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How does litigation affect health financing?

Ottar Maestad¹, Octavio Ferraz,² Alicia Ely Yamin,³ Ole Frithjof Norheim,⁴ Siri Gloppen⁵

In the last fifteen years, judicial claims to secure health services as a matter of right have become an important phenomenon in a number of countries including South Africa, India, Brazil, Colombia, Argentina, and Costa Rica. Little systematic empirical information is available with respect to the impact on health financing of such litigation. However, a multi-disciplinary research project coordinated by the Chr. Michelsen Institute provides some preliminary findings.

Impacts can be sizeable, but contexts vary significantly

Under certain circumstances, health rights litigation can significantly affect health budgets. In a number of Latin American countries, individual claims are relatively easy to bring and yield rapid relief for petitioners. However, this is not the case in India where both the costs of bringing individual claims and delays in the judicial system are high. Thus, in Brazil, Argentina and Colombia, tens of thousands of individuals bring claims each year to get access to different medications and services. Many, if not most, of these services and treatments should be provided under national plans, and therefore should not incur additional budgetary outlays when financing is done through capitation. In purely public funded schemes, litigation will produce costs even in such cases, but these “quality-skimping” cases are materially different from cases in which medications or treatments sought fall outside of the national scheme. Indeed, it is often claims for medications and treatments that are not included in national plans, and which tend to be highly costly, that create the largest financial impact of litigation. For example, in Sao Paulo, the largest state in Brazil, expenditures for drugs triggered by litigation amounted to 25% of the drug budget and 4.3% of the total health budget in 2008.

Preliminary evidence indicates significant variation in how the costs induced by litigation are financed, whether through budgetary reallocation, raising additional revenues, or reductions in fraud, waste and inefficiencies.

Exploiting individual opportunities v. health system change

While most litigation related to services and treatments is brought by individuals who seek to exploit the opportunities within the health system, there are also examples of strategic litigation and judicial decisions aimed at more fundamental changes in the health system. Examples include the Treatment Action Campaign in

¹ Director, Christian Michelsen Institute

² Assistant Professor of Law, University of Warwick

³ Joseph H Flom Fellow on Global Health and Human Rights, Harvard Law School, Adjunct Lecturer, Harvard School of Public Health, Associated Senior Researcher, Christian Michelsen Institute

⁴ Professor of Medicine, University of Bergen

⁵ Research Director, Christian Michelsen Institute, Professor of Political Science, University of Bergen

South Africa, which extended PMTCT services to mothers and children throughout the country, and HIV/AIDS litigation in India which ensured universal life-time access to first-line anti-retroviral treatment.⁶ Another example is Judgment T760/08 by the Constitutional Court of Colombia, which aims at increasing coverage and equalizing benefits for those earning less than twice the minimum wage or outside of the formal sector.

The pro-poor impacts of litigation for system change contrasts with the impacts of litigation for individual benefit. Data from Brazil, Colombia and Argentina indicate that individual litigation directed at exploiting opportunities within the health system has tended not surprisingly to benefit the middle classes – who have greater access to courts – more than the poor. The long-term socioeconomic gradient of health rights litigation depends partly on whether court orders create precedents or whether health authorities respond to multiple individual judgments cases by universalizing access to a given treatment.

Potential reallocation of health budgets

Again, under certain circumstances, health rights litigation may increase the share of health budgets allocated to curative care, as opposed to public health measures. The high numbers of individual cases in Latin America involving medication and various other treatments reflects both that private demand for curative health care tends to be stronger than for preventive services and that collective suits more apt to public health measures can be more difficult to bring before the courts.

Preliminary data indicates that a substantial share of the individual treatments that are not included in national health plans but are nevertheless granted through court orders has relatively low cost-effectiveness. In several countries, litigation began to secure ARV therapy for AIDS victims. The profile of claims has changed over time to include advanced and costly treatments for cancer, hepatitis C, multiple sclerosis, etc. Where they are flooded with individual cases, courts often do not have readily available evidence on cost-effectiveness, or lack good procedures for evaluating it alongside other rights considerations.

In short, to delineate the impact of health rights litigation on health financing is difficult, not only due to data limitations, but also because the health financing system may itself affect judicial interventions.⁷ Existing evidence portrays a mixed picture where litigation on the one hand may force greater governmental responsiveness and open a path to systemic changes, while in other cases litigation may exacerbate existing inequities in health.

Further information:

AE Yamin and S Gloppen eds, *Litigating health rights: Can courts bring more equity to health?* (Cambridge, MA: Harvard University Press; forthcoming, 2011).

⁶ Litigation to ensure universal access to second line treatment is presently pending.

⁷ See e.g. Constitutional Court of Colombia. *Sentencia T-760/08* (2008) Magistrado ponente: Manuel José Cepeda Espinosa.