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The Judicialization of Health Care: A Global South Perspective

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Abstract

This article charts the trajectory of the judicialization of health care from the perspective of Global South countries. It shows how the emergence of health rights litigation in the 1990s and early 2000s was bolstered by the global expansion of the HIV/AIDS epidemic and by major constitutional reforms that triggered a period of rights revolutions in South Africa and several Latin American countries. This article also tracks the litigation epidemic in countries like Colombia and Brazil, where the escalation of health rights lawsuits is threatening the financial stability of health systems and the fair allocation of scarce health resources. It concludes by discussing a fundamental challenge confronting the field, namely, how to look upstream for new approaches to the right to health to reinstate litigation and adjudication as mechanisms to promote more equitable health systems.

INTRODUCTION

The term judicialization has been used to describe the growing reliance on the adjudication of rights for the resolution of complex political decisions, such as the distribution of scarce resources (Michelman 2008, Waldron 2006). The most common charge waged against the judicialization of politics is that it creates incentives for the judiciary to usurp the prerogatives of the elected branches of government (Hirschl 2009, 2011; Tate & Vallinder 1995; Vallinder 1994). However, some authors contend that, on the contrary, social rights constitutionalism can complement the work of more representative branches of government and of civil society organizations (Brinks et al. 2015).

The judicialization of health care, i.e., the use of legal actions and rights-based injunctions to obtain medical treatments and pharmaceuticals, has been an important and controversial subject in the literature that explores the enforcement of socioeconomic rights. Pioneer empirical and comparative studies in this area include *Courting Social Justice* (Gauri & Brinks 2008), an edited book that focuses on the legalization process of socioeconomic rights in countries like Brazil, India, Indonesia, Nigeria, and South Africa. *Courting Social Justice* pioneered an innovative methodology to analyze the enforcement of socioeconomic rights in the Global South as part of a legalization process that involved the participation of litigants, judges, policy makers, and civil society organizations (Gauri & Brinks 2008, p. 343).

The prominence of the judicialization of health care in the socioeconomic rights literature is due, in great part, to the strong presence of the right to health in most national constitutions and in the jurisprudence of a vast number of higher courts and regional bodies (Langford 2008). For instance, a study found that approximately 70% of constitutions worldwide entrench health-related guarantees and that 40% of constitutions include a justiciable right to health (Jung & Rosevear 2011). A growing body of comparative literature shows that during the past three decades health rights litigation has taken many different forms around the world—in both middle- and high-income countries—and across health systems (Brinks & Forbath 2013, Flood & Gross 2014b, Gauri & Brinks 2008, Yamin & Gloppen 2011). However, most comparative studies have paid special attention to health rights litigation in Global South countries, such as Argentina, Brazil, Colombia, Costa Rica, India, and South Africa (Brinks & Forbath 2013, Brinks & Gauri 2014, Yamin & Gloppen 2011, Young & Lemaitre 2013). Authors who study the judicialization of health care in high-income countries—such as the United Kingdom, the Scandinavian countries, and the United States—have analyzed the institutional arrangements and policy determinants of those nations' health systems, which, contrary to the cases of middle-income countries like Colombia and Brazil, inhibit the surge of health rights litigation and adjudication (Hoffman 2014, Lind 2014, Nedwick 2014).

Most studies approach the enforcement of the right to health and other socioeconomic rights in middle-income countries from a developmental and economic perspective (Brinks & Gauri 2014, Rodríguez-Garavito 2013, Yamin & Gloppen 2011). However, some scholars argue that this emphasis in the literature has led to an underestimation of regulatory issues, administrative reforms, the rule of law and good governance, and their impact on the enforcement of socioeconomic rights (Ginsburg 2013, Peerenboom 2013).

The cases of South Africa and of several Latin American countries have been at the forefront of the scholarly debates about the judicialization of health care in Global South countries. These two different approaches to the judicialization of health—the South African and the Latin American—have created, over the years, divergent paths for the litigation and judicial enforcement of the right to health and have bolstered a growing comparative and empirical literature (Brinks & Gauri 2014).

One of the most important differences between the two set of cases is that the threshold for standing and bringing rights-based claims in South Africa is much higher than in Latin American countries like Colombia, Brazil, and Costa Rica. Because of this, health rights litigation in South Africa is far less widespread than in Latin America. For instance, a comparative study found that the number of health rights lawsuits per one million individuals was 3,289 in Colombia; 206 in Brazil; 109 in Costa Rica; 29 in Argentina; and only 0.3 in South Africa (Moestad et al. 2011).

Furthermore, in highly litigious countries like Colombia, Brazil, and Costa Rica, the judicialization of health care has been spearheaded by thousands of plaintiffs who, acting separately, use the courts to demand access to specific drugs and treatments (Gloppen 2008). In contrast, the judicialization of health care in South Africa during the early 2000s was not the result of the accumulation of thousands of lawsuits clustering around individual demands for medications and treatments, a phenomenon that has been described as the routinization of litigation (Abramovich & Pautassi 2009, Bergallo 2011). On the contrary, in South Africa health rights litigation has been conducted by support structures of well-financed rights-advocacy lawyers and civil society organizations similar to those that prompted a rights-based legal mobilization in the United States during the 1970s (Epp 1998). The ultimate goal of health rights litigation in South Africa has been to obtain structural judicial remedies, such as policy reform, in favor of a large class of individuals (Forman 2008a).

