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UNIVERSAL HEALTH COVERAGE AND LITIGATION IN LATIN AMERICA

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In recent years, several middle-income Latin American countries have seen a steep increase in the number of cases litigating access to curative services and inputs. A renewed judicial approach to the enforcement of the right to health, the expansion of health coverage, a more demanding public interest, an increased prevalence of non communicable diseases and a limited capacity for fair and solid benefit basket design lie at the basis of this phenomenon. Using an interdisciplinary approach and evidence from Argentina, Brazil, Chile, Colombia, Costa Rica, Peru, and Uruguay, this paper examines this complex phenomenon and outlines some of its roots and impacts. It also argues for the need to incorporate a rights-based approach to health policy as a foundation to societal efforts to achieve universal health coverage.

seek the realization of their right to health, a phenomenon also called judicialization of the right to health.

This activism is explained by the fact that the courts regard administrative inefficiencies and prioritization processes of health services that fail to protect an individual's access, as a violation of government duties towards this right. As a result, the courts have become the de facto overseers and guarantors of policies that affect the right to health.

Despite the increases in coverage achieved by many countries, public policies have not advanced at the same pace as social demands and health needs—and have not recognized the importance of a human rights approach to social policy. As a result, countries are left with benefit plans that do not provide the participatory processes and technical criteria that would make chosen priorities legitimate.

Latin America's population is ageing fast and the incidence and prevalence of non-communicable diseases is rising while advances in (costly) medical technologies become available. These factors exercise pressure over health systems' spending and service delivery capacity, challenging their financing and ability to address the more complex health needs of the population. If health systems are not able to respond adequately to these pressures, the trend of increased judicialization of health services is not only likely to continue, but to increase.

The Determinants of Health Litigation

The process of democratization in Latin America, which began in the 1980s, led to many constitutional changes. These revised and new constitutions give citizens guaranteed rights, including the right to health. In addition, several also describe the government's role regarding the provision of basic social services and direct the allocation of public resources to fulfill these obligations. In cases where citizens believe that their rights are being denied, most constitutions ensure judicial protection (writ of protection) fairly easily and with little cost. The writ of protection not only protects the individual's constitutional rights, but also allows the Judiciary to safeguard the constitution itself.

Through the jurisprudence created while ruling writs of protection, Latin American courts have assumed an active role in interpreting and protecting those rights. On several occasions, court rulings have forced the Executive to redefine its policies. This context has led individuals to use writs to



The Evidence

Information available on the number, nature, and costs of cases, as well as on the socio-economic characteristics of the plaintiffs is incomplete, thereby limiting a comprehensive analysis of the phenomenon. Nevertheless, the data available suggest a worrisome tendency of increasing judicialization in the seven countries being studied and provide useful information on the overall nature of the phenomenon.

The phenomenon of health judicialization impacts not only government budgets, but also affects the process in which health resources are allocated. While rights-base health litigation can be used for different purposes, such as environmental health, litigations demanding access to curative health care are by far the most frequent in the region.¹ Most of these lawsuits affect only one plaintiff (*inter partes*), and therefore do not necessarily affect the entire population (*erga omnes*).

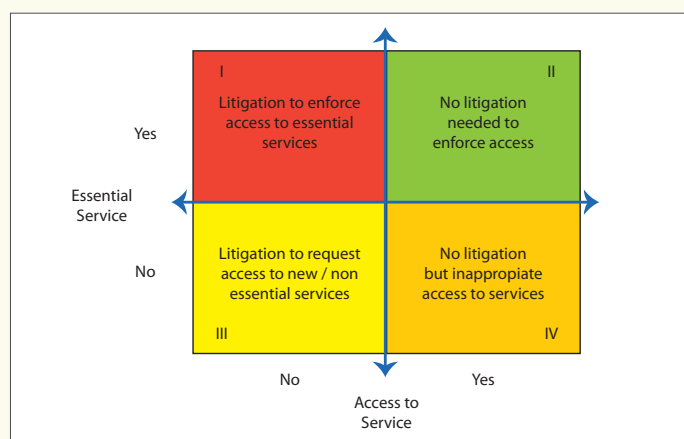
In Brazil, federal financial resources spent on paying claims ordered by the courts increased by almost 40 times between 2005 and 2010. The Ministry of Health reported that, in 2010, payments on medications at the federal level alone totaled approximately US\$550 million. Data from seven states account for 240,000 cases. The State of Sao Paulo alone paid US\$380 million on claims for high cost medications, or 50 percent of its entire annual budget for exceptional medications.

In Colombia, the Ombudsman's Office estimates that there were 95,000 writs of protection in health in 2010, making it the most protected fundamental right in the country. The Ministry of Health estimates that in 2009, the direct cost of litigations reached US\$300 million in the Contributive Regime alone, which is directed at the formally employed and has a more comprehensive essential list of services than the Subsidized Regime.

It is estimated that there have been 4,000 accumulated writs in health in Costa Rica since 1989. Between 1989 and 1998, there were 179 health cases against the Costa Rican Social Security Institute (CCSS). Between 1999 and 2008, that number had increased to 2,524.

In Argentina, where judicialization occurs mostly in the social security subsystem, only one court in the city of Buenos Aires received 1,159 cases during 2007. Uruguay still has a low, but growing, level of judicialization, with 34 of the 40 litigation cases of the last ten years occurring in the last two-and-a-half years.

