2 Making Effective Use of Law in the Global Governance of NCD Prevention

*Jonathan Liberman**

1 Background

The World Health Organization ('WHO') estimates that in 2008 36 million deaths, or 63 per cent of the 57 million deaths that occurred globally, were due to non-communicable diseases ('NCDs'), primarily cardiovascular diseases, cancers, chronic respiratory diseases and diabetes.[1] Approximately 80 per cent of these deaths (29 million) occurred in low- and middle-income countries, with a higher proportion (48 per cent) of the deaths in these countries being premature (under the age of 70) compared to high-income countries (26 per cent).[2] The WHO projects that the total annual number of deaths from NCDs will increase to 55 million by 2030 if 'business as usual' continues.[3]

The continuation of 'business as usual' will also result in a loss of productivity and an escalation of health care costs in all countries.[4] Losses to low- and middle-income countries from the four major NCDs are estimated to surpass US$7 trillion over the period 2011–25, an average of nearly US$500 billion per year.[5] This yearly loss is equivalent to approximately 4 per cent of these countries' current annual output.[6] For all countries, the cost of inaction far outweighs the cost of taking action.[7] Affordable interventions provide a good return on investment. The total cost of implementing a combination of very cost-effective population-wide and individual interventions, in terms of current health spending, amounts to 4 per cent in low-income countries, 2 per cent in lower middle-income countries and less than 1 per cent in upper-middle-income and high-income countries.[8]

After being long neglected as a global health, economic and political priority, the case for attention and action on NCDs has become irresistible. The last few years have seen the steady rise of NCDs on the global agenda, highlighted by the landmark September 2011 United Nations ('UN') General Assembly High-level Meeting on the Prevention and Control of NCDs and the substantial series of follow-up activities that the High-level Meeting has generated. In the *Political Declaration* adopted at the High-level Meeting ('Political Declaration'), the 193 member states of the UN acknowledged that:

> the global burden and threat of non-communicable diseases constitutes one of the major challenges for development in the twenty-first century, which

> undermines social and economic development throughout the world, and threatens the achievement of the internationally agreed development goals.[9]

While also underlining the importance of providing treatment to people with NCDs – and making commitments to do so – states '[r]ecognize[d] that prevention must be the cornerstone of the global response to non-communicable diseases'.[10] They recognised that the most prominent NCDs 'are linked to common risk factors, namely tobacco use, harmful use of alcohol, an unhealthy diet, and a lack of physical activity',[11] and the 'critical importance of reducing the level of exposure of individuals and populations' to these common modifiable risk factors, and their determinants.[12]

As the Director-General of the WHO, Dr Margaret Chan, recently noted, socioeconomic progress is creating the conditions that favour the rise of NCDs.[13] This reality contrasts sharply with many other diseases, the burden of which tends to reduce as living conditions improve. Economic growth, modernisation and urbanisation 'have opened wide the entry point for the spread of unhealthy lifestyles'.[14] 'Unhealthy commodities industries' – including tobacco, alcohol and ultra-processed food and drink – are now 'major drivers of NCD epidemics worldwide';[15] 'the vectors of spread are not biological agents, but transnational corporations'.[16]

These realities have major implications for the governance of NCDs, and the role of law in that governance. First, perhaps more than for any other global health priority, progress will be limited if NCDs are addressed solely as a health issue, through the health sector. As recognised in the Political Declaration, 'a whole-of-government and a whole-of-society effort' is required.[17] Leadership and multi-sectoral approaches are needed across such sectors as health, education, energy, agriculture, sports, transport, communication, urban planning, environment, labour, employment, industry and trade, finance and social and economic development'.[18]

The *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020* ('Global Action Plan'), endorsed by the World Health Assembly at its May 2013 session, expands this list of sectors to also cover food, foreign affairs, housing, justice and security, legislature, social development, tax and revenue and youth affairs.[19]

This underlines the sheer complexity and political challenge of addressing NCDs, and explains why NCDs merited a UN General Assembly High-Level Meeting. NCDs cannot be addressed by the WHO, and the constituencies with which it most directly engages, alone.

Second, efforts to prevent NCDs conflict with the interests of powerful commercial operators.[20] Large and well-resourced corporations, and the interest groups that represent them, work hard to resist the adoption and implementation of measures that will affect their bottom lines. They can exert significant power, lobbying, advocating and campaigning both behind the scenes and in prominent public view, substantially increasing the political costs to governments of taking action.

Measures adopted to combat NCDs are also liable to face legal challenge by these powerful interests and their supporters, whether in domestic courts or in international fora. The lawfulness of measures adopted to promote and protect public health is being adjudicated upon in non-health fora, in which health norms, instruments and values are not the predominant considerations. In addition to the uncertainty that such challenges – or their threat (or mere possibility) – create, they can dramatically increase the implementation costs of measures that would otherwise be inexpensive.

This chapter attempts to offer some observations about the effective use of law in reducing exposure to tobacco, alcohol and unhealthy foods,[21] recognising that the effective use of law is indispensable to global NCD governance. Part 2 sets out the current political and institutional context of global NCD governance, briefly sketching its evolving architecture. Part 3 locates the challenges of global NCD governance within three of the broader themes of global health governance, namely its ever-increasing complexity and the inter-relationships between global health and foreign policy, and global health and development. Part 4 focuses on the role of law, outlining both its use as a proactive intervention and its role in setting the context in which power is exercised. It offers a number of observations relating to the important role of legal capacity within the NCD workforce, and through policy research, development and implementation; the power of treaties and of non-binding instruments; challenges involved in dealing with existing international trade and investment treaties; the need for deference to public health imperatives and governments' regulatory choices in trade and investment adjudication; and managing the similarities and differences between tobacco, alcohol and unhealthy foods within the NCD agenda. Part 5 offers some concluding thoughts. It suggests that the 'law and NCD prevention' endeavour requires speaking, listening and learning across different disciplines, which make sense of and explain the world in different ways. Interdisciplinary respect and patience are key to its success.

2 The evolving global NCD governance architecture

A substantial global NCD governance architecture is being developed to steer the global response called for by the Political Declaration. The arrangements affirm the WHO's 'leadership and coordination' role, as the 'primary specialized agency for health',[22] but the approach underlines that effectively combating NCDs is beyond the power, mandate and capacity of the WHO alone.

The key components of this evolving global NCD architecture are:

- targets and indicators to allow for monitoring and assessment of progress;
- a new WHO Global Action Plan on NCDs;
- a new UN Interagency Task Force on the Prevention and Control of NCDs; and
- a new global coordination mechanism for NCDs.

