



A CAP on Health?

The impact of the EU Common Agricultural Policy on public health



FACULTY OF
PUBLIC HEALTH

A report by the Faculty of Public Health

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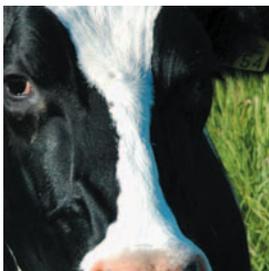
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The impact of the EU Common Agricultural Policy
on public health

A report by the Faculty of Public Health

Principal author: Dr Christopher Birt

foreword



Our health is very much affected by our everyday diet but our choice of food and drink is heavily influenced by agricultural policy.

The European Union (EU) Common Agricultural Policy (CAP) has been the dominant influence in this respect for over 40 years. The EU spends 46% of its budget on the CAP - almost 55 billion Euros worth of food subsidies - and, through a variety of measures affecting food availability and price, has had profound effects on the health of the population. Some estimates suggest that the massive CAP support to dairy and beef farmers, compared to that given to fruit and vegetable growers, leads to thousands of premature deaths from heart disease, stroke and cancer across the EU every year.

This report outlines the development of the CAP, identifies areas in which current agricultural policies are damaging to health, and explains how they need to change to reverse these effects.

Discussions on CAP reform are scheduled to start in 2008. I hope that this publication will contribute to the debate and that policymakers take on board the public health implications of their decisions. Nothing less than the future health of the entire European community is at stake.

Professor Rod Griffiths CBE
President of the Faculty of Public Health

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executive summary

- For over 40 years the Common Agricultural Policy (CAP) has subsidised massively the production of dairy products, red meat and sugar. At the same time the policy has resulted in the systematic destruction of large quantities of fruit and vegetables.
- Although a number of factors influence diet, people's choice of food is largely determined by price and availability, particularly for people on low incomes. The widespread availability of relatively cheap milk, butter, cream and cheese, and of meat and meat products, has contributed largely to the high consumption of saturated fats by the UK public, particularly in low income households. Cheap sugar, ubiquitous in sweet snacks and drinks, is also more likely to be consumed by people on low incomes. By contrast, the relatively high price of fruit and many vegetables is reflected in the lower consumption of these foods by lower income groups.
- High intakes of saturated fat and sugar, and low consumption of fruit and vegetables, are factors known to be associated with a number of major diseases and disorders, most notably obesity, high blood pressure, type 2 diabetes, and premature coronary heart disease and stroke. These problems – all potential killers – are common throughout the EU, particularly in the UK, and are generally more prevalent in people on lower incomes. It has been estimated that since CAP's creation hundreds of thousands of premature deaths could be linked to the adverse effects of CAP subsidies.
- To reverse the historical impact of CAP policies on nutritional health, and to narrow the gap in health inequalities, the Faculty is calling on EU policymakers to:
 - **reduce subsidy of beef** while encouraging more lean beef production;
 - **reduce subsidy of dairy products** and to **convert excess dairy fat into industrial products such as fuel and lubricants** rather than food products;
 - **ensure only low fat dairy products are subsidised for provision to the not-for-profit sector**;
 - **increase the production of monounsaturated and polyunsaturated vegetable oils**;
 - **concentrate CAP subsidies on the production of fruit and vegetables**;
 - **increase the availability of fruit and vegetables to the not-for-profit sector** through subsidies;
 - **continue to encourage the cereal sector to produce food for human consumption.**
- Such reforms would need to be implemented gradually to avoid disrupting rural economies and to continue protecting rural environments, ensuring food safety and preventing animal cruelty.

The European Union Common Agricultural Policy (CAP) was introduced in 1962 to provide an equitable framework for supporting the agricultural economies of the six original member states¹ and to help ensure that food supplies were widely available at affordable prices. These basic aims have continued to the present day and the policies that have supported them have, in the Faculty's view, had a profound effect on public health.

The food we eat is one of the most significant determinants of our health and is widely recognised as playing an important part in the development of many diseases and disorders including the rising prevalence of overweight/obesity, type 2 diabetes and cardiovascular diseases, such as coronary heart disease and stroke. Nutritional intake in younger life can largely determine our health in later life, and access to a choice of good quality, affordable food providing a nutritionally balanced diet is fundamental to public health.

There are many influences on diet, including cultural, social and economic factors. Price and availability are also important determinants. For example, historically in northern European countries (including the UK), cattle farming has been a longstanding tradition, shaping the diet into one predominated by dairy and beef products. This contrasted with counterparts in southern European countries who have had no such tradition and who are significant consumers of fruit, vegetables, poultry and fish – the so-called 'Mediterranean diet'. However, with the spread of large supermarket chains across Europe over the

past few decades, these differences in diet have become blurred.

Instead, the most significant determinants of food choice today are price and availability. There is good evidence that the contents of the UK family shopping basket is largely influenced by CAP through the provision of financial support in the form of subsidies which favour one food group over another in terms of price and availability – most notably dairy and meat production over fruit and vegetable production. This has consequences for the average UK diet and therefore for public health.

Using the UK as a case study, this report aims to show how CAP food policies are likely to have contributed to current public health problems, and strongly recommends

There is good evidence that the contents of the UK family shopping basket is largely influenced by CAP through the provision of financial support in the form of subsidies which favour one food group over another



¹Belgium, France, Italy, Luxembourg, the Netherlands and the Federal Republic of Germany formed the original European Economic Community (EEC).

that the forthcoming discussions on the reform of CAP, scheduled for 2008, should put public health considerations at the forefront of decision-making.

Historical background

In the immediate aftermath of World War II, severe hunger and famine were widespread throughout many parts of Europe, particularly (among the original EEC members) in the Netherlands and Germany. The continuation of food rationing in the UK for several years after the end of the war in 1945 aimed to ensure that any excess food production by European countries could be diverted to those countries most affected to alleviate suffering and prevent starvation.^{1,2,3}

When the EEC was formed in 1957, one of its founding principles was that Europe should never again suffer such food shortages. It was envisaged that this would be achieved through an informal 'contract' between the member states which would bring an end to almost all rural poverty and offer a route to eventual prosperity. This 'contract' formed the basis for the establishment in 1962 of the Common Agricultural Policy (CAP).

