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Treat(y)ing Global Health

The potential for a Framework Convention on Global Health to impact the actions of businesses in the underlying determinants of health.

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Abstract

The right to health and its underlying determinants are central for the realisation and enjoyment of other human rights, and these rights are increasingly impacted upon by business enterprises and their activities. At present, no international legislation exists which specifically targets the impact of these business activities upon the human right to health, but the proposed Framework Convention on Global Health presents a significant opportunity in this area. Previous literature surrounding the FCGH has predominantly focused on whether such a document is necessary and the nature of its contributions to the field of global health. This thesis focuses however specifically on the potential for an FCGH to impact the actions of businesses in the underlying determinants of health, using qualitative research and analysis. Following an examination of how the activities of business enterprises impact the underlying determinants of health, the FCGH is analysed and conclusions are drawn highlighting its utility as a human rights instrument with a focus on ending inequities on health.

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Finally, to my Nasty Women. Thank you for always being there to remind me that happiness can be found, even in the darkest of times, if one only remembers to turn on the light.

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List of Abbreviations

CESCR	Committee on Economic, Social and Cultural Rights
CSR	Corporate Social Responsibility
FCGH	Framework Convention on Global Health
FCTC	Framework Convention on Tobacco Control
HiAP	Health in All Policies
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IGO	Intergovernmental organisation
IHR (2005)	International Health Regulations
KCTMO	Royal Borough of Kensington and Chelsea Tenant Management Organisation Limited
MDG	Millennium Development Goals
MNC	Multinational corporation
NCD	Non-communicable disease
NGO	Nongovernmental organisation
NSA	Non-state actor
PHEIC	Public health emergency of international concern
SDG	Sustainable Development Goals
SWOT	Strengths, Weaknesses, Opportunities, Threats (analysis)
TNC	Transnational corporation
TPD	Tobacco Products Directive
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNGP	United Nations Guiding Principles on Business and Human Rights
WHO	World Health Organisation

"No man is an island, entire of itself; every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friend's or of thine own were: any man's death diminishes me, because I am involved in mankind, and therefore never send to know for whom the bell tolls; it tolls for thee."

– John Donne

Chapter 1: Introduction and Outline

1.1 Introduction

If ever there existed an issue which is truly transnational in nature, it is global health. Strict border controls mean nothing to an errant mosquito. Territorial boundaries are of no concern to a choleraic water source. Cancer can be kept at bay by no fence, nor wall. These boundless issues are met with boundless solutions; in our increasingly globalised world, the actors at play in health worldwide are multiple and varied.[1] No longer limited to states and international organisations such as the World Health Organisation (WHO), global health today and the structures which underpin it are characterised by a multiplicity of actors interacting in a highly complex system. Peter Hough holds that:

> "A global health world based on non-state actors has been evolving for as long as the state system, and this is a process continuing towards an ever-more advanced form of global governance since it is a policy area that starkly exposes the limitations of sovereignty."[2]

There are, then, a multitude of non-state actors in global health; it is useful to categorise them into three broad types: non-governmental organisations, intergovernmental organisations and transnational corporations.[3] This thesis focuses on the third of these categories. It is held that businesses play a significant role in the realisation of the right to health across the globe, for better but more frequently, for worse. Businesses and other such non-state actors are today playing an increasingly significant role in the fields of international relations and international law. In her work "Are Women Human?", feminist legal scholar Catharine MacKinnon builds upon this notion of the importance of non-state actors, positing that;

> "Recognition that states per se are often not the most immediate violators of women's humanity (although they often collaborate in it) has required recognition, in turn, that other-than-state actors regularly perpetrate serious human rights violations."[4]

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[1] Steven J. Hoffman, Clarke B. Cole, and Mark Pearcey, "Mapping Global Health Architecture to Inform the Future" (Centre on Global Health Security, Chatham House, 2015), 2.
[2] Peter Hough, "Non-State Actors in the Global Health World," in *The Ashgate Research Companion to Non-State Actors*, ed. Bob Reinalda (Ashgate Publishing Ltd, 2011), 433.
[3] Bob Reinalda, *The Ashgate Research Companion to Non-State Actors*, Book, Whole (Farnham: Ashgate, 2011), 3.
[4] Catharine MacKinnon, "Introduction: Women's Status, Men's States," in *Are Women Human? And Other International Dialogues*, Kindle Edition (Harvard University Press, 2007), 106.

MacKinnon's claim therefore highlights that non-state actors frequently perpetrate human rights violations, and given the growing significance of such actors on the international field, there is a need to hold them accountable. Fidler explains this, noting that whilst states were the traditional subjects of international law, this list now includes non-state actors, and that this is reflective of "[…] the extent to which states have, in the development of international society created new tools (e.g., IGOs) and crafted new public-private partnerships with NGOs and MNCs as part of international cooperation."[5] A realist comprehension of international relations does not ascribe importance to those actors outwith the sphere of states,[6] but a more *realistic* view of the world today cannot possibly deny the important influence of businesses upon peoples' lives, as well as upon the actions of states.

It is with this important influence of business on health in mind that this thesis will discuss the potential impacts of a Framework Convention on Global Health (FCGH) upon business enterprises and their activities which negatively impact the underlying determinants of health. The FCGH is a proposal (in its drafting phase) from a multi-stakeholder platform which will essentially take the form of an international treaty – with significant scope – aimed at achieving health equality.[7] A core goal then of this proposed framework is treating and closing global health inequities which exist today,[8] and this thesis will show that human rights and health inequities are inextricably linked to business enterprises. The potential positives and pitfalls of this treaty proposal have been written about at length since its conception,[9] but there has not, thus far, been significant in-depth analysis on the potential of this treaty to limit and change the role played by businesses with regard to the human right to health.

As mentioned, the scope of international legislation does not normally stretch to businesses; they are classically actors with rights, but no real responsibilities, as Kamminga notes, "In

[5] "WHO | 7. International Law," *WHO*, accessed June 17, 2017, http://www.who.int/trade/distance_learning/gpgh/gpgh7/en/index3.html.
[6] The Realist school of thought holds that states are the primary actors within an anarchic international system, and that these states act in their own self-interest. Key authors include Hans J. Morgenthau and Kenneth Waltz.
[7] FCGH Platform, "Platform for a Framework Convention on Global Health: Realizing the Universal Right to Health Fundamental Principles and Joining the Platform," accessed May 12, 2017, http://www.globalhealthtreaty.org/docs/platform-for-an-fcgh-full.pdf.
[8] "FCGH | Framework Convention for Global Health," accessed June 17, 2017, http://www.globalhealthtreaty.org/.
[9] This can be seen, for example, by the existence of the Special Issue on the Framework Convention on global Health in Global Health Governance (cited multiple times throughout thesis). Key authors to note regarding the FCGH include Lawrence Gostin and Eric Friedman.

traditional international law, multinational corporations have rights but no obligations."[10] Businesses can, therefore – and often do – behave with impunity on the international stage, with no recourse to justice available for the victims of the human rights abuses that these enterprises perpetrate. It must also be stated that this rigid position and approach to the role of businesses in international legislation is undergoing a formative phase (as can be seen from the cited work of MacKinnon), and it is for this reason, amongst others, that now is a pertinent time to analyse the potential of a Framework Convention on Global Health. It is for these reasons that the FCGH will be examined through the lens of business enterprises; finding ways to control their behaviour is the first step towards making corporations accountable to the people that work for them, the people that they market to, the people whose everyday lives they affect enormously.

1.1 Outline

This thesis seeks to answer the question '*will a Framework Convention on Global Health impact the actions of businesses in the various roles which they play in the underlying determinants of health?'* This issue gives rise to the sub-question, '*what are these impacts?'*. The impacts will be explained by studying the actions of businesses in the underlying determinants of health, which are understood as "food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."[11] The methodology which will be employed in order to answer these questions and approach these themes is set forth in the succeeding chapter (1.2.1). An additional theme which is necessitated by the core question of this topic include the roles of businesses in the underlying determinants of health. This is an extremely broad topic with significant prior research, and so will be approached in this thesis with a clear 'problem-solution' method; the roles of businesses in global health will be examined through the solution-based lens of the FCGH.

The body of this thesis is divided into three principal chapters. Chapter 2, 'The Right to Health', introduces the right to health as it stands today in terms of both current global health trends as well as the status and location of the right in international legislation. The obligation to protect

[10] Menno T. Kamminga, *Multinational Corporations in International Law*, n.d., //www.oxfordbibliographies.com/document/obo-9780199796953/obo-9780199796953-0049.xml.
[11] "UN Committee on Economic, Social and Cultural Rights (CESCR), 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)', 11 August 2000, E/C.12/2000/4, Available at: Http://Www.refworld.org/Docid/4538838d0.html (Accessed 17 May 2017),", §4.

as it emerges in the right to health and how this pertains to non-state actors such as businesses will be a focal point in this chapter.

Chapter 3 considers the role of businesses in the underlying determinants of health, with an additional initial focus on the ways in which business enterprises are currently impacted in international law. It is accepted and understood that while businesses can play multiple roles in global health, it is outwith the scope of this thesis to determine the impacts and actions of businesses at each of these junctures. This thesis will focus solely on the actions and roles played by business enterprises with regard to the underlying determinants of health. Additional points at which business does intersect with the right to health, which merit further investigation from the lens of the FCGH, include the provision of medicines as well as the privatisation of the health sector and the growing number of private-public partnerships in healthcare systems worldwide. Following the examination of the role of businesses in the underlying determinants of heath there will be a discussion of the Health in All Policies approach to global health, which has been used as a tool for ensuring that the human right to health remains foremost in state policy-making across all sectors.

Finally, in Chapter 4, the proposed FCGH will be discussed in detail. The international precedent of such a piece of legislation concerning the right to health will be approached, utilising the most significant legal instruments from the global health and human rights world; the Framework Convention on Tobacco Control and the International Health Regulations. To allow for a broader grasp on the obligations of businesses in human rights, the UN Guiding Principles on Business and Human Rights will also be analysed as a potentially instructive example for the proposed FCGH. The chapter will close with a SWOT analysis of the FCGH as a potential regulator for businesses and their actions in the underlying determinants of health.

1.2 Method, Perspectives and Definition of Terms

1.2.1 Method and perspectives

This thesis is based upon qualitative research with a multidisciplinary perspective. The research conducted centres around the analysis of various sources, specifically; the proposed Framework Convention on Global Health; academic papers on the subjects of global health and human rights; and existing legal frameworks and instruments concerned with legislating the right to health or the impact of the private sector. The multidisciplinary perspective is

therefore gained from the fields of international relations, global health and law, all of which are woven together in order to provide a holistic and comprehensive answer to the core and sub- questions set forth by this thesis. In addition to examining academic works, Chapter 3 of this thesis contains a case study analysis on the Grenfell Tower fire in the United Kingdom. A significant portion of the results of this research are finally compiled and explained using a SWOT analysis as a methodological tool which evaluates the internal strengths and weaknesses and the external opportunities and threats to the FCGH and its potential to impact the actions of businesses in the underlying determinants of health. In terms of geographical delimitations, this thesis adopts a broad global perspective and does not offer a specific regional focus, since the FCGH itself aims to be an internationally ratified document. This said, this thesis does not offer a specific perspective with regards to extraterritorial obligations of state and non-state actors, as such an issue is outwith the scope of this investigation.

1.2.2 Definition of Terms

Global health is a broad term and field of study; it is important for the purposes of clarity within this thesis to outline it more specifically. The definition put forth by Koplan et al. in The Lancet provides an all-encompassing example which will be utilised for the purposes of this work. They advance that:

> "Global health is an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasises transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population based prevention with individual-level clinical care."[12]

Global health will therefore be understood as per the aforementioned terms, with its focus on improving health and achieving equity in health for all people across the world.

Another key term of this thesis whose choice merits explanation is business enterprise (or business). There is a significant amount of literature written regarding corporate

[12] Jeffrey P. Koplan et al., "Towards a Common Definition of Global Health," *The Lancet* 373, no. 9679 (2009): 1995.

responsibilities and human rights, with a rich terminology attached to it. Businesses may be referred to as transnational corporations, multinational enterprises, or international corporations, depending upon various factors such as the geographical location of the parent company or headquarters. With so many terms available,[13] for the purposes of this thesis it is necessary to select the most inclusive insofar as subject matter is concerned. The UN Guiding Principles on Business and Human Rights offer a straightforward solution to this, focusing on the term 'business' and understanding business enterprises as "both transnational and others, regardless of their size sector, location, ownership and structure."[14] This approach will therefore be adopted throughout this thesis.

Finally, it is necessary to provide a short introduction by means of definition to the proposed Framework Convention on Global Health prior to proceeding with discussions of this proposal. The Framework Convention on Global Health (FCGH) is a proposed document that has gained traction and which has continued to evolve since its origin in 2008.[15] Such growing attention is highlighted by the fact that then UN Secretary General, Ban Ki-moon, stated in April 2016 that he encouraged "the international community to consider and recognize the value of a comprehensive framework convention on global health."[16] Today, such a convention would essentially be a "global treaty based in human rights and aimed at national and global health equality."[17] The FCGH will seek to "regulate existing resources for health, coordinate between disparate actors in global health governance, set standards and goals for health outcomes, and solidify the centrality of the right to health in law and policy."[18] This notion of solidifying the right to health as central in law and policy is key; Kastler notes that the FCGH will place "the right to health at the center of global health policy and global governance for health by

[13] "Multinational Corporations in International Law - International Law - Oxford Bibliographies - Obo," accessed May 13, 2017, http://www.oxfordbibliographies.com/view/document/obo-9780199796953/obo-9780199796953-0049.xml.
[14] John Ruggie, "Report of the Special Representative of the Secretary-General on the Issue of Human Rights and Transnational Corporations and Other Business Enterprises" (United Nations, March 21, 2011), 6, http://www.ohchr.org/documents/issues/business/A.HRC.17.31.pdf.
[15] Lance Gable et al., "Introduction: The Framework Convention on Global Health," *Global Health Governance*, Special Issue on the Framework Convention on Global Health, 9, no. 1 (2015): 3.
[16] UN General Assembly, "On the Fast-Track to Ending the AIDS Epidemic: Report of the Secretary-General, UN Doc. A/70/811. April 1, 2016" (United Nations, April 1, 2016), http://undocs.org/A/70/811. (accessed 16/05/17) §74
[17] "A Rights-Based Framework for the SDGs and Beyond: A Framework Convention on Global Health", *Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI),* accessed May 15, 2017, https://www.jalihealth.org/documents/a-rights-based-framework-for-the-sdgs-and-beyond.pdf
[18] Gable et al., "Introduction: The Framework Convention on Global Health," 3.

clarifying present ambiguities in the right to health."[19] At present, the Framework Convention is housed on an online platform whilst drafting is underway, and its drafters are self-described as:

> "[…] organizations and individuals from all spheres of public life who refuse to tolerate unconscionable health inequities that persist today. We believe in the power of law, coupled with powerful social movements, to create change and help us along the path towards social justice."[20]

Based in human rights and the elimination of inequities, with a bottom-up approach and an inclusive belief that it must involve those who it will be written *for* in its writing, the FCGH has considerable potential. The utility of this proposed treaty will be examined with business enterprises in mind.

[19] Florian Kastler, "Why the World Health Organisation Should Take the Lead on the Future Framework Convention on Global Health," *Global Health Governance*, Special Issue on the Framework Convention on Global Health, 9, no. 1 (2015): 132.
[20] "About Us | FCGH," accessed May 16, 2017, http://www.globalhealthtreaty.org/about-us/.

Chapter 2: The Right to Health

2.1 Global Health Today

Global health today gives rise to both optimism and concern. Optimism can be found, for example, when examining the incidences of and mortality rates for malaria, which fell by 21% and 29% respectively between 2010 and 2015 due to improved international commitment to prevention and control.[21] The eradication of diseases is no longer a far-off goal, but an achievable one, thanks to vaccines. Smallpox, which claimed the lives of around 300 million people in the 20th century,[22] was officially declared an eradicated disease in 1979.[23] Polio was once a horrifying force of truly global nature, paralysing children for life. Today, 80% of the world's population live in certified polio-free zones.[24] The maternal mortality ratio fell between 1990 and 2015 by approximately 44%.[25] Between 1965 and 2015, global child mortality also dropped from 17% of children across the world dying in their first five years of life, to approximately 4%.[26] These are all, undoubtedly, reasons for optimism surrounding the state of global health. Facts are difficult to argue with, and statistics speak the truth; these percentages show undeniable progress and the ongoing upward arc in the state of global health.

Yet these reasons to be hopeful can always be offset by causes for concern; serious global health issues persist throughout the world today, and these issues disproportionately affect the poor,[27] both within and between societies. These chasms of care are best known as health inequities, which are "differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age."[28] Paul Farmer explores these inequities at length in his work, *Pathologies of Power,* noting for example;

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[21] "WHO | Malaria," *WHO*, accessed May 4, 2017, http://www.who.int/mediacentre/factsheets/fs094/en/.
[22] "BBC - History - British History in Depth: Smallpox: Eradicating the Scourge," accessed May 13, 2017, http://www.bbc.co.uk/history/british/empire_seapower/smallpox_01.shtml.
[23] Max Roser "Eradication of Diseases," *Our World In Data*, accessed May 13, 2017, https://ourworldindata.org/eradication-of-diseases/.
[24] "WHO | 10 Facts on Polio Eradication," *WHO*, accessed May 4, 2017, http://www.who.int/features/factfiles/polio/en/.
[25] WHO et al., "Trends in Maternal Mortality: 1990 to 2015 Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division" (World Health Organization, November 2015), 15.
[26] "Global Child Mortality over Time," *Our World In Data*, accessed May 13, 2017, https://ourworldindata.org/grapher/global-child-mortality-timeseries.
[27] Poor in this context is defined as 'lacking sufficient money to live at a standard considered comfortable or normal in a society.'
"Poor - Definition of Poor in English | Oxford Dictionaries," *Oxford Dictionaries | English*, accessed May 15, 2017, https://en.oxforddictionaries.com/definition/poor.
[28] "WHO | 10 Facts on Health Inequities and Their Causes," *WHO*, accessed May 14, 2017, http://www.who.int/features/factfiles/health_inequities/en/.

> "The insight is, in a sense, an epidemiological one: most often, diseases themselves make a preferential option for the poor. Every careful survey, across boundaries of time and space, shows us that the poor are sicker than the nonpoor. They're at increased risk of dying prematurely, whether from increased exposure to pathogens (including pathogenic situations) or from decreased access to services - or, as is most often the case, from both of these 'risk factors' working together."[29]

Examples of the poor being 'sicker than the nonpoor' are abound. While, as aforementioned, global life expectancy is improving, the differences in life expectancy from state to state remain vast; a baby boy born in the Central African Republic can expect to live to the age of 51,[30] whilst a man in Japan will live, on average, thirty years longer than this.[31] And in low-income states such as the Central African Republic, this man's chances of living his shortened life without the presence of his mother is also higher; the lifetime risk of maternal death in low-income states is approximately 80 times higher than that of high income states.[32] The disparities that exist between high-income versus low- or middle-income countries are glaring.

