

# Part 1

## Introduction and Overview

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# 1 Trade, Health and Dietary Change

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## 1.1 How trade became a health issue

In 2001, trade ministers of the 148 member countries of the World Trade Organization (WTO) met in Doha, Qatar, to launch a new round of multilateral trade negotiations. At the meeting, the ministers agreed to an unprecedented declaration on public health which clearly stated that the WTO trade rules on intellectual property (the Agreement on Trade-Related Aspects of Intellectual Property Rights, or TRIPS) should not prevent members from taking measures to protect public health. This joint declaration came after the unparalleled mobilisation of global civil society against the negative impacts of patents on access to essential drugs. It was this high-profile controversy that first placed trade policy onto the global health agenda (Smith *et al.* 2009; Stiglitz 2009).

The TRIPS agreement, which was agreed to by WTO member countries in 1994, drew strong criticisms as it was perceived as a legal obstacle to the production of affordable generic drugs, i.e. it placed limitations on the capacity of national government to adopt measures to override patent protection. The HIV/AIDS epidemic in sub-Saharan Africa highlighted the risks associated with the TRIPS agreement. For instance, TRIPS stipulates that the production of generic drugs under compulsory licences should focus only on domestic needs, making it difficult for countries producing generic drugs to export them to the sub-Saharan African countries with no manufacturing capacity to produce their own drugs.<sup>1</sup>

There were also concerns about the impact of high patent protection on the price of pharmaceutical drugs, and access to health-related products like vaccines and medical supplies and equipment. While there is indeed strong evidence that patent protection leads to higher drug prices (Commission on Intellectual Property Rights 2002), proponents of strong patent regulations argue that without sufficient patent protection, the incentive to innovate, develop and manufacture new drugs is significantly reduced.

The issue of patent protection is still the subject of much political activism on both sides of the debate. Much of this concerns the attempts by the United States

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<sup>1</sup> The public debates around the TRIPS agreement and the capacity to provide affordable drugs for HIV/AIDS patients in Africa and around the world led to changes to the WTO agreement, with a waiver allowing all countries to produce generic drugs to export to countries without manufacturing capacity.

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#### 4 Trade, Food, Diet and Health

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**Box 1.1** Core linkages between trade and health.

- Trade in health-related products (pharmaceutical products, vaccines and medical equipment)
- Trade in health services
- Trade in harmful products
- Trade and social determinants of health
- Trade in food

to strengthen patent protection beyond what is provided in the multilateral trade rules of the TRIPS in their bilateral trade negotiations (Correa 2006).

Access to drugs was the first, but not the only health issue bringing trade onto the health agenda (and vice versa). As shown in Box 1.1, four further concerns have raised the profile of trade as a health issue: trade in health services, trade in harmful products, trade and the social determinants of health and trade in food.

Trade in health services is associated with three public health concerns. The first is 'health tourism' which takes place when a patient travels abroad to receive health care. Health tourism has increased significantly since the 1990s, especially to Asia (Anon 2008). It includes American patients without health insurance travelling to India to receive care they cannot afford at home, Japanese patients travelling to Thailand for annual health examinations and high-income patients coming from low-income countries where sophisticated health services are not available. The patterns of such trade are still evolving, but some policy implications have emerged. For instance, in Thailand, health tourism has drawn health professionals away from rural and public establishments towards large private urban hospitals which cater to foreign patients. To deal with the problem, the Thai government adopted mitigating measures to limit the negative impacts of such an internal 'brain drain' (Pachanee & Wibulpolprasert 2006). The second type of trade in health services is the temporary movement of health professionals abroad to provide care. This phenomenon is distinct from the permanent migration of health professionals, but nevertheless raises the concern that greater temporary mobility of health professionals could worsen the existing 'brain drain' of physicians and nurses from developing countries (especially sub-Saharan Africa) to developed nations. A third type of trade in health services is when a foreign investor establishes a commercial establishment, such as a clinic or a hospital, to offer health services or health insurance services. The policy implications of foreign investment in health care services are similar to some of the concerns associated with private financing and delivery of health services (such as increased inequity in access to services). For instance, research on foreign investment in health establishments in China highlights how the coastal regions, already better served in terms of availability of facilities and services, have received all of the foreign investment in the establishment of specialised clinics (Shi 2003).

