



# EUROHEALTH

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## ➤ Addressing Obesity in Europe

- The role of public health organisations
- Childhood obesity and policies to address it
- Obesity in England: A big issue requiring bold solutions
- An increasing public health problem in Germany
- Tackling the obesity challenge in Italy
- Addressing obesity in the Republic of Moldova
- Public health activities in Poland



## EUROHEALTH

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Currently, obesity is one of the most visible but neglected public health challenges. Since a range of serious health disorders can result from obesity and prevalence continues to grow, some governments have started to take action to recognise and address it.

However, tackling obesity is challenging as it is a complex condition with behavioural, psychological and social components to consider. Everyone is affected by obesity – across Europe, across all ages and across social groups. In this issue, we look to public health organisations throughout Europe and examine the ways they are recognising and addressing obesity.

In the **Eurohealth Observer** article by Hernández-Quevedo and Rechel, the authors review the role of public health organisations in nine European countries. The results vary in the different contexts with some countries recognising obesity as a public health priority, while in others obesity doesn't feature prominently in public policy debates. They also look at the level of planning, decision-making and implementation of obesity-related policies, then present efforts for monitoring and evaluation.

Obesity and overweight in children is also of growing concern in Europe. The **Eurohealth International** article identifies the range of policies undertaken to address this growing burden at the national and international level. Also discussed are the related obstacles presented by the media and the food industry, which require a multisectoral approach to evoke change.

The **Eurohealth Systems and Policies** section begins with an article by Schalkwyk and Middleton who present the case of England, where obesity has been recognised as a national priority for over two decades. They present the evolution in the role of public health organisations as they face several barriers to combatting obesity, and argue for the need to focus more on cross-departmental action and bridging institutional silos. Focusing on Germany, Plümer argues that obesity is still an underestimated public health problem. He emphasises the benefits of taking an approach which addresses people's living environment which could be designed in such a way as to promote a healthy life, including preventing obesity.

Although Italy has lower adult obesity, obesity in children is high, and obesity represents an important public health issue. The authors discuss recent policy efforts which have led to well-coordinated national surveillance systems. Despite this, several weaknesses prevail including regional differences. Also presented is Moldova that faces the challenge of a low level of awareness of obesity as a problem and Poland where they have only recently started undertaking specific activities to combat obesity.

The monitor section looks at health policy news and new publications. We hope you enjoy!

*Sherry Merkur, Editor in Chief*

*David McDaid, Editor*

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# THE ROLE OF PUBLIC HEALTH ORGANISATIONS IN ADDRESSING OBESITY IN EUROPE

By: [Cristina Hernández-Quevedo](#) and [Bernd Rechel](#)

**Summary:** This article reviews the role of public health organisations in addressing obesity in nine European countries (England, France, Germany, Italy, the Netherlands, Poland, Republic of Moldova, Slovenia and Sweden). It finds that public health organisations contribute to issue recognition and the monitoring of obesity prevalence, but that recognition of obesity as a pressing public health challenge varies widely across countries. This is partly due to the influence of the food industry that works to undermine meaningful public health action, such as through public-private partnerships or more covert methods. Public health organisations should aim to address this interference.

**Keywords:** *Public Health Organisations, Obesity, Overweight*

## Introduction

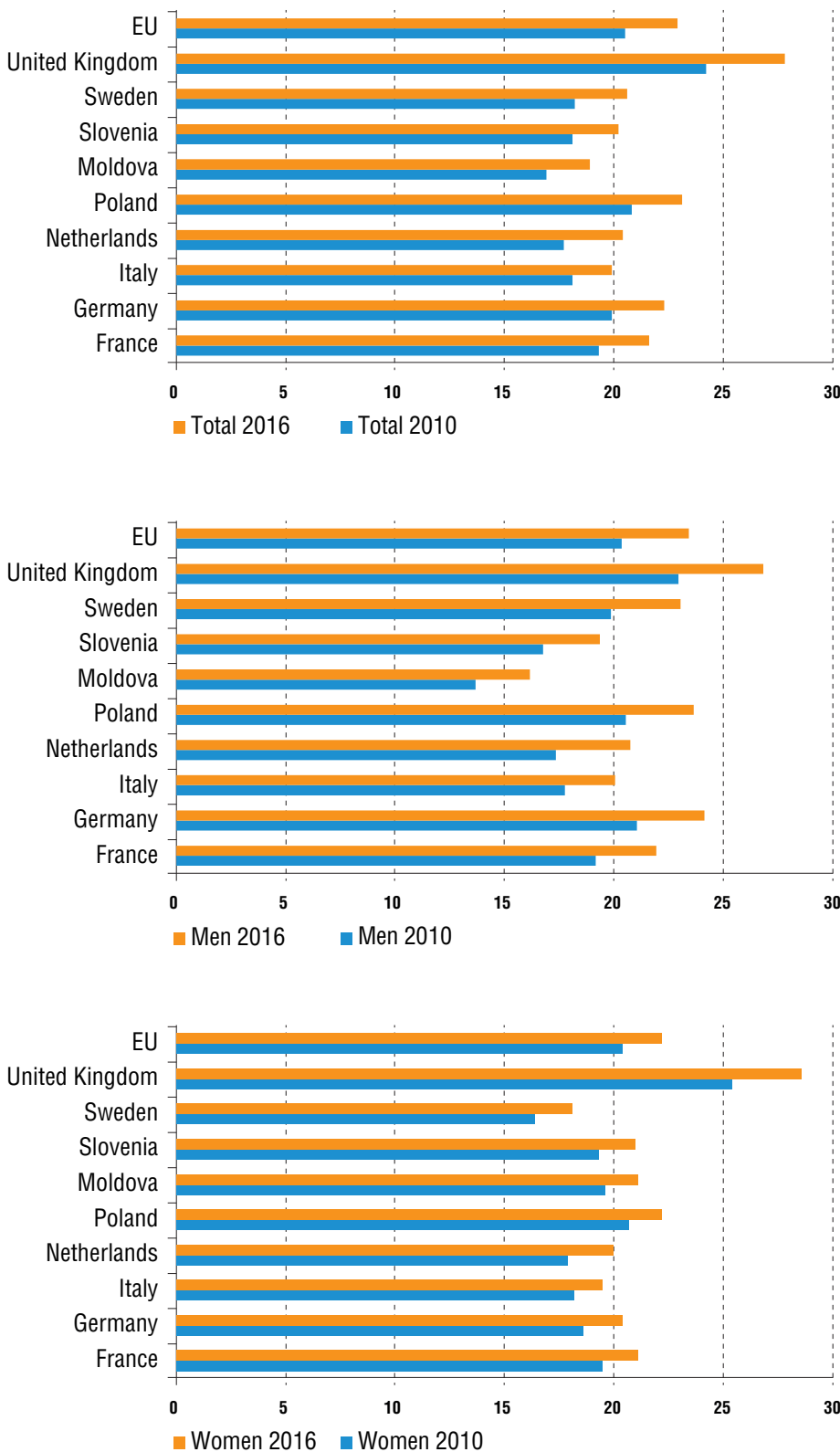
Obesity and overweight are among the greatest public health challenges in the WHO European Region; they are among the main risk factors associated with the rise of noncommunicable diseases (NCDs). Prevalence rates of obesity have more than doubled in Europe in the last decade. This article reviews the involvement of public health organisations in policies aiming to address the challenge of obesity in nine selected European countries (England, France, Germany, Italy, the Netherlands, Poland, Republic of Moldova, Slovenia and Sweden), based on detailed country reports that describe the policy response and the involvement of public health organisations in different stages of the policy cycle.<sup>1</sup>

## Scale of the problem

Obesity, “the epidemic of the 21st century”,<sup>2</sup> has been recognised as a core challenge for health systems worldwide. It is on the political agenda of many countries and international organisations, as evidenced by an increasing number of national and international strategies and action plans,<sup>3 4 5</sup> Yet, despite these initiatives, the prevalence of obesity in adults has increased in all nine countries between 2010 and 2016 (see **Figure 1**). Within most countries, obesity rates tend to be higher in lower socioeconomic groups and disadvantaged areas.<sup>6</sup> The prevalence of overweight and obesity among children is another major concern, as discussed in our second contribution to this issue.

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**Figure 1: Age-standardised prevalence of obesity (defined as BMI  $\geq 30$  kg/m<sup>2</sup>) in people aged 18 years and over, WHO estimates, 2010 and 2016 (%) (selected countries)**



Health care costs associated with obesity are substantial. Treating obesity and its consequences is estimated to cost the English National Health Service (NHS) £6.1 billion (approximately €7 billion) per year, with the wider costs of obesity to society from lower productivity and higher absenteeism estimated to be around three times this amount.<sup>8</sup> In Germany, the economic costs of obesity (including treatment, medications, surgery, rehabilitation and sick pay) are estimated to amount to up to €27 billion per year.<sup>9</sup> In the Netherlands, the total direct costs to the health system of those who are overweight are estimated at 2.2% of total health expenditure.<sup>10</sup>

### National action plans and strategies

At the national level, many policies and programmes have been adopted in recent years in Europe, focusing on both the prevention of obesity and its treatment and management. Almost all of the nine countries considered in our study have adopted national strategies or programmes in this area.<sup>11</sup> All plans define the physical and food environment as a crucial factor in the development of obesity.

“Prevalence rates of obesity have more than doubled in Europe”

### Problem identification and issue recognition

While obesity is generally perceived as a public health problem, the level of recognition differs between and within countries, with obesity hardly appearing in public policy debates in some of the countries (e.g. Moldova and Poland), but recognised as a public health priority in others.

Source: <sup>7</sup>

At the national level, the Ministry of Health or its subordinated agencies (including public health agencies such as Public Health England, *Santé publique* in France or the National Centre for Disease Prevention and Control in Italy) are in charge of identifying problems that require government attention. In some countries, advisory bodies to the Ministry of Health were specifically created to tackle obesity, such as the Council for Diet, Physical Activity and Health in Poland.

Other government departments have key roles to play in obesity policy in some of the countries. In England, for example, the Department for Education, the Department of Culture, Media and Sport (physical activity and control of advertising/marketing standards), the Department for Communities and Local Government, and the Department for Environment, Food and Rural Affairs are involved. This is not the case in other countries such as Moldova, where a lack of intersectoral collaboration has been highlighted (see the article by Obreja and Ciobanu in this issue).

At regional or local level, local authorities tend to be responsible for assessing the health needs of the population, including with regard to obesity, and for organising and funding effective local interventions (e.g. regional and local self-governments in Poland, municipalities in Sweden, and regional health agencies in France).

While in some countries (such as England), non-governmental organisations (NGOs) play a strong role in lobbying, policy advocacy and services on food, fitness and healthy environments, in others (such as Poland), they have little impact on problem identification and issue recognition. Other important actors are international organisations and scientific or professional associations. International commitments have been crucial for some countries to develop their strategies to deal with obesity, such as for Moldova. Furthermore, a number of institutions are part of WHO's European network for the promotion of health-enhancing physical activity (HEPA).<sup>11</sup>

## Policy formulation

In all nine countries, the Ministry of Health is responsible for the formulation of national health policies as well as for defining priority areas for national programmes. In all nine countries, public health organisations provide information to support policy formulation. The European Union (EU) contributes to national policy formulation to tackle obesity. Its Action Plan on Childhood Obesity 2014–2020 serves as a guidance document for many EU member states.

Policy formulation can be intersectoral. For example, in Slovenia, an intersectoral working group for developing the national programme was established under the Ministry of Health, comprising representatives from the National Institute of Public Health and other ministries (Ministry of Agriculture and Food Industry, Ministry of Education and Sport, Ministry of Labour, Family and Social Affairs, Ministry of Economy, Ministry of Transport, Ministry of Environment, and Ministry of Defence).

The regional or local level is responsible for the formulation of regional or local policies and for the implementation of national policies on obesity. In Italy, for example, the central government sets the main policy direction, while the regions are responsible for the formulation of their respective regional policies and for the organisation of regional public health services and health care.

