

The Comparative Fortunes of the Right to Health: Two Tales of Justiciability in Colombia and South Africa

Katharine G. Young* & Julieta Lemaitre**

INTRODUCTION

The legal recognition of the right to health worldwide has never been so advanced. At least 115 constitutions around the world have entrenched the right to health or health care,¹ whether as justiciable claim-rights, aspirational guarantees, or a combination of the two.² As of November 2012, every country except South Sudan is a party to at least one human rights treaty that addresses the right to health or other health-related rights.³ Often, international obligations lead to policy recommendations and supervisory measures within the international legal domain, which can affect domestic law and health policy.⁴ Yet increased levels of mobilization and

* Associate Professor, ANU College of Law, Australian National University; BA/LLB (Hons) (University of Melbourne), SJD (2009) (Harvard).

** Associate Professor, Universidad de los Andes Law School, Colombia; LLB (1995) (Universidad de los Andes), MA (1998) (NYU), SJD (2007) (Harvard). This article has benefited from presentations to the Right to Health Panel of the Annual Meeting of the Law and Society Association, Chicago, June 2010; the Social and Economic Rights Reading Group, Harvard Law School, September 2011; and the South African Reading Group, New York Law School, March 2012. Our thanks to all who were present, as well as to Thomas Faunce, Everaldo Lamprea, Sandra Liebenberg, Vlad Perju, and Lucie White for their feedback on earlier versions. The usual caveat applies.

1. Office of the U.N. High Comm'n for Human Rights, *The Right to Health: Fact Sheet No. 31* 10 (2008), <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>.

2. In this article, we adopt the terminology of justiciability to refer to claims that may be brought by individuals before courts, and aspirational guarantees that direct a government to take certain measures, which cannot, by themselves, form a cause of action before a court. We note that certain combinations exist, such as the "Directive Principles of State Policy" which form the basis of the right to health care in India, and yet also form a cause of action because of the link to the right to life. See KATHARINE G. YOUNG, *CONSTITUTING ECONOMIC AND SOCIAL RIGHTS* 116–18 (2012).

3. Office of the U.N. High Comm'n for Human Rights, *supra* note 1, at 1.

4. See U.N. Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights [ICESCR]), ¶ 9, U.N. Doc. E/C.12/2004 (Aug. 11, 2000) (influential statement of government obligations with respect to the right to health under the ICESCR). These obligations are not justiciable under the ICESCR until a new complaints mechanism becomes effective. See Optional Protocol to the ICESCR, G.A. Res. 63/117, U.N. Doc. A/RES/63/117 (Dec. 10, 2008). The Optional Protocol recently received its tenth ratification and will enter into force on May 5, 2013. State Parties include Argentina, Bolivia, Bosnia and Herzegovina, Ecuador, El Salvador, Mongolia, Portugal, Slovakia, Spain, and Uruguay. See Status of Chapter IV, Human Rights, 3.

litigation have also occurred at the national level with respect to the right to health provisions entrenched locally.⁵ For advocates of the right to health, the path is open to create health systems that are more rights-respecting and more just.⁶

Yet deep uncertainty about the legal operation of the right to health remains. Opponents argue that its entrenchment leads to an expansion of judicial power—as well as the introduction of incommensurable individual and curative claims⁷—in a necessarily utilitarian policy area. We suggest two questions to unlock this debate. First, what are the effects of justiciability on a healthcare system? Second, how do matters of institutional design change those effects?

In this Article, we examine these questions by comparing the operation of the right to health in the domestic legal systems of Colombia and South Africa. Since 1991 in Colombia, and 1996 in South Africa, the right to health has been entrenched as a justiciable guarantee that moves beyond mere public health protections.⁸ Yet the legal impact of the right to health has followed divergent paths. In Colombia, the right to health has grounded an elaborate structure of private litigation and a new consciousness of healthcare entitlement. In South Africa, the right to health has supported limited judicial interventions only in particular health scenarios, along with some extra-judicial space for negotiating healthcare policy.

We seek to describe and explain these differences through a detailed study that accounts for legal and constitutional arguments, questions of institutional design, and the urgency and substance of civil society demands.⁹ By providing an almost two-decade snapshot of the legal meaning

ICESCR, UNITED NATIONS TREATY COLLECTION, http://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-3-a&chapter=4&lang=en (last visited Mar. 23, 2013).

5. See generally LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH? (Alicia Ely Yamin & Siri Gloppen eds., 2011) [hereinafter LITIGATING HEALTH RIGHTS] (detailing case studies in Argentina, Brazil, Colombia, Costa Rica, India, and South Africa). See also, e.g., Colleen M. Flood, Lance Gable & Lawrence O. Gostin, *Introduction: Legislating and Litigating Health Care Rights Around the World*, 33 J.L. MED. & ETHICS 636, 637–38 (2005) (presenting data from New Zealand, Israel, Canada, South Africa, Norway, the United Kingdom, and the United States).

6. See generally NORMAN DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY (2008) (revising an earlier work on justice in health care to focus on general questions of health, driven by equality norms); JENNIFER PRAH RUGER, HEALTH AND SOCIAL JUSTICE (2009) (developing a social justice account of health reliant on human capability).

7. See, e.g., Jacob Mchangama, International Policy Network, *Health as a Human Right: The Wrong Prescription* 3, 12 (2009).

8. See *infra* text accompanying notes 17 and 22. See also Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT'L L.J. 285, 291 (2004) (presenting data that suggests that two thirds of all constitutions contain provisions protective of health or health care, and noting that more recent constitutions are more likely to reflect statements of duty and entitlement).

9. We engage in comparative constitutional law to shed light on these questions. For further reference, see Mark Tushnet, *The Possibilities of Comparative Constitutional Law*, 108 YALE L.J. 1225 (1999) (proposing the various functional, expressive, and bricoleur impulses that guide the comparative endeavor); Kim Lane Scheppele, *Constitutional Ethnography: An Introduction*, 38 LAW & SOC'Y REV. 389 (2004) (highlighting the importance of detailed description in constitutional comparison).

of the right to health in these two jurisdictions, we integrate an analysis of text, case law, and societal responses. We pay special attention to the different features of judicial review—standing, access, review, and remedies—that configure the traditional debate about the tension that the justiciability of human rights (and particularly economic and social rights) is said to create for democracy. In addition, we raise questions about the background institutional design of the allocation of healthcare resources. This allows us to shift the present parameters of the right to health debate, which focus on either broad ethical questions or narrow institutional ones, to include multiple variables that shape the right in each scenario.¹⁰

Part I of the Article provides an overview of the legal definition of the right to health and introduces the key institutional features of Colombia's and South Africa's guarantees. In Parts II and III, we characterize the operation of the right to health as involving forms of justiciability, which we label either "high-intensity" or "low-intensity," in Colombia and South Africa, respectively. In Part IV, we disaggregate the evidence of justiciability into four variables: doctrinal arrangements (whether they are supportive of content-heavy, core, substantive rights or procedural obligations), judicial roles (whether they are supportive of access to courts and individual remedies), private financing arrangements (how profit-seeking incentives for efficiency and non-health-related interests are arranged), and the configurations of civil society. Far from leading inexorably to the expansion of judicial power, and to litigious, individualistic, and curative biases in health systems, the entrenchment of a justiciable right to health can instead produce only minimal litigation, private negotiations in the shadow of litigation, and civil society pressure for legal change. Our conclusions are important for further research, as well as for current policy and legal design around health care and human rights.

I. THE RIGHT TO HEALTH AS A LEGAL RIGHT

The right to health is a relatively new legal concept, borrowed from the aspirational terms of international human rights instruments and of evolu-

10. For present contributions on the justiciability of the right to health, see, e.g., LITIGATING HEALTH RIGHTS, *supra* note 5; Octavio L. M. Ferraz, *The Right to Health in the Courts of Brazil: Worsening Health Inequities?*, 11.2 HEALTH AND HUMAN RIGHTS 33 (2009); Lisa Forman, *Justice and Justiciability: Advancing Solidarity and Justice Through South Africans' Right to Health Jurisprudence*, 27 MED LAW 661 (2008). Justiciability has become a recent focus of much scholarship on economic and social rights. See, e.g., COURT AND SOCIAL TRANSFORMATION IN NEW DEMOCRACIES (Roberto Gargarella et al. eds., 2006); COURTING SOCIAL JUSTICE: JUDICIAL ENFORCEMENT OF SOCIAL AND ECONOMIC RIGHTS IN THE DEVELOPING WORLD 38 (Varun Gaufi & Daniel M. Brinks eds., 2008) [hereinafter COURTING SOCIAL JUSTICE]. For the Latin American context, see VICTOR ABRAMOVICH & CHRISTIAN COURTIS, LOS DERECHOS SOCIALES COMO DERECHOS EXIGIBLES (2002); Rodolfo Arango, *Promoción de los derechos sociales constitucionales por vía de protección judicial*, in EL OTRO DERECHO, 103–22 (2002).

ing philosophies of distributive justice.¹¹ International efforts to define the right to health, and to establish it within a legal framework, have been long-standing.¹² The World Health Organization defines health as “a state of complete physical and mental well-being.”¹³ In the International Covenant on Economic, Social and Cultural Rights (“ICESCR”), “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”¹⁴ is limited only by what States can progressively realize.¹⁵ Further interpretations of this obligation have advanced “core obligations” to include, *inter alia*, the protection of the social determinants of health, the provision of “essential” drugs, and equitable access to health care.¹⁶

In Colombia, the right to health is constitutionally protected in Article 49 of the Constitution:

Attention to health and environmental sanitation are public services [of the] responsibility of the State. The access to services of promotion, protection and recovery of health are guaranteed to all persons.

It corresponds to the State to organize, direct and regulate the provision of health services . . . in accordance with the principles of efficiency, universality and solidarity. [It corresponds] also [to the State], to establish policies for the provision of health services by private entities, and to exercise supervision and control [over them]. Likewise, to establish the competences of the Nation, the territorial entities and individuals and to determine the contributions of [their] responsibility in the terms and conditions specified in the law.

11. Distributive justice refers to normative principles for the allocation of resources and opportunities in a given society, and usually adopts egalitarian criteria. This can be contrasted with a conception of justice as compensatory or desert-based. *See, e.g.*, JOHN RAWLS, *A THEORY OF JUSTICE* 86–89 (1999). *See also* DANIELS, *supra* note 6, at 56–63 (applying Rawls’ equality of opportunity to the health context).

12. The spread of diseases beyond national borders spurred early international efforts to define the right to health. In 1903, the Office International d’Hygiène Publique, which ultimately became the Health Organization of the League of Nations, began to discuss the concept of primary health care for all, which was later taken up by the United Nations. A somewhat different focus came from work-related issues of health, explored by the International Labor Organization, founded in 1919. *See* Eibe Riedel, *The Human Right to Health: Conceptual Foundations*, in *HEALTH: A HUMAN RIGHTS PERSPECTIVE*, 21, 21–22; JOHN TOBIN, *THE RIGHT TO HEALTH IN INTERNATIONAL LAW* 56–63 (2011). The obligation created by international treaties to recognize the right to health does not always align with an obligation on states to provide a judicial remedy. *Id.* at 207. Often justiciability is restricted only to the principle of non-discrimination in the provision of health care. *See* U.N. Econ. & Soc. Council, General Comment No. 14, *supra* note 4, at ¶ 1.

13. Constitution of the World Health Organization [WHO] pmbll., July 22, 1946, 62 Stat. 2676, 14 U.N.T.S. 185.

14. ICESCR, *supra* note 4, at art. 12(1). The right to health care is also found in the Convention on the Elimination of Discrimination Against Women [CEDAW], art. 12, Dec. 18, 1979, 1249 U.N.T.S. 13; the Convention on the Rights of the Child [CRC] art. 24, Nov. 20, 1989, 1249 U.N.T.S. 14; and the African Charter on Human and Peoples’ Rights [Banjul Charter], art. 16, June 27, 1981, 1520 U.N.T.S. 217.

15. ICESCR, *supra* note 4, at art. 2(1).

16. U.N. Econ. & Soc. Council, General Comment No. 14, *supra* note 4, at ¶¶ 9, 14.

Health services shall be organized in a decentralized manner, by level of care and with participation of the community.

The law shall specify the terms under which basic care for all inhabitants will be gratuitous and obligatory.

Every person has the duty to provide for [*procurar*] comprehensive attention to their health and to [that] of their community.¹⁷

This provision takes the form of an “institutional guarantee,”¹⁸ although, as we will see in Part II below, it has been converted by the Colombian Constitutional Court (“CCC”) into a subjective and justiciable right.¹⁹ The right is supported by the availability of a *tutela* action, which allows any individual to bring an action for their fundamental rights.²⁰ Colombia is also a party to the ICESCR and to other regional human rights instruments that protect the right to health care,²¹ a matter of great relevance given the CCC’s repeated insistence that international human rights treaties are part of the Constitution.²²

17. CONSTITUCIÓN POLÍTICA DE COLOMBIA [C.P.] art. 49, amended by Acto Legislativo 2 de 2009 to include a provision on drug abuse as of special concern to the Constitution. L. 2/09, 21 de diciembre de 2009, DIARIO OFICIAL [D.O.]. Furthermore, article 50 establishes free health care for all infants under one year of age whether they are insured or not. CONSTITUCIÓN POLÍTICA DE COLOMBIA [C.P.] arts. 49–50.

18. An institutional guarantee is the guarantee, entrenched in the Constitution, of the existence of a given institution that cannot be suppressed by legislature. See ROBERT ALEXY, *A THEORY OF CONSTITUTIONAL RIGHTS* 324 (2002).

19. This is based not only on article 49, but also on the constitutional entrenchment of the rights to life, dignity, and social security, and the reflection that this right includes the right to health. CONSTITUCIÓN POLÍTICA DE COLOMBIA [C.P.] art. 49; see generally EVERALDO LAMPREA, *LA CONSTITUCIÓN DE 1991 Y LA CRISIS DE LA SALUD* (2011) (providing an account of the debates on the right to health in the 1991 Constitutional Assembly).

20. See generally RODOLFO ARANGO & JULIETA LEMAITRE, *JURISPRUDENCIA CONSTITUCIONAL SOBRE EL DERECHO AL MÍNIMO VITAL* (2003) [hereinafter ARANGO & LEMAITRE, *JURISPRUDENCIA CONSTITUCIONAL*] (describing the role of jurisprudence regarding core minimum rights); see also Julieta Lemaitre, *El Coronel Sí Tiene Quien le Escriba: La Protección Judicial del Derecho al Mínimo Vital en Colombia* 3–9 (Yale Law School Seminario en Latinoamérica de Teoría Constitucional y Política, Paper No. 43), http://digitalcommons.law.yale.edu/yls_sela/43 (last visited Oct. 4, 2012) [hereinafter Lemaitre, *El Coronel*]. Available in English as Julieta Lemaitre, “Someone Writes to the Colonel: Judicial Protection of the Right to Survival in Colombia and the State’s Duty to Rescue” (2005). *SELA (Seminario en Latinoamérica de Teoría Constitucional y Política) Papers*. Paper 42. http://digitalcommons.law.yale.edu/yls_sela/42.

21. Organization of American States, Additional Protocol to the American Convention of Human Rights in the Area of Econ., Cultural, and Soc. Rights, art. 10, Nov. 17, 1988, O.A.S.T.S. No. 69.

