

Editorial: nutrition, obesity and EU health policy

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Editorial

Nutrition, Obesity and EU Health Policy

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1. Obesity — A European Challenge

In September 2010 the OECD published a new report which examines what the OECD calls the “current obesity epidemic”.¹ According to the report, changes in food supply and eating habits, combined with a dramatic fall in physical activity, have made obesity a global epidemic. Across OECD countries, one in 2 adults is currently overweight, and 1 in 6 is obese. Even though the rates of overweight and obesity are highest in the United States and Mexico, the situation in Europe is not very promising either. In England, the country with the highest overweight rates in Europe, 2 out of 3 men are overweight and 1 in 4 people are obese; moreover, the overweight rate in England is projected by the OECD to rise a further 10% during the next 10 years. In Ireland, the situation is not much better, with an overweight rate (including obesity) as high as 61% (2007). The countries which are the next in this ranking are Greece (59% in 2008), Luxembourg and Spain (both 55% in 2007, respectively 2009).

2. The Challenge of Preventing Obesity

In view of these rates, there is agreement in Europe and elsewhere that a comprehensive approach is required to resolve the problems of nutrition and obesity. The focus thereby is on strategies of primary prevention. Medical conditions such as diabetes, high blood pressure, or high cholesterol, which are considered to be induced by obesity, are to be prevented by keeping people from becoming overweight in the first place. A variety of primary prevention measures might be

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¹⁾ OECD, *Obesity and the Economics of Prevention: Fit not Fat* (2010).

adopted. Those interventions which are only minimally intrusive are least controversial, such as health education, the promotion of a culture of healthy eating, or the provision of nutrition guidelines. However, the debate becomes more controversial when it is about interventions which cost money or regulate (“paternalize”) such as tax increases or the limitation of marketing activities.

2.1. *The Evidence Gap*

A central problem of any prevention policy in the field of nutrition and obesity is the lack of reliable data (evidence gap). At first glance, the phenomenon of obesity seems rather self-explanatory. Basically, it is the well-known story of humans who are hunter-gatherers by nature, but nowadays are surrounded by omnipresent cheap high-energy food so that they no longer move or cook and thus become obese, incur high costs and die early. However, the phenomenon of obesity becomes more complicated for those who choose an evidence-based approach to obesity. From the perspective of evidence-based public health the whole discussion about obesity is first of all characterized by a lack of evidence. No matter whether it is about the health consequences of obesity, the economic costs associated with obesity, proper diet, or the reasons for obesity, virtually every aspect of obesity is controversial.²

The evidence gap poses the greatest challenge when the discussion is about how to prevent obesity. Studying articles about the current state of evidence with regard to obesity prevention leaves one with a feeling of helplessness. There is a marked mismatch between the public health importance of obesity and the evidence available to assess the effectiveness of obesity prevention. Take the example of obesity in children and adolescents: Even nowadays there is only sparse data on the association between dietary factors and the development of obesity in childhood and adolescence. It is not even possible to draw conclusions on the impact of snack foods and fast food. And even if there is more data, as with regard to the role of energy intake and consumption of fat and sugar-sweetened beverages, the findings are inconsistent.³ With regard to the effectiveness of prevention strategies the state of evidence is not much better either. The situation is, as a Cochrane review states, a paradox: “At a time in which we see obesity prevention nominated as a public health priority, we have only a limited number of studies from which to examine findings”.⁴

²⁾ H. Schmidt-Semisch and F. Schorb, ‘Obesity Interventions: Prototypes and Premises’, in: A. Gerhardus et al. (eds.), *Evidence-based Public Health* (2010), p. 149 et seqq. (in German).

³⁾ A. Lanfer, A. Hebestreit and W. Ahrens, ‘Diet and Eating Habits in Relation to the Development of Obesity in Children and Adolescents’, *Bundesgesundheitsbl* 2010, 53:690 (in German).

⁴⁾ C.D. Summerbell et al., ‘Interventions for Preventing Obesity in Children’. *Cochrane Database of Systematic Reviews* 2005, Issue 3. Art. No.: CD001871. DOI: 10.1002/14651858.CD001871.pub2; currently published in *The Cochrane Database of Systematic Reviews* 2010 Issue 10.

Evidence-based public health thus delivers a message that nobody really wants to hear: as long as we do not know more about obesity and its prevention, any rash preventive campaigns/activities would be pointless. Preventive measures can also cause harm if they are inappropriate, and even apparently simple, exclusively communication-related prevention measures will at least tie-up resources which might have been used for better purposes elsewhere.

