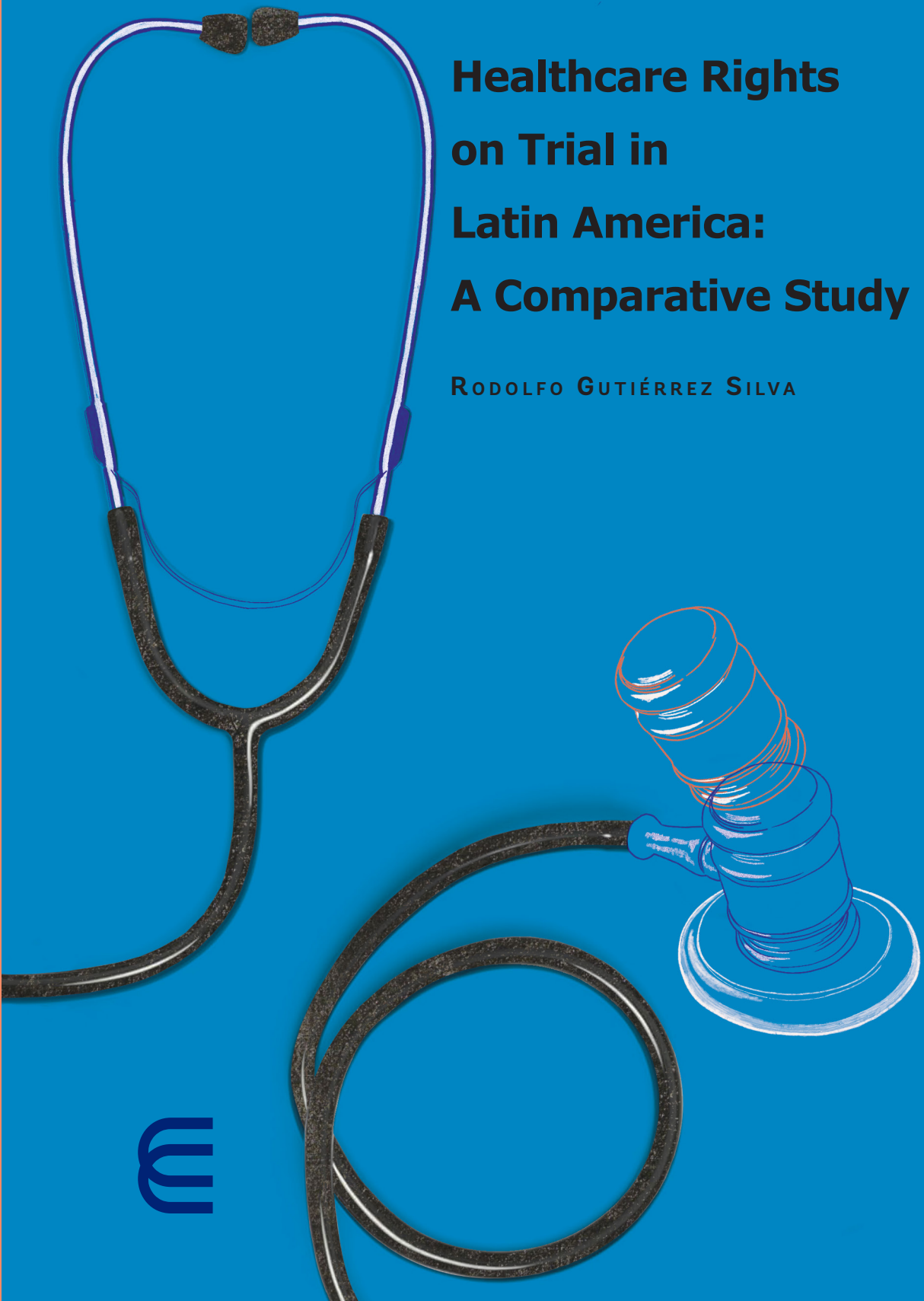
Healthcare Rights on Trial in Latin America: A Comparative Study

Rodolfo Gutiérrez Silva



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Abstract

Background: Many patients are being denied access to health services and medicines in Latin America; therefore, judges have to intervene. This trend of judicialization has accelerated during the past decade. In a similar vein, existing literature on the justiciability and judicialization of the right to health is concerned with the question of whether judges should intervene or not in the protection of the right to health. **Objective:** To evaluate the challenges arising from the litigation of the Right to Health in Colombia, Argentina, Brazil, and Mexico. **Methodology:** Qualitative, descriptive, and comparative analytical and methodological framework. It includes a literature review and 37 semi-structured interviews with judges, academics, and government officials. In addition to that, a jurisprudential analysis of the latest jurisprudence, in four countries, was carried out through content analysis. **Results:** A Moderate-Downstream approach to litigation concerned with the consequences of the judicialization process is persistent in the four countries studied. This entails, first, the incorporation of some limits and conditions in the recognition of the right to health by Courts and, second, in general terms, that judgments are not considering the structural causes affecting litigiousness. Structural causes such as corruption, pharmaceuticalization, institutional arrangements, and privatization are triggering the judicialization process. In terms of consequences, countries have also introduced new strategies, including tests, laws, policies, institutions, mechanisms, and practices. **Conclusions:** Courts should move towards intentional equilibrium in the recognition, remedies, monitoring, and evaluation of judgements. This entails being more reflexive and strategic rather than reactive and passive. In other words, the more immature the health system is, and the more structural causes are perceived, the more reflexive and strategic Courts should be, and the more recognition, protection, monitoring, and evaluation should be promoted. States should also adopt strong measures against the structural causes and must operationalize a more practical rights-based approach to health.

Keywords: Health Systems, Justiciability, Judicialization, Litigation, Medicines, Right to Health.

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Resumen

Antecedentes: A muchos pacientes se les niega el acceso a los servicios de salud y a los medicamentos en América Latina, por lo que los jueces tienen que intervenir. Esta tendencia de judicialización se ha acelerado durante la última década. En un sentido similar, la literatura existente sobre la justiciabilidad y judicialización del derecho a la salud se ocupa de la cuestión de si los jueces deben intervenir o no en la protección del derecho a la salud. **Objetivo:** Evaluar los desafíos derivados del litigio del Derecho a la Salud en Colombia, Argentina, Brasil y México. **Metodología:** Marco analítico y metodológico cualitativo, descriptivo y comparativo. Incluye una revisión bibliográfica y 37 entrevistas semiestructuradas a jueces, académicos y funcionarios gubernamentales. Además, se realizó un análisis jurisprudencial de la jurisprudencia más reciente en los 4 países mediante análisis de contenido. **Resultados:** En los cuatro países estudiados persiste un enfoque moderado orientado a las repercusiones en el litigio y, preocupado por las consecuencias del proceso de judicialización. Esto supone, en primer lugar, la incorporación de algunos límites y condiciones en el reconocimiento del derecho a la salud por parte de los Tribunales y, en segundo lugar, en términos generales, que las sentencias no están teniendo en cuenta las causas estructurales que afectan a la litigiosidad. **Conclusiones:** Los tribunales deberían avanzar hacia un equilibrio intencional en el reconocimiento, los remedios, la supervisión y la evaluación de las sentencias. Esto implica ser más reflexivos y estratégicos que reactivos y pasivos. En otras palabras, cuanto más inmaduro sea el sistema sanitario y más causas estructurales se perciban, más reflexivos y estratégicos deberían ser los Tribunales y más se debería promover el reconocimiento, la protección, la supervisión y la evaluación. Los Estados también deben adoptar medidas contundentes contra las causas estructurales y deben hacer operativo un enfoque de la salud más práctico y basado en los derechos, de manera tangible.

