Chapter - IV
Right To Health – An Analysis Of Judicial Pronouncements

ABSTRACT
“Maintenance and improvement of public health have to rank high as these are indispensable to the very physical existence of the community and on the betterment of these depends, the building of the society of which the Constitution makers envisaged. Attending to public health, in our opinion, therefore is of high priority perhaps the one at the top.”

Rangnath Mishra, J. in Vincent Panikurlangara v. Union Of India & Ors
RIGHT TO HEALTH – AN ANALYSIS OF JUDICIAL PRONOUNCEMENTS

“A healthy body is the very foundation for all human activities. That is why the adage “Sariramadyam Khaludharma Sadhanara”. In a welfare State, therefore, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health.”

Rangnath Mishra, J in Vincent Panikurlangara vs Union of India & Ors [1987 AIR 990, 1987 SCR (2) 468]

4.1. CHARACTERISTICS OF RIGHT TO HEALTH

Health is a matter of every day concern for each one of us. Any kind of health concern, regardless of our age, gender, socio-economic, or ethnic background interferes with enjoyment of life with full freedom and dignity. Any of the celebrated human rights may not be of much value and meaning for an individual suffering devoid of his health. Therefore, right to health becomes pertinent, rather a precondition to realisation of other fundamental rights.

Even before the coming into force of the UDHR and recognition of fundamental human rights, “the right to the enjoyment of the highest attainable standard of physical and mental health”, was articulated in the Constitution of the World Health Organization (WHO) in 1946. It defined defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. It further stated that “the enjoyment of the highest

1 Preamble of the Constitution of the World Health Organization (WHO) in 1946
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.\textsuperscript{2} All later human rights instruments beginning Article 25 of the UDHR have incorporated health as essential human rights.\textsuperscript{3}

Given the expanding nature of the health rights and complexities in its interpretation and implementation, in the year 2000 the UN Committee on Economic, Social and Cultural Rights issued legal guidance for implementation of right to health under General Comment 14. Besides the human rights treaties and national legislative and constitutional basis, the General Comment 14 is a key source for identifying the key components of right to health, which include, \textit{inter alia} the right to:

- Appropriate health care facilities
- An adequate supply of water, food, nutrition and housing
- A healthy environment and healthy working conditions
- Maternal, child and reproductive health
- Gender equality.
- Participate in health related decision making
- Access related information
- Prevention, treatment and control of diseases
- Access to essential medicines
- A system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health

\textsuperscript{2} Preamble of the Constitution of the World Health Organization (WHO) in 1946
The human right to health care means that hospitals, clinics, medicines, and doctors’ services must be accessible, available, acceptable, and of good quality for everyone, on an equitable basis, where and when needed. Particularly for vulnerable and marginalized groups in societies who tend to bear an undue proportion of health problems. A comprehensive health right regime must adhere to the following human rights standards:

- **Universal Access:** Everyone must have access to equal high-quality and comprehensive health care.
- **Equity:** Resources and services must be distributed and accessed according to people’s needs. We get what we need and give what we can.
- **Non-Discrimination:** Health care must be accessible and provided without discrimination
- **Availability:** Adequate health care infrastructure in all geographical areas and to all communities.
- **Acceptability and Dignity:** Health care institutions and providers must respect dignity, medical ethics and protect confidentiality.
- **Quality:** All health care must be of good quality, guided by quality standards and control mechanisms, and provided in a timely, safe, and patient-centered manner.
- **Accountability:** The health care system must be accountable to the people it serves.
- **Transparency:** The health care system must be open with regard to information, decision-making, and management.
• **Participation**: The health care system must enable meaningful public participation in all decisions affecting people’s right to health care.

The right to health is an inclusive right. It is not just about access to health care services but also the underlying determinants of health. The underlying determinants are much broader and include relevant elements for tobacco control.\(^4\) Further the Rio Political Declaration on Social Determinants of Health enumerates global political commitment for the implementation of social determinants of health approach aiming at the reduction of health inequities and a holistic development of life.\(^5\) However, it is also important to understand what all may not be considered right to health.\(^6\) Right to health is not:

- **The same as the right to be healthy** – Does not mean that State has to guarantee us good health, which is influenced by several factors that are outside the direct control of States, such as an individual’s biological make-up and socio-economic conditions.

- **Only a programmatic goal to be attained in the long term** – Does not mean that no immediate obligations on States arise. In fact, States must make every possible effort, within available resources, to realize the right to health and to take steps in that direction without delay.

- **Absolves a country in difficult financial situation from having to take action to realize the right to health** – Though, availability of resources at that time and the development context are taken into account, no State can justify a failure to respect its obligations because

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\(^4\) UN Committee on Economic Social and Cultural Rights

of a lack of resources. States must guarantee the right to health to the maximum of their available resources, even if these are tight.

The above described principles of right to health (both, what it is and what it isn’t) must be adopted by countries in their domestic constitutions and given effect through an appropriate public health legislative framework. However, in the absence of express provisions and if an issue of uncertainty arises (as by a lacuna in the law, obscurity in its meaning or ambiguity in a relevant statute), courts may seek guidance in the general principles of international law, as accepted by the community of nations as declared in the ‘Bangalore Principles on the Domestic Application Of International Human Rights Norms.’

The judge may ascertain and declare what the relevant rule of domestic law is and incorporate the rule into domestic law, which then makes it part of domestic law. The decision of the Supreme Court in the case of Sheela Barse (incorporating provisions of CEDAW and CRC) and Vishaka’s (incorporating provisions of CEDAW to draw guidelines for prevention of sexual harassments at workplaces) are celebrated examples of using the Bangalore Principles.

Indian Courts have also used these principles in reading international human rights to health in within the domestic constitutional and legal framework. The

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8 “[T]here is a growing tendency for national courts to have regard to these international norms for the purpose of deciding cases where the domestic law - whether constitutional, statute or common law - is uncertain or incomplete. It is within the proper nature of the judicial process and well-established judicial functions for national courts to have regard to international obligations which a country undertakes - whether or not they have been incorporated into domestic law - for the purpose of removing ambiguity or uncertainty from national constitutions, legislation or common law”. Honourable Justice Michael Kirby. The Road from Bangalore the First Ten Years of the Bangalore Principles on The Domestic Application Of International Human Rights Norms Available at: http://www.lawfoundation.net.au/lj/app/90BF20D1903CE6ECCA2571A60082D75B.html accessed on 26-01-2017
section below gives a detailed account of the judicial interpretation of right to health in India.

4.2. RIGHT TO HEALTH UNDER INTERNATIONAL HUMAN RIGHTS REGIME

The right to health includes both freedoms and entitlements:

- **Freedoms** include the right to control one’s health and body (e.g. sexual and reproductive rights) and to be free from interference (e.g. free from torture and from non-consensual medical treatment and experimentation).

- **Entitlements** include the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health.

The right to health as widely recognized creates entitlements to access adequate health care facilities, goods and services, and the underlying determinants of health, such as food, housing, access to water and adequate sanitation, safe working conditions and a healthy environment.\(^9\) These entitlements place duties to progressively realize access within available resources on a broad range of actors, including primarily states but also international organizations and other non-state actors. The realization of these entitlements is relative to variable development levels across the world and within a country; however, a minimum essential level of standard vis-à-vis right to health has been defined in the various international human rights instruments.

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4.2.1. Universal Declaration of Human Rights (UDHR, 1948)

Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the WHO, or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable.\(^{10}\)

The first notion of a right to health under international law is found in the 1948 Universal Declaration of Human Rights, which was unanimously proclaimed by the UN General Assembly as a common standard for all humanity. The Declaration sets forth the right to health under Article 25 as:

(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.*

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The Declaration does not define the components of a right to health, however, it both include and transcend medical care. Under international law, there is a right not merely to health care but to the much broader concept of health. Because rights must be realized inherently within the social sphere, this formulation immediately suggests that determinants of health and ill health are not purely biological or “natural” but are also factors of societal relations. Thus, a rights perspective is entirely compatible with work in epidemiology that has established social determinants as fundamental causes of disease.

4.2.2. **International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966)**

The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. Article 12 reads:

1. *The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*

2. *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*

   (a) *The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*

   (b) *The improvement of all aspects of environmental and industrial hygiene;*
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

According to the Committee on Economic, Social and Cultural Rights (under Para 4 of the Report), the reference in article 12.1 of the Covenant to “the highest attainable standard of physical and mental health” is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.\(^{11}\)

Non-discrimination and equal treatment is one of the key principles of right to health under the ICESCR. By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil,\(^{11}\)

political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.\textsuperscript{12}

\subsection*{4.2.3. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979)}


One of the rights guaranteed under the Convention in relation to tobacco control is the right to equality in the full enjoyment of health. Article 12 of the CEDAW requires State Parties to eliminate discrimination against women in all aspects of their health care, including drug addiction and related problems. Although tobacco is not specifically mentioned, it is covered by Article 12 and has been interpreted by the CEDAW Committee as an issue on which governments can be held accountable. An important theory guiding the CEDAW is that the maintenance of health affects the very existence of human beings and is a fundamental need that forms the basis for securing human rights. This can be included as a part of women’s rights to health under Article 12. The CEDAW Committee also notes that women’s health should be given a high priority because women are the providers of health care to their families, and their role in health care, including childbirth and child rearing, is of great significance to successful development.

The issue of a human rights approach to women’s health is not limited to Article 12 of the CEDAW (3). For example, Article 7 of the Convention gives women the right to participate in public life and political decision-making. The effective implementation of this right would mean involving women in designing and implementing national health policies and programmes. Article 2 notes that States must propose a policy to guarantee women the exercise and enjoyment of human rights and fundamental freedoms, covering both the private as well as public sectors. This means that women must be fully informed about their rights, a provision that can be applied to legislation on tobacco control. Article 11.1 refers to the right of women to the protection of health and safety in working conditions, a provision that is directly relevant to the hazards of passive smoking.

The CEDAW Committee also has the power to make general recommendations that interpret and update its articles. According to General Recommendation 24, governments have a duty to report to the CEDAW on their health legislation plans and policies, with reliable data, disaggregated by sex, on the incidence of the severity of conditions hazardous to women’s health.

The FCTC and its provisions concerning women can also be used to commit governments to formulate more gender-sensitive policies and legislation. It will provide a legal basis for the interpretation of or amendments to the existing national laws, and assist in the enactment of new legislation regarding women’s health related to tobacco. The FCTC can also create an expanded human rights framework for women that is acceptable within the given culture or under the country’s legal system. To strengthen the role of women in global tobacco control, governments and the World Health Organization should link the FCTC...
and CEDAW, which is the only UN convention specifically on the rights of women of all age groups.

4.2.4. The Convention on the Rights of the Child (CRC, 1989)

The Convention on the Rights of the Child was adopted in 1989 and it came into force in September 1990. The interpretation of the articles of the Convention by the Committee on the Rights of the Child demonstrates that the use of and exposure to tobacco are, indeed, a human rights issue. Since the Convention is legally binding, the ratifying States are legally bound to ensure that children can enjoy all of the rights guaranteed under the Convention, including protection from tobacco. CRC was ratified by India on December 2, 1992.

One of the most important articles of the Convention, Article 3, states that in every decision affecting a child, the best interests of the child shall be a primary consideration. Article 18 of the Convention makes it clear that the principle of best interests is not confined to the public sphere, but applies to private welfare institutions and to parents as well. Article 4 requires States to take all appropriate legislative, administrative and other measures towards the realization of children’s rights.

Article 24 emphasizes the right of the child to enjoy ‘the highest attainable standard of health’ and includes detailed obligations for States, many of which are relevant to protecting children from the harmful effects of tobacco. According to Article 19 of the Convention, children should be protected from all forms of violence, injury, abuse or neglect while in the care of their parents. The State is obligated to undertake appropriate measures to ensure that children’s
health and rights are not imperilled by adults smoking in spaces where children live, study, work and play.

Article 6 guarantees the child’s rights to life, survival and development. This encompasses not only the fundamental concept of protection from arbitrary deprivation of life, but also the positive obligation to promote life compatible with the human dignity of the child. Article 27 guarantees an adequate standard of living, without which, the rights to survival and development cannot be realized in their fullest sense. The use of tobacco clearly imposes significant economic costs, both at the household and national levels, thus diminishing the likelihood of children having a standard of living that is adequate for their development.

Article 17 ensures that children shall have access to information from a diversity of sources, especially those aimed at the promotion of their social and moral well-being and physical and mental health. The right of the child to information is spelt out in Article 13 of the Convention. This right has been interpreted to include a positive obligation on States to ensure access to information held by the Government. In the case of tobacco, this would seem to impose upon the state an obligation to counter misinformation by the tobacco industry, and the State would be required to provide accurate and complete information to children on the true effects of tobacco use.

The right of children to be protected from economic exploitation and work that is detrimental to their development finds expression in Article 32 of the Convention. Child labour in the tobacco industry would seem to fit this description.
According to the Human Rights Watch, thousands of children work on Indonesia’s 500,000 tobacco farms. Many, get sick in the process. Human Rights Watch interviewed more than 100 child tobacco farmers, half of whom reported nausea, vomiting, headaches, or dizziness — symptoms consistent with acute nicotine poisoning, which happens when nicotine from tobacco plants is absorbed through the skin.\(^\text{13}\) All of these children handled tobacco while they helped to plant, maintain, harvest, and cure the crop. Many children also mixed and sprayed toxic pesticides, worked in extreme heat, used sharp tools, or worked at dangerous heights in barns with nothing to protect them from falling.\(^\text{14}\) Indonesia is one of only a few countries that has not ratified the WHO-FCTC, and thus also allows tobacco advertisement in the country that lure adolescents and young children to tobacco use. A recent study of 360 schools in five Indonesian cities found that billboards and banners advertising tobacco products were visible from one-third of the schools. Tobacco advertisements at kiosks, minimarts, and stores where they are sold were found near 85 percent of the schools. What the ads don’t say is, “This product may be made with child labour.”\(^\text{15}\)

4.2.5. UN Convention on Rights of Persons with Disabilities (UNCRPD, 2008)

The Convention on the Rights of Persons with Disabilities spells out clearly and unconditionally that persons with disabilities have equal access and a right to full and effective enjoyment of all human rights – the removal of barriers

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\(^{15}\) Ibid.
explicitly termed as a condition for access and the enjoyment of equality. The Convention also maintains the significance of right to health as a fundamental right of all human beings and its Article 25 embraces the same as:

**Article 25: Health**

*People with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination. Countries must take all appropriate measures, including measures that are gender-sensitive, to ensure that people with disabilities have access to the same range, quality and standard of health care that is available to everyone else, and which are close to people’s own communities.*

A cornerstone of the right to health in the context of rights of persons with disabilities is of course accessibility. Again this is something the CESCR Committee has commented on more generally, stating that health service should have the key features of availability, accessibility, affordability, acceptability and quality.\(^{16}\) The CESCR Committee’s discussion of the right to health is a most helpful tool in determining the boundaries between curative prevention and measures that counter-act the spirit of the Convention and therewith the rights of persons with disabilities.\(^{17}\)

Health as a standalone human right has been entrenched in several international human rights treaties and instruments, and in each of the major regional human rights systems. The right to health, in the recent past, has undergone an unprecedented level of interpretation and expanding, form


\(^{17}\) Ibid.
defining the content of the entitlement as well as clarifying what states ought to do to progressively realize these duties.\textsuperscript{18}

Both as freedom and entitlement, the understanding of the ‘right to health’ in the domain of international human rights norms has been evolving over the years. From an aspirational right under the prominent international instruments to a more specific obligations for implementation by states, the ambit of right to health has moved beyond the traditional notion of individual-centric healthcare – focused on aspects such as access to medical treatment, medicines and procedures – to the collective dimension of protection, prevention and promotion of public health. There is a foundational logic for health rights to be addressed through the language of human rights.\textsuperscript{19} As Prof. Jonathan Mann puts it,

\begin{quote}
"Modern human rights, precisely because they were initially developed entirely outside the health domain and seek to articulate the societal preconditions for human well-being, seem a far more useful framework, vocabulary, and form of guidance for public health efforts to analyze and respond directly to the societal determinants of health than any inherited from the biomedical or public health traditions."
\end{quote}

Today, the right to health as a human right holds an international legal force among the civilized nations under the umbrella of United Nations. According to the Office of the UN High Commission for Human Rights, nearly 115

\textsuperscript{18} Committee on Economic, Social and Cultural Rights: General Comment 14, The right to the highest attainable standard of health. 2000, Rep. No. UN Doc. E/C.12/2000/4
\textsuperscript{20} Mann, J. et al., Health and Human Rights: A Reader (New York: Routledge, 1999) at p. 444
constitutions around the world speak to the right to health.\textsuperscript{21} However, the domestic legal force of these human rights treaties vary considerably, and at times depends on domestic implementation of treaties under the national legislation. Nonetheless, the right to health is enjoying greater enforceability in domestic courts due to increased ratifications of international human rights treaties, increased entrenchment in domestic bills of rights and increased judicial willingness to enforce health rights. The Indian interpretation of right to health as part of the fundamental right to life and liberty is a testimony to this judicial will.

