

IMPROVING GLOBAL HEALTH INEQUITY THROUGH ACCESS TO JUSTICE: PROPOSED FRAMEWORK ON HEALTH JUSTICE PARTNERSHIPS

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ABSTRACT

Over the years, the United Nations and the World Health Organization (WHO) have established numerous goals and programs that prioritize the right to highest attainable level of health. Unfortunately, inequities around the world continue to prevent individuals from actualizing this right. Effective governance mechanisms organizing these goals and programs are lacking. This Comment discusses the use of one specific solution, health justice partnerships (HJPs), that may effectively fill the structural gap in international health governance. Health justice partnerships utilize cross-disciplinary advocacy to coordinate efforts and collectively remedy individual health obstacles. Tracking patterns of inequity, they then serve as channels for policy advocates to create lasting change. By incorporating this model in a new WHO Convention, international governance will be more informed by individuals' voices which will, in turn, better address health inequities globally. HJPs may strengthen the network of existing UN programs and operationalize health equity goals through increasing access to justice. This Comment adds to current discourse on the use of HJPs by explaining how they serve as effective governance mechanisms, how they fit into the broader WHO legal framework, and how they will require national buy-in and funding to be effective.

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INTRODUCTION

In the coordinated drive to improve global health, international regulations historically prioritize national security and trade over equitable health outcomes. Indeed, international governing bodies such as the United Nations and the World Health Organization (WHO) declare broad policy initiatives to support health equity. Most existing programs, however, lack the enforcement power necessary to vindicate health injustice in any meaningful way, in part because WHO was not originally designed to have enforcement authority. The reason to prioritize health equity is simple, but doing so is less straightforward. Healthy individuals create healthy societies, and people suffering from illness are less able to both realize their health care needs and effectively participate in a growing society.¹ But this introduces another question: How can individuals fight for their right to health when large-scale channels do not function in their best interest—or do not exist in the first place?

“Health” has been enshrined as a human right since the foundation of the UN after World War II. The Universal Declaration of Human Rights established a right to the “highest attainable level of health,” and

¹ Paula Braveman et al., *Health Disparities and Health Equity: The Issue is Justice*, 101 AM. J. PUB. HEALTH S149, S150 (2011).

individual countries often work towards this goal gradually—improving public health as they develop.² In 2015, the right to health was further ingrained as the third goal in the UN General Assembly’s 2030 Agenda for Global Sustainable Development.³ WHO has backed some of the UN’s sustainable development goals with initiatives supporting monitoring systems, volunteer groups that support national programs, and resources that investigate the causes of poor health.⁴ Most of the action that WHO and the UN take, however, generally centers on regulating the trade of health-harming products (i.e., tobacco)⁵ and coordinating emergency responses to health threats.⁶

While these initiatives are certainly beneficial, they do not capture the broader intricacies involved in improving global health. Systematic health disparities uniquely and adversely affect socially disadvantaged groups.⁷ Of course, health disparities can impact anyone anywhere, but a clear connection exists between someone’s socioeconomic status and their access to the highest attainable level of health.⁸ When a society lacks the means to provide adequate health systems, the whole community suffers: “If systematic differences in health for different groups of people are avoidable by reasonable action, their existence is, quite simply, unfair.”⁹

Only relatively recently have researchers begun classifying health factors as social determinants of health (SDoH). Sparking this increased awareness, the WHO Commission on the Social Determinants of Health released a final report underscoring the importance of the SDoH in 2008.¹⁰

² *Id.* at S150 (citing G.A. Res. 2200A (XXI), International Covenant on Economic Social and Cultural Rights (ICESCR)); see G.A. Res. 2200(A)(XXO), art. 12; see also G.A. Res. 217 (III) A, Universal Declaration of Human Rights, art. 25 (Dec. 10, 1948).

³ G.A. Res. 70/1, Transforming Our World: The 2030 Agenda for Sustainable Development, at 16 (Oct. 21, 2015).

⁴ See generally Sam F. Halabi, *The Origins and Future of Global Health Law: Regulation, Security, and Pluralism*, 108 GEO. L.J. 1607, 1651–52 (2020) (describing different initiatives WHO has supported).

⁵ Lawrence O. Gostin & Devi Sridhar, *Global Health and the Law*, 370 NEW. ENG. J. MED. 1732, 1734–36 (2014) (discussing the FCTC).

⁶ World Health Organization [WHO], *International Health Regulations*, at 1 (2005), <https://apps.who.int/iris/bitstream/handle/10665/246107/9789241580496-eng.pdf> [<https://perma.cc/7KP7-3EP2>].

⁷ Halabi, *supra* note 4, at 1627.

⁸ Michael Marmot et al., *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, 372 LANCET GLOB. HEALTH 1661, 1661 (2008).

⁹ *Id.*

¹⁰ See generally Final Rep. of the Comm’n on Soc. Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, WHO,

Yet WHO initiatives don't often utilize legal enforcement mechanisms in their approaches to improving global health.¹¹ To fill this gap, the McNeill-Lancet Institute, a primary contributor to global health law discourse, explained that the law can be used to “translate vision into action on sustainable development . . . strengthen governance of global health institutions . . . implement fair, evidence-based health interventions . . . [and] emphasize[] the importance of building legal capacities for health.”¹² And while some studies have proposed options to improve health and justice through partnerships,¹³ WHO initiatives must go further to incorporate such suggestions. So far, WHO has only encouraged member states to strengthen their efforts on addressing the SDoH¹⁴ and created an operational framework for monitoring SDoH.¹⁵ Not only should WHO continue to monitor the SDoH as indicators of progress,¹⁶ but it should also implement a health justice partnership (HJP) model as a flexible legal tool for furthering global health equity.¹⁷ The reasoning is clear: as much as health systems can impact inequitable SDoH, the justice system “sits upstream of health care, mediating the impact of social stratification and poor social conditions on the intermediary determinants of health.”¹⁸ International organizations such as the UN and WHO can play a role in global responses to health needs, especially in an increasingly globalized society.¹⁹ Because of WHO's limited enforcement power, however, global health initiatives can only be implemented through domestic governance.²⁰ Separating health law data into domestic and international areas of control

WHO/IER/CSDH/08.1 (Aug. 27, 2008) [hereinafter Final Rep. of the Comm'n on Soc. Determinants of Health, WHO].

¹¹ Ashley Schram et al., *Advancing Action on Health Equity Through a Sociolegal Model of Health*, 99 MILBANK Q. 904, 906 (2021).

¹² *Id.*

¹³ *Id.* at 905.

¹⁴ WHO, Assembly Res. WHA74.16, *Social Determinants of Health*, at 3 (May 31, 2021).

¹⁵ WHO, *Operational Framework for Monitoring Social Determinants of Health Equity*, at 29 (2024) [hereinafter WHO, *Operational Framework for Monitoring Social Determinants of Health Equity*].

¹⁶ Marmot et al., *supra* note 8, at 1668.

¹⁷ WHO, *Operational Framework for Monitoring Social Determinants of Health Equity*, *supra* note 15, at 76.

¹⁸ Schram et al., *supra* note 11, at 916.

¹⁹ See WHO, *Operational Framework for Monitoring Social Determinants of Health Equity*, *supra* note 15, at 80.

²⁰ Gostin & Sridhar, *supra* note 5, at 1734.

helps global health actors coordinate the initiatives they codify into law or prioritize in policy.²¹

If properly established, the HJP model may become a critical tool for tackling global health inequity. Although HJPs are currently used primarily on a national scale, they have improved patient care and population health outcomes because of their interdisciplinary structure.²² They effectively leverage networks of medical specialists, legal scholars, and social sector workers to address inadequacies in national health initiatives. As patients navigate the health care system, they are connected to advocates in the HJP who increase access to justice through capacity building (self-advocacy) and offer law as a tool for addressing unfair treatment in medical systems.²³ HJPs address many of the obstacles that currently interfere with access to health, while harnessing the power of social and legal networks to advocate for better population health outcomes.²⁴ Implemented internationally, HJPs would likely increase coordination of health-based policies and provide access to justice if countries disregard such policies.

If countries around the globe are expected to collaboratively address the health inequities existing today, then WHO must implement formal structures creating channels for advocacy and policy change. Part I of this Comment provides a brief background on three underlying principles: the relationship between SDoH and health equity, WHO's use of authority in the global law landscape, and the use of advocacy networks to complement international governance mechanisms. Part II discusses the benefits and obstacles of using HJPs to better address health inequity. Part III concludes with affirming the reasoning behind using law as a tool to minimize health inequity.

I. BACKGROUND

A. PRINCIPLES OF HEALTH EQUITY

A person's socioeconomic status directly influences their health. Within the United States, individuals who are the most disadvantaged socioeconomically (those without a high school diploma and living below

²¹ See generally WHO, *Operational Framework for Monitoring Social Determinants of Health Equity*, *supra* note 15, at 74.

²² See Marsha Regenstein et al., *Addressing Social Determinants of Health Through Medical-Legal Partnerships*, 37 HEALTH AFFS. 378, 378 (2018).

²³ Schram et al., *supra* note 11, at 918.

