

Non-communicable Diseases: Global epidemics; global determinants; global solutions?

Towards a healthy role for transnational food, beverage and alcohol industries in the global governance of noncommunicable disease risk

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I. Introduction: Will today’s global health governance mechanisms be able to rein in the rise in NCDs?

Growing rates of non-communicable diseases (NCDs) in all regions of the world, and particularly in low- and middle-income countries (LMICs), are a major development concern while also exemplifying the complexity, the shifting power dynamics, the growing inequities and challenge of global governance that characterize our world today.

NCDs – principally cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – have become the leading cause of death and disability worldwide. In 1990, 47% of disability-adjusted life years worldwide were attributable to communicable, maternal, neonatal, and nutritional deficits and 43% attributable to NCDs. By 2010,

these proportions had shifted to 35% and 54%, respectively.¹ The misconception that NCDs are an affliction of the affluent is increasingly outdated: 80% of all NCD-related deaths occur in LMICs. The burden of these diseases is rising fastest among lower-income countries, populations and communities, where they impose large, avoidable costs in economic, social and human terms.²

This shift in the pattern of disease (from infectious to non-communicable) is driven by a change in exposure to risk, attributable to both success in global health efforts to reduce risks related to infectious disease as well as several broader development trends including globalization, economic growth in LMICs, urbanization and changing lifestyles. To attempt to control NCD morbidity and mortality primarily through treatment would bear a price tag far too expensive for any country, even the wealthiest. Alternatively, cost-effective, feasible interventions could prevent up to 80% of all heart disease, stroke and diabetes, and more than 40% of cancers.³ Prevention, however, unlike traditional global health challenges of infectious disease and child and maternal mortality, puts health actors at immediate odds with powerful transnational corporations who profit from the sale of unhealthy products and wield well-orchestrated and well-funded opposition to protect vested interests. Globalization, in addition to accelerating the displacement of traditional diets in favor of processed, calorie-rich, high-sugar, high-salt, high-fat foods, has also shaped the power dynamics in health politics, as large multinationals exert influence to protect profits.

Global market dynamics are a much more powerful force than formal global governance mechanisms – yet some progress has been made in combatting the tobacco industry and reducing consumption, as evidenced by the Framework Convention on Tobacco Control and subsequent experience in its implementation. The global health community, led by the World Health Organization (WHO), has been unequivocal in its refusal to collaborate with the tobacco industry in health promotion.⁴ Yet the optimal nature of reciprocal engagement between the global food and beverage industry and global health governance mechanisms, from collaboration to regulation, remains a matter of debate.

Skyrocketing rates of NCDs across all countries, and the transnational nature of their

¹ Institute for Health Metrics and Evaluation. *The Global Burden of Disease: Generating Evidence, Guiding Policy*. Seattle, WA: IHME, 2013.

² World Health Organization (2011), 'Global status report on non-communicable diseases', http://whqlibdoc.who.int/publications/2011/9789240686458_eng.pdf

³ World Health Organization (2011), 'Global status report on non-communicable diseases', http://whqlibdoc.who.int/publications/2011/9789240686458_eng.pdf.

⁴ Chan M. Address to the Sixty-sixth World Health Assembly. 2013.

determinants, demand a global collective response. Yet what processes are available to effectively hold the commercial sector accountable? Is the multilateral state-led forum of the WHO and the larger global health governance architecture, which were established to address diseases and conditions of poverty, fit to fight profit-driven diseases? What type of interaction with industry promotes health and protects the public from conflicts of interest? Does industry have a legitimate role to play in global health governance – or are conflicts of interest between health and profit too profound to demand anything short of public regulation and international norms? Yet, given the influence of private authority on agenda-setting, what is the scope for enhancing various forms of transboundary legal and prescriptive frameworks?

In order to examine these questions, this paper will review growing complexity in global governance for health, and explore whether current governance mechanisms are capable of addressing the political determinants of NCDs – which are largely in the hands of the private commercial sector – particularly in the absence, as yet, of a universal standard to advance multi-sectoral, rules-based global health governance. It will review the growing and often subversive influence of industry in governance, forms of private authority in global health governance, emerging and proposed initiatives for the global governance of NCDs, and the challenges and opportunities confronting health actors in their efforts to bring health and dignity to all.

II. Novel architecture, private authority and new poles of power: The transformation of global health governance

Over the last 15 years, global health governance – defined as “the use of formal and informal institutions, rules and processes by states, intergovernmental institutions, and non-state actors to deal with challenges to health that require cross-border collective action to address effectively”⁵ – has undergone a striking transformation, in hand with wider economic and geopolitical shifts. This transformation is characterized by the proliferation of global health institutions, a shift towards private authority in global

⁵ Fidler D. The challenges of global health governance. New York: Council on Foreign Relations, 2010.

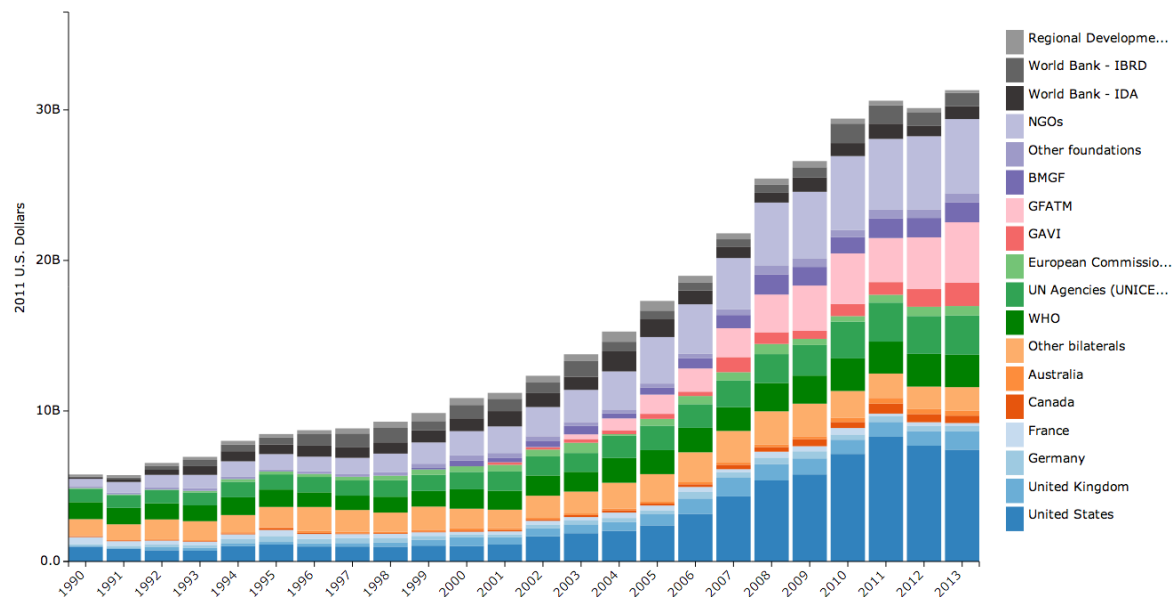
governance, the rise of emerging economies on the global stage, and the escalation of transnational activities as a determinant of poor health.⁶

Global health emerges as a global political priority – though NCDs largely off the agenda

The 2000s have been dubbed the ‘golden years’ of global health. Recognition of the links to security and economic stability as well as the soft power of health diplomacy brought unprecedented political priority and rapid resource scale-up for global health. The Security Council discussed its first health issue – HIV – in 2000, signaling the emergence of health as an issue of international politics. Three of the eight Millennium Development Goals, set in 2001, focused on health issues (MDG 4 on child health, MDG 5 on maternal health, MDG 6 on HIV, TB and malaria). Development assistance for health grew exponentially, and reached an all-time high of \$31.3 billion in 2013, five times greater than in 1990 (Figure 1). Overall spending on health reached US\$6.5 trillion in 2010, with 84% of that spent on the 18% of the world’s population living in the 34 countries of the OECD.⁷

Figure 1. Growth in development assistance for health, 1990 to 2013

Source: Institute for Health Metrics and Evaluation (IHME). Financing Global Health Visualization. Seattle, WA: IHME, University of Washington, 2014. Available from <http://vizhub.healthdata.org/fgh/>.



