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### Comparison of Nutrition Policy Implementation in Scotland with Twelve Countries. Scottish Diet Action Plan Review. Ministry of Health, Scotland, United Kingdom

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**COMPARISON  
OF NUTRITION POLICY IMPLEMENTATION IN  
SCOTLAND WITH TWELVE COUNTRIES**

**AN INTERNATIONAL EXPERT COMMENTARY  
FOR THE SCOTTISH DIET ACTION PLAN REVIEW  
BY  
AILEEN ROBERTSON**

**SUHR'S UNIVERSITY COLLEGE  
DENMARK  
FEBRUARY 2006**

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## **Aileen Robertson**

Aileen Robertson until 2004 was WHO Regional Adviser for Nutrition and Food Security, in the WHO European Region. She was responsible for advising 52 countries, in the European Region, on public health and national nutrition policy over 12 years.

Aileen carried out her Ph.D. with Professor Philip James, at the Rowett Research Institute, Aberdeen. With Professor James and the Committee she helped draft "The Scottish Diet" report for Chief Medical Officer of Scotland in 1993. Aileen co-authored the chapters "Food is a political issue" published in 1st and 2nd editions of "Social Determinants of Health", Oxford University Press, by Professors Marmot & Wilkinson (1999 & 2006).

During her time at WHO, she edited and wrote two books: "Feeding & Nutrition of Infants and Young Children" together with Professor Lawrence Weaver from Glasgow University; and "Food & Health in Europe: A new basis for action". She was involved with the publication of EUROHEALTH (vol. 10, no. 1, 2004) where the integration of public health and agriculture policy is addressed and where she co-authored a paper on Rural Development with Professor John Bryden, from Aberdeen University.

Aileen has published extensively regarding public health nutrition and was instrumental in the endorsement of WHO's First Action Plan for Food and Nutrition Policy in Europe. She also produced two major reports comparing nutrition policies in the fifty Member States of the WHO European Region.

Aileen is now employed as a public health nutritionist at Suhr's University College for Nutrition and Health in Copenhagen, Denmark.

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## **Summary**

Nutrition Policy implementation is at an exciting time of development internationally and it is timely to compare progress and achievements in Scotland with those of other countries. This report provides an analysis of some similarities and differences between policies in Scotland and 12 other countries (Australia, Canada, Denmark, England, France, Ireland, Israel, New Zealand, Norway, Slovenia, Sweden, and USA).

Generally most national experts believed that the success of nutrition policy implementation depends very much on the willingness of different stakeholders to work together. It also appears that ministries, such as agriculture or education, have difficulty in being co-ordinated by a Ministry of Health. Hence it is recommended to place co-ordination mechanisms under the cabinet or prime minister. Suggestions on how to improve intersectoral collaboration included the creation of a Ministry of Public Health. The main responsibility of this ministry or agency would be to engage with other sectors and carry out health impact assessments, thus concentrating on public health and not the health care system. In addition, while qualified public health experts are needed as project leaders, there also needs to be support and political commitment from Director Generals and Chief Executives. Good management and organizational skills are also needed, along with written agreements which are explicit about who has responsibility for implementation between different government departments.

Scotland relies on data from UK surveys for some of its nutritional information. Whereas Scotland could benefit, like New Zealand, Ireland, Sweden and Norway, by carrying out nationally representative surveys and establish comprehensive monitoring systems to underpin nutrition policy. It is difficult to compare directly the human and financial resources invested in policy implementation between countries because of the lack of precise information. However one useful

analysis in the future would be to analyze what percentage of the total health budget is spent on nutrition policy implementation in the different countries.

Interesting research projects, commissioned by the health sector, are helping to support the need for nutrition policy in different countries. This includes research carried out in New Zealand on “Nutrition and Burden of Disease”. In The Netherlands an analysis of the health losses due to food borne diseases compared with chronic nutrition-related diseases (“Dutch Meals”) was carried out. In both Slovenia and Sweden Health Impact Assessments of agriculture policy were carried out. In Sweden experts calculated the potential direct and indirect costs that could be saved via nutrition policy implementation and in addition thirty times more is spent on marketing foods high in fat, sugar and salt compared with fruit and vegetables; in Denmark there are plans to calculate the costs of obesity and other nutrition related diseases. These examples are fundamental measures needed to build the evidence base to underpin nutrition policy and Scottish experts are encouraged to carry out similar investigations.

Countries with the best international collaboration are undoubtedly the Nordic countries. All EU national experts interviewed participate regularly in EU meetings such as the Nutrition and Physical Activity Network and the Platform for Diet and Physical Activity. In addition all national experts interviewed, except Scotland, participate regularly in WHO nutrition meetings. All national experts value international opportunities to share information and learn from each other. In general Scotland compares very well with the achievements in other countries, although Scottish nutrition experts are disadvantaged due to having less official international collaboration regarding nutrition policy development and implementation.

## **1. Purpose of the report**

Nutrition policy implementation is at an exciting time of development internationally, and it is timely to compare progress and achievements in Scotland with those of other countries.

This report was commissioned to contribute an international perspective to the evidence presented to the SDAP Review Panel on progress and impacts of the implementation of the Scottish Diet Action Plan over the last ten years. The main objectives for the international report were to assess:

- the appropriateness of the Scottish Diet Action Plan’s vision and framework for action to achieve population level dietary change when compared with other policy frameworks internationally in equivalent developed countries

- the relative effectiveness of Scotland's policy implementation compared to other comparator countries in terms of the extent to which delivery/actions have been resourced and supported, nationally and locally<sup>1</sup>
- In the light of the learning about the implementation of contemporary food policy internationally and national (Scotland) population trends, the priorities for food and health policy in Scotland for the next five years to 2010.

This report is intended to build on existing documentary policy analysis<sup>2 3</sup> and provide a commentary on the policy implementation process across a range of countries, addressing the following questions:

- What has been done since the country's food/nutrition and health policy was published?
- What's worked/been successful? What's been less successful/more difficult to implement or influence?
- How was this achieved?
- What was the process of policy implementation?
- What, if any, has been the influence of Scottish food and health policy on the development and/or implementation of this country's policy?

This report provides an analysis of the similarities and differences in nutrition policies and their implementation between Scotland with 12 other countries: Australia, Canada, Denmark, England, France, Ireland, Israel, New Zealand, Norway, Slovenia, Sweden, and USA.

It is recognized however that Scotland differs from many of these countries in a number of important ways. Most significant is that Scotland is part of the UK and political decision-making is devolved to the Scottish Executive in specific areas only. Although decision-making on the health service is devolved to the Scottish Executive, many aspects affecting the protection of public health are 'reserved' powers decided at a UK level. One example of how public health policy implementation differs in Scotland compared with England is the ban on smoking in public places, including pubs and restaurants.

In addition, Scotland's geographical size relative to its small population (c5 million) and the remoteness of some parts means that Scotland cannot be directly compared with many countries included in this report, except perhaps

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<sup>1</sup> See report from Laurie True, *Child Overweight: What's a Government to Do? Going Upstream to Turn the Tide in Scotland*, Atlantic Fellow in Public Policy 2005. This provides a recent account of the formulation and implementation of Scotland's policy strategies to improve diets and increase physical activity

<sup>2</sup> See report by Professor Ian Crombie et al (2005) *Public health policies to tackle obesity: an international perspective*. NHS Health Scotland, March 2005. <http://www.phis.org.uk/projects/network.asp?p=fh> This reviews public health policies on nutrition as well as physical activity in fourteen developed countries: Australia, Canada, Denmark, England, Finland, Ireland, Japan, New Zealand, Northern Ireland, Norway, Scotland, Sweden, USA and Wales.

<sup>3</sup> See WHO (2003) *Comparative analysis of food and nutrition policies in WHO European member states*, WHO Copenhagen

Norway. The comparator countries range in population size from USA (almost 300 million) to Slovenia (2 million). The next largest after the USA is France (65m), England (50m), Canada (32m), Australia (20m), to those under 10 million inhabitants: Sweden (9m), Israel (7m), Denmark (5½m), Norway (4½m), Ireland and New Zealand (4m). From a population perspective, Scotland can therefore best be compared with Ireland, Denmark, New Zealand and Norway.

## 2. Methods

Information about the nutrition policies and their implementation in the 13 countries was gathered via interviews with key informants in each country (Annex 1). Most of the key informants were national experts employed within the government's health sector, with the exception of the USA (former employee of Health Department), Australia (nutrition policy expert from academia), and Denmark (Head of Nutrition Office, Ministry for Family and Consumer Affairs). National experts in Finland, The Netherlands and Japan were also contacted for interview, but it was not possible to get responses in the time available.

The national experts were initially contacted by email and, after their agreement had been obtained, telephone interviews were carried out, with the exception of Denmark and Slovenia where face-to-face interviews were possible. Following the interviews, the completed questionnaires were returned to the respondent for checking and permission to cite their names as the national expert interviewed was sought. This report was shared with all those who participated in the survey and they were assured that their permission would be sought prior to publication of any parts of the report.

The interviews were based on a questionnaire<sup>4</sup> which was sent to national experts before each interview, so that they had time to consider their responses, but they were not asked to complete the questionnaire. During the interview key informants were invited to answer specific questions in a free style and to focus on those questions which they believed were most important. The questions were structured around ten main headings:

- The existence of public health and/or nutrition policy documents
- Policy implementation and infrastructure
- Intersectoral collaboration
- Monitoring and evaluation
- Financial and technical resources
- Leadership
- Policy instruments used to implement nutrition policy
- International collaboration
- Sustainability and future challenges
- Food culture.

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<sup>4</sup> Questionnaire available on request.

All questions related to the public health policies and/or nutrition policy/action plans developed at national level. National experts were welcome to provide additional information. After the interviews each questionnaire was completed by Aileen Robertson and returned to the respondents to ensure that the completed questionnaire reflected the responses given during the interview.

### **3. Results and discussion**

Twelve countries were interviewed in addition to Scotland. It was hoped that experts in Finland, The Netherlands and Japan could also be interviewed but, although experts were contacted, it was not possible to get their responses in the time available.

#### **3.1 Nutrition policy as an aspect of public health policy**

The national experts were asked for the names and web-links for the national public health and nutrition policy documents (Annex 2). Most countries have both national Public Health Policy documents and specific Nutrition Policy documents. Sweden's new Public Health Policy is recognized internationally for its pioneering approach. Nutrition Policy features as one of the major priorities requiring implementation within these international pioneering policy approaches to overall public health. In contrast Scotland's Diet Action Plan was published in 1996, three years in advance of its main public health policy, "Towards A Healthier Scotland" (1999).

Most countries first published nutrition policies in the 1990s, except for Norway, which developed a nutrition policy as early as 1976, and Slovenia where the first Food and Nutrition Policy was endorsed by the government in Spring of 2005. There is no nutrition policy as such in USA, but US dietary guidelines provide the basis for US dietary policy guidance and these are promoted in all federal nutrition policies and programmes. During the past 10-15 years most countries have up-dated their nutrition policies at least once and some three times. In the US for example the dietary guidelines are up-dated every 5 years. Not all countries have carried out evaluations but interesting lessons can be learned from Australia<sup>5</sup>. The Scottish Diet Action Plan was published in 1996 and an evaluation is now being carried out in 2005/2006.

The Scottish Diet Action Plan was produced following the James Report on *The Scottish Diet* (1993) and a two year period of consultation with key stakeholders in the public, private and voluntary sectors. This policy development process was similar in most countries and the process took around one to two years from beginning to end. In England the nutrition policy process was delayed because the overarching public health policy process ("Choosing Health") started later and so the publication of the Food and Health Action Plan was delayed to become

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<sup>5</sup> Food & Nutrition Policy – First 3 years of implementation (1998)  
[www.health.gov.au/pubhlth/publicat/document/fnp.pdf](http://www.health.gov.au/pubhlth/publicat/document/fnp.pdf)

one of the components and one delivery plan of “Choosing Health”. In England, Phase 1 of the consultation identified patterns and trends in nutrient and food intake that impact on health and disease and key influences on diet and eating patterns. The output was the Food and Health Problem Analysis. Phase 2 developed solutions and actions to the problems identified during Phase 1 in co-operation with stakeholders. The output was the Food and Health Action Plan (web link in Annex 2).

In Canada *Nutrition for Health: An Agenda for Action* 1996, was the result of an intense Canada-wide process of intersectoral collaboration involving government departments, NGOs and the private sector. A Joint Steering Committee was responsible for releasing the *Agenda* in 1996. Six years later, in September 2002, Federal/Provincial/Territorial Ministers of Health announced their agreement to work together on a Healthy Living Strategy, which would initially focus on physical activity, healthy eating and their relationship to healthy weights. The goals of the Strategy are to improve overall health outcomes and to reduce health disparities. In September 2004, First Ministers highlighted the importance of efforts to address disease prevention, health promotion and public health, and the sustainability of the health system. First Ministers committed to working across sectors through the Strategy's framework on initiatives such as Healthy Schools. The federal Budget 2005 announced funding of \$300 million over five years for the Integrated Strategy on Healthy Living and Chronic Disease. At the annual meeting of Federal, Provincial and Territorial Ministers of Health in October 2005, Ministers further demonstrated their commitment and leadership in advancing public health through agreement on a set of goals for improving the health of Canadians. A process started recently to establish new population goals for the health of Canadians, including nutrition goals as a high priority. The Canadian Health Goals Initiative<sup>6</sup> is expected to be finalised in 2006.

In Denmark nutrition policy development and implementation is jointly undertaken by two Boards: one for “Health” (MOH) and one for “Food” (Ministry of Family & Consumer Affairs – which was formerly under Ministry of Food, Agriculture & Fisheries). The Board of Health deals mainly with implementation of nutrition policy via the Health Care System and The Board of Food deals with public health via other sectors such as schools, work places and enforcement of the Food Law.

New Zealand's Nutrition Action Plan, “Healthy Eating - Healthy Action” (HEHA see web-link in Annex 2) was produced after extensive consultation. The HEHA Implementation Plan took even longer and was developed in consultation with 4 advisory groups: (i) internal for the health departments; (ii) external experts; (iii) food and physical activity industry groups; and (iv) Government agencies & departments.

