



BMJ Open How prices and income influence global patterns in saturated fat intake by age, sex and world region: a cross-sectional analysis of 160 countries

Amelia Ahles ¹, Andrew Muhammad ², Jacqueline N Yenerall,² Julia Reedy,³ Peilin Shi,³ Jianyi Zhang,³ Frederick Cudhea,³ Josh Erndt-Marino,³ Victoria Miller,³ Dariush Mozaffarian,³ Global Dietary Database

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¹Texas A&M University, College Station, Texas, USA

²The University of Tennessee Institute of Agriculture, Knoxville, Tennessee, USA

³Friedman School of Nutrition Science and Policy, Tufts University, Boston, Massachusetts, USA

Correspondence to

Dr Andrew Muhammad; amuhamm4@utk.edu

ABSTRACT

Objective When considering proposals to improve diets, it is important to understand how factors like price and income can affect saturated fat (SF) intake and demand. In this study, we examine and estimate the influence of price and income on intake across 160 countries, by age and sex, and derive sensitivity measures (price elasticities) that vary by age, sex and world region.

Design We econometrically estimate intake responsiveness to income and prices across countries, accounting for differences by world region, age and sex. Intake data by age, sex and country were obtained from the 2018 Global Dietary Database. These data were then linked to global price data for select food groups from the World Bank International Comparison Programme and income data from the World Development Indicators Databank (World Bank).

Results Intake differences due to price were highly significant, with a 1% increase in price associated with a lower SF intake (% energy/d) of about 4.3 percentage points. We also find significant differences across regions. In high-income countries, median (age 40) intake reductions were 1.4, 0.8 and 0.2 percentage points, given a 1% increase in the price of meat, dairy, and oils and fats, respectively. Price elasticities varied with age but not sex. Intake differences due to income were insignificant when regional binary variables were included in the analysis.

Conclusion The results of this study show heterogeneous associations among prices and intake within and across countries. Policymakers should consider these heterogeneous effects as they address global nutrition and health challenges.

INTRODUCTION

While nutritional guidelines call for reductions in saturated fat (SF), the literature is not clear and remains controversial on the causal link between SF intake and cardiovascular disease risk and other health-related outcomes.^{1–3} Studies note that different food sources of SF may have different relationships with risk, for example, a higher risk for red meats and their fats, generally neutral

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ We compared price responsiveness across population subgroups (by age and sex) and across countries by world region.
- ⇒ The analysis allowed for price elasticity comparisons across the primary contributing food categories, which included the price of meat, dairy, and oils and fats.
- ⇒ Price and income measures were at the country level and could not account for within-country price and income differences.
- ⇒ The price series used in this study was limited to the primary contributing food categories and did not include, for instance, ultra-processed foods.

relationships for dairy foods and their fats, and protective associations for plant oils.⁴ In addition, low SF intake has been associated with higher mortality risk in studies comprising mostly low-income and middle-income countries, and very low SF intake is associated with higher risk of haemorrhagic stroke, potentially due to increased cerebral vascular fragility.^{3,4}

Governments and international organisations have proposed economic interventions to improve diets and health outcomes.^{5–8} The associated intake and health responses from the taxation of unhealthy foods have been the subject of many studies.^{9–12} For instance, studies have considered the effectiveness of economic interventions to reduce the consumption of sugar-sweetened beverages and calorically dense foods across countries and cities over the past decade. However, the effectiveness of these economic interventions in reducing intake and improving health varies widely.^{9,13,14} For instance, taxation in a particular jurisdiction could increase cross-border shopping (ie, purchasing outside of

the jurisdiction) or substitutions for unhealthy, untaxed alternatives.^{9 13}

In considering these proposals to improve diets, it is important to understand how factors like price and income influence SF intake and demand.^{6 15–17} Sensitivity to prices of SF-source foods could vary by per capita income, age, sex, educational attainment, etc. This relationship may also vary by world region, given differing cultural preferences, with important implications for health policy interventions.^{18–20} However, to date, no evidence exists on the global income and price sensitivity of SF intake, nor is there any potential variation by important demographic characteristics. Other than a few noted exceptions, global assessments of SF intake have been limited, particularly when considering price and income effects.^{21 22}

To help address these knowledge gaps, this investigation assessed how price and country income relate to SF intake. We used nationally representative intake estimates from the 2018 Global Dietary Database (GDD) to estimate how per capita income and prices jointly relate to SF intake by age and sex globally. Since nutrients are found in food, examinations of nutrient demand must consider food source demand, with price and income as explanatory variables.^{23–25} Using price and expenditure data from the World Bank International Comparison Programme, we constructed a global price series based on three food categories: meat, dairy, and oils and fats. This series sufficiently explained SF intake differences across countries and allowed for the assessment of the relationships between per capita income and price in each food category.

METHODS

Data and sources

We used secondary data sources for the analysis. SF intake data measured in per cent of total energy per day (% energy/d) for a representative individual was obtained from the 2018 GDD. The GDD, maintained by the Global Nutrition and Policy Consortium at Tufts Friedman School of Nutrition Science and Policy, provides comprehensive and comparable dietary intakes for major foods and nutrients in 185 countries and territories. The GDD was developed using systematic searches of available survey data on individual-based dietary intakes for key food and nutrient categories at the national and subnational levels. GDD intake estimates are based on the results of existing surveys (1248 in total), representing 188 countries and approximately 99% of the global population. It is the first database to provide estimates of daily consumption levels by food or nutrient category and contains representative individual intake data by age (0–1 year, 1–2 years, 2–5 years and then by increments of 5 years to age 97.5) and sex.²⁶ The GDD also disaggregates individual intakes by three education levels and residence (urban and rural). The GDD data estimation process included

extensive communication with researchers and government authorities and large subnational surveys when other options were unavailable.^{27 28} For details on the GDD coverage, data methodology and data collection, see <https://www.globaldietarydatabase.org/methods/summary-methods-and-data-collection>.

National food expenditure and price data from the World Bank International Comparison Programme (ICP) were used to derive an SF price series. Although our intake measure is comprehensive and inclusive of all food sources, the price series used for the analysis was limited to the primary contributing food categories: meats, dairy, and oils and fats. The price series for the *meats* category in the ICP database is an aggregation of the following: beef and veal; pork; lamb, mutton, and goat; poultry and other meats and meat preparations. *Dairy*—fresh milk, preserved milk and other milk products, cheese and curd, and eggs and egg-based products. *Oils and fats*—butter and margarine and other edible oils and fats.²⁹ Although SF is readily found in a wide array of foods, these categories have been identified as major contributors to saturated fatty acids in diets.³⁰ While other foods, such as sweet and savoury snacks, also contribute and are included in our SF intake variable, global price series for these food categories are not widely available.