²⁴ *Id.*

the poverty line) have a life expectancy of sixty-four years.²⁵ In contrast, those among the most advantaged (master's or higher degree and family income at or above 400 percent of the poverty threshold) have a life expectancy of eighty-one years—a seventeen-year difference.²⁶ Results of studies in Germany and the United Kingdom are similar.²⁷

Socioeconomic factors such as affordable and stable housing, employment, access to welfare benefits, and family stability also influence a person's health.²⁸ Take, for example, a person who ends up hospitalized—despite proper asthma treatment—because their home is filled with mold, or a person whose blood sugar is dangerously low despite medication because the patient can't afford healthy food.²⁹ Poor living conditions are often a result of structural inequities. Individuals suffering from inadequate living conditions may have a more difficult path to success—both in their aspirations and in accessing quality care.³⁰ This pattern exists everywhere and is (alone) cause for concern. To reflect the intricate links between someone's socioeconomic status and their wellbeing, WHO redefined “health” to not only refer to a life free from disease, but also to mean a “state of complete physical, mental, and social well-being.”³¹

WHO formed the Commission for the Social Determinants for Health in 2005.³² In its final report, the commission divided the social determinants into three parts: (1) socioeconomic and political context, (2) socioeconomic position, and (3) intermediary determinants of health.³³ Generally, SDoH concern both the processes that stratify health outcomes along the socioeconomic gradient and the factors that impact overall population health on their own.³⁴ Particularly relevant for this Comment is the first part—socioeconomic and political context. This part includes public policy decisions, governance structures, and the norms and values of

²⁵ Gopal K. Singh & Hyunjung Lee, *Marked Disparities in Life Expectancy by Education, Poverty Level, Occupation, and Housing Tenure in the United States, 1997-2014*, 10 INT'L J. MATERNAL & CHILD HEALTH & AIDS 7, 14 (2021).

²⁶ *Id.* at 15.

²⁷ *Id.* at 14–15.

²⁸ Hazel Genn, *When Law is Good for Health: Mitigating the Social Determinants of Health Through Access to Justice*, 72 CURRENT LEGAL PROBS. 159, 162 (2019).

²⁹ Regenstein et al., *supra* note 22, at 378.

³⁰ Final Rep. of the Comm'n on Soc. Determinants of Health, WHO, *supra* note 10, at 3.

³¹ WHO Constitution, July 22, 1946, pmbl., 62 Stat. 2679, 14 U.N.T.S. 185, 186–87; Final Rep. of the Comm'n on Soc. Determinants of Health, WHO, *supra* note 10, at 33.

³² *See* Final Rep. of the Comm'n on Soc. Determinants of Health, WHO, *supra* note 10.

³³ Schram et al., *supra* note 11, at 907.

³⁴ *Id.*

individual states. The socioeconomic and political context of SDoH can also be thought of as inequities.

Only recently have global health law scholars begun to utilize a combination of social and legal determinants to address unmet health and legal needs. Together, these determinants make up a sociolegal framework for health equity discourse.³⁵ The framework explains how increasing individuals' access to healthy living and wellbeing impacts their capacity for success, thus improving health equity for communities around the world.³⁶ Some of the research focuses on domestic health governance strategies, where the emphasis is on national solutions rather than international cooperation.³⁷ Global health governance, however, refers to the efforts "at the international level geared towards protecting and promoting health."³⁸

The Lancet-O'Neill Institute Commission on Global Health and Law reframed the social determinants to fall within the function of the law. Their framing became the foundation for scholarship on using law as a tool to improve health equity.³⁹ The Lancet Commission outlined three functions of the law that could address SDoH inequity: (1) governance of public and private institutions, (2) establishment of the standards and norms that guide conduct, and (3) dispute resolution.⁴⁰ These functions of the law show how HJPs remedy SDoH inequities. They will be discussed more in Part II.

Strategies to improve health equity must be founded in the idea that access to health is a human right, not a market commodity. Access to quality services based on an individual's needs and preferences—regardless of income, status, or residency—empowers people and improves the population's health overall.⁴¹ On the flip side, inadequate living conditions are often a result of policies that ignore their direct and indirect impacts

³⁵ *Id.* at 906–07.

³⁶ *Id.* at 907.

³⁷ See, e.g., Dayna B. Matthew, *The Law as Healer: Help Paying for Medical Legal Partnerships Saves Lives and Money*, CTR. HEALTH POL'Y AT BROOKINGS 5, 13–26 (Jan. 2017); Regenstein et al., *supra* note 22; Mallory Curran, *Preventative Law: Interdisciplinary Lessons from Medical-Legal Partnership*, 38 N.Y.U. REV. L. & SOC. CHANGE 595, 596 (2014).

³⁸ Brigit Toebes, *International Health Law: An Emerging Field of Public International Law*, 55 INDIAN J. INT'L L. 299, 321 (2015).

³⁹ See generally Schram et al., *supra* note 11, at 910 (distinguishing law as a tool for health from "health law" as a field of law).

⁴⁰ Schram et al., *supra* note 11.

⁴¹ See Final Rep. of the Comm'n on Soc. Determinants of Health, WHO, *supra* note 10.

on health.⁴² When viewed with this lens, the right to health contains both the right to access quality care and the right to pursue SDoH equity.⁴³

WHO has done initial research on the SDoH, but it has not yet incorporated that research into structures that can improve health determinants.⁴⁴ Missing from WHO's final report on the SDoH are mechanisms by which individuals might remedy inaccessible health care or structural inequities.⁴⁵ The report never intended to provide the legal channels needed to increase individual voices at the international stage for policy changes, despite those channels being a critical facet of improving health outcomes generally.

As professor of sociolegal studies Hazel Genn stated: "Social problems or social needs can become legal needs when the law provides a right or benefit that would alleviate or attenuate the social need but the law cannot be mobilized, for example, because of lack of knowledge or opportunity to take advantage of a legal process or remedy."⁴⁶ The Lancet Commission acknowledged the role of law in social advocacy by forging a sociolegal framework on the SDoH,⁴⁷ allowing WHO's vision to become actionable. Since the right to the highest attainable standard of health exists, there should be avenues to address these social problems that become legal needs. If the international community continues to ascribe to this highest attainable standard of health, global infrastructure must seek to remedy injustice caused by SDoH inequity.

B. WHO'S AUTHORITY TO IMPLEMENT GLOBAL HEALTH LAW

After World War II, the United Nations established WHO in part to propose conventions and agreements in pursuit of the right to the highest level of health attainable.⁴⁸ The preamble of the WHO Constitution clarifies that health—a state of complete physical, mental, and social

⁴² Genn, *supra* note 28, at 179.

⁴³ U.N. Comm. on Econ., Soc. & Cultural Rts., The Right to the Highest Attainable Standard of Health, U.N. Doc. E/C12/200/4 (Aug. 11, 2000).

⁴⁴ See generally Final Rep. of the Comm'n on Soc. Determinants of Health, WHO, *supra* note 10.

⁴⁵ *Id.*

⁴⁶ Genn, *supra* note 28, at 164.

⁴⁷ Schram et al., *supra* note 11.

⁴⁸ Lawrence O. Gostin, *World Health Law: Toward A New Conception of Global Health Governance for the 21st Century*, 5 YALE J. HEALTH POL'Y L. & ETHICS 413, 414 (2005) [hereinafter Gostin, *World Health Law*].

wellbeing—is a fundamental right that depends on the “fullest cooperation of individuals and States” to achieve peace and security.⁴⁹

The World Health Assembly (WHA), the legislative arm of WHO, has express authority to propose agreements concerning the highest level of health attainable. Under Article 19 of the WHO Constitution, the WHA can “adopt conventions or agreements with respect to any matter within the competence of the Organization.”⁵⁰ Under Article 21, the WHA can adopt legally binding recommendations in five public health areas:

sanitary and quarantine regulations; nomenclatures on diseases, causes of death, and public health practices; standards for diagnostic procedures for international use; standards for safety, purity, and potency of biological, pharmaceutical, and similar products moving in international commerce; and advertising and labeling of biological, pharmaceutical, and similar products moving in international commerce.⁵¹

Together, Articles 19 and 21 create the constellation of authority for WHO to propose new conventions or agreements that the WHA can pass into binding agreements.⁵² From there, WHO member states sign on to the agreement, and they commit to uphold the statements therein.

The constitution further explains that government responsibility, informed options, and extension of benefits are ways to avoid the “common danger” of unequal development and health inequity.⁵³ The UN has passed specific resolutions concerning human rights and health such as distributing vaccines for the COVID-19 pandemic,⁵⁴ rectifying discrimination leading to inequality,⁵⁵ increasing access to justice for survivors of sexual violence,⁵⁶ preserving the right to a clean and healthy environment,⁵⁷ and more. Acting in advisory power, WHO has also taken steps to reduce health inequity—just not through direct advocacy mechanisms.

⁴⁹ WHO Constitution, July 22, 1946, pmb., 62 Stat. 2679, 14 U.N.T.S. 185, 186–87. The right is also enshrined in the Universal Declaration of Human Rights. G.A. Res. 217 (III), *supra* note 2.

⁵⁰ WHO Constitution, July 22, 1946, art. 19, 62 Stat. 2679, 14 U.N.T.S. 185, 186.

⁵¹ Jennifer Prah Ruger, *Normative Foundations of Global Health Law*, 96(2) GEO. L.J. 424, 435 (2008).

⁵² Toebe, *supra* note 38, at 305–06.

⁵³ WHO Constitution, July 22, 1946, pmb., art. 19, 62 Stat. 2679, 14 U.N.T.S. 185, 186.

⁵⁴ See G.A. Res. 76/175, Ensuring Equitable, Affordable, Timely and Universal Access for all Countries to Vaccines in Response to the Coronavirus Disease (COVID-19) Pandemic (Dec. 16, 2021).

⁵⁵ See G.A. Res. 76/136, Promoting Social Integration Through Social Inclusion (Dec. 16, 2021).

⁵⁶ See G.A. Res. 76/304, International Cooperation for Access to Justice, Remedies and Assistance for Survivors of Sexual Violence (Sept. 2, 2022).

⁵⁷ See G.A. Res. 76/300, The Human Right to a Clean, Healthy and Sustainable Environment (July 28, 2022).

