



THE JUSTICIABILITY OF THE RIGHT TO HEALTH: A LOOK INTO THE BRAZILIAN CASE

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Abstract

The increasing number of individual cases reaching courts with the view of ensuring the implementation of social rights through judicial mechanisms gave rise to highly polemic debates in different countries, prominently in the last ten years. By way of a study of the Brazilian case, the paper presents a comprehensive overview on the justiciability of the right to health, asking how the judiciary is, or at least should be, best suited to realize this guaranteed right concretely.

Keywords: social rights, right to health, justiciability, Brazil.

Resumen

El creciente número de casos individuales que llegan a los tribunales buscando garantizar la implementación de derechos sociales por la vía judicial ha provocado debates polémicos en diferentes países, de manera destacada en los últimos diez años. Con base en un estudio del caso brasileño, el artículo presenta un panorama general sobre la justiciabilidad del derecho a la salud, cuestionando cómo el poder judicial puede garantizar más adecuadamente la realización efectiva de este derecho.

Palabras clave: derechos sociales, derecho a la salud, justiciabilidad, Brasil.

Introduction

In December 2009 the doctor Anne Murai was arrested, pursuant to a warrant issued by the judge Andrew Nicolitt, for disregarding a judicial order requiring the admission of the patient Elza Maria da Silva Aquino, 64, to the Intensive Care Unit (ICU) of a hospital in the state of Jacarepaguá in Rio de Janeiro, Brazil. The doctor refused to accept the

admission of Ms. Aquino due to the unavailability of beds at the ICU, which was already filled with previous patients under treatment. She was released at the following morning, but the disturbing images of a respectful doctor leaving the hospital handcuffed remained, being recalled several times by Brazilian media during the next days. Even for the overall public there seemed to be something terribly wrong with that situation.

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This singular case represents an extreme example of a highly controversial and polemic discussion that takes place in Brazil prominently in the last ten years, and similarly in different countries throughout the world, as well as at the international sphere. How to frame what is the main topic behind this scenario is not really an easy task though, as it would appear to be at first glance. The debate vehemently divides opinions, with strong arguments being held for both sides, since it involves a plurality of issues and expertise from a wide range of subject-areas.

How to ensure human rights at the national level? How to conciliate individual claims with larger social needs? How to deal with the alleged scarcity of resources and budgetary constraints? How to reconcile a human rights-based approach to development with tragic choices and trade-offs? What should be the role of the judiciary in achieving broad social justice and equality? Those are only few instances of numerous questions that could be raised in this regard, and that inevitably will be touched upon in the present paper.

It must be made clear from the beginning, however, that it is no longer a question of whether rights of the same nature of the right to health, i.e.: economic and social rights, are justiciable¹ or not; or in other words, that those

1 Justiciability, as employed in this paper, means that a competent judicial or quasi-judicial body can identify violations and provide for adequate corrective measures without infringing into the work of other branches of the government (Golay, 2009, p.22). To some authors, meanwhile, the concept of justiciability is taken more broadly, as understood that it should not be limited only to traditional mechanisms of conflict resolution (Benvenuto, 2001).

rights are in fact susceptible to being effectively brought and adjudicated before courts and tribunals.² For the purposes of the present paper, the crucial point revolves around how the judicial apparatus is, or at least should be, best suited to realize those rights concretely. An agreed answer to this question is by no means straightforward, but arresting doctors definitely seems not to be it.

“The key question, then is not whether unelected judges should ever take positions on controversial political questions. It is to define in a principled way the limited and functionally manageable circumstances in which the judicial responsibility for being the ultimate protector of human dignity compels them to enter what might be politically contested terrain”. (Sachs, 2009: 9)

Some would frame the debate in terms of how to give rights “teeth”, others in terms of the *phenomenon of the increasing judicialization*³ of economic and social

2 Here it is taken as an assumption that the justiciability question of economic social and cultural rights (ESCR) was settled on december 2008, with the unanimous adoption of the Optional Protocol to the International Covenant on ESCR. This argument is further explored in the following section II. iii. on the role of courts.

3 The term *judicialization of health* has been recurrently employed by the Brazilian legal, medical and pharmaceutical communities and the press, to refer to the increasingly growing number of individual cases that reach the national courts aiming at ensuring the provision of a specific medical treatment through injunctions. In this context, the term has acquired a perhaps bad connotation by being more frequently employed in negative terms, as if the growing engagement judiciary was a distortion that should be avoided. For this reason, a choice was made to limit the employment of this term in the present text. Meanwhile, the term judicialization by itself was

rights. How to define the problem, notwithstanding, implies important presuppositions. This means that the wording choice may already be revealing of some ethical pre-assumptions made by the authors. In this sense, a particular carefulness will be placed on elucidating what definitions were used for the basic concepts on which the present text is based.

In the light of the above, this paper aims at presenting an overview on the topic of the Justiciability of the Right to Health. It is by no means an exhaustive presentation, but it pretends to be comprehensive enough so as to touch the main axes of the debate and, by doing so, shed some light on the possible contributions to how the debate may move forward in Brazil. Such objective assumes a particular relevance when one realizes that the discussion in Brazil does not currently take into account similar developments that are taking place in other countries or at the international level, hence, possibly missing significant points in terms of best practices and available solutions to hard dilemmas.

In order to do so, the paper is divided in three main sections, in addition to this introduction. Section II presents an overview of the right to health. First, it

borrowed from a more broad literature which deals with the so-called *judicialization of politics* and/or the *politicization of the judiciary*. Here, it is used to refer to the expansion of the judiciary's role on the formulation and implementation of public policies, and the constant interaction and interference between the political/administrative and the judicial branches of the government. According to Tate and Vallinder's definition, "judicialization is the judiciary's reaction to the provocations of a third party which aims to review the decision of a political power by building upon the Constitution". (Carvalho, 2004).

briefly defines the concept and presents its main legal basis under international law. After, it delineates some considerations about the titularity of such right and, in more abstract terms, the role of courts in implementing it. The subsequent Section III is devoted to a deeper analysis of the realization of the right to health in the Brazilian case. This third section is divided into two subparts, comprehending an elaboration on the national legal basis of the right and, following, a presentation of the Brazilian trajectory. This last part discusses facts, figures and trends as well as controversial aspects related to the litigation of the right to health in the Brazilian context. The final section corresponds to the concluding remarks.

