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COMMISSION OF THE EUROPEAN COMMUNITIES

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**COMMISSION STAFF WORKING DOCUMENT**

**Accompanying the:**

**White Paper from the Commission to the European Parliament and the Council  
A strategy for Europe on Nutrition, Overweight and Obesity related health issues  
Summary of the IMPACT ASSESSMENT**

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## 1. PROBLEM DEFINITION

Poor diets and low levels of physical activity account for 6 of the 7 leading risk factors for ill health in Europe, according to the WHO, see Figure 1 in Annex. It is estimated that 80 % of heart disease, stroke and type 2 diabetes, and 40 % of cancer, could be avoided if common lifestyle risk factors were eliminated (including smoking).

There is evidence that diets and physical activity levels are worsening in the EU, on the basis that obesity and overweight are rising. The data indicates that that 19 out of 27 Member States already have mean BMIs over the healthy level of 25 kg/m<sup>2</sup>, see Figure 2 in Annex.

Assuming linear growth, and with no intervention, it is estimated that the prevalence of obesity in EU-27 will reach 20.1 % in 2020, see Figure 3 in Annex.

Assumptions underlying the above calculations indicate that these may be conservative predictions. For example, the experience of the US from the late 1980's is of a much steeper curve. Secondly, the analysis does not take into account the way that obesity and overweight are rising in children. There is evidence that childhood obesity is increasing steadily with the highest prevalence found in southern European countries, see Figures 4 and 5 in Annex.

Prevalence of obesity appears to increase through adulthood with highest levels among adults in their 50s and 60s. Gender differences are not uniform regarding obesity.

Salt intake is another aspect of nutrition that causes ill health (particularly cardiovascular disease and stroke). Data suggests that salt intake in the EU is significantly higher than the recommended 5 g sodium chloride per day, at around 9-10 g per day with most salt coming from processed foods. Long term comprehensive salt reduction programmes have been found to be very effective in producing health benefits. For example, in the North Karelia project in Finland, an average 30-35 % reduction in salt intake reported during 30 years in Finland was associated with a dramatic 75 % to 80 % decrease in both stroke and coronary heart disease mortality in the population under 65 years.

The causes of poor nutrition, low physical activity and the rise in overweight/obesity are complex and multi-factorial, relating to factors as diverse as international trade; agricultural policy; knowledge, attitude and awareness of food and well as availability and food choices; opportunities and motivation for physical activity which are in turn influenced by the physical environment, school policy, family habits etc.

There is evidence that Europeans are eating more, and the diet is not balanced. The Food and Agriculture Organization figures suggest that during 1961-2001, the energy supplied by food grew over 15 % in Europe. There is also data indicating that the percentage of total energy from fat consumed rose very slightly between 1996 and 1998, and that fruit and vegetable intake is well below recommended levels in most countries. Such small increases in food consumption can easily cause weight gain, or other health effects. There is limited data available relating to trends in physical activity, although data does show that current levels of activity fall considerably short of that recommended for health.

## **2. THE CASE FOR ACTION AT EU LEVEL**

There have been repeated calls from the Council for the Commission to do more in this area. There are a range of competences at the EU level, and existing legislation, which contribute to shaping the environment for healthy decision making at Member State level. This includes legislation linked to food, the development of programmes in agricultural sectors, structural funds, research, transport and urban policy, and media.

There are trans-national aspects to improving nutrition and physical activity levels within Member States, and a strong internal market dimension to the issue such as in the cross border sale of agricultural and manufactured goods. As far as trans-national aspects are concerned, food manufacturers have reduced the level of nutrients (such as salt) in products for some Member States but not for others. The result is that in some countries a basket of manufactured foods will be a higher risk for hypertension (high blood pressure) and stroke than the same basket in another country. Action at the EU level can avoid intra-EU inefficiencies by creating a level of playing field for food manufacturers and retailers. Major economies of scale are likely to arise from an EU-led dialogue with these actors, rather than separate MS dialogues – for all concerned.

Although Member States are increasingly taking action, there is little sign that obesity and overweight are levelling or beginning to fall anywhere. In fact, obesity and overweight levels are increasing everywhere at different speeds. This supports the notion that there are Community wide or global factors influencing the picture, that should form part of the response.