WHO utilizes its power to create a variety of standard-setting instruments to influence the behavior of individual states, ultimately impacting individuals. The binding norms are considered “hard” law while the nonbinding norms, such as recommendations and comments from the UN, are considered “soft” tools.⁵⁸ Both types of standard-setting instruments can only influence domestic policy after countries negotiate and adopt them as their own.⁵⁹ Although the binding norms often concern government action, some authors argue that health equity and direct advocacy mechanisms must be placed more firmly on the international agenda to balance the concern for member states’ economic growth with the protection of individuals and groups.⁶⁰ Arguably, governing bodies should consider the impact of global health laws on individuals as equally important as the laws’ impact on member states’ security and economies.⁶¹ But this is not always the case. Historically, the only binding regulations have concerned national security in the face of health emergencies (i.e., the SARS and COVID-19 pandemics) and economic flow of health-harming products like tobacco.⁶²

One example of WHO “hard” law is the International Health Regulations (IHR), which was created through a national security lens to protect countries from health threats—namely, pandemics.⁶³ This binding treaty has recently been put forth for revision at the Seventy-fifth World Health Assembly in May of 2023.⁶⁴ The last revision to the IHR occurred in 2005 in response to the SARS pandemic and enabled WHO to coordinate efforts on public health emergencies of international concern.⁶⁵ However, the suggestions in the IHR were much ignored during the COVID-19 pandemic. Now, the proposed revisions have less to do with health equity–related solutions than they do with surveillance and sharing “pathogen genetic sequence data and introducing shorter deadlines for reporting

⁵⁸ Gostin & Sridhar, *supra* note 5, at 1732.

⁵⁹ *Id.*

⁶⁰ Toebes, *supra* note 38, at 301.

⁶¹ Gostin & Sridhar, *supra* note 5, at 1732.

⁶² WHO, *International Health Regulations*, at 3 (2005), <https://apps.who.int/iris/bitstream/handle/10665/246107/9789241580496-eng.pdf> [<https://perma.cc/HC5G-9BWH>] [hereinafter WHO, *International Health Regulations*]; see WHO, *WHO Framework Convention on Tobacco Control* (2005), <https://iris.who.int/bitstream/handle/10665/42811/9241591013.pdf?sequence=1> [<https://perma.cc/G9DR-AGPG>] [hereinafter *WHO Framework Convention on Tobacco Control*].

⁶³ WHO, *International Health Regulations*, *supra* note 62, at 1.

⁶⁴ Silvia Behrendt & Amrei Müller, *The Proposed Amendment to the International Health Regulations: An Analysis*, OPINIOJURIS (Feb. 27, 2023), <http://opiniojuris.org/2023/02/27/the-proposed-amendments-to-the-international-health-regulations-an-analysis/> [<https://perma.cc/GK4K-44S6>].

⁶⁵ Gostin & Sridhar, *supra* note 5, at 1735–36.

and responding to emerging threats.”⁶⁶ As individual countries negotiate the upcoming revisions, however, they must refocus on health equity to achieve goals related to the SDoH.⁶⁷ Instead of considering a revision to the IHR, this Comment considers how a new treaty styled after the IHR—but centered on increasing health advocacy through HJPs—could create more equitable health outcomes.

The Framework Convention for Tobacco Control (FCTC) is the first and only WHO treaty established under Article 19 of the WHO Constitution.⁶⁸ The FCTC was created in 2005 to better regulate tobacco’s pricing and advertising.⁶⁹ As a treaty, every member state consents to be bound by the agreement and to further its goals—or at least not actively contradict them. But creating the buy-in necessary for effective enforcement is sometimes easier said than done. The FCTC provides an appropriate template for a future convention on HJP utilization.

There is one major obstacle to global health equity enforcement: no organized legal system exists to enforce international health law policies. Instead, each country must navigate the network of “soft laws” and treaties if health equity is to improve.⁷⁰ WHO and the UN have attempted to do so by creating groups such as the UN’s cooperatives and WHO’s Civil Society Engagement Mechanism.⁷¹

WHO’s goals for equitable health outcomes are clear, but the mechanisms to achieve the outcomes are not. Some scholars have recommended strengthening the governance powers of WHO to address the deficit.⁷² Other global groups such as the Joint Action and Learning Initiatives on National and Global Responsibilities for Health have begun campaigning for a new Framework Convention on Global Health.⁷³ Efforts geared towards effective governance ensure that norms, policies, and laws are

⁶⁶ Editorial, *The Future of the International Health Regulations*, 10 LANCET GLOB. HEALTH, July 2022, at 927.

⁶⁷ *Id.*

⁶⁸ Gostin & Sridhar, *supra* note 5, at 1735. The revisions for the IHR previously discussed are also proposed as a treaty under Article 19; see Behrendt & Müller, *supra* note 64.

⁶⁹ Toebe, *supra* note 38, at 306; *WHO Framework Convention on Tobacco Control*, *supra* note 62.

⁷⁰ Gostin & Sridhar, *supra* note 5, at 1732.

⁷¹ Both of which will be explained later in the comment. U.N., About Cooperatives, International Co-Operative Alliance Statement on the Co-Operative Identity, <https://www.un.org/en/events/co-opsyear/about.shtml> [<https://perma.cc/49SJ-JTEY>] [hereinafter U.N., About Cooperatives]. Informational Flyer, WHO, Civil Society Engagement Mechanism for UHC2030 [CSEM] (Sept. 2020), <https://csemonline.net/wp-content/uploads/2020/10/CSEM-Flyer-Sept2020.pdf> [<https://perma.cc/CY7Q-J9QG>].

⁷² Toebe, *supra* note 38, at 321.

⁷³ *Id.* at 326.

“transparent, accountable and participatory, taking into account the relevant human rights, humanitarian and ethical standards . . . equity, effectiveness, and efficiency.”⁷⁴ Ideally, each participating state’s health systems reflect these values as well.⁷⁵

Rather than focus on a strictly top-down approach, this Comment proposes a collaborative approach where legal channels amplify voices from local communities to be heard at the international scale when patterns of health obstacles require it. A framework combining both the top-down approach and the bottom-up approach creates the most opportunity to meet individual needs.⁷⁶ As of yet, however, a partnership approach like this has not been proposed as the primary mechanism for improving health equity.

C. PRINCIPLES OF THE HEALTH JUSTICE PARTNERSHIP MODEL

Health justice partnerships are practical interventions that allow individuals to resolve “the social and environmental circumstances that contribute to health disparities and have a remedy in civil law.”⁷⁷ Effective governance, informed policies, and access to health justice are central goals of both the WHO Commission for the Social Determinants for Health and the Lancet Commission for the Legal Determinants of Health. But each of these goals can only be reached through an accessible civil remedy for individuals to use at the local level yet has influence at the international level. HJPs are not new,⁷⁸ but they do require formal accountability structures that have yet to be put in place. The traditional HJP model (otherwise known as a medical legal partnership) offers a strong starting point for WHO and the UN to create accountability mechanisms and ultimately reach the three goals outlined above.

HJPs act as a community resource for individuals to resolve issues such as food insecurity, barriers to employment, housing, and medical payment issues.⁷⁹ The benefits to patients are significant. Where an individual would otherwise struggle to know how to proceed in a medical-legal issue,

⁷⁴ *Id.* at 321.

⁷⁵ *Id.* at 322; see also Paul Hunt & Gunila Backman, *Health Systems and the Right to the Highest Attainable Standard of Health*, 10 HEALTH & HUM. RTS. 81 (2008).

⁷⁶ See Lawrence Gostin et. al., *A Framework Convention on Global Health*, 91 BULL. WORLD HEALTH ORG., 790 (2013) [hereinafter *Framework Convention on Global Health*].

⁷⁷ Regenstein et al., *supra* note 22, at 378.

⁷⁸ See Matthew, *supra* note 37, at 8.

⁷⁹ See *id.* at 13–26.

health justice groups increase access to benefits,⁸⁰ provide advocacy for debt relief,⁸¹ decrease stress to avoid readmission,⁸² and provide support for the patient so they can better communicate their needs to medical professionals.⁸³ HJPs can then group similar cases into one cause that can be brought before legislatures, judges, and governing bodies like WHO. This case-to-cause approach of HJPs is what makes the mechanism valuable for global health equity. When there is a repeated pattern of injustice or inequity, legal representatives within the partnership can begin advocating for changes at the global governance level. In this way, legal representatives bridge the gap between individual needs, communal patterns, and global policy changes to improve global health. HJPs are thus one of the main ways that individuals can be screened for sociolegal determinants of health to increase access to justice, advocate in a case-to-cause policy model, and inform procedure modification to increase good governance.⁸⁴

People seek advice from medical professionals more frequently than they do from lawyers or legal advocacy groups.⁸⁵ But some health barriers find their remedies in civil law. Individuals can utilize HJPs to consolidate local health barriers into policy initiatives at an international level or to refer cases to other adjudicatory bodies for civil remedy. HJPs build capacity by utilizing networks between healthcare organizations and legal services organizations, increasing the channels between the individual and the decision-making body.⁸⁶ If the international community adopts HJPs, it will allow a more diverse set of voices at the table to inform international policies and treaties. This would in turn increase equitable representation during negotiations and treaty implementation.

Not many low- and middle-income countries have fully considered adopting HJPs. But Australian health justice scholar Ashley Schram suggests that “a more legally oriented approach may also help embed a human rights platform in the work of health actors and strengthen the rights-based discourse as a foundation on which the research on and policy for [the social determinants of health] are based.”⁸⁷ Viewing health policy through a human rights-based approach acknowledges that health

⁸⁰ Regenstein et al., *supra* note 22, at 378.