The objectives of CAP were, and still are, to:^{4,5,6}

- increase agricultural productivity by promoting technical progress and expansion of agriculture to maximise and support rural employment to prevent rural depopulation;
- ensure a fair standard of living for the agricultural community, in particular by increasing the individual earnings of

those employed in it;

- stabilise markets;
- assure the availability of supplies;
- ensure that supplies reach consumers at reasonable prices.

These objectives are pursued mainly through:

- providing direct financial support (in the form of production subsidies) to farmers who produced certain crops or other farmed products, eg. milk and beef;
- guaranteeing minimum market prices, (also known as a 'floor price') at which level the European Commission (EC)ⁱⁱ would intervene by buying produce at that price to guarantee an adequate return to farmers.

However, a consequence of these objectives has been overproduction – particularly of dairy products – resulting in so-called 'mountains' and 'lakes' of unsold food and drink. As a result, the EC has, in recent years, been required to dispose of such excess production. This has been achieved through a variety of means, many of which are counterproductive to achieving good public health:⁵

- export subsidies, enabling food to be sold outside the EU at world market prices;
- subsidies to the 'not-for-profit' sector within the EU, enabling sale at cheap prices (eg. of full cream milk to schools, or of butter to hospitals);
- subsidies to allow sale at cheap prices to the food industry (eg. of butter fat for pastry production);
- destruction of seasonal products that

cannot be easily stored, to avoid flooding the market and a price crash (this has applied mainly to fruit and vegetables).^{5,7}

Whilst established on the basis of the sound public health principles of preventing food shortages and rural deprivation, there is evidence that CAP has become increasingly detrimental to public health throughout the EU as health needs have changed. Some of the main threats to public health in most of Europe today are diet-related disorders such as obesity, hypertension (high blood pressure), type 2 diabetes, cardiovascular disease (eg. coronary heart disease and stroke), and some cancers (eg. bowel cancer).^{8,9} These disorders are associated with a number of nutritional risk factors including a high

intake of energy-dense foods and foods high in saturated fats, and a low intake of antioxidants and various micronutrients.

The main elements of the CAP which impact on these nutritional risk factors concern the provision of milk, beef, fruit and vegetables, sugar and cereals.^{5,10} This brief report therefore focuses on these agricultural sectors, and does not cover other sectors of potential relevance to health, such as tobacco or viticulture (eg. wine making).

NOTE: Evidence suggests beneficial effects of fish oil on health.¹¹ However, the fishing industry and the marketing of fish comes under the Common Fisheries Policy rather than CAP, and is therefore beyond the remit of this report.

milk

Milk has a long tradition, particularly in northern European countries, of being seen as a healthy, nutritious food which is an important dietary source of calcium, especially for children. Since its establishment, the EC has provided subsidies to farmers producing milk, with the greatest premiums paid on a 'per cow' basis for milk with the highest fat content. This 'per cow' subsidy provided incentives for more farmers to enter dairy farming and to maximise their production, resulting in over-production of both dairy produce and beef. However, in 1984, steps were taken to limit this over-production through 'capping'

– production quotas for individual producers were introduced along with fines for those who exceeded them. Nevertheless, production of dairy fat in the EU has been (and continues to be) significantly higher than would be the case if producers had to sell their dairy products at world market prices. The scale of excess production has been further aggravated by a reduction in consumer demand following successful drives to encourage people in Europe to buy low-fat dairy products in the interests of better health.

The EC is legally bound to dispose of all

excess dairy fat and milk. Much of this excess milk is converted to milk powder for sale outside the EU, potentially shifting the health burden of excess dairy fat to other parts of the world. (This surplus also has the effect of reducing prices, undermining domestic producers in developing countries.) The other main method of disposal involves redirecting dairy fat back into the European diet, in two ways:⁵

- 'Hidden' methods involve using subsidies to encourage the food industry to use 'cheap' dairy fats in manufactured pies, pastries, cakes and biscuits.
- 'Direct' methods involve subsidising milk and butter for use by the 'not-for-profit' sector, eg. schools and hospitals.

Potential impact on nutritional health

Milk and milk products as a group are the main source of saturated fat in the average UK diet.¹² A diet high in saturated fat predisposes the individual both to cardiovascular disease and to obesity. The World Health Organisation and Food and Agriculture Organisation recommend a total fat intake of between 15-30% as a proportion of energy intake (ie. calories consumed), with 10% or less made up of saturated fat.¹³ Scotland and England have set interim targets for total fat (35% of food energy intake) and saturated fat (11%).^{14,15} Average saturated fat intake in the UK is 13.4% for men and 13.2% for women.¹² In children, total fat intakes are similar to those of adults, but with a higher saturated fat intake: 14.2% and 14.3% for boys and girls respectively.¹⁶ Milk and milk products account for 14% of total fat intake and 24% of total saturated fat intake in the average adult's diet in the UK.¹²

The highly successful CHD prevention project in North Karelia, Finland, has shown that reducing the mean population serum cholesterol level has been the main contributor to the considerable reduction in CHD mortality since the mid 1970s. It was also found that a reduction in the consumption of dairy fat contributed more than any other change to this reduction in the mean population serum cholesterol level.¹⁷

Research in Sweden also suggests that in schools accepting the EC's subsidised, full-fat, school milk, each child consumes, per year, on average an extra 1.5kg of saturated fat compared to their intake if they had drunk skimmed milk, and that this is likely to contribute to increased incidence of CHD and increased prevalence of obesity in the next generation.^{5,18}

The fat content of milk has risen steadily since 2000 and is projected to continue to rise until 2009.¹⁹

CAP subsidies for beef cattle producers have been closely related to those for the dairy sector - both having been on a 'per cow' basis (see 'Milk' above). As with dairy production, subsidies have made beef production very attractive to farmers, and generally they have earned substantially more per cow from subsidy than from sale of cattle at markets. In recent years, this production has also been supplemented by increasing amounts of beef imported into the EU. This has resulted in large quantities of cheap beef being made available to the European consumer.²⁰

Large-scale cattle-rearing requires large quantities of cattle-feed (soya, maize, etc), which is generally grown and supplied by developing countries, where both land and labour cost considerably less. This has implications for public health in these countries (eg. diversion of land away from local human food production, so forcing up local food prices). Such cheap cattle food, together with CAP subsidies have, in effect, provided a 'double subsidy' to cattle farmers, encouraging even more overproduction. However, the EC must now by law prevent a repetition of the disastrous 'beef mountains' of the 1980s - therefore excess production is either exported (with an export subsidy to facilitate this), or sold at greatly reduced prices (again, facilitated by subsidies) to the food industry. This provides a basis for the mass production of cheap beef products such as burgers.