The ICP is a global initiative that estimates purchasing power parities (PPPs) and price level indices (PLIs) across countries, which allows for global comparisons of spending and economic well-being. PPPs are spatial price deflators that make it possible to compare expenditures across economies.³¹ PLIs are PPPs standardised to a common currency (generally the US dollar) or indexed to a global average or base country.³² The most recent ICP data round (2017) included comparative prices and expenditure data from 176 participating economies.³²

For income, we used 2018 PPP-adjusted, gross domestic product (GDP) per capita from the World Development Indicators (WDI) database. Because differences in currency values and exchange rates do not always consistently reflect price-level differences across countries, PPP-adjusted GDP allows for cross-country comparisons because overall price disparities across countries are taken into account.³³

The analysis was limited to the 160 countries represented in all three databases (GDD, ICP and WDI), which are listed in online supplemental table 1 by geographical region (see the online supplemental file 1): East Asia, Southeast Asia, and Asian Pacific (Asia) (14 countries); Central and Eastern Europe and Central Asia (CEE) (27 countries); Latin America and Caribbean (LAC) (29 countries); Middle East and North Africa (MENA) (17 countries); South Asia (S-ASIA) (seven countries); Sub-Saharan Africa (SSA) (43 countries) and high-income/rest of world (HIC) (24 countries). HIC is an aggregation of HIC in the Western hemisphere, Australia and New Zealand, with the addition of a few surrounding islands. Countries without data in any of the three databases were excluded.

See the online supplemental file 1 for a more detailed discussion of the price, expenditure and income data by geographical region.

Patient and public involvement

We used secondary data for this study. All data are publicly available and did not require direct patient involvement in the study design or implementation.

Model and estimation

To estimate SF intake demand, we used a semilog functional form that has been proven to be consistent with economic theory and rational consumer behaviour.^{34 35} Many studies have used a double-log form.³⁶ However, a problem with the double-log form is that significant intake differences across subgroups can be lost in log conversions. A semilog relationship allowed for a better assessment of subgroup effects on intake responsiveness. Also, it has been shown that semilog models contain the necessary information for obtaining, for instance, reliable measures of consumer welfare and the underlying preference structure of consumers.³⁴ Prior studies have also used a demand-system approach, primarily due to the adding-up property when using expenditure data (ie, expenditures on all food categories ‘add up’ to total food expenditures), which results in the error terms being correlated across equations specific to each food category. Since this relationship does not exist with individual intakes, particularly when the correspondence between purchases and intakes is not one-to-one, we can estimate intake demand for a single food or nutrient category separately.^{19 20}

Let q_{gC} represent the % energy/d from SF for demographic subgroup g (g : sex and age) in country C , and let p_C represent the price level index for the contributing food categories in country C . Let Y_C and P_C represent real per capita income and the food price level index, respectively, in country C . Given these terms, the following model was used to estimate the relationship between intake, income and prices:

$$q_{gC} = \beta_0^* + \beta_1^* \ln(Y_C) + \beta_2^* \ln\left(\frac{p_C}{P_C}\right) + u_{gC} \quad (1)$$

The β_k^* terms ($k=\{0,1,2\}$) are parameters to be estimated, and u_{gC} is a random error term. Note that the price term is defined by the price of contributing food categories (p_C) relative to overall food prices (P_C). Thus, the model discounts any price differences across countries due to differences in overall food prices and implicitly accounts for the cross-price effects of other foods. For instance, if dairy prices were the same in two countries but overall food prices differed, intake would be greater in the country with the higher food price level since dairy is *relatively* cheaper when compared with food overall. Note that equation (1) does not include higher-order income and price effects (eg, quadratic income and price–income interactions). In preliminary analysis, these higher-order terms were highly insignificant, which implied that price

or income responsiveness did not depend on the level of per-capita income.

Using equation (1), we estimated intake demand using a procedure that allowed for error correlations among observations from the same country (ie, country-clustered errors).³⁷ To account for differences in preferences across countries due to cultural differences or other related factors, we included regional binary variables in the analysis (ASIA, CEE, LAC, MENA, S-ASIA and SSA). We accounted for age and sex by allowing these factors to have a direct effect on intake as well as an additional effect through income and prices. Thus, the beta terms (β_k^*) were expanded to account for age and sex interactions: $\beta_k^* = f(\text{sex}, \text{age}) \forall k$. Further disaggregations (education level and residence) were not considered due to estimation concerns resulting from negligible differences in SF intake across these factors. Although we used a single price index (p_C) to represent the three food categories (meats, dairy, and oils and fats), intake responsiveness with respect to the price of each food category was easily derived. Defining the conditional expenditure share and price for the i th food category in country C as s_{iC} and p_{iC} , respectively, p_C is as follows: $p_C = \sum_i s_{iC} p_{iC}$. Thus, the relationships between q_{gC} and p_{iC} were derived using the estimate of the price term in equation (1) (β_2^*) and the conditional expenditure share s_{iC} as follows: $\frac{\partial q_{gC}}{\partial p_{iC}} = \frac{\partial q_{gC}}{\partial p_C} \frac{\partial p_C}{\partial p_{iC}} = \frac{\beta_2^*}{p_C} s_{iC}$.

RESULTS

Descriptive statistics and SF intake overview

The descriptive statistics for the variables used in the model are shown in [table 1](#). The mean SF intake across all observations was 10.83% energy/d and ranged from 2.39 to 27.48. PPP-adjusted real GDP per capita ranged from \$780 to \$117 245 (mean=\$22 226). The deflated price index ($\frac{p_C}{P_C}$) ranged from 0.71 to 1.40 (mean=1.00). Mean values for the region and sex variables reflect the country and subgroup representation in the data.^{26 33}

Violin plots for SF intake by sex, age and region based on all observations ($n=7040$) are shown in [figure 1](#). Violin plots use kernel densities to visualise the distribution of intake. The width of the violin plot corresponded to the probability of an observation taking a specific value of SF intake, and the vertical black line in each violin plot corresponded to the median value. In general, the violin plots showed that the distribution of SF is similar across age and sex subgroups, although there was greater variation across regions. Additionally, the presence of long right tails across most subgroups suggested the presence of outliers with very high values of SF intake.²⁶

While the median value for SF intake was around 10.60% energy/d, there were notable differences ([figure 1](#)). Median SF intake was slightly higher in females (females=10.88 and males=10.40). Across regions, median SF intake was lowest in S-ASIA (6.42) and highest in HIC (13.78). Overall, the maximum value for SF intake

Table 1 Descriptive statistics for study variables

Variable	Measure	Mean	SD	Min	Max
SF intake	% energy/d	10.83	3.09	2.39	27.48
Female	Binary	0.50	0.50	0	1
Age	5-year intervals*	45.6	30.83	1	98
ASIA	Binary	0.09	0.29	0	1
CEE	Binary	0.17	0.37	0	1
HIC	Binary	0.15	0.36	0	1
LAC	Binary	0.18	0.39	0	1
MENA	Binary	0.10	0.30	0	1
S-ASIA	Binary	0.04	0.20	0	1
SSA	Binary	0.27	0.44	0	1
Real GDP per capita (PPP)	\$/person	\$22 226	\$21 646	\$780	\$117 245
Deflated price	index (US=1)	1.00	0.12	0.71	1.40

Note that n=7040 (160 countries×44 demographic subgroups); n=160 for the GDP and price index.

*5-year intervals apply to age ≥ 10. Younger age groups include age ≤ 1, 2, 5, and 8.

