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Universal health coverage and litigation in Latin America

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Abstract

Purpose – Over the last five years many middle-income Latin American countries have seen a steep increase in the number of cases litigating access to curative services. The purpose of this paper is to explore this complex phenomenon and outline some of its roots and impacts.

Design/methodology/approach – The authors use an interdisciplinary approach based on a literature review and workshops convened to discuss the issue.

Findings – A range of reasons can explain this increased legal activity. These include: a renewed judicial approach to the enforcement of the right to health; a more demanding public interest; an increased prevalence of non communicable diseases; and limited capacity for fair benefit package.

Originality/value – The findings in this paper argue for the need to incorporate a rights-based approach to health policy as a foundation of societal efforts to achieve universal health coverage in Latin America.

Keywords Argentina, Brazil, Chile, Colombia, Costa Rica, Peru, Uruguay, Health care, Health services sector, Latin America, Universal health coverage, Litigation

Paper type General review

1. Introduction

In recent years, several middle-income Latin American countries have seen a steep increase in the number of cases litigating access to curative services and inputs. A renewed judicial approach to the enforcement of the right to health, a more demanding public interest, an increased prevalence of non communicable diseases, and a limited capacity for fair and solid benefit basket design lie at the basis of this phenomenon. Using an interdisciplinary approach and evidence from seven countries of the region (Argentina, Brazil, Chile, Colombia, Costa Rica, Peru and Uruguay), this paper examines this complex phenomenon outlines some of its roots and impacts. Finally, it argues for the need to incorporate a rights-based approach to health policy as a foundation to societal efforts to achieve Universal Health Coverage.

Journal of Health Organization and Management
Vol. 26 No. 3, 2012
pp. 390-406

1477-7266
DOI 10.1108/14777261211239034

The authors of this article wish to thank the over 200 Latin American practitioners that have made possible the existence of this document by generously sharing their knowledge in the Regional Initiative on Priority Setting, Equity and Constitutional Mandates. The views expressed in this article are those of the authors and do not necessarily represent the views of, and should not be attributed to, The World Bank Group.

2. Background

2.1 Constitutional evolution

Over the last 30 years, Latin American countries have undergone major socio-economic and political transformations – including dictatorships to democracies, structural adjustments in fiscal policy, and the opening of markets. A number of countries amended or introduced new constitutions that would give its citizens guaranteed rights, including the right to health (R2H), which was based on the concept of human dignity (Constitutional Court of Colombia, 2003). In addition, several constitutions described the government's role regarding the provision of basic social services especially those related to health and social security, and determined forced them to the allocations of public funds to fulfill these obligations. Furthermore, in such cases where citizens believed their rights are being denied, most constitutions ensure judicial protection (writ of protection) fairly easily and with little cost. This writ of protection not only protects the individual's constitutional rights, but also allows the Judiciary to protect the constitution itself.

Table I shows the most relevant articles present in the constitutions of the seven countries studied that are related to the right to health (R2H) and the writ of protection. It also refers to the fundamentality (a basic human entitlement) and absoluteness (an absolute right is unconditional and cannot be over-ridden) nature of the right to health in these countries.

2.2 The courts

Latin American courts have assumed an increasingly active role in interpreting and protecting those rights, and on several occasions, court rulings have forced the executive branch to redefine its policy priorities. This has mostly been done through the jurisprudence generated while ruling writs of protection. Consequently, the writ of protection has been increasingly used by thousands of individuals who seek the realization of their R2H, a phenomenon also called judicialization of the right to health.

Country	Right to health	Writ of protection	Fundamental right	Absolute right	Year of the constitution
Argentina	Article 41 and 42	Article 43	Yes	No	1853/1860 (1994)
Brazil	Article 6, 196, and 197	Article 5	Yes	No	1988
Colombia	Article 48, 49 and 50	Article 86	Yes	No	1991
Costa Rica	Not explicitly stated. Its existence has been affirmed based on Articles 21, 46, 50, 73 and 74 of the Constitution	Article 48	Yes	No	1949 and its subsequent amendments
Chile	Article 19. n. 9	Article 20	Yes	No	1980
Peru	Article 7, 9. 10 and 11	Article 200	Yes	No	1993
Uruguay	Not explicitly stated. Its existence has been affirmed based on Articles 7, 44 and 72 of the Constitution	Article 332 and Law 16.011 of 1988	Yes	No	1967 (1997)

Table I.
Constitutional articles on the right to health

According to the courts, when administrative inefficiencies or prioritization processes of health services fail to protect an individual's right, the courts' intervention is justified.

As a result, the courts have become the *de facto* overseer and guarantor of policies that affect the R2H. The full impact of this role is yet to be realized.

