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JUDICIAL ACTIVISM IN THE ARGENTINE HEALTH SYSTEM: RECENT TRENDS

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ABSTRACT

This article explores judicial activism in Argentina as it relates to health, as evidenced by courts' willingness to address health issues and to monitor public policies. It examines the strategic use of the courts to channel claims against the government or companies providing health care services both by organizations devoted to litigation in the public interest and by individuals. In addition, the article looks closely at conflicts that have been adjudicated in the courts and various court responses. Special focus is given to the possible effects of certain court decisions on the Argentine health system following its reform during the 1990s, which included transfer and decentralization of functions and services.

INTRODUCTION

During the past 20 years, Argentina has undergone significant economic, social, and institutional reform in the midst of structural adjustment processes, a central feature of which has been sectoral decentralization to provincial and municipal jurisdictions. In the health sector, reforms have been aimed at establishing basic benefits and directing government resources to only the most disadvantaged groups, supposedly to achieve greater levels of efficiency and quality in services and to increase user satisfaction. These goals have not been reached, however, and there are serious questions about the assumptions — ordered by the lending institutions within the Washington Consensus — upon which the transformations were built.[1]

Historically, the organizational model of Argentina's health sector was defined by the administrations — whether national or provincial — and implemented by their nationwide agencies. These agencies were normally divided into three sub-sectors: 1) *Public*, under public administration — national, provincial, and municipal — formed by the network of free-access health care providers across the country; 2) *Social Security*, composed of the *obras sociales*, compulsory-membership health care plans for salaried workers; and 3) *Private*, agencies that have come into being more recently, and are composed of a complex network of commercial diagnostic institutions, clinics, and pre-pay health care systems.

A number of elements in the health care system reform and decentralization that took place in Argentina during the 1990s led to the impact on service delivery and court action that is discussed in this paper. Among these reform-related processes, for example:

- Fiscal criteria were applied to the health care sector that had a detrimental effect on public health due to the subsequent cost-reduction policy;
- The sector's regulation, management, supply, and financing functions were separated;

- Those insured through the *obras socials* were now offered a supposed "freedom of choice" in selecting providers;
- A basic package of medical benefits was implemented;
- There was inadequate consideration of the strategic importance of human resources that were affected by the reform;
- Government expenditures were reduced as cost-recovery mechanisms were implemented through co-payment systems or "voluntary" fees; and
- Reforms were applied in a "gender-neutral" fashion among both sectoral workers and users.

The need to guarantee health as a right arose in response to new disparities and inequities that were created by the health system reforms. As a result, significant judicial activism began to emerge that was linked to achieving greater guarantees in the area of health. Judicial activism, as it is discussed throughout this paper, refers to both the strategic use of the courts by organizations devoted to public interest litigation, as well as greater use of the courts by private citizens in order to direct complaints to the state or to health service companies. The concept of activism in this article also includes the greater disposition of the courts to become involved in these matters, to monitor public policies, or to create a balance in contractual relations between private individuals.[2]

The novelty of the process became evident in the fact that people were able to file more health-related claims within the context of diminishing social institutions, particularly the health sector. This new increase in health-related claims contrasted with other areas, such as labor rights or social security, where an important tradition of litigation already existed. Consequently, both the Supreme Court of Justice as well as the lower courts now face a significant number of cases regarding the right to health.[3]

This article presents an overview of the issues considered by the courts and analyzes the jurisprudence in Argentina. In the cases selected, we will analyze the type of conflict and the judicial response, considering the principles and criteria established by the Supreme Court of Justice, as well as the possible effects of certain court decisions regarding the rules defining the health system. We also present some of the most contentious issues examined by the courts, such as the extent of the regulatory function of the state with respect to the private suppliers, the relationship between the federal government and the provinces, and the role of the national government with regard to unequal access to health in the various jurisdictions.[4]

Of note, there are to date no empirical studies on the impact of these judicial decisions on sectoral policies. This analysis therefore does not contribute information on the concrete results of judicial intervention in the health system. We will, however, put forth the premise that some case law policies developed by the courts may be in conflict with the policies and rules that shape the system's operation.

GUARANTEES AROUND THE RIGHT TO HEALTH

Upon ratifying its constitution in 1853, Argentina adopted a federal, representative, republican system of government. The federal government is composed of 23 provinces, which hold all power and authority not expressly delegated to the national level, and the city of Buenos Aires, whose autonomy was recognized in the 1994 constitutional reform. Each province has its own local constitution, reserving the right to create its own local institutions and elect its governor, legislators, members of the judiciary, and other provincial officers without interference from the federal government. Most provinces also guarantee the right to health in their constitutions and have the autonomy to organize their own systems of health provision. This guarantee often implies a transfer of functions and services from the province to its municipalities.[5]

Unlike other social rights, the right to health had not been adequately addressed in earlier versions of the Argentine constitution. Article 14 bis, incorporated during the 1957 constitutional reform, merely *implies* a right to health: "The State shall grant the benefits of social security, which shall be of an integral nature and may not be waived. In particular, the laws shall establish: compulsory social insurance."[6] Thus, for the better part of Argentine history, there was no express constitutional guarantee of a right to health; its provision was linked to covering social eventualities in the context of formal, salaried labor.

However, the failure of the 1957 constitution to explicitly recognize a right to health did not hinder the development of a public health system. Universal health coverage was provided through a broad network of government-financed health care providers

and a system of *obras sociales* for salaried workers. This paradigm of subsidizing health care services was questioned during the 1990s in the context of the applied adjustment policies.

