POLICY BRIEF FOR GLOBAL PUBLIC HEALTH - Priti Patnaik

Non-Communicable Diseases (NCDs): Linkages between Trade & Food

Joint meeting of the WHO & FAO, April 2012

Briefing for representatives from the trade & health ministries (Middle & Lower Income Countries)

EXECUTIVE SUMMARY:

Non-communicable diseases (NCDs) account for more than 60% of deaths worldwide. Young populations from middle and low income countries get sick before they reach productive years. WHO identifies the four biggest killers as cardiovascular disease, cancer, diabetes and chronic respiratory diseases. **There are low-cost immediate interventions to address the challenge of NCDs. Spending on prevention is more important and cost effective than providing only for treatment. Pushing for greater use of flexibilities within trade agreements for manufacture of drugs to increase access is important. Tobacco control projects result in direct savings on health care costs, making room for bigger budgets for state-sponsored health services.** Discouraging use of tobacco and alcohol, and improving awareness of healthy diet and physical activity - recommendations by the WHO, have to be implemented on an urgent basis. It is time to acknowledge and recognize the link between trade liberalization, ineffective food laws and rise of chronic diseases.

QUESTION TO BE ADDRESSED:

How should middle and low-income countries address NCDs within existing frameworks to improve access to medicines and influence food consumption patterns, in light of WHO recommendations to combat NCDs?

BACKGROUND:

More than 60% of deaths globally (36 million) in 2008, were due to NCDs, caused by cardiovascular diseases, diabetes, cancers and chronic respiratory diseases. A whopping 80% of NCD deaths occur in low-and middle-income countries.[i] There is an urgent need to address risk factors of NCDs since it directly impacts economic growth in these countries.

Cumulative losses in global economic output due to NCDs will total $47 trillion or 5% of the GDP by 2030 as a result of heart disease, alcohol misuse and depression in high and upper middle-income countries.[ii] It is expected to be worse for low-income countries.

Table 1: Economic Burden of NCDs, 2011-2025 (trillions of US$ in 2008)

Country income group	Diabetes	Cardiovascular diseases	Respiratory diseases	Cancer	Total
Upper middle	0.31	2.52	1.09	1.20	5.12
Lower middle	0.09	1.07	0.44	0.26	1.85
Low income	0.02	0.17	0.06	0.05	0.31
Total of low and middle	**0.42**	**3.76**	**1.59**	**1.51**	**7.28**

Image Source: From Burden to "Best Buys": Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries, WHO & WEF 2011

There needs to be a rethink on how to address public health concerns more aggressively. Liberalization has largely been driving the policy objective, with minimal considerations to public health.[iii] It is an imperative now, since countries risk jeopardising any demographic dividends that they would have hoped to reap. It is important to look at NCDs, not in isolation, but in the context of having global scope and cross-industry relevance.[iv] They are a result of a mix of factors including infectious diseases, illicit trade, migration, terrorism, food insecurity, urbanization and climate change.

Recent studies have shown that trade affects chronic diseases. It is important to recognize this crucial link[v](See annexe). Although, trade treaties can be helpful, they need to be structured to help reduce the global diffusion of risk factors. Treaties can enforce an end to domestic subsidies for harmful agricultural exports including sugars, fats and tobacco. Treaties can remove of tariffs on the import of drugs used to treat NCDs.

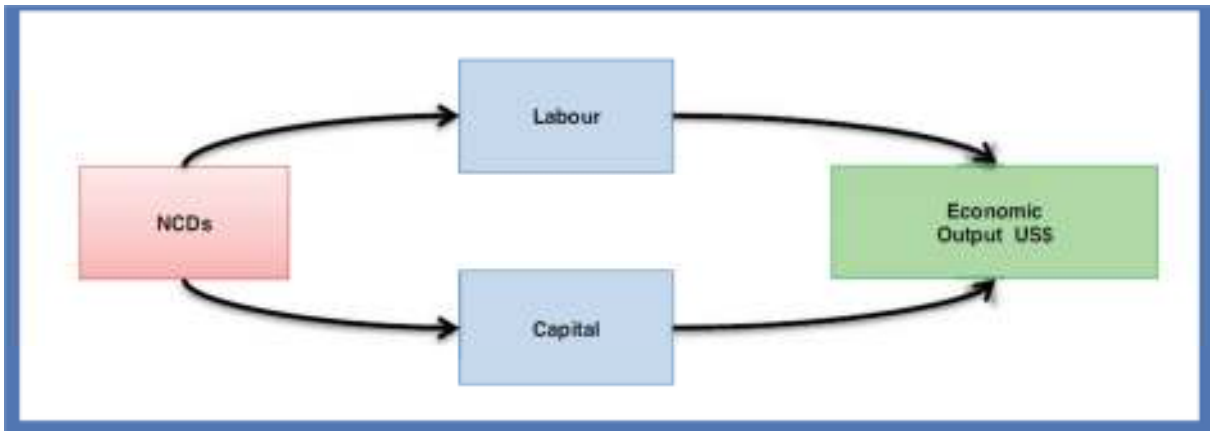

Image: WHO's EPIC tool (Economic costs of NCDs)

EXISTING POLICY:

WHO's global status report on NCDs, recommends 'best-buy' interventions including [vi] protecting people from tobacco smoke, banning smoking in public places, warn about the dangers of tobacco use, enforce effective bans on tobacco and alcohol advertising, promotion and sponsorship, raise taxes on tobacco & alcohol and restrict access to retailed alcohol. It also calls for reducing the salt content of food, replace trans-fat in food with polyunsaturated fat and promote public awareness about diet and physical activity. The WHO has put in place a NCD surveillance mechanism to review the preparedness of countries to tackle NCDs.