ASIA, East and Southeast Asia; CEE, Central and Eastern Europe and Central Asia; GDP, gross domestic product; HIC, high-income countries/rest of world; LAC, Latin America and Caribbean; MENA, Middle East and North Africa; PPP, purchasing power parity; S-ASIA, South Asia; SF, saturated fat; SSA, Sub-Saharan Africa.

occurred in the Philippines (27.48) among female infants (<1 year old), while the overall minimum occurred in Nepal (2.39) among females between the ages of 20 and 25. Even within regions, notable differences occurred. In HIC, for instance, intake ranged from a high of 23.02% energy/d in France among female infants to 9.45% energy/d in Portugal among males, aged 95 years and older.²⁶

Estimation results

We first estimated the model using intake values at the country level (ie, intake averaged over all demographic subgroups, n=160) (see online supplemental table 2). Since our explanatory variables (price and income) were country-specific and did not vary with demographic subgroups, it was useful to examine the

significance of price or income without age and sex differences. The country-level analysis also revealed the importance of each variable in explaining global differences in SF intake. For instance, Model 1 showed that regional differences accounted for a large share of intake differences across countries (adjusted $R^2=0.39$). When regional differences were not accounted for, both income (1.03, $p<0.01$) (Model 2) and price (−3.90, $p<0.05$) (Model 3) were significant. When regional differences were accounted for (Model 4), the price was still significant (−4.33, $p<0.05$), but income was insignificant. The negative price estimate was consistent with economic theory (higher prices being associated with lower intake) and indicated that a unit increase in the

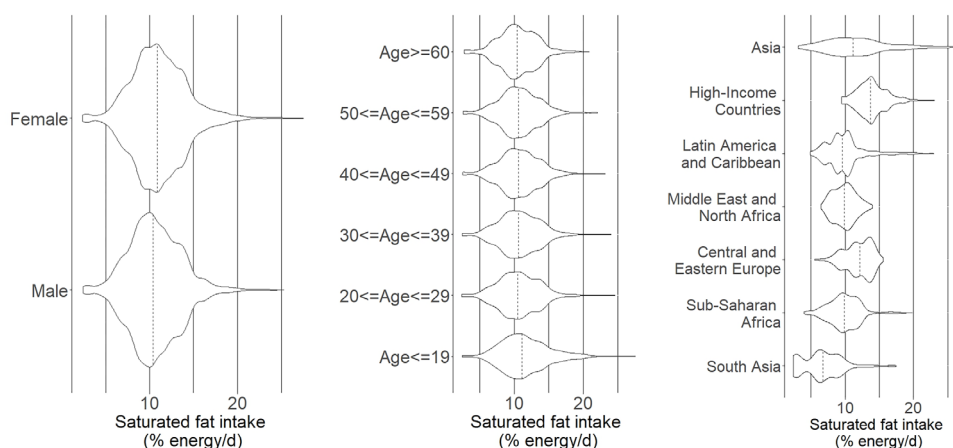


Figure 1 Comparison of percentage energy from saturated fat among individuals in sex, age and country-specific strata globally and across world regions. Note that n=7040 (160 countries×44 demographic subgroups). Female: n=3520 and male: n=3520. Age categories: age ≤19, n=1920; age ≥60, n=2560 and for all other age groups, n=640. Regions: South Asia, n=308; Sub-Saharan Africa, n=1892; Central and Eastern Europe, n=1188; Middle East and North Africa, n=704; Latin America and Caribbean, n=1276; high-income countries n=1056 and Asia, n=616. Source: Global Dietary Database, 2018.

Table 2 Saturated fat intake estimates using country and demographic (sex and age) level data (n=7040)

	Model 1	Model 2	Model 3	Model 4
Constant	14.64 (0.39)***	2.81 (1.73)	12.44 (2.89)***	12.01 (2.90)***
ASIA	-2.20 (1.14)*		-1.61 (1.12)	-1.61 (1.12)
CEE	-1.94 (0.48)***		-1.68 (0.51)***	-1.68 (0.51)***
LAC	-3.97 (0.49)***		-4.09 (0.65)***	-4.09 (0.65)***
MENA	-3.98 (0.52)***		-3.35 (0.55)***	-3.35 (0.55)***
S-ASIA	-7.26 (1.00)***		-6.08 (1.08)***	-6.08 (1.08)***
SSA	-4.03 (0.49)***		-3.47 (0.81)***	-3.47 (0.81)***
Female	0.48 (0.04)***	0.48 (0.04)***	0.48 (0.04)***	0.06 (0.31)
Age	-0.04 (0.01)***	-0.04 (0.008)***	-0.04 (0.01)***	-0.10 (0.04)***
Age ²	0.00 (0.00)***	0.00 (0.00)***	0.00 (0.00)***	0.00 (0.00)***
ln(Y)		0.93 (0.18)***	0.19 (0.26)	0.24 (0.27)
Female×ln(Y)				0.04 (0.04)
Age×ln(Y)				0.01 (0.00)
Age ² ×ln(Y)				0.00 (0.00)***
ln(P)		-3.73 (1.59)***	-4.32 (1.88)**	-7.16 (2.29)***
Female×ln(P)				-0.13 (0.14)
Age×ln(P)				0.20 (0.06)***
Age ² ×ln(P)				0.00 (0.00)***
Adjusted R ²	0.34	0.18	0.36	0.37

The dependent variable is saturated fat intake in % energy/d. Robust SEs (clustered by country) are in parenthesis; *p<0.10; **p<0.05 and ***p<0.01. Y is real GDP per capita, purchasing power parity adjusted. P is an inflation-adjusted price index for meats, dairy products and eggs, and oils and fats.

ASIA, East and Southeast Asia; CEE, Central and Eastern Europe; LAC, Latin America and Caribbean; MENA, Middle East and North Africa; S-ASIA, South Asia; SSA, Sub-Saharan Africa.

log of price was associated with lower SF intake by 4.33 percentage points.

Since the intake variable was measured as a per cent, it is important to clarify the difference between a percentage point change and a per cent change. For instance, intake falling from 10.83 to 6.50% energy/d, is a 4.33 percentage point decline, but a 40% decline: $-4.33 \div 10.83$). This distinction is important when considering elasticity relationships where both intake and prices are measured in percentage. Assuming mean intake (10.83% energy/day) as the base, intake falling by 4.33 percentage points or 40%, given a unit change in the log of price (a twofold increase), suggested a price elasticity of about -0.40. That is, SF intake declines by 0.40% for every 1% increase in price, which indicates minimal price sensitivity and inelastic demand. Note that this result is based on a price increase across all food categories in the price series. As discussed later in this section, intake responsiveness to the price of a particular food category (eg, dairy) was smaller.

Estimation results for the full model (Model 4) are reported in table 2. Other than ASIA, SF intake was significantly lower in all regions relative to HIC intake. Intake also decreased with higher age (-0.10, p<0.01), but this effect was less significant with older adults. Results (Model 4) indicated a price effect of -7.16 (p<0.01), where the

magnitude became smaller with age (0.20, p<0.01) but then increased for older populations. There was no significant difference in the price effect by sex, and like the country-level analysis, the income effect on intake was insignificant when regional differences were considered. Consequently, we did not examine income effects in detail and the price-specific measures that follow are not specific to sex.