This health coverage system was not updated despite the structural changes that took place in the labor market, where formal salaried work is no longer the prevalent model, since hiring conditions have undergone extreme changes, resulting in more flexible and less secure labor. As a result, in 2006, for example, 29.1% of salaried men and 28.6% of salaried women lacked health coverage, with noteworthy income-based segmentation in formal or private salaried employment.[7]

Only within the 1994 constitutional reform was the right to health formally acknowledged. The first explicit reference is found in Article 42 of the constitution, which states that "consumers and users of goods and services have the right to the protection of their health, safety, and economic interests"[8] Clearly, this provision does not guarantee a universal right to health but rather locates protection within consumption, constituting, according to Courtis, "an updated reflection of limiting health protection to the work relationship."[9]

Another means of protection achieved in the 1994 reform, and greater in scope, is found in Article 75, section 22, which grants constitutional status to 11 declarations and international human rights treaties. Specifically, as a result of Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) — which defines health as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" — the state is legally obligated to guarantee the *minimal amount* of economic, social, and cultural rights and cannot hide behind lack of resources to justify non-compliance.[10] In this sense, the Committee on Economic, Social and Cultural Rights (CESCR) — the body that monitors fulfillment of government obligations established in the ICESCR — has stated that "States parties have a 'core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights' enunciated in the Covenant."[11]

This broader recognition of the right to health by means of international instruments occurred during a period of reform and structural adjustment, during which the health system itself was dismantled and the model of universalism associated with the provision of health was contested. In the case of the public sub-sector, this challenge came in the form of "self-financing" public hospitals, through the Self-Managed Public Hospital proposal. Although this "self-financing" model was not completely implemented, it set concrete limits in terms of the provision of health and government responsibility to guarantee medical care.

The behavior of government expenditures in health was historically cyclical, having seen an increase early in the decade and stagnation since 1995. During crisis situations such as the one occurring at the end of 2001, in contexts of greater poverty and decline in coverage, the response of the health sector was to reduce spending. Consolidated government expenditure in 2000 represented 4.96% of GDP, while in 2001, it rose to 5.11%. In 2002, in the midst of a full-blown crisis, it was 4.47%, stagnating in 2006 at 4.58% of GDP.[12] During the processes that transferred health care providers and related human resources from the national to provincial level, responsibility for health care passed to the provinces, and in many cases, from there to the municipalities.[13]

The mechanism designated to coordinate the health system following the transfer of responsibility was the National Health Council (*Consejo Federal de Salud*, or Cofesa). The council is composed of the Argentine Ministry of Health and the nation's provincial health ministers, and was given the objective of integrating the system and defining substantive health sector policies. In reality, far from defining a key strategy, Cofesa has not promoted any action in the indicated direction. This is compounded by its failure to advance a new fiscal agreement to sustain the provincial and municipal health systems, which would include an adequate proportion of federal co-participation.

In a similar vein, the crux of the reform was the deregulation of *obras sociales*, which removed the obligatory nature of membership in a salaried worker's *obra social* according to union of affiliation, allowing for "free choice" of any other entity that offered better benefits at a better price. In this way, the number of private (pre-pay) insurers grew extensively, competing for the market with the historic *obras sociales*. Yet coverage did not grow — on the contrary, it diminished; the reforms implemented as part of structural

adjustment led both the health system and other public policy sectors to change their method of operation and thus stray from their founding objectives.

HEALTH IN THE COURTS

As described, numerous factors are linked to the increase in claims filed in the courts in the effort to ensure access to treatment and medicine. These claims include demands for coverage by *obras sociales* and private health plans of diagnostics and specific treatments and the inclusion of cancer patients or those under HIV/AIDS treatment.

The courts have ruled on cases demanding positive government obligations — for example, access to medicine and therapeutic treatment — as well as negative obligations, such as the prohibition on arbitrary cancellation of pre-pay health contracts. The cases have been as much against the state as against private defendants, whether dealing with *obras sociales* or pre-pay health care companies. A notable characteristic of the justicialization of the right to health is the role played by the covenants and international human rights instruments by identifying a constitutionally-protected health right in each case. Most often, however — with some important exceptions — they have been decided on a legal basis.[14]

The Supreme Court has determined that legislation passed by the National Congress constitutes one of the measures adopted by the state to comply with international obligations related to the right to health. Therefore, non-compliance by the national administration with its legal obligations — especially those that require access to treatment or medication — paved the way for individual or collective claims demanding the fulfillment of those obligations. The Court has stated that the federal government is the ultimate guarantor of the health system — regardless of the existence of obligations by other subjects, such as the provinces or *obras sociales* — and that the right to health imposes positive obligations, not only negative ones, upon the state.

The courts have also maintained that in fulfillment of obligations arising from international instruments, the state is empowered to impose obligations on private subjects — such as the *obras sociales* and pre-pay health care companies — in matters of health. In addition, the courts have considered the obligations of both public as well as private actors with respect to the protection of the health of children and those with disabilities. In the case of the latter, the judges decided that private providers have special obligations for care toward their clients and users, which exceed merely commercial dealings. The justification for these special obligations stems from the fundamental nature of the right to health, whose guarantee has been assumed by the private subjects and goes beyond a commercial agreement.

Despite these important advances in terms of positive and negative obligations, several issues remain unresolved. Among them, the problem of the essential nature of the right to health according to international human rights documents — that is, the obligatory nature of the right, which cannot be ignored, delayed, or altered by legislators. Since the majority of cases have been decided on a legal basis, the courts have said little on this matter. Questions also remain about the scope of the state's positive obligations in the area of health, especially with respect to the poor, who are often unable to pay for health services.[15] To that effect, both individual and collective cases directed against the national government have been precisely aimed at ensuring access to treatment.