2.2. *Japan as Evidence?*

However, those who take the evidence gap seriously but nevertheless want to urge for action in obesity prevention might try to point to a different kind of evidence: the example of Japan. There are three reasons why it might be worth looking at Japan in the debate on public health and obesity prevention. It is the country with the highest life expectancy and the lowest obesity rate of all OECD countries, and its health expenditure per head lies well below the OECD average.⁵ Japan thus first of all proves that higher life expectancy does not necessarily require higher health expenses. Nevertheless, the high life expectancy in Japan is not God-given either. As late as the 1960s, Japan ranked last of all OECD countries in relation to life expectancy, though it has now surpassed all other countries.⁶

There are good reasons to assume that this increase in life expectancy is also due to lifestyle and nutrition. Already more than 20 years ago, Marmot and Smith investigated the reasons for the increased life expectancy of the Japanese in the *British Medical Journal* (“Why are the Japanese living longer?”) and identified nutrition as a major factor.⁷ Japan has long pursued a consistent and comprehensive prevention strategy with a special focus on nutrition, and it is this long-term strategy which is regarded as one of the major reasons for Japan’s leading position in life expectancy.⁸ As early as in 1978, the first National Health Promotion Program was launched in Japan. Major activities of this program included the promotion of programs focusing on nutrition, exercise and rest, and the establishment of health promotion councils. The Second National Health Promotion Program was initiated 10 years later, again with a focus on primary prevention and the establishment of a balanced lifestyle in terms of nutrition, exercise and rest. The Third Program (“Health Japan 21”) was initiated in 2001 as a 10-year national

⁵ OECD Health Data 2010, How Does Japan Compare, online at: <http://www.oecd.org/dataoecd/45/51/38979974.pdf>.

⁶ Japanese Ministry of Health & Welfare, Annual Report on Health and Welfare 1999 (Figure 3-1-1; International Comparison of Average Life Expectancy), online at: <http://www.mhlw.go.jp/english/wp/wp-hw/vol1/p1c3s1.html>.

⁷ M.G. Marmot and G.D. Smith, ‘Why are the Japanese living longer?’, *BMJ* 1989; 299: 1547-51.

⁸ W. Böcking et al., ‘Prevention, Life Expectancy and Health Expenditure’, *Dtsch Med Wochenschr* 2007; 132: 2217-2220 (in German). See also, from an Asian perspective, M.K. Melby et al., ‘Overview of Nutrition Reference and Dietary Recommendations in Japan: Application to Nutrition Policy in Asian Countries’, *Asia Pac J Clin Nutr* 2008; 17 (S2): 394-398, emphasizing the long history of integrated and holistic approaches to nutrition in Japan.

campaign, placing even greater emphasis on primary prevention. Numerous efforts have been made under Health Japan 21 to promote a favourable diet, such as the improvement of food environment, dissemination of dietary guidelines, promotion of dietary education, and the development of human resources such as registered dietitians and volunteers.⁹

However, even all those comprehensive and long-term health promotion programs cannot answer the question of how to effectively promote a favourable diet and thus prevent obesity. Thanks to Health Japan 21 there is plenty of data regarding the effects of preventive programs. Under the program, various goal items have been established and monitored in a systematic way such as to reduce average daily fat energy ratio, to increase average daily vegetable intake, or to increase the proportion of persons who read nutrition labels.¹⁰ The overall result though is mixed and does not permit any definite conclusions about the success or failure of individual measures. The general results are inconsistent: some dietary habits (e.g. salt intake) could be improved, others did not change, and some even deteriorated (e.g., intake of vegetables and calcium-rich food). The same applies with regard to knowledge about and attitude towards proper diet and weight: while the awareness of inappropriate diet and the motivation to improve it increased, there was a decrease of those who are aware of their own optimal weight and practice weight control. In a mid-term evaluation, the overall progress of Health Japan 21 has been evaluated as “not necessarily satisfactory”.¹¹ Thus, even Japan, although having a long tradition of and experience in health promotion programs, seems to be in the middle of a “trial and error” process when it comes to the effective prevention of obesity.

