State Responsibility for Tobacco Control: The Right to Health Perspective

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Abstract

Tobacco smoking, which has been proven to cause various illnesses (lung cancer, emphysema, cardiovascular disease) and early death, has been declared an emergency public health crisis by the World Health Organization (WHO). To fight this crisis, the Framework Convention on Tobacco Control (FCTC), the first health-related treaty sponsored by the WHO, came into force in 2005 and addresses various aspects of tobacco control, from tobacco smuggling to tobacco advertising and the extent of the liability of tobacco companies. Although the FCTC demonstrates the idea that tobacco control is a major health issue requiring firmer state action than in the past, some of its key provisions are non-mandatory and fail to comprehensively protect individuals' right to health. To address these shortfalls, this article applies the framework of the right to health as a supplemental strategy to explore and examine the state's responsibility in tobacco control — including the state's responsibility to provide smoking cessation services, to combat tobacco smuggling, and to guarantee individuals access to health-related tobacco information, among other issues. This article finds that applying human rights institutions to address tobacco-related human rights violations can help identify a state's failure to carry out effective tobacco control initiatives, strengthen the voice of public health, and concretize the scope of applicable rights under international laws. The right-to-health paradigm then can bring new perspectives to addressing the challenges the FCTC faces and can effectively complement global tobacco control efforts.

Keywords: Right to Health, State Responsibility, Tobacco Control, FCTC

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I. Tobacco Control: A New Global Resolve

Scientific evidence has shown that smoking and the inhalation of secondhand smoke causes tobacco-related illnesses that can lead to disabilities and death. Numerous prospective studies on cigarette smoking and health hazards have been published.[2] According to the World Health Organization (WHO) estimates, there are currently 4 million deaths a year from tobacco, a figure expected to rise to about 8.4 million by 2020. Over 70% of these deaths will occur in developing countries.[3] Liaw's study shows that cigarette smoking has had striking impacts on mortality and deaths from various causes in Taiwan. During 1982-1986, smokers had a 140% increase in risk of dying from all cancer sites combined, and 730% from lung cancer.[4] Yuan's study also shows that 36% of all cases of cancer and 21% of all deaths in Shanghai, China could be attributed to cigarette smoking.[5] These reports all identified tobacco smoking as an important cause of several types of cancer, cardiovascular diseases, chronic bronchitis, emphysema, and many other diseases. In addition to impacts on public health, tobacco consumption also causes serious economic loss. Increasing health costs and loss of productivity due to tobacco-related diseases are well known results of tobacco use.[6] Bates' study shows that the losses of life and the economic costs of smoking are clearly far higher than the so-called "benefits" (such as tobacco revenue tax for the state and the "satisfaction" of smoking for the individual).[7] Individual expenditures on tobacco may also use up money that is needed for family essentials including food and medicine.[8]

Since tobacco consumption causes tobacco-related illnesses and early death, and significantly increases societies' health care expenditures, the state's failure to curb the use of tobacco then might violate individuals' right to maintain "highest attainable standard" of

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[2] E. Rogot and J.L. Murray, *Smoking and Causes of Death among U.S. Veterans: 16 Years of Observation*, 95 Public Health Rep 213, 213–22 (1980).
E.C. Hammond and H. Seidmen, *Smoking and Cancer in the United States*, 9 Prev Med 169, 169–73 (1980).
R. Doll and R. Peto, *Mortality in Relation to Smoking: 20 Years' Observation on Male British Doctors,* 2 BMJ 1525,1525–36 (1976).

[3] World Health Organization, *Illicit Tobacco Trade Contributes to Global Disease Burden*, available at http://www.who.int/mediacentre/news/releases/who62/en/ (last modified on August 8, 2008).

[4] K.M. Liaw and C.J. Chen, *Mortality Attributable to Cigarette Smoking in Taiwan: A 12-Year-Follow-Up Study*, 7 Tob Control 141, 144-46 (1998).

[5] J.M. Yuan et al., *Morbidity and Mortality in Relation to Cigarette Smoking in Shanghai, China: A Prospective Male Cohort Study*, 275 JAMA 1646, 1646-50 (1996).

[6] Shu-Fang Shih et al., *An Investigation of the Smoking Behaviours of Parents Before, During and After the Birth of Their Children in Taiwan*, 8 BMC Public Health 67, 68 (2008).

[7] Clive Bates, *Study Shows That Smoking Costs 13 Times More Than It Saves*, 323 Brit. Med. J. 1003, 1003 (2001).

[8] *Id.*

physical and mental health[9] (the right to health).[10] Namely, tobacco control, which provides strong governance against tobacco threat to population health, is strongly related to the protection of the human right to health.[11] Therefore, states that have ratified human rights treaties[12] obligating them to protect rights to life and health should also be required to adopt legislative or other measures (including banning tobacco advertising, discouraging consumption of tobacco products, and ensuring smoke-free workplaces and public spaces) to protect their citizens from health hazards caused by tobacco.[13,14]

However, even though tobacco control is a human rights issue, most governments have failed to adopt efficient and effective tobacco control initiatives (such as tobacco advertising bans, cigarette tax increases, and tobacco cessation programs subsidizations) to prevent, or at least to stem the spread of this "epidemic".[15] Regarding the contents of governments' failure to implement tobacco control is twofold: not only do they disregard the possibility of curbing or reducing preventable tobacco-related diseases, but they also violate their citizens' internationally recognized right to health.

While recognizing the catastrophic impact of tobacco consumption plus their failure in implementing efficient tobacco control, states acknowledge that multilateral acts must be taken to curb this global threat to public health. Especially when health risks of tobacco consumption are becoming increasingly globalised,[16] it is necessary to have an international

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[9] See e.g., *Universal Declaration of Human Rights* art. 25.1(1948).
International Covenant on Economic, Social, and Cultural Rights (ICESCR) art. 12 (1966).
World Health Organization Constitution Preamble (1946).

[10] For example, Carol Bellamy, Executive Director of the United Nations Children's Fund (UNICEF), has stated that the main violators of children's right to health are the easily obtained tobacco and alcohol.
World Health Organization, *Confronting the Epidemic: A Global Agenda for Tobacco Control Research*, available at http://www.who.int/tobacco/research/en/print.html (last modified on August 8, 2008).

[11] Gro Brundtland, WHO Director-General, underscored the link between tobacco control and the human right to health: "Using the WHO mandate and the general international legal framework, WHO Member States recently negotiated a vital new mechanism to protect and promote the individual's right to health — the Framework Convention on Tobacco Control."
Gro Brundtland, *Statement to the 59th Commission on Human Rights*, Mar. 20, 2003, available at http://www.who.int/dg/speeches/2003/commissionhumanrights/en/ (last modified on August 8, 2008).

[12] For example, in July 2008, 159 states were parties to the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which has involved support for the equal status and importance of the right to health; compared with 162 parties to the International Covenant on Civil and Political Rights (ICCPR) in the same year. Available at http://www2.ohchr.org/english/bodies/ratification/3.htm and http://www2.ohchr.org/english/bodies/ratification/4.htm (last modified on August 9, 2008).

[13] Melissa E. Crow, *Smokescreens and State Responsibility: Using Human Rights Strategies to Promote Global Tobacco Control*, 29 Yale J. Int'L L. 209, 221 (2004).

[14] Smokers might argue that governmental smoking restrictions, which protect public health, smack of paternalism and violate their freedom to choose to smoke. However, the personal freedom to smoke is not an absolute right. Individuals' freedom to smoke must be balanced against public health benefits. If the state can prove that a compelling interest that was substantially furthered by governmental smoking restrictions, it is then justified to restrict such a freedom in exchange for greater utility. See more discussions in section VI.

[15] Melissa E. Crow, *Smokescreens and State Responsibility: Using Human Rights Strategies to Promote Global Tobacco Control*, 29 Yale J. Int'L L. 209, 2 11 (2004).

[16] For example, Meier found that "while the U.S. companies agreed on sweeping restrictions in this country on

framework to fight tobacco use because health determinants and outcomes in tobacco control cannot be achieved through actions taken at the national level alone.[17] Considering this, the World Health Assembly's (WHA) 191 members then unanimously agreed to establish a Framework Convention on Tobacco Control (FCTC) in 1999[18] and adopted the FCTC in 2003. The FCTC is no doubt a cornerstone of tobacco control because it is a comprehensive multilateral treaty that covers most factors related to tobacco control, from tobacco smuggling to tobacco advertising and the extent of the liability of tobacco companies.[19] In addition, unlike resolutions and recommendations proposed by the WHA[20] prior to the FCTC that urge rather than obligate states to carry out certain implementation steps in fighting tobacco use, for states that ratify the FCTC, the obligations are legally binding after this treaty as a whole came into force in 2005.[21] Once they adopt the FCTC, states are encouraged to reevaluate their domestic tobacco control policies and are provided opportunities for information sharing, coordination, and consensus-building among governments on global best practices.[22]

Furthermore, because tobacco control raises issues associated with most efforts to implement the right to health, in addition to obligating the state to give priority to citizens' right

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cigarette marketing and second-hand smoke and to bold cancer-warning labels, they are fighting as hard as ever in the third world to convince the media, the public and policymaker that similar changes are not needed." Barry Meier, *Tobacco Industry, Conciliatory in U.S., Goes on the Attack in the Third World*, N.Y. Times, Janurary 18, 1998, at A8.
Virginia Leary, *Concretizing the Right to Health: Tobacco Use as a Human Rights Issue*, in Fons Coomans et al. eds., *Rendering Justice to the Vulnerable* 166-67 (Netherlands: Kluwer Law International, 2000).

[17] Jeff Collin, Kelley Lee, and Karen Bissell, *The Framework Convention on Tobacco Control: The Politics of Global Health Governance*, 23(2) Third World Quarterly 265, 273 (2002).

[18] *Id.*

[19] Alyssa Woo, *Health versus Trade: The Future of the WHO's Framework Convention on Tobacco Control*, 35 Vand. J. Transnat'l L. 1731, 1731 (2002).

[20] For example, in 1986 WHA39.14 resolution, World Health Assembly (WHA) urged WHO Member States to ensure that non-smokers receive effective protection from involuntary exposure to tobacco smoke, to promote abstention from the use of tobacco, to eliminate socioeconomic, behavioral and other incentives to maintain and promote the use of tobacco, and to establish programs of education and public information on tobacco and health issues. In WHA43.16 resolution, the WHA continued encouraging member states to implement multisectoral, comprehensive tobacco control strategies (which, at a minimum, contain the nine elements outlined in WHA39.14 resolution) and to consider including in tobacco control strategies for legislation or other effective measures at the appropriate government level providing for: (a) effective protection from involuntary exposure to tobacco smoke; (b) progressive financial measures aimed at discouraging the use of tobacco, and progressive restrictions and concerted action to eventually eliminate all direct and indirect advertising, promotion, and sponsorship concerning tobacco.
Chang-fa Lo, *Establishing Global Governance in the Implementation of FCTC: Some Reflections on the Current Two-Pillar and One-Roof Framework*, 1 Asian J. WTO & Int'l Health L. & Pol'y 569, 579 (2006).
World Health Assembly Resolution, *Tobacco or Health, WHA39.14 (May 14, 1986)*, available at http://www.who.int/ tobacco/framework/wha_eb/wha39_14/en/index.html (last modified on July 24, 2008).
World Health Assembly Resolution, T*obacco or Health, WHA43.16 (May 17, 1990)*, available http://www.who.int/ tobacco/ framework/wha_eb/wha43_16/en/index.html (last modified on July 24, 2008)

[21] Press Release, World Health Organization, *An International Treaty for Tobacco Control*, available at http:// www.who.int/features/2003/08/en/index.html (last modified on July 24, 2008).