2.1 Targets and indicators adopted by the World Health Assembly in May 2013

The Political Declaration initiated a process that led to the adoption by the World Health Assembly – the WHO's governing body – at its May 2013 session of a 'comprehensive global monitoring framework'[23] including:

1. A set of nine voluntary targets for achievement by 2025 for the prevention and control of NCDs, including:
   a. an overarching target of a 25 per cent relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases; and
   b. targets for behavioural risk factors (harmful use of alcohol, physical inactivity, salt/sodium intake, and tobacco use).[24]
2. A set of 25 indicators that, inter alia, track the nine targets.[25]

The aim of the Global Monitoring Framework is to 'monitor trends and to assess progress made' in the implementation of national strategies and plans on NCDs.[26]

2.2 The WHO Global Action Plan on NCDs 2013–20

The new Global Action Plan, endorsed by the World Health Assembly at its May 2013 session, aims to 'operationalize the commitments of the Political Declaration'.[27] Its vision is '[a] world free of the avoidable burden of [NCDs]'.[28]

The Global Action Plan focuses on the four major NCDs and their four shared behavioural risk factors.[29] It 'provides a road map and a menu of policy options for all Member States and other stakeholders, to take coordinated and coherent action, at all levels, to attain the nine voluntary global targets'.[30]

2.3 Establishment of the UN Interagency Task Force on the Prevention and Control of NCDs

On 12 July 2013, the UN Economic and Social Council ('ECOSOC') requested the UN Secretary-General to establish the UN Interagency Task Force on the Prevention and Control of NCDs (the 'Task Force').[31] The Task Force is to be established by way of expanding the mandate of the existing United Nations Ad Hoc Interagency Task Force on Tobacco Control ('IATFTC'), established by the Secretary-General in 1999 to coordinate the tobacco control work being carried out by different UN agencies.[32] It is to be convened and led by the WHO, report to the ECOSOC through the Secretary-General and incorporate the work of the IATFTC. The new Task Force will be mandated to coordinate the activities of relevant UN funds, programs and specialised agencies and other intergovernmental organisations to support the realisation of the commitments made in the Political Declaration, in particular through the implementation of the Global Action Plan.

2.4 Establishment of a global coordination mechanism for NCDs

The Global Action Plan foreshadows the development by the WHO Secretariat, in consultation with WHO member states, of a global mechanism to coordinate the activities of the UN system and promote engagement, international cooperation and accountability among all stakeholders.[33] WHO member states have requested the WHO Director-General to develop draft terms of reference for a global coordination mechanism, aimed at facilitating engagement among member states, UN funds, programs and agencies and other international partners and non-state actors, while safeguarding the WHO and public health from undue influence by any form of real, perceived or potential conflicts of interest.[34]

3 Understanding the challenges of NCD governance within the broader context of global health governance

The challenges and opportunities facing global NCD governance are best understood within the context of those of global health governance more broadly. They touch upon larger questions and themes that underscore the ever-increasing complexity of global health governance, and the inter-relationship between global health, foreign policy and sustainable development.

3.1 The ever-increasing complexity of global health governance

Global health governance has become increasingly fragmented.[35] It is no longer seen as being solely about 'health governance' or 'governance *of* health', but as including 'governance *for* health'.[36] The WHO describes 'governance *for* health' as an advocacy and public policy function that seeks to influence governance in other sectors in ways that positively impact on human health,[37] recognising that many of the areas in which change can have a positive impact on health are those in which existing rules and regimes are managed by different international institutions.[38] This evolution in global health governance has seen it become, as David Fidler observes, 'more political and less dominated by humanitarian-focused technical experts applying the tools of science, medicine and epidemiology'.[39]

Indeed, the WHO views work on NCDs as 'illustrat[ing] the importance of governance for health'.[40] While many health conditions are influenced by governance decisions in other sectors, NCDs 'have a particularly wide and multi-layered range of interrelated social, economic and environmental determinants'.[41] These are linked to income, housing, employment, transport, agricultural and education policies, which in turn are influenced by patterns of international commerce, trade, finance, advertising, culture and communications.[42] While policy levers can be identified for these factors individually, 'orchestrating a coherent response across societies remains one of the most prominent governance challenges in global health'.[43]

3.2 Increasing recognition of global health as a foreign policy issue

Global health – including the NCD challenge – is now increasingly understood as interacting with the core functions of foreign policy: achieving security, creating economic wealth, supporting development in low-income countries and protecting human dignity.[44] The UN General Assembly's December 2012 resolution on global health and foreign policy welcomed the Political Declaration and acknowledged that 'many of the underlying determinants of health and risk factors of both non-communicable and communicable diseases … are associated with social and economic conditions, the improvement of which is a social and economic policy issue'.[45] The General Assembly acknowledged the need to continue to promote, establish or support and strengthen multi-sectoral national policies and plans for the prevention and control of NCDs and to take steps to implement such policies and plans.[46]

3.3 Health and NCDs in the sustainable development agenda: now and post-2015

The first objective of the Global Action Plan is to 'raise the priority accorded to the prevention and control of non-communicable diseases in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy'.[47] Without the prevention and control of NCDs, health cannot be attained as a result of human development, nor can it serve as a means to achieve that development.[48] NCDs impose enormous costs on families, households, communities and economies. They contribute to inequity and have a disproportionate effect on poor people, who are more likely to be exposed to NCD risk factors and consequently bear a higher burden of disease, yet have fewer resources to deal with them.[49] The burden of NCDs is increasing fastest in low-and-middle income countries ('LMICs').[50]

It has often been noted that NCDs have been largely absent from the development agenda. This, too, is changing.[51] In the Outcome Document to the June 2012 Rio+20 UN Conference on Sustainable Development, 'The Future We Want', states recognised[52] that 'health is a precondition for and an outcome and indicator of all three dimensions of sustainable development' – economic, social and environmental – and that the goals of sustainable development 'can only be achieved in the absence of a high prevalence of debilitating communicable and non-communicable diseases'.[53] Echoing the Political Declaration, they acknowledged that 'the global burden and threat of non-communicable diseases constitutes one of the major challenges for sustainable development in the twenty-first century'[54] and committed to establish or strengthen multi-sectoral national policies for the prevention and control of NCDs.[55]

The first report of the UN System Task Team on the Post-2015 Development Agenda, *Realizing the Future We Want for All*,[56] identifies the increase in NCDs as one of the issues not adequately addressed by the Millennium Development Goals ('MDGs').[57] It includes NCDs as one of the priorities for social development.[58] NCDs were also recognised in the final report of the UN High-Level Panel

convened to make recommendations on the content of a framework to replace the MDGs.[59] The report suggests 12 goals including '[e]nsuring healthy lives'.[60] Five illustrative targets are offered for this goal: ending preventable infant and under five deaths; increasing the proportion of people vaccinated; decreasing maternal mortality; ensuring universal sexual and reproductive health rights; and, reducing the burden of disease from HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and *priority non-communicable diseases*.[61]

Building on these developments, the Global Action Plan includes among its policy options for WHO member states the dissemination of information about the effectiveness of interventions or policies to intervene positively on linkages between NCDs and sustainable development,[62] and the integration of NCD prevention and control into national health-planning processes and broader development agendas and processes.[63] Proposed actions for international partners and the private sector include 'encouraging the continued inclusion of [NCDs] in development cooperation agendas and initiatives, internationally-agreed development goals, economic development policies, sustainable development frameworks and poverty-reduction strategies'.[64]

4 Law and NCD prevention

4.1 Law as a proactive intervention and as setting the context in which power is exercised

As the individual chapters of this book show, the law is relevant to the regulation of the NCD risk factors of tobacco, alcohol and unhealthy foods in multiple ways and at multiple levels. Its role and function can broadly be seen as falling into two categories: law as a proactive intervention to reduce exposure to NCD risk factors, and law as setting the context in which power is exercised and constraints on the exercise of that power.