2.3 Health systems

In the late 1980s and throughout the 1990s, countries all over the world were engaged in health system reforms. Latin American countries were not an exception. In fact, the processes of political and constitutional changes noted before, made the region particularly suitable for the introduction of health systems reforms, which continued in the new millennium.

These reforms intended to tackle health systems' low performance and inequity. Latin American health systems were "fragmented" in three tiers, or subsystems: the private sector, which provided services for those willing and able to pay for services; social security schemes which covered those formally employed; and services provided by Ministry of Health facilities, which were the only source of care for the remaining majority of the population. Not only were the region's relatively high levels of health expenditure (Govindaraj *et al.*, 1997) not being translated into health outcomes, but the high level of out-of-pocket (OOP) expenditures, particularly among the uninsured, made the poor and uninsured not only underserved but proportionally more at risk of falling further into poverty when facing illness (Baeza and Pakcard, 2005).

Inequity in health care provision has been characteristic to Latin America. For example, in Peru in 1996 only 14 percent of child deliveries of the country's poorest women were attended to by trained personal, while the richest had assistance nearly 100 percent of the time. Inequity in deliveries attended by trained personal also existed in Colombia during the same time period, although the disparity was less pronounced; 61 percent for its poorest citizens compared to 98 percent of its richest. Also, while the poor should receive priority in public hospitals, the richest group was using them more often than the poor (Gwatkin *et al.*, 2007). Throughout the 1990s OOP were not only high in the region but financial protection was traditionally associated with formal employment in the region and only a few were insured: 28 percent of the population of Colombia in 1992 (Giedion *et al.*, 2011) and 38 percent in Peru in 2006 (Bitran *et al.*, 2011).

Even though the countries of the region have followed different approaches, improving equity has been at the core of the 1990s reforms for which countries mobilized financial resources; reorganized service delivery; identified health priorities; and some introduced insurance and competition. For example Brazil created a national health system, the Sistema Unico de Saude (SUS – Unified Health System), and Colombia introduced a social health insurance scheme based on the principles of managed competition. Some countries have constructed benefits plans using burden of disease and cost-effectiveness estimates, but the use and technical sophistication of financial risk protection estimates and of participatory processes were limited when not absent. Examples are the introduction of the "Plan Obligatorio de Salud POS and POS-Subsidiado" in Colombia (mandatory health benefits plan and subsidized mandatory health benefits plan); the "Plan Medico Obligatorio PMO" in Argentina (mandatory medical plan); and the "Seguro Escolar Gratuito (free health insurance for

school children SEG) and Seguro Materno-Infantil (maternal and child insurance SIS) in Peru", among others.

Overtime, not only social demands and health needs have grown, but also the importance and understanding of a human rights approach to social policy. However, public policy did not advance at the same pace, and countries were left with benefit plans that did not fully respond to participatory processes and technical criteria that could make chosen priorities legitimate; despite the expansion of coverage and reduction of out-of-pocket payments (OOP) that have occurred overtime (Table II).

Latin America's population is ageing fast (Cepal, 2008) and the incidence, prevalence and mortality due to non-communicable diseases (NCDs) are rising (PAHO, 2009) while medical technology advances (Cotlear, 2011). These factors exercise pressure over health spending and on service delivery capacity. Some Latin American countries already spend a relatively high share of their GDP in health but the absolute amount of resources they spend is not enough to fulfill their needs. Although Latin American countries spend in health a similar proportion of their GDPs as developed countries, their per-capita spending is much lower (Figure 1). However, the decline in communicable disease, ageing of the population and the rise of chronic disease in the region are making health needs similar to those in developed countries. Furthermore, these demographic and epidemiological phenomena have imposed and will continue to impose an increasing burden on the region's health systems, challenging their financing and their capacity to address the more complex health needs of the population. Such a scenario makes the definition of clear and explicit prioritization criteria an imperative. If health systems are not able to adequately respond to these pressures, the trend of increased judicialization of health is not only likely to continue, but to increase.

3. The evidence

The phenomenon of health judicialization has appeared, with variations, in several countries of Latin America, impacting not only government budgets, but also affecting the process in which health resources are allocated. Health litigation can be used for different purposes (medical malpractice lawsuits are not considered human rights litigations). For example in 2004 a group of residents in the Matanza/Riachuelo basin filed a suit before the Supreme Court of Argentina, seeking compensation from damages resulting from water pollution (Supreme Court of Justice of Argentina, 2008). Notwithstanding, litigations demanding access to

	1998 (%)	2009 (%)
Brazil	38	31
Chile	25	34
Colombia	22	8
Costa Rica	21	26
Peru	37	31
Uruguay	18	12
Argentina	28	20
Mexico	52	48

Source: Authors' formulation using WDI data (http://databank.worldbank.org)

