

NCDs and Trade Policy in the Caribbean

Series of HCC NCD Policy Briefs

Informing Civil Society Advocacy for Action



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The HCC Series of NCD Policy Briefs

This policy brief highlights the interactions and relationships between trade and noncommunicable diseases (NCD) and the role of trade policy actions in support of the prevention and control of this group of diseases in the Caribbean. The brief provides information and case studies on the interconnection and relevance of trade to NCD prevention and control and outlines linkages between trade policies and specific NCD risk factors, specifically tobacco and alcohol use and unhealthy diets. It closes with recommendations for priority policy actions, which can be used as a starting point for civil society led advocacy.

The brief is one of a series that builds a case for NCD policy action across non-health, health-influencing government sectors in the Caribbean, and is part of the Healthy Caribbean Coalition's (HCC) ongoing NCD advocacy agenda. It builds on the *HCC NCD Policy Brief: Promoting healthy diets, food security and sustainable development in the Caribbean through joint policy action: The role of civil society*(1); developed in April 2015 in collaboration with the Caribbean Public Health Agency (CARPHA).

There is growing urgency for governments to embrace a multisectoral, whole-of-government response to the epidemic of chronic diseases. Many of the practices and policies that influence NCD risk and their social and commercial determinants rest outside of health. The burden of NCD prevention and control cannot be borne by the health sector alone. A 'health in all policies', or in this instance an 'NCDs in all policies', approach is fundamental to a strong and effective public sector contribution to the multisectoral response. This calls for a paradigm shift wherein non-health ministries are required to think and act outside of their traditional spheres of operation and to systematically consider the NCD-related implications of their programmes and policies in order to improve overall population health and equity. We encourage ministries that have traditionally operated within silos to work collaboratively to ensure policy coherence. A first step is to build multisectoral awareness around the linkages between NCD risk and sectors outside of health such as trade, agriculture, finance, environment, and transportation, and to make a compelling case for action on NCDs as an investment, not a cost. Simultaneously, effective policies and practices in non-health ministries which mitigate NCD risk can be highlighted.

In order to strengthen our capacity to advocate effectively, civil society has a responsibility to understand and appreciate the various NCD-related policy options and policy processes across non-health sectors of government.

This brief was prepared by Nicole Foster, HCC Policy Advisor, with contributions from Vincent Atkins, HCC Trade Policy Advisor, Maisha Hutton, HCC Executive Director, Sir Trevor Hassell, HCC President and Alena Matzke, Advocacy Manager, NCD Alliance.



Who is this policy brief for?

Civil Society

The policy brief is an advocacy tool, first and foremost for Caribbean civil society organisations (CSOs) to inform their advocacy efforts aimed at triggering the development and implementation of trade policies which support a reduction in the burden of NCDs. It is hoped that CSOs will gain a greater understanding of key trade and NCD-related issues and policy options leading to more strategic and effective advocacy.

With improved policy literacy, CSOs are better equipped to advocate for the development and implementation of multisectoral NCD policies and programmes at the national level.

High-level Policymakers in Non-Health Ministries

Policymakers in non-health ministries are the secondary target group for this policy brief. Ministries of Health continue to be challenged in achieving meaningful engagement of non-health sectors of government in the realisation of 'Health in All Policies'.

This series of briefs seeks to increase awareness and action among decision-makers outside of the health sector, and likewise can help equip health policymakers with tools to demonstrate how policies across these sectors of government can affect health and ultimately reduce or contribute to the burden of NCDs.

NCD Commissions

HCC has committed to working with National NCD Commissions (NNCDCs) as potentially powerful tools for strengthening national multisectoral responses to NCDs.

The brief can be used as a tool for these NNCCDs to inform non-health, trade sector commissioners around policy options for NCD prevention and control.

INTRODUCTION

50% OF CARICOM
COUNTRIES
IMPORT

+ 80%
OF WHAT THEY CONSUME



Increased trade liberalisation has resulted in dramatic alterations in the supplies of important commodities which directly and indirectly influences the health of nations. Trade policy has had a significant impact on access to essential medicines, the availability, affordability and marketing of tobacco and alcohol products, and the transformation of local diets. Trade liberalization policies have contributed to the “nutrition transition” or rapid changes in food availability and consumption patterns in developing countries that lead to shifts from diets consisting largely of traditional plant-based and home-cooked foods to meat-derived and processed products(2). This ‘nutrition transition’ has been accompanied by an epidemiological transition from infectious diseases to chronic, non-communicable diseases such as obesity, diabetes and cardiovascular disease (2). **In the Caribbean, half of CARICOM countries import more than 80% of what they consume** (3) fueling dramatic changes in diet towards greater **consumption of processed foods** (leading the top five food imports in the region (3)) **contributing to an ‘epidemic’ of obesity and diet-related NCDs.**

If we are to achieve national and global NCD targets, policy and decision-makers across all sectors of government including Ministries of Trade will need to consider policy development through an NCD lens. When non-health ministries such as trade ministries operate in isolation, in the absence of broad consultation and with little consideration for the far-reaching health impacts, the resulting policies have the potential to significantly and negatively influence the health of nations. There is an urgent need for greater policy coherence between Ministries of Trade and Health, in order to align trade policies to health objectives resulting in mutual benefits for both sectors. Specific policy actions can be taken within the trade sector which supports overall population health while achieving trade objectives. These include taxation of unhealthy foods; incentives to encourage the importation, production and consumption of healthier choices; and regulation of marketing of unhealthy foods. Increased health awareness within Ministries of Trade and coordination with Ministries of Health, highlighting trade-related externalities resulting in high costs to the health sector and negatively impacting economic development, may create environments which incentivize increased policy coherence and ultimately improved health and development outcomes.





BACKGROUND

Burden of NCDs Globally and in the Caribbean

The main NCDs are cardiovascular diseases, cancers, chronic respiratory diseases and diabetes. These diseases share a common set of risk factors: exposure to tobacco smoke, harmful use of alcohol, unhealthy diets and physical inactivity. NCDs are currently the leading cause of premature mortality worldwide. The World Health Organisation (WHO) estimates that NCDs kill 39.5 million people globally each year, with over three quarters of these deaths occurring in low to middle income countries (4). In 2012 Member States of the WHO committed to a 25% reduction in premature mortality from NCDs by 2025 through the achievement of 9 global targets as set out in the NCD Global Monitoring Framework (5).



The post -2015 **Sustainable Development Agenda** contains 17 interconnected Sustainable Development Goals (SDGs)(6) including **GOAL 3: 'Ensure healthy lives and promote well-being for all at all ages'**. Within this health goal are targets 3.4; 3.5 and 3.a:

<p>3 GOOD HEALTH AND WELL-BEING</p> 	<p>3.4 NCD MORTALITY</p>  <p>The reduction of premature mortality from NCDs through prevention and treatment by a third by 2030</p>	<p>3.5 SUBSTANCE ABUSE</p>  <p>Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol</p>	<p>3.a FCTC IMPLEMENTATION</p>  <p>Strengthen the implementation of the WHO Framework Convention on Tobacco Control</p>
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<p>2 ZERO HUNGER</p> 	<p>17 PARTNERSHIPS FOR THE GOALS</p> 
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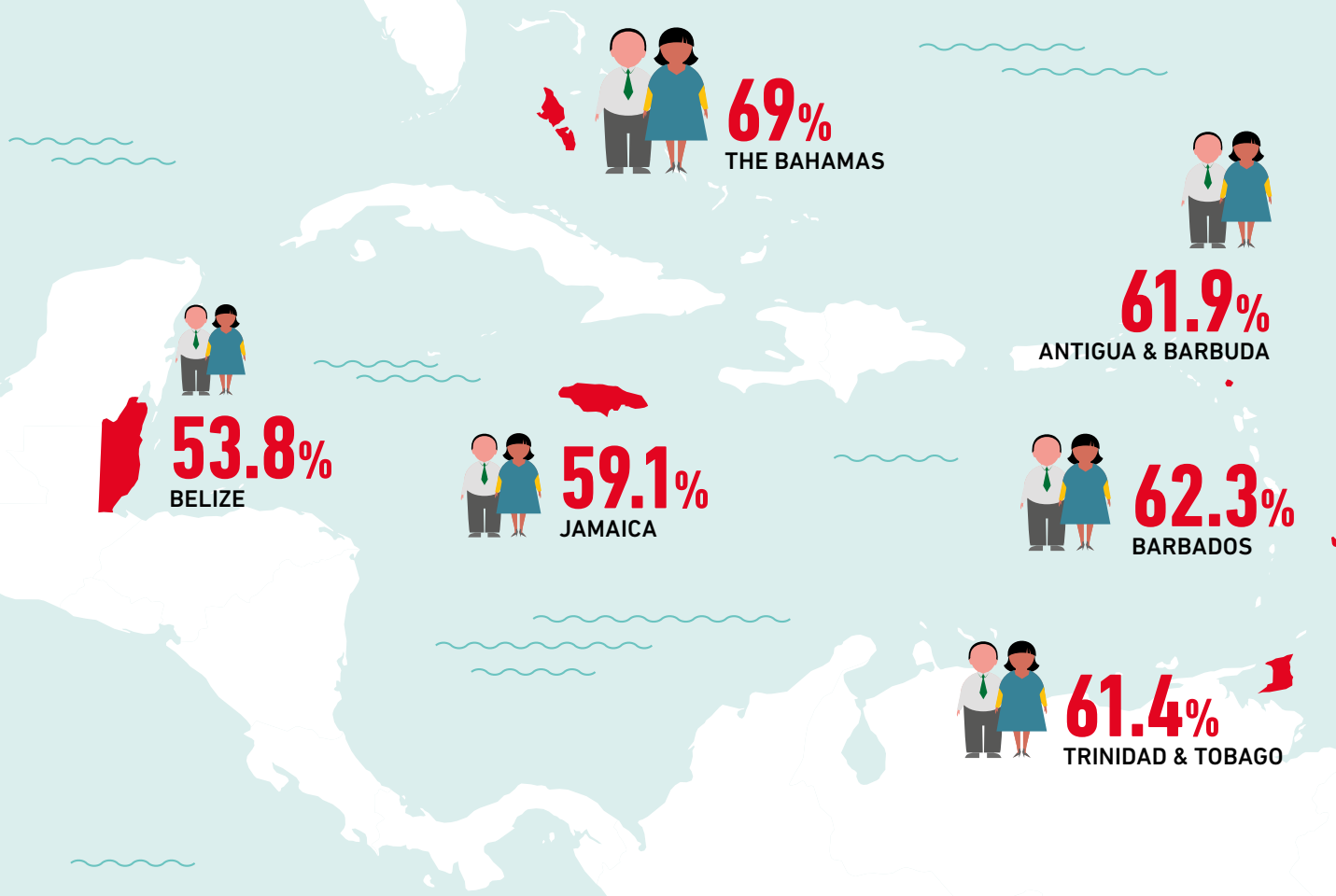
GOAL 2: 'End hunger, achieve food security and improved nutrition and promote sustainable agriculture'; and **GOAL 17:** 'Revitalize the global partnership for sustainable development'; are also important within the context of trade and NCDs.

The **Caribbean region** has not been spared the devastating impacts of NCDs. The region has the highest NCD related mortality in all of the Americas. NCDs account for 62%-80% of all premature deaths (30-70 years) across CARICOM (with the exception of Haiti) (7). The recent 2016 Port of Spain Declaration Evaluation (7) found that heart attacks, stroke and diabetes cause most premature deaths, followed by cancers. Hypertension is the leading risk factor for death and the prevalence of diabetes is twice the global prevalence (7) with rates as high as 15% (8) in some territories. Cancer is the second leading cause of mortality in the region (9). NCD risk factors such as alcohol consumption, physical inactivity, unhealthy diets and obesity are on the rise (7). One-fifth of men across most CARICOM countries reporting binge drinking and 10 to 20% are current tobacco smokers. Despite a pervasive sense of comfort in some quarters that tobacco use is no longer a priority

issue in the region, Caribbean youth aged 13-15 years have the highest prevalence of current tobacco use in the Americas(10). Caribbean adults are among the heaviest in the world with Antigua & Barbuda, The Bahamas, Barbados, Belize, Jamaica and Trinidad & Tobago recording staggering rates of adult overweight/obesity: 61.9%, 69%, 62.3%, 53.8%, 59.1%, and 61.4% respectively(12). Perhaps more worrisome is the emerging challenge of childhood obesity in the region where prevalence rates for overweight and obesity are between 28% and 35% in some Caribbean countries(13). The Global School-based Student Health Surveys(11) found that less than a third of school children meet the recommended levels of physical activity. Evidence shows that childhood obesity tracks into adulthood predisposing individuals to adult obesity, and development of diabetes, cardiovascular diseases and certain cancers(14)(15).

CARIBBEAN ADULTS ARE AMONG THE HEAVIEST IN THE WORLD

Rates of adult overweight/obesity (12)






In 2007 CARICOM Heads of Governments convened a special Heads of Government Summit on Chronic Non-Communicable Diseases, the first of its kind globally – resulting in the seminal *Port of Spain Declaration*¹ containing 15 mandates and 27 commitments and providing the region with a framework for NCD prevention and control. Caribbean leaders were at the forefront of efforts leading to the first United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, 19-20 September, 2011 – hence reaffirming

their resolve to raise the political priority of NCDs. Since 2011, on various occasions thought leaders across the region including heads of government, ministers of health and public health stalwarts, have recognized the potentially profound impact of NCDs on our development, and urged action at all levels. In 2008, former Prime Minister of Barbados, Hon. David Thompson remarked that ‘*If left to chance, all the gains achieved in the Caribbean during the march from poverty to relative affluence since Independence could be wiped out by NCDs*’ (16).

¹ <http://caricom.org/media-center/communications/statements-from-caricom-meetings/declaration-of-port-of-spain-uniting-to-stop-the-epidemic-of-chronic-ncds>

The macroeconomic and human costs of NCDs

SUSTAINABLE DEVELOPMENT GOAL 3

 **Ensure healthy lives and promote well-being for all**

RECOGNISES, INTER ALIA, THE HIGH HUMAN AND ECONOMIC IMPACT OF NCDs

CUMULATIVE ECONOMIC LOSSES from NCDs to low and middle income countries are estimated to surpass

US\$7 TRILLION BY 2025 (17)

From a macro-economic perspective, the majority of CARICOM States are Small Island Developing States (SIDS) with limited natural resources, thus their primary resource is their human capital. Individuals between the ages of 30 to 70 years comprise a high percentage of the populations of the region despite the regional trend of an aging population. High mortality rates among the productive segment of the population as a result of premature death due to

NCDs reduce labour supply and tax revenue. Another macroeconomic impact of NCDs within CARICOM occurs as a result of absenteeism and productivity costs incurred by private sector employers and the State as a result of sick leave due to NCDs.

