Local Maladies, Global Remedies

Reclaiming the Right to Health in Latin America

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The promise of the right to health, and why we have to keep it: closing reflections

A. QUITTING THE RIGHT TO HEALTH?

One of the defining features of the right to health in the Global South is expressed by the fact that the judicialization of health care, the configurations of social and legal mobilization, and the regulation of health technologies, are being shaped by the growing demands for pharmaceutical products used in the treatment of chronic medical conditions and noncommunicable diseases (NCDs). Middle-income countries like Brazil and Colombia try to respond to such health-care demands while, at the same time, patients deploy litigation as a mechanism to obtain costly biotech drugs, all of which generates an adverse effect on equity and on public health budgets. Physicians and scientists participate in global research networks that tend to privilege brand-name drugs over generics and biosimilars, and Big Pharma companies build coalitions with key stakeholders to defend their economic interests against those of competitors and government regulators. Under the conditions set by the complex political economy of health care, transnational pharmaceutical companies are influencing not only the litigation of the right to health; they are also redefining the mobilization of patients' interests, molding doctors' preferences for brand-name drugs with questionable innovative value, impacting the regulation of drug prices, and determining the availability of cheaper generics and biosimilars.

In highly litigious countries like Brazil and Colombia, pharmaceuticalization has made the conundrum of the right to health even more acute. By *pharmaceuticalization*, in this book I mean the disproportionate importance accorded to brand-name drugs in the judicialization of health care and in the perceptions about the right to health among patients, litigants and judges. In Colombia and Brazil, the move towards pharmaceuticalization was clearly established during the second period of litigiousness (2000–2020). In that juncture, patients' organizations and litigants became closely associated with the interests of large pharmaceutical companies and focused their advocacy work on obtaining costly biotech drugs for the treatment of chronic medical conditions like cancer. In both countries the shift towards pharmaceuticaliza-

tion had a negative impact on the way litigants and judges conceive the right to health as a transformative tool with the potential to distribute scarce health resources.

Another adverse effect of the pharmaceuticalization of health care can be assessed in terms of equity. A growing scholarship asks whether the judicialization of health care has fostered the unequal distribution of health care by assigning costly drugs to a privileged set of litigants, skewing resources away from poor patients in favor of the more affluent. More precisely, the cases of countries like Colombia and Brazil offer enough evidence to hypothesize that the enforcement of the right to health in Latin America is characterized not only for being highly individualized, routinized and pharmaceuticalized, but also for being at loggerheads with the equal distribution of scarce health resources.

The tendency towards pharmaceuticalization is not only observable in the judicialization of health care, but also in the trajectory of health mobilization in Latin America. During the past decades there has been a progressive decline of globalized social movements that advocate for access to affordable health care. At the same time, we have witnessed the emergence of a fragmented, divisive, and localized legal mobilization led by patients' groups whose demands are centered on brand-name medicines. More concretely, during the 1990s and early 2000s the agendas of transnational advocacy networks (TANs), centered on access to affordable HIV/AIDS medicines, permeated Latin American policymaking, litigation, and social mobilization. However, during the past two decades (2000–2020) HIV pro-generics activism was gradually sidestepped by a diverse configuration of patients' groups whose agendas are focused on demands for brand-name medicines. In Colombia, Brazil and Costa Rica, there are clear indications that patients' groups are supported by transnational pharmaceutical companies interested in financing health-care lawsuits as an indirect mechanism to boost their sales.[1]

Facing the contradictions of the right to health in the Global South, we should give serious consideration to the arguments of some politicians, policymakers, and scholars,[2] according to which the litigation and adjudication on the right to health should be reformed, restrained, or eliminated altogether. In

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[1] Siri Gloppen and Mindy Roseman (2011), "Litigating the Right to Health: Are Transnational Actors Backseat Driving?" in Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?*, Cambridge, MA: Harvard University Press; Everaldo Lamprea (2015), *Derechos en la Práctica*, Bogotá: Los Andes University Press.

[2] Octavio Ferraz (2011b), "Latin American Constitutionalism: Social and Economic Rights: Harming the Poor through Social Rights Litigation: Lessons from Brazil," *Texas Law Review*, 89, 1643–977.