⁸¹ *Id.* at 379.

⁸² *Id.*

⁸³ *Id.* at 379.

⁸⁴ See Schram et al., *supra* note 11.

⁸⁵ *Id.* at 918.

⁸⁶ See *id.*

⁸⁷ *Id.* at 921.

outcomes are not the same across the board, but that we are all entitled to the highest attainable level of health. The legal needs resulting from poverty and health injustice are inextricable, but HJPs are a critical tool for coordinating their improvement globally.

HJPs offer a unique opportunity for the UN to create tailored systems in developing countries where social determinants and socioeconomic challenges differ. As medical-legal needs are addressed from the ground up, WHO and the UN can set regulatory goals to ensure success from the top down. “Effective coordination mechanisms between levels of the health system will be needed to allocate resources efficiently and reduce disruption to care.”⁸⁸ HJPs are such mechanisms.⁸⁹ They can bridge the gaps between medicine and law to better address health inequity globally, but they must be given a formal legal foundation to have a lasting and coordinated impact.

II. DISCUSSION

Addressing global health inequity is a particularly daunting task because of the myriad issues impacting health at every level of policy change. Individual choices play a role just as much as government policies do on local, national, and international levels. Every sector of the economy—finance, education, housing, employment, transportation, and law—has some impact on health.⁹⁰ Societal and cultural patterns also prioritize (or limit) access to certain health care procedures and rights.⁹¹ The social determinants of health represent each of these facets. The UN established the 2030 Agenda for Sustainable Development, encouraging improvements of global health equity,⁹² but a gap exists regarding how these improvements will be accomplished. The HJP model best fills this gap. HJPs must be given appropriate points of entry so that advocates can utilize their authority to represent individuals on an international scale while honoring member state sovereignty to choose distinct health governance structures.

⁸⁸ Jonathan Liberman et al., WHO, *Considerations for Health Governance: Strengthening Institutional Capacity and Connectedness Through COVID-19 Responses*, at 5, WPR/DHS/2021/002 (Jan. 21, 2021).

⁸⁹ *Id.*

⁹⁰ See Final Rep. of the Comm’n on Soc. Determinants of Health, WHO, *supra* note 10, at 10.

⁹¹ See Dana Ciccone et al., *Linking Governance Mechanisms to Health Outcomes: A Review of the Literature in Low- and Middle-Income Countries*, 117 SOC. SCI. & MED. 86, 91 (2014).

⁹² G.A. Res. 70/1, *supra* note 3, at 16.

The following subparts discuss three considerations of how HJPs may be implemented in international law. Subpart A analyzes why the partnership model is an appropriate tool to reach the UN's Sustainable Development Goals. Subpart B discusses potential ways to situate the partnership model within the UN's broader infrastructure. Subpart C considers obstacles (enforcement and funding) and anticipated outcomes (efficacy and cultural flexibility) of using HJPs as a tool for improved health around the world.

A. IMPROVING SDOH AND GLOBAL HEALTH EQUITY THROUGH HJPS

Governance mechanisms are most effective when they are transparent, accountable to all stakeholders, responsive to the needs of the governed, and inclusive of diverse perspectives.⁹³ The core elements of HJPs prioritize transparency, accountability, and responsiveness essential to effective governance.⁹⁴ More specifically, HJPs respond to poor health and injustice by holding both medical and legal actors accountable for their roles in policy changes. And as a result, they create more responsive and equitable regulations through their collaborative advocacy. But HJPs efficacy depends on member states buying into the process before they can moderate the determinants of health discussed in the background. The following part discusses three projected outcomes of an agreement implementing HJPs: (1) operationalization of goals into governance mechanisms, (2) strengthened governance within and between member states, and (3) effective health governance networks generally.

First, legal determinants of health operationalize global health policy, suggesting a foundation on which HJPs may begin to transform WHO's malleable health equity goals⁹⁵ into actionable steps to remedy injustice.⁹⁶ The Lancet-McNeill Institute recommends implementing the right to health as a constitutional or statutory right.⁹⁷ Law can be used as a "foundation for Universal Health Coverage, which is a crucial element of

⁹³ Ciccone et al., *supra* note 91, at 86.

⁹⁴ *Id.*

⁹⁵ G.A. Res. 70/1, *supra* note 3, at 16.

⁹⁶ See generally WHO, *Operational Framework for Monitoring Social Determinants of Health Equity*, *supra* note 15.

⁹⁷ Selina Lo & Richard Horton, *Legal Determinants of Health: Facing Global Health Challenges*, 393 LANCET COMM'N 1781, 1781 (2019).

sustainable development.”⁹⁸ But law also functions as a governance mechanism to remedy violations of societal norms and standards.

Public health laws’ efficacy depends on the same tenants of transparency, accountability, and responsiveness on which all other governance mechanisms depend. When legal channels like HJPs exist for individual remediation of health-related standards, public health policies carry more enforcement power. This in turn holds governing bodies more accountable to the public for violations of health-related standards. Much in the same way adjudicatory bodies might provide justice for civil rights violations, HJPs can vindicate community health injustice through advocacy and policy change—but in a more collaborative manner.⁹⁹ And if properly merged into the existing WHO organizational structure, HJPs may also increase accountability for global health actors. If HJPs become the channel through which individual voices are heard, domestic and international accountability, transparency, and responsiveness will skyrocket.¹⁰⁰

Second, an agreement implementing HJPs would strengthen governance within and between member states. Health system governance owes its complexity to the various motivations held by powerful actors within health systems. Market forces, insurance and payor systems, and state-based priorities weave together but retain opposing interests. It follows then that effective health governance is not solely controlled by the government, but by coordinated efforts of political, economic, and administrative stakeholders.¹⁰¹ Governance actors must prioritize additional tenants beyond the transparency, accountability, and responsiveness mentioned earlier. These are inclusiveness, strategic vision, the rule of law, consensus-oriented participation, equity, effectiveness, ethics, and information-sharing.¹⁰² HJPs can reprioritize all of these tenants through collaborative advocacy.¹⁰³

These tenants would also serve as a tool to assess the effectiveness of HJPs as an international governance mechanism. As mentioned in the background, HJPs are created through agreements between healthcare

⁹⁸ Lawrence Gostin et al., *The Legal Determinants of Health: Harnessing the Power of Law for Global Health and Sustainable Development*, 393 LANCET COMM’N 1857, 1857 (2019) [hereinafter Gostin, *Harnessing the Power of Law*].

⁹⁹ Ciccone et al., *supra* note 91, at 86.

¹⁰⁰ See Schram et al., *supra* note 11, at 921.

¹⁰¹ Sameen Siddiqi et al., *Framework for Assessing Governance of the Health System in Developing Countries: Gateway to Good Governance*, 90 HEALTH POL’Y 13, 14 (2009).

¹⁰² *Id.* at 18.

¹⁰³ See *id.* at 18.

organizations and legal services organizations to serve a population's legal- and health-related needs in a holistic process. The partnerships rely on information sharing and consensus-oriented participation between the two systems to effectuate ethical solutions, which increase equity and accountability overall.

Additionally, HJPs are guided by the effective governance tenants as advocates work with individuals toward a common vision of equity, inclusion, and improved health outcomes. HJPs increase access to justice by addressing health-harming legal needs.¹⁰⁴ Advocacy begins locally through medical and legal professionals' responses to health obstacles. These advocates transparently communicate during client contact to "identify and address opportunities for systemic improvement."¹⁰⁵

Many health justice advocates can recall a time when a client came to them explaining how they could—by medical diagnosis—qualify for disability benefits, but were denied in their application because they needed to remain substantially and gainfully employed to pay their bills.¹⁰⁶ Although the advocate cannot resolve that client's medical needs, they can assist with the appeal for disability benefits and help the client navigate care access obstacles. When patterns of inequities occur with other clients, that very same advocates can connect with representatives to initiate policy change. Through a patient-to-policy approach, HJPs can drastically improve the quality of health system governance and health outcomes.

Third, WHO would be implementing a flexible, fair, and evidence-based health government mechanism by endorsing HJPs.¹⁰⁷ When effective tools like HJPs support health systems, health indicators such as life expectancy, infant and maternal mortality rates, and self-reported health status improve.¹⁰⁸ In contrast, any time transparency and other indicators lack, systemic symptoms such as corruption and secrecy arise.¹⁰⁹ The benefit of using HJPs to improve governance indicators and SDoH is that the partnerships focus on how individuals are presently impacted by the health system. When individuals are overbilled or marginalized,

¹⁰⁴ Curran, *supra* note 37, at 595.

¹⁰⁵ *Id.* at 596.

¹⁰⁶ "To be eligible for disability benefits [in the United States], a person must be unable to engage in substantial gainful activity (SGA). A person who is earning more than a certain monthly amount (net of impairment-related work expenses) is ordinarily considered to be engaging in SGA." *Substantial Gainful Activity*, SOC. SEC. ADMIN., <https://www.ssa.gov/oact/cola/sga.html> [<https://perma.cc/MV5R-KTSA>].

¹⁰⁷ Gostin, *Harnessing the Power of Law*, *supra* note 98, at 1882.

¹⁰⁸ Ciccone et al., *supra* note 91, at 87.

¹⁰⁹ *See id.* at 91–92.

advocates within the partnership have the tools and knowledge to push for remedies and reform in law and policy.