The HIV/AIDS epidemic provides an instructive example of the inequities that exist both between and within societies, as well as an illustration of the progress that can be achieved when the international community pools its resources and focuses on concerted action; it therefore illustrates both the issues of inequity facing the international community currently, as well as an example of concerted action which the FCGH could draw upon. In 2012, 70% of HIV/AIDS deaths occurred in the Sub-Saharan African region,[33] yet another instance highlighting the disparity between high and low income states. In addition to this, however, disturbing inequities clearly exist *within* societies, and this is again demonstrated using the HIV/AIDS example. In the USA, for instance, "African Americans represent only about 13% of the population but account for almost half of all new HIV infections. There is no biological or genetic reason for these alarming differences."[34] Despite progress, then, it is evident that the

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[29] Paul Farmer, *Pathologies of Power: Health, Human Rights and the New War on the Poor* (Berkeley: University of California Press, 2003), 139.
[30] "WHO | Central African Republic," *WHO*, accessed May 14, 2017, http://www.who.int/countries/caf/en/.
[31] World Bank data, accessed May 14, 2017, http://data.worldbank.org/indicator/SP.DYN.LE00.MA.IN
[32] "Maternal Mortality," *UNICEF DATA*, accessed May 16, 2017, //data.unicef.org/topic/maternal-health/maternal-mortality/.
[33] "WHO | 10 Facts on the State of Global Health," *WHO*, accessed May 4, 2017, http://www.who.int/features/factfiles/global_burden/en/.
[34] "WHO | 10 Facts on Health Inequities and Their Causes."

inequities between and within societies remain unconscionable. The HIV/AIDS epidemic, for its part, has evolved from a full-blown crisis in the 1980s to a disease which has finally received an accelerated global response. During the early years of the crisis, in both high and low income states, an HIV diagnosis was ultimately a "death sentence".[35] Yet it took years for the US administration of the time to recognise the seriousness of the epidemic; "Ronald Reagan was president for almost five years before he said the word 'AIDS' in public."[36] Today though, the life expectancy for patients infected with HIV is close to normal.[37] The global death rate from HIV/AIDS is steadily falling,[38] and international attention is increasingly turning to other types of diseases.

This example of the HIV/AIDS epidemic clearly highlights the importance of recognition and understanding from the political sphere; without political will, action is often simply non-existent. Piot et al. emphasise this necessary political will, noting that "AIDS has underscored the imperatives to think and act beyond the confines of the classic public health arena, adopt comprehensive approaches, and engage leadership at all levels."[39] This concept of political will to achieve progress is significant for the proposed FCGH, and will be further considered throughout the body of this thesis, specifically in Chapter 3 regarding the Health in All Policies approach as well as in the discussion of the precedents for global health regulation in international law in Chapter 4.

With the HIV/AIDS epidemic slowly being managed, international attention is today turning toward other types of diseases. Non-communicable diseases[40] (NCDs) are a significant example of this turn in attention. This is clearly evidenced by the fact that the prevention of NCDs was the focus of a 2011 United Nations summit, the High-level Meeting of the General

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[35] "When HIV Was a Death Sentence - CNN.com," accessed July 5, 2017, http://edition.cnn.com/2015/11/30/health/cnnphotos-hiv-aids-portraits/index.html.
[36] Maria L. La Ganga, "The First Lady Who Looked Away: Nancy and the Reagans' Troubling Aids Legacy," *The Guardian*, March 11, 2016, sec. US news, https://www.theguardian.com/us-news/2016/mar/11/nancy-ronald-reagan-aids-crisis-first-lady-legacy.
[37] pmhdev, "Life Expectancy for People with HIV Now 'near Normal' - National Library of Medicine," *PubMed Health*, accessed May 15, 2017, https://www.ncbi.nlm.nih.gov/pubmedhealth/behindtheheadlines/news/2017-05-11-life-expectancy-for-people-with-hiV-now-near-normal/.
[38] "Fact Sheet - Latest Statistics on the Status of the AIDS Epidemic | UNAIDS," accessed May 14, 2017, http://www.unaids.org/en/resources/fact-sheet.
[39] Peter Piot, Sarah Russell, and Heidi Larson, "Good Politics, Bad Politics: The Experience of AIDS.," *American Journal of Public Health* 97, no. 11 (2007): 4.
[40] Non-communicable diseases are non-infectious illnesses which are typically of long duration. The most common examples are cancer, cardiovascular disease, chronic respiratory diseases and diabetes (https://ncdalliance.org/why-ncds/NCDs_)

Assembly on the Prevention and Control of Non-communicable Diseases. This was "only the second time in the history of the UN that the General Assembly [met] on a health issue (the last issue was AIDS)";[41] the Assembly adopted a political declaration following this meeting which recognised that NCDs constitute "one of the major challenges for development in the twenty-first century".[42] NCDs, however, have long been seen as diseases of the rich,[43] diseases which are the result of lifestyle 'choices'. In the introduction to a 2011 report, the WHO points out that this focus on 'choice' is "often linked to victim 'blaming'".[44] Yet these so-called diseases of affluence account for almost 70% of deaths worldwide, with over three-quarters of those deaths occurring in low and middle income states.[45] NCDs are clearly not diseases of the rich. As Taylor posits,

> "Evidence confirms that NCD-related risk factors are not randomly assigned within and between societies, but rather patterned along the social gradient, such that poorer people with greater exposure to health bads and less access to health goods will suffer disproportionately."[46]

These 'risk factors' Taylor discusses tend to be attributed to four categories; unhealthy diet, lack of physical activity, harmful use of alcohol and tobacco usage.[47] The relationship between businesses and NCDs will be one of the key focuses of this thesis, and will be explored in depth in Chapter 3. The state of global health today then is one of contradictions and shifts; the general arc of progress is favourable, yet unacceptable inequities do persist across the world. The globalisation of trade and industry, and the businesses that control such a large portion of these domains, have played and continue to play a significant role in these shifts, and it is this specific aspect of global health which will be approached in Chapter 3.

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[41] "WHO | United Nations High-Level Meeting on Noncommunicable Disease Prevention and Control," *WHO*, accessed May 14, 2017, http://www.who.int/nmh/events/un_ncd_summit2011/en/.
[42] UN General Assembly, "Draft Political Declaration of the High-Level Meeting on the Prevention and Control of Non-Communicable Diseases" (United Nations, September 16, 2011), http://undocs.org/A/66/L.1.
[43] Abdesslam Boutayeb and Saber Boutayeb, "The Burden of Non Communicable Diseases in Developing Countries," *International Journal for Equity in Health* 4, no. 1 (2005): 2.
[44] Ala Alwan, "Global Status Report on Noncommunicable Diseases 2010" (World Health Organisation, 2011), 8, http://www.who.int/nmh/publications/ncd_report_full_en.pdf.
[45] "WHO | NCD Mortality and Morbidity," accessed July 5, 2017, http://www.who.int/gho/ncd/mortality_morbidity/en/.
[46] Sebastian Taylor, "A Political Economy Of International Health: Understanding Obstacles To Multilateral Action On Non-Communicable Disease," *Global Health Governance*, Special Issue on the Framework Convention on Global Health, 9, no. 1 (2015): 80.
[47] "NCDs | NCD Alliance," accessed May 14, 2017, https://ncdalliance.org/why-ncds/NCDs.

2.2 The Legal Basis for The Right to Health

The right to the highest attainable standard of health – commonly referred to in its shortened version as the right to health – is a fundamental human right. To understand the status of this right today, it is important to track its development in the context of the global human rights regime. The first example of the right to health being set forth can be found in the preamble to the Constitution of the World Health Organisation[48] (WHO). The preamble states that:

> "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[49]

It merits note at this stage that the preamble to the WHO Constitution also offers an extremely holistic definition of what 'health' entails. It is referred to as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[50] This is both relevant to the right to health, given that the WHO is mandated with directing and coordinating international health within the UN system[51] and is therefore a core player in global health, and is additionally of relevance to the Framework Convention on Global Health. The FCGH adopts a holistic approach in its understanding of health and the right to health; this will be examined in greater detail in Chapter 4.

Given that the WHO was born out of discussions surrounding the creation of the United Nations, in addition to the fact that the two remain inextricably linked, the development of the UN human rights regime must now be approached. The UN came about in the aftermath of World War II, and with it, came the first real international human rights system. Whilst the Universal Declaration of Human Rights (UDHR) was ratified a mere three years after the UN itself was founded,[52] it took until 1966 for the two treaties setting forth these rights to be signed, and a further ten years until they received sufficient signatures for their ratification and entry into force. It was in 1976 then that these two treaties, the International Covenant on Civil and

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[48] Judith Paula Asher, *The Right to Health: A Resource Manual for NGOs*, 1st ed., vol. 6;6., Book, Whole (Boston;Leiden; Martinus Nijhoff Publishers, 2010), 27.
[49] "Preamble to the Constitution of WHO as Adopted by the International Health Conference, New York, 19 June - 22 July 1946; Signed on 22 July 1946 by the Representatives of 61 States (Official Records of WHO, No. 2, P. 100) and Entered into Force on 7 April 1948.,".
[50] Ibid.
[51] "WHO | Who We Are, What We Do," accessed June 3, 2017, http://www.who.int/about/en/.
[52] The UN was founded on October 24th 1945. The UDHR was ratified on December 10th 1948.

Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), became binding international legal documents. The latter of the two, along with the UDHR, provide the primary source for the right to health.

The right to health is clearly articulated in the UDHR, which has become such a core document in international human rights law that although a technically non-legally binding declaration, it is in its essence a binding soft law document. The text of Article 25.1 of the UDHR reads:

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."[53]

This broad, holistic definition is then further elaborated in Article 12 of the text of the ICESCR:

> "1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
> (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."[54]

Whilst the content of the UDHR and the ICESCR are instructive and invaluable regarding the right to health, arguably the most important document in this area is General Comment 14, adopted by the Committee on Economic, Social and Cultural Rights (CESCR) on the 11th

[53] UN General Assembly, "Universal Declaration of Human Rights, 217 A (III)," December 10, 1948, http://www.un.org/en/universal-declaration-human-rights/index.html., accessed 17/05/2017
[54] UN General Assembly, "International Covenant on Economic, Social and Cultural Rights" (United Nations, December 16, 1966), http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx., accessed 17/05/2017

August 2000. The text serves to clarify and build upon the normative content of Article 12 of the ICESCR, and does so in over twenty pages. Key aspects of this elucidation note (emphasis added):

> "The right to health is **closely related to and dependent** upon the realization of **other** human rights […]
>
> […] the right to health embraces a **wide range of socio-economic factors** that promote conditions in which people can lead a healthy life, and **extends to the underlying determinants of health,** such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.
>
> […] There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health […]the right to health must be understood as a right to the enjoyment of **a variety of facilities, goods, services and conditions** necessary for the realization of the highest attainable standard of health."[55]

Various tenets of the right to health can be extricated from the text of General Comment 14. First, the text underlines the interrelatedness and interdependence of all human rights; the human right to health cannot be realised without other human rights, nor can these other rights be realised without a right to health. This interdependence is true of all human rights[56] – both civil and political as well as economic, social and cultural – yet health is perhaps the most significant of these. Without our health, our ability to claim our human rights is threatened, as Safaei notes, "As ill health undermines our capacity to learn, to work, and to enjoy life, it is critical to make sure our health can be maintained and restored when it is compromised."[57] Another core tenet emphasised by the CESCR is the importance of the underlying determinants

[55] "UN Committee on Economic, Social and Cultural Rights (CESCR), 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)', 11 August 2000, E/C.12/2000/4, Available at: Http://Www.refworld.org/Docid/4538838d0.html (Accessed 17 May 2017).": §3, §4, §9.
[56] "OHCHR | Vienna Declaration and Programme of Action," accessed July 5, 2017, http://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx.
[57] Jalil Safaei, "Health for the Common Good," *Global Health Governance*, Special Issue on the Framework Convention on Global Health, 9, no. 1 (2015): 44.

of health. This shows once again the broad definition of health and the right to health adopted by the human rights regime, as per the WHO definitions, and it is this underlying determinant question which will prove worthy of note in Chapter 3.2.

These three documents together – the UDHR, the ICESCR and General Comment 14 – compose the primary legal basis and the foundation for the right to health. It must be noted, however, that multiple additional international and regional treaties and documents also recognise this right.[58] [59]

A key issue which arises in the main sources of the right to health is the idea of *progressive realisation*[60] within states' *maximum available resources* (as per in Article 2.1 of the ICESCR).[61] Whilst all human rights are universal, qualifying economic, social and cultural rights with the notion of progressive realisation is often seen by critics as creating a get-out for states to ignore their obligations. As Asher clarifies, however, this potential 'get-out' clause is limited by the content of General Comment 14, which makes it clear that "…[governments] must move as expeditiously and effectively as possible towards the full realization of the right to health and other human rights."[62] Therefore whilst the concept of progressive realisation is a necessary one to acknowledge and allow for the differences in the 'available resources' between states, it does not constitute a get-out clause for these states. In addition to this, General Comment 14 clarifies that there are *minimum core obligations* arising in the ICESCR which are not subject to the idea of progressive realisation. These are those obligations upon states which are considered to be of immediate effect in order to meet the minimum essential level of each of the human rights in the treaty. These obligations include:

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[58] For example the International Convention on the Elimination of All Forms Racial Discrimination (article 5E), the International Convention on the Elimination of All Forms of Discrimination against Women (articles 11.1F and 12), the Convention on the Rights of the Child (article 24), the European Social Charter (article 11), the African Charter on Human and Peoples' Rights (article 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (article 10)

[59] "UN Committee on Economic, Social and Cultural Rights (CESCR), 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)', 11 August 2000, E/C.12/2000/4, Available at: Http://Www.refworld.org/Docid/4538838d0.html (Accessed 17 May 2017).": §2.

[60] "Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."

[61] UN General Assembly, "International Covenant on Economic, Social and Cultural Rights.", accessed 17/05/2017

[62] Asher, *The Right to Health: A Resource Manual for NGOs*, 6;6.: 37.

> "(1) ensuring non-discriminatory access to health facilities, goods and services, especially for vulnerable or marginalised people, (2) ensuring access to food, basic shelter, housing, sanitation and water, (3) providing essential drugs as defined by the World Health Organisation (WHO), (4) ensuring equitable distribution of all health facilities, goods and services and (5) adopting a national public health strategy and plan of action addressing the concerns of all."[63]

The General Comment is clear, then; minimum obligations arise in the ICESCR which states must fulfil to comply with international human rights law. The right to health, the broadly-defined right which is the focus of this thesis, engenders the same three key state obligations as many other human rights; the obligations to respect, protect, and fulfil. The obligation to protect is of particular interest for the purposes of this work, as it is within this framework that the potential for international law – usually limited to state interactions – may stretch to include, in some way, business enterprises and other non-state actors. This potential for international law to stretch has been commented on with regard to the FCGH by Toebes, who states that;

> "Some potential lies in a clear definition in the FCGH of the "obligation to protect" of States parties, which would imply a duty to regulate private actors and to hold them to account when they violate domestic law reflecting human rights standards."[64]

This potential implied duty to regulate private actors is significant. The FCGH could have the potential to offer a means by which business enterprises could be held accountable for their actions by international law; what this might mean for them in terms of their role in the right to health will be analysed in Chapter 3. Currently the responsibility for regulating the right to health lies with states and states alone, meaning that they are expected to work within their own sovereign territory, taking businesses to task in the context of their national legal order. The FCGH could strengthen and solidify these responsibilities. Ultimately then, the right to health "has a considerable legal weight and [it] has the potential to impact on the health and

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[63] Lisa Forman et al., "Conceptualising Minimum Core Obligations under the Right to Health: How Should We Define and Implement the 'morality of the Depths,'" *The International Journal of Human Rights* 20, no. 4 (May 18, 2016): 534.

[64] Brigit Toebes, "The Framework Convention On Global Health: Considerations In Light Of International Law," *Global Health Governance*, Special Issue on the Framework Convention on Global Health, 9, no. 1 (2015): 19.

wellbeing of individuals all over the world".[65] An FCGH would give further weight to this right, and the potential impacts on health would be widened if the FCGH sets forth specific obligations and responsibilities regarding states and business enterprises. This idea will be further discussed in Chapter 3.1.2 where the current human rights obligations on businesses – and upon states with regard to businesses – will be examined in detail.

[65] Brigit Toebes et al., *The Right to Health: A Multi-Country Study of Law, Policy and Practice*, 2014th ed., Book, Whole (The Hague: T.M.C. Asser Press, 2014): xiii.

Chapter 3: Businesses and the Right to Health

3.1 Overview

3.1.1 Introduction to businesses and the right to health

The processes of globalisation and trade liberalisation have impacted upon our world in almost every way imaginable. Whilst economic interdependence between states is the most striking symptom of globalisation, scholarly attention has increasingly turned towards "challenges to the state's primacy, migration, global security concerns, culture, crime, the environment, and technology."[66] Transnational health issues should undoubtedly be considered paramount amongst these challenges of globalisation, and whilst there remains much debate about what globalisation actually entails, as well as its value, there is agreement that "…transnational corporations (TNCs) are either directly or indirectly involved in many if not most of these cross-border activities".[67] Businesses are central then to the process of globalisation, which has, *inter alia,*

> "…led to a transformation of patterns of health and diseases, and their broad determinants, on a transplanetary scale. This transition includes the territorial expansion of known health problems such as the spread of unhealthy lifestyles, as well as emergent risks that demonstrate new patterns of causation and outcome, such as antibiotic resistance and pandemic disease."[68]

It is clear that business enterprises intersect with global health in a variety of complex ways. For the purposes of clarity within this thesis, what might be considered the primary and most basic intersection of business and the right to health is under scrutiny; the actions of business enterprises in the underlying determinants of health. This juncture between health and business will be discussed at length in this chapter. Prior to analysing the connections between business and the underlying determinants of health, an analysis of the current legal obligations of businesses, and of states with regards to the actions of business entities, will be carried out. Following this consideration, there will be an exploration of *what* the role of business

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[66] David Atkinson, *Globalization*, n.d., //www.oxfordbibliographies.com/document/obo-9780199743292/obo-9780199743292-0009.xml.
[67] Clifford L. Staples, "Cross-Border Acquisitions and Board Globalization in the World's Largest TNCS, 1995-2005," *The Sociological Quarterly* 49, no. 1 (2008): 31.
[68] Nora Kenworthy et al., *Case Studies on Corporations and Global Health Governance : Impacts, Influence and Accountability* (London : Rowman & Littlefield International, 2016): 170.

enterprises is with regard to the underlying determinants of health, followed by an examination of whether this role is harmful regarding the realisation of the right to health across the world. The Health in All Policies approach will then be reviewed as an international recognition of the impact of non-health sector policies upon health issues. Finally, the potential of the proposed Framework Convention on Global Health will be assessed in terms of its possible impacts (and their utility) upon businesses acting in the underlying determinants of health.

3.1.2 Human rights obligations of states regarding business enterprises

To examine the ways in which an FCGH might impact upon the actions of businesses acting in the underlying determinants of health, it is necessary to understand what the current human rights obligations of business enterprises are. As discussed in Chapter 1 with reference to the work of MacKinnon, for example, it is evident that non-state actors (and specifically businesses) can and do perpetrate human rights abuses. The ways in which the private sector can be constrained by international law, however, are limited. In Chapter 2.2, the legal basis for the right to health was set forth. Prior to explaining the role of business in the underlying determinants of health, the human rights obligations which arise from international legislation and concern business enterprises will be discussed.

Some of the most useful sources regarding the human rights obligations of the business sector for the purposes of this thesis are the publications of the Committee on Economic, Social and Cultural Rights, particularly the General Comments of this Committee. General Comment 12 – which is concerned with the right to food – offers some instruction regarding the human rights obligations of businesses. Paragraph 12 of this document notes that whilst only states are parties to the ICESCR, "all members of society [including the private business sector] have responsibilities in the realization of the right to adequate food".[69] This is a transformative aspect of the Comment as it serves to recognise that non-state actors do have responsibilities in terms of the realisation of human rights. This notion of the responsibilities of business entities which occur in international human rights documents will be further developed in Chapter 4.1.3 which discusses the UN Guiding Principles on Business and Human Rights. Suffice to say then that whilst states are primarily responsible for the upkeep of human rights, business enterprises are not exempt from this responsibility.

