

CNAMTS and CCMSA

CONTRIBUTION TO THE GREEN PAPER DEBATE

“Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases”

10 MARCH 2006

INTRODUCTION

Today, there is no doubt that unless something is done, obesity will, in just a few years from now, have dramatic consequences on the state of health and life expectancy of the population and will directly, or indirectly, generate an additional financial burden that French, and more generally speaking, European, health insurance schemes will find hard to bear.

The CNAMTS and the MSA participate in French public policies to combat obesity by mobilising their expertise in order to analyse the quality of the care dispensed to those covered by national health insurance schemes and by financing various programmes and structures aimed at improving care by means of better spending. The CNAMTS and the MSA, therefore, combine, roles as protagonists in the fight against obesity and chronic disease, and as sponsors. In addition, they lead, or take part in, lots of local prevention initiatives, following the logic of local social and healthcare development. It is, in fact, essential to act as close to the ground as possible, in synergy with national initiatives.

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Some figures

According to a survey conducted by the “Institut National de la Santé et de la Recherche Médicale” (INSERM) [French national institute for health and medical research] in 2003, France had over 5.3 million obese adults. The prevalence increased, on average, by 5.5% per year between 1997 and 2003 (8.2% in 1997 and 11.3% in 2003). Serious forms of obesity and childhood obesity (13% of children aged between 4 and 16, 11% of children under 18, i.e. 1.6 million) have also experienced a significant increase. The rural population has not been spared from problems of overweight and obesity. A 2003 appraisal devoted to health checks on the agricultural population showed that, between 38 and 65, nearly half of rural men and one third of rural women are overweight and approximately one fifth of both men and women are obese. In France, it seems that medical consumption by obese adults is 27% higher than that of adults of normal weight (39% for drugs alone). Nearly three times more obese people than people of normal weight submitted expenses for primary healthcare due to an “Affection de Longue Durée” (ALD) [long-term illness]. Annual reimbursement for primary healthcare expenses for obese adults is 56% higher than for people of normal weight and this figure is 27% when using an identical age structure. Compared with consumption by persons of normal weight, consumption is higher in terms of consultation of doctors and dentists (+7%), for prescriptions (+41%) and for drugs (+39%). In addition, obese people consult, more specifically, cardiologists, rheumatologists, pneumatologists and diabetologists.

The national framework for action

The “Programme National Nutrition Santé français” (PNNS) [French national nutrition and health programme] launched in 2001 and in which the CNAMTS and the CCMSA are taking part, set as its main objective the improvement of the state of health of the entire population by acting on one of its major determinants: nutrition. This programme’s main strategies are as follows: to inform and guide citizens on the subject of diet, to set up monitoring systems to improve screening, prevention and research, to encourage dialogue between the food industry, the institutional catering industry and consumers.

The main players

In addition to the French national health insurance scheme, the main players involved in the fight against obesity include the “Institut National de Prévention et d’Education pour la Santé” (INPES) [National institute for prevention and health education], the “Groupements régionaux de santé publique” (GRSP) [Regional public health consortia] and the “Centres d’Examens de Santé” (CES) [Healthcheck centres]. The “Institut National de Prévention et d’Education pour la Santé”, mainly financed by the French national health insurance scheme, is more particularly responsible for implementing the PNNS. One of its objectives is to combat obesity. Its activities take the form of studies, advertising campaigns, training, documentation etc. The “Groupements régionaux de santé publique” (whose Boards of Directors include representatives from the French national health insurance scheme) which have now been set up, aim to adopt the PNNS on a regional level, to decide which projects are eligible for financing, to develop cooperation and to bring together the relevant regional players. Finally, the “Centres d’Examens de Santé” (managed or officially recognised by National health insurance scheme bodies) and the preventive examinations offered to the agricultural population aim, in particular, to take part in screening, information and health education campaigns. They may also contribute to data collection. They perform periodic health checks and diet appraisals. Due to their organisation and existence throughout the France, they constitute a preferred location for observing the effects of lifestyles on health and its determinants.

STRUCTURES AND TOOLS AT COMMUNITY LEVEL

Health across European Union policies

What are the concrete contributions which Community policies, if any, should make towards the promotion of healthy diets and physical activity, and towards creating environments which make healthy choices easy choices?