2.3. *Consequences*

Again, it has to be concluded that from the perspective of evidence-based public health there is no justification to call for specific preventive measures against obesity yet. Instead, in the first place, evidence has to be created through a systematic process of “trial and error”, a path that Japan has been following for a long time. It is not enough to launch a variety of programs without any clear strategy merely for the sake of it. What is required are carefully planned programs with defined objectives and targets which can be subjected to critical evaluation.

⁹ For an overview of the different Japanese Health Promotion Programs see K. Udagawa et al., ‘Mid-term evaluation of “Health Japan 21”: focus area for the nutrition and diet’, *Asia Pac J Clin Nutr* 2008; 17 (S2): 445-452.

¹⁰ In total 70 goal items in 9 fields, among them “Nutrition and Diet”, were set in “Health Japan 21” in order to recognize health problems, to assess the results of health promotion, and to develop effective health promotion; N. Shibaike et al., ‘5. Action by Ministry of Health, Labor and Welfare Nationals Health Promotion in the 21st Century “Health Japan 21”’, *Inter Med* 2002; 41: 70-71.

¹¹ Udagawa et al., *supra* n. 9. at 451.

Nevertheless, there are also measures that can be implemented straightaway, despite the lack of data on the efficiency of prevention measures. There are certain basic principles which always apply and can be implemented irrespective of the level of scientific evidence. In the field of nutrition and diet, these are above all *empowerment of consumers* and *protection of children*. As long as we do not know which dietary recommendations, educational approaches, and other preventive measures are appropriate and/or effective it is even more important to at least protect consumers and children from deception, misinformation and persuasion. Therefore, legislation has to ensure that nutritional information (including advertising) is of high quality, i.e. that any kind of nutritional information is accurate, complete and comprehensible in order to enable consumers to make informed and meaningful choices. Furthermore, in order to protect children, legislation has to restrict the marketing of food to children. Already there is considerable evidence that food marketing has an adverse effect on children's diet.¹² But even if there was not: in any case, it is not the business of profit-oriented enterprises, but of parents and public institutions such as schools and pre-school programs to influence, inform, or educate children about good nutrition.

3. The Role of the EU

What is the role of the EU in all this? Health policy is primarily the domain of the Member States. Even after Lisbon and under the TFEU (Treaty on the Functioning of the European Union) the main responsibility for health policy still lies with the Member States. In accordance with Art. 6 lit. a TFEU, Art. 168 sect. 1 TFEU, the European Union's competence is restricted to a coordinating function, supporting, coordinating and supplementing the measures of the Member States. This also and particularly applies to health prevention. However, Art. 9 TFEU clearly states that the Union aims to ensure a high level of health protection in defining and implementing its policies and activities. The revised regulation refers to the principle of "health in all policies" and emphasizes the responsibility of the EU for the guarantee of a high level of health protection within the Union.

EU policy has reflected this responsibility in many respects already and frequently even paved the way for an effective prevention policy, even though the Union's competence is only complementary in health policy matters. This has become particularly evident in the field of tobacco control where Member States such as Germany have failed almost completely. Although tobacco has long been identified as a major health risk factor, hardly any preventive measures were implemented at national level. The long overdue advertising ban and other

¹²⁾ Marketing of Food and Non-Alcoholic Beverages to Children, Report of a WHO Forum and Technical Meeting, Oslo, 2-5 May 2006.

product regulations were initiated by EU legislation. It has been much discussed whether the EU thereby assumed a health policy competence it is not entitled to.¹³ From the public health point of view the question remains why Member States like Germany for such a long time have been unwilling to make use of their health competence in order to adopt long overdue measures of effective tobacco control.

Health policy in the field of nutrition appears to follow a similar pattern. As far as uncontroversial measures like health education or promotion of healthy eating are concerned, there appears to be considerable Member State activity. Regulatory measures, and in particular those restricting the marketing freedom of food industries, however, are again based on Community law. The most prominent example is the EU Regulation on nutrition and health claims which imposes considerable restrictions on the freedom of food companies to label, present or market their products as nutritious and healthy. The EU was once again criticised for exceeding its competence with this regulation, while in fact the regulation has brought about considerable progress with regard to the quality of nutritional information. In fact, the regulation has implemented the basic idea of “evidence-based” information by stipulating that nutrition and health claims made on foods must not be based on the benevolent self-assessment of the producing company but on evidence accepted by the whole scientific community. Thus, the European legislator has established one of the essential conditions for consumers to be able to make informed and reasonable choices about the food they consume.

