



GOOD PRACTICE BRIEF

THE PUBLIC CATERING DECREE IN HUNGARY: Intersectoral public health action to improve nutrition and address social inequalities with a binding legal instrument

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Summary

The Public Catering Decree was published in 2014 after a long preparatory phase and intense intersectoral cooperation with relevant stakeholders. This legal tool is one component of a complex set of public health measures to address the root causes of obesity. The Decree pertains to dietary risk factors primarily in educational settings (including free summer meals for disadvantaged children) and in hospitals and addresses not only health-related but also social and equity issues. Three years after its introduction, favourable changes in the school nutrition environment were seen, and a positive change in the attitude of the food industry. Robust communication activities to supplement the legislation improved understanding of its public health goals, thus strengthening the public perception and acceptance.

Comprehensive approach required to improve nutrition outcomes

Chronic noncommunicable diseases, in particular cardiovascular diseases and cancers, are major causes of premature mortality in Hungary. Obesity contributes to these outcomes and is thus a major public health concern, particularly among children. In Hungary, 28% of children are overweight and more than 11% are obese (1). National surveys show that children's diets already contain nutritional risk factors.

Healthy nutrition is important for the mental and social development of children and their well-being and improves school performance and attendance (2). As children spend most of their day in preschools and schools, they consume 35–65% of their daily energy there. Thus, schools and preschools have a pivotal role in ensuring access to healthy nutrition and shaping children's health behaviour. Making the preschool and school food and nutrition environment healthy is a long-term investment in health, with positive effects lasting well into adulthood.

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Key Messages

- Voluntary actions alone are not enough to catalyse changes in the food environment or in dietary behaviour; binding legislation is also required.
- A complex policy tool that affects health, social and equity issues requires strong and aligned intersectoral cooperation.
- Strong political commitment from the Government both in its mission and in financial terms is required to deliver such complex results.
- Diet-related noncommunicable diseases cannot be reduced effectively only by a "silver bullet" such as the Public Catering Decree. This complex problem requires a systematic approach and a comprehensive, aligned, system-wide response.
- The structural change in the public administration that has merged health, social affairs, education, youth and sport into a single ministry facilitated the process by ensuring more efficient intersectoral cooperation.
- Robust communication activities to supplement the legislation led to better understanding of its public health goals, thus strengthening the public perception and acceptance.

Recognizing that voluntary action alone had not been successful in changing unfavourable nutritional outcomes, the Hungarian Government launched a complex set of mandatory legal actions to address lifestyle-related risk factors, including nutrition and physical activity. The renewal of nutritional standards in public catering was driven in particular by high demand from both professionals and the public.

The Public Catering Decree

The Chief Medical Officer renewed the nutrition guidelines for public caterers in 2011, introducing the new approach of food-based recommendations. The new guidelines essentially encourage greater intake of vegetables and fruit and reductions in fat, salt and sugar consumption.

The new ministerial decree on public catering was based on these guidelines. Preparatory intersectoral work was led by the Ministry of Human Capacities, a “supra-ministry” covering health, social affairs, education, youth and sport.

The decree was widely and thoroughly negotiated for three years by all relevant stakeholders, including Government bodies, professional and public organizations such as caterers’ associations, parent associations, patient associations and local governments and the food industry. Reasons for opposition included fear in local governments and among caterers of increases in the price of raw materials and pressure from the food industry for swift, costly technological changes. During the negotiations, a number of compromises were made to take into account the facilities and opportunities of local governments and the food industry. Preliminary modelling and pricing of menus that respected the new decree were developed to avoid unnecessary financial constraints for providers. Good practices of careful, reasonable menu planning with locally produced food and seasonal menus were collected during the preparatory phase to enable caterers to comply with the new decree.

The decree was published in 2014, entered into force on 1 January 2015 and has been applicable since 1 September 2015. It covers preschools, primary and secondary schools and other educational settings, in-patient care facilities and certain services that provide social and child protection care.

The decree legislates application of food-based standards and an additional set of standards for some nutrients (e.g. salt, sugar, total fat, calcium). For salt, a stepwise approach was used. Providers gradually comply with reference values for the daily maximum salt intake for different age groups, reaching the final value over six years. The decree stipulates the specific food groups to be provided daily (milk and dairy products, whole grains and cereals, fruit and vegetables). The decree also regulates the number of meals to be provided, the age-appropriate portion sizes, the frequency of certain food groups over a 10-day catering period, energy requirements per age and the variety of meals. The decree restricts the use of some food categories and prohibits a list of foodstuffs (e.g. energy drinks, sweetened soft drinks, non-fruit-based syrups, caffeine-containing beverages for children under the age of 18 years) and a list of food colorants for children.

The decree obliges caterers to provide adequate information to consumers by displaying the amounts of nutrients and the presence of allergens. One section is dedicated to mandatory training of caterers. It legislates the provision of nutritious, healthy meals appropriate for age and physiological status and also for people with special dietary needs, such as those with intolerance to lactose, sensitivity to gluten and other intolerances justified by a specialist, as listed in European Union legislation. This element of the legislation is forward-looking, as this aspect of public catering has not previously been addressed.

The decree emphasizes equity and enforcement of the basic right to health. It has a strong social element, providing for healthy meals free of charge for children in socially disadvantaged families. A tendering system is in place to cover the cost of summer catering for schoolchildren in an increasing number of disadvantaged settlements.

Intensive communication activities, including setting up a webpage to disseminate authentic messages for health education and awareness-raising, country-wide public roadshows, collecting good practices and sharing recipes to promote healthy catering, have been implemented by the Ministry of Human Capacities and the National Institute of Pharmacy and Nutrition. Explanations of the rationale for the legislation and dissemination of its public health goals helped to improve public (and parental) perception and acceptance.

