Chapter - I
Introduction

ABSTRACT
Public health is “the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals.” –

Charles-Edward Amory Winslow
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1. INTRODUCTION

Health, According to the World Health Organization (WHO), “is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹ Further, the Universal Declaration of Human Rights (UDHR), outlined that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family.² But the larger question remains as to what produces health? According to Lawrence O Gostin, there is no definitive answer to that question. However, three overlapping interventions can be mentioned in this regard i.e. health care, public health and broader socio-economic determinants of health.³ In the last century health largely meant and health interventions mostly focused to

² Universal Declaration of Human Rights Article 25: 1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. 2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.
health care – providing primary, secondary and tertiary medical/hospital services. The basic idea of providing health care was centred on the individual’s, society’s and states’ response in treating the individual who become ill or injured.

On the other hand, public health "refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease." The term “public” in public health denotes both the entity that takes the responsibility of the public’s health i.e. the government and also the population at large who has a legitimate expectation of receiving the benefits. As Madison and Ruth puts it, social justice is the foundational moral justification for public health. they go on to define public health as the social institution charged with promoting human welfare by bringing about a certain kind of human good, the good of health. The moral ground for public health thus remains a general obligation in beneficence to promote good or welfare, and the extent may lie from a utilitarian commitment to bringing about as much health as possible for all.

Whatever the definitions and general understanding of public health, it is abundantly established over the period of time that improving public’s health

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requires contribution of many people in many different walks of life. It is virtually everybody’s business. From doctors, engineers, politicians, professionals, policy makers to the members of public. The health for all strategy of the WHO in 1978 recognised that the solutions to ill health did not lie in health care alone and proposed comprehensive collective approach to improving health. It was taken a step further by the Ottawa Charter in 1986 which identified five key areas for action:

1. Building healthy public policy
2. Creating supportive environments
3. Strengthening community action
4. Developing personal skills
5. Re-orienting health services

The Ottawa Charter provided a useful backdrop to the development of health promotion as an integral part of public health. It has been defined as any activity that promotes health and such activity is focused on the social, economic and environmental determinants of health.7

Another important aspect that determines health is the overall economic inequality in a society i.e. societies with wide disparities between rich and poor tend to have worse health status than societies with smaller disparities. The World Health Organization’s Commission on Social Determinants of Health concluded, “the social conditions in which people are born, live and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and miserable one.” It can be said that social equity and justice cannot be achieved unless illness and health

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figure as a major concern and thus, health equity cannot be concerned only with health, seen in isolation.

As Nobel laureate Prof Amartya Sen puts it, “health equity is most certainly not just about the distribution of health, not to mention the even narrower focus on the distribution of health care. Indeed health equity as a consideration has an enormously wide reach and relevance.” According to the WHO Commission on Social Determinants of Health, in different countries, at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health. Where these differences are avoidable through reasonable action they are unfair and amount to health inequity. Putting right these inequities – the huge and remediable differences in health between and within countries – is a matter of social justice and reducing health inequities is an ethical imperative. Social injustice is killing people on a grand scale.

Though states and individuals across the globe have become more connected, rather inter-dependent due to globalisation, the promised benefits of globalization have not reached to the marginalised rather contributed to marginalisation of certain group of individuals, population and economies. Globalization has only widen the health inequality across the globe both among and within countries. Among other things, it has impacted population health by affecting quality of health services, environmental

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contamination and adoption of new lifestyles.\textsuperscript{10} This has also led to the erosion of local autonomy and national sovereignty with greater reliance and dependency on liberal, free-market economics. The divide has been increasing and consequently the patterns of health and the prevalence of diseases has changed significantly. While hitherto causes of mortality and morbidity are declining and being successfully tackled, the market driven economy has imposed a marked change in the way people eat, drink and live. Consequently, Un-healthy diet, physical inactivity, alcohol consumption and high levels of tobacco use have presented a larger breed of serious health concerns collectively called as non-communicable or 'lifestyle' diseases (NCDs).\textsuperscript{11}

In the past century most of the countries suffered from the epidemic of communicable diseases. This was also reflected in the priorities of the countries in global trade while negotiating the General Agreement on Tariffs and Trade (GATT), as the primary focus of the public health practice was infectious disease. This continued even when GATT was included in the Marrakesh Agreement establishing the World Trade Organization (WTO). However, the increased competition and lower prices, as a consequence of open markets, stimulate consumption of harmful products with correlative increase in associated morbidity and mortality due to NCDs.\textsuperscript{12} This has been the greatest negative health consequence of trade liberalisation. Several trade and health experts have examined this phenomenon and concluded that trade liberalisation has led to increased smoking, particularly in low and

\textsuperscript{11} Ibid.
middle income countries (LMICs).\textsuperscript{13} Though, the proponents of free trade claim that it will help everyone as the growth from increased trade will be shared and will improve people's lives. But they have not been able to answer the fundamental question of how to formulate trade policy to simultaneously achieve growth and benefit health.\textsuperscript{14}

Public health cannot be confined to local or national arenas. A shrinking world in terms of economic development and improved communications brings with it new public health challenges. Public health problems are no respecters of local or national boundaries. Whether it be HIV/AIDS, drug abuse, NCDs, toxic waste disposal or global warming; collective global responses are required to deal with these multi-national problems. Therefore, it is critical for institutions and international agreements to focus not only on illness but also on the essential conditions that enable people to stay healthy throughout their lifespan: nutrition, clean water, mosquito control, and tobacco reduction.\textsuperscript{15}

Most of the developing world is going through a transitional period of urbanization, industrialization and growth on the one hand and another transition in public health and wellbeing in addressing the emerging vector born and infectious diseases to escalating incidence of non-communicable diseases related to lifestyles. Although, over the years the high burden of public health diseases has been addressed through health promotion,
specific protection and rehabilitation, but an important function that needs to be more deeply looked into, is formulation of regulations, laws and policies that advance public health. As per WHO, “Medicine or curative services is not the only contributor to health and well-being of population”, it is the right to good health and right to minimum conditions to enable individuals to enjoy this right and provide primary health services in an equal and fair manner (Universal Declaration on human rights).

The emergence of a global economy has led to the erosion of local autonomy and national sovereignty with an associated emphasis on the spread of liberal, free-market economics. This is creating a clear divide between those benefiting from and those disadvantaged by this process. The most serious and unintended consequence of this process if the change in the patterns of health and the prevalence of disease. While infant mortality may be declining the changes in diet, alcohol consumption and high levels of smoking have resulted in steep increase in 'lifestyle illnesses'.16 The global burden of disease due to NCDs is escalating, principally due to a sharp rise in the developing countries which are experiencing rapid health transition in the wake of globalisation and urbanisation. Altered diets and diminished physical activity are critical factors contributing to the acceleration of NCD epidemics, along with increase in alcohol abuse and steep rise in tobacco use in these countries. A comprehensive public health response must integrate policies and programmes that effectively impact on the multiple determinants of these risk factors and provide protection over the life span through primordial,

primary and secondary prevention. Populations as well as individuals at risk must be protected through initiatives that espouse and enable strategies to prevent, protect and promote public health.