Potential impact on nutritional health

Red meat, such as beef, and meat products derived from it, are a significant source of saturated fat in the UK diet.¹² Much of the potential impact on health is as described under Milk (see p.8). There is also a significant link between high meat consumption and bowel cancer.²¹ In the UK, the average consumption of meat is 90g/day (cooked weight). It was recommended that this level of consumption should not increase, and that individuals consuming more than this should reduce the amount of meat they consume - particularly high consumers (those averaging 140g/day or more).²² However, the abundance of readily available, cheap meat and meat products means that consumers are encouraged to buy more of these foods.

Meat and meat products contribute nearly a quarter of the total amount of fat (23%), and saturated fat (22%), in the average UK adult diet.¹² Over-consumption of calories and saturated fat is linked to rising obesity and serum cholesterol levels – increasing the risk of high blood pressure, type 2 diabetes, coronary heart disease, stroke, and some cancers such as bowel cancer.

Due to the importance placed on dairy and beef production by CAP, few production subsidies for fruit and vegetable growers have been provided. Instead, support has usually been in the form of price guarantees; whenever the price falls below an agreed 'floor' price, the EC buys the remaining crop at the guaranteed price. Products are also withdrawn from the market to help keep prices high.

Traditionally, the EC has provided subsidies for the destruction of withdrawn/surplus products, on the grounds that they are rapidly perishable (and that this approach is ultimately cheaper). Although such destruction has diminished in recent years – to bring production more in line with demand and to address some of the environmental questions arising from the destruction of large quantities of produce (eg. the need for landfill) – very large quantities of fruit and vegetables are still disposed of in this way each year. For example, in 2000/01 approximately 1.1million tonnes of fruit and vegetables were withdrawn (for which producers were compensated), of which 70-80% was destroyed (in contravention to regulations which stipulate that withdrawn produce should be, as a first choice, used for human consumption).⁵ The remainder was either used for human consumption (eg. through 'surplus food schemes'), for animal feed, or converted (for example, into alcohol) via distillation. Nectarines and peaches were by far the biggest groups withdrawn from the market.

Ironically, the EU is the largest importer of fruit and vegetables, and the second largest exporter of fruit and vegetables, after the US.²³

In the absence of producer subsidies, there has been little encouragement for expansion of fruit and vegetable production; use of land for dairy, beef, sugar or cereal production has generally been more profitable for farmers. However, the establishment of a new combination of producer subsidies, reduction of price minimum guarantees, and the ending of the withdrawal of fruit and vegetables from the market should encourage increased production and consumption.

cereals

Cereal production has been given considerable price support by CAP. Although EU cereal production has remained steady over recent years, an increasing proportion has been diverted for use as animal feed - a worrying development given that cereals in the human diet can help to reduce both coronary heart disease and obesity by replacing high fat foods.

It is also noteworthy that several of the more recent EU accession states are substantial grain producers (for both human

Potential impact on nutritional health

Consumption of fruit and vegetables at recommended levels of intake can reduce the risk of coronary heart disease and some cancers, including bowel cancer.²⁴ This may be due to the protective effects of micronutrients, such as Vitamin C, fibre content and antioxidants. The World Health Organization has estimated that about 31% of ischaemic heart disease, 19% of gastrointestinal cancer and 11% of strokes are attributable to low fruit and vegetable intake.⁹ In the UK, guidelines recommend at least five portions of fruit and vegetables per day²⁴ – current consumption is three portions per day.²⁵ In southern European countries, where consumption of fruit and vegetables is higher than in northern European countries (which have a higher consumption of dairy and beef products), death rates from coronary heart disease are lower and life expectancy is greater. CAP policies towards the production of fruit and vegetables can also contribute to health inequalities (see p.14).

Consumption of locally produced fruit and vegetables also has environmental benefits, eg. low 'food miles' (the distance food has travelled to reach supermarket shelves) mean a reduction in fuel use and thus a reduction in carbon dioxide production.²⁶

and animal consumption) and agriculture features as a major component of their national economies. Accordingly, continuing EU support to the cereal sector could contribute significantly to stabilising rural economies in these countries, and even to preventing rural depopulation. However, present CAP subsidies in the accession states are provided at much lower rates than those available to farmers in the longstanding EU member states.

Potential impact on nutritional health

Grains provide starchy carbohydrate, fibre, protein and micronutrients, including vitamins and minerals. Cereals, rice and breads, depending on how they are prepared and consumed, can partially replace high fat foods, helping to prevent both coronary heart disease and obesity. The higher fibre content of wholegrain cereals can help to both lower cholesterol and protect against bowel disorders. Cereals and cereal products provide about one third (31%) of our average energy intake. It is recommended that half our daily food energy intake should be made up of complex (starchy) carbohydrates, such as cereals, potatoes, bread, rice or pasta.¹²

The CAP sugar regime has been constructed to maintain sugarbeet production in the EU, particularly in northern European countries such as the UK and Germany. Without it, member states would have to rely much more on imported cane sugar.

Within the EU, an artificially 'high' price for sugar is maintained – three times the world market price. This ensures that sugarbeet farming and refining are financially viable. More sugarbeet is produced than is actually needed within the EU and most of the excess is exported, requiring export subsidies to enable the EU's high sugar price to be

lowered to match the world market price. However, the scale of European over-production is so substantial that these subsidised sales depress the price of sugar on the world market. This has the effect of making cane sugar production in the richer end of the developing world (eg. in South Africa) scarcely viable. However, the system has been substantially reviewed.

