

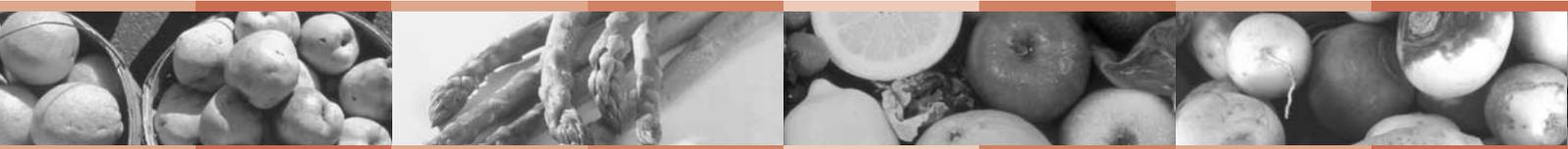


# Food, Nutrition and Cardiovascular Disease Prevention in the European Region: Challenges for the New Millennium

Summary of core findings and recommendations

may 2002





# Executive Summary

In Europe, cardiovascular diseases (including coronary heart disease and stroke) are already known to be the main cause of death and a major cause of premature death. One in eight men and one in seventeen women die from CVD before the age of 65.

Poor diet and inactive lifestyles are thought to account for about one-third of cardiovascular disease. Small changes to individual risk factors can lead to huge benefits for the health of the population as a whole. With growing recognition that cardiovascular disease is the biggest burden on the world's health, there is increasing pressure on governments to protect their citizens. This will require prevention strategies and a commitment to ensuring that other policies are not counterproductive to healthy nutrition.

Since the publication of *Food, Nutrition and Cardiovascular Disease Prevention in the European Union* by the European Heart Network in 1998, scientists have reached a new consensus on the population goals which are required to prevent cardiovascular disease. There has also been a recognition that a wide range of international and national policies may have an impact on diets in Europe, and since 1998 there have been significant developments within Europe to promote healthy nutrition.

The European Heart Network recommends comprehensive and integrated food and nutrition policies both at European and national level to promote heart-healthy nutrition. In order for these to be developed, new structures which involve senior policy makers will be required. Critical to the success of these measures is the degree to which political commitment to improving nutrition can be sustained. To help maintain this essential political will, a regular report on the state of nutritional health across Europe and within Member States should be published.

**The European Heart Network considers that there are five key goals for heart healthy nutrition in Europe:**

- a reduction in the intake of saturated fat and trans fats;
- an increase in the consumption of fruit and vegetables;
- a reduction in the intake of salt;
- an increase in physical activity levels; and
- a reduction in body mass index.

**Policies affecting the attainment of these goals will include:**

- providing information and education relating to food, nutrition and physical activity;
- re-orienting production incentives and subsidies;
- formulating standards for food composition and catering;
- regulating food labelling, advertising and promotion; and
- pricing and retailing strategies.

# Introduction

World Health Organization analyses of health and illness patterns globally show that cardiovascular disease (CVD) is the biggest overall burden on the world's health. CVD is predicted to stay at the top of that list until at least 2020.

Scientific knowledge concerning the links between diet and health is continually developing. Small changes to individual risk factors can lead to huge benefits for the health of the population as a whole. Population-wide action to change diet and lifestyles for the prevention of CVD has already been seen to work in practice.

With growing awareness that CVD is the world's biggest health burden, and widespread recognition that governments can play a vital role in disease prevention, governments will increasingly be called upon to take effective action to protect their citizens from CVD. This will require promoting prevention strategies *and* ensuring that other policies are not counterproductive to promoting healthy nutrition and lifestyles.

In *Food, Nutrition and Cardiovascular Disease Prevention in the European Union*, published in 1998, the European Heart Network set out a summary of the current thinking on the relationship between diet and CVD, outlined provisional dietary goals for Europe, and called for an integrated European food and nutrition policy to be developed. There has been considerable progress since then, and there are signs of Europe-wide action to promote better nutrition.

The European Heart Network's new policy position paper embraces the wider European region and provides an up-to-date synopsis of the current consensus of scientific thinking on diet and the prevention of CVD. This summary goes on to outline key recommendations for decision makers.

Recent food safety crises have sounded a strong warning to European consumers that things are not right with the European food chain. The time is ripe to review how food, agriculture, trade, transport and health policies in Europe are inextricably linked and to look for ways to revise the food supply to improve public health as well as to restore consumer confidence. There is an opportunity for nutrition to have a new priority on the public health agenda. This opportunity should not be wasted – concerted action at the local, national and European level can promote healthy nutrition and improve the cardiovascular health of the European population.

# Cardiovascular disease: The heaviest burden

Cardiovascular diseases (including coronary heart disease and stroke) are the main cause of death and a major cause of premature death in Europe,<sup>1</sup> accounting for 49% of all deaths (Figure 1) and 30% of all deaths before the age of 65 (Figure 2). One in eight men and one in seventeen women die from CVD before the age of 65.<sup>2</sup> CVD also accounts for 19% of all Disability-Adjusted Life Years (DALYs) lost in Europe (Figure 3).

Europe faces a huge forthcoming burden from CVD. In Western Europe, although mortality rates from CVD have gradually declined, the prevalence of CVD is predicted to increase. The risk of chronic disease increases with age; improved CVD treatment and survival rates, coupled with an ageing population, is likely to mean that an increasing number of Europeans will live with impaired cardiovascular health.

Countries from Central and Eastern Europe are faced with a very different situation. Health trends were similar to those of Western Europe until the late 1980s, but subsequently they have diverged markedly, with an alarming rise in mortality rates from chronic diseases and a shortening of average life expectancy. In Romania, for example, CVD mortality rose by 41% between 1984 and 1994.<sup>3</sup> There is up to a 10-fold difference in premature mortality rates between Western Europe and countries in Central and Eastern Europe (Figures 4 and 5). These vast differences in CVD mortality rates are attributable to differences in environmental, non-genetic risk factors, of which diet, tobacco smoking and physical inactivity are all major contributors, along with declining access to treatment.

<sup>1</sup> In this paper the European region refers to the 51 Member States of the World Health Organization's European Region, stretching from Iceland in the West to Kazakhstan in the East, and including the 15 countries of the European Union.

<sup>2</sup> British Heart Foundation. *European Cardiovascular Statistics*. BHF, London, 2000.

<sup>3</sup> British Heart Foundation. *European Cardiovascular Statistics*. BHF, London, 2000.

Taken together, the demographic effect of an ageing population in the West, and the deteriorating health and economic situation in the East, mean that unless there is concerted action to prevent CVD, the European region will be confronted with a large increase in the number of cardiovascular patients in the years to come.

It is estimated that in Europe, poor diet and inactive lifestyles are responsible for about a third of CVD, and a third of cancers.<sup>4</sup> Changes in diet and lifestyle can result in changes to individual risk factors, and when these changes occur across a whole population, impressive improvements can be achieved. In Finland, between 1972 and 1992 a 60% drop in deaths from coronary heart disease (CHD) was achieved.<sup>5</sup> Diet and lifestyle changes can also prevent further development of disease in people already affected by CVD (secondary prevention). Given the increasing numbers of people surviving with CHD, strategies for secondary prevention will be of growing importance.