It may be interesting to make a link with the Open Coordination Method (OCM) which has been extended to health and long-term care. “An improvement in the wellbeing (...) of patients” has already been cited as one of the common challenges and problems identified in the joint Report from the Commission and the Council “Supporting national strategies for the future of healthcare and care for the elderly” (2003). Studies show that obesity plays a definite role in the appearance of chronic diseases – high blood pressure, diabetes, cardiovascular diseases etc.– requiring long-term care and, therefore, a heavy financial drain on social protection systems. Earlier obesity prevention would, indeed, make it possible to combat the appearance of these pathologies.

On which areas related to nutrition, physical activity, the development of tools for the analysis of related disorders and consumer behaviour, is more research needed?

Knowledge relating to the determining factors of overweight, could be increased as far in advance as possible, including “in utero”. It would also be beneficial to tackle obesity not just from the perspective of people as “consumers” via the promotion of a healthy diet and physical activities. The issue should also be understood from the perspective of people as “patients”. For this reason, it would be useful to conduct or continue research in one key domain: the link between corpulence and medical consumption.

The Public Health Action Plan

How can the availability and comparability of data on obesity be improved, in particular, with a view to determining the precise geographical and socio-economic distribution of this condition? What are the most appropriate dissemination channels for the existing evidence?

It may be relevant to conduct studies by cross-referencing data available from Health Insurance funds with data from national statistical institutes. These studies (carried out nationally and/or according to country) should take into consideration the following factors: age, sex, place of residence, medical consumption, socio-professional category, pathologies suffered and, in particular, chronic diseases, so as to produce cross-referenced analyses and show that obesity is not a uniform phenomenon. In fact, when all these data are gathered together, we realise, for example, that the situation for one age group is not necessarily the same from one region to another. These statistical studies could prove to be very precious in terms of initiatives specific to one area of life.

There would be grounds for regularly circulating these studies, for example, via press releases, so as to stimulate reflection and raise awareness with regard to health professionals, national and local institutional players, patient associations etc.

Example of good practice

In Champagne-Ardenne, one Fund has coordinated, financed and piloted the implementation of a **transfrontier health trend chart** taking stock of existing data, bringing together available indicators and analysing the information obtained. The partners involved in this initiative are the General Council, the Regional Council, the “Agence régionale de l’hospitalisation” [Regional Hospitalisation Agency], decentralised Department of health services etc.

AREAS FOR ACTION

Consumer information, advertising and marketing

How can effectiveness in self-regulation be defined, implemented and monitored? Which measures should be taken towards ensuring that the credulity and lacking media literacy of vulnerable consumers are not exploited by advertising, marketing and promotion activities?

In France, the law of 9 August 2004 stipulated that drinks with added sugar, salt or synthetic sweeteners and manufactured products which are the subject of television or radio advertising must contain health-related information. It would be interesting to know whether the impact of other national laws, such as those banning food advertising on television during periods when children, who are, as we know, particularly sensitive to advertising messages, are most likely to be watching.

It is, in addition, important to stress that Health insurance schemes can only play an after-the-fact role with regard to food industry advertising. Any claim in this respect should be based on the actual nutritional qualities of the products since it would be false to lead consumers to believe that there are no good or bad foods but only good or bad diets. In extreme cases, it has been possible to detect a clear distortion of information between, on the one hand, industrialists who are seeking to hide the negative effects of their products and, on the other, consumers who have not been warned about the effects of these products on their health. One solution would, therefore, be to induce manufacturers to provide scientific proof of the content of their messages prior to putting a product on the market.

Consumer education

How can consumers best be enabled to make informed choices and take effective action?

Doubtless we should talk about “citizens” rather than “consumers”. One interesting route would be to intensify initiatives targeted at those covered by a social security scheme at a local level, in collaboration with social economy sector networks.