Intake responsiveness and food prices

Using the country-level estimates from online supplemental table 2, we derived measures of aggregate intake change with respect to price changes specific to the food categories in the SF price series (meat, dairy, and oils and fats) (figure 2). Note that our dependent variable is SF intake from all foods, including ultra-processed food. Thus, the price effects reported in this section measure how changes in the price of meat affect total SF intake, not just SF intake from meat. An increase in the meat price index resulted in the largest intake decrease: -2.47 percentage points from a twofold increase in price (IQR: -2.29 to -2.78). Assuming mean intake as the base, this implied a price elasticity of about -0.23 (ie, a 0.23% decline for every 1% increase in meat prices). The next highest intake decrease was in response to the dairy price index (-1.30 percentage points and IQR: -1.01 to -1.56),

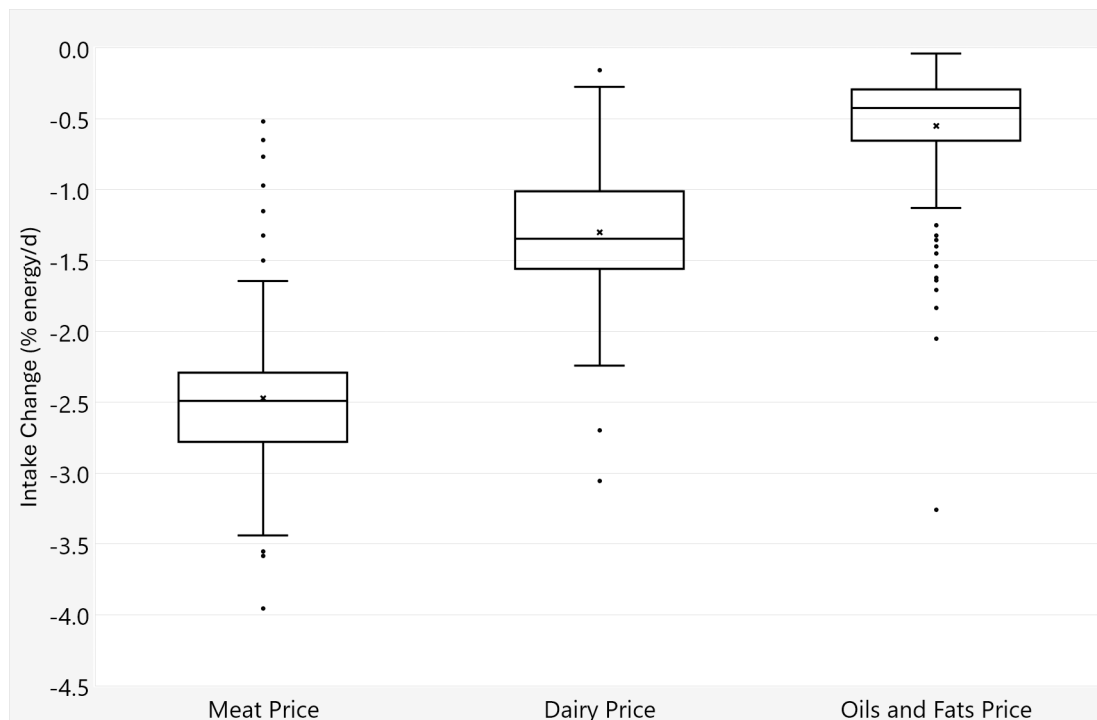


Figure 2 Change in saturated fat intake when prices double for each food category. Intake change values measure the change in % energy/d from saturated fat. Boxes denote the median value and IQR; error bars are min and max values, and data points are outliers.

implying a price elasticity of -0.12 . The results for oils and fats indicate the lowest intake response to a price change (-0.55 percentage point change and IQR: -0.29 to -0.65); the elasticity with respect to the price of oils and fats is about -0.06 .

Using the estimates from [table 2](#), we assessed intake responsiveness by food category, age and region (see [figure 3](#)). Across regions, meat prices resulted in the largest variation in SF intake, with S-ASIA being the only exception. In HIC, for instance, median SF intake reductions at age 40 were 1.37, 0.78 and 0.15 percentage points, for 1% higher prices of meat, dairy and oils and fats, respectively. In contrast, intake reductions in S-ASIA at age 40 were highest for dairy prices (1.14 percentage points) followed by meat prices (0.62 percentage points) and then the price of oils and fats (0.48 percentage points). However, the IQR overlap for meat and dairy in S-ASIA suggested that intake responsiveness to these two prices was not significantly different.

Across regions, there were key differences in intake responsiveness with respect to price changes. In HIC, there was no IQR overlap, suggesting significantly higher intake responsiveness to meat prices when compared with dairy prices, and dairy prices compared with the price of oils and fats. Similar patterns were observed for CEE, LAC and MENA. In SSA, however, intake changes from meat prices were significantly larger, but the estimates for dairy and oils and fats prices show considerable IQR overlap.

Results also indicated that middle-aged groups (age 40–60 years) were the least sensitive to price changes. This was consistent with expectations as the middle-aged

groups often have higher incomes and may be less sensitive to price changes. Based on the ‘All Countries’ estimates (upper left panel), the median intake response from a twofold increase in meat prices was -2.10 percentage points (age 20), responsiveness then decreased to -1.32 percentage points by age 50 and then increased to -2.71 percentage points by age 80. There was a similar pattern for dairy and oils and fats prices, but the differences between age groups were not as large.

DISCUSSION

This investigation provides evidence on how differences in income and food prices might jointly influence SF consumption by sex and age across the spectrum of rich and poor countries. Both the country-level and disaggregated (age and sex) analysis indicated that intake differences due to income were insignificant. These results suggest that intake differences across countries are better explained by regional dissimilarities and not economic well-being as measured by per-capita income. In contrast, differences due to food prices were highly significant. Globally, a 1% increase in prices was estimated to decrease SF intake by about 0.40%. Across regions, the meat-price sensitivity of SF intake was relatively high, except for S-ASIA where the dairy price sensitivity of SF intake was higher. Within regions and by age, price sensitivity was lowest among middle-aged adults.

The higher sensitivity of SF intake to price changes in meat consumption suggests that fiscal policies focused on reducing SF intake would be more effective through

