The Right to Health in the Courts of Brazil: still worsening health inequities?

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Abstract: The Brazilian constitution of 1988, adopted three years after the end of the military dictatorship (1964-1985) is generous in the recognition of human rights, both of the civil and political and the social and economic kinds (arts. 5 to 15). It has also strengthened significantly the powers of the judicial branch, including in the chapter of fundamental rights and guarantees that "no law can exclude from the consideration of the Judiciary a violation or a threat to a right" (art. 5, XXXV), specifying a series of remedies for the protection of rights and collective interests (habeas corpus, LXVII; writ of mandamus, LXIX; actio popularis, LXXIII) and guaranteeing legal aid for those incapable of affording litigation (LXXIV). In the specific field of social and economic rights, although the instruments of litigation have been available since at least the 1988 constitution, the prevalent jurisprudence considered these rights as "programmatic norms", i.e. not amenable to direct judicial enforcement, for about a decade. This more deferential approach was however gradually replaced by a more assertive one that finally consolidated into the view that social and economic rights, as constitutional norms, are just as enforceable as civil and political ones. This led to a growth in litigation in the fields of health and education, and to a lesser extent in other rights such as housing (included only in a 2000 amendment) and the minimum wage. In the field of health, one can talk of a real explosion of litigation where claimants sought through the judiciary, by and large successfully, the provision of a wide range of medical treatments and goods, that came to be known as the "judicialization of health". Many celebrate the judicialization of health in Brazil as a transformative tool in the service of the vulnerable. However, this is unfortunately not what the few empirical academic studies carried out so far allow us to conclude. As I tried to show in a study published in 2009 with the title “The Right to Health in the Courts of Brazil: worsening health inequities?”, the then existing data on right to health litigation indicated that the Brazilian case was problematic from the perspectives of both equity and administrative disruption. In this article I review those conclusions in light of new studies that have emerged since, in particular one on the state of Rio Grande do Sul that claims to challenge most of the conclusions I and others arrived at in our work. My conclusion is that, unfortunately, there is no reason yet to dismiss the concerns about the negative effects of the judicialization of health in Brazil.
1. Introduction

“Brazil is not a poor country, but a country with a lot of poor.”¹ This statement was made in an article published in the year 2.000 by three leading researchers of inequality in Brazil. Their main aim was to show that as well as to focus on economic development, Brazil would need to implement redistributive policies if it was to succeed in reducing poverty significantly and sustainably. At that juncture, poverty remained stubbornly high above 30% of the population, affecting some 50 million people, and kept going up and down in the preceding two decades, fluctuating between 28% and 45% depending on the state of the economy.² Given that, as they also showed in the article, Brazil was not a poor country, there was plenty of scope to add redistribution to economic growth as a way of bringing poverty down to acceptable levels.

Move forward to 2013 (just before the economic crisis hit hard), and the situation had significantly improved. Poverty was down to 9% of the population,³ and it is undisputed that this has been achieved not only by economic growth but also redistributive policies adopted since the early 2000s, in particular the recurrent rises of the legal minimum wage above inflation and other progressive social policies funded by taxation, in particular conditional cash transfers (Programa Bolsa Familia) and non-conditional ones received by those unable to work due to disability or old age (Beneficio de Prestacao Continuada - “BCP”).⁴

There is undoubtedly a lot to celebrate, and the electoral success of the Brazilian Workers Party (PT) in 4 consecutive elections solidly grounded on the vote

² Idem. The actual figures were: 39,6% in 1977; reaching the highest point of 51% in 1983; going down to 28,2% in 1986; going up again to 45,3% in 1988 and then falling to 33,9 in 1995 and further to 33% in 1998 (50 million people).
³ 9,6% if one takes the World Bank US$3,30 threshold, or 8,9% if one takes the lower national threshold. http://data.worldbank.org/indicator/SI.POV.NAHC/countries/BR?display=graph
⁴ This has been, of course, a trend in all of South America since the 2000. http://www.theguardian.com/news/datablog/2015/mar/27/income-inequality-rising-falling-worlds-richest-poorest
of the poorest in society (brought to an end by a controversial impeachment process)\(^5\), is evidence that these policies have indeed benefited the needy. It is however important to put this improvement in perspective to see the remaining difficulties and perils of retrogression that undoubtedly exist. Brazil is still way behind in its constitutional promises of social improvement, which started as far back as the 1930s and culminated with the current 1988 comprehensive constitutional social protection system. Even in terms of poverty the absolute numbers are still staggering, at around 20 million people in 2014, and projected to get worse if the economic crisis persists, as it seems likely to be the case.\(^6\) As regards inequality, despite celebrated decreases in the past couple of decades, the base was so high that Brazil remains one of the most unequal countries in the world, with a Gini of 51.5, lower only than a handful of countries, such as Botswana (60.5), The Central African Republic (56.2) and Colombia (53.5).\(^7\) Moreover, some begin to question if the decrease was real or artificially generated by incomplete data.\(^8\)

Furthermore, the strong and celebrated focus placed on so-called targeted anti-poverty policies in the recent decades has not been accompanied by an equal enthusiasm for the universal ones promised in the constitution, such as education and health services, where, arguably, the real transformative impact resides. As starkly put by Lena Lavinias in an insightful article on what she calls “21st Century Welfare” in Latin America:

“The dynamic of privatization has been boosted, and the concept of universality in social provision undermined. A third of the adult Brazilian population believes that public services should be limited to the destitute, and therefore narrowed in scope and quality; although a large majority—75 per cent—supports some

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\(^6\) https://nacoesunidas.org/numero-de-pobres-no-brasil-teca-aumento-de-no-minimo-25-milhoes-em-2017-aponta-banco-mundial/

\(^7\) http://hdr.undp.org/en/indicators/67106 The other countries with higher inequality than Brazil are Haiti (60.8), Namibia (61), Lesotho (54.2), Paraguay (51.7), Zambia (55.6) and South Africa (63.4).