The Right to Health: an Overview

Defining the concept

Health is a very strong candidate for a universal human value, if we consider that such a thing exists. In fact, very few people would chose bad health instead of good, since enjoying a strong and positive health condition is a prerequisite for the realization of almost any other goal in life. In the same direction, when thinking in terms of rights, there appears to be no controversies on the fact that every human being should benefit from the *right to health*. However, when speaking in such broad terms, such right appears to be rather abstract and intangible, giving rise to much misunderstanding and confusion. This is the reason why, since 1946 when the Constitution of the World Health Organization

first elaborated on this concept, various sources have been devoting efforts towards defining the concept, giving it meaning and elaborating on its content.⁴

The majority of the provisions of the International Covenant on Economic, Social and Cultural Rights (ICESCR) were drafted in the form of obligations of result rather than obligations of conduct. When taken at this more general level, these obligations cannot easily be made justiciable. Consequently, elaborating on the content of the right to health acquire an ultimate importance for our purposes in the present paper, since “it is only when they are broken down into their more specific components that justiciability becomes practicable”. (Eide et al., 2001: 25).

The landmark document in this regard dates from 2000. It refers to the General Comment N. 14 of the Committee on Economic, Social and Cultural Rights on the article 12 of the ICESCR, i.e.: The right to the highest attainable standard of health. Through this General Comment, the Committee settles the converging understanding among scholarship and practitioners of what this right is, what it is not, and what kind of obligations it entails for states.

It is particularly clear from the outset that the right to health is not the right to be healthy. This point is crucial since good health cannot be ensured solely by states, nor can governments provide

protection against every possible cause of human disease; everyone will be sick once in a while and the state apparatus cannot have overall control over this fact. In addition, *being healthy* is culturally defined, and is socially and historically contingent. The parameters may change over time and across societies. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary to the highest attainable standard of health and, as such, is not limited to health care.

Briefly, in the words of the Committee,

“the highest attainable standard of physical and mental health’ is not confined to the right to health care. On the contrary, (...) [it] embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.”

The right to health is thus defined as an inclusive right, which entails the following elements: availability (sufficient quantity), accessibility (comprising non-discrimination, physical access, affordability, and access to information), acceptability (ethical and cultural sensitive aspects), and quality (scientific and medical appropriateness). In doing so, the Committee acknowledges the interrelation and interdependency of

4 The work of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has been of particular relevance in this regard.

all rights, as well as its intrinsic relation to the central notion of human dignity. The concept of *underlying determinants* of health was coined precisely to refer to the social underpinnings required for the full realization of this right.⁵

Accordingly, the hereinafter called *right to health* must be understood as a short-hand broadly accepted expression for a more complex set of freedoms and entitlements,⁶ as previously defined. References to this right appear, in diverse formats, in numerous international instruments, ranging from specific human rights treaties to soft-law mechanisms, among other kinds of international acts. For the purposes of this paper, it is worthy to recall the following provisions which constitute its core international legal basis: article 25(1) of the Universal Declaration of Human Rights (UDHR, 1948); article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966); the Declaration of Alma Ata on Primary Health Care (1978); article 55 of the United Nations Charter (UNC, 1945); and, finally, article 10 of the Additional Protocol to

the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights – Protocol of San Salvador (1988).

Based on the long-standing tripartite typology of respect, protect and fulfill⁷ (the latter also including the other dimensions of facilitate, provide and promote),⁸ General Comment 14 also elaborates on the fact that all rights, in spite of their character as civil, political, social or economic, comprise elements of immediate effect, as well as elements of progressive realization. This understanding is borne out of the perception that compliance with each and every right may require various measures ranging from passive non-interference to active insurance, putting an end to the dichotomy negative/positive rights.⁹ It is worth mentioning that, in pointing out the general legal obligations for States Parties, this General Comment is closely connected to another, which dates from one decade before, that is, the General Comment N. 3 on the nature of States parties' obligations (Article 2 (1)).

5 Some conceptualization may be required at this point to elucidate that a rights-based approach to public health is different from the realization of the right to health, even though both notions are intrinsically related. The first simply refers to the imperative of being attentive to the respect and promotion of human rights in the administration of public health policies, while the latter is the object of the present study.

6 "Freedoms include the right to control one's health, including the right to be free from non-consensual medical treatment and experimentation. Entitlements include the right to a system of health protection (i.e. health care and the underlying determinants of health) that provides equality of opportunity for people to enjoy the highest attainable standard of health." (Hunt, 2003, p. 8).

7 The idea was first introduced by Henry Shee in 1980 and further crystallized around this terminology by Asbjørn Eide in 1987 in his role as special rapporteur for the UN Sub-Commission on the Protection and Promotion of Human Rights.

8 It is important to recognize, on the other hand, that there are some authors, as Koch (2009), which are very critical to the tripartite typology approach, objecting the applicability and usefulness of this predominant typology.

9 As Koch puts it, "the challenge today is not to question the positive/negative dichotomy but rather how to go about the fact that some human rights are more vaguely worded and more resource demanding than others" (2009, p. 26). Judicial bodies have responded creatively to this question as will be further elaborated.

Additionally, the General Comment also defined the core content¹⁰ of the right, which includes a range of specific criteria – such as, disease prevention and reduction, equal access to health facilities and treatment, dissemination of information, among others.¹¹ Furthermore, it recognizes the right of victims to have access to effective remedies¹² and accountability mechanisms, including judicial and quasi-judicial instruments. It must not be forgotten that a crucial way to elaborate on the substance of a right is exactly by judicial interpretation. The courts play a fundamental role in defining the scope of abstract rules when applying it to concrete cases.

Defining the subjects – Considerations on titularity

As so defined, the right to health is recognized as both a subjective and a collective right, as a *right of each and everyone*. This co-titularity of rights implies that individual claims cannot be ignored, but must at the same time be balanced by considerations of broader social justice and equity. Theorists on the co-titularity of rights defend that the diffuse character

of welfare rights places the community as a whole as its main holder, without excluding the possibility of a residual subjective adjudication (Lins, 2008). In this sense, the social and the individual dimensions must be understood as two interconnected and interrelated spheres of realization of the right.

The contours of this problematic become significantly bold when we touch upon the issue of the allocation of scarce resources for the realization of such rights: should the government be under the obligation to provide high-cost medicines for one particular patient when, at the same time, this will result in the unavailability of other basic medicines at the popular pharmacy? When faced with such hard dilemmas, one should bear in mind that there are no absolute guarantees. One guarantee will necessarily face its limits when confronted to the limits of another equally fundamental guarantee. In those cases of conflict, the proportionality principle,¹³ as applied by the judge, will have a fundamental role to play, particularly in cases like Brazil where the Constitution democratically entertained conflicting interests of different groups.

10 The notion of “core content” refers to the very minimum components, the so-called “survival kit” (Riedel), that states must ensure and are not allowed to derogate; otherwise the right would be deprived from its own *raison d’être* and, thus, cease to exist. This minimum essential must be guaranteed to the maximum of available resources (including the obligation to seek for international cooperation and assistance when it is the case).

