Chapter 3: Assessing the case for the reform of public health law

SUMMARY POINTS

- Countries may review their public health laws for different reasons. For example, public health laws may be outdated, inconsistent or incoherent; major health hazards and current challenges may require new legislative frameworks, and governments may lack the powers they need to discharge their public health responsibilities effectively. Current laws may also fail to appropriately balance the rights and interests of individuals with public health, and with other public interests.

- Although the focus of a legislative review process may be quite narrow, it nevertheless provides the opportunity for countries to consider updating their public health laws in a more systematic way, and to consider priorities for the future.

- In federal countries, the centralization or decentralization of regulatory power may have important impacts on public health. Subject to the division of legislative powers in the national constitution, federal governments should carefully consider the advantages and disadvantages of centralizing control of a particular issue at the federal level, or alternatively, permitting state, city and local governments to introduce additional laws, provided they are consistent with any relevant federal laws.

- Despite their differences, countries need strong legal frameworks to deal with important public health challenges that are shared across nations and regions, including HIV, tuberculosis and pandemics of infectious disease.

- Noncommunicable diseases – principally cardiovascular disease, cancer, respiratory diseases and diabetes – are responsible for around 68% of global mortality and have led to a double burden of disease in many countries. As a result, countries need to develop effective legal responses to obesity and dietary risks, and to scale up the implementation of tobacco control.

- Injuries have been neglected in many countries. Priority areas for governments include enforcing laws requiring motor cycle helmets, mandatory seat belts and child restraints. Important interventions to reduce violence and intentional injuries include strengthening the control of alcohol, and firearms laws.

- Although the health ministry will often take the lead in public health law reform, consultation with other ministries may be critical to effective implementation and enforcement.

- A variety of events may trigger the reform of public health laws, including disease outbreaks, sunset clauses in legislation and obligations under international law. In some countries, formal mechanisms may provide opportunities for public health and civil society organizations to put health issues on the government’s agenda and to participate in law-making. In countries where constitutional, health-related rights are justiciable, litigation may compel governments to amend their laws and to take action to protect public health.
3.1 Common reasons for reviewing and updating public health laws

There are many different reasons why governments may undertake a review of public health laws. For example:

1. Over time, a country’s public health laws may have become outdated, fragmented and even incoherent in ways that undermine government efforts to manage health challenges effectively.

2. Major health hazards and current challenges may require new legislative frameworks, and provide the impetus for law reform.

3. Governments may lack the specific legislative tools that enable them to discharge their public health and human rights responsibilities effectively.

Public health laws tend to develop in a reactive fashion, in response to the specific health challenges a country has faced over time. A review of public health laws may be similarly narrow, focusing on a specific problem or challenge. Nevertheless, the process of reviewing public health laws provides the opportunity for countries to consider updating their laws in a more systematic and proactive way, and to identify priorities for the future. This chapter considers some of the reasons that may justify carrying out a review of public health laws, either generally or in a specific area.

(a) The problem of outdated laws

In some cases, the political impetus for law reform comes about because public health law statutes are simply too old and have become outdated. A great deal of public health legislation was framed in the late-19th and early-to-mid-twentieth centuries. As a result, public health laws in some countries contain provisions that fail to conform to evidence-based approaches to epidemiology and disease, or to human rights principles (Box 3.1). Over time, specific provisions and parts of health legislation may simply fall into disuse.

Box 3.1: The legacy of 19th century British public health laws

Public health laws framed in the 19th century in Britain assumed that disease was transmitted by harmful, airborne “miasmas” that were concentrated in rubbish and in damp, poorly ventilated buildings. Disease was also understood to be transmitted by water, but the agent of infection was not understood. Rapid population growth, together with migration from rural to urban areas contributed to overcrowded and insanitary living conditions that promoted the spread of disease. Public health laws from this period increased the powers of the State over land and premises, particularly in poor urban areas, since public health authorities noticed that this was where epidemics of disease often arose.

Legislation empowered public health officials to impose quarantine, to require the removal of filth and rubbish, to “cleanse” premises, and to regulate offensive trades. For example, the Public Health
Act of 1875 not only required landlords to provide for proper sanitation, ventilation and drainage, but to comply with and to enforce a moral code that was associated with cleanliness and good health. Landlords operating “lodging houses”, a type of affordable urban housing, were required to file “certificate[s] of character” and were prohibited from allowing unmarried tenants of the opposite sex to cohabit. There was little in this legislation to ensure that landowners and occupiers were treated fairly, and racial groups sometimes suffered discrimination.

Public health legislation in those countries that inherited their laws from Britain often reflects the legacy of this period. For example, many state public health laws in the United States were influenced by a report published in 1850 which reflected the belief that sanitation, health and morality were closely intertwined. This report has been described as “one of the most farsighted and influential documents in the history of the American public health system”, despite the fact that late 19th century developments in scientific understanding about the causes of disease disproved the notion that immorality was the root of poor health.

Outdated public health laws can undermine public health in two main ways. Firstly, due to gaps in the legislation, governments and public health officials may lack the mandate and the legal powers that they need to respond to established and emerging health threats. In some cases, legislation itself may be missing, and the extent of government powers may be ambiguous and uncertain.

