Issues in the Justiciability of the Right to Health

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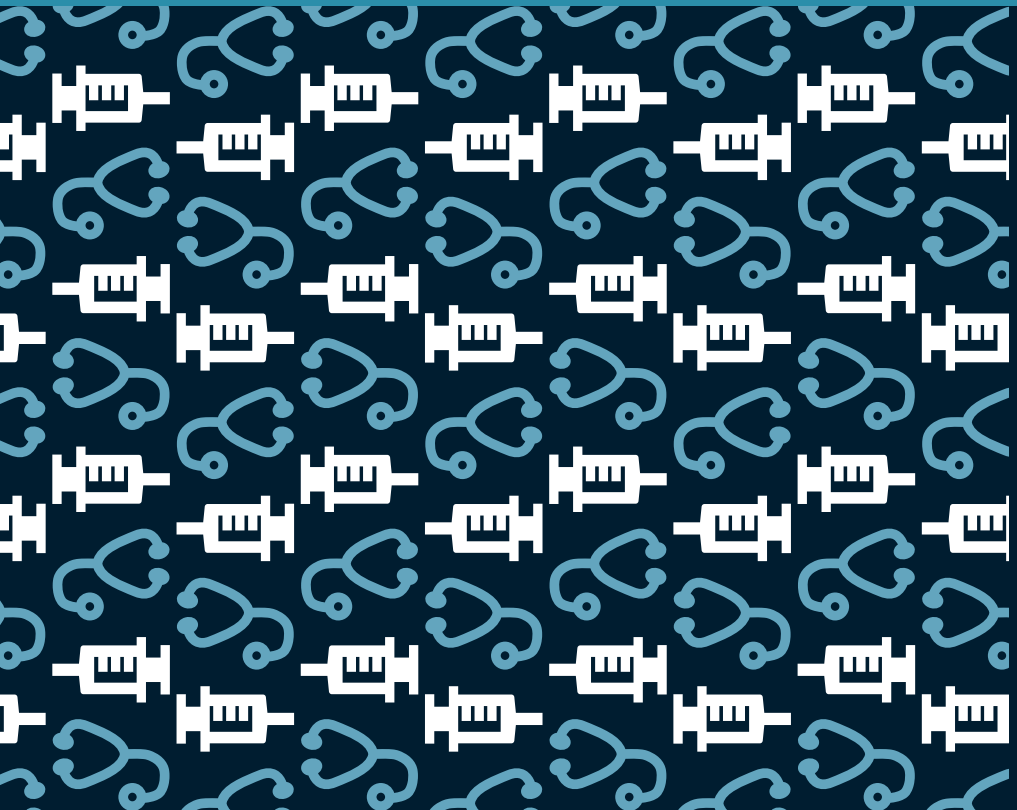

Issues in the Justiciability of the Right to Health

Abstract

The judicialization of health care is increasing dramatically in the last decade worldwide. Although this judicial activism has undoubtedly contributed to guaranteeing the protection of this right, many challenges remain despite this progress. The objective of this book is to evaluate the different challenges and opportunities that States have in the protection of the Right to Health while maintaining a balanced level of judicial activism. More specifically, it looks to identify in what contexts judicial activism is justified in order to protect the right to health by analysing the dynamics of litigation as well as its consequences. The book starts by presenting a case in Spain. Juan Antonio Maldonado shows how conflicts between different institutions might arise as a result of disagreements about the protection of the right to health in contexts of economic crisis. As a result of that, the Court had to make difficult decisions about how to solve such conflicts. It then presents an experience in Slovakia, Central Europe. Barbara Pavlíkova examines the Health system in Slovakia describing how the health system has evolved in this country after the fall of communism and how the health system is currently being affected by many factors. In a similar vein, Cippitani and Colcelli focus on the topic of Social Rights and how they are recognized in the Italian context, and finally, Rodolfo Gutiérrez examines the case of Colombia, scrutinizing how the system, despite expanding its level of coverage, is currently generating a high level of judicialization of health. The concluding chapter carries out a comparative analysis of the cases studied in order to generate some recommendations.

Keywords: Health Care, Irregular Immigration, Justiciability, Social Rights, Universality.

