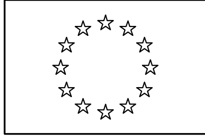

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GREEN PAPER

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

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GREEN PAPER

THE COMMENTS OF THE DEPARTMENT OF HEALTH AND CHILDREN, IRELAND, ARE IN BOLD.

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

I. STATE OF PLAY AT EUROPEAN LEVEL

I.1. Unhealthy diets and lack of physical activity are the leading causes of avoidable illness and premature death in Europe, and the rising prevalence of obesity across Europe is a major public health concern *(cf annex 2 for background information)*.

I.2. The Council has invited the Commission to contribute to promoting healthy lifestyles[(i)][1], and to study ways of promoting better nutrition within the European Union, if necessary by presenting appropriate proposals to that end[2]. The Council has also called upon Member States and the Commission to conceive and implement initiatives aimed at promoting healthy diets and physical activity[3].

I.3. The Community has a clear competence in this area: Article 152 of the Treaty requires that a high level of human health protection be ensured in the definition and implementation of all Community policies and activities. A number of areas of Community policy are relevant to nutrition and physical activity, and the Council has confirmed the need to mainstream nutrition and physical activity into relevant policies at the European level[4].

I.4. Action at national level may usefully be complemented at the Community level. Without limiting the scope for actions which Member States may wish to initiate, Community action may exploit synergies and economies of scale, facilitate Europe-wide action, pool resources, disseminate best practice and thereby contribute to the overall impact of Member State initiatives.

I.5. The Council underlined that the multi-causal character of the obesity epidemic calls for multi-stakeholder approaches[5] - for which the European Platform for Action on Diet, Physical Activity and Health (*cf section IV.1*) is a prominent example - and for action at local, regional, national and European levels[6]. The Council also welcomed the Commission's intention to present this Green Paper and to present in 2006 the results of the public consultation exercise initiated with the Green Paper[7].

(i) References are grouped in Annex 3 at the end of the document

I.6. The European Economic and Social Committee underlined that action at Community level can reinforce the effect of initiatives taken by national authorities, the private sector and NGOs[8].

I.7. A number of Member States are already implementing national strategies or action plans in the field of diet, physical activity and health[9]. Community action may support and complement these activities, promote their coordination, and help to identify and disseminate good practice, so that other countries can benefit from experience gained.

II. HEALTH AND WEALTH

II.1. Apart from the human suffering it causes, the economic consequences of the increasing incidence of obesity are of particular importance. It is estimated that in the European Union, obesity accounts for up to 7% of health care costs[10], and this amount will further increase given the rising obesity trends. Although detailed data are not available for all EU countries, studies underline the high economic cost of obesity: A report prepared by the United Kingdom's National Audit Office in 2001 estimated that obesity in England alone accounted for 18 million days of sickness absence and 30,000 premature deaths, corresponding to an annual direct health care cost of at least GBP 500 million. The wider costs to the economy, which include lower productivity and lost output, were estimated at a further GBP 2 billion per year[11]. The 2004 report from the United Kingdom's Chief Medical Officer on the impact of physical activity and its relationship to health estimated the cost of physical inactivity at GBP 8.2 billion annually (including both the health care cost and the wider cost to the economy, such as days lost from work)[12]. In Ireland, the direct cost of treating obesity was estimated at some €70 million in 2002[13]. In the USA, the CDC estimated obesity-attributable health care costs at $75 billion[14]. At an individual level, studies estimate that the average obese adult in the United States incurs annual medical expenditures that are 37% higher than an average person of normal weight[15]. These direct costs do not take into account reduced productivity due to disability and premature mortality.

II.2. An analysis made by the Swedish Institute of Public Health concludes that in the EU, 4.5% of disability-adjusted lifeyears (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 smoking16.

II.3. A recent report by the Netherlands Institute for Public Health and the Environment, RIVM, examined unfavourable dietary composition and health loss. One of the conclusions is that an excessive intake of the 'wrong' type of fats, such as saturated and trans fatty acids, increases the likelihood of developing cardiovascular disease by 25%, while eating fish once or twice a week will reduce this risk by 25%. In the Netherlands, every year, 38,000 cases of cardiovascular disease among adults aged 20 and above can be attributed to an unfavourable composition of the diet[17].

II.4. Tackling overweight and obesity therefore is not only important in public health terms, but will also reduce the long-term costs to health services and stabilise economies by enabling citizens to lead productive lives well into old age. This Green Paper will serve to determine if, by complementing Member States' activities, action at Community level may contribute to reducing health risks, curbing health care spending, and improving the competitivity of Member States' economies.

III. THE CONSULTATION PROCEDURE

III.1. As announced in the Communication "Healthier, safer, more confident citizens, a Health and Consumer Strategy"[18], the Commission is preparing a series of Community strategies to tackle the most important health determinants, including nutrition and obesity. In this context, the present Green paper aims at opening a broad-based consultation process and at launching an in-depth discussion, involving the EU institutions, Member States and the civil society, aiming at identifying the possible contribution at Community level of promoting healthy diets and physical activity.

III.2. The Commission calls on all interested organisations to submit responses to the issues raised in this Green Paper, no later than 15 March 2006, to the following address (preferably by e-mail):

European Commission
Directorate-General Health and Consumer Protection
Unit C4 – Health Determinants
E-mail: SANCO-C4-NUTRITIONGREENPAPER@cec.eu.int
Postal address: L-2920 Luxembourg
Fax: (+ 352) 4301.34975

These responses should not be scientific papers, but concrete and evidence-based proposals for policy building mainly at EU level. In particular, responses are expected from economic operators on issues within their specific area of interest (e. g. advertising and marketing, labelling…), patient associations and health and consumer protection NGOs.

III.3. Unless respondents make a declaration to the contrary, the Commission services will assume that they do not object to having their responses, or parts thereof, published on the Commission's website and/or quoted in reports analysing the outcome of the consultation process[19].

III.4. Given the multifactorial nature of diseases linked to unhealthy dietary habits and physical inactivity, and the multi-stakeholder response needed to address them, this Green Paper includes certain issues that fall primarily under the competence of EU Member States (e. g. education, town planning); it should also contribute to determine where the EU could nevertheless provide added value, e.g. by supporting networking amongst stakeholders and disseminating good practice.

IV. STRUCTURES AND TOOLS AT COMMUNITY LEVEL

IV.1. European Platform for Action on Diet, Physical Activity and Health

IV.1.1. In order to establish a common forum for action the European Platform for Action on Diet, Physical Activity and Health was launched in March 2005. The Platform brings together all relevant players active at European level that are willing to enter into binding and verifiable commitments aimed at halting and reversing current overweight and obesity trends. The objective of the Platform is to catalyse voluntary action across the EU by business, civil society and the public sector. Members of the Platform

include the key EU-level representatives of the food, retail, catering, and advertising industries, consumer organisations and health NGOs.

IV.1.2. The platform is to provide an example stimulate other initiatives at national, regional or local level, and to cooperate with similar fora at national level. At the same time, the Platform can create input for integrating the responses to the obesity challenge into a wide range of EU policies. The Commission regards the Platform as the most promising means of non-legislative action, as it is uniquely placed to build trust between key stakeholders. First results from the Platform are encouraging: involvement of other Community policies is strong, Platform members are planning far-reaching commitments for 2006**.** Moreover, agreement has been secured by Sports Ministers to offer support to the Platform. A first evaluation of the outcomes of the Platform will take place mid-2006 [20].

Ireland welcomes the cross-Directorate discussions that have arisen as part of the Platform initiative- with the Education and Culture Directorate General (which led to securing agreement by the EU's Sports Ministers to offer support to Platform), with the Research Directorate General (commitment to network current and future research nutrition activities with Platform activities) and with the Agriculture Directorate General (on the consequences of Common Agriculture Policy reform). We look forward to feedback on specific actions arising from these discussions.

Continued open and transparent communication between stakeholders represented on the Platform and the Network on Nutrition and Physical Activity is important.

IV.2. European Network on Nutrition and Physical Activity

IV.2.1. A network on Nutrition and Physical Activity composed of experts nominated by the Member States, the WHO (consumer, **food industry** and health NGOs are present as **observers**) has been established by the Commission services in 2003 to advise the Commission on the development of Community activities to improve nutrition, to reduce and prevent diet-related diseases, to promote physical activity and to fight overweight and obesity. The Network will be closely involved in analysing the feedback to the present Green Paper.