Dietary patterns have traditionally varied across Europe and, while culinary and dietary diversity is to be celebrated, differences in nutritional patterns do contribute to disparities in the rates of death and illness between and within countries.

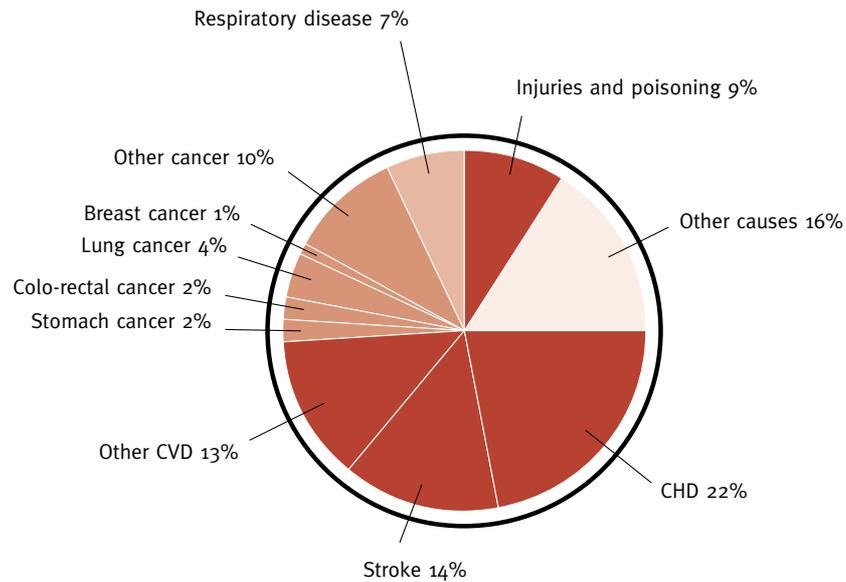
## Healthy nutrition to prevent cardiovascular disease - population dietary goals

A set of population dietary goals was recently proposed by the EU-funded Eurodiet project; these goals are taken as the basis of the

<sup>4</sup> European Heart Network. *Food, Nutrition and Cardiovascular Disease Prevention in the European Union*. EHN, Brussels, 1998.

<sup>5</sup> Puska, P., Tuomilehto, J., Nissinen, A. and Vartiainen, E. *The North Karelia Project: 20 year results and experiences*. National Public Health Institute, Helsinki, 1995.

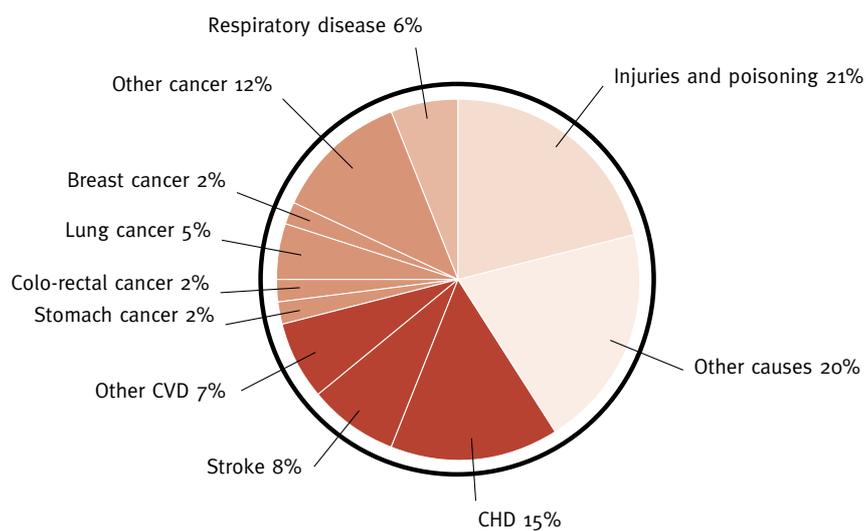
**Figure 1. Deaths by cause, latest available year, Europe**



Source: Rayner, M., Petersen, S. (2000) European cardiovascular disease statistics. British Heart Foundation: London. ([www.heartstats.org](http://www.heartstats.org))

CVD is the main cause of death in Europe accounting for 49% of all deaths. CVD is the main cause of death for both men and women in all European countries with the sole exception of France where more men die from cancer.

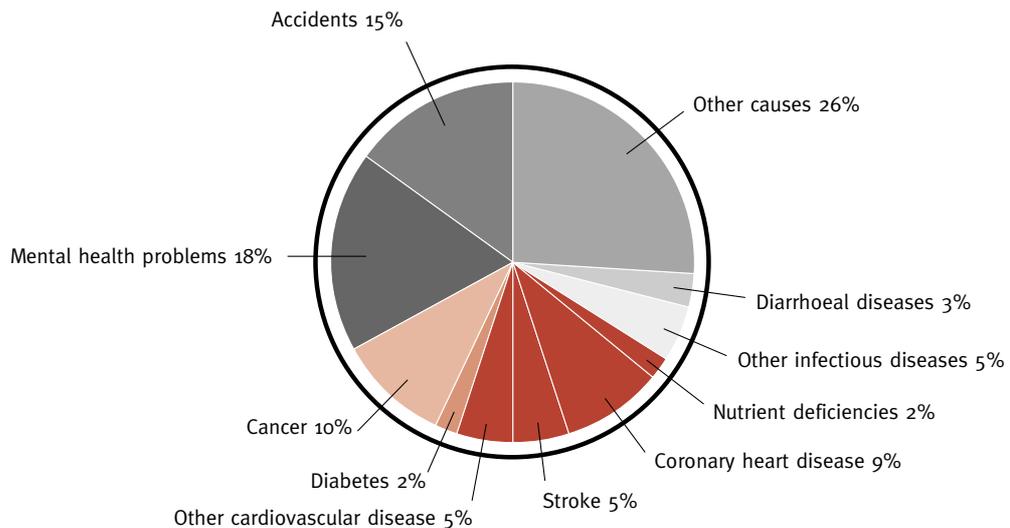
**Figure 2. Deaths under 65 by cause, latest available year, Europe**



Source: Rayner, M., Petersen, S. (2000) European cardiovascular disease statistics. British Heart Foundation: London. ([www.heartstats.org](http://www.heartstats.org))

CVD is the main cause of early death in Europe accounting for nearly 30% of all early deaths. One in eight men and one one in 17 women die from CVD before the age of 65.

**Figure 3. The major causes of lost DALYS (Disability-Adjusted Life Years), 1990, Europe**



Source: Murray, C.J.L., Lopez, A.D., (1996) *The Global Burden of Disease*. WHO: Geneva.  
 CVD is the major cause of DALYs lost in Europe. All together, diet-rated diseases (CVD, cancer, diabetes and nutritional deficiencies) account for 33% of DALYs lost whereas food-borne diseases (some diarrhoeal diseases and a tiny minority of other infectious diseases) account for about 3% of DALYs lost.

recommendations in this policy position paper.<sup>6</sup> In addition, other consensus documents and major articles that were published after the Eurodiet report was produced have been consulted.

