



Political economy, trade relations and health inequalities: lessons from general health

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This article argues that health outcomes, specifically nutrition related health outcomes, are socially determined, and can be linked to a wider political economy in which peoples’ dietary consumption is structurally determined, evolving from political, economic and social forces. The article examines trade and investment agreements as regulatory vehicles that cultivate poor dietary consumption and inequalities in health outcomes between and within countries. How does this happen? The liberalization of trade and investment, and unfettered influence of powerful economic interests including transnational food and beverage companies has resulted in trade agreements that enable excess availability, affordability and acceptability of highly processed, nutrient poor foods worldwide, ultimately resulting in poor nutrition and consequently oral and other non-communicable diseases. These trade and nutrition policy tensions shine a spotlight on the challenges ahead for global health and development policies, including achievement of the Sustainable Development Goals.

Key words: *trade and investment treaties; nutrition; oral health, political economy; health inequities*

Introduction

What shapes life chances in health, and what forces determine outcomes for individuals and populations? A political economy of health argument proposes that it has very little to do with ‘chance’, but rather that peoples’ circumstances are structurally determined, evolving from political, economic and social contexts (Navarro and Shia, 2001).

As the Commission on Social Determinants of Health (CSDH, 2008) demonstrated, structural factors, including global, national and local politics and modes of governance; international treaties; economic, social and health policies; business practices and social and cultural norms have each generated and distributed power, income, goods and services. These are distributed unequally between countries and across the social hierarchy within countries. These structural factors shape the daily conditions in which people are born, grow, live, work and age. This results in inequities in access and uptake of education and health care, good working conditions, quality housing and built environments, and healthy commodities (Marmot *et al.*, 2008; Moodie *et al.*, 2013).

Here we focus on diet-related health inequities. Many of the structural drivers of poor nutrition and diet-related health inequities operate directly through the food system (Friel *et al.*, 2015). Greater economic globalization, marketization, and the increasing power and influence of the business sector (Nye and Kamarck, 2002) have profoundly altered the purpose and functioning of the food system, shifting the relative balance of healthy and unhealthy foods that are available for consumption; their price, and the acceptability

and hence willingness to consume highly processed foods among communities (Baker and Friel, 2016; Buse *et al.*, 2017; Clapp and Fuchs, 2009; Schram *et al.*, 2015).

In the 1980s two major global policy processes cemented a paradigm shift from nationally focused state intervention to globally-oriented market based policy: Trade liberalisation and structural adjustment programs (McMichael, 2009; Stiglitz, 2006). The World Bank and International Monetary Fund structural adjustment programs gave loans to developing countries to ease their balance of payments problems on older debts, on condition of national policy reform. These policy reforms required low and middle income countries (LMICs) to open up their economies to market forces through the liberalisation of trade, investment and the financial sectors and the deregulation and privatisation of nationalised industries; to remove regulatory controls on private sector activity; devalue their currency and tighten monetary policy (Labonté *et al.*, 2009). The Uruguay Round of the General Agreement on Tariffs and Trade (GATT) in 1994 and the creation of the World Trade Organisation (WTO) required signatory countries to open their agri-food markets by reducing tariffs and non-tariff barriers to trade and investment (Hawkes and Murphy, 2010). WTO rules promoted the integration of national food markets (e.g. through harmonization of food safety regulations) and provided a more favourable operating environment for the private sector (e.g. through protecting intellectual property), with implications for fast food sector trademarks and the protection for plant varieties.

Also, the focus of trade policy increasingly shifted to include not just agricultural production, but also other parts of the food supply chain. Through the liberalisation of investment and trade in services, countries opened up to investment in food processing, manufacturing, retail and advertising by international companies. This had a number of implications – it created new mass markets in food stuffs previously unavailable; it consolidated ownership across sectors and markets, and it provided mechanisms that enabled greater food industry influence in domestic policy making (Hawkes, 2005).