22. This is known as the doctrine of the “constitutional block” (*bloque de constitucionalidad*) and has been developed over numerous decisions that make explicit reference to international human rights treaties to expand the interpretation of certain rights, or to include new rights in the Constitution. The CCC developed this concept in the late nineties with a series of decisions regarding international humanitarian law (considered to be included in the constitutional block). See Corte Constitucional [C.C.] [Constitutional Court], 18 de mayo de 1995, Sentencia C-225/95, available at <http://www.corteconstitucional.gov.co/relatoria/1995/c-225-95.htm>; Corte Constitucional [C.C.] [Constitutional Court], 4 de diciembre de 1995, Sentencia C-578/95, available at http://www.secretariasenado.gov.co/senado/base/doc/cc_sc_nf/1995/c-578_1995.html; Corte Constitucional [C.C.] [Constitutional Court], 5 de agosto de 1997, Sentencia C-358/97, available at <http://www.corteconstitucional.gov.co/relatoria/1997/c-358-97.htm>.

In South Africa, Section 27 of the Constitution protects the right to health, alongside other economic and social rights:

27. Health care, food, water and social security
 - (1) Everyone has the right to have access to—
 - (a) health care services, including reproductive health care;
 - . . .
 - (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
 - (3) No one may be refused emergency medical treatment.²³

There are additional, and less qualified, guarantees for the right to health for children and for those in detention, and the right to an environment that is not harmful to health.²⁴ While constitutional decision-makers are required to consider international law in the interpretation of the Constitution,²⁵ South Africa has signed, but not yet ratified, the ICESCR.²⁶

The textual differences between the two forms of constitutional protection accompany an entirely different set of institutional arrangements. In short, we describe the operation of the right to health in Colombia and South Africa as following contrastingly high and low levels of justiciability. This has led to very different avenues of legal and political support for the right to health.

II. HIGH-INTENSITY JUSTICIABILITY: COLOMBIA

Colombia's right to health was introduced in its 1991 Constitution, which was adopted after a long period of violence and repression dating from the mid-1940s to the late-1980s.²⁷ The new Constitution introduced a new conception of the state—one based on the “social rule of law” (*estado social de derecho*), which warrants the justiciability of economic and social rights in certain circumstances.²⁸ It also established the CCC, which would

23. S. AFR. CONST., 1996, § 27(3).

24. S. AFR. CONST., 1996, § 28(1)(c), § 35(2)(e), § 24(a).

25. S. AFR. CONST., 1996, § 39(b).

26. On South Africa's status as signatory of the ICESCR, see Status of Chapter IV, Human Rights, ICESCR Ratification Campaign Driver Group, South Africa to Ratify International Socio-Economic Rights Covenant (Oct. 12, 2012) (on file with author). South Africa is, however, a party to CEDAW, CRC, and the Banjul Charter, which do address the right to health. See *supra* note 14.

27. For the historical context and debates that introduced the right to health in Colombia's 1991 Constitution, see generally LAMPREA, *supra* note 19 (providing an account of the debates on the right to health in the 1991 Constitutional Assembly).

28. The 1991 Colombian Constitution included the term “social rule of law” inspired in the German *sozialrechtsstaat* tradition, which enshrines as a constitutional principle the normative implications of the distributional policies of the welfare state. CONSTITUCIÓN POLÍTICA DE COLOMBIA [C.P.] art. 1. As in the case of the right to health, these specific circumstances have evolved in the court's decisions. In

oversee the actions of the lower courts and would exercise concrete, rather than merely abstract, review.²⁹ Finally, it limited the procedural barriers of access to courts with a striking innovation: the *tutela* action, in which individuals were able to bring any constitutional claim before any court.³⁰

The Colombian *tutela*, as enshrined in Article 86 of the 1991 Constitution, is an action presented before any judge for the immediate protection of a fundamental human right. While the action was first defined in the Constitution, Decree 2591 of 1991 and the CCC's jurisprudence developed the *tutela* into an expansive institution in which courts have expanded powers to make decisions in human rights cases, eliminating all of the constraints of standing as well as most procedural limitations that fetter other systems.³¹ Any person can bring forth a *tutela* claiming violations of his or her fundamental rights, the rights of a larger group (e.g., a neighborhood or an ethnic group), or the rights of a person in a vulnerable situation (e.g., children or the elderly). Any judge is qualified to order the government to take specific actions to protect the right. Unlike in the *amparo* action elsewhere in Latin America, standing in *tutela* is very generous, as are courts' powers. In addition, the procedure includes both strict time limitations for judges, and sanctions for public officials, including jail for contempt of court if they fail to comply.³²

Tutela actions were initially limited to civil and political rights. Court precedent expanded it to include some economic and social rights (including the right to health) as well as certain rights pertaining to vulnerable groups (e.g., ethnic minorities, children, and internally displaced persons).³³

1992, Sentencia T-406/92 famously made the normative principle of the social rule of law central to *tutela* decisions. The case refers to an unfinished, overflowing sewer in the municipality of Cartagena. The court ordered the municipality to finish the sewer and clean up the damages, holding that there was an immediate threat to the right to public sanitation, and that it was the court's duty to interpret rights in the light of a social rule of law. The incorporation of welfare policies in the very nature of the State has henceforth implied for the court the State must effectively guarantee certain minimal living standards, including basic sanitation. Corte Constitucional [C.C.] [Constitutional Court], 5 de junio de 1992, Sentencia T-406/02, Gaceta de la Corte Constitucional [G.C.C.] (vol. 2, p. 190). For more cases and explanations of the importance of the concept, see generally Rodolfo Arango, *Experiencia Colombiana Sobre la Justiciabilidad de los Derechos Económicos, Sociales y Culturales*, in *DERECHOS ECONÓMICOS, SOCIALES Y CULTURALES* (Juan Carlos Contreras, ed., 2005) (analyzing the justiciability of economic, social, and cultural rights); see also RODOLFO ARANGO, *EL CONCEPTO DE DERECHOS SOCIALES FUNDAMENTALES* (2005) (providing an overview of the concept of fundamental social rights).

29. CONSTITUCIÓN POLÍTICA DE COLOMBIA [C.P.] art. 241.

30. CONSTITUCIÓN POLÍTICA DE COLOMBIA [C.P.] art. 81.

31. Decreto 2591, 19 de noviembre de 1991, DIARIO OFICIAL [D.O.]. See generally Lemaitre, *El Coronel*, *supra* note 20.

32. See generally ALLAN BREWER-CARÍAS, *CONSTITUTIONAL PROTECTION OF HUMAN RIGHTS IN LATIN AMERICA: A COMPARATIVE STUDY OF AMPARO PROCEEDINGS* (2008) (providing a comparison of similar procedures in the region).

33. For a helpful English translation of excerpts from the CCC's health jurisprudence, see Manuel Jose Cepeda Espinosa, *Readings on the Colombian Constitutional Court* (Feb. 13, 2012), http://www.utexas.edu/law/colloquium/papers-public/2011-2012/02-13-12_Espinosa_Opinions%20of%20Colombian%20Constitutional%20Court_post.pdf. Professor Cepeda Espinosa was Former Justice of the Constitutional Court of Colombia, 2001–2009.

As a result, *tutela* actions have been central to a constitutional transformation that has permeated every sphere of state activity to include the concern with human rights, and to put courts at the reach of ordinary citizens. *Tutelas* have thus produced unprecedented implications for the redistribution of goods and services in this dramatically unequal society.³⁴

The introduction of *tutelas* has produced a massive amount of private litigation in Colombia; between 1999 and 2010 there have been 2,725,361 *tutela* decisions.³⁵ The annual number of *tutelas* filed has been continually increasing.³⁶ A striking proportion of *tutelas* are directed to the right to health: in 2008, 41.5% of all *tutelas* claimed protection for the right to health.³⁷ In the last two years, approximately one quarter of all *tutelas* were related to the right to health.³⁸ Through the use of the *tutela*, and its support by the CCC, the right to health has been heavily litigated and now features a mode of justiciability that we describe as “high-intensity.” Below, we categorize three prominent phases of Colombia’s justiciable right to health.

A. 1992–2008: *The Path to Justiciability*

The CCC decided its first right to health cases in 1992. These cases, which were decided before the 1993 reform of the national health system, established that the right to health was justiciable through the *tutela* jurisdiction, provided that several conditions were met. When not met, the right to health remained a “programmatically” or non-justiciable right.³⁹ Since then, the CCC’s jurisprudence has focused on limiting and developing these conditions of justiciability.

34. See generally ARANGO & LEMAITRE, JURISPRUDENCIA CONSTITUCIONAL, *supra* note 20 (describing the role of jurisprudence regarding core minimum rights); see also Lemaitre, *El Coronel*, *supra* note 20.

35. DEFENSORIA DEL PUEBLO, LA TUTELA Y EL DERECHO A LA SALUD 2010 14 (2011).

36. The numbers stood at 344,468 in 2008; 370,640 in 2009; and 403,380 in 2010. *Id.*

37. DEFENSORIA DEL PUEBLO, LA TUTELA Y EL DERECHO A LA SALUD 2008 26 (2009). After a peak of 41%, the percentage diminished by 2010 to 23%, after the creation of administrative mechanisms to solve patient-insurance company disputes following the CCC’s order to do so in 2008. DEFENSORIA DEL PUEBLO, LA TUTELA Y EL DERECHO A LA SALUD 2010 15 (2011).

38. The percentages were 27.1% in 2009 and 23.4% in 2010. DEFENSORIA DEL PUEBLO, *supra* note 37.

39. “Programmatically” refers to the aspirational guarantees mentioned above—also known as the progressive realization of rights. See *supra* note 2. See, e.g., Corte Constitucional [C.C.] [Constitutional Court], 24 de junio de 1992, Sentencia T-426/92, Gaceta de la Corte Constitucional [G.C.C.] (vol. 2, p. 452); Corte Constitucional [C.C.] [Constitutional Court], 5 de junio de 1992, Sentencia T-406/92, Gaceta de la Corte Constitucional [G.C.C.] (vol. 2, p. 190); Corte Constitucional [C.C.] [Constitutional Court], 2 de octubre de 1992, Sentencia T-548/92, Gaceta de la Corte Constitucional [G.C.C.] (vol. 6, p. 729); Corte Constitucional [C.C.] [Constitutional Court], 11 de agosto de 1992, Sentencia T-484/92, Gaceta de la Corte Constitucional [G.C.C.] (vol. 4, p. 234); Corte Constitucional [C.C.] [Constitutional Court], 16 de septiembre de 1992, Sentencia T-518/92, Gaceta de la Corte Constitucional [G.C.C.] (vol. 5, p. 218); Corte Constitucional [C.C.] [Constitutional Court], 26 de octubre de 1992, Sentencia T-571/92, Gaceta de la Corte Constitucional [G.C.C.] (vol. 6, p. 880); Corte Constitucional [C.C.] [Constitutional Court], 16 de diciembre de 1992, Sentencia T-613/92, Gaceta de la Corte Constitucional [G.C.C.] (vol. 7, p. 666).

Initially, such conditions were satisfied when a clear link was established between the health claim and a “fundamental right,” especially the rights to life and dignity.⁴⁰ The CCC adopted an expansive definition of this connection, including not only a person’s physical life, but also elements necessary to preserve one’s dignity.⁴¹ Thus, for example, as early as 1992, the CCC ordered an eye operation for an indigent man who otherwise would lose his eyesight, out of concern for protecting the man’s right to life, right to work, and right to health, and thereby his dignity.⁴² Later, other decisions expanded the justiciability of the right to health. Most notably, the CCC determined that the right to health was always justiciable in the case of subjects of special constitutional protection (*sujetos de protección constitucional especial*), such as children, pregnant women, and the elderly.⁴³

In 1993, Law 100 transformed the public health system into one of mandatory health insurance provided by private and public companies, combining cross-subsidies among the insured with public financing of health insurance.⁴⁴ This law defined the content and responsibility for the

40. CONSTITUCIÓN POLÍTICA DE COLOMBIA [C.P.] arts. 1, 11.

41. In its well-known 2006 decision on abortion, the CCC sums up its definition of dignity: “En efecto, ha sostenido esta Corporación que en aquellos casos en los cuales se emplea argumentativamente la dignidad humana como un criterio relevante para decidir, se entiende que ésta protege: (i) la autonomía o posibilidad de diseñar un plan vital y de determinarse según sus características (vivir como se quiere), (ii) ciertas condiciones materiales concretas de existencia (vivir bien), (iii) la intangibilidad de los bienes no patrimoniales, integridad física e integridad moral (vivir sin humillaciones).” Corte Constitucional [C.C.] [Constitutional Court], 10 de mayo de 2006, Sentencia C-355/06 § 8.1, available at <http://www.corteconstitucional.gov.co/relatoria/2006/c-355-06.htm>. [Translation by authors: “In effect, this court has held that in the various cases where human dignity is a relevant criteria for making a decision, it is understood to protect: (i) autonomy or the possibility to make one’s own life plan and self-determination according to its characteristics (to live as one wishes), (ii) certain concrete material conditions for existence (to live well), (iii) the intangibility of non-patrimonial goods such as physical and moral integrity (to live without humiliation)”. For a discussion of the interpretive relation between life and dignity, see generally Katharine G. Young, *The Minimum Core of Economic and Social Rights: A Concept in Search of Content*, 33 YALE J. INT’L L. 113 (2008).

42. Corte Constitucional [C.C.] [Constitutional Court], 23 de septiembre de 1992, Sentencia T-533/92, Gaceta de la Corte Constitucional [G.C.C.] (vol. 5, p. 452).

43. This line of argument starts in 1992 with Corte Constitucional [C.C.] [Constitutional Court], 3 de junio de 1992, Sentencia T-401/92, Gaceta de la Corte Constitucional [G.C.C.] (vol. 2, p. 140), on mentally disabled persons and the general duty to protect of the State *vis-à-vis* people in situations of “debilidad manifiesta” (evident weakness). In relation to the right to health and its justiciability, the court has also deemed it is immediately justiciable based on “debilidad manifiesta.” Jurisprudence is quite extensive on this category. Some landmark cases are: Corte Constitucional [C.C.] [Constitutional Court], 20 de mayo de 1998, Sentencia SU-225/98, Gaceta de la Corte Constitucional [G.C.C.] (vol. 4, p. 1031) (in the case of children); Corte Constitucional [C.C.] [Constitutional Court], 23 de abril de 1999, Sentencia T-208/99, (in the case of prisoners); Corte Constitucional [C.C.] [Constitutional Court], 23 de septiembre de 1992, Sentencia T-533/92, Gaceta de la Corte Constitucional [G.C.C.] (vol. 5, p. 452) (in the case of the homeless); Corte Constitucional [C.C.] [Constitutional Court], 24 de junio de 1992, Sentencia T-426/92, Gaceta de la Corte Constitucional [G.C.C.] (vol. 2, p. 452) (in the case of the elderly); Corte Constitucional [C.C.] [Constitutional Court], 28 de enero de 2004, Sentencia T-025/04, Gaceta de la Corte Constitucional [G.C.C.] (vol. 1, p. 353) (in the case of internally displaced people).

44. Health insurance premiums are a fixed percentage of income, and these premiums go to a common fund. As a result, those who earn more pay more, effectively subsidizing those who earn less. Government funds cover those who do not work.

mandatory health insurance plan, *Plan Obligatorio en Salud* (“POS”), which included a scheduled list of benefits.⁴⁵ The list was established by the government through a national council with the representation of different health industry participants, including hospital professionals, doctors, and medical experts. The POS continues to control health care rationing decisions, and is reformed periodically to adapt to epidemiological data and new services and medicines. The CCC’s departure from the POS has been a considerable point of controversy, as we document below.

