

# Meeting Report

## Consultation on Overweight, Obesity, Diabetes and Law in the Western Pacific Region



9–11 April 2014  
Manila, Philippines

(WP)DHP/NHP(03)/2014

Report series number: RS/2014/GE/66(PHL)

English only

MEETING REPORT

CONSULTATION ON OVERWEIGHT, OBESITY, DIABETES  
AND LAW IN THE WESTERN PACIFIC REGION

Co-hosted by

INTERNATIONAL DEVELOPMENT LAW ORGANIZATION

and

UNIVERSITY OF SYDNEY

Boden Institute, WHO Collaborating Centre for Physical Activity, Nutrition and Obesity

and

Sydney Law School

Co-sponsored and convened by

WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Manila, Philippines

9–11 April 2014

Not for sale

Printed and distributed by:

World Health Organization  
Regional Office for the Western Pacific  
Manila, Philippines

## **NOTE**

The views expressed in this report are those of the participants in the Consultation on Overweight, Obesity, Diabetes and Law in the Western Pacific Region and do not necessarily reflect the policies of the International Development Law Organization, the University of Sydney, or the World Health Organization.

This report has been prepared by the World Health Organization, drafted by Sydney Law School at the University of Sydney with contributions from the International Development Law Organization, for Member States, participants of the consultation, and all stakeholders, donors, and partners, including civil society organizations, whose generous support and ongoing engagement are essential to addressing overweight, obesity and diabetes through law.

## SUMMARY

Overweight and obesity are responsible for an estimated 410 000 deaths in the Region annually. The Region is home to 138 million adults with diabetes, of whom 50% are undiagnosed. Left unchecked, the number of diabetes cases in the Region could reach 201 million, or over 11% of adults, by 2035.

Overweight, obesity, and diabetes are closely linked to rapidly changing lifestyles and environments. With urbanization, including increased access to motorized transport and decreased areas for exercise, physical activity continues to drop. Over recent decades, diets in the Pacific have been shifting steadily from traditional foods (e.g., root vegetables and fresh fish with water) to highly processed products (e.g., corned beef, instant noodles and sugar-sweetened beverages). Governments must now create environments that support healthy lifestyles.

Law can be a powerful tool to bring about such changes to the environment. While the linkages between medicine, public health, and law remain relatively weak, a human rights approach offers one way of linking these disciplines. The right to the highest attainable standard of health was first recognized in the Constitution of the World Health Organization and provides a standard to motivate, guide and evaluate the use of law to support healthy food choices and physically active lifestyles.

To assist countries in strengthening their legal frameworks to address overweight, obesity and diabetes, the International Development Law Organization and the University of Sydney co-hosted this consultation, co-sponsored and convened by World Health Organization (WHO) at the Regional Office for the Western Pacific in Manila, Philippines, from 9 to 11 April 2014.

The objectives of the consultation were:

- a) to outline the current response to overweight, obesity and the diabetes epidemic in the Region;
- b) to identify the most important current and emerging legal issues that relate to the prevention, detection and treatment of overweight, obesity and diabetes, including related discrimination;
- c) to identify examples of best practice in legislation, governance and policy for the prevention, detection and treatment of overweight, obesity and diabetes in the Region, and in addressing related discrimination;
- d) to identify areas where further research on key legal issues remains to be done; and
- e) to make recommendations on next steps, including a possible regional programme on overweight, obesity and diabetes and law.

The participants examined the issues from a range of perspectives, including medicine, public health, legislation and regulation, discrimination, access to medicines and trade. Six key areas for action were identified:

1) Generating and sharing evidence for action

There is a strong need to build the evidence-base on legal interventions relating to obesity, diabetes and population diets. Such evidence might relate to the need for a new intervention, its effectiveness, or its assessment, implementation or enforcement phases. Given the nature of the challenge, countries should take a broad view of evidence. Accordingly, case studies, feasibility studies, guidelines, summaries and other tools could all assist countries to share their knowledge and experience with one another. Researchers and academics have an important role to play. Building networks within the Region will facilitate information sharing.

2) Capacity-building: Developing local expertise

The participants agreed that it is vital to develop local expertise. This will involve strengthening the linkages between health and law and building the knowledge base and capacity of each profession to understand and work together at country level. Building capacity in this way will also reduce the need for consultants from outside the Region.

3) Topic-specific interventions

In addition to the general principle of generating and sharing evidence, there is a need for in-depth technical advice on specific promising interventions. These include regulation and taxation of sugar-sweetened beverages, restrictions on marketing unhealthy food products and beverages to children; requirements for interpretative front-of-pack labelling on packaged foods; and legislation to facilitate environments that are conducive to physical activity.

4) Social mobilization

Support from civil society will be crucial to the development, implementation and enforcement of innovative legal approaches to overweight, obesity and diabetes. Civil society participation will play an important role in ensuring that interventions are targeted and appropriate to the local context.

5) Actions to address industry interference

The role of the food and drinks industries in relation to public health and changing diets is complex. Some experts expressed the view that engagement with the industry may be necessary, while others felt that the industry would always seek to oppose regulation aimed at improving diets. All agreed that addressing industry interference in policy-making is a priority action. Clear guidelines are needed to avoid conflicts of interest and to ensure that government interactions with the food industry are transparent and constructive, and do not jeopardise public health goals.

6) Putting law on the WHO agenda

Law is central to advancing the goals of WHO and can enable countries to protect, respect and fulfil the right to health. The right to health offers the possibility of placing health at the centre of countries' law- and policy-making processes and governance structures. The participants would like to see law better integrated into the WHO agenda.

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### Keywords:

Obesity - prevention and control / Overweight - prevention and control / Diabetes mellitus - prevention and control / Public health - legislation and jurisprudence
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## 1. INTRODUCTION

Globally, at least 2.8 million deaths each year are attributable to overweight or obesity. This makes overweight and obesity the fifth leading risk factor for global mortality. Obesity prevalence in 2008 was 10% of men and 14% of women, compared with 5% and 8% respectively in 1980. Prevalence in the Western Pacific Region varies considerably, but is highest in the Pacific island countries (up to 70%), around 25–30% in Australia and New Zealand, and rapidly increasing in the Asian countries. Overweight and obesity are responsible for an estimated 410 000 deaths in the Region annually. Obesity is also highly correlated with diabetes, accounting for 44% of the global diabetes burden – which affects 382 million people. The Region is home to 138 million adults with diabetes, of whom 50% are undiagnosed. Left unchecked, the number of diabetes cases in the Region could reach 201 million, or over 11% of adults, by 2035.

Overweight, obesity and diabetes are closely linked with rapidly changing lifestyles and environments. With rapid urbanization, including increased access to motorized transport and decreased areas for exercise, the opportunities for physical activity continue to drop. Globally, the food supply is characterized by the increased availability of highly processed and mass-produced products of poor nutritional value. These tend to be highly palatable, energy-dense, accessible and convenient, and promoted through persuasive and pervasive food marketing. Over recent decades, for instance, diets in the Pacific have been shifting from traditional foods (e.g., root vegetables and fresh fish with water) to highly processed products (e.g., corned beef and instant noodles and sugar-sweetened beverages). These shifts are conducive to weight gain, and governments must now take action to reverse these trends. Governments must create environments that better support healthy food choices and physically active lifestyles.

Law can be a powerful tool to bring about such changes. However, with some notable exceptions (such as HIV) the links between medicine, public health and law remain relatively weak. A human rights approach offers one way of linking these disciplines.

The right to the highest attainable standard of health (the right to health) was first recognized in the Constitution of the World Health Organization. This right is now protected in six international human rights treaties (including the International Covenant on Economic, Social and Cultural Rights), in three major regional human rights agreements, and in the national constitutions of several countries. The right to health provides a standard to motivate, guide and evaluate the use of law to create environments that support healthy lifestyles.

To assist countries in strengthening their legal frameworks to address overweight, obesity, and diabetes, the International Development Law Organization (IDLO) and the University of Sydney co-hosted this consultation, co-sponsored and convened by WHO at the Regional Office for the Western Pacific in Manila, Philippines, from 9 to 11 April 2014.

### 1.1 Objectives

The objectives of the consultation were:

- a) to outline the current response to overweight, obesity and the diabetes epidemic in the Region;
- b) to identify the most important current and emerging legal issues that relate to the prevention, detection and treatment of overweight, obesity and diabetes, including related discrimination;

- c) to identify examples of best practice in legislation, governance and policy for the prevention, detection and treatment of overweight, obesity and diabetes in the Region, and in addressing related discrimination;
- d) to identify areas where further research on key legal issues remains to be done; and
- e) to make recommendations on next steps, including a possible regional programme on overweight, obesity and diabetes and law.

## 1.2 Participants

The Consultation was attended by 34 temporary advisors and observers from 18 countries: Australia, Cambodia, Fiji, Guam (United States of America), Indonesia, Lao People's Democratic Republic, Malaysia, Mongolia, New Caledonia, Palau, Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Tonga, Vanuatu and Viet Nam. Participants included representatives from ministries of health, national parliaments, law school faculties and the legal profession, medical school faculties and the medical profession, nongovernmental organizations (NGOs), and other intergovernmental agencies. The Secretariat comprised 12 WHO staff. The list of participants is available at Annex 1.

## 1.3 Meeting Organization

The participants elected three co-chairs and a rapporteur from the hosting parties:

Co-Chair: Mr David Patterson, IDLO

Co-Chair: Professor Stephen Colagiuri, Boden Institute,  
WHO Collaborating Centre for Physical Activity, Nutrition and Obesity, SU

Co-Chair: Professor Roger Magnusson, Sydney Law School, SU

Rapporteur: Ms Jenny Kaldor, Sydney Law School, SU

The agenda consisted of plenary sessions and small group work sessions. The programme of activities is available at Annex 2. To highlight the event, WHO Regional Office for the Western Pacific issued a press release entitled *Building a stronger public health framework for a fitter and healthier world: a landmark consultation on overweight, obesity, diabetes and law* (available at: <http://www.wpro.who.int/mediacentre/releases/2014/20140411/en/>).

## 2. PROCEEDINGS

### 2.1 Opening ceremony

On behalf of Dr Shin Young-soo, Regional Director for the Western Pacific, Dr Susan Mercado, Director, Division of Building Healthy Communities and Populations, opened the consultation. The text of the speech is available at Annex 3.

The Region is diverse and dynamic, but faces the challenge of protecting health in the face of globalization, rapid and unplanned urbanization and industrialization. The aim of the consultation is to explore specific legal mechanisms to cope with and tackle overweight, obesity and diabetes, within the wider effort towards effective and sustainable health systems.

Contemporary food systems are characterized by deep contradictions. Despite rapid economic growth and increased spending power, many people still survive on inadequate diets. They are starving for food that is high in nutritional quality. Populations in the Region are consuming too much cheaply processed, poor quality food, high in sugar, fat and salt. These changes, together with decreasing opportunities for physical activity in daily life, are driving rising rates of diabetes and obesity.

Dr Mercado introduced a theme of potential challenges to legal interventions from the vested interests of the food and drinks industries. Public health engagement with industry is always complex. This engagement requires cross-sectoral coordination within countries. In determining whether and how to use law to address overweight, obesity and diabetes, countries will need to innovate and be practical, mindful of their national contexts and capacities.

Finally, Dr Mercado reminded the participants of the wider context of working towards universal health coverage. She invited the participants to consider how law might be used to ensure access to essential medicines, and to promote equity in health systems.

In their opening remarks, the co-chairs emphasized:

- The importance of a human rights approach: working with communities as well as with governments to tackle vested commercial interests.
- The opportunities to learn from other contexts, particularly the experience of HIV/AIDS.
- The fact that the challenges of overweight, obesity and diabetes are too vast for any one country or organization to tackle alone. Collaboration and collective action will be crucial.
- The need to form coalitions across disciplines and to draw on the expertise of those with local knowledge of the political structures and opportunities in their home countries.

The co-chairs also acknowledged the financial support of the Australian Government, which provided funding for 10 participants from the Pacific to attend the consultation.

### 2.2 Overview of overweight, obesity, diabetes and the law in the Western Pacific Region

#### 2.2.1 Diabetes epidemiology and background

An epidemiological overview by Professor Stephen Colagiuri emphasized the shared risk factors of overweight, obesity and diabetes. Population and high-risk approaches to prevention should be adopted. In the case of people in the healthy weight range, the goal is to stop them progressing to

overweight or obesity. For those who are already obese, the goal is to lose weight. For obesity and diabetes, the aim of lifestyle modification (i.e. interventions targeted at individual patients) and population health (i.e. policies that impact on the health of the population at large) should be the achievement of healthier diets and more physical activity, with weight reduction for those who are overweight or obese. Even a 5% weight loss can translate into a 50% reduction in the risk of developing diabetes.

### 2.2.2 The Regional response

Dr Susan Mercado described the *Regional Action Plan for the Prevention and Control of Noncommunicable Diseases 2014–2020 (RAP)*. This plan is aligned with the WHO's Global Action Plan on Noncommunicable Diseases (NCDs) and its strategies include:

- Support for policy, strategies and national multisectoral plans of actions on NCDs;
- Surveillance, research and information sharing;
- Capacity-building, training, leadership development;
- Regulatory frameworks and legislation;
- Using a life-course approach and settings-based interventions for health, e.g. working with cities, schools, workplaces to promote healthier diets, active transport and physical activity;
- Universal health coverage as a platform for early detection, screening, service delivery, drugs and medicines;
- Stakeholder engagement and co-creation of approaches;
- Action for healthier families and workers' health; and
- Disability and rehabilitation services to assist people with diabetes-related disability, such as amputation and blindness.

Communities affected by high rates of overweight, obesity and diabetes are often vulnerable and marginalized. Policy-makers must be mindful that new laws and policies do not further entrench poverty.