[22] R. Hammond and M. Assunta, *The Framework Convention on Tobacco Control: Promising Start*, Uncertain Future, 12 Tob Control 241, 241 (2003).

to health, the FCTC specifically references four international human rights treaties — the Constitution of the World Health Organization, the International Covenant on Economic, Social, and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC) — with special emphases on the right to health.[23]

II. Obstacles to Global Tobacco Control

Despite this progress, the tobacco control movement could face new challenges in the post-FCTC era. First, even though the FCTC provides countries with the building blocks to enact comprehensive tobacco control legislation, many of these measures enumerated in this treaty are not mandatory[24] and are inconsistent with international documents of the right to health. For example, the FCTC article 14(a) does not place firm mandates on states to address clinical smoking cessation, without which individuals' right to access health care[25] might be violated (see more discussions in section IV-A). According to the FCTC article 10, individuals' right to access health-related tobacco information[26] is confined because they can only access limited information (information related to toxic constituents) rather than comprehensive review of material ingredients of tobacco products (see more discussions in section IV-C). Thus, even though the FCTC is binding for its members, some key provisions still contain many non-mandatory words[27] and have no enforcement mechanisms for states that violate the right to health in tobacco control policies. In other words, the FCTC only requires states to meet minimal obligations for tobacco control rather than human rights obligations; if the FCTC had established mandatory measures this could have met formidable political obstacles that could have prevented global consensus on this treaty.[28] However, the existing weak implementation mechanism of the FCTC may undermine the state's obligations to respect, protect, and fulfill the right to health.

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[23] *Framework Convention on Tobacco Control (FCTC)* preamble.
[24] Melissa E. Crow, *Smokescreens and State Responsibility: Using Human Rights Strategies to Promote Global Tobacco Control*, 29 Yale J. Int'L L. 209, 218 (2004).
[25] According to ICESCR art. 12(d), the state has the human rights obligation to create conditions "which would assure to all medical service and medical attention in the event of sickness."
[26] According to the CESCR General Comment No. 14 art. 11, "[t]he Committee interprets the right to health … as an inclusive right extending not only to timely and appropriate health care but also to … access to health-related education and information … ."
[27] Chang-fa Lo, *Establishing Global Governance in the Implementation of FCTC: Some Reflections on the Current Two-Pillar and One-Roof Framework*, 1 Asian J. WTO & Int'l Health L. & Pol'y 569, 583 (2006).
[28] Allyn Lise Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 Am. J.L. & Med. 301, 296-97 (1992).

Second, under the FCTC, tobacco control policy might face the proverbial "glass ceiling" caused by political obstacles, the tobacco industry's well-funded opposition, and public retrenchment.[29] For example, the FCTC article 2(1) only "encourages" member states to implement measures beyond those required by the Convention and its protocols.[30] Because this article implies that FCTC measures are simply minimum standards, a member state that ratified the FCTC then may adopt the minimum tobacco regulations enumerated in the FCTC and easily proclaim its tobacco control initiatives are satisfying the requirements of the FCTC, while in fact they fail to fulfill promises of the right to health. The FCTC's minimum tobacco control standards also create grounds for the tobacco industry to lobby government leaders and politicians not to implement or enforce stricter tobacco control policies.[31]

In addition, even if a state wants to apply stricter tobacco control measures, according to the FCTC 2(1) these measures must be consistent with the FCTC and its protocols. But the FCTC wording is too vague to provide a basis "to let countries comprehend what kinds of stricter requirements, which are consistent with the FCTC, are available for the adoption of Parties."[32] Due to the vagueness, it then becomes difficult to prevent authorities' (a government or the tobacco industry) arbitrary interferences with the adoption of stricter tobacco control, which would provider more comprehensive protection of the right to health. For example, even if there is no proper justification, a state can refuse to provide clinical smoking cessation to people addicted to nicotine by simply arguing that this measure is "beyond" the FCTC and its protocols.

Third, in terms of government decision-making and priority-setting in tobacco control, which strongly relates to the protection of individuals' health, the right to health is often lost in a sea of other considerations. For example, although many countries have carried out various tobacco control programs to protect citizens' right to health, cost-effectiveness always takes

[29] P.D. Jacobson and A. Banerjee, Social Movements and Human Rights Rhetoric in Tobacco Control, 14 Tob. Contro ii45, ii45 (2005).

[30] The FCTC art. 2(1), "In order to better protect human health, Parties are encouraged to implement measures beyond those required by this Convention and its protocols, and nothing in these instruments shall prevent a Party from imposing stricter requirements that are consistent with their provisions and are in accordance with international law."

[31] Studies have shown that "the tobacco industry has dedicated itself to shaping activities of regulatory bodies that can have some impact on the cigarette production process," and encourage the government to thwart the passage of proposed legislation of stricter tobacco control.
Melissa E. Crow, *Smokescreens And State Responsibility: Using Human Rights Strategies To Promote Global Tobacco Control*, 29 Yale J. Int'L L. 209, 212 (2004).
Jeff Collin, Kelley Lee, and Karen Bissell, *The Framework Convention on Tobacco Control: The Politics of Global Health Governance*, 23(2) Third World Quarterly 265, 272 (2002).

[32] Chang-fa Lo, *Establishing Global Governance in the Implementation of FCTC: Some Reflections on the Current Two-Pillar and One-Roof Framework*, 1 Asian J. WTO & Int'l Health L. & Pol'y 569, 581 (2006).

priority over the protection of the right to health and hinders the implementation of tobacco control programs. In other words, efforts to promote tobacco control and the right to health often run up against powerful economic forces.[33] Studies also show that the tobacco industry has actively lobbied governments to oppose proposed tobacco control legislation[34] regardless of the documented harmful effects of tobacco smoke. In addition, under the principle of "progressive realization",[35] which means the state is merely obligated to take steps toward the progressive fulfillment of the right to health base upon available resources, the open-ended nature of the right to health leaves great flexibility and discretion to individual states. The state thus maintains substantial authority to interpret "efficiency" in tobacco control without making human rights impact assessments that are enforceable and monitorable. Tobacco control then has been typically framed as a conflict between social benefits (public health), economic interests, and international trade without regard to the protection, respect, and fulfillment of an individual's right to health.

These challenges are in part caused by the absence of the human rights paradigm and the lack of moral force in the state's efforts to control tobacco consumption.[36] International and regional human rights institutions thus could play a critical role in addressing these shortfalls and challenges. In other words, in addition to advancing the tobacco control agenda (the FCTC), applying human rights institutions to address tobacco-related human rights violations can help identify governments' failures to undertake effective tobacco control initiatives (which the FCTC bypasses), strengthen the public's health voice, and concretize

[33] For example, the continuing conflict between states and tobacco manufacturers in the effort to limit tobacco use evidences the economic strength of the tobacco industry.
Virginia Leary, *Concretizing the Right to Health: Tobacco Use as a Human Rights Issue*, in Fons Coomans et al. eds., *Rendering Justice to the Vulnerable* 165 (2000).

[34] Melissa E. Crow, *Smokescreens And State Responsibility: Using Human Rights Strategies To Promote Global Tobacco Control*, 29 Yale J. Int'L L. 209, 212 (2004).

[35] According to article 2 of the ICESCR, the right to health is subject to the principle of progressive realization, meaning that the state is merely obligated to take steps toward the progressive fulfillment of the right to health on the premise of available resources, and the state can raise the issue of resource scarcity as a legitimate reason for not fulfilling the right to health. In other words, the state party only needs to take steps to the maximum its available resources, with a view to progressively achieving the full realization of the right to health, including adopting legislative measures.
On the contrary, because civil and political rights have often been characterized as negative rights, and because civil and political rights are cost-free rights, which means that protection of these rights can be achieved without the state incurring significant costs, civil and political rights then the state is considered to be capable of fully and immediately realizing these rights. All the state must do is enact legislation that outlaws activities that violate these rights.
See e.g., Committee on Economic, Social, and Cultural Rights, *CESCR General Comment No. 14* art. 2, E/C.12/2000/4 (November 8, 2000).
Cristina Baez et al., *Multinational Enterprises and Human Rights*, 8 U. Miami Int'l & Comp. L. Rev. 183, 223 (2000).
United Nations Development Programme, *Human Development Report 2000* 93 (Oxford: Oxford University Press 2000).

[36] Robin Appleberry, *Breaking the Camel's Back: Bringing Women's Human Rights to Bear on Tobacco Control*, 13 Yale J.L. & Feminism 71, 72 (2001).

the scope of applicable rights under international laws. The human rights approach can also help to rationally evaluate the tradeoff between tobacco production and sales (economic interests) and tobacco control (public health benefits), and between different approaches to various rights in tobacco control policy.

However, I am not suggesting that the weak implementation mechanism or the "glass ceiling" of the FCTC violate individuals' human rights to health. The FCTC no doubt has provided significant guidance as to the types of governmental initiatives that can prevent tobacco-related human rights violations.[37] I am merely suggesting that, coordinating the FCTC and the human rights paradigm is essential to efficient and effective tobacco control policies because recognizing the links between tobacco consumption and the right to health can avoid limitations of any single lens onto tobacco control.[38] Therefore, in stead adding stricter tobacco control measures to the FCTC, I propose that the broad state obligations for tobacco control of the FCTC should be supplemented by international human rights institutions, which can assist the international society effort to develop tobacco control policies, bring new perspectives to bear on the challenge of promoting global tobacco control, and thus promote better health.

III. Framework of the Right to Health

In the 18th and 19th centuries, many philosophers, policymakers and scholars, faced with significant inequalities in the distribution of health care services, began to discuss the concepts of socio-economic rights, and put forth the concept that health can be a "notion of basic individual rights."[39] In the 20th century, the U.N. Universal Declaration of Human Rights (UDHR) recognized two sets of human rights: (1) civil and political rights, and (2) economic, social, and cultural rights, with the right to health included in the latter. Based on the fact that

[37] Melissa E. Crow, *Smokescreens and State Responsibility: Using Human Rights Strategies to Promote Global Tobacco Control*, 29 Yale J. Int'L L. 209, 225 (2004).

[38] Robin Appleberry, *Breaking the Camel's Back: Bringing Women's Human Rights to Bear on Tobacco Control*, 13 Yale J.L. & Feminism 71, 79 (2001).

[39] For example, Johann Gottlieb Fichte argued that the government has the obligation to help people when they face accidents or illnesses. In the development of the socialist movement in the 20th century, the labor/working class argued that the government has the obligation to protect citizens' rights to health and work. Van der Ven argued that the state is obligated to provide sufficient health care services to protect people's physical and mental health. G. Brunner and T. Tommandl also assert that the state is obligated to maintain the minimum standards of life, including health care services and housing for the public. The Treaty of Versailles, which was crafted by the International Labour Organization (ILO) in 1919, argued that the "injustice, hardship and privation" that workers must endure should be eradicated, and that "fair and humane conditions of labour" should be guaranteed.
Xinmin Chen, *Basic Theory of Constitutional Basic Rights* 95-128 (Taipei: Angle Press 1992) (in Chinese).
Norman Daniels, *Just Health Care* 4 (Cambridge: Cambridge University Press 1995) (1985).

people and organizations worldwide rank health as one of the greatest goods,[40] international human rights documents, such as the ICESCR, the WHO Constitution,[41] national constitutions,[42] and non-governmental organizations (NGOs),[43] have proposed that individuals should have the right to maintain the "highest attainable standard" of physical and mental health, and have gradually recognized an individual's right to health as a basic socio-economic right. Even though some countries, such as the United States, do not recognize the right to health in their constitutions,[44] they have developed related but subordinate laws to substantially protect some significant contents of the right to health care[45]

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[40] Harvard Law School Human Rights Program, *Economic and Social Rights and the Right to Health: An Interdisciplinary Discussion Held at Harvard Law School* 17 (unpublished manuscript, on file with the Harvard Law School Library 1995).