Palabras clave: derecho a la salud, justiciabilidad, judicialización, litigios, medicamentos, sistemas de salud.

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Sobre la portada

Decidí combinar la figura del estetoscopio con un martillo de juez para simbolizar la conexión existente entre la salud y la justicia. El estetoscopio, siendo un símbolo omnipresente en el ámbito médico, representa el derecho universal a la atención médica y la importancia vital de este servicio. Por otro lado, el martillo de juez representa la autoridad judicial y la capacidad de dictar sentencias que pueden afectar el acceso a la atención médica. Esta fusión de imágenes resalta cómo los derechos humanos en el campo de la salud pueden estar sujetos a decisiones judiciales. La combinación de estos dos objetos también refleja la complejidad y la interacción entre ambos ámbitos, al tiempo que ofrece una representación visual intrigante y evocadora para la portada del libro.

Fiorella Ferroni.

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Abbreviations

ADRES	Administrator of the Resources of the General System of Social Security in Health *Administradora de los Recursos del Sistema General de Seguridad Social en Salud*
AIDS	Acquired Immunodeficiency Syndrome
ANVISA	National Health Surveillance Agency *Agencia Nacional de Vigilancia Sanitaria*
ANS	National Agency for Private Health insurance and Plans *Agencia Nacional de Saúde Suplementar*
CONITEC	National committee for technology incorporation *Comissáo nacional de incorporação de tecnologias no sistema único de saúde*
CNJ	National Council of Justice (Brazil)
CSJN	Supreme Court of Justice of Argentina *Corte Suprema de Justicia de Argentina*
EPS	Health Promoting Entity (Colombia) *Empresa Promotora de Salud*
ESCR	Economic Social and Cultural Rights
EMA	European Medicines Agency
FDA	U.S. Food and Drug Administration
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HTAS	Health Technology Assessment Technical Advice Centers *Núcleos de Asistencia Técnica*

ICESCR	International Covenant of Economic, Social, and Cultural Rights
IMSS	Mexican Institute of Social Security *Instituto Mexicano de Seguridad Social*
IMSS-O	Mexican Institute of Social Security – Opportunities Programme
INSABI	Institute of Health for Well-being *Instituto de Salud para el bienestar*
IOMA	*Obra social* of the Province of Buenos Aires *Instituto Obra Médica asistencial*
ISSTE	Institute for Social Security and Services for State Workers
OECD	Organisation for Economic Co-operation and Development
PAMI	*Programa de Atención Médica Integral* (Comprehensive Medical Attention Program)
PEMEX	Mexican Petroleum *Petroleos Mexicanos*
PMO	Compulsory Medical Programme (Argentina) *Programa Médico Obligatorio*
PQRD	Questions, Complaints, Claims, and suggestions
RS	State of Rio Grande do Sul of Brazil
SCJN	Supreme Court of Justice of the Nation of Mexico *Suprema Corte de la Justicia de la Nación*
SEDENA	Secretariat of National Defense (Mexico) *Secretaría de Defensa Nacional*
SEMAR	Secretariat of the Navy of Mexico *Secretaría de Marina de México*

SESA	Department for State Health Services (Mexico) *Servicios Estatales de Salud*
SPSS	System of Social Protection in Health (Mexico) *Sistema de Protección Social en Salud*
SPS	Seguro Popular de Salud (Mexico) *Popular Health Insurance*
SUS	Unified Health System (Brazil) *Sistema Único de Saúde*
UDHR	Universal Declaration of Human Rights

Introduction

Introduction

Health rights litigation is increasing dramatically worldwide. This phenomenon might be understood as a reflection of the failures of the public policies of states, and particularly, it might also demonstrate a lack of fulfilment[1] of their commitments under international law. Despite some advances in indicators of wellbeing, we have not been able to fulfil this right for everyone. The organization of health care delivery[2] worldwide is currently characterized by a lack of government intervention and the introduction of unregulated market mechanisms of supply and demand, as well as complex and technical processes that include a myriad of actors and roles at the global, national, and community levels. Left unchecked, such unregulated market mechanisms in the health sector end up promoting a culture that seeks only to increase profits and reduce costs[3]. In addition, some deficiencies in the level of coordination and organizational processes of health systems, as well as structural dysfunctions such as decentralization processes in some countries, are also affecting the standards of availability, accessibility, acceptability, and quality.

Similarly, although some progress in medical research has led to the introduction of new biological drugs and treatments, it has also led to increases in the prices of some medicaments. As a result, healthcare litigation is expanding throughout the world. In the last 20 years, we have witnessed a massive increase in the use of the courts as a last resort to guarantee the right to health[4]. The claims filed in courts are related to many issues, such

1 Such a lack of fulfilment might be due to a lack of complex factors such as institutional capacity, political unwillingness, and structural dysfunctions or conditions.

2 Reid (2010), in his book, "The healing of America: A global quest for better, cheaper, and fairer health care", argues that there are different types of health systems in the world: 1) Beveridge (Cuba, England, Spain, the Nordic countries, and New Zealand). 2) National Health Insurance (Taiwan, Canada, and South Korea). 3) Bismarck (Japan, Germany, France, Belgium, Netherlands, and Switzerland) and 4) Out of Pocket (United States and some African countries).

3 For instance, according to Durham (2015), the lack of regulation has led to deplorable health indices and a highly segmented and informal healthcare system in Haiti. Similarly, in Sub-Saharan African countries, such unregulated mechanisms is leading to exclusions and lack of quality of health services (Mackintosh, 2006).

4 In the literature, Gloppen (2008) have documented that since the 1990s it has increased dramatically. In Brazil, for instance, cases during the period 2014-2019 ranged between 702 739 and 1 293 625. An average of 117 123-215 604 a year (Ferraz, 2020, p.9).

as access to medicaments and services included in the plan of health and excluded, high-cost or low-cost experimental technologies or without a registry. It might also include the request for a judicial review of health policies or the construction of infrastructure, among others. Such judicial activism might be measured according to its intensity. Thus, in some jurisdictions, such as Colombia[5], Brazil[6], Argentina,[7] and Costa Rica[8], the intensity of judicial activism might be higher, while in countries such as Chile[9], Mexico[10], and South Africa[11], it might be weaker.

