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Imagining Global Health with Justice: Transformative Ideas for Health and Wellbeing While Leaving No One Behind

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Imagining Global Health with Justice: Transformative Ideas for Health and Well-Being While Leaving No One Behind

LAWRENCE O. GOSTIN* & ERIC A. FRIEDMAN**

TABLE OF CONTENTS

INTRODUCTION	1537
I. FROM UNIVERSAL HEALTH COVERAGE TO HEALTH FOR ALL: THE THREE STRANDS OF GLOBAL HEALTH	1545
A. UNIVERSAL HEALTH COVERAGE	1545
B. PUBLIC HEALTH SERVICES	1546
C. SOCIAL DETERMINANTS OF HEALTH	1547
D. PROGRESS IN GLOBAL HEALTH THROUGH INTERACTIONS AMONG HEALTHCARE, PUBLIC HEALTH, AND SOCIAL DETERMINANTS	1550
II. HEALTH FOR SOME	1552
A. GLOBAL HEALTH INEQUALITIES	1552
B. DOMESTIC HEALTH INEQUALITIES	1553
III. MOVING BEYOND GLOBAL HEALTH TO GLOBAL HEALTH WITH JUSTICE	1556
A. NORMATIVE FOUNDINGS OF GLOBAL HEALTH WITH JUSTICE	1556
B. IMPLICATIONS OF NORMATIVE UNDERPINNINGS	1559
C. TWO MORE CONDITIONS OF GLOBAL HEALTH WITH JUSTICE	1560
IV. THE LEGAL GROUNDING OF GLOBAL HEALTH WITH JUSTICE: THE RIGHT TO HEALTH	1561
V. FRAMEWORK CONVENTION ON GLOBAL HEALTH: IMAGINING GLOBAL HEALTH WITH JUSTICE	1565
A. THE POWER OF A TREATY	1570

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B.	THE CORE CONTENT OF THE FCGH	1572
C.	THE STRUCTURE OF THE FCGH	1576
D.	IN THE NATIONAL INTEREST: WHY GOVERNMENTS SHOULD SUPPORT THE FCGH AS AN EMPOWERING INSTRUMENT	1578
E.	TAKING THE FCGH FORWARD	1579
VI.	NATIONAL HEALTH EQUITY PROGRAMS OF ACTION	1581
A.	THE SEVEN PRINCIPLES OF HEALTH EQUITY PROGRAMS OF ACTION.	1584
1.	Maximizing Health Equity	1584
2.	Empowering Participation and Inclusive Leadership	1585
3.	Health Systems and Beyond	1585
4.	Every Population Counts.	1586
5.	Actions, Targets, and Timelines	1586
6.	Comprehensive Accountability	1586
7.	Sustained High-Level Political Commitment.	1587
B.	WHAT GOVERNMENTS WOULD GAIN FROM HEALTH EQUITY PROGRAMS OF ACTION	1587
C.	CHALLENGES AND PATHWAYS TO OVERCOMING THEM	1589
D.	ADVANCING HEALTH EQUITY PROGRAMS OF ACTION.	1590
VII.	RIGHT TO HEALTH CAPACITY FUND (R2HCF).	1591
A.	THE POWER OF CIVIC ACTION FOR THE RIGHT TO HEALTH.	1592
B.	FUNDING CIVIC ACTION.	1593
C.	RIGHT TO HEALTH CAPACITY FUND: EMPOWERING CIVIL SOCIETY, EMPOWERING COMMUNITIES.	1598
1.	The R2HCF Mission and Core Focus.	1598
2.	Advancing Health Equity Beyond the Fund's Core Mission: Outstanding Questions	1599
a.	<i>To Fund or Not to Fund?: Governments.</i>	1600
b.	<i>To Fund or Not to Fund?: Direct Health Interventions for Marginalized Populations.</i>	1601

2020]	IMAGINING GLOBAL HEALTH WITH JUSTICE	1537
	3. R2HCF Governance	1602
	4. R2HCF Financing	1603
	D. TAKING THE R2HCF FORWARD.	1603
	CONCLUSION: THE TIES THAT BIND	1604
	POSTSCRIPT: TOWARDS A POST-COVID-19 HEALTH ARCHITECTURE OF GLOBAL HEALTH WITH JUSTICE	1606

INTRODUCTION

As this Article goes to press, the coronavirus disease 2019 (COVID-19) pandemic that began in Wuhan, China, in late 2019 has now fully enveloped the world¹ with cases, hospitalizations, and deaths rising daily. Our own country, the United States, has emerged as the global epicenter. We have watched in horror as the number of dead in New York climbed above the death toll of September 11, 2001, and continued to rise. The daily news reminds us that everyone is at risk. Even powerful politicians, lawmakers, and celebrities have been infected, and some have died. We worry about the health and safety of our own families and communities. Most of the country, and the rest of the world, has shut down, with stay-at-home orders, business closures, bans on public gatherings, and even cordons sanitaires (guarded areas where people cannot enter or leave). For the most part, the public is following stay-at-home advisories or orders to protect ourselves, our families, and the wider community.

But that is not the full story, for a tale even darker than that of a national and global health catastrophe is unfolding. It is a tale where rich and poor, powerful and disenfranchised, do both become infected and die, but people who are poor and disenfranchised are far more likely to become infected and perish. And although one of the world’s richest country is today’s epicenter, we have great fears that disease and death in poorer countries will rise to an even higher level of horror. (We fervently hope, however, that today’s probabilities do not become tomorrow’s reality.)

Here in the United States, communities that have long been suffering discrimination and marginalization, like black, Latino, and Native American populations, are at heightened risk of infection and fatal complications, driven by crowded conditions, underlying health conditions, and inadequate access to healthcare.² And they are more likely to have jobs that do not offer the luxury of working from home.³ Many work in essential businesses and services that remain open

1. Kurtis Lee & Michael Finnegan, *Coronavirus Deaths Pass 100,000 Globally*, L.A. TIMES (Apr. 10, 2020), <https://www.latimes.com/world-nation/story/2020-04-10/coronavirus-death-toll-global>.

2. Editorial, *COVID-19 Is Disproportionately Killing Minorities. That’s Not a Coincidence*, L.A. TIMES (Apr. 8, 2020), <https://www.latimes.com/opinion/story/2020-04-08/coronavirus-racial-disparity>.

3. John Eligon, Audra D. S. Burch, Dionne Sarcey & Richard A. Opiel Jr., *Black Americans Face Alarming Rates of Coronavirus Infection in Some States*, N.Y. TIMES (Apr. 8, 2020), <https://www.nytimes.com/2020/04/07/us/coronavirus-race.html>.

and operational, like grocery stores and public transportation, heightening their risk even as they help keep society functioning. In a tale of a social justice turned on its head, people belonging to the most marginalized groups seem at greatest risk, such as people who are incarcerated,⁴ who are homeless,⁵ and who live in group homes for people with developmental disabilities.⁶

Meanwhile, although present numbers of infections and deaths in poorer regions of the world are comparatively low, they are growing. A doctor practicing in the eastern part of the Democratic Republic of Congo (DRC) wrote us that he is “conscious of the looming catastrophe if the Corona virus would bring about respiratory complications.”⁷ Health systems in the DRC and many other lower income countries are far less prepared than in the United States, even as we were not ready. The same doctor informed us that the referral hospital in the region’s main city, Beni, has only two oxygen concentrators and regular power cuts.⁸ The Central African Republic has three ventilators.⁹

If health systems are overrun with COVID-19 patients, or vaccination programs are suspended in the face of the pandemic, or medical supply chains are disrupted, how many more people will lose their lives from other diseases and health threats? The United Nations warns of resources being diverted from sexual and reproductive health (including to prevent maternal mortality), while domestic violence soars with women locked down in the same homes as their abusers.¹⁰ And once therapies and vaccines are developed, will they be equitably distributed based on need, or will they go people in the countries most able to pay for them, or where they are manufactured? Current signs are worrying; critically needed medical supplies and equipment are going primarily to the United States and countries in Europe, which can pay more.¹¹

The vulnerabilities continue. People who live in packed areas, like slums or camps for refugees or internally displaced persons, cannot practice physical

4. Editorial, *America’s 2.3 Million Prisoners Are Sitting Ducks for This Virus. Here’s How to Save Them*, WASH. POST (Apr. 9, 2020, 4:19 PM), https://www.washingtonpost.com/opinions/americas-23-million-prisoners-are-sitting-ducks-for-this-virus-heres-how-to-save-them/2020/04/09/2dd9479e-79c6-11ea-b6ff-597f170df8f8_story.html.

5. Emma Gray Ellis, *For Homeless People, Covid-19 is Horror on Top of Horror*, WIRED (Apr. 2, 2020, 12:43 PM), <https://www.wired.com/story/coronavirus-covid-19-homeless/>.

6. Danny Hakim, *‘It’s Hit Our Front Door’: Homes for the Disabled See a Surge of Covid-19*, N.Y. TIMES (Apr. 17, 2020), <https://www.nytimes.com/2020/04/08/nyregion/coronavirus-disabilities-group-homes.html>.

7. E-mail from Réginald Moreels, Humanitarian Surgeon & Former Minister of Int’l Cooperation, Belg., to Eric A. Friedman, Glob. Health Justice Scholar, Georgetown Univ. Law Ctr. (Apr. 6, 2020, 6:08 AM) (on file with author).

8. *See id.*

9. Aryn Baker, *Few Doctors, Fewer Ventilators: African Countries Fear They Are Defenseless Against Inevitable Spread of Coronavirus*, TIME (Apr. 7, 2020, 9:11 AM), <https://time.com/5816299/coronavirus-africa-ventilators-doctors/>.

10. U.N., POLICY BRIEF: THE IMPACT OF COVID-19 ON WOMEN 2 (2020), https://www.un.org/sites/un2.un.org/files/policy_brief_on_covid_impact_on_women_9_april_2020.pdf.

11. Jane Bradley, *In Scramble for Coronavirus Supplies, Rich Countries Push Poor Aside*, N.Y. TIMES (Apr. 9, 2020), <https://www.nytimes.com/2020/04/09/world/coronavirus-equipment-rich-poor.html>.

distancing¹² and have reduced access to clean water and hygiene. Diseases like HIV and tuberculosis increase risk of complications. Social protection systems that can provide food, income, and other essentials of life are still weaker in poorer nations. People may have no choice to work if they are to eat or to pay for healthcare. The economic effects and possible interruptions in supply chains threaten food security, particularly in regions already facing hunger crises, and among the most vulnerable people.¹³ Further, although wealthy countries have the resources to recover economically, what will be the longer term effects on health systems and people's ability to earn enough money to purchase food and medicine in low- and middle-income countries?

COVID-19 is novel, but this second, darker narrative is painfully familiar. Yes, until this pandemic, rather than recording ever-growing suffering, the global health headlines had come to assume a welcome familiar ring—new annual lows for maternal and child mortality,¹⁴ increasing numbers of people on antiretroviral therapy to combat HIV,¹⁵ and rising life expectancies in much of the world, with the fastest growth in low- and lower-middle-income countries.¹⁶

Yet a glance around the world today—a view from the ground even before COVID-19—was telling a different story. Talk to people in communities of color in the United States, or indigenous communities, or people who live in poverty or have little education, or LGBTQIA+ people,¹⁷ or migrant workers. People who

12. Aryn Baker, *Few Doctors, Fewer Ventilators: African Countries Fear They Are Defenseless Against Inevitable Spread of Coronavirus*, TIME (Apr. 7, 2020, 9:11 AM), <https://time.com/5816299/coronavirus-africa-ventilators-doctors/>.

13. *Over 10,000 Confirmed COVID-19 Cases in Africa; Zimbabwe and South Sudan Among Most Vulnerable*, UN NEWS (Apr. 8, 2020), <https://news.un.org/en/story/2020/04/1061352> [<https://perma.cc/4PML-VCN4>].

14. See, e.g., *Maternal Mortality*, WORLD HEALTH ORG. (Sept. 19, 2019), <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality> [<https://perma.cc/H77P-S5EL>] (explaining that between 2000 and 2017 the number of maternal deaths per 100,000 live births decreased by approximately thirty-eight percent worldwide); *Under-Five Mortality*, UNICEF (Sept. 2019), <https://data.unicef.org/topic/child-survival/under-five-mortality/> [<https://perma.cc/TSE5-LS27>] (explaining that the under-five mortality rate has decreased by more than half since 1990).

15. *Antiretroviral Therapy (ART) Coverage Among All Age Groups*, WORLD HEALTH ORG., https://www.who.int/gho/hiv/epidemic_response/ART_text/en/ [<https://perma.cc/N9S7-Z244>] (last visited Mar. 8, 2020) (explaining that global antiretroviral therapy coverage increased from approximately seven percent in 2005 to sixty-two percent in 2018).

16. See, e.g., *GDP Growth (Annual %)*, WORLD BANK, <https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?end=2018&start=2018&view=map> [<https://perma.cc/74VC-J7H9>] (last visited Mar. 8, 2020); *Life Expectancy at Birth, Total (Years)*, WORLD BANK, <https://data.worldbank.org/indicator/SP.DYN.LE00.IN> [<https://perma.cc/GR8Q-DULM>] (last visited Mar. 8, 2020).

17. LGBTQIA+ stands for lesbian, gay, bisexual, transgender, questioning (or queer), intersex, and asexual. Along with the standard usage of LGBT, we also include intersex in our shorthand for people of different gender identities and sexual orientation because this is a condition not encompassed by LGBT. Intersex individuals are born with an anatomy that does not fit typical definitions of male or female. Questioning refers to people who are uncertain of their sexual orientation or gender identity. Queer is a broad term that refers to people who are not heterosexual or not the gender that matches the sex assigned at birth. People who are asexual experience little or no sexual attraction. And the + symbol denotes any other sexual orientation or gender identity not included. See Michael Gold, *The ABCs of L.G.B.T.Q.I. A.+*, N.Y. TIMES (June 7, 2019), <https://www.nytimes.com/2018/06/21/style/lgbtq-gender-language.html>.

know what it is like to live on society's margins are not likely to speak of the triumph of global health. Rather, they might lament unaffordable medical bills, health services they cannot access, or the poor care they receive. Or they might speak of their inability to afford nutritious food or decent housing, or lack of trust in the safety of their water or the cleanliness of the air they breathe. The reason could be as simple, but as profound, as discrimination due to their race, gender, religion, or sexual orientation.

Here, we propose an ambitious agenda to bridge the gap between years of laudatory global health headlines and the realities of vast swaths of the world's people, with proposals that could comprise part of a new global health architecture to prepare the world for the next pandemic, which must have the goal of protecting even the poorest people in the poorest countries. We offer three far-reaching ideas that, collectively, would span from international law to domestic law and policy to grassroots empowerment: a Framework Convention on Global Health, a Right to Health Capacity Fund, and health equity programs of action. If enacted, these proposals would have a transformative impact on population health, leaving no one behind.

How is it that astounding health progress has been accompanied by deep disquiet? This riddle has an answer: it is possible to achieve significant advances in overall health outcomes, but with the benefits distributed inequitably. That is, we can make great strides in global health, but without justice. Global health with justice—a world where all people, wherever they live and whoever they are, can equally benefit from health improvements—remains seemingly over the horizon. We live in a world where scientists can alter human DNA with growing efficacy,¹⁸ discover new drugs by combining big data with machine learning,¹⁹ and use light to control neural activity in living brains.²⁰ Yet we seem unable (probably unwilling) to rectify the grave injustice of a mother or infant dying needlessly, or that by one measure, at least half the world's people cannot access essential health services.²¹ Huge numbers of the world's people, overwhelmingly poor and marginalized, have not benefited from global health improvements. And in an era of human rights, of social media and mass communications, of rising expectations, people who are poor and marginalized know that this is not how it needs to be.

18. See, e.g., Satyajit Patra & Araromi Adewale Andrew, *Human, Social, and Environmental Impacts of Human Genetic Engineering*, 4 J. BIOMEDICAL SCI. 1, 1–2 (2015).

19. See, e.g., Jennifer Bresnick, *Informatics, Machine Learning Accelerate Pharmaceutical Discovery*, PRECISION MED. NEWS (July 17, 2017), <https://healthitanalytics.com/news/informatics-machine-learning-accelerate-pharmaceutical-discovery> [<https://perma.cc/7KMW-N3G3>].

20. See, e.g., Akash Guru et al., *Making Sense of Optogenetics*, 18 INT'L J. NEUROPSYCHOPHARMACOLOGY 1, 1 (2015).

21. See News Release, World Health Org., World Bank and WHO: Half the World Lacks Access to Essential Health Services, 100 Million Still Pushed into Extreme Poverty Because of Health Expense (Dec. 13, 2017), <https://www.who.int/news-room/detail/13-12-2017-world-bank-and-who-half-the-world-lacks-access-to-essential-health-services-100-million-still-pushed-into-extreme-poverty-because-of-health-expenses> [<https://perma.cc/CN5E-ALWY>].

What could transform these profound injustices? In a phrase, truly implementing the universal right to health—a right that is codified in international treaties²² and national constitutions around the world.²³ Imagine if we could truly achieve the right to health—for all. It would require three indispensable conditions for good health, which we will categorize as universal health coverage, public health services, and the social determinants of health. First, people need access to comprehensive and high-quality healthcare services that are universally affordable, accessible, and equitably distributed. Second, every community requires robust public health services, including potable water, clean air, safe and nutritious food, tobacco control, vector abatement, and injury prevention. And third, we need a sharp focus on social determinants of health, outside the realm of healthcare and public health, like income, housing, education, employment, and nondiscrimination.²⁴

Yet in many countries around the world, governments remain isolated from the needs of their people; or they rule by fear and force rather than consent and compromise; or they are too easily swayed by corporate—rather than the public’s—interest. There is, in other words, a growing disconnect between those who govern and the people whom they govern. Achieving global health with justice requires governments that are accountable to their people. This accountability, then, is a fourth and necessary element of global health with justice.

Global forces, however, make it exceedingly hard to achieve health with justice. First, there are vast differences in the resources available to governments around the world. Low- and middle-income countries often lack the resources needed to safeguard the public’s health, especially if there are significant disease burdens and large or fast-growing populations. As we write, the possibility of COVID-19 unleashing a catastrophe on countries with weak health and social support systems is frightfully real. Second, no country acting alone can ensure all of the conditions for health. Think about transnational forces such as greenhouse gas emissions, or global rules and norms in areas such as trade and investment,²⁵ or transnational corporations that actively seek low-tax, low-regulation destinations—or the rapid spread of communicable diseases, like COVID-19. Thus, a fifth condition for global health with justice is an international order and transnational action that systematically advances the conditions for good health and for accountable governance, particularly for people in countries on the short end of global health disparities.

It is not enough simply to diagnose the causes of poor health and gross injustice. More important is having a genuine impact on people’s lives. Thus, we focus

22. See, e.g., G.A. Res. 2200A (XXI), annex, International Covenant on Economic, Social and Cultural Rights art. 12 (Dec. 16, 1966).

23. See Mark Wheeler, UCLA, *A Constitutional Right to Health Care: Many Countries Have It, but Not the U.S.*, SCIENCE DAILY (July 19, 2013), <https://www.sciencedaily.com/releases/2013/07/130719104927.htm> [<https://perma.cc/A9JU-HM54>].

24. See LAWRENCE O. GOSTIN, *GLOBAL HEALTH LAW* 24–25, 417–18 (2014).

25. See Ole Petter Ottersen et al., *The Political Origins of Health Inequity: Prospects for Change*, 383 LANCET 630, 643–47 (2014) (describing the impact of investment treaties on health equity).

on how to overcome these obstacles, to bend public institutions in the direction of the public interest and human rights. Six years ago, we framed the idea of global health with justice as the critical thesis of a book on global health law.²⁶ Our aim now, building on this idea, is to advance the quest toward global health with justice by offering three far-reaching and mutually reinforcing proposals that taken together, if implemented rigorously, would transform our world toward better health and a far fairer distribution of the public “good” of human health. And it would help to protect all of us, including in the poorest countries and in the most marginalized communities, against the next pandemic that sweeps the globe, epidemic that threatens a region, or local outbreak that could devastate communities.

The first idea is negotiating and adopting a Framework Convention on Global Health (FCGH), initially proposed in *The Georgetown Law Journal* at the founding of the O’Neill Institute for National and Global Health Law more than a decade ago.²⁷ Grounded in the right to health and aimed at national and global health equity, this global treaty would take the international right to health to the next level, bringing specificity to presently vague human rights standards and providing concrete tools to achieve them. The FCGH provides a pathway to achieve global health with justice through core human rights principles of equality, participation, and accountability; creation of national and domestic financing frameworks; and embedding a “Health in All Policies” approach in national law and in international agreements.²⁸ It would create a missing regime of accountability for the right to health.

The second idea is to build health equity programs of action, primarily a domestic strategy to close health inequities.²⁹ Programs of action would be founded on two core insights: we must plan for and measure what we value, and marginalized populations face both shared and particular obstacles to health equity. These systematic, systemic, and inclusive programs of action would cut across the social determinants of health, putting countries on the path toward domestic health equity, with their actions incorporated into national health and development plans. Although programs of action would have the most direct impact at the national level, they could also be developed locally. And when

26. GOSTIN, *supra* note 24, at 59–61, 423–28.

27. See Lawrence O. Gostin, *Meeting Basic Survival Needs of the World’s Least Healthy People: Toward a Framework Convention on Global Health*, 96 GEO. L.J. 331, 374–91 (2008).

28. A “Health in All Policies” approach entails all sectors systematically taking health into account when they formulate policies, seeking to avoid harm to health and instead improve population health and health equity. *The 8th Global Conference on Health Promotion, Helsinki, Finland, 10–14 June 2013*, WORLD HEALTH ORG., https://www.who.int/healthpromotion/conferences/8gchp/statement_2013/en/index1.html [<https://perma.cc/877G-RSZE>] (last visited May 19, 2020) (announcing a “Health in All Policies” framework at the Eighth Global Conference on Health Promotion in Helsinki, Finland).

29. See generally O’NEILL INST. FOR NAT’L & GLOB. HEALTH LAW, HEALTH EQUITY PROGRAMS OF ACTION: AN IMPLEMENTATION FRAMEWORK (2019), <https://oneill.law.georgetown.edu/media/HEPA-Guide-1.pdf> [<https://perma.cc/7UB8-H999>] (proposing a comprehensive approach to create a sustained national focus on health equity).

governments truly take action to ameliorate health injustices, it can impact neighboring states, regions, and the world.

The third idea is to establish a Right to Health Capacity Fund (R2HCF), which responds to the imperative of financing the right to health and those who are fighting for it. Even worthwhile ideas need resources for effective implementation. The R2HCF would finance bottom-up social mobilization for the right to health, from civil advocacy to mechanisms for inclusive participation, and from social accountability to government right to health enforcement capacities. It would be a fund chiefly for the marginalized—the populations neglected by their own governments and the civil society organizations neglected by donors.

During the past several decades, the world made once unthinkable progress in global health, even as COVID-19 demonstrates how far remains to go in having health and social systems that can protect global health in the face of newly emerging health threats. Will we see a justice-focused COVID-19 recovery, and then decades marked by progress on justice in health? We are confident that it is possible, for we have seen it before. The AIDS response taught us that the best way to achieve transformational political action is through bottom-up social mobilization. Social justice movements the world over, typically led by the people experiencing the injustices—whether people living with HIV, women, LGBTQIA+ communities, people with disabilities, or racial or ethnic minorities—have demonstrated their enormous power. The instruments of political action include social protest, public interest litigation, and lobbying legislatures.

If the United Nations and its specialized agencies (such as the World Health Organization), global institutions (for example, the Global Fund to Fight AIDS, Tuberculosis and Malaria, Gavi, and Unitaid), and governments partner with civil society and communities, the answer to whether we will see historic progress on justice in health will be a resounding “yes.” It is past time to take the bold actions that global health with justice demands. Here, we offer a detailed framework not only to continue, and accelerate, the unparalleled improvements in aggregate health worldwide and to help protect us from emerging health threats, but also to truly fulfill the U.N. Sustainable Development Agenda’s pledge to leave no one behind.³⁰ In a phrase, with community mobilization and political will, we can realize global health with justice—the ultimate measure of the right to health.

These three proposals have their origins in the literature. The FCGH has a history of a dozen years, though it has evolved considerably and deepened over time.³¹ The O’Neill Institute developed a comprehensive framework of health equity programs of action.³² And in the pages of the *Health and Human Rights Journal*, dozens of health and human rights advocates proposed a Right to Health

30. G.A. Res. 70/1, Transforming Our World: The 2030 Agenda for Sustainable Development, at 1 (Sept. 25, 2015) (“As we embark on this collective journey, we pledge that no one will be left behind.”).

31. See Gostin, *supra* note 27, at 335.

32. See generally O’NEILL INST. FOR NAT’L & GLOB. HEALTH LAW, *supra* note 29 (detailing seven principles to guide countries and local jurisdictions in developing and implementing health equity programs of action).

Capacity Fund.³³ This Article will further conceptualize all three of these approaches, including reasons for governments and international institutions to support them and concrete paths forward for each. We show how these three ideas act in concert, creating a cumulative real-world impact. And we firmly plant all three under the banner of global health with justice, a concept that we root here in powerful theories of justice that aim at human flourishing for all.

Most significantly, this Article presents the FCGH, health equity programs of action, and the R2HCF as a formidable and systematic set of proposals with transformative potential for advancing the right to health and global health with justice, and even creating health and social systems that can withstand new health threats. It covers actions through both international law and national law and policy, via the FCGH and health equity programs of action, respectively. And it covers a proposal to bridge the often-cavernous gap between commitments states assume through treaties, statutes, and policies on the one hand, and actually implementing them, on the other: empowering civil society and communities through the R2HCF. We also explain how the three instruments could interact, bolstering one another, and all helping to empower people as their own best advocates for justice.

Given the imperative and urgency of global health with justice, we aim to reach all those who write, and act, in the fields of global health and social justice. We want to encourage global movements around big ideas, with partners who will further develop and sharpen these proposals and help them come to fruition—an FCGH adopted and ratified, national health equity programs of actions with high-level political support in every country, an international R2HCF established and funded.

All of these will require government support. Government health officials would have a leadership role, including to advance the FCGH through the World Health Organization (WHO) or United Nations. Legislators, health and other agency officials, and other government policymakers could also advance these proposals through their own channels. High-level political leadership will be essential for health equity programs of actions to be developed, resourced, and rigorously implemented. Foundations alone could finance an R2HCF, but far more funding would be available with government financial support.