Examples of good practice

In Bourgogne, the Funds have developed a module called “**Alimentation Programme Prévention Santé Seniors 21**” [Health prevention diet programme for seniors], in cooperation with the “**Fédération Départementale des retraités et Personnes Agées**” [Departmental federation of retired and elderly persons]. This is an information programme – training has been compiled on good dietary practices for those over the age of 50. Individual dietary consultations were offered to volunteers. In the central region, Funds financed and spearheaded events, together with a Social Initiative Centre, as part of an educational initiative to promote a balanced diet in schools. They mobilised the educational team, involved school catering services by organising an informative conference and put on a show to get children, adolescents, professionals and the National Education Authority and parents interested.

What contributions can public-private partnerships make toward consumer education?

According to all the evidence, public-private partnerships appear to be highly effective in local initiatives.

Examples of good practices

In Auvergne, one Fund has financed and piloted a project called “**Nutrition santé sur un quartier**” [neighbourhood nutrition and health]. This project involves analysing eating habits and how food is represented, awareness raising and information about balanced diet, setting up various workshops, distributing brochures and training “adultes relais” [adults meeting certain pre-determined social requirements]. Social and medical welfare institutions, mutual benefit associations and private insurance companies, healthcare establishments and associations have all taken part in this project. In Brittany, one Fund has financed a project named “**Défi Santé Voile**” [sailing health challenge] which has mobilised municipalities, research institutes and private companies. A nutritional education programme has been implemented via breakfast meetings, the creation of an educational pamphlet, experiments with a fruit distributor within the school environment and the organisation of sports days, conferences and exhibitions.

In the field of nutrition and physical activity, which should be the key messages to give to consumers, how and by whom should they be delivered?

It is vital that the messages to be delivered are accurately targeted but without overwhelming consumers with overall bans that may result in rejection. Four key messages could, therefore, be developed as a priority: promotion of the consumption of starchy foods, promotion of the consumption

of fruit and vegetables, limitation of the consumption of sugary products and the promotion of physical activity.

In France, each of these topics has been the subject, over the last few years, of specific advertising campaigns, under the general expression “manger bouger” [Move Eat !]. These were conducted as part of the PNNS and mobilised all of its stakeholders. By way of example, in February 2004, the Department of Health, the Family and the Disabled, the French national health insurance scheme and the INPES launched the first national campaign promoting physical activity (<http://www.mangerbouger.fr>). This large-scale initiative was aimed at the wider public and, in particular, at women and the over forty fives – in consideration of the prevalence of physical inactivity in these populations – via a press, radio and tv campaign.

Example of good national practice

A media and non-media strategy was implemented in the 1st half of 2004, making it possible to promote the PNNS recommendation of “**the equivalent of at least 30 minutes fast walking each day**” and to make this a part of French daily life. Objective: to heighten awareness of the public health challenge represented by the promotion of physical activity in respect of opinion makers (with a warning in the national daily press), to play down the effort linked to physical activity (with a film focusing on physical activity as a natural everyday activity) and to encourage putting these ideas into practice.

A national radio campaign, a community-based public transport initiative (introduction of signs urging people to take the stairs rather than the escalators in the Paris Metro, use of banners on buses encouraging people to get off a stop early), initiatives conducted with companies to relay the physical activity promotion campaign by targeting the public at their workplace (in 35,000 companies with over 50 employees) by developing a series of light-hearted in-house signs encouraging people to take action (brochures to distribute, stickers to put on lifts, posters etc.) have all been used. Initiatives aimed at 150,000 health professionals (general practitioners, cardiologists, rheumatologists, endocrinologists, gynaecologists, gastroenterologists, paediatricians and dieticians received a communications tool kit as well as a “Health quiz”). Finally, initiatives have been conducted with local authorities: “Why urge your fellow citizens to take their health in hand?” (strong message to pass on: the equivalent of at least 30 minutes fast walking every day protects your health), “What role can you play?” (encouraging action by organising community-based initiatives in communes), “What tools are at your disposal?” (CDs, panels for an exhibition on the PNNS, posters urging fellow citizens to get moving, events media, signs to put up in living quarters).

A focus on children and young people

What are good examples for improving the nutritional value of school meals and how can parents be informed on how to improve the nutritional value of meals at home? What is good practice for the provision of regular physical activity in schools? What is good practice for fostering healthy dietary choices in schools, especially with regard to the excessive intake of energy-dense snacks and sugar-sweetened soft drinks? How can the media, health services, civil society and relevant sectors of industry support health education efforts made by schools? What role can public-private partnerships play in this regard?