The increasing global crisis in NCDs has been identified as one of the greatest barrier to achieving the development goals. In 2011, the Lancet\(^\text{17}\) NCD Action Group and the NCD Alliance\(^\text{18}\) chose tobacco control as the most urgent and immediate priority intervention to reduce the global NCD burden. It proposed as a goal for 2040, a world essentially free from tobacco where less than 5% of people use tobacco. If widely adopted, tobacco control interventions will achieve the global goal of reducing NCD death rates by 2% per year, averting tens of millions of premature deaths in this decade. The seriousness of NCD burden due to tobacco use is reflected in the adoption of international instrument such as the WHO Framework Convention on Tobacco Control (FCTC) in 2003. The UN High Level Meeting on NCDs held in September 2011 also highlighted the need for curbing tobacco use globally to prevent NCDs. The Political Declaration thereat (the UN General Assembly Special Session on NCDs) called member countries to fully implement the WHO-FCTC to achieve the desired goal of reduction in NCDs globally. The global goals for Sustainable Development adopted last year by the UN General Assembly include the health goal of ‘ensuring healthy lives and promoting well-being for all at all ages.’ The goal inter alia propose to reduce a third of premature deaths from NCDs and to this effect calls for strengthening implementation of the

\(^{17}\) The Lancet is a leading UK journal. It is one of the world's oldest and best known general medical journals.

\(^{18}\) NCD Alliance unites 2,000 civil society organisations in more than 170 countries, dedicated to improving NCD prevention and control worldwide.
WHO FCTC as one of its targets. This makes it clear that implementation of FCTC is at the Core of the Global Development Agenda (See Fig-1.1 below).

**Figure-1.1: FCTC at the core of SDG 2030**

### 1.1. Why Tobacco is a Threat to Development

#### 1.1.1. Threat to Environment

The environmental impact of tobacco use merits a mention given the growing worldwide concern about environmental degradation and global warming. Tobacco cultivation is responsible for deforestation, soil erosion and much faster depletion of soil nutrients and water.\(^{19}\) Large quantities of wood fuel need to be burnt for ‘flue-curing’ tobacco.\(^{20}\) Several harmful chemicals and pesticides used in tobacco cultivation can enter into food


chain and thereby cause adverse health effects among humans.\textsuperscript{21} Tobacco is also a water-intensive crop and its cultivation can aggravate water shortages.\textsuperscript{22,23} Moreover smoked tobacco products are frequently the cause of fire which causes loss of life, property and forestry.\textsuperscript{24} Environmental pollution also results from tobacco smoke, spitting of smokeless tobacco, inappropriate disposal of cigarette butts and plastic packs for smokeless tobacco.\textsuperscript{25,26,27}

1.1.2. Threat to Poverty

In most countries, tobacco use is more prevalent among the poorer sections of the society and among those with no or little education.\textsuperscript{28} Strong evidence links poverty, lack of education and other social determinants to NCDs and their risk factors including tobacco use.\textsuperscript{29} Besides, lower the socioeconomic position, the worse is the health outcomes.\textsuperscript{30} Among LMICs of South-East Asia and Middle East expenditures on tobacco use vary from 10% of

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household expenditure to as much as 10 times more than the amount spent on education.\(^\text{31}\)

### 1.1.3. Threat to Farmers and Workers

Workers in the tobacco industry, who include children and women, often suffer from ‘Green Tobacco Sickness,’ which raises the issue of labour rights as they often remain devoid of treatment. Similarly, millions of poor and illiterate beedi rollers in South East Asian countries including India and Bangladesh have been exploited by contractors and left disabled in old age.\(^\text{32}\) Tobacco companies have been infringing the rights of the farmers and workers globally by subjecting them to deplorable working conditions and treating them as slave labour.\(^\text{33,34}\)

### 1.1.4. Threat to Food

About 4.2 million hectares of land that could be used for other crop production are presently diverted for tobacco production.\(^\text{35}\) In a world where food insecurity is affecting millions and the UN Secretary General calls for a doubling of food production, the use of arable land for tobacco production rather than for nutrient crops is unacceptable.

### 1.1.5. Threat to Human Rights

Every individual has “a right to the enjoyment of a variety of facilities, goods and services and conditions necessary for the realisation of the highest


attainable standard of health."\textsuperscript{36} Exposure to SHS is very common among spouses and children of smokers and infringes on their right to health. Imposing complete prohibition on smoking in public places in India, the Supreme Court of India observed exposing unsuspecting individuals to SHS, with ominous consequences, amounts to taking away their life, by a slow and gradual process and labelled it as violation of the right to life enshrined under Article 21 of the Constitution of India.\textsuperscript{37} Recent evidence on epigenetics suggests that active or passive exposure to tobacco smoke can have trans-generational effects on risk of disease, thereby threatening the rights of more than one generation.\textsuperscript{38} Tobacco contravenes the rights enshrined in the Universal Declaration of Human Rights, Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and Convention on the Rights of the Child (CRC).\textsuperscript{39} Tobacco control as a human rights concern has long been identified as area of action by the National Human Rights Commission in India.

1.1.6. Tobacco and NCD burden

NCDs account for 62\% of all deaths in India and one of four Indians are at risk of dying of NCDs before 70 years of age.\textsuperscript{40} Among the major risk factors for NCDs, tobacco use is a leading cause of premature death and disability: more than one million people die annually. Despite a decline in smoking prevalence among men over recent years, prevalence among women and

\textsuperscript{37} Murli S. Deora v. Union of India, WP 316/1999 (2001.11.02)
\textsuperscript{38} Perera F, Herbstman J. Prenatal environmental exposures, epigenetics, and disease. Reproductive toxicology 2011;31:363-373.
\textsuperscript{40} Global Burden of Disease-2015
A Thesis Submitted by Amit Yadav for the Award of Ph.D. Degree in Law

Public Health, Tobacco and International Trade and Investment Treaties of India: A Constitutional Analysis

Chapter I: Introduction

youth has remained constant.\textsuperscript{41} To deal with the rising burden of NCDs, primarily related to tobacco use, keeping with the global developments, the Government of India enacted the Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act 2003 (COTPA), and also ratified the WHO-FCTC in 2004. The national tobacco control law consists of provisions such as smoke-free public places, prohibition on advertising, promotion and sponsorship, ban on sale to and by minors and around educational institutions and specified pictorial health warnings on tobacco packs. To effectively implement the national and global tobacco control laws the government started National Tobacco Control Programme (NTCP) in 2007. In 2011 at the UN Summit on NCDs, the Indian Government pledged action to tackle the NCD epidemic and has since adopted a National Action Plan and Monitoring Framework for Prevention and Control of NCDs and set specific national targets: to reduce the number of premature deaths from NCDs by 10\% by 2020 and by 25\% by 2025.

