THE RIGHT TO HEALTH IN LATIN AMERICA: THE CHALLENGES OF CONSTRUCTING FAIR LIMITS

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ABSTRACT

There is increasing scholarly attention to judicial enforcement of the right to health, but too often it extrapolates general lessons from one country or region. The impacts of judicial enforcement depend largely on the reasons people turn to courts, the nature of judicial decisions, and the extent to which courts can open political opportunity structures for greater equity and transparency. Drawing on case studies from five countries in the region, the Article argues that the experience of constitutionalization and judicial enforcement of the right to health in Latin America shows a number of lessons and challenges. Against backdrops of extreme social inequality, with poor responsiveness from the executive and legislative branches of government, as well as chronic regulatory failures within health systems, it is unsurprising that people take advantage of the favorable opportunity structures that exist in many courts. Nevertheless, contrary to widespread thinking, easy access to justice, combined with individual decisions can promote queue jumping and potentially exacerbate inequities in health

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systems. The example of a mega-judgment in Colombia shows both that under certain circumstances apex courts can play important roles in catalyzing action by political branches but also suggests that there are significant limitations of transformative constitutionalism, at least in the health field.

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1. INTRODUCTION

The history of how health-related rights have evolved in Latin America is inextricably linked to contestation over boundaries between private morality and public policy, between individual and social responsibility for health, and between the role of the state and markets. In a region of profound social inequalities[1] that are deeply reflected in social determinants of health, as well as health outcomes, health systems have been sites of social contestation, from the incorporation of health and social protections for workers in the wake of enormous immigration to movements for social medicine to market-based liberalization and reforms. Moreover, since colonial times, when health was largely conceived of as charity organized by religious institutions, there has remained a deeply embedded discourse of health conditions as divine punishment for "sin,", which is most acutely evidenced in relation to sexual and reproductive health.[2] Indeed, the *right to health* is perhaps the most radical of social rights because it challenges what is taken for granted as "natural."[3]

The contours of the right to health are also especially susceptible to the accelerating pace of pharmaceutical and technological innovation and the changing epidemiological profiles of populations. Both trends not only drive demand in health care markets but also create ever more stress on financing those systems. In the second half of the Twentieth Century, not only did much of the region—particularly urban populations—undergo a significant epidemiological transition from infectious diseases to chronic conditions, technological advancements also drove the organization of health systems to evolve significantly. The archetypical physician with the little black bag was replaced by a

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[1] Inter-American Development Bank, *Gini Coefficient of Per Capita Household Income – Countries comparison*, https://data.iadb.org/ViewIndicator/ViewIndicator?languageId=1&indicatorId=1719&typeOfUrl=C [hereinafter IADB, *GINI*].

[2] Anne-Emmanuelle Birn & Laura Nervi, *Political Roots of the Struggle for Health Justice in Latin America*, 385 The Lancet 1174, 1174–1175 (2015) (discussing how social movements incorporated health care into struggles for better working and living conditions).

[3] Alicia E. Yamin, *Redefining Health: Challenging Power Relations*, *in* POWER, SUFFERING, AND THE STRUGGLE FOR DIGNITY: HUMAN RIGHTS FRAMEWORKS FOR HEALTH AND WHY THEY MATTER 3, 73–98 (2015).

complex apparatus that depended upon specialized equipment and specialty practices, which in turn called for entirely different financing, as well as service delivery, arrangements.[4]

In the late 1980's and 1990's, much of the region was facing the effects of structural adjustment policies, often adopted under undemocratic regimes, as well as new health reforms adding market-based regulation to fragmented regimes based largely on divisions between formal and informal employment sectors. At the same time, in the wake of military dictatorships or particular political inflection points (e.g. Colombia), a wave of new constitutions and constitutional amendments came into being. These new constitutions enshrined principles of transformative constitutionalism that established social or welfare purposes as integral to the design of the state, sometimes included enumeration of specific social rights, and in many cases incorporated international human rights norms through "constitutional blocs" ("*bloques de constitucionalidad*"). In conjunction with chronic democratic deficits and a lack of capacity on the part of many governments to either respond to public clamor for health demands or to effectively regulate health systems, easy individual access to courts through such protection writs has created an acute demand for medical treatments through judicial action.[5]

One way of understanding judicialization of health rights in the region is precisely the gap between supply and demand, which was accentuated in many instances by health reforms that increased coverage of social insurance.[6] However, in this Article I argue that this analysis understates a principal conceptual implication of construing health as a right, which is neither to deny the scarcity of resources nor the need for rationing. It is rather to understand the health system as a core social institution, and the definition of the contours of an enforceable legal entitlement as requiring a legitimate democratic process just as much as a credible

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[4] NORMAN DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY 161 (Cambridge University Press ed., 2008).

[5] Alicia E. Yamin, *Power, Suffering and Courts: Reflections on Promoting Health Rights through Judicialization, in* LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH? 333–372 (2011) [hereinafter Yamin Reflections LHR].

[6] EVERALDO LAMPREA, DERECHOS EN LA PRÁCTICA. JUECES, LITIGANTES Y OPERADORES DE POLÍTICAS DE SALUD EN COLOMBIA (1991-2014) 31 (2015) [hereinafter Lamprea, 2015].

application of scientific-technical evidence.[7] Understood in this light, health systems embed normative decisions, from macro-levels in terms of solidarity of financing, including whether irregular migrants are included, to the most micro-levels regarding information provided by providers to patients.[8] Further, in this view, courts have a role to play in ensuring that the decisions taken in health systems are justified and in keeping with fundamental constitutional commitments, ranging from safeguarding the dignity of women who seek abortions after sexual assault to the extent of governmental obligations to provide health entitlements that reflect equal concern and respect for all members of society.[9]

Yet all too often in the region, judicial remedies have been appended onto broken systems and, while empirical evidence regarding the equity effects of the flood of legal enforcement of individual entitlements remains ambiguous, there are well-founded concerns regarding the potential for judicialization to skew attention to curative care from public health promotion measures and to reduce aspirations for health justice to a feeble "sufficientarianism."[10] In Part II of this Article, I outline the constitutional provisions in relation to health rights[11] in five countries in the region—Argentina, Brazil, Colombia, Costa Rica, and Mexico—pointing to some shared contextual factors and concepts, as well as distinctive aspects that have shaped judicial interpretation. In Part III, I then turn to experiences with judicialization of health rights in the region. After briefly setting out some context for the wholesale exploitation of individual judicial actions, I explore the potential opportunities and

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[7] Alicia E. Yamin, *Taking the Right to Health Seriously: Implications for Courts and Health Systems'* 39(2) HUM. RTS. Q. (2017) [hereinafter Yamin HRQ].

[8] Alicia E. Yamin & Ole F. Norheim, *Taking Equality Seriously: Applying Human Rights Frameworks to Priority Setting in Health*, 36 HUM. RTS. Q. 296, 296–324 (2014) [hereinafter Yamin and Norheim HRQ].

[9] Corte Suprema de Justicia de la Nación de Argentina [CSJN] [National Supreme Court of Justice], 13/5/2012, "F. A. L. s/medida autosatisfactiva, Fallos (259. XLVI) (Arg.); Corte Constitucional [C.C.] [Constitutional Court], julio 31, 2008, Sentencia T-760/08 (Colom.) [hereafter Colombia T-760/08].

[10] Lukas Meyer, *Sufficientarianism: Both International and Intergenerational?* in ABSOLUTE POVERTY AND GLOBAL JUSTICE: EMPIRICAL DATA, MORAL THEORIES, INITIATIVES, 133–141 (Elke Mack et al. eds., 2009).

[11] This phrase is used rather than the "right to health" because in the case of Costa Rica, the Court has derived the right to health from two constitutional rights: the protection of human life and the right to social security protection.

challenges of dialogical remedies as a response to massive judicialization. This is based upon a case study of the most sweeping structural decision to date in this area, T 760/08, in which the Colombian Constitutional Court called for reform of the health system based upon the right to health.[12] I conclude that while dialogical remedies can potentially foster dialogue with the executive as well as shifts in public discourse regarding health as a right, there are significant limitations to the extent to which judiciaries can destabilize the steep asymmetries of information and power within health sectors, and catalyze greater democratic participation in constructing the limits of health rights.

2. CONSTITUTIONAL PROVISIONS: CONCEPTS AND CONTENT

Although the actual constitutional provisions, as well as the nature of the health system, differ substantially across countries in the region, health rights are defined in terms of more than medical care and are connected to larger economic and social issues and policies in most of the constitutions of the region. This is critical, as much greater percentages of population health and morbidity are determined by social and political determinants of health than by curative care. Moreover, across these countries, structural innovations in the wave of new constitutions and reforms have deeply impacted how health rights have come to be interpreted and enforced by courts. These have included two or more of the following aspects: (a) the establishment of a "constitutional jurisdiction," sometimes with a high court or specialized chamber of a high court overseeing it; (b) the introduction or modification of protection writs (e.g., *amparos*, *tutelas*) as a mechanism to protect and promote the rights endowed in the constitution; (c) the incorporation of international human rights norms and standards through a constitutional bloc; (d) the expansion of abstract review of legislation; and (e) the reduction or virtual abolition of standing requirements.[13] The development of jurisprudence on the right to

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[12] Colombia T-760/08, *supra* note 9.

[13] Alicia E. Yamin, *Decision T-760 (2008) (Colom), in* MAX PLANCK ENCYCLOPEDIA OF COMPARATIVE CONSTITUTIONAL LAW (last updated Nov. 2017) at ¶ 7, 9–10 [hereafter Yamin T-760/08].

health has been further enabled by a reduction in formalism on the bench, reflected both in substantive erosions of distinctions between directive principles and fundamental rights as well as in practices regarding, e.g., *amicus curiae*.

