

LETTER TO THE EDITOR

Moving the Debate Forward in Right to Health Litigation

OCTAVIO LUIZ MOTTA FERRAZ

The debate on the judicialization of social and economic rights in general, and the right to health in particular, has been beset by polarization between pro- and anti-judicialization supporters and lack of empirical data to allow an impartial analysis of the consequences of that growing phenomenon. The type of empirical study carried out by Biehl, Socal, and Amon, entitled “The judicialization of health and the quest for state accountability: Evidence from 1,262 lawsuits for access to medicines in southern Brazil” and published recently in *Health and Human Rights* (Volume 18, Issue 1, June 2016), is therefore a highly commendable contribution to the debate.¹

As the authors appropriately put it: “The judicialization of the right to health in Brazil is not a single phenomenon, and failing to acknowledge regional differences and attempting to fit all data into one singular narrative may be contributing to a biased interpretation of the nature of judicialization, and limiting the understanding of its drivers, consequences, and implications at local levels.”

Their study, based on a sizable amount of relevant empirical data on the Brazilian state of Rio Grande do Sul, will certainly help to shed light on the still incomplete and fragmentary picture of the judicialization of health in Brazil.

It is important, however, to avoid the temptation to incur the very problems that the authors warn against, that is, to stretch the significance of their findings beyond their appropriate reach and repudiate too quickly the findings of other studies.

I offer the following comments in the spirit of a contribution to move the debate forward.

Myths?

The myths about the judicialization of health in Brazil, according to the authors, are four. Judicialization is driven by urban elites and is not available to the poor (myth 1); is driven by private attorneys specializing in health-related lawsuits and physicians seeking to promote high-cost treatment (myth 2); is mostly used to access high-cost treatments and off-formulary drugs (myth 3); and disrupts health policy making and bypasses administrative procedures designed for appropriate, efficient, and equitable access to medicines (myth 4).

OCTAVIO LUIZ MOTTA FERRAZ, LLB, LL.M, PhD, is a Reader in Transnational Law, King's College, London.

Please address correspondence to the author at octavio.ferraz@kcl.ac.uk.

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In my view, none of these positions can be properly qualified as myths (“widely held and false beliefs”).² They are certainly not widely held. There are many, including, importantly, most judges of the country, but also lawyers, scholars, activists, and journalists who actually see judicialization as a positive and much-needed practice with very little, if any, negative consequences.³

Moreover, those who are critical of judicialization ground their conclusions on rather plausible concerns backed by empirical studies conducted in different regions of Brazil at the municipal, state, and federal levels.⁴ Perhaps all these studies are flawed and their conclusions therefore false, but the authors’ data on a single state in Brazil, however important Rio Grande do Sul may be, is not sufficient to challenge these conclusions.⁵

It is also important to avoid oversimplification of the views qualified as myths. Many of the studies cited do not claim that litigation is unavailable to the poor or never driven by state attorneys rather than private lawyers. What many claim, plausibly and based on empirical evidence not directly challenged by the authors, is that at the federal level, and in several cities and states, there does seem to be a social gradient in right to health litigation. In other words, it is easier for the better off—not necessarily the richest, but nonetheless individuals who cannot be described in any sense as poor—to access the courts and demand the right to health.⁶

Rather than challenge myths, what Biehl, Socal, and Amon do is reveal important new empirical data from Rio Grande do Sul that adds an interesting perspective for further reflection on the judicialization of health in Brazil.

Limitations of their data

Their main, and bold, claim is that judicialization “largely serves the disadvantaged [“low-income plaintiffs including the very poor” at page 210] 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 page 216) They see in Rio Grande do Sul, therefore, “a process of judicialization from

below.” (at page 216)

If this claim is correct, it would not disprove, as already stressed, the studies carried out in other places that found a prevalence of litigants represented by private lawyers, living in places of low socioeconomic exclusion and claiming expensive medicines not included in government formularies. But it would certainly make of Rio Grande do Sul an example of what we could regard as a more benign, legitimate, and progressive type of judicialization.

But the claim seems stronger than the data warrants. As to the socioeconomic profile of litigants, studies in other states have used multiple indicators such as indexes of social vulnerability, the human development index (HDI), and even direct data on a claimant’s income, as well as indirect indicators such as type of legal representation (private lawyers versus state attorneys) and type of health service used (private versus public) to build a plausible picture of who litigates.

The authors’ study would have benefited from using some combination of these indicators, instead of relying solely on type of legal representation. The fact that 57% of claims in their sample are filed by the Public Defensory (PD), which “provides free legal assistance to people classified as low-income (defined as earning three times the national minimum wage or less)” proves only that litigation is not restricted to the richest, but not that it is accessible to the very poor, not even to low-income plaintiffs.

This is because the PD threshold of “low-income” of three times the national minimum wage is rather high, amounting currently to R\$2.640,00 (around US\$760 per month), that is, much higher than the average income in Rio Grande do Sul (R\$1.435,00, US\$420)⁷, and almost 35 times higher than the extreme poverty threshold in Brazil (R\$77,00, US\$22).⁸

Without direct data on a claimant’s income, or other stronger indicators such HDI, it is unfortunately impossible to know if the poor and the poorest are really benefiting from litigation despite all known obstacles they usually face to access justice.⁹

A similar difficulty affects the authors’ conclusion that the majority of the drugs claimed (56%) “are on government formularies and should be

available in government health centers.” The mere fact that the active principle of the drug is on government formularies is not sufficient evidence that the lawsuit is a result of policy failure. 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 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.¹⁰ Offering a generic version of a drug can be hardly regarded as an obvious policy failure.