[41] The right to health has been recognized in numerous international instruments. For example, article 25.1 of the United Nation's Universal Declaration of Human Rights (UDHR) affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services." In accordance with article 12.1 of ICESCR, state parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," while article 12.2 of ICESCR enumerates, by way of illustration, a number of "steps to be taken by the States' parties ... to achieve the full realization of this right." The preamble of the World Health Organization (WHO) Constitution asserts that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," and that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." Additionally, the right to health is recognized in article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) of 1979, and in article 24 of the Convention on the Rights of the Child (CRC) of 1989. Several regional human rights instruments also recognize the right to health, such as article 11 of the European Social Charter of 1961, article 16 of the African Charter on Human and Peoples' Rights of 1981, and article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988.

[42] For example, Section 27 of South Africa constitution includes "health care, food, water and social security" as basic human rights. In Section 15(a) of the Finnish Constitution Act of 1995, the right to health is included in a broader provision of welfare rights. In Article 25 of Japanese constitution, the state is obligated to maintain the minimum standards of wholesome and cultured living, which implies the right to health of all citizens. Section 157 and Amendment Section 10 of the Taiwan Constitution states that the government should provide adequate and sufficient health care services to support the health of people, especially the elderly, women, children, and the handicapped. Even when some countries, such as the United States, do not recognize the right to health in their constitutions, the related but subordinate issues of the right to health are present in statutes and common laws. For example, the Social Security Act of 1935 first supported grants for maternal/infant care. The Economic Bill of Rights introduced "the right to adequate care and the opportunity to achieve and enjoy good health." The Patients' Bill of Rights of 2005 also mentioned "access to [health] care" and "nondiscrimination."
In conclusion, the fact that the right to health is codified in a substantial number of national constitutions implies that states generally recognize their responsibility regarding the health of their citizens, and support the existence of an international right to health in "delivery of services," "quality assurance," "promoting good medical practice," etc.

[43] In addition to international documents, domestic constitutions and laws, NGOs also provide comprehensive articles on the right to health. For example, the World Medical Association's (WMA) "Declaration of the Rights of the Patients" of 1995 presents important concepts about the right to health, such as the right to medical care of good quality, the right to health education, and the right to dignity in receiving health care, etc. In 1980, the Japanese Bar Association also declared that health rights are basic human rights based upon constitutional rights, and that the state is obligated to equally fulfill citizens' health care needs, and that people have "active" rights to ask the state, public hospitals and physicians to provide adequate health care services, and to educate and empower patients in health care policy. The American Hospital Association's "Patient's Bill of Rights" of 1973, and the Japanese "Patients' Bill of Rights" declared by the "Drafting Committee of Patients' Bill of Rights" in 1984 also contain similar rights to health care concepts.

[44] Kenneth R. Wing, *The Right to Health Care in the United States*, 2 Annals Health L. 161, 163 (1993).

[45] For example, in the United States, Franklin D. Roosevelt's proposed Economic Bill of Rights of 1944 introduced the idea of the right to adequate medical care and for every citizen the opportunity to achieve and enjoy good health. The National Health Planning and Resources Development Act of 1974 required federal policy to provide "equal access to quality care at a reasonable cost."

(although these contents are more precisely characterized as political rights or entitlements than constitutional rights[46]).

According to CESCR General Comment No. 14 article 8, the right to health can be further divided into two distinct dimensions: healthcare freedoms (negative rights) and healthcare entitlements (positive rights). The healthcare freedoms, which require the state to (negatively) stay out of people's health business, include "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation."[47] By contrast, the healthcare entitlements, the rights to be provided by others (state or individuals) with a particular action, good, or service (a right to benefits),[48] include "the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."[49]

Even though the distinction between negative rights (freedoms) and positive rights (entitlements)[50] is generally applied in the framework of international human rights,[51,52] some experts disagree with this distinction and argue that the right to health cannot easily be categorized by consensus as positive or negative.[53] But the distinction recently has been

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Economic Bill of Rights of 1944, 90 Cong. Rec. 55-57 (1944).
National Health Planning and Resources Development Act of 1974, 42 U.S.C. §300K (1974).

[46] See e.g., Carolynne Shinn, *The Right to the Highest Attainable Standard of Health: Public Health's Opportunity to Reframe a Human Rights Debate in the United States*, 4(1) Health and Human Rights 115, 115 (2000).
Kenneth Wing, *The Right to Health Care in the United States*, 2 Annals Health L. 161, 161 (1993).
Janet O'Keeffe, *The Right to Health Care and Health Care Reform*, in Audrey Chapman eds., *Health Care Reform: A Human Rights Approach* 36 (Washington D.C.: Georgetown University Press 1994).

[47] Committee on Economic, Social, and Cultural Rights, *CESCR General Comment No. 14* art. 8, E/C.12/2000/4 (November 8, 2000).

[48] Tom Beauchamp and Ruth Faden, *The Right to Health and the Right to Health Care*, 4(2) The Journal of Medicine and Philosophy 118, 120 (1979).

[49] Committee on Economic, Social, and Cultural Rights, *CESCR General Comment No. 14* art. 8, E/C.12/2000/4 (November 8, 2000).

[50] The wording of conventions or agreements signals the difference between the state's obligations to fulfill positive rights and negative rights. For example, the ICESCR employs the concept such as "state parties recognize the right of everyone to" whereas the ICCPR contains terms such as "everyone has the right to" or "no one shall be."

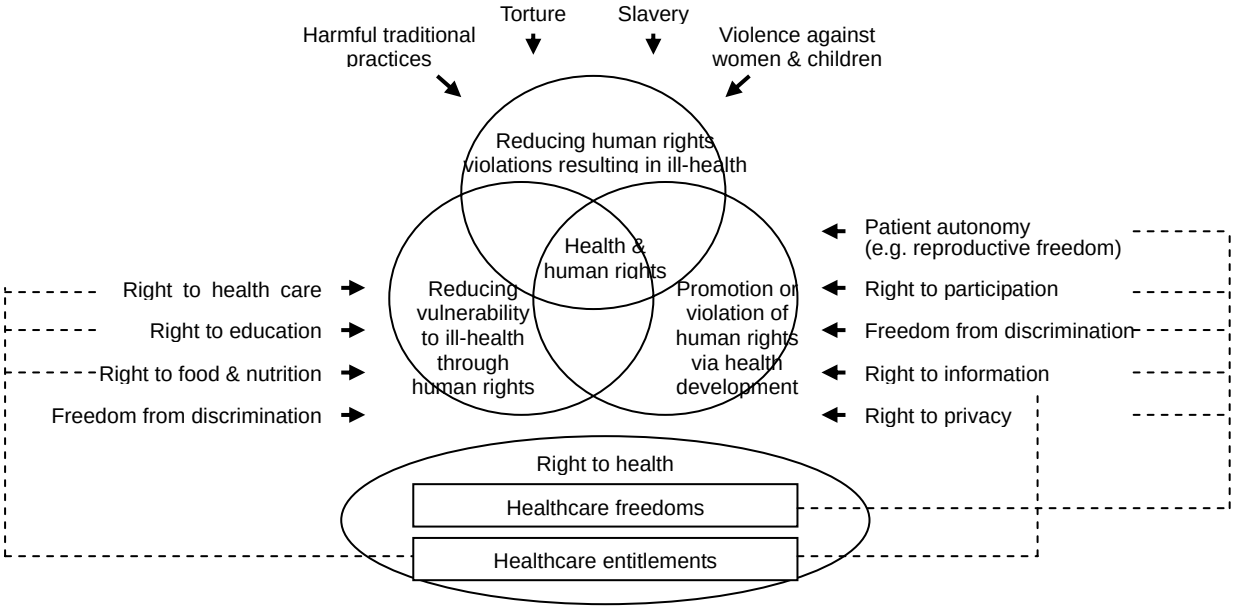
[51] For example, the International Convention of Economic, Social, and Cultural Rights (ICESCR) employs the concept such as "state parties recognize the right of everyone to" whereas the International Convent of Civil and Political Rights (ICCPR) contains terms such as "everyone has the right to" or "no one shall be."

[52] This distinction is to differentiate the state's various obligations to fulfill negative rights (freedoms) and positive rights (entitlements). The state is required to fulfill civil and political rights immediately ("everyone has the right to…") because these rights only require the state to (negatively) stay out of people's business ("no one shall be…") and grant people limitless natural rights (e.g., the state does not recognize that the provision is subject to the availability of resources). On the contrary, socio-economic rights only require the state's reorganization based on the availability of resources with a view to progressively achieving the goals (respecting, protecting, and fulfilling socio-economic rights) because these rights mainly depend on the state's ability to provide resources and services. According to this distinction, the fulfillment of the right to health essentially depends upon the state's ability to access resources and to progressively provide them. This then forms the rationale behind the experts' argument that the right to health is a positive right because its fulfillment requires the state to implement significant actions and to provide significant resources and/or services.

[53] Frank B. Cross, *The Error of Positive Rights*, 48 UCLA L. Rev. 857, 864 (2001).

applied in the framework of the right to health.[54] For instance, the U.N. Development Programme asserts that the state has both positive and negative duties to fulfill the right to health, which include both freedoms (resources not required) and entitlements (resources required).[55] Beauchamp and Faden also argue that "if health care is broadened to include certain abstentions from actions intended as preventive and protective measures, the right to health might also contain elements of a negative right, depending … upon one's analysis of that notion in light of the alternatives."[56] Figure 1 illustrates the close relationship between healthcare freedoms and healthcare entitlements.

Figure 1. Interaction Between Health and Human Rights[57]



However, many governments' noncommittal and contradictory position on the right to health has hindered further development of this right. On the one hand, some states have

[54] It must be noted that healthcare freedoms were ignored in some earlier international human rights approaches. For example, Article 12 of the ICESCR merely states that the right to health is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (e.g., the reduction of the stillbirth-rate, the provision for the healthy development of the child, the improvement of environmental and industrial hygiene, the assurance of all medical service and medical attention in the event of sickness, and the prevention, treatment, and control of epidemic, endemic, occupational diseases) without mentioning healthcare freedoms.

[55] United Nations Development Programme, *Human Development Report* 93 (New York: Oxford University Press 2000).

[56] Tom L. Beauchamp and Ruth R. Faden, *The Right to Health and the Right to Health Care*, 4(2) The Journal of Medicine and Philosophy 118, 120-21 (1979).

[57] This figure is a slight variation on one proposed by the World Health Organization (WHO).
World Health Organization, *Health and Human Rights* 1, available at http://www.who.int/hhr/information/MIP_HHR_InfoSheet_final7.pdf (last modified Mar. 15, 2007).
Gaston Sorgho, *What Is To Be Gained by Adding the Human Rights Dimension to Efforts to Improve Health Status of the Population?* Address at the Harvard University School of Public Health (Nov. 6, 2002) (unpublished transcript) (on file with author).

maintained the importance and equal status of the right to health.[58] But on the other hand, their support has been limited because they have failed to take steps to establish the right constitutionally, to adopt legislative and/or administrative provisions based explicitly on the recognition of the right to health as an international human right, or to provide effective means of redress to individuals or groups alleging violations of this right. In addition, even though international human rights institutions have labored to create important points[59] to further elaborate upon, and to more profoundly and completely explore the right to health, the definition and range of the right to health remain too broad and vague to provide a basis for a monitorable, assessable, and enforceable right.

