

The Right to Health and the Global Rise of Non-Communicable Diseases

BRIGIT TOEBES

1. INTRODUCTION

Due to global changes in lifestyle, the world is facing a dramatic change in disease incidence and patterns. Chronic or ›non-communicable‹ diseases (NCDs), including diabetes, cancer, cardiovascular and respiratory diseases are currently responsible for two thirds of the world's yearly deaths, more than 40% of which were premature deaths under the age of 70 years.¹ Almost three quarters of all NCD deaths occur in low- and middle-income countries, which could lose \$500 billion per year over the period 2011-2025 due to NCD morbidity and mortality.² NCDs are, therefore, not only a health challenge but also a most important development challenge, both in terms of the human suffering they cause and the harm they inflict on the socio-economic position of countries.³ In 2015 all UN Member States agreed in the Sustainable Development Goals (SDGs) to »[b]y 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment [...]«.⁴

1 WHO (2015).

2 WHO (2014), ix and xi; Magnussen/Patterson (2014), 1; referring to the report by the World Economic Forum/Harvard School of Public Health (2011).

3 WHO (2014), ix and xi.

4 UN Sustainable Development Goals, available <https://sustainabledevelopment.un.org/?menu=1300> [13.03.2016]. See also WHO (2013).

While NCDs have now gradually emerged onto the global health and development agenda,⁵ there is still very little shared understanding of how NCDs can best be prevented and reduced through international and domestic law, including human rights law.⁶ Human rights play an increasingly important role in other global health areas, including in the field of HIV/AIDS,⁷ however their contribution to NCD prevention and control is still ill-understood and limited in practice.⁸ More specifically, little attention has been paid to how the concepts as developed under the right to health framework can be applied in the context of the NCD pandemic.

To address this gap, this contribution analyses whether the tools developed under the right to health framework offer any support and guidance in curbing the NCD pandemic. Important notions that are discussed in the context of the right to health include the so-called ›AAAQ‹ (availability, accessibility, acceptability and quality), the concept of progressive realization, and the social determinants of health. Before addressing these matters, this contribution will briefly outline the current NCD pandemic and the international response to this new development in global health.

2. THE NATURE OF THE NCD PANDEMIC AND THE PUBLIC HEALTH RESPONSE

NCDs were responsible for 38 million (68%) of the world's 56 million deaths in 2012, more than 40% of which were premature deaths under the age of 70 years. As mentioned, almost three quarters of all NCD deaths occur in low- and middle-income countries.⁹ According to the World Health Organization (WHO), NCDs are particularly devastating in poor and vulnerable populations.¹⁰ We can speak of a vicious circle where NCDs wors-

5 Gruskin et al. (2014), 773.

6 Ibid.

7 Magnusson/Patterson (2014), 3.

8 Ibid.

9 WHO (2014), ix and xi.

10 Ibid., 1.

en poverty, while poverty contributes to rising rates of NCDs, thus posing a threat to public health and economic and social development.¹¹

Four types of NCDs make the largest contribution to morbidity and mortality: cardiovascular diseases, cancer, chronic respiratory diseases and diabetes.¹² They can be linked to four shared so-called ›behavioural risk factors‹ that enhance the incidence of these diseases: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol.¹³

The international public health community, including the WHO, have slowly but increasingly engaged with this matter over the past two decennia. In 1998 the World Health Assembly¹⁴ adopted a resolution calling on WHO member states to develop a global strategy for the prevention and control of NCDs.¹⁵ This led to the adoption of the *Global Strategy for the Prevention and Control of Noncommunicable Diseases* in 2000 and subsequent action plans for the periods of 2008 to 2013 and 2013 to 2020.¹⁶ To give an idea of what the Strategy aims to achieve, the latter contains the following nine voluntary targets:¹⁷

Box 1: WHO's Action Plan 2013–2020

A 25% reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases
At least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context
A 10% relative reduction in prevalence of insufficient physical activity
A 30% relative reduction in mean population intake of salt/sodium
A 30% relative reduction in prevalence of current tobacco use
A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances

11 A/66/L.1, 16 September 2011, para. 4.
 12 Sixty-Sixth World Health Assembly, WHA 66,10, 27 May 2013, para. 6.
 13 Ibid.
 14 Decision-making body of the WHO.
 15 World Health Assembly, WHA 53, 17, 11–16 May 1998.
 16 WHA 53.14, March 2000; WHO (2008a) and (2013).
 17 WHO (2013).

