ⁸.

In Australia, the UPLIFT study successfully used physical activity in the management of depressed old people, by means of a progressive resistance training program, while the University of Western Australia started in 2003 a three-year community-based physical activity program focused on people between 60 and 80 years old.

The WHO released in 1996 the Heidelberg guidelines for promoting physical activity among older persons⁹, and the scientific committee in charge of developing these guidelines selected those people aged 50 and above as the most appropriate target, i.e. the group of people for which “*the benefits of regular physical activity can be most relevant from the point of view of avoiding or minimizing many of the physical, psychological and social problems which often accompany advancing age*”. The WHO also prepared a report aimed at old people’s physicians to recommend the prescription of physical activity to their patients: “*Growing older, staying well*”¹⁰.

By contrast to all the initiatives cited above, little is known about systematic promotion of physical activity among the elderly in Italy and in many EU member states.

We suggest that a promotion of physical activity among people aged 60 and above should be undertaken by means of initiatives similar to those described above that proved to be successful in the US and Australia.

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