This ambiguity partially reflects the fact that the right to health remains intellectually underdeveloped,[60] which has made it difficult to outline and expand upon the state's responsibility to promote tobacco control. Equally undefined as the contents of the individual right to health are states' duties, because principles of international law articulate only three types of obligations under the right: to respect, to protect, and to fulfill the rights of citizens to the enjoyment of the highest attainable standard of health.[61]

IV. The Right to Health Dimension of Tobacco Control

Even in the absence of definitive standards, numerous violations of the right to health arise in the government's tobacco policies, all of which center on an individual's ability to effectively promote and protect his or her own health.[62] Since most states across the globe have recognized the right to health for every citizen and have explicitly supported and accepted international human rights laws, the state then should respond to the tobacco crisis more effectively based on the right-to-health paradigm.

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[58] Supra note 12.

[59] For example, Marks has developed several approaches to support the human rights to development (including the right to health care): the holistic approach, the human rights based approach, the social justice approach, the capabilities approach, the right to development approach, the responsibilities approach, and the human rights education approach.
Stephen Marks, *The Human Rights Framework for Development: Seven Approaches*, in Basu, Mushumi et al. eds., *Reflections on the Right to Development* 291-350 (New Deli: Sage Publications 2005).

[60] Philip Alston, *Out of the Abyss: The Challenges Confronting the New U.N. Committee on Economic, Social and Cultural Rights*, 9 Hum. Rts. Q. 332, 351 (1987).

[61] Lawerence Gostin, *The Human Right to Health: A Right to the "Attainable Standard of Health"*, 31 Hastings Center Report 29, 29-30 (2001).
Rebecca Cook, *State Accountability for Women's Health*, 49(1) Int'l Dig. Health Leg. 265, 272 (1998).

[62] Robin Appleberry, *Breaking the Camel's Back: Bringing Women's Human Rights to Bear on Tobacco Control*, 13 Yale J.L. & Feminism 71, 86 (2001).

On the one hand, formulating tobacco control policy with careful consideration of its impacts on the right to health can help a society to assess whether pursued financial gains (such as the increase of tobacco revenue tax or the reduction of administrative cost) outweigh intended health benefits in tobacco control policies. For example, due to the extremely high administrative costs,[63] a government might decide not to adopt and implement licensing system to control or regulate the production and distribution of tobacco products.[64] This tobacco control policy then needs to be carefully assessed to ensure that there is a proper trade-off between increased health risks of smoking and pursued financial gains (the reduction of administrative cost) served by such a policy, and this trade-off is balanced and justified. The human rights approach then can help to establish a monitorable and enforceable mechanism to evaluate the trade-off relationship. For example, the impact on the right to health placed by the tobacco control policy can be assessed by the following criteria[65]: (1) examining the human rights burdens that a proposed tobacco control care policy places on individuals' human rights to health, (2) clarifying the tobacco control policy's purpose and assessing whether the tobacco control policy could or does achieve its objectives, (3) evaluating the effectiveness of the tobacco control policy and assessing whether the tobacco control policy provides the least restrictive alternative to achieve its proposed purpose, and (4) accessing the trade-off relationship between the restricted health rights and the proposed economic and social interests in the tobacco control policy.

On the other hand, because the FCTC contains discretionary and indirect (rather than mandatory and direct) implementation mechanisms (see discussions of obstacles to global tobacco control in section II), identifying and evaluating all the potential infringements on the right to health in a tobacco control policy can prevent the state from arbitrarily undertaking less effective tobacco control initiatives. For example, FCTC article 19(1) states that, even for the purpose of tobacco control, the state still only needs to simply "consider" taking legislative action (such as providing compensation) where "necessary" or "appropriate." Thus, while the FCTC has obligated the state to implement appropriate initiatives to protect individuals from

[63] However, in the Drafting and Negotiation of a Protocol on Illicit Trade in Tobacco Products, many delegations have called for the protocol to contain clear and strong licencing obligations, such as periodic licencing renewal. *Drafting and Negotiation of a Protocol on Illicit Trade in Tobacco Products* arts. 7-15, FCTC/COP/INB-IT/1/7 (February 15, 2008).

[64] Asian Center for WTO & International Health Law and Policy, *Comments and Recommendations on the Drafting and Negotiation of a Protocol on Illicit Trade in Tobacco Products: Taiwan Perspective* 10, available at http:// www.law.ntu.edu.tw/ center/wto/project/UserFiles/File/FCTC/FCTCU.pdf (last modified on July 26, 2008).

[65] Gostin and Mann also proposed a human rights impact assessment similar to my proposal. Lawrence Gostin and Jonathan Mann, *Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, in Jonathan Mann et al. eds., *Health and Human Rights,* 54-71 (New York: Routledge 1999).

the diseases and hazards caused by tobacco use, this FCTC article 19(1) leaves the state much leeway to interpret "necessity" and "appropriateness". Integrating the FCTC with the right-to-health institutions, which specify the state's human rights obligations, would help us to resolve this problem because the right-to-health framework can help states to identify the core requirements of tobacco control, to clarify the state's responsibility in tobacco control, and to enhance the likelihood of states' compliance.

Since tobacco control is seen as a human rights issue, it is then necessary to apply the right to health, including both healthcare freedoms and healthcare entitlements (see discussions in section III), to explore the state's responsibility in tobacco control.

Guaranteeing healthcare freedoms is an important and controversial human rights issue in tobacco control. These freedoms are strongly related to an individual's autonomy to make his or her own health care decision (smoking or not smoking), concerned with his or her own body, without interference from others (states or individuals). Therefore, smokers might argue that, for example, the FCTC article 8(2) (which aims to prevent individuals from smoking in workplaces or other public places) and article 6 (which encourages states to adopt the tax mechanism as a financial incentive to lower smoking rate) smack of paternalism and violate their healthcare freedom to choose to smoke (and negatively affect their own health if they so wish).

However, the personal freedom to smoke is not an absolute right. Individuals' freedom to smoke must be balanced against the responsibility of the state to protect public health, the expenses incurred by the state in doing so due to tobacco use, and the pursued public health benefits.[66] If the state can prove that a compelling interest that was substantially furthered by governmental smoking restrictions, it is then justified to restrict individuals' freedom to smoke in exchange for greater utility. In addition, limiting tobacco use does not suggest that the practice outlawed, made criminal, etc. As with the protection of other human rights, the state still needs to adopt most effective, least restrictive alternative in tobacco control. Due to the complicated relationship between healthcare freedoms and tobacco control, I will not discuss this issue any further here until another article.

Because most tobacco control measures in the FCTC are relate to healthcare entitlements (such as establishing effective tobacco cessation programs for people addicted

[66] Virginia Leary, *Concretizing the Right to Health: Tobacco Use as a Human Rights Issue*, in Fons Coomans et al. eds., *Rendering Justice to the Vulnerable* 164 (2000).

to tobacco, ensuring smoke-free workplaces and public spaces, and imparting tobacco health-related information), in this article I focus only on the state's obligations to fulfill healthcare entitlements in tobacco control policy.

V. Healthcare Entitlements and Tobacco Control

One dimension of the right to health regarding tobacco control relates to positive rights, which guarantee individuals' healthcare entitlements to particular actions, goods, or services provided by the state (a right to benefits).[67] Plenty of international documents and domestic statutes can be cited as the source of healthcare entitlements (see Table 1) when considering whether a tobacco control policy complies with or violates healthcare entitlements. Applying the human rights markers of the right to health as a basis upon which to construct healthcare entitlements can help us to evaluate the state's possible human rights burdens imposed by implementing a tobacco control policy. If the state's tobacco control policy fails to protect or to fulfill the healthcare entitlements listed in international human rights documents or domestic laws, this policy would be considered a potential human rights burden on the entitlements.

Table 1 shows that certain requirements in the FCTC are related to healthcare entitlements. However, it is questionable whether the state's FCTC obligations are consistent with its obligations to respect, to protect, and to fulfill healthcare entitlements. For example, FCTC article 14, which requires the state to provide citizens with basic access to health care such as regular screening and counseling for tobacco use, and adequate treatment for tobacco dependence,[68] is related to the state's human rights obligation to adopt legislation or other measures ensuring access to health care and health-related services.[69] Article 16, which requires the state to "prohibit the sales of tobacco products to persons under the age set by domestic law, national law or eighteen," is consistent with the Convention on the Rights of the Child (CRC) articles 6(2) and 24.[70] In FCTC article 18, the state's responsibility to

[67] Tom Beauchamp and Ruth Faden, *The Right to Health and the Right to Health Care*, 4(2) The Journal of Medicine and Philosophy 118, 120 (1979).

[68] FCTC art. 14(1), "Each Party shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence."

[69] Committee on Economic, Social, and Cultural Rights, *CESCR General Comment No. 14* arts. 35-37, E/C.12/2000/4 (November 8, 2000).

[70] Convention on the Rights of the Child art. 6(2), "States Parties shall ensure to the maximum extent possible the survival and development of the child."
Convention on the Rights of the Child art. 6(2) (1989).

"have due regard to the protection of the environment and the health of persons in relation to the environment in respect of tobacco cultivation and manufacture," is part of the state's responsibility to provide environmental hygiene.[71] FCTC articles 10 (regulation of tobacco product disclosures)[72] and 11 (packaging and labelling of tobacco products)[73] are aimed to protect individuals' right to access and receive health-related information (such as the health risks of smoking).[74]

This paper focuses on relationships between three key tobacco control issues and the right to health, which most states ignore: measures concerning tobacco dependence and smoking cessation, tobacco smuggling (illicit trade in tobacco products), and regulations of tobacco products disclosures.

Table 1. Contents of Healthcare Entitlements and Their Correspondence with the FCTC
(compiled from cited sources)

Topics	Healthcare Entitlements	Treaty Provisions	FCTC
Health care	General medical care	UDHR 25.1 WHO Constitution ICESCR 12.2(c)(d) CESCR General Comment 14	FCTC 14 – demand reduction measures concerning tobacco dependence and cessation
	Primary health care	ICESCR 12.2(c) CRC 24.2(f) CESCR General Comment 14	FCTC 8 – protection from exposure to tobacco smoke FCTC 9 – regulation of the contents of tobacco products FCTC 15 – illicit trade in tobacco products, FCTC 18 – protection of the environment and the health of persons
	Preventive health care	ICESCR 12.2(c) CRC 24.2(f) CESCR General Comment 14	
	Maternal/reproductive health	UDHR 25.2	

[71] Environmental health is generally regarded as covered by the term "environmental hygiene" in the ICESCR article 12(2)(b) and "risks of environmental pollution" in the CRC article 24(2)(c).
Brigit C.A. Toebes, *The Right to Health as a Human Right in International Law*, 256 (Oxford: Hart-Intersentia 1999).
International Covenant on Economic, Social, and Cultural Rights (1966).
Convention on the Rights of the Child art. 6(2) (1989).

[72] FCTC art. 10, "Each Party shall, in accordance with its national law, adopt and implement effective legislative, executive, administrative or other measures requiring manufacturers and importers of tobacco products to disclose to governmental authorities information about the contents and emissions of tobacco products. Each Party shall further adopt and implement effective measures for public disclosure of information about the toxic constituents of the tobacco products and the emissions that they may produce."

[73] The FCTC art. 11(1)(b), "[each Party shall ensure that,] each unit packet and package of tobacco products and any outside packaging and labelling of such products also carry health warnings describing the harmful effects of tobacco use, and may include other appropriate messages." Article 11(1)(c), "[each Party shall ensure that,] each unit packet and package of tobacco products and any outside packaging and labelling of such products shall ... contain information on relevant constituents and emissions of tobacco products as defined by national authorities."