The EU Regulation on the provision of food information to consumers will be a further step towards high-quality nutritional information. In 2008, the Commission presented a proposal for the consolidation and harmonisation of food labelling regulations.¹⁴ In terms of public health the purpose of the regulation is to protect consumers from misleading information, to create transparency about food quality, and to provide help to consumers in making “healthy choices”. Much of the discussion about the regulation so far has been centred on the question whether or not to introduce the so-called traffic-light food labelling, i.e., to use red, amber and green signs to alert consumers how much sugar, salt and fat they are about to consume. This labelling model has been supported by most consumer associations, doctors, and healthcare organisations but has been rejected by the European Parliament. Instead, the Parliament opted for the GDA (Guideline Daily Amount) model, which tells consumers what percentage of the recommended intake of calories, sugars, salt and fat is in each portion.¹⁵

¹³) This discussion was ended by ECJ Judgment (case C-380/03) of 12 December 2006, ruling that Article 95 EC constituted an appropriate legal basis for the prohibitions of tobacco advertising and sponsorship.

¹⁴) Proposal for a Regulation of the European Parliament and of the Council on the provision of food information to consumers, COM/2008/0040 final — COD 2008/0028.

¹⁵) European Parliament legislative resolution of 16 June 2010 on the proposal for a regulation of the

Basically, the discussion about whether or not to introduce traffic-lights is again a discussion about evidence. For those in favour of the traffic-light model, there is more than enough evidence that this model enables consumers to make informed and healthy choices.¹⁶ On the contrary, for those against this model there is even “impressive” evidence that traffic lights do not work.¹⁷ As so often, it seems that people’s basic principles and attitudes influence their view of the evidence, rather than the evidence influencing their decision about what is the best public health approach.¹⁸ In fact, due to the lack of practical examples in most countries, there is simply not enough evidence yet to justify conclusions about whether and how traffic lights would influence consumers’ nutritional behaviour.¹⁹ From the perspective of evidence-based public health, it is therefore justified that the Parliament has rejected mandatory traffic-light labelling. On the other hand, exactly because of this lack of evidence, it must be left to the Member States to decide whether or not to introduce traffic-light labelling. As long as existing data do not allow a conclusion as to which labelling system is the best one, there is no justification to forbid any of those labelling systems at national level.²⁰ Instead, the “trial and error” path has to be pursued, i.e., by using different approaches at national level which then have to be compared and subjected to critical evaluation in order to find out the best labelling system.

4. Conclusions

It appears that the EU will once again, as it did with regard to tobacco control, assume a central role in the development of an effective prevention policy for nutrition and obesity. The greatest challenge of obesity prevention is the lack of evidence. We still know far too little about the causes and effective prevention of obesity, which makes it even more important to acquire this knowledge. This cannot be achieved by uncoordinated action and selective government “well-being programs”. What we require are consistent and long-term prevention approaches

European Parliament and of the Council on the provision of food information to consumers (COM(2008)0040 — C6-0052/2008 — 2008/0028(COD)).

¹⁶ See e.g. the German consumer organisation foodwatch: “Scientific evidence supports traffic light colours”; available at: <http://foodwatch.de/e6380/e34762/e35853/>.

¹⁷ See the German food industry lobby group BLL (Federation for Food Law and Food Science): “...studies have impressively documented that “traffic lights labelling” is not properly understood by consumers”; available at: <http://www.bll.de/themen/naehrwertinformation.html/absurde-lebensmittel-ampel> (in German).

¹⁸ See M.G. Marmot, ‘Evidence based policy or policy based evidence? Willingness to take action influences the view of evidence — look at alcohol’, *BMJ* 2004; 328: 907-7.

¹⁹ K. Hagen, ‘Nutritional Information: Traffic Light Labelling Is the Best Way to Reach Consumers’, *DIW Weekly Report* No. 19/2010.

²⁰ The European Parliament deleted in its resolution (Fn. 15) Art. 34 par. 5 which allowed the use of graphical forms or symbols for the presentation of the nutrition declaration under a national scheme.

which are subject to critical evaluation. Japan has already been following this path for a long time, and the Japanese example shows that this path is slow and tedious without any guarantee for concrete results. However, it is the only possible way to create evidence at all. Irrespective of this, any prevention policy must be aimed at the empowerment of consumers and the protection of children. Clear rules on information and advertising restrictions are an important part of any prevention policy in the field of nutrition and obesity. It is to be hoped that future regulation on the provision of food information to consumers will significantly contribute to this.