Halt the rise in diabetes and obesity
At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes
An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major non-communicable diseases in both public and private facilities.

In the interim, the UN General Assembly adopted a resolution (2011) which encourages UN member states to implement cost-effective population-wide interventions to address the NCD risk factors, including through regulatory and legislative actions.¹⁸ Four years later, it adopted the Sustainable Development Goals (SDGs) at its 70th Session to be held from 25 to 27 September 2015. As mentioned above, in these SDGs all UN Member States have pledged to reduce premature mortality from NCDs through prevention and treatment by one-third in 2030.¹⁹

3. THE RIGHT TO HEALTH AND NCDs

The above illustrates that there is an increasing political commitment to stem the global increase in NCDs. The question arises, how do human rights and the right to health in particular respond to this development? Given that human rights law is aimed at protecting the human dignity and social well-being of individuals – how can it serve as a suitable framework for advancing NCD prevention and reduction as the current most pressing threat to global health? And what is the role of the right to health more specifically, as a human right that aims to protect the health of individuals worldwide?

Many rights are implicated in NCDs, including a range of economic and social rights such as the rights to health, food, education and development, as well as civil and political such as rights to privacy, freedom of expression and ultimately the right to life. As Baytor and Cabrera explain, human rights have been used to both to attack and to advocate for NCD reduction,

18 A/66/L.1, 16 September 2011.

19 UN Sustainable Development Goals, available: <https://sustainabledevelopment.un.org/?menu=1300> [13.03.2016].

in particular when it comes to the regulation of tobacco, alcohol and healthy foods as so-called ›behavioural risk factors‹.²⁰ Opponents of such regulation have argued that regulation of these products is paternalistic and interferes with personal autonomy.²¹ Along these lines, the tobacco industry has claimed a ›right to smoke‹.²² Proponents of addressing NCDs through regulation, on the other hand, have argued that the incidence of NCDs impacts on human rights, in particular the rights to health and food.²³ The analysis below will focus mostly on how human rights standards offer protection against the NCD pandemic, and will thus be more in line with the arguments of the proponents.

While the right to health is set forth in a range of international and regional human rights treaties, most emphasis will be placed in this contribution on the right to health in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966) as the most authoritative international expression of the right to health. In this context, elaborate attention will be paid to General Comment No. 14 on the right to the highest attainable standard of health,²⁴ which provides a comprehensive explanation of Article 12 ICESCR. By way of background information, it may be important to explain that general comments are authoritative yet non-binding documents adopted by the human rights treaty-monitoring bodies providing an explanation of a wide range of subjects, including on the nature of the substantive rights.

It should be noted that General Comment No. 14 was adopted in 2000 by the Committee on Economic, Social and Cultural Rights and drafted at a time that there was not yet much awareness about the global NCD pandemic. While the term non-communicable or chronic diseases does not appear in this General Comment, the text more generally refers to ›formerly unknown diseases‹ such as HIV/AIDS and cancer, and recognizes that these create new obstacles for the realization of the right to health which need to be taken into account.²⁵ More recent documents reflect the contemporary

20 Baytor/Cabrera (2015), 69.

21 Ibid., 78.

22 Ibid.

23 Inter alia, Human Rights Council (2011).

24 E/C.12/2000/4, 11 August 2000.

25 Ibid., para. 10.

developments and insights in the field and are, therefore, more specific in regulating NCDs. General Comment No. 15 on the right to health of the child in Article 24 of the Convention on the Rights of the Child (CRC), adopted thirteen years later by the Committee on the Rights of the Child (CRC Committee), is more explicit on NCDs and also refers to, for example, obesity and fast food.²⁶