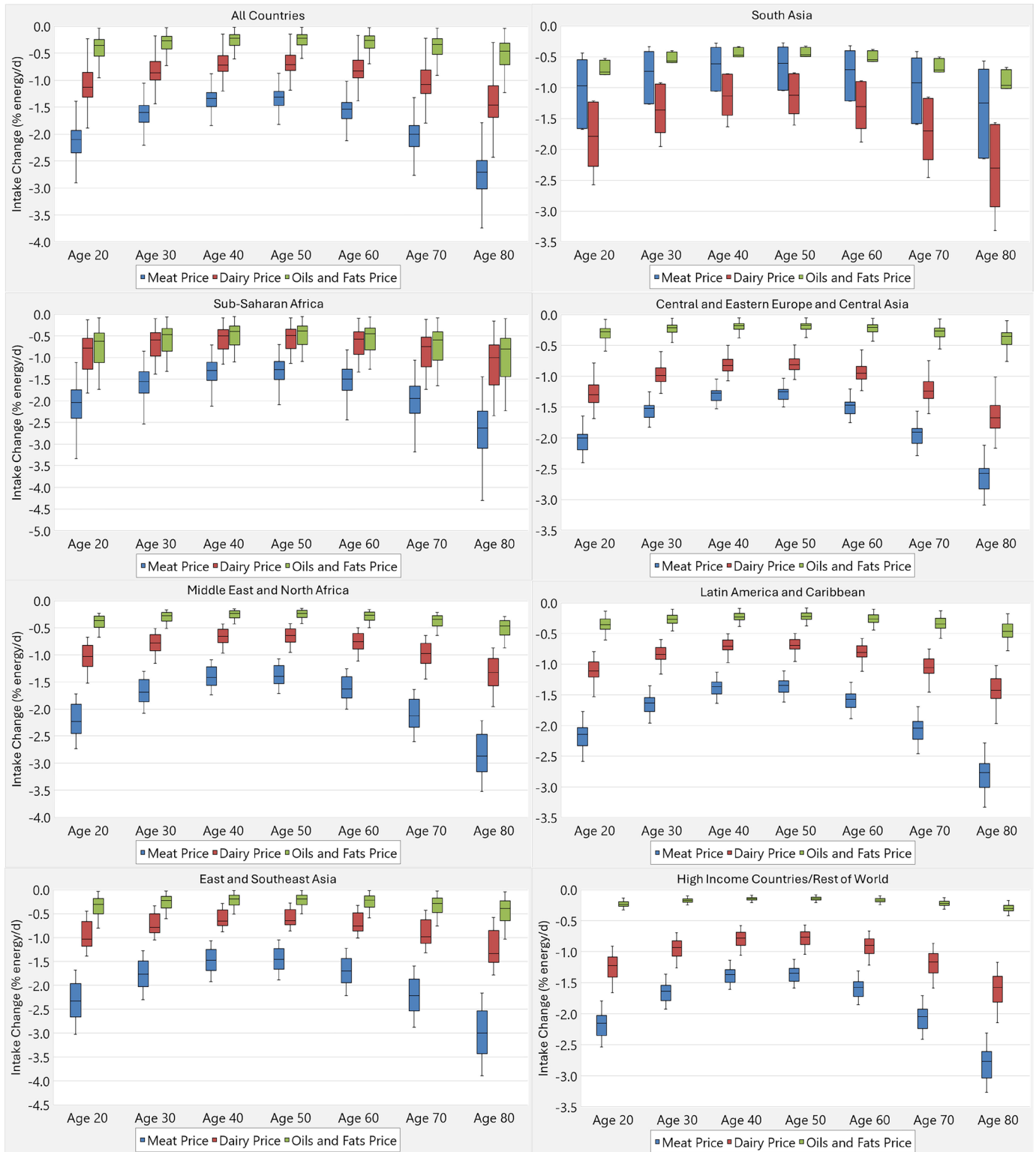


Figure 3 Change in saturated fat intake when prices double for each food category by select region and age. Intake change values measure the change in % energy/d from saturated fat. Boxes denote the median value and IQR, and error bars are min and max values.

meat-price interventions. That said, the magnitudes of price sensitivity were small, indicating relatively inelastic demand. Thus, high taxes would be needed to reduce intake: for example, global findings suggest that a twofold increase in meat prices (ie, a 100% tax) is

associated with decreased intake of only 2.47 percentage points. Our results are consistent with previous findings. Research has shown that fat taxes in Denmark, Hungary and France had small and ambiguous effects on demand.^{38 39} A similar outcome was observed from the

Danish fat tax experience that targeted dairy and vegetable fat sources.⁴⁰

The findings in this study can help to inform strategies that counter worsening diets. However, our modelling cannot prove causality of price changes on intake, and thus our findings should be interpreted cautiously when informing interventions and evaluations. Furthermore, the invariability of price and income across demographic subgroups ignores differences within countries and may have affected results, although we address this issue, in part, with age and sex variable interactions. Although the lack of price data for other food categories limited our ability to parse out other intake–price relationships, to the degree that our derived SF price series based on meat, dairy and oils and fats is representative of a ‘true’ global SF price the aggregate price effects could be applied to other food categories.

The benefit of our analysis is the country coverage. While relationships between income, prices and food choice have been studied, combining GDD, World Bank and ICP data allowed for a global coverage rarely seen in food and nutrition research, allowing for comparisons across individuals in rich and poor countries and an examination of intake responsiveness by age and sex.^{19 20}

CONCLUSION

Our results provide novel global evidence on how income and prices influence SF intake by region, age and sex. Our results confirm that the effectiveness of price interventions would be limited in most countries but provide evidence of where interventions would be most effective if implemented (meat vs dairy or oils and fats; youth, young adults and the elderly). These observed relationships can assist policymakers as they consider how pricing policies can be leveraged to tackle nutrition challenges.

Collaborators Pamela Abbott, Director of the Centre for Global Development, University of Aberdeen, UK; Morteza Abdollahi, National Nutrition and Food Technology Research Institute (NNFTRI); SBMU; Parvin Abedi, Menopause Andropause Research Center, Ahvaz Jundishapur University of Medical Sciences; Suhad Abumweis, Al Ain University, Abu Dhabi, UAE; Linda Adair; Mohannad Al Nsour, Eastern Mediterranean Public Health Network: EMPHNET; Iftikhar Alam, BKUC.edu.pk; Nasser Al-Daghri and Dr. Shaun Sabico, King Saud University, Saudi Arabia; Nawal Ai, alHamad, Public Authority For Food and Nutrition, Kuwait; Suad Al-Hooti, Kuwait Institute for Scientific Research; Eman Alissa, King Abdulaziz University; Sameer Al-Zenki; Simon Anderson, University of Manchester; Karim Anzid, Cadi Ayyad University; Carukshi Arambepola, Faculty of Medicine, University of Colombo, Sri Lanka; Mustafa Arici, Hacettepe University Faculty of Medicine; Joanne Arsenault, FHI Solutions; Renzo Asciani; Lajos Biró; Noël Barengo, Herbert Wertheim College of Medicine; Simon Barquera, Juan Rivera Dommarco, Daniel Illescas-Zarate, Luz Maria Sánchez-Romero, Sonia Rodriguez Ramirez, and Ivonne Ramirez Silva, National Institute of Public Health (INSP), Mexico; Murat Bas, Acibadem University; Wulf Becker; Sigrid Beer-Borst; Per Bergman, Anna Karin Lindroos, Jessica Petrelius Sipinen, and Lotta Moraeus, Swedish National Food Agency; Sesikeran Boindala, National Institute of Nutrition India; Pascal Bovet, University Center for Primary Care and Public Health (Unisanté), Lausanne, Switzerland, and Ministry of Health, Seychelles; Debbie Bradshaw; Norikilil Bukhary Ismail Bukhary, Ministry of Health (Malaysia); Kanitta Bundhamcharoen; Mauricio T. Caballero, Fundacion INFANT and Consejo Nacional De Investigaciones Cientificas y Tecnicas (CONICET); Neville Calleja, Directorate for Health Information & Research; Xia Cao; Mario Capanzana, Food and Nutrition Research Institute, Department of Science and Technology; Jan Carmikle, Senior Intellectual Property Office; Katia