Ireland actively participates in the Network and the special issue meetings.

- **Platform and WHO European region (13/03/06): Exchange of best practice between European and national Platform-type activities, (Ireland has been invited to present our experience at this meeting)**
- **Transatlantic dialogue (11/05/06): Exchange of experience between European and US stakeholders.**

We look forward to helping in analysing feedback to the Green Paper.

IV.3. Health across EU policies

IV.3.1. Preventing overweight and obesity implies an integrated approach to fostering health, an approach which combines the promotion of healthy lifestyles with actions aimed at addressing social and economic inequalities and the physical environment, and with a commitment to pursue health objectives through other Community policies. Such an approach would need to cut across a number of Community policies (e. g. agricultural, fishery, education, sport, consumer, enterprise, research, social, internal market, environment and audio-visual policies), and to be actively supported by them.

IV.3.2. At Commission level, a number of mechanisms are currently operating in order to ensure that health is taken into consideration in other Community policy areas:

- on major policy proposals from other Commission services, the Health and Consumer Protection Directorate-General is systematically consulted;
- the inter-service group on health discusses health-related issues between all concerned Commission services;
- the Commission's impact assessment procedure, which has been established as a tool to improve the quality and coherence of the policy development process and which includes the assessment of health impacts.

Ireland welcomes these mechanisms and supports a sharing of this information , especially, health impact assessment results with MS.

Questions on which the Commission invites contributions include:

– 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?

EU Community policies can play a key role in facilitating the promotion of healthy diets and physical activity and in creating environments that facilitate healthy choices at MS level. The EU provides a strong mandate for nutrition and physical activity to MS through it's resolutions which MS implement. This means building on previous EU resolutions from the French and Danish Presidency Health Initiatives.

Health impact assessments on all EU policies that impact on healthy eating and physical activity. The Commission can also consider seriously the health impact assessments carried out by MS , for example, Sweden has carried out a health impact assessment on the Common Agriculture Policy and it's consequences on healthy eating.

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

Establish an EU School Fruit Scheme similar to the EU school Milk Scheme.

Expand fruit and vegetable programmes like the 'Food Dudes ' programme (UK and Ireland) especially in disadvantaged areas, facilitating children being exposed to a range of fruit and vegetables and aquiring a liking for them.

– **Offer at EU level, better incentives to produce fruit and vegetables .**

– **Educate the small grower, the first link in the food chain, to find ways to increase**

the supply of fresh produce

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?

– **Standardised EU screening tools for assessing conditions, such as obesity in children, need to be established. Using these tools at pan- European national level needs to allow for flexability.**

– **Consumer behaviour on food choices and activity habits needs to be ongoing and trends/changes in behaviour monitored and used to inform policy and actions**

– **MS need assistance in identifying evidence –based healthy eating and activity intervention programmes that work. To fast-track this process , the Commission could establish and support an independent EU research review group for 5 years. This group would develop criteria and review models of best practice. These models of best practice could be made available to MS via an on –line data bank. The recent synthesis of evidence with best practice recommendations for reducing obesity and related chronic disease risk in children and young people would be an excellent starting point. (Flynn et al)**

All MS could access the data bank and chose suitable programmes. These could be pilot-tested and adapted to local situations. Feedback to the working group for effectiveness validation could also be included.

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IV.4. The Public Health Action Programme

IV.4.1. The importance of nutrition, physical activity and obesity is reflected in the Public Health Action Programme[21] and its annual Work Plans. Under the health information strand, the Programme supports activities aimed at collecting more solid data on the epidemiology of obesity, and on behavioural issues[22]. The Programme is putting in place a comparable set of indicators for health status, including in the area of dietary intake, physical activity and obesity.

IV.4.2. Under the health determinants strand, the Programme is supporting pan-European projects aimed at promoting healthy nutrition habits and physical activity, including cross cutting and integrative approaches which foster the integration of approaches on lifestyles, integrate environmental and socio-economic considerations, focus on key target groups and key settings and link work on different health determinants[23].

IV.4.3. The Commission's proposal for a new Health and Consumer protection programme[24] puts a strong focus on promotion and prevention, including in the area of nutrition and physical activity, and foresees a new action strand on the prevention of specific diseases.

Regarding nutrition and physical activity,Ireland welcomes the 2006 focus on the identification of good practice and networking concerning:

- **good practice in school meals and nutritional education programmes,**
- **evaluating campaigns on healthy lifestyle in communities or in targeted population groups,**

- **the effectiveness of educational programmes and of campaigns run by the food industry, retailers, consumer organisations, etc. aiming to promote healthy diets, and**
- **good practice in building architecture and urban development to encourage physical activity and healthy lifestyles.**

Questions on which the Commission invites contributions include:

– How can the availability and comparability of data on obesity be improved, in particular with a view to determining the precise geographical and socio-economic distribution of this condition?

– **Standarised criteria could be drawn up for national nutrition surveillance programmes and national food consumption and lifestyle surveys. These criteria should specify a large enough component of socially disadvantaged to make results statistically significant for this vulnerable group.**

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– 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?

– **Prioritise nutrition and physical activity in all programme activitiets. A needs assessment to establish current level of awareness would be useful. Translation of knowledge into healthy lifestyle behaviour choices is the real challenge. Research to investigate best practice in achieving this would be most useful.**

– **Include nutrition and physical activity in the curriculum for all healthcare professionals**

– **Include healthy eating and physical activity at all levels in schools curriculum. The development of a healthy lifestyle cross- curricular teacher and pupil tool kit with key healthy eating and being active messages could be a useful pan –European mechanism**

– **Provide briefing material/sessions for EU and national media – such as an information news release each month.**

– **Have annual round table meeting in MS, like recent Commission meeting on EU Green Paper in Dublin in Feb 06, and invite decision makers, health professionals, , consumer organizations, national parent councils, national teachers representative organizations and employers federations. The media could perhaps attend a specific part of the meeting or have a separate press meeting.**

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

Through existing EU networks , for example, Network on Nutrition and Physical Activity, EU Platform (and local platforms nationally), and other research dessimination channels such as Relay , Department of Agriculture and Food. Existing news sheets like public sector news could also provide a means of distribution.

An EU healthy lifestyles update web link on the Commission website would also be valuable.

IV.5. European Food Safety Authority (EFSA)

IV.5.1. The European Food Safety Authority can make an important contribution to underpinning proposed actions on nutrition (e. g. on recommended nutrient intakes, or on communication strategies aimed at health professionals, food chain operators and the general public on the impact of nutrition on health) with scientific advice and assistance (*on the role of EFSA in the establishment of food-based dietary guidelines, cf section V.9 below)*

Ireland has commenced a review of the healthy eating guidelines. Our approach will be consistent with the ESFA nutrient goals . We will use the EFSA food-based dietary guidelines report to devise appropriate guidelines for the Irish population.

V. AREAS FOR ACTION

V.1. Consumer information, advertising and marketing

V.1.1. Consumer policy aims to empower people to make informed choices regarding their diet. Information about the nutritional content of products is an important element in this respect. Clear, consistent nutrition information about foods can, along with relevant consumer education, act as the foundation of informed dietary choice. With this objective, the Commission has submitted a proposal for a regulation to harmonise the rules on nutrition on health claims[25]. This includes the principle of setting nutrient profiles, in order to prevent foods high in certain nutrients (such as salt, fat, saturated fat and sugars) making claims about their potential nutrition or health benefits. The Commission is also considering amendments to the current rules on nutrition labelling.

V.1.2. As far as advertising and marketing is concerned, it has to be ensured that consumers are not misled, and that especially the credulity and lacking media literacy of vulnerable consumers and, in particular children, are not exploited. This regards in particular advertising for foods high in fat, salt and sugars, such as energy-dense snacks and sugar-sweetened soft drinks, and the marketing of such products in schools[26]. Industry self regulation could be the means of choice in this field, as it has a number of advantages over regulation in terms of speed and flexibility. However, other options would need to be considered should self-regulation fail to deliver satisfactory results.