Though the Indian legislatures, keeping with the mandates of the Constitution of India (discussed earlier in chapter III), have made several laws to protect and advance public health, it is the judicial interpretation of such laws and judicial direction in absence of such laws, that have paved the way for including health as a fundamental right under Part-III of the Constitution of India. The right to health is, therefore, not merely a 'manifesto' right nor simply a rhetorical tool for advocacy, but an increasingly well-developed and enforceable legal right in India.

The above international instruments adopt a rights based approach to be implemented at domestic level based on consent and cooperation, and have a binding effect on ratifying bodies. The fundamental mandate relating to right to health as stipulated under the above and some of the other key public health instruments have been neatly summarised by Hazarika S. et al (2009) and is reproduced below.\textsuperscript{22}


Table 4.1: International public health instruments and key recommendations

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<thead>
<tr>
<th>Sl.No</th>
<th>Name of instrument</th>
<th>Key recommendation</th>
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<tbody>
<tr>
<td>1</td>
<td>Universal Declaration of Human Rights (1948)</td>
<td>Guarantees respect for economic, social and cultural rights since they are indispensable for human dignity</td>
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<tr>
<td>2</td>
<td>International Covenant on Economic, Social and Cultural Rights (1966)</td>
<td>Recognition of relevant rights to be exercised without discrimination in the context of a universal right to health</td>
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<td>3</td>
<td>Declaration of Alma Ata (1978)</td>
<td>Primary healthcare approach to be developed as an integral whole, including promotive, preventive, curative and rehabilitative components</td>
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<tr>
<td>4</td>
<td>The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979)</td>
<td>Requires state parties to eliminate discrimination against women in all aspects of their healthcare, including drug addiction and related problems</td>
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<tr>
<td>5</td>
<td>The Convention on the Rights of the Child (CRC, 1989)</td>
<td>Emphasizes the right of the child to enjoy ‘the highest attainable standard of health’</td>
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<td>6</td>
<td>International Health Regulations (IHR, 2005)</td>
<td>Specific undertakings for international assistance in health</td>
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<td>7</td>
<td>UN Convention on Rights of Persons with Disabilities (UNCRPD, 2008)</td>
<td>States parties to take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation</td>
</tr>
<tr>
<td>8</td>
<td>The Declaration of Istanbul on Organ Trafficking and Transplant Tourism, 2008</td>
<td>All forms of transplant commercialism, which targets the vulnerable; transplant tourism and organ trafficking to be prohibited</td>
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4.3. THE JUDICIAL INCORPORATION OF RIGHT TO HEALTH IN INDIA

A justiciable right to health within the Indian constitutional framework was considered absent for a few decades after the adoption of the Constitution in 1950. However, the Indian judiciary interpreted right to health through various case laws from time to time. Keeping with the international human rights developments, the Indian Constitution also divided human rights in two separate parts, wherein, the justiciable human rights formed the Part III of the constitution as ‘Fundamental Rights’, which in conventional human rights language may be termed as civil and political rights. While the aspirational human rights formed the Part IV of the constitution as the Directive Principles of State Policy (DPSPs), or the economic, social and cultural rights. Several aspirational provisions under Part IV (discussed in the previous Chapter III) cover various aspects of health rights, including improvement of public health.
However, with the passage of time the judiciary found that right to life guaranteed under the article 21 of the Constitution of India is incomplete without the right to live with human dignity which encompasses various other rights like the right to education, the right to livelihood, the right to health and housing etc. Thereby, it upgraded the right to health, to a justiciable fundamental right under article 21 of the Indian constitution, as initially intended by the framers of the Constitution. This section dwells on the recognition of the ‘right to health’ in some of the prominent decisions given by the Indian judiciary.

4.3.1. The Supreme Court of India on Right to Health

Considering the question, whether a Court can compel a statutory body to carry out its duties to the community by constructing sanitation facilities? The Supreme Court of India accepted the use of sec. 133 CrPC for removal of public nuisance and directed the Municipality to take immediate action within its statutory powers to construct sufficient number of public latrines, provide water supply and scavenging services, to construct drains, cesspools and to provide basic amenities to the public.\(^{23}\) The Court held, “A responsible municipal council constituted for the precise purpose of preserving public health and providing better finances cannot run away from its principal duty by pleading financial inability. Decency and dignity are non-negotiable facets of human rights and are a first charge on local self-governing bodies.”\(^{24}\)

While hearing the appeal for the right of detenu to have interview with his lawyer and family, the Apex Court held, “[T]he right to life enshrined in Article 21 cannot be restricted to mere animal existence. It means something much more than just physical survival. Every limb or faculty through which life is


\(^{24}\) Para 10. ibid.
enjoyed is thus protected by Article 21 and a fortiorari, this would include the faculties of thinking and feeling.” The Court further elaborated that the right included “the right to live with human dignity and all that goes along with it, namely, the bare necessaries of life such as adequate nutrition…”

Treating a letter addressed to itself, on behalf of persons belonging to socially and economically weaker sections complaining violation of their rights under various social welfare legislations, as a writ petition (in the nature of public interest litigation) the Apex Court observed that, “the right to live with human dignity enshrined in Article 21 derives its life breath from the Directive Principles of State Policy and particularly clauses (e) and (f) of Article 39 and Articles 41 and 42 and at the least, therefore, it must include protection of the health and strength of workers, men and women, and of the tender age of children against abuse, opportunities and facilities for children to develop in a healthy manner and in conditions of freedom and dignity, educational facilities, just and humane conditions of work and maternity relief.” The Court considered these as “the minimum requirements which must exist in order to enable a person to live with human dignity…”

Considering a petition against closure of slaughter house for seven specified days in a year as violation of fundamental right to carry on trade, the Apex court observed that, “the expression ‘in the interest of the general public’ in clause (6) of Article 19 is of wide import comprehending public order, public health, public security, morals, economic welfare of the community and the objects

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25 Francis Coralie Mullin vs The Administrator, Union Territory of Delhi & ORS [1981 AIR 746, 1981 SCR (2) 516]
26 Bandhua Mukti Morcha Vs Union of India 1984 AIR 802, 1984 SCR (2) 67
mentioned in Part IV of the Constitution." A great import of this decision on public health relates to trade in harmful products like tobacco or alcohol and their regulations by the state. The court reasoned that, “[i]f the law requires that an act which is inherently dangerous, noxious or injurious to the public interest, health or safety or is likely to prove a nuisance to the community shall be done under a permit or a license of an executive authority, it is not per se unreasonable and no person may claim a license or a permit to do that act as of right."  

Further, hearing a petition against the imposition of ban on certain items of noisy fireworks, the Apex court held that Article 19 (1) (g) does not guarantee the freedom which takes away that community’s safety, health and peace. Delivering the judgement, Asish Baran Mukherjee, J. held, “safety, health and peace is guaranteed to the citizens of India and none can carry on any trade or business which may seriously affect safety, health and peace of the Community.” 

The court referred to its decision in Cooverjee v. Excise Commissioner and the Chief Commissioner, Ajmer, that “[T]he State has the power to prohibit trades which are illegal or immoral or injurious to the health and welfare of the public. There is no inherent right in a citizen to sell intoxicating liquors…” It further observed that enacting a prohibition and not a mere regulation may at times be lawful e.g. prohibiting trades in noxious or dangerous goods or trafficking in women cannot be held to be illegal. The Court decided that, “right of every

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28 Ibid.  
29 Burrabazar Fire Works Dealers Association and Others v. Commissioner of Police, Calcutta [AIR 1998 Cal 121]  
30 1954 AIR 220, 1954 SCR 873
citizen to pursue any lawful trade or business is obviously subject to such reasonable condition as may be deemed by the Governing Authority of the country essential to the safety, health, peace, order and morals of the community.”

The Court reiterated that “Article 19(1)(g) of the Constitution of India does not guarantee the fundamental right to carry on trade or business which creates pollution or which takes away that communities’ safety, health and peace. It cannot be said that a citizen have a fundamental right under Article 19(1)(g) of the Constitution of India to carry on trade or business and/or manufacture poison which may be used for killing of people. This right is negative as nobody has any right to carry on any trade or business in intoxicating liqueurs by virtue of the right conferred under Article 19(1)(g).” The same argument shall hold true for trade in tobacco or fireworks.

With respect to fireworks, the court held that there was “no inherent or fundamental right in a citizen to manufacture, sell and deal with fireworks that create sound beyond permissible limit and which will generate pollution which would endanger the health and the public order.” Such trade takes away, suspends and renders meaningless the fundamental rights guaranteed under Article 19(1)(a) and other provisions of the Constitution of the captive listener of the fireworks.

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31 Cooverjee v. Excise Commissioner and the Chief Commissioner, Ajmer 1954 AIR 220, 1954 SCR 873
32 Burrabazar Fire Works Dealers Association and Others v. Commissioner of Police, Calcutta AIR 1998 Cal 121
33 Burrabazar Fire Works Dealers Association and Others v. Commissioner of Police, Calcutta AIR 1998 Cal 121
Children have been given special protections under the Constitution of India with respect to education,\(^{34}\) employment,\(^{35}\) and childhood care,\(^{36}\) however, looking at the despicable situations of the mentally ill children and their custody in jail, the Court was, “extremely pained and anguished that these children should be kept in jail instead of being properly looked after, given adequate medical treatment and imparted training in various skills which would make them independent and self-reliant.”\(^{37}\) The Court quoted from the preamble of the National Policy for the Welfare of Children and directed the state for making arrangements for comprehensive physical, mental and moral health of children to reduce inequality and ensuring social justice. Similarly, in a case pertaining to the admitting of non-criminal mentally ill persons to prisons in West Bengal, the Supreme Court held that “Admission of non-criminal mentally ill persons to jails is illegal and unconstitutional.... The Judicial Magistrate will, upon a mentally ill person being produced, have him or her examined by a Mental Health Professional/Psychiatrist and if advised by such MHP/Psychiatrist send the mentally ill person to the nearest place of treatment and care.” It has further directed the state to improve mental health institutions and integrate mental health into primary health care.\(^{38}\)

An advocate moved the Supreme Court seeking directions to ban import, manufacture, sale and distribution of such drugs which have been banned in Western countries or recommended to be banned by the Drugs Consultative Committee under the Drugs and Cosmetics Act, 1940.\(^{39}\) The court observed

\(^{34}\) Article 21A Constitution of India  
^{35}\) Article 24 Constitution of India  
^{36}\) Article 45 Constitution of India  
^{37}\) Sheela Barse & Ors vs Union Of India & Ors JT 1986 136, 1986 SCALE (2)230  
^{38}\) Sheela Barse & Ors vs Union Of India & Ors 1993-(004)-SCC -0204 -SC  
^{39}\) Vincent Panikulangara vs. Union of India 1987 AIR 990, 1987 SCR (2) 468
that, “[A] healthy body is the very foundation for all human activities. That is why the adage “Sariramadyam Khaludharma Sadhanara”. In a welfare State, therefore, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health.” While endorsing the decision in Bandhua Mukti Morcha and Francis Mullin's case the court referred to Article 47 as one of the primary duties of the State and held that “maintenance and improvement of public health have to rank high as these are indispensable to the very physical existence of the community and on the betterment of these depends the building of the society of which the Constitution makers envisaged. Attending to public health, in our opinion, therefore, is of high priority – perhaps the one at the top.”

With respect to industries that engage in activities that are hazardous or inherently dangerous and which poses a potential threat to the health and safety of the persons working in the factory and residing in the surrounding areas, the court held that such enterprise “owes an absolute and nondelegable duty to the community to ensure that no harm results to anyone on account of hazardous or inherently dangerous nature of the activity which it has undertaken.” It further decided that, “if any harm results on account of such activity, the enterprise must be absolutely liable to compensate for such harm and it should be no answer to the enterprise to say that it had taken all reasonable care and that the harm occurred without any negligence on its part.”

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40 Bandhua Mukti Morcha Vs Union of India 1984 AIR 802, 1984 SCR (2) 67
41 Francis Coralie Mullin vs The Administrator, Union Territory of Delhi & ORS 1981 AIR 746, 1981 SCR (2) 516
42 Vincent Panikulangara vs. Union of India 1987 AIR 990, 1987 SCR (2) 468
43 MC Mehta v Union of India, 1987 AIR 1086, 1987 SCR (1) 819
44 MC Mehta v Union of India, 1987 AIR 1086, 1987 SCR (1) 819
In another matter by the same petitioner on pollution of the water in River Ganges by the leather tanneries the Supreme Court held, “[T]he pollution of the river Ganga is affecting the life, health and ecology of the Indo-Gangetic Plain….Those tanneries which have failed to take minimum steps required for the primary treatment of industrial effluent are directed to be closed. No doubt closure of tanneries may bring unemployment, loss of revenue, but life, health and ecology have greater importance to the people.”\(^{45}\) The case is another example of restriction on the right to carry on trade to protect the right to health and wellbeing of the population at large.

