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Medicine in Europe

This is the seventh in a series of articles looking at medical issues in Europe.

Europe and nutrition: prospects for public health

Michael O'Connor

After the second world war the major nutritional problems in Europe, if not the United Kingdom, arose from deficiencies of protein, minerals, and vitamins.[1] As western European economies recovered the problems became more those of overconsumption of nutrients such as fat, sugar, and salt. The problems are now ones of quality, not quantity, but the legacy of deprivation is still present. Much food policy is still geared towards producing large quantities of food and protecting the economic interests of farmers and food manufacturers rather than promoting healthy diets, protecting the environment, or even reflecting consumer demand.

European dietary patterns

There are no standardised studies on consumption in Europe that can be used to produce compatible data on food or nutrient intake. It is possible, however, to use food balance sheets produced by the Food and Agriculture Organisation of the United Nations. These tables show the nature of the food supply and so may not fully represent what people are actually eating, but they provide a useful picture of trends in food consumption (figs 1 and 2; table).

Compared with just after the war Europeans now eat more food of animal origin and less of vegetable origin.[1] They eat every day the foods they used to eat on festive days. There are large regional variations. Mediterranean countries still derive a larger part of their energy from vegetable products than do northern European countries. The "Mediterranean diet" is believed to be healthier. Unfortunately, there are signs that these countries, and those in eastern Europe, are adopting unhealthy northern European diets.[2] People in southern and eastern European countries suffer most from obesity, but as a whole the region compares favourably with other developed regions such as North America and Australasia.[3]

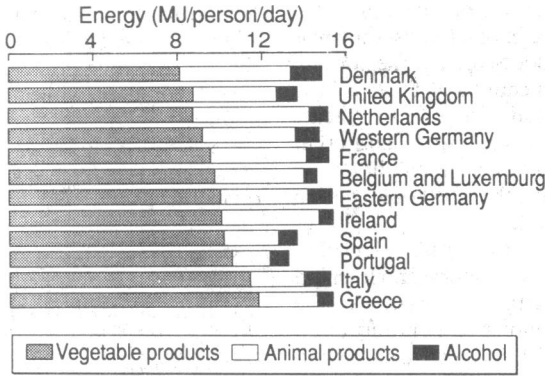

FIG 1—*Total energy available per person per day from vegetable and animal products and from alcohol in European countries, 1979-81*
Source: World Health Organisation.

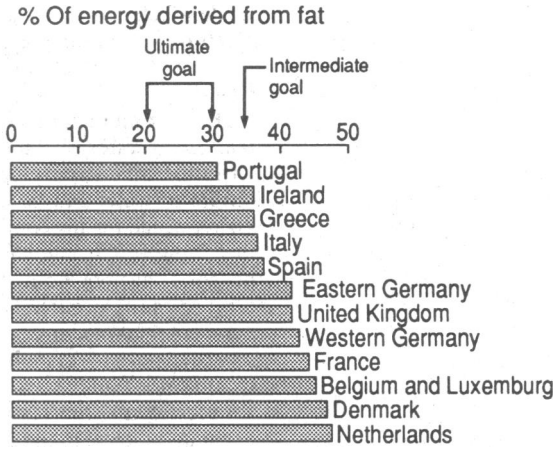

FIG 2—*Estimated percentage of total energy derived from fat in some European countries*
Source: World Health Organisation.

Intermediate and ultimate nutrient goals for Europe

	Intermediate goals*		
	General population	Group with high cardiovascular risk	Ultimate goals*
% Of total energy† derived from:			
Complex carbohydrates‡	>40	>45	45-55
Protein	12-13	12-13	12-13
Sugar	10	10	10
Total fat	35	30	20-30
Saturated fat	15	10	10
Ratio of polyunsaturated:saturated fat	≤0·5	≤1·0	≤1·0
Dietary fibre (g/day)§	30	>30	>30
Salt (g/day)	7-8	5	5
Cholesterol (mg/4·18 MJ)		<100	<100
Water fluoride (mg/l)	0·7-1·2	0·7-1·2	0·7-1·2

*Several ultimate and intermediate goals for the general population and the high risk group are the same: alcohol intake should be limited; iodine prophylaxis should be given when necessary; nutrient density should be increased; and body mass index should be 20-25 kg/m^2 (though this value is not necessarily appropriate for the developing world, where the average index may be 18 kg/m^2).
†All values given refer to alcohol free total energy intakes.
‡These figures are implications of the other recommendations.
§Values are based on analytical methods that measure non-starch polysaccharide and enzyme resistant starch produced by food processing or cooking methods.