Leadership from heads of state and government could help propel these ideas onto national and global agendas, providing critical support. The leadership at the WHO, the global health agency, could provide crucial backing for all three of these proposals—and the WHO could itself initiate a process toward the FCGH.

And perhaps above all, we hope that this Article will reach members of civil society. For civil society's passion and social mobilization are vital to turn these proposals into a reality.

33. Eric A. Friedman et al., *Global Health in the Time of COVID-19: Responsive Health Systems Through a Right to Health Fund*, 22 HEALTH & HUM. RTS. J. (forthcoming June 2020), <https://www.hhrjournal.org/2020/05/global-health-in-the-age-of-covid-19-responsive-health-systems-through-a-right-to-health-fund/> [<https://perma.cc/DPZ6-ALE7>].

I. FROM UNIVERSAL HEALTH COVERAGE TO HEALTH FOR ALL: THE THREE STRANDS OF GLOBAL HEALTH

What does it take to make a population healthy? Or put another way, what can governments do to assure the conditions in which people can be healthy?³⁴ These are deceptively simple questions, but the answers are insufficiently acknowledged, much less implemented. Healthy people in healthy communities have three requirements: universal health coverage, public health, and positively structured social determinants of health.

The scope of the three ideas we propose, unlike many health interventions, reach far beyond healthcare and the universal health coverage that, at least until COVID-19, was consuming much of the global health agenda—even as they are indispensable components. Here, we expand on why, and how, these three essential conditions will bring us far along the path of global health with justice. Every country needs universal health coverage, but all countries also need to provide the full panoply of public health services and assure the vital social determinants of good health.

A. UNIVERSAL HEALTH COVERAGE

When most people think about what good health requires they are likely to choose the first condition of population health—curative treatment in the event of illness. People yearn for affordable, equitable, and high-quality healthcare, including well-trained health workers, well-equipped health facilities, and effective medicines. Indeed, this is the focus of both national political conversations (healthcare reform) and global resolutions (for example, the September 2019 U.N. Political Declaration of the High-Level Meeting on Universal Health Coverage).³⁵

Most of the political space, and financial investments, have been taken by national healthcare systems, neglecting public health and social determinants. In many ways, existing policies and funding are even more neglectful of the full conditions for public health. Resources are allocated or donated primarily for disease-specific programs rather than investment in national health systems.

Healthcare—physical and mental medical services—is a vital component of good health. It spans from clinical prevention services (such as screenings for

34. No government policy can assure that any given person will be healthy. Every individual is born and lives with unique capacities. People may have genetic conditions that are stubbornly unalterable. Or they may have been born with a congenital disability. Or they may have suffered a catastrophic injury. But what government *can* do is create the conditions in which everyone has a fair chance of leading a healthy and safe life, consistent with their unique capabilities.

35. See G.A. Res. 74/2, ¶ 1 (Oct. 10, 2019) (recognizing “the right of every human being, without distinction of any kind, to the enjoyment of the highest attainable standard of physical and mental health”); see also Lawrence O. Gostin et al., Correspondence, *Launching the Universal Health Coverage Legal Solutions Network*, 395 LANCET 112–13 (2019), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)32221-4/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32221-4/fulltext) [<https://perma.cc/6KYB-D7BU>] (discussing the United Nation’s universal health coverage resolution and arguing that the “universal health coverage must be built on legal foundations, the rule of law, and human rights”).

cancer, cholesterol, or hypertension) to treatment, rehabilitation, and palliative care.³⁶ Care should be of high quality throughout, including accurate diagnosis, precise and timely treatment, and culturally acceptable care.³⁷ Accessing health services or affordable medicines in the event of illness should not be hard. Nor should it impoverish sick patients and their families. People are demanding decent health services. They want caring, compassionate, and highly qualified professionals. They demand affordable access to essential medicines, vaccines, and medical devices. And they do not want to be left behind, for example, due to their poverty, social marginalization, or because they live in rural communities. With the astounding possibilities in modern medicine, it is not too much to ask that everyone—rich or poor—fairly shares the benefits.

B. PUBLIC HEALTH SERVICES

Yet, as important as they are, medical services constitute only a small part of what makes a population healthy—that is, living well throughout the lifespan. Human health is determined even more by what happens outside the healthcare system.³⁸ A second element of what good personal health, and global health, requires is essential public health services that keep us healthy in the first place. These are the attributes that are typically ensured at the population level, supplied or protected at the community level, rather than at the individual level.

36. *Primary Health Care*, WORLD HEALTH ORG. (Feb. 27, 2019), <https://www.who.int/news-room/fact-sheets/detail/primary-health-care> [https://perma.cc/9BL8-MKUX].

37. U.N., Comm. on Econ., Soc. & Cultural Rights [CESCR], General Comment No. 14: The Right to the Highest Attainable Standard of Health, ¶ 12(d), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR, General Comment No. 14] (“As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.”); Margaret E. Kruk et al., *High-Quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution*, 6 LANCET GLOBAL HEALTH e1196, e1198 (2018) (“High-quality care involves thorough assessment, detection of asymptomatic and co-existing conditions, accurate diagnosis, appropriate and timely treatment, referral when needed for hospital care and surgery, and the ability to follow the patient and adjust the treatment course as needed.”).

38. See Carlyn M. Hood et al., *County Health Rankings: Relationships Between Determinant Factors and Health Outcomes*, 50 AM. J. PREVENTIVE MED. 129, 130 (2016) (“[T]he health determinants exerting the most powerful and sustained influence on health and the distribution of disease, illness, injury, disability, and premature death in the population are social and economic factors.”); Gregfell500, *What Proportion of Health Outcomes Are Attributable to Health Care*, SHEFFIELD DPH (July 16, 2017), <https://gregfellpublichealth.wordpress.com/2017/07/16/what-proportion-of-health-outcomes-are-attributable-to-health-care/> [https://perma.cc/T6HS-2UTN] (collecting sources discussing “the extent to which health care contributes to health outcomes”); Sanne Magnan, *Social Determinants of Health 101 for Health Care: Five Plus Five*, NAT’L ACAD. OF MED. (Oct. 9, 2017), <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/> [https://perma.cc/7WRC-5BH2] (citing estimates that medical care accounts “for only 10–20 percent of the modifiable contributors to healthy outcomes for a population”); see also INST. OF MED. OF THE NAT’L ACADS., *THE FUTURE OF THE PUBLIC’S HEALTH IN THE 21ST CENTURY* 83 (2003) (“Many of the determinants of health are part of the broad economic and social context and, thus, beyond the direct control of administrators in public- and private-sector health care organizations.”).

Some public health services are basic essentials of health and life—for example, clean air, potable water, sanitation, nutritious food, and vector abatement³⁹—whereas others are necessities born of modern life, like tobacco and alcohol control, injury prevention (such as traffic safety, occupational health, and firearms control), environmental regulations, and built (physical) environments with spaces for physical activity like walking, biking, and recreating.⁴⁰ Some public health services go back centuries, even as they were a core part of the COVID-19 response, and are designed to track and respond to infectious diseases—for example, surveillance, contact tracing, partner notification, isolation, and quarantine.⁴¹

Some necessities of good health mix population-based measures with clinical health services and the health system. Prevention of disease and illness includes primary care, health screening, and vaccinations. For example, people receive vaccines through their individual health provider, but countries also conduct health education and mass immunization campaigns. Public health surveillance, data systems, and laboratories engage the health system to protect the population's health. Meanwhile, some population-based public health measures have an individual component. A municipality might connect all homes to piped water but cut off residents who fail to pay. Regulations, safety net programs, and even well-designed subsidies can effectively promote a nutritious diet, but people's access to sufficient safe and nutritious food will often depend on their income and where they live (for example, if they live in so-called “food deserts”).⁴²

C. SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the third necessity for good health.⁴³ Broadly, these are “the conditions of daily life” and the “distribution of power, money, and resources.”⁴⁴ What matters most to foster good health through the lifecycle is determined by where you live, work, learn, and recreate. Place matters. Neighborhoods may have high levels of crime, pollution, poverty, and unemployment; or, they may have safe, clean streets, with mostly well-educated residents who hold high-paying jobs. Sometimes, neighborhoods with such vast differences in conditions of life may be only miles apart, or not even.

39. Vector abatement involves any measure to reduce or eliminate organisms (the vector), such as mosquitoes, that transmit diseases including malaria and dengue.

40. See GOSTIN, *supra* note 24, at 415.

41. See LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 290, 302–04, 428–29 (2d ed. 2008).

42. See Rebecca A. Krukowski et al., *Neighborhood Impact on Healthy Food Availability and Pricing in Food Stores*, 35 J. COMMUNITY HEALTH 315–16, 318–19 (2010).

43. Social determinants of health are sometimes considered to include the range of factors that we point to here, but out of concerns that they may be conceived of incompletely, they are sometimes described to include other determinants, such as the social (including cultural), environmental, economic (including commercial), and political determinants of health. We use the term “social determinants of health” to encompass all of these. See O'NEILL INST. FOR NAT'L & GLOB. HEALTH LAW, *supra* note 29, at 61–73.

44. WORLD HEALTH ORG., *CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH* 1, 2 (2008), https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf [<https://perma.cc/234A-W7C7>].

Social determinants are “upstream” causes of ill-health—that is, “the macro factors that comprise social-structural influences on health,” including the economic, environmental, physical, political, and social factors that determine health.⁴⁵ These conditions exist primarily outside the formal health system. They encompass, for example, childhood development and education, employment and safe working conditions, income support, housing, and social protection, and extend to such social and political factors as nondiscrimination, inclusion, and democratic participation.⁴⁶ Others relate to a person’s identity, such as gender, ethnicity, religion, or whether the person has a disability.⁴⁷ Some, like the natural and built environments, overlap with public health necessities.⁴⁸ Wealth and education are among the determinants with the most data linking them to health services and outcomes, with poorer and less-educated people consistently having less access to services and higher levels of disease and premature death.⁴⁹

Social determinants of health operate through many causal pathways to affect health, often related to people’s ability to access quality health services and public health necessities. For example, people who are poor or who face discrimination have less access to health services. Marginalized populations are more likely to live in areas without clean air, safe water, and affordable, nutritious food,⁵⁰ or not conducive to the physical distancing required during COVID-19 such as homeless encampments or slums. Big corporations often target harmful marketing campaigns to the most disadvantaged neighborhoods and communities—for example, for alcohol, tobacco, and ultraprocessed fast foods.⁵¹

Social determinants such as unemployment, homelessness, and a stressful workplace also directly affect health. Unemployment has been directly linked to

45. Nazleen Bharmal et al., *Understanding the Upstream Social Determinants of Health 1* (RAND Health, Working Paper WR-1096-RC, May 2015), https://www.rand.org/content/dam/rand/pubs/working_papers/WR1000/WR1096/RAND_WR1096.pdf [<https://perma.cc/HT2B-36PM>].

46. For a list of thirty-four social determinants, see O’NEILL INST. FOR NAT’L & GLOB. HEALTH LAW, *supra* note 29, at 61.

47. *See id.*

48. *See id.* at 65–66.

49. For country-specific information across a number of health dimensions, see *Health Equity Monitor Database*, WORLD HEALTH ORG., <http://apps.who.int/gho/data/node.main.nHE-1540?lang=en> [<https://perma.cc/32JG-LWQB>] (last visited Mar. 9, 2020).

50. MEGAN MCCONVILLE, U.S. ENVTL. PROT. AGENCY, CREATING EQUITABLE, HEALTHY, AND SUSTAINABLE COMMUNITIES: STRATEGIES FOR ADVANCING SMART GROWTH, ENVIRONMENTAL JUSTICE, AND EQUITABLE DEVELOPMENT 7–9 (2013), <https://www.epa.gov/sites/production/files/2014-01/documents/equitable-development-report-508-011713b.pdf> [<https://perma.cc/F3JW-BADW>].

51. *See* ALCOHOL JUSTICE, ALCOHOL MARKETING TO YOUTH OF COLOR (2014), <https://alcoholjustice.org/images/factsheets/AlcoholMarketingYouthofColor2014.pdf> [<https://perma.cc/8HZ6-YDRP>]; Cristina Maza, *Ads for Junk Foods and Soda Target Minorities More than Whites, Study Finds*, CHRISTIAN SCI. MONITOR (Aug. 12, 2015), <https://www.csmonitor.com/Business/The-Bite/2015/0812/Ads-for-junk-food-and-soda-target-minorities-more-than-whites-study-finds>; *Tobacco Is a Social Justice Issue: Racial and Ethnic Minorities*, TRUTH INITIATIVE (Feb. 3, 2017), <https://truthinitiative.org/research-resources/targeted-communities/tobacco-social-justice-issue-racial-and-ethnic-minorities> [<https://perma.cc/R2NZ-74DD>].

an increased risk of heart attacks.⁵² Homelessness exposes people to sweltering heat, freezing cold, wind, and rain, and leads to chronic stress, itself a driver of ill-health.⁵³ Adverse social conditions vastly increase multiple health risks, ranging from cardiovascular diseases, diabetes, and emotional distress to injuries and infectious diseases (for example, sexually transmitted infections including HIV/AIDS).⁵⁴ Low social status can lead to emotional and physical neglect or abuse (including battered children and partners), physical dependency (through alcohol, illicit drugs, and opioids), and self-harm or suicides.⁵⁵

More generally, a variety of biological pathways contribute to cancers, cardiovascular disease, mental illness, and even weight gain. Intense, prolonged stress (distress)—for example, from job loss or tense working conditions, food or income insecurity, or fear of deportation—elevates cortisol levels and epinephrine (adrenaline) levels, and promotes hypertension.⁵⁶ Generalized hopelessness can lead to depression and even suicides.⁵⁷

Social determinants themselves are interlinked and often reinforcing. Poor people and racial or ethnic minorities often live in neighborhoods with more

52. Nanci Hellmich, *Study: Unemployment May Raise Risk of Heart Attack*, USA TODAY (Nov. 19, 2012, 4:01 PM), <https://www.usatoday.com/story/news/nation/2012/11/19/unemployment-increases-heart-attacks/1710469/> [<https://perma.cc/C52L-QVGR>].

53. See Andrew Baum et al., *Socioeconomic Status and Chronic Stress: Does Stress Account for SES Effects on Health?*, 896 ANNALS N.Y. ACAD. SCI. 131, 140 (2006).

54. See Paula Braveman & Laura Gottlieb, *The Social Determinants of Health: It's Time to Consider the Causes of the Causes*, 129 PUB. HEALTH REP. (Supp. 2) 19, 24 (2014) (“Physiological regulatory systems thought to be affected by social and environmental stressors have included the . . . sympathetic (autonomic) nervous system[] and immune/inflammatory, cardiovascular, and metabolic systems.”); William C. Cockerham et al., *The Social Determinants of Chronic Disease*, 52 AM. J. PREVENTIVE MED. S5, S6 (2017) (“[T]he effect of social determinants is not limited to infectious diseases; it extends to chronic diseases as well, including cardiovascular disease, Type 2 diabetes, stroke, cancers, pulmonary diseases, kidney disease, and many other ailments.”); Tanya Telfair Sharpe et al., *Summary of CDC Consultation to Address Social Determinants of Health for Prevention of Disparities in HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis*, 125 PUB. HEALTH REP. (Supp. 4) 12–13 (2010) (discussing social determinants of HIV/AIDS, sexually transmitted diseases, and tuberculosis).

55. See, e.g., INST. FOR RESEARCH ON POVERTY, UNIV. OF WIS.-MADISON, *THE OPIOID EPIDEMIC AND SOCIOECONOMIC DISADVANTAGE* (2018), <https://www.irp.wisc.edu/publications/fastfocus/pdfs/FF32-2018.pdf> [<https://perma.cc/KNR3-SSUL>]; William C. Kerr et al., *Economic Recession, Alcohol, and Suicide Rates: Comparative Effects of Poverty, Foreclosure, and Job Loss*, 52 AM. J. PREVENTIVE MED. 469, 472–73 (2017); Maren K. Dale, *Addressing the Underlying Issue of Poverty in Child-Neglect Cases*, AM. BAR ASS'N (Apr. 10, 2014), <https://www.americanbar.org/groups/litigation/committees/childrens-rights/articles/2014/addressing-underlying-issue-poverty-child-neglect-cases/> [<https://perma.cc/E4B7-WAS6>].

56. See Jaskanwal D. Sara et al., *Association Between Work-Related Stress and Coronary Heart Disease: A Review of Prospective Studies Through the Job Strain, Effort-Reward Balance, and Organizational Justice Models*, 7 J. AM. HEART ASS'N 1, 8–10 & fig.3 (2018); Brett Spiegel, *Stress Heart Risks: New Studies Show How Stress Affects Cardiovascular Health*, HUFFPOST (April 17, 2013, 6:58 PM), https://www.huffpost.com/entry/stress-heart-risks-cardiovascular-health_n_3104449 [<https://perma.cc/U2TA-ALE9>] (explaining a study “found that the risk for stress-related heart attack increased significantly for unemployed middle-aged to elderly people and rose higher with each subsequent job loss”).

57. See E. David Klonsky et al., *Hopelessness as a Predictor of Attempted Suicide Among First Admission Patients with Psychosis: A 10-Year Cohort Study*, 42 SUICIDE & LIFE-THREATENING BEHAV. 1, 2, 7–8 (2012).

crime, homelessness, and unemployment.⁵⁸ A stable income plays a large role in determining how people experience other social determinants of health, such as whether they have decent housing, nutritious food, and safe and reliable transportation.

D. PROGRESS IN GLOBAL HEALTH THROUGH INTERACTIONS AMONG HEALTHCARE, PUBLIC HEALTH, AND SOCIAL DETERMINANTS

Interactions among these three necessary conditions for health—healthcare, public health, and social determinants of health—lead to good health or to illness, injury, disability, and premature death. Each of the key conditions for good health can affect other conditions of health. For those experiencing deficits in all three, we see a spiral of impoverishment, disease, disability, and early death. If people acquire an infection because they are forced to drink unsafe water, will they be able to receive a prompt diagnosis and treatment? If polluted air or water causes cancer, will the person be able to receive high quality, often expensive, cancer treatment? If people suffer from debilitating chronic disease, will they access a range of services? And, will they have a “good death,” including humane palliative care and pain relief?⁵⁹

The connections among these three conditions make precise measurements of the contributions of each a difficult, if not fraught, exercise, though studies, largely from the United States and Europe, consistently point to the dominant role of social determinants of health.⁶⁰ What we can better measure, though, is the level of health these interactions yield—that is, how well we are advancing toward the U.N. Sustainable Development Goal (SDG) of “[e]nsur[ing] healthy lives and promot[ing] well-being for all at all ages” (living, aging, and dying well).⁶¹ Everyone wants to live vigorously and without chronic illness or disability. And everyone wants to maintain relatively high physical and mental capacities as we age. And finally, at life’s end, we want a dignified death, free from unremitting pain and suffering.

On these measures, the world has seen great progress, even as there remains a long way to go. For every four years that passed during the quarter-century between 1990 and 2015, life expectancy globally increased by about a year, altogether from 65.4 years to 72 years.⁶² Over the same time span, maternal deaths

58. For example, a study of the largest 150 metro regions in the United States found “that people of color, in general, are much more likely to live in high-unemployment neighborhoods, regardless of their own employment status.” JUSTIN SCOGGINS ET AL., RACE, PLACE, AND JOBS: REDUCING EMPLOYMENT INEQUALITY IN AMERICA’S METROS 4 (2017), https://www.policylink.org/sites/default/files/Race_Place_Jobs_02-15-17.pdf [<https://perma.cc/34CQ-FYR9>].

59. The WHO recognizes palliative care as part of the right to health, required for many diseases to prevent and reduce pain and other suffering and to improve the quality of life. *See Palliative Care*, WORLD HEALTH ORG. (Feb. 19, 2018), <https://www.who.int/en/news-room/fact-sheets/detail/palliative-care> [<https://perma.cc/X69G-9JTG>].

60. *See, e.g.*, Hood et al., *supra* note 38, at 132 (finding that “health outcomes appeared most strongly predicted by social and economic factors”); Gregfell500, *supra* note 38 (collecting studies).

61. *See* G.A. Res. 70/1, *supra* note 30, at 14, 16.

62. *See Life Expectancy at Birth*, *supra* note 16.

fell from 282 to 385 per 100,000 live births (estimates vary) to 196 to 216 per 100,000 live births.⁶³ Still greater progress came in reductions in child deaths, from 12.7 million to 5.9 million.⁶⁴ At the other end of the lifespan, the number of people living to be 100 is expected to grow from 95,000 in 1990 to almost 4 million in 2050.⁶⁵

Global health continues to improve, but will we see a backsliding, principally due to inequities? Already, and even apart from any effect that COVID-19 may have, life expectancy in the United States and parts of Europe has leveled off, and even diminished.⁶⁶ With the compounding threats of the climate crisis, mass migrations, political violence, and poor governance, will hard-won health gains begin to crumble? Will we remain unprepared for other foreseeable health threats like antibiotic resistance and new and emerging diseases? Will long-time trends be reversed, and our children and grandchildren live shorter lives, with more sickness and disability, than we do?

The question arises: do we need global health (ever-increasing aggregate measures of good health and longevity), or do we need justice (fair distributions of the “public goods” of health)? It is possible to have rising health outcomes collectively, but poor distribution—that is, global health without justice. So too, it is possible to have more equitable distributions of good health, but with relatively flat overall health outcomes—that is, justice without rising health outcomes. The answer is that we need *both*: advancing health for large populations, but fairly distributed among the “haves” and “have nots.”

It is for this reason that we do not adopt the common terminology of “global health justice” or simply “health justice.” Rather, we think “global health with justice” better captures global aspirations—that is, continual and more rapid increases in measurable population-level health outcomes *and* more equitable

63. See WORLD HEALTH ORG. ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2015, at 20 (2015) (estimating higher figures for both 1990 and 2015); Nicholas J. Kassebaum et al., *Global, Regional, and National Levels of Maternal Mortality, 1990–2015: A Systematic Analysis for the Global Burden of Disease Study 2015*, 338 LANCET 1775, 1783, 1784 tbl.1 (2016) (estimating lower figures for both 1990 and 2015).

64. The data is for children under the age of five. Press Release, UNICEF, Child Mortality Rates Plunge by More than Half Since 1990 but Global MDG Target Missed by Wide Margin (Sept. 9, 2015), https://www.unicef.org/media/media_83145.html [<https://perma.cc/65YS-P3W7>]. The number of under-five deaths further decreased to 5.3 million in 2018. *Global Health Observatory (GHO) Data: Under-Five Mortality*, WORLD HEALTH ORG., https://www.who.int/gho/child_health/mortality/mortality_under_five_text/en/ [<https://perma.cc/K8DM-DQ3W>] (last visited Mar. 10, 2020).

65. There will be an estimated 3,676,000 people aged 100 or more in 2050. Renee Stepler, *World's Centenarian Population Projected to Grow Eightfold by 2050*, PEW RESEARCH CTR.: FACT TANK (Apr. 21, 2016), <https://www.pewresearch.org/fact-tank/2016/04/21/worlds-centenarian-population-projected-to-grow-eightfold-by-2050/> [<https://perma.cc/G2XN-L5NE>].

66. Life expectancy in the United States edged downward for the third year in a row in 2017. Owen Dyer, *US Life Expectancy Falls for Third Year in a Row*, BRIT. MED. J. (Dec. 4, 2018), <https://www.bmj.com/content/363/bmj.k5118>. Life expectancy has also dropped in the United Kingdom, and the pace of gains in some other European countries has slowed. See Lucinda Hiam et al., *Why Is Life Expectancy in England and Wales ‘Stalling’?*, 72 J. EPIDEMIOL. & COMMUNITY HEALTH 404, 404–06 (2018); Austl. Associated Press, *Australians Living Longer but Life Expectancy Dips in US and UK*, GUARDIAN (Aug. 15, 2018, 7:42 PM), <https://www.theguardian.com/society/2018/aug/16/australians-living-longer-but-life-expectancy-dips-in-us-and-uk> [<https://perma.cc/8652-H35E>].

distributions of the benefits of good health. And although we focus on large population indicators of good health, fairly distributed, every individual yearns for those same values—living a healthy, long life and not being left behind.

II. HEALTH FOR SOME

The significant global health achievements we have examined, however, are far from the complete picture of global health today. Here, we highlight the massive inequalities in health within and among countries, injustices that motivate our proposals and that they seek to redress. Then, in Part III, we will explain why these inequalities represent such a deep affront to justice. For not everyone benefits equally from contemporary advances in global health—far from it.

A. GLOBAL HEALTH INEQUALITIES

As of 2017, people in high-income countries had a life expectancy eighteen years longer than people in low-income countries, nearly an extra generation of life, while the difference was even greater—twenty years—between countries in sub-Saharan Africa and in the European Union (sixty-one years versus eighty-one years).⁶⁷ Life expectancy in fourteen countries was less than sixty years, whereas it was over eighty years in thirty-four countries.⁶⁸

And these immense inequities remain despite progress in reducing them over the past several decades. Life expectancy rose by 9.8 years from 2000 to 2017 in low-income countries (53.6 to 63.4 years),⁶⁹ compared to 3.1 years in high-income countries (77.6 to 80.7 years).⁷⁰ This is welcome, but not surprising. Nothing lowers life expectancy more than the death of children,⁷¹ and we have effective tools to prevent child deaths, such as clean water, pediatric care, and antibiotics. From 1990 through 2017, the number of children under five years old dying each year fell by more than seven million.⁷² Nutritious food and clean water save young lives.⁷³ As basic measures to save the lives of younger people

67. See *Life Expectancy at Birth*, *supra* note 16.

68. See *id.*

69. See *Life Expectancy at Birth, Total (Years) – Low Income*, WORLD BANK, https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=XM&name_desc=false [<https://perma.cc/LF29-TQHU>] (last visited Mar. 10, 2020).

70. See *Life Expectancy at Birth, Total (Years) – High Income*, WORLD BANK, https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=XD&name_desc=false [<https://perma.cc/9QZE-2JYD>] (last visited Mar. 10, 2020).

71. See Max Roser et al., *Life Expectancy*, OUR WORLD IN DATA (2013), <https://ourworldindata.org/life-expectancy> [<https://perma.cc/WGT2-LFEU>] (last revised Oct. 2019). Life expectancy measurements are particularly sensitive to the deaths of infants and children because these deaths do the most to lower the average; life expectancy is a measure of the average lifespan.