\(^8\) Marcelo Medeiros, Pedro Souza e Fabio Castro. “The Upper Tip of Income Distribution in Brazil: First Estimates with Income Data and a Comparison with Household Surveys (2006-2012)”, DADOS – Revista de Ciências Sociais, Rio de Janeiro, vol. 58, no 1, 2015, pp. 7 a 36, claiming, based on the first estimate of the concentration of income among the richest in Brazil calculated based on income tax return statements rather than household surveys that tend to sub-estimate the income of the richest that “…income data reveals concentration at the top that is substantially greater than other sources and, in general terms, remained stable in the period analyzed.”
redistribution in favour of the poor, they do so only if it is tied to conditionality
and controls, with non-compliance bringing loss of benefits. The link between
social provision and selectivity has become strong, as the idea of universal
rights to decommodified public services wanes.”

The frustration (bordering on irony), at least for socially minded lawyers, is that
the flagship, widely celebrated anti-poverty social policy of the past decades and the
one that no political party of whatever hue now dares to discontinue, the Bolsa Familia,
necessary but insufficient, is not even among the social rights recognized in the
generous 1988 constitution. One has the awkward, somewhat paradoxical situation,
thus, of not being able to resort to the constitution in the event of an attempt by a
conservative government to scrap it, but also not needing to do it (as such event
seems politically unlikely now), whereas, as regards all other social, universal rights
guaranteed by the constitution, although that legal avenue remains wide open (for how
long though?), and extremely necessary given the neglect of those rights, it is
seemingly ineffective, when not pernicious, as we shall see below as regards the
social right to health.

It is within such context that we ought to insert any discussion of the impact of
social rights litigation in the actual enjoyment of social rights by the population in Brazil.
A context of diminishing but persistent poverty, diminishing but stubbornly high
inequality, and a recent history of much greater enthusiasm for targeted as opposed
to universal social policies.

In this paper I focus on the field of right to health litigation as, in the past couple
of decades, it has achieved significant proportions in terms of both volume and
budgetary impact, as well as given rise to a fierce and polarized debate between what
we could call a pro and an anti judicialization camp. So far I have tended to side with
the anti judicialization group, not due to a principled objection to the involvement of
judges with social policies10, but rather due to the negative empirical effects (actual

9 Lena Lavinas, 21st Century Welfare, The New Left Review, 84, Dec 2013,
10 For a longer discussion of my view on this see Octavio Ferraz, “Harming the Poor through Social Rights Litigation”, Texas Law Review, Issue 7 of Volume 89, 2011
and potential) I perceive analyzing the available, albeit incomplete and fragmented data on the issue. From the studies so far conducted I think there is enough evidence to make one “jurisketical” (to use Gauri and Brinks terminology)\textsuperscript{11}, i.e. at least very cautious of hailing judicialization as an unquestionably benign practice with no negative consequences to worry about. If the data changed, however, I would be more than happy to also change my opinion, in genuine Keynesian fashion.\textsuperscript{12} Despite being currently sceptical in the Brazilian case, I am not sceptical in general of the potential transformative effect of litigation when the conditions are propitious.\textsuperscript{13}

The article proceeds as follows. It starts with a brief history of the judicialization of health under the current 1988 constitution (section III). With that in place, the paper moves on to analyse the available data on the impact of litigation in the actual enjoyment of the right to health by the population and what conclusions, even if tentative, can be drawn from that data (section IV). The overall conclusion is that much more data than we currently have would be needed to enable us to go beyond tentative assertions yet, with the currently available data, no major departure from the jurisketical stance is warranted. Section V concludes by indicating what is missing in the data and in the analytical framework currently available for a more robust conclusion to be reached on the vexed question of the transformative impact of right to health litigation in Brazil and sketching a model of what ought to be regarded progressive judicialization.

2. A Brief history of the Judicialization of Health in Brazil (volume, costs and equity)


\textsuperscript{12} As the anecdote goes, John Maynard Keynes is supposedly said: “When the facts change, I change my mind. What do you do, sir?”. A variation was actually said by another famous economist, Nobel Laureate Paul Samuelson: “When my information changes, I alter my conclusions.” See John Kay, FT 4.8.2915, “Keynes was half right about the facts” https://www.ft.com/content/96a620a8-3a8d-11e5-bbd1-b37bc06f590c?mhq5j=e1

\textsuperscript{13} For important classic studies that delved into the analysis of these conditions see Charles Epp, The Rights Revolution, University of Chicago Press, 1998 and Stuart Scheingold, The Politics of Rights, University of Michigan Press, 1984.
The Brazilian constitution of 1988, adopted three years after the end of the military dictatorship (1964-1985) is generous in the recognition of human rights, both of the civil and political and the social and economic kinds (arts. 5 to 15). It has also strengthened significantly the powers of the judicial branch, including in the chapter of fundamental rights and guarantees that "no law can exclude from the consideration of the Judiciary a violation or a threat to a right" (art. 5, XXXV), specifying a series of remedies for the protection of rights and collective interests (habeas corpus, LXVIII; writ of mandamus, LXIX; actio popularis, LXXIII) and guaranteeing legal aid for those incapable of affording litigation (LXXIV). In the specific field of social and economic rights, although the instruments of litigation have been available since at least the 1988 constitution, the prevalent jurisprudence considered these rights as "programmatic norms", i.e. not amenable to direct judicial enforcement, for about a decade. This more deferential approach was however gradually replaced by a more assertive one that finally consolidated into the view that social and economic rights, as constitutional norms, are just as enforceable as civil and political ones. This led to a growth in litigation in the fields of health and education, and to a lesser extent in other rights such as housing (included only in a 2000 amendment) and the minimum wage. The relevant articles are article 6 and, in the specific field of health, articles 196 to 200.