## Decision-making

Decision-making on obesity-related policies and programmes takes place both at the national and regional level, involving different levels of government. As a rule, public health organisations are not involved in the decision-making process. In England, for example, local authorities are free to determine local policies, based on local needs. In Slovenia, the municipalities are the local authorities responsible for decision-making at the local level and can approve regional programmes on food and nutrition, addressing specifically obesity. In France, the regional health agencies have considerable autonomy in public health,

setting priorities and implementing activities according to the needs of their local population.

“the food industry is one of the most influential lobby groups

One of the key actors involved in decision-making on obesity policies is the food industry. In Moldova, for example, the food industry is powerful and intervenes at different levels of policymaking, either directly or through public authorities such as the Ministry of Economy and the Ministry of Agriculture and Food Industry. For instance, the food industry tried to prevent legislation banning the sale of unhealthy foods within and around schools; it also intervenes every time new initiatives emerge that may affect their commercial interests. In Poland, the food industry is one of the most influential lobby groups, with well-organised representation and significant financial resources.

## Policy implementation

Responsibility for the implementation of obesity policies can lie at the national or regional level. Public health organisations are often given a leading role in either overseeing implementation or directly implementing policies themselves.

In some countries, the Ministry of Health and the regions (e.g. France, Italy), county councils or municipalities (e.g. Sweden) share responsibility for policy implementation. In other countries, responsibility for implementation of national health policies rests with the local level, such as in the Netherlands and Poland. However, responsibilities are not always clearly delineated or coordinated across different levels.



A large range of other actors are involved in the implementation of obesity policies, including other public authorities, NGOs, the media, but also the food industry. In Italy, for example, formal mechanisms for collaboration are established with the National Institute of Health (ISS), AGENAS, the National Medicines Agency (*Agenzia Italiana del Farmaco*), the Ministry of Education, University and Research (e.g. Keep an Eye on Health, HBSC), the European Network for the Promotion of Health-enhancing Physical Activity – HEPA, the Department of Youth Affairs, the Ministry of Agriculture (e.g. for the development of dietary guidelines), the food industry, trade and food chain associations, and the National Committee for Dietetics and Nutrition. In some other countries, the food industry is also heavily involved in the implementation of obesity-related policies. In Poland, for example, the food industry closely cooperates with the Ministry of Health, as well as with the National Food and Nutrition Institute and the Chief Sanitary Inspectorate.

### Monitoring and evaluation

Monitoring and evaluation are most commonly done with regard to obesity prevalence and most of the countries analysed (except Sweden and Poland) have mechanisms in place for monitoring national obesity levels. Public health agencies tend to play a leading role in monitoring obesity prevalence, but other actors are also important, such as national statistical institutes or NGOs. The monitoring and evaluation of national public health policies on obesity is less well developed, but in those countries where it exists, public health agencies also tend to have a leading role. In France, for example, this role falls in part to the French Institute for Prevention and Health Education (*Institut national de prévention et d'éducation pour la santé*, INPES), now part of *Santé publique France*. Since the early 1990s, INPES, in cooperation with many institutions, has been conducting a series of surveys which examine health behaviours and attitudes.

### Conclusion and outlook

Countries vary considerably with regard to whether and how public health organisations are involved in addressing the burden of obesity. Not all nine countries have relevant national health policies in place, with Sweden being a notable exception. A challenge, pointed out in Italy and Poland, is that the problem of obesity is still poorly recognised by health professionals and policymakers. In some countries, obesity is mainly seen as an individual lifestyle problem and not as a population health problem – a stance that is strongly promoted by the food industry. In some cases, the industry and the private sector prevent problem identification and issue recognition. One of the main challenges to implementation of obesity policies is funding. In Moldova, for example, during the period of 2014–2015, no funds were allocated for implementing the National Food and Nutrition Programme.

“obesity is mainly seen as an individual lifestyle problem”

Worryingly, the food industry seems to have a major influence on obesity policies in several countries in Europe and this might counteract any influence public health organisations have. The use of public-private partnerships in countries such as England, Germany and the Netherlands can pose a challenge to enacting and implementing effective obesity policies and public health organisations need to be wary of overt and covert interference from industry in public health policies.

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# CHILDHOOD OBESITY IN EUROPE AND POLICIES TO ADDRESS IT

By: [Cristina Hernández-Quevedo](#), [Charmaine Gauci](#) and [Bernd Rechel](#)

**Summary:** Childhood overweight and obesity in Europe have taken on dramatic dimensions, with one in three 11-year-olds in the WHO European Region estimated to be overweight or obese in 2014. Boys are at higher risk than girls and there is a pronounced social gradient, with higher rates among the most disadvantaged groups. A range of policies at national and international level have been instigated to address this challenge. This article describes some promising examples, as well as some of the obstacles that will need to be overcome.

**Keywords:** *Obesity, Overweight, Childhood, Intersectorality, Food Industry*

## Introduction

Increasing childhood obesity has been recognised as an important public health issue in Europe, as overweight or obese children are likely to become overweight or obese adults. They are more likely to suffer serious health and social consequences, including a higher risk of premature death and disability in adulthood. Moreover, higher obesity rates are usually found in children from lower socioeconomic groups and disadvantaged areas, illustrating the equity dimension of obesity.<sup>1</sup>

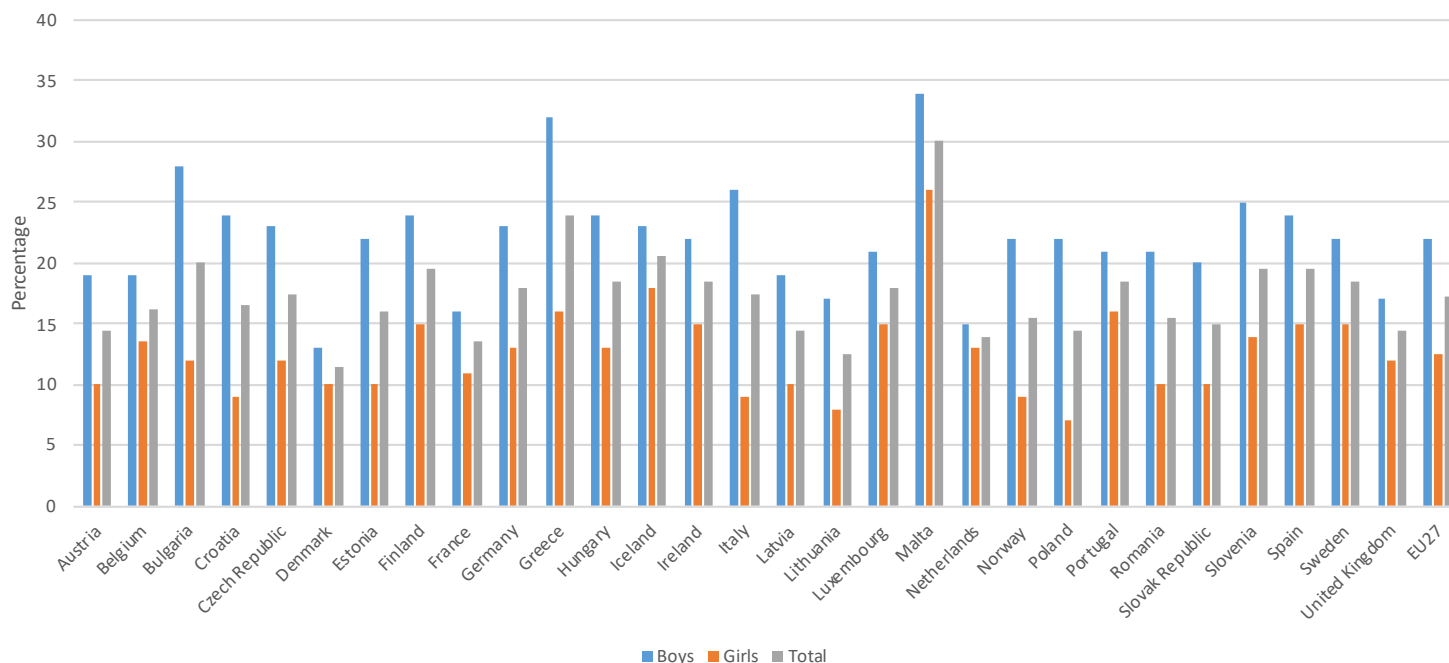
## Scope of the challenge

Data from the 2013/2014 cross-national survey on Health Behaviour in School-aged Children (HBSC) indicate worryingly high obesity rates in 15-year-old boys and girls in a number of countries (see Figure 1). They also show gender differences, with 15-year old boys more likely to be overweight or obese.<sup>2</sup> The latest data (2015–2017) from the WHO Childhood Obesity Surveillance Initiative

(COSI) confirm the gender gap in obesity, but also show that southern European countries have the highest rates of childhood obesity for six to nine year-olds in Europe. Cyprus, Greece, Italy, Malta, and Spain have the highest obesity rates for both boys (rates from 18% to 21%) and girls (from 14% to 19%), while rates are much lower in Denmark, France, Ireland, Latvia and Norway (from 5% to 9% for both boys and girls).<sup>3</sup>

Country-specific evidence included in Rechel et al. (2018)<sup>4</sup> suggests that childhood obesity is unequally distributed within countries. For example, the prevalence of childhood obesity is twice as high in the most deprived areas in England and Germany, compared to the least deprived areas. In Sweden, growing social inequalities are a key contributor to rising overweight and obesity rates, given that unhealthy nutrition and low levels of physical activity are more prevalent among lower educated groups. Even countries with low levels of obesity, such as France, have high social inequalities, with an

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**Figure 1: Self-reported overweight (including obesity) among 15-year-olds, boys and girls, 2013–2014**

Source: <sup>2</sup> Note: No data available for Cyprus.

obesity prevalence of 1.3% in children from the upper class and 5.8% in children from working class families.<sup>1</sup>

### International responses

A range of international and national responses have been developed to tackle childhood obesity. In 2013, the WHO World Health Assembly adopted the *Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020*, to tackle preventable chronic diseases, by stopping the increase in obesity (including among children) and diabetes. In September 2015, the countries of the WHO European Region adopted the *Physical Activity Strategy for the WHO European Region 2016–2025*, oriented towards both children and adults, with a specific focus on multisectoral collaboration.<sup>2</sup> The WHO's *European Food and Nutrition Action Plan 2015–2020* aims to reduce the burden of overweight, obesity and malnutrition and to halt the increase in overweight among children under five years of age.<sup>3</sup> Other international responses include the high-level Commission on Ending Childhood Obesity established by the former WHO Director-General to better inform a comprehensive response, meeting for the first time in 2014. Its latest policy recommendations to address childhood

obesity from the 2016 report include: promoting intake of healthy foods; promoting physical activity; preconception and pregnancy care; improving early childhood diet; and promoting physical activity and healthy nutrition for school-aged children.<sup>4</sup>

At the European Union (EU) level, a Plan of Action against childhood obesity was adopted in 2014 for the period 2014–2020, which covered eight focal areas, including family, environment and research. The Plan recognised the increase in obesity and overweight in adults, children and young people in the EU and aims to: demonstrate the shared commitment of EU member states to addressing childhood obesity; set out priority areas for action; develop a possible toolbox of measures for consideration; and propose ways of collectively keeping track of progress. The Action Plan recognises and respects member states' roles and freedom of action.<sup>5</sup>

### National responses

At the national level, many policies and programmes have been adopted in recent years in Europe, aiming to prevent obesity and improve its treatment and management. A review of nine European countries (England, France, Germany,

Italy, Poland, the Republic of Moldova, Slovenia, Sweden, the Netherlands)<sup>6</sup> found that almost all of them had adopted national strategies or programmes in this area. This also applies to Malta, which had placed childhood obesity as a priority area during its European Presidency in the first half of 2017.<sup>7</sup>

In the Republic of Moldova, for example, the National Health Policy (2007–2021) was the first policy document that addressed obesity as one of the main health determinants and called for intersectoral, whole-of-government and whole-of-society actions to prevent it. In 2014, the Moldovan Government endorsed the first National Food and Nutrition Programme for 2014–2020 and the Action Plan for 2014–2016. One specific objective of this programme is to halt the increase in obesity prevalence among children and adults.