72. See Press Release, UNICEF, A Child Under 15 Dies Every Five Seconds Around the World – UN Report (Sept. 17, 2018), <https://www.unicef.org/press-releases/child-under-15-dies-every-five-seconds-around-world-un-report> [<https://perma.cc/76RJ-57Y3>] (noting that the number of children under the age of five who died in 1990 was 12.6 million, compared to 5.4 million in 2017).

73. See FOOD & AGRIC. ORG. OF THE U.N., FOOD COMES FIRST: FAO AND THE EIGHT MILLENNIUM DEVELOPMENT GOALS 22–23 (2010), http://www.fao.org/fileadmin/user_upload/mdg/doc/booklet_mdg_en.pdf [<https://perma.cc/SJ6P-LHYK>]; Isabel Günther & Günther Fink, *Water and Sanitation to Reduce Child*

are taken, we may see a welcome reduction in the health equity gaps pervading the world.⁷⁴

Yet even in the death of young children, global disparities remain stark. Infant mortality is more than ten times higher in lower income countries than in wealthy countries (48 compared to 4 deaths per 1,000 live births in 2018).⁷⁵ The disparities are even greater for their mothers; maternal mortality rates are more than forty times higher (462 compared to 11 deaths per 100,000 births in 2017).⁷⁶

Meanwhile, emerging health threats pose particular risks to poorer populations. People in lower income countries are most vulnerable to the ravages of climate change⁷⁷ and have health systems and a social and economic infrastructure less able to deal with novel and emerging infectious diseases.⁷⁸ Poor governance, violence, and political instability is most often felt by people in lower income countries.⁷⁹ By comparison, costly gene therapy and precision medicine are most available in wealthier countries.⁸⁰ Without a focus on justice, new possibilities for longer and healthier lives will most likely primarily benefit people in higher income countries, leaving the poor behind, once again.

B. DOMESTIC HEALTH INEQUALITIES

These immense global health disparities are echoed in gaping inequities within countries—sometimes narrowing, but often expanding. An analysis of health outcomes related to the Millennium Development Goals, United Nations targets for 2015—covering maternal and child health along with AIDS, tuberculosis, and malaria—found that for all the progress globally, in one-quarter of the sixty-four countries surveyed, the poorest forty percent were actually doing *worse off* than

Mortality: The Impact and Cost of Water and Sanitation Infrastructure 28–29 (World Bank, Policy Research Working Paper No. 5618, 2011), <http://documents.worldbank.org/curated/en/548461468326222308/pdf/WPS5618.pdf> [<https://perma.cc/8YKD-MUHQ>].

74. Reducing child deaths has and should continue to have a discernable effect on reducing global health equity gaps because children's deaths are numerous—despite steady reductions, 5.3 million children under the age of five died in 2018—and concentrated in lower income countries. *GHO Data: Under-Five Mortality*, *supra* note 64. Low-income countries had an under-five mortality rate nearly fourteen times higher than that of high-income countries in 2018. *Id.*

75. *Mortality Rate, Infant (Per 1,000 Live Births)*, WORLD BANK, <https://data.worldbank.org/indicator/SP.DYN.IMRT.IN> [<https://perma.cc/LN3Y-LWUD>] (last visited Mar. 10, 2020).

76. *See Maternal Mortality*, *supra* note 14.

77. *See* Jonah Busch, *Climate Change Is Regressive*, CTR. FOR GLOBAL DEV. (Apr. 1, 2014), <https://www.cgdev.org/blog/climate-change-regressive> [<https://perma.cc/PER7-BBEP>].

78. For example, the West African Ebola epidemic that peaked in 2014–2015 tragically demonstrated the inability of weak health systems in lower income countries to respond to novel and, in this case, emerging infectious diseases. *See* Marie-Paule Kieny et al., *Health-System Resilience: Reflections on the Ebola Crisis in Western Africa*, 92 BULL. WORLD HEALTH ORG. 850 (2014).

79. TONY ADDISON ET AL., CHRONIC POVERTY RESEARCH CTR., FRAGILE STATES, CONFLICT, AND CHRONIC POVERTY 2 (2010), <https://perma.cc/TAV7-9YLW>.

80. *See* Thomas M. Drake et al., *Global Inequities in Precision Medicine and Molecular Cancer Research*, 8 FRONTIERS ONCOLOGY 1, 1–2 (2018).

before.⁸¹ Further, “in a sizable fraction of countries, the poorest 40 percent have progressed less quickly than the richest 60 percent.”⁸²

Indeed, wealth is a powerful determinant of health. The latest available data (spanning 2003–2009) revealed that women in South Asia in the top wealth quintile are almost five times more likely to be attended by a skilled birth attendant than women in the poorest quintile.⁸³ For all the gains in reduced child mortality, in Latin America under-five mortality is three times higher for children in the poorest quintile than for those in the richest.⁸⁴ Globally, when it comes to the health of mothers and children, the greatest inequality in health services is related to births in health facilities and access to water and sanitation infrastructure—interventions that require significant infrastructure.⁸⁵ Race and ethnicity are frequently other divides. White South Africans had a life expectancy 16 years longer (72.6 years) than black South Africans (56.4 years) in 2015.⁸⁶ Even as California halved its overall African-American maternal mortality rate between 2008 and 2013, the level remained three to four times higher for African-Americans than for women in other racial/ethnic groups.⁸⁷

Characteristics of discrimination are often intertwined. If Wildwood, Missouri were a country, its residents would enjoy a life expectancy five years longer than people of the country with the longest life expectancy (the European microstate of Monaco).⁸⁸ Yet, only the people of the Central African Republic, Chad, Lesotho, Nigeria, and Sierra Leone live shorter lives than those who live in Kinloch, Missouri.⁸⁹ Both Wildwood and Kinloch are suburbs of St. Louis. Most residents of Wildwood, where the life expectancy is ninety-one years, are white

81. Adam Wagstaff et al., *Progress on Global Health Goals: Are the Poor Being Left Behind?*, 29 WORLD BANK RES. OBSERVER 137, 137 (2014).

82. *Id.* at 158.

83. UNICEF, PROGRESS FOR CHILDREN: ACHIEVING THE MDGs WITH EQUITY 27 (2010), https://www.unicef.org/publications/files/Progress_for_Children-No.9_EN_081710.pdf [<https://perma.cc/J8AG-6YWN>].

84. Veronica Valdivieso, *The Issue of Inequalities: A Look at the Underlying Causes of Maternal and Child Death in Latin America and the Caribbean*, USAID: IMPACT BLOG (Sept. 10, 2013), <https://blog.usaid.gov/2013/09/the-issue-of-inequalities-a-look-at-the-underlying-causes-of-maternal-and-child-death-in-latin-america-and-the-caribbean/> [<https://perma.cc/494S-2JB9>].

85. Adrienne Clermont, *The Impact of Eliminating Within-Country Inequality in Health Coverage on Maternal and Child Mortality: A Lives Saved Tool Analysis*, 17 BMC PUB. HEALTH (Supp. 4) 734, 737–38 (2017).

86. John Campbell, *Overcoming the Legacy of White Supremacy in South Africa*, COUNCIL ON FOREIGN REL. (Jul. 26, 2016), <https://www.cfr.org/expert-brief/overcoming-legacy-white-supremacy-south-africa> [<https://perma.cc/YT2S-FK57>].

87. Gregory Twachtman, *California Bucks Trend of Rising U.S. Maternal Mortality*, OB. GYN. NEWS (Nov. 19, 2016), <https://www.mdedge.com/obgynnews/article/118467/obstetrics/california-bucks-trend-rising-us-maternal-mortality> [<https://perma.cc/U46X-Q2N2>].

88. See *Life Expectancy at Birth*, *supra* note 16. The life expectancy in Monaco is eighty-six years. *Demography*, MONACO STAT., <https://www.monacostatistics.mc/Population-and-employment/Demography> [<https://perma.cc/J6DT-WNPP>] (last visited May 5, 2020).

89. See *id.* Life expectancies in these countries are less than fifty-six years. *Id.*

and wealthy.⁹⁰ Most residents of Kinloch, where the life expectancy is fifty-six years, are poor and black⁹¹—a painful reminder of how much race and income matter.

The health injustices that people of color have always suffered in the United States are exacerbating the effects of COVID-19 on minority communities. Early data revealed that blacks and Latinos were dying at twice the rate of whites in New York City.⁹² Comparable disparities were being echoed in other states, including Illinois and Louisiana.⁹³ Other marginalized populations are also at heightened risk. An early study of people with living in group homes and similar facilities for the developmentally disabled in and near New York City found that residents were about five times more likely to become infected with and to die from COVID-19 as the general population.⁹⁴

To take one other example, long histories of injustice have left indigenous people with worse health services and outcomes than their non-indigenous counterparts throughout the world. In Canada, the indigenous Inuit people have tuberculosis (TB) incidence more than 300 times that of non-indigenous Canadians.⁹⁵ Life expectancy of aboriginal people in Australia is approximately eight to nine years lower than the national average (2015–2017).⁹⁶ The disparity in life expectancy between Native Americans and the overall United States population is 5.5 years⁹⁷—and twenty years in some states.⁹⁸ Native American men in

90. FERGUSON COMM'N, FORWARD THROUGH FERGUSON: A PATH TOWARD RACIAL EQUITY 9, 158 (2015), https://3680or2khmk3bzpk33juiea1-wpengine.netdna-ssl.com/wp-content/uploads/2015/09/101415_FergusonCommissionReport.pdf [<https://perma.cc/T7WJ-BHPN>].

91. *Id.*

92. Jeffrey C. Mays & Andy Newman, *Virus Is Twice as Deadly for Black and Latino People Than Whites in N.Y.C.*, N.Y. TIMES (May 7, 2020), <https://www.nytimes.com/2020/04/08/nyregion/coronavirus-race-deaths.html>.

93. John Eligon, Audra D. S. Burch, Dionne Sarcey & Richard A. Opiel Jr., *Black Americans Face Alarming Rates of Coronavirus Infection in Some States*, N.Y. TIMES (Apr. 14, 2020), <https://www.nytimes.com/2020/04/07/us/coronavirus-race.html>.

94. Danny Hakim, *'It's Hit Our Front Door': Homes for the Disabled See a Surge of Covid-19*, N.Y. TIMES (Apr. 17, 2020), <https://www.nytimes.com/2020/04/08/nyregion/coronavirus-disabilities-group-homes.html>.

95. Indigenous Servs. Can., *Eliminating Tuberculosis Across Inuit Nunangat by 2030; At Least a 50% Reduction by 2025*, CANADA.CA (Mar. 23, 2018), <https://www.canada.ca/en/indigenous-services-canada/news/2018/03/eliminating-tuberculosis-across-inuit-nunangat-by-2030-at-least-a-50-reduction-by-2025.html> [<https://perma.cc/QN5R-RH49>].

96. Media Release, Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Life Expectancy Lowest in Remote and Very Remote Areas* (Nov. 29, 2018), <https://perma.cc/NRM8-59RG> (noting new data showing that “life expectancy at birth of Aboriginal and Torres Strait Islander men in 2015–2017 was 8.6 years lower than for non-Indigenous men, while that of Aboriginal and Torres Strait Islander women was 7.8 years lower than that of non-Indigenous women”).

97. *Disparities*, INDIAN HEALTH SERV. (Oct. 2019), <https://www.ihs.gov/newsroom/factsheets/disparities/> [<https://perma.cc/8T2V-EJY8>]. Native Americans experience diabetes at 3.2 times the rate, and chronic liver disease and cirrhosis at 4.6 times the rate, of the overall U.S. population. *Id.*

98. See Eric Whitney, *Native Americans Feel Invisible in U.S. Health Care System*, NPR: SHOTS (Dec. 12, 2017, 5:00 AM), <https://www.npr.org/sections/health-shots/2017/12/12/569910574/native-americans-feel-invisible-in-u-s-health-care-system> [<https://perma.cc/K5UA-2DV4>].

Montana have the same life expectancy as the residents of Kinloch, Missouri.⁹⁹

III. MOVING BEYOND GLOBAL HEALTH TO GLOBAL HEALTH WITH JUSTICE

These inequalities represent a profound injustice. Social justice movements have long known this. As Dr. Martin Luther King Jr. observed, of all inequalities, health inequalities are the “most shocking and inhuman.”¹⁰⁰

Many of us likely share Dr. King’s perspective, with an intuitive understanding that something so arbitrary as the hue of your skin, where you happen to be born, or whether you are able to secure a well-paid job should not determine whether you live a long, healthy life or have a short, disease-filled existence. We now dig behind this instinct for a theory of justice that explains why the health inequalities all around us are such a deep injustice.

Gaining this fuller understanding of the unconscionability of health injustice has three core functions, besides offering a theoretical underpinning to a widely shared human value. First, it will demonstrate why, of the government’s many responsibilities, redressing health inequalities should hold a particular command of the state’s energies and of public resources. Second, we will see—beyond its global endorsement and universal legally binding nature—that the right to health, with its intimate connection to health justice, justifies, and even compels, bold measures to narrow health inequalities, as is the case for our proposals. And third, we will see that our proposals, both aimed at improving overall health outcomes and with a deep emphasis on narrowing health inequalities, will contribute to a more just world.

A. NORMATIVE FOUNDINGS OF GLOBAL HEALTH WITH JUSTICE

Our account of global health with justice draws from several distinct, yet in significant ways convergent, political theories. In particular, we look to Norman Daniels—who himself draws heavily on John Rawls’s theory of justice as fairness—and the capabilities approach of Amartya Sen, Martha Nussbaum, and, extended to global health, Jennifer Prah Ruger.

We begin with the foundational normative value that people ought to have the opportunity “to lead the kind of lives they value—and have reason to value,” as Sen framed it,¹⁰¹ or to achieve “human flourishing”¹⁰² or a “flourishing life,”¹⁰³ as Prah Ruger and Nussbaum term it, respectively. We posit that of all the aspirations that people strive for, physical and mental health is at, or near, the top. People, of course, can and do lead fulfilling lives even if they live with pain or disability or disease. Still, possessing and maintaining physical and mental

99. *Id.*

100. Amanda Moore, *Tracking Down Martin Luther King, Jr.’s Words on Health Care*, HUFFPOST (Jan. 18, 2013, 4:00 PM), https://www.huffpost.com/entry/martin-luther-king-health-care_b_2506393 [<https://perma.cc/8GLL-UZRF>].

101. AMARTYA SEN, *DEVELOPMENT AS FREEDOM* 18 (1999).

102. JENNIFER PRAH RUGER, *GLOBAL HEALTH JUSTICE AND GOVERNANCE* 83 (2018).

103. MARTHA C. NUSSBAUM, *CREATING CAPABILITIES: THE HUMAN DEVELOPMENT APPROACH* 33 (2011).

capacities can contribute to many of life's joys, fulfilment, and opportunities. This gives health, as Daniels understands it, a "special moral importance."¹⁰⁴ No person is more or less deserving to live a long healthy life than another.

Health has a special moral value for another reason. Health is inextricably linked to virtually all aspects of a good society. Good or bad, health is both a product and a marker of the nature and fairness of political, social, and economic structures. A person's education, level of income, housing, and social status all affect her health, and all are substantially determined by social, political, and economic forces.¹⁰⁵ These forces could reinforce the effects of the tickets we draw in the morally arbitrary "natural and social lotteries."¹⁰⁶ Or, they could counter the effects of these lotteries so that we all may have equal opportunities to flourish—and to be healthy. Who is healthy and who is not, then, is a fundamental issue of justice. As Daniels puts it, "*social justice in general is good for population health and its fair distribution.*"¹⁰⁷

Health justice is a concept that knows no borders. All people, everywhere, ought to have similar opportunities for good health. Health justice, then, is a fundamentally global concept and requires health equality within and across countries and regions.¹⁰⁸ Health injustices will persist as long as the child born in the Central African Republic can expect a shorter, less healthy life than the child born in Japan or Switzerland.¹⁰⁹ We hold an ethical duty to narrow health inequalities at the regional and global level.

Not all health inequalities are unjust, because some factors beyond society's control determine health, whatever our societal arrangements. Bad genetic luck may increase a person's risk of chronic or terminal disease, or an unintentional event can cause a devastating injury. Yet most of the conditions for good or bad health are within society's control. And this is what global health with justice requires: that society responds to modifiable determinants of health to everyone's equal benefit—in accessing quality healthcare, living in healthy and safe environments, and enjoying the full gamut of social determinants of health.¹¹⁰

Health equity requires removing the ways in which life's lottery affects health, for ultimately, a society is unjust if it fails to take actions within its power and

104. NORMAN DANIELS, *JUST HEALTH: MEETING HEALTH NEEDS FAIRLY* 21 (2008). Martha Nussbaum includes bodily health among ten core capabilities in her elaboration of the capabilities approach. NUSSBAUM, *supra* note 103, at 33.

105. See WORLD HEALTH ORG., *supra* note 44, at 1.

106. DANIELS, *supra* note 104, at 71.

107. *Id.* at 82 (emphasis in original).

108. We commend Prah Ruger's extension of the capabilities approach to a global theory of justice—provincial globalism—and extending it to health. Our approach resonates deeply with provincial globalism. See PRAH RUGER, *supra* note 102, at 81–141 (describing provincial globalism).

109. The Central African Republic has the world's lowest life expectancy, fifty-three years (in 2018), compared to Japan and Switzerland, with among the world's highest life expectancies, each with a life expectancy of eighty-four years (in 2018). See *Life Expectancy at Birth*, *supra* note 16.

110. See Ottersen et al., *supra* note 25, at 630; *Equity*, WORLD HEALTH ORG., <https://www.who.int/healthsystems/topics/equity/en> [<https://perma.cc/8YLN-Q2QP>] (last visited Mar. 11, 2020).

control to do so.¹¹¹ This may require devoting more resources to some people than to others—namely, to people to whom nature’s lottery and the social lottery have dealt a harsh hand, such as a disability or debilitating disease,¹¹² whether stemming from a genetic disease, a car crash, or even from our own, considered actions, whether extreme sports, smoking, or unhealthy eating. Those, too, are ultimately traceable to that morally arbitrary beginning and the societal forces that shape our lives. Indeed, unless society takes proactive steps to assure equitable access, one might foresee widening health inequalities as our scientific prowess grows, with most benefits going to those who can afford cutting-edge technological advancements.

Justice will require hard political tradeoffs, given resource constraints. How much should society spend on research and development of new medicines, even as it ensures that drugs and vaccines are affordable? How much should governments invest in health services, education, and public transportation when all have unmet needs and all require investments for greater health and social justice? How progressive does a tax system need to be to promote genuine equity? How much must one country spend on international development assistance to achieve more equal health for people in other nations?

These are questions that defy easy answers—bringing us to another meaning of justice, what Daniels calls “accountability for reasonableness,”¹¹³ and Sen calls “participatory capabilities.”¹¹⁴ Society needs a fair way to resolve political tradeoffs. Accountability for reasonableness offers four conditions to “connect decisions at any institutional level to a broader educative and deliberative democratic

111. Human rights law makes this point. As a general matter, with respect to economic, social, and cultural rights, states are under an obligation to “take steps . . . to the maximum of [their] available resources” toward fully realizing people’s rights, using “all appropriate means.” International Covenant on Economic, Social and Cultural Rights art. 2, ¶ 1, *opened for signature* Dec. 19, 1966, 993 U.N.T.S. 3, 5 (entered into force Jan. 3, 1976). Put another way, states must do what they can—to act “to the maximum of [their] available resources”—to ensure everyone their rights. *See id.* A state that fails to do so is violating its human rights obligations to the society it represents (in a democratic state) or controls (in an undemocratic state), and is therefore unjust.

Looking to equity in particular, states are under an obligation to eliminate substantive discrimination, a concept akin to inequity, when “effective enjoyment of the [International] Covenant [on Economic, Social and Cultural] rights [are] . . . influenced by whether a person is a member of a group characterized by the prohibited grounds of discrimination.” Comm. on Econ., Soc. & Cultural Rights, General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights, ¶ 8(b), U.N. Doc. E/C.12/GC/20 (July 2, 2009) [hereinafter CESCR, General Comment No. 20]. Eliminating discrimination is a chief requirement of human rights law. In the area of health, for instance, nondiscrimination is an expressly delineated “core obligation[,]” and therefore “non-derogable.” *See* CESCR, General Comment No. 14, *supra* note 37, ¶¶ 43(a), 47. Again, a society that fails to do whatever must be done to eliminate injustice—in this case, health inequities—is failing to meet its human rights obligations. Human rights violations persist in that society; the society is unjust.

112. Society has an obligation to devote extra resources to people with disabilities to enable their full inclusion in society. They should have a range of opportunities open to them that is as close as possible to being equal to the range open to people without disabilities. *See* Convention on the Rights of Persons with Disabilities art. 1, *opened for signature* Mar. 30, 2007, 2515 U.N.T.S. 3, 72 (entered into force May 3, 2008); DANIELS, *supra* note 104, at 147–49.

113. DANIELS, *supra* note 104, at 117–33.

114. SEN, *supra* note 101, at 18.

process,”¹¹⁵ enabling public officials to be publicly interrogated and, through those deliberative processes, revise these decisions: (1) publicly accessible decisions and rationales, (2) relevant reasons for decisions, (3) the opportunity for decisions to be appealed and revised, and (4) regulation that ensures these conditions are met.¹¹⁶ Thus, procedural justice requires inclusive participation in making political choices that affect health and well-being.

B. IMPLICATIONS OF NORMATIVE UNDERPINNINGS

Taken together, these key aspects of health justice inform our proposals in three ways. First, solutions should be far-reaching, moving as far as possible along the path toward full health justice, nationally and globally, because *modifiable* variations from health equity are inherently unfair.¹¹⁷ Health equity programs of action, for instance, should strive for the highest level of health equity society can achieve.

Second, the right to health provides a firm normative basis for our proposals, for the right to health reflects the principles of health justice. Health rights are universal, shared equally by all members of society, with special concern for people who are marginalized. The state is the principal duty bearer for health equity, yet the right to health also requires mutual solidarity and international cooperation, key features of the FCGH and R2HCF. Health justice requires the international community to do its utmost to make up for the disadvantages that people within and across states face. We ground the FCGH on the right to health.

Third, all of our proposals embrace procedural justice through participatory and accountable decisionmaking—two more important features of the right to health. There would be inclusive participation in negotiating the FCGH, even if it were ultimately adopted by WHO (or U.N.) member states. Health equity programs of action would also be developed through bottom-up deliberative processes, as would decisions on R2HCF parameters and how to prioritize R2HCF resources.

Notably, our proposals also address shortcomings of the right to health, such as vague standards, failures in state compliance, and lack of accountability mechanisms. The FCGH would create far sharper mandates than extant human rights

115. DANIELS, *supra* note 104, at 119.

116. *Id.* at 118–19.

117. This is not strictly true. It is possible that in their decisions about what they value and conceptions of the good, people in one country may develop arrangements that lead to worse health than arrangements people develop in another country. For example, perhaps the challenge of extreme sports, which leads to heightened death and disability rates for young adults, forms many people’s conception of the good. Or people in another country highly value exercise, leading to low levels of cardiovascular and other diseases. To the extent these decisions that lead to differences in health across countries are matters of public policy, or within the possible scope of public policy, such decisions must be reached through deliberative, democratic processes that fully enable the voices of disadvantaged people. And, per John Rawls’s difference principle, they should ensure societal arrangements where “[s]ocial and economic inequalities are to be arranged so that they are both (a) to the greatest benefit of the least advantaged and (b) attached to offices and positions open to all under conditions of fair equality of opportunity.” JOHN RAWLS, *THEORY OF JUSTICE* 83 (1971). However, such examples are speculative and will have only a marginal difference.

treaties, especially regarding state duties for health justice. And it would govern transnational drivers of poor health, such as marketing of unhealthy products (like alcohol, sugary beverages, and ultraprocessed foods). The R2HCF would fill a large gap in funding advocacy needed to achieve health justice.

C. TWO MORE CONDITIONS OF GLOBAL HEALTH WITH JUSTICE

The present state of the world we describe in earlier sections is best understood as achieving significant strides in global health, but not health justice.¹¹⁸ Existing national and international norms, policies, and funding, moreover, are poorly designed for global health with justice. Thus, along with the three conditions of health that we described earlier—universal health coverage, population-based public health, and positively structured social determinants of health—we add two more conditions for global health with justice, foreshadowed earlier.

First, governments must be accountable to their inhabitants, placing people's interests above commercial or political interests. Governments must be accountable for failures to achieve health with justice. Global health with justice cannot simply be an aspiration. It requires careful measurement, with strong accountability for achieving better, and more equitable, health outcomes. Without concrete measures to quantify and evaluate progress toward health justice (including through disaggregated data), and absent methods for holding policymakers accountable, it is highly unlikely that governments and the community of nations will fulfill the Sustainable Development Agenda pledge of leaving no one behind.¹¹⁹

And second, global health with justice requires global governance and robust institutions to advance improved health, equitably distributed. This condition for global health with justice is underscored by the simple observation that existing international arrangements frequently undermine health justice.¹²⁰ Thus, for example, regimes such as the World Trade Organization give primacy to intellectual property protection rather than affordable biotechnologies.¹²¹ The World Bank and International Monetary Fund ushered in an era of user fees for health services and structural adjustment that diminished national health budgets.¹²² And laissez-faire capitalism gives carte blanche for transnational corporations to move to low-tax, low-regulation states, thus depleting domestic resources for health and failing to regulate corporate marketing, products, workplace safety, and environmental impacts that harm the public's health and safety.¹²³ Meanwhile, the world's central health agency, WHO, lacks the legal authority to ensure equitable, needs-based distribution of medical supplies and equipment,

118. See *supra* Sections I.D, II.A, and II.B.

119. See G.A. Res. 70/1, *supra* note 30.

120. See Ottersen et al., *supra* note 25, at 637–53 (presenting case studies of “seven policy intervention areas in which the existing system of global governance has failed to promote or protect health”).

121. See *id.* at 641.

122. See *id.* at 646–47.

123. See *id.* at 647–48.

and vaccines and therapies, during a pandemic, heightening the vulnerability of people in poorer countries.

We turn now to a fuller description of the human right to health, which underlies our proposals for action and funding toward achieving global health with justice.

