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Law in the Time of Chronic Disease

Inaugural lecture Prof. mr. dr. Brigit Toebes
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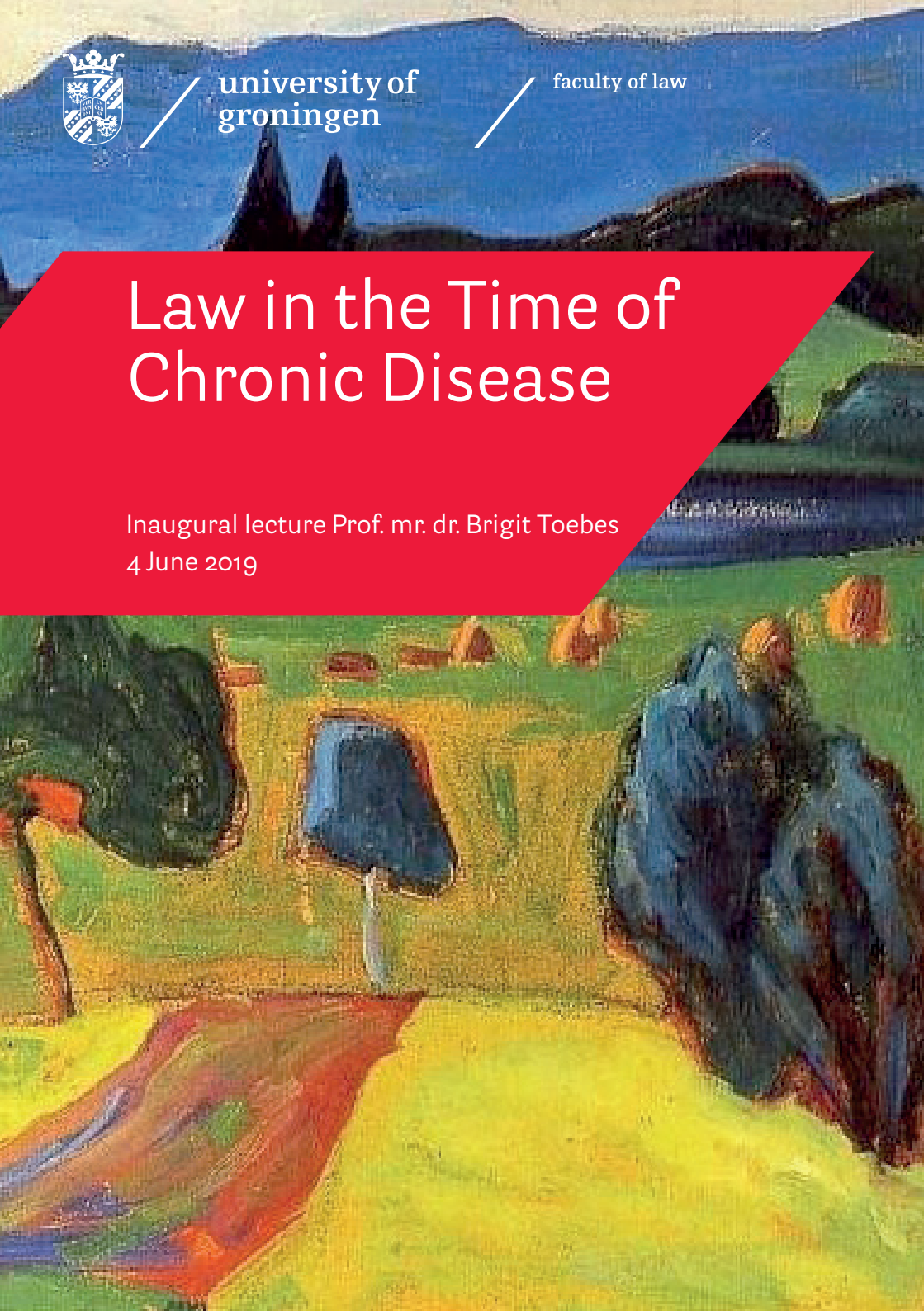

Law in the Time of Chronic Disease

Brigit Toebes, 4 June 2019

Cover: ‘Mountain Lake’, Gabriele Münter (1908)
Design: Anja Robbeson

Summary

Chronic noncommunicable diseases (NCDs) including cancer, diabetes, cardiovascular and respiratory diseases are the most important public health challenge of our times. Four behavioral risk factors are at the root of these diseases: smoking, excessive use of alcohol, unhealthy diet and a lack of physical exercise.

This inaugural lecture addresses the way in which international and domestic law can play a role in reducing these risk factors. Law is a powerful tool to be wielded in the effort to reduce unhealthy behavior in society and has the untapped potential to be applied more effectively in this context.

At the international level, there is the possibility of adopting new treaties regulating alcohol and unhealthy diet, complementing the existing WHO Framework Convention on Tobacco Control. At the domestic level, measures including smoking bans, sugar taxes and a prohibition on the marketing of alcohol are all effective ways to curb unhealthy lifestyles.

This lecture also discusses the way in which regulating unhealthy diets touches upon human rights, including the right to health and the right to autonomy. In addition, attention is paid to the fact that healthy behavior is quite often a symptom of an unhealthy living environment. This discussion will shed light on how law can play a facilitating role in protecting human health in this context .

