Seminar 3: Global Substantive Health Issues

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Notes for Remarks by Professor Stephen Marks

The Human Right to Tobacco Control

When the main human rights instruments were drafted, the idea that production, marketing, and consumption of tobacco were contrary to human rights was not considered, because smoking was widely accepted in all parts of the world. It was also true that during the active period of human rights standard-setting, essentially from the 1950s through the 1970s, several issues, such as violence against women and reproductive human cloning, had not been addressed in terms of universal human rights norms. Subsequently, public awareness of their significance and the political will to do something about them contributed to their being acknowledged as violations of internationally recognized human rights. The topic of violence against women was finally addressed in the Declaration of 1993 and the appointment of a Special Rapporteur. Reproductive human cloning was not dealt with as a human rights issue until the Council of Europe drafted a protocol to its Biomedicine Convention and UNESCO adopted its Declaration of 1997. It was also true of the human right to water until the adoption by the Committee on Economic, Social and Cultural Rights in 2002 of the General Comment on the Right to Water.[1]

Our claim is that the evidence has become so compelling and the policy priorities have evolved so far that a strong case can be made for the emergence of an implied derivative human right to tobacco control. The analogy with the right to water is perhaps the most apt insofar as the Committee drew on three main arguments: one based on evidence, one on logic, and the third on legal construction.

First, knowledge of the problems of water created by the failure to guarantee access to it was uncontested and required urgent action. The Committee noted that "Over one billion persons lack access to a basic water supply, while several billion do not have access to adequate sanitation, which is the primary cause of water

1. *The Right to Water (Arts. 11 and 12 of the International Covenant on Economic, Social and Cultural Rights)*, General Comment No. 15, U.N. ESCOR, Comm. on Econ., Soc. & Cult. Rts., 29th Sess., U.N. Doc. E/C.12/2002/11 (2002) [hereinafter General Comment 15].

contamination and diseases linked to water."[2] The evidence is compelling of a causal relation between great human suffering and the problem of water supply.

The second argument is based on a logical construction, according to which water as a human right is a necessary consequence of the nature of this commodity. The Committee argues as follows: "Water is a limited natural resource and a public good fundamental for life and health. The human right to water is indispensable for leading a life in human dignity. It is a prerequisite for the realization of other human rights."[3]

The third basis for positing the right to water as a human right was the legal interpretation of existing human rights norms as the foundation for the right. The title of the General Comment on the right to water mentions Articles 11 and 12 of the International Covenant on Economic, Social and Cultural Rights and the Committee explains how these two rights (adequate standard of living and health) are "inextricably related" to the right to water. The General Comment also notes that "The right to water has been recognized in a wide range of international documents, including treaties, declarations and other standards."[4] The Committee relates the right to water to other human rights, including the right to life, the right to adequate food, right to gain a living by work, the right to take part in cultural life, as well as certain rights in the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child.

Following the pattern of other general comments, the Committee then addresses the normative content of the right to water in terms of availability, quality, accessibility, and information and devotes special attention to issues of discrimination and vulnerable groups.

The human right to tobacco control lends itself to a similar analysis. First is evidence of the magnitude of the problem. As discussed in some detail above, extensive evidence is available regarding tobacco-related diseases, which kill 5 million people per year and this figure will reach 10 million by 2023. It is the largest cause of preventable death in the world.[5] Such evidence is on a scale similar to the importance of water to human existence.

Second is the logical argument that consumption of tobacco is lethal when used as intended and that production and marketing are harmful. The extensive and preventable impact of tobacco on mortality and morbidity is incontestable. Therefore, control of such deadly and harmful activity is an imperative to protect life and livelihoods.

The third element is the legal construction of the right. Like the right to water, the right to tobacco control, although not mentioned in the basic human rights instruments, derives from the right to life and the right to health. It would simply be unthinkable for a state to claim to have fulfilled its obligations to respect, protect, and

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2. The Committee cited WHO data for this claim. *See id.* ¶ 1, n.1.

3. *Id.*

4. *Id.* ¶ 4.

5. WORLD HEALTH REPORT 2003, *supra* note 8, page 91.

fulfill the right to health without an effective tobacco control program. Similarly, it would be difficult to consider that a country was carrying out its minimum core obligation regarding the right to health if it did not implement the right of everyone to adequate tobacco control. Its obligations to improve "all aspects of environmental and industrial hygiene" and to prevent, treat, and control epidemic diseases would be neglected if it did not respect the right to tobacco control.