To understand this complex topic, different perspectives have been adopted particularly in the field of constitutional law. This general framework has not often been applied specifically to the right to health and the intention in this book is to apply it specifically to the debate about the intervention of judges in the protection of this particular right. Generally speaking, there are two perspectives. The first perspective sustains that judges should intervene in the protection of the right to health. Transformative constitutionalism[12], for instance, believes that direct and indirect changes are possible. By using the law, society might be able to fight injustices and remove social structures of power that have the potential to

5 In Colombia, 2,419,480 tutela were filed between 2000-2021.

6 In Brazil, cases ranged between 702,739 – 1,293,625 from 2014-2019 (Ferraz, 2021, p.9).

7 Similarly in Argentina, the new legal framework as well as the economic crisis have increased litigation.

8 In Costa Rica amparos have grown to almost three quarters of its caseload in 2019.

9 A recent study suggests that in Chile litigation is increasing despite recent initiatives including a new law Ricardo Soto for high-cost diseases, a new committee for high-cost drugs in the case of cancer and a new plan of health (Aguilera, 2022).

10 In Mexico, litigation is expected to increase due to the new constitutional reforms, the COVID-19 pandemic, and a lack of medicines.

11 South Africa has very few cases when compared to other countries such as Colombia. However, some of their cases, particularly in the field of economic, social, and cultural rights, have been widely discussed in the literature. One of the most important cases is Constitutional Court of South Africa, Minister of Health et al vs. Treatment Action Campaign et al Case CCT 8/02 (2002). In this case the Court ordered that a medicine called Nevirapine be made available in all hospitals and clinics.

12 For a discussion on Transformative Constitutionalism, see the experience of South Africa: Klare (1998). Also see the international experience: von Bogdandy & Urueña (2020). And the Colombian Experience: Roa (2020).

generate systematic human rights violations. Similarly, among the primary objectives of Neo-Constitutionalism[13], is to protect social rights. This type of constitutionalism is also optimistic, believing that judges, as constitutional guardians, may be crucial in guaranteeing the protection of the right to health. Furthermore, the new Latin American constitutionalism believes that judges should interfere in the protection of the right to health precisely because the Latin American context has been" threatened by structural issues and unfavorable economic policies" (d'Avila, et al., 2020)[14]. This type of constitutionalism breaks from the Eurocentric model. Finally, deliberative constitutionalism[15] believes the role of judges should be to facilitate the protection of the right to health through the deliberative process and alliances.

On the other hand, a second perspective sustains that judges should not intervene in the protection of the right to health. For instance, the general view of popular constitutionalism[16], might suggest that judges should not have the last word in relation to the protection of the right to health, but Congress or the Government and its institutions. Indeed, the intervention of judges in the health system affects the separation of powers since judges are not experts in medicaments or physicians, it also affects financial sustainability because judges are not economists. Indeed, judges are constantly blamed for promoting judicial-left populism that affects the financial sustainability of health systems, mainly when ordering expensive treatments and medications (many of which are excluded from the official list or are experimental) since they are not professional economists or doctors. According to this position, judges do not know how to evaluate the impact of their judgments on the economy, or the type of treatment

13 For a discussion about different theories in relation to Constitutionalism movement, see: Carbonell & Jaramillo (2010).

14 For a discussion about the New Constitutionalism in Latin America see: Pastor & Dalmau (2011).

15 For a discussion about deliberative constitutionalism, see: Niembro & Ramírez-Ordas (2022).

16 The theory of Popular Constitutionalism sustains that interpreting a constitution shouldn´t be solely the task of judicial elites but should actively involve the people in constitutional matters. For instance, see Tushnet (2008). Also, according to Niembro (2013), three main strands are found within popular constitutionalism. The Founding Fathers's strand, democratic constitutionalism and mediated popular constitutionalism and among the most important authors are found the works of Mark Tushnet, Larry Kramer, Robert Post, Reva Siegel, and Barry Friedman. The key point in their theories is the limitation of judicial supremacy.

and medicine users need. Therefore, judges should abstain from ordering public institutions and providers the supply of goods and services in the health sector at the local and national levels. Judges are similarly blamed for affecting the democratic process since people may not always be able to have the final word on constitutional interpretation, instead the decision of whether to grant or not a medicament or service is taken by a group of judges who have not been elected democratically. Those who might adopt a more deliberate approach might argue that the democratic debate in relation to the right to health should be the priority rather than a judicial debate. Similarly, a perspective of Juristocracy[17] might suggest that the intervention of judges ends up only protecting the elites and this generates more inequalities. On the other hand, Classical Liberal Constitutionalism[18] might also insist that judges should not interfere in the operations of demand and supply in the market of health services, treatments, medicaments, and technologies.

The causes of litigation might be diverse. Without a doubt, the spread of HIV and constitutional reforms (Lamprea, 2017) have resulted in a massive increase in litigation. In addition to that, the lack of capacity of states to monitor and enact sanctions, technological innovations (Vargas-Peláez et al., 2019), institutional design (Reveiz et al., 2013), as well as cutbacks generated and the decentralisation process (Lamprea, 2017), have contributed to increasing these levels.

On the other hand, in general terms, for some commentators, the effect of health rights litigation has been mixed. For instance, Uprimny (2016) argues that the impact of justiciability in Colombia has had a mixed effect since, on the one hand, it has been regressive because the tutela, in the end, have benefited only the middle and upper classes. However, on the other hand, it has been positive since, through judgement T-760 of 2008 that delivered structural remedies, the Constitutional Court has promoted equality by ordering the government to unify the Mandatory Health Plan. This position is consistent with what Piza (2016) suggests, who also argues that the impact

17 For a view on Juristocracy, see Hirschl (2009).

18 For a discussion on liberal constitutionalism and the prohibition of judicial intervention on the economy see: Roa (2015).

of the judicialization of health has also been mixed since, on the one hand, it could be negative because if accessibility to the courts is increased, the health system would collapse because of a lack of financial sustainability. However, for other authors, it has had positive effects since many Costa Ricans can access health services.

In the literature, some positions consider that the justiciability process has had a regressive impact (Ferraz, 2016), particularly in Brazil, since it has benefited only the middle classes who can hire private lawyers. Patients have claimed costly medicines; therefore, the intervention of judges does not end up helping the poorest. This position differs from the results obtained by other studies, such as that carried out by Biehl et al. (2016), which defies arguments that the judicialization process increases inequities and weakens the universal health system. Judges should play a significant role as a last resort in the protection of health because we live in a world full of risks and complexities, but the government should be primarily accountable for the delivery of health. However, the lack of administration and political will might be affecting its actions. Some commentators also argue that when judges order a massive number of treatments and medicines through their judgments, it affects the efficiency of the system since no government in the world can afford the universality of services.

For a right to be considered justiciable, the existing legal regulations must recognize it as such. However, many courts have traditionally understood the right to health as non-fundamental. It is essential to mention that the debate on the justiciability of the right to health has revealed many obstacles that have not yet been overcome due to the magnitude and complexity of various variables that interact in the context of globalized change. Without a doubt many constitutions at the world level now recognize the right to health, therefore, the debate is shifting from asking whether social rights are justiciable to the analysis of the most effective forms of justiciability. Uprimny (2016) suggested that we should focus on researching and replicating the best methods of justiciability (Cervantes et al., 2014). Similarly, Rodríguez Garavito & Rodríguez Franco (2015) emphasize the value of "dialogic structural remedies"[19], which have recently shown significant promise in enhancing the protection of social rights.

