The Case Law on the Right to Health as an Example and as a Problem

The Distortive Effects of Litigation Reconsidered

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1. INTRODUCTION: THE CASE LAW ON THE RIGHT TO HEALTH AS AN EXAMPLE AND AS A PROBLEM

One of the aims of this book is to discuss the question of whether the right to health is an empty promise or not. More precisely it is alleged that

»while even highly developed countries have come to realize that expensive health technologies may not be affordable for everyone under all circumstances, the absence of an adequate healthcare infrastructure in some developing countries renders the universal right to health hopelessly utopian – or so it may seem.«[1]

The answer is: the right to health is not an empty promise. The evidence of the case law demonstrates that the right to health is justiciable. Empirical studies show that the right to health is not any more a matter of concern because of the lack of constitutional recognition: approximately 70% of constitutions worldwide contain health-related guarantees, and the right to

1 See: http://archiv.efi.fau.de/projekte/human-rights-in-healthcare/stand-150715_efi-conference-programm_the-right-to-health-berlin.pdf [19.06.2017].

health is justiciable in approximately 40%.[2] Accordingly, it is more than a promise. It entails a normative aspiration that imposes negative and positive obligations for the states. The case law shows in general that these obligations enable the individuals to bring a claim against the state or other agencies of the healthcare system before a court.[3]

What lessons can be learned from the case law on the right to health? To address the question, we highlight two uses[4] of the case law on the right to health: 1) the case law as an example to analyse the structure of the right to health and to address some objections regarding the determination of the content of the right and 2) the case law as a problem of inequality.

The first use is found in different types of documents (articles, books, handbooks, factsheet No. 31 of the UN about the right to healthcare, general comments and general recommendations), in which the content of the right to healthcare is developed. The case law helps to sustain an idea with an example.[5] In these documents the case law is not a problem. It is a matter of inspiration or illustration. The authors of these works do not pick up some examples while excluding others. The case law is used to illustrate: type of obligations (positive-negative obligations; definitive-principle obligations; core obligations, »obligations of comparable priority«[6]), type of defendant (state, social security agencies, private pre-pay healthcare com-

2 Jung et al. (2015), 1043–1094.

3 Abramovich/Pautassi (2008), 53–65 and 261–282.

4 The case law can also be used as indicator. Although it exceeds the objective of our work, we have to point out that case law can be analyzed as an expression of factual and judicial issues that those entitled to the right to health have to deal with when they need to enforce their right. The importance of the information extracted from case law is highlighted to evaluate the compliance of the state as regards the right to medical care, as outlined by the Committee on Economic, Social and Cultural Rights (CESCR) of the United Nations on its Final Considerations on the Third State Report of Argentina: E/C.12/ARG/CO/3, 14.12.2011, para. 6, 7; especially when the lack of inclusion of case law on social rights is observed. See Abramovich (2005), about the use of courts to monitor public policies in Argentina.

5 About the uses of examples and illustrations in the practical argumentation see Perelman/Olbrechts-Tyteca (1969), 350–362.

6 Forman (2015), 43.

panies), type of plaintiff (individuals, individuals, NGOs, consortiums of NGOs, public defenders, indigenous communities), subject of the claims (access to medicaments and treatments covered by the law or plan or basket and not-covered by the law, these include claims to have access to expensive new drugs or the use of expensive health technologies; lack of social determinants of the right to healthcare like access to clean water, sanitation, housing, education, protection of the environment), standards to evaluate the violation of the right to health (minimal core obligations, procedural review, reasonableness, proportionality review, equality review, multidimensional equality test), type of reparative measures (material, symbolic; individual, collective), among others.[7] To sum up: case law presents powerful examples of the right to health and is rich enough to promote further reconstruction on the rationality of legal argumentation on the right to health.

The second use of the case law supposes that the great majority of individual health rights actions are successful. Then it asks whether this can reinforce or produce inequality, »if limited public resources are diverted to those with the means and ability to litigate their right to health, as has been argued is the case in, for example, Colombia and Brazil«.[8] In the debate on the distortive effects of litigation in the healthcare sector in Latin America, a considerable portion of the literature assumes that both actors and the requested services represent the middle and upper classes of the population, whereas vulnerable, low-income sectors would be left out of this litigation universe.[9] However, recently it has also been pointed out that these effects depend on the concrete context in which litigation is brought about, and the importance of this tool is highlighted as guarantee the right to health of the most vulnerable.[10] Our work aims to analyse this theme concerning Argentina, based on the studies on local litigation in healthcare issues of the Province of Buenos Aires.[11] The question is simple: Does litigation favour and protect the wealthy ones at the expense of the most vulnerable population in

7 See, for example, in general, Langford (2011).

8 Flood/Gross (2014), 62–72.

9 Ferraz (2011), 1643–1668; Da Silva Virgilio et al. (2011), 825–853; Yamin et al. (2011); Reveiz et al. (2013), 213–222.

10 Biehl et al. (2016).

11 As we explain in the next section, the *local* case law is not object of inquiry of the mainstream of the research about the right to health. See Biehl et al. (2016).

countries with high inequalities in healthcare systems? The results of the analysis challenge the distorting effects thesis and points out case law that may enable a more robust debate on equitable access to health.