Notwithstanding this, within the European economy the price of sugar to the food industry and consumer in real terms, compared to most other food ingredients, is relatively low.

...cheap sugar, used as a bulking agent as well as a sweetener in a wide variety of both savoury and sweet food and drink, leads to over-consumption and contributes to rising levels of overweight and obesity.

Potential impact on nutritional health

Sugar is energy dense and the widespread availability of cheap sugar, used as a bulking agent as well as a sweetener in a wide variety of both savoury and sweet food and drink, leads to over-consumption and contributes to rising levels of overweight and obesity.²⁷ Frequent snacking with sugary food and drinks (particularly carbonated soft drinks) is also associated with a higher risk of dental caries and gum disease.²⁸ Excessive consumption of sugar can contribute to health inequalities – for example, the prevalence of dental caries is higher in children from disadvantaged backgrounds. This could be due to foods which are high in sugar being more affordable than other, more expensive, healthier options such as fresh fruit and vegetables.²⁹

A daily intake for an average adult of 'free sugars' (ie. those added to cooking etc) should be less than 10% of total daily energy intake.¹³ Currently, the average for boys and girls is 16.7% and 16.4% respectively. Confectionery and fizzy drinks are the main sources.³⁰



CAP expenditure v nutritional health

CAP has an annual budget of approximately €55,500m, around 46% of the overall European Union budget.³¹ The two charts below (figures 1 and 2) provide an interesting comparison between the

WHO's dietary targets for healthy eating and the amount the CAP spends on supporting the broadly similar agricultural groups.

Fig 1:

Dietary targets WHO/FAO (%)

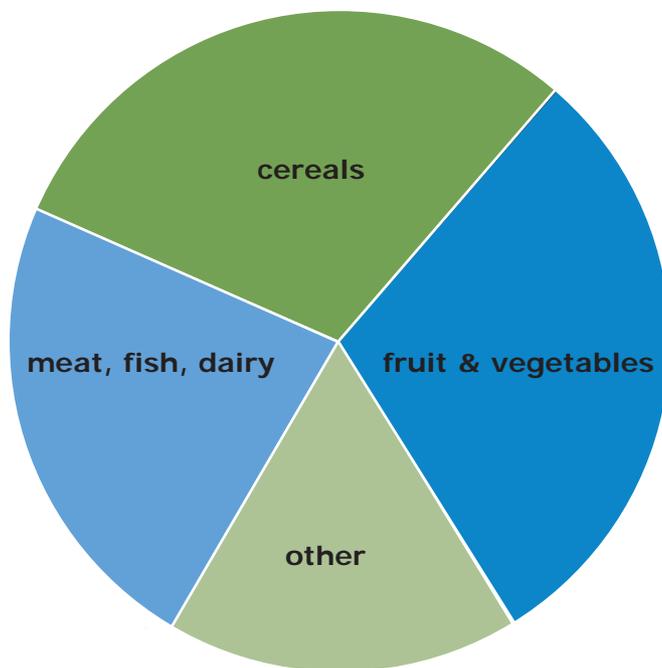
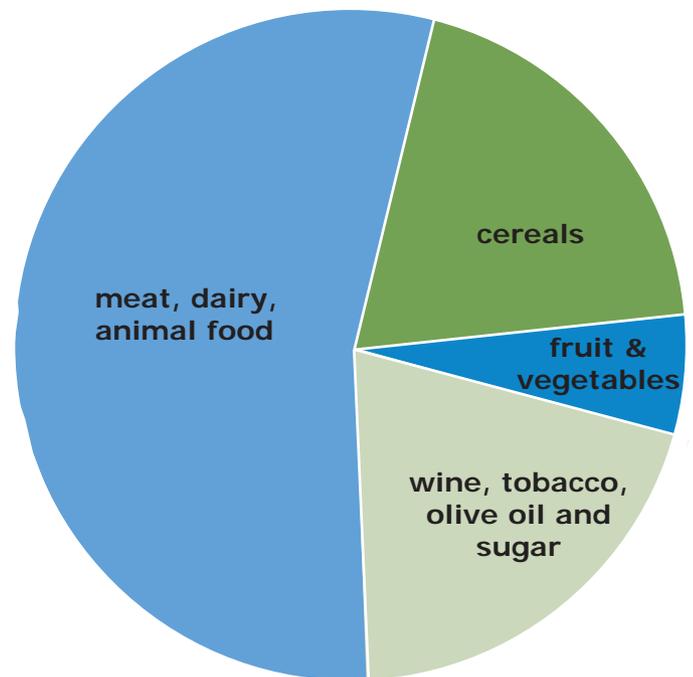


Fig 2:

Common Agricultural Policy budget (%)



health inequalities

The most striking effect of CAP policies is likely to have been on health inequalities. By heavily subsidising milk and beef, they ensure that foods with high saturated fat content are more affordable for people on low incomes. By contrast, fruit and vegetables, which receive little support from CAP, are relatively expensive. Cheap fatty

and sugary foods, and expensive fruit and vegetables, contribute to food poverty, ie. "the inability to afford or have access to food to make up a healthy diet."³⁵ This inequality in diet predisposes to inequality in diet-related disease – people on lower incomes have higher rates of coronary heart disease, obesity and diabetes.³⁶

In the UK, the gap in life expectancy between those in the professional socioeconomic groups and those in unskilled manual socioeconomic groups has increased in the last 30 years.³⁷ Rates of premature death from coronary heart

disease is more than two times higher in female manual workers than in female non-manual workers. For men, the difference is much greater.³⁸ There are also significant

inequalities in diet-related diseases across different socioeconomic groups.³⁹

Prevalence of overweight and obesity, particularly in women and children, are significantly higher in 'semi-routine and routine' (unskilled manual) households than in 'managerial and professional' households.³⁹ Prevalence of certain cancers, such as bowel cancer, are higher in disadvantaged groups. Survival rates are also lower.^{29,40} Dental caries is also more prevalent in children from disadvantaged groups.²⁹

These disparities in health can, in part, be attributed to the considerable differences in what people eat, in which socioeconomic status plays a significant role.²⁹ Until the last few years, people in lower income households consumed more (per capita) whole-milk and cream, meat and meat products, fats and oils, potatoes, bread biscuits, sugar and preserves, and consumed less fish, fresh fruit and fresh vegetables than those in higher income households.⁴¹ Since 2000 these differences have diminished to some extent, but, compared with people in households in the highest fifth of income, those in the lowest fifth still consume more milk and cream, more meat products, about 50% more fats and oils, and twice the amount of sugar and preserves (See Fig 3).⁴²

Low income households are also less likely to consume a wide range of fruits and vegetables including raw salad vegetables, leafy green vegetables, pears, apples, bananas and citrus fruit.