11 For a complete list, please refer to UN Docs n. E/C.12/2000/4

12 Remedies for violations may include: restitution, rehabilitation, compensation, satisfaction, non-repetition;

13 The legal principle of proportionality may acquire different meanings under different fields of domestic or international law. Under the domestic constitutional and administrative laws of many countries it has a particular importance related to the balance of individual rights and the interests of the general public. It provides an analytical framework (which includes: reasonable choice of means, fair assessment and balancing of interests) that enables judicial bodies to review the propriety of certain measures on the basis of a value comparison, resulting in an element of *fine-tuning* among means and ends.

The role of the Courts – Some general aspects

Along with the notions of internationalism, universalism and indivisibility, justiciability is an indispensable component of the modern conception of human rights (Benvenuto, 2001). As stressed by Bobbio in the *Age of Rights*, every right raises a correlative obligation and, consequently, a right whose recognition and effectiveness are postponed *sine die* cannot be properly called right.

As already recognized in the Limburg Principles (1987), there are different elements, or pathways, that allow for the realization of ESCs rights. *All appropriate means*, as defined in Article 2 of the ICESCR, include legislative, administrative, judicial, economic, social and educational measures. Therefore, the enforceability of ESCR is by far not limited, nor should be, to judicial mechanisms, but those are certainly a very important element for its effective realization.

As a matter of fact, for many decades, what prevailed was a convoluted discussion on whether such rights were justiciable or not. It is not in the scope of the present paper to elaborate much further on this issue, but it is necessary just to point out that, even though the resistance and skepticism of certain states on this topic extends back in time, the two traditionally invoked arguments to challenge the justiciability character of such rights (i.e.: abstract formulation and progressive realization) are no longer applicable. There is nothing inherent to ESCR that precludes its

justiciability, and there is plenty jurisprudential evidence that demonstrate so (Golay, 2009).¹⁴ As mentioned earlier, for the present purposes, the debate is considered to be settled after December 2008, with the adoption of the Optional Protocol to the ICESCR.

However it may be, what it is impossible to deny is the fact that the judicial enforcement of socio-economic rights often still raises a number of difficult and complex issues.¹⁵ These include, among others: the separation of powers; the legitimacy of unelected courts determining policy and expenditure; the problems of institutional capacity, process and evidence; and a reconceptualisation required about the nature of rights that expand over time and are expressly made dependent on resources (Sachs, 2009) some of which will be assessed in the study of Brazilian case in the following sections.

In this context, what one understands by democratic principles turn out to be particularly relevant. Indeed, the answer to many of the questions posed will depend on how one defines the paradigm of democracy, and perceives the interrelationship between democracy and human rights.

14 According to Benvenuto (2001), this recent development in terms of the justiciability of *all* rights is an attestation of the virtually universal acceptance in our times of the thesis of the interrelationship and indivisibility of human rights.

15 "It is a matter of common knowledge that it is much more difficult in practice to enforce enjoyment of an economic or social right before a court of law than is enforcement of a civil and political right" (CPR) because, more strongly than CPR, ESCR require making political choices, setting priorities, allocating resources and rearranging budgets (Coomans, 2006).

The theory of separation of powers and institutional dialogue between all governmental branches, for instance, becomes crucial, since it is exactly the interaction among them that makes one accountable to the other. The question generally posed in this regard is about whether or not judges and tribunals may interfere in the political deliberation of bodies that represent an electoral majority. Similarly to what many authors suggest, it is argued here that it might be the case that for a restricted number of circumstances involving highly contentious matters, there is actually an advantage for judges not to be accountable to the electorate. Unequivocally, the role of the courts as the ultimate protectors of human dignity and constitutional guarantees compels them to enter what might be politically contested terrain (Sachs, 2009; Mendes, 2010). The question, then, is to define a principled way of doing so.

Realizing the right to health in Brazil

Constitutionalization

The right to health is an integral part of the 1988 Brazilian Federal Constitution (FC). Besides being expressly recognized under Article 6 on Social Rights, it has an exclusive section devoted to it (i.e.: Title VIII, Chapter II, Section II, arts. 196 to 200), which establishes a national unified public health system, the so-called *Sistema Único de Saúde* (SUS). This step represented a radical transformation in the conception of health protection system in the country, being internationally

recognized nowadays as one of the most advanced systems in the world.

Indeed, the 1988 Constitution is the ultimate consecration of the democratic transition that took place in Brazil after 21 years of military rule and, as such, has a crucial role for the consolidation of the rule of law in the country, as well as for the proclamation of the fundamental guarantees.¹⁶ The charter consecrates in its first article the principle of human dignity as foundational for the Republic. Likewise, article 5 *caput* guarantees the right to life for all citizens.

The FC also provides a framework of principles which should guide all public health policies in the country. Accordingly, the SUS is based on the general principles of universality, equity and integrality; and organized around the axes of decentralization and unified command, resolvability, regionalization and hierarchy, popular participation and complementarity of the private sector (Brazilian Ministry of Health, 1990).¹⁷ Moreover, as Ferraz (2009) points out, the FC expressly acknowledges that the right to health is not simply restricted to the provision of care, but also involves comprehensive measures and policies to meet all determinants of health, ranging from preventive measures to sanitation,

¹⁶ To Canotilho, the crucial difference between the concepts of Human Rights and Fundamental Guarantees is in what terms and in what framework the rights are defined, the first one belonging to international instruments that apply to all humanity in spite of a nationality and citizenship attribution, while the latter refers to the rights recognized under the national legal order, the beneficiaries of which are the right-holders as so defined in such order.

¹⁷ The SUS is also regulated by the Health Organic Laws N. 8080 and 8142 from 1990.

preservation of environment, control of food quality, etc.¹⁸

Even though the state remains as the sole human rights' guarantor, it is interesting to notice that the right to health is connected, by virtue of article 227, to the principle of solidarity. In the sense that it is also a duty of the society as a whole the promotion and protection of the right to health, especially for the child and youth, under what Canotilho names a shared responsibility (Sarlet and Figueiredo, 2008: 7)

Before 1988, the protection of the right to health in Brazil was restricted to ordinary legislation, or to indirect references in the constitutional texts under provisions related to public epidemiologic emergencies, as in the case of article 179 of the 1824 Constitution, or to the inviolability of the right to subsistence, as in the article 113 of the 1934 Constitution. During the military rule, the right to health was particularly related to the well-being of workers and safe labor conditions, since the access to health was conditioned by individual's contribution to the social security.

The process of constitutionalization – that is to say, of positive codification of specific rights as provisions in the Magna Carta of the country -, should hence be understood in the scenario of a broader evolution of ordinary

systems of protection, and in the context of the national prominence of the Sanitary Reform Movement. The claims raised during the VIII National Health Conference, in 1986, had a notable influence on the constitutional assembly deliberations (Sarlet and Figueiredo, 2008).