IV. THE LEGAL GROUNDING OF GLOBAL HEALTH WITH JUSTICE: THE RIGHT TO HEALTH

The right to health embodies the concept of global health with justice. First, the right is legally binding, codified in the International Covenant on Economic, Social and Cultural Rights (ICESCR) as well as numerous other global and regional treaties.¹²⁴ Second, governments widely agree on the global norm of good health. The vast majority of countries—170 as of early 2020—have ratified the ICESCR,¹²⁵ and every country has ratified at least one treaty containing the right to health.¹²⁶ Further, various iterations of the right to health are included in more than 130 constitutions around the world.¹²⁷ And third, decades of guidelines and

124. See International Covenant on Economic, Social and Cultural Rights art. 12, ¶ 1, *supra* note 111, 993 U.N.T.S. at 8 (“The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”); see also, e.g., Convention on the Rights of Persons with Disabilities art. 25, *supra* note 112, 2515 U.N.T.S. at 84 (“States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.”); Convention on the Rights of the Child art. 24, ¶ 1, *adopted* Nov. 20, 1989, 1577 U.N.T.S. 3, 52 (entered into force Sept. 2, 1990) (“States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.”); Convention on the Elimination of All Forms of Discrimination Against Women art. 12, ¶ 1, *adopted* Dec. 18, 1979, 1249 U.N.T.S. 13, 19 (entered into force Sept. 3, 1981) (“States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.”); International Convention on the Elimination of All Forms of Racial Discrimination art. 5, *open for signature* Mar. 7, 1966, 660 U.N.T.S. 195, 220, 222 (entered into force Mar. 12, 1969) (“States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: . . . The right to public health, medical care, social security and social services[.]”).

125. *Status of Ratification Interactive Dashboard: International Covenant on Economic, Social, and Cultural Rights*, OFFICE OF THE U.N. HIGH COMM’R FOR HUMAN RIGHTS, <http://indicators.ohchr.org/> (last visited Mar. 11, 2020).

126. OFFICE OF THE U.N. HIGH COMM’R FOR HUMAN RIGHTS & WORLD HEALTH ORG., THE RIGHT TO HEALTH: FACT SHEET NO. 31, at 1 (2018), https://www.who.int/hhr/activities/Right_to_Health_factsheet31.pdf [<https://perma.cc/6D34-CF9G>]. The United States, for example, by 2014 had ratified, signed, or agreed to at least five treaties and declarations that recognize a right to health, including the International Convention on the Elimination of All Forms of Racial Discrimination. *Six US-Signed Treaties and Declarations Recognizing a Right to Health Care*, PROCON.ORG (Sept. 17, 2014), <https://healthcare.procon.org/six-us-signed-treaties-and-declarations-recognizing-a-right-to-health-care/> [<https://perma.cc/8MEZ-QNRL>] (describing six international instruments, but the sixth does not contain a right to health); see, e.g., International Convention on the Elimination of All Forms of Racial Discrimination art. 5, *supra* note 124, 660 U.N.T.S. at 220, 222 (binding parties to “guarantee the right of everyone . . . in the enjoyment of . . . [t]he right to public health [and] medical care”).

127. GOSTIN, *supra* note 24, at 263.

jurisprudence on the right to health chart a course toward global health with justice.¹²⁸

The Committee on Economic, Social and Cultural Rights, established by the United Nations to monitor the ICESCR, issued General Comment 14, an authoritative interpretation of the right to health, in 2000.¹²⁹ The right's scope also extends beyond healthcare to encompass public health services and "the underlying determinants of health," such as clean water, adequate sanitation, nutritious food, safe housing, and a healthy environment.¹³⁰ Governments must make healthcare services and the underlying determinants available in sufficient quantity; accessible without discrimination, including geographically and financially; acceptable, including culturally and following medical ethics; and of good quality.¹³¹

128. These include, for example, reports of the U.N. special rapporteur on the right to health, a general comment and concluding observations of the U.N. Committee on Economic, Social and Cultural Rights, and decisions from several regional courts and from numerous countries. *See id.* at 257–67.

129. CESCR, General Comment No. 14, *supra* note 37, ¶ 11. The Office of the U.N. High Commissioner for Human Rights has called general comments "the most authoritative source of interpretation of the international human rights treaties." OFFICE OF THE U.N. HIGH COMM'R FOR HUMAN RIGHTS, THE HUMAN RIGHTS TREATY BODIES: PROTECTING YOUR RIGHTS 6 (2015), https://www.ohchr.org/Documents/HRBodies/TB/TB_booklet_en.pdf [<https://perma.cc/DY8N-8B8G>]. They are not themselves directly legally binding. However, as the most significant source for interpreting the provisions of human rights treaties, which are legally binding, they are an important source for guiding state action on right to health obligations and measuring how they are complying. *See Overview of International Legal Frameworks for Disability Legislation*, UN ENABLE (2007), <https://www.un.org/esa/socdev/enable/disovlf.htm> [<https://perma.cc/56EY-3U7S>]. They are, therefore, a key source of understanding state human rights obligations, both "good faith" interpretations of their obligations under Article 31(1) Vienna Convention on Treaties and, to the extent states indicate their acceptance of the interpretations (such as by using them to guide how they are reporting on their implementation to human rights treaty bodies, including the Committee on Economic, Social and Cultural Rights), under Article 31(3)(b) of the Vienna Convention, referring to state practice. *See* Vienna Convention on the Law of Treaties arts. 31(1), 31(3)(b), *adopted* May 23, 1969, 1155 U.N.T.S. 331, 340 (entered into force Jan. 27, 1980); Helen Keller & Leena Grover, *General Comments of the Human Rights Committees and Their Legitimacy*, in UN HUMAN RIGHTS TREATY BODIES: LAW AND LEGITIMACY 116, 129 (Helen Keller & Geir Ulfstein eds., 2012); Kerstin Mechlem, *Treaty Bodies and the Interpretation of Human Rights*, 42 VAND. J. TRANSNAT'L L. 905, 911, 920–22 (2009).

130. *See* CESCR, General Comment No. 14, *supra* note 37, ¶ 11.

131. *See id.* ¶ 12. States Parties to international treaties, including human rights treaties, hold direct responsibility for fulfilling treaty obligations. But right to health duties also extend beyond countries that have ratified the ICESCR, especially because a number of health rights are found in multiple, widely adopted international instruments. As noted, all countries have ratified at least one treaty containing the right to health, *supra* note 126 and accompanying text, and further, the constitution of WHO, an organization with virtually universal membership, recognizes the right to health. Constitution of the World Health Organization, July 22, 1946, 14 U.N.T.S. 185, 186 (entered into force Apr. 7, 1948). Moreover, beyond these treaties, countries must heed all human rights via their obligations under the U.N. Charter. Under the Charter, all U.N. member states "pledge themselves to take joint and separate action in co-operation with the Organization for the achievement of the purposes set forth in Article 55," which include "universal respect for, and observance of, human rights and fundamental freedoms." U.N. Charter arts. 55(c), 56. States, therefore, have committed themselves to human rights, and this commitment is only meaningful with specific content, a certain set of rights. With the centrality to the U.N. system of the International Bill of Rights—the Universal Declaration of Human Rights, the ICESCR, and the International Covenant on Civil and Political Rights—and the core human rights treaties more generally, the human rights

Three principles are central to the right to health. The first is nondiscrimination and equality.¹³² This includes both formal equality (avoiding express forms of discrimination, such as failing to provide health services specific to women or excluding migrants from full participation in national health programs) as well as substantive equality.¹³³ Substantive equality goes beyond equal treatment, requiring proactive, systematic state measures to achieve a state of health equity, from countering discriminatory attitudes to providing interpretation services.¹³⁴ States must pay particular attention to marginalized groups in their planning, ensure the equitable distribution of health services and resources, protect vulnerable groups, and respond to particular needs of marginalized populations.¹³⁵

A second principle is participation. People have a right to participate “in all health-related decision-making at the community, national and international levels.”¹³⁶ People must have the opportunity to have a say in setting priorities and selecting, implementing, monitoring, and evaluating policies.¹³⁷ Key here is participation in actual decisionmaking processes; consultation alone—soliciting people’s views but without necessarily taking them into account—is insufficient.¹³⁸

And third, governments must be accountable for their failures and successes, including sharing knowledge and acting transparently.¹³⁹ Accountability encompasses remedies for past violations and, even more importantly, prospective, systematic measures to prevent future violations and better fulfill the right.¹⁴⁰ Governments must monitor and evaluate how the measures they take affect the health, adjusting them when necessary.¹⁴¹

in these instruments form the logical basis for the content of universal human rights obligations, including the right to health. See OFFICE OF THE U.N. HIGH COMM’R FOR HUMAN RIGHTS, FACT SHEET No.2 (REV.1), THE INTERNATIONAL BILL OF HUMAN RIGHTS (1996), <https://www.ohchr.org/Documents/Publications/FactSheet2Rev.1en.pdf> [<https://perma.cc/4342-H5U8>]; *The Core International Human Rights Instruments and Their Monitoring Bodies*, OFFICE OF THE U.N. HIGH COMM’R FOR HUMAN RIGHTS, <https://www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx> [<https://perma.cc/B8SS-5UBG>] (last visited Mar. 11, 2020). Lending further support to the universal recognition of the right to health is the repeated recognition in U.N. resolutions reaffirming health rights, such as the 2012 U.N. General Assembly resolution on the right to health, see G.A. Res. 67/81 (Dec. 12, 2012), and the 2019 political declaration on universal health coverage adopted at the U.N. high-level meeting, see G.A. Res. 74/2, ¶ 1 (Oct. 10, 2019). Consequently, although States Parties remain the direct duty holder for ICESCR obligations, we suggest that with respect to their own right to health obligations, states not parties to the ICESCR should also give considerable weight to the interpretations of the CESCR, including General Comment 14—though we acknowledge that other scholars may disagree with our position and reasoning.

132. CESCR, General Comment No. 20, *supra* note 111, ¶¶ 2–3.

133. *Id.* ¶ 8.

134. See *id.* ¶¶ 8–9.

135. See CESCR, General Comment No. 14, *supra* note 37, ¶¶ 18, 37, 43(e), 43(f).

136. *Id.* ¶ 11.

137. *Id.* ¶ 54.

138. See HELEN POTTS, UNIV. ESSEX HUMAN RIGHTS CTR., ACCOUNTABILITY AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH 10 (2008), <http://repository.essex.ac.uk/9717/1/accountability-right-highest-attainable-standard-health.pdf> [<https://perma.cc/FB4S-DSWF>] (describing the role of participation in the right to health).

139. *Id.* at 13.

140. *Id.*

141. *Id.*

General Comment 14 requires governments to respect, protect, and fulfill the right to health.¹⁴² For these and all right to health (and other human rights) obligations, governments have a threefold obligation. First, *respect* for the right to health means not directly contributing to its violation such as through drafting discriminatory laws, impeding access to vital health information (for example, on sexual and reproductive health), or marketing unsafe drugs.¹⁴³ Second, governments must *protect* the right to health from third-party violations, requiring states to issue and enforce laws and regulations to prevent private sector violations, such as discrimination in health services, corporate marketing of unhealthy or unsafe products, and polluting the environment.¹⁴⁴ Finally, governments must directly *fulfill* the right to health, developing systems that ensure available, accessible, acceptable, and quality healthcare and underlying determinants of health, instituting participatory processes, and proactively improving the health of marginalized populations.¹⁴⁵

The CESCR had earlier posited in General Comment 3 that each right contains “minimum core obligation[s],” which are “minimum essential levels” without which the ICESCR “would be largely deprived of its *raison d’être*.”¹⁴⁶ Minimum core obligations of the right to health include universal access to essential primary healthcare; nutritious food; sanitation, safe water, and housing; and essential medicines.¹⁴⁷ The core extends to “equitable distribution of all health facilities, goods and services,” and includes developing a health plan through participatory and transparent processes that pay particular attention to marginalized populations, along with indicators and benchmarks to enable monitoring.¹⁴⁸ Whereas General Comment 3 required states to prioritize these obligations, using all possible resources and making “every effort,”¹⁴⁹ General Comment 14 raised the bar, describing these obligations as “non-derogable.”¹⁵⁰ Yet the CESCR tacitly acknowledges progressive realization of health rights by urging international assistance to prioritize core obligations,¹⁵¹ recognizing the difficulty that lower income states will have in fully achieving these obligations due to resources constraints.

Acknowledging resource constraints, states are not required to fulfill immediately all aspects of social, economic, and cultural rights—including the right to health—in their entirety; rather, they must use “the maximum of [their] available resources” to progressively achieve these rights.¹⁵² This, however, is not an

142. CESCR, General Comment No. 14, *supra* note 37, ¶ 33.

143. *Id.* ¶ 34.

144. *Id.* ¶ 35.

145. *Id.* ¶¶ 36–37.

146. Comm. on Econ., Soc. & Cultural Rights, General Comment No. 3: The Nature of States Parties’ Obligations (1990), ¶ 10, U.N. Doc. HRI/GEN/1/Rev.6 (2003) [hereinafter CESCR, General Comment 3].

147. CESCR, General Comment No. 14, *supra* note 37, ¶¶ 43(a)–(d).

148. *Id.* ¶¶ 43(e)–(f). The Committee explains “that a State party [to the ICESCR] cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations.” *Id.* ¶ 47.

149. CESCR, General Comment No. 3, *supra* note 146, ¶ 10.

150. CESCR, General Comment No. 14, *supra* note 37, ¶ 47.

151. *Id.* ¶ 45.

152. *See id.* ¶ 47.

excuse to go slowly. To the contrary, as General Comment 3 explains, states must act as “expeditiously and effectively as possible” to realize the rights in the Covenant.¹⁵³ The ICESCR also creates an obligation of “international assistance and co-operation” toward fulfilling these rights, though it does not further define this critical element.¹⁵⁴

Thus, despite less than ideal clarity and enforceability (which one of our proposals—the FCGH—would address), the right to health provides a solid basis for global health with justice. Its emphasis on equity, inclusive participation, and accountability can empower individuals and civil society to claim their rights. It charges the state with not only advancing the right to health but also regulating corporations and other actors that may undermine it. And it is broad, covering healthcare, public health, and underlying determinants of health. The ICESCR and its counterpart, the International Covenant on Civil and Political Rights (ICCPR), also address many other social determinants of health.¹⁵⁵

How, then, to fulfill the promise of the right to health and give life to its empowering principles? No one proposal alone—or even three proposals—is sufficient enough to enable everyone to realize a state of good health. Ultimately, that will take political will and governments that are truly committed to their people’s rights. However, our proposals would move the world decidedly closer to a state of global health with justice.

V. FRAMEWORK CONVENTION ON GLOBAL HEALTH: IMAGINING GLOBAL HEALTH WITH JUSTICE

When we imagine a world of global health with justice, we yearn for a world in which the right to health is being realized. With new tools to ameliorate public health threats old (such as mosquito-borne diseases, tuberculosis, and plague) and new (such as ultraprocessed foods, guns, unsafe roads, and the climate crisis), and transformative advances in health technologies, the highest attainable standard of health to which people are entitled is constantly evolving upward. And overall, most people are experiencing longer and healthier lives.¹⁵⁶ Yet many people are not benefiting. Justice requires that everyone is assured the conditions necessary for good health, but in reality, opportunities for good health are available only for some.

ICESCR and other treaties codifying the right to health have been transformative as powerful norms that have often been infused into national law, empowered advocates, and guided policy.¹⁵⁷ Human rights treaties, including the ICESCR,

153. CESCR, General Comment No. 3, *supra* note 146, ¶ 9.

154. G.A. Res. 2200A (XXI), *supra* note 22, at annex, art. 2, ¶ 1.

155. See International Covenant on Civil and Political Rights, arts. 19, 21, 22, 25, *adopted* Dec. 19, 1966, 999 U.N.T.S. 171, 178–79 (entered into force Mar. 23, 1976). These rights include the rights to form and join trade unions, the rights to take part in the conduct of public affairs and to peacefully assemble, and freedoms of expression and of association. *Id.* These are all rights critical for affecting political change to redress imbalances of power and resources and otherwise address the determinants of health and health inequities.

156. See *Life Expectancy at Birth*, *supra* note 16.

157. See, e.g., GOSTIN, *supra* note 24, at 252, 63–64.

also have established treaty bodies that have created a degree of accountability—a forum for exchange with states on their treaty implementation that can trigger state action.¹⁵⁸

And yet, from life expectancy that varies by a generation—and sometimes more—across countries and even zip codes,¹⁵⁹ to the persistence of inadequate funding and undemocratic, poorly governed countries, we live in a world that is far from one where the right to health is fully realized. The chief failures of the international human rights regime, including aspects of the regime for the right to health, are often vague standards and low compliance.¹⁶⁰ Enforcement mechanisms in international human rights treaties rely on monitoring, reporting, and oversight by treaty bodies that issue unenforceable “concluding observations,”¹⁶¹ and even regional human rights courts lack enforcement powers.¹⁶²

Often vague standards, even with the elaboration of General Comment 14, further obstruct accountability. Although special rapporteurs spotlight deficiencies and issue influential recommendations,¹⁶³ their primary power is moral persuasion.¹⁶⁴ They facilitate dialogue during country visits, but there is only one special rapporteur on the right to health, with a global mandate,¹⁶⁵ meaning that most countries will rarely, if ever, benefit from the visit of the special rapporteur.

158. Benjamin Mason Meier et al., *Accountability for the Human Right to Health Through Treaty Monitoring: Human Rights Treaty Bodies and the Influence of Concluding Observations*, 13 GLOBAL PUB. HEALTH 1558, 1560–61 (2018). The authors report, for instance, “The Committee has requested that states take steps to ensure that third parties do not interfere with health (whether through privatised health services, harmful traditional practices or harm to vulnerable populations), and these efforts to protect individuals from nonstate actors have led to an increase in state efforts to protect the right to health.” *Id.* at 1571.

159. See Nicole Zub, *ZNA: Could Your ZIP Code at Birth Predict Your Health?*, L. STREET MEDIA (Nov. 8, 2016), <https://legacy.lawstreetmedia.com/issues/health-science/zip-code-predict-disease/> [<https://perma.cc/TD85-9M6C>]; *Life Expectancy at Birth*, *supra* note 16 and accompanying text.

160. See ERIC A. POSNER, *THE TWILIGHT OF HUMAN RIGHTS LAW* 79–104 (2014).

161. Meier et al., *supra* note 158, at 1560–61.

162. See James L. Cavallaro & Stephanie Erin Brewer, *Reevaluating Regional Human Rights Litigation in the Twenty-First Century: The Case of the Inter-American Court*, 102 AM. J. INT’L L. 768, 778 (2008).

163. Special rapporteurs are U.N. Human Rights Council-appointed independent experts, some of whom cover thematic areas, such as health, and others of whom address human rights situations in certain countries. See *Special Procedures of the Human Rights Council*, OFFICE OF THE U.N. HIGH COMM’R FOR HUMAN RIGHTS, <https://www.ohchr.org/EN/HRBodies/SP/Pages/Welcompage.aspx> [<https://perma.cc/88B6-5YMA>] (last visited Mar. 11, 2020). The special rapporteurs with a thematic mandate issue reports on topics related to issues within their mandate, visit countries and subsequently issue reports, and send communications to states regarding specific allegations of human rights abuses. See *id.*

164. See Surya P. Subedi, *Protection of Human Rights Through the Mechanism of UN Special Rapporteurs*, 33 HUM. RTS. Q. 201, 203 (2011) (noting that “[i]n practice, the special rapporteurs perform a supervisory, consultative, advisory or monitoring function rather than one of enforcement”); see also *Speaking Truth to Power: The UN Experts Fighting for Global Human Rights*, U.N. NEWS (Nov. 8, 2019), <https://news.un.org/en/story/2019/11/1050931> [<https://perma.cc/TTUX-ZD2W>] (quoting Ahmed Shaheed, Special Rapporteur on Freedom of Religion or Belief: “If you are speaking up for what is right, then you have to prepare to face the criticism that comes with it, and what enables me to go on, is the fact that there are people who need attention, and there are people who find value in the work. I do that despite opposition from governments. Very often, however, they take notice and do the right thing.”).

165. See GOSTIN, *supra* note 24, at 260.

The chief purpose of the FCGH would be to weave a “web of accountability”¹⁶⁶ around the right to health and, in so doing, advance health equity, nationally and globally. It may seem paradoxical to propose an international human rights treaty to respond to the chief deficiency in the right to health—insufficient compliance. Yet there are many tools within the scope of international law—even without states agreeing to use the most forceful mechanisms, like sanctions, to enforce health rights—that can be deployed, but have not been used sufficiently, or at all, with respect to the right to health.

The FCGH would be the only treaty devoted entirely to the right to health.¹⁶⁷ It would set specific standards that clarify core elements of the right to health and the ICESCR, like equality, participation, and accountability, along with progressive realization,¹⁶⁸ maximum available resources, and extraterritorial obligations. Further, the treaty would offer specific tools to implement these standards, guiding governments, empowering civil society advocates, and informing courts and other national accountability bodies. Meanwhile, it would utilize a host of approaches to strengthen the international regime of monitoring and compliance, from target setting to creative incentives. Through its measures, the FCGH would bolster accountability both from below—empowering civil society and local initiatives—and above—creating global compliance mechanisms and incentives. Although these will not ensure complete compliance, collectively they hold considerable promise for more fully realizing the right to health.

The FCGH would be the first international health instrument that targets all three essential conditions for human health. It would not act in silos, for example, for a specific disease (for instance, AIDS), a specific barrier to access (such as patents and affordable medicines), or a specific intervention (for example, vaccines). Rather, it would encompass the health system, including affordable, equitable, quality universal health coverage. It would be the only instrument to defend the value of broader public health services, catalyzing evidence-based public health interventions, including behavioral risk factors (such as poor diet, lack of physical activity, and alcohol), vector control (mosquitos, rats), sanitation (potable water), and injury prevention (car crashes and workplace safety). And, given their overarching importance, the FCGH would extend to the social determinants of health, including nondiscrimination, education, housing, and employment, and social support systems that can promote and protect people’s health in both ordinary and extraordinary times.

166. Paul Hunt, *SDGs and the Importance of Formal Independent Review: An Opportunity for Health to Lead the Way*, HEALTH & HUM. RTS. J.: SDG SERIES (Sept. 2, 2015), <https://www.hhrjournal.org/2015/09/sdg-series-sdgs-and-the-importance-of-formal-independent-review-an-opportunity-for-health-to-lead-the-way/> [<https://perma.cc/KR7C-6CWE>].

167. Current health treaties, the Framework Convention on Tobacco Control (FCTC) and the International Health Regulations (IHR), have scopes that are limited to specific, albeit important, health concerns: tobacco and global health security.

168. The progressive realization requirement refers to states’ obligation “to take steps . . . to the maximum of [their] available resources, with a view to *achieving progressively the full realization of the rights* recognized in the [ICESCR].” G.A. Res. 2200A (XXI), *supra* note 22, at annex, art. 2, ¶ 1 (emphasis added).

The FCGH also would promote justice, above all for the people to whom governments are least accountable—those with the least power, who are most marginalized, and who have the worst health. These are the people who are hurt most when there is corruption, when clean water and adequate sanitation are not universal, when public health facilities are dilapidated and poorly equipped, when medicines are absent, and when there are no forums for public input. And of course, they are hurt most when governments discriminate and do not adhere to their commitments to equality and the equitable distribution of resources and services.

In an age of rising political support for populism and increasing prioritization of national sovereignty over the common good,¹⁶⁹ an ambitious global treaty on human rights may seem beyond reach. Even in matters central to global health (for example, noncommunicable diseases, alcoholic beverages, affordable access to essential medicines), the WHO—the natural home of the FCGH—has refrained from exercising its incomparable lawmaking powers.¹⁷⁰ Arguments claiming that formal treaties are too resource intensive, time consuming, and politically hard to accomplish have taken hold.¹⁷¹ In its more than seventy-year history, the WHO has adopted only two major international instruments—the Framework Convention on Tobacco Control (FCTC) and International Health Regulations (IHR).¹⁷² Even then, the WHO inherited the IHR at its founding, taking over responsibility from the then-existing International Sanitary Regulations.¹⁷³

Yet despite powerful forces arrayed against international law, civil society has pressed for a Framework Convention on Global Health.¹⁷⁴ The need is as urgent

169. See, e.g., Nicolò Conti et al., *The European Union Under Threat of a Trend Toward National Sovereignty*, 14 J. CONTEMP. EUR. RES. 231, 244 (2018).

170. Unusually for U.N. agencies, the WHO's constitution provides two routes to creating binding international law. See GOSTIN, *supra* note 24, at 110. First, it has a convention treaty-making power, which is enhanced by the requirement that member states notify the WHO's Director-General within eighteen months of treaty adoption whether they accept or reject the treaty and provide reasons if they are not acceding to the treaty. See Constitution of the World Health Organization, *supra* note 131, 14 U.N.T.S. at 192. No similar power exists in any other global regime. Second, the WHO can adopt regulations on topics enumerated in its constitution. *Id.* at 192–93. Such regulations automatically come into force in all member states, except any that expressly rejects the regulations within a given time period. *Id.* at 193.

171. Even after the success of the FCTC and numerous treaty proposals (such as the FCGH) that followed, the WHO has yet to make meaningful progress toward any new treaties seventeen years after the FCTC was adopted (fifteen years after it came into force), demonstrating the organization's reluctance to engage in treaty-making. Arguments about the difficulties of treaty-making evidently hold considerable sway. Common arguments include the time and resources required to develop treaties and the political difficulties of doing so. Cf. Steven J. Hoffman & John-Arne Røttingen, *Dark Sides of the Proposed Framework Convention on Global Health's Many Virtues: A Systematic Review and Critical Analysis*, 15 HEALTH & HUM. RTS. J. 117, 119 (2013) (pointing to arguments that have been made against the FCGH that are essentially against developing treaties in general, including the expense of negotiating treaties and the political difficulty of achieving agreements).

172. Lawrence O. Gostin et al., *The Global Health Law Trilogy: Towards a Safer, Healthier, and Fairer World*, 390 LANCET 1918, 1918 (2017).

173. GOSTIN, *supra* note 24, at 180. The WHO did fundamentally revise the IHR in 2005, so it goes well beyond the International Sanitary Regulations. See *id.* at 180–82.

