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On The Judicialization of Health

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# ON THE JUDICIALIZATION OF HEALTH

ANA SANTOS RUTSCHMAN\*

## I. INTRODUCTION

The provision of health care has long been at the forefront of domestic and international debates, philosophical inquiries, and political agendas. A growing body of legal scholarship has added to the debate by examining the role of judicial review in the context of health-related litigation. What role, if any, should courts play in compelling the provision of health care or in furthering access to potentially life-saving medicines?

This question intersects with multiple strands of the law. For instance, it has an institutional component that interrogates the function(s) of courts within systems of checks and balances. It ties into constitutional design choices, as the right to health is expressly recognized by some national constitutions while others are silent on the matter. And, perhaps more fundamentally, it invites us to revisit our notions of fairness and distributive justice in a world of soaring drug and health care costs.

Judge Santos' timely piece, *Beyond Minimalism and Usurpation*,<sup>1</sup> richly interweaves constitutional law analysis and empirical data on health-related litigation in Brazil to ponder these issues. Brazil, it should be noted, is not only a country where the right to health is constitutionally protected,<sup>2</sup> but also an epicenter of litigation surrounding socio-economic rights<sup>3</sup> and one of the global leaders in the access to medicines movement.<sup>4</sup>

In the Article, Judge Santos proposes that we look beyond what he calls “the American models of judicial activism or minimalism”<sup>5</sup> when

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1 Pedro Felipe de Oliveira Santos, *Beyond Minimalism and Usurpation: Designing Judicial Review to Control the Mis-Enforcement of Socio-economic Rights*, 18 WASH. U. GLOBAL STUD. L. REV. 493 (2019).

2 CONSTITUIÇÃO FEDERAL [C.F.] [CONSTITUTION] art. 196 (Braz.) (“Health is the right of all and the duty of the National Government and shall be guaranteed by social and economic policies aimed at reducing the risk of illness and other maladies and by universal and equal access to all activities and services for its promotion, protection and recovery.”).

3 See generally Mark Tushnet, *Reflections on Judicial Enforcement of Social and Economic Rights in the 21st Century*, 4 NAT'L U. JURID. SCI. L. REV. 177 (2011).

4 See ERIKA MALICH & SARAH MARION, CIGI, GRADUATE FELLOWS SERIES POLICY BRIEF NO. 2, INCREASING ACCESS TO MEDICINES: LEVERAGING BRAZIL'S EXPERIENCE (2015); see also Tatiana Chama Borges Luz et al., *Trends in Medicines Procurement by the Brazilian Federal Government from 2006 to 2013*, PLOS ONE, Apr. 7, 2017, at 1, <https://doi.org/10.1371/journal.pone.0174616>.

5 Santos, *supra* note 1, at 533.

reflecting on the role that courts play or *should* play in interpreting and adjudicating health-related claims. Moreover, Judge Santos suggests that the Brazilian experience in this field might yield lessons that are relevant for other countries in the developing world.<sup>6</sup> In the first half of this response, I have chosen to highlight aspects of the Article that speak to these two prongs, as they carry a special resonance in today's debates on the provision of health goods and services.

But I believe that Judge Santos is too modest in assessing the implications of his work and in connecting some of the topics covered in *Beyond Minimalism and Usurpation* to phenomena taking place well beyond the developing world. The second half of the response thus turns to parallels between some of the arguments put forth in the Article and selected aspects of health-related litigation in the United States. More broadly, I argue that Judge Santos' Article advances both scholarship and overall awareness of the phenomenon of judicialization of health, which both encompasses and transcends localized manifestations of judicial review of health-based claims.

## II. HETEROEGENEITY OF RESPONSES IN THE DEVELOPING WORLD

The enforcement of socio-economic rights has been fraught with conceptual constraints and (mis)apprehensions, as thoroughly described in *Beyond Minimalism and Usurpation*. But it has also been fraught with practical constraints, even when courts take on a dynamic role<sup>7</sup> in the case-by-case application of socio-economic rights. Nowhere is this more apparent than in the resource-scarce jurisdictions of the developing world. In this Part, I highlight a few examples of these problems—not because they should deter the equality-enhancing function of courts as they operate in the socio-economic arena, but because they further Judge Santos's point that courts in the developing world “must exercise creativity and institutional innovation”<sup>8</sup> when deciding issues that involve socio-economic rights.

In exploring the role of courts as catalysts<sup>9</sup> for the advancement of the right to health, *Beyond Minimalism and Usurpation* presents empirical data on litigation taking place in Brazil,<sup>10</sup> but it also hints at similar

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6 *Id.* at 491.