ACCESS TO MEDICAL BENEFITS

The first case we analyze is *Campodónico de Beviacqua,* regarding a demand for coverage for a disabled child, in which the Court upheld an appeal and ordered the national government to continue providing medicine to a child with a disability. The government had previously decided to terminate its supply of the medication, informing the mother that the provision had been merely for "humanitarian reasons," and that its cessation did not constitute a violation of legal obligations. The Supreme Court confirmed the decision of the Tribunal and established an important precedent, indicating six points:

- The right to preservation of health — included in the right to life — has constitutional status, based on international treaties specified in the Argentine constitution.[16]
- The scope of government obligation in the area of provision and continuity of treatment is such that the right to health must be guaranteed with positive actions, without prejudice to the obligations of local jurisdictions, *obras sociales,* or prepaid health plans.[17]
- Among the measures that must be adopted in

order to guarantee the right to health — as outlined in the ICESCR — is the establishment of an action plan to reduce infant mortality, achieve the healthy development of children, and facilitate assistance and medical services in case of illness.[18]

- The States parties have obligated themselves "to the maximum of [their] available resources . . . to achieving progressively the full realization of the rights recognized" in the ICESCR.[19]
- The ICESCR makes clear that "the federal government has the legal responsibility to guarantee the enforcement of the covenant" because the national government is the ultimate guarantor of the health system, regardless of its being transferred or decentralized to provinces and municipalities.[20]
- The Convention on the Rights of the Child includes the obligation of states to "encourage and ensure" effective access to health and rehabilitation services to minors with physical or mental impediments, to strive to see that they are not deprived of these services, and "to achieve the full realization of this right . . . to benefit from social security . . . in accordance with their national law . . . resources and the circumstances of the child and persons having responsibility for the maintenance of the child."[21]

In addition to the above, the doctrine set by the Court in this case indicates that "the national State has therefore assumed explicit international commitments aimed at promoting and facilitating health benefits required by minors and cannot legally free itself from those duties, under the pretext of inaction by other public or private entities, especially when they participate in the same health system and when what is at stake is the higher interest of the child, who must be protected above all other considerations by all governmental departments."[22]

In other trials, the position of the Supreme Court has been similar — ruling, for example, to grant medical coverage to persons with HIV/AIDS; enforcing the extension of medical coverage for certain unforeseen situations regarding pre-pay health companies and union and state *obras sociales*; and granting interim relief in order to ensure access to medication and treatment in situations of extreme urgency.[23] Similarly, the lower courts have frequently decided cases of access to medical coverage in favor of the claimants.[24]

The Supreme Court of Justice also ruled in favor of a class action suit involving state non-compliance with a clause of the so-called "AIDS Law," which obligates the state to provide necessary medication for treatment of HIV/AIDS. In the *Asociación Benghalensis* case, a coalition of NGOs sued the state to demand full compliance with a law enacted by the Congress of the Nation that guarantees the supply of medications to fight HIV/AIDS to public hospitals.[25] The Appeals Court granted the relief and the state disputed the decision. The Court confirmed the decision of the Tribunal, in agreement with the judgment of the Attorney General of the Nation, who established, followed by a majority vote of the Court, that the right to health is recognized by international human rights treaties with constitutional status.[26]

As a result, the "State must not only abstain from interfering in the exercise of individual rights but has, in addition, the duty to carry out positive assistance, so that the exercise of the former does not become null and void."[27] On this basis, the Attorney General affirmed in this case that "said principles lead one to conclude that the State has the obligation to furnish the substances and medications necessary for the diagnosis and treatment of the disease."[28] The ruling has two concurring votes, which add emphasis and greater detail to the judgment of the Attorney General.

The lower courts have also ruled on the right to access to private health benefits and preventive measures. In the *Viceconte* case, the Tribunal of Federal Administrative Litigation considered collective relief and stated that the virtual cessation of the production of a vaccine aimed at eradicating an endemic disease constituted a violation of the right to health.[29] The plaintiff represented a population of approximately 3.5 million people potentially exposed to Argentine hemorrhagic fever. The state had previously been highly successful in treating the disease after it had assigned funds to carry out the research, tested the vaccine, ordered the production of an experimental batch from a foreign laboratory, and initiated the process of vaccinating the population. However, a series of political and administrative changes led to a halt in construction of the laboratory in which the vaccine would be produced locally. When the doses ordered from the foreign laboratory ran out, access to the vaccine ceased. The plaintiff argued that the interruption of vaccine production violated the state's obligation to prevent, treat, and control endemic and epidemic

diseases, recognized in Article 12.2 c of the ICESCR. The Court of Appeals ruled in favor of the plaintiff and ordered the government to assign the budget lines and adopt measures to assure production of the vaccine. In this case, the court established a follow-up mechanism to ensure compliance with the ruling. Follow-up consisted of public hearings, personal appearances by the Minister of Health, the Ombuds' Office intervention, progress reports on construction of the laboratory that would produce the vaccine, subsequent scientific testing, and even annual budget commitments to ensure funds for the building maintenance and implementation of the obligations. The case demonstrated the difficulties that the tribunals faced in rendering decisions to implement public policies that have heavy budget commitments. In this case the process took approximately ten years before all the administrative steps were complete and the vaccination campaigns began.

RIGHT TO HEALTH OF VULNERABLE GROUPS

In some cases, as in *Ramos*, the Supreme Court showed reluctance to consider that right-to-health violations existed.[30] In this lawsuit, a woman with eight children argued that she was unemployed, that her children could not attend school for lack of resources, that one of her daughters suffered from heart disease and needed surgery, and that there was no one she could ask for food. The plaintiff stated that her situation and that of her children constituted a violation of the social rights recognized by the Constitution and human rights treaties ratified by Argentina, and she demanded assistance from federal and provincial authorities to guarantee her right and that of her children to food, health, education, and housing. She requested a monthly subsidy to cover her basic needs, medical coverage for her daughter's cardiopathy, guarantee of her children's right to attend school, and a declaration that the behavior of the public authorities was unconstitutional and illegal.

The Court rejected the appeal. It argued that 1) the plaintiff did not demonstrate the existence of manifestly illegal and arbitrary conduct by the state, since the public authorities did not directly deny access to education or medical treatment for her children; and that 2) the claims should not have been directed to the courts but rather to the Administration. In *obiter dictum* considerations, the majority of the Court affirmed that it does not have the authority to evaluate general situations that go beyond its jurisdiction, nor to arbitrarily assign budget resources.

