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Export Curbs on Essential Goods in the Wake of COVID-19 and the Least Developed Countries: Permanent Scarring from a Temporary Outburst

Summary

Anything that jeopardises progress towards the Sustainable Development Goals – such as a global pandemic and how governments react to it – is thus a major source of concern, in particular for least developed countries (LDCs).

The first half of 2020 witnessed governments imposing dozens of export curbs on essential medical goods and foods that the LDCs, among other nations, depend upon. Although some of those curbs have subsequently been removed, there is a substantial risk of a permanent reduction in essential goods supplied to LDC markets, as current multilateral trade disciplines on export controls do not specifically require a return to the pre-pandemic status quo.

Let us not forget that the G20 trade and investment ministers declared on 3 November 2020 that "any emergency trade measures designed to tackle COVID-19, including export restrictions on vital medical supplies and equipment and other essential goods and services, if deemed necessary, are targeted, proportionate, transparent, temporary, reflect our interest in protecting the most vulnerable, do not create unnecessary barriers to trade or disruption to global supply chains, and are consistent with WTO rules" (G20, 2020). Evidence on resort to export restrictions suggests, however, that G20 fealty to this pledge was uneven.

The purpose of this Briefing Paper is to outline the key policy developments implicating the trade in essential goods during the first nine months of the COVID-19 pandemic before drawing out the implications for development policy and trade policy cooperation. These lessons need to be taken on board quickly if the mistakes made in 2020 are not to be repeated in 2021, when policymakers and the private sector around the world face the imperative of the equitable and efficient global distribution of COVID-19 vaccines. Recent export controls on such vaccines suggest important lessons from last year have not been taken on board universally.

The key findings and policy recommendations are:

- Permanent disruption to trade routes in medical goods and medicines cannot be ruled out as a result of temporary export curbs.
- Revisit the World Trade Organization (WTO) rules that allow export curbs during emergencies.
- LDCs should increase their buying power by joining together to buy medical goods and medicines from a diversified set of production locations.
- Such buying power would be multiplied if LDCs joined forces with leading development agencies and the multilateral development banks.
- Stockpiling in advance of any future pandemic offers no cast-iron guarantee, as no-one can know for sure what medical goods will be in high demand.

LDC sourcing of essential goods from abroad

Like many other nations, the LDCs source plenty of medical goods and food from suppliers abroad. When it comes to medical goods (taken to be medical consumables, medical equipment and medicines) and food, as a group the LDCs source large shares from the major trading powers, in particular the European Union (EU). For example, LDCs sourced 40 per cent of their medicines and 36 per cent of their medical equipment from the 28 nations that were members of the EU in 2019. These totals for the LDCs, however, mask considerable differences across the members of that group. As Bown (2020) has reported, Benin sourced an impressive 68 per cent of its protective spectacles and visors but only 36 per cent of its face shields from the EU during the years 2016-2018. Likewise, the Central African Republic depended entirely on EU suppliers for protective spectacles and visors, sourced 74 per cent of its mouth-nose protective equipment and 70 per cent of its gloves from the EU. Among other medical goods, Niger bought just 5 per cent of its protective garments from the EU.

Export curbs on essential goods in 2020

Concerning the immediate trade policy responses by governments to the COVID-19 pandemic, there were two important triggers for action. The first was the realisation that the public health response to COVID-19 generated enormous, unanticipated increases in the demand for medical goods, to levels well ahead of that produced locally. The second was that the shutdown of much of the international transport infrastructure raised concerns about food security.

Many governments, often working with little knowledge about the scale and operation of cross-border supply chains, turned to export controls of different forms to prevent whatever essential goods that were in circulation nationally from being "lost" abroad, even when foreign buyers had paid for the goods in question. The imposition of these export controls disrupted the international supply chains for food and medical goods, much to the chagrin of the firms and customers involved, leading to outcomes that garnered massive attention in the traditional media and on social media (Fiorini, Hoekman, & Yildirim, 2020).

Many governments eased or removed impediments to importing essential goods as COVID-19 spread. Before the pandemic hit, 141 WTO members charged taxes on imported soap – in fact, according to the WTO's Tariff Download Facility, 79 of them imposed ad valorem tariffs on soap of 15 per cent or more. At a time when medical experts were advising us all to wash our hands frequently, a tax on soap is a tax on health. Fortunately, many governments were sensible enough to recognise this and undertook reforms.