[69] "UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 12: The Right to Adequate Food (Art. 11 of the Covenant), 12 May 1999, Available at: Http://Www.refworld.org/Docid/4538838c11.html [Accessed 3 July 2017],":. §12.

This said, it remains the case that states are primarily responsible for ensuring that human rights are respected, and the publications of the CESCR are instructive in this sense. For example, General Comment 12 the Committee plainly sets out the obligations of States Parties with regard to business enterprises, stressing that States Parties to the ICESCR should ensure that businesses act in accordance with the right to food.[70] This point is further emphasised by the Committee in General Comment 15 on the right to water, where it notes that states should "take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to water in pursuing their activities."[71] Both the right to food and the right to water are core to the underlying determinants of health, and this assertion from the CESCR that states must ensure that businesses act in accordance with these rights is significant in terms of the regulation of business by states, as it serves as a reminder to states that businesses must be regulated.

The newly adopted General Comment 24 on State Obligations under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities significantly elaborates upon the issue at hand. Paragraph 11 reiterates that States Parties to the Covenant are the only actors which the Comment deals with directly, but points out that the conduct of business entities can be dealt with indirectly by States Parties, and underlines that there are cases in which States Parties can be held *directly responsible* under international law for the actions of businesses. These cases are when a business is acting under instruction, direction, or control of the State Party (i.e. public contracts); when a business is able, according to national legislation, to employ elements of government authority or does so in the absence of official authorities; or when a State Party recognises and adopts the behaviour of the business entity as its own.[72] General Comment 24 then explains further ways in which private actors can be considered responsible for human rights; this is evidently useful with regard to the potential for international law to constrain businesses in their activities when those activities infringe upon rights.

[70] Ibid. §27.
[71] "UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 15: The Right to Water (Arts. 11 and 12 of the Covenant), 20 January 2003, E/C.12/2002/11, Available at: Http://Www.refworld.org/Docid/4538838d11.html [Accessed 3 July 2017]," n.d. §49
[72] "UN Committee on Economic, Social and Cultural Rights, General Comment No. 24 on State Obligations under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities," June 23, 2017. §11.

General Comment 24 also further elaborates upon the obligation to protect – which has been briefly discussed in Chapter 2.2 – as it relates to the conduct of business entities. It holds that this obligation means that states must prevent business activities from infringing upon human rights, and that there must be measures adopted by states in order for this protection to be effectively in place.[73] Such measures include legislative, administrative as well as educational measures, and access to effective remedy is an additional core aspect of the obligation to protect.[74] As well as this understanding of the obligation to protect, General Comment 24 also holds that this obligation "at times necessitates direct regulation and intervention."[75] The example which the General Comment offers is of tobacco control, bringing products in line with the FCTC, but the Comment proposes a broad overview of this issue in general and notes that in order to fulfil the obligation to protect, measures adopted should include, for example, "restricting marketing and advertising of certain goods and services in order to protect public health".[76] Such an approach could also be adopted by an FCGH. The obligation to protect constitutes just one of the three main pillars of state responsibility – to respect, to protect, and to fulfil – but it is evident from the text of General Comment 24 that this is significant in terms of the obligations of states with regard to business enterprises.

In conclusion then, whilst businesses themselves may not have specific obligations arising upon them from international human rights legislation, it is certainly the case that states do have obligations to regulate the activities of business enterprises when they violate and abuse human rights. An FCGH which draws upon these obligations could serve to strengthen the current regime by building upon the existing legislation surrounding businesses and human rights, specifically the right to health. Chapter 3.2 goes into further detail as to why it is necessary for business enterprises to be regulated in their activities regarding the right to health.

3.2 Businesses and the underlying determinants of health

3.2.1 Introduction

The underlying determinants of the right to health are referred to by the WHO as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and

[73] Ibid. §14.
[74] Ibid. §14.
[75] Ibid. §19.
[76] Ibid. §19.

systems shaping the conditions of daily life."[77] These determinants are therefore extremely comprehensive and include economic and political agendas and systems. In addition to the WHO definition, the underlying determinants of health are set forth in General Comment 14 on the Right to the Highest Attainable Standard of Health. According to the CESCR, these determinants are essentially the conditions necessary in order for people to live healthy lives, and include "food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."[78] Each of these determinants are impacted by a great variety of factors in addition to and extending beyond the sphere of business enterprises, but it is the impact of businesses specifically upon these underlying determinants which is of interest for the purposes of this thesis.

Businesses can and do impact upon almost every one of the underlying determinants of health. According to a 2008 WHO report, "the marketplace and private sector actors have, without doubt, great power in influencing social conditions, including many if not all the major social determinants of health."[79] This recognition from the WHO Commission on Social Determinants of Health serves to highlight the significance of the private sector in the health sphere, and yet it is telling that the private sector receives barely three pages of attention in this report of over two hundred pages. This report, along with the presence of the private sector at the 2011 UN meeting on NCDs,[80] brings to light the fact that international organisations and the global health sector would prefer to work alongside this private sector rather than impose regulations upon it. This desire to 'work together' and the necessity of political will to intervene in the role of private corporations will be further considered in the SWOT analysis and the concluding remarks of this thesis. There are then are multiple points at which businesses do intervene in the underlying determinants that merit significant discussion: this thesis will focus on just two of these examples, namely the underlying determinants of food and nutrition and housing.

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[77] "WHO | Social Determinants of Health," *WHO*, accessed May 27, 2017, http://www.who.int/social_determinants/en/.

[78] "UN Committee on Economic, Social and Cultural Rights (CESCR), 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)', 11 August 2000, E/C.12/2000/4, Available at: Http://Www.refworld.org/Docid/4538838d0.html (Accessed 17 May 2017).": 4.

[79] CSDH, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health.* (Geneva: World Health Organization, 2008), 142.

[80] David Stuckler, Sanjay Basu, and Martin McKee, "COMMENTARY: UN High Level Meeting on Non-Communicable Diseases: An Opportunity for Whom?," *BMJ: British Medical Journal* 343, no. 7821 (2011), 454.

3.2.2 Food and nutrition: the role of businesses in non-communicable diseases

The sheer severity of the global NCD epidemic has already been discussed in Chapter 2.1 of this thesis; the risk factors for these diseases – when approached from the perspective of the underlying determinants of health – are primarily related to food and nutrition. For this reason, it is pertinent to approach the question "what roles do businesses play in the underlying determinants of health?" from the angle of non-communicable diseases. Given that these diseases are an increasingly significant cause for concern to the international community, the role of businesses in the proliferation of these diseases – and how this role may potentially be limited – is certainly worthy of further analysis.

As previously explained, the risk factors for non-communicable diseases are fourfold, and include unhealthy diet, a lack of physical activity, the harmful use of alcohol and tobacco usage.[81] These four risks are evidently outwith the reach of the healthcare sector alone, and so a multi-sectoral approach, as championed by the FCGH, is the only sensible point of departure. This approach is multifaceted and potentially difficult, however, as noted in a recent WHO report;

> "To address the underlying determinants of health, public health has long relied on collaboration with friendly sister sectors, like education, nutrition, housing, and water supply and sanitation. Tackling the forces that drive the marketing of health-harming products is far more complex and contentious, but it can be done."[82]

This report on 'Ten Years in Public Health' dedicates a significant section to the burgeoning NCD problem, and it can be seen that whilst some sectors are seen as 'friendly sisters' to the public health field, those who market health-harming products are less like close siblings, and rather more difficult acquaintances. These marketing businesses mentioned in the report are the tobacco and alcohol industry, and whilst 'nutrition' has been tagged here as a 'friendly sister', the relationship between the food and drink industry and global health is decidedly more complex than this characterisation and comparison to the education and sanitation sectors

[81] "NCDs | NCD Alliance."
[82] Margaret Chan, "Ten Years in Public Health, 2007–2017: Report by Dr Margaret Chan, Director-General, World Health Organization." (World Health Organization, 2017), 95, http://apps.who.int/iris/bitstream/10665/255355/1/9789241512442-eng.pdf?ua=1.

would lead us to believe. The tobacco and alcohol industries, as well as the food and beverage industry, are primary vectors of the global NCD epidemic,[83] and so the role of business enterprises powering these industries of "unhealthy commodities"[84][85] will be approached in this section.

It is well established in the study of human rights today that all rights are interdependent, interrelated and indivisible.[86] The indivisibility of economic, social and cultural rights, especially regarding the right to health, is irrefutable. Being able to live a physically and mentally fulfilled life is evidently a prerequisite for the enjoyment of almost all other human rights. This said then, the causal relationship between the right to food and the right to health is undeniably inextricable, as can be seen in Chapter 3.1.2 regarding General Comment 12. In addition to this, the connection between these rights has been clearly delineated by various Special Rapporteurs of both rights. In a 2011 report, Olivier de Schutter (then the Special Rapporteur on the right to food) outlined the serious impact of malnutrition and undernutrition on health.[87] Anand Grover, previous Special Rapporteur on the right to health, noted the interdependence of the right to food and the right to health in his 2014 report, pointing out that the realisation of the right to health "is also inextricably linked to the fulfilment of the right to food."[88] Given that the right to food and the right to health are intimately connected, at what point do business enterprises come into this equation?

The juncture at which business first makes its appearance in the complex relationship between the right to food and the right to health is outlined by de Schutter when he notes that, "We have created obesogenic environments and developed food systems that often work against, rather than facilitate, making healthier choices."[89] This idea is further supported by Grover's report, which posits that corporations "have influenced food consumption patterns and promoted the

[83] Rob Moodie et al., "Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-Processed Food and Drink Industries," *Lancet (London, England)* 381, no. 9867 (2013): 670–79, doi:10.1016/S0140-6736(12)62089-3. 670.
[84] David Stuckler et al., "Manufacturing Epidemics: The Role of Global Producers in Increased Consumption of Unhealthy Commodities Including Processed Foods, Alcohol, and Tobacco," *PLoS Medicine* 9, no. 6 (June 2012):. 1.
[85] Soft drinks and processed foods that are high in salt, fat, and sugar, as well as tobacco and alcohol.
[86] "OHCHR | Vienna Declaration and Programme of Action."
[87] Olivier De Schutter, "Report Submitted by the Special Rapporteur on the Right to Food, Olivier De Schutter" (United Nations, December 26, 2011).
[88] Anand Grover, "Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover" (United Nations, January 4, 2014), 1.
[89] De Schutter, "Report Submitted by the Special Rapporteur on the Right to Food, Olivier De Schutter," §26.

use of tobacco, especially in developing countries."[90] These obesogenic environments are intrinsically linked, then, to the corporations which are increasingly impacting diets and lifestyles around the globe.

The ultra-processed food and drink industries[91] are among these forces which drive the marketing of the aforementioned 'health harming products' in today's 'obesogenic environments'. Ex Director-General of the WHO, Margaret Chan, addressed the UN General Assembly at the High-level meeting on NCDs in 2011, stating that:

> "Widespread obesity in a population is not a marker of failure of individual willpower, but of failure in policies at the highest level. Processed foods, very high in salt, trans fats, and sugar, have become the new staple food in nearly every corner of the world. They are readily available and heavily marketed. For a growing number of people, they are the cheapest way to fill a hungry stomach. The world certainly needs to feed its population of nearly 7 billion people. But it does not need to feed them junk food."[92]

The speech from Chan, and this quote specifically, highlight several key features of the discussion surrounding the NCD epidemic and its relationship with the ultra-processed food and drink industry. Initially, and significantly, it draws attention to the fact that 'widespread obesity' is generally seen as an indication of 'failure of individual willpower.' Positing individual behaviour as the driving factor behind obesity and decrying government attempts to curb the power of and impose restrictions upon the ultra-processed food and drink industry as 'nanny state' tactics has been found to be a significant strategy employed by these industries. Moodie et al. note that the social marketing techniques of transnational food corporations "place responsibility for the purchasing decision on the individual, and in doing so, separate these choices from the circumstances in which they are made."[93] Taylor furthers this idea still, and advances that the global consumption of ultra-processed foods is inextricably tied to the liberal market model. He holds that conflating 'behaviour' and 'choice' allows for the rooting

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[90] Grover, "Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover," §36.
[91] Moodie et al., "Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-Processed Food and Drink Industries.", 670.
[92] "WHO | United Nations High-Level Meeting on Noncommunicable Disease Prevention and Control."
[93] Moodie et al., "Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-Processed Food and Drink Industries." 674.

of "the NCD problem (behaviour) firmly in a market-oriented solution (choice)."[94] Taylor goes on to drive home the point that this behaviour-choice nexus is an exceptionally convenient one for business enterprises, stating that:

> "Increasing global consumption of ultra-processed food reflects a remarkably neat alignment of household perceptions of affordability, satisfaction, or status – all heavily shaped by poverty and inequality – and the profit-maximising model of a global food trade."[95]

This 'remarkably neat alignment' should not go unnoticed, and framing government intervention in public health as so-called nanny-state action does not serve the population; it serves the business corporations who dictate the 'choices' the population 'makes'. It is certainly significant then that the WHO Director General underlined the fact that high-level policies, and not individuals, are to blame for the global NCD problem at the UN high-level meeting. This being said, there has been criticism surrounding this meeting due to the presence of the private sector; some authors are dubious about offering these corporations a seat at the table in these discussions of global health.[96] The influence and power of business entities and industry players will be discussed further in Chapters 4 and 5.

The second feature of the quote from Chan to be drawn out and discussed is the very fact that processed food products have today become the staple food in countries – of varying income levels – across the globe. In a 2013 study, it was found that these ultra-processed foods "dominate the food supplies of high-income countries, and that consumption of these products is now rapidly increasing in middle-income countries."[97] This domination of the food chain is rapidly becoming more evident both globally and on national levels; according to Moodie et al., "75% of world food sales are of processed foods, whose largest manufacturers control a third of the global market."[98], whilst in the USA, over 50% of all food sales are controlled by

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[94] Taylor, "A Political Economy Of International Health: Understanding Obstacles To Multilateral Action On Non-Communicable Disease." 81.
[95] Ibid. 82.
[96] Stuckler, Basu, and McKee, "COMMENTARY," 454.
[97] C. A. Monteiro et al., "Ultra-Processed Products Are Becoming Dominant in the Global Food System," *Obesity Reviews* 14 (November 1, 2013):. 27.
[98] Moodie et al., "Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-Processed Food and Drink Industries." 671 – 672.

the ten largest food companies.[99] This domination then is not only by business enterprises in food supplies in general, but it is also glaringly obvious that a certain few of these enormous enterprises dominate the global market. The fact that businesses play a significant role in the realisation of the right to food – and, therefore, the right to health – is undeniable. Given that three-quarters of world food sales are processed foods (see Moodie et. al, above), the numbers speak for themselves. The question arises then; what is it about the role of businesses in the underlying determinants of health – specifically food and nutrition – that is inherently harmful?

3.2.3 Harms perpetrated by business in the food-related underlying determinant

It is held that the role played by businesses in the underlying determinant of food and nutrition is harmful, and this harm has been seen in multiple ways across the globe. The primary harms perpetrated by businesses in the food and nutrition sector are the **production and sale** of tobacco, alcohol, and ultra-processed food and drinks (together, **'health-harming products'**) in high, middle and low-income countries as well as the **irresponsible marketing** of these health-harming products.

It has been proven that trends in diet worldwide are shifting away from fresh foods and prepared meals towards ultra-processed ready-to-consume foodstuffs[100] and these ultra-processed products, produced by businesses, are unhealthy; these commodities lack nutrition and have high percentages of sugar, salt, and saturated fats; all of which can lead to becoming overweight or obese.[101] In a global study conducted in 2013, Basu et al. concluded (emphasis added) that:

> "[…] soft drink consumption was significantly associated with obesity and diabetes prevalence worldwide, even in low- and middle-income countries. Thus, the continued rise of soft drink consumption poses a **global public health risk** of worsening obesity and diabetes."[102]

[99] David Stuckler and Marion Nestle, "Big Food, Food Systems, and Global Health," *PLoS Medicine* 9, no. 6 (June 2012):. 1.
[100] Monteiro et al., "Ultra-Processed Products Are Becoming Dominant in the Global Food System." 27.
[101] Stuckler and Nestle, "Big Food, Food Systems, and Global Health.", 1.
[102] Sanjay Basu et al., "Relationship of Soft Drink Consumption to Global Overweight, Obesity, and Diabetes: A Cross-National Analysis of 75 Countries," *American Journal of Public Health* 103, no. 11 (2013):. 2077.

A global public health risk generally suggests infectious diseases that spread rapidly transnationally, bringing frightening predictions to our news cycle; the words 'Ebola', 'Zika', or 'H1N1' all spring to mind. Yet this global public health risk will not be spread by a mosquito or a cough. It will be spread by a can of soda. These processed foods and drinks, filling hungry stomachs in the cheapest way possible, are made readily available and are heavily marketed by the powerful food and beverages industry. These are businesses; their remit is not to feed the hungry the most nutritious foodstuffs available. Their remit is to increase profit for their shareholders. It is within this remit to turn a profit that we see the irresponsible marketing of the product. Moodie et al. employ the term 'industrial epidemic' to explain the damages to health associated with certain products, including (but not limited to) the food and drink, tobacco and alcohol industries.[103] According to those authors;

> "In industrial epidemics, the vectors of spread are not biological agents, but transnational corporations. Unlike infectious disease epidemics, however, these corporate disease vectors implement sophisticated campaigns to undermine public health interventions."[104]

These 'sophisticated campaigns' of the corporations assume many forms, but can be seen particularly clearly through the corporate social responsibility (CSR) campaigns of the food and drinks industry; CSR is understood as "a management concept whereby companies integrate social and environmental concerns in their business operations and interactions with their stakeholders."[105] CSR campaigns undertaken by the soda industry, for example, have elicited comparisons with the methods used by tobacco companies following the backlash against those corporations. Dorfman suggests that there are some key differences in these campaigns and the behaviours of the corporations, pointing out that "unlike tobacco, at the first signs of soda denormalization soda companies quickly launched comprehensive, well-funded, international CSR campaigns that take advantage of social media."[106] The CSR campaigns of soda companies are profit-seeking, which Dorfman highlights as a contrast to the actions of the tobacco industry. These campaigns of the soda businesses tend toward blaming individual behaviours and encouraging active lifestyles to improve these individual lifestyle 'choices'.

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[103] Moodie et al., "Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-Processed Food and Drink Industries.", 671.
[104] Ibid. 671.
[105] "What Is CSR?," accessed June 2, 2017, /csr/o72054.html.
[106] Lori Dorfman et al., "Soda and Tobacco Industry Corporate Social Responsibility Campaigns: How Do They Compare?," *PLoS Medicine* 9, no. 6 (June 2012): 4.

Effectively though, such campaigns only serve to distract from the issue at hand, which is the unhealthy product being marketed. Encouraging young children to get healthy by playing outside whilst simultaneously selling them a sugary drink is hardly a responsible campaign tactic. Tobacco companies can no longer advertise their commodity as anything other than what it is: a product which is extremely harmful to human health. The fact that the stated goal of PepsiCo's 'Refresh Project' "is to increase long-term sales by engaging youth in the initiatives and to build loyalty by associating PepsiCo with benevolent, worthwhile ventures"[107] shows that the ultra-processed food and beverage industries have not yet undergone the same vilification as the tobacco industry, and are still able to explicitly seek to increase sales and create brand loyalty. Given that the businesses behind these extremely prosperous industries are all quite literally feeding into the worldwide NCD epidemic, the quicker this vilification of ultra-processed food and drinks happens, the better.