By heavily subsidising milk and beef, CAP policies ensure that foods with high saturated fat content are more affordable for people on low incomes. By contrast, fruit and vegetables, which receive little support from CAP, are relatively expensive.



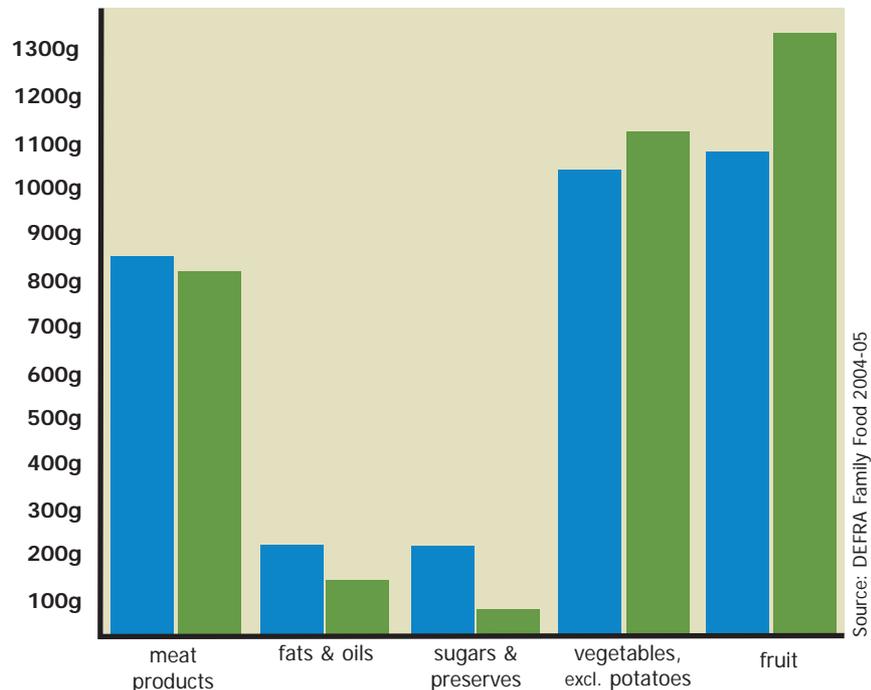
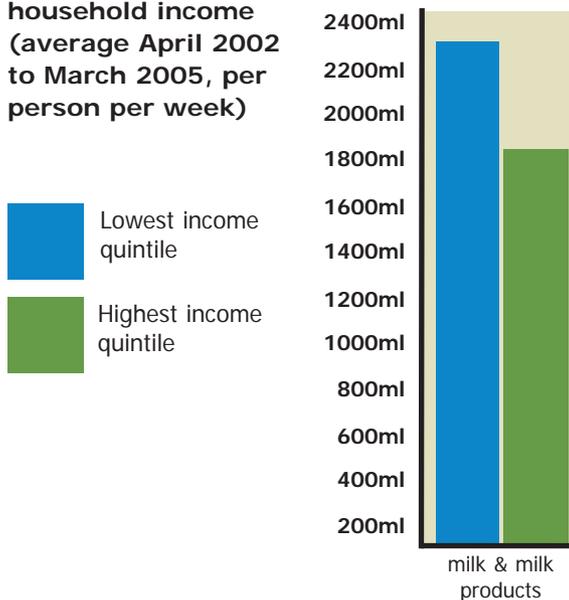
In 2001, it was estimated that some 48,050 CHD deaths and 17,800 stroke deaths per decade across the EU (at that time comprising 15 countries) could be attributed to inadequate fruit and vegetable intake.⁴³ More recently, it was estimated that, if everyone ate the minimum recommended level of fruit and vegetables per person per day, 7% of CHD events and 4% of strokes could be prevented, representing over 50,000 lives saved per year across the same 15 EU countries.⁴⁴

A further study has estimated the mortality impact from CAP-associated subsidies for saturated fats across 15 EU countries.⁴⁵ This study assumed that, without CAP subsidies, per-capita saturated fat consumption would have been 1% lower, and monounsaturate

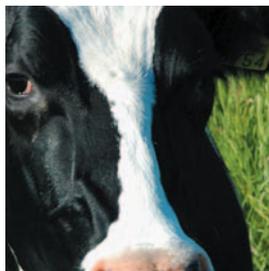
and polyunsaturate intake each 0.5% higher. It was estimated that this would have resulted in average blood cholesterol levels being approximately 0.06mmol/l lower and that this in turn would have resulted in some 21,420 fewer CHD deaths and 2,460 fewer stroke deaths each year.

In conclusion this study indicates that, since its creation, CAP subsidies and withdrawals could have been responsible for hundreds of thousands of premature deaths across the EU. The true figures are likely to be much higher than the conservative estimates above. Reform of current CAP policies, as outlined in this report could therefore prevent a great many further deaths.

Fig 3: **Selected food purchases by household income (average April 2002 to March 2005, per person per week)**



Source: DEFRA Family Food 2004-05



Trends in nutritional health – a case study

Shifts in food consumption in the UK have been influenced by a number of factors over the past 40 years. These include: a steady increase in disposable income; the rise of the supermarket and decline of local providers; increasing consumer knowledge of what constitutes a healthy diet; exposure to different types of food; an increasingly multicultural society; globalisation (such as the ability to quickly transport large quantities of produce around the world); and, of course, CAP policies supporting the production of particular food products (and therefore affecting their price to the consumer). Disentangling the impact of these different influences on food consumption is highly complex. Ultimately, however, the key determinant for most consumers is price, particularly for those on lower incomes, and in this respect CAP has played a very significant part (see *Health inequalities* p.14).