Returning to General Comment No. 14, while it does not elaborate on NCDs, it does offer a suitable set of tools for addressing NCDs. Importantly, the document explains that the right to health is a broad human right extending not only to access to healthcare services but also to the underlying determinants of health, including access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information.²⁷ As such, the right to health has two dimensions: a right to healthcare services and a right to the above-mentioned broad set of underlying conditions or determinants.²⁸ Given its broad scope it has many cross-connections with the other existing human rights standards (indirectly) aimed at protecting health, including the right to education, housing, and (health-related) information.²⁹ This broad approach towards protecting health is an important starting point for the analysis in relation to NCDs, as it underlines that laws and policies addressing NCDs should focus not only on regulating access to healthcare, but also on securing the underlying determinants to health (Box 2):

Box 2: The right to health: two dimensions

Access to healthcare: laws and policies regulating access to healthcare and medicines for NCDs	Underlying determinants to health: creating the conditions under which people are less vulnerable to NCDs
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This overview shows that a balance needs to be drawn between the delivery of healthcare services to persons with an NCD and attention to preventive

26 CRC/C/GC/15, 17 April 2013, inter alia, paras. 5 and 47.

27 E/C.12/2000/4, 11 August 2000, paras. 8 and 11.

28 Ibid., para. 4.

29 Ibid., para. 3.

policies for the wider population and for future generations.³⁰ Below, these two dimensions in the right to health are taken as a starting point for a further discussion of the implications of right to health in relation to NCD prevention and control (sections 4.1 and 4.2 respectively).

4. NCDs AND THE TWO DIMENSIONS IN THE RIGHT TO HEALTH

4.1 Securing Fair Access to Healthcare: The ›AAAQ‹ and ›Progressive Realization‹

The so-called ›AAAQ‹ as recognized under General Comment No. 14 sets an authoritative standard for ensuring equitable access to healthcare services in relation to NCDs.³¹ It requires that health-related services are available, accessible, acceptable and of good quality for everyone.³² Accessibility has four overlapping dimensions, i.e. non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility (Box 3).³³ These or comparable principles are also mentioned in the Committee on Economic, Social and Cultural Rights General Comments on the rights to water, food, and education.³⁴ The broad acknowledgment of these principles is also evidenced by state practice. To quote from the explanatory memorandum of the Dutch Health Insurance Act (Zvw):

»The Constitution of the Netherlands and international treaties require that the Dutch government establishes a health care system that provides the Dutch population with access to necessary and good quality medical services.«³⁵

Along similar lines, the Australian and Danish National Human Rights Institutions have applied the AAAQ in their policies,³⁶ while the Colombian

30 Magnusson/Patterson (2014), 3.

31 E/C.12/2000/4, 11 August 2000, para. 12.

32 Ibid.

33 Ibid.

34 Hesselman (2017).

35 The Dutch House of Representatives, Tweede Kamer der Staten-Generaal 2003–2004, Explanatory memorandum Health Insurance Act., No. 29 763, 2.

Constitutional Court has applied the AAAQ in a case concerning the right to water.³⁷

Box 3: The AAAQ

Principle	Health facilities, goods and services must
Availability	[...] be available in sufficient quantity within the State party [...].
Accessibility	[...] be accessible to everyone [...].
Non-discrimination	[...] be accessible to all, especially the most vulnerable sections of the population [...].
Physical accessibility	[...] be within safe physical reach for all sections of the population [...].
Economic accessibility	[...] be affordable to all [...].
Information accessibility	[...] include the right to seek, receive and impart information [...].
Acceptability	[...] be respectful of medical ethics [...] and of the culture of individuals [...].
Quality	[...] be scientifically and medically appropriate and of good quality [...].

Source: E/C.12/2000/4, 11 August 2000, para. 12

In the context of this contribution, the question arises: what are the consequences of the AAAQ for NCD treatment and care? In terms of *availability*, adequate treatment for NCDs requires that NCD services and drugs are available in a sufficient quantity to service the entire population within a State.³⁸ It should be noted that securing ‘availability’ in this context is not an easy challenge, as treatment for cancer and other NCDs is often complex and costly, often going far beyond offering primary care. The global rise in NCDs exerts a heavy strain on domestic health budgets, as a result of which

36 Australian Human Rights Commission (2012); Danish Institute for Human Rights (2014).

37 Colombian Constitutional Court, T-916 of 2011, Judge Rapporteur: Jorge Ignacio Pretelt Chaljub, 7 December 2011, para. 6.3.2, in: Murillo Chávarro (2016).