This case-to-cause system spans all levels of governance and coordinates efforts between countries as well. For example, advocates working at the local level can address needs within the community-based system or draw national policymakers' attention. In respect of sovereignty, most decision-making power would remain at the national level. However, where global health policy concerns arise, such as sanitation technology improvement to limit the spread of disease, national-level advocates can carry policy initiatives into higher-level, regional decision-making organizations (e.g., the Pan-American Health Organization) or internationally at WHO. In its Universal Health Coverage initiative (UHC2030), WHO created the Civil Society Engagement Mechanism to ensure civil groups are involved in the delivery and planning of health services.¹¹⁰ It also collaborated with "related health systems initiatives" to assist in health policy research and development.¹¹¹ A binding agreement committing to the use of HJPs globally could utilize these engagement mechanisms to inform additional policy changes. Coordinating existing resources then streamlines advocacy efforts, which reduces population-specific health inequities overall.

WHO does endorse a process of "participatory advocacy" that is focused on dynamic cooperation.¹¹² It already collects data on health areas such as malaria, HIV, child immunization, COVID-19, sanitation and hygiene, women's empowerment, and reproductive and maternal health.¹¹³ When it comes to the advocacy process, WHO has previously mentioned that there is no universal approach.¹¹⁴ Instead, flexibility fosters political and public engagement.¹¹⁵ Here, HJPs function as the evidence-based

¹¹⁰ Informational Flyer, *supra* note 71.

¹¹¹ UNIVERSAL HEALTH COVERAGE 2030, INTERNATIONAL HEALTH PARTNERSHIP 2 (2020), https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/Related_Initiatives/UHC2030_Related_Initiatives_FINAL_April_2020.pdf [<https://perma.cc/R74F-CPXK>].

¹¹² WHO, *Advocacy Strategies for Health and Development: Development Communication in Action*, at 2–3, HED/92.4 (Nov. 9–13, 1992) [hereinafter Division of Health Education, *Advocacy Strategies*]; see also WHO, *Operational Framework for Monitoring Social Determinants of Health Equity*, *supra* note 15, at 59.

¹¹³ See Health Inequality Monitor, WHO, <https://www.who.int/data/inequality-monitor/> [<https://perma.cc/3FRD-MR2Y>].

¹¹⁴ Division of Health Education, *Advocacy Strategies*, *supra* note 112, at 5.

¹¹⁵ *Id.* at 18; see also WHO, *Operational Framework for Monitoring Social Determinants of Health Equity*, *supra* note 15, at 76.

intervention that would aid interactive agreement for future health equity advocacy, yet sustain the vision for flexibility.

Finally, prior research has described in detail how HJPs build capacity for individuals to achieve health outcomes through medical-legal assistance.¹¹⁶ Here, legal infrastructure is the focal point. The law's function of increasing governance, setting norms and standards, and resolving disputes depends on an individual's ability to access and effectively utilize the legal system. Of course, not every health problem has a legal solution. Some SDoH do not require an attorney's help to remedy. However, many individuals do benefit from legal assistance to help them navigate health systems, housing, or community issues. The Lancet Commission suggests that states should build legal frameworks to enact and implement public health laws focused on the Sustainable Development Goals.¹¹⁷ This is just what HJPs would do. A legally binding agreement proposing accountability measures through HJPs would build a legal framework for remedying health inequities. The partnerships would tie together national efforts and global institutions to expand the reach of individual voices as social determinants improve.¹¹⁸

B. FRAMING AND IMPLEMENTING AN HJP TREATY

Coordinated efforts from various sectors, including private actors and governing bodies, are necessary to accomplish the UN's Sustainable Development Goals and to secure the right to the highest attainable level of health. But what is the role of law in reaching these goals? In an ideal world, principles of good governance would be a shared, demonstrated commitment of each member state. In practice, however, countries push back on such a commitment.¹¹⁹ Social and political factors determine if and to what extent individual governments are willing to negotiate for the greater good. Even more, countries' views differ on whether reforming financing, restructuring health systems, or taking a rights-based approach to health is most important.

Although the Lancet Commission's work on the legal determinants of health and the recommendation for a rights-based approach have

¹¹⁶ Schram et al., *supra* note 11, at 919.

¹¹⁷ Gostin, *Harnessing the Power of Law*, *supra* note 98, at 1876–77.

¹¹⁸ See generally WHO, *Operational Framework for Monitoring Social Determinants of Health Equity*, *supra* note 15.

¹¹⁹ See Gostin, *World Health Law*, *supra* note 48, at 417.

recently sparked discussion, there has not yet been an agreement on how to solidify health as a human right in binding international agreements. Questions continue to abound concerning who has authority to set the governing law, what form the law should take, and how it should be enforced. Although treaties are critical for asserting the right to health, ratification of such treaties only has a moderate direct impact on individual health indicators.¹²⁰ Without more, treaty ratification “cannot be assumed to produce rights enforcement; whether it does or not depends on implementation strategies and on a complex set of other interconnected factors.”¹²¹ The international law has a role in harmonizing member states’ laws and policies to encourage cooperation, but the specific challenge in global health governance lies in enforceability.¹²²

A human rights approach to health equity requires buy-in from member states before any coordinated effort towards enforceability can be negotiated. This is especially true now, given that support for globalization and cooperation has somewhat soured due to politicization, threat of war, and resource scarcity.¹²³ Treaties and regulations can set “the overarching goals, strategies for attaining these goals, and valuation of various outcomes.”¹²⁴ At the same time, legal frameworks that balance domestic governments’ objectives with global health objectives can move the international community towards rights-based health and wellbeing.¹²⁵ Although WHO and the UN have the social determinants of health somewhat, there are shortcomings; the sociolegal determinants are also critical to reaching the UN’s Sustainable Development Goals. A treaty agreement including the HJP model would better enforce the appropriate balance of accountability and flexibility necessary to reach these goals.

1. *Reprioritizing equity through a rights-based approach.*

Global health law developed mostly out of national security concerns in the context of health emergencies and economic initiatives such

¹²⁰ Alexis Palmer et al., *Does Ratification of Human-Rights Treaties Have Effects on Population Health?*, 373 LANCET COMM’N 1987, 1989 (2009).

¹²¹ Jacqueline Bhabha, *Half a Century of a Right to Health?* (Dec. 2016), <https://www.un.org/en/chronicle/article/half-century-right-health> [https://perma.cc/7W3N-KARP].

¹²² Gostin, *Harnessing the Power of Law*, *supra* note 98, at 1878.

¹²³ *The Future of the International Health Regulations*, *supra* note 66, at e927.

¹²⁴ Ciccone et al., *supra* note 91, at 86.

¹²⁵ *See* Lo & Horton, *supra* note 97, at 1781.

as healthcare systems and trade.¹²⁶ Rather than independently rooting global health in a rights-based approach, health equity goals are built on top of the existing framework of international health governance, which is more concerned with national security and trade. Because of this, a rights-based approach has been deprioritized. Although the International Covenant on Civil and Political Rights¹²⁷ and the International Covenant on Economic, Social and Cultural Rights¹²⁸ were intended to promote the Universal Declaration of Human Rights' aspirational goals, the global political division resulted in uneven development of health-rights infrastructure.¹²⁹ The result was a focus on trade and economic development rather than collaboration towards securing the right to health.

Any proposed solution to global health inequity must operationalize the right to the highest attainable level of health. A specific agreement providing the framework for HJPs would reprioritize the right to health and the UN's Sustainable Development Goals while offering accountability mechanisms to ensure positive change for member state policy. The following paragraphs explain how the rights-based approach differs from the national security and economic-development lenses. Current WHO agreements offer guidance to better implement a treaty focused on HJPs.

a. Rights-based approach to health

A rights-based approach acknowledges that health issues are not bound by state borders, and that human flourishing requires a commitment to the health of all people.¹³⁰ Such a commitment requires coordinated efforts to equitably balance global resources, negotiate legislation and policy, ensure accountability, and create public goods—all while providing enough flexibility for states to address cultural, social, and economic realities.¹³¹

The UN has been committed to an inclusive right to health, promising both freedoms (e.g., the right to be free from nonconsensual medical treatment and inhumane or degrading treatment) and entitlements (e.g., the right to timely and equitable prevention, treatment, and control of

¹²⁶ See Toebes, *supra* note 38, at 312.

¹²⁷ G.A. Res. 2200A (XXI), International Covenant on Civil and Political Rights (Dec. 16, 1966).

¹²⁸ *Id.*

¹²⁹ Bhabha, *supra* note 121.

¹³⁰ See Ruger, *supra* note 51, at 425–26.

¹³¹ See *id.*; *The Future of the International Health Regulations*, *supra* note 66, at e927.

diseases).¹³² The UN also recognizes that underlying determinants of health—factors that “protect and promote the right to health”—go beyond health services to require access to food, water, freedom from discrimination, and other basic living standards.¹³³ But without enforcement power, WHO must rely on treaties that leverage both binding and nonbinding mechanisms to create global norms that prioritize these rights. Thus, any treaty that will add accountability to the highest attainable level of health must be grounded in a rights-based framework, rather than a national security or economic-development focus.

Many WHO resolutions comment on the need to improve health around the globe,¹³⁴ but none implement advocacy channels furthering the “right to health.”¹³⁵ Advocacy efforts in furtherance of the rights-based framework are a much newer strategy in global health discourse.¹³⁶ Since this approach so new, HJPs may assist negotiations for future rights-based treaties. As inequities grow due to resource scarcity and destabilized economies, framing health in the human rights-based approach is critical to a treaty’s enforcement.

b. National security approach to health

Instead of considering global health equity from a coordination of human rights, international agreements on health have often focused more on a “sovereign-state approach to infectious diseases,” like the IHR, if not through an economic-development focus.¹³⁷ The goal of that approach is to increase national health and economic security in the face of emergent health threats.¹³⁸

The 2011 Pandemic Influenza Preparedness (PIP) Framework is one example of this approach. The PIP Framework was developed after Indonesia withheld H5N1 avian flu virus samples from the WHO Global Influenza Surveillance and Response System.¹³⁹ WHO had developed a system meant to assist developing countries afford the samples that

¹³² WHO, *The Right to Health, Fact Sheet No. 31*, at 3–4 (June 2008).