2.1. Argentina

Argentina has a federal system of government, and health is regulated at both the national and provincial levels. The military dictatorship in Argentina (1976-83) incurred $36 billion in foreign debt,[14] and subsequent democratic governments implemented structural adjustment programs to pay off national debt until the government defaulted in 2001.[15] Both the structural adjustment and the default, and subsequent "*Corralito*," had substantial impacts on the health system.[16] According to UN Independent Expert Cephas Lumina, the crisis "severely affected the public health system, with hospitals suffering a serious shortage of basic supplies and prices of medicines soaring. In addition, the drastic drop in employment left roughly 60 per cent of the population outside the social health insurance system."[17] The current health system is composed of public, social (a contributory regime for those in formal employment based upon a social insurance package), and private health sectors; and in practice is fragmented to the point of what has been called "atomization," which produces inequities across plans and providers.[18]

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[14] International Monetary Fund, *The Role of the IMF in Argentina, 1991-2002*, Issues Paper/Terms of Reference for an Evaluation by the Independent Evaluation Office (July 2003), https://www.imf.org/External/NP/ieo/2003/arg/index.htm [https://perma.cc/95LF-SL7H].

[15] *See* Rep. of the Indep. Expert on the Effects of Foreign Debt and Other Related Int'l Financial Obligations of States on the Full Enjoyment of all Hum. Rts., particularly Econ., Soc. and Cultural Rts., U.N. Doc. A/HRC/25/50/Add. 3, at 6–14 (Apr. 2, 2014), http://www.undocs.org/A/HRC/25/50/Add.3 [https://perma.cc/XDH7-T9Y2] (describing the transformation of Argentina's economy in 2001, key challenges and implications, and obligations under human rights law).

[16] *Id.*

[17] *Id.* at 6 ¶13.

[18] Cf., Thomas Bossert et al., *Comparative Review of Health System Integration in Selected Countries in Latin America*, INTER-AMERICAN DEVELOPMENT BANK [IDB] TECHNICAL NOTE IDB-TN-585 (Jan. 2014),

Social rights were initially embedded in the 1949 Constitution under Juan Domingo Perón, reflecting the strong influence of the labor movement under Peronism at the time. In the 1957 text, Article 14 bis, incorporated social constitutionalism, which established a "Social Security" system that included both traditional social security and a broader concept of social protection.[19] However, it was through constitutional amendments introduced in 1994 that announced equality and social justice as organizing principles for the state, and gave human rights treaties constitutional status through Article 75.22.[20]

The current constitutional protection of the right to health extends well beyond medical care. For example, the constitution protects the collective right to "a healthy and balanced environment for human development" (Article 41) and consumers' rights "to the protection of their health, safety, and economic interests" (Article 43). Further, Article 75 mandates the Legislature to provide certain health and other social protections on the basis of social equality (Article 75), understood as including both formal and substantive dimensions.[21]

The Argentine Supreme Court has recognized the constitutional status of the right to health as a result of the constitutional bloc.[22] The Court has cited international norms in

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https://publications.iadb.org/bitstream/handle/11319/6024/Technical%20Note%20585-%20Health%20System%20Fragmentation.pdf [https://perma.cc/RR9K-884G] (exploring the fragmentation of Latin American health systems across six countries, Brazil, Chile, Colombia, Costa Rica, Ecuador, and Mexico; however commenting on Juan-Luis Londono and Julio Frenk's framework for understanding Latin American health systems which describes Argentina's as an "atomize private model").

19 Art. 14, Constitución Nacional [CONST. NAC.] [NATIONAL CONSTITUTION] (Arg.).

20 *See* Paola Bergallo, *Argentina: Courts and the Right to Health: Achieving Fairness Despite "Routinization" in Individual Coverage Cases?, in* LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH?, 43–75 (Alicia Ely. Yamin & Siri Gloppen eds., 2011) [hereinafter Bergallo LHR] (noting how the 1994 amendments introduced new institutions for the protection of social rights with specific implications for the right to health, and how the right to health was further defined by references to human rights treaties which were included in Article 75.22).

21 *Id.*

22 Corte Suprema de Justicia de la Nación [CSJM] [National Supreme Court of Justice] 24/10/2000, Ana Carina Campodónico de Beviacqua c. Ministerio de Salud y Acción Social – Secreteria de Programas de Salud y Banco de Drogas

support of protecting against unilateral termination of health services by different health insurers, including private ones,[23] in enforcing obligations to guarantee access to treatment,[24] and holding that the federal government is a subsidiary guarantor in various cases against provincial public contributory insurers.[25] The Court has also addressed the protection of the right to health in relation to vulnerable groups, such as children,[26] persons with disabilities,[27] people with severe diseases,[28] and socially marginalized communities.[29]

Paola Bergallo argues that courts' increased involvement in health in particular can be attributed not just to legal developments, but also the failures of political organs of government to respond to regulatory and oversight failure in the fragmented health sector. Bergallo explains the *amparo* cases clustering around demands for certain treatments or services.[30] As a result of regulatory failure, these clusters have emerged around disputes over coverage for a particular illness or a particular group of patients, as well as around particular insurer defendants.[31]

Neoplásicas, (Arg.), https://sj.csjn.gov.ar/sj/tomosFallos.do?method=iniciar [https://perma.cc/7KF6-32SU] [hereinafter Campodónico CSJN].

[23] *Id.*

[24] Corte Suprema de Justicia de la Nación [CSJM] [National Supreme Court of Justice], 1/6/2000, Asociación Benghalensis y Otros c. Ministerio de Salud y Acción Social – Estado Nacional, A. 186 (Arg.).

[25] Corte Suprema de Justicia de la Nación [CSJM] [National Supreme Court of Justice], 21/8/2003, Neira, Luis Manuel y Otra c. Swiss Medical Group S.A., (Arg.); Corte Suprema de Justicia de la Nación [CSJM] [National Supreme Court of Justice], 8/6/2004, Martín, Sergio Gustavo y Otros c. Fuerza Aérea (Arg.).

[26] Campodónico CSJN, *supra* note 22.

[27] Corte Suprema de Justicia de la Nación [CSJM] [National Supreme Court of Justice], 1/10/2001, Monteserín, Marcelino c. Estado Nacional – Ministerio de Salud y Acción Social – Comisión Nacional Asesora para la Integración de Personas Discapacitadas – Servicio Nacional de Rehabilitación y Promoción de la Persona con Discapacidad, (Arg.).

[28] Corte Suprema de Justicia de la Nación [CSJM] [National Supreme Court of Justice], Dec. 18, 2004, Asociación de Esclerosis Múltiple de Salta c. Ministerio de Salud – Estado Nacional (Arg.), Corte Suprema de Justicia de la Nación [CSJM] [National Supreme Court of Justice], 28/8/2007, Cambiaso Péres de Nealón, Celia María Ana y Otros c. Centro de Educación Médica e Investigaciones Médicas (Arg.).

[29] Corte Suprema de Justicia de la Nación [CSJM] [National Supreme Court of Justice], 18/9/2007, Defensor del Pueblo de la Nación c. Estado Nacional y Otra (Provincia del Chaco) s. proceso de conocimiento (Arg.).

[30] Bergallo LHR *supra* note 20, at 60.

[31] *Id.*

At the same time, other authors point to significant structural precedents going beyond medical treatment and to precedents that have utilized dialogical remedies. In the early case of *Viceconte,*[32] public interest litigation sought to require the state to provide a vaccine against the Argentine hemorrhagic fever that threatened the lives of 3.5 million people, most of whom did not have access to preventive medical services.[33] The Federal Administrative Court of Appeals ultimately ordered the government to designate funds for completing the vaccination campaign and ensuring the production of the vaccine, put a follow-up framework in place to oversee compliance with its ruling, and established a deadline for the state to meet the requirements.[34]

In a case involving the cleanup of the highly polluted Matanza-Riachuelo River Basin,[35] the Argentine Supreme Court issued a dialogical decision that established benchmarks and a timeline for cleanup of the river basin, but left significant discretion to the various agencies involved. The court also created a compliance authority to manage all the activities triggered by a decision, giving both civil society organizations and ordinary residents of the affected area a voice and a place to be heard.[36] Nevertheless, after ten years, implementation has been less than satisfactory.[37]

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[32] Cámara Nacional de Apelaciones en lo Contencioso Administrativo Federal, Sala IV (CNFed.) [National Court of Appeals in Federal and Administrative Litigation of the Federal Capital: Court of Appeals in Administrative Matters], 2/6/1998, Viceconte, Mariela C. c. Ministerio de Salud y Acción Social La Ley [L.L.] (1998-F-305) (Arg.)

[33] *Id.*

[34] *Id.*

[35] Corte Suprema de Justicia de la Nación [CSJM] [National Supreme Court of Justice], 8/7/2008, Mendoza Beatriz Silvia y Otros c. Estado Nacional y Otros s. Daños y Perjuicios, (Arg.).

[36] *See generally* Daniel M. Brinks, Varun Gauri & Kyle Shen, *Social Rights Constitutionalism: Negotiating the Tension Between the Universal and the Particular*, 11 Ann. Rev. of L. and Soc. Sci. 289, 289–308 (2015), https://www.annualreviews.org/doi/10.1146/annurev-lawsocsci-110413-030654 (discussing court monitoring/compliance efforts work to the extent that they create new spaces for political mobilization).

[37] See Roberto Gargarella, Deliberative Democracy, Dialogic Justice and the Promise of Social and Economic Rights, in SOCIAL AND ECONOMIC RIGHTS IN THEORY AND PRACTICE 105, 115 (Helena Alivar Garcia, Karl Klare & Lucy A. Williams eds., 2016) (noting a mismatch in progressive social right protections and their implementation due to an outdated and inefficient constitutional structure

Indeed, the court has recently called attention to a number of deficiencies that continue to hinder implementation efforts during a public hearing, including the failure of multijurisdictional agency, ACUMAR (Authority of the Matanza-Riachuelo River Basin) to integrate human rights and environmental protection concerns sufficiently in its work.[38]

2.2. Brazil

Brazil is a Federal Republic that stands out in the region both for the scope and specificity of the right to health in its 1988 post-dictatorship Constitution, as well as for the Unified Health System (SUS, for its acronym in Portuguese) created under that constitution. The country's deep health inequities increased under the dictatorship. For example, while children in the lowest wealth quintile were 4.9 times more likely to be stunted than those from families in the highest wealth quintile in 1974-75, this ratio increased to 7.7 by the late 1980's.[39] The creation of the SUS, including innovative mechanisms for citizen participation[40], was an integral part of the struggle for democratization in Brazil.[41] In contrast to Argentina, however, despite the incorporation of international human rights norms into national law through the constitution, relevant treaties have not been cited to extend the contours of the right to health.