In England, an action plan on childhood obesity was published in 2016, but largely shied away from regulatory measures. However, in recognition of the fact that teenagers in England are the biggest consumers of sugar-sweetened drinks in Europe, an introduction of a tax on sugary drinks was announced in March 2016 and came into force in April 2018. The levy is applied to manufacturers, with

### Box 1: Tackling children obesity in Malta

The increasing prevalence of overweight and obesity especially in children is a major public health issue in Malta. It has been estimated that 40% of school-aged children in Malta are overweight or obese. Various actions have been put in place to tackle this problem.

#### A. Use of legislative instruments for noncommunicable diseases

Considering the fact that children spend a lot of time in school, the school setting was a particular focus. In 2016, the government of Malta enacted the “The Healthy Lifestyle Promotion and Care of Non-Communicable Diseases Act” which aimed to establish and ensure an inter-ministerial lifecourse approach favouring physical activity and healthy balanced diets to achieve healthy lifestyles and reduce noncommunicable diseases in all age groups.<sup>8</sup> An intersectoral Advisory Council was set up that recommended various measures. One of the initiatives the Advisory Council developed was outlining a legislative tool for schools. A situation analysis was carried out on school environments, showing that there was a need for strengthening the school environment to help the whole school community to adopt healthier patterns of living by encouraging consumption of healthy foods and limiting the availability of products high in salt, sugar and fats.

In August 2018, the Maltese government issued subsidiary legislation to regulate the food being sold and provided by schools, implement programmes for healthy eating, ban advertising or sponsorship of unhealthy foods, and ensure provision of drinking water in schools. The Advisory Council developed criteria for healthy foods which were based on the WHO nutrient profiling model. Random inspections are carried out by specifically trained environmental health practitioners.

#### B. Public Procurement of Food for Health – technical report on the school setting

The Maltese Presidency of the Council of the EU selected childhood obesity as one of its priority areas. One of the gaps identified across EU member states was in outlining food procurement tenders for schools that promoted healthy eating. The major obstacle was in the translation of school food standards into adequate procurement contract language. To ensure the smooth implementation of public procurement of healthy food, it is important to set clear specifications of the foods and food services to be procured.

A technical report on public procurement guidelines for healthy food within school settings was developed with support from the Joint Research Centre and experts from EU member states. It is intended as a practical tool for those who purchase food and food-related services for schools at national, regional or local level, as well as for health and nutrition awareness and capacity building. The report details a range of options and considerations that EU member states may wish to use and adapt for their specific context. Adaptation to the national and local context through consultations with all relevant stakeholders ensures that the legal, cultural and economic context are taken into consideration.<sup>9</sup>

drinks with more than 8g per 100ml facing a tax rate equivalent to 24p (€0.28) per litre while those containing 5–8g of sugar per 100ml, a slightly lower rate of tax, of 18p (€0.21) per litre. Furthermore, the United Kingdom was one of the first countries to restrict marketing to children

via legislation and to introduce a front-of-pack traffic light label, although this has remained a voluntary scheme.

In Poland, a 2016 Regulation by the Minister of Health addressed groups of food intended for sale to children and adolescents in the education system. In addition, the School Programme

Strategy 2017/18–2022/23 has, as one of its goals, the promotion of a healthy, balanced diet among children and parents. In particular, it aims to change the eating habits of children by increasing the share of fruit and vegetables and the intake of milk.

“growing social inequalities are a key contributor to rising overweight and obesity rates

#### A multisectoral approach to tackle childhood obesity

In some countries, reducing childhood obesity is a task shared by the Ministry of Health with the Ministry of Finance (responsible for taxes for food high in saturated fat and sugary soft drinks), the Ministry of Education (for school curricula, healthy nutrition education and physical activity), the Ministry of Agriculture and Food Industry (for free school fruit and vegetable schemes and sustainable healthy food supplies), and the sports sector, among others. For example, in England, government departments other than health have key roles to play in obesity policy, including the Department for Education, the Department of Culture, Media and Sport (physical activity and control of advertising/marketing standards), the Department for Communities and Local Government, and the Department for Environment, Food and Rural Affairs. This is not the case in other countries, such as the Republic of Moldova, where a lack of intersectoral collaboration has been identified.

#### The media

In some countries, television, radio, telecommunications and wireless communication services are regulated, setting standards for advertising to protect children from the overconsumption of foods high in fat, salt and sugar. For



example, in the United Kingdom, the national Office of Communications (Ofcom) is the independent regulator of television, radio, telecommunications and wireless communications services and sets standards for television advertising. Its regulatory objectives include the protection of children under the age of 16 from the overconsumption of foods high in fat, salt and sugar. Since 2006, Ofcom does not allow TV advertisements for such foods to be shown in or around programmes specifically made for children (which includes preschool children) or in or around programmes of particular appeal to children under 16. The United Kingdom's statutory ban on television advertising of foods high in fat, sugar and salt during children's programming was a world first. It broke new ground for imposing more stringent conditions on the food and drink industries.

“  
imposing more  
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### The role of the food industry

In some of the countries of the WHO European Region, the food industry has considerable influence, both formal and informal, into policies aimed to tackle childhood obesity. In the Republic of Moldova, for example, the food industry exerts influence through the Ministry of Economy and the Ministry of Agriculture and Food Industry. It attempted to block legislation banning the sale of unhealthy foods within and around schools and intervenes every time new initiatives emerge that may affect its commercial interests. In Poland, the food industry is one of the most influential lobby groups, with well-organised representation and significant financial resources. Poland is also one of the participating countries in the Choices Programme, an initiative introduced in the Netherlands in 2006

in response to WHO's call for the food industry to take an active voluntary role in tackling obesity. The programme has since been expanded to the Czech Republic and Poland.<sup>10</sup>

In the United Kingdom, as mentioned above, *Childhood obesity: a plan for action*, was adopted in August 2016, covering the period 2016–2026. Its key anticipated actions include the introduction of a levy on the soft drinks industry and the encouragement of the foods and drinks industry to voluntarily reduce the sugar content of their products. The overall emphasis on voluntary action and the failure to include further restrictions to advertising aimed at children in the action plan, however, were criticised by public health experts and attributed to sustained lobbying by industry against regulatory measures.

### Future challenges

Tackling childhood obesity is a very complex issue. The most progress has been made on topics such as issuing nutritional guidance, encouraging breastfeeding, banning vending machines and encouraging physical activity in schools. EU member states are waiting for the revision of the audio-visual media services directive (AMSD), which also regulates advertising. Advertising, not only on TV, but also through tablets and mobile phones, has a significant impact on children.

What is worrying is that, despite increases in prevalence, there are still countries in Europe in which childhood obesity has not entered public health debates. Among the many areas of potential action, in some countries there is a lack of resources for the implementation of publicly financed education programmes for children and young people dedicated to obesity. Constructively engaging with the food industry, including through regulation, taxation and market mechanisms, is another challenge.

The case of Malta highlights some of the areas where progress can be made through multiple approaches. The development of healthy food procurement guidelines for schools can be used to initiate change across EU member states in schools

and which can be extended to other sectors. Progressive and targeted public procurement of healthy food can reward companies that provide nutritionally balanced meals and food products, prompting innovation, food reformulation and social responsibility to achieve better diets and positively impact public health.

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# OBESITY IN ENGLAND: A BIG ISSUE REQUIRING BOLD SOLUTIONS

By: [May CI van Schalkwyk](#) and [John Middleton](#)

**Summary:** Since 1998, when England recognised obesity as a national priority, a range of policies and strategies have been developed with concomitant evolution in the role of public health organisations. However, progress in addressing obesity – which continues to be a leading cause of ill-health and inequalities – has been minimal, hindered by siloed working, focused on individual responsibility, and lacking in much-needed systems thinking and regulation. Until recently, there has been political reluctance to address commercial vested interests in the food and related sectors, who profit from the obesity epidemic. A step change is needed to achieve meaningful impact.

**Keywords:** *Obesity, Overweight, Inequalities, Public Health*

## Scale of the problem

Tackling the obesity epidemic is one of the greatest public health challenges of the 21st century, affecting populations globally, irrespective of level of income or development. Nations around the world continue to struggle to address high obesity rates, and the consequent detrimental health impacts, in children and adults of all ages. The picture in England is no exception. The Health Survey for England (2016) estimated that 26% of adults were obese, almost double the level recorded in 1993 (15%).<sup>1</sup> According to the National Childhood Measurement Programme 2016–2017, approximately 10% of children in their reception year (aged 5–6 years) and 20% in year 6 (aged 10–11 years), are obese.<sup>2</sup> Between 2015 and 2017, hospital admissions recorded as directly attributable to obesity increased by 8%, totalling 10,705 (with 72% being female).<sup>3</sup>

In 2007, the then Government’s Foresight report, predicted that greater than half of the UK adult population could be obese by 2050, with a concomitant doubling of the cost to the health service. Wider societal and productivity costs were estimated to reach almost £50 billion per year (at 2007 prices, about €55 billion).<sup>4</sup> Furthermore, obesity remains an important driver, and result, of social and health inequities.

Obesity has been recognised as a national priority since the late 1990’s. Public interest, as evidenced by media coverage, has accelerated since then, and it remains a topical agenda. Recent media coverage predominantly frames obesity in terms of “self-control” with an emphasis on personal responsibility and medical interventions.<sup>5</sup> The Foresight report identified parental obesity as the most significant predictor of childhood obesity and promoted the “calories in – calories out” model as a means of conceptualising

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the problem.<sup>2</sup> This framing has been favourable to industries who produce high-sugar products, allowing them to assert that there are “no bad foods, only bad diets”. There has been a renewed interest in the theory that sugar plays a key role in the causation of obesity. Sugars, which are not as high calorie as fats, contribute to obesity substantially through their impact on insulin sensitivity.<sup>3</sup> A report by Public Health England (PHE) on the evidence for action further encouraged the view that sugar consumption was a key component of obesity and recommended control measures and further research of sugar’s role in obesity and diabetes.<sup>4</sup>

## Policies and programmes

*The Health of the Nation*, England’s first health improvement strategy, was launched in 1992. This report made very little mention of obesity, but by 1998, when the Public Health Green Paper, *Saving Lives: Our Healthier Nation* was released, obesity represented a new priority. Importantly this paper outlined the need to adopt a life course approach to address such factors as smoking, poor nutrition, obesity and physical inactivity, and fundamentally recognised inequalities in the distribution of adverse behaviours and that action directed at the underlying social, economic and environmental conditions was required. While this link among obesity, health variables and socioeconomic inequality was echoed in the Wanless Report (2002), the publication of the government *White Paper Choosing health: making healthy choices easier* (2004) would see a focus on individual behaviour change and the role of primary care trusts in reducing inequalities. The White Paper also set out a Public Service Agreement (PSA) on child obesity incorporating measures that aimed to curb the year-on-year increase in obesity rates among 11-year-olds by 2010. It also introduced “health trainers” aimed at supporting individuals, particularly those living in poorer communities with “lifestyle problems”, an approach drawn from the “personal trainer” model within the private sector.

As mentioned, the Foresight report raised obesity even further up the national agenda and detailed the complexities of factors driving obesity, including

obesogenic environments and sedentary lifestyles, which in turn prompted the 2008 Department of Health initiative on Healthy Towns. This focused on healthy town planning that promoted active travel and accessible physical activity. Additionally, broadcasting restrictions were introduced in 2007, limiting exposure of children to television advertising of foods high in fat, saturated fat, salt and sugar. In 2008, an ambitious cross-government strategy, which set out to ensure that everyone was able to achieve and maintain a healthy weight, was adopted. The UK’s proposed statutory ban on television advertising of foods high in fats, sugar and salt during children’s programming represents a world first, setting a precedent for imposing more stringent conditions on the food and drink industries.<sup>5</sup>

The formation of the coalition government (between 2010 and 2015) saw the dissipation of any central government pressure to control irresponsible fast food advertising. Radical organisational changes, including the transfer of public health departments to local authorities from 2013, exacerbated uncertainties around investment in obesity programmes and it became difficult to plan and develop new services, or advocate for national policy changes. Furthermore, while certain public health services were mandated to be provided or commissioned by the local authority under the Health and Social Care Act 2012, obesity prevention and weight management were omitted.

