Volume 10 Number 1, 2004

eurohealth

Integrating public health with European food and agricultural policy

The Common Agricultural Policy: a public health perspective

European fruit and vegetable sector reform

Rural development and food policy in Europe

Health Impact Asessment: Implementing CAP in Slovenia

Mental health impact of a Foot and Mouth Disease outbreak in Wales

COMMENT

Food for thought

At the recent World Health Assembly, the World Health Organisation adopted the Global Strategy on Diet, Physical Activity and Health, so it perhaps particularly appropriate that much of this issue of *Eurohealth* is devoted to health issues arising from European agricultural policy.

Karen Lock from the London School of Hygiene and Tropical Medicine has brought together an eclectic collection of articles including reflections on the development and potential reform of the Common Agricultural Policy (CAP), current nutritional intake levels, and the health consequences for a new Member State of joining the CAP. We hear much now about the links between health and wealth; issues linking agricultural policy with rural development are also discussed as well as the adverse impacts, particularly on the mental health of agricultural workers during periods of economic downturn or agricultural crisis. It is important that we improve our understanding of potential risk factors for health and well-being, and experience from Wales using a rapid health impact assessment during an outbreak of foot and mouth disease illustrates one possible approach.

It is perhaps a misconception to think that European agricultural thinking has always ignored health. As Tim Lang notes, the CAP was created at a time in post-war Europe when rationing, food shortages and a poor infrastructure meant that the prime health concern was under-consumption. It is only over time has the health aspect of agricultural policy been marginalised, so that it can now be argued that specific aspects of the CAP, such as tools used to maintain artificially high prices for fruit and vegetables, the provision of subsidies for foodstuffs with a high level of saturated fat, and subsidies for tobacco crops are positively detrimental to health.

Recently, at the EU Open Forum on Health in Brussels, Commissioner Byrne spoke of the need for health interests to be at the core of all policy agendas; one key challenge is to strengthen the links between public health, food and agriculture policy, both at a European and nation state level. This though is just a beginning, having an impact on consumer preferences and dietary behaviour may prove to be an even more onerous task.

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Why should public health be part of an integrated European agriculture and food policy?

Karen Lock

"In health terms CAP should be seen as a systematic failure"

This edition of *Eurohealth* explores the wide range of health issues raised by European Agriculture policy, from nutrition to mental health and rural socioeconomic inequalities. But why are we devoting so much of *Eurohealth* to articles on agriculture and food policy? Why should people in the health sector think about agriculture at all when there are so many other pressures on health system resources?

To some the answer is clear: agriculture policy has a strong influence on what food is produced, how it is produced, processed and sold, and is a key determinant of what people eat. Yet many voices in the health sector continue to advocate that diet is merely a matter of public choice, focussing on individual behaviour and not on the environmental factors that might assist or impede healthy choices. Food and nutrition are now at the top of the political agenda. This is mainly due to recognition that the rapid worldwide increase in obesity, and with it non-communicable diseases, is determined to a large extent by dietary factors. Much of the public debate on the international obesity epidemic relates to how different actors, e.g. government, the food industry and interest groups, determine the availability, accessibility and affordability of healthy foods. Yet the health sector is struggling with how to best support people to eat a well-balanced nutritious diet that will reverse these worrying disease trends.

The government in the UK is one that acknowledges that improving diet and tackling the dietary causes of many non-communicable diseases is not simply about improving how we get the message across. In the recent study led by the Treasury (Finance Ministry) which reviewed the public health aspects of British policy, obesity was considered as a key issue. The report 'Securing good health for the whole population' focuses on the wider determinants of health.[1] It is based on a previous Treasury study that concluded that the National Health Service (NHS) must focus more on health improvement and disease prevention rather than just treating ill-health. By doing so, it predicts the NHS could save £30 billion by 2022, equivalent to half its current expenditure. Although this report accepts that individuals are ultimately responsible for their own health, it acknowledges that people need to be supported more actively to make better decisions because there are 'widespread , systematic failures that influence decisions individuals currently make'. It proposes that these broader, systems issues can only be tackled by the collective action of national and local government, businesses, society and the voluntary sector. It is increasingly clear that action to ensure good population nutrition needs both a well informed public that is able to make choices about their diet, and a multi-sector production system that provides access to a wide range of healthy food.

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The Common Agricultural Policy

Currently the EU Common Agricultural Policy (CAP) is the strategy which determines national food policies across Europe and, indirectly, in many other parts of the world. Sadly in health terms the CAP should be seen as a 'systematic failure'. Put simply, the CAP fails to produce the range of foods that would allow the EU population to meet basic healthy eating recommendations. Tim Lobstein's article shows clearly that if all of Europe suddenly decided (and was able) to eat according to internationally agreed dietary guidelines then the agricultural sector would not be able to meet the needs of the European population, given its current production focus. This basic contradiction demonstrates a key failure of the CAP as the major determinant of diet.

Current European agricultural policy is not economically efficient, nor does it provide good health or value for money to its citizens. The EU agricultural policy consumes

nearly 50 percent of the total EU budget, and costs consumers and taxpayers €117 billion per year through higher food prices and taxes.[2] Ninety percent of citizens in a European wide survey of over 16,000 people want the CAP to ensure safe and healthy food.[3] It is clear that the CAP is not achieving this basic consumer goal. Public health costs include the impact on the poor of higher prices, and the externalised costs on non-communicable diseases and obesity through subsidies for the production and consumption of animal fat, tobacco and alcohol, and supply of insufficient amounts of fruit and vegetables.

Several articles in this edition point out how specific aspects of the current CAP are detrimental to population health. The Swedish Institute of Public Health has assessed the health effects of specific CAP policy elements including dairy products, tobacco and alcohol. Liselotte Schäfer Erlinder's article identifies measures in four sectors which directly or indirectly harm public health and currently cost €3.4 billion per year. This article, together with the articles by Lock and Schäfer Erlinder, Lobstein and also that of Lang show that agricultural interests currently conflict with public health when subsidising the production and consumption of food.

Current health goals therefore cannot be achieved without appropriate changes to agriculture policy. Recent CAP reforms have largely been driven by financial concerns arising from EU expansion, but future reforms (including the revision of the fruit and vegetable policy currently being considered) need to take public health into account as outlined in article 152 of the Amsterdam Treaty.

Food policy

Food policy in Europe is currently dominated by the agriculture and retail food industry. The CAP still promotes the goal of delivering health via higher productivity and food security, but this fails to reflect the concerns in Europe today with increasing production of dairy products and livestock mirroring increases in the proportion of people eating diets high in animal fats and the concomitant increase in non-communicable disease. Tim Lang argues that the CAP objectives, as formulated in the Treaty, are not in line with the needs of contemporary society and should be changed fundamentally.

But it is important to remember that food and nutrition are not the only agricultural issues that public health should be concerned with. European agriculture policy has wide ranging health effects, particularly on the rural economy where there has been rapidly rising rates of unemployment and increasing socioeconomic inequalities. Two articles in this edition widen the scope of the debate to include the health effects of rural development policy. The Welsh experience highlights the importance of considering the mental as well as physical impacts on people's health and well-being in agricultural policy, particularly in response to adverse situations impacting rural areas such as that which occurred during the food and mouth disease outbreak in the UK in 2001. The paper on European rural development policy by Bryden and Robertson clearly outlines the role of agriculture in influencing health determinants such as socioeconomic factors, culture and education in rural areas. Rural development aspects of the CAP are important for some of the EU15 that have large rural populations (e.g. Greece, Portugal, Ireland), but will be even more so in some new member states, such as Poland, which have a larger proportion of the population living in rural poverty. However, despite the importance of rural development it is important to ensure that the Pillar II aspects of the CAP (containing support for rural development and environmental protection) which are potentially positive for public health are not used to legitimise the whole CAP budget, 90% of which is used for artificially supporting food production to the detriment of health.

"90% of Europeans surveyed want CAP to ensure safe and healthy food"

Inter-sectoral approach

Despite the health sector continuing to point out the wide ranging health dis-benefits of the CAP, so far there has been little evidence of any change. What can the public health sector do to make a difference? We need to think of new ways of working together with the agriculture and food sector. In the articles which follow, a range of solutions are proposed to ensure that food and farming policy gives equal weight to human health, environmental concerns and agriculture and rural interests.

Tim Lang argues for a new inter-sectoral approach to food policy where public health needs to learn from the environmental sector about how to create alliances with the agriculture and food sector. This will not be easy. Many health organisations including EPHA, European Heart Network and other NGOs including Sustain and Oxfam have been lobbying

"Current drivers of European agriculture policy may prevent the promotion of public health through farming and food policy"

about the health effects of CAP for many years. We have to continue to try and engage people more widely. This means overcoming the disinterest in agriculture shown by health ministries and public health officials. But equally we must improve the knowledge of agricultural decision-makers about the links between CAP policy, nutrition and health. Their knowledge of production, economics and technicalities of CAP policy instruments does not extend to what happens to their products, or how new markets can be created using health as a factor. Most importantly we have to get agriculture and health ministries in the EU and nationally working together. Advocating a 'whole system approach' to food policy is not new. This concept underpins the recent launch of the Global fruit and vegetable promotion initiative, a joint venture between the WHO and the UN Food and Agriculture Organisation,[4] as part of the WHO Global Strategy on Diet, Physical Activity and Health.[5] The EC could apply a similar the approach to the opportunities presented by the current reform of the CAP fruit and vegetable sector, where the health and agriculture sectors could easily work together for mutual benefits in a number of ways as noted by Lock and Schäfer Elinder. Currently the public health community has not been involved in the new fruit and vegetable proposals. We need to ensure that in all future developments of the CAP the health sector is an invited partner, not an external observer.

Health Impact Assessment

One way to stimulate this could be to improve the evidence for the health impacts of agricultural policy in Europe, assuming that evidence is going to be used to drive decisions. The current lack of evidence is not because important agriculture and health linkages do not exist, but mainly due to lack of funding for research in this area. Neither the health or agriculture sector seems to prioritise such inter-sectoral public health research.

Several authors also propose the need for methods of auditing or evaluating the health effects of CAP, and other new agriculture and food policies before they are introduced. The Swedish Institute of Public Health and the Slovenian Government have used different approaches to assess the impact of CAP on health nationally. In Sweden a more general desk-based analysis was conducted,[2] whilst in Slovenia, as discussed in this issue by Gabrijelcic-Blenkus and colleagues, a multi-sectoral health impact assessment (HIA) methodology was used which involved participation by a wide range of stakeholders. The Welsh Assembly government has also used HIA in many different policy settings, here Kenkre and colleagues illustrate that it has proved to be a useful tool in responding to the health needs of the agricultural sector. Health impact assessment is clearly one approach that could prove a useful mechanism for achieving intersectoral working on health and agriculture at national and European level.[6]

Moving forward

These articles have highlighted some of the difficulties which need to be overcome to improve agricultural policy, nutrition and public health inter-sectorally at the European level. It is clear that, even if national governments wish to promote public health through improved farming and food policy, sometimes they are incapable of doing so because of the current drivers of European agricultural policy that exist centrally. These barriers to change need to be tackled urgently so that all countries can address the mounting public health and economic pressures created by the rising trends in obesity and non-communicable disease across Europe. Our task is to help develop an integrated European agriculture and food policy, which balances competing and sometimes conflicting interests but which includes public health as a core priority.

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European agricultural policy: *Is health the missing link?*

Tim Lang

"We need to build a tough political alliance to promote an ecological public health approach to agricultural policy"

What should people in public health think about agriculture? I argue here that if we wish to inject a more health-sensitive approach to European agriculture and food policy, we need to do four things:

- Be clearer about the drivers behind current policy.
- Take a long, strategic view at the purpose of agriculture.
- Situate farming within the entire food supply chain, and in particular understand the power of retailers, traders and processors.
- Build a tough political alliance to promote an ecological public health approach to agriculture and food policy.

The public health movement is often ill-informed about why the Common Agricultural Policy (CAP) came into existence. It is a commonplace belief among critics that European agricultural thinking has ignored health. This may be true today, but it was not always so. The CAP is by far the most significant policy sector of European convergence, not least financially as it accounts for just under half the total EU budget. The reason agriculture has this dominance in European public policy is because CAP was born out of the ashes of World War 2, which is where health comes in.

In 1992 I was speaking at a conference looking at whether agricultural policy could address the environmental challenge. Sicco Mansholt, former EU Agriculture Commissioner and a key figure in creating and attempting to modernise CAP from the 1950s was a key speaker. I asked: 'what about the public health dimension?' His private reply to me was clear. Do not forget that CAP emerged in the bleak period of post war reconstruction. Western and Eastern Europe had been separated. Despite peace, for the decade after the war, European populations continued to suffer food shortages, rationing, discontinuity of supply and a weak farming infrastructure.

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CAP's mechanisms were born when the prime health concern was under-consumption. The goals were to increase security of supply, raise production and deliver stability for farming populations. Gradually, CAP's policy-makers lost touch with this health foundation, and a narrow subsidy-led approach to managing the food supply chain triumphed. Today, that in turn is challenged by environmental and safety issues, yet the big health agenda is still marginal.

The international health vision in post-war agriculture

The food security motive for CAP's creation was not peculiar to Europe. It also featured in the creation of the United Nations' Food and Agriculture Organisation (FAO). The 1930s had been marked by poverty in towns and the countryside, volatility and collapse in world commodity markets, social despair and chronic hunger across the world. John Boyd Orr, the Scottish public health doctor and first FAO Director-General, also promoted the need for production-oriented agriculture policy. Boyd Orr and other architects of the post World War 2 agriculture policy such as Stanley Bruce (a former Prime Minister of Australia who first proposed the idea of setting up the FAO) championed the case for increasing the food supply and ensuring its proper distribution. If Europe, Australia, Latin America and the USA could apply science and produce vast surpluses, these could feed the needy in Asia and Africa. The policy framework also appealed to some business sectors. The health vision was to apply nutrition and plant science to husbandry and to apply sound science to reduce waste. The appeal was egalitarian and re-distributionary.

Within a decade, however, this global vision was at odds with political reality in the ex-colonial world. Liberation leaders pursued self-reliance, aware how dependency on external sources concedes power. The Cold War cemented this fissure and drove health needs down the agenda. Health was assumed to follow from sufficiency. The idealism that agriculture could

"CAP is not alone in needing reform, the entire world's food chains do as well"

feed the world and deliver health was still in evidence at the 1974 World Food Summit in Rome. Since then, neo-liberalism has become the economic orthodoxy and hunger analysts have shifted policy in two directions. Firstly, the view has been promoted by the World Bank and others that open markets optimise food supply. Why grow your own cereals if you can gain foreign currency by some other means (usually exploiting cheap labour) and buy food cheaper on world markets? The second element of the new orthodoxy was to focus less on national food security and more on household and individual access to food and towards improving what might be called micro-food security.

This transition in dominant food policy thinking has occurred leaving CAP somewhat isolated, and criticised by so many. Ironically, 21st century food policy may now take some heat off CAP. In an era of global uncertainty – oil shortages, climate change, political instability – food security is not so easily assumed through open markets. The post 1999 uproar around the World Trade Organisation and the GATT world trade system is but one expression of the new *realpolitik*. For us in public health, the key factor demanding policy change is political awareness of the cost of diet's impact on health.

Tackling the environmental impact of food production has long been championed by NGOs and scientists. But who has championed the need to tackle the impact of the nutrition transition sweeping the world, introducing new diet-related epidemics of non-communicable diseases in developing countries. The new policy framework will have to grapple with under-consumption, over-consumption and mal-consumption side-by-side. CAP is not alone in needing reform, the entire world's food chains do as well.

A short history of CAP

The 1957 *Treaty of Rome*, which established the Common Market, stated, in Article 3, that one of the tasks of the community should be to establish the CAP. Article 39 stated that CAP's objectives should be:

- To increase agricultural productivity by promoting technical progress and the optimum utilisation of the factors of production, in particular labour.
- Thus to ensure a fair standard of living for the agricultural community, in particular by increasing the individual earnings of persons engaged in agriculture.
- To stabilise markets.
- To assure the availability of supplies.
- To ensure that supplies reach consumers at reasonable prices.

The 1958 Stresa Conference put flesh on these policy bones. Five key mechanisms emerged: price supports, import taxes, intervention, stock disposal and export subsidies. Surpluses are often sold outside the EU at prices lower than EU market rates. This has led to considerable criticism from other market producers and from developing nations.

Although pressure from environmentalists and proponents of developing country interests have had some impact, the current agricultural policy framework has mainly been influenced by two other factors: EU enlargement and financial crises. Even before accession of the 10 new member states was proposed, the cost of the agricultural support system was prohibitively high. With large numbers of small farmers entering the EU in May 2004 the CAP system is under immense pressure. Further reform of the CAP is inevitable. The June 2003 reform heralds the rolling of the variety of subsidies into one and removal of the incentives to intensify production. It proposes to 'de-couple' payments from production and to link payments to environmental and other standards. The agreement makes subsidies dependent on farmers meeting certain EU environmental, food safety, plant and animal health and animal welfare standards as well as maintaining their land in good agricultural and environmental condition. More subsidies will also be diverted from production to wider rural development and environmental initiatives which farmers undertake.

The agreement allows Member States to implement policy differently in different regions. The good news is that is a genuine policy shift. The bad news is that, yet again, the big public health picture is missing. There are four key reasons for this policy failure. First, the public health movement is weak and is not yet a serious player in lobbying DG Agriculture. Second, there has not been enough agreement about the case for a new nutrition and population health perspective. Third, there are strong forces determined to keep issues of diet and health out of the agriculture and EU policy remit. Fourth and paradoxically, agriculture itself is not the powerful player it used to be. The drivers of farming are now off the land.

The rise of productionism

In some senses, Europe's agricultural policy has been extraordinarily effective in pursuing 'efficiency'. The size of herds and land-holdings became larger, while farm employment has declined. Crop yields have boomed, due to fertilisers and pesticides albeit with environmental and occupational health costs. Everywhere there has been intensification, as farmers strove to get more from capital, land, labour, plants and animals. Member states and EU subsidies provided support through extension schemes and help in marketing. A mix of private investment and public support has created a formidable array of new techniques, both on and off the land, and an unparalleled range of foods on retail shelves.

But this productionist paradigm which promoted and institutionalised the drive for efficiency also delivered consumer concerns about quality and negative health impacts of food. Mono-cropping, 'scientific farming', the focus on profit, and squeeze on small, traditional farming systems are now being questioned.