**article 6.** Education, health, food, work, housing, leisure, security, social security, protection of motherhood and childhood, and assistance to the destitute are social rights, as set forth by this Constitution.

**article 196.** Health is a right of all and a duty of the state and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and egalitarian access to actions and services for its promotion, protection and recovery.\(^{14}\)

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\(^{14}\) My direct translation from the Portuguese: “Art. 196. A saúde é direito de todos e dever do Estado, garantido mediante políticas sociais e econômicas que visem à redução do risco de doença e de outros agravos e ao acesso universal e igualitário às ações e serviços para sua promoção, proteção e recuperação.”
In the field of health, one can talk of a real explosion of litigation where claimants sought through the judiciary, by and large successfully, the provision of a wide range of medical treatments and goods, that came to be known as the "judicialization of health". But it is extremely difficult to put together a comprehensive picture of the judicialization of health in Brazil. This is due not only to the lack of comprehensive and reliable data that often plagues empirical studies in general, but also to the complex and fragmented nature of the Brazilian public health system. The duty to provide health actions and services is held concomitantly by the Federal Union, the 27 state units and the more than 5,550 municipalities. A truly comprehensive study would need to cover lawsuits against all of them. No such study has been carried out so far. One needs therefore to rely on the fragmented data available from partial studies conducted in different states and municipalities.

In a study I carried out in 2009 and 2010 for a project coordinated by Harvard Public Health School and the Christen Michelsen Institute in Bergen, Norway ("Harvard-Bergen study" from now on), information provided by the Federal Ministry of Health showed that the Federal Union had responded to 5,323 lawsuits between 2003 and 2009, resulting in an expenditure of R$159.03 million (US$80 million). More recent data publicised by the same Ministry displays a rise of 25% from 2009 to 2012 (10,498 to 13,051). In the Harvard-Bergen study, information from the São Paulo State revealed an expenditure of R$400 million (US$200 million) 2008, Rio Grande do Sul, R$78 million (US$39 million), and Minas Gerais another R$40 million (US$20 million) in 2008. In terms of volume of litigation, information from Rio de Janeiro revealed 2,245 cases in 2006, up from 1,144 in 2002; Rio Grande do Sul (1,846 cases in 2002 and 7,970 in 2007); Santa Catarina (24 in 2002 to 2,511 in 2007); the Federal District - Brasilia (281 in 2003 to 682 in 2007) and the state of São Paulo (4,123 lawsuits in 2006 alone). On the aggregate number of patients receiving treatment through judicial orders, there was data on São Paulo (25,000 in 2009), and Rio Grande do Sul (20,527 in in 2008).

As regards the municipal level, an electronic survey was conducted with municipal secretariats of health between November 2009 and March 2010, sent to all then 5,566 Brazilian municipalities asking whether the judicialization of health was an important issue in that municipality and, if so, requesting data on the volume and costs of health litigation. Responses were received from 1,337 municipalities (24% of the total). Of these, 34% said that the judicialization of health was growing and was an important issue; 23% responded that it was growing but was not yet an important issue; and 43% stated that they did not have that problem. 624 municipalities reported on the number of individuals currently receiving treatment through judicial orders. The aggregate total was 44,708 (an average of 71.64 per respondent municipality), and the total volume of lawsuits stood at 12,766 in 2007, 15,735 in 2008, and 14,560 in the first six months of 2009. Costs also grew from R$47 million (US$24 million) in 2007 to R$73 million (US$37 million) in 2008, and had already reached R$57 million in the first six months of 2009. In addition, most of the claims were for medication, confirming the same trend found at the federal and state levels.

These data collected in 2009-2010, even if incomplete and fragmented, also gave some credence to an argument often raised by public health professionals and health administrators that the Brazilian model of right to health litigation had important problems in terms of rational and equitable expenditure of resources. As the available data showed:

"... the vast majority of right-to-health cases in Brazil to date have been filed by individual claimants and have concerned the provision of curative medical treatment (mostly medicines) which can be enjoyed individually. As to the outcome of litigation, the Brazilian model is characterized by an extremely high success rate for claimants. ... most Brazilian judges and courts, including the STF, see the right to health as an individual entitlement to the satisfaction of all one’s health needs with the most advanced treatment available, irrespective of costs."\(^{16}\)

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The available data also showed "a strong positive correlation between high socioeconomic status and volume of claims". The most striking finding emerged from the lawsuits against the Federal Union, where ten states with the highest HDI (above 0.8) together generated 93.3% of lawsuits (4,013), whereas the other seventeen states with the lowest HDI (below 0.8) together originated a meagre 6.7% of lawsuits (330).\footnote{It is important to note that this strong correlation remains when we adjust for population size. The country’s average, based on the lawsuits in the database of the SCTIE-MS, is one lawsuit against the federal government for every 42,364 inhabitants. But there is huge variation when one disaggregates that number by region. The northeast, the poorest region of Brazil, has a very low ratio of lawsuits to inhabitants (1/177,704)—over four times lower than the country’s average—whereas the south, the region with the highest HDI, is the champion of litigation, with a ratio of 1/11,902— almost four times higher than the country’s average. Figure 4.5 shows the ratios for all regions of the country.”, idem.}

My tentative conclusion based on these findings as regards the equity of the system were these.

