Right to health litigation in Brazil: Why are collective suits so hard to enforce?

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The Brazilian constitution of 1988 is generous in the recognition of justiciable social and economic rights. Article 6 establishes that “[e]ducation, health, work, housing, leisure, security, social security, protection of motherhood and childhood, and assistance to the destitute, are social rights under this Constitution”. Article 7, with 34 subsections, regulates in detail conditions of work, including unemployment insurance (7, iii), the minimum wage (iv) and maximum working hours (xiii). Then follows freedom of association to form trade unions in article 8 and the right to strike in article 9.

After redemocratization and the establishment of the new constitutional order, moreover, courts have not shied away from adjudicating these rights. The good reception by judges of the first few cases has encouraged new ones to come to court and litigation soon became a regular strategy of social rights claimants and activists, resulting in some areas in an explosion of litigation that has often been called, with a hint of criticism, “judicialization”.

There is a notable difference, however, in the volume of litigation among different areas, and even within areas there is significant variation. So, for instance, whereas health and education have witnessed an explosion of litigation and it is not uncommon to hear of a “judicialization of health” or “judicialization of education” phenomenon, housing has to this date not experienced a similar situation. Within health, moreover, whereas thousands of individualised cases have been reaching the courts demanding medication, operations and other types of treatment, the same does not occur when the issue in question is a comprehensive health programme or measure affecting a larger group of people or the population as a whole (such as basic sanitation, hospital equipment etc). In a recent survey of right to health cases filed against the federal government it was found that less than 3% are collective ones.
What explains these differences? Why do individuals litigate significantly more to guarantee their right to health and education than they do to enforce their right to housing equally recognised in the constitution? For what reasons individualised claims for all sorts of health treatments have flooded the courts whereas collective ones are so few and far between?¹

In this paper I focus on the latter question, restricted to the field of health. But I believe that an in depth investigation of this field can shed light also on the more general issue of why social and economic rights litigation in general varies so much in volume across different fields.

My main hypothesis, which I believe is confirmed by the empirical research I present in this paper, is that difficulties in enforcement explain to a significant extent the significantly lower volume in collective litigation in health rights.² By enforcement here I mean both compliance with a court order already handed down by a judge (we might call this specific enforcement) and ability of a judge to translate a legal norm into a practical and implementable remedy (we might call it generic enforcement). To give an example, imagine a lawsuit based on the right to health sponsored by an NGO aiming to force the state to adopt a comprehensive programme that benefits all individuals suffering from diabetes in a given region. The claim can fail at two different stages, both related to enforcement in the way I am proposing to understand the term. It can succeed in convincing the judge to order government to do so, yet fail due to an inability or unwillingness of government, for whatever reason, to implement the judgement. That would be a problem of specific enforcement. But it can also fail at an earlier stage, due to an unwillingness of the judge to determine what policies government should implement to guarantee the right to health. Here I believe the problem is also one of enforcement, i.e. of implementation in the real world of a legal norm. I am proposing to call it generic enforcement for lack of a better

¹ See my “Health Inequalities, Rights and Courts: The Social Impact of the “Judicialization of Health” in Brazil”, in Yamin and Gloopen (eds), forthcoming Harvard University Press 2010
² Another explanatory factor has to do with inequalities in access to courts in Brazil which track socio-economic inequalities. A significant percentage of right to health cases is brought to courts by middle class individuals (I explore this is more detail in O. Ferraz, “The Right to Health in the Courts of Brazil: Worsening Health Inequities?”, Health and Human Rights, An International Journal Vol 11, No 2 (2009)). It is unlikely that this group would ever need to claim a right to housing in courts.
term (Lawrence Sager referred to these norms as “underenforced constitutional norms”).

In either case, as I aim to show in this paper, the result is a discouragement of litigation as a viable strategy for claiming social and economic rights, whereas the opposite, i.e. a series of rulings that do determine what government should do to implement a particular social right (generic enforcement) and a consistent practice of government to comply with these rulings (specific enforcement) create a favourable environment for social rights litigation.

In the field of health in Brazil this explanation seems rather plausible. On one hand, we have a burgeoning volume of litigation by individuals claiming a specific health treatment. On the other hand, we have a stagnant, and perhaps decreasing, number of lawsuits where a collective health measure is at issue (a recent interesting case is that of swine flu vaccine\(^3\)). Whereas almost all lawsuits of the former kind are successful in terms of specific and generic enforcement, most of the lawsuits of the latter type fail either at the first enforcement hurdle (generic enforcement) or the second (specific). Preliminary interviews conducted with lawyers who represent claimants in right to health litigation cases confirm that these enforcement difficulties are indeed one of the main reasons that prevent them from pursuing the collective route more often.

But this profile of litigation, we might call it the “Brazilian model of litigation” is not a good model for the implementation of social and economic rights. This is because, as I discuss in detail elsewhere, this high prevalence of individualised claims for healthcare often results in more rather than less health inequalities and therefore defeats the purpose of the social and economic rights recognised in the constitution.\(^4\) Appropriately devised collective suits, on the contrary, would have a better potential to tackle health inequalities.

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\(^3\) A judge in the state of Paraná has ordered that state to provide the vaccine to the whole of the population, and not only to children, the elderly and others at special risk as determined by the Ministry of Health. My impression is that, even if it stands at the higher instances, this decision will suffer from lack of specific performance.