⁶ For path breaking work on the rise of private power in global health governance see Sell, S. Private Power, Public Law: The Globalization of Intellectual Property Rights. Cambridge: Cambridge University Press, 2003.

⁷ WHO Factsheet. Spending on health: a global overview. Available at: <http://www.who.int/mediacentre/factsheets/fs319/en/>

Development assistance resources ushered in a wave of institution-building – overwhelmingly focused on infectious disease and maternal and child health – the most high profile of which are GAVI and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Resources and political priority, in the neoliberal policy environment of the turn of the millennium, attracted new players – particularly the private sector. The Global Fund and GAVI firmly established a new model of global cooperation, where voting rights and board membership are granted to the private sector and philanthropic organisations. The other major change to the governance system, and the other major new source of financing, has been the emergence of philanthropic foundations as major governance actors, with the Bill and Melinda Gates Foundation by far the largest and most influential. Many of these new health institutions have eagerly sought to work with industry and private firms, most notably in the area of access to medicines. The new modality of health governance has also been reflected in the abundance of business techniques, concepts, practices and language adopted by the new governance institutions.⁸ As in other areas of global governance, we are witnessing a marked and largely deliberate turn in global health governance away from states and international organisations towards private and hybrid public-private authority.

Defining private authority

Helen Milner (1991)⁹ defines authority as ‘legitimized power’ and acknowledges that private actors can exercise legitimate authority. This can take the form of (1) compulsory power (direct material coercion of another), (2) institutional power (the ability to create rule-systems and attach indirect but material consequences to compliance or failure to comply – and claim the legitimate authority to do so), (3) structural power (shaping social structures and actors’ self-understanding with a view to legitimizing a particular world view), and (4) productive power (production of subjects through diffuse social relations) (see Barnett and Duvall 2005¹⁰).

In practice, power and authority are closely related; private authority generally refers to institutionalised forms of power exercised effectively by private or hybrid actors. It is worth keeping in mind, however, that though public and private authority is often conceptualized as dichotomous, in practice there is often significant interdependence or hybridisation across domains. As Palan and Abbott note, ‘capitalist enterprises need the

⁸ Williams OD and Rushton S. Are the good times over? Looking to the future of global health governance. *Global Health Governance* 5:1 (Fall 2011), pp.1-19.

⁹ Milner: Helen Milner, ‘The Assumption of Anarchy in IR: A Critique’, *Review of International Studies*, 17 (1) (1991), 67-85.

¹⁰ Barnett & Duvall: http://home.gwu.edu/~barnett/articles/2005_power_io.pdf

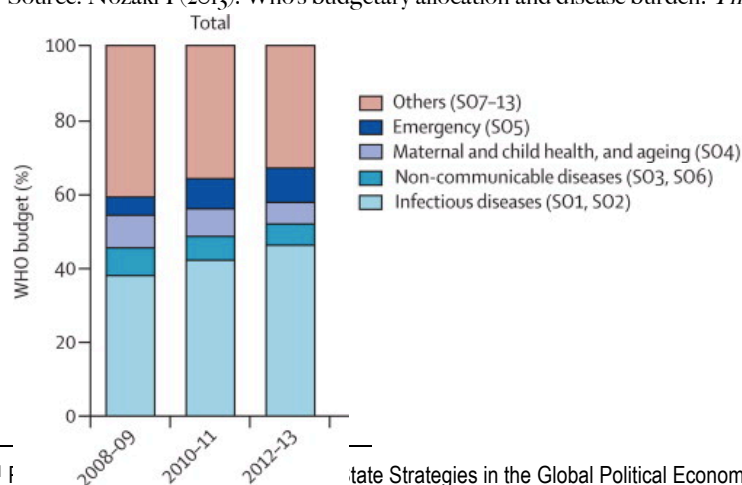
state to provide...the political and social conditions of accumulation'.¹¹

Private authority refers to non-state actors – civil society, the commercial sector or transgovernmental networks. Public authority would be member states and their representatives. The key distinction is that these two categories of actors derive their (legitimate) authority from quite different sources. Private authority can take the form of standalone private organisational structures (e.g. The Global Fund) or private standards and certification schemes (e.g. the International Organization for Standardization) for example, which often operate in coordination with or parallel to international multilateral organisations such as the WHO or other UN agencies. There may also be examples of hybrid forms of authority, most commonly observed in public-private partnership schemes.

Global efforts to control NCDs benefited little from the surge in global health spending. Only US\$185 million of the US\$28.2 billion spent globally on development assistance for health in 2010 was dedicated to NCDs.¹² WHO's 2012-2013 regular budget allocated just 6.7% to NCDs (Figure 2). WHO's 2014-2015 regular budget begins to address this misalignment as NCDs ascend its list of priorities – though largely a function of major slashes to other parts of the budget and a modest increase from \$264 million (2012-2013) to \$318 million for NCDs (up to 8% of the budget).¹³ Meanwhile, the Gates Foundation which spent \$892 million on global health in 2012 devoted only \$27 million to tobacco advocacy and policy work¹⁴.

Figure 2. WHO's budgetary allocation according to health category

Source: Nozaki I (2013). Who's budgetary allocation and disease burden. *The Lancet* 382(9896): 937-938.



¹¹ F... state Strategies in the Global Political Economy. London: Pinter, 1996.

¹² Institute for Health Metrics and Evaluation (2012) Financing global health 2012: the end of the golden age? Seattle: IHME.

¹³ WHO. Proposed programme budget. 19 April 2013.

¹⁴ Bill and Melinda Gates Foundation 2012 Annual Report. Available at: http://www.gatesfoundation.org/~media/GFO/Documents/Annual%20Reports/2012_Gates_Foundation_Annual_Report.pdf

Emerging economies bringing dynamism and contestation to global health governance

The rise of emerging economies on the global stage is causing a similarly fundamental transformation in global governance – though the implications for global health governance are not yet fully understood. The United States has long boasted both an unrivalled economy and unparalleled global clout, and with the other G8 countries, devised and bankrolled much of the recent global health institution-building. Today, however, the six largest middle-income economies – China, India, Russia, Brazil, Indonesia and Mexico – and the 6 largest high-income economies – United States, Japan, Germany, France, United Kingdom, and Italy – both account for 32 per cent of the world GDP (Purchasing Power Parities-based).¹⁵ With their economic ascendance, emerging economies are demanding a transformation of existing arrangements of global governance mechanisms dominated by industrialised countries (e.g. World Bank voting structures) and the establishment of new platforms (e.g. G20; BRICS Head of State Summits) for greater voice and representation. Since 2011, the BRICS Ministers of Health have met regularly and are currently developing a roadmap for tackling NCDs in their countries¹⁶.

While continuing to confront significant health challenges at home, emerging economies, are embracing global health as a critical component of their international outreach and increasingly engaged in global health policy discussions and diplomacy, bringing both enhanced dynamism and contestation. For example, Brazil and India have posed a significant challenge to the political economy of trade, intellectual property and access to medicines. Brazil led the successful negotiation of the Framework Convention on Tobacco Control. Most recently, Brazil has also spearheaded resistance to WHO's Framework for Engagement with Non-State Actors, contrary to the views of the EU, UK and US, over concerns that it doesn't adequately address conflicts of interest with the private commercial sector. Further, these emerging economies are home to the rapidly growing rates of NCDs and, with the growing purchasing power of their citizenry, their markets the target of transnational food, alcohol and tobacco companies. As the locus

¹⁵ World Bank. Summary of results of the International Comparison Program, April 2014.

¹⁶ Harmer A, Buse K. The BRICS - a paradigm shift in global health?. Contemporary Politics. 2014; 20(2): 127-146

of decision-making is ostensibly moving from the G7 to the G20, there remains little indication that the latter will assume a global health leadership role. Yet whether the response to NCDs can generate the level of political priority, funding and shifts in global norms that delivered much of the success of the AIDS response, may be a matter of whether a powerful bloc of emerging economies, encouraged by a well-organized civil society movement, forcefully champions and invests in NCD control.