Assuming the influence and power of advertising and marketing to be significant, it is noted that certain dangerous habits, "[…] such as smoking, tend to be more prevalent in lower than higher income groups because of social factors, such as tobacco advertising targeting poor neighborhoods."[108] This advertising then significantly deepens health inequities which already exist within and between societies, as discussed in Chapter 2.1. In addition to the example of tobacco advertising targeting poor communities, a recent report from the University of Connecticut found that the targeted marketing of unhealthy foods and drinks to communities of colour in the USA contributes to health disparities amongst American youth.[109] Targeting specific swathes of American youth then further deepens health inequities within American society, yet it is more worrying still that this marketing contributes to those inequities which exist *between* societies. For example, a Guardian report discovered that people in lower income countries were significantly more exposed to tobacco marketing, nothing that "overall, those in low-income countries were almost 10 times more likely to report exposure to at least one form of traditional tobacco marketing."[110] Business actors in the underlying determinants to

[107] Dorfman et al., "Soda and Tobacco Industry Corporate Social Responsibility Campaigns: How Do They Compare?": 4.
[108] Audrey R. Chapman, "The Social Determinants of Health: Why We Should Care," *The American Journal of Bioethics* 15, no. 3 (2015): 47.
[109] Jennifer Harris et al., "Food Advertising Targeted to Hispanic and Black Youth: Contributing to Health Disparities" (Rudd Center for Food Policy and Obesity, University of Connecticut, 2015), 4.
[110] "Big Tobacco Targets the Young in Poor Countries – with Deadly Consequences," *The Guardian*, December 1, 2015, sec. Global development, https://www.theguardian.com/global-development/2015/dec/01/big-tobacco-industry-targets-young-people-poor-countries-smoking.

health then are significantly contributing to the existing health inequities and disparities within and between societies in global health, and the deepening of these chasms in health and welfare are profoundly concerning.

Targeted advertising towards young people is in itself a dangerous trend; the ultra-processed food and drink industry, similarly to the tobacco industry "develops customers as young as possible, using tactics such as early-childhood health promotion schemes."[111] Developing a customer base from a young age is therefore a tactic employed by multiple businesses within the health-harming product industries. Once such a customer base has been created, it is also the case that "[…] the systematic and aggressive mass-marketing campaigns of alcohol, ultra-processed foods and drink, and tobacco contribute to demand."[112] It can be seen then that the business enterprises involved in the production and marketing of so-called health-harming products create the demand for these products, which they then supply to people across the globe.

Finally, it is necessary to state the obvious; the products marketed and supplied by these industries are inherently harmful. Smoking is the number one cause of preventable death in the world, and it is estimated by current trends that it will cause over 8 million deaths yearly by 2030.[113] The harmful use of alcohol creates an enormous societal burden and is the cause of "more than 200 disease and injury conditions in individuals, most notably alcohol dependence, liver cirrhosis, cancers and injuries."[114] In 2012, almost 6% of deaths worldwide were attributed to the use of alcohol.[115] In the USA today, 68% of foods purchased in grocery stores contain added sugars.[116] While, as explained previously, the sugar industry itself has not yet been vilified to the same extent as the tobacco industry, the harms and addictive properties of sugar have been the subject of significant recent research and the findings are increasingly concerning. For example, it has been found that the intense sweetness of sugar "can surpass

[111] Moodie et al., "Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-Processed Food and Drink Industries." 673.
[112] Ibid. 672.
[113] CDC's Office on Smoking and Health, "Smoking and Tobacco Use; Fact Sheet; Fast Facts," *Smoking and Tobacco Use*, accessed June 3, 2017, http://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/.
[114] "WHO | Alcohol," *WHO*, accessed June 3, 2017, http://www.who.int/substance_abuse/facts/alcohol/en/.
[115] Ibid.
[116] Margot Sanger-Katz, "You'd Be Surprised at How Many Foods Contain Added Sugar," *The New York Times*, May 21, 2016, sec. The Upshot, https://www.nytimes.com/2016/05/22/upshot/it-isnt-easy-to-figure-out-which-foods-contain-sugar.html.

cocaine reward".[117] These products are all the key drivers of the NCD epidemic and the inequities it entails, causing serious health harms to vast swathes of the global population.

To conclude, it has been seen that the actions of businesses in the underlying determinant of food and nutrition have a significant impact upon the health of millions of people across the world. With a focus on the role of businesses in food and nutrition, it has been shown that the tobacco, alcohol and ultra-processed food and drinks industries significantly contribute to the burgeoning NCD epidemic, whilst simultaneously deflecting attention away from themselves and government policy, and towards individual 'bad behaviour', by employing complex CSR and marketing strategies. Not only are these businesses predominantly to blame for the creation of some of the NCD risk factors (i.e. the harmful consumption of alcohol and the use of tobacco), but they are also guilty of evading the responsibility for the problem that they have created.

> "In the view of the WHO Director-General, the widespread occurrence of obesity and diabetes throughout a population is not a failure of individual willpower to resist fats and sweets or exercise more. It is a failure to make bold political choices that take on powerful economic operators, like the food and soda industries. If governments understand this duty, the fight against obesity and diabetes can be won. The interests of the public must be prioritized over those of corporations."[118]

The ex-Director-General of the WHO has referred to the role of businesses in global health multiple times, clearly highlighting in her speeches the gravity of the situation and the urgency of action. Yet thus far, businesses acting in the underlying determinants of the right to health, especially as far as food and nutrition are concerned, have been effectively unconstrained in their behaviour by international law. How then, if at all, can these businesses be held accountable for their actions? Will the proposed FCGH be able to impact businesses in this role, and if so, how? These questions will be considered in Chapter 4.

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[117] Magalie Lenoir et al., "Intense Sweetness Surpasses Cocaine Reward," ed. Bernhard Baune, *PLoS ONE* 2, no. 8 (2007): 1.
[118] Chan, "Ten Years in Public Health, 2007–2017: Report by Dr Margaret Chan, Director-General, World Health Organization.," 103.

In summary then, to assume that the health and welfare of the global population is paramount amongst the concerns of the ultra-processed food and beverage industry would be as naïve as to assume that the tobacco industry behaves in the best interests of smokers. Despite corporate social responsibility campaigns that point to the 'good' being perpetuated by soda businesses, for example, it remains the case that these businesses exist to turn over a profit. International human rights treaties are many. But these treaties are written to protect human beings from harms perpetrated by states and state actors. It is for this reason that the only possible way to constrain business enterprises is to do so via international legislation; self-regulation in the for-profit sector is uncommon and is ultimately done solely to increase profit. If the soda industry is the example, the only way in which this industry will increase its profit is by selling more soda. This is clearly not in the favour of global health.

3.2.4 Businesses and the underlying determinants of health: housing

3.2.4.1 Introduction

The underlying determinants of health are many, but food and housing are certainly two significant examples as far as business enterprises are concerned. Whilst the literature surrounding the impact of the actions of businesses acting in the field of food and nutrition is vast and merits significant analysis, as far as the underlying determinant of housing is concerned, a case study can in this instance provide a significant example of the harm that businesses can and do perpetrate in the right to health, and why this harm must be better controlled and accountability mechanisms should be put in place. The case study which will be examined is the recent fire in the UK at Grenfell Tower.

3.2.4.2 Case Study: the Grenfell Tower Fire

On the 14th June 2017, Grenfell Tower – a 24-storey tower block in the London district of Kensington and Chelsea – caught fire and burned throughout the night. The death toll currently stands at 80, with the number expected to rise.[119] In the days and weeks following the devastating blaze, questions have been raised about the safety of the building,[120] and journalists

[119] "London Fire: A Visual Guide to What Happened at Grenfell Tower," *BBC News*, June 28, 2017, sec. UK, http://www.bbc.co.uk/news/uk-40301289.
[120] "Concerns Raised about Grenfell Tower 'for Years,'" *BBC News*, June 14, 2017, sec. London, http://www.bbc.co.uk/news/uk-england-london-40271723.

have commented on the nature of the district in which the fire took place;[121] one characterised by wealth and poverty and glaring inequality. The incident at Grenfell Tower provides a significant example of the horrifying harms that can be perpetrated in the sphere of businesses and the underlying determinants of health when there is no means by which they are held accountable for their actions.

Grenfell Tower was social housing owned by the local public authority, Kensington and Chelsea Council, but the building was managed by a private firm called KCTMO; Royal Borough of Kensington and Chelsea Tenant Management Organisation Limited.[122] The fire of the 14th June is subject to an ongoing public inquiry,[123] but many experts have pointed fingers at the cladding[124] (which was not compliant with building standards)[125] installed on the exterior of the tower during an £8.6m renovation of the building, completed in May 2016.[126] Residents of the tower had raised their concerns about its safety but these went unaddressed by KCTMO.[127] In November 2016, a resident group – Grenfell Action Group – which raised these issues with the management of KCTMO stated (emphasis added);

> " […] the Grenfell Action Group firmly believe that **only a catastrophic event** will expose the ineptitude and incompetence of our landlord, the KCTMO, and bring an end to the dangerous living conditions and neglect of health and safety legislation that they inflict upon their tenants and leaseholders."[128]

The tragic foresight of the Grenfell Action Group stretches further still, with the resident group's blog also condemning the lack of fire safety and emergency information received by

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[121] Caelainn Barr, "Wealth and Poverty Sit Side by Side in Grenfell Tower's Borough," *The Guardian*, June 15, 2017, sec. UK news, https://www.theguardian.com/uk-news/2017/jun/15/wealth-and-poverty-sit-side-by-side-in-grenfell-towers-borough.
[122] "THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA TENANT MANAGEMENT ORGANISATION LIMITED - Overview (Free Company Information from Companies House)," accessed July 3, 2017, https://beta.companieshouse.gov.uk/company/03048135.
[123] Heather Stewart Political editor Harriet Sherwood, "Theresa May Announces Public Inquiry into Grenfell Tower Fire," *The Guardian*, June 15, 2017, sec. UK news, https://www.theguardian.com/uk-news/2017/jun/15/theresa-may-announces-public-inquiry-into-grenfell-tower-fire.
[124] Tom Symonds and Daniel De Simone, "Grenfell Tower: Cladding 'Changed to Cheaper Version,'" *BBC News*, June 30, 2017, sec. UK, http://www.bbc.co.uk/news/uk-40453054.
[125] "PMQs Verdict: Jeremy Corbyn Hits Powerful Notes but May Unshaken | Politics | The Guardian," accessed June 29, 2017, https://www.theguardian.com/politics/2017/jun/28/pmqs-verdict-jeremy-corbyn-hits-powerful-notes-but-theresa-may-not-shaken.
[126] "London Fire."
[127] "Concerns Raised about Grenfell Tower 'for Years.'"
[128] grenfellactiongroup, "KCTMO – Playing with Fire!," *Grenfell Action Group*, November 20, 2016, https://grenfellactiongroup.wordpress.com/2016/11/20/kctmo-playing-with-fire/.

tenants from their landlord; they stated in 2016 that residents of Grenfell Tower "received no proper fire safety instructions from the KCTMO."[129] The catastrophic event the Grenfell Action Group warned of happened, and KCTMO released a statement which outlined their awareness of past concerns raised by residents and their affirmation that such concerns are taken seriously.[130]

The residents of Grenfell Tower knew that a disaster might occur in their building, yet their warnings were not heeded. A 2013 coroner's report into another fatal fire in London recommended the retroactive fitting of sprinklers in high-rise buildings[131] as well as the publication of "consolidated national guidance"[132] regarding the "stay put" principle – a principle which has been the focus of significant criticism[133] following the high death toll of the Grenfell Tower fire. Safe housing is a paramount component for the realisation of the right to health and its underlying determinants.[134] The people who lived in Grenfell Tower warned KCTMO that their homes were not safe, and the UK government had been given recommendations by the coroner's office to retrofit sprinklers and consolidate fire safety advice in high rise buildings; yet all of this went unheeded. The human rights of the residents of Grenfell Tower were violated by the business which managed their homes, KCTMO, and were further neglected by the state which allowed a private enterprise to perform the governmental obligation to provide social housing without properly regulating the enterprise. The state failed to uphold its obligation to protect, especially in light of the fact that a private enterprise was in this instance fulfilling the duty of a state agency – managing the state owned social housing building. This is evidently an example of a time in which the state can be held directly responsible under international law for the actions of businesses, as discussed in Chapter 3.1.2, since in the case of KCTMO and Grenfell Tower, the business enterprise in question was exercising aspects of government authority.

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[129] Ibid.
[130] Marketing Manager, "Kensington and Chelsea Tenant Management Organisation - News," accessed July 3, 2017, http://www.kctmo.org.uk/news/336/further-statement-on-the-fire-at-grenfell-tower.
[131] Frances Kirkham CBE, "Lakanal House Fire 3 July 2009," March 28, 2013, https://www.lambeth.gov.uk/sites/default/files/ec-letter-to-DCLG-pursuant-to-rule43-28March2013.pdf.: 3.
[132] Ibid. 2
[133] "'Stay Put' Safety Advice to Come under Scrutiny after Grenfell Tower Fire | UK News | The Guardian," accessed July 3, 2017, https://www.theguardian.com/uk-news/2017/jun/14/stay-put-safety-advice-under-scrutiny-grenfell-tower-fire.
[134] According to the WHO, the health impacts of housing as an underlying determinant of health include home accident prevention and fire prevention.
"WHO | The Determinants of Health," *WHO*, accessed July 3, 2017, http://www.who.int/hia/evidence/doh/en/index4.html.

The persistent inequalities within the district of Kensington and Chelsea which were plainly exposed following the fire at Grenfell Tower are also significant as far as health inequities are concerned. According to Oxfam's Max Lawson, only 8% of the population of the UK live in public housing, and this percentage is "overwhelmingly from the poorest and most deprived sections of society."[135] These poor and deprived sections of society present themselves in Kensington and Chelsea in a stark contrast; the borough has the highest average salary in the UK (£123,000 p.a.), yet it also hosts the largest gap between the average and median salaries in the country,[136] an indicator of its divisions and inequalities. Writing for the Guardian, Leilani Farha, the UN Special Rapporteur on the right to adequate housing, has pointed out that the Grenfell Tower fire is a "devastating illustration of the impact of substandard housing on the lives of poor people."[137] It has been demonstrated in Chapter 2.1 that the risk factors for NCDs are patterned along the social gradient. It is evidently also the case that these risks and inequities patterned along social gradients are not limited to the diet and nutrition sectors of health, but can be seen across the underlying determinants of health, including housing.

The role of business then in the Grenfell Tower blaze is evident; it was a business enterprise which managed the building, it was a business enterprise that ignored the concerns of residents; it was a business enterprise that spent £8.6m on a refurbishment which sought to improve the aesthetic of the building for the wealthier inhabitants of the rest of the borough;[138] and it was a business enterprise – along with a local authority – that saved money[139] by using sub-standard cladding material that was not compliant with building regulations.[140] This specific case study has served to demonstrate again the impact of the activities of business enterprises in the underlying determinants of health, and highlights the fact that while the UK should, according to its human rights obligations, have protected the residents of Grenfell Tower, it did not do

[135] "The Meaning of Grenfell Tower | From Poverty to Power," accessed July 3, 2017, http://oxfamblogs.org/fp2p/grenfell-tower-is-a-hurricane-katrina-moment-revealing-the-shameful-state-of-britain/.
[136] "London Fire."
[137] "Grenfell Tower Is a Terrible Betrayal of Human Rights," *The Guardian*, June 21, 2017, sec. Housing Network, https://www.theguardian.com/housing-network/2017/jun/21/grenfell-tower-terrible-betrayal--human-rights-uk-government.
[138] "Grenfell Tower Cladding That May Have Led to Fire Was Chosen to Improve Appearance of Kensington Block of Flats | The Independent," accessed July 3, 2017, http://www.independent.co.uk/news/uk/home-news/grenfell-tower-cladding-fire-cause-improve-kensington-block-flats-appearance-blaze-24-storey-west-a7789951.html.
[139] Simone, "Grenfell Tower."
[140] "PMQs Verdict: Jeremy Corbyn Hits Powerful Notes but May Unshaken | Politics | The Guardian."

so. An FCGH could solidify these obligations and increase public awareness and understanding of these obligations so that such disasters do not occur again in the future, and certainly do not occur without significant access to remedy and justice.

3.3 Health in All Policies

It has therefore been shown that businesses have a significant role to play in the underlying determinants of health, and that these determinants of health are impacted by multiple factors which extend far beyond the health sector alone. One response at the international level to this issue is the Health in All Policies (HiAP) approach, championed by the Finnish Presidency of the EU in 2006 and by the WHO, and which has now seen integration into various national policies. HiAP is defined by the WHO as,

> "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity […] It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being."[141]

The very existence of the HiAP approach, which is also intrinsically linked to the achievement of the Sustainable Development Goals, shows a certain level of international political will and momentum. The SDGs are holistic and all-encompassing, and if they are to be realised, the underlying determinants of health – and the policies which impact and shape them – must be tackled on an international level. Gostin notes that this approach,

> "[…] recognizes that ministries of health cannot accomplish major reforms on their own […] Beyond governments, an 'all-of-society' approach seeks to include all social sectors to achieve meaningful results, such as businesses, foundations, the media, and academia."[142]

This recognition that the health sector alone cannot – and should not – be responsible for achieving major reforms or indeed the full realisation of the right to health is significant, and the FCGH does adopt this multi-sectoral approach. If businesses are to be regulated, there must

[141] "WHO | The 8th Global Conference on Health Promotion, Helsinki, Finland, 10-14 June 2013," *WHO*, accessed June 28, 2017, http://www.who.int/healthpromotion/conferences/8gchp/statement_2013/en/.
[142] L.O. Gostin, D. Sridhar, and D. Hougendobler, "The Normative Authority of the World Health Organization," *Public Health* 129, no. 7 (July 1, 2015): 858.

first be this recognition that they do have responsibilities and that they do not act in a vacuum. Another facet of the HiAP approach is the notion that such an approach is beneficial to all parties, seeking "[…] to find the 'win-wins' where all partners have a positive stake in the action and all can share in beneficial outcomes."[143] The idea of finding 'win-win' situations for both health outcomes and business enterprises is an interesting one, and if it is indeed the case that these situations occur and function, then this is certainly significant in terms of moving forward with the FCGH. As aforementioned, self-regulation in the for-profit sector is rare when no clear benefits to the business can be perceived. If businesses can be assured of positive outcomes in limiting their bad behaviour in the underlying determinants of health, then surely, they can be convinced to adhere to domestic state rules and the international Framework Convention.

The HiAP approach then is an encouraging sign of international political will and a real desire to ensure that policy- and deal-making do not result in health consequences. It also serves to confirm and underline the fact that businesses and non-health sectors do indeed play a significant role in the right to health, and that there is a need for this role to be better regulated. It was stated at the Adelaide Conference in 2017 on the HiAP approach and the SDGs that "health is a political choice",[144] and the point was furthered by emphasising that these political decisions have significant influence upon social inequity. The HiAP approach and its strategies and tools are then a demonstrable example of the international community recognising the role of businesses in the underlying determinants of health. This said, HiAP is an approach, a method, a tool: it is not a piece of international legislation and so its impact should perhaps not be overstated. In terms of recognition of an issue and potential to create public awareness via national policy-making, HiAP is significant and certainly conveys a message from the international community with regard to health. Yet in order to fully assess the situation then, it is necessary to evaluate the existing instruments of international law which relate specifically to the right to health.