"... the model’s overall social impact is negative. Rather than enhancing the provision of health benefits that are badly needed by the most disadvantaged— such as basic sanitation, reasonable access to primary health care, and vaccination programs—this model diverts essential resources of the health budget to the funding of mostly high-cost drugs claimed by individuals who are already privileged in terms of health conditions and services."\footnote{Ibid, Ferraz (2011), note 23 above.}

Several new studies have been conducted since then. They all indicate that the volume and costs of litigation continue to grow significantly and that the social gradient mentioned above continues to operate. The Ministry of Health estimates that in 2016 the judicialization of health will cost R$ 7 billion to the Federal Union, States and municipalities combined\footnote{In some municipalities the expenditure with judicialization is higher than total expenditure with the population. E.g. Tubarão (SC) expenditure with basic pharmacy R$ 971,000 in 2011, expenditure with judicialization R$ 975,000}, almost 4% of the budget.\footnote{http://www2.planalto.gov.br/acompanhe-planalto/noticias/2016/09/governo-eleva-orcamento-de-2017-para-saude-e-educacao} The Office of the Advocate General (Advocacia Geral da União - AGU) estimates that between 2010 and 2015 the expenditure of the Ministry of Health with judicialization grew a staggering 727%. The 20 most costly medicines purchased through judicialization cost R$ 959 million
per year to the Federal Government. In terms of *per capita* expenditure, judicialization consumes approximately 8.5 times more resources than the health system.

In the most comprehensive study carried out so far, the National Justice Council (Conselho Nacional de Justiça) found the staggering number of 854,506 lawsuits related in some way to the topic of health in all courts and tribunals of Brazil in 2015.

Source: Own formulation with data reported in the press and official websites (Ministerio da Saude)

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21 Idem. Two of the most expensive drugs are Idursulfase 2mg/ml, for Hunter's disease, R$ 622 mil. Brentuxmab 50mg, for cancer, R$ 538 mil. For a good study of judicialization focused on these drugs see D. Diniz, M. Medeiros, and I.V.D. Schwartz, “Consequências da judicialização das políticas de saúde: custos de medicamentos para as mucopolissacaridoses,” Cadernos de Saúde Pública 28/3 (2012), pp. 479-489

22 If one considers that the system caters for about 75% of the Brazilian population, i.e. 150 million people approximately, whereas judicialization reaches approximately 47000 thousand individuals.

Out of those, more than 470,000 (just below 50%) were against the state health system (SUS), the rest were against the private system. Of the lawsuits against the public system, 42% were exclusive claims for medicines; another 32% were claims for hospital treatment and medicines; 12% were exclusive claims for hospital treatment and 16% were classified generically as health services claims.²⁴

Source: Own formulation with data from CNJ, 2014

The picture when a correlation is run in these data between socio-economic indicators and volume of litigation is similar to that found in the 2009-2010 Harvard-Bergen study.

²⁴ The database of the CNJ can be further explored to extract data on age of litigants.
As it can be seen, most of litigation at the state level concentrates on a few states of the wealthier south and south-east regions of the country. Just Rio Grande do Sul and Minas Gerais alone, account for 54% of the lawsuits related to health. If we add Rio de Janeiro and Sao Paulo, we get a staggering 82% of the lawsuits concentrated in four of the most developed states of Brazil (all states with high HDI). Conversely, if we focus on the least developed states in Brazil, Para, Piaui and Maranhao, they account, together, for a mere 916 cases, that is, 0.2% of the total of litigation in Brazil. The social gradient found at the Federal level repeats itself at the state level. As it probably does within states and in many municipalities as well, although the data here is less complete. The best way of seeing this is by correlating the address of the claimant with an indicator of social development. The original study to have done this was most likely that of Vieira and Zucchi with all lawsuits against the municipality of Sao Paulo in 2005. As they graphically showed using the addresses of the claimants, there was a strong correlation between the IEX, an index of social exclusion, and volume of litigation. The higher the IEX in the district of residence of

25 Alagoas, the poorest state, has not provided data through the electronic system, like Pernambuco, Amazonas and Paraiba. The press officer for the Alagoas Court of Appeal informed 6303 cases related to health, a number that surprises and would therefore warrant further investigation.
the claimant, the lower the number of lawsuits to be found in a particular district of the city.  

A very similar picture was found in other studies, such as those carried out by Chieffi and Barata also in Sao Paulo and by Gomes et al in the state of Minas Gerais. In the latter, the authors looked at more than 6,000 cases registered at the Secretariat of Health from 1999 to 2009. They analysed only, for this study, those related to procedures rather than medicines, ending up with a sample of 783 cases (12,8%). Cases concentrated in a small number of municipalities (14%, 122/853) and,
within these, 22.3% originated in the capital, Belo Horizonte, which has the second highest IHD of the state, and in Divinopolis (19.8%), with the 21st highest HDI.

2.1 New data: a different picture in Rio Grande do Sul?

The debate on the judicialization of health in Brazil has traditionally been fought in the pages of newspapers. Every so often a piece of news is published either on a new individual case granted by the courts against the state for a certain medicine or procedure, or on the growing aggregate volume and costs of judicialization in a certain state, municipality or the Federal Union. Such reports are often accompanied by a generic statement by a government official, often the Minister or a Secretary for Health about the negative effects of judicialization on the budget. In depth and rigorous academic studies of the phenomenon are few and far between. Yet they have increased in number and quality in the past decade, as discussed in the previous section, enabling us to form a better picture today than we had ten or fifteen years ago. They also allow us reflect about how future studies could be designed in order to overcome some of the problems we notice in the existing ones.