Health was recognized as a fundamental right in the Constitution of 1988, under Title II. Article 6 states: "education, health, work, housing, leisure, security, social security, protection

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and divisions between the branches of government) [hereafter Gargarella Deliberative Democracy].

[38] Corte Suprema de Justicia de la Nación [CSJM] [National Supreme Court of Justice], 27/12/2016, "*Mendoza Beatriz Silvia y otros c. Estadio Nacional y otros s/ daños y perjuicios*, Fallos (2016-339-1795) (Arg).

[39] Cesar G. Victoria et al., *Maternal and Child Health in Brazil: Progress and Challenges*, 377 THE LANCET 1863, 1869–76 (2011) (discussing how Brazil has undergone rapid changes in major social determinants of health and in the organization of health services).

[40] Armando De Negri Filho, *Brazil: A Long Journey towards a Universal Healthcare System*, *in* ADVANCING THE HUMAN RIGHT TO HEALTH 173–80 (2013).

[41] Anne-Emmanuelle Birn & Laura Nervi, *Political Roots of the Struggle for Health Justice in Latin America*, 385 THE LANCET 1174, 1174–5 (2015) (discussing how Brazil's health reform, is directly linked to the re-democratization movement).

of motherhood and childhood, and assistance to the destitute, are social rights under this Constitution." The right to health must be interpreted in light of Articles 196 to 200, which inter alia, state clearly that health is to be guaranteed *"by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery . . . ."* [42] Thus, the right to health is defined broadly, beyond medical care to include actions and policies involving "social and economic policies" in general (Article 196), as well as public health measures such as "preventative activities" (Article 198), "sanitary and epidemiological actions," "health of workers," and "preservation of the environment" (Article 200).

A small fraction of the litigation relating to health in Brazil does relate to pre-conditions of health, such as sanitation.[43] While sanitation is a compulsory public service in Brazil, the constitution does not establish a specific right to such services. Instead, Brazil's courts have referred to a right to sanitation services as a social and economic right, tying it to the Brazilian constitution's health rights (Articles 6 and 196), environmental rights (Article 225) and, in some cases, housing rights (Article 6).[44] However, while there is evidence that the courts have favored public health policies granting sanitation services and that their decisions have fostered greater political priority on sanitation, these decisions addressed only a small part of the country's need for sanitation services.[45]

Health rights litigation in Brazil, as elsewhere in the region, has concentrated overwhelmingly on individual access to medical care and, in particular, medications. Indeed, the great preponderance of the tens of thousands of health rights claims have involved the use of provisional protection measures to provide access to

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[42] Art. 196 CONSTITUIÇÃO FEDERAL [C.F.] [Constitution] (Braz.).

[43] Ana P. de Barcellos, *Sanitation Rights, Public Law Litigation, and Inequality: A Case Study from Brazil*, 16(2) H. AND HUM. R. J. 35, 37–38 (2014) (discussing how litigation has addressed fewer than 177 out of the 2,495 Brazilian municipalities that lack both sewage collection and treatment systems, and lawsuits are concentrated in the richer cities, not in the poorest ones).

[44] *Id.* at 37.

[45] *Id.* at 42.

individual entitlements.[46] And nowhere are the equity impacts of judicial enforcement of health rights more contested than in Brazil. Octavio Motta Ferraz has written that judicialization has favored the middle class and expensive medications, and has undermined notions of formal equality in the Brazilian constitution by fostering queue jumping.[47] Joseph Amon and Joao Biehl have contested critiques of judicialization as largely "myths" and have argued that findings of benefits going to the middle class should simply spur greater efforts at equal access to justice rather than restrictions on judicial enforcement.[48] Mariana Mota Prado notes that the debates over equitable impact of the granting of entitlements obscures another important aspect of judicial enforcement, which is greater accountability and oversight in the complex Brazilian health system.[49] Although Brazil has a unified health system, the differentiated responsibilities of the federal, state, and municipal governments, as well as increasing privatization and failure to establish parameters for *convênios* with the private sector, undermine both equity and accountability.[50]

The politicized nature of judicialization of health rights has led the judiciary and legislature to take certain measures recently. In 2011, Federal Act 12401 was passed calling for treatment to be provided according to health system protocols and establishing a new National Council for the Incorporation of Technologies (CONITEC, by its acronym in Portuguese).

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[46] Octavio L.M. Ferraz, *The Right to Health in the Courts of Brazil: Worsening Health Inequities?*, 11 H. AND HUM. R. J. 33–45 (2013) (discussing how the majority right-to-health cases in Brazil to date have been filed by individual claimants and have concerned the provision of curative medical treatment) [hereinafter Ferraz HHRJ].

[47] Octavio L.M. Ferraz et al., *Judging the Price of Life: Cost Considerations in Right to Health Litigation*, *in* JURIDIFICATION AND SOCIAL CITIZENSHIP IN THE WELFARE STATE, 121–45 (2014).

[48] João Biehl, Mariana P. Socal & Joseph J. Amon, *The Judicialization of Health and the Quest for State Accountability: Evidence from 1,262 Lawsuits for Access to Medicines in Southern Brazil*, 18(1) H. AND HUM. R. J. 209–20 (2016) (discussing how judicialization may serve as a grassroots instrument for the poor to hold the state accountable).

[49] Mariana Mota Prado, *The Debatable Role of Courts in Brazil's Health Care System: Does Litigation Harm or Help?* 41(1) THE J. OF L. MED. & ET. 124–37 (2013) (discussing about the right to health litigation in Brazil which could be generating policy and institutional changes within the health care system).

[50] Maria I. BRAVO, ET AL., A MERCANTILIZAÇÃO DA SAÚDE EM DEBATE: AS ORGANIZAÇÃO SOCIAIS NO RIO DE JANEIRO. (UERJ: Cadernos de Saúde Pública 2015).

In 2014, the Superior Court of Justice, denied an ordinary appeal based on the fact that "registration with ANVISA is a necessary condition to benefit from the product, being the first requirement for the SUS to consider its incorporation" and therefore, "in general, the treatment provided by the SUS should be privileged rather than a different option chosen by the patient, whenever the ineffectiveness or impropriety of the existing health policy is not proven."[51] The Supreme Federal Tribunal had been seeking to unify two judgments, one involving a treatment that has not yet been registered by the Brazilian Sanitary Authority (ANVISA, for its acronym in Portuguese) and one involving a high cost treatment not yet incorporated by the Public Health System.[52] The judgment, which was temporarily suspended by a justice who later died in a plane crash, would unify standards for granting health entitlements that are not approved by the relevant executive branch authorities. Nevertheless, on April 26, 2017, the Superior Court of Justice (below the Supreme Federal Tribunal) ordered the suspension of proceedings in cases where the medicine was not incorporated in the SUS.[53]

2.3. Colombia

Colombia's Constitution, adopted in 1991, enshrines principles of transformative constitutionalism, including a "social state of law."[54] However, Article 49 of the constitution defined health care, as well as social security, not as a right but as a public service, to be regulated, controlled and overseen by the state, yet open to the participation of private capital.[55] Since the adoption of the

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[51] Superior Tribunal de Justiça [STJ] [Superior Justice Tribunal] Apr. 23, 2015, Recurso em Mandado de Segurança, RO 2014/0130056-0, No. 45.703 (Braz.).

[52] Supremo Tribunal Federal [STF] [Supreme Federal Court] May 13, 2010, Recurso Extraordinário, RE 566471, No. 86/2010 (Braz.); Supremo Tribunal Federal [STF] [Supreme Federal Court] Nov. 17, 2011, Recurso Extraordinário RG 657718 MG (Braz.).

[53] Superior Tribunal de Justiça [STJ] [Superior Justice Tribunal] Recurso Especial, RJ 2017/0025629-7, No. 1657156 (Braz.).

[54] *See* Yamin T-760/08, *supra* note 13, at ¶ 6 (describing the basis and principles upon which Colombia's Constitution of 1991 was founded upon).

[55] Art. 49 CONSTITUCIÓN POLÍTICA DE COLOMBIA [C.P.] [Political Constitution of Colombia] July 4, 1991; *see also* Everaldo Lamprea, *Colombia's Right-to-Health*

constitution, Colombia's newly-created Constitutional Court has actively shaped enforcement of the right to health and health policy through a more engaged and less formalistic adjudication.[56]

In 1993, the enactment of Law 100 initiated a major reform of Colombia's health system, introducing a two-tiered system of benefits, based upon an obligatory social insurance scheme tied to managed care: a contributory regime for those in the formal sector (POS-C) and a subsidized regime (POS-S), which contained approximately half the benefits.[57] Law 100 greatly increased formal coverage.[58] However, regulatory failure and fragmentation between its main oversight bodies plagued Colombia's health system, making it difficult for the state to oversee the wide array of private and public actors involved in operationalizing the complex new system. [59]

The evolution of judicial interpretation and enforcement of the right to health in Colombia can be divided into four periods: 1) a first phase characterized by generous court judgments related to the right to health; 2) a second phase during which the use of *tutelas* exploded; 3) the structural approach to the right to health in judgment T-760/2008;[60] and 4) subsequent developments, including the enactment of a new Statutory Framework Law on Health based on the state's obligations to respect, protect, and fulfill the right to health.

Litigation in a Context of Health Care Reform, in THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY 131 (Colleen M. Flood & Aeyal Gross eds., 2014) [hereinafter Lamprea 2014] (discussing the involvement of private insurance companies in Colombia's public health insurance system).

[56] *See* Manuel J. Cepeda, *Transcript: Social and Economic Rights and the Colombian Constitutional Court*, 89 TEX. L. REV. 1699, 1700–1705 (2011) (discussing the impact of the decision T-7606 of 2008 on the right to health).

[57] L. 100/93, diciembre 23, 1993, DIARIO OFICIAL [D.O.] (Colom.).

[58] *See* Lamprea 2015, *supra* note 6, at xii, 64 (detailing the massive increase in formal health insurance coverage of Colombian citizens following the passage of Ley 100 of 1993).

[59] Alicia E. Yamin, Oscar Parra-Vera & Camila Gianella, *Colombia: Judicial Protection of the Right to Health: An Elusive Promise?*, *in* LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH? 103, 110 (Alicia E. Yamin & Siri Gloppen eds., 2011) [hereafter Yamin Colombia LHR].

