40 National nutrition policy

Summary

The World Health Organization has offered to help member governments to formulate national nutrition policies. Such policy formulations will require contributions from several sectors of society. The objectives of national nutritional policy need to be clear. Several countries, under-developed and industrialised, have now formulated policies. In 1979 dietary guidelines for Australians were developed. Nutrition policy is now in operation, most clearly in the State of Victoria. The relative claims of the individual and the community at large will need reconciliation.

Introduction

A National Nutrition Policy in Australia should enable Australians to obtain locally produced food appropriate to their nutritional needs. The Thirtieth World Health Assembly of the World Health Organization (WHO) in 1977 adopted a resolution urging member governments 'to further multi-sectional programmes specifically orientated to improve the nutritional situation of the population... and to consider the food and nutritional implications of their development policies and plans.'

Interest groups

A National Nutrition Policy cannot be formulated without consultation between various sectors of the community, including the following:

1. health professionals (nutritionists and dietitians, nurses, physical educationists, medical practitioners);
2. farmers and agriculturalists;
3. the food industry;
4. educators;
5. consumers; and
6. government.

Specific objectives

Some suggested objectives of a national nutrition policy would be:

1. to produce food locally or within Australia as far as possible; the less the food imports the less vulnerable the food supply system; the total energy costs of locally grown food would also be less;
2. to produce food with as little ecological disturbance as possible and with the least demand on non-renewable resources;
3. to ensure an adequate energy and nutrient intake for all Australians, an adequate diet;
4. to promote a food intake pattern that carries the least risk for those disorders that most affect Australians, a prudent diet; and
5. to assist food-deficit countries to achieve a satisfactory local food production and, where necessary, to produce additional food within Australia to make good food shortages in those countries.

Experience in other countries

For the developing countries, nutrition problems have been more evident for longer and efforts have been made to develop nutrition policies which would ameliorate the burden of malnutrition. Amongst developed countries, Sweden was the first to introduce a programme aimed at modifying nutrient intake, and in 1971 a ten year Diet and Exercise program was begun. Already in 1963 Sweden had a national farm policy which included nutritional considerations. Other countries have followed with similar recommendations: the Netherlands in 1973, Norway in 1975, Canada in 1976, the Federal Republic of Germany in 1976, the U.S.A. in 1977 and the U.K. in 1978.

The United States Senate Select Committee on nutrition and human needs under the chairmanship of Senator McGovern published its first report in 1977. The recommendations were quantitative and were subsequently modified in regard to the amounts and/or proportions of macronutrients. Finally, the directional changes thought desirable were embodied in the qualitative combined recommendations of Health, Education and Welfare (HEW) and the United States Department of Agriculture in January 1980. These are listed below.

Dietary guidelines for Americans

1. Eat a variety of foods.

To assure yourself an adequate diet eat a variety of foods daily, including selections of:
(a) fruits;
(b) vegetables;
(c) wholegrain and enriched breads, cereal and grain products;
(d) milk, cheese and yoghurt;
(e) meats, poultry, fish, eggs; and
(f) legumes (dry peas and beans).