Castetbon, Institut de Veille Sanitaire; Michelle Castro, Departamento de Alimentação Escolar; Corazon Cerdana; Hsing-Yi Chang, National Health Research Institutes; Karen Charlton; Yu Chen, NYU School of Medicine; Shashi Chiplonkar, HC Jehangir Medical Research Institute, Pune India; Yoonsu Cho, Korea University; Khun-Aik Chuah; Simona Costanzo, Marialaura Bonaccio, and Licia Iacoviello, IRCCS INM Neuromed; Melanie Cowan; Albertino Damasceno, Faculty of Medicine, Eduardo Mondlane University, Maputo, Mozambique; Saeed Dastgiri, Tabriz University of Medical Sciences; Stefaan De Henauw and Carl Lachat, Ghent University, Belgium; Karin DeRidder, Belgian Public Health Institute; Eric Ding, Harvard School of Public Health; Rokiah Don; Charmaine Duante; Vesselka Duleva, National Center for Public Health, Sofia, Bulgaria; Samuel Duran Agüero, Universidad San Sebastian, Chile; Veena Ekbote, Hirabai Cowasji Jehangir Medical Research Institute, Jehangir Hospital, Pune, India; Jalila El Ati, National Institute of Nutrition and Food Technology & SURVEN RL; Alison Eldridge, Nestle Research Center; Tatyana El-kour and Laetitia Nikiema, World Health Organization (WHO); Ibrahim Elmadafa, University of Vienna; Helene Enghardt Barbieri; Alireza Esteghamati, Tehran University of Medical Sciences; Zohreh Etemad, Dutch National Institute for Public Health and the Environment (RIVM); Fariza Fadzil, Ministry of Health, Malaysia; Farshad Farzadfar; Mei Fen Chan; Anne Fernandez, Perdana University, Royal College of Surgeons in Ireland; Duliitha Fernando; Regina Fisberg, University of Sao Paulo, Brazil; Simon Forsyth, The University of Queensland School of Public Health; Edna Gamboa Delgado, Fundacion Cardiovascular de Colombia; Didier Garriguet, Statistics Canada; Jean-Michel Gaspoz; Dorothy Gauci; Johanna M. Geleijnse, Wageningen University; Brahmam Ginnela; Giuseppe Grosso, Department of Biomedical and Biotechnological Sciences, University of Catania, Italy; Idris Guessous, Geneva University Hospitals; Martin Gulliford, King's College London; Ingibjorg Gunnarsdottir and Inga Thorsdottir, University of Iceland; Holmfrídur Thorgeirsdóttir, Directorate of Health, Iceland; Wilbur Hadden; Aida Hadziomeragic, Institute of Public Health of Federation of Bosnia and Herzegovina; Christian Haerpfner; Jemal Haidar Ali, Addis Ababa University; Rubina Hakeem, Ziauddin University Karachi; Aminul Haque, University of Dhaka; Maryam Hashemian, Tehran University of Medical Sciences and Utica University; Rajkumar Hemalatha, Avula Laxmaiah, Indrapal Meshram, Hari Kumar Rachakulla, and Nimmathota Arlappa ICMR-National Institute of Nutrition, Hyderabad; Sigrun Henjum, Oslo and Akerhus University College; Hristo Hinkov, National Center of Public Health and Analyses (NCPHA); Zaiton Hjadaud; Daniel Hoffman, Rutgers University; Beth Hopping; Anahita Houshiar-rad, National Nutrition & Food Technology Research Ins; Yao-Te Hsieh, Institute of Biomedical Sciences, Academia Sinica, Taipei, Taiwan; Shu-Yi Hung; Inge Huybrechts, International Agency for Research on Cancer; Nahla Chawkat Hwalla, American University of Beirut; Nayu Ikeda; Manami Inoue; Olof Jonsdottir; Hamid Jan Bin Jan Mohamed, Universiti Sains Malaysia; Chandrashekar Janakiram, Amrita School of Dentistry; Ranil Jayawardena, University of Colombo; Rajesh Jeewon, University of Mauritius; Nattinee Jitnarin; Lars Johansson; Ola Kally; Mirmalini Kandiah; Tilakavati Karupaiah, National University of Malaysia; Lital Keinan-Boker, Rebecca Goldsmith, and Tal Shimony, Israel Center for Disease Control; Roya Kelishadi, Research Institute for Primordial Prevention of NCD, Isfahan University of Medical Sciences; Anuradha Khadiiikar, Hirabai Cowasji Jehangir Medical Research Institute; Cho-il Kim, Korea Health Industry Development Institute; Eda Koksali, Gazi University; Jurgen Konig, University of Vienna, Department of Nutritional Sciences; Liisa Korkalo, Riitta Freese, and Majjalisa Erkkola, University of Helsinki; Eva Roos, University of Helsinki, Department of Food and Nutrition; Jeremy Koster, University of Cincinnati; Irina Kovalskys, ICCAS (Instituto para la cooperacion cientifica en ambiente y salud), Argentina; Anand Krishnan, All India Institute of Medical Sciences; Herculina Kruger, North-West University, Potchefstroom South Africa; Rebecca Kuriyan-Raj, St John's Research Institute; Kyungwon Oh, Sanghui Kweon and Sihyun Park, Korea Disease Control and Prevention Agency (KDCA); Yuen Lai; Pulani Lanerolle, University of Colombo, Sri Lanka; Indu Waidyatilaka, University of Colombo, Sri Lanka; Catherine Leclercq; Meeli-Shyuan Lee; Hae-Jeung Lee, Eulji University; J Lennert Veerman, The University of Queensland; Lydia Lera Marques, Unidad de Nutricion Publica-Professor Asociado; Yanping Li, Harvard School of Public Health; Jaana Lindström; Annie Ling; Nur Indrawaty Lipoeto, Andalas University; Patricio Lopez-Jaramillo, FOSCAL and UDES; Amy Luke, Loyola University Chicago; Widjaja Lukito; Nuno Lunet, Faculty of Medicine, University of Porto, Portugal; Carla Lopes and Milton Severo, Faculty of Medicine/ Institute of Public Health, University of Porto, Portugal; Duarte Torres, Faculty of Nutrition and Food Sciences / Institute of Public Health, University of Porto, Portugal; Elisabette Lupotto, Aida Turrini, Stefania Sette, and Raffaella Piccinelli, CREA-Alimenti e Nutrizione; Guansheng Ma; Yi Ma; Zaleha Abdullah Mahdy, National University of Malaysia (UKM); Reza Malekzadeh, Digestive Disease Research Institute, Tehran University of Medical Sciences; Wan Manan, Universiti Sains Malaysia; Dirce Marchioni, University of Sao Paolo; Pedro Marques-Vidal, Lausanne University