The third issue linking trade to the health agenda is the trade of products that damage health, particularly tobacco, alcohol, small arms or toxic waste. This first became a concern as the reduction of tariffs on tobacco products led to price

reductions and increased consumption. The negative impact of trade liberalisation on tobacco use is well documented (Taylor *et al.* 2001). The negotiations of the Framework Convention on Tobacco Control (FCTC) did not directly address this potential tension between international trade law and health, but contains provisions that have implications for trade rules. An earlier draft of the FCTC included text that gave supremacy to trade rules over the implementation of such provisions, but this was excluded from the final draft (Smith & Onzivu, 2009).

The fourth area is the effect of trade liberalisation on social determinants of health, such as poverty, economic insecurity and inequality (Blouin *et al.* 2009). This issue has long been a concern of civil society groups and was in fact an original stimulus for the founding of the People's Health Movement (2000). Although increasingly documented in research-based texts (e.g. Labonté *et al.* 2009) and, most recently, by the World Health Organization (WHO) Commission on the social determinants of health (WHO 2008), this issue remains relatively absent from mainstream trade and health circles, partly due to the prevailing belief that trade has a positive impact on health (e.g. Dollar 2001; Feachem 2001).

The fifth issue that brought trade onto the health agenda was food. In the last few decades, there has been a significant increase in cross-border flows of foodstuffs and investment in the agri-food industry. This phenomenon has raised three main policy concerns from a public health perspective: food security, food safety and diet-related health risks.

## 1.2 Trade and food-related health

### 1.2.1 Food security

As global food trade has grown (as described in Chapter 2), external markets have become an increasingly important source of national food supplies. It is debated whether this change has resulted in higher or lower levels of national and/or household food security. In theory, removing trade barriers has the effect of reducing food prices, thus increasing access to food by the poor. However, lower-priced imports can undermine the domestic market for food produced by domestic farmers, many of whom are poor, thus worsening their food security (e.g. Madely 2000). In an attempt to resolve the debate about the impact of agricultural trade liberalisation on food security, a report from the Food and Agriculture Organization of the United Nations (FAO) concluded that 'even where food prices do fall [as a result of trade liberalisation] this is not necessarily a straightforward advantage. The outcome depends on the location and employment of the food insecure, i.e. of the poorest strata of society. If many of the poorest households are dependent directly or indirectly on agricultural production for their main income, the overall effect on food security may be negative' (FAO 2003a: Chapter 1, Section 6). A second major empirical study by the FAO also concluded that 'trade reform can be damaging to food security in the short to medium term if it is introduced without a policy package designed to offset the negative effects of liberalisation' (FAO 2006: 75). Although the debate continues, the need to consider food security in trade

policy has become a more mainstream concern. As put by Watkins and von Braun (2003: 2), ‘At risk of understatement, the crucial links between agricultural trade, poverty, and food security do not figure prominently on the WTO agenda. All of this is bad news for global poverty reduction efforts’.

A related debate concerns whether WTO agreements limit the capacity of national governments to adopt measures that ensure food security. Some have argued that the existing multilateral Agreement on Agriculture (AoA) reduces the ability of national governments to adopt policies that promote food security (see Murphy 2003). They point to the WTO restrictions on government intervention in agriculture, such as the prohibition on the introduction of new non-tariff border measures and export subsidies, and the obligation to convert existing non-tariff measures into tariffs and to reduce most tariffs. Conversely, other analysts have questioned the extent to which current WTO rules on agriculture really limit the policy space available for food-insecure states to pursue food security policies (FAO 2003b). For example, FAO (2003b: 63) conclude that the AoA ‘does not in general, at this stage, limit the policy space to implement food security programmes and that the main constraints are lack of funding and institutional capability and, to some extent, political will’. There is nevertheless concern that new trade negotiations may limit the policy space available to promote food security. As a result, the FAO has proposed specific criteria defining situations in which developing countries could have greater flexibility in applying WTO rules (FAO 2005). Notably, too, the Doha round of trade talks at the WTO has discussed how to integrate food security in the trade agreements, such as creating exceptions to existing rules and obligations which could be used by national governments to adopt public policies which promotes food security.

More recent events have again brought trade and food security into the spotlight. Rising food prices in 2006–2008 were blamed in part on international trade in biofuels diverting crops from food uses (UN 2008). These high prices are now considered a core risk for rising food insecurity. In 2008, the FAO identified 34 countries at serious risk of food insecurity partly because of higher food and fuel commodity prices (FAO 2008). The crisis has also given rise to debates about whether more food trade can help resolve the food insecurity (e.g. World Bank 2008), or whether reducing trade and promoting domestic self-sufficiency is the key (e.g. La Via Campesina 2008).