Underscoring the value of life as enshrined under Article 21 of the Constitution and the obligation on the State to preserve life, the Apex Court held that “A doctor at the Government hospital positioned to meet this State obligation is, therefore, duty-bound to extend medical assistance for preserving life.” The court further extended this obligation to “Every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life.” The Apex court barred any state action that may cause a delay in the discharge of this total, absolute and paramount obligation. It also held that “laws of procedure whether in statutes or otherwise which would interfere with the discharge of this obligation cannot be sustained and must, therefore, give way.”\(^{46}\)

In a matter of employee insurance for the labourers of the contractors of the Calcutta Electricity Supply Corporation (India) Ltd. The court held referring to the importance of right to health under the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights

\(^{45}\) M.C. Mehta vs Union Of India & Others 1988 AIR 1115, 1988 SCR (2) 530
\(^{46}\) Parmanand Katara Vs Union of India 1989 AIR 2039, 1989 SCR (3) 997
held that, “Article 39(e) of the Constitution enjoins the State to direct its policies to secure the health and strength of workers. The right to social justice is a fundamental right. Right to livelihood springs from the right to life guaranteed under Article 21. The health and strength of a worker is an integral fact of right to life.” in light of these international instruments and the socio-economic justice assured in our Constitution, “right to health is a fundamental human right to workmen.” The court further held that, “[T]he term health implies more than an absence of sickness. Medical care and health facilities not only protect against sickness but also ensures stable man power for economic development.”

Hearing a petition related to the concerns of occupational health hazards and diseases to the workmen employed in asbestos industries in India, the Apex Court referred to the Universal Declaration on Human Rights that asserts the human sensitivity and moral responsibility of every State and observed that “[t]he jurisprudence of personhood or philosophy of the right to life envisaged under Article 21, enlarges its sweep to encompass human personality in its full blossom with invigorated health which is a wealth to the workman to can his livelihood to sustain the dignity of person and to live a life with dignity and equality.” The Court further explained that, “[t]he expression 'life' assured in Article 21 of the Constitution does not connote mere animal existence or continued drudgery through life. It has a much wider meaning which includes right to livelihood, better standard of life, hygienic conditions in work place and leisure.” The Court increasing the meaning and ambit of Article 21 of the Constitution held, “that right to health, medical aid to protect the health and vigour to a worker while in service or post retirement is a fundamental right

under Article 21, read with Articles 39(e), 41, 43, 48A and all related Articles and fundamental human rights to make the life of the workman meaningful and purposeful with dignity of person.\textsuperscript{48}

Considering the question whether, the non-availability of facilities for treatment of the serious injuries sustained by a citizen in the various Government hospitals result in denial of his fundamental right guaranteed under Article 21 of the Constitution, the Apex Court replied in the affirmative. It held, “Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life.”\textsuperscript{49} The court further observed that a failure to do so will result in breach of the right under Article 21 and the State cannot avoid its responsibility for such denial of the constitutional right and shall be liable to pay adequate compensation to the victim. Further, the Court ordered that Primary health care centres be equipped to deal with medical emergencies. It has also been held in this judgement that the lack of financial resources cannot be a reason for the State to shy away from its constitutional obligation.\textsuperscript{50}

In another matter considering the question if the medical expenditures incurred by a government servant in a specialized approved private hospital is reimbursable by the state, the Supreme Court answering in the positive held that, “[I]t is now settled law that right to health is an integral to right to life. Government has constitutional obligation to provide the health facilities.”\textsuperscript{51} In a

\textsuperscript{48} Consumer Education and Resource Centre Vs Union of India 1995 AIR 922, \textsuperscript{49} Paschim Baga Khet Mazoor Samiti Vs State of West Bengal. 1996 SCC (4) 37 \textsuperscript{50} Ibid. \textsuperscript{51} State of Punjab and Others v. Mohinder Singh Chawla SLP (C) No.12472/96
similar matter the Court again held that “the State can neither urge nor say that it has no obligation to provide medical facility. If that were so it would be ex facie violative of Article 21” and directed the state to pay for the medical expenses of the respondents incurred in a private hospital.\textsuperscript{52}

4.3.2. High Courts of India on Right to Health

Hearing a plea for the establishment of a primary health centre in a village the High Court of Orissa held, “[l]ife is a glorious gift from God. It is the perfection of nature, a master-piece of creation. Human being is the epitome of the infinite prowess of the divine designer, great achievements and accomplishments in life are possible if one is permitted to lead an acceptably healthy life. Health is life’s grace and efforts are to be made to sustain the same. In a Country like ours, it may not be possible to have sophisticated hospitals but definitely villagers of this Country within their limitations can aspire to have a Primary Health Centre. The Government is required to assist people, and its endeavour should be to see that the people get treatment and lead a healthy life.”\textsuperscript{53}

Deliberating on the question, that whether the State machinery is bound to assure adequate conditions necessary for health, in a matter involving the maintenance of sanitation and drainage facilities by Municipal Corporation, the High Court of Madhya Pradesh held that the State and its machineries are bound to assure hygienic conditions of living. The Court observed that, “the Corporation cannot sit silent and adopt an apathetic attitude. The Corporation has corresponding statutory obligation under the Act (M.P. Municipal

\textsuperscript{52} State of Punjab & Ors. V. Ram Lubhaya Bagga Etc. 1998 AIR 1703
\textsuperscript{53} Mahendra Pratap Singh v. State of Orissa AIR 1997 Ori 37
Corporation Act, 1956) to take necessary remedial measures and corrective action against the Society.\textsuperscript{54}

Considering the challenge on the ban on sale of tobacco products within 100 yards of educational institution, the High Court of Delhi observed that, “the principles laid down in Cooverjee B. Bharucha v. Excise Commr., Ajmer\textsuperscript{55} and P.N. Krishna Lal v. Govt. of Kerala,\textsuperscript{56} that there is no fundamental right to trade in dangerous and noxious substances, would nevertheless apply to tobacco which has now been universally accepted as a major public health hazard.” Referring and agreeing with reasoning in Regina (Sinclair Collis Ltd.) Vs. Secretary of State for Health (2012) Q.B. 394 the Court concluded that “[s]ale of cigarettes and other tobacco products, whether in wholesale or in retail, near the educational institution has the potential of attracting the students thereof…The benefits from the said prohibition far outweigh the harm or loss to the handful of wholesellers.”\textsuperscript{57}

The High Court of Karnataka, deliberating on the right of an individual to have access to drinking water, held that the right to dig bore wells therefore can be restricted or regulated only by an Act of legislature and that the right to life includes the right to have access to clean drinking water.\textsuperscript{58}

In a petition against the health hazards to the inhabitants of Gwalior, on account of the pollution of the atmosphere by smoke emitted by vehicles running on unauthorized kerosene and diesel the High Court of Madhya

\textsuperscript{54} Citizens and Inhabitants of Municipal Ward vs. Municipal Corporation, Gwalior AIR 1997 MP 33, 1996 (0) MPLJ 642
\textsuperscript{55} AIR 1954 SC 220
\textsuperscript{56} 1995 Supp (2) SCC 187
\textsuperscript{58} Puttappa Honnappa Talavar v. Deputy Commissioner, Dharwad (Karnataka HC) AIR 1998 Kar 10
Pradesh observed, “[t]here can be no doubt that the human life is more important than the vehicle and traffic.” The Court directed the state to comply with the statutory obligations and take necessary steps to ensure that emission standards are implemented to maintain a pollution free atmosphere.59

Hearing two similar petitions of denial of benefits to two mothers below the poverty line (BPL) during their pregnancy and immediately thereafter, under various government schemes60 the High Court of Delhi held that, “these petitions are essentially about the protection and enforcement of the basic, fundamental and human right to life under Article 21 of the Constitution and focus on two inalienable survival rights that form part of the right to life. One is the right to health, which would include the right to access government (public) health facilities and receive a minimum standard of treatment and care. In particular this would include the enforcement of the reproductive rights of the mother and the right to nutrition and medical care of the newly born child and continuously thereafter till the age of about six years. The other facet is the right to food which is seen as integral to the right to life and right to health.”

With respect to the failure of the state to provide the benefits of the scheme resulting in death of one of the mother the Court awarded compensation in both cases with detailed arrangement for the benefits to be extended to the husband and child of the deceased mother61 and for the mother62 and the child in the

59 Santosh Kumar Gupta v Secretary, Ministry of Environment, New Delhi (Madhya Pradesh HC) AIR 1998 MP 43
60 The Janani Suraksha Yojana (JSY), the Integrated Child Development Scheme (ICDS), the National Maternity Benefit Scheme (NMBS), the Antyodaya Anna Yojana (AAY) and the National Family Benefit Scheme (NFBS).
61 Mother died as a result of being refused adequate maternal health care despite the fact that she qualified for the free services under the existing State-sponsored schemes. The Court ordered Government of Haryana to pay compensation of 2.4 lakhs to the husband.
62 The Court ordered Municipal Corporation of Delhi to pay compensation of Rs 50,000 to the mother for the violation of her fundamental rights by being compelled to give birth to her daughter under a tree.
other case. The Court also directed the state to extend all benefits of the various government schemes and the benefit amounts forthwith to the husband of the deceased mother and her child and to the mother and the child in respective matters.  

Considering the issue, whether a minor child of poor family suffering from a chronic and rare disease, gaucher, is entitled to free medical treatment the High Court of Delhi held that the State is under a legal obligation to ensure access to life saving drugs to patients as it is critical to promoting and protecting the right to health. The Court observed, “[g]overnment cannot cite financial crunch as a reason not to fulfil its obligation to ensure access of medicines or to adopt a plan of action to treat rare diseases. In the opinion of this Court, no government can wriggle out of its core obligation of ensuring the right of access to health facilities for vulnerable and marginalized section of society, like the petitioner by stating that it cannot afford to provide treatment for rare and chronic diseases.” The Court, further highlighting the need for poor people of the society to be able to enjoy the benefits of technological advancement in medical and health care, observed that “government needs to seriously consider expanding its health budget if their right to life and right to equality as enumerated in Articles 14 and 21, are not to be rendered illusionary.” The Court concluded thus:

63 Laxmi Mandal v. Deen Dayal Harinagar Hospital, (2010) 172 DLT 9
64 The treatment cost was about rupees six lakhs per month. However the treatment is known, prognosis is good and there is every likelihood of petitioner leading a normal life if he continues to get the treatment. Wherein the State Government, the Union of India and AIIMS stated that in view of their restricted resources they were not able to fund the treatment of the petitioner as it was lifelong and his condition was chronic.
“To conclude, today, on account of lack of Government planning, there is ‘pricing out’ of orphan drugs for rare and chronic diseases, like Gaucher. The enzyme replacement therapy is so expensive that there is a breach of constitutional obligation of the Government to provide medical aid on fair, reasonable, equitable and affordable basis. By their inaction, the Central and the State Governments have violated Articles 14 and 21 of the Constitution.

Just because someone is poor, the State cannot allow him to die. In fact, Government is bound to ensure that poor and vulnerable sections of society have access to treatment for rare and chronic diseases, like Gaucher especially when the prognosis is good and there is a likelihood of the patient leading a normal life. After all, health is not a luxury and should not be the sole possession of a privileged few.”

In light to the above observations and decisions of the Supreme Court of India and various High Courts in the Country, it may be inferred that the courts in this country have sufficiently elaborated on the right to health being one of the non-derogable fundamental rights ingrained under the right to life i.e Article 21 of the Constitution of India. Going a step further, courts have suggested affirmative action by the state to ensure that the poor, vulnerable and marginalized section of the society are extended the protection of fundamental right to health. As such, for a population, which is predominantly at the poverty

65 Mohd. Ahmed (Minor) vs Union Of India & Ors. W.P.(C) 7279/2013. High Court of Delhi on 17 April, 2014
or subsistence level, expecting people to go to the courts to seek justice for what is constitutionally ordained as a right is unrealistic as well as discriminatory. The state and its machinery should take proactive and progressive measures to ensure that the fundamental right to life ordained under the Constitution of India, including the right to health may be effectively delivered and realized by the citizen of the country. The mere constitutional provision is not a sufficient condition to guarantee a right, and more so in a situation like health and health care where in provisions in the form of services and commitment of vast resources are necessary to fulfil the right.66

Above discussed are just a few among the plethora of health rights litigation that have influenced the deliberation and adoption of public health policy especially in the areas of regulation of blood banks, regulation of drugs, emergency care, mental health care, medical negligence and malpractice by public entities, tobacco control laws, and reproductive rights. In each of these instances, guidelines issued by the courts have recommended the adoption of measures to fill existing policy and legislative gaps, which have triggered government initiatives thereon. There is no way to determine whether these policy and legislative initiatives would have been adopted in the absence of health rights litigation. But correlations between the Court’s pronouncements and subsequent policy and legislative developments are clear (See Table 4.2 below).

### Table 4.2: Impact of litigation on public health policy outcomes in India

<table>
<thead>
<tr>
<th>Case</th>
<th>Litigation outcome</th>
<th>Health policy outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood banks (1998)</td>
<td>Licensing system outlined for blood banks</td>
<td>Blood bank legislation extensively revised in 1999 to include good manufacturing practices, standard operating procedures, and validation of equipment (Blood Index 2007)</td>
</tr>
<tr>
<td>Drugs and vaccines (1995, 1996)</td>
<td>Specific orders issued banning the drug Analgin</td>
<td>Directives issued by central government in 1996 banning the manufacture, sale, and distribution of fixed-dose combinations of Analgin and antispasmodics (Pharmainfo.net 2009) Mashelkar Committee appointed by Ministry of Health to comprehensively review the drug regulatory system to prevent the manufacture and sale of substandard and spurious drugs</td>
</tr>
<tr>
<td>Mental health care (1991)</td>
<td>Government ordered to improve mental health institutions and integrate mental health into primary care</td>
<td>National Human Rights Commission delegated oversight of three mental institutions (National Human Rights Commission 2006, 2), which later reported progress in practice</td>
</tr>
<tr>
<td>Medical negligence (2001)</td>
<td>Guidelines framed under which a doctor could be held criminally liable for professional negligence or deficiency of service</td>
<td>Medical Council of India ordered to institute a formalized mechanism for hearing complaints In 2002, regulations on professional conduct, etiquette, and ethics adopted by Medical Council of India; chapter 8 concerns punishment and disciplinary action (Medical Council of India Notification 2002)</td>
</tr>
<tr>
<td>Tobacco control laws (2001)</td>
<td>In the absence of statutory provisions, smoking prohibited in public places (e.g., hospitals, health institutions, educational institutions). All levels of government directed to take necessary action to implement the ban</td>
<td>Tobacco-control legislation passed</td>
</tr>
</tbody>
</table>

### 4.3.3. Courts on Right to Health and Human Right vis-à-vis Tobacco

The judicial system universally acknowledges that tobacco use and its catastrophic consequences violate the basic tenets of human rights. The
preambular text of the FCTC makes several references to the established human rights treaties including ICESCR, CRC and CEDAW.\textsuperscript{67} Further, the judiciary in India, as the guarantor of the fundamental rights, in several occasion took \textit{suo moto} cognizance of matters involving the abuse of human rights and while in other cases allowed public interest litigation to remedy public wrongs caused by tobacco use.