38 E/C.12/2000/4, 11 August 2000, para. 12.

countries struggle to ensure that health-related services are sufficiently available.³⁹ So how does the principle of ›availability‹ apply in this context?

San Giorgi, in her study on the human right to access to healthcare, provides a comprehensive analysis of the AAAQ in relation to access to healthcare.⁴⁰ According to San Giorgi, criteria adopted by the CESCR for the assessment of the *availability* of healthcare comprise, for example, the amount of resources allocated to healthcare, and the length of waiting time for admission to healthcare services.⁴¹ This author explains that although these criteria are applied as indicators to evaluate the available healthcare in a specific State, such assessments remain dependent on various factors, amongst which the developmental level of a State and the demand for healthcare within that State.⁴² As such, States parties to the ICESCR can realize the right to health ›progressively‹ and ›to the maximum of their available resources‹.⁴³

The term ›progressive realization‹ potentially leaves States with a wide margin to decide when and how to ensure the availability of health-related services.⁴⁴ Based on human rights law there are, nonetheless, certain commitments that have to be guaranteed immediately (Box 4):⁴⁵

Box 4: Immediate obligations under human rights law

• States should use the maximum of their available resources; ⁴⁶
• States should move as expeditiously and effectively as possible towards the realization of the rights; ⁴⁷
• States should take deliberate, concrete and targeted steps towards the full realization of the right to health; ⁴⁸ and

39 For the African perspective see also Aantjes et al. (2014).
 40 San Giorgi (2012). See also Toebes/San Giorgi (2014).
 41 San Giorgi (2012), 52.
 42 E/C.12/2000/4, 11 August 2000, para. 12.
 43 See Article 2(1) ICESCR.
 44 See Saul et al. (2014), 133–172.
 45 E/C.12/2000/4, 11 August 2000, para. 31 (see also para. 30); E/1991/23, 14 December 1990, paras. 1 and 2.
 46 Article 2(1) ICESCR.
 47 E/1991/23, 14 December 1990, para. 9.

- States should guarantee that the right to health is exercised without discrimination of any kind.⁴⁹

While it goes beyond the scope of this contribution to discuss all these elements elaborately, some attention is paid here to the key notion of ›maximum of available resources‹. The CESCR does not provide for concrete yardsticks or benchmarks on how this obligation is to be met, yet we may assess this target in light of international statistics on domestic health expenditures.⁵⁰

In fact, WHO statistics indicate that some countries have a relatively low health expenditure as a proportion of total government expenditure (less than 10%, as compared to a global average of 14%).⁵¹ Along similar lines, the European Committee on Social Rights (Council of Europe) concluded that where States spent less than 5% of their gross domestic product (GDP) on healthcare, the situation in that specific State was not in conformity with the right to protection of health in Article 11, para. 1 of the European Social Charter.⁵² However, health expenditure does not tell the whole story. The WHO estimates that 20–40% of all health spending is currently wasted through inefficiency.⁵³ It observes that:

»[...] national wealth is not a prerequisite for moving closer to universal coverage. Countries with similar levels of health expenditure achieve strikingly different health outcomes from their investments. Policy decisions help explain much of this difference [...].«⁵⁴

Hence, while States have considerable leeway to realize the right to health ›to the maximum of their available resources‹, insufficient health expendi-

48 E/C.12/2000/4. 11 August 2000, para. 30.

49 Ibid.

50 E/C.12/2007/1, 10 May 2007.

51 Gostin (2012), 2088, referring to WHO (2011).

52 San Giorgi (2012), 53, inter alia referring to the Conclusions of the European Committee of Social Rights with regard to: XVII-2 Turkey: 2,43% of GDP in 2003 and XVII-2 Poland, 3,96 in 2002.

53 WHO (2010).

54 Ibid.

ture, health sector inefficiency and corruption can be signs that the State is not meeting its obligations under the right to health.