4.1.1 Law as a proactive intervention to reduce exposure to NCD risk factors

In the Political Declaration, states committed to:

> [a]dvance the implementation of multisectoral, cost-effective, population-wide interventions in order to reduce the impact of the common non-communicable disease risk factors … through the implementation of relevant international agreements and strategies, and education, *legislative*, *regulatory* and fiscal measures.[65]

The Global Action Plan recognises the role of regulatory measures and laws in creating supportive environments that protect physical and mental health and promote healthy behaviour.[66]

Interventions to reduce exposure to tobacco, alcohol and unhealthy food that can, or must, be implemented through the use of legislation or regulation are outlined in Table 2.1.

Table 2.1 Legal /regulatory interventions to reduce exposure to tobacco, alcohol and unhealthy food

	Tobacco	*Alcohol*	*Unhealthy food*
Recognised in	WHO FCTC, the Political Declaration and the Global Action Plan	Political Declaration, the WHO Global Strategy to Reduce the Harmful Use of Alcohol and the Global Action Plan	Political Declaration, the WHO Global Strategy on Diet, Physical Activity and Health, the WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children and the Global Action Plan

Regulatory measures	• protection of public health policies relating to tobacco control from the commercial and other vested interests of the tobacco industry
	• price and tax measures
	• protection against exposure to tobacco smoke
	• regulation of tobacco product contents and emissions
	• regulation of disclosure of information about contents and emissions
	• packaging and labelling measures, including health warnings and bans on misleading packaging
	• bans on tobacco advertising, promotion and sponsorship
	• measures to combat illicit trade in tobacco products
	• bans on sales to and by children
	• bans on the manufacture and sale of sweets, snacks, toys or any other objects in the form of tobacco products which appeal to children
	• bans on the distribution of free tobacco products
	• bans on the sale of individual cigarettes and cigarettes in small packets
	• bans or restrictions on sale through vending machines
		• regulation of the availability of alcohol including:
		  • limitations on the distribution of alcohol and the operation of alcohol outlets (including retailer licensing schemes)
		  • regulation of the number and location of outlets
		  • regulation of days and hours of retail sales
		  • regulation of modes of retail sales
		  • regulation of retail sales in certain places or during special events
		  • minimum purchase or consumption age
		  • prevention of sales to intoxicated persons
		  • seller and server liability
		  • regulation of drinking in public places or at certain functions
		  • combating illicit production, sale and distribution
		• regulation of alcohol advertising, promotion and sponsorship
		• price and tax measures
			• regulation of consumer information, including product labelling
			• regulation of unhealthy food advertising, promotion and sponsorship, including in settings where children gather (including nurseries, schools, school grounds and pre-school centres, playgrounds, family and child clinics and paediatric services and during any sporting and cultural activities that are held on these premises)
			• regulation of health claims
			• regulation of salt, sugar and saturated fat content
			• replacement of trans fats with unsaturated fats
			• regulation of the provision and availability of healthy food in public institutions including schools, other educational institutions and the workplace
			• availability of fruit and vegetables and other healthy food products
			• regulation of portion size
			• regulation of energy density

4.1.2 Law as setting the context in which power is exercised and constraints on the exercise of that power

In both its domestic and international forms, law provides a framework within which power is exercised. Law confers power, and requires or supports its exercise. For example:

- constitutions conferring legislative, executive and judicial power and responsibilities on parliaments, executive governments and courts;
- legislation or regulation empowering regulatory or administrative action; and
- international instruments requiring, encouraging or supporting governments to take legislative or other action.

Law also constrains the exercise of that power. For example:

- constitutional or other domestic protections of expression (personal, political and, in some jurisdictions, commercial) or private property;
- international (including regional) instruments requiring, encouraging or supporting governments to protect expression or private property;
- distribution and/or separation of powers between different levels or branches of government (whether within individual states or through supranational arrangements);
- regulation of the processes or procedures through which law is developed or implemented; and
- regulation of the adoption and implementation of 'discriminatory' or 'trade restrictive' regulatory measures.

4.1.3 Law and NCD prevention – a complex interplay of domestic and international powers, duties and constraints

The field of 'law and NCD prevention' thus involves a complex interplay of legal powers, duties and constraints, and of relationships between national (and subnational) and international law, and between different international instruments adopted through different processes and institutions, and having different kinds of legal (and political) status. At the international level, 'law and NCD prevention' involves relationships between:

- instruments adopted or endorsed through the WHO/World Health Assembly including the *WHO Framework Convention on Tobacco Control* ('WHO FCTC'),[67] the Global Action Plan, the WHO *Global Strategy to Reduce the Harmful Use of Alcohol*,[68] the WHO *Global Strategy on Diet, Physical Activity and Health*,[69] and the WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children*;[70]
- instruments adopted in other multilateral fora such as the Political Declaration, the Moscow Declaration of the First Global Ministerial

Conference on Healthy Lifestyles and Noncommunicable Disease Control[71] and the Outcome Document to the Rio+20 UN Conference on Sustainable Development;[72]

- international human rights law, particularly the right to the highest attainable standard of health enshrined in the *International Covenant on Economic, Social and Cultural Rights*;[73]
- the World Trade Organization ('WTO') agreements, including the *Agreement on Technical Barriers to Trade* ('TBT'),[74] the *Agreement on Trade-Related Aspects of Intellectual Property Rights* ('TRIPS'),[75] the *General Agreement on Tariffs and Trade* ('GATT')[76] and the *General Agreement on Trade in Services* ('GATS');[77]
- other agreements applying to the trade in goods or services and to the protection of intellectual property (whether regional, plurilateral or bilateral); and
- agreements applying to foreign investments (whether in regional, plurilateral or bilateral investment treaties, or investment chapters in trade agreements).

At the domestic level, the interplay can take very different forms in different countries, which have different laws, legal systems, procedures, traditions and values.[78] For example, domestic legal challenges to identical measures brought in different jurisdictions can engage very different substantive laws (eg the right to life, the right to health, the right to information, private property rights, freedom of expression), be resolved through very different processes and engage with evidence in very different ways.[79]

4.2 Doing 'law and NCD prevention' well

Against this background, the remainder of Part I attempts to offer some observations and suggestions about how those interested in reducing the burden of NCDs might think about some of the challenges and opportunities that the use of law presents.