Impact

The public catering and nutrition environment in primary schools was assessed in 2017 by the National Institute of Pharmacy and Nutrition within the framework of the Biannual Collaborative Agreement between the WHO Regional Office for Europe and the Ministry of Human Capacities, Hungary. (3) The preliminary results show a number of favourable changes in meals in primary schools between 2013 and 2017 (Fig. 1).

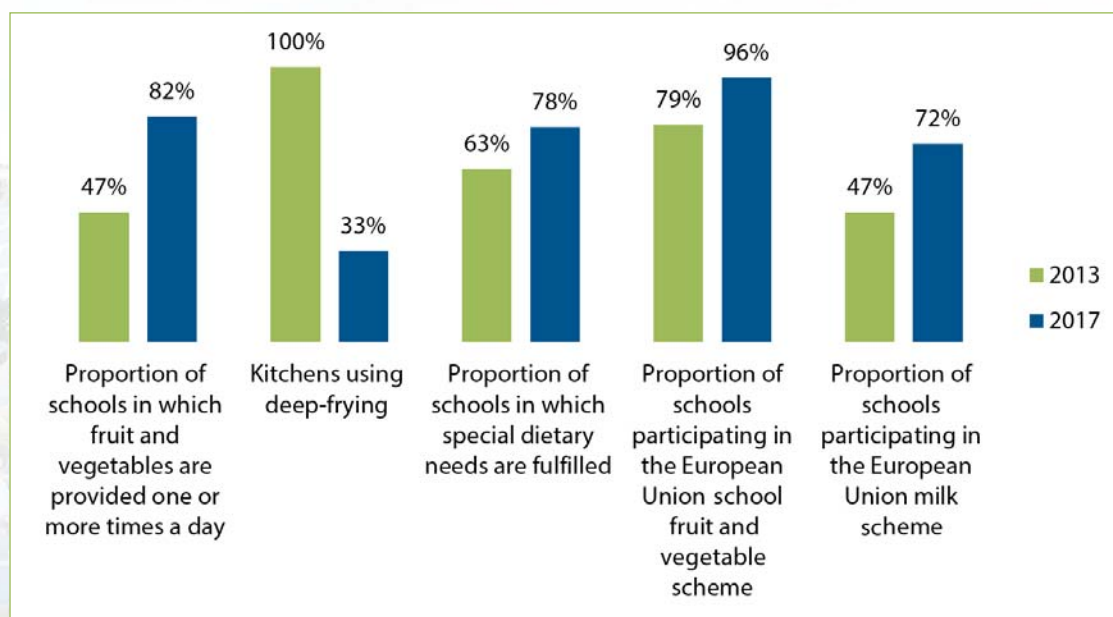
- In 90% of schools, caterers comply with the regulations on sugar, energy and fat content.
- Healthy meals and ingredients are available or being introduced, and only a minority of children dislike them.
- The proportion of schools in which fruit and vegetables are provided one or more times a day has increased significantly.
- The traditional cooking technique of deep-frying is used in significantly fewer kitchens.
- The proportion of schools in which special dietary needs are fulfilled has increased substantially.

The school nutrition environment also became healthier during 2013–2017.

- One fourth of schools reported that they had kitchen and/or school gardens.
- The proportion of schools participating in the European Union school fruit and vegetable schemes and in the milk scheme increased.
- The number of school snack shops selling sugar-sweetened beverages or colas, pre-packaged candies, chocolate, biscuits or wafers has decreased.

With these changes, the meals provided in the public catering sector have become healthier, with more milk and/or dairy products, greater consumption of fruit, vegetables, whole-grain products and cereals, and lower intakes of salt and saturated fatty acids. The food industry has shown increased willingness to reformulate foods to obtain low-fat meat products and less salt.

Fig. 1. Changes in selected indicators 2013-2017



Lessons learned

- **Voluntary actions alone are not enough to catalyse changes in the food environment or in dietary behaviour; binding legislation is also required** to design a framework and to urge all relevant stakeholders, including the food industry, to act.
- **A complex policy tool that affects health, social and equity issues requires strong, aligned, intersectoral cooperation** among government bodies, professional organizations, civil society, the food industry, local governments, schools and families.
- **Strong political commitment from the Government** both in its mission and in financial terms is required to deliver such complex results through design, negotiation and implementation.
- **Diet-related noncommunicable diseases cannot be tackled effectively only by a “silver bullet”** such as the Public Catering Decree. This **complex problem requires a systematic approach and a comprehensive, aligned, system-wide response**. The legislation is one of an extensive set of measures, including legal tools, model school programmes, operative programmes, intersectoral initiatives and communication campaigns targeting dietary risk factors, nutritional behaviour and health literacy. All are important elements of the complex response.
- **The structural change in the public administration** that has merged health, social affairs, education, youth and sport into a single ministry **facilitated the process by ensuring more efficient intersectoral cooperation**.
- **Robust communication activities** to supplement the legislation **led to better understanding of its public health goals**, thus strengthening the public perception and acceptance.

References

- (1) WHO Childhood Obesity Surveillance Initiative (COSI). Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/activities/who-european-childhood-obesity-surveillance-initiative-cosi>, accessed 8 June 2018).
- (2) Arvidsson L. Bidirectional associations between psychosocial well-being and adherence to healthy dietary guidelines in European children: prospective findings from the IDEFICS study. BMC Public Health, 2017;17:926.
- (3) Assessment of the Public Catering Decree in primary schools in Hungary (draft report). Budapest: National Institute of Pharmacy and Nutrition (forthcoming).

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