Alongside the reforms moving towards the Act, the *Public Health Responsibility Deal* was introduced in 2011. The Responsibility Deal was intended to be a public-private partnership between government, industry and public health organisations to co-develop interventions by industry to demonstrate their corporate social responsibility and promote health. Multiple public health lobby groups refused to take part, and many withdrew subsequently, as it became apparent that government commitments to legislate on plain packaging for cigarettes, and a minimum unit price for alcohol, were shelved. Adoption of meaningful interventions by government, such as effective legislation, taxation and regulation was successfully prevented by industry lobbying conducted behind closed

doors. Subsequent evaluations have found the *Public Health Responsibility Deal* as being ineffective and flawed.<sup>7–9</sup>

*Childhood obesity: a plan for action*, an action plan for tackling childhood obesity, was adopted in August 2016, spanning 2016–2026. Its overarching emphasis on voluntary action and omission of further restrictions to advertising aimed at children were met with widespread criticism by the public health community and was attributed to continued industry lobbying against regulation. Although PHE had endorsed a sugar tax and reductions in the sugar content of foods (included in the plan), it had also advocated for more effective measures such as banning price-cutting promotions of junk food in supermarkets, banning the promotion of unhealthy foods to children in restaurants, cafes and takeaways, and further restricting advertising of unhealthy food to children on TV, social media and the Internet. As part of this strategy, a Soft Drinks Industry Levy (SDIL), or “sugar tax”, came into effect in the UK in April 2018, aiming to curb sugar consumption by influencing manufacturers to reformulate brands high in sugar and avoid paying the levy. This resulted in 50% of soft drink products having their sugar content reduced even prior to the levy’s implementation.

In her 2018 annual report, England’s Chief Medical Officer (CMO), called upon the UK Government to extend the levy to other food products that are high in trans fats, salt and sugar to address noncommunicable diseases. The National Health Service (NHS) forward view, like the NHS five year forward view before it, similarly focuses on prevention. However, this latest strategy frames prevention within the context of informing and supporting individual choice and responsibility to adopt healthy lifestyles aided by technological solutions. This would seem at odds with the current stance taken by the CMO who stated in late 2018:

- “We have a system at the moment where people are benefiting from selling unhealthy foods and then not paying for the harm that that’s doing ... to us as a society and the NHS.”



- “We have an unbalanced societal environment. It’s not easy to make healthy choices. We’ve got to make it easier.”<sup>10</sup>

### Role of public health organisations

Setting of public health policy in England, including that pertaining to obesity, is the responsibility of the Secretary of State for Health and the Department of Health and Social Care. PHE is the national public health body charged with policy formulation and implementation, acting as an advisory body to the Department of Health and Social Care on policy direction, as well as providing advice on policy and strategy implementation to local authorities, the NHS and others. PHE develops, translates and assembles evidence, and oversees surveillance data for England on all aspects of obesity. Informed by consultation with Directors of Public Health on what the priorities should be for PHE to tackle obesity in local communities, PHE have previously developed an obesity workplan and published advice on early approaches to tackling obesity.

On the ground, local authorities are afforded the freedom to implement local policies. Local government can strive to address obesity and associated issues through its management of public health services, environmental licensing, consumer protection and social care, as well as through forming partnerships with health and community organisations. The transfer of public health responsibility to local authorities since 2013 has meant that they provide or commission services such as weight management and local preventive campaigns and services. While public health agencies are vital to their local communities, their ability to act and be accepted in local partnerships is variable and precarious, depending on how their host councils view their relevance and importance, and on other competing local priorities.

PHE monitors obesity prevalence and other relevant lifestyle factors, including dietary habits, through the National Diet and Nutrition Survey. The National Child Measurement Programme (NCMP)<sup>11</sup> measures the height and weight of children in school reception year (aged 4–5 years)

and year 6 (aged 10–11 years) documenting overweight and obesity levels in primary school aged children. The data are used to calculate a body mass index (BMI) centile. These data can be used to support local public health initiatives and inform the local planning and delivery of services for children. Data from the NCMP 2006/2007 to 2014/2015 are now available online as a child obesity data tool for local authorities. This tool also includes inequalities data and information on the density of fast food outlets. These data were previously collected and analysed by the National Obesity Observatory. The Observatory is now part of PHE’s knowledge and intelligence function, which assimilates evidence into practical analytical and evidential tools for the local system, including the dataset for local authorities known as Fingertips. Additionally, Public Health Outcomes Framework profiles are available for the nine regions of England. These collate local authority indicators for physical activity, fruit consumption, breast-feeding rates, life expectancy and diet-related cancers.

The English public health community plays an important role in researching and voicing the co-benefits of adopting an upstream and broader systems approach to obesity. Cross-departmental action is arguably pivotal to tackling leading drivers of ill-health and health inequities, such as obesogenic environments and systems that concomitantly contribute to other pressing issues, such as climate change and air pollution. Public health professionals and institutions play a key role in advocating for interventions that maximise the health co-benefits and in helping to bridge institutional silos.

### Conclusion

Obesity remains a major public health issue in England and indeed the world. While it has received much public and political attention, arguably little has been achieved in having a meaningful impact on an issue that continues to drive ill-health and inequalities, simultaneously placing a substantial burden on the NHS and compromising economic productivity. Despite the plethora of policies and strategies that have been produced since obesity gained recognition as a national

health priority in the 1990’s, none have been translated into the real-world changes that are ultimately needed. Industry continues to benefit from close relationships with government, allowing it to influence policy content and implementation which, in combination with ineffective voluntary targets, like those set out in the Responsibility Deal, hinders meaningful progress. This has been accompanied by the adoption of a policy stance, by successive governments, predominantly centred on personal responsibility and the blaming of individuals for their poor choices.

The precariousness of the current political environment in the UK and the single focus on Brexit, continue to leave little space for debate and focus on other issues, particularly ones as complex and heated as obesity. However, it is exactly for these reasons that we cannot be complacent. Maintaining momentum, and public and political interest are paramount to ensure any gains are not lost and that real change is delivered to the English population.

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# OBESITY – AN INCREASING PUBLIC HEALTH PROBLEM IN GERMANY

By: Klaus D. Plümer

**Summary:** Obesity is a growing public health problem in Germany. The share of adults with obesity almost doubled between 1990 and 2015, and lies above the OECD average. A social gradient in obesity prevalence exists, with overweight and obesity occurring more often in people with a low socioeconomic status. In 2008, the nationwide Initiative to Promote Healthy Diets and Physical Activity (IN FORM) was set up but did not reverse the trend. The 2015 *Act to Strengthen Health Promotion and Prevention* addresses explicitly living-environment intervention measures in relevant settings as a promising approach.

**Keywords:** Obesity, Overweight, INFORM, Public Health Service, Setting Approach, Germany

## Scale of the problem

Obesity is an ongoing issue on the health agenda in Germany, with cyclical debates about healthy and unhealthy diets in the media. Diets are a domain of dietitians, nutritionists and sports scientists in conjunction with general practitioners and health scientists yet the recommendations given can be of dubious value and have very little effect. Several intervention measures over recent years have not been able to reverse the steadily increasing trend of overweight and obesity.

According to OECD data, the share of adults with obesity in Germany almost doubled between 1990 and 2015, from 12% to 23.6%, and was – for the first time –

in 2015 well above the OECD average of 19.5%, ranking in the top ten of obese countries.<sup>1</sup>

The third health report of the Robert Koch Institute ‘Health in Germany’ (2015) summarised the most important results on overweight (defined as BMI  $\geq 25$  kg/m<sup>2</sup>) and obesity (defined as BMI  $\geq 30$  kg/m<sup>2</sup>):

- Almost 25% of adults and about 6% of children and adolescents are severely overweight (obese).
- Especially among young men, the proportion of obese adults has risen significantly in the last 15 years.

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- In adolescents, obesity prevalence has increased since 2006, while the prevalence of overweight has remained the same.
- The lower the socioeconomic status, the more often overweight and obesity occur.

In Germany, 53% of women and 67% of men are overweight, while 24% of women and 23% of men are considered obese. The prevalence of obesity in the adult population has remained stable at a high level over the last decade, but over the same period the incidence of obesity has increased, especially among young men.<sup>8</sup>

It has been estimated that the economic costs of obesity in Germany (including treatment, medications, surgery, rehabilitation and sick pay) amount to up to €27 billion per year.<sup>9</sup> Most of these costs are borne by the Statutory Health Insurance funds.

### Policies and programmes

Recognising the importance of obesity as a health issue, in 2008 the German government, led by the Federal Ministry of Food, Agriculture and Consumer Protection and the Federal Ministry of Health, set up the intersectoral National Initiative to Promote Healthy Diets and Physical Activity, called IN FORM.<sup>4</sup> This initiative aims to achieve sustainable improvements in healthy diets and physical activity by 2020. It frames obesity as a public health problem and contains five main areas for action:

1. for the Federal government, the states and communes to ‘set an example’ (such as through Health Impact Assessments, in the allocation of public funds, as employers, and as funding bodies of community facilities);
2. the provision of information on diet, physical activity and health;
3. the promotion of physical activity in daily life;
4. improving the quality of catering away-from-home; and
5. providing a fresh impetus for research.

A range of other federal policies have an impact on overweight and obesity, sometimes in line with a Health in All Policies (HiAP) approach. Some of the most important are the National Cycling Plan 2020,<sup>5</sup> which promotes cycling, walking and the use of public transport, and two programmes of the Federal Centre for Health Education (FCHE): *Gut Drauf* (Feeling Well), which aims to improve the health of children and adolescents aged 12 to 18 years, and *Tutmirgut* (Good For Me), aimed at children aged 5 to 11 years.

“most of the programmes lacked proper evaluation”

Many programmes that tackle obesity have been set up at the local level, and mostly focus on children and adolescents. In 2007, there were 708 programmes for overweight or obese children and adolescents in Germany, reaching approximately 44 000 persons. However, their quality and the financial resources devoted to them differed greatly.<sup>6</sup> Calculations suggest that the programmes reached 33–55% of overweight or obese children at the time, indicating major gaps in coverage. An assessment concluded that most of the programmes lacked proper evaluation, had only short-term effects and that the actual impact on BMI was low.<sup>7</sup>

Within the context of IN FORM, a toolbox consisting of seven workbooks has been developed by the Federal Centre for Health Education and the State Association Health Berlin-Brandenburg for practitioners in the field, entitled *Take Action for Health. Work tools for prevention and health promotion in the neighbourhood*. The seven workbooks provide background information, practical examples and checklists for daily activities. As an aid for projects on a smaller budget, IN FORM has also developed three online guidelines for ‘Quality Assurance’, ‘Communication’ and ‘Evaluation’.<sup>8</sup>

### Role of public health organisations

Public health services (*Öffentlicher Gesundheitsdienst, ÖGD*) in Germany have played no major role in putting obesity on the political agenda. They mainly deal with obesity from three specific perspectives: in child and adolescent health services; as case-based nutrition counselling; and when hiring staff in the public service, particularly regarding permanent employment.

A *National Action Plan against Obesity* was presented to the Federal Ministry of Health (BMG) and the Federal Ministry of Food, Agriculture and Consumer Protection (BMELV) in March 2007, following an initiative by the German Obesity Society.<sup>9</sup> The corresponding *National Action Plan for the Prevention of Poor Dietary Habits, Lack of Physical Activity, Overweight and Related Diseases* in 2013 makes explicit reference to overweight in its title and also discusses obesity.

IN FORM shies away from regulatory measures, and instead relies on informing consumers and freedom of choice. The underlying expectation is that various stakeholders, including individuals and industry, will opt for healthier nutrition and more active lifestyles, if they are well informed about these.<sup>10</sup> A traffic-light food coding system has been discussed, but not adopted. There has also been no ban on the sale of unhealthy foods in vending machines in schools.