Secondly, outdated legislation may undermine effective public health practice because those powers that do exist fail to achieve an appropriate balance between the rights and interests of individuals, public health and other public interests. For example, there are significant differences between the ways in which sexually transmitted infections, including HIV, and airborne infectious diseases (e.g. influenza) are transmitted. The failure to recognize that strategies for the prevention of influenza may not be appropriate for HIV can lead to significant injustice, as when HIV is simply added to existing schedules in legislation, activating a range of generic powers and obligations that are ill-suited to HIV prevention. This can lead to situations such as those in which outdated public health laws prohibit individuals with HIV from riding on public transport, require them to publicly warn others of their infection, or subject individuals to other forms of discrimination that neither reduce the spread of disease nor respect basic human rights. Identifying, removing or updating outdated provisions is an urgent priority, not only because they may be ineffectual, but because they alienate the individuals and communities whose cooperation is required in order to minimize disease transmission.

(b) The problem of multiple layers of law

Public health laws in many countries are made up of successive layers of statutes, regulations and amendments that have accumulated over many decades in response to existing or perceived health threats. Public health laws may contain provisions that were introduced in response to a wide range of epidemics including smallpox, yellow fever, cholera, tuberculosis, polio, HIV and other sexually

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transmitted infections, West Nile virus, severe acute respiratory syndrome (SARS), and more recently, novel forms of influenza. Laws enacted in such an ad hoc, reactive fashion can become inconsistent, redundant, ambiguous and confusing.

(c) The problem of inconsistency

In addition to multiple layers of law, significant variations can develop over time between the public health laws of different jurisdictions. In countries that have state or provincial governments in addition to a national government (i.e. federal systems), state or provincial laws may evolve independently of each other, with little or no coordination. In some cases, the legislative review process can give governments the opportunity to carry out an assessment of inconsistencies, and to consider both the advantages and disadvantages of either centralizing regulatory control, or alternatively, permitting regulation to continue at the subnational level.

In federal countries, the division of legislative and regulatory power between the national or federal government, and state or provincial governments, is usually set out in the national Constitution. The Constitution may grant exclusive regulatory power in a particular area to either the federal or to state governments; alternatively, regulatory power may be shared. One benefit of a federal structure is that state governments will have their own legislative powers, and thus the flexibility to try new approaches. State governments may be able to move ahead with reforms that would be impossible to achieve, for political or economic reasons, at the national level.

In countries where there is an overlap between the legislative powers of federal and state legislatures, federal governments can encourage a shared approach to regulation. For example, federal laws may make it clear that the federal government does not claim exclusive power to regulate, thereby enabling state, city and local governments to introduce additional laws, provided they are consistent with any relevant federal legislation. Australia’s Tobacco Advertising Prohibition Act, for example, explicitly preserves the right of the states and territories to pass their own laws restricting tobacco advertising, provided that they are capable of operating concurrently with federal legislation. This federal provision has enabled Australia’s states to introduce a number of innovative tobacco control laws, including laws prohibiting all tobacco advertising at point of sale, laws requiring that tobacco products for sale at retail premises must not be visible from either inside or outside the premises, and laws requiring tobacco products to be sold from a single point of sale within premises.

On the other hand, the existence of inconsistent laws at the state level in a federal country may carry disadvantages for health, due to inequality in services provided by states, and inconsistent approaches to contentious issues, such as reproductive health. In some areas, the lack of national consistency can interfere with a rapid or coherent response to health threats of regional, national or even global significance. Lack of consistency in state public health laws may cause particular problems when responding to air or water pollution, disposal of toxic waste and the rapid spread of infectious diseases such as cholera, West Nile virus, Ebola or pandemic influenza.

Inconsistencies may also develop over time between the laws and policies administered by different ministries or portfolios within the same level of government. This can undermine the coherence of
efforts to improve public health and to reduce risk factors for disease. For example, laws and programmes that provide production subsidies and other forms of economic support for tobacco farmers may encourage domestic production and demand, undermining tobacco control laws and increasing the burden of tobacco-related disease. Similarly, policies to stimulate the production of palm oil, and other oils that are high in saturated fats, may have a negative impact on rates of ischaemic heart disease in countries where these policies result in an increase in consumption, given the association between higher palm oil consumption and mortality from ischaemic heart disease.  

In summary, a review of public health legislation governing a particular issue or health challenge should include a review of the problems and limitations of existing laws. It is important to understand the historical context in which existing laws were introduced, and to seek out the views of those who are responsible for administering and enforcing the legislation and performing core public health functions (such as licensing, inspections, investigations, prosecutions and responding to health emergencies). The views of professional groups, patient groups, nongovernmental organizations, development partners and international and regional organizations may also be useful. The following questions may assist in identifying the limitations of existing laws, and in making the case for law reform:

- Do existing laws reflect a modern, evidence-based understanding of the causes of disease, routes of transmission (where relevant), and consequences of illness? Or were they framed in ignorance of modern understandings of the causes of diseases and mechanisms of transmission?

- Are current laws antiquated, redundant, ambiguous or even incoherent? How well do they work in practice? Are there any major gaps, and if so, where are they?

- Do public health laws give government officials a clear mandate to protect and promote the health of the population? Do public health authorities have the specific powers that they need to respond effectively to the health challenges that are the focus of the review?

- Are there inconsistencies between public health laws at local, state, or regional levels, and do these inconsistencies threaten a coordinated and coherent approach? Is a national approach required, or are there benefits in protecting the ability of regional and local governments to regulate in this area?

- Do existing laws take account of the legitimate interests and rights of individuals and groups, impinging on those rights to the minimum extent necessary to achieve their health objectives?