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[143] "Local Wellbeing, Local Growth: Why We Need Health in All Policies | Public Health Matters," accessed June 28, 2017, https://publichealthmatters.blog.gov.uk/2016/10/25/local-wellbeing-local-growth-why-we-need-health-in-all-policies/.

[144] "WHO | Health in All Policies: Progressing the Sustainable Development Goals," *WHO*, accessed June 28, 2017, http://www.who.int/phe/events/HiAP-conference-March2017/en/.

3.4 Conclusions: the potential impacts of FCGH upon businesses

The harmful activities of business enterprises in the underlying determinants of health have been clearly set out in this chapter. The significance of an FCGH lies in its holistic approach and its focus on health equity and justice; if the Grenfell Tower fire example is an example of a lack of justice, then the FCGH is much needed and could certainly be impactful in this regard. Accountability mechanisms and access to justice for victims of corporate rights abuse which could arise in an FCGH would certainly strengthen the existing frameworks that are in place with regards to global health. The human rights focus of an FCGH is key; only by understanding global health inequities as injustices and abuses of human rights can the activities of businesses effectively be constrained by international legislation. The FCGH itself will now be analysed at length in Chapter 4.

Chapter 4: The Framework Convention on Global Health

4.1 Introduction

The right to health has been set forth and the significant impact of the activities of business enterprises upon this right has been evidenced. The Framework Convention on Global Health has been introduced in Chapter 1, but in order to fully appreciate and understand its potential as an instrument of international law acting in the health field, it will now be thoroughly evaluated. First the precedent for global health regulations in international law will be discussed, given that the FCGH will add to this body of legislation. Secondly there will be an analysis of the UN Guiding Principles on Business and Human Rights which serve as an instructive example of the ways in which businesses can be regulated by international frameworks. Following this evaluation of the precedent of the FCGH, the details of the proposed treaty itself will be set forth. These details will then be unpacked and analysed in the form of a SWOT analysis, and subsequently conclusions on the FCGH and its potential will be drawn.

4.2 Precedent for global health regulations in international law

The utility and impact of the proposed Framework Convention on Global Health will be subject to a variety of factors, and its success is not guaranteed. As seen throughout the body of this thesis, businesses are rapidly becoming key actors in the international sphere, and it is evident that international law is morphing and adapting its traditions to encompass a greater number of actors in its scope. The scope of international law and the actors which it seeks to regulate can be seen through past treaties, and for the purposes of this thesis, it is useful to study the predecessors in the field of international law and health in order to assess the potential of the FCGH. International legislation which impacts upon the right to health is significant; many environmental conventions, for example, have an impact upon human health.[145] However, whilst there are several international conventions and treaties which impact upon human health, there are fewer which are *specifically* targeted at health issues. And while treaties that are explicitly aimed at health inequities (as the proposed FCGH will be) do not yet exist, there are pieces of international legislation which could be very instructive in terms of the drafting of the FCGH. The three documents that will be examined then, are the Framework Convention on Tobacco Control (FCTC), the International Health Regulations (IHR (2005)), and the UN

[145] Yasmin von Schirnding, William Onzivu, and Andronico O Adede, "International Environmental Law and Global Public Health.," *Bulletin of the World Health Organization* 80, no. 12 (2002): 970.

Guiding Principles on Business and Human Rights: Implementing the "Protect, Respect, and Remedy" Framework (UNGPs).

From a legal perspective, these three documents are of different character. The FCTC and the IHR (2005) are both legally binding international instruments – one a convention, the other a set of regulations – adopted under the auspices of the World Health Organisation. These are both documents that pertain specifically to health issues. The UNGPs, on the other hand, were adopted by the United Nations and are not concerned with health, but rather with businesses and corporate social responsibility, which is evidently of interest to this thesis. The UNGPs are notably not a legally binding instrument; they are a set of 31 principles which form a framework that elaborates on "the implications of relevant provisions of existing human rights standards […] [they] refer to and derive from States' existing obligations under international law."[146] Together, the UNGPs, the FCTC and the IHR (2005) are useful instruments of analysis in assessing the potential of the FCGH. They will be evaluated in turn.

4.2.1 Framework Convention on Tobacco Control

The FCTC came about as a direct response from the WHO to the worldwide tobacco epidemic. The health harms of tobacco are well documented; today in many states it is the norm to see cigarettes sold in boxes plastered with disturbing images of tarred lungs and grave tumours. Given that tobacco kills up to half of its consumers,[147] this is a necessary measure, clearly understood by the international community, and one which is a result of the FCTC. The FCTC entered into force on 27th February 2005, and today it has 180 States Parties.[148] Its stated objective is to protect human beings from "…the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke",[149] which it aims to achieve through the implementation of tobacco control measures by the States Parties on national, regional and international levels. The Convention seeks to limit not only the *supply* of tobacco products but is also committed to reducing the *demand* for those products in the first place, which distinguishes it from previous drug control treaties.[150] Articles 6 to 14 of the

[146] Office of the United Nations High Commissioner for Human Rights, "Frequently Asked Questions About The Guiding Principles on Business and Human Rights" (United Nations, 2014). 8.
[147] "WHO | Tobacco," *WHO*, accessed June 17, 2017, http://www.who.int/mediacentre/factsheets/fs339/en/.
[148] "United Nations Treaty Collection," accessed June 17, 2017, https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-4&chapter=9&clang=_en.
[149] "WHO Framework Convention On Tobacco Control" (World Health Organization, 2003). 5.
[150] "WHO | WHO Framework Convention on Tobacco Control," *WHO*, accessed June 17, 2017, http://www.who.int/fctc/text_download/en/.

FCTC detail the demand reduction provisions, which include both price and tax as well as non-price measures to diminish demand, whilst articles 15, 16 and 17 set out the supply reduction provisions, and are concerned with "illicit trade in tobacco products, sales to and by minors, provision of support for economically viable alternative activities."[151] This attention to both the supply and the demand sides of the global tobacco trade is significant, as it highlights a holistic approach adopted by the WHO in the fight against the tobacco industry; this preventative rather than curative method is also one which is apparent in the proposed FCGH document. Has this holistic, preventative approach of the FCTC been successful in curtailing the role of the tobacco industry in the human right to health, and its impact on the underlying determinants of health? The answer to this question is key if the FCGH is to utilise the FCTC as an example in its drafting.

The success of the FCTC, according to the current literature available on the subject as well as the WHO's own impact assessments, is mixed. Statistical findings generally appear to suggest that the implementation of the Convention has realised a decrease in prevalence of smoking in its Parties,[152] yet the literature also tends to point to the fact that this progress has been slow. One positive example of regional implementation of the FCTC can be seen in the European Union (EU), where the Tobacco Products Directive (TPD) was adopted in 2001 but was revised in 2009 in order to adopt a more coherent approach to the problem following the creation of the FCTC.[153] The revised TPD currently expects to achieve – amongst other goals – a 2% annual decrease in EU public healthcare costs related to tobacco consumption.[154] In addition to the concerns surrounding the slow progress of the FCTC, there has (unsurprisingly) been significant retaliation from the tobacco industry which no doubt influences the efficacy of the Convention. As far as statistics are concerned, though, the data is primarily encouraging. According to a worldwide study carried out by Gravely et al., between 2005 and 2015 the mean smoking prevalence in 126 of the Parties to the FCTC fell by 2.5%.[155] The key findings also include:

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[151] Ibid.
[152] Shannon Gravely et al., "Implementation of Key Demand-Reduction Measures of the WHO Framework Convention on Tobacco Control and Change in Smoking Prevalence in 126 Countries: An Association Study," *The Lancet Public Health* 2, no. 4 (n.d.): 166.
[153] Roberto Bertollini et al., "Tobacco Control in Europe: A Policy Review," *European Respiratory Review* 25, no. 140 (May 31, 2016): 153.
[154] "EU Rules on Tobacco Products: Infographic" (European Commission, May 2016), https://ec.europa.eu/health/sites/health/files/tobacco/docs/tobacco_infograph2_en.pdf.
[155] Gravely et al., "Implementation of Key Demand-Reduction Measures of the WHO Framework Convention on Tobacco Control and Change in Smoking Prevalence in 126 Countries: An Association Study," 166.

> "Unadjusted linear regression showed that increases in highest-level implementations of key measures between 2007 and 2014 were significantly associated with a decrease in smoking prevalence between 2005 and 2015. Each additional measure implemented at the highest level was associated with an average decrease in smoking prevalence of 1.57 percentage points."[156]

According to this study, then, the implementation of the demand-reduction provisions of the FCTC is "significantly associated with lower smoking prevalence, with anticipated future reductions in tobacco-related morbidity and mortality."[157] Yet whilst implementing demand-reduction measures has been found to correlate with decreasing tobacco usage, it is also the case that in many States Parties, the most effective measures – increased prices and taxation of the product – are those which are least implemented.[158] A 2009 WHO report on the progress of the implementation of the FCTC highlighted similar trends, and found that implementation varied not only between different policy measures, but also on a regional basis.[159] The fact that the implementation and the impact of the FCTC varies so greatly from region to region and policy to policy also serves to illuminate a key issue with regard to international conventions: political will and commitment is vital if the instrument is to succeed. For an international global health treaty to be translated into practice, the full participation of all core actors involved – both state and non-state actors – is an essential requirement. Without this political will and participation, the legislation is relegated to the background as another piece of paper in the bureaucracy of human rights treaties.

There are clearly lessons to be learned from the FCTC for the proposed FCGH, especially in light of the fact that it is the piece of international legislation which is most comparable in nature to the FCGH. As the first treaty under Article 19 of the WHO Constitution, the FCTC illustrates the potential of the WHO as a law-making authority, which is critical if the FCGH is to be housed under the auspices of this organisation. Kastler has pointed out that the FCTC

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[156] Gravely et al., "Implementation of Key Demand-Reduction Measures of the WHO Framework Convention on Tobacco Control and Change in Smoking Prevalence in 126 Countries: An Association Study." 166
[157] Ibid. 166.
[158] Adriana Blanco, "Ten Years of the WHO Framework Convention on Tobacco Control: Progress in the Americas.," *Salud Pública de México,* 59 (2017): 122.
[159] World Health Organization, "2009 Summary Report on Global Progress in Implementation of the WHO Framework Convention on Tobacco Control" (Geneva, 2009), 29.

made room for "normative activity" [160] in the field of international global health law-making; this innovative space will be important if the FCGH is to be creative in its design in order to incorporate businesses, in some way, in its scope. It has also been suggested by authors in discussions of the proposed FCGH that the "overall positive experiences gained through existing framework conventions in the field of environmental law and tobacco control seem to indicate that this is a suitable tool for addressing global health inequities."[161] Both of these points then show that a Framework Convention, under the auspices of the WHO in its lawmaking capacity, is a strong tool for international health law. Yet one key issue in the FCTC is the fact that whilst many member states have complied with the reporting requirements of the treaty and are committed to awareness-raising, it remains the case that "few member states have adopted FCTC recommendations to ban advertising".[162] Banning advertising is clearly one of the many aspects of the FCTC concerned with regulating businesses and their actions in the underlying determinants of health; if all Parties to the FCTC have not controlled the activities of the tobacco industry – an industry which is globally vilified – then is it likely that member states of the FCGH would be able to do so to other industries, such as the ultra-processed food and beverage industry? DeLaet does suggest however that despite this, "areas of implementation effectiveness indicate that specialized legal regimes may show promise of success in generating voluntary cooperation among states on certain highly focused objectives."[163] The experiences from the FCTC suggest that if states voluntarily cooperate, and the document lends itself to it, there is an opportunity for businesses to potentially be regulated by the actions of states. This is an experience that the FCGH can build upon.

4.2.2 International Health Regulations

The foundations of the IHR (2005) can be dated back to the European cholera epidemics of 1830 and 1847,[164] which triggered the first example of international cooperation in public health, and can be traced further still to Venetian Republic of the 15th century and its

[160] Kastler, "Why the World Health Organisation Should Take the Lead on the Future Framework Convention on Global Health," 140.
[161] Toebes, "The Framework Convention On Global Health: Considerations In Light Of International Law," 19.
[162] Debra DeLaet, "What A Wonderful World It Would Be: The Promise And Peril Of Relying On International Law As A Mechanism For Promoting A Human Right To Health," *Global Health Governance*, Special Issue on the Framework Convention on Global Health, 9, no. 1 (2015). 93.
[163] Ibid. 108.
[164] "Frequently Asked Questions about the International Health Regulations (2005)" (World Health Organization, 2009), http://www.who.int/ihr/about/FAQ2009.pdf?ua=1. 1.

lazaretti.[165] The IHR (2005) as they appear today were initially adopted in 1969 and were preceded by the International Sanitary Regulations of 1951. They were revised in 2005, entered into force on 15th June 2007 and are today legally binding upon 194 states. The Regulations themselves are essentially concerned with controlling the spread of disruptive infectious diseases and preventing international outbreaks of epidemics. According to the WHO, the aim of the Regulations is:

> "[…] to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."[166]

The IHR (2005) were revised to include newly emerging diseases and threats, and to ensure that they encompassed anything which would equal a public health emergency of international concern (PHEIC).[167] A PHEIC is defined by the WHO as an extraordinary event which is found to be a public health risk to other countries via transnational spread of disease, or which will potentially necessitate a coordinated international response.[168] The PHEIC definition is, according to Taylor, one which could potentially be exploited in a FCGH. His argument regarding NCDs and their relationship to the IHR (2005) is significant in terms of the potential impact of an FCGH upon businesses. According to Taylor, then;

> "The projected global epidemiological transition to NCDs, and the overwhelming evidence of the role of economic globalisation, trade, and shifting consumption patterns in this process, must surely now be accorded the status of [PHEIC]. Commensurately, causally-linked economic and trade policies forged at the global level may be viewed as analogous to transnational pathogens, and subject therefore to an international regulatory framework for health."[169]

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[165] Taylor, "A Political Economy Of International Health: Understanding Obstacles To Multilateral Action On Non-Communicable Disease." 77.
[166] WHO, "International Health Regulations (2005)" (World Health Organization, 2008), http://www.who.int/ihr/publications/9789241596664/en/. 1.
[167] "WHO | IHR Procedures Concerning Public Health Emergencies of International Concern (PHEIC)," *WHO*, accessed June 18, 2017, http://www.who.int/ihr/procedures/pheic/en/.
[168] Ibid.
[169] Taylor, "A Political Economy Of International Health: Understanding Obstacles To Multilateral Action On Non-Communicable Disease." 75.

These shifting global consumption patterns have already been approached in this thesis in Chapters 2 and 3. These patterns are frequently created and maintained by businesses; the precedent set by the IHR (2005) in its approach to PHEICs is, as Taylor posits, noteworthy given that this definition could potentially be stretched and manipulated to encompass NCDs and the environments (multinational businesses and international trade deals, for example) which allow and, indeed, lead to their proliferation. The fact that the IHR (2005) include in their core aim the avoidance of unnecessary interference with international trade again serves to highlight the power and influence of businesses and the economic sector; measuring the severity of a disease not by how many human beings it infects or kills, but by how much lost trade it amounts to is hardly a glowing reference for the IHR (2005) in terms of human rights. Taylor furthers this argument, establishing a link between the liberal market model, economically dominant states, and the focus on disruptive infectious diseases from the IHR (2005);

> "[…] the origins of the architecture of international health are rooted in the concern of economically dominant nations […] the primary imperative of a global health system is to manage and control the diseases that pose a threat to trade—fast-moving epidemic infectious diseases; but, by the same token, to constrain action on non-communicable diseases where such action might challenge liberal economic development and consumption-as-choice."[170]

The word 'trade' is mentioned twelve times in the IHR (2005), yet the term 'private sector' does not feature at all;[171] whilst trade is evidently a priority for the Regulations, the businesses which have such an impact upon it receive no mention or regulation in the document. This serves again to highlight the power and influence of the private sector in terms of the creation of human rights treaties. The IHR (2005) are, like the FCTC, an instructive example for the FCGH, given that they ultimately remain the dominant multilateral agreement in terms of legally binding instruments upon states in the field of health. This said though, their narrow focus on infectious diseases has elicited criticism from some – like Taylor – and it is also true that this narrow focus has not always yielded positive results or praise from the international community. One such situation was the Ebola crisis of 2014.

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[170] Ibid. 80.
[171] WHO, "International Health Regulations (2005)."

As per its powers under the IHR (2005) to declare public health emergencies,[172] the WHO declared the Ebola outbreak a PHEIC in August 2014. Its response to this crisis, including the late declaration in August, has been the subject of significant criticism. Some analysis of this response in the context of precedent for the FCGH is necessary given the fact that the behaviour of the WHO following the Ebola outbreak was inextricably bound to the IHR (2005) and its protocols; the shortcomings of the IHR (2005) must be learned from if the FCGH is to overcome them. The epidemic began with a case in southern Guinea in December 2013, but it took three months for this to be recognised as Ebola; by May 2014, the disease had spread through Guinea, Sierra Leone and Liberia. By October 2015, there were 11,312 recorded deaths from the epidemic. It took five months for then Director-General Chan to declare the outbreak a PHEIC,[173] and this has been the subject of heavy criticism. In a report by a multidisciplinary review committee about the implementation of the IHR (2005) in the Ebola epidemic, it was noted that the global response to Ebola was characterised by similar shortcomings to those of the 2009 H1N1 pandemic, and the weaknesses of the IHR (2005) were brought into plain sight.[174] This said, the primary findings of the report ultimately note that "The failures in the Ebola response did not result from failings of the IHR themselves, but rather from a lack of implementation of the IHR."[175] In terms of lessons to be learned from the IHR (2005) for the FCGH, this finding is instructive. Firstly, the lack of implementation by Member States of the IHR (2005) is not a weakness unique to this legal instrument – it is a persistent problem in terms of international law. Especially given the fact that the WHO does not have an enforcement mechanism, this lack of implementation is unsurprising. The reasons behind the gap in implementing the Regulations merit further discussion, because these reasons are primarily economic and inextricably tied to the realisation of the right to health.

Many of the Parties to the IHR (2005) are at the lower end of the scale of economic development (including those West African states where the Ebola outbreak wreaked such devastating havoc). It is often said that ESC rights require positive government intervention (as opposed to the oft cited requirement from civil and political rights, which is non-

[172] "WHO | IHR Procedures Concerning Public Health Emergencies of International Concern (PHEIC)."
[173] The declaration of an event as a PHEIC is key for the mobilisation of the international community.
[174] World Health Organization, "Implementation of the International Health Regulations (2005): Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response" (Geneva: World Health Organization, May 13, 2016). 8.
[175] Ibid. 9.

interference from the state), and it is certainly the case as far as the IHR (2005) are concerned that some positive actions were required from governments to meet the core capacity requirements. The IHR (2005) necessitate core capacity requirements from their 194 signatories to prevent the acceleration of outbreaks; these core requirements can be divided into efficient surveillance (including detection, assessment, notification and reporting) and rapid, effective response.[176]I These requirements have strict deadlines set for their realisation, yet as of 2014, two thirds of Parties had not met them.[177] In addition to this, the IHR (2005) "did not include binding obligations for donors to provide support to poorer countries to meet these obligations, nor to fund WHO to fulfil its mandate to provide technical assistance."[178] It took a massive international emergency – Ebola – to expose this issue.