Resumen

La judicialización de la atención médica ha aumentado dramáticamente en la última década en todo el mundo. Si bien este activismo judicial ha contribuido indudablemente a garantizar la protección de este derecho, subsisten muchos obstáculos a pesar de los avances en el tema. El objetivo de este libro es evaluar los diferentes desafíos y oportunidades que tienen los estados para proteger el derecho a la salud, al tiempo que mantiene un nivel equilibrado de activismo judicial. Más específicamente, busca identificar en qué contextos se justifica el activismo judicial para proteger el derecho a la salud mediante el análisis de la dinámica de los litigios y sus consecuencias. El libro comienza presentando un caso en España: Juan Antonio Maldonado muestra cómo pueden surgir conflictos entre diferentes instituciones como resultado de desacuerdos sobre la protección del derecho a la salud en contextos de crisis económica. En consecuencia, la Corte tuvo que tomar decisiones difíciles sobre la manera en que se deben resolver estos conflictos. Posteriormente, se presenta una experiencia en Eslovaquia, Europa Central. Barbara Pavlíkova examina el sistema de salud eslovaco que describe su desarrollo después de la caída del comunismo y cómo muchos factores lo están afectando actualmente. En una línea similar, Cippitani y Colcelli se centran en el tema de los derechos sociales y en cómo se reconocen en el contexto italiano. Y finalmente, Rodolfo Gutiérrez examina el caso de Colombia, analizando cómo el sistema, a pesar de ampliar su nivel de cobertura, está generando actualmente un alto nivel de judicialización de la salud. El capítulo final lleva a cabo un análisis comparativo de los casos estudiados para hacer algunas recomendaciones.

Palabras clave: Atención a la salud, inmigración irregular, justiciabilidad, derechos sociales, universalidad.

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Preface

Without any doubt, we have made some progress in the protection of the right to adequate health worldwide. However, new risks embedded in the globalisation process are generating complex changes in the model of health that has traditionally characterised different countries. These changes are clearly affecting the welfare of millions of people and triggering, what the economic historian Karl Polanyi might call, a triple reaction in a system led by judges who are looking to make a contribution to solving structural problems that are generating, in different contexts, a massive and systematic violation of human rights. The objective of this judicial activism is to generate a new balance in the system through the adoption of jurisprudential innovations. However, such judicial intervention is unfortunately not yet able to generate a strong impact on people´s lives. This book provides evidence of the need for greater intervention by judges in politics in order to ensure the necessary checks and balances whilst protecting constitutional values such as equality and liberty. Judges have traditionally been criticised because of their lack of legitimacy, however, if judges do not interfere in politics, the principles of the constitution might not be fulfilled.

Generally speaking, there are two debates in relation to the issue of Justiciability: the debate about the "challenges faced by the Justiciability […]" or *Reactionary Justiciability* and the debate about the "challenges raised by the Justiciability" *or Transformative Justiciability*. *Reactionary Justiciability* implies the assumption that the recognition of the Human Right to Health by Courts, although possibly affecting principles such as the Separation of Powers, Democracy, Legitimacy and Financial Sustainability —in the case of the provision of expensive medicines or universal accessibility—, is justified because if judges do not interfere — in politics—, the right to health would be massively violated. This debate has been led by many NGOs, the International Commission of Jurists and many academics worldwide. Without any doubt, on a national level, many countries have recognised the right to health in their constitutions. In a similar vein, on a regional level, the right to health has also been recently recognised

by Courts as an autonomous right protected by Article 26 of the American Convention. For example, in *Poblete Vilches y Otros vs Chile* (2018) the Inter-american Court declared the international responsibility of the Chilean state for not guaranteeing the right to health. This debate has also been studied by academics in 4 separate parts:

a. Recognition —of the right to health by Judges—.
b. Remedies issued by Judges.
c. Supervision of implementation of judgments.
d. Impact.

In the last twenty years we have made some progress in the recognition of the right to health by Courts, therefore, the challenges that we have today are certainly different:

1. The type of remedies that courts should order to protect the right to health —Judges ordering a structural transformation of an entire health system— vs Individual remedies — Judges ordering a treatment or a medicine—.
2. The type of monitoring strategies for the implementation of judgments —in India, the Court used Commissioners to monitor the implementation of judgments while in Colombia—, public hearings were led by the Constitutional Court (Tribunal Constitucional or TC) with the participation of several stakeholders.
3. The type of impact —high, medium, low— achieved in the Health System through Judgments.