Table II.
OOP as percentage of total health expenditure

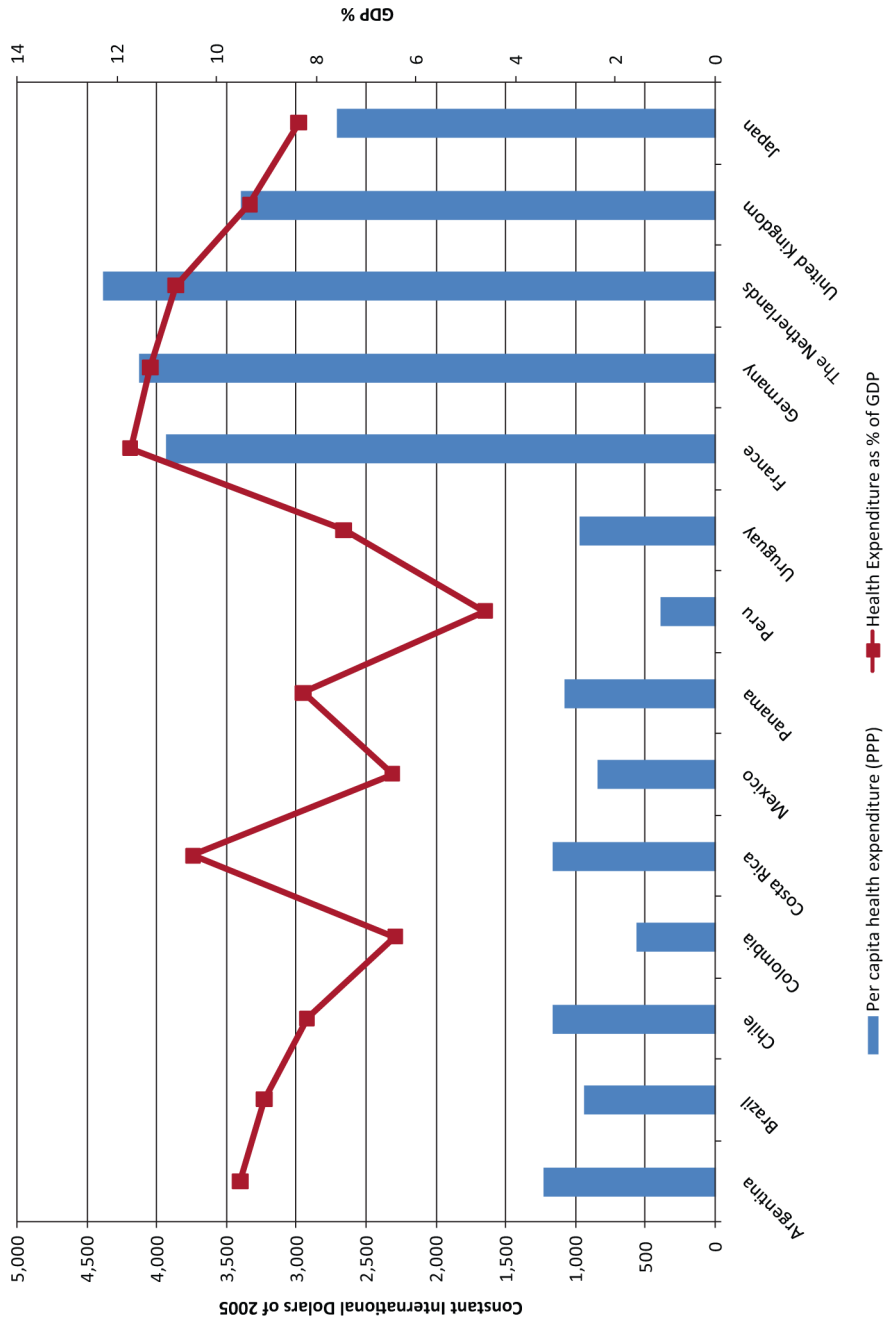

Figure 1.
Constant international dolars of 2005

curative health care are by far the most frequent in the region. Most of these lawsuits affect only one plaintiff (are *inter partes*), and therefore do not necessarily affect the entire population (*erga omnes*).

Information available from the judiciary and/or from payers' databases on the number, nature and costs of cases, as well as on the socio-economic characteristics of the plaintiffs is incomplete, thus limiting a comprehensive analysis of the phenomenon. Nevertheless, the data available suggest a worrisome tendency of increasing judicialization in the seven countries being studied and provide useful information on the overall nature of the phenomenon.

3.1 The magnitude of litigation

Brazil's health care system is decentralized and municipalities, states and the federal government have separate health budgets, with cases brought before the corresponding court. Because of this, it is difficult, to obtain an accurate measure of the total cost of judicialization in the country. It is, however, evident that the number of cases filed across all levels of government and the financial resources spent on paying claims ordered by the courts has increased sharply since 2005 (Figure 2).