Trade and investment: cultivating consumption and manufacturing disease

The result of these fundamental global policy changes has been a much more market-oriented commodity approach to food, nationally and internationally. What has this meant for nutrition and health inequities? On the face of it, reductions in barriers to trade and investment should increase consumer food choices and improve supply for net-food importing countries. But these structural changes have raised very real nutrition concerns by creating the conditions that cultivate the consumption of unhealthy foods and thus the ‘manufacture’ of non-communicable disease epidemics (Stuckler *et al.*, 2012). These conditions are created in a number of ways. Liberalisation of trade and investment directly influences the volume and nutritional quality of foods available for consumption, and indirectly through expanding the influence of transnational food companies within countries by attracting investment in the manufacturing, retail and advertising of highly-processed foods (Friel *et al.*, 2013; Hawkes, 2006; Stuckler and Nestle, 2012). The trade mechanisms via which the resulting transformation of local consumer food environments occurs are: trade in goods, trade in services and foreign direct investment (FDI), and health policy space, each of which is described briefly below.

Trade in goods

Food trade liberalisation can result in disproportionately large increases in imports and domestic production of highly processed foods, resulting in a food supply that is skewed towards foods which are high in saturated fat, calorie-rich and nutrient-poor (Blouin *et al.*, 2009; Ravuvu *et al.*, 2017; Thow *et al.*, 2010). While this benefits the food industries, it undermines the opportunities among populations to consume a healthy diet. For example, the historical experience of Pacific Island countries, such as Tonga and Samoa, demonstrates that trade liberalization is associated with decreased availability of starchy staple foods such as yam and taro and increased availability of non-traditional processed cereals including white rice, wheat bread, and noodles during periods of liberalization (Thow *et al.*, 2010; Ravuvu *et al.*, 2017). The opening of markets and the import of goods such as cheap fatty meats like mutton flaps from New Zealand or turkey tails from the USA has further undermined domestic agriculture and contributed to import dependency, and high levels of consumption of these foods via ready availability and affordability compared to other foods (Legge *et al.*, 2011). The lowering of trade barriers between Mexico and the USA following the signing of the North American Free

Trade Agreement (NAFTA) saw imports of sugar, snack foods, and processed meat products into Mexico increase significantly, and foreign investment by US businesses more than triple. Not only did this influx of food products contribute to the high levels of obesity and diabetes in Mexico (Clark *et al.*, 2012), but NAFTA is also understood to have put Mexican farmers out of business and restructured food distribution. NAFTA enabled government subsidized US farm products into Mexico at artificially low prices, which local farmers in Mexico could not compete with. Similarly, the entry of US retailers, Walmart and Costco, shifted grocery shopping from local markets to these companies (Reardon and Berdegue, 2002).

Trade in services and foreign direct investment (FDI)

Provisions in multilateral, regional and bilateral trade and investment agreements have increasingly mandated the liberalization of FDI and trade in services. These are major pathways to non-communicable diseases, with the trade provisions opening up countries to investments in food processing, manufacturing, retail and advertising. Transnational Food Corporations (TFCs) use FDI to extend global food supply chains, with control over the food supply chain shifting to large agri-food processors and transnational manufacturing, retail and food service companies such as Pepsico, Unilever, Nestle, Carrefour, Wal-Mart, and KFC.

Not only has the market penetration by TFCs led to the global phenomenon of marketplaces crammed with highly refined cheap foods (Moodie *et al.*, 2013), it has also been accompanied by increasing market concentration and thus market power held by a small number of firms (Baines, 2014; Havinga *et al.*, 2015). Ten food processors / manufacturers control 28% of the global market. Nestle, Pepsi-Co and Kraft are the top three most profitable firms that manufacture agricultural products into food products. Walmart, Carrefour and Tesco are the most profitable food retailers that sell these foods to the consumer (EcoNexus, 2013).

Market concentration increases the buying and selling power of TFCs, allowing them to dictate terms of trade, influence eating habits through the products they choose to manufacture, sell, set buying and retail prices, and preferentially promote (Baker and Friel, 2016). In the manufacturing sector, concentration has been highest in ultra-processed foods, in particular the soft drinks, biscuits, and snack foods categories. The net effect of increasing TFC power is greater availability, affordability, and palatability of heavily marketed ultra and highly processed foods (Baker and Friel, 2014; Lang and Heasman, 2004; Popkin, 2017). Also, with the attendant gains in power by the TFCs, has come the removal of power from local producers, consumers and in many instances policy-makers (Ghosh, 2010).