Questions on which the Commission invites contributions include:

– When providing nutrition information to the consumer, what are the major nutrients, and categories of products, to be considered and why?

– **Nutrients: Fat (total and saturated and trans fats), calories, carbohydrate, sugar, salt and fibre.**

– **Categories of products: all food groups, especially foods high in fat and /or salt and /or sugar like savoury snacks, confectionary and sugar sweetened drinks. There is convincing evidence that consuming energy-dense micronutrient poor foods increases the risk of obesity (WHO/FAO 2002)**

– **A novel approach to providing nutrition information to the consumer for fast- food products is needed , eg provided mainly by garage forecourt outlets in Ireland needs to be developed.**

– **Large portion sizes eg 'super' and ' mega' also need to provide nutrition information- these large portions, often sold for very little more than regular size portions contain large amounts of fat and or /sugar. Regular portions sizes have increased over the last decade and have led to 'passive over-consumption' of calories. Portion sizes have an influence on weight gain contributing to the rise in overweight and obesity.(N/SIFCS, 2001)**

– 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?

– **An easy to follow labelling system that is pilot tested in a representative number of MS needs to be put in place. An education programme jointly with the food retail sector, eg supermarket tours provide consumers with the necessary skills to make healthy choices at the point of sale.**

Nutrient profiling needs to accepted by the food industry as a means of providing accurate and credible info to the consumer. Adding sterols to reduce cholesterol to foods that contain high levels of fat and cholesterol, and little other nutrition, is misleading to the public, especially socially disadvantaged groups with low literacy skills and low food budgets. Food manufacturers need to accept this, if they genuinely want to work with the Commission and national Governments towards achieving an agenda that has as it's *primary* goal public health.

There are a number of agencies who could provide this information at a national level

The Health Service Executive, Population Health, the Food Safety Authority of

Ireland and the Food Safety Promotion Board (an all –island body)

– 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?

Ireland has decided to consider voluntary codes ("self-regulation") as a first step for limiting the advertising and marketing of energy-dense and micronutrient-poor foods) However , if self- regulation fails, steps will be taken to enforce a mandatory code. (Irish Priminister, Obesity Strategy launch, 2005)

The Food Industry can make an important contribution to the challenge of reducing levels of obesity, if they accept that healthy, tasty products will sell. Take low fat milk as an example, 20 years ago, sectors of the dairy industry challenged this – however low fat milk now has a strong market share in many countries .

All food manufacturers should follow the lead of those who have already diversified into making healthy food alternatives, especially healthy convenience foods for which

there is a growing market.

An EU food manufacturer mechanism could be established where by a set target, for example, a minimum percentage of total food products company be reformulated so they comply with approved health criteria. This could be done over a 5 year period , as is happening *with forward thinking* manufacturers of salt containing foods.

The Broadcasting Commission of Ireland has implemented a Children's Advertising Code. This Code is a positive step forward in protecting children up to eighteen years old, from the pressure of advertising of unhealthy foods. The Code is currently being reviewed after one year in operation.

– 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?

– **Specific criteria for self-regulation be need to be defined, implemented and monitored. These will need to be drawn up by a monitoring group which includes nutrition experts. (Hastings)**

– **The issue of media literacy for vulnerable groups, especially children needs to be examined and controlled.**

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V.2. Consumer education

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V.2.1. Improving public knowledge on the relationship between diet and health, energy intake and output, on diets that lower risk of chronic diseases, and on healthy choices of food items, is a prerequisite for the success of any nutrition policy, whether at national or Community level. Consistent, coherent, simple and clear messages need to be developed, and disseminated through multiple channels and in forms appropriate to local culture, age and gender. Consumer education will also contribute to creating media literacy, and enable consumers to better understand nutrition labelling.

Questions on which the Commission, in view of identifying best practices, invites contributions include:

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

– **New evidence- based strategies creating the key effective actions of awareness , knowledge and behaviour change need to be developed and implemented. These intervention programmes need to be relevant to the target audience. Priority needs to be given to children and socially disadvantaged groups, as these groups in society are the most vulnerable.**

-Ongoing education and information needs to be assessable in relevant settings throughout the lifestages, for example children, adolescents, pregnant mothers, employees

– **School lessons on healthy lifestyles, nutrition and cooking skills for all school children** .

– What contributions can public-private partnerships make toward consumer education?

– **Public – private partnerships can make positive contributions towards consumer adult programmes when there is a clear understanding by the partnership that public health is the primary goal. The issue of educating children is different. Given their lower literacy level and their vulnerability, their nutrition education should be undertaken by public services only.**

– 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?

Key Messages for consumers

- **A high intake of energy dense foods and sugary drinks can lead to weight gain.**
- **High proportions of food prepared outside the home and large portion sizes may contribute to obesity.**
- **Regular physical activity protects against weight gain and obesity.**
- **Adults and children are not meeting physical activity recommendations.**
- **Adults require 45-60 minutes of moderate intensity activity to prevent the transition to overweight or obesity; 60-90 minutes per day for weight loss and the maintenance of weight loss.**
- **Children should be involved in at least 60 minutes of moderate physical activity each day.**

A cross- sectional approach should be taken regarding delivering these messages.

They should be delivered by the relevant state agencies and government departments, and public/private partnership is also an option.

The EU Health And Consumer Protection Directorate could set up a Register of health claims by food and drink companies regarding their overall marketing policies and commitment to providing accurate consumer communication.

Messages that encourage healthy eating and active living, especially those aimed at children and vulnerable groups, should be undertaken by relevant state agencies and government departments.

V.3. A focus on children and young people

V.3.1. Important lifestyle choices pre-determining health risks at adult age are made during childhood and adolescence; it is therefore vital that children be guided towards healthy behaviours. Schools are a key setting for health-promoting interventions, and can contribute to the protection of children's health by promoting healthy diets and physical activity. There is also growing evidence that a healthy diet also improves concentration and learning ability. Moreover, schools have the potential to encourage children to undertake daily physical activity[27]. Relevant measures could be considered at the appropriate level.

V.3.2. In order to avoid that children are exposed to conflicting messages, health education efforts by parents and in schools need to be supported by efforts from the media, health services, civil society and relevant sectors of industry (positive role models…) *(for marketing towards children, cf section V.1).*

Key issues include

Maternal nutrition; genetic predisposition; parents health status, especially their weight; breast-feeding practices; parents' health knowledge and budgeting, shopping and cooking skills

More family meals should be promoted as research shows that families who eat together have healthier eating habits. Looking at the family as a unit provides many opportunities to discuss and raise awareness of health issues across the lifespan.

Shaping the school services towards health promoting settings is important. This also includes crèches, pre-schools and all third level educational institutions. This would strengthen the capacity of these settings for healthy eating and active living particularly in settings that provide catering services.

Protection for children from advertising and marketing techniques that sustain the pressure to adopt unhealthy patterns of consumption and activity.

All actions need to be based on evidence based information and training. Research into changing behaviours of children and sustaining these changes needs to be ongoing and could be undertaken at an EU level, and the key recommendations shared with MS.

Questions on which the Commission, in view of identifying best practices, invites contributions include:

– 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?

- All schools, as part of their school development planning, should be encouraged to develop consistent school policies to promote healthy eating and active living, with the necessary support from the Departments. Such policies should address opportunities for physical activity, what is being provided in school meals, including breakfast clubs, school lunches and, in the case of primary schools in partnership with parents, children's lunch boxes.

Food &Nutrition Guidelines for preschools, primary schools and post- primary schools and third level institutions are good examples of improving the nutritional value of school meals. Ireland has drawn up Guidelines for these groups (except for third level institutions and can share these with other MS. These Guidelines have been developed following national consultation and are provided at training sessions organised for preschool leaders/school teachers.

In developing guidelines, MS need to

- **analyse the nutritional value of existing school meals**
- **develop an evidence base on the nutritional concerns of the target audience**
- **draw up Food and Nutrition Guidelines for schools**
- **have multi- stakeholder consultation**
- **provide training sessions, and only schools who have completed training should be given the guidelines.**
- **A monitoring system should be put in place and schools supported by local health promotion teams**

All the above should be carried out for each schools population- preschools, primary schools, post- primary schools and colleges.