As is typical for Germany the ‘setting approach’ has been undertaken, which means using an interplay of behavioural and living environment prevention measures. Beyond only promoting healthy behaviours among participants, the living environment should be designed in such a way as to promote a healthy life. Hence, the core strategy and measures of IN FORM start where people live, work, learn or play.

Since 2008, the two leading ministries have funded over 200 projects with a total of €77 million.<sup>11</sup> The collaborative



stakeholder strategy was already established with the National Cooperation Network 'Equity in Health' in 2003.

## Conclusion

Obesity is still an underestimated public health problem in Germany; the policy response has so far been insufficient and obesity levels continue to increase dramatically. However, along with Canada and the United States, Germany is one of the countries that has an explicit state-level obesity policy, aiming to encourage healthy diets and physical activity.

Germany has an explicit state-level obesity policy

The Robert Koch Institute has launched the German Health Interview and Examination Survey for Children and Adolescents (KiGGS-Study) as part of its health monitoring programme, with a baseline study in 2003–06 and a follow-up study in 2014–17 (KiGGS Wave 2). The results of the second study were published in March 2018. They pointed to a strong social gradient, with the prevalence of overweight (including obesity) reaching 27.0% and 24.2% in girls and boys respectively aged 3 to 17 years with low socioeconomic status compared to 6.5% in girls and 8.9% in boys with high socioeconomic status.<sup>2</sup>

IN FORM, as the main obesity-related policy and programme, has had some encouraging impacts in terms of attempts to enhance the quality of local interventions and health promotion activities. Toolboxes and instruments for practitioners in the field have been developed, and databases of activities and models of good practice have been set up, providing an overview of what is going on in the country. However, a first interim report, originally planned to be published in 2011 was only released in December 2017.

The report makes for interesting reading, especially since the Platform on Diet and Physical Activity (PEB) was heavily criticised in 2014 by some of its public health members on Frontal21, a feature of the German TV channel ZDF.<sup>11</sup> In view of the dominant approach of IN FORM of focusing on individual behaviours in addressing obesity and neglecting social and political determinants, most notably the roles of the food industry and agriculture, outcome measures on obesity levels are unlikely to be encouraging.

During the 'Green Week' in Berlin, farmers and citizens protested against industrial agriculture. Tens of thousands of participants, interested in a more conscious agricultural policy, gathered around the Brandenburg Gate under the motto 'We are fed up!' campaigning for climate-friendly agriculture and healthy food. The organisers reported the number of demonstrators at 35,000.

With the *Act to Strengthen Health Promotion and Prevention* the practiced core strategy of IN FORM, which starts where people live, work, learn or play, has become the guiding concept that explicitly addresses living-environment intervention measures in relevant settings as a promising approach. This is based on a target-oriented cooperation of stakeholders in the field of action at a local and regional level.

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# TACKLING THE OBESITY CHALLENGE IN ITALY

By: **Elena Azzolini** and **Walter Ricciardi**

**Summary:** Overweight and obesity represent a priority public health issue in Italy. Although the adult obesity rate is one of the lowest in OECD countries, rates of child obesity are among the highest in Europe. Several policies and programmes involving multiple strategies have been implemented in the last decade to tackle obesity. The responsibility for identifying health needs, formulating health care policy and for policy implementation is shared between the central government and the regions. To reverse the obesity epidemic among the Italian population several weaknesses need to be addressed, including the persistence of strong regional disparities in health status.

**Keywords:** *Obesity, Overweight, Public Health Policy, Public Health Organisations, Italy*

## Scale of the problem

Notwithstanding pasta, lasagne, pizza or calorie-laden gelato, Italy has long been recognised as having one of the healthiest populations in the world. But can all Italians expect to live a long and healthy life? Obesity is having a serious impact on the physical health and wellbeing of the Italian population and it would not be a surprise if in a few years Italian life expectancy began to decline. It seems almost a paradox considering the benefits of the Mediterranean diet, but countries bordering the Mediterranean Sea have the highest rates of childhood obesity in Europe. Data from the Childhood Obesity Surveillance Initiative (2015–17) of the World Health Organization show that Italy is ranked first in Europe for child obesity, with 21% of children obese or overweight, above the prevalence recorded in Greece and Spain.<sup>1</sup> Some 42% of boys are obese or overweight, while among girls the figure drops to 38%. The good news

is that, despite the high rate of obesity, the proportion of obese and overweight children in Italy has decreased by 13% in less than ten years, according to the OKkio Health Surveillance System, promoted by the Ministry of Health and coordinated by the Italian National Institute of Health.<sup>2</sup>

As for adults, in Italy more than a third of the adult population (35.5%) is overweight, while just over one in ten people are obese (10.4%); overall, 45.9% of people aged 18 years and over carry excess weight.<sup>3</sup>

The differences by territory are considerable and, in the interregional comparison, the North-South gradient is pronounced: the southern regions show the highest prevalence of obesity and overweight for people aged 18 years and over (Abruzzo 14.2%, Puglia 13.1% and Molise 12.4%), (Basilicata 40.6%, Calabria 40.4% and

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Molise 39.8%), compared to Northern regions, which show the lowest prevalence for obesity (Bolzano 8.1%, Trento 8.3% and Lazio 8.6%) and overweight (Bolzano 30.7%, Trento 31.6% and Valle d'Aosta 31.7%). The percentage of the population with excess weight grows with increasing age and also differs by gender (see Table 1). The highest percentage of people with excess weight is for those aged 65–74 years.<sup>8</sup>

However, despite being considered an important issue, with numerous obesity-related organisations and initiatives, the true extent of the problem is often not properly considered and accurate knowledge of the national obesity rate is still very low among policymakers.<sup>9</sup>

Efforts to tackle child obesity are seen as more successful than efforts to combat adult-obesity, but a high percentage of policymakers are not sure about the impact of policies. This uncertainty is particularly alarming in a country where, although adult obesity is one of the lowest in OECD countries,<sup>8</sup> the rates of child obesity are among the highest in Europe.

“rates of child obesity are among the highest in Europe”

### Policies and programmes

In the last decade, several policies and programmes involving multiple strategies have been implemented to tackle obesity in Italy. One of the greatest achievements is the presence of a National Prevention Plan, as well as Regional Prevention Plans, which increasingly concentrate on the prevention of noncommunicable diseases (NCDs) and the promotion of healthy lifestyles. All Italian regions have adopted at least one intervention specifically aimed at controlling obesity, albeit with great diversity between regions.<sup>8</sup>

**Table 1: Excess weight by age and gender**

Population group	Overweight	Obese
18–24 years	14.8%	2.6%
65–74 years	45.6%	15.5%
All Men	44.5%	11.1%
All Women	27.2%	9.8%
Men 65–74 years	52.9%	16.0%
Women 65–74 years	39.1%	15.1%

Source: <sup>8</sup>

### Box 1: Italian monitoring systems for public health

- “Keep an Eye on Health” (*OKkio alla Salute*), coordinated by the National Institute of Health, in collaboration with the Ministry of Education, University and Research;
- the HBSC (Health Behaviour in School-aged Children) study promoted by WHO;
- the Health Progress in Italian Local Authorities system (*Sorveglianza PASSI – Progressi delle Aziende Sanitarie per la Salute in Italia*), which provides information about risk factors (including obesity), people’s perceptions of health, and the delivery of health services to people aged 18 to 69;
- the “PASSI Silver” system (*PASSI d’Argento*): a surveillance system on the health and quality of life of people over 64;
- the “Heart” project (*Progetto CUORE*): a large prospective cohort follow-up study of cardiovascular risk factors and high-risk conditions, such as obesity, in the Italian population through periodic standardised, rigorous and accurate physical examinations.

An important milestone in the recent history of Italian public health has been achieved with the national programme “Gaining Health” (*Guadagnare Salute*), with the main objective to prevent and change unhealthy behaviours that promote increases in degenerative and chronic diseases.

At the European level, “Gaining Health” is fully part of the strategy for the prevention and control of chronic diseases promoted by the WHO in 2006.<sup>8</sup> The programme is promoted by the National Centre for Disease Prevention and Control (*CCM*), whose main target is active prevention through the promotion of healthy lifestyles and screening. Since 2004, concrete projects have been undertaken towards health prevention in many areas relevant to obesity including: environment and

climate, chronic diseases, promotion of healthy lifestyles, support for vulnerable people, and information flows.

National monitoring systems for adults and children have also been established to collect evidence on the spread of unhealthy lifestyles and diseases (see Box 1). However, this progress threatens to be undermined by recent budget cuts to prevention, which have left fewer resources that can be allocated to tackling obesity.

### Role of public health organisations

In Italy, the Ministry of Health is in charge of identifying health problems and priorities that require government attention.

The National Centre for Disease Prevention and Control (CCM) is the public health agency with a clear mandate to detect (and prevent) major health problems and potential threats to public health, including obesity. It operates as a coordinating body between central and regional health institutions for surveillance, prevention and effective emergency response activities. Negotiations between the state and regional governments result in the ratification of National Prevention Plans, the most recent of which covers the period 2014–18.

Responsibility for formulating health care policy and for policy implementation is shared between the central government and the regions. Within Italy's quasi-federal arrangements, the Ministry of Health fulfils the function of setting the main policy directions, while the regions are responsible for the formulation of their respective regional policies and for the organisation of regional public health services and effective local interventions.

Other local and national bodies responsible for obesity are the Food and Nutrition Health Services (SIAN); the National Institute for Food and Nutrition Research (INRAN), which is responsible for national guidelines on healthy diets; the National Platform on Diet, Physical Activity and Tobacco, established and chaired by the Ministry of Health, which is a technical committee tasked with formulating policies and implementing actions, in line with the "Gaining Health" programme, providing the arena for defining cross-sectorial strategies and for developing synergies among all stakeholders according to the principle of Health in All Policies.

Formal mechanisms for collaborations are established with the National Institute of Health (ISS), the Italian National Agency for Regional Healthcare Services (AGENAS), the National Medicines Agency (AIFA), the Ministry of Education, University and Research, European Network for the Promotion of Health-enhancing Physical Activity (HEPA), the Department of Youth Affairs, the Ministry of Agriculture, the food industry, trade and food chain associations, and National Committee for Dietetics and Nutrition.

Other key actors involved in decision making are health professionals who provide primary care services and more generally, each region's network of Local Health Authorities (*Aziende Sanitarie Locali*, ASLs) and hospital trusts (*Aziende Ospedaliere*, AOs) to which executive functions are largely delegated.

ASLs are also required to promote contact between social and health services and schools, businesses, the youth entertainment sector, sports associations, the voluntary sector and patients' associations.

“persistence of strong regional disparities in health status”

With regard to funding, there is no specific budget allocation to address obesity. The Ministry of Health and the CCM decide on an annual programme of prevention-related activities to be funded. Several million Euros per year have been assigned to reinforce organisational and professional resources involved in the implementation of activities coordinated or financed by the CCM, including planning, monitoring and evaluating Regional Prevention Plans.

Monitoring and evaluation of policies addressing obesity are directly undertaken by Regional Health Departments. Routine monitoring is also provided by the Ministry of Health's annual monitoring of the delivery of the health benefits package, known as the Essential Levels of Assistance (*Livelli Essenziali di Assistenza*, LEA) across the country. Obesity is included as part of the descriptive lifestyle indicators and as a risk factor for NCDs. The State-Regions Conference has approved the issuing of an improved instrument for the evaluation of Regional Prevention Plans for 2020–25, whose priority lines will be a proactive action aimed at tackling health needs, including the reduction of the main social

and geographical inequalities observed in the country, and the definition of homogeneous, measurable and robust indicators linked to monitoring of LEA.

Overweight and obesity prevalence are also monitored by the Italian National Institute of Health and the National Institute of Statistics (ISTAT) which produces the multipurpose Aspects of Daily Life Survey, and collaborates with the National Observatory on Health Status in the Italian Regions (*Osservatorio Nazionale sulla Salute nelle Regioni Italiane*). This body collects comparable regional data from different sources and monitors population health in Italy's regions. These national surveillance systems provide useful information for planning preventive and protective measures for population health.