¹³³ *Id.* at 6.

¹³⁴ See generally WHO, *Operational Framework for Monitoring Social Determinants of Health Equity*, *supra* note 15.

¹³⁵ David P. Fidler, *The Globalization of Public Health: The First 100 Years of International Health Diplomacy*, 79 BULL. WORLD HEALTH ORG. 842, 842–49 (2001).

¹³⁶ Halabi, *supra* note 4, at 1608.

¹³⁷ Ruger, *supra* note 51, at 425.

¹³⁸ See Ruger, *supra* note 51, at 425–26.

¹³⁹ Gostin & Sridhar, *supra* note 5, at 1736.

industrialized countries had researched, developed, and patented.¹⁴⁰ But by withholding its samples after being denied vaccines, Indonesia created inequitable access to vaccine distribution and development.¹⁴¹ In response, the WHA amended Article 23 of the WHO Constitution through a resolution in May 2011, requiring research firms to share intellectual property and other countermeasures “critical to pandemic response.”¹⁴²

One option for a human rights-based agreement on HJPs framework is to mirror the hybrid structure of the PIP Framework. There, WHO exerted regulatory power not through treaty negotiations, but by “an innovative hybrid,” combining normative soft law with certain “binding obligations.”¹⁴³ In turn, this required biotechnology companies to share the benefits of scientific progress related to pandemic influenza through contractual duties.¹⁴⁴ The contractual nature of this agreement created accountability for individual member states to share their research, with the assumption that they would benefit in return. By leveraging the normative power of contractual obligations, the Framework functions with few legal enforcement mechanisms that could be used if member states failed to comply.

The model provided by the PIP Framework is powerful but may lack the buy-in required from member states to create lasting and transparent change. Just as Indonesia withheld its research on H5N1 because it was told that it would not benefit from the contractual agreements, couching HJPs as another type of hybrid agreement may make withdrawal or withholding of solutions to health inequality more likely. Global health inequity exists not just within individual member states, but also between countries due to lack of trust and inequitable negotiations of international cooperation for global health.¹⁴⁵

Although individual member states negotiate the agreement together, a hard-law agreement like a treaty or resolution exerts more pressure on countries to enact the policy initiatives. Treaties stand in contrast to the soft-law contractual strategy of the PIP Framework by offering more authority to the HJPs than a soft-law strategy might. Negotiated between

¹⁴⁰ David P. Fidler, *Influenza Virus Samples, International Law, and Global Health Diplomacy*, 14 EMERGING INFECTIOUS DISEASES 88, 88 (2008).

¹⁴¹ Halabi, *supra* note 4, at 1626–27.

¹⁴² *Id.* at 1623.

¹⁴³ Gostin & Sridhar, *supra* note 5, at 1736.

¹⁴⁴ *Id.*

¹⁴⁵ See Gostin, *World Health Law*, *supra* note 48, at 423.

countries, each member state consents to be bound by the final agreement and to invest in national policies that implement the agreed-upon terms.

One such treaty, the International Health Regulations (IHR), provides a useful template for a treaty concerning HJPs. This treaty purports to “prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.”¹⁴⁶ The IHR is like other WHO initiatives that assess health security and monitor pandemic preparedness,¹⁴⁷ but it incorporates feedback loops called Joint External Evaluation (JEE) processes to gauge countries’ capacities to identify and address gaps in health systems by detecting laws that a country has developed in response to the IHR.¹⁴⁸ JEEs help the IHR function as a monitoring and evaluation system, and they could be a template for compiling advocacy suggestions generated by HJPs.

In theory, JEEs are voluntary and comprehensive reporting mechanisms that allow WHO to gather information on countries’ capacities to address infectious diseases.¹⁴⁹ The reporting process identifies critical gaps within health systems. It also helps countries prioritize their responses to emergencies and partner with donors to effectively target resource distribution.¹⁵⁰ The process is meant to be multisectoral, engaging both health partners and other related government sectors. This all takes time, but once the report is published online, other countries can view the results and individual countries can use the report to plan their emergency preparedness and response. JEE implementation has adapted over the years in response to various health emergencies; in 2020, the secretariat revised a tool outlining JEE procedures.¹⁵¹ Once JEE reports are shared, member states can then revise their laws to better facilitate the goals outlined in the IHR.

The voluntary nature of JEEs, however, makes the incentive to self-report a less effective tool for monitoring health emergencies. Some countries are understandably reluctant to self-report. Often, sovereignty

¹⁴⁶ *International Health Regulations*, *supra* note 6, at 1.

¹⁴⁷ See Gostin, *World Health Law*, *supra* note 48, at 420.

¹⁴⁸ Halabi, *supra* note 4, at 1651–52.

¹⁴⁹ *Global Health Protection and Security, Int’l Health Regulations (IHR)*, CTR. FOR DISEASE CONTROL & PREVENTION (Apr. 26, 2022), <https://www.cdc.gov/globalhealth/healthprotection/ghs/ihr/index.html> [<https://perma.cc/DR4U-6RBD>].

¹⁵⁰ *Id.*

¹⁵¹ WHO, *International Health Regulations (2005) Joint External Evaluation Tool*, at 1 (2005).

principles or political or economic interests drive these decisions.¹⁵² Another reason for the lack of compliance is that low-income countries may not have the capacity and legal tools to provide consistent reports.¹⁵³ The Global Health Security Agenda (the collaborative effort between governments, NGOs, and international organizations utilizing JEEs to better respond to global health emergencies) increase the capacity of such countries by providing financial assistance in exchange for cooperation with JEE reporting.¹⁵⁴ This strengthens the countries' compliance with the IHR.¹⁵⁵ Such a solution, however, is costly and requires the security agenda to assist countries with potentially recurring patterns of diminished capacity, and it is not guaranteed to last.

Due in part to poor enforcement, the IHR has not been entirely effective, even with the use of JEE processes. The lack of national surveillance tools and other mechanisms may be a large part of why compliance with the IHR is lacking. The IHR works to foster global partnerships; strengthen disease prevention, response, and security; and sustain procedures that manage global health risks.¹⁵⁶ WHO has no enforcement power to ensure compliance with IHR.¹⁵⁷ Although there are dispute resolution procedures in place to address the lack of notification, WHO has never utilized them.¹⁵⁸ Since the IHR functions more as a monitoring tool than a regulatory tool, the treaty simply was not structured to garner the national buy-in necessary for international enforcement.

To be clear, the IHR is focused on health security rather than health as a human right. IHR functions alongside the Global Health Security Agenda and the UN Security Council to monitor and address health threats after they have occurred. In contrast, a human rights approach would address health through a lens of preventative law. JEEs can be a valuable blueprint for organizing and presenting micro- and mesolevel advocacy to WHO or the UN for macrolevel policy negotiations. Yet, many of the same practical issues for the effectiveness of JEEs may be present with HJPs. Knowing these issues in advance can help avoid the obstacles in HJP implementation. The agreement can incorporate different enforcement powers while maintaining the multisectoral reporting model.

¹⁵² See Gostin, *Harnessing the Power of Law*, *supra* note 98.

¹⁵³ *Id.* at 1879.

¹⁵⁴ *Id.* at 1880.

¹⁵⁵ *Id.*

¹⁵⁶ See Gostin, *World Health Law*, *supra* note 48, at 420.

¹⁵⁷ Ruger, *supra* note 51, at 437.

¹⁵⁸ *Id.*

The IHR serves as a marker of how individual nations may respond to proposed recommendations. The resolution is meant to manage global health security and respond to health threats.¹⁵⁹ But detrimental social determinants of health exist long before emergencies arise. When individuals do not have access to the infrastructure and legal remedies for when their health is impeded, health emergencies only worsen. If the IHR is a model for responses to lack of health access, then human rights–focused health equity laws are the preventative and complementary model required to ensure health and wellbeing. As the Lancet Commission warns, prioritizing equity will be essential to the future success of the IHR:

Unanimous approval of the IHR amendments in 2005 was achieved when globalisation and cosmopolitanism were favoured. Now the political climate has changed, a consensus is ever more difficult to reach amid the rise of populism, nationalism, and geopolitical tensions. Against this backdrop, an emphasis on equity may be the only way towards trust and collaboration, and the newly agreed provision for all Member states to submit amendment proposals is therefore a welcome move.¹⁶⁰

Individual nations’ interests in sovereign-state security almost directly conflict with a collective mentality of health equity and human flourishing. The timing of response differs—preventative versus responsive—and the interest in preservation versus accountability is distinct. Without a focus on health equity, future IHR recommendations may fail to adequately address causes of health emergencies and make an impact. A new treaty is necessary to reframe the global health law discourse around equitable health as a human right and implement HJPs.

c. Economic and trade approach to health

The WHO Constitution makes clear that health is not to be treated as a market commodity, but as a human right. As previously stated, many resolutions address human rights concerns related to health generally. However, when it comes to directly addressing health as a human right, WHO resolutions often center on trade as a tool to mitigate health concerns or foster economic growth to improve health, rather than directly operationalizing the right through legal mechanisms. Although this reality fosters the development of global public goods, it “lacks a strong normative

¹⁵⁹ Toebe, *supra* note 38, at 313.

¹⁶⁰ *The Future of the International Health Regulations*, *supra* note 66, at 927.

component” and is—at most—“neutral with respect to equity.”¹⁶¹ Even so, these treaties centered on economic development can provide insight into human rights–based treaties for health.