Biehl, Socol and Amon’s recently published “The Judicialization of Health and the Quest for State Accountability: Evidence from 1,262 Lawsuits for Access to Medicines in Southern Brazil” is another important contribution to the debate. It is important to analyse it in a separate subsection because of their strong and bold claim that their data show a significantly different picture to that found in other studies. They have also claimed that their data challenge what they provocatively label four “myths” propagated by the press and other studies. It is not my point here to take issue with their mischaracterization of some of the positions they label myths (including my own) nor with their misuse of the concept of a myth. I have done it elsewhere, and they have responded. My aim here is to analyse their own data in order to gauge if they justify a change in the overall tendency of the academic literature in seeing right to health

litigation as a problematic practice.

The first important thing to note is that their data is limited to Rio Grande do Sul, a single state of the 27 of Brazil. As I clarified above, given that constitutional responsibility for health is equally shared among the Federal Union, the states, and all municipalities (5,570 as of 2016), we are talking of 5,598 potentially different “judicializations”. I am not suggesting, of course, that only if we have data on all municipalities, states and the Federal Union we can draw general conclusions about the judicialization of Brazil as a whole. I am however suggesting that one should be particularly careful about the representativeness of one’s sample given the geographical size, socio-economic diversity and administrative complexity of Brazil.

Given that important caveat, the next important step is to try to establish how representative the Rio Grande do Sul data is of the phenomenon of the judicialization of health in Brazil before drawing any conclusions from its data. If, by hypothesis, we came to the unlikely conclusion that Rio Grande do Sul is a perfect microcosm of the judicialization of health in Brazil, we could take the result of the study (assuming we accept the data as reliable and comprehensive) as a definitive portrait of the phenomenon in the country. At the other end of the spectrum we ought to consider Rio Grande do Sul, a single state among 27, and a single unit among 5,598 in a large and diverse country as too small and peculiar to allow any extrapolation of its data to a general picture of the whole country. The adequate place of Rio Grande do Sul is probably somewhere in-between the two extremes of that spectrum. Finding the exact spot would be obviously impossible, and finding even a rough spot would take up the whole article. But a brief contextualization of Rio Grande do Sul within Brazil will suffice, I think, to convince the reader that any attempt to generalize its findings would be fraught with obstacles.

Rio Grande do Sul (RS) is a state in the relatively richer south of Brazil34, with a reasonably large population of 11,286,500 (around 5.4% of the Brazilian population) and a comparatively high per capita household income of R$ 1,554,00, the third

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34 As a rule of thumb, of the five macro-regions of Brazil, the south and the south-east are the richest, almost twice as rich on average than the states of the north and the north-east. The centre-west is in-between, but has the capital Brasilia (DF) which has the highest per capita household income of the country, pulling up the rest of the region, as well as important agricultural states such as Mato Grosso do Sul, whose income per capita is not far from that of the states of the south-east and south.
highest in Brazil, whose average stands at R$ 1.226,00,\textsuperscript{35} ranging widely (4 times),
given pronounced regional disparities, from R$ 2.351,00 (Brasilia, DF) to R$ 575,00 (Maranhao).\textsuperscript{36} The same wide variation seen in income repeats in education and health, as the IHD attests. The IHD of RS is the 5\textsuperscript{th} highest of Brazil, at 0,779, considered high according to the UNDP criterion. The country average is 0,761\textsuperscript{37} ranging from 0,839 (very high Brasilia, DF) to 0,667 (medium, Alagoas).

In light of such significant socio-economic disparities among the 27 states of Brazil and the high position of Rio Grande do Sul, among the top 5 in terms of human development and top 3 in terms of economic development, it seems immediately clear that it would be highly problematic to take that state as a good indicator of the judicialization of health in Brazil. This is especially so when one of the main arguments is that judicialization is a “process from below”. (I will return to this important issue later).

I think we can safely conclude, thus, that whatever the data on Rio Grande do Sul show, it will be useful mostly as a picture of what is happening in that particular state, generating potential comparative insights with the data collected in other states, but not much beyond that. This seems to be accepted by the authors themselves in the following passage of their article:

“Rio Grande do Sul has a much higher volume of right-to-health litigation than other Brazilian states, with more cases than the next four states with the most litigation (São Paulo, Rio de Janeiro, Ceará, and Minas Gerais, respectively) combined. These differences reflect the varied performance of the decentralized health care system throughout the country, as well as the significant differences in economy, demography, and administrative capacity within and across the 26 Brazilian states. … the heterogeneity of right-to-health litigation across the

\textsuperscript{35}http://www.ibge.gov.br/estadosat/perfil.php?sigla=rs\textsuperscript{36} http://www1.folha.uol.com.br/mercado/2017/02/1861675-20-estados-tiveram-renda-per-capita-abai xo-da-media-em-2016-diz-ibge.shtml\textsuperscript{37} For a comparative basis, the UK, one of the most unequal developed countries, the medium household per capita income varies 1,5 times from £ 25,293 (London) to £15,913 (Northern Ireland). To achieve the magnitude of the regional variation in Brazil one needs to disaggregate by local area £52,298 (Kensington and Chelsea) and £12,779 (Nottingham). \texttt{https://www.ons.gov.uk/economy/regionalaccounts/grossdisposablehouseholdincome/bulletins/region algrossdisposablehouseholdincomedh/2015} \texttt{https://noticias.uol.com.br/cotidiano/ultimas-noticias/2016/11/22/df-sao-paulo-e-santa-catarina-lideram-desenvolvimento-humano-entre-estados.htm}
Brazilian states indicates the need for a more nuanced and in-depth analysis of its drivers and implications at local levels.” (at 218)  