In 2010, the Ministry of Health reported that there were 240,000 cases in seven states and at the federal level, totaling payments of approximately US$550 million only on medications (Advocacia – Geral Da União, 2011). The State of Sao Paulo alone, paid US$380 million (Advocacia – Geral Da União, 2011) on claims for high cost medications (exceptional medications), – or 50 percent of its entire annual budget for exceptional medications (Correa, 2010). The State of Sao Paulo reported 24,267 cases between January and July of 2010 (Correa, 2010). In contrast, Ferraz (2010) conservatively estimates a total of 40,000 annual cases for the entire country.

In Colombia, the Ombudsman's Office estimates that there were 95,000 writs of protection in health in 2010, placing it as the most protected fundamental right in the country (Defensoría del Pueblo de Colombia, 2010) (Table III). The Ministry of Health estimates that the direct cost of litigations reached US$300 million only in the Contributive Regime during 2009 (Alfonso, n.d.).

In Costa Rica, Navarro (2010) estimates in 4,000 the accumulated number of writs of protection in health since 1989, including those affecting the Costa Rican Social Security Institute (CCSS, for its Spanish acronym). While there were 179 health cases against the CCSS between 1989 and 1998, in the following ten years (i.e. between 1999 and 2008) that number had increased to 2,524. Not all claims impose higher expenditure in Costa Rica. Some are to ensure opportunity of service skipping wait lists orders (Zambrano, 2010).

In Argentina, where judicialization occurs mostly in the social security subsystem, Bergallo (2010) finds that only one court in the city of Buenos Aires received during 2007 1,159 cases. Uruguay still has a low level of judicialization with 50 writs of protection in five years (Pereira, 2010), but with a growing trend, as seen in the other countries.

3.2 Litigated services and inputs

The relationship between lawsuits to access health care services and the official list of services in benefit plans (from now on, essential services) is shown in Figure 3. Litigation is used to obtain access to both essential (quadrant III) and non-essential

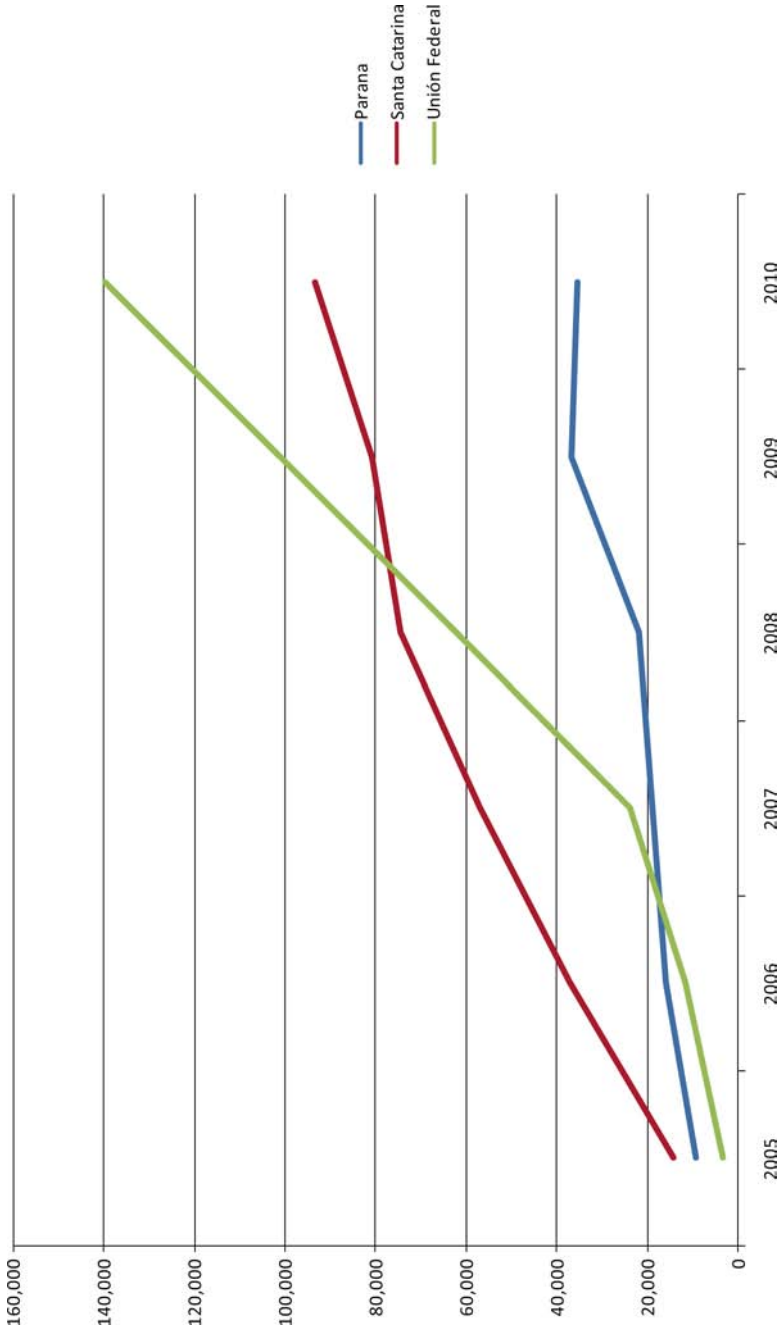

Figure 2.
Trend of direct costs of the writs of protection to federal and states health budgets in Brazil (thousands of 2010BRL)