### 2.2.3 Current and emerging legal issues relating to the prevention, detection and treatment of overweight, obesity and diabetes

Professor Roger Magnusson and Ms Jenny Kaldor introduced some central concepts of public health law and outlined the role that law can play in creating healthy environments and supporting healthy behaviours. They highlighted the role that legislation and regulation have played in all major public health successes. They also set out some of the different legal strategies that can support public health, including the provision of information and guidelines, the regulation of harmful substances or corporate marketing and advertising, and the creation of new governance structures. Law can add significant value by helping to improve the environments in which people live, work, eat and spend their leisure time, making them less conducive to weight gain. Improving environments means that there is less need to rely on the motivation of each individual to change their behaviour. Law also acts as a powerful restraint on the actions of vested commercial interests, by setting mandatory and uniformly applicable standards. A background paper on these issues is available at Annex 4.

Although overweight, obesity and diabetes are costly in economic, social and health terms, high-level action has lagged behind other burdens on population health, such as tobacco use. Potential priorities for action in the Region include regulating food marketing to children, front-of-pack nutrition labelling initiatives, regulations on sugary beverages, and governance structures for cross-sectoral action on obesity and diabetes.

## 2.3 Good practices in legislation and regulation

### 2.3.1 Presentations from three jurisdictions

The experts heard presentations from three jurisdictions that have passed, or are in the process of passing, laws to address risk factors of overweight, obesity and diabetes. Each identified political leadership, strong evidence, innovative thinking, and support from civil society, as critical elements in passing new or innovative laws.

#### *The Republic of Korea's Special Act on Safety Management of Child Nutrition (2008)*

Dr Cho-II Kim presented the context and process for passage of this legislation. In the late 1990s, the Republic of Korea saw a series of scandals involving food poisoning and sub-standard school food. At the same time, childhood obesity was coming to be regarded as a threat to the health and safety of children. The aim of the legislation was to ensure both the provision of safe and nutritionally balanced foods and to promote of good dietary habits to children under 18 years of age. It was the first law in the Republic of Korea to establish the concept of nutritionally balanced foods.

Data supporting the introduction of the legislation was provided by several sources. These included NGO monitoring of the school environment, mandatory national reporting of food poisoning incidents, and longitudinal national child health and nutrition surveys. The legislation encourages local governments to take a lead role in creating enabling environments for nutrition safety. Among other provisions, the legislation establishes “green food zones” protecting food safety and nutrition in the vicinity of select schools. While the legislation was initially opposed by the food industry, well-designed governance arrangements and strong support from civil society, including consumer and parent advocacy groups, have ensured implementation.

#### *Legislation to establish Tonga's Health Promotion Foundation (2007)*

Dr Viliami T'au Tangi presented the process of legislating for the creation of Tonga's Health Promotion Foundation. Dr Tangi was a key participant and champion in this process.

As Minister of Health, Dr Tangi made NCDs a priority issue in Tonga. As a result, Tonga committed to designing a National Strategy for the prevention and control of NCDs and to legislating for a health promotion foundation. The process included gathering evidence, learning from other jurisdictions and visiting other health promotion foundations, including VicHealth in Australia.

Dr Tangi emphasized the importance of strong political leadership in achieving the goal of a health promotion foundation. Strong leadership had two dimensions: Firstly, one central figure (in this case, the Minister of Health) acted as a champion for the new law, leading the process and advocating to other parliamentary colleagues. Secondly, this champion gained the support of other leaders, such as Cabinet and ministers outside of the health portfolio. Given that the Minister of Health does not control the budget, the support of the Finance Minister and a commitment to sustainable annual funding were critical factors.

#### *The Philippines' House Bill No. 3365 (2014)*

The Honorable Estrellita B Suansing presented her efforts to push for the passage of House Bill No. 3365 in the Philippine House of Representatives.

The Bill, currently before the Parliament of the Philippines, would impose a 10% ad valorem tax on soft drinks and carbonated drinks through the national internal revenue code. Ms Suansing described how advocates marshalled the evidence linking sugar-sweetened beverage consumption to a range of poor health outcomes including diabetes and heart disease. She also set out practical aspects of the tax’s design, such as the creation of a rehabilitation fund: the revenue raised would be hypothecated to help victims of natural disasters with livelihood development, mass housing and infrastructure. The bill faces opposition from the drinks industry, but has the support of the Department of Finance and of the schools.

Several participants spoke of the need for multisectoral coordination, mobilizing medical experts, politicians and lawyers as well as donors. Participants also discussed the importance of strong leadership for enacting innovative legislation.

### 2.3.2 Group work: current situation and challenges

The participants worked in groups to identify relevant legal and policy interventions that exist in their countries and in the Region. The aim of the exercise was to obtain a pool of quantitative information on the kinds of laws and policies that exist (including their key provisions, challenges, champions and methods of implementation) to identify regional trends. The interventions were classified under five headings – examples are listed in Table 1.

Table 1 – Key examples from the Region as identified by the participants

Topical area	Examples
Marketing restrictions (e.g., on advertising, promotion and sponsorship)	<ul style="list-style-type: none"> <li>• Republic of Korea’s Special Act on Safety Management of Child Nutrition limits advertising of children’s “favorite foods” and prohibits offers of toys in conjunction with such marketing.</li> <li>• Similarly, Australia’s Children Television Standards prohibits marketing to children with promotional items (e.g., toys), but the law is not strictly enforced.</li> <li>• Fiji is pursuing a blanket ban on advertising of unhealthy foods and non-alcoholic beverages to children.</li> <li>• Whereas Malaysia and Singapore allow for self-regulation, the effectiveness of such voluntary regimes was questioned.</li> </ul>
Labelling requirements (e.g., back-of-pack and front-of-pack)	<ul style="list-style-type: none"> <li>• The Republic of Korea’s Special Act on Safety Management of Child Nutrition requires a colour-coded “traffic light” system to indicate high levels of sugar, salt, fat, and trans fatty acids on front-of-pack food packaging.</li> <li>• The Australian state of New South Wales mandates calorie content labelling on menus of restaurants with 20 or more outlets in the state and 50 or more outlets nationally.</li> <li>• Fiji’s Food Safety Act and Australia’s Food Standards Code regulate health claims on packaging.</li> <li>• Although the Codex Alimentarius Commission has not yet established standards for “high” levels of sugar, salt, fat, and trans fatty acids within a nutritional context, there has been extensive discussion of the issue at the Codex Committee for North America and South West Pacific.</li> <li>• Despite labeling regulations in Mongolia, the requirements are often not enforced on imported products.</li> </ul>
Supply controls (e.g., zoning, licensing)	<ul style="list-style-type: none"> <li>• The Republic of Korea’s Special Act on Safety Management of Child Nutrition prohibits the sale of “High Calorie Foods with Low Nutritional Values” within “Green Free Zones” (200 metres of select schools).</li> <li>• Samoa’s Public Health Act banned sales of turkey tails, but the ban was lifted under pressure from the World Trade Organization.</li> <li>• Under the Fair Trading Decree, which allows prohibition of goods adverse to health, Fiji has banned importation of mutton flaps.</li> <li>• The Lao People's Democratic Republic is considering a regulation on food safety and nutrition in schools.</li> </ul>

Fiscal measures (e.g., taxation of unhealthy products and subsidies for healthy products)	<ul style="list-style-type: none"> <li>• Fiji, Nauru and New Caledonia have introduced taxes on various unhealthy foods and beverages.</li> <li>• Malaysia offers tax rebates on select sports equipment.</li> <li>• To varying extents, children in United States Affiliated Pacific Islands, including Guam, American Samoa, Palau, and Northern Marianas, are on subsidized federal school lunch programmes, potential platforms for promoting healthy diets.</li> </ul>
Other	<ul style="list-style-type: none"> <li>• Institutional reform, such as the creation of a health promotion foundation with a broad mandate (e.g. Tonga).</li> <li>• Interventions to improve the built environment, such as building bike lanes (e.g. the Philippines) and public cafeterias (e.g. Malaysia).</li> </ul>

This session raised several themes, which were reflected in later sessions:

- The importance of country context and of each country understanding its needs and capacities in relation to addressing overweight, obesity and diabetes. Discussion revealed significant differences in food cultures, health systems and regulatory environments of countries in the Region. Law and regulation must therefore take into account community realities – including how they grow, buy and prepare food – rather than seeking to apply a generic formula. Even concepts such as “the food industry”, a term used throughout the consultation, will mean different things in different countries. For example, the food industry in a small island nation reliant on subsistence agriculture and imported foods will be quite different to the food industry in a large country with a mature and ubiquitous production, processing and marketing industry.
- The Ministry of Health has a vital advocacy role to play as steward of the health system. If the Ministry is strong enough, it can act as a champion for ambitious law reform and gain political support from other ministries within government.
- The role of civil society, including faith groups, as advocates and agents for change at the grassroots level. For instance, the Christian churches are very influential in Pacific island communities. In Tonga, the largest church set an example by reducing the amount of feasting on significant holidays.
- Opportunities for learning from the lessons of tobacco control law, but with the major caveat that food and nutrition involve far more complex issues.
- Potential barriers to law-making, including a lack of nutrient profiles and precise definitions (e.g., “junk food” or “sugar-sweetened beverages”), the absence or failure of political will, and the interference of the food and beverage industry in policy processes.

#### 2.4 Overweight, obesity and diabetes discrimination in the Region, including access to medicines

This session was structured as a roundtable discussion between Dr Abdul Wahid Khan, Ms Daiana Buresova, Dr Manisha Shridhar and Mr Deni Ahmad Fauzi. Participants presented issues relating to discrimination, access to medicines and the importance of social mobilization. A human rights framework provided the link between these concepts, but there is still much work to be done in connecting prevention with eliminating discrimination and strengthening health systems.

##### *Discrimination and diabetes*

Diabetes-related disability, including blindness and amputation, is rising significantly in the Region. While diabetes-related discrimination is still poorly understood, anecdotal evidence suggests it is also very common. Social stigma around overweight and obesity is deeply rooted in some communities, and stereotypes of overweight people are perpetuated in the media. In many Pacific communities, type-2 diabetes is stigmatized, and is often seen as a social rather than a medical

problem. Because of this, inappropriate beliefs (such as the idea that diabetes is a moral punishment) can flourish and people may become socially isolated.

#### *Discrimination and gender*

Gender can have a significant impact on both the risk factors of diabetes and the experience of living with this condition. In many countries, women experience worse social stigma than men due to diabetes, and may also experience moral judgment. In Fiji, women living with diabetes experience discrimination in employment, and also when seeking to marry. As a result, many women living with diabetes become financially dependent on their families, leading to further marginalization.

#### *Discrimination and access to treatment*

Fear of discrimination can make people reluctant to seek treatment for diabetes, and this is exacerbated where the local health system is weak. Efforts to combat discrimination therefore need to be accompanied by strengthening health systems. Governments can take strategic action by:

- maintaining a national database of diabetic medications;
- ensuring consistency and quality in diabetes primary care, including access to essential diabetes medicines;
- supporting accessible and affordable medications, for instance through:
- making use of the “flexibilities” for affordable medicines available under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), or
- entering into voluntary licence agreements for specific medications.
- Uniformity in diabetes care must also be underpinned by a national health insurance scheme. A human rights framework can thus help to guide national efforts to tackle discrimination and health system deficiencies.

#### *Discrimination and international law*

The Convention on the Rights of Persons with Disabilities shows how international law can support national action to address discrimination. States that have ratified the Convention are required to protect people from discrimination on the basis on their disability (such as arising from diabetes). This requires specific national legislation, as has been adopted by Cook Islands.

#### *Discrimination and social mobilization*

Social mobilization is the process of bringing together all feasible and practical intersectoral allies to raise awareness of, and demand for, a particular programme, to assist in the delivery of resources and services, and to strengthen community participation for sustainability and self-reliance.

Important components of social mobilization include:

- ensuring the role of community organizations in service provision, policy and programme development, at all stages;
- involving multiple sectors and partners, from government to the private sector, and including community leadership from faith-groups, professional associations, legal aid organizations and academia;
- communication on multiple platforms, including social media;

- supporting policy and programmes with the latest research and evidence; and
- protecting and enhancing health care using a human rights approach.

The experience of grassroots HIV movements provides a valuable lesson for overweight, obesity and diabetes. In the early days of the epidemic, HIV-related stigma and discrimination presented significant barriers to treatment, care and support. In many cases, laws worked against, rather than in the interests of, public health. Laws targeted and isolated groups who were already marginalized and at higher risk of infection. This increased the stigma, making people more vulnerable and even less likely to seek treatment.

Globally, social mobilization has contributed to huge HIV-funding increases, the significant drop in prices for HIV medications, and heightened awareness of the importance of addressing discrimination to achieve prevention and treatment goals. Specific examples from Fiji, Indonesia, and Thailand illustrated the achievements of community sector organizations in securing social, political and legal recognition, as well as access to health coverage, for people living with HIV and other affected populations. Some important parallels were suggested for populations affected by overweight, obesity and diabetes.

## 2.5 Trade and public health law

### 2.5.1 Trade agreement and health policy: Building capacity for policy coherence in the Region

Dr Deborah Gleeson highlighted the potential for international trade agreements to negatively impact national health policy, and underscored the importance of including stakeholders and goals in trade negotiations. Trade agreements can cover goods, services (including health care), intellectual property, labour mobility, investor protection, government procurement, health and safety provisions, dispute settlement provisions and more.

In theory, eliminating barriers to trade should lead to the free movement of goods and services. Such trade liberalisation should in turn encourage economic and social development, greater wealth and a higher standard of health. In practice though, many countries in the Region have not seen the promised benefits of opening up their markets. Instead, they have experienced both a flood of cheap products from, and a drain of skilled workers to, richer nations. Specifically in relation to healthy diets, trade agreements can mean:

- higher levels of direct foreign investment by multinational food and drink companies;
- cheap soft drinks flood the market; and
- governments can focus on exports at the expense of local food supplies.

At the level of policy, trade agreements can limit the scope of national governments to introduce laws or strengthen health systems to prevent or cope with NCDs. Participants discussed case studies from Fiji, which banned mutton flaps, and Samoa, which attempted to ban turkey tails (both are fatty cuts of meat dumped in these countries by trading partners).