The relation to other rights is also demonstrable, whether the right to food, the right to information, the right to work, or the right to protection of the child, among other rights. The right to information, for example,has a measurable impact on the realization of the right to tobacco control. Indeed, when access to information about the risks of tobacco is readily available to the society, particularly to youth, striking changes can be seen in tobacco consumption. In California, aggressive and relatively well-funded educational programs have lowered the smoking rates to 15.4 percent overall, which is a greater than 32 percent decline over the past six years.[6] As a consequence of California's comprehensive tobacco control program since 1988, a dramatic drop in both cardiovascular disease and lung cancer incidence has been documented.[7] This program is probably the best example of a comprehensive program that encompasses prohibition of advertising to youth, information campaigns aimed particularly at youth to prevent initiation, and legislation that emphasizes clean indoor air with smokefree workplaces. As a result, the outcome has been a demonstrable reduction in per capita consumption of cigarettes, a reduction in the number of people who smoke, and a reduction in the number of tobacco related medical illnesses.

Improving the access to smoking cessation interventions, such as those provided through the National Health Service (NHS) in the United Kingdom is a cost-effective practice.[8] The program in the United Kingdom began in 2001 and provides ready access to expert assistance and pharmacotherapy, as recommended by national smoking cessation guidelines. It was the first national program to emphasize the importance of smoking cessation for the national public health.[9] No other country has as yet instituted such a national program with financial support behind medications to

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6. In 1988, California, approved Proposition 99 that provided a 25 cent tax on each pack of cigarettes with 5 cents earmarked for tobacco control. This has allowed California to be very proactive in tobacco control compared to the other states. See California Dept. of Health Services, *available at* http://www.dhs.ca.gov/tobacco/-documents/PressRelease05-22-05.pdf.

7. James M. Lightwood & Stanton A. Glantz, *Short-Term Economic and Health Benefits of Smoking Cessation: Myocardial Infarction and Stroke,* 96 CIRCULATION 1089 (1997); Joaquin Barnoya & Stanton Glantz, *Association of the California Tobacco Control Program with Declines in Lung Cancer Incidence,* 15 CANCER CAUSES & CONTROL 689 (2004).

8. Christine Godfrey et al., *The Cost-Effectiveness of the English Smoking Treatment Services: Evidence from Practice,* 100 ADDICTION (Suppl. 2) 70 (2005).

9. United Kingdom's Department of Health, *available at* http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008602&chk=SYvQYW.

help people stop smoking. Outcome studies have determined that this financial investment through the medical system, which supports both counseling and pharmacotherapy, substantially delivers an "estimated cost per life-year saved," which was significantly better than standard accepted benchmarks.[10] It is predictable that, as people stop smoking with effective programs such as the NHS, the number of illnesses and deaths caused from tobacco should also decline in the near future.

It is no longer necessary to wait until further information is acquired before implementation of methodologies that are effective in decreasing the health effects from tobacco. Comprehensive smokefree policies have been demonstrated to quickly decreased smoking rates. One of the most basic of these methods is the dissemination of information about the known harmful effects of tobacco, particularly to populations that are currently uninformed. Similarly, children should be protected from the onslaught of well-crafted advertisements specifically designed to attract their attention. If children can be prevented from being seduced before becoming addicted, there will be a smaller population of smokers requiring smoking cessation interventions. New York City demonstrated an 11 percent decline in smoking rates over just one year from 2002-2003 as a result of comprehensive tobacco control policy that included public education programs, smokefree workplaces, nicotine replacement therapy for smoking cessation programs, and tax increases.[11] A comprehensive tobacco control program provides a circumferential agenda and is essential for the public health of the society, particularly of vulnerable groups.

The relationship to tobacco control and malnutrition is immediate and measurable. In many developing countries, tobacco is grown as a cash crop in preference to growing foodstuffs. As a result, the farmer is dependent on an adequate return on the sale of the tobacco to support purchase of food and shelter. The economic realities of growing tobacco, particularly for the small farmer results in persistent poverty due to high input costs, low crop prices and the significant labor required, often involving the entire family. As a result, little money is available for purchase of food. In addition, if one or more of the family units consume tobacco, the effect on cash outflow for the purchase of the addictive product affects the remaining amount for food. In addition, tobacco consumption affects the individual's basal metabolic rate and adds to the caloric needs of the individual. All of these factors combine to result in an insufficient number of daily caloric intake to maintain adequate nutrition--both for the individual and the family.