To assure your baby an adequate diet:
(a) breast feed unless there are special problems;
(b) delay other foods until baby is three to six months old; and
(c) do not add salt or sugar to baby's food.
2. Maintain ideal weight.
To improve eating habits:
(a) eat slowly;
(b) prepare smaller portions; and
(c) avoid 'seconds'.
To lose weight;
(a) increase physical activity;
(b) eat less fat and fatty foods;
(c) eat less sugar and sweets; and
(d) avoid too much alcohol.
3. Avoid too much fat, saturated fat and cholesterol.
To do this:
(a) choose lean meat, fish, poultry, dry beans and peas as your protein sources;
(b) moderate your use of eggs and organ meats (such as liver);
(c) limit your intake of butter, cream, hydrogenated margarines, shortenings and coconut oil, and foods made from such products;
(d) trim excess fat off meats;
(e) broil, bake, or boil rather than fry; and
(f) read labels carefully to determine both amount and types of fat contained in foods.
4. Eat foods with adequate starch and fibre.
To eat more complex carbohydrates daily:
(a) substitute starches for fats and sugars; and
(b) select foods which are good sources of fibre starch, such as wholegrain breads and cereals, fruits and vegetables, beans, peas and nuts.
5. Avoid too much sugar.
(a) use less of all sugar, including white sugar, brown sugar, raw sugar, honey and syrups;
(b) eat less of foods containing these sugars, such as candy, soft drinks, ice cream, cakes, cookies;
(c) select fresh fruits or fruits canned without sugar or light syrup rather than heavy syrup;
(d) read food labels for clues on sugar content: if the names sucrose, glucose, maltose, dextrose, lactose, fructose, or syrups appear first, then there is a large amount of sugar; and
(e) remember, how often you eat sugar is as important as how much sugar you eat.
6. Avoid too much sodium.
(a) learn to enjoy the unsalted flavours of foods;
(b) cook with only small amounts of added salt;
(c) add little or no salt to food at the table;
(d) limit your intake of salty foods, such as potato chips, pretzels, salted nuts and popcorn, condiments (soy sauce,

steak sauce, garlic salt), cheese, pickled foods, cured meats; and

(e) read food labels carefully to determine the amounts of sodium in processed foods and snack items;

7. If you drink alcohol, do so in moderation.

In May 1980, the Food and Nutrition Board of the United States National Academy of Sciences issued a document 'Towards Helpful Diets'. It restricted its dietary recommendations to the following:

1. Select a nutritionally adequate diet from the foods available, by consuming each day appropriate servings of dairy products, meats or legumes, vegetables and fruits, and cereal and breads.
2. Select as wide a variety of foods in each of the major food groups as is practicable in order to ensure a high probability of consuming adequate quantities of all essential nutrients.
3. Adjust dietary energy intake and energy expenditure so as to maintain appropriate weight for height; if overweight, achieve appropriate weight reduction by decreasing total food and fat intake and by increasing physical activity.
4. If the requirement for energy is low (e.g. reducing diet), reduce consumption of foods such as alcohol, sugars, fats, and oils, which provide calories but few other essential nutrients.
5. Use salt in moderation; adequate but safe intakes are considered to range between 3 and 8 g of sodium chloride daily.

The Food and Nutrition Board took a more cautious approach to dietary fat modification for the community at large, preferring individuals with risk for cardiovascular disease to be identified and counselled accordingly. It will be noted that the Food and Nutrition Board emphasised weight control as a relatively more important issue than did the combined HEW–U.S. Department of Agriculture document. It could be argued that, to a large extent, most other nutritional considerations fall into place when control is achieved.

The Food and Nutrition Board was also particularly concerned about the risk of inadequate nutrient intake when diets of less than 5000 kJ (1200 calories) are consumed.

Dietary guidelines for Australians

In 1978 a working party was set up by the Australian Association of Dietitians to formulate a national nutrition policy and to develop dietary guidelines. The working party included members of the health professions, academic nutritionists, home economists, a food industry representative, consumer interests and government. Its dietary guidelines were released in August 1979:

1. Eat a variety of foods each day.
2. Prevent and control obesity.
3. Limit the fat in your diet.

4. Decrease sugar consumption.
5. Limit alcohol consumption.
6. Increase your intake of fruit, vegetables, bread and cereals.
7. Reduce sodium intake.
8. Enjoy water.
9. Encourage breast feeding.

The Australian Department of Health through its spokesman, Dr Spike Langsford, announced similar guidelines in April 1979 in a 'set of eight dietary goals for Australians'. Although the Australian Department of Health's guidelines did not include 'to encourage the intake of water', this guideline has subsequently been supported by the Australian Department of Health.*

It is of interest how additional issues are now emerging which might ultimately find their way into dietary guidelines: the desirability of increased fish consumption, the need to monitor pesticide residue levels, and the value of olive oil, for example.

Nutrition policy

At the end of 1984, the Australian State of Victoria released a draft food and nutrition policy. As a consequence, the Deakin Institute of Human Nutrition, together with the government departments of health, agriculture and education, have cooperated in a project 'To make healthy food choices, easier choices'. By 1988, the Victorian policy was in place, having been launched in 1987, with an interdepartment governmental committee, a community consultative group, and the first of various implementation committees.