The goals outlined here represent a recommended average nutrient goal for the population as a whole. Particular groups of the population, such as infants and children, pregnant women and older people, will have different requirements. These goals are not intended to guide individual consumption but are designed to inform food policy and to enable policy makers to compare current intakes with recommended dietary patterns and monitor progress.

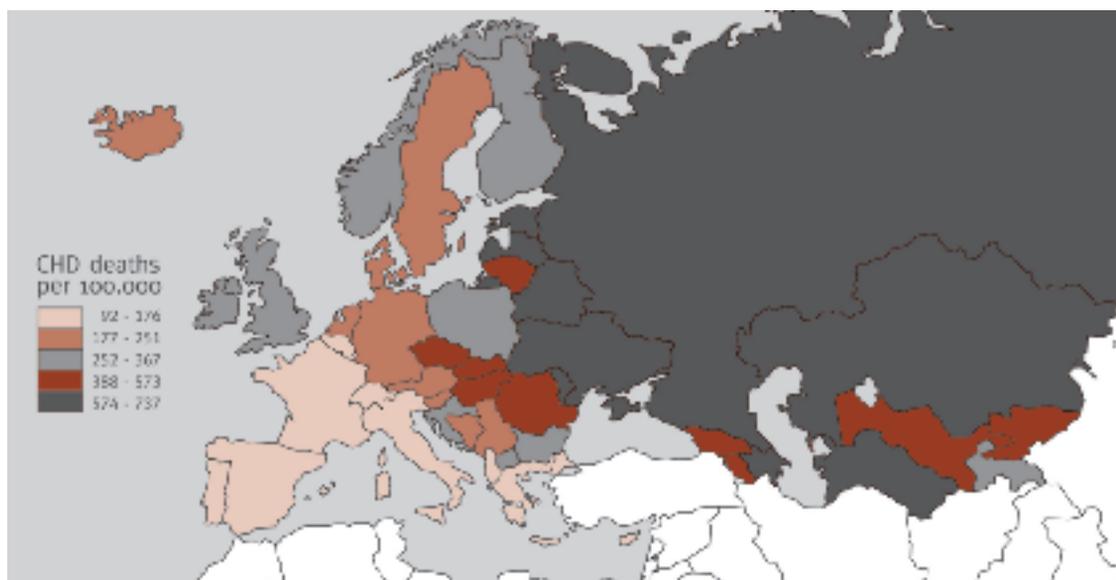
<sup>6</sup> Eurodiet Project, Eurodiet Core Report, Report of Working Party 1 and supporting papers by Renaud, S., Lanzmann, D. Coronary heart disease dietary links and pathogenesis; and Kromhout, D. Epidemiology of cardiovascular diseases in Europe. *Public Health Nutrition*, V4, 1(A). Special Issue February 2001. (<http://Eurodiet.med.uoc.gr>)

The five key population goals proposed by the European Heart Network are set out below. Each of these population goals has important policy implications at the local, national and European level.

**Key Population Goal: Saturated fat and trans fats – less than 10% of dietary energy from saturated fat and less than 2% of energy from trans fats**

Saturated fats are mainly found in fats from animal sources, such as meat and dairy products, but many processed foods and processed foods also contain considerable amounts. The main dietary sources of trans fats are margarines and shortenings used in bakery products. Trans fats are formed in food manufacturing processes when vegetable or fish oils are processed (hydrogenated) to make hard or semi-solid fats. They are also formed in frying oils which are used repeatedly, and there are high levels in most oils used in restaurants and fast food chains.

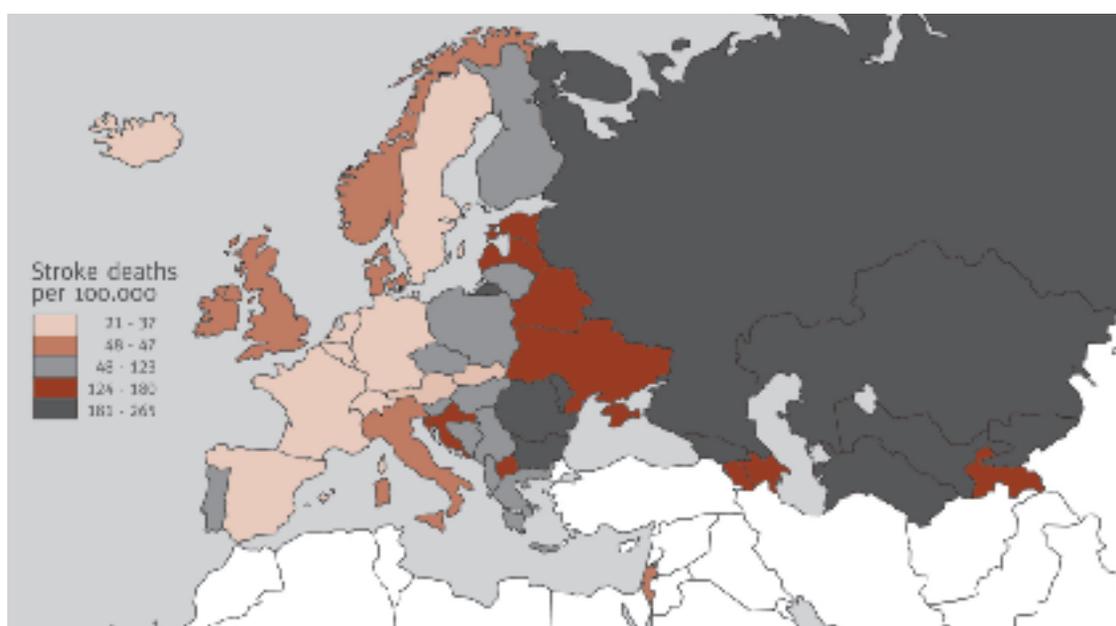
**Figure 4. Age-adjusted death rates from coronary heart disease, men aged 35-74, latest available year, Europe**



Source: Rayner, M., Petersen, S. (2000) European cardiovascular disease statistics. British Heart Foundation: London. ([www.heartstats.org](http://www.heartstats.org))

Death rates from CHD are generally higher in Northern, Central and Eastern Europe than in Southern and Western Europe. For example the death rate for men aged 35-74 living in Russia is eight times higher than in France and for women it is 12 times higher. Western European countries generally have higher rates than Southern European Countries. For example the death rate for men aged 35-74 living in Ireland is twice as high as in Italy and for women it is three times higher.

**Figure 5. Age-adjusted death rates from stroke, women aged 35-74, latest available year, Europe**



Source: Rayner, M., Petersen, S. (2000) European cardiovascular disease statistics. British Heart Foundation: London. ([www.heartstats.org](http://www.heartstats.org))

Death rates from stroke are higher in Central and Eastern Europe than in Northern, Southern and Western Europe. For example the death rate in men aged 35-74 living in Russia is nine times higher than in France and for women of the same age it is 10 times higher.

High intakes of saturated fats and trans fats raise cholesterol levels and significantly increase the risk of CVD. High blood cholesterol levels in the population exacerbate the dangers of smoking and high blood pressure for CVD risk. There is still some scientific debate about the precise effects of trans fats; it is possible that trans fats are *more* harmful than saturated fats.