The presentation outlined several principles from the World Trade Organization (WTO) agreements that may assist policy-makers to ensure that health policy remains compliant with international and regional trade agreements. These include ensuring that national policies:

- treat like-products in a similar way, and do not discriminate between equivalent domestic and imported products;
- are no more trade-restrictive than necessary to protect health; and

- are based on science, i.e. the strongest possible evidence.
- some actions advocates might take to build healthy trade policies include:
- fostering dialogue between health and trade officials at national, regional and global levels;
- promoting leadership by health ministries;
- building institutional mechanisms for collaboration;
- engaging different stakeholders in the process; and
- building the case using accurate and compelling evidence on the cost of NCDs and how trade can impact NCDs.

The trade law landscape is constantly evolving, responding to the needs of consumers and suppliers of goods and services. This includes legislative reforms and judicial pronouncements at the national level. It is therefore essential to constantly monitor these developments so that Member States may respond effectively and safeguard public health. Community and nongovernmental organizations play an important role in helping to monitor developments, mobilizing support and making the case to government.

#### 2.5.2 Group work

The participants were asked to use a case study from one jurisdiction and discuss the following questions:

- Identify a legal intervention that you would like to introduce in your country to address obesity and diabetes. How would you ensure the intervention was designed in a way that was compliant with your country's trade agreements?
- Identify a trade agreement your country is negotiating that could present risks to diet-related health. What could you do about these risks?
- How could capacity be improved to improve policy coherence between trade and healthy diets, in your country and in the Region?

Some groups focused on specific country examples, while others focused on more conceptual enablers and barriers to healthy trade policy. These capacity and technical considerations are summarized in Table 2.

This group-work session highlighted the need to build capacity, and to encourage meaningful dialogue and debate including:

- Enhancing research capacity and building the evidence base for various country-level legal interventions and how these might impact upon, or be impacted upon by, trade agreements. Interventions might include controls on sugar-sweetened beverages, fatty meats or advertising. The evidence should relate to health as well as economic impacts. It should also consider policy coherence between communicable and noncommunicable disease policy. For instance, tariffs that increase the price of infant formula may disadvantage women with HIV who cannot breastfeed their babies.
- Building structures and processes for intra-country communication. Networks are growing in the Region between people and groups who are already working on specific issues, and they have much to teach others. This is especially relevant for smaller or less developed

countries, which may have limited scope to conduct research. It is difficult to be the first country to move into a new policy area; larger and more developed countries must show leadership and generate evidence and expertise.

- Developing international or regional standards, or even a treaty, around trade and health. This might help to create a level playing field, encouraging companies to behave with the same level of responsibility in all countries where they trade. The WHO guidelines on the marketing of food and non-alcoholic beverages to children might provide a precedent. Mandates from WHO can provide countries with a shared framework for discussion, and also with an impetus for action.
- The role of regional organizations in providing leadership, building technical expertise and disseminating information. Regional organizations can help to identify and disseminate best practice, and can help fill gaps where country capacity may be lacking. They can also help to train leaders and experts at regional and country level, supporting countries to negotiate trade agreements in an informed manner.
- Educating the primary health workforce about trade issues. This might happen in medical schools, or through civil society organizations. A more educated workforce means that discussions of trade and health can take place from the bottom up, as well as from the top down.
- The need for increased transparency in trade negotiations. The public is a stakeholder and needs to understand how negotiations are being conducted.

Table 2 – Enablers of, and challenges to, healthy trade policy: Capacity and technical considerations

	Capacity considerations	Technical considerations
<b>Enablers of healthy trade policy</b>	<ul style="list-style-type: none"> <li>• Communication, collaboration and consultation between trade, health and civil society stakeholders.</li> <li>• Increased knowledge and awareness among the health community (including primary care) of trade issues, and vice versa.</li> <li>• Policy coherence within a country, especially if it comes to a challenge in the WTO. Need to prepare for opposition and discuss rebuttal.</li> <li>• Strong and well-informed civil society organizations (e.g. Fiji’s Consumer Council)</li> <li>• Local political support for healthy trade policy.</li> <li>• Good evidence; support of academic institutions.</li> <li>• Regional groupings (e.g. Pacific nations) working together can present a unified voice in trade negotiations.</li> </ul>	<ul style="list-style-type: none"> <li>• Existing national food law can strengthen countries’ ability to protect health in a trade context. Food standards may provide support for a country to decline imported food that breaches the standard. E.g. Papua New Guinea improved the quality of imported mutton flaps using its <i>Pure Food Act</i>.</li> <li>• An excise or sales tax is likely to be more trade-compliant than an import tax, because it applies to <i>all</i> products.</li> <li>• Provisions requiring an impact assessment of a prospective law can protect health.</li> <li>• Strong food labelling laws, applying equally to domestic and imported foods (e.g. Malaysia).</li> <li>• National Constitutions may provide protection for health.</li> <li>• The potential role of international standards and Codex Alimentarius.</li> </ul>
<b>Challenges to healthy trade policy</b>	<ul style="list-style-type: none"> <li>• Poor knowledge of trade law by health advocates.</li> <li>• Power imbalances between public health advocates and trade decision-makers.</li> <li>• Lack of coordination between those negotiating the trade agreements and those implementing them.</li> <li>• Philosophical objections: while the</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of national food standards may affect countries’ ability to regulate imported foods.</li> <li>• Countries that joined the WTO more recently (e.g. Samoa, Papua New Guinea) had to agree to more restrictive trade provisions than earlier Member States like Fiji.</li> <li>• Weak or non-existent food labelling</li> </ul>

	<p>general WTO principle is one of lowering/reducing tariffs, many public health interventions seek to raise tariffs on unhealthy commodities.</p>	<p>regulations mean consumers have little information about poor quality imports (e.g. Mongolia).</p> <ul style="list-style-type: none"> <li>• Language barriers in labels on imported foods.</li> <li>• Codex Alimentarius can be a long and time-consuming process.</li> </ul>
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## 2.6 Effective law-making for public health impact

Making public health law is not just a process for lawyers. The health workforce, community organizations, politicians and many other groups will also be involved. This session comprised a presentation, panel discussion, and group-work exercise. These formats allowed the participants to share their experiences of drafting, passing and enforcing new public health laws – including challenges and failures along the way.

### 2.6.1 How can we make laws that have the desired impact?

Law can be a very powerful tool for responding to health risks at the population level. However, it is imperative that public health laws are designed thoughtfully. Mr David Clarke described some of the features of effective laws for public health impact.

*Good public health law:*

- is technically sound;
- meets community needs and addresses public health risks that affect the community;
- is clear and understandable, not written in legal jargon;
- is practical and capable of being implemented, and
- is a sustainable response, capable of enduring and perhaps evolving over time.

When designed well, public health law can act across populations, combat powerful vested interests and allow for the coordination of regional and international efforts to address NCDs. On the other hand, a poorly designed public health law will not work, and may worsen problems.

*Bad laws may:*

- be poorly drafted, overly rigid or out-of-date;
- lack community understanding or support;
- impose unnecessary costs or unintended consequences on communities;
- have been subject to interference by the industry they seek to regulate;
- be enforced unevenly or unfairly; or
- not be properly enforced due to a lack of resources, capacity or political commitment.

Bad, unfair, unnecessary or out-of-date public health law can undermine public confidence in the government and in the law. It is therefore important first to understand the problem we are seeking to solve, and to ask whether a new law can actually address it – or whether there might be alternative approaches. The role of customary law should not be underestimated in the Region. For

instance, a measure such as banning sugary drinks might be achieved through the influence of customary leaders. This again underscores the importance of designing local solutions to address local problems.

Once a community has decided that law is the best way forward, enforcement can pose particular challenges. This was addressed in the subsequent panel discussion.

## 2.6.2 Panel discussion and group work: What do we need to do to get effective laws implemented?

The panel, which included a former politician, a bureaucrat, a civil society representative and a health practitioner, brought their perspectives and expertise to this question. The wider group of experts also joined them for discussion. Several themes emerged, which were consolidated and elaborated upon in the subsequent group work. Those themes are summarized in Table 3.

Table 3 – Making Effective laws: What do we need to do?

Themes	Details
First, be clear that law is the most appropriate way forward.	<ul style="list-style-type: none"> <li>• Not every problem has a legislative solution!</li> <li>• There will always be alternatives to law, e.g. community interventions, voluntary industry approaches and the role of traditional leaders. Each has its own strengths and weaknesses.</li> <li>• A bad law may be worse than no law at all.</li> </ul>
Local problems need local solutions...	<ul style="list-style-type: none"> <li>• Each jurisdiction must determine its own needs, which may involve a mix of legislative and non-legislative responses.</li> <li>• An intervention that works in one context may not work in another. This must be assessed critically.</li> <li>• Small countries are tired of having to rely on consultancies from elsewhere. There is a significant need to build local expertise.</li> <li>• Laws and policies need to align with local culture, including spirituality and ways of living, as well as with local governance and judicial circumstances.</li> </ul>
... <i>but</i> regional and international organizations do have a part to play.	<ul style="list-style-type: none"> <li>• Appropriate support from inter- and non-governmental organizations might involve developing guidelines and technical advice, and coordinating knowledge sharing.</li> <li>• Development partners and donors can be vital in smaller or vulnerable countries.</li> </ul>
Understand the context in which you are operating.	<ul style="list-style-type: none"> <li>• Law reform can be a slow process, requiring persistence and consistency.</li> <li>• Understand how your own country context works: <ul style="list-style-type: none"> <li>• What are some enabling features? E.g. is health protected in the Constitution?</li> <li>• What are some barriers? E.g. corruption, weak health system, the philosophy of the present government?</li> </ul> </li> <li>• Be realistic about what is appropriate and achievable in the circumstances.</li> </ul>
Make use of local expertise.	<ul style="list-style-type: none"> <li>• Legal interventions to encourage healthy diets and physical activity are still relatively new. However, there is a substantial pool of people with experience of alcohol and tobacco control, and of the social mobilization around other health challenges such as HIV.</li> </ul>
Be prepared! Get the evidence right.	<ul style="list-style-type: none"> <li>• If advocating regulation of junk food or sugary beverages in schools, find evidence to show the negative effect of junk food on children's health and wellbeing, or the effect of marketing on children's preferences.</li> <li>• If making an economic argument, gather evidence about revenue raising or cost saving opportunities.</li> </ul>

Themes	Details
Be prepared! Make sure you have buy-in from stakeholders.	<ul style="list-style-type: none"> <li>• Hold meetings in advance with stakeholder groups who will be affected by a law reform proposal; make sure they understand the nature and purpose of the new law. Gather all the relevant interests together, for instance: <ul style="list-style-type: none"> <li>• Across sectors (government, non-government, health, industry, civil society); and</li> <li>• Across different ministerial portfolios within government.</li> </ul> </li> <li>• Understand the importance of communication: <ul style="list-style-type: none"> <li>• This may involve community consultation, writing letters to the newspaper or using social media.</li> <li>• Consultation documents should be expressed in clear and simple language.</li> </ul> </li> <li>• Framing can also be important in challenging community preconceptions about law. For instance, frame public health law as enabling rather than punitive.</li> <li>• Address technical and practical considerations relating to the enforcement of the law right from the beginning.</li> </ul>
Innovative law needs decisive political leadership...	<ul style="list-style-type: none"> <li>• Along with technical aid and local experts, innovative law requires strong champions. These might be respected politicians, health advocates, or customary or civil society leaders.</li> <li>• Champions can drive the process and harness expertise from diverse sectors.</li> </ul>
... <i>but</i> also brings the community along with it.	<ul style="list-style-type: none"> <li>• Law does not exist in a vacuum. Eating and drinking have social and cultural meanings. Law reform needs first to understand the context for unhealthy behaviours, before seeking to change norms and values.</li> <li>• Engage and consult with the affected communities in ways that are meaningful to them. Be mindful of access issues, including how the law is expressed.</li> <li>• Language barriers may prevent communities from participating in the process, responding to, supporting or challenging the law.</li> </ul>
Choose your moment.	<ul style="list-style-type: none"> <li>• There can be many different triggers for law reform. A change of government or minister, a crisis situation, a new report into the state of public health, a logical place in the parliamentary timetable or an outgoing leader who wishes to leave behind a legacy... can all be potential windows of opportunity.</li> <li>• In other cases, aligning a new law with the overall national health strategy will be more practical and strategic.</li> <li>• Sometimes, a trial and error approach will be necessary. Sunset clauses might be useful where a law is particularly novel or innovative.</li> </ul>
Many of these laws will regulate corporate behaviour: be prepared to counteract industry opposition.	<ul style="list-style-type: none"> <li>• The processed food and drinks industries may use tactics similar to the alcohol and tobacco industries to oppose regulation and influence policy-making. These may include: <ul style="list-style-type: none"> <li>• targeting trade/finance ministers with objections about the cost of regulation;</li> <li>• attempting to water down the new law;</li> <li>• delaying tactics, e.g. asking for further consultation; quibbling over technical definitions; and</li> <li>• circumventing advertising restrictions with corporate social responsibility and positive media coverage.</li> </ul> </li> <li>• Industry is often one step ahead, winning the public relations battle. Public health advocates will rarely have the marketing budget to match this. They therefore need to be creative, proactive, strategic and persistent.</li> <li>• Naming and shaming through the media is one way to counteract industry spin. In other cases, personal stories might be just as powerful.</li> </ul>
Finally, getting the law passed is only the first step.	<ul style="list-style-type: none"> <li>• There will be an ongoing role for stakeholders from all sectors, champions and experts in enforcing, evaluating and learning from the new public health laws.</li> </ul>

### 3. CONCLUSIONS

The final session of the consultation focused on building a regional agenda for advancing legal interventions to address overweight, obesity and diabetes, and to improve public health nutrition. Participants worked in groups to identify priorities and next steps. When compiled, the key themes and areas for action fell under six major themes:

#### 1) Generating and sharing evidence for action

There is a strong need to build the evidence-base on legal interventions relating to obesity, diabetes and population diets. Such evidence might relate to the need for a new intervention, its effectiveness, or assessment, implementation or enforcement phases. For example, for sugar-sweetened beverages, evidence might relate to the contribution of sugar to dietary energy or to the potential impact of regulation.