The 2015 UNDP Investment Case for NCD Prevention and Control in Barbados found that while Bds\$64 million was spent on the treatment of cardiovascular diseases and diabetes, the economy may be losing as much as Bds\$145 million annually due to missed work days, low productivity and reduced workforce participation (18). Claim pay-outs for hospital stays, medications and out-patient visits due to NCDs are also a burden on national insurance systems, which in turn increases public health and social expenditure. The high incidence of NCD-related illnesses also increases operating costs related to treatment as well as prevention and screening. This is vividly illustrated by countries such as Barbados which has a high level of type 2 diabetes related amputations per capita, with some estimates as high as 936 cases per 100,000 (19).

In terms of actual economic costs, in 2001 alone the direct and indirect costs of diabetes and hypertension to Barbados were Bds\$58,265,659 (1.41% of GDP) and Bds\$120,436,828 (2.91% of GDP) respectively; in 2002 these costs were \$23,084,247 (0.43% of GDP) and \$35,281,854 (0.65% of GDP) respectively for Bahamas, and \$182,364,045 (2.33% of GDP) and \$236,942,186 (3.02% of GDP) respectively for Jamaica in 2001 (20). Moreover, hypertensive agents and diabetes

2015 BARBADOS

UNDP Investment Case for NCD Prevention and Control

\$64 MILLION

was spent on the treatment of cardiovascular diseases and diabetes



THE ECONOMY MAY BE LOSING AS MUCH AS

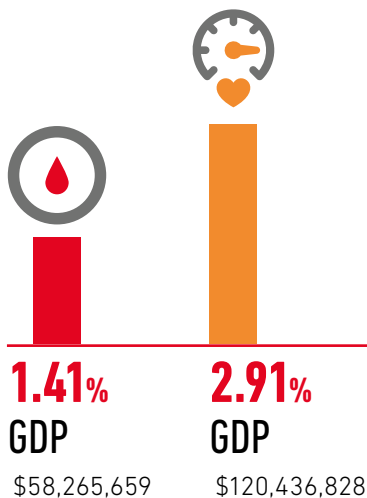
\$145 MILLION

ANNUALLY DUE TO MISSED WORK DAYS

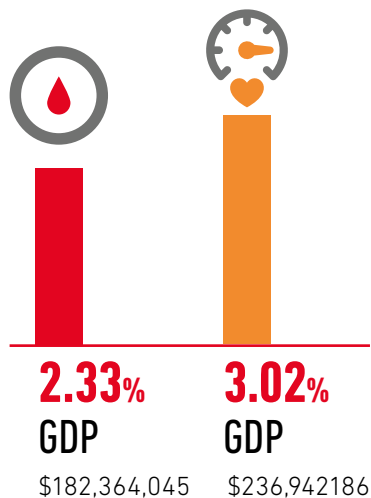


COSTS OF DIABETES AND HYPERTENSION

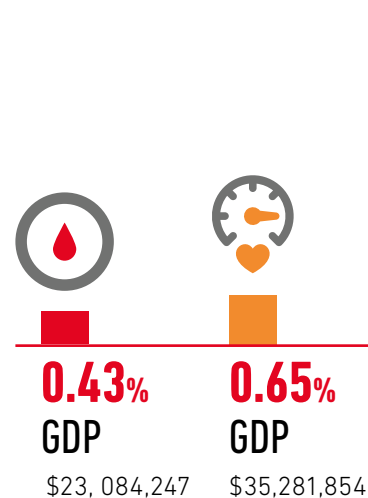
2001
BARBADOS



2001
JAMAICA



2002
BAHAMAS



medications topped the Barbados Drug Service expenditure in the public and private sectors in 2011 and 2012 (21).

Through a PAHO/Harvard collaboration using a tool to simulate the economic consequences of NCDs, the impact of NCDs and mental health (NMH) on GDP in Jamaica was estimated to be \$17.22 billion; or 3.9% in GDP annually over the 15-year period, 2015 to 2030 (22). The projected impact of NMH on GDP is equivalent to 18.5 times the level of health expenditure in Jamaica or 106% of Jamaica's 2013 GDP over this period.

IMPACT of NCDs and MENTAL HEALTH (NMH) on GDP in JAMAICA



Finally, from a human perspective, the decreased household income coupled with increased costs associated with the loss of breadwinners in households due to premature deaths or disabilities from NCDs increases the financial burden on households. This also has implications for poverty reduction, which is the aim of Sustainable Development Goal 1. Higher household health care expenditure also affects the ability of households to save and accumulate assets.

SUSTAINABLE DEVELOPMENT GOAL 1

NO POVERTY



HIGHER HOUSEHOLD HEALTH CARE EXPENDITURE ALSO AFFECTS THE ABILITY OF HOUSEHOLDS TO SAVE AND ACCUMULATE ASSETS

Health in All Policies (HiAP)

“HiAP is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. As a concept, it reflects the principles of: legitimacy, accountability, transparency and access to information, participation, sustainability, and collaboration across sectors and levels of government” (23).

HiAP is based on recognition of the complex and inter-connected nature of the world’s current health challenges which in turn call for multi-sectoral coordination and collaboration to develop co-benefit solutions. Essentially HiAP calls for health considerations to be integrated across all sectors and government agencies. The concept of HiAP is not new and has its roots in the 1978 Alma Ata Declaration on Primary Health Care, the 1986 Ottawa Charter for Health Promotion and the 1988 Adelaide Statement on HiAP, ultimately culminating in its global recognition in the 2010 WHO Adelaide Statement on HiAP (24). The 2030 Agenda recognizes the importance of trade as a cross cutting means for development and further calls on countries to enhance policy coherence across all sectors for sustainable development (target 17.14). The integrated nature of the 2030 Agenda reminds us of the relevance of the HiAP approach for tackling our most pressing development challenges.

In September 2014 PAHO Member States adopted the Regional Plan of Action on Health in All Policies (25). The purpose of this HiAP Plan of Action is to provide concrete guidance on implementation of the HiAP approach within the Americas. The HiAP Plan of Action is aligned with the WHO 2014 Health in All Policies Framework for Country Action.

There are several examples of HiAP in action in the Americas (26) including: the Green and Healthy Environments Program (PAVS) initiative launched by the municipal government of the city of São Paulo, Brazil, in order to address environmental issues within the context of health promotion activities; and the Ecuadorian National Plan for Good Living which is an effort to coordinate various sectoral agendas and devise policies, strategies, programs, and projects with the overall aim of promoting sustainable development and ‘good living’. In May 2015, PAHO/WHO hosted the first Caribbean sub regional HiAP training in Paramaribo, Suriname (27). One of the key outcomes was the formation of a national multistakeholder group consisting of technical experts and senior staff from 17 government ministries who worked together for a year to formulate 12 intersectoral health policies for implementation in 2017/18. The policies span 7 key areas including: education; spatial planning and development; the built environment; integrated approach at community and household levels; consumables; training and employment of staff; health systems governance and management. There is also a Monitoring Strategy Steering Group (chaired by a staff member from the Cabinet of the Vice President) to oversee implementation and serve as an accountability and evaluation mechanism.



NCDs and TRADE POLICY

Why is the NCD epidemic a trade issue?



Trade policy comprises the rules and regulations governments put in place to govern transactions across borders (28). International trade treaties in turn are principally designed to foster lower prices, greater competition, more vigorous marketing and greater economic efficiency, leading - according to standard economic theory - to increased production and consumption.