### **1.2.2 Food safety**

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A second food issue that brought trade further onto the health agenda is food safety. There are two main concerns here. The first is that the increasing trade in foodstuffs augments the risk of transmission of food-borne diseases. Since foods produced in a single location are now traded to multiple locations all around the world, it is feared that trade increases the potential for the spread of new food safety hazards, the revival of previously controlled risks and more widespread contamination. Complex trade patterns also raise concerns that tracing the source

of the food safety risk is more difficult, making it more difficult to resolve the problem.

The era of greater food trade has certainly been accompanied by a rise of reported food-borne diseases. In the United States, for example, the average annual number of food-borne illnesses associated with fresh produce more than doubled between 1973–1987 and 1988–1991 (from 4 to 10 outbreaks per year), a trend that continued into the late 1990s (Calvin 2003). Yet beyond isolated and usually highly publicised cases, it is not possible to attribute this increase to imports. There is, in fact, little evidence to confirm whether food safety risks are increasing, remaining stable or decreasing with more food trade (Buzby & Unnevehr 2004).

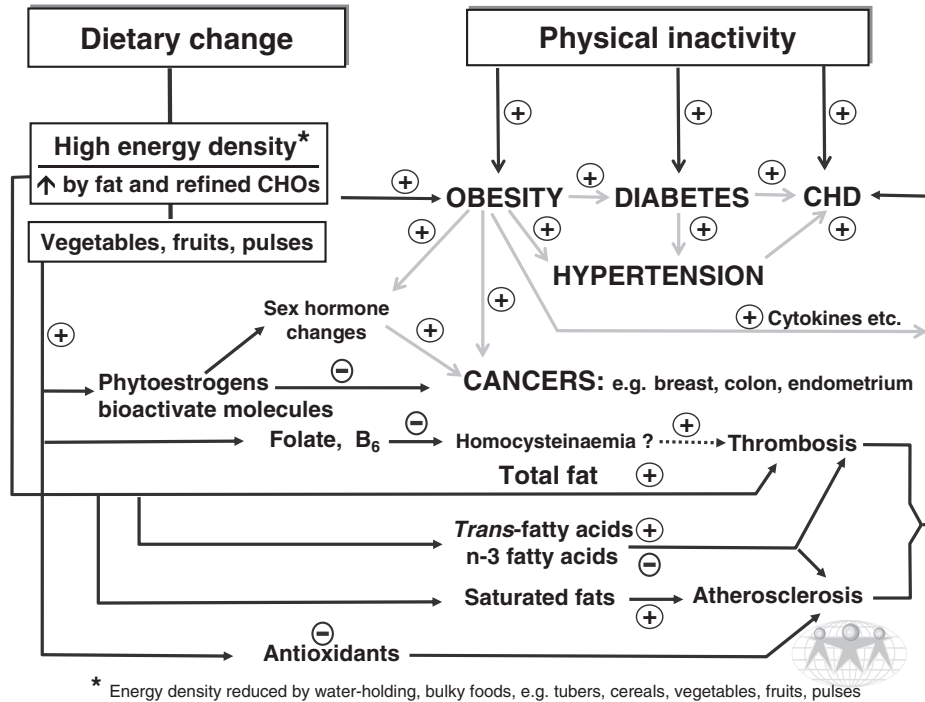
The second concern is that national regulations on food safety present a barrier to trade. Such concerns were the reason for the adoption of the WTO's Agreement on Sanitary and Phytosanitary Measures (SPS Agreement), which aims to discipline national measures on food safety. The agreement specifies that food safety standards should be based on scientific evidence and international standards, but should not be overly trade restrictive. Despite resulting concerns that the SPS Agreement undermines stronger national standards and thus increases food safety risks (Silverglade 2000), there nevertheless remains a wide variety of different food safety regulations around the world (Josling *et al.* 2004).

The third issue that has brought food onto the trade and health agenda is the rise of obesity and diet-related chronic diseases worldwide. This much more recent issue has received far less attention in trade circles and is the principal focus of this book.