Litigation is used to obtain access to both essential and non-essential services (see Figure I). This distinction is important, as the former detects deficiencies in the administration and delivery of essential services and errors in the prescription of drugs



(Quadrant I in Figure I), while the latter reflects a direct conflict with the priorities established in the list of essential services (Quadrant IV in Figure I).² The existing evidence clearly shows that some non-essential medications appear as common sources of litigation throughout the region.³

Less common are those litigations and court decisions that can affect the overall health system's structure and/or functioning. These refer to rulings ordering the executive and/or legislative branches of government to modify health policies in order to enhance the protection of the right-to-health. In Brazil, for example, a public hearing called by the Supreme Federal Tribunal led to the approval of a reform of the decision-making process used to determine the essential list of services. In Chile the Constitutional Tribunal declared unconstitutional risk-adjusted premiums affecting almost three million individuals. The Court entrusted its redress to the legislative and executive branches of government.

In Sentence T-760 of 2008, the Colombian Constitutional Court calls for structural changes in the health system. According to the Court, the regulation of the health system was flawed and, therefore, ordered the Executive to amend it. The Court also ordered the adoption of a unified essential list of services for children under 18, and a posterior unification of lists for the rest of population, to be implemented according to resource availability. Following this ruling, the Colombian health authorities reviewed the regulatory framework, and began the progressive unification of the essential lists of services.

Finally, preliminary evidence suggests that litigation might not be currently used by those most in need. In Brazil, the majority of writs take place in states with the highest human development index, and the largest proportion of claims in the City of São Paulo originate from the neighborhoods with the lowest levels of exclusion or social vulnerability. Similarly, for Argentina: the majority of writs in the City of Buenos Aires are not claims from low income areas. In Colombia, the number of writs of protection filed in the Contributive Regime, was six

¹ For the purpose of this paper medical malpractice lawsuits are not considered human rights litigations.

² Examples include the case of branded medications when its generic alternative is in the essential list; new health care technologies or life-saving medications without a clinical alternative in the essential lists; and services without evidence of clinical effectiveness that are infrequently claimed.

³ Examples include Rituximab, for cancers, Imiglucerase for rare diseases or Insulin Glargina for diabetes.

times higher than in the Subsidized Regime.

Concluding Discussion

The tension between the judiciary and health authorities, generated by the judicialization of the right to health, occurs in many countries of the region independently of the judicial model or type of health system adopted. Several factors help explain this fact. First, public demands have changed from the solution of public health issues to the delivery of timely, high quality, and service-oriented health care. Second, constitutions and notions of the State have also changed, creating a fertile ground to accept citizens' demands. Third, growing public demands are being met by an increasing judicial activism, that is, by courts willing to study such demands. Fourth, health systems maintain prioritization and resource allocation processes that still lack technical validity, transparency, participation, and accountability. Finally, demographic and epidemiological transitions are shaping the population's clinical needs while a larger and more expensive array of health care technologies are available to face such needs.

It is evident that right-to-health litigation has held governments accountable for their constitutional duties and provided access for thousands of individuals to administrative or judicial mechanisms to enforce their rights. According to the courts, arguments solely based on resource constraints may hide inefficiencies, incapacities, or even corruption and, hence, cannot be accepted to deny access to care.

Litigation has also raised awareness among all members of society of individual rights and the government's responsibilities. The traditionally discretionary authority of the Executive branch of government to allocate public resources is now being held accountable for its decisions. Furthermore, judicialization has allowed for democratic deliberation to have a role in policy design and monitoring, reinforcing checks and balances, foundational elements of a democracy. In fact, achieving universal health coverage will require a participatory dialogue to legitimately decide resource allocation and technology. Increased transparency and accountability will not only improve human rights protection but ultimately will also strengthen health systems.

There are, however, two main equity-related concerns that arise from the process of judicialization in health. First, access to justice, like access to health, is unequally distributed because is conditioned by socio-economic factors. Thus, while the process of judicialization aims at

addressing a real and legitimate problem of the region, the inequitable access to health services and inputs, it may be, unintentionally, generating a different type of inequity, and/or reinforcing existing ones, as those that already have better access to health are also likely to have better access to the judicial system. Second, the lack of collective actions (*erga omnes*) may generate horizontal inequities, that is, equals being treated differently.

The phenomenon of judicialization may also have efficiency consequences, as it may lead to an increase of investments in health care technologies that otherwise might not be prioritized. Therefore, is the process of judicialization creating a context in which courts are, in some cases, *de facto* defining health sector priorities? While the answer to this question is not clear, the fact is that the process is generating a different and evolving relationship between the Judicial and Executive powers.

Some court rulings have systematically favored the concept of the treating physician over the opinion of peer clinical experts or the clinical protocols of the health authority. This positioning poses three main risks:

- It may force the system to deliver drugs/services for which there is no evidence of its clinical effectiveness.
- Medical opinion could be biased because of conflict of interest on the part of the treating physician.
- The limited technical capacity of the courts might lead to suboptimal decisions for society as a whole, given the opportunity cost of no delivery of other services.

In summary, medical autonomy needs to be balanced with the fact that in complex clinical cases an individual medical opinion may not necessarily be the most suitable.

It is still early to quantify all these effects and developing fair, transparent, technically sound, and progressive priority setting processes is at the top of the next generation of policy challenges that Latin American health systems face. Better data, improved information systems and future research on these issues are needed to tackle these challenges and to fully understand the direct financial impact as well as the opportunity costs associated with the overall process of judicialization.

The experience of these seven Latin American should draw the attention of other developing countries within and outside the region, particularly now when many are committed to expanding population and service coverage. Courting social rights is an increasingly common global phenomenon with cases arising both in common and civil law countries, and in insurance and non-insurance based health systems. Furthermore, the greater the success of the citizenry demands, the greater the possibilities of extending the intervention of the Judiciary to other areas besides health. In this sense, promoting a fluid dialogue between consequentialist and deontological approaches and between human rights and health systems views will certainly be beneficial.



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