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European developments in labelling allergenic foods

More still needs to be done

The new European Union directive on food labelling, requiring manufacturers of packaged foods to detail clearly the presence of certain known allergens, comes into effect later this month. This welcome legislation will directly benefit the many people who experience adverse reactions to foods and could save lives, given the increasing numbers of people with IgE-mediated food allergy who may develop anaphylaxis after even minimal exposure. Similar initiatives are being pursued in the United States, Australia, and New Zealand, indicating that the plight of those who live with the daily threat of allergic reactions to foods is, in some countries at least, at last being taken seriously.

Manufacturers of packaged foods containing any of the 12 major allergens (see box) will, as of 25 November this year, be obliged by the European Union regulations to label these ingredients. Importantly, this new legislation removes the previously unhelpful “25% rule,” which exempted labelling of constituent ingredients if they amounted to less than 25% of the final product, thereby resulting in an appreciable risk of inadvertent exposure to, for example, nuts in chocolates. Even use of the smallest quantities of these 11 ingredients will now require labelling. Moreover, many manufacturers have already begun implementing this new requirement, consumers need to be aware that stocks of products manufactured and packaged before 25 November may continue to be sold. It is also important to note that other ingredients of compound preparations may in some cases be exempt from labelling if they constitute less than 2% of the final product. Given that sensitisation may be increasing to, for example, certain stoned or exotic fruits such as apples or kiwi fruit used in small quantities in desserts or jams, this is worrying.

More concerning, however, is the exclusion from these EU regulations of freshly prepared foods, because
Primary care trusts: do they have a future?
Yes as guardians of public sector commissioning; no as service providers

Primary care trusts (PCTs) are the local statutory organisations in the English NHS responsible for improving public health, providing primary health care, and commissioning secondary and tertiary care services for populations of around 250 000 people. When created in 2002 primary care trusts were intended to become powerful local purchasing agencies, rooted in primary care, and well placed to integrate primary health care, community services, and hospital care.1 In the international context, one of the most notable features of primary care trusts has been the continuing belief by NHS policy makers in England in the value of integrating the purchasing of health care with the delivery of primary care. However, over the past year or more the view that primary care trusts are failing to “punch their weight” in the health system has gained currency, in particular in relation to their supposed inability to achieve strategic change in secondary care.2,3

This has led to renewed interest in strengthening the commissioning function in the NHS. The assumption is that there will be fewer primary care trusts and that these will concentrate on funding and contracting for primary care, supporting the purchasing of other services led by practice based commissioners, and divesting themselves of their provider responsibilities such as community nursing and health visiting.3 This is driven partly by the perception of the trusts’ “failure” as commissioners. But it is arguably driven more so by policy makers’ encouragement of a greater range of providers of primary care beyond traditional NHS general practice and the resultant competitive pressures being applied to the NHS, in particular by the private healthcare sector.4

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