Year	Total	Writs of protection Health
1999	83,313	21,301
2000	131,764	24,843
2001	133,272	34,319
2002	143,887	42,734
2003	149,439	51,944
2004	198,125	72,033
2005	224,270	81,017
2006	256,166	96,228
2007	283,637	107,238
2008	344,468	142,957
2009	370,647	100,490
2010	403,380	94,502
Total	2,725,361	869,604

Source: Ombudsman Office (2010)

Table III.
Volume of writs of protection in Colombia

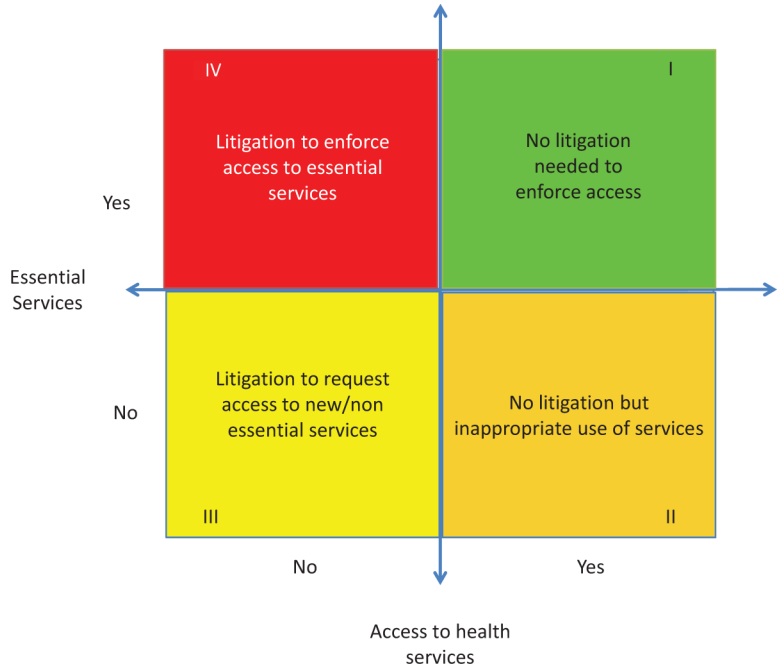

Figure 3.
Litigation to access health care services

services (quadrant IV). This distinction is important, as the former detects deficiencies in the administration and delivery of essential services and errors in the prescription of drugs (Ferraz, 2010), while the latter reflects a direct conflict with the priorities established in the essential services. Examples include the case of branded medications when its generic alternative is in the essential list; new health care technologies or

life-saving medications without a clinical alternative in the essential lists; and services without evidence of clinical effectiveness that are infrequently claimed.

The existing evidence unequivocally shows that some health care technologies are frequently litigated in the region (Table IV).

3.3 Equity

Preliminary evidence suggests that litigation might not be currently used by those most in need. Ferraz (2010) finds the majority of the writs of protection take place in the Brazilian states with the highest human development index (UNDP, 2011). A similar distribution is indicated by existing evidence in the case of Colombia (Figure 4). Vieira and Zucchi (2007) and Chieffi and Barata (2009) reported that the largest proportion of claims in the city of São Paulo originate from the neighborhoods with the lowest levels of exclusion or social vulnerability. In Argentina, Bergallo (2010) finds that the majority of writs in the City of Buenos Aires are not claims from low-income areas. In Colombia, the number of writs of protection filed in the Contributory Regime, which has a more comprehensive essential list of services and is directed at the non-poor, was six times higher than in the Subsidized Regime (Cepeda, 2012).

3.4 Structural litigations and court decisions

We have, until now, discussed the most common types of litigations, those aimed at protecting the R2H of an individual or a group of individuals by granting access to essential and/or non-essential services. Although less common, there are also litigations and court decisions that can affect the health system's structure and/or functioning. These refer to rulings ordering the executive and/or legislative branches of government to modify health policies in order to enhance the protection of the R2H of many. In Chile, for example, judicialization has been mostly related to the premium paid by vulnerable groups – women of reproductive age, elderly and children under two years of age – to private insurance plans (ISAPRES). After ruling on an increasing number of individual cases (Table V), the Constitutional Tribunal declared unconstitutional risk-adjusted premiums affecting almost three million individuals. The Court entrusted its redress to the legislative and executive branches of government (Tribunal Constitutional de Chile, 2011).