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<sup>6</sup> [www.healthycanadians.ca](http://www.healthycanadians.ca)

Scotland compares favourably with most of the other countries considered. The consultation process for the development of the SDAP took around 2 years (1994 -1996). However, the SDAP preceded the development of the national public health policy in Scotland, *Towards A Healthier Scotland* (1999), creating both opportunities and challenges: opportunities because there was less competition for resources; and challenges because the success of the SDAP implementation depended on the creation of a completely new way of working. To be able to successfully implement the Action Plan intersectoral collaboration was vital and so new infrastructures for the SDAP delivery and a workforce capable of delivering them had to be developed from scratch. In contrast the updated nutrition policy “Eating for Health – meeting the Challenge”, published in 2004, was influenced by the SDAP (1996) but was also rooted in the new Public Health policy “Improving Health in Scotland - The Challenge” (2003).

**Scotland’s next food and nutrition policy should be embedded in an overarching public health policy. Food and Nutrition policy is not sustainable as an isolated policy and its implementation is more likely to be successful if rooted in the national political commitments to sustainability and public health.**

### **3.2 The implementation of nutrition policies**

The national experts were asked to what extent their national policy on nutrition had been implemented. In ten countries the policies had been implemented to some degree, whereas in France and Denmark as well as Scotland, most of the recommended actions had been implemented. The country that appears to stand out as making the most rapid progress is France. In other countries, such as Australia, where implementation began around the same time as Scotland, implementation was strong in the initial phase, especially via demonstration projects, but after 3 years resources diminished. In contrast implementation in Scotland has been stronger in the latter five year phase, especially after the appointment of a National Food and Health Co-ordinator in 2000.

In New Zealand, Ireland, England, Slovenia and Sweden their latest nutrition policy implementation has just started and so it is too early to evaluate their progress. In New Zealand priorities were decided and a phased implementation plan agreed by both external and internal stakeholders. Moreover in both Sweden and Slovenia, although the documents had not been ratified by their respective governments, implementation started as a direct result of the consultation process (in Sweden 10 of the recommended 79 actions are being implemented).

All countries highlighted the growing awareness concerning the escalating rates of chronic diseases and obesity as the key driver for nutrition policy implementation. The second most important driver is the growing awareness of inequalities and the need to tackle the consequences of poverty. In Slovenia the requirements to join the EU and enforcement of EU directives (e.g. control of marketing of breast milk substitutes which comes under national Food Law) created a major opportunity. Although the focus of EU membership was mainly food safety, Food Law and enforcement of EU directives, nevertheless this provided an opportunity to bring nutrition policy onto the political agenda. A similar situation arose in Australia where the need for new Food Safety Regulations, via Codex Alimentarius and W.T.O., created an opportunity for nutrition via new regulations on health and nutrition claims, fortification, and labeling laws.

### **3.2.1 Challenges to nutrition policy implementation**

The national experts were asked what the main challenges were that had to be overcome to implement their policies. They all agreed that there are some key factors that influence the extent to which policies can be implemented successfully and ranked them:

- intersectoral collaboration (9 countries);
- financial resources (9 countries);
- human resources (6 countries);
- sustained political commitment (4 countries).

In common with eight other countries, the national experts in Scotland identified the main challenges as improving intersectoral collaboration and developing robust organisational infrastructures. A clear commitment to and responsibility for implementation was identified as an important factor.

Responsibility for implementation not only has to be clear, but also shared across sectors. It appears that, if the Health Ministry is perceived as having sole responsibility, it is difficult to get commitment from the other Ministries and stakeholders.

For example in Denmark disease prevention and health promotion is voluntary. It is carried out mainly at the local level and the extent of local health promotion actions by local authorities is very variable. However, from 2006, health promotion will no longer be voluntary and local authorities will be held responsible for implementation in Denmark.

The commitment of financial resources to policy development and its implementation was also seen to be critical. In some countries there exists the misconception that because we all have to eat, improving eating habits can be addressed without additional funding. This lack of understanding of the

complexities of implementation of nutrition policy can only change if new evidence, that demonstrates the need for action, is developed. One country that appears to have overcome some of these difficulties, within a relatively short time, is France.

### **3.2.2 Institutional infrastructure for nutrition policy implementation**

National experts were asked which institutions or individuals were primarily involved in driving nutrition policy implementation. In Scotland, the implementation of the Scottish Diet Action Plan was allocated to a range of national bodies and local groups, including a range of government departments, the Health Education Board for Scotland (HEBS), the Scottish Consumer Council, the food industry and retailing sector and local Directors of Public Health. Since 2000, the Food Standards Agency in Scotland has also become a major player in nutrition policy implementation.

In Australia, Slovenia and Ireland individuals (academics, politicians and civil servants) played a major role in gaining political support for nutrition policy. In other countries, a range of different institutions have played a major role.

In Canada, Health Canada has provided national leadership in nutrition since the late 1930's. Established in 2001, the Office of Nutrition Policy and Promotion (ONPP) provides a focal point for nutrition both within the Department and for national leadership. The role of the ONPP is to promote the nutritional health and well-being of Canadians by collaboratively defining, promoting and implementing evidence-based nutrition policies and standards.

In Denmark, nutrition policy development and implementation is jointly undertaken by both the Boards of Health and Food.

In France, implementation is the responsibility of the Ministry of Health along with three national agencies: INPES (National Health Promotion Institute); AFSSA (Food Standards Agency); and INVS (National Surveillance Institute). In addition the Social Security and "Mutuelles" and the Ministry of Agriculture in France became involved in 2003.

In Ireland, the National Nutrition Surveillance Centre plays an important role along with Health Promotion. In Israel the Food and Nutrition Administration at the MOH is the driving force. In Norway the National Nutrition Council (Annex 4 and 5) along with the Directorate of Health have been effective with regard to nutrition policy implementation. In Sweden, the Food Administration (under Ministry of Agriculture) and the Institute of Public Health (under Ministry of Health) are responsible for the implementation process. In England, similar to Scotland, the Department of Health and Food Standards Agency (FSA) are now the lead agencies with responsibility for policy implementation; the role of the Health Education Authority in supporting policy implementation was lost in 2001.

### 3.2.3 Administrative structures overseeing the implementation

National experts were asked if there is a national level administrative structure (in addition to a scientific advisory structure) which is responsible for overseeing and co-ordinating policy implementation and whether or not it is effective. Not all countries have administrative structures but it appears that those that do, have the most effective nutrition policy implementation.

In Scotland, it was not until 2000 that a National Co-ordinator for the implementation of the Scottish Diet Action Plan was appointed, as a secondee to the Health Improvement Strategy Division within the Scottish Executive Health Department. In 2005, the Food and Health Council was established to bring together the key players in policy implementation nationally and locally.

The Steering Committee structures of New Zealand and France are considered to be effective. In New Zealand there are two coordinating groups: The HEHA internal Coordinating Group<sup>7</sup> and the HEHA external Coordinating Group<sup>8</sup>. The Public Health Directorate and Sport and Recreation New Zealand (SPARC) provide leadership.

In France a Steering Committee of strategic support, made up of representatives from different sectors (scientific experts, public health specialists, voluntary and private sectors) contribute, under the aegis of the Ministry of Health (MOH), to the implementation and evaluation of the National Healthy Nutrition Programme (PNNS). The French Prime Minister announced that the PNNS would be co-ordinated by the Secretary of State for Health and Disabilities in liaison with the government sectors responsible for education, agriculture and fisheries, research, youth and sports and consumers. High-ranking members attend Steering Group meetings regularly. The creation of this Steering Committee is one of the main reasons for success in France. Originally the Steering Committee consisted of only 25 members, but in 2005 this increased to 30 (Ministry of Social Affairs; Institute of Cancer; Food Council (industry); Retailers; Mass Catering; Consumers; Local Authorities; Scientists (sociologists, public health, nutritionists & paediatricians). In France there are also intersectoral steering committees at regional level, which feed into the national Steering Committee.

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<sup>7</sup> Chaired and led by the Public Health Directorate (composed of nutrition advisors, physical activity advisor, Maori health advisor, cancer control advisor, Pacific group, Operations group (group managing contracts for public health services, (SPARC policy advisor), and policy analysts from other directorates in the Ministry including clinical services, disability services, District Health Board funding and performance, sector policy, primary health care and Maori health).

<sup>8</sup> includes the fruit and vegetable alliance (FAVA); Pacific Food & nutrition advisory group, National Heart Foundation, Agencies for Nutrition Action, Maori nutrition & physical activity group, Fitness NZ, Health Sponsorship Council, Advertising Standards Authority, Food and Grocery Council. DHB membership includes chief executive reps, Public Health leader group and Maori PH manager group. Gov dept/agencies include Transport, Work and Income, Social Development, Local Gov NZ, NZFSA and SPARC.

In Canada, action to improve nutrition is a shared responsibility. Nutrition cuts across many areas, and decisions related to health, agriculture, education, social and economic policy impact the nutritional health of Canadians. Recognizing this broad scope, the ONPP works closely with its partners, from policy making to implementation. The ONPP provides leadership and co-ordination to the Federal, Provincial Territorial Group on Nutrition. Provinces and Territories play a critical role in promoting the nutritional health and well-being at the community level. While many programmes vary from province to province and between communities, many build upon standards and guidelines developed collaboratively at the national level, such as *Canada's Food Guide to Healthy Eating*. To enhance collaboration, co-operation and alignment of efforts to support healthy eating in Canada, the ONPP established and co-chairs the Network on Healthy Eating. This includes consumer groups, voluntary health organizations, industry representatives, and other NGOs.

In England administrative mechanisms have only recently been created within government. The Obesity Programme Board will report to the Health Improvement Board, set up to drive the cross-government implementation of the public health policy, *Choosing Health*, and the DfES *Change for Children* Group. Its responsibilities include overseeing the work of stakeholder sub-groups. Members include the Department of Health (Chair); Department of Education; Department of Culture, Media and Sport; Department of Transport; Department of Environment, Food and Rural Affairs; Office of the Deputy Prime Minister (Planning and Local Government); HM Treasury; Food Standards Agency and Regional Directors of Public Health.

In USA there used to be one coordinating mechanism responsible for overseeing the implementation of Dietary Guidelines but there are now two units:

1. Under Agriculture sector – Centre for Nutrition Policy and Promotion
2. Under Health sector – Office of Disease Prevention and Health Promotion.

It appears that one rather than two coordinating mechanism would be preferred, so that responsibility is not split between two governmental departments.

Generally most national experts believed that the success of the administrative structures depends very much on the willingness of the members to work together. This can be influenced by the positioning of the structure to ensure that the contributing parties are given appropriate position and status. For example, it appears that Ministries, such as Agriculture or Education, have difficulties in being co-ordinated by Health. In this situation, cross-government co-ordination mechanisms might best be positioned under the Cabinet or Prime Minister.

Examples of countries where administrative co-ordinating structures were considered less effective include Australia where only the public health sector was represented and, after two years, only junior officers attended meetings instead of the intended high ranking decision-makers. In Slovenia structures were not so effective when government sectors were sitting together with NGOs

and the private sector. Therefore, in Slovenia, an inter-governmental structure for representatives of different ministries will be created and a second coordination mechanism will be established to include all the sectors (public, private and voluntary) in Slovenia.

**Scotland's next food and nutrition policy should be developed by the Food and Health Council where all the relevant stakeholders are given appropriate recognition and status to ensure regular attendance of high ranking representatives of different sectors.**

**In most countries Nutrition Advisory Committees or Councils have a degree of independence from government. In addition the appointed Chair persons are often experienced Professors e.g. of Public Health Nutrition in Norway.**

**Participation at meetings, concerning Food and Nutrition Policy within the European Union, WTO, WHO and Codex Alimentarius, is essential for Scotland, and thus ensure both that national experts are exposed to future international challenges and that Scotland can influence international decisions on food and health.**

**To enable successful nutrition policy implementation, sustained commitment, both financial and political, will be needed in Scotland from the highest possible level.**

### **3.3 Intersectoral collaboration**

National experts were asked to name the main institutions/sectors that collaborate regularly on policy implementation. Those sectors collaborating most included the public health services and health promotion departments. In addition the voluntary sector, especially NGOs working on prevention of heart disease or cancer, and the private sector, especially the food industry, are very interested in how nutrition policy is implemented.

The education sector was seen as more difficult to engage, especially when political changes mean that policies keep changing. However, via processes such as Health Promoting Schools, there has been partial success. In New Zealand a tripartite Memorandum of Understanding between MOH, SPARC and the Education sector has improved joint working where clear responsibility for implementation is agreed and a joint work programme carried out. In Scotland a national initiative "Being Well – Doing Well" between the Ministers for Education

and Young People and Health has been established to create a framework for health promoting schools in Scotland.

In most countries the authorities responsible for food safety are beginning to work in closer collaboration with nutrition policy implementation, whereas the primary health care and dental sectors are not always seen as important implementation partners. However, in New Zealand health promotion is emerging as a joint initiative between the 21 District Health Boards (DHBs) and Primary Health Organisations (PHOs). An innovation fund has been set up by MOH (1 million NZ\$ /yr for next 3 years). Existing or new projects can apply for funds and DHBs must match Ministry funding and include evaluation.

The Agriculture sector in most countries is becoming a major player, especially where policies on sustainable rural development and organic farming are pursued. In Slovenia and Sweden, Health Impact Assessments (HIA) of agriculture policy helped to create a more effective dialogue between the health and agriculture sectors. In Denmark, under their Innovation Policy, the Agriculture Ministry has made funds available for campaigns to promote fruit and vegetable consumption and to promote the intake of fish twice per week. In Scotland, the collaboration with the Agriculture sector has been slower to develop. Therefore the Scottish health sector has to find ways to better understand the issues facing the agriculture sector (e.g. via Health Impact Assessments) and how the different government departments can work jointly to address national concerns of food and nutrition security.

Other sectors reported by the national experts as being important collaborators include:

- Catering and the Food Service Sector; and Research Institutes and Agriculture Research Institutes in France
- Elderly Care and Social Services in Sweden and New Zealand
- Food Importers and the Media in Israel
- Ministry of Fisheries in Norway
- The Media in Scotland.

### **3.3.1 What makes intersectoral collaboration effective**

National experts were asked what makes inter-sectoral collaboration effective. In Scotland, the appointment of a National Food and Health Co-ordinator within the Health Department was seen to have improved inter-sectoral collaboration.