- What changes would be required in order to make current laws consistent with best practices?

### 3.2 Identifying priorities for public health law reform

The specific areas that are the subject of a formal legislative review or enquiry will usually reflect the health challenges, political priorities and specific experience of each country. National priorities for
law reform will typically be identified by government and will be informed by advice from the health ministry. Professional groups, development partners and the media may also seek to place particular law reform issues on the political agenda (see Section 3.3).

However, it is not always the case that the major health challenges that a country is facing will be high on the political agenda. For example, the impact of disease on poor and marginalized populations may be overlooked. Governments may have erroneous views about the causes of disease, and ignore evidence about the best way to combat it. Governments may simply lack the political will to do what is needed to address public health priorities, such as tobacco or alcohol control, due to concerns about the impact that law reform may have on taxation revenues, or the influence and interference of industry bodies. In some cases, issues such as violence against women, or maternal and child health, may have long been neglected due to power imbalances and other inequalities within society. Governments face many challenges that compete for their attention, and the opportunity to review a country’s public health laws may only arise infrequently. When it does arise, it is vital to ensure that law reform priorities are informed by evidence of the burden of disease and the leading health challenges the country is facing.

This section highlights some major risks to health that are shared across nations and regions. Both communicable diseases – such as HIV and pandemic influenza – and noncommunicable diseases – such as cancer, heart disease and diabetes – require urgent attention in many countries. Effective prevention and control of these diseases requires strong legal frameworks.

(a) Communicable diseases

Pandemics of contagious diseases, including novel forms of influenza, pose a powerful threat to global health security, with the potential to overwhelm health systems, and threaten economic growth and stability (Box 3.2).

Infectious diseases with pandemic potential

The SARS epidemic in 2003 was an important catalyst for the completion of the revised International Health Regulations (2005), which require States to notify WHO if there is the possibility of a “public health emergency of international concern”. H1N1 circled the globe in 2009 and 2010, becoming the first global pandemic of the 21st century. SARS, H1N1, and Middle East respiratory syndrome coronavirus illustrate that pathogens can be transmitted from one species to another, and particularly in the case of SARS and H1N1, spread through casual contact.

Box 3.2: Pandemic influenza: a threat to global health and security

Influenza pandemics have occurred at various points in human history, causing widespread illness, death and social disruption. In 1918, the “Spanish Flu” pandemic resulted in an estimated 20 to 50 million deaths worldwide. The 1957 “Asian Flu” and the 1968 “Hong Kong Flu” pandemics also resulted in significant human and economic harm. As global travel, urbanization and overcrowded living conditions increase, novel influenza viruses are more likely to spread rapidly around the
In 2009, WHO declared the H1N1 influenza pandemic to be a public health emergency of international concern. Although the H1N1 virus is not highly pathogenic, modern epidemiological models predict that a severe pandemic could result in as many as seven million deaths.

Law plays a critical role in preventing and mitigating the health consequences of contagious epidemics, in two distinct ways. Firstly, law establishes the institutional structures and formal processes through which governments respond to disease outbreaks. Secondly, law sets limits for the exercise of coercive power over citizens and businesses in order to mitigate the risk of disease spread. This is discussed further in Chapters 9–11.

HIV/AIDS

HIV infection and HIV-related disease are a critical challenge, both nationally and globally. This is especially true in sub-Saharan Africa, where nearly 5% of adults are infected, and the prevalence of HIV infection is 25 times higher than the next most affected regions, South, South-East and East Asia. Sub-Saharan Africa accounts for 70% of people living with HIV, and over 70% of AIDS-related deaths. Globally, in 2014, nearly 37 million people were living with HIV, nearly half of whom were unaware of their infection. In the same year, 1.2 million people died from AIDS-related diseases, and around 2 million people became newly infected with HIV (a 35% decline from 2000; see further in Box 3.3).

Box 3.3: The global impact of HIV infection

Since the HIV epidemic was first recognized in the early 1980s, 39 million people have died. In high-income countries, a person with HIV has a similar life expectancy to someone without HIV; however, this depends on access to antiretroviral medication. The percentage of people with HIV who were not receiving antiretroviral therapy fell from 90% in 2006 to 63% in 2013. By June 2015, 15.8 million people were receiving antiretroviral therapy. Yet globally, this means that around three out of five people living with HIV are still not yet receiving the treatment they need.

At the end of 2013, over US$ 19 billion was being invested, with more than half of this coming from domestic spending. However, despite decades of effort, HIV remains one of the most pressing global health problems, with many marginalized and vulnerable groups excluded due to poverty, legal and social inequalities and harmful gender norms. According to the United Nations Development Programme, HIV “has inflicted the ‘single greatest reversal in human development’ in modern history”. HIV exacerbates health inequalities both within countries and between countries and regions, with socioeconomically disadvantaged communities bearing the brunt of suffering and early death. HIV has serious economic as well as health consequences. HIV primarily affects otherwise young and productive workers, interrupting income-generating activities, exhausting family savings, reducing taxation revenues and interfering with schooling, because families can no longer afford school fees or because children are required to look after sick relatives.