The benefits and costs of the two approaches have been weighed by a growing interdisciplinary literature. On the one hand, during the past two decades several Latin American countries have experienced a litigation epidemic of health rights (Yamin & Gloppen 2011), with negative effects on public health care budgets and on the government's capability to allocate scarce health resources. In Colombia and Brazil, increasing numbers of litigants demand cutting-edge and high-cost medications for the treatment of rare diseases and conditions like cancer, diabetes, and renal failure, among many others. According to some authors, this type of litigation both negatively impacts the financial stability of health systems and is regressive, since it skews resources from the public health system in favor of privileged litigants (Ferraz 2011b).

One of the most important lessons conceded by the litigation epidemic in Latin America is that litigants and judges tend to concentrate on the right to health downstream, or at the point of delivery (Daniels 2000), when patients are already sick and have to file a lawsuit to demand access to a specific pharmaceutical or treatment that is being refused—illegally in some cases—by health providers or insurers. The greatest problem of this downstream approach is that litigation and adjudication are incapable of transforming the upstream determinants—e.g., regulatory, institutional, economic, environmental, and social—that are producing the violation of rights of vulnerable patients (Farmer 2003). According to a growing number of scholars, this type of individualized and downstream litigation exploits the system but is incapable of transforming it (Yamin 2014).

On the other hand, during the early 2000s, the South African Constitutional Court pioneered an upstream approach to the judicialization of health care, which focused on the global and local determinants—e.g., the regime of intellectual property rights—that were keeping vulnerable patients from having access to life-saving treatments, such as HIV/AIDS pharmaceuticals.

But whereas the upstream approach to health rights adjudication pioneered by South Africa's Constitutional Court lost traction over time, in litigious countries like Brazil the downstream approach to the judicialization of health care and the resulting surge of health rights litigation led to the empowerment of thousands of vulnerable citizens—such as persons living with AIDS (PLWA)—affected by the life-threatening and discriminatory decisions of policy makers and health officials (Scheffer 2005). Similarly, in Colombia, where the downstream approach to the judicialization of health care has been predominant, "judicial leadership has ingrained into the

popular consciousness a sense of healthcare entitlement" that is not present in South Africa, according to a comparative study of the two countries (Young & Lemaitre 2013, p. 197).

This article discusses the upstream and downstream approaches to the judicialization of health care, as exemplified by the cases of South Africa and several Latin American countries. The article begins by mapping the literature that explores the origins of the judicialization of health care in the Global South. The picture that emerges from these studies suggests that two factors triggered the first wave of health rights litigation in countries like South Africa and Brazil during the 1990s: (*a*) major constitutional reforms that introduced an enforceable right to health and effective judicial mechanisms for the protection of basic and socioeconomic rights and (*b*) the global expansion of the HIV/AIDS epidemic, which pushed civil society organizations and patients to file lawsuits whereby they demanded access to medications and treatments or that required the government to reform its health policy.

The second part of this article charts the empirical literature that grapples with the causes and unintended consequences of the surge of health rights litigation in Colombia and Brazil, the two most litigious countries in the region (Flood & Gross 2014b, Moestad et al. 2011). The article briefly discusses an emerging subject in the literature, the pharmaceuticalization of health (Biehl et al. 2012, Petryna 2002, Petryna & Kleinman 2006), and the complex political economy behind the judicialization of health care in highly litigious countries—e.g., whether stakeholders, like transnational pharmaceutical companies, are the ultimate beneficiaries of the surge of health rights litigiousness (Gloppen & Roseman 2011, Lamprea 2015). The article goes on to comment on the recent efforts of Colombian and Brazilian higher courts to implement an upstream model of structural reform adjudication (Lamprea 2016, Rodriguez-Garavito 2011) aimed at achieving two interrelated goals: containing the litigation epidemic of health rights and crafting multilateral and dialogic judicial orders (Gargarella 2011, Zaring 2004) capable of nudging policy makers to implement measures designed to transform the regulatory and institutional determinants that are triggering the escalation of health rights litigation.

Given the space-related constraints of this article, there was no choice but to be selective with the extant literature. As such, a granulated account of only a limited set of country cases, judicial opinions, and scholarly debates is presented. Nevertheless, this article aims to provide a big-picture account of the status of the field and chart where the literature on the judicialization of health care is heading.

THE HIV/AIDS EPIDEMIC AND THE RISE OF HEALTH RIGHTS LITIGATION IN SOUTH AFRICA: AN UPSTREAM APPROACH

The reconceptualization of the right to health as a judiciable entitlement took place in a post–Cold War context, where the boundaries between socioeconomic and civil-political rights became increasingly blurry (Flood & Gross 2014b, Gross & Barak-Erez 2007). The literature that sprung from this historical juncture (Andreassen et al. 1987, Michelman 1979, Örücü 1986, Shue 1980) championed the cause of basic, enforceable socioeconomic rights and foreshadowed the pioneering decisions of higher courts that, during the 1990s, ordered governments to comply with their duties toward the right to health, as well as other socioeconomic rights like housing, food, education, social security, and minimum subsistence conditions (Bignami & Spivack 2014).

During the 1990s and early 2000s, the HIV/AIDS epidemic was the springboard for the pioneering judicial opinions on the enforceability of the right to health (Gloppen 2008, Horgerzeil et al. 2006). A study found that during that period the higher courts of 12 middle- and low-income countries handed down several landmark judgments on access to antiretroviral therapy (ART) (Horgerzeil et al. 2006). Based on that evidence, some authors contend that the global diffusion

of health rights litigation emerged in the 1990s with the early demands for effective ART (Yamin 2011). The only major exception to that trend is India, where health rights litigation emerged in the 1980s with judicial opinions on medical reimbursement claims by public officials, medical negligence, and workplace safety (Parmar & Wahi 2011).