19 In the literature, several authors are starting to acknowledge this. For instance, according to Gotlieb et al. (2017), judges need to use more structural remedies rather than concrete remedies.

The Justiciability of the Right to Health

In the literature, the debate about healthcare litigation has been built around different concepts such as justiciability, judicialization and judicial activism, which have many things in common[20]. Justiciability is the recognition by judges of the right in question, such as the right to health. Its concept is associated with the search for justice by the right-holders since there is a right to the highest level of health of citizens recognized in the legal structure. Indeed, Justiciability includes the possibility of citizens claiming their rights before a court through a range of legal or technical procedural instruments. In general terms, most of the claims received by courts are individual cases involving simple and concrete remedies concerning the accessibility of goods and services rather than collective cases that require courts to issue complex structural remedies that could generate a complete transformation of the entire health system in a country.

Generally speaking, such a process within the legal field is assumed to be framed within a Neo-Constitutionalist context[21] and understood as a project that aspires to become a path to achieving principles and values such as freedom and equality by extending and protecting social rights to groups that have traditionally been excluded. Neo-Constitutionalism is undoubtedly a project that seeks some level of transformation by recognizing social rights and introducing more rigid constitutions with binding force and where the judge is different from the typical judge of a traditional, civil, and private nature (Gutiérrez, 2015). The judge uses mechanisms and tools of legal interpretation[22] that allow any gap to be overcome thanks to the recognition of morals and principles, thus

20 See discussions by Barroso (2019), Vargas Peláez et al. (2019), Andía & Lamprea (2019), Cote, (2020), Borota de Oliveira & Lippi (2020), and Alves et al., (2020).

21 The Neo-Constitutionalist discourse acknowledges that after the Second World War, many constitutions started to recognise social rights. Then we might find, for instance, the Constitutions of Italy in 1947, France in 1958, Germany in 1949, Portugal in 1976, Greece in 1975, Brazil in 1988, Spain in 1978, and Colombia in 1991. It also recognizes the development of constitutional courts around the world. In this discourse, principles prevail over rules, and the Constitution is interpreted as a space where values and principles converge.

22 Among these new tools are the courts' declaration of an "Unconstitutional State of Affaire" which allows them to declare a systematic violation of human rights caused by omissions and a lack of coordination among agencies, as well as the proportionality, reasonableness, and scrutiny tests.

promoting a unique balance of powers that helps strengthen democracy. However, the discourse of Neo-Constitutionalism has been also criticized for its European orientation, which limits the possibility of applying its principles, particularly in the Latin American context[23].

Despite its recognition at the constitutional level in many countries, in practice, the right to health has traditionally been acknowledged as programmatic, subject to available resources rather than fundamental. This is also although the International Covenant on Economic, Social and Cultural Rights (ICESCR) that entered into force in 1976 impose obligations of immediate effect[24], including "the obligation to take steps" by using "the maximum of its available resources, to achieve the full realization of the rights recognized in the present Covenant by all appropriate means" (art. 2.1) and without any discrimination (art. 2.2). Importantly, by defining the duties to respect, protect, and uphold the obligations of conduct and result, as well as by defining the violations through acts of commission and acts of omission, the Maastricht Guidelines established what constitutes a violation of ESCR in 1997. The obligation to fulfil incorporates the duty to promote, facilitate, and provide. Similarly, the ESCR Committee has established 2 General Comments about the right to health[25]. The right to health is recognised in the art. 25 of the UDHR[26] and art. 12 of the International Covenant of ESCR[27], which establish that everyone has a right to enjoy "the highest attainable standard of physical and mental health". At the same time, the concept of the right to health was explained in more detail in General Comment N. 14 and involves not only medical attention but also "a wide range of socio-economic factors that promote conditions in which people can lead a healthy life and extend to the underlying determinants of health..." (Par. 4) and crucially, "a

23 It is useful to see the works of Ruben Martínez and Roberto Viciano from the University of Valencia, who advocate for a "New Latin American Constitutionalism" rather than a "Neo-Constitutionalism" and argue that the Neo-Constitutionalism discourse does not apply in Latin America because its countries are characterised by high levels of inequality, extreme poverty, colonialism, indigenous people, environmental rights, and excessive executive power.

24 Also see Par. 2 of CESCR (1991).

25 Also see CESCR (2000; 2016).

26 UN (1948).

27 UN (1976)

right to the enjoyment of a variety of facilities, goods, services, and conditions necessary for the realization of the highest attainable standard of health" (Par. 9). Importantly, consistent with the Committee, states should provide "at the very least, minimum essential levels... including primary health care" (Par. 43). Though paragraph 8 of General Comment 14 states that "the right to health is not to be understood as a right to be healthy", the interdependence of the right to health from a rights-based perspective also acknowledges the right of persons to be able to be healthy. This right is universal and includes "food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment" (Par. 4). The preamble of the Constitution of the World Health Organization (1946) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". It is also an inclusive right since it recognizes freedoms and entitlements. Healthcare services, goods, and facilities are instances of entitlements that must be provided to everyone, without exception, and that must be readily available, acceptable, and of high quality. Various Universal System conventions have also gradually acknowledged this right[28]. At the Inter-American level, it has been included in Article XI of the American Declaration of the Rights and Duties of Man (1948), art. 26 of the American Convention on Human Rights (1969) , and art. 10 of the Protocol of San Salvador (1999).

The universal system has also appointed a Special Rapporteur specializing in the right to health who undertakes research and reports to the UN about the right to health. Some positions give priority to the argument of financial sustainability or availability of resources[29,] while others have taken an approach to the protection of the right to life[30]. Thus, some commentators,

28 Articles 5 of the International Covenant on the Elimination of All Forms of Racial Discrimination, 11 and 12 of the Convention on the Elimination of All Forms of Discrimination Against Women, 25 of the Convention on the Rights of Persons with Disabilities, and 24 of the Convention on the Rights of the Child.

29 In *Soobramoney v Minister of Health, Kwazulu-Natal (CCT32/97),* the Court of South Africa did not recognise the right to health of a patient in need of dialysis, and instead gave priority to the argument of the availability of resources.

30 For instance, the Supreme Court of Chile has stated that the right to life prevails over the availability of resources. Corte Suprema, Sentencia Rol N. 17043-2018, considerando 8.

such as Perehudoff & Forman (2019), have argued that, in general, the jurisprudence of the Right to Health has moved from a focus on the essential minimum to a focus on the argument of the availability of resources. Therefore, many courts are only considering how the financial sustainability of the health system might be affected at the moment of ordering treatments or medicines rather than how the violation of the right to health might affect the right of people to have an adequate life with dignity.