From the 1970s, while environmentalists began to critically assess these processes, public health proponents were less vociferous. The nutritional case about disease patterns and life expectancy is more complex; people live longer, yet die from diet-related disease. The public health movement remained largely content with the policy model put in place by Boyd Orr and colleagues globally and by Mansholt et al in Europe. This may be represented as a social 'equation':

Science + Capital + State Support = increased production, which if distributed = health + well-being

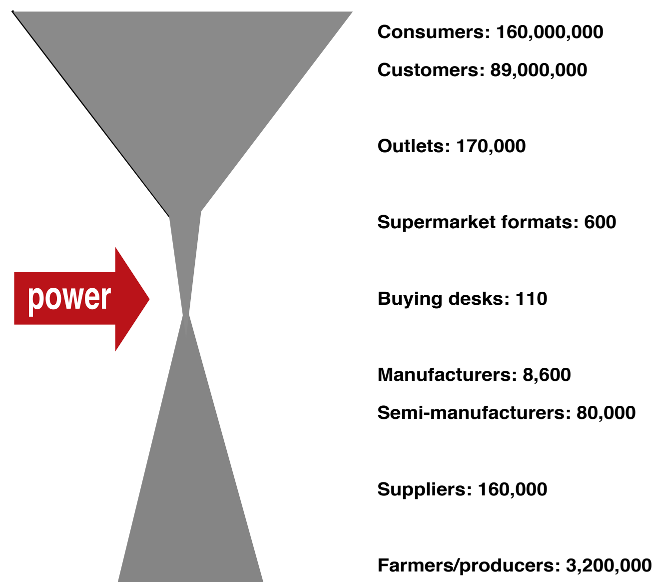
It is this policy formula which public health now has to criticise and modernise. It may have been evidence-based in the past, but no longer. New paradigms are emerging to transform the relationship of agriculture to health. One paradigm is ecological, in that it proposes a sustainability approach to food and farming, arguing that farms are a primary source of health by growing raw ingredients for health. The other is more industrial in that it draws on the life sciences to view agriculture as the source of ingredients which processing turns into value-added foods. Europe's agriculture is currently poised to follow either paradigmatic route.

Without doubt, retailers not farmers will be the key factor determining which route Europe's farming takes. They are the real decision-makers of the modern food supply chain. When CAP was founded, power was already shifting from farming to food manufacturers, but by the 1970s, supermarket chains were able to determine the shape of production through sophisticated systems of contracts and specifications. By the new millennium, around 600 retail chains dominated how the production of 3.2 million farmers arrived on the plates of 250 million consumers. New alliances among the retailers mean that, as shown by a recent CAP Gemini/Ernst & Young study, in practice 100 buying desks have the ultimate power to frame 'value chains' (see Figure 1). These desks in consortia of supermarket chains are where the specifications are laid down which stipulate what farmers, pickers, packers, shippers and truckers all have to meet.

The State, in other words, is no longer the sole driver of policy. Indeed, there are now two policy regimes: one State (EU + Member States), the other Corporate. This new dual policy regime is most visible in the area of food safety, where European food retailers are rapidly creating their own system of safety and specifications (e.g. EUREP-GAP). This is now going worldwide, with the giant food companies determined to create one world system of standards. Europe may have created a Food

"Retailers not farmers will be the key factor determining the route farming takes"

Figure 1
THE SUPPLY CHAIN 'BOTTLENECK' IN EUROPE



Source: Grievink, 2003/CAP Gemini/Ernst & Young

Safety Authority, but corporate giants now drive the specifications. This is the reality public health policy-makers must now grapple with.

What is agriculture for?

Why does this transformation matter? It could be argued that CAP has proven its worth or outlived its usefulness, but even its most committed supporters admit EU agricultural policy has not been a complete success. Measured against its own goals, CAP has not maintained rural employment; indeed, farm employment has collapsed. Between 1970 and 1993, i.e. before the current WTO induced reforms, EU agricultural employment dropped from 13.5% of total employment to 5.5%. The number of farmers in the EU halved between 1970 and 1990.

"20% of CAP farmers receive 80% of CAP subsidies"

The big scandal about CAP is social injustice. The Commission has estimated that 20% of European farmers (the largest and richest) receive 80% of the CAP subsidies. Oxfam International recently conducted a study of how CAP supports some of the UK's largest and richest landowners. The largest 2% of landholdings in the UK account for around a fifth of all subsidies received. Just 224 farmers received £47m (€70m) a year, and the subsidies go to regions which are already rich and profitable: England's East Anglia and Lincolnshire. Precisely eight farms in Lincolnshire, for example, receive an average payment of more than £337,000 each (€505,000).

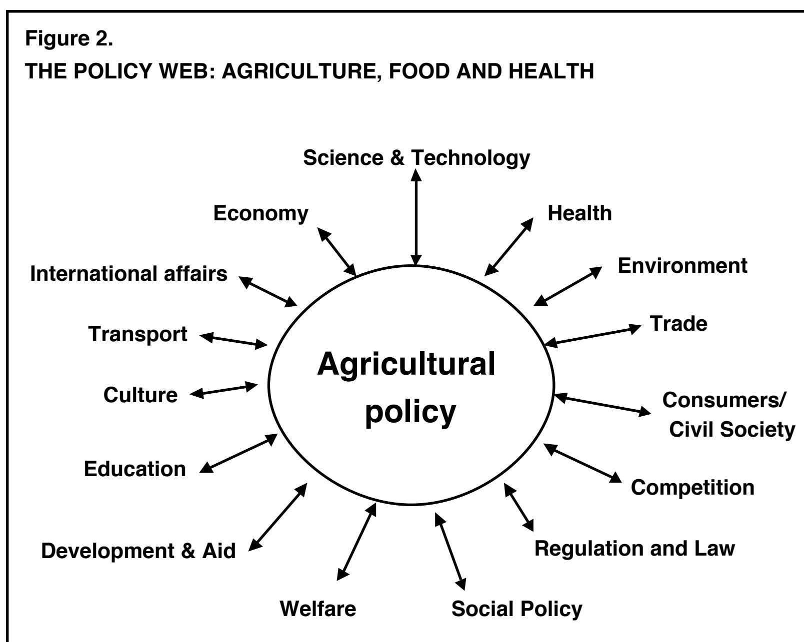
CAP's original goal of delivering reasonably priced food for consumers is more problematic. It has maintained farm-gate (and hence food) prices at higher levels than would otherwise have been achieved, but farmers' earnings have declined as they are squeezed by giant retailers and processors. The consumer movement constantly attacks CAP for unnecessarily raising prices compared to world prices. Surely from a public health perspective, the policy question to pose is not just whether some prices are too high but whether others are too cheap? What is the health impact of price mechanisms? Dairy fats versus fruit? Wine or cereals?

These questions highlight, as did the pioneering 2003 study by Sweden's National Institute of Public Health (NIPH), the current agricultural policy's health deficiencies. An unpublished 1992 study on dairy goods and health by Reading University economists for the UK Coronary Prevention Group argued that CAP had positive effects by keeping dairy fats expensive and therefore reducing consumption These studies are rare. There is a real deficit of good evidence by which to audit Europe's agriculture for its impact on health. Most consumer research focuses on the gap between world prices and CAP support prices but this does not necessarily translate into product prices, or consumption.

Conclusions

Auditing CAP for health revitalises the original food security question: do we even want a farming sector in Europe? I have heard many industrialists arguing that Europe should be fed by a handful of giant farmers and the Americans. In a world with political instability this would be a risky food policy. To let small farms disappear, to buy from wherever it is cheapest, to rely on large-scale farming and to buy more Third World food are all legitimate policy options. But we should be cautious about the health gains here. Cheaper sources can mean hidden exploitation, particularly of the labour process. Employment is a public health issue. Migrants are already a growing feature of Europe's agriculture for picking and processing. My point is that with modern food supply chains, we require a more sophisticated policy framework (see Figure 2).

Figure 2.
THE POLICY WEB: AGRICULTURE, FOOD AND HEALTH



Environmentalists are 30 years ahead of the health sector in producing evidence to inform policy. They have persuasive arguments and evidence that food production already fails to include its full costs and the impact of environmental damage. They can

point to the environmental damage of transporting food long distances and can estimate the bill for cleaning up water from agrichemical residues. The health sector lacks similar types of evidence because food and health research has never been a priority. The Commission and Member States should act to change this.

The EU's failure so far to address public health challenges such as poor diets, rising obesity, and rapid changes to food cultures is troubling. These are not separate from but part of the failure to conduct health audits of agriculture itself. Our task now is to help develop an integrated coherent European agriculture and food policy, which balances competing and sometimes contradictory or divergent interests. The continuing absence of a genuine public health element to CAP reform is unforgivable. As the evidence of food's impact on health mounts, pressure on the Commission to create a modern Common Food Policy that gives health a central role will rise. Obesity and the battles over food advertising are the tip of the food policy iceberg.

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Suppose we all ate a healthy diet..?

Tim Lobstein

If we all followed the World Health Organisation's dietary guidelines what would happen to food supplies in Europe?

The president of a leading potato snack manufacturer told me last January that his company is reducing the saturated fat content of their potato chips.

"When will we see the new product?" I asked.

"Ah, well, it will take at least three years," he said. "We have to negotiate contracts with palm oil growers, we must find new sources of vegetable oil, and we may need to change the potato varieties to cope with the new oils. Then we will need to have faster delivery systems to ensure the products are not on the shelves so long, the saturated fat helps stop the chips from going stale."

If it takes three years to make a small change in the saturated fat content of a single product what would have to happen if the majority of consumers started to take their diets more seriously and followed the healthy diet recommended by the World Health Organisation (WHO)?[1] For example, suppose we cut saturated fats, limited total fats, and cut our salt and sugar intake. Suppose we bought fewer snacks, soft drinks, and confectionery and purchased more fruit, vegetables, wholegrain foods and lean meats. What would it mean to our food supplies?

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Table 1. Which member states are eating healthy diets?

Target	Over 50% of population achieving target	Less than 50% of population achieving target
Dietary fat: less than 30% total energy	Portugal	Austria, Belgium, Denmark, Finland, France, Germany, Greece (Crete), Ireland, Italy, Netherlands, Spain (Catalonia), Sweden, UK.
Saturated fat: less than 10% total energy	Portugal	Austria, Belgium, Denmark, Finland, France, Germany, Greece (Crete), Ireland, Italy, Netherlands, Spain (Catalonia), Sweden, UK.
Fruit and vegetables: more than 400 grams per day	Greece (Crete), Italy, Portugal, Spain (Catalonia)	Austria, Belgium, Denmark, Finland, France, Germany, Ireland, Netherlands, Sweden, UK.
Dietary fibre: 25-30 grams per day	0	Austria, Belgium, Denmark, Finland, France, Germany, Greece (Crete), Ireland, Italy, Netherlands, Portugal, Spain (Catalonia), Sweden, UK.

"In the UK only one person in 2000 has a healthy diet"

Huge problems, for sure. The current patterns of farming and food imports could not meet the new demands. Dramatic changes would be required and the food companies leading those changes are the ones that will survive the best.

Present problems, future needs

Dietary surveys taken in 14 member states over the last decade show that the proportions of the populations meeting the recommended healthy eating targets, such as those set by the WHO, are extraordinarily low. As Table 1 shows, hardly any member states are meeting their goals.

Further targets could be added, such as those relating to sugar, salt, obesity, but still the majority of member states would fail to achieve them. More seriously, there is evidence that even when people achieve one target, such as for fat, they fail to achieve another target, such as for sugar. Very few people are actually eating a fully healthy diet. In the UK, for example, a 1994 survey found only one person in 2,000 meeting four or more of the criteria for a healthy diet.[3]

Put a different way, the vast majority of the population of Europe, including accession countries, can benefit from improvements in their diets.Assuming that member states and the European Commission seriously wish to improve health through dietary changes, then they need to ask: where will that healthy food come from? What changes in policy can ensure that food supplies will provide what is needed?

Putting numbers to needs

First we need to be able to measure what is happening. What are food supplies providing at present?

Every member state collects figures, known as food balance sheets, which estimate the amount of food grown, the amount imported, the amount exported, and the amount put into storage or wasted. The remainder is the amount that moves from supply into consumption.

Food consumption estimated from supply figures are not the same as actual dietary consumption figures, but they can be linked. Thus a food supply of, say, 10kg of fruit per person per month may be recorded as household purchases of 7kg fruit (with 3kg being supplied in the form of juices, jams, confectionery, pastry content etc), and a dietary consumption of 5kg fruit (2kg being lost through perishing, or during preparation or cooking or plate waste).

Setting aside the issue of fruit juices, we can use food supply figures to roughly estimate dietary consumption. In fact, using dietary surveys from 14 member states during the 1980s and 1990s, and comparing these with food supply figures during the same period, we have estimated that this ratio is roughly true, with a supply of 10kg leading to monthly consumption of 5.13kg on average.[4]

We can use this relationship to estimate what would be needed to meet the WHO's recommended dietary intake of at least 400g fruit and vegetables per person per

day, as a population average target. This equates to a supply of 780g fruit and vegetables, or more, per person per day. Similarly a dietary target of not more than 10% energy from saturated fats would translate into a food supply of around 60g of fat, or less, from animal products per person per day. A target of not more than 30% energy from all fats translates into a supply of around 135g total fat, or less, per person per day.

We can use these figures to evaluate the health impact of food supplies. For example, food supplies in Italy in 1965 provided around 720g fruit and vegetables, 38g saturated fat and 90g total fat, per person per day. This is a good Mediterranean diet with adequate fruit and vegetables and lower than maximum levels of fats. By the end of the last century, Italy enjoyed a fruit and vegetable supply of 860g per person per day, but the animal fat supply had risen dramatically to 70g and the total fat to 152g. This shows a significant oversupply of fats, especially saturated fats, and a potential threat to the health of the Italian population. Even if the figures are not exactly correct, the trends in food supply tell enough of the story. For Italy, the fat levels have risen significantly and the saturated fats more than doubled. Health policy-makers can immediately see that this is a trend in the wrong direction. For health services, it is time to train more heart surgeons!

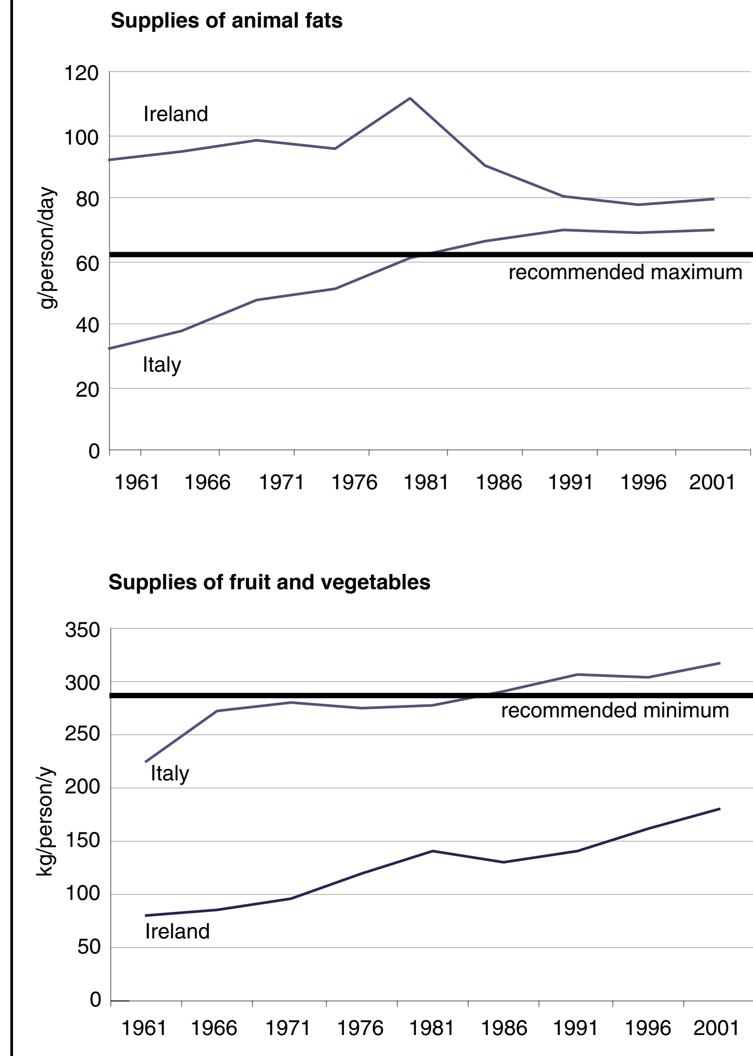
Figure 1 shows the trends in animal fat supplies in Italy, and also in Ireland over the last four decades. The figure also shows the trends for fruit and vegetable supplies. Data from other countries suggests that, within the EU15, only Greece has healthily low supplies of animal-based fat (below the 60g mark) while Greece and Portugal, like Italy, have healthy supplies of fruit and vegetables (above the 780g mark). These findings almost exactly reflect the figures obtained from dietary consumption surveys, shown in Table 1, and provide further arguments in favour of using food supply figures as a means of monitoring healthy eating policies.

Data for sugar are harder to obtain, but estimates can be made. These indicate that southern European supplies of sugar have increased by some 50% over the last four decades, approaching the high levels supplied in northern Europe.[5]

Food balance sheets do not record salt supplies. Recent work by the UK Food Standards Agency has suggested a different

Figure 1

Trends in the supply of animal fats and fruit and vegetables to Italy and Ireland over four decades



approach. In their analysis, salt contributions to the diet have been estimated according to the typical salt levels found in those foods (usually the more processed foods in a diet) and weighted according to the quantities of the different foods eaten (based on dietary surveys). This allows certain categories of food products, such as snack foods and canned soup, to be ranked according to their contribution to the population's total salt intake. This approach provides an alternative means of estimating the health impact of foods and the possible consequences of making changes in processed food recipes.

Resistance to change

Dietary surveys are expensive and few countries undertake a large-scale survey more than once in a decade. Food supply figures, in contrast, are collected on an annual basis, and for many countries the

"Food companies only supply people what they want - but is this true?"

data are available since the early 1960s. As shown, these supply figures can provide an excellent proxy for consumption, and help to pinpoint the 'upstream' problems which are shaping our consumption patterns, such as trade and agriculture policies.

In a free market, economists might argue, the food supplies are purely 'demand-led' – i.e. the supply chain only reflects the changing tastes and demands exercised by consumers. Animal fat supplies have risen because people want more animal products in their diet, they argue. 'The companies only supply what people want,' they say.

There are several reasons why the market is not as pure as it could be. The first is that food companies spend a large amount of their income trying to influence what we want. The global marketing budget for food promotion exceeds the gross national products of many countries. For every dollar the World Health Organisation spends on non-communicable disease programmes, food companies are spending $500 on marketing their products, mostly high in fats, sugar and/or salt, and low in fresh fruit or vegetables.[6]

Secondly, there are large amounts of public cash being used to support, and distort, the food marketplace. The Common Agricultural Policy costs some €40 billion annually, much of which is used to ensure high levels of production of milk, butter and cheese, meat, grain for animal feed, oils and alcohol, to say nothing of tobacco. The budget for fruit and vegetable production is partly used to pay for the destruction of fruit and vegetables to maintain high prices, and the removal of orchards from production. A similar policy operates for fish, in which the catch is destroyed if the price falls too low.