One of the main barriers identified by most national experts was that nutrition policy was seen solely as the responsibility of the Ministry of Health. The creation of a Ministry for Public Health was recommended as one way to improve intersectoral collaboration. This function could also be achieved by an external 'arms-length' public health body sitting outside the MoH (e.g. the Health

Directorate in Norway, National Institute for Public Health in Sweden, or SPARC in NZ). The main responsibility of this Public Health body would be to engage with other sectors and carry out health impact assessments of their policies, thus concentrating on public health and not on a therapeutic health care system. In addition while qualified public health experts are needed as project leaders, there also needs to be support and political commitment from Director Generals and Chief Executives. Also good management and organisational skills are needed along with written agreements between government departments regarding collaboration and responsibility for implementation. Joint work programmes should be agreed and specific responsibility and resources assigned. Collaboration can be more effective if a mechanism is created under the cabinet/prime minister where all the stakeholders meet regularly to reach a consensus on how nutrition policy should best be implemented.

In France, the Steering Committee structure works by reaching a consensus on how to implement concrete activities and ensure that these are relevant for all the sectors represented on the Co-ordination Steering Group. In New Zealand some of the best intersectoral collaboration has been achieved by meeting with governmental departments to discuss specific issues. Moreover it is better if departments themselves identify nutrition as being a priority e.g. The Ministry of Social Development identified nutrition as one of the five priorities within “Opportunity for All” in New Zealand.

In Norway, the agriculture sector is collaborating well with the health sector. For example the production of fruits and vegetables has been increased and more “win-win” situations are being found via the Rural Development policies. In contrast, in Scotland the “Agricultural Strategy” and “Food & Drink Strategy” were developed without reference to the SDAP. However the appointment of a National Food and Health Co-ordinator, the strengthened “Health Improvement” policy and the “Sustainability Agenda” (e.g. Curry Report) are helping to ensure that food and health issues are now discussed within the policies of other departments.

National experts were asked if there had been a change in the number of sectors wishing to collaborate since their nutrition policy was adopted. It appears that the development of a nutrition policy can be enough to improve the collaborative process and the likelihood of implementation becomes stronger if accompanied by written agreements. Examples of new partnerships included: the food industry (perhaps to try to limit the damage to their interests) have started a number of initiatives such as “Obesity Summits” and supporting government to carry out national dietary intake surveys. Perhaps as a reaction against this, more NGOs are springing up especially around single issues, such as lobbying against marketing to children.

National experts stated that commercial sector food marketing tactics can make collaboration difficult. In one country, McDonalds made their own food pyramid

which showed how one could eat fast food daily and still eat within the government's nutritional recommendations - by eating mostly fruit and vegetables for breakfast and evening meal; McDonalds also give coupons for sport awards and put their logo on training jackets.

Many food industries are lobbying aggressively against regulations about marketing unhealthy food to children. In most countries, the food industry has introduced voluntary codes concerning responsible advertising of food especially to children. However there are calls from parents for better collaboration between the Health and Education Sectors to avoid mixed messages being given to children.

In the UK the authorities are working with the food industry to reduce composition of fat, sugar and salt of "normal" foods and not just to create niche products. In many countries the food industry is very powerful and representatives meet Ministers in an attempt to influence political decisions. Their desire to demonstrate their "Corporate Social Responsibility" is increasing against mounting public pressure.

In general there appears to have been a substantial increase in the number of sectors, such as education, agriculture and the food industry, interested in nutrition policy implementation. In Scotland there is growing interest from: Scottish Enterprise; Environmental Health Services (via the Health Improvement Agenda), Food Industry (including retailers, hospitality industry, & manufacturers); the Education Sector and Local Government.

### **3.3.2 Collaboration between Food Service and Nutrition**

During various interviews it became clear that the catering sector in general and more specifically the school meals sector provides an excellent opportunity for the successful implementation of nutrition policy.

National experts were asked if the catering sector in general is engaged in the implementation of nutrition policy. It was remarkable that the broadcasting of the TV programme Jamie Oliver's *School Dinners* in most countries has increased the interest of the catering sector generally, and especially by the education sector, even if the situation is perceived as not as bad as it appears in England. The Catering sector can influence consumption patterns and has also the possibility of influencing production patterns through procurement policies.

In Scotland, following the publication of the SDAP, model guidelines for catering in the public sector were developed and led to national initiatives such as *Scottish Healthy Choices Award*. Nutritional catering guidance is being rolled out into other public institutions, such as prisons, and the "Healthy Choices" award is being re-developed as a national catering award for the private sector with workplace catering a key focus. There is collaboration with the Royal Institute of

Environmental Health and also with FSA regarding training modules in Scotland. Furthermore, there has been significant investment in improving the nutrient standards of school meals in Scotland through the *Hungry for Success* initiative. This is also seeking to improve school dining areas, train school catering staff and better-equip school kitchens so that cooks can prepare more home-cooked food. *Hungry for Success*, the school food policy and national standards for school lunches, has recently been positively evaluated by the school inspectorate<sup>9</sup>.

In France, 50-80% of children eat at school and there is a tradition for providing good quality hot school meals (3-4 courses) daily and much effort goes into this. Primary school meals are subsidized by the local authorities and are free for children from low income families. In Secondary Schools, meals are currently subsidized by the national government, but in 2006 this responsibility transfers to the Regions.

In Sweden one new recommendation is to implement training for school catering staff. This recommendation was included in the previous nutrition policy but it was not properly implemented because there was no-one overseeing this. In Slovenia voluntary standards have been developed for most public institutions such as kindergartens, schools, student hostels, universities, hospitals and work places. In Norway children take packed lunches and the Nutrition Council and Health Directorate developed nutrition standards.

In New Zealand hot school meals are not provided and decisions are made by individual schools and School Boards. Some schools have implemented the Health Promoting School concept; others offer breakfast programmes; others have been awarded “Healthy Heart Awards” from NGOs (e.g. National Heart Association). In Denmark authorities do not provide school meals and children take packed lunches. However in Copenhagen, the municipality has just started a pilot project in seven primary schools. A choice of 2 hot meals plus sandwiches, water or milk are provided and subsidized by local authorities. Parents cover the cost of the raw ingredients and the meals are prepared centrally. If successful this could result in a change in the school meals system throughout Denmark. In 2003 “Alt-om-Kost – Smag-for-Livet” (All-About-Food – Taste-for-Life) was established. The aims are to support local institutions caring for children, to implement food policies with good nutritional standards. “A Travelling Team” consisting of food safety inspectors (eight inspectors are based nationally and another eight are based within the local food safety inspection services) who are trained about nutrition. Initially it was difficult but now they are being eagerly sought to help implement school food and nutrition policies while not violating food safety regulations. The issue of violating food safety regulations is of great

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<sup>9</sup> [www.scotland.gov.uk/Topics/Education/School-Education/18922/15872](http://www.scotland.gov.uk/Topics/Education/School-Education/18922/15872)

<sup>9</sup> [www.hmie.gov.uk/documents/publication/hmiemihs.pdf](http://www.hmie.gov.uk/documents/publication/hmiemihs.pdf)

concern to many countries because strict food safety regulations can easily hamper the implementation of nutrition policy (see 3.3.3.).

In England, standards for school meals were published in 2005<sup>10</sup>. In both England and Scotland mass catering in public authorities is seen as a good opportunity for working with public procurement policies. Indeed in Scotland procurement policies are believed to have a great untapped potential to influence the food chain right from production to consumption. For example with regard to school meals, local authorities have used FSAS target nutrient product specifications in the criteria for procurement tenders. In Scotland standards for school meals are voluntary but the Scottish Executive writes to Directors of Education in local authorities with official guidance, which are accompanied with funding. It is rare that local authorities do not enact this guidance.

### **3.3.3 Collaboration between food safety and nutrition**

National experts were asked if there exists good collaboration between the food inspection service and those responsible for implementing nutrition policy. As stated above many experts reported examples where the increase in stricter food safety regulations can potentially block the implementation of nutrition policy, especially in institutions responsible for feeding children and the elderly, because of the fear of cross contamination and potential risk of food poisoning. In some instances food preparation and meal provision is stopped because of the potential risks.

In Scotland, a “Concordat” between the Health Department and Food Standards Agency (FSAS) is overseen by a senior level liaison committee that clarifies who has responsibility for what. While this operates well at a national level, problems can arise at local level. For example, environmental health officers may stop prepared meals being provided by institutions because of the potential risk. However food inspectors could be a potential untapped resource for the implementation of nutrition policies, if food inspectors received more training about nutrition and how best to implement nutrition policies.

In the US two things led to better collaboration between food safety and nutrition experts: In 2000 the Dietary Guidelines included for the 1<sup>st</sup> time recommendations about food safety. This helped governmental experts working with food safety or nutrition to become more aware of the need to collaborate. Secondly from 1996-2000, the Deputy Minister for Agriculture with responsibility for Food Safety was a nutrition scientist. This helped to create awareness that food safety and nutrition messages should not be conflicting.

In Australia good collaboration between food inspectors and nutritionists happens at the local level. Local authorities are working with health promotion officers and

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<sup>10</sup> [www.dfes.gov.uk/consultations/conDetails.cfm?consultationId=1319](http://www.dfes.gov.uk/consultations/conDetails.cfm?consultationId=1319)

Professor Sally Macintyre<sup>11</sup> was invited to explain the process of “Community Mapping” with regard to try to solve some of the “food desert” problems in Australia.

In Denmark their FSA is in same building as the nutrition office. There is an “in-house” policy where collaboration takes place and local food control units should not issue press releases without checking with National Authorities. “Alt-om-Kost”, mentioned above, has also helped to prevent conflicting messages because its food inspectors have training in nutrition. In Ireland, the FSAI’s Food Safety Promotion Board also has responsibility for nutrition promotion. In Sweden one new proposal includes carrying out “an enquiry into how nutrition policy could be implemented via the food inspection service.” In Israel there is good collaboration between the food inspection and nutrition services because a nutritionist is chief of both.

Ironically even although the health loss caused by nutrition related diseases is huge compared with food borne disease, much more resources go to enforcing food safety regulations compared with nutrition policy. Around half of the national experts estimated that a huge amount more money is spent on enforcing food safety regulations. For example in Sweden and New Zealand, experts estimated that 7 and 10 times more respectively is spent on food safety compared with nutrition policy. Figures from FSA Scotland indicate that in 2006 there will be more than 15 times more spent on enforcement of food safety regulations compared with nutrition policy implementation in Scotland. This is in stark contrast to the huge health losses, due to chronic nutrition-related diseases, which have been calculated to be approximately 40 to 100 times greater than the health losses resulting from the food-borne diseases due to unsafe food e.g. in the Netherlands<sup>12</sup>.

**Intersectoral Collaboration is vital to the successful implementation of Nutrition Policy. Especially the agriculture and education sectors are important partners. In Scotland, the health sector has successfully collaborated with the Education Sector but needs to understand better the issues facing the Agriculture Sector and how the governmental departments can work jointly to address concerns of national food and nutrition security.**

**Scotland can continue to build on its successful collaboration with the education sector. The schools meals sector specifically and the catering sector in general provides new opportunities for implementation of nutrition policy through, for example, procurement policies which could**

<sup>11</sup> Director, MRC Social & Public Health Sciences Unit, University of Glasgow

<sup>12</sup> “Measuring Dutch Meals” Institute Public Health, Netherlands  
[www.rivm.nl/bibliotheek/rapporten/270555008.pdf](http://www.rivm.nl/bibliotheek/rapporten/270555008.pdf)

**also lead to better collaboration with the Agriculture Sector .**

**It will be important for Scotland to prevent implementation of stringent food safety regulations which conflict with nutrition policy implementation, and so closer collaboration with the Environmental Health Service is recommended.**

**Given the resources invested on food safety enforcement in Scotland, it would be useful to compare the national morbidity from food-borne diseases compared with nutrition-related illness in Scotland, similar to the analysis carried out by the Institute of Public Health in the Netherlands<sup>12</sup>.**

### **3.4 Monitoring and Evaluation**

National experts were asked about the types of surveys and monitoring systems used to track trends and evaluate outcomes of nutrition policies. All national experts were very aware that monitoring and evaluation are essential to improve the implementation of successful policies and action plans. However, very few countries go beyond nutritional surveillance - monitoring nutrition-related outcomes/targets in the population - and include evaluations of progress with policy implementation and its impacts, including the impacts of particular programmes or actions.

Scotland has systems for both nutritional surveillance and policy evaluation, although it doesn't carry out its own nationally representative food and nutrition survey, as in New Zealand, Ireland, Sweden and Norway. The National Dietary and Nutrition Survey (NDNS) is a UK wide survey of food and nutrient intakes and the sample for Scotland (< 200) is not large or representative enough to meet Scottish needs. In addition, the Expenditure and Food Survey (EFS) and the Scottish Health Survey provide national level data on household food purchasing and self-reported eating patterns respectively. A Scottish Executive working party in 2004 produced a plan for comprehensive monitoring and surveillance. In terms of evaluation, HEBS/NHS Health Scotland monitor and evaluate the impacts of specific health education social marketing campaigns and programmes and has been tracking changes in adult's health-related knowledge, attitudes, motivations and behaviours since 1996. Since 2003, NHS Health Scotland has taken on responsibility for coordinating the evaluation of health improvement policy in Scotland. As part of this, a series of independent reviews of the effectiveness of policy implementation has been initiated, starting with the review of the Scottish Diet Action Plan in 2005/06, of which this report is a part.

Performance monitoring of NHS health improvement investment and actions in Scotland is carried out on an annual basis by the Scottish Executive Health Department via Accountability Reviews and the NHS Performance Assessment

Framework. More informally, part of the National Food & Health Coordinator's role is to continually find ways to improve nutrition policy implementation.

The objectives of most nutrition policies are described in a way in which they can be measured and monitored. For example in Slovenia some of the targets include: increase vegetable consumption by 30%; increase fruit consumption by 15%; decrease consumption of total fats by 20%; decrease consumption of saturated fats by 30%; decrease alcohol consumption by 35% in men, and by 20% in women; decrease over-weight by 15% & 10% in children & adults respectively; 60% of mothers exclusively breast-feeding to six months & 40% breast-feeding until 1st year.

There is awareness that it takes time to develop a robust nutritional surveillance survey methodology. In France it took 2½ years to develop the methodology for a survey that will be repeated every 5 years.