“Dear Rector, Members of the Board, dear Honourable Guests”,

In this inaugural lecture I will take you on a journey through the global landscape of health law.[1] In order to spark your imagination, I will illustrate this journey through a set of images.

‘Mountain Lake’, Gabriele Münter (1908)

Substantial improvement of global public health

I will make the plea for increased advertency to prevention in order to reduce chronic diseases.

What is the state of the world concerning global public health? Let us start with the good news.[2] Over the last 150 years, the world has made tremendous progress in improving human health. Life expectancy has

[1] I thank Nikee van der Gouw and Meaghan Beyer for helping me translate this lecture from Dutch to English.

[2] See also Hans Rosling et al, *Factfulness: ten reasons why we’re wrong about the world – and why things are Better than you think*, Sceptre 2018.

risen dramatically, to the degree that people around the world are now becoming twice as old as 150 years ago.[3] Child mortality has decreased, significantly more people have access to essential drugs, and 80% of the world's population is vaccinated against the most important infectious diseases.[4]

Increase in chronic diseases

Despite these advances, there are also reasons for grave concern. Both in the Netherlands as well as globally, there has been a substantial increase in chronic, non-communicable diseases (NCDs). The four most widespread chronic diseases are cancer, diabetes, cardiovascular and respiratory disease. Worldwide, 70%-80% of overall mortality is caused by these chronic diseases.[5]

Some may argue that this is in fact good news. It is better to die of cancer at the age of 80, than of an infectious disease at the age of five. However, the bad news is that many people die of such diseases prematurely, before the age of 70 years old. In other words: more than half of people who die before they are 70 years, will do so from a chronic disease.[6]

Chronic diseases are no longer a phenomenon of high-income countries only. By now, three-quarters of these deaths occur in low- and middle-income countries.[7] Diabetes is also progressing steeply in the slums of Kenya and South-Africa.[8]

Chronic diseases cause a lot of physical and mental anguish for the patient at hand. Treatment usually comes at a high price and is not always covered by insurance, and disease often results in loss of income.

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[3] *Our world in data*, https://ourworldindata.org/life-expectancy.
[4] *The Borgen Project*, https://borgenproject.org/improvements-in-global-health/.
[5] WHO, *Global status report on noncommunicable diseases 2014*, Genève: WHO Press, 2014, and WHO website, 'Global Health Observatory (GHO) data: NCD mortality and morbidity', http://www.who.int/gho/ncd/mortality_morbidity/en/.
[6] WHO 2014 (see note 5).
[7] WHO, *Global Health Observatory Data* (see note 5).
[8] Steven van de Vijver et al, *Vet arm – leven in de sloppenwijken van Nairobi* [living in the slums of Nairobi], Nijgh & van Ditmar, November 2015.

As a result, many patients and families often find themselves in poverty due to these chronic diseases.

Patients and their families are not the only ones affected; treatment poses a heavy financial burden on governments and employers. In the Netherlands, treatment for chronic diseases accounts for approximately 70% of total healthcare costs.[9] On a yearly basis, the loss of labour productivity costs Dutch society 26 billion euros.[10] For a wealthy country like the Netherlands that might just be feasible however, in low- and middle income countries this constitutes an enormous burden.[11] Imagine the difficulty countries such as Kenya or Mexico face in order to finance cancer treatment.

Lifestyle and chronic diseases

Why do people living in the slums in Kenya become diabetic? Chronic diseases are also known as lifestyle diseases due to the four so-called 'behavioural risk factors' at the root of chronic diseases: tobacco use, unhealthy diet, excessive use of alcohol and lack of physical exercise.[12]

'Tree Roots', Vincent van Gogh (1890)

[9] Volksgezondheidenzorg.info, '*Chronische ziekten en multimorbiditeit: Cijfers & Context*' [Chronic diseases and their multi-morbidity: facts & context].
[10] Centrum Werk en Gezondheid, *Impact Graphic Fit for Work Program*, cost of non-participation.
[11] WHO website, 'Global Health Observatory (GHO) data: NCD mortality and morbidity', https://www.who.int/gho/ncd/mortality_morbidity/en/.
[12] WHO website, NCDs, https://www.who.int/ncds/introduction/en/.

By adopting a healthy lifestyle the amount of chronic diseases can be reduced to approximately half of the current numbers.[13] It is an uneasy message to be confronted with, but we must not ignore the facts. In addition to the amount of suffering that could be spared, potential also lies in the amount of money that could be saved.

How does the law respond to these global public health challenges? How should it respond? And most importantly, how can law contribute to the best solution?

Global health law

I want to start with the international standards that protect health and then move down to the Dutch legal landscape. I will do so in close interaction with the health facts that I have just identified.

'Road Network', Pauline Westerman (2015)

Over the past years as a Rosalind Franklin Fellow at this University, I have had the unique opportunity to study the international standards protecting health. I have done so in an interaction with my colleagues in

[13] Calculated on the basis of WHO 2014 (see note 5).

the field of international law, from the *Global Health Law Groningen Research Centre*, as well as with colleagues from all over the world.[14]

Global health law forms part of public international law. When teaching my students, I ask them to visualise public international law as a tree. The stem of the tree represents the foundation of international law, including for example, the sources of international law and state responsibility. The branches of the tree represent the different fields in international law, such as international trade law, international environmental law and international humanitarian law. When a tree grows it adds branches one by one; this is also the case with international law, a field which has grown forcefully in the past decennia. As such, global health law has shaped itself into a new branch of public international law.