[60] César Rodríguez-Garavito, *The Judicialization of Health Care: Symptoms, Diagnosis, and Prescriptions, in* LAW AND DEVELOPMENT OF MIDDLE-INCOME COUNTRIES: AVOIDING THE MIDDLE-INCOME TRAP, 246–269 (Randall Peerenboom & Tom Ginsburg eds., 2014) [hereinafter Rodríguez-Garavito 2014] (describing the shift away from mass litigation towards structural reform following the T-760/08 decision to resolve issues surrounding the right to health).

The Constitutional Court's early rulings relied upon a doctrine of "fundamental rights by virtue of connection" (*doctrina de conexidad*) to hold that despite being a directive principle, the right to health could be claimed before courts when the lack of a good or service endangered the life of the claimant *or* the possibility to lead a dignified life, despite being a directive principle. The court also held the right to health, enforceable in cases involving a person or group of people in especially vulnerable circumstances, or a claim for health care defined in the POS.[61] It is important to note that the court issued opinions that went beyond individual entitlements, considering proposed budget cuts to the subsidized regime, eligibility requirements for establishing indigence, definitions of comprehensive care, and protections from interruption of coverage.[62]

However, by 2008, courts throughout the country had become an essential "escape valve" for individual Colombians who were denied access to medicines, surgeries, and treatments by a health system incapable of regulating itself.[63] The Human Rights Ombuds Office calculated that between 1999 and 2008 individuals presented 674,612 *tutelas* relating to health rights.[64] Both the Human Rights Ombuds Office and the non-governmental organization, DeJusticia, called for the court to step in and declare an "unconstitutional state of affairs."[65]

In 2008, a specialized review chamber of the Constitutional Court issued judgment T-760/08, which resolved twenty-two individual *tutelas* that represented systematic failures, and called for structural reforms in the health system. The orders, which largely reiterated and synthesized prior jurisprudence and were based upon existing legislative frameworks, included: updating the

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[61] Corte Constitucional [C.C.] [Constitutional Court], agosto 11, 1992, Sentencia T-484/92, Relatoría de la Corte Constitucional No. 2130 (Colom.).

[62] *See* Corte Constitucional [CC] [Constitutional Court], septiembre 6, 2000, Sentencia C-1165/00, Relatoría de la Corte Constitucional No. D-2873) (Colom.) (discussing how budget cuts in the POS-S constitute an impermissible retrogression, and the budget was subsequently revised.).

[63] Yamin T-760/08, *supra* note 13, at ¶ 22.

[64] Yamin Colombia LHR, *supra* note 59, at 113.

[65] PROCURADURÍA GENERAL DE LA NACIÓN & DEJUSTICIA, EL DERECHO A LA SALUD EN PERSPECTIVA DE DERECHOS HUMANOS Y EL SISTEMA DE INSPECCIÓN, VIGILANCIA Y CONTROL DEL ESTADO COLOMBIANO EN MATERIA DE QUEJAS EN SALUD 11 (2008).

bundles of health benefits and achieving universal coverage, progressively unifying the subsidized, and contributory insurance regimes to improve the health system's reimbursement procedures. The court also called for greater oversight of different insurance companies (EPS, for their acronym in Spanish) and administrative mechanisms aimed at resolving disputes.[66]

The decision adopted what Roberto Gargarella describes as a "dialogical understanding" of the system of checks and balances.[67] While the court set broad goals and implementation pathways, set deadlines and included the need for progress reports, it left substantive decisions and detailed outcomes to governmental agencies.[68] Based on the example of a previous case relating to Internally Displaced Persons (T 025/04), the court established a follow-up unit to gather information, monitor compliance with the decision's orders, and organize public hearings for issues relating to the orders.[69] In 2015, in the wake of T-760/08, Colombia's Congress passed the Statutory Framework Law (Law 1751), which places the right to health at the center of the health system.[70] Nevertheless, individual health rights litigation in Colombia remains intense.[71]

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[66] *See* Corte Constitucional [C.C.] [Constitutional Court], julio 31, 2008, Sentencia T-760/08, Relatoría de la Corte Constitucional (Colom.) (reasserting the right to health and detailing types of regulation necessary to maintain this right). *See also* Yamin T-760/08, *supra* note 13, at ¶23–6, 45 (describing the Constitutional Court's ruling that the executive and legislative branches reform the health industry and the steps taken by the Santos administration following this ruling to provide further oversight).

[67] Gargarella Deliberative Democracy, supra note 37, at 105.

[68] *See* Charles F. Sabel & William H. Simon, *Destabilization Rights: How Public Law Litigation Succeeds*, 117, HARV. L. R. 1030, 1016–1100 (2004) (discussing the transformation of the government's function from provider to guarantor of care).

[69] *See* Lamprea 2015, *supra* note 6, at 88 (describing the special three magistrate chamber process similar to the one used in T 025/04 assigned to provide oversight).

[70] L. 1751/15, febrero 16, 2015, DIARIO OFICIAL [D.O.] (Colom.).

[71] *See* Defensoría del Pueblo de Colombia, *Sigue Creciendo el Número de Tutelas en Salud,* DEFENSORÍA DEL PUEBLO COLOMBIA (Apr. 7, 2015), http://www.defensoria.gov.co/es/nube/noticias/3414/Sigue-creciendo-el-n%C3%BAmero-de-tutelas-en-salud-Tutelas-salud-D%C3%ADa-Mundial-de-la-salud-justicia-Plan-Obligatorio-de-Salud-Fallos-de-tutela-Derechos-Humanos-EPS.htm) [https://perma.cc/5B2C-D6XC] (detailing a report by the Ombudsman's Office regarding an increase in health-related legal action between 2013 and 2014).

2.4. Costa Rica

Compared with other countries in the region, Costa Rica's health statistics reflect fewer disparities. Yet, by comparison with international standards, the country still has a high degree of income inequality (GINI 50.69 in 2015),[72] which translates into differential health outcomes and health gaps. There are major challenges in terms of skilled health professional's density, which is why efforts should be made to increase the expenditure on health research and development, considering it is one of the lowest in the world.[73] Costa Rica's health system is composed of a public and a private sector. The public sector is mainly based on a social insurance scheme provided through the *Caja Costarricense de Seguro Social* (CCSS), an autonomous institution in charge of financing, purchasing, and delivering health services. For its part, the private sector includes ambulatory and hospital care services, which are financed mostly out-of-pocket or with insurance premiums.[74]

The constitution, which dates from 1949, contains an extensive list of civil and political rights, but not social rights.[75] The right to health is a derived right, constructed from the right to life (Article 21) and the right to social security (Article 73).[76]

Judicial enforcement of health rights was enabled by a 1989 constitutional amendment that added a seven-member constitutional chamber to the existing three chambers of the Costa Rican Supreme Court (Sala IV) and amended Article 48 to include a

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[72] Inter-American Development Bank, *supra* note 1 (indicating the per capita household income for Latin American countries).

[73] World Health Organization [WHO], *World Health Statistics 2016*: *Monitoring Health for the SDGs, Sustainable Development Goals* 79 (2016) http://www.who.int/gho/publications/world_health_statistics/2016/en/ [https://perma.cc/6JAG-QX6K].

[74] *See* María del Rocío Sáenz et al., *The Health System of Costa Rica,* 53 SALUD PÚBLICA DE MEX., 5156, 5156–7 (2011) (discussing how the private sector includes a broad set of services offering ambulatory and hospital care).

[75] *See generally* Constitución Política de Costa Rica [C.P.C.R.] Nov. 7, 1949.

[76] *See* Bruce M. Wilson, *Costa Rica: Health Rights Litigation: Causes and Consequences*, *in* LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH? 132, 142 (Alicia Ely Yamin & Sirir Gloppen eds., 2011) [hereinafter Wilson LHR] (explaining that the 1949 Costa Rican Constitution lacks an explicit right to health).

constitutional bloc, giving international human rights treaties the same force as constitutional law, along with Articles 10, 105 and 128.[77]

Bruce Wilson argues that unlike the prior supreme court, the Sala IV used its centralized judicial review powers to abandon the legal formalism of the earlier court, and to assertively enforce individual rights, including health-related rights, through its interpretation of the right to life.[78] The enabling law that accompanied the creation of the Sala IV (*Ley de la Jurisdicción Constitucional),* not only mandated the court to guarantee the supremacy of the norms and constitutional principles, international law, and communal law in force, as well as their uniform interpretation and application, it also removed virtually all barriers to accessing the court.[79]

The role of the Sala IV in expanding and enhancing the understanding of health rights has been significant. Through its rulings it has imposed and delineated the Caja's way towards the full enjoyment of health rights. For instance, the Sala IV has regularly ruled in favor of transplant patients, antiretroviral coverage for HIV/AIDS patients and keeping clinics open that the Caja wanted to close. Indeed, the ability of marginalized individuals and organizationally weak groups in Costa Rica, including LGBT groups, to seek protection and enforcement of their constitutional rights made this judicial avenue particularly attractive. As Wilson writes:

> [O]nce the court had constructed a fundamental right to health—and once it became clear that the Caja Costarricense routinely complied with the court's rulings—the legal opportunity structure became increasingly obvious . . . . While the average success rate for *amparo* cases is approximately 25%, the success rate in recent years for health rights *amparo* claims against the Caja is over 60%.[80]

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[77] *Id.*

[78] *Id.*

[79] *Id.* at 138 (suggesting that the judicial resolution to disputes involving rights violations increased the court's caseload).

[80] *Id.* at 140–1.

2.5. Mexico

From the time of the Mexican Revolution, health has been addressed in relation to agrarian reform, the establishment of social security and labor protections, and ambiguous efforts concerning the status of indigenous groups. The health system was historically based upon segmented schemes for those employed in formal and informal sectors, with a few special regimes, e.g. for the military. In 2003, the program *Seguro Popular* at least formally created universal social protection and health coverage. The architect of the *Seguro Popular* and Minister of Health at the time, Julio Frenk, stated:

> The shift in power [in the election of President Vicente Fox from the opposition, PAN] that took place in 2000 was an indication that Mexico had made major progress in the exercise of civil and political rights. The following step was to reduce inequalities by creating the conditions for the universal and effective exercise of social rights, including the right to health care.[81]

Nonetheless, inequalities and segmentation persist in Mexico's health system and reflect those of the overall society.[82]

The Mexican Constitution of 1917 is often considered as a font of social constitutionalism in the region, as well as the inspiration for many of the economic and social rights provisions in the Universal Declaration of Human Rights.[83] It was the first

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[81] *See* Julio Frenk & Octavio Gómez-Dantés, *Ethical and Human Rights Foundations of Health Policy: Lessons from Comprehensive Reform in Mexico*, 17(2) H. AND HUM. RTS. J. 31, 33–37 (2015) (discussing the "democratization of health").