It is telling that, since 2005, only 11% of the countries have fulfilled their legally binding commitments within the Framework Convention on Tobacco Control.[vii] A number of factors ranging from fears about job losses in the agriculture sector, subsidies to harmful crops, illicit trade in tobacco, a powerful industry lobby, inadequate regulation of advertising have contributed to the ineffective crackdown on tobacco related diseases. Tobacco accounts for a sixth of the NCDs such as cancer. More than 70% of the world's tobacco is consumes in developing countries (FAO 2004).

For every dollar invested in NCDs, a return of $3 can be expected.[viii] It has been estimated that implementing WHO 'best-buy' interventions, can cost $11.4 billion in low and middle-income countries, which translates into an annual investment of $1 per person in low income countries.

Further, it is estimated that there could be a fall in 2% of annual NCD deaths if interventions are adopted.[ix] A recent study found that a 10 per cent reduction in rate of deaths from non-communicable diseases will accelerate progress towards achieving the Millennium Development Goal (MDG) for tuberculosis.

RECOMMENDATIONS & ACTIONABLE GOALS:

1. **Increase government spending for preventive approach. Ramp up detection and diagnostics.**

There are lessons from investments in HIV. It is important to prioritize prevention over treatment.[x] Learning from the HIV case demonstrates that more number of deaths can be averted per dollar by focussing on prevention, especially in poorest countries. This can be especially applicable to tackle NCDs. The precarious state of health infrastructure in most countries is not capable in dealing with complex treatment procedures. NCDs require lifelong treatment and the costs associated are tremendous. Earmarking a greater percentage of health expenditure for detection and diagnostic procedures will therefore be important. Companies specializing in diagnostic equipment may be given tax breaks and lower import barriers.

2. **Use licenses and price differentiation of drugs to improve access of medicines.**

Voluntary licenses allow local generic companies to manufacture patented medicines in return for a small royalty payable to the innovator. Although there are difficulties of manufacturing high quality generics, it will be a challenge for generic drug makers and force them to be competitive to exploit markets in low-income countries. There are huge domestic markets where drugs for NCDs can be sold.

Differential pricing, as a strategy can be used to increasing access to drugs in lower income countries. It allows manufacturers to leverage economies of scale to supply good quality drugs, even as sufficient revenues from high priced drugs in high income countries can be used to reinvest in R&D. [xi]

Compulsory licenses (CLs) have not been exploited adequately to meet access to medicines. The barriers to CL use in low income countries go beyond the lack of production capacity, and are "likely extend to health system incapacity, political pressure against CLs, and the legislative difficulties of issuing a CL."[xii] It becomes all the more important to use Paragraph 6 interventions to address the use of CLs in least developed countries. While pressure must be articulated on a multilateral level for the effective use of CLs, governments must continue to push for CLs for NCDs. There has to be an objective assessment on the real risks to Foreign Direct Investment (FDI). Further, removal of tariffs on the import of off-patent drugs will promote greater access to medicines.

3. **Revamp food safety and protection laws to protect public health**

Create greater awareness about trans-fatty acids (TFAs). Food safety and protection laws in many countries do not have specific norms for TFAs. Partner with local manufacturers, not just large companies to enforce standards in the food industry.[xiii] In many countries, public health laws need to be revamped. Countries find it difficult to frame domestic laws and implement international obligations. Countries must seek technical legal assistance in doing so. Create awareness on

unhealthy diet and lack of physical exercise as contributors to disease. Involve community based interventions. (See annexe.)

4. **Crackdown on Tobacco to generate additional health budget**

Enforce public smoking ban stringently. This can be a source of revenue for government with strained health sector budgets. Recent studies show that tobacco control projects cost a fraction of the billions that are saved in direct health care costs.[xiv] (See annexe) It turns out that the loss in revenue from taxation of tobacco is a false predicament for governments, for an investment in a tobacco control program results in savings on direct health care costs. (See annexe for example) This can be useful in designing state-sponsored coverage for health services. Annually, direct payments for health services push 100 million people into poverty.[xv]

EVIDENCE

By addressing obvious risk factors like tobacco use, alcohol misuse, poor diet and physical inactivity the most important NCD deaths can be addressed.

ON DIAGNOSTICS: Many developing countries such as India and China have access to sex-detection techniques. Sex determination procedures have proliferated in villages, even in places where there are no primary health care centres. This demonstrates that, there is demand for diagnostics and ingenuous supply channels.

