

Ratification of human rights treaties: the beginning not the end

I appreciate Alexis Palmer and colleagues' empirical research on the effects of ratification of human rights treaties on population health (June 6, p 1987).¹ Despite their conclusion that ratification has no benefits on health, issues surrounding the effect of human rights norms within treaties are complex and might not be fully captured through an analysis of correlations between ratifications of international treaties and selected aggregated indicators.

Quantifiable improvements require a range of measures, including incorporation of treaty obligations into domestic legislation and, just as importantly, appropriate public spending on health personnel and infrastructure, policy development, and national plans of action. One major advantage of treaty ratification is that it obliges states to have their progress—or lack of it—periodically examined by independent experts on the various committees (or "Treaty Bodies") that assess whether or not states are doing what they said they would do.

The Treaty Bodies receive information from a broad range of sources, including civil society. Although not an enforcement process in the strict sense, reporting has had profound effects on the enjoyment of human rights in many states, and I would encourage more health specialists to make better use of this means to stimulate change in their national health systems.

I hope Palmer and colleagues' study stimulates further debate and, more importantly, further concerted action by doctors, lawyers, health administrators, and non-governmental organisations to push states into making tangible improvements in public health around the world.

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- 1 Palmer A, Tomkinson J, Phung C, et al. Does ratification of human-rights treaties have effects on population health? *Lancet* 2009; **373**: 1987–92.

Alexis Palmer and colleagues¹ argue that a country's status with regard to ratification of human-rights treaties is not correlated with health outcomes, and is therefore not a good indicator of the realisation of the right to health.

Yet health outcomes do not necessarily correlate directly with the right to health. Human rights principles such as equitable access to health care and non-discrimination might not be apparent in all measures of health status, and ratification has varying legal consequences in different countries. Even among governments who assign the greatest weight to ratification (ie, having the effect of constitutional law), there is still variability in enforcement and respect for the right.

If Palmer and colleagues had examined the human rights environment more broadly, their results might have been different. Studies have shown^{2,3} that individuals are healthier and live longer where governments respect social and political rights. We have noted that governments have historically recognised their fundamental obligations to provide health care and control infectious disease outbreaks, but that many, irrespective of treaty ratification, restrict rights in response to emerging infections or when addressing the health needs of criminalised and marginalised populations.⁴

We agree that realisation of the right to health ultimately requires improved accountability. In addition to the important accountability mechanisms of existing treaties, this effort might be strengthened through a specific treaty related to international cooperation on basic health needs—eg, a Framework Convention on Global Health.⁵

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Although we disagree with the methods and assumptions that led Alexis Palmer and colleagues¹ to find no association between ratification of human rights treaties and population health outcomes, we agree that their findings "should not be interpreted to mean that human-rights treaties have no effect on important health issues." Understanding the associations between human rights and health requires additional qualitative research to examine the multiple pathways linking international law, domestic policy, and population health outcomes.²

Here, Palmer and colleagues do not look at appropriate underlying variables, examining apple seedlings to assess an orange harvest. Treaty ratification is only a preliminary indication of a state's commitment to human rights for health. Thus, the regression used oversimplifies the extended causal pathway between treaty ratification and population health (figure).

Instead of examining ratification and outcomes, researchers should probe the full range of human rights indicators, as clarified by the UN Special Rapporteur on the



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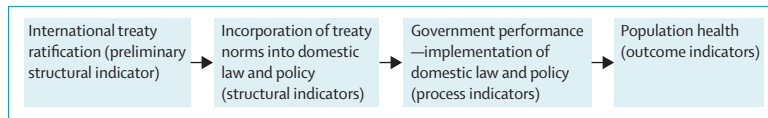


Figure: Pathway between ratification of human rights treaties and population health

Right to Health.^{3,4} Human rights indicators for health—derived from treaty language, selected by state parties, and legitimised through monitoring bodies—can better assess whether states' domestic policy implementation is in accordance with human rights obligations.³

Given states' obligations to progressively realise the right to health, examinations of intermediate variables, especially process indicators, would prove a far more useful means of measuring a state's realisation of population health.

It is not that human rights treaties are meaningless to health promotion, but rather that qualitative research is necessary to understand the causal pathways linking international human rights law to rights-based policy development.^{2,5}

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Voglibose for prevention of type 2 diabetes mellitus

Ryuzo Kawamori and colleagues (May 9, p 1607)¹ report a 40% reduction in progression to type 2 diabetes in patients with impaired glucose tolerance treated with voglibose. However, on the basis of the data provided, the clinical relevance of the 40% risk decrease cannot be assessed. Presentation of the results as relative risk reductions, and the use of diagnostic categories instead of metabolic parameters such as glucose and glycosylated haemoglobin (HbA_{1c}), can lead to overestimation of the effects on diabetes risk and on the prevention of late complications.

Surveys have shown that, if study results are communicated as a 60% reduction in diabetes risk, about 90% of diabetes experts would interpret the effects as important or very important.^{2,3} By contrast, if the underlying changes in HbA_{1c} concentrations are presented instead, less than 20% would rate the results as important. Transformation of continuous metabolic data into diagnostic categories interferes with the understanding of study effects.

Diabetes prevention studies typically include individuals with impaired glucose tolerance who are already on the brink of diabetes. Therefore, small differences of 0.3 mmol/L in fasting plasma glucose or of 0.1% in HbA_{1c} could relate to pronounced differences in the proportions of

people with a diagnosis of diabetes, and risk reductions of more than 50%.^{2,3} Small differences are magnified by transformation of continuous data into categorical data.

The omission of crucial metabolic parameters such as glucose and HbA_{1c} has also happened in other diabetes prevention studies.⁴

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Ryuzo Kawamori and colleagues¹ should be commended for their detailed analysis of the effectiveness of voglibose in the prevention of type 2 diabetes in Japanese patients with impaired glucose tolerance. However, more details in this paper should be clarified.

Besides the baseline patient characteristics considered by Kawamori and colleagues, others should also have been controlled for. Fasting and postprandial insulin concentrations,² physical activity levels,³ and socioeconomic status⁴ can all have an effect on the development of type 2 diabetes.

During the course of drug treatment, eligible patients with impaired glucose tolerance were advised to follow a standard diet and take regular exercise, which are factors that might improve type 2 diabetes mellitus. Therefore the possibility that the effect of