On the other hand, *Transformative Justiciability* adopts a macro perspective to study the actions of different actors. It looks at the causes and the consequences of Justiciability. Some countries, for instance Colombia and Brazil, are currently experiencing high levels of litigation and this undoubtedly reflects a real flaw in their policies that in turn is triggering violations of the right to health. I believe that the dynamics —impact and causes— of health care litigation vary among countries, not only in terms of their legal models and health systems, but also due to state constraints including structural dysfunctions

or conditions relating to, for example, the conduct of third parties —such as corruption and elite capture— as well as political instability, lack of regulation or mechanisms of surveillance. This book is looking to make a contribution to the debate of *transformative justiciability* of the right to health.

RODOLFO GUTIÉRREZ
BOGOTÁ, 6 FEBRUARY 2019

Introduction

Despite recent improvements in the protection of the right to adequate health[1], for instance, some health indicators have improved (Lamprea & García, 2016) and budgets have slightly increased in terms of resource allocation, violations of the right to health continue to grow. A clear failure of public policies adopted by States might be considered as one of the central causes of these violations and as a result of that, in some jurisdictions, judicial activism has emerged with the objective of generating a balance in the system by protecting the rights of the most vulnerable.

Generally speaking, this judicial activism is not only expressed in terms of the level of international influence of Courts —or the capacity and frequency of Courts to invalidate legislation— but could also be interpreted in relation to the level of their judicial practice. This entails the capacity of courts to recognise social rights, to issue diverse type of remedies and deliver some monitoring of social rights judgments. In some cases and contexts, this type of judicial activism may even have the potential of influencing Public Policies at the national, regional and international level particularly when policies are (re)formulated as part of the process of implementing judgments (Gloppen, 2005)[2]. In a growing number of countries, litigation has been used as a strategy to advance the right to health of people by transforming and formulating policies[3]. In Colombia, for example, in 1999 there were just 21,301 writs of protection —Tutela actions—, however, by 2008 this number increased dramatically to 142,957.

1 According to the OECD (2015), in Colombia, insurance coverage has risen rapidly from 23.5 % of the population in 1993 to 96.6 % in 2014 while affiliation increased most rapidly in the poorest quintiles —from 4.3 % in 1993 to 89.3 % in 2013— and in rural areas from 6.6 % in 1993 to 92.6 % in 2013.

2 According to Gloppen (2005) litigation processes may also influence Social Policy formation in more indirect ways too, through stimulating social mobilisation around social rights issues, creating awareness and media attention, feeding advocacy, bringing social rights issues into social policy discourse and framing marginalised people´s grievances in terms of social rights violations.

3 Colombia is a country where patients tend to go first to the Judge rather than the doctor because providers tend to deny health services. After some time, the Constitutional Court orders structural remedies to the government in order to transform and (re)formulate social policies.

As a result of that, the Court issued Decision T-760 in 2008. Through this structural judgment "the court collected twenty-two 'tutelas' —twenty brought by individuals and two brought by providers— which the Second Review Chamber of the Court selected in order to illustrate systemic problems in the health system" (Yamin, 2011, p. 117). One of the objectives of this structural dialogic judgment was to reduce the high level of writs of protection by unifying the plans of health which were unequal as well as recognise the right to health as a fundamental right in order to fulfil its obligations of protection under international law. In Brazil, on the other hand, and according to Ferraz (2016) litigation has increased from 387 in 2003 to 12,811 in 2011 and just at the federal level, this has led to a massive and fragmented response from Courts regarding individual remedies. At the same time, Costa Rica after designing a health system that focuses on universal accessibility has also experienced problems in this area, which has led to a significant increase in individual litigation. This trend will hardly decrease unless substantial changes are made to the health system (Piza, 2016). Health care litigation and judicial activism are also growing in countries such as México where an increase in litigation is expected due to the constitutional reforms of 2011 (Charvel, 2016), and also, in Uruguay where increases in litigation are expected to severely impact upon financial sustainability in the medium and long-term (Pereira, 2016). On a regional level, the right to health has also been recognised as an autonomous right protected by Art. 26 of the American Convention. In *Poblete Vilches y Otros vs Chile,* the Interamerican Court declared the international responsibility of the Chilean state for not guaranteeing the right to health. In another important case[4], the Interamerican court stated that an absolute ban of in-vitro fertilisation violated several rights including: privacy, family and personal integrity and ordered the State to incorporate access to in-vitro fertilisation into its health system (Corte IDH, 2012).