Countries should take a broad view of evidence. It may be difficult to assess the effectiveness of individual interventions, particularly if countries introduce a basket of different policies and laws. Accordingly, case studies, feasibility studies, guidelines, summaries and other tools can assist countries to share their knowledge and experience with one another. Researchers and academics have a role to play. Building networks in the Region will facilitate information sharing.

#### 2) Capacity-building: Developing local expertise

While acknowledging the role of international and regional organizations, the participants agreed that it was vital to develop local expertise. This will involve strengthening the linkages between health and the law and building the knowledge base and capacity of each profession to understand and work together at country level. Suggestions included:

- training the legal and health workforces through changes to academic curricula;
- conducting workshops and forums to encourage greater dialogue between government and civil society, and
- developing multidisciplinary groups of public health law experts.

Building capacity in this way will also reduce the need for consultants from outside the Region.

#### 3) Topic-specific interventions

In addition to the general principle of generating and sharing evidence, there is a need for in-depth technical advice on specific promising interventions. These include:

- regulation and taxation of sugar-sweetened beverages;
- restrictions on marketing unhealthy food products and beverages to children;
- requirements for interpretative front-of-pack labelling on packaged foods; and
- legislation to facilitate environments that are conducive to physical activity.

4) Social mobilization

Support from civil society will be crucial to the development, implementation and enforcement of innovative legal approaches to overweight, obesity and diabetes. Civil society participation will play an important role in ensuring that interventions are targeted and appropriate to local contexts.

5) Actions to address industry interference

The role of the food and drinks industries in relation to public health and changing diets is complex. Some participants expressed the view that engagement with the industry may be necessary, for instance in relation to promoting healthier foods and drinks. Others felt that industry would always seek to oppose regulation aimed at improving diets. They described such experiences, including in primary schools. All agreed that addressing industry interference in policy-making is a priority action. Clear guidelines are needed to avoid conflicts of interest and to ensure that government interactions with the food industry are transparent and constructive, and do not jeopardise public health goals.

6) Putting law on the WHO agenda

Law is central to advancing the goals of WHO, and can enable countries to protect, respect and fulfil the right to health. The right to health offers the possibility of placing health at the centre of countries' law- and policy-making processes and governance structures. The participants would like to see law better integrated into the WHO agenda. The Regional Office for the Western Pacific's recent appointment of a public health law expert to its NCDs team is one example. Another possibility is to address public health law at the upcoming session of the Regional Committee for the Western Pacific.

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## PROGRAMME OF ACTIVITIES

Wednesday, 9 April 2014

<b>08:30-09:00</b>	Registration	
	<b>(1) Opening ceremony</b>	
<b>09:00-09:30</b>	Welcome remarks	<b>Dr Hai-Rim Shin</b> Team Leader Noncommunicable Diseases and Health Promotion (NHP) WHO Regional Office for the Western Pacific (WHO WPRO)
	Opening address	<b>Dr Susan Mercado</b> Director Division of Building Healthy Communities and Populations WHO WPRO
		<b>Mr David Patterson</b> Senior Legal Expert Health Department of Strategy and Innovation International Development Law Organization (IDLO) Netherlands
		<b>Dr Stephen Colagiuri</b> Professor of Metabolic Health Boden Institute of Obesity, Nutrition, Exercise and Eating Disorder WHO Collaborating Centre for Physical Activity, Nutrition and Obesity The University of Sydney (SU) Australia
		<b>Mr Roger Magnusson</b> Professor of Health Law Sydney Law School The University of Sydney (SU) Australia

**Ms Premila Kumar**  
Chief Executive Officer  
Consumer Council of Fiji  
Fiji

Round of introductions from  
participants

Nomination of office-bearers

**(2) Overview of overweight, obesity,  
diabetes and law in the Western  
Pacific**

**Moderator:**  
**Dr Feisul Idzwan Mustapha**  
Public Health Specialist  
Cardiovascular Diseases and Diabetes Unit  
Ministry of Health  
Malaysia

**09:30-10:30**

Review of meeting objectives,  
Agenda and background materials,  
ground rules

**Mr David Patterson**

Overweight, obesity and the diabetes  
epidemic in the Western Pacific,  
including health inequalities and  
historical perspectives

**Dr Stephen Colagiuri**

Discussion

**10:30-11:00**

***Group photo and mobility break***

**11:00-11:15**

Regional response to overweight,  
obesity and diabetes

**Dr Susan Mercado**

**11:15-12:30**

Current and emerging legal issues  
relating to the prevention, detection  
and treatment of overweight, obesity  
and diabetes

**Mr Roger Magnusson**  
**Ms Jenny Kaldor**

Discussion

**12:30-13:30**

***Lunch break***

**(3) Best practices in governance,  
policy, legislation and regulation**

**Moderator:**  
**Atty Maria Paz G. Luna**  
Trustee and Board Secretary  
Health Justice, Inc.  
Philippines

**13:30-14:30**

Republic of Korea: Special Act  
on Safety Management  
of Child Nutrition

**Dr Cho-II Kim**  
Director  
Department of Health, Industry  
and Policy  
Korea Health Industry Development  
Institute  
Republic of Korea

Tonga: Legislation to establish the  
the Tonga Health Promotion  
Foundation

**Dr Viliami T'au Tangi**  
Chief Surgeon Specialist  
Viola Hospital  
Tonga

Philippines House Bill 3365 to  
increase tax on sugar-sweetened  
beverages (SSB)

**Hon Estrellita B. Suansing**  
Representative, Nueva Ecija, 1<sup>st</sup> District  
House of Representatives  
Philippines

Discussion

**14:30-15:00**

***Mobility break***

**15:00-16:00**

Group work  
(current situation and challenges)

**Dr Ki-Hyun Hahm**  
Consultant  
NHP  
WHO WPRO

- (1) Marketing restrictions
- (2) Label regulations
- (3) Retail controls
- (4) Fiscal measures
- (5) Other interventions

**16:00-17:00**

Report from group work

Discussion

**17:00-19:00**

***Reception***

**Thursday, 10 April 2014**

**08:45-09:00**

Recap of Day 1

**Dr Ki-Hyun Hahm**

**(4) Discrimination concerning, overweight, obesity, and diabetes in the Western Pacific, including access to medicines**

**Moderator:**  
**Ms Premila Kumar**  
Chief Executive Officer  
Consumer Council of Fiji  
Fiji

**09:00-10:30**

Roundtable discussion  
(current situation and challenges)

**Mr David Patterson**

**Dr Abdul Wahid Khan**  
Honourable Secretary  
World Organization of Family Doctors  
Asia Pacific Region  
Chair  
Diabetes Fiji  
Fiji

**Ms Daiana Buresova**  
Senior Legal Policy Researcher  
Pacific Regional Rights Resource Team  
Secretariat of the Pacific Community  
Fiji

**Dr Manisha Shridhar**  
Regional Advisor  
Intellectual Property Rights  
and Trade and Health  
WHO Regional Office for  
South-East Asia  
India

**Mr Deni Ahmad Fauzi**  
Programme Manager  
HIV, Governance & Social Protection  
United Nations Development Programme  
Indonesia

**10:30-11:00**

*Mobility break*

**(5) Trade and public health law**

**Moderator:**  
**Dr Viengxay Vansilalom**  
Acting Director  
Food Control Division  
Food and Drug Department  
Ministry of Health  
Lao PDR

**11:00-11:30** Trade agreements and health policy;  
building capacity for policy coherence  
in the Region

**Dr Deborah Gleeson**  
Lecturer  
School of Public Health  
and Human Biosciences  
La Trobe University  
Australia

**11:30-12:30** Group work

**12:30-13:30** *Lunch break*

**13:30-14:30** Report from group work

Discussion

**14:30-15:00** *Mobility break*

**(6) Effective law-making  
for public health impact**

**Moderator:**  
**Dr Stevenson Kuartei**  
Pacific Family Medical Supply  
and Clinic  
Palau

**15:00-15:30** Introduction

**Mr David Clarke**  
Law and Policy Consultant  
Law and Policy Limited  
New Zealand

**15:30-16:00** Panel discussion

**16:00-17:00** Group work with periodic reports

**Friday, 11 April 2014**

<b>08:45-09:00</b>	Recap of Day 2	<b>Dr Ki-Hyun Hahm</b>
	<b>(7) Technical recommendations towards a regional agenda for advancing legal interventions to address overweight, obesity, and diabetes, and to improve public health and nutrition</b>	<b>Moderator: Dr Temo Waqanivalu Coordinator NCD Health Promotion WHO DPS</b>
<b>09:00-10:00</b>	Group work (technical recommendations)	
<b>10:00-10:30</b>	Report from group work	
<b>10:30-11:00</b>	<i>Mobility break</i>	
<b>11:00-12:00</b>	Discussion	
	<b>(8) Closing ceremony</b>	
<b>12:00-12:30</b>	Next steps	<b>Mr David Patterson</b>
	Closing remarks	<b>Dr Hai-Rim Shin</b>

**OPENING ADDRESS**

**DR SHIN YOUNG-SOO**  
**WHO REGIONAL DIRECTOR FOR THE WESTERN PACIFIC**

9-11 April 2014

Manila, Philippines

The World Health Organization has long recognized the important role of the law in public health. Many of you also attended the consultation earlier this week that reviewed health legislation as a key component of developing effective and sustainable health systems. Now at this consultation, our mission is to explore specific legal mechanisms for countries to deal with overweight, obesity and diabetes. I am very pleased that the International Development Law Organization and both the medical and law faculties at the University of Sydney have taken the initiative to co-host this event, with strong support from our Regional Office.

The Western Pacific is one of the most diverse and dynamic regions in the world. Our Member States are at the forefront of the many issues associated with globalization and urbanization and modernization. Ironically, with rapid economic growth and increased spending power, many people in our Region are still starving. They are starving for foods that are high in quality and nutritional value. People are consuming too much cheaply processed, nutrition-poor food. The dominance of such foods has been driven by mass production and aggressive promotion and distribution. In the Pacific, for example, the typical diet has changed from traditional yam and taro to corned beef and hot dogs. Sugary beverages have replaced water on many tables. These changes have played large parts in driving prevalence rates of obesity to 75% among adult islanders.

Unhealthy diet is a major risk factor for diabetes and other noncommunicable diseases – which account for more than 80% of deaths in the Region each year. As with any NCD, diabetes is a complex problem. It must be viewed from various perspectives and approached holistically. The approach must envision, embrace and engage medical interventions, as well as economic and cultural considerations – and, of course, legal mechanisms –for prevention and management of the disease.

First, we must learn what Member States have already done. For example, we need to examine laws on marketing to children, retail restrictions, zoning, formulation and labelling, among other items.

Second, we must find new ways of solving problems when the existing options are not enough. We have to work together and be innovative and creative, while at the same time being practical. The endgame is to help Member States operationalize the ideas that you bring to the table, so please be mindful of national contexts and capacities.

Third, we must anticipate potential obstacles and challenges, especially in relation to industries and other sectors such as trade and finance. We should address these concerns proactively, rather than waiting for that sector or industry to react to laws. We must be mindful of the long-term effects of any proposal – the implications for jobs, pricing, and commodities. Consider related issues, such as taxation, intellectual property and insurance.

Finally, in light of our push towards universal health coverage, we should consider how the law can be used to ensure access to essential medicines and to promote equity, justice and fairness.

I am confident that your insights and ideas will prove invaluable in helping set the agenda for WHO to better assist Member States in dealing with overweight, obesity, and diabetes. I look forward to hearing your recommendations to guide our work going forward at the close of this consultation.

Thank you.

# Overweight, obesity, diabetes and the law in the Western Pacific Region: Emerging issues & legal options

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## *Background paper*

This background paper has been prepared for the Western Pacific Region expert consultation on overweight, obesity, diabetes and law, co-hosted by the International Development Law Organization (IDLO) and the University of Sydney, and co-sponsored by WHO Western Pacific Regional Office. The paper will be finalised after the consultation, which will take place in Manila on 9-11 April 2014.

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Reviewers: Roger Magnusson, David Patterson, Deborah Gleeson, Dave Clarke, Ki-Hyun Hahm, Cherian Varghese and Katrin Engelhardt.

*The views expressed in this paper are those of the author and do not necessarily reflect the views or policies of the University of Sydney, IDLO, the WHO or its Member Parties.*

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## List of abbreviations used in this document

IDLO	International Development Law Organization
NCDs	Noncommunicable diseases
NGO	Non-governmental organization
SES	Socio-economic status
TRIPS	the Agreement on Trade-Related Aspects of Intellectual Property Rights
UN	United Nations
WHO	World Health Organization
WTO	World Trade Organization

## 1. Introduction and purpose

The purpose of this Background Paper is to introduce, and encourage further discussion of, ways in which law can be used to tackle the burden of overweight, obesity and diabetes in the Western Pacific region. The paper focuses on the potential for legal interventions in three areas:

- (i) To prevent the shared risk factors of obesity and diabetes, including unhealthy diet and physical inactivity;
- (ii) To manage and treat diabetes and ill-health associated with overweight and obesity;
- (iii) To address the social consequences of overweight, obesity and diabetes, particularly discrimination.

At the country level, a comprehensive response to overweight, obesity and diabetes requires multiple (legal as well as non-legal) actions, across a number of sectors. In isolation, law may be ineffectual in achieving good public health outcomes and may even be harmful. Laws must be implemented and enforced. Furthermore, legal or regulatory approaches must complement other actions, including education, health promotion, advocacy, fiscal policy and governance reform. These actions are recognised in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases (2013-2020) and in the Western Pacific Regional Action Plan for the Prevention and Control of Noncommunicable Diseases (2014–2020).<sup>1</sup>

Where possible, this paper uses examples from the region. However, it also draws on legal interventions from around the world and from other arenas of public health law. These examples have been included to illustrate particularly innovative or instructive approaches, and to encourage creative thinking on overweight, obesity, diabetes and the law in the Western Pacific region.