'Evening; The Red Tree', Piet Mondriaan (1908-1910)

[14] See also Gian Luca Burci en Brigit Toebes, *Research Handbook on Global Health Law*, Cheltenham/Northampton: Edward Elgar Publishing, 2018.

What is this new branch, and moreover: does this branch present an adequate response to the health challenges the world faces today, in particular chronic diseases?

These questions are best answered by simply observing which standards have thus far been adopted. What can be seen is a patchwork of standards, a fragmented field composed of binding and non-binding standards, standards stemming from various areas in international law. A field with unclear boundaries, in other words, a field difficult to define as a new branch of international law.

'Mount Sainte-Victoire', Paul Cézanne (1904)

Are we then even in need of on a new branch within international law?[15] My answer is yes. The protection of health reflects an important value,

[15] Regarding the fragmentation of international law see *inter alia* UN Doc. A/CN.4/L.682, 13 april 2006, (study group *International Law Commission*; Martti Koskenniemi).

a value that is under constant pressure globally. Global health law focuses on the protection of this value. Within classic international law considerable attention is devoted to preserving peace and security. However, it is 117 times more likely that a world citizen will die from cardiovascular or respiratory disease than die as the result of armed conflict or terrorism.[16] The unhealthiness of people is where the biggest pain lies.

Moreover, the protection of public health has a transboundary character. Let me give you a concrete example. Australia implemented compulsory neutral cigarette packaging, packages without, for example, that recognizable camel, but got into a dispute with – among others – Cuba and Indonesia. These countries submitted a complaint against Australia, in the framework of the World Trade Organisation, claiming that the use of the brand name and logo on cigarette packages should be permitted.[17] As of yet, the case against Australia fizzled out and Australia was allowed to continue the tobacco legislation.[18]

However, this example illustrates the tension between global health law and other fields of international law, especially international trade law. There is a true need for manpower and knowledge in order to place public health on the international agenda, and in order to provide a counterbalance towards other interests, such as international trade.

In conclusion, global health is a matter of international law, and global health law plays a crucial role in this.

Human rights standards

Human rights standards compose the foundation of global health law and shape the values that lie at its heart. One might say that human rights are infused into every aspect and level of health law.

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[16] Calculated on the basis of *Our world in data*, https://ourworldindata.org/causes-of-death.

[17] *WTO – Tobacco Plain Packaging*, Panel Reports, https://www.wto.org/(...)/cases_e/ds435_e.htm.

[18] Pedro Villareal and Brigit Toebes, WTO Plain Packaging reports – some reflections, blog post Global Health Law Groningen Blog, 1 September 2018.

The right to the highest attainable standard of health, in short: the 'right to health', is the most important human right in this context. This human right has not been free from controversy over the past decennia.[19] The term 'right to health' suggests that people have a right to be healthy, or a right of access to every possible type of medical care. By now it is widely acknowledged that there is no right to be healthy, but that the right to health is a broad standard that embraces two important dimensions, reflecting a certain duality: on one hand a right to health care, and on the other hand a right to healthy living conditions, which also embraces a right to prevention.[20]

'Orange and Yellow', Mark Rothko (1956)

[19] Brigit Toebes, *The right to health as a human right in international law*, Antwerp/Groningen/Oxford: Intersentia/Hart, 1999.
[20] UN CESCR, General Comment 14, *The right to the highest attainable standard of health (Art. 12)*, UN Doc. E/C.12/2000/4, 11 August 2000, para. 4.

As such, the right to health adequately reflects the challenges we stand for globally: in order to guarantee health, governments need to ensure access to affordable, high quality, and accessible health care, as well as provide an environment in which we can grow up and live in a healthy manner. In other words, a right to health care *and* a right to prevention.[21]

The right to health is at the heart of global health law, but as an open norm it is not very explicit about chronic diseases and reducing unhealthy behaviour.

WHO Convention on Tobacco Control (WHO FCTC)

For more specific standards we must look at the World Health Organization (WHO) as the most important global standard-setter in the field of health. While WHO has significant standard-setting powers, it has barely used this authority since its establishment in 1946. As an organization primarily ran by medical professionals, it has not engaged with law as much as it could have.

'Smoke', Marlene Dumas (2018)

[21] See also Jos Dute's inaugural lecture: *Gezondheidspreventie is een mensenrecht* [health prevention is a human right], 19 September 2013.

One binding WHO instrument focuses on smoking as one of the most important risk factors for chronic diseases. The WHO Framework Convention on Tobacco Control (FCTC) was adopted in 2003 and at the moment 181 countries are party to this convention.[22] Even though this convention contains rather open-ended standards, the convention has an enormous impact on the way that national governments configure their tobacco policies.