Using courts to solve public policy issues has led some critics to suggest that Judges should not interfere with politics since they lack institutional capacity and their actions impact negatively on democratic processes as well as the principle of separation of powers, therefore, according to this perspective judges lack legitimacy. This topic has also generated a debate about the impact

4 Artavia Murillo et al v. Costa Rica (2012).

of litigation on policies and the protection of health with some academics arguing against litigation since they believe that, in practice, litigation does not benefit the poor. For instance, in Brazil, health expenditures have been allocated mainly to middle-class groups who are benefiting from expensive medicines and treatments (Ferraz, 2016). This position gives priority to the financial sustainability of the health system and suggests that as long as the litigation process allows middle classes access to health services, it could clash with the limited availability of resources that health systems face today and could even increase levels of inequality in the provision and access to health care (WorldBank, 2011). Therefore, proponents of this view sustain that the impact of litigation has been regressive since it is reproducing inequalities and it is affecting the financial sustainability of health systems. Contrary to this view, another group of commentators have pointed out that litigation has brought a positive impact particularly in the protection of the right of the poorest (Biehl, Socal & Amon, 2016). Thus, according to this view litigation is contributing to the fulfilment of the principle of equality. Alternatively, Uprimny (2016) argues that the impact (in Colombia) has been mixed. On one hand it has been regressive or negative because the writs of protection have benefited only middle classes thereby reproducing inequalities, however, at the same time it has been positive because the remedies of Decision T-760/08 have promoted equality by ordering the Government the unification of the plans of health. In a similar vein, Andia (2017) suggests that the direct impact of Decision T-760/08 has been positive and includes not only the unification of the Plans of Health within the contributory and the subsidised regime in Colombia but also all the reforms of health policies led by the new Statutory Law 1751 of 2015 that recognises health as a fundamental right and also Law 1438/11. Decision T-760/08 also had symbolic effects in Colombia since it has produced a change in knowledge and attitude, thus, today users, as well as public servants, talk about health in terms of rights and not in terms of public services or charity. This type of activism, whether fragmented or structural, as well as the increase in litigation, raises different type of questions, for instance, "To what extent can Courts solve public policy problems?" And if so, "In what type of contexts could judicial activism make a strong impact in order to protect the right to health given the failure of public policies?" Finally, and crucially for this research, "What policy reforms are needed in order to protect

the right to health as well as to strengthen the institutional capacity of public government institutions?".

Unfortunately, most of the literature that has studied this phenomenon tends to be fragmented. Thus, there are very few multidisciplinary studies that evaluate and capture not only the problem of failures of public policies but at the same time their relationship with the degree of judicial activism. In other words, in the last twenty years, we have witnessed an increase in research that evaluates how the new judicial activism has impacted upon the protection of health and social rights through litigation by measuring its impact. Unfortunately, this type of research does not focus well enough on generating proposals to improve public policies in the field of health while maintaining a balanced judicial activism. The literature is indeed very fragmented and includes in-depth single-country studies that evaluate the impact of individual lawsuits filed by rights holders with a specific health condition in a specific region as well as systematic reviews that evaluate different characteristics of lawsuits. At the same time, this literature seems to ignore how macro processes or structures might be affecting States in the delivery of effective policies. What the literature reveals is a problem related to access to health services caused by weaknesses in health systems that are unable to fulfil the obligations of guaranteeing adequate health with dignity. Indeed, missing in the literature are studies that evaluate in what type of contexts judicial activism, whether in its strongest or weakest forms, might contribute to the protection of the right to Health formulating at the same time some policy reforms in order to strengthen the institutional capacity of public government institutions. Studies that evaluate judicial activism and their interaction with public policy strategies are urgently needed in some countries in order to protect the right to health by transforming the way public institutions operate. Therefore, a careful comparative analysis of sociological aspects, as well as social policy strategies, is necessary in order to evaluate through a multidisciplinary study more general patterns that might be triggering this complex process. The approach also requires specific knowledge of the legal and health systems, social policies and a sociological imagination. Despite some advances, we do not yet have a clear grasp of the relationship between health care litigation, the right to health and public policy variables. Therefore, this book seeks to contribute to filling a gap in the literature and the specific aim is to produce some information that will have an impact on the

different institutions responsible for the design of public health policies such as ministries and government departments, as well as research groups and civil society organisations, in order to improve public policies. This type of research is also relevant since the number of people being denied access to health in these countries is very high and growing disproportionately.

The objective of this book then is to evaluate the different challenges and opportunities that States have in the protection of the right to health while maintaining a balanced level of judicial activism. More specifically it looks to identify in what contexts judicial activism is justified in order to protect the right to health by analysing the dynamics of litigation as well as its consequences. The book will try to provide solutions through different policy reforms that States could undertake in order to have a greater impact, thus, contributing to guaranteeing constitutional principles and values. To appreciate the complexity of this phenomenon requires not only an understanding of the legal aspects but also the undertaking of a multidisciplinary and comparative study that includes the analysis of the various health systems and the structural dysfunctions that affect them. Therefore, the methodology includes a qualitative approach, under the methodological design of a comparative documentary research.