A potential opportunity which could be seized by the FCGH in terms of tackling the lack of implementation from less economically developed states – who are often unable to afford implementation – can be found in the text of the ICESCR. By considering the notions of progressive realisation, minimum core obligations, maximum available resources and the responsibilities of the international community to assist in the realisation of these obligations which arise from the ICESCR, the FCGH could impose binding obligations in a manner that the IHR (2005) does not. An FCGH could, then, impose such obligations in order to ensure that poorer states receive assistance from wealthier Parties so that they are able to fulfil the minimum requirements set by the FCGH. This notion of achieving the minimum core obligations no matter what the nature of the state's economy is furthered in General Comment 3 of the Committee on Economic, Social and Cultural rights which is concerned with the nature of States' Parties obligations. Paragraph 14 notes (emphasis added) that:

> "The Committee wishes to emphasize that in accordance with Articles 55 and 56 of the Charter of the United Nations, with well-established principles of international law, and with the provisions of the Covenant itself, international cooperation for development and thus for the realization of economic, social and cultural rights is an obligation of all

[176] WHO, "International Health Regulations (2005)," §5, §13, §19, §20, §21, §22.
[177] Suerie Moon et al., "Will Ebola Change the Game? Ten Essential Reforms before the next Pandemic. The Report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola," *The Lancet* 386, no. 10009 (n.d.):. 2208.
[178] Ibid. 2208.

> States. It is **particularly incumbent** upon those States which **are in a position to assist** others in this regard."[179]

The text of General Comment 3 then highlights that the international community does have responsibilities that extend beyond sovereign borders; the questions raised surrounding donor responsibilities and the fact that core capacity requirements were unfulfilled by states due to funding are answered by the text of the General Comment.

The strengths and weaknesses of the IHR (2005), and the lessons to be learned from them, are many. One significant lesson which must be understood and taken into account before the FCGH is adopted is this: without an enforcement mechanism and collective political will, global action in the field of health is neither guaranteed nor likely. Put simply, it must be noted that if the experience of the WHO with its IHR (2005) is to be taken seriously and learned from, then the lesson is threefold. Without an enforcement mechanism, action can still be taken, but such a mechanism would certainly be preferable; cooperation across the international community is imperative; and finally, political will is vital.

The IHR (2005) and the FCTC both serve to offer evidence that the WHO is willing to employ 'hard power' tools in its fight for global health. Historically the organisation has been criticised for being hesitant to construct binding legal instruments, with its primary focus being on guidelines and recommendations.[180] If, as the precedent of the FCTC and the IHR (2005) suggest, the WHO is today willing and able to create such binding norms, this is surely good news for the proponents of the FCGH.

4.2.3 UN Guiding Principles on Business and Human Rights: Implementing the "Protect, Respect, and Remedy" Framework

The UNGPs (also referred to as the Ruggie Principles after their author, John Ruggie)[181] are dissimilar to the previously analysed documents, the FCTC and the IHR (2005) in many ways. The UNGPs constitute a framework based upon guidance rather than being a formal treaty;

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[179] "UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant), 14 December 1990, E/1991/23, Available at: Http://Www.refworld.org/Docid/4538838e10.html [Accessed 25 June 2017]," n.d., 5-6: §14

[180] Gostin, Sridhar, and Hougendobler, "The Normative Authority of the World Health Organization.", 857.

[181] John Ruggie was UN Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises.

they are adopted and adhered to on a non-binding, voluntary basis; they do not have a health focus nor were they adopted under the auspices of the WHO. This said, the UNGPs form a significant example for the proposed FCGH in terms of its possibility to regulate businesses, given that they are expressly concerned with regulating business enterprises.

Unanimously approved and endorsed by the UN Human Rights Council in June 2011, the UNGPs are a UN response to the issue of the human rights obligations of businesses. Importantly, it is made clear in the Ruggie Principles that the UNGPs do not impose new normative standards. Instead, Ruggie maintains that the contribution of these principles "lies […] in elaborating the implications of existing standards and practices for States and businesses; integrating them within a single, logically coherent and comprehensive template."[182] If the Ruggie Principles can solidify and elaborate upon the existing obligations of states in the framework of human rights, the FCGH has the potential to do the same. This is extremely significant in terms of the potential of the Framework Convention to have an actual, tangible impact, given that states are often unwilling to ratify legislation which may be too stringent – especially where the economy is concerned, as would evidently be the case if businesses are to be included.

The UNGPs are based upon three core pillars, which are: The State duty to protect against human rights abuses by third parties; corporate responsibility to respect human rights; and access to remedy for victims of corporate abuse of human rights.[183]

It is therefore clear in the Ruggie Principles that states remain primarily responsible for upholding human rights frameworks and ultimately protecting citizens against abuses from not only state actors, but also third parties such as business enterprises. Given that this is the case – and it has also been shown that the text of General Comment 14 means that states must be mindful of their human rights obligations when entering into agreements with businesses – the fact that a causal link is gradually appearing between NCDs and the sugar industry, for example, certainly implies a duty upon states to act to constrain the actions of such industries.

[182] Ruggie, "Report of the Special Representative of the Secretary-General on the Issue of Human Rights and Transnational Corporations and Other Business Enterprises.", 5, §14.
[183] Ibid.

Chapter 2 of this thesis set forth the existing legal documents surrounding the right to health, and the contribution of General Comment 14 in legislating the right to health was made clear. Moon draws together the UNGPs and General Comment 14 as far as the right to health and businesses are concerned, first citing paragraph 42 of the General Comment which explicitly mentions non-state actors (including the business sector).[184] Yet Moon points out that whilst it is stated in the text that NSAs have responsibilities, these responsibilities are not elaborated upon at any stage.[185] Whilst the UNGPs are more specific than the General Comment, the FCGH must exercise caution in the language it employs; vague responsibilities of business enterprises and vague obligations upon states do not make for strong instruments.

The content of the Ruggie Principles is then instructive for the FCGH; the fact that businesses can be constrained in their activities by states if states are correctly interpreting their responsibility to protect is vital for the drafting of the FCGH. In addition to the content of the UNGPs, its format is one which must also be discussed from the perspective of the potential FCGH.

The nature of the UNGPs – i.e. the fact that they are concerned with businesses, which are non-state actors – necessitated a multi-stakeholder approach to their development. As has been discussed in the body of this thesis, the role of non-state actors in international law is becoming increasingly accounted for and discussed given the changing nature of our globalised world. The approach adopted by Ruggie, including the sector he aimed to regulate in the framework in its writing, has led, according to Addo, "to a high level of appreciation but also affirmed the significance of subsidiarity in international law-making."[186] He goes on to highlight the lessons which can be learned from this inclusive law-making approach, noting that,

> "[…] the development of norms such as international economic law, international development law or international environmental law, for example, with direct impact on non-State actors may have to be approached differently from the traditional State-centre process if their full potential is to be appreciated."[187]

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[184] Suerie Moon, "Respecting the Right to Access to Medicines: Implications of the UN Guiding Principles on Business and Human Rights for the Pharmaceutical Industry," *Health and Human Rights* 15, no. 1 (2013): 33.
[185] Moon, "Respecting the Right to Access to Medicines: Implications of the UN Guiding Principles on Business and Human Rights for the Pharmaceutical Industry." 33.
[186] Michael K. Addo, "The Reality of the United Nations Guiding Principles on Business and Human Rights," *Human Rights Law Review* 14, no. 1 (March 1, 2014)., 146.
[187] Ibid. 146.

The UNGPs acknowledge then the shifts in international law and international relations, and recognise that states are no longer the only actors who can impact human rights (and who can be held responsible for said impact). Realist, state-centric international politics are increasingly irrelevant in today's interconnected world, as can be seen from the experience of the unanimous adoption of the UNGPs by the Human Rights Council.

An FCGH can learn much from the experience of the UNGPs in terms of both content and format. Despite – and perhaps, indeed, because of – their status as a soft law instrument, the Ruggie Principles have seen considerable success in terms of a "relatively high uptake of the PRR framework and GPs".[188] One key aspect of the FCGH is its multi-sectoral approach; if the experiences of the UNGPs are to be considered useful precedent for the Framework Convention, this approach is indeed encouraging. Whilst the UN received criticism for inviting key industry players from the ultra-processed food and beverage industry to its NCD conference, and any involvement of Big Tobacco in the FCTC is proscribed by the WHO, it is perhaps worth considering here the positive experiences of the UNGPs going forward. If a FCGH is to successfully impact upon businesses acting in the underlying determinants of health, engaging them in its drafting is perhaps not a poor idea.

4.2.4 Conclusion: learning from the precedent in international law

There is a large body of international legislation today which focuses on various aspects of health and human rights and business. This chapter focused on three such documents which must be examined and utilised as examples for the FCGH if the instrument is to be a success. The UNGPs' focus on regulating businesses and holding these enterprises – and the states which turn a blind eye to them – accountable for human rights violations is a relatively new one in international law and it is certainly one which highlights the importance of a multi-sectoral approach. The FCTC has a narrow goal which is exclusively aimed at the tobacco industry, and there has been debated success as far as this treaty is concerned. The IHR (2005) provide an example of a WHO treaty which is focused at a global health issue, yet they have been significantly scrutinised and criticised (for good reason) following their implementation during the Ebola epidemic. Precedent clearly shows then both successes and failures in terms of regulating the right to health. A multi-sectoral approach as favoured by the UNGPs and

[188] Ibid. 146.

indeed the FCGH is one which has received positive feedback, and must continue to be championed in the drafting of the FCGH. One significant issue seen in both the FCTC and the IHR (2005) comes from the challenge of implementation. If the FCGH is to be successful, implementation difficulties must be approached; this is no easy feat in the field of the historically state-centric international relations. The real challenge for the proposed FCGH, then, is building upon the successes of international precedent in a meaningful way, and finding creative solutions to the failures and problems which exist in the current legislation surrounding the right to health.

4.3 The proposed Framework Convention on Global Health

4.3.1 Details of the proposal

The proposed FCGH has already been briefly summarised in the 'Definition of Terms' of this thesis. Prior to utilising a tool to analyse and summarise its potential in terms of impacting businesses operating in the field of the underlying determinants of health, however, it is necessary to briefly outline the key principles of the proposed document. The FCGH Platform's Statement of Principles details the following areas which will be addressed in the Framework Convention and which are of relevance to this thesis; universal equitable health systems; social determinants of health and global governance for health; funding for universal health systems and the social determinants of health; and human rights. [189] As has already been ascertained in Chapter 3 of this thesis, business enterprises significantly contribute to health inequities across the world today, and so their regulation must be included if the FCGH is to achieve universal equitable health systems and uphold the values of human rights. The FCGH has significant scope and is certainly an ambitious document. In seeking health justice and including a broad spectrum of actors in the discussions surrounding its drafting, it is certainly unlike the various other international legal instruments that have been subjects of enquiry within this thesis. It focuses on:

> " […] solidarity among all people to eliminate health inequities, ensure sustainable and equal access to social determinants of health, promote rights, establish participatory

[189] FCGH Platform, "Platform for a Framework Convention on Global Health: Realizing the Universal Right to Health Fundamental Principles and Joining the Platform."

> governance structures involving local, national, and global movements, and help all people to reach their potential."[190]

This rights-based, people-centred FCGH then certainly places substantial emphasis on the social and general underlying determinants of health, with multiple discussions to be found across their online platform[191] in addition to the written principles. Chapters 2 and 3 of this thesis focused on the right to health and the ways in which the activities of business enterprises impact upon this right, noting the significant role that they play in the underlying determinants of health. Ensuring that these underlying determinants are realised and that there is equity in health are core aspects of the FCGH, and it has been ascertained in the body of this thesis that to fulfil the underlying determinants and achieve health equity, business enterprises must be effectively constrained by international law. It has been seen that there is increasing recognition of the role of NSAs in the fields of global health, international relations and international law, and that this recognition has in turn led to instruments focusing specifically on the private sector. The UNGPs are an example of such an instrument, and the recent General Comment 24 from the CESCR also serves to demonstrate the fact that the activities of business enterprises can no longer go unnoticed and unregulated. No instrument exists as yet which would marry together the issues of human rights, global health, the underlying determinants and the private sector in the way that the FCGH intends to. A SWOT tool will now be utilised to assess the extent to which the FCGH will be able to make these ambitions a reality.

4.3.2 SWOT Analysis: The Framework Convention on Global Health

A SWOT analysis is a tool employed to evaluate the Strengths, Weaknesses, Opportunities and Threats which are at play in a project.[192] It is especially useful when undertaken at the beginning of the project if its findings are to be studied and further analysed, given that it identifies not only challenges, but can offer potential solutions to those challenges via opportunities. It is a useful method in terms of analysing the FCGH and its impact upon businesses and the underlying determinants of health, as it allows for the encapsulation of all core issues and additionally offers a visual tool. Strengths and weaknesses focus on issues which are internal to the project being analysed – in this case, the FCGH and platform itself – whilst the opportunities and threats come from external forces. First, the visual SWOT table

[190] Ibid.
[191] "Publications | FCGH," accessed July 5, 2017, http://www.globalhealthtreaty.org/resources/publications/.
[192] "SWOT Analysis | The Economist," accessed July 5, 2017, http://www.economist.com/node/14301503.

will be presented, followed by a detailed explanation of its noted strengths, weaknesses, opportunities and threats.

4.3.2.1 SWOT Table

Strengths	***Weaknesses***
• Bottom-up nature of the document, engaging civil society in drafting • Format of document as a treaty; benefits of legal approach • Potential to use existing legal instruments i.e. General Comment 14	• No host organisation at present.* • International law classically the domain of states. • Broad scope and focus. *Presents its own additional opportunity.
Opportunities	***Threats***
• Public awareness of issues due to globalisation, rise of the Internet • Sustainable Development Goals • WHO presidential changes • Unspecified international norms regarding health inequities and health justice	• Power of the lobby of the businesses in question • Multiple existing legal instruments and frameworks on right to health; risk of saturation?

4.3.2.1 Strengths

The **bottom-up nature** of the FCGH in terms of its drafting is a significant strength of the document in terms of its potential to impact businesses; the positive multi-sectoral experience of the UNGPs as discussed in this chapter offer evidence of this. The intention of the FCGH to extend its normative influence beyond the traditional state sphere will help to guarantee compliance. Listening to voices from all sectors of society, with the vital inclusion of

marginalised communities who are so often refused a seat at the table of international policy-making, and then using the findings to draft a strong document is extremely meaningful. Marginalised communities are all too often the victims of the decisions of multinational corporations and other businesses, and so with the inclusion of their suggestions in the FCGH, it will have much greater chances of impacting businesses and holding them accountable for their human rights failings. In addition this, if civil society has been engaged in the drafting of the document itself, the Framework Convention will gain credibility in terms of its content. The inclusion of voices from everyday citizens is one way in which to tell business enterprises that they are accountable to their consumers or their clients, and that they cannot act with impunity.

The Framework Convention is currently envisaged as an **international treaty,** a format which brings with it the strengths of the legal approach. Whilst political approaches can certainly be effective, these approaches are of course plagued by politics. Focusing on making the right to health justiciable and creating accessible legal mechanisms will allow for more stringent obligations upon businesses. This can clearly be seen from Chapter 3, where the legal obligations on states to regulate businesses has been set forth, and the example of the FCTC in Chapter 4 provides clear evidence of the benefit of this legal approach. Pillinger notes that there are multiple advantages to a legal approach, including; strengthened and more precise commitments which arise from codification; litigation necessitating established access to remedy; the potential for activists to utilise legal processes to draw attention to their cause; and, finally, the importance of a transformation of a 'commitment' (political) into an 'obligation' (legal) should not be underestimated.[193] Enforcing legal obligations upon states – even obligations which clearly already exist in international law – will in turn mean that businesses will be constrained in their harmful roles in the underlying determinants of health.

Following the preceding point, then, it is also a strength of the FCGH that the obligations that it sets forth upon states are essentially obligations which **already exist in the international human rights framework**. The most elaborate description of the obligations upon the state to protect its citizens from violations perpetrated by third parties (such as businesses) comes in General Comment 14 and the recently adopted General Comment 24 which are not, as has been discussed in Chapter 3, binding documents. The FCGH has the potential then to transform the

[193] Mara Pillinger, "It's Not Just for States Anymore: Legal Accountability for International Organizations under the Framework Convention on Global Health," *Global Health Governance* 9, no. 1 (2015)., 118.

text of these powerful documents into an enforceable legal instrument. This would of course have a positive impact – from a human rights perspective – upon the actions of business enterprises, holding them accountable and ensuring that states themselves limit the actions of businesses violating human rights.

4.3.2.2 Weaknesses

At present, the FCGH **does not have a host organisation** – there is no platform taking ownership of document. This is a complex weakness, however, because although the political clout which would come from UN or WHO backing would be cause for celebration, it is also the case that both of these institutions have been criticised for their own international legal instruments. It was clearly seen in Chapter 4.1, for example, that the IHR (2005) were deeply scrutinised following the Ebola crisis and the WHO itself received a large amount of this scrutiny. This weakness can then be moulded into an opportunity: the FCGH can ultimately be developed on its own platform at present, free from the politics and bureaucracy of international organisations, and decisions regarding the most appropriate host for the treaty can be made once it is in a more concrete draft format. Such politics of international organisations have been seen in Chapter 3.2 concerning the presence of industry players at the UN meeting on NCDs.

Whilst it is certainly the case that NSAs play an increasingly significant role in terms of international relations, it remains the case that **international law is ultimately concerned with states,** as has been noted at multiple junctures throughout this thesis**.** This can be seen as a potential weakness with regard to the potential for the FCGH to impact businesses, but it should also be noted and remembered that the obligations upon states concerned with businesses in their territory[194] are clearly set forth in multiple legal instruments, as would be the case in the FCGH. In addition to this, the text of General Comment 24 is significant in this issue – and as noted in Chapter 1 – the field of international law is currently undergoing a formative phase. This potential weakness therefore does have limitations.

The FCGH has been described in this thesis as ambitious. This is certainly the case, but it is also a document which is **broad in its scope.** This breadth then means that the Framework

[194] Whilst unfortunately outwith the scope of this thesis, it is recognised that extra-territorial obligations must be discussed and set forth in the FCGH especially with regards to businesses and state obligations.

Convention risks becoming so all-encompassing that it loses its meaning. Toebes suggests that a narrower focus is an idea to be considered, and points toward a potential "emphasis on global and domestic health inequalities".[195] This would indeed be a positive move in terms of regulating the actions of business enterprises in the underlying determinants of health, given the significant links between these underlying determinants and social inequities. It is held then that the scope can and should be narrowed slightly; it would still encompass human rights but would be more focused on the aspect of inequities which it has been seen are significant and damaging and are already a core focus of the FCGH, and would transform this weakness of the document into a strength.

4.3.2.3 Opportunities

The negative impacts of the international processes of globalisation have been discussed at length in this thesis in terms of the spread of unhealthy commodities. Yet one of the most intrinsic features of **globalisation – the Internet** – also forms a great opportunity for the FCGH. Today's news is inherently international; we have a world of information and headlines available to us at our fingertips. Public awareness then is extremely high, and this can only be positive in terms of the drafting of the content of the FCGH. With the election of President Trump and the Brexit and snap election results in the UK, as well as significant political shifts in other parts of the world, global civil society currently appears highly active and vocal. As far as regulating businesses are concerned, this is key: public awareness (and public outrage) could be instrumental. The HIV/AIDS example of Chapter 2 was subject to significant levels of public outrage, and it was this awareness which ultimately led to the increased political will to tackle the problem. The role of civil society in the drafting of documents and the necessity of adopting an all-encompassing approach can be seen in the successes of the HiAP approach as well as the UNGPs, as described in Chapter 4.1. The FCGH should mobilise and work alongside civil society organisations and publicise its efforts to regulate business enterprises so as to achieve greater impact from the document itself.

The **Sustainable Development Goals** (SDGs) were adopted in 2015, succeeding the Millennium Development Goals (MDGs). Given that their implementation is still relatively recent, there remains public attention surrounding them, and they include a health-related goal.