Among the countries studied by the extant literature, South Africa became the most powerful illustration of the potential of legal mobilization for contesting the global and domestic intellectual property regimes that were keeping vulnerable individuals from having access to ART and other treatments for HIV/AIDS. A combination of supply- and demand-side variables explains the rise of HIV litigation in South Africa. Some authors understand supply-side variables, generally, as the legal system and the social rights infrastructure (Hoffman & Bentes 2008). Other authors prefer to define supply-side variables as the "legal opportunity structure" for health rights litigation, such as a low threshold for health rights litigation represented in easy access to courts or informal judicial mechanisms available to plaintiffs (Yamin & Parra-Vera 2010). Contrastingly, the demand-side variables that influenced the emergence of HIV litigation in South Africa can be broadly understood as the overall socioeconomic makeup of litigation, for instance, whether litigants are supported by civil society organizations or the plaintiffs' level of income and education (Hoffman & Bentes 2008).

There is agreement in the literature that the most important supply-side variable that determined the emergence of HIV legal mobilization in South Africa was the 1996 constitution's establishment of a robust bill of rights with a number of socioeconomic rights, including the right to health care (Berger 2008, Bilchitz 2008, Davis 2007, Sunstein 1999). Nevertheless, the language of the South African constitution does not indicate that the right to health is a judiciable entitlement (Forman & Singh 2014). On the contrary, Article 27 of the constitution reiterates the formulation of the International Covenant on Economic, Social and Cultural Rights, which stipulates that state duties toward the right to health are limited to progressive realization within maximum available resources (Forman et al. 2016, Young 2008).

Most scholars understand the emergence of HIV litigation in South Africa to be strongly influenced by a set of demand-side variables, specifically the public interest litigation that crystallized around the Treatment Action Campaign (TAC), an association of civil society organizations that was part of a larger transnational advocacy network (Forman 2008b, Keck & Sikkink 1999). At both local and global levels, the TAC played a decisive role in South Africa's two landmark judicial cases on the right to health: the 2001 Pharmaceutical Manufacturers Association (PMA) and the 2002 TAC cases.

In the PMA case, the Constitutional Court studied a legal challenge presented by an association of transnational pharmaceutical companies, the PMA. According to the PMA, the South African Medicines Act, a statute that guaranteed access to affordable drugs, breached the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the domestic regime of intellectual property rights. The TAC not only joined the government in defending the constitutionality of the Medicines Act but also invoked human rights arguments to show that the well-being of thousands of PLWA trumped the intellectual property interests of pharmaceutical companies (Forman 2008b). In April 2001, after the TAC's successful local and global advocacy campaign, the PMA decided to withdraw the lawsuit pending before the Constitutional Court.

In 2002, the Constitutional Court handed down the TAC judgment (Bilchitz 2008; Pieterse 2004a,b), considered by some scholars to be its most momentous case on the right to health. In the TAC judgment, the Court ordered the Ministry of Health to expand its program for the prevention of mother-to-child transmission of HIV by making nevirapine, a drug used to prevent such transmission, which is included in the World Health Organization's (WHO's) list of

essential medicines,[1] available at all public hospitals, in addition to previously government-designated locations (Forman 2005, Forman & Singh 2014). The Court also elaborated on the justiciability of the right to health, reaching the conclusion that judges can intervene in the government's health policy if it has detrimental effects on the right to health of the population (Pieterse 2004b).

The importance of the TAC judgment is that it nudged the South African government to implement a policy plan that addressed the national health emergency triggered by the rapid advance of the HIV/AIDS epidemic (Syrett 2007). This upstream approach to the judicialization of health care led the Constitutional Court to identify the institutional and regulatory determinants that were keeping vulnerable patients from having access to life-saving medical treatment. Furthermore, the Court ordered the government to transform those institutional determinants to protect the right to health of thousands of individuals. But instead of defining how the government should design and implement the policy plan or the new institutions, the Court decided to hand down what some authors call weak remedies in a context of strong rights, i.e., judicial remedies that refrain from encroaching on the policy-making prerogatives of the executive branch but that nevertheless force the government to design policies that meet the rights-based standards defined by the court (Dixon 2007, Tushnet 2009).

However, the Constitutional Court of South Africa became increasingly reluctant to intervene in the government's health and social rights policy after these two landmark opinions, raising real concerns about the Court's willingness to enforce the constitution's socioeconomic rights against government policy (Forman & Singh 2014). According to a comparative study, during the past decade, "the right to health has been interpreted and enforced by tentative, incremental and partial steps on the part of the Constitutional Court, and a less widespread challenge to, and disruption of, the overall health system" (Young & Lemaitre 2013, p. 197).

THE LITIGATION EPIDEMIC OF HEALTH RIGHTS IN LATIN AMERICA: A DOWNSTREAM APPROACH

Access to Courts and Health Systems

According to most comparative studies, two main variables explain why some countries experience extremely high volumes of health rights litigation, whereas others do not: easy access to courts and the institutional arrangement of health systems.

On the one hand, in countries where access to courts is easy and the threshold for bringing rights-based claims is low, there are more chances to find high levels of health rights litigiousness than in countries like the United States, where there is not a constitutional right to health and access to courts is highly restricted for patients who demand access to specific health-care services, medications, and health technologies (Hoffman 2014).