No EU Member State currently meets the population goal for saturated fat, though Portugal, Spain and Greece come close to doing so (Figure 6).

Policy needs to be directed towards changing the composition of fats in the food chain from saturated fat and trans fats to mono and polyunsaturated fats. New processing techniques using emulsifiers have made it possible for manufacturers to produce margarines and spreads with a much lower level of trans fats, but these methods are not widely used.

### **Key Population Goal: Fruit and vegetables - more than 400g/day**

Diets rich in fruit and vegetables are protective against CVD and a wide range of other chronic diseases affecting the European Region. The protection appears to be dose-related: the more fruit and vegetables consumed, the better the protection. Quite small increases in fruit and vegetable consumption have recently been found to be associated with significant benefits.<sup>7</sup>

The precise reasons why diets rich in fruit and vegetables are beneficial are uncertain. Most fruits and vegetables are virtually fat-free, rich in dietary fibre and contain more than 100 compounds

<sup>7</sup> Khaw, K. et al. Relation between plasma ascorbic acid and mortality in men and women in EPIC-Norfolk prospective study: a prospective population. *Lancet* 2001; 357: 657-663.

which may be responsible for their protective effects. It appears that the protective effect of fruit and vegetables is due to the collective action of the range of compounds rather than any single compound on its own.

Data on food supply suggests that in many countries supplies of fruit and vegetables may be insufficient to meet the 400g/day population goal (Figures 7 and 8).

Given the strong evidence of the benefits of fruit and vegetable consumption, coupled with evidence that current supply is often insufficient for these health benefits to be achieved, policy needs to be directed towards increasing the supply of, and access to, fruit and vegetables. This will include measures to reduce the prices of fruit and vegetables.

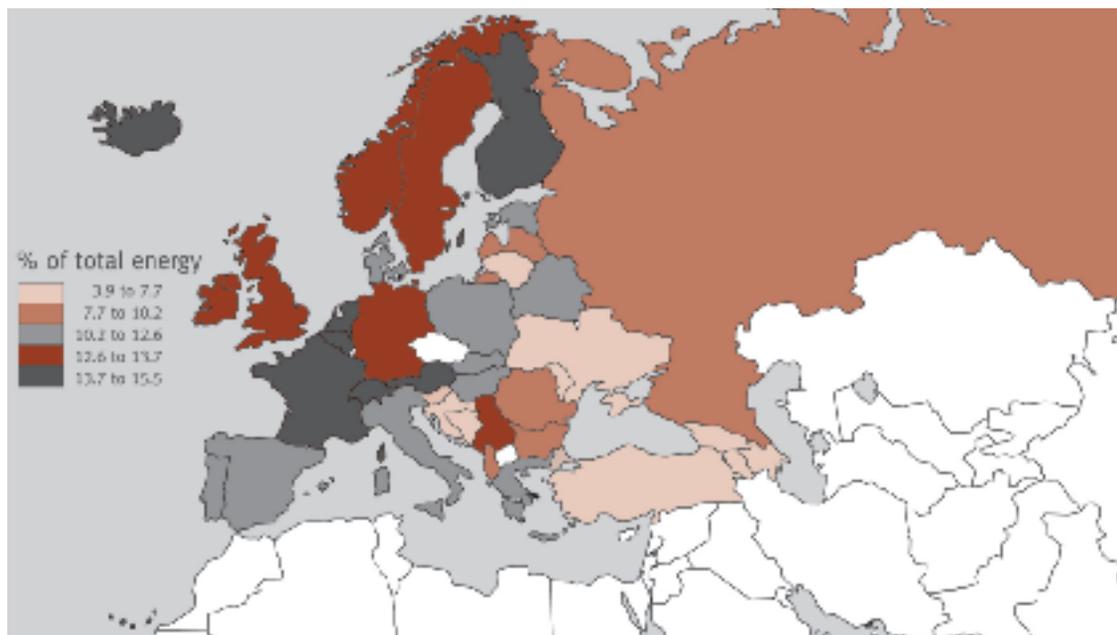
### **Key Population Goal: Salt - less than 6g/day**

Sodium intake, principally from salt, may lead to high blood pressure and hence increase the risk of stroke and CHD. Reducing salt intake lowers blood pressure and risk of CVD, in normal people as well as in people with high blood pressure. Proposals for population-wide reductions in salt intake have been controversial but new evidence is strongly supportive of such a strategy.<sup>8</sup>

Many Europeans have little control over the amount of salt they consume because most of their salt intake comes from manufactured foods. Salt from manufactured food accounts for 80% of salt intake in the UK and Finland, although this is lower in some countries where more home prepared foods are consumed.

<sup>8</sup> Sacks, F.M. et al. Effects on blood pressure of reduced dietary sodium and the dietary approaches to stop hypertension (DASH) diet. *New Eng J Med* 2001; 344: 3-9.

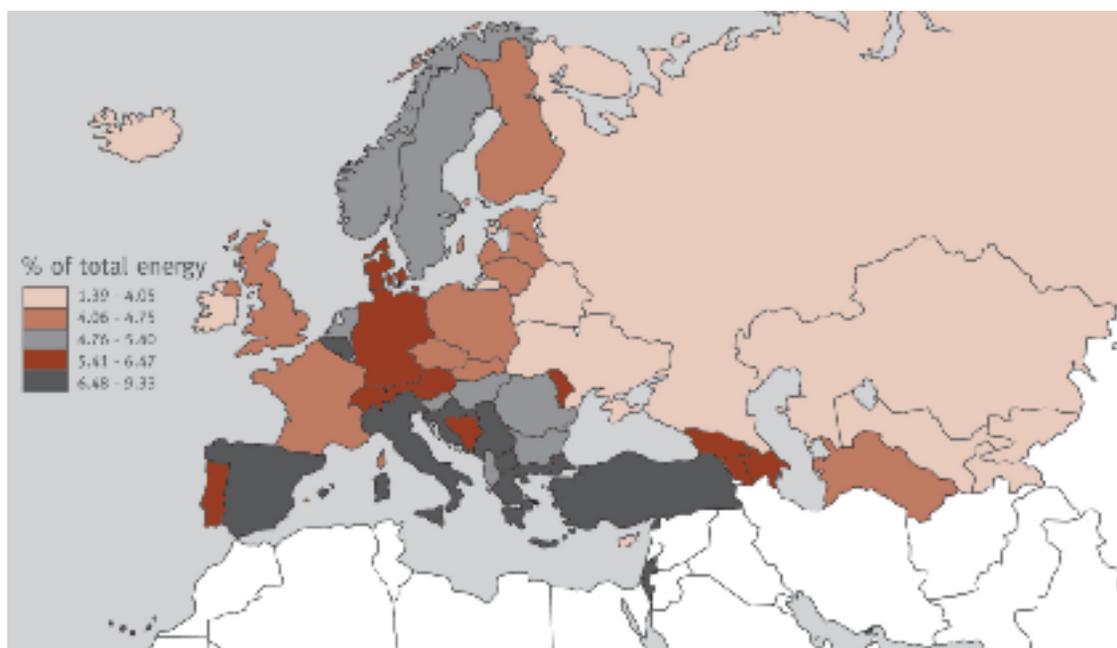
**Figure 6. Percentage of energy from saturated fat, 1998, Europe**



Source: A Ferro-Luzzi, National Institute for Food and Nutrition Research, Rome using data from Food and Agriculture Organisation of the United Nations ([www.fao.org](http://www.fao.org))

Saturated fat intake is higher in Northern and Western Europe than it is Southern, Central and Eastern Europe.