The High Court of Kerala recently observed, “[w]e note with distress that the use of tobacco and allied products is spreading like cancer among the children and adolescents below the poverty line to which the majority of the population belongs….the smokers dig not only their own grave prematurely, but also pose a serious threat to the life of innocent non-smokers who get themselves exposed to environmental tobacco smoke thereby violating their right to life.”\textsuperscript{68}

The Supreme Court of India in 2001 had observed that, “[F]undamental right guaranteed under Article 21 of Constitution of India, inter alia, provides that none shall be deprived of his life without due process of law. Then - why a non-smoker should be afflicted by various diseases including lung cancer or of heart, only because he is required to go to public places? Is it not indirectly depriving of his life without any process of law? The answer is obviously - 'yes'. Undisputedly, smoking is injurious to health and may affect the health of smokers but there is no reason that health of passive smokers should also be


\textsuperscript{68} Kerala Voluntary Health Services v. The Union of India and others WP No. 38513, High Court of Kerala at Ernakulam (2012)
injuriously affected. In any case, there is no reason to compel non-smokers to be helpless victims of air pollution.\textsuperscript{69}

The Lahore High Court termed cigarette advertisements on TV/Radio as detrimental to life and body of the people and thus contravened with the right to life enshrined under the Pakistan’s Constitution (Article 4)\textsuperscript{70}. The Court held that, the citizens of this country (Pakistan) and particularly the younger generation are entitled to protection of law from being exposed to hazards of cigarette smoking by virtue of the command contained in Article 4 (2) (a) of the Constitution.\textsuperscript{71}

A High Court in Bangladesh reiterated that tobacco use and its promotion violated the basic right to life enshrined under Article 31\textsuperscript{72} of the Constitution of Bangladesh and passed an order of stay directing the respondent tobacco companies and their allies not to proceed with promotional advertisement activities through their “Voyage of Discovery”. The Court held that the “state


\textsuperscript{70} Right of individuals to be dealt with in accordance with law, etc. (1) To enjoy the protection of law and to be treated in accordance with law is the inalienable right of every citizen, wherever he may be, and of every other person for the time being within Pakistan.

(2) In particular :-

(a) no action detrimental to the life, liberty, body, reputation or property of any person shall be taken except in accordance with law;

(b) no person shall be prevented from or be hindered in doing that which is not prohibited by law; and

(c) no person shall be compelled to do that which the law does not require him to do.

\textsuperscript{71} Pakistan Chest Foundation and others Vs. Government of Pakistan and others reported in 1997 CLC 1379 arising out of Writ Petition No. 14433 of 1994.

\textsuperscript{72} Article 31. Right to protection of law: To enjoy the protection of the law, and to be treated in accordance with law, and only in accordance with law, is the inalienable right of every citizen, wherever he may be, and of every other person for the time being within Bangladesh, and in particular no action detrimental to the life, liberty, body, reputation or property of any person shall be taken except in accordance with law.
has a duty to protect the ordinary human being from the ill effects of the use of tobacco related products.”

The High Court of Kerala in a plea to prevent smoking in public places held that, “Public health action by policy makers to eliminate exposure to environmental tobacco smoke (ETS) is long overdue. A total ban on smoking is preferred on various grounds. Policy makers should pursue all strategies that would help accomplish that goal, including education, legislation, regulation, litigation and enforcement of existing laws.” Justice Narayana Kurup further added that, “public smoking of tobacco in any form whether in the form of cigarettes, cigars, beedies or otherwise is illegal, unconstitutional and violative of Article 21 of the Constitution of India.”

4.3.4. Tobacco Litigation in India

4.3.4.1. Preventing abetment of smoking in public places

Keeping with the mandates of the regulations under Section 4 of COTPA, Municipal Corporation of Mumbai issued circular prohibiting the sale of tobacco or tobacco-related products in any form and the presence of any device designed to facilitate smoking in eating houses. To avoid compliance with the circular the owners of restaurants challenged the legality of the circular in the High Court of Bombay and argued: that corporation did not have the right to impose such restrictions as they amounted to a total ban on the sale of tobacco products, exceeding the power provided by India’s tobacco control law. Further the restaurant owners argued that, hookahs did not fall within the restrictions and that hookah smoking is not dangerous or injurious to public health.

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74 K. Ramakrishnan And Anr. vs State Of Kerala And Ors. AIR 1999 Ker 385
However, the Court dismissed the write petitions and upheld the legality of the circular.\textsuperscript{75}

4.3.4.2. Access to minors

Bombay High Court directed Ministry of Health and Family Welfare, Government of India to notify the implementation of Section 6 (b) of COTPA with respect to the prohibition of sale of tobacco products within 100 yards of educational institution. As a result Section 6(b) of COTPA was notified and came into force on September 18, 2009. \textsuperscript{76} Following this order, other high courts in the country issued directions to the appropriate enforcement authorities including in various Departments and Municipal Corporations to take necessary steps to implement the provisions of COTPA, in particular, Section 4 (prohibition on smoking in public place) and Section 6 (prohibition on sale of tobacco products to minors and near educational institutions).\textsuperscript{77,78,79,80}

The Hon’ble Delhi High Court dismissed the petition of tobacco wholesalers association seeking exemption to do wholesale business within 100 yards of educational institution (prohibited under S.6(b) of COTPA) and ordered the said association to pay costs to both the Central and State Governments, which would be utilized for anti-tobacco initiatives.\textsuperscript{81} However, when appeal is filed against the High Court order on 01.02.2013, the Hon’ble Supreme Court ex-

\textsuperscript{76} Sumaira Abdulali v. Union of India, PIL/182/2007, High Court of Bombay [Date of judgment/order_09.07.2009]
\textsuperscript{77} Jammu and Kashmir Voluntary Health and Development Association v. State and Others, OWP(PIL) No. 406/2010, High Court of Jammy and Kashmir. [Date of judgment/order_03.06.2011]
\textsuperscript{78} World Lung Foundation South Asia v. Ministry of Health and Family Welfare, High Court, MANU/DE/2692/2012, High Court of Delhi (Date of judgment/order_16.05.2012)
\textsuperscript{79} Cancer Patients Aid Association v. State of Karnataka & Another, Writ Petition (Civil) No. 17958/2009, High Court of Karnataka ([Date of judgment/order_29.03.2011])
\textsuperscript{80} Kerala Voluntary Health Services v. Union of India, Writ Petition 38513 of 2010, High Court of Kerala ([Date of judgment/order_26.03.2012])
\textsuperscript{81} Naya Bans Sarv Vyapar Association v. Union of India and Ors , W.P. (C) No. 7292/2011 and W.P.(C) No. 4392/2012, High Court of Delhi [Date of judgment/order_09.11.2012]
parte stays the High Court Judgment with the condition that the petitioners shall transact their wholesale business only after 2.00 P.M. and they will not indulge in any retail business.82

4.3.4.3. Pictorial health warnings on all tobacco products

The implementation of pictorial health warning on all tobacco products in India was only possible due to writ petitions filed by public spirited groups. The Government of India notified the pictorial health warnings as a result of a PIL before the Hon’ble Himachal High Court in the year 2006.83 Subsequently, after extensive delay and dilution the pictorial warnings finally came after the Apex Court demanded an undertaking that the pack warnings would be implemented without delay.84

4.3.4.4. Point of sale advertisements of all tobacco products

The Ministry of Health notified certain restrictions on advertisements at the point of sale, however, enforcement of these regulations were stayed in an ex-parte proceeding by the Bombay High Court in 2005.85 It is only through a petition before the Hon’ble Supreme Court of India the Bombay High Court order was set aside and paved way for implementation of the rules.86

4.3.4.5. Display of tar and nicotine contents

At the direction of the Hon’ble Delhi High Court, the Government gave an undertaking that they will create the requisite institutional capacity to test

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82 Supreme Court of India SLP(C)No(s).39271-39272/2012
83 Ms Ruma Kaushik v. UOI CWP No. 1259 of 2007, High Court of Himachal Pradesh (Date of judgment/order_07-06-2006 and 06-07-2006)
84 Health for Millions Trust v. Union of India and Others, Writ Petition (Civil) 549 of 2008, Supreme Court of India (Date of judgment/order_06.05.2009)
85 Namdeo Kamathe v. Union of India Writ Petition (Civil) 8763/2005, High Court of Bombay and Sridhar Kulkarni v. Union of India Writ Petition (Civil) 6151/2005, High Court of Bombay (Date of judgment/order_19.12.2005 and 27.03.2006)
86 Health for Millions v. Union of India and Others, Special Leave Petition No. 413-414 of 2013, Supreme Court of India (Date of judgment/order_22.07.2013)
the nicotine and tar contents of tobacco products by setting up tobacco testing laboratories to enforce the provisions of COTPA, Section 7(5), that mandates display of tar and nicotine contents on the packs containing tobacco products.\textsuperscript{87}

4.3.4.6. Restrictions on tobacco advertising, promotion and sponsorship (TAPS)

High Court of Gujarat issued directions to the Gujarat State Road Transport Corporation and Ahmedabad Municipal Transport Services for removal of advertisements of gutkha and/or pan masala displayed on the public transport vehicles.\textsuperscript{88}

Karnataka High Court directed the Government of India to withdraw sponsorship extended by the Tobacco Board of India to a tobacco industry sponsored event in October 2010 to ensure compliance with Section 5 of COTPA.\textsuperscript{89} Further, on February 8, 2011 an undertaking was given by the Government that they would strictly adhere to and implement the provisions of COTPA. The Government also gave an assurance of considering the Petitioner’s proposal of a Code of Conduct for public officials, to prevent interference from the Tobacco Industry, whilst developing and implementing public health policies and programs pertaining to tobacco control, in accordance with Article 5.3 of the FCTC.\textsuperscript{90}

While Delhi High Court was hearing a petition for quashing a notification whereby subsidies and exemptions to the manufacturers of Gutkha and

\textsuperscript{87} Puneet Gupta v. Union of India and Others W.P. (C) No.18440 of 2004, High Court of Delhi (Date of judgment/order 10.12.2008)

\textsuperscript{88} Amarsinh Z Choudhari v.. Union of India, Special Civil Application (SCA) /4848/2009 2/2, High Court of Gujarat (Date of judgment/order 22.12.2010)

\textsuperscript{89} Institute of Public Health v.. The State Government of Karnataka and Others, Writ Petition 27692/2010, High Court of Karnataka (Date of judgment/order 08.02.2011)

\textsuperscript{90} Article 5.3: “In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.”
chewing tobacco products were restored; the Government withdrew the said notification. 97

4.3.4.7. Complete prohibition on sale of gutkha

The very first ban under the Food Safety And Standards Regulation, 2011 was imposed by the State of Madhya Pradesh and at the very first instance the Ghoi foods private limited 92 went to the Gwalior Bench of the Madhya Pradesh High Court challenging the State notification. Similarly, the notification of the Government of Kerala was challenged by the All Kerala Tobacco Dealers' Association, 93 the notification of the Government of Bihar was challenged before the Hon'ble Patna High Court by Lal Babu Yadav, 94 the notifications of the Delhi, 95 Rajasthan, 96 Bombay 97 Karnataka Governments, and many other such cases were filed one after another across the country challenging the decisions of the governments. However, all the Hon'ble High Courts rejected the gutkha Companies plea for stay of the State government's notifications imposing the ban.

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91 Bejon Mishra v.. Union of India and Others, Writ Petition (Civil)7789/2006, High Court of Delhi (Date of judgment/order_10.05.2007).
92 Ghoi Food Pvt. Ltd. V. Union of India, Writ Petition No. 3131/2012; High Court of Madhya Pradesh (Gwalior Bench) (Date of judgment/order_07.05.2012)
93 All Kerala Tobacco Dealers' Association v. State of Kerala Writ Petition W.P.C Nos. 12352/2012, 12932/2012, 13271/2012 & 13580/2012, High Court of Kerala (Date of judgment/order_02.08.2012)
94 Lal Babu Yadav v.. State of Bihar and Ors Civil Writ Jurisdiction Case No.10297 of 2012; High Court of Patna (Date of judgment/order_10.07.2012)
95 Trimurti Fragrance vs Union of India and Others. The Writ Petition(C) No. 6483/2012, High Court of Delhi (Date of judgment/order_12.10.2012)
96 Dinesh Tobacco Industries v.. State and others (W.P.(C) 8602/2012) Rajasthan High Court (Jodhpur Bench)
97 M/s. Dhariwal Industries Limited and another v. The State of Maharashtra and others. (WP No. 1631 or 2012); Ghodawat Pan Masala Products (I) Pvt. Ltd V. The State of Maharashtra and Others (WP No. 1632 or 2012); Rajnandini Foods Pvt. Ltd. V. The State of Maharashtra (WP No. 1633 or 2012); SDD Agencies Pvt. Ltd. V. The State of Maharashtra (WP No. 1634 or 2012), M/s. Hira Enterprises V. The State of Maharashtra (WP No. 1635 or 2012); Rajat Industries Pvt. Ltd. V. The State of Maharashtra (WP No. 7592 or 2012)
The Indian Dental Association of the State of Uttar Pradesh, has filed in the Allahabad High Court for issuance of similar order as the State Government of MP, for implementation of the FSSAI Regulation 2.3.4, banning gutkha. The Hon’ble High Court of Allahabad directed the State Governments to take steps for enforcement of the Regulation banning gutkha. Similar order was passed by the Hon’ble High Court of Delhi, the Hon’ble High Court of Jammu and Kashmir and the Hon’ble High Court of Andhra Pradesh. The Bombay High Court also dismissed a petition seeking exemption from ban on gutkha manufactured for exports purposes. Hearing a special leave against this order, the three judge bench of the Hon’ble Supreme Court dismissed the petition.

Considering the volume of litigations regarding the Regulation, the Government of India, through the Ministry of Health and Family Welfare, filed a transfer petition namely Union of India & Another v. Dharampal Satyapal Ltd. and Others and Food & Safety Authority of India Etc. v. M/s Kaipan Panmasala Pvt. Ltd. And Others requesting the Hon’ble Supreme Court to transfer all the cases and hear the matter itself to avoid passing of inconsistent and conflicting decisions by different High Courts and also adverse orders against the enforcement of the Regulation. The Hon’ble Supreme Court allowed the transfer petition and directed all the Health Secretaries of the State.

