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Food, Health and Globalisation: is health promotion still relevant?

Or

Food, Health and Globalisation: has health promotion any relevance?

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Introduction

What is the approach of health promotion to food and food policy? We can perhaps best demonstrate this by a recent experience of two of the current authors (JC and MC), on submission of an article on food policy and health promotion to a well renowned health promotion journal, the feedback was that the authors were '*against regulatory authorities, science and technology and the food industry*' and that we needed to include more examples of partnerships with the food industry of which one referee assured us there were many! On revision of the article and submission and acceptance by a public health journal we were told we were being too soft on the food industry and the corporate power of transnational companies. This illustrates for us the battleground for food policy and health promotion. Our experience is that health promotion practice has a tendency to engage with the food industry as partners and focus downstream on the solutions (Labonte, 1998, Labonte, 2003). This misses the bigger picture of who controls and distributes the food we eat and limiting our choices to one of selection as opposed to true choice.

Figure 1 Spheres of influence adapted from Dahlgren and Whitehead (1992).

At the risk of simplifying the issues the model proposed by Dahlgren and Whitehead illustrates the policy divide. We are arguing that health promotion has focused on the inner rings with a concentration on individuals, families and communities and that a national policy dimension has been the focus of these efforts ignoring the wider global economy.

This chapter will explore whether health promotion has any relevance in the context of global and trans-national control of food. It sets out the current trends in food supply and their impact on human and ecological health by identifying a number of the policy 'hot spots' and explores whether national and international policy is making any sense of the long-term health aspirations. The authors ask whether policy is being driven by trends and considers whether, *vice versa*, policy and the political process could exert control over the trends.

The chapter asks questions such as whether health promotion is more comfortable with fostering and monitoring national, local projects and initiatives based on the provision of information and encouraging people and communities to make healthy choices. It is our contention that health is inevitably marginalized by macro-economic forces. Why, in the face of the immediate past quarter century of 'reform' and restructuring has health promotion been so unable and unwilling to argue the

case for public health? Is this due to lack of clout or due to faulty models and approaches? The current emphasis in health promotion on capacity building is exposed as another term for community development and the emphasis being placed in the community to amend and change its practices. A way forward is offered by the use of the original five Ottawa Charter approaches ranging from the importance of settings to the role of health promotion as a key 'investment' and essential element of social and economic development. The global economy and the ways in which its advocates offers a challenge for health promotion practice but is an area that is fraught with tensions (Barber, 1995).

The Nutrition Transition

The terms low, middle and high income used by others in this volume to describe the status of countries pose certain problems when talking about the distribution of both non communicable diet related diseases (NCDs) and infections carried by food. The nutrition transition is a phenomena occurring both globally and locally and highly influenced at a structural level by income but not just incomes between countries but also incomes within countries.

John/Tim these are the terms used in this volume to categorise countries.

Low income: Sub Sahara Africa and Central and East and South Asia

Middle income: Eastern Europe, Central and South America, the Middle East and North Africa

High income: Western Europe, North America, Japan, Australia and New Zealand.

These terms disguise the inequalities inherent within countries ranging from high income to low income. The reason for this is that the determinant of inequality is its relative as opposed to absolute value. Figure 2 shows the widening inequality gap in some of the regions of the world. Sub-Saharan Africa shows an increasing inequality gap, while the East Asian economies and the Middle East and North Africa