Let me give an example that addresses the interaction between the tobacco industry and government. Article 5, paragraph 3 of the FCTC obliges State parties to protect their tobacco policies from the interests of the tobacco industry. In a case against the Dutch State, the close ties between government and the tobacco industry were critically brought into the limelight. While the Court in The Hague rejected the claim, this case eventually led to a concrete change in policy.[23] We may conclude that as a direct result of the FCTC, the Dutch government has more distance from the tobacco industry.[24]

An alcohol- and a diet convention?

Altogether, the FCTC is a global success. As such it forms an important source of inspiration for possible new treaties regulating unhealthy products, such as unhealthy food and alcohol.

With regard to unhealthy diets and alcohol, thus far, only non-binding strategies have been adopted. Such non-binding standards, also known as *soft law*, play a pivotal role in international law, due to their flexibility and the manner in which they can engage with a multitude of actors.[25] They are, so to speak, the glue within international society, but they lack the influence and authority that a binding convention possesses. That is

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[22] WHO Framework Convention on Tobacco Control (FCTC), adopted 21 May 2003.

[23] *Stichting Rookpreventie Jeugd tegen against the Dutch State*, Court of First Instance The Hague, 9 September 2015, C/09/475711 / HA ZA 14-1193.

[24] [24] See also Gohar Karapetian and Brigit Toebes, The legal enforceability of Articles 5(3) and 8(2) of the WHO Framework Convention on Tobacco Control: the case of the Netherlands, *Brill Open Law*, 22 May 2018, p. 1-13.

[25] J. Pauwelyn, R.A. Wessel and J. Wouters, 'When Structures Become Shackles: Stagnation and Dynamics in International Lawmaking', *European Journal of International Law* 2014-25/3, p. 733-763.

why we must discuss the possibility of adopting binding treaties in the field of unhealthy diets and alcohol.[26]

'The Drunken Couple', Jan Steen (1665)

Adopting these type of conventions is a very unruly and time-consuming process, which can take up more than twenty years to complete. This calls for complex substantive questions, along the lines of: do alcohol and unhealthy diet lend themselves for regulation through a treaty? Many parallels can be drawn between tobacco and alcohol products, as a result, the FCTC evidently offers inspiration. However, food concerns a much less unequivocal product, and not every type of food composes a threat towards one's health. Nevertheless, a point of attention could be reducing the amount of fat, sugar and salt in products. Moreover, it is feasible to incorporate the provision from the FCTC that regulates the interaction between the government and the

[26] Shiu Lun Au Yeung and Tai Hing Lam, 'Unite for a Framework Convention for Alcohol', *The Lancet*, Vol. 393, 4 May 2019, p. 1778-1779.

industry. For example, when a government aims to reduce the number of points of sale of fast food restaurants, this should be done without consulting the fast food branch in advance, or in other words, they should not be given a seat at the negotiating table given their clearly conflicting interests.

Legal questions are not the only ones at play in this discussion, political strategic considerations are also central to the debate: what are the necessary political processes in order to adopt these treaties? Adopting such treaties requires a strong support from science and *civil society*, and the desire and motivation at the top of the ladder at the WHO in order to take the necessary steps.[27]

These are treacly processes, which we should however not evade. In the years to come I hope to contribute to the movement towards potential treaties for alcohol and diet.

The role of the industry

I have now arrived at the role businesses play in the field of global health. They are the motor of our economies, however, their actions often inflict harm on our interests and our wellbeing. Consider the tobacco industry, which produces inherently deadly products, but additionally consider the food- and alcohol industries which significantly contribute to the occurrence of chronic diseases. In this context, referral is made to an industrial epidemic, in which the businesses are the pathogens.[28]

What really bothers me is that these industries increasingly target low- and middle-income countries. These countries are substantially behind

[27] Former WHO-Director Gro Harlem Brundtland played a pivotal role in the adoption process of the WHO FCTC. See also Marlies Hesselman and Brigit Toebes, 'Adopting new international health instruments', what can we learn from the FCTC?, *International Journal of Health Policy and Management*, 2018, 7(3), p. 264-267.

[28] R. Moodie et al, 'Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries', *The Lancet* 381(9867), 23 February 2013, p. 670-679.

in or often simply lack regulations concerning unhealthy products.[29] It is tragic to see how consumers in these countries change their traditional food patterns by shifting to the 'convenience' of products provided by the fast food industry coming at a high price for human health.

'The Shop', Neo Rauch (2005)

It is, therefore, very regretful that multinational corporations are not bound by international law; only States are. In my opinion, due to the crucial influence that businesses have on our wellbeing and on our health, they carry a societal responsibility in this context. We need to talk about how businesses can commit to this responsibility on a structural basis.

Concluding, global health law faces immense challenges. In the upcoming years, it is my desire to contribute to the promotion of this field of law.

[29] Pieter de Coninck and Jos Dute, 'Alcohol', in Brigit Toebes et al, 'Ongezond gedrag, de rol van het recht'[Unhealthy behaviour: the role of law], in *Preadvies Vereniging voor Gezondheidsrecht*, The Hague: Sdu, 2019, p. 169-212, at p. 181.

The steering role of law on a national level

I have now made my way to the national level, to the Dutch context. I have established that promoting healthy behaviour generates significant benefits for health. What steps can domestic governments take in order to achieve this?