Similarly, since its inception, the debate about the justiciability of the right to health has also been framed within a macro discussion about social rights. In this particular debate, the belief was that social rights were expensive to finance for governments. Therefore, such rights were not justiciable, while political and civil rights did not have a price. This debate, which involved the recognition of positive and negative obligations, was later superseded by a discussion on the recognition of this right by the courts at the state and regional levels. Thus, some constitutions did not recognize the right to health as a fundamental right but instead included the right to health as a programmatic right in a separate and fragmented chapter of ESCR. Consequently, some courts had to introduce new methods of interpretation highlighting the prioritization of the rights to life, dignity, and vital minimum[31]. Therefore, the right to health was protected only through indirect justiciability. In addition to that, courts must examine the question of the indeterminacy of rights. Back in the 1990s, the elements of the right to health were not very clear. The solution that the courts adopted was to search for a basis for their interpretation in the new jurisprudence at the international level and the new general comments and legal instruments of the Universal System.

Similarly, at the regional level, the Interamerican Court[32] had previously recognized the right to health only in connection with other rights.

31 This is the case of the Constitution of Colombia that although it did not recognize the right to health as a fundamental the Constitutional Courts recognised its justiciability by considering the connection of a fundamental right such as the right to life and the right to health. Similarly, in the case of Argentina, the Court has based its decisions on international human rights treaties the country has ratified.

32 The Interamerican Convention on Human Rights is the main legal instrument of the Interamerican System. This document is legally binding for all Latin American members. There is also a Protocol of San Salvador, but many countries still need to ratify it (OAS, 1969).

For instance, in Artavia, Murillo et al. v. Costa Rica (2012)[33] , this court declared a violation of the right to personal integrity, and family, and ordered the State to include a specific treatment in the official plan of health. However, recently, the Interamerican Court has started to recognise the justiciability of the right to health directly through art. 26 of the Interamerican Convention[34], particularly in the case of Poblete Vilches vs Chile (2018), where it declared an international responsibility of the Chilean State while acknowledging its immediate and progressive obligations. In a similar case, in Cuscul Piraval vs Guatemala (2019)[35], the Court ruled that the Guatemalan government was internationally liable for the infringement of the right to health as a result of a lack of comprehensive medical care for 49 individuals living with HIV, including the violation of the principle of progressivity.

Generally speaking, the debate on the justiciability of the right to health is part of the macro debate on the justiciability of ESCR. However, it is essential to highlight that currently, this debate has moved from a debate on the recognition of rights to a discussion on the types of remedies (monological vs. dialogic) and the best forms of justiciability, and very recently, the debate is framed within the context of the evaluation and monitoring of judgments and transformative constitutionalism. In the debate on justiciability of ESCR, we find commentators such as Gargarella (2006), Langford (2008), Gauri & Brinks (2008), and Rodríguez Garavito & Rodríguez Franco (2015), who have undoubtedly highlighted the new function of courts in defending social rights. For their part, authors such as Abramovich (2002) have highlighted different ways to claim the right to health. Among them is the direct enforceability through which the affected

33 Corte IDH. Case Artavia Murillo and others (In Vitro Fertilization) vs. Costa Rica Preliminary Exemptions, Fundo, Repairs, and Costs. Sentencia enviada el 28 de noviembre de 2012.No. 257 in Serie C.

34 "The States Parties undertake to adopt measures, both internally and through international cooperation, especially those of an economic and technical nature, with a view to achieving progressively, by legislation or other appropriate means, the full realisation of the rights implicit in the economic, social, educational, scientific, and cultural standards set forth in the Charter of the Organization of American States as amended by the Protocol of Buenos Aires".

35 Corte IDH. Case *Cuscul Pivaral y otros vs. Guatemala*. Preliminary Excepción Sentencia Interpretation, Fundo, Reparations, and Costs. Sentence dated May 14, 2019.Serie C No. 378.

right is directly invoked, and, as a result, states must recognize it and implement measures to guarantee its protection. Along the same line, they also highlight its indirect enforceability, which consists of various strategies that could be used to seek its protection, especially by defining its connection with other rights such as equality and non-discrimination, due process, civil and political rights, and other social rights. Finally, this book differs from the work of Yamin & Gloppen (2011), which also seeks to assess the consequences and causes in different countries, however, this book takes very seriously into account the behaviour of third parties, including corruption and it examines a range of structural dysfunctions that directly or indirectly affect the entire process of the justiciability of the right to health.

The Judicialization of the Right to Health and Judicial Activism

While judicialization is a process, judicial activism is an attitude of interpretation of the constitution (Barroso, 2019) intending to protect the right to health, particularly in cases where there is an omission from the legislator, the executive, or civil society in general. In general terms, the judicialization process is defined as complex and involves different dimensions. For instance, according to Vargas-Peláez et al. (2019), judicialization has two aspects: normative and social; indeed, "within the normative approach, judicialization is understood as the interference of the Judicial Power in the Executive Power, whereas within the social approach, judicialization is considered a form of citizen participation". Judicialization might also involve a "transfer of power to the judicial institutions" (Barroso, 2019, p. 113). The expression "the judicialization of health care" can be used to characterize the use of rights-based litigation to seek access to drugs and medical care (Andía & Lamprea, 2019). Judicial practice is understood here in terms not only of the capacity of courts to recognize rights but also of the type of remedy issued, the type of monitoring of the implementation of judgments, and the type of impact achieved.

Similarly, in the literature, some academics have been interpreting the concept of judicial activism as a negative action; thus, "judicial activism is a pejorative expression that denotes an apparent excess of the judge in the performance of his duties" (Cote, 2020, p. 21). This type of perception has

had negative consequences for protecting health since many cases related to the denial of medicaments or accessibility to health services have not been recognized by judges. Indeed, the concepts of "judicialization" and "judicial activism" have been traditionally interpreted in a negative and individualistic way, particularly as related mainly to the improper use of public money for health by agents who do not know how to make rational decisions.

Different studies are also keen to highlight that the government is the key responsible for the provision of health outcomes and the obligation to provide quality health services and that judges should be used as a last resort when such an institution fails. Thus, according to Borota de Oliveira & Lippi (2020, p. 246), "Judicialization and judicial activism are alternative and not mandatory means to solve public health demands because [the] judiciary is not responsible for making public health policies" Such a view might be reasonable; however, some countries are not simply prepared for the provision and delivery of services of quality, thus lacking institutional capacity. In addition to that, the delivery of public services depends on a significant level of political willingness. Another aspect that is important to consider is the restrictions and limitations imposed by governments through different structures.

Barroso (2019) asserts that judicialization and judicial activism are inextricably linked. They are members of the same family and visit the same locations, yet their origins are very different. They are not, strictly speaking, generated by the exact direct causes. In the Brazilian context, judicialization occurs as a consequence of the constitutional model chosen rather than as a result of an intentional political decision (Alves et al., 2020). Meanwhile, judicial activism is the deliberate adoption of a particular and aggressive approach to constitutional interpretation, thus extending both its meaning and reach. Judicial activism typically occurs in times of relative legislative and executive branch disengagement, of a disconnect between the political establishment and society that prevents social demands from being met effectively, or in acts that can absolve most institutions of their responsibility, as the latter relies on perpetual popular legitimacy, whereas the judiciary branch does not (Alves et al., 2020). In other words, judicial activism is often linked along with a larger and more active role for the judiciary, as well as more intervention in the domains of the other two

institutions, most notably by demanding or prohibiting government action, particularly on public issues (Alves et al., 2020).