The European Commission also arranges that any excess butter is bought into intervention and then sold to manufacturers at a subsidy. Consumers who are cutting their purchases of butter in order to improve their health may not realise how much is being fed to them in 'hidden' forms in processed food, thanks to public subsidy. Approximately 1kg of butter is sold in 'hidden' form in processed food for every 2kg purchased by householders.

There are other hidden subsidies in the food chain which distort a pure market. Tax advantages go to food production using capital-intensive methods (offsetting the costs of equipment and agrochemical inputs). Producers do not pay for the pollution costs, transport costs and the damage done to the environment by food freight, the environmental costs for processed food packaging, and a host of other externalised production costs which can distort the market, and may favour the production of mass-produced, processed, low nutrient foods against fresh, local produce.

Nor is the marketplace a balanced one between the producer and the consumer. When it comes to purchasing power, some consumers have more power than others. Indeed the whole concept of consumer power and consumer choice should be examined: for example, the processed food manufacturers are the 'consumers' of much of the primary agricultural produce from our farms and from imported commodities, as the president of the potato chip company proved.

Similarly, the supermarket chains buy from farms and food processors, making choices based on price and volume, not nutritional quality. Catering outlets, including fast food chains but also public caterers such as school meal and hospital caterers, are the purchasers of large amounts of the food passing along the food chain, choosing what they put on their menus. At household level, the person who does the shopping may be making choices for several other people in the home. Thus the individual who eats the food at the final link in the chain is only a small part of the marketplace, with only a small part in determining what is available to be eaten.

Other distortions are also occurring. From the farmers' point of view, the best income is received from crops and livestock which have high yields, are disease-resistant, can be harvested easily and have other technical advantages. Farmers are rewarded for the volume of what the produce, not for the nutritional quality of their products.

Food technologies can give advantages to processed foods over fresh foods. Food preservation techniques, once a valuable means of ensuring food supplies during times of scarcity, are widely used to supply food of poorer nutritional value (e.g. fatty meat products) at a lower cost than fresh unprocessed equivalents. Colouring and flavouring additives are used to give an advantage to foods of inferior nutritional quality. These cheap chemical compounds provide an unfair advantage to manufacturers of processed foods over the suppliers of fresh, less processed foods.

These distortions in the market come between the supplier of healthier foods and

the consumer who might want to eat them. They add to the difficulties consumers face, making it hard for 'the healthiest choices to be the easiest choices'. Yet they must be tackled if dietary health is to be taken seriously. Changes are needed all along the food chain. These will need explicit policy changes at member state and European level.

Ten steps towards healthy change in food policy

Many policies can be implemented to help change the current supply trends to encourage better health. Here are some examples:

1. *Remove support for the status quo.* Current policies encourage food supplies that do not meet health needs. Policies need to be reassessed, including the Common Agricultural Policy and also funding of food industry research.

2. *Improve market feedback.* In a 'pure' market, changes in consumer purchasing would be transmitted back to producers, to make changes in production. The CAP, with its subsidies and market support schemes, creates an artificial market and distorts this.

3. *Establish dietary goals.* Set national dietary targets and a monitoring body to ensure that policies aim at achieving those targets. Ensure food producers are aware of the targets.

4. *Set food supply targets.* These can be derived from the national dietary targets, using the techniques suggested earlier. Food supplies can be monitored more easily than dietary patterns, and are more readily understood by food producers and manufacturers.

5. *Set food compositional standards.* Limit the amounts of salt, fat and saturated fat allowable in a range of specified food types and use these limits to create fair market conditions for all manufacturers. If the limits are exceeded by some producers, then name-and-shame publicity or regulatory sanctions can be considered.

6. *Change the recipes.* Provide support for the improvement of processed foods. Provide support for storage and distribution technologies for fresh and relatively unprocessed foods.

7. *Restrict the use of additives.* Legislation requires additives to be used only when there is a technological need, but current practices allow many 'cosmetic' colourings and flavourings to be used in foods of poor nutritional value, giving these poorer foods an unfair market advantage undermining healthy choices. Review and tighten the controls on their use.

8. *Improve the coherence of dietary advice.* Food messages come from many sources, including schools, health services, family members, the media and the food industry, for example, food labelling and advertising. These messages should not conflict with the promotion of healthy diets. Food marketing messages must not undermine or conflict with health policy.

9. *Consider fiscal measures.* To repair the damage that the CAP does to the market, CAP-recovery levies might be taken from products which have gained an advantage from CAP subsidy. Purchase and sales taxes currently being levied on foods should be assessed for their health effects: for example, taxes on foods which are currently over-supplied, such as those containing animal fats, can be used to subsidise foods which are under-supplied. Taxation of food advertising might also be considered.

10. *Use public purchasing power.* Use public sector procurement to set gold standards for dietary health. In particular ensure that schools are beacons of good practice, providing and promoting healthy diets, good health messages and physical activity. Extend this concept to hospitals, prisons, and government offices.

Food companies need to see what change in policy is coming. As the potato chip president knows, there are big advantages if you get ahead of the game.

"Changes are needed all along the food chain"

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The EU Common Agricultural Policy from a public health perspective

Liselotte Schäfer Elinder

"The biggest health threats from food today are not bacteria and toxins but calories"

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Agriculture policy has been identified as a significant determinant of population health. It regulates the production of food and other agricultural products, food safety and price levels. According to economic theory, price and availability are the main determinants of consumption. The Common Agricultural Policy (CAP) also regulates international trade with and marketing of agricultural products, rural development, farmer's income and occupational health and affects the environment. Through the last 15 years organisations such as the EU Consumer Committee, NGO's including the European Public Health Alliance and OXFAM, and many academic experts have criticised the EU CAP for its negative health impacts. The WHO Global Strategy on Diet, Physical Activity and Health endorsed in May 2004 by the World Health Assembly, states that "Member States need to take healthy nutrition into account in their agricultural policies". This commitment adds to the pressure on the EU Commission and national governments to conduct health impact assessments before new agricultural reform measures are decided upon.

A number of food scares, such as BSE and dioxin-polluted feed, have resulted in food safety completely dominating the food policy agenda, in terms of media and political interest and funding. However, the biggest health threats from food in Europe today are not bacteria and toxins but calories. There was an assumption, emerging from times of food shortage that food security automatically would result in improved public health (see article by Tim Lang in this issue). The worldwide obesity epidemic and a rapid increase in rates of non-communicable disease, shows that this view needs to be modified.

Health consequences of over-consumption

Evidence clearly shows that over-consumption of animal fats, sugar and alcohol and under-consumption of dietary fibres, fruits and vegetables, is linked to cardiovascular diseases, cancer, diabetes, obesity and alcohol-related diseases.[2] These diseases account for the loss of 22 million healthy life years or 41% of the disease burden in Europe, corresponding to more than three million premature deaths each year.[3] The six leading risk factors for total disease burden are smoking, high blood pressure, alcohol, high serum cholesterol, being overweight and a low intake of fruit and vegetables, all of which are linked to the consumption of agricultural products. By doubling the intake of fruit and vegetables in Northern and Central Europe the disease burden could be decreased by 3–4%. Eliminating obesity could reduce it by 7–8%, eliminating smoking 12% and eliminating alcohol consumption would decrease the disease burden by 9%.[3]

What happened to public health concerns in European agriculture?

The reason for the creation of the EU Common Agricultural Policy (CAP) 42 years ago was actually public health. The devastation of the Second World War resulted in serious food shortages in Europe which were remedied by policies to increase productivity and provide income support for farmers. Today, with food security assured, the fundamental purpose of agricultural policy, the promotion of human health, appears to have been forgotten. Public health has never since been mentioned as a driver for policy change, which could be due to the fact that this fundamental objective is not mentioned in the objectives of the policy formulated over 40 years ago as noted by Tim Lang in his article in this issue. Instead income support has come to dominate the policy debate and policy reform process, strongly backed up by lobby activities from farmers' organisations. The requirement since 1999 for health to be considered in all community policies, as expressed in article 152 of the Amsterdam Treaty, is ignored by keeping measures in place that are hindering public health goals to be reached. Examples of this are discussed below.

The latest CAP reform in June 2003[4] is no exception to this rule. The main element of this reform is 'decoupling', which means that a major part of direct financial support to producers will no longer be linked to production volumes. The aim of this

scheme is to eliminate over-production and reduce costs. However, not all commodities were included in this reform, and critical issues for public health in milk regulation were not removed. This means that production and consumption aids to support animal fats and wine have survived another reform round and will continue. Why do governments and the public continue to accept this infringement of the Treaty and the current threats to public health exerted by agriculture?

Health implications of the CAP

The National Institute of Public Health in Sweden, having done some pioneering work assessing the public health impacts of the CAP in the mid-nineties,[5] decided to do a follow up study. The aim was to evaluate if succeeding reforms of the CAP had changed some of the most problematic measures identified in four sectors: fruit and vegetables, milk and milk products, wine and tobacco.[6] This analysis showed that although some minor improvements have taken place, public health concerns continue to be absent in agriculture apart from food safety. Some examples of how health is clearly not considered are illustrated for these four sectors.

Subsidising milk fat consumption

Milk and beef fat contain more than 50% saturated fat. Such high rates are a significant dietary risk factor for heart disease and diabetes.[2] In Sweden, similar to other Nordic and Central European countries, only 20% of the population eats less than the recommended level of fat (total fats being less than 30% of energy intake) and less than 5% of the population eats less than the recommended saturated fat intake (10% of their energy from saturated fat). In order to reach the latter recommendation, milk fat and fatty meat should be dramatically reduced and largely avoided in the diet.[7]

The dairy sector is one of the most regulated in the CAP, aiming to maintain the EU target price for milk well above that of the world market. As a consequence production exceeds demand by more than 20%. There are two major EU measures to get rid of the surplus, which is in the form of butter and skimmed milk powder, export subsidies and consumption aid. Export subsidies are financial support which farmers receive to make up the difference between the EU and the world market price for milk, which otherwise could not be exported out of the EU. But export subsidies are an expensive way of disposing of the surplus and increasingly unpopular in discussions on international trade (export subsidies are prohibited in all other sectors than agriculture). Consumption aid is financial support to farmers to cover their losses when selling their products below the cost of production to the food industry. The result is a food industry that obtains huge amounts of raw materials below the market price for making high fat processed foods e.g. ice cream, pastries. This shows that if food is over produced somebody will eventually eat it, often unsuspectingly, and that this is a matter of price. Therefore, in order to decrease consumption of milk fat, production should be lower in the first place.

"Animal fat consumption should not be subsidised"

The use of butter consumption aid varies between Member States, with France, Germany, Belgium, UK and Netherlands using 93% of the total consumption aid available in 2002.[6] The total amount of butter sold with subsidies is substantial corresponding to one third of total butter production in the EU. If distributed across the EU every citizen would get 1.5 kilograms per year. In light of the obesity epidemic and the high prevalence of heart disease and diabetes subsidising animal fat consumption should not take place.

The school milk scheme, funded by the EU, is another outlet of surplus milk. Full fat milk receives a 74% higher subsidy compared to skimmed milk. As a result skimmed milk, which for health reasons should be the main type of milk served at schools, presently accounts for only 5% of school milk served in Sweden. In light of health evidence and the alarming prevalence figures on childhood obesity, subsidising full fat milk products to children should not occur at all on public health grounds.

In the 2003 reform it was agreed to prolong and expand milk quotas until 2015. This means that EU production will continue to be far above the level of unsubsidised consumption (i.e. we will continue to pay to produce more than consumers want). The whole budget for the milk sector is used to sustain this surplus production to the detriment of public health and the dairy sector in developing countries, where surplus is dumped at prices below those of local markets.[6] As part of the 2003 reform, price support will be lowered and eventually decoupled from production from 2008. But as long as economic incentives such as consumption aids are in place, over production will continue. Swedish experts believe that

"Wine promotion campaigns financed with CAP funds target 20–40 year olds with message that wine is healthy"

milk production in the EU will continue to fill the expanding quotas but will move to countries with lower production costs (Swedish Milk, personal communication).

The EU Commission has no plans to phase out these aids but expects that the associated costs will decrease as intervention prices decrease (EU Commission, personal communication). This means that in the future more milk fat will enter the EU-market at a lower price. This will work against any public health messages to decrease total and saturated fat intake. The losers in this game will continue to be mainly low-income households and the less well educated who already carry the highest disease burden.[8] The food industry is likely to gain the most from continuing EU dairy support by being supplied with cheap raw materials.

Subsidising wine production and consumption

The CAP subsidises a 20% over-production of wine in the form of distillation aid for products classified as unmarketable.[6] Wine consumption in producer countries and in the EU as a whole is decreasing from previously very high levels. Alcohol taxation is one one effective instrument in reducing consumption. But wine-producing countries continue to maintain a zero-rate of taxation on wine nationally due to the difficult market situation. The zero-rate tax combined with the single market harmonisation requirement, is pressuring EU countries with high alcohol taxes to reduce taxes on all alcoholic beverages and to open borders to unlimited imports. In Sweden this appears to have resulted in a massive increase in alcohol consumption, from eight litres of pure alcohol per year to ten litres over a five year period with no sign of levelling off and the negative health consequences have started to become measurable.[9] This pressure to decrease alcohol taxes in the EU counteracts the initiatives taken by the public health sector to reduce alcohol-related harm. Although alcohol consumption overall is decreasing in the EU, it is still a major health problem. This is particularly true in new member states, some of which have the highest rates of alcoholic liver cirrhosis in the world, for example, Slovenia. Even worse, wine promotion campaigns financed from CAP funds, target 20–40 year olds with the message that wine drinking is healthy. This is clearly counteracting interventions to reduce alcohol consumption paid by the new EU public health programme which has a budget of €50 million per year. Even in the best case that 10% of the public health money will be allocated to reducing alcohol-related disease, this will still be 130 times less than what is yearly spent on distillation aid and about the same amount as spent on wine promotion during 2001.

Subsidising tobacco production

Tax payers currently contribute 80% of tobacco farmers' incomes via production premiums.[6] This ongoing financial support to maintain production of one of the biggest single risk factors for disease seems perverse, particularly as the Commission also financially supports tobacco control policies including advertising bans. The Commission does not deny that this is more of a social than an agricultural policy. In fact, paying support directly to farmers without having to grow tobacco would cost less than half as much according to the OECD.[10] After many years of resistance from producer countries, the Commission tabled a reform proposal in September 2003 in line with the June 2003 reform to decouple support from tobacco production. There is some mention of public health in this proposal, but the main reason for reform is probably economic. Nevertheless, continuous pressure from the public health sector has surely contributed to the Commission's standpoint. The decision to decouple the tobacco sector starting in 2006 and ending in 2010 is a step in the right direction. However it means that old and new member states will continue to support tobacco production for another six years.

Keeping prices up by limiting availability of fruit and vegetables

Over 1 million tonnes of classified fruit and vegetables (1.3% of production), were withdrawn from the EU market in 2001 with the aim of keeping prices up. Eighty per cent of this produce was destroyed. It is clearly not in the interest of consumers and taxpayers to have prices of fruit and vegetables maintained artificially high. Furthermore, destruction of produce violates the regulation which states that the first option for withdrawn produce should be human consumption.

As the EU is the world's largest importer of fruit and vegetables, there is considerable potential for EU agriculture to expand in this sector. This sector is due to be reformed later in 2004, which constitutes a window of opportunity for the public health sector to influence this process. (For a more extensive discussion of fruit and

vegetable sector reform see the article by Lock and Schafer Elinder in this issue.)

The 'red box' of public health

The red box of public health is analogous to the red box of the World Trade Organisation containing prohibited trade instruments. The box above summarises the current costs of measures in these four sectors which directly or indirectly harm public health, amounting to €3.4 billion per year compared to the total CAP expenses in the four sectors in 2001 of €5.6 billion. These measures must be regarded as policy failures in as much as they have negative effects on public health and should therefore be phased out as soon as possible.

Rural development and public goods

The CAP budget is divided in two pillars. Pillar I, currently taking up 90% of the budget, constitutes market support measures as discussed above. Securing the food supply was the original objective of this support, a true public good. However, today nobody will raise their voice to defend over-production, and therefore Pillar II, formally introduced in 1999, was created. It contains support for rural development and environmental protection, public goods which are potentially positive for public health. If one listens carefully to the debate one will notice that Pillar II objectives (not even included the Treaty) are used to legitimise the whole CAP budget. The 2003 reform implies that some funds will be transferred from the first to the second pillar. However, this does not change the fundamental requirement, namely that expenditure under Pillar I should only be given if the product is undersupplied by the market, and production needs to be boosted according to health criteria. Currently, the only sector complying with these criteria is fruit and vegetables.

Tackling the 'red box' of public health

Politicians and agricultural bureaucrats are not working in the long-term interest of the voting public, farmers or employers if they seek to maintain the present CAP. The CAP objectives, as formulated in the Treaty, are not in line with the needs of contemporary society and must be fundamentally changed. Agricultural interests come into in conflict with public health when subsidising the production and consumption of animal fat, tobacco and alcohol, while at the same time not supplying sufficient amounts of fruit and vegetables. Population health goals cannot be reached without appropriate changes in agriculture policy.

The EU agricultural policy costs consumers and taxpayers €117 billion per year through higher food prices and taxes.[11] This corresponds to about €1,150 per year for a four-person household. For this money society has the right to receive food suitable for optimum human health. A first step could be to tackle the items listed in the 'red box' of public health as priorities

The 'red box' of public health (2001 prices)

	Current annual cost
• Withdrawal and destruction of quality fruit and vegetables	117 million
• Aided consumption of milk fat on the EU market	460 million
• Export subsidies for milk products	1.1 billion
• Aided consumption of high-fat milk to schoolchildren	50 million
• Aid for distillation of wine	650 million
• Promotion actions for high-fat milk products and wine	10 million
• Production support for tobacco	965 million

Source: EU Commission and Schäfer Elinder L, 2003.[6]

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Health impact assessment: Implementing the CAP in Slovenia after accession

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This article describes the experience of the Slovenian government in carrying out a health impact assessment (HIA) of national agriculture policy, and the potential effects of incorporating the Common Agricultural policy (CAP) after accession to the European Union in May 2004.

Why conduct a HIA in Slovenia?

HIA is a structured method for assessing and improving the health consequences of projects and policies in the non-health sector.[1] Agriculture and food programmes and policies worldwide are often subjected to environmental impact assessments, but there have been very few studies of HIA applied to agriculture, particularly at the national policy level.