### 1.3 Trade, diet and diet-related chronic diseases

As with many phenomena, it was the perceived visibility of the effects of trade, and of globalisation more generally, that led researchers, civil society and the media to begin to highlight the link between trade and poor dietary patterns. As Coca-Cola spread rapidly around the world in the 1980s, followed by McDonald's in the 1990s, researchers coined the terms 'Coca-Colonisation' and 'McDonaldisation' to describe the westernisation of the global diet. This perception was soon backed by evidence that people all over the world were consuming fewer traditional staples (cereals and complex carbohydrates) and far more energy-dense foods high in fats, sweeteners and highly refined carbohydrates (though the research did not necessarily identify soft drinks and burgers as the cause). The term 'nutrition transition' was coined to describe the shift towards these unhealthy diets (Popkin 1998).

Diets higher in animal foods, sugar, fruits, vegetables, oils and fats became more prevalent in most developed countries in the late nineteenth century (e.g. Grigg 1995). For example, in England, it is estimated that the per person consumption of fat and refined carbohydrates increased 5- to 10-fold over the past two centuries, while the consumption of fibre-rich grains declined substantially (Uusitalo *et al.* 2002). This same shift is now taking place in middle- and low-income countries, but with a significant difference: the rate of change is far faster (Popkin 2002). The shift typically begins with major increases in domestic production and imports



**Figure 1.1** The dietary inter-relationships with chronic diseases. CHD, coronary heart disease. *Source:* James and Rigby (2007). By permission of Oxford University Press.

of oilseeds and vegetable oils (Drewnowski & Popkin 1997). Consumption of foods from animal sources (such as meat and milk) and processed foods (such as snacks, soft drinks, breakfast cereals and processed dairy products) then increases. The transition is also characterised by increased consumption of foods away from home, such as street foods and fast foods, and an inadequate consumption of fruits and vegetables.

Scientific evidence shows that these dietary patterns – specifically, diets high in fats (especially saturated fats and *trans*-fatty acids), free sugars, and salt and low in fruits, vegetables, pulses (legumes), whole grains, and nuts – pose significant risks for chronic diseases (WHO/FAO 2003). Along with declining levels of physical activity, diets have thus been implicated in the emergence of chronic diseases as a leading cause of mortality and morbidity in the world today. As shown in Figure 1.1, dietary change has direct and indirect impacts on obesity, diabetes, hypertension, heart disease and cancers.

According to the WHO, such chronic (often termed ‘non-communicable’) diseases are the largest cause of death in the world, led by cardiovascular disease (17 million deaths in 2002, mainly from ischemic heart disease and stroke) and followed by cancer (7 million deaths), chronic lung diseases (4 million) and diabetes mellitus (almost 1 million) (Yach *et al.* 2004). In 2008, more than 31 million people are thought to have died from the four leading chronic diseases: heart disease,

cancer, respiratory disease and diabetes (Stuckler 2008). Close to half of these deaths are estimated to be premature (WHO 2005). Although chronic diseases have been the leading cause of death in developed countries for decades, 80% of deaths from chronic diseases now occur in developing countries and cardiovascular disease is the leading cause of mortality in these countries (WHO 2005). Analysis of mortality data shows that almost half the disease burden in low- and middle-income countries was from chronic diseases in 2001 (Lopez *et al.* 2006). The most recent projections by the WHO indicate that, until 2030, there will be a dramatic shift in the distribution of deaths from younger to older ages, and from communicable, maternal, perinatal and nutritional causes to chronic disease causes (Mathers & Loncar 2006). Specifically, the proportion of deaths due to chronic disease is projected to rise from 59% in 2002 to 69% in 2030.

This shift is also characterised by the increasing prevalence of intermediate risk factors for these diseases such as overweight, obesity, high cholesterol and hypertension. According to the WHO, in 2005, approximately 1.6 billion adults (age 15+) worldwide were overweight, 400 million of whom were obese (WHO 2006a). In addition, at least 20 million children under the age of five were overweight. The WHO further projects that, by 2015, approximately 2.3 billion adults will be overweight and more than 700 million will be obese. A review of available data in 2006 found that childhood overweight has increased over past years in almost all countries for which data are available (Wang & Lobstein 2006).

Many factors have been blamed for the nutrition transition and associated increases in obesity and diet-related chronic diseases, including changes in people's income, employment pattern, and what are often termed 'lifestyles', and more distal, global causes related to economics, culture and technology. At the macro-level, the 'globalisation' of the food system is often talked of in a general way as a culprit. As put by Kennedy *et al.* (2004: 1), 'globalisation is having a major impact on food systems around the world . . . [which] affect availability and access to food through changes to food production, procurement and distribution . . . in turn bringing about a gradual shift in food culture, with consequent changes in dietary consumption patterns and nutritional status that vary with the socio-economic strata'. This is where trade – as a key component of globalisation – comes in. But while the links between trade and the way food is produced and moved around the world are well established, the links with changing food consumption patterns are not.