- Widen cooperation between school medicine and teachers. To improve the nutritional value of school meals, it is also vital that public authorities communicate with the people in charge of the relevant organisations. In France, two circulars act as reminders of nutritional requirements, how meals

should be composed and the need to educate children about diet. Likewise one solution to encourage pupils to make healthy food choices in schools would be to promote the availability of certain foods in schools. In France, fizzy drinks and sugary snacks are prohibited in primary and secondary school vending machines.

- Support innovative initiatives.

Example of good multiregional practice

The French national health insurance scheme has supported the setting up of prevention, screening and obesity prevention and management networks, known as REPOPs. These have been introduced in three regions (Paris/Ile de France, Toulouse and Lyons) and their initiatives have, more often than not, been developed in nursery or primary schools. Tools have been shared and lots of conferences and meetings have been held to exchange ideas, making it possible to break down the divisions between the National Education Authority, teachers and "services de promotion de la santé des élèves" (PSE)[student health promotion services], REPOPs and "services de Protection maternelle et infantile" (PMI) [maternal and child welfare services]. These initiatives were financed by various funds including the French national health insurance scheme.

With all these initiatives, one of the dangers to avoid is that of focusing solely on children who are already overweight. Initiatives should, in the first instance, be aimed at all children so as to prevent future cases of obesity. What's more, it is necessary to diagnose all causes that may explain potential or established weight gain, over and above the simple physiological reasons (particular family event or sudden change in lifestyle). If obesity is both more consequential and more established, the efficacy of therapeutic options is more relative. Diet rebalancing requires a more sustained effort, which is why it is important to act preventatively and to divert, as early as possible, those cases at risk.

In addition, it is necessary to take into consideration the fact that the family is the preferred place for the construction of "health capital". For children, lifestyles and daily activities are important when it comes to passing on know-how in terms of "what to do and how to be" that can be either beneficial or harmful for their health. This often happens without the knowledge of the family itself as it gets caught up in daily life (meals, sleep, school, television, games, leisure time etc.). Lifestyles and habits passed on will, therefore, have an influence on each family member throughout their life.

It is, therefore, at the level of the nuclear family that the fight against a sedentary lifestyle and poor eating habits should begin i.e. eat fruit and vegetables, increase the occasions on which you expend physical energy (get on your bike instead of taking the car, take the stairs etc.). It is up to all members of the family to take up this challenge, not just the ones that may be showing signs of being overweight. Since parents are an example to their children, everyone must adopt the same behaviour.

This is why a family environment that is alert to the dangers of obesity and aware of good practice will be the best means of slowing weight gain. In addition to national campaigns, local initiatives aimed at families must be supported. Community-based initiatives with specific, but accurately identified groups, will achieve results that are at least equivalent to those achieved by more global awareness raising measures.

National example of good practice

A national competition “**When it comes to the family diet, I would like balance!**” has been launched in rural areas. Recognising the fact that families are skilled when it comes to teaching their own children, the initiative calls upon families to use their experience to raise the subject of diet within the family and to urge them to write their own story about “food and physical activity within the family” as they live it or could live it in their daily life. The aim is to open up a direct dialogue with families about their nutritional habits and behaviours and, from their description of daily life, get them to talk about their own behaviours, as well as the way in which they pass these on to their children, in a workshop environment. Their participation is sought in the form of a game resulting in the creation of an album of cartoons, drawn from “scenes” suggested by the families who have now become joint script-writers, on diet and physical activity using their daily life as a reference. The families will describe, then write, their own stories about nutrition. A national jury will select seven scenarios. Illustrated by a cartoonist, they will be compiled and published in an album between now and the end of 2006. In addition to publication of this album, this competition will make it possible to develop information and awareness raising initiatives, aimed at both parents and children with the aim of promoting healthy behaviours, and at health, education and social welfare professionals.

Local example of good practice

In Normandy in 2004, the Funds launched an appeal for projects aimed at rural areas entitled “**Ose la forme, bouge en famille**” [dare to show your figure, move as a family] which aimed to support parents who get involved in a collective initiative to preserve children’s health capital. Twelve initiatives focused on diet and practising sports within the family received a prize worth € 1,000.