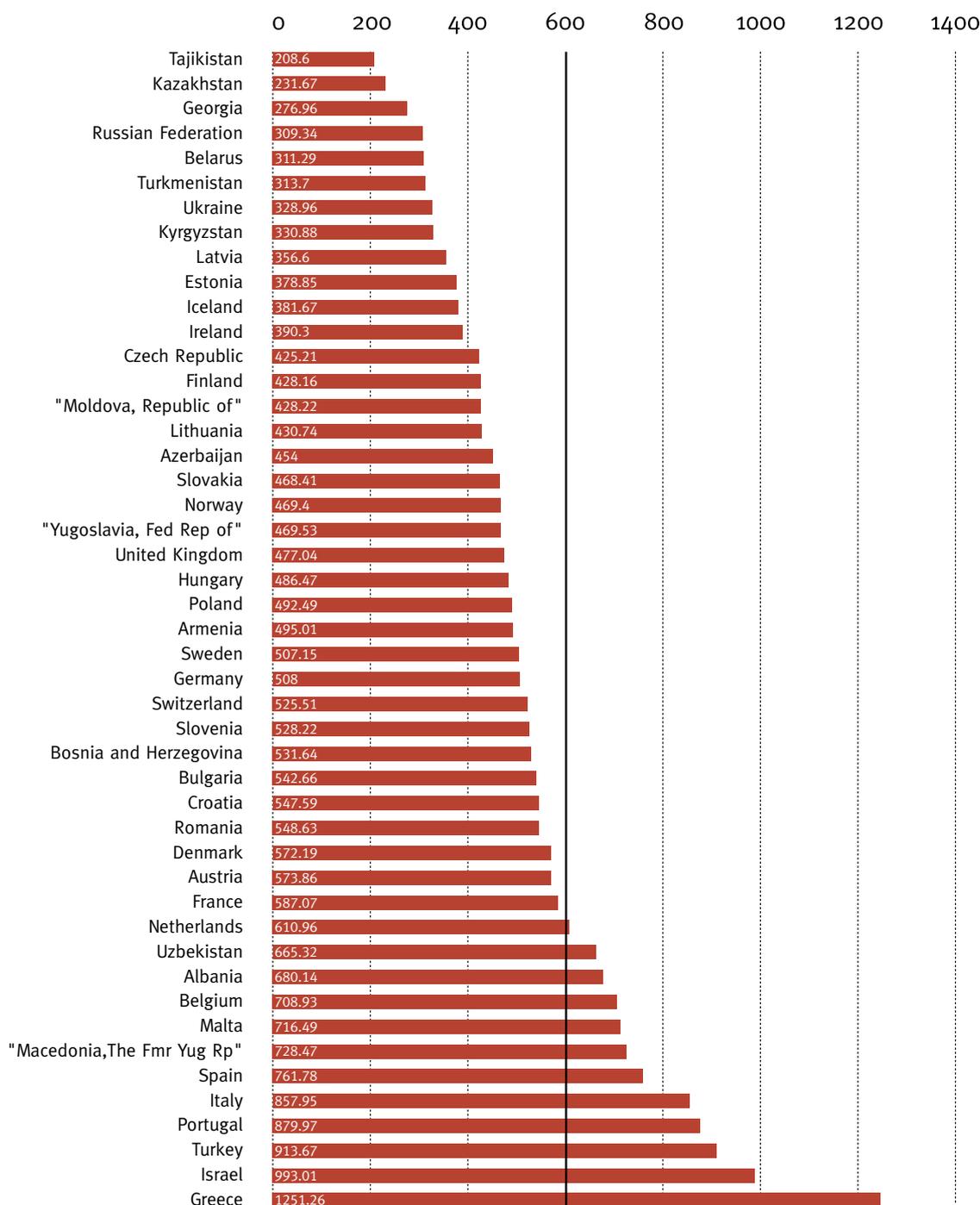
**Figure 7. Percentage of energy from fruit and vegetables, 1997, Europe**



Source: Rayner M, Petersen S (2000) European cardiovascular disease statistics. British Heart Foundation: London. ([www.heartstats.org](http://www.heartstats.org))

Fruit and vegetable intake is higher in Southern European countries than it is in Northern, Western, Central and Eastern European countries. For example people in Spain eat twice as much fruit and vegetables as in the UK and three times as much as in Kazakhstan.

**Figure 8. Availability of fruit and vegetables, 1999, Europe**



Source: Food and Agriculture Organization (2002) FAOSTAT Database. ([www.fao.org](http://www.fao.org))

Data on supply of fruit and vegetables. On average 30% is lost due to spoilage, waste or destruction. Total availability needs to be at least 600g per day to allow for an average consumption of at least 400g per day. Currently only 12 countries out of 48 in the European region have sufficient supply and availability is as low as 210g in Tajikistan.

Policy needs to be directed towards a blanket reduction of salt in manufactured foods, and action is necessary at a national or regional level to obtain the cooperation of manufacturers.

### **Key Population Goals: Obesity and Overweight - a Body Mass Index of 23; a Physical Activity Level of more than 1.75**

Obesity and overweight increase the risk of CVD and non-insulin dependent diabetes mellitus. Levels of overweight and obesity are high across the European region and levels of obesity are increasing rapidly in all age groups. For example, obesity levels in adults in England have tripled in the past 20 years. Prevalence of obesity and overweight in childhood is also increasing and excess weight in later childhood tends to persist into adult life. Data from a self-reporting survey in the EU found that more than one in four adults is overweight and around one in ten is obese.<sup>9</sup>

The population goal of a mean body mass index of 23 represents a significant challenge for many countries in the European Region. Setting nationally appropriate intermediate goals may be a pragmatic first step towards achieving change.

Physical activity can reduce risk of CVD and limit weight gain. A physical activity level of 1.75, which is equivalent to 60-80 minutes per day of moderate activity or 30 minutes per day of vigorous activity, is necessary to limit weight gain on typical European diets. However, 30 minutes a day of moderate activity will also have a significant impact on the risk of CVD.

Europe's population is becoming increasingly sedentary; it is estimated that the majority of people in the EU are physically active for less than 30 minutes a day.<sup>10</sup> Raising physical activity levels is one of the most important European goals for public health because it has such a strong effect on CVD risk and because activity levels in the European population are so low.

Policy needs to be directed towards providing opportunities for incorporating physical activity into the daily lives of Europeans in order to achieve a lowering of body mass index.

In addition to the four key population goals, there are other diet-related population goals to help prevent CVD. These goals are not included in the key messages because either the evidence for their effectiveness is not as strong or the public health gain is more moderate than for the five key goals outlined previously.

These goals are summarised in the table on the following page.

<sup>9</sup> British Heart Foundation. *European Cardiovascular Statistics*. BHF, London, 2000.