This opinion of the Court was largely inconsistent with its own previous and later decisions. Two factors might explain this inconsistency. From a technical point of view, the claim was vague: no definite legal clause was mentioned, the plaintiff superimposed several demands in the same action without properly specifying them, and she did not offer the Court criteria to detail the content of the different rights invoked. The proceeding was held shortly after the devastating social, political, and economic crisis of December 2001 — the worst such crisis in Argentina's history. Poverty rates, which had fluctuated between 15% and 17%, rose to a range of 47–60%. The Court was probably conscious of the potential cascade effect that a favorable ruling for the plaintiff would have created in such a delicate economic and political context — as much due to its possible interference in the government's political powers as the possibility of stimulating an unbearable case load.

In a recent case that addressed a different context of relief as it related to health rights, the Supreme Court considered a demand for government intervention for a group of people in a situation of exclusion and extreme poverty. In this case, *Defensor del Pueblo,* the Court granted interim relief measures, ordering the national government and the Chaco Province to provide drinking water and food to the Toba indigenous communities, which inhabit two departments in that province.[31] The Court granted the measure in the context of a known action brought against both bodies by the Ombuds' Office, who represented the collective rights of the affected Toba communities. In the framework of interim relief, and to determine which collective was affected, the Supreme Court requested census and registry information on the population. In addition, the Court requested data on programs of health, food and health assistance, potable water supply, fumigation and disinfection, and educational and housing services. It called the plaintiff and both governments to a public hearing at the seat of the provincial tribunal.

This precedent-setting decision, although adopted in the delimited procedural framework of interim relief (in which the Court does not advance its opinion on the possible infringement of individual and

collective social rights), demonstrated a great degree of activism by the provincial tribunal. What apparently establishes the basis for such activism is the situation of extreme poverty of the affected social group. The active role of the tribunal was reflected not only in the infrequent remedy, but also in the chosen procedure — an appearance by the federal and provincial governments at a public hearing, with the prior obligation to respond to a concrete request for information essential for evaluating the relevance of the policies implemented. At the hearing, the judges posed questions on general and specific aspects of the implementation of social policies designed for the Toba communities, and required specific actions and plans regarding the case. Without a doubt, the urgency of the situation and the precarious condition of the indigenous communities were decisive in the Court's action on the issue, going so far as to involve the federal government in matters that are — in principle — within the realm of provincial public policies.

GUARANTEES BY PRIVATE PROVIDERS: LIMITS AND MATTERS PENDING

Another recurring matter on which the tribunals ruled concerned inclusion and exclusion of health plan coverage, especially by private entities (pre-pay health care companies and *obras sociales*). Some of these cases related to issues of discrimination; other cases concerned the effects of unemployment: since coverage by the *obras sociales* requires that an employee work in the formal sector. Unemployment breaks this legal bond and terminates medical coverage by the individual's healthcare plan or *obra social*.

In *Etcheverry v. Omint*, the Supreme Court decided that a pre-pay health company's refusal to continue health coverage when the plaintiff was diagnosed with HIV constituted a violation of the rights of the consumer and of the right to health.[32] The plaintiff was a client of a pre-pay health plan through an agreement with his employer. When he became unemployed, he requested continuation of the coverage at his own expense. When the plaintiff was diagnosed with HIV, the pre-pay company refused to keep him on the health plan. The Supreme Court, in agreement with the judgment of the Attorney General, established that the pre-pay health care companies "acquire a social commitment with their users that prevents them from invalidating a contract without cause, at the risk of contradicting their own objective, which must effectively assure the beneficiaries the agreed-upon and legally established coverage," since their activity is aimed at "protecting the constitutional guarantees to a person's life, health, security and integrity." The Court ordered the pre-pay health company to maintain the plaintiff's health plan coverage. The Court and other lower tribunals have decided a number of similar cases.[33]

Other cases addressed the constitutional validity of regulations on health matters issued by public authorities. The Supreme Court decided a case in which a civil association demanded the nullification of a Ministry of Health resolution that had reduced coverage for multiple sclerosis. In the case of *Asociación de Esclerosis Múltiple de Salta*, the Court confirmed the judgment on appeal that annulled the Ministry of Health's resolution excluding coverage from the Compulsory Medical Program (*Programa Médico Obligatorio*, or PMO) of some low-incidence and high-cost treatments related to the disease.[34] The Court also concurred with the opinion of the Attorney General and decided that the challenged resolution lacked reasonableness, and affected the right to health recognized by international human rights treaties. Although the Attorney General did not expressly refer to a prohibition on regression, his interpretation of the principle of "reasonableness" came very close. Of note in this case is that despite the fact that declarations of unconstitutionality in Argentine legal tradition usually concern its impact on individuals, the fact that an NGO filed a suit representing all the members of a group of persons with multiple sclerosis in the province resulted in the entire group benefiting from the outcome of the case.

In some cases, private health service providers challenged the imposition of legal obligations in the area of health — for example, compulsory coverage for HIV/AIDS treatment. The basis for the challenge was that the right to property and contractual freedom was violated, and that the regulations were unreasonable. In the *Hospital Británico* case, the Supreme Court rejected those grievances and ruled that the imposition of obligations on private health service providers constituted a valid means of fulfilling international obligations assumed by the state related to the right to health.[35] In another suit, *Policlínica Privada,* the Court decided that a local government could not force a private hospital to keep a patient hospitalized

after the term of coverage had ended, and that the state had the obligation to place the patient in a public health institution.[36]

These precedents do not conclusively define the scope of the state's regulatory authority in the realm of private health service contracts. But they do assert a basic principle in designing any normative model, which is the affirmation of the state's regulatory role with respect to the activity of private health providers, and the limits on property rights when constitutionally-based social rights are at stake. In these cases, the right to health does not operate as a source of obligations of state provision of goods or services, but rather as the foundation for assigning the state a protective role in the event of abuses or arbitrary acts by private providers. This social right functions by modulating the scope of property rights of health service entrepreneurs. The Court has ratified the principle that the fundamental right to health also has a place in the relationship between private parties and that the state has the authority, and at times the duty, to intervene to balance unequal power relations in this contractual field and assure respect for the law by companies and individuals.