ON COMPULSORY LICENSING: According to a recent study, a majority of CL activity occurred within upper middle income countries, including for NCD drugs. Although there are opportunities and incentives for countries to use CLs on a wide range of medicines, countries face considerable pressure from corporate lobbies and foreign governments. So the existing structure is inhibiting the use of CLs, given the context of TRIPs Plus agreements. (See annexe)

ON SUCCESSFUL TOBACCO CONTROL: The evidence in favour of a smoking ban has been overwhelmingly positive. According to a study, quitting smoking for just 1 year, halves the risk of heart attack. The study cites examples from USA and Scotland, where hospital admissions for asthma dropped after the introduction of smoke-free laws.[xvi]

The California tobacco control programme cost US$1.4 billion during its first 15 years, and saved $86 billion in direct health-care costs, a 61 times return on investment. Further, the authors say that in middle-income countries, tobacco is bought at the expense of priorities like food. So tobacco impacts standard of living and human capital levels. A study in Bangladesh, for instance, showed that if people reallocated 69% of their usual tobacco expenditure on tobacco on food, 10.5 million fewer Bangladeshis would be malnourished.[xvii]

EXAMPLE OF COMMUNITY BASED INTERVENTION ON NCDs: Rome-based inter-governmental body, International Development Law Organization (IDLO) cites the example of how Finland combated what was once the highest death rate from cardiovascular disease due to high tobacco use, and a high fat diet. A massive consumer-community intervention coupled with laws banning tobacco advertising and regulations to promote healthy diets, helped counter the trend.

CONCLUSION:

There is scope today for countries to reclaim their policy space, given the political commitment at the international level to tackle NCDs. Ahead of the UN high-level meeting on non-communicable disease in September 2011 in New York City, the UN General Assembly passed resolution 265, 'Prevention and control of non-communicable diseases'. Armed with an important international mandate middle income and low income countries must push through important reforms in areas of public health law and food protection. It is important to note that even a poor country can push through major health improvements by using the available resources in socially productive ways.[xviii]

ANNEXE

ON TRADE AND FOOD: The growth of cross-border food trade, through regional blocs have enabled transnational food companies to exert enormous influence on what food is grown, and how, where and at what price — all of which has health implications.[xix] The direct linkages have long been established: increased exposure to the use of alcohol and tobacco. The rise of foreign direct investment and the mushrooming of retail chains, have made processed food easily available. The indirect effect of trade has been changes in labour markets leading to economic and employment insecurity, associated with increased chronic disease risk.

ON COMPULSORY LICENSING: Recent studies show that although upper middle income countries have shown efforts towards compulsory licensing, there are considerable countervailing pressures against CL use even in such countries. It is anticipated that there is "a low probability of continued CL activity."[xx]

---

[i] World Health Organization 2010, Global Status Report on non-communicable diseases

[ii] Bloom, David et all (2011), The Global Economic Burden of Non-communicable Diseases, World Economic Forum

[iii] Labonté et al. Framing International Trade and chronic disease, Globalization and Health 2011,

[iv] Silent Killer, Economic Opportunity: Rethinking Non-Communicable Diseases, Chatam House Briefing Paper, February 2012

[v] Food, the law and public health: Three models of the relationship, Tim Lang, Centre for Food Policy, City University, Journal of the Royal Institute of Public Health, 2006.

[vi] World Health Organization (2011), 'Global status report on non-communicable diseases'

[vii] WHO report on the Global Tobacco Epidemic, 2011

[viii] Beagehole, Robert et al. (2011), 'UN high-level meeting on non-communicable disease: addressing four questions', Lancet.

[ix] The Lancet Editorial (2011), 'Time for action in New York on non-communicable diseases.'

[x] The challenge of non-communicable diseases in developing countries, by Phillip Stevens, September 2011,The Center for Medicine

[xi] The challenge of non-communicable diseases in developing countries, by Phillip Stevens, September 2011,The Center for Medicine

[xii] Beall, Reed, Kuhn Randall, Trends in Compulsory Licensing of Pharmaceuticals Since the Doha Declaration, A Database Analysis, January 2012, Plos Medicine.

[xiii] Yach, Derek et al (2010), 'The role and challenges in food industry in addressing chronic disease'.

[xiv] Effective tobacco control is key to rapid progress in reduction of non-communicable diseases
Prof Stanton Glantz ,Mariaelena Gonzalez, The Lancet - 31 March 2012

[xv] Silent Killer, Economic Opportunity: Rethinking Non-Communicable Diseases, Chatam House Briefing Paper, February 2012

[xvi] Effective tobacco control is key to rapid progress in reduction of non-communicable diseases

Prof Stanton Glantz ,Mariaelena Gonzalez, The Lancet - 31 March 2012

[xvii] From the Lancet: http://www.ncdalliance.org/node/3522

[xviii] Nobel Laureate Professor Amartya Sen quote

[xix] Food, the law and public health: Three models of the relationship, Tim Lang, Centre for Food Policy, City University, Journal of the Royal Institute of Public Health, 2006.

[xx] Beall, Reed, Kuhn Randall, Trends in Compulsory Licensing of Pharmaceuticals Since the Doha Declaration, A Database Analysis, January 2012, Plos Medicine.