Law 100 of 1993 delegated responsibility for dispensing the listed benefits to private healthcare providers, although one public provider remained. The law opened the way for private health insurance companies, known as *Entidades Promotoras de Salud* (“EPS”) to mediate between individuals, the government, and healthcare providers.⁴⁶ The law also mandated that every individual contribute a percentage of his or her salary to buy health insurance from any one of these companies (the so-called contributory regime). In addition, the system provided for subsidized health insurance for the poor (the so-called subsidized regime) bought by the government and also administered by the EPS. The EPS paid healthcare providers for any expenses generated by the people they insured through either regime (contributory or subsidized), as long as the expenses were on the scheduled list. In turn, the companies received funds from the government as well as from individual contributions.

As early as 1997, the CCC attempted to limit its jurisprudence on the right to health and elaborated increasingly complex rules.⁴⁷ This was a response in part to the increase in *tutelas* during a time of economic crisis, and in part to the CCC’s developed understanding of the new healthcare system.⁴⁸

The CCC’s jurisprudence was tied to the potentials and shortcomings of the healthcare system designed by Law 100. Justiciability was thus granted on one of two bases. The first was when the claimant had been improperly denied the medicines and services included in the scheduled list. In these cases, the CCC generally accepted the justiciability of the right to health,

45. L. 100/93, 23 de diciembre de 1993, DIARIO OFICIAL, [D.O.] arts. 156(b)–(c), 162.

46. L. 100/93, 23 de diciembre de 1993, DIARIO OFICIAL, [D.O.] arts. 177–84.

47. In 1997 the court limited right to health litigation with SU-111, which insisted that the court ordered protection had to be exceptional, and that the person had to prove he or she could not cover the costs. However, that same year, with SU-480, the court insisted that EPS recover costs for court-ordered medicines and treatments from the government, which might have limited litigation if the government had expanded the scheduled list. Corte Constitucional [C.C.] [Constitutional Court], 25 de septiembre de 1997, Sentencia SU-480, Gaceta de la Corte Constitucional [G.C.C.] (vol. 9, p. 1077), available at <http://www.corteconstitucional.gov.co/relatoria/1997/SU480-97.htm>. Since it did not, in practice this decision expanded litigation by removing EPS incentive to avoid court orders. Also, the court henceforth did not insist on the SU-111 rule that patients prove they did not have funds to cover the medicine or treatment. Corte Constitucional [C.C.] [Constitutional Court], 6 de marzo de 1997, Sentencia SU-111/97, available at <http://www.corteconstitucional.gov.co/relatoria/1997/SU111-97.htm>.

48. See Alicia Ely Yamin, Oscar Parra-Vera, and Camila Gianella, *Colombia: Judicial Protection of the Right to Health: An Elusive Promise?*, in LITIGATING HEALTH RIGHTS, *supra* note 5.

especially when there was urgency in receiving the medicine or service.⁴⁹ The second type of claim was when medicines or services were not included in the scheduled list, which extended to high-cost illnesses such as HIV/AIDS, known as the “excluded benefit” cases. In these cases, the CCC decided that the right to health was justiciable when there was a threat to life or dignity.⁵⁰ These were the more controversial cases.⁵¹ In Colombian commentary, this issue has been framed as the “government by judges” criticism, levied especially by local economists in the 1990s,⁵² as well as by, in general terms, legal scholars elsewhere.⁵³

In response to these charges, the CCC established a general rule in Decision SU-111 in 1997 to limit the further expansion of justiciability *but only on the more controversial “excluded benefit” cases*. The rule stated that if the medicine or service was not on the scheduled list, the right to health required the State to provide the medicine or service 1) when it was ordered by a doctor, 2) when it was required to save the person’s life or personal integrity, 3) only if the person could not afford to pay for the treatment, and 4) the State could afford to pay for the treatment.⁵⁴ If the criteria were satisfied, then the case would be both actionable and remediable, and judges could order the government to reimburse the EPS for court-ordered expenses.⁵⁵ This latter insistence on reimbursement was probably meant to

49. There are literally thousands of these cases. Their presence in the system is analyzed in decision T-760/08. Corte Constitucional [C.C.] [Constitutional Court], 31 de julio de 2008, Sentencia T-760/08, available at <http://www.corteconstitucional.gov.co/relatoria/2008/t-760-08.htm>.

50. For some early cases, see, e.g., Corte Constitucional [C.C.] [Constitutional Court], 25 de diciembre de 1993, Sentencia T-597/93, available at <http://www.corteconstitucional.gov.co/relatoria/1993/t-597-93.htm> (ordering orthopedic treatment for a disabled child recovering from surgery—the treatment was not included); Corte Constitucional [C.C.] [Constitutional Court], 23 de junio de 1995, Sentencia T-271/95, Gaceta de la Corte Constitucional [G.C.C.] (vol. 6, p. 788) (ordering HIV medication which was then not in the scheduled list); Corte Constitucional [C.C.] [Constitutional Court], 1 de diciembre de 1995, Sentencia T-571/95, available at <http://www.corteconstitucional.gov.co/relatoria/1995/T-571-95.htm> (ordering a surgery for a child not included in the list). Of these initial cases, the HIV cases were the first to spark some activism, as news of the granting of the *tutela* traveled within the community of people affected by the disease. Interview by Julieta Lemaitre with Néstor Alvarez, Leader, Asociación de Usuarios Nueva EPS (Association of New EPS Users), in Bogotá, Colombia (Nov. 26, 2011).

51. Mauricio García, *Derechos sociales y necesidades políticas*, in *EL CALEIDOSCOPIO DE LAS JUSTICIAS EN COLOMBIA* 455 (Mauricio García and Boaventura de Sousa Santos eds., 2001); Rodrigo Uprimny, *Constitución de 1991, Estado Social de Derecho y Derechos Humanos: Promesas Incumplidas, Diagnósticos y Perspectivas*, in *EL DEBATE A LA CONSTITUCIÓN*, (Victor Montcayo et al. eds., 2002). For a different point of view, see ARANGO & LEMAITRE, *JURISPRUDENCIA CONSTITUCIONAL*, *supra* note 20.

52. For an authoritative summary of the economists’ criticism of the Constitutional Court, see Salomón Kalmanovitz, *Constitución y Modelo Económico*, in *EL DEBATE A LA CONSTITUCIÓN*, *supra* note 51.

53. See, e.g., RAN HIRSCHL, *TOWARDS JURISTOCRACY* (2004); THE GLOBAL EXPANSION OF JUDICIAL POWER (C. Neal Tate & Torbjörn Vallinder eds., 1995).

54. Corte Constitucional [C.C.] [Constitutional Court], 6 de marzo de 1997, Sentencia SU-111/97, available at <http://www.corteconstitucional.gov.co/relatoria/1997/SU111-97.htm>.

55. *Id.* The government used the *Fondo de Solidaridad y Garantía del Sistema General de Seguridad en Salud* (“FOSYGA”) (Solidarity and Guarantee Fund of the General Health Social Security System) for this type of reimbursement. FOSYGA was created by Law 100 of 1993 (art. 218) and actually set up three years later through Decree 1283, July 23, 1996. It did not, however, contemplate compensation for non-POS court-ordered expenses. These were later included through the Ministry of Health’s Reso-

give the government an incentive to expand the coverage of the POS, but it had perverse effects, as we shall show.⁵⁶

In fact, this reimbursement rule opened the door to massive corruption and mismanagement in the healthcare system. The restrictive rule adopted in SU-111 disappeared from subsequent cases, especially after 1998, when the court adopted Decision SU-480. The reimbursement rule, however, remained in place. Because the government did not expand the POS, reimbursement benefitted the EPS (whose doctors ordered new services and medicines not on the list), pharmaceutical companies (which pushed for their own products in place of cheaper generics), and corrupt public officials and judges (who funneled money from the reimbursement system into their private pockets).⁵⁷

The litigation profiles of the *tutela* actions reveal the unintended consequences of the CCC-devised rules: litigation for benefits included in the scheduled list by patients in the contributory regime became the major type of litigation, followed by litigation for excluded benefits.⁵⁸ Part of the reason for this lay in the dearth of administrative mechanisms to resolve conflicts between patients and insurance companies, leading to a massive use of the courts. However, it was also the result of attempts by EPS to get additional compensation for providing services and medicines that were already in the scheduled list by getting courts to order them. Additionally, this mechanism created an inadvertent litigation bias in favor of the middle class, as these patients were more adept at using the legal system.⁵⁹

In 2003, the CCC attempted to clarify its concept of the right to health, entrenching a “minimum core” approach specifying under which specific circumstances there is a threat to the justiciable core of the right.⁶⁰ This

lution 02312 of 1998 and required EPS to have technical committees that approved the medication or treatment, rather than allow the courts to oversee the granting of non-POS treatments and medications. The process was further regulated by Law 1122 of 2007.

56. Because the system is designed so that each EPS receives a fixed amount for each person insured, see L. 100/93, art. 156(f), 23 de diciembre de 1993, DIARIO OFICIAL [D.O.], CCC could have speculated that it was in the government’s interest to include new treatments and medicines in the scheduled list of benefits. This, however, was easier said than done for reasons that remain obscure.

57. For a recent document uncovering unscrupulous pricing that resulted in having the state overpay some medications, see JUAN GONZALO ZAPATA ET AL., FEDESARROLO, PERTINENCIA DE INCENTIVAR LA COMPETENCIA EN EL MERCADO DE MEDICAMENTOS BIOTECNOLÓGICOS EN COLOMBIA Y SU IMPACTO SOBRE LAS FINANZAS DEL SECTOR DE LA SALUD (2012).

58. For a numerical analysis of this trend, see DEFENSORIA DEL PUEBLO, LA TUTELA Y EL DERECHO A LA SALUD 2009 (2010); DEFENSORIA DEL PUEBLO, LA TUTELA Y EL DERECHO A LA SALUD 2010 (2011); DEFENSORIA DEL PUEBLO, LA TUTELA Y EL DERECHO A LA SALUD 2011: 20 AÑOS DE USO EFECTIVO DE LA TUTELA 1992–2011 104 (2012).

59. See Octavio Luiz Motta Ferraz, *Harming the Poor through Social Rights Litigation: Lessons from Brazil*, 89 TEX. L. REV. 1643, 1661 (2011). See also David Landau, *The Reality of Social Rights Enforcement*, 53 HARV. INT’L L.J. 402, 441 (2012) (applying this to Colombia).

60. See Corte Constitucional [C.C.] [Constitutional Court] 17 de marzo de 2003, Sentencia T-227/03, available at <http://www.corteconstitucional.gov.co/relatoria/2003/T-227-03.htm>; Corte Constitucional [C.C.] [Constitutional Court] 25 de septiembre de 2003, Sentencia T-859/03, available at <http://www.corteconstitucional.gov.co/relatoria/2003/T-859-03.htm> (developing when the right to health is justiciable).

decision brought a new clarity to the right to health, which, due to the high volume of complaints, had not always been consistent. However, it did not address the real issues that were increasingly veering the healthcare system toward a major financial crisis.

B. *Decision T-760: Court-Ordered Transformation*

In 2008, the CCC's focus on clarifying justiciability shifted to addressing the healthcare system's overwhelming financial problems more directly. While previous right to health cases often had policy implications that affected the system as a whole, Decision T-760 in 2008 was the first decision to adopt structural litigation guidelines to specifically order the government to address the major problems in the healthcare system.⁶¹ The court ordered the government to revise the scheduled list of benefits, both to include those that were consistently ordered by courts through *tutelas*, and to eliminate persistent disparities between the contributive and the subsidized regimes. In addition, the court asked the government to design non-judicial mechanisms to resolve disputes between patients and healthcare providers, and create effective mechanisms to reduce both the promotion of litigation and the denial of services and information by the EPS.⁶²

Further issues of mismanagement made the healthcare system untenable.⁶³ The government faced increasing delays in actually making reimbursements, which the EPS often pointed to in justifying the delay of their own payments to hospitals and other healthcare facilities. This contributed to the bankruptcy of many hospitals, especially public hospitals that served the poor. Complex government-designed procedures for filing claims and suspect financial decisions (such as the use of healthcare funds to buy government debt bonds, which have long periods before they can be cashed in) also led to delays in reimbursements. Lastly, the government increased the

61. Corte Constitucional [C.C.] [Constitutional Court], 22 de enero de 2007, Sentencia T-016/07, available at <http://www.corteconstitucional.gov.co/relatoria/2007/T-016-07.htm>; Corte Constitucional [C.C.] [Constitutional Court], 31 de julio de 2008, Sentencia T-760/08, available at <http://www.corteconstitucional.gov.co/relatoria/2008/T-760-08.htm>.

62. Since 2009 the administrative agency in charge of overseeing EPS, the *Superintendencia de Industria y Comercio* (henceforth *Superintendencia*), opened an investigation against the fifteen national EPS and their national association, ACEMI, for denying services in the scheduled list. Resolution 10958/09 of the *Superintendencia* claims that ACEMI worked to unify information and practices among the different EPS and agreed to deny certain services to keep their profit levels high, also denying the government information that would lead to the inclusion of certain medicines and services in the scheduled list in order to keep receiving reimbursements for their provision. *Superintendencia de Industria y Comercio Resolución 10958/09*, 6 de marzo de 2009, available at http://www.sic.gov.co/siyc/memoria/resolucion/superindustria/2009/resolucion_superindustria_10958_2009.html; *Con los 63 millones de dólares se hicieron polémicas propuestas para la salud*, SEMANA.COM (Feb. 22, 2010), <http://www.semana.com/salud—seguridad-social/63-millones-dolares-hicieron-polemicas-propuestas-para-salud/135225-3.aspx>.

63. For a sampling of media coverage of the healthcare crisis, see, e.g., Leonardo Cañón, Juan Carlos Cortés & Emilio Cassasco, *Un debate postergado*, EL ESPECTADOR, Feb. 8, 2010, <http://www.elespectador.com/impreso/articuloimpreso186415-un-debate-postergado>; *Cartilla para entender el lío de la salud*, SEMANA.COM (Feb. 6, 2010), <http://www.semana.com/nacion/cartilla-para-entender-lío-salud/134674-3.aspx>.

number of people insured through the subsidized regime while the number insured in the contributory regime did not increase proportionally, threatening the long-term sustainability of the system.

The combination of the justiciability of the right to health, the privatization of healthcare insurance through profit-seeking EPS, and government mismanagement resulted in a system that incentivized increasing government expenditures, which were not always reflected in improved healthcare provision. What was perhaps even more worrisome was the lack of growth in preventive healthcare services (reflected also in rising costs in services for preventable illnesses).

Decision T-760 ordered the government to address the many shortcomings of the healthcare system.⁶⁴ However, the decision coincided with a significant increase in right to health cases and with further instability of the health insurance system.⁶⁵ By the end of the year, it was clear the system needed major reform. The CCC, following its own structural litigation system, monitored the orders with a series of follow-up awards as an attempt to pressure the government into adopting reforms, especially increased regulation.⁶⁶ Nonetheless, the CCC's efforts were overshadowed by the public protest that characterizes the third phase of the impact of the right to health in Colombia.