On the other hand, a growing number of authors contend that some types of health systems are more prone to trigger a surge of health rights litigation than others. Whereas in high-income countries with tax-funded public health systems—e.g., the Nordic countries (Lind 2014) and the United Kingdom (Nedwick 2014)—health rights litigation is virtually nonexistent, in middle-income countries that have reformed their health systems to introduce privatizing schemes for the delivery and insurance of health care, there are more chances to find high volumes of health rights litigation (Flood & Gross 2014a,b).

[1] **http://www.who.int/topics/essential_medicines/en/**.

There is ample evidence that access to courts is particularly easy for litigants in Colombia and Brazil, all of which has produced, in the two South American countries, the highest levels of health rights litigiousness in the region (Gloppen 2011, Yamin 2014). Contrastingly, litigation on the right to health is rare in Latin American countries like Chile and Mexico, despite the fact that both countries' constitutions incorporate mechanisms for the protection of basic rights: the *amparo* in Mexico and the *recurso de protección* in Chile.

The Mexican writ of *amparo*, entrenched in both the 1847 and 1917 constitutions, is Latin America's oldest legal mechanism for the judicial enforcement of basic rights. However, the *amparo* is usually implemented as a delaying tactic in civil lawsuits and not as a mechanism for the protection of constitutional rights or entitlements (Zamora & Cossio 2005). Additionally, owing to the technical intricacy of the procedural arguments that tend to support *amparo* lawsuits, claimants usually have to rely on the services of attorneys (Schor 2009). The procedural minutiae and high-opportunity cost for prospective claimants of Mexico's *amparo* are in stark contrast with the informal, expedient, and cost-efficient procedures of Colombia's *tutela*, Costa Rica's *amparo*, and Brazil's *ações individuais*, which allow any citizen to file a lawsuit without the aid of an attorney and omitting mention to the right or constitutional entitlement that supports the claim.

In Chile, the blockade on right-to-health litigation arises not because of the procedural obstacles of the *recurso de protección*, entrenched in Article 20 of Chile's constitution, but because of the restrictive judicial approach to the enforceability of socioeconomic rights. More concretely, the Chilean supreme court has interpreted the constitution's lack of explicit mention of an enforceable right to health care in a highly restrictive way, thus barring the litigation and adjudication of socioeconomic rights like health care (Contesse & Parmo 2008). Facing the litigation brought by PLWA who demanded access to ART, the Chilean supreme court decided that despite the imminent life-threatening risk faced by these patients, their cases were

> outside the bounds of the writ of protection [*recurso de protección*] . . . it corresponds to the health authorities [assigned with] putting into practice the health policies planned and implemented by the State Administration, in accordance with the means at their disposal, and with other criteria that it is not our role to elaborate on.[2]

For most authors, the conjunction of easy access to courts and privatizing health reform produced a nurturing setting for the uncontrolled escalation of health rights litigiousness in both Colombia and Brazil. In 1988, the Brazilian constitution overhauled the national health system, introducing a mixed public/private scheme for the delivery and coverage of health care—a double-track health system—that strongly incentivized the surge of litigiousness (Ferraz 2009, 2011a,b; Mota Prado 2013, 2014). Similarly, in 1993 Colombian policy makers adopted a new health system, loosely inspired by privatizing schemes for the delivery and coverage of health care, which has triggered a tsunami of health rights litigation (Lamprea 2014).

The hypothesis according to which the institutional arrangement of a health system is the best predictor of high levels of litigiousness has gained terrain in the comparative literature. For instance, a comparative study identifies Colombia's health system as a clear-cut case of a managed-competition/privatized model that has incentivized high levels of litigiousness. Costa Rica's public health system is located at the opposite extreme of Colombia's, with Brazil's mixed public/private system at a halfway point between the two extremes (Gloppen 2011). According to this study, the clash between privatizing health care reform and the enforcement of the right to health was

[2]C.S.J., 9 Oct. 2001, Rol de la causa: 2.186 (Chile) (Contesse & Parmo 2008).

not a head-on collision in Brazil and Costa Rica, and thus resulted in a less pronounced growth of health rights litigation compared to Colombia. Furthermore, cross-national variation between Costa Rica and the other two countries may be explained by the fact that Costa Rica's traditional public health system remained, to a greater extent than Brazil's and Colombia's, shielded from the imposition of privatizing health care reform by international financial institutions (IFIs) (Clark 2002, Montenegro Torres 2013, Rosenberg 1981, Wilson 2011). As a result of this, Costa Rica's public health system produces less infringements on the citizenry's right to health than Brazil's moderately privatized and Colombia's highly privatized health care sector, all of which results in lower levels of health rights litigiousness in Costa Rica compared to Brazil and Colombia (Wilson 2009). In the following two sections, I explore how these two variables—easy access to courts and health care reform—have played in out in the cases of Brazil's and Colombia's escalation of health rights litigation.

Brazil: The HIV/AIDS Epidemic and the Two-Track Health System

As it happened in South Africa, legal mobilization in Brazil was strongly influenced by the rapid advance of the HIV/AIDS pandemic. The most important supply-side variable that determined the emergence of HIV litigation in Brazil was the 1988 enactment of a rights-laden constitution that also introduced judicial mechanisms for the protection of basic rights, most prominently the *ações individuais*. Additionally, Brazil's constitution defined health care as a fundamental and enforceable right of all citizens (Article 196) and set the foundations of a new health care system (*Sistema Único de Saúde*, or SUS) based on the principles of universality, plurality, decentralization, and solidarity (Article 200) (Biehl 2009, Mota Prado 2014). The enactment of Law 9.313 of 1996, the first statute of its kind to universalize access to highly active antiretroviral therapy (HAART) in a developing country (UNAIDS 2015), was equally important as a supply-side variable.