The primary focus to achieve the NCD targets is to reduce current tobacco use by 15\% by 2020 and by 30\% by 2025. In 2015, India also signed up to reduce NCDs by a third by 2030 to help achieve the UN SDG 3 on health, by strengthening implementation of the FCTC in the country. The Government of India have begun to use measures such as taxes, restrictions on marketing, product regulation, and labelling measures, including pictorial health warnings on tobacco products to meet its public health objectives. This research is set to examine if and to what extent the international trade

\textsuperscript{41} Global Burden of Disease-2015
law, as implemented under the aegis of the World Trade Organization, restrict India’s capacity to implement such public health measures regulating trade in tobacco. The study, in particular, examines the trade and investment agreements of India and its impact on tobacco control. The relationship and common grounds among the WTO Agreements, international health instruments, the domestic laws, in particular the Constitution of India besides the judicial decisions have been examined. It also reviews decisions of the WTO dispute settlement body and awards from the arbitration tribunal on investor state disputes to examine the relevance and reliance upon public health in such forums, in particular on the WHO FCTC in matters involving trade in tobacco. The study envisions addressing the issue of trade from a public health, specifically in the context of tobacco control, and constitutional perspective at a time of heightened global interest in the matter.

1.2. PURPOSE OF THE RESEARCH

The purpose of the research is highlighted in the title of the research i.e. “Public Health, Tobacco and International Trade and Investment Treaties of India: A Constitutional Analysis.”

Why public health: Unlike ‘health’ which is an aspirational condition of individual or ‘health care’ which is about making provision for treatment and maintaining a medical condition of an individual or a community; “public health” includes all efforts made by individuals, community and the government for protecting and improving the safety and health of individual and communities through promotion of healthy lifestyles, disease and injury prevention and detection and control of such diseases. Keeping with the
adage of ‘a stitch in time saves nine’ or as they say ‘prevention is better than cure’, ‘public health’ is all about prevention and promotion of health through all possible means including legal and policy intervention as may be required.

Why tobacco: India is the second largest producer and consumer of tobacco in the world.\textsuperscript{42} Tobacco use leads to 1.2 million deaths in India and this figure is expected to rise to 1.5 million by the year 2020.\textsuperscript{43} Of these deaths, about 10% are caused due to exposure to second-hand smoke.\textsuperscript{44} Five thousand five hundred children take up tobacco use every day in India.\textsuperscript{45} Prevalence of any tobacco use in India varies from 14.6% among youth,\textsuperscript{46} to 35% in adults (48% in males and 20% among females).\textsuperscript{47} Tobacco control in India is further complicated due to the myriad varieties of tobacco products (smoking forms and smokeless forms) and tobacco packs available. Tobacco is the only legally available product that kills half of its customers if used as intended by its manufacturers. It is the greatest public health threat of our times that kills more people every year than HIV/AIDS, malaria and road accidents put together.

Why trade and investment treaties: This colossal burden on public health is largely due to globalisation of tobacco trade and allowing foreign

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\item \textsuperscript{43} ITC Project. \textit{TCP India National Report. Findings from the Wave 1 Survey (2010-2011)}. University of Waterloo, Waterloo, Ontario, Canada; Healis-Sekhsaria Institute for Public Health, Navi Mumbai, India. 2013.
\item \textsuperscript{47} International Institute for Population Sciences (IIPS) and Ministry of Health and Family Welfare, Government of India. \textit{Global Adult Tobacco Survey (GATS) India 2009-2010}. New Delhi: IIPS, MoHFW, Gol, CDC, WHO. 2010.
\end{itemize}
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investment in such demerit good, which has resulted in its proliferation in the country. It is estimated that the number of smokers in the country have trebled by 2015 when compared to 1998. The leading global agency on health i.e. WHO unequivocally suggests that trade liberalisation and opening up of markets have contributed to increase in tobacco use in hitherto closed economies.\textsuperscript{48} It has also resulted in greater price and product competition and aggressive marketing among new and existing players in the market.\textsuperscript{49}

In addition, the tobacco industry has a history of using international trade agreements to force open new markets in low and middle income countries, greatly increasing tobacco use and the consequent death/disease it causes. These big companies also challenge measures to reduce tobacco use as violations of trade and investment agreements. The tobacco industry challenge to the Australian plain packaging (Tobacco companies resorted to investment protections under Australia-Hong Kong investment agreement for proving that the plain packaging norms were against the best interest Australia and would require Australia to pay hefty amount of compensation for appropriation of the trademark and intellectual property rights over the tobacco packs.\textsuperscript{50}) and Uruguay’s decision to introduce larger graphic warnings before investor-state dispute settlement tribunals with claim of billions of dollars are meant to intimidate and discourage other countries.


from taking such strong, effective and evidence based tobacco control measures.

**Why a constitutional analysis:** Such industry tactics questions and intend to derail and defeat the very public health purpose of the laws in the country. Such a challenge primarily runs contrary to the fundamental right of the citizens to health as stipulated under the Constitution of India. Being a student of the law, the researcher aims to undertake a critical review of international trade and investment treaties of India in reference to the constitutional mandate on right to health and right to trade. The researcher also examines the constitutional provisions for treaty-making in India and the obligation to respect international treaties in reference to ensuring compliance with the treaty obligations under WHO FCTC and the WTO agreements.

**1.3. STATEMENT OF THE PROBLEM**

Considering the sheer magnitude of the public health burden due to trade interests, like tobacco, it is imperative to take a more definitive view on the promotion of such trade or trade practices. State is under a constitutional obligation to ensure the health and wellbeing of its citizens and must protect the present and future generation from the colossal burden of tobacco use while ensuring uninterrupted enjoyment of right to health as enshrined under the Constitution of India. However, given the trade and economic aspects around tobacco, a product that is identified as the greatest public health burden responsible for several non-communicable diseases, it continues to be legally sold in the country. Ironically, the industry responsible for
promoting such deadly product claims to be treated at par with other consumer goods available in the market in terms of constitutional restrictions on its trade besides tax and tariff advantages under trade and investment treaties. The problem being dealt in this study is two-fold; firstly, whether there is room for ensuring inviolability of public health measures under the international trade regime, and if so, whether the existing trade and investment treaties entered to by India provide such protection against implementation of tobacco control measures under international and national tobacco control laws. Secondly, the study attempts to review the constitutional position related to freedom of trade and protection of right to health along with judicial decisions to this affect and assess if the Constitution of India *per se* and post judicial review contemplates a binding character of right to health over that of freedom to trade in the country. In light of the above the key issues of the problem may be stated as below:

i. Relation between trade and public health often becomes a contentious issue while implementing domestic and international public health measures in the face of a trade or investment commitment or priority under treaty obligations.