7 *Id.* at 476. See also generally David Landau, *A Dynamic Theory of Judicial Role*, 55 B.C. L. REV. 1501 (2014).

8 Santos, *supra* note 1, at 539.

9 *Id.* at 476. See also Joanne Scott & Susan P. Sturm, *Courts as Catalysts: Rethinking the Judicial Role in New Governance*, 13 COLUM. J. EUR. L. 4 (2007).

10 Santos, *supra* note 1, at 507-11. See also João Biehl et al., *The Judicialization of Health and the Quest for State Accountability: Evidence from 1,262 Lawsuits for Access to Medicines in Southern*

experiences in other countries.<sup>11</sup> Looking elsewhere in the developing world, Judge Santos notes in passing<sup>12</sup> a landmark case dealing with the right to health in South Africa, which I believe merits further contextualization, as it helps illustrate some of the practical hurdles surrounding the enforcement of the right to health. In *Minister of Health v. Treatment Action Campaign* (TAC), a civil society organization successfully sued the government in 2002 for its failure to provide and implement programs to prevent child-to-mother transmission of HIV.<sup>13</sup> The claim was rooted in article 27(1)(a) of the South African Constitution, which establishes, inter alia, that “[e]veryone has the right to have access to health care services, including reproductive health care.”<sup>14</sup> The Constitutional Court directed the government to make the anti-retroviral drug Nevirapine available to HIV-positive pregnant women and newborns of HIV-positive mothers.<sup>15</sup>

The TAC case, as it became known, is often hailed as a pivotal moment in the history of judicial review and enforcement of socio-economic rights.<sup>16</sup> Yet, several commentators have pointed out that the ruling of the Court in this case produced only limited welfare-enhancing gains: the program subsequently set up by the government to distribute Nevirapine reached only an estimated thirty percent of women who needed it.<sup>17</sup>

TAC is part of a larger set of cases probing the boundaries of the right to health *qua* social right in South Africa. Another case that would be instructive to add to the examples considered by Judge Santos is *Soobramoney*, which dates from 1997 and involved a patient in need of dialysis.<sup>18</sup> Thiagraj Soobramoney was refused treatment at a state hospital after being diagnosed as terminally ill and having exhausted his personal resources on private treatment. Mr. Soobramoney sued the government, relying on article 27(3) of the South Africa Constitution, which states that

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Brazil, 18 HEALTH & HUM. RTS. J. 209 (2016).

11 Santos, *supra* note 3, at 555.

12 *Id.* at 432.

13 See *Minister of Health v. Treatment Action Campaign* 2002 (5) SA 721 (CC) (S. Afr.).

14 S. AFR. CONST., 1996, art. 27. For a broader discussion on the enforcement of socio-economic rights in South Africa’s recent constitutional history, see Craig Scott & Patrick Macklem, *Constitutional Ropes of Sand or Justiciable Guarantees? Social Rights in a New South African Constitution*, 141 U. PA. L. REV. 1 (1992).

15 *Minister of Health v. Treatment Action Campaign* 2002 (5) SA 721 (CC) at para. 135.

16 See generally Mark V. Tushnet, *New Forms of Judicial Review and the Persistence of Rights- and Democracy-Based Worries*, 38 WAKE FOREST L. REV. 813 (2003).

17 Amy Kapczynski & Jonathan Berger, *The Story of the TAC Case: The Potential and Limits of Socio-Economic Rights Litigation in South Africa*, in HUMAN RIGHTS ADVOCACY STORIES 4 (Deena R. Hurwitz et al. eds., 2009).

18 *Soobramoney v. Minister of Health* 1997 (1) SA 765 (CC) (S. Afr.).

“[n]o one may be refused emergency medical treatment,” in conjunction with article 11, which protects the right to life.<sup>19</sup> The Durban High Court dismissed the claim, and the Constitutional Court upheld the decision. In a now often-quoted passage, the latter court reasoned that

the obligations imposed on the state by sections 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources. Given this lack of resources and the significant demands on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled. This is the context within which section 27(3) must be construed.<sup>20</sup>

*Soobramoney* was the first case in which South Africa’s highest court dealt with socio-economic rights after the 1996 Constitution was adopted. In the opinion, the Court further noted that it would be “slow to interfere with rational decisions taken in good faith by the political organs and medical authorities.”<sup>21</sup>

*TAC* and *Soobramoney* embody distinguishable judicial approaches, to which commentators have dedicated numerous articles.<sup>22</sup> Nevertheless, both cases speak to the perennial problems of resource scarcity, resource allocation and equitable access to health goods and services. Although at opposite ends of the spectrum, these cases illustrate how rationales of scarcity condition the right to health: in *Soobramoney* they inform the practice of judicial restraint, while in *TAC* they operate ex post, effectively curtailing the intervention of the court.