This passage from ordinary legislation to the highest normative rank of a legal order is extremely significant in terms of the enforceability of those rights. Even though it is clear that there is an imperative need for secondary forms of legislation and executive action, which tends to be much more precisely formulated, for an effective realization; being inscribed at the Bill of Rights places those rules at the top of the hierarchy. This means that they are harder to change and must serve as parameters for any further legislative act, being thus subject to judicial review. Ordinary legislation may be changed relatively easily, what brings the risk of a decrease in levels of protection according to political and factual changes.

Additionally, one must take into account that the adoption of the 1988 text also took place in a highly conducive context where international pressures, deriving from the recent promulgation and growing acceptance of international human rights standards, exercised great influence. In this sense, the 1988 Constitution might be considered very progressive in terms of recognizing ESCs rights, especially as rights of immediate application, as defined in article 5(1), and not only as social goals or policy

18 To Ferraz (2009), this point is particularly relevant when analyzing right to health litigation in Brazil, "which has been overwhelmingly concerned, if not exclusively, with health care, in particular pharmaceutical care."

indications.¹⁹ This means that the judiciary, including the Brazilian Supreme Court (the higher constitutional guarantor), when invoked to apply it, may not refuse to exercise its role.²⁰

Paradoxically, for its own complexity, this huge normative, administrative and institutional structure has been giving signs of failure and debilities. The time has come when it is no longer possible to postpone the necessity for the adoption of reasonable and objective criteria to be followed when the judiciary is faced with demands related to this issue.

Brazilian trajectory

a) Facts, figures and trends

In Brazil the constitutionalization of the right to health brought to the heart of the legal world one of the most complex areas of public policy of the modern state (Ferraz e Vieira, 2009). Mainly after the

end of the 1990s,²¹ thousands of lawsuits have been raised across the country in this area, hundreds of which end up at the highest court, in what seems to be an ascendant curve of individual cases. From a closer look, it is possible to identify some patterns, not only in terms of facts and figures, but also a tendency that has been followed by the judiciary in its decisions.

In spite of the relative scarcity of quantitative data on the field of legal research in the Brazilian doctrine, which is traditionally focused on qualitative analysis, an information recollection from a variety of sources – including particularly local news releases, pronouncements of concerned authorities and reports from the Brazilian Ministry of Health and the National Council of Justice –, allow for some impressive figures.

“There is not yet any comprehensive and systematic study that provides a clear picture of the magnitude of the phenomenon in Brazil. But several localized studies and one recent comparative study, together with data released periodically in the press by health authorities, suggest that the phenomenon is widespread, is growing exponentially, and is likely to be reaching (or to have already reached) significant levels in terms of volume and costs.” (Ferraz, 2009: 4).

According to data from the Brazilian Ministry of Health, between 2003 and 2009, there were raised 5,323 lawsuits

19 It is key to identify the legal status of economic and social rights in each individual country, since the way welfare rights are incorporated in the national legislation may assume a large variety of forms. Even where they are part of the constitutional text, the way they are drafted is subject to crucial differences. They may be phrased as rights that can be directly invoked by individuals, as in the Brazilian case (and also in Hungary), or only as programmatic obligations or directive principles directed at the government (for instance, in the cases of India, the Philippines and Spain). (Coomans, 2006).

20 Those developments took place within the framework provided by a legal-academic movement which became to be known as the Brazilian doctrine of effectiveness: “Effectiveness was the turning point from the old to the new constitutionalism; the Constitution ceased to be a mirage, with the honors of a false supremacy which was not translated for the citizens’ benefit.” (Barroso, 2008, p. 6).

21 This movement was spurred initially in the 1980s by those seeking (successfully, as it turned out to be) drugs for the treatment of HIV/AIDS, but later it spread to several other areas of health (Ferraz, 2009).

aiming at the provision of medicines not contemplated in the SUS' list.²² This number refers only those cases that reached the national level. Total figures are surely much higher, since it also includes cases pending at courts at the municipal level, as well as demands other than for medicines (e.g.: requests for UIT beds, specific medical equipment such as prostheses, treatment abroad, etc.). As a result, the Ministry's expenditure on pharmaceutical assistance more than tripled in the last seven years (from approximately US\$ 1.2 billion in 2003 to US\$ 3.9 in 2009).²³

More recently, some preliminary data available from the National Council of Justice (CNJ) reveals that in 2010 the total number of cases involving health-related demands was of 112,313. Out of those 92,767 were at the local and municipal levels and the others 19,546 reached federal instances. By analyzing the disaggregated data by region, it is possible to notice an acute discrepancy among different federative units. For instance, São Paulo had 44,690 cases, while the state of Acre had only 7 (those correspond respectively to the opposite extremes). It is not the focus here to elaborate on particular reasons for that difference. On the other hand, it certainly provides an interesting point of departure for deeper reflections upon regional inequalities in Brazil and

disparities among the populations in what relates to rights-awareness and access to justice.

These statistics are part of a broader project that was inaugurated on, and developed ever since, August 2010 by the CNJ: the National Forum for Judicial Monitoring and Resolution of Claims for Health Care (or simply called, the Forum of Health).²⁴ This recent initiative was launched after the Public Hearing N. 4 held by the Supreme Court on the same issue. Its main objective is to serve as a think-tank, elaborating studies and proposing measures and standards for the improvement of procedures, and prevention of further legal conflicts in health care. By serving as an arena for constructive dialogue among scholars, magistrates, doctors and technicians from the field of public health, the Forum seeks to create additional concrete actions aimed at the optimization of procedural routines, as well as further institutionalization of specialized judicial units.

Curiously enough, the creation of the Forum by itself should be accessed in the light of the historic evolution of the debate in the country, with its polemic aspects. In the view of Milton Nobre, the motto chosen for the campaign (*Justice is good for health*) fits squarely within this new configuration of the Brazilian reality, where the Judiciary assumes an active attitude, no longer isolating itself, nor mistakenly taking indifference or insensibility as if impartiality. The 1990s

22 The list includes around 600 different types of medicines that are delivered for free at popular pharmacies.

23 Speech of the former Brazilian minister of health, Mr. José Gomes Temporão, in 2010. Source: http://www.cnj.jus.br/images/programas/forumdasaude/discurso_ministro_temporao.pdf

24 More information available at: <http://www.cnj.jus.br/mapa-do-site/455-rodape/acoes-e-programas/programas-de-a-a-z/forum-da-saude>

decade come out as a turning point, when the judiciary effectively began to decide in favor of the claimants in a generalized manner, in a much progressive attitude. In effect, Barroso (2008: 24) argues that in several cases prior to that date the conservative approach was predominant. The engagement of the court gives evidence of its willingness to take action in preserving fundamental rights.