While the first use of the case law promotes jurisdiction on the right to health, the second one claims to use the litigation of the right to health with caution. The second one challenges the legitimacy of judicialization as a whole. If it is right, then it could undermine the legitimacy of the first one. This cannot be the case for two reasons. On the one hand, the first use is vital for developing the doctrine of fundamental social rights, which is underdeveloped in comparison to the »traditional civil and political rights«.[12] On the other hand, in countries with high inequalities in healthcare systems, litigation is one way »to advance health equity, although this too requires a judiciary willing to enforce it effectively«.[13]

2. THE DISTORTIVE EFFECTS OF LITIGATION RECONSIDERED FROM A BOTTOM UP PERSPECTIVE: THE INCLUSION OF THE LOCAL DIMENSION

One of the recurring diagnoses of specialized literature regarding litigation in the healthcare sector in Latin America is its distorting or unfair effects. It has been suggested that litigation in healthcare brings about more inequality, due to the fact that the people who go into litigation generally come from the middle and upper classes and have healthcare plans, and at the same time judges tend to grant any type of claims, even those that are not covered by law and irrespective of its appropriateness.[14] We name this

12 See Ferrajoli (2002), 13.

13 Forman/Singh (2015), 317; Flood/Gross (2014), 62–72; and related to Colombia: »*tutela* actions [judicial claim] 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.« Young/Lemaitre (2013), 186 [emphasis added, L.C./L.V.] .

14 See a systematization of the literature by Reveiz et al. (2013), 213–222.

diagnosis the »distorting effect thesis«, it has also been used to describe Argentina's case.[15]

However, according to parts of the specialized literature, although there actually are specific contexts, institutional designs[16] and types of decisions that allow us to predict the regressive and unfair effects of judicial health protection, it is also possible to identify other factors that would provide this judicial protection with democratic and redistributive potential.[17] In other words, the distorting effect thesis does not necessarily materialize in all cases. But then, which are the factors that could facilitate this inclusive and redistributive effect?

This question is the starting point of this chapter. Our aim is to find out whether the distorting effect thesis is applicable when considered in the local sphere of litigation rather than in the higher sphere of the judicial branches and supreme courts. For instance, in Argentina most publications on the issue take as a starting point the analysis of decisions made by Argentina's Supreme Court.[18] Therefore, it is also relevant to include studies on *local* cases, due to the health systems' particular functioning in a federal state.[19] This line of research is not the mainstream on the right to health. However, there are pioneering studies such as the one from Biehl, Sokal and Amon. They used a systematic sample of 1,262 lawsuits for access to

15 Gotlieb et al. (2016).

16 In this sense, our work inscribed in the recent line of work that analyzes litigation in relation to the particularities of national health system: »[T]he right to health plays different roles in different types of health systems […] in middle-income countries with big gaps between a poor public health system and a rich private one […] In some of these countries, constitutional rights were included as […] an attempt to address huge inequities within society. Here the scale of health inequities suggests that courts need to be bolder in their interpretation of healthcare rights. We conclude that in adjudicating health rights, courts should scrutinize decision-making through the lens of health equity and equality to better achieve the inherent values of health human rights«. Flood/Gross (2014), 62.

17 Uprimny/Durán (2014), 60; Krennerich (2013); Suárez Franco (2009).

18 For instance, the work of Abramovich/Pautassi (2008), 261–282; Bergallo (2005); Cano (2005), 111–120.

19 On federalism and the right to health in Argentina see, among others: Arballo (2013), 1621–1652; Vita (2013), 17–63.

medicines filed against the southern Brazilian state of Rio Grande do Sul, and showed that

»the majority of patient-litigants are in fact poor and older individuals who do not live in major metropolitan areas and who depend on the state to provide their legal representation, and that the majority of medicines requested were already on governmental formularies.«[20]

They concluded that judicialization »may serve as a grassroots instrument for the poor to hold the state accountable«.[21]

In our work we choose as case study the cases filed in local courts of the Buenos Aires province, for two reasons. Firstly, Buenos Aires has a socioeconomically heterogeneous population. In Buenos Aires, considerable proportion of the population from low-income homes and neighbourhoods coexist with people from middle income and high income homes and neighbourhoods.[22] Therefore, it is best suited to analyse the access of people in situation of poverty to the Courts. Secondly, as explained above, because we are interested in highlighting the local case law to the specialized debate on the healthcare sector.

For our research we focused on a qualitative and quantitative analysis concerning litigation in the healthcare sector. There is no official information as regards the total amount of claims (generally injunctions) about the sector in the province, but we managed to get databases published by the courts (especially the province's Supreme Court), the Argentine System of Judicial Information (Sistema Argentino de Información Jurídica) and judicial reviews to make our sample.[23] Likewise, our research focuses on

20 Biehl et al. (2016), 1; Clérico/Vita (2015), 70–85.

21 Biehl et al. (2016),1.

22 According to the Permanent Homes Survey (Encuesta Permanente de Hogares) and the Basic Food Basket calculated by INDEC in 2010.

23 The sample consists of 172 solved cases between 1995 and 2014 found searching in the Supreme Court of Justice of the Province of Buenos Aires' database (www.scba.gov.ar), the Argentine System of Judicial Information (Sistema Argentino de Información Jurídica) (www.infojus.gov.ar) and La Ley's database (www.laleyonline.com.ar). In all cases the keywords »derecho a la salud«

the actors, claims and decisions taken in the rulings, which include first district courts, courts of appeal and the province's Supreme Court. We make some references to Supreme Court of Justice of Argentina's case law (from now on, the »National Supreme Court«), but only to the claims initiated in the province.