4.2.1 Strong legal capacity is essential to an effective NCD workforce

Strong legal capacity is an essential component of an effective NCD workforce. It is no less important today to know what the TBT Agreement is, or whether a domestic constitution protects private property rights, or what 'fair and equitable treatment' means in international investment law, than it is to know how to run an effective healthy living education program or how to estimate the economic costs of NCDs.

The Global Action Plan acknowledges the importance of legal training for NCD prevention. Its second objective addresses the need to 'strengthen institutional capacity and the workforce', and notes the value of addressing law within public health institutions.[80] But much more can be done.

Stronger interdependent collaborations between public health and legal institutions should be pursued. For example, 'law and NCD prevention' should be integrated into law school curricula, whether as a standalone subject or taught within

broader health law subjects, or identified as it intersects with more specific subjects, such as constitutional law, human rights law, international trade law, international investment law and intellectual property law. Interdisciplinary research opportunities that reflect the multi-sectoral nature of the NCD challenge should be supported and pursued. Law students should be encouraged and assisted to undertake internships with health organisations that work on NCDs – something that is common in many countries for human rights education and training.

'Law and NCD prevention' raises a large number of fascinating domestic and international legal questions that will engage and stimulate legal academics and law students, offering rich opportunities for research and interdisciplinary collaboration. The NCD community needs to think systematically about how to develop the 'law and NCD prevention' workforce of today and tomorrow, both through academic institutions and the creation of stable and rewarding career paths.

4.2.2 The need for legal expertise to be engaged across all stages of policy research, development and implementation

The effective development, implementation and defence of laws and regulations designed to reduce exposure to NCD risk factors requires the ongoing engagement of legal expertise. The role of lawyers should not be seen as limited to legal drafting, or being called upon when a legal challenge is threatened or initiated. Rather, lawyers have a valuable role to play in all stages of policy development and implementation.

Involvement of legal expertise in the design of research can contribute to the formulation of research questions that precisely address the issues likely to be litigated in the event of a challenge, increasing the utility of the research findings in the event of such litigation. An intricate understanding of likely or possible legal challenges, and the substantive issues on which their resolution is likely to turn, can inform the drafting of legislation to enhance its potential to withstand legal challenge.

Similarly, when the implementation of measures is being monitored and evaluated, the involvement of lawyers in research design can contribute to the collection of useful and meaningful 'evidence' (in the legal sense). This is not to suggest that lawyers should dictate or vet research, but that they have important contributions to make to its design, conduct and use.

In addition, the involvement of lawyers throughout the policy process will help to foster interdisciplinary understanding and trust, which will be critical in the event that measures do need to be defended before a court or tribunal. Lawyers and public health researchers should not be learning to understand each other's languages and disciplines for the first time under the pressures of defending large-scale litigation.

4.2.3 Contextualising the power of treaties and of non-binding instruments

It is often pointed out that tobacco is the only NCD risk factor currently the subject of an international treaty. Doubtless, this puts tobacco on a different legal

and political plane from other NCD risk factors. I have suggested elsewhere that, through its terms and the institutions and processes it has generated, the WHO FCTC has: raised the global profile of tobacco control; strengthened governments in their fight against the tobacco industry politically and legally; reinforced the view that tobacco products are not normal consumer products, contributing to the ongoing global denormalisation of the tobacco industry; catalysed the formation and deepening of transnational civil society coalitions; facilitated the sharing of experiences, expertise and capacity among and between governments and non-governmental organisations (NGOs); and brought new resources – political, financial and human – into the field.[81] This is an impressive list of achievements, and it is little wonder that commentators and advocates have called for similar framework conventions on alcohol and obesity.[82]

The relative legal and political strengths and weaknesses of treaties and 'softer' international instruments have been much discussed and debated.[83] Without question, treaties do tend to indicate a higher degree of political commitment than other kinds of instruments. This is both reflected in the decision to negotiate, adopt and then ratify treaties, and then further reinforced by these acts. This is likely to have important implications in many countries for the implementation of domestic measures to address the subject matter of an international instrument. And it is also true that in the interplay of international instruments mentioned earlier, a binding treaty is 'stronger' than other instruments.

Nevertheless, other instruments need not be seen as 'weak' or meaningless. The collective normative, political and legal weight (even if not 'legally binding') of the instruments listed earlier should be championed rather than downgraded or devalued. The propensity to downgrade or devalue these instruments may reflect a number of matters including:

- First, a tendency among some advocates to apply their experiences at domestic level – where (binding) legislation is often essential to ensure activity, and anything less is often regarded dismissively – to an international context that is not analogous.[84] Whereas corporations may often adopt measures that would be effective to reduce exposure to NCD risk factors, and that would affect their bottom lines, only when legally required to do so, or under threat of regulation, governments do not take action only where legally bound under international law to do so.
- Second, a sometimes exaggerated sense of the constraints that existing trade and investment agreements pose to the capacity of governments to regulate in the public interest, including public health.
- Third, and relatedly, a sense that these agreements are in 'conflict' with health measures and values, meaning that 'binding' instruments are needed to 'trump' them. This view may reflect in part a conflation of conflict seen at the (more superficial) level of narrative (eg trade *versus* health) with conflict in a strict legal sense. Assumption of conflict in the legal sense may understandably give rise to a perception that a 'competing' binding instrument is needed if health interests are to be asserted and respected. But if no such conflict

exists, non-binding normative instruments can be understood as having the capacity to significantly inform the way in which trade and investment treaties, with all of their flexibilities, are interpreted and applied.[85]

4.2.4 Dealing with the reality of existing trade and investment agreements

Public health advocates are becoming increasingly engaged with, and concerned about, the implications of international trade and investment treaties for NCD prevention, and, in particular, the ways in which such agreements may constrain governments' capacity to regulate NCD risk factors. This concern has been galvanised by Philip Morris Switzerland's challenge to Uruguay's tobacco packaging measures under a bilateral investment treaty between Switzerland and Uruguay,[86] Philip Morris Asia's challenge to Australia's plain tobacco packaging measures under a bilateral investment treaty between Australia and Hong Kong[87] and complaints against Australia's plain packaging measures initiated in the WTO by Ukraine, Honduras, the Dominican Republic, Cuba and Indonesia.[88] The level of concern has been heightened by the fact that Philip Morris Asia acquired its interest in Philip Morris Australia some 10 months after Australia's plain packaging measures were announced[89] – giving rise to fears about the multinational tobacco industry's ability to endlessly restructure in order to take advantage of investment treaties to bring litigation against governments – and the tobacco industry's openness about its support for the bringing of WTO complaints by states.[90] However strong the legal ground on which Uruguay and Australia stand might be, these challenges are expensive and resource-intensive to defend. The initiation of these challenges presumably has a collateral objective, namely to dissuade other governments considering the adoption of similar measures from doing so – the well-known concept of 'regulatory chill'.[91]

While public health advocates may, quite justifiably, believe that governments should not have to defend their tobacco control measures under such agreements and in such fora, a balance must be struck between efforts to change the system that allows this to happen – understanding the political and legal difficulties of doing so, particularly within the WTO's consensus decision-making processes[92] – and efforts to proceed with strong and effective measures within the existing system. A further complication is that new trade and investment agreements are being negotiated – including, most prominently at the moment, the *Trans-Pacific Partnership Agreement* ('TPP')[93] – and many advocates have legitimate concerns about how such agreements may impact on national policy space.[94] This all creates a very delicate context for advocacy.