On another level, both cases illuminate the often undertheorized relationship between courts and other institutional players engaged in the provision of goods typically associated with socio-economic rights. *Soobramoney* underscores the idea that courts operate in a continuum populated with differentiated actors. In some cases, the interests and policies that move these actors may be complementary, as showcased by

19 S. AFR. CONST., 1996, arts. 27(3); 11.

20 *Soobramoney v. Minister of Health* 1997 (1) SA 765 (CC) at para. 11.

21 *Id.* para. 29.

22 See, e.g., Linda van Rensburg, *Interpreting Socio-Economic Rights—Transforming South African Society?* 1 POTCHEFSTROOM ELECTRONIC L.J. 15 (2003); Cass R. Sunstein, *Social and Economic Rights? Lessons from South Africa* (John M. Olin Program in Law & Econ., Working Paper No. 124, 2001). See also Pierre de Vos, Grootboom, *The Right of Access to Housing and Substantive Equality as Contextual Fairness*, 17 S. AFR. J. HUM. RTS. 258 (2001) (further discussing the evolution of the judicial enforcement of socio-economic rights in South Africa).

the deference given by the South African Constitutional Court to democratically elected institutions, as well as to the institutions that are arguably the leaders in the provision of health care—hospitals. On the other hand, the shortcomings of the implementation of *TAC* remind us that other types of actors and interventions are needed to create and maintain effective health systems. Despite the de facto hurdles in implementing *TAC*, the concerted efforts of a civil society organization produced a legal outcome that solidifies the justiciability of the right to health, and—at least to some extent—of socio-economic rights in general.

*Soobramoney* and *TAC* are but two illustrations of the constraints that surround the judicial and extra-judicial implementation of the right to health. They share many of the features that we encounter in Judge Santos' narrative about the asymmetrical implementation of socio-economic rights<sup>23</sup> and the dialogical relationship that Brazilian courts ruling on health-related matters maintain with the larger institutional ecosystem, however fragmentarily.<sup>24</sup>

Nonetheless, I would also argue that they serve as cautionary notes as to how transposable lessons extracted from a particular country experience might be. *Beyond Minimalism and Usurpation* suggests that the Brazilian case study may yield valuable lessons to developing countries with economic profiles that are perceived as being somewhat similar to Brazil's: the Article specifically names South Africa, Mexico, Argentina, Colombia and India as possible future testing grounds for Judge Santos' frameworks. While I wholeheartedly embrace Judge Santos' call for richer comparative work in this field, I believe it is equally important to stress the heterogeneity of experiences in discrete legal, social and political systems within the developing world.

Take the case of the *tutela* action in Colombia, a procedural mechanism created in the 1990s to enable individuals to bring claims rooted in the violation of constitutionally protected rights.<sup>25</sup> The *tutela* pathway became especially appealing in health-related litigation and was used extensively by private citizens to request the provision of medicines not covered by the national Mandatory Health Plan.<sup>26</sup> However, the exponential spread of

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23 Santos, *supra* note 1, at 514.

24 *Id.* at 463-64 (noting that “Brazilian scholars denounce the fact that judges have guided the health care programs; however, from time to time, the government expands the list of services and drugs provided by the public system regarding the contents of the rulings delivered by courts, such as in the HIV/AIDS case.”).

25 For a description of the development of the *tutela* action in Colombia, see David Landau, *The Reality of Social Rights Enforcement*, 53 HARV. INT'L L.J. 189, 205-207 (2012).

26 See Katharine G. Young & Julieta Lemaitre, *The Comparative Fortunes of the Right to*

litigation through *tutelas* ultimately posed severe strains on the judicial review of health-based claims:<sup>27</sup> first, by greatly increasing the workload of courts;<sup>28</sup> and second, by being linked to the escalating costs of health-related litigation, which skyrocketed from USD 1.48 million in 2001 to USD 344 million in 2008.<sup>29</sup>

Of course, this phenomenon alone does not caution against the adoption of mechanisms that impose greater demands on the time and resources of courts, or that increase health-centric litigation in general. But it is worth keeping this and other examples<sup>30</sup> in mind as different legal systems in different countries move to accommodate the demands of socio-economic litigation, and as scholars and policy reflect on the ramifications of the justiciability of health rights.