In 1986, the Federal Australian 'Better Health Commission' and its Nutrition Taskforce defined three broad goals:

1. to reduce the incidence and prevalence of diet related health disorders;
2. to provide a food supply that promotes health;
3. to promote the skills and knowledge which enable Australians to make healthy food choices.

The targets postulated from these stated goals were:

1. The present level of breast feeding at 3 months of life is approximately 50 per cent. It is proposed that this proportion be increased to 80 per cent by the year 2000.
2. A survey conducted in 1983 by the National Heart Foundation in collaboration with the Commonwealth Department of Health concluded that 38 per cent of persons in a sample population between 25 and 64 years of age were either overweight or obese. It is proposed that this proportion be reduced to 25 per cent by the year 2000.
3. The total fat contribution to the Australian diet is at present 38 per cent. It is proposed that this be reduced to 33 per cent by 2000.
4. Refined sugars contribute 14 per cent to the total energy content of the Australian diet. It is proposed that this be reduced to 12 per cent by the year 2000.
5. The dietary fibre content of the Australian diet is currently 17 grams per day. It is proposed that this is increased to 30 grams per day by the year 2000.
6. Dietary sodium intake is at present 165 mmol per day. It is proposed that by the year 2000 this be reduced to 100 mmol per day.

7. Alcoholic beverages contribute 6 per cent to the total energy content of the Australian diet at present. It is proposed that this should decline to 5 per cent by the year 2000.
8. The report of the taskforce on Cardiovascular Disease provides targets for mean fasting plasma cholesterol, diastolic blood pressure and the proportion of adults participating in sport. These can be regarded as additional targets relating to those of the Nutrition Taskforce.

The Nutrition Taskforce emphasised the importance of keeping these dietary goals under regular review as more data about the nutritional health of Australians and from research into the relationship between diet and health becomes available. In particular, there is a need for more research in regard to diet as a casual factor in cancer, hypertension, diabetes (Type 1 and 2) and coronary heart disease. The strategies envisaged to assist in reaching the stated goals include the following points.

Policy

1. There should be an immediate strengthening of the formal mechanism for policy formulation and the establishment of a formal mechanism for policy implementation.
2. There should be a continuation of data collection on nutrient composition of the food supply and on food consumption by the general population and by specific disadvantaged groups. Funds should be provided.
3. Nutrition research into diet and disease should be commissioned and co-ordinated by a specially constituted national committee.

Food supply

A commitment should be obtained from governments to introduce uniform national legislation for food standards and to remove barriers to marketing foods which facilitate appropriate dietary changes. Immediate action should be taken by appropriate committees of the National Health and Medical Research Council, with a view to making proposals at an early date.

Primary industry groups should receive assistance and advice concerning priorities for agricultural production to meet dietary needs and preferences.

State and Territory authorities responsible for standards of foods provided in institutions should supplement education by setting appropriate standards for food served.

Nutrition education

Commonwealth and state governments should formulate a national education program, including both schools and the community, to promote healthier dietary attitudes and habits. The development of this program should involve experts in nutrition and education, community groups, industry, and the media.

A national information and education resource group is required to support this initiative and funds should be provided for the training of nutritionists and education personnel, for research into nutrition education methods, particularly as they apply to disadvantaged groups, and for the development of innovative educational programs.

Broader health concerns
A special national expert group should be established to develop and promote strategies for the prevention of chronic diseases in general.

The individual and the community

In formulating dietary guidelines for the community, the nutritionally related problems of the majority are borne in mind. One concern is that there may be some groups within the community for whom the guidelines are not appropriate. In the case of the dietary guidelines for Australians listed above, for example, it may be that those with particularly high energy needs could accommodate energy-dense foods with a high fat or sucrose content. Even alcohol might meet extra energy needs in the particularly physically active, although this does not diminish predictably the risks of organic disease arising from excessive alcohol consumption. It may be that in a particularly hot environment more sodium could be accommodated in the diet. There are some women who have particular difficulty in breast feeding and the guideline to encourage breast feeding would not be intended to make such women unduly anxious about the welfare of their infants.