Another important human rights term is the notion of ›retrogressive steps‹. When entering a financial crisis or situation of emergency, States may consider the taking of ›retrogressive measures‹, i.e. diminishing the level of essential services provided. If such measures are taken, the State has the duty to prove that they have been taken »after the most careful consideration of all alternatives and that they are duly justified [...] in the context of the full use of the State party's maximum available resources.«⁵⁵ Should the state use ›resource constraints‹ as an explanation for retrogressive steps, according to the CESCR they should be considered in light of:

Box 5: States' retrogressive measures under human rights law

• The country's level of development;
• The severity of the alleged breach;
• The country's economic situation;
• The existing of other serious claims on the state's budget (e.g. natural disasters);
• Whether the country had identified low-cost options; and
• Whether the state had sought cooperation and assistance. ⁵⁶

As mentioned, *accessibility* implies non-discrimination, financial accessibility (affordability), and physical accessibility.⁵⁷ Firstly and as mentioned, *non-discrimination* is a key obligation of immediate effect when it comes to providing access to NCD services. San Giorgi describes how the criterion of non-discrimination is considered of great importance by various human rights committees, institutions and organisations. In addition to the CESCR, the Parliamentary Assembly of the Council of Europe argued in its recommendation *The reform of health care systems in Europe: reconciling equity, quality and efficiency* that:

»[...] [T]he main criterion for judging the success of health system reforms should be effective access to health care for all without discrimination, which is a basic hu-

55 E/C.12/2000/4, 11 August 2000, para. 32.

56 E/C.12/2007/1, 10 May 2007, para. 10.

57 San Giorgi (2012), 54.

man right. This also has the consequence of improving the general standard of health and welfare of the entire population.«⁵⁸

This implies, according to the Parliamentary Assembly, that the pursuit of cost containment and maximizing efficiency should not go at the expense of equality in access to healthcare.⁵⁹

As explained by San Giorgi, there should be no *discrimination* on the grounds of any of the prohibited grounds, and healthcare organizations should be responsive to the needs of the recipients.⁶⁰ There should be no discrimination in access to healthcare which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to healthcare.⁶¹ Unequal enjoyment of the right to health is at stake when an apparently equal treatment in obtaining access to healthcare results in unequal access to healthcare. This can, for example, be the case when the personal characteristics of a patient or group of patients, such as healthcare needs and financial possibilities, are not sufficiently taken into account, i.e. they are treated the same as others.⁶² When it comes to NCD treatment, the principle of non-discrimination plays a key role in making fair decisions in the allocation of scarce resources. From a different perspective, there is also a need to address discrimination and stigma around obesity, diabetes, and alcoholism.⁶³

In the context of NCD treatment, thorny questions arise when it comes to reimbursing expensive new medicines, some targeting only small patient populations. While the principle of non-discrimination implies that everyone's needs should be taken into account, difficult choices arise when an expensive medicine potentially eats up a considerable portion of the overall health budget. As argued by Perehudoff et al., the human rights approach

58 Council of Europe (2003), para. 4.

59 Ibid., paras. 2 and 5.

60 San Giorgi (2012), 55.

61 San Giorgi (2012), 55, referring to Concluding Observations of the CESCR with regard to India, E/C.12/IND/CO/5, para. 52; E/CN.4/2003/58, 13 February 2003, para. 61.

62 San Giorgi (2012), 16.

63 Magnusson/Patterson (2014), 7.

does not automatically create an immediate right for treatment at any cost.⁶⁴ In light of the principle of progressive realization that was discussed above, the order and timing of the fulfilment of the right to services can only be gradual. Thus, progressive realization justifies ranking treatments for reimbursement, with more cost-effective treatment being included first. This ranking system ensures that available resources are used as effectively as possible.⁶⁵

Financial accessibility, thirdly, requires that healthcare, including drugs, are affordable for everyone.⁶⁶ The costs of healthcare should, therefore, not place an excessive financial burden on individuals as access to healthcare should be based on need and not on ability to pay.⁶⁷ If necessary, steps must be taken to reduce the financial burden on patients.⁶⁸ NCD treatment often requires a costly combination of drugs, as a result of which large segments of the population in low and middle income countries are pushed into poverty.⁶⁹