This book has developed a simple analytical framework to analyse the cases from a systemic perspective; this entails looking at the whole and not only the fragmented parts. The parts include: legal variables, State constraint variables, obligation of conduct variables and obligation of results variables. It is important to highlight that this book is not only trying to evaluate the impact of health litigation on indicators of results but also on public policies. The cases studied reflect the situation of challenges and opportunities that many countries face regarding protecting the right to adequate health. Spain, Italy and Slovakia are European countries whose health systems have many features and elements of the health systems that characterise the Beveridge framework. However, at the same time, these particular systems have very slowly integrated Bismarckian elements. On the other hand, Colombia has transformed their systems from a segmentation model and has come a little closer to resemble Bismarck's model even though their labour markets remain very segmented and with a high level of informal economy, unemployment and inequalities among groups. The difficulty in analysing the protection of the right to health merely from a welfare point of view and not from a rights-based approach

is that unfortunately, we are not able to appreciate the interdependence of obligations by the State as well as the space or the context where such interdependence takes place. From a human rights perspective we need to analyse the interdependence of the right to environment and the right to health and to do so we must interpret nature as a space connected to the people. This interdependence is part of the vital minimum that everyone needs in order to live a life with dignity. The Interamerican Court of Human Rights adopted this approach in *Comunidad Campesina de Santa Barbara vs Peru.* In this case, the Court not only interprets Private Property as a mechanism used to protect the vital minimum but also as a space directly connected to the people, a space where people can develop their life project and their cultural identity, and ordered the Peruvian State to provide adequate housing to the victims. To interpret the interdependence of rights we also have to interpret the interdependence of obligations.

The authors of this publication come from different backgrounds in the areas of Law, Sociology and Social Policy and have chosen a mix of cases dealing with a range of topics related to health. These cases are particularly related to how institutions such as the judiciary and the government have responded to ensure its protection. Colombia is a very interesting country to analyse. Not only does this country have to deal with a very complex conflict between different actors that lasted more than 50 years[5] but also, in a similar way to many Latin American countries, Colombia has now evolved from the previously segmented and fragmented health system. This country has embraced a neoliberal approach and although its health system in different occasions has been recognised as one of the best in the world by the World Health Organization, nevertheless it continues to generate many inequalities and violations in terms of access to health care. As a result of that, its population has had to resort to the judicialisation process in order to guarantee protection of the right to adequate health. According to the World Health Organization (2017), Colombia had a population of 48,653,419 in 2016. A fragmented health system, that failed to provide sufficient coverage and quality of health services, led the country to transform its system like many Latin American countries, thus, supporting many of the neoliberal policies promoted by international

5 The guerrilla groups and the Government reached an agreement in 2016.

entities such as the World Bank and the International Monetary Fund who were advocating for economic change[6].

Unfortunately, the country did not recognise the right to health as a fundamental right in its 1991 constitution, leading Colombia instead to create a structured health system with Bismarckian elements. Therefore, as some commentators suggest "Via Law 100… Colombia created the General System of Social Security in Health (Sgsss in Spanish), composed of two insurance schemes, the contributory scheme for formal sector employees and people of means, and the subsidised scheme for people without ability to pay; each scheme has a different benefit package (Garcia-Subirats et al., 2014). In other words, "Law 100 established a two-tier insurance system- a contributory regime for those in employment and a subsidised regime for those without formal employment- centered on multiple private insurers and service providers under a regulated competition model" (Hawkins & Alvarez Rosete 2017)[7]. The health system in Colombia though has many challenges. Despite General Comment 14 Art. 12 (a) states that "…functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party", the number of nurses and midwives (per 1,000 people) in Colombia in 2014 was 1.1 while in the Slovak Republic that number was 6.4, in Italy 5.6 and Spain 5.3. In a similar vein, the specialist surgical workforce (per 100,000 population) was very high in Italy 114.0, while in Slovakia the number was 57.2 and Colombia 16.2. Despite decision T-760/08, almost ten years later the writs of protections are still growing and this might suggest that there could be a massive violation of the right to health in the country. According to recent reports from the Ombudsman´s office in Colombia, the number of writs of protection has increased from 142,957 in 2008 to 163,977 in 2016 (Defensoría del Pueblo, 2017) and 197,055 in 2018 (El Tiempo, 2019). In addition to that, the Superintendence of Health also received 1,061,677 complaints through the administrative mechanism in 2017. Thus, this might suggest that structural decision T-760/08 did not have

6 Colombia also ratified the International Covenant on Economic, Social and Cultural Rights through Law 74 of 1968.

7 In practice, the government established a "competitive surrogate model" (Yamin, 2009).

a strong impact in the reduction of writs of protection and the protection of health and it might also be an indicator of a real flaw in public policies.