Finally, the discussions on the elements that include the right to health seem to have no end. There have also been discussions about whether the judicialization process affects equity (Andía & Lamprea, 2019). Crucially, a challenge of the judicialization process is its limits on its transformational potential "as a tool of social transformation and social rights that remain embedded in ideological baggage even where they have been constitutionally entrenched and enforced" (Forman, 2008, p. 661). The debate on this subject has been around whether the intervention of judges through different types of remedies has been able to achieve a significant transformation and change in people's lives.

The study of the judicialization of the right to health is still developing and limited but growing (Ferraz, 2018). Because the first studies of the judicialization of health had information problems, authors such as Biehl et al. (2018) argue that some of the earlier studies "faced enormous information-gathering challenges" (p. 2). Therefore, this author proposes another way to research this subject, one that is more systematic, integrated, and cooperative in which the impact of judgments is studied more, including the causal factors and "how the new structures created in response to the judicialization have influenced the occurrence and the results" (Biehl et al., 2018, p. 5). In addition, the literature concerning this topic remains fragmented (Gutiérrez, 2019). Most of the studies remain country-based rather than multi-country or multi-disciplinary. The analysis of results provided by Scopus reveal that research on Justiciability and Judicialization has increased in the last 20 years until 2019.

However, due to the pandemic, the literature studied slowly decreased, with some studies also focusing on the intervention of courts in the context of COVID-19. Most documents are articles, and the country with the most research on this topic is Brazil. The diversity of studies differs in terms of their types of cases, namely individual vs collective, and in terms of their object of study, whether a private or public defender brought the claim or whether the claimant was trying to obtain special treatments or medicines that were already included in the official plan of health. One of the central problems evident in these studies is the lack of reflexivity on the type of

structural change that courts should undertake at the internal level, as well as the changes those public institutions should carry out to ensure that these violations won't happen again. In the last 30 years, different actors in Latin America, including academics, courts and think tanks, have attempted to elaborate different studies in relation to the guarantee of the fulfilment of the right to health through the intervention of Courts. An evaluation of the different challenges raised by the justiciability or judicialization of the right to health is missing from the literature, particularly by focusing on the structural causes that are triggering the judicialization process.

This book seeks to evaluate the challenges arising from healthcare rights litigation in Colombia, Argentina, Brazil, and Mexico. The book will result in a set of recommendations on the design and implementation of reforms that governments should undertake to fulfil their obligations under international law. More specifically, this book will attempt to identify the causes of the litigation of the right to health in the countries studied; second, it will attempt to establish the consequences of litigation related to healthcare rights; and finally, it will describe the reforms that states must undertake to improve social policies and health indicators, thereby promoting more equitable and socially sustainable development outcomes.

Methodological Framework of this Book

The methodology of this research is mainly qualitative, descriptive, and comparative. The researcher carried out a literature review of this topic, including an analysis of the latest jurisprudence in the four countries studied. Around 307 documents were reviewed. It is important to mention that the literature review did not evaluate claims related to the judicialization process of issues such as abortion or responsibility for medical liability due to negligence or errors or demands associated directly with the collective dimension of the right to health that recognizes the interdependence of this right with other ones such as the environment.

In order to analyze the argument that judges have been forced to intervene in the business of governments or politics, more concretely in the protection of the right to health because states are not acting out their obligations of fulfilment, it was imperative, first, to evaluate the extent to which the countries studied are indeed complying with their legal and political

commitments through adequate, reasonable, and proportional measures that meet specific standards and principles. Only after identifying the level of fulfilment and guarantee of rights protection in each country was this research able to isolate different factors that could also be potentially contributing to the phenomenon of rising judicialization in these specific countries and examine its consequences. Indeed, the root of the problem is that it might be argued that judges could be carrying out their duties as guardians of the constitution; however, it is necessary to understand why public authorities are failing to comply with their obligations and what would be the strategies to guarantee the protection of the right to health.

The Jurisprudential analysis was carried out by assigning two general categories. The first category was applied to generate a brief description of the case. In contrast, the second category was created to highlight some critical elements that the Court considered. Recent judgements were analyzed in the four countries concerning different issues through a process of identification, screening, and categorization. In the case of Colombia, 15 recent decisions issued by the Constitutional Court of Colombia were characterized into four main categories: 1) Medicines without registration from the National Food and Drug surveillance (Invima), 2) Treatments not incorporated into the health system. 3) Availability, Accessibility, and continuity of health services; and 4) Vulnerable groups. In addition to that, Judgement T-760/08, which is the main structural judgement in the health sector, was analyzed in relation to the fulfilment of its 16 orders. In the case of Argentina, 13 recent rulings issued by courts at different levels were characterized into four categories: 1) Experimental, 2) Treatments not incorporated into the health system, 3) Availability, Accessibility, and continuity of Services and 4) Vulnerable groups. Ten recent judgements were analyzed for the case of Brazil and were characterized into five categories: 1) Joint liability, 2) Legitimacy, 3) Public Health, 4) Treatments not incorporated into the health system, and 5) Vulnerable people. In addition, extraordinary appeals 657.718/2019 and 566.471/2020 were analyzed. Most of these judgements were selected because of their general repercussion at the federal level. Finally, in the case of Mexico, seven judgements from the SCJN were characterized into four main groups: 1) Public health, 2) Treatments and medicaments not incorporated into the health system,

3) Availability, Accessibility and Continuity of health services, and 4) Vulnerable groups.

In addition, 37 semi-structured interviews were carried out with judges, academics, and government officials. Indeed, the causes of the differences in the justiciability and judicialization of the Right to health and its consequences were analyzed in the four countries studied based on the data obtained from the semi-structured interviews. Semi-structured interviews with significant players within the health, academic, and judicial sectors were undertaken, and they included state officials in charge of health policy, magistrates, and officials of the courts involved in the cases, as well as academic researchers at universities.

Concerned about the alarming increase in individual litigation, this project seeks not only to contribute to the goal that states have of ensuring the progressivity of this right sustainably and equitably, trying to assist those in society who are most economically marginalized but also to allow an analysis of how much this justiciability may be affecting the budgets of the States in the health sector. This research is important because there is an imperative need[36] to continue evaluating and monitoring the consequences of health litigation, as this will contribute to strengthening the public policies of the states regarding health. There is currently a gap in comparative justiciability studies in the field of health because perhaps it is a topic that many researchers prefer not to discuss due to its complexities derived from the need to apply multiple frameworks such as law, sociology, social policy, health policy, medicine, among others. Therefore, any study that might analyze this phenomenon from a different perspective will undoubtedly make a substantial contribution to finding solutions to this problem. This study is relevant and urgent since the number of people being denied access to health care is very high and is growing excessively. Solutions to problems of this magnitude and complexity are needed. Healthcare litigation is increasing, and if this phenomenon is not studied, states will be unable to fulfil their international obligations at the international level, and a culture of denial of services and a higher level of debt will be sponsored.