As a final comment to this section, it is relevant to consider the results of an interesting review conducted by Ferraz (2009), which worked on the systematization of the findings of 13 empirical academic studies that have looked into the problem of right to health litigation in Brazil up to 2009. By relying on the framework proposed by Gloppen (2009),²⁵ his analysis head to the following conclusions: most studies converge on the findings that vast majority of cases involve an individual claim for the direct provision by the state of medicines or treatment that start in first instance courts (where one judge alone makes a decision), then, when appealed, go up to the Court of Appeal (where 3 and potentially 5 judges hear the case), and finally, if appealed on a point of federal law, they go up to the Superior Justice Tribunal or, if appealed on a point of constitutional law, they go up to the Supreme Federal Tribunal. There is also

25 In the author's own words, in order to evaluate the potential of litigation as a strategy to advance the right to health in society as a whole, Gloppen proposes a framework to address the systemic impact of health litigation efforts taking into account who benefits from it. In order to do so, it divides the phenomenon into four stages: claim formation, adjudication, implementation and social outcomes, each of which raises a series of questions that warrant investigation.

the possibility of the Public Prosecutor to act on behalf of individuals or groups. There is rarely any obstacle to admissibility, and the final judgment, as found in his review, has been in favor of the claimant in the overwhelming majority of the cases. Compliance varies enormously across the country, but there are few researches conducted on the social outcomes of decisions.

b) The problem of resources

Under article 167, the FC evidences the concern that the constitutional assembly had in cautiously planning and limiting all the future governmental expenditures, prohibiting the initiation of programs or projects not included in the annual budget, as well as the relocation or transfer of funds from one program or agency to another without prior legislative authorization. Additionally, the constitutional amendment N. 29, from 2000, established a minimum floor that, although subject to regulation, must be allocated for health-related expenditures.

Yet it is clear that this fact does not preclude the judge to order the executive to perform certain expense to enforce a particular constitutional right:

“(...) between protecting the inviolability of the right to life and health, which are inalienable individual rights guaranteed to all by the Federal Constitution, or to opt to the prevalence, against this fundamental prerogative, of a secondary financial interest of the State, I understand – once configured this dilemma – that motivations of ethical

and legal groundings impose on the judge only one possible option: the one that favors the indeclinable respect for life and human health.” (HE Celso de Mello, judge of the Supreme Court, in assessing the petition RE 482.611-SC).

For example, the former secretary of health of the state of São Paulo, Mr. Luiz Roberto Barata, published in 2005 an report stating that the approximately US\$ 53 million spent by the state with lawsuits of this nature, in the first half of 2005, amounted to almost the double of resources spent for the same purpose in the precedent year of 2004. Accordingly, in 2006, around US\$ 16 million were spent per month with 10 thousands judicial orders, while the regular supply of drugs to 266,000 people consumes 70 million. Thus, expenditures of such nature corresponded at that time to approximately a quarter of the total budget of the Department of Health of the state.²⁶

The referred passage, extracted from a 2004 extraordinary appeal, became a landmark for the Brazilian jurisprudence and has been repeatedly quoted on other similar decisions, and may be revealing of a mismatch between what the judiciary and the health experts understand by health rights. Indeed, when confronted with a single case with such strong moral imperative, where life is at risk, to the court is compelled to do decide in favor of the patient and *do justice*, since apparently the state will always have sufficient resources to provide for the need of one particular individual.

²⁶ Source: <http://www.cremesp.org.br/?siteAcao=Jornal&id=753>

But this micro-approach to justice, once ignoring macro-components, may often result in unexpected adverse effects to the collectivity. There will always be material constraints. The idea that the government machinery is capable of meeting the needs of every member of the community indefinitely, either in health or any other field, is utopian even for the richest of the countries.²⁷

Technicians and professionals from the field of public health are confronted in a day-to-day basis by hard choices. For instance, about which patient should receive an organ transplant or who should be given priority in the access to limited places for hemodialysis or Units of Intensive Treatment. Inevitably, there are no easy answers, but it is clear for them that principles of medical ethics based on distributive justice must guide their decisions. Not even the utilitarian maxim of the greater good to the larger number provides a straightforward adequate decision to all situations.

However, to place emphasis on the *scarcity-of-resources argument* risks representing a major embarrassment, particularly in a country like Brazil. This is because Brazil is undeniably a very rich country, with huge potentials for growth and development, but unfortunately it is also a

²⁷ In order to demonstrate by way of an extreme exemplification the absolute scarcity of material resources, Ferraz and Vieira (2009) perform some projections and reach the astonishing conclusion that the financial resources necessary to implement a specific therapeutic care policy to only 1% of the Brazilian population for only two diseases would be higher than the total expense of all spheres of government for a comprehensive set of actions and health services.

country of contrasts, of tremendous inequalities and resources concentration. Additionally, it is a country where the tax burden is incredibly high, where one is constantly confronted with scandals on corruption and diversion of resources, where parliamentarians and other public officials benefit from skyrocketing salaries and recurrently legislate in their own favor for wages increase.²⁸ This argument never seems to be persuasive enough. It is not a problem of scarcity, one may correctly argue, but about efficient allocation and prioritization. This is why it is important to distinguish between absolute and relative scarcity.²⁹

The perceived general tendency of the magistrate not to assess more carefully the budgetary impacts of its decisions may be also consequence of the above mentioned perception. Ferraz e Vieira (2009: 10) emphasizes that, even though there has been a real increase on the Brazilian public investment in health *per capita* in relation to its GDP, evidence suggests that Brazilian population has worse public health indicators when compared to neighboring countries that spend less. Brazil spends more, but worse.

28 A research conducted by the NGO Transparência Brasil found that the Brazilian parliamentarians are the most expensive in the world. Available at: <http://www.youtube.com/watch?sns=fb&v=eySRDPHO8XM>

29 The co-called *political economy of health* is mainly about distribution of resources. It is worth noting that investment in the health system can work as a tool for development, since it is not only about costs and expenses, but essentially about improving the overall underlying conditionings of health and, hence, allowing for greater future revenues and larger social gains (Morgan and Turner, 2009).