But despite the importance of these supply-side variables, legal mobilization conducted by civil society organizations played a decisive role in the judicialization of health care in Brazil, as it did in South Africa. As several authors have pointed out, health care policy in Brazil has been shaped by social mobilization since the 1960s (Falleti 2010, Nunn 2009, Weyland 1995). According to Falleti (2010), the overhaul of Brazil's health system and the introduction of an enforceable right to health at the 1988 constitutional convention were influenced by the agendas of civil society organizations like the *sanitaristas*, a left-leaning group of public health experts that infiltrated the Ministry of Health to advocate for structural health reform (Falleti 2010). The reform path opened by the *sanitaristas* was broadened during the 1990s by an alliance of activists, government officials, development agencies, and some pharmaceutical companies—specifically those that produced generic drugs—which successfully lobbied the government and congress to pass Law 9.313 of 1996 (Biehl 2007).

Brazil's HIV program, and its cornerstone Law 9.313, was presented with global and domestic challenges that compromised the government's ability to guarantee HAART to all Brazilians living with HIV/AIDS. In 1999, foreign-based drug companies rallied against Brazil's expected use of compulsory licensing (a flexibility mechanism included in the TRIPS agreement) to reduce the prices of two HIV/AIDS drugs, Merck's efavirenz and Roche's nelfinavir (Flynn 2013). However, the most daunting global threat to Brazil's HIV program came in 2001, when the United States government requested a World Trade Organization Dispute Settlement Body, arguing that Brazil's HIV program disrupted the intellectual property rights of pharmaceutical companies and breached the TRIPS agreement. Facing this challenge, the Brazilian government allied with non-governmental organizations (NGOs) and like-minded governments to contend, at international forums like the United Nations Commission on Human Rights, the World Health Assembly of

the WHO, and the UN General Assembly Special Session on HIV (UNGASS), that universal access to ART constituted a fundamental human right (Teixeira et al. 2003). After a successful global campaign launched by the Brazilian government, it became clear that Brazil's HIV program had dramatically reduced mortality rates and hospitalizations of PLWA. During the UNGASS meeting on June 25, 2001, the United States announced that it had decided to withdraw its World Trade Organization complaint (Flynn 2013).

At the local level, the main challenge to Brazil's Law 9.313 of 1996 came from public and private medical facilities that discriminated against PLWA and refused to provide ART and HAART. As the hospital refusals increased, so did litigation. By 2005, almost 10 years after the congress enacted Law 9.313, PLWA had filed thousands of basic rights lawsuits at federal tribunals and state courts (Duran Ferreira & Ferrao 2004, Scheffer 2005). In most of their opinions, courts were deferential to the demands brought by plaintiffs. Furthermore, judges tended to interpret Law 9.313 as if it included a general mandate to provide all medication necessary for the patients' treatment, an interpretation that led plaintiffs to demand an ever-increasing list of HAART and medical procedures (Hoffman & Bentes 2008). As Scheffer (2005) described, HIV/AIDS patients and NGOs became repeat litigants (Galanter 1974) that used litigation in a routinized fashion to obtain drugs that had not been incorporated into the list of approved medications and procedures known as the *Consenso* or that had not been approved by ANVISA, the Brazilian drugs and food regulatory agency.

Despite the fact that NGO-sponsored litigation became the blueprint of the judicialization of health care in Brazil during the 1990s and early 2000s, the importance of NGOs as support structures for health rights litigation diminished over the years. Some authors have identified several possible explanations for this phenomenon. On one hand, *Ministério Público*, the public prosecutor's office, became the dominant support structure for health rights litigation in the country, creating a crowding-out effect that diminished the importance of NGOs as the main support structures for the judicialization of health care in Brazil (Hoffman & Bentes 2008). On the other hand, the particularities of HIV legal mobilization during the 1990s required an active role of domestic and international NGOs. However, as HIV policy stabilized and NGOs succeeded in dissuading perceptions of AIDS as the "gay cancer," the importance of civil society support structures for health rights litigation gradually decreased (Mota Prado 2014).

Although less marked than in Colombia, the explosion of litigiousness in Brazil during the past two decades has been remarkable. Whereas there was only a single case of health litigation in the state of Rio de Janeiro in 1991, there were 1,144 lawsuits in 2002 (Messeder et al. 2005). Another study found there were 2,245 cases in the state of Rio de Janeiro in 2005, representing a growth of more than 100% from 2002 levels (Borges 2007). This trend has been consistent in most Brazilian states, which also have a high success rate for claimants, ranging from 82% in lower courts to nearly 100% in Brazil's Federal Supreme Court (BFSC) (Ferraz 2009).

According to the leading authors studying the Brazilian case, the institutional design of Brazil's health care system provided the strongest incentives for the escalation of health rights litigiousness (Biehl 2009; Biehl et al. 2012; Ferraz 2009, 2011a,b; Mota Prado 2013, 2014). For Paim et al. (2011), some of the aims of the 1988 health care reform, which introduced the SUS, were achieved: The growth of the insured population and the unification of key areas of the health system are the two most important examples. However, among the unintended effects of Brazil's health care overhaul, the decentralized financial scheme introduced by the 1988 reform created a chronic underfunding of health care in many regions. The budgetary cutbacks weakened the network of hospitals, and as the average fee for health services decreased, the best private providers terminated their contracts with the SUS, all of which had a negative effect on the quality of services provided in the public sector (Lobato & Burlandy 2000). Additionally, the implementation of the 1988 health care reform

did not substantially transform the traditional two-track health system, in which an underfunded and low-quality public system that delivers health care to the majority of the population (70–80%) coexists with a well-funded and high-quality health system that covers the most well-off sectors of Brazilian society (20–30%) (Mota Prado 2014).