36 Indeed, the debate now is also taking place at the regional level. For instance, one of the objectives of the forum of fair prices organized by the WHO in 2021 was to analyze the causes and its effects in the health systems (Bracamonte & Cassineiro, 2021).

Finally, advances in the justiciability of the right to health will substantially affect state public policies, so this project intends to make a significant contribution to institutional reforms, which will guarantee the quality of care and accessibility of many people's rights.

In general terms, four countries were carefully selected, three of them because of the high level of judicialization in the last 20 years: Brazil, Colombia, and Argentina. These countries have been giving precedence to recognizing the right to life when attempting to protect the right to health. On the other hand, an additional country, Mexico, was also chosen since it expects a high level of judicialization due to recent constitutional reforms. There is also an imperative need to improve the decisions issued by judges. Therefore, this study will contribute a lot to the different strategies the judicial sector might undertake to avoid future increases in litigation.

The situation in Colombia is very complex. The health system of this country was once classified as one of the best in the world[37]. However, in practice and since its inception, the system has always faced many challenges, particularly concerning lack of accessibility, high levels of debt, and corruption. As a result, the number of claims peaked back in 2008 (142 000 tutela). Despite having adopted three macro reforms[38] and the intervention of the Constitutional Court in 2008 by ordering 16 structural remedies through judgement 760/2008, however, such high levels have not only haven't decreased but also a large number of complaints are being canalized through other channels, such as through the administrative mechanism of the Superintendence of Health, which from 1st July 2021 to 31st March 2022 received around 1 796 096 PQRD from users. Around 312 045 were related to delays and lack of opportunity for medical appointments, particularly with specialists (Supersalud, 2022). This shortage of specialists is evident in the statistics. Indicators from the World Bank (n.d.) suggest that the quantity of specialist surgical personnel (per 100 000 population) in Colombia, Brazil, and Argentina is very low, with 23, 55, and 50, respectively. In 2019, the Superintendence of Health in Colombia

37 According to the WHO, Colombia is ranked 22nd among the best health systems in the world (Tandon et al., 2000)

38 Law 1122 of 2007, Law 1438 of 2011, and Law 1751 of 2015.

mentioned that it has had to issue 269 sanctions against health-promoting entities and providers. These fines amount to 600 billion Colombian pesos. To reorganize the health system, the Superintendence of health has been liquidating the worst health-promoting entities[39] and transferring health users to other providers. Some providers have been barred from delivering services and operations in some departments[40].

Colombia has considerable challenges in reducing the judicialization process, mainly by not allowing some health-promoting entities, such as Medimás, to operate in the country. This case is evidence of how corruption affected the health system. In Colombia, the health-promoting entity "Medimás" was one of the worst performers, with more than 4024 incidents of contempt of court decisions (El Espectador, 2019), and was liquidated in 2022. President Gustavo Petro won the elections in 2022 and has promised to transform the health system by eliminating the Health Promoting Entities. A new law to improve the health system is expected in 2023. This new law is seeking to transform the role of Health Promoting entities while focusing more on the primary attention of health. Indeed, the government of President Gustavo Petro is seeking structural reforms including that public health resources be administered by the State, the consolidation of a special labor regime for health care workers, a new public online information system as well a strong focus on primary attention and social determinants of health.

According to the World Bank (2019), in Brazil, between 2003 and 2014, more than twenty-nine million people left poverty. Brazil is a federation composed of 5570 municipalities, 26 states, and a federal district. The right to health is included in the Constitution of 1988 (art. 196) and has been regulated by Law 8080, which requires the state to provide access to treatments and medications. In 1930, a system of health care with a public and private sector was established. The system is perceived as having hospitals without enough available staff and, in general, overcrowded hospitals

39 In 2019, the Health Promoting Entities "*Comfacor*", "*EndiSalud*" and "*Cruz Blanca*" were liquidated, leaving a total of 1.3 million users assigned to other health promoting entities.

40 The health-promoting entity "Medimás" was prohibited from operating in the departments of Chocó, Sucre, and Cesar, while "Coomeva" was prohibited from operating in Cundinamarca, Meta, and Causa, and "Comparta" was prohibited from operating in Cundinamarca, Bolívar, and Huila.

that do not offer enough hope to patients. The high level of bureaucracy also affects accessibility and opportunities in the delivery of services. This has initiated a massive increase in health litigation in recent years, with patients trying to access mainly medicines. According to the World Bank (n.d.), Brazil increased its current health expenditure per capita from US $313 in the year 2000 to US $1017 in 2014. This means that the increase occurred during the governments of ex-presidents Lula and Dilma Rouseff. To put it into context, ex-president Lula was released from prison after being in jail for 580 days, while Dilma Rousseff was impeached and removed from office in 2016. The government of President Jair Bolsonaro was considered a populist, favoring right-wing supporters and carried out reforms through cuts and other measures in different sectors, including health. Therefore, the situation has worsened since 2018, and more than 8300 Cuban doctors left Brazil after Bolsonaro was in power.

In contrast, and at the national level in Rio de Janeiro, an economic crisis is generating a high level of debt, thus affecting the delivery of public services and mainly the payment of doctors and hospitals, leaving many patients without access to medicines and treatments. President Luis Ignacio Lula won the elections in October 2022 by promising citizens to improve the welfare of Brazilians. Indicators are getting worse. According to statistics from the World Bank (n.d.), in 2017, 1700 women died from pregnancy-related causes in Brazil, 290 in Argentina, 610 in Colombia, and 740 in Mexico. The health system in Brazil is also currently affected by constitutional amendment 95/2016[41] in the allocation of resources and the realization of the right to health, which will trigger more litigation (Paula, Silva, & Bittar, 2019). Because the constitution of 1988 recognized the right to health as a fundamental right, this has led to a massive number of claims in the country involving claims of medicines and treatments in a country where there are many injustices and inequalities. Very recently, in the case of *State of Paraná v. Office of the Paraná State Prosecutor,* the Court highlighted that "health is an inalienable constitutional right, guaranteed through the implementation of public policies, imposing on the state the obligation to create objective conditions that allow effective access to such service" (De Lazari & Dias, 2019, para. 3).

41 For the next 20 years, Brazil's government will be limited in its spending.

High levels of crime, drug cartels, corruption, and poverty are affecting Mexico. Mexico is also a federal state, composed of 31 states and one federal capital. The country included the right to health in 1983. However, it was not considered justiciable; therefore, human rights were not entrenched in the Constitution until 2011, when it underwent a major revision and reforms to the Amparo trial were introduced. Such constitutional reform has ensured that all Mexican citizens may enjoy all human rights recognized in the constitution and especially in international instruments that the country has ratified. The reform also introduced several provisions that highlight different obligations. For instance, the Mexican State must "promote, respect, protect, and guarantee human rights, following the principles of universality, interdependence, indivisibility, and progressiveness". Under the law, the state is obligated to prevent, investigate, prosecute, and remedy violations of human rights. Mexico also introduced the principle of "*Pro Homine*" or "*Pro Persona,*" establishing that all authorities must apply the law or the interpretation most favorable to the person.