The scale of the HIV pandemic, its capacity to rob countries of young and productive people, and the economic and health inequalities it perpetuates, have spurred a number of international initiatives
to support prevention and treatment. Evidence of global political support ranges from the United Nations General Assembly’s Declaration of Commitment on HIV/AIDS in 2001, to the creation of the United States President’s Emergency Plan for AIDS Relief, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The international community has focused on achieving several shared goals, including universal access to comprehensive prevention programmes, treatment, care and support. However, these goals cannot be achieved at the national level without strong government, supported by adequate resources and rational laws to optimize the delivery of comprehensive HIV programmes.

Significant work has been done to assist countries to identify the kinds of laws that are best suited to preventing and controlling the spread of HIV, as well as existing laws that create obstacles to effective treatment and prevention. But major challenges remain. For example, in 2012 the Global Commission on HIV and the Law reported that while 61% of countries reported having laws to protect people living with HIV from discrimination, these laws are “often ignored, laxly enforced, or aggressively flouted”. The Commission also pointed out that laws explicitly criminalizing the transmission of HIV, and laws criminalizing key populations, including commercial sex workers, men who have sex with men, and injecting drug users, ignore evidence and undermine efforts to prevent transmission and encourage treatment.

**Tuberculosis**

Tuberculosis (TB) remains a persistent threat to global health. TB is a contagious, airborne infection, second only to HIV in terms of global mortality from a single infectious agent. In 2014, an estimated 9.6 million people developed TB, including more than 1.1 million new cases among people with HIV. Although mortality from TB has fallen by 47% since 1990, 1.5 million people died from TB in 2014; around 25% of these deaths were in people co-infected with HIV. Although TB can be effectively treated, mortality rates are high in the absence of treatment. This problem is exacerbated by the fact that more than one third of new TB cases each year remain undiagnosed.

In addition to the challenge of improving access to antiretroviral therapy and anti-TB drugs for people who are coinfected with HIV and TB is the escalating crisis of multidrug-resistant TB (MDR-TB), defined as resistance to both rifampicin and isoniazid, two first-line anti-TB drugs. Globally, in 2015, around 3.3% of new TB cases and 20% of previously-treated cases were of MDR-TB. Of these, nearly 10% were estimated to have extensively drug-resistant TB (XDR-TB), due to resistance to second-line drugs. By the end of 2014, 105 countries had reported cases of XDR-TB.

MDR-TB and XDR-TB not only jeopardize progress in TB control, they also illustrate the global importance of strengthening health systems, including universal coverage, and in this case universal access to diagnosis, care and treatment for people with TB and MDR-TB. Progress towards universal coverage requires improvements in diagnostic and surveillance capabilities, and uninterrupted, timely access to quality-assured anti-TB medicines, supported by adequate financing. Bottlenecks to improved management of MDR-TB include weak drug procurement and supply systems, limited laboratory capacity, lack of trained staff and adequate treatment facilities, the absence of secure funding, and problems with programme management. In addition to the role that law plays in strengthening the components of the health system, the global challenge of TB draws attention to
the need for adequate legal powers to encourage treatment adherence by those with TB in ways consistent with the human rights and dignity (see Section 10.3).

(b) Noncommunicable diseases

Noncommunicable diseases (NCDs) – principally cardiovascular disease, cancer, respiratory diseases and diabetes – are responsible for around 68% of global mortality (in 2012, around 38 million deaths). The global transition from communicable to noncommunicable diseases is the result of several factors. These include longer life spans due to the relative success of efforts to address communicable diseases, the growth of risk factors for NCDs within populations, and the promotion of harmful products. Important risk factors for NCDs include tobacco use, harmful use of alcohol, excess saturated fat, salt and sugar in the diet, overweight and obesity, inadequate physical activity and high blood pressure. WHO has estimated that if current trends continue, by 2030 there will be 52 million deaths per year caused by noncommunicable diseases.

Obesity

Obesity is now recognized as a major risk factor for heart disease, cancer and diabetes. Between 1980 and 2013, the global prevalence of overweight and obesity increased by 27.5% for adults and 47.1% for children. In 2014, the age-standardized global prevalence of obesity was nearly 11% in men and nearly 6.5% in women; if current trends persist, by 2025 it will reach 18% in men and more than 21% in women. Although in developed countries rates of overweight and obesity are higher in men than in women, the reverse is true in developing countries. In low- and middle-income countries, the rapid increase in rates of obesity has created a double burden of communicable and noncommunicable diseases, with obesity, micronutrient deficiencies, underweight and stunting seen side by side within communities and even within the same household. In 2014, more than 600 million adults were obese, and more than 1.9 billion were overweight. The number of adults with diabetes has been projected to rise from 382 million to 592 million between 2013 and 2035, with a 108% increase in low-income countries. Childhood obesity has also become a serious concern, given the higher risks that obese children will face in adult life (see Box 3.4).

Box 3.4: The epidemic of childhood obesity

In 2013, around 8% of children and adolescents in developing countries were overweight or obese. In developed countries, the rate was around 23%. However, rates of increase of child overweight and obesity are around 30% higher in low- and middle-income countries than in high-income countries. Overweight and obese children are likely to remain obese into adulthood and are more likely to develop NCDs such as diabetes and cardiovascular diseases at a younger age.