[195] Toebes, "The Framework Convention On Global Health: Considerations In Light Of International Law.", 19.

Goal 3 of the SDGs aims to "ensure healthy lives and promote well-being for all at all ages".[196] Here then there is an evident nod towards closing the gaps and erasing the health inequities which persist today and which the FCGH is focused upon. Whilst the SDGs do not place significant emphasis on business, this focus on health inequities is positive and, as has been seen, these inequities are often deepened or instrumentalised by business enterprises. The SDGs present an opportunity for cooperation and synthesising across the domains of political agendum and international legislation. This multisectoral approach – one which will also be adopted by the FCGH – has been the subject of analysis with regards to the UNGPs and the HiAP approach, and it has been held at various junctures within the body of this thesis that the issues surrounding the underlying determinants of the right to health cannot be solved by the health sector alone. The SDGs recognise this, and this momentum at the international level could certainly be instrumental for the FCGH.

The **WHO elected its new Director-General** in May 2017.[197] Dr Tedros is the first African candidate to win this position, and the change in leadership from Dr Chan comes at a time when whispers of reform at the WHO have been becoming louder and more insistent. This is a key time of change then, and there is significant potential for the FCGH to harness this change in order to further its agenda of eliminating health inequities and achieving health justice. With its recent focus on NCDs and, in addition to this, the denouncement by Dr Chan of the ultra-processed food and beverage industry, the FCGH can certainly use this time of reform in order to work with the WHO. Perhaps the treaty would be a new lease of life and a strong addition to the current direction that the organisation is taking. It could be a 'win-win' situation, to use the language of HiAP.

Health inequities and health justice are ultimately "unspecified principles"[198] at present. According to Toebes, this presents an opportunity for the drafters of the Framework Convention, as it could allow these principles to be set forth globally, as well as enabling the creation of "a regulatory regime with a two-step procedure: a framework convention setting out the broad standards underpinning the right to health, and more specific protocols regulating a number of health-specific issues."[199] This thesis has found that health inequities are deepened

[196] "SDGs .:. Sustainable Development Knowledge Platform," accessed June 29, 2017, https://sustainabledevelopment.un.org/sdgs.
[197] "WHO | World Health Assembly Elects Dr Tedros Adhanom Ghebreyesus as New WHO Director-General," *WHO*, accessed June 29, 2017, http://www.who.int/mediacentre/news/releases/2017/director-general-elect/en/.
[198] Toebes, "The Framework Convention On Global Health: Considerations In Light Of International Law," 10.
[199] Toebes, "The Framework Convention On Global Health: Considerations In Light Of International Law." 10.

and perpetuated by business enterprises (see Chapter 3) and so if these principles are solidified and then regulated, the opportunity for an FCGH is significant. These specific protocols and their specific issues then could focus centre upon businesses, ensuring that business enterprises adhere to human rights law and holding them accountable when they do not.

4.3.2.4 Threats

Today, "37 of the world's largest 100 economies are corporations."[200] It is no wonder then, that **industry and business enterprises are powerful international actors with significant lobbying capabilities.** An example of the lobbying power of these industries can be seen from the 2003 case in which the USA's Sugar Association threatened to insist upon the withdrawal of US funding from the WHO if the Organisation released healthy eating guidelines which lowered the recommended daily sugar intake. [201] The WHO was forced to alter the guidelines as a result. The sugar lobby in this case was backed by additional food and beverages companies, including PepsiCo and Coca-Cola.[202] The potential for these industries to have an impact on the FCGH prior to its adoption or ratification is not insignificant, and if the FCGH is to be housed under the auspices of the WHO, the aforementioned example must certainly be kept in mind. The power and influence of business entities and the private sector have been seen multiple times throughout this thesis, including the examples of the NCD conference at the UN and the Grenfell Tower case study.

The number of **international legal instruments concerning human rights is significant and ever-growing.** This could be a potential threat to the FCGH as the treaty could risk adding to an already bulky field, especially given the fact that NSAs are mentioned in many other documents of international law. This said, the role of businesses specifically in the field of health has not been legislated at the international level, and to date there are no binding international treaties which impose obligations upon businesses as well as States. Whilst the FCGH may not impose such direct obligations upon businesses as this, it is certainly important that a document exists which clearly sets out, in no uncertain terms, the link between businesses and the underlying determinants of health in addition to health inequities.

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[200] Damiano de Felice and Andreas Graf, "The Potential of National Action Plans to Implement Human Rights Norms: An Early Assessment with Respect to the UN Guiding Principles on Business and Human Rights," *Journal of Human Rights Practice* 7, no. 1 (February 1, 2015)., 41.
[201] Sarah Boseley and health editor, "Sugar Industry Threatens to Scupper WHO," *The Guardian*, April 21, 2003, sec. Society, https://www.theguardian.com/society/2003/apr/21/usnews.food.
[202] Ibid.

4.3.3 Conclusions on the proposed Framework Convention on Global Health

As can be seen from the SWOT analysis of the document, the proposed FCGH presents more strengths and opportunities than it does weaknesses and threats. The FCGH will successfully constrain the actions of businesses in the underlying determinants of health – as the FCTC has done to an extent with the tobacco industry – if it is a strong enough document and maintains a level of focus on this particular issue. At present, the broad scope of the FCGH would be improved by narrowing the focus on the document to health inequities as per Toebes' aforementioned suggestion; this would certainly encompass the activities of business in the underlying determinants and would then be sufficiently narrow to allow for deeper obligations and improved enforcement. The Framework Convention undertakes a multi-sectoral, multi-stakeholder approach and seeks to resolve the persistent and unconscionable health inequities that exist today; these health inequities are inextricably linked to business enterprises. For example, the burgeoning global NCD problem has been shown to be a serious issue in terms of health inequity given that it is so deeply related to social-economic circumstances and with the patterning of the four risk factors for these diseases along the social gradient. In addition to this, research into the relationship between, for example, the sugar industry and NCDs is ongoing; with increased public awareness and – to an extent – increased international political will to tackle the NCD problem (as can be seen from the WHO focus on the issue), the time is ripe for a treaty which deals with the issues. Political will has been seen to be a significant factor in terms of the success of other frameworks, such as the HiAP approach. If the FCGH is concerned with resolving inequities in health, then including a strong stance on businesses and their actions in the underlying determinants of health is a vital addition to the treaty.

An FCGH will have the potential to limit the impact of businesses in terms of holding them accountable for their actions and ensuring that they refrain from violating human rights and causing damage to people's lives. The obligation upon States to protect from external abuses is already clearly set forth in the international human rights framework in multiple locations, as has been shown throughout the body of this thesis. The FCGH then, as has been the experience of the UNGPs, does not necessarily need to impose new regulations; it must synthesise current obligations upon states that appear in existing regulation in such a way that States can no longer turn a blind eye to them. In addition to this, whilst it remains the case that businesses are not strictly bound by human rights standards, if the FCGH adopts the wording of the text of General Comment 14 then all actors in the health sector do have responsibilities

in terms of the right to health. An FCGH will then be able to regulate businesses in the right to health if it can find creative ways of marrying together the existing frameworks and obligations, given that the possibility to impact businesses could be said to exist in all of these. Given that there is already significant international legislation which does make passing reference to the private sector as well as the responsibility of States to monitor this sector, it is important to bear in mind that States have essentially already agreed to binding international treaties which could – had they had the will – have potential impact upon business enterprises. For example, many States have already adopted the HiAP approach and are parties to the UNGPs, the FCTC, the IHR (2005), and the ICESCR. All of these obligations on States to control businesses in the right to health already exist. The FCGH ultimately provides a space for implementation to really be carried out, especially if the proposed document does include a specific focus on business enterprises given its concern with health inequities.

It is of course true that the proposed FCGH will face a significant challenge in persuading States to ratify this type of treaty, which imposes binding obligations upon them as well as potentially the businesses within their territory. States are historically not desperately eager to negotiate these types of responsibilities, and tend to fiercely guard their sovereignty. Many business enterprises are enormous in their scale, with their economies greater than those of some states, and so the power of these businesses in influencing the decisions of states should also not be underestimated. However, Moon makes a valid argument in this case, positing that the negotiation of an FCGH by even just a strategic and small number of states would be significant, given that the nature of information is such that the data from the treaty would be widely available.[203]

In addition, the bottom-up nature of the FCGH, which has already been identified as a strength of the document, presents multiple examples of the type of impact which the proposed convention could have. Gostin, one of the proponents of the FCGH, has stated that when normative influence is extended to multiple stakeholders, compliance will be more ensured, and that "Advocates could exert political influence and rally public opinion. For example, NGOs could issue 'shadow reports', holding stakeholders to account for failing to live up to their promises."[204] Holding stakeholders to account today is an action not to be underestimated;

[203] Moon, "Respecting the Right to Access to Medicines: Implications of the UN Guiding Principles on Business and Human Rights for the Pharmaceutical Industry.", 41-42.
[204] Gostin, Sridhar, and Hougendobler, "The Normative Authority of the World Health Organization.", 858.

consumer power and the role of public opinion can indeed hold corporations to account.[205] The proposed FCGH has broad scope and significant potential to be an invaluable tool for the erasing of health inequities that exist today, especially when these inequities are frequently exacerbated by the actions of businesses which impact the underlying determinants of health.

[205] Corporate social responsibility campaigns could be considered a response to public outrages and a means by which corporations can be held accountable.

Chapter 5: Concluding Remarks

This thesis set out to answer the question, '*will a Framework Convention on Global Health impact the actions of businesses in the various roles which they play in the right to health?'* and its subsequent sub-question, '*what are these impacts?'*. The answers are in short that yes, an FCGH will impact the actions of businesses in the right to health and that the impacts could potentially be many, but this depends upon the nature of the principles set forth in the document and the extent to which obligations are placed upon non-state actors specifically, as opposed to the onus being on states to regulate businesses themselves.

This thesis has examined the current status of the right to health in terms of global health as well as the legal basis for the right itself, and has concluded that the activities of businesses cause significant harm in the underlying determinants of the right to health. A causal relationship between the private sector and the global NCD epidemic has been established, highlighting the damage caused by the ultra-processed food and beverage industry. An approach to health inequities and health justice, as set forth in the FCGH, necessitates a recognition of the severity of the NCD epidemic. If this recognition does take place, the causal relationship that has been established between unhealthy foods and beverages/tobacco/alcohol and NCDs is one which clearly has a strong connection to industry. The business enterprises which promote and market the consumption of these health harming products are directly impacting upon people's right to health, and States have an obligation to protect their citizens from this type of behaviour. Additionally, in Chapter 3 the influence and power of businesses is clearly visible through the lens of the Grenfell Tower case study and the health injustices and human rights violations suffered by those residents. In order to ascertain a comprehensive overview of the potential of the proposed FCGH, the existing precedent in terms of international legislation surrounding the right to health – as well as precedent regarding regulating business enterprises – has been examined. The core issues which must be addressed in the proposed FCGH of the current international legislation are primarily the lack of implementation by Member States (as seen from the experiences of the IHR 2005)) and the necessity of political will in order to ensure enforcement of the FCGH. In a final analysis, the details of the FCGH itself have been studied to establish the potential positives and pitfalls of such a document in terms of regulating the activities of businesses in the sphere of the underlying determinants of health.

Ultimately, a Framework Convention on Global Health *will* impact the actions of businesses. Taking into account the weaknesses and threats presented in the final analysis of this thesis and tackling them prior to the adoption of the FCGH will allow the document to have a stronger focus and an improved approach to business enterprises; this approach has been shown to be a necessity given the focus on human rights and health equity of the FCGH. The proposal could ensure greater regulation by States upon businesses, improved monitoring mechanisms, as well as greater access to remedy for those whose rights are violated by business enterprises. In order for the FCGH to be as impactful as it could be, the document must narrow its focus to deal with health inequities, which, as this thesis has shown, are deepened and perpetuated by business enterprises on a global scale. With this narrowed focus and its holistic, multi-sectoral, multi-stakeholder approach, the potential of the FCGH is immeasurable.

The inextricable and causal link between businesses and the inequities which exist in global health merits further analysis. Future research into the impact of businesses in global health – and the ways in which an FCGH could limit the negative impact – should include the other multiple roles played by the private sector in this field. Examples, as mentioned in Chapter 1, include the provision of medicines with regard to the pharmaceutical industry, as well as the privatisation of the health sector; business enterprises certainly play a significant role in each of these which merits further analysis from the solution-based lens of the FCGH.

It has been proven that the activities of businesses in the underlying determinants of health have harmful impacts upon the human right to health and deepen global health inequities. Whilst the existing international legislation concerning the right to health – such as the FCTC and the IHR (2005) – have had impact in the field of global health, the proposed FCGH and its multisectoral approach and human rights focus offer a vital addition to the field. The strengths and the opportunities presented by the FCGH are significant, and given the transformative phase that international law is currently undergoing with regard to the role of non-state actors, there has never been a better time for the creation of a document which includes specificities regarding business enterprises and the harms that they commit in the right to health. With the momentum of the SDGs and the speed with which information is transferred transnationally on the internet, international political will could indeed sway in favour of the FCGH, and this will has been found to be a vital component for the success of any international legal instrument. The proposed Framework Convention on Global Health will have an impact upon the activities of businesses in the underlying determinants of health, but whether this treaty is

implemented – and whether these businesses are truly held accountable – will depend upon the political will of the international community. Dr. Martin Luther King, Jr. once said;

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."[206]

These shocking and inhumane injustices and inequalities that Dr. King referred to are perpetuated by business enterprises. An FCGH could bring them to an end.

[206] Amanda Moore, "Tracking Down Martin Luther King, Jr.'s Words on Health Care," *Huffington Post*, January 18, 2013, http://www.huffingtonpost.com/amanda-moore/martin-luther-king-health-care_b_2506393.html.

Bibliography

"About Us | FCGH." Accessed May 16, 2017. http://www.globalhealthtreaty.org/about-us/.

Addo, Michael K. "The Reality of the United Nations Guiding Principles on Business and Human Rights." *Human Rights Law Review* 14, no. 1 (March 1, 2014): 133–47. doi:10.1093/hrlr/ngt041.

Alwan, Ala. "Global Status Report on Noncommunicable Diseases 2010." World Health Organisation, 2011. http://www.who.int/nmh/publications/ncd_report_full_en.pdf.

Asher, Judith Paula. *The Right to Health: A Resource Manual for NGOs*. 1st ed. Vol. 6;6. Book, Whole. Boston;Leiden; Martinus Nijhoff Publishers, 2010.

Atkinson, David. *Globalization*, n.d. //www.oxfordbibliographies.com/document/obo-9780199743292/obo-9780199743292-0009.xml.

Barr, Caelainn. "Wealth and Poverty Sit Side by Side in Grenfell Tower's Borough." *The Guardian*, June 15, 2017, sec. UK news. https://www.theguardian.com/uk-news/2017/jun/15/wealth-and-poverty-sit-side-by-side-in-grenfell-towers-borough.

Basu, Sanjay, Martin McKee, Gauden Galea, and David Stuckler. "Relationship of Soft Drink Consumption to Global Overweight, Obesity, and Diabetes: A Cross-National Analysis of 75 Countries." *American Journal of Public Health* 103, no. 11 (2013): 2071–77. doi:10.2105/AJPH.2012.300974.

"BBC - History - British History in Depth: Smallpox: Eradicating the Scourge." Accessed May 13, 2017. http://www.bbc.co.uk/history/british/empire_seapower/smallpox_01.shtml.

Bertollini, Roberto, Sofia Ribeiro, Kristina Mauer-Stender, and Gauden Galea. "Tobacco Control in Europe: A Policy Review." *European Respiratory Review* 25, no. 140 (May 31, 2016): 151. doi:10.1183/16000617.0021-2016.

"Big Tobacco Targets the Young in Poor Countries – with Deadly Consequences." *The Guardian*, December 1, 2015, sec. Global development. https://www.theguardian.com/global-development/2015/dec/01/big-tobacco-industry-targets-young-people-poor-countries-smoking.

Blanco, Adriana. "Ten Years of the WHO Framework Convention on Tobacco Control: Progress in the Americas." *Salud Pública de México,* 59 (2017). http://saludpublica.mx/index.php/spm/article/view/8682/11142.

Boseley, Sarah, and health editor. "Sugar Industry Threatens to Scupper WHO." *The Guardian*, April 21, 2003, sec. Society. https://www.theguardian.com/society/2003/apr/21/usnews.food.

Boutayeb, Abdesslam, and Saber Boutayeb. "The Burden of Non Communicable Diseases in Developing Countries." *International Journal for Equity in Health* 4, no. 1 (2005): 2. doi:10.1186/1475-9276-4-2.

Chan, Margaret. "Ten Years in Public Health, 2007–2017: Report by Dr Margaret Chan, Director-General, World Health Organization." World Health Organization, 2017. http://apps.who.int/iris/bitstream/10665/255355/1/9789241512442-eng.pdf?ua=1.

Chapman, Audrey R. "The Social Determinants of Health: Why We Should Care." *The American Journal of Bioethics* 15, no. 3 (2015): 46–47. doi:10.1080/15265161.2014.998375.

"Concerns Raised about Grenfell Tower 'for Years.'" *BBC News*, June 14, 2017, sec. London. http://www.bbc.co.uk/news/uk-england-london-40271723.

CSDH. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health.* Geneva: World Health Organization, 2008.

De Schutter, Olivier. "Report Submitted by the Special Rapporteur on the Right to Food, Olivier De Schutter." United Nations, December 26, 2011.

DeLaet, Debra. "What A Wonderful World It Would Be: The Promise And Peril Of Relying On International Law As A Mechanism For Promoting A Human Right To Health." *Global Health Governance*, Special Issue on the Framework Convention on Global Health, 9, no. 1 (2015).

Dorfman, Lori, Andrew Cheyne, Lissy C Friedman, Asiya Wadud, and Mark Gottlieb. "Soda and Tobacco Industry Corporate Social Responsibility Campaigns: How Do They Compare?" *PLoS Medicine* 9, no. 6 (June 2012): e1001241. doi:10.1371/journal.pmed.1001241.

"Eradication of Diseases." *Our World In Data*. Accessed May 13, 2017. https://ourworldindata.org/eradication-of-diseases/.

"EU Rules on Tobacco Products: Infographic." European Commission, May 2016. https://ec.europa.eu/health/sites/health/files/tobacco/docs/tobacco_infograph2_en.pdf.

"Fact Sheet - Latest Statistics on the Status of the AIDS Epidemic | UNAIDS." Accessed May 14, 2017. http://www.unaids.org/en/resources/fact-sheet.

Farmer, Paul. *Pathologies of Power: Health, Human Rights and the New War on the Poor*. Berkeley: University of California Press, 2003.

"FCGH | Framework Convention for Global Health." Accessed June 17, 2017. http://www.globalhealthtreaty.org/.

FCGH Platform. "Platform for a Framework Convention on Global Health: Realizing the Universal Right to Health Fundamental Principles and Joining the Platform." Accessed May 12, 2017. http://www.globalhealthtreaty.org/docs/platform-for-an-fcgh-full.pdf.

Felice, Damiano de, and Andreas Graf. "The Potential of National Action Plans to Implement Human Rights Norms: An Early Assessment with Respect to the UN Guiding

Principles on Business and Human Rights." *Journal of Human Rights Practice* 7, no. 1 (February 1, 2015): 40–71. doi:10.1093/jhuman/huu023.

Forman, Lisa, Luljeta Caraoshi, Audrey R. Chapman, and Everaldo Lamprea. "Conceptualising Minimum Core Obligations under the Right to Health: How Should We Define and Implement the 'morality of the Depths.'" *The International Journal of Human Rights* 20, no. 4 (May 18, 2016): 531–48. doi:10.1080/13642987.2015.1128137.