[82] Inter-American Development Bank, *supra* note 1; *see also* WHO, *Global Health Observatory: México: Country Profiles*, (2011), http://www.who.int/gho/countries/mex/country_profiles/en/ [https://perma.cc/RN9A-ZRPL].

[83] *See* Roberto Gargarella, *Latin American Constitutionalism: Social Rights and the "Engine Room" of the Constitution,* 4, NOTRE DAME J. OF INT'L & COMP. L. 9, 12–18, (2014) (describing the engine room which consists of the power-granting provisions of the constitution that determine the relative authority of governmental actors).

constitution in the world to include justiciable social rights, including health and a healthy environment (Article 4).[84]

The Constitution established that: "Every person has the right to health protection. The law shall determine the bases and terms to access health services and shall establish the competence of the Federation and the Local Governments in regard to sanitation."[85] It also explicitly protects the right to health for children and indigenous people. In the 1980's, through legislation creating the social security institute, Article 4 came to be understood as an individual right.

Articles 103 and 107 of the constitution establish writs of *amparo* as a means of seeking protection of constitutional rights.[86] *Amparo* extends, but is not limited, to the first 29 Articles of the Mexican Constitution, which include the right to health. It also extends to human rights enshrined in international treaties, through a constitutional bloc incorporated via the 2011 amendment to the constitution. However, Article 1 stipulates that these treaties are incorporated *to the extent they do not contradict the Mexican Constitution*.[87] The 2011 amendment also expanded standing to bring an *amparo* to any party with a legitimate interest ("*interés legítimo v interés jurídico*"), whether individual or collective.[88]

These recent structural reforms in the Constitution, following a significant reform of the judiciary in 1994, were instrumental in enabling what Justice Gutierrez Ortiz Mena has described as "a new attitude" on the Mexican Supreme Court (and in turn other courts), which construed the constitution as enforceable law, as opposed to a political text. The Radilla Pacheco case, an enforced disappearance case in which the Inter-American Court of Human Rights declared the national government of México responsible for sub-national failures, also came to be an inflection point in regard

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[84] *See* Constitución Política de los Estados Unidos Mexicanos [CPEUM], Arts. 3, 4, 5 and 123, feb. 2, 1917.

[85] *Id.* at art. 4 (4).

[86] *Id.* at arts. 103 and 107.

[87] *Id.* at art. 1.

[88] *Id.*, at art. 107(I) (mandating that the constitutional adjudication (appeal on the grounds of unconstitutionality) shall be carried out at the request of the offended party. The offended party is the holder of an individual or collective right, which has been violated by the challenged act, affecting his/her legal framework, either directly or by the means of his/her special situation before the legal system.).

to the incorporation of federal constitutional principles to states and the supremacy of national laws.[89]

In recent years, the court has decided cases relating to regulation of products affecting health,[90] decriminalization of abortion,[91] and access to entitlements. For example, in 2014, the court considered two important cases. In the *Pabellón 13* case, the court granted an *amparo* in favor of three HIV/AIDS patients and concluded that the failure to execute the project for the construction of a specialized ward for HIV/AIDS was a violation of the right to health.[92] Second, the court considered a lawsuit brought by seventeen patients that would have required the Mexican social security system, IMSS, to cover Soliris for a condition that some 250 patients have, at a cost of nearly $140 million every year.[93] The court did not rule that that the health system must pay for Soliris, noting that the drug had not yet gone through review by a commission that is charged with including or excluding drugs from the basic catalog of drugs.[94] Arguably, the Mexican Supreme Court deferred to a commission that does not meet the requirements of a fair process, because it lacks adequate transparency and does not include a range of stakeholders in its deliberation.[95] To date, unlike Colombia for example, the Mexican

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89 *See* Case of Radilla-Pacheco v. Mexico, Inter-Am. Ct. H.R. (ser. C.) No. 209 (Nov. 23, 2009).

90 Amparo en revisión, quejosos y recurrentes 237/2014. Pleno de la Suprema Corte de Justicia de la Nación de México [CSJN], Semanario Judicial de la Federación del viernes 11 de julio de 2014 (Mex.); Amparo en Revisión 350/2014, Pleno de la Suprema Corte de Justicia de la Nación de México [CSJN], Semanario Judicial de la Federación de septiembre 17, 2014 (Mex.).

91 Acciones de inconstitucionalidad 146/2007 and 147/2007. Pleno de la Suprema Corte de Justicia de la Nación de México [CSJN], Semanario Judicial de la Federación y su Gaceta, agosto 28, 2008 (Mex.).

92 Amparo en Revisión 378/2014, Pleno de la Suprema Corte de Justicia de la Nación de México [CSJN] Semanario Judicial de la Federación y su Gaceta, noviembre 14, 2014. (Mex.).

93 Amparo en Revisión 350/2014, Pleno de la Suprema Corte de Justicia de la Nación de México [CSJN], Semanario Judicial de la Federación de septiembre 17, 2014 (Mex.).

94 *Id.*

95 *See* Norman Daniels et al., *Role of the Courts in the Progressive Realization of the Right to Health: Between the Threat and the Promise of Judicialization in Mexico*, 1 HEALTH SYS. & REFORM 229, 232 (2015) (discussing the commission that was charged with including or excluding drugs from a basic catalog of drugs).

Supreme Court has not asked the Executive for rationale or reasoning underpinning legislation and regulations in relation to health. In a 2015 lecture at Harvard, Justice Gutierrez Ortiz Mena argued that as a counter-majoritarian institution, the court may "jump-start" the political process, but it must not substitute for it.[96]

3. JUDICIALIZATION OF HEALTH RIGHTS: FROM INDIVIDUAL ACTIONS TO DIALOGICAL REMEDIES

Since the introduction of these new constitutions and amendments, the region has seen an unparalleled explosion of health rights litigation. The volume of litigation has been greatest in Colombia, with 1,323,292 *tutelas* related to health filed between 1999 and 2014, according to the Human Rights Ombuds office.[97] Notably, the number of *tutelas* filed each year increased from approximately 20,000 in 1999 to over 118,000 in 2014.[98] In Brazil, there are an estimated 800,000 accumulated cases still pending from 2014 to 2017 at all levels (federal, state, and municipal) in courts across the country, and an estimated average of 200,000 new cases a year in each of the past four years.[99]

In Costa Rica, approximately 19,000 health-related cases were filed before the Sala IV between 1989 and 2009. While few health cases were filed initially during that timeframe, health-related cases rose at a much faster rate than the court's total caseload after 1999.[100] In Argentina, the lack of systematic record-keeping makes it difficult to continuously tally cases. However, a study done by Bergallo found 6,528 right to health claims filed between 1998 and

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[96] Justice Alfredo Gutierrez Ortiz Mena, *The Role of the Mexican Supreme Court in Mexico's Democracy*, lecture at David Rockefeller Center for Latin American Studies, Harvard University, (Dec. 4, 2015), (transcript available at https://drclas.harvard.edu/event/mexican-supreme-court) [https://perma.cc/GY6Z-2DES].

[97] DEFENSORÍA DEL PUEBLO OF COLOMBIA, LA TUTELA Y LOS DERECHOS A LA SALUD Y A LA SEGURIDAD SOCIAL 86 (Def. del Pueblo, 2015) [hereinafter Defensoría Colombia Tutela Salud].

[98] *Id.*

[99] OCTAVIO LUIZ MOTTA FERRAZ, HEALTH AS A HUMAN RIGHT (forthcoming 2019)(manuscript at 8–10, on file with author).

[100] Wilson LHR, *supra* note 76, at 140.

2007, with the number per year tripling during that time (449 cases in 1998; 1,159 cases in 2007).[101][101]

A number of factors underlie the volume of health rights litigation, which stem from the health system as well as political and legal systems. The health systems, although differing in their institutional arrangements, are characterized by ineffective oversight and regulation, and inadequate administrative dispute resolution mechanisms. For example, in Colombia and Argentina, "quality-skimping"—i.e., where benefits included in the POS or PMO, respectively, are routinely denied—accounts for the majority of lawsuits. Incentives created for providers and insurance companies, through a combination of inadequate pharmaceutical regulations and reimbursement procedures, also contribute both to the medications and services claimed, as well as compliance rates.[102] These are more accurately understood as market failure and regulatory gap problems, and not "judicial activism."[103]

Further, administrative mechanisms for resolving disputes are often cumbersome or perceived as captured by insurance companies or governmental corruption. For example, in Mexico, while the percentage of complaints related to discontent with health services received by CONAMED (National Commission of Medical Arbitration) has been relatively low, around 2%, public human rights bodies are receiving approximately 3,000 right to health protection complaints each year.[104] According to the UN High Commissioner's Mexico Office, because direct tools for demanding the right to health do not exist, individuals are instead

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101 *See* Bergallo LHR, *supra* note 20, at 52–53 (presenting figures depicting the graphs on health *amparos* filed before the Federal Civil and Commercial Courts of the City of Buenos Aires).

102 *See generally* Rodrigo Uprimny & Juanita Duran, *Equidad y Protección Judicial del Derecho a la Salud en Colombia*, Series Políticas Sociales 197, ECON. COMMISSION FOR LATIN AMERICA AND THE CARIBBEAN [ECLAC] 1–68 (2014), [hereinafter Uprimny Duran] https://repositorio.cepal.org/bitstream/handle/11362/36758/S2014181_es.pdf?sequence=1&isAllowed=y [https://perma.cc/K33Y-RRBA].

103 *See* Yamin Reflections LHR, *supra* note 5, at 355–357 (explaining the other dimensions of equity in the healthcare priority setting).