In MS where schools meals are not widely available, like Ireland, a scheme needs to be put in place for socially disadvantaged children, to ensure that these children have sufficient nourishment to allow them to take full advantage of the education being provided to them. Education is a key factor in facilitating disadvantaged children in moving out of the poverty trap.

A School Food Scheme for socially disadvantaged children is available in Ireland and nutrition guidelines for meals are available.

To improve the nutritional value of home meals, food buying, preparation and cooking skills can be taught through local community programmes, using schools and commumity premises. The national parents' organisations for primary and post-primary schools should work with parents and support them in encouraging healthy eating and active living.

Skills programmes which teach and develop training in basic food preparation and budgeting should be introduced in schools. Schools can also support parents by organising parent meetings and cooking skills workshops on healthy eating and healthy cooking.

– What is good practice for the provision of physical activity in schools on a regular basis?

All schools, as part of their school development planning, should be encouraged to develop consistent school policies to promote healthy eating and active living, with the necessary support from the Department of Education and Science. Such policies should address opportunities for physical activity, what is being provided in school meals, including breakfast clubs, school lunches and, in the case of primary schools in partnershipwith parents, children's lunch boxes.

The emphasis in all schools should be on increased physical activity including participation in sports.

With a view to achieving the optimum 60 minutes of physical activity per day recommendation (excluding PE time) every child should be enabled, through restructuring the school day if necessary, to achieve a minimum of 30 minutes dedicated physical activity every day in all educational settings.

Schools should develop increasing opportunities for physical activity that are inclusive and that are appropriate to age, gender, and ability, such as those that concentrate on increasing physical activity among teenage girls.

Regular activity during class or break time needs to be mandatory. Physical activity programmes may need to be adapted for overweight children, for example strength training.

All schools should meet the minimum requirement of two hours of physical education per week delivered by appropriately qualified staff.

Nutrition and physical activity levels of school children should be seen as part of the duty of care of the school.

– 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?

– **School Healthy Eating Policies, including school lunch and school break policies, are an ideal way of making healthy choices available, esp healthy alternatives in Tuck shops and vending machines. In developing these healthy eating policies, children, parents and teachers should work together. A healthy eating policy can be included in Food & Nutrition Guidelines for schools.**

-School catering services, where appropriate, such as in designated disadvantaged schools, should provide food of high nutritional quality.

– 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?

– **All the above sectors can support health education efforts made by schools by working together in line with national Food and Nutrition Guidelines, which have children's health as their key objective. There are opportunities also to support Healthy Breakfast clubs, afterschool food and initiatives taken to reduce Food Poverty in disadvantaged schools.**

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

V.4.1. Work places are a setting which has a strong potential to promote healthy diets and physical activity. Canteens that offer healthy choices, and employers who foster environments which facilitate the practice of physical activity (e. g. provision of showers and changing rooms) can make important contributions towards health promotion at the workplace.

> Questions on which the Commission, in view of identifying best practices, invites contributions include:
>
> – How can employers succeed in offering healthy choices at workplace canteens, and in improving the nutritional value of canteen meals?
>
> **– Employers in Ireland can enrol for the Happy Heart at Work programme, a good example of a joint initiative by the Irish Heart Foundation and the Health Promotion Unit, Department of Health. This programme has a healthy eating component , which includes a dietitian carrying out an audit of the workplace and awarding a certificate to workplaces that put in place healthy eating practises. A Department guide, with examples of good practise is also available from the Department of Health – Healthy Bodies/Healthy Work**
>
> – What measures would encourage and facilitate the practice of physical activity during breaks, and on the way to and from work?
>
> **– The Happy Heart at Work programme also has a physical activity component which is often undertaken in conjunction with a physical activity 'Lifestyle Challenge' where large numbers of employees commit to physical activity over a number of weeks.**

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

V.5.1. Health services and health professionals have a strong potential for improving patients' understanding of the relations between diet, physical activity and health, and for inducing necessary lifestyle changes. Patients could receive important stimuli for such changes if health professionals included in routine contacts practical advice to patients and families on the benefits of optimal diets and increased levels of physical activity. Obesity treatment options need also to be addressed[28].

> Questions on which the Commission invites contributions include:
>
> – Which measures, and at what level, are needed to ensure a stronger integration aiming at promoting healthy diets and physical activity into health services?

All health professionals have a role in the management of childhood and adult obesity

- **General practioners, clinical dietitians, behavioural therapists and practice nurses teams have a role in treating overweight and obesity. At a community level, community dietitians, physical activity health promotion officers have a role in health promotion and supporting overweight and obese individuals.**

- **Midwives meet women in early pregnancy and provide continuity of care up to and including the postnatal period. Midwifery care provides many opportunities to support breast-feeding and to promote good nutrition for mother, baby and family thus promoting healthy lifestyles.**

- **Public health nurses because of their wider remit in the community also provide care across the lifespan and have regular contact with families, infants and children from birth through to school going age.**

- **Additional, public heath nurses also provide school health services and have contact with a variety of client groups, agencies and support groups in the community.**

- **The development of primary care teams incorporating an interdisciplinary team-based approach to care has the potential to provide a broad range of skills that could be maximised in the management of obesity.**

- **The nursing/midwifery function within primary care teams may include public health nurses, practice nurses, midwives, general nurses and other nurses . Nurses and midwives have a pivotal role to play in leading, co-ordinating and evaluating initiatives in the prevention, detection and management of adult and childhood obesity in collaboration with GPs, community dieticians, other healthcare professionals and educators in the community.**

- **Standardised detection and assessment criteria should be used by all health professionals – see appendix 1. Training and ongoing research should also be supported.**

V.6. Addressing the obesogenic environment

.

V.6.1. Physical activity can be integrated into daily routine (e. g. walking or cycling instead of using motorized transport in order to get to school or work). Transport and urban planning policies can ensure that walking, cycling and other forms of exercise are easy and safe, and address non-motorised modes of transportation. The provision of safe cycling and walking paths to schools could be one means to address the particular worrying trends for overweight and obesity in children.

V.6.1. Physical activity can be integrated into daily routine (e. g. walking or cycling instead of using motorized transport in order to get to school or work). Transport and urban planning policies can ensure that walking, cycling and other forms of exercise are easy and safe, and address non-motorised modes of transportation. The provision of safe cycling and walking paths to schools could be one means to address the particular worrying trends for overweight and obesity in children.

Several barriers contribute to the Obesogenic Environment.

- **Specific strategies/actions need to be developed and implemented within a specified timeframe to address each of the barriers.**

- **For example, some actions need to be directed specifically at the food industry while others need to focus on media messages and sponsorship that links the promotion of high-energy foods with sporting and other physical and outdoor activities.**
- **This requires interdepartmental collaboration along with input from healthcare professionals and teachers.**

- **The"obesogenic environment" which promotes obesity by simultaneously restricting mobility and stimulating higher calorie intake should be the key target for change, involving the full range of government departments as well as the private sector.**

Questions on which the Commission invites contributions include:

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

The Priminister/Taoiseach’s office should take the lead responsibility and provide an integrated and consistent proactive approach to addressing overweight and obesity and to the implementation, monitoring and evaluation of the national policies on Obesity in conjunction with all government departments, relevant bodies and agencies, industry and consumer groups.

Research to examine the influence of fiscal policies on consumer purchasing and their impact on overweight and obesity, for example risk-benefits assessment of taxation that supports healthy eating and active living, subsidies for healthy food such as fruit and vegetables.

Ireland should play an advocacy role within the European Union to reform policies relating to healthy eating and active living among those that govern activities relating to global trade and the regulation of marketing and advertising of food to children.

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

Departments of the Environment should develop coherent planning policies for urban/rural housing, transport, amenity spaces and workplace settings to encourage spontaneous increases in physical activity in adults and children.

Departments of Trade and Employment should ensure that future safety, health and welfare at work legislation promotes and protects health with a particular emphasis on healthy eating and active living.

Financial Services Regulatory bodies should examine the high costs of public liability and their impact on physical activity. It should foster initiatives to address these costs.

Departments of Trade and Employment, the electronic leisure industry and consumer groups should review the design, production and marketing policies surrounding products that impact on healthy eating and active living, particularly in relation to children.