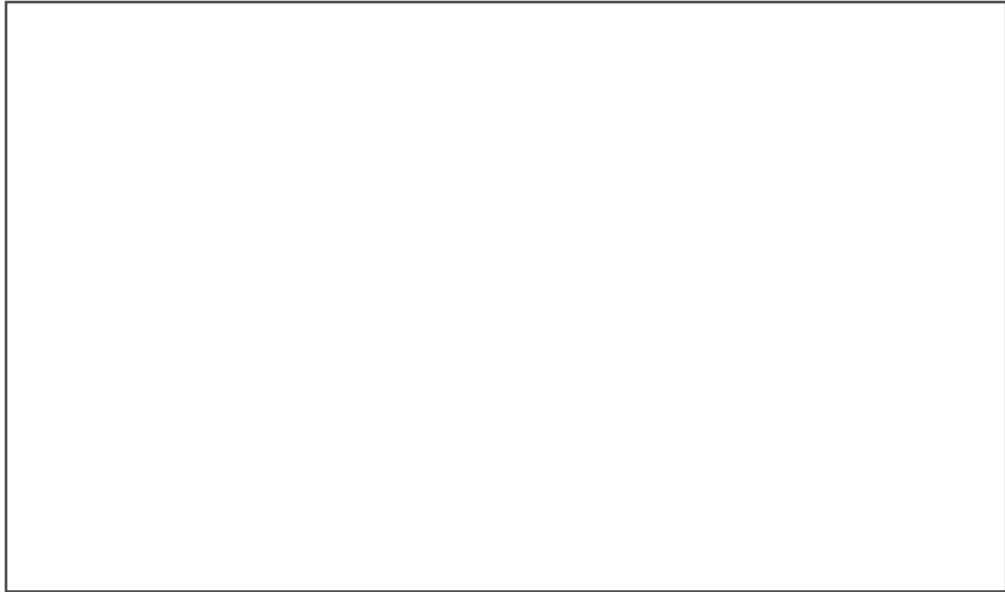


Figure 2 Income inequality across regions Taken from <http://www.developmentgoals.org/Poverty.htm>

Or Figure 2
Annual Average growth Rates in GDP per capita needed to end hunger and actual 1975-1999 rates

Country/region	1975-1999 GDP per capita in constant 1999 US\$	2025 (%)	2050 (%)
Sub-Saharan Africa	0.5	6.3	3.5
East Asia	1.8	7.0	3.9
China	7.5	7.0	3.9
South Asia	3.2	6.8	3.7
Latin America	1.5	7.0	3.9
Middle East/North Africa	.1	6.6	3.7
Newly Independent States	0.1	7.0	3.9

Taken from Runge, Senauer, Pardey and Rosegrant (2003)

Both the developed and developing worlds are experiencing a so-called ‘nutrition transition’ (Popkin, 1998; Caballero and Popkin, 2002) with diseases, such as type II or late onset diabetes and obesity, previously associated with middle age and lifestyle factors now skipping a generation and occurring amongst younger members of society. Diseases of want are occurring alongside those of affluence. The nutrition transition is driven by trends in globalization, two of the prime of which are urbanisation and income & price of food.

Popkin’s (1998) analysis of the dietary shifts associated the ‘nutrition transition’ shows that fat consumption increases in low-income nations with resultant increases of obesity and chronic diseases - the ‘diseases of affluence.’ Partly responsible for

this shift is the greater availability of cheap fats as a result of global trade. The first indications of the shift are differences in the urban/rural populations and the urban affluent classes adopting the food habits of the 'developed' world and the consequent diseases of affluence. This is accompanied by changes in the preparation of such foods and the use of more processed foods, thus giving the consumer less control over the way in which food is prepared and an increase in fat and salt in the diet.

Later stages of the transition are characterised by the adoption by the remainder of the population of first world food habits and diseases, while the urban rich return to healthy diets based on peasant diets. An example of this is the adoption of the so-called 'Mediterranean diet' in Europe by the rich of the northern climes as the peasant classes of the Mediterranean shift to a diet high in fat and sugar. The other driver of the transition is income both between and within countries and how this determines access to food. Diseases associated with low income and high income exist side by side (Wilkinson 1996). Figure 2 shows that the projected rate of GDP will be insufficient to address hunger. The issue here is hunger not wider aspects of poverty such as social exclusion from the norm, because you cannot afford culturally appropriate food. This is a situation that has occurred in the NIS in recent years. From figure 2 above the NIS would have to achieve growth rates of 7 per cent to 2025 and of 3.9 up to 2050 to banish hunger, while they only achieved a growth rate of 0.1 percent between 1975 and 1999.

Recent analysis suggested strategies to promote healthy eating and dietary change were among the most cost-effective of methods of preventing cardiovascular disease (Brunner, Cohen and Toon, 2001). The costs of poor nutrition, obesity and low physical activity for Europe, calculated in DALYs is 9.7%, which compares to 9% due to smoking (World Health Organization, 2000).

The nutrition transition demonstrates how NCDs cross national borders and the causes are not infectious agents but the new agencies of culture and behaviour, different mechanisms than communicable diseases. Whereas the latter spread by infection (usually), the former tend to spread in ways that reflect changes in food supply, culture and lifestyle related to food (Lang and Caraher, 2002).

For example, diet-related diseases are spreading globally through lifestyle and social changes. Obesity and Coronary Heart Disease (CHD) have until relatively recently been seen as a diseases of affluence, less of a problem in developing countries than in rich, industrialised ones. CHD and some food-related cancers (e.g. bowel) (WCRF, 1997) are on the increase in developing countries, where the more affluent social groups are tending towards a more 'Western' lifestyle – eating different foods, taking less exercise and not just aspiring to, but achieving, western patterns of consumption. In developing countries obesity now exists alongside more traditional problems of under-nutrition. As in developed countries, abundance exists alongside people going hungry (Dowler, Turner with Dobson, 2002). Food poverty is a phenomenon not only associated with developing countries or with differences between nations.