In 2009, the increasing number of writs of protection in health led the Brazilian Supreme Federal Tribunal to call for a public hearing. During this public hearing the court heard from all groups of society their thoughts about the judicialization in health (Supremo Tribunal Federal, 2010). Although the approach of the Brazilian judiciary to

Table IV.
Non-essential health care technologies litigated in the region

Associated medical entity	Litigated health care technology
Oncology	Rituximab, Cetuximab, Imatinib, Transtuzumab
Autoimmune	Etanercept, Infliximab, Adalimumab
Lysosomal storage diseases	Imiglucerase, Agalsidase
Coronary heart disease	Clopidogrel
Epilepsy	Lamotrigine
Diabetes	Insulin Glargina

Source: Machado *et al.* (2011); Alfonso (n.d.); Vargas (2010); Norheim and Gloppen (2011); Correa (2010)

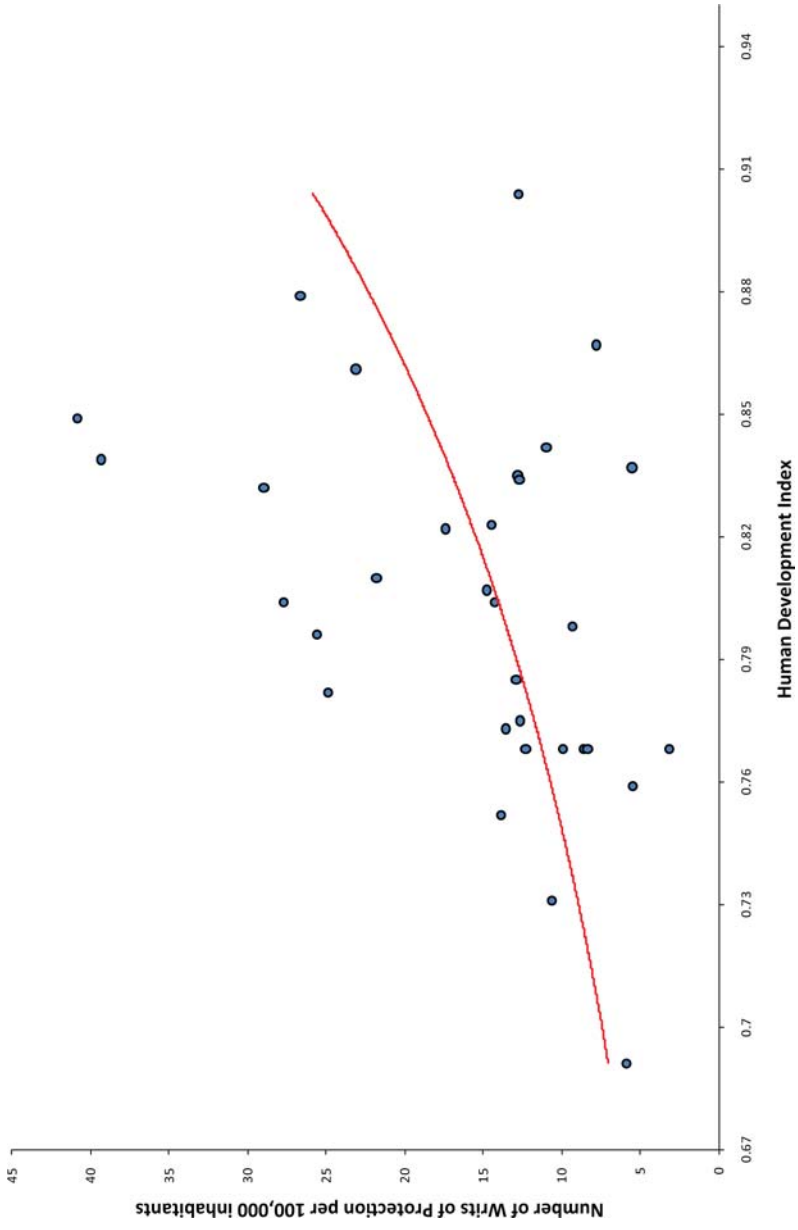

Figure 4.
Correlation between vulnerability (HDI) and volume of litigation in Colombia

writs of protection has not significantly changed, this public hearing fostered a renewed participatory dialogue that led to the approval in May of 2011 of a reform of the decision-making process used to determine the essential list of medications.