## Conclusion

Obesity represents an important public health issue in Italy. Although the adult obesity rate is one of the lowest in Europe, rates of childhood obesity are among the highest.

In the last decade, Italy has adopted and implemented several policies and programmes to tackle obesity. These developments have been underpinned by policymakers' strong advocacy for more public health-oriented policies and practices at the national and regional level and have given rise to well-coordinated national surveillance systems.

However, several weaknesses need to be addressed, including the persistence of strong regional disparities in health status and in the quality of public health services, coupled with budget cuts to prevention funding over the last few years, which have left fewer resources that can be allocated to tackling obesity. Furthermore, health information and monitoring systems are not always fully capable of translating findings to aid decision makers and government mechanisms to support high quality research are lacking.

An urgent stepping-up needs to be taken to raise awareness among policymakers and the population of the extent of the challenge posed by the consequences of obesity, as well as the benefits associated



with healthy diets and active lifestyles. Future developments are likely to focus on increasing the number and improving the governance of inter-sectoral plans/actions on obesity, putting in place a broad range of communication policies, as suggested by Goryakin et al.<sup>8</sup> and strengthening intensive collaboration with the food supply chain. Therefore, a long-term evidence-based commitment is required to tackle one of the greatest health challenges of this century.

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# ADDRESSING OBESITY IN THE REPUBLIC OF MOLDOVA

By: Galina Obreja and Angela Ciobanu

**Summary:** Overweight and obesity are among the main risk factors associated with the rising prevalence of noncommunicable diseases (NCDs) in the Republic of Moldova. Moldova's government has recognised obesity as an important public health issue and has committed to its prevention and control by developing and endorsing the Food Law and the multisectoral National Food and Nutrition Programme (NFNP) and its Action Plan. The low level of awareness of the obesity problem, a lack of resources and unclear responsibilities undermine the achievement of targets in counteracting obesity.

**Keywords:** Obesity, Overweight, Public Health Policy, Noncommunicable Disease, Public Health Organisation, Republic of Moldova

## Scale of the problem

A survey on NCD risk factors found that more than half of adults (56%) were overweight or obese in 2013 in the Republic of Moldova. Overweight, including obesity is similar in men (56.0%) and women (55.8%) with more women being obese (28.5%) and more men being overweight (38.2%).<sup>1</sup> These figures are higher than in 2005, when half of adults were overweight or obese.<sup>2</sup> The increasing trend has accelerated in recent years and in 2016, almost seven out of ten individuals were overweight or obese.<sup>3</sup> Overweight and obesity among children is also of concern. About 5% of children under five were overweight in 2012<sup>4</sup> compared to 0% in 2005.<sup>5</sup> The survey on seven year-old children conducted in 2013 as part of the WHO European Childhood Obesity Surveillance Initiative found that one in five boys (19%) and one in eight girls (13%) were overweight or obese, with the prevalence of obesity higher in boys

(7% boys vs. 4% girls).<sup>6</sup> Overweight and obesity lead to an increase in cholesterol, insulin resistance and blood pressure. In 2013, one in five (20.6%) adults had impaired fasting or raised blood glucose, and three out of ten (29.4%) had raised total cholesterol.<sup>7</sup>

The increasing rates of obesity are contributing to a rise in the prevalence of chronic diseases, which pose a significant burden for the health system, families and society as a whole. The incidence of cardiovascular disease has recently stabilised, but remains one of the highest in the region. The incidence of diabetes and cancer are continuously increasing. In 2017, these diseases accounted for 75.1% of deaths and 44.4% of disability in the Republic of Moldova.<sup>8</sup> Overweight is mainly seen as the responsibility of the individual and not as a population health-related issue.

## Policies and programmes

The government started to address obesity during the last decade. The National Health Policy (2008–2021) addressed obesity as one of the main health determinants for the first time and called for multisectoral actions to prevent it. In 2009, the Law on Public Health established methods to control obesity including:

- reducing the consumption of high energy density, but nutrient-poor food;
- reducing marketing of unhealthy foods, especially for children;
- food reformulation to reduce the content of salt, sugar and saturated fat;
- ensuring adequate nutrition and physical activity within preschools and for school children;
- ensuring access to healthy foods, especially fruit and vegetables;
- providing accurate and adequate information to consumers regarding the nutritional value of food via labelling and advertising.

Overweight and obesity among children is also of concern


Nevertheless, concrete actions to tackle obesity were only undertaken in 2012. The Food Law was amended and preparation, selling and distribution of unhealthy food on school premises and within 100 meters of schools was banned.

Further in 2014, the government endorsed the first National Food and Nutrition Programme for 2014–2020 (NFNP) and its Action Plan with a specific objective: *zero increase in obesity prevalence*. The NFNP and its Action Plan provide for multisectoral actions regarding health promotion and obesity prevention via taxes, mandatory nutritional labelling, restrictions on advertising and banning

the involvement of children in food advertising, elimination of *trans*-fats, reformulation of food to reduce the content of sugar, fat and salt, health education and establishing a national obesity surveillance system.

In 2017, the Parliament adopted the Law on the provision of food information to consumers (which came into force from 2019), which introduced mandatory nutritional labelling.

However, the implementation of these interventions in counteracting obesity has been minimal and subject to delay. The banning of unhealthy food was enforced within schools, but was unsuccessful in the areas surrounding schools. The advertising and promotion of unhealthy food has neither been properly regulated nor enforced.

Nutritional surveillance data are essential to effectively design, implement and evaluate national policies on prevention and control of obesity. Thus, the Republic of Moldova became part of the WHO Europe Childhood Obesity Surveillance Initiative (COSI) from 2013 and participated in the third and fourth rounds of this initiative. The baseline ‘STEPS’ survey was conducted in 2013 and the ‘Salt consumption survey’ was carried out in 2016;  both being part of the national surveillance system on NCDs.

## Role of public health organisations

**Problem identification and issue recognition.** The Ministry of Health, Labour and Social Protection recognises obesity as an essential public health issue and has addressed it in the National Health Policy (2007), Law on Public Health (2009), Food Law amended in 2012 and 2016, and Law on the provision of food information to consumers (2017).

Scaling up obesity at the international and regional levels and with WHO efforts, as the main international partner, have contributed to the prioritisation of obesity on the government policy agenda.

The National Agency for Public Health (NAPH) with its territorial departments is responsible for surveillance in all areas of public health. One of its missions

is to conduct surveys as part of the surveillance system for NCDs and their risk factors. The above-mentioned surveys collected data on BMI and physical activity. The Agency is also responsible for routinely collecting, analysing and annually publishing data on morbidity and mortality. These publications are used as reference tools by decision makers.

“concrete actions to tackle obesity were only undertaken in 2012”

**Policy formulation.** The Ministry of Health, Labour and Social Protection is the central level authority responsible for the development of overall national health and public health policy. In 2013, in order to tackle the increasing burden of NCDs and obesity as a key risk factor, the Ministry initiated the development of a policy document to address this issue. An intersectoral working group, which included representatives of relevant central level authorities (agriculture and food industry, education, economy, finance) as well as civil society, was established under the Ministry with the aim to develop a draft National Food and Nutrition Programme and the Action Plan. The Ministry’s Department of Public Health led the process together with the NAPH. In 2014, after many debates, the policy documents were endorsed by the government. There are also other authorities with specific roles in policy formulation (**see Table 1**).

There is no clear delineation of responsibilities between central and local authorities, including for public health issues such as obesity. National health programmes are not mandatory for local authorities, even though they are responsible for protecting and promoting health and preventing disease. Local

**Table 1: Authorities tasked with working to address obesity**

Authority	Task
Ministry of Agriculture, Regional Development and Environment	Increasing the availability of fruits and vegetables via agricultural policies
Ministry of Finance	Establishing excise taxes for unhealthy food
Ministry of Economy and Infrastructure	Observing food prices
Ministry of Education, Culture and Research	Development and integration of nutrition and health and physical activity in school curricula
Local authorities	Development and implementation of local policies directed at creating an environment that encourages physical activity and a healthy food environment in schools

authorities are, however, invited by the central government to contribute to implementation.

**Decision making** is divided between the Parliament, government and the Ministry of Health, Labour and Social Protection at central level and municipal/raion Council at local level. Parliament adopted the laws mentioned above. The government approved the National Health Policy as well as the NFNP and its Action Plan. Local authorities can decide on additional initiatives to promote health and to prevent obesity. It should also be mentioned that the food industry is powerful in the Republic of Moldova and can interfere at different levels of policymaking.

**Policy implementation.** For every activity specified in the NFNP and Action Plan, including for those on obesity prevention, there is a designated responsible authority. The Ministry of Health, Labour and Social Protection is the leading institution responsible for intersectoral coordination and the organisation of the implementation of the NFNP and its Action Plan. Public health interventions, including on obesity are financed by the state budget that is allocated by the Ministry of Finance based on the midterm budgetary framework. Even though interventions to control obesity are part of the Action Plan of the NFNP approved by the government, there are no specific activities reflected in the midterm budgetary framework. Therefore, financial resources have been not allocated by the government to implement the NFNP and Action Plan. So, activities are implemented using scarce internal

resources, both human and financial, or using support provided by development partners.

The NAPH is the main institution responsible for the implementation of the NFNP and its Action Plan, both at national and local level. Other authorities are also responsible for implementation as mentioned above. To date only a few activities have been initiated and implemented by these authorities.

“ specific objective – zero increase in obesity prevalence

**Monitoring and evaluation.** The Ministry of Health, Labour and Social Protection is responsible for monitoring and reporting annually on the progress of NFNP implementation to the government. This responsibility was delegated to the NAPH. Other responsible central authorities have to report annually to the Ministry of Health, Labour and Social Protection on the progress of NFNP implementation.

## Conclusion

The main strength in obesity prevention and control is the recognition of obesity as a public health problem by the government and its commitment to prevent and control it, as demonstrated by the development and endorsement of the multisectoral NFNP and enacting legislation. Among the weak points are the low level of awareness of obesity issues and lack of willingness to act by some authorities (specifically agriculture and finance), a lack of dedicated human resources in the Ministry of Health, Labour and Social Protection and NAPH, and the absence of financing. Obesity continues to be a public health problem in Moldova and to counteract it, intersectoral cooperation could be strengthened.

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# OBESITY IN POLAND – PUBLIC HEALTH ACTIVITIES

By: Michał Brzeziński, Paulina Metelska and Bogumiła Sutkowska

**Summary:** Poland is a high-income country in Central Europe that has undergone a significant transition over the past thirty years from a communist regime to a democracy. Nowadays, about one quarter of adults, 12% of boys and 6% of girls are obese. For many years, obesity was not recognised as a disease, but rather as a risk-factor for cardiovascular diseases. It was only in 2016 that the government undertook specific activities, such as the National Health Programme, and secured financial resources to tackle the burden of obesity. Nevertheless, there remains a large gap between the strategy and actual implementation.

**Keywords:** Obesity, Overweight, Public Health Policy, Public Health Organisation, Health Programme, Poland

## Scale of the problem

Until 1989, Poland was ruled by an authoritarian communist regime. Following a transition to democracy, the country joined NATO (in 1999) and the European Union (in 2004) and has undergone significant social and economic transformation, with per capita GDP rising from €5,000 in 1995 to €11,200 in 2016.<sup>1</sup> This socioeconomic transformation, along with improvements in health system performance, has contributed to increasing life expectancy, but has also been associated with deteriorating diets and decreased physical activity. Consequently, since the mid-1990s, Poland has seen an increase in the prevalence of overweight and obesity across all age groups.