The main motivation for undertaking a HIA by the Ministry of Health was Slovenia's decision to join the EU. The HIA project commenced as a collaboration between the Slovenian Ministry of Health and the World Health Organisation (WHO) in 2002. This was at the end of the accession negotiations with the European Commission. Each new member state has had to accept that European law takes precedence over national law, including the influence of the EU CAP on national agricultural systems. The agriculture chapter of the acquis was still being negotiated when the HIA work started. All candidate countries, including Slovenia, had experienced difficulties in the agricultural negotiations, especially concerning the national financial terms for adopting the CAP. Overall the EU position with all accession countries was that there would be progressive introduction of EU-funded direct payments to farmers. However, differential agreements means that the levels and rates of introduction will vary across the new member states. But all new member states will be at a financial disadvantage compared to current member states in the common agricultural market for between 3–10 years.[2]

In addition there was concurrent development of a National Food and Nutrition Action Plan due for completion in 2003, based on the WHO European regional policy document.[3] The State Secretary for Health was worried about how accession, and especially changes in agriculture, would affect the health status of the population. Although life expectancy in Slovenia is better than in many new member states, the country has several major health problems compared to EU-15.[4] These include some of the highest rates of suicide and liver cirrhosis in Europe. There are also marked regional health differences, for example in mortality rates for cardiovascular disease, accidental injury and cancers between the regions in the east and west of Slovenia.[5] The reasons for the regional differences had not been explained, but the north-east region, Promurje, which has the highest all-cause mortality, is also the region with the largest agricultural sector in the country. Nationally agriculture contributes only 3.2% of GDP, and is dominated by dairy farming, animal stock, and cereals with the main crops being corn, barley and wheat. In Promurje, agriculture is much more important economically with 20% of the population employed in farming or related industries, which are most likely to be affected after accession.

The HIA methods used

HIA was proposed as an appropriate approach that could be used to investigate how adopting some of the specific aspects of CAP funding and policy would impact on population health. This was important as public health was not a directly negotiated factor within the CAP. The public health aspects within EU agricultural and food production policies are limited mostly

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to food safety, animal welfare and environmental protection.

HIA methodology is flexible depending on the context and is still being tested and improved, particularly at a national policy level.[6] The HIA approach used in Slovenia is summarised in Table 1.

The first, and most difficult task, was to clarify which policies and instruments of CAP we should consider, and what effect they would have when implemented nationally. It became clear that this could not be done with certainty, partly because there were ongoing negotiations with the EU about the amount of CAP subsidies that Slovenia would be allocated on accession, and also because of the different way each country applies the regulations. To assist the analysis agricultural experts from the University of Ljubljana modelled and interpreted potential policy scenarios which would be likely when integrating CAP requirements in Slovenia.[7]

To simplify the HIA it was proposed to focus on three agricultural regimes; dairy products, fruit and vegetables and wine, which were analysed in greater detail due to their importance in agriculture and their potentially significant health impacts. The dairy regime is among the most distorting agricultural policy in the EU, receiving a considerable amount of the total agricultural budget not related to market share. Animal production and particularly dairy farming is also a large part of the agricultural sector in Slovenia. It was important to consider because it has wide ranging implications for market developments and health impacts.

Fruit and vegetable policy in the EU has been reformed, however, it still creates market distortion. There are obvious health benefits that can be gained with the promotion of production and increased consumption of fruit and vegetables. Slovenian agriculture is well suited to some fruit production and there are already efforts to reorient production into the growing organic sector.

The EU wine regime is primarily oriented to maintain the income levels of producers. Slovenia also has a large number of small scale wine producers. The Slovenian population has a high alcohol intake and high rates of alcohol related diseases, especially in rural areas.

It was also felt that the HIA must recognise that there are other drivers of health and policy change in the agricultural sector, including issues of rural development, socioeconomic and cultural change which must be taken into account as part of the HIA process. The HIA considered how some aspects of the proposed Rural Development funding could be used to benefit the health and well-being of rural populations.

Table 1

THE HIA METHODOLOGY USED IN SLOVENIA

Description and analysis of policies and instruments of CAP
Rapid appraisal workshops with stakeholders
Review of research evidence on health impacts
Analysis of Slovenian health indicators
Formation of policy recommendations for Slovenian Government

After identifying some of the key instruments that would be used to implement CAP in Slovenia, the HIA identified and collected information about possible health impacts that a policy might create. The HIA approach taken in Slovenia involved collecting information from national and regional stakeholders in a series of meetings. The first workshops were held in March 2002 in the north-east region of Promurje. In total, 66 people participated, including representatives of farmers, food processors, consumer organisations, schools, public health, non-governmental organisations, development agencies, and officials from government ministries. These included Ministries of Agriculture, Economic Development, Education, Tourism, and Health. During the workshops participants considered the core agricultural policy issues and identified potential health issues and other concerns. These concerns were grouped under various headings outlined in Table 2.

"HIA is a structured method for assessing and improving the health consequences of policies and projects outside the health sector"

The next stage in the HIA process was to

Table 2

KEY CONCERNS ABOUT AGRICULTURAL POLICY DEVELOPMENT AFTER ACCESSION IN SLOVENIA

Loss of income, employment, housing and social capital in rural communities
Increased food imports and impact on exports
Nutritional value of food and food safety
Environmental issues: e.g. intensification of farming
Potential benefits of organic production
Barriers to small and medium sized enterprises
Occupational health
Capacity of local services (employment, education, health & social) to adapt to any changes post-accession

Source: Outcomes of stakeholder HIA workshops, Slovenia 2002

compare stakeholders' concerns with the existing evidence in the scientific literature. It was planned that literature reviews would be used in combination with the existing data in Slovenia to support or refute the health concerns put forward by the stakeholders. Various reviews were planned including: environmentally friendly farming; mental health and rural restructuring; socioeconomic factors and social capital in rural areas; occupational health; and nutrition and public health. Not all reviews have been completed, so only the implications of the latter review are discussed in this article.

"Results and recommendations were presented to the parliamentary intergovernmental committee on health"

Indicators of how polices may affect the current situation in Slovenia were based on existing nationally and regionally collected data on: the level of food production (for example, milk and vegetables and fruit); methods of food production (for example, intensive versus organic); levels of food imports and exports; food processing including on farm processing; access of consumers to food (for example, retail outlets and prices;) patterns of food consumption; food-borne disease statistics; environmental pollution; occupational health; and socioeconomic factors including correlation between high unemployment, inequalities and the prevalence of disease.

The final HIA report was completed by the Ministry of Health in October 2003. This presented the results and recommendations for the government of Slovenia on a range of agricultural issues. It was presented to the parliamentary inter-governmental committee on health on November 19th 2003.

Potential health impacts of the CAP in Slovenia

The main findings regarding nutrition and public health in Slovenia were worrying. The current energy intake (especially from fats, saturated fats and sugar) is too high. The intake of fruits and vegetables are on average 100g short of the WHO minimum recommendations of 400 grams per day.[8] Fifteen percent of the adult population are obese and 38% of the adult population are overweight. Moreover the levels of blood pressure and blood cholesterol are high resulting in the high prevalence of heart diseases and high premature mortality rates in Slovenia.

Scientific research and evidence from other countries show that if nutrition policy recommendations are implemented this can result in a significant reduction in premature deaths from cardiovascular diseases.[9] For example, in Slovenia, it is estimated that if fruit and vegetable intake is increased, this could reduce the risk of coronary heart disease, stroke and cancer by 10%, 6%, and 6% respectively.

Several policy recommendations were made following the HIA in Slovenia to improve health and wellbeing. Many of the policy changes recommended cannot be taken by the Slovenian Government alone without changes to the CAP at a European level. Therefore the recommendations made are of relevance to and include policy changes that must be addressed by all ministries of agriculture in Europe.

Fruit and vegetables

1. Increase Slovenian production of fresh and frozen fruit and vegetables to meet dietary guideline requirements. Demand should be stimulated by healthy eating campaigns. Determine which fruits and vegetables are most suited to both the agricultural system and market demand.

2. Evaluate the possibility of restructuring production from intensive-growing of grains to more labour intensive, value-added fruit and vegetable production. Investigate the viability of small farms to convert to horticulture with support from rural development funds.

3. Agricultural, economic, and health sectors should develop better integrated statistics on fruit and vegetable production and consumption. These data could help improve market research and marketing with the aim of increasing consumption of fruit and vegetables.

4. Support farmers, through various CAP measures (food safety and environmental measures), to produce fruit and vegetables with reducing levels of pesticides.

5. Any withdrawal of fruit and vegetables from the market should be used for human consumption according to EU regulations (unlike the current situation where much is used for composting). It is proposed that withdrawals could become part of a subsidised school fruit scheme.

Wine regime

1. Stop EU supported promotion of wine drinking to 20–40 year olds. This is totally against Slovenian public health policy, particularly as alcohol consumption in this age group is rising most rapidly. This is particularly important as Slovenia has one of the highest rates of alcoholic liver disease in the world.

2. Reduce surplus wine production by converting vineyards and providing conversion support to vine growers. Discourage the use of EU funds for distillation support for surplus wine production and increase use of EU funds for conversion aid.

3. Create a register of all vineyards in Slovenia and use it to monitor wine production and use of surplus wine production, to track changing use of alcohol production after accession.

Milk products

1. Use EU funding to give incentives to farmers to reduce the butter fat percentage in cow's milk and provide the technical support, for example, through changing feeding practices as has been done in other countries.

2. Allow more use of EU support for low-fat milk products in line with public health dietary guidelines. This should include marketing the public health benefits of consumers switching to low fat milk from both agricultural and health sectors.

3. There is currently 20% over-production of milk in Slovenia. The Government should work to reduce the amount of surplus milk and butter fat produced, by reducing subsidies.

4. The EU schemes which allow the highest subsidies for full fat milk in schools should be changed. The Slovenian guidelines only support the supply of low fat milk, instead of full-fat milk, to school children and this should be supported by the agriculture sector.

Rural development measures

1. It was felt more work needed to be done in Slovenia to assess the likely health impact of post accession-rural development measures as specific polices and funding were still being developed.

2. Ideally rural development measures should encourage investment in crops that contribute to a healthy balanced diet e.g. processing of fruit and vegetables, not processing of surplus milk.

3. The Government could ensure a local market for Slovenian products by supporting a policy of procurement contracts between local producers and governmental institutions such as hospitals, schools, prisons, elderly homes and local government canteens.

4. Rural development measures to support income diversification, livelihoods of small farmers and to tackle rural unemployment should be investigated.

Conclusion

The HIA in Slovenia was a pilot project to estimate the likely impact on health of complex policies such as agriculture. It was acknowledged at the start that there would be a need to continue to develop the methodology and that, given the complexity of policies, the analysis would not be as comprehensive as desired. An important part of this process are the lessons that are learned regarding the implementation of HIA and agriculture policy in Slovenia and other countries. There were many limitations to the methods used, including lack of data, time and resources.[2] However, the HIA proved to be a useful method for improving inter-sectoral collaboration between sectors, in this case, ministries of health, agriculture and regional development agencies. Work needs to be continued to develop methods to assess health impacts of complex policy areas such as the CAP. Just as CAP now considers public health in the form of food safety and environmental protection this needs to be expanded to consider nutrition and broader public health determinants.

As far as we were aware, Slovenia is the only country, which has undertaken a prospective health impact assessment of new national agricultural policy. Although this case study relates to Slovenia, we believe that the experience and recommendations are applicable for all EU countries (both new and old Member States) and the European Commission. From this work it is clear that, even if governments wish to make changes in line with public health and nutrition recommendations, they are sometimes unable to do so because of the agricultural agreements that exist at the European level. This article has highlighted some of the challenges and the need for action to improve agricultural policy, nutrition and public health inter-sectorally at the European level. Health impact assessment is one approach that could prove a mechanism for achieving this at national level.

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Health impact assessment:

Mental health impacts of a Foot and Mouth Disease outbreak in Wales

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The Welsh Assembly Government is committed to developing the use of health impact assessment (HIA) in Wales to assist the development of a more integrated approach to policies and programmes across policy areas. National guidance was published on the subject followed by a development programme. The programme included awareness raising and training events, pilot projects to test the use of health impact assessment, and more recently, the establishment of the Welsh Health Impact Assessment Support Unit to assist organisations in Wales to utilise the concept. The Assembly Government's experience on a range of issues has been documented in papers and reports. This paper discusses how the approach was applied to the agricultural sector following an outbreak of foot and mouth disease in 2001.

Although health impact assessment may be defined in many ways, the World Health Organisation (WHO) provides one of the most useful definitions:

A combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of the population, and the distribution of these effects within the population.

The 2001 Foot and Mouth Disease outbreak

In 2001, a major outbreak of foot and mouth disease (FMD) occurred in the UK for the first time since 1968. Between February and September 2001, 2,000 cases of FMD were identified. The UK government introduced an extensive disease control policy, which led to the slaughter and disposal of over 4 million animals. In Wales, the first case was recorded on Anglesey in north Wales on 27 February 2001, which was followed by confirmation of a further 117 cases. Most cases were located in Powys in mid-Wales (78 cases).

Foot and mouth disease (FMD) is a self-limiting, non-fatal infectious disease affecting cloven-hoofed animals, in particular cattle, sheep, pigs, goats and deer. The disease has serious implications for the economics of the livestock industry as it limits exports. It can spread by direct or indirect contact with infected animals. The disease is also spread by the movement of animals, people, vehicles, and other items that have been contaminated by the virus. The control and slaughter policy was aimed at containing the spread of the disease.

FMD is virtually unknown in humans, with only one case being recorded in 1966. A literature review revealed a limited selection of articles from previous outbreaks on the impact on human mental health and well-being of FMD in the UK. Prior publications mainly concentrated on the physical health impacts of the disease . However, there existed a small body of international literature that explored the health impacts of such disasters and social crises, which reinforced the need to examine the wider psychological effects of the outbreak on the population of Wales.

The Welsh Assembly Government recognised that the disease was having an impact on mental health and well-being. It commissioned the Institute of Rural Health (IRH) to undertake a rapid assessment at the time of the outbreak. Subsequently, the IRH and the University of Glamorgan were commissioned to undertake a more detailed retrospective health impact assessment with the aim of determining the nature and magnitude of the mental health impacts on people in the affected areas. The initial rapid assessment provided valuable information to policymakers during the outbreak and also served as a scoping study

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Further information: Welsh Assembly Government information on health impact assessment: www.cmo.wales.gov.uk/content/work/health-impact/resources-e.htm

for the more detailed assessment that followed .

Approach

The study followed the health impact assessment approach described in the Welsh Assembly Government's guidance, which is summarised in Table 1. The study was conducted over a six-month period (1 October 2001 to 31 March 2002 inclusive) during which time aspects of the management of the outbreak were still in operation. It was undertaken in a relatively short time period due to the importance of minimising recall bias in the target groups.

Given the short study period, two areas were selected for the assessment, Anglesey and Montgomeryshire (northern Powys). Both areas were significantly affected by the outbreak. On Anglesey, while there were fewer FMD cases than in Montgomeryshire, many farms were affected by the FMD control policy, which led to a mass livestock cull of contiguous farms surrounding infected farms. In Montgomeryshire there were farms with livestock slaughtered due to FMD, others with livestock slaughtered due to contiguous culling, and restricted farms where movement of livestock was prohibited. Consequently, the two target areas for this study contained farms from across all categories of farm businesses affected by the outbreak.

Screening

There was no formal screening process, but the health impact assessment was triggered by anecdotal evidence and recognition by the Welsh Assembly Government of the likely impacts on people's health and wellbeing.

Scoping

The rapid assessment commissioned by the Welsh Assembly Government served as the scoping study. Telephone interviews were conducted with service providers from the statutory and voluntary sector. This identified the three target groups for the in-depth study, farm businesses, other rural businesses (for example, businesses requiring access to agricultural land such as hauliers, feed merchants and non-agricultural businesses such as hotels and cafes) and service providers (for example, slaughtermen and officials from the government agricultural department).

Risk Assessment

90 interviews were undertaken in total across the two study areas (15 interviews from each of the target groups in each area). Most of the interviews in Anglesey were conducted in the Welsh language. The interviews included two validated health questionnaires (SF36, Hospital Anxiety and Depression Scale, HAD) and a semi-structured interview schedule on self-reported health, and personal experiences during and as a consequence of the disease outbreak. There were 58 males and 32 females in the final sample. The majority of people were in the 45 to 64 age group.

Table 1

STAGES OF THE HEALTH IMPACT ASSESSMENT OF THE 2001 FOOT AND MOUTH DISEASE OUTBREAK IN WALES

Stage	Nature of work
1. Screening	Preliminary assessment to determine if the situation poses health questions
2. Scoping	Process to broadly outline the possible hazards and benefits
3. Risk assessment	Characterising the nature and magnitude of harmful and beneficial factors
4. Decision making	Consideration of the report by the Welsh Assembly Government together with the risk assessment and potential impact on future policy decisions
5. Implementation and monitoring	Welsh Assembly Government to action and implement decisions made and to observe the consequences

"58% of study sample felt that the FMD outbreak had an effect on their health"

Findings

Impact on services

Services in Wales that provided practical advice and support, including financial grants to farmers were in high demand and considered to be a 'lifeline' to those with short and long financial difficulties. Demand was also placed on agencies offering emotional support. However, this was much less frequent and raised the issue of whether they were accessible and acceptable for those in need of emotional support and advice at the time.

Impact on individuals:

The analysis of the SF36 showed that our sample had poorer emotional health than would be expected from our comparative data (the Welsh Health Survey). The data also showed that 19% of the sample had mild, moderate or severe depression.

Anxiety was also evident with 38% of our sample having mild, moderate or severe anxiety, with the 45 to 64 age group suffering the greatest levels of anxiety. Overall 58% of our sample felt that the FMD outbreak had had an effect on their health, but this was much higher in Powys (71%) than

"The impact was not just restricted to farmers, business owners and officials, but had a wider impact on family life"

in Anglesey (46%). At the time of the survey, 24%of the sample still felt that their health was suffering as a result of the FMD outbreak and some people (particularly slaughtermen) were suffering flashbacks.

Through the interview data our sample highlighted a range of specific factors that they felt had affected their mental health and well-being. These included some distressing aspects of the foot and mouth situation:

- The cull of animals, in particular newborn lambs, and pets (affected farming families including children and slaughtermen).
- A feeling of loss of control over events.
- Frustration and anger related to lack of information.
- Uncertainty.
- Isolation from family members.
- Feeling of guilt/contamination.

The impact was not just restricted to farmers, business owners and officials, but had a wider impact on family life. A high proportion (63%) of those with children stated that the outbreak had had an effect on them. This was even higher in the farm businesses group (86%).