While this is happening globally, the big concern is in emerging economies. With their large populations and growing wealth, these countries are particularly attractive investment targets for commodity-producing companies. For example, TFCs have been targeting Asian markets with their high economic growth rates, rapidly urbanizing lifestyles, young and growing populations, and the adoption of export-led growth strategies favourable to foreign investment (Baker and Friel, 2014; Baker and Friel, 2016; Patel, 2012).

Vietnam's entry into the WTO and the subsequent required removal of restrictions on foreign direct investment, led to greater investment by TFCs into Vietnam. This enabled significant growth in the sales of sugar sweetened carbonated beverages in the country – an increase from 6.7% of total beverage sales per year to 23% per year (Figure 1). Vietnam is projected to be one of the largest growth markets for Coca Cola and Pepsico (Schram, Labonte *et al.*, 2015).

Policy space

The third way in which trade and investment agreements create the conditions that enable greater food industry penetration into countries, resulting in a cultivation of consumption, is through constraints on domestic public policy space i.e. constraints on the 'freedom, scope, and mechanisms that governments have to choose, design, and implement public policies to fulfil their aims' (Koivusalo *et al.*, 2008). All trade agreements, by design, constrain domestic policy space to regulate for health. Under global trade rules, domestic policies must not discriminate between 'like' products imported and produced domestically, and must be considered the 'least trade distorting' measure. In principle, under GATT articles XIV and XX, countries are allowed to adopt trade restrictive measures when it is 'necessary to protect human, animal or plant life and health'. However, it must be demonstrated that the action is both necessary to protect health and that no other less trade-restrictive measure is available. This provision has been interpreted very narrowly in trade disputes and successful appeals on public health grounds have been limited (Labonte *et al.*, 2011). The effect of this on domestic health policy was observed in Thailand. When the government proposed the introduction of a front of pack traffic light labelling system on snack food products, on public health grounds, the USA and other countries claimed that it would restrict free trade and contravened the WTO Agreement on Technical Barriers to Trade (WTO, 2007). Although no ruling was ever made on this claim, the Thai government abandoned the traffic light system and implemented a monochrome Guideline Daily Amounts label (Sirikeratikul and Vasquez, 2011), a decision widely regarded as reflecting the interests of the food industry.

While risks to regulatory policy space are present in all trade agreements, new generation trade agreements such as the mega-regionals like the Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP) and the Regional Comprehensive Economic Partnership (RCEP) extend their reach. The new agreements typically provide stronger investor protections; and can require more changes to domestic policies to enable, for example, regulatory coherence, transparency, trade facilitation and harmonization. These 'behind-the-border' regulatory controls on government increasingly limit the policy space (Koivusalo and Tritter, 2014). The inclusion of investment protection clauses like investor-state dispute settlement (ISDS) arguably preference private rights over public interests (Gleeson and Friel, 2013), with the potential for health protection measures to attract lengthy and costly trade and investment disputes via Investor-State Dispute Settlement provisions. This can lead to 'regulatory chill' - discouraging governments from moving forward with policy measures or new legislation, or encouraging them to hesitate while they await the outcomes of trade disputes (Lencucha and Drope, 2015). If, as described above, trade and investment agreements intensify the presence of TFCs in domestic markets, particularly in developing countries, this may increase the influence of the food industry over regulatory decision-making, and reduce the ability of governments to embed nutrition in policy-making relating to the food supply (Thow *et al.*, 2015).

What does this mean for oral health and oral health inequities?

It is internationally recognised that poor oral health has a profound impact on overall burden of disease (Kassebaum *et al.*, 2017). The three most prevalent dental diseases at a global level, dental caries, periodontal disease and oral cancer, are all influenced by the products and practices of TNCs, specifically the sugar (dental caries) and tobacco industries (periodontal disease, oral cancer).