Colombia and Brazil, right-wing governments have tried to curb right-to-health litigation alleging, as scholars like Ferraz do,[3] that the judicialization of health care harms the poor and worsens inequalities.[4] In Colombia, the conservative government of Álvaro Uribe went to great lengths to slash the litigation on socioeconomic rights, putting a particular emphasis on the need to constrain the litigiousness on the right to health—one of the most litigated rights in the country. However, Uribe's attempt utterly failed when patients, doctors and civil society organizations took to the streets and protested the government's proposals to reform the rights-based injunction—*tutela*—that is widely used in Colombia to demand drugs and health services. However, the project to clamp down on the right to health is very much alive in both countries.

Should we be skeptical, then, about the concept and practice of the right to health, plagued by contradictions that may have rendered it unable to promote fairness and to alleviate the situation of vulnerable individuals in dire need of health care?

I would like to stress in these closing remarks that despite the appeal of the calls to abandon the project of materializing the right to health, citing equity, budgetary and ethical concerns, the reasons to keep the promise of the right to health are today more pressing than ever, especially in a context where the COVID-19 pandemic has laid bare the urgent need to provide health care to all as a basic human entitlement.

B. BRAZIL AND COLOMBIA: TWO SOCIAL LABORATORIES FOR THE RIGHT TO HEALTH

It is difficult to think of countries other than Brazil and Colombia where the right to health has been experienced in such unique and puzzling ways by laypeople, litigants, judges and policymakers. It is also unlikely that, in other countries, the right to health has become so deeply ingrained in the legal culture as in Brazil and Colombia. From its origins in the early 1990s, to the current litigation epidemic, the two neighboring South American countries have functioned as social laboratories where the right to health has gone through major transformations.

Brazil's 1988 and Colombia's 1991 constitutions not only rekindled the main institutional arrangements that allow the different branches of government to function; they also ushered in a new era of rights that radically altered

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[3] Octavio Ferraz (2009b), "The Right to Health in the Courts of Brazil: Worsening Health Inequities?" *Health and Human Rights*, 11(2), 33.

[4] Tatiana S. Andia and Everaldo Lamprea (2019), "Is the Judicialization of Health Care Bad for Equity? A Scoping Review," *International Journal for Equity in Health*, 18(1), 61.

the way Colombians and Brazilians conceive their role in a democracy. The DNA of both constitutions lies less in the governing principles of decentralization—in Colombia's case—or federal government—in Brazil's—than in the bill of civil, political, and socioeconomic rights that the Brazilian and Colombian constituent assemblies enshrined as the blueprint for defining the state's obligations towards its citizens.

The history of the right to health in Brazil and Colombia illustrates how the 1988 and 1991 constitutions were rapidly appropriated by vulnerable groups who, facing deep-seated situations of destitution and exclusion, found in basic rights and in rights-based litigation the only effective mechanisms to challenge discriminatory practices that were widely extended and even tolerated in both countries.

In the case of health care, and thanks to the rights revolutions bolstered by the 1988 and 1991 constitutions, HIV/AIDS litigants pioneered, during the early period of litigiousness (1990–2000), a novel notion of the right to health that conceived of access to life-saving drugs and medical treatments as a basic entitlement that patients could demand from their governments using rights-based litigation. Taking advantage of the recently enacted constitutions, which incorporated effective and informal injunctions for the protection of basic rights, HIV/AIDS patients in Brazil and Colombia embodied the role of litigants and cause lawyers. Pioneering HIV/AIDS advocates were not only litigants who defended, by means of judicial mechanisms, the interests of persons living with HIV/AIDS (PLWHA); they were also activists who took part in global and local HIV social movements. The lawsuits that litigants filed at local and higher courts on behalf of PLWHA nudged governments and ministries into implementing policies and programs that, over the years, significantly reduced barriers to accessing HIV/AIDS treatment for all patients.

In a context of widespread discrimination against PLWHA, the Colombian Constitutional Court and the Brazilian Federal Supreme Court were receptive to the first wave of HIV litigation. A highly innovative judicial precedent, which set the foundations of the minimum core of the right to health in both countries, allowed PLWHA to further deploy litigation to obtain antiretroviral (ARV) therapy. But more importantly, the accumulation of judicial orders favorable to plaintiffs pushed the Brazilian and the Colombian health systems to include state-of-the-art ARV drugs in health benefit plans.

The groundbreaking litigation conducted by HIV/AIDS litigants not only saved thousands of lives, but also produced a seismic shift in the way Brazilians and Colombians understood the right to health. Additionally, the judicialization of health care during this first period gave shape to a type of litigation focused on demands for drugs and health services that claimants considered indispensable to guaranteeing their physical subsistence.