The results, as we will see, show that litigation in the healthcare sector in Argentina confirms only *partially* the distorting effect thesis. It is possible to identify several rulings, some of them in leading cases, in which the plaintiffs belong to vulnerable groups, such as women, children, people with disabilities and the elderly people. In several occasions these are not only individual claims,[24] but rather seek a collective impact, because notwithstanding the fact that they were initiated by one plaintiff, they involve groups of affected people or also seek the implementation of a health care program or agenda or the adoption of public policies for a group of people. There is also a significant tendency in jurisprudence to use a wider conception of the right to health that includes »social determinants of health«.

We will lay out herein below a brief outline of the healthcare mechanism in the province and the different factors that must be taken into account to understand its dynamics and the context in which the local cases are set. Then we will outline the main results of our research on litigation in the province's healthcare sector. Lastly, we will discuss those results in the light of the ongoing debate on litigation and lay out some hypothesis on the possible factors that allow a certain degree of redistributive or democratic effect of litigation in this specific case.

(»right to health«) were used as search criteria, providing as a result approximately 200 files, which in some instances referred to the same cases.

24 Most of the claims are from individuals. Nonetheless, evidence shows that decisions in individual cases are used to solve similar cases. For instance, this is the case of Campodónico de Beviacqua, the Supreme Court in Argentina ordered the State to ensure the continued provision free of charge of a drug against bone disease in the case of a child with disability. Abramovich/Pautassi (2008) sustained that the case of Campodónico de Beviacqua impact direct in the ruling on several cases about medical coverage to persons with disabilities, among others.

3. THE HEALTHCARE SYSTEM IN THE PROVINCE OF BUENOS AIRES: THE LOCAL CONTEXT

Health as a human right issue enjoys robust constitutional and legislative protection in the province. Indeed, the provincial Constitution, as amended in 1994, recognizes the right to health in Article 36.[25]

Nevertheless, the real functioning of the healthcare system replicates that of its national counterpart. The health system in Argentina is one of the most fragmented systems.[26] For instance, such as the national healthcare system, the province's is made up of three subsectors (public,[27] private[28] and social security or social insurance system[29]) that, due to the govern-

25 These constitution can be interpreted as part of the trend highlighted – for example by Flood/Gross (2014) – that includes countries in Latin America and Southern Africa, which have created (or reform) constitutions to include health and other social rights »as part of a strategy to accelerate an equity and equality agenda in the aftermath of legacies of dictatorship and apartheid resulting in enormous disparities between rich and poor.« (Ibid., 64)

26 Health System in Argentine is one of the most fragmented system, »with more than 500 private health-care insurers, national social insurance organizations, and provincial health insurance organizations regulated by provinces, which are responsible for health service provision. Argentina has almost 16,000 health-care providers, including 3000 with inpatient facilities«. Atun (2014), 1230–1247.

27 Public subsystem, under public administration – national, provincial, and municipal – is formed by the network of free-access healthcare providers across the country (hospitals).

28 Private agencies are composed of a complex network of commercial diagnostic institutions, clinics, and pre-pay healthcare systems. This subsystem is funded by private contributions, paid from the users.

29 Social Security, composed of the »obras sociales«, compulsory-membership healthcare plans for salaried workers. The most number of the social security insurances are organized and administrated by labor unions. »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.« Abramovich/ Pautassi (2008), 274.

ment's federal scheme, coexist in the province with the federal subsystems. That is to say, we can be dealing with a national or provincial public subsystem, a private national or provincial subsystem and provincial or national social security systems.

Buenos Aires has 15,625,084 inhabitants. According to official data resulting from census 2010 almost half of them (47.7%) has social security coverage, approximately 15% has private health insurance (5% of them can access it through their social security coverage)[30] and only a 1.28% has some type of state health plan coverage. This means that the rest (35.37%) can only count on the national or provincial public subsystem.[31]

The significance of social security coverage in the province is clear. Its origins are both at the national and provincial level.[32] Within the provincial social security medical coverage, I.O.M.A.[33] is the most important. Its beneficiaries are divided in two groups: members and voluntaries. The first group includes provincial state personnel and public administration employees, teachers, retirees and pensioners from the province's Institute of Social Prevision as well as other state departments. Voluntaries can be individuals, groups, relatives of deceased members, transitory agents, officials with elected posts, judges from the Judicial Branch and state personnel under unpaid leave rights. Also, Malvinas War ex-combatants residing in the province have been incorporated. Nowadays, the total amount of beneficiaries is approximately two million.

The public subsystem includes the network of provincial and municipal hospitals with the main headquarters in the province as well as the provin-

30 On the complex link between private providers and unions' medical care see, among others, Fidalgo (2008).

31 Source: Table P12-P. Buenos Aires Province. Population in private homes by type of medical coverage, according to sex and age, year 2010. Online: http://www.censo2010.indec.gov.ar/resultadosdefinitivos.asp [17.02.2016].

32 Conference given by I.O.M.A.'s President, Antonio La Scaleia, in »Presente y futuro de las obras sociales provinciales«, Asociación de Magistrados del Departamento Judicial de La Matanza. Online: http://www.ioma.gba.gov.ar/archivos/futuro_obras_sociales.html [12.06.2017].