As Ferraz (2009), very wisely acknowledges,

“For its level of economic development (an upper middle income country), Brazil actually performs poorly in many areas of human development when compared to countries of similar and lower wealth [which] (...) despite having similar or less resources, have nonetheless better indicators than Brazil in life expectancy, adult literacy, infant and child mortality. (...) What explains Brazil’s underperformance? (...) One important explanatory factor is the high degree of inequality of income and associated standard of living in the country. Indeed, in all health indicators there is a clear gap between that of the highest quintile of the population (20% richest) and the lowest quintile (20% poorest). The impact of income inequalities on health inequalities will vary in great part according to how income inequalities translate into inequalities in the other so-called social determinants of health (...). There is emerging evidence that income inequality *per se* is a social determinant of health, i.e. that in more unequal societies even the richest have worse health outcomes than they do in more equal ones.” (Ferraz, 2009: 6)

On the other hand, borne out of this context of insufficiency of resources, the literature in Brazil has been largely referring to the particular doctrine of what has been called the *reserva do possível* (or the costs of rights),³⁰ along with the notion of “mínimo existencial” (the

30 Expression coined by the Constitutional Court of Germany (*Vorbehalt des Möglichen*) widely used in Portugal and Brazil. Translation was made by the author.

survival minimum). This doctrine elaborates on the idea that the full realization of specific guarantees is limited by material considerations, which would restrain, or at least justify, the non-compliance with a judicial order. Arguments in this regard, nevertheless, should always be read suspiciously taking into account that the burden of proof will always lie with the state to demonstrate the real feasibility of it, and also that, as party to the ICSECR, Brazil is under the international obligation to fulfill its treaty's commitments to *the maximum of available resources* (article 2). Yet, it is not within the scope of the present article to elaborate this topic further into detail.

Sometimes, with creative solutions it is possible to overcome the limitations imposed by the budgetary contingencies. A good illustration include decisions that impose on the government the obligation to include a specific provision in the next annual budget plan, not necessarily requiring immediate steps. Another, is the possibility for the government to seek for the provision of a specific treatment by means of a public-private partnership based of tax advantages (Gandin et al., n. d.).

c) Access to Justice

Another very polemic and central aspect is the access to justice. Unfortunately, the reality that still prevails in Brazil is very unequal in what refers to who, or more precisely, to what sectors of society have access to the court. The most poor face many difficulties in having access to several public services,

among which the jurisdictional one is no exception. The judicial-determined reallocation of resources is not random and, in fact, even if not deliberately, it ends up following a perverse logic of transference of benefits from the most in need to the most privileged of society. Either due to the ignorance of their own rights, because they cannot afford the costs of legal proceedings, among other reasons, the fact is that marginalized segments of society remain excluded from the access to judicial remedies. As Morgan and Turner (2009) rightly affirm, equal rights do not produce equal outcomes; and the legalization of rights does not necessarily empower the poor.

According to Golay (2009), a number of conditions must be met in order to ensure access to justice. First, the right must be enshrined in the legal system, that is, it must have a legal basis. Second, legal remedies must exist, be available and applied to protect the victims from violations. Third, the petitioned oversight bodies must recognize the right, as well as its role as guarantor of the respect, protection, and fulfillment of the right. Those three conditions will determine why victims of violations are able to secure access to justice under some legal systems and not others.

Nevertheless, what happens in Brazil is that, even though there is legal basis for the right to health, even if legal remedies exists and the courts do recognize the right as well as its role, the rights of the poorest are not being respected. As Afonso da Silva (n.d.) creatively puts it, judicial enforcement of

social rights in Brazil is often leading to an *anti-Robin Hood* effect, according to which the courts allows for a sort of distributive injustice.

Afonso da Silva & Terrazas (2008) conducted an empirical research in order to know the profile of the beneficiaries of the decisions issued by the Municipal Court of the state of São Paulo involving plaintiffs requesting medicine for the treatment of hepatitis between 1998 and 2006. Their survey's results should serve as an illustration of the argument previously presented, and it evidenced the following:

“(...) after crossing this information with other data, it was possible to clearly identify two distinct groups of plaintiffs. The first one consists of people with a low income, whose medical prescriptions were issued at a regular public hospital, and whose lawsuit has been filed by a public attorney. People in this group have usually demanded simple nursery goods or less expensive drugs. The other group consists of persons with a higher household income, whose medical prescription was issued at a private hospital, and whose lawsuit has been filed by a private lawyer. People of this second group have usually requested (very) expensive drugs.” (p. 12).

However, they also found that most of the medical prescriptions (60.63%) used in the judicial demands were issued in a private hospital or clinic. This, together with other pieces of evidence, exemplifies that judicial activity concerning the right to health especially benefits people

who can afford health insurance and, more importantly, afford a lawyer.

In agreement with the argument developed by Afonso da Silva & Terrazas (2008: 12), people who benefit from a judicial decisions in those cases are to be considered doubly privileged citizens, “for they not only have access to medicines and treatments often not available to the users of the regular public health services, but also have the guarantee that such medicines will never be out of stock (which is very common in regular public hospitals) because they are protected by a judicial decision.” Hence, unfortunately, the poorest are (once again) excluded; this time “from receiving the most modern and efficient medicine and medical treatment, which, in spite of being funded with public money, are accessible only to those who overcome the first hurdle” of obtaining access to the Judiciary (p.13).

Although access to the Judiciary branch is formally open to everyone and that indeed courts treat all litigants, whether rich or poor, in an equal and non-discriminatory basis, the Judiciary acting alone and by itself is far from being an effective institutional mechanism for promoting social equality in Brazil. Courts are very distant from the lower classes because their services presuppose access to resources and attributes that in overall are not available to marginalized sectors of society, or are at least more predominant in higher socioeconomic groups. Those include: rights awareness, organizational strength and ability to mobilize, access to legal assistance,

technical expertise, and financial resources (Gloppen, 2008). “Empirical data has shown that an effective access to the judicial system in Brazil is almost exclusively reserved for the financially well-resourced litigants” (Afonso da Silva, p. 16).

As a result, there is a distortion on the principles of universality and equity that conceptually makes SUS one of the most relevant politics of social inclusion of the country. Equality here means that the individual necessity *per se* is not a sufficient criteria to determine the outcome. In referring to the landmark case of *Soobramoney v. Minister of Health KwaZulu-Natal* (2005), the South African judge Albie Sachs expressed what is one of the most lucid opinions on this regard:

“(...) being placed in a queue for access to scarce resources is not to find yourself being subject to a limitation of your right, but to be put in a position to enjoy your right together with others (...) provided that the queue is fairly established, and the criteria are rational and non-discriminatory. (...) these agonizing decisions should be taken not as a matter of abstract principle by the court, but by those most intimately involved with the situation, provided that the procedures and criteria they used met constitutional standards of fairness.”