CONCLUSIONS

One of the basic objectives of the health reforms was to achieve *equity*, which may be defined from various perspectives and using different political and conceptual frameworks. In the definition that most international lending organizations employ, equity refers to the guarantee of minimal levels of health and access to care for the most vulnerable groups. Evaluations carried out in Latin America, and in Argentina in particular, show that this objective is far from being reached. Both the most vulnerable groups and salaried workers, are precisely those who are most affected, with these groups demonstrating greater heterogeneity, segmentation, and employment conditions that do not ensure health care equity.[37]

In contrast to Peter Lloyd-Sherlock's definition of equity, in which it is understood as the way and degree to which economic and social policies reduce differences in a population's health conditions, the health sector in Argentina is showing signs of an increasing gap.[38] The lack of reliable statistics and information represents a grave deficit in the Argentine institutional system, as there are no evaluations on the impact of health policy. However, the increase in court cases appears symptomatic of a shortfall in the provision of minimal health coverage, and indicates difficulties in access to benefits granted by the social security and pre-pay systems, including specific medical treatments. In other words, the problems affect not only public benefits but also the *obras sociales* and pre-pay health systems.

Furthermore, segmentation of the job market related to employment flexibility during the past decade has effectively translated into a loss of minimal levels of coverage and access. In addition, the country-wide Atención Primaria en Salud (Primary Health Care) system crisis, coinciding with the global sectoral crisis, points to a severe deficit in the system.

In the context of these issues and concerns, the cases that have been discussed here could contribute toward restoring violated rights, but cannot effect a structural remedy of Argentina's health sector. The ramifications of litigation in health should not, however, be underestimated. This summary analysis reveals how the courts have recognized the existence of a right to health and to health assistance. This recognition is evident in both the enactment of the 1994 constitutional reform and in the context of the government's willingness to assume obligations with the ratification of international human rights treaties.

Recognizing the right to health as a *fundamental* right with a constitutional basis is a first step in assuring its jurisdictional protection. Such recognition leads to the possibility, for example, of filing interim relief proceedings and, under some circumstances, even activating the extraordinary jurisdiction of the Supreme Court of Justice of the Nation. Jurisprudence has, in addition, established that the right to health imposes both negative duties and positive obligations on the state. These duties and obligations justify the lodging of judicial actions that may either demand certain benefits of the state or may require the state to define health policies.

Strictly speaking, the organization of the health system and the very health regulations approved by the Congress and its own administrative bodies (such as the Ministry of Health in its role as the system's directive body) represent one method for fulfilling these constitutional obligations. Administrative noncompliance with these laws therefore authorizes those

who are harmed (either individually or collectively) to judicially demand that obligations are fulfilled.

The national government's obligation as the ultimate guarantor of the right to health has also been established independent of obligations corresponding to other public or private actors. International obligations of the state empower it to levy its own obligations regarding coverage for health treatments to non-state actors, such as *obras sociales* and pre-pay health care companies. According to this same principle, non-state actors within the health system — such as *obras sociales* and the pre-pay health care companies — have, with respect to their members or potential members, specific obligations that go beyond the merely commercial nature of the relationship, given that their activity is intended to protect a fundamental right. In this sense, constitutional jurisprudence recognizes the theory of the "horizontal effect" of fundamental rights — that is, its application to relations between private entities. Another relevant aspect of this obligation is the guarantee function exercised by the federal government concerning health benefits and services organized by the provinces.

The Court's jurisprudence has, however, left several issues unresolved and in need of greater conceptual detail. Among them are the following:

- the content of the obligations constituting the right to health that issue directly from international documents of constitutional rank, which are mandatory and not open to modification or denial by legislators;
- the scope of the state's positive obligations as relates to medical assistance, especially for persons in situations of extreme need who cannot afford services;
- the scope of the federal government's obligation when provincial health systems fail, or in the case of gaps or profound inequality in access to health between the various jurisdictions;
- the scope of the state's obligation when faced with deficiencies or non-compliance by private providers and the authority for state regulation of health contracts between private parties; and
- the definition of equitable access to health.

The active intervention of the courts to ensure individual access to certain benefits could help restore those rights violated through omission by public authorities. In particular, they could help to address situations of pressing urgency or those in which persons are disadvantaged in accessing state services. The sum of individual claims admitted by the courts could serve as a forum for problems with public policy that required state solutions, and could heighten public awareness of health system issues.[39] However, judicial activism in individual cases could also potentially provoke distortions in the health system — for example, if the courts failed to consider the impact of their decisions on the system as a whole or the consequences of budget commitments produced by their rulings. There do not yet seem to be clear rules regarding when benefits not authorized by law or administrative authority can be judicially guaranteed due to the potential violation of the right to health.

The development of even the minimal provisions that are contained in the right to health could contribute to deciding these matters. At times, the court has ordered compliance only for the compulsory medical programs established by the administrative authority, or has granted benefits that the state itself assumed in laws or provisions (as in the case of the antiretrovirals for HIV). But the inclusion of benefits or medication not regulated by public policy, by virtue of judicial decisions in individual cases, could have a distorting effect and even widen the gaps and inequalities of the health system itself, due to the possible diversion of public resources to non-priority demands in sectors with greater access to legal resources.[40]

Paradoxically, truly structural cases on access to health have yet to be brought before the Argentine courts. Such cases could elicit judicial and political responses to the obligations contained in the Constitution and human rights treaties, especially the right to equal access to health assistance and the role of federal and provincial authorities in reestablishing such equity.

The trends outlined here suggest a scenario in which institutional adjustments will likely be necessary in order for the current health system to conform to constitutional standards. The complexity of these adjustments might require not only case law interpretations but also political accords which employ legal frameworks and develop those commitments into services and policies.

In addition, the debate in bodies of popular representation will allow for setting more coherent, stable,

and legitimate institutional rules. It could also contribute to achieving an adjustment between norms and policies, the effective reconstitution of the governing role of the federal government, which establishes the law, and an improvement in the linkage mechanisms between the federal and local governments. Progress toward reinstituting broad guarantees and equitable conditions in health remains highly desirable.

This article has been translated from Spanish into English by Victoria Furio.