However, HIV/AIDS litigation during the early 1990s, conducted by support structures of rights lawyers and civil society organizations like those that prompted a rights-based legal mobilization in the United States during the 1970s,[5] was short lived. By the early 2000s the litigation model of cause lawyering was no longer an appropriate framing to account for the accumulation of thousands of lawsuits clustering around individual demands for a wide array of medications and treatments. But more importantly, a new approach to litigation centered on the demand for costly brand-name drugs used in the treatment of noncommunicable diseases took hold of the practices of litigants and judges. That approach to litigation cast serious doubts on the transformative potential of the judicialization of health care in Colombia and Brazil, where the litigation epidemic[6] of the right to health had deleterious effects on public budgets.

Brazil and Colombia became, during the 2000s, the only two Latin American countries that experienced a major escalation of litigiousness centered on the right to health. Additionally, in both countries the right to health underwent deep transformations marked by the turn towards the *pharmaceuticalization of health care*—i.e., a disproportionate emphasis on pharmaceutical expenditure inimical to a more robust public health approach.[7] One of the most salient features of pharmaceuticalization can be observed in the judicialization of health care, which became associated in Brazil and Colombia with patients' demands for brand-name, costly pharmaceutical products. In both countries, the judicialization of health care had negative effects on the fiscal stability of health systems and on the government's ability to allocate scarce health resources. Moreover, the complex political economy behind the judicialization of health care in both countries has led scholars to raise the question of whether transnational pharmaceutical companies are the main beneficiaries of the surge of health rights litigiousness.[8]

The support structures for legal mobilization also experienced deep transformations during the second wave of litigiousness in Brazil and Colombia. The particularities of HIV litigation during the 1990s and early 2000s required an active role of transnational advocacy networks (TANs) and NGOs. However,

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[5] Charles Epp (1998), *The Rights Revolution: Lawyers, Activists, and Supreme Courts in Comparative Perspective*, Chicago, IL: University of Chicago Press.

[6] Alicia Yamin and Siri Gloppen (eds) (2011), *Litigating Health Rights: Can Courts Bring More Justice to Health?*, Cambridge, MA: Harvard University Press.

[7] Adriana Petryna and Arthur Kleinman (2006), "The Pharmaceutical Nexus," in Andrew Lakoff, Adriana Petryna, and Arthur Kleinman (eds), *Global Pharmaceuticals: Ethics, Markets, Practices*, Durham, NC: Duke University Press.

[8] Gloppen and Roseman (2011), "Litigating the Right to Health: Are Transnational Actors Backseat Driving?"; Lamprea (2015), *Derechos en la Práctica*.

as HIV policy stabilized in both countries and as TANs and NGOs succeeded in mitigating widespread discrimination against PLWHA, the importance of civil society support structures for health rights litigation gradually decreased. Instead, what we are witnessing today in both countries is the emergence of litigation support structures led by patients' organizations financed by pharmaceutical companies, all of which is weakening the cohesiveness of social mobilization and is allowing Big Pharma companies to profit from the wave of lawsuits that demand access to expensive biotech drugs.

Facing a litigation epidemic with disruptive effects on the financial stability of the Brazilian and Colombian health systems, the Colombian Constitutional Court (CCC) and the Brazilian Federal Supreme Court (BFSC) signaled, in 2008 and 2009 respectively, a new approach to the judicial enforceability of the right to health. Following a dialogic and multilateralist perspective to adjudication,[9] both higher courts convened public hearings where government officials, experts, civil society organizations and patients' groups came together to devise, in a deliberative fashion, alternatives to de-escalate a form of litigiousness centered on the demand for costly drugs and medical treatments excluded from health benefit plans.

There are comparative advantages and disadvantages in the Brazilian and Colombian strategies to contain the surge of health rights litigiousness. In both countries the attempts to contain the litigation epidemic of the right to health were aimed at changing the judicial precedent, instituting technocratic agencies to evaluate the cost-effectiveness of drugs and treatments, and designing focused health system reforms. Although some of these measures proved to be helpful, they were ultimately ineffective to reshape the local and global determinants that are spurring litigiousness and the pharmaceuticalization of the right to health in both countries.