ii. Industry interferences and intimidation against public health measures aimed at reducing tobacco use and its burden are aimed to delay, dilute and at times defeat the very purpose of such public health laws, regulations and policies.

iii. Tobacco industry is increasingly using international trade and investment treaties and domestic trade laws and litigation or the threat of litigation to delay and undermine implementation of the
public health measures enshrined under the WHO FCTC or a national tobacco control law.

iv. As the legal principle goes, ‘Nemo debet esse judex in propia causa’ i.e. ‘no one ought to be a judge in his own cause’; interference of tobacco industry with tobacco control policies is anathema to fundamental principles of rule of law and must be prevented. Being the very vector of tobacco induced death and diseases tobacco industry is at the root of the problem. It is therefore, unequivocally stated in the WHO-FCTC Article 5.3 to keep the commercial and other vested interests of the tobacco industry away from public health policies concerning tobacco control. This must be upheld in practice under the domestic tobacco control laws.

v. Aggressive marketing both direct and indirect of product known to be hazardous and harmful to health by the tobacco industry and demand for favourable treatment under trade treaties is inimical to the constitutional protection to public health of Indian citizen.

vi. The most common challenge to public health ride on the most unlikely premise of violation of Article 14 and infringement of the fundamental freedoms under Article 19 (1) (a) and 19 (1) (g) by extending economic and trade arguments. Economists have repeatedly warned against them, NGOs have fought them, and some governments have begrudgingly (at least in appearance) signed them. Yet, in the last twenty years the growth in number of trade and
investment agreements has been unabated.\(^{51}\) In this regard, the researcher feels that the existing national and international policy framework concerning trade and investment agreements must be evaluated in terms of their commitment to economic gains or public health concerns. In particular the researcher envisions studying the problems in execution of trade and investment agreements which are driven by commercial interests and examine if there are any reflexion of key concerns of public health in such negotiations.

According to estimates released by the Ministry of Health and Family Welfare, Government of India, tobacco related diseases in the country posed a humongous burden of Rs. 1,04,500 crore in 2011. Globally, about 150 million people suffer financial catastrophe annually, and 100 million, about 15 million only in India, are pushed below the poverty line as a result of health care expenditures due to tobacco use.\(^{52}\) According to a recent report by the World Economic Forum and the Harvard School of Public Health, India stands to incur a cost of US $4.58 trillion between 2012 and 2030 due to NCDs, this is more than double the country’s GDP.\(^{53}\) It may be fair to say that the economic growth alone is not the sole indicator of development as adverse health outcomes are greater threat to development, especially tobacco related disease burden, its health care cost, social cost, cost to environment (related to deforestation, waste management etc.) act as huge


constraint to development. It is in this regard that there is a felt need to assert the significance of public health and public health laws e.g. consideration of tobacco control laws in the overall national and international trade and investment regime.

There appears to be a conflict between the commercial and economic interest under the trade agreements vis-à-vis its direct impact on health outcomes and incidental health burden. The fundamental problem, therefore, is whether trade rights take precedence over health rights or vice-versa. It is important to study the *a priori* constitutional design and mechanism to harmonise health and trade rights of citizens while analysing the processes, practices and patterns in the existing and proposed trade and investment agreements. The Inter-Country Consultations of WHO South East Asia Region Member Countries on ‘Tobacco and Trade’ held in New Delhi during 3-4 October 2012 inter alia recommended that “Research in the area of tobacco and trade should be promoted and information thereon disseminated.” The researcher, thus, envisions examining the following key problems related to tobacco and trade vis-à-vis its impact on public health:

i. Considering the colossal public health burden of tobacco trade it is imperative to take a more definitive view on the promotion of such trade or trade practices through trade and investment agreements.

ii. There is a need to examine the existing national and international legal framework concerning trade and investment agreements in terms of their economic gains vis-à-vis public health burden.
iii. Understand and examine the surrounding environment (legal, constitutional and judicial) with negotiation, execution and implementation of a trade and investment agreement.

iv. Lack of co-ordination and co-operation between various ministries and their departments, acts as a deterrent to effective tobacco control. It is imperative to take an integrated approach for a harmonious construction of the commercial and public health interests in trade treaty negotiations and their implementation.

v. Tobacco is a biggest threat to development and there is glaring consequences of ignoring this threat to both development and public health both at a macro level and specifically in trade negotiations.

vi. Need to assess if there is any conflict between the existing trade and investment agreements and right to health and the fundamental problem that challenges any public health law scholar is whether there exists any constitutional preference in favour of trade rights over health rights or vice-versa.

In light of the above, the researcher envisions investigating these problems in the context of the trade and investment agreements entered by India in relation to other international obligations under the trade and the health law regime besides the corresponding mandates under the Constitution of India.

1.4. BACKGROUND INFORMATION AND LITERATURE REVIEW

The WHO definition of health\(^54\) is now progressively interpreted to include ‘socially and economically productive life,’ thus moving to a more humane

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\(^54\) Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by
perspective of ‘well-being’ compared to a mere biological and pathological condition. This is more evident and strongly reaffirmed in the very first Para of the Alma-Ata Declaration of 1978\(^{55}\) that;

“[H]ealth, which is a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector”

A nineteenth century German physician Rudolph Virchow had said: ‘Medicine is a social science, and politics nothing but medicine on a grand scale.’ In the present-day globalised society, one must understand the social implications and the over-arching role of law in advancing public health.\(^{56}\) Article 25 of the Universal Declaration on Human Rights recognised the multiple aspects of public health and wellbeing as fundamental to one’s human rights:

*Article 25. (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the*


event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

All subsequent Human Rights Treaties under the aegis of the United Nations recognized the right of everyone to enjoyment of the highest attainable standard of physical and mental health. Over the last few decades there have been consistent legal interventions to address public health concerns. In the 21st century, health is conceived as a shared responsibility and several national and international organizations including the World Health Organization, International Committee of the Red Cross and international instruments including Universal Declaration of Human Rights, the Declaration of Alma Ata, the International Covenant on Economic, Social and Cultural Rights have emerged to support the governments in their efforts to expand the spectrum of effective public health strategies. Several issues relating to nutrition, tobacco control, occupational health, motor vehicle and road safety have been addressed by legislations, international monitoring, regulatory enforcement, litigation or a combination of them.

