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Non-Communicable Disease: Challenges and Opportunities for Global Regulation of Tobacco, Unhealthy Food, and Alcohol

Katharina Ó Cathaoir[1], Margherita Melillo[2] and Roger S. Magnusson[3]

[1]Faculty of Law, University of Copenhagen, Denmark; [2]Georgetown Law, Washington, United States and [3]Sydney Law School, University of Sydney, Sydney, New South Wales, Australia

Abstract

Non-communicable diseases (NCDs) represent a significant global health challenge, requiring distinct prevention and control strategies. Public health efforts have concentrated on regulating three primary risk factors: tobacco and nicotine products, unhealthy foods and beverages, and alcohol. While the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) stands as a legally binding international treaty, similar international legal efforts for alcohol and unhealthy foods have never gained significant traction. Consequently, global governance of NCD risk factors largely relies on soft law instruments, including WHO strategies, UN resolutions, and cross-sectoral initiatives that set political goals and technical standards. The article argues for the potential of a human rights-based approach to enhance global NCD regulation, emphasizing legal capacity building and managing industry influence. Future efforts should leverage regional and local governance, and ensure robust legislative frameworks to overcome the limitations of current international law and effectively address NCD risk factors.

Keywords: soft law; non-communicable diseases; conflicts of interest; Framework Convention on Tobacco Control; food and alcohol control

Introduction

In *Global Health Law*, Gostin drew attention to noncommunicable diseases (NCDs) as a silent but mighty epidemic that desperately warranted global action. Marked by the absence of a single contagious vector, their prevention and control look very different from that of infectious diseases. Public health responses to NCDs have focused on addressing modifiable risk factors. Legally, this has meant focusing on regulation of three main product classes: tobacco and nicotine, unhealthy foods and beverages, and alcohol. The exact scope and definition of NCD modifiable risk factors has changed over time and is still debated, with the World Health Organization (WHO) now addressing five risk factors: tobacco use, physical inactivity, alcohol, unhealthy diets, and air pollution.[1]

While from a public health perspective regulation of these products is typically conceptualized under the same umbrella, the regulatory framework is fragmented. There are historical reasons that explain this: evidence and awareness of the risks posed by these products has emerged at different times. Fundamentally, tobacco and recreational nicotine products, unhealthy foods and beverages, and alcohol have different consumption patterns, traditions, and uses. They pose different types and magnitudes of risks. While important lessons can be transferred from one product to another, it is difficult to imagine the same regulatory measures being successfully applied across all three product classes.

Against this backdrop, it is perhaps no surprise that global governance of NCD risk factors is fragmented across hard and soft law and limited from a classical international law standpoint. Tobacco is the only one of these risk factors in relation to which a legally binding international treaty has been adopted.[2] Although this early success prompted calls for a Global Convention on unhealthy diets and a Global Convention on Alcohol Control,[3] the latter products have resisted binding international intervention due to various factors, spanning lack of political will, industry obstruction and cultural and economic factors.

While, in principle, international conventions could bring significant value in terms of political and legal action, we recognize that current geopolitical battles make new international treaties on NCD prevention even less likely. Nevertheless, Professors Lawrence Gostin and Devi Sridhar have argued persuasively that nonbinding normative standards (so-called "soft law") can make important contributions to global health.[4] Accordingly, this article focuses on the contribution of soft law in articulating technical standards, setting political goals, and advancing the adoption of measures to regulate NCD risk factors at the domestic and local level.

This article begins by briefly describing relevant soft law instruments, illustrating how international policies on NCD risk factors extend beyond WHO and increasingly represent cross-sectoral UN action. We then look to the future, underscoring the potential of a human rights-based approach and the need for legal capacity-building to move policies from the global to the local level. We

Corresponding author: Katharina Ó Cathaoir; Email: katharina.o.cathaoir@jur.ku.dk
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conclude that this necessitates clear and considered guidelines on conflicts of interest to avoid industry interference.