In this context, as Ferraz (2009) mentions, some authors even made the point that the right to health should be claimed only collectively, via class actions sponsored by public lawyers on behalf of large groups of disadvantaged

individuals. Certainly, there are quite a few ideas that may be raised as suggestions on how to overcome this distortion, and such extreme opinions may not necessarily be the only viable solution. How to allow for equal access to justice to all segments of society is another question that must be considered, but which is beyond the scope of the present article.

d) Other controversies

Nevertheless, the problem presents other controversial features that are worth mentioning. One is related to the risk of the judiciary turning into a battlefield of business corporations seeking to obtain larger profits out of lawsuits. Among the beneficiaries are pharmaceutical companies, who can introduce their high-cost drugs on the market. The slow reaction of the government to the rapid technological improvements in the field of medicine, reflected for instance in the huge delay for the incorporation of new medicines in the SUS' list, is a major stimulus to the creation of a new industry between doctors, laboratories and lawyers.³¹

There are also risks of reaching schizophrenic situations; for instance, as a result of the execution of judicial decisions during a time-span where there is no system put in place to assure the State that the patient remains alive. Other sad

31 In 2006 the Department of Health of the state of São Paulo, Brazil, obtained an injunction determining the removal out of the *façade* of the Hospital das Clínicas a banner which read: “Free access to medicines is your right. Get in touch with a lawyer. Call this number.” Available at: <http://www.cremesp.org.br/?siteAcao=Jornal&id=753>

possibilities include fraud, corruption and manipulation of the judiciary.³²

Concluding remarks

As a matter of conclusion, it is interesting to point out that the more recent literature on this topic in Brazil has been revolving around attempts to suggest more objective parameters that could guide a balanced judicial action. The CNJ's Forum of Health initiative is a major example of this trend, which could be assessed in very optimistic terms. A constructive dialogue of this kind, one that seeks alternative and creative solutions for the tensions inherent to this problematic, present a real potential for positive transformations in Brazil.

On the other hand, many authors have been really critics of the *progressive jurisprudence*, pointing out the problems that arise from what they call *the dominant judicial interpretation*.³³ But facing those opposite arguments might be of particular relevance for the debate, especially when pondering what should be the role of the judge. Realizing a fundamental right requires a high degree of creativity,³⁴ since to extract its maximum ef-

fectiveness the interpreters of the norm must be able to overcome one's own intellectual limits, often seeking answers out of sources of scientific knowledge other than law. If one's understands the role of law as an instrument of social change, this multidimensional approach to the problem becomes even more important.

Certainly, comparative studies are also needed, since Brazil could draw insights from similar experiences taking place in other countries, especially those with similar levels of development, such as Colombia, India and South Africa. Sharing best practices and judicial expertise on realizing ESCR would allow for new perspectives and possible solutions.

There will always be certain cases when resorting to judicial remedies is the single possible solution to effectively cease and redress human rights violations; however, those mechanisms are never supposed to be sole alternative for all circumstances. In Gloppen words,

“Litigation can contribute toward holding governments accountable with respect to both ‘policy gaps’ and ‘implementation gaps’. Health rights litigation may serve to hold governments accountable to their laws and policies and aid implementation by empowering individuals and groups to enforce the

called *enforcement action of social commitments* (literal translation), designed to ensure the execution by public authorities of the social commitments made in governmental programs specifically in regard to ESCR. The public administrator who unjustifiably fails to realize concretely the assumed action-plan would have to respond civil and criminally for his omission and could be held liable.

32 According to the national press, in 2008, the Brazilian police conducted an investigation on the involvement of pharmaceutical employees in a millionaire fraud. The scheme consisted on using false names to go to court and demand payment for unnecessary medications (Globo.com, 2008).

33 The work of Prof. Luís Barroso (2008) acquired a particular prominence in this field, arguing in favor of a more restricted judicial involvement.

34 Benvenuto (2001), for instance, provides a very audacious suggestion of framework that would consist in a new legal instrument to ensure the enforceability of ESCR, similar to what already exist in relation to CPR (e.g. *habeas corpus*). His proposal is the creation of a legal remedy to be

laws more directly. This does not mean that litigation is the best approach to advance the right to health in a society – nor that it necessarily contributes positively.” (Gloppen, 2008, p. 4)

As already shown, a sole courts-centric approach may increase inequalities. Broad social justice and equity are goals that can only be realized through an ensemble of actions that require not only coordination of all governmental branches, but also a strong commitment of the society as a whole. The realization of the right to health, of ESCR, as of all rights, is a continuous process that depends, ultimately, in the achievement of larger social peace.

Bibliography

- Afonso da Silva, V. & Terrazas, F. (2008). *Claiming the right to health in Brazilian Courts: the exclusion of the already excluded*. Social Science Research Network.
- Afonso da Silva, V. (n.d.). *Taking from the poor to give to the rich: the individualistic enforcement of social rights*. Available at: <http://www.enelsyn.gr/papers/w13/Paper%20by%20Prof.%20Virgilio%20Afonso%20da%20Silva.pdf>
- Barroso, L. R. (2008). *Da falta de efetividade à judicialização excessiva: direito à saúde, fornecimento gratuito de medicamentos e parâmetros para a atuação judicial*. Available at: http://www.uniube.br/publicacoes/unijus/arquivos/unijus_15.pdf
- Benvenuto, J. (2001). *Los derechos humanos, económicos, sociales y culturales*. Plataforma Interamericana de Derechos Humanos, Democracia y Desarrollo – (PIDHDD).
- Carvalho, E. (2004). Em busca da judicialização da política no Brasil: apontamentos para uma nova abordagem. *Revista Sociologia e Política*, Curitiba, pp. 115-126.
- Castro, M. F. (n.d.). O Supremo Tribunal Federal e a judicialização da política. *Revista Brasileira de Ciências Sociais*, N. 34. Available at: <http://www.anpocs.org.br/portal/content/view/70/54/>
- Clapham, A. & Robinson, M. (eds.). (2009). Realizing the right to health. *Swiss Human Rights Book Vol. 3* Available at: http://www.swisshumanrightsbook.com/SHRB/shrb_03.html
- Coomans, F. (ed.) (2006). *Justiciability of economic and social rights: experiences from domestic systems*. Antwerp: Oxford.
- Eide, A.; Krause, C.; & Rosas, A. (eds.). (2001). *Economic, social and cultural rights: a textbook*. 2nd Rev. Ed. Haag: Kluwer Law.
- Ferraz, O. (2009). *Justiça distributiva para formigas e cigarras – Crítica à obra de Dworkin, R. A Virtude Soberana – Teoria e Prática da Igualdade*. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0101-33002007000100013
- Ferraz, O. & Vieira, F. (2009). *Direito à saúde, recursos escassos e equidade: os riscos da interpretação judicial dominante*. Available at: <http://www.stf.jus.br/portal/cms/verTexto.asp?servico=processoAudienciaPublicaSaude&pagina=Artigos>
- Ferraz, O. L. (2009). *Right to health litigation in Brazil, an overview of the research*. SSRN eLibrary.
- Ferraz, O. L. (2009). The right to health in the courts of Brazil: worsening health inequities? *Health and Human Rights Journal*, Vol. 11, N. 2. Pp. 33-45.