TNCs contribute to oral health inequities primarily through their influence on regulatory structures governing their activities, for example, regulation on tobacco products in economically disadvantaged countries. In many wealthy countries, oral health inequalities appear to be increasing,

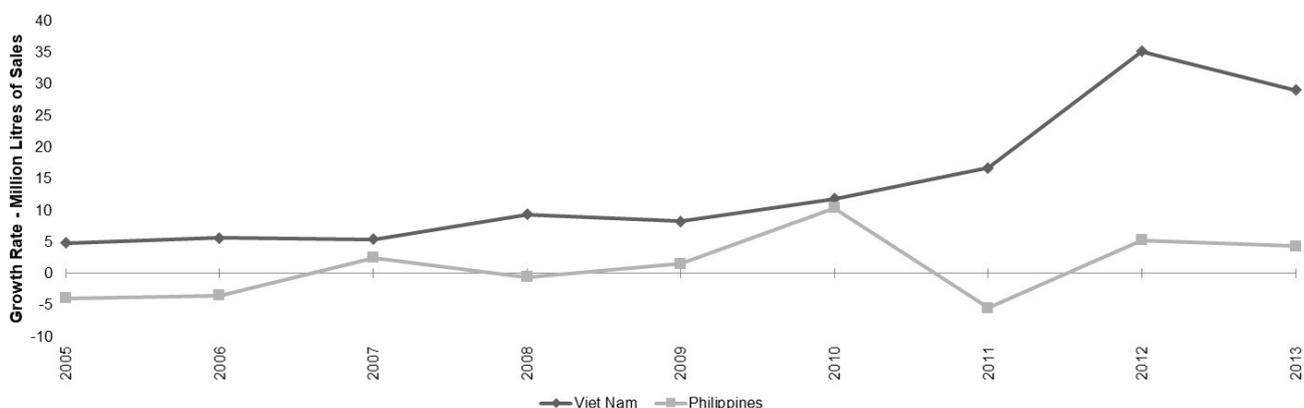


Figure 1: Trends in foreign sugar-sweetened carbonated beverages sales in Vietnam and the Philippines, before and after Vietnam's expanded liberalisation commitments

particularly in relation to untreated dental caries (Kassebaum *et al.*, 2015). Lee and colleagues (2016) reported that, for example, consumption of sugar-sweetened beverages in remote Indigenous Australian communities is both high and normalised, and that without supportive regulation and market intervention, this consumption is likely to increase.

Windows of opportunity in global policy?

There are important structural and normative policy changes happening at the global level that are tantalisingly positive. In Kingdon's (1995) terms, policy formation occurs when 'problem, policy and politics' streams couple, i.e. when simultaneously a problem is recognized, a solution is available, and the political climate is positive for change, a window of opportunity opens which may facilitate policy change. Possibly supported by the growing numbers of policy entrepreneurs in the trade, health and nutrition area, as indicated by the growing number of quality publications in the field, policy advocates for action on global malnutrition have ensured that one of the seventeen Sustainable Development Goals (SDGs) aims explicitly to end hunger and all forms of malnutrition by 2030. However, commitments to further trade liberalisation are positioned, somewhat ironically, as key mechanisms via which to pursue the SDGs (Buse and Hawkes, 2015; United Nations, 2015). At the same time, the UN General Assembly has proclaimed the UN Decade of Action on Nutrition from 2016 to 2025, with UN agencies and states committed to reducing malnutrition and the burden of NCDs (WHO/FAO, 2014). One of the six action areas is trade and investment for improved nutrition. This is an important window of opportunity, with a direction from the highest level of the United Nations to governments and UN agencies to work out how to ensure trade can be used in such a way that improves nutrition and health

Within WHO, the tide may be turning in relation to trade and the commercial determinants of health, in particular unhealthy commodity industries. When Dr Margaret Chan, the then Director General of WHO gave her speech at the 2014 World Health Assembly, she noted pointedly the tensions between trade, investment and health policy goals:

"International trade has many consequences for health, both positive and negative. One particularly disturbing trend is the use of foreign investment agreements to handcuff governments and restrict their policy space. For example, tobacco companies are suing governments for compensation for lost profits following the introduction, for valid health reasons, of innovative cigarette packaging. In my view, something is fundamentally wrong in this world when a corporation can challenge government policies introduced to protect the public from a product that kills." *Dr Margaret Chan speech at the World Health Assembly, 2014*

While Chan's address did not speak to nutrition related issues, what it did do is signal that the key global health institution, WHO, is taking seriously the threats from trade agreements and the influence of commercial actors on health policy. Importantly, this will cascade through to national ministries for health and, hopefully, across to other health issues including nutrition.