Nutrition policy in the EC

In the context of current wider political debates some people may question the need for European nutrition policies. These are essential to maintain high

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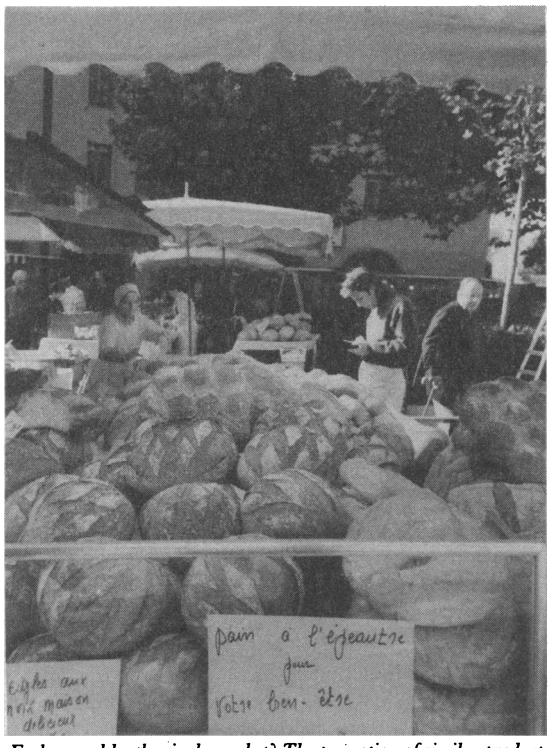

Endangered by the single market? The promotion of similar products throughout Europe may erode regional differences

standards because any product that is legally sold in one member state cannot be excluded from another state except for special reasons and on rare occasions. So in the absence of centrally agreed rules any member state's high standards—for example, on labelling, toxicology, or nutrient content—could be undermined by lower quality imports from elsewhere in the community. A more positive reason arises from the development of the European Community (EC) from simply a free trade area into a more rounded social and economic union.[4] While nutritional needs are biologically driven, diet is largely socially and economically determined.

One of the main reasons for the failure to develop integrated food and nutrition policies is that until the discussions at Maastricht are ratified the promotion of public health does not feature in the Treaty of Rome, the legal basis for community action. Despite the lack of an explicit legal base EC policies do have an impact on health in, for example, food production and labelling, where trade concerns are involved.[5] In the World Health Organisation's charter, health takes precedence over trade; in the EC it has been the other way round and as a result the community has often trod blindly in matters of health.

The effects are clearly seen in the common agriculture policy. This fails to mention health as it is designed to secure production and meet the economic needs of farmers. The result is overproduction at vast cost to consumers and frequently in just those areas where in health terms we should be cutting back—for example, dairy products. A well known folly is the £900m spent each year by the EC on subsidising tobacco growing. Less well known is the £400m spent annually subsidising sales of butter to food producers.

There are proposals to revise the common agriculture policy.[6] Its vast costs, plus pressure from outside the EC to limit subsidies in the interests of fair trade, have made the current agreement untenable. Reform of the policy is not easy, and no government can afford to ignore the farming lobby, but the United Kingdom is supporting some reform. Ensuring that the common agriculture policy promotes health has not featured in the argument.

Another example of the domination of trade over health interests is the case of nutrition claims. The European Commission is currently drafting a directive on claims such as "low fat" and "high fibre." Its concern, however, is simply to secure fair trade rather than promote health. Recent drafts would allow nutrition claims if they were true in relation to similar products. Thus it would be acceptable to describe an intrinsically high fat product, such as a spread, as low fat if it is lower in fat than a similar brand. The United Kingdom Food Advisory Committee's recent report suggested basing definitions on an absolute rather than relative basis.[7] The Coronary Prevention Group and the International Heart Network have been urging a nutritional banding scheme as a base for defining claims.[8]

In general the European Commission has been reluctant to legislate on nutrition. It has limited itself to peripheral matters such as food additives, materials in contact with food, foods for particular nutritional uses, methods of preservation, inspection of premises, and enforcement of food law. Issues like food irradiation, labelling of permitted residues, and novel foods have not yet been agreed at a European level. In contrast, there are strict regulations governing agricultural products such as meat, milk, and eggs. Once again these are designed to promote trade rather than protect health. For example, the meat regulations apply only when meat is exported to another member state and not when it is for the home market.[9]

The future

Europe's future diet will depend on many variables, including changes in public awareness, results of new scientific research, the response of the food industry, and the agricultural sector and government policies. The single market will develop, making trade easier, and larger enterprises will probably gain most. As a result, the market for food may become more concentrated in the hands of fewer producers. Multinational food companies may extend their operations across Europe and take a larger share of the market. Similar products, especially processed food with high added value and a range of nutrient values, may be promoted throughout Europe and this may erode regional differences (el, der, and le hamburger). Within countries a greater variety of foods may become available. Closer political union may make it easier to adopt international policies on food and nutrition.