Terminology shift 1: From “international health” to “global health”

With these transformations, a linguistic shift has occurred over the last several years, revealing a steady evolution in the philosophy and practice of improving health around the world. While definitions vary, “international health” has generally been understood to encompass the health-related cooperation between sovereign nations with a focus on maternal and child health and the control of epidemics in low-income countries.¹⁷ A range of definitions of “global health”, however, emphasizes the achievement of health improvement and health equity for all people worldwide, above the concerns of particular nations and by acting on the global forces that determine health.^{18, 19} “Global” thus tends to refer to any health issue that concerns multiple countries or is affected by transnational determinants, including the noncommunicable diseases. The global in global health also accounts for more complex transactions between societies (low-, middle- and high-income countries) and sectors (private, public and civil). It reflects and provides space to the rise in the private authority of non-state actors including non-profit civil society organisations, private foundations, faith-based organisations and the commercial sector. The shift in terminology has been rapid and appears to be resolute: By 2004, usage of “global health” in all Google-accessible books (five million-plus) overtook “international health” (Figure 3).

Figure 3. Use of “global health” versus “international health”, 1910-2008

¹⁷ Brown T, Cueto M, Fee E (2006). The World Health Organisation and the transition from “international” to “global” public health. *Am J Public Health* 96(1): 62-72.

¹⁸ Koplan J et al 2009. Towards a common definition of global health. *Lancet* 373(9679): 1993-1995.

¹⁹ Kickbush I. The need for a European strategy on global health. *Scand J Public Health* 2006; 34: 5615.

Source: Google books Ngram Viewer, <https://books.google.com/ngrams>.



While the shift in discourse is clear, the institutional shift is arguably less so. Recently established global health institutions have largely defined the agenda of the last decade of global health – particularly the Global Fund, GAVI and the Gates Foundation. These institutions are certainly “global” in their mandates to deliver global public goods, in their institutional profiles as either public-private partnerships or private institutions and use and promotion of innovative financing mechanisms that secure support beyond traditional development assistance. Yet these organizations remain preoccupied with “international” concerns, in their predominant focus on infectious diseases and the health-related MDGs in low-income countries.

Terminology shift #2: From global health governance to global governance for health

“Global health governance” is predominantly concerned with the formal and informal institutions and processes dealing with cross-border health issues.²⁰ – including the newly established health-focused institutions mentioned above. Yet, with globalization, poor health and health inequity are increasingly the result of transnational activities that involve actors with different interests and degrees of power, outside the traditional spectrum of health.²¹ Further, the proliferation of bilateral investment treaties and increasing disputes between investors and states demonstrates that global norms that safeguard market interests generally supersede other concerns.²²

²⁰ Fidler D. The challenges of global health governance. New York: Council on Foreign Relations, 2010.

²¹ The Lancet–University of Oslo Commission on Global Governance for Health (2014). The political origins of health inequity: prospects for change. *The Lancet*, 383(9917): 630-667.

²² Mamudu HM. The interlocking world of global health governance: the tobacco industry, bilateral investment treaties and health policy. In *Law and Global Health*, Freeman M, Hawkes S, Bennett B (eds). Oxford University Press, 2014.

Recognising that health is not merely a technical or functional outcome, but also based on a logic of distribution of political and economic power, the recent Lancet Commission on Global Governance of Health promotes the concept of “global governance for health”.²³ The Commission calls for an approach to governance that recognizes that addressing the global and political challenge of health inequity requires action beyond the health sector or nation states alone, and should seek improved governance across all sectors. Global governance for health thus seeks to accurately identify and address the political determinants of health, defined as transnational norms, policies, and practices that arise from political interaction across all sectors that affect health.²⁴ The political determinants of NCDs include, for example, trade liberalization and the penetration of multinational food and beverage corporations into new markets, food price speculation and the illicit trade of tobacco products as well as the lack of a forceful, coordinated civil society movement to demand global action and accountability.

Responding to the global burden of NCDs requires a strategic – and particularly political – assessment of the global processes that are likely to be most effective in encouraging the implementation of effective policies at country level to influence industry behavior.

III. Bigger waistlines; bigger margins: NCDs as a profit-driven epidemic

More than 36 million people die annually from NCDs (63% of global deaths), including more than 14 million people between the ages of 30 and 70. Low- and middle-income countries bear 86% of the burden of these premature deaths as well as the development costs: Premature NCD-related deaths in LMICs will result in estimated economic losses of US\$7 trillion over the next 15 years and trap millions of people in poverty.²⁵ Prevalence of overweight and obesity – estimated to cause 3.4 million deaths in 2010 – combined rose by 27.5% for adults and 47.1% for children between 1980 and 2013.²⁶ No national success stories in controlling obesity however have been reported in the past 33 years. With demographic shifts towards older populations, coupled with globalization, urbanization, and economic growth, the rate of increase in cumulative NCD-related losses will pick up sharply by 2030. The value of life lost, including lost

²³ The Lancet–University of Oslo Commission on Global Governance for Health (2014). The political origins of health inequity: prospects for change. *The Lancet*, 383(9917): 630-667.

²⁴ The Lancet–University of Oslo Commission on Global Governance for Health (2014). The political origins of health inequity: prospects for change. *The Lancet*, 383(9917): 630-667.

²⁵ WHO. Global Action Plan for the prevention and control of noncommunicable diseases 2013-2020. WHO, 2013.

²⁶ Ng M et al (2014) Global, regional, and national prevalence of overweight and obesity in children and adults during 1980–2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet* - 29 May 2014.

income, out-of-pocket spending related to medical care and pain and suffering due to NCDs will double between 2010 and 2030.²⁷

Global economic trends create increasingly ripe conditions for NCD risk factors, particularly the overconsumption of unhealthy processed food, beverages, alcohol and tobacco. Among the top ten global risk factors for disease in 2010, seven were associated with “lifestyle” – high blood pressure (ranked first), tobacco smoking (second), diet low in fruit (fourth), alcohol use (fifth), high body mass index (sixth), high plasma glucose (seventh) and low physical activity (tenth).²⁸

Over the past 10 years, packaged food sales globally have grown 92% while soft drink sales have more than doubled.²⁹ Increased consumption of “Big Food” products – sugar (particularly fructose)-sweetened beverages and processed foods enriched with salt, sugar, and fat – tracks closely with rising levels of child and adult obesity and diabetes and other cardiovascular diseases.³⁰ Highly processed food, alcohol and tobacco consumption are on the rise across LMICs, in part due to the mass marketing campaigns and foreign direct investments of multinational companies in these countries. Food and drink companies are rapidly penetrating emerging global markets: Virtually all “Big Food” and “Big Tobacco” sales growth is occurring in LMICs (Figure 4), and will continue for the foreseeable future.³¹ In Brazil, China and Russia sales are three to four times their 2002 levels. Tobacco and alcohol manufacturers have also clearly recognized the gendered nature of risk-taking and have increasingly shifted their focus to marketing their products to women, especially in LMICs, using novel and effective marketing techniques such as “light” products with lower calorie (but not alcohol) content.³²

Figure 4. Growth of Big Food and Big Tobacco sales in developing countries: An example.

Source: Stuckler D, Nestle M (2012) Big Food, Food Systems, and Global Health. *PLoS Med* 9(6): e1001242. doi:10.1371/journal.pmed.1001242

²⁷ World Economic Forum. Global economic burden of noncommunicable diseases. 2011.

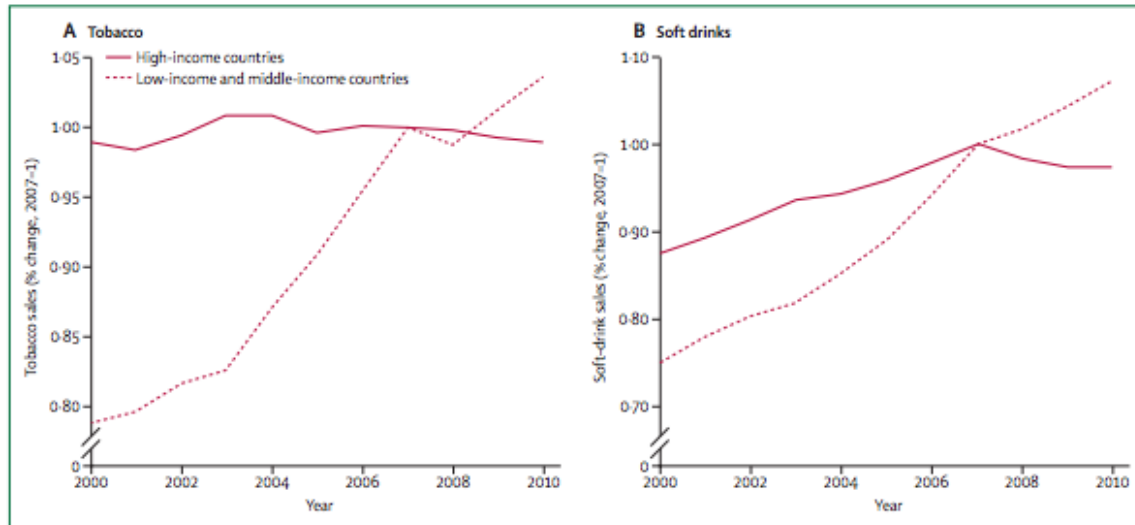
²⁸ Lim S et al. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *The Lancet*, 380(9859): 2224-2260.