'The Trekvliet', Johan Hendrik Weissenbruch (1870)

Once more I present the facts straight: approximately nine million people have a chronic disease in the Netherlands, which is over half of the total population.[30] In the Netherlands approximately 22% of the adult population smokes, leading to about 20.000 deaths a year. Further, approximately half of the adult Dutch population suffers from overweight and approximately 14% of the population is categorized as obese.[31]

[30] Volksgezondheidenzorg.info.

[31] Volksgezondheidenzorg.info, see also Brigit Toebes, 'Inleiding', in *Preadvies Vereniging voor Gezondheidsrecht* (note 29), p. 25-26.

'Man with a book', Fernando Botero (2001)

Law is a powerful tool to reduce unhealthy behaviour. National governments have a range of legal tools at their disposal. Examples include smoking bans, sugar taxes and a prohibition of alcohol marketing.

Much research has been carried out into the effectiveness of such measures. We know from existing evidence that a range of top down measures is highly effective. The WHO formulates a number of *best buys* on the basis of this research, which are the most effective measures that governments may take in order to reduce unhealthy behaviour.[32]

[32] WHO, *'Best buys' and other recommended interventions for the prevention and control of noncommunicable diseases: Updated (2017) Appendix 3 of the Global Action Plan for the prevention and control of noncommunicable diseases 2013-2020*, May 2017.

Concerning smoking, the WHO mentions price- and tax increases, implementing neutral packaging, extensive marketing bans, comprehensive smoking bans and mass media campaigns.[33]

Increasing the price of cigarettes is one of the most effective measures to reduce smoking. According to the WHO, a price increase of 10% leads to a 4% decrease in number of smokers.[34] Australia was able to reduce the number of smokers from approximately a quarter to 12% of the adult population by increasing the price of a pack of cigarettes to 18 euros. This is an enormous difference compared to the Netherlands, where (as mentioned) approximately 22% of the adult population still smokes.[35]

Moreover, there is scientific evidence that a sugar tax, that is to say, an excise duty or consumption tax on sugar-containing products, is effective.[36] Research shows that increasing the price of sodas is particularly effective.[37] The revenue of the sugar tax in the Netherlands will go into the general budget, but can subsequently be earmarked for more specific purposes. As such, this money can be used to for example, subsidize vegetables and fruit, or promote healthy school lunches and school sports. The possibilities to this end, also in the European context, are insufficiently studied and explored.

Unhealthy behaviour and human rights

Should the Netherlands now simply adopt all these measures?

Introducing such measures also summons discomfort. Regulating behaviour touches on the autonomy of the individual.

This is why it is important to weigh the judicial *best buys* in the light of human rights, especially the rights to autonomy and privacy. We need to continually evaluate how far we want to go as a society with these

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[33] WHO *best buys* (see note 5) and *VGR Preadvies* (see note 29).

[34] WHO, *Tobacco-Free Initiative*.

[35] Volksgezondheidenzorg.info.

[36] 'Sugar tax drives make promising start around the world', *Nature* (*BDJ)* Vol. 225, 27 July 2018, p.102–103.

[37] See, for example, website of the UK Government, 'Soft Drinks Industry Levy comes into effect'.

measures. Is it acceptable to ban smoking in cars, or even in houses? Should the government pass our doorstep and extend its reach that far into our lives?

As such, this is about balancing human rights. Roughly it comprises balancing the right to health and the right to autonomy. However, I will not place these values against one another diametrically; rather I will consider and weigh out both values.

One could argue that from the perspective of the right to health all the measures mentioned are highly desired. After all, if a smoker stops smoking due to the high price of cigarettes, this improves his or her (right to) health.

This argument especially holds ground when it comes to children.

'Girl at a Window', Rembrandt van Rijn (1645)

Children are vulnerable in various ways. Unhealthy behaviour that develops at a young age is difficult to change in hindsight. Around 90% of the adult smokers started smoking before they turned 19 years old.[38] The tobacco industry sees children as 'replacement smokers', meaning smokers that replace the current adult smokers.[39] Children with obesity are more likely to develop chronic diseases at a later stage in their life.[40] Children are extremely susceptible to the marketing of unhealthy products.[41]

The United Nations Convention on the Rights of the Child (CRC) offers a firm legal basis for protecting children against various practices of being unhealthy. The best interests of the child need to be protected in this context, and children have a right to information, a right to survival and development, and a right to health.[42]

Simultaneously, there is a right to autonomy reflecting the integrity and privacy of individuals. The question is whether and in how far lifestyle interventions infringe upon this standard.

As consumers we are very vulnerable when it comes to the way in which unhealthy products invade our living environment. Unhealthy products can be bought at every street corner and at a very affordable price; the industry knows how to seduce us time and time again with smart marketing strategies. How free are we in making choices when these cigarettes, chocolate bars or that new soda are lying for grabs at the counter? And what about the alcoholic: does he drink in freedom, or does he find himself chained to the bottle?