The Constitution of India, inter alia, sought “justice-social and economic” for the citizens57 and amplified and elaborated the objective in the Directive Principles of State policy. Though the Constitution of India does not prescribe a fundamental right to health, it recognizes the right to life and

57 Preamble to the Constitution of India 1950.
liberty of every individual and the Indian judiciary gave new and progressive
dimensions to Article 21 to include ‘right to live with dignity’. The realization
of this right though, per se, depends on one’s health and wellbeing,
therefore, making right to health an indispensable part of right to life. The
Indian judiciary has time and again vindicated this fact in plethora of its
decisions and called for a legal recognition to right to health as an integral
part of the fundamental right to life and relying on international human rights
treaties, considered right to health as a fundamental right.\textsuperscript{58} A progressive
example can be seen in the Constitution of South Africa, in its Bill of Rights,
that expressly declares access to healthcare, food, water and social security,
besides emergency medical treatment, as the fundamental rights of
individuals.\textsuperscript{59}
The preservation of public health is among the most important goals of
governments and law can serve as an effective tool not only at the individual
level but also at a larger community level.\textsuperscript{60} A basic reading of the
Constitution of India suggests that ‘public health’\textsuperscript{61} is a subject matter of
legislation for the states.\textsuperscript{62} However, very few states in India have crafted
laws with regard to comprehensive public health and wellbeing.

\textsuperscript{58} CESC Ltd. vs. Subash Chandra Bose, AIR 1992 SC 573,585
\textsuperscript{59} Article 27 of the Constitution of South Africa: 27. Health care, food, water and social
security
Everyone has the right to have access to
health care services, including reproductive health care;
sufficient food and water; and
social security, including, if they are unable to support themselves and their dependants,
appropriate social assistance.
The state must take reasonable legislative and other measures, within its available
resources, to achieve the progressive realisation of each of these rights.
No one may be refused emergency medical treatment.
\textsuperscript{60} Gostin, L.O. (ed). Public health law and ethics: A reader. California: University of
\textsuperscript{61} Entry 6 of the State List under Schedule VII. Constitution of India 1950.
\textsuperscript{62} Article 243 (3) Constitution of India 1950.
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One of the greatest threat to public health globally is tobacco. Tobacco, considered as the most profitable cash crop globally and marketed by top grossing Multinational Corporations of the world, kills half of its users. Once a problem primarily, in high-income countries, disease and death from tobacco use has increasingly become a burden for developing countries as well.\textsuperscript{63} The World Health Organization estimates that if current rates continue, tobacco will kill more than 8 million people every year by 2030, with four out of five of these deaths occurring in low and middle-income countries.\textsuperscript{64} In India, more than one million deaths annually are attributed to smoking alone.\textsuperscript{65} Tobacco use contributes to approximately 60% of all Cardio-Vascular Diseases deaths in India,\textsuperscript{66} and 42% and 18% of cancer deaths among men and women respectively are due to tobacco use.\textsuperscript{67}

Tobacco use is not only a health burden, as huge economic losses are incurred due to massive expenditures on the treatment of diseases caused from tobacco use.\textsuperscript{68} It is estimated that direct expenditures on tobacco use and out of pocket expenditures on health care cost, which otherwise could be spent on food or education for children, impoverishes roughly 15 million people in India.\textsuperscript{69}

\textsuperscript{64} WHO. MPOWER.2008
\textsuperscript{67} Rajesh, D. et al., Cancer mortality in India: a nationally representative survey. The Lancet, Published online March 28, 2012 DOI:10.1016/S0140-6736(12)60358-4
Yet, India is the third largest producer and second largest consumer of tobacco, according to the Global Adult Tobacco Survey India Report (GATS-2009-10), there are nearly 275 million tobacco users in India (47% male and 20% female) and this number is increasing at an alarming rate, especially among vulnerable populations including women and the youth.\textsuperscript{70} As per the Global Youth Tobacco Survey 2009 (India), 14.6% of youth (13-15 years) use tobacco in some form (GYTS-2009) whereas, sixth grade students are two to four times more likely to consume tobacco as compared to eighth grade students.\textsuperscript{71} Gender gap is narrowing with more young girls starting to use tobacco.\textsuperscript{72}

To deal with the problem, as early as 1948, Sardar Bhopinder Singh Man proposed putting the word "tobacco" between the words "drinks" and "drugs" in Article 47 of the Constitution of India, during the debates of the National Constituent Assembly in 1948.\textsuperscript{73} His motion, unfortunately, was rejected by


\textsuperscript{71}\textsuperscript{71}Reddy, K.S., Perry, C.L., Stigler, M.H., and Arora, M. Differences in tobacco use among young people in urban India by sex, socioeconomic status, age, and school grade: assessment of baseline survey data. The Lancet. 2006;367(9510):589-94.


\textsuperscript{73}\textsuperscript{73}Sardar Bhopinder Singh Man (East Punjab: Sikh) while moving his amendment motion in the Constituent Assembly on November 24, 1948 said, "Mr. Vice-President I would like that where these words, namely, "Drinks and drugs" occur, the word "tobacco" also be added between them. Mr. Vice-President, I am aware that in moving this amendment; I would be incurring the displeasure of the influential members of this House and I also feel that I am going against the temper of the majority. In reminding Mr. Tyagi regarding this omission I am submitting it after judging it according to the test laid down by him. He has made out two points, namely, to prohibit those intoxicants that are bad and dangerous for health. Judging by this test we should see whether it can be classified as an intoxicant or not, or whether it is harmful to health. I have no doubt that tobacco is an intoxicant and is more harmful to health than liquor. This is the considered opinion of the medical men that tobacco has nicotine - a poison - most harmful to health. Take the villagers; they get liquor only off-and-on, but they smoke tobacco day and night, and due to their indolence they let suffer even their important tasks. As far as the economic aspect is concerned, I can assure you that much greater loss is incurred on account of tobacco than by liquor. Not only lakhs but crores of rupees annually flow out of the country on this account. When it is realised that tobacco is...
A comprehensive law on tobacco control was enacted by the Indian Parliament, 55 years later, only in 2003. The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 (COTPA) completely prohibited advertisements of all tobacco products and provided the framework for effective regulation of both smoking and smokeless tobacco products.

Global efforts to curb tobacco use resulted in the adoption of the first global public health Treaty under the aegis of the WHO in the form of the Framework Convention on Tobacco Control (WHO-FCTC) in 2003, which is in force since February 27, 2005. India was the 8th country to ratify the Treaty.

Director-General of WHO, Dr Margaret Chan, observed that the tobacco industry is increasingly using litigation or the threat of litigation to delay or undermine implementation of the FCTC. This includes challenges brought in both domestic (such as constitutional challenges) and at the international fora (action by tobacco companies against sovereign nations under bilateral treaties).