Drawing upon an intense real-time monitoring initiative undertaken by the Global Trade Alert team, in collaboration with colleagues from the European University Institute and the World Bank, Figures 1 and 2 plot – respectively for medical goods and food and agri-food – the total numbers of export controls and import reforms introduced in 2020 that were in force in each month of last year and (given known phase-out dates) are likely to be in force in 2021 (Evenett et al., 2020).

The total number of export curbs on medical goods in force peaked in April 2020 at 147. As of this writing, that total had fallen to 100, of which 22 affect shipments of medical goods to LDCs. Furthermore, 99 of the export curbs put in place last year will still be in force at the end of 2021, suggesting that the disruption to international trade flows in this critical sector will not be temporary.

With respect to the resort to export curbs on foodstuffs, this appears to have been less of a concern than at the time of the global economic crisis a decade ago. Still, by April 2020 a total of 40 export controls of different types had been imposed on shipments of food. As of this writing, LDC imports of food have been adversely affected by five export bans imposed by foreign governments this year, the

Figure 1: Two-thirds of 2020's export controls on medical goods were still in force in 2021

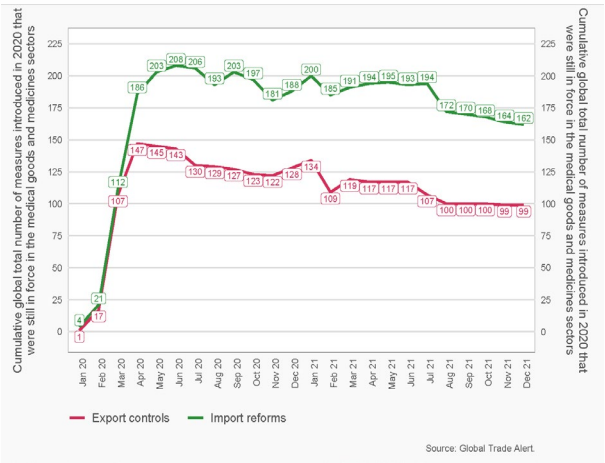
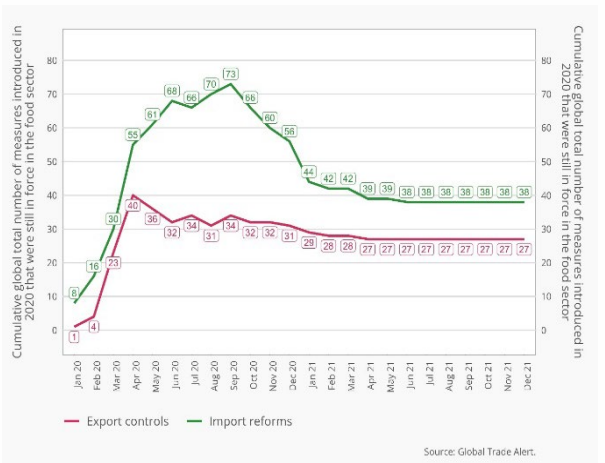


Figure 2: Although there were fewer food export curbs, a smaller fraction are scheduled to be removed



Source: Data assembled from files obtained at Global Trade Alert (2020)

imposition or increase of export taxes on food on four other occasions and an export licensing requirement.

It is important to stress, however, that not every major trading nation resorted to export curbs once the COVID-19 pandemic took hold. To the best of my knowledge, Australia, Canada and Japan did not prevent their manufacturers of medical goods from fulfilling orders placed by foreign customers. Unfortunately, to date, few LDCs sourced medical goods from these three G20 members.

Fallout from the resort to export curbs

In addition to the inevitable ill will created by resorting to sicken-thy-neighbour export curbs on medical supplies and the like, there are good reasons for supposing that the fallout from last year's reflexive move to resort to export controls will be more far-reaching and longer-lasting than the seemingly temporary nature of these policy interventions.

In assessing the longer-term consequences of the export curbs imposed this year on public health grounds, existing multilateral rules afford little guidance. Article XX of the General Agreement on Tariffs and Trade – the relevant legal provision concerning the application of exceptions on supposedly non-trade-related grounds – does not require exceptions to be time-limited. Nor does this Article require that the WTO be notified of exceptions invoked. It is widely believed that the text of this Article is vague and has limited bite.