## 2. A public health law approach

A useful definition of *public health* is “what we, as a society, do collectively to assure the conditions for people to be healthy.”<sup>2</sup> *Public health law* focuses more narrowly on the role of governments in protecting, promoting and supporting the health of their people. Law provides an important set of tools – discussed throughout this paper – for preventing disease, extending life, and increasing healthy life expectancy for the population. The use of law to improve public health raises issues about both the powers and duties of governments to foster public health, and also the limitations on those powers and duties.<sup>3</sup>

The exercise of legal authority should also be understood within a broader human rights framework: law is an important means by which states discharge their obligations to respect, protect and fulfil the right to health.<sup>4</sup> Further, the right to health is an important, over-arching standard for guiding and evaluating governments' use of legal powers.

### (a) What is law?

There are many ways of describing “law”, from an expression of cultural values to a rationalised framework of power.<sup>5</sup> At a basic level, law provides the frameworks of authority within which states exercise their functions, including safeguarding public health. This authority is exercised in a variety of ways, including through:

- Primary **legislation**, or law that has been adopted by the legislature (Parliament, Congress or a state legislature). Legislation operates at a general level, by setting out objects and principles, offences and penalties, and the powers of authorised officers.<sup>6</sup> Legislation may also allow for the adoption of:
- Subsidiary **regulations, decrees** or specific **rules** made by the government, often in order to implement and achieve the regulatory objectives set out in legislation.

Both legislation and regulations may be reviewed by:

- Systems of **dispute resolution** (courts, tribunals and other decision-making bodies).<sup>7</sup>

Different sources of law are described at section 2 below.

### **(b) What is public health law?**

Historically, core areas of public health law have included sanitation and environmental health risks, food safety, and communicable diseases. Laws regulating medical care and other health services may also have an important role in public health, by providing universal access to screening, diagnostic and treatment services, and by seeking to reduce disparities in health status within the population.

Other laws, frequently falling outside the responsibility of the Health Ministry, may nevertheless exert a powerful influence on the health and wellbeing of the community. Examples of this include fair trading laws (including laws creating penalties for misleading and deceptive conduct), urban planning laws, gun control laws, road safety, child protection laws and laws regulating advertising. However, it is perhaps less important to characterize what is and what is not public health law, and more important to adopt an *approach* to law-making that seeks to create the conditions in which people can lead healthier lives.<sup>8</sup>

### **(c) What does public health law do?**

In the context of public health, law is often seen as a “hard” policy tool, i.e. one that prescribes technical requirements and imposes penalties for non-compliance. Law is contrasted with less interventionist policy options, such as social marketing campaigns, education and self-regulation.

On the other hand, there are few policy approaches, hard or soft, which do *not* require the use of law for their implementation. This is because law creates the enabling environment and the framework of authority within

which public health policies and responses can be implemented. Examples of laws that enable policy to be implemented include laws that establish organisations (such as a health promotion foundation or anti-discrimination commission), laws that create and define formal roles, and laws that set and maintain standards by establishing offences and penalties for non-compliance.<sup>9</sup>

With some exceptions (e.g. class actions brought under tort law), public health law is predominantly public law, made by legislatures and codified by statutes and regulations. These laws define the scope and limits of public health practice, and create rights and obligations. They also give substance to the duties of states to ensure the conditions for their citizens' health and, under some circumstances, the health of non-citizens within their borders. Laws may be made or changed by many different agencies or bodies, and also by different levels of government (including national, regional/state and local government).

#### **(d) Why use law, rather than encouraging individuals to change their behaviours?**

Historically, governments seeking to address unhealthy diets and physical inactivity have tended to focus on policies encouraging individuals to change their behaviour. Examples include health promotion campaigns, education, social marketing and dietary guidelines. However, lifestyle is not only influenced by individual factors: it is also a population issue. The steep rise in obesity and diabetes over recent decades suggests that it is better explained by environmental influences shaping the eating and physical activity patterns of the population as a whole, rather than by changes to individuals' genetic factors or levels of motivation.<sup>10</sup>

Law shapes and organises societies by providing the organisational structures for governments, the economy and civil society. Rather than simply acting on individuals, law acts on the broad underlying influences (or "determinants") of health within a population. As such, it has the potential to

powerfully influence public health. Examples of determinants include food prices, access to health services, and the environments in which people live, work and spend their leisure time. Governments may seek to influence these determinants, and in so doing support healthier choices and reduce individuals' exposure to risk factors.<sup>11</sup> This can have the effect of discouraging behaviours that impede good health (such as smoking), or encouraging behaviours that protect health (such as wearing seat-belts in cars).<sup>12</sup>

Further, the use of law can be justified by the epidemic rates of overweight, obesity and diabetes and their associated mortality and morbidity. This preventable mortality and morbidity is subject to health disparities associated with determinants such as race, income, and level of education. As Professor Lawrence Gostin writes, "*if the problem were related to pathogens, tobacco, or lead paint, most would support aggressive measures to protect innocent individuals from hazards created by others*".<sup>13</sup> There is little evidence that policy approaches focused on influencing individual behaviour (such as education and health promotion) are likely to be effective in reducing obesity – especially when the environment does not support or encourage a healthy lifestyle.<sup>14</sup> Also, to the extent that governments can use law to create healthier environments, it will be "less necessary to keep on persuading individuals".<sup>15</sup> For this reason, governments and the public health community should consider the opportunities for law and regulation to strengthen health systems and prevention efforts.

### **(e) Why use law rather than other regulatory approaches?**

Governments that are considering introducing laws or adopting a regulatory approach to overweight, obesity and diabetes may need to be convinced that a legal approach is the best option, when compared to other forms of regulation. For a variety of reasons, governments may find it more appropriate to first encourage voluntary, self-regulatory or co-regulatory approaches to improving population diets. Examples of these include voluntary food reformulation schemes or self-regulatory advertising and marketing codes. Some of the strengths and weaknesses of these approaches are summarised in Table 1, below.

It is important to emphasise that these options need not be mutually exclusive.<sup>16</sup> Governments may take the view that legal measures are required only once non-legal approaches have failed to achieve their public health aims, or in order to strengthen the operation of non-legal measures. A good example of this is Mexico, which recently stepped up its efforts on sugar-sweetened beverages. Following the Ministry of Health's beverage guidelines in 2008 (a co-regulatory measure),<sup>17</sup> in 2014 Mexico introduced a (mandatory) 10% tax on sugary drinks.<sup>18</sup> In many cases, governments will use a mix of regulatory tools, introducing legislation to regulate certain issues, but relying on co-regulatory or voluntary schemes in other areas.

Regardless of the approach selected, governments should ensure that the policy measures are independently monitored and evaluated against clear targets. This allows for what the Australian National Preventative Health Taskforce described as a cyclical, "*do, measure, report*" approach, whereby harder regulation can be implemented as necessary, after evaluating softer approaches.<sup>19</sup>

### Discussion questions

- (a) Consider an example of public health law reform in your country. What were the issues in that case? Who were the stakeholders? What were the challenges?
- (b) What kind of policy responses to obesity and diabetes have been used in your country to date?
- (c) In what circumstances might it be appropriate to adopt a legal and regulatory approach to risk factors for obesity and diabetes, rather than education, health promotion, or voluntary commitments by food manufacturers and retailers, the media, schools and educational institutions, and other stakeholders?

**Table 1 - Strengths and weaknesses of different regulatory approaches**

Approach	Strengths	Weaknesses
<p><b>Laws and regulations</b> (technical standards set and imposed by government)</p>	<ul style="list-style-type: none"> <li>+ Clarity and consistency for all market actors.</li> <li>+ Law and regulation are binding and enforceable.</li> <li>+ Subject to accountability and transparency within the democratic process.<sup>20</sup></li> <li>+ Can support public health in cases where there is no economic incentive for business to self-regulate in a credible way.<sup>21</sup></li> </ul>	<ul style="list-style-type: none"> <li>+ May be regarded as unduly coercive.</li> <li>+ Can be expensive to enact and enforce.</li> <li>+ May be undermined if commercial interests claim they were not included in the legislative and deliberative processes.</li> </ul>
<p><b>Co-regulatory</b> schemes (i.e. developed in consultation between government and industry. Industry participation is mandatory and overseen by the government)<sup>22</sup></p>	<ul style="list-style-type: none"> <li>+ Retains many of the monitoring and enforcement advantages of legal/regulatory approaches, but shifts much of the cost onto the regulated industry.</li> <li>+ Government maintains an open dialogue with the regulated industry, and can step up its involvement if necessary.</li> </ul>	<ul style="list-style-type: none"> <li>+ May be criticised for “regulatory capture”, i.e. the scheme is seen to advance the interests of the regulated industry rather than the public.</li> </ul>
<p><b>Self-regulatory</b> schemes (i.e. designed, implemented and enforced by the regulated industry)</p>	<ul style="list-style-type: none"> <li>+ Little or no cost to government.</li> <li>+ Cheaper compliance costs for industry.</li> <li>+ Allows industries the opportunity to prove themselves “good corporate citizens”, and to respond to evolving market and social demands, before being externally regulated.</li> </ul>	<ul style="list-style-type: none"> <li>+ Self-regulatory schemes may give the appearance that the industry is taking action, while closer scrutiny reveals that their commitments are often weak or watered down over time.<sup>23</sup></li> </ul>
<p><b>Voluntary</b> action</p>	<ul style="list-style-type: none"> <li>+ Entirely market-based, with no cost to government.</li> </ul>	<ul style="list-style-type: none"> <li>+ Effective only where the aims of industry and public health are aligned (e.g. manufacturers of exercise equipment).</li> </ul>

### 3. Technical elements of public health law: institutions, strategies, settings

The range of legal interventions that might be relevant to public health in general, and overweight, obesity and diabetes in particular, may be described in many ways. These include by reference to:

- **Who** can make public health law?
- **What** can public health law regulate? or
- **Where** can public health law effect change? (Or, to which **settings** can public health law be targeted?)

This section deals briefly with each of these elements. Section 4 uses concrete examples from the region and around the world to illustrate the operation of these principles and to raise different legal issues and options.

#### (a) Institutions & sources of law: Who makes public health law?

An important step in assessing legal options for overweight, obesity and diabetes is to determine who can make such law. Public health law can be made at different levels of government, and by different institutions and agencies both within government and at the international level. The Western Pacific region includes diverse legal and political systems. Relevant legal institutions and sources of law may include:

**National legislatures**, which in most cases control the major policy levers of taxation and budget, and may also regulate industry, communications and trade.<sup>24</sup> In general, their authority to make legal instruments derives from the national Constitution.

☞ For example, the Malaysian national government implemented an obesity prevention program that aimed to increase public awareness regarding nutrition. This involved media campaigns, nutritional labeling on packaged food, and the establishment of nutritional information centres and community kitchens.<sup>25</sup>

☞ For example, China enacted legislation in order to incorporate at a national level the provisions of the WHO's international code of marketing of breast milk substitutes.<sup>26</sup>

**International law**, which includes inter-governmental agreements, the rules and regulations made by international bodies (e.g. WHO, WTO), and regional and bilateral agreements. These establish countries' obligations under international law. By ratifying an international agreement, countries agree to carry out the requirements of the treaty at the national level.

☞ For example, Papua New Guinea is a signatory to the UN Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW"). In relation to healthcare, this requires the government to implement specific obligations to ensure equality of access to health services for rural women.<sup>27</sup>

**State legislatures** may pass legislation implementing their responsibilities as set out in the national Constitution.

☞ For example, public health is generally considered a state issue under the Australian Constitution.<sup>28</sup> The Australian state of New South Wales recently used its powers to introduce legislation mandating calorie labelling on food sold in fast food and snack food chains.<sup>29</sup>

**Local or city legislatures** will often have jurisdiction\* over the physical spaces in which communities live. They can effect change at the local level, including the built environment, using planning and environmental regulations.

☞ For example, the Health Promotion Board of Singapore allows hawker stalls to display a "Healthier Choice" logo if they have agreed to certain changes to their food, such as the use of reduced-saturated fat oil and whole-grain rice and noodles.<sup>30</sup>

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\* Jurisdiction refers to the scope of an institution's power to make law, and may be limited by geographic area or by subject matter.

☞ In the USA, many local and city councils have legislated to facilitate active transportation (such as cycling or walking) or better access to fresh fruits and vegetables.<sup>31</sup>

Where relevant, **customary or tribal law** can be an important source of public health law. This may include societal structures and traditions, declarations of local village custom and customary approaches to decision-making.

In contrast to the forms of state law described above, customary or tribal law is often an oral rather than a written tradition.

☞ For example, Fiji's *Public Health Act* does not apply in villages, which instead rely on customary forms of law and social organisation to manage minor public health threats.<sup>32</sup>

Where relevant, **presidents** can act as effective champions, and may make executive orders.

☞ For example, in 2010, Brazil's National System for Food and Nutrition Security (SISAN) was strengthened by a Presidential decree establishing a National Food and Nutritional Security Policy and Plan. Among other things, this decree specifies the criteria to be met by government and non-profit organisations that wish to become members of SISAN, as well as the financial obligations of each level of government. This helped to overcome the challenges posed by Brazil's decentralised political system, by allowing for consistency among the country's 5,500 municipalities.<sup>33</sup>

**Executive agencies** (i.e. agencies of the executive arm of government) can be authorized to make regulations and rules under existing legislation.

☞ For example, the United Kingdom's communications regulator, Ofcom, implemented regulations in 2007 banning the advertisement of food high in fat, sugar, and salt (as defined by a nutrient profiling system) during children's television programs.<sup>34</sup>

The statutory powers given to **statutory office-holders** appointed under an Act, such as an ombudsman or inspector, may also include the power to make regulations or decisions that may affect public health.

**Portfolio agencies** or **statutory agencies** may play a particularly important role in bringing together different sectors and departments of government to achieve public health goals.

☞ For example, the Tonga Health Promotion Foundation (known as TongaHealth) is an independent body established by the Health Promotion Foundation Act 2007. Its remit is to act as a link between the community, NGOs, and the government to promote health and tackle NCDs.<sup>35</sup>

In common law countries and other jurisdictions where their rulings have the force of law, **courts**, **tribunals** and other **decision-makers** can adjudicate claims. Individuals or groups may claim for compensation, or seek injunctions or other remedies from decision-makers.