174. See Lawrence O. Gostin et al., *The Next WHO Director-General's Highest Priority: A Global Treaty on the Human Right to Health*, 4 LANCET e890, e890 (2016); Letter from Action for Glob. Health (Eur.) et al. to Dr. Tedros Adhanom Ghebreyesus, Dir.-Gen., World Health Org. (Sept. 7, 2017), <https://>

as ever, perhaps more so. The FCGH's aim has not altered since that time, with a vision of global health with justice. Equity—ending the vast gaps in health between rich and poor—has always been at the treaty's core. In the ensuing years, the treaty's core content has taken shape, along with a bottom-up grassroots movement advocating for its adoption (see [Figure 1](#)).

Figure 1: The Evolution of the Framework Convention on Global Health: From the Founding Idea in 2008 to Today

Features of the FCGH	2008	2020
Core Idea	Organizing global health governance to meet the needs of the world's least healthy people	Enhancing accountability to right to health obligations
Institutions	Global health organizations and funders	Global and domestic institutions
Justice	Health inequalities between countries	Health inequalities within and between countries
Global Governance	Global health governance, involving organizations and rules with a primary focus on health around the world	Global governance for health, encompassing health-focused rules and organizations, as well as regimes, outside of the health sector that affect health
Specificity	Primarily general principles, reflecting lack of organizing framework for global health governance; more details in protocols	Primarily specific mandates, reflecting general principles developed through human rights treaties and interpretations; additional protocols as needed

fcghalliance.org/wp-content/uploads/2019/08/9-7-2017_WHOnewDG_FCGHsupport-1.pdf [https://perma.cc/ZBY9-VXL5] (urging the new WHO Director-General to support the FCGH in a letter from nearly 100 NGOs and global health leaders).

From its beginning, as conceptualized in *The Georgetown Law Journal*, the FCGH was conceived as an instrument to advance health equity. Since that time, the FCGH evolved considerably, subjected to civil society and academic interrogation.

A. THE POWER OF A TREATY

Securing adoption and widespread ratification of a new treaty is a formidable task, requiring arduous negotiations over years. Yet even as the WHO could more easily adopt a nonbinding instrument,¹⁷⁵ we continue to call for a treaty, with the power that comes from the binding nature of international law.

First, as binding law, a FCGH would stand above the plethora of other instruments that speak to the right to health, such as General Comment 14, even as it builds on and reinforces them. Its norms would carry formal state legal obligations—and hence a greater chance of implementation—that exceed the current body of international law aimed at the right to health. The FCGH’s principles and specific elements would build on existing WHO resolutions and other instruments, U.N. declarations, U.N. special rapporteurs’ reports, and the CESCR’s general comments. These instruments’ implementation remains weak, with sometimes flagrant violations. Something more forceful is required.

The FCTC points to the power of legally binding norms. Even with a compliance regime limited to reporting obligations,¹⁷⁶ that treaty has catalyzed action. For example, within a dozen years after it went into effect, more than fifty countries enacted or implemented comprehensive smoking bans, at least thirty-eight passed comprehensive bans on tobacco advertising, promotion, and sponsorship, and more than 115 developed pictorial warning labels covering at least thirty percent of tobacco packaging, in line with the FCTC’s requirement.¹⁷⁷ Imagine the progress we would see toward global health with justice if the FCGH were

175. To give one concrete example of the inadequacy of “soft law,” the WHO’s Pandemic Influenza Preparedness (PIP) Framework is in tension with the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from Their Utilization (a Protocol to the Convention on Biological Diversity). See Gostin et al., *supra* note 172, at 1924. The PIP Framework seeks broad access to pandemic influenza virus samples for essential biomedical research on vaccines and antiviral treatments. See *id.* at 1922–23. Yet, Nagoya States Parties often resist sharing, claiming sovereignty over viruses discovered within their territories. See *id.* at 1924. Thus, the WHO under the PIP Framework (a “soft” instrument) has a weakened position when it conflicts with Nagoya’s treaty obligations. Accordingly, the U.N. Secretary-General’s report on the West African Ebola epidemic recommended negotiating the framework into a full-blown treaty, expanded to include all pathogens (not only pandemic influenza viruses). See *id.*

176. See WHO Framework Convention on Tobacco Control art. 21, *adopted* May 21, 2003, 2302 U.N.T.S. 166, 242–43 (enacted Feb. 27, 2005).

177. *Global Issues: WHO Framework Convention on Tobacco Control*, CAMPAIGN FOR TOBACCO-FREE KIDS, <https://www.tobaccofreekids.org/what-we-do/global/fctc> [<https://perma.cc/9ZDC-KMVP>] (last updated Sept. 11, 2017); see also WHO Framework Convention on Tobacco Control art. 11, *supra* note 176, 2302 U.N.T.S. at 235 (describing requirements for packaging and labeling of tobacco products). But see Steven J. Hoffman et al., *Impact of the WHO Framework Convention on Tobacco Control on Global Cigarette Consumption: Quasi-Experimental Evaluations Using Interrupted Time Series Analysis and In-Sample Forecast Event Modelling*, 365 BRIT. MED. J. 12287 (2019) (failing to

adopted and, within a similar timespan after it were to come into force, spurred dozens or scores of countries to enact sweeping new laws and regulations to implement the right to health, along with allocating the resources needed for robust health systems that can deliver on universal health coverage and withstand the next novel disease outbreak.

Second, multiple international regimes pose threats to global health, each grounded in treaty law. These include the trade regime, where intellectual property rights may impede access to affordable medicines, and investment treaties, which may inadequately protect health in the face of competing commercial interests.¹⁷⁸ Currently, most WHO norms do not rise to the level of binding international law.¹⁷⁹ The FCGH would ensure that the right to health has equivalent status in any conflict involving states party to both treaties.¹⁸⁰ And the FCGH could similarly make it more likely that dispute resolution bodies developed through trade and investment treaties will protect health in their rulings.

Third, the binding nature of the FCGH will empower both civil society health rights advocates and—as we will turn to later—even ministries of health, with national benefits. In countries that ratify the FCGH, advocates could use the FCGH to ensure that courts protect the right to health, as well as use it as a basis for political action.¹⁸¹ The binding nature of the FCGH also stands to strengthen health advocates' case for action on the right to health as they engage health and other policymakers. Even in countries that fail to ratify the FCGH, advocates and policymakers could look to its norms,

find evidence that the adoption of the FCTC accelerated the decline of global cigarette consumption during the past thirty years).

178. See U.N. SEC'Y-GEN.'S HIGH-LEVEL PANEL ON ACCESS TO MEDS., PROMOTING INNOVATION AND ACCESS TO HEALTH TECHNOLOGIES 17–27 (2016), <https://static1.squarespace.com/static/562094dee4b0d00c1a3ef761/t/57d9c6ebf5e231b2f02cd3d4/1473890031320/UNSG+HLP+Report+FINAL+12+Sept+2016.pdf> [<https://perma.cc/MN88-X4QC>]; Louise Delany et al., *International Trade and Investment Law: A New Framework for Public Health and the Common Good*, 18 BMC PUB. HEALTH 2–3 (2018).

179. See GOSTIN, *supra* note 24, at 104, 120–21.

180. Under the Vienna Convention on the Law of Treaties, when states are party to two treaties that are in conflict, the requirements of the more recent treaty—which would be the FCGH, in this case—would prevail. See Vienna Convention on the Law of Treaties art. 30, *supra* note 129, 1155 U.N.T.S. at 339.

181. Although all treaties are legally binding on states that ratify them, courts do not always enforce a treaty even after ratification. In some countries, treaties (including, and sometimes in particular, human rights treaties) are directly enforceable and have priority over national law. See EUROPEAN COMM'N FOR DEMOCRACY THROUGH LAW, DRAFT REPORT ON THE IMPLEMENTATION OF INTERNATIONAL HUMAN RIGHTS TREATIES IN DOMESTIC LAW AND THE ROLE OF COURTS 4 (2014), [https://www.venice.coe.int/webforms/documents/default.aspx?pdffile=CDL\(2014\)046-e](https://www.venice.coe.int/webforms/documents/default.aspx?pdffile=CDL(2014)046-e) [<https://perma.cc/ND5A-SSRD>]. Sometimes these treaties have constitutional status, but sometimes they are below the constitution. In other countries, courts only enforce treaties after they have been domesticated through legislation or if they consider treaties (or certain provisions) to be self-executing, not requiring implementing legislation. See *id.* at 9, 13–14. Some courts look to international law even when a treaty is not directly incorporated into the legal order or incorporated through national legislation. See *id.* at 14. In addition, courts may use international human rights law to guide interpretation of their countries' constitutional human rights protections. See *id.*

much as U.S. tobacco control legislation draws on FCTC standards for warning labels.¹⁸²

And fourth, even the negotiations themselves could bring real benefits. Negotiations would result in several years of shining the global spotlight on the right to health, the challenges of achieving it, and how those challenges could be overcome—an unprecedented high-level focus on the right to health. And the negotiations would facilitate a sustained dialogue between states and civil society advocates, an opportunity for powerful advocacy that need not be confined to the FCGH but can also be an entryway to engagement and action on the right to health at the national and local level. Political parties may even choose to support the FCGH in their party platforms. Therefore, although the treaty aspect of the FCGH has been criticized as creating additional costs of a lengthy process of negotiating, adopting, and state ratification of the treaty, and the time this takes,¹⁸³ the negotiation process may not be as great a drawback to the treaty approach as has been asserted—or even a drawback at all.

B. THE CORE CONTENT OF THE FCGH

To achieve its aims of bringing accountability to the right to health, thereby advancing global health with justice, the FCGH would have three central features: (1) advancing core right to health principles; (2) resourcing the right to health; and (3) advancing the right across sectors and actors, nationally and globally. These would all be buttressed by an overall regime of accountability.¹⁸⁴

182. The United States is not party to the FCTC, but the treaty's imprint is clear in the Family Smoking Prevention and Tobacco Control Act, enacted four years after the FCTC came into force. See David Hammond, *Tobacco Packaging and Labeling Policies Under the U.S. Tobacco Control Act: Research Needs and Priorities*, 14 NICOTINE & TOBACCO RES. 62, 63 (2012). As noted above, the FCTC requires warning labels, which may include pictures, to cover at least thirty percent, but preferably half, of tobacco packaging. See WHO Framework Convention on Tobacco Control art. 11, ¶ 1(b), *supra* note 176, 2302 U.N.T.S. at 235. The Act, in turn, requires graphic warnings to cover half of cigarette packages and text warnings to cover thirty percent of smokeless tobacco product packaging. See Hammond, *supra*, at 63–64.

183. See Hoffman & Röttingen, *supra* note 171, at 121.

184. Some of these measures are drawn from the FCGH Alliance. FCGH ALLIANCE, A RIGHTS-BASED FRAMEWORK FOR THE SDGs AND BEYOND: A FRAMEWORK CONVENTION ON GLOBAL HEALTH 1–3 (2018), <https://fcghalliance.org/wp-content/uploads/2019/02/FCGH-briefing-paper-March-2018.pdf> [<https://perma.cc/4F2N-GCNH>].

Figure 2: Clarifying Right to Health Standards

Key right to health standards in international law are vague, or even unstated within the ICESCR's delineation of the right to health, such as participation. Even where authoritative CESCR interpretations provide clarity, in practice these carry less weight with states than do unambiguous treaty commitments. A degree of ambiguity is a common feature of constitutional law, providing overall guidance and the potential for broad applicability and evolution with the times. If the ICESCR is the constitution of economic, social, and cultural rights, the FCGH would be implementing regulations of the right to health, bringing the specificity required to turn broad commands into readily actionable standards. For example:

- The FCGH would establish standards for meaningful participation in health-related decisionmaking, addressing such features as what makes participation meaningful—with people's genuine ability to influence decisionmaking processes—and inclusive—ensuring that even marginalized populations are part of these processes. These standards will guide well-intentioned governments and provide a powerful platform for civil society and community advocacy.
- Drawing on the CESCR's General Comment 20,¹⁸⁵ the FCGH would specify a set of populations against whom discrimination is unambiguously prohibited that is broader than included in the ICESCR. These prohibitions would include making discrimination in health services for migrants, including those without documentation, impermissible. In today's age of xenophobia (such as exclusion of migrants, particularly those without documentation, from a full package of health services),¹⁸⁶ this will be politically challenging, but could not be more important.
- Despite the ICESCR's progressive realization requirement (based on the resource demands of the right to health and other economic, social, and cultural rights),¹⁸⁷ aspects of the right—such as avoiding discrimination, enabling participation, and providing accountability—are within the capacity of every state. General Comment 14 lays out core obligations,¹⁸⁸ yet some are not immediately realizable, for they require developing systems or mobilizing resources that are beyond the present capacity of the poorest countries. The CESCR itself tacitly acknowledges this limitation by emphasizing that states should prioritize these core obligations in their international assistance.¹⁸⁹ The FCGH would clarify which right to health requirements are subject to immediate fulfillment and which are subject to progressive realization, as well as what progressive realization entails.

185. CESCR, General Comment No. 20, *supra* note 111, ¶ 30 (describing how “nationality should not bar access to Covenant rights”).

186. See Lawrence O. Gostin, *Is Affording Undocumented Immigrants Health Coverage a Radical Proposal?*, 322 JAMA F. 1438, 1438 (2019); Jan Hoffman, *What Would Giving Health Care to Undocumented Immigrants Mean?*, N.Y. TIMES (July 3, 2019), <https://www.nytimes.com/2019/07/03/health/undocumented-immigrants-health-care.html>.

187. G.A. Res. 2200A (XXI), *supra* note 22, at annex, art. 2, ¶ 1 (requiring states “to take steps . . . to the maximum of [their] available resources, with a view to achieving progressively the full realization of the rights recognized in the [ICESCR]”).

188. CESCR, General Comment No. 14, *supra* note 37, ¶¶ 43–44.

189. See *id.* ¶ 45.

Advancing core right to health principles: The FCGH would reinforce core elements of the right to health, including substantive equality, inclusive and meaningful participation, and accountability. It would do so, first, by providing greater specificity, replacing ambiguities with clear standards, and turning authoritative CESCR interpretations into express state commitments (see Figure 2). Second, the FCGH would set out specific actions to advance the right to health, such as health equity programs of action and community and national mechanisms to foster participation and enhance accountability (see Figure 3).

Resourcing the right to health: Second, for rights to be realized, they need to be resourced. The FCGH would establish the first-ever national and global health financing framework (see Figure 3). Without significantly more financing, universal health coverage is not possible, much less coverage of the underlying determinants of health. The WHO has estimated universal health coverage costs at an additional nearly \$400 billion per year in low- and middle-income countries, with about thirty-five countries needing “major donor funding” to scale up primary health coverage alone, a foundation of universal health coverage.¹⁹⁰ The massive economic disruptions that COVID-19 is causing will likely mean more countries requiring greater levels of international assistance. And the FCGH could address other health funding, such as for human resources, with measures on equitable distribution, improved retention, expanded training, and ethical recruitment.

Advancing the right across sectors and actors, nationally and globally: And third, the FCGH would establish national and global right to health accountability mechanisms across all actors and sectors. To protect against violations by businesses, the FCGH could establish specific commitments grounded in the U.N. Guiding Principles on Business and Human Rights,¹⁹¹ applied to health. For example, states could incorporate right to health standards into contracts with private healthcare providers (see Figure 3). The FCGH would also establish regulatory standards to protect the public from marketing and product formulation relating to unhealthy products, such as highly processed foods, sugary sweetened beverages, and alcohol. This becomes ever more important with the growth of noncommunicable diseases, a “slow motion disaster,” in the WHO’s words, now accounting for seven in ten deaths globally.¹⁹² The Convention would go

190. WORLD HEALTH ORG., PRIMARY HEALTH CARE ON THE ROAD TO UNIVERSAL HEALTH COVERAGE: 2019 GLOBAL MONITORING REPORT: CONFERENCE EDITION 95, 97–98 (2019), https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf [<https://perma.cc/AA24-TYHC>]. To encompass countries with ninety-five percent of the world’s people living in low- and middle-income countries, total primary health coverage investments needs are about \$200 billion annually above current spending, whereas UHC would require about \$371 billion annually above current spending. *Id.* at 95.

191. *See generally* OFFICE OF THE U.N. HIGH COMM’R FOR HUMAN RIGHTS, GUIDING PRINCIPLES ON BUSINESS AND HUMAN RIGHTS IMPLEMENTING THE UNITED NATIONS “PROTECT, RESPECT AND REMEDY” FRAMEWORK (2011), https://www.ohchr.org/Documents/Publications/GuidingPrinciplesBusinessHR_EN.pdf [<https://perma.cc/N2R2-NRSQ>] (setting forth principles regarding corporate responsibility for human rights).

192. *Noncommunicable Diseases: The Slow Motion Disaster*, WORLD HEALTH ORG., <https://www.who.int/publications/10-year-review/ncd/en/index2.html> [<https://perma.cc/UE9C-DA2G>] (last visited Mar. 11, 2020).

upstream, targeting important behavioral risk factors for noncommunicable diseases, such as alcohol and unhealthy diets.¹⁹³ Also safeguarding the right to health beyond the health sector and encompassing both domestic and international actions, the FCGH would set a new norm for right to health impact assessments¹⁹⁴ (see Figure 3).

Complying with the FCGH: Atop FCGH provisions in these three areas, the treaty would develop an innovative and participatory regime of compliance, including, but also extending beyond, standard monitoring and reporting. It would include conducting joint external evaluations and implementing their findings (see Figure 3). Other features of the compliance regime could include regional special rapporteurs to monitor and promote compliance¹⁹⁵ and benefits to countries with strong compliance (see Figure 3). Further, if not already established, the FCGH could create an R2HCF, empowering civil society advocacy around accountability to the FCGH. And if we want action on health inequities, we will have to measure them. Thus, the FCGH will require careful monitoring of health inequities through disaggregated data along specified metrics (see Figure 3).

Figure 3: Key Mechanisms of the FCGH

Mechanism	Goal	Description
Health equity programs of action	Advance health equity, nationally and globally	Systematic, systemic, and inclusive action-driven approaches to health equity, based on seven principles (described in section VI.A)
Accountability and participation mechanisms	Enable inclusive and meaningful participation and enhance government accountability to its right to health obligations	Wide-ranging structures, policies, and approaches to enable people to participate in health-related decisions and to enable people to hold their governments accountable, such as sufficiently resourced village health committees whose members know their rights, public education on the right to health, transparent health-related budgets and processes for determining health benefits, and integrating right to health metrics into performance reviews used in health ministries
National and global health financing framework	Enhance domestic and international healthcare and public health financing	Targets on domestic healthcare and public health financing based on the maximum of available resources standard of the ICESCR, international health assistance, equitable health financing, and potentially global health institutions (for example, the WHO), combining global standards with inclusive national processes to adapt targets and timelines to national circumstances

193. *Id.* The other two risk factors are tobacco use, addressed through the FCTC, and physical inactivity. *Id.*

194. See Lawrence Gostin & Jonathan Mann, *Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Health Policies*, 1 HEALTH & HUM. RTS. J. 58, 60, 78 (1994).

195. See Eric A. Friedman, *An Independent Review and Accountability Mechanism for the Sustainable Development Goals: The Possibilities of a Framework Convention on Global Health*, 8 HEALTH & HUM. RTS. J. 129, 135 (2016).

Mechanism	Goal	Description
Private sector contracting	Ensure the private sector respects and contributes to realizing the right to health	Contracts between states and private health providers could incorporate requirements on nondiscrimination, affordability, inclusive participation, independent monitoring, and human rights due diligence, where providers assess their human rights impact and act to prevent and remedy identified harms
Right to health impact assessments	Ensure that all policies, programs, and projects that significantly impact the right to health do not undermine—and where possible, promote—the right to health	Analyses, developed through processes that involve people affected by the actions, of how national and international actions (for instance, treaty negotiations) stand to affect the right to health, offering recommendations to avoid undermining the right to health that states would commit to follow
Disaggregated data	Enable effective monitoring and accountability	Data that is broken down by wealth or income, sex, race, ethnicity, migratory status, disability, geographic location, and other categories relevant in national contexts (for example, indigenous status) ¹⁹⁶
Joint external evaluations	Enhance credibility of reporting on FCGH implementation and provide pathway ahead to overcoming shortcomings	Reviews of progress where government officials, civil society, and independent external actors (such as from the Office for the U.N. High Commissioner for Human Rights, and from civil society and health and human rights officials from peer countries) jointly evaluate implementation, highlighting any shortcomings and offering recommendations to redress them
Regional right to health special rapporteurs	Enhance monitoring and stimulate national dialogue	Like U.N. special rapporteurs, issuing thematic and country reports and holding country dialogues, but with greater potential effect due to small set of countries and regional expertise
Creative incentives	Encourage FCGH compliance by providing states global benefits for strong compliance	Possibly encouraging FCGH parties to support nationals of countries with high FCGH compliance for leadership positions in global health institutions

C. THE STRUCTURE OF THE FCGH

Specific standards: Framework conventions vary considerably. They can, like the U.N. Framework Convention on Climate Change (UNFCCC), provide broad standards, moving toward specificity through future protocol adoption, like the

196. These categories mirror those in the SDG target on disaggregated data, SDG 17.18. See G.A. Res. 70/1, *supra* note 30, at 27.

Kyoto Protocol and Paris Agreement. Or, like the FCTC, they can embed more precise standards in the convention itself, with detailed criteria such as requiring rotating warning labels to cover at least thirty percent of the “principal display areas” of tobacco packaging, even as they “should” cover fifty percent.¹⁹⁷ With the ICESCR already embracing the right to health, further elaborated upon by the CESCR and other bodies, the FCGH would embed considerable specificity within the treaty—sharpening right to health standards while tightening monitoring and compliance.

Treaty form: The FCGH would draw on recent treaties to become an innovative twenty-first century instrument for the right to health. Like the UNFCCC and FCTC, it could have protocols that require additional detail or that cannot secure sufficiently wide agreement.¹⁹⁸ For example, a protocol could establish mechanisms to ensure that medical supplies and equipment, and vaccines and therapies, are equitably distributed based on where most are needed, in the face of global shortages and pandemics. Also adapting from the FCTC, some provisions of the FCGH could provide states a menu of options of measures from which they could choose a certain number to advance aspects of the right to health.¹⁹⁹ Further, the FCGH can build on the approach of the Paris Agreement on climate change, in which nationally determined and progressively strengthened targets enable countries to tailor approaches to their differing circumstances.²⁰⁰ Under the FCGH, countries would develop their specific targets through inclusive, participatory processes, which would be backed by the treaty’s comprehensive approach to accountability.

The protocols and nationally determined targets could have another benefit: embedding participation in the political processes needed to abide by core FCGH obligations. It would create a space for continued, inclusive global deliberations on key questions of how to better implement the right to health, thereby ensuring that the treaty meets its aims and remains cutting edge, and advancing people’s right to participate in decisions at the international level that affect their health. And it would similarly embed inclusive participation at the national level for determining how to meet FCGH aims and mandates, helping to guarantee the key role of civil society and marginalized populations in health-related decisionmaking.

197. WHO Framework Convention on Tobacco Control art. 11, ¶ 1(b), *supra* note 176, 2302 U.N.T.S. at 235.

198. See *Protocol to Eliminate Illicit Trade in Tobacco Products*, WORLD HEALTH ORG., <https://www.who.int/fctc/protocol/en/> [<https://perma.cc/Y4ED-HX8W>] (last visited Mar. 12, 2020) (describing a protocol for the FCTC); *The Paris Agreement*, U.N. CLIMATE CHANGE, https://unfccc.int/files/essential_background/convention/application/pdf/english_paris_agreement.pdf [<https://perma.cc/ST87-VQSH>] (last visited Mar. 12, 2020) (describing a protocol for the UNFCCC); *What is the Kyoto Protocol*, U.N. CLIMATE CHANGE, https://unfccc.int/kyoto_protocol (last visited Mar. 12, 2020) (same).

199. For example, Article 16 of the FCTC prohibits the sale of tobacco products to minors and offers four possible measures for states to take to ensure the effectiveness of this prohibition. See WHO Framework Convention on Tobacco Control art. 16, ¶ 1, *supra* note 176, 2302 U.N.T.S. at 239.

200. See Environment and Conservation: Climate Change (Paris Agreement) art. 4, ¶¶ 2–3, *adopted* Dec. 12, 2015, T.I.A.S. No. 16-1104.

Contracting mechanisms, like those in the WHO's Pandemic Influenza Preparedness (PIP) Framework,²⁰¹ would enable the FCGH to apply mandates directly to corporations. Further, the process of developing and negotiating the FCGH must, like the Convention on the Rights of Persons with Disabilities (CRPD), provide a central role for civil society organizations,²⁰² including grassroots organizations, as well as marginalized communities.

D. IN THE NATIONAL INTEREST: WHY GOVERNMENTS SHOULD SUPPORT THE FCGH AS AN EMPOWERING INSTRUMENT

It may seem counterintuitive to suggest that a treaty imposing duties on sovereign governments is empowering rather than constraining. However, ministers of health—key stakeholders at the WHO, who frequently head national delegations at meetings of the organization's governing structures, the Executive Board and World Health Assembly—should find the FCGH empowering. The FCGH would guide health ministers in carrying out their responsibilities to protect the public's health. The treaty would offer binding norms, specific strategies to improve health equity and enhance participation, and accountability mechanisms. In all these ways, the FCGH would advance health ministry goals of healthier populations.

Even more significantly, and highlighting the importance of a binding legal document, the FCGH would strengthen the hand of health ministries when faced with competing interests, both within and outside of their governments. Within governments, ministries compete for a fair share of the national budget; health spending targets in the FCGH will strengthen the case for health-related expenditures. Health impact assessments²⁰³ will strengthen health ministers' hands in

201. See Gostin et al., *supra* note 172, at 1922–24. The PIP Framework is an international agreement designed to facilitate sharing of pandemic influenza virus samples and the fair sharing of the benefits of influenza research to ensure more equitable distribution of effective vaccines and antiviral medications. See *id.* at 1923–24. It includes an innovative contract mechanism between the World Health Organization and industry or academic laboratories designed to enforce commitments to fair sharing of benefits. *Id.* at 1923 & tbl.2.

202. See *Frequently Asked Questions Regarding the Convention on the Rights of Persons with Disabilities*, U.N. DEP'T OF ECON. & SOC. AFFAIRS, <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/frequently-asked-questions-regarding-the-convention-on-the-rights-of-persons-with-disabilities.html> [<https://perma.cc/KXG7-PQVT>] (last visited Mar. 12, 2020) (describing the role of civil society in CRPD negotiations).