The Spanish economy, on the other hand, has started to show some growth over the last years after the economic recession. However, the country must overcome some political challenges. The new government of Pedro Sanchez is looking to expand again the universality of the right to health to immigrants. On the other hand, according to Human Rights Watch, the authorities of Catalonia held an independence referendum however they "used constitutional powers to dissolve the Catalan regional government and impose direct rule… [whilst also beginning] criminal proceedings against 14 representatives of the dissolved Catalan government for sedition and other offenses" (Human Rights Watch, 2018). Indicators suggest that "life expectancy at birth in Spain reached 83 years in 2015, up from 79.3 years in 2000 and is currently the highest among EU countries" (OECD et al., 2017). With a population in 2016 of 46,484,533, Spain has a decentralised and universal health system that is well known worldwide because of its quality. According to some commentators, the system "offers almost universal coverage as well as a wide variety of services and a high-quality network of hospitals and primary care centres. Although it is a national system, financed with general tax revenue, the devolution of health services to the country's 17 autonomous communities has led to a variety of management models" (Martin-Moreno et.al 209). In that sense, the Spanish Health System is different from the British model. According to the OECD "The Ministry of Health, Social Services and Equality is responsible for certain strategic areas and the national monitoring of health system performance. The highest body for coordination is the NHS interterritorial Council which gathers national and regional Ministers of Health" (OECD et al., 2017, p. 6). Therefore, in practice, this council act as a coordinator planning different types of strategies to deal with disease outbreaks and a space of democratic discussion.

The economic crisis forced Spain to reduce its spending on health, thus, affecting many social groups. However, despite this Spain has shown its commitment to the protection of the Right to Health by fulfilling the principle of Progressivity[8]. On the other hand, although the courts in Spain are more active

8 After the economic crisis, and according to the OECD/European Observatory on Health Systems and Policies (2017) [...] health spending per capita in Spain decreased in real terms

regarding the judicialisation process, the ruling remained largely unobserved by the political and administrative elite and the courts were unable to push for change (Martisen 2017). In terms of obligation of Conduct, the right to health is also recognised in the Spanish Constitution in art. 43 that states:

1. The right to health protection is recognised.
2. It is incumbent upon the public authorities to organise and watch over public health using preventive measures and the necessary benefits and services. The law shall establish the rights and duties of all in this respect.
3. The public authorities shall foster health education, physical education and sports (Constitución Española, 1978).

Due to the recession, Spain had to adopt strict measures to confront the economic challenges, particularly by reducing public spending on health in order to achieve fiscal sustainability. Measures included a national law to ensure fiscal sustainability in the health sector, the increase of payments by users or co-payments and Royal Decree-Law 16/2012 that through a series of measures try to control the increase of costs. As a consequence, universal entitlements were reduced thereby excluding non-registered immigrants who were not given accessibility except for certain services in the case of medical emergencies as well as maternal and child care (OECD et al., 2017)

Contrary to Spain, Slovakia has a population of 5.4 million and ratified the International Covenant of Economic, Social and Cultural Rights on 28 May 1993. In 2015, domestic general government health expenditure as a percentage of current health expenditure was higher in the Slovak Republic (79.7 %) than in Italy (74.9 %), Spain 71.0 and Colombia 66.8. Slovakia has a system that is not Bismarckian or Beveridgean, however, there are elements of the market that are affecting the system. In Slovakia, health insurer's funds have been put under the monitoring of the Healthcare Surveillance Authority (HCSA). The human rights report of the State Department 2017 considered that one

and relative to the European Union average, however, spending started to rise again in recent years in 2015. Spain spent EUR 2374 per capita on health care compared to the EU average 2797. This equals 9.2% of GDP and it is also below the EU average of 9.9 %. Around 71 % of health spending in Spain is publicly funded, whereas out-of-pocket payment accounts for 24 % of total health spending, a much higher share than the EU average of 15 %. (p. 1).

of the most significant human rights issues included corruption. This position was also shared by the World Bank´s Worldwide governance indicators that also suggested that corruption remained a problem. Transparency International in 1995 also released a survey showing that 96 % of citizens believed that bribery or corruption existed in the health sector with 64 % describing it as widespread and 22 % admitting to having paid bribes for health service. Out-of-pocket expenditure —percentage of current health expenditure— in the Slovak Republic was at 18.4 % in 2015 while in Italy that number was 22.8 % and Colombia 18.3 %.