²⁹ Euromonitor

³⁰ Basu S, Stuckler, D McKee M, Galea G (2012) Nutritional drivers of worldwide diabetes: An econometric study of food markets and diabetes prevalence in 173 countries. *Public Health Nutrition* 16(1):179-86.

³¹ Stuckler D, Nestle M (2012) Big Food, Food Systems, and Global Health. *PLoS Med* 9(6): e1001242. doi:10.1371/journal.pmed.1001242

³² Hawkes S and Buse K. Gender and global health: Evidence, policy and inconvenient truths. *The Lancet*, 381(9879): 1783-1787.



The combined market capitalisation of the five largest tobacco corporations is more than US\$400 billion; \$600 billion for the five largest beverage firms; \$800 billion for 5 largest pharma firms³³ – thus dwarfing most economies, not to mention public health budgets (Figure 5). In 2011, the GDP of 124 economies was less than \$100 billion. As Margaret Chan, Director-General of WHO, warned at the 2011 UN High-Level Meeting on Noncommunicable Diseases, “Many of the risk factors for noncommunicable diseases are amplified by the products and practices of large and economically powerful forces. Market power readily translates into political power.”³⁴ Global producers are driving the “nutrition transition” from traditional, simple diets to highly processed foods. Global public health has been slow to respond, for a host of reasons both endogenous and exogenous. On one hand, fault may lie in the belated recognition by public health professionals of the burden of noncommunicable disease in lower-income settings. Furthermore, there has been rather tepid civil society activism to demand political priority and action – a central force in the unprecedented global mobilization for the AIDS response,³⁵ and to a lesser extent tuberculosis and malaria. As explored above, the very success of the infectious disease responses to generate resources and establish institutions – and institutional path dependency – may be thwarting a more rapid response to NCDs, as well as the active advocacy efforts on the part of the infectious disease lobby to maintain political priority over other health issues. On the other hand, controlling NCDs equates to threatening the hefty profits of transnational companies

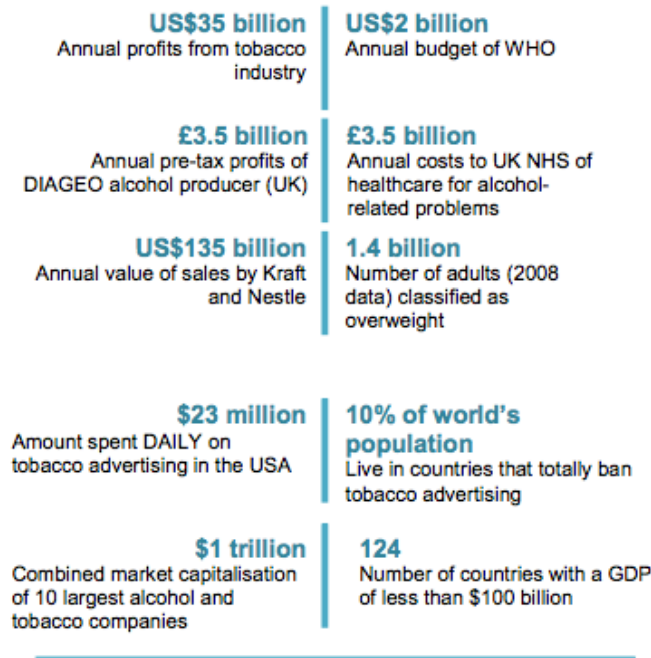
³³ The Lancet–University of Oslo Commission on Global Governance for Health (2014). The political origins of health inequity: prospects for change. *The Lancet*.

³⁴ Chan, M. Address to the 66th World Health Assembly, 2011.

³⁵ Altman D, Buse K “Thinking politically about HIV: Political analysis and action in response to AIDS” *Contemporary Politics*. 2012; 18(2): 127-40.

with strong influence over national governments. As “Big Food” faces competing interests in generating profit, managing public relations and minimizing the risk of regulation, transnational companies are playing an increasingly visible and varied role in global governance for health.

Figure 5. Resource inequality: Private and public institutions concerned with NCDs



IV. Convergence or conflict of interests in the control of NCDs: Forms of private commercial authority in global governance for health

Buse and Naylor propose a conceptual framework for classifying the involvement of the commercial sector in global health governance.³⁶ They identify three types of governance where the commercial sector plays a central role: self-regulation, co-regulation and private influence on public regulation. The implications for public health in general and the NCDs in particular, are explored below.

Self-regulation through private rules and standards

Private business actors often set and enforce rules in an attempt to regulate both “market standards” (to facilitate commerce) and “social standards” (on the basis of public or social concern). In response to growing consumer demand, as well as the threat of public regulation, Big Food is keen to demonstrate that it is actively responding to the NCD epidemics. This has most visibly taken the form of voluntary codes of conduct and highly publicized pledges to governments and the public. The International Food and Beverage Alliance (IFBA), a group of eleven giants including Coca-Cola, Mondelez and Nestlé whose 2010 revenue was more than \$350 billion, was formed in 2008 “to support WHO’s 2004 Global Strategy on Diet, Physical Activity and Nutrition”.³⁷ Since then, IFBA members have made global commitments to a range of initiatives such as reducing sodium and sugar in their products, responsible marketing to children and promote healthy lifestyles. More specific pledges are being made in wealthy countries, where obesity rates and scrutiny are higher. In the UK hundreds of companies have pledged to improve public health through “responsibility deals” with the Department of Health.³⁸ Success has been reported on various aspects. Salt intake in the UK, for example, has been reduced by around 10% over the past decade or so, by raising public awareness of salt as a public health issue and encouraging product reformulation.³⁹ As part of the calorie reduction pledge, Britvic will produce only their no-added sugar Fruit Shoot in Great Britain. It is estimated this will remove 2.2 billion calories from the children’s’ drinks market. Coca-Cola has pledged to reduce calories in some of its leading soft drinks by 30%.⁴⁰ Effective self-regulation on the part of industry leaders can deliver considerable impact in reducing NCDs – Coca-Cola and PepsiCo for example control three-quarters of the world beverage market – if standards such as

³⁶ Buse K, Naylor C. Commercial Health Governance, in: Making Sense of Global Health Governance. Palgrave Macmillan: 2009.

³⁷ <https://ifballiance.org/>

³⁸ <https://responsibilitydeal.dh.gov.uk/>

³⁹ UK Department of Health. Assessment of Dietary Sodium Levels Among Adults (aged 19-64) in England, 2011. 21 June 2012.

⁴⁰ <http://www.coca-cola.co.uk/health/responsibility-deal/coca-cola-government-responsibility-deal-update.html>

transparency, meaningful objectives and benchmarks, and independent accountability are ensured.

Codes of conduct are popular with business as they can serve several important business functions, including responding to concerns of consumers and thereby increasing sales or staving off boycotts, differentiating the firm from competitors that do not participate in the code and preventing or delaying statutory regulation.⁴¹ From a social perspective, voluntary codes can also have benefits over statutory regulation, particularly by generating better compliance than intergovernmental and national regulation, where enforcement may be ineffective, and are of little financial cost to the public sector.