Departments of Transport should
apply a specifically designated percentage of all road budgets to the construction of safe walkways and cycleways.
increase the provision of safe and efficient public transport and set targets for the reduction of car use.

Local environment authorities should
- ensure that their mission statements, corporate plans and planning policies take account of their impact on healthy living.
- work in partnership with community groups to actively promote sporting and leisure opportunities that support active living.
- ensure that sports, recreational, leisure, and play facilities are available, accessible and equitable to all members of the public.
- prioritise pedestrianisation and cycling and ensure that there is adequate provision for these amenities.
- in partnership with local communities and the gardaí should ensure the provision and maintenance of safe and accessible green spaces for physical activity. They should be supported by government in this and related work.

V.7. Socio-economic inequalities

V.7.1. Food choice is determined by both individual preferences and socio-economic factors[29]. Social position, income and education are determinants of diet and physical activity. Certain neighbourhoods could discourage physical activity, lack recreation facilities and affect the disadvantaged more than those who can afford or have access to transportation. Lower levels of education and poorer access to relevant information reduce the capacity to make informed choices.

Questions on which the Commission invites contributions include:

– Which measures, and at what level, would promote healthy diets and physical activity towards population groups and households belonging to certain socio-economic categories, and enable these groups to adopt healthier lifestyles?

Mea**sures at both a national and local level are important:**

Departments of Social welfare (assistance) payments to take account of the relatively high cost of healthy foods for socially disadvantaged groups

Access to a healthy diet (for example fruit and vegetables) should be included as an indicator to measure food poverty as part of the national anti-poverty agreements and the social inclusion.process.

Specific examples of community initiatives are discussed below.

– How can the "clustering of unhealthy habits" that has frequently been demonstrated for certain socio-economic groups be addressed?

Peer-led community development programmes should be fostered and developed to encourage healthy eating and active living. These programmes should be prioritised for lower socio-economic groups, ethnic minority groups, early school leavers, people with learning and physical disabilities and they should be based on the principle of developing self-esteem and empowerment.

Community skills-based programmes should be developed which provide skills such as food preparation, household budgeting, and those skills which have the potential to promote physical activity

Building on the work undertaken by community groups, community initiatives should be developed to tackle the issues of food poverty and accessibility through local food programmes and co-operatives

Existing and future parenting courses within communities should develop and implement healthy eating and active living education as part of their programmes

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

V.8.1. A coherent and comprehensive approach aimed at making the healthy choices available, affordable and attractive involves taking account of mainstreaming nutrition and physical activity into all relevant policies at local, regional, national and European levels, creating the

necessary supporting environments, and developing and applying appropriate tools for assessing the impact of other policies on nutritional health and physical activity[30].

V.8.2. The prevalence of chronic conditions related to diet and physical activity can vary greatly between men and women, age groups, and between socio-economic strata. Moreover, dietary habits, as well as physical activity behaviours, are often embedded in local and regional traditions. Therefore, approaches aimed at promoting healthy diets and physical activity need to be sensitive to gender, socio-economic and cultural differences, and to include a life-course perspective.

Questions on which the Commission invites contributions include:

– Which are the most important elements of an integrated and comprehensive approach towards the promotion of healthy diets and physical activity?

– **Addressing the social determinants of health are the most important elements to be addressed**

– **Environmental changes, especially those that relate to the obesogenic environment are also very important, as these facilitate making the healthier choice the easier choice.**

– **At the individual level, developing skills relating to self-esteem and empowerment are also important**

– Which role at national and at Community level?

– **At an EU Community level, health- proofing all EU policies that relate to the obesogenic environment areimportant to facilitate making the healthier choice the easier choice. Major policies relating to food and being active should be subjected to Health Impact Surveys.**

– **The Community should also continue to provide a forum for the sharing of best practise among MS. Supporting ongoing research is also important.**

– **At a national level, addressing the social determinants of health is crucial. Public policies should also be health- proofed to facilitate making the healthier choice the easier choice. Major policies relating to food and being active should be subjected to Health Impact Surveys.**

– **Other suggestions are included throughtout this response.**

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

V.9.1 The WHO/FAO Report[31] provides general recommendations on population nutrient intake and physical activity goals in relation to the prevention of major non- communicable diseases.

V.9.2. The Eurodiet project[32] has proposed quantified population goals for nutrients, and underlines the need for these to be translated into food-based dietary guidelines (FBDGs). FBDGs need to be based on customary dietary patterns, and take socio-economic and cultural factors into account.

V.9.3. The Commission has asked the European Food Safety Authority (EFSA) to update the advice on energy, macronutrients and dietary fibre. Following on from this, EFSA will also advise on population reference intakes of micronutrients in the diet and, if considered appropriate, other essential substances with a nutritional or physiological effect in the context of a balanced diet. Moreover, EFSA will provide advice on the translation of nutrient based dietary advice into guidance on the contribution of different foods to an overall diet that would help to maintain good health through optimal nutrition. .

Questions on which the Commission invites contributions include:

– 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?

– **The suggested EFSA approach of developing nutrient based dietary goals and providing a guidance document on developing Food –Based Dietary Guidelines to support MS national governments in drawing up Food –Based Dietary Guidelines is a positive task.**

– **Funding to implement this task should be given priority**

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

The gaps can be overcome by implementing, monitoring and evaluating national healthy eating and physical activity initiatives.

– How can dietary guidelines be communicated to consumers?

– **Guidelines can be communicated through awareness and education programmes , supported by changing behaviour interventions at local level eg supermarket tours and healthy cooking skills development initiatives**

– In which way could nutrient profile scoring systems such as developed recently in UK contribute to such developments[33]?

– **Nutrient profiling scoring systems could contribute through using nationally agreed standardised criteria. Standardised criteria between close trading MS would also be important to provide the consumer with accurate, consistent information.**

V.10. Cooperation beyond the European Union

V.10.1. Some reflection is currently taking place at international level as regards the global involvement of Codex Alimentarius[34] in the field of nutrition. In line with the request in the WHO Global Strategy on Diet, Physical Activity and Health, the EU supports the view that general consideration should be given to how nutrition issues should be integrated into Codex work, while retaining the current mandate of Codex.

V.10.2. Nutrition, diet and physical activity should be the subject of close cooperation between regulators and stakeholders in the EU and in other countries where rising levels of overweight and obesity are of concern[35].

Questions on which the Commission invites contributions include:

– 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?

– **The WHO Second Food and Nutrition Action Plan could be useful vehicle to exchange experience and identify best practice between the EU and non-EU countries. The WHO Ministerial Conference could also be used as a vehicle , as could the existing networks like the EU Nutrition and Physical Activity network and the WHO national counterparts meetings.**

V.11. Other issues

Questions on which the Commission invites contributions include:

– 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?

– **All major issues are addressed in the Green Paper. Focusing on changing the obesogenic environment and looking in more detail at disadvantaged groups and how to support them in addressing health inequalities needs more attention and a higher profile.**

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

– **Promoting healthy diets and physical activity among children, young people and socially disadvantaged groups , especially the young should receive first priority.**

– **Community initiatives to address these vulnerable groups are suggested in this response** .

VI. NEXT STEPS

VI.1. The Commission services will carefully analyze all contributions received in reply to the consultation process launched by the present Green Paper. It is expected that a report summarizing the contributions will be published on the Commission's website by June 2006.

VI.2. In the light of the results of the consultation process, the Commission will reflect upon the most appropriate follow-up, and will consider any measures that may need to be proposed, as well as the instruments for their implementation. Impact assessment will be carried out as appropriate, depending on the type of instrument chosen.

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APPENDIX 1

- **For detection:**
- **-set standards for commercial or self-help groups in the community**
- **-develop new systems to allow patients to identify their own risk**
- **-develop criteria to alert both patient and health care professionals of**

- **excess weight in all patients attending for any episode of health care**
- **-screen obese patients' children to allow for preventative action or**
- **early therapeutic intervention**
- **-develope tools for health professionals to identify and screen those needing**

referral to GPs.