Even if the application of export curbs on essential goods this year were time-limited, this does not mean there will not be longer-term adverse consequences for developing countries and the world trading system in general. Developing countries have been encouraged to liberalise their import regimes as they integrate their economies into world markets. With respect to essential goods, governments may legitimately reason that one prerequisite for doing so is that trading partners reliably deliver supplies (on normal commercial terms) as and when needs arise. Should trading partners cut off supplies during a pandemic or other emergency, then the government of the importing country may determine that its needs should be met by local manufacturers, therefore making it less willing to liberalise its import regime in the first place and more likely to engage in import substitution.

As I have argued elsewhere with Alan Winters, the very notion of reciprocity in trade relations – especially as they relate to development-sensitive essential goods – needs to be revisited (Evenett & Winters, 2020). Previously, market access bargains for goods largely involved agreements to lower import barriers on a reciprocal basis: A government may be willing to cut its import tariffs if trading partners make sufficiently generous offers to cut their tariffs as well.

Now, a government whose public health system is largely dependent on supplies delivered from abroad may be willing to lower its tariff rates only if trading partners commit to limit or eschew resorting to export curbs in times of crisis. Such a government may be reluctant to participate in a plurilateral or multilateral trade accord involving essential goods if no assurances on security of supply are received from trading partners. The prospects for further import liberalisation of trade in essential goods in the context of a binding trade accord seem bleaker as a result of this year's rush to curb exports at the start of the COVID-19 pandemic.

In sum, another casualty of the rush to export curbs this year may be multilateral trade reform in essential goods. At a minimum, negotiating such an accord may have become a lot more difficult and cannot be confined to commitments to lower import barriers and facilitate imports. The latter observation is particularly germane given a proposal from the EU to negotiate new trade disciplines on trade in medical goods.

Policy recommendations

At this time, a combination of national and international cooperative actions would advance public health in LDCs as well as demonstrate that the world trading system can contribute meaningfully to tackling the COVID-19 pandemic.

Clearly, WTO members need to revisit the weaknesses of existing rules on resort to export curbs in medical emergencies. Without some assurance that foreign firms will fulfil their deliveries of essential goods, no one should be surprised that net importers of medical goods and the like are reluctant to further integrate those sectors into the world economy. Similar considerations apply for the cross-border delivery of foodstuffs.

Individually, regionally or in other groups, governments of LDCs should consider (joint) purchases of medical goods and medicines from a more diversified set of locations. What matters here is not the total number of suppliers, rather that the goods produced are shipped from a larger number of trading nations – thereby reducing the risk associated with any one government imposing an export curb. It may be the case that a multinational medical equipment manufacturer has production sites in a number of nations, so diversified geographical sourcing need not diminish the combined buying clout of a number of LDC governments across a larger number of suppliers.

When making future sourcing decisions for essential goods, strong consideration should be given to the track records of governments last year in relation to the resort to export controls. As noted earlier, not every government frustrated the export of medical goods and medicines by their nation's manufacturers. Proper risk assessments ought to be conducted by LDC (and other) government buyers. Arguably, in the future more should be sourced from economies where governments resisted the temptation to block exports during the COVID-19 pandemic. All governments are responsible for pandemic preparedness and associated risk assessments.

Proposals to individually or jointly stockpile medical goods and medicines sound appealing. However, as medical emergencies vary, it is impossible to predict accurately every need of a national health system. Even so, there may be some items – such as personal protective equipment, including gloves, masks and surgical gowns – that can reasonably be expected to be in demand during future medical emergencies. Ultimately, although an imperfect solution, stockpiling of often-used medical gear buys time while the private sector ramps up production of whatever medical goods there is a surging demand for.

Even if supply chains are not disrupted and global markets for medical goods and medicines remain open, a global public health emergency is likely to lead to buying frenzies on the part of governments. In these circumstances the depth of a nation's pockets matters and, on their own, LDC governments may find themselves outbid for essential goods. There is a clear role here for aid agencies from wealthier nations and the multilateral development agencies to create funds, or contingent financial instruments, that enable LDC governments and the agents procuring on their behalf to secure a larger share of available supplies of essential goods.

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Simon Evenett
Professor of International Trade and Economic Development
University of St. Gallen and Founder, St. Gallen Endowment for Prosperity Through Trade

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Tulpenfeld 6 · 53113 Bonn · Germany · Tel.: +49 (0)228 94927-0 · Fax: +49 (0)228 94927-130
die@die-gdi.de · www.die-gdi.de · twitter.com/DIE_GDI · www.facebook.com/DIE.Bonn · www.youtube.com/DIEnewsflash
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