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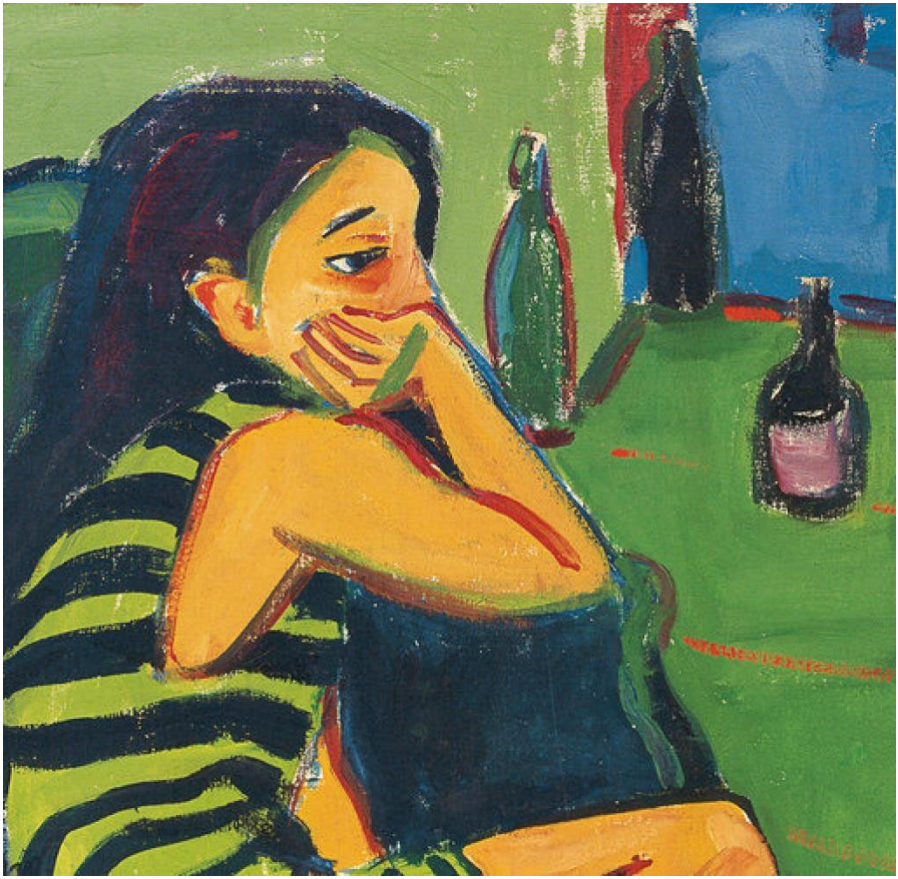
[38] US Department of Health & Human Serv., 'Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General' 8 (2012), in Marie Elske Gispen and Brigit Toebes, 'The Human Rights of Children in Tobacco Control', *Human Rights Quarterly*, May 2019 (in press).

[39] Sick of Smoking, 'Replacement Smokers'. See also Marie Elske Gispen, 'Tabaksontmoediging', in *Preadvies Vereniging voor Gezondheidsrecht*, 2019 (see note 29), p. 75.

[40] Renate Dietvorst,'Ongezond voedsel en preventie', in *Preadvies Vereniging voor Gezondheidsrecht* (note 29), p. 135.

[41] Gispen and Toebes, *Human Rights Quarterly*, mei 2019.

[42] Idem.


'Marcella', Ernst Ludwig Kirchner (1910)

As far as I am concerned, there is a need for an interpretation of the concept of autonomy that places more emphasis on the vulnerability of the consumer, and offers room for his protection. Thus, alongside respecting 'autonomy' there should be emphasis on the principle of 'protection'.[43] This means that consumers should be steered more explicitly towards healthier choices. The government needs to provide a compelling counterbalance towards the power of the industry. Not only

[43] Aart Hendriks identifies three core principles for health law in his inaugural lecture: autonomy, protection and equality. *In Beginsel, De gezondheidsrechtelijke beginselen uitgediept* [In principle, identifying health law principles], Leiden: Stichting NJCM-Boekerij, 2006.

by providing information, but also through price regulation, reducing the number of sales points and by requiring unhealthy products to be kept out of sight.

In the Netherlands, such measures are quickly identified as patronizing. But are the Dutch really that allergic to behavioural interventions, or is this an image that is gladly fuelled by interested parties? As such, I am curious about the genuine and actual experience of autonomy by the Dutch population. We became accustomed to the safety seat belt in the car and the smoking bans in cafés soon enough; how much resistance would there really be against a few additional measures? I would say, let us research this further and let us start challenging what is now known as the status quo.

National Prevention Agreement

Considering all these issues I raised, where does the Netherlands stand? Is the Netherlands performing well?

In November 2018 the Dutch government signed the National Prevention Agreement, containing arrangements with over 70 societal bodies concerning the reduction of unhealthy behaviour.[44]

Bringing so many organizations to the table provides an excellent opportunity to inform and involve them in this mission. The Universal Declaration of Human Rights calls for human rights responsibility for 'every individual and every organ of society'. It seems that the National Prevention Agreement strongly appeals to this notion.[45]

Society as a whole, including ourselves, carries a responsibility in this mission.[46] Take for instance diabetes type 2, which requires some patients to take over ten different kinds of pills, while diabetes type 2 is curable through a change in lifestyle.[47] Reducing type 2 diabetes incidence is a task for several actors together, including general practitioners, dentists and other healthcare providers, but also for

[44] Dutch Government, *Nationaal Preventieakkoord*, November 2018.