Existing EU level action has broadened policy consensus and the effort of many actors. The 2004 Obesity Round Table and 2005 Nutrition Platform have created more momentum in some Member States than existed before. Economic operators have variously welcomed the "recognition" the EU level brings for their efforts, the cooperation and the challenge to economic operators to improve their game. Moreover, EU level co-ordination and action has the potential to be the catalyst to spread to the EU27 the health gains that have been shown in less than 5 years in countries such as Finland (salt and heart health initiatives) and Poland (fats and heart health initiatives).

The approaches that countries are adopting to tackle nutrition and physical activity issues are very different. For example, Denmark and Norway have both approached the issue of restricting the level of trans-fats in foods through different approaches. Denmark has pursued a regulatory approach, while Norway has opted for voluntary methods. The evidence would indicate that similar results have been achieved.

## **3. OBJECTIVES**

The general objective is to reduce the health and economic harm due to poor diets and low levels of physical activity and thereby contribute to a healthier society, higher productivity and a sustainable economic development in line with the objectives set out in the European Council's Lisbon objective of more Healthy Life Years for all.

More specifically, the objective of the European Commission is to support Member States to improve diet and physical activity levels of the EU population, and in particular to reduce the prevalence of obesity and overweight. Reducing the prevalence of obesity is a key medium term objective (and an indicator for success).

### 3.1. The options

Options A and B are self standing options, and mutually exclusive. Options C and D are cumulative.

According to article 152, the Commission should work towards strong coherence between all its policies and public health objectives. Therefore, developing integration with policies across the Commission relates to all options.

- **A No EU level activity:** In this option, policy decisions and initiatives would be left largely to Member States and stakeholders, without coordination at European level. Existing actions would be abandoned.
- **B Status Quo:** The EU would continue to facilitate the dialogue between stakeholders through EU Platform and the Network on Nutrition and Physical Activity for as long as these forums are perceived to add value, as well as continuation with the financing of projects under the Public Health Programme.
- **C A comprehensive EU-wide strategy:** Building on option B, this option would seek to develop actions at Community level but also attempt to develop action at local and regional level within Member States, and through new channels that are not normally responsive or reachable through the use of innovative approaches. This option would seek to focus on voluntary mechanisms, although such an approach would not alter the Commission's approach in areas where there are legislative frameworks already in place, such as for nutrition labelling. Rather it would seek to strengthen these areas by promoting complementary voluntary actions.
- **D Purely regulatory approach:** Building on option B, this option would seek to strengthen the legislative framework for those policy areas where there is further potential to do so (such as restrictions on advertising to children etc, and reformulation) rather than pursue stakeholder approaches in these areas.

## 4. ANALYSIS OF IMPACTS

### 4.1. Economic impacts

The total direct and indirect annual costs of obesity alone in 2002 in the EU15 were estimated to be €32.8 billion per year. A study in 2005 estimated direct and indirect costs of obesity (BMI  $\geq$  30kg/m<sup>2</sup>) at 0.3 % of GDP for the EU15. Extrapolating this to the EU25<sup>1</sup> using 2005 GDP figures, results in the cost of obesity as €40.5 billion a year, and a cost to the EU25 of €81 billion for obesity and overweight assuming (based on UK data) that adding the cost of overweight doubles the cost of obesity.

These figures underestimate the cost of poor diets and physical activity overall because (1) weight gain is only one effect of poor diets and low levels of physical activity, (2) the studies do not tend to consider the cost of consequences of weight gain in children, (3) even considering cost of obesity, estimates do not include additional costs related to other conditions such as back pain and depression which are exacerbated by weight gain, and (4)

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<sup>1</sup> Composite GDP figure for EU27 was not found.

there are intangible costs related to personal suffering, loss in quality of life and premature death that are difficult to quantify.

### *Impact of actions on the food industry*

The analysis of impact on industry, focuses on the food and drinks industry as the second largest manufacturing sector after the metal industry in 2001 accounting for 11 % and 13 % of total EU manufacturing value added and employment, respectively.

The structure of the sector is important: a number of large food and drink companies dominate. The largest 1 % of food and drink companies employ 39 % of workers, and account for 51 % of the sector's turnover.