As for the other health- and food-related issues on the trade agenda, there are many differing perspectives on the role of trade in diet-related changes. Basically put, some perceive trade as a main driver of the westernisation of diets (see, for example, the essays in WHO 2002 and FAO 2004). Others, in contrast, view trade as a positive purveyor of greater dietary diversity and consumer choice (e.g. Regmi *et al.* 2004). On the policy side, some perceive a need to intervene directly in trade to stop the rising tide of diet-related disease; others view policies targeting consumers much more appropriate and not at all inconsistent with open trade. These different perspectives have not been well explored in the research and policy literature. To address this gap, this book brings together a range of studies on trade, food, diet and health, presenting different perspectives on a debated issue.

## 1.4 Book overview

Conflicting views about the role trade could or should play in the global economic order have given rise to what is often highly polarised debate about trade. Indeed, the history and functioning of food trade described in Chapter 2 shows that much of the advance of food trade has been the result of specific policy decisions influenced by particular political-economic beliefs. But rather than taking a single view, this book presents a range of diverging perspectives. It is an approach that reflects the diversity of the contributors, who come from a range of disciplines, including economics, law, public health, nutrition and sociology, and sectors that include academia, national governments, non-governmental organisations, trade organisations and international organisations. Given the different languages used by different disciplines and sectors, and the often very technical nature of trade policy, the book includes a **glossary** of the trade terms used in the chapters.

The book is divided into two parts: the linkages between trade and diet (Part 1) and the policy options available to address these linkages (Part 2). Chapter 2 traces the history of food trade, addressing the question ‘why trade food?’ It provides an overview of trade and investment in food and agriculture, and the resultant impacts on imports, exports and the whole food supply chain, not least the growth of transnational corporations that produce, process and sell food. Chapters 3 and 4 look at links between trade and the consumption of specific foods. Focusing on vegetable oils, meat and highly processed foods, Chapter 3 suggests that trade liberalisation has been a facilitator of the nutrition transition by changing food availability, prices and marketing, thereby encouraging consumers to consume certain foods over others. Chapter 4, looking at fruits and vegetables, comes from the opposite perspective, indicating that it is changes in consumption patterns and increasing demand for new types of fruits and vegetables at affordable prices that have driven increased global trade flows of fruits and vegetable, not the other way around. Chapter 5 looks at the issue of prices and costs in greater depth, arguing that international trade lowers the relative costs of energy-dense foods and diets, thus facilitating the growth of obesity in the developing world. Chapter 6 argues that trade affects what people eat primarily through indirect rather than direct channels. Using a global value chains approach, it examines how processes beyond the simple export and import of finished food products, such as the trade in ingredients, are more important, and that an in-depth understanding of how the global food industry operates is a key to understanding the linkages involved. Transnational supermarkets, increasingly a key player in the global food industry, is the subject of Chapter 7. This chapter likewise shows that it is a trade-related process beyond food imports and exports – the foreign investment that has fuelled rapid supermarket growth in developing countries – that is the key. It finds that, because supermarkets market and procure food differently from traditional retailers, they likely have an effect on food prices and diets.

The following three chapters present studies of the linkages between trade and food in specific geographical zones. Delving into Europe first, Chapter 8 examines

whether a vast instrument of agricultural trade policy – the European Union’s Common Agricultural Policy (CAP) – has been a factor in changing dietary patterns in Europe since the 1970s. While it finds no evidence of a link, it does suggest that the CAP may have affected food consumption elsewhere in the world. In contrast, the trade policies of the Pacific Islands do appear, as reviewed in Chapter 9, to have had a direct impact on the diets and health of Pacific Islanders; the relatively small size and bounded nature of the Pacific Island countries provides unique insights into the pathways between trade and diet. Moving into Asia, Chapter 10 examines the case of Thailand, asking whether food imports have played a role in driving dietary change. It finds that the nutrition transition in Thailand has not been driven by food imports so much as domestic changes and the more diffuse influences of globalisation. It nevertheless suggests that the policy options needed to address dietary changes need to take a global perspective given the global nature of the influences, and makes the case for the adoption of nutrition profiling for this purpose.