Trade policies can be coherent or incoherent with health goals. Implementation of trade liberalisation policies influences the levels of import and exports, foreign investments, services and government revenue. These policies in turn influence the availability of products and their prices, employment and the national infrastructure that constitute the environment within which decisions are made which

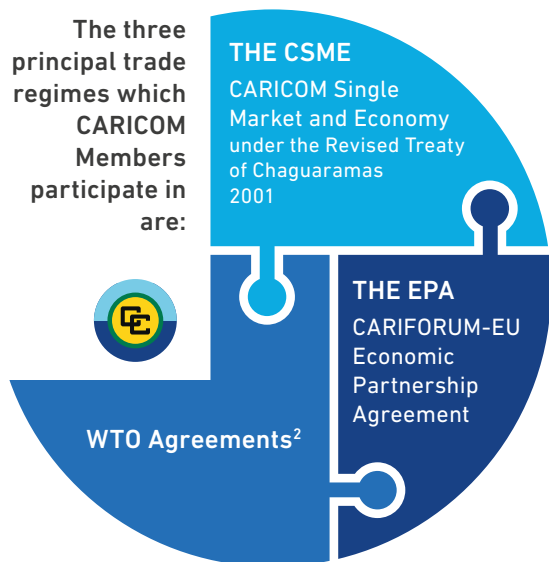
determine to a certain extent, our individual and collective NCD risk, morbidity and mortality. For example, lower taxes on imported sugar sweetened beverages, cigarettes, alcohol and other unhealthy goods, are likely to reduce their cost to consumers which can lead to increased consumption, thereby increasing the NCD burden, and the converse is equally true.

The linkage between trade and health generally first came to the fore internationally with the establishment of the World Trade Organisation ('WTO') in 1995, together with the globalisation of health services. Since then states have increasingly come to recognise that the two seemingly separate spheres of health and trade are in fact very much inter-connected.



Trade Policy in CARICOM

The key question to be considered in examining the link between trade and NCDs in the Caribbean, is the extent to which multilateral, regional and bilateral trade rules constrain CARICOM governments' ability to take effective action on NCDs.



The three principal trade regimes which CARICOM Members participate in are: the CARICOM Single Market and Economy (the CSME) under the Revised Treaty of Chaguaramas 2001; the CARIFORUM-EU Economic Partnership Agreement ('the EPA'); and the WTO Agreements.² As trade agreements, all three arrangements embody the basic trade principle of non-discrimination (expressed in the form of Most Favoured Nation and national treatment obligations) and the prohibition on quantitative restrictions. **Importantly, however, these agreements also contain general exceptions clauses which allow for ostensibly trade-inconsistent action for public health reasons, albeit subject to some restrictions.**³ Similarly the Technical Barriers to Trade ('TBT Agreement') also allows some limited policy space to address public health concerns through labelling schemes.⁴ Accordingly, the principal considerations which policy makers should bear in mind when using trade measures to achieve public

health objectives, including in responding to the NCD epidemic, is that these measures should be formulated and applied in a non-discriminatory manner in order to avoid interpretation as a restriction on international trade.

The WTO plain packaging litigation, discussed later, also raised the issue of the compatibility of plain packaging and related restrictions with the provisions of the WTO Agreement on Trade Related Aspects of Intellectual Property ('TRIPS Agreement').

The important interlinkages between health and trade and in particular its potential impact on NCDs prevention and control, make a clear and compelling case for the HiAP approach in this area. As discussed previously, such an approach would allow for the cross-sectoral (and inclusive) dialogue that is critical if CARICOM states are to devise feasible and effective responses to this epidemic. A first step could be the establishment of a broad-based regional working group on this issue mirroring the approach taken by Thailand when drafting its intellectual property legislation (23).



² CARICOM also has the following other bilateral trade agreements: CARICOM-Dominican Republic Free Trade Agreement (1998) and CARICOM-Costa Rica (2004), and the following partial scope agreements: CARICOM-Venezuela Trade and Investment Agreement (1992), CARICOM-Colombia Trade and Technical Assistance Agreement (1998) and CARICOM-Cuba Trade and Economic Cooperation Agreement (2000)

³ See, for example, GATT 1994 Article XX(b) and relevant case law.

⁴ See Article 2.2, TBT Agreement and relevant case law.



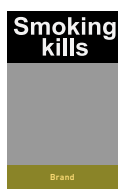
Tobacco Control and Trade Policy

The nature of the potential conflict between trade and health was brilliantly demonstrated in the late 1990's when pharmaceutical companies challenged the consistency of South Africa's HIV anti-retroviral drug programme with their intellectual property rights under the TRIPS Agreement. More recently, in a NCDs specific context, there have been a number of high profile international legal challenges brought in respect of Australia and Uruguay's tobacco control programmes. The WHO Framework Convention for Tobacco Control (FCTC) is a global public health treaty which entered into force in 2005 and essentially set out specific steps for member states to address tobacco through a series of articles. The FCTC has provided the foundation upon which governments have taken action to reverse tobacco use in the interest of public health. The tobacco industry has responded vehemently as member states seek to fulfil their commitments as FCTC signatories within an environment of pro-industry global trade policy. This has led to a growing tension between health and industry as seen in the international cases with Phillip Morris and Australia and Uruguay. These legal challenges all raise the broader question of the policy space that States have to effectively address public health concerns such as NCDs without violating international trade rules. In the case of Uruguay, Philip Morris' challenge under a bilateral investment treaty was ultimately unsuccessful and the tribunal's July 2016 decision is widely regarded as a significant public health victory for sovereign states seeking to protect the health of their citizens over commercial interests (29). In the case of Australia, it faced legal challenges within the WTO from Honduras, the Dominican Republic, Cuba and Indonesia on its legislation implementing the Guidelines on plain packaging, developed pursuant to the FCTC.⁵ These countries claimed that Australia's regulations violated the TRIPS Agreement, the General Agreement on Tariffs and Trade 1994 ('GATT 1994') and the WTO Agreement on Technical Barriers to Trade ('TBT Agreement'). While the panel report on this dispute has not yet been made public, press reports on the interim report that was shared with the parties indicate that the panel has ruled in Australia's favour, yet another significant win for public health advocates. Finally, in October 2016, Singapore and Australia reached agreement on amendment of their

existing Free Trade Agreement ('FTA') to include a 'tobacco carve-out' (30). This tobacco carve-out insulates tobacco control measures from legal challenge by investors under the FTA. This is another clear victory for tobacco control advocates and an important example of consistency in policy-making at the national and international levels by Australia, one of the global leaders on tobacco control. These examples all clearly demonstrate that it is possible for trade policy to be developed and implemented in a manner supportive of public health policies and concerns such as NCDs.

All Caribbean countries with the exception of Haiti are signatories to the FCTC yet only five member states have implemented at least one of the articles of the FCTC. Within the context of trade policy: only 3 countries have implemented graphic health warnings; although cigarettes are taxed at greater than 50% of their cost in 4 countries - none of them have reached 75% of the cost (St. Lucia has the highest rate of cigarette tax in the region at 62.9%); and less than one third have banned tobacco advertising, promotion and sponsorship.

WITHIN THE CONTEXT OF TRADE POLICY



Only
3 COUNTRIES
HAVE IMPLEMENTED GRAPHIC
HEALTH WARNINGS

4 COUNTRIES
CIGARETTES
ARE TAXED at
GREATER than
50% ↑
TAX



NONE
OF THEM HAVE
REACHED
75% ⊗
of the cost

St. Lucia has the highest rate of cigarette tax in the region at 62.9%

⁵ WT/DS/435, WT/DS/441, WT/DS/458, WT/DS/467.