33 Instituto de Obra Médico Asistencial de la Provincia de Buenos Aires (provincial social security medical coverage), see Online: http://www.ioma.gba.gov.ar/index.html [12.06.2017].

cial health programs.[34] Also, the province has a Public Health Insurance (Seguro Público de Salud, SPS) created in 2005. This insurance aims to provide health care for »scarce economic resources population that has got no other type of coverage« (Section 2, Law No. 13.413) and in practice has widened the subsystem's coverage in real terms, with a tendency towards a sanitary model based in the essential concepts of primary health attention, promotion and prevention.[35] Nevertheless, the option of public insurance does not seem to have strengthened the provincial public system. As the Institute of Statistics and Census's (INDEC) statistics show, more than 35% of the population depends exclusively on the public health system. The SPS has had positive effects, but it still benefits a low portion of the population when compared to resources destined to free medical attention in hospitals and regional medical attention centers.[36]

Finally, a last factor to be taken into account is the decentralization process undergone by first level health care services (the primary health attention centers, »CAPS«[37]), now under municipal orbit. While this process has had a positive impact on the primary attention at the national level, several

34 On the province's critical situation of public hospitals see Crojethovich (2013), 2411–2433.

35 Maceira (2008).

36 Yavich et al. (2013), 26–34. This research's objective is to evaluate whether the Province's Public Health Insurance had strengthened its first level medical attention and enhanced the access and integrity of the attention. Towards that objective home surveys were made in eight municipalities (2,413 individuals in all). This allowed them to access information on the use of services among beneficiaries of the Public Health Insurance in individuals younger than eight years. According to the results, more than 95% of beneficiaries received medical care using the insurance and other services. They affirm that the insurance varied among municipalities. They point out that beneficiaries that used the insurance and other services achieved higher attention integrity and access to medical consults than those who used the Insurance exclusively. In the same way, the use of hospitals was significantly lower among users of the insurance. They conclude that the insurance »was more effective while being articulated with the network of municipal services«. And as regards accessibility to health attention in Bahía Blanca through the SPS, see Moscoso Nebel et al. (2010).

37 Centros de Atención Primaria de la Salud.

investigations show that it has had specific negative consequences in terms of equality in the region. Inequality is present among municipalities in the province, due to the disparities in the levels of public spending in the health sector per uncovered inhabitant, which are especially detrimental to residents from the Buenos Aires metropolitan area.[38]

4. LITIGATION IN THE HEALTH SECTOR BEFORE PROVINCIAL COURTS AND THE NATIONAL SUPREME COURT

The results of the analysis of the decisions taken at the provincial first circuit courts, courts of appeals, the Supreme Court of the Province of Buenos Aires and some cases taken by the National Supreme Court can be read from different angles: the content of the claim, the profile of the defendant or the profile of the plaintiff.

As to the content of the claim, most of them are related to medical treatments and the delivery of medicines. As to medicines, most part of the claims focus on different cancer[39] and HIV treatments.[40] Therefore, diseases for which treatments are included in the Mandatory Medical Plan (Plan Médico Obligatorio, PMO), and therefore guaranteed by law. In only one case we found a request for a high-cost medicine to treat a low-incidence

38 Lago et al. (2012), 263–274. In the same sense: Chiara et al. (2009), 97–128; Lago et al. (2013), 40–54.

39 For instance: »A.B.M. c/I.O.M.A.«, Juzgado de 1ra. Instancia en lo Contencioso Administrativo Nro. 1 de La Plata, 20/02/2004; »García, Juan Adolfo c/Medicus S.A.«, Juzgado en lo Correccional Nro. 4 de Mar del Plata, 26/03/2008; »Beccaceci, Mónica Noemi c/MANO SALUD S.A. s/amparo«, Cámara de Apelaciones de Morón, 21/03/2006 y »Alba Eduardo Vicente c/O.S.P.R.E.R.A. s/amparo«, Cámara de Apelación de San Nicolás, 19/6/2007.

40 For instance: »G., E. L. c/I.O.M.A.«, Juzgado de 1ra. Instancia en lo Contencioso Administrativo Nro. 1 de La Plata, 06/09/2004; »B., G. S. c/I.O.M.A.«, Juzgado de 1ra. Instancia en lo Contencioso Administrativo Nro. 1 de La Plata, 12/12/2005; »P., C. H. c/P. d. B. A. y o. s/Demanda contencioso administrativa«, Suprema Corte de Justicia de la Provincia de Buenos Aires, 22/08/2012.

disease.[41] In this same line, in addition to specific treatments and medicines, we found claims to request hearing aid objects, wheelchairs and different kinds of prosthetics.[42]

The second place in terms of amount of requests is connected in one way or the other to what is called »social determinants of health«. This means, the right to health includes an ample variety of socioeconomic factors that promote the conditions through which people can access it, including feeding and nutrition, housing, access to drinking water and adequate sanitary conditions, safe and healthy working conditions and a healthy environment.[43]

In this way, in some cases the State is compelled to guarantee not only medical coverage for individuals or a family but also to address housing emergency situations[44] and the lack of a monthly income.[45] The accessi-

41 »A., A. A. c/M. S. d. A. M. y C. s/Amparo«, Suprema Corte de Justicia de la Provincia de Buenos Aires, 19/02/2015.

42 For instance in: »González de Ricci, María Cristina c/I.O.M.A.«, Cámara 1a de Apelaciones en lo Civil y Comercial de Bahía Blanca, sala II, 12/04/2007; »Divita, Virginia Daniela c/I.O.M.A. s/amparo«, Cámara de Apelación en lo Contencioso Administrativo con asiento en San Martín, octubre de 2010; »H., E. c. Instituto de Obra Médico Asistencial«, Juzgado en lo Correccional Nro. 4 de Mar del Plata, 22/12/2008 y »Ferrari, María L. c. Instituto de Obra Médico Asistencial (I.O.M.A.)«, Juzgado de 1ra. Instancia en lo Contencioso Administrativo de San Martín, 18/06/2004.