C. LESSONS FROM A LITIGATION EPIDEMIC

There are two overarching lessons that can be drawn from the trajectory of the right to health in Colombia and Brazil during the past two decades. Firstly, the Colombian and Brazilian cases provide powerful insights about the potential of individual and structural judicial remedies for the protection of the right to health. Secondly, health-care policy, on the one hand, and the enforcement of the right to health, on the other, can collide, producing several intended

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[9] David Zaring (2004), "National Rulemaking through Trial Courts: The Big Case and Institutional Reform," *UCLA Law Review*, 51, 1015; Roberto Gargarella (2011), "Dialogic Justice in the Enforcement of Social Rights: Some Initial Arguments," in Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?*, Cambridge, MA: Harvard University Press.

and unintended effects. In both countries, the surge of litigiousness looms large as the most negative unintended effect of that collision. By contrast, a positive intended effect is that, in some junctures, the judicial mechanisms for the protection of rights introduced by the 1991 Colombian Constitution and 1988 Brazilian Constitution have interacted productively with health policy. For instance, without the dramatic expansion of health-care coverage in Colombia bolstered by the implementation of the 1993 health-care reform, right-to-health entitlements would be circumscribed to only a privileged minority of Colombians. Similarly, universal health-care coverage in Brazil can be considered as the direct product of the 1988 Constitution and of the successful integration of the right to health as a core component of health policy.

However, the crisis produced by the litigation epidemic has exposed the clash between health policy and the right to health. In Brazil, the two-track health-care regime has deepened inequalities on two levels: firstly, because the public sector has been depleted of resources and human capital in favor of the privatized health system; secondly, because wealthy Brazilians exploit the public purse by using litigation as a mechanism to obtain expensive drugs and treatments from the national health sector. As a result of this, the key piece of the institutional architecture of Brazil's health system—the double-track system— collides frontally with the notion of the right to health entrenched in the 1988 Constitution and in the judicial precedent of higher courts.

In Colombia's case, the 1993 health-care overhaul can be defined as a utilitarian policy that privileged the goal of accomplishing universal health-care coverage. By 1993, policymakers wanted to accomplish the greatest good for the greatest possible number of people by designing a health system geared towards universal health coverage. However, they downplayed other possible goals like protecting the rights of individual patients. The precedence of achieving universal health-care coverage in the goals of the 1993 reformers must be set, however, against the background of a failed and unequal health system— circumscribed to less than one-fourth of the population—which policymakers tried to reform radically and abruptly. Additionally, by 1993 the idea of basic and socioeconomic rights was still in the making and had not yet percolated into social policy.

Striking a marked contrast with the two-track policy in Brazil and the utilitarian goal of achieving universal coverage in Colombia, the CCC and the BFSC precedents on the right to health were tailored to protect the interests of the individual, irrespective of the effects that the enforcement of rights may have on other patients, institutions, budgets, or the health system. In a context of egregious violations of the right to health, the judges who shaped the foundations of the minimum core of socioeconomic rights gave preeminence to the interests of individual plaintiffs over other possible considerations. Yet, the surge of right-to-health litigation during the past two decades in Colombia

and Brazil has taught judges a difficult, yet potentially transformative lesson: the most conducive way to eliminate or control the determinants of litigation in Colombia and Brazil is by embedding health policy in the right to health, and vice versa.

The structural approach to judicial remedies implemented since 2008 by the Colombian Constitutional Court (CCC) and the Brazilian Federal Supreme Court (BFSC) indicates that the trajectories of health policy and the right to health can be corrected and aligned. As the cases of Colombia and Brazil suggest, by incorporating the protection of the right to health as one of the building blocks of policymaking, the executive and legislative branches can make the health system a more legitimate, fair, and accountable institutional arrangement. Additionally, judicial remedies for the protection of the right to health can be boosted if courts open the black box of adjudication to the deliberation and participation of actors such as policymakers, advocates, NGOs, patients' organizations, and pharmaceutical companies.

The monitoring mechanisms implemented by the CCC and the BFSC since 2009, which have consisted of public hearings and follow-up procedures that assess the governments' compliance with structural orders handed down by higher courts, are an important step in the right direction. A message conveyed by the CCC and the BFSC is that effective judicial remedies to redress the violation of the right to health require more than ordering the government, private insurance companies and hospitals to deliver health-care services and drugs to individual plaintiffs. A relevant lesson is that if courts concentrate only on solving the concrete situations of the plaintiffs filing the lawsuits, the underpinning regulatory failures