In Canada the ONPP provides secretariat support to the Food and Nutrition Surveillance System Working Group, which has membership from across Health Canada, the Public Health Agency of Canada and provincial/territorial ministries of health. Its goal has been to work towards a comprehensive and sustainable approach to food and nutrition surveillance. In recognition of a critical need for more extensive and timely information about the nutrition of Canadians, it was decided that 2<sup>nd</sup> Cycle of Canadian Community Health Survey would focus on nutrition. The primary goal of the Nutrition Survey is to provide reliable, timely information about dietary intake, nutritional well-being and their key determinants to inform and guide programmes, policies and activities of the federal and provincial governments. Statistics Canada released the first wave of data from the survey in 2005, which included data on measured heights and weights, physical activity levels, food security, and fruits and vegetable. The second wave of findings will include the data on consumption of food, nutrients and supplements and these are expected in February 2006.

In Ireland a National Nutrition Surveillance Centre was established in 1992. This includes information on food consumption, food prices, behavioural change, and food availability in addition to nutrition intake and status. Collation of data also includes national and European food production, food retail & marketing, patterns of food import and export, household expenditure on food, and food and health data. Another aspect is a database of effective nutrition interventions and evaluation of changes in agricultural policy that may affect the health. The results from the North South Food Consumption Survey (2001), and the Diet and Lifestyle Surveys (1998 and 2002) provide comprehensive data on health and lifestyle behaviours in the Irish population. In the National Children Survey, 2005 (funded by Ministry of Agriculture & FSAI) the intention is to measure additives from a safety perspective but will also be used to get nutritional information about children's nutritional intake. The data will provide very detailed information about children's nutritional intake from the weighed intake food records for children.

In New Zealand food and nutrition monitoring includes monitoring food supply (national and household), food consumption patterns, nutrient composition of foods, nutrient intake, nutritional status and nutrition-related health status, together with variables that may influence these processes and outcomes such as food culture, food security and socio-demographic factors. However, food and nutrition monitoring in New Zealand currently lacks co-ordination, and has some important gaps, especially with regard to monitoring food supply. A report<sup>13</sup> was the first step towards improving food and nutrition monitoring in New Zealand. Other improvements include: investigating secondary data sources that may be useful for monitoring food supply at a national and household level; strengthening networks and developing a reporting schedule to improve co-ordination of monitoring activities and dissemination of data; and exploring the feasibility of including additional nutrition questions in other surveys to enable key aspects of dietary behaviour to be monitored in the years between national nutrition surveys.

New Zealand is one of the few countries that have carried out a very comprehensive “Nutrition and the Burden of Disease” analysis<sup>14</sup>, based on the Global Burden of Disease Methodology (WHR 2002<sup>15</sup>) and used this to underpin the national *Healthy Eating – Healthy Action* (HEHA) implementation plan. The results provided reliable estimates of the mortality burden of nutrition-related risk factors in New Zealand. It estimates that as many as 11,000 deaths in 1997 (40% of all deaths) may be attributable to the joint effect of sub-optimal diet and physical inactivity levels. This includes over 85% of ischaemic heart disease, 70% of stroke mortality, 80% of diabetes mortality and 6% of all cancer mortality. The results confirmed that two well-established nutrition-related risk factors – serum cholesterol and blood pressure – are, along with tobacco smoking, the three major modifiable causes of premature death in New Zealand. The estimates of avoidable burden also showed that feasible changes in vegetable and fruit intake and in BMI could have a major impact on population health within a decade. The implication is that a wide focus of policy attention is needed.

**In Scotland there should be consideration about whether the food and nutrient intake surveys are good enough to provide representative data and information required to evaluate and advise policy development. It appears that more improvements are needed in the food and nutrition surveillance and monitoring system in Scotland.**

**In addition, it could be useful to carry out a “Nutrition and the Burden of Disease” analysis in Scotland such as was carried out in New Zealand.**

<sup>13</sup> Food and Nutrition Monitoring in New Zealand, 2003  
[www.moh.govt.nz/moh.nsf/49b6bf07a4b7346dcc256fb300005a51/710a109fcb91a43acc256ddd006ed8c6/\\$FILE/FoodandNutritionMonitoring.pdf](http://www.moh.govt.nz/moh.nsf/49b6bf07a4b7346dcc256fb300005a51/710a109fcb91a43acc256ddd006ed8c6/$FILE/FoodandNutritionMonitoring.pdf)

<sup>14</sup> Nutrition and the Burden of Disease, New Zealand 1997–2011, 2003  
[www.moh.govt.nz/moh.nsf/0/7B9C6DE0D0AC6483CC256D7A000B58AB/\\$File/nutritionandtheburdenof disease.pdf](http://www.moh.govt.nz/moh.nsf/0/7B9C6DE0D0AC6483CC256D7A000B58AB/$File/nutritionandtheburdenof disease.pdf)

<sup>15</sup> World Health Report, 2002

### 3.5 Financial and technical resources

National experts were asked about the financial and human resources available for nutrition policy implementation. The data in Annex 3 are rough estimates and should be interpreted with extreme caution since it is very difficult to make direct comparisons between countries regarding the financial resources and the number of professional staff employed to implement nutrition policy. One reason is the many different organizational infrastructures that have evolved within each country. Similarly it is difficult to make direct comparisons between the different national budgets listed in Annex 3. More importantly in the time available it was not possible to double-check these figures and to ask each national expert to re-assess the specific numbers against specified criteria, so the figures definitely cannot be directly compared between countries.

Some countries have a lot of staff working on nutrition policy implementation employed centrally in the Ministry of Health (e.g. Israel employs 40 staff). Other countries have very few staff dedicated to nutrition policy employed within MOH but employ staff in national agencies, such as food authorities, institutes of public health and/or health promotion agencies e.g. Denmark (34), Scotland (27), Sweden (10), Slovenia (10). In contrast, France and Ireland employ more staff regionally: in Ireland around 80 staff dedicated to nutrition policy implementation are employed at regional level. When asked which skills are needed by those employed at national level, those most frequently mentioned are research and evidence-based practice to underpin nutrition policy development and implementation.

Sweden has recently carried out an interesting exercise to calculate the cost of implementing Sweden's new nutrition action plan. This was calculated to cost 500 million Swedish Crowns per year (£36 million). Another useful comparative indicator of policy implementation suggested by national experts, is the percentage of the total health budget spent on nutrition policy implementation. This calculation would facilitate between country comparisons, and show how much is spent in different countries relative to their overall health budgets.

**Scotland appears relatively well off both with regard to both financial and human resources when compared with other countries. However it could be useful when the new Food and Nutrition Policy is developed to estimate the cost of its implementation, using the methodology developed by the Institute of Public Health in Sweden. This would help policy makers to prioritise between the different implementation strategies.**

**It would be interesting if Scotland could instigate an international comparison of what percentage of total health budgets is spent on nutrition policy implementation compared with, for example, the percentage spent on enforcement of food safety regulations in different countries.**

### 3.6 Political will

National experts were asked the relative importance of having either political commitment or strong advocacy and community level mobilization. In general all national experts believe that both are important. However political will appears more important and the economic costs, likely to result from not implementing nutrition policy, helps create this political will. A good example is the Wanless Report from the UK, Ministry of Finance (HM Treasury<sup>16</sup>). Political will is strong in Scotland and this is important since the general public is not so vocal.

It is important that the policy implementation infrastructure is institutionalized while there is political will to do this. This helps to prevent changes in political parties leading to changes in policy. In France the political support has been very strong and consistent although there has been five different Ministers of Health in the past five years. Also nutrition is now seen as very important both by the scientific community and the media, as well as politicians. Evidence from the scientific community was crucial in ensuring that the public health law was accepted by the government in France.

In the US most progress with nutrition policy happened when members of Congress became interested. Mid-level civil servants ceased to object to the need for dietary guidelines because of the “1990 Act”. The combination of the momentum from Congress combined with increased interest from civil servants, in Health and Agriculture simultaneously, made a difference even if Ministers were not personally involved.

In New Zealand the Minister of Health got personally involved and she remained the minister for 2 terms (6 years). Similarly in Norway political champions are important, indeed the Minister of Agriculture was the one to develop Norway’s 1<sup>st</sup> nutrition policy in 1976. In Slovenia the Secretary of State for Health was the major driving force. Sweden’s National Public Health Policy has created a public health mechanism, which includes four ministries (Health, Education, Agriculture & Environment), to support policy implementation. In Sweden community mobilization was achieved through the publication of relevant research by the scientific community and this was communicated effectively via the media to the public and politicians. Many national experts, including Scotland, stated that the media play an important role, along with the political parties that are in opposition. Political champions are important in Norway, New Zealand, Slovenia and Scotland where the general public is not so vocal and those most in need don’t tend to express their views.

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<sup>16</sup> *Securing Our Future Health: Taking a Long-Term View*, Final Report. HM Treasury, April 2002

**Political will and leadership is strong in Scotland and this will continue to be important since the general public traditionally have not been so vocal. In order to maintain this political will it will be necessary to develop the appropriate analyses and evidence to demonstrate how much money can be wasted if national resources are not invested appropriately in nutrition policy implementation.**

### **3.7 Implementation strategies**

National experts were asked what were the main strategies used to implement their nutrition policies.

#### **3.7.1 Education and communication**

All national experts use education and information strategies. This was a major part of HEBS contribution to the implementation of the Scottish Diet Action Plan, both in terms of producing health education materials on nutrition and healthy eating and developing media campaigns with a strong healthy eating focus. From 2001, the Scottish Executive took on this role and developed a new *healthyliving* campaign and branding for nutrition and physical activity.

In New Zealand a well-known social marketing campaign by Sport and Recreation New Zealand (SPARC) focused mainly on physical activity but included nutrition. "Push Play" was made possible using funds from the Cancer control funding for HEHA. An evaluation of this campaign is published<sup>17</sup>. In New Zealand, information about Health Education is provided via a government website ([www.healthed.govt.nz](http://www.healthed.govt.nz)) with health education materials available to Primary Health Organizations, NGOs, Public Health Units, the general public and District Health Boards.

#### **3.7.2 School curriculum**

Healthy eating and nutrition education are under pressure in Scotland but there appears to be a movement back to more vocational skills being taught in the Scottish school curriculum. In Slovenia home economics is mandatory in all primary schools where home-economists usually also teach biology and are also responsible for nutrition policies in schools. In Slovenian secondary schools Home Economics is voluntary and materials have been developed to include food and health in other subjects such as history; physics; chemistry and maths in the curriculum. In Norway home economics is taught to 12-15 year olds and a

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<sup>17</sup> Bauman A. et al, Evaluation of the National 'Push Play' campaign in New Zealand - Creating population awareness of physical activity. The Journal of the New Zealand Medical Association , Vol 116, No 1179, 2003, [www.nzma.org.nz/journal/116-1179/535/](http://www.nzma.org.nz/journal/116-1179/535/)

data-base<sup>18</sup> is being established by the Health Directorate and the Ministry of Education to share information about school interventions and to disseminate those that are successful. The number of successful “after” school initiatives is increasing in Norway and Denmark, and includes physical activity and nutrition.

In Ireland nutrition is included in school curriculum via biology and Home Economics; also social and personal health education is taught in primary and secondary schools. In Scotland Home Economics is taught during 1<sup>st</sup> and 2<sup>nd</sup> year of secondary school and there are also short add-on courses; both primary and pre-schools have food skills included in the curriculum. The issue in the future could be how and where home economic teachers receive their training since many courses are disappearing.

### **3.7.3 Subsidizing fruit in schools and Fiscal Measures**

Free fruit schemes in schools exist in both Scotland and England<sup>19</sup>. In Scotland the free fruit is provided to all 4-6 year olds on 3 days per week and funding is given to local authorities to operate their own schemes so that they can buy from local producers in Scotland. Annex 7 summarizes the school fruit schemes in Denmark, England, The Netherlands, Norway and USA<sup>20</sup>, where the policy in Scotland could also be compared. In Norway all schools can participate in the national Fruit Scheme, but only around 10-12% of pupils take advantage of it.

In New Zealand the HEHA is being implemented in schools via the cancer control strategy and action plan e.g. in low income schools (60 initially increasing to 120 in 2006) free fruit is provided and funded by the government (in order to receive this schools also have to implement healthy eating, promote physical activity, be Sun Smart and Smoke-free to fit with the cancer theme). After 3 years these schools should be self-sustainable in providing free fruit and the funds will then go to supporting other “high-need” schools.

In Ireland Food Dudes is being pilot-tested in 2 areas where free fruit is supplied to schools. In the UK welfare food schemes exist for low-income families<sup>21</sup>.

In Norway and Denmark there is a tax on soft drinks, chocolates and sweets (19% before VAT); the primary rationale for this tax is economic rather than health improvement. The National Nutrition Council in Norway is providing economic advice to the government about other fiscal measures, such as

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<sup>18</sup> <http://lom.udir.no/> and the project “Fysisk aktivitet og måltider i skolen” (physical activity and meals in schools)

<sup>19</sup> Free School Fruit for all State Schools (2 classes – 4-6 year olds), 2000.  
[www.renewal.net/Documents/RNET/Policy%20Guidance/Nationalschoolfruit.pdf](http://www.renewal.net/Documents/RNET/Policy%20Guidance/Nationalschoolfruit.pdf)

<sup>20</sup> personal communication Robert Pederson from his M.Sc. thesis in Food Policy from City University

<sup>21</sup> Food Scheme for Low Income  
[www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MaternalAndInfantNutrition/MaternalAndInfantNutritionGeneralArticle/fs/en?CONTENT\\_ID=4112476&chk=ycC/gd](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MaternalAndInfantNutrition/MaternalAndInfantNutritionGeneralArticle/fs/en?CONTENT_ID=4112476&chk=ycC/gd)

taxation on certain unhealthy foods and subsidising fruit and vegetables (Annex 5). Similar economic analyses are being carried out in Sweden and Denmark.

In France in January 2006 a law comes into force where France will be taxing advertising campaigns unless food companies use the messages given to them by the MOH. Otherwise companies have to pay the government 1.5% of the total cost of their advertising campaigns to the National Institute of Health Promotion. The Article<sup>22</sup> was adopted by the parliament in 2004.

### **3.7.4 Regulation of food marketing and sales to children**

Government regulation of the marketing activities of the food industry, in particular where these target children, is a policy mechanism pursued by some countries. In Scotland, there are restrictions on the marketing of unhealthy foods in schools in the form of the removal of commercial branding from school vending machines.