According to the United Nations Children's Fund, 'one in five persons in the developing world suffers from chronic hunger - 800 million people in Africa, Asia and Latin America. Over 2 billion people subsist on diets deficient in the vitamins and minerals essential for normal growth and development, and for preventing premature death and such disabilities as blindness and mental retardation (UNICEF, 1997). While such facts are sobering, inadequacies of income affect dietary intake in affluent countries too (Dowler and Rushton, 1993). The Food and Agriculture Organisation (FAO 1999) estimates for the period 1995/7 that 790 million people in the developing world did not have enough to eat. The same report points out that in the industrialised countries of the first world there were 8 million people undernourished and suffering serious food deprivation. In Eastern Europe this figure is estimated to be 4 million and in the newly independent states of the former USSR 22 million (7% of the population). These figures refer to under-nourishment as opposed to the availability of culturally and socially appropriate foods. The emergence of global consuming and under-consuming classes is accompanied by a globalization of inequalities. All this leads to confusion in the mind of the public who are bombarded with messages about the abundance of food and are then told that there are many in society who do not have access to culturally sufficient amounts of food and who regularly go hungry.

The hidden costs of the globalization of food

In addition to the direct impact on health of changes in food supply there are a number of other costs which are referred to as hidden, these include impacts on the environment, local economies and the social fabric of societies (Bové and Dufour, 2001, Barling, Lang and Caraher, 2001/2002).

In Europe, increases in fruit consumption can be largely accounted for by the increase in purchases of fruit juice, which does not provide equivalent nutrition to its fresh counterpart. This fruit juice consumption, however, is often of juices from long-distant fruit, notably oranges from Brazil. The Wupperthal Institute in Germany calculated that 80% of Brazilian orange production is consumed in Europe. Annual German consumption occupied 370,000 acres of Brazilian productive land, three times the land down to fruit production in Germany. If this level of German orange juice consumption was replicated world-wide, 32 million acres would be needed just for orange production (Kranendonk, and Bringeau, 1994). The increasing range of fruit available throughout the year also contributes to this rise in consumption. Such developments result in:

- An increase in food miles with food travelling greater distances
- An increase in pollution
- A reduction in local indigenous crops as they are replaced by foods for export.

These are the indirect costs of the global food market, which we pick up in other arenas such as health, damage to the environment, pollution or road accidents.

This change in distribution not only gives retailers power over the entire food system, but also affects what the farmer grows and how she or he grows it, by the

use of contracts and specifications, and also affects poor consumers. They have to pay for transport that they can ill afford. Shops sell vegetables which can and used to be grown locally, which are now brought thousands of miles. In this way, the consumer gains an illusion of choice while monoculture spreads on the land.

Food citizenship rights and responsibilities

In addition the vertical control of food supplies means that the major retailers control what is grown locally and this may have an impact on local food security. In many parts of the developing world, the development of neo-liberal economies has focussed on the growth of cash crops for export (Griffiths, 2003). In Latin America the power of the supermarkets and fast food chains are changing the horticultural and agrifood systems of countries in the region, supply chains, the face of local retailing and consumer behaviour (Reardon and Berdegue 2002, Gutman 2002, Chavez 2002, Rodríguez *et al* 2002).

All these development and the neo-liberal economic approach is premised on the idea being that cash is then available for local distribution and buying goods on global markets at competitive prices. This is all a house of cards subject to unexpected and uncontrollable issues. The world market for staple goods such as maize or rice is subject to fluctuations.

An unforeseen effect is the demise of local subsistence agriculture which often acted year on year as the bulwark against famine or want. In Lesotho in 2000-2002 there was a shortage of food followed by a famine, this was compounded by weather but aggravated by the fact that the World Bank had pursued a policy of encouraging the growing of potatoes as a cash crop for export to South Africa but the collapse of the export market resulted in money not being available to buy goods and the shift of the local growing of maize as a subsistence crop meant there was nothing left to fall back on. This is a feature of famines across the globe, where the issue is not the lack of food but the lack of entitlement to that food.