In my view, a number of advocates campaigning against new agreements such as the TPP – either in their entirety or in relation to their potential impacts on tobacco control or public health more broadly – have advanced their concerns in ways that undermine the power of governments to act within their existing international obligations. In painting worst case scenarios of the ways in which such agreements might be interpreted and applied so as to diminish governments' capacity to regulate to protect and promote public health – including terms and

concepts that are in the WTO Agreements and in many other trade and investment treaties by which governments are already bound – such advocates at times say things that are strikingly similar to things the tobacco industry routinely says to governments in its efforts to dissuade them from implementing tobacco control measures. In these circumstances, regulatory chill is being contributed to by both the tobacco industry and (purported) tobacco control advocates. I put the word 'purported' in brackets here, because at times it can appear that tobacco control is used as a convenient, politically powerful 'lightning rod' issue by some who have broader complaints about international trade and investment agreements, and may not particularly care whether governments do or do not implement effective tobacco control measures. Strong views about the constraints that trade and investment agreements purportedly impose on tobacco control are at times offered in analyses that appear to diminish the WHO FCTC and show very little awareness of, or regard for, the contents of the treaty, its guidelines or other critical decisions of its Conference of the Parties ('COP').

In contrast, the approach taken with respect to the relationship between the WHO FCTC and WTO agreements by the WHO FCTC's COP and by the WHO has reflected a belief that the WTO agreements do not represent a threat to WHO FCTC implementation. At its 2010 and 2012 sessions, the COP adopted decisions promoting cooperation between the Convention Secretariat and the WTO[95] and between the Convention Secretariat, the WHO, the WTO and the United Nations Conference on Trade and Development.[96] The 2012 *Ad Hoc Interagency Task Force on Tobacco Control Report* stated that: 'It should be clarified at global trade forums that World Trade Organization agreements and implementation of the Convention are not incompatible so long as the Convention is implemented in a non-discriminatory fashion and for reasons of public health'.[97] The former Director-General of the WTO, Pascal Lamy, also explained that WTO rules and the implementation of the WHO FCTC are not incompatible.[98]

It is, however, important to distinguish between the WTO agreements and other international agreements regulating international trade or investment, and particularly the large number of bilateral investment treaties into which states have entered.[99] A WHO report prepared for the fifth session of the WHO FCTC's Conference of the Parties in relation to cooperation with the WTO on trade-related tobacco-control issues evinces a different view of the latter, noting that '[i]nternational investment agreements are of particular concern in the context of challenges being made to the tobacco-control measures of Parties'.[100] Unlike WTO dispute settlement, which is state-to-state, many international investment agreements allow challenges to be brought directly by foreign investors against states. In addition, dispute settlement under international investment agreements takes place through ad hoc tribunals that are not part of a unified system, where no unified substantive law is applied, cases are conducted in a less transparent manner than is ordinarily applied in domestic litigation and tribunal decisions are not generally subject to appeal. This makes for an uncertain system, and these uncertainties can be, and are, exaggerated and exploited by those who have an interest in persuading governments that they are unable to act.

The point here is not that public health advocates should be unconcerned with existing trade and investment agreements, or the negotiation of new ones. I share the view that governments should not be forced to defend bona fide public health measures before international trade and investment tribunals, with all of the political, financial and resource implications of having to do so, and all of the incentives for industry to threaten legal action as a way of dissuading governments from regulating, and to bring such legal action, however spurious a claim might be. However, advocates have a responsibility to engage in a nuanced and sophisticated way, understanding that the things they say in one forum – where their intention is to portray the constraints of trade and investment agreements as crippling – may prove highly damaging in others.

4.2.5 The need for respect, sensitivity and deference in trade and investment adjudication

Generally speaking, international trade and investment treaties do, in my view, afford significant space to states to regulate in the public interest in general, and for the protection and promotion of public health in particular. Nevertheless, decisions ultimately fall to be made in particular cases by individual panels and tribunals, composed of individuals who tend not to have great experience of, or knowledge about, public health imperatives, values and approaches to the collection, understanding and use of evidence in policy-making, implementation and evaluation. It is unrealistic to expect trade and investment panelists and tribunal members to become overnight public health experts, but it is perfectly reasonable to expect them both to appreciate the limitations of their own expertise and to show an appropriate degree of deference to public health imperatives, values and approaches and to governments' regulatory choices.[101]

Three areas in which such deference can (and should) be exhibited are: engagement with scientific evidence, articulation of the objective or objectives against which challenged measures should be assessed and the standards of 'proof' or 'persuasion' applied to governments' explanations or justification of their challenged measures. As Andrew Higgins, Andrew Mitchell and James Munro argue,[102] the WTO's Appellate Body has tended to show considerable deference in all three respects. For example, it has:

- recognised that there may be a degree of uncertainty regarding scientific evidence.[103] In *Canada – Continued Suspension*, it held that, in seeking to justify a measure as 'necessary to protect human health', a Member may rely 'on scientific sources which … may represent a divergent, but qualified and respected, opinion';[104]
- recognised that gaps in scientific knowledge are inevitable, and that such gaps do not necessarily render available knowledge insufficient;[105]
- held that a given measure need only contribute to the achievement of the objective at issue, rather than comprehensively achieve the objective, in order to satisfy the 'necessity' test. WTO jurisprudence acknowledges that certain complex public health and environmental problems require 'a comprehensive

policy comprising a multiplicity of interacting measures', individual elements of which cannot be examined in isolation from one another;[106]
- permitted the use of quantitative projections or qualitative reasoning to demonstrate that a measure is 'apt to produce a material contribution to the achievement of its objective'.[107] Such evidence can be relied on in lieu of evidence of 'actual contribution' to the objective; and
- held that results obtained from certain actions, including certain preventive actions to reduce the incidence of diseases that may manifest themselves only after a certain period of time, can be evaluated only with the benefit of time.[108]

If public health measures generally, and NCD prevention measures in particular, are to be challenged under trade and investment treaties, it is essential that panels and tribunals exhibit this kind of respect, sensitivity and deference. Indeed, international legal challenges to measures implemented by governments to reduce exposure to NCD risk factors represent one of the key coalfaces of the multisectoral nature of NCD governance (and global health governance more broadly), at which cross-sectoral policy coherence must be realised. Trade and investment panels should be expected to view their exercise of power within the political and legal context of the increasingly urgent global efforts to combat NCDs.