Energy intake in the UK has seen a steady decline over the past 40 years. This has been due in part to a reduced intake of fat – notably a shift from whole milk and full-fat dairy products to semi-skimmed milk and low fat dairy products - and partly to a reduced intake of sugar.³² There has also been a steady switch from saturated to polyunsaturated fats – from a ratio of just under 6:1 in 1959 to just over 2:1 in 2000 – as people have partly replaced butter with polyunsaturated margarines and lard with polyunsaturated cooking oils.³³

Trends in fruit and vegetable consumption in the UK are mixed. Whilst consumption of fruit has risen steadily, vegetable consumption has fallen. Taken together, the net effect has been a slight reduction of total fruit and vegetable consumption since 1962, with a shift in the ratio of vegetables to fruit from just under 4:1 in 1962 to about 2:1 in 2000.³⁴ Current average intakes still fail to meet the minimum recommendation of five portions of fruit and vegetables a day.

In recognition of the negative aspects of CAP outlined above, the Council of the EU in 2000 invited the European Commission to "allow for nutritional health to be taken into account when drawing up and implementing any relevant Community policies, and develop tools for assessing the health impact of Community policies."^{46,47} In addition, the EC's White Paper on Food Safety proposed a comprehensive and coherent nutritional policy for the EU and a 'nutrition action plan'.⁴⁸

Following the EC's 'Mid-term Review' in 2003, a major reform package for the Common Agricultural Policy was agreed (although improved nutrition remained outside any reform of CAP objectives). The essence of these reforms, implemented in the UK in 2005, was to disconnect subsidy from production.⁴⁹ Thus a farmer can no longer attract additional subsidy by rearing more beef cattle, nor by growing more cereals.

Subsidies are now awarded on the basis of a 'whole farm package', (under the 'Single Farm Payment Scheme' in the UK) where

the land is used for an approved agricultural purpose (but which does not include market gardening for fruit or vegetable production), provided that, in addition, three minimum standards (where relevant) are also achieved:

- preservation of the local rural environment in accordance with a locally agreed protocol;
- maintenance of recommended food safety standards; and
- adherence to legislation to prevent animal cruelty.

The public health lobby had hoped that this reform might encourage some farmers to move away from dairy and beef production towards more health-promoting food products such as fruit and vegetables. However, this reform contains no direct stimulus to move production from one type of farming to another, and it is therefore likely that the majority of farmers will continue to negotiate whole-farm packages based on their existing production and that the reforms therefore will have little impact on the types of food produced.

what would a healthy CAP look like?



Health across the EU would benefit from a health-centred farming structure which encourages:^{5,10,50,51}

- substantially less consumption of saturated fat (eg. from dairy and red meats);
- greater substitution of saturated fats with more unsaturated fats (eg. sunflower, rape and olive oil);
- greatly increased consumption of fruit and vegetables;
- increased consumption of starchy foods, such as potatoes and cereals.

This vision for food and farming was proposed by the World Health Organization (WHO) and the Food and Agriculture Organization (FAO) in their joint report on non-communicable disease, *Diet, nutrition and the prevention of chronic diseases*,¹³ and in the WHO's *Global strategy on diet, physical activity and health*.⁵² The implication of such a policy shift – making health the driver of food policy – is not lost on powerful producer interests which

have calculated severe cuts in output of some commodities.^{53,54} However, a health-promoting CAP would also be one which sought to:

- improve nutritional health;
- reduce food poverty and global health inequalities;
- promote health-promoting, environmentally friendly, ethical quality food production;
- protect the rural economy;
- support rural communities;
- prevent rural poverty;
- promote diversity in forms of agriculture; and

- preserve the look of the landscape. These considerations are critically important for those EU member states (particularly the newer accession states such as Poland, Hungary, Latvia, Lithuania and Estonia) that contain substantial rural populations reliant on a successful agricultural sector.⁵⁵ There is a strong case for continuation of subsidies to rural communities who are engaged in agricultural production. However, this raises questions on how the land should be used and what should be produced.⁵⁶

Making health the driver of food policy would ultimately improve health across the EU



Article 152 of the Amsterdam Treaty begins with the clause: "A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities". Article 153 of the same Treaty requires that: "...the Community shall contribute to protecting the health, safety and economic interests of consumers, as well as to promoting their right to information, education and to organise themselves in order to safeguard their interests".⁵⁷

As it currently stands, the CAP operates largely in contravention to the health element of these Treaty articles. What CAP requires is a new package of reforms which will ensure adherence to and promotion of the ethos of these Treaty articles. It is understood that current UK government policy for CAP reform envisages, ultimately, the abolition of all agricultural subsidies related to production (though some subsidy might continue to be paid to farmers for maintaining the countryside environment, for example). However, it is unlikely that such a bold objective will be achieved in the near future. Given that subsidies will remain for the time being, they should, therefore, be used to encourage development of health-promoting (rather than health-destroying) agriculture. Consequently, any reform intending to take account of the requirements of public health nutrition should seek to move policy towards:

- **reduction of subsidy of beef production** (though it is worth noting that some subsidies could be used to encourage production of grass-fed cattle which produces a higher quality beef with lower (saturated) fat, and greater lean meat content. Such beef would, however, probably be more expensive, potentially contributing to food inequalities and food poverty);
- **reduction of subsidy of dairy production** (except for that with a low fat content which may encourage some farmers to move to this kind of production). Any excess dairy fat, which the Commission might need to dispose of should, instead, be converted to products suitable for industrial use such as lubrication oils and fuels, and not used for human consumption (particularly as 'hidden' ingredients in products such as cakes, pastries etc);
- **provision of subsidised dairy products to the not-for-profit sector consisting exclusively of low-fat versions**
- **increasing production of monounsaturated and polyunsaturated vegetable oils** (such as olive, rape, sunflower oil). If any sector of the food industry is to be provided in future with subsidised fat, this must be sourced from oils such as these, and not from dairy production;

/continued overleaf

recommendations

- the majority of CAP subsidies should be directed to **encouraging a substantial increase in the production of fruit and vegetables**; this support should see the end of artificial inflation in the price of fruit and vegetables on the open market. As a consequence, prices should fall, encouraging much greater consumption than at present. **Increased production of fruit and vegetables combined with subsidy should ensure a reasonable return for farmers**, and any surplus could be disposed of on an additional subsidised basis – to the not-for-profit sector, including hospitals and schools, possibly including free provision of fruit to all school children.
- **continued encouragement of the cereal sector to produce products suitable for human consumption**, and as rich sources of vegetable protein provide healthier alternatives to red meat; subsidies should support only cereal production for human consumption, and not that produced to be animal fodder.