While clearly the preferred approach of industry – as well as the default approach of many governments and the UN,⁴² many remain skeptical of the capacity of self-regulation to effectively govern global health concerns. The Lancet NCD Action Group is more than skeptical, stating: “Despite common reliance on industry self-regulation and public-private partnerships, there is no evidence of their effectiveness or safety”.⁴³ The UK Government, for example, based much of its initial public health strategy on “nudge theory” and voluntary action of the food and alcohol industries with the Public Health Commission and the Responsibility Deals. Public health experts, however, have criticized these deals as “putting the interests of industry ahead of improving people’s health” and in July 2013 the UK’s Faculty of Public Health (a standard-setting body within the Royal College of Physicians) withdrew from the responsibility deals.⁴⁴

Co-regulation

A second model of governance is co-regulation, defined as public sector involvement in business self-regulation, or as concerted attempts to involve non-state actors in public governance, based on the belief that engagement with industry is more effective than traditional public regulation or private self-regulation alone. Public regulation often lags behind technological innovation, is costly to the public, and particularly in the case of transnational corporations, suffers from jurisdictional constraints. Public health actors

⁴¹ Buse K, Naylor C, Commercial Health Governance, in: Making Sense of Global Health Governance. Palgrave Macmillan: 2009.

⁴² Moodie R, Stuckler D, Monteiro C, Sheron N, Neal B, Thamarangsi T, Lincoln P, Casswell S, on behalf of The Lancet NCD Action Group (2013), Profits and Pandemics: prevention of harmful effects of tobacco, alcohol and ultra-processed food and drink industries. The Lancet, 381(9867):670-679.

⁴³ Moodie R, Stuckler D, Monteiro C, Sheron N, Neal B, Thamarangsi T, Lincoln P, Casswell S, on behalf of The Lancet NCD Action Group (2013), Profits and Pandemics: prevention of harmful effects of tobacco, alcohol and ultra-processed food and drink industries. The Lancet, 381(9867):670-679.

⁴⁴ Faculty of Public Health, UK. “FPH withdraws from responsibility deals”. Press release 15/07/13. Available at: http://www.fph.org.uk/fph_withdraws_from_responsibility_deals

who promote this model pursue partnerships and initiatives and take jobs with industry. We all must eat; this view holds therefore that we must work with industry to make healthier products and market them responsibly.

Co-regulation often takes the form of public-private partnerships. Such partnerships with the food and beverage industry have quickly expanded and are endorsed at the highest political levels.⁴⁵ The formation and strengthening of multisectoral partnerships with the private sector is a central theme of WHO's 2013-2020 Global Action Plan on NCDs. US First Lady Michelle Obama describes her anti-obesity initiative, 'Let's Move', as a 'public-private partnership that, for the first time, sets national goals to end childhood obesity in a generation'. In a calorie-reduction pledge towards advancing the goals of 'Let's Move', the Healthy Weight Commitment Foundation consisting of 16 of the leading food and beverage companies in the US, boasted a cut of 6.4 trillion calories from its products since 2007.⁴⁶ These findings however were released in advance of the publication of the actual study, which appears to remain under review.

At the global level, industry is increasingly welcomed into formal governance mechanisms. Since 1999, UN and WHA resolutions have invited private business actors to participate in health governance – though this is highly contested. The World Health Organization's 2008–13 Action Plan for Non-Communicable Diseases explicitly calls for the involvement of the private sector as one of the international 'partners'. Food and alcohol industry representatives participated in the 2011 UN High-Level Meeting on NCDs (HLM) and host side-events at the World Health Assembly. Industry has also been a central player in the development of WHO's Global Coordination Mechanism for the Prevention and Control of NCDs.

Increasingly close ties between WHO and the food and beverage industry clearly raise concerns of conflicts of interest and the capacity of industry to wield influence over global health policy⁴⁷. For example, the Conflicts of Interest Coalition emerged from concerns about Big Food's influence at the HLM on NCDs which called on the UN to distinguish between business-interest not-for-profit organisations and public interest non-governmental organisations and develop a clear framework for interacting with the private sector.⁴⁸ During the May 2014 World Health Assembly, Member States debated

⁴⁵ Hawkes C, Buse K. Public-private engagement for diet and health: addressing the governance gap. *UN Standing Committee on Nutrition*, 2011;39:6-11.

⁴⁶ Evich H (2014). Food giants cut 6.4 trillion calories, keep promise to first lady Michelle Obama. *Politico*, 9 Jan 2014. <http://www.politico.com/story/2014/01/food-companies-calories-michelle-obama-101982.html>

⁴⁷ Buse K, Hawkes S. Health post-2015: Evidence and power. *The Lancet* 2013; [http://dx.doi.org/10.1016/S0140-6736\(13\)61945-6](http://dx.doi.org/10.1016/S0140-6736(13)61945-6)

⁴⁸ <http://coicoalition.blogspot.fr/>

a draft Framework of Engagement with Non-State Actors⁴⁹. Despite the establishment of an emergency drafting group, consensus could not be reached – particularly on the issue of managing potential conflicts of interests, including whether alcohol and food industries should be explicitly listed alongside tobacco and arms as those industries with which WHO does not engage.⁵⁰

While WHO corporate commitment to preventing conflicts of interest in its partnerships with industry is clear, the scope of the challenge may be impossible to actually govern. A Reuters investigation, for example, found at least two of the 15 members of WHO's Nutrition Guidance Expert Advisory Group had direct financial ties to the food and nutrition industry.⁵¹ The flow of people between the private and public sector, including secondment to WHO, while advantageous in sharing ideas, expertise and promoting positive health policies from within industry, clearly also raises challenges. Further, WHO's financial insecurity may be creating new space for the engagement of industry as well. In 2012, WHO's Latin American regional office, the Pan American Health Organization (PAHO), accepted hundreds of thousands of dollars of industry funding – including from Coca-Cola, Nestlé and Unilever (though such donations are prohibited for Geneva headquarters and the other regional offices).⁵² Critics of co-regulation warn that any partnership must create profit for industry – but see no clear, established or legitimate mechanism through which public health professionals might increase profit.⁵³

Interviewed by Reuters, Boyd Swinburn, co-director of the International Obesity Task Force, said: 'Food and beverage companies exert a huge influence on policies that affect the health of millions. Industry is buzzing all around... Even in things like nutrition guidelines, they're usually in the room at the policymaking table or buzzing around it and putting all sort of pressure on, bringing their huge conflicts of interest and their huge resources to it – and we're wondering why we don't get much public interest policy coming out'.⁵⁴

⁴⁹ http://apps.who.int/gb/ebwha/pdf_files/EB134/B134_8-en.pdf

⁵⁰ Third World Network (2014) WHO: Drafting Group established on “non-state actors” engagement. 21 May 2014. <http://www.twinside.org.sg/title2/health.info/2014/hi140504.htm>

⁵¹ Wilson D, Kerlin A. Special Report: Food, beverage industry pays for seat at health-policy table. Reuters, 19 October 2012. <http://www.reuters.com/article/2012/10/19/us-obesity-who-industry-idUSBRE89I0K620121019>

⁵² Wilson D, Kerlin A. Special Report: Food, beverage industry pays for seat at health-policy table. Reuters, 19 October 2012. <http://www.reuters.com/article/2012/10/19/us-obesity-who-industry-idUSBRE89I0K620121019>

⁵³ Stuckler D, Nestle M (2012). Big food, food systems and global health. PLOS 19 June 2012.

⁵⁴ Wilson D, Kerlin A. Special Report: Food, beverage industry pays for seat at health-policy table. Reuters, 19 October 2012. <http://www.reuters.com/article/2012/10/19/us-obesity-who-industry-idUSBRE89I0K620121019>

Private influence on public regulation

The shortcomings of self-regulation and the inherent conflicts of interest of co-regulation lead many public health experts to propose public regulation, or at least the threat of regulation, as the only effective approach to achieve change in industry behavior.⁵⁵ Decades of public efforts to control tobacco consumption however have revealed the lengths of well-funded and well-orchestrated subversion to which industry will go to protect its profitability.⁵⁶ The result of one particular litigation, the State of Minnesota versus Philip Morris⁵⁷, was a requirement that tobacco companies open all secret records. Exploration of the records by the Tobacco Free Initiative revealed a decades-long campaign to subvert public policies.⁵⁸ WHO together with the World Bank produced a report demonstrating well-financed and effective industry efforts to stop, slow, or delay the introduction of effective tobacco control policies within WHO and member states.⁵⁹ Similarly, Sell reveals how the 1994 WTO adoption of the Trade-Related Aspects of Intellectual Property Rights – which dictates how states should regulate intellectual property protection – was the direct result of lobbying by powerful multinational corporations who succeeded in shaping international law to protect their markets.⁶⁰ In protecting their interests, food and beverage companies have often adopted similar tactics, through building financial and institutional relations with health professionals, non-governmental organisations, and national and international health agencies (as above), and undertaking influencing tactics such as:

- **Direct lobbying of decision-makers:** Days before the publication of the 2003 WHO guidelines on healthy eating, the Sugar Association wrote to WHO's Director General at the time, stating that it will "exercise every avenue available to expose the dubious nature" of the WHO's report on diet and nutrition, including challenging its \$406m (£260m) funding from the US.⁶¹ The sugar industry claimed that the recommendation that sugar should not account for more than 10% of a healthy diet

⁵⁵ Moodie R, Stuckler D, Monteiro C, Sheron N, Neal B, Thamarangsi T, Lincoln P, Casswell S, on behalf of The Lancet NCD Action Group (2013), Profits and Pandemics: prevention of harmful effects of tobacco, alcohol and ultra-processed food and drink industries. *The Lancet*

⁵⁶ Yach D (2013). The origins, development, effects, and future of the WHO Framework Convention on Tobacco Control: a personal perspective. *The Lancet* - 17 May 2014 (Vol. 383, Issue 9930, Pages 1771-1779).