43 See E/C.12/2000/4, 11 August 2000, par. 11; Berlinguer (2007), 1; Lema Añón (2009).

44 About the judicialization of the right to housing at the local level to advance equality in favor of the most vulnerable people, see Cardinaux et al. (2013), 33–74.

45 »A., G. C. c/Fisco de la Provincia de Buenos Aires y otra s/amparo«, Cámara de Apelación en lo Contencioso Administrativo con asiento en La Plata, marzo de 2011; »M. A. C. c/Provincia de Buenos Aires«, Juzgado Contencioso Administrativo Nº1, La Plata, 05/2006; »R., J. O. c/Municipalidad de San Fernando s/amparo«, Cámara de Apelación en lo Contencioso Administrativo con asiento en San Martín, 12/2010; »Correa, Sandra Dolores c/Ministerio de Infraestructura viv. y serv. s/amparo«, Cámara de Apelación en lo Contencioso Administrativo con asiento en La Plata, 11/2011; »Duarte, Iris Paola c/Fisco de la Provincia de

bility to a home as a precondition to physical access to medical establishments[46] and families' socioeconomic conditions have also been laid out as a protection in a context of high vulnerability and exposition to epidemics such as Hantavirus.[47]

All referred cases detailed descriptions of the individuals' states of vulnerability and the clear correlation between this situation and access to health. In this same regard we need to mention certain cases taken by the National Supreme Court, mostly close to the December 2001 Argentine crisis,[48] where the right to adequate food is directly connected to health. We refer to the rulings in cases such as »Ramos«[49], »Rodríquez«[50], »Quiñone«[51] and »Esquivel«[52], all of them families with young children living in Buenos Aires Province and women, mothers, who are either the sole or primary breadwinners for the family.[53]

The connection between access to health and social determinants of health appear also in several cases which deal with environmental pollution

Buenos Aires s/amparo«, Juzgado Contencioso Administrativo Nº1, La Plata, 12/2008; »A., G.C. Amparo. R.E.N.-R.I.L.«, Suprema Corte de Justicia de la Provincia de Buenos Aires, 30/10/2013.

46 For instance in »M. A. C. c/Prov. De Bs As.«, Juzgado Contencioso Administrativo Nº1, La Plata, 5-2006.

47 »García, Juan C. y otra c/Municipalidad de Zárate«, Juzgado de 1ra. Instancia en lo Contencioso administrativo Nro. 1 de Zárate-Campana, 28-5-2004.

48 See Maurino/Nino (2014), 299–333.

49 National Supreme Court (from now on CSJN), »Ramos, Marta R. y otros c/Ministerio de Desarrollo Social y Medio Ambiente y otros«, 12/03/2002.

50 CJSN, »Rodríguez, Karina Verónica c/Estado Nacional y otros s/acción de amparo«, 7/3/2006.

51 CSJN, »Quiñone, Alberto Juan c/Buenos Aires, Provincia de s/amparo«, 11/07/06.

52 CSJN, »Esquivel, Roberto y otro c/Buenos Aires, Provincia de y otros s/amparo«, 07/03/2006.

53 The other significant case relating to the violation of right of housing and healthcare is »Q. C.« decided by the National Supreme Court, 24/04/2012, see Clérico et al. (2015).

connected to construction[54] and industrial activities.[55] There are also several cases that dealt with access to drinking water and sanitation.[56] In some of them, the Provincial Supreme Court ordered a municipality to adjust the supply of water to legally established quality standards,[57] also ordering the provider to adjust to such standards for the provision of drinking water in homes.[58]

We found some cases linked to the prevention of affection of health through social determinants of health, such as in a case in which the court

54 »Carrasco, Juan A. y otros c. Delegación Puerto Paraná Inferior, Dirección Provincial de Actividades Portuarias y otros«, Juzgado de 1ra. Instancia en lo Contencioso administrativo de San Nicolás, 16/06/2004; »Guzmán, Juan José c/ Telecom Personal S.A. y Otra s/Interdicto de obra nueva«, Suprema Corte de Justicia de la Provincia de Buenos Aires, 07/05/2014.

55 »Fundación Ecosur, Ecología, Cultura y Educación para los Pueblos del Sur c/Municipalidad de Vicente López y otro, s/Recurso extraordinario de inaplicabilidad de ley«, Suprema Corte de la Provincia de Buenos Aires, 28/12/2010.

56 Asociación para la Protección del Medio Ambiente y Educación Ecológica '18 de Octubre' c/Aguas Argentinas SA y Otros, Cámara Federal de Apelaciones (La Plata) 3156/02, RDAmb 2004-0-193, Online: http://www.ecolex.org:8984/server2neu.php/libcat/docs/COU/Full/En/COU-143728S.pdf [13.06.2017]: collective claim about the violation of the right to health and a healthy environment of the inhabitants who live near the coast of the River Plate in Quilmes, because of the rise of the groundwater level produced by the activities undertaken by a private water company (under a public concession contract), that were not monitored by the competent public authorities.

57 »Boragina, Juan Carlos, Miano, Marcelo Fabián y Iudica, Juan Ignacio c/ Municipalidad de Junín. Amparo«, Suprema Corte de Justicia de Buenos Aires, 15/07/2009.