The Evolution and Development of Global Governance of NCDs

Regulation of alcohol and tobacco (and to a limited extent, unhealthy foods and beverages) have a long history. However, the movement to adopt a global regulatory framework for NCD prevention measures started only relatively recently. Prompted by the tobacco industry's long history of obstructing domestic tobacco control, negotiations for what would become the WHO Framework Convention on Tobacco Control (FCTC) began in 1999, and concluded with its adoption by the World Health Assembly (WHA) in 2003.[5] The FCTC was designed to be a "living instrument" and open the way to the adoption of several protocols.[6] However, with the exception of the Protocol on Illicit Trade in Tobacco Products, the FCTC parties have mostly advanced the FCTC provisions by adopting soft law instruments like guidelines.[7]

Since the successful adoption of the FCTC, the WHO's response to other NCD risk factors has been through soft law instruments. The push started with the 2000 Global Strategy for the Prevention and Control of NCDs, which encouraged Member States to take actions to address NCD risk factors.[8] WHO has now produced strategies for the central NCD risk factors (tobacco and nicotine products, alcohol, and unhealthy food), the Global Strategy on Diet, Physical Activity, and Health (2004), the Global Strategy on the Harmful Use of Alcohol (2010) and the Global Strategy on Tobacco (2018).

These strategies are increasingly underwritten by firmer commitments. In 2012, the WHA committed to a 25% reduction in NCD mortality by 2025. The Global Action Plan for the Prevention and Control of NCDs 2013–2020 (NCD-GAP) meanwhile outlines a range of policy options and sets a monitoring framework with targets for physical activity, alcohol, tobacco, blood pressure and obesity reduction, and access to technologies and medicines. In 2019, NCD-GAP was extended to 2030 to align with the Sustainable Development Goals (SDGs), followed by the development of a Road Map 2023–2030 with the aim of accelerating progress.

Global initiatives to tackle NCD risk factors have expanded beyond the WHO. Of particular note is the 2011 High-Level Meeting of the UN General Assembly on the prevention and control of NCDs and its subsequent political declaration, which led to the NCD-GAP. The UN Secretary General also established a UN Inter-Agency Task Force on Control and Prevention of NCDs. The 2013 WHO Global Coordination Mechanism for NCDs establishes a platform for facilitating multi-stakeholder engagement and cross-sectoral collaboration to prevent and control NCDs and mental health conditions.[9] Moreover, SDG target 3.4 commits to a reduction in premature mortality from NCDs by a third by 2030.[10] In 2019, the Global Action Plan for Healthy Lives and Well-being for All was established, bringing together 15 multilateral health, development, and humanitarian agencies.[11] While not backed by formal sanctions, the above frameworks increasingly include time-bound targets, voluntary goals, and indicators.[12]

However, despite this long list of soft law resolutions and strategies, evaluations have found that progress has been insufficient. In 2017, the UN Secretary General reported that progress was patchy, with states unlikely to meet SDG target 3.4.[13] The midway evaluation of the NCD-GAP set a more hopeful tone, noting that it had succeeded in raising the profile of NCDs internationally. However, the report lamented that this profile has not been accompanied by the requisite funding, and implementation has been "slow and incremental."[14]

Future Developments

It is evident that beyond political statements, sustained and concrete investment of resources is necessary to address NCD risk factors. In 2025, the Fourth High-level Meeting of the UN General Assembly on NCDs will be held, with the aim of developing a political declaration for adoption by the UN General Assembly.[15] While renewed attention is welcome, it should be noted that past UN high-level meetings have not resulted in the mobilization of sufficient resources for NCD prevention.[16]

The continued involvement of the broader UN system poses risks and opportunities for the future regulation of NCD risk factors. A multi-sectoral approach is welcomed, given that NCD risk factors are not only health crises but are also closely linked to, *inter alia*, international trade policy that supports the proliferation of unhealthy products across borders, climate change that undermines opportunities to exercise outdoors and growing of vegetables and fruits, agriculture policies that support ultra-processed food, and transport and urban planning that inhibit active transport. Yet there is a risk that health is diluted among these sectors and that NCDs do not receive the necessary prioritization. So where are the opportunities for regulation at the global level?