104 *See generally* Comisión Nacional de los Derechos Humanos, *Indicadores sobre el a la Salud en México*, UN High Commissioner of Human Rights [UNHCHR] 5–204 (2011), http://www.hchr.org.mx/images/doc_pub/indicadores_salud.pdf [https://perma.cc/64QY-CRWS].

turning to the *amparo* mechanism for the realization of this right.[105] Similarly, the Scientific-Technical Committees which were created in Colombia through Law 1428 to resolve claims for services outside the obligatory insurance scheme were widely perceived as rubber-stamping insurance company decisions and had little impact on the use of *tutelas*.[106]

Additionally, the combination of chronic political failure and extremely easy access to courts to resolve health claims (through protection writ mechanisms) has fostered an explosion in judicialization. Legislatures are often perceived as transactional rather than representative, and there is high distrust of executive branches that are perceived as corrupt, ineffectual and politicized.[107] It is worth pointing out for example that in Colombia the most litigated right is the "derecho a la petición" (right of petition) which is invoked when a bureaucrat fails to carry out his or her functions.[108] On the other hand, extremely low financial, legal, and procedural barriers make pursuing health rights claims through the courts an appealing option. In all of the countries discussed above, access to the courts is very easy, and people are guaranteed a decision within days.[109]

Judicialization of health rights should not necessarily be celebrated. The exploitation of "rights" for individual entitlements has the potential to exacerbate, rather than mitigate, underlying inequities associated with access to health services and treatments. More troubling than possible outliers, such as a 1997 Brazilian case involving treatment in the United States for Duschenne's muscular dystrophy, is evidence that courts may be systematically exacerbating inequities.[110] In Colombia, a study by Uprimny and

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105 *Id.* at 55.

106 Mauricio Torres-Tovar, *Resistencias y Luchas Sociales en Latinoamérica por la Garantía del Derecho a la Salud. El Caso Colombiano*, *in* POR EL DERECHO UNIVERSAL A LA SALUD: UNA AGENDA LATINOAMERICANA DE ANÁLISIS Y LUCHA 99–120 (Carolina T. Henrion & Asa C. Laurell eds., 2015) [hereinafter Torres-Tovar].

107 VICTOR ABRAMOVICH & CHRISTIAN COURTIS, LOS DERECHOS SOCIALES COMO DERECHOS EXIGIBLES (Trotta ed., 2004). *See also,* ROBERTO GARGARELLA & JUAN F. GONZALEZ-BERTOMEU, THE LATIN AMERICAN CASEBOOK: COURTS, CONSTITUTIONS, AND RIGHTS (Routledge ed., 2016).

108 Defensoría Colombia Tutela Salud, *supra* note 97, at 73.

109 Siri Gloppen, *Litigating Health Rights: Framing the Analysis*, *in* LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH? 20 (Alicia E. Yamin & Siri Gloppen eds., 2011).

110 Ferraz HHRJ, *supra* note 46.

Duran found that 35.2% of *tutelas* have been brought by 53.11% of those affiliated with the subsidized regime (containing half the benefits) and 35.8% of *tutelas* brought by 46.89% of those affiliated with the contributory regime in 2012.[111] Further, substantive equality in health is not just a matter of socio-economic inequality; it is also a matter of life chances determined by the severity of illness or condition. In a study based on random sampling of cases decided by the Sala IV in Costa Rica, Norheim and Wilson found that 3% of awarded treatments and services to be "high priority" in accordance with generally accepted criteria of priority-setting, including the "worst off" in terms of severity of illness, while over 70% would have been low priority.[112] While the weightings of criteria may vary, the conclusions are troubling in that they suggest a distortion of budgetary priorities by the Caja.

Further, the reduction of health rights to individual claims may skew policies and programs toward the subjects of litigation, and therefore, away from public health measures that have the potential to benefit the poor to a greater extent. It also may reduce robust egalitarian aspirations of health—and in turn social—justice to minimal packages of care.[113] High courts in the region have issued structural orders in health not only in response to a collective suit, but also in response to concerns about the inequity of individual concession of entitlements or the legitimate use of the judicial system, or sometimes both. Such remedies—whether in the case of T-760/08 in Colombia or the Matanza-Riachuelo case in Argentina—are appropriate for systematic violations,[114] where complex orders relating to institutions and processes are involved, rather than dictating specific outcomes. Through dialogical remedies, courts may be better able to not only preserve their own constitutional legitimacy in addressing complex policy questions,

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111 Uprimny Duran, *supra* note 102, at 33.

112 *See* Ole F. Norheim & Bruce M. Wilson, *Health Rights Litigation and Access to Medicines: Priority Classification of Successful Cases from Costa Rica's Constitutional Chamber of the Supreme Court* 16(2) HEALTH AND HUM. RTS. J. 47, 53 (2014) (discussing the results of health rights litigation for medications).

113 Yamin Reflections LHR, *supra* note 5; Yamin HRQ, *supra* note 7.

114 *See* Roberto Gargarella, *Dialogic Justice in the Enforcement of Social Rights: Some Initial Arguments*, *in* LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH? 232, 242–243 (2011) (providing examples of what judges could do in situations of massive, structural violations of rights).

but also catalyzing democratic participation and dialogue between branches of government regarding spending priorities and critical health policy questions.[115] No judgment relating to health rights has been more sweeping than T-760/08 in Colombia, which illustrates both the potential and challenges for dialogical justice in relation to health in the region.

3.1. The Potential and Challenges of Dialogical Remedies: T-760/08

The law that reformed Colombia's health system in 1993, Law 100, was a striking example not just of a wave of what Juan Arroyo has classified as "silent reforms" in health in the region, due to the lack of democratic discussion about them, but also of the dysfunction in the Colombian political and legislative arena.[116] Law 100 was defined and written by teams of technocrats and insulated from broad public debate. The final law was rushed through the legislature, passed shortly before Christmas—December 23, 1993—and implemented as quickly as possible through decrees, before a change of presidential administration would take place months later.[117]

The benefits package was put together without a comprehensive epidemiological analysis of the needs of the population, the burden of disease or the institutional capacities of the health system, and were not systematically costed to calculate the capitation rates. After 1993, the benefits package was amended in piecemeal fashion, largely in response to political pressures rather than empirical evidence. Further, the managed competition

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[115] Alicia E. Yamin, POWER, SUFFERING, AND THE STRUGGLE FOR DIGNITY: HUMAN RIGHTS FRAMEWORKS FOR HEALTH AND WHY THEY MATTER 142 (University of Pennsylvania Press ed., 2016) [hereinafter Yamin Power, Suffering, and the Struggle for Dignity].

[116] JUAN ARROYO, SALUD: LA REFORMA SILENCIOSA 9 (Universidad Peruana Cayetano Heredia ed., 2000), https://www.researchgate.net/publication/280930380_Salud_La_Reforma_Silenciosa_Lima_Universidad_Peruana_Cayetano_Heredia_enero_del_2000_213_pags [https://perma.cc/LV6Z-GXAC]. *See supra* note 106.

[117] *See* Alicia E. Yamin & Oscar Parra-Vera, *Judicial Protection of the Right to Health in Colombia: From Social Demands to Individual Claims to Public Debates*, 33 HASTINGS INT´L & COMP. L. REV. 431, 437 (2010) (discussing the process by which Law 100 was implemented by "change teams" who were cloaked from the public eye).

system adopted in Law 100 required a regulated market in which effective governmental agencies would guide the financing, organization, and service delivery in the health system to align with public interest.[118] But policies to improve the efficiency and equity of the health system were not implemented; regulations regarding eligibility and updating of services were neglected; complaints were not addressed in a systematic manner. In short, patients were left with no alternative but to use *tutela* writs.[119]

After Law 100 was enacted, there were brief periods of social mobilization around health from workers and certain user groups, but a strong social movement around health has not been sustained through the years.[120] This is partially due to the nature of the health sector, with its strongly organized financial actors and often poorly organized or fragmented groups of patients. It is also due to the particular nature of Colombia, plagued by armed conflict, and other forms of violence as well as political capture, where outside of large urban areas social mobilization around health was scant to non-existent.

Despite efforts by the Constitutional Court to unify jurisprudence and to emphasize policy criteria, two problems persisted: (1) the EPS were recalcitrant with respect to implementing the policies and interpretations of "integral care," "continuous care," etc. called for by the Court; and (2) lower courts that heard *tutela* cases throughout the country were not well-equipped to determine whether medications and other treatments outside the defined obligatory benefit plan should be provided as a matter of right.[121] In judgment T-760/08 the court moved from a case-by-case approach to a structural approach that focused on resolving the systematic failures underlying the avalanche of individual claims.[122]

In the judgment, the court explicitly asserted that a structural approach to the health system's failings was necessary because "the organs of government responsible for the regulation of the

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118 Lamprea 2014, *supra* note 55, at 132–134.

119 Rodríguez-Garavito 2014, *supra* note 60, at 256–257.

120 *Id.*, at 258–261.

121 Yamin Power, Suffering, and the Struggle for Dignity, *supra* note 115, at 123–125.

122 Rodríguez-Garavito 2014, *supra* note 60.

health system have not adopted decisions that guarantee the right to health without having to seek recourse through the *tutela*."[123] Notably absent in the expansive structural approach, however, is a gender perspective regarding the failures of the health system to respect and protect reproductive health, or the disproportionate burden on women of the two-tiered system given their dependence on male partners and predominantly work in the informal sector.[124]

Beyond resolving the twenty-two individual cases, the court addressed its diagnosis of the structure of the system, calling for remedies and reforms that included updating the bundles of health benefits, unifying the subsidized and contributory insurance regimes, improving the health system's financial arrangements, and achieving universal coverage.[125] The court further called for adequate information regarding the institutional performance of different insurance companies.[126] Additionally, the court asked the other branches of government to design administrative mechanisms to resolve disputes in order to reduce the amount of litigation, as well as the denial of both services and information by providers and insurers.[127]

As noted above, this judgment exemplifies Sabel and Simon's theory of "experimentalist regulation."[128] In the opinion, the court established broad goals and implementation pathways, set deadlines, and included the need for progress reports, but importantly left substantive decisions and detailed outcomes to governmental agencies.[129] This form of remedy not only arguably

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123 Colombia T-760/08, *supra* note 9.