Medium and long term issues to be addressed

Many people who were interviewed considered that their health was worse than prior to the outbreak with significant levels of poorer general and emotional health, anxiety and depression. The qualitative data demonstrated a continued level of stress and physical ill health as a result of the cull of animals and other aspects relating to the outbreak. Children were affected by the outbreak. The assessment concluded that it would be useful to investigate the longer-term impacts on the mental and physical well-being of the population, especially in children.

Reflections on the health impact assessment

HIA is promoted as a tool for policymakers and there is an increasing literature on its use and usefulness. However, it needs to be tested in different situations and while assessment as part of policy and programme development is important, testing its use in a retrospective sense is also vital.

The use of the HIA model was helpful to guide the approach by providing a framework for both the rapid assessment and the more detailed study highlighting the connections between people's health and other policy areas. The rapid assessment commissioned during the outbreak was useful in its own right as a source of information on the impact of the disease on service providers and support agencies at the time of the outbreak. However, it was also useful as a scoping study for the more detailed assessment, and the combination of actions illustrates well the flexibility of the health impact assessment concept. To be useful, health impact assessment has to be able to cope with the realities, including timescales of the circumstances in which it may need to be used. Commitment to its use is also important and in this case, the Welsh Assembly Government's commissioning of the assessment ensured that its findings were fed back directly to policy makers.

While retrospective health impact assessments cannot influence the design or shape of a programme in development, they can inform policy makers on the handling of, and response to, unplanned events that may occur in future and the development of policies and programmes around this. This assessment also highlights the importance of considering the mental as well as physical impacts on people's health and well-being.

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Rural development and food policy in Europe

John M Bryden

Aileen Robertson

Rural populations often show negative health trends but what can public health do to reverse these? Rural Development Policy should be designed to produce both sustainable food supplies and healthy rural communities. We need to understand what makes rural communities economically, socially, culturally and environmentally healthy, and how policy-makers can best work together to achieve these aims.[1,2]

Emerging European Union (EU) Rural Development policies present an opportunity for improving public health in rural areas. The European Commission (EC) is planning the most radical shake-up of agricultural policy and rural development funding since the late 1980s with plans for a possible dedicated European Rural Fund to come into effect from 2007. The new fund would bring together all the diverse sources of funding that are currently split between the Common Agriculture Policy (CAP) and the Structural Fund budget. A range of new Rural Development policy initiatives will be available: support for meeting standards; improving food quality; occupational safety; enhancing animal welfare; and support for young farmers. Incentive payments will support food production under the EU's protection of geographical origin schemes as well as conversion to organic farming. Also funds will be available to producer groups to inform consumers about these schemes. Hopefully there will also be a range of support for rural diversification, small enterprises, and services.

As new EU Rural Development policies are being shaped, how can the health sector ensure that the need for healthy rural communities is at their core? We propose seven broad indicators which can be used to identify healthy rural communities: population and migration; economic diversification; human health; rural identity, culture, history, environment, and education; property ownership and access to credit; institutional capacities and governance; and finally who does rural development.

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Population and migration

Healthy rural communities should be able to maintain their population within a viable age range. However it is anticipated that rural depopulation will continue so that 90% of the EU population (76% in southern Europe) will be living in cities by 2030, leaving only around 10% in rural areas. The rate of rural depopulation is expected to speed up in many new Member States after they join the EU. This will negatively affect rural areas and will also increase the socioeconomic and health problems in cities resulting from rapid urbanisation. EU agriculture ministers have pledged to stem the migration from low-income rural communities. However this rural exodus can only be reduced by creating new kinds of employment and providing rural dwellers with a good standard of living and quality of life.

Economic diversification

Rural incomes are generally lower than those in urban areas and rural areas have a higher share of their population unemployed and living in poverty.[3] Agricultural employment in the EU-15 declined markedly from 7.6% in 1988 to only 4.4% in 1999. In western Europe the massive loss of agricultural employment was not compensated for by the creation of new local jobs and fewer family members can find full time employment in agriculture. More than 75% of the EU's 13.5 million agricultural labour force works part-time. In the new Member States an even higher proportion of rural people are engaged in agriculture and in both old and new EU member states, families on small farms survive by a mixture of subsistence and off-farm earnings.[4,5] In 2000, 21% of the male workforce in Poland and 22% in Romania were engaged in agriculture but many were aged over 64. Few self-employed farmers in Romania and Poland receive adequate pensions and so older workers will remain in agriculture unless social security pension schemes support their retirement. Such

retirement schemes appear essential to mitigate the large rural unemployment problems that will occur in the EU after May 2004.

Some rural regions have successfully diversified their economic base, provided jobs and maintained employment rates even with reductions in the numbers of farms and fishing boats. New growth areas include: production of vegetables and fruit, since employment rates in horticulture are 5–10% more when compared with intensive agriculture; new value-added and niche products; activities related to local culture, environment, recreation and tourism. Austria's bed & breakfast farmhouses inject some €700–900 million per year into the rural economy and around 7% of farming households are letting out rooms or cottages.

"There is more ill health, high levels of poverty and inequalities in rural areas"

Human health

Public health is affected by a broad range of socioeconomic determinants. There is more ill health in rural areas where there are also high levels of poverty and inequalities. In the Czech Republic, Slovakia, Romania and Bulgaria, infant mortality is nearly twice as high in the rural regions and a health impact assessment in Slovenia revealed that levels of unemployment, educational attainment, Gross Domestic Product, mortality rates and life expectancy are all worse in rural areas.

Despite the emphasis on public health in the EU treaties, public health aspects within EU agricultural policies are limited mostly to food safety. It is paradoxical that a vast amount of regulations and resources are focussed on preventing food-borne diseases which are much less significant in terms of mortality compared with the major diseases linked to nutrition.[6] Indeed overly rigorous hygiene regulations may even have some negative impact on socioeconomic determinants of health. The closure of local food markets, small slaughterhouses and food processors, as a result of EU regulations, may create food insecurity and increase unemployment in rural areas. Fortunately, according to Commissioner Byrne, small local food producers should not be penalised by new hygiene rules and support will be available to help meet new higher standards. Local suppliers of small quantities of primary products direct to the consumer or local shops will be unaffected by the rules, and there will be further flexibility regarding traditional methods of production and food businesses in remote areas. The impact of new regulations on small local producers and processors should be monitored and checks made to ensure that regulations do actually help to reduce the incidence of food-borne diseases.

The EU's 'Community Initiative' LEADER (Liaison Entre Actions pour le Development de L'Economie Rurale), started in 1990, has played a key role in stimulating the rural economy. With important funding from the Structural Fund and CAP, governments and private enterprises LEADER has supported new initiatives in rural tourism, culture, environment, small enterprise, training, promotion and packaging, upgrading equipment, research and development and networking. For example, the LEADER programme was used by the Environmental Health Services in Ireland to support training for family butchers and nursing home owners in new EU food hygiene regulations.

In rural regions footpaths and hiking trails provide the possibility of promoting physical activity while boosting the local economy. Walkers in England spend the equivalent of €8.7 billion a year supporting about 254,000 full-time jobs. The longest walking trail in south-western England generates the equivalent of around €435 million per year for the local economy and around 30% of tourists visited because of the path.[7] Local people also benefit by taking around 23 million walks per year.

Health care, like many public services, is more difficult to provide in rural areas. The provision of health care should be adapted to the rural situation, and should deliver equivalent standards of care to those in urban areas. Unfortunately there are problems in supplying quality health care, including problems of recruitment and retention of professionals, and rural transport preventing access. Research into rural health services should be a priority and more action is needed.

Value of rural identity, culture, environment and education

In the EU-15, and in the new Member States, the level of education among the rural population, particularly farm workers, is below average. Much should be done to secure equality of educational attainment with urban areas. Rural people's employment opportunities and future incomes will continue to be disadvantaged if they do not have similar learning opportunities. Increased agricultural unemployment will be one of the major political challenges in

new member states and the local food sector could provide diversification opportunities, for example, market gardening, food processing and organic production. In rural areas the education system should provide 'place based' learning that respects local culture, and supports people to enhance their quality of life as part of a life-long learning approach. Farmers will only be able to take advantage of new opportunities if re-training is accessible.

The public sector in England is investigating new procurement guidelines to encourage food served in schools and hospitals to be sourced locally. Small and medium sized suppliers are being made aware of public sector tendering requirements. Instead of buying for the best price alone, public sector purchasers will be encouraged to take into account the concept of "food sustainability" which includes nutritional content, freshness, animal welfare, energy and pesticide usage. If successful this initiative could boost local economies by the equivalent of €7 billion and create new long-term local jobs. The benefits include: better-quality food; more market opportunities and greater profitability; reduction in costs for public sector; reduction in diet related diseases; improvements in environment and social benefits.

Property ownership and access to credit

Rural communities need to be able to own their property and often need financial support for local small and medium sized enterprises. In some places, as in Scotland, land reform to return ownership to local communities plays its part. Transaction costs for loans are generally higher in new member states than in EU-15, and this combined with relative poverty explains the low rates of rural investment and business start ups there. In some new Member States there was low uptake or limited use of EC funds because of a lack of knowledge by the rural population. In Slovenia funds were mainly invested in food-processing and marketing of agricultural and fishing products and in Hungary for marketing and processing of fruit and vegetables.

A survey of the local food sector in the United Kingdom[8] revealed that only 14% of businesses surveyed had received any financial support. Many enterprises said that banks were not sufficiently responsive to the needs of local food businesses. Problems were experienced because some sources of funding cannot be applied for retrospectively and, if an enterprise has to wait, it could miss a market opportunity. There is a need for government funded support and marketing of local food. For example national programmes, implemented by Regional Development agencies, could include trade directories, increasing competitiveness, publicity, food fairs and raising consumer awareness of the benefits of local food such as healthy eating.

Institutional capacities and governance

Successful rural areas have a relatively high degree of autonomy along with good local government and governance where agencies have good relations with civic and private sectors. The LEADER programme has led to a restructuring of regional and local government structures in some cases and has stimulated local initiatives by private businesses, local communities, and the voluntary sector. Thanks to EU funding, isolated communities in Scotland developed their own policies on how to make the best of their local food sector: sustainable land use, marketing, adding value and local processing were of major importance. However in the new EU member states, local institutional structures are generally weak and they have a legacy of highly centralised government and a low degree of local decision making and fiscal autonomy.

"Successful rural areas have a relatively high degree of autonomy and good local government"

At a national level, the Norwegian Ministry of Agriculture created a 'Value Creation Programme for Food' where the aim is to increase the market share of niche products to 10% of its food production sector by creating a Norwegian 'mark of origin'. A variety of products such as brown cheeses, dried beef marinated in local herbs, reindeer milk and tiny carrots are being marketed. The carrots cannot be sold through normal channels due to European standards governing acceptable size and weight. Similarly Hungarian farmers were unable to capitalise on their bumper apricot and cherry harvests, and demand from EU, in 2003 because their produce did not meet EU standards on size.

Countries could establish coordinating centres, funded via rural development, to help the local food sector improve its efficiency and work with farmers, processors and retailers to get their products to consumers. The Hungarian Ministry of Agriculture has already increased the level of support for producer organisations in fruit and vegetable sector to help marketing.

"There is a need for EU and national policies to work in an integrated way"

There are many retailing challenges for the local food sector, including international supermarkets that source food from outside the rural areas where they are located. In France local authorities were given the right to veto construction of supermarkets over 1,000 square metres in order to protect the social and economic cohesion of society and they could negotiate the supermarkets´ procurement policies. In the UK, one company plans to build a supermarket in south-western England in cooperation with a group of eight local farmers where half of the floor space will be given to local produce. This site will include micro-industrial units for use by small local producers and processors; a demonstration farm to show how food is produced; a test kitchen; a trade hall where producers can meet buyers; and advisers to provide advice to consumers.

Around half of the United Kingdom's population feel supermarket chains have too much power and 70% would prefer to shop locally. Of those who expressed a preference about where their food was grown, 52% said they would like to see it grown locally. However, small producers often have difficulty in getting contracts because they cannot guarantee year-round supplies of vegetables. The demise of local shops exacerbates the situation and this is most pronounced in rural areas. The Rural Shops Alliance estimates that there are fewer than 12,000 rural shops left in Britain and these are disappearing at a rate of 300 per year. In an attempt to combat the reduction in retail outlets, local farmers markets can be established and also food purchasing cooperatives in cities, possibly set up by rural regeneration funds, could create direct links to local producers who may supply fresh produce at lower costs than supermarkets.

Who is doing the rural development?

Last, and most important, rural communities should do their own development, and not have it done for them by others. However, political and practical support should be available to ensure communities can take advantage of all the opportunities discussed.

Conclusion

There remains a lot to be done to secure 'healthy' or 'sustainable' rural communities in the enlarged EU-25. There is a need for both EU and national policies to work in an integrated way if the broader concerns of rural people in terms of jobs, incomes, employment, quality of life, health and education are to be addressed. Although many of these challenges are significantly greater in the new member states, the problem is far from solved in the EU-15. The European Commission has signalled that it would like to create a new 'European Rural Fund' after 2007 to provide a single source of revenue for rural development. It must also provide a good mechanism for sharing good practices between regions such as the now defunct European LEADER Observatory.

Rural communities need to learn from each other's successes and transfer experiences. Agriculture or intensive farming cannot save rural places. However, the development of rural areas can help to save farming families and help to create a sustainable food supply. The food sector should strive to communicate its positive role in social, economic and community life. In the words of the First WHO European Action Plan for Food and Nutrition (2000–2005):[9] "Growing, buying and eating the right kinds of food can reduce the risk of disease and simultaneously promote a sustainable environment".

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European fruit and vegetable sector reform

An opportunity to benefit both agriculture and public health

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The EU burden of disease due to low fruit and vegetable consumption

Health policymakers in Europe are increasingly concerned about the growing burden of chronic non-communicable diseases, including cardiovascular disease, cancer and obesity.[1] They are the leading causes of death and disability worldwide and are increasing rapidly throughout the world.[2] The WHO World Health Report 2002 estimated that the burden of non-communicable diseases accounted for 8.3 million (76.6% of the total) deaths in Europe in the year 2001.[2]

Although the major risk factors for non-communicable diseases are complex, most are now well known and many are modifiable. They include tobacco, physical activity and diet. Awareness of the health benefits of fruit and vegetable consumption has been increasing in the last ten years, with clear evidence of their protective effect for heart disease, stroke, diabetes, obesity and some cancers.[3] Findings from the recent Global Burden of Disease study suggest that 4.4% of the total burden of disease in the region could be attributed to low fruit and vegetable intake, and 7.8% to being overweight or obese. Current low fruit and vegetable intake is estimated to cause up to 31% of heart disease and 11% of stroke.[2] The UN International Agency for Research on Cancer (IARC) estimates that the amount of all cancers preventable by increasing fruit and vegetables ranges from 5–12%, and up to 20–30% for upper gastro-intestinal cancers.

A recent international expert committee recommended that fruit and vegetable consumption be increased to at least 400–500 g/day[3] to improve public health worldwide. One study has reported that 23,000 premature deaths (before the age of 65) from cardiovascular diseases and major cancers could be prevented in the EU if mean fruit and vegetable consumption was increased to the minimum recommended levels.[4] However, in Europe consumption of fruit and vegetables is very variable between countries. Only a few Mediterranean countries, for example, Greece where availability is high and prices low, are currently meeting the recommendation on a population level. But despite a relatively high mean consumption of 500g per day in Greece, 37% of the population is still below the recommended level. This is surprising considering that the climate and agricultural conditions in southern and central Europe are ideal for producing sufficient fruits and vegetables to feed the whole region year-round.[5]

Consumption clearly varies within countries between different social classes and age groups; in Sweden, only 10% of 15-year olds eat fruit and vegetables every day;[6] and surveys in 15 countries show that low income households have the lowest fruit and vegetable intakes.[7] In many European countries population mean intake needs to double to meet health goals. The clear health message to everyone in Europe is to increase consumption of fruit and vegetables, but how can this be supported by agricultural policy?

EU fruit and vegetable production

The EU is the world's largest importer of fruit and vegetables and the second largest exporter. It produces about 10% of the world's total production of fruit and vegetables. The fruit and vegetable sector uses about 4% of the agriculture budget, and accounts for about 16% of the total value of agricultural production in the EU.[8] The total production of vegetables in the EU has been reasonably stable for several years at about 55 million tonnes and the total production of fruit approximately 30 million tonnes. European demand has also remained stable at about 41 million tonnes of vegetables (approximately 133 kg/per person/year) and 29 million tonnes of fruit (approximately 92 kg/per person/per year), although there is a trend of increasing consumption of fruit juices.

The CAP creates a trend towards the intensification of farms, resulting in fewer and larger production units which generally employ fewer workers. The fruit and vegetable sector is more labour intensive, with a higher net value of production per hectare

"23,000 premature deaths could be prevented in the EU if fruit and vegetable consumption increased by recommended levels"

than that for agriculture as a whole.[9]

The Common Market Organisation for fruit and vegetables

Several mechanisms exist through which the EU can intervene on the agricultural market to effect quantity of production and price. For fruit and vegetables the two mechanisms used are withdrawal of produce from the market and using import tariffs.[8] These measures artificially maintain prices above the world market and thus ensure a high income for farmers, one of the objectives of the CAP.

The previous 1996 reform of the fruit and vegetable sector aimed to give more responsibility to producers to handle and distribute withdrawn produce and to lower levels above which no withdrawal support payment can be obtained.[8] Across the EU the amount of fruit and vegetables withdrawn with EU financial support has been reduced. From 1993 to 1996 the withdrawal quantity halved and is expected to reach the lowest level in the market year 2002/2003 where the withdrawal ceilings have reached their lowest levels.[8] In 2001, 1.1 million tonnes (approximately 1.3%) of total production was still withdrawn at a cost of €117 million, falling to 0.6 million tonnes in 2002 at a cost of €61 million (European Commission).

Withdrawn produce should only be used for certain purposes such as free distribution via charities as a first choice, disposed of as animal feed, distilled for alcohol, or destroyed as a as a last resort. Currently up to 80% of withdrawn produce is destroyed and only about 5% is actually going back into the human food chain. Although it is recognised that there are limitations, as some fruits and vegetables are perishable, the current situation is clearly not in line with the EU regulation, nor public health goals.

Proposals for the 2004 reform of the fruit and vegetable sector

The fruit and vegetable sector of CAP is due to be revised later in 2004. This creates a window of opportunity for the public health sector to work with the agriculture sector for mutual gains. The new proposals have yet to be presented. Issues that may be considered include how the market organisation for fruit and vegetable policy will effect new member states, reducing destruction of withdrawn produce, improving quality of produce, and how withdrawal compensation can be phased out. This last issue is unlikely to be popular with all Member States, but it should be emphasised by the public health sector . Although clearly a major motivation for reform is economic pressures on the CAP, it could also be interpreted as a sign that public health messages are slowly being heard.