4.2.6 Managing the similarities and differences between tobacco, alcohol and unhealthy foods within the NCD agenda

The bundling together of tobacco, alcohol and unhealthy foods into a single global NCD prevention agenda makes a good deal of conceptual and governance sense. Much can be learned across the three different risk factors, and a number of common and overlapping challenges (and opportunities) arise in addressing them. At the global level in particular, health governance needs to be broken down into a limited number of agendas and processes if it is to remain manageable.

Yet this bundling does not always make for a comfortable fit. For all of their commonalities, each product category (not to mention sub-category) is different, causes different kinds and degrees of harm and is used in different ways and for different reasons. They cannot be treated in an identical fashion. In addition, at the domestic level, tobacco, alcohol and unhealthy foods may not be grouped together within an NCD governance framework. For example, tobacco and alcohol may be regulated within the context of a drug strategy that includes both licit and illicit drugs (and not unhealthy foods).

These tensions can play out in a number of ways. Some tobacco control advocates view the NCD agenda as (at least partially) a threat to progress in tobacco control, by diluting the uniqueness of tobacco, diffusing the political attention it currently receives and weakening the power of the WHO FCTC by grouping tobacco with other risk factors within more nebulous governance arrangements than exist for the treaty. Advocates for progress in combating other risk factors may wish for stronger governance for these risk factors at global and domestic

levels, expressing frustration at the unique treatment that tobacco receives, and at the continued indulgence of the unhealthy food and alcohol industries compared to the tobacco industry. The tobacco industry, in its resistance to the introduction of stronger tobacco control measures such as plain tobacco packaging, uses 'thin end of the wedge' scaremongering – 'tobacco today, alcohol tomorrow, fast food the day after'.[109]

It is clear that tobacco and the tobacco industry are regarded, and treated, very differently from alcohol and unhealthy food. Most obviously, tobacco has its own treaty. Echoing art 5.3 of the WHO FCTC and its implementation guidelines,[110] the Political Declaration '[r]ecognize[s] the fundamental conflict of interest between the tobacco industry and public health'.[111] Concerns about the role of, and engagement with, other industries finds expression only through the inclusion of the words 'where appropriate' and 'as appropriate' in conjunction with references to the role of the 'private sector'.[112] The difference in approach is also reflected in the Global Action Plan. While one of its overarching principles and approaches is '[m]anagement of real, perceived or potential conflicts of interest',[113] the tobacco industry is singled out, with 'non-State actors' to be engaged being defined to 'include academia and relevant nongovernmental organizations, as well as selected private sector entities as appropriate, *excluding the tobacco industry*'.[114]

If NCD governance is to work effectively, it will need to be able to capture all of the risk factors within a single sensible and manageable framework, allowing for necessary streamlining in governance and the learning of lessons across the risk factors, while concurrently allowing each to be treated on its health, political and legal merits. This will require civil society organisations with mandates that focus on only one risk factor to be conscious of the way in which their policy and advocacy work might affect progress on other risk factors. For example, might efforts to respond to the risks that trade and investment agreements under negotiation pose to tobacco control solely by advocating that tobacco should be treated differently from all other products[115] have adverse implications for the treatment of other risk factors? Might differential treatment of tobacco legally or politically weaken, even to some small degree, the general exceptions available to governments to defend other measures, by suggesting that these exceptions do not give governments sufficient room to regulate for the protection and promotion of public health?[116] The problems for global health governance arising from foreign investors being able to sue governments under investment agreements over public health measures are much broader than tobacco, and would ideally be addressed at that broader level. While tobacco should be treated differently from other products as a matter of regulatory *choice*, governments should have no less regulatory *autonomy* to deal with these other products. On the other side of the coin, those who work on other risk factors will need to respect what is different about tobacco, and what is unique and powerful about the global governance of tobacco, as enshrined in the WHO FCTC.

The new UN Interagency Task Force on the Prevention and Control of NCDs may well be a test of this challenge. The work of the Task Force, being established

by way of expanding the mandate of the Ad Hoc Interagency Task Force on Tobacco Control, must enhance global coordination of activities on tobacco control, and uphold and strengthen the power of the WHO FCTC, rather than dilute or undermine them. The World Health Assembly acknowledged this, recognising the need to 'ensur[e] that tobacco control continues to be duly addressed and prioritized in the new task force mandate'.[117]

5 Conclusion

The conception of this book recognises that the effective use and understanding of law, both domestic and international, are critical to making progress in combating NCDs. While the effective use of law is essential to global health governance generally, as this chapter has argued, it is particularly so in the case of NCDs. NCDs cannot be combated solely as a health issue, through the health sector. Efforts to prevent NCDs represent a threat to the commercial interests of powerful industries, meaning that measures adopted by governments are liable to face legal challenges (or threats of such challenges) in both domestic and international fora.

The field of 'law and NCD prevention' is rapidly developing. At its heart lies the challenge of speaking, listening and learning across different disciplines, each with its own language, values, concerns, priorities, institutions and ways of managing conflict and uncertainty.

Key to the success of the 'law and NCD prevention' endeavour is interdisciplinary respect and patience. Lawyers need to understand the limitations of their expertise and training, and be respectful of the way other disciplines make sense of and explain the world. Lawyers need to learn how to understand and value the way in which evidence is generated by other disciplines, and treat that evidence with respect in legal fora.[118] Lawyers need to do their best to demystify the law, complex as it undoubtedly can be. At the same time, other disciplines need to accept that many critical policy issues cannot be resolved at the level of theme or narrative or value, but only through detailed, technical legal analysis. Lawyers are often criticised for refusing to give straight 'yes' or 'no' answers to questions, preferring to qualify their responses. In their defence, this does not necessarily reflect an unwillingness to take a position, but rather a sense that questions are often asked at a level of generality that does not lend itself to a meaningful legal answer.

In the complex web of domestic and international law described in this chapter, questions about *what* governments can do, and *how* they can do it, often fall to be answered in highly specific circumstances. If we are going to answer these questions in a way that advances our collective efforts to reduce the burden of NCDs, and encourages others to do so, we are going to have to answer them collectively. This is not an easy undertaking, but it is essential, and it can be immensely rewarding, both intellectually and, more importantly, in health outcomes ultimately achieved.

Notes

* My thanks to Caroline Henckels, Alexandra Jones, Laura Perriam, ,Tania Voon and Devon Whittle for very helpful comments, suggestions and editorial assistance.