C. 2009–2010: Protest and Crisis

The third stage in Colombia's right to health trajectory was marked by protest and crisis. In response to Decision T-760, the government adopted ten decrees that reformed the health system in January 2010.⁶⁷ The decrees

64. See Corte Constitucional [C.C.] [Constitutional Court], 31 de julio de 2008, Sentencia T-760/08 available at <http://www.corteconstitucional.gov.co/relatoria/2008/t-760-08.htm>. Former Justice Manuel José Cepeda-Espinosa, who authored (and orchestrated the public hearings behind) Decision T-760, has commended the order's deliberate focus on "financial sustainability," and the need to equalize benefits to protect the poor. Manuel José Cepeda-Espinosa, *Transcript: Social and Economic Rights and the Colombian Constitutional Court*, 89 TEX. L. REV. 1699, 1701–02 (2011).

65. DEFENSORIA DEL PUEBLO, LA TUTELA Y EL DERECHO A LA SALUD 2010 93 (2011).

66. The Constitutional Court has adopted a large amount of follow-up awards, to the point where it has appointed a special chamber within the court (an assistant judge, working with a group of clerks, and solely devoted to health issues) to oversee the awards. Some of the awards pressured the government into adopting reforms before January 2010. For example, on January 26, 2009, the court asked the government to produce a report showing how they were implementing decision T-706/08. Earlier in the year, the court created a special "follow-up" group of experts, which produced reports that were then sent to the government. See Seguimiento al Cumplimiento de la Sentencia T-760 de 2008, CORTE CONSTITUCIONAL SALA ESPECIAL DE SEGUIMIENTO, available at <http://www.corteconstitucional.gov.co/inicio/SEGUIMIENTO%20EN%20SALUD/> (last visited Oct. 14, 2012). The court has a special website for the numerous follow-up awards. For the list of specific awards including those that examine whether or not the government has complied, see Autos Proferidos por la Sala Especial de Seguimiento, CORTE CONSTITUCIONAL, <http://www.corteconstitucional.gov.co/inicio/SEGUIMIENTO%20EN%20SALUD/AUTOS%20ESPECIFICOS%20PROFERIDOS%20POR%20LA%20SALA%20ESPECIAL.php> (last visited Oct. 14, 2012).

67. The decrees adopted were Decreto 126, 21 de enero de 2010, DIARIO OFICIAL [D.O.] (establishing disciplinary and criminal sanctions for fraud in the healthcare system, as well as increasing government powers to intervene EPS, fine them, control their expenses, and monitor prices paid for

did not comply with CCC doctrine, however. Instead, they focused on dealing with the budget crisis by limiting services and funneling tax revenues into the system, including new taxes on alcohol and lotteries. The decrees proved to be highly controversial, especially the measure that limited services not on the scheduled list to resource availability. The decrees also limited doctors' ability to order services and medicines, curtailing patients' access to specialists and fining doctors for ordering medicines and services not on the scheduled list. Finally, the decrees allowed EPS and hospitals to use external (and non-unionized) providers of health services and diagnostic exams.

Surprisingly, given the relative marginality of the right to health in a country with serious problems with violence, and (at that time) a very popular government, the decrees gave rise to an unexpected level of protest.⁶⁸ Many of the protests, framed as a defense of the right to health, specifically addressed medicines and services (especially coverage of high-cost illnesses) that the CCC had identified as being covered by a justiciable right to health.⁶⁹ Part of the resistance was foreseeable: the measures were a clear threat to patients with high-cost illnesses. These patients (especially those

medications); Decreto 127, 21 de enero de 2010, DIARIO OFICIAL [D.O.] (increasing taxes for alcohol and cigarettes and funneling them to cover healthcare expenses); Decreto 128, 21 de enero de 2010, DIARIO OFICIAL [D.O.] (establishing mechanisms for patients to finance their own extra-POS benefits, including dipping into mandatory savings for housing and education); Decreto 129, 21 de enero de 2010, DIARIO OFICIAL [D.O.] (creating new sanctions and fines for those who evade paying mandatory health insurance even though they can); Decreto 130, 21 de enero de 2010, DIARIO OFICIAL [D.O.] (creating new taxes on gambling and lotteries to fund health care); Decreto 131, 21 de enero de 2010, DIARIO OFICIAL [D.O.] (creating a national technical system to mediate patient-EPS conflicts and explicitly limit healthcare services to financial availability); Decretos 132 and 133, 21 de enero de 2010, DIARIO OFICIAL [D.O.] (funneling new resources from the general budget to health care); Decreto 134, 21 de enero de 2010, DIARIO OFICIAL [D.O.] (increasing budget for health care in the national budget); Decreto 135, 21 de enero de 2010, DIARIO OFICIAL [D.O.] (directing funds from the law enforcement budget to the prevention and treatment of drug addiction). To these initial ten decrees, adopted in January, the government added in February Decreto 358, 4 de febrero de 2010, DIARIO OFICIAL [D.O.] (sanctioning doctors that create unnecessary expenses for the healthcare system) and Decreto 398, 5 de febrero de 2010, DIARIO OFICIAL [D.O.] (insisting that access to health care is guaranteed during the transition to the new system).

68. Interview by Julieta Lemaitre with Néstor Alvarez, *supra* note 50; Interview by Julieta Lemaitre with Alicia Taffur, Leader, Asociación de Pacientes del Instituto Nacional de Cancerología (Association of Patients of the National Cancer Institute), in Bogotá, Colombia (Nov. 29, 2011); Interview by Julieta Lemaitre with Everaldo Lamprea, former Clerk, CCC, involved with the follow-up awards, in Bogotá, Colombia (Nov. 7, 2011); Observations by Julieta Lemaitre during a public march in Bogotá, Colombia (Feb. 18, 2010) and a protest before the court in Bogotá, Colombia (Feb. 18, 2010). For the media coverage, see *supra* note 63.

69. For press coverage of the marches, see, e.g., *Ciudades marchan en contra de los decretos de emergencia social*, SEMANA.COM (Feb. 6, 2010), <http://www.semana.com/nacion/ciudades-marchan-contra-decretos-emergencia-social/134643-3.aspx>; *Enfermos presentaron 42 demandas ante la Corte*, EL TIEMPO, Feb. 17, 2010, <http://www.eltiempo.com/archivo/documento/MAM-3842436>; *Marchan contra decretos de salud implantados en Colombia*, SEMANA.COM (Feb. 18, 2010), <http://www.semana.com/nacion/marchan-contra-decretos-salud-implantados-colombia/135146-3.aspx>; *Pacientes, centrales obreras y hospitales marcharán este jueves contra la Emergencia*, EL TIEMPO, Feb. 17, 2010, <http://m.eltiempo.com/vidadehoy/pacientes-centrales-obreras-y-hospitales-marcharan-manana-contra-la-emergencia/7235227/home>; *Protestas en el país por los decretos de emergencia social*, EL TIEMPO, Feb. 6, 2010, <http://www.eltiempo.com/archivo/documento/MAM-3828102>.

with HIV/AIDS, cancer, or transplant needs) and their supporters formed a vocal network of grassroots activists and patients' rights organizations.⁷⁰ Less foreseeable was the outrage of doctors and medical students who resented government interference with their medical autonomy to decide on the best course of action—an autonomy the courts had defended.⁷¹ This resentment fed on older grievances with EPS-mandated time limits for consultations, diagnostic exams, and even salaries. Health sector workers, including nurses and paramedic associations, perceived the decrees as an attack on their unions. They were supported by national workers' unions and by organizations that generally rejected the privatization of healthcare services. Finally, the measures also offended middle class contributors to health insurance, whose benefits were significantly curtailed.

The decrees generated numerous marches and protests accompanied by sustained pressure to force the government to back down on what the national media widely claimed was regressive health reform. This put substantial pressure on the Uribe government leading up to the 2010 election, in which President Uribe was running for a second term. The EPS were the only major interest group to support the decrees.⁷²

The government responded by insisting on the need for substantial reform, as well as by arguing that special interests fueled opposition to the reform.⁷³ According to the government, the goals of the decrees were to 1) limit non-POS expenses to life-threatening illnesses and to people who have no other means to pay, and 2) increase tax revenue to pay for the health system. The National Planning Department increased control over the EPS.⁷⁴ The government insisted in its website that there were many mis-

70. For an interview with the movement leaders, see Pablo Correa and Carolina Gutiérrez, *Los Escuderos de los Pacientes*, EL ESPECTADOR, Feb. 17, 2010, <http://www.elespectador.com/impreso/vivir/articuloimpreso188384-los-escuderos-de-los-pacientes?q=impreso/vivir/articuloimpreso188384-los-escuderos-de-los-pacientes>.

71. For examples of criticism from the medical front, see, e.g., Pablo Correa, *Médicos temerosos a la hora de formular*, EL ESPECTADOR, Feb. 4, 2010, <http://www.elespectador.com/impreso/negocios/articuloimpreso185962-medicos-temerosos-hora-de-formular>; *Médicos dicen que son "aberrantes" los decretos de la emergencia social*, SEMANA.COM (Feb. 1, 2010), <http://m.semana.com/problemas-sociales/medicos-dicen-aberrantes-decretos-emergencia-social/134430-3.aspx>; *Se agudiza polémica con médicos por decretos que reforman la salud*, EL TIEMPO, Feb. 3, 2010, <http://www.eltiempo.com/archivo/documento/MAM-3821976>.

72. Édmer Tovar, *Decretos de emergencia social se quedaron corto: Juan Manuel Díaz Granados presidente de ACEMI*, EL TIEMPO, Jan. 25, 2010, <http://www.eltiempo.com/archivo/documento/MAM-3808717> (in which the president of the national association of the EPS says not only that the austerity measures were necessary, but also that they were insufficient).

73. The government opened a web-page with the explicit goal of defending the decrees and the declaration of a social emergency more generally. WEB.PRESIDENCIA.GOV, INFORME ESPECIAL: EMERGENCIA DE SALUD, http://web.presidencia.gov.co/especial/emergencia_social/index.html (Oct. 4, 2012, 7:31 PM).

74. The National Planning Department circulated an animated defense of the decrees responding to the many criticisms. DEPARTAMENTO NACIONAL DE PLANEACIÓN, LO BÁSICO DE LA EMERGENCIA SOCIAL, (Feb. 2010), available at http://web.presidencia.gov.co/especial/emergencia_social/cartilla3.pdf (last visited Sept. 12, 2012).

conceptions of the reform, and that popular protest was fueled by private companies that stood to gain from the prior system.⁷⁵

Eventually, the CCC declared the ten decrees to be unconstitutional, but not before national protests from January to March forced the government to recant on some reforms and revealed enormous grassroots support for the CCC's prior decisions on the right to health. When the court announced that the declaration of social emergency, and therefore the decrees, was unconstitutional, a cheering crowd received the decision.⁷⁶ In a pragmatic and controversial aspect of its decision, the CCC deferred the unconstitutionality of the increased taxation until the end of 2010, allowing the government to fund health sector debt while congressional reforms were adopted.⁷⁷ In the meantime, the government paid a high political cost for the attempted reforms, not only because of the unexpectedly intense public reaction against the emergency decrees, but also because of several accusations of corruption against both the government and the EPS during this period.⁷⁸ Allegations of corruption in the preparation of the studies that had recommended the decrees were particularly damaging.⁷⁹

In June 2010, President Juan Manuel Santos came into power and introduced a new scheduled list of benefits, which now includes most of the previously excluded court-ordered medicines and services.⁸⁰ The Superintendencia de Industria y Comercio (the Superintendent of Industry and Commerce), the Procuraduría (the Office of the Inspector General, which makes disciplinary investigations of public official misconduct), and the Contraloría (the Office of the Comptroller General, which oversees the ad-

75. See INFORME ESPECIAL: EMERGENCIA DE SALUD, *supra* note 73. See also Vice-President's declarations of February 18, 2010, SECRETARIA DE PRENSA, "Reforma a la salud pisa los intereses de quienes se lucran del actual sistema": Vicepresidente Santos, <http://web.presidencia.gov.co/sp/2010/febrero/18/29182010.html>; and of the then Minister of Social Protection (equivalent to a Secretary of Health), Carolina Gutiérrez and Pablo Correa, *Hay muchos críticos con intereses económicos*, EL ESPECTADOR, Jan. 31, 2010, <http://www.elespectador.com/impreso/negocios/articuloimpreso185210-hay-muchos-criticos-intereses-economicos-diego-palacio>.

76. Corte Constitucional [C.C.] [Constitutional Court], 16 de abril de 2010, Sentencia C-252/10, at §7.3, available at <http://www.corteconstitucional.gov.co/relatoria/2010/C-252-10.htm>.

77. *Id.*

78. Carlos Fernández and Sonia Perilla, *Sistema de Salud está en jaque por sobrecostos de medicamentos*, EL TIEMPO, Mar. 10, 2010, <http://www.eltiempo.com/archivo/documento/CMS-7389047>.

79. EPS en la emergencia social: Vargas Lleras acusa, Palacio se defiende, SEMANA.COM, (Feb. 10, 2010), <http://www.semana.com/salud—seguridad-social/eps-emergencia-social-vargas-lleras-acusa-palacio-defiende/134805-3.aspx>; *Derogarán norma Uribe da reversa en el uso de cesantías en salud*, EL TIEMPO, Feb. 12, 2010, <http://www.eltiempo.com/archivo/documento/MAM-3837092>; *Emergencia Social: Un paso para adelante y dos para atrás*, SEMANA.COM, (Feb. 7, 2010), <http://m.semana.com/salud—seguridad-social/emergencia-social-paso-para-adelante-dos-para-atras/135132-3.aspx>.

80. In July 2012 the government adopted a new scheduled list that included many formerly non-POS treatments and medications. MINISTERIO DE SALUD Y PROTECCIÓN SOCIAL: *Plan Obligatorio de Salud, Listado completo de medicamentos del POS – Anexo 1* (2011), available at <http://www.pos.gov.co/Documents/Noticias%20del%20POS/Anexo%201%20Listado%20de%20medicamentos%20de%20POS%20%20Acuerdo%2029%20de%202011%20de%20la%20CRES.pdf>; MINISTERIO DE SALUD Y PROTECCIÓN SOCIAL: *PLAN OBLIGATORIO DE SALUD, Listado completo de procedimientos y servicios del POS – Anexo 2* (2011), available at <http://www.pos.gov.co/Documents/Noticias%20del%20POS/Anexo%202%20Listado%20de%20procedimientos%20y%20servicios%20del%20POS%20%20.pdf>.

ministration of public funds) are currently investigating EPS mismanagement.⁸¹ There are also criminal investigations against many former members of the previous government, in particular those responsible for reimbursing the EPS.⁸² During the past two years, several EPS have gone bankrupt, and the government has taken over their administration to guarantee healthcare coverage.⁸³ Non-governmental organizations such as Observatorio del Medicamento reveal that the Uribe government negotiated unreasonably high prices with international pharmaceutical companies for many expensive brand-name medicines on the scheduled list.⁸⁴ These new allegations softened earlier critiques of a “government by judges” and focused attention on the health system’s crisis of corruption and mismanagement as well as on pharmaceutical companies’ pressure and co-optation.⁸⁵

In 2011, Colombia adopted Law 1438, which addressed many of the criticisms of the healthcare system and avoided the types of reforms that sparked so much protest under the Uribe proposal of 2010. As well as seeking to improve the accountability and functionality of the EPS, Law 1438 established procedures for the gradual unification of benefits for the contributory and the subsidized regimes as ordered by the Constitutional Court in 2008, earmarked resources for primary and preventive care, and ordered the updating of the POS every two years.⁸⁶ It also ordered full, free healthcare coverage for children.⁸⁷ Despite these efforts, there is a persistent perception of the system’s crisis as well as an ongoing discussion about the

81. For the Juan Manuel Santos report on the EPS’s financial health, see SUPERINTENDENCIA DE SALUD, INFORME SITUACIÓN FINANCIERA ENTIDADES PROMOTORAS DE SALUD Y REGIMEN SUBSIDIADO VIGENCIA 2011 (2012), available at <http://www.supersalud.gov.co/supersalud/LinkClick.aspx?fileticket=GS3WyXZPAL0%3D&tabid=93&mid=1489>.