The economist Amartya Sen (1981) sees the issues related to food as about the entitlements one has, famine he argues is rarely the result of a lack of food but of a lack of entitlement. Sen says that famine '*is the characteristic of some people not having enough food to eat. It is not the characteristic of there not being enough food to eat.*' Famine is a consequence of people lacking the entitlement to access the available food. This is an important distinction as in the old global order the nation states had some commitment to their citizens and ensuring entitlement, however this was manifested (eg food welfare schemes). The new order owes no such allegiance to its customers. Yet health promotion practice acts or reacts in a way that suggests that famines are new phenomena as opposed to age old occurrences influenced by weather and national conditions but also by markets and global trade (Davis, 2002).

Health promotion has been accused of making the consumer the link in its approaches and methodologies and nowhere is this more apparent than in the area of food, where the rhetoric is one of rights of the individual as opposed to one of duties of the state or business.

We now turn our attention to the issue of global food supply and its regulation and control.

Global Food Supply

Any approach to food in the modern world has to acknowledge the reality of global trade and the impact of this on inequalities. The developed world has always had an imperialist perspective which saw the developing world as its 'grainstore'. For decades, the neo-liberal economic perspective had promoted a view that health would gain from greater wealth, which in turn would be unleashed by trade liberalization, restriction or privatisation of the State and encouragement of private enterprise. While many campaigns and campaigning organisations developed their expertise in relation to national governments and the rights of citizenship, the new world order of TNCs demands a new way of dealing with the issues.

It is not sufficient that an individual country has an adequate food supply, it must look at the way it sources its food and if is self sufficient in food production the food and way it exports its surplus. Australia with a population of 18 million, grows enough to feed 60 million people (Bawden, 1999), for many items it is self sufficient and could be seen to be a model of agricultural prudence. The consequences of this surplus has 3 hidden impacts; the first is the impact of intensified food production systems in the vast amounts of once arable land now laid barren by loss of top soil and salinity problems, and waterways and rivers polluted by toxic algal bloom produced by fertiliser run-off (Coveney, 2000); the second is the impact on the internal communities in Australia where the intensification of agriculture has meant that far flung rural and aboriginal communities are dependent on food being brought to them – at a price. Thirdly the impact on the economies exported to Australian food exports to south east Asia displace rather than supplement local food production. It stands to reason therefore that the globalising effects of Australian food production and export has far reaching effects on the local economies of Asian countries (ref to follow).

Farmers in developed countries receive subsidies making it difficult for farmers from the developing world to compete. MORE DETAIL TIM??

Allied to this is the concentration of power in the hands of a number of trans national global companies who ????. Yet the benefits of this concentration are not passed onto producers. Nestle (2002) contends that 80% of the US food dollar goes to categories other than the 'farm value' of the food itself. As food systems get more complex and value is added to the food so variations emerge in who makes money from food –the farmers' percentage declines as the processors/retailers rise. This is a situation repeated the world over. This is in stark contrast to claims that food liberalization will bring the benefits to the grower producer of cash crops. In reality nearly 80% of food expenditure goes on the so called 'added value' to the food itself such as processing, packaging, transport, advertising and taxes. In addition the growers/producers of 'healthy' foodstuffs are less likely to receive their fair share of the retail cost of the food. The producers of foods such as beef receive 50-60% of the retail cost of the food as opposed to vegetable producers who receive as little as 5%.

The assets of the largest 300 firms in the world are now worth approximately a

quarter of the productive assets in the world (TIM REF?). Transnational corporations (TNCs) account for 70% of total world trade (i.e. in all goods, not just food). Of those TNCs, the top 350 account for around 40%. In food, such power is common, according to research by the United Nations Centre on Transnational Corporations (1981) and high levels of concentration are common in the food system. Cargill, a family owned commodity trader, has 60% of world cereal trade (Lang and Hines 1993). The biggest five corporations control 77% of the cereals trade, the biggest three have 80% of the banana market, the biggest three have 83% of cocoa, the biggest three have 85% of the tea trade (Madden 1992). TIM CHANGE AS NECESSARY?

The global regulation of world food and trade –implications for health promotion and public health

The wealth of individual countries or blocks of countries are not totally within the control of national governments (Labonte, 2003). This process of trade liberalization and the global regulation of food and other goods and services is regulated by the World Trade Organisation (WTO). This allows wealthy consumer societies to source elements of their diet globally. The neo-liberal economic rationale is that the ‘cash-in-hand’ resulting from such trade, enables people to buy food – the ‘trickle down effect’. Cheap food for the consumer in the developed world does not necessarily equate with fair prices for the producer.