Finally, the Italian National Health System follows a model similar to the Beveridge Model (Nuti, S, et al., 2012). Regarding current health expenditure, Italy was spending 9.0 % of its GDP in 2015 while the Slovak Republic 6.9 %, Colombia 6.2 % and Spain 9.2. Italy´s health outcomes are generally above the EU average and the health system appears cost-effective. In Italy, current health expenditure per capita (current US$) was down on previous years to 2,700.4 while in the Slovak Republic was 1,108.4, Spain 2,353.9 and Colombia 374.2. Current health expenditure per capita PPP —Current international $— in Italy was 3,350.6 in the Slovak Republic 2,062.0, in Spain 3,182.5 and in Colombia 852.8. The number of physicians —per 1,000 people— was higher in Italy 3.9, Slovak Republic 3.5 and Spain 3.9 in 2015, while Colombia only has 1.8 physicians per 1,000 people in 2014. However, unmet needs for medical care are high and increasing. This trend might suggest problems with accessibility. Social expenditure for people with disabilities is high but shows only mixed results. The Italian system has many challenges, particularly regarding how to deal with increasing levels of immigration and discrimination. According to Human Rights Watch (2018, p. 224) "over 114,000 migrants and asylum seekers had reached Italy by sea by mid-November […] The government adopted harsher policies amid a toxic political debate over migration".

This book starts by presenting a case in Spain. *Juan Antonio Maldonado*, adopting a particular approach, shows how conflicts between different institutions might arise as a result of disagreements about the protection of the right to health in contexts of economic crisis. As a result of that, the Court had to make difficult decisions about how to solve such conflicts. The book then presents an experience in Slovakia, Central Europe. *Barbara Pavlíkova* examines the Health system in Slovakia describing how the health system has

evolved in this country after the fall of communism and how the health system is currently being affected by many factors. In a similar vein, *Cippitani and Colcelli* focus on the topic of Social Rights and how they are recognised in the Italian context, and finally, *Rodolfo Gutiérrez* examines the case of Colombia, scrutinising how the system, despite expanding its level of coverage, is currently generating a high level of judicialisation of health. The concluding chapter carries out a comparative analysis of the cases studied in order to generate some recommendations.

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THE EXCLUSION OF FOREIGNERS IN AN IRREGULAR SITUATION FROM THE RIGHT TO HEALTH CARE IN SPAIN

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Abstract

The economic crisis has had a strong impact on the Spanish Social Protection System, including the Health Care System. Until 2012, the principle of universality had no exceptions, with the entire population being covered, including foreigners in an irregular situation. However, the reform approved that year omitted this group. Faced with this, the regional governments within their legislative powers decided not to assume this limitation, extending protection to everyone again. However, the TC has declared that the Autonomous Communities do not have the power to do so, admitting that the right to effective protection of health may be subject to general interests, those that the state legislator deems convenient at the time. Finally, after RDL 7/2018, of July 27th, both foreigners who are legally residing in Spain, as well as those who are not registered or authorised as residents in Spain, have the right to health protection and health care in Spain; the same conditions as for people with Spanish nationality, provided that said persons meet certain requirements.

Keywords: Irregular Immigration, Health Care, Universality.

Resumen

La crisis económica ha tenido un fuerte impacto en el Sistema español de Protección Social, incluyendo el Sistema de Salud. Hasta 2012, el principio de universalidad no tenía excepciones, estando cubierta toda la población, incluyendo los extranjeros en situación irregular. Sin embargo, la reforma aprobada ese año dejó fuera a este colectivo. Frente a ello, los gobiernos regionales decidieron no asumir esa limitación, extendiendo la protección nuevamente a todos, dentro de sus competencias legislativas. Sin embargo, el Tribunal Constitucional declaró que las Comunidades Autónomas no tienen competencia para ello, admitiendo que el derecho a efectiva protección de la salud puede quedar supeditado a los intereses generales, que los que el legislador estatal estima convenientes en cada momento. Finalmente, tras el RDL 7/2018, de 27 de julio, tanto los extranjeros que se encuentren residiendo legalmente en España, como los que no estén registrados ni autorizados como residentes en España tienen derecho a la protección de la salud y a la atención sanitaria en las mismas condiciones que las personas con nacionalidad española, siempre que dichas personas cumplan determinados requisitos.