Cost-benefit analyses are required when the relative merits of community oriented programmes against individually based advice is considered. For example, the cost of assessing the major coronary risk factors of all individuals in the community may be quite large, even though advice based on such individual assessments might theoretically be preferred.

One particular advantage of individual assessment and counselling about nutritional matters is that nutritional questions can be set alongside other priorities in the individual's life. Furthermore, the risks of non-nutritionally related health problems can be considered, and, in the light of these considerations, the relative merits of dietary change can be evaluated. Then, too, while a given overall change in food intake may be favourable for the majority, there may be a minority for whom it is not favourable: individual counselling would obviate this problem. Also, we have to consider the extent to which advice to the community is actually directed at a minority who die prematurely.

These are some of the problems facing those who are called upon to formulate national nutrition policy.

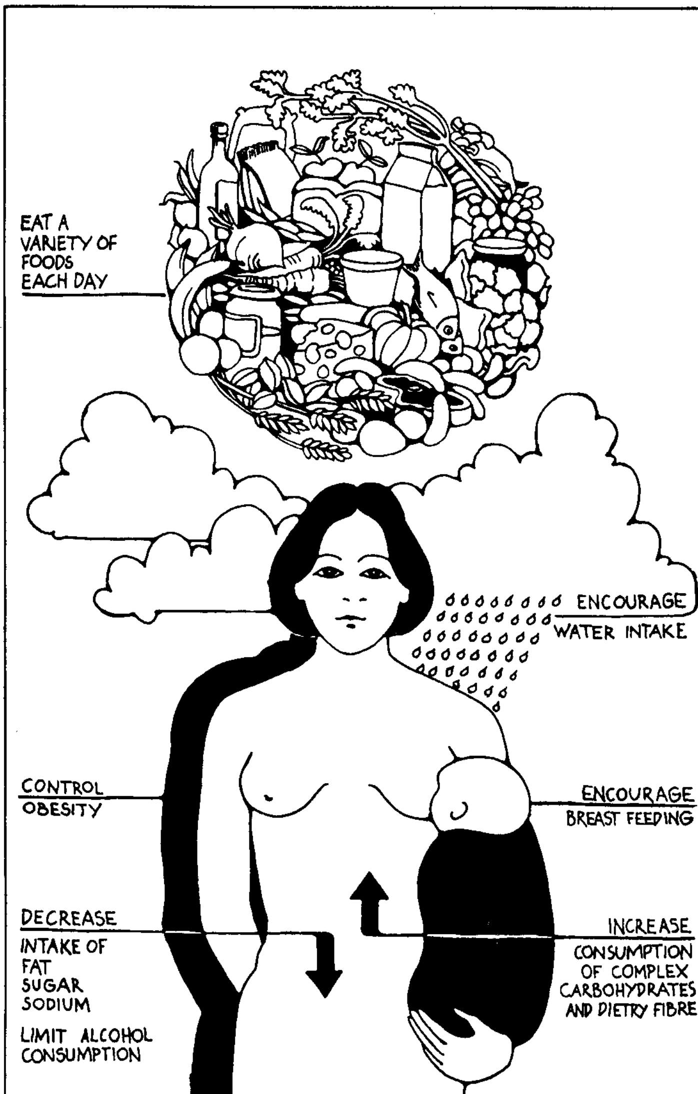

Figure 40.1 Dietary guidelines for Australians take into account the need for an adequate diet and address the nutritional problems evident in Australia.

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Questions

1. When life expectancy in Australia is considered, to what extent do you think a national nutrition policy is justified?
2. What are some of the differences in dietary guidelines that have been formulated in different countries, and what might be the basis for the differences?
3. To what extent has the overall question of energy balance, other than energy intake alone, been taken into account in the formulation of national nutrition policy and dietary guidelines?
4. Take one group that would have a particular interest, economic or otherwise, in a national nutrition policy in Australia and consider how it might approach the question of nutrition policy.

FOOD & NUTRITION IN AUSTRALIA

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