One of the clearest illustrations of the unequal access to health care in Brazil lies in the barriers to access to life-saving pharmaceuticals and medical treatment faced by vulnerable and poor citizens. According to Scheffer (2005), right-to-health litigation during the 1990s was instrumental to overcome those barriers. Additionally, the escalation of litigation led to the introduction of public policy aimed at guaranteeing access to essential medical treatment like antiretroviral medication.

Striking a contrast with Scheffer' optimistic appraisal of the effects of litigation, scholars like Ferraz (2009; 2011a,b) underscore the harmful effects on equity of the surge of health rights litigation in Brazil. Drawing from evidence indicating that middle- and upper-middle-class individuals with enough financial means to buy private health insurance are currently filing most right-to-health lawsuits, Ferraz posits that health rights litigation in Brazil is being hijacked by free-riders who have incentives to start litigation to appropriate public health resources that never reach the have-nots. According to Ferraz, the escalation of right-to-health litigation in Brazil is contributing to the deepening inequality created by the two-track health care system introduced by the military government in the 1960s (Falleti 2010, Paim et al. 2011).

Colombia's "Perfect Storm": Privatizing Health Care Reform and Easy Access to Courts

Among the overwhelming number and diversity of rights-based lawsuits in Colombia, health rights cases stand out. A set of studies published by *Defensoría del Pueblo*, Colombia's human rights ombudsperson office, indicate the right to health was the most litigated right in Colombia between 1999 and 2014, with an aggregate of 1,323,292 cases out of a total of 4,507,850 basic and social rights lawsuits. According to the ombudsman's studies, rates of success in favor of plaintiffs have been extremely high (close to 80%) since 1999.

According to most authors, the uncontrolled surge of health rights litigation in Colombia is the product of two judicial institutions introduced by the 1991 Colombian constitution, which lowered the threshold for bringing rights-based claims to courts. On the one hand, the *tutela* claim, an informal injunction that allows any citizen to seek judicial protection when her rights are threatened by the state or by a third party, eliminated most procedural obstacles to rights litigation and unleashed an unprecedented wave of rights-based litigiousness, particularly in the case of the right to health (Yamin et al. 2011). The *tutela*'s fast track and inexpensive procedure allowed thousands of individuals to obtain expedited judicial responses from local and higher courts to their demands for health care services without the involvement of attorneys or fees (Cepeda 2004, Yamin et al. 2011). However, the introduction of a constitutional court endowed with exclusive constitutional review powers and with faculties for selecting and overturning any number of *tutela* rulings handed down by local judges and higher courts created a supercourt. This supercourt has enough clout to shape and enforce a vigorous precedent on the justiciability of socioeconomic rights (Landau 2005, Uprimny 2006). The court's progressive precedent provided the legal opportunity structure for the massive use of the *tutela* claim to demand health care services that health insurance companies and hospitals refused to provide (Yamin & Parra-Vera 2010). Additionally, this pioneering precedent on the justiciability of the right to health trickled down to Colombia's lower and local courts, whose rulings reflected the Colombia Constitutional Court's (CCC's) relinquishment of judicial formalisms, the adoption of broad definitions of standing, the elimination of barriers to access for litigants, and the expedited resolution of cases (Wilson 2009).

Although the *tutela*'s effective procedure and the CCC's progressive social rights opinions are widely recognized as the main drivers of health rights litigiousness in Colombia, some authors suggest that another key variable to explain the litigation epidemic of health rights resides in the institutional arrangement and performance of the health system. For instance, experts on the Colombian case argue that the characteristics of the local health system are key to understanding why the volume of litigation has been greater in Colombia than anywhere else in the world (Yamin et al. 2011). Several authors claim that the neoliberal and privatizing agenda of IFIs like the World Bank was the most important determinant of Colombia's 1993 health care overhaul and the rise of litigation (Groote & Unger 2005, Homedes & Ugalde 2005, Kurtz & Brooks 2008, Yamin 2011). According to some accounts, at the heart of Colombia's uncommon escalation of right-to-health litigation lies a clash between the health system's neoliberal "push toward commodification, commercialization, and privatization [that] undermines both the concept and enjoyment of a right to health" and the reactive role of litigants and courts, which have acted as "bulwarks against the hegemonic onslaught of neoliberalism" (Yamin 2011, p. 336).

Yet, the weight given to privatization of health systems as an explanatory variable to address cross-national variation in patterns of health rights litigation is problematic on several grounds. Firstly, it is inaccurately assumed that by implementing competition among health care providers, health reforms like Colombia's incentivized the health system's privatization. On the contrary, according to WHO statistics, Colombia's health care system outperforms Brazil's and Costa Rica's in areas such as public health expenditure, lower out-of-pocket expenditure, and lower private insurance coverage (World Health Organ. 2014). Secondly, health care reforms such as Colombia's cannot be pigeonholed as clear-cut cases of the privatizing managed-competition model, as classically defined by Enthoven (1993). As recent contributions to the literature indicate, Colombia's multifaceted and complex health system is more similar to social insurance models (e.g., the Dutch system), in which the governmental regulation of competition among private and public health providers is aimed at guaranteeing universal coverage and solidarity schemes among rich and poor (Flood & Gross 2014a,b; Flood & Haugan 2010; Lamprea & García 2016; Paris et al. 2010). Thirdly, the top-down privatization hypothesis is not sensitive to the local determinants of health care reform in Latin America and with the agency of local policy makers. For instance, most authors who defend the privatization hypothesis seem to start from the assumption (usually without empirical support) that Colombian policy makers followed a standard model conceived by IFIs such as the World Bank and the Inter-American Development Bank when they introduced a 1993 healthcare overhaul. However, as some scholars have shown, such a simplistic, top-down approach is at odds with the complex local and global factors that prompted health reforms in Latin America during the 1990s (Brooks 2009).