REFERENCES

1. The "Washington Consensus" referred to commonly shared themes on policy advice by Washington-based institutions that included the International Monetary Fund (IMF), the World Bank, and the U.S. Treasury Department, as these themes were relevant to economic and fiscal crises in Latin America during the 1980s. For an analysis of health reforms in Argentina, see S. Belmartino, *Nuevas Reglas de Juego para la Atención Médica en la Argentina* (Buenos Aires: Lugar Editorial, 1999); S. Belmartino, "La Reforma del Sector Salud en Argentina," in M. Rico and F. Marco (eds), *Mujer y Empleo. La Reforma de la Salud y la Salud de la Reforma en Argentina* (Buenos Aires: CEPAL and Siglo XXI Editores, 2006), pp. 101–150; J. Burijovich and L. Pautassi, "Reforma Sectorial, Descentralización y Empleo en Salud en Córdoba," in Rico and Marco (Ibid.); C. Mesa Lago, *Las Reformas en Salud en América Latina y el Caribe: Su Impacto en los Principios de la Seguridad Social.* Documento de Proyectos (Santiago de Chile: CEPAL); O. Parra Vera, *El Derecho a la Salud en la Constitución, la Jurisprudencia y los Instrumentos Internacionales* (Bogotá: Defensoría del Pueblo, 2003); and L. Pautassi, "El Empleo en Salud en Argentina. La Sinergia entre Calidad del Empleo y Calidad de la Atención," in Rico and Marco, *Mujer y Empleo. La Reforma de la Salud y la Salud de la Reforma en Argentina*, pp. 193–233.

2. See V. Gauri and D. Brinks, "Rights-Based Approach to Social and Economic Policy in Developing Countries: Law, Politics and Impact," in V. Gauri and D. Brinks (eds), *The Impact of Litigation for Claiming Economic and Social Rights* (Cambridge, UK: Cambridge University Press, 2007).

3. Reliable statistics do not exist on the number of judicial health rights cases in the country. In a presentation before the Inter-American Commission of the OAS in March 2002, the Ministry of Health indicated that, between December 1, 2001 and the end of February 2002, 200 appeals for relief due to suspended medicine supply were presented in the city of Buenos Aires alone. (Source: *Centro de Documentación*, *Centro de Estudios Legales y Sociales*—CELS). This information has to do with a specific case that led to an escalation in justicialization at the height of the 2001–2002 economic and political crisis. An as-yet unpublished investigation underway by Paola Bergallo, researcher at the *Universidad de San Andrés*, reported in the legal magazines, *La Ley* and *Jurisprudencia Argentina,* and in Supreme Court records that the total number of rulings on the right to health ascends to 460 judgments between 1987 and 2007, excluding medical malpractice suits (personal communication with the author).

4. For an expanded version of this article, see V. Abramovich and L. Pautassi, "El Derecho a la Salud en los Tribunals: Algunos Efectos del Activismo Judicial Sobre el Sistema de Salud en Argentina, *Salud Colectiva* 4/3 (2008), pp. 261–282. Available at http://www.unla.edu.ar/public/saludColectivaNuevo/publicacion12/pdf/2.pdf, revised for *Health and Human Rights* with the permission of *Salud Colectiva.*

5. The 1853 Constitution was successively reformed in 1860, 1866, 1898, 1949 (never entered into force), 1957, and finally, in 1994. In the last version, 11 covenants and international human rights treaties were incorporated with constitutional status (Section 75, para. 22).

6. Constitution of the Argentine Nation, First Part, Chapter One, art. 14 bis. Available at http://www.argentina.gov.ar/argentina/portal/documentos/constitucion_ingles.pdf.

7. Currently the only way to analyze coverage is through the data of the Permanent Survey of Homes (*Encuesta Permanente de Hogares* — EPH) of the Institute of Statistics and Census (INDEC), with urban coverage centered in provincial capitals and large urban centers, which shows a recovery in levels of access to coverage in paid health services, but this coverage remains below the 1991 level. Access to coverage in paid health services shows gaps in coverage by income levels: despite improvement in the last three years, almost seven of every ten women between 15 and 49 years of age who live in the poorest homes do not have health coverage, indicat-

ing an increase in inequality between the poorest and riches quintiles (Equipo Latinoamericano de Justicia y Género [ELA], *Informe sobre Derechos Humanos de las Mujeres* [Buenos Aires: ELA, 2008]).

8. Available at http://www.argentina.gov.ar/argentina/portal/documentos/constitucion_ingles.pdf (pg. 5).

9. C. Courtis, "La Aplicación de Tratados e Instrumentos Internacionales Sobre Derechos Humanos y la Protección Jurisdiccional del Derecho a la Salud: Apuntes Críticos," in V. Abramovich, A. Bovino, and C. Courtis (eds), *La Aplicación de los Tratados de Derechos Humanos en el Ámbito Local. La Experiencia de Una Década (1994–2005)* (Buenos Aires: Ed. del Puerto, 2007), pp 281–318. Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. No. E/C.12/2000/4 (2000), para. 43, emphasizes that fulfillment of the minimal content is mandatory and is not subject to exceptions, not even in emergency situations; compare CESCR, General Comment No. 3, The Nature of States Parties' Obligations, UN Doc. No. E/C.12/1991/23 (1990).

10. International Covenant on Economic, Social and Cultural Rights, Article 12. Available at http://www.unhchr.ch/html/menu3/b/a_cescr.htm.

11. Available at http://www2.ohchr.org/english/bodies/cescr/docs/statements/E.C.12.2001.15HRIntel-property.pdf (pg. 5).

12. Data are from the Ministry of Economy (Mecon), Department of Analysis of Government Expenditure and Social Programs, 2008.

13. Twenty hospitals that had remained in the national sector (as a result of transfer policies that had been carried out by various administrations) were transferred to provincial jurisdictions. These transitions resulted in both gains and setbacks, transforming the equitable bases that gave birth to the public system of health care in Argentina. Currently, the provinces have jurisdiction over 65% of all public hospitals, with 69% of all beds, and the municipalities have jurisdiction over 35% of the hospitals and health providers, which represents 29% of all hospital beds (Mesa Lago [see note 1, p. 171]). In 2001, the percentage of provincial government expenditure (excluding the municipalities) with respect to GDP was 2.32% and in 2006, 2.05% (Mecon [see note 12]).