[45] Brigit Toebes, Conclusions to *Preadvies* (note 29), p. 227.

[46] See also CESCR General Comment 14, 2000 (note 20), para. 42.

[47] See, for example, interview with Hanno Pijl in *NRC Handelsblad*, 'Genees toch zélf je diabetes' [Cure your own diabetes], 31 December 2018, p. 20.

health insurers, employers, supermarkets, sports clubs, parents, and for everyone in this room.[48] Let us consider how we can facilitate all these actors to take action on this front.

Returning to the National Prevention Agreement: the collaboration with so many social organizations is the strength, but also the weakness of the Agreement. The Agreement contains many terms such as 'agreements', 'evaluation', 'research', 'creating a platform', and 'attention to'. Agreements with the industry and self-regulation by the industry form important aspects of the National Prevention Agreement. Moreover, sanctions are hardly identified.

When it comes to tobacco the National Prevention Agreement is progressing in the right direction. The price of cigarettes will rise by one euro and plain cigarette packaging is being introduced. Due to the FCTC, the tobacco industry was no longer welcome at the negotiating table.[49] Nonetheless, the National Prevention Agreement reflects a missed opportunity when it comes to regulating unhealthy diets and excessive use of alcohol. There will be no sugar tax and neither will vegetables and fruit be subsidized. The marketing of alcohol will not be limited or constrained drastically, nor will there be any regulation on the visibility and availability of alcohol in for example supermarkets. This is precisely due to the fact that the alcohol and food industry had a seat at the table during negotiations of the National Prevention Agreement.

This approach reflects the Dutch Polder Model. However, no concessions should be made, especially with regards to prevention. Health prevention is particularly incompatible with making compromises. In my view, the ball is in the court of the government of the Netherlands now.

Health inequalities

There is an even deeper layer in the story regarding chronic diseases. Man is the product of his living environment, and this strongly applies when it comes to his health. Where you grow up, go to school and work, who your family and friends are, but also what you earn, whether you

[48] Brigit Toebes, Introduction to *Preadvies*, para. 3 (note 29), p. 227.
[49] With one euro in 2020; see Rijksoverheid.nl.

have debts, if your roof is leaking: all these factors influence how much stress you have, what and how you consume, and ultimately your health and wellbeing. Smoking, consuming alcohol and eating *junk food* are therefore quite often a symptom of an unhealthy living environment and of a much broader set of socio-economic problems.

The Potato Eaters, Vincent van Gogh (1885)

These differences in living environments translate into dramatic health inequalities. In the Netherlands this is usually measured based on the level of education. The life expectancy of persons with a higher level of education is approximately seven years higher than the life expectancy of less educated people in the Netherlands. Moreover, highly educated people experience their lives as healthy 18 years longer than those who are less educated.[50] Concretely, people in Haren live much longer and

[50] CBS website, 'Hogeropgeleiden leven langer in goede gezondheid' [those with a higher education live longer in good health] and 'Kloof in levensverwachting tussen hoog- en laagopgeleiden blijft even groot' [gap between people with high and low education levels remains large]; and I. Kulhánová, R. Hoffmann, T.A. Eikemo, G. Menvielle and J.P. Mackenbach, 'Educational inequalities in mortality by cause of

feel a lot healthier than people from the Selwerd area in Groningen, at around an eight kilometres distance. Even within a small region like Groningen these differences can be very significant.[51]

'After the visit', Jan Altink (1925)

death: first national data for the Netherlands', *Int J Public Health* 2014-59, p. 687-696. See also Brigit Toebes, Introduction to *Preadvies* (note 29), p. 27-31.

[51] Jochen Mierau, *De gezondheidsverschillen in Noord-Nederland zijn bizar* [health inequalities in the north of the Netherlands are bizarre], rug.nl/news.

In future research I aim to study the role of law in enhancing a healthy living environment and reducing health inequalities.

Law can be seen as one of the determinants of health, as a factor that can influence health in both positive and negative ways.[52] With that, the question arises, how law can be designed in such a way that it fosters health. Realising that our living environment is so decisive to our health, this question becomes infinitely more complex. As such, not only tobacco regulation matters, but also legislation that influences our housing, our income, and the taxes we pay.

Finding an answer to these questions thus requires that we conduct empirical research into how law and policy influence our health. Has that smoking ban actually led to less damage to the health of smokers and second-hand smokers; but additionally: does the increase in minimum wages lead to a lower rate in infant mortality?[53]

Health inequalities also touch upon human rights. From a human rights perspective this means: reflecting on the vulnerability of people and avoiding discrimination and stigma. Pondering how to help the group that is falling behind, where the actual needs lie, and how those falling behind can participate in identifying solutions to these issues. So besides 'autonomy' and 'protection', we must also think in terms of 'equality'.[54]

These are not simple questions. Whenever I think about it myself, my head starts spinning. Nonetheless, I see it as a pivotal challenge in my field. I want to actively engage in these questions in an interaction with scientists from other disciplines. The Aletta Jacobs School of Public Health provides an excellent platform to do so.

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[52] Scott Burris, 'From Health Care Law to the Social Determinants of Health: A Public Health Law Research Perspective', *University of Pennsylvania Law Review* 2011: 159(6), p. 1649-1667.