In Norway and Sweden TV marketing to children is regulated. In New Zealand and Australia the “Food & Grocery Council” produced the “Food Industry Accord” and is making efforts to produce voluntary codes in order to avoid regulation by government. In the State of Victoria (Australia), an analysis of the cost effectiveness of eight possible interventions to tackle obesity (ACE) indicates that a ban on food advertising to children may be one of the most cost effective (even cost saving) measures<sup>23</sup>.

In England, in the new Food & Health Action Plan it is stated that food marketing regulations will be considered if the food industry does not enforce voluntary codes of conduct. The regulation of food sales to children is primarily focused on the sale of unhealthy foods (chocolates, sweets, crisps and sweet fizzy soft drinks) in vending machines within the school setting. Some countries have opted for an outright ban on vending machines in schools while others pursue the enforcement of a voluntary code.

In Scotland, school vending machines have been removed from school dining halls with agreement by the education sector. The national school nutrition initiative, “Hungry for Success” provides advice on a whole school approach to healthy eating and encourages schools to consider good practices. Direct negotiations between the government and the soft drinks industry has established a mandatory vending set that must include healthy diet and still water options. New government guidance on school vending machines is planned.

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<sup>22</sup> [www.legifrance.gouv.fr/WAspad/UnTexteDeJorf?numjo=SANX0300055L](http://www.legifrance.gouv.fr/WAspad/UnTexteDeJorf?numjo=SANX0300055L) gives the full text of the law, in French, 2004. See Articles 29 (on advertising) & 30 (on distributors).

<sup>23</sup> The person in charge of this project is Michelle Haby ([Michelle.Haby@dhs.vic.gov.au](mailto:Michelle.Haby@dhs.vic.gov.au)) at state government in Victoria.

In France, from September 2005 no vending machines are allowed in primary or secondary schools. In Slovenia there is a recommendation not to install vending machines for sweetened soft drinks in schools. Where vending machines have already been installed, the contents are regulated in accordance with national nutrition standards. In Ireland, vending machines are not allowed in primary schools and there is a voluntary code in secondary schools about the contents of vending machines.

In Norway, the Health Directorate has produced guidelines on what kind of foods should be available in school vending machines. In Denmark, only 50 out of 2000 schools have vending machines and most of these are situated in the teachers' room.

### **3.7.5 Community food initiatives**

In Scotland, there are now many community food initiatives that seek to improve the accessibility and availability of healthy food in low income areas. These are coordinated and supported at national level by "The Scottish Community Diet Project", one of the major successes of the SDAP. The community health approach has been strengthened in Scotland by the development of 'community planning' which obliges local authorities, health boards and the voluntary sector work together to deliver local services and promote well-being in their communities. Funding for community food initiatives is provided via a number of local and national funding streams, including the Big Lottery, regeneration, health improvement, and quality of life.

In Norway community food projects have become more important after the 2003 public health White Paper and the expansion of the professional health promotion workforce. In Slovenia some regional food initiatives (e.g. in Pomurje<sup>24</sup>) are already showing improvements on some of the indicators used to evaluate success. In Ireland there are many different Community initiatives (including "Cook-It!") where teaching cooking skills are also a part of NGOs work to combat poverty and homelessness. In Canada, the provinces and territories play a critical role in promoting and supporting healthy eating at the community level e.g. Toronto. While programmes vary from province to province and between communities, many build upon standards and guidelines developed collaboratively at the national level, such as *Canada's Food Guide to Healthy Eating*.

### **3.7.6 Workplace**

Scotland appears to be the only country that is seeking to implement its nutrition policy in a systematic way within the workplace setting. The workplace and promoting the health of working age adults is a major 'pillar' of the 2003 public

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<sup>24</sup> "Let Us Live Healthily", Pomurje Region, Slovenia  
[http://www.euro.who.int/socialdeterminants/socmarketing/20051024\\_2](http://www.euro.who.int/socialdeterminants/socmarketing/20051024_2)

health strategy (*Health Improvement Challenge*). The long established national award schemes, Scotland's Health at Work, and Scottish Healthy Choices are evolving to become part of a new health improvement strategy called "Healthy Working Lives".

### **3.7.7 Health Impact Assessment**

Policies and practice in many sectors can affect public health nutrition, positively or negatively. Health Impact Assessment (HIA) is a way to predict these public health impacts, in order to recommend improvements in policies to improve health outcomes. HIA is seen by many countries as a tool that can help create a better dialogue on health and nutrition with other sectors and at the same time provide an analysis of the potential risks and benefits of different policies and practices on public nutrition and national food security.

For example, in Slovenia and Sweden, the HIA process applied to agriculture policy was seen as a very useful tool to help create a dialogue between the Ministries of Health and Agriculture MOH and MOA<sup>25</sup>. In New Zealand, local authorities have carried out HIA work around issues such as transport policy and supermarket placement.

The health impacts of world trade policies on primary food producers is another area where HIA can be applied. For example, in Australia, tomato growers and citrus fruits growers have been particularly badly affected by international competition. In order to conserve local food production capacity, in some countries, such as Norway, Slovenia and Australia there are interesting joint initiatives between agriculture, health and rural development e.g. the potential use of "Country of Origin Labelling"<sup>26</sup>. However, the Australian expert pointed out that inventing new food labels is unlikely to succeed unless changes also happen at international (WTO) level.

### **3.7.8 Other implementation strategies**

In Scotland, along with other countries, there exists a strong commitment to the policy tools of consensus-building, partnership working and joint planning for health improvement, before having to resort to imposing government measures and regulations. The former are seen to provide key opportunities for win-win situations. For example Scottish experts stress the opportunities that could arise from public sector procurement policies.

The need for more evidence was identified, by a number of national experts, as the fundamental building block for developing and implementing nutrition policy e.g. research in New Zealand and The Netherlands on the "Nutrition and Burden of Disease" and "Dutch Meals" respectively. In Sweden and Denmark, health

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<sup>25</sup> A copy of the report of the HIA in Slovenia & Sweden can be provided.

<sup>26</sup> [www.foodstandards.gov.au/mediareleasespublications/factsheets/factsheets2005/countryoforiginlabel3022.cfm](http://www.foodstandards.gov.au/mediareleasespublications/factsheets/factsheets2005/countryoforiginlabel3022.cfm)

economic analysis of the cost of obesity and related illness and sick leave to both the health system and workplace. In Sweden, it is estimated that around 16 billion Swedish Crowns (£1.2 billion) per year is spent directly and indirectly on social security and lost business profits - more than 300 times more compared with the estimated 50 million Crowns (£36m) needed for nutrition policy implementation.

The country experts interviewed identified a number of other policy tools that they have used, or would recommend, for their national nutrition strategies. These are listed below:

France	Train Social Workers and the Media.
Slovenia	Strengthen intersectoral collaboration; better understand how to get “Health into All Policies <sup>27</sup> ”
England	Target setting as a policy tool e.g. setting targets for reducing obesity levels and salt intakes by 2010.
Norway	Primary care initiative – GPs give patients “Green” prescriptions to increase physical activity and provide nutritional advice.

**Lifeskills learned at school, such as food purchase and food preparation skills, are essential if children are to be healthy adults. One of the challenges in Scotland is how to preserve these skills and ensure that future generations of Scots are able to utilise the raw food grown and produced in Scotland.**

**In France, from September 2005 no vending machines were allowed in primary or secondary schools. Scotland could consider recommending similar types of measures within the next food and nutrition policy, in a special effort to try to reduce the increasing high trend in sugar intake.**

**Scotland cannot develop national taxation policies which are decided at UK level, however it would be interesting to see if there are some models that could be used, such as that in France or the State of Victoria in Australia, to help implementation of the next food and nutrition policy.**

**Scotland stands out compared with other countries, with initiatives such as “Hungry for Success” and the “The Scottish Community Diet Project”, one of the major successes of the SDAP and the new workplace initiative “Healthy Working Lives”. This work-place initiative, like the “The Scottish Community Diet Project”, could lead to a process, where the international community can also learn from.**

<sup>27</sup> This is one the themes, selected by the Finnish government for their EU Presidency in 2006.

### 3.8 International collaboration

National experts were asked about the importance of international collaboration. All the national experts strongly valued the opportunities for international exchange and collaboration. The countries with the best international collaboration are undoubtedly the Nordic countries. Denmark, Norway and Sweden representatives all valued the opportunity to work together to learn about nutrition policy implementation. All EU national experts interviewed participate in meetings organized by the EU (DG SANCO), EFSA and the Network of National food agencies. In addition, all the national experts (except Scotland) participate in nutrition meetings organized by WHO.

Most national experts believe that participation in international meetings, collaboration and exchange enables access to the best expertise in research and policy implementation. In Ireland learning from the comparisons of what is going on in other countries was seen as very important. Similarly in New Zealand, it was seen as very important to get new knowledge and share information. In Slovenia international collaboration is regarded as indispensable for small countries where they cannot be expected to do everything alone. England especially values international support for public health policies and the opportunity to learn from priorities in different countries.

Next year (2006) is an important year concerning new EU directives which will have a strong impact on nutrition policy. This process is not always transparent. For example the new EU regulations concerning marketing of breast milk substitutes is not openly discussed and minutes of meetings are not readily available. This creates problems for those responsible for national nutrition policies because they may be unaware of the negotiations and so are unable to advise their government about the potential consequences: e.g. marketing of breast milk substitutes can have a negative impact on breast feeding; In England, the recommendation to the EU is that follow-on milks should be included in the marketing ban and that no marketing should be allowed to health professionals. Norway also believes that the EU directives should be based on the International Code of Marketing of Breast Milk Substitutes. Jenny Warren, Scotland's breastfeeding coordinator, carried out an excellent analysis<sup>28</sup> of promotion of breastfeeding activities in Scotland compared with the EU Blue-Print 2004.

Another example is stringent enforcement of new EU food safety regulations that could lead to nutrition insecurity especially in public mass catering and food service institutions.

Another new EU directive, due in 2006, on labeling (e.g. traffic light system or the key hole in Sweden) will also have an impact on national nutrition policy. The

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<sup>28</sup> Available on request

results of a new Nordic labeling project initiated by the Ministry of Agriculture in Sweden<sup>29</sup> are expected in 2006. Similarly research is in progress in France into nutrition labeling and what should be recommended.

In general, experts in Norway do not support fortification (risk from excess nutrient intakes leading to toxicity) but they are especially worried about fortification of sweets and other unhealthy foods. Norway had to follow the EFTA court judgment which supported Kelloggs' position on fortification of breakfast cereals.

The new EU directive on Health and Nutrition Claims will have an unknown impact on national nutrition policies. In England, this is supported but only if these claims can be properly substantiated and experts state these should be regulated properly.

In Scotland, there needs to be a better mechanism for international collaboration on nutrition policy, especially with regard to improving the Scottish Executive's engagement (input and feed-back) with EU processes. Only half of the national experts interviewed (England, Slovenia, Israel, Ireland, New Zealand and Norway) had heard of the Scottish Diet Action Plan. At present in Scotland, much of the international exchange and collaboration happens at the level of the national Public Health agency rather than the Scottish Executive policy perspective. For example, Health Scotland was a major contributor to the Council of Europe report '*Eating at School - Making Healthy Choices*' (2003) and drafting the text for the consideration of the council ministers for a resolution on healthy eating in schools for all European states (*Resolution RES.A.P (2005) 3 On Healthy Eating in Schools*). NHS Health Scotland has a senior post dedicated to International Development and is an active member of Eurohealthnet and IUHPE. In addition Health Scotland is a WHO Collaborating Centre and hosts the international coordination the cross-national Health Behaviours of School Children study which has a strong focus on young people's diet and body shape.

**It is impressive that Scotland has succeeded to develop so many international links related to health promotion. Perhaps lessons can be learnt from this process so that Scotland can have a stronger voice on the many influential international food and nutrition policy platforms. These platforms are important as fewer decisions are made at national level and decisions about food and health are made within the European Union or via Codex Alimentarius and the World Trade Organisation.**

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<sup>29</sup> [www.norden.org/MR-fisk-livs-jord/ministermoede2005/sk/WS3\\_Baginfo\\_graensehindringer.pdf](http://www.norden.org/MR-fisk-livs-jord/ministermoede2005/sk/WS3_Baginfo_graensehindringer.pdf)  
[www.norden.org/MR-fisk-livs-jord/ministermoede2005/sk/NKO-mote\\_30juni05.htm](http://www.norden.org/MR-fisk-livs-jord/ministermoede2005/sk/NKO-mote_30juni05.htm)

### **3.9 Sustainability and future challenges**

National experts were asked about future challenges and how they believed nutrition policy implementation could be more sustainable. One of the common recommendations included establishing a mechanism where senior decision-makers support and oversee implementation and ensure coherence between all sectors.

In USA, the development process for Dietary Guidelines is regarded as good but their implementation in practice could be strengthened. There is lack of funding but in addition one of the main problems is the lack of an overall coordinating mechanism for implementation. Ideally this mechanism should be established at a high political level to ensure sufficient power to implement decisions. For example in the US there used to be an Interagency Committee where deputy ministers of both Health and Agriculture were the joint chairs and regular meetings were held 3 times per year.

Similarly in France one of the most important factors identified is the need for coherence between all sectors. Every stakeholder should provide the same nutrition messages whether at school, home, work, and generally throughout society. However it can be difficult to achieve a strong consensus without political commitment. Indeed as more and more niche market products come onto the market, the messages are getting more and more complex and the public will be even more confused.

In Australia coherence between all food sectors and consistency of different policies is considered of prime importance. There is a need to carry out evaluation of relative benefits of different policy instruments using tools such as HIA of agriculture policies. In Slovenia one of the main barriers recognized is the need for better intersectoral collaboration. The implementation of nutrition policy would be ensured if embedded in a good delivery system together with sustainable financial resources and a well functioning platform for intersectoral collaboration.

In Sweden, nutrition policy implementation is not considered sustainable if the policy is isolated. It has to be embedded within national political commitments to sustainability and public health. In addition an awareness by the general public has to be created so that it is acceptable for governments to protect public health and protect the most vulnerable from potential harm by others, just as in enforcement of food safety regulations. Public attitude can change if we are presented with evidence such as the fact that 30 million Swedish Crowns (£2.2 m) per year is spent on marketing on fruit and vegetables compared with 900 million (£66.5m) on marketing of unhealthy food.