58 »Conde, Alberto J.L. c/Aguas Bonaerenses S.A. (A.B.S.A.). Amparo-Recurso extraordinario de inaplicabilidad de ley«, Suprema Corte de Justicia de Buenos Aires, 11/2011. In the same sense in »Florit, Carlos Ariel y otro c/Provincia de Buenos Aires y Aguas Bonaerenses S.A. (A.B.S.A. S.A.). s/Amparo. Recurso extraordinario de inaplicabilidad de ley«, Cámara de Apelación en lo Contencioso Administrativo con asiento en La Plata, abril 2011. See Faierstein/Levenzon (2013), 1233–1275.

ordered a provincial road to be repaired so as to prevent accidents,[59] or another in which the court ordered the restriction of gambling games legally promoted by the province, highlighting its link to the promotion of health.[60]

In the same line of claims that contemplate the link among conditioning factors and access to health there finally appears an interesting set of considerations in which some of the structural flaws of the Province's system are highlighted: cases which concern the discussion of public hospitals' conditions, either because the demands focus in the conditions of the buildings' infrastructure[61] or because they focus in the appointment of doctors or nurses in one of the province's pediatric hospital,[62] or also because what is demanded is the cancellation of an x-ray service until the security measures to protect hospital personnel and patients' are met.[63] A common characteristic of these judicial claims is that they do not necessarily respond to the individualistic feature that is predominant in the distorting effect thesis. Indeed, although several of these claims do not reach the level of a structural litigation questioning the inequality of the whole healthcare system, they do present a claim that exceeds the problem of a particular individual or family and that needs a broad type of answer from the State.[64]

59 »O., H. G. c/Dirección de Vialidad de la Provincia de Buenos Aires y otros«, Juzgado de 1ra. Instancia en lo Contencioso Administrativo Nro. 1 de Mercedes, 10-8-2009, see also: WaterLex/Wash United (2014); Winkler (2008).

60 »Juzgado de Faltas 2º (Juzgado de Defensa del Consumidor)«, Juzgado de Faltas Nro. 2 Defensa del Consumidor de la Municipalidad de La Plata, 04/05/2010.

61 »Gutierrez Griselda Margarita y otro/a c/Hospital Zonal A. Korn y otro/a«, Cámara de Apelación en lo Contencioso Administrativo con asiento en La Plata, september 2010.

62 »Gaviot, María Cecilia y otros c/Fisco de la Provincia de Buenos Aires«, Juzgado de 1ra. Instancia en lo Contencioso Administrativo Nro. 1 de La Plata, 29/5/2008.

63 »Espolsin, Miryam E. y otros c. Hospital Bocalandro y otra«, Juzgado de 1ra. Instancia en lo Contencioso Administrativo de San Martín, 14/06/2004.

64 »Florit, Carlos Ariel y otro c/Provincia de Buenos Aires y Aguas Bonaerenses S.A. (A.B.S.A. S.A.). s/Amparo«, Cámara de Apelación en lo Contencioso Administrativo, La Plata, April 2011; »Asesoría N°1 c. Fiscalía de Estado –

In the third place, by amount of claims according to their object, appear cases linked to membership to social security coverage or private health care providers. In most of these claims the discussions focus on waiting periods before the patient can request a service[65] or also the admission of a spouse or partner in an equal set of conditions as those of the actor.[66]

Fourthly, we find a set of judicial decisions that address the lack of execution of certain provincial health programs. For instance, regarding the provincial system of haemotherapy, which had not been implemented in the province for more than eight years,[67] the Provincial Growth Hormone Deficit Program[68] suspended without any reason the delivery of medicines for the year 2007. Likewise, a similar situation occurred with the delivery of medicines in connection with the »PROFE« provincial programme,[69] which

Prov. de Buenos Aires s/Art. 250 del CPCC«, Cámara de Apelaciones en lo Contencioso Administrativo de Mar del Plata, 30/09/2014; Asociación para la Protección del Medio Ambiente y Educación Ecológica '18 de Octubre' c/ Aguas Argentinas SA y Otros [2003] Cámara Federal de Apelaciones (La Plata) 3156/02, RDAmb2004-0-193. Online: http://www.ecolex.org/server2.php/libcat/docs/COU/Full/En/COU-143728S.pdf [13.06.2017].

65 Por ejemplo en »González Bonorino M. c/Ministerio de Salud – I.O.M.A. s/amparo«, Cámara de Apelación en lo Contencioso Administrativo con asiento en Mar del Plata, junio 2012; »Benigni Maria Luisa c/I.O.M.A. s/amparo«, Cámara de Apelación en lo Contencioso Administrativo con asiento en La Plata, octubre 2011.

66 »S.L.N. c/I.O.M.A.«, Juzgado en lo Criminal y Correccional Nro. 1 de Transición de Mar del Plata, 12/03/2002; »M, A. G. c. Instituto de Obra Médico Asistencial«, Cámara de Apelaciones en lo Contencioso Administrativo con asiento en La Plata, 26/11/2004 y »Benítez Roque c/I.O.M.A.«, Juzgado en lo Criminal y Correccional Nro. 1 de Transición de Mar del Plata, 12/9/2005.

67 »Fundación Hematológica Sarmiento c/Instituto de Hemoterapia de la Provincia de Buenos Aires. Hospital Interzonal Especializado s/Amparo«, Suprema Corte de Justicia de la Provincia de Buenos Aires, 03/2005.