Fourthly, *physical accessibility* implies that healthcare has to be within safe reach and physically accessible for everyone.⁷⁰ NCD treatment often requires complex interventions, thus the need to offer specialist care. This may lead to a concentration of hospitals, which may affect the physical accessibility of NCD treatment and care. Although not an explicit element of the AAAQ, timely accessibility is also an important component of the right to health. General Comment No. 14 stresses in para. 17 that the right to health facilities, goods and services includes timely access to basic preventive, curative or rehabilitative health services.⁷¹

64 Pehudoff et al. (2016).

65 Ibid.

66 E/C.12/2000/4, 11 August 2000, para. 12(b); E/C.12/2008/2, 24 March 2009, paras. 56(b) and 57(f).

67 Council of Europe, Digest of case law of the European Committee of Social Rights, September 2008, 83.

68 San Giorgi (2012), 57.

69 Magnusson/Patterson (2014), 5.

70 E/C.12/2000/4, 11 August 2000, para. 12(b); E/C.12/2008/2, para. 56(a). See also Toebe/San Giorgi (2014), 409.

71 Toebe/San Giorgi (2014), 11.

According to General Comment No. 14 *acceptable healthcare* signifies that it must be »culturally appropriate, *i.e.* respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements.«⁷² This means that the cultural tradition of persons may have to be respected. When it comes to NCD treatment and control, what could be discussed in this context is whether alternative treatments and medicines should be reimbursed.

Lastly, *quality* requires that health services are scientifically and medically appropriate and of good quality.⁷³ As San Giorgi explains, this requires scientifically approved and unexpired drugs and up-to-date hospital equipment and an adequate training of healthcare personnel, including as regards health and human rights.⁷⁴ Other elements that are of importance in order to obtain an impression of the level of quality of the healthcare provided and of the healthcare system, is life expectancy, infant mortality rates, the number of healthcare professionals with secondary or higher education, waiting lists, and waiting times.⁷⁵

4.2 Underlying or ›Social Determinants‹ – and Regulating Lifestyle

As pointed out above, from a human rights perspective there is a need to ensure equitable and inclusive access to health services. But it is also important to address the socio-economic conditions which enhance NCD incidence. In the well-known ›Whitehall study‹, conducted in the UK in the 1960s, civil service clerks were four times more likely to die young than civil servants with higher positions but with the same access to healthcare services.⁷⁶ It is widely acknowledged that the causes of ill health and health inequalities go far beyond the possibility to access healthcare services, which affirms the need to address the ›underlying determinants of health‹ in

72 E/C.12/2000/4, 11 August 2000, para. 12(c).

73 Ibid., para. 12(d).

74 San Giorgi (2012), 57; E/C.12/2000/4, 11 August 2000, para. 12(d); E/C.12/2008/2, 24 March 2009, para. 56(c) and 56(d).

75 San Giorgi (2012), 60, referring to Council of Europe/Committee of Ministers (1999), para. 3.

76 As quoted in, inter alia, Marmot (2004), 38–39; Gostin (2014), 24.

the context of the right to health. Public health experts use the broader term ›social determinants of health‹, which go as far as to include our general living environment and the structures of society at large as decisive conditions to our health.⁷⁷

This raises the difficult question of how the social determinants of health can be addressed from the perspective of human rights and international law more generally. After all, the social determinants are very broad, which may lead to a very complex human rights analysis. Part of the solution may lie in connecting the different human rights together. Knowing that the ways we are raised, educated and work are decisive to our health implies looking into how the right to health is connected to other health-related rights, including the rights to education, housing and work, which reflect the need to provide good quality education and to guarantee healthy working conditions. This approach is very much in keeping with the notion of the ›indivisibility, interdependence and interrelatedness‹ of all human rights, as was affirmed in the Vienna Declaration and Programme of Action, adopted in 1993.⁷⁸