[74] For example, CESCR General Comment No.14 articles 3, 11, and 12, and the European Social Charter (ESC) article 11 contain the state's obligation to provide health-related information. The civil and political right to freedom of expression also includes freedom to receive and impart information. This freedom has increasingly been interpreted as to include a positive government obligation to provide information.
Brigit C.A. Toebes, *The Right to Health as a Human Right in International Law*, 269.

	services	ICESCR 12.2(a) CEDAW 12.2 CRC 24.2(d) CESCR General Comment 14	
	Infant /child health services	UDHR 25.2 ICESCR 12.2(a) CRC 24 CESCR General Comment 14	FCTC 16 – sales to and by minors
	Mental health services	ICESCR 12.1 WHO Constitution CESCR General Comment 14	
	Family planning services	CEDAW 12 CRC 24.2(f)	
	Quality	CESCR General Comment 14	
(Freedom to) Health-related information[75]	Health-related information	WHO Constitution CRC 24(2)(e) ESC 11(2)	FCTC 10 – regulation of tobacco product disclosures, FCTC 11 – packaging and labeling,of tobacco products FCTC 13 – tobacco advertising, promotion and sponsorship
	Health education	WHO Constitution CRC 24.2(e) CESCR General Comment 14	FCTC 12 – education, communication, training, and public awareness of tobacco control issues
Underlying preconditions for health	Healthy & natural workplace environments	ICESCR 12(2)(b) CRC 21(c) CESCR General Comment 14	FCTC 8 – protection from exposure to tobacco smoke FCTC 18 – protection of the environment and the health of persons
	Clean drinking water	ICESCR 12(2)(b) CRC 24(2)(e) CESCR General Comment 15	
	Adequate nutritious foods	CRC 24(2)(c) CEDAW 12(2)	
	Adequate sanitation	ICESCR 12(2)(b) CRC 24(2)(e)	

Sources:
UDHR: Universal Declaration of Human Rights (1948)
WHO Constitution: World Health Organization Constitution (1946)
ICESCR: International Covenant of Economic, Social, and Cultural Rights (1966)
CEDAW: Convention on the Elimination of All Forms of Discrimination against Women (1979)
CRC: Convention on the Right of the Child (1989)
ESC: European Social Charter (1961)
CESCR General Comment 14: Committee on Economic, Social, and Cultural Rights, General Comment No. 14 (2000)
CESCR General Comment 15: Committee on Economic, Social, and Cultural Rights General Comment No. 15 (2002)
FCTC: Framework Convention on Tobacco Control (2003)

A. Right to Access General Health Care: Smoking Cessation Services

The state's responsibility to develop and provide appropriate and effective measures of tobacco cessation can be linked to its fulfillment of individuals' right to access health care. Scholars have posited that a lack of easy access to, or effective incentives for obtaining, smoking cessation services reflects not only a lack of appreciation of the serious of health

[75] Because the right to access health-related information involves both (i) the negative obligation not to intervene in the public's receipt of health-related information and (ii) the positive obligation to provide health-related information, this right can be categorized as a healthcare entitlement and/or healthcare freedom.

hazards, but also a serious violation on the right to health.[76] Therefore, the state should have the human rights obligation to "establish in health care facilities and rehabilitation centres programmes for diagnosing, counselling, preventing and treating tobacco dependence".[77]

This obligation is based on the belief that tobacco dependence treatment should be a general health care provision under which individuals with nicotine addiction (a chronic disease) are entitled to (see Table 1). Tobacco dependence is generally classified as a physical and mental disorder in major international classifications of diseases.[78] Most tobacco products deliver nicotine (the basic ingredient of tobacco products) to the brain very effectively, which brings on the maintenance of addiction. Because nicotine is a proven addictive substance[79] that can induce pharmacological and behavioral processes similar to drugs,[80] it is unreasonable to expect smokers to sustain smoking cessation without proper health care measures to cope with nicotine withdrawal symptoms.[81] For example, due to the tobacco's pharmacological addictive qualities, the rate of unaided smoking cessation remains low even when public awareness of the health hazards of smoking is comparatively high.[82] Individuals who try to quit smoking on their own have a chronically high rate of relapse,[83] or they simply switch to "light" cigarettes,[84] which only minimally (if at all) lower the detrimental effects of tobacco smoke. Therefore, tobacco dependence is a morbid addiction that impairs autonomous decision-making[85] and is a chronic illness considered beyond an individual's free choice. Tobacco dependence then is hardly a so-called "lifestyle disease".[86] Since tobacco dependence is a chronic illness from the right-to-health perspective, the state then is obligated to provide functioning and sufficient public health and health care facilities, goods

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[76] Robin Appleberry, *Breaking the Camel's Back: Bringing Women's Human Rights to Bear on Tobacco Control*, 13 Yale J. L. & Feminism 71, 86 (2001).
[77] *FCTC* art. 14(2)(c) (2003).
[78] *Id.* at Preamble.
[79] E.W. Lee and G.E. D'Alonzo, Cigarette Smoking, Nicotine Addiction, and Its Pharmacologic Treatment, 153 Archives Internal Med. 34 (1993).
[80] Benjamin Mason Meier, *Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health*, 5 Yale J. Health Pol'y, L. & Ethics 137, 161 (2005).
[81] Nicotine withdrawal symptoms include headache, anxiety, nausea, and a craving for tobacco.
Rudy Chen et al., *The Impact of Smoking Cessation Programs on Smoking-Related Health Belief and Rate of Quit-Smoking among Schizophrenic Patients*, 22(5) J. Med. Sci. 215, 216 (2002).
[82] For example, statistics show that the number of smokers in Taiwan has remained stable even when anti-smoking campaigns have increased.
Taiwan Tobacco and Wine Monopoly Bureau, *Report from Tobacco and Alcohol Consumption Survey in Taiwan Area* (Taipei: TTWMB, 1963-1996).
[83] European Partnership to Reduce Tobacco Dependence, *WHO Evidence Based Recommendations on the Treatment of Tobacco Dependence* 3 (2001).
[84] C.R. Hsieh, T.W. Hu, and C.J. Lin, *The Demand for Cigarettes in Taiwan: Domestic Versus Imported Cigarettes*, 17 Contemp. Econ. Policy 223, 223-34 (1999).
[85] Robert E. Goodin, *No Smoking: The Ethical Issues* 7 (1989).
[86] Cheryl Healton and Kathleen Nelson, *Reversal of Misfortune: Viewing Tobacco as a Social Justice Issue*, 94 Am. J. Pub. Health 186, 187 (2004).

and services[87] for individuals to "recover" from tobacco dependence.

However, when the FCTC seeks to create a non-smoking social environment[88] through broad regulations on mandatory warning labels, bans on tobacco advertising, and taxation, it fails to "affirmatively" obligate the state to provide individuals proper health care services (such as smoking cessation programs) to break their addictions to tobacco products.[89] Even though FCTC article 14 contains a general, normative principle about "demand reduction measures concerning tobacco dependence and cessation" and states that the state "shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence,"[90] it uses nonobligatory language and trivializes the role of tobacco cessation programs.[91] It fails to firmly stipulate states' responsibility to provide clinical smoking cessation programs to the public and thus it forsakes and abandons individuals addicted to nicotine and those vulnerable to the morbidity and mortality of smoking.[92] For example, according to FCTC article 14, an individual who needs a clinical smoking cessation services has no entitlement to require the state to provide such health care because the state has no affirmative obligation.

The lack of "the right to health" provision in the FCTC consequently leaves room for the state to offer whatever services it wishes in this domain, and to make arbitrary decisions and broad claims as to how and when and how much resources to spend to prevent and to treat tobacco dependence. If the state, according to the FCTC, only has a "moral" obligation to provide adequate treatment for tobacco dependence, the state then can readily deny, without justification, any requirements for well-trained healthcare providers to provide fundamental cessation interventions (such as prescribing a nicotine patch). This bodes poorly for the fulfillment of the right to health because the contents of smoking cessation programs are largely subject to the state's interpretation rather than an individual's right to health. For example, under FCTC article 14, state public health ministries' proposed smoking cessation programs can nonetheless be overruled by finance ministries if the forgoing programs cannot

[87] Committee on Economic, Social, and Cultural Rights, *CESCR General Comment No. 14* art. 11(a), E/C.12/2000/4 (November 8, 2000).
[88] Benjamin Mason Meier, *Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health*, 5 Yale J. Health Pol'y, L. & Ethics 137, 147 (2005).
[89] Even though the FCTC treats tobacco consumption as a serious health problem, it avoids using the terms such as "disease" or "addiction," which are used as a public health basis for the need for tobacco control.
[90] *FCTC* art. 14(1) (2003).
[91] Benjamin Mason Meier, *Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health*, 5 Yale J. Health Pol'y, L. & Ethics 137, 149 (2005).
[92] Benjamin Mason Meier, *Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health*, 5 Yale J. Health Pol'y, L. & Ethics 137, 139 (2005).

meet cost-benefit analysis (which applies monetary benefits as a criterion to evaluate outcomes and costs of tobacco interventions). Thus, the state's obligation to develop smoking cessation programs should be free from scrutiny under trade law,[93] and subject to international human rights institutions.

However, some have argued that smoking cessation should not fall under the right to health.[94] For example, during preliminary negotiations, the FCTC drafters considered personal treatment issues, such as treatment of tobacco dependence, as not needing their own provisions (e.g., the Protocol on the Treatment of Tobacco Dependence[95] proposed by WHO's Tobacco-Free Initiative) but be considered a part of tobacco control programs.[96] This argument is understandable. Generally speaking, the core content of the right to health is a health baseline (minimal health) below which no individual should find themselves,[97] and the state thus has only the obligation to provide minimum health care services that realizes this health baseline. In other words, the state's core obligation to fulfill the right to health should be limited to caring for and curing patients with diseases which are life-threaten or related to substantial physical and mental functions (e.g., providing medical treatment for common diseases, immunization, and essential drugs). But nicotine, which is responsible for the dependence-forming properties of tobacco smoking, does not promote the development of cancer in healthy tissue on its own. Since nicotine is not the direct cause/agent of deadly consequences for smokers and those exposed to environmental tobacco smoke but rather tar, and individuals addicted to nicotine would not fall below the health baseline (minimal health), the tobacco cessation program then is regarded as a primary disease prevention strategy, which seeks to prevent the initial occurrence of a disease[98] and that is outside of the scope of the core content of the right to health.[99] Thus, the state's failure to provide regular screening for tobacco dependence or appropriate smoking cessation services should not deemed as a

[93] Joseph Eckhardt, *Balancing Interests in Free Trade and Health: How the Who's Framework Convention on Tobacco Control Can Withstand WTO Scrutiny?* 12 Duke J. Comp. & Int'l L. 197, 220 (2002).
[94] Robin Appleberry, *Breaking the Camel's Back: Bringing Women's Human Rights to Bear on Tobacco Control*, 13 Yale J. L. & Feminism 71, 85-86 (2001).
[95] *Possible Subjects of Initial Protocols: Elaboration of Technical Components of Three Possible Protocols*, Working Group on the WHO Framework Convention on Tobacco Control, 2d mtg., Agenda Item 6, WHO Doc. A/FCTC/WG2/4 (Feb. 15, 2000).
[96] Framework Convention Alliance, *Comments on the Chair's Text of a FCTC Joint New Zealand NGO Submission* (Mar. 2001), available at http://fctc.org/archives/INB2nzngo.shtml (last modified July 12, 2008).
[97] World Health Organization, *Global Strategy for Health for All by the Year 2000* 31 (Geneva: World Health Organization 1989) (1981).
[98] Brigit Toebes, *The Right to Health as A Human Right in International Law* 247 (1999).
[99] For example, article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) is more or less exclusively focused on health care, in that "protections for health" are left unmentioned by this provision.

direct infringement of the core content (minimal health[100] or minimum health services[101]) of the right to health.