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2 Ibid.
3 Ibid.
4 Ibid [12].
5 World Health Organization and World Economic Forum, *From Burden to 'Best Buys': Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries* (2011) <http://www.who.int/nmh/publications/best_buys_summary.pdf>.
6 Ibid.
7 Global Action Plan [12].
8 Ibid.
9 *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*, GA Res 66/2, UN GAOR, 66th sess, 3rd plen mtg, Agenda Item 117, UN Doc A/RES/66/2 (24 January 2012, adopted 19 September 2011) annex ('Political Declaration').
10 Ibid [34].
11 Ibid [20].
12 Ibid [35].
13 Dr Margaret Chan, Director-General of the World Health Organization, 'Opening Address' (Speech delivered at the 8th Global Conference on Health Promotion, Helsinki, Finland, 10 June 2013) <http://www.who.int/dg/speeches/2013/health_promotion_20130610/en/index.html>.
14 Ibid.
15 Rob Moodie et al, 'Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-processed Food and Drink Industries' (2013) 381 *The Lancet* 670, 670.
16 Ibid 671.
17 Political Declaration [33].
18 Ibid [36].
19 Global Action Plan [18].
20 Dr Margaret Chan, Director-General of the World Health Organization, *Opening Address* (Speech delivered at the 8th Global Conference on Health Promotion, Helsinki, Finland, 10 June 2013) <http://www.who.int/dg/speeches/2013/health_promotion_20130610/en/index.html>.
21 While law also has an important role to play in promoting physical activity, this book focuses on tobacco, alcohol and unhealthy foods.
22 Political Declaration [13], [51]; see also World Health Assembly, *Follow-up to the Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*, WHA Res WHA66.10, 66th sess, 9th plen mtg, Agenda Items 13.1 and 13.2 (27 May 2013) ('*Follow-up to the Political Declaration*') 2.
23 *Follow-up to the Political Declaration* preamble.
24 See Global Action Plan [36], [37], [40], [42]. The framework also includes targets for biological risk factors (raised blood pressure, and diabetes and obesity), and national system responses (drug therapy to prevent heart attacks and strokes, and essential NCD disease medicines and basic technologies to treat major NCDs).
25 *Follow-up to the Political Declaration* [1(2)].

26 Ibid.
27 Global Action Plan [3].
28 Ibid [16].
29 Ibid [6], though it recognises that there are many other conditions of public health importance that are closely associated with the four major NCDs.
30 Global Action Plan [5].
31 *United Nations Interagency Task Force on the Prevention and Control of Non-communicable Diseases*, ESC Res 2013/L.23, Agenda Item 7(g), UN Doc E/2013/L.23 (12 July 2013).
32 See World Health Organization, *United Nations Ad Hoc Interagency Task Force on Tobacco Control* <http://www.who.int/tobacco/about/partners/un_taskforce/en/>.
33 Global Action Plan [14].
34 *Follow-up to the Political Declaration* [3(2)].
35 Jonathan Liberman and Andrew Mitchell, 'In Search of Coherence Between Trade and Health: Inter-Institutional Opportunities' (2010) 25 *Maryland Journal of International Law* 143, 153–5. See also Jonathan Liberman, 'Combating Counterfeit Medicines and Illicit Trade in Tobacco Products: Minefields in Global Health Governance' (2012) 40 *Journal of Law, Medicine & Ethics* 326, 326–8; Allyn Taylor, 'Governing the Globalization of Public Health' (2004) 32 *Journal of Law, Medicine & Ethics* 500; Lawrence Gostin and Allyn Taylor, 'Global Health Law: A Definition and Grand Challenges' (2008) 1 *Public Health Ethics* 53.
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37 Ibid [15].
38 Ibid [22].
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43 Ibid.
44 *Global Health and Foreign Policy: Strategic Opportunities and Challenges: Note by the Secretary-General*, General Assembly 54th sess, Agenda Item 123, UN Doc A.64.365 (23 September 2009). See also Fidler, above n 39, 5.
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46 Ibid.
47 Global Action Plan, objective 1.
48 George Alleyne et al, 'Embedding Non-communicable Diseases in the Post-2015 Development Agenda' (2013) *The Lancet Non-Communicable Diseases Series* 4, 7.
49 Ibid 10–12.
50 World Health Organization, *Global Status Report on Noncommunicable Diseases 2010* (World Health Organization, 2011) <http://www.who.int/nmh/publications/ncd_report_full_en.pdf>.
51 Helen Clark, 'NCDs: A Challenge to Sustainable Human Development' (2013) *The Lancet Non-Communicable Diseases Series* 4, 2.
52 *The Future We Want*, GA Res 66/288, UN GAOR, 66th sess, 123rd plen mtg, Agenda Item 19, UN Doc A/RES/66/288* (11 September 2012, adopted 27 July 2012) annex.
53 Ibid [138].
54 Ibid [141].

55 Ibid.
56 UN System Task Team, *Realizing the Future We Want for All: Report to the Secretary General* (2012) <http://www.un.org/en/development/desa/policy/untaskteam_undf/report.shtml>
57 Ibid [19].
58 Ibid [67].
59 United Nations, *A New Global Partnership: Eradicate Poverty and Transform Economies Through Sustainable Development: The Report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda* <http://www.un.org/sg/management/beyond2015.shtml>.
60 Ibid.
61 Ibid.
62 Global Action Plan [21(a)].
63 Ibid [21(b)].
64 Ibid [23(a)]. Note that the need for integration into the development agenda and its programs has been recognised for some time in respect of tobacco control: see, eg, WHO FCTC Conference of the Parties, *FCTC/COP4(17) Financial Resources, Mechanisms of Assistance and International Cooperation*, WHO Doc FCTC/COP/4/DIV/6, 4th sess, 10th plen mtg (6 December 2010, adopted 20 November 2010).
65 Political Declaration [43] (emphasis added).
66 Global Action Plan [34].
67 *WHO Framework Convention on Tobacco Control*, opened for signature 21 May 2003, 2302 UNTS 116 (entered into force 27 February 2005) ('WHO FCTC').
68 World Health Assembly, *Global Strategy to Reduce the Harmful Use of Alcohol*, WHA Res 63.13, 63rd sess, 8th plen mtg, WHO Doc WHA63/2010/REC/1 (21 May 2010).
69 World Health Assembly, *Global Strategy on Diet, Physical Activity and Health: Report by the Secretariat*, WHA Res 57.17, 57th sess, 8th plen mtg, WHO Doc A57/2004/REC/1 (22 May 2004).
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71 World Health Organization, *First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control: Moscow Declaration* (28–29 April 2011) <http://www.who.int/nmh/events/moscow_ncds_2011/conference_documents/en/>.
72 *The Future We Want*, GA Res 66/288, UN GAOR, 66th sess, 123rd plen mtg, Agenda Item 19, UN Doc A/RES/66/288* (11 September 2012, adopted 27 July 2012) annex.
73 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976).
74 *Marrakesh Agreement Establishing the World Trade Organization*, opened for signature 15 April 1994, 1867 UNTS 3 (entered into force 1 January 1995) annex 1A ('Agreement on Technical Barriers to Trade') ('TBT Agreement').
75 *Marrakesh Agreement Establishing the World Trade Organization*, opened for signature 15 April 1994, 1867 UNTS 3 (entered into force 1 January 1995) annex 1C ('Agreement on Trade-Related Aspects of Intellectual Property Rights') ('TRIPS Agreement').
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78 Jonathan Liberman, 'Plainly Constitutional: The Upholding of Plain Tobacco Packaging by the High Court of Australia' (2013) 39 *American Journal of Law & Medicine* 361, 381.