Some actions (if they are successful in changing consumer preferences for products) could result in a lower consumption of certain foods, such as energy dense foods, and a higher consumption of others, such as fruit and vegetables. Industry analysis sees potential costs and benefits in this. Costs relate to lower sales growth and diminished brand equity for those foods that are consumed less, or for which advertising is reduced. But a JP Morgan report also notes, "there is an opportunity for brands which genuinely embody 'health' and 'wellness' to build a long-term competitive advantage which should translate into sustainable sales growth and margin expansion."

The picture that companies which respond to health concerns will be rewarded in the market place is backed up by evidence of the adaptability of the food manufacturing sector to the trends. Globally 18 of the 24 fastest growing categories and 6 out of 7 categories growing at double-digit rate are related to consumer perception of health and wellness, with these categories are now acting as a key growth engine for the sector. Conversely, the report also pointed to categories perceived by consumers to be less healthy and which are now exhibiting slower growth or are in decline.

Other important industry impacts include the potential cost to different media sectors (television, publishing etc) that would result from reduced advertising of food and drink products that are high in fats, salt and sugar to children.

#### **4.2. Environmental impact**

Actions that promote physical activity through the promotion of "active commuting", either through awareness raising campaigns or using Commission funds to improve transport infrastructure for cycling and walking, would be expected to have a positive environmental impact by decreasing the demand for motorised transport.

Elsewhere, if future actions result in changes to the Common Agricultural Policy in sectors such as fruit and vegetables, or milk, there may be environmental impacts related to land use. There are no foreseen negative environmental impacts associated with actions such as the development of partnerships, awareness campaigns, with reformulation or with changes to advertising practice.

#### **4.3. Societal impact**

The data also indicates that poor diets and low physical activity levels, if leading to obesity, are a problem to certain groups including those with lower educational attainment, lower social states and lower self-esteem. From the literature:

- There is an inverse correlation between BMI and education in only about half of the male population groups, but in virtually all female groups.
- Both obesity and diabetes are more strongly correlated with inequality indicators (e.g. income Gini coefficients) than with national average income.
- Perceived social status and self-esteem are also correlated in ways that suggest a link to health behaviour, consistent with studies showing that most health outcomes are correlated with social status.

Therefore the social impact of strategies to reduce overweight and obesity relate both to social inclusion and to non-discrimination. The discrimination and social disadvantage associated with obesity are compounded by the correlation between obesity and overweight and socio-economic status.

## 5. COMPARING THE OPTIONS

### 5.1. Summary comparison of policy options

As the table below sets out, there are a range of policy options that the Commission can take that can add value to the actions of Member States, and contribute to the objective to improve nutrition and physical activity levels, and reduce obesity and overweight. The table below summarises the strengths and weakness associated with the four options.

Table 1: Summary of strengths/weaknesses associated with the four options

Option	Strengths	Weaknesses
A (abandon)	Resources released to focus on other public health priorities of the EU	No contribution at the EU level on a number of areas that influence diet and physical activity  Ignores requests by Council and Parliament  No co-ordination of stakeholders, Member States left to engage independently
B (Status Quo)	Current stakeholder actions (widely perceived to be positive) continues  No new risks	No common strategic direction for all actors at the EU level  No promotion of stakeholder forums at MS and local levels  Missed opportunity for the Commission to help MS tackle the issue
C (Voluntary)	Common framework for all	Costs of participation in

<p>approach)</p>	<p>actors</p> <p>Developing policy coherence at Community level may be easier within the context of a comprehensive EU strategy</p> <p>Opportunity to identify "Win-win" actions. Optional participation of industry actors based on the interests of the business and therefore costs restricted to fewer companies.</p> <p>Opportunities for faster response</p>	<p>additional meetings/networks for stakeholders (MS and private actors)</p> <p>Greater monitoring burden to participating stakeholders linked to need to demonstrate the implementation of actions.</p>
<p>D (Stronger legislative framework)</p>	<p>Uniform EU wide response, and from all actors</p>	<p>Costs for a greater number of private actors</p> <p>May be disproportional if voluntary 'win-win' options alone are sufficient to tackle the problem.</p> <p>Longer timeframe to observe response.</p> <p>Legislation can become "out of date" in an ever changing market.</p>

*Boundary aspects*

The costs to the EU of non action are very great: with €80 billion each year a conservative estimate. This greatly outweighs the costs of the options under consideration.