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98 Indian Dental Association U.P. State And Another v. State Of U.P. And Another. PIL No. 19126 of 2012; High Court of Allahabad (Date of judgment/order_17.09.2012)
99 Doctors For You Through Its Vice-President v.. State of Delhi and Ors. WP(C )5103/2012, High Court of Delhi (Date of judgment/order_22.08.2012)
100 SJJ Exports Company Vs Food Safety Commissioner & Ors., WP No.2266/20 Special leave petition No(s).8432/2013 vide order dated 01/03/2013
101 Union of India & Another v. Dharampal Satyapal Ltd. and Others Transfer Petition (Civil) 683 Of 2012, Supreme Court of India (Date of judgment/order_03.08.2012)
102 Food & Safety Authority of India Etc. v. M/s Kaipan Panmasala Pvt. Ltd. And Others Transfer Petition (Civil) 1147 -1152 of 2012, Supreme court of India
Governments that had banned gutka and pan masala (containing tobacco and nicotine) under the FSSAI Regulation 2.3.4, to file a compliance report on the status of the implementation of the ban, and all the Health Secretaries of the States that have not issued any ban orders under the FSSAI Regulation 2.3.4, to file an affidavit stating as to why they have not implemented the ban.¹⁰⁴

All these petitions relating tobacco control issues before the various high courts and the Supreme Court of India involved key constitutional question of freedom to trade in tobacco, freedom to express including to advertise, right to livelihood of the tobacco sellers, growers and workers on the one hand and the right to life including right to health and healthy environment on the other. The Courts have invariable, except for a few instance on technical grounds of such specific matter, have taken upon themselves to protect the human rights including right to health of the citizens of this country.

4.4. WTO DISPUTE SETTLEMENT AND PUBLIC HEALTH

According to a joint study by WTO and WHO, formal dispute settlement at the WTO is a last-resort option and it is preferable that countries solve their differences among themselves, whether bilaterally, plurilaterally or multilaterally.¹⁰⁵ Several disputes between WTO members are unlikely ever come before the DSB while several others do not reach to the formal dispute settlement procedures. Members have all options open to resolve the dispute at any stage and it is only where members are not able to reach to a solution otherwise, they bring the dispute to the WTO. The dispute relates to failure of

¹⁰⁴ Ankur Gutkha Vs Indian Asthma Society & Ors. Special Leave Petition No. 16308 of 2007, Supreme Court of India
the member to comply with WTO agreements or commitments. A member cannot complain about another government's health policy as such, it can only complain if it believes a particular measure breaks an agreement or commitment that the other government has made in the WTO. Companies, organizations or investors do not have a right to bring claim against governments before the DSB under WTO. However, they can bring dispute before the arbitration tribunals like ICSID or UNCITRAL for violation of the treaty obligations under the bilateral investment treaties.

With respect to public health related matter before the DSB the WTO panels have been willing to consider extraneous public health instruments even without any reference to a rule explicitly allowing them to do so. In light of the Doha Declaration and the declaration on WHO-FCTC at the Punta Del Este, international health instruments, including FCTC, are being used to interpret the scope of WTO norms or to allow health interests to be integrated with WTO law. Experts suggest that health instruments should be utilized as tools for the effective interpretation of international norms.  

According to WHO commissioned report on tobacco epidemic in the times of trade and investment liberalisation, WTO panels and the Appellate Body have proven to be more deferential to non-trade goals than some commentators once feared they would be. The following section takes a look at some of the disputes, before the WTO and other arbitration tribunals, which have a bearing on public health in

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general and some specifically on tobacco control and implementation and enforcement of the FCTC.


The health and tobacco trade debate dates back to the late 1980s when the US government initiated actions to get Thailand and some other Asian countries to open their markets to US tobacco products. The US government succeeded in entering into favourable agreements with several countries, however under the 1966 Tobacco Act, Thailand prohibited the importation of cigarettes and other tobacco preparations, but authorized the sale of domestic cigarettes. Cigarettes were also made subject to an excise tax, a business tax and a municipal tax.

The US government challenged the import restrictions saying it were inconsistent with GATT Article XI and considered that they could not be justified by either (i) some of the exceptions to the elimination of quantitative restrictions allowed under Article XI or (ii) Article XX(b) since as applied by Thailand they were not necessary to protect human health. It also argued that the internal taxes were inconsistent with GATT Article III:2 relating to "National Treatment on Internal Taxation and Regulation". However, Thailand defended the import restrictions on the ground of Article XX(b) as the tobacco control measures adopted by the Thai government could only be effective if cigarette imports were prohibited. It contended that the chemicals and other additives contained in United States cigarettes makes them more harmful to human health than Thai cigarettes.

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US government requested the panel to recommend that: Thailand eliminate its quantitative restrictions on imports of cigarettes and that it bring its tax laws and practices into conformity with its obligations under the General Agreement. Whereas, Thailand requested the Panel to reject the complaint of the United States.

The Panel held meetings with the parties to the dispute on 2 and 27 July 1990. It consulted with officials of the World Health Organization on 19 July 1990. The delegation of the European Communities made an oral submission to the Panel at the meeting held on 27 July 1990. The Panel submitted its report to the parties on 21 September 1990.

The European Communities stated their significant interest in the opening of the Thai market for cigarettes which was estimated to be worth approximately US$1,500 million annually. It believed that the operation of Thailand's import licensing régime for cigarettes constituted a de facto prohibition inconsistent with Article XI:1, which was not covered by the exceptions set out in Article XI:2 or Article XX(b) and could not be justified under Thailand's Protocol of Accession to the GATT.109

While deposing before the Panel, the representative from the WHO highlighted the difference between the cigarettes of two countries and the concern that how allowing import of cigarettes leads to increase in smoking. Further, the multinational tobacco companies circumvent the regulations prohibiting advertisements and entice young children and women by manufacturing, advertising and promoting specially designed cigarettes for them. The statement read:

“There were sharp differences between the cigarettes manufactured in developing countries such as Thailand and those available in developed countries. In Thailand like in other developing countries, the market was dominated by a state-owned monopoly which promoted smoking minimally, in the absence of competition. Locally grown tobacco leaf was harsher and smoked with less facility than the American blended tobacco used in international brands. Locally-produced cigarettes were unlike those manufactured in western countries in that sophisticated manufacturing techniques such as the use of additives and flavourings, or the downward adjustment of tar and nicotine were not generally available, or were primitive in comparison to the techniques used by the multinational tobacco companies. These differences were of public health concern because they made smoking western cigarettes very easy for groups who might not otherwise smoke, such as women and adolescents, and create the false illusion among many smokers that these brands were safer than the native ones which consumers were quitting.”

However, the US did not consider that the WHO was specially competent to address the "health consequences of the opening of the market for cigarettes" as requested by Thailand.


111 Para 58. Ibid.
The Panel found that the import restrictions were inconsistent with Article XI and not justified under the exceptions which that Article allows for. It further concluded that the import restrictions were not "necessary" within the meaning of Article XX(b) (i.e. not necessary for the protection of human life or health). The Panel considered that there were various measures consistent with the General Agreement which were reasonably available to Thailand to control the quality (Para 77), quantity including demand (Para 78) and supply (Para 79) of cigarettes smoked and which, taken together, could achieve the health policy goals that the Thai government pursues by restricting the importation of cigarettes inconsistently with Article XI:1. The Panel found therefore that Thailand's practice of permitting the sale of domestic cigarettes while not permitting the importation of foreign cigarettes was an inconsistency with the General Agreement not "necessary" within the meaning of Article XX(b). The internal taxes, on the other hand, were found to be consistent with Article III:2.\textsuperscript{112}

Though the import restrictions by Thailand were held inconsistent with the GATT, the panel allowed Thai government to continue the restriction on direct and indirect advertisement of tobacco products and also the point of sale promotions. Other countries that engaged in bilateral agreement with US ended up allowing advertising.


France imposed a prohibition of asbestos and products containing asbestos, including a ban on imports of such goods under a Decree of 24 December 1996. On 28 May 1998, Canada requested consultations with the EC, with

respect to the prohibition and alleged that these measures violate Articles 2, 3 and 5 of the SPS Agreement, Article 2 of the TBT Agreement, and Articles III, XI and XIII of GATT 1994. Canada requested the establishment of a panel to settle the dispute.  

The panel found that chrysotile asbestos and the substitute products had, inter alia, similar “end-uses”, making the products alike. Thus, the French ban violated the national treatment provisions of GATT Article III.4 Nevertheless, the panel decided that France had a right to apply the ban under GATT Article XX (b) because the health risk of asbestos was substantial (Panel Report, paragraph 8.119). Canada appealed the ruling.

The WTO Appellate Body reversed the panel’s decision on three counts however, overall it affirmed the result of the dispute panel’s ruling in favour of EU.

- The French Decree was not inconsistent with the European Communities’ obligations under the WTO agreements;
- Reversed the Panel’s finding and found that the TBT Agreement applies to the measure viewed as an integrated whole. It held the French measure in question consistent with the TBT Agreement;
- Reversed the Panel’s findings that the Panel erred in excluding the health risks associated with asbestos from its examination of “likeness” under Article III:4.
- Reversed the Panel’s conclusion and itself examined Canada’s claims under Article III:4 of the GATT 1994 and ruled that Canada has not

satisfied its burden of proving the existence of “like products” under that provision; and

- Upheld the Panel’s conclusion, under Article XX(b) of the GATT 1994, that the French Decree is “necessary to protect human life or health”.

It is important to note that the Appellate Body overruled the finding of the panel, which held that as a general matter, health risks cannot be taken into account in dealing with likeness. The Appellate Body brought in health concerns when dealing with the physical differences between asbestos and the substitute products. It held, “Under Art. III:4 health risks may be relevant in assessing the competitive relationship in the marketplace between allegedly “like” products”.\(^{114}\) It also noted that not only physical characteristics, but consumer tastes, end uses, and other criteria may be relevant to assessing “likeness” from the point of view of “competitive relationships among and between products”.\(^{115}\)

### 4.4.3. European Communities v. Brazil (2005-2007)

This case arise from the decision of Brazil to impose import prohibition on re-treaded tyres (import ban), levy fines on importing, marketing, transportation, storage, keeping or warehousing of re-treaded tyres (fines), national law restricting marketing of imported re-treaded tyres and exemptions of re-treaded tyres imported from Mercosur countries from the Import Ban and fines (“MERCOSUR exemption”).\(^{116}\) The EC considered that these measures are inconsistent with Brazil’s obligations under Articles I:1, III:4, XI:1 and XIII:1 of

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\(^{114}\) Asbestos, para. 115

\(^{115}\) Asbestos, para. 103

the GATT 1994. In July 2005, Argentina requested to join the consultations, which Brazil agreed to.

Argentina, Australia, Japan, Korea and the United States reserved their third party rights at the meeting. Subsequently, China, Cuba, Guatemala, Mexico, Paraguay, Chinese Taipei and Thailand reserved their third party rights. Keeping with the ECs second request in March 2006, the Director-General composed the panel.

Brazil invoked Article XX (b) to justify the ban and argued that retreaded tyres have a shorter lifespan than new tyres and its import increases the accumulation of waste tyres to a greater degree than new tyres. The waste tyres are breeding ground for disease-carrying mosquitoes and release harmful chemicals when burnt and thus pose threat to human health. Though the Panel agreed that the import ban contributed to protect human health and discarded arguments that taking steps to clean up waste tyres and encourage domestic retreading may constitute a reasonable available alternative to the ban.

Notwithstanding the recognized necessity of the measures to protect human health, Brazil ultimately lost the dispute as the partial approach adopted by Brazil did not comply with the chapeau of Article XX.

The Panel concluded that Brazil’s import prohibition on retreaded tyres and the fines imposed were inconsistent with Art. XI:1 and is not justified under Article XX(b) of GATT 1994. Further, it held that the Brazilian law was inconsistent with Art. III:4 of GATT 1994 in that it accords less favourable treatment to
imported retreaded tyres than to like domestic products and is not justified under Article XX(b) of GATT 1994.\textsuperscript{117}

The Appellate Body upheld the Panel's finding that the Import Ban was provisionally justified as “necessary” within the meaning of Art. XX(b). It reversed the Panel's findings and held that the MERCOSUR exemption has resulted in the import ban being applied in a manner that constitutes arbitrary or unjustifiable discrimination within the meaning of the chapeau of Article XX. The Appellate Body also upheld, albeit for different reasons, the Panel's findings that the import ban is not justified under Article XX of the GATT 1994. Brazil agreed to implement the recommendations and rulings of the DSB in a manner consistent with its WTO obligations.

**4.4.4. Indonesia v. United States (2010-2014)**

In this instance, Indonesia challenged United States restrictions on flavoured tobacco products that prohibit clove cigarettes but not menthol cigarettes.\textsuperscript{118} Indonesia alleged that Section 907 is inconsistent, inter alia, with Article III:4 of the GATT 1994, Article 2 of the TBT Agreement, and various provisions of the SPS Agreement and is not defensible under Article XX (b) of the GATT 1994, and requested for consultation and later for the establishment of a panel.\textsuperscript{119}

\textsuperscript{117} WTO Dispute (DS332). Brazil – Measures Affecting Imports of Retreaded Tyres. Available at: https://www.wto.org/english/tratop_e/dispu_e/cases_e/ds332_e.htm accessed on 12-06-2016.

\textsuperscript{118} Section 907(a)(1)(A) of the Federal Food, Drug, and Cosmetic Act (“Section 907(a)(1)(A)”), a tobacco control measure adopted by the United States.

\textsuperscript{119} WTO Dispute DS406. United States — Measures Affecting the Production and Sale of Clove Cigarettes. Available at: https://www.wto.org/english/tratop_e/dispu_e/cases_e/ds406_e.htm accessed on 13-06-2016.
Brazil, the European Union, Guatemala, Norway and Turkey reserved their third-party rights. Subsequently, Colombia, the Dominican Republic and Mexico reserved their third-party rights.\textsuperscript{120}

These restrictions were found to be discriminatory in violation of Article 2.1 of the Agreement on Technical Barriers to Trade (TBT Agreement). Appellate Body disagreed with the Panel that the concept of “like products” in Art. 2.1 should be interpreted based on the regulatory purpose of the technical regulation at issue and held that is should be based on an analysis of the traditional “likeness” criteria of physical characteristics, end use, consumer tastes and habits, and tariff classification.\textsuperscript{121}

The Panel observed that Indonesia failed to demonstrate that the ban on clove cigarettes:

- Exceeds the level of protection sought by the United States.\textsuperscript{122}
- Makes no material contribution to the objective of reducing youth smoking.\textsuperscript{123} Panel did not agree with its argument that banning clove cigarettes will do little to deter young people from smoking.\textsuperscript{124}
- Is more trade-restrictive than alternative measures that would make an equivalent contribution to achievement of the objective at the level of protection sought by the United States.\textsuperscript{125}

\textsuperscript{120} WTO Dispute DS406. United States — Measures Affecting the Production and Sale of Clove Cigarettes. Available at: https://www.wto.org/english/tratop_e/dispu_e/cases_e/ds406_e.htm accessed on 13-06-2016.
\textsuperscript{121} ibid.
\textsuperscript{122} Paras. 7.373–7.374. ibid.
\textsuperscript{123} Para. 7.389. ibid.
\textsuperscript{124} para. 7.401. ibid.
\textsuperscript{125} Para. 7.422. ibid.
4.4.5. WTO Dispute (406) and WHO-FCTC

During the proceedings the parties have referred to the FCTC,\textsuperscript{126} as part of the current international efforts to curb smoking\textsuperscript{127} and said, “we are aware of the important international efforts to curb smoking within the context of the WHO FCTC and its WHO Partial Guidelines”.\textsuperscript{128} The panel observed that “the FCTC was negotiated in response to concerns about a globalized tobacco epidemic, exacerbated by increasing international trade in tobacco and foreign direct investment.”\textsuperscript{129} The Panel also referred to the Partial Guidelines for implementation of Article 9 and 10 of the FCTC and noted that the Partial Guidelines provided, among other things, that “from the perspective of public health, there is no justification for permitting the use of ingredients, such as flavouring agents, which help make tobacco products attractive.”\textsuperscript{130} The Partial Guidelines also recommend, among other things, that the “parties should regulate, by prohibiting or restricting, ingredients that may be used to increase palatability in tobacco products”\textsuperscript{131}

Although the Panel in this case drew upon the WHO FCTC extensively, neither disputer requested the Panel to consider whether partial guidelines for

\textsuperscript{126} Both the Parties have not ratified WHO-FCTC. However, the United States is a signatory to the FCTC but Indonesia is not.