- **-paediatricians could develop simple appraisal methods to enable**
- **schools/families and their health centres to identify when children are**
- **becoming obese.**
-
- **For assessment:**

-agreement on the criteria for categorising children's weights

- **-large-scale standardised surveys of children's current weight status- eg HBSC- measured**
- **-repeated sampling within age groups to monitor emerging trends (HBSC)**
- **-repeated sampling of cohorts to establish sequential developments9?HBSC also)**
- **-surveys of the incidence of obesity-related disorders,for example, type 2 diabetes.NB**
-
- **For treatment: some of these are probably done and included in treatment/management working group recs**
-
- **-develope guidelines on managing childhood obesity -**
-
- **-agree standardised protocols for managing adult obesity and related conditions**
-
- **-train nurses to run weight management groups with dietary and exercise schemes set up with the dietetic profession, and exercise and behavioural specialists.**

- **All health professionals , particularly GPs, dietitians, behavioural therapists, practice nurses and Heartwatch teams can provide support for these initiatives.**
-

- **-leisure and sports centres could be charged with developing new ways of**
- **bringing in obese groups for strength training and other non-competitive activity**
-
- **-schools could take on a new community role after school hours by the use**
- **of their kitchen and playing fields in conjunction with local weight**
- **management initiatives.**
-
- **Government departments and individuals who can lead, co-ordinate and evaluate these initiatives should**
- **be identified.**

ANNEX 1

Figures and Tables

Table 1
Prevalence estimates of diabetes mellitus

	estimate	**estimate**
Country	prevalence	prevalence
Austria	9.6	11.9
Belgium	4.2	5.2
Cyprus	5.1	6.3
Czech Republic	9.5	11.7
Denmark	6.9	8.3
Estonia	9.7	11.0
Finland	7.2	10.0
France	6.2	7.3
Germany	10.2	11.9
Greece	6.1	7.3
Hungary	9.7	11.2
Ireland	3.4	4.1
Italy	6.6	7.9
Latvia	9.9	11.1
Lithuania	9.4	10.8
Luxembourg	3.8	4.4
Malta	9.2	11.6
Netherlands	3.7	5.1
Poland	9.0	11.0
Portugal	7.8	9.5
Slovakia	8.7	10.7
Slovenia	9.6	12.0
Spain	9.9	10.1
Sweden	7.3	8.6
United Kingdom	3.9	4.7

source: Diabetes Atlas, 2nd edition, International Diabetes Foundation 2003

Fig. 2: Deaths in 2000 attributable to selected risk factors (European region) (source: World Health Report 2002)

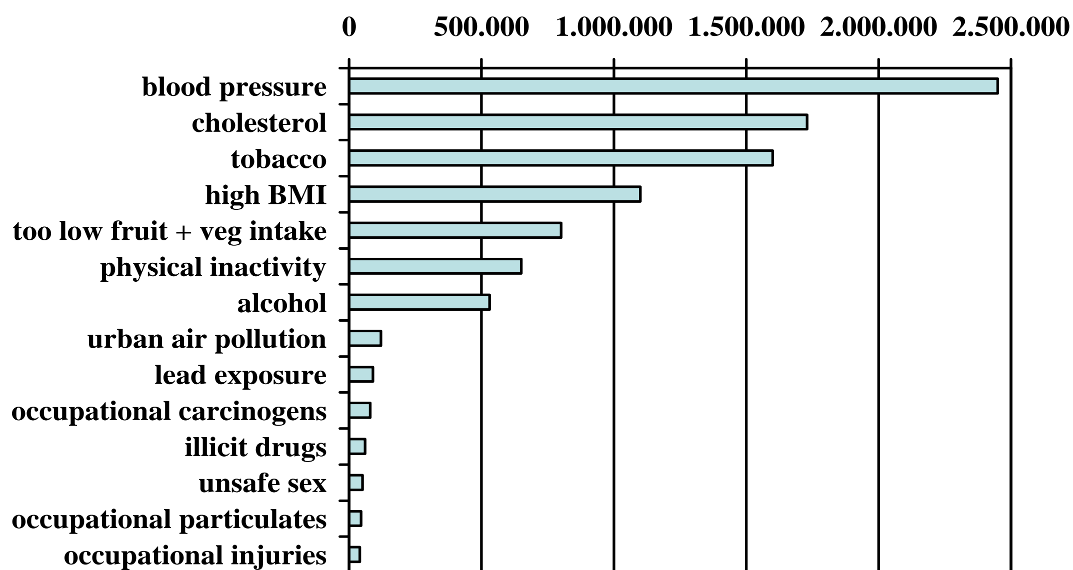


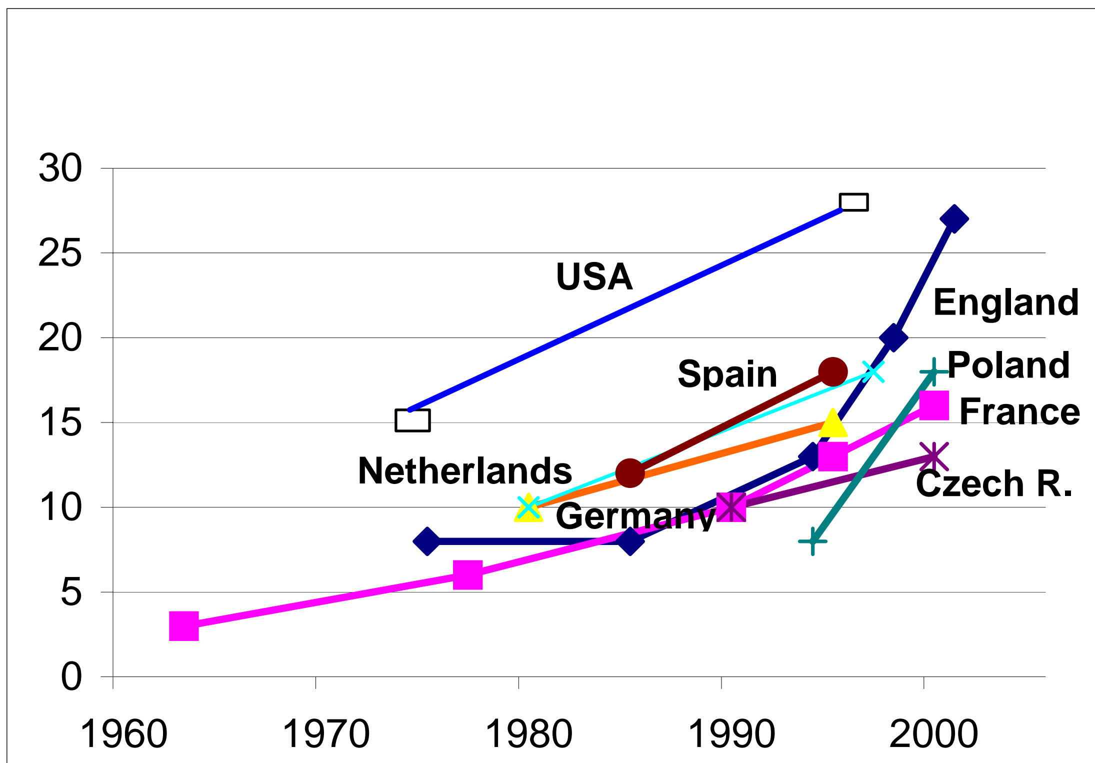
Table 2 - Overweight and obesity among adults in the European Union							
		Males			Females		
Country	Year of Data Collection	%BMI[1] 25-29.9	%BMI≥30	%Com-bined BMI ≥25	%BMI 25-29.9	%BMI ≥30	%Combined BMI≥25
Austria	1999	40	10	50	27	14	41
Belgium	1994-7	49	14	63	28	13	41
Cyprus	1999-2000	46	26.6	72.6	34.3	23.7	58
Czech Republic	1997/8	48.5	24.7	73.2	31.4	26.2	57.6
Denmark	1992	39.7	12.5	52.2	26	11.3	37.3
England[2]	2003	43.2	22.2	65.4	32.6	23.	55.6
Estonia *(self reported)*	*1994-8*	*35.5*	*9.9*	*45.4*	*26.9*	*15.3*	*42.2*
Finland	1997	48	19.8	67.8	33	19.4	52.4
France *(self reported)*	*2003*	*37.4*	*11.4*	*48.8*	*23.7*	*11.3*	*35*
Germany	2002	52.9	22.5	75.4	35.6	23.3	58.9
Greece	1994-8	51.1	27.5	78.6	36.6	38.1	74.7
Hungary	1992-4	41.9	21	62.9	27.9	21.2	49.1
Ireland	1997-99	46.3	20.1	66.4	32.5	15.9	48.4
Italy *(self reported)*	*1999*	*41*	*9.5*	*50.5*	*25.7*	*9.9*	*35.6*
Latvia	1997	41	9.5	50.5	33	17.4	50.4
Lithuania	1997	41.9	11.4	53.3	32.7	18.3	51
Luxembourg		45.6	15.3	60.9	30.7	13.9	44.6
Malta	1984	46	22	68	32	35	67
Netherlands	1998-2002	43.5	10.4	53.9	28.5	10.1	38.6