The World Health Assembly has historically underutilized its treaty-making power concerning trade to bettering global health. When the Framework Convention for Tobacco Control was first created, WHO began with a softer, normative advisory approach by reporting on the tobacco industry to undermine its work. When that didn’t lead to change, a legally binding treaty became essential.¹⁶² Guided by Article 19 of the WHO Constitution and other articles, the World Health Assembly adopted the treaty.¹⁶³ The FCTC regulated the supply-and-demand factors at play in international trade to reduce the health risk.¹⁶⁴

The FCTC is an appropriate example of how WHO can combine hard law and softer normative powers to increase efficacy. To truly impact global health equity, buy-in from each country is required so that all signatory member states coordinate efforts rather than contradict each other. Since the FCTC was created under Article 19, it required two-thirds of all member states’ votes to be ratified.¹⁶⁵ Its phrasing contains voluntary wording that allows for national interpretation, adaptation, and legislation.¹⁶⁶ It could be expected that international regulation of health systems would experience much the same pushback as the tobacco industry gave the FCTC. Since these industries benefit more from voluntary regulations, these parties will often push for softer forms of law.¹⁶⁷

A treaty employing HJPs could be similarly structured to the FCTC but allow space for soft-law norms to occur at the national level. Just as the binding nature of the FCTC may have been necessary due to interwoven regulation of the tobacco industry, the binding nature of an HJP framework treaty may be just as necessary. The normative power in soft law only goes so far.¹⁶⁸

¹⁶¹ Ruger, *supra* note 51, at 427.

¹⁶² See Catherine Regis & Florian Kastler, *Improving the World Health Organization’s Normative Strategy with Respect to Global Health Goals: What Should We Aim for*, 51 BELG. REV. INT’L L. 138, 150 (2018).

¹⁶³ Gostin & Sridhar, *supra* note 5, at 1735; Toebe, *supra* note 38, at 306.

¹⁶⁴ Halabi, *supra* note 4, at 1623; see also Gostin & Sridhar, *supra* note 5, at 1735.

¹⁶⁵ Toebe, *supra* note 38, at 305–06.

¹⁶⁶ Regis & Kastler, *supra* note 162, at 146.

¹⁶⁷ Toebe, *supra* note 38, at 306.

¹⁶⁸ See Regis & Kastler, *supra* note 162, at 149.

In contrast, a binding agreement would allow for added international accountability and standardization of HJP implementation. This hybrid treaty model utilizes binding hard law to require standardized HJP utilization but leaves flexibility in how the HJPs would advocate for patients and policy changes. Individual member states might be more willing to sign on to a treaty that helps them protect members of their communities through preferred strategies and prevent inequity in the first place. It would also create a foundation on which member states may rely to raise cross-border concerns related to SDoH. The hybrid treaty model may further increase the success of HJP utilization and health outcomes because it prioritizes effective governance indicators.¹⁶⁹ Such an agreement strikes the ideal balance of accountability and buy-in to bind consenting countries.

2. *Connecting existing WHO initiatives with HJPs*

Law must be used as a tool to increase access to justice that in turn increases access to the highest attainable level of health. The current patchwork of various soft-law strategies and efforts of groups unattached to one another leads to inconsistency in the laws' application and underenforcement in the response to injustice, which then further spirals to inequitable health outcomes. Nongovernmental organizations attempting to improve health outcomes—nationally or internationally—may struggle to determine the scope of their authority. What's more, they may lose out on the opportunity to assist in coordinated improvements because there is no system in place to navigate the web of soft law, hard law, existing channels of resource streams, and more.

The WHO Constitution sets out the “highest attainable standard of health.”¹⁷⁰ But without domestic adoption, the statement is without teeth. With government buy-in, however, certain core obligations are implemented, such as the “provision of health facilities, goods, and services, without discrimination and distributed equitably . . . with public accessibility, ethnic and cultural acceptability, and good quality, as outlined in general comment 14 of the UN Committee on Economic, Social, and Cultural Rights.”¹⁷¹ Thus, collaboration is required among countries so they can adopt the recommendations as their own and ensure accountability.¹⁷²

¹⁶⁹ Siddiqi, *supra* note 101, at 14.

¹⁷⁰ WHO Constitution, July 22, 1946, pmbl., 62 Stat. 2679, 14 U.N.T.S. 185, 186.

¹⁷¹ Gostin & Sridhar, *supra* note 5, at 1736.

¹⁷² *See id.* at 1733.

WHO treaty ratification including an HJP mechanism would increase collaboration in health system governance at all levels, improving global health equity. Once again, this treaty would not be entirely new ground; WHO has previously adopted a conceptual framework for the social determinants of health.¹⁷³ There, WHO acknowledged the importance of intersectoral strategies moderating the intricate web of social determinants at play in individual communities, but it did not go further to suggest strategies to address the SDoH.¹⁷⁴ These intersectoral strategies would presumably focus on improved resource sharing and joint decision making between people who are interested in and affected by the policy choices. Prior examples of these intersectoral policies include nationwide school programs supporting the transition from school to work.¹⁷⁵ Another example is Chile's "Puente" program, which provides benefits packages to low-income citizens to improve their quality of life.¹⁷⁶

These intersectoral strategies would be one facet of how HJPs could coordinate participating nations' efforts and move local patient concerns to a national or international level. WHO has not applied the conceptual framework to establish intersectoral policies through existing channels because there aren't any with the capacity to incorporate and enforce them. HJPs would complement this conceptual framework and provide the legal infrastructure increasing the participatory nature of the policy negotiations. Furthermore, a global system of HJPs could increase concerted efforts toward balancing policy outcomes and avoiding global inequity.

Another legal mechanism that could complement HJPs could be the use of the United Nations' "cooperatives." This initiative, which began approximately eleven years ago, concerns an autonomous "association of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly-owned and democratically-controlled enterprise."¹⁷⁷ Members are elected to advise policy initiatives, and UN agencies rely on the cooperatives for insight into how the change would impact their cooperative areas.¹⁷⁸ Some groups are topical,

¹⁷³ See Orielle Solar & Alec Irwin, *A Conceptual Framework for Action on the Social Determinants of Health*, Social Determinants of Health Discussion Paper 2, WHO (2010).

¹⁷⁴ See *id.* at 56.

¹⁷⁵ *Id.*

¹⁷⁶ *Id.* at 56–57.

¹⁷⁷ UN, *About Cooperatives*, *supra* note 71.

¹⁷⁸ *Id.*; see generally G.A. Res. 65/184, *Cooperatives in Social Development* (Dec. 21, 2010).

and some are focused on general participation within the member state.¹⁷⁹ Yet the cooperatives did not seem to carry equal weight in all countries, or even as a long-term solution, despite the UN's efforts to increase awareness.¹⁸⁰

The UN secretary general recently commented on cooperatives' dependence on a supportive and enabling legal environment to improve pandemic responses.¹⁸¹ One example used in the report explained the model of a cooperative in Spain. The group worked to generate five thousand new jobs in the face of job loss from the pandemic.¹⁸² Some countries, like Argentina, have even taken to including cooperatives in their national budgets.¹⁸³

While cooperatives have seen some success, a framework establishing HJPs as the advisory structure—and networking with cooperatives as needed—might better coordinate movement to reduce global and national health inequities. The structure of UN cooperatives functions much the same as HJPs, which makes them a clear group with which HJPs can transfer information and direct responses to SDoH. Cooperatives have been helpful at rectifying the socioeconomic strain from the pandemic. But as the UN secretary general explained, cooperatives need a more supportive legal structure if they are to function well.¹⁸⁴

The report further acknowledges that the International Cooperative Alliance statement, a compilation of the guidelines to which cooperatives should adhere, should be binding. But because there is no “legal responsibility or a conducive legal environment to abide by the statement at the national level,” the statement lacks force.¹⁸⁵ There are national-level laws governing cooperatives in some states, but not in others.¹⁸⁶ In some states, legal frameworks are obstacles for the cooperatives rather than supportive mechanisms.¹⁸⁷ The WHO treaty incorporating HJPs would provide the necessary binding authority to which cooperatives could refer in their efforts to assist member state strategies improving the SDoH.

¹⁷⁹ See, e.g., U.N. Secretary-General, *Cooperatives in Social Development*, U.N. Doc. A/76/209, at 3–4 (July 22, 2021).

¹⁸⁰ See G.A. Res. 65/184, *Cooperatives in Social Development* (Dec. 21, 2010).

¹⁸¹ See U.N. Secretary-General, *Cooperatives in Social Development*, U.N. Doc. A/76/209, at 2 (July 22, 2021).

¹⁸² *Id.* at 3.

¹⁸³ *Id.* at 4.

¹⁸⁴ See *id.* at 2.

¹⁸⁵ See *id.* at 6.

¹⁸⁶ See *id.* at 12.

¹⁸⁷ See *id.* at 8.

Finally, in recent years, WHO has increased efforts to coordinate movement towards universal health coverage (UHC), presumably as a way to increase access to the highest attainable level of health.¹⁸⁸ The current goals are to increase attention on health systems and healthcare infrastructure so that everyone can access healthcare everywhere.¹⁸⁹ UHC2030 is guided by the same key principle as HJPs—increasing access to health—but the two differ in many respects. While UHC2030’s mission is principled on leaving no one behind and utilizing a rights-based approach to increase transparency, accountability, and equity, it does not utilize law as a tool for health.¹⁹⁰

The Civil Society Engagement Mechanism for UHC2030 does work to increase public health financing and focus on the role of health workers to raise civil society voices.¹⁹¹ Once again, this channel is a wonderful mechanism to increase advocacy efforts to ensure UHC policy initiatives are inclusive and equitable, but they do not address legal obstacles individuals face that prevent them from accessing health and wellbeing.