☞ While it may be expensive and time-consuming, litigation can also be influential if used strategically. For example, a court decision finding a particular food manufacturer liable will act as a warning across the whole industry: “lessons are learned and future consumers may be better protected”.<sup>36</sup> In the USA, experts draw on the lesson of tobacco litigation as a template for similar actions on obesity.<sup>37</sup>

☞ In some countries, statutory bodies have been created to hear and conciliate complaints of unlawful discrimination. For example, under New Zealand's *Human Rights Act 1993*, the Human Rights Commission hears complaints of unlawful discrimination relating to a range of contexts, including work, education, official practice and policy, and the provision of goods and services. Disability, which includes a physical illness or impairment, is one of the grounds on which the Commission may hear a complaint of unlawful discrimination.<sup>38</sup>

Where **government is a litigator** seeking to enforce the law, the terms of settlement can also be used strategically to enforce changes in the behaviour of businesses in ways that better protect consumers and reduce health risks.

☞ For example, in Australia, the competition and consumer regulator put an end to the marketing of so-called “light” and “mild” cigarettes by accepting

enforceable undertakings from tobacco manufacturers in exchange for discontinuing court actions against them for misleading and deceptive conduct under consumer protection legislation.<sup>39</sup>

### Discussion questions

- (d) Which institutions of public health law do you consider to be the most promising, or the most effective, in tackling overweight, obesity and diabetes in your country?
- (e) Which institutions could be strengthened (or created) to tackle overweight, obesity and diabetes?

### (b) Strategies: What can public health law regulate?

A second way of looking at the operation of public health law is to describe its different targets. Governments seeking to respect, protect and fulfil the right to health may regulate the risk factors of overweight, obesity and diabetes, or they may regulate *themselves* by creating new governance structures. Some of these different strategies are set out below, in Table 2.<sup>40</sup>

### Discussion questions

- (a) What are the most promising targets of regulation to strengthen your country's response to overweight, obesity and diabetes?

Table 2 - Targets of regulation

What can public health law regulate?	Description
<b>Governmental structures</b>	<p>Governments can use “inward-facing” regulation to implement their governance arrangements: to create new agencies (including within the healthcare system) and regulatory processes and to specify the powers of agencies and public officials.</p> <p>Such regulation can enable the development of comprehensive, multi-sectoral policy approaches to diet, nutrition and physical activity by establishing the mandates, institutions, processes and capabilities that are needed to achieve public health goals.</p>
<b>The information environment</b>	<p>The use of law to advise, warn and correct misconceptions; to decrease populations' exposure to unhealthy messages through the media or marketing; and encourage and enable people to make healthier decisions through education, guidelines and labels.</p>
<b>The physical or built environment</b>	<p>The use of legal institutions and instruments to improve the environments in which people live, work, eat and play.</p>
<b>Socioeconomic health disparities</b>	<p>The use of law to address wider social determinants of health, to reduce socioeconomic health disparities, and to foster the conditions necessary to live a healthy life.<sup>41</sup></p>
<b>The availability and affordability of different food options</b>	<p>Governments can encourage healthier choices through fiscal and budgetary measures altering the costs of different behaviours, through taxing, spending, and making grants or subsidies. They can create economic incentives for businesses to implement workplace health promotion, and they can fund food programs to support better nutrition for vulnerable and low-income groups.</p> <p>Taxes raise revenue, which can be used for health promotion and can also educate consumers.<sup>42</sup></p>
<b>Individuals and businesses</b>	<p>The use of law to directly regulate the activities of persons, professionals and businesses, by imposing technical requirements (e.g. prohibiting the use of <i>trans</i>-fats in restaurant food).</p>
<b>When law is a barrier to good health</b>	<p>Deregulation may be appropriate in certain cases: for example, where public liability laws prevent children from playing in school-grounds after school hours.</p>

### (c) Settings: where might public health law operate?

A third way of thinking about public health law is to pinpoint the specific *settings* or *contexts* in which it might operate. Some examples of settings are illustrated below, in Figure 1. Identifying plausible settings for interventions can be a useful first step in determining the legal and regulatory options that might be implemented.

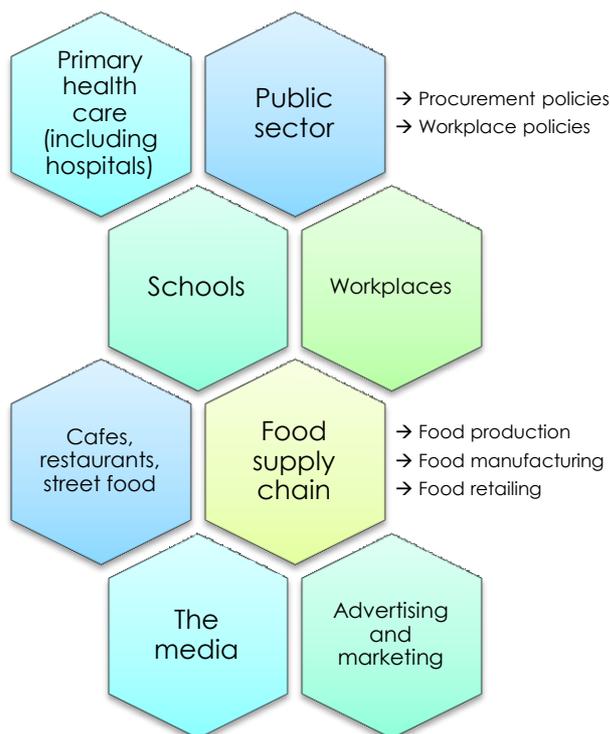


Figure 1 – Some settings for public health law

#### Discussion questions

- (b) What are the priority settings for tackling overweight, obesity and diabetes in your country?
- (c) How do these priority settings relate to the Institutions and Strategies (discussed above) of public health law?

## 4. Legal options and issues for overweight, obesity and diabetes

Table 3 sets out some of the most promising legal interventions for seeking to prevent and reduce overweight, obesity and diabetes, together with concrete examples and potential barriers and challenges. The issues in the final column (potential barriers and challenges to the use of law in this area of public health) are discussed in greater detail at Section 5, below.

**Table 3 - Options and issues**

Legal option or issue	Regulatory objective/s	Practical application to overweight, obesity and diabetes	Possible barriers, challenges and considerations
<p><b>Taxation of:</b></p> <ul style="list-style-type: none"> <li>+ Sugary drinks and other high-sugar products.</li> <li>+ High-fat products.</li> <li>+ High-salt products.</li> </ul>	<p><b>To reduce consumption of these products by...</b></p> <ul style="list-style-type: none"> <li>+ Altering their price cues and accessibility.</li> <li>+ Altering cultural norms in relation to those products.</li> <li>+ Encouraging reformulation by manufacturers.</li> <li>+ Raising revenue for health promotion.<sup>43</sup></li> </ul>	<p>Nauru and French Polynesia both enacted health-driven soft drink taxes. In French Polynesia, the funds were earmarked for health promotion.<sup>44</sup></p> <p>A review of the evidence for taxing unhealthy foods found that taxes should be at least 20% in order to be effective.<sup>45</sup></p>	<ul style="list-style-type: none"> <li>+ Compliance with obligations under WTO agreements and other international and regional trade agreements.</li> <li>+ Taxes can be regressive, i.e. they may disproportionately affect lower SES groups. This may be offset through subsidies on healthy foods or through the social welfare system.</li> <li>+ Importance of stating clear standards and objectives for the tax, and of channelling the revenue into health promotion. (Taxes may otherwise be seen as a revenue-raising measure unrelated to health).</li> </ul>

Legal option or issue	Regulatory objective/s	Practical application to overweight, obesity and diabetes	Possible barriers, challenges and considerations
<p><b>Restrictions on marketing and advertising of specified foods</b></p> <ul style="list-style-type: none"> <li>+ Media advertising (television, internet, billboards, magazines, etc).</li> <li>+ Product placement.</li> <li>+ Corporate sponsorship, including corporate social responsibility.</li> <li>+ Tie-ins, giveaways, sweepstakes, and other promotional offers/events</li> <li>+ Loyalty programs</li> </ul>	<p>To reduce consumption of these products by reducing exposure to a commercial environment that encourages the consumption of unhealthy foods.</p>	<ul style="list-style-type: none"> <li>+ In 2007, the UK's communications regulator, Ofcom, banned the advertising of food high in fat, sugar, and salt (as defined by a nutrient profiling model) from being shown during television programs that have particular appeal to children (under 16 years old).</li> <li>+ Republic of Korea has recently implemented bans on advertising toys with fast food (i.e. "Happy Meals").</li> </ul>	<ul style="list-style-type: none"> <li>+ Companies may argue that marketing restrictions conflict with free speech laws or principles.</li> <li>+ Companies may propose voluntary, industry-led initiatives as a way around legal frameworks (but see above, Table 1: voluntary initiatives limiting the marketing of unhealthy foods to children may lack transparency and accountability).<sup>46</sup></li> <li>+ Political lobbying by food manufacturers and retailers may weaken the terms of legal restrictions, reducing their overall impact.</li> <li>+ Cross-border (e.g. satellite TV, internet, imported materials) enforcement is difficult or virtually impossible</li> </ul>

Legal option or issue	Regulatory objective/s	Practical application to overweight, obesity and diabetes	Possible barriers, challenges and considerations
<p><b>Planning and development law</b> / land-use policies, zoning regulations</p> <ul style="list-style-type: none"> <li>+ Restricting new fast-food outlets (e.g. near schools).</li> <li>+ Encouraging fresh fruit and vegetable vendors in poorly-served areas.</li> <li>+ Creating opportunities for active transport and recreation.</li> <li>+ Integrating health impact assessment within planning and development approval processes.</li> </ul>	<p>To alter (either/both) the food and physical activity environments at the local level, reducing access to unhealthy food and increasing opportunities for communities to eat healthily and exercise.</p>	<ul style="list-style-type: none"> <li>+ Detroit, Michigan (USA) requires a distance of at least 500 feet between fast-food restaurants and local schools.<sup>47</sup></li> <li>+ New York City (USA) provides zoning and tax incentives to qualifying retailers, i.e. those devoting a specified amount of floor space to the sale of fresh produce, dairy, canned and frozen foods, and fresh and prepared meats, fish, and poultry.<sup>48</sup></li> <li>+ Republic of Korea law provides for "Green Zones" around schools.</li> </ul>	<ul style="list-style-type: none"> <li>+ Zoning restrictions may come into conflict with private-property owners' rights and interests (especially in densely populated urban areas such as Manila or Seoul).<sup>49</sup></li> <li>+ Planning and development decisions will usually be subject to administrative review. Legal instruments should permit authorities to take obesity, diabetes and other public health goals into consideration in making decisions about planning permits and zoning; decision-makers must not exceed the authority granted to them in authorizing legislation, etc.</li> <li>+ Finance, economic development.</li> </ul>

Legal option or issue	Regulatory objective/s	Practical application to overweight, obesity and diabetes	Possible barriers, challenges and considerations
<p><b>Labelling</b></p> <ul style="list-style-type: none"> <li>+ Nutrient and calorie information panels (“back-of-pack”).</li> <li>+ Interpretative labels (“front-of-pack”).</li> <li>+ Product warnings e.g. “High fat content”.</li> <li>+ Regulation of the use of health and nutrition claims.</li> </ul>	<p><b>To shift population diets in a healthier direction by...</b></p> <ul style="list-style-type: none"> <li>+ Altering the information that consumers have available when choosing between foods (in the case of back-of-pack and front-of-pack labels)</li> <li>OR</li> <li>+ Informing consumers of the risks to health associated with certain foods, thereby negatively influencing demand for those foods (in the case of front-of-pack labels and product warnings).<sup>50</sup></li> <li>+ Labels may further encourage food manufacturers to reformulate their products in accordance with public policy objectives.</li> </ul>	<ul style="list-style-type: none"> <li>+ Under the Australia New Zealand Food Standards Code, manufacturers must include a nutrition information panel on packaged foods that contain more than one caloric ingredient and are sold commercially. Standard 1.2.8 specifies the information that the label must include (e.g. calories, sodium, protein, fat, carbohydrates, sugars, and biologically active ingredients, serving sizes).</li> <li>+ In May 2011, Thailand became the first country to introduce mandatory front-of-pack nutrition labels for five snack categories. South Korea has also introduced a voluntary “traffic light” system for children’s foods, with a view to stepping up to a mandatory system in 2013-4.<sup>51</sup></li> <li>+ Fiji’s Food Safety Act (2003) includes a provision to allow the use of warning statements on food labels, e.g. “This is a high-fat food. Excessive consumption of high-fat foods can contribute to obesity and diet-related ill-health”.<sup>52</sup></li> </ul>	<ul style="list-style-type: none"> <li>+ Labelling may be ineffective if the labels are not clear enough, or not supported by information campaigns to explain what the labels mean. Consumers need adequate background knowledge in order to use labels to make healthier choices.</li> <li>+ Labelling may reinforce health inequalities if it is mostly used by those who are already making healthier choices.<sup>53</sup></li> <li>+ Countries fear that labelling regulations may not comply with obligations under WTO agreements and other international and regional trade agreements.</li> </ul>