But health care should not be restricted to only medical care provided by medical professionals. Even though there is no standard definition of the term "health care" at the international level of human rights to health, health care is generally regarded as care offered by the healthcare profession, which is broader than curative medical care[102] and includes preventive and rehabilitative care services.[103] There is a tendency to broaden the scope of the right to health to include almost everything involving health[104] (including smoking cessation services). Since tobacco cessation programs not only arrest existing illnesses (tobacco dependence) but also offers the promise to reduce (or prevent, which is impossible to measure) the initial occurrence of smoking-related diseases and to advance the underlying preconditions of lowering mortality and mortality,[105] individuals thus should be granted the right to access this health-related service.[106] For example, Wen's study provides strong evidence for the benefits of smoking cessation programs in Taiwan[107]: (1) after smokers quit, mortality risk from smoking-related diseases decreased, and (2) the birth weight of newborns significantly improved as smoking mothers quit smoking. (The second benefit is strongly related to the core content of the right to health because, according to ICESCR article 12.2(a), improving the birth weight (which relates to the stillbirth-rate and of infant mortality) is an important step that the state can take to protect the right to health.) Therefore, in the tobacco

[100] *Henry Sigerist* defined health as merely a "physical" or a "physical and mental" notion (negative or moderate concept of health) by deleting "mental and social well-being". According to this negative concept of health, the state only has the obligation to guarantee the minimal health, which include biomedical functions directly related to life-saving, or to an individual's substantial physical and mental functions.

Henry E. Sigerist, *Medicine and Human Welfare*, 53-104 (1941).

Brigit C.A. Toebes, *The Right to Health as a Human Right in International Law*, 23 (1999).

[101] According to the WHO, the minimum health services include appropriate treatment of common diseases and injuries, immunization against the major infectious diseases, maternal and child health care, provision of essential drugs, etc.

World Health Organization, *Global Strategy for Health for All by the Year 2000* 34 (Geneva: World Health Organization 1989) (1981).

Brigit C.A. Toebes, *The Right to Health as a Human Right in International Law*, 283 (1999).

[102] *Id.* at 246-47.

[103] Committee on Economic, Social, and Cultural Rights, *CESCR General Comment No. 14* art. 17, E/C.12/2000/4 (November 8, 2000).

[104] At the international human right to health level, the state should protect individuals' right to access to health care in the event of sickness and disability.

International Covenant of Economic, Social, and Cultural Rights art. 12(2)(d) (1966).

Brigit Toebes, *The Right to Health as A Huamn Right in International Law* 259 (1999).

[105] Benjamin Mason Meier, *Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health*, 5 Yale J. Health Pol'y, L. & Ethics 137, 142 (2005).

[106] In addition, it must be noticed that, during the early drafting stages of the FCTC, the WHO tried to make smoking cessation treatment a key component of primary health care.

Crystal H. Williamson, *Clearing the Smoke: Addressing the Tobacco Issue as an International Body*, 20 Penn St. Int'l L. Rev. 587, 610 (2002).

[107] C.P. Wen et al., *The Health Benefits of Smoking Cessation for Adults Smokers and for Pregnant Women in Taiwan*, 14 Tob. Control 56, 58 (2005).

control debate, the state should have the *obligation* to establish programs in health care facilities and rehabilitation programs .[108] In other words, the state is obligated to provide medical programs to diagnose and treat tobacco dependence (and it should not be limited to providing health care to patients suffering from smoking-related diseases), and also to provide counseling and preventive programs for addicted tobacco users.

In addition, some argue that leaving smoking cessation out of the FCTC is imperative because including it is legislative overreaching[109] to create a basic duty to establish smoking cessation treatment measures that are practical, effective, cost-effective and available to all who need them. Because smoking cessation services are often prohibitively expensive and inaccessible, obligating the state to provide such services would force the state to take "unreasonable" legislative and other measures "beyond" its available resources. Therefore, the FCTC allows states to promote measures of tobacco control (including measures concerning tobacco cessation) based upon economic considerations,[110] or to postpone economically painful decisions regarding costly programs (such as providing smoking cessation services) until a later date.

However, resource-requiring (paying for resources) should not be the state's excuse to ignore its human rights obligation. According to ICESCR article 2.1, the right to health falls under the principle of progressive realization,[111] and the state simply needs to "take steps … to the maximum of its available resources, with a view to achieving progressively the full realization of the rights … by all appropriate means, including particularly the adoption of legislative measures."[112] In addition, the right to health is not to be understood as a right to be healthy[113] because "it suggests that people have something that cannot be guaranteed, namely 'perfect health' or 'to be healthy.'"[114] According to the Committee the Committee on Economic, Social, and Cultural Rights (CESCR), the notion of the highest attainable standard of health should "[take] into account both the individual's biological and socio-economic preconditions and a State's available resources."[115] Therefore, holding the state human rights

[108] *FCTC* art. 14(2)(c) (2003).
[109] Benjamin Mason Meier, *Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health*, 5 Yale J. Health Pol'y, L. & Ethics 137, 150-51 (2005).
[110] *FCTC* Preamble (2003).
[111] Supra note 35.
[112] *International Covenant of Economic, Social, and Cultural Rights* art. 2.1 (1966).
[113] Committee on Economic, Social, and Cultural Rights, *CESCR General Comment No. 14* art. 8, E/C.12/2000/4 (November 8, 2000).
[114] Brigit Toebes, *The Right to Health Care as a Human Right in International Law* 16 (Oxford: Intersentia-Hart 1999).
[115] Committee on Economic, Social, and Cultural Rights, *CESCR General Comment No. 14* art. 9, E/C.12/2000/4 (November 8, 2000).

obligation to "progressively realize" tobacco interventions for those with tobacco dependence then does not imply that the state must fulfill individuals' right to access tobacco cessation services regardless of its available resources.[116] The principle of progressive realization then leaves the state enough room to balance economic interests and health benefits, and allows accessibility to smoking cessation services to be progressively facilitated and examined, where and when possible, over time.

However, unlike the FCTC, which does not articulate the right to health as the normative justification for any of its obligations on states,[117] the burden of human rights obligation requires the state to prove that, in a tobacco control policy which fails to emphasize cessation interventions, the restricted health care entitlements (addicted smokers' health care benefits) are not out of proportion to the proposed economic and social interests. In other words, to justify excluding tobacco cessation from its tobacco control policy, the state needs to show that the purpose of its tobacco control policy is to protect and/or to promote its greater economic interests or social benefits, and show that these benefits are greater than the projected health benefits, and thus justify the trade-offs between restricted healthcare entitlements (the right to access health care) and its pursuit of social gains (e.g., economic benefits for the whole).

B. Right to Access Primary Health Care: Tobacco Smuggling

Primary health care includes promotive, preventive, curative and rehabilitative services for the primary health problems in the community.[118] Based on various international institutions,[119] primary health care, which is broader than merely health care (or medical) services and includes a broad range of issues such as an adequate supply of safe drinking water and basic sanitation and freedom from serious environmental health threats, are

[116] Even though measures to meet the right to health must be calculated to attain the goal expeditiously and effectively, "the availability of resources is an important factor in determining what is reasonable." *Government of the Republic of South Africa vs. Grootboom*, 2000 SACLR LEXIS 6, 13 (2000).

[117] Benjamin Mason Meier, *Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health*, 5 Yale J. Health Pol'y, L. & Ethics 137, 163 (2005).

[118] *Declaration of Alma-Ata* art. VII(2) (1978).

[119] Committee on Economic, Social, and Cultural Rights, *CESCR General Comment No. 14* arts. 43-45, E/C.12/2000/4 (November 8, 2000).
International Conference on Primary Health Care, *Declaration of Alma-Ata* arts. 6-7 (1978).
World Health Organization, *Global Strategy for Health for All by the Year 2000* 31-38 (1989).
World Health Organization, *Primary Health Care* 34-50 (Geneva: World Health Organization, 1948).

regarded as the core contents of the right to health.[120]

The issue here is whether the state's obligation to eliminate tobacco smuggling illustrated in FCTC article 15[121] is consistent with its human rights obligation to develop primary health care. Three factors support the argument that the strategies against tobacco smuggling should be regarded part of primary health care, and that the state's obligation to combat tobacco smuggling should be regarded as a human rights to health obligation. First, failing to implement effective measures to eliminate tobacco smuggling would impose greater health risks than legal tobacco on public. No doubt, tobacco, legal or illegal, is an unhealthy product. However, since it is now impossible to forbid tobacco production and sale (due to states' and scholars' contradictory and conflicting positions on tobacco prohibition), the state at least should fulfill its human rights obligation to regulate the contents of tobacco products in order to guarantee individuals access to the "least hazardous" tobacco products. Thus, according to FCTC article 9 and regulations in most countries, each government is required to establish "guidelines for testing and measuring the contents and emissions of tobacco products, and … [to regulate] these contents and emissions."[122] Many states also impose strict regulations on tobacco contents. For example, Taiwan requires that nicotine contained in one cigarette cannot exceed 1 mg while tar is limited to 10 mg.[123] Regarding the manufacture and sale of tobacco products, EU Directive 2001/37/EC also sets the maximum tar, nicotine and carbon monoxide yields of cigarettes.[124] Some scholars have proposed that tobacco manufacturers should be forbidden to use non-tobacco ingredients in their products unless a government board can prove (or the manufacturer could demonstrate) that the ingredient is not harmful to the public health under the intended conditions of use.[125,126] Therefore, through these

[120] Brigit Toebes, *The Right to Health Care as a Human Right in International Law* 243-89 (1999).

[121] Article 15 section 1 of the FCTC, "The Parties recognize that the elimination of all forms of illicit trade in tobacco products, including smuggling, illicit manufacturing and counterfeiting, and the development and implementation of related national law, in addition to subregional, regional and global agreements, are essential components of tobacco control."
FCTC art. 15(1) (2003).

[122] *FCTC* art. 9 (2003).

[123] *Examination Standard for Nicotine and Tar of Tobacco Products* art. 7 (2008) (Taiwan).

[124] Department of Health, *Social Services and Public Safety, A Five Year Tobacco Action Plan (2003-2008)* 44 (UK: Belfast 2003).

[125] This was proposed in the Master Settlement Agreement (tobacco settlement) in the U.S., which arose from lawsuits "for monetary, equitable, and injunctive relief against tobacco product manufacturers for violating consumer protection laws and for interference with the states' abilities to further public health goals, including reducing the incidence of underage smoking."
Lucien Dhooge, *Smoke Across the Waters: Tobacco Production and Exportation as International Human Rights Violations*, 22 Fordham Int'l L.J. 355, 381-82 (1998).
Christine Bump, *Close but No Cigar: The WHO Framework Convention on Tobacco Control's Futile Ban on Tobacco Advertising*, 17 Emory Int'l L. Rev. 1251, 1283 (2003).

[126] Even though this strict guideline was not adopted, most countries require tobacco manufacturers to produce a wider range of information about the ingredients of tobacco products. E.g., FCTC article 10 requires the state to "adopt and implement effective legislative, executive, administrative or other measures requiring manufacturers

guidelines, a government can at least control health hazards caused by “legal” tobacco to a certain degree. In other words, implementing these guidelines is an important primary health care step that the state should provide because, on the premise that tobacco is a legal product, they can at least reduce or curb the occurrence of smoking-related diseases.

