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What Can Food Policy Do to Redirect the Diet Transition?

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In the twenty-first century, developing countries will have to cope with the transition from acute disease to acute plus chronic disease. The two main contributors to this trend are diet and activity levels, both of which are changing at historically rapid rates. This paper focuses on dietary changes. Where good data on food consumption are available, they show that the availability and intake of foods that are risk factors for chronic diseases are increasing rapidly in urban and rural areas and across all income groups. Increases in overweight and obesity rates in the developing world show similar patterns. The coexistence of a double burden of undernutrition and “overnutrition” adds to human suffering and economic costs. It also complicates the design of food policy.

This paper asks: “What can food policy do to redirect the transition in diets toward healthier outcomes?” The paper reviews the drivers of the changes in diet and the potential of both demand- and supply-side food policy options to influence the drivers. The paper ends by highlighting the challenges posed to food policy design by the coexistence of—and linkages and trade-offs between—under- and overnutrition.

Drivers of Dietary and Nutrition Trends

The commonly listed drivers of consumption trends include (1) income growth, (2) changes in relative prices caused by technology, institutional, and policy changes, and (3) the socio-economic and activity changes associated with urbanization.

As income grows, consumers want to diversify out of cereals and other starchy staples. The consumption of the poorest households tends to be most responsive to increases in income. Preliminary simple regression analysis of producer prices in Nigeria, South Africa, and India did not demonstrate any significant systematic differences in relative price increases by food category. In China, however, oils low in saturated fats (soybean, sunflower, rapeseed, and sesame) posted significantly higher price increases over the 1976–95 period than palm oil (high in saturated fat), which showed one of the lowest price increases over the period. In the United States, the price of nonalcoholic beverages (dominated by carbonated sweetened soft drinks) dropped dramatically over the 1982–97 period compared to an all-food average, as have the prices of dairy products, fats and oils, eggs, meat, poultry, and fish. Projections of the internationally traded prices for nonstaple, nonfruit, and nonvegetable goods indicate a continuation of these trends.

More analyses of past trends in producer and retail food prices need to be undertaken from a health perspective. For example, we do not have consumer food price trends by fat content or, preferably, by type of fat content. Such trends would help identify the main sources of any decline or increase in the price of fat or added sugar. Such information, as we will see, is important for policy formulation. In addition, more studies are

needed that seek linkages between price trends and health outcomes. Many studies link undernutrition to price changes but few link rates of chronic disease or obesity to relative price changes while controlling for a range of other factors. Two of the few such studies to do so using U.S. data suggest that 40 percent of the growth in weight of the U.S. population between 1976 and 1994 is due to technology-based reductions in food prices.

Technology innovation and policy may be one important source of change in the relative prices of foods that pose a chronic health risk; institutional policy changes are another. For example, more research is needed from a health perspective on how trade liberalization (e.g., China’s membership of the WTO and its impact on edible oil prices faced by Chinese consumers) will affect the price of different foods that represent different health risks.

Urbanization is proceeding rapidly in the developing world and is accompanied by a marked reduction in physical activity for the majority of the labor force. The higher population density of urban areas lowers the per person cost of mass-media advertising, where the spending power of food manufacturers and processors surely outweighs that of public health authorities. The urban environment is also marked by a greater physical disconnect between places of work and residence and smaller household sizes, especially for women. In this environment, free time is scarcer, at least for those gainfully employed, and where the fixed costs of food preparation are higher in smaller families, more food tends to be purchased outside the home even for poor households. This food tends to be much more highly processed, and higher in salt and fat.

What can food policy do to redirect the diet transition? We have identified a number of options on the supply and demand sides. These have had mixed success in industrialized countries. The policy trade-offs in the developing world are even more complicated.

What Can Food Policy Do?
What is the rationale for public action to steer the diet transition toward greater healthiness? Perhaps the most obvious rationale is information asymmetry between producers and consumers about what is and is not healthy. The paper reviews options from the supply and

demand sides and discusses some of the trade-offs between addressing under- and overnutrition that are accentuated in developing countries.

Possible supply-side interventions considered include (1) more public investment in technology to deliver high-productivity, low-cost vegetables and fruits and low-fat live-stock products to poorer consumers, (2) eliminating incentives on growing high-fat foods and relaxing restrictions on growing healthier foods, and (3) evaluating food trade policy from a health perspective.

Demand-side interventions considered include (1) increasing the relative cost of purchasing unhealthy choices (either through

changing location of purchases or price), (2) providing clearer information about product contents, and (3) improving awareness about consequences of poor diet.

Policy formulation on dietary change in the developing world must build on the evidence base accumulated in the industrialized world. However, the developing country context is very different. First, policymakers in the developing world are faced with food consumption deficits. Second, certain groups need to consume even foods that are “empty” sources of the dietary component being discouraged, e.g., edible oils, to increase the energy density of infant complementary foods. Third, the capacity to influence preferences via the public sector is likely to be lower than in the industrialized world.

Finally, it is important to note that food represents a class of commodities that is difficult to influence in a predictable manner—for example, efforts to increase the price of high fat products will also increase the price of any micronutrients they contain. Moreover, food is not yet like tobacco, in that there are fewer “triggers” in place for strong public action to occur.

Information and Analysis Gaps

Research in the area of diet transition in developing countries is in its infancy. Most of the work has been spent documenting the transition and, to a lesser extent, analyzing its causes. Much of this work has made do with crude food consumption data, and very little research has focused on policy analysis.

The paper suggests that (among other things) there is a need to (1) use *existing* nationally representative household survey data to systematically chart trends in availability of “bad” diet components, (2) better connect the location of food purchase and the health content of that purchase, (3) generate food-price elasticities for large developing countries that are disaggregated enough to be policy relevant (e.g., “edible oil” is not useful, but “high-saturated fat edible oil” is), (4) evaluate nonprice interventions to change diets, both in terms of quality and quantity, (5) spell out the trade-offs in terms of the consumption changes of different dietary components of different population sub-groups resulting from the change in the price of a single community and the implications for smallholder income generation, and (6) conduct more research on the investments and institutional innovations that smallholder farmers need to link up

with growing domestic and international markets for healthy foods.

Conclusion

The diet transition in the developing world seems to be accelerating. It seems to be a transition toward an increased burden of chronic disease. It is increasing human costs in terms of mortality and the disease burdens, and it is increasing economic costs in terms of lower productivity. It is driven by changing preferences fueled by growing incomes, changing relative prices, and urbanization; by changing food choice options fueled by changes in food technology and in food distribution systems; and by a legacy of low birth weights from the previous generation. Is there a case for public investment in efforts to influence the transition toward increasingly healthy outcomes? The existence of information asymmetries and negative externalities suggests that there is.

What can food policy do? We have identified a number of options from the food supply and demand sides. These options have had mixed success in industrialized countries. The policy trade-offs in the developing world are even more complicated. For example, efforts to overcome overnutrition might undermine efforts to overcome undernutrition. The public health anti-smoking policy model offers some insights, but it should not be leaned on too heavily—food is not tobacco. There are plenty of areas in which additional technical research is needed to assess competing risks and to help develop policy options. But there is also a great need for research to engage actors in the policy process underlying the diet transition. In a debate where so much is at stake—market shares, profits, livelihoods, and life itself—there is a potentially powerful role for researchers to bring different actors to the table. This may help to improve the decisionmaking processes underlying the attempts of food policy to redirect the diet transition toward healthier outcomes.

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