82. See, e.g., *Allanan sedes de cinco EPS por investigaciones de corrupción*, SEMANA.COM (May 24, 2011), <http://www.semana.com/nacion/allanan-sedes-cinco-eps-investigaciones-corrupcion/157268-3.aspx>.

83. See *id.* For news coverage of the issue, see, e.g., Redacción Vivir, *Sólo el 19% de las EPS son solventes*, EL ESPECTADOR, Apr. 21, 2012, <http://www.elespectador.com/noticias/salud/articulo-294436-humana-vivir-oficialmente-intervenida>.

84. See generally OBSERVATORIO DEL MEDICAMENTO COLOMBIA, <http://www.observamed.org/> (last visited Nov. 7, 2012) (Observatorio del Medicamento Colombia’s coverage of the issue). The Juan Manuel Santos government has been trying to reduce the high prices allowed by the previous government. See Norbey Quevedo, *Lupa a Precios de 19 Medicamentos*, EL ESPECTADOR, May 21, 2012, <http://www.elespectador.com/noticias/investigacion/articulo-347766-lupa-precios-de-medicamentos>.

85. See, e.g., *Allanan sedes de cinco EPS por investigaciones de corrupción*, *supra* note 82; *EPS implicadas en corrupción serían intervenidas*, EL TIEMPO, July 5, 2011, http://www.eltiempo.com/justicia/ARTICULO-WEB-NEW_NOTA_INTERIOR-9325524.html; *Supersalud abrió 326 investigaciones contra EPS en 2010*, EL TIEMPO, May 11, 2011, http://www.eltiempo.com/vida-de-hoy/salud/ARTICULO-WEB-NEW_NOTA_INTERIOR-9328367.html.

86. L. 1438/11,19 de enero de 2011, DIARIO OFICIAL [D.O.] at arts. 18–19. The law also made adjustments in response to criticisms, such as having EPS technical scientific committees respond to patient complaints, *id.* at art. 27, and making EPS coverage valid nationwide and not limited to certain cities, *id.* at art. 22. It also created a national commission to control the prices of medications, *id.* at art. 87, and guaranteed doctor autonomy when ordering medicines and treatments, *id.* at art. 105.

87. L. 1438/11,19 de enero de 2011, DIARIO OFICIAL [D.O.], art. 19.

need for further healthcare system reform, including a proposal to return to the state provision of health care and eliminate EPS mediation altogether.⁸⁸

One thing that remains from the 2010 impasse is the importance of the concept of the right to health, at least formally. As of September 2012, the government is considering a new health reform law it calls the Statute for the Right to Health.⁸⁹ The new Minister of Health, Alejandro Gaviria, who is a long-standing critic of court-ordered spending, has emphasized the need for financial, rather than medical, expertise.⁹⁰ Because the quantity of right to health litigation has not been reduced by the reforms, the issue of justiciability will be sure to receive attention.⁹¹

As shown in this section, Colombia has experienced an intense level of litigation, adjudication, and enforcement in its evolution of the right to health. Judicial leadership has ingrained into the popular consciousness a sense of healthcare entitlement. Unscrupulous companies have manipulated complex financial reimbursements and entitlements under the insurance scheme. Together, these factors brought about fiscal crisis and protest. This may be contrasted with the justiciability of the right to health in South Africa.

III. LOW-INTENSITY JUSTICIABILITY: SOUTH AFRICA

In contrast to Colombia, South Africa's engagement with the right to health has been marked by a low-intensity approach to justiciability. The right to health has been interpreted and enforced by tentative, incremental, and partial steps on the part of the Constitutional Court of South Africa ("CCSA"), and a less widespread challenge to, and disruption of, the overall health system. Despite vigorous contestations around health rights and remarkably successful instances of social movement mobilization and representation, the right to health remains a changeable discursive resource that

88. For an analysis of the crisis in 2012, see *Remedios para el sistema de salud*, SEMANA.COM (July 14, 2012), <http://www.semana.com/nacion/remedios-para-sistema-salud/180758-3.aspx>; *El panorama del sistema de salud es "dramático", dice el procurador*, SEMANA.COM (July 12, 2012), <http://www.semana.com/nacion/panorama-del-sistema-salud-dramatico-dice-procurador/180640-3.aspx>; *El SOS que envió el sector salud al Presidente Santos*, SEMANA.COM (May 22, 2012), <http://www.semana.com/nacion/sos-envio-sector-salud-presidente-santos/177562-3.aspx>. See also Laura Victoria Botero, *La academia plantea reforma estructural del sistema de salud*, EL COLOMBIANO, Sept. 10, 2012, <http://www.elcolombiano.com/Banco-Conocimiento/L/la-academia-plantea-reforma-estructural-del-sistema-de-salud/la-academia-plantea-reforma-estructural-del-sistema-de-salud.asp>; Colprensa, *Avanza acto legislativo que eleva la salud a derecho fundamental*, EL PAÍS, Sept. 11, 2012, <http://www.elpais.com.co/elpais/colombia/noticias/avanza-acto-legislativo-eleva-salud-derecho-fundamental>.

89. *La salud necesita un experto en finanzas y no un médico (entrevista con Alejandro Gaviria)*, VANGUARDIA LIBERAL, Sept. 16, 2012, <http://www.vanguardia.com/actualidad/colombia/174571-la-salud-necesita-un-experto-en-finanzas-y-no-un-medico>.

90. *Id.*

91. The 2011 data published in 2012 show a slight increase in 2011 (105,947 right to health *tutelas*) in relation to 2010 (94,502). DEFENSORIA DEL PUEBLO, LA TUTELA Y EL DERECHO A LA SALUD 2011: 20 AÑOS DE USO EFECTIVO DE LA TUTELA 1992–2011 104 (2012).

will be shown to reflect a less tangible entitlement than that presently provided in Colombian constitutional law.⁹²

Like Colombia's Constitution, South Africa's Constitution of 1996 came at the end of a long period of repression and violence. While Colombia's Constitution may be characterized by the "social rule of law" concept, South Africa's can be described as belonging to the category of "transformative constitutionalism."⁹³ This goal seeks to create a new legal and political system from the legacy of officially sanctioned racism.⁹⁴ Expanding access to health care by entrenching the right to health care is part of an overall project of transformation, as is the establishment of a new, separate Constitutional Court, itself an innovation in a common law system. The CCSA occupies a major role in transformative constitutionalism, which has been explicitly endorsed by its judges.⁹⁵ While access and standing rules for the CCSA are designed to be lenient,⁹⁶ and submissions from *amicus curiae* are welcomed,⁹⁷ there is no equivalent to the *tutela* in South Africa. Furthermore, the CCSA hears vastly fewer cases than its equivalent in Colombia—now averaging around 25 per year.⁹⁸ The CCSA also shares constitutional jurisdiction with the South African Supreme Court of Appeal and the High Courts, yet the main litigation involving the right to health has been dealt with by the CCSA.

Another major difference between the two countries is the design and financing of the healthcare system. In South Africa, health care is delivered in two tiers. The private health system, which covers less than 15% of the population, consists of general practitioners and private hospitals funded

92. See *supra* text accompanying notes 17 and 22 for the textual wording.

93. See Karl E. Klare, *Legal Culture and Transformative Constitutionalism*, 14 S. AFR. J. HUM. RTS. 146 (1998).

94. *Id.* at 147. For the judicial recognition of the role that race played in health care allocations, see Soobramoney, para 20, fn 10, ("We have only recently emerged from a system of government in which the provision of health services depended on race. On occasions seriously injured persons were refused access to ambulance services or admission to the nearest or best equipped hospital on racial grounds.").

95. See Dikgang Moseneke, *Fourth Bram Fischer Memorial Lecture: Transformative Adjudication*, 18 S. AFR. J. HUM. RTS. 309, 314 (2002) (arguing that "a creative jurisprudence of equality coupled with substantive interpretation of the content of 'socio-economic' rights should restore social justice as a premier foundational value of our constitutional democracy side by side, if not interactively with, human dignity, equality, freedom, accountability, responsiveness, and openness. Implicit in this proposition is that the Constitution enjoins the judiciary to uphold and advance its transformative design.").

96. S. AFR. CONST., §§ 38, 167(6) (allowing any person "when it is in the interests of justice and with leave of the Constitutional Court—[to] (a) bring the matter directly to the Constitutional Court; or (b) appeal directly to the Constitutional Court from another court").

97. See *In re certain amicus curiae applications: Minister of Health v. Treatment Action Campaign*, 2002 (5) SA 713 (CC).

98. Between 1995 and 2011, the CCSA handed down a total of 411 judgments. See CONST. COURT OF S. AFR., *Overview of the Judgments of the Constitutional Court of South Africa 1994 to 2005* (June 2011), available at <http://www.constitutionalcourt.org.za/site/judgments/Judgments-Summarised-Delivered-1995-2005>; CONST. COURT OF S. AFR. *Overview of the Judgments of the Constitutional Court of South Africa Since 2006*, (June 2011), available at <http://www.constitutionalcourt.org.za/site/judgments/Judgments-Summarised-Delivered-2006-August-2011>.

mainly by private medical schemes.⁹⁹ A further 21% of the population relies on the private sector, mainly for primary care on an out-of-pocket basis. The remaining 64% of the population depends on the public sector for all healthcare services.¹⁰⁰ Further aggravating these imbalances, almost half of the country's healthcare expenditures go to the private medical scheme, and public health users have been radically under-resourced: in 2005, less than ZAR 1300 (USD 160) was spent per person for government primary care and hospital services, with a strong tilt towards curative hospital care.¹⁰¹ This imbalance is further amplified by the disease profiles of those of low socio-economic status who must rely on the public system: HIV/AIDS; tuberculosis; maternal, infant, and child mortality; non-communicable diseases; and the effects of injury and violence.¹⁰² This is a clear legacy of apartheid, reflecting the racial agenda, gender biases, and lack of resources for the provinces during the apartheid regime.¹⁰³

South Africa's jurisprudence on the constitutional right to health is responsive to this context, as we shall see, but has had little direct effect on the deep imbalances of the healthcare system. The CCSA's jurisprudence on the right to health, which commenced six years after the CCC's, is markedly distinct from the strident steps taken in Colombia. While each body of jurisprudence has developed through the intermediary of international human rights law, and with mutual comparative influences such as the German Basic Law,¹⁰⁴ the differences in the language of jurisprudence—and the relative scarcity of Spanish-to-English translations—have meant the two are neither directly cited, nor apparently read by the other court. Of course, members of the Constitutional Courts of each jurisdiction are still undoubtedly in conversation, through the transjudicial dialogue that takes place through conferences, websites, and other informal forums.¹⁰⁵ Yet they are usefully compared to highlight the distinct treatment given to the con-

99. Medical schemes are South African private health insurance companies, defined by the South Africa Medical Scheme Act as “the business of undertaking liability in return for a premium or contribution.” Act 131 of 1998 § 1.1. For coverage, see generally Hoosen Coovadia et al., *The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges*, 374 *THE LANCET* 817 (2009).

100. See Coovadia, *supra* note 99, at 827.

101. *Id.* at 826–27.

102. *Id.* at 818.

103. See Dep't of Health, *White Paper for the Transformation of the Health System in South Africa*, S. Afr. Gov't Info. (April 1997), <http://www.info.gov.za/whitepapers/1997/health.htm> (last visited Oct. 14, 2012). In 1997 the new South African government set out the challenge of transforming the legacy of apartheid in health care provision. *Id.* (“Although classified as a middle-income country and spending 8.5% of GDP on health care[,] South Africa exhibits major disparities and inequalities. This is the result of former apartheid policies which ensured racial, gender and provincial disparities.”).

104. See generally ERIKA DE WET, *THE CONSTITUTIONAL ENFORCEABILITY OF ECONOMIC AND SOCIAL RIGHTS: THE MEANING OF THE GERMAN CONSTITUTIONAL MODEL FOR SOUTH AFRICA* (1996). For the influence of the German model on Colombia through the creation of the institutional guarantee and the social rule of law, see *supra* notes 18 and 28.

105. For a description of this dialogue, see Anne-Marie Slaughter, *A Global Community of Courts*, 44 *HARV. INT'L L.J.* 191, 197 (2003).

stitutional right to health. We suggest that a characteristically “low-intensity” form of justiciability flows from CCSA’s doctrinal stance, which we characterize as “reasonableness review,” as well as the formative context of the HIV/AIDS pandemic. We draw these links in the following sections.

A. 1998–2002: Reasonableness Review

Soon after the CCSA confirmed the justiciability of economic and social rights in 1998,¹⁰⁶ litigation on the right to health commenced. *Soobramoney* involved a claim by a chronically and terminally ill, recently destitute claimant who sought renal dialysis.¹⁰⁷ A public hospital had rejected his request on the basis of a rationing process that favored patients with a chance of long-term recovery.¹⁰⁸ *Soobramoney* argued that the refusal deprived him of his right to life and his right to emergency medical treatment.¹⁰⁹ The CCSA declined to hear the matter on these bases, holding that renal dialysis was a life-prolonging intervention, rather than an immediate remedial treatment that would be associated with an emergency.¹¹⁰ In particular, it held that a rationing process that apportioned scarce resources among those who urgently need services did not infringe upon the right to life.¹¹¹

Instead, the CCSA explored the state’s obligations under the right to access health care.¹¹² The CCSA conceded the tragic choice undergirding the case, and the implications for weighing *Soobramoney*’s life against the lives of others.¹¹³ Yet the CCSA also emphasized that the resources of the hospital in question, and of the public healthcare system in general, were scarce.¹¹⁴ Rationing was an everyday reality. Adopting an orientation that was utilitarian despite being coded with the language of rights,¹¹⁵ the CCSA accepted that public health must be organized for the welfare of all, and not biased towards those whose claims had managed to reach the courts.¹¹⁶

106. *In re Certification of the Constitution of the Republic of S. Afr.*, 1996 (4) SA 744 (CC).

107. *Soobramoney v. Minister of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC).

108. *Id.* at 769 para. 3.

109. *Id.* at 770 para. 7.

110. *Id.* at 774 para. 21.

111. *Id.* at 773–74 para. 19.

112. *Id.* at 774 para. 22.

113. *Id.* at 784 paras. 57–59.

114. *Id.* at 769–70 paras. 2–3; 771 para. 11; 774–75 para. 24; 776–77 paras. 30–31.

115. The language of rights is often used to refer to interests or claims that trump utilitarian concerns because of their particular normative force. See generally, Ronald Dworkin, *Rights as Trumps*, in *THEORIES OF RIGHTS* 153 (Jeremy Waldron ed., 1984) (presenting the metaphor of the trump card). Yet the CCSA used this language while balancing other concerns. See Karin Lehmann, *In Defense of the Constitutional Court: Litigating Economic and Social Rights and the Myth of the Minimum Core*, 22 AM. U. INT’L L. REV. 163, 169 (2006) (suggesting that the *Soobramoney* decision is better characterized as utilitarian rather than rights-based).