As the world's largest importer there is considerable potential for EU fruit and vegetable production to expand to supply the home market. Production could best be increased if a multi-systems approach was taken with the agriculture and health sectors working together to simultaneously increase supply and demand. This approach has been advocated by a new international fruit and vegetable promotion initiative jointly launched by the WHO and United Nations Food and Agriculture Organisation (FAO) in November 2003[10] as part of the Global Strategy on Diet, Physical Activity and Non-Communicable Diseases.

It does not appear to be in the interest of consumers, especially low-income households who currently have the lowest intakes,[7] to have prices of fruits and vegetables maintained artificially high through the use of withdrawal compensation and import tariffs being imposed on countries outside of the EU . Evidence suggests that consumption of fruit and vegetables could be increased by lowering prices and increasing availability. A recent Swedish Public Health report[8] has called for all fruit and vegetable withdrawals to be suspended in the EU, because this measure raises the price by limiting the supply. It is hypothesised that lower production prices would lead to lower consumer prices. This should stimulate increased purchase of fresh produce by consumers, particularly low-income households, and in turn establish higher market demand. However, this is under the condition that the supermarket retail sector, which is dominant in Europe, does not take the opportunity to increase its revenues. EU-farmers could still use health arguments as an opportunity to work with the public health sector to win new market segments.

The 2003 June CAP reforms actually created a disincentive to fruit and vegetable growing. This introduced a single farm decoupled payment for growers of cereals, beef and several other commodities, allowing farmers to change the type of crop grown or not to grow anything at all without loss of subsidies. However, fruit and

vegetable growing is excluded. This means that farmers wishing to switch their land use to growing fruit and vegetables will be penalised (compared to other farmers), as they are therefore not entitled to receive the new single payment. The only exception to this is new member states that have an exemption until 2008. This policy disincentive should be changed immediately to encourage not discourage production.

Increasing production of fruit and vegetables can also deliver benefits for rural populations, which have the highest rates of unemployment and poverty. The horticulture sector is more labour intensive (on average employment levels are 5–10% higher) than the overall agriculture sector, helping the unemployment situation in rural communities and creating a source of income for smaller-scale farmers. To ensure that small farmers and the rural poor benefit to the same extent as large scale producers, the CAP could finance the establishment of a food supply chain support centre in each country. The aim would be to work with growers, processors, and smaller retailers to get products to consumers, reducing the dominance of a few large supermarkets across Europe and increasing competition.

Finally, how can the coming 2004 reform of the fruit and vegetable sector in the CAP benefit both farmers and public health? The idea of phasing out withdrawal compensation, if set forward by the Commission, is clearly welcome from a public health perspective. If not counteracted by other measures, this could lead to falling prices which most likely would stimulate consumption. If combined with other public health measures, addressing the needs of children and that of low-socioeconomic households, the time has come where the public health sector and agriculture could work hand in hand to achieve major reductions in the key health problems facing Europe including cardiovascular disease, cancer and obesity.

It is very important that the new fruit and vegetable policy increase the amount of withdrawn produce supplied for human consumption in low consumers, such as children or low income groups. In the dairy sector, some of the excess milk produced and withdrawn from the market is used to supply school milk schemes. Could a similar scheme be introduced for fruit and vegetables in schools? The arguments for this are strong. As there is a school scheme for milk this means that the logistics for setting up and supplying such schemes already exist. Increasing fruit in schools will also lead to an increase the demand for fruit and vegetables more widely in the population (as has been shown in the evaluation of the Danish School Fruit programme). Fruit in school schemes, if leading to substitution for intake of high sugary and fatty snacks in schools, could be considered one mechanism for tackling the rise in childhood obesity.

"The June 2003 CAP reform actually created a disincentive to fruit and vegetable growing"

Conclusions

Despite the potential health gains possible through increasing fruit and vegetable consumption, the effect of the CAP has actually been the reverse, by increasing prices and reducing availability of fruit and vegetables for consumers. Reform of the fruit and vegetable policy in 2004 presents a huge opportunity for agriculture and health policymakers to work together to provide benefits to consumers and farmers alike, while improving the health of the European population.

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Illness and employment: Retaining the link to work

The European Foundation organised, in conjunction with the Italian Presidency, a conference on the subject of Illness and Employment: Retaining the Link to Work, in Reggio Calabria on 17–18 November 2003. Links between social inclusion, illness and employment were major issues for the EU Year of People with Disabilities.

The aims of the conference were:

- *to discuss policy measures and initiatives related to the employment of people with a chronic illness or disability;*
- *to spread information and raise awareness of this issue among policymakers, social partners and relevant NGOs; and*
- *to contribute to promoting this issue, both in terms of new policies and more effective implementation of existing measures.*

Conference report by Susan Leigh Doyle and Ray Mulvihill, consultants at Leigh-Doyle and Associates, Dublin

Sickness, unhealthy lifestyles, work accidents and socioeconomic factors all contribute to chronic illness and disability. The incidence of chronic illness or disability continues to rise due to the ageing of the EU's population and a growing incidence of mental health problems. Simultaneously the concept of disability is changing from a traditional one confined to physical and sensory impairments to include a wider range of disabling illnesses and chronic diseases. The issues of health, chronic illness, disability, employment and exclusion are all multi-dimensional, and there is a strong interaction between work and health.

The links between health and work also embrace consideration of social security systems, labour legislation, and information promotion. Prevention of accidents and work-related illnesses is a priority. The promotion of employment opportunities for people who acquire a disability or chronic illness is also a key objective; rehabilitation and integration has a key role to play in achieving this. The health situations and employment needs of people with traditional disabilities and illnesses (for example, physical, sensory, mental health) and newer illnesses (aids, cancers, stress) must all be considered. Legislation, policies and actions at European, national, regional and local community levels are required to ensure that the rights of people with a disability and chronic illness are upheld. A common language and dialogue is also required. A broad spectrum of policies and action focused on prevention, rehabilitation, integration, and retention must be considered.

The conference comprised a plenary session, four workshops and a panel discussion. The workshops were informed by examples of good practice in member states and drew out lessons for both practice and policy. The conference benefited from presentations of recent research on various aspects of illness and employment. A summary of the presentations and discussions that took place over the two days is presented here.

This conference report was first published by the European Foundation for the Improvement of Work and Living Conditions, and is available on their website at http://www.eurofound.ie/publications/EF0474.htm.

Context

The European Commission report on increasing labour force participation submitted to the Barcelona summit in 2002 concluded that illness, as well as disability, can limit participation in employment.[1] Similarly, the 2002 Joint Report on Social Inclusion[2] highlighted chronic illness and disability as factors leading to social exclusion. The exclusion process can commence with onset of illness and short-term absence from work, followed by longer-term absence from work, acquiring the classification of disability, and ultimately loss of contact with the work-place.

Within the context of the European Year of People with Disabilities 2003, social partners, national governments and European Union institutions and bodies directed attention to measures against discrimination and in favour of the social inclusion of people with illness or disabilities. In particular, there was a growing interest in promoting the participation of people with illness and disabilities in working life, both in order to prevent their social exclusion and meet the demand for labour.

Specific aspects addressed during the conference in plenary session, workshop sessions and in panel discussion included:

- Prevalence of chronic illness and disability
- Measures to retain workers who develop a chronic illness or disability
- Preventing exclusion from the labour market of people with mental health problems, physical disabilities or chronic illness
- Relationship between social security and employment services: responsibilities of the public authorities
- Responsibilities of social partners, families and civil society.
- Roles and actions at European level.

Setting the scene

Prevalence of chronic illness and disability

Chronic illness or disability affects about one in six of the working age population in the EU. There are about 25 million adults in the current European Union with a 'severe' chronic illness or disability. One in eight of the working-age population have a *work-limiting* illness or disability, 8–10% of the work-force has a *significant* chronic illness or disability and 6% are receiving a disability-related benefit. Half of those who acquire a disability do so in their working lives.

Sickness, unhealthy lifestyles, work accidents and socioeconomic factors all contribute to the increase in the rate of chronic illness and disability, from 5% for young persons to 40% at retirement age. Sickness and health-care benefits represent over a quarter (27%) of social protection expenditure in the EU, while disability payments account for a further 8%.

Labour market participation

Non-participation or very low levels of participation in the labour market is common for people with a disability: 78% of severely disabled people aged 16-64 are outside of the labour force as compared to 27% for those without chronic illness or disability. Even among those in the labour force, the unemployment rate is nearly twice as high among the severely disabled as compared to the non-disabled. Only 16% of those in employment who face work restrictions are provided with some assistance to work. People with a chronic illness are similarly less likely to obtain or retain a job. For all persons non-participation in the labour market increases substantially after the age of 50 years. At present, the majority of workers exiting employment for serious health reasons never return. Many of them are deprived of an adequate income and opportunities for social participation.

Disincentives to employment include bureaucracy and administrative inflexibility, taxation traps, discrimination in wage and income levels, and the fear of losing allowances and medical benefits by returning to the workforce. Inaccessibility of work-premises, lack of assistive technology, accessible public transport or car-parking can be significant barriers to retention and re-integration of many employees with a physical disability. Many public and private sector organisations, especially small and medium-sized enterprises, are housed in inaccessible buildings. Cultural barriers within many organisations inhibit retention or re-integration; these may include lack of support from management or co-workers, low expectations of both workers and employers, extremely demanding work situations and long working hours.

Social exclusion

Social exclusion caused by restricted opportunity to participate in work can result from chronic illness. Moving from illness to exclusion impacts on many levels. There are fiscal costs in terms of costs of health, labour, social protection and services. Individual costs arise in respect of personal, economic and sociocultural impacts. Costs for employers include negative effects on productivity and morale, more recruitment and replacement of individual workers. Social costs are reflected in impacts on solidarity, social cohesion, equality and engagement.

"Chronic illness or disability affects about one-sixth of the EU working age population."

The processes whereby chronically ill people can be retained or reintegrated in the workplace are being examined by the European Foundation. The project 'Illness and inclusion –maintaining people with chronic illness and disabilities in employment' has developed a theoretical framework for addressing the issue of social exclusion through illness. In particular, a set of assessment tools for evaluating policies and initiatives to tackle social exclusion caused by through illness has been developed. A complex range of factors at system level, work level and individual level have been identified as underlying causes in the process of moving from illness to exclusion. A series of 'thresholds' for retention and reintegration in employment has been identified as a key element of the conceptual model of the disability and exclusion process. Thresholds operate as either inhibitors or enhancers in return to work. They consist of a range of interacting factors operating at the individual level, the workplace level, and the family or social context of the individual. They also operate at the level of services available to the individual and in the broad area of policies that affect the income and career prospects of the ill or injured worker.

Exclusion from the labour market of people with mental health difficulties

Workers are experiencing increased stress levels due to a range of global factors that include longer working hours and fast-changing technology. Pressures also result from changes in employment and work patterns, for example, the migration of jobs and widespread atypical employment. Such

"Mental health problems may be the most common health reason for absenteeism."

factors impact directly on workers and may also impact negatively on dependants, thereby creating additional stress. Problems related to mental health are already increasing; it is estimated that mental disorders will account for 22% of the burden of disease in 2020. There is a 4% prevalence rate for depression in the general population. Mental health problems may be the most common health reason for absenteeism. Depression is associated with longer time periods off work. There is evidence that depression and work-related stress are highly related to job satisfaction. 3 to 4% of total GNP in the EU is spent on mental health problems. Mental illness is associated with high levels of co-morbidity. Consequent productivity losses are substantial and social and personal costs can be severe.

Workplace health actions

Workplace health is covered by two main areas of legislation: Occupational Safety and Health (OSH) legislation that includes occupational accidents and disease and covers prevention and protection; and the more recent anti-discrimination directives. Disability legislation to date has had limited focus on return to work.

The OSH approach concerns the *prevention* of occupation-related disease and accidents. Workplace health *promotion* is focused on the good health of individuals and organisations. Rehabilitation and *reintegration* approaches are primarily concerned with ensuring safe and healthy return to work following accident or illness, and may involve workplace or work organisation adaptation. Rehabilitation and reintegration approaches are perhaps the least developed of the three; in many cases key elements of a successful re-integration strategy are missing, especially in smaller enterprises. All three approaches should ideally be developed and promoted within companies. A more pro-active role is required, which may involve a modernised role for OSH, and integration with human resource management (HRM) and other departments in companies. Ensuring effective re-integration of an individual with a chronic illness or disability requires commitment in three policy areas, OSH, HRM policy and equality.

An occupational safety and health policy should incorporate monitoring of the returning worker's health and well-being, assessment of risks associated with the job, and communicating to managers and co-workers the capabilities of the returning worker. The HRM policy should incorporate incentives for returning to work, joint labour-management agreements, occupational health services, and commitment to opportunities for transitional work, training and development. The HR function and policy should also have responsibility for communication of re-integration management policy throughout the organisation. An equality policy should address non-discrimination against people with a disability, facilitate reintegration, and state, at least, the commitment of the company to provide equal opportunities and access to suitable employment for returning workers.

Of course the presence of these services and policies is only part of the story; their effectiveness and quality must also be considered. There is strong evidence that systematic organisation-wide approaches are most effective in reducing work-related stress. This may include staff support, two-way communication structures, enhanced job control, flexible working hours, increased staff involvement and an improved working environment. Building a partnership between all employment stakeholders, health and social care professionals, and others is a key way forward. To date there has been little formal analysis undertaken of workplace interventions. While more needs to be done to build the case for investment in work place prevention, promotion and retention, the high cost of lost employment compared with the relatively low cost of effective interventions, suggests they are likely to be cost effective for employers.

There is a considerable need for awareness raising and training to better inform employers, HR and training professionals, trade union officials, politicians and other stakeholders and partners. These objectives can be facilitated by increased engagement with NGOs and disability stakeholder groups. They can assist in awareness raising, in clarifying best practice for inclusion of people with a disability, in identifying appropriate occupational areas and sectors, and in providing training.

Responsibilities of social partners, families and civil society

A supportive workplace environment is necessary to ensure integration of people with a disability and re-integration of persons returning following an illness or acquired disability. Social partners are the essential actors in this endeavour: employers, unions and work colleagues all have a role in ensuring a supportive work envi-

ronment. Positive action programmes and targets have been found to be useful instruments. A wide definition and range of work options is required to ensure maximum integration for people with a disability; opportunities for participation in supported work environments should be provided in addition to employment opportunities in the open labour market,

Families are a key resource in supporting integration of a person with a disability or chronic illness within the workforce, particularly in sustaining motivation. Families themselves however may need information, guidance and support in best practice to achieve this. It is also necessary to recognise the employment situations and needs of other family members, in particular, the impact on the work situations of the primary carers of a person with a disability or chronic illness. Civil society organisations have traditionally played a role in supporting people with a disability by providing information, advisory and specialist services. Increased NGO involvement in advocacy, and the growth of forums and networks of people with a disability, are likely to further support integration of people into work and influence employment policy.

The experience of the Netherlands in dealing with work disability is instructive. Many of the efforts of the 1990's failed to arrest the increasing trend for people to exit the workforce on disability pensions. This highlights the necessity for employers, social partners and public authorities to ensure that remaining at work is a worthwhile and attractive alternative to exiting from the workforce.

Responsibilities of public authorities

A review of public employment support measures in Ireland for people with a disability or illness generated a range of recommendations. These included:

- Incorporating data collection/evaluation systems be incorporated in any government programme in order to assess its effectiveness.
- Addressing the issue of the 'benefits trap' together with the fear of loss of benefits on returning to employment.
- Regularly reviewing national government employment programmes.

Flexible employment support schemes may be required to more effectively meet the needs of people with a disability or chronic illness. Following legislation and positive action measures in Luxembourg, people with a disability currently represent 5% of the work force there. Positive action measures have been directed at employers, in both the private and public sector, and at employees. Further legislation is currently being developed in Luxembourg which focuses on illness in the broader sense, and aims at ensuring that people are retained within the workforce. Companies and social security managers are reviewing illness and disability definitions to achieve consistency; so that people on sick-leave are not made redundant.

More cooperation between the different partners within the public services and authorities is needed. An inter-sectoral and multi-disciplinary approach, involving all of the actors engaged in serving people with a chronic illness or disability is necessary. More systematic follow-up, and evaluation of initiatives and programmes that support the employment of people with a disability is also desirable. Much of the responsibility and costs to date in respect of chronic illness among workers have been born by social insurance agencies. These agencies should become more active in workplace health promotion. More understanding of why companies initiate workplace health promotion is required. The correct balance between corporate and public health responsibilities in this context also needs to be explored. Public authorities have a key role in fostering inclusion and integration through the promotion and development of mainstreaming policies in education, training and employment.

"It is necessary to ensure that remaining at work is a profitable and attractive alternative to exiting the workforce"

Roles and actions at European level

In 2003, the European Trade Union Confederation (ETUC), and the employer groups UNICE/UEAPME and CEEP presented a joint declaration on promoting equal opportunities and access to employment for people with a disability. Its purpose was to demonstrate that occupational integration of people with a disability is a shared interest of enterprises, employers and employees. Similar arguments apply to retaining the skills and experience of people who develop a chronic illness during working life. This interest is reflected in the emerging development of policies and actions at European level to address the circumstances of people with a disability or long-term illness. Firstly there are policies and actions to ensure the entry and integration of people with a disability (be it, physical, sensory, intellectual, mental health or other) into the workplace. Secondly there are (less developed) policies and actions to ensure retention in the workforce of these

people and of those who have developed a chronic illness during their working life.

Policies and actions to achieve entry and integration into the workforce of people with a disability have focused on ensuring that directives on equal treatment are implemented. These measures have included the development by Member States of guidelines and targets for the employment of people with a disability; and strengthening EU directives on public procurement (through including the employment of people with a disability and incorporating accessibility in design as selection criteria). There has been an emphasis on professional training, workplace adaptation, employment quotas and targets, employment protection, changing attitudes in organisations, anti-discrimination legislation and voluntary initiatives within enterprises.

"New technology and distance working can facilitate increased employment of people with a disability."

The EU emphasises the need for coordinating education, training, employment, social inclusion and social security strategies. It recognises and promotes the importance of consultation with all stakeholders, particularly organisations of people with a disability, in the shaping and development of policy. This can be seen, for example, in the development of national action plans and monitoring of policy implementation. Workforce retention policies and actions, particularly in northern Europe, have evolved in a context that encourages corporate social responsibility, the involvement of all social partners and the implementation of tripartite agreements.

The European Economic and Social Committee has focused on health and safety issues linked to employability, and on social dialogue to develop preventive policies and job-retention actions. An emphasis has also been placed on 'making work pay', linking social security and employment policies; together with incentives and supports for the employment of people with a chronic illness or disability. Future actions at European level could include promoting social enterprises and social cooperatives, which have demonstrated their valuable role, particularly regarding the employment of persons with mental health difficulties. Employment initiatives will be promoted within both the public and private sectors.