In sentence T-760 of 2008, the Constitutional Court of Colombia calls for structural changes in the health system. According to the court, the regulation of the health system was flawed and, therefore ordered the executive to amend it. The court also ordered the adoption of a unified essential list of services for children under 18, and a posterior unification of lists for the rest of population, to be implemented according to resource availability. Furthermore, the Court has been tracking the fulfillment of its ruling using provisions and a public hearing, of which the Court has recently published a report (Corte Constituticional de Colombia, 2010). Following this ruling, the Colombian health authorities have reviewed the regulatory framework, and began the progressive unification of the essential list of services for the entire population (Republica de Colombia, 2010).

4. Discussion

In order to better understand the judicialization of the right to health in Latin America, it is necessary to take into account the cultural, historical and ideological context in which deontological, and consequentialist precepts coexist, but often clash. This becomes evident in the described resource allocation tension between the judiciary and health authorities. Interestingly, this tension occurs in many countries of the region independently of the judicial model or type of health system adopted.

Several factors may contribute to explain today's phenomenon: first, public interest has changed. During the 1940s in Costa Rica, public interest demanded public solutions to health issues; during the 1970s, universal health coverage was demanded. Nowadays, Costa Ricans demand timely, high quality and service oriented health care (Navarro, 2010).

Second, constitutions and notions of state have also changed, creating fertile ground to accept citizens' demands. Third, there is an increasing judicial activism where a renewed public interest finds the willingness of courts to study these demands. Thus, the greater the success of the citizenry demands, the greater the possibilities of extending the intervention of the Judiciary to other areas besides health care.

Fourth, health systems in the region maintain prioritization and resource allocation processes that still lack of sufficient technical validity, transparency, participation and accountability. Finally, demographic and epidemiological transitions are shaping population's clinical needs, while a larger and more expensive array of health care technologies are available to face such needs.

Table V.
Writs of protection in health in the private sector

Year	Writs of protection to the private health sector	Percentage of the total of writs of protection
2007	737	32
2008	5,214	75
2009 (six mos.)	4,357	83

Source: Informe de la Comisión Presidencial (2010)

4.1 Impact of judicialization of the right to health

The impact of judicialization of health care services is different in each country and thus should be studied in relation to its own socio-economic, political and institutional context (Garavito, 2010; Pavlovic and Cubillos, n.d.). Nonetheless, from a synoptic view from the experience of the seven Latin American countries studied, it is possible to identify some of the changes brought by litigation (for simplicity referred here as "impact").

4.1.1 Positive impact. It is evident that R2H litigation has held governments accountable for their constitutional duties (Gloppen, 2008). Previously, thousands of individuals did not have administrative or judicial mechanisms to enforce their rights if and when those were considered affected. Litigation has saved lives; such is the case of the Acute Hemorrhagic Fever Vaccine in Argentina (Del-Cerro, 2010).

Litigation has also raised awareness among all members of society of individual rights and government's responsibilities (Hartlev, 2011). The traditionally discretionary authority of the Executive branch of government to allocate public resources is now being held accountable for its decisions. For instance, the Brazilian Law 12.401 of 2010 introduced after the Supremo Tribunal Federal's public hearing, seeks to elucidate the criteria used to assess health care technologies and to subsequently allocate resources.

Judicial evaluation of health policies assesses their constitutionality and the adoption of rights-based principles. Furthermore, judicialization has allowed for democratic deliberation to have a role in policy design and monitoring, reinforcing checks and balances, foundational elements of a democracy (Rodriguez, 2010). As previously mentioned, the Chilean Constitutional Tribunal, the Brazilian Supreme Tribunal, and the Colombian Constitutional Court have introduced public hearings as part of judiciary interventions, involving major stakeholders, including civil society organizations.

A progressive realization of the right to health requires a consistent critique of governments' actions by society as a whole. The State may not always have, for example, the incentive to update its essential list, thus slowing down the progressive realization of the R2H. Often, judicial interventions challenging the status quo have pushed the frontier of public policy to include important benefits for society. This has had the positive effects of maintaining the need to update the essential lists in the government's agenda and of reaching patients who otherwise would continue to be underserved. For example, following litigations brought before courts by organized groups of patients, Chile, Costa Rica and Brazil passed national laws in which HIV prevention was prioritized and its treatments were included in the essential lists. It must be noted, however, that these litigations also create a precedent for an increasing large group of organized patients to follow the same path.

4.1.2 Negative impacts.

4.1.2.1 Financial. The traditional path followed by the judiciary of litigating individual cases may hide from view their cumulative effect. Litigation in 2009 forced the municipality of Campinas in Brazil, with a population of one million to allocate 16 percent of the health budget to medicines to treat 86 new patients (Advocacia – Geral Da União, 2011). In the same year, Colombia allocated 5 percent of its health budget to pay for individual lawsuits (Yamin, 2010), and the Costa Rica's Social Security Institute (CCSS) quantified the direct cost of judiciary rulings in 1 percent of its total

medication's budget (without incorporating the *erga omnes* effect, thus underestimating the real impact). Further research is needed to fully understand the direct financial impact as well as the opportunity costs associated with the overall process of judicialization.