Palabras clave: inmigración irregular, asistencia sanitaria, universalidad

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JUSTICIABILITY OF THE RIGHT TO HEALTH AND THE HEATH SYSTEM IN SLOVAKIA

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Abstract

The chapter provides a deeper insight into health care within the Slovak Republic, a state located in central Europe. It introduces the national health care institutions and their mutual relations, as well as the fundamental legislation. Then the contribution presents the financing of the health care and a system of health insurance. It mainly focuses on the right to health in Slovakia and on its justiciability. It uses three concrete examples (Simon Buch, Sebastian and compulsory vaccination) in order to illustrate how the justiciability of the right to health works in the country.

Keywords: Health Care, Health Insurance, Justiciability, Slovakia.

Resumen

El capítulo proporciona un análisis del sistema de salud de Eslovaquia, Europa Central. El documento describe las instituciones nacionales de salud, su interacción con otros actores y su marco normativo. Luego se presenta el sistema de financiación en el sector salud y el sistema de seguros para posteriormente centrarse principalmente en el derecho a la salud en Eslovaquia y su justiciabilidad. Utilizando tres ejemplos concretos —Simon Buch, Sebastian y la vacuna obligatoria— se ilustra cómo opera la justiciabilidad del derecho a la Salud en el país.

Palabras clave: cuidado de la salud, seguro de salud, justiciabilidad, Eslovaquia.

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PUBLIC AND PRIVATE ENFORCEMENT OF SOCIAL RIGHTS

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Abstract

The constitutions adopted in the second half of the twentieth century and the international and transnational legal sources all recognise 'social rights'. According to the Italian legal literature and jurisprudence, social rights may be not considered as real individual rights. This is because of their constitutional origin: their content seems to be 'moral' and not economically measurable, and they are expected to satisfy a public more than an individual interest. However, based on European legal sources, this paper seeks to show that such exceptions can be overcome and that social rights are genuine individual rights. As a matter of fact, social rights may be protected by the courts, particularly with the help of the instruments made available by private law.

Keywords: Social Rights; Enforcement; Italian Legal System and European Legal Framework

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Resumen

Las constituciones adoptadas en la segunda mitad del siglo XX y las fuentes legales internacionales y transnacionales reconocen "los derechos sociales". Según la literatura y la jurisprudencia italiana no pueden considerarse derechos individuales reales. Esto se debe a su origen constitucional: su contenido parece ser "moral" y no medible económicamente, y se espera que satisfagan a un público más que un interés individual. Sin embargo, según las fuentes legales europeas, este documento busca demostrar que tales excepciones pueden superarse y que los derechos sociales son derechos individuales genuinos. De hecho, los derechos pueden estar protegidos por los tribunales, en particular con la ayuda de los instrumentos puestos a disposición por el derecho privado.

Palabras clave: derecho social; ejecución; sistema judicial italiano; marco legal europeo

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THE JUSTICIABILITY OF THE RIGHT TO HEALTH IN COLOMBIA

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Abstract

Without any doubt, the indicators of the right to adequate health have improved in the last years in Colombia. However, judicialisation of the right to health has increased dramatically in the last decade in the country. The general objective of this paper is to evaluate the challenges and opportunities of the right to health in the Colombian context. Using a documentary and comparative research with the analysis of literature over the last ten years, this paper will provide some recomendations and a new strategy for the country in order to fulfil their obligations under international law.

Keywords: Justiciability, Institutional Capacity, Corruption, Health Care

Resumen

Sin lugar a dudas, los indicadores del derecho a una salud adecuada han mejorado en los últimos años en Colombia. Sin embargo, la judicialización del derecho a la salud está aumentando dramáticamente en la última década en el país. El objetivo general de este capítulo es evaluar los desafíos y oportunidades del derecho a la salud en el contexto colombiano. Utilizando una investigación documental y comparativa con el análisis de la literatura en los últimos diez años. Este documento proporcionará algunas recomendaciones y una nueva estrategia para el país con el fin de cumplir con sus obligaciones conforme al derecho internacional.

Palabras clave: justiciabilidad, capacidad institucional, corrupción, salud.

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