⁵⁷ Tobacco Control Laws. State of Minnesota v. Philip Morris Inc. <http://www.tobaccocontrolaws.org/litigation/decisions/us-19960725-state-of-minnesota,-et-al.-v.->

⁵⁸ WHO. Tobacco company strategies to undermine tobacco control activities at the world health organization: report of the committee of experts on tobacco industry documents. http://www.who.int/tobacco/en/who_inquiry.pdf.

⁵⁹ WHO. The world health report. http://www.who.int/whr/1999/en/whr99_en.pdf.

⁶⁰ Sell S. *Private Power, Public law: The globalization of intellectual property rights*. Cambridge University Press: 2003.

⁶¹ Bosely S, 2003. Political context of the world health organization: Sugar industry threatens to scupper the WHO. *Intl J Health Services*, 33 (4): 831-833.

was scientifically flawed. Simultaneously, the sugar industry enlisted two US Senators to block the report.⁶²

- **Using ostensibly independent front organisations, e.g. research institutes, trade associations:** The American Dietetic Association (ADA), “devoted to improving the nation’s health” produces a series of Nutrition Fact Sheets – industry sources pay \$20,000 per fact sheet and take part in writing the documents.⁶³ ADA industry partners are provided access to key influencers and decision makers, and outlets for research findings including professional meetings and scientific publications.
- **Commissioning research and funding academics:** A meta-analysis of available research showed clear relationships among the consumption of soft-drinks, poor nutrition and negative health outcomes.⁶⁴ The meta-analysis demonstrated that, unsurprisingly, studies funded by industry were more likely to find results favorable to industry. In the UK, the Scientific Advisory on Nutrition is a committee of independent experts that provides advice to health and government agencies – including the role of sugar in a healthy diet. Several of these experts have received funds from chocolate, ice-cream and fizzy drink companies like Mars, Unilever, Coca-Cola and the lobby group Sugar Nutrition – though these relationships have been disclosed and seen by some as beneficial.⁶⁵
- **Framing the debate:** Industry consistently frames personal responsibility as the cause of unhealthy diet, and emphasize physical activity and education as the most effective solutions. A variety of related messages are also typical of industry framing, including that companies offer choices and pleasure, emphasize moderation and do not encourage consumers to overuse their products.⁶⁶
- **Discrediting opponents:** Industry often vilifies critics with totalitarian language, characterizing them as the food police, leaders of a nanny state, and even “food fascists,” and accuse them of desiring to strip people of their civil liberties.⁶⁷

Industry is clearly active in the realm of influencing public sector regulation. With increasing awareness of these strategies, the public sector is in a better position to develop policies and guidelines to protect against conflicts of interests, undue influence

⁶² Ibid.

⁶³ Brownell KD, Warner KE (2009). The perils of ignoring history: Big Tobacco played dirty and millions died. How similar is Big Food? *Milbank Q* 87(1):259-94.

⁶⁴ Vartanian L, Schwartz M, Brownell K (2007) Effects of soft drink consumption on nutrition and health: A systematic review and meta-analysis. *Am J Public Health* 97(4):667-675.

⁶⁵ Bosely S. Sugar intake must come down, says WHO – but UK likely to resist. *The Guardian*, 7 September 2013.

<http://www.theguardian.com/lifeandstyle/2013/sep/07/sugar-diet-who-uk-experts>

⁶⁶ Brownell KD, Warner KE (2009). The perils of ignoring history: Big Tobacco played dirty and millions died. How similar is Big Food? *Milbank Q* 87(1):259-94.

⁶⁷ <http://www.consumerfreedom.com/>

and conferring unfair advantages to certain segments of the market so as to protect and promote health.

V. Is “voluntary” enough: Scope for exercising WHO’s legal authority for NCDs

The 2011 UN High-Level Meeting on NCDs was only the second time health has been elevated to this level (the first being the 2001 UN High-Level Meeting on HIV/AIDS). A series of global policy and coordination mechanisms have since been established, including:

- WHA endorsement of a comprehensive **Global Monitoring Framework** for the Prevention and Control of Non-Communicable Diseases⁶⁸, which includes a set of 9 voluntary global targets and 25 indicators (Annex 1) and calls on countries to (1) set national NCD targets for 2025; (2) develop multisectoral national NCD plans and enable health systems to respond; and (3) submit progress reports towards these targets in 2015, 2020 and 2025;
- WHA endorsement of a **Global Action Plan** for the Prevention and Control of Non-communicable Diseases 2013-2020,⁶⁹ which provides a roadmap and menu of policy choices for countries and international partners towards achieving the voluntary global targets;
- WHA endorsement of a limited set of **Action Plan indicators** for the Global Action Plan (Annex 2);
- ECOSOC resolution E/RES/2013/12 requested the UN Secretary-General to establish a **United Nations Interagency Task Force** on the Prevention and Control of Noncommunicable Diseases, which has now met three times.⁷⁰
- WHA development of terms of reference for the **Global Coordination Mechanism** for the prevention and control of non-communicable diseases.

As mandated in the 2011 Political Declaration, a comprehensive review and assessment of progress will be held during the UN General Assembly in 2014.

Whether these frameworks will encourage meaningful policy change at the country level, industry behavior change and a reduction in NCDs remains to be seen. The Political Declaration however has been criticized as being particularly weak in its

⁶⁸ http://www.who.int/nmh/global_monitoring_framework/en/

⁶⁹ http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1

⁷⁰ http://www.who.int/nmh/events/ncd_task_force/en/

language concerning engagement with the food and beverage commercial sector and tempers previous WHO recommendations on the marketing of food and beverages by calling on the private sector to implement them “as appropriate”.⁷¹ The lack of a human rights framing throughout the NCD global policy frameworks however raises concerns of the strength of the accountability architecture.⁷² The former UN Special Rapporteur on the right to health, Paul Hunt, has defined accountability as “ensuring that health systems are improving, and the right to the highest attainable standard of health is being progressively realized, for all, including disadvantaged individuals, communities and populations”.⁷³ Most significantly, the lack of a global legal framework to guide national action and international cooperation to reduce risk factors related to alcohol abuse and unhealthy diet greatly arguably reduces the ability of states to curb the growing NCD epidemic.

The WHO's most significant achievement in controlling the NCD pandemic has been the 2003 Framework Convention on Tobacco Control (FCTC)—the first convention adopted under Article 19 of the WHO Constitution. The FCTC requires signatories to restrict the influence of the tobacco industry on national health policies and ensure that safeguards are in place to protect the public from secondhand smoke. Other provisions include limiting or banning advertising and ensuring clear health warnings on tobacco products. It is one of the most widely embraced treaties in the history of the UN, with 174 signatories. The WHO reports that most parties have “passed or are renewing and strengthening national legislation and policies” related to the treaty. Progress is notable – but uneven.

Perceived success of the Framework Convention on Tobacco Control (FCTC) in influencing national and global public health policies has led to growing interest in new international legal instruments to address global health issues.⁷⁴ There is a growing campaign for a Framework Convention on Global Health, led by the Joint Action and Learning Initiative, which aims to reshape global governance for health by establishing binding national and international commitments to health.⁷⁵ Such a treaty, supporters argue, would incentivize concerted action against the drivers of health disadvantages by empowering civil society to litigate the right to health and elevating health and placing it

⁷¹ Taylor A, Dhillon I, Hwenda L (2012). A WHO/UNICEF Global Code of Practice on the marketing of unhealthy food and beverages to children. *Global Health Governance*, 5(2).