\textsuperscript{127} Indonesia’s first written submission, paras. 110-111; Indonesia’s response to Panel question Nos. 19 and 97; United States’ first written submission, paras. 140-143; United States’ second written submission, paras. 7, 13, 20, 143; United States’ response to Panel question Nos. 19 and 97.

\textsuperscript{128} Para 7.5 Report of the Panel. United States – Measures Affecting The Production And Sale Of Clove Cigarettes. Available at: https://www.wto.org/english/tratop_e/dispu_e/cases_e/ds406_e.htm accessed on 13-06-2016.

\textsuperscript{129} Para 2.29. ibid.

\textsuperscript{130} Para 2.31. ibid.

\textsuperscript{131} Targeted ingredients include those: (i) that are used to increase palatability; (ii) that have colouring properties; (iii) that are used to create the impression that products have health benefits; and (iv) those associated with energy and vitality. Among the ingredients that increase palatability listed in the WHO Partial Guidelines are sweeteners (e.g. glucose, molasses, honey and sorbitol), masking agents (e.g. benzaldehyde, maltol, menthol and vanillin), and spices and herbs (e.g. cinnamon, ginger and mint).
Articles 9 and 10 constitute international standards for the purposes of the TBT Agreement.\footnote{To determine whether the products are “like” the panel drew on the TPSAC report, on the work of a WHO scientific advisory committee and on the WHO FCTC partial guidelines for Articles 9 and 10. (Para 7.413. Report of the Panel)}


In this dispute, the Philippines brought a claim against Thailand concerning Thailand’s treatment of Philip Morris cigarettes imported from the Philippines.\footnote{Panel Report, Thailand – Customs and Fiscal Measures on Cigarettes from the Philippines, WT/DS371/R, 15 November 2010. Geneva, World Trade Organization, 2010.} The Philippine did not challenge the tobacco control measures, but concerned measures administering the Thai tobacco tax system. Australia, China, the European Union, India, Chinese Taipei and the United States have reserved their rights to participate in the Panel proceedings as a third party.\footnote{Para. 1.6. ibid.}

The Panel agreed with the Philippines, finding that Thailand’s Customs authorities had violated a number of procedural obligations governing how imported goods should be valued.\footnote{Summary Report of the Dispute DS371. Available at: https://www.wto.org/english/tratop_e/dispu_e/cases_e/1pagesum_e/ds371sum_e.pdf accessed on 13-06-2016.}

- Thai Customs acted inconsistently with CVA Articles 1.1 and 1.2(a) in rejecting the transaction value of the imported cigarettes.
- The basis for rejecting the transaction value was inadequate within the meaning of CVA Article 16.

The Panel found that:

- The Thai action was to increase the amount of tax due on imported cigarettes, but not on domestic cigarettes, resulting in a violation of Article III:2 of the GATT.\footnote{Para. 7. 567 Panel Report, Thailand – Customs and Fiscal Measures on Cigarettes from the Philippines, WT/DS371/R, 15 November 2010,. Geneva, World Trade Organization, 2010.}
• The procedural obligation to apply for a rebate created a risk of discrimination that was sufficient to violate Article III:2 of the GATT.  

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• The administrative requirements in question were not compliant with Article III:2 of the GATT and, therefore, Article XX (d) could not be invoked. However, this aspect of the Panel’s decision was reversed by the Appellate Body, although the Appellate Body ultimately held that Thailand had not substantiated its defence under Article XX (d).  

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• The Appellate Body upheld the Panel’s finding that Thailand treats imported cigarettes less favourably than like domestic cigarettes by imposing additional administrative requirements only on resellers of imported cigarettes and thus violates Article III:4 of the GATT.  

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• The Appellate Body found that this system does not ensure prompt review of administrative action and upheld the Panel’s finding that Thailand acted inconsistently with Art. X:3(b).  

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Thailand agreed with the determination of the Appellate Body and informed the DSB that it intends to implement the recommendations and rulings of the DSB in a manner that respects its WTO obligations and that it would need a reasonable period of time to do so.

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140 Ibid.

On 8 October 2003, Honduras requested consultations with the Dominican Republic concerning certain measures affecting the importation and internal sale of cigarettes. Honduras considers that these Dominican Republic’s measures are inconsistent with Articles II:1(b), III:2, III:4, X:1, X:3(a), XI:1, and XV:4 of GATT 1994 and thus it requested for consultation and later for establishment of a Panel. Chile, China, European Communities, El Salvador, Guatemala, Nicaragua and United States requested to join the consultations as third parties.

Dominican Republic required that tax stamps be affixed to cigarettes at the point of importation in the Dominican Republic. This requirement meant that imported products had to be unpacked and stamped on importation, which increased the cost of production and undermined the capacity of foreign manufacturers to control how their products were presented. This was basically discriminatory in favour of domestic manufacturers who could stamp product at the point of manufacture.

The Panel found that:

- The transitional surcharge and the foreign exchange fee imposed by the Dominican Republic are inconsistent with Article II:1(b) of GATT 1994. The foreign exchange fee is not justified under Article XV:9(a) of GATT 1994;
- The stamp requirement imposed on cigarettes by the Dominican Republic is inconsistent with Article III:4 of GATT 1994;

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141 This request is a new and expanded version of a complaint filed by Honduras on 28 August 2003 (WT/DS300/1)
Honduras did not demonstrate that the bond requirement imposed on cigarette importers by the Dominican Republic violates either Article X:1 or Article III:4 of GATT 1994; and

Before the legislation was amended in January 2004, the Dominican Republic imposed its Selective Consumption Tax on imported cigarettes in a manner inconsistent with Articles III:2 and X of GATT 1994.

The Appellate Body upheld three findings but reversed four of the Panel’s legal findings. The Appellate Body found:

- The stamp requirement imposed on cigarettes by the Dominican Republic is not justified under the exception of Article XX(d) of the GATT 1994;
- The bond requirement imposed on cigarette importers by the Dominican Republic violates Article III:4 of GATT 1994.

Dominican Republic agreed with the determination by the DSB and agreed to implement the recommendations and rulings of the DSB, and indicated that it would need a reasonable period of time to implement the recommendations and rulings of the DSB.

4.4.8. Ukraine, Honduras, Dominican Republic, Cuba, Indonesia v. Australia (Plain Packaging of Tobacco Products) – Since 2012

With the adoption of the plain packaging legislation in Australia in 2011, the tobacco industry got in action to challenge the law at all possible fronts. The industry has already lost in the domestic court and the arbitration under

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144 The tobacco industry challenge the legislation under the Constitution before the highest domestic court, under the bilateral treaty (With Hong Kong) before the arbitration tribunal and under the WTO regime before the WTO Dispute Settlement Body.
bilateral investment treaty with Hong Kong. The following table gives a glimpse of the matters brought before the WTO Dispute Settlement Body by different countries.

**Table 4.3: Disputes concerning Australia’s plain packaging.**

<table>
<thead>
<tr>
<th>Dispute #</th>
<th>Parties and Issues</th>
<th>Date of Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DS434</td>
<td>Australia — Certain Measures Concerning Trademarks and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging (Complainant: Ukraine)</td>
<td>13 March 2012</td>
</tr>
<tr>
<td>DS435</td>
<td>Australia — Certain Measures Concerning Trademarks, Geographical Indications and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging (Complainant: Honduras)</td>
<td>4 April 2012</td>
</tr>
<tr>
<td>DS441</td>
<td>Australia — Certain Measures Concerning Trademarks, Geographical Indications and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging (Complainant: Dominican Republic)</td>
<td>18 July 2012</td>
</tr>
<tr>
<td>DS458</td>
<td>Australia — Certain Measures Concerning Trademarks, Geographical Indications and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging (Complainant: Cuba)</td>
<td>3 May 2013</td>
</tr>
<tr>
<td>DS467</td>
<td>Australia — Certain Measures Concerning Trademarks, Geographical Indications and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging (Complainant: Indonesia)</td>
<td>20 September 2013</td>
</tr>
</tbody>
</table>

Source: Index of disputes issues from the WTO searchable dispute settlement database.

All the countries challenge the following Australian measures:

- The Tobacco Plain Packaging Act 2011, Act No. 148 of 2011
- The Tobacco Plain Packaging Regulations 2011
- Tobacco Plain Packaging Amendment Regulation 2012
- The Trade Marks Amendment (Tobacco Plain Packaging) Act 2011
- Any related measures adopted by Australia, including measures that implement, complement or add to these laws and regulations, as well as any measures that amend or replace these laws and regulations.

Under following provisions of the WTO Agreements by limiting or prohibiting the use of trademarks, geographical indications or both on tobacco products, and by requiring these products only to be sold in standardized packaging.
Table 4.4: Provisions of WTO Agreements used to challenge Australia’s plain packaging

<table>
<thead>
<tr>
<th>Countries</th>
<th>TRIPS</th>
<th>TBT Agreement</th>
<th>GATT 1994</th>
<th>3rd Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ukraine</td>
<td>Articles 1, 1.1, 2.1, 3.1, 15, 16, 20 and 27</td>
<td>Article 2.1 and 2.2</td>
<td>Article III:4</td>
<td>35</td>
</tr>
<tr>
<td>Honduras</td>
<td>Articles 2.1, 3.1, 15.4, 16.1, 20, 22.2(b) and 24.3</td>
<td>Article 2.1 and 2.2</td>
<td>Article III:4</td>
<td>34</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>Articles 2.1, 3.1, 15.4, 16.1, 20, 22.2(b) and 24.3</td>
<td>Article 2.1 and 2.2</td>
<td>Article III:4</td>
<td>31</td>
</tr>
<tr>
<td>Cuba</td>
<td>Articles 2.1, 3.1, 15.4, 16.1, 20, 22.2(b) and 24.3</td>
<td>Article 2.1 and 2.2</td>
<td>Articles III:4 and IX:4</td>
<td>30</td>
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<tr>
<td>Indonesia</td>
<td>Articles 2.1, 3.1, 15.4, 16.1, 16.3, 20, 22.2(b) and 24.3</td>
<td>Article 2.1 and 2.2</td>
<td>Article III:4</td>
<td>32</td>
</tr>
</tbody>
</table>

A single set of panelists was appointed in May 2014 to handle the five cases, now combined. However, on 28 May 2015, Ukraine requested the panel to suspend its proceedings in accordance with Article 12.12 of the DSU.

A record number of WTO Members (forty one in total, including the five complainants) have indicated their intention to join one or more of the five WTO disputes as third parties. Argentina, Brazil, Canada, Chile, China, Chinese Taipei, Cuba, The Dominican Republic, Ecuador, Egypt, The European Union, Guatemala, Honduras, India, Indonesia, Japan, Republic of Korea, Malawi, Malaysia, Mexico, Moldova, New Zealand, Nicaragua, Nigeria, Norway, Oman, Panama, Peru, Philippines, Russian Federation, Kingdom of Saudi Arabia, Singapore, South Africa, Thailand, Trinidad and Tobago, Turkey, Ukraine, United States, Uruguay, Zambia and Zimbabwe have reserved their third party rights in these disputes.

The significance of the issue in this dispute is evident from the number of third parties to the dispute. Several of these countries are waiting for the determination of the dispute to implement standardized or plain packaging of tobacco products. While the tobacco industry is also mindful of the domino effect of this effective and evidence-based tobacco control measure and is thus putting up with all its might a strong fight against plain packaging at all possible
forums. Other two countries that have already implemented plain packaging are France and United Kingdom.

4.5. BIT DISPUTES AND TOBACCO CONTROL

Germany decided to phase out nuclear energy post the Fukushima disaster. Governments of Uruguay and Australia introduced compulsory health warnings and plain packaging on tobacco packs to protect public health in line with their obligation under the WHO-FCTC. South African government extends economic privileges to black people to redress centuries of inequalities created by the apartheid regime. What do these scenarios have in common?145

All these decisions have been legally challenged, not in the host countries’ courts but before an international tribunal under bilateral treaties, by companies that considered them harmful to their profits.146 Although the bilateral investment treaties have been used by the countries to negotiate favorable investment regime for last several decades, it is only in the past couple of decades wherein the investors have claimed compensation and damages against governments. Such claims in in the past were generally against the host government’s action for the promotion or protection of the environment, but it is only recently that claims have been based on the argument that health-related measures are inconsistent with a treaty commitment.147

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146 In the past 20 years, many of these tribunals have granted big business hefty sums in compensation – paid out of taxpayers’ pockets often for democratically made laws to protect the environment, public health or social well-being.

Following are some of the key investor claims against state that have garnered worldwide attention. The major contention in such claims against public health measures by the governments have been the alleged expropriation of the investor’s intellectual property rights, i.e. infringement of trademarks and patents.

### 4.5.1. Philip Morris Products (Switzerland) v Republic of Uruguay

Philip Morris, one of the Big Tobacco Company, filed a claim against the Republic of Uruguay before the International Centre for Settlement of Investment Disputes Washington, D.C. Phillip Morris challenged the Uruguayan Ministry of Public Health Ordinance 466 and 514 and Presidential Decree of 287/009 which proposed following tobacco control measures:

- a. Graphic images ("pictograms") that purport illustrate the adverse health effects of smoking reflected in the text warnings.
- b. Each cigarette brand to have a "single presentation" i.e. prohibits different packaging or presentations for cigarettes sold under a given brand (e.g. only one among the “Marlboro Red”, “Marlboro Gold”, “Marlboro Blue” and “Marlboro Green (Fresh Mint)” could be sold).
- c. Increase in the size of health warnings on cigarette packages from 50% to 80 per cent of the surface of the front and back of the package.

It is claimed that these provisions constitute breaches of the Uruguay’s obligations under Articles 3(1), 3(2), 5 and 11 of the BIT, entitling the Claimants to compensation under the BIT and international law. In addition, the claimants

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argue that a so-called umbrella clause\textsuperscript{149} has been violated. These measures, Philip Morris argues, are unreasonable, overbroad and bear no rational relationship to their purported public health objectives while the single presentation requirement constitutes an expropriation of Philip Morris's trademarks by prohibiting their use on multiple brands.