203. See *Health Impact Assessment*, WORLD HEALTH ORG., <https://perma.cc/4SSG-A256> (last visited Mar. 12, 2020) (“Health Impact Assessment (HIA) is a means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques.”). For an evaluation of HIAs in the United States, demonstrating their impact, see generally CTR. FOR CMTY. HEALTH & EVALUATION, DO HEALTH IMPACT ASSESSMENTS MAKE A DIFFERENCE? (2014), <https://www.rwjf.org/en/library/research/2014/04/do-health-impact-assessments-make-a-difference-.html> [<https://perma.cc/DV6C-HJV9I>] (finding HIAs can facilitate policy outcomes beneficial for health). For countries and subnational jurisdictions with laws requiring HIAs in certain circumstances, see Eric Friedman & Gian Luca Burci, *Taking Health in All Policies Seriously: Health Impact Assessments, WHO Leadership, and International Law*, LANCET GLOBAL HEALTH BLOG (Sept. 5, 2017), https://marlin-prod.literatumonline.com/pb-assets/Lancet/langlo/TLGH_Blogs_2013-2018.pdf [<https://perma.cc/Y42V-B7FA>].

pressing ministries concerned with economic development and energy, for instance, to account for health impacts—rather than proceeding with policies and projects that harm health and impose costs on the health sector.

Looking beyond potentially countervailing forces within government, the food, beverage, alcohol, tobacco, and fossil fuel industries often resist regulations or taxes on their products. The FCGH could help health ministries—and the government at-large—counteract this resistance. For example, the FCGH could exclude certain industries (such as tobacco or alcohol) from participating in policymaking processes²⁰⁴ and could promote health and safety regulations, bolstering confidence the regulations will prevail in court.²⁰⁵

Ministers of health are not the only government actors who stand to benefit. FCGH guidance could inform legislators in their oversight responsibilities and in crafting legislation. Finance ministries should welcome provisions on participation and accountability. Investments and other improvements in these areas could lead to more efficient and effective use of larger amounts of health-related funding, and provide confidence that increased budget allocations for health will have measurable results. Healthy populations are more productive populations, which enables greater economic growth and tax revenue,²⁰⁶ while health systems able to quickly contain disease outbreaks can preclude disastrous economic consequences of an uncontrolled epidemic. And lower income countries could expect increased health assistance under the treaty's health financing framework.

Politicians should also appreciate the political advantages of implementing the FCGH. As populations see a government that not only works for and listens to them but also provides the health services that they expect, they may reward governing parties with their vote.

E. TAKING THE FCGH FORWARD

Even with these governmental interests, experience over the dozen years since the FCGH was first proposed indicates that without external forces working toward an FCGH, the treaty will remain beyond reach. After all, as much as the FCGH would advance the interests of health ministers and governments, the natural tendency will be for governments to see a treaty and its mandates as constraints on sovereignty. And indeed, even with adaptability of treaty mandates to national circumstances and ways in which it would contribute to goals of health

204. The FCTC includes a provision that, although not explicitly excluding the tobacco industry from participating in policymaking, does require state parties to protect public health policies from the influence of the tobacco industry. See WHO Framework Convention on Tobacco Control art. 5, ¶ 3, *supra* note 176, 2302 U.N.T.S. at 233 (“In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.”).

205. See, e.g., Suzanne Y. Zhou et al., *The Impact of the WHO Framework Convention on Tobacco Control in Defending Legal Challenges to Tobacco Control Measures*, 28 TOBACCO CONTROL (Supp. 2) s113, s113–17 (demonstrating the value of the FCTC in defending tobacco control policies in court).

206. See JEFFREY D. SACHS, COMM’N ON MACROECONOMICS & HEALTH, MACROECONOMICS AND HEALTH: INVESTING IN HEALTH FOR ECONOMIC DEVELOPMENT 1, 21–27 (2001), <http://www1.worldbank.org/publicsector/pe/PEAMMarch2005/CMHReport.pdf> [<https://perma.cc/35J5-9CFW>].

and health equity, the FCGH will include binding mandates that require action, and possibly new ways of conducting governmental affairs (such as deep community engagement and outreach to marginalized populations). Public oversight also would be decidedly against the interests of corrupt officials in the health sector and beyond.

Moreover, there will be countervailing external forces, whether tobacco, alcohol, sugary drink, or ultraprocessed food companies that would fear tighter regulations or higher taxes, or pharmaceutical companies concerned about the effects of prioritizing the right to access affordable medicines, or companies further afield (perhaps involved with extractive or other polluting industries) whose actions harm the right to health.

Above all, then, a successful push for the FCGH will require the type of bottom-up processes that led to the CRPD, with social movements led by people whose rights are most at stake.²⁰⁷ Grassroots mobilization—from educating governments about the potential benefits to exerting political pressure—could motivate governments to act.

In an important step, a coalition of FCGH advocates coalesced into the FCGH Alliance, an NGO established in Geneva and launched on Human Rights Day in December 2017.²⁰⁸ With leadership from the global South²⁰⁹ and existing primarily as a global, online community, the Alliance has started to develop an initial FCGH draft. In developing the draft, the Alliance is committed to maximizing input from civil society and communities, particularly from people in countries where and from populations for whom the right to health is distant. It uses an advocacy strategy that seeks to build support by region, bringing civil society, community members, health professionals, academics, and governments on board to champion the FCGH.

The WHO also has a vital role and should welcome the proposed treaty's potential for advancing the right to health, one of the WHO constitution's core principles,²¹⁰ and contributing to the responsive health systems that are a core element of global health security. The WHO is unlikely to launch negotiations on an

207. See Theresia Degener & Andrew Begg, *From Invisible Citizens to Agents of Change: A Short History of the Struggle for the Recognition of the Rights of Persons with Disabilities at the United Nations*, in THE UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES: A COMMENTARY 1, 10 (Valentina Della Fina et al. eds., 2017).

208. FCGH ALLIANCE, <https://fcghalliance.org/about/about-the-fcgh-alliance/> [https://perma.cc/QCL3-Q5V3] (last visited Mar. 12, 2020). Another civil society coalition, the Framework Convention Alliance, provided critical, bottom-up support for the FCTC. See *About Us*, FRAMEWORK CONVENTION ALLIANCE, <https://www.fctc.org/about-us/> [https://perma.cc/8W4B-WPE9] (last visited Mar. 12, 2020).

209. The global South encompasses low- and middle-income countries. See Marlea Clark, *The Global South: What Does It Mean and Why Use the Term?*, UNIV. OF VICT.: POL. SCI. GLOBAL S. POL. COMMENTS. (Aug. 8, 2018), <https://onlineacademiccommunity.uvic.ca/globalsouthpolitics/2018/08/08/global-south-what-does-it-mean-and-why-use-the-term/> [https://perma.cc/LA4Y-ZQAW]. The term also has more complex meanings, often linked to the global processes and structures that have contributed to global inequalities. See *id.* Contrasting with the global South is the global North, encompassing high-income countries. See *id.*

210. See Constitution of the World Health Organization, *supra* note 131, 14 U.N.T.S. at 186.

FCGH without member state buy-in. To generate that buy-in, the WHO should create an FCGH working group that would report on the potential benefits, principles, scope, structure, and modalities of an FCGH, and propose a roadmap toward negotiating and adopting the treaty. Such a working group could come about through leadership of the Director-General, who has continued to express his commitment to human rights,²¹¹ or as an initiative from WHO member states that have interest in an FCGH that is born of civil society education and advocacy, such as through the FCGH Alliance.

In line with the importance of inclusive participation to the right to health, the working group should include not only WHO member states but also academics, health workers, and, most importantly, civil society and community members. The working group's report would raise the prominence of the FCGH among WHO member states, building understanding of, and support for, the FCGH, and catalyzing negotiations that will ultimately lead to the pinnacle of international lawmaking: a treaty.

Any political negotiations are likely to lead to a treaty that lacks aspects advocates desire. Governments might push back (whether due to sovereignty concerns or by bending to corporate vested interests), watering down treaty rights. That is why persistent advocacy and mobilization—and early buy-in from states that recognize how the FCGH would advance their own stated goals and commitments—are vital. And we know it can be done. Look at the CRPD, a human rights treaty with an unyielding commitment to the full inclusion and equal rights of people with disabilities.²¹² This 2006 treaty was transformative, requiring changes in how many countries relate to people with disabilities—ranging from changing laws in order to recognize the full legal capacity of people with disabilities, to calling for new policy and practice, like shifting from institutionalization to community-based living.²¹³ Today, 181 states are party to this Convention.²¹⁴ The FCGH as a treaty with the sole purpose of achieving global health with justice is within reach.

VI. NATIONAL HEALTH EQUITY PROGRAMS OF ACTION

The FCGH is an international law response to today's massive health injustices. We now propose a comprehensive national approach to changing law and policies to advance health justice: health equity programs of action.²¹⁵

211. See Lawrence O. Gostin, et al., *70 Years of Human Rights in Global Health: Drawing on a Contentious Past to Secure a Hopeful Future*, 392 LANCET 2731, 2734 (2018) (committing to protect human rights in an article co-authored by WHO Director-General Tedros A. Ghebreyesus).

212. See Convention on the Rights of Persons with Disabilities art. 1, *supra* note 112, 2515 U.N.T.S. at 72.

213. See *id.* arts. 12, 19, *supra* note 112, 2515 U.N.T.S. at 78, 81.

214. See *Status of Ratification Interactive Dashboard: Convention on the Rights of Persons with Disabilities*, *supra* note 125.

215. See generally Eric A. Friedman et al., *Putting Health Equity at the Heart of Universal Coverage—The Need for National Programmes of Action*, 367 BRIT. MED. J. 5901, 5902 (2019) (describing and

Stark inequalities in people's health and vibrancy because of their economic and social status is a defining challenge of our time. To fulfill the global promise that "no one will be left behind,"²¹⁶ governments should adopt and rigorously implement national health equity programs of action. Ask any astute epidemiologist: what is the single greatest predictor of good (or poor) health? The answer is a person's zip or postal code.²¹⁷ The place where you were born and live must no longer be allowed to so powerfully determine human health and well-being.

We have seen how stark health inequities persist, with gaps in many countries slowly closing, but sometimes not narrowing at all, or even widening.²¹⁸ A review of sixty-four countries had a finding that should distress us all: in nearly half, the relative gaps between the wealthiest sixty percent and poorest forty percent of the population for Millennium Development Goal (MDG) health outcome indicators (stunting, underweight, infant mortality, under-five mortality, and HIV prevalence) was actually *growing* during the MDG era.²¹⁹

To reverse such trends and accelerate progress toward health equity, we propose that countries develop health equity programs of action, catalyzing domestic actions designed from the ground up, for the singular purpose of reducing stark inequalities in health.²²⁰ National programs of action would be systematic, systemic, and participatory action plans for speedily progressing toward health equity, following seven principles as detailed below. Although several high-income countries (and subnational jurisdictions) have developed health equity strategies,²²¹ none has the same systematic, action-oriented structure that we propose, nor have they been developed through highly participatory processes.

It is worth pausing to reflect on this paucity of dedicated, action-oriented planning to ameliorate health inequities, despite health disparities being one of the most striking modern injustices. Countries plan to address other inequalities, in income for example, or even within the health system, such as the inequitable distribution of health workers or lack of affordable healthcare. Yet a genuine

advocating for health equity programs of action); O'NEILL INST. FOR NAT'L & GLOB. HEALTH LAW, *supra* note 29, at 5 (same).

216. G.A. Res. 70/1, *supra* note 30, at 1.

217. *See* Zub, *supra* note 159.

218. *See supra* Sections II.A and II.B.

219. *See* Wagstaff et al., *supra* note 81, at 137, 143. The sixty-four countries were the only ones for which the necessary data was available. *Id.* at 142–43. By MDG era, we refer to the years 2000 through 2015. The Millennium Development Goals were launched in 2001, growing out of the U.N. Millennium Declaration in 2000. *See* David Hulme, *The Millennium Development Goals (MDGs): A Short History of the World's Biggest Promise* 33–42 (Brooks World Poverty Inst., BWPI Working Paper 100, Sept. 2009), <http://hummedia.manchester.ac.uk/institutes/gdi/publications/workingpapers/bwpi/bwpi-wp-10009.pdf> [<https://perma.cc/T85E-8WYL>] (describing the history of the MDGs' creation after the Millennium Declaration). Many targets were applied retrospectively, and covered the years 1990 through 2015, though several targets were for 2005, 2020, or had no specific date attached to them. *See id.* at 49–50.

220. *See generally* Friedman et al., *supra* note 215 (proposing and detailing even principles for health equity programs of action).

221. LAURA ANDERSON & SEONG-GEE UM, WELLESLEY INST. FOR HEALTH QUALITY ONT., INTERNATIONAL REVIEW OF HEALTH EQUITY STRATEGIES 4 tbl.A (2016), <http://www.wellesleyinstitute.com/wp-content/uploads/2016/07/International-Review-of-Health-Equity-Strategies.pdf> [<https://perma.cc/48QT-HVDC>].

response to health inequity must encompass a wide range of injustices—in the built and natural environments, quality health services, education, and income, to name a few. It is, indeed, a prodigious task. Yet given the breadth of causes of health inequities (cutting across healthcare, public health, and the social determinants of health), and the power of poor health to impact every part of the human experience, governments must take comprehensive action to tackle the profound human and social harms of health disparities.

We focus on national health equity programs of action because countries have a duty to safeguard the health and safety of *all* their inhabitants. Discrimination is often a country-wide phenomenon with a national history—for instance, against indigenous peoples and peoples of African descent in the Americas, with their legacies of genocide and slavery.²²² Many policies that have contributed to inequities are rooted in national laws, policies, and budget choices. It is distinctly within the power of governments to ameliorate health inequities.

Necessary responses, such as laws and policies to redress discrimination, are correspondingly national. Healthcare systems typically have a national framework. Environmental, health, education, and labor laws are often promulgated nationally.²²³ The government's taxing and spending powers can either mitigate or exacerbate wealth and income inequities and generate (or fail to generate) adequate revenue for measures to rapidly reduce health inequities. National action also is necessary to ensure that no one is left behind because if left to local action, some localities would implement health equity programs of action, but others might not.

Health equity programs of action should be incorporated into national health plans or sustainable development strategies. Yet actions aimed at maximizing justice must be everywhere. The principles upon which they are based should and can, to a significant degree, inform other health-related plans, strategies, and initiatives, such as HIV policies, TB programs, pandemic preparedness strategies, and prevention or early detection of cancer, diabetes, and cardiovascular disease.

And although they are an instrument of domestic policies, programs of action should incorporate transnational considerations, including climate change mitigation and adaptation; the cavernous gaps in health globally; and the international spread of infectious diseases, which typically most impact people living in poorer countries and vulnerable situations.²²⁴ These actions might include, for example, accelerating action toward zero-carbon emissions, eliminating agricultural subsidies that cause economic dislocation among farmers in lower income countries, increasing and reforming international assistance for health to target inequities,

222. See COMM'N OF THE PAN AM. HEALTH ORG. ON EQUITY & HEALTH INEQUALITIES IN THE AMS., *JUST SOCIETIES: HEALTH EQUITY AND DIGNIFIED LIVES* 7–8 (2019) [hereinafter *JUST SOCIETIES*], <http://iris.paho.org/xmlui/handle/123456789/51571> [<https://perma.cc/DV6C-HJV9>].

223. Consider in the United States, for example, the Every Student Succeeds Act (2015), the Patient Protection and Affordable Care Act (2010), the Clean Water Act (1972), the Clean Air Act (1963), and the National Labor Relations Act (1935).

224. O'NEILL INST. FOR NAT'L & GLOB. HEALTH LAW, *supra* note 29, at 33, 45.

and developing extra capacity to produce personal protective equipment²²⁵ to create a health system surge capacity for meeting not only domestic needs, but also for contributing to international needs.

Yet local policies—from environmental standards and water and sewage systems to zoning laws and urban design—also critically shape whether we experience justice in our daily lives. Healthy conditions of life include the quality of our schools, the safety of our water, the design of our neighborhoods (for example, promoting physical activity), the safety standards on roads, and the availability and affordability of nutritious food.²²⁶ States, provinces, and municipalities could also develop their own health equity programs of action. Such “laboratories of democracy”²²⁷ can also be laboratories of health equity. The Healthy Chicago 2.0 plan, for example, follows a Health in All Policies approach for municipal governance, with each city agency using a health equity lens.²²⁸ The plan covers ten action areas (for example, partnerships and community engagement, education, and violence), supports multisectoral collaboration, and includes thirty goals that encompass eighty-two objectives and over two hundred strategies.²²⁹

A. THE SEVEN PRINCIPLES OF HEALTH EQUITY PROGRAMS OF ACTION

Governments are likely to close unconscionable health gaps only through systematic, well-funded plans of action. National health equity programs of action, moreover, will not succeed without adhering to seven core principles.

1. Maximizing Health Equity²³⁰

Any health inequity is, per se, unjust. Health equity programs of action should aim for full justice, with the greatest achievable narrowing of disparities as quickly as possible. Full health equity will take time, requiring undoing injustices that often have roots in centuries-old discrimination. And the health inequities that affect children—malnutrition, toxic stress, and air pollution, for instance—might not be entirely undone in their lifetimes.

Health equity requires programs of action to reach the deepest determinants of health: structural injustices from systematic discrimination and political

225. Personal protective equipment includes medical masks, gloves, goggles, and gowns. Health workers wear this gear to protect themselves and their patients from infectious diseases. The world faced severe shortages during the COVID-19 pandemic. See News Release, World Health Org., Shortage of Personal Protective Equipment Endangering Health Workers Worldwide (Mar. 3, 2020), <https://www.who.int/news-room/detail/03-03-2020-shortage-of-personal-protective-equipment-endangering-health-workers-worldwide> [https://perma.cc/H2QZ-BPUJ]

226. See O’NEILL INST. FOR NAT’L & GLOB. HEALTH LAW, *supra* note 29, at 61–73 (describing social determinants of health).

227. See *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (“It is one of the happy incidents of the federal system that a single courageous state may . . . serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”).

228. CHI. DEP’T OF PUB. HEALTH, HEALTHY CHICAGO 2.0: PARTNERING TO IMPROVE HEALTH EQUITY: 2016–2020, at 8 (2016), https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/HC2.0Plan_3252016.pdf [https://perma.cc/7GCX-W3QQ].

229. *Id.* at 2, 7.

230. See O’NEILL INST. FOR NAT’L & GLOB. HEALTH LAW, *supra* note 29, at 28–29.

exclusion to unfair land distribution and control over other economic resources. It also requires a robust understanding of the causes of health inequities and effective actions to address them. Programs of action need to be based in evidence, with ongoing monitoring, evaluation, and research.

2. Empowering Participation and Inclusive Leadership²³¹

Members of marginalized communities should be central to the processes of developing and implementing health equity programs of action. Their participation should be empowering, with genuine decisionmaking power and leadership roles, such as chairing or co-chairing committees tasked with spearheading programs of action.

Individuals have a right to participate in health-related decisions that can intimately affect their lives. Inclusive participation will also lead to more successful plans. People know best their own health needs and realities, and thus what actions will most favorably impact their lives and contribute to their health and well-being. This participation also will ensure a plan that is ambitious and excludes no population; marginalized communities are their own most forceful advocates.

Yet above all, inclusive participation is the surest—and maybe only—way to ensure that health equity programs of action serve their purpose. Even the best plans can go unimplemented. Having the people experiencing health inequities take ownership of the programs of action will help protect against poor execution; their understanding and commitment will make them powerful advocates for full implementation.

The opportunity to participate as equals alongside government officials, even in leadership roles, can help change expectations among people whose past experiences have taught them that no one will listen. A powerlessness that once seemed inevitable may begin to feel unacceptable. Changed mindsets and new capacities could engender the confidence and skills to effectively engage in policymaking processes.

3. Health Systems and Beyond²³²

Dozens of social determinants contribute to health inequities.²³³ Thus, plans should address all of these social determinants, even if some are prioritized. Programs of action, therefore, should systematically interrogate each determinant for how it contributes to health inequities, and then plan corresponding actions. Health in All and Equity in All Policies will need to become the norm, as will intersectoral engagement and collaboration. Most ministries and sectors have an impact on health, extending from housing, education, and urban planning to agriculture, the environment, and the treasury.

231. *See id.* at 20–27.

232. *See id.* at 30–34.

233. *See id.* at 31, 61–73 (listing and describing social determinants of health).

Countries will need new mechanisms and policies, including forums for inter-sectoral collaboration. Health ministers need to lead, but leadership should cut across sectors and include other ministries incorporating health equity into their mandates. Health equity impact assessments could be required for assessing policies, programs, and projects that may affect health equity. At their best, impact assessments should be transparent and participatory, leading the government (and private sector) to respond to findings to mitigate inequities.

4. Every Population Counts²³⁴

Reflecting deep discrimination, health inequities affect a highly diverse set of people: indigenous peoples and migrants, women and members of the LGBTQIA+ community, racial and ethnic minorities, people with disabilities, people who live in poverty, and more. Programs of action should not leave any group out.

Many of these communities share numerous characteristics, such as being disproportionately poor, having relatively less education, and reduced access to healthcare. Yet each group also faces specific obstacles. Migrants may be denied health and other social benefits because they are not citizens or lawful residents. People with disabilities face institutionalization and pervasive social stigma. Racial minorities and indigenous people may have experienced centuries of discrimination and exclusion and possibly a past of slavery or genocide. Even as programs of action address shared obstacles to good health, they will need to address each population's particular circumstances. They should, therefore, systematically identify each population experiencing health inequities, analyze the causes of these inequities, and incorporate actions to address them.

5. Actions, Targets, and Timelines²³⁵

Programs of action are meant to be a platform for just that: action. This means detailing specific policies and programs that countries undertake to establish, implement, reform, transform, or terminate. Specific targets should accompany actions. Targets may focus on particular areas of action (for example, educational attainment, income support, or healthcare access) or metrics of health outcomes (for example, maternal health, child mortality, or life expectancy). They should also include concrete benchmarks and timelines, thus facilitating critical evaluation of progress toward health equity. The actions and associated budgets, targets, and timelines should be integrated into plans for the relevant sectors.

6. Comprehensive Accountability²³⁶

A thorough regime of accountability will not only help ensure that programs of action are implemented, but it will also enable iterative improvements. Governments should regularly report on progress. Independent reporting, through methods like joint external evaluations, should supplement government reports.

234. *See id.* at 35–42.

235. *See id.* at 43–50.

236. *See id.* at 51–58.

Reports would analyze shortcomings and offer recommendations on how to overcome them.

As long as measurements of success remain aggregated—that is, on an overall population level—it will be impossible to know which groups are left behind and why. Consequently, measurement and evaluation must include disaggregated data collection and use.²³⁷ Capacity to collect and evaluate subpopulation data must be strengthened to enable effective monitoring of progress. Along with data for monitoring and accountability, data will help ensure an informed public, helping enable people to confidently and effectively engage policymakers and hold them accountable. Further, programs of action could include a range of measures to increase accountability, including access to courts, village health committees, legislative oversight, and right to know laws, along with capacity building for civil society. Above all, we need tools to collect, measure, and evaluate how governments are fulfilling their right to health obligations—and to ensure redress when they are falling short.

7. Sustained High-Level Political Commitment²³⁸

The sweeping nature of health equity programs of action requires high-level political commitment if they are to be faithfully implemented. High-level commitment is needed to ensure coordination and collaboration across ministries and agencies, actions in every sector, and the necessary funding. Heads of government or the legislature could establish a supraministerial committee to oversee and drive intersectoral action, and a national SDG advisor could report to the president or prime minister on progress. Continued civil society and community vigilance, including strategic advocacy and use of the media, will be critical.

B. WHAT GOVERNMENTS WOULD GAIN FROM HEALTH EQUITY PROGRAMS OF ACTION

Matching the magnitude of the immense injustices that they seek to remedy, health equity programs of action would be major undertakings, requiring new forms of government operations—working with communities and civil society as equal partners, as well as extensive multisector collaboration—and new and reformed laws and policies. Powerful constituencies will likely resist equity action programs, including corporations that profit from targeting marginalized communities with unhealthy products, landowners who benefit from the

237. Not long before the SDGs were adopted, an analysis from the U.N.-linked Sustainable Development Solutions Network estimated that \$1 billion per year was “required to enable 77 of the world’s lower income countries to catch-up and put in place statistical systems capable of supporting and measuring the SDGs.” JESSICA ESPEY ET AL., SUSTAINABLE DEV. SOLS. NETWORK, DATA FOR DEVELOPMENT: A NEEDS ASSESSMENT FOR SDG MONITORING AND STATISTICAL CAPACITY DEVELOPMENT 6 (2015), <https://sustainabledevelopment.un.org/content/documents/2017Data-for-Development-Full-Report.pdf> [<https://perma.cc/7PD6-KRSL>]. The SDGs include a target (17.18) of building capacity “to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts.” G.A. Res. 70/1, *supra* note 30, at 27. More than just funding will be needed. For example, countries need to include relevant dimensions in survey instruments and provide more training for public health authorities. See Friedman et al., *supra* note 215, at 2.

238. See O’NEILL INST. FOR NAT’L & GLOB. HEALTH LAW, *supra* note 29, at 59–60.

concentration of land and power in their hands, and wealthy individuals who benefit from low tax rates. It is often hard for public officials to resist the political contributions and lobbying of vested interests or adjust to different ways of operating. Why might a government nonetheless initiate a health equity program of action?

At the most basic level, health equity programs of action would help governments fulfill their SDG pledge of leaving no one behind. Universal health coverage is unachievable without inclusive access to health coverage, which requires understanding and responding to each population's obstacles to health services, many of which are linked to social determinants.²³⁹ SDG targets in areas such as reductions in noncommunicable diseases, mental illness, road traffic deaths, and substance abuse²⁴⁰ are integrally linked to social determinants,²⁴¹ with prevention requiring actions outside the health system. The SDGs also encompass global health security,²⁴² yet if health and social systems are not designed to protect marginalized populations in the face of an infectious disease outbreak, members of these populations will perish at higher rates, while increasing the spread of disease into other populations. And beyond the SDGs, health equity programs of action will help governments fulfill their right to health obligations.