⁷² Gruskin S, Ferguson L, Beaglehole R (2014). Noncommunicable diseases and human rights: A promising synergy. *Am J Public Health*, 104(5): 773-775.

⁷³ Hunt P and Backman G (2008). Health Systems and the Right to the Highest Attainable Standard of Health. *Health and Human Rights*, 10(1), pp. 81-92.

⁷⁴ Gostin LO (2012) A Framework Convention on Global Health: health for all, justice for all. *JAMA*, 307(19):2087-2092.

⁷⁵ Gostin LO, Friedman E, Buse K, Waris A, Mulumba M, Joel M, et al. (2013). Towards a framework convention on global health. *Bulletin of the World Health Organization*, 91(10), 790-793.

closer to the centre of the goals and activities of other international legal regimes. Similarly, some advocates are calling for a framework convention on alcohol⁷⁶ and obesity⁷⁷.

The complexity of NCDs however presents unique challenges to forging a unified and comprehensive global response, such as those for tobacco or the AIDS response. The diversity of NCDs and their drivers require multiple interventions and multiple actors, and are not easily reduced to legal principles. Similarly, the lack of a single 'industry enemy' as is the case in tobacco control, the active role that food and beverage companies have taken to demonstrate their commitment to public health and the willingness of some public health actors to partner with these companies further complicates efforts to push for global regulatory frameworks. WHO's preference for a "voluntary" approach may rest on several assumptions: that partnering with industry is the most effective way of aligning commercial incentives with consumer health interests, that regulation will destroy communication channels with business, and that regulatory options are not politically feasible.⁷⁸

It also reflects the historical reticence of authorising actors within WHO and IO structures more generally to subjecting corporations to supranational oversight and control. As Abbott and Snidal pointedly note, 'states have denied virtually all IOs direct access to private targets and strong regulatory authority'.⁷⁹ This has had important consequences in terms of both delimiting inquiry into the determinants of global health outcomes, as well as the repertoire of possible interventions to safeguard provision of global public goods from the negative externalities of decentralized private activity. As highlighted in the previous section, it is important to first make legible how private actors exercise agency through direct instrumental power (mobilizing resources and compulsion) but also through indirect channels which nevertheless have material consequences (acquiring authoritative informational status, expertise, and access to decision-making forums).⁸⁰ At a micro-level then, a shift towards global governance of non-communicable diseases urgently requires deeper understanding of how private power is exercised across scales in this domain. It also demands that innovative new

⁷⁶ <http://www.add-resources.org/appeal-to-who-framework-convention-on-alcohol-control.442256-315780.html>

⁷⁷ The Lancet (2011). Urgently needed: a framework convention for obesity control. *The Lancet* 378(9793): 741.

⁷⁸ Magnusson R (2007). Non-communicable diseases and global health governance: enhancing global processes to improve health development. *Globalization and Health* 3:2 doi:10.1186/1744-8603-3-2.

⁷⁹ Abbott, K. and Snidal, D. Taking Responsive Regulation Transnational: Strategies for International Organizations. *Regulation and Governance*, 7 (2013): 96.

⁸⁰ Sell, S. *Private Power, Public Law: The Globalization of Intellectual Property Rights*. Cambridge: Cambridge University Press, 2003.

forms of IO cooperation and regulation targeting private actors, developed by entrepreneurs such as John Ruggie, are scaled up.⁸¹

Given the current governance architecture, and in the absence of additional legally binding treaties on NCDs, scholars promote the application of a human rights frame to NCD prevention and control – as human rights “offer a logical, robust set of norms and standards; define the legal obligations of governments; and add accountability mechanisms to traditional public health strategies”.⁸² As such, accountability can be advanced through the robust use of existing UN human rights machinery such as the universal periodic reporting to the UN Human Rights Council and UN human rights treaty bodies. Notably, the UN Committee on Economic, Social and Cultural Rights has a long track record of issuing authoritative guidance on the obligations and avenues for implementation of the right to health, particular attention should be given to engaging the Special Procedure on the Right to Health –independent expert appointed by the Human Rights Council – to ensure that their activity on non-communicable diseases is scaled up.⁸³

Specific national mechanisms for accountability may also be warranted. Beaglehole and colleagues advocate national independent NCD accountability mechanisms, modeled on national AIDS commissions, as the most promising means to mobilise tangible progress on the NCD commitments made by the global community.⁸⁴ Such a system rests on three principles: 1) Mandating an independent group to gather and analyse progress and submit it to the highest multilateral authority; 2) Adopting the human rights model of accountability that employs monitoring, review and remedy, and; 3) Ensuring a manageable and measurable set of targets and indicators. Independent accountability mechanisms would provide valuable oversight to industry self-regulation and co-regulation initiatives to combat NCDs, the monitoring of national policies to regulate the food, beverage and tobacco industries and their enforcement, and ensure remedial action in relation to all relevant actors. Lessons could usefully be drawn from the experience of the Independent Expert Review Group (iERG) which reports regularly to the UN Secretary-General on the results and resources related to the Global Strategy for Women’s and Children’s Health. The accountability framework used has its origins in

⁸¹ See Ruggie, J. (2014) Global Governance and “New Governance Theory”: Lessons from Business and Human Rights. *Global Governance*, 20(1): 5-17.

⁸² Gruskin S, Ferguson L, Beaglehole R (2014). Noncommunicable diseases and human rights: A promising synergy. *Am J Public Health*, 104(5): 773-775.

⁸³ UN Human Rights Council: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover, U.N. Doc. A/HRC/26/31 (2014) [Main focus: unhealthy foods and non-communicable diseases].

⁸⁴ Beaglehole R, Bonita R, Horton R (2013). Independent global accountability for NCDs. *The Lancet*, 381(9867): 602-605.

human rights bodies—namely, monitoring (based on a small number of health status and coverage indicators), transparent and participatory review, and remedy and action.⁸⁵ Others have proposed that national accountability mechanisms should include an emphasis on civic engagement to promote social accountability – although the evidence for impact is still limited.⁸⁶

Contributions of non-binding instruments for global health governance: Experience of the AIDS response⁸⁷

The 2001 United Nations General Assembly Special Session Declaration of Commitment on HIV/AIDS (DoC) and the Global AIDS Reporting Mechanism established to monitor its implementation provide a concrete example evidencing that non-binding instruments can constitute valuable tools for international health cooperation and accountability. The DoC affirmed a human rights approach to AIDS, provided a concrete framework to reverse the pandemic and established a cogent reporting mechanism to monitor implementation. At the country level, the reporting process is typically led by the National AIDS Council, the Ministry of Health or its equivalent. In 2012, 96% of all UN Member States produced country reports, giving it the highest response rate for any international health and development mechanism.

The AIDS response demonstrates that non-binding legal instruments can offer benefits over slower, more rigid binding legal approaches to governance. Given their flexibility, non-binding instruments can facilitate compromise and cooperation among states with different goals and time horizons because states do not run risks to reputation or countermeasures if they breach treaty commitments. Moreover, consensus may be easier to achieve since non-binding standards do not involve formal legal commitments and the political sanctions they can entail. Further, unlike binding international law, the negotiation and implementation of non-binding instruments can more readily involve non-state actors – which in the case of the AIDS response has been crucial to ensuring the interests of affected communities are represented at national and global levels, forging a common sense of purpose to foster accelerated progress, and significantly enhancing overall effectiveness and legitimacy.

⁸⁵ Every woman, every child: from commitments to action: the first report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health. WHO, 2012.

http://www.who.int/woman_child_accountability/iERG/reports/2012/iERG_report_low_resolution.pdf?ua=1

⁸⁶ Flores W. Accountability and Monitoring in Health Initiative, Open Society Foundations (2011). Community monitoring for accountability in health: review of literature.

⁸⁷ Taylor AL, Alfvén T, Hougendobler D, Tanaka S, Buse K. Leveraging non-binding instruments for global health governance: Reflections from the Global AIDS Reporting Mechanism for WHO reform. *Public Health*, 128(2014): 151-160.