So what does all this mean for NCD prevention and control? In this context, it is key that attention be paid more specifically to lifestyle, given that the most prominent NCDs have been linked by WHO to four risk factors, i.e. tobacco use, harmful use of alcohol, unhealthy diets, and lack of physical activity.⁷⁹ While the right to health provides a general framework for addressing such issues, more specific regulation could be provided through specific treaties under international law. However, so far tobacco is the only risk factor that is addressed through a legally binding international treaty. The Framework Convention on Tobacco Control (FCTC, adopted by the WHO in 2005), was the first global health treaty adopted by the WHO and is now adopted by 180 countries. The Preamble of the FCTC mentions the right to health, thus building a bridge between this treaty and human rights law. The FCTC is an authoritative treaty in the field of tobacco control which has a strong impact on domestic tobacco control regulation. But

77 WHO (2008b).

78 Vienna Declaration and Programme of Action, A/Conf.157/23, 12 July 1993, para. 5. See also Marmot et al. (2012).

79 WHO (2015).

it also sets an important standard and example for potential new standard setting instruments regulating food, alcohol and other beverages.⁸⁰

Clearly, there is a need to develop more domestic and international instruments regulating lifestyle. Yet regulating lifestyle choices raises the difficult question if, and if so how, international and domestic authorities should attempt to influence the behavioural and consumption patterns of individuals.⁸¹ Due to an emphasis on autonomy and ›personal responsibility‹ in many high-income countries there is a certain resistance to the implementation of such preventive measures.⁸²

Influencing consumer behaviour can be done, for example, through the regulation of consumer information, the taxation of unhealthy products, but more broadly also through the creation of healthy living environments, which may include tobacco free school yards and the banning of soda machines from schools. So far, Governments have attempted to regulate certain aspects of tobacco, food and beverages, such as the advertisement, number of sale points, packaging, size and salt, sugar and (trans) fat content.⁸³

5. NON-STATE ACTORS, NCDs AND THE RIGHT TO HEALTH

Health insurance companies, hospitals, pharmaceutical companies, the pharmaceutical industry as well as the tobacco, food and beverage industries all exert a tremendous influence and power over our health and well-being. This is why there has been an increasing call on governments to submit these actors to tighter rules. To bring this back to human rights law: under the right to health, States are under a ›duty to protect‹ the health and well-being of individuals against the human rights violations of non-state actors. General Comment No. 14 provides many important examples of when the State violates the right to health when failing to regulate private actors:

80 Consumers International/World Obesity Forum (2014).

81 Sunstein (2014).

82 Magnusson/Patterson (2014).

83 Taylor (2015).

»[...] failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances; the failure to protect women against violence or to prosecute perpetrators; the failure to discourage the continued observance of harmful traditional medical or cultural practices; and the failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.«⁸⁴

Subsequently, the question arises whether private actors also carry moral or even legal responsibilities under human rights law. Whilst recognizing the primary obligation to protect of States, the human rights framework recognizes that the protection and promotion of health involves a shared responsibility, requiring a multi-stakeholder approach. General Comment No. 14 recognizes that:

»[...] *all members of society* – individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector – *have responsibilities regarding the realization of the right to health* [...].«⁸⁵ [emphasis added, B.T.]

Hence, many different actors have responsibilities under the right to health – setting aside the question of whether such responsibilities are legal or moral in character. Potentially thus, the food and beverage producers themselves, although strictly speaking not legally bound by the human rights treaties, have indirect responsibilities under human rights law to ensure the quality and healthiness of their products.⁸⁶

84 E/C.12/2000/4, 11 August 2000, para. 51.

85 Ibid., para. 42.

86 See, for example, Corporations in the Global Food System and Human Rights (2014).

6. CONCLUSIONS

The broad understanding of the right to health is important when it comes to NCD prevention and control. It mandates that attention should be directed not only at providing equitable and inclusive access to healthcare and medicines, but also at securing a range of determinants to health. Investments in treatment should be matched by laws and policies targeting the whole population, aimed at empowering individuals to lead healthier lives.⁸⁷

While the right to health framework is not very specific in regulating NCDs, it offers a set of principles or guideposts that may guide the field, that have been discussed in this contribution. Given the striking nature of the NCD pandemic, it is worth paying more attention to this framework. Potentially, it offers a robust set of norms and standards that define the legal obligations of governments, while adding accountability mechanisms to traditional public health strategies.⁸⁸

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