- Special attention should be given to the elderly. Focusing on young people must not leave certain types of populations by the wayside, the elderly being at the forefront. The question of obesity is, in fact, highly relevant for this age group – in particular, after retirement – and preventing obesity in the oldest members of society would also make it possible to prevent the appearance of chronic diseases.

Example of good practice

A national action plan aimed at the elderly entitled “**Seniors, soyez acteurs de votre santé**” [**Seniors, take an active role in your health**] has been launched in rural areas. Healthy lifestyles and, consequently, diet and the prevention of obesity, are at the heart of this campaign to raise awareness in respect of both the insured and the prescribers. The “INPES” and the “Fédération Nationale des Aînés Ruraux” [National federation of the rural elderly] have come together for this initiative. On the ground, cantonal conferences are being organised on the proper use of medication and on the key elements of “growing old well”. These are followed by the distribution of a diary that combines various pieces of advice and guidelines for healthy living. One example is an initiative that has been conducted throughout the territory by Funds to set up conference discussions, including one entitled “**Pas de retraite pour la fourchette**” [**No retirement for the fork**].

- Develop a gender-based approach. This means recognising that there are roles that are played more by the father or by the mother and that these have to be taken into consideration, either for modification or reinforcement. In lots of regions and/or socio-professional environments – for example, populations of immigrant origin, rural families, homes where the mother does not work etc.–, the mother in the family continues to be the centre of reference around which lots of family habits are built, in particular, in terms of nutrition. She is also the main dictator when it comes to food, including during

pregnancy, and plays a major role in the preparation of meals and the purchasing of foodstuffs etc. If initiatives aiming to help children directly to prove effective, since they correspond to specific requirements and problems, the implementation of initiatives aimed at women would seem, therefore, to be another possible means of reaching children indirectly. The gender-based approach can also be practised using specific initiatives aiming to increase the involvement of the father in these aspects. All of these initiatives are disseminated through local channels. Sometimes, although these channels are quite old they can, nevertheless, still boast great modernity, i.e. cooking courses, local meetings or evening classes.

Building overweight and obesity prevention and treatment into health services

Which measures and at what level, are needed to reinforce the promotion of healthy diets and physical activity in health services?

The messages diffused by the PNNS and by all the skilled players when it comes to health education and prevention are proving to be effective if families take them on board. It is not always obvious to these health professionals that questions relating to healthy lifestyles and eating habits need to be tackled. This is why primary care doctors can play an effective role, due to the fact that they enjoy a much closer relationship with their patients.

Example of good practice

In France, the national medical services contract dated January 2005, signed by general practitioners and specialists and by the National Health Insurance Scheme Funds, charged the latter with the task of providing preventive care (screening, health education etc.) and contributing to health promotion. The implementation of coordinated care paths has, therefore, created an opportunity to involve doctors in a planned and consistent prevention initiative with public health goals. This initiative covers all age groups and gives meaning to the primary care doctor description, even for those who only consult a doctor occasionally. Obesity prevention falls well within this framework, since the primary care doctor is the main player when it comes to two mechanisms, one in the area of prevention, the other in the area of “Long-term illness” (ALD), a term which refers to the notion of chronic disease. The primary care doctor should, in fact, encourage a better diet so as to prevent obesity, and this should be via several actions: a systematic initiative for all relevant patients, an initiative organised for a limited period in accordance with individual risks detected, information, awareness raising and mobilisation of patients and, if necessary coordination with multidisciplinary third parties and, finally, keeping medical records fully documented with each of the actions taken and their results.

To help with these tasks, French national health insurance funds will put several levers in place: the provision of tools (information, risk-related awareness raising, risk assessment, information about what is on offer with regard to community-based prevention, information on patient reimbursements), feedback (on the primary care doctor’s preventive medicine practice, on results observed, both individually and collectively, on patient participation in programmes), the development of recognised training on the subjects of prioritised prevention (detection and assessment of risk factors, prevention practices, management strategy) and the promotion of professional practice assessment by building prevention practices and financial incentives into a public health contract.