**6. THE PREFERRED OPTION**

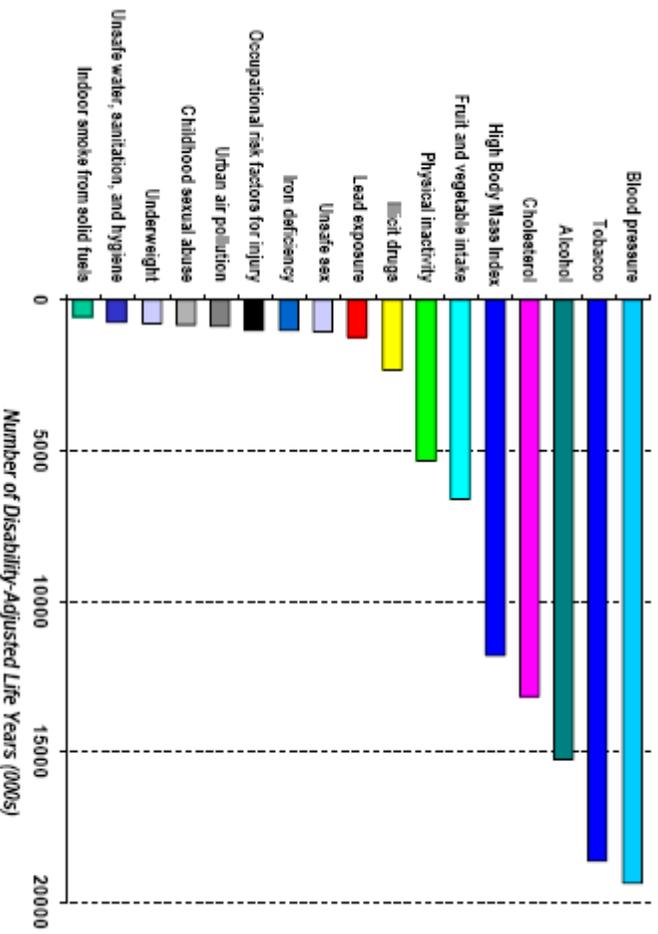
There is a clear rationale for a stronger response from the Community – indicating a choice of option C or D. Option C is preferred given (i) indications that it may prove as effective (ii) that as a voluntary approach it may yield faster results, and (iii) because the structure of the food industry is one where a few, large companies dominate and industry data indicates that these companies will benefit from implementing actions in this area.

## **7. MONITORING AND EVALUATION**

The foreseen Commission White Paper will include proposals to improve the monitoring of nutrition and physical activity health status, and actions at all levels, in particular in relation to obesity and overweight. Obesity prevalence will be a key indicator of progress in the EU, but others indicators will be identified related to progress in pursuing setting up voluntary systems under the preferred Option C.