Opportunities for oral health advocacy and coalition building

There is a clear role for advocacy among all dental professionals/oral health policy makers in addressing TNCs' involvement in shaping international oral health inequalities. Connecting with other health-oriented actors will increase the reach and impact of the oral health ideas and needs. The 'sugar tax', now implemented in a number of OECD countries and recommended by the WHO, may yield considerable benefits in reducing oral health inequities. Schwendicke and colleagues (2016) reported that, in Germany, implementing a 20 percent sales tax on sugar-sweetened beverages was likely to reduce caries increment (and therefore treatment cost) at a population level, especially in young low-income males, thereby also reducing inequalities in the distribution of caries experience. Increasing the reach of sugar tax to a truly global level, as well as continued advocacy of tobacco regulation, will likely lead to marked improvements in oral health inequalities. And, as with the policy entrepreneurs mentioned above, there is also a growing number of quality researchers and advocates in the oral health space to challenge the modus operandi of transnational corporations and the impact they have on oral health outcomes at a global level.

References

- Baines, J. (2014): Food price inflation as redistribution: towards a new analysis of corporate power in the world food system. *New Political Economy* **19**, 79-112.
- Baker, P. and Friel, S. (2014): Processed foods and the nutrition transition: evidence from Asia. *Obesity Reviews* **15**, 564-577.
- Baker, P. and Friel, S. (2016): Transnational food and beverage corporations, ultra-processed food markets and the nutrition transition in Asia. *Globalization and Health* **12**, 80.
- Blouin, C., Chopra, M. and van der Hoeven, R. (2009): Trade and social determinants of health. *The Lancet* **373**, 502-507.
- Buse, K. and Hawkes, S. (2015): Health in the sustainable development goals: ready for a paradigm shift? *Globalization and Health* **11**, 1.
- Buse, K., Tanaka, S. and Hawkes, S. (2017): Healthy people and healthy profits? Elaborating a conceptual framework for governing the commercial determinants of non-communicable diseases and identifying options for reducing risk exposure. *Globalization and Health* **13**, 34.
- Clapp, J. and Fuchs, D.A. (2009): *Corporate power in global agrifood governance*, MIT Press.
- Clark, S., Hawkes, C., Murphy, S.M., Hansen-Kuhn, K.A. and Wallinga, D. (2012): Exporting obesity: US farm and trade policy and the transformation of the Mexican consumer food environment. *International Journal of Occupational and Environmental Health* **18**, 53-65.
- CSDH (2008): *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on the Social Determinants of Health*. Geneva, World Health Organisation.
- EcoNexus (2013): *Agropoly – A handful of corporations control world food production*. Switzerland, Berne Declaration & EcoNexus.
- Friel, S., Hattersley, L., Snowdon, W., Thow, A.M., Lobstein, T., Sanders, D., Barquera, S., Mohan, S., Hawkes, C. and Kelly, B. (2013): Monitoring the impacts of trade agreements on food environments. *Obesity Reviews* **14**, 120-134.
- Ghosh, J. (2010): The Unnatural Coupling: Food and Global Finance. *Journal of Agrarian Change* **10**, 72-86.