Significantly, and to reduce breaches in inequality in health, the country created a national commission of social protection in health known as "Popular Insurance" or "Seguro Popular". However, President Andrés Manuel López Obrador's administration replaced the "Seguro Popular" with INSABI in 2019 and 2020, and due to different problems in April 2023INSABI was replaced by IMSS-Bienestar. The country continues to have problems with inequities, accessibility, and corruption. The recognition of this right by the courts in Mexico has been deficient. For different reasons, judges have resisted recognizing this right in their jurisprudence. Although judicialization is still very low (Jiménez, 2019), health litigation is growing due to constitutional reforms. As reported by the World Bank, in 2019, Mexico's current health spending (per cent of GDP) was extremely low (5.43), while Argentina was at 9.51, Brazil was at 9.59, and Colombia was at 7.71.

Argentina is a federal state with a national constitution and twenty-four constitutions[42]. The country has reformed the constitution several times. However, it has not been able to recognize the right to health directly. In 1994, Argentina undertook a reform that did not change the main characteristics of

42 23 provincial constitutions and the Buenos Aires Constitution

the 1853 Constitution, but it introduced some reforms that had some effects on the accessibility of this right in the country, particularly, including some precepts associated with the right to health and the protection of consumers or users of health services, as well as giving constitutional status to some norms at the worldwide level that recognize the right to health. Such recognition is established in Art. 75, Subsection 22, which states:

> The following [international instruments], under the conditions under which they are in force, stand on the same level as the Constitution, [but] do not repeal any article in the First Part of this Constitution, and must be understood as complementary to the rights and guarantees recognised therein.

The right to health is recognized indirectly by the Constitution of Argentina, which granted constitutional hierarchy to various norms of international law to recognize the right to health. Such recognition also implies the obligation of the state to adopt a rights-based approach to the delivery of goods and services in this sector to fulfil the principles and values of human rights. Simultaneously, it has been integrated into other articles, such as 42, that recognize the guarantee of consumers' right to health[43].

The main arguments that this book intends to develop is that the main challenges raised by the litigation of the Right to health are: 1) Courts should move towards intentional equilibrium in the recognition, remedies, monitoring, and evaluation of judgements. This entails being more reflexive and strategic rather than reactive and passive. In other words, the more immature the health system is, and the more structural causes are perceived, the more reflexive and strategic Courts should be, and the more recognition, protection, monitoring, and evaluation should be promoted. 2) States should also adopt strong measures against the structural causes that trigger the litigation process such as Corruption, Pharmaceuticalization, Institutional arrangements, and Privatization and 3) States must operationalize a more practical rights-based approach to health by focusing on the right holder.

43 "Consumers and users of goods and services have the right, in the consumer relationship, to the protection of their health, safety, and economic interests; to adequate and truthful information; to freedom of choice; and to conditions of equitable and dignified treatment."

Therefore, the structure of this book is as follows: the first chapter starts by delineating the contextual framework and theoretical overview in relation to the intervention of judges in the protection of the right to health. By exploring some experiences, cases, and approaches of different courts around the world in relation to solving health-related cases the chapter starts by acknowledging that such judicial intervention is taking place in a context of imbalances and new risks that is distorting the legal, political, economic, democratic, and environmental fields which have been created through emergent processes of absorption and fragmentation within a morphogenetic tissue. The cases presented reveal how judges have been reacting in different jurisdictions. Since in each society the type of intervention of the judiciary is different, therefore it is necessary to build a robust typology with the different types of intervention by judges. Therefore, the chapter presents a typology that attempts to map the different types of judicialization. Similarly, the chapter provides a general analysis of the causes and consequences triggering the intervention of judges in the protection of the right to health, as well as provides a thorough examination of the judicialization of health from different perspectives. Perspective type A argues that judges should intervene in the protection of the right to health, while perspective type B holds the opposite view. Each perspective is supported by different theoretical frameworks. The chapter then continues by exploring different aspects in relation to the recognition of the right to health and the type of remedies. Various scholars' perspectives are examined including the importance of dialogic remedies that involve a deliberative process. Another crucial aspect discussed is the monitoring and supervision of the implementation of judgements. Different monitoring mechanisms employed by courts, such as public hearings, and special monitoring rooms are also examined. Finally, the chapter, addresses the evaluation of the impact of judgements, the neorealist and constructive perspective are presented by emphasizing the direct, indirect, symbolic, or material effects of Socio-economic rights litigation proposed by Rodríguez Garavito (2010).

Then, Chapter 2 introduces the four case studies, namely, Colombia, México, Argentina, and Brazil by providing an overview of the health system of each country and the state of health as well as an examination of

their commitments and obligations. Each case study also includes an analysis of the judicialization process of each country by evaluating at the same time its causes and consequences. The section on Colombia provides an in-depth examination of the judicialization process of the right to health in Colombia and its effects. Without any doubt the health system of Colombia presents many persistent challenges not only in relation to institutional barriers, accessibility issues and a serious problem of corruption, but also in relation to institutional arrangements and pharmaceuticalization. It highlights how the intervention of judges has evolved considering recent legal developments including the project reform of 2023. Perhaps, one of the main arguments is that despite the many barriers including geographical access, the intervention of judges has been crucial in protecting the right to health. However, such intervention is taking place in a context that include a health system that faces corruption. Such intervention is leading to positive and negative effects. On the one hand, it has contributed to different crucial reforms such as the reform of 2015 through law 1751 that formally recognized the right to health as a fundamental right. This reform was also a response to Judgement T-760 of 2008. On the other hand, many patients continue facing denial of access to health services. The rise in healthcare litigation is also leading to abuses as well as judicial congestion.

The section on Argentina examines how the intervention of judges in the protection of the right to health has evolved in Argentina, starting from cases related to access to cancer treatments, and growing into a more systemic issue. Amparos have been filed against *Obras Sociales* or private providers known as *"prepagas"* due to their denial of services not recognized by the Basic Plan of Health (PMO). The Courts, considering evidence of medical prescriptions and the financial capacity of the patient, often grant coverage. Healthcare litigation in Argentina has been driven by many factors including a lack of supervision, and fragmentation in the health system, prompting demands for access to new technologies and drugs. A lack of a strong pharmaceutical policy, and crucially, the clear absence of a health technology evaluation agency, as well as inequities in health services are perceived as causes of the litigation process. Without any doubt, the economic crisis that faced the country as well as the COVID-19 pandemic has exacerbated these issues.

Author Profile

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The judicialization of the right to health in Latin America has increased, but a moderate approach persists in Colombia, Argentina, Brazil, and Mexico. This qualitative and comparative study reveals that judicial rulings do not address the underlying structural causes. Therefore, courts are urged to balance the recognition and remedies of the right to health, considering structural causes and promoting more reflective and strategic approaches. Additionally, states must address underlying causes and adopt rights-based measures to improve access to healthcare.

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