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74 Article 47 of the Constitution of India, 1949 states “Duty of the State to raise the level of nutrition and the standard of living and to improve public health The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavor to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health”.

investment treaties for taking effective tobacco control measures e.g. Industry backed suits against Australia under Australia-Hong Kong BIT and Uruguay under Uruguay-Switzerland BIT). In addition to litigation brought by the tobacco industry, several member states of FCTC have raised concerns about the trade implications of tobacco control measures in the WTO Technical Barriers to Trade (TBT) Committee and Trade-related Aspects of Intellectual Property Rights (TRIPS) Council (a record number of 40 countries, including the complainants, have impleaded themselves in the WTO dispute challenging the plain packaging decision of Australia). With states’ regulatory sovereignty regarding tobacco increasingly being challenged in local and international courts and tribunals, the questions relating to the capacity of governments to regulate tobacco products and the tobacco industry represents a critical constitutional and public health challenge.76

Indonesia has successfully challenged the US restrictions on flavoured cigarettes under WTO law, and the Ukraine, Honduras and others have initiated consultations in the WTO against Australia’s world-first plain packaging measures. As Dr Chan said: ‘The high-profile legal actions targeting Uruguay, Norway, Australia, and Turkey are deliberately designed to instil fear in countries wishing to introduce similarly tough tobacco control measures. What the industry wants to see is a domino effect. When one country’s resolve falters under the pressure of costly, drawn-out litigation

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and threats of billion-dollar settlements, others with similar intentions are likely to topple as well.\textsuperscript{77}

Tobacco control measures have been the subject of litigation in Indian courts over the last decade, however, the basic issue to be considered for realization of one’s right to health, in the given context, is the existence of conflicting constitutional and legal rights. The right to trade in tobacco versus right to protection of health are at loggerheads with the tobacco industry challenging every tobacco control effort in the country. The basic premise of the challenge being alleged discriminatory policy in violation of Article 14, infringement to freedom of speech and expression under Article 19 (1) (a) and a breach of the freedom to carry on any trade or business under Article 19 (1) (g).

The conflict of interest between ‘trade’ and ‘health’ was not so explicit in the pre-liberalisation era of the India economy. However, with the increased engagement with the global trade and investment regimes and opening up of the Indian markets to the transnational corporations resulted in greater incongruence with increased trade versus health divide in India. With increased commitment at the WTO, India has signed almost about 100 bilateral and multilateral trade and investment agreements in the past few decades. More than ever, the trade policy of the country significantly affects the day to day lives of the common man today, impacting not only the food habits and lifestyle but also access to treatment and medicines directly. However, this economic growth is not free from its own side effects with

more than ever increasing income, social, gender, demographic and above all health inequalities across the country. There is evidence to suggest that the poorer sections of India were actually further marginalised under the neoliberal economic regime introduced in India in the early 1990s.\(^78\)

It is to be noted that a state’s duty under international or domestic trade law can potentially conflict with its duties pertaining to right to health under another international human rights law or under the national constitution. Government’s should be cognizant of the distinct obligations under the two set of treaties and legal obligations and respect individuals and the communities right to health, limiting not only to their own citizen, but in other jurisdictions as well. States must ensure that any trade or investment agreement or trade policy does not run contrary to or adversely affect the right to health of its citizen. They should not promote a trade deal, or enforce existing trade rules, in a way that undermines the enjoyment of health rights in their own and other states.\(^79\)

In this context, it is important to look at some of the trade agreements including the Trans Pacific Partnership Agreement (TPPA) under negotiation between New Zealand, Australia, the USA and nine other countries. The Agreement is significant from the point of view that it has considered keeping tobacco out of the preview of the dispute settlement body under the Agreement. Tobacco control groups called for a total exclusion of tobacco from trade agreements, including from tariff reductions. While they did not achieve this in the TPPA, they were able to


get a carve out of tobacco control measures from TPPA investor-state claims.\textsuperscript{80}

Some of the leading trading block of nations from our region of Asia include the Association of Southeast Asian Nations (ASEAN) was established in 1967 in Bangkok by the five original member countries, namely, Indonesia, Malaysia, the Philippines, Singapore, and Thailand. Brunei Darussalam joined on in 1984, followed by Vietnam (1995), Laos and Myanmar (1997), and Cambodia (1999).\textsuperscript{81} South Asian Free Trade Area (SAFTA) Agreement was signed on 6 January 2004 during Twelfth SAARC Summit held in Islamabad, Pakistan. The Agreement entered into force on 1 January 2006, and the Trade Liberalization Programme commenced from 1st July 2006.\textsuperscript{82} These agreements provide an insight to the trade and health interface and how those are dealt within the domestic trade and health regime, especially in the context of tobacco as a product of trade between countries Party to such free trade agreements.

An important offshoot of the international trade law is the international investment law. It is one of the fastest growing areas of international law. It has led to the signing of thousands of agreements, mostly in the form of investment contracts and bilateral investment treaties. Also, in the last two decades, there has been an exponential growth in the number of disputes

\textsuperscript{80} The TPP Tobacco Carveout: A Triumph of Politics Over Good Policy http://www.huffingtonpost.com/entry/the-tpp-tobacco-carveout_b_8683498.html?section=india


\textsuperscript{82} Agreement on South Asian Free Trade Area (SAFTA) http://www.saarc-sec.org/userfiles/saftaagreement.pdf
being resolved by investment arbitration tribunals.\(^{83}\) Under most investment treaties, States have waived their sovereign immunity, and have agreed to give arbitrators a comprehensive jurisdiction over what are essentially regulatory disputes.\(^{84}\) However, the legal principles at the basis of international investment law and arbitration remain in a state of flux with wide disagreement among investment tribunals on some of the core concepts underpinning the regime, such as investment, property, regulatory powers, scope of jurisdiction, applicable law, or the interactions with other areas of international law.\(^{85,86}\)

In light of above, this study explores significance of public health within the national and international trade and health law regime from a tobacco control perspective. The researcher proposes to examine the process of incorporating public health mandates under the domestic laws within the bilateral and multilateral trade and investment treaties to protect tobacco control measures from being challenged under such agreements. In so doing, the researcher envisions to present a harmonious construction between the trade and health rights, within the constitutional priorities and restrictions. Though this may be overcome by a common legal principle of *sic utere tuo ut alienum non ledas* that might support restrictions *vis-à-vis* enjoyment of the fundamental freedom to the extent it impacts on another’s enjoyment of life, property and well-being. The study proposes to examine

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\(^{83}\) As a wide variety of state regulations allegedly aimed at protecting public health may interfere with foreign investments, a tension exists between the public health policies of the host state and investment treaty provisions.


how these treaties, both in the field of health and trade, find their underpinnings within the constitution of India.

This paper will attempt to not only look at the conceptual foundations in order to shed light on the practices of international investment law, but also analyse the Indian investment agreements from a public health perspective and in particular their present and future impact on any effective tobacco control measures. It will look at the structural arrangements, both under international and national legal regime, to manage foreign investment transactions and the potential disputes arising from them.