8. ANNEX

Figure 1: Leading risk factors for ill health in the European Region



Source: World Health Report 2002

Figure 2: Mean BMI in EU Member States

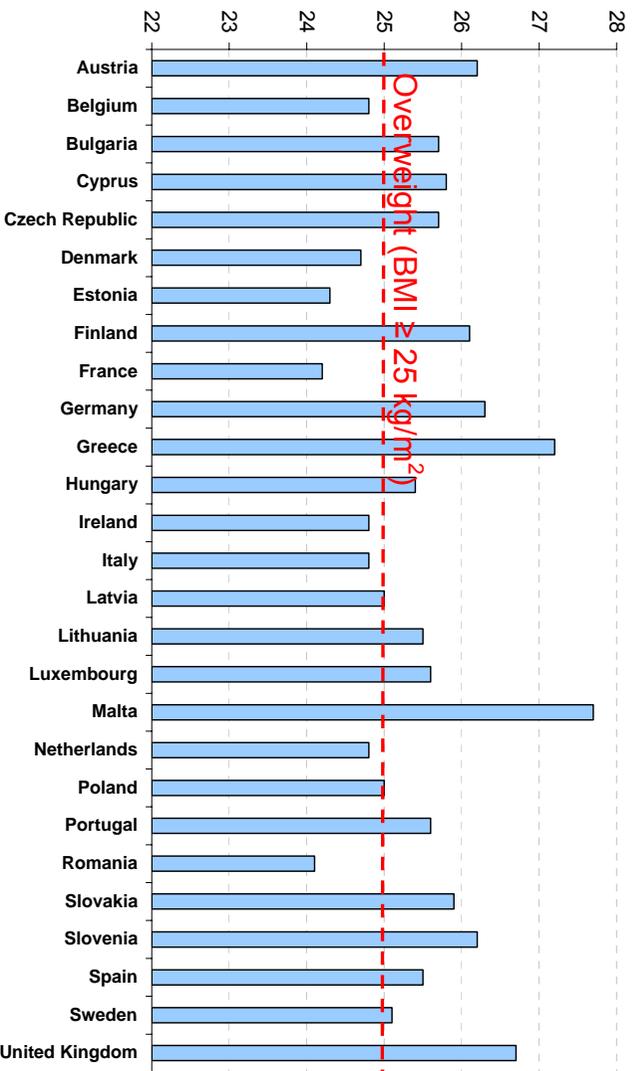
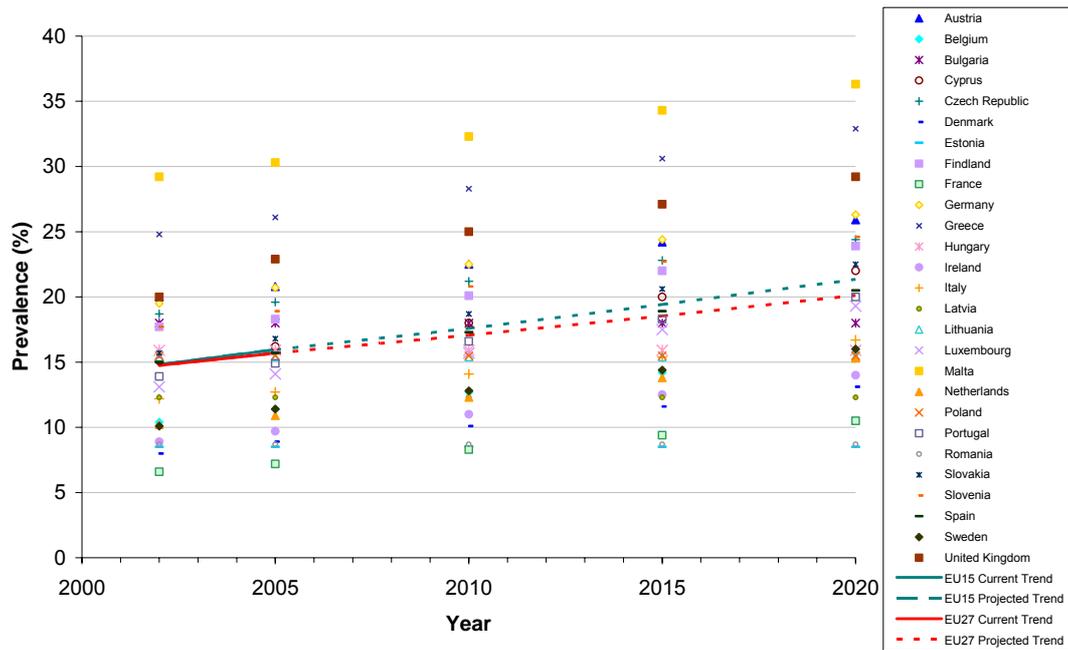
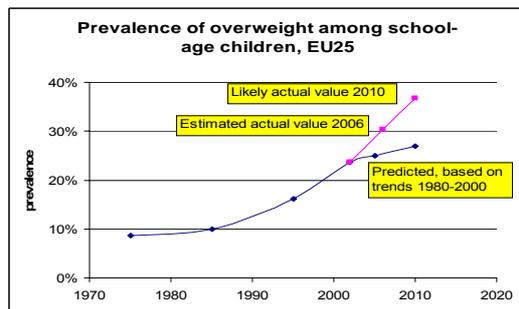


Figure 3. Obesity in Europe: trend analysis



Source: WHO Infobase and analysed by RAND Europe

Figure 4: Prevalence of overweight among school age children, EU25



Source: International Obesity TaskForce Child Obesity Report 2007

Figure 5: Prevalence of overweight among school-aged children in selected countries of the EU27, based on surveys 1958-2003