- Gleeson, D. and Friel, S. (2013): Emerging threats to public health from regional trade agreements. *The Lancet* **381**, 1507-1509.
- Havinga, T., Waarden, F.v. and Casey, D. (2015): *The Changing Landscape of Food Governance Public and Private Encounters*, Edward Elgar Publishing.
- Hawkes, C. (2005): The role of foreign direct investment in the nutrition transition. *Public health nutrition* **8**, 357-365.
- Hawkes, C. (2006): Uneven dietary development: linking the policies and processes of globalisation with the nutrition transition, obesity and diet-related chronic diseases. *Globalisation and Health* **2**.
- Hawkes, C. and Murphy, S. (2010): An overview of global food trade. *Trade, Food, Diet and Health Perspectives and Policy Option*. Hawkes C, Blouin C, Henson S, Drager N and Dube L, Wiley & Sons Inc.
- Koivusalo, M., Schrecker, T. and Labonte, R. (2008): *Globalization and policy space for health and social determinants of health*. Globalization Knowledge Network Research Papers. Ottawa, University of Ottawa.
- Koivusalo, M. and Titter, J. (2014): "Trade creep" and implications of the transatlantic trade and investment partnership agreement for the United Kingdom National Health Service. *International Journal of Health Services* **44**, 93-111.
- Labonté, R., Blouin, C. and Forman, L. (2009): Trade and Health. *Global Health Governance: Crisis, Institutions and Political Economy*. Kay, A and Williams, O. London, Palgrave Macmillan.
- Labonte, R., Mohindra, K. and Lenchuca, R. (2011): Framing international trade and chronic disease. *Globalization and Health* **7**, 21.
- Lang, T. and Heasman, M. (2004): *Food wars : the global battle for minds, mouths, and markets*. London; Sterling, VA, Earthscan.
- Lencucha, R. and Drope, J. (2015): Plain packaging: an opportunity for improved international policy coherence? *Health Promot Int* **30**, 281-290.
- Marmot, M., Friel, S., Bell, R., Houweling, T.A.J., Taylor, S. and Hlt, C.S.D. (2008): Closing the gap in a generation: health equity through action on the social determinants of health. *Lancet* **372**, 1661-1669.
- McMichael, P. (2009): A food regime analysis of the 'world food crisis'. *Agriculture and Human Values* **26**, 281-295.
- Moodie, R., Stuckler, D., Monteiro, C., Sheron, N., Neal, B., Thamarangsi, T., Lincoln, P., Casswell, S. and Lancet, N.C.D.A.G. (2013): Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. *Lancet* **381**, 670-679.
- Navarro, V. and Shia, L. (2001): The political context of social inequalities and health. *Social Science and Medicine* **52**, 481-491.
- Patel, R.C. (2012): *Stuffed and Starved: The Hidden Battle for the World Food System*. Westminster, MELVILLE HOUSE PUBLISHING.
- Popkin, B.M. (2017): Relationship between shifts in food system dynamics and acceleration of the global nutrition transition. *Nutrition Reviews* **75**, 73-82.
- Ravuvu, A., Friel, S., Thow, A.-M., Snowdon, W. and Wate, J. (2017): Monitoring the impact of trade agreements on national food environments: trade imports and population nutrition risks in Fiji. *Globalization and Health* **13**, 33.
- Reardon, T. and Berdegue, J.A. (2002): The rapid rise of supermarkets in Latin America: challenges and opportunities for development. *Development policy review* **20**, 371 - 388.
- Schram, A., Labonte, R., Baker, P., Friel, S., Reeves, A. and Stuckler, D. (2015): The role of trade and investment liberalization in the sugar-sweetened carbonated beverages market: a natural experiment contrasting Vietnam and the Philippines. *Globalization and Health* **11**, 41.
- Sirikeratikul, S. and Vasquez, O. (2011): *Thai FDA's New Guideline Daily Amounts (GDA) Labeling*. Washington DC, United States Department of Agriculture Foreign Agricultural Service.
- Stiglitz, J. (2006): *Making Globalization Work*. New York, WW Norton and Company.
- Stuckler, D., McKee, M., Ebrahim, S. and Basu, S. (2012): Manufacturing epidemics: The role of global producers in increased consumption of unhealthy commodities including processed foods, alcohol, and tobacco. *PLOS Medicine* **9**, 1-8.
- Stuckler, D. and Nestle, M. (2012): Big food, food systems, and global health. *PLOS Medicine* **9**, e1001242.
- Thow, A.M., Snowdon, W. and (2010): The effect of trade and trade policy on diet and health in the Pacific Islands. *Trade, Food, Diet and Health: Perspectives and Policy Options*. Hawkes C, Blouin C, Henson S, Drager N and Dubé, L. Oxford, Wiley Blackwell.
- Thow, A.M., Snowdon, W., Labonte, R., Gleeson, D., Stuckler, D. and Hattersley, L. (2015): Will the next generation of preferential trade and investment agreements undermine prevention of noncommunicable diseases? A prospective policy analysis of the trans Pacific partnership agreement. *Health Policy* **119**, 88-96.
- United Nations (2015): *Transforming Our World: The 2030 Agenda for Sustainable Development. A/RES/70/1*. New York, United Nations.
- WHO/FAO (2014): *Rome Declaration on Nutrition: Second International Conference on Nutrition, 19-21 November 2014*. Rome, World Health Organization and the Food and Agriculture Organization