79 Ibid.
80 Global Action Plan [30(h)].
81 Jonathan Liberman, 'Four COPs and Counting: Achievements, Underachievements and Looming Challenges in the Early Life of the WHO FCTC Conference of the Parties' (2012) 21 *Tobacco Control* 215.
82 See, eg, Robin Room et al, 'International Regulation of Alcohol' (2008) *British Medical Journal* 337; The Lancet 'A Framework Convention on Alcohol Control' (2007) 370 *The Lancet* 1102; Sally Casswell 'Current Status of Alcohol Marketing Policy – an Urgent Challenge for Global Governance' (2012) 107 *Addiction* 478; The Lancet, 'Urgently Needed: A Framework Convention for Obesity Control' (2011) 378 *The Lancet* 741.
83 See, eg, Allyn Taylor and Ibadat Dhillon, 'An International Legal Strategy for Alcohol Control: Not a Framework Convention – at Least Not Yet' (2013) 108 *Addiction* 450; Jonathan Liberman, 'Alternative Legal Strategies for Alcohol Control: Not a Framework Convention – at Least Not Right Now' (2013) 108 *Addiction* 456; Steven Hoffman and John-Arne Røttingen, 'Dark Sides of the Proposed Framework Convention on Global Health's Many Virtues: A Systematic Review and Critical Analysis' (2013) 15(1) *Health & Human Rights Journal* 117.
84 Jonathan Liberman, 'Alternative Legal Strategies for Alcohol Control', above n 83.
85 However, if advocates are looking for 'binding' instruments to introduce into the interplay, international human rights law seems to me to have been somewhat neglected. The 160 parties to the *International Covenant on Economic, Social and Cultural Rights* (opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976)) 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health': art 12.1. This is one of the rights in relation to which states agree 'to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of [their] available resources' to progressively achieve the full realisation, 'by all appropriate means, including particularly the adoption of legislative measures': art 2. Under art 12.2, steps to be taken include 'those necessary for … [t]he prevention … of epidemic, endemic, occupational and other diseases'. See also Chapter 4 of this volume.
86 *Philip Morris Brand Sàrl v Uruguay (Decision on Jurisdiction)* (ICSID Arbitral Tribunal, Case No ARB/10/7, 2 July 2013).
87 *Philip Morris Asia Ltd v Australia (Procedural Order)* (Permanent Court of Arbitration, Case No 2012-12, 31 December 2012).
88 *Australia – Certain Measures Concerning Trademarks and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging*, WTO Doc WT/DS434/11 (17 August 2012) (Request for the Establishment of a Panel by Ukraine); *Australia – Certain Measures Concerning Trademarks, Geographical Indications and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging*, WTO Doc WT/DS435/16 (17 October 2012) (Request for the Establishment of a Panel by Honduras); *Australia – Certain Measures Concerning Trademarks, Geographical Indications and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging*, WTO Doc WT/DS441/15 (9 November 2012) (Request for the Establishment of a Panel by Dominican Republic); *Australia – Certain Measures Concerning Trademarks, Geographical Indications and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging*, WTO Doc WT/DS458/1 (7 May 2013) (Request for Consultations by Cuba); *Australia – Certain Measures Concerning Trademarks, Geographical Indications and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging*, WTO Doc WT/DS467/1 (25 September 2013) (Request for Consultations by Indonesia).
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91 Liberman and Mitchell, above n 35, 165–6.
92 *Marrakesh Agreement Establishing the World Trade Organization*, opened for signature 15 April 1994, 1867 UNTS 3 (entered into force 1 January 1995) art IX:1.
93 See Department of Foreign Affairs and Trade, *Trans-Pacific Partnership Agreement Negotiations* <http://www.dfat.gov.au/fta/tpp/>.
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101 Caroline Henckels, 'Balancing Investment Protection and the Public Interest: The Role of the Standard of Review and the Importance of Deference in Investor-State Arbitration' (2013) 4 *Journal of International Dispute Settlement* 197.
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103 Ibid 8.
104 Appellate Body Report, *Canada – Continued Suspension of Obligations in the EC – Hormones Dispute*, WTO Doc WT/DS321/AB/R (adopted 14 November 2008) [529].
105 Higgins, Mitchell and Munro, above n 102, 5.
106 Ibid 6; Appellate Body Report, *Brazil – Measures Affecting Imports of Retreated Tyres*, WTO Doc WT/DS332/AB/R (adopted 17 December 2007) [151].
107 Ibid.
108 Appellate Body Report, *Brazil – Measures Affecting Imports of Retreated Tyres*, WTO Doc WT/DS332/AB/R (adopted 17 December 2007) [151].
109 British American Tobacco Australia's campaign against plain tobacco packaging included an advertisement with the caption 'What company would stand for this?' depicting a can of cola, and an advertisement about compensation for the taking of intellectual property rights depicting a bottle of beer.
110 WHO FCTC Conference of the Parties, *Guidelines for Implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control*, WHO Doc FCTC/COP3(7) (22 November 2008).

111 Political Declaration [38]. Though note that the art 5.3 guidelines refer to 'fundamental *and irreconcilable* conflict between the tobacco industry's interests and public health policy interests', see World Health Organization, *WHO Framework Convention on Tobacco Control: Guidelines for Implementation* (2011) 5 (emphasis added).
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113 Global Action Plan [18].
114 Ibid [15] nn 3, [33] nn 1 (emphasis added).
115 See, eg, Robert Stumberg, 'Safeguards for Tobacco Control: Options for the TPPA' (2013) 39 *American Journal of Law & Medicine* 382.
116 See, eg, Jamie Strawbridge, 'Cigarettes, TPP and the Wisdom of Product-Specific Rules in Trade Deals' (2012) 5 *Transnational Dispute Management* <http://www.transnational-dispute-management.com/article.asp?key=1873>.
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118 Jonathan Liberman, 'On the Balance of Probabilities' on World Cancer Research Fund International, *Cancer Prevention Research & Policy Blog* (10 April 2013) <http://www.wcrf.org/blog/on-the-balance-of-probabilities>.