Hospital (CHUV) and University of Lausanne, Switzerland; Yves Martin-Prevel, Institut de Recherche pour le Développement; Hajah Masni Ibrahim; Angie Mathee; Yasuhiro Matsumura, Bunkyo University, Faculty of Health and Nutrition; Paramita Mazumdar, Centre For Media Studies; Abba M. Sibai, Faculty of Health Sciences - American University of Beirut; Anjum Memon, Brighton and Sussex Medical School, UK; Gert Mensink, Robert Koch Institute; Alexa Meyer, University of Vienna, Austria; Parvin Mirmiran, Research Institute for Endocrine Sciences, Shahid Beheshti University of Medical Sciences; Masoud Mirzaei, Yazd Cardiovascular Research Centre, Shahid Sadoughi University of Medical Sciences; Puneet Misra, All India Institute of Medical Sciences; Anoop Misra, Fortis CDC Center for Excellence for Diabetes; Claudette Mitchell and David Balfour, University of the Southern Caribbean; Noushin Mohammadifard, Nizal Sarrafzadegan, Moses Mwangi, and Maryam Maghrour, Isfahan Cardiovascular Research Center, Cardiovascular Research Institute, Isfahan University of Medical Sciences; Fatemeh Mohammadi-Nasrabadi, National Nutrition and Food technology Research Institute; Zailah Mohd Shariff, Universiti Putra Malaysia; Foong Ming Moy, University of Malaya; Abdulrahman Musaiger, Arab Center for Nutrition; Elizabeth Mwaniki, The Technical University of Kenya; Jannicke Myhre; Balakrishna Nagalla, National Institute of Nutrition, Hyderabad; Androniki Naska; Augustin Nawidimbamba Zeba, Institut de Recherche en sciences de la Santé; Shu Wen Ng, University of North Carolina at Chapel Hill; Le Tran Ngoan, Hanoi Medical University; Sina Noshad, Tehran University of Medical Sciences; Angelica Ochoa, Universidad de Cuenca; Marga Ocke, Dutch National Institute for Public Health and the Environment; RIVM; Jillian Odenkirk; Mariana Oleas, Universidad Tecnica del Norte; Sonia Olivares, Institute of Nutrition and Food Technology (INTA), University of Chile; Philippos Orfanos; Johana Ortiz-Ulloa, Cuenca University; Johanna Otero, Fundacion Oftalmologica de Santander (FOSCAL); Marja-Leena Ovaskainen; Mohammadreza Pakseresht, University of Alberta; Cristina Palacios, Florida International University; Pam Palmer; Wen-Harn Pan, Institutes of Biomedical Sciences, Academia Sinica; Demosthenes Panagiotakos, Harokopio University; Rajendra Parajuli, Tribhuvan University; Gulden Pekcan; Stefka Petrova, National Centre of Public Health and Analyses; Noppawan Piaseu, Mahidol University; Christos Pitsavos; Kalpagam Polasa, National Institute of Nutrition; Luz Posada, Universidad de Antioquia; Farhad Pourfarzi, Ardabil University of Medical Sciences; Alan Martin Preston, Univ Puerto Rico-Med Sci Dept Biochemistry; Ingrid Rached, Centro de Atencion Nutricional Antimano (CANIA); Ali Reza Rahbar; Colin Rehm; Almut Richter, Robert Koch Institute; Leanne Riley; Benoit Salanave; Norie Sawada and Shoichiro Tsugane, National Cancer Center Institute for Cancer Control, Japan; Makiko Sekiyama, Graduate Program in Sustainability Science Global Leadership Initiative (GPSS-GLI), The University of Tokyo; Rusidah Selamat; Khadijah Shamsuddin, Universiti Kebangsaan Malaysia Medical Centre; Sangita Sharma, University of Alberta; Harri Sinkko; Isabelle Sioen; Ivan Sisa, Universidad San Francisco de Quito; Sheila Skeaff, University of Otago; Laufey Steingrimsdottir; Tor Strand, University of Bergen; Milton Fabian Suarez-Ortega, University of Edinburgh; Sumathi Swaminathan, St John's Research Institute; Gillian Swan; Elzbieta Sygnowska; Maria Szabo; Lucjan Szponar, National Food and Nutrition Institute; Ilse Khouw and Swee Ai Ng, FrieslandCampina, The Netherlands; Heli Tapanainen, The National Institute for Health and Welfare (THL); Reema Tayyem, Qatar University and University of Jordan; Bemnet Tedla; Alison Tedstone; Robert Templeton; Celine Termote, Bioversity International; Anastasia Thanopoulou, Diabetes Center, 2nd Department of Internal Medicine, Athens University, Greece; Dimitrios Trichopoulos; Antonia Trichopoulou, Hellenic Health Foundation and University of Athens; Coline van Oosterhout; Erkki Vartiainen; Sivi Virtanen, National Institute for Health and Welfare; Peter Vollenweider; Marieke Vossenaar, CeSSIAM in Guatemala; Eva Warensjo Lemming, Risk and Benefit Assessment Department, Swedish Food Agency; Anna Waskiewicz, Department of CVD Epidemiology, Prevention and Health Promotion, Institute of Cardiology, Warsaw, Poland; Lothar Wieler, Robert Koch Institute; Suh Wu; Roseyati Yaakub; Mabel Yap; Safiah Yusof; Sahar Zaghoul, National Nutrition Institute, Egypt; Gábor Zajkás; Maria Elisa Zapata, CESNI; Khairul Zarina; Fatemeh Vida Zohoori, Teesside University; Mark Manary, Washington University in St. Louis; Zipporah Bukania and Yeri Kombe, Kenya Medical Research Institute; Sirje Vaask, Tallinn University; Julie Long, K. Michael Hambidge, Tshilenge S. Diba, Shivanand C. Mastiholi, Umber S. Khan, and Gabriela Tejeda, University of Colorado Anschutz Medical Campus; Eha Nurk, Estonian National Institute for Health Development; Keiu Nelis; Ute Nöthlings and Ute Alexy, University of Bonn, Department of Nutrition and Food Sciences; Cornelia Tudorie and Anca Nicolau, University Dunarea de Jos, Galati, Romania; Amanda de Moura Souza, Institute of Studies in Public Health, Federal University of Rio de Janeiro (UFRJ); Alan de Brauw, Mourad Moursi, International Food Policy Research Institute (IFPRI); Alicia Roviroso, Centro de Estudios sobre Nutrición Infantil; Carol Henry, Getahun Ersino, and Gordon Zello, University of Saskatchewan, Saskatoon, Canada; Chanthaly Luangphaxay, Daovieng Douangvichit, and Latsamy Siengsounthone, Lao Tropical and Public Health Institute; Christine Hotz; Constance Rybak, Leibniz Centre

for Agricultural Landscape Research; Corina Aurelia Zugravu, University of Medicine and Pharmacy Carol Davila Bucharest Romania; Donka Baykova, Medical Center Markovs; Elizabeth Yakes-Jimenez, The University of New Mexico; Gudrun B. Keding, University of Goettingen, Germany; Lydiah M. Waswa, Egerton University, Kenya; Irmgard Jordan, Justus Liebig University Giessen; J.V. Meenakshi, Delhi School of Economics, University of Delhi; Josie Desnacio and Imelda Angeles Agdeppa, Food and Nutrition Research Institute (DOST-FNRI); Justin Chileshe and Sydney Mwanza, Tropical Diseases Research Centre; Kalyana Sundram, Malaysian Palm Oil Council (MPOC); Laila Eleraky and Wolfgang Stuetz, University of Hohenheim; Lalka Rangelova, National Centre of Public Health and Analyses; Lilian Aluso, Julia Boedecker, and Francis Oduor, Consultative Group on International Agricultural Research (CGIAR); Lluís Serra-Majem, University of Las Palmas de Gran Canaria (ULPGC), Canary Islands, Spain; Tamene Taye Asayehu, College of Applied Sciences, Department of Food Science and Applied Nutrition, Addis Ababa Science and Technology University; Veronika Janská, Public Health Authority of the Slovak Republic; Ward Siamusantu, National Food and Nutrition Commission; Ken Brown, University of California, Davis.

Contributors AA and AM contributed to the study conceptualization; JR, PS, JZ, FC, JEM VM and DM contributed to data curation; AA and AM contributed to the methodology and economic analysis; AA, AM, JNY and DM contributed to writing the original draft; AA, AM and JNY contributed to writing (review and editing). AM is responsible for the overall content as guarantor.