Such a series of recommendations would need to be implemented over a gradual period of time, to avoid disrupting rural economies as a consequence of too rapid change, for example by making some types of farming uneconomic and unsustainable, causing a rapid increase in rural unemployment, before sustainable farming of more 'healthier products' becomes established in those same areas. Moreover, such a reform package should not be seen as in any way antagonistic to the objectives of the Mid-term Review (see p.17). The CAP objectives to protect the rural environment, ensure food safety and prevent animal cruelty should be preserved in the context of any reform encompassing proposals such as those outlined above.

Adoption of a package of reforms along these lines could open the way towards a much healthier Europe within a few years. It would support efforts to halt the rising prevalence of obesity and diabetes and help prevent coronary heart disease, as well as a number of other significant public health objectives, including the reduction of health inequalities. If coupled with environmental goals, this could truly be a public health advance, and set public policy in a direction appropriate for the 21st century.



1. Correspondence between President Harry Truman and Herbert Hoover. (Letters of 18 and 19 January 1947). Truman Presidential Museum and Library. Accessed on 24 April 2006 from: <http://www.trumanlibrary.org/hover/documents.php?page=3>
2. The President's Economic Mission to Germany and Austria, Report No. 1: German Agriculture and Food Requirements, issued by Herbert Hoover on 26 February 1947. Truman Presidential Museum and Library. Accessed on 24 April 2006 from: <http://www.trumanlibrary.org/hover/documents.php?page=3>
3. Garfield S. 2004. *Our Hidden Lives*. London: Ebury Press.
4. Stead DR. Common Agricultural Policy. EH.Net Encyclopedia. Accessed on 24 April 2006 from: www.eh.net/encyclopedia/?article=Stead.CAP
5. Elinder LS, Joossens L, Raw M, Andreasson S, Lang T. 2003. *Public health aspects of the EU Common Agricultural Policy*. Stockholm: Swedish National Institute for Public Health.
6. European Commission. 1997. *Amending the Treaty on the EU, the Treaties establishing the European Communities and certain related acts*. Brussels: European Commission.
7. Whitehead M, Nordgren P (eds.) 1996. *Health Impact Assessment of the EU Common Agricultural Policy. A NIPH Policy report*. F-serien 8. Sweden: Swedish National Institute of Public Health.
8. Commission of the European Communities. 2000. *Proposal for a decision of the European Parliament of the Council, adopting a programme of Community action in the field of public health (2001-2006)*. Brussels: Commission of the European Communities.
9. World Health Organization. 2002. *The World Health Report 2002: Reducing Risks, Promoting Healthy Life*. Geneva: World Health Organization.
10. Jones M, Birt CA, McCarthy M. 2003. *Health at the Heart of CAP*. London: Faculty of Public Health Medicine.
11. He K, Song Y, Daviglius M, Lieu K *et al.* 2004. Accumulated evidence on fish consumption and coronary heart disease mortality. A meta analysis on cohort studies. *Circulation* 109: 2705-11.
12. Hoare J, Henderson L *et al.* 2004. *The National Diet & Nutrition Survey: Adults Aged 19 to 64 years. Summary Report. Volume 5*. London: Her Majesty's Stationery Office.
13. World Health Organization/Food and Agriculture Organisation. 2003. *Diet, Nutrition and the Prevention of Chronic Diseases. Report of the Joint WHO/FAO Expert Consultation. WHO Technical Report Series, no. 916 (TRS 916)*. Geneva. World Health Organization & Food and Agriculture Organisation.
14. Department of Health. 2005. *Choosing a Better Diet: a Food and Health Action Plan*. London: Department of Health.
15. Scottish Executive. 2004. *Eating for Health. Meeting the Challenge*. Edinburgh: Scottish Executive.
16. London Economics in Co-operation with Dr Susan Mews. 2005. *Evaluation of the National Top-up to the EU School Milk Subsidy in England for the Department for the Environment, Food and Rural Affairs*. London: London Economics.