\(^4\) See Ferraz (2009, note 2 above).
It is important to know, therefore, why collective suits face such greater difficulties in terms of enforcement and whether these difficulties can be overcome. This is what I aim to discuss in this paper.

Some preliminary thoughts regarding the variables proposed

1.1. **Legal variables**: this set of factors relate to rules and practices of the applicable legal system, such as:

- **Rules regarding access to courts and legal processes to claim the recognition of social rights** (standing, class actions or other types of collective actions, level of institutionalization of collective actions, etc.)

  *The prevalence of individual lawsuits cannot be explained by the absence, in Brazil, of collective claims procedures. On the contrary, the constitution and ordinary laws do establish such procedures, such as the Ação Civil Pública (the “Civil Public Action”, hereafter simply “ACP” from the Portuguese acronym) Federal Law nº 7.347, from 24.7.1985 and the “Mandado de Segurança Coletivo” (“Collective Mandamus”, or “Collective Writ of Certiorari”), whose function is exactly to protect collective interests in a variety of areas, including health.*

- **Rules and practices regarding remedies** (e.g., types of remedies available and used, the strength of the remedial order (e.g. ‘should’ or ‘must’, consequences if not followed), existence of complex enforcement, structural remedies, procedures for the design of remedies and execution of court decisions)

  *Brazilian judges have effective instruments of contempt of court to make their decisions effective. In the field of health, the threat of prison of the recalcitrant health official (often the Secretary of State) is arguably one of the reasons why compliance is so high. Structural remedies are also available, yet less often used.*

- **Rules and practices regarding court’s supervisory jurisdiction** (e.g., court’s continued competence to follow-up on ruling implementation)
Courts have competence to follow up on implementation but need to be prompted by the parties to the case (see civil society variables below).

- Whether the case is individual or collective/structural in nature and involves positive or negative obligations
  
  *This, as I mentioned above in the introduction, is arguably the most important variable in the Brazilian case.*

- Whether the fact of being a case on economic and social right (and not a more traditional civil and political rights case) could have placed additional hurdles for enforcement
  
  *After the 1988 constitution this is no longer an important hurdle.*

- Common law vs. civil law systems
  
  *This seems to have important implication for individualized cases in Brazil. Given that they do not establish precedent, judges seem less worried with the potential social impact of their decisions in these cases.*

1.2. Political variables: this set of factors relate to the characteristics of the state apparatus and the political system, such as:

- Capacity of the state apparatus to implement ESC rights rulings
  
  *There are some structural barriers for the use of collective instruments in right to health litigation. There is a clear constraint in the number of public lawyers devoted to collective health litigation. In São Paulo, for instance, there are only 2 public attorneys devoted full time to health issues and 5 public defenders who deal with health issues as well as all other social and economic rights, such as education, housing etc.*
  
  *Given that the preparation of collective suits is usually significantly more burdensome than that of individual ones, this might explain to a great extent the discrepancy in volume of litigation.*

- Institutional arrangements ruling relations between the judiciary, on the one hand, and the executive and the legislature, on the other.
  
  *The authorities who have to comply with court orders are the health departments of the administrative unit sued by the claimant (federal, state or municipal). Compliance is by and large high, and there is usually a high degree of respect for court orders.*

- Characteristics of judges

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Judges in Brazil are seen to be on the more conservative side and not particularly keen on exercising their power to bring about more social justice. On the other hand, they are often not very deferential to the political branches.

- **Extent of budgetary and economic resources involved in the solution of the issue**
  
  This seems to be an important variable to be investigated in more detail in Brazil. Although judges usually dismiss budgetary considerations in individualized right to health cases, their unwillingness to enforce collective cases would seem to be somehow related to their financial implications.

- **Other broader ESC characteristics of country such as level of social inequality, religiousity etc**
  
  High levels of socio-economic inequalities produce high levels of health inequalities and also inequalities in access to the judiciary. This explains, in part, the Brazilian model of litigation, highly individualized, as I claim in another paper. But can it explain the paucity of collective suits? Perhaps indirectly.

1.3. **Civil society variables**: this final set of factors relate to patterns of mobilization of the legal system by social movements, NGOs and other civil society actors. Among such patterns are:

- **Structure and level of cohesion of civil society coalitions litigating ESC rights cases**
  
  There are strong and well resourced NGOs litigating health issues, particularly in the field of HIV and Diabetes. Yet they also find it hard to enforce health rights through collective cases.

- **Trajectory of legal mobilization (e.g. civil society actors’ tendency to resort to courts as opposed to the executive or the legislature in order to advance ESCR)**
  
  Brazilian society in general is rather quick to resort to courts if they have resources to hire lawyers, which is true of most NGOs.

- **Characteristics of litigants of the case (organization or individual lawyer, level of prestige and trajectory of organization or lawyer, coalition of organizations, partnership between affected persons and/or social movements and NGOs/lawyers, etc)**
As I claim in another paper, the characteristics of the litigant is a decisive factor for success in right to health litigation. This is related to the resources available to the claimant to follow up the decision of the courts. The well resourced HIV-AIDS NGOs, for instance, or private lawyers representing individuals, apply constant pressure on the authorities for them to comply with the decision, whereas poorer claimants represented by less well resourced public attorneys will not be able to do so, and might not even follow up a favourable decision.