HJPs uniquely combine medical and legal advocates to complement the current mission of UN cooperatives and the Civil Society Engagement Mechanism for UHC2030. Just as HJPs can direct those SDoH that are better addressed by the UN to cooperatives, HJP advocates can rely on the Civil Society Engagement Mechanism to set progressive goals at the international level. In other words, HJPs can coordinate with cooperatives for micro- and mesolevel change, while they network with the Civil Society Engagement Mechanism for macrolevel policy change. Plugging into the networks of both systems would streamline information sharing to coordinate both initiatives’ efforts from local concerns up to the existing international groups.

A binding framework for HJPs could create synergy between the goals for universal health coverage, goals for better health and wellbeing, and goals for improved welfare. This binding framework would only require that medical and legal advocates be used to incorporate law both on

¹⁸⁸ See *Universal Health Coverage*, WHO (Oct. 5, 2023), [https://www.who.int/news-room/factsheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/factsheets/detail/universal-health-coverage-(uhc)) [<https://perma.cc/GQJ9-5MEZ>].

¹⁸⁹ See generally G.A. Res. 74/2, Political Declaration of The High-Level Meeting on Universal Health Coverage (Oct. 10, 2019).

¹⁹⁰ UNIVERSAL HEALTH COVERAGE 2030, INTERNATIONAL HEALTH PARTNERSHIP, GLOBAL COMPACT FOR PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE, https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/mgt_arrangemts_docs/UHC2030_Official_documents/UHC2030_Global_Compact_WEB.pdf [<https://perma.cc/W46A-78F6>].

¹⁹¹ See generally Informational Flyer, *supra* note 71.

the individual level for consumers and on the intergovernmental level for policy change and additional agreements. The FCTC was approved by two-thirds of member states to create binding agreements, but it also used language that allows for national implementation of those agreements. Likewise, a framework outlining the procedure of HJPs could allow for the flexibility for individual member states to choose whether they want to apply the framework towards universal health coverage or another strategy increasing access to health. There must be a coordinated effort between each of these initiatives to best utilize resources and effectively address global health needs. A treaty on HJPs offers the binding standardization necessary to accomplish this.

C. EXPECTED OUTCOMES AND POTENTIAL OBSTACLES OF AN HJPS-BASED WHO TREATY

As with most issues in international law, a treaty utilizing the HJP framework requires intentional consideration of other logistical obstacles. In 2016, WHO's third global health security financing meeting highlighted that any multisectoral efforts and investments must be "underpinned by strong national ownership and leadership at the highest level."¹⁹² Much the same is true for health rights. Investment into the infrastructure for HJPs would not be a one-time contribution, but an ongoing commitment to domestic solutions and sustainability. Between countries, the Civil Society Engagement Mechanism could provide the structure for coordination of financing.¹⁹³ Most funding for HJPs in the United States comes from government support or law school clinics, but if the model was to be scaled to international implementation, financing for attorneys and support staff must be available nationally, regionally, and internationally.¹⁹⁴

Of course, individual countries have differing financing options to address these needs. Legal and regulatory frameworks in each country set the "ecosystem of a country's approach towards the health and wellbeing of its people."¹⁹⁵ Within the United States, for example, some options may

¹⁹² WHO, *Delivering Global Health Security through Sustainable Financing*, at 8 (2018), <https://iris.who.int/bitstream/handle/10665/274158/WHO-WHE-CPI-2018.38-eng.pdf?sequence=1> [<https://perma.cc/PLJ8-XEU2>] [hereinafter WHO, *Delivering Global Health Security through Sustainable Financing*].

¹⁹³ See generally Informational Flyer, *supra* note 71.

¹⁹⁴ See Matthew, *supra* note 37, at 7.

¹⁹⁵ WHO, *Regulations and Laws Promoting Health and Well-Being Goals (SDG3) in WHO South-East Asian Countries*, at 1 (2022) https://iris.who.int/bitstream/handle/10665/362021/9789290209805_eng.pdf?sequence=1 [<https://perma.cc/F8RB-QQ2D>]; see

involve using reimbursement funding through Medicaid-managed care organizations for medically necessary legal services designated in lieu of other, more costly services.¹⁹⁶ This would also allow flexibility for individual countries to choose to allocate their resources to the areas that need it most in each country, rather than based on a one-size-fits-all healthy living solution set by one country's interpretation of "health." There is preexisting investment infrastructure at the national level, the regional level (e.g., Pan American Health Organization), and the international level at WHO.¹⁹⁷ Continuous investment at the national level has the potential to build resilient health systems that can help to achieve the UN's Sustainable Development Goals and continuous learning to improve sociolegal determinants of health.¹⁹⁸ Sustainable financing of equity-based health solutions is also one of the highest determinants of health improvement in a country.¹⁹⁹

There remains the initial question of what investment occurs at the regional or international level. If a country lacks the funding of strategic planning cycles to create change, there are existing mechanisms established for international financing, such as the World Bank International Development Association, Asian Development Bank, and others. HJPs would be used to connect national groups to such mechanisms if necessary. To create equity-focused legal frameworks for the success of HJPs, any country agreeing to this proposed treaty must pay close attention to the long-term sustainable financing of national, regional, and international HJPs.

A second consideration in treaty negotiations for a proposed HJP framework is how to establish norms and standards when global governance must incorporate differing worldviews and even outright disagreement for the need for an international governing body. It must be noted, however, that this Comment discusses the shortcomings and advantages of current legal tools such as the IHR to equitably address the SDoH and reach the Sustainable Development Goals. In discussing these shortcomings, a framework for international feedback and policy changes must be

also The Quality Payment Program: A Primer on Improvement Activities for MLPs, NAT'L CTR. FOR MED. LEGAL P'SHIP GEO. WASH. (Apr. 2, 2018), <https://medical-legalpartnership.org/mlp-resources/quality-payment-program-primer/> [<https://perma.cc/UCM7-FRBW>].

¹⁹⁶ Matthew, *supra* note 37, at 34 (proposing six other potential options for funding HJPs in the United States).

¹⁹⁷ Siddiqi, *supra* note 101, at 15.

¹⁹⁸ See WHO, *Delivering Global Health Security through Sustainable Financing*, *supra* note 192, at 11.

¹⁹⁹ Ciccone, *supra* note 91, at 86.

done with collaboration and synergy. Furthermore, the proposed treaty in this Comment works to amplify individual voices to the global stage so that policymakers can know how to address global health and advise on equitable solutions. WHO's normative approach places it in a unique position to "provide guidance and leadership in improving national legal compliance with respect to laws and norms prescribing global health goals."²⁰⁰ Yet the relationship between international norms and national legal compliance is not well understood.²⁰¹

HJPs would guide how and to what extent national laws implement WHO's goals and treaties according to effective governance indicators. WHO advises and aids national programs, but its power to enforce is limited. But the focus of HJPs is to service a designated population by addressing unmet legal needs (defined by national legal systems). HJPs are creatures of agreement between medical and legal disciplines that rely on information sharing and efficient funding. They serve from a bottom-up lens and are bound by the norms and standards in place for the medical and legal communities. When a dispute arises at the national level, it would be resolved in accordance with the laws of that sovereign state. Thus, WHO enforcement would be up to member states, not the intrinsic power of WHO. When an international or regional dispute arises, the framework's human rights principles would guide, and disputes would be resolved accordingly. An agreement implementing this approach would be focused on providing access to justice around the globe. Collaboration, negotiation, legislation, and litigation create the environment for health needs to be addressed within each state. This is just as much a function of the law as increasing accountability and defining standards and norms within a community. HJPs are on the forefront of channeling legal and medical needs and to each one of these categories so that individuals can access justice to better address their health.

III. CONCLUSION

The COVID-19 pandemic unearthed inequitable access to health. The United Nations has recognized that health is a human right inextricably bound up in a person's access to SDoH. Housing, safety, food, water, and timely prevention and treatment of disease all influenced the ways in which the COVID-19 pandemic impacted countries. Health systems

²⁰⁰ Regis & Kastler, *supra* note 162, at 140.

²⁰¹ *Id.* at 149.

around the United States (and indeed the world) buckled under the pressure to meet individuals' health needs. Our legal systems were unprepared to remedy any inequities because they were appropriately reacting to the emergency. There is now a collective opportunity to establish the mechanism that will assist in avoiding global health inequities that made the COVID-19 pandemic so harmful to certain groups.

Although global health discourse has crept towards a human rights-based approach to health, formal mechanisms must be put in place to standardize the approach, increase accountability, and provide cultural flexibility for each member state's unique health needs. A treaty implementing an HJP model that acts solely as a channel for increasing voices and advocacy provides a proper balance between each of these considerations.

WHO has a unique role in providing guidance to individual member states, standardizing approaches between states, and binding states to adhere to specific negotiated agreements towards health. Utilizing a combination of soft-law mechanisms and hard, binding laws would best balance the desire for member state buy-in as well as require enforcement mechanisms. Global health law has developed out of national security concerns and concerns for the economic development of individual states, and trade regulations have been effective at avoiding health-harming products. But to effectively increase global health equity, the focus must shift to one of collaborative, human rights-based reasoning for health policies.

Law can be used both as a tool to increase access to justice and health as well as a tool to coordinate efforts focused on improving health equity. Any future effort towards improving health equity requires both a top-down and a bottom-up approach. This is only possible through partnerships that remain consistent channels for advocacy. HJPs are thus the most appropriate tool to channel law into action and improve health equity at the individual, community, national, and international levels.