Socio-economic inequalities

Which measures, and at what level, would promote healthy diets and physical activity to population groups and households belonging to certain socio-economic categories, and enable these groups to adopt healthier lifestyles? How can the “clustering of unhealthy habits” frequently adopted by certain socio-economic groups be addressed?

As has already been raised above, the family is the preferred place for the construction of health capital. Local, targeted initiatives can, therefore, be aimed, as a priority, at less advantaged socio-economic categories.

It is advisable to give less advantaged populations the information required for them to feed themselves a balanced diet as cheaply as possible. It is, therefore, preferable for health structures to target these populations as a priority, especially with regard to obesity prevention. In France, the CES provide a periodic health check for all those covered by national health insurance and their families. These health checks are offered as a priority to certain categories: the unemployed, those in receipt of the “Revenu Minimum d’Insertion” [social/occupational integration minimum income], the young unemployed, retired people, those who take no exercise, volunteers covered by the National health insurance scheme, populations exposed to particular risks, those in the margins of the care system or not benefiting under legislation, from a regular medical check-up (university medicine, occupational medicine etc.). In addition, the creation in France of reference centres, in the form of eight inter-regional centres specialising in obesity, will also target these populations and households belonging to certain less advantaged socio-economic categories. These centres should make it possible to group together multidisciplinary teams (dietitians, psychologists, psychiatrists, kinesiologists etc.).

Examples of good practice

In Aquitaine, one Fund has launched an initiative called “**Health comes with eating**”. It aims to inform about diet and physical activity and to provide health education for women in precarious situations or with social integration difficulties, school children and members of management responsible for relaying information, via the mounting of an exhibition in schools and the preparation of a balanced breakfast in primary schools. In Normandy, one Fund has set up a project entitled “**Nutritional education for those in precarious situations**” (i.e. those in integration schemes or identified individually and brought together in groups). This involves leading a group of people in a series of 5 workshops entitled “the pleasure of eating - cooking simple, economic (7 Euros/meal for 5 people) and varied meals”. These workshops are jointly organised and led (dietician + integration scheme manager or social worker in charge of the group defined as above).

Cooperation beyond the European Union

Under which conditions should the Community engage in exchanging experience and identifying best practice between EU and non-EU countries? If so, by what means?

The Community may support initiatives with an international dimension, undertaken by national players in the relevant field, support which may, in particular, take the physical form of assistance with dissemination.

Example of an initiative with an international dimension

Within the scope of their contribution to the activities of the International Social Security Association (ISSA), and within a transnational group bringing together representatives from different continents so that the issues raised are not just those relating to industrialised countries, the CNAMTS and the MSA have chosen to work with other French organisations on the topic of optimisation of chronic disease management. The aim is to initiate an international cooperation project between social security organisations which goes beyond simply carrying out studies and actually confronts concrete national experiences. This will result in the setting up of a transnational technical working party. This working party will make it possible to provide new and innovative responses to questions raised in many countries. The objective would be, in addition to exchanging information and analysing related successes and failures, to be in a position to issue recommendations and advocacy that can be reproduced in all the relevant countries. This project will require technical and operational expertise, including both medical and economic dimensions of the problem. It will be necessary to analyse the question of chronic disease from the point of view of health management.

CONCLUSION

The CNAMTS and the CCMSA share the analysis made by the Commission in its Green paper. Starting with the double deal that obesity is a pathology that affects all of our societies and that the response given cannot be solely from a health perspective, it would seem necessary to mobilise all the national and local players i.e. health professionals and populations of course, but also social protection agencies, associations, institutional managers, teaching bodies, the food industry etc. These are actions involving all those who will obtain the best results, actions based on concrete and local awareness raising programmes revolving around the promotion of a balanced diet, physical and sporting activities and therapeutic education.

The importance of good links between community, national and local levels can therefore be understood. This last point is of vital importance, since local initiatives are best at creating a dynamic and positive spirit in populations with regard to a health problem that is still little understood. These initiatives must not just rely on bans, but on initiatives being taken by both individuals and families themselves. They must take their health into their own hands. Local health and welfare initiatives raise awareness of the influence of the social link, of a healthy lifestyle and diet on the weight of the individual. They also contribute to organising local events in regional areas, moving towards improved social and territorial cohesion. These initiatives also make it possible to reduce the number of messages being relayed. They serve as sounding-boxes for other parents or other local associations and mobilise the education sector. Finally, since there are a great number of regional disparities when it comes to obesity, local initiatives are even more effective because they can be adapted to what is really going on in the local area.