But contraband (smuggled) tobacco, which is usually disqualified tobacco without proper labeling nor proper tests and measures of health impacts of the contents and emissions, would impose unpredictable and serious danger to individuals’ health. Studies showed that contraband tobacco’s content of nicotine or tar usually exceeds the limits set by the state, or is apparently moldy, damp, or otherwise deteriorated.[127] Furthermore, in order to maintain consumers, illicit tobacco manufacturers constantly add addictive and unknown ingredients to cigarettes, which pose greater risks than legal tobacco to public health. But for consumers, it is hard to distinguish between qualified and disqualified (legal and illegal) cigarettes and to avoid the later because the packages are usually similar or even identical. Therefore, the state should bear the human rights obligation to protect individuals from buying contraband (and possibly dangerous) tobacco.

Second, smuggled tobacco could weaken the state’s governance in the implementation of tobacco control (as a primary health care measure). As discussed earlier, the state is obligated to adopt proper regulations for testing and measuring the contents and emissions of tobacco products. But contraband tobacco does not have to comply with these strict regulations that apply to the rest of the tobacco industry with regard to ingredients or to toxic emissions’ information on products. Because contraband tobacco does not receive proper governmental tests and assessments of its contents and emissions of health impacts, which are important primary health care measures in tobacco control, failing to combat tobacco smuggling and to prevent contraband tobacco from entering the market thereby creates serious obstacles to the state’s implementation of tobacco control and sustainable fulfillment of the right to health.

Third, illicit tobacco trade undermines one of the most effective ways to stop people from smoking – tobacco taxation. Because contraband tobacco competes with legal tobacco,

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and importers of tobacco products to disclose to governmental authorities information about the contents and emissions of tobacco products.” Taiwan also requires that manufacturers and importers of tobacco products report the ingredients, additives, and related toxicity information of tobacco.
FCTC art. 10 (2003).
Tobacco Hazard Control Act arts. 8 (2007) (Taiwan).

[127] Interview by Asian Center for WTO and International Law and Policy, National Taiwan University with the Information Bureau, Demonstration of Coastguard in Taipei, Taiwan (May.27.2008).

tobacco prices in the face of smuggling could be lower due to more supply (contributed by smuggled tobacco), and tobacco consumption then could be higher than it would be in the absence of smuggled tobacco.[128] In addition, the threat of tobacco smuggling also discourages governments from raising taxes (such as the health and welfare surcharge in Taiwan[129]), resulting in lower tobacco prices.[130] Given the price sensitivity, tobacco smuggling then would significantly contribute to individuals' tobacco consumption and have the greatest impact on their health.[131] Smuggled tobacco, which evades the state's tests and measures of tobacco contents and emissions, then can somehow corrupt the state's handling of tobacco issues and regulations.

Therefore, contraband tobacco not only damages individuals' direct health with unidentified contents, but also spoils the state's control of the tobacco industry. In other words, combating tobacco smuggling is not only an economic supply-demand issue but also a health governance issue. Because tobacco smuggling undermines the state's tobacco taxation policy, which evidence shows is one of most effective ways to reduce tobacco consumption as well as an effective method of raising revenue,[132] failing to adopt efficient and effective strategies to combat tobacco smuggling and allows contraband tobacco to be freely distributes in the market then would impair a state's effective and successful implementation of primary health care (curbing tobacco consumption). From the human rights and public health protection perspective, a state's failure to prevent tobacco smuggling then can be construed as failing to prevent or retard tobacco-related diseases at a peripheral level and be viewed as a violation of the right to health.

In conclusion, because the illicit tobacco industry (including illicit tobacco production, trafficking and abuse) and its related ills are not only problematic in and of themselves, but

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[128] Luk Jossens et al., *Issues in the Smuggling of Tobacco Products* 394, in Prabhat Jha & Frank Chaloupka eds., *Tobacco Control in Developing Countries* (New York: Oxford University Press, 2000).

[129] According to the Tobacco Hazard Control Act and Tobacco and Alcohol Tax Act in Taiwan, the Health and Welfare Surcharge shall be imposed on tobacco products (e.g., NT$500 per 1,000 sticks of cigarettes) in consideration of elements affecting the price of tobacco products and prevention and control of smoking hazards.
Tobacco and Alcohol Administration Act art. 4 (2004) (Taiwan).
Tobacco and Alcohol Tax Act art. 22 (2008) (Taiwan).

[130] Luk Jossens et al., *Issues in the Smuggling of Tobacco Products* 394, in Prabhat Jha & Frank Chaloupka eds., *Tobacco Control in Developing Countries* (2000).

[131] C.P. Wen et al., *Paradoxical Increase in Cigarette Smuggling after the Market Opening in Taiwan*, 15(3) Tob Control 160, 165 (2006).
Press Release, World Health Organization, *Illicit Tobacco trade Contributes to Global Disease Burden*, available at http://www.who.int/ mediacentre/news/release/who62/en/print.html (last modified on July 18, 2008).

[132] Framework Convention Alliance, *FCA Briefing paper setting out why COP-1 should prioritise starting a process to develop a protocol to combat the illegal tobacco trade* 2, available at www.fctc.org/docs/documents/fca-2006-cop-illicit-trade-cop1-briefing-en.pdf (last modified on August 10, 2008).

also threaten the success of tobacco control (a primary health care measure) and sustainable human development, the state the should bear human rights obligations to take reasonable legislative action and adopt relevant measures to stem the illicit trade in tobacco products within the constraints of its available resources.

But several points must be considered when evaluating the state's obligation to control tobacco smuggling. First, imposing a human rights obligation on the state to combat tobacco smuggling does not mean that the state needs to exhaust its available resources to fulfill this obligation. We must recognize that, due to the state's limited resources, some practical difficulties (such as the increase of financial costs) will arise when setting concrete criteria for determining the state's obligation. Therefore, no precise content of the state's obligation, such as how much financial and/or human resources should be spent to enhance the capacity of the custom administrations, should be delineated at the FCTC level.[133] Second, even if the state simply needs to realize its obligation progressively (within its available resources), under the right to health framework, the state still must prove that the means used to combat tobacco smuggling are reasonably likely to achieve the proposed purpose, and that an adequate and direct connection exists between the state's actions and the policy's purposes. In other words, it is justified for the state to adopt different strategies for tobacco smuggling control based upon economic and social considerations if, and only if, the state can clarify the policy's purpose, examine the impacts and burdens on the right to health of the proposed policy, evaluate the effectiveness of the policy, and assess the tradeoffs between pursued economic interests and restricted rights. Employing the right to health as a justification to evaluate the state's tobacco smuggling control policies, integrating with the implementation of the FCTC, then can help to prevent the state from arbitrarily deciding to adopt less effective initiatives on tobacco smuggling control.

C. Access to Health-related Information: Tobacco Product Disclosures

There is a strong relationship between the level of health-related information the public receives and its health. According to the International Covenant of Civil and Political Rights (ICCPR), the civil and political right to freedom of expression includes individuals' freedom to

[133] Asian Center for WTO & International Health Law and Policy, *Comments and Recommendations on the Drafting and Negotiation of a Protocol on Illicit Trade in Tobacco Products: Taiwan Perspective* 15, available at http:// www.law.ntu.edu.tw/ center/wto/project/UserFiles/File/FCTC/FCTCU.pdf (last modified on July 26, 2008).

receive and impart information.[134] Several provisions of the right to health (e.g., CESCR General Comment No. 14, articles 3, 11, and 12, and European Social Charter (ESC) article 11) also delineate the state's obligation to provide health-related information to the public.[135] These international documents *assert* that the underlying nature of the right to access health-related information involves both a positive and negative right.[136] Thus, the freedom to access health-related information has increasingly been interpreted to include: (1) the state's negative obligation not to intervene in the public's receipt of health-related information, and (2) the state's positive obligation to provide health-related information.[137] The right to health then is accordingly interwoven with the freedom to access information if the information concerns health-related issues.[138]

The FCTC takes the significance of health-related tobacco information into consideration, and requires the state to "promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate."[139] In addition, the state should also commit to providing, in a prompt manner, the public with tobacco information (such as the contents and toxic emissions of tobacco products) it has obtained that is particularly relevant to public health.[140] The state, in accordance with its constitutional principles, also needs to prohibit false, misleading, or deceptive advertising in the promotion of tobacco.[141]

However, according to FCTC article 10, tobacco manufacturers and importers are required to disclose only to "governmental authorities" (and not the public), information about the contents and emissions of tobacco products. Individuals can access only certain information (confined to toxic constituents of tobacco products) only when the state decides to reveal it. In addition, this article only requires the state to "adopt and implement effective measures for public disclosure" without mentioning whether the state can choose to reveal only portions of the information that tobacco manufacturers provide to it. Therefore, the public in fact knows very little about what the industry adds to tobacco products and what smokers

[134] *International Covenant on Civil and Political Rights (ICCPR)* art. 19 (1966).
Brigit Toebes, *The Right to Health As a Human Right in International Law* 269 (Oxford: Intersentia-Hart 1999).
[135] *European Social Charter* art. 11 (1961).
Convention on the Rights of the Child art. 24 (1989).
[136] Bridgit Toebes, *The Right to Health as a Human Rights in International Law* 257 (1999).
[137] For example, the Convention on the Rights of the Child (CRC) article 24(2)(e) stipulates that parents and children should "have access to basic knowledge of child health and nutrition information, the advantages of breast-feeding, hygiene and environmental sanitation, as well as the prevention of accidents."
Convention on the Rights of the Child art. 24(2)(e) (1989).
[138] Bridgit Toebes, *The Right to Health as a Human Rights in International Law* 269 (1999).
[139] *FCTC* art. 12(1) (2003).
[140] *Id.* at art. 10.
[141] *Id.* at art. 13(4)(a).

(and those inhaling second-hand smoke) actually end consuming.[142] FCTC article 10 thus fails to comprehensively protect individuals' freedom to access health-related information regarding tobacco.

More specifically, two human rights problems might arise when implementing FCTC article 10. First, the fact about "the toxic constituents of tobacco products" (as stated in FCTC article 10) should not be the only material information that the public receives (and needs to receive) in the state's tobacco control efforts. For example, some ingredients in tobacco products might not be toxic but are associated with adverse effects, such as ingredients that enhance or quicken nicotine delivery. Some studies have shown that tobacco manufacturers use numerous (approximately 700) ingredients in their products.[143] Information about these ingredients is also important and pertinent to an individual's health care decision (smoking or quitting smoking). By focusing only on certain information (such as toxic constituents) provided by the tobacco industry might cause the public to miss some important tobacco information that might substantially restrict an individual's capacity to develop and exercise his or her own conception of the good in the use of tobacco. Therefore, some states in the U.S. have adopted a disclosure statute that requires the tobacco industry to disclose the identity of ingredients, other than tobacco, in their products.[144] Because health-related tobacco information is extremely important for an individual to make a rational well-informed health care decision (smoking or quitting smoking), more information (in addition to the toxic constituents of tobacco products and their emissions) should be readily available to the public.

Second, according to FCTC article 10, individuals are not entitled to access complete health-related tobacco information (from the state or from the tobacco industry) and can only access limited information that the tobacco industry decides to reveal. In other words, under

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[142] Framework Convention Alliance, *Civil Society Monitoring of the Framework Convention on Tobacco Control: 2007 Status Report of the Framework Convention Alliance* 85 (Geneva: Framework Convention Alliance, 2007).

[143] Andrew S. Nix, *Statutory Disclosure of Tobacco Ingredients: Secrets Up in Smoke?* 54 Ala. L. Rev. 1413, 1415 (2003).

