

Food, fuel, and health

For several years, lower food prices were thought to lead to excess food consumption, and that low prices for fuel encouraged more motorised transport and automated labour, reducing physical activity. It might follow that a rise in the price of these commodities would bring an era of better diets and more active living. However, we fear a rise in food and fuel prices will worsen the disease burden and exacerbate health inequalities.

In developed economies, rising food prices will widen the gap between those able to maintain a healthy diet of fresh produce, fish, lean meat, etc, and those needing to find the cheapest sources of calories. Cheap calories are found in the most highly processed, long-shelf-life products, containing hardened fats and bulk starches, preserved with sugar or salt.

In developing economies, large urban populations will experience similar pressures to consume the cheapest sources of calories, and with rising transport costs will face difficulties accessing the fresh, perishable foods that provide micronutrients essential to protect from infection and chronic disease. Infant nutrition will also be threatened by a lack of fresh nutritious foods, and the quality of maternal milk will fall if the mother's diet deteriorates. The coexistence of overnutrition and undernutrition within households in transitioning countries is likely to increase.

Food variety and access to it is affected by transport costs, for urban and rural dwellers alike, whether through access to local supplies in street markets or air-freighted salads in supermarkets. Refrigeration will be more expensive. To avoid microbiological contamination, greater emphasis will be put on preserved and packaged foods.

Quite apart from the incentive to grow crops for biofuels, farmers will seek to increase production, maximise crop yields, and perhaps

turn to genetically modified species which, thus far, create dependency on monopolistic corporations for seed supply and the technology for germination and treatment of crops.

Far from turning back the clock, current developments will create novel circumstances. We believe price increases will combine with wealth inequalities, large urban populations, and concentrated ownership of technology to create a greater disease burden than ever before.

We declare that we have no conflict of interest.

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Futures and food prices

In a timely and well documented Comment (May 17, p 1648),¹ Noemi Pace and colleagues argue that increased participation (ie, trade volume and open interest) by speculators in agricultural commodity futures and options markets in the USA is responsible for higher food prices and has therefore indirectly contributed to higher levels of malnutrition in developing countries.

However, the three economics references (two unpublished) they provide in support of their conclusions are not representative of overall research. Rather, researchers have generally found that speculation by large or small traders does not cause sharp changes in prices or volatility and that on the contrary there is much evidence that they provide a useful price discovery role.^{2,3} Moreover, commodity exchanges already have an incentive to increase margin levels, as an insurance mechanism, during periods of high volatility.⁴

Lastly, in its May 15, 2008, communication,⁵ the Commodity Futures Trading Commission, which

is responsible for US commodity derivatives regulation, concluded that "commodity price levels...are being driven by powerful fundamental economic forces and the laws of supply and demand", and notes that "[m]arkets where index trading is greatest as a percentage of total open interest (live cattle and hog futures) have actually suffered from falling prices during the past year".

Although additional monitoring might be warranted, overly stringent futures regulation is unlikely to lead to lower food prices.

I declare that I have no conflict of interest.

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Authors' reply

Gabriel Power highlights three main points about speculation and food prices. First, there is no consensus in the literature about the relation between food commodity derivatives markets and price increase and volatility. However, as well as the work cited in our Comment, there are many other papers that support our hypothesis.^{1,2} The broad range of conclusions provided by the literature seems to depend on the dataset used and the analysis techniques adopted.

The printed journal includes an image merely for illustration

Research by the Organisation for Economic Co-operation and Development³ and testimony presented by Masters to the US Senate⁴ state that the sharp increase in prices might be caused by increasingly large long positions (buying contracts) placed by institutional investors, also called index traders, such as corporate and government pension funds, sovereign wealth funds, and university endowments. Masters⁴ highlights how institutional investors buy futures and then extend their positions by buying calendar spreads. In this way, they consume liquidity and provide zero benefit to the futures markets. Two of his three proposed actions could be implemented—ie, to modify the regulations of pension funds to prohibit commodity index replication strategies and to act to close the swaps loophole.

Second, we agree with Power that commodity exchanges already have an incentive to increase margin levels, as an insurance mechanism, during periods of high volatility. However, even though the effect of margin requirements is controversial, we support the findings of Dutt and Wein,⁵ which suggest that, after adjusting for risk, there is an economically and statistically significant negative effect of margin requirements on trading volume as predicted by theory.

Finally, we agree, of course, that the laws of supply and demand are driving the slow upward trend noticeable since 2000. However, they still fail to explain the recent sharp increase in prices. Moreover, the same Commodity Futures Trading Commission communication cited by Power states that “it is clear that more analysis and research about index trading needs to occur in order to inform this debate and CFTC staff will be studying ways to improve the transparency and efficiency of the markets regarding these types of traders”.

We are aware that more technical studies, involving time series and causality tests, are needed to confirm any relation between the volume of

commodity derivatives trading and food price increases, its magnitude, and, eventually, the causal direction of this relation. However, the case for improved market transparency and regulation is urgent.

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MVP and vinorelbine for malignant pleural mesothelioma

Martin Muers and colleagues (May 17, p 1685)¹ found that addition of chemotherapy, either with MVP (mitomycin, vinblastine, cisplatin) or vinorelbine, to active symptom control had no significant benefit in terms of overall survival in patients with malignant mesothelioma. Their conclusion suggests that vinorelbine merits further investigation. However, this conclusion is misleading, because of potential methodological pitfalls.

First, the trial design was changed from a three-group to a two-group comparison because of a slow accrual. Second, the pathological diagnosis was not systematically reviewed by

a pathologist. Several studies have highlighted the necessity for central pathological review because 30% can have misleading diagnoses.^{2,3} Third, addition of vinorelbine showed a non-significant survival advantage over active symptom control alone (hazard ratio 0.80, 95% CI 0.63–1.02; p=0.08) in an exploratory analysis.

The standard chemotherapy regimen since 2003 has now moved to cisplatin plus pemetrexed. This combination showed a significant benefit in overall survival in a randomised trial when compared with cisplatin alone.⁴ For all these reasons, we believe that pemetrexed-based regimens are to date the best option in this setting. Active symptom control or vinorelbine offer the advantage of immediate tolerability and lower cost, but evidence clearly favours a more aggressive option for these patients.

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Authors' reply

Improving the outcomes of patients with malignant pleural mesothelioma is a major challenge. Mesothelioma is a relatively rare disease, patients tend to be elderly and symptomatic, and, beyond palliation, treatment options are limited: radical surgery is only possible for a small minority