The Pharmaceuticalization of Health Rights Litigation

The fact that most of the public expenditure associated with the judicialization of health care in Colombia (Andia 2011, Méndez et al. 2012), Brazil (Vieira 2009), and Costa Rica (Norheim & Wilson 2014) is invested in paying for costly, but not necessarily cost-efficient, drugs has led some authors to explore the increasing pharmaceuticalization of health rights litigation in those countries. According to the work of several health anthropologists, the term pharmaceuticalization implies an "overfetichization" of medications inimical to a more robust public health approach (Petryna 2009, Petryna & Kleinman 2006).

There is abundant evidence about the growing pharmaceuticalization of health rights litigation in Brazil, Colombia, and Costa Rica. For instance, a set of studies shows that most of the federal government's expenditure on health services demanded by Brazilian litigants is focused

on expensive biotech drugs for chronic medical conditions like cancer, arthritis, and rare diseases, which are not included in the health benefit plan (Chieffi & Barata 2009, Vieira & Zucchi 2007). A study concluded that the state of São Paulo, attending the orders handed down by judges, spent 65 million Brazilian reais to provide drugs for approximately 3,600 claimants in 2006. Contrastingly, during the same year, the Ministry of Health's Special Medication Program (which provides medicines for the treatment of rare or chronic diseases that reach a limited number of users who, for the most part, use them for prolonged periods) and the state of São Paulo's Health Department spent 838 million reais to provide drugs for 380,000 patients. That means that whereas a litigant was awarded, on average, 18,000 reais (US$5,400) in medications, a patient who obtained drugs from the Special Medication Program received only 2,200 reais (US$660) worth of drugs (Chieffi & Barata 2009), or eight times less than the litigant.

In Colombia, the pharmaceuticalization of health care is as acute as in Brazil. According to a study published by Observamed, a Colombian think tank, in 2008 the government reimbursed health insurance companies approximately US$156 million for seven high-end biotech drugs demanded by litigants. That figure represents approximately 22% of the total public pharmaceutical expenditure. Even more striking is the fact that five out of the seven pharmaceuticals are oncologic. These five oncologic medications alone represented approximately 15% (close to US$101 million) of Colombia's public pharmaceutical expenditure in 2008 (Andia Rey 2009).

In Costa Rica, according to a recent empirical study, the health rights opinions handed down by the Supreme Court's Sala IV failed to foster fair access to medications (Norheim & Wilson 2014). In their study, Norheim & Wilson randomly selected cases on access to medicines handed down by the Supreme Court and found that approximately 70% of the judicial opinions ordered the government to provide experimental or low-priority pharmaceuticals with only marginal benefits for patients.

Based on the findings that indicate that health rights litigation in Latin America is strongly related to the growing pharmaceuticalization of health care, an emerging literature has investigated how transnational pharmaceutical companies are deploying pro bono litigation counseling conducted by patients' organizations as a mechanism to boost the sales of their products at the expense of Colombia's, Brazil's, and Costa Rica's health systems. A study of Brazil's health rights litigation argues that pharmaceutical companies might have, indirectly, incentivized right-to-health litigation through NGOs and patients' organizations (Hoffman & Bentes 2008). A different study found evidence that in Brazil, Costa Rica, and Colombia, national and transnational pharmaceutical companies have stimulated health rights litigation through their ties with patients' organizations. Yet, Gloppen & Roseman (2011, p. 264) concluded that the linkages between pharmaceutical companies and civil society organizations like patients' groups "are difficult to uncover and credibly establish." They also concede that the comparative literature's data about such links "are still rudimentary, and more research is needed to reach a firm conclusion on the nature and extent of this influence" (Gloppen & Roseman 2011, p. 264).

An empirical study conducted in Colombia offered an account of the multifaceted linkages between patients' organizations that provide pro bono litigation support and transnational pharmaceutical companies (Lamprea 2015). The findings of this study suggest patients' organizations and advocacy groups that provide a support structure for litigation in Colombia advance a political or moral cause in which they believe in helping high-cost patients to obtain life-saving medical treatment refused by health insurance companies and not covered by the health system, despite the economic linkages tying them to sponsoring pharmaceutical companies (Scheingold 2004, Scheingold & Sarat 2004). But at the same time, owing to their underpinning linkages with the pharmaceutical industry, the patients' organizations and advocacy groups have ambiguous and puzzling features of what the sociolegal literature calls cause-lawyering (Scheingold 2004).