Alcohol and Trade Policy

The WHO Global Strategy to reduce the harmful use of alcohol (31) recognizes the potentially negative influence of trade agreements on Member States' ability to control alcohol related harm and commits the WHO Secretariat support to Member States by: *advocating appropriate consideration by parties in international, regional and bilateral trade negotiations to the need and the ability of national and subnational governments to regulate alcohol distribution, sales and marketing, and thus to manage alcohol-related health and social costs; and responding to Member States' requests for support of their efforts to build the capacity to understand the implications of international trade and trade agreements for health.* The Global Strategy also urges Member States to exploit the flexibilities in trade agreements which allow for governments to 'take measures to protect human health'.

In some settings, taxation of domestic and imported alcoholic products (adjusted for inflation) can serve not only as a revenue generator but also as a public health measure to deter consumption of higher content products. Jamaica has a Special Consumption tax (SCT), which is an indirect excise tax, levied on all alcoholic beverages based on alcoholic content. Since March 13, 2017, Jamaica's Specific SCT on all alcoholic

beverages is \$1,230 per litre of pure alcohol (L.P.A.) (up from the previous rate of \$1,120 per L.P.A.) (32).

Although excise duties are widely used throughout CARICOM to tax alcoholic beverages, imposing high levels of duties on alcoholic beverages originating from outside of CARICOM is also a useful tool to regulate the demand for alcohol. A significant amount of the alcohol consumed in CARICOM Member States, apart from rum which is the main form of alcohol produced in CARICOM, is sourced from outside of CARICOM and is therefore liable to the imposition of import duties. The rates of duty levied by CARICOM Member States range from 20% ad valorem in Antigua and Barbuda to 100% in Guyana. Guyana imposes the maximum rate of duty permissible under Schedule II of its WTO Schedule of Tariff Concessions. Other Member States of CARICOM therefore have the policy space to increase the duty on imported alcohol beyond current levels to their WTO bound rates. Given the relatively high volume of imports and consumption of non-originating alcoholic beverages in the region, the use of import duties to influence the price and levels of consumption of alcohol can complement the extensive use of excise duties to influence alcohol consumption levels.





(Un)healthy Diets and Trade Policy

The 2014 Rome Declaration emerging from the Second International Conference on Nutrition (ICN2) calls for trade policies to be supportive of fostering food and nutrition security for all.

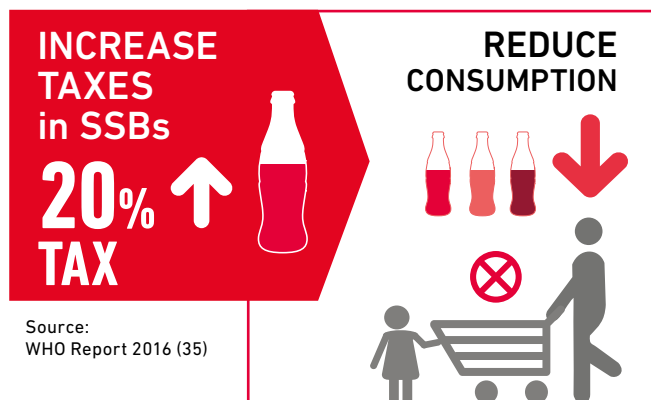


The accompanying ICN2 Framework for Action (33) recommends that countries identify opportunities to support achievement of global food and nutrition targets through trade and investment policies (28). In April 2016 the United Nations Decade for Action on Nutrition was launched to catalyse member state action across six pillars based on the commitments of the Rome Declaration and the ICN2 Framework for Action (34).

Trade and investment for improved nutrition was among the six pillars highlighting the importance of trade policy to combat all forms of malnutrition. The Caribbean and other SIDS have experienced tremendous trade liberalization which has influenced the food systems in many countries towards increased availability, affordability and accessibility of ultra-processed food and greater consumption of foods high in fat, sugars and salt, thus contributing to an obesity epidemic of alarming proportions (28). Excessive calorie consumption in CARICOM (with the exception of Haiti) exceeds the recommended

maximums and is related to the exorbitant regional importation of relatively cheap, processed foods (3) and ubiquitous marketing of these products including to children. The resulting food environment is one of increased supply, relative affordability and increased consumption of (unhealthy) imported products and decreased demand for healthy domestic options (3).

Across the globe, in an effort to shift towards healthier more sustainable food environments, various measures have been explored such as policies which increase taxes on unhealthy ultra-processed foods or impose restrictions on the imports of such foods. These policies are aimed at limiting the availability of energy dense nutrient poor (EDNP) foods in the local market due to an increase in price to the consumer; ultimately leading to a reduction in their accessibility and consumption by the general public, low-income individuals and other vulnerable groups. Conversely, some countries have considered policies which lower taxes on healthy foods to incentivise more nutritious, diverse, safe and healthy diets.



The WHO 2016 Report on Fiscal Policies for Diet and Prevention of Noncommunicable Diseases (35) concluded that there is sound evidence that proportionate reductions in consumption of sugar sweetened beverages (SSBs) can be achieved by taxation aimed at raising the retail price of sugary drinks by 20% or more. Similarly increases in consumption of fruits and vegetables can be observed by providing subsidies for fresh fruits and vegetables that reduce prices by 10%-30%. A 2017 modelling study predicted taxes and subsidies on foods and beverages can be combined to achieve significant improvements in overall population health and cost-savings to the health sector; with the sugar tax yielding the greatest overall cumulative health benefits (36). Taxes on sugar sweetened beverages have been implemented at various rates in many countries including Mexico, and Barbados and Dominica (37) in the Caribbean.

Mandatory requirements for labelling and packaging can also be used to empower consumer choice away from consumption of unhealthy products. The CARICOM Regional Organisation for Standards and Quality (CROSQ) is responsible for setting regional standards for the labelling of pre-packaged foods. These standards can then be adopted by CARICOM member states and can be included in legislation that would require food manufacturers and importers to adhere to the standards. The CARICOM standards are based on international standards developed by the Codex Alimentarius.

From a global perspective, developed countries' heavy subsidisation of their agricultural sectors makes it challenging for local agricultural products (often healthier options) to compete. This is compounded by the fact that, although the WTO Agreement on

