National and international nutrition policies are not new. In the UK in the 1940s war years, John (later Lord) Boyd Orr, then Director of the Rowett Research Institute in Aberdeen, led and advised Churchill’s Scientific Committee on Food Policy. Boyd Orr helped to formulate a system of food rationing designed to maximize the possibility of good nutrition in the British population in difficult circumstances. After the War, he tried to develop nutrition policy within a much wider frame after he was appointed as the first Director General of the Food and Agriculture Organization of the United Nations. However, his vision of the establishment of a World Food Board was rejected in 1947, and was forgotten by the early 1950s; at this time, the people of Europe were fed largely on the produce of the agricultural land surrounding main towns and cities. There were almost no national or international food industries.

Meanwhile, in much of the middle of Europe, in the 1940s and even into the early 1950s, there was severe famine and even starvation in many areas as a consequence of the World War. Anecdotal reports of this tragic situation provided much of the basis for the Marshall Plan, and the starvation situation began to improve from 1947. However, as post-war agriculture policy began to be formulated, the cities of central Europe called for increased supplies of meat, milk and other dairy products, cereals (for bread) and sugar. So these were the types of agricultural production most encouraged, mainly through production subsidies, when the forerunner of the Common Agricultural Policy (CAP) was established a few years later in 1958.

Yet, within a decade, these production subsidies led to overproduction, especially of beef, milk and sugar. The consequence for health was dire: in the absence of any nutrition-based guidelines for the CAP, Europe’s diet became dominated by many foodstuffs with high content of saturated fat, their consumption sometimes being promoted further by consumer subsidy support from the European Commission (EC). Worse still, no subsidies were provided (until 2008) to support production of fruit and vegetables. Sixty years later, the CAP is still failing to address Europe’s need for nutritionally healthy agricultural produce.

Furthermore, nutrition inequalities (leading to health inequalities) are evident in many parts of Europe, and successful means of addressing such inequalities need to be identified. Undernutrition also remains a serious issue for children and pregnant women, and for some disabled, aged and other socially excluded groups. Potential dietary deficiencies, such as those relating to calcium and trace elements, vitamins B and D, iodine and folic acid (to prevent birth defects), must also be addressed. Should the people of Europe have routine vitamin D supplementation of certain foods, as happens in the USA and Canada, with folic acid added to flour, as in more than 50 other countries?

The damage caused to health in Europe by poor nutrition (substantially mediated through the CAP) has become increasingly well understood in recent years. However, the EC has never thus far substantially mediated through the CAP) has become increasingly well understood in recent years. However, the EC has never thus far addressed seriously, this new CAP must address energetically the supply side of food production as well as the demand side. In addition to revising agricultural subsidies, taxation of saturated fat-rich and sugar-rich processed foods, greater control over the advertising of junk foods and sugary drinks and simple food labelling (the ‘traffic lights’ system), all require serious consideration. Improved nutrition surveillance, and better systems for the evaluation and monitoring of nutrition intervention programmes are needed urgently. This requires expansion and development of appropriate public health capacity at all levels of decision making. The public health workforce has too often in the past lacked appropriate skills in public health nutrition.

Finally, in today's complex world, nutrition policy cannot be considered in isolation. Indeed, agriculture, the food industry and fish production impinge on the environment, on transport policy and on economic policy itself. Agriculture contributes more than 20% of total global warming gases, much more than does any other single industry. Furthermore, curbing agricultural saturated fat production, and reducing agriculture’s output of global warming gases, share a common strategy: a general reduction in use of cows within farming. Improvements in nutrition could halve the burden of non-communicable disease in Europe and globally; effective policy interventions are available. It is certainly the role of WHO to recommend such policies, but it must be the business of the EC, and of all European governments, to intervene and to implement them: it is a primary business of government to protect and to safeguard the wellbeing of citizens against threats that are beyond individual control. This is the true significance of nutrition policy.

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A new agenda for health in Europe

Helmut Brand

Department of International Health, CAPHRI School of Public Health and Primary Care, Faculty of Health, Medicine and Life Science, Maastricht University, The Netherlands

Correspondence: Helmut Brand, Department of International Health, CAPHRI School of Public Health and Primary Care, Faculty of Health, Medicine and Life Science, Maastricht University, The Netherlands, e-mail: Helmut.Brand@MaastrichtUniversity.NL

In 2013 we saw the 20th anniversary of the public health mandate of the European Union (EU). Looking back we can conclude that progress towards a healthier Europe has been made and that the glass of achievements in European public health policy is half full already (see also the viewpoint section in this issue). There are now institutional structures with a directorate for health, agencies (e.g. the European Centre for Disease Control), health programmes and a health strategy. Additionally, the European Court of Justice’s (ECJ) decisions shaped the work as crises like BSE, SARS and H1N1 did. Work on the main determinants of health has been evaluated with mixed results.

What is the impact of the upcoming elections?

In 2014, there will be European parliament elections. The turnout of voters might be at an all-time low with austerity as the solution to the sovereign debt crisis the European project lost credentials among its citizens. As a consequence we might see Eurosceptic parties gaining power in the Parliament. On the other hand, progress on solving the democratic deficit of the EU and making the EU more responsible and accountable to the European citizen is going on.

The European Citizen Initiative adds elements of direct democracy to Europe. The first successful initiative with public health relevance called ‘Right2Water’ has led to change of a Commission proposal in line with the European Citizen Initiative’s objectives.

During the upcoming legislative period, the new Parliament will have more rights and will elect the European Commission’s president on the basis of a proposal made by the European Council, taking into account the European elections. There will be a new Commission with new commissioners—also in health. And there will be most probably a new treaty.

What will be the future of the health mandate?

The measures taken during the financial crises to set up a banking and fiscal union have to be integrated into the legal framework of the EU. And as Europe begins to influence the management of health systems in the Member States (MS) for economic reasons, it is stretching the existing treaty to its limits, as health service management is the responsibility of MS. Examples are the work around the Council Conclusion towards modern, responsive and sustainable health systems and the European Semester that already gave country-specific recommendations on health system reforms to MS.

Beyond single additions to the treaty or intergovernmental agreements, there is the possibility that the whole treaty with all its articles may be unwrapped and even being transformed into a constitutional treaty, getting closer towards a more political union. The Public Health community might welcome this, as it would start a fresh discussion about the article on health. But we have to be aware that the necessary adoptions in the treaty are because of the fiscal developments in Europe, not because of the need for a stronger public health mandate. And there are also risks for European integration in the field of public health, too: There is a tendency that MS will try to re-nationalize power back from the EU to compensate for losses of competencies in other areas. In this process, the health article could be bargaining chips to political compromises and might lose its importance. The Europeans might vote against a new treaty when asked by their national governments, as it happened in 2005. Hence, European Public Health might end up with a less powerful article than we have now.

What should the Public Health community do?

The public health community needs to be more visible and engaged in European health policy. Therefore, before the European elections take place, we should establish a stronger health agenda by organizing events in which the political parties have to explain their thoughts of a healthier Europe. When the Parliament is elected, we should realize that Members of the European Parliament have gained power, and hence, we should not only lobby the European Commission but also our elected representatives. As new commissioners have to be approved by the Parliament, we can help Members of the European Parliament to ask health-directed questions in the hearings. Let us use the establishment of a new commission as a window of opportunity to start a discussion on the update of the expired Health Strategy. And most important of all: be prepared to get involved in the discussion on a new treaty and an update of the health mandate.