116. *Soobramoney* 1998 (1) SA at 784 para. 58.

The standard for the right to health care was the reasonableness test, which would become key to the CCSA's economic and social rights jurisprudence. In highlighting that Section 27 of the Constitution guaranteed only an obligation to "take reasonable measures," rather than a stand-alone subjective right, the CCSA introduced a quasi-procedural scrutiny of the government's actions that exemplified a careful judicial restraint.¹¹⁷ The CCSA accepted that the public hospital's rationing process, itself subject to ethical guidelines, was reasonable.¹¹⁸ There was a "nation-wide problem" of limited dialysis machines, and the court deferred to the "guidelines . . . to assist the persons working in these clinics to make the agonizing choices which have to be made in deciding who should receive treatment, and who [should] not."¹¹⁹ The CCSA also found reasonable the provincial health department's prior budgetary allocations.¹²⁰

Undoubtedly, the *Soobramoney* decision created a temporary chilling effect on further health rights claims.¹²¹ If the CCSA were willing to defer to governmental and hospital decision-making, and concede the scarcity of state resources, it appeared that the prospects for other complaints were low. *Soobramoney's* claim had not attracted much public sympathy or a significant social movement, although many noted the tragedy when he passed away three days after judgment.¹²² The case contains clues for the present orientation of reasonableness review, which is a rejection of high-cost treatments as a state responsibility, an acknowledgment of the inescapable tragedy in healthcare allocations, and a formulation of deference to hospitals and government when making such decisions.

Reasonableness review received new attention after a successful complaint in relation to the right to housing. In the famous *Grootboom* decision, the CCSA held that the government's housing policy was unreasonable because it had failed to cater for vulnerable individuals and groups in the position of the complainant.¹²³ *Grootboom* is directly relevant to right to health jurisprudence because it signaled that the reasonableness standard could have some teeth. The CCSA was prepared to scrutinize the government's housing policy, asking questions of it that clearly went beyond the standards of rationality in government decision-making—questions that drew uncommon judicial attention to the poor and vulnerable who were

117. *Id.* at 771 para. 10.

118. *Id.* at 775 para. 25.

119. *Id.* at 775 para. 24.

120. *Id.* at 776 para. 29.

121. Craig Scott & Philip Alston, *Adjudicating Constitutional Priorities in a Transnational Context: A Comment on Soobramoney's Legacy and Grootboom's Promise*, 16 S. AFR. J. HUM. RTS. 206, 241 (2000) (worrying that the CCSA's decision, despite presenting "a certain conception of fairness in allocation," "arguably does so in a way that ends up coming close to denying that any given person or group can legitimately assert a priority constitutional claim on resources.").

122. Albie Sachs, *Social and Economic Rights: Can They Be Made Justiciable?* 53 SMU L. REV. 1381, 1386 (2000).

123. *Gov't of the Republic of S. Afr. v. Grootboom* 2001 (1) SA 46 (CC), paras. 52–54, 53–56.

omitted from, or burdened by, a particular policy.¹²⁴ This approach would open the way for a more careful scrutiny of those who would be burdened by a particular health policy in the *Treatment Action Campaign* (“TAC”) decision to come.¹²⁵ The CCSA also declined to adjudicate a justiciable, subjective “minimum core” of the right to housing, finding the more flexible standard of reasonableness to be more consistent with its own competence for economic and social rights adjudication.¹²⁶ This general orientation would continue for parallel litigation in sanitation, electricity, and water,¹²⁷ all rights for which the minimum core is much more extensively defined in international law.¹²⁸

Even though the CCSA was reluctant to prescribe entitlements during this phase, it nevertheless achieved “a standard of transparency in government decision making” that might not have been achieved without the justiciable right.¹²⁹ Moreover, the court’s orientation also ensured that it would peer into the consideration given to economically vulnerable groups.¹³⁰ As a result, government policies are required to focus on both short-term and long-term beneficiaries in the design of public schemes. Of course, to insist that policy does not ignore the needs of vulnerable groups does not in itself confer any tangible benefits on them.¹³¹ Nonetheless, attention to vulnerable groups constitutes a potent standard when combined with the equality guarantee.¹³² This orientation reflects a degree of weighted utilitarianism in the CCSA’s rights jurisprudence—that is, a re-

124. SMU L. REV. 1381, 1386 (2000). *Understanding Grootboom: A Response to Cass Sunstein*, 12 CONST. F. 41, 41 (2001).

125. See *Treatment Action Campaign* 2002 (5) SA 713. For the impact of this decision, see *infra*, Part II.B.

126. *Grootboom* 2001 (1) SA at 65–66 paras. 29–33. For a critique of the claim of determinacy for the minimum core in both international and comparative constitutional law, see Young, *The Minimum Core of Economic and Social Rights*, *supra* note 41.

127. *Mazibuko v. City of Johannesburg* 2010 (4) SA 1 (CC); *Compare City of Johannesburg v. Mazibuko* 2009 (3) SA 592 (SCA); *Mazibuko v. City of Johannesburg* 2008 (4) ASA 471 (W); [2009] ZAGPHC 106 (18 Apr. 2008); Case No. 06/13865, High Court of South Africa (Witwatersrand Local Division).

128. *Compare* U.N. Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights, General Comment No. 15: The Right to Water (Art. 11 of the ICESCR) U.N. Doc. E/C.12/2002 (Jan. 20, 2003) with U.N. Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights, General Comment No. 4: The Right to Adequate Housing (Art. 11(1) of the Covenant), U.N. Doc. E/1992/23 (Dec. 13, 2003), and U.N. Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights, General Comment No. 7: The Right to Adequate Housing (Art. 11(1)): Forced Evictions, U.N. Doc. E/1998/22 (May 20, 1997). Cf. SCOTT LECKIE, U.N. DEV. PROGRAMME, UNDP HUMAN DEVELOPMENT REPORT 2000, HOUSING RIGHTS § 18 (Nov. 20, 1999), <http://hdr.undp.org/en/reports/global/hdr2000/papers/leckie.pdf>.

129. Puneet K. Sandhu, *A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?*, 95 CAL. L. REV. 1151, 1178 (2007). But see *Minister of Health v. New Clicks S. Afr. (Pty.) Ltd.* 2006 (2) SA 311 (CC) (exhibiting the stand-alone role of administrative justice requirements).

130. See, e.g., *Grootboom* 2001 (1) SA 46.

131. Marius Pieterse, *Possibilities and Pitfalls in the Domestic Enforcement of Social Rights: Contemplating the South African Experience*, 26 HUM. RTS. Q. 882, 891–902 (2004).

132. This has become more evident after the CCSA’s decision in *Khosa v. Minister of Social Dev.* 2004 (6) SA 505 (CC). See Marius Pieterse, *Resuscitating Socio-Economic Rights: Constitutional Entitlements to Health Care Services*, 22 S. AFR. J. HUM. RTS. 473, 493 (2006).

luctance to establish the minimum substance of economic and social rights, along with an acknowledgement of the special burdens experienced by the poor and vulnerable. This orientation was to remain until the implications of the HIV/AIDS pandemic exploded onto the judicial scene.

B. The Formative Context of the HIV/AIDS Pandemic

The incrementalism of reasonableness review was to change in light of the overwhelming nature of the HIV/AIDS pandemic in South Africa. On the one hand, HIV/AIDS presented a disease of such seriousness and such drastic ramifications that it could not be ignored. On the other hand, President Mbeki's apparent denial of the link between HIV/AIDS and the ANC administration's prevarications and delay in organizing a medical response raised alarming implications for the spread and treatment of the disease.¹³³

In such a scenario, the standard of reasonableness became more robust. The *TAC* case was brought by Treatment Action Campaign, a South African activist organization defending the rights of people living with HIV/AIDS, against the government's handling of the prevention of mother-to-child transmission of HIV at childbirth.¹³⁴ After mobilization by the TAC, a pharmaceutical company had donated a five-year stock of an antiretroviral drug ("ARV"), Nevirapine, to prevent mother-to-child transmission.¹³⁵ Yet the government prohibited the use of the ARV in public hospitals, apart from its limited trial in 16 public sites.¹³⁶

The TAC claimed that the restriction on the drug was unreasonable, especially in light of the gravity of the consequences—transmission of HIV/AIDS—of denying access to the drug.¹³⁷ It based its arguments both on the right to health and the specific right of children to health care. It produced evidence of doctors, medical experts, and patients about the ramifications of the policy and its arbitrariness. The government defended its position on the grounds that the effective provision of ARVs was unaffordable (because it would require testing, counseling services, and formula milk), that the efficacy and safety of Nevirapine was not proven, and that the use of Nevirapine would risk a negative impact on public health.¹³⁸

The CCSA's examination of the reasonableness of the government's policy was robust. The CCSA peered behind the reasons given for the seemingly rational restriction, finding all of them wanting. It held that the costs of testing and counseling were minimal.¹³⁹ Furthermore, the safety of the

133. For an exploration of the attraction that President Mbeki felt for the "dissident" view on HIV/AIDS, see DIDIER FASSIN, *WHEN BODIES REMEMBER: EXPERIENCES AND POLITICS OF AIDS IN SOUTH AFRICA* 2–17 (2007).

134. *Treatment Action Campaign* 2002 (5) SA at 7 para. 2.

135. *Id.* at 12 para. 19.

136. *Id.*

137. *Id.* at 8 para. 4.

138. *Id.* at 10–11 paras. 14–15.

139. *Treatment Action Campaign* 2002 (5) SA at 18 paras. 49–51; 22 para. 71.

drug had been vouched for by the South African Medical Review Board, which had registered the drug for private sale.¹⁴⁰ Holding that the restriction of the ARV to designated sites was unreasonable because it excluded people who could reasonably have been included in the ambit of the policy,¹⁴¹ the CCSA ordered the government to end the restriction and mandated the provision of counseling and other necessary services, the latter enforceable through a contempt of court order. It allowed for the revisability of the Nevirapine ARV treatment if better treatments became available. It also declined to order a structural injunction to require the government to carry out each concrete step, noting its expectation that the government would carry out the declaratory order. Despite the mandatory elements of the testing and counseling remedy, there was nothing equivalent to the sort of structural order of transformation produced by the health rights cases in Colombia.¹⁴²

Vigorous organization and mobilization on the part of the TAC arguably made the TAC case and the orders that followed easier for the CCSA. Because of considerable public attention, public marches, and other mobilizations during the course of the litigation, some provincial governments had already made significant concessions and changes prior to the decision.¹⁴³ Several additional mobilizations by the TAC, regular monitoring of health clinics, and treatment literacy programs for mothers after the decision ensured that the orders were implemented and that many lives were saved.¹⁴⁴

The activities of the TAC bear much of the credit for the protective reach of the right to health into the government's HIV/AIDS policy.¹⁴⁵ The TAC had drawn membership from people living with HIV/AIDS and supporters of people living with HIV/AIDS. The profile of this social movement crossed race and class lines.¹⁴⁶ By the time of the TAC case, its members were already involved in a range of national and international protest actions involving sit-ins, singing, and other responses, as well as a didactic treatment literacy campaign.¹⁴⁷ The leadership of the TAC had borrowed

140. *Id.* at 10 paras. 12–13.

141. *Id.* at 22 para. 70, 32 para. 125.

142. See *supra*, Part II.B, discussing Sentencia T-760.

143. Mark Heywood, *Current Developments: Preventing Mother-to-Child HIV Transmission in South Africa: Background, Strategies and Outcomes of the Treatment Action Campaign Against the Minister of Health*, 19 S. AFR. J. HUM. RTS. 278, 281–82, 287–95, 300–03, 310–12 (2003) (detailing the TAC's mobilization and litigation strategies prior to, and during, the TAC case).

144. Pride Chigwedere et al., *Estimating the Lost Benefits of Antiretroviral Drug Use in South Africa*, 49 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 411, 412 (2008).

145. Heywood, *supra* note 143.

146. See STEVEN FRIEDMAN & SHAUNA MOTTIAR, *REWARDING ENGAGEMENT?: THE TREATMENT ACTION CAMPAIGN AND THE POLITICS OF HIV/AIDS* 34 (2004), <http://ccs.ukzn.ac.za/files/Friedman%20Mottier%20A%20Moral%20to%20the%20Tale%20Long%20Version.pdf> (a case study for the University of KwaZulu-Natal project, *Globalisation, Marginalisation and New Social Movements in post-apartheid South Africa*).

147. William Forbath, *Cultural Transformation, Deep Institutional Reform, and ESR Practice: South Africa's Treatment Action Campaign*, in *STONES OF HOPE: HOW AFRICAN ACTIVISTS RECLAIM HUMAN*

heavily from the anti-apartheid repertoire as well as tactics from foreign anti-AIDS groups, such as the U.S. ActUp campaign.¹⁴⁸ Thus, by the time of the case, it was a significant political force.

Indeed, earlier mobilizations around the right to health had themselves enhanced the profile of the TAC case. One case in particular spurred a concerted effort to seek to reduce the cost of essential medicines in South Africa. The *Pharmaceutical Manufacturers Association* (“PMA”) litigation involved an ongoing claim, begun in 1997, by pharmaceutical companies about protecting their monopolies on drug prices.¹⁴⁹ This litigation was a response to amendments to the Patents Act that made generic medicines more available.¹⁵⁰ Pharmaceutical companies argued that the legislation infringed on their constitutional right to property, along with other rights.¹⁵¹ The government’s early defense of its legislation was lumbering and ineffective. The delay in the courts had postponed the price savings of an increased access of generic medicines for over one year. During this delay, the TAC sought to join the action as *amicus* in 2001 and defend the access regime on the basis of the right to health.¹⁵² Its remarkable success in bringing increased South African and worldwide attention to this issue resulted in the withdrawal of the case by the pharmaceutical companies as well as a boost in the TAC’s local credibility and readiness for its own litigation.¹⁵³

The activities of the TAC, other legal organizations, and social movements organized around the issue of HIV/AIDS have been key to the emerging right to health in South Africa. These organizations have combined sophisticated modes of public protest with a highly selective and targeted use of constitutional litigation.

Has the formative context of the HIV/AIDS pandemic carved out a singular, and unique, duty of treatment in South Africa? Does it signal a curative rather than preventive meaning of the constitutional right to health? Other successful litigations around the right to health concerning the special protection of those in detention to medical treatment have also involved

RIGHTS TO CHALLENGE GLOBAL POVERTY, 51, 77–86 (Jeremy Perelman & Lucie White, eds., 2011) (describing the TAC’s efforts at education).

148. Group Telephone Interview with Zackie Achmat, National Chairperson, TAC, in Bellagio, Italy. (Dec. 2006).

149. Katharine G. Young, *Securing Health through Rights, in INCENTIVES FOR GLOBAL PUBLIC HEALTH: PATENT LAW AND ACCESS TO ESSENTIAL MEDICINES* 364 (Thomas Pogge, Matthew Rimmer & Kim Rubenstein, eds., 2010).

150. Medicines and Related Substances Control Amendment Act 90 of 1997 § 10.

151. *The Pharm. Mfrs. Ass’n of S. Afr. v. Gov’t of S. Afr.*, Notice of Motion, Case Number 4183/98, in the High Court of South Africa (Transvaal Provincial Division). S. AFR. CONST., 1996, § 25 states, *inter alia*, that “(1) No one may be deprived of property except in terms of law of general application, and no law may permit arbitrary deprivation of property. (2) Property may be expropriated only in terms of law of general application—(a) for a public purpose or in the public interest; and (b) subject to compensation. . . .”