68 »Asociación Civil Creciendo c. Ministerio de Salud«, Juzgado de 1ra. Instancia en lo Contencioso Administrativo Nro. 1, La Plata, 14/05/2007.

69 See, for example, »Ramírez Susana c/Ministerio de Salud y otro/a s. amparo«, Cámara de Apelación en lo Contencioso Administrativo de Mar del Plata, 12/2012 and National Supreme Court, »González Fabiana Lucía«, 26/06/2012 y

aims to guarantee access to the right to health for persons with disabilities. What is interesting in this group of cases is that, as in other cases which center on health social conditioning factors, these are not always individual claims that demand the implementation of the provincial programme for a singular person. Rather, in some of these cases, we find collective injunctions (amparos colectivos) referring to the Province's lack of compliance and the corresponding impairment of the population's health.

Finally, we could identify a fifth group of cases linked to reproductive and sexual health. In some of them the plaintiffs request abortion of an anencephalic foetus,[70] artificial insemination currently treatments not covered by the law,[71] and two cases in which women with low-income backgrounds request tubal ligation medical procedures, both cases initiated before the passing of Law No. 26.862 of surgical contraception. In one of the cases the focus is put on the severe health consequences undergone by a person after having a not-safe abortion.[72] Neither in these nor in other cases have we found an approximation to the right to health from a gender perspective.

Additionally, it is important to mention that not many cases have risen in which the object of the claim is the non-intervention of the state. For instance, the one case on blood transfusions to children belonging to a religious group that prohibits them,[73] a case in which parents of a child in its first years deny its right to vaccination[74] and another in which an 84

CSJN, »Insfrán, Alberto – en representación de su hija P. M. I. F. –/c PROFEBA Ministerio de Salud de la Provincia de Buenos Aires«, 11/09/2012.

70 »Parisotti, Fátima Viviana s/Amparo«, Suprema Corte de la Justicia de la Provincia de Buenos Aires, 05/05/2004.

71 Ronconi (2010), 17–28.

72 »N. d. Z., M. V. c/F. S. S. p. l. F. s/Reclamo contra actos de particulares«, Suprema Corte de la Provincia de Buenos Aires, 8/8/2007, see Bergallo (2014), 143–165.

73 »Hospital Interzonal General de Agudos Dr. Oscar Alende (HIGA)«, Juzgado en lo Criminal y Correccional Nro. 1 de Transición de Mar del Plata, 09/05/2005.

74 CSJN, »N.N. o U.,V. s/Protección y guarda de personas«, 12/06/2012; Suprema Corte de la Provincia de Buenos Aires, 6/10/2011.

years old woman requests that her right to a death with dignity be respected.[75]

Now, as regards the profile of the defendants, I.O.M.A. is the defendant with most cases against it. To a much lesser extent appear other agencies/providers of the social security coverage system, »mutuals« or medical insurance providers. After I.O.M.A., the provincial state and municipalities occupy the second place, most times with demands initiated concurrently. It can be identified as a case-law rule that the state providers' heterogeneity (national state, province or municipality; social security agencies) does not matter at all when facing the disease's diagnosis severity or the person's state of need; in general terms the most effective provider is the one which was already bound to render the services and threatens to interrupt them. This means that the complexity and fragmentation of the system is no excuse for the provider not to render the services it should provide under the light of the right to health. A transversal analysis of this case-law allows us to affirm that it is not the person affected with a health problem the one who should bear the burden of the lack of effective coordination among the different subsystems.

One of the most interesting results of this research can be seen in the plaintiffs' profiles. Contrary to what the distorting effect thesis postulates, the predominant profile is not that of high-income individuals. In effect, in several cases the plaintiffs' social and economic vulnerability is highlighted.[76] Plaintiffs are mostly I.O.M.A. members, what means that for the most part they are state employees of the province or volunteers, which implies a wide variety of profiles. A considerable portion of these plaintiffs belong to vulnerable socioeconomic sectors: the elderly, persons with disabilities,

75 »B., I. N. Causa nº 4033«, Juzgado en lo Correccional Nro. 4 de Mar del Plata, 3/10/2014.

76 For instance in: »Torres, Leonardo E.«, Juzgado en lo Criminal y Correccional Nro. 1 de Transición de Mar del Plata, 02/04/2004; »Álvarez, Cristian A. c/Ministerio de Salud«, Juzgado de 1ra. Instancia en lo Contencioso Administrativo Nro. 1 de La Plata, 20/02/2004; »E., C. E. c/Provincia de Buenos Aires y otros«, Juzgado de 1ra. Instancia en lo Contencioso Administrativo Nro. 1 de La Plata, 11/10/2005, apart from the cases already mentioned and many other in which it is mentioned that the plaintiff has the »right to litigate for free«, which means that it cannot afford to pay for the legal services rendered.

women and children living in a state of poverty. Generally speaking, the claimants bringing up a case against I.O.M.A. (or the provincial State) is not a wealthy individual nor do they request expensive or high-tech treatments. As we said before, for the most part requests focus on simple treatments, mainly covered by law.

5. FINAL CONSIDERATIONS

The main aim of our chapter was to challenge the distorting effect thesis taking seriously the bottom up perspective, the analysis of case law initiated and produced at the local level, not the high court's federal level.