British nutrition policy has recently taken important steps forward with the publication of dietary reference values by the Committee on the Medical Aspects of Food Policy[10] and the proposition of population nutrition targets in *The Health of the Nation*.[11] These are essential precursors to an integrated food and nutrition policy, but much remains to be done to find ways of helping and motivating people to choose a healthier diet.

What is being done

The EC has declared 1995 to be European Year of Nutrition, and an action plan is being organised by the Social Affairs Department. The draft targets are:

- To increase citizens' overall knowledge in the area of nutrition and awareness about the important relation between diet and health
- To increase the awareness of dietary habits that may lead to reducing disease related risk factors and enhancing health status and overall wellbeing
- To stimulate activities focusing on the nutritional needs of specific groups of the population
- To inform the general public of the effects and

benefits, relative to quality and safety of foodstuffs, of community legislation

- To improve nutrition education in schools
- To encourage training in nutrition of health personnel

The size of the budget for these laudable objectives is not yet known, but latest rumours suggest it will be a paltry £8·5m. A wide range of activities is suggested, including:

- Promoting studies and investigations into the best ways of protecting health and preventing disease by way of a balanced diet
- Disseminating knowledge about activities relating to food and health
- Encouraging greater consideration of nutritional and health aspects in other aspects of the community's activities
- Fostering awareness of hygiene in various stages of the food cycle
- Organising conferences and disseminating knowledge on the dangers of alcohol
- Promoting consumer understanding of food labels
- Stimulating activities focusing on the nutritional needs of elderly people
- Promoting training programmes on nutrition.

These measures are essentially passive. Like British policy they rely on health education rather than health promotion. At some levels there are signs that the community wishes to be more active in nutrition matters. For example, the commission has applied for membership of Codex Alimentarius, the world body that sets food standards. It will be unfortunate if the EC's voice is dominated by trade interests as are those of so many national delegations.

What should be done

Nearly half the deaths in people aged under 65 in Europe result from diseases to which diet makes an important contribution.[2] Improving the nutritional status of Europeans will require action by governments and voluntary bodies, food growers and processors, retailers and advertisers, the media and schools, and health professionals and individuals. Decisions should be taken at the lowest possible level. Each level should be responsible for the action best taken at that level. Policies should recognise and respect the diversity of dietary cultures across Europe. Governments, individually and acting collectively, should encourage and facilitate multisectoral and multidisciplinary working by establishing integrated food and nutrition policies.

It is easier to call for an integrated food and nutrition policy in the EC than to define one. Its development will depend on three factors. Firstly, it requires a sound scientific base. There is a continuing need for nutrition research, but a good deal is already known about what constitutes a healthy diet. Secondly, we need a strategic understanding of the interrelation of policies on production, trade, environment, consumerism, and general economics. Thirdly, we need to know more about health promotion policies that work. British nutrition policy is based heavily on health education; as such it fails to address the reasons why people do not always make a healthy choice despite a relatively high level of awareness. European policy must not fall into the same trap.

Possible changes

- Revised price support systems under the common agriculture policy
- Compulsory nutritional labelling
- Subsidies on foods for consumption by economically less advantaged regions and individuals
- Promotion of better training in nutrition for health professionals and caterers
- More medical and scientific research programmes
- Financial support for changes in manufacturing technology
- Public contract compliance on nutritional grounds
- A progressive tax on processed foods that would favour less processed products
- Controls on the promotion of foods containing large amounts of nutrients which are consumed in excess
- Regulations specifying minimum nutrient contents for staple foods

An integrated food and nutrition policy would reach into many areas under a new commissioner for health working alongside the commissioner for agriculture. Decisions need to be taken on priorities—a first step should be to agree on nutrient goals and priority areas for action. Target dates should be set, and should not preclude individual member states setting tougher targets. Once the EC has agreed its targets it should devise and implement policies to achieve them and establish systems to monitor progress. It should launch an immediate audit of all policies that have an impact on food and nutrition.

People cannot and should not be forced to eat a healthy diet, but society can contrive to make the healthy choice easier.

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