To reduce levels of obesity among children, governments need to confront the factors that are rapidly changing the food and physical activity environments in many countries. Governments need to moderate the advertising and promotion of foods and beverages that contain high levels of fat and sugar but lack nutritional value. Fresh produce and healthy food options should be available, accessible and affordable, especially in low-income neighbourhoods. Communities need safe areas where children can play and engage in physical activity, both indoors and outdoors. The
meals children eat at school should be healthy and nutritious. In many countries, efforts to reduce childhood obesity should be integrated with policies for improving food security and preventing undernutrition. In addition to population-wide policies and local community initiatives, governments need to allocate resources in order to monitor NCD risk factors, to plan for workforce needs, to develop guidelines and policy advice, and to support partnerships with professional groups, nongovernmental organizations and other stakeholders.

Cardiovascular disease, cancer and tobacco-related diseases

Cardiovascular disease (CVD) is the leading cause of death worldwide, accounting for 17 million deaths each year. This number is expected to increase to more than 22 million by 2030. Over three quarters of CVD deaths, and nearly 90% of deaths from chronic obstructive pulmonary disease, occur in low- and middle-income countries. Cancers caused by infections – such as human papillomavirus, Helicobacter pylori and hepatitis B and C – also have a disproportionate impact on low- and middle-income countries, accounting for 26% of all cancer cases.

In 2012, cancers were responsible for over 8 million deaths; by 2030, WHO estimates that there will be more than 12 million cancer deaths each year. Tobacco use, lack of physical exercise, obesity, harmful use of alcohol, air pollution, infections and ultraviolet exposure are some of the leading modifiable risk factors. However, tobacco use stands apart in terms of the sheer scale of harm caused by a single, preventable risk factor.

Tobacco is responsible for around 6 million deaths each year and nearly 9% of global mortality, including 71% of global lung cancer deaths. Seventy per cent of these deaths occurred in low- and middle-income countries. Due to population growth and aggressive marketing tactics, tobacco consumption is rising in many low- and middle-income economies. By 2030, tobacco is likely to be responsible for 8 million deaths each year, and 10% of global mortality.

The international community has responded to the epidemic of tobacco deaths with the WHO Framework Convention on Tobacco Control (WHO FCTC). The WHO FCTC commits its Parties to passing national laws that address both demand for, and supply of, tobacco products (see Chapter 13). Implementing and enforcing the obligations contained in the WHO FCTC is not only the first priority for reducing mortality from NCDs, but a sure strategy for extending healthy life expectancy and improving productivity.

WHO’s Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 sets out a menu of policy options for the prevention and control of the leading NCDs and their risk factors. Law has a significant role to play in implementing many of these interventions, and in strengthening health systems to treat and manage NCDs effectively (see Chapter 7). At the national level, governance reforms will also be required to facilitate cross-sectoral engagement of relevant ministries to reduce risk factors.
(c) Injuries

Injuries from violence, suicide and accidents – including falls, drowning, burns and poisoning – claim more than 5 million lives each year (9% of global deaths), and leave millions more disabled. Around 90% of fatal accidents occur in low- and middle-income countries. Where injury-related disability affects the head of the household, the impact on family income may lead to reductions in family expenditures on food, education, medical care and to greater vulnerability to illness. While injuries affect all age groups, some groups are more at risk: for those between the ages of 15 and 29 years, three of the top five leading causes of death are injury-related.

WHO classifies injuries into two groups: intentional (or violence-related) injuries and unintentional (accidental) injuries. Each year, over 1.3 million people die from violence, and many more are affected by physical, sexual, reproductive and mental health problems as a result of experiencing and witnessing violence. Violence has a negative impact on national economies, costing billions of dollars each year in health care costs, law enforcement and lost productivity. In the second group, road traffic injuries cause over 1.2 million deaths each year, with a further 20–50 million non-fatal injuries.

There are a number of powerful interventions that could save lives and reduce unintentional injury-related disabilities. These include:

- mandatory use of motorcycle helmets, seat belts, and child restraints;
- physically separating pedestrians from motor vehicles and motor cycles;
- enforcing controls on speed limits and on driving while under the influence of alcohol;
- use of safer stoves for cooking;
- child resistant containers for storing poisons;
- barriers to separate children from water.

These interventions rely on improvements in the local environment, the introduction and enforcement of legislation, public education and improved product safety.

Similarly, interventions are available to reduce intentional injuries from violence and self-harm. Specific legislative measures include increasing excise taxes on alcoholic beverages, amending liquor licensing laws to restrict the time of sale and location of retail alcohol outlets, minimum age purchasing laws and restrictions on the promotion and advertising of alcohol. In countries where gun ownership is lawful, violence and accidental injuries can be reduced by requiring background checks on licence applications for all categories of firearm, by imposing licence restrictions that regulate where it is lawful to possess a firearm, and by banning military-style weapons and other firearms, including automatic and semi-automatic weapons, which have a massive and rapid destructive force. Rates of death and disability from both intentional and unintentional injuries can be reduced by improving the availability and quality of emergency care.
3.3 Who can initiate public health law reform?

With so many global health challenges and priorities, who sets the agenda for public health law reform? In many countries, the health ministry will initiate the process of legislative review. However, legislative review and law reform activities can also originate in other ministries or departments, requiring careful collaboration with the health minister. The prime minister or president, the cabinet or a law reform commission may also be instrumental in public health law reform. The leadership or support of senior ministers and other executives within government can be crucial to ensuring that government and parliamentary resources are made available for the drafting and debating of the proposed changes, the conduct of community consultation, and for ensuring that public health law reform retains its place among the other priorities competing for the government’s attention.