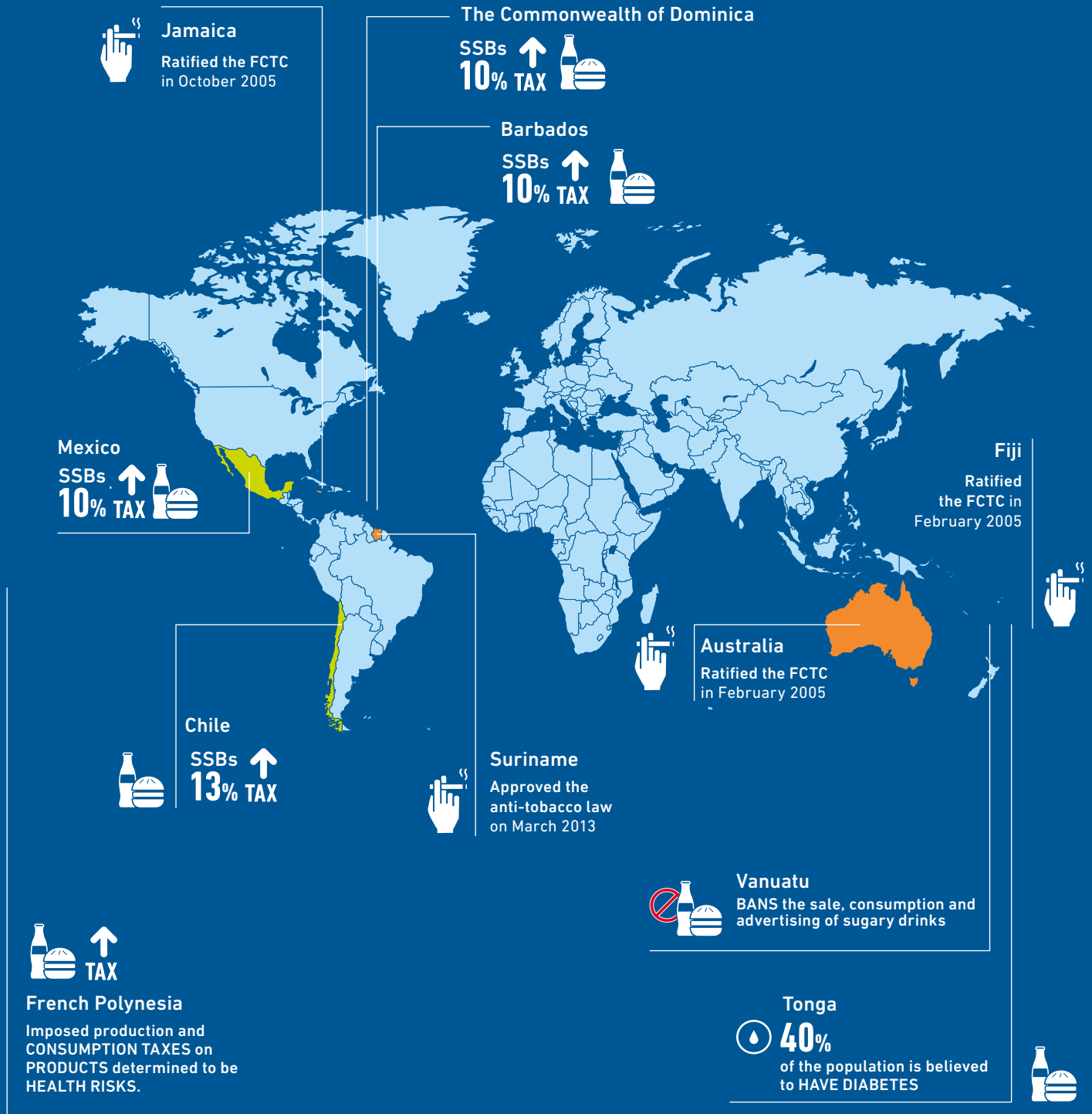
Agriculture does provide some limited room for provision of subsidies to their agricultural sector to promote production of local, healthier food options, most developing countries, including those in CARICOM, do not have the financial resources to take advantage of this flexibility (38).⁶



⁶ The principal rules in this area are found under the WTO Agreement on Agriculture and the WTO Agreement on Subsidies and Countervailing Measures.

Country Examples of NCDs and Trade

The examples below seek to highlight good practices regionally and internationally that demonstrate positive consideration of trade policy impact on the NCD epidemic. Care has been taken to select countries that both reflect the most ambitious efforts to date as well as approaches which are both reasonable and feasible within a CARICOM context.





Tobacco Control

Jamaica

Jamaica ratified the FCTC in October 2005 and has received praise from PAHO and WHO on its tobacco control regulations. Jamaica has banned smoking in enclosed public places, indoor and outdoor workplaces and public transportation. The Public Health (Tobacco Control) Regulations 2013⁷, updated and amended in July 2014⁸, establishes smoke-free spaces. The legislation also requires all tobacco products to have 60 percent of the principal display surface of both sides permanently affixed with health advisories warning users about the health risks associated with tobacco and tobacco product use. Vendors who sell these products without health warnings or disguise them are guilty of an offence. The regulation also prohibits the use of terms such as “low tar”, “light” and other terms which seek to minimise or dispel the health risk associated with smoking. Also included in the regulation, is a requirement for tobacco companies to disclose product contents.

In Jamaica, there is a Special Consumption tax (SCT) on tobacco products which as of 2014 translated to an approximate tax of 42.9% (10). Twenty percent of the tax from the SCT is earmarked for the National Health Fund. In Jamaica, the National Health Fund revenues are derived from tobacco and payroll taxes and are used to finance health education and promotion, health infrastructure improvements and to ensure affordable access to medicines for people suffering from NCDs (39). The NHF provides medicines for a range of chronic lifestyle diseases for close to 500,000



**NO
SMOKING**

VIOLATORS ARE SUBJECT TO PROSECUTION
The Public Health (Tobacco Control) Regulations, 2013

Jamaicans. Although Jamaica does not have one consolidated Act, addressing advertising, promotion or sponsorship of tobacco or tobacco products, the Broadcasting and Radio Re-Diffusion Act and the Television and Sound Broadcasting Regulations, 1996, prohibit any broadcaster licensed in Jamaica from advertising tobacco products on radio and television⁹. Unfortunately advertising in the cinema, electronic media, outdoor venues and billboards are allowed. Jamaica currently has a draft comprehensive tobacco control bill that will cover the articles of the FCTC not included in the current Regulations, including tobacco advertising promotion and sponsorship (TAPS). The new administration (elected in February 2016) committed to prioritise the legislation. Cabinet submission for this draft bill is out for comment to key stakeholders and should be submitted to Cabinet by the end of 2017.

Special Consumption
TAX on TOBACCO PRODUCTS

SCT
42.9% ↑

The TAXES and are used to FINANCE HEALTH in



EDUCATION



INFRASTRUCTURE



ACCESS TO MEDICINES

⁷ [http://www.japarliament.gov.jm/attachments/412_The%20Public%20Health%20\(Tobacco%20Control\)%20Regulations,%202013.pdf](http://www.japarliament.gov.jm/attachments/412_The%20Public%20Health%20(Tobacco%20Control)%20Regulations,%202013.pdf)

⁸ [http://www.japarliament.gov.jm/attachments/412_The%20Public%20Health%20\(Tobacco%20Control\)\(Amendment\)%20Regulations,%202014.pdf](http://www.japarliament.gov.jm/attachments/412_The%20Public%20Health%20(Tobacco%20Control)(Amendment)%20Regulations,%202014.pdf)

⁹ <http://jis.gov.jm/satisfying-outcome-tobacco-regulations/>

Fiji

Fiji ratified the FCTC in February 2005. Fiji's Tobacco Control Regulations 2012 set out comprehensive regulations for tobacco labelling for retail containers containing cigarettes, loose or pipe tobacco or cigars and other tobacco products.¹⁰ For a flip top pack of cigarettes for example, a health warning which includes the text "Fiji Government Health Warning" in English is required to be displayed on 30 percent on the front while the health warning in the iTaukei and Hindi language is to cover 90% of the back face of the package. The Fiji Government Health warning text is to be printed below the rest of the warning message typed in font size not greater than 40% of that used for the remainder of the message. The legislation also prescribes several areas as smoke-free areas and requires owners of specified types of business to prominently display no smoking signs on the premises. As of November 18, 2015, the Fiji Department of Health Tobacco Control Enforcement Unit had fined 405 people for breaching the Tobacco Control Decree.¹¹

Australia

The Commonwealth of Australia is a world leader in tobacco control laws. It ratified the FCTC on February 2005. In December 2012 Australia became the first country to require plain packaging of tobacco products retailing in Australia through the Tobacco Plain Packaging Act, the Tobacco Plain Packaging Regulations 2011 (amended) and the Trade Marks Amendment (Tobacco Plain Packaging) Act 2011. Many Australian states have banned tobacco product advertising and some have banned all forms of tobacco sponsorship. Each State has its own legislation dealing with smoke free environments. In the state of New South Wales the Smoke-Free Environment Act, 2000 and its subsequent amendments and regulations prohibit smoking in most public areas and workplaces, while the Public Health (Tobacco) Act New South Wales makes it an offence to smoke in cars carrying children under 16 years of age. Tasmania, which has some of the most stringent anti-tobacco laws in the Commonwealth of Australia, goes further. The 2006 amendment to its Public Health Act 1997 bans smoking in all enclosed public spaces and workplaces and is one of the only Australian states which imposes a ban on all enclosed areas of casinos.