Legal option or issue	Regulatory objective/s	Practical application to overweight, obesity and diabetes	Possible barriers, challenges and considerations
<p><b>Portion size controls</b> in various food industry settings: targeting</p> <ul style="list-style-type: none"> <li>+ Manufacturing (reformulation).</li> <li>+ Retail (“two-for-one” deals).</li> <li>+ Restaurants, fast-food outlets (serving sizes).</li> </ul>	<p><b>To reduce the total amount of calories consumed by individuals, by...</b></p> <ul style="list-style-type: none"> <li>+ Reducing opportunities for passive overconsumption.</li> <li>+ Discouraging large serving sizes of unhealthy foods and drinks.</li> </ul>	<ul style="list-style-type: none"> <li>+ Under the UK's Public Health Responsibility Deal, certain food manufacturers have taken a “calorie reduction pledge”, committing to reduce the portion size of packaged foods.<sup>54</sup></li> <li>+ New York City's attempt to regulate the upper allowable size in which sugary sodas could be served was ultimately struck down by an appeals court (see below for further discussion).</li> </ul>	<ul style="list-style-type: none"> <li>+ One of the most restrictive options and thus most likely to meet opposition on the grounds of infringement on personal freedoms, as well as from the food industry.</li> <li>+ May be ineffective: there is nothing to stop someone from buying multiple sodas or foods. Also, may lack public credibility if there are too many exceptions (e.g. coffee-based drinks, fruit juice, beverages sold in certain establishments, etc.)</li> <li>+ May be criticised (by industry and individuals) as arbitrary: “how much is too much?”</li> </ul>
<p><b>Discrimination</b></p> <ul style="list-style-type: none"> <li>+ In the healthcare context.</li> <li>+ In the labour context.</li> <li>+ In accessing a healthy diet and opportunities for physical activity.</li> </ul>	<ul style="list-style-type: none"> <li>+ Respecting, protecting and fulfilling the human right to health.</li> <li>+ Minimising the social consequences of overweight, obesity and diabetes; minimising associated morbidity and mortality e.g. depression.</li> </ul>	<p>Countries may recognize overweight, obesity and diabetes as medical conditions, and hence prohibited grounds of discrimination under national legislation implementing the Convention on the Rights of Persons with Disabilities.</p>	<ul style="list-style-type: none"> <li>+ In addressing the social consequences of diabetes and its risk factors, it is important to engage with civil society groups; there are important lessons from the HIV context for diabetes and non-communicable diseases generally.<sup>55</sup></li> <li>+ Some have argued that raising the stigma associated with obesity is necessary in order to mobilise people to lead healthier lives and to avoid health risks.<sup>56</sup></li> </ul>

**Discussion questions**

- (d) Which of the options and issues set out in Table 3 have been used in your country?
- (e) Which do you see as being the most relevant?
- (f) In your jurisdiction, can you identify any specific barriers, challenges or other considerations that are relevant to implementing any of the options described?

## 5. Challenges and barriers

It is important to consider the potential challenges and barriers that might stand in the way of successfully passing and implementing legal strategies for overweight, obesity and diabetes. A number of the most important challenges are considered below, together with some responses to those challenges.

### (a) Generating the evidence for action

**Challenge:** In a world of evidence-based policy, generating and translating persuasive evidence can present significant hurdles for public health. Law-makers may require a higher standard of proof from those seeking to change the status quo.<sup>57</sup> While much is already known about the drivers and epidemiology of obesity and diabetes, there are large gaps in evidence about the effectiveness of policy options for prevention. For this reason, public health advocates often draw the comparison to the early days of tobacco control.<sup>58</sup>

**Response:** Economic modelling comparing the costs of prevention with the costs of failing to take action can help identify cost-effective interventions and build the case for interventions.<sup>59</sup> However, the epidemiological evidence for *population-level* prevention (as opposed to medical interventions) represents a new frontier and is currently under-developed. Building this evidence base may be expensive and time-consuming – in the face of overwhelming evidence on the need for urgent action.

In response to this challenge, the Australian National Preventative Health Taskforce has advocated a “learning by doing” approach to obesity, emphasising “the staged trialling of a package of interventions *accompanied by good monitoring and evaluation*” (emphasis added), informed by experience from other epidemics and other jurisdictions.<sup>60</sup>

Experience from tobacco control also suggests that a mutually reinforcing set of policies will be more effective than the implementation of one or two isolated policies.

## (b) Opposition from “Big Food”

**Challenge:** Multinational food corporations – recently identified as “Big Food” by WHO Director-General Margaret Chan<sup>61</sup> – have greater power and influence than the public health community. Additionally, in both financial and political terms, Big Food has much to lose from legal and regulatory interventions promoting a shift toward healthier diets.<sup>62</sup> In the United States, the food industry has invested significant sums of money to lobby against and to defeat efforts to improve the nutritional quality of government-funded school meals, and encourage the use of voluntary, government-sponsored guidelines for food marketed to children.<sup>63</sup> This echoes the experience worldwide of countries seeking to implement the WHO's international code of marketing of breast milk substitutes, in the face of industry opposition or undermining.<sup>64</sup>

Again, the comparison with tobacco control is relevant. Leading researchers have highlighted the similarity between tactics used by the tobacco and food industries in countering evidence, lobbying policy-makers, and influencing public perceptions about tobacco and obesity.<sup>65</sup> The industry tends to be well-organised and strategic. Industry argues against regulatory options such as those presented in Table 3, above, on the grounds that:

- There is no such thing as unhealthy foods, only unhealthy diets/poor choices by individuals;
- If change is necessary, then industry is in the best position to self-regulate rather than having regulation imposed on it by government;<sup>66</sup> and
- Industry self-regulation is a cost-effective way of achieving changes – for example, reducing the marketing of foods that are high sugar, salt or saturated fat to children.<sup>67</sup>

**Response:** Civil society plays a vital role in challenging the power and influence of the food industry, particularly in low- and middle-income countries where Big Food is less entrenched as a policy actor.<sup>68</sup> Civil society groups can strengthen their voices by forming coalitions across different sectors, different interests or within the region, and by seeking the support of global public health funders. A human rights framework, based on the right to health and allied rights, is useful in framing the entitlement of the population to a healthier food environment.

### (c) Constitutional or jurisdictional issues

**Challenge:** In some cases, the ability to legislate or regulate at the local or national level may be limited by a country's constitution, or pre-empted either by legislation made at a higher level of government, or by international law. For example, New York City's attempt to ban restaurants from serving sugar-sweetened beverages in containers larger than 6 ounces (473 ml) was struck down by a state court decision. The appellate judges found that the city council had overstepped its authority to regulate public health, and violated the separation of powers doctrine. The court also drew attention to the regulation's loopholes and exceptions.<sup>69</sup>

In addition, legislation at state (or even federal) level may specifically prohibit local and city governments from legislating in particular areas. For example, in 2013, the US State of Mississippi passed a law preventing local and city legislatures from passing laws in a number of areas relating to food regulation. These included local laws regulating nutrition labelling for food and non-alcoholic beverages in restaurants; the regulation of toys and other incentive items in food purchases; and any restrictions on the sale of food based on its nutritional quality.<sup>70</sup>

**Response:** These examples illustrate that it is important for advocates to share best practice in drafting and implementing innovative public health laws. In addition to understanding the technical legal issues, civil society groups need

to consider the roles that federal, state and local/city legislatures should play, respectively, in responding to the challenges of obesity and diabetes.

#### (d) “Nanny State” arguments

**Challenge:** As with other lifestyle issues in public health (such as alcohol and tobacco consumption, or road safety), proposals for legal and regulatory interventions in overweight, obesity, and diabetes frequently encounter opposition on the grounds that these would inappropriately curtail liberty or interfere with individual choice. A nanny is a caregiver for a young child, and the image of the Nanny State is often used to attack governments and public health groups seeking to implement policies that are interventionist or paternalistic, rather than market-based or *laissez-faire*.<sup>71</sup>

These arguments will be most influential in countries with a strong tradition of individualism and personal freedoms. In these contexts, as Professor Gostin has noted, policies seen as paternalistic will need to counter arguments that “*people are capable of deciding what to eat, and making the trade-offs between taste, current pleasures, and future health consequences*”.<sup>72</sup>

**Response:** Much like ensuring national security, safeguarding public health is an ancient and core function of government, and is only achieved through collective action.<sup>73</sup> While there is plenty of scope for debating the nature and extent of government intervention in private activities and in the free market, slogans such as the Nanny State should not detract from a focus on the issues and a considered evaluation of all policy options. Countries need not apologise from taking action to protect the health of children and young people. Many states will have obligations to protect the interests of children under national and international law.<sup>74</sup>

## (e) WTO and international trade issues

**Challenge:** International trade rules and obligations can impact on a country's national food regulations. Countries that are members of the WTO must abide by the WTO Agreements\* establishing the framework for international trade liberalisation. Central to this framework is the principle of "non-discrimination", whereby local and imported goods that are otherwise similar must receive equal opportunity to compete in the importing marketplace.<sup>75</sup> So for instance, a WTO member country seeking to impose compositional standards specifying the allowable fat content of imported meat would need to demonstrate that the standards do not constitute a discriminatory barrier to trade under the relevant WTO Agreement.

**Response:** While the principle of non-discrimination is central to the WTO's objectives, countries are permitted to negotiate this principle where a legitimate objective exists (i.e. reducing overweight, obesity and diabetes). Countries are then required to demonstrate that the regulatory option is not more trade-restrictive than is necessary to fulfil the legitimate objective.

A related issue, which affects access to medicines, is the Agreement on Trade Related Aspects of Intellectual Property ("TRIPS").<sup>76</sup> The TRIPS agreement requires WTO member countries to enact and enforce national legislation granting and protecting pharmaceutical patents. However, TRIPS also recognises a range of "flexibilities" which permit countries access to generic formulations of medicines patented under law.<sup>77</sup> In order to take advantage of these, countries should ensure that their national patent laws authorise the use of the flexibilities, and should also avoid entering into bilateral agreements that exclude their right to use these flexibilities.<sup>78</sup>

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\* These include the Agreement on Agriculture, the Agreement on the Application of Sanitary and Phytosanitary Measures, and the Agreement on Technical Barriers to Trade.

**Discussion questions**

- (g) In your experience of public health or public health law, what are the most useful strategies to respond to these and other challenges?
- (h) What kinds of legal research or legal knowledge could best assist progress on overweight, obesity and diabetes in your country?

## References

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- <sup>1</sup> WHO (2013) Global action plan for the prevention and control of noncommunicable diseases 2013-2020 (WHA66.10, 27 May 2013); WHO Regional Office for the Western Pacific (2013) Western Pacific Regional Action Plan for the Prevention and Control of Noncommunicable Diseases 2014–2020 (WPR/RC64/8).
- <sup>2</sup> Institute of Medicine. *The future of public health*. Washington, DC, National Academy Press, 1988.
- <sup>3</sup> Gostin LO (2008) *Public health law: power, duty, restraint*, 2<sup>nd</sup> edition. Berkeley, University of California Press.
- <sup>4</sup> World Health Organization (1948) Constitution of the World Health Organization (Preamble), WHO: Geneva; and International Covenant on Economic, Social and Cultural Rights, opened for signature on 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976), Article 12.
- <sup>5</sup> Reynolds, C (2004) *Public health: law and regulation*. Annandale, NSW, Federation Press.
- <sup>6</sup> Reynolds C (2011) *Public and environmental health law*, Annandale, NSW: Federation Press, p.28.
- <sup>7</sup> Jewell J, Hawkes C, Allen K (2013). Law and obesity prevention: addressing some key questions for the public health community. WCRF International.
- <sup>8</sup> Reynolds C (2011) *Public and environmental health law*, Annandale, NSW: Federation Press.
- <sup>9</sup> Reynolds C (2011) *Public and environmental health law*, Annandale, NSW: Federation Press, p.8.
- <sup>10</sup> Magnusson R (2012) "How law and regulation can add value to prevention strategies", in *A modern epidemic: expert perspectives on obesity and diabetes*, Baur LA, Twigg SM and Magnusson RS (eds.), Sydney: Sydney University Press, pp.207-244; Jewell J, Hawkes C, Allen K (2013). Law and obesity prevention: addressing some key questions for the public health community. WCRF International.
- <sup>11</sup> Reynolds C (2011) *Public and environmental health law*, Annandale, NSW: Federation Press, p.17; Egger G and Swinburn B (1997) "An 'ecological' approach to the obesity pandemic", *BMJ*, 315, p.477; Magnusson R (2012) "How law and regulation can add value to prevention strategies", in *A modern epidemic: expert perspectives on obesity and diabetes*, Baur LA, Twigg SM and Magnusson RS (eds.), Sydney: Sydney University Press, pp.207-244.
- <sup>12</sup> Ashe M, Feldstein LM, Graff S, Kline R, Pinkas D and Zellers L. (2007) "Local venues for change: legal strategies for healthy environments", *Journal of Law, Medicine and Ethics*, 35(1), pp.138-47.
- <sup>13</sup> Gostin LO (2007) Law as a tool to facilitate healthier lifestyles and prevent obesity, *JAMA*, 297(1):87-90.
- <sup>14</sup> Swinburn BA (2008) "Obesity prevention: the role of policies, laws and regulations" *Australia and New Zealand Health Policy*, 5:12.