"Frequently Asked Questions about the International Health Regulations (2005)." World Health Organization, 2009. http://www.who.int/ihr/about/FAQ2009.pdf?ua=1.

Gable, Lance, Ames Dhai, Robert Marten, Benjamin Meier Mason, and Jennifer Prah Ruger. "Introduction: The Framework Convention on Global Health." *Global Health Governance*, Special Issue on the Framework Convention on Global Health, 9, no. 1 (2015).

Ganga, Maria L. La. "The First Lady Who Looked Away: Nancy and the Reagans' Troubling Aids Legacy." *The Guardian*, March 11, 2016, sec. US news. https://www.theguardian.com/us-news/2016/mar/11/nancy-ronald-reagan-aids-crisis-first-lady-legacy.

"Global Child Mortality over Time." *Our World In Data*. Accessed May 13, 2017. https://ourworldindata.org/grapher/global-child-mortality-timeseries.

Gostin, L.O., D. Sridhar, and D. Hougendobler. "The Normative Authority of the World Health Organization." *Public Health* 129, no. 7 (July 1, 2015): 854–63. doi:10.1016/j.puhe.2015.05.002.

Gravely, Shannon, Gary A Giovino, Lorraine Craig, Alison Commar, Edouard Tursan D'Espaignet, Kerstin Schotte, and Geoffrey T Fong. "Implementation of Key Demand-Reduction Measures of the WHO Framework Convention on Tobacco Control and Change in Smoking Prevalence in 126 Countries: An Association Study." *The Lancet Public Health* 2, no. 4 (n.d.): e166–74. doi:10.1016/S2468-2667(17)30045-2.

"Grenfell Tower Cladding That May Have Led to Fire Was Chosen to Improve Appearance of Kensington Block of Flats | The Independent." Accessed July 3, 2017. http://www.independent.co.uk/news/uk/home-news/grenfell-tower-cladding-fire-cause-improve-kensington-block-flats-appearance-blaze-24-storey-west-a7789951.html.

"Grenfell Tower Is a Terrible Betrayal of Human Rights." *The Guardian*, June 21, 2017, sec. Housing Network. https://www.theguardian.com/housing-network/2017/jun/21/grenfell-tower-terrible-betrayal--human-rights-uk-government.

grenfellactiongroup. "KCTMO – Playing with Fire!" *Grenfell Action Group*, November 20, 2016. https://grenfellactiongroup.wordpress.com/2016/11/20/kctmo-playing-with-fire/.

Grover, Anand. “Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover.” United Nations, January 4, 2014.

Harris, Jennifer, Catherine Shehan, Renee Gross, Shiriki Kumanyika, Vikki Lassiter, Amelie Ramirez, and Kipling Gallion. “Food Advertising Targeted to Hispanic and Black Youth: Contributing to Health Disparities.” Rudd Center for Food Policy and Obesity, University of Connecticut, 2015.

Health, CDC’s Office on Smoking and. “Smoking and Tobacco Use; Fact Sheet; Fast Facts.” *Smoking and Tobacco Use*. Accessed June 3, 2017. http://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/.

Hoffman, Steven J., Clarke B. Cole, and Mark Pearcey. “Mapping Global Health Architecture to Inform the Future.” Centre on Global Health Security, Chatham House, 2015.

Hough, Peter. “Non-State Actors in the Global Health World.” In *The Ashgate Research Companion to Non-State Actors*, edited by Bob Reinalda. Ashgate Publishing Ltd, 2011.

Kamminga, Menno T. *Multinational Corporations in International Law*, n.d. //www.oxfordbibliographies.com/document/obo-9780199796953/obo-9780199796953-0049.xml.

Kastler, Florian. “Why the World Health Organisation Should Take the Lead on the Future Framework Convention on Global Health.” *Global Health Governance*, Special Issue on the Framework Convention on Global Health, 9, no. 1 (2015).

Kenworthy, Nora, Ross MacKenzie, Kelley Lee, mq-iris:0000164692, and University of Washington. *Case Studies on Corporations and Global Health Governance : Impacts, Influence and Accountability*. London : Rowman & Littlefield International, 2016. http://hdl.handle.net/1959.14/1187711.

Kirkham CBE, Frances. “Lakanal House Fire 3 July 2009,” March 28, 2013. https://www.lambeth.gov.uk/sites/default/files/ec-letter-to-DCLG-pursuant-to-rule43-28March2013.pdf.

Koplan, Jeffrey P., T. Christopher Bond, Michael H. Merson, K. Srinath Reddy, Mario Henry Rodriguez, Nelson K. Sewankambo, Judith N. Wasserheit, and Consortium of Universities for Global Health Executive Board. “Towards a Common Definition of Global Health.” *The Lancet* 373, no. 9679 (2009): 1993–95. doi:10.1016/S0140-6736(09)60332-9.

Lenoir, Magalie, Fuschia Serre, Lauriane Cantin, and Serge H Ahmed. “Intense Sweetness Surpasses Cocaine Reward.” Edited by Bernhard Baune. *PLoS ONE* 2, no. 8 (2007): e698. doi:10.1371/journal.pone.0000698.

“Local Wellbeing, Local Growth: Why We Need Health in All Policies | Public Health Matters.” Accessed June 28, 2017.

https://publichealthmatters.blog.gov.uk/2016/10/25/local-wellbeing-local-growth-why-we-need-health-in-all-policies/.

"London Fire: A Visual Guide to What Happened at Grenfell Tower." *BBC News*, June 28, 2017, sec. UK. http://www.bbc.co.uk/news/uk-40301289.

MacKinnon, Catharine. "Introduction: Women's Status, Men's States." In *Are Women Human? And Other International Dialogues*, Kindle Edition. Harvard University Press, 2007.

Manager, Marketing. "Kensington and Chelsea Tenant Management Organisation - News." Accessed July 3, 2017. http://www.kctmo.org.uk/news/336/further-statement-on-the-fire-at-grenfell-tower.

"Maternal Mortality." *UNICEF DATA*. Accessed May 16, 2017. //data.unicef.org/topic/maternal-health/maternal-mortality/.

Monteiro, C. A., J.-C. Moubarac, G. Cannon, S. W. Ng, and B. Popkin. "Ultra-Processed Products Are Becoming Dominant in the Global Food System." *Obesity Reviews* 14 (November 1, 2013): 21–28. doi:10.1111/obr.12107.

Moodie, Rob, David Stuckler, Carlos Monteiro, Nick Sheron, Bruce Neal, Thaksaphon Thamarangsi, Paul Lincoln, Sally Casswell, and Lancet NCD Action Group. "Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-Processed Food and Drink Industries." *Lancet (London, England)* 381, no. 9867 (2013): 670–79. doi:10.1016/S0140-6736(12)62089-3.

Moon, Suerie. "Respecting the Right to Access to Medicines: Implications of the UN Guiding Principles on Business and Human Rights for the Pharmaceutical Industry." *Health and Human Rights* 15, no. 1 (2013): 32–43.

Moon, Suerie, Devi Sridhar, Muhammad A Pate, Ashish K Jha, Chelsea Clinton, Sophie Delaunay, Valnora Edwin, et al. "Will Ebola Change the Game? Ten Essential Reforms before the next Pandemic. The Report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola." *The Lancet* 386, no. 10009 (n.d.): 2204–21. doi:10.1016/S0140-6736(15)00946-0.

Moore, Amanda. "Tracking Down Martin Luther King, Jr.'s Words on Health Care." *Huffington Post*, January 18, 2013. http://www.huffingtonpost.com/amanda-moore/martin-luther-king-health-care_b_2506393.html.

"Multinational Corporations in International Law - International Law - Oxford Bibliographies - Obo." Accessed May 13, 2017. http://www.oxfordbibliographies.com/view/document/obo-9780199796953/obo-9780199796953-0049.xml.

"NCDs | NCD Alliance." Accessed May 14, 2017. https://ncdalliance.org/why-ncds/NCDs.

Office of the United Nations High Commissioner for Human Rights. “Frequently Asked Questions About The Guiding Principles on Business and Human Rights.” United Nations, 2014.

“OHCHR | Vienna Declaration and Programme of Action.” Accessed July 5, 2017. http://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx.

Pillinger, Mara. “It’s Not Just for States Anymore: Legal Accountability for International Organizations under the Framework Convention on Global Health.” *Global Health Governance* 9, no. 1 (2015).

Piot, Peter, Sarah Russell, and Heidi Larson. “Good Politics, Bad Politics: The Experience of AIDS.” *American Journal of Public Health* 97, no. 11 (2007).

pmhdev. “Life Expectancy for People with HIV Now ‘near Normal’ - National Library of Medicine.” *PubMed Health*. Accessed May 15, 2017. https://www.ncbi.nlm.nih.gov/pubmedhealth/behindtheheadlines/news/2017-05-11-life-expectancy-for-people-with-hiV-now-near-normal/.

“PMQs Verdict: Jeremy Corbyn Hits Powerful Notes but May Unshaken | Politics | The Guardian.” Accessed June 29, 2017. https://www.theguardian.com/politics/2017/jun/28/pmqs-verdict-jeremy-corbyn-hits-powerful-notes-but-theresa-may-not-shaken.

“Poor - Definition of Poor in English | Oxford Dictionaries.” *Oxford Dictionaries | English*. Accessed May 15, 2017. https://en.oxforddictionaries.com/definition/poor.

“Preamble to the Constitution of WHO as Adopted by the International Health Conference, New York, 19 June - 22 July 1946; Signed on 22 July 1946 by the Representatives of 61 States (Official Records of WHO, No. 2, P. 100) and Entered into Force on 7 April 1948.,” n.d.

“Publications | FCGH.” Accessed July 5, 2017. http://www.globalhealthtreaty.org/resources/publications/.

Reinalda, Bob. *The Ashgate Research Companion to Non-State Actors*. Book, Whole. Farnham: Ashgate, 2011.

Ruggie, John. “Report of the Special Representative of the Secretary-General on the Issue of Human Rights and Transnational Corporations and Other Business Enterprises.” United Nations, March 21, 2011. http://www.ohchr.org/documents/issues/business/A.HRC.17.31.pdf.

Safaei, Jalil. “Health for the Common Good.” *Global Health Governance*, Special Issue on the Framework Convention on Global Health, 9, no. 1 (2015).

Sanger-Katz, Margot. “You’d Be Surprised at How Many Foods Contain Added Sugar.” *The New York Times*, May 21, 2016, sec. The Upshot. https://www.nytimes.com/2016/05/22/upshot/it-isnt-easy-to-figure-out-which-foods-contain-sugar.html.

Schirnding, Yasmin von, William Onzivu, and Andronico O Adede. “International Environmental Law and Global Public Health.” *Bulletin of the World Health Organization* 80, no. 12 (2002): 970–74.

“SDGs .:. Sustainable Development Knowledge Platform.” Accessed June 29, 2017. https://sustainabledevelopment.un.org/sdgs.

Sherwood, Heather Stewart Political editor Harriet. “Theresa May Announces Public Inquiry into Grenfell Tower Fire.” *The Guardian*, June 15, 2017, sec. UK news. https://www.theguardian.com/uk-news/2017/jun/15/theresa-may-announces-public-inquiry-into-grenfell-tower-fire.

Simone, Tom Symonds and Daniel De. “Grenfell Tower: Cladding ‘Changed to Cheaper Version.’” *BBC News*, June 30, 2017, sec. UK. http://www.bbc.co.uk/news/uk-40453054.

Staples, Clifford L. “Cross-Border Acquisitions and Board Globalization in the World’s Largest TNCS, 1995-2005.” *The Sociological Quarterly* 49, no. 1 (2008): 31–51.

“‘Stay Put’ Safety Advice to Come under Scrutiny after Grenfell Tower Fire | UK News | The Guardian.” Accessed July 3, 2017. https://www.theguardian.com/uk-news/2017/jun/14/stay-put-safety-advice-under-scrutiny-grenfell-tower-fire.

Stuckler, David, Sanjay Basu, and Martin McKee. “COMMENTARY: UN High Level Meeting on Non-Communicable Diseases: An Opportunity for Whom?” *BMJ: British Medical Journal* 343, no. 7821 (2011): 453–54.

Stuckler, David, Martin McKee, Shah Ebrahim, and Sanjay Basu. “Manufacturing Epidemics: The Role of Global Producers in Increased Consumption of Unhealthy Commodities Including Processed Foods, Alcohol, and Tobacco.” *PLoS Medicine* 9, no. 6 (June 2012): e1001235. doi:10.1371/journal.pmed.1001235.

Stuckler, David, and Marion Nestle. “Big Food, Food Systems, and Global Health.” *PLoS Medicine* 9, no. 6 (June 2012): e1001242. doi:10.1371/journal.pmed.1001242.

“SWOT Analysis | The Economist.” Accessed July 5, 2017. http://www.economist.com/node/14301503.

Taylor, Sebastian. “A Political Economy Of International Health: Understanding Obstacles To Multilateral Action On Non-Communicable Disease.” *Global Health Governance*, Special Issue on the Framework Convention on Global Health, 9, no. 1 (2015).

“The Meaning of Grenfell Tower | From Poverty to Power.” Accessed July 3, 2017. http://oxfamblogs.org/fp2p/grenfell-tower-is-a-hurricane-katrina-moment-revealing-the-shameful-state-of-britain/.

“THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA TENANT MANAGEMENT ORGANISATION LIMITED - Overview (Free Company

Information from Companies House).” Accessed July 3, 2017. https://beta.companieshouse.gov.uk/company/03048135.

Toebes, Brigit. “The Framework Convention On Global Health: Considerations In Light Of International Law.” *Global Health Governance*, Special Issue on the Framework Convention on Global Health, 9, no. 1 (2015).

Toebes, Brigit, Rhonda Ferguson, Milan M. Markovic, Obiajulu Nnamuchi, and SpringerLink (Online service). *The Right to Health: A Multi-Country Study of Law, Policy and Practice*. 2014th ed. Book, Whole. The Hague: T.M.C. Asser Press, 2014. doi:10.1007/978-94-6265-014-5.

“UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 3: The Nature of States Parties’ Obligations (Art. 2, Para. 1, of the Covenant), 14 December 1990, E/1991/23, Available at: Http://Www.refworld.org/Docid/4538838e10.html [Accessed 25 June 2017],” n.d.

“UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 12: The Right to Adequate Food (Art. 11 of the Covenant), 12 May 1999, Available at: Http://Www.refworld.org/Docid/4538838c11.html [Accessed 3 July 2017],” n.d.

“UN Committee on Economic, Social and Cultural Rights (CESCR), ‘General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)’, 11 August 2000, E/C.12/2000/4, Available at: Http://Www.refworld.org/Docid/4538838d0.html (Accessed 17 May 2017),” n.d.

“UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 15: The Right to Water (Arts. 11 and 12 of the Covenant), 20 January 2003, E/C.12/2002/11, Available at: Http://Www.refworld.org/Docid/4538838d11.html [Accessed 3 July 2017],” n.d.

“UN Committee on Economic, Social and Cultural Rights, General Comment No. 24 on State Obligations under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities,” June 23, 2017.

UN General Assembly. “Draft Political Declaration of the High-Level Meeting on the Prevention and Control of Non-Communicable Diseases.” United Nations, September 16, 2011. http://undocs.org/A/66/L.1.

———. “International Covenant on Economic, Social and Cultural Rights.” United Nations, December 16, 1966. http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx.

———. “On the Fast-Track to Ending the AIDS Epidemic: Report of the Secretary-General, UN Doc. A/70/811. April 1, 2016.” United Nations, April 1, 2016. http://undocs.org/A/70/811.

———. “Universal Declaration of Human Rights, 217 A (III),” December 10, 1948. http://www.un.org/en/universal-declaration-human-rights/index.html.

“United Nations Treaty Collection.” Accessed June 17, 2017. https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-4&chapter=9&clang=_en.

"What Is CSR?" Accessed June 2, 2017. /csr/o72054.html.

"When HIV Was a Death Sentence - CNN.com." Accessed July 5, 2017. http://edition.cnn.com/2015/11/30/health/cnnphotos-hiv-aids-portraits/index.html.

WHO. "International Health Regulations (2005)." World Health Organization, 2008. http://www.who.int/ihr/publications/9789241596664/en/.

"WHO | 7. International Law." *WHO*. Accessed June 17, 2017. http://www.who.int/trade/distance_learning/gpgh/gpgh7/en/index3.html.

"WHO | 10 Facts on Health Inequities and Their Causes." *WHO*. Accessed May 14, 2017. http://www.who.int/features/factfiles/health_inequities/en/.

"WHO | 10 Facts on Polio Eradication." *WHO*. Accessed May 4, 2017. http://www.who.int/features/factfiles/polio/en/.

"WHO | 10 Facts on the State of Global Health." *WHO*. Accessed May 4, 2017. http://www.who.int/features/factfiles/global_burden/en/.

"WHO | Alcohol." *WHO*. Accessed June 3, 2017. http://www.who.int/substance_abuse/facts/alcohol/en/.

"WHO | Central African Republic." *WHO*. Accessed May 14, 2017. http://www.who.int/countries/caf/en/.

"WHO | Health in All Policies: Progressing the Sustainable Development Goals." *WHO*. Accessed June 28, 2017. http://www.who.int/phe/events/HiAP-conference-March2017/en/.

"WHO | IHR Procedures Concerning Public Health Emergencies of International Concern (PHEIC)." *WHO*. Accessed June 18, 2017. http://www.who.int/ihr/procedures/pheic/en/.

"WHO | Malaria." *WHO*. Accessed May 4, 2017. http://www.who.int/mediacentre/factsheets/fs094/en/.

"WHO | NCD Mortality and Morbidity." Accessed July 5, 2017. http://www.who.int/gho/ncd/mortality_morbidity/en/.

"WHO | Social Determinants of Health." *WHO*. Accessed May 27, 2017. http://www.who.int/social_determinants/en/.

"WHO | The 8th Global Conference on Health Promotion, Helsinki, Finland, 10-14 June 2013." *WHO*. Accessed June 28, 2017. http://www.who.int/healthpromotion/conferences/8gchp/statement_2013/en/.

"WHO | The Determinants of Health." *WHO*. Accessed July 3, 2017. http://www.who.int/hia/evidence/doh/en/index4.html.

"WHO | Tobacco." *WHO*. Accessed June 17, 2017. http://www.who.int/mediacentre/factsheets/fs339/en/.

"WHO | United Nations High-Level Meeting on Noncommunicable Disease Prevention and Control." *WHO*. Accessed May 14, 2017. http://www.who.int/nmh/events/un_ncd_summit2011/en/.

"WHO | WHO Framework Convention on Tobacco Control." *WHO*. Accessed June 17, 2017. http://www.who.int/fctc/text_download/en/.

"WHO | Who We Are, What We Do." Accessed June 3, 2017. http://www.who.int/about/en/.

"WHO | World Health Assembly Elects Dr Tedros Adhanom Ghebreyesus as New WHO Director-General." *WHO*. Accessed June 29, 2017. http://www.who.int/mediacentre/news/releases/2017/director-general-elect/en/.

"WHO Framework Convention On Tobacco Control." World Health Organization, 2003.

WHO, UNICEF, UNFPA, World Bank Group, and United Nations Population Division. "Trends in Maternal Mortality: 1990 to 2015 Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division." World Health Organization, November 2015.

World Health Organization. "2009 Summary Report on Global Progress in Implementation of the WHO Framework Convention on Tobacco Control." Geneva, 2009.

———. "Implementation of the International Health Regulations (2005): Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response." Geneva: World Health Organization, May 13, 2016.