Governments should also create health equity programs of action to meet their significant responsibilities, which range from safeguarding the public's health to fostering economic growth and development. Heightened levels of disease, disability, and injuries among disadvantaged communities undermine the health and economic well-being of all, from communicable diseases that spread from person-to-person and violence from which no one is immune, to the healthcare costs and social benefit outlays of treating illnesses and supporting people who are unable to work.

Improved economic productivity from the better health of disadvantaged populations will contribute to economic growth and government tax revenue.²⁴³ And a formidable response to health inequities could win international accolades and cement politicians' legacies.²⁴⁴ More significantly, even if powerful interests resist systemic action toward health justice, elected officials could bear

239. See Douglas C. Dover & Ana Paula Belon, *The Health Equity Measurement Framework: A Comprehensive Model to Measure Social Inequities in Health*, 18 INT'L J. FOR EQUITY HEALTH 1, 4 (2019).

240. See G.A. Res. 70/1, *supra* note 30, at 16.

241. See O'NEILL INST. FOR NAT'L & GLOB. HEALTH LAW, *supra* note 29, at 7–8 (discussing connections between SDGs and health). See generally Jessica Allen et al., *Social Determinants of Mental Health*, 26 INT'L REV. PSYCHIATRY 392 (2014) (describing the link to mental illness); Michael Marmot & Ruth Bell, *Social Determinants and Non-Communicable Diseases: Time for Integrated Action*, 365 BRIT. MED. J. (Supp. 1) 10 (2019) (describing the link to noncommunicable diseases); *Factors That Impact Addiction and Problematic Substance Use*, CAN. MENTAL HEALTH ASS'N, ONT., <https://ontario.cmha.ca/factors-that-impact-addiction-and-substance-misuse/> [<https://perma.cc/3H2Z-27F6>] (last visited May 5, 2020) (describing the link to substance abuse). Road deaths are, at their core, a matter of transportation, which is one of the social determinants of health. See O'NEILL INST. FOR NAT'L & GLOB. HEALTH LAW, *supra* note 29, at 66.

242. G.A. Res. 70/1, *supra* note 30, at 17 (Sept. 25, 2015).

243. See SACHS, *supra* note 206, at 1, 21–27.

244. Consider, for example, the centrality of the Civil Rights Movement and the War on Poverty to President Lyndon B. Johnson, and what his legacy might have been if not for the Vietnam War. See

considerable political dividends.²⁴⁵ Even apart from the collective benefits of health equity, the many groups that most directly benefit from health equity programs of actions—from women and poorer people to people with disabilities and to racial and ethnic minorities—will invariably comprise a large portion of the population.

C. CHALLENGES AND PATHWAYS TO OVERCOMING THEM

Considering the ever-present question of political will, along with the funding that implementing programs of action would entail, developing health equity programs of action poses practical challenges. Given the centrality of inclusive participation in developing programs of action, mindsets of government officials who are not accustomed to working closely with community members and civil society organizations—much less sharing with them control over decisions—will need to change. Similarly, officials might have little experience working closely with counterparts in other sectors, yet formulating the cross-sector health equity program of action and addressing the social determinants of health will require such collaboration.

The process of developing programs of action would entail expenses and would be a complex undertaking given the multifaceted nature of health inequities. The process would need to involve all sectors that impact health equity, which in many countries could be virtually every sector. Programs of action would require extensive analyses, covering numerous social determinants of health and numerous populations and subpopulations.

Yet these challenges ought not to dissuade action. For a start, technological advances such as artificial intelligence could process large quantities of data to help identify disparate causes of health inequalities²⁴⁶, as well as potential remedies. Moreover, financial investments in health equity today will lead to more productive populations and yield significant economic returns over time.²⁴⁷ The process may be complex, but the potential rewards—measured both by people’s

Doris Kearns Goodwin, *The Divided Legacy of Lyndon B. Johnson*, ATLANTIC (Sept. 7, 2018), <https://www.theatlantic.com/ideas/archive/2018/09/the-complicated-legacy-of-lyndon-johnson/569068/>.

245. Following a study that “revealed the significance of health shocks on the vulnerability of the poor, particularly in rural areas,” user fees in Uganda became a “major election issue” in 2001. JEREMY HOLLAND ET AL., WORLD BANK, TOOLS FOR INSTITUTIONAL, POLITICAL, AND SOCIAL ANALYSIS OF POLICY REFORM: A SOURCEBOOK FOR DEVELOPMENT PRACTITIONERS 232 (2007), <http://documents.worldbank.org/curated/en/434581468314073589/pdf/390220Tools0fo101OFFICIAL0USE0ONLY1.pdf> [<https://perma.cc/2HX7-LSCE>]. In facing the electorate, the government ended user fees in public health facilities. *Id.*

246. See I. Glenn Cohen, *Informed Consent and Medical Artificial Intelligence: What to Tell the Patient?*, 108 GEO. L.J. 1425, 1430–31 (2020).

247. See Dean T. Jamison et al., *Global Health 2035: A World Converging Within a Generation*, 382 LANCET 1898, 1898 (2013) (“The returns on investing in health are impressive.”). Reductions in mortality accounted for eleven percent of income growth in low- and middle-income countries from 1970–2000. *Id.* at 1913. The greatest potential for gains in reductions in mortality—and therefore, potentially, income growth—are among marginalized populations, experiencing the highest mortality. Meanwhile, under what the *Lancet Commission* calls a “full income approach,” the *Commission* found that investments in a number of areas (reproductive, maternal, newborn, and child health; HIV, TB, and malaria; and neglected tropical diseases) would yield benefits that exceed costs by a factor of nine in low-income countries and a factor of twenty in lower-middle-income countries. *Id.* at 1919, 1922–23. The full income approach values not only the increased productivity that comes with better health but

health and productivity—are tremendous. Leadership from the top can provide a model of social engagement and cross-sectoral collaboration, signaling a change in culture and expectations. Training can provide officials the skills required for new ways of operating, as can regional and global exchanges with countries and localities where cross-sector collaboration is more common and where social participation is a regular part of policymaking.

The complexity of health equity programs of action could be addressed from several directions. One would be a decentralized process, with different populations developing action plans regarding the health inequities they face. A collaborative process, involving members of affected populations, government officials, and others, could then bring separate streams of action into a coherent whole.

Alternatively, countries could begin with a modestly scaled-back program of action. For example, they initially could address only a subset of the most significant determinants of health inequities and then iteratively include others over a period of several years. Similarly, programs of action could include a smaller set of priority actions, with follow-on programs adding more actions. Countries could also undertake proof-of-concept programs of action in subnational jurisdictions or for particular health challenges and use resulting lessons to develop a full national health equity program of action.

D. ADVANCING HEALTH EQUITY PROGRAMS OF ACTION

Taking programs of action from concept to practice could be achieved through multiple pathways: bottom-up, top-down, or a combination of both. A bottom-up approach requires local or national leadership. One or several countries, or subnational jurisdictions, might recognize the far-ranging benefits of health equity programs of action—from political gain and meeting international commitments to improved public health and workforce productivity—and pioneer this approach. The WHO or one of its regional offices could lead a top-down strategy. The WHO could promote health equity programs of action as part of its commitment to universal health coverage and the SDGs. At least one regional office is in position to act. Following its Commission on Equity and Health Inequalities in the Americas,²⁴⁸ the Pan American Health Organization (PAHO) is developing a regional strategy on health equity,²⁴⁹ with the potential to catalyze national health equity programs of action. Wealthier countries could offer resources to help lower income countries develop and finance the programs of action.

also “people’s willingness to trade off income, pleasure, or convenience for an increase in their life expectancy.” *Id.* at 1898.

248. See JUST SOCIETIES, *supra* note 222, at 3.

249. In October 2019, the PAHO Executive Committee gave the green light to PAHO to develop a health equity strategy. See PAN AM. HEALTH ORG., 165TH SESSION OF THE EXECUTIVE COMMITTEE: FINAL REPORT, CE165/FR 5–6, 9 (2019), https://www.paho.org/hq/index.php?option=com_docman&view=download&alias=51338-ce165-fr-e-final-report&category_slug=ce165-en&Itemid=270&lang=en [<https://perma.cc/G2CW-9E97>] (proposing and deciding to add “a strategy on equity in health” to the policy program for the 166th Session of the Executive Committee in 2020); E-mail from Anna Coates, Chief, PAHO Office for Equity, Gender, & Cultural Diversity, to Eric A. Friedman, Glob. Health Justice Scholar, Georgetown Univ. Law Ctr. (Oct. 10, 2019, 4:36 PM) (on file with author).

This much is clear: the SDGs and their promise of leaving no one behind cannot be achieved without deliberate planning. Health equity programs of action entail just such planning. They would bridge the gap between countries' commitments in international forums and the moral imperative of health justice, on the one hand, and action at home, on the other. Like the FCGH at the international level, too much is at stake for this domestic approach to go unexplored and unimplemented.

VII. RIGHT TO HEALTH CAPACITY FUND (R2HCF)

International law turned the right to health into a universal obligation.²⁵⁰ The FCGH would create additional obligations while bringing accountability for fulfilling the full panoply of health-related human rights. International mandates have little meaning unless their core principles are implemented into domestic laws and policies. Yet domestic action on the right to health often lags behind international law. Mobilizing an all-of-government or all-of-society approach to the right to health requires civic action, from the cooperative (civil society meeting with policymakers to discuss concerns and chart paths ahead) to the confrontational (NGOs bringing strategic litigation to the courts or social movements taking their demands to the streets).

Civic action and social mobilization require resources to build capacity to participate effectively in health governance. Civil society organizations need sustainable funding. Human rights lawyers cannot always work pro bono. Educating people on their health rights and government officials on their obligations requires effective training. Technologies to empower community monitoring cost money.

Governments and international partners do fund, however inadequately, the health services to which everyone is entitled under the right to health, from primary care to essential vaccines and medicines. Yet funding for civic action is vital to ensure that these services are in fact available and live up to their potential of benefitting people's health. Capacity building for the right to health is neither a focus of international government assistance for health nor, with rare exceptions, foundations.

An expanding civil society coalition emerged last year to support a right to health initiative to help fill this gap: a Right to Health Capacity Fund (R2HCF)²⁵¹ with an initial financing target of \$500 million annually—a level low enough to be achievable, but large enough to be transformative.

We turn now to the power of civil society and community-led advocacy and accountability, followed by the case for funding civic action. Finally, we turn to proposed parameters for the R2HCF itself, as well as the genuine potential for establishing it.

250. See Gostin et al., *supra* note 211, at 2733–34.

251. Friedman et al., *supra* note 33.

A. THE POWER OF CIVIC ACTION FOR THE RIGHT TO HEALTH

Why is capacity building for civic action so essential? The answer is that the most remarkable health landmarks have been achieved only through bottom-up social mobilization.²⁵² Communities have the unique power to hold their government accountable. Social movements best succeed when led by people who are themselves subject to marginalization and sweeping discrimination. We have seen this time and again—in the U.S. civil rights struggle and in national and global movements for the rights of women, LGBTQIA+ people, and people living with HIV, for example.

After decades of chipping away at discrimination and gaining national protections, people living with disabilities, under the banner of “Nothing About Us Without Us,” secured the CRPD, with a genuine promise of full inclusion.²⁵³ It took the Treatment Action Campaign, led by people living with HIV and AIDS, to force the South African government to provide antiretroviral therapy, as they combined litigation with grassroots advocacy.²⁵⁴ Litigation and social action have also been the recipe of the right to food campaign in India, with successes including court orders on cooked midday meals for primary school children and covering topics as diverse as maternal and child health and homelessness.²⁵⁵

Yet it is far from only court cases or national social movements that advance the right to health. Take municipal-level accountability in rural indigenous communities in Guatemala. The Center for the Study of Equity and Governance in Health Systems (CEGSS) works with indigenous leaders to strengthen their networks and to provide training on documenting health service deficiencies and advocating for their health rights.²⁵⁶ This has led to ambulances purchased and maintained, prescriptions filled, and closed facilities re-opened and staffed.²⁵⁷

252. In recent years, perhaps the most remarkable global health achievement has been the transformation of AIDS from a disease neglected by politicians and for which there was no treatment, to a disease with a treatment deemed unaffordable for the vast majority of HIV-positive people who lived in lower income countries, to one for which, by mid-2019, nearly twenty-five million people were receiving antiretroviral therapy. See UNAIDS, POWER TO THE PEOPLE 5 (2019), https://www.unaids.org/sites/default/files/media_asset/power-to-the-people_en.pdf [<https://perma.cc/YXM9-H4NH>]; Richard Parker, *Grassroots Activism, Civil Society Mobilization, and the Politics of the Global HIV/AIDS Epidemic*, 17 BROWN J. WORLD AFF. 21, 21–22, 27–28 (2011).

253. Eli A. Wolff & Mary Hums, “Nothing About Us Without Us” — Mantra for a Movement, HUFFPOST (Sept. 6, 2017), https://www.huffpost.com/entry/nothing-about-us-without-us-mantra-for-a-movement_b_59aea450e4b0c50640cd61cf [<https://perma.cc/RQ96-2VHX>]; see also Convention on the Rights of Persons with Disabilities art. 1, *supra* note 112, at 72 (describing the purpose of the CRPD).

254. See Jonathan Berger, *Litigating for Social Justice in Post-Apartheid South Africa: A Focus on Health and Education*, in COURTING SOCIAL JUSTICE: JUDICIAL ENFORCEMENT OF SOCIAL AND ECONOMIC RIGHTS IN THE DEVELOPING WORLD 38, 83–84 (Varun Gauri & Daniel M. Brinks eds., 2008); GOSTIN, *supra* note 24, at 265.

255. See GOSTIN, *supra* note 24, at 265–66.

256. Alison Hernández et al., *Pathways to Accountability in Rural Guatemala: A Qualitative Comparative Analysis of Citizen-Led Initiatives for the Right to Health of Indigenous Populations*, 113 WORLD DEV. 392, 394 (2019).

257. *Id.* at 397.

These steps toward functioning health systems may seem mundane, but they save lives, as nominal health coverage becomes meaningful access to vital health services.

In Ghana, a team that included community members evaluated maternal and child care in thirty-seven health facilities across eight districts.²⁵⁸ After assessing nine domains, such as infrastructure, essential equipment, essential drugs, and water, sanitation, and hygiene, the team developed scorecards to display the results.²⁵⁹ Communities used the scorecards to improve care. They took the initiative themselves, such as by raising funds to fill gaps. Community radio programs disseminated results. And community members advocated.²⁶⁰ One district created a health advocacy network that garnered support of the local parliamentarian.²⁶¹ Health workers themselves were empowered, such as a nurse whom the scorecard gave confidence to approach her superiors to insist upon the equipment she needed, and facility staff that succeeded in getting an additional midwife and more patient beds from higher level government authorities.²⁶² Care improved at most facilities, especially infrastructure, the availability of essential drugs, and patient–provider interactions.²⁶³

Multiplied many times over, across communities and countries, approaches such as those in Guatemala and Ghana could be the difference between universal health coverage in policy and universal health coverage in practice.

B. FUNDING CIVIC ACTION

The case for funding to enable increased—and more effective—civic action is compelling. But what about a more straightforward approach of direct funding for universal health coverage? A global fund could be established to finance health systems, including clinics, health workers, and essential medicines.

The funding needs for universal healthcare and the public health systems that can prevent and respond to disease outbreaks are immense, and governments both domestically and through international assistance ought to massively scale up investments in health systems. To give an idea of the scale of funding needed, the WHO estimates that to achieve comprehensive universal healthcare that encompasses the third SDG’s health targets, low- and middle-income countries would need at least an additional \$371 billion every year.²⁶⁴ Although national governments would provide most of these resources, billions of additional funding in development assistance would also be required. The WHO observed that

258. Carolyn Blake et al., *Scorecards and Social Accountability for Improved Maternal and Newborn Health Services: A Pilot in the Ashanti and Volta Regions of Ghana*, 135 INT’L J. GYNECOLOGY & OBSTETRICS 372, 373 (2016).

259. *Id.* at 373–74.

260. *Id.* at 374.

261. *Id.* at 377.

262. *Id.* at 376–77.

263. *Id.* at 374.

264. WORLD HEALTH ORG., *supra* note 190, at 95. The WHO made this estimate in 2017 based on and encompassing sixty-seven low- and middle-income countries with ninety-five percent of the total population in low- and middle-income countries. *Id.* Actual costs would be somewhat higher given the need to also ensure universal health coverage in the several low- and middle-income countries not included in this estimate.

about thirty-five countries will “need major donor funding” for primary health-care investments alone,²⁶⁵ and this does not include universal coverage of health-care and public health services, nor does it account for the immense economic losses that countries are experiencing due to COVID-19.

Yet it is this gaping shortfall that leads us to focus our energies instead on the R2HCF. The Global Fund to Fight AIDS, Tuberculosis and Malaria already invests \$1 billion annually “to build resilient and sustainable systems for health,”²⁶⁶ an important contribution but one still dwarfed by the overall need, despite being at a level twice the proposed level of R2HCF financing. Even with stepped-up domestic financing, lower income countries would need many billions of additional dollars to make a significant dent in the financing gaps.

By contrast, a \$500 million annual R2HCF would utterly reshape the right to health funding landscape. Unlike other areas of health, there are no estimates of current funding for the core areas of R2HCF investments, such as civil society advocacy and mechanisms for accountability and inclusive participation. But excluding the critical, yet discrete, area of sexual and reproductive health rights funding, we estimate that the funding presently available is—at best—merely several hundred million dollars annually (see [Figure 4](#)).

Figure 4: Key Actors and the Existing Right to Health Advocacy Funding Landscap

Global Fund to Fight AIDS, Tuberculosis and Malaria	Total funding to address human rights barriers, both in an initiative in twenty countries launched in 2017 and through the regular proposal process	\$123 million (over the three-year period 2017-2019) ²⁶⁷
	Funding requested in concept notes submitted in 2014 and 2015 to overcome legal barriers	\$48 million ²⁶⁸ (for three-year funding cycles) ²⁶⁹

265. *Id.* at 97–98.

266. *Resilient & Sustainable Systems for Health*, GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS & MALARIA (July 29, 2019), <https://www.theglobalfund.org/en/resilient-sustainable-systems-for-health/> [<https://perma.cc/78CB-FV6K>].

267. See GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA, OFFICE OF THE INSPECTOR-GENERAL, ADVISORY REVIEW: REMOVING HUMAN RIGHTS-RELATED BARRIERS: OPERATIONALIZING THE HUMAN RIGHTS ASPECTS OF GLOBAL FUND STRATEGIC OBJECTIVE 3 (2019) 2, https://www.theglobalfund.org/media/9020/oig_gf-oig-19-023_report_en.pdf [<https://perma.cc/XSA2-EJWC>].

268. Ralf Jürgens et al., *Human Rights and the Global Fund to Fight AIDS, Tuberculosis and Malaria: How Does a Large Funder of Basic Health Services Meet the Challenge of Rights-Based Programs?*, 19 HEALTH & HUM. RTS. J. 183, 190 (2017).

269. *Funding Model*, GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS & MALARIA, <https://www.theglobalfund.org/en/funding-model/> [<https://perma.cc/WDS3-6Z5E>] (last visited Mar. 12, 2020).

Canada ²⁷⁰	Three-year initiative to fund sexual and reproductive health launched in 2017	\$650 million (Canadian) (over three years) ²⁷¹
Open Society Foundation	Health and human rights advocacy funding for 2019	Nearly \$47 million ²⁷²
Robert Carr Fund	Building capacity of regional and global civil society networks committed to health and rights of marginalized populations; grants covering 2019–2021	Nearly \$33 million ²⁷³
Gates, Rockefeller, and Ford Foundations	No focus on health rights advocacy	N/A

There is, moreover, a high demand for R2HCF resources. The history of human rights funding in other realms demonstrates that when funding for civil society action is available, the demand will be there, perhaps many times over. When the Dutch government launched a women's rights fund in 2008, it had 70 million euros (then about \$95 million) available for three- and four-year grants, yet applicants sought ten times this level.²⁷⁴ Demand for funding from the even more inadequately sized U.N. Democracy Fund massively outstrips resources. In 2019, it funded fewer than 50 of 2,307 proposals.²⁷⁵ R2HCF grants may even

270. Norway, which emphasizes human rights throughout its work on international development, also specifically emphasizes sexual and reproductive health within its health development efforts. *See How Norway Works with Global Health*, NORAD (Feb. 23, 2018), <https://norad.no/en/front/thematic-areas/global-health/how-norway-works-with-global-health/> [<https://perma.cc/FJM5-TZGA>]. Similarly, more than sixty percent of Sweden's health assistance channeled through the Swedish International Development Cooperation Association (SIDA) is for sexual and reproductive health and rights. *See* Press Release, Ministry of Foreign Affairs, Gov't Offices of Swed., Government Increasing Support to Sexual and Reproductive Health and Rights (Mar. 2, 2017), <https://www.government.se/press-releases/2017/03/government-increasing-support-to-sexual-and-reproductive-health-and-rights/> [<https://perma.cc/X5FZ-PZZQ>].

271. *See* Geoffrey York & Michelle Zilio, *Canada Spending \$650-Million on Reproductive Rights, Including Fighting Global Anti-Abortion Laws*, GLOBE & MAIL (Apr. 14, 2017), <https://www.theglobeandmail.com/news/politics/ottawa-announces-650-million-for-sexual-and-reproductive-health/article34237503/> [<https://perma.cc/226V-B9UC>].

272. *See* *Financials*, OPEN SOC'Y FOUNDS., <https://www.opensocietyfoundations.org/who-we-are/financials> [<https://perma.cc/3NSZ-5KCC>] (last visited Mar. 12, 2020).

273. *See* *Funding*, ROBERT CARR FUND FOR CIVIL SOC'Y NETWORKS, <https://robertcarrfund.org/funding> [<https://perma.cc/HG9C-X569>] (last visited Mar. 12, 2020).

274. *See* LYDIA ALPÍZER ET AL., ASS'N FOR WOMEN'S RIGHTS IN DEV., 2009–2010 FUNDHER RESEARCH UPDATE BRIEF 1: TRENDS IN BILATERAL AND MULTILATERAL FUNDING 24–25 (2010), https://www.srh-ask-us.org/wp-content/uploads/2017/07/AWID_2010_Brief1_TrendsInBilateralMultilateralFunding-1.pdf [<https://perma.cc/TRN7-ALWY>].

275. U.N. DEMOCRACY FUND, U.N. SECRETARY-GENERAL, UNDEF BOARD, APPROVE ALMOST 50 NEW PROJECTS 1 (2019), https://www.un.org/democracyfund/sites/www.un.org.democracyfund/files/Newsletter/uu42_july_2019.pdf [<https://perma.cc/857P-JNBN>]. In its first fourteen years, from 2005 through 2018, contributions totaled only approximately \$195 million. *See* U.N. DEMOCRACY FUND, STATUS OF

extend beyond civic action (see [Figures 6 and 7](#)). And based on demand and a growing understanding of the overall funding for civic action for the right to health, the R2HCF could alter its funding target.

We recognize that \$500 million in annual revenue is not trivial. But an R2HCF promises to be transformative at far lower—and achievable—financing levels than would be required to directly fund health systems. Our proposed R2HCF is in line with the aspirations of recent innovative financing mechanisms in the global health space. For example, the Pandemic Emergency Financing Facility raised \$475 million over its first three years.²⁷⁶ Similarly, the Global Financing Facility, which provides catalytic investments in “reproductive, maternal, newborn, child, and adolescent health and nutrition,” is seeking approximately \$333 million annually for 2018–2023.²⁷⁷ R2HCF funding also would be far less than funding for the two most significant existing global health funds, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and Gavi, the latter of which funds vaccinations. For example, R2HCF funding levels would be nearly ten times lower than annual Global Fund grants.²⁷⁸ And the R2HCF’s financing needs would be less than two percent of annual official development assistance for health.²⁷⁹

The power of right to health advocacy and the relative achievability of an R2HCF are not the only reasons that such a fund should command international support—including among international health and human rights organizations

CONTRIBUTIONS IN US DOLLARS (2019), https://www.un.org/democracymfund/sites/www.un.org.democracymfund/files/doc_1_status_of_contributions_undef_2019_0.pdf [<https://perma.cc/A6U9-P4UN>]

276. Over its initial period of July 2017 to June 2020, \$425 million was available from the fund’s insurance window and \$50 million from its cash window. See PANDEMIC EMERGENCY FIN. FACILITY, OPERATIONAL BRIEF FOR ELIGIBLE COUNTRIES 2, 6 (2019), <http://pubdocs.worldbank.org/en/478271550071105640/PEF-Operational-Brief-Feb-2019.pdf> [<https://perma.cc/GF6X-UPMC>].

277. *Financing Model*, GLOBAL FIN. FACILITY, <https://www.globalfinancingfacility.org/financing-model> [<https://perma.cc/3NAD-KDP8>] (last visited Mar. 12, 2020); see GLOB. FIN. FACILITY, A NEW FINANCING MODEL FOR THE SUSTAINABLE DEVELOPMENT GOALS ERA: THE GLOBAL FINANCING FACILITY IN SUPPORT OF EVERY WOMAN EVERY CHILD 4 (2017), <https://perma.cc/U99F-AAL4> (explaining the fund is seeking to mobilize \$2 billion over six years).

278. The Global Fund will invest more than \$1 billion annually after receiving \$14 billion for 2020–2022. See *Global Fund Donors Pledge \$US14 Billion in Fight to End Epidemics*, GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS & MALARIA (Oct. 10, 2019), <https://www.theglobalfund.org/en/news/2019-10-10-global-fund-donors-pledge-usd14-billion-in-fight-to-end-epidemics/> [<https://perma.cc/K4TY-P846>]. Gavi is seeking \$7.4 billion for the five-year period of 2021–2025, or nearly \$1.5 billion per year, which is three times the proposed size of the R2HCF. See GAVI: THE VACCINE ALL., PREVENT, PROTECT, PROSPER: 2021–2025 INVESTMENT OPPORTUNITY 4 (2019), <https://www.gavi.org/sites/default/files/publications/2021-2025-Gavi-Investment-Opportunity.pdf> [<https://perma.cc/5KXX-A8PF>].