By shifting a farmer who grows tobacco and is economically struggling due to market forces to growing a more sustainable and/or edible crop, one of the etiologies of malnutrition due to tobacco will be modified. The responsibility for helping the individual farmer to shift crops should come from the state or international community as a result of their commitment with the concept of this essential right to be free from hunger. Specifically, the ICESCR states:

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10. Martin Raw et al., *Lessons from the English Smoking Treatment Services*, 100 ADDICTION (Suppl. 2) 84, 84 (2005).

11. Press Release, New York City Department of Health and Mental Hygiene, Office of Communications, New York City's Smoking Rate Declines Rapidly From 2002 To 2003, The Most Significant One-Year Drop Ever Recorded (12 May 2004), *available at* http://www.nyc.gov/html/doh/html/press_archive04/pr052-0512.shtml.

> The States Parties to the present Covenant, recognizing the fundamental right of everyone to be free from hunger, shall take, individually and through international cooperation, the measures, including specific programmes, which are needed: (a) To improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such a way as to achieve the most efficient development and utilization of natural resources.[12]

The tobacco companies that are responsible for both the purchase of the tobacco farm product and the production of the consumed product are transnational and reside in wealthy developed nations. Multinationals tobacco companies intentionally control the buying price of the crop and the farmer becomes financially dependent on the industry for loans to buy tobacco seeds, fertilizer, or pesticides.[13] Article 6 of the ICESCR on the right of everyone to work affirms that it is the duty of the state party to assure that the right is fully realized "under conditions safeguarding fundamental political and economic freedoms to the individual." The financial trap resulting from these loans from the multinational tobacco industry and the frequent inability to repay the loans due to underpayment for their crop seriously hinders the farmer's economic freedom.

These examples serve to illustrate the normative character of the human right to tobacco control, which could be summarized in terms of accessibility, appropriateness, and accountability. Accessibility could include access to information on effects of tobacco use, to treatment for diseases caused by tobacco, and to therapies to reduce addiction to tobacco. Appropriateness could include adapting interventions to the specific types of tobacco consumption that prevail in a given society and the cultural significance of patterns of use, making adjustments for religious practices, which may need to be respected while reducing harm. Accountability could address the liability of companies for harm caused to the health and deflection of resources in the health care system due to the need to respond to the consequences of tobacco use. In the discussion of international cooperation, due attention could be given to the Framework Convention for Tobacco Control. Thus, in the current state of scientific knowledge on the epidemic and of international human rights law, it is possible to define the normative content of the derivative human right to tobacco control. Whether this right has serious prospects of being effectively implemented is the separate and equally important criterion for recognizing it as a human right.

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12. ICESCR, *supra* note 36, art. 11(2).

13. Christian Aid has documented examples in Brazil of how Souza Cruz, a subsidiary of British American Tobacco affects the income and health of its contracted tobacco farmers. See Christian Aid, *available at* http://www.christian-aid.org.uk/indepth/0201bat/batsum.htm. Indentured servitude occurs on the manufacture side also, and with children, as their freedom is sold to produce bidis in India, *available at* http://www.cbsnews.com/stories/1999/11/22/60II/main71386.-shtml.

My main contention is that tobacco control is not only a valid approach to fulfilling the right to health but it is so crucial that a human right to tobacco control is emerging in the practice of states and international institutions. The purpose of making this claim is not to contribute to the proliferation of rights but rather to identify the elements of a norm *de lega ferenda*. The evidence of the progressive emergence of the human right to tobacco control lies in the extensive use of legal restraints on advertising and on smoking in public places. The right to privacy and property were regarded a few decades ago as prevailing over any public interest in legal restraints on smoking; today, more and more countries are now willing to adopt smokefree environment legislation, to restrict advertising, and to require labeling and education to warn of the harmful effect of smoking. Several UN and regional mechanisms have adopted guidelines and even made judicial determinations to advance the human right to tobacco control.

The principal obstacle to recognizing tobacco control as a human right is determining who should be held accountable for the human rights deprivations that result from the legal operations of the tobacco industry. The culprits for most tobacco control advocates are the oligopolies that dominate the industry. However, these multinational corporations are theoretically operating within the law and in accordance with the rules of international trade.

The parallel with the human right to water is a telling one: Today one billion people lack access to a basic water supply and over 1 billion people smoke with a 50 percent chance of dying from it and millions more affected by the cultivation of tobacco. Both access to water and tobacco control are so essential to the rights to life and health that the protection of those rights is inconceivable without acknowledging the specificity of these two derivative human rights. The human right to tobacco control will probably take another decade to be formally recognized, but the essential components are already emerging in the practice of states and international institutions.