Firstly, the content of the claims is not focused on complex judicial matters or unusual medical treatments not covered by the law. The claims are related to medicaments or treatments covered in general by the law. This confirms what evidence shows, that

»[…] the legal structure of the health care system itself – with its emphasis on a defined package of benefits that are part of contract insurance – frequently provides the conditions conductive to litigation of health care rights.«[77]

There are clear cases, where the defendant's breach is obvious and in which the obligation to perform and provide cannot be put off. If the provider does not fulfil its obligations, it is not only impairing the effective right to medical care but also – in a great amount of cases – the survival of the individual.

Secondly, we have observed that do not exclusively arise from an individualistic pattern of violation of the right to health. In several cases these health demands are linked to access to social conditions that enable the exercise of the right, like sanitation and clean water, or to the critical situation of provincial hospitals. They may not be the most numerous, but their existence and variety force us to seek more complex diagnoses.

Thirdly, most cases are against the agency of the provincial social security system I.O.M.A. In regard to the plaintiffs' profiles, the results of our inquiry show that they are not part of the better-off sector of society. In

77 Flood/Gross (2014), 460.

several cases there also appear individuals that belong to the most vulnerable population of society. And while they directly demand the province, they are not only requesting access to healthcare in a restricted way, but also in an ample one, that contemplates social conditions that make the exercise of the right to health possible, such as access to housing, food and education.

In all, these conclusions do not imply that at the provincial level we do not find cases in which middle and high-income individuals demand a private medical company to access some high-complexity treatment that the provider refuses to provide.[78] Or demands granted by judges without taking into account the impact it may have on the state budget. These cases exist, but they are neither the rule nor the most part of case law related to the right to health in the province of Buenos Aires.

That is the reason why we do not take the distorting effect thesis for this local research as an unquestionable truth. Therefore, we present some hypothesis on the factors that contribute to the result that this thesis does not completely materialize in the province of Buenos Aires. Evidently, public law defender services play an important role in specific cases in which the plaintiff could have not otherwise have brought a judicial case.[79] This access to justice is undoubtedly insufficient and requires to be widened with structural claims that addressed the right to health violation from an overall health system perspective.

78 See a. o., Clérico et al. (2013), 1417–1495.

79 Evidence shows that the access to right health litigation for poor people increased when the cases are litigated by the public defense office (Defensoría Pública, publicly funded legal services), which offers legal services for free to people who cannot afford lawyers. Informal interviews with professionals from the public defense office from the City of Buenos Aires revealed the existence of case law at the local level to access to housing as a material condition for the right to health. The plaintiffs are homeless women with children with severe disabilities. Regarding the judicialization of the right to housing at the local level to advance equality in favour of people in vulnerable situation, see Cardinaux et al. (2013), 33–74; Aisenstein (2013), 1845–1869; Pucciarello (2013), 2455–2475; and in connection with judicialization the right to education, Blanck (2013), 40–87.

A second hypothesis deals with a case-law tradition that has been long present as regards the right to medical care in Argentina. Already in the nineties and in a context of a state structural adjustment, the National Supreme Court advanced in consolidating a clear line of guarantees regarding the right to medical care that establishes that if the omission or insufficient action on the part of the state affects the individual's subsistence, then we are clearly in front of a violation against the right to medical care.[80] This line of reasoning follows a case-law sequence from the National Supreme Court that starts with the »Campodónico«[81] case and partially consolidates with »Orlando«[82], »Sánchez«[83], »Passero«[84], »Floreancig«[85] and »Reyes Aguilera«[86] cases, and which we see reflected in the province's courts' analysed decisions.

It is true that the Supreme Court's rulings have not even questioned structural factors[87] of Argentina's healthcare system.[88] There are no cases in which the existence of three coverage subsystems or the forced inequality brought about by the national variable and the resource distribution among the provinces has been questioned. It may be possible that such demand is not something that the argentine society (better said, the privi-

80 It is the urgency argument, which among others was dealt with by Arango (2005).

81 CSJN, »Campodónico de Beviacqua, Ana Carina«, ruling dated 24/10/00.

82 CSJN, »Orlando, Susana Beatriz c. Provincia de Buenos Aires y otros s/amparo«, ruling dated 24/05/2005.

83 CSJN, »Sánchez, Norma Rosa c/Estado Nacional y otro s/amparo«, ruling dated 20/12/2005.

84 CSJN, »Passero de Barriera, Graciela Noemí c/Estado Nacional s/amparo«, ruling dated 18/09/2007.

85 CSJN, »Floreacing, Andrea C. y otro por sí y en representación de su hijo menor H., L. E. c. Estado Nacional«, ruling dated 11/07/2006.

86 CSJN, »Reyes Aguilera, Daniela c/Estado Nacional«, ruling dated 04/09/2007.

87 See this hypothesis in Abramovich/Pautassi (2008); Clérico (2010), 93–118, among others, and confirmed in Gotlieb et al. (2016).

88 In contrast to the Colombian Constitutional Court's ruling T-760 of 2008 that ordered government to address the systemic factors driving right to health litigation. See Yamin et al. (2011).

leged part of it[89] that can push the political agenda) is actually willing to put forward. Therefore, for people living in situation of vulnerability, litigation is the only way they could raise their voices to demand their rights to access to healthcare.

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89 There are different theories that try to explain the structural problems of the health system in Argentina. From a human rights perspective, the main concern must be the problem of inequality to the detriment of people who are in vulnerable situations. Like Tittor, among others, explains in the case of Argen-tina: the structures of the health sector reflect social structures: the influential groups have »privileges«, which they defended for decades, while the poorest groups, especially those that are unorganized, have far less access and quality of healthcare, see Tittor (2012), 49.

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