<sup>10</sup> British Heart Foundation. *European Cardiovascular Statistics*. BHF, London, 2000.

Component	Population Goal	Comment
Total fat	Less than 30% of energy	Fat is the most energy dense of nutrients and this goal is based on the need to reduce the energy density of European diets for the prevention of obesity.
Polyunsaturated fat	n-6 polyunsaturated fat: 4-8% of energy; n-3 polyunsaturated fat: 2g/day of linolenic and 200mg/day of very long chain fatty acids	Replacing saturated fat in the diet with unsaturated fat leads to a reduction in the levels of harmful blood cholesterol. Recently, however, scientists have become more interested in the composition of the polyunsaturated fat. The n-3 group of polyunsaturated fatty acids, which are found in oily fish, rapeseed and soya oils, are thought to be particularly beneficial.
Complex carbohydrate Dietary fibre	More than 55% of energy More than 25g (or 3 g/MJ) per day	Complex carbohydrates from starchy foods such as bread, potatoes, pasta and rice are ideal for making up the bulk of a lower fat diet. Diets rich in fruit, vegetables, pulses, potatoes and whole grain cereals will lead to achievement of these population goals.
Folate	More than 400µg/day from food	Inadequate intakes of folate can induce anaemia and neural tube defects in babies of deficient mothers. Currently there is also a suggestion that folates may also help protect against CHD. Increasing consumption of fruit, vegetables, pulses and whole grain cereals should improve intakes.
Sugary foods	Four or fewer occasions per day (for prevention of dental caries)	There is no evidence that sugar is causally related to the development of CVD. However sugary foods tend to be energy dense and it is sensible to limit sugar intakes to address the major problem of rising obesity.

**Key to table:** The population goals are expressed as a recommended maximum (less than x) or minimum (more than x), unless there is evidence that both high and low intakes are of concern. The goals are for the average (mean) of populations, and are not for individuals.

## Influencing dietary change

When the links between diet and disease were first identified, it was thought that widespread dietary change would be achieved by educating people about what constituted a healthy diet or an unhealthy diet. Although people do need to know about healthy nutrition, it has become increasingly recognised that the reasons why people eat what they eat are complex and the factors that can have an impact on dietary patterns are many and varied.

There has been a significant shift in thinking and it is now well recognised that many different policies at the local, national and international level have an impact on what we eat and have the potential to help promote or prevent CVD.

It is also recognised that many existing policies may have negative effects on nutrition. This is because the drive behind food policy has often been to increase agricultural production and to promote national self-sufficiency in food and agricultural produce. The EU Common Agricultural Policy (CAP), for example, was designed to increase the quantity of agricultural production in a post-World War II context. This resulted in huge increases in milk and meat consumption throughout the Union. Those European countries currently in economic transition, in Central and Eastern Europe, can learn from the mistakes made in Western Europe during the 1940s and 1950s.

Any policy that has an impact on the type of food produced (by farmers, by food manufacturers or by caterers) has the potential to affect diet-related disease. Examples of such policies include production incentives and subsidies, food compositional standards, and school and workplace nutrition standards.

Similarly, policies that influence the types and quantities of food consumed by Europe's citizens

can have a health impact. Policies in this category include food labelling legislation, rules on advertising and promotion of food products, pricing, retailing and policies strategies which affect the availability of foods, and education relating to food and nutrition.

In addition to policies that have an impact on food produced and food consumed, a whole range of policies affecting, for example, physical activity patterns, poverty and social inequalities, can have an impact on public health nutrition.

### Towards the Population Goals

Concerted action to achieve the five key population goals is necessary at both national and European levels. Governments will be required to develop national action plans to improve the dietary health of the population. These plans will differ from country to country and should be developed through systematic analyses involving first assessing the current nutritional situation and secondly identifying opportunities for and barriers to achieving the goals. (See Annex II for more information on conducting these systematic analyses.)

Clearly there is a role for national governments in promoting healthy nutrition through national policies and strategies. Governments have a responsibility to ensure that their citizens have access to a choice of affordable and healthy food and to provide the population with clear, accessible information about what constitutes a healthy diet. Many national governments have set dietary goals for their populations.

However, as many in the field of public health have long been arguing, there is also a need for action at the European level. There has been a tendency for the role of international structures

such as the World Health Organization (WHO) or the EU in relation to nutrition to be overlooked. There are, however, signs that this is shifting, and a number of European developments on nutrition and health have been initiated recently.

In September 2000, the World Health Organization's Regional Office for Europe (WHO EURO) adopted a food and nutrition policy document and action plan for the period 2000-2005. The Action Plan is directed at reducing levels of non-communicable disease, protecting the health of adults and children, and assisting Member States to develop effective systems to deal with food and nutrition issues. It will culminate in a World Health Organization Regional ministerial conference in 2005 where Member States will be asked to report on their actions under the plan.<sup>11</sup>

In the EU, there have been several recent developments aimed at promoting healthy nutrition – in particular the establishment of the Eurodiet Project in 1998 as a first step towards developing a Europe-wide public health nutrition programme. Stemming from the publication of a White Paper on Food Safety in January 2000,<sup>12</sup> which called for the development of comprehensive and cohesive nutritional policy for Europe, and the adoption of a Resolution on Nutrition by the Council in December 2000,<sup>13</sup> plans to develop a Nutrition Action Plan for the EU have been announced. A European Food Safety Authority has been established, and its remit covers some aspects of nutrition (see Annex I for further details of these EU initiatives).

## Drawing on past successes

Successful policy initiatives to promote nutrition and/or prevent disease show that population-based interventions work. One of the most notable success stories took place in Finland, where the country's position at the bottom of Europe's league table for CHD in the 1970s inspired a comprehensive and dynamic response to improve the country's cardiovascular health.

The North Karelia project, in East Finland, was initiated in 1972 following a community petition to demand government funding to tackle the problem. By 1992, CHD mortality in men had fallen by 60%. These dramatic reductions were achieved by a community-based programme which included measures to change the traditional North Karelia diet, which was high in dairy fats and salt and very low in vegetables.

<sup>11</sup> World Health Organization Regional Office for Europe. WHO First Action Plan for Food and Nutrition Policy for the WHO European Region 2000-2005. WHO, Copenhagen, 2000. ([www.who.dk/eprise/main/WHO/Progs/NUT/FoodandNutActPlan/20010906\\_2](http://www.who.dk/eprise/main/WHO/Progs/NUT/FoodandNutActPlan/20010906_2))

<sup>12</sup> Commission of the European Community. White Paper on Food Safety. COM(1999) 719 final, 2000.

<sup>13</sup> Commission of the European Community. Resolution of the Council of 14 December on Health and Nutrition, 2000.

# European Heart Network Recommendations for preventing CVD and improving public health through nutrition-related policies in Europe

As outlined in the previous sections of this policy position paper, there are many policy decisions which could play a role in improving nutrition for the prevention of CVD. Some of these decisions will depend on the situation in a particular country. Other decisions will require further research before the implications of various options can be explored. The European Heart Network urges governments, the World Health Organization and the European Commission to pursue these enquiries, to assess the current situation and to explore the options of change without delay.