124 *Id.*

125 *Id.*

126 *Id.*

127 Katherine G. Young & Julieta Lemaitre, *The Comparative Fortunes of the Right to Health: Two Tales of Justiciability in Colombia and South Africa,* 26 HARV. HUM. RTS., J. 180, 191–192 (2013) [hereinafter Young and Lemaitre].

128 Sabel & Simon, *supra* note 68, at 1019.

129 Ceasar Rodriguez-Garavito, *Beyond the Courtroom: The Impact of Judicial Activism on Socioeconomic Rights in Latin America*, 89 TEX. L. REV. 1669, 1677 (2011), http://www.corteidh.or.cr/tablas/r27171.pdf [https://perma.cc/WUG6-3LNL], *reprinted in* Alicia Ely Yamin & Fiona Lander, *Implementing a Circle of Accountability: A Proposed Framework for Judiciaries and Other Actors in Enforcing Health-Related Rights*, 14 J. OF HUM. RTS. 312, 324 (2015) ([the court] "set broad goals and clear implementation paths through deadlines and progress reports, while leaving substantive decisions and detailed outcomes to government agencies") [hereinafter Yamin and Lander].

preserves the democratic and institutional legitimacy of the judiciary better than command-and–control remedies, but also importantly avoids the possibility of serious judicial error in the interpretation of a specific aspect of the right to health.

Citing the government's failure to take steps toward a unification of the contributory and subsidized plans as mandated in Law 100, the court ordered the government to unify the POS-C and POS-S immediately for children and progressively, in keeping with available resources, for adults.[130] However, it did not propose what goods and services would be included in a unified POS for adults, or automatically equate unification with equalization; rather, it left that to the relevant government agencies but stipulated that the process of devising a unification plan was to be participatory—including the medical and scientific community as well as users of the system—transparent in terms of its reasoning, and evidence-based.[131]

The judgment established a monitoring process, modeled on an earlier judgment concerning internally displaced persons (IDPs), T-025/2004, also authored by Justice Cepeda.[132] The possibility of such a follow-up review was made possible by the *tutela*, although subsequent changes to the statute of the Constitutional Court in 2015 make such a review chamber more difficult to establish in the future. In 2009, only months after the judgment, Justice Cepeda finished his term on the court.[133] The follow-up chamber and attendant follow-up unit were subsequently overseen by Justice Jorge Ivan Palacio.

The developments after judgment T-760/08 have been shaped by conflict and cooperation among the Constitutional Court, the executive and legislative branches of government, and social

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130 Colombia T-760/08, *supra* note 9.

131 *See generally* Yamin and Lander, *supra* note 129 (noting the benefits of accountability in the health care space, especially those plans which are collectively derived from both needs and evidenced based research).

132 Corte Constitucional [C.C.] [Constitutional Court], enero 22, 2004, Sentencia T-025/04 (Colom.) (declaring that the fundamental rights of the country's internally displaced persons were being disregarded in such a massive, protracted, and recurring manner, that an "unconstitutional state of affairs" had arisen and issuing a number of complex orders aimed at overcoming the problems that gave rise to this situation and protecting the rights of the country's entire displaced population.).

133 Yamin Colombia LHR, *supra* note 59, at 114.

movements. The Uribe administration (2002–2010) was openly resistant to the judgment. Arguing that health rights litigation had brought about an imminent financial collapse of the health system, Uribe employed the extraordinary provisional powers of the constitution, and in December 2009 declared an economic state of emergency and issued 13 decrees that resulted in substantial changes to the immediate functioning of the health system.[134]

The impact of the T-760/08 decision likely would not have been as great were it not for the Uribe administration's autocratic response. The decrees created an uproar among patients and medical associations, as well as the general public. The decrees gave way to an unexpected level of protest that included doctors, medical students, health sector workers and middle-class contributors, whose benefits were significantly curtailed.[135] Importantly, these protests included people who were not typical social dissidents, such as physicians and members of the Catholic hierarchy.[136] By February 2010, mass protests were taking place across Colombia using the slogan, "Health is not a favor; it is a right."[137]

Although scholars have debated the impact, breadth, and strength of the social movements, Uribe's response arguably promoted greater social mobilization around health in Colombia. Suddenly, the wide range of stakeholders that advocated for health as a right were aligned and galvanized in their advocacy and actions, and those who defended the model of health as a commodity were more visible. The Uribe administration's reaction inspired the reorganization of civil society groups around health in the "Alianza Nacional por la Salud" (ANSA for their Spanish acronym).[138]

In April 2010, in Judgment C-252/2010,[139] the Constitutional Court declared the emergency decrees unconstitutional, except for

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134 Lamprea 2014, *supra* note 55; Yamin Colombia LHR, *supra* note 59.

135 *See* Young and Lemaitre, *supra* note 127 at 184 (describing the decades of civil unrest that led to the eventual adoption of the universal right to health in the 1991 Colombian Constitution); *see also* Yamin Colombia LHR, supra note 58, at 121–122.

136 *See* Yamin Colombia LHR, *supra* note 59, at 121.

137 *Id.*

138 Torres-Tovar, *supra* note 106, at 113.

139 Corte Constitucional [C.C.] [Constitutional Court], abril 16, 2010, Sentencia C-252/2010 (Colom.), http://www.corteconstitucional.gov.co/relatoria/2010/C-252-10.htm

the tax measures that funneled more resources to the health sector.[140] However, although the decrees were declared unconstitutional, society's response to the decrees showed how important the right to health and the *tutela* were to Colombians.[141] The Uribe government also paid a high political price for the emergency decrees.[142]

Between 2008 and 2016 the court's review/follow-up chamber issued 213 follow-up orders. The chamber also organized public hearings in which the court invited representatives of public agencies, civil society and experts to present information on the implementation of the judgment's orders.[143] Although this monitoring process was designed to keep the Executive accountable, the process had several weaknesses. While the court convened voluntary independent experts (of which this author was one), there remained a substantial lack of technical capacity that made interpreting health data and other information difficult.[144] In addition, latent and at times open conflict –what one informant referred to as a "Cold War"—between the court and the Executive resulted in extensive, abstract and complicated reports delivered by the Executive that were difficult for the court to understand, and which made the monitoring process even more difficult.[145]

When President Juan Manuel Santos took office in August 2010, health system reform was one of the first issues on the agenda. However, according to Everaldo Lamprea, former Auxiliary Magistrate of the court in charge of the follow-up unit

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[https://perma.cc/SR5U-37HM] (holding that the declaratory decree of a state of emergency relating to public health is unconstitutional).

140 Lamprea 2014, *supra* note 55, at 148.

141 Lamprea 2015, *supra* note 6, at 117 (describing the response of the Colombian people and health professionals to the decrees and the Constitutional Court ruling).

142 Young and Lemaitre, *supra* note 127, at 195 (detailing the political aftereffects of the failed decrees on the Uribe government, such as the loss of the 2010 election).

143 *Id.* at 192.

144 *Id.* at 192.

145 Jorge I. Palacio, El Punto Ciego en el Derecho a la Salud Efectiva, Entre el Simbolismo y la Evidencia Social (Presentation in Quibdo -Department of Choco- during a visit of the Constitutional Court) (Jan. 31, 2015), http://viva.org.co/attachments/article/271/Punto%20ciego%20salud%20-%20Jorge%20Iv%C3%A1n%20Palacio.pdf [https://perma.cc/V58E-8KXW].

during some of this time, even though the Santos administration recognized issues critical to the efficiency and equity of the health system, and passed legislation in Law 1438 that introduced important reforms, such as pharmaceutical policy, priority setting, and the significance of primary care, health promotion and prevention, between 2010-2014 it was the review chamber, composed of Jorge Ivan Palacio and two other justices, which most dramatically influenced the government's decision making processes related to health.[146]

During these years, the review/follow-up chamber convened two public hearings, in July 2011 and in May 2012. Lamprea characterized these public hearings as spaces of authentic deliberation that created substantial pressure on the government for such issues as the pharmaceutical regulation.[147]

More broadly, some commentators have described these hearings as potentially destabilizing mechanisms that prompted the government to commit to public policies designed to comply with the judgment's orders.[148] Others have noted that although the court created forums that made it possible to express extremely divergent opinions, there was no actual deliberation taking place—merely the declaration of widely differing views in a relatively "safe space."[149] Indeed, some view Cepeda's original opinion skeptically because it attempted to paste a deliberative process onto a profoundly unequal, polarized and non-deliberative society.[150]

Many agree on limits in practice even if they do not concur on the responsibilities for those defects: the hearings have not been open enough to guarantee the participation of the most vulnerable; access to information has not been easy to obtain for the public or even for many civil society organizations; and the criteria for

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146 Lamprea 2015, *supra* note 6, at 100 (reviewing the initial decisions and actions taken by Palacio regarding health matters following his accession to office).

147 *Id.* at 121–122 (providing graphical representation and descriptions of the pressure on various government officials following the two hearings); Lamprea 2014, *supra* note 55, at 150.

148 Interview with 060915A, Bogotá (June 9, 2015).

149 Interview with 061015B, Bogotá (June 10, 2015).

150 *Id.*

participation in hearings, conferences, events and consultations has not been clearly set.[151]

Yet, at the same time, commentators agree that the court did spur the government to adopt the new statutory framework Law on Health, which was passed by Congress in May 2014. The law was reviewed and declared to be constitutional by the Constitutional Court in judgment C-313/14 with important revisions. In the decision, the court provided for greater deference to physicians and limited the possibility of restriction on treatments by administrative mechanisms and bodies. The court also made clear that the system was going to be based on a presumption of inclusions, and that the list of goods and services excluded should be determined based on a participatory process, as called for in the law.[152] The court also insisted on aspects of quality of care and asserted the need for integral care and the continuity of care, maintaining that the obligation to provide health services cannot be interrupted for any administrative or economic reasons.[153] Lamprea and García have argued that "Law 1751 and the Colombian Constitutional Court's ruling C-324 are good indicators that Colombian policymakers and judges are trying to close the gap between formal and material health care coverage. We are particularly optimistic about the convergence between the right to health and health care coverage in Law 1751."[154]

I disagree. In its best light, Justice Cepeda's original opinion can be read as an effort to catalyze a broader political discussion about the collective construction of "no."[155] This approach in contrast recreates the pitfalls of implicit rationing, based on waiting lists and doctor discretion (which is greatly enhanced under the statutory law), which will invariably favor the better off

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151 *Id.*; Interview with 061215C, Bogotá (June 12, 2015).