¹⁰ <http://www.tobaccolabels.ca/wp/wp-content/uploads/2013/12/Fiji-2012-Tobacco-Control-Regulations.pdf>

¹¹ <http://www.fijitimes.com/story.aspx?id=330223>



Suriname

Suriname utilised the HiAP approach in the negotiating process leading up to enactment of its tobacco legislation pursuant to the WHO Framework Convention on Tobacco Control ('FCTC'). This initiative was led by the Ministry of Health which brought together the three branches of government as well as a variety of other stakeholders such as the Ministries of Justice, Environment, Labour and Trade Industry, the national Law School, youth organisations, transportation organisations to develop the anti-tobacco legislation. The advocacy involved all social sectors, public education and the establishment of an inter-sectoral Tobacco Commission. The anti-tobacco bill was passed unanimously by the National Assembly and signed into law on March 6, 2013.



(Un)healthy Diets

Barbados

In July 2015 the Government of Barbados (GoB) imposed a 10 percent excise tax applied to the cost of locally produced and imported sweetened beverages effective August 1, 2015 with the aim of changing high sugar consumption patterns. The tax is levied on the value of the product before Value Added Tax is applied (40). The tax includes beverages such as juices, sports drinks and carbonated beverages. However, beverages that contain intrinsic sugars such as 100% natural fruit juice, coconut water and milk, are exempted from the tax. The measure is intended to raise revenue and dampen demand for and consumption of sugar sweetened non-alcoholic drinks. The Minister of Finance estimated the tax would raise \$10 million in revenue for fiscal year 2015-2016 (41) however data on actual revenue to date was unavailable. The government committed to review the Act two years post implementation in 2017 to determine whether it should be extended or amended. There is no data on the impact of the tax on pricing and consumption, however an evaluation led by the University of the West Indies and collaborators is currently underway and approaching completion. Given the recent recommendation by the WHO to implement SSB taxes of no less than 20% (35), the GoB is exploring a possible increase in the tax from 10% to 20%. The HCC 2015 publication: *'A closer look. The Implementation of Taxation on Sugar-Sweetened Beverages by the Government of Barbados: A civil society perspective'* assessed the implementation of the Barbados Tax from the perspective of civil society and found that stakeholder consultation was inadequate and noted that community engagement prior to the implementation of the Barbados policy would have been instrumental in sensitizing the public about the policy and allaying fears and addressing concerns, objections and misinformation raised by opponents of the tax including the beverage industry (40).



Chile

In Chile, five of every 10 children are overweight and one of every 11 deaths is linked to obesity (42). In response to these staggering numbers, Chile is now leading the way in policy action on unhealthy diets. In January 2015 Chile applied an 18% ad valorem tax to sugary drinks with sugar content greater than 6.25 g of sugar per 100 mL (37). Prior to this, in October 2014, a 13% ad valorem tax was applied to these sugary drinks. Sugary drinks include all non-alcoholic drinks with added sweeteners including energy drinks and waters. Sugary drinks with less than 6.25 g of sugar per 100 mL are taxed at 10%. In addition to taxation, in 2016 Chile introduced the Law of Food Labelling and Advertising (Law 20.606), commonly known as the “Super 8 Law” (43). This is the strictest labelling law in the world which closely follows a series of recommendation by the WHO regarding the quantity of key substances such as sugars, fats and salts (42). The legislation requires front of pack labels to be placed on all foods high in sugar, calories, sodium or saturated fat. Every 100 grams of solid food cannot exceed 275 calories, 400 milligrams of salt, 10 grams of sugar and 4 grams of saturated fats. Any food or drink product which exceeds these limits must have a black warning label with large letters stating for example “High in sugars”. The law also bans the sale of any of those products in schools as well as advertisements for them that target children under age 14. The sale of these products with toys is also prohibited. As expected the law has received fierce opposition from the food and beverage industry however it has been applauded regionally and globally by those lobbying for stronger structural interventions aimed at create healthier food environments.

The Commonwealth of Dominica

On the 1 September 2015, the Commonwealth of Dominica imposed a 10% excise tax on food and drinks with high sugar content including sweets, candy, chocolate bars, soft drinks and other sweetened drinks (including energy drinks) (37). The government stated that revenues from the tax would contribute to a national “Get Healthy” campaign (44). Prior to implementation of the tax, one community consultation was held with various stakeholders including civil society. At the time of the publication of this brief the tax had not been evaluated.

French Polynesia

In response to the growing concern about NCDs, French Polynesia imposed production and consumption taxes on products determined to be health risks.¹² The revenue raised from these taxes finances a special preventative health fund administered by the Etablissement Publique Administratif pour la Prevention (ETAP).¹³ The consumption tax was introduced by Article 27 of Deliberation n°2001-208 APF of December 11, 2001 and is imposed on alcoholic drinks, sweetened drinks, confectionaries and ice cream. The revenues raised by the taxes are used to finance health interventions and a wide range of activities undertaken by the Fund including youth activities, education and road safety. As a result of the tax initiatives outlined, SSBs are now reported to be more expensive than bottled water in French Polynesia.



¹² <http://www.contributions.gov.pf/spip.php?rubrique68> (French text)

¹³ http://www.ccomptes.fr/content/download/8198/123080/version/1/file/JF00111467_JF_INTERNET1.pdf

Mexico

Mexico, which has the second highest adult obesity population among OECD countries (45), imposed taxes on sweetened beverages and high calorie foods on the 1st January 2014 (37). One of the measures is a tax of MX\$1 (US\$0.80) per litre of sweetened beverages resulting in a 10% increase in the cost of SSBs. The law defines sweetened beverages as those with added sugars but exempts milk and yoghurt. The legislation enforcing the tax requires that the revenue from the tax be used to finance programmes on nutrition, obesity and chronic diseases arising from obesity.

The second measure is a high calorie food tax. This is a tax of 8% on the cost of foods containing 275 calories or more for each 100 grams and includes chocolates and cocoa-based products, potato chips, among others. Two years post implementation of the tax, researchers found purchases of taxed beverages decreased 5.5 % in 2014 and 9.7 % in 2015, yielding an average reduction of 7.6 % over the study period (46). Moreover, households at the lowest socioeconomic level had the largest decreases in purchases of taxed beverages in both years directly refuting beverage industry arguments that SSB taxation is regressive. In 2014 sales of non-taxed beverages, such as bottled water, increased by 4% (47). The passage of SSB tax in Mexico was a result of strategic and targeted advocacy focused on increasing awareness around the issues of obesity and creating a sense of urgency among the public and policymakers (48). Civil society was a major actor in this effort working with key partners to implement highly emotive and effective national advocacy campaigns (48).

Tonga

In addition to a soft drink tax, introduced in Tonga in 2013, the nation has implemented an import duty of 15% on turkey tails, lamb flaps and lamb breasts and reduced import duties from 20% to 5% for imported fresh, tinned or frozen fish (37) (49). Turkey tails and lamb flaps are the fat-saturated offcuts of meat which the South Pacific islands have been importing since the 19th and 20th centuries. Tonga has some of the highest rates of obesity in the world (12) and up to 40% of the population is believed to have diabetes (50). The combined measures are designed promote healthier diets by discouraging consumption of energy dense nutrient poor foods while increasing the affordability and consumption of healthy foods.