14. In this section, we continue what was developed in V. Abramovich and C. Courtis, *Los Derechos Sociales como Derechos Exigibles* (Madrid: Trotta, 2001); V. Abramovich and C. Courtis, "La Justiciabilidad de los Derechos Sociales en la Argentina: Algunas Tendencias," in G. Escobar (ed), *Derechos Sociales y Tutela Antidiscriminatoria* (Seville: Thomson-Aranzadi, Cizur Menor, forthcoming); and Courtis (see note 9).

15. This point is extremely important with respect to the focus of some policies in the sector; even more so when this was a situation that, according to Decree 578/93, would govern the public health system (Hospital Self-Management), granting public hospitals the ability to administer resources in a decentralized way. Its purpose is to identify people with coverage who recur for indigent care services in order to facilitate payment for the care received by their respective *obra social*, Job Risk Administrator (*Administradora de riesgos del trabajo,* known as ART), or pre-payment company. Strictly speaking, the strategy is part of an embryonic policy to subsidize demand, seen in some jurisdictions as programs of coverage for specific groups, which could also be legally considered as a regressive line of action with respect to the conditions of access to basic health benefits.

16. Compare *Campodónico de Beviacqua*, citing Consid. 16, 17 (*Ana Carina v. Ministerio de Salud y Acción Social.* Constitutional Court, File C.823.XXXV (October 24, 2000; Argentina).

17. Ibid., citing Consid. 16.

18. Ibid., citing Consid. 18, with explicit reference to Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).

19. Ibid., citing Consid. 19, with explicit reference to Article 2.1 of the ICESCR.

20. Ibid., citing Consid. 19, with explicit reference to the doctrine established by the Committee on Economic, Social and Cultural Rights in its final observations to the Swiss Government Report of November 20 and 23, 1998 (Concluding Observations of the Committee on Economic, Social and Cultural Rights: Switzerland, UN Doc. No. E/C.12/1/Add.30, December 7, 1998).

21. Ibid., citing Consid. 20, with explicit reference to Articles 23, 24, and 26 of the Convention on the Rights of the Child.

22. Ibid., citing Consid. 21, with explicit reference to Article 3 of the Convention on the Rights of the Child.

23. On medical coverage to a disabled child: Supreme Court, *Monteserin, Marcelino c. Estado Nacional-Ministerio de Salud y Acción Social-Comisión Nacional Asesora para la Integración de Personas Discapacitadas-Servicio Nacional de Rehabilitación y Promoción de la Persona con Discapacidad*, October 16, 2001; on persons with HIV/AIDS: Supreme Court, *A. C. B. C. Ministerio de Salud y Acción Social s/Amparo Ley 16.986,* March 19, 1999, judgment of the Attorney General of the Nation; June 1, 2000, Court decision; on unforeseen situations regarding insurance: Supreme Court, *N., L. M. otra c. Swiss Medical Group, S. A.*, June 11, 2003, judgment of the Attorney General of the Nation, ruling by the Court, August 21, 2003; *Martín, Sergio Gustavo y Otros c. Fuerza Aérea Argentina-Dirección General Bienestar Pers. Fuerza Aérea Argentina s/Amparo,* October 31, 2002, opinion of the Attorney General of the Nation, June 8, 2004, decision by the Court; *M. S. A. s/Materia: Previsional s/Recurso de Amparo*, November 23, 2004. Similarly, the National Appeals Tribunal of Federal Administrative Litigation, Chamber II, *R., R. S. c. Ministerio de Salud y Acción Social y Otro s/Amparo*, October 21, 1997; National Civil Appellate Court, Chamber C, *T., J. M. c. Nubial S. A.*, October 14, 1997; on interim relief in situations of extreme urgency: see, for example, Supreme Court, *Alvarez, Oscar Juan c. Buenos Aires, Provincia de y Otro s/Acción de Amparo*, July 12, 2001; *Orlando, Susana Beatriz c. Buenos Aires, Provincia de y Otros s/Amparo*, April 4, 2002; *Díaz, Brígida c. Buenos Aires, Provincia de y Otro (Estado Nacional Ministerio de Salud y Acción Social de la Nación) s/Amparo*, March 25, 2003; *Benítez, Victoria Lidia y Otro c. Buenos Aires, Provincia de y Otros s/Acción de Amparo*, April 24, 2003; *Mendoza, Aníbal c. Estado Nacional s/Amparo*, September 8, 2003; *Rogers, Silvia Elena c. Buenos Aires, Provincia de y Otros (Estado Nacional) s/Acción de Amparo*, September 8, 2003; *Sánchez, Enzo Gabriel c. Buenos Aires, Provincia de y Otro (Estado Nacional) s/Acción de Amparo*, December 18, 2003; *Laudicina, Angela Francisca c. Buenos Aires, Provincia de y Otro s/Acción de Amparo*, March 9, 2004; *Sánchez, Norma Rosa c/Estado Nacional y Otro s/Acción de Amparo*, May 11, 2004. The Court granted interim relief but declared itself not competent in *Diéguez, Verónica Sandra y Otro c. Buenos Aires, Provincia de s/Acción de Amparo*, December 27, 2002; *Kastrup Phillips, Marta Nélida c. Buenos Aires, Provincia de y Otros s/Acción de Amparo*, November 11, 2003; *Podestá, Leila Grisel c. Buenos Aires, Provincia de y Otro s/Acción de Amparo*, December 18, 2003.