VI. Conclusion

The rise in NCDs reflects deep shifts in global social norms and social structures. Urbanisation, industrialization, changes in gender norms – these and other factors combine to reduce our opportunities for physical exercise while also increasing exposure to products which are energy-and profit-dense, thus contributing to the growing epidemic of overweight and obese populations. Moreover, changes in social values and increases in disposable incomes combined with sophisticated marketing techniques increase the social desirability of products directly harmful to health (tobacco) or harmful if used to excess (alcohol). The ability of the global health sector to influence NCD risk exposure, or deal with NCD outcomes, is limited. Nonetheless, we know enough at the present time to make a significant impact on the burden of NCDs⁸⁸. WHO recommends a set of cost-effective, feasible “best buy” interventions (the majority of the interventions related to reducing risk factors involve public regulation, Figure 6). However, a persistent gap remains between policy knowledge at the global level and national policy implementation.

Much of this gap is due to weak institutional capacity at the national level, as well as the pervasive authority of the commercial sector in (resisting) policy change. Some of this shortfall may also be due to WHO’s continued struggle to incentivise the engagement of other sectors in negotiations on health and action on the broader determinants of health, such as trade and the marketing of unhealthy food and beverages. Global accountability for progress made towards the voluntary global NCD targets will require a however a global coordinated approach that reflects the scale, complexity, multisectorality and urgency of the NCD epidemic. The May 2014 WHA endorsed terms of reference and workplan for the Global Coordination Mechanism for NCDs, led by WHO, to improve coordination among member states, international organisations and the non-state actors. Whether this forum will be able to advance meaningful multisectoral action and provide a public arena in which actors are expected to be answerable for the health consequences of their actions remains to be seen.

The rapid rise in NCDs, and their disproportionate impact on lower-income countries and populations, represents an unacceptable social injustice. Addressing the political

⁸⁸ WHO and World Economic Forum (2010). From burden to best buys: Reducing economic impact on noncommunicable diseases in low- and middle-income countries.

http://www3.weforum.org/docs/WEF_WHO_HE_ReducingNonCommunicableDiseases_2011.pdf

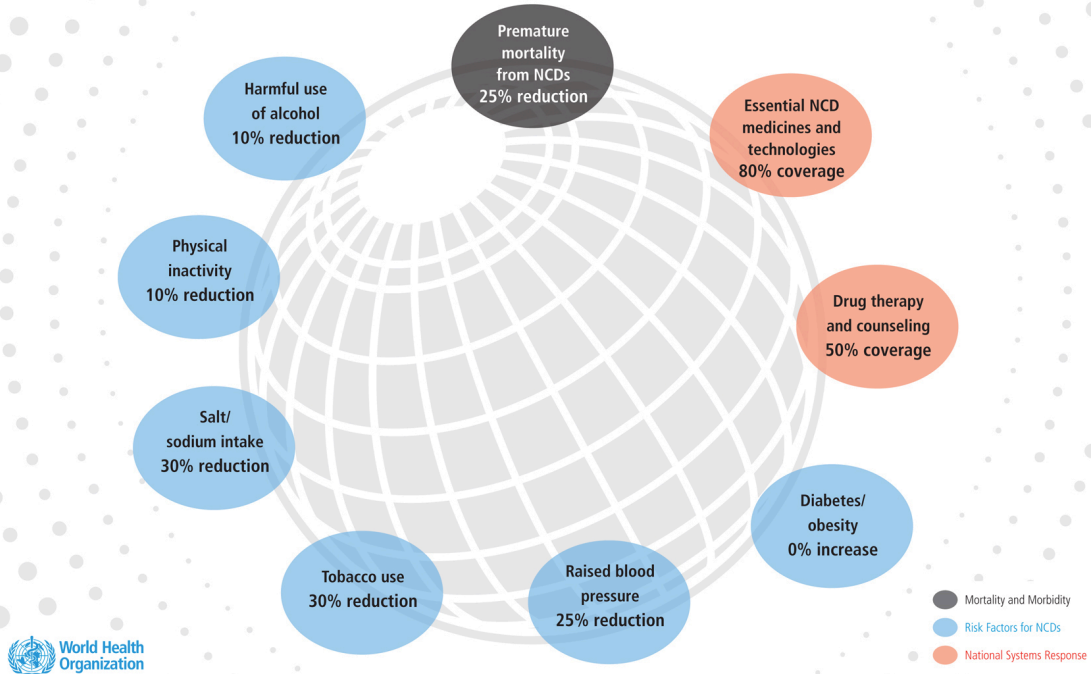
determinants of NCDs, particularly transnational activities, will demand a dynamic combination of private self-regulation, co-regulation, public regulation and international legal standards, a stronger global civil society movement and more forceful national leadership, especially among emerging economies. Reaching the global community's target to reduce NCDs by 25% by 2025 is not a question of technical knowledge or financial resources but of political will – upon which, in today's globalized world, the well-being of millions, and perhaps billions, depends.

Figure 6. WHO Recommended ‘best buys’ to reduce NCD-related risk factors

Risk factor / disease	Interventions
Tobacco use	<ul style="list-style-type: none"> • Tax increases • Smoke-free indoor workplaces and public places • Health information and warnings • Bans on tobacco advertising, promotion and sponsorship
Harmful alcohol use	<ul style="list-style-type: none"> • Tax increases • Restricted access to retailed alcohol • Bans on alcohol advertising
Unhealthy diet and physical inactivity	<ul style="list-style-type: none"> • Reduced salt intake in food • Replacement of trans fat with polyunsaturated fat • Public awareness through mass media on diet and physical activity
Cardiovascular disease (CVD) and diabetes	<ul style="list-style-type: none"> • Counselling and multi-drug therapy for people with a high risk of developing heart attacks and strokes (including those with established CVD) • Treatment of heart attacks with aspirin
Cancer	<ul style="list-style-type: none"> • Hepatitis B immunization to prevent liver cancer (already scaled up) • Screening and treatment of pre-cancerous lesions to prevent cervical cancer

Annex 1. NCD Global Monitoring Framework Targets and Indicators

Set of 9 voluntary global NCD targets for 2025



Global Monitoring Framework

Mortality & Morbidity

Unconditional probability of dying between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases

Cancer incidence by type of cancer

Risk Factors

- Harmful use of alcohol (3)
- Low fruit and vegetable intake
- Physical inactivity (2)
- Salt intake
- Saturated fat intake
- Tobacco use (2)
- Raised blood glucose/diabetes
- Raised blood pressure
- Overweight and obesity (2)
- Raised total cholesterol

Total number of related indicators in brackets

National Systems Response

- Cervical cancer screening
- Drug therapy and counseling
- Essential NCD medicines & technologies
- Hepatitis B vaccine
- Human Papilloma Virus vaccine
- Marketing to children
- Access to palliative care
- Policies to limit saturated fats and virtually eliminate *trans* fats

25 Indicators

Annex 2. NCD Global Action Plan Indicators

A set of nine Action Plan indicators to inform reporting on progress made in the process of implementing the Global Action Plan have been agreed by WHA Member States as follows:

(a) Number of countries with at least one operational multisectoral national policy, strategy or action plan that integrates several non-communicable diseases and shared risk factors in conformity with the global and regional non-communicable disease action plans 2013-2020;

(b) Number of countries that have operational non-communicable disease units/branches/departments within the ministry of health, or equivalent;

(c) Number of countries with an operational policy, strategy or action plan, to reduce the harmful use of alcohol, as appropriate, within the national context;

(d) Number of countries with an operational policy, strategy or action plan to reduce physical inactivity and/or promote physical activity;

(e) Number of countries with an operational policy, strategy or action plan, in line with the WHO Framework Convention on Tobacco Control, to reduce the burden of tobacco use;

(f) Number of countries with an operational policy, strategy or action plan to reduce unhealthy diet and/or promote healthy diets;

(g) Number of countries that have evidence-based national guidelines/protocols/standards for the management of major non-communicable diseases through a primary-care approach, recognized/approved by government or competent authorities;

(h) Number of countries that have an operational national policy and plan on non-communicable disease-related research, including community-based research, and evaluation of the impact of interventions and policies;

(i) Number of countries with non-communicable disease surveillance and monitoring systems in place to enable reporting against the nine voluntary global non-communicable disease targets.