279. Governments’ international health assistance ranged from about \$26 billion to \$28 billion each year from 2011 through 2018. See INST. FOR HEALTH METRICS & EVALUATION, UNIV. OF WASH., FINANCING GLOBAL HEALTH 2018: COUNTRIES AND PROGRAMS IN TRANSITION 49 fig.7 (2019), http://www.healthdata.org/sites/default/files/files/policy_report/FGH/2019/FGH_2018_full-report.pdf [<https://perma.cc/7GJP-EDP4>]. Meanwhile, total international assistance for health, including from foundations, NGOs, and development banks, was approximately \$37 billion to \$40 billion per year over the same time period—meaning that a \$500 million R2HCF would not be even 1.5% of yearly international health assistance when nongovernmental sources are included. See *id.* at 51 fig.9.

and governments that support the right to health. The R2HCF could, itself, function as a low-cost health systems fund in at least two ways.

First, some of the advocacy that the R2HCF supports could be directed at increased domestic government funding for healthcare and the underlying determinants of health. If such advocacy unlocked even one percent of the additional funds required for universal health coverage, that would be nearly \$4 billion,²⁸⁰ comparable to annual Global Fund grants. And second, by increasing the accountable use of health funding, the R2HCF would help ensure that the funds are properly spent in the most efficient and effective manner—which, in terms of health benefits, may be equivalent to millions, if not billions, of dollars in additional health systems financing. By holding governments to account, including uncovering corruption, an R2HCF could leverage far more resources than it actually spent.

Further, even copious levels of health system financing are unlikely to secure universally accessible and affordable healthcare, along with underlying determinants of health, and policies that will respond to the needs of marginalized communities in light of emerging health threats, like climate change and novel diseases. Achieving global commitments to universal health coverage and health security requires health coverage to extend to the most politically marginalized groups, whose health may continue to be a low political priority. Even where policymakers have the best intentions, policies are unlikely to reach remote or discriminated-against communities unless they can communicate their realities—and have them listened to. People also will need to be able to safely report if guarantees of universal health coverage or other health protections²⁸¹ are being violated, with avenues for redress. A drive toward universal health coverage and universal health security without an abiding committing to equity and empowerment seems destined to fall short.

The reasons we focus on the R2HCF do not end there. They extend to two fundamental benefits of supporting civic action. First, the R2HCF would reach communities that governments and donors cannot, or will not, fund. Governments themselves are unlikely to target their own failures of accountability. It is no coincidence that many low- and middle-income countries are fragile or poorly governed.²⁸² They certainly need more health system spending—people will suffer grievously without it. Yet the R2HCF would strike at the root cause of states' governance failures: lack of accountability.

280. As noted above, the WHO found that the additional annual investments required to achieve universal health coverage would be nearly \$400 billion, and one percent of this is close to \$4 billion. See WORLD HEALTH ORG., *supra* note 190, at 97–98.

281. Other health protections might include, for instance, paid sick leave or health facilities that adhere to rigorous infection prevention and control standards.

282. See Andrea Abel et al., *The OECD Fragility Framework*, in STATES OF FRAGILITY 2016: UNDERSTANDING VIOLENCE 78 (2016); George Ingram & Jonathan Papoulidis, *State Fragility Is Key to Reaching the Last Mile in Ending Poverty*, BROOKINGS: FUTURE DEV. (Nov. 21, 2017), <https://www.brookings.edu/blog/future-development/2017/11/21/state-fragility-is-key-to-reaching-the-last-mile-in-ending-poverty/> [<https://perma.cc/B9QD-NZDH>].

The second additional reason we advance the idea of an R2HCF is that by building capacity and resilience in communities, it would become a powerful affirmation of human dignity. It would send a different message to people who have been told through their governments' actions that they do not matter: they, their perspectives, and their concerns do matter, and they can hold those governments to account if public officials disregard their well-being and their rights. This would be a potent response to the narrowing of civil society space, eroding of human rights, and growing discrimination and xenophobia that much of the world is experiencing.

C. RIGHT TO HEALTH CAPACITY FUND: EMPOWERING CIVIL SOCIETY, EMPOWERING COMMUNITIES

1. The R2HCF Mission and Core Focus

The mission of the R2HCF would be to empower civic action on the right to health, with two core areas of focus (see [Figure 5](#)). First, the fund would provide grants to civil society organizations to increase their capacity to advocate for the right to health. It would support, for example, basic organizational capacity, policymaker engagement, and strategic litigation, such as the types of action in South Africa and India described earlier.²⁸³ Second, it would fund community-based and other civil society organizations to empower people to participate in decisions that affect their health and to hold governments accountable. The CEGSS-supported initiative in Guatemala is of this ilk,²⁸⁴ though there are many other iterations, such as training community members to effectively participate in local health committees,²⁸⁵ participatory health impact assessments,²⁸⁶ community-driven urban planning,²⁸⁷ social audits of health budgets and expenditures,²⁸⁸ and paralegals and other forms of legal empowerment.²⁸⁹

283. See *supra* notes 254–55 and accompanying text.

284. See *supra* notes 256–57 and accompanying text.

285. See, e.g., Moses Mulumba et al., *Using Health Committees to Promote Community Participation as a Social Determinant of the Right to Health: Lessons from Uganda and South Africa*, 20 HEALTH & HUM. RTS. J. (SPECIAL SECTION) 11, 16–17 (2018).

286. See, e.g., Lea den Broeder et al., *Community Participation in Health Impact Assessment. A Scoping Review of the Literature*, 66 ENVTL. IMPACT ASSESSMENT REV. 33, 41 (2017).

287. See, e.g., MONTRÉAL URBAN ECOLOGY CTR., PARTICIPATORY URBAN PLANNING: PLANNING THE CITY WITH AND FOR ITS CITIZENS 2–10 (2015), https://participatoryplanning.ca/sites/default/files/upload/document/participatory_urban_planning_brochure_2016.pdf [<https://perma.cc/8K2H-4X8Z>].

288. See, e.g., SOC. JUSTICE COAL. ET AL., A GUIDE TO CONDUCTING SOCIAL AUDITS IN SOUTH AFRICA 11–13 (2015), <https://www.internationalbudget.org/wp-content/uploads/social-audits-in-south-africa-guide-2015.pdf> [<https://perma.cc/KSP9-CGLA>].

289. See, e.g., Ellie Feinglass et al., *Transforming Policy into Justice: The Role of Health Advocates in Mozambique*, 18 HEALTH & HUM. RTS. J. (SPECIAL SECTION) 233, 244 (2016); Vivek Maru, *Between Law and Society: Paralegals and the Provision of Justice Services in Sierra Leone and Worldwide*, 31 YALE J. INT'L L. 427, 428–29 (2006).

Figure 5: Acting for Human Rights: Types of Activities an R2HCF Would Support

<p><u>Civil-Society Advocacy</u></p> <ul style="list-style-type: none"> • Human rights organizations' advocacy, policy analysis, monitoring, and litigation • Capacity building for health rights civil society organizations • Information exchanges on successful right to health advocacy strategies • Civil society organizations' capacity to participate in health policymaking processes <p><u>Empowering Participation and Accountability</u></p> <ul style="list-style-type: none"> • Local health service and other social accountability measures, such as village health committees and health facility monitors • Community-driven health impact assessments for policies, programs, and projects that affect the right to health, whether adversely (mines, fossil fuel subsidies, or deforestation) or positively (parks, public transportation, or healthy school meals) • Right to health advocacy and policymaking training for community members • Right to health literacy and education, including for community members, public officials, health workers, educators, judges, lawyers and paralegals, law enforcement, and the media • Participatory health planning to ensure urban design promoting health for all and pandemic preparedness plans that respond to additional risks that marginalized populations may face • Participatory budgeting for, and public expenditure tracking of, health-related budgets • Right to health monitoring through community platforms • Access to justice programs to support legal assistance to claim the right to health • Developing partnerships between legal service organizations and health providers to increase patients' understanding of their rights and their access to justice • Participatory processes to develop health equity programs of action <p>The fund could encompass targeted initiatives, such as innovative mechanisms for accountability and participation and accelerated grants for right to health emergencies.</p> <p><i>This table is adapted from: Friedman et al., supra note 33.</i></p>

The R2HCF would give grantmaking priority to civil society organizations in lower income countries, particularly grassroots organizations with the least access to funding. It is these countries where people's health is worst and its distance from the highest attainable standard of health is greatest—and where each dollar will go the furthest. Yet extreme health disparities and human rights violations also exist in higher income countries. And civil society organizations in the global North can develop partnerships in lower income countries. Civil society organizations everywhere, therefore, should be eligible for funding.

2. Advancing Health Equity Beyond the Fund's Core Mission: Outstanding Questions

Funding civil society organizations is not the only way the R2HCF could contribute to accountability and equity. Should the R2HCF's scope be broader, encompassing governments and targeted health interventions?

a. To Fund or Not to Fund?: Governments.

Governments are responsible for human rights violations but also enable (or hinder) accountability. Governments, for example, are essential for generating and evaluating disaggregated health data needed to monitor progress and for effective oversight (for example, conducting legislative oversight and investigations). [Figure 6](#) explores the benefits and risks of making governments eligible for R2HCF grants.

Figure 6: To Fund or Not to Fund?: Governments

<p><u>Pros</u></p> <ul style="list-style-type: none"> • Governments can make important contributions to right to health accountability. For example: <ul style="list-style-type: none"> ○ A legislative health committee could hire staff to more effectively carry out its oversight responsibilities ○ A national human rights institution could conduct more investigations into right to health violations ○ Village health committees could be sufficiently resourced ○ Public health authorities could carry out environmental testing in marginalized communities • International funding sources for these activities are limited <p><u>Cons</u></p> <ul style="list-style-type: none"> • Funding governments would reduce funds available for civic action • Governments have more avenues of potential financial resources than does civil society, including different financial policies (for example, higher taxes on wealthier individuals) and budget allocations (with more to health)—though in low-income countries, even notably higher government health funding would be insufficient for universal health coverage • Governments may point to efforts through the R2HCF as proof of their commitment to the right to health while failing to address underlying causes of right to health shortcomings (for example, poor governance, inadequate budgets, or discriminatory policies)

If solely civil society organizations were eligible for R2HCF grants, they could partner with government—for example, national human rights institutions—to strengthen oversight and to conduct joint investigations. Making civil society the focal point for grants would be a pioneering paradigm shift: governments would need to turn to civil society for buy-in, rather than communities being beholden to governments that often fail to truly represent them.

Or, along with civil society organizations' ability to seek R2HCF funding on their own, they could choose to apply jointly with governments when seeking to bolster governments' right to health capacities and mechanisms. This may increase government

buy-in, important for sustaining progress and funding after the grants come to end.²⁹⁰

b. To Fund or Not to Fund?: Direct Health Interventions for Marginalized Populations.

The most direct path to greater health equity would be support for interventions to improve the health of people in marginalized communities, though again, this would divert funding from civic action (see [Figure 7](#)).

Figure 7: To Fund or Not to Fund?: Direct Health Interventions for Marginalized Populations

<p><u>Pros</u></p> <ul style="list-style-type: none"> • Direct funding can bring health services to highly marginalized populations, at times funding activities that the government will not fund. For example: <ul style="list-style-type: none"> ○ Improved water and sanitation in urban slums ○ Well-equipped and supervised community health workers in remote, rural communities ○ Supervised injection sites ○ Family living for children with disabilities • International funding for many of these activities may be limited <p><u>Cons</u></p> <ul style="list-style-type: none"> • Funding health interventions would reduce funds available for civic action • Sustained R2HCF funding will not be available, though activities will need to be sustained (like paying for training, compensation, equipment, and supervision of community health workers), and even capital outlays (like connecting a community to water and sewage systems) would typically still have recurring maintenance and operations costs

If the R2HCF were to directly fund services for marginalized populations, there are several ways grants could be structured to mitigate civil society concerns. Governments could agree to assume funding responsibilities once R2HCF funding ends, possibly with co-financing during the grant period, or agree to policy changes (for example, permitting safe injection sites, or deinstitutionalization and community and family living for people with disabilities). To remain true to the R2HCF's core mission, health system funding could be linked to funding community empowerment to make sure the government abides by its commitment to sustained financing and policy reform.

290. E-mail from Eric A. Friedman, Global Health Justice Scholar, Georgetown Univ. Law Ctr, to Ralf Jürgens, Senior Coordinator, Human Rights, Global Fund to Fight AIDS, Tuberculosis and Malaria (Mar. 25, 2020, 9:52 PM) (on file with author).

3. R2HCF Governance

To fulfill its mission and to challenge current power structures, the R2HCF's governance structure should give primary control to civil society organizations, upending the norm for existing global funds (see Figure 8). The R2HCF, for example, could be established as an independent organization. Or, the R2HCF could be housed within an existing organization, operating independently while benefitting from the organization's infrastructure, such as its administration, finances, and communications. An alternative model would be for the R2HCF to be incorporated into an existing health or human rights funder, though few organizations are fit for this purpose (see Figure 8).

Figure 8: R2HCF Governance: Civil Society and Communities in the Lead

<u>Possible Board Composition</u>		
<ul style="list-style-type: none"> • Primarily civil society and community representatives • Foundations experienced with funding civil society human rights advocacy and community-based organizations • International agencies (in particular, the WHO and the Office of the U.N. High Commissioner for Human Rights) • Governments that support the right to health; in a reversal of normal power dynamics, R2HCF civil society and community delegations could vet interested governments, with eligibility decisions supplemented by objective criteria 		
<u>Existing Health and Human Rights Funders</u>		
Funder	Connection to health rights advocacy	Potential drawback(s) of funder as home for an R2HCF
Open Society Foundation	Funds civil society around the world to advance human rights, including a program on health and human rights ²⁹¹	Mandate extends far beyond health
Robert Carr Fund	Capacity building for regional and global civil society networks committed to the health and rights of marginalized populations ²⁹²	Lacks the national and community focus of the R2HCF and has a special focus on HIV, compared to the R2HCF's broader remit
Fund for Global Human Rights	Supports a wide range of civil society human rights advocacy ²⁹³	Not health focused and dozens of times smaller than what we envision for the R2HCF
Global Fund to Fight AIDS, Tuberculosis and Malaria	Supports civil society and includes human rights as a core objective ²⁹⁴	Civil society and community members are a small minority of its board members, and a minority on their Country Coordinating Mechanisms

291. *What We Do*, OPEN SOC'Y FOUNDS., <https://www.opensocietyfoundations.org/what-we-do> [<https://perma.cc/UQS4-R6PM>] (last visited Mar. 13, 2020).

292. *About the Robert Carr Fund*, ROBERT CARR FUND FOR CIVIL SOC'Y NETWORKS, <https://robertcarrfund.org/about-rcf> (last visited Mar. 13, 2020); *Strategy*, ROBERT CARR FUND FOR CIVIL SOC'Y NETWORKS, <https://robertcarrfund.org/about-rcf/strategy> (last visited Mar. 13, 2020).

4. R2HCF Financing

Like most global financing models, a combination of governments, foundations, and the private sector could provide the R2HCF with resources. But also, like many of today's significant public-private partnerships, the R2HCF would include innovative financing.

Unitaid offers a possible model. Along with donations, Unitaid receives funding from a dedicated airline tax that at least ten partner countries have implemented for flights under their jurisdiction.²⁹⁵ R2HCF's financing could be linked to its mission, with partner governments levying taxes on goods, services, or profits of corporations whose activities impede realization of the right to health. These could include unhealthy products that most countries already tax, such as tobacco and alcohol (and, increasingly, sugary drinks), but also could extend to private sector water providers that fail to equitably serve marginalized communities, mining and other companies that pollute our air and water, or pharmaceutical companies that price medications beyond people's reach. Even low tax rates in these spheres could generate considerable funds.

D. TAKING THE R2HCF FORWARD

The R2HCF is within reach. New global health financing mechanisms continue to be developed. In just the past several years, the World Bank and partner governments launched the Global Financing Facility²⁹⁶ and the Pandemic Emergency Financing Facility,²⁹⁷ while Norway, India, and nongovernment partners spearheaded the Coalition for Epidemic Preparedness Innovations.²⁹⁸ The WHO

293. The Fund for Global Human Rights provides about \$9 million in grants each year. *See* Fund for Glob. Human Rights, IRS Form 990, Return of Organization Exempt from Income Tax (OMB No. 1545-0047) (2017), <https://globalhumanrights.org/wp-content/uploads/2019/10/FY17-18-FGHR-990.pdf> [<https://perma.cc/J5RA-WHH3>]. As discussed below, we envision a R2HCF that is more than fifty times this size.

294. Three of the Global Fund's twenty board members are from civil society and communities. *Board: Members*, GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, & MALARIA, <https://www.theglobalfund.org/en/board/members/> [<https://perma.cc/N57Y-BFXV>] (last visited Mar. 13, 2020) (identifying Maurine Murenga, Mike Podmore, and Andriy Klepikov). The Global Fund requires that at least forty percent of the members of Country Coordinating Mechanisms, which develop and monitor implementation of countries' proposals to the Global Fund, are from civil society and communities. GLOB. FUND TO FIGHT AIDS, TUBERCULOSIS, & MALARIA, *Guidelines and Requirements for Country Coordinating Mechanisms* 15 (2013), <https://perma.cc/XR28-Z5FV>.

295. *See About Us*, UNITAID, <https://unitaid.org/about-us/#en> (last visited Mar. 13, 2020). Unitaid grants help fast-track access to, and reduce the prices of, treatment and diagnostics for AIDS, tuberculosis, malaria, and HIV co-infections, prominently hepatitis C. *See id.*

296. GLOBAL FIN. FACILITY, <https://www.globalfinancingfacility.org> [<https://perma.cc/Z86N-Y5CR>] (last visited Mar. 13, 2020).

297. *Pandemic Emergency Financing Facility*, WORLD BANK, <https://www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-financing-facility> [<https://perma.cc/579U-QY6P>] (last updated May 7, 2019).

298. *Coalition for Epidemic Preparedness Innovations*, DEVEX, <https://www.devex.com/organizations/coalition-for-epidemic-preparedness-innovations-cepi-72733> [<https://perma.cc/AMS2-JCSW>] (last visited Mar. 13, 2020).

established its Contingency Fund for Emergencies.²⁹⁹ The United Kingdom and China launched the Global Antimicrobial Resistance Research Innovation Fund.³⁰⁰ When the Netherlands launched a campaign to fund organizations that lost U.S. foreign assistance for performing, or even discussing, abortions, at least nine other countries joined forces for human rights.³⁰¹ And new institutions will likely be created in the wake of COVID-19.

A civil society campaign is now underway to further conceptualize and advocate for the R2HCF. Along with civil society organizations, additional stakeholders are important, including supportive governments, foundations, and international organizations such as the WHO, the Office of the U.N. High Commissioner for Human Rights, and the Global Fund. In addition to creating an operationally shared vision of the R2HCF, this process would secure broader buy-in for the R2HCF and establish a pathway for its launch.

The Universal Declaration of Human Rights proclaimed the right to health more than seven decades ago. The United Nations adopted the ICESCR more than half a century ago. It is long past time to fully resource the right to health.

CONCLUSION: THE TIES THAT BIND

We have sought to offer transformative ideas to achieve a world in which people are safer and healthier, and where the public good of human health is more equitably shared by all. The FCGH, health equity programs of action, and the R2HCF are distinct but closely related proposals, not only conceptually but also in direct interactions. The FCGH, for example, could mandate that countries develop health equity programs of action, and any funding and capacity-building mechanisms the FCGH includes could support their development. Through the power of the norms the FCGH creates, even states not party to the treaty may develop programs of action once the treaty has come into existence, while benefiting from lessons of programs of action that FCGH parties undertake.

If the R2HCF is not already established, the FCGH could create it, establishing an R2HCF as a mechanism linked to the FCGH or through state-party agreement to launch the fund. The fund could support the national and local participation and accountability mechanisms the treaty catalyzes, along with civil society advocacy for treaty compliance. Likewise, by making funding available, the R2HCF could incentivize development of health equity programs of action, as well as related accountability and participation mechanisms.

299. *Contingency Fund for Emergencies (CFE)*, WORLD HEALTH ORG., <https://www.who.int/emergencies/funding/contingency-fund/en/> [<https://perma.cc/DYC2-TMT5>] (last visited Mar. 13, 2020).

300. *UK and China Start Global Fund to Tackle Drug Resistant Infections* (Oct. 23, 2015), <https://www.gov.uk/government/news/uk-and-china-start-global-fund-to-tackle-drug-resistant-infections> [<https://perma.cc/7XSH-EXV6>].

301. See Jonathan Abbamonte, *Norway Becomes Tenth Country to Pledge Support for Global Abortion Fund*, POPULATION RES. INST. (Feb. 24, 2017), <https://www.pop.org/norway-becomes-tenth-country-to-pledge-support-for-global-abortion-fund/> [<https://perma.cc/B7WX-CJPR>].

What we have learned in multiple public health realms—from tobacco and alcohol to firearms and automobile crashes—is that no single policy is sufficient on its own. Rather, we need a suite of interventions, tackling complex problems on varied fronts. So too with our proposals. Any one of these ideas does stand to make a marked, even transformative, difference. Yet none these proposals alone can truly achieve the dream of global health with justice. We need to push on several fronts, from the global binding norms of an FCGH and the deliberative domestic planning of health equity plans of action, to financing for both—and much more—through an R2HCF.

These three ideas are integrally bound together in another, more fundamental way, beyond simply mutually reinforcing each other. Our proposals—all aimed at realizing the right to health, demonstrate an abiding faith in the power of people. They work collectively to advance health with justice within their communities and countries, and globally. All would be developed through inclusive, participatory processes, would lead to strengthened participation and accountability, and in the case of the R2HCF, would even directly support community and civil society advocacy—people bringing their demands directly to those who hold power. Whether movements of people with disabilities or with HIV, or movements for equal rights for blacks, women, or members of the LGBTQIA+ community, the power of people is the force that makes the arc of history bend toward justice.³⁰²

The FCGH, health equity programs of action, and the R2HCF will require mass social mobilization to secure their place in the global health landscape. Imagining global health with justice compels us to empower people whom society has pushed to the margins to push back. Currently, many who are poor or marginalized have learned through hard experience that there is little they can do to fundamentally change their circumstances. They live with a dispiriting sense of hopelessness. It will be the core mission of our trilogy of high-impact proposals, then, to undo this cruel lesson, to catalyze the power of people to make a difference in their lived experiences and in the lives of their neighbors—whether for the person next door, their fellow citizens, or the common humanity of the world's people.

If our proposals come into existence, their success will be judged in large measure by data and how they advance health and close health inequalities. But they should be judged every bit as much by whether they enable more people to experience both the dignity of being able to have a genuine say in decisions that affect their health and also the deep satisfaction of knowing that the inherent human dignity in which human rights—their rights—are based is more powerful than the seemingly unmatchable might of governments. For when their government is not meeting its

302. We borrow from President Barack Obama, who was fond of the phrase “the arc of history bends towards justice,” as he paraphrased Dr. Martin Luther King Jr., who said “the arc of the moral universal is long, but it bends towards justice.” Dr. King, in turn, was paraphrasing part of a sermon delivered in 1853 by Theodore Parker, an abolitionist minister. Editorial, *The Guardian View on Obama's Legacy: Yes He Did Make a Difference*, GUARDIAN (Jan. 19, 2017, 3:02 PM), <https://www.theguardian.com/commentisfree/2017/jan/19/the-guardian-view-on-obamas-legacy-yes-he-did-make-a-difference/> [https://perma.cc/Z6GF-YBU9]; Mychal Denzel Smith, *The Truth About 'The Arc of The Moral Universe'*, HUFFPOST (Jan. 18, 2018, 5:49 AM), https://www.huffpost.com/entry/opinion-smith-obama-king_n_5a5903e0e4b04f3c55a252a4 [https://perma.cc/7JWL-YQJV].

right to health obligations, there are places to which they can turn—legislative representatives, national human rights institutions, and independent judiciaries—to force accountability. There are institutions that can provide redress through deep structural changes, creating meaningful, lasting advances in their ability to enjoy their rights.

Equity, participation, and accountability are intimately interwoven. Justice requires them all. It is our hope that these three proposals can advance action in all these realms, and to move our world nearer to the profound aspiration of global health with justice.

POSTSCRIPT: TOWARDS A POST-COVID-19 HEALTH ARCHITECTURE OF GLOBAL HEALTH WITH JUSTICE

Already, there is talk of the need for new international institutions following COVID-19,³⁰³ and the UN Secretary-General has insisted that we must “recover better.”³⁰⁴ The reshaped institutional architecture for health should have the right to health as its core tenet with the FCGH, R2HCF, and health equity programs of action among its formative pillars.

Imagine if the participation standards in the FCGH were in place before COVID-19 struck. Marginalized communities would have had a strong say in planning for pandemics. Planning would have accounted for the fact that these populations’ jobs often meant that they could not work from home, avoid public transportation, or stay home if they were sick. Imagine how much better prepared even the poorest countries would have been with the FCGH’s funding framework and an R2HCF that would have supported powerful advocacy for well-resourced health systems. Right to health impact assessments of export controls and sanctions would have ensured that these regimes do not limit poorer countries’ access to needed medical supplies and equipment. Imagine if countries had implemented health equity programs of action, so that marginalized communities had good access to healthcare, healthy food, and clean environments, protecting them from such underlying conditions as diabetes and asthma that make people particularly vulnerable to COVID-19 complications.³⁰⁵ In these ways, and others, countries would have been better able to withstand COVID-19, and its impact across populations would not have born the dark mark of injustice.

When the next novel infection enters the human population and spreads through a community, across a country, or around the globe, let’s not again have to imagine how much suffering we might have avoided if only we had national and global systems for health that had the right to health at their heart. Let’s instead institutionalize global health with justice in our countries and throughout the world.

303. Mark Dybul & Deus Bazira, *COVID-19: Now Is the Time to Create the Future We Want*, HILL (Mar. 26, 2020, 8:00 PM). <https://thehill.com/opinion/healthcare/489778-covid-19-now-is-the-time-to-create-the-future-we-want> [<https://perma.cc/V4NM-8JBD>]

304. António Guterres, “*This Is, Above All, a Human Crisis That Calls for Solidarity*,” UNITED NATIONS COVID-19 RESPONSE (Mar. 19, 2020), <https://www.un.org/en/un-coronavirus-communications-team/above-all-human-crisis-calls-solidarity> [<https://perma.cc/4F5U-26MH>]

305. *Groups at Higher Risk for Severe Illness*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html> [<https://perma.cc/FU9R-MJSZ>] (last reviewed May 14, 2020).