In the meantime, there are a number of key recommendations that should be enacted now to help create a framework for the establishment of effective strategies to tackle CVD. These recommendations, and the thinking behind them, are outlined below.

**Central recommendation: A comprehensive, integrated food and nutrition policy, which involves all relevant sectors, is required to promote heart-healthy nutrition.**

This includes:

- **Developing integrated food and nutrition policies** – The main message of the North Karelia experience and other successful examples is the need for integrated food and nutrition policy. The development and implementation of such policies is a major commitment, whether it is at international, national or local level, and requires a serious investment in time.
- **Engaging a wide range of sectors and enlisting high-level political support** – To implement an integrated food and nutrition policy at the national level, Member States need to conduct an enquiry into current trends for each of the key areas. By doing this, and by engaging with a wide range of sectors and enlisting high-level political support, the possible actions can be identified (see Annex II).
- **Supporting the WHO EURO Food and Nutrition Action Plan** – At the World Health Organization European Region (WHO EURO) level, a comprehensive food and nutrition policy is taking shape through the recent adoption of the Food and Nutrition Action Plan. WHO EURO has a crucial role to play in supporting and facilitating the actions of Member States, particularly those European countries on the outside of the powerful EU block and the Central and Eastern European countries which are still undergoing economic development/transition.
- **Introducing a comprehensive nutrition policy at EU level** – For the EU, the Commission has promised to introduce a comprehensive nutrition policy, as described earlier. It is essential that this comprehensive nutrition policy be developed and that it take account of the impact of various EU policies on nutrition and introduce real and significant changes to these areas of EU policy. EU policies which affect the consumption of saturated fat, trans fats, salt, and fruit and vegetables, as well as those which affect bodyweight and physical activity, need to be identified.

- **Assisting Member States in implementing effective nutrition policies** – It is also important that the EU recognise its role in assisting Member States to implement an effective nutrition policy. Provision of excellent, consistent scientific advice which Member States can use in developing their own policy responses is one way in which the EU can support its members.

**Recommendation:** New structures which involve senior policy makers are required to implement the comprehensive food and nutrition policy.

This includes:

- **Setting up proper support structures** – In order to develop and implement an effective nutrition policy, a proper support structure will be needed. Implementation of an integrated plan, which threads through many areas of policy, will require close collaboration and improved coordination. In addition, an independent group is required to identify the options which would be most effective in public health terms. This group should be free of interference from vested interests.

At the national level, some high-level policy group is needed. The National Nutrition Council in Norway is often cited as an example that was highly effective as an appropriate model.

- **Establishing a nutrition task force within the European Commission** – Within the EU, improved mechanisms to coordinate the efforts of different parts of the Commission, and other relevant players, to improve nutrition are required. A nutrition task force within the Commission is needed to improve coordination.

**Recommendation:** Political commitment to improving nutrition should be sustained by publishing a regular report on the state of nutritional health.

There are a number of barriers to progress that routinely undermine efforts to improve nutrition and promote health, including conflicts of interests, paralysis by analysis, and lack of involvement of health professionals. It is important to be aware of these factors, which have impeded progress in many countries in the past.

Key factors in overcoming these barriers are:

- **Maintaining political commitment** – The commitment to taking action on public health nutrition which has been demonstrated in Europe in the last two years should not be wasted. In order to sustain efforts to promote nutrition and prevent CVD, it is essential to maintain the political will to take action in this field. The introduction of a follow-up mechanism, requiring the periodic production of a report on the progress made relating to nutritional health, is one way to maintain political drive.
- **Building cross-sectoral alliances** – Involving a wide range of stakeholders and building a broad alliance, as happened in Norway and Finland, will help to maintain momentum and overcome the barriers described above. Building public support for actions to improve the nation's nutrition is important for encouraging all other sectors to become involved and to be seen to contribute to these efforts.

### Note on the production of this policy position paper:

This is a summary of a longer document with the same title. The longer document was prepared by the European Heart Network's Nutrition Expert Group.

#### Group members

**Ineke van Dis**, MSc  
Netherlands Heart Foundation,  
The Netherlands

**Anna Ferro-Luzzi**, MD  
The National Nutrition Institute,  
Italy

**Kaare Norum**, MD, PhD  
Institute for Nutrition Research,  
University of Oslo,  
Norway

**Mike Rayner**, MA, DPhil (Chair)  
British Heart Foundation Health Promotion  
Research Group, University of Oxford,  
United Kingdom

**Philip James**, CBE, MD, FRCP, FRSE  
International Obesity Task Force,  
United Kingdom

#### Coordinator

**Susanne Løgstrup**, Cand Jur, MBA  
Director, European Heart Network,  
Belgium

#### Authors

**Carol Williams**, MSc  
Public Health Nutrition Consultant,  
United Kingdom.

**Karen McColl**, MSc  
Public Health Nutrition Consultant,  
United Kingdom

**Gill Cowburn**, BSc, SRD, RPHNutr  
British Heart Foundation Health Promotion  
Research Group, University of Oxford,  
United Kingdom

### The European Heart Network (EHN)

The European Heart Network is a Brussels-based alliance linking 30 national heart foundations and other national non-governmental organisations committed to the prevention of cardiovascular disease, in particular coronary heart disease and stroke, in 26 countries across Europe. The European Heart Network's mission is to play a leading role in networking, collaboration and advocacy in the prevention and reduction of cardiovascular disease so that it will no longer be a major cause of premature death and disability in Europe.

# Annex I

## Review of Recent Developments to Promote Healthy Nutrition across Europe

Early attempts to promote action on nutrition at the EU level were not successful. In December 1990, there was a Council resolution noting the importance of nutrition as a determinant of health, which invited the Commission to present a programme on nutrition.<sup>14</sup> Specifically, the Council suggested that this programme should include a Year of Nutrition, some general awareness-raising activities, and some pilot projects on nutrition, research into nutrition and health, and that the Scientific Committee for Food should give a more prominent role to nutrition. The Commission did not produce any programme on nutrition following this Resolution, choosing instead to incorporate nutritional components into the health promotion and health monitoring programmes and a campaign against cancer.

Many aspects of the overall environment for public health policy in Europe have changed since 1990, when the earlier Council Resolution on nutrition appeared to have minimal impact. Crucially, the Treaty of Amsterdam increased the scope for Community action in the field of public health and recognised that many different areas of EU policy can have an impact, often unforeseen, on health. Article 152 of the Treaty states that 'a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities'.

There have also been major structural changes in the organisation of public health issues within the Commission, culminating in the reorganisation that took place in 2000. This saw nutrition and

food safety both coming under the umbrella of the new Health and Consumer Protection Directorate-General (DG SANCO).

There now appears to be increasing recognition that there is a need for action on nutrition at the EU level. Many existing decisions and policies at the EU level already have an impact on food consumption and on nutrition. Examples include legislation on food quality, agricultural produce pricing policies, the management of surpluses, rules on food labelling and the education of health professionals. There has also been an awakening to the potential for the EU to support Member States in promoting healthy nutrition.