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ORCID iDs

Amelia Ahles <http://orcid.org/0000-0002-3591-5986>

Andrew Muhammad <http://orcid.org/0000-0002-4825-9324>

REFERENCES

- Forouhi NG, Krauss RM, Taubes G, *et al.* Dietary fat and Cardiometabolic health: evidence, controversies, and consensus for guidance. *BMJ* 2018;361:k2139.
- Yu E, Hu FB. Dairy products, dairy fatty acids, and the prevention of Cardiometabolic disease: a review of recent evidence. *Curr Atheroscler Rep* 2018;20:24.
- Siri-Tarino PW, Sun Q, Hu FB, *et al.* Meta-analysis of prospective cohort studies evaluating the Association of saturated fat with cardiovascular disease. *Am J Clin Nutr* 2010;91:535–46.
- Dehghan M, Mente A, Zhang X, *et al.* Associations of fats and carbohydrate intake with cardiovascular disease and mortality in 18

- countries from five continents (PURE): a prospective cohort study. *The Lancet* 2017;390:2050–62.
- 5 Khan R, Misra K, Singh V. Will a fat tax work. *Marketing Science* 2016;35:10–26.
 - 6 Powell LM, Chaloupka FJ. Food prices and obesity: evidence and policy implications for taxes and subsidies. *Milbank Q* 2009;87:229–57.
 - 7 Powell LM, Chriqui JF, Khan T, *et al.* Assessing the potential effectiveness of food and beverage taxes and subsidies for improving public health: a systematic review of prices, demand and body weight outcomes. *Obes Rev* 2013;14:110–28.
 - 8 World Health Organization. World health organization. fiscal policies for diet and the prevention of Noncommunicable diseases. Technical Meeting Report; Geneva, Switzerland, 2016
 - 9 Aguilar A, Gutierrez E, Seira E. The effectiveness of sin food taxes: evidence from Mexico. *J Health Econ* 2021;77:S0167-6296(21)00040-0.
 - 10 Blakely T, Cleghorn C, Mizdrak A, *et al.* The effect of food taxes and subsidies on population health and health costs: a Modelling study. *Lancet Public Health* 2020;5:e404–13.
 - 11 Caro JC, Ng SW, Taillie LS, *et al.* Designing a tax to discourage unhealthy food and beverage purchases: the case of Chile. *Food Policy* 2017;71:86–100.
 - 12 Cornelsen L, Mazzocchi M, Smith RD. Fat tax or thin subsidy? How price increases and decreases affect the energy and nutrient content of food and beverage purchases in great Britain. *Soc Sci Med* 2019;230:318–27.
 - 13 Cawley J, Thow AM, Wen K, *et al.* The Economics of taxes on sugar-sweetened Beverages: A review of the effects on prices, sales, cross-border shopping, and consumption. *Annu Rev Nutr* 2019;39:317–38.
 - 14 Popkin BM, Ng SW. Sugar-sweetened beverage taxes: lessons to date and the future of taxation. *PLOS Med* 2021;18:e1003412.
 - 15 Andreyeva T, Chaloupka FJ, Brownell KD. Estimating the potential of taxes on sugar-sweetened Beverages to reduce consumption and generate revenue. *Prev Med* 2011;52:413–6.
 - 16 Andreyeva T, Long MW, Brownell KD. The impact of food prices on consumption: a systematic review of research on the price elasticity of demand for food. *Am J Public Health* 2010;100:216–22.
 - 17 Blaylock J, Smallwood D, Kassel K, *et al.* Economics, food choices, and nutrition. *Food Policy* 1999;24:269–86.
 - 18 Muhammad A, Seale JL, Meade B, *et al.* International evidence on food consumption patterns: an update using 2005 international comparison program data. *SSRN Journal* 2011.
 - 19 Muhammad A, D'Souza A, Meade B, *et al.* How income and food prices influence global dietary intakes by age and sex: evidence from 164 countries. *BMJ Glob Health* 2017;2:e000184.
 - 20 Muhammad A, Meade B, Marquardt DR, *et al.* Global patterns in price Elasticities of sugar-sweetened beverage intake and potential effectiveness of tax policy: a cross-sectional study of 164 countries by sex, age and global-income Decile. *BMJ Open* 2019;9:e026390.
 - 21 Elmadfa I, Kornsteiner M. Dietary fat intake – A global perspective. *Ann Nutr Metab* 2009;54:8–14.
 - 22 Micha R, Khatibzadeh S, Shi P, *et al.* Global, regional, and national consumption levels of dietary fats and oils in 1990 and 2010: a systematic analysis including 266 country-specific nutrition surveys. *BMJ* 2014;348:g2272.
 - 23 Behrman JR, Wolfe BL. More evidence on nutrition demand: income seems overrated and women's schooling Underemphasized. *J Dev Econ* 1984;14:105–28.
 - 24 Huang KS. Nutrient Elasticities in a complete food demand system. *American J Agri Economics* 1996;78:21–9.
 - 25 Lancaster KJ. A new approach to consumer theory. *J Polit Economy* 1966;74:132–57.
 - 26 Global Dietary Database. Global nutrition and policy consortium. 2022. Available: <https://www.globaldietarydatabase.org/about-us>
 - 27 Khatibzadeh S, Saheb Kashaf M, Micha R, *et al.* A global database of food and nutrient consumption. *Bull World Health Organ* 2016;94:931–4.
 - 28 Miller V, Reedy J, Cudhea F, *et al.* Global, regional, and national consumption of animal-source foods between 1990 and 2018: findings from the global dietary database. *Lancet Planet Health* 2022;6:e243–56.
 - 29 World Bank. *Purchasing Power Parities and the Size of World Economies: Results from the 2017 International Comparison Program*. Washington, DC: World Bank Group, 2020.
 - 30 Huth PJ, Fulgoni VL, Keast DR, *et al.* Major food sources of calories, added sugars, and saturated fat and their contribution to essential nutrient intakes in the U.S. diet: data from the national health and nutrition examination survey (2003–2006). *Nutr J* 2013;12:116.
 - 31 World Bank. *Purchasing Power Parities and the Real Size of World Economies: A Comprehensive Report of the 2011 International Comparison Program*. World Bank, 2015.
 - 32 World Bank. *Purchasing Power Parities for Policy Making: A Visual Guide to Using Data from the International Comparison Program*. Washington, DC: World Bank, 2021.
 - 33 World Bank. World development indicators. 2023. Available: <https://databank.worldbank.org/source/world-development-indicators>
 - 34 LaFrance JT. Incomplete demand systems and Semilogarithmic demand models. *Australian Journal of Agricultural Economics* 1990;34:118–31. 10.1111/j.1467-8489.1990.tb00697.x Available: <https://onlinelibrary.wiley.com/toc/14678489a/34/2>
 - 35 vonRH. A complete characterization of the linear, log-linear, and semi-log incomplete demand system models. *J Agricult Res Econom* 2002;27:281–319.
 - 36 Sahn DE. The effect of price and income changes on food-energy intake in Sri Lanka. *Economic Development and Cultural Change* 1988;36:315–40.
 - 37 Cameron AC, Trivedi PK. *Microeconometrics: Methods and Applications*. Cambridge: Cambridge University Press, 2005.
 - 38 Allais O, Bertail P, Nichèle V. The effects of a fat tax on French households' purchases: A nutritional approach. *American J Agri Economics* 2010;92:228–45.
 - 39 Smed S, Scarborough P, Rayner M, *et al.* The effects of the Danish saturated fat tax on food and nutrient intake and modelled health outcomes: an econometric and comparative risk assessment evaluation. *Eur J Clin Nutr* 2016;70:681–6.
 - 40 Vallgård S, Holm L, Jensen JD. The Danish tax on saturated fat: why it did not survive. *Eur J Clin Nutr* 2015;69:223–6.