Assessing the Colombian and Brazilian Strategies to Rein in Health Rights Litigiousness

In 2008 and 2009, the CCC and the BFSC began their first steps toward the de-escalation of health rights litigation. In 2008, the CCC handed down an opinion (T-760) that ordered the government to implement regulatory measures aimed at correcting the institutional incentives that were driving the wave of litigiousness (Lamprea 2016, Rodriguez-Garavito 2011, Yamin 2014). T-760/08 laid down a total of 32 orders. The first 16 orders commanded several health insurance companies to deliver the health care services demanded by the 22 individual plaintiffs who filed the lawsuits. The remaining 16 orders were addressed to the Ministry of Health and other regulatory agencies like the Regulatory Health Commission and the Superintendence of Health. These structural orders cover a wide range of regulatory measures that the CCC considered the government must implement to protect the right to health of Colombian patients and rein in health rights litigiousness. Bolstered by opinion T-760 of 2008, the CCC instituted a follow-up mechanism to assess the government's compliance with the court's orders and hosted two public hearings in 2011 and 2012. In these public hearings, government officials, experts, and civil society organizations deliberated about the policies implemented by the government to materialize the regulatory orders handed down by opinion T-760. Taking into account the judicial orders and the follow-up procedure chosen by the CCC, Lamprea (2016) argued that opinion T-760 embraced an experimental approach to public law remedies that abandons top-down, command, and control judicial decrees and "emphasizes ongoing stakeholder negotiation, continuously revised performance measures and transparency" (Sabel & Simon 2004, p. 1016).

Similarly, in 2009 the BFSC conducted a set of public hearings in which governmental officials, scholars, and representatives of civil society organizations discussed the surge of right-to-health litigation in Brazil and considered alternatives to contain the harmful effects of litigation on federal and local health budgets (Wang 2013). As a result of these public hearings, the BFSC handed down a set of opinions establishing several guidelines for the adjudication of right-to-health cases in 2010. These guidelines were supposed to slow the escalation of lawsuits in which claimants demanded drugs and treatments excluded from the health benefit plans.

The interventions of the BFSC and the CCC, and more particularly the use of public hearings by the two higher courts, are instances of a multilateralist model of adjudication in which the judge is not the main or sole actor (i.e., the unilateralist model), but in which a network of actors interact in the adjudicative process (Zaring 2004). Additionally, the public hearings hosted by the BFSC and the CCC represent an instance of dialogic judicial activism because both courts decided to act upon an issue (in this case the escalation of right-to-health litigation) after a deliberative process that involved, e.g., governmental agencies, civil society organizations, patients, and experts (Gargarella 2011).

The two strategies adopted by the CCC and the BFSC began to diverge markedly when, as a result of the orders handed down by the CCC in opinion T-760 of 2008, Colombia's congress passed Law 1751 of 2015. Law 1751 not only incorporates the basic right to health as the cornerstone of Colombia's health system but also orders the government to design a new health benefit plan consistent with a set of categories of excluded medications and treatments that the health system is not obliged to provide to patients, instead of a detailed list of mandatory treatments and drugs. It is understood that the health system, composed of both private and public health providers and insurers, has the obligation to guarantee all drugs and treatments that are not part of the excluded categories of health care services. According to the policy makers who designed Law 1751, this new benefit plan, being based on an implicit list of health services, should eliminate the incentives that are driving plaintiffs to demand, via litigation, drugs and treatments that are not part of the current health benefit plan (Chapman et al. 2015).

In contrast, the BFSC opinions that created guidelines for the adjudication of health services excluded from the health benefit plans refrained from handing down structural reform orders addressed to policy makers. Partially as a result of this, the regulatory and institutional determinants that are pushing the escalation of right-to-health litigation in Brazil remained unaddressed by the BFSC. According to Mota-Prado (2013), judicial rulings like Colombia's T-760, which promote institutional change, have a broader impact than rulings like the ones handed down by the BFSC. This is because the CCC opinion included procedural modifications and institutional changes to the health system, whereas the BFSC rulings simply provided judicial guidelines for the provision of new treatments and services to patients. This point is further strengthened by Wang's (2013) results, according to which the BFSC precedent has remained pretty much the same with respect to cases where a patient demands drugs or treatments excluded from the health benefit plan following the 2009 public hearings and the 2010 guidelines. According to the current BFSC precedent, the Brazilian state must rescue any patient whose life depends on a treatment, irrespective of whether the medication or medical technology demanded is still in an experimental phase or if it has to be provided abroad. Although the BFSC conceded that resources are scarce, it failed to consider whether the health system must ration the provision of costly drugs and treatments that create distribution dilemmas.

CONCLUSION

One of the main lessons that can be derived from the literature covered in this article is that the standard definitions of the right to health as an adequate standard of living and well-being (Universal Declaration of Human Rights) or as the highest attainable standard of health (WHO) are challenged by the complex political economy surrounding the judicialization of health care. The tensions judges experience when they enforce the right to health by ordering the delivery of an expensive biotech pharmaceutical that the taxpayers of a middle-income country have to pay for; the dilemmas of litigants and activists who advocate for the rights of vulnerable patients thanks to the funding provided by pharmaceutical companies; or the challenges faced by higher courts when they experiment with judicial remedies that could destabilize their traditional practices of adjudication—all of these conundrums can be better understood, and eventually transformed, from a perspective centered on how rights actually work in social practice, and not only on the definitions of the right.

The litigation epidemic of health rights and the diminishing importance of health rights adjudication in South Africa have forced scholars, litigants, and judges to take a hard look at the social, economic, and institutional determinants of right-to-health litigation. Just as Norman Daniels (2000) called attention to the tendency of bioethics and health reforms to focus on medicine only at the point of delivery and to neglect an analysis of the determinants of health upstream, in countries like Colombia and Brazil judges and litigants have focused on the right to health only downstream, overlooking the economic, social, and institutional determinants of health rights litigation. Although the CCC has provided a meaningful example of how to mitigate the unwanted effects of the epidemic of health rights litigation by deploying an upstream approach to the judicialization of health care, much remains to be done. The acknowledgment of the global and local political economies that drive health rights litigation must become a topic as important as the discussions surrounding structural reform of judicial orders and health care reform.

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