Even where a formal proposal for the introduction of a new law has taken place, it may need to be submitted several times before it is accepted within government as a credible option that deserves serious consideration. Advocacy for law reform may need to continue through several parliamentary and budgetary cycles before new laws are successfully passed. Throughout this process, the advocacy and support of senior government officials remains crucial.

Whichever agency provides leadership, it is important for consultation to occur with other agencies and departments that play a role in the implementation or administration of the law. Consultation with other ministries can lead to a better understanding of the obstacles that need to be resolved in order to implement the law successfully. The experience of Papua New Guinea illustrates this point (see Box 3.5).

Box 3.5: The development of Papua New Guinea’s Provincial Health Authorities Act

Papua New Guinea’s experience with the Provincial Health Authorities Act illustrates the importance of intensive consultation during the process of drafting new public health laws. This Act reflected the policy decision, by the National Department of Health, to unify the delivery of public health and hospital services at the provincial level. The effective implementation of the new Act required the Department to alter its arrangements for the payment of budgeted health funds in order to accommodate the newly-created provincial health authorities. Treasury planning and budgeting processes required that the payment of funds from the central government to the provincial government (for health services delivery) be redirected to the provincial health authorities in order to avoid loss of funds to non-health purposes. Since the central budget and financial systems were controlled by the treasury, frequent discussions were required in order to fully explain the new policy, and to gain the understanding and support that was necessary for the modification of the budgetary process and implementation of the legislation. One outcome of this consultation process was that treasury guidelines were amended to make explicit reference to the new provincial health authorities and to the need for funds to be paid directly to them.

Outside government, proposals for the reform of public health laws may be improved by consultation with other major stakeholders, including the health professions, the private sector, civil
society, philanthropic organizations, academia and the media. Government can encourage feedback by publishing discussion papers that set out draft proposals and invite comment.

In some cases, civil society organizations may become directly involved in law reform. A dramatic illustration of this occurred in Brazil during the period of constitutional reform in the latter half of the 1980s, when the text of the constitutional amendments dealing with health was developed by a group of nongovernmental organizations working in the health sector. The text of these popular amendments was adopted, with only minor changes, by the Constituent Assembly and now appears in the Federal Constitution of the Brazilian Republic (1988). These provisions confirm the right to health and recognize a corresponding duty at all levels of government to protect and promote it. They also established a public health system (Sistema Único de Saúde, or “SUS”), financed from the social security budget, with contributions from other levels of government, that encompasses the control of health risks and the “promotion, protection and recovery” of health.

Although stakeholder input can influence the design of new laws, governments should take care to ensure that lobbyists and sectional interests do not undermine the public health goals that they are seeking to achieve. The risk of industry interference has been widely recognized. For example, the guidelines for implementation of the WHO FCTC, adopted by Parties to the Convention, emphasize the importance of resisting the tobacco industry’s attempts to influence the development and implementation of tobacco control laws and policies. Other industries, including the alcohol, food and pharmaceutical industries, have a strong commercial interest in influencing laws and policies that affect them. In all cases, policy-makers will need to determine whether, and for what specific purposes, consultation or collaboration is appropriate, bearing in mind the possibility that industry groups may seek to weaken regulation and to undermine the goals that the government is seeking to achieve.

3.4 What factors can act as triggers for public health law reform

(a) Triggers for public health law reform within government

Within government, there will be a variety of political opportunities for prioritizing public health policies and for initiating the process of law reform. These may arise within the context of developing a poverty reduction strategy, a national public health strategy, or reporting to development partners. Disease outbreaks and national public health emergencies may also provide opportunities for advocacy to government by professional and nongovernment organizations, and for leadership by government in the area of public health law reform. Sunset clauses may also require the government to formally consider re-authorizing, extending or reforming current laws.

International instruments can draw attention to particular health challenges arising at the country level and serve as a catalyst for national law reform. Examples include the WHO FCTC, the International Health Regulations (2005), the International Code of Marketing of Breast-milk Substitutes, the set of recommendations on the marketing of foods and non-alcoholic beverages to
children,\textsuperscript{82} and the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020.\textsuperscript{83} In the case of treaties and regulations, countries have an obligation under international law to implement these instruments by amending their domestic laws and developing their national capabilities.

(b) Community participation as a trigger for public health law reform and policy-making

In some countries, formal mechanisms for community participation in government processes may assist civil society organizations to put health issues on the agenda of government and to participate in law-making. For example, citizen-initiated referenda may allow citizens to petition government on a popular issue. In Brazil, legislation enacted in 1990 establishes the National Health Council as a “permanent collegiate deliberative body” representing government, service providers, health workers and health service users, which participates in the development of health policies and monitors their implementation.\textsuperscript{84} At the state and municipal levels, the establishment of health councils is a precondition to the receipt of federal funds from the National Health Fund.\textsuperscript{85} By 2008 there were over 5500 municipal health councils in Brazil.\textsuperscript{86}

Policy conventions and health congresses provide opportunities for citizens to identify national health priorities, to monitor progress in implementation, and to advocate for law reform. In Brazil, the National Health Conference is required to meet every four years to evaluate the health situation in Brazil and to propose health policy directives.\textsuperscript{87} In Thailand, the National Health Act of 2007 formalizes community participation in the formation of health policy through the National Health Assembly (NHA).\textsuperscript{88} Topics that are successful in reaching the agenda of the NHA are supported by briefing papers and debated. Although resolutions passed at the NHA are non-binding, they are re-shaped by the National Health Commission for consideration by relevant ministries.