- Flood, C. M.; Gable, L. & Gostin, L. (2005). Introduction: legislating and litigating health care rights around the world. *The Journal of Medicine and Ethics*.
- Forman, L. (2005). Ensuring reasonable health: health rights, the judiciary and south african hiv/aids policy. *Journal of Law, Medicine and Ethics*.
- Gandin, J.; Barione, S. & Souza, A. (n.d.). A *judicialização do direito à saúde*: a obtenção de atendimento médico, medicamentos e insumos terapêuticos por via judicial – critérios e experiências. Available at: <http://bdjur.stj.gov.br/xmlui/handle/2011/16694>
- Gauri, V. (2003). *Social rights and economics*: claims to health care and education in developing countries. The World Bank: Development Research Group.
- Gloppen, S. (2008). Litigation as a strategy to hold governments accountable for implementing the right to health. *Health and Human Rights Journal*, Vol. 10, N. 2.
- Golay, C. (2009). *The right to food and access to justice*. Examples at the national, regional and international levels, FAO. Available at: http://www.fao.org/righttofood/publi09/justiciability_en.pdf
- Gontijo, G. (2010). Judicial interference in health rights. *Revista Med Minas Gerais* pp. 606-611 Available at: <http://www.medicina.ufmg.br/rmmg/index.php/rmmg/article/viewFile/323/309>
- Gorczevski, C. & Rosa, M. *A concretização dos direitos humanos sociais e a reserva do possível*. CONPEDI. Available at: http://www.conpedi.org.br/manaus/arquivos/anais/salvador/marizeli_peglow_da_rosa.pdf
- Hunt, P. (2003). *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. Report of the Special Rapporteur.
- Koch, I. (2009). *Human Rights as indivisible rights*: the protection of socio-economic demands under the European Convention on Human Rights. Nijhoff: Lieden, Boston.
- Lins, L. (2008). A tutela inibitória coletiva das omissões administrativas: um enfoque processual sobre a justiciabilidade dos direitos fundamentais sociais. *Revista Direito do Estado*. N. 12, Rio de Janeiro: Renovar/ Instituto Idéias. Pp. 223-261.
- Marques, S. (2008). Judicialização do direito à saúde. *Revista de Direito Sanitário*. São Paulo. Vol. 9, N. 2, pp. 65-72.
- Morgan, R. & Turner, B. (2009). *Interpreting human rights: social science perspectives*. Routledge: Abington.
- Ordacgy, A. (n.d.). *A Tutela de saúde como um direito fundamental do cidadão*. Available at: http://www.dpu.gov.br/pdf/artigos/artigo_saude_andre.pdf
- Sachs, A. (2009). *The judicial enforcement of socio-economic rights: the grootboom case*. Available at: <http://www.lawsociety.ie/documents/committees/hr/lectures/23.6.2005.pdf>
- Sarlet, I. & Figueiredo, M. (2008). *Algumas considerações sobre o direito fundamental à proteção e promoção da saúde aos 20 anos da Constituição Federal de 1988*. *Revista de Direito do Consumidor* N. 67, pp. 125-172.
- Sarlet, I. & Figueiredo, M. (2008). Reserva do possível, mínimo existencial e direito à saúde: algumas aproximações. *Revista de Doutrina da 4ª Região*. Porto Alegre, N. 24, Available at http://www.revistadoutrina.trf4.jus.br/artigos/edicao024/ingo_mariana.html

Sepúlveda, M. (2003). *The nature of the obligations under the International Covenant on Economic, Social and Cultural Rights*. 1st ed.

Vallinder, T. (1994). *A World-wide Phenomenon: Introduction – The Judicialization of Politics*. International Political Science Review. Available at: <http://ips.sagepub.com/content/15/2/91>

Key Documents:

Additional protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights – Protocol of San Salvador (1988).

Brazilian Ministry of Health – Secretaria Nacional de Assistência à Saúde (1990). ABC do SUS: Doutrinas e Princípios. Available at: <http://www.geosc.ufsc.br/babcsus.pdf>

Committee on Economic, Social and Cultural Rights - General Comments, General Comment N.3 (1990). The nature of States parties' obligations (article 2 (1)).

Committee on Economic, Social and Cultural Rights - General Comments, General Comment N.14 (2000). The right to the highest attainable standard of health (article 12).

Committee on Economic, Social and Cultural Rights - General Comments, General Comment N. 9 (1998). The domestic application of the Covenant.

Constituição da República Federativa do Brasil, (1988).

Constitution of the World Health Organization, (1946).

Declaration of Alma Ata on Primary Health Care, (1978).

International Commission of Jurists (ICJ), Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, (1997),

International Covenant on Economic, Social and Cultural Rights – ICESCR, (1966).

Limburg Principles on the Implementation of Economic, Social, and Cultural Rights, (1987).

Optional Protocol to the International Covenant on Economic, Social and Cultural Rights – ICESCR, (2008).

Universal Declaration of Human Rights, UDHR (1948).

Vienna Declaration of the World Conference on Human Rights, (1993).

Landmark Cases:

Government of the Republic of South Africa v. Grootboom and Others case, 2001.

Mendes, G. (2010). Suspensão de Tutela Antecipada, Agravo Regimental, Saúde pública, Voto – STA 175. Available at: <http://www.stf.jus.br/arquivo/cms/noticiaNoticiaStf/anexo/STA175.pdf>

Minister of Health and Others v. Treatment Action Campaign and Others, 2002.

Recurso Extraordinário N. 482.611 – Santa Catarina, Brazil, 2004. Available at: <http://www.stf.jus.br/arquivo/cms/noticiaNoticiaStf/anexo/RE482611CM.pdf>

Soobramoney v. Minister of Health (Kwazulu-Natal) case, 2005.

Other sources:

Brazilian National Council of Justice (Conselho Nacional de Justiça – CNJ) – Fórum

- Nacional do Judiciário para Assistência à Saúde. Disponible en <http://www.cnj.jus.br/mapa-do-site/455-rodape/acoes-e-programas/programas-de-a-a-z/forum-da-saude>
- International Network for Economic, Social and Cultural Rights. Available at: <http://www.escr-net.org/>
- International Symposium "Realizing the Right to Health: Whose Role is it Anyway?" on 22 June 2009, organized by the Geneva Academy of International Humanitarian Law at Geneva, Switzerland. Webcast available at: http://www.swisshumanrightsbook.com/SHRB/event_090622.html
- Jornal Globo.com (2008). Quadrilha aplica golpe dos remédios em São Paulo. Disponível em: <http://video.globo.com/Videos/Player/0,,GIM889197-7759,00.html>
- Jornal O Globo (2009). Médica é presa por não internar paciente. Disponível em: <http://oglobo.globo.com/rio/mat/2009/07/29/medica-presa-por-nao-internar-paciente-757019873.asp>
- Sachs, A. (2002). Enforcing Socio-Economic Rights: the experience of the South African Constitutional Court. Speech. Available at: <http://www.unep.org/law/symposium/Speeches.htm>
- United Nations Office of the High Commissioner for Human Rights – UN OHCHR, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Website: <http://www2.ohchr.org/english/issues/health/right/>

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