Even in the absence of WHO further using its lawmaking authorities, international human rights and global public health can be mutually reinforcing.[17] While in the early years of NCD risk factor regulation, the tobacco industry used human rights arguments to resist regulation, increasingly, human rights are recognized as a basis for state action to advance the right to the highest attainable standard of health.[18] The right to adequate food can be interpreted as encompassing a right of access to culturally acceptable food, including the protection of indigenous diets.[19]

While the enforcement of human rights under international law is imperfect, it provides for examination of states' records in human rights fulfillment through treaty bodies and the Universal Periodic review mechanism.[20] These mechanisms could be harnessed to a greater degree by civil society to advocate for action on the part of states.[21] As human rights bodies lack detailed insights into health policy, WHO technical recommendations can enhance human rights recommendations and help to inform states' somewhat vague obligations under the rights to health and food.[22] Furthermore, the potential for guidelines on human rights, healthy diets and sustainable food systems should be further explored to galvanize action from the human rights and public health communities.[23]

Beyond adopting legally binding measures, the important role of the WHO in providing technical assistance must not be overlooked. This includes the role of legal capacity-building, which is already an integral part of the European human rights system[24] and increasingly prioritized in NCD prevention.[25] WHO can support states in drafting legislation to tackle NCD risk factors and in sharing knowledge regarding suitable legal measures. For example, WHO has recommended NCD "best buys," interventions that are cost-effective, some of which are legislative measures.[26]

With the prospects of international law limited, innovative legal measures at multiple levels of governance should be considered, including through partnerships with new non-state actors. In this respect, the role of philanthropic foundations can hardly be underestimated. Since 2005, Bloomberg Philanthropies has invested

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$1.58 billion to fight tobacco use, financing a broad network of international and local nongovernmental organizations, as well as the WHO itself.[27] In the last 10 years, Bloomberg Philanthropies has expanded its support to organizations working in promoting healthy food regulations.[28]

Smaller intergovernmental organizations, such as the International Development Law Organization, and those with a more limited geographical footprint, also have a role to play. For example, the Pacific Community's Public Health Division has invested in the "MANA Dashboard," which tracks the levels of achievement of Pacific Island Countries and Territories (PICTs) in implementing best buys from the NCD-GAP.[29] The MANA Dashboard was the impetus for the "Pacific Legislative Framework", which sets out policy priorities, a legislative plan, and draft legislative provisions for regulating NCD risk factors and is used in gap analysis and law reform in PICTs.[30]

The role of local governments and local policies, while not a panacea, should also be highlighted. This is particularly critical in states where federal action is politically contentious, such as the United States. Local action can also allow for tailoring regulations so as to take into account specific epidemiological needs and deep cultural dimensions of alcohol and food consumption. Yet, it is important to bear in mind that in some jurisdictions, local governments may have limited powers and lack funding to effectively regulate NCD risk factors.[31]

Finally, the issue of how best to manage industry participation in law and policymaking lingers. In the case of tobacco control, the tobacco industry has officially been excluded, with the guidelines to Article 5.3 of the FCTC recognizing a "fundamental and irreconcilable conflict" between the tobacco industry and public health. However, this does not equate with noninference on their part.[32] In 2016, the WHA adopted the WHO Framework of Engagement with Non-State Actors (FENSA), which aims to manage potential conflicts of interests with external actors, including industry. With the exception of the tobacco and weapons industries, FENSA permits the involvement of industry representatives in public policymaking. However, the WHO has been criticized for its failure to adhere to FENSA in its contacts with the alcohol industry[33] and for enabling the food industry to influence global health policy discourse despite contributing to obesity.[34] Furthermore, FENSA lacks enforcement and sanctioning mechanisms.[35]

Conclusion

While the prospect of advancing the regulation of NCD risk factors through binding international law remains limited at present, WHO and UN soft law instruments occupy a central role. These instruments rely on political will and mobilization of resources, which have regrettably been lacking. Pressing issues include adequate resourcing of WHO and its NCD policies as well as the need to effectively mitigate conflicts of interests with industry actors. We have highlighted the importance of legal capacity-building, which is crucial to implementing sustainable legal solutions on the ground. Finally, in the absence of binding health norms, international human rights law can be drawn upon to underscore states' obligations to protect public health from unhealthy food, alcohol, and tobacco, while supporting physical activity.

Katharina Ó Cathaoir, B.C.L., LL.M., Ph.D., is an associate professor of health law at the Faculty of Law, University of Copenhagen, Denmark and a Pro Futura Scientia Fellow at the Swedish Collegium for Advanced Studies, Uppsala, Sweden.

Margherita Melillo, Ph.D., is a scholar at the O'Neill Institute for National and Global Health Law and works as an independent consultant.

Roger S. Magnusson, B.A./LL.B.(Hons), Ph.D., is Professor of Health Law & Governance at Sydney Law School, The University of Sydney, and an Adjunct Professor of Health Law at Georgetown University Law Center.

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