152. See generally Mark Heywood, *Debunking ‘Conglomo-talk’: A Case Study of the Amicus Curiae as an Instrument for Advocacy, Investigation and Mobilisation*, 6 L., DEMOCRACY AND DEV. 144 (2002).

153. *Id.* at 157; see also YOUNG, CONSTITUTING ECONOMIC AND SOCIAL RIGHTS, *supra* note 2, at 370–71.

HIV/AIDS.¹⁵⁴ Yet the prominence of the HIV/AIDS issue is understandable in light of the terrible pandemic experienced by South Africa. The CCSA affirmed that HIV/AIDS is “the greatest threat to public health in our country.”¹⁵⁵ We suggest that the extension of the right to health to other diseases, many of them associated with poverty, such as tuberculosis and cancer, has come about indirectly through the emphasis on drug affordability and regulation within the HIV/AIDS campaigns. Moreover, the way in which the ARVs act to both prevent the spread of HIV, as well as to treat it, indicates a certain collapsibility of the curative/preventive paradigm.¹⁵⁶ Since 2002, the right to health has been litigated more indirectly—through duties to regulate the healthcare system and to provide for the social determinants of health through other economic and social goods.

C. Post-2002: Healthcare Regulation and the Social Determinants of Health

More recent protections of the right to health by the CCSA have been indirect. The National Health Act, passed in 2004, attempted to correct some inequities by centralizing power and responsibility for primary health care within the provinces.¹⁵⁷ Nonetheless, the public sector continues to perpetuate the inequities of health care due to the lack of resources, poor management, and aging infrastructure.¹⁵⁸ In some instances, while access has increased, the quality of healthcare services has deteriorated or remains poor.¹⁵⁹ Litigation has focused on the government’s right to regulate the prices of medicines and the provision of private healthcare services, usually according to administrative law principles. Attempts to provide what we might call indirect support for the right to health has come from other economic and social rights litigation, affecting rights to access the “social determinants of health,” such as clean water, sanitation, and housing.¹⁶⁰

The CCSA has adopted the position that with regard to the pharmaceutical industry, the government performs its duty to protect the right of access

154. See Carole Cooper, *Health Rights Litigation: Cautious Constitutionalism*, in LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH? 190, 209 (Alicia Ely Yamin & Siri Gloppen, eds., 2011); S. AFR. CONST., 1996 § 35(2)(e) (guarantees the right of prisoners “to conditions of detention that are consistent with human dignity, including . . . the provision, at state expense, of . . . medical treatment).

155. *Treatment Action Campaign* 2002 (5) SA at 26 para. 93.

156. Noah Novogrodsky, *The Duty of Treatment: Human Rights and the HIV/AIDS Pandemic*, 12 YALE H.R. & DEV. L.J. 1, 2 (2009) (describing the treatment processes of antiretroviral medications).

157. See National Health Act 61 of 2003, chs. 3–5 (establishing health governance at national, provincial, and district levels).

158. See generally Coovadia, *supra* note 99.

159. SARA BENNETT & LUCY GILSON, DFID HEALTH SYSTEMS RESOURCE CENTER, HEALTH FINANCING: DESIGNING AND IMPLEMENTING PRO-POOR POLICIES (2001).

160. For a discussion of social determinants of health, see DANIELS, *supra* note 6, at 79–102 (examining the associations between daily living conditions, the general distribution of resources, and health inequities). For international support from the public health field, see also WHO, *Outcome of the World Conference on Social Determinants of Health*, 65th Sess., WHA65.8 (May 26, 2012), available at <http://www.who.int/sdhconference/background/en/index.html>.

to healthcare services as a regulator, rather than a provider, of these services.¹⁶¹ In *Minister of Health v. New Clicks South Africa (Pty.) Ltd.*, the CCSA held that the government was constitutionally obliged, as well as permitted, to take reasonable measures to control drug prices through medicine regulation in order to make medicines “more accessible and affordable by means of a transparent pricing system.”¹⁶² Although the case was decided by recourse to administrative principles, rather than economic and social rights, the judgment noted the importance of legislation aimed at securing affordable medicines to realize economic and social rights like the right to health care.¹⁶³

The court has also pressured the legislature to regulate health care. The constitutional requirement to legislate and to regulate comes not only from the positive obligations flowing from the right to health provision itself,¹⁶⁴ but also from the explicit duty to protect, as well as respect and fulfill, constitutional rights.¹⁶⁵ This duty places an obligation to enact and enforce legislation that is required to regulate and enable private actors to fulfill their duties in socio-economic spheres.¹⁶⁶ Such a duty becomes more prominent in the context of the privatization of health and other social services.¹⁶⁷ This duty exists alongside the “horizontal application of constitutional rights,” in which rights may be constitutionally binding on private relationships that do not explicitly include the state.¹⁶⁸ Because the CCSA has been reluctant to intervene in exactly how such horizontality changes the private common law, the pressure on the legislature to regulate according to the Constitution is even greater. In such cases, the CCSA has relied primarily on the legislation at issue, rather than allowing parties to bypass it to proceed directly to the constitutional standard.¹⁶⁹

This position has impacted health care through non-constitutional cases without direct recourse to the right to health. In targeting the prices charged by two companies in the *Hazel Tau* litigation, for example, the TAC and other organizations complained that the cost of ARVs breached

161. For a three-part division into duties of provision, regulation, and obligations, see Jonathan Berger, *Litigating for Social Justice in Post-apartheid South Africa: A Focus on Health and Education*, in *COURTING SOCIAL JUSTICE*, *supra* note 10, at 38.

162. *New Clicks S. Afr. (Pty.) Ltd.*, 2006 (2) SA at 343 para. 16.

163. *Id.* at 524–25 paras. 704, 707.

164. S. AFR. CONST., 1996, § 27(2).

165. S. AFR. CONST., 1996, § 7(2).

166. SANDRA LIEBENBERG, *SOCIO-ECONOMIC RIGHTS: ADJUDICATION UNDER A TRANSFORMATIVE CONSTITUTION* 332 (2010).

167. *Id.* (citing *Grootboom*, para. 35, where the CCSA stated, with respect to the right to housing, that the State is responsible not only for the provision of houses, but also for enabling individuals to themselves provide housing, through legislative and other measures).

168. *Id.* See also S. AFR. CONST., 1996, § 8. For an early flagging of this issue, see Frank I. Michelman, *The Constitution, Social Rights and Reason*, 14 S. AFR. J. HUM. RTS. 299 (1998).

169. See, e.g., *New Clicks S. Afr. (Pty.) Ltd.*, 2006 (2) SA 311.

the excessive pricing provision of the Competition Act.¹⁷⁰ In argument before the Competition Commission, a statutory body authorized to investigate and control restrictive business practices, medical experts testified on the need for a complex regimen of different ARVs to treat HIV/AIDS effectively.¹⁷¹ Economic evidence compared the high cost of drugs in South Africa with the costs of generic alternatives elsewhere. In a non-judicial outcome that went further than the TAC's success behind the *PMA* litigation, which had only resulted in the withdrawal of the companies' litigation against moves to allow licensing arrangements under the Patents Act, the companies settled, agreeing to license the manufacture of generics subject to a maximum 5% royalty. Further out-of-court settlements followed, thus vastly lowering the costs of medicines, without any involvement of the CCSA.¹⁷² No equivalent litigious processes were attempted in Colombia, in part due to the judicial availability of *tutelas* and the efforts of non-litigation action, which contributed to a lack of patient incentives to seek reductions in treatment costs directly with pharmaceutical companies.¹⁷³

Attempts to create indirect support for the right to health, through the litigation of other economic and social rights cases affecting the social determinants of health, have sometimes been effective.¹⁷⁴ The constitutional rights to access food, water, housing, education, and social security have great import for health, and have been litigated far more often, relative to the right to health care, in direct contrast to the Colombian experience. The successful claim in *Grootboom* introduced a new pressure on policymaking: to give attention to the needs of vulnerable groups. A raft of other housing cases also led to a degree of protection for communities rendered homeless or insecure in informal settlements, by prescribing a duty of "meaningful engagement" and a search for alternative accommodation prior to eviction,¹⁷⁵ and by dispensing with other legal formalities in emergency hous-

170. Statement of Complaint, *Hazel Tau & Others v. GlaxoSmithKline and Boehringer Ingelheim*, Competition Commission of S. Afr. (Sept. 2002), available at <http://www.section27.org.za/wp-content/uploads/2010/10/TauvGSKEvidenceAndLegalSubmissions.pdf>.

171. The Competition Commission is "a statutory body constituted in terms of the Competition Act, No 89 of 1998 by the Government of South Africa empowered to investigate, control and evaluate restrictive business practices, abuse of dominant positions and mergers." COMPETITION COMMISSION OF SOUTH AFRICA, <http://www.compcom.co.za/> (last visited Oct. 13, 2012). For further description, see Cooper, *supra* note 154; Berger, *supra* note 161.

172. Berger, *supra* note 161.

173. Peter Maybarduke, *Colombian NGOs File Compulsory License Request on Lopinavir/Ritonavir*, AM. U. PROGRAM ON INFORMATION JUSTICE AND INTELLECTUAL PROPERTY BLOG (July 16, 2008), <http://www.wcl.american.edu/pijip/go/blog-post/colombian-ngos-file-compulsory-license-request-on-lopinavir/ritonavir-kaletta>.

174. For a discussion of the importance of social determinants, see *supra* text accompanying note 160. A broader discussion of the developments in other economic and social rights cases is provided in YOUNG, CONSTITUTING ECONOMIC AND SOCIAL RIGHTS, *supra* note 2, at 133–66 (describing case law developments in the right to housing, health care, water, and in sanitation and electricity protections).

175. *Port Elizabeth Municipality v. Various Occupiers* 2005 (1) SA 217 (CC); *Occupiers of 51 Olivia Road v. City of Johannesburg*, 2008 (3) SA 208 (CC); *Residents of Joe Slovo Community Western Cape v. Thubelisha Homes*, 2010 (3) SA 454 (CC).

ing scenarios.¹⁷⁶ In some cases, goals of housing and health appear to conflict. In *Olivia Road*, for example, the City of Johannesburg made policy arguments around health in order to expedite the eviction of families from a housing complex that was argued to be inhabitable. However, the CCSA chose to balance habitability concerns with the very real danger of homelessness, the latter outweighing the former.¹⁷⁷

In other cases, goals of housing, sanitation, and health have more clearly aligned, such as when communities have been protected from evictions when alternative accommodations were not accessible, or when sanitation measures have been contested.¹⁷⁸ Nonetheless, while these cases indicate that the social determinants of health have been more litigated than the right to access health care per se, with a great potential impact on public health, the CCSA has remained distant from the health dimensions of the arguments in such cases. In the access to water litigation of 2010, for example, the health-related impact of insufficient water was expressly raised on the papers and dealt with explicitly by the High Court and the Supreme Court of Appeal but not by the CCSA.¹⁷⁹ In litigation involving the access to toilets and lighting by residents in an informal settlement, the CCSA chose to defer to the government's upgrading program under its National Housing Code, rather than consider the importance of health.¹⁸⁰

The three stages of health rights jurisprudence outlined here fall into an introductory embrace of the reasonableness standard of review, followed by a greater robustness in the CCSA's scrutiny of government behavior after the challenges of the HIV/AIDS epidemic, and lastly a continued low-scale embrace of reasonableness review with greater attention to other socio-economic rights outside of the right to access health care. Even the *TAC* decision, at the height of the HIV/AIDS crisis, is low-intensity in character, especially when compared with the rigorous management and large-scale reforms embarked upon by the CCC in Colombia.¹⁸¹ No other litigation directly challenging the government's behavior on the basis of the right to health care has been brought, although NGOs continue to rely on the right

176. *Minister of Pub. Works v. Kyalami Ridge Envtl. Ass'n* 2001 (3) SA 1151 (CC).

177. See *Olivia Road* 1999 (3) SA 208.

178. *Nokotyana v. Ekurhuleni Metro. Municipality* 2010 (4) BCLR 312 (CC); *Mazibuko v. City of Johannesburg* 2010 (4) SA 1 (CC).

179. *Mazibuko v. The City of Johannesburg* 2010 (4) SA 1 (CC); *City of Johannesburg v. Mazibuko* 2009 (3) SA 592 (SCA) and *Mazibuko v. City of Johannesburg* [2008] 4 All SA 471 (W); [2009] ZAGPHC 106 (18 April 2008); Case No. 06/13865, High Court of South Africa (Witwatersrand Local Division).

180. *Nokotyana v. Ekurhuleni Metro. Municipality* 2010 (4) BCLR 312 (CC); David Bilchitz, *Is the Constitutional Court Wasting Away the Rights of the Poor?* *Nokotyana v. Ekurhuleni Metropolitan Municipality* 127 SALJ. 591 (2010).

181. Members of the CCSA have themselves downgraded the interventionist aspect of *TAC*. See *Mazibuko v. City of Johannesburg* 2010 (4) SA 1 (CC) at [65]: ("The orders made . . . illustrate the Court's institutional respect for the policy-making function of the two other arms of government. The Court did not seek to draft policy or to determine its content. Instead, having found that the policy adopted by government did not meet the required constitutional standard of reasonableness, the Court . . . required government to revise its policy . . . to remove anomalous restrictions.").

to health to publicly criticize or challenge proposed legislation or policy reforms.¹⁸² In the next section, we explore four variables that account for the differences between the two systems.

IV. FOUR VARIABLES OF JUSTICIABILITY

While Colombia's justiciable right to health has been formed against a backdrop of judicially-led criteria, snowballing litigation, litigious interventions of both insurance companies and patients, and mass demonstrations, South Africa's tells the tale of provisional justiciability, minimal litigation, private negotiations in the shadow of litigation, and a more open defense of other economic and social rights. This comparison weakens claims about the inevitability of judicial power in right to health complaints. Indeed, the comparative fortunes of the two rights to health have been remarkably distinct, marked by the very different orientations towards the intensity of justiciability. We conclude this article by raising four variables that can explain these distinctions and are worthy of further study, namely A) legal doctrine, B) the role of the judiciary, C) the institutional financing of health care, and D) citizen participation.

A. *Judicial Doctrine*

The CCC and the CCSA have followed vastly different routes for doctrinal resolution of the problems of indeterminacy and justiciability, starting from their framing of the institutional guarantee of the right to health. The substantively-informed orientation of the CCC lies in contrast to the procedurally-informed orientation of the CCSA. In this context, text and interpretation have played a strong role.

In Colombia, the CCC has chosen to entrench a minimum core of the right to health, linking Colombian jurisprudence with international standards in order to provide determinacy and perhaps independence to the definition of the right. The CCC has also sidestepped (or refuted) the morally difficult question of the rationing of high-cost illness and high-cost treatments, finding dignity and life to be more salient interests, and refusing to accept the inevitability of rationing decisions. This has led to a highly moral orientation to the CCC's defense of people with high-cost illnesses and its willingness to depart from the POS. This had occurred in some cases involving the same disease profiles of those in South Africa—namely, patients living with HIV/AIDS. However, the categorical orientation of the CCC may have reduced the leverage, or at least the motivation, for finding other healthcare solutions, such as through negotiation for the

182. See, e.g., Press Statement, Sanac Law and Human Rights Sector Working Group, National Strategic Plan on HIV and AIDS (2007–2011) A New Opportunity for a Fairer South Africa (May 2, 2007), available at <http://www.tac.org.za/content/national-strategic-plan>.

availability of generic medicines that has been successful in the South African HIV/AIDS context.