[1] BMI = Body Mass Index: a person's weight in kg divided by (height in metres)^2 ; persons with a BMI between 25 and 30 are considered overweight, persons with a BMI >30 are considered obese

[2] Data from Health Survey for England, which does not include data for Scotland, Wales and Northern Ireland

Poland *(self report)*	*1996*	*n/a*	*10.3*	*n/a*	*n/a*	*12.4*	*n/a*
Portugal (urban)	Published 2003	n/a	13.9	n/a	n/a	26.1	n/a
Slovakia	1992-9	49.7	19.3	69	32.1	18.9	51
Slovenia *(self reported)*	*2001*	*50*	*16.5*	*66.5*	*30.9*	*13.8*	*44.7*
Spain	1990-4	47.4	11.5	58.9	31.6	15.3	46.9
Sweden *(adjusted)*	1996-7	41.2	10	51.2	29.8	11.9	41.7
Age range and year of data in surveys may differ. With the limited data available, prevalences are not standardised. Self reported surveys may underestimate true prevalence. Sources and references are from the IOTF database (© International Obesity Task Force, London – March 2005)							

Fig. 2: Rising prevalence of overweight in children aged 5-11 (source: IOTF)



ANNEX 2 - Relationship between diet, physical activity and health

1. The relationship between diet, physical activity and health has been scientifically established, in particular regarding the role of lifestyles as determinants of chronic non-communicable diseases and conditions such as obesity, heart disease, type 2 diabetes, hypertension, cancer and osteoporosis[36].

2. Particularly alarming is the increase in the prevalence of **diabetes** *(cf table 1, Annex 1)*. Type-2-diabetes, which accounts for over 90% of diabetes cases worldwide, is related to obesity, a sedentary lifestyle and diets high in fat and saturated fatty acids. Both prevention and treatment of type-2 diabetes need to focus on lifestyle changes (weight loss, physical activity, diets low in fat and saturated fatty acids)[37].

3. **Cardiovascular diseases** (CVD) are together with cancer the most important causes of death and disease in Europe. Stopping smoking, increasing physical activity levels and adopting healthier diets are the most important factors in the primary prevention of CVD. The key recommendations for CVD prevention are maintenance of normal body weight, moderate physical activity of 30 minutes or more every day and avoidance of excess consumption of saturated fatty acids and salt.

4. Dietary factors are estimated to account for approximately 30% of all **cancers** in industrialized countries[38], making diet second only to tobacco as a theoretically preventable cause of cancer. Consumption of adequate amounts of fruits and vegetables, and physical activity, appear to be protective against certain cancers. Body weight and physical inactivity together are estimated to account for approximately one-fifth to one-third of several of the most common cancers[39].

5. **Osteoporosis** is a disease in which the density of bones is reduced, increasing the risk of fracture. Around the world, it affects one in three women and one in five men over the age of fifty. Although genetic factors will determine whether an individual is at heightened risk of osteoporosis, lifestyle factors can influence the acquisition of bone mass in youth and the rate of bone loss later in life. The joint WHO/FAO expert consultation[40] concludes that dietary and lifestyle recommendations developed for the prevention of other chronic diseases may prove helpful to reduce osteoporosis risk.

6. The *World Health Report 2002*[41] describes in detail how a few **major risk factors** account for a significant proportion of all deaths and diseases in most countries *(cf figure 1, Annex 1)*. Six out of the seven most important risk factors for premature death (blood pressure, cholesterol, Body Mass Index, inadequate fruit and vegetable intake, physical inactivity, excessive alcohol consumption) relate to diet and physical activity (the odd one out being tobacco). Unhealthy diets and lack of physical activity are therefore the leading causes of avoidable illness and premature death in Europe.

7. The **underlying determinants** of the risk factors for the major chronic diseases portrayed above are largely the same. Dietary risk factors include shifts in the diet structure towards diets with a higher energy density (calories per gramme) and with a greater role for fat and added sugars in foods; increased saturated fat intake (mostly from animal sources) and excess intake of hydrogenated fats; reduced intakes of complex carbohydrates and dietary fibre; reduced fruit and vegetable intakes; and

increasing portion sizes of food items. Other important lifestyle-related risk factors, apart from smoking and excessive alcohol consumption, include reduced levels of physical activity. Of particular concern is the increasingly unhealthy diet and physical inactivity of adolescents and children.

8. As relatively few risk factors cause the majority of the chronic disease burden, the related morbidity and mortality is to a great extent preventable. It is estimated that up to 80% of cases of coronary heart disease, 90% of type 2 diabetes cases, and one-third of cancers can theoretically be avoided if the whole population followed current guidelines on diet, alcohol, physical activity and smoking. Addressing lifestyle factors such as nutrition and physical activity therefore has an enormous potential for the prevention of severe morbidity and mortality.

9. **Obesity** (BMI[42] >30) is a risk factor for many serious illnesses including heart disease, hypertension, stroke, type-2-diabetes, respiratory disease, arthritis and certain types of cancer. The rising prevalence of obesity across Europe *(cf. Annex 1, table 2)*, particularly among young people *(cf. Annex 1, fig. 2)*, has alarmed health experts, the media and the population at large, and is a major public health concern.

10. Evidence from population surveys suggests that obesity levels in the EU have risen by between 10-40% over the past decade, and current data suggest that the range of obesity prevalence in EU countries is from 10% to 27% in men and up to 38% in women[43]. In some EU countries more than half the adult population is overweight[44] (BMI >25), and in parts of Europe[45] the combination of reported overweight and obesity in men exceeds the 67% prevalence found in the USA's most recent survey[46]. Despite efforts by individuals the loss of health to the population as a whole due to unhealthy diets and inactivity is extraordinarily high: a small increase in Body Mass Index (BMI), e. g. from 28 to 29, will increase the risk of morbidity by around 10 % [47].

11. The number of EU children affected by overweight and obesity is estimated to be rising by more than 400,000 a year, adding to the 14 million-plus of the EU population who are already overweight (including at least 3 million obese children); across the entire EU25, overweight affects almost 1 in 4 children[48]. Spain, Portugal and Italy report overweight and obesity levels exceeding 30% among children aged 7-11. The rates of the increase in childhood overweight and obesity vary, with England and Poland showing the steepest increases[49].

12. The factors underlying the onset of obesity are widely known (high intake of energy dense micronutrient poor foods or sedentary lifestyles are the most convincing factors determining obesity risk; high intake of sugars sweetened soft drinks and fruit juices, heavy marketing of energy dense foods or adverse socioeconomic conditions are also probable determining factors. High intake of non starch polysaccharides and regular physical activity are convincing factors lowering obesity risk; breastfeeding and home or school environments supporting healthy food choices for children are also probable lowering factors). It should however be borne in mind that for some people it is going to be harder to maintain a healthy weight than for others because they are genetically disposed to storing fat, or because they have genetic dysfunctions which make it difficult for them to control the feeling of hunger. In fact, even if some scientists[50] estimate that 40-70% of the variation in fat mass between individuals is determined by genetic factors, environmental factors remain important and determine the expression

of these genes in individuals; addressing the "obesogenic environment" (*cf section V.6*) therefore has a strong potential to curb obesity[51].

13. While the effects of diet and **physical activity** on health often interact, particularly in relation to obesity, there are additional health benefits from physical activity that are independent of nutrition and diet. Likewise, there are significant nutritional risks that are unrelated to obesity.