The researcher also attempts to comparatively examine the process and practice of treaty negotiation other comparable democratic jurisdictions with that of India. This is crucial from the point of assessing the participation of key stakeholder departments engaged in treaty negotiation, in particular relating to trade and health, and their understanding of the constitutional mechanism in this regard.

Given that the existing literature on the subject is limited with no detailed analysis of the impact of health and trade treaties from a constitutional perspective. Since every legislative, executive and judicial power in the country is subject to the Constitution of India, it is important to understand the extent to which right to health is subject to the economic interests of the country.

There is a pressing need for the legislature to realize the urgency of regulating the modifiable patterns of behaviour among people through adopting and implementing public health laws. It can begin with giving effect to international conventions and agreements advancing public health, while
strengthening the capacity of the community against public health risks involving, in particular, use of tobacco, alcohol, unhealthy diet and lack of activity. It is equally important to highlight that such legislation should also be insulated from challenges or to be pitched against a competing priority, e.g. trade and investment interests, in achieving the intended public health goals. Above all, all laws, including the international treaties and trade agreements having a compliance requirement within the territory of India, must confirm to the basic principles established under the Constitution of India.

1.5. OBJECTIVES OF THE STUDY

The study primarily aims to undertake an analysis of the domestic and international public health and trade related laws and treaties and in particular to assess their impact and influence on the enjoyment of right to health in India from a constitutional perspective. Specific objectives include:

a. Review and analyse domestic and international public health and trade laws to assess their significance and impact on public health, especially tobacco control.

b. Examine WTO agreements and its fundamental principles which guide the actual implementation of the trade and investment treaties as they relate to public health or tobacco control.

c. Present experience from case studies of various trade and investment agreements and the public health challenges, specifically related to tobacco use and implementation of WHO FCTC in other countries.
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d. Examine various judicial pronouncements of the courts in India and decisions of the arbitration tribunals related to significance of public health and protection of tobacco control while dealing with national and international trade in tobacco.

e. Conduct an empirical study with key stakeholder interviews to assess the significance of international health and trade agreements vis-à-vis the constitutional guarantees of right to health and freedom to trade; essential elements of treaty negotiation to ensure health concerns are addressed in trade treaties while examining compliance with the WHO-FCTC principles in adopting plain packaging to advance tobacco control and the opportunities, barriers and challenges thereof.

1.6. HYPOTHESIS

1.5.1. Hypothesis 1 – The legal and constitutional policy framework of India sufficiently protects the public health interests of the people of India.

1.5.2. Hypothesis 2 – The existing trade and investment agreements of India ensure compliance with the legal and constitutional policy mandates concerning protection and promotion of public health in India.

1.7. RESEARCH QUESTIONS

1. Is the WTO trade and patent rights regime in conflict with the basic national and international health rights regime?
2. Are there challenges in ensuring compliance with the international health and trade treaty obligations?

3. What is the constitutional mechanism for protection and promotion of public health, compared to trade in India?

4. Is the present construct of the trade and investment agreements involving India confirm with the constitutional mandates on public health?

5. Is there a need for a legal mechanism for India to deal with future global trade and health agreements?

6. How to strike a balance between right to health and right to trade i.e. promoting public health while ensuring sustainable development?

7. Is there a lack of policy coherence and integration both at substantive and procedural levels in protecting public health interests compared to the trade interests in treaty negotiations in India?

8. Should health impact assessment of all treaties in negotiations be made mandatory?

1.8. RESEARCH METHODOLOGY

The researcher adopted a mixed method approach in this study using descriptive analysis and empirical methods for the research. Besides the descriptive analysis of the phenomenon under the enquiry, the study also focus on conducting key stakeholder interviews to collect empirical data through using semi-structured interview tools.
The subject matter of the research includes but is not limited to the:

1. International public health and trade instruments and treaties.
2. Public health and trade within the ambit of the Constitution of India.
3. International trade and investment agreements of India.
4. National and global developments in tobacco control.
5. Indian judiciary on public health.
6. Global and national judicial and arbitration awards related to tobacco and trade.
7. Knowledge, opinions, perceptions and priorities of state and non-state actors vis-à-vis public health and trade regime in India.

1.8.1. Data collection and data source

A comprehensive desk review of available literature on the subject matter has been carried out and includes published policy documents, reports, evaluation and or other relevant documents from the concerned ministerial departments and national and international agencies and research organisations.

Qualitative method involving key stakeholders interview has been employed to collect empirical data. A semi-structured, interviewer administered questionnaire was developed (appendix-I) comprising standard questions aimed at gathering information from key officials of the concerned government departments and non-government stakeholders.
1.8.2. Sampling design and size

In addition to the doctrinal approach, the proposed data collection included interviews with officials from the Ministry of Health and Family Welfare and the Ministry of Commerce and Industry. Information was also collected from leading civil society organizations working in the field of public health, trade and consumer rights, legal experts, academicians and representatives from national and international organizations including WHO. In addition, officials from Ministry of Consumer Affairs, Ministry of Law and Justice, Ministry of Women and Child Development, National Commission for Women, National Commission for Protection of Child Rights, National Human Rights Commission, World Trade Organization, and World Intellectual Property Organization were also approached. However, the researcher could not get a positive response from these stakeholders for conducting the interviews for this study.

Key international experts and advocates on the subject matter were also contacted. Experts engaged in advocating for Plain Packaging policy initiatives and following the TPPA negotiations in Australia and experts and lawyers defending Australia’s position in the High Court, Inter-State Investment Treaty and at the WTO dispute settlement body were contacted to understand and examine the health and trade treaties in diverse constitutional framework.
1.8.3. Data analysis

National and international public health and trade laws, in particular related to tobacco, and trade and investment agreements have been analysed based on the fundamental principles enshrined under the Constitution of India. A review and analysis of public health and trade laws is attempted along with case studies from other jurisdictions where public health interest have been protected through legal provisions, judicial decisions or arbitration awards along with the trade interests. The trade and investment agreements are analysed from a legal and constitutional perspective particularly related to public health with a specific focus on tobacco control. The study also attempt to make an assessment of the existing trade and investment treaties that confirm to the ‘constitutional mandate’, while analysing and suggesting potential areas where the legislative, judicial and administrative responses is needed to cater to the public health challenges in such treaties, both in their negotiation and implementation. The data collected from the key stakeholder interviews is analysed on the variables related to knowledge and opinion of the key stakeholders besides understanding the processes and parameters to be considered for entering into global health and trade treaties besides.

1.8.4. Limitations of the study

- Given the changing policy and political scenarios over time, it is difficult to conclusively ascertain the political and bureaucratic thinking behind the trade and investment treaties and generalize the same for all times and all countries.
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- Key stakeholders were not willing to share information. As many as 50 stakeholders were approached for the interview from different departments and sectors, however, only 19 stakeholders agreed to complete the interview based on the questionnaire while one suggestion on the methods of data collection was received over email. Others did not respond to the request for interview, precluding their perspective in the study.