It is encouraging to see that in the matter organisations like Pan American Health Organization (PAHO),\textsuperscript{150} World Health Organization (WHO) and WHO FCTC Secretariat have filed \textit{amicus curiae} briefs (based on Rule 37(2) of the ICSID Arbitration Rules) supporting Uruguay's tobacco control efforts.\textsuperscript{151}

Though the Tribunal held a hearing on the merits in Washington, D.C. from October 19, 2015 to October 29, 2015 and on November 2, 2015 it issued Procedural Order No. 5 concerning procedural matters which is not available publicly. The parties have been asked to file their submissions as to costs. While the final decision of the Tribunal is still pending an analysis of the claim by Todd Weiler, an international lawyer whose practice focuses on investment treaty arbitration suggests that,

\begin{quote}
“PMI's BIT claim against Uruguay is emblematic of its long standing strategy to vehemently oppose the adoption of measures that might some day lead to plain paper packaging of their products, or other measures that substantially interfere with the use and enjoyment of its crucial investment in its tobacco
\end{quote}

\begin{footnotesize}
\textsuperscript{149} A clause in the BIT requiring Uruguay to respect commitments it has made with regard to the investments of Swiss nationals.
\textsuperscript{150} Procedural Order No. 4 \textit{Philip Morris Brands Sàrl, Philip Morris Products S.A. and ABAL Hermanos S.A. (The Claimants) and Oriental Republic of Uruguay (The Respondent)} (ICSID Case No. ARB/10/7) available at: https://icsid.worldbank.org/ICSID/FrontServlet?requestType=CasesRH&actionVal=showDoc&docId=DC5672_En&caseId=C1000 accessed on 14-06-2016
\textsuperscript{151} Procedural Order No. 3 ibid.
\end{footnotesize}
brands. In my opinion, the claim is nothing more than the cynical attempt by a wealthy multinational corporation to make an example of a small country with limited resources to defend against a well-funded international legal action, but with a well-deserved reputation as a worldwide leader in tobacco control.”

4.5.2. Philip Morris Asia Limited v Commonwealth of Australia

With the announcement of Australia implementing plain packaging of tobacco products, various other members of the Philip Morris (PM) group had repeatedly made clear their objections to the proposed plain packaging legislation. It is when such objections were not accepted by the Australian Government PM Asia acquired its shares in PM Australia on 23 February 2011 to take benefit of the BIT between Australia and Hong Kong. However, as the Australian Government contested, Article 10 of the BIT did not confer jurisdiction on an arbitral tribunal to determine pre-existing disputes that have been re-packaged as BIT claims many months after the relevant governmental measure has been announced. The Tribunal as well, “found that the adoption of the Plain Packaging Measures was foreseeable well before the Claimant’s decision to restructure was taken (let alone implemented).” It further observed that the action taken by PM Asia was rife with malafide as the Tribunal concluded:

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“that the initiation of this arbitration constitutes an abuse of rights, as the corporate restructuring by which the Claimant acquired the Australian subsidiaries occurred at a time when there was a reasonable prospect that the dispute would materialise and as it was carried out for the principal, if not sole, purpose of gaining Treaty protection. Accordingly, the claims raised in this arbitration are inadmissible and the Tribunal is precluded from exercising jurisdiction over this dispute.”\textsuperscript{154}

It may be noted that both Australia and Uruguay have referred to articles 11 and 13 of the FCTC in their responses to claims brought against their packaging measures under bilateral investment treaties by Philip Morris Asia and Philip Morris International respectively.\textsuperscript{155}

4.5.3. Grand River Enterprises Six Nations v United States of America

In this matter the claimants contended that actions taken by various states of the United States of America to implement the 1998 Master Settlement Agreement (MSA)\textsuperscript{156} violated their rights under Chapter 11 of NAFTA. Though the MSA was concluded between a number of U.S. states and major U.S. cigarette manufacturers, the United States was internationally responsible under NAFTA for their actions. In order to minimize the adverse impact of the


\textsuperscript{156} The Master Settlement Agreement settled litigation between a number of US states and the major tobacco companies of USA and required those tobacco manufacturers that were parties to the litigation to pay compensation to States that are parties.
MSA on the competitiveness of participating companies, nonparticipating companies were subjected to separate legislative requirements. These requirements, in particular the allocable share amendments adopted in 2003-2004 by various states were the subject of the claims. The Tribunal dismissed the claims – related to MSA, the Escrow Statutes (as they existed prior to March 12, 2001), and other related enforcement measures adopted or implemented by U.S. States prior to March 12, 2001 – with prejudice as barred by Articles 1116(2) and 1117(2) of the NAFTA and reserved the breach of NAFTA directly arising out of the adoption and implementation of the allocable share amendments for consideration on the merits.\textsuperscript{157}

While discussing the claims on merits, the Tribunal noted that “trade in tobacco products has historically been the subject of close and extensive regulation by US states, a circumstance that should have been known to the Claimant from his extensive past experience in the tobacco business. An investor entering an area traditionally subject to extensive regulation must do so with awareness of the regulatory situation”.\textsuperscript{158} Further, with respect to expropriation, the Tribunal emphasized that Article 1110 of NAFTA concerns expropriation of an investment, not part of an investment. The Tribunal stated that “expropriation must involve the deprivation of all, or a very great measure, of a claimant’s property interests”.\textsuperscript{159}


\textsuperscript{159} Para. 154 ibid.
This case suggests that investors must be aware of the regulatory regime in the country and in the absence of some representation by government to the contrary an investor, including tobacco companies, are unlikely to have a legitimate expectation that they can avoid new regulations. Since the Tribunal held that expropriation must involve deprivation of all or a greater part of the claimant’s property, claims relating to the use of trademarks on packaging, are unlikely to constitute expropriation within the meaning of this decision.  

4.5.4. **Feldman Karpa v Mexico**

In this case the claim was against expropriation of investment by a claimant from United States. The claimant, who purchased cigarettes from bulk retailers in Mexico and sold them abroad was denied tax rebates at the point of purchase in Mexico that were subsequently exported. The Claimant alleged that through the conduct of its Ministry of Finance and Public Credit, Mexico’s refusal to rebate excise taxes applied to cigarettes exported by Corporación de Exportaciones Mexicanas, S.A. de C.V. (CEMSA) and Mexico’s continuing refusal to recognize CEMSMA’s right to a rebate of such taxes regarding prospective cigarette exports constituted a breach of NAFTA Articles 1102 (National Treatment), 1105 (Minimum Level of Treatment), and 1110 (Expropriation and Compensation). In total, Feldman claimed in excess of US$ 50 million as compensation.  

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The Tribunal rejected the claim of expropriation partly on the basis that the claimant continued to run a successful business.\textsuperscript{162} The Tribunal observed, "whether a particular interference with business activities amounts to an expropriation, the test is whether that interference is sufficiently restrictive to support a conclusion that the property has been ‘taken’ from its owner."\textsuperscript{163} The Tribunal decided that:

"[T]he regulatory action (enforcement of longstanding provisions of Mexican law) has not deprived the Claimant of control of the investment, CEMSA, interfered directly in the internal operations of CEMSA or displaced the Claimant as the controlling shareholder. The Claimant is free to pursue other continuing lines of export trading, such as exporting alcoholic beverages, photographic supplies, or other products for which he can obtain from Mexico the invoices required under Article 4, although he is effectively precluded from exporting cigarettes. Thus, this Tribunal believes there has been no “taking” in the present case."\textsuperscript{164}

However, the Tribunal found a breach of Article 1102 NAFTA and it compensated Feldman only for the tax rebates that Feldman had actually requested and had not been paid by Mexico. The total amount awarded by the Tribunal was 16,961,056 Mexican pesos (principal amount of 9,464,627 plus simple interest of 7,496,428).\textsuperscript{165}


\textsuperscript{164} Para. 152 ibid.

The larger implications of this case for the relationship between tobacco control and international investment law are minimal; however, it is important to note the claims and violations of WTO principles specific to the facts of the case which are significant in terms of precedence in BIT disputes.

4.6. KEY TOBACCO CONTROL LITIGATION AND WHO-FCTC

Tobacco control litigation in India have served a useful purpose of institutionalizing the national tobacco control law in the country as an imperative public health action to curb the deaths and diseases caused due to tobacco use. The judicial interpretation and sanction in support of implementation of effective tobacco control measures, even before the adoption of the national tobacco control law and the first global public health treaty helped preventing people from exposure to second hand smoke in public places. On several occasions in the last two decades, the Supreme Court of India and various High Courts of the country elucidated and analyzed the components of tobacco control law within the constitutional matrix of right to health as a fundamental right. These judicial reviews provide much needed clarity and lie at the very heart of the implementation of the tobacco control law in the country. An increasing number of legislation, across the globe, to tackle the health effects of tobacco has led the industry to challenge its legality all the more. However, a study of such challenges highlights how the dominant cause of action has been founded in Public Law, specifically Constitutional and Human Rights Law, and the FCTC rather than International or Private Law on trade.¹⁶⁶

Not only in India, with the adoption of the WHO-FCTC, tobacco control litigation has increased manifolds globally. The tobacco industry invariably takes every tobacco control measure to the court, in each of the country where such measure is proposed, as the last resort to defer, delay and dilute effective, evidence based and FCTC backed tobacco control measures. However, a review of litigation documents in several of these cases reveals that the WHO FCTC has been affirmatively alluded and integrated into the domestic judicial discourse relating to tobacco control since the Treaty’s coming-into-force in February 2005. The Treaty has been extensively quoted by the governments in defense of the stronger tobacco control measures while on several occasions courts have also resorted to and highlighted the significance of the treaty in the court judgements. With 180 Parties to the Treaty, the provisions of the Convention and the Guidelines and the Protocol adopted for their implementation are a reflection of the global standards to regulate tobacco. These standards of WHO-FCTC are increasingly being recognized globally by judicial authorities, read within the domestic legal and constitutional ambit.

4.6.1. South Africa

South Africa was the 63rd country to ratify the Treaty on 19th April, 2005, nearly two months after coming into force of the treaty. Keeping with the mandates of the Treaty the health ministry of South Africa amended their Tobacco Products Control Act 83 of 1993 vide the Tobacco Products Amendment Act 63 of 2008. Section 3(1)(a) of the amended Act stipulated that, “No person shall advertise or promote, or cause any other person to advertise or promote, a tobacco product through any direct or indirect means, including through sponsorship of

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any organisation, event, service, physical establishment, programme, project, bursary, scholarship or any other method.”

The tobacco industry’s main complaint was that the prohibition infringed the right to engage in commercial expression and the right to freedom of expression of tobacco consumers who are denied the right to receive information concerning tobacco products. Hence, the definition of ‘advertisement’ is unconstitutional to the extent it limits the right to freedom of expression, as set out in Section 16 of the South African Constitution.

The Court found that there exists powerful public health considerations for a ban on the advertising and promotion of tobacco products and that the seriousness of the hazards of smoking far outweigh the interests of the smokers as a group.\textsuperscript{167} The Court noted country’s obligation under FCTC and in particular Article 13 of the Treaty that recommends prohibition on tobacco advertisement promotion and sponsorships (TAPS) and observed:

“I do not think that it was open to the Minister and the legislature to ignore the Framework Convention when considering what steps to take to deal with the risks posed by tobacco use. In respect of international conventions the Constitutional Court, per Moseneke DCJ and Cameron J, clearly indicated the approach to be adopted with regard to conventions that impose obligations on the Republic. In Glenister the Constitutional Court dealt with conventions which required State parties to create anticorruption units that has the necessary independence (see para 189). The majority found that those conventions were binding on the

Republic. By parity of reasoning, in determining whether or not to impose a ban on advertising and promotion of tobacco products the Minister would have been obliged to have regard to the Framework Convention. This Court is therefore obliged, under the Constitution, to give weight to it in determining the question of justification or the limitation of the right to freedom of speech.”

4.6.2. Sri Lanka

Sri Lanka was the fourth country to ratify the Treaty on 11th November, 2003. Based on the treaty obligations, the national legislation regulating tobacco use was amended to provide for smokefree indoors in 2006. The tobacco industry challenged the constitutionality of the provisions of the Amended Bill. The Court held that the restrictions imposed by the proposed law are within the ambit of the Sri Lankan Constitution and the objective of the Act is in line with the Framework Convention on Tobacco Control which recognizes that the Treaty “is an evidence based treaty that reaffirms the right of all people to the highest standards of health”. The Court extensively referred to the Treaty, in particular, Article 5 and Article 8 to uphold the restriction on smoking in indoor public places. The Court observed:

In this background there would be no basis to any general challenge of the contents of clause 40 intended to prohibit smoking in enclosed public places. The restriction comes well within the ambit of Article 16(7) of the Constitution which permits

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restrictions by law of any of the fundamental rights guaranteed, inter alia, by Articles 12 and 14, for "the protection of public health". Exposure to tobacco smoke as envisaged in the WHO (FCTC) or "passive smoking" in common parlance which would necessarily result from smoking in public places is undoubtedly harmful to public health and a law could be validly enacted to prevent such exposure to tobacco smoke in enclosed public places.

In 2012 the Ministry of Health adopted regulations requiring 80% pictorial health warnings on tobacco products in Sri Lanka. The tobacco industry challenged the regulations and sought interim relief from implementation of the regulations, which was denied by the Court of Appeal. The Court observed that the regulation was sufficiently clear for implementation and the timeline of the regulation provided sufficient time for implementation and the balance of convenience supported the Minister.\textsuperscript{170} Later, on hearing the arguments that the regulations violate the company’s intellectual property rights the Court reduced the size of the warnings to between 50% to 60% of the cigarette pack in order to give tobacco companies more space in which to display their trademark.\textsuperscript{171}

However, the newly elected Sri Lankan President sought judicial review of the constitutionality of the law that proposed to implement 80% pictorial health warnings. The tobacco industry opposed the matter arguing that the threat of

illicit trade outweighed the health risks and the proposed pack warnings will also violate intellectual property laws. The Court disagreed on both counts, noting that attending to public health is of high priority, "perhaps the one at the top." The Court also held that the amendments did not violate any constitutional provisions and the proposed law only intended to comply with the Article 11 of the FCTC in national interest and keeping with the international obligation of Sri Lanka with a view to protect public health. The judgement in particular made reference to Article 2.1 and Article 5.2 of the FCTC and held that the Amendment Bill and all its provisions are constitutional.\textsuperscript{172}

4.6.3. Thailand

Thailand was the 36\textsuperscript{th} country to ratify the Treaty on 8\textsuperscript{th} November, 2004. In line with the treaty requirement of Article 11 and the guidelines thereunder the Minister of Public Health adopted the 85% pictorial health warnings in 2013.\textsuperscript{173} Upon challenge the Central Administrative Court of first instance ordered temporary suspension of the regulations of 2013 until the Court renders a decision or issues orders to the contrary. However, hearing the appeal, the Supreme Administrative Court recognised that the objective behind the "enlargement of the images from an area of 55 percent of the front and back of the cigarette pack to 85 percent is done to comply with the World Health Organization Framework Convention on Tobacco Control (FCTC)." The Court

\textsuperscript{172} In the matter of reference in terms of Article 122(1)(b) of the Constitution. S.C. (SD) No. 2/2015. Available at: http://www.tobaccocontrollaws.org/litigation/decisions/lk-00000000-in-the-matter-of-article-1221b accessed on 12-06-2016.