In South Africa, on the other hand, the court has resolutely rejected the minimum core idea and has instead preferred an approach that assesses the reasonableness of government conduct, assisted by procedural criteria such as whether certain interests have been taken into account, or whether certain groups have been consulted. Of course, more substantive notions of distributive justice guide the questions of who counts as vulnerable and whose interests require attention. The CCSA has also placed great stock in the fact that the right to health is, in the main, protected only according to the standard of “progressive realization,” requiring only “reasonable” measures on the part of the state “within its available resources.”¹⁸³ As with the standards of obligation recently adopted in international human rights law,¹⁸⁴ this test is consistent with a responsive, almost procedural, orientation towards economic and social rights. Hence, while economic and social rights were created to ensure that the legacy of apartheid be addressed, their main aim has been to create a “culture of justification” for government,¹⁸⁵ rather than a substantive, subjective entitlement. The substantive connection between life and health has not been dwelt upon as a sustainable line of jurisprudential inquiry. Even dignity, a value prominent in other economic and social rights cases, has been sidelined in the procedural orientation of the CCSA’s health decisions.¹⁸⁶

Even so, over time, the right to health has gained meaning in explicit scenarios in South African jurisprudence, such as in relation to the HIV/AIDS pandemic. In addition, other economic and social rights appear most robust when claimants raise equality and discrimination concerns, and when particularly vulnerable groups are claimants.¹⁸⁷ It would be a mistake to see too great a division between South Africa and Colombia in this regard. Nonetheless, it is clear that, in contrast with Colombia, the right to health cases figure very low in the CCSA’s record, and that its developing doctrinal content has not given rise to a substantive entitlement.

183. S. AFR. CONST., 1996 § 27(2). See also S. AFR. CONST., 1996 § 36 (general limitations clause, which applies to the health rights of children).

184. See Optional Protocol to the ICESCR, G.A. Res. 63/117, art. 8(4), U.N. Doc. A/RES/63/117 (Dec. 10, 2008) (adopting the “reasonable” standard of obligation for the new Optional Protocol to the ICESCR). See generally Brian Griffey, *The ‘Reasonableness’ Test: Assessing Violations of State Obligations under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*, 11 HUM. RTS. L. REV. 275 (2011).

185. Etienne Mureinik, *Beyond a Charter of Luxuries: Economic Rights in the Constitution*, 8 S. AFR. J. HUM. RTS. 464, 470–74 (1992).

186. See, e.g., *Grootboom* 2001 (1) SA at 69 para. 44; *Kbosa* 2004 (6) SA at 539–40 paras. 80–82. For a discussion of the use of dignity in the minimum core approach, see DAVID BILCHITZ, *POVERTY AND FUNDAMENTAL RIGHTS: THE JUSTIFICATION AND ENFORCEMENT OF SOCIO-ECONOMIC RIGHTS* 146–49 (Oxford Univ. Press, 2007).

187. *Kbosa* 2004 (6) SA 505 (involving both the constitutional guarantee of access to social security and equality protections).

B. *Judicial Roles*

A second variable is the role of judicial review in each jurisdiction. The conception of judicial review emerges from institutional design and political culture, and affects a court's mode of scrutiny and remedy.¹⁸⁸ Extending an analysis of the different forms of judicial review to local expectations and institutions is a useful way in which to compare Colombia's and South Africa's divergent experiences of justiciability.¹⁸⁹

Colombia's civil law structure, its shared constitutional jurisdiction between the CCC and other courts, and the availability of *tutela* claims set in place a specific trajectory for the right to health.¹⁹⁰ Early on, the CCC arrogated to the judicial branch responsibility to resolve disputes between patients and health service providers and insurers, a relationship that has often been fraught with conflict considering its high stakes.¹⁹¹ By directly ordering health sector reform in 2008, the CCC went further and insisted on its own leadership and indirectly the leadership of courts in inserting the right to health into the heart of the healthcare system's design. In the words of the main author of Decision T-760, the CCC represents "biting substantive progressiveness" by addressing individual complaints, fixing the content of rights, redesigning plans, imposing large costs, and ordering regulatory action.¹⁹² In this sense, the CCC enjoys a strong, perhaps supremacist, role conception characterized by a managerial orientation in resolving economic and social rights through judicial review.¹⁹³ Through delivering structural remedies, it has sought to take over the dysfunction of the legislative and administrative branches.¹⁹⁴

The CCSA, on the other hand, has taken a more catalytic approach—that is, one that "opens up the relationship between courts and the elected

188. See generally YOUNG, CONSTITUTING ECONOMIC AND SOCIAL RIGHTS, *supra* note 2, chs. 6–7 (introducing an analysis of "role conceptions" to demarcate distinctive styles of the judicial review of economic and social rights in South Africa, Colombia, India, and the United Kingdom).

189. For a proposal on the inclusion of institutional analysis in comparative constitutionalism, see MARK TUSHNET, WEAK COURTS, STRONG RIGHTS: JUDICIAL REVIEW AND SOCIAL WELFARE RIGHTS IN COMPARATIVE CONSTITUTIONAL LAW 18–42 (Princeton Univ. Press, 2008) (comparing the forms of judicial review in New Zealand, the United Kingdom, and Canada to the forms of judicial review practiced in the United States).

190. See Manuel José Cepeda-Espinosa, *Transcript: Social and Economic Rights and the Colombian Constitutional Court*, 89 TEX. L. REV. 1699 (2011) (offering a former justice's account of developments); Rodrigo Nunes, *Ideational Origins of Progressive Judicial Activism: The Colombian Constitutional Court and the Right to Health*, 52 LATIN AM. POL. & SOC'Y 67 (2010) (seeking to explain the judicial behavior that has resulted in a judicially-led expansion of welfare benefits).

191. This argument is developed in Diego E. López Medina, *El derecho fundamental a la salud y el sistema de salud: los dilemas entre la jurisprudencia, la economía y la medicina*, in LA PROTECCION JUDICIAL DE LOS DERECHOS SOCIALES 375–415 (Christian Courtis & Ramiro Ávila Santamaría, eds., 2009), http://www.justicia.gob.ec/wp-content/uploads/downloads/2012/07/8_Proteccion_judicial.pdf.

192. Cepeda-Espinosa, *supra* note 190.

193. YOUNG, CONSTITUTING ECONOMIC AND SOCIAL RIGHTS, *supra* note 2, at 196–200.

194. See generally David Landau, *Political Institutions and Judicial Role in Comparative Constitutional Law*, 51 HARV. INT'L L.J. 319 (2010) (explaining how the CCC has viewed dysfunctional political institutions as a license to take on a more activist role).

branches and lowers the political energy that is required in order to achieve a rights-protective outcome.”¹⁹⁵ While frustrating for individual claimants, who are often left without a direct remedy, the CCSA’s more tentative approach to judicial review has led to multidimensional and multi-actor reforms.¹⁹⁶ South Africa’s court structure, although also sharing constitutional jurisdiction between the CCSA, Supreme Court of Appeal, and High Courts, belongs primarily to the common law tradition. Its access-to-justice provisions, though generous, contain no parallel to the *tutela* action. Health actions are rare, due to cost and access problems. The CCSA’s early deference probably curbed the enthusiasm for further litigation.¹⁹⁷ This has led to an incremental, and partial, protection of the right to health. The later success of the TAC litigation involved a declaratory remedy,¹⁹⁸ and the CCC in particular has been reluctant to involve itself in mandating and supervising detailed plans for the government to take.¹⁹⁹ The relative difficulty in accessing the CCSA has meant that plaintiffs usually require the support of a public interest organization to proceed. Several of these organizations—such as the Legal Resources Center, the AIDS Law Project (now called Section 27), and the Center for Applied Legal Studies—have been repeat players in constitutional litigation since apartheid.²⁰⁰ Often they accept “test case” complaints with less regard for individual merits but more regard to the potential for structural impact of the case.²⁰¹ Soobramoney’s unsupported, and unsuccessful, claim is an example of this strategy at work in the health care context. This has combined to produce a

195. Katharine G. Young, *A Typology of Economic and Social Rights Adjudication: Exploring the Catalytic Function of Judicial Review*, 8 INT’L J. CONST. L. 385, 385 (2010). See also YOUNG, CONSTITUTING ECONOMIC AND SOCIAL RIGHTS, *supra* note 2, at 172 (developing this characterization further in a comparative context).

196. YOUNG, CONSTITUTING ECONOMIC AND SOCIAL RIGHTS, *supra* note 2, at 172–91.

197. *Soobramoney v. Minister of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC); see also Alston & Scott, *supra* note 121.

198. In *Treatment Action Campaign*, the CCSA ordered the testing and counseling provisions for the delivery of the ARV. *Treatment Action Campaign* 2002 (5) SA at 33–34 para. 135.

199. In litigation against the Westville Prison, the High Court imposed a supervisory order to remove restrictions preventing prisoners from accessing ARV treatment, and gave the government two weeks to lodge an affidavit setting out its plan of compliance. See *N v. Gov’t of Republic of S. Afr. & Others (No 1)* 2006 (6) SA 543 (D); *N v. Gov’t of Republic of S. Afr. & Others (No 2)* 2006 (6) SA 568 (D); *N v. Gov’t of Republic of S. Afr. & Others (No 3)* 2006 (6) 575 (D). The failure to comply led to further litigation, and the remedy facilitated the development of a plan for nationwide provision of ARVs in prisons. See Cooper, *supra* note 154, at 196. In other economic and social rights cases, the CCSA has been prepared to order mandatory remedies, particularly in evictions cases, see, e.g., *Olivia Road* 1999 (3) SA 208, or grant suspended declarations of invalidity, see, e.g., *Kbosa* 2004 (6) SA 505. Yet lower courts have been more ready to do so in South Africa. See Danielle Elyce Hirsch, *A Defense of Structural Injunctive Remedies in South African Law*, 9 OR. REV. INT’L L. 1, 7–8 (2007).

200. The Legal Resources Center, for example, was founded in 1979 to use law to fight apartheid. *About Us*, LEGAL RESOURCES CENTER, <http://www.lrc.org.za/about-us> (last visited Nov. 7, 2012). It instructed the lawyers for the TAC litigation and appeared on behalf of the amici in the *Grootboom* decision, which was commended by the CCSA. See *Grootboom* 2001 (1) SA at 30.

201. Cooper, *supra* note 154, at 193–94.

very different character than the private, individual focus of Colombia's litigation.

C. Financing Backdrop

A third variable to account for differences in right-to-health justiciability is the healthcare financing backdrop within each jurisdiction. Colombia's privatized health insurance scheme, with both contributory and subsidized regimes of health care, inadvertently created incentives for insurance companies to limit their financial exposure by the strategic use, and support, of *tutela* actions. As discussed in Parts II.A and II.C, corruption and the exploitation of these financing arrangements further distorted the costs of this healthcare system.

In South Africa, it is the public health system that has been targeted in health rights litigation, although the meagerness of its budget and the support of rationing have meant that litigation is unlikely to result in greater access to public health care. While private companies have been held accountable for the right to health—usually in the mobilizations against pharmaceutical companies—their actions against government have usually been settled on the basis of public protest,²⁰² rather than in court.

Unlike Colombia, South Africa contains no provision for universal insurance coverage. Nonetheless, there are measures in place to reform the system of healthcare financing into a National Health Insurance scheme.²⁰³ This process, which will be phased in over a period of 14 years, will provide coverage to the whole population and attempt to minimize individual burdens of payment. Individuals will contribute according to their ability to pay, and pooled payments will then be used to fund benefits in line with each individual's need for care. Cross-subsidization will thus be established.²⁰⁴ Under present proposals, both public and private providers will deliver health care.²⁰⁵ The government views the reforms as consistent with the constitutional right to access health care because they implement the principles "that access to health services must be free at the point of use and that people will benefit according to their health profile."²⁰⁶ Such reforms may signal a different trajectory for South Africa's right of access to health care in the future, and perhaps a greater potential convergence with Colombia's model, insofar as private providers may be incentivized to litigate and insofar as the new system may create new opportunities for profit-seeking that are difficult to regulate.

202. Young, *supra* note 153.

203. See Dep't of Health, NATIONAL HEALTH INSURANCE IN SOUTH AFRICA: POLICY PAPER (Aug. 11, 2011).

204. *Id.*

205. *Id.* The contractual arrangements with private providers remain vague. *See id.* at paras. 85–86. Accreditation standards will determine the minimum range of services to be provided. *Id.* at para. 100. A National Health Insurance Fund will administer the costs of health care. *See id.* at para. 132.

206. *Id.* at para. 52(a).

D. *Civil Society*

Finally, both systems have different configurations of civil society. A consciousness of the importance of the right to health is common in each. In both Colombia and South Africa, the right to health was entrenched in a new Bill of Rights, and accompanied great expectations of social, political, and legal change. In Colombia, the vision of universal health care, while persistently unrealized, remained an important legacy of social-liberalism of the 1930s, as well as part of progressive aspirations of social justice. In South Africa, the experience of health and ill health was explicitly linked to the historic racism of apartheid, which had defeated earlier attempts to provide free health care for all.²⁰⁷

Nowadays, civil society participation includes professionals, such as doctors and nurses, who have been hugely invested in the right to health as supportive of their professional autonomy and professional ethics. Mobilizations also include patients' movements in both countries, and the mobilization of patients living with HIV/AIDS occurred at an early stage in each. Nonetheless, active patients' groups in Colombia have mobilized around high-cost diseases and have usually reflected the middle class litigating for its own interest, sometimes with the support of pharmaceutical companies. These patient and professional groups have targeted the government as the appropriate provider of quality health care. At least in 2010, their cause garnered massive popular support. In South Africa, the depth and intensity of the HIV/AIDS response, by movements such as the TAC, as well as the history of an anti-apartheid repertoire of protest, has created a different degree of social movement activity centered on access to medicines and the state's duty to regulate, rather than merely provide, health care. Such movements have targeted pharmaceutical companies, often shoring up the state in its attempts to regulate the industry. Their use of litigation is strategic and minimal. This, combined with and itself influenced by factors of financing and doctrine, has led to a very different path for the right to health.

V. CONCLUSION

The right to health is highly contingent on background judicial and legal structures. The debates for and against its constitutional entrenchment, ratification, or domestic implementation should proceed with an understanding that, while text may count, institutional configurations are most at issue. The Colombian experience of high-intensity justiciability within its civil law system has led to substantive interpretations of the core of the

207. The South African National Health Service Commission of 1942–1944 (led by Dr. Henry Gluckman) pioneered a proposal for a National Health Tax, which would ensure that health services could be provided free at the point of service for all South Africans. Progress to implement this proposal was reversed with the election of the National Party in 1948 and the institution of apartheid. For a description of this Commission, see Dep't of Health, *supra* note 203, paras. 41–42.

right to health; numerous *tutela* actions; and both individual and structural, supervised remedies. The South African experience of low-intensity justiciability is demonstrated by the use of a procedurally-focused, common law style reasonableness review; largely declaratory remedies; and the persistence of health petitions and negotiations outside of the courts. Justiciability is affected by the variables of what we term legal doctrine, judicial roles, healthcare provision and financing schemes, and civil society participation in each country. Attention to these parameters helps to ground and inform the arguments for and against a justiciable right to health.