There are also lawsuits brought by patients who have private insurance and use the public system exclusively to access expensive drugs not covered in their insurance policies (such as some cancer drugs) that the public system offers in principle only to patients being treated in the system.

These examples show, again, that without more detailed data and analysis, the mere percentage of on-formulary drugs featuring in litigation gives us only limited indication of the possible causes of judicialization.

The way forward?

The brief discussion above shows, I hope, how Biehl, Socal, and Amon’s important contribution could elicit even further and deeper insights into the intricate phenomenon of the judicialization of health in Brazil through more detailed investigation of the socioeconomic profile of health litigants and the reasons so many go to court.

It also reaffirms, in my view, what I called the Brazilian model of right to health litigation, a model that needs to change, even if it may at times lead to positive outcomes of the sort that may have occurred in the case of Rio Grande do Sul. As I argued:

The defining features of this “Brazilian model” are related to the profile of claims (the litigator and the object of litigation) and the outcome of litigation (the rates of success and failure of litigation). As to the profile of claims, the vast majority of right-

to-health cases in Brazil to date have been led 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. This model, I suggest, is encouraged by the dominant interpretation of the right to health by the Brazilian judiciary. As noted above, 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.¹¹

I did not include in the model, deliberately, the socioeconomic profile of litigants, but rather that of the claims: individualized claims for curative treatment (mostly medicines). There may well be, I repeat, cases from several jurisdictions in which these individualized claims do not favor the urban elites represented by private lawyers forcing the state to provide them with off-formulary high-cost treatment. But in many cases they do, as several studies conducted so far have shown.

The challenge ahead for all who support the right to health is to change the Brazilian model so that it prevents this pernicious kind of judicialization and encourages a more positive kind to flourish. A further challenge is to develop more specific criteria to identify what should be counted as positive judicialization, which is much harder and more controversial than identifying the opposite, pernicious kind.

We seem to agree on the general aim: the effective protection of the right to health of the whole population involves an equitable distribution of the necessarily limited resources of the public health system. There is much less agreement, however, on what specific health goods and benefits an equitable distribution would entail. It is towards this consensus that we should, in my view, work. Beyond determining the socioeconomic profile of claimants and the status of the goods and services they claim (on or off-formulary), we need to develop criteria to assess whether these goods and services ought to be part of the coverage in the public health system or not as a corollary of the right to health. This is no

easy task, but it starts with understanding the need for prioritization and a focus on the needs of the worse-off (especially where health inequalities are high, like in Brazil). The current Brazilian model, and that would also include Rio Grande do Sul, is not the most conducive to delivering that task.¹²

References

1. As I argued elsewhere, we need more of these studies to illuminate the judicial enforcement of social and economic rights. See O. Ferraz, "Where's the evidence? Moving from ideology to data in economic and social rights." Available at <https://www.opendemocracy.net/openglobalrights/octavio-luiz-motta-ferraz/where-s-evidence-moving-from-ideology-to-data-in-economic>.

2. Oxford English Dictionary.

3. To cite one influential opinion and representative of many human rights activists in Brazil, see the current national secretary for Human Rights, Flavia Piovesan's contribution in Malcom Langford's *Social rights jurisprudence: Emerging trends in international and comparative law* (Cambridge University Press: 2008), stating: "In order to develop a human rights jurisprudence and consolidate the judiciary as a 'locus' for safeguarding these rights, it is therefore essential that civil society, through its multiple organisations and movements, submit cases to the courts with more frequency, maximising the emancipatory and transformational potential of law. Litigation strategies should be scaled up ... This is the only way to ensure greater transparency and accountability concerning the duty of the state to guarantee the rights to health and education." (at p. 191).

4. For a review of the literature and original research, see O. Ferraz, "Health inequalities, rights and courts: The social impact of the "judicialization of health" in Brazil," in A. Yamin and S. Gloppen (eds.), *Litigating the right to health: Can courts bring more justice to health systems?* Harvard University Press, 2011.

5. Although the authors do qualify the reach of their claims by adding "at least in Rio Grande do Sul" to some of their conclusions, in many other parts of the article they don't, and the general argument of challenging "myths" seems to be meant to apply much more broadly.

6. It is interesting to note that some of the authors themselves have raised these concerns in an earlier article. J. Biehl et al, "Judicialisation of the right to health in Brazil," *The Lancet*, 373/9682, pp. 2182-2184.

7. *ZH Notícias*, "Gaúcho tem a terceira maior renda domiciliar do país." Available at <http://zh.clicrbs.com.br/rs/noticias/noticia/2016/02/gaucha-tem-a-terceira-maior-renda-domiciliar-do-pais-4984327.html>.

8. 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.

9. The indicator related to occupation offers little help. 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 about socio-economic status from the sample. The authors remind us that "Brazilian law also allows for individuals without the ability to pay to request that the state pay legal fees. In 91% of the lawsuits (n=1,147) plaintiffs requested this support." Yet as anyone familiar with litigation in Brazil knows, it is extremely easy to get legal fees exempted in Brazil, sufficing to make a self-declaration which is rarely challenged or rejected in court.

10. Secretariat of Health of the State of Sao Paulo, May 2015 (on file with author).

11. See note 5.

12. For a good overview of the problem and its potential solutions, see A. Voorhoeve, T. Ottersen, and O. Norheim, "Making fair choices on the path to universal health coverage: a précis," *Health Econ Policy Law* 11/1, pp. 71-77.