\textsuperscript{173} Notice of Rules, Procedures, and Conditions for the Display of Images, Warning Statements, and Contact Channels for Smoking Cessation on Cigarette Labels of 2013. Ministry of Public Health, Thailand
reversed the order of the Administrative Court of First Instance and denied any suspension on the enforcement of the regulations.\textsuperscript{174}

4.6.4. Australia

Australia was the 34\textsuperscript{th} country to ratify the Treaty on 27\textsuperscript{th} October 2004. Australia has implemented stronger and effective tobacco control measures to effectively contain tobacco use in the country. It introduced, plain packaging of tobacco products from December 1, 2012.\textsuperscript{175} The constitutionality of the Tobacco Plain Packaging Act 2011 was challenged by the tobacco industry. While defending the plain packaging legislation, the Commonwealth of Australia argued about the ways in which plain packaging would improve public health, “is consistent with the consensus of the 174 Parties to the FCTC,” noting Articles 11 and 13 of the FCTC and their guidelines.\textsuperscript{176} Though the court in the case did not consider this question as the only contention in the matter was about whether plain packaging amounts to appropriation of the intellectual property of the tobacco industry, to which as well the Court answered in negative. Had it been necessary for the Court to consider the Commonwealth’s alternate arguments, consideration would likely have been given to the significance of the FCTC, at least to the question of whether plain packaging is “appropriate and adapted to reducing harm to members of the public and public health.”\textsuperscript{177}


\textsuperscript{175} Australia has been an international leader in tobacco control and became the first country to implement plain packaging of tobacco products in December 2012.

\textsuperscript{176} JT International SA v Commonwealth of Australia [2012] HCA 43

4.6.5. Canada

Canada was the 38th country to ratify the treaty on 26th November, 2004. Post ratification of the Treaty, the Canadian Government amended its Tobacco Act of 1997 to strengthen tobacco control efforts in the country. The law envisioned a ban on misleading advertising for promoting health, protecting consumers, and preventing young people from smoking. It also imposed a ban on using corporate names in sponsorship promotion and required that the statutory health warnings occupy at least half of the package display surface. The provisions were challenged by the tobacco industry.178 The Supreme Court of Canada, though agreed that the provisions infringe s. 2(b) of the Canadian Charter of Rights and Freedoms, it upheld their constitutionality since the infringement was a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the Canadian Charter of Rights and Freedoms. In deciding the matter the Supreme Court cited WHO-FCTC on three following occasions:179

Para 10: Governments around the world are implementing anti-tobacco measures similar to and, in some cases, more restrictive than Canada’s. The WHO Framework Convention on Tobacco Control (2003), 2302 U.N.T.S. 229, which Canada ratified in 2004, mandates a comprehensive ban on tobacco promotion, subject to state constitutional requirements. The Convention, with 168 signatories and 148 parties, is one of the most widely embraced of multilateral treaties. Domestically, governments now widely

179 ibid.
accept that protecting the public from second-hand smoke is a legitimate policy objective.

Para 66: The words false, misleading or deceptive do not do the work assigned to the additional phrase, “likely to create an erroneous impression”. Nor is it easy to find narrower words that would accomplish that task. The exact wording of the impugned phrase appears in the English version of Art. 11(1)(a) and 13(4)(a) of the WHO Framework Convention on Tobacco Control.

Para 138: The reasonableness of the government’s requirement is supported by the fact that Australia, Belgium, Switzerland, Finland, Singapore and Brazil require warnings at least as large as Canada’s, and the minimum size in the European Union is 48 percent of the package. The WHO Framework Convention stipulates that warning labels “should” cover at least 50 percent and “shall” cover at least 30 percent of the package.

4.6.6. Argentina

Though Argentina is neither signatory nor a Party to the Treaty, the Argentine Supreme Court noted the significance of FCTC as an international standard for tobacco control policies. While justifying the total ban on advertisement, promotion and sponsorship of tobacco products under a sub-national law of the Province of Santa Fe, the Court held that ‘a total ban of advertising and promotion- are appropriate and proportional. The ban on advertising proves to be conducive to achieving the reduction of the smoking habit, and in turn, does not constitute an excessive restriction of the economic freedoms of companies’. The Court held that the ban was a reasonable restriction of commercial
freedoms, since commercial speech is not entitled the same level of protection as political or social speeches, and observed that the law was in line with the state’s obligations derived from the right to life and the right to health under the Argentine Constitution.180

4.6.7. Columbia

The Constitutional Court of Columbia also observed that the FCTC did not conflict with the Political Charter but rather constitute the development of principles and values contained therein, especially the promotion of public health and the rights of children, adolescents and pregnant women. It also upheld the restrictions on tobacco advertisements, promotion and sponsorships and sale of loose or individual cigarettes as recommended by FCTC.181 The Court held that TAPS ban does not amount to restriction on freedom of expression as guaranteed under the Constitution not does it infringe the right to economy and enterprise or freedom to enterprise which in any case are not absolute. The court held that, commercial speech can be restricted in a higher degree than other speech because it is more closely linked to freedom of enterprise than to freedom of expression. Citing the court decision an administrative authority, Coljuegos, in charge promotional games in Colombia, prohibited tobacco companies from using promotional strategies, such as raffles, at the point of sale, and held that the FCTC Guidelines (under Article 13) should be considered subsequent agreements under the Vienna Convention on the Law of Treaties.

180 Nobleza Piccardo v. Provincia de Santa Fe http://www.tobaccocontrollaws.org/litigation/decisions/ar-20151027-nobleza-piccardo-v-provincia-
4.6.8. Switzerland

Responding to a challenge to the constitutionality of a popular initiative, “Second-hand smoke and health” of the Grand Conseil of the Canton of Geneva - that intended to protect the staff of public establishments as well as the persons frequenting them - the Court cited Article 8 of the FCTC, which calls for smoke-free public places. The court further observed that the initiative is undeniably in the public interest since it sets forth measures designed to safeguard public health, and no other measure is equally effective in that respect. Furthermore, the ban is consistent with the postulate of the WHO FCTC. Switzerland signed the Convention on 25 June 2004, which is an indication that the Federal Council’s willingness to adopt the WHO plan. As soon as this multilateral treaty – WHO's first legally binding treaty – is ratified, recognition of the harmful effects of tobacco smoke will constitute an international obligation for Switzerland.”

4.6.9. United Kingdom

The United Kingdom was the 46th country to ratify the treaty on 16th December 2004. Keeping with the obligations of the Treaty the UK parliament adopted law prohibiting sale of tobacco products through vending Machine. The tobacco industry challenged the law wherein the High Court of Justice Court of Appeal (Civil Division) noting that the World Health Organization FCTC Guidelines recommend that “[v]ending machines should be banned because they constitute by their very presence a means of advertising or promotion under the

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terms of the Convention" held that the ban was lawful. The Court held that, “in so far as the purpose of the ban in this case is reasonably intended to reduce smoking among those under 18, the reasoning of the court would suggest that it is prima facie lawful.”


The Department of Health of the United Kingdom adopted standardized packaging of tobacco products. Four of the world’s largest tobacco companies i.e. British American Tobacco, Imperial Tobacco, Philip Morris International and Japan Tobacco International launched a High Court battle against the regulations in 2015 to fight the ban on branded cigarette packaging due to come into force on May 20th 2016.

The Court wholly rejected the tobacco industry legal challenge, saying the new government regulations were “suitable and appropriate” and the companies had no right to compensation as they engaged in activities “which impose vast cost on the state” in terms of public healthcare.

The tobacco companies claimed that the regulations were not proportionate and were contrary to EU and UK law and the rules would deprive them of their intellectual property and business goodwill without compensation.

The Court rejected all the arguments put forward by the tobacco companies and noted that, there was a “significant moral angle” to the new regulations, “which is about saving children from a lifetime of addiction and children and adults from premature death and related suffering and disease”.

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184 BAT v. Secretary of State for Health, PMI v. Secretary of State for Health, JTI v. Secretary of State for Health and Imperial Tobacco v. Secretary of State for Health [2016] EWHC 1169 (Admin), In The High Court of Justice Queen's Bench Division Administrative Court.
The judge said that in the UK 600 children each day are encouraged into smoking and are future customers of the tobacco companies, placing a “vast financial burden on the state in medical and care costs”.  

The court extensively referred to the FCTC (FCTC is mentioned 135 times in the published judgment) and relied to by the Court to uphold the standardized packaging of tobacco products in the UK, it held, “the Regulations were lawful when they were promulgated by Parliament and they are lawful now in the light of the most up to date evidence.”

4.6.10. India

In India, litigation has been used as an effective means to enforce tobacco control laws due to strong civil society as well as a responsive judiciary that has not only delivered strong judgments but has also followed through with monitoring enforcement of such pronouncements. The Hon’ble Supreme Court directed and prohibited smoking in public places even before the adoption of WHO-FCTC and the enactment COTPA. The Court directed the Union of India, State Governments and the Union Territories to effectively prohibit smoking in public places recognizing that the rights of non-smokers to breathe air, free from tobacco smoke, and vindicated their fundamental right to life guaranteed under the Constitution of India. Considering that India enacted a comprehensive tobacco control law, i.e. COTPA, even before the adoption of the WHO-FCTC the domestic courts have not only upheld the constitutionality

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185 High Court rejects Big Tobacco’s appeal against plain packaging. Available at: http://www.ft.com/cms/s/0/6b0164e0-1dbc-11e6-b286-cddde55ca122.html#axzz4AMVE8Gdp accessed on 02-06-2016.
186 BAT v. Secretary of State for Health, PMI v. Secretary of State for Health, JTI v. Secretary of State for Health and Imperial Tobacco v. Secretary of State for Health (2016) EWHC 1169 (Admin), In The High Court of Justice Queen's Bench Division Administrative Court.
of COTPA but also directed state and its machinery to enforce the law and regulations therein in its letter and spirits.

4.6.10.1. Plain Packaging and Indian Judiciary

Hearing a petition urging a ban on public display, distribution and sale of tobacco and its plain packaging, the Allahabad High Court directed the Centre and the State Governments to consider implementation of plain packaging of tobacco products.188 The petitioner argued that “an attractive packaging is a pseudo mode of advertisement. The cigarettes are being packed in such an attractive packaging that it attracts the youths for smoking.” 189 Thus the very objective of enacting COTPA to reduce smoking and tobacco use can never be achieved in its complete sense if plain packaging norms are not included in the legislation. The Court noting the developments in Australia, Ireland and other developed countries acknowledged that “Plain packaging has been recommended by the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) as a component of marketing restrictions.” 190 Keeping with the state’s obligation under Article 47 of the Constitution, the court observed that, “Tobacco plain packaging measure would be a long term investment to safeguard the health of the Indian youth. The plain packaging aims to reduce the attractiveness of tobacco products.” 191 Disposing the petition, the Court strongly recommended the Government of India to consider the feasibility of implementing the plain packaging of

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188 Love Care Foundation v. UOI WP NO.1078 (M/B) of 2013 [Order date:21st July, 2014]  
189 ibid.  
190 ibid.  
191 ibid.
cigarettes and other tobacco products and take necessary steps to that effect.\textsuperscript{192}

The Rajasthan High Court, while considering a petition against the delay in implementation of the larger pictorial health warnings, addressed the issue of plain packaging and observed, “The plain packaging as an improved and effective strategy, therefore, should be given a serious thought by legislative.”\textsuperscript{193}

4.7. Public Health Impact of National and international dispute settlement

In view of the express provisions under the international human rights instruments and their enforcement at the domestic level under the national constitution, legislation and judicial interpretation, it is abundantly clear that right to health is an integral fundamental human right. The plethora of judicial pronouncements by the Indian judiciary leaves no doubt whatsoever that protection and promotion of public health is imperative to and part and parcel of the right to health as enjoined within the right to life guaranteed under the Constitution of India for every citizen.

The courts in India have taken strong reservation against any effort to derail tobacco control measures and time and again have direct both the state and the tobacco industry to respect individual’s right to health. The catena of pronouncements on tobacco control litigations in India indicate the judicial and constitutional preference accorded to public health while making right to trade in a demerit good like tobacco a subservient right to public health.

\textsuperscript{192} Love Care Foundation v. UOI WP NO.1078 (M/B) of 2013 [Order date:21st July, 2014]
\textsuperscript{193} Rahul Joshi v. Union of India (Rajasthan High Court, 2015)
Further, an analysis of the decisions under the dispute settlement regime of the WTO also suggests that the exception of public health can be sustained if such action to protect and promote public health is not inconsistent with the fundamental WTO principles of equality and non-discrimination while introducing and implementing necessary international standard as barrier to trade.

The recent decisions of the international tribunals in the matters of investor state dispute relating to tobacco have been encouraging. The fact that tribunals, comprising of trade experts primarily dealing with trade dispute, have allowed intergovernmental regional and UN agencies like Pan American Health Organization, WHO and the Convention Secretariat of the FCTC to intervene in the matters challenging tobacco control regulations. Given the subject matter experts submission before the tribunals, it has been able to highlight the actual public health impact of the regulations while denying the claims of the tobacco industry.  

Trade tribunals have also acknowledged the significance of public health while interpreting Parties obligations under trade and investment treaties. As the Dispute Panel in US-Indonesia Clove Cigarettes case emphasized that the “measures to protect public health are of the utmost importance, and that the WTO Agreements fully recognize and respect the sovereign right of Members to regulate in response to legitimate public health concerns.”

It may be noted, though, the decisions of the WTO DSB and various arbitration tribunals established under BITs tend to extend a greater importance to

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195 US-Clove Cigarettes - Panel, paras 7.2 and 7.3.
liberalization of economic and trade related aspects and take a highly restricted view of the health concerns raised in such disputes. In this regard it is important for the global community as a whole to take a serious view of the significance of public health, even in matters of trade, industry and commerce. Given that wide range of matters under consideration in a trade and investment treaty will give rise to disputes of various kinds. Keeping in view of this multidiscipline trade interests, a dynamic approach is needed to meet any eventuality related to public health by introducing a whole of government approach in dealing with trade treaties and the disputes therein. Engaging the health, environment, agriculture and labour department along with industry, commerce, law and the treaty and legal division at the external affairs will go a long way in preventing any public health causality while also protecting the trade interests of the country.

To begin with the FCTC provides a strong common ground for the countries to prioritize health as fundamental human right over trade interests. Several pronouncements across various judicial systems relying on and referring to FCTC indicates the great global value and universal acceptance of the FCTC as the basic international standard for dealing with one of the greatest public health burden of our times i.e. tobacco.

Chapter V