17. Puska P, Tuomilehto J, Nissinen A, Vartiainen E. 1995. *The North Karelia Project: 20 Year Results and Experiences*. Helsinki: National Public Health Institute (KTL).
18. Elinder LS. 2005. Obesity, Hunger and Agriculture: the Damaging Role of Subsidies. *British Medical Journal*; 331:1333-6.
19. European Commission Directorate-General for Agriculture. 2002. Prospects for Agricultural Markets 2002-2009. Update for EU Markets. Accessed on 19 May 2006 from: <http://ec.europa.eu/comm/agriculture/publi/caprep/prospects2002/update.pdf>
20. European Commission. Agriculture, Beef and Veal. Accessed on 25 May 2006 from: http://ec.europa.eu/comm./agriculture/markets/beef/index_en.htm
21. Cancer Research UK. Diet and Cancer: the evidence. Accessed on 4 September 2006 from: <http://info.cancerresearchuk.org/healthyliving/dietandhealthyeating/howdoweknow/#source34>
22. Health Education Authority. 1999. Nutritional Aspects of the Development of Cancer. A Briefing Paper. Accessed on 4 September 2006 from: <http://www.publichealth.nice.org.uk/page.aspx?o=502131>
23. European Commission. The Horticulture Sector in the European Union. Accessed on 24 April 2006 from: http://europa.eu.int/comm/agriculture/publi/fact/horti/2003_en.pdf
24. Department of Health. 2003. 5 A Day Health Benefits. Accessed on 17 February 2006 from: <http://www.dh.gov.uk>
25. Henderson L, Gregory J, Swan G. 2002. *National Diet and Nutrition Survey: Adults Aged 19 to 64 years. Volume 1*. London: Her Majesty's Stationary Office.
26. Sustain 1999. *Food miles - Still on the road to ruin? An assessment of the debate over the unnecessary transport of food, five years on from the food miles report*. London: Sustain.
27. House of Commons Health Committee. 2004. *Obesity. Third report of session 2003-04. Volume 1*. London: The Stationery Office.
28. Department of Health. 2005. *Choosing Better Oral Health: an Oral Health Plan for England*. London: Department of Health.
29. Press V, on behalf of the National Heart Forum, Faculty of Public Health, Government Office for the North West, Government Office for the West Midlands, and the West Midlands Public Health Observatory. 2004. *Nutrition and Food Poverty: a Toolkit for those Involved in Developing or Implementing a Local Nutrition and Food Poverty Strategy*. London: National Heart Forum.
30. British Nutrition Foundation. Nutrition Basics: Energy and Nutrients - Carbohydrate. Accessed on 2 May 2006 from: www.nutrition.org.uk/home.asp?siteId=43§ionId=608&parentSection=324&which=undefined
31. European Commission. Financial programming and budget. Accessed on 26 June 2006 from: http://europa.eu.int/comm/budget_detail/policy_areas_en.htm
32. National Statistics. 2006. *Family Food in 2004-05. A National Statistics publication by DEFRA*. London: The Stationery Office.

33. DEFRA. National Food Survey – datasets. Accessed on 18 August 2006 from: <http://statistics.defra.gov.uk/esg/publications/nfs/datasets/nutshist.xls>
34. DEFRA. National Food Survey – datasets. Accessed 18 August 2006 from: <http://statistics.defra.gov.uk/esg/publications/nfs/datasets/allfood.xls>
35. Department of Health. 2004. *Choosing Health: Making Healthy Choices Easier*. London: The Stationery Office.
36. European Commission. Tobacco fund. Accessed on 21 June 2006 from: http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/funds_tobacco_en.htm
37. Babb P. 2005. *A Summary of Focus on Social Inequalities*. London: Office of National Statistics.
38. Joint Health Surveys Unit. 2003. *Health Survey for England 2001*. London: The Stationery Office.
39. Joint Health Surveys Unit. 2004. *Health Survey for England 2003*. London: The Stationery Office.
40. Department of Health. 2000. *The NHS Cancer Plan*. London: Department of Health.
41. DEFRA. National Food Survey - datasets. Accessed on 18 August 2006 from: <http://statistics.defra.gov.uk/esg/publications/nfs/datasets/73web.xls>
42. DEFRA. Family Food in 2004-05 Accessed on 1 September 2006 from: <http://statistics.defra.gov.uk/esg/publications/efs/2005/chapter8.pdf>
43. Joffe M, Robertson A. 2001. The potential contribution of increased vegetable and fruit consumption to health gain in the European Union. *Public Health Nutrition* 4:893-901.
44. Lock K, Pomerleau J. 2005. *Fruit and Vegetable Policy in the European Union: Its Effect on Cardiovascular Disease*. Brussels: European Heart Network.
45. Capewell S, Lloyd-Williams F, Mwatsama M, Birt C, Ireland R, Lock K. 2006. Death CAP? Estimating the cardiovascular mortality burden attributable to the European Common Agricultural Policy. *Journal of Epidemiology and Community Health* 60 (Suppl 1) A9.
46. European Commission. 2001. Resolution of the Council 14 December 2000 on Health and Nutrition (2001/C 20/01). Official Journal of European Communities.
47. Société Française de la Santé Publique. 2000. *Health and Human Nutrition: Elements for European Action*. Nancy: Société Française de la Santé Publique.
48. Commission of the European Communities. 2000. *White Paper on Food Safety*. Brussels: Commission of the European Communities.
49. Burch M, Gomez R. 2004. *Manchester Papers in Politics: Devolution and European Policy Series 4/2004. The Reform of the EU Common Agricultural Policy in a Devolved UK. Paper no.12*. Manchester: University of Manchester.
50. World Health Organization. 2001. *The First Action Plan for Food and Nutrition Policy. WHO European Region 2000-2005*. Copenhagen: World Health Organization.

51. European Heart Network. 1998. *Food, Nutrition and Cardiovascular Disease Prevention in the European Union*. Brussels: European Heart Network.
52. World Health Organization. 2004. *Global Strategy on Diet, Physical Activity and Health*. Geneva: World Health Organization.
53. Irz X, Shankar B, Srinivasan C. 2003. *Dietary Recommendations in the Report of a Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases (WHO Technical Report Series 916, 2003): Potential Impact on Consumption, Production and Trade of Selected Food Products: Report for the International Federation of Agricultural Producers and Institute for European Food Studies*. Reading: University of Reading Department of Agricultural and Food Economics.
54. Irz X. 2003. *Impact of WHO Dietary Recommendations on World Sugar Consumption, Production and Trade. Report Prepared for the World Sugar Research Organisation*. Reading: University of Reading Department of Agriculture and Food Economics.
55. WHO Regional Office for Europe and European Commission. 2002. *Health Status Overview for Countries of Central and Eastern Europe that are Candidates for Accession to the European Union*. Copenhagen: WHO Regional Office for Europe.
56. Lang T. 2006. What is Food and Farming For? - The (Re)emergence of Health as a Key Policy Driver. In: Frederick H. Buttel and Philip McMichael (eds) *New Directions in the Sociology of Global Development. Volume 11*. New York: Elsevier.
57. European Commission. 1999. Treaty of Amsterdam Amending the Treaty on European Union, the Treaties Establishing the European Communities and Related Acts. Accessed on 24 April 2006 from: <http://www.europa.eu.int/eur-lex/lex/en/treaties/dat/11997D/htm/11997D.html>



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