The European Disability Forum (EDF) proposes increased rapprochement between the concepts and supports applied to workers with a disability and workers with a chronic illness. It recommends additional and improved data collection to assist policy development. The forum underlines the need to complement non-discrimination legislation and measures with positive actions. It endeavours to ensure that laws are implemented which promote equal access to training and career development for all workers, and that workplace accessibility is improved. Improved accessibility to work includes better physical access and more work time flexibility. Since many disabled people acquire their disability in the course of their working life, EDF believes that employment policies for people with disabilities should include job retention policies. It acknowledges that additional measures in the wider environment (i.e. transport, education, social security and health benefits) are required to ensure entry and integration into employment.

From an employer perspective, it was recognised that both private employers and public sector employers (and central governments) have a role to play in meeting the employment needs of people with a disability or chronic illness. Barriers in the workplace need to be tackled. This is also crucial in the context of an increasingly ageing population and a shortage of skilled and experienced workers. New technology and distance working can facilitate increased employment of people with a disability. Incentives should be available to employers, particularly to small and medium size enterprises, for the provision of any necessary supports to employees with a disability. Quota systems for employment of people with a disability are not judged to be effective in the private employment sector.

From the trade union perspective, the need for greater commitment and responsibility in urgently addressing the needs of workers with chronic illness or disability was highlighted. It was suggested that a social partners framework agreement on job retention could be useful at European, regional and local levels. Attitudinal change is required, with increased focus on the potential contribution from people with an illness or disability, rather than on the costs of employing them; management have a key role to play here. Partnership is needed between employers and trade unions, together with organisations of people with a disability and their families.

Conclusions

Disability, chronic illness and work

The conference demonstrated the importance and usefulness of jointly addressing the employment situation of people with a

chronic illness or disability. It also highlighted the importance of job retention and reintegration strategies for people with a chronic illness. The multi-faceted nature of the difficulties facing people with a chronic illness as well as their carers was acknowledged. There is a need for an improved range of policies and actions at a variety of levels and from a wide range of stakeholders. Speakers were in agreement on the importance of highlighting the issue of chronic illness and work; the conference played its role in placing this on a European agenda. Changing attitudes was also seen to be essential, focusing on the positive benefits for companies, individuals and society of retaining people with a chronic illness or disability at work. Likewise, the conference endorsed the need to combat discrimination, and protect the rights of those with a chronic illness or disability in relation to employment or access to work.

Retention and reintegration strategies

There was general agreement that, while there is a great potential for retaining in work people who develop a chronic illness, this is not generally realised. Job retention or reintegration is often impeded by a lack of coherence and coordination between systems, particularly social security and employment services. At the workplace level, different strategies must concentrate on prevention, retention and reintegration. People who experience severe mental health difficulties during their working life must be re-empowered and assisted to reintegrate. The three approaches, occupational health and safety, workplace health promotion, and rehabilitation/reintegration, should be developed and strengthened within companies. A more pro-active role is required, which may involve a modernised role for OSH, and its integration with HRM and other departments in companies. There is a lack of knowledge of what constitutes best practice, and empirical research is required to demonstrate the most effective measures.

Social partner roles and responsibilities

Strategies for maintaining people at work must be multi-faceted but coordinated – involving the employer, social security systems, the individual concerned and his/her family. Employers should address the integration and retention of people with an illness/disability in the workforce as part of their corporate social responsibility. They need to examine ways in which people can manage their chronic illness or disability by more flexible working arrangements, shorter working weeks and distance working. Cost benefit analysis of workplace interventions is necessary to further develop the case for investment in work place prevention, promotion and retention.

Stress reduction in the workplace is necessary and there is strong evidence that organisation-wide approaches are most effective. Such approaches can include staff support, better communication, enhanced job control, flexible working hours, increased staff involvement and an improved work environment.

The social partners are major actors in maintaining, retaining or reintegrating people with a chronic illness or disability in employment. Employers, unions and work colleagues all have a role in ensuring a supportive work environment. Partnership approaches, together with integration, coordination and prevention strategies, can contribute to success but can be difficult to implement. Time, skills and resources are needed to ensure effective responses.

Family, civil society and public authority roles and responsibilities

Families are a key resource in supporting a person with a disability or chronic illness to integrate into work. Families themselves, however, may need information, guidance and support. It is also necessary to recognise the impact of caring on the employment situations and needs of family members. Raising awareness and training are required to better inform employers, HR and training professionals, trade union officials, politicians and other stakeholders and partners. NGOs and disability stakeholder groups can assist in raising awareness; in clarifying best practice; in identifying appropriate occupational areas/sectors; and in training.

National systems of incentives and support are needed for both employers and employees to encourage workplace integration and retention of people with a disability and chronic illness. A complex range of parties and sectors may be involved: for example, social protection agencies, rehabilitation agencies, public transport and housing sectors. It is necessary to ensure that remaining at work is a profitable and attractive alternative to exiting the workforce, for both employers and employees. An associated issue to be addressed is the ‘benefits trap’, which can discourage people from returning to work. This is just one aspect of lowering the thresholds to facilitate a return to work.

“National systems of incentives and support are needed for both employers and employees to encourage workplace integration and and retention”

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NEW PUBLICATIONS

Eurohealth aims to provide information on new publications that may be of interest to readers. Contact David McDaid d.mcdaid@lse.ac.uk if you wish to submit a publication for potential inclusion in a future issue.

Health Policy and European Union Enlargement

Edited by Martin McKee, Laura MacLehose and Ellen Nolte

Open University Press, 2004.

ISBN 0-335-21353-7

294 pages. Softback £24.99

This book is a first attempt to determine what are the implications of the different levels of health across the enlarged EU, and to consider whether the enhanced free movement of goods, services and people will be beneficial for both health and health care. Moreover, it also reflects on what has been learnt from past enlargement experiences, highlighting how enlargement brings both opportunities and challenges. Patients from the new Member States will be able to obtain some health care services throughout the EU. Health professionals will be free to travel, with some seeking more lucrative jobs in the wealthier Member States. There will be new regulatory regimes, and health care managers will have to comply with an extensive body of legislation on issues such as working time, health and safety, and data protection. Free-trade policies will have to be balanced with public health considerations, particularly with regard to substances that are legally traded but potentially hazardous, such as tobacco and alcohol. The new borders of the EU enclose large vulnerable populations, such as elderly people and minority groups, and it will be important to ensure that they do not fall behind. All these and many other issues will have implications for health care systems.

Contents: Health and Enlargement; The Process of Enlargement; Health Status and Trends in Candidate Countries; Health and Health Care in Candidate Countries; Investing in Health for Accession; Integration of East Germany into the EU: Investment and Health Outcomes; Challenges of Free Movement of Health Professionals; Free Movement of Health Professionals, The Polish Experience; The Market for Physicians; The UK, Europe and International Recruitment of Nurses; Free Movement of Patients; Health and Safety; Communicable Disease Control; Free Trade versus the Protection of Health, Examples of Alcohol and Tobacco; The Case for Health Impact Assessment; European Pharmaceutical Policy and Implications for Current Member States and Candidate Countries; Lessons from Spain: Accession, Pharmaceuticals and Intellectual Property Rights.

Contributors: R Adany, T Albreht, I Bozicevic, J Buchan, R Coker, E Delcheva, C-A Dubois, A Gilmore, A Heloma, R Hess, E Jakubowski, N Jennett, P Kanavos, M Lobato, K Lock, M McKee, L MacLehose, S Nicholas, E Nolte, S Orĕsković, E Österberg, A M Rafferty, M Rosenmöller, A Wright-Reid, M Zajac, W Zatonski.

Regulating Pharmaceuticals in Europe: Striving for Efficiency, Equity and Quality

Edited by Elias Mossialos, Monique Mrazek and Tom Walley

Open University Press, 2004.

ISBN 0-335-21465-7

368 pages. Paperback £24.99

The rising cost of pharmaceutical expenditure is of concern to governments right across Europe. This book adopts a broad perspective encompassing institutional, political and supranational aspects of pharmaceutical regulation, and examines approaches used to manage pharmaceutical expenditure across Europe and what impact these strategies have had on the efficiency, quality, equity and cost of pharmaceutical care. This incisive text should be of use to policy makers, service managers and students everywhere. Sir Alisdair Breckenridge, Chairman of the Medicines and Healthcare Products Regulatory Agency in the UK, has said that it makes "a valuable and timely contribution to understanding the many debates about regulating industry, medicines and prescribing across Europe."

Contents: Regulating Pharmaceuticals in Europe, An Overview; The Politics of Pharmaceuticals in the EU; The European Community Dimension: Coordinating Divergence; Measuring, Monitoring and Evaluating Policy Outcomes in the Pharmaceutical Sector; Regulating Pharmaceutical Prices in the EU; Reimbursement of Pharmaceuticals in the EU; Good Prescribing Practice; Patients and their Medicines; Financial Incentives and Prescribing; Regulating Pharmaceutical Distribution and Retail Pharmacy in Europe; Hospital Pharmacies; Influencing Demand for Drugs Through Cost Sharing; The Off-Patent Pharmaceutical Market; The Over-The –Counter Pharmaceutical Market; The Implications of Pharmacogenetics and Pharmacogenomics for Drug Development and Health Care; Should We Pay For Lifestyle Drugs? Alternative Medicines in Europe; The Pharmaceutical Sector and Regulation in the Countries of Central and Eastern Europe; Access to Pharmaceuticals and Regulation in the Commonwealth of Independent States.

Contributors: J Abelson, C Altenstetter, V Bertele, C Bond, M Bouvy, C Bradley, S Champman, A Dixon, M Drummond, P Durieux, E Ernst, A Fidler, E Fortess, R Frank, S Garattini, L Hancher, E Holme Hansen, S Hudson, K de Jonchere, P Kanavos, S Kooiker, J-M Leder, G Lewis, D Light, A McGuire, E Mossialos, M Mrazek, M P Orru, G Permanand, G Petrova, M Pirmohamed, D Ross-Degan, F Rutten, S Soumerai, D Taylor, S Thomson, T Walley.

WEBwatch

E-mail d.mcdaid@lse.ac.uk to suggest websites for inclusion in future issues.

International Association for the Study of Obesity

www.fao.org

IASO aims to improve global health by promoting the understanding of obesity and weight related diseases through scientific research and dialogue, whilst encouraging the development of effective policies for their prevention and management. The society has two journals, *The International Journal of Obesity* and *Obesity Review*. Links are provided on the website to both publications. In addition a six monthly newsletter is also produced. The association has also established an International Obesity Task Force that collaborates with international organisations and has established working groups for a range of issues including prevention, childhood obesity, management and economic costs. Information on awards, grant opportunities, research, conferences and links to other relevant sites are also provided.

Food and Agriculture Organisation of the United Nations

www.fao.org

The Food and Agriculture Organisation of the United Nations leads international efforts to defeat hunger. Serving both developed and developing countries, FAO acts as a neutral forum where all nations meet as equals to negotiate agreements and debate policy. FAO is also a source of knowledge and information. It assists developing countries and countries in transition to modernise and improve agriculture, forestry and fisheries practices and ensure good nutrition for all.

European Food Safety Authority

http://efsa.eu.int

Working closely with national authorities and stakeholders, the European Food Safety Authority is committed to providing independent scientific advice of the highest possible quality and clear communication of existing and emerging risk associated with food safety issues throughout the food chain. Through its own scientific expertise and the work of its Scientific Committee and Expert Panels, EFSA provides risk assessments on all matters linked to food and feed safety, including animal health and welfare and plant protection. In addition, the Authority provides scientific advice on nutrition in relation to Community legislation.

World Health Organisation Regional Office for Europe – Nutrition and Food Security

www.who.dk/Nutrition

This web site provides information on the nutrition and food security programme (NFS) of the WHO Regional Office for Europe. It aims to make available information and tools on a wide range of nutrition issues for the benefit of health professionals and policy makers. NFS encourages the development of national food and nutrition action plans. Action plans include food-based dietary guidelines and infant/young child feeding strategies and are an integral part of national health policies. It also supports the development of nutrition information systems that highlight the relationship between food, nutrition and health, such as micronutrient deficiencies (iodine and iron deficiencies) and non-communicable diseases (cardiovascular disease, cancer, obesity and diabetes). There are links to a range of WHO and other publications in support of the development of nutrition intervention strategies. Most documents can be downloaded from this web site, in both English and Russian.

World Health Organisation Regional Office for Europe – Food Safety

www.who.dk/eprise/main/who/progs/FOS/Home

The food safety programme ensures that: information on food safety is properly collected and circulated to provide the basis for policy and monitoring; health guidelines are constantly updated to provide assistance to countries with state-of-the-art knowledge; and an international independent body plays a public health advocacy role in counterpoint to the strong economic forces acting within the areas of food production, retailing and global marketing. Recent publications listed include *Food and Health in Europe: A New Basis for Action*, which was prepared especially for health professionals, and discusses in depth the components of food and nutrition policies and the evidence supporting them. The site also contains links to key policy documents, and information on surveillance, and biological risks.

Department of Health Management and Food Policy – City University

www.city.ac.uk/ihs/hmfp/foodpolicy/

The Food Policy team at the Department of Health Management and Food Policy in the Institute of Health Sciences at City University, London conducts much research on how public policy impacts on food. Their remit is wide covering the whole food chain, including the impact of the supply chain on human/public health, the environment, social justice and the public good. Information on a wide range of publications is also provided.

ALCOHOL TAXATION: COMMISSION REPORT LAUNCHES DEBATE

The European Commission has presented a report on the operation of the EU-wide system of minimum rates of excise duty on alcohol and alcoholic beverages.

The report considers how the present system affects the proper functioning of the Internal Market, the competition between the different types of alcoholic drinks due to differences in levels of excise duty, the current real value of the minimum rates that were set in 1992 and the wider objectives of the EU Treaty. It recognises that health policy and agricultural policy are particularly relevant to any consideration of alcohol taxation, and notes that the majority of Member States do not usually take into account health policy considerations when fixing their rates.

The report concludes that more convergence of the rates of excise duty in the different Member States is needed in order to reduce distortions of competition and fraud. Given the complexity and the politically sensitive aspects of the issues, however, the report is not accompanied by a proposal for a Directive. Instead the Commission wishes to launch a broad debate in the Council, the European Parliament and the Economic and Social Committee. On the basis of the outcome of this debate the Commission will decide whether or not to submit proposals on all or some of the issues raised in the report.

The full report is available at: http://europa.eu.int/comm/taxation_customs/whatsnew.htm

A document, 'Alcohol tax report, frequently asked questions', is available at: http://europa.eu.int/rapid/pressReleasesAction.do?reference=MEMO/04/126&type=HTML&aged=0&language=EN&guiLanguage=en

EUROPEAN MINISTERS SIGN ACTION PLAN AND DECLARATION TO PROTECT CHILDREN

On 25 June European ministers of health and the environment committed themselves to a set of specific actions to ensure a better future for the children of the WHO European Region.

In the Children's Environment and Health Action Plan for Europe (CEHAPE) and the Conference declaration, adopted at the closing of the Fourth Ministerial Conference on Environment and Health in Budapest, Hungary, ministers agreed on a series of concrete measures to reduce the impact on children's health of air pollution, water, chemicals and injuries, which account for one third of all deaths and diseases in the group aged 0–19 years.

Fifty of the fifty-two countries in the European Region participated in the conference with more than forty ministers attending.

Signing the documents on behalf of all European ministers were Dr Mihály Kökény, Minister of Health, Social and Family Affairs of Hungary and Chairman of the Conference; Dr Miklós Persányi, Minister of Environment and Water of Hungary; and Dr Marc Danzon, WHO Regional Director for Europe. Ms Margot Wallström, European Commissioner for the Environment, and Mr Pavel Telicka, Member of the European Commission, endorsed these commitments on behalf of the European Union.

"Tomorrow's children will be our judges," says Dr Marc Danzon, WHO Regional Director for Europe. "The care we have taken today in crafting these policy options is the legacy of European leadership in health and environment, and the further efforts needed to shepherd these recommendations into national and regional and global realities will be our testing ground. Success will be measured by a fairer, healthier and safer future for our children."

Acknowledging that marked differences across the Region and across age groups indicate the need for targeted action in specific countries, regions or populations, the ministers called for national plans to be developed by 2007.

A set of actions was elaborated from which Member States and local authorities can select the most appropriate, with an emphasis on prevention strategies as the most cost-effective.

Margot Wallström, European Commissioner for the Environment said at the conference "promoting a healthy environment for our children is a major task and I am glad that it has been the focus of the discussions here in Budapest. But it is a challenge that requires cooperation from all parties involved, and I trust that the CEHAPE and the EU Environment and Health Action Plan will jointly support each other in meeting our common goals of promoting a more 'child-friendly' environment and taking another step along the road to sustainable development. We must never forget that what is good for our children is good for society as a whole."

The conference declaration and Children's Environment and Health Action Plan for Europe are available at www.euro.who.int/document/eehc/edoc06.pdf

DRIVING PUBLIC HEALTH IN EUROPE – THE ROLE OF WORKPLACE HEALTH PROMOTION

European Commissioner for Health and Consumer Protection David Byrne delivered a keynote speech at the 4th European Conference on Promoting Workplace Health in Dublin on 14 June.

In his speech the Commissioner set out how workplace health promotion contributes to the improvement of public health in Europe. Noting that health promotion plays a central role in the Community action programme in the field of public health, he stated that this "can particularly be pursued at workplaces, because this setting not only provides access to large portions of the population, but also, and perhaps even more importantly, distinct incentives for health improvements that go beyond the promotion of health 'for its own sake'. I am talking about economic incentives which are generated by better health, namely, more productivity, more innovation, and more wealth."

He further added that by integrating health into other policy fields "we ensure that fulfilling our health potential becomes a driver of European policies in general, helping to reach overall policy objectives such as competitiveness, sustainability and the capacity to innovate. Health enhances economic prosperity. Or to summarise it, health equals wealth. Accordingly, healthy workplaces do both. They help to improve overall public health and stimulate economic and socially sustainable development."

The Commissioner noted that work can make people sick, but also that secure employment can add meaning to an individual's life. He emphasised the importance of the quality of the working environment, noting that "We know about the dramatic fall in absenteeism as the so-called quality of the job improves. Better employment seems to lead to better health."

Commissioner Byrne drew attention to evidence of effective approaches to improving workplace health related to weight control and smoking, muscular-skeletal disorders and stress related health problems. Companies could play a greater role, "Although an increasing number of European companies are implementing workplace health activities, this could be improved. Many companies may simply lack the relevant knowledge about how health in the workplace pays off for everyone concerned. The role health insurance companies could play would be an important factor also as the US experience demonstrates." Employees also have a role to play. "a health culture at work requires more responsibility [by employees] for their own health. They have to understand that by choosing unhealthy lifestyles they too are giving up opportunities, namely those for enjoying better health, more wealth and a more rewarding, longer life. I am convinced that people in Europe not only should, but also want to take more responsibility for their own health. Europe can help to enable them to do so by providing comprehensive and reliable information, and by ensuring a high level of health protection."