Claims for accessing curative care for NCDs, particularly oncology, autoimmune, diabetes and orphan diseases are among the most frequent cases brought to the courts (Table IV). Interestingly, pharmaceutical markets with the highest growth potential are directed to treat those conditions (IMS Institute, 2011) and, at the same time, the value of the Latin American pharmaceutical market increased from USD 40 billion in 2009 to US$63 billion in 2012 (Cercone, 2011) growing 50 percent in three years. Meanwhile, the national GDP's are expected to grow, on average, under 7 percent annually (IMS Institute, 2011). Consequently, it is advisable to better understand the potential future financial consequences of health care technology uptake.

4.1.2.2 Equity and efficiency. There are two main equity-related concerns that arise from the process of judicialization in health. First, access to justice, like access to health, is unequally distributed as it is conditioned by socio-economic factors (Hoffman and Bentes, 2008). Consequently, is possible that litigation is forcing an unequal resource allocation, which would be even of great concern if it undermines access to services for the most vulnerable. In summary, while the process of judicialization aims at addressing a real and legitimate problem of the region, the inequitable access to health services and inputs, it may be, unintentionally, generating a different type of inequity, and/or reinforcing existing ones, as those that already have better access to health are also likely to have better access to the judicial system. Second, the lack of collective actions (*erga omnes*) may generate horizontal inequities, i.e. the equal are treated differently. In addition, the phenomenon of judicialization may have efficiency consequences, as it may lead to an increase of investments in health care technologies that otherwise might not be prioritized (Norheim and Gloppen, 2011). The process of judicialization is creating a context in which courts are, in some cases, *de facto* defining health sector priorities and thus policies, a task that is beyond their capacity and mandate.

4.1.2.3 Medical sustentation of judicial decisions. When ruling a case, some courts have systematically favored the concept of the treating physician over the opinion of peer clinical experts or the clinical protocols of the health authority. While courts are under pressure to solve cases in a short period of time, medical autonomy needs to be balanced with the fact that in complex clinical cases an individual medical opinion may not necessarily be the most suitable (Chaix-Couturier *et al.*, 2000; Sturm *et al.*, 2009). This positioning poses three main risks:

(1) It may force the system to deliver drugs/services for which there is no evidence of its clinical effectiveness.

(2) Treating physician may have a conflict of interest that could bias his/her medical opinion. In such cases the courts might be forcing, for example, the delivery of drugs that are not yet proven to be clinically effective, or that are suboptimal for a patient's condition.

(3) The courts' decisions could be suboptimal for society as a whole given the opportunity cost of no delivery of other services.

It is still early to quantify all these effects and better data and future research on these issues is needed.

5. Conclusion

As judicialization is on the rise in Latin America, courts are now key actors of health policy. As the existence of checks and balances are central to well functioning democracies in the region, today the judiciary not only protects civil and political rights but is also increasingly protecting the R2H.

However, not surprisingly, court rulings have generated tensions with health authorities, as most writs of protection are inter partes and granting access to curative services/inputs. Furthermore, courts have generally not accepted resource constraints as the main justification to deny access to non-essential services. Preliminary evidence suggests that these allocations defined by the Judiciary may result in worsened inequities or in the provision of ineffective services. A smaller, but more outreaching, subset of rulings mandates fundamental redress in health policy. By adding democratic deliberation to this redress courts may substantively improve policy design and monitoring.

Developing fair, transparent, technically sound and progressive priority setting processes is at the top of the next generation policy challenges that Latin American health systems face. To achieve this improved data and health information systems are a necessity. Judicialization of the R2H has evidenced weaknesses in these processes, particularly as health systems fail to provide solid reasons for health technology exclusions. According to the courts, arguments solely based in resource constraints may hide inefficiencies, incapacities, or even corruption hence they cannot be reasonably accepted to deny access to care. However, the non-absoluteness of R2H is not in question.

Epidemiological and demographic transitions will continue to affect health systems, as service needs increase and costs rise. Not surprisingly, non-essential high-cost NCD treatments are among the most commonly litigated services in the region. A human rights approach to complex decisions may provide health systems with a unique opportunity to review decision-making results and procedures. Furthermore, achieving universal health coverage will require a participatory dialogue to legitimately decide resource allocation and technology. Increased transparency and accountability will not only improve human rights protection but ultimately will also strengthen health systems.

The experience of these seven Latin American should draw the attention of other developing countries within and outside the region, particularly now when many are committed to expanding population and service coverage. Courting social rights (Gauri and Brinks, 2008) is an increasingly common global phenomenon with cases arising both in common and civil law countries, and in insurance and non – insurance based health systems. Promoting a fluid dialogue between consequentialist and deontological approaches, between human rights and health systems will be certainly beneficial.

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