As such, overweight and obesity are public health challenges of growing importance in Poland. While the self-reported obesity rate in Poland, at 15.8% in adults (2009 data), is close to the OECD

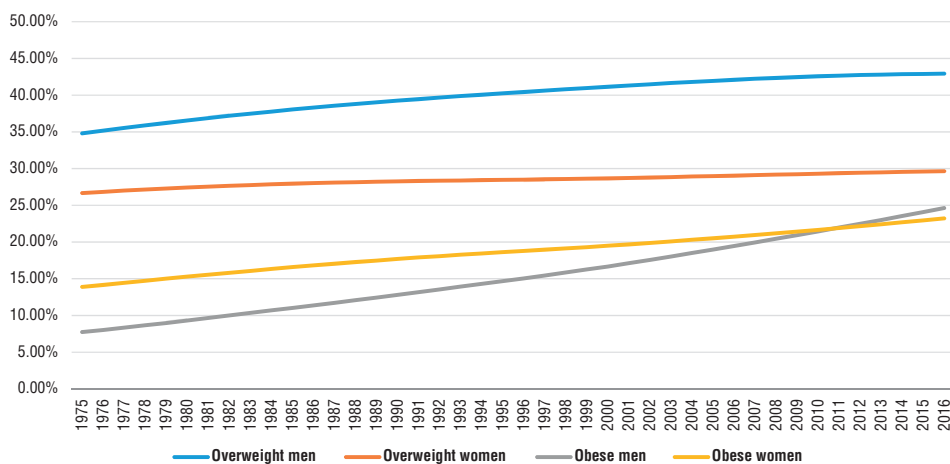
average of 15.5% (2006–2013 data), it has increased over the last 20 years (11.4% of adults self-reported as being obese in 1996).<sup>2</sup> Recent data from representative studies (WOBASZ) show an increase in the prevalence of both obesity and overweight in all adult age groups and in both sexes. In the years 2013–2014, the age-standardised prevalence of obesity (body mass index [BMI]  $\geq 30$  kg/m<sup>2</sup>) was 24.4% in men and 25.0% in women, an increase from 20.0% and 22.3% respectively in 2003–2005.<sup>3</sup>

The fastest increase has been observed in children and adolescents. Evidence shows that 22% of primary school children were overweight or obese (2013),<sup>4</sup> compared to 15% in 1990.<sup>5</sup> This is among the most rapid increase in Europe.<sup>6</sup> Recent data from the European Childhood Obesity Surveillance Initiative (COSI) study<sup>7</sup> performed in Poland in 2016 show that 32.4% of 8-year-old boys and 29.1% of 8-year-old girls were overweight (based

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**Figure 1: Prevalence of overweight and obesity in Polish adults, 1975–2016**



Source: <sup>8</sup>

on WHO 2007 cut-off points). Other data from the Health Behaviour in School-aged Children (HBSC) study from 2014 show that overweight and obesity was present in 20.5% of 11-year-old boys and 15.1% of 11-year-old girls, 18.8% of 13-year-old boys and 10.1% of 13-year-old girls.

**Figures 1 and 2** show the increase in obesity and overweight prevalence over the period of 1975–2016 for Polish adults and children, respectively.

### Policies and programmes

In spite of these negative trends, the problem of obesity appears to be underestimated by medical professionals and policymakers. Obesity is mainly seen as an individual lifestyle problem or as an aesthetic issue and not as a population health issue.

Since 1995, Poland has adopted three editions of the National Health Programme (1995–2005, 2007–2015, 2016–2020). These Programmes have provided strategic direction for the Polish health system, identifying key health challenges and ways of addressing them. The first two editions of the programme focused rather narrowly on cardiovascular disease and cancer treatment and prevention strategies. Despite the growing burden of overweight and obesity, Poland had no specific national programme to tackle these concerns until 2007.

The first *National Program for the Prevention of Overweight and Obesity and Chronic Non-Communicable Diseases through Improved Nutrition and Physical Activity 2007–2011* was introduced in 2006, largely as a response to the WHO Global Strategy on Diet, Physical Activity and Health (the latter was published in May 2004). In 2012, the programme was further extended as the National Programme for the Prevention of Non-Communicable Diseases 2012–2014. Both versions of the programme outlined an active role for the central and local governments in health polices and promoting prevention on noncommunicable diseases (NCDs), including NCD-related risk factors such as obesity. Finally the problem of obesity is recognised in Poland's strategic public health document, the National Health Programme 2016–2020, as one of the main strategic goals.<sup>9</sup> Yet, the obesity-related goals included in these documents are poorly translated into actions and few measures are undertaken to address the problem as can be inferred from the first three years of implementation of the strategy.

Responsibility for implementing the program was delegated to the local level, including responsibility for the financing/co-financing of program implementation. This was despite local authorities being poorly prepared in terms of technical expertise and personnel. As a result, few activities have been carried out at the local level, which decreased the speed

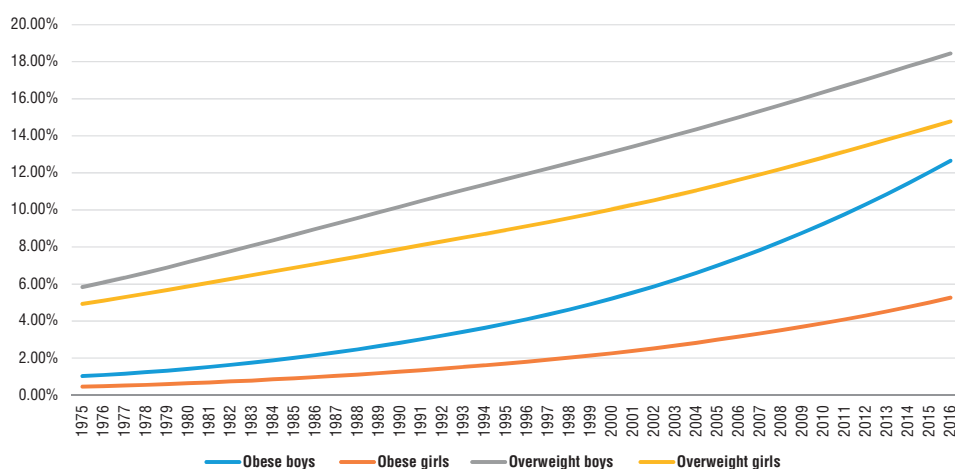
of program implementation. Rather, the programs described above were implemented mainly at the national level by the Ministry of Health (MoH) and its agencies including the National Institute for Public Health – National Institute of Hygiene (NIPH-NIH) and the National Food and Nutrition Institute (NFNI), with little impact on and support from regional and local governments. The MoH was not able to engage the local level in the implementation process due to restricted human and financial capacity.

“obesity appears to be underestimated by medical professionals and policymakers

Health education is the primary approach to tackling obesity promoted in national health policy documents, such as the National Health Programmes (NHPs) for 2007–2015 and 2016–2020. However, there are no publicly financed education programmes for children and young people dedicated to obesity, nor are there national education campaigns for the general population. The only medical obesity treatment that is available under the public system is bariatric surgery. Little attention is also paid to policy tools such as legislative change, marketing bans or fiscal instruments such as taxes. The focus of health policy debates on lifestyle choices is partly due to the active role of food industry representatives in policy debates. They have successfully argued that the responsibility for health choices lies with individuals and not with the state. The control of advertisements and TV broadcasters was dominated by advertisers who created their own self-regulation, which effectively stopped all attempts to comply with external control regulations in this area for many years.

On the whole, the problem of obesity attracts little attention in public policy debates in Poland. More controversial

**Figure 2: Prevalence of overweight and obesity in Polish children, 1975–2016**



Source: <sup>1</sup>

issues, such as in vitro fertilisation, tend to command more public interest. Although some actions were taken in 2015 (notably, the introduction of a ban on high salt, sugar and fat (HSSF) food in schools, which has since been mostly withdrawn) there is a lack of a clear strategic plan for obesity prevention. However, the implementation of the new Act on Public Health and its executive document (i.e. the NHP 2016–2020<sup>1</sup>) may help to focus more attention on public health problems such as obesity, physical inactivity, and tobacco and alcohol consumption.

Local and regional governments and city authorities also play an important role in implementing high-quality activities in the field of tackling obesity. They mostly focus on children but some activities are dedicated to adults, with some receiving financial support from the NHP 2016–2020. Local activities focus mostly on screening, such as the early detection of children with excess body mass. Different follow-up actions are recommended to all children/adolescents identified as having excess body mass, ranging from dietary consulting to long-term care by qualified interdisciplinary teams (physicians, dieticians, psychologists, physical activity trainers), that last from one to two years. Although the number of such local activities remains low (about 50 local activities in 2018), they may have a positive impact on reducing obesity prevalence in the future. Additionally, all

of those locally implemented and publicly financed health policy programmes, need to be assessed ex-ante by a government body – the Agency for Health Technology Assessment in Poland. This implies that all activities approved by the Agency are well-organised and evidence-based.

### Role of public health organisations

In Poland, the MoH is the main authority responsible for identifying problems and setting the agenda in the field of public health, including obesity. The Department of Public Health has primary responsibility for all activities undertaken within the NHP. The Department is also responsible for the implementation of the Public Health Act. Nevertheless, many other departments within the MoH undertake public health activities, e.g. the Department of Mother and Child is responsible for preventive health care for children and pregnant women and the Department of Science and Higher Education supervises the NIPH-NIH and the NFNI.

The NFNI and the NIPH-NIH, both subordinated to the MoH, are the two key national institutes that undertake epidemiological research in the area of obesity and related issues, such as nutrition, and provide data to support the MoH in problem identification and issue recognition. Both institutes undertake this work independently and on behalf of the Ministry. Most of their activities

are financed from national sources (MoH, National Science Centre) or with support from EU strategic funds, or the Swiss Contribution (a fund organised by Switzerland for the 10 countries that joined the EU in May 2004). However, there is little systematic data collection on the prevalence of obesity and overweight in Poland and data that are gathered are often not representative of the whole population or comparable across surveys. Except for the international HBSC survey, there are no systematic national surveys in the area of obesity in Poland. None of the major national population surveys (NatPol, NatPol 2011, WOBASZ, MONICA) focus on obesity (they mainly look at cardiovascular disease prevalence and their treatment outcomes) and collected data are confined to selected regions or populations (e.g. various age groups) and based on different methodologies (e.g. some use self-reported data). The key source of information on obesity-related diseases is the National Health Fund (NHF), which collects data on the provision of publicly financed health services to patients with obesity-related diseases.

“the obesity-related goals are poorly translated into actions”

The National Health Programme included several institutions as key leaders – as mentioned earlier NIPH-NIH and NFNI play a key role in this process. However, their role in prevention and treatment of obesity is mainly limited to educational activities, provided both directly (training, consultations) and through public health media campaigns. They do not look at other activities such as food taxation or media regulation.

Regional and local governments may contribute to obesity prevention and management at those levels. Regional and local self-governments are responsible

for developing their own health policies and health programmes, depending on the needs of their populations. These policies and programmes are usually part of their wider development strategies and reflect strategic national goals included in the NHP. Since they are financed mainly from local budgets and since developing prevention and health promotion policies and programs is not mandatory, only a few self-governments have introduced such policies and programmes in the area of obesity.

The Act on Public Health, adopted in September 2015, foresaw the establishment of the Public Health Council, which will act as an advisory body to the MoH by providing opinions but also suggesting new activities in the area of public health. Nevertheless, they have not yet recommended any important policies to the MoH in the field of obesity.

## Conclusion

The potential role of public health in creating a healthy society and contributing to economic development remains poorly recognised by the majority of political and government institutions in Poland. This attitude, however, seems to be slowly changing and the importance of public health problems, including obesity, is being increasingly recognised. Yet, there is still little understanding among policymakers of the effectiveness of various policy tools that could be used to tackle public health problems, in particular with regard to legal and fiscal measures.

Systematic monitoring of obesity prevalence in the population and evaluation of implemented programs are still missing. The New Public Health Act states that at least 10% of resources allocated to the implementation of the NHP will be dedicated to monitoring, evaluation and scientific research in the field of public health, including obesity. If this target is met, significant improvements could be made to data collection and evaluation in this area.