The conference brought together over 300 participants from enterprises, politics, academia, social insurance and unions from all over Europe. Successful instruments and methods, (toolbox), strategies and the evidence base (business case) were presented, from information collected by the network in a two year European project. The Dublin conference was jointly organised by the European Commission, the Irish Department of Health and Children and European Network for Workplace Health Promotion.

The full text of Commissioner Byrne's speech is available at http://europa.eu.int/rapid/pressReleasesAction.do?reference=SPEECH/04/297 &format=HTML&aged=0&language=EN&guiLanguage=en

REPORT ON TRUST IN FOOD IN EUROPE

A recently published study "Trust in Food in Europe, A Comparative Analysis", presents data from surveys in six countries.

Levels of consumer trust in food are reportedly high in the United Kingdom, Denmark, and Norway, but relatively low in Germany, Italy and Portugal. Consumers in all six countries are most sceptical about meat products, fast-food outlets and processed food. Similar variations between countries were found when consumers were asked about their trust in various institutional players in the event of a food scare.

The study was conducted as part of the EU TRUST IN FOOD project (2002-2004). The initiative is part of general EU research on consumer perceptions and behaviour, socio-economic and demographic factors, as well as the acceptability of typical food products. The analysis indicates that many consumers are pessimistic, they believe that the price, taste and quality of food as well as farming methods, nutrition and safety have deteriorated over time. Italian and Portuguese consumers display the highest level of pessimism, with 60%–80% believing that food prices, taste and quality have worsened over the past twenty years. A smaller number however believe that food safety or nutrition have deteriorated.

The report can be downloaded at www.trustinfood.org.

More information on the theme 'food quality and safety' the 6th EU Research Framework Programme (FP6) can be found at www.cordis.lu/food/home.html

MICHEÁL MARTIN RECEIVES WHO AWARD FOR LEADERSHIP IN GLOBAL TOBACCO CONTROL

At the recent Change is in the Air conference held in Limerick Irish Minister for Health and Children Micheál Martin was presented with the World Health Organisation's Special Director-General's award, for his leadership in Global Tobacco Control 2004 by Dr Catherine Le Galès-Camus, WHO Assistant Director-General and in recognition of his outstanding contribution to tobacco control. Minister Martin is only one of two recipients of this prestigious award in 2004 and the only awardee from Europe.

Dr Le Galès-Camus said "Since his appointment as Ireland's Minister for Health and Children in January 2000, Micheál Martin has been consistent in his commitment to the fight against tobacco and has made a remarkable contribution to tobacco control. He has made the reduction of smoking prevalence one of his top priorities and has demonstrated political courage in relation to the tobacco issue. He has pushed the Irish Government's Towards a Tobacco Free Society policy with vigour adopting a comprehensive tobacco control programme which mirrors WHO recommendations.

Recognising that tough tobacco control legislation is essential and effective in reducing the numbers of people smoking, in particular children, he has built on previous legislation by banning advertising, raising the legal age for sales to 18 years and presided over the enactment of wide-ranging tobacco control legislation by the Irish parliament. Under his stewardship, tobacco control activities have attracted additional funding and resources for compliance building measures and substantial investment has been made in health promotion activities with sustained information campaigns. On 29 March 2004, Ireland became the first European country to implement legislation creating smoke-free enclosed workplaces, including bars and restaurants. This ground-breaking measure demonstrates Minister Martin's strong leadership and steadfastness in putting public health to the fore.

In addition to the significant measures at a national level (Ireland's smoking prevalence has dropped by more than 4% since he took office), he has ensured that Ireland played a strong, positive, constructive and supportive role in the development of the WHO Framework Convention on Tobacco Control," Dr Le Galès-Camus concluded.

At the conference the Irish Government ratified the Framework Convention on Tobacco Control and Minister Martin also stated that the EU is also now finalising ratification of the Convention. The minister said that he was " very pleased to announce that the EU is today [17 June] finalising the process of ratifying the FCTC. This is a very significant step as the Union formally commits to the implementation of this far reaching international agreement to respond effectively to the global threat posed by tobacco. I am also pleased to announce that at last Tuesday's Government meeting Ireland's ratification of the Convention was formally agreed."

EU MINISTERS DISCUSS CONCLUSIONS AND PROGRESS AT MEETING OF HEALTH COUNCIL

On June 2, Irish Minister for Health and Children, Mr Micheál Martin, chaired the formal Meeting of the European Council of Ministers with responsibility for health. The Council adopted Conclusions on Promoting Heart Health, E-Health, Influenza Pandemic Preparedness Planning, Patient Mobility, Alcohol and Young People and Childhood Asthma.

Minister Martin said the exchange of views on the various topics had been positive, constructive and encouraging and said that he was confident that decisions taken at the Council would ensure further progress is made on the important issues on which agreement was reached to provide high quality healthcare to all the citizens of the European Union.

The *Conclusions on Heart Health* call on the Member States and the Commission to promote cardiovascular health within the context of the national public health strategies and in the framework of the Public Health Action Programme, while those for E-Health invite the Member States and the Commission to develop and implement e-health in the context of national strategies and of Community programmes in the field of public health.

In relation to *Influenza Pandemic Preparedness Planning* the Conclusions invite the Member States and the Commission to cooperate with a view to adopting appropriate measures in the area. The Conclusions on Alcohol and Young People follow up the Council Recommendation of 5 June 2001 on issues surrounding the drinking of alcohol by young people and recognises the need for cooperation at Community level to develop a strategy to reduce such alcohol related harm particularly among the young.

On *Childhood Asthma* the Council's Conclusions recognise the increasingly serious impact of childhood asthma and underlines its serious effects on quality of life of children and of their families. The text proposes a set of measures to be taken by Member States and the Commission in order to respond fully to this public health challenge.

The Council also adopted Conclusions on *Patient Mobility and Health Care* developments in the European Union. The Conclusions are intended to be the Council's initial response to the Commission Communication of 20 April 2004 on the follow-up to the December 2003 report of the high level reflection process on patient mobility and health care developments in the European Union; and on the setting up by the Commission of a High Level Group on Health Services and Medical Care. It reflects the Council's concern on improving access to high quality and cost-effective health care, inviting the Member States to cooperate, exchange information and best practices and to develop measures to be taken in the

field of health protection. The Commission is further invited to ensure coordination with international bodies such as the World Health Organisation.

Adoption of the Conclusions was followed by an exchange of views on patient mobility and other current healthcare developments including the Ministers' views on a permanent mechanism reporting to the Council of Ministers to oversee health policy developments in the Community. During the discussion a number of Health Ministers expressed concern with regard to the potential impact of the proposed Directive on Services of General Interest on health services and healthcare delivery in the Member States.

The Council took note of the Decision on the negotiating directives for the Commission with a view to the revision of *International Health Regulations* within the framework of the World Health Organisation (WHO). The Decision set out the negotiating directives for the Commission for the regional consultations that took place in Copenhagen. The Council also received progress reports from the Commission on discussions and consultations between Member States and the Commission on the draft text of the revised International Health Regulations under the framework of the World Health Organisation. The Council also noted the decision to ratify the Framework Convention on Tobacco Control of the WHO.

The Council also took note of progress reports on a proposal for a European Parliament and Council *Regulation on Nutrition and Health Claims made on Food* and on a proposal for a European Parliament and Council Regulation on the Addition of Vitamins, Minerals and other Substances to Food. The opinion of the European Parliament is still awaited on both of these proposals. The Council noted papers prepared by the Irish Presidency on Osteoporosis and Diabetes.

The conclusions of the Council are available at http://ue.eu.int/ueDocs/cms_Data/docs/pressData/en/lsa/80729.pdf

NEW REPORT HIGHLIGHTS RISKS TO THE HEALTH OF YOUNG PEOPLE

In June the WHO Regional Office for Europe published *Young people's health in Context*. This reports on the most recent survey of the *Health Behaviour in School-aged Children* study, which covers almost 162,000 young people aged 11, 13 and 15 years in 35 countries and regions in the WHO European Region and North America.

The report examines young people's health through a wide range of key health indicators, including alcohol, tobacco and cannabis use, injuries, physical activity, bullying and physical fighting, and sexual behaviour. It also describes the social and economic circumstances of young people's lives: their family situations, contact with friends and experience of school.

"All these topics are commonly reported and discussed, but now we can provide unique research in these areas, which could be relevant and helpful for policy- and decision-makers. The report reveals the real behaviour of young people that affects their health – and their lives," comments Dr Marc Danzon, WHO Regional Director for Europe.

The risks to young people's health can never be reduced to zero, but the study provides information that can help lower them to more acceptable levels. The report points out that joint action is needed from governments, civil society, international agencies, parents and young people, in order to protect young people and help them protect themselves.

The survey found that, among 15-year-olds, 8%-32% of boys and 13%-63% of girls in the 35 countries and regions report their health to be fair or poor. Girls are more likely to report poor or fair health than boys. Over 42% of girls report poor health in Latvia, Lithuania, the Russian Federation and Ukraine. The report's findings show that many young people engage in behaviour that can weaken or harm their health. By the age of 15, 24% report smoking and 29% report drinking on a weekly basis. Cannabis use is also common among 15-year-olds: 22% have tried it and 8% report using it regularly (3 to 39 times in the previous 12 months). Levels vary widely, however, among the countries and regions.

A large majority of the young people surveyed are physically inactive. On average, fewer than two-fifths meet the guidelines for an acceptable amount of weekly physical activity. One-quarter watch television four or more hours a day.

The survey shows that around a third of girls and a fifth of boys think they are too fat. Among 15-year-olds, 23% of girls and 7% of boys are dieting or doing something else to lose weight. Reports suggest that around 12% of those aged 13 and 15 years are overweight, including 2% who are estimated to be obese. Many of the participants in the survey eat too little fruit and vegetables, and consumption decreases with age.

The number of 15-year-olds who report having had sexual intercourse varies greatly, from under 10% of girls in Croatia, Greece, Israel, Poland and The former Yugoslav Republic of Macedonia to over 40% of girls in Greenland and Wales. Among boys, the lowest rates (under 25%) are found in Austria, Croatia, the Czech Republic, Estonia, Latvia, Poland and Spain, and the highest (over 40%) in Greenland, the Russian Federation and Ukraine.

On average, among the sexually active, 70% of girls and 80% of boys report using condoms during intercourse. Rates of condom use are highest in some southern European countries, and lowest in Finland, Germany, Sweden and the United Kingdom.

More information on the study and survey results are available at www.euro.who.int/youthhealth

WORLD HEALTH ORGANISATION ADOPTS 'GLOBAL DIET', WHILE COMMISSIONER DAVID BYRNE NOTES THAT IT IS 'TIME TO TAKE ON OBESITY'

The Executive Board of the World Health Organisation (WHO) has adopted the Global Strategy on Diet, Physical Activity and Health during the 57th World Health Assembly. This non-binding strategy was requested by WHO Member States to address the major risks responsible for the heavy and growing burden of non-communicable diseases. It emphasises the need to limit the intake of certain fats, sugars and salt, and increase consumption of fruit and vegetables, and levels of physical activity.

The Strategy initially met with opposition from the US delegation, who vetoed a proposed draft on the basis that more scientific evidence is needed to substantiate the recommendations in the draft. The revised Plan now includes the concession that trade interests should not be harmed by the promotion of a healthy diet.

EU Public Health Commissioner Byrne welcomes this WHO/FAO (Food and Agriculture Organisation of the United Nations) strategy, noting that "obesity may be to the 21st century what smoking was to the 20th century." Two out of three Europeans could suffer from obesity by 2030 if there is no change in eating habits, while it has been estimated that obesity could cost between €70 and €130 billion to healthcare systems in the EU.

EU action against obesity focuses on three main areas: Supporting the identification and development of effective public health strategies; providing EU-wide data and analysis; and ensuring EU food labelling law plays a positive role.

Under the EU Public Health Programme, the Commission has established a network of experts on nutrition and physical activity, which brings together Europe-wide knowledge on the causes of obesity, and is helping to improve the monitoring and analysis of data from around the continent. The Public Health Programme is also funding a major project on children and obesity, while work is underway that involves the World Health Organisation and its network of health promoting schools.

Additional information on the EU's Public Health policies is available on:http://europa.eu.int/comm/health/index_en.htm

For information on EU initiatives relating to diet and nutrition see: http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/nutrition_en.htm

FIRST OPEN HEALTH FORUM HELD IN BRUSSELS

The EU Health Forum according to the Commission serves as an information and consultation mechanism to ensure that the aims of the Community's health strategy are made clear to the public and to respond to their concerns. It provides an opportunity to representative organisations of patients, health professionals and other stakeholders, such as health service providers, to make contributions to health policy development, implementation and the setting of priorities for action.

The first Open Forum was held in Brussels on 17 May under the theme 'Health in the enlarged Europe'. This event is a key element of the Health Forum, serving as an annual conference and exhibition event. This year's event was attended by more than 300 participants from patient groups, health professionals, public health NGOs, trade unions, healthcare providers and health related industries from all over Europe.

In addressing the participants Commissioner for Health and Consumer Protection David Byrne reflected on how the emphasis of the work of the Commission has shifted since 1999 from an initial concentration on defensive issues of public safety and health security towards a more proactive broader approach to public health. "The broad concept of good health identifies health not only as a key element of individual welfare and happiness, but also as a key element in a broader societal context, for social cohesion, productivity and economic sustainability…we need to broaden our horizons, and focus more on the prevention of serious illnesses and disability, both physical and mental, wherever possible, and on minimising the effects of illness and disability when they do arise. We need to put in place the conditions to enable people not only to live longer but also to make their full contribution to society. To add life to their years and not just years to their life."

Calling for health interests to be at the centre of the policy agenda, Byrne sees the European role as "basically one of a catalyst for change. An enabling influence. One which facilitates progress; defines direction. One which seeks to change the political weather, to bring Europe closer to its people by putting their concerns at the centre of EU politics, and by showing them that Europe can change their lives for the better. We need to support the work of the Member States' health authorities, and to help them address some of the key health policy challenges."

Other plenary speakers included Antonios Trakatellis MEP, Zsuzsanna Jakab, Permanent Secretary of State for the Ministry of Health, Social and Family Affairs, Hungary, and Christine Hancock, President of the International Council of Nurses.

Information on the Open Forum together with access to speeches and documentation can be found at http://europa.eu.int/comm/health/ph_overview/health_forum/open_forum_en.htm

News in Brief

First World Blood Donor Day

June 14 marked the first World Blood Donor Day with a campaign entitled *Blood, a gift for life. Thank you*. The worldwide celebration has been introduced to thank voluntary donors and invite people, particularly the young to give blood regularly. Increasing the number of volunteers who regularly donate safe blood is crucial for an effective health care system and essential for disease prevention. Evidence from around the world demonstrates that voluntary non-remunerated donors are the foundation of a safe blood supply as they are least likely to transmit HIV and other infections through their blood. Yet, too many countries still rely on family replacement or paid donors. A recent survey shows that out of the 52 countries in the WHO European Region, only 24 have 100% voluntary, unpaid blood donation.

More information available at www.wbdd.org

Free movement of workers – information available on-line

Information on the transitional rules governing the free movement of workers post-enlargement is now available on-line at the European Job Mobility Portal *http://europa.eu.int/eures.*

What is the effectiveness of home visiting or home-based support for older people?

The vast majority of older people wish to keep living in their own homes, and institutional care is costly. This creates social and economic imperatives to prevent ill health and disability in older people and enable them to remain in their homes as long as possible. A report from the Health Evidence Network (HEN) written by Ruth Elkan and Denise Kendrick from the University of Nottingham includes evidence showing that home visiting and home-based support can reduce mortality and nursing home admissions in some groups of older people.

The report is available at www.who.dk/eprise/main/WHO/Progs/HEN/Syntheses/homesupport/20040614_3

Ban on smoking in restaurants and bars introduced in Norway

From June 1, smoking was banned in all places that serve food or drinks for consumption such as restaurants,cafés, discos, bars and pubs. According to the Ministry of Health the main purpose of the legislation is to protect employees, as well as guests, from passive smoking. Up to 200,000 people with allergies or asthma will no longer be excluded from restaurants, bars and the like. Minister of Health, Dagfinn Høybråten called the ban on smoking in the hospitality business a milestone in the fight against the damage caused by tobacco.

Report on health and care in an enlarged Europe

The European Foundation for Living and Working Conditions has published a comparative report on health and health care issues across 28 European countries. People in the acceding and candidate countries (ACC) are, on average, less satisfied with their health care systems and social services than those in the EU15. Austrians and Finns report the highest satisfaction levels while people in Bulgaria and Turkey are least satisfied. People in Portugal and Greece, however, report similarly low levels of satisfaction.

The report is available at www.eurofound.ie/publications/EF03107.htm

Presidency Conference on eHealth held in Cork

A major conference *Empowering the European citizen through eHealth* was run under the auscpices of Department for Health, Children in Ireland and the European Commission as part of the Irish Presidency programme. This was a follow up to an initial event held in Brussels in 2003 as part of the Greek Presidency. The conference included a series of plenary and seminar sessions highlighting developments in the field from political and technological perspectives, and a series of awards were also presented.

Further information is available from www.ehealthconference2004.com

EU drugs agency plays key role in evaluation

Officials from the 25 EU Member States met at a Conference in Dublin to map the way forward with respect to EU action against drugs in the coming years. The Conference prepared the ground for the December European Council, which is expected to approve a new EU drug strategy from 2005 onwards. The final evaluation of the ongoing EU drug strategy and action plan (2000–2004), conducted by the European Commission with technical assistance from the EU drugs agency (EMCDDA) and Europol will also provide key information to determine the nature of future drug policy in the EU.

The EMCDDA has also released the latest edition in its policy briefing series "Drugs in Focus", which is available at www.emcdda.eu.int/data/ docs/63en.pdf

Devolution in Scotland: A success for the NHS

Dr John Garner, chair of the British Medical Association's Scottish section, believes devolution for Scotland has been a success story for the Scottish NHS. In his final speech as chair he said "Since 1999 spending on health has increased by more than £3billion. The NHS in Scotland has undergone reform, waiting times are falling and survival rates for many previously life threatening conditions have improved. We have better relationships with ministers, their civil servants and politicians in all parties which has helped us enormously in getting to the position we are in now. I believe devolution has worked. Our health service is delivering for the people of Scotland and although we still have a long way to go, I think we have a brighter future ahead."

The full speech is available at www.bma.org.uk/ap.nsf/Content/ARM04chScotland

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