Vanuatu

This small nation state in the South Pacific, consisting of 13 inhabited islands, has banned imported foods at all government facilitates and tourism establishments in an effort to deal with an exploding obesity epidemic and unacceptably high diabetes rates, largely attributable to excessive consumption of imported junk food (51) (52). The measure is also expected to promote increased consumption of indigenous produce by supporting the local agricultural industry. This step supports Vanuatu’s Sweet Drink Policy, introduced in public institutions – particularly in schools (37). The policy implemented in October 2014 is part of the Vanuatu Health Promoting School Program and bans the sale, consumption and advertising of sugary drinks and promotes water, plain milk and fresh coconut water.

MEXICO

has one of the **HIGHEST OCCURRENCES** of **CHILD OBESITY AND OVERWEIGHT** WORLDWIDE



Imposed taxes on sweetened beverages and high calorie foods on the 1st January 2014

SSBs TAX 10%

HIGH CALORIE FOODS 8% TAX

Civil Society Advocacy Priorities: Recommended Trade Policies to enhance NCDs prevention and control

Civil society organisations in the Caribbean have a growing appreciation for the social and commercial determinants of health – those non-health and industry-based drivers which directly and indirectly influence the risk factors and the incidence and prevalence of chronic disease. The intersection between trade policy and the burden of NCDs is a critical area which requires greater understanding and focussed advocacy efforts. Globalisation, the resulting fluidity of borders and the plethora of complex trade agreements governing the movement of products and services in sovereign nations, has resulted in local environments which are wreaking havoc on the health of nations. As governments struggle to balance economic productivity and protecting the health of their citizens within the context of regional and global trade agreements, the rising economic costs associated with NCDs has intensified the need for urgent action. In this regard, it is worth noting that at the 37TH Meeting of CARICOM Heads of Government held July 4 – 6, 2016, CARICOM Heads committed to address, inter alia, the banning of smoking in public places, trade-related measures, banning advertising of unhealthy foods which target children, raising the levels of tax on foods high in salt, sugar and trans-fats.¹⁴ Against this background and in the context of the growing body of national, regional and international NCD related recommendations and action frameworks which recognise trade as a key driver; civil society has a responsibility to advocate for trade policies that create environments which support declines in exposure to all NCD risk factors and ultimately reductions in NCD morbidity and mortality.

The HCC therefore recommends a focussing of Caribbean civil society advocacy efforts in support of the following recommended trade policies which have the potential to positively influence prevention and control of NCDs within CARICOM. Many of the recommended policy actions are also found in the updated Appendix 3¹⁵ of the WHO Global Action Plan on NCDs.

¹⁴ Communiqué issued at the conclusion of The Thirty-Seventh Regular Meeting of the Conference of Heads of Government of the Caribbean Community (CARICOM), 4-6 July 2016, Georgetown Guyana. Available at: <http://caricom.org/media-center/communications/communiques/communique-issued-at-the-conclusion-of-the-thirty-seventh-regular-meeting-of-the-conference-of-heads-of-government-of-the-caribbean-community-caricom-4-6-july-2016-georgetown-guyana>

¹⁵ Appendix 3 consists of a menu of policy options ('best buys') to support the implementation of the 6 objectives of the Global NCD Action Plan. An updated Appendix 3 was endorsed at the 70th WHA to take into consideration the emergence of new evidence of cost-effectiveness, new WHO recommendations since the adoption of the WHO Global NCD Action Plan 2013-2020, and to refine the existing formulation of some interventions based on lessons learnt from the use of the first version (53).

POLICY RECOMMENDATIONS

ALCOHOL

INCREASE
EXCISE
TAXES ON
ALCOHOL¹⁶

RESTRICTIONS on the
MARKETING and SALE OF
ALCOHOLIC BEVERAGES
with a particular emphasis
on children¹⁷

IMPOSE/INCREASE
TAXES ON SUGAR
SWEETENED
BEVERAGES OF AT
LEAST 20% (35)²¹

(UN)HEALTHY DIETS

RESTRICT the MARKETING
and SALE OF UNHEALTHY
FOODS with a particular
emphasis on children.²⁵

IMPOSE
HIGHER
TARIFFS ON
UNHEALTHY
FOODS²²

PROHIBIT
IMPORTATION
OF
UNHEALTHY
FOODS²³

Require mandatory front of
PACK NUTRITION LABELING of
food products and beverages²⁴

Provide SUBSIDIES ON
HEALTHY FOODS, in particular
fruit and vegetables (35).

Use the flexibilities under Article 6.2
and the de minimis provisions of the
Agreement on Agriculture to benefit
domestic PRODUCTION OF HEALTHY
FOODS OR TO GENERATE INCOME WHICH
PROVIDE ACCESS TO THESE FOODS.

TOBACCO



PROHIBITION OF SALE OF TOBACCO PRODUCTS TO MINORS (Article 16 FCTC)

INCREASE EXCISE TAXES ON TOBACCO (Article 6 FCTC)¹⁸



Smoking kills

Graphic health warnings used in conjunction with plain packaging

Brand

Adopt PLAIN PACKAGING using CARICOM regional standards (source) (Article 11 FCTC)²⁰

Removal of DUTY FREE CONCESSIONS on tobacco products (Article 6 FCTC)



PROHIBITION ON IMPORTATION of tobacco products (Article 8 FCTC)¹⁹

CROSS CUTTING

Advocate for Ministry of Trade representation (at the highest levels) on national NCD coordinating mechanisms such as National NCD Commissions or their equivalents.

Advocate for the establishment of inter-ministerial committees which facilitate greater dialogue and learning between Ministries of Trade and Ministries of Health as well as other related ministries such as agriculture.

Advocate for policy coherence across relevant ministries such that health and trade related policies are complimentary and reinforcing rather than conflicting. This would include dialogue between health representatives and overseas Missions to ensure that health perspectives are fed into relevant meetings and negotiations in fora such as WTO and Codex Alimentarius.

¹⁶ This would have to be done in a WTO-consistent non-discriminatory manner (essentially, the excise taxes should apply equally to domestic and imported alcoholic products).

¹⁷ Such restrictions would have to comply with the principle of non-discrimination or be able to satisfy the requirements of the public health exception under Article XX(b) GATT 1994.

¹⁸ This would have to be done in a WTO-consistent non-discriminatory manner (essentially, the excise taxes should apply equally to domestic and imported tobacco products).

¹⁹ Such measures would have to meet the requirements of the public health exception under Article XX(b) GATT 1994 since generally speaking WTO Members cannot impose quantitative restrictions on imported goods. WHO Recommended minimum taxation rate of 20%.

²⁰ The WTO litigation on this issue will provide guidance on the exact limits of this policy measure.

²¹ This would have to be done in a WTO-consistent non-discriminatory manner (essentially, the excise taxes should apply equally to domestic and imported products).

²² This would have to be done in a WTO-consistent manner either by using the flexibility under Article II GATT 1994 to raise applied rates up to 'bound' levels, through re-classification or by meeting the requirements of the public health exception under Article XX(b) GATT 1994.

²³ Such measures would have to meet the requirements of the public health exception under Article XX(b) GATT 1994 since generally speaking WTO Members cannot impose quantitative restrictions (bans) on imported goods.

²⁴ Such measures would have to meet the requirements of the TBT Agreement and similar provisions in other trade agreements.

²⁵ Such restrictions would have to comply with the principle of non-discrimination or be able to satisfy the requirements of the public health exception under Article XX(b) GATT 1994.

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