152 *See* Yamin HRQ, *supra* note 7, at 6 (discussing the general guidance provided in the General Comments, such as the emphasis on devising participatory national plans for action).

153 *See id.,* at 11 (describing the Colombian Court's emphasis on establishing fair process and equal access to health care).

154 Everaldo Lamprea & Johnattan García, *Closing the Gap Between Formal and Material Health Care Coverage in Colombia*, 18(2) H. AND HUM. R. J. 49–65 (2016) (discussing the gap between formal and material coverage).

155 Interview with 060915D, Bogotá (June 9, 2015).

in Colombian society. By creating a list of exclusions, the statutory law reproduces an already existing problem of "gray zones." Because everything is included unless it is explicitly excluded, the law may turn out to substantially expand uncertainty around covered services.[156] Many agree that the executive branch's efforts to promote civic participation in defining the exclusions were not adequate. Although the Ministry did surveys and media efforts, it lacked a coherent methodology for deliberative participation. At the end of the day, there is skepticism that the lack of process will again lead people to distrust the definition of benefits package.[157]

The significance of the process to define the contours of the updated POS, and in turn, the right to health cannot be overstated. Although it may appear to be driven only by highly technical considerations, priority setting reflects profound ethical and normative judgments.[158] If health is to be taken seriously as a right in Colombia, the criteria to include or exclude goods and services from the benefits packages must be made explicit, visible to the public and be subject to justification by the political branches of government.[159] As Young and Lemaitre argue, it appears likely that "[i]f the Colombian public does not understand the criteria used to include and exclude certain treatments in the new POS, and if the criteria for these decisions are not clear, people may very well continue to seek redress in massive numbers through court orders [*tutelas*], as the only mechanism through which to defend their right to health."[160]

Beginning in 2014, the court implemented a more dogmatic approach to the monitoring process, demanding evidence of compliance in particular cases that, from its point of view, represent examples of weakness in the Ministry of Health's initiatives.[161] The very specific orders with which the court demanded compliance—such as conditions in a departmental hospital—also arguably went beyond the original orders in T

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156 Interview with 061015E, Bogotá (June 10, 2015).

157 Interview with 060915F, Bogotá (June 9, 2015); Interview with 061015C, Bogotá (June 12, 2015); Interview with 060915G, Bogotá (June 9, 2015). Interview with 060915A, Bogotá (June 9, 2015); *see also* Yamin HRQ, *supra* note 7.

158 Yamin HRQ, *supra* note 7, at 10; Yamin and Norheim HRQ, *supra* note 8.

159 Yamin HRQ, *supra* note 7, at 10.

160 Young and Lemaitre, *supra* note 127.

161 Interview with Jorge Ivan Palacio Palacio, Former president of the Constitutional Court, Bogotá (June 11, 2015).

760/08.[162] Over this period of time, a noticeable shift in *tutela* claims that went beyond the POS could be detected from access to medicines and treatment, to *tutelas* claiming ancillary services, including payments for caregivers.[163] A lawyer involved in the original opinion and the implementation of the case noted that the follow-up had ceased to be "dialogical judicialism" when the court got involved in such details rather than focusing on the original opinion's structural orders.[164] At the same time, larger issues such as criteria for participation in priority-setting and evaluations of oversight and regulation seemed less front and center on the Court's agenda. The Ministry of Health reacted to this new more dogmatic approach and adversarial tone with some resistance, which was reflected in process of implementing the Statutory Framework Law which went into effect in 2017.

Further, changes made to the statute of the Constitutional Court after a political scandal make it difficult for a review chamber to exercise ongoing review of a *tutela* in the same manner as T 760/08 and T 025/04 had done before.[165] For example, a 2015 case involving structural reform of prisons set up the civil society follow-up unit, but did not place a follow-up unit within the court itself.[166] A 2017 judgment regarding health conditions in the very deprived department of Vaupés, where the issue was public health conditions and access to primary care, called for significant structural changes, but notably established no follow-up unit.[167] A 2018 case from the court even appeared to show the willingness on

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162 Corte Constitucional [C.C.] [Constitutional Court], septiembre 16, 2015, Auto 413/15 (Colom.).

163 *See, e.g.*, Rodrigo Uprimny and Juanita Durán, Equidad y Protección Judicial del Derecho a la Salud en Colombia, CEPAL - Serie Políticas Sociales N° 197 (Santiago, Chile: Naciones Unidas, 2014) 22–23.

164 Interview 060915D, *supra* note 156.

165 Corte Constitucional [C.C.] [Constitutional Court], julio 22, 2015, Acuerdo 02 de 2015 por medio del cual se Unifica y Actualiza el Reglamento de la Corte Constitucional, (Colom.)

166 Corte Constitucional [C.C.] [Constitutional Court], Sentencia T-762/15, Magistrada Ponente: Gloria Stella Ortiz., 16 de diciembre de 2015 (Colom.)

167 Corte Constitucional [C.C.] [Constitutional Court], Sentencia T-357/17, Magistrada Ponente: Maria Stella Ortiz, 13 de julio de 2017 (Colom.) (containing a note discussion justifying the use of tutela for a structural case due to figure of Defensor del Pueblo as plaintiff on behalf of communities).

the part of some justices to limit the use of the *tutela*.[168] Finally, in the wake of the new Statutory Framework Law, the turbulent post-conflict situation Colombia faces, and the election of conservative President Ivan Duque in 2018, the current justices in the Follow-Up Chamber appear to be seeking criteria to close the T 760/08 judgment.

This experience of T 760/08 illustrates the importance of a shared understanding of the conditions for meaningful dialogue on grounds of rough equality, and of moving from an adversarial posture to a collaborative one in the implementation of such a systemic judgment. It further demonstrates the need for setting explicit criteria, from the beginning, for both defining the parameters of such a monitoring process, and under what circumstances the court could consider follow up to be complete, without capitulating to the political vicissitudes of the day.[169] The T 760/08 decision stretches the boundaries of judicial authority, but even so reveals the limited capacity of even the most assertive courts to transform the institutional arrangements necessary to realize health rights in practice.

4. CONCLUDING REFLECTIONS

The experience of constitutionalization and judicialization of the right to health in the region shows a number of lessons and challenges. The setting of priorities to include within obligatory social insurance schemes in the region is generally not done in a systematic and transparent fashion that provides room for social consultation and deliberation regarding the criteria for ranking services and treatments. Rather, health systems are often plagued by irrational rationing and implicit forms of allocating care—through waiting lines, access to specialists, out-of-pocket payments. In this context of poor responsiveness from the executive and legislative branches of government, as well as chronic regulatory failures within health systems, it is unsurprising

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168 Corte Constitucional [C.C.] [Constitutional Court], SU- 2018-N0005 (Unificando Jurisprudencia en relación del uso de Tutelas en T-60627321-602941-6294392-6384059-6356241-6018806-6134961) 13 de febrero de 2018 (Colom.).

169 Yamin HRQ, *supra* note 7.

that people take advantage of the favorable opportunity structures that exist in many courts.

Structural reforms in constitutions have been as important as the enumeration of specific rights relating to health in constitutions across the region in producing the rise in judicialization. Individual exploitation of opportunities within systems has exploded, using constitutional litigation as an avenue, while broader collective efforts to reform the health systems through litigation are far less frequent. Such individual litigation for entitlements, while often better understood as regulatory gap problems, can challenge principles of formal equality by fostering queue-jumping for expensive medications and treatments by those with better access to justice. It also may distort health systems toward curative care, rather than investing in long-term structural infrastructure for the health system and in preconditions for health, which have wider benefits for the disadvantaged.

In response to the massive judicialization in health, as well as to other systemic and structural problems, some courts in the region, including those in Argentina and Colombia, have issued broad structural remedies. These judgments need not be seen as isolated from social struggles.[170]

Indeed, Judgment T-760/08 led not just to a new Statutory Law on Health, but also to the reframing of the discourse around the health system and crisis in Colombia.[171] After the T-760/08 Judgment, civil society groups were quick to appropriate the definition of health as a fundamental right, which led to the origination of social organizations, academia, and NGOs focused on activities around the statutory law.[172] However, the actual participation in redefinitions of the benefits scheme, or exclusions therein, or of new health policies, has been limited.[173] Meaningful

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170 Rodrigo Uprimny, *La Judicialización de la Política en Colombia: Casos, Potencialidades y Riesgos*, 6 SUR: REVISTA INT´L. DE DERECHOS HUMANOS 53–69 (2007) (discussing the intensification of the judicialization in Colombia).

171 *See* Rodríguez-Garavito 2014, *supra* note 60; *see also* Cesar Rodríguez-Garavito, *Beyond the Courtroom: The Impact of Judicial Activism on Socioeconomic Rights in Latin America*, 89(7) TEXAS L. REVIEW 1669–1698 (2011) (discussing the impact of judicial activism in high court decisions, like T-760/08).

172 Young and Lemaitre, *supra* note 127, at 197.

173 Interviews with 061015B, 060915A, 061015C, 060915F, 060915D, Bogotá (June 9–12, 2015).

dialogue in a sector as rife with asymmetries of power and technical information poses particular challenges to democratization through dialogue. Similarly, the backdrop of a deeply polarized society and non-representative government, which may be particularly acute in Colombia but is similarly present in other countries, poses a stark challenge to the necessary limit-setting process that fair-minded deliberation should foster.

Ultimately, health is a very sensitive reflection of social justice, and health systems are intimately connected to the degrees of social solidarity and democracy that exist in countries. Thus, even the most progressive and innovative of courts can only offer feeble alternatives to more robust egalitarian aspirations. Just as Garcia Villegas and Uprimny have argued generally that "constitutional justice can become an important tool for democratic progress, as long as it is part of broader social struggles," so too may be said of health justice in particular. [174]

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[174] Rodrigo Uprimny & Mauricio García-Villegas, *The Enforcement of Social Rights by the Colombian Constitutional Court: Cases and Debates*, *in* COURTS AND SOCIAL TRANSFORMATION IN NEW DEMOCRACIES: AN INSTITUTIONAL VOICE FOR THE POOR? 147 (Roberto Gargarella et al. eds., 2008).