In the UK an interesting Kings Fund report “*Nanny or Steward? The role of government in public health*”<sup>30</sup> states:

".....The past year has seen some contentious debates about public health, focusing on a ban on smoking in public places, food labeling and food advertising to children. Some people have argued that any government intervention in these areas is 'nanny statist' - an unnecessary intrusion into people's lives and what they do, eat and drink. Others have argued that only the state can effectively reduce the poverty that is so often the root cause of ill health.....This paper suggests that there is a strong argument to be made for government intervention to safeguard public health. Legislation brings about changes that individuals on their own cannot, and sets new standards for the public good. Rather than condemning such activity as nanny statist, it might be more appropriate to view it as a form of 'stewardship'. Stewardship implies government has a responsibility for protecting national health, and to serve in the public interest and for the public good. It suggests a protective function, where individuals are protected from harm by others. Stewardship implies that paternalistic government is acceptable under certain conditions, and the debate should focus both on defining these conditions and the likely benefits”.

The main issue is to find out what kind of regulations to implement nutrition policy work best. If implementation happens without regulations then perhaps these are not necessary especially since enforcement of regulations is costly. So one question for government is, what is the cost of enforcing nutrition policy regulations versus the cost if the disease burden from nutrition-related diseases continues to escalate?

Interesting research commissioned by The Norwegian Directorate for Health and Social Affairs and carried out by the Norwegian Agricultural Economics Research Institute, includes:

- Reduced prices on fruits and vegetables as a tool for nutrition policy. 2000.
- The demand for fruits and vegetables – effects of price and income changes on different households. Memorandum No. 2002-20. 2002.
- Taxes on sugar, chocolate and foods with added sugar. Memorandum No. 2002-21. 2002.
- The demand for soft drinks – effects of taxation changes on soft drinks in households with different levels of consumption. No. 2004-13. 2004.

In Ireland the successful implementation of the Food and Nutrition Strategy requires :

- long term, sustained commitment by government.

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<sup>30</sup> [www.kingsfund.org.uk/resources/publications/nanny\\_or.html](http://www.kingsfund.org.uk/resources/publications/nanny_or.html)

- interdisciplinary collaboration across sectors involved in food and nutrition policy.
- all partners, including government departments and the food industry need to address simultaneously all diet- related issues
- a mechanism to provide this joined up thinking collaborative approach across government departments
- sufficient production of healthy food in a sustainable environment to meet nutrient recommendations and dietary guidelines for healthy eating for the Irish population
- actions that are comprehensive, multicultural, multidisciplinary and participatory- consistent with the principles contained in the Ottawa Charter for Health Promotion
- actions that recognise the social determinants of health.
- access to healthy food choices by all the population especially socially disadvantaged and vulnerable groups
- priority needs to be given to activities that have a positive impact in the poorest sections of the population.
- an advisory body to provide scientific nutrition advice to the Minister for Health and Children and to Department of Health and Children policy makers scientific based recommended nutrient reference values and dietary guidelines directed at the whole population and special groups
- food-based dietary guidelines for the general population and for population sub-groups
- accountability by all partners in reducing the preventable risks to health and in putting in place strategies and programmes that will improve population health

In England sustained political will and raised importance of food in the minds of the general public is important, especially an understanding about the impact that food has on health, right from production through to consumption.

#### **In Scotland future challenges:**

- **There is a need for more rigorous implementation plans which outline who will do what by when, along with how this will be monitored and what kind of policy instruments, evidence and surveys are needed. This monitoring and surveillance should take place regularly so that progress can be reviewed on the short rather than long term.**
- **Find ways how Scotland can more effectively influence issues at a European and Global level via high level decision-making platforms.**
- **The future “Scottish Diet” will mean different things for different segments of the population. This will demand that public health experts prioritize and design targets for specific vulnerable groups along with specific actions.**

### 3.10 Food culture

“Food culture” has many different definitions. “Culinary culture” can be a shorthand term for the ensemble of attitudes and tastes people bring to cooking and eating food. “Culture” is understood in sociology and anthropology to mean all that is “learned, shared and transmitted” among groups of human beings from generation to generation. It is therefore not surprising that the idea of food culture has been associated with research of an historical-sociological kind aimed at explaining how different social group – especially different societies or nations – came to develop different attitudes towards food. Interesting for Nutrition Policy is how different food and culinary cultures might affect policy implementation positively or negatively. The national experts were asked to provide some views of how they see their national food cultures and how this may affect Nutrition Policy implementation.

In US the food culture is predominantly convenience and “can I take it with me?”. However there are signs that this may be changing via more interest in local food production, community supported agriculture, and farmer markets.

In France food culture is strong because the French value food and eating occasions are given time during daily life. Policy makers use this social awareness to promote positive messages around food. The cultural nature of food is recognized in the information produced by the authorities (e.g. booklets<sup>31</sup>) for different target audiences.

In Sweden the changes in their traditional food culture is beginning to alert society to the scale of the commercial interests all around them daily. Society is beginning to realize that the consumer does not have the ability or the choice to decide.

In Slovenia cooking skills are very important but these are starting to disappear. These skills are usually learned at home or in primary school. As families have less time to cook, children don’t learn at home and so one of the most important issues about preserving Slovenian culture is to preserve the skills needed to prepare and cook food.

In the Nordic countries, via the Nordic Council of Ministers, there is a project<sup>32</sup> established which is looking into Nordic traditional food culture and the importance of family meals, rather than grazing style eating patterns (expected in 2006).

In Norway packed school lunches are the norm and this makes it difficult to increase daily vegetables intake. The Ministry of Agriculture is helping with

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<sup>31</sup> [www.mangerbouger.fr](http://www.mangerbouger.fr)

<sup>32</sup> [www.norden.org/MR-fisk-livs-jord/ministermoede2005/sk/Ny-nordisk-mad.pdf](http://www.norden.org/MR-fisk-livs-jord/ministermoede2005/sk/Ny-nordisk-mad.pdf)

increased vegetable production in Norway and is also looking at the importance of country origin labels for national food products<sup>33</sup>. The latter can help implement nutrition policy and, at same time, support issues such as rural development and maintain employment levels in rural areas.

In England the social aspects of food are important but food is still not very high on the priority list. England is among the largest markets for pre-prepared foods and ready meals. Therefore it is crucial to work with food manufacturers to reduce the content of fat, sugar and salt in processed foods. The following is sales information<sup>34</sup> of pre-prepared foods:

- Growth (estimated) of 52% in ready meals between 2000 to end 2005;
- Growth of 40% in burger sales from 2001 to 05 (although no growth between 04 & 05);
- Growth of 26% in pizzas sales from 1999 to 2004 (£728m p.a.);
- Growth of 25% in “eating out” between 2000 to end 2005.
- Growth of almost 20% in sausage sales from 2001 to 04;

The most prolific ready-meal eaters are consumers aged 15-19 and 35 – 44, essentially students and families.

In Ireland, food culture is being affected due to loss of cooking skills. However cooking appears to be becoming more “trendy” along with newly established local markets. The Slow Food Movement is becoming popular and local food champions are making cooking and good food more exciting. Also there is a large influx of asylum seekers and they are affecting food culture and in some cases increasing the rates of food poverty. An interesting book “French Women don’t get fat” explains some of the issues around the status of food culture in France compared with western countries such as Ireland.

In Scotland building a new food culture could be part of a sustainable development agenda for Scotland that can create exciting new possibilities. Food culture has the potential to bind different sectors together via regeneration, sustainability, tourism, farming, food production, rural development and the media. Creating a shared vision of what a Scottish Food Culture could look like and what this could mean to the future of a Smart Scotland.

There are signs that this is already happening in Scotland via initiatives such as: the Slow Food Movement; Renaissance of Scottish Food; box schemes; and farmers markets. A strong food culture can pull the Food and Health Agenda together by fulfilling different needs and providing mutual support for the segments of society. Similar movements are taking place in the overall Health Improvement Agenda where the health improvement culture is becoming more

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<sup>33</sup> [www.norden.org/MR-fisk-livs-jord/ministermoede2005/sk/landdistriktsudvikling.pdf](http://www.norden.org/MR-fisk-livs-jord/ministermoede2005/sk/landdistriktsudvikling.pdf)

<sup>34</sup> Mintel reports

concrete via healthy behaviour and empowering individuals. Ireland's initiative, "Island of Food", provides a good example for Scotland with excellent links to Europe. Scotland has some building blocks in areas, such as Orkney, and this could be expanded into a widespread movement that evolves into a sustainable Scottish Food Culture.

## **4. Conclusions and recommendations**

In general Scotland compares very well with the achievements in other countries even though Scottish experts are disadvantaged due to less international collaboration at a policy level.

Scotland stands out compared with other countries, with initiatives such as "Hungry for Success" and the "The Scottish Community Diet Project", one of the major successes of the SDAP and the new workplace initiative "Healthy Working Lives". This work-place initiative, like the "The Scottish Community Diet Project", could lead to a process, from where the international community can also learn.

It is impressive that Scotland has succeeded to develop so many international links around health promotion. Perhaps lessons can be learnt from this and transferred to help experts in Scotland have a stronger voice on the many influential international platforms. These platforms will be important as fewer decisions are made at national level and important decisions about food and health are made either within the European Union or via Codex Alimentarius and the World Trade Organisation (WTO). International participation concerning European Union, WTO and Codex Alimentarius representation is essential for Scotland.

Scotland appears relatively well off with regard to both financial and human resources when compared with other countries. Political will and leadership is also strong in Scotland and this will continue to be important since the general public traditionally have not been vocal. In order to maintain this political will, it will be necessary to develop the appropriate analyses and evidence to demonstrate how much resources should be invested to implement a successful nutrition policy.

Scotland's next food and nutrition policy should be embedded in an overarching public health policy. Food and Nutrition policy is not sustainable as an isolated policy and its implementation is more likely to be successful if rooted in the overall political commitments to sustainability and public health. Scotland's next food and nutrition policy will be developed by the relatively young Food and Health Council. In order to support the Food and Health Council in the early stages it is recommended to consider a study tour to, especially Norway and perhaps France.

Intersectoral collaboration is vital to the successful implementation of Nutrition Policy. In Scotland, the Health Sector has successfully collaborated with the Education Sector but needs to understand better the issues facing the Agriculture Sector and how the government can work to address concerns of national food and nutrition security. Government procurement policies could provide an opportunity for better collaboration with the Agriculture Sector. In addition it will be important for Scotland to prevent conflict between enforcement of food safety regulations and nutrition policy implementation, and so closer collaboration with the Environmental Health Service is recommended. Given the national resources invested on food safety enforcement in Scotland, it would be interesting to investigate the scale of the national morbidity figures from food-borne diseases compared with nutrition-related illness in Scotland.

It appears that more improvements are needed in the food and nutrition surveillance and monitoring system in Scotland. The food and nutrient intake surveys should be redesigned to provide representative data and information required to evaluate and advise policy development.

In France, from September 2005 no vending machines were allowed in primary or secondary schools. Scotland could consider recommending similar types of measures within the next food and nutrition policy, in a special effort to try to reduce the increasing trend in high sugar intake. Scotland cannot develop national taxation policies which are decided at UK level, however it would be interesting to see if there are some models that could be used, such as that in France or the State of Victoria in Australia, to help implementation of the next food and nutrition policy.

Life-skills learned at school, such as food purchase and food preparation skills, are essential if children are to be healthy adults. One of the challenges in Scotland is how to preserve these skills and ensure that future generations of Scots are able to utilise the raw food grown and produced in Scotland. Building a new food culture in Scotland could be part of a sustainable development agenda for Scotland that can create exciting new possibilities. Food culture has the potential to bind different sectors together via regeneration, sustainability, tourism, farming, food production, rural development and the media. Creating a shared vision of what a Scottish Food Culture could mean to the future of a Smart Scotland could be the focus of Scotland's next Food and Nutrition Policy.

## Annex 1: National experts interviewed

Country	Responding national expert
1. Australia	Mark Lawrence, PhD, Senior Lecturer, School of Exercise & Nutrition Sciences, Faculty of Health and Behaviour Sciences, Burwood Campus Melbourne Victoria Telno.61 3 924 437 89 <a href="mailto:mark.lawrence@deakin.edu.au">mark.lawrence@deakin.edu.au</a>
2. Canada	Mary Bush, Director General, Office of Nutrition Policy & Promotion, Health Products & Food Branch, Health Canada, 2936 Baseline Rd., Qualicum Tower A, Rm. D391, Address Locator: D3303, Ottawa, Ontario Tel: 613-941-8595, direct number 00 1 613 957 8330 <a href="mailto:Mary_Bush@hc-sc.gc.ca">Mary_Bush@hc-sc.gc.ca</a> ; <a href="mailto:Ann_Ellis@hc-sc.gc.ca">Ann_Ellis@hc-sc.gc.ca</a>
3. Denmark	Else Molander, Chief, Nutrition office, Board of Food. Ministry of Family Affairs and Consumers Mørkhøj Bygade 19, 2860 Søborg, Tlf.: 33956037 Mail: <a href="mailto:elmo@fvst.dk">elmo@fvst.dk</a>
4. England	Dr Sheela Reddy Principal Nutritionist Department of Health, Health Improvement and Prevention Wellington House, 133-155 Waterloo Road London SE1 8UG Office +44 020 7972 1365 E-mail <a href="mailto:Sheela.reddy@dh.gsi.gov.uk">Sheela.reddy@dh.gsi.gov.uk</a>
5. France	Michel Chauillac MOH /DGS/SD5 14 avenue Duquesne, 75007 Paris <a href="mailto:Michel.CHAULIAC@sante.gouv.fr">Michel.CHAULIAC@sante.gouv.fr</a> Tel no. + 33 1 40 56 41 24
6. Ireland	Ursula O'Dwyer, MOH
7. Israel	Dorit Kaluski, MOH
8. New Zealand	Elizabeth Aitken Team Leader & Senior Advisor (Nutrition) Non Communicable Diseases Policy, Public Health Directorate, Ministry of Health, <a href="http://www.moh.govt.nz">www.moh.govt.nz</a> <a href="mailto:elizabeth_aitken@moh.govt.nz">mail:elizabeth_aitken@moh.govt.nz</a> , Tel + 64 4 495 4335