- 
- <sup>15</sup> Rose G (1985) "Sick Individuals and Sick Populations" *International Journal of Epidemiology*, 14:32-38 at 37.
- <sup>16</sup> Bartle I and Vass P (2007) "Self-regulation within the regulatory state: towards a new regulatory paradigm?" *Public Administration* 84:885-905.
- <sup>17</sup> Popkin BM, Adair LS and Ng SW (2011) "Global nutrition transition and the andemic of obesity in developing countries", *Nutrition Reviews* 70(1):3-21.
- <sup>18</sup> Boseley S (2014) "Mexico enacts soda tax in effort to combat world's highest obesity rate" *The Guardian*, 17 January (URL: <http://www.theguardian.com/world/2014/jan/16/mexico-soda-tax-sugar-obesity-health>).
- <sup>19</sup> National Preventative Health Taskforce (2009) *Australia: The Healthiest Country by 2020 – National Preventative Health Strategy – the roadmap for action*. Canberra: Commonwealth of Australia, p.39.
- <sup>20</sup> Jewell J, Hawkes C, Allen K (2013). *Law and obesity prevention: addressing some key questions for the public health community*. WCRF International.
- <sup>21</sup> Reeve B and Magnusson R (2013) "Legislative scaffolding': a new approach to prevention", *Australian and New Zealand Journal of Public Health* 37:5 at 494-6.
- <sup>22</sup> *Australian National Preventive Health Agency Act 2010*; ANPHA website (URL: <http://anpha.gov.au/internet/anpha/publishing.nsf/Content/about-us>, accessed February 2014) p.57.
- <sup>23</sup> Brownell KD, Warner KE (2009) "The perils of ignoring history: Big Tobacco played dirty and millions died. How similar is Big Food?" *Millbank Quarterly*, 87(1):259-94; Panjwani C and Caraher M (2014) "The Public Health Responsibility Deal: Brokering a deal for public health, but on whose terms?" *Health Policy*, 114:163-173.
- <sup>24</sup> Jewell J, Hawkes C, Allen K (2013). *Law and obesity prevention: addressing some key questions for the public health community*. WCRF International, p.20.
- <sup>25</sup> Davey TM, Allotey P and Reidpath DD (2013) "Is obesity an ineluctable consequence of development? A case study of Malaysia", *Public Health* 127:1057 e1062 at 1061.
- <sup>26</sup> Costello A and Sachdev HS (1998) "Protecting breast feeding from breast milk substitutes" *BMJ* 316:1103-4.
- <sup>27</sup> See UN Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendations Nos. 19 and 20, adopted at the Eleventh Session, 1992 (contained in Document A/47/38)*, 1992, A/47/38; and Howse G (2012) *Public health law in the Pacific: A reviewers' companion*. WPRO (WPRO: [http://www.wpro.who.int/topics/legislation/public\\_health\\_law\\_legislators\\_companion.pdf](http://www.wpro.who.int/topics/legislation/public_health_law_legislators_companion.pdf)).
- <sup>28</sup> Reynolds C (2011) *Public and environmental health law*, Annandale, NSW: Federation Press, p.39.

- 
- <sup>29</sup> Food Act 2003 (NSW), Part 8, Division 4 (ss.106K-106R).
- <sup>30</sup> Singapore Government Health Promotion Board (2012) "Survive the hawkker paradise" (URL: <http://www.hpb.gov.sg/HOPPortal/health-article/2694>, accessed February 2014).
- <sup>31</sup> Ashe M, Feldstein LM, Graff S, Kline R, Pinkas D and Zellers L. (2007) "Local venues for change: legal strategies for healthy environments", *Journal of Law, Medicine and Ethics*, 35(1), pp.138-47.
- <sup>32</sup> Howse G (2012) Public health law in the Pacific: A reviewers' companion. WPRO: [http://www.wpro.who.int/topics/legislation/public\\_health\\_law\\_legislators\\_companion.pdf](http://www.wpro.who.int/topics/legislation/public_health_law_legislators_companion.pdf), p.86.
- <sup>34</sup> Hawkes C (2007) "Regulating food marketing to young people worldwide: trends and policy drivers", *American Journal Of Public Health*, 97(11), pp.1962 -1973.
- <sup>35</sup> TongaHealth website (URL: [http://www.tongahealth.org/#!about\\_us/csgz](http://www.tongahealth.org/#!about_us/csgz), accessed March 2014).
- <sup>36</sup> Reynolds C (2011) *Public and environmental health law*, Annandale, NSW: Federation Press, p.39.
- <sup>37</sup> Fried E (2010) "The potential for policy initiatives to address the obesity epidemic: a legal perspective from the United States", *Obesity Epidemiology – From aetiology to public health*, Crawford D, Jeffery RW, Ball K and Brug J (eds.), 2<sup>nd</sup> edition, Oxford: Oxford University Press, p.325ff; Daynard RA, Howard T and Wilking CL (2004) "Private enforcement: Litigation as a tool to prevent obesity", *Journal of Public Health Policy*, 25(3-4), pp. 408-417.
- <sup>38</sup> New Zealand Human Rights Commission (2014) Website, URL: <http://www.hrc.co.nz/enquiries-and-complaints-guide/what-can-i-complain-about/disability/>.
- <sup>39</sup> "Mild, light cigarette descriptions axed", *Sydney Morning Herald*, 7 November 2005.
- <sup>40</sup> See Gostin LO (2008) *Public health law: power, duty, restraint*, 2<sup>nd</sup> edition. Berkeley, University of California Press, and Magnusson R (2011) "Using a legal and regulatory framework to identify and evaluate priorities for cancer prevention", *Public Health*, 125(12), 854-875. See also: Brambila-Macias J et al (2011) "Policy interventions to promote healthy eating: A review of what works, what does not, and what is promising", *Food and Nutrition Bulletin*, 32(4), pp.365-376, and Alemanno A and Garde A (2013) Regulating lifestyles in Europe: how to prevent and control non-communicable diseases associated with tobacco, alcohol and unhealthy diets, SIEPS Report No 7.
- <sup>41</sup> It is worth noting that as per capita wealth increases, this usually leads to an increase in per capita energy intake: see for instance Davey TM, Allotey P and Reidpath DD (2013) "Is obesity an ineluctable consequence of development? A case study of Malaysia", *Public Health* 127:1057 e1062. There is a potential conflict between economic development and the right to health: "the feedback loop between increased growth, obesity, and the subsequent increased requirement for food which in turn increases economic growth through higher demand and consumption of food products, may present ongoing dilemmas for developing countries" (p.1060).

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<sup>42</sup> Kaplin L and Thow AM (2013) "Using economic policy to tackle chronic disease: Options for the Australian Government" *Journal of Law and Medicine* 20, pp.604-620.

<sup>43</sup> Kaplin L and Thow AM (2013) "Using economic policy to tackle chronic disease: Options for the Australian Government" *Journal of Law and Medicine* 20, pp.604-620.

<sup>44</sup> Thow AM et al (2010) "Taxing soft drinks in the Pacific: implementation lessons for improving health" *Health Promotion International*, 26(1) pp. 55-63.

<sup>45</sup> Mytton O, Clarke D and Rayner M (2012) "Taxing unhealthy food and drinks to improve health" *BMJ*, 344:e2931.

<sup>46</sup> Reeve B (2013) "Private governance, public purpose? Assessing transparency and accountability in self-regulation of food advertising to children", *Journal of Bioethical Inquiry*, 10:149-163.

<sup>47</sup> Mair JS, Pierce MW and Teret SP (2005) "The use of zoning to restrict fast food outlets: a potential strategy to combat obesity", CDC publication for its *Healthy Places* online hub (URL: <http://www.publichealthlaw.net/Zoning%20Fast%20Food%20Outlets.pdf>, accessed February 2014).

<sup>48</sup> Special Regulations applying to FRESH Food Stores, Zoning Resolution of the City of New York, Ch 3 (9 December 2009) Ch 3 (New York City, United States of America).

<sup>49</sup> Mair JS, Pierce MW and Teret SP (2005) "The use of zoning to restrict fast food outlets: a potential strategy to combat obesity", CDC publication for its *Healthy Places* online hub (URL: <http://www.publichealthlaw.net/Zoning%20Fast%20Food%20Outlets.pdf>, accessed February 2014).

<sup>50</sup> Lawrence M (2010) "The potential of food regulation as a policy instrument for obesity prevention in developing countries", in *Obesity Epidemiology – From aetiology to public health*, Crawford D, Jeffery RW, Ball K and Brug J (eds.), 2<sup>nd</sup> edition, Oxford: Oxford University Press, pp.340ff.

<sup>51</sup> EUFIC Global Update on nutrition labelling (2013) (URL: [http://www.eufic.org/upl/1/default/doc/GlobalUpdateExecSumFeb2013\\_FINAL.pdf](http://www.eufic.org/upl/1/default/doc/GlobalUpdateExecSumFeb2013_FINAL.pdf), accessed February 2014).

<sup>52</sup> Lawrence M (2010) "The potential of food regulation as a policy instrument for obesity prevention in developing countries", in *Obesity Epidemiology – From Aetiology to public health*, Crawford D, Jeffery RW, Ball K and Brug J (eds.), 2<sup>nd</sup> edition, Oxford: Oxford University Press, pp.340ff.

<sup>53</sup> Bowers K, Suzuki S (2014), "Menu-Labeling Usage and its Association with Diet and Exercise: 2011 BRFSS Sugar-Sweetened Beverage and Menu Labeling Module" *Preventing Chronic Disease*, Vol 11, 2 January 2014; online at: <http://www.cdc.gov/pcd/index.htm>.

<sup>54</sup> Panjwani C and Caraher M (2014) "The Public Health Responsibility Deal: Brokering a deal for public health, but on whose terms?" *Health Policy*, 114:163-173, p.163.

<sup>55</sup> UNAIDS (2005) *Resource guide for UN Theme Groups on HIV/AIDS*. Geneva: UNAIDS.

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<sup>56</sup> Callahan D (2012) "Obesity: Chasing an Elusive Epidemic", *Hastings Center Reports*, 43:34-40.

<sup>57</sup> International Association for the Study of Obesity (2014) Policy Briefing: The prevention of obesity and NCDs: Challenges and opportunities for governments, IASO

<sup>58</sup> *Australian National Preventive Health Agency Act 2010*; ANPHA website (URL: <http://anpha.gov.au/internet/anpha/publishing.nsf/Content/about-us>, accessed February 2014) p.51.

<sup>59</sup> International Association for the Study of Obesity (2014) Policy Briefing: The prevention of obesity and NCDs: Challenges and opportunities for governments, IASO, p.2; Beaglehole R et al (2011) "Priority actions for the non-communicable disease crisis" *Lancet* 377(9775):1438-47.

<sup>60</sup> *Australian National Preventive Health Agency Act 2010*; ANPHA website (URL: <http://anpha.gov.au/internet/anpha/publishing.nsf/Content/about-us>, accessed February 2014) p.52.

<sup>61</sup> Chan M (2013) Opening address by the Director-General of the World Health Organization, 8th Global Conference on Health Promotion, Helsinki, Finland, 10 June 2013 (URL: [http://www.who.int/dg/speeches/2013/health\\_promotion\\_20130610/en/](http://www.who.int/dg/speeches/2013/health_promotion_20130610/en/), accessed February 2014).

<sup>62</sup> Moodie R, Stuckler D, Monteiro C, Sheron N, Neal B, Thamarangsi T (2013), "Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries" *Lancet* 381:670-679; Stuckler D, McKee M, Ebrahim S, Basu S (2012), "Manufacturing epidemics: the role of global producers in increased consumption of unhealthy commodities including processed foods, alcohol, and tobacco" *PLoS Medicine* 9(6):e1001245.

<sup>63</sup> Wilson D, Roberts J (2012), "Special report: how Washington went soft on childhood obesity" *Reuters*, 27 April 2012 (URL: <http://www.reuters.com/article/2012/04/27/us-usa-foodlobby-idUSBRE83Q0ED20120427>, accessed March 2014).

<sup>64</sup> Costello A and Sachdev HS (1998) "Protecting breast feeding from breast milk substitutes" *BMJ* 316:1103-4.

<sup>65</sup> E.g. Brownell KD and Warner KE. (2009) "The perils of ignoring history: Big Tobacco played dirty and millions died. how similar is Big Food?", *The Milbank Quarterly*, 87:1, pp.259-294; Dorfman L, Cheyne A, Friedman L, Wadud A, Gottlieb M (2012), "Soda and tobacco industry corporate social responsibility campaigns: how do they compare?" *PLoS Medicine*, 9(6):e1001241.

<sup>66</sup> Jewell J, Hawkes C, Allen K (2013). Law and obesity prevention: addressing some key questions for the public health community. WCRF International, p.25.

<sup>67</sup> "Advocating a self-regulatory approach to advertising to children", Food Industry Asia (URL: <http://foodindustry.asia/advocatinga-self-regulatory-approach-to-advertising-to-children>, accessed March 2014); FIA Position Statement on Responsible Marketing and Communications (URL: <http://foodindustry.asia/responsible-marketing-and-communications>, accessed March 2014).

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<sup>68</sup> International Association for the Study of Obesity (2014) Policy Briefing: The prevention of obesity and NCDs: Challenges and opportunities for governments, IASO, p.4.

<sup>69</sup> Ax J (2013) "Bloomberg's ban on big sodas is unconstitutional: appeals court", *Reuters*, Tuesday 30 July (URL: <http://www.reuters.com/article/2013/07/30/us-sodaban-lawsuit-idUSBRE96T0UT20130730>, accessed February 2014).

<sup>70</sup> Mississippi Legislature, 2013 Regular Session, Senate Bill 2687, passed 18 March 2013 (URL: <http://legiscan.com/MS/bill/SB2687/2013>, accessed March 2014).

<sup>71</sup> E.g. Daube M, Stafford J and Bond L (2008) "No need for Nanny", *Tobacco Control*, 17:426-427.

<sup>72</sup> Gostin LO (2007) Law as a tool to facilitate healthier lifestyles and prevent obesity, *JAMA*, 297(1):87-90.

<sup>73</sup> Gostin LO (2008) *Public health law: power, duty, restraint*, 2<sup>nd</sup> edition. Berkeley, University of California Press, pp.8-9.

<sup>74</sup> See: *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1588 UNTS 530 (entered into force 16 January 1991).

<sup>75</sup> Lawrence M (2010) "The potential of food regulation as a policy instrument for obesity prevention in developing countries", in *Obesity Epidemiology – From aetiology to public health*, Crawford D, Jeffery RW, Ball K and Brug J (eds.), 2<sup>nd</sup> edition, Oxford: Oxford University Press, p.342.

<sup>76</sup> *Agreement on Trade-Related Aspects of Intellectual Property Rights: Marrakesh Agreement Establishing the World Trade Organization*, Annex 1C, The legal texts: the results of the Uruguay round of multilateral trade negotiations 321 (1999), 1869 UNTS 299 (15 April 1994) ("TRIPS Agreement") arts 7, 27-28.

<sup>77</sup> Musungu S, Oh C: The use of flexibilities in TRIPS by developing countries: can they promote access to medicines? Geneva: World Health Organization; 2005 (URL: <http://www.who.int/intellectualproperty/studies/TRIPSFLEXI.pdf>).

<sup>78</sup> For further discussion, see Magnusson RS, Patterson D (2014) "The role of law and governance reform in the global response to non-communicable diseases" *Globalization and Health* (forthcoming).



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