[144] For example, Texas, Minnesota, and Massachusetts have required tobacco companies to disclose the identity of each added ingredient in order of weight, measure, or count. However, in Phillip Morris, Inc. v. Harshbarger, a cigarette manufacturer challenged Massachusetts's ingredient-reporting statute, and argued that the law forces them to reveal trade secrets. The court then faulted Massachusetts for failing to "identify any background principles of state law that successfully obviate [the manufacturers'] property interest in their trade secrets." Therefore, the disclosure statute in tobacco control remains a controversial issue and legislative action remains debatable in tobacco control issues.
Tex. Health & Safety Code Ann. §§ 161.351-.355 (Vernon 2001).
Minn. Stat. §461.17 (2001).
Mass. Gen. Laws ch. 94, § 307B (1997).
Philip Morris, Inc. v. Reilly, 312 F.3d 24 (2002).

the FCTC framework, an individual is not entitled to decide what information is essential for him or her to access. However, it is improper to exclude individuals from deciding what information is essential in tobacco product disclosures because individuals' final ends and aspirations are so diverse and the specific contents of the conceptions about good health are incommensurable. In addition, the data provided by the tobacco industry may not fully uphold the core principle of tobacco control. It is thus hard to argue that the FCTC has guaranteed an individual enough autonomy to make well-considered decisions about his or her health care affairs (smoking behavior).

Let us look at informed consent (e.g., what information must be revealed to patients and what may be excluded) as an example, which is broadly discussed in health care law[145] and bioethics literature.[146] Material medical information[147] that an individual should be assured to access is information that a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the information in deciding whether or not to forego the proposed therapy.[148] Thus, the government and/or professionals should not decide on the content of material information. Similarly, in tobacco control, individuals should grant the right to decide what health-related tobacco information is material for them. Or, at least, shared criteria, rather than arbitrary criteria identified by the government, should be established to determine what health-related tobacco information is "important" for the public to have in order to make an informed choice. In addition, because of the inequality of professional knowledge between the tobacco industry and the public, requiring the industry to disclose health-related tobacco information only to governmental authorities then not only

[145] See, e.g. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (the patient has the right to know the nature of his or her condition, the alternative treatment options, and the risk of his or her well-being that treatment involves.)
Johnson v. Kokemoor, 545 N.W.2d 495 (Wis. 1996) (The patient has the right to know the physician's experience.)
Truman v. Thomas, 27 Cal.3d 285 (Cal., 1980) (The patient has the right to know the risk of non-treatment).
Moore *v. Regents of the University of California*, 51 Cal. 3d 120 (Cal., 1990) (The patient has the right to know the physician's conflicts of interest.)
Araton v. Avedon, 5 Cal. 4th. 1172 (Cal. 1993) (The patient does not have the right to know the life expectancy.)
Neade v. Portes, 193 Ill. 2d. 433 (Ill. 2000) (The patient does not have the right to know the physician's interest with the health planner.)

[146] See e.g., Ruth Faden and Tom Beauchamp, *A History and Theory of Informed Consent* (Oxford: Oxford University Press 1986).
Stephen Wear, *Informed Consent: Patient Autonomy and Physician Beneficence within Clinical Medicine* (Boston: Kluwer Academic Publishers 1993).
Fay Rozovsky, *Consent to Treatment: A Practical Guide* (Frederick: Aspen Publishers 2005).
Peter Schuck, *Rethinking Informed Consent*, 103 Yale L. J. 899 (1993).
Cathy Jones, *Autonomy and Informed Consent in Medical Decision Making: Toward a New Self-Fulfilling Prophecy*, 47 Wash & Lee L. Rev. 397 (1990).

[147] The material medical information is much broader than health risks, and include reasonable medical alternatives, all proposed procedures, the risks of death and serious complications of each treatment option, the probability of success, and the physician's experience level, and etc.

[148] *Canterbury v. Spence*, 464 F.2d 772, 787 (1972).

prevent individuals from accessing important information in decision-making but also can increase power imbalance between the tobacco industry and the public.[149] Shared criteria, which guarantee both individuals' right to access health-related information and right to participation, then can help to ease this power imbalance.

Since FCTC article 10, which uses a vague form of tobacco product disclosures and contains very little mandatory contents, might fail to fully protect individuals' right to access health-related tobacco information, I propose to integrate the right to health into the FCTC mechanism. In other words, the right to health can be applied as a justification for the state's obligation to provide more specific and correct health-related tobacco information and to grant individuals entitlements to access such information.

It is important to advocate for individuals' freedom to access health-related information in tobacco control. It is also important to impose on the state a human rights obligation to inform the public on a broad range of health-related tobacco issues and to guarantee individuals' right to request and acquire information about tobacco products. Two reasons support this obligation. First, health-related tobacco information is closely related to individuals' health care decisions, and individuals should be guaranteed by law the right to informed participation in decisions involving their health (their bodies). Since tobacco consumption causes tobacco-related illnesses that can lead to disabilities and death, smoking (or not smoking) is then an important decision related to an individual's health. The individual thus needs adequate and sound information about smoking (and tobacco) to make well-considered decisions. Focusing only on health care of physical condition (e.g. tobacco cessation services) and circumstance (e.g. tobacco-free environment), excluding the more abstract ideals of empowerment and autonomy, would overlook the fact that restricting the freedom to receive and impart health-related information would restrict an individual's capacity to develop and exercise his or her health care decisions. Because people unable to obtain and absorb accurate information on the effects of smoking then are also denied the chance to control their health,[150] states thus should have the human rights obligation to inform or to educate the public about a broad range of tobacco health-related issues and make such information accessible to public. For example, these measures should include, at a minimum, the implementation of regulations requiring detailed or graphic health warnings

[149] George J. Annas, *The Rights of Patients: The Authoritative ACLU Guide to the Rights of Patients* 113 (New York: New York University Press 2004) (1989).
[150] Robin Appleberry, *Breaking the Camel's Back: Bringing Women's Human Rights to Bear on Tobacco Control*, 13 Yale J.L. & Feminism 71, 8 (2001).

on cigarette packages and the provision of public awareness campaigns.[151] Failing to provide this information in its tobacco control efforts, whether due to a lack of awareness or deceptive promotional techniques employed by the tobacco industry, would violate the internationally recognized right to access health-related information.

Second, health-related tobacco information strongly relates to the respect of individuals' autonomy. In the international human rights paradigm, the fundamental status of the freedom to access health-related information derives from the close connection between personal autonomy and receiving health-related information. Clearly, information equals power, and this holds true in the health care field. Therefore, scholars agree that the protection of autonomy should be a requirement in making well-informed decisions.[152] Thus, an individual's autonomous health behavior should be based on the premise that information is provided to an individual before making an important health-related decision. For example, with the absence of material health-related tobacco information, an individual cannot be expected to be capable of developing his or her conception of the good about tobacco consumption. In this example, even if the individual's autonomy to smoke is guaranteed, he or she still cannot make autonomous decisions because the individual has no information to help him or her to evaluate the trade-off between smoking and its possible consequences. It is unreasonable to expect an individual to make "autonomous" health care decisions regarding smoking if he or she is not cognizant of the risks of consuming tobacco products or of exposure to secondhand smoke. Therefore, not only an individual's actual choices but also his or her underlying essential capacities (access to health-related information)[153] should be at issue in tobacco control.

The fundamental status of the freedom to access health-related information then can further help us to clear up the myth that the tobacco industry, through effective lobbying, actively persuades the public to believe. The myth is that tobacco use is an individual

[151] Bridgit Toebes, *The Right to Health as a Human Rights in International Law* 234 (1999).
[152] Janet Dolgin and Lois Shepherd, *Bioethics and the Law* 47-49 (New York: Aspen 2005).
[153] For example, Nussbaum argues that basic capabilities should include (1) life (being able to live to the end of a human life of normal length, not die prematurely, or before one's life is so reduced as to be not worth living), (2) bodily health (being able to have good health, including reproductive health, to be adequately nourished, and to have adequate shelter), (3) bodily integrity (being able to move freely from place to place, to be secure against violent assault, including sexual assault and domestic violence, having opportunities for sexual satisfaction and for choice in matters of reproduction), and (4) senses, imagination, and thought (being able to use the senses, to imagine, to think, and to reason, and to do these things in a truly human way; being able to use one's imagination and thoughts in connection with experiencing and producing expressive works and events of one's choice, religious, and so forth; being able to use one's mind in ways protected by guarantees of the freedom of expression with respect to both political and artistic speech and freedom of religious exercise).
Martha Nussbaum, *Capabilities, Human Rights, and the Universal Declaration*, in Burns Weston & Stephen Marks eds., *The Future of International Human Rights* 44-45 (New York: Transnational Publishers 1999)

behavior choice and that tobacco illness is a lifestyle disease,[154] and that consequently, individuals should be held responsible for their unhealthy behaviors (smoking habits) and consequences (tobacco-related diseases). However, this argument basically assumes that individuals should be held responsible for their own choices and ends, regardless of the fact that, holding individuals morally responsible for their choices and antecedent behaviors (e.g., smoking or quitting smoking) also assumes that individuals act as if they can exercise their underlying knowledge to form, to revise, and to pursue their behaviors. Based upon empirical evidences, which show that many smokers in low- and middle-income are unaware of the health risks of smoking[155] and that individuals have no access to complete information about all ingredients (more than hundreds) used in tobacco manufacturers' products,[156] this argument (holding people responsible for their own smoking behaviors) is obviously misleading because it is based upon the erroneous hypothesis that smokers can access comprehensive health-related tobacco information, and are able to use the information to a make rational, well-informed decision (to smoke). Therefore, even though people should be held responsible for their smoking behavior, the state cannot ignore its positive responsibility to provide a certain set of circumstances (access to health-related tobacco information) to guarantee an individual's basic capabilities to make a rational decision.

In conclusion, based upon supra two reasons the state should have both FCTC and human rights obligations to guarantee individuals to access health-related tobacco information and education.

VI. Conclusion

The tobacco epidemic is fueled by different factors and thus indicates that the state should be responsible for addressing each factor as a violation of the right to health. The FCTC clearly reflects the belief that widespread tobacco use is an emergency public health issue[157] requiring firmer action from the state. But the use of hortatory rather than legal

[154] Cheryl Healton and Kathleen Nelson, *Reversal of Misfortune: Viewing Tobacco as a Social Justice Issue*, 94 Am. J. Pub. Health 186, 187 (2004).

[155] Economics of Tobacco Control, *Working Group of the WHO Framework Convention on Tobacco Control, 1st mtg.,* 8-9, WHO Doc. A/FCTC/WG1/2 (1999), available at http://www.who.int/gb/fctc/PDF/wg1/e1t2.pdf (last modified on July 23, 2008).

[156] Andrew S. Nix, *Statutory Disclosure of Tobacco Ingredients: Secrets Up in Smoke?* 54 Ala. L. Rev. 1413, 1415 (2003).

[157] In the traditional framework of the right to health, the core health-related issues are confined to serious infectious diseases, of which only a small number listed in the International Health Regulations (IHR). Thus, tobacco control has not been perceived traditionally as a high priority in public health policy or in the right to

statements, soft rather than hard laws, in the FCTC leaves states plenty of room to decide how and whether to implement tobacco control programs. Therefore, to prevent the FCTC's loose language and weak requirements from hampering the development of the tobacco control programs and protecting the public health, the fight against tobacco should be based not only on the implementation of the FCTC but also on states' human rights obligation to fulfill the right to health. By integrating FCTC mechanisms and human rights principles, this paper finds that tobacco control by states will more likely succeed in reducing the health threat by focusing on issues that the FCTC fails to regard (such as the provision of smoking cessation services, and the accessibility of more specific health-related tobacco information). In addition, by highlighting and applying human rights principles to this issue can help the society to better identify and address the state's violations of individuals' right to health. In conclusion, coordinating international human rights institutions with the FCTC to address tobacco-related health issues can help to highlight the state's role in derailing or promoting effective tobacco control initiatives, involve a broader range of participants in the debate about effective tobacco control strategies, and ultimately create a comprehensive and solid foundation for effective tobacco control policy.

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