Let me then turn to the authors main claim and assess it within these limits. Unlike what some of the studies carried out in Sao Paulo, Rio de Janeiro, Minas Gerais and other places have found, the authors’ conclusion is that in Rio Grande do Sul right to health litigation does not favour mostly the better off, does not focus on high cost off-formulary medicines and does not disrupt health policy. On the contrary:

“the results of our study … reveal a process of judicialization from below, stemming from poor and older individuals who do not live in major metropolitan areas, and who depend on the state to provide their legal representation. We did not find that judicialization represented a phenomenon of “Robin Hood in reverse”; quite the contrary: we found evidence that judicialization largely serves the disadvantaged who turn to the courts to secure a wide range of medicines, more than half of which are on government formularies and should be available in government health centers.” (at 216)

If this were an accurate and plausible interpretation of the data in Rio Grande do Sul, it would show a surprisingly different picture from other places in Brazil emerging in studies carried out in Sao Paulo and Minas Gerais for example, that found a prevalence of litigants represented by private lawyers, living in places of low socio-economic exclusion and claiming expensive medicines not included in government formularies. (e.g. Vieira e Zucchi; Chiefi and Barata, Silva and Terrazzas, Gomes et al). It does not show, of course, that these scholars important findings are incorrect, let alone that they are myths.  

But does the data collected by the authors actually justify their strong conclusions even if restricted to Rio Grande do Sul?

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38 But it is hard to reconcile this balanced conclusion with other passages where “myths” are challenged and where the authors seem to extrapolate their conclusion to the rest of Brazil. “Our study challenged myths about the negative impact of judicialization on both public health administration and on the broader question of equitable access to care in Brazil. While directly based on work in the south of Brazil, the information presented here is also relevant to national and international discussions of how to advance the goal of universal health coverage.” At 218.

39 Biehl et al don’t even discuss the findings of these studies in their article.
In my view, the conclusions are stronger than the data support for two main reasons. Firstly, although reasonably extensive, the data on Rio Grande do Sul is still incomplete, and in parts significantly thinner than the data collected in the studies that arrived at different conclusions. Secondly, the authors give too much weight to some indicators that are not very reliable for the intended purposes.

2.1.1 Judicialization from below?

Take, first, the crucial issue socio-economic profile of litigants, extremely relevant if one is trying to gauge if judicialization is a process from below or driven by elites. Studies in other states have used a combination of indicators to try and reach a reasonably robust picture of this elusive aspect of litigation. These included: the index of social vulnerability, the index of human development, direct data on claimant’s income (self-reported in the lawsuit), as well as more indirect indicators such as type of legal representation (private lawyers or state attorneys), type of health service used (private or public) and claimant’s residential address.

In their study of Rio Grande do Sul, the authors have relied almost exclusively on type of legal representation and access to legal aid, which are perhaps the least reliable indicators available of the socio-economic profile of the litigant.

Graph 2: Percentage of claims represented by private lawyers
As the authors themselves appropriately state, the public defensory, responsible for 57% of claims in their sample\textsuperscript{40}, “provides free legal assistance to people classified as low-income (defined as earning three times the national minimum wage or less)”. The authors do not discuss, as other studies do, the situation of poverty in Brazil and Rio Grande do Sul so as to allow the reader to understand what 3 times the minimum wage actually means. It is a reasonably high threshold. At R$ 2,640,00 (around US$ 760,00 a month and 3 x R$880,00, the minimum wage), it is much higher than the average income in Rio Grande do Sul, at R$ 1,435,00 (US$ 420,00)\textsuperscript{41} at the time of their study (R$ 1,554,00 now), and almost 35 times higher than the extreme poverty threshold in Brazil (R$77,00, US$ 22,00).\textsuperscript{42}

The same can be said of access to legal aid, which was granted in staggering 91% of the lawsuits. As anyone familiar with litigation in Brazil knows, it is extremely easy to be exempted from court’s fees in Brazil, sufficing to make a self-declaration of “legal poverty” which is rarely challenged or rejected in court. That in turn explains why even those resourceful enough to retain private lawyers are able to access legal aid.

The indicator related to occupation used by the authors offers little help, as the five categories chosen are not fine-grained enough (professional, manual, retired, unemployed and student). If one adds the retired (32%) who can be in any socio-economic bracket to the 26.9% of the sample where no information is available, one has 58.9% of the sample where it is not possible to draw any conclusion whatsoever about socio-economic status from the sample. Manual or service sector workers (14.5%) could, again, fit into several different income brackets, although they tend to have lower salaries than professionals (4.7%). Even the unemployed (21%) are not in

\textsuperscript{40} Another 9,4\% were represented by “federal legal counsel” (7\%) and university clinics (2,4\%). At 213.
\textsuperscript{41} “Gaúcho tem a terceira maior renda domiciliar do país” ZH Notícias available at http://zh.clicrbs.com.br/rs/noticias/noticia/2016/02/gaucho-tem-a-terceira-maior-renda-domiciliar-do-pais-4984327.html NEED FULL CITATION.
\textsuperscript{42} It should also be noted that the PD threshold is often not followed in right to health cases, especially those claiming drugs that are costly, when public defenders tend to relax the admissibility criteria for accepting to represent the litigant.
themselves a very good indicator without further data about their actual predicament in terms of income. Students fall into the same problem, but their participation in the sample is so negligible that one can safely disregard them (0.9%).