14. Weight gain in an individual is the result of an excess of energy consumed as food over energy expenditure. There is a strong tendency for excess weight to continue to accumulate from childhood through to middle age. It is therefore important to achieve an optimum body weight throughout life through proper diet and daily physical activity. In addition to promoting overall feelings of wellbeing and apart from weight management aspects, physical exercise has also independent positive effects on the prevention of diseases such as cardiovascular disease, type II diabetes, osteoporosis and depression, and contributes to maintaining muscular strength in older age.

15. To maintain cardiovascular health, the recommended daily amount of exercise is at least 30 minutes for most of the days of the week. There is no general agreement on the level of physical activity needed to prevent weight gain, but a total of one hour on most days of the week is probably needed. However, all physical activity increases energy consumption and contributes to weight management[52].

16. A 2003 Eurobarometer survey[53] showed that around 60 % of Europeans (EU 15) had no vigorous physical activity at all in a typical week, and more than 40 % did not even have moderate physical activity in a typical week. Europe-wide, only about one third of schoolchildren appear to be meeting recognised physical activity guidelines[54]. Exercising seems to be more common among people who claim they eat healthily and do not smoke, which is in line with the generally observed "clustering of good habits".

17. The **WHO Global Strategy on diet, physical activity and health** was adopted by the World Health Assembly in May 2004[55] as an outcome of a global consultation process and consensus-building exercise. The Global Strategy underlines the importance of achieving a balanced diet reducing the consumption of fats, free sugars and salt, of increasing the intake of fruits, vegetables, legumes, grains and nuts, and of performing moderate physical activity during at least 30 minutes a day.

18. The Community has actively supported the WHO Global Strategy process since its beginning. The Global Strategy can serve as an extremely valuable input in the development of a comprehensive Community action on nutrition and physical activity, and active use should be made of the scientific evidence underpinning it[56] when building the rationale for a broad Community strategy in this area.

ANNEX 3 – References

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2. Council Resolution of 14 December 2000 on health and nutrition (2001/C 20/01) - Official Journal of the European Communities C 20/1 of 23.1.2001
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6. Council conclusions on obesity, op. cit.
7. Council conclusions on obesity, op. cit.
8. Opinion of the European Economic and Social Committee on Obesity in Europe – role and responsibilities of civil society partners, SOC/201**,** September 2005 http://eescopinions.esc.eu.int/EESCopinionDocument.aspx?identifier=ces\soc\soc201\ces1070-2005_ac.doc&language=EN
9. Member States launched in recent years a number of initiatives to promote healthy nutrition and physical activity. Some Member States like Ireland (http://www.healthpromotion.ie/topics/obesity/) and Spain (http://www.msc.es/home.jsp) established National Strategies to counter obesity, involving Public Administrations, independent experts, the food industry, the physical activity sector, NGOs etc. in multi-sectorial actions aimed at promoting healthier diets and physical activity. France launched in 2001 a four year national healthy nutrition plan (http://www.sante.gouv.fr/), covering a wide range of measures at the inter-sectorial level, with the objective to reduce the prevalence of obesity and overweight. More recently, in March 2005 the Slovenian Parliament approved a National Nutrition Policy Programme for 2005–2010 (http://www2.gov.si/mz/mz-splet.nsf). The Netherlands integrated obesity as one of the priorities of its national health care prevention policy (http://www.minvws.nl/). Nutrition and physical activity are also mentioned as an important area for public heath action in the United Kingdom's White Paper Choosing health: making healthier choices easier, released in November 2004 (http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5Cor). Germany established a national platform for nutrition and physical activity (http://www.ernaehrung-und-bewegung.de/).
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17. The RIVM report 'Measuring Dutch meals: Healthy diet and safe food in the Netherlands' recommends increasing fish consumption from the average consumption (1998) of 2 to 3 times per month to 1 or 2 times per week. It should be noted that in the Netherlands, consumption of fish (per capita consumption: 20.5 kg/head/year) is at the mid point for EU25; Austria, Germany, Ireland, the United Kingdom, Belgium and Luxemburg and all of the new Member States apart from Malta, Cyprus and Estonia are below the Dutch level of consumption. Three Member States (Hungary, Slovakia and Slovenia) are at only one third of the Dutch consumption level. http://www.rivm.nl/bibliotheek/rapporten/270555008.html

[18] COM (2005) 115 http://europa.eu.int/eur-lex/lex/LexUriServ/site/en/com/2005/com2005_0115en01.pdf

[19] A report on the contributions received will be published on the Commission's website at the following address: http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/green_paper/consultation_en.htm

[20] Further information on the work of the Platform is available at the following internet address:http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/platform/platform_en.htm

[21] More information on the scope of the Public Health Action Programme, the conditions for participation in the calls launched under the Programme, and on projects financed so far can be found at the following internet address: http://europa.eu.int/comm/health/ph_programme/programme_en.htm.

[22] i. a. the Working Party 'Lifestyle and other Health Determinants' aims at improving the availability of comparable information on nutritional habits and physical activity levels in Europe. Its Scientific Secretariat can be contacted at [public.health@mailbox.tu-dresden.de]

[23] Numerous Commission financed projects in particular under the former Cancer, Health Promotion and Health Monitoring Programmes have developed activities in the field of nutrition, physical activity and health. An overview of these initiatives is set out in the *Status report on the European Commission's work in the field of nutrition in Europe*, 2002 (http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/documents/nutrition_report_en.pdf)

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[26] cf Gerard Hastings et al: Review of research into the effects of food promotion to children - Final Report Prepared for the Food Standards Agency; 22 September 2003 http://www.foodstandards.gov.uk/multimedia/pdfs/foodpromotiontochildren1.pdf

[27] cf also Universität Paderborn, et al. (2004): "Study on young people's lifestyles and sedentariness and the role of sport in the context of education and as a means of restoring the balance" http://europa.eu.int/comm/sport/documents/lotpaderborn.pdf

[28] these include dietary therapy (instruction on how to adjust a diet to reduce the number of calories eaten), physical activity, behaviour therapy (acquiring new habits that promote weight loss), drug therapy (to be used in high BMI patients or patients with obesity-related conditions together with appropriate lifestyle modifications and under regular medical control), and surgery (in extremely high BMI patients or patients with severe obesity-related conditions, used to modify the stomach and/or intestines to reduce the amount of food that can be eaten)

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[30] Information and communication technologies can play an important role in health promotion by providing sound and high-quality information on lifestyle and diet. This can be done, for example, through personal devices highlighting individualised health information that can give feedback, guidelines, forewarning, and can help to avoid acute events resulting from unhealthy lifestyles. A number of Community supported projects have developed information systems relating to health and diet, such as VEPSY UPDATED (http://www.vepsy.com/index.htm) and MYHEART (http://www.hitech-projects.com/euprojects/myheart/)

[31] Diet, Nutrition and the Prevention of Chronic Diseases, *op. cit*. The recommendations include: Achieve energy balance for weight control; Substantially increase levels of physical activity across the life span; Reduce energy intake from fat and shift consumption from saturated fats and trans-fatty acids towards unsaturated fats; Increase consumption of fruit and vegetables as well as legumes, whole grains and nuts; Reduce the intake of "free" sugars; Reduce salt (sodium) consumption from all sources and ensure that salt is iodized.

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[33] cf Mike Rayner et al: Nutrient profiles: Options for definitions for use in relation to food promotion and children's diets; Final report; British Heart Foundation Health Promotion Research Group, Department of Public Health, University of Oxford; October 2004 http://www.food.gov.uk/multimedia/pdfs/nutrientprofilingfullreport.pdf

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and promoting coordination of all food standards work undertaken by international governmental and non-governmental organizations. http://www.codexalimentarius.net/web/index_en.jsp

[35] In this context, the scope for more proactive EU-US cooperation will be examined, and a major review of best practices in EU and US will be organised early 2006 with relevant US administration counterparts. Also, the broad regulatory EU-US dialogue which has started in this field will be intensified. Moreover, a plenary meeting of the European Platform for Action on Diet, Physical Activity and Health will be convened together with representatives of the US Administration, the American food industry and consumer organisations.

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[43] International Obesity Task Force EU Platform Briefing Paper, March 2005

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