This is one reason why national governments commit to health education programmes as they do not threaten the status quo or involve debates with companies who may be large contributors to part funds.

TIM CAN YOU PUT IN SOME BITS ON GLOBAL GOVERNANCE.

Discussion

Food itself, its production and trade links demand our attention due to the inequalities inherent in the process and the subsequent impact it has on widening existing inequalities (Hertz, 2001; Ollila, 2003; Bettcher, Yach and Guindon 2000). As Coveney notes there is a need to understand the pre-swallowing aspects of food (such as production, transport and distribution) as well as the post-swallowing aspects (such as nutrition and diet-related diseases); it is, the latter which health promotion practice have mainly concentrated on.

But, the diverse nature of and understanding of the global food system by various interests also provides potential areas of diversion??

Food itself is a unifying issue that can be both a public good in that it can be seen as contributing to the health of a population but also a private good in that it is subject to the law of supply and demand. The entitlement to food occupies both the realms of citizenship where as citizens people and communities have a right to an adequate amount of safe wholesome food; and at the same time food is a consumer good where the entitlement may be mediated by trade and financial rights (Sen, 1981).

We have painted a complex picture of food trade, regulation within a globalizing system which shows control being exercised by a small number of TNCs with budgets, resources and influence greater than that of many national governments, see table 8. The TNCs have had free reign since the 1960s to develop and control the global food market, basking in the glow of trade liberalization and the demise of national borders as barriers to trade. The restructuring of this agenda need to be seen as long term project not an overnight one.

Many of the debates tend to get transmogrified into consumer rights as these are the ones that are most easily won and the current regulatory systems recognise (GMOs provide an example). Health promotion practice has probably drawn too much on this rhetoric and lost the has concept of public good/public health and citizenship as a basis for action. It works not on the basis of consumer rights and as an advocate for the food consumer but as an extension of global capital by providing an avenue for health education advice. GATS and the freeing up of trade in goods and services are examples of this. The lack of a clear citizenship/public health rights debate is not surprising given the shift in power from national governments to TNCs (Lee, Buse and Fustukian 2002). However this ground needs to be reclaimed in the light of the global economy and the role of food in promoting the health of nations.

In developing a health promotion approach the role of national governments as advocates of the health of their citizens should be encouraged. In the past they have been, perhaps, unwilling to adopt this approach as free-trade and the establishment of fluid national boundaries were considered essential for economic growth. National governments while encouraging agricultural representation at WTO groups such as Codex Alimentarius Commission saw little value in the health departments being represented, although the impact of the Codex committee on health was far reaching (Lee, Buse and Fustukian 2002).

There is now a call for health promotion to recover some of its fundamental principles (Baum, 2002). In brief, this means reconsidering the Ottawa Charter as a mandate for progressive health improvements. The platform provided by the original Ottawa Charter has been built on progressively with international conferences in Adelaide, Australia (1988), Sundsvall, Sweden (1991) and Jakarta, Indonesia (1997). Throughout this time, several key ingredients aimed at lifting the health status of people, improving their quality of life, and providing cost-effective solutions to health problems, have been clarified. Evidence clearly indicates that:

- . Comprehensive approaches using all five Ottawa strategies are the most effective
- . Certain 'settings', such as schools, workplaces, cities and local communities, offer practical opportunities for effective health promotion
- . People, including those most affected by health issues, need to be at the heart of health promotion action programmes and decision making processes to ensure real effectiveness
- . Real access to education and information, in appropriate language and styles, is vital
- . Health promotion is a key 'investment' – an essential element of social and

economic development

Moreover it has become increasingly clear that the 'privatization' of health promotion, through public-private partnerships, does not always lead to positive public health outcomes. Food is a good case in point here. A recent review of marketing partnerships between food companies and health associations and charities in the UK (The Food Commission, 2002) found that overall benefits to consumers were often dubious, that previously good reputations of health organizations were often sullied, and that public health benefits were often limited. Nestle's description of industry-professional relationships in the USA (Nestle, 2002), highlights numerous difficulties with partnerships with the food industry. Strong links with food industry has damaged the reputation and credibility of the American Dietetic Association, a professional association with over 70,000 members. In Australia, industry partnerships have created a division within the Dietetians Association of Australia, with some senior members leaving the ranks (ABC, 2001). So while the financial advantages of industry sponsorship of health promotion and health professional activity may seem attractive, the difficulties of 'getting into bed with industry' are clear. Health promotion, and health promoters, should never lose sight of the primary responsibility of advancing public health through socially just and publicly accountable means.

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