It seems clear to me, thus, that the data collected by the authors on legal representation, legal aid and occupation is insufficient to support a minimally robust conclusion about the socio-economic profile of litigants, let alone the claim that judicialization in Rio Grande do Sul is a process from below, that “largely serves the disadvantaged.”

2.1.2 Mostly state failure?

Different problems affect the authors’ claim that judicialization in Rio Grande do Sul does not follow the pattern seen in other places of concentration in high cost and off-formulary medicines. Firstly, the data presented by the authors do not show such a significantly different picture from other places as they make out to exist. Secondly, the binary classification into on and off formulary drugs is not sufficient to capture the full complexity of health policy in order to determine whether a medicine should be provided or not by the state.

The authors present their findings in two different ways. Firstly, they mention the total number of drugs requested (3.468), which is much higher than the number of lawsuits analysed (1.262) as one lawsuit (often one patient) can and often claim more than one drug. When analysing by drug rather than by lawsuit, the authors find a lower yet not too low percentage of medicines off-formulary requested in Rio Grande do Sul when compared to other states. Still, a far from negligible 44% of all drugs claimed in RS are off-list.
They then present the data organised by lawsuit rather than medicine, showing that 41% of the plaintiffs requested on-formulary medicines exclusively, 27% requested off-formulary medicines exclusively, and 32% requested both. By adding the 41% of exclusive on-formulary requests with the 32% of what could be called “mixed requests”, they reach the high but misleading proportion of 73% of lawsuits that have requested at least one on-formulary drug. One could however ask: why not add those that have requested at least one off-formulary drug? That would also result in a high 59% of lawsuits requesting off-formulary drugs, a number not dissimilar to that found in other studies. Moreover, it is not at all warranted to conclude, as the authors do, that because in 73% of the claims there were drugs “part of governmental drug formularies” these claims were originated by a failure of the state to provide these drugs. The literature mentions at least three plausible explanations for why a claimant may end up adding to its judicial demand an on-formulary drug even when that drug is available in the public system (e.g. her doctor did not follow the therapeutic guidelines\textsuperscript{43}, the on-formulary drug was claimed simply as part of the treatment that

\textsuperscript{43} Some lawsuits request brand name medicines whose generics are available in the official lists. A good example is acetylsalicylic acid (“Aspirin,” “ASA”) that is part of the official list but is one of the most frequently litigated drugs in the authors’ sample. In the state of São Paulo, where it also generates
included the off-formulary drug, the claimant is not a habitual user of the public system). The authors do not discuss any of these possibilities.

In any event, the fact is that this binary classification into on and off-formulary is not as useful to assess the legitimacy of right to health litigation as it is usually thought to be. It is true that inclusion in the state’s list (on-formulary) provides some indication of state failure whereas non-inclusion (off-formulary) provides some indication of the contrary. Yet neither provides definite indication of one or the other. I have already mentioned three potential reasons why even a drug that is on-formulary may nonetheless not be provided, legitimately, to a claimant. For an example, think of a patient who is not being treated in a public reference hospital but wants to access drugs only available in these public institutions (cancer drugs often fall in this case, as regulations limit their provision to reference public hospitals). Without more fine-grained investigation it is therefore unwarranted to conclude, as the authors did, that any lawsuit claiming an on-formulary drug represents a state failure to comply with the claimant’s right to health.

It would be equally unwarranted to conclude that any request for an off-formulary drug is automatically illegitimate. There are at least three different types of claims here. The most obviously illegitimate type of claims are those in which claimants demand medicines that state authorities have already rejected simply because there is no scientific evidence of their efficacy (e.g., the infamous cancer pill, the eye surgical procedure in Cuba etc). We may call these “rogue” drugs or procedures’ claims. But there are also claims for off-formulary drugs that are scientifically proven to be effective. Here we must distinguish among several different cases. Drugs or other interventions that, despite being effective, have therapeutic alternatives that are equally effective but are less costly (i.e., are more cost-effective), effective drugs or other interventions whose therapeutic alternatives are not as effective but are much

significant litigation, a more detailed study showed that 1,725 lawsuits in 2014 requested 22 different brand names or presentations of ASA to the ones offered in the public system. Offering a generic version of a drug can be hardly regarded as an obvious policy failure. Secretariat of Health of the State of Sao Paulo, May 2015 (on file with author)
less costly, and drugs and other interventions that have no therapeutic alternative. The first type of claim, again, seems clearly illegitimate, as it asks the public system to spend more money to achieve the exact same outcome. The other two are more complex, and require a difficult assessment of what a public system ought to provide with its limited resources, which is the crucial and most difficult question in the determination of the content of the right to health.

The above discussion, even if briefer than the complexity of the topic requires, is nonetheless sufficient, I think, to demonstrate the inadequacy of the conclusion that in Rio Grande do Sul most litigation benefits the disadvantaged and is legitimate simply because a large proportion of claims involve on-formulary drugs.

3. Conclusion: towards legitimate judicialization

Social policy in Brazil got stronger from the 1930s government of Getulio Vargas (“The Father of the Poor”) and became increasingly constitutionalized with each new constitution (1946, 1964, 1969) until it reached a kind of climax with the 1988 “Citizen Constitution” adopted after the end of the military regime. Despite the significant progress experienced in the past few decades in terms of social development, there remains an important gap between social conditions and constitutional promises. The universal constitutional benefits of health and education have experienced much less improvement in the recent past than the non-constitutional target anti-poverty policies such as Bolsa Familia. The judicialization of social and economic rights in general, and that of health in particular, is seen by many as an important tool in the fight to reduce that gap.