24. See, among many others, Civil and Commercial Appellate Court of Bahía Blanca, Chamber II, *C. y Otros c. Ministerio de Salud y Acción Social de la Provincia de Buenos Aires*, September 2, 1997 (imposed treatment by a public hospital); Tribunal of Administrative Litigation of Tucumán, Chamber II, *González, Amanda Esther c. Instituto de Previsión y Seguridad Social de Tucumán y Otro s/Amparo*, July 15, 2002 (imposed treatment by a government *obra social*); Court of Appeals in Administrative and Tax Litigation of the city of Buenos Aires, Chamber II, *Sociedad Italiana de Beneficencia en Buenos Aires c. GCBA s/Otras Causas*, October 7, 2004; Court of Appeals in Administrative and Tax Litigation of the city of Buenos Aires, Chamber I, *Centro de Educ. Médica e Invest. Clínicas Norberto Quirno c. GCBA s/Otras Causas*, June 22, 2004 (confirmed the assessment of legal obligations for coverage by private providers); Court of Appeals in Administrative and Tax Litigation of the city of Buenos Aires, Chamber II, *Trigo, Manuel Alberto c. GCBA y Otros s/Medida Cautelar*, May 12, 2002; Court of Appeals in Administrative and Tax Litigation of the city of Buenos Aires, Chamber I, *Rodríguez Miguel Orlando c. GCBA s/Otros Procesos Incidentales,* December 22, 2004; Court of Appeals in Administrative and Tax Litigation of the city of Buenos Aires, Chamber I, *Defensoría del Pueblo de la Ciudad de Buenos Aires* (non-compliance claim regarding member Brenda Nicole Deghi) *c. GCBA s/Otros Procesos Incidentales*, February 10, 2005 (confirmed relief imposing treatment by a government *obra social*); Court of Appeals in Administrative and Tax Litigation of the city of Buenos Aires, Chamber I, *Zárate, Raúl Eduardo c. GCBA s/Daños y Perjuicios*, August 21, 2002; Court of Appeals in Administrative and Tax Litigation of the city of Buenos Aires, Chamber II, *Villalba de Gómez, Leticia Lilian c. GCBA (Hospital General de Agudos Franciso Santojani) y Otros s/Daños y Perjuicios*, April 8, 2003; Court of Appeals in Administrative and Tax Litigation of the city of Buenos Aires, Chamber II, *Echavarría, Adriana Graciela c. GCBA*

y Otros s/Daños y Perjuicios, April 22, 2003; Court of Appeals in Administrative and Tax Litigation of the city of Buenos Aires, Chamber I, *B. L. E. y Otros c. OSBA s/Daños y Perjuicios*, August 27, 2004 (granted compensation for damages produced by denial of or inappropriate medical treatment); Court of Appeals in Administrative and Tax Litigation of the city of Buenos Aires, Chamber I, *Roccatagliata de Bangueses, Mercedes Lucía c. OSBA s/Otros Procesos Incidentales*, June 10, 2002; Court of Appeals in Administrative and Tax Litigation of the city of Buenos Aires, Chamber I, *Urtasun, Teodoro Alberto c. Instituto Municipal de Obra Social s/ Cobro de Pesos,* April 22, 2004 (imposed treatment by a government *obra social*).

25. Supreme Court, *Asociación Benghalensis y Otros c. Ministerio de Salud y Acción Social –Estado Nacional s/Amparo Ley 16.688,* judgment by the Attorney General of the Nation on February 22, 1999, decision by the Court on June 1, 2000.

26. The court cited Article 12 (c) of the ICESCR, Articles 4.1 and 5 of the American Convention on Human Rights, and Article 6 of the International Covenant on Civil and Political Rights.

27. *Asociación Benghalensis*, cit., judgment of Attorney General, Consid. X.

28. Ibid.

29. Tribunal of Federal Administrative Litigation, Chamber IV, *Viceconte, Mariela c. Estado Nacional — Ministerio de Salud y Acción Social s/Amparo Ley 16.986*, June 2, 1998.

30. Supreme Court, *Ramos, Marta Roxana y Otros c. Buenos Aires, Provincia de y Otros s/Amparo*, March 12, 2002.

31. Supreme Court, *Defensor del Pueblo c/Estado Nacional y Otra (Provincia del Chaco) s/Proceso de Conocimiento*, September 18, 2007.

32. Supreme Court, *Etcheverry, Roberto E. c. Omint Sociedad Anónima y Servicios*, judgment of the Attorney General, December 17, 1999, decision of the Court on March 13, 2001.

33. Supreme Court, *V., W. J. c. Obra Social de Empleados de Comercio y Actividades Civiles s/Sumarísimo,* December 2, 2004.

34. Supreme Court, *Asociación de Esclerosis Múltiple de Salta c. Ministerio de Salud —Estado Nacional s/Acción de Amparo-medida Cautelar*, judgment of the Attorney General on August 4, 2003; decision by the Court on December 18, 2003.

35. Supreme Court, *Hospital Británico de Buenos Aires c. Estado Nacional-Ministerio de Salud y Acción Social s/Amparo*, judgment of the Attorney General, February 29, 2000; decision by the Court on March 13, 2001.

36. Supreme Court, *Policlínica Privada de Medicina y Cirugía S. A. c. Municipalidad de la Ciudad de Buenos Aires*, June 11, 1998.

37. Mesa Lago (see note 1) indicates, based on Pan American Health Organization (PAHO) data, that in 2002, 84% of the population under the poverty line accessed some public service, and 45% had to acquire medicine with their own resources.

38. P. Lloyd-Sherlock, "Salud, Equidad y Exclusión en América Latina: Argentina y México," *Comercio Exterior* 53/8 (2003), pp. 700–710.

39. On the use of courts to monitor public policies in Argentina, see V. Abramovich, "Líneas de Trabajo en Derechos Económicos, Sociales y Culturales: Herramientas y Aliados," in *SUR, Revista Internacional de Derechos Humanos* 2/2 (2005). Available at http://www.surjournal.org/esp/index2.php.

40. Informal interviews with professionals from the legal departments of the Ministry of Health and some officials in public health areas revealed concern over cases of judicial findings against the state and trade union *obras sociales* to cover certain surgeries, such as gastric bypass, non-essential esthetic surgeries, or certain reproductive treatments. These benefits do not fall within public coverage plans.