(c) Litigation and public health law reform

Civil society organizations have often turned to the courts as a remedy for injustice and discrimination within the health sector, litigating the absence of tobacco control laws, lack of access to health care services, clean water, sanitation and housing, and adequate food.\textsuperscript{89} National constitutions frequently protect individuals from legislative and executive actions that interfere with the civil and political rights of the individual. Some constitutions also recognize social and economic rights and oblige the State to take positive actions to secure these rights for the benefit of the population. This section focuses on legal claims which assert that the fundamental protections contained in a national constitution, a bill or charter of rights, or a ratified international agreement, require governments to alter their policies or practices – in ways that advance the realization of the right to health. In some cases, successful litigation may prove to be the catalyst for the subsequent introduction or amendment of public health laws.

Around two thirds of countries have constitutional provisions recognizing a right to health or health care services.\textsuperscript{90} Typically, these provisions require the legislature, the executive and other organs of State to take reasonable measures to secure the enjoyment of the right within the limits of available
resources. For example, in several cases the South African Constitutional Court has ruled that the
government has a positive obligation to take reasonable measures to fulfil basic socioeconomic
rights, including the right to health care, food and water, and housing or land.91

In South Africa, the existence of social and economic rights in the Constitution obliges government
to protect these rights not only through legislation, but also through the effective implementation of
policies designed to improve public health. For example, when ruling that the Constitution imposes a
positive obligation on the government to take action to fulfil the right to housing, the South African
Constitutional Court stated that legislation alone – without effective change – would not satisfy this
duty.92 Box 3.6 presents a case study of litigation whose substantive effect was to require the South
African government to implement a national plan of action to provide HIV-positive pregnant women
with reasonable access to nevirapine, a drug for preventing the perinatal transmission of HIV from
mother to child.

Box 3.6: The right to health and reasonable access to nevirapine in South Africa

In Minister of Health v Treatment Action Campaign (No. 2),93 a coalition of civil society organizations
challenged the decision of the South African Government to impose restrictions on the availability of
nevirapine within the public health sector.

WHO recommended nevirapine for the prevention of mother-to-child HIV transmission in January
2001, and the Medicines Control Council formally approved its use in South Africa in April of the
same year. As a result, medical practitioners in the private sector became entitled to prescribe
nevirapine in appropriate cases. The risk of HIV transmission from a pregnant, HIV-positive woman is
substantially reduced through a single dose of nevirapine during pregnancy, and by the
administration of a few drops to the baby within 72 hours of delivery. According to government
estimates at the time, around 70 000 children became infected with HIV per inately each year.

Despite the fact that the manufacturers of nevirapine had offered it to the South African
Government without charge, for a period of five years, the ability to prescribe nevirapine within the
public health system was limited to two sites per province, while research continued for a further
period of two years into the safety and efficacy of the drug and the operational challenges of making
it more widely available. These included the challenges of making confidential counselling and HIV
testing services widely available to pregnant women.

The South African Bill of Rights provides that everyone has the right to access “health care services,
including reproductive health care”.94 Every child has the right to “to basic nutrition, shelter, basic
health care services and social services”.95 The State is required to use legislative and other
measures, to progressively realize these rights, within its available resources.96

The South African Supreme Court held that the safety concerns about nevirapine were no more than
“hypothetical”, and that the cost of nevirapine was not at issue. It held that the government was not
justified in restricting the availability of nevirapine to those sites where it could be provided as part of a
broader “comprehensive package” of services for preventing mother-to-child transmission and that
the restrictions on public sector availability unreasonably excluded women who could not access the
chosen sites. The Court said: “To the extent that government limits the supply of nevirapine to its
research sites, it is the poor outside the catchment areas of these sites who will suffer”.97
The Court concluded that the government’s “inflexible” policy of limiting the availability of a “potentially lifesaving drug” was in breach of both the right to health care in Article 27 and the rights of children as set out in Article 28. As the Court pointed out, this finding required a change in government policy: “The policy will have to be that nevirapine must be provided where it is medically indicated at those hospitals and clinics within the public sector where facilities exist for testing and counselling”.98

The orders made by the Court emphasized the positive obligations imposed on the government by the constitutional right to health. These included the delivery, within available resources, of a comprehensive health care programme to progressively realize the rights of pregnant women and their children to services to prevent the transmission of HIV, including reasonable measures for testing and counselling of women to reduce the risk of perinatal transmission.

In Colombia, the Ministry of Social Protection initiated a sweeping reform of its health system – including changes in the coverage of health care services – following a finding by the Constitutional Court that systemic problems within the public health system constituted failure to fulfil the right to health.99 Other courts have mandated that states reallocate funds to secure access to treatment for all, regardless of expense. Peru and the Bolivarian Republic of Venezuela also adjusted their public health spending following such rulings.100

Even in countries where the constitution does not protect the right to health, other constitutional rights may nevertheless provide indirect protection. For example, although there is no right to health in the Indian Constitution, the Supreme Court has interpreted the constitutional right to life (Article 21) to impose a duty on the government to safeguard life, which extends to providing for emergency health care services.101

In Murli Deora v Union of India,102 the Supreme Court of India held that smoking in public violates the right to protection of life and personal liberty contained in the Constitution. It issued an order requiring the federal and state governments to ensure implementation of the prohibition on smoking in a number of public settings. These restrictions were included in subsequent national tobacco control legislation, passed in 2003 (Box 3.7).