As well as having an important role to play in terms of raising awareness and communication, national and community players will, therefore, be able to give their support to these local nutrition-related projects. Partnerships with local authorities should be encouraged.

All the actions taken by National health insurance schemes will not, however, be enough on their own to serve as a defence against the explosion of obesity. Encouraging European populations to adopt a healthy diet and take more physical activity is only acting after the fact. The fight against obesity is not just a simple problem of public health, it also has an industrial, commercial, economic, societal and, consequently a political, dimension.

It is, therefore, within this framework that the CNAMTS and the MSA will follow with interest the reactions evoked by the Green paper and hope that the Commission will put mechanisms in place to support local and national initiatives.

The stakeholders in the debate wish to point out that, since its creation in 1945, the French social protection system has sought to respond to high demands from the French population in terms of solidarity and security. For over a half century now, it has been developed around missions and values that have become the cement of French society, i.e. solidarity, equality, equity, quality and universality. This system, recognised by citizens, today plays a vital role in contributing to their well-being. It has been able to compel recognition as much for being a primordial factor of social cohesion as for its role as a stabiliser of economic balance sheets. Under this system, the mandatory French national health insurance scheme aims to provide the entire population residing in France with regular cover against all the financial repercussions of sickness in general, but also maternity, disability, occupational illnesses, accidents at work or death. This cover applies irrespective of age, professional status, income or state of health of the individual at the point of entry into the scheme.

La Caisse Nationale d'Assurance Maladie des Travailleurs Salariés – CNAMTS

Covering 84 % of the population, the main Health insurance fund, an insurer with joint and several liability, aims to make it possible for all those covered by social insurance and their families to access care of the highest possible quality. It functions as a network, made up of decentralised, autonomous bodies which provide a public service. To do so, it acts as part of a chain linked to other players: on the one hand the Government and its decentralised authorities and, on the other, health professionals, public and private hospitals and companies. In order to perform its duties, which extend on an operational level to reimbursement for care, compensation for loss of earnings, disease prevention and health and welfare initiatives, the 'Assurance maladie' is organised into several levels.

A public institution of an administrative nature, the Caisse Nationale d'Assurance Maladie des travailleurs salariés (CNAMTS) heads 250 Health insurance agencies. It is responsible for the provision of finance for two separately managed areas, on the one hand, health insurance, maternity pay, disability and death and, on the other, insurance to cover accidents at work and occupational illnesses. For this reason, it is consulted and gives an opinion on all draft laws and regulations.

President: **Michel Régereau**, Director: **Frédéric van Rookeghem**, Website: www.ameli.fr

La Mutualité Sociale Agricole – MSA

Being the largest professional social protection scheme in France, the Mutualité Sociale Agricole (MSA) manages mandatory social protection for the entire agricultural profession: operators, employers, salaried workers and their families, i.e. over 4 million people. It is this population's only contact when it comes to social protection as a whole: health, family, retirement, recovery, social work, services.

The national rung of the MSA, the "Caisse Centrale de MSA" (CCMSA) is an organisation governed by private law and is responsible for a public service mission. It contributes, with its network of funds, to the implementation of agricultural social policy defined by the Minister of Agriculture and represents the MSA in respect of third parties and, in particular, public authorities.

The MSA embodies, in its actions, the values of mutualism: solidarity, responsibility, democracy. Its action is based on a dense local network which enables it to get as close as possible to its members and to offer them appropriately tailored responses. A force for making proposals to public authorities and a force for innovation, the MSA permanently seeks to express its capacity to respond to new environmental demands and the needs of agricultural and rural populations. Managed by representatives elected by members, the MSA continues to be an indispensable player when it comes to social protection and its development. In 2005, the MSA was behind the setting up of ENASP, the European network of agricultural social protection systems.

President: **Gérard Pelhate**, Director general: **Yves Humez**, Website: www.msa.fr