The policy options are taken up in more detail in Part 2. From an advocacy perspective, Chapter 11 starts by outlining evidence that trade liberalisation has strongly negative dietary implications for a particularly vulnerable group: children. It then outlines the policies needed to address the outcomes of trade liberalisation on childhood obesity at the global, national and local levels. The next two chapters look at existing trade-related mechanisms available to promote healthy diets: the WTO’s SPS Agreement (Chapter 12) and the Codex Alimentarius (Chapter 13). Chapter 12 provides a comprehensive review of the effects of the SPS Agreement on the transparency and harmonisation of national food safety regulations and highlights the lessons it provides for interventions to promote healthy diets. Chapter 13 examines how the Codex Alimentarius could be used to advance the recommendations in one of the key global policy documents in this area: the WHO’s Global Strategy on Diet, Physical Activity and Health. It also provides an example of how one national experiences of implementing this Global Strategy – from Canada – can be used to help the Codex in doing so.

The next two chapters examine the policy space available to governments to implement policies given their international obligations under trade agreements. Chapter 14 asks whether developing countries have scope within the WTO’s AoA to implement agricultural policies that have a health-promoting effect. Chapter 15 makes a detailed analysis of whether policies commonly recommended to address obesity, specifically those set out in the European Charter for Counteracting Obesity, would be permitted within the disciplines imposed by trade agreements. These analyses find that these policies are indeed possible within the disciplines imposed, although interventions like banning imports of energy-dense foods would not be permitted.

## 1.5 Key messages and conclusions

As already indicated, the book contains a variety of perspectives. Nevertheless, several key messages emerge strongly from the different chapters. First, the trade

processes linked with changing consumption patterns involve a lot more than just the imports and exports. While the movement of foodstuffs across borders have been the traditional concerns for food security and food safety, dietary matters involve other trade-related drivers, such as foreign investment, the growth of transnational corporations and supermarket growth, as well as urbanisation and income growth. And while due attention is often paid to the effect of WTO agreements on food and agriculture relative to other trade policies, bilateral and regional agreements, investment agreements and unilateral decisions made by governments, are also critical, if not, in some cases, more so. Second, the links between trade and diet are often more indirect than direct. While specific changes in trade policy can be linked directly with consumption trends in some cases, it is the totality of these more amorphous effects of trade operating on many different facets of the food industry and people's lives that matter. Third, there is a tension between conceptualising increased food trade as being driven by changing consumer eating habits, and conceptualising increased food trade as being driven by changing eating habits. This is likely a false binary, with both forces operating in both directions. Fourth, then, the picture emerges that, while the links are at times indirect or amorphous, trade and trade policy has implications for the food we eat, particularly the process of trade and financial liberalisation.

So how to address such a complex picture? The first step is to diagnose whether trade is in anyway the cause of the problem – as has been attempted by many of the chapters in this book. Trade processes that may intuitively appear to have important implications for diet and health may not, and vice versa. Thus, diagnosing the risks and benefits associated with specific trade policy and agreements is a first key step. A case-by-case approach is needed to assess whether trade and trade policy are fostering changes that are coherent with policies on diet and nutrition at the national level. This approach has been expressed in the WHO Resolution on International Trade and Health adopted by the World Health Assembly in 2006 (WHA 59.26) which also urged members 'to adopt, where necessary, policies, laws and regulations that deal with issues identified in that dialogue and take advantage of the potential opportunities, and address the potential challenges that trade and trade agreements may have for health, considering, where appropriate, using the flexibilities inherent in them' (WHO 2006b). The WHO has sponsored such a diagnostic tool on trade and health, to be used for national policy makers for developing national strategies on trade and health, including trade in foodstuffs (Blouin *et al.* 2009).

With regard to the policy options, emerging from the chapters are two possible approaches: intervening in the trade process itself and/or intervening in the outcomes of the trade process. The former involves intervening in trade and related agreements, or intervening in the actions of transnational food companies, while the latter approach involves developing policies that affect food availability, influence prices or regulate different aspects of food marketing. While the analysis indicates that banning import or exports on diet-related health grounds would likely contravene international trade law, policy approaches that address some of the outcomes of trade liberalisation are not at all inconsistent with rules and

regulations laid out in trade agreements. Both approaches have their advocates and opponents.

This book wishes to inform this debate and contribute to improving policymaking in this area by providing more information and evidence on the linkages between trade, food, diet and health.

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