Box 3.7: Protection from exposure to second-hand smoke through the constitutional right to life and to personal liberty in the Indian Constitution

Part III of the Constitution of India sets out a number of fundamental rights and liberties, including Article 21, which states: “No person shall be deprived of his life or personal liberty except according to procedure established by law”. Under Article 32 of the Constitution, individuals may petition the Supreme Court to enforce these rights, and the Supreme Court may issue appropriate orders.

In Murli S. Deora v Union of India,103 the petitioner relied on Article 21 of the Constitution to seek an order protecting non-smokers from harm caused by exposure to tobacco smoke in public places. At the time the case was heard, India’s federal Tobacco Act contained no restrictions on smoking in public places, although a bill had been introduced into Parliament and was awaiting consideration by a Select Committee. The Attorney-General of India and counsel for the various states agreed that it
was in the interests of citizens for the Court to make an order protecting citizens from environmental tobacco smoke until the federal Act could be amended.

Referring to the rights guaranteed under Article 21, the Court asked why a non-smoker should be threatened with fatal diseases, including cancer or heart disease, as a result of exposure to tobacco smoke in public: “Is it not indirectly depriving [a person] of his life without any process of law? The answer is obviously – ‘yes’.”

After considering the effect of smoking on both smokers and non-smokers, the Court issued an order prohibiting smoking in public places and requiring federal and state governments to “take effective steps to ensure [the prohibition of] smoking” in “auditoriums, hospital buildings, health institutions, educational institutions, libraries and court buildings, and public conveyances including railways.”

The effect of this order was to give constitutional protection against exposure to second-hand smoke in public places in India. In 2003, the Parliament of India passed the Cigarettes and Other Tobacco Products Act, which prohibits smoking in a “public place”, defined to include the places identified in the order of the Supreme Court.

Similarly, in 2001, a public interest applicant, the Environmental Action Network, sought a declaration in the High Court of Uganda that public smoking violated a number of constitutional rights including the right to life (Article 22) and the right to a healthy and clean environment (Article 39). In one of several judgments relating to this application, Justice Ntabgoba commented that “unregulated smoking in public places constitutes a violation of the rights of non-smoking members of the public”, depriving them of a clean and healthy environment. As a result of this litigation, the National Environment Management Authority issued regulations in 2004 banning smoking in a range of public places.

Cases like this illustrate that litigants, and public health organizations, can be powerful agents for change. The history, and legal and constitutional context of each country is unique. It follows that stakeholders will need to identify allies, and to consider how the available political, legal and constitutional processes might be used most effectively to build momentum towards the improvement of public health policies and the introduction of effective public health laws. The environment for reform is likely to be most favourable where deficiencies in a country’s public health laws have been recognized and demonstrated, where law reform proposals have been identified and discussed with major stakeholders, and where political champions are ready and able to take the issue forward. Civil society organizations and the media play a vital role throughout the public health law reform process.
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3 Public Health Act 1875, 38 & 39, Vict c 55, s 80(1) (England).


5 Tobacco Advertising Prohibition Act 1992 (Australia) s. 6.

6 Public Health (Tobacco) Act 2010 (New South Wales) ss. 9–10, 16.


8 In 2003, the World Health Assembly, in resolution WHA56.29, called on the Director-General “to take into account evidence, experiences, knowledge and lessons acquired during the SARS response when revising the International Health Regulations” (http://apps.who.int/gb/archive/pdf_files/WHA56/ea56r29.pdf).


15 Establishment of regional cooperation on avian influenza prevention and control (SEA/RC57/Inf.6 (Rev.1)). New Delhi: World Health Organization Regional Committee for South-East Asia; 2004.


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76 Constituição Federal de 1988 [Federal Constitution] (Brazil).


84 Lei No. 8.142 de 28 Dezembro de 1990, art 1 s 2 (Brazil).

85 Lei No. 8.142 de 28 Dezembro de 1990, art 4(II) (Brazil).


87 Lei No. 8.142 de 28 Dezembro de 1990, art 1 s 1(II) (Brazil).


91 The Court has interpreted sections 26(2) and 27(2) of the South African Constitution to require the government to make reasonable provision within available resources for people without access to health care, food, water, land, or housing. For example, see Government of the Republic of South Africa and Others v Grootboom and Others 2001 (1) SA 46 (CC), paras 93-4 (South Africa); Minister of Health and Others v National Treatment Campaign and Others (No 2) 2002 (5) SA 721 (CC): para 36 (South Africa).

92 Government of the Republic of South Africa and Others v Grootboom and Others 2001 (1) SA 46 (CC): para. 42 (South Africa).

93 Minister of Health v Treatment Action Campaign (No 2) 2002(S) SA 721 (CC) (South Africa).


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98 Minister of Health v Treatment Action Campaign (No 2) 2002 (5) SA 721 (CC) 115 (South Africa).


100 Azanca Alheli Meza García, Tribunal Constitutional de Peru, 20 April 2004 (expediente 2945-2003-AA/TC) (Peru); Sentencia 196, Cruz del Valle Bermúdez y otros v. MSAS s/amparao, Tribunal Supreme de Venezuela, 15 May 1999 (expediente 15.789) (Venezuela).

101 For example, see Paschim & Ors v State of West Bengal, A.I.R. 1996 S.C. 2426, 2429 (India).


109 The National Environment (Control of Smoking in Public Places) Regulations 2004 (Uganda).