[53] David H. Cloud et al, 'State minimum wage laws and newly diagnosed cases of HIV among heterosexual black residents of US metropolitan areas', *Population Health* 7 (2019) 10327; Kelli A. Komro et al, 'The effect of an increased Minimum Wage on Infant Mortality and Birth Weight', *American Journal of Public Health*, August 2016, Vol. 106, No. 8, p. 1515-1516.

[54] Aart Hendriks, 2006 (see note 43).

Public health law

In the years to come I aim to investigate the role of law in preventing diseases and in creating a healthier living environment. As such, I move towards 'public health law', a discipline within health law that is still rather uncharted in the Netherlands.

More generally, I want to engage in health law as a transboundary discipline that wanders through various dimensions of international and national law. This is the reason I count myself fortunate to work at the department of Transboundary Legal Studies.

I find myself at the end of my journey through the health law landscape I hope you have not lost sight of the bigger picture at hand and that I have managed to carve out several paths worth following.

'Woldgate Woods', David Hockney (2006)

In this inaugural lecture I have made a case for greater intervention from the public domain in the behaviour of the public. I am, however, aware that this message touches upon the things that make life enjoyable.

To your health!

Ik heb gezegd.

Thank you!

I thank my colleagues from the Law Faculty for all the support I received in my trajectory towards this appointment.

In particular, I am grateful to my colleagues from international law and the broader Department of *Transboundary Legal Studies* for their wonderful collaboration and collegiality. I thank Marcel Brus for his enthusiastic leadership, Marlies Hesselman for her inspiring collaboration and, André de Hoogh and Antenor Hallo de Wolf among other colleagues from international law for their wisdom and the more than pleasant teaching collaboration.

I also thank my colleagues from *Global Health Law Groningen* for their inspiration and for their enthusiasm to continuously place topics related to health and human rights on the agenda. I hope to collaborate with them for many years to come and that future generations will carry the field forward.

I thank the Dutch cancer Society (KWF) for the wonderful grant allowing me to place the rights of children in tobacco control on the agenda. I am grateful to Marie Elske Gispen for her amazing drive in the development of this project (and for the laughter we shared).

I am also particularly inspired by the new interdisciplinary collaboration with my colleagues from the *Aletta Jacobs School of Public Health*. I look forward to shaping the Justice Pillar together with Viola Angelini. In this context, I also wholeheartedly thank Scott Burris for coming to Groningen this summer, not only to cycle around but also to help us further understand our task.

I am also grateful to Gian Luca Burci for his dynamic and humorous collaboration in editing the *Research Handbook on Global Health Law*. I thank Frederick Abbott, my fellow co-chair on the *Global Health Law Committee* of the *International Law Association*, this committee has enabled us to establish global collaboration in the field.

I thank IFFHRO for the long-lasting valuable collaboration. I thank the board of the Dutch Society of Health Law for the rewarding collaboration and for the possibility to place prevention on the Dutch health law agenda. I thank my partners in the Pharmaceutical Accountability Foundation for their energetic collaboration and for their steps to take action. My words about the societal responsibility of the industry are of course also applicable to the pharmaceutical industry.

For their wonderful support in the drafting process of this inaugural lecture I would like to thank a number of people. I thank in particular Gijs Fehmers, Nikee van der Gouw, Anja Robbeson, Meaghan Beyer, José Pouwels, Marcel Brus, Hans Hogerzeil, Jitse van Dijk, Frederieke Jeletich-Visser, Scott Burris, Aart Hendriks, Charlotte Pavillon, Esther Oldekamp, Harry Zijderveld, Edwin Woerdman, Irene Burgers, André Krom, Pieter de Coninck, Jos Dute, Renate Dietvorst, Stefan Weishaar, Pauline Westerman, Anneke Heins, Elvira Narouz, Bolomey Wijnimport and Lopend Vuurtje. They will know why.

Chronic diseases are a phenomenon of our times. Maarten and Julia Fehmers died of it when they were far too young; Huub Toebes fought against it for a very long time. I should like to commemorate them here in gratitude.

I thank Cara Toebes and Ton Casparie for their support and for their incentive to *happy ageing*.

Above all, I thank Gijs Fehmers for the more than fantastic support, for his inspiration and his stimulating questions in the background.

I dedicate this lecture to Hugo and Koen, my beloved sons, from whom I learnt the most. They own the future.

Biography

Brigit Toebes (Hattem 1969) obtained her PhD at Utrecht University with her thesis entitled 'The Right to Health as a Human Right in International Law' (1999). She subsequently lived and worked in The Hague, Aberdeen and Copenhagen.

Since 2012 she has been working at the Law Faculty of the University of Groningen, successively as an assistant professor and a Rosalind Franklin Fellow. In September 2018, she was appointed professor in the Chair 'Health Law in a Global Context'.

Brigit's expertise is at the intersection of human rights and health law. Her current research focuses on global health law as a discipline within public international law. The global rise in chronic diseases is a recurring theme in this research, and the questions of whether and to what extent unhealthy behavior such as smoking and unhealthy diet, often at the root of these diseases, can be regulated. Further, she also focuses on Dutch health law, and the role of prevention therein.