The new awakening to the significance of healthy nutrition has not been limited to within the EU. The World Health Organization Regional Office for Europe (WHO EURO) undertook a major initiative to develop a food and nutrition policy document and action plan for the European Region, which includes more than 50 countries, for the period 2000-2005. In September 2000, the Regional Committee for Europe adopted a resolution which endorsed the Action Plan and recommended that Member States take steps to carry out the Plan.

One sign of an increased commitment to nutrition within the EU context was the Commission's January 2000 publication of the White Paper on Food Safety.<sup>15</sup> This document, although largely concerned with food safety issues, did contain several commitments relating to nutrition, including the presentation of an

<sup>14</sup> Commission of the European Community. Resolution of the Council of 3 December 1999 concerning a community action on nutrition and health. *Official Journal*, C329 31/12/90, 1990.

<sup>15</sup> Commission of the European Community. White Paper on Food Safety. COM/99/719, 1999.

action plan and the development of 'a comprehensive and cohesive nutritional policy'.<sup>16</sup>

Another key issue also signalled in the White Paper on Food Safety was the intention to establish a European Food Authority. This leads to the establishment of the European Food Safety Authority in January 2002. Included in the EFSA's remit<sup>17</sup> are the following provisions on nutrition:

**Article 22: The mission of the EFSA shall also include: scientific advice and scientific and technical support on human nutrition in relation to Community legislation and, at the request of the Commission, assistance concerning communication within the framework of the Community health programme.**

**Article 28: The following scientific panels shall be set up: the Panel on dietetic products, nutrition and allergies.**

**Article 33: The EFSA shall search for, collect, collate, analyse and summarise relevant scientific and technical data in the fields within its mission. This shall involve in particular the collection of data relating to: food consumption and the exposure of individuals to risks related to the consumption of food.**

Meanwhile throughout 2000 further developments continued to push nutrition on the EU agenda and in December, the Council adopted a Resolution on Health and Nutrition.<sup>18</sup> The Resolution asserted the importance of nutrition

<sup>16</sup> Commission of the European Community. White Paper on Food Safety. COM/99/719,1999.

<sup>17</sup> Regulation 178/2002/EC of the European Parliament and of the Council laying down the general principles and requirements of food law, establishing the European Food Safety Authority and laying down procedures in matters of food safety.

<sup>18</sup> Commission of the European Community. Resolution of the Council of 14 December 2000 on Health and Nutrition. *Official Journal* C20/1 23/1/2001.

for health and invited Member States and the Commission to take action to promote better nutrition.

The Commission noted the Council's invitations and replied that it will 'examine their feasibility in the context of preparing the action plan on nutrition policy announced in the White Paper on Food Safety'.

The adoption of the Council Resolution represented the culmination of the French government's push to promote nutrition as a priority theme of its Presidency of the EU in the second half of 2000. The work of the French Presidency expert group,<sup>19</sup> which included a representative from each Member State, drew heavily on the work of the EU-funded Eurodiet Project. For the Eurodiet Project, four expert working groups examined:

- the relationships between health and nutrients;
- how to translate nutrient targets into meaningful dietary advice (based on foods rather than nutrients);
- effective ways to encourage healthy nutrition and physical activity; and
- barriers and opportunities for promoting healthy nutrition in the European policy context.

Following on from these analyses, Eurodiet's experts were able to identify population goals for nutrients, some foods, and other lifestyle features for the prevention of major public health problems in Europe. The proposed population goals cover physical activity, body mass index, dietary fat, types of fat, carbohydrates, consumption of sugary foods, fruit and vegetables, folate from food, dietary fibre, sodium, iodine and breast feeding.

<sup>19</sup> Société Française de Santé Publique. *Health and Human Nutrition: Elements for European Action*. SFSP: Nancy, 2000.

The report of the French Presidency called on the Commission to adopt these agreed population goals as an EU Recommendation on dietary guidelines (which was promised in the White Paper on Food Safety). Working towards the population goals in such a recommendation, Member States could then develop their own dietary guidelines to take into account their current national situation and dietary differences.

Since these developments during 2000, an inter-Directorate-General working group of the Commission has been working towards an Action Plan on Nutrition. To this end, a status report on the European Commission's work in relation to nutrition is expected to be published in the second quarter of 2002 and will lay the groundwork for the Action Plan.

## Annex II

### Developing strategies to improve nutrition

Strategies to improve nutrition, whether at the international, national or local level, should first investigate the current nutritional situation and identify the barriers which prevent nutritional improvement and the opportunities for promoting dietary change.

A framework has been devised by scientists working in New Zealand and Australia to help structure these investigations.<sup>20</sup> The basic questions to address in relation to diet and nutrition are outlined below.

**What is available to the population (physical environment)?** Which foods provide a high proportion of the saturated fat or trans fats consumed? What quantities and types of fruits and vegetables are available? Which foods provide the most salt to the nation's diet? What is available at the micro level in different food outlets – supermarkets, restaurants, schools, vending machines? Similarly, the influences on the availability of different foods at the macro-environment level – such as national or EU policies which influence the types and amounts of food produced – need to be identified.

**What are the economic factors relating to food consumption?** Which policies influence the price consumers pay for products? Tax, pricing policies, producer subsidies and retailer competition can all have an influence. As well as policies that influence food prices, factors affecting the income of the population and the individual are important.

**What rules and regulations are relevant?** Aspects of the political environment, including rules, regulations and policies, can also be important environmental factors. Examples include school nutrition policies at the level of the micro-

environment and legislation governing food labelling, compositional standards for foods and food advertising at the macro-environment level.

#### **What socio-cultural factors are important?**

The attitudes and beliefs related to food within a community can influence consumption. At the individual level, these beliefs and attitudes may be influenced by the culture or the ethos in the home, school or workplace. At the macro-environment level, the mass media play an important role in shaping attitudes.

Having identified a comprehensive list of factors which are potentially important, the next stage is to assess the relative importance of the factors along with an assessment of whether it is possible to modify each factor.

Once the relevant factors have been ranked in terms of priority, the possibilities for research and for intervention can be identified and, in turn, prioritised.

It is a daunting prospect to undertake an analysis of the whole nutrition situation. This exercise should involve people from all sectors including agriculture, food manufacturing, health services, schools and education authorities, caterers, the media, government and national authorities.

It is clear that not all the answers to all the questions will be available in the beginning. This should not be cause for dismay and should, instead, be useful in identifying important research priorities if the nutritional health of the population is to be improved in the long-term.

<sup>20</sup> Swinburn, B., Egger, G. and Raza, F. Dissecting obesogenic environments: the development and application of a framework for identifying and prioritizing environmental interventions for obesity. *Preventive Medicine* 1999; 29: 563-570.



**Published by  
European Heart Network**

**Mrs Susanne Løgstrup**  
Director

Rue Montoyer, 31  
B-1000 Brussels  
Belgium

telephone: +32 2 512 9174  
fax: +32 2 503 3525  
e-mail: [ehn@skynet.be](mailto:ehn@skynet.be)  
website: [www.ehnheart.org](http://www.ehnheart.org)

**The mission of the  
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through networking,  
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advocacy in the  
prevention and  
reduction of  
cardiovascular  
disease so that it  
will no longer be  
a major cause of  
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and disability  
throughout Europe.**