The new Public Health Act promises to introduce many other improvements in the area of obesity policy: a dedicated institution responsible for the development of policies in this area and dedicated

financing for research and data analysis on obesity. Unfortunately, the anticipated financial resources fall short of what was recommended by experts and remains politically dependent as the annual budget will be determined by government. Moreover, while many organisations are willing to play a major role in the area of public health, none of them, including the NIPH-NIH, is fully prepared to assume a leading role. This lack of preparedness is due to a lack of knowledge, resources, staff and experience. Future developments will very much depend on building a clear mandate for the government's new plenipotentiary for public health, created by the Act on Public Health.

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# NEW PUBLICATIONS

## The role of public health organizations in addressing public health problems in Europe: The case of obesity, alcohol and antimicrobial resistance

**Edited by:** B Rechel, A Maresso, A Sagan, C Hernández-Quevedo, E Richardson, E Jakubowski, M McKee, E Nolte

**Copenhagen:** World Health Organization (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies), 2018

**Number of pages:** xiii + 104 pages; **ISBN:** 978 92 890 5171 2

**Available at:** [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0011/383546/hp-series-51-eng.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0011/383546/hp-series-51-eng.pdf?ua=1)

Growing levels of obesity, continued harmful consumption of alcohol, and the growing threat of antimicrobial resistance (AMR) are some of the greatest contemporary challenges to the health of European populations. While their magnitude varies from country to country, all are looking for policy options to contain these threats to population health. It is clear that public health organisations must play a part in any response, and that



intersectoral action beyond the health system is needed. What is less clear, however, is what role public health organisations currently play in addressing these problems.

This volume provides detailed country reports from nine European countries (England, France, Germany, Italy, the Republic of Moldova, the Netherlands, Poland, Slovenia and Sweden) on the involvement of public health organisations in addressing

obesity, alcohol and antimicrobial

resistance. These reports explore the power and influence of public health organisations vis-a-vis other key actors in each of the stages of the policy cycle (problem identification and issue recognition, policy formulation, decision-making, implementation, and monitoring and evaluation).

A cross-country comparison assesses the involvement of public health organisations in the nine countries covered. It outlines the scale of the problem, describes the policy responses, and explores the role of public health organisations in addressing these three public health challenges.

**Contents:** Cross-country analysis: Introduction, Obesity, Alcohol, Antimicrobial resistance, Key policy lessons; Country reports.

## Averting the AMR crisis. What are the avenues for policy action for countries in Europe?

**By:** M Anderson, C Clift, K Schulze, A Sagan, S Nahrgang, DA Ouakrim, E Mossialos

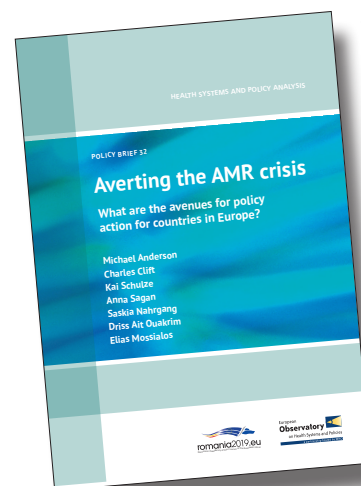
**Copenhagen:** World Health Organization (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies), 2019

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This policy brief summarises some of the key policy avenues for tackling antimicrobial resistance (AMR). Following the widely



accepted 'One Health' approach to combating AMR, the brief aims to support the implementation of national action plans (NAPs) on AMR, drawing on numerous examples of effective policies implemented by European Union Member States and involving the human, animal and environmental health sectors.

This policy brief was prepared to support the Romanian EU Council

Presidency, which hosted a

conference on 'Next Steps to Making the EU a Good Practice in Combating Resistance to Antimicrobials' (Bucharest, 1 March 2019). It draws significantly on a forthcoming study, Challenges in Tackling Antimicrobial Resistance: Economic and Policy Responses, being co-produced by the Observatory and the Organisation for Economic Co-operation and Development (OECD).

**Contents:** Foreword; Acknowledgments / Acronyms; List of tables, figures and boxes; Key messages; Executive summary; Introduction; The health and economic impact of AMR; Global action to date; What are the options? Essential AMR policies and priority interventions; Facilitating successful implementation of 'One Health' AMR NAPs: governance is key; Discussion; Appendix; References.



# HSPM COUNTRY NEWS

**The Observatory's Health Systems and Policy Monitor platform provides systematic descriptions of country health systems and features up-to-date information on ongoing health reforms and policies. See the individual country pages for these news items and more:**

<http://www.hspm.org>



**Compiled by Gemma Williams, based on July–December 2018 reform logs.**

## Croatia: Adoption of a national plan for the development of hospitals

In September 2018, the government adopted the new National Plan for the Development of Clinical Hospital Centres, Clinical Hospitals, Clinics and General Hospitals in the Republic of Croatia (2018–2020). The plan is a continuation of an earlier plan that was in place for the 2015–2016 period. Its main goals are to increase access to hospital care, improve quality of hospital care, and increase efficiency of care delivery in hospital. The implementation of these goals will be guided by two principles described in the plan: the principle of subsidiarity and functional integration of hospitals. The plan will also help steer the implementation of EU funded investments projects in the area of hospital infrastructure.

## Czech Republic: Strengthening primary care physicians' competencies for oncology patients

As part of primary care reforms, primary care physicians (GPs) will be able to gain new competencies as of January 2019 to treat patients following successful oncological treatment that require specialised regular checkups and examinations, but are not in need of further therapeutic treatment. Monitoring of recovered oncology patients will be

handed over to GPs based on individual agreements between the GP and the treating oncologist and by an explicit approval of the patient. Professional associations believe that GPs are easier to reach for the majority of patients and will enhance access to care. Monitoring of patients at a high risk of disease relapse will however remain the responsibility of oncologists. Oncologists estimate that two thirds of specialised oncology centres' patients will be affected by this care delivery change. GPs will be paid for this new task through fee-for-service, additional to general capitation payments.

## Estonia: Health workers' collective agreement for the next two years agreed

Representatives from provider associations and health professionals' unions signed a collective agreement for the next two years in November 2018. The minimum hourly wages for doctors, nurses and other health care professionals will increase up to €13.30, €8.00 and €5.00 respectively by 2020. This translates into an increased minimum wage of 18.1% for doctors, 16.8% for nurses and 19.0% for other health professionals. In addition, night and weekend shift allowances, compared to the minimum required by the law, will gradually be introduced. These negotiations received relatively little public attention compared to previous negotiations, in part due to a strong economic environment which supported a positive approach towards negotiations.

## France: The introduction of advanced nursing practice

Advanced nursing practice was introduced in France in July 2018 to improve access to care and management of chronic diseases. Nurses with at least three years of experience can now complete two years of additional training at Master's level to undertake tasks formerly completed by medical doctors. According to the new legislation, trained nurses will be able to

follow chronically ill and complex patients identified by GPs or specialists with whom they will collaborate directly in primary care teams or within hospital and social care institutions. Advanced nursing practices will cover prevention and screening activities, prescription of complementary exams, and renewal or adjustment of medical prescriptions. Advanced nurses will first be introduced for chronic diseases managed in primary care (e.g. diabetes or epilepsy), oncology, haemato-oncology and chronic renal disorders, before being extended to other clinical areas.

## Germany: HPV vaccination for boys will be covered by statutory health insurance

Statutory sickness funds will pay for the human papillomavirus (HPV) vaccination to be extended to boys. The Joint Federal Committee decided on 20th September 2018 to include the HPV vaccination for all children between 9 and 14 years in the statutory health insurance benefit catalogue. The decision is based on a recommendation of the Standing Vaccination Commission (STIKO) based at the Robert-Koch-Institute (RKI) for this age group. The vaccine has been recommended for girls to prevent cervical cancer since 2007. In June 2018, the STIKO recommended extending vaccination coverage to boys.

## Ireland: The public health alcohol act 2018

The Public Health Alcohol Act came into law on 3 October 2018. The law is historic as it is the first time the Irish government has used legislation as a public health measure in relation to alcohol and because it introduces restrictions on alcohol not in place in other countries. The wide-ranging piece of legislation supports implementation of a minimum unit price of €0.10 per gram of alcohol; restrictions on advertising and warning labels on alcohol products including cancer warnings; the separation and reduced visibility of alcohol

products in mixed trading outlets; and the regulation of the sale and supply of alcohol in certain circumstances.

### **Lithuania: Locations for the sale of selected medicines to be expanded**

Starting from January 2019, certain non-prescription medicines are available for sale not just in pharmacies, but also in stores, petrol stations, and other retail points. Approximately 50 medications will be available for sale outside of pharmacies, mostly those used to treat mild disorders in children over the age of 12 and in adults, for example those containing paracetamol or ibuprofen. The medicines must be sold in packaging containing the smallest available quantities, while only adults over 16 years of age can purchase no more than one pack of the same medicine. The prices of medicines sold in retail points cannot exceed the price of equivalent medicines sold in pharmacies.

### **Portugal: Increased availability of HIV self-testing kits**

HIV self-testing, as well as Hepatitis B and Hepatitis C self-testing, will be available over the counter in Portugal, following government approval of their sale in community pharmacies without the need for a medical prescription (Decree-Law No. 79/2018, of 15 October 2018). Tests are already available in community pharmacies in Cascais (since 10 October 2018), and will be gradually expanded to other pharmacies throughout the country. The decision follows 2016 WHO guidelines on HIV self-testing which recommend that: "HIV self-testing should be offered as an additional approach to HIV testing services", aiming to reduce late HIV diagnosis and eliminate HIV epidemics by 2030.

### **Romania: Improved access to innovative treatment for Hepatitis C**

In September 2018, the National Health Insurance House (NHIH) announced that Hepatitis C treatment will be made available to 13,000 patients in all stages of fibrosis. The number of contracted providers was also increased. Access to innovative

treatment for Hepatitis C has been extended since 2016, when an innovative interferon-free treatment was made available to 5,860 patients with advanced stage of fibrosis (F4). In 2017 treatment was offered to almost 10,000 patients, including those in stages F3 and F2. Prevalence of Hepatitis C virus infection stands at 3.3% of the Romanian population (over 660,000 people), which is the highest rate in the EU. The measures described above are meant to contribute to the WHO and EU efforts to eliminate Hepatitis C by 2030.

### **Poland: Piloting of comprehensive care for people with heart failure**

In November 2018 the Minister of Health initiated a two-year pilot of Comprehensive Care for People with Heart Failure (Kompleksowa Opieka Nad Osobami z Niewydolnością Serca, KONS). The pilot will be implemented by six coordinating centres and will cover over 5,000 patients. KONS comprises ambulatory, hospital and home care. Care will be coordinated by a team consisting of a family doctor, nurse, cardiologist and other specialists. Telemedicine will be used to improve coordination between the family physician and the cardiologist. Patients with the most advanced form of heart failure will be referred to educational and advisory centres where they (and their families) will receive diet and psychological advice.

### **Spain: Extension of the common health benefits package**

In November 2018, the Ministry of Health and the regional health representatives approved a revision to the common health benefits package. New benefits covered include both areola and nipple micropigmentation techniques as part of breast reconstruction, new models of external prosthesis for breast implants, facial restoration and eye readers for motor neurone disease and hearing aids for older people. In addition, the screening programme for cervical cancer will become population-based, while five patient groups with Type I diabetes requiring more than six glycaemic controls per day will benefit from the use of flash glucose monitors.

### **Switzerland: Six groups of surgical interventions to be moved to outpatient care**

From 1 January 2019, six groups of surgical interventions will only be reimbursed if undertaken on an outpatient basis in an effort to create uniform regulations for all insured individuals in Switzerland who undergo these procedures. The interventions affected are: 1. unilateral varicose vein surgery of the legs; 2. haemorrhoid procedures; 3. unilateral inguinal hernia surgery; 4. examinations/interventions on the cervix or uterus; 5. knee arthroscopy, including arthroscopic surgery on the meniscus; 6. tonsil and adenoid surgery. Criteria are being developed to determine exceptional cases in which inpatient treatment can continue to be reimbursed.

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