If this is true or not is of course an empirical question, and the few empirical studies conducted so far on right to health litigation have tended to see the Brazilian case as problematic from the perspectives of both equity and administrative disruption. I have argued in this article that this is still the case, and that a recent dissonant study

45 For a good nuanced analysis of different types of claims see Figueiredo TA, Osorio-de-Castro CG, Pepe VL, “Evidence-based process for decision-making in the analysis of legal demands for medicines in Brazil”, Cad Saude Publica. 2013 Nov;29 Suppl 1:S159-66.
carried out in Rio Grande do Sul has unfortunately not been able to challenge that general sense.

Can judicialization ever be truly transformative in the sense discussed in this article? Can it help the most disadvantaged in Brazilian society to improve their dire health condition, e.g. to live longer and healthier lives? I am by and large skeptical of the power of lawyers and judges to transform in any significant and lasting manner the structural inequalities of society, even when willing to do so (not a common scenario)\(^\text{46}\). As Upendra Baxi has properly stated, "Courts are, at the end of the day, never an instrument of total societal revolution . . . never a substitute for direct political action."\(^\text{47}\) The significant health inequalities prevailing in Brazil can only be effectively tackled through large scale distributive social and economic policies that only the political system can deliver.

What Brazilian courts can (and should) do, however, is adopt a more responsible approach to right to health litigation, i.e. one that avoids the pernicious effects discussed above and, in a more modest yet important manner, enhances the accountability of the political branches in their constitutional duty to promote the health of the Brazilian population. Most urgent towards that goal is the need for Brazilian judges to understand that the right to health cannot be interpreted as an entitlement to any treatment an individual may need according to his individual doctor, whatever its costs. No country in the world, however developed and rich, can adopt such an expansive conception of the right to health. As the British judge Thomas Bingham has emphatically put in the leading Child B case in the UK.\(^\text{48}\)

I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot

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\(^{46}\) See, for a longer discussion, my *Harming the poor*, note 10 above.


\(^{48}\) The UK has one of the best public health systems in the world:
provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research they would like; they cannot build all the hospitals and specialist units they would like. **Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients.** (my emphasis)

The right to health, like any human right, is universal, that is, it should benefit everyone, and not just the individual that manages to come before the court and make a claim against the state. When the judge is confronted with a right to health claim, it should not simply assess whether the individual claimant really needs it, according to the opinion of his or her medical doctor. The analysis is a much more complex and intractable one of whether the state health system, with its necessary limited resources, ought to provide such treatment not only to that individual in front of the judge, but all other individuals in the same situation. And this is, of course, not a simple arithmetic calculus of whether there is enough money in the budget to cover that particular treatment for that particular group of individuals who happen to suffer from the same health problem. It is a polycentric analysis of how to distribute the limited resources of the health budgets among the myriad of health needs of the whole population. To quote judge Bingham again, these are "difficult and agonising judgments", and ones that for him, and many others, judges are neither legitimised nor competent to make.

We do not need to engage in this controversial debate about the appropriate role of courts in social rights adjudication here. All I am asking is that Brazilian judges realise the complexity of the problem and abandon the simplistic interpretation of the right to health as a "right to everything, no matter its costs" that currently prevails in Brazilian jurisprudence.

Once this crucial step is taken, it will become naturally evident that courts are not in a very good position to order the provision of specific treatments to individuals against the decisions of the health authorities. They can still perform a very important accountability role, however, in the following manner.

They can demand from health authorities a transparent and rational justification for not providing the specific treatment claimed by the litigant. If the health authorities can show that the treatment has not been incorporated in the system for valid reasons
of security, efficacy and cost-effectiveness, the courts should not overrule this decision simply because the doctor of the patient has prescribed the treatment. This is to fall back into the simplistic interpretation of the right to health that disregards the need to prioritise resources that produces the negative consequences in terms of equity and administrative disruption discussed above. The courts should only interfere if there is clear evidence that health authorities have failed to comply with the security, efficacy and cost-effectiveness criteria established in the legislation.49

If the health authorities do not provide valid reasons to justify the denial of treatment then the courts have the following options depending on the specific situation. Here are a few possibilities.

1. If the treatment has been incorporated in the state system (i.e. is on-formulary) and has been prescribed by the doctor following the official clinical protocol and therapeutic guidelines as well as any other administrative regulations in place, the courts can safely condemn the state to provide the treatment as we are clearly in the face of administrative failure;

2. If the treatment has not yet been assessed by the health authorities in terms of security, efficacy and cost-effectiveness the courts should do the following:

   2a. if the process of assessment is underway and not delayed according to the deadlines established in the legislation, the court should suspend the case until such assessment is carried out and then decide;

   2b. if the process of assessment is not underway, or is delayed, the courts should order the state to perform or complete it according to the procedures and deadlines established in the legislation under threat of a fine;

   2c. as a last resort, if the process of assessment is unreasonably delayed, the courts may, exceptionally, substitute their own decision for that of the

49 Law nº 12.401/2011
health authority after hearing experts on security, efficacy and cost-effectiveness criteria established in the legislation.

If Brazilian courts adopted these recommendations they would not of course solve all the problems of the Brazilian health system, let alone redress the despicable health inequalities that exist among the Brazilian population, our most pernicious disease. They would however provide a responsible and important accountability mechanism that would help improve the quality and fairness of decision making about scarce health resources in Brazil, not a small feat, and a far cry from the current simplistic approach whose potential (and likely) effects on equity and administrative disruption are so dire.