9. Norway	<p>Bodil Blaker  Senior Adviser, Section for Nutrition and Food Safety  Public Health Department,  Norwegian Ministry for Health &amp; Social Affairs  Boks 8011 Dep 0030, OSLO  phone no +47 22 24 86 02. Email <a href="mailto:Bodil.Blaker@hod.dep.no">Bodil.Blaker@hod.dep.no</a></p>
10. Scotland	<p>Maureen Bruce,  Head of Health Education,  Scottish Executive Health Department  2 ES St Andrews House  Edinburgh EH1 3DG  0131 244 2499, email: <a href="mailto:maureen.bruce@scotland.gsi.gov.uk">maureen.bruce@scotland.gsi.gov.uk</a></p> <p>Gillian Kynoch  Scottish Food and Health Co-ordinator  Scottish Executive Health Department  2 ES St Andrews House  Edinburgh EH1 3DG  Tel: 0131 244 4387  Email: <a href="mailto:gillian.kynoch@scotland.gsi.gov.uk">gillian.kynoch@scotland.gsi.gov.uk</a></p>
11. Slovenia	<p>Mojca Gabrijelcic,  Head of the Health Promotion,  National Institute of Public Health,  Ljubljana, Slovenia  tel no. +386 51 371 85; <a href="mailto:Mojca.Gabrijelcic@ivz-rs.si">Mojca.Gabrijelcic@ivz-rs.si</a></p> <p>Rok Policni,  <a href="#">Ministry of Health</a>  <a href="#">Republic of Slovenia</a>  <a href="#">Sector for health prevention and healthy lifestyle</a>  <a href="mailto:Rok.Policnik@gov.si">Rok.Policnik@gov.si</a></p>
12. Sweden	<p>Liselotte Schäfer Elinder, Associate professor, Head of unit,  Department of health behaviour, National Institute of Public Health  S-103 52 Stockholm, Sweden  Tel: 08 5661 3638/+46 8 5661 3638  <a href="mailto:liselotte.elinder@fhi.se">liselotte.elinder@fhi.se</a></p>
13. USA	<p>Linda Meyers, Ph.D.,  Director,  Food and Nutrition Board,  Institute of Medicine,  National Academies, Washington , DC  Phone: 202-334-3153, E-mail: <a href="mailto:lmeyers@nas.edu">lmeyers@nas.edu</a>  Note: National Academies is a non-governmental, non-profit organization.</p>

## Annex 2: Public health and nutrition policy documents

Country	Public health policy document & Nutrition Policy documents
Australia	<p>1. Food &amp; Nutrition Policy (1994)  <a href="http://www.health.gov.au/pubhlth/publicat/document/fpolicy.pdf">www.health.gov.au/pubhlth/publicat/document/fpolicy.pdf</a></p> <p>2. Food &amp; Nutrition Policy - 1st 3 years implementation (1998)  <a href="http://www.health.gov.au/pubhlth/publicat/document/fnp.pdf">www.health.gov.au/pubhlth/publicat/document/fnp.pdf</a></p> <p>3. Acting on Australia's weight (1997) - A strategic plan for the prevention of obesity  <a href="http://www.health.gov.au/nhmrc/publications/pdf/n21">www.health.gov.au/nhmrc/publications/pdf/n21</a></p> <p>4. Eat Well Australia (2001) - A Strategic Framework for Public Health Nutrition 2000-2010 ( <a href="http://www.nphp.gov.au/publications/signal/eatwell1.pdf">www.nphp.gov.au/publications/signal/eatwell1.pdf</a> );</p> <p>Other relevant policy initiatives:</p> <p>5. National Better Health Programme</p> <p>6. National Public Health Partnership (end of 90s) (based on Ottawa charter) which was an all Government Approach (Ag, Health &amp; Trade)</p> <p>7. National Food Industry Strategy</p> <p>8. Food Regulations have pushed nutrition issues onto the political agenda.</p> <p>9. State Policies could be useful for Scotland – especially the work going on in Victoria and New South Wales.</p>
Canada	<p>1. Nutrition for Health: Agenda for Action 1996  <a href="http://www.hc-sc.gc.ca/fn-an/nutrition/index_e.html">www.hc-sc.gc.ca/fn-an/nutrition/index_e.html</a></p> <p>2. Building Partnerships for Health: Lessons Learned 1998</p> <p>3. Integrated Pan-Canadian Healthy Living Strategy 2004:  <a href="http://www.phac-aspc.gc.ca/hl-vs-strat/index.html">http://www.phac-aspc.gc.ca/hl-vs-strat/index.html</a>  The Healthy Living Strategy was approved at the annual meeting of the Federal, Provincial and Territorial Ministers of Health in October 2005. Information on federal funding of HL Strategy, through the Integrated Strategy on Healthy Living and Chronic Disease:  <a href="http://www.phac-aspc.gc.ca/media/nr-rp/2005/2005_37bk1_e.html">www.phac-aspc.gc.ca/media/nr-rp/2005/2005_37bk1_e.html</a></p> <p>4. Canada's Food Guide to Healthy Eating is being updated and revised version expected in May 2006.  <a href="http://www.hc-sc.gc.ca/fn-an/food-guide_aliment/revision/index_e.html">www.hc-sc.gc.ca/fn-an/food-guide_aliment/revision/index_e.html</a></p> <p>5. Development of national Health Goals for Canada 2006.  <a href="http://www.healthycanadians.ca">www.healthycanadians.ca</a></p> <p>7. Nutrition and Healthy Eating at Health Canada (general website):  <a href="http://www.hc-sc.gc.ca/fn-an/nutrition/index_e.html">www.hc-sc.gc.ca/fn-an/nutrition/index_e.html</a></p>

	<p>8. Nutrition Labelling from 2002 onwards:  <a href="http://www.hc-sc.gc.ca/fn-an/label-etiquet/nutrition/index_e.html">www.hc-sc.gc.ca/fn-an/label-etiquet/nutrition/index_e.html</a></p>
Denmark	<p>1. Healthy throughout Life (2002) – targets &amp; strategies for public health policy of the Government of Denmark, MOH 2002–2010  <a href="http://www.folkesundhed.dk/ref.aspx?id=190">http://www.folkesundhed.dk/ref.aspx?id=190</a></p> <p>2. Tryhed og Frihed, Ministry Food, Agriculture &amp; Fisheries, 2003  <a href="http://www.ft.dk/Samling/20031/redegoerelse/R5.htm">http://www.ft.dk/Samling/20031/redegoerelse/R5.htm</a></p> <p>3. NATIONAL ACTION PLAN AGAINST OBESITY 2003 – Recommendations and Perspectives – short version in English  <a href="http://www.sst.dk/publ/publ2003/National_action_plan.pdf">http://www.sst.dk/publ/publ2003/National_action_plan.pdf</a></p> <p>4. Better health for children &amp; youth, 2003 - Interministerial initiative jointly by Ministries of: Employment; Finance; Food, Agriculture &amp; Fisheries; Health &amp; Home Affairs (Interior); Environment; Social Welfare; Education. Published by MOH  <a href="http://www.sum.dk/publikationer/bedre_sundhed/bedre_sundhed.pdf">http://www.sum.dk/publikationer/bedre_sundhed/bedre_sundhed.pdf</a>  <a href="http://www.sum.dk/publikationer/bedre_sundhed/index.htm">http://www.sum.dk/publikationer/bedre_sundhed/index.htm</a></p> <p>5. A strengthened effort against overweight, January 2005 Joint by MOH and Ministry for Family &amp; Consumer Affairs  <a href="https://www.minff.dk/fileadmin/template/minffdk/pdf/presse/Folder-overvaegt.pdf">https://www.minff.dk/fileadmin/template/minffdk/pdf/presse/Folder-overvaegt.pdf</a></p> <p>6. National Board of Food - Nutrition Strategy 2005-80 (Feb 2005) (Fødevarestyrelsens Ernæringsstrategi paper copy in Danish).</p>
England	<p>1. Food and Health Action Plan – DOH Food and Health Action Plan. London, 2003.  <a href="http://www.dh.gov.uk/assetRoot/04/10/57/09/04105709.pdf">http://www.dh.gov.uk/assetRoot/04/10/57/09/04105709.pdf</a></p> <p>2. Choosing Health? A consultation on action to improve people's health. Secretary of State for Health, London: UK Parliament, 2004.  <a href="http://www.dh.gov.uk/assetRoot/04/07/58/52/04075852.pdf">www.dh.gov.uk/assetRoot/04/07/58/52/04075852.pdf</a></p>
France	<p>1. Nutrition is included in the Health Action Plans to prevent specific diseases including CVD, Cancer, Diabetes, Elderly and Vulnerable groups.</p> <p>2. National Nutritional Health Programme (PNNS) 2001-2005  <a href="http://www.sante.gouv.fr/htm/pointsur/nutrition/1nbis.htm">http://www.sante.gouv.fr/htm/pointsur/nutrition/1nbis.htm</a></p>
Ireland	<p>1. Nutrition Health Promotion - Framework for Action (1991).</p> <p>2. Shaping a Healthier Future (1994)</p> <p>3. The National Breastfeeding Policy for Ireland (1994)</p> <p>4. A Health Promotion Strategy- Making the healthier choice the easier choice (1995).</p> <p>5. Recommendations for a Food &amp; Nutrition Policy for Ireland (1995).</p> <p>6. Framework for Action Review (1997)</p>

	<p>7. Working for health and well-being (1998-2001)</p> <p>8. Adding Years to Life and Life to Years -A Health Promotion Strategy for Older Persons (1998).</p> <p>9. Recommendations for a National Infant Feeding Policy (1999)</p> <p>10. Building Healthier Hearts: The Report of the Cardiovascular Health Strategy Group (1999)</p> <p>11. Recommendations for a National Food and Nutrition Policy for Older People (2000)</p> <p>12. The National Children’s Strategy: Our Children –Their Lives (2000)</p> <p>13. FSAI Dietary Recommendations (2000)</p> <p>14. Quality and Fairness: A Health system for You 2000</p> <p>15. National Health Promotion Strategy (2000-2005)</p> <p>16. Report from the National Taskforce on Obesity (2005).</p> <p>17. Breast feeding in Ireland – A 5 yr Strategic Action Plan, October 2005</p> <p>18. New Nutrition Policy 2005.</p> <p><a href="http://www.doh.ie/publications/hpstrat.html">http://www.doh.ie/publications/hpstrat.html</a></p>
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## New Zealand

1. Ministry of Health. The NZ Health Strategy. Wellington: Government of NZ, 2000. [http://www.moh.govt.nz/moh.nsf/f872666357c511eb4c25666d000c8888/fb62475d5d911e88cc256d42007bd67e/\\$FILE/NZHthStrat.pdf](http://www.moh.govt.nz/moh.nsf/f872666357c511eb4c25666d000c8888/fb62475d5d911e88cc256d42007bd67e/$FILE/NZHthStrat.pdf) & [www.moh.govt.nz/nzhs.html](http://www.moh.govt.nz/nzhs.html)

Implementation of nutrition policy includes:

- Breastfeeding: A guide to action (Ministry of Health 2002a)
- Reducing Inequalities in Health (Ministry of Health 2002c)
- Health of Older People Strategy (Associate Minister of Health and Associate Minister for Disability Issues 2002)
- New Zealand Cancer Control Strategy (Minister of Health 2003) and Cancer Control Action Plan (MoH 2004)
- Achieving Health for All People (Ministry of Health 2003b)
- Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0-2) A background paper (MoH 2000); ...for Healthy Children (MoH, 1997);...for Healthy Adolescents (MoH 1998); ...for healthy pregnant and breastfeeding women (under review and being combined into one publication-see consultation document 2005);
- ...for healthy adults (MoH 2003);
- ...for healthy older people (MoH 1996). all on website.

2. Ministry of Health. DHB Toolkit. Obesity. Wellington: New Zealand Government, 2001. <http://www.newhealth.govt.nz/toolkits/obesity/Obesity0102.pdf>

3. Ministry of Health. Healthy Eating - Healthy Action (HEHA). A background. Wellington: NZ Gov, 2003. [http://www.moh.govt.nz/moh.nsf/0/6F0CB6922A8575B5CC256CE6000D3A6F/\\$File/heh-a-background.pdf](http://www.moh.govt.nz/moh.nsf/0/6F0CB6922A8575B5CC256CE6000D3A6F/$File/heh-a-background.pdf)

4. MoH Healthy Eating - Healthy Action (HEHA). A strategic framework. Wellington: NZ Gov, 2003. [http://www.moh.govt.nz/moh.nsf/0/6088A42CFAA9AC6FCC256CE0000DAE66/\\$File/heha-strategicframework.pdf](http://www.moh.govt.nz/moh.nsf/0/6088A42CFAA9AC6FCC256CE0000DAE66/$File/heha-strategicframework.pdf)

5. Healthy Eating – Healthy Action (HEHA): Implementation Plan: 2004–2010: June 2004 <http://www.moh.govt.nz/moh.nsf/49ba80c00757b8804c256673001d47d0/cd182e2c03925c09cc256ebd0016cf4b?OpenDocument>

## Norway

1. Ministry of Social Affairs. Prescriptions for a Healthier Norway. A broad policy for public health. Oslo: Norwegian Government, 2003. See Chapt on Food & Nutrition – Same goals as in 1994

<http://odin.dep.no/archive/hdvedlegg/01/07/folke013.pdf>

2. In Dec 2004 the Government developed a policy for Physical Activity which involved 8 Ministries. A similar initiative may now take place for nutrition policy. This should be ready for consultation in 2006 along with the governments comments on the latest document from the Nutrition Council:

	A WHOLESOME DIET FOR GOOD HEALTH, NATIONAL COUNCIL FOR NUTRITION, Strategy plan for 2005–2009, including proposed courses of action. Commissioned by the Norwegian Directorate for Health & Social Affairs, JUNE 2005
Scotland	<p>1. SCOTTISH DIET ACTION PLAN 1996</p> <p>2. Eating for Health – meeting the challenge (Food and Health Action Plan for 2004)  <a href="http://www.scotland.gov.uk/Resource/Doc/47060/0012960.pdf">www.scotland.gov.uk/Resource/Doc/47060/0012960.pdf</a></p> <p>3. Towards a Healthier Scotland. Scottish Office, 1999 (just before devolution)</p> <p>4. “Improving Health in Scotland - The Challenge” 2003 provides a framework to support an active programme to deliver the policy for health improvement set out in Partnership for Care, Scotland’s Health White Paper. March 2003.  <a href="http://www.scotland.gov.uk/Resource/Doc/47034/0013854.pdf">http://www.scotland.gov.uk/Resource/Doc/47034/0013854.pdf</a></p>
Slovenia	The Resolution on the National Programme of Food and Nutrition Policy 2005-2010 (in English).
Sweden	<p>Sweden's new public health policy (NPHP), created the foundation and climate for the development of latest nutrition policy which is expected to be adopted by government in Spring 2006. The Nutrition (&amp; PA) policy is the first to be created after the publication of the NPHP. The NPHP is remarkable in that it is truly an intersectoral policy document which has created the necessary “back-drop” for an intersectoral nutrition policy. It contains 79 actions which have recently been costed<sup>b</sup>. Also see lessons learnt in Scan Journal of Public Health.</p> <p>1. The National Institute of Public Health. Sweden's New Public-Health Policy. Stockholm, 2002:1-8.  <a href="http://www.fhi.se/upload/PDF/2004/English/roll_eng.pdf">http://www.fhi.se/upload/PDF/2004/English/roll_eng.pdf</a></p> <p>2. Agren G. Sweden's new public health policy. National public health objectives for Sweden. Stockholm: Swedish National Institute of Public Health, 2003.  <a href="http://www.fhi.se/shop/material_pdf/newpublic0401.pdf">http://www.fhi.se/shop/material_pdf/newpublic0401.pdf</a></p> <p>3. Link to proposal for action plan, full document (February 2005):  <a href="http://www.fhi.se/upload/2702/TheSwedishActionplan.pdf">http://www.fhi.se/upload/2702/TheSwedishActionplan.pdf</a></p> <p>4. New document on costs and financing (Sept 2005):  <a href="http://www.fhi.se/templates/Page_6473.aspx">http://www.fhi.se/templates/Page_6473.aspx</a></p> <p>5. The Swedish Public Health Policy and the National Institute of Public Health. Scan J Public Health, supplement 64, 2004 (December).</p>
USA	<p>1. US Department of Health and Human Services. Healthy People 2010. Washington DC: US Government Printing Office, 2000.  <a href="http://www.healthypeople.gov/Publications/">http://www.healthypeople.gov/Publications/</a></p> <p>2. New Dietary Guidelines <a href="http://www.health.gov/dietaryguidelines">www.health.gov/dietaryguidelines</a></p>

### Annex 3: Human and financial resources

Country	Human Resources	Explanation
Australia	8-20	Estimated no. employed in Population Health Division of MOH working on obesity, nutrition and physical activity.
Canada	35	Within Office on Nutrition Policy & Promotion
Denmark	34	Board of Food: 21; Surveillance Centre: 5; & Board of Health: 8: Total = 34 (National level only)
England	10-15	DOH & FSA
France	2	2 at MOH + those working in national agencies
Ireland	1	1 at MOH + 8 employed in each of 10 Boards: Total = 80 (20% time support PHC) + FSAI
Israel	40	MOH
New Zealand	5	MOH does not include other agencies such as NZFSA
Norway	12	MOH + Health Directorate
Scotland	27	Includes Scottish Executive, FSA, NHS Scotland (does not include those at regional or local level)
Slovenia	10	3 within MOH; 6 within National and Regional Institutes of Public Health: Total = 10
Sweden	10	5 in Institute of Public Health & 5 in the Food Administration (MOA): Total = 10
USA	23	Centre for Nutrition Policy and Promotion (Agri) (approx 20); Health & Human Sciences, Office of Disease Prevention & Health Promotion (approx 3): Total = 23

	Financial resources/ yr	Explanation
Canada	Canadian \$ 4.5 million	ONPP
Denmark	DKK 10 million (2004) + Board of Health budget	Board of Health funds provided for initiating & evaluating specific interventions in local authorities.
England	£16-17 million	(£ 50 million for next 3 years)
France	€15 million	+ 2 salaries at MOH ...much more if one counts funds from: Min of Agric; Regional & Local Authorities; Salaries of personnel in key Agencies
New Zealand	NZ \$8.27 million (2002/3)	For both nutrition & physical activity – “Health & Independence Report”, MoH

		2003. "Health & Independence Report", MoH 2004) (pg22) & expenditure on nutrition (pg215). Plus Cancer Action Plan includes funding for parts of HEHA of 6.4 MILLION/yr from July 2005.
Norway	NKK 40 million + 20 million to F&V scheme	+ salaries
Scotland	£25 million	
Slovenia	€333,000	
Sweden	Sweden costed all the 79 Actions in New Action Plan	funds are expected after government has ratified new document and SEK 500 Million /yr is estimated to be needed to implement the 79 actions in new Action Plan.

## **Annex 4: Norwegian Policy Recommendations 2005, National Council for Nutrition**

Strategy plan for 2005–2009, including proposed courses of action, as commissioned by the Norwegian Directorate for Health & Social Affairs, JUNE 2005. This strategy document has been drawn up by the National Council for Nutrition as commissioned by the Norwegian Directorate for Health and Social Affairs. Based on the vision of a wholesome diet for life-long good health, the National Council has proposed a list of priorities for promoting healthy eating habits and good nutrition in Norway. The primary focus is on reducing the consumption of solid fats, sugar and energy-dense, nutrient-poor foods, while increasing the consumption of fruits and vegetables. To achieve this, the National Council for Nutrition has designated 4 high-priority areas: measures to encourage healthy choices, measures in educational institutions, measures in the health services and measures to enhance knowledge through monitoring and research. These priorities are based on information about which types of measures are effective and can help reduce social disparities in health. Covering a time frame from 2005 to 2009, the plan stipulates specific objectives within each of the four areas during the period in question.

This document presents the National Council for Nutrition's recommendations to the authorities on the initiatives that should be given priority in various segments of society to promote a healthy diet.

### **Summary**

The average Norwegian diet is healthy in many ways, and developments over the past 30 years have been favourable in several respects. Important changes during this period include a reduction in the intake of saturated fats and trans fats, accompanied by an increase in the consumption of fruits and vegetables. However, from a health perspective, large segments of the population still eat too many foods with a high content of saturated fats, sugar and salt, and not enough nutrient-rich foods such as whole-grain breads and vegetables.

The National Council for Nutrition's vision is *a wholesome diet for life-long good health*. Health challenges related to diet and trends in eating habits form the basis for the following dietary goals in Norway:

1. a higher intake of vegetables, fruits, berries and whole-grain products
2. a lower intake of solid fats (saturated fats and trans fats)
3. a lower intake of energy-dense, nutrient-poor foods

These strategic goals will help continue to reduce the incidence of cardiovascular disease and the prevalence of diet-related cancer, and stop the increase in overweight and obesity. The course of action chosen to attain these goals is to facilitate healthy choices and increase general knowledge about food, diet and

health. One primary objective for nutrition work is to *reduce social disparities in health*.

To achieve these goals, the National Council for Nutrition will focus on the following high-priority target areas and measures:

- 1) Measures to facilitate healthy choices
  1. lower prices for fruits and vegetables
  2. higher prices for energy-dense, nutrient-poor foods
  3. prevent the marketing of unhealthy foods to children and adolescents
  
- 2) Measures in educational institutions
  1. Free fruits and vegetables in daycare centres and schools
  2. ensure basic health literacy
  3. ensure basic cooking skills
  4. ensure good teaching skills
  
- 3) Measures in the health and social services
  1. intensify nutrition work in prenatal health services, children's health clinics, school health services, nursing and care services, and primary and specialist health services
  2. enhance nutritional knowledge among health care personnel
  
- 4) More focus on research and monitoring
  1. focus on health-promoting and preventive measures that address public health challenges
  2. conduct regular studies of eating habits and diet-related health and disease indicators in the population, monitoring height, weight, blood pressure and various blood parameters
  
- Communication measures
  - put more emphasis on communication to enhance the public's knowledge about food, diet and health.

Cross-sectoral cooperation and involvement are prerequisites for achieving rapid, satisfactory results from nutrition work within these high-priority areas. These challenges cannot and should not be resolved by the health sector alone. Nutrition work must be viewed in the context of public health as a whole, with the public health chain and alliances for public health playing key roles.

## **Annex 5: Statutes of the Norwegian National Council for Nutrition**

Adopted on 13 June 2003 by the Ministry of Health and Care Services

### *Section 1 Scope of Activity*

The National Council for Nutrition (the National Council) is a professional, independent body for knowledge and competence in the field of diet and nutrition, appointed by the Ministry of Health and Care Services and under the administrative auspices of the Norwegian Directorate for Health and Social Affairs (hereinafter called the Directorate).

### *Section 2 Objective*

The National Council shall work to improve the nutritional situation of the population.

### *Section 3 Functions*

The National Council shall give the authorities professional advice on matters concerning nutrition and health. The National Council may, on its own initiative, issue statements on matters concerning nutrition.

### *Section 4*

The National Council shall contribute to documentation work, keeping up to date on research results and monitoring Norwegian dietary trends. The National Council can propose that scientific studies or reports be undertaken on diet and nutrition.

The National Council shall contribute to information about diet and nutrition and about the conditions and measures that affect diet and health. The National Council shall also make recommendations for measures to enhance the role of diet and nutrition in health-promoting activities, prevention, treatment and rehabilitation.

The National Council shall help evaluate the effect of preventive and health-promoting measures in the field of diet and nutrition.

### *Section 5 Appointment*

The National Council consists of up to 15 members who collectively represent the broad competence of the National Council's areas of activity.

The members, including the Chair and Deputy Chair, are appointed by the Ministry of Health and Care Services. Members are appointed for four-year terms. Members may be reappointed.

### *Section 6 Administrative provisions*

The Directorate may request that the National Council submit reports on specific matters. The Ministry may, on its own or on behalf of other ministries, seek expert

advice from the National Council through the Directorate. Copies of the National Council's recommendations shall be submitted to the Ministry.

#### *Section 7*

The National Council shall have a meeting schedule that is deemed adequate for fulfilling the National Council's responsibilities and tasks and that remains within the budgetary parameters available to the Directorate. Remuneration will be paid by the Directorate in accordance with the government wage scale.

The Chair of the National Council is responsible for convening the meetings. One-third of the members may also demand that the Chair call a meeting to handle a specific issue. In consultation with the Directorate, the National Council may invite persons outside the National Council to participate in specific meetings and in the handling of specific issues. Members and other participants are to be called meetings on a minimum of 14 days' notice. The Deputy Chair shall assume the Chair's role when the Chair is absent. The Directorate has the right to attend and speak at the meetings of the National Council.

Minutes shall be kept of the National Council meetings. Any National Council member is entitled to make comments for the record. A copy of the minutes shall be sent to the Ministry.

The Directorate shall serve as the secretariat for the National Council.

The individual National Council member may take part in the implementation of high-priority tasks at the request of and in close cooperation with the Directorate.

#### *Section 8*

The National Council takes its decisions by simple majority. In the event of a tie, the Chair has the deciding vote. The minority opinion shall be entered in the minutes. At least one-half of the members must be present for the National Council to have a quorum.

The National Council shall cooperate with the other National Councils associated with the Directorate in areas where this is natural. The National Councils shall have at least one joint meeting annually.

#### *Section 9*

The Ministry of Health and Care Services may amend the statutes.

**Annex 6:**  
**School fruit programmes in five countries**

### Annex 6. School fruit programmes in five countries

Country	Ownership	Organisation	Policy	Budget <sup>35</sup>	Evaluation	Advantages (+) Disadvantages (-)
<b>Denmark</b>	Partnership between 13 organisations representing fruit & vegetable industry, governmental food & health organisations, and NGO health/disease prevention organisations	Subscription system non-subsidized, full end user payment	No national policy for the provision of school meals. Joint marketing is funded 50% by the Directorate of Food Industry funds to ensure innovation in the food sector.	600,000 € (4.2 mil. DKK)  50 % matching funds.	Several process evaluations of pilot project, and one peer reviewed article	(+) Public-private partnership creates a sustainable solution with minimal government spending (-) low uptake at both school and individual levels
<b>England</b>	100 % ownership DOH, initially with funding from New Opportunities Fund, from 2004 with 100 % funding from NHS	Free for 1 <sup>st</sup> 3 yrs of school 4 – 7 yr. olds	Meal provision	110.7 mil. € (77 mil £) 2004	Process evaluations	(+) Free for all (-) sustainability relies on public funding (+) targets children at an early age (-) no follow-up in older children.
<b>Holland</b>	Fruit and vegetable Marketing Board, & Department of Health.	Pilot project distributing free fruit in 7 cities in Holland Primary 4 – 7 yrs.	No policy documents available in English	4.8 mil. € 1.4 mil. € for educational materials funded 50% EU	Preliminary results show increase in F&V intake in Hague & Leiden	(+) reduction of costs because fruit only given 2 dy/wk but modest increase compared to free fruit on all week days
<b>Norway</b>	1998 - 2000 cooperative agreement between MOA & NFU; 2002 – 2003 funded by Norwegian Fruit & Vegetable Marketing Board & Dept. Health & Social Affairs	Available to all schools in Norway both primary & secondary	White paper on Public Health ensures funding	20 mil. NOK - 2004 NFVMB (50%) + DHSA (25 %) + Cancer Plan (25%).	Outcome evaluation of pilot in Ostfold county	(+) medium term evaluation (+) national programme (-) only 15% children
<b>USA</b>	Pilot project funded by the Farm Bill 2002, however many other agencies and NGOs have contributed to add-on programmes i.e. educational	Pilot project in 4 States extended to 3 more & an Indian reservation in 2004.	Permanent programme by act of congress as of June 2004	6 mil. USD 2002 7.2 mil. € (9mil. USD) 2004	Process evaluation but no plans for outcome evaluation,	(-) no national rollout (+) good qualitative evaluation

<sup>35</sup> Figures are converted to EURO for comparison. All conversions use average conversion rate for 2004: USD EURO 0.79635; GBP EURO 1.46554 avg.; NOK EURO 0.11535 avg.; DKK EURO 0.13430 avg.; NLG EURO 0.45380 avg. Source: Robert Pederson, M.Sc. thesis 2005, City University, London