- Time constraint in which the study was completed affected primary and secondary data collection. With respect to the secondary data, though latest data has been used, some recent data were not available at the time of analysis hence data available until such time has been included.

- Given the large number of cases from the Indian courts, courts in other countries, WTO dispute settlement body and international arbitration tribunals, it was difficult to include all cases that may be related to and more importantly relevant to public health or tobacco control which has been the focus of this study.

- Any generalization of the study findings, conclusions and recommendations is focused on India and may be limited to international jurisdictions in low and middle income countries functioning in a constitutional framework similar to that of India.
The study is limited in its enquiry with respect to public health aspects of trade and investment treaties and may not present the overall characteristics and/or compliances with other pertinent issues related to labour, environment, human rights, etc.

Within the realm of public health concerns, the study, in particular, focus on tobacco control within the trade and investment treaties and does not cover other important public health issues like access to medicine, food processing and patenting, exposure to other hazardous chemicals etc.

1.9. PLAN OF THE STUDY CHAPTERISATION

The study is structured in the following manner i.e. after giving a brief introduction of the theme and providing a general background and review of relevant literature Chapter One further includes the statement of problem, the object and methodology of the research, describes the hypothesis, research questions and the limitations of this thesis.

Chapter Two, titled “The International Trade and Health Law Regime” examines the relevant provisions of the international trade and health laws and their implications at the domestic and international level on trade, public health and in particular tobacco control and tobacco trade. The chapter is divided into following three sections:

i. International health and trade related instruments – harmony between WHO and WTO objectives: This section provides details of the existing international legal regime under
the WTO Agreements including the TRIPS and the international trade dispute resolution mechanisms. It also describes the global legal framework on health including various declarations, international health regulations and in particular about the WHO regime and the only public health treaty under its auspices i.e. the Framework Convention on Tobacco Control and its global significance.

ii. **Non-tariff measures, also known as the technical barriers to trade, and other exceptions covered under trade and investment agreements:** This section describes the non-tariff measures identified under the international trade regime and examine how and under what circumstances they can be used to advance public health by any member state of the WTO. The section also covers other exceptions under trade agreement, including the health exceptions and other resolutions adopted later allowing countries to take action for the protection and prevention of public health.

iii. **Right of sovereign nations and obligations of MNCs and their liabilities under national and international law:** This section examines the extent of sovereignty in matters of trade and investment treaties and to what extent the member states party to such agreements compromise and concede their right to decide in a matter governed by an international legal framework. How such decision making is in conformity with the domestic constitutional mandates, in particular when it relates
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to a private multinational corporation’s ability to challenge a sovereign’s decision before an international arbitration tribunal.

The section also covers the manner in which such corporations function, how they ought to function and their role and responsibility in a new globalised, liberal world.

Chapter Three titled, “Public Health and Trade under the Constitution of India” examines the existing legal framework with respect to the extent of regulating trade and health in India. The chapter looks at the pre-and post-constitution developments in the field of trade and health. This chapter is divided into two sections looking at the two aspects in detail.

i. Constitutional and Legislative framework of public health laws in India: This section presents a complete analysis of the existing pre and post-constitution mechanisms have a bearing on public health. It also deals with the evolving significance of public health in India and the manner in which public health has been emphasised within the Constitution of India.

ii. Trade under the Constitution of India: This section examines the constitutional freedom relating to trade and the limitations on the freedom contemplated thereunder. It also presents an analysis of the limitations on trade in tobacco within the constitutional framework besides making an assessment, in the light of the Constitution and judicial observations, whether tobacco could be considered as ‘res extra commercium’?
Chapter Four, titled, “Right to Health – An Analysis of Judicial Pronouncements” includes discussion on the significance of public health from the perspective of human and health rights. This chapter looks at the development in international and national human rights regime to argue protection of public health as the basic requirement to enjoyment of right to health as a human rights. The chapter also includes the judicial observations from various courts from across the world that upheld public health measures (in particular related to tobacco control) when challenged as against implementation of trade rights. The chapter also discusses right to health from a constitutional perspective with special reference to public health and tobacco control. Decisions citing the WHO FCTC to sustain national and local tobacco control measures are discussed in this context. Judgments from the Supreme Court of India are extensively discussed and analysed for deducting the fundamental position in the country with respect to trade versus enjoyment of right to health.

Chapter Five, titled, “Trade and Investment Agreements of India: A Public Health Perspective” presents a compilation of all the major trade and investment agreements entered into by India with various countries. The chapter provides the basic information about the nature of these agreements and how aspects of public health have been dealt in each of them. The researcher intends to present a comparison of the Indian agreements with the model investment agreement developed by the United Nation Conference on Trade and Development (UNCTAD). The model focuses on the development dimension including health, and presents a comprehensive Investment Policy Framework for Sustainable Development (IPFSD). The
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IPFSD consists of a set of Core Principles for investment policymaking, guidelines for national investment policies, and guidance for policymakers on how to engage in the international investment policy regime, in the form of options for the design and use of international investment agreements (IIAs). This chapter envisage investigating and weighing the Indian investment agreements compliance to these international sustainable development standards, especially in the wake of the adoption of the UN Sustainable Development Goals (UNSDG) for 2030, with special reference to Goal 3 i.e. “health for all at all ages”. The Chapter also discusses the model BIT adopted by the Government of India in 2015. The chapter also presents an analysis of the impact of trade and investment agreements on tobacco use, its trade and efforts of tobacco control in the country.

Chapter Six, titled, “Praxis and Challenges in Negotiating Public Health in Trade Treaties: An Empirical Analysis” includes a comparative analysis of the treaty making process in India with other larger democracies. The comparison is limited to the constitution and legislative framework in these countries for entering into and implementing an international treaty. The chapter further substantiates this analysis from the stakeholder interviews undertaken to assess the extent of compliance with public health obligations, in particular under WHO-FCTC. It intends to empirically assess the impact of trade and investment treaties on public health obligations under national and international tobacco control laws and how aspects of public health are covered in such treaty arrangements both in terms of its negotiation and implementation. In particular, it is envisaged to gauge the feasibility of implementing stronger tobacco control measures, including
plain packaging, in India and assess the opportunities and barriers for such a tobacco control policy and to understand the process and impact of such an intervention.

**Last Chapter** of the thesis, i.e. “**Conclusions and Recommendations**”, provides a brief discussion on all the findings arising out of the literature review and the key stakeholder interviews and concludes this work by delivering an assessment upon the interface between health and trade. It also summarises the implications for future tobacco control efforts and initiatives in India, including plain packaging of tobacco products. It tries to give the brief summary and concluding remarks for the key chapters and presents the policy recommendations for relevant stakeholders while identifying the future areas of research work based on the observations from this thesis.