These caveats are nonetheless compatible with the spirit in which Judge Santos wrote *Beyond Minimalism and Usurpation*. Without explicitly using this formulation, the Article continuously entreats courts in Brazil not to adopt one-size-fits-all models of judicial review. Judge Santos' careful approach to themes so closely related to his professional and scholarly endeavors indicate that he would also caution against one-size-fits-all transplants of the Brazilian experience.

The Article invites readers to (re)visit the boundaries of comparative constitutional law and health care systems in the developing world. While my response has so far engaged with one sliver of that universe, I now briefly turn in the opposite—but complementary—direction.

### III. BRINGING IT HOME: JUDICIALIZATION OF HEALTH IN THE UNITED STATES

The Symposium in which Judge Santos discussed his Article on February 19, 2019 was entitled *The Judicial Enforcement of Social Rights in Dysfunctional Democracies*. This response is not the appropriate venue to characterize the present state of democratic institutions in the United

*Health: Two Tales of Justiciability in Colombia and South Africa*, 26 HARV. HUM. RTS. J. 179 (2013).

27 Everaldo Lamprea & Tatiana Andia, Local Maladies, Global Remedies: Rethinking Right to Health Duties 1 (2008) (unpublished), <https://www.researchgate.net/publication/252068548>.

28 Alicia Ely Yamin & Oscar Parra-Vera, *How Do Courts Set Health Policy? The Case of the Colombian Constitutional Court*, 6 PLOS MED. 147 (Feb. 7, 2006), <https://doi.org/10.1371/journal.pmed.1000032>.

29 Lamprea & Andia, *supra* note 27, at 6. It should be noted that, while the use of the *tutela* action was tied to escalating economic costs of health-related litigation, *tutelas* alone were not responsible for the entirety of the cost of health-related litigation. *Id.* at 15-16 (noting that Colombia also had some of the most expensive pharmaceuticals at the time).

30 See, e.g., Olman Rodríguez Loaiza et al., *Revisiting Health Rights Litigation and Access to Medications in Costa Rica: Preliminary Evidence from the Cochrane Collaboration Reform*, 20 HEALTH & HUM. RTS. J. 79 (June 2018) (analyzing judicial review of health claims in Costa Rica).

States. What I would like to emphasize here is that there are relevant points of contact between the debate surrounding the role of courts in health-related litigation in the developing world and ongoing events in the United States.

Judge Santos' ultimate quest is to investigate "how courts may produce more justice in socio-economic-rights-related litigation."<sup>31</sup> If nothing else, this question should encourage debate in developing and developed countries alike. At a more specific level, however, many of the elements upon which Judge Santos touches in *Beyond Minimalism and Usurpation* directly relate to issues we are currently facing in the United States.

Because Judge Santos spends significant parts of the Article critiquing the reductionist view embodied by what he calls the "American models of judicial activism or minimalism,"<sup>32</sup> I will leave aside the question of whether and to what extent American courts should be involved in health-related litigation. But I will outline a few possible avenues of inquiry that highlight how American courts have been involved in health-related litigation.

I will start by addressing one aspect related to the (in)existence of a right to health in the United States. Unlike Brazil and several other countries, the United States Constitution does not enshrine socio-economic rights.<sup>33</sup> Without delving into the many implications of this omission, it is worth noting that the absence of a federal right to health is not synonymous with American courts not having to engage in considerations—or, more to the point, in the application of laws and doctrines—that directly or indirectly affect the provision of health goods and services.<sup>34</sup> Rather, in the United States we have a web of constitutional provisions, ad hoc federal legislation, state laws, case law, and regulations that continually require courts to play a dynamic role that decisively shapes most aspects of the provision of health care, access to medicines, and health equity in America.

Against this backdrop, substantive American health law<sup>35</sup> is intrinsically tied to the work of courts operating within this legal and

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31 Santos, *supra* note 1, at 535.

32 *Id.* at 469.

33 See, e.g., Susan Bandes, *The Negative Constitution: A Critique*, 88 MICH. L. REV. 2271, 2273 (1990) (describing and critiquing the historical view of the United States Constitution as a "charter of negative liberties.").

34 To give but one example, consider the Supreme Court's decision in *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012). See also Jack M. Beermann, *NFIB v. Sebelius and the Right to Health Care: Government's Obligation to Provide for the Health, Safety and Welfare of Its Citizens*, 18 N.Y.U. J. LEGIS. & PUB. POL'Y 277 (2015).

35 And, I would add, large segments of health policy.

normative patchwork. Health is largely judicialized in the United States. Most of the literature overtly investigating the judicialization of health comes from scholars in the developing world,<sup>36</sup> but America might just have the grandest of natural experiments in this field.

Given the plethora of legal instruments, as well as the breadth of institutions and actors involved in health law and policy in the United States, Judge Santos' remark that "courts must exercise creativity and institutional innovation"<sup>37</sup> in health-related litigation could well have been addressed to American courts. Likewise, the Article's framing of Brazilian courts as steeped in a complex institutional ecosystem reminds us that courts do not decide health-related issues in a legal and policy vacuum. *Mutatis mutandis*, the relational perspective adopted by the South African Constitutional Court in the *Soobramoney* case underscores this idea.<sup>38</sup>

The second point that I would like to make in connection with Judge Santos' article relates to the fact that, while we do not have a federal right to health in the United States, we certainly do have state constitutions in which there is a recognition or quasi-recognition of a state right to health. For instance, since 1963, section 51 of article IV of the Michigan Constitution has established that "[t]he public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health."<sup>39</sup>

One could be tempted to read the letter of the law as to imply that the state of Michigan has a right to health that mirrors the one enshrined in the 1988 Brazilian Constitution,<sup>40</sup> or in any other national constitutional laws that have adopted a positive right to health. But, as Elizabeth Weeks Leonard has noted, Michigan courts have interpreted section 51 in a way that "does not create and, in fact, seems to negate, any enforceable claim with respect to state action or inaction."<sup>41</sup> For example, in *Michigan Universal Health Care Action Network v. State*,<sup>42</sup> several advocacy groups

36 See, e.g., Biehl et al., *supra* note 10.

37 Santos, *supra* note 1, at 539.

38 See *supra* Part II.

39 MICH. CONST. art. IV, § 51.

40 CONSTITUIÇÃO FEDERAL [C.F.] [CONSTITUTION] art. 196 (Braz.) ("Health is the right of all and the duty of the National Government and shall be guaranteed by social and economic policies aimed at reducing the risk of illness and other maladies and by universal and equal access to all activities and services for its promotion, protection and recovery."); cf. Santos, *supra* note 1, at 437 (emphasizing the positive constitutional dimension of the right to health in Brazil).

41 Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Health Care*, 12 U. PA. J. CONST. L. 1325, 1350 (2010).

42 Mich. Universal Health Care Action Network v. Michigan, No. 261400, 2005 WL 3116595 (Mich. Ct. App. Nov. 22, 2005) (per curiam).

representing uninsured and underinsured Michigan citizens brought a lawsuit to compel the state to establish a Michigan-wide health care plan.<sup>43</sup> Even though section 51 contains mandatory language,<sup>44</sup> “the court concluded that the provision did not ‘require the state to provide state-funded health care coverage.’”<sup>45</sup>

Leaving aside the interpretive history of state constitutional language on the right to health,<sup>46</sup> as well as ingrained constitutional traditions outside the scope of this response,<sup>47</sup> let us consider *Beyond Minimalism and Usurpation*’s invitation to look for solutions that might disrupt the status quo. Are courts correct in reading language like “the legislature shall pass...” as enabling rather than mandatory? Must interpreters of American law operate on a negative-positive right constitutional dichotomy, rather than a spectrum where both types of rights may coexist in meaningful ways? Or even more broadly: is there something fundamentally different about patient populations in the United States that keeps us from breaking the mold of long-held traditions? And if the answers (or parts thereof) to these questions are so intimately connected to our constitutional interpretive practices and traditions, are these practices and traditions necessarily welfare-enhancing and hence worth maintaining?

The context in which these questions arise is far removed from South Africa’s *TAC* case example. However, the interplay between the role of courts, democratic institutions and civil society should prompt us to ask fundamental questions that are the core of democracy, whether we find ourselves in a functional or dysfunctional one.

#### IV. CONCLUSION

This two-part response has surveyed some of the ways in which courts are involved in health-related litigation and how the work done by courts affects the right to health, when it is constitutionally recognized and when it is not. In my reading of *Beyond Minimalism and Usurpation*, I have sought to advance the point that the judicialization of health is pluriform. I read Judge Santos’ work as an ample invitation to reflect and to enrich academic and non-academic discourses on the role of courts in health-

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43 Weeks Leonard, *supra* note 41, at 1349.

44 “The legislature shall pass suitable laws for the protection and promotion of the public health.” MICH. CONST. art. IV, § 51.

45 Weeks Leonard, *supra* note 41, at 1349 (quoting *Mich. Universal Health Care Action Network*, 2005 WL 3116595, at \*2) (internal citation added).

46 See generally Weeks Leonard, *supra* note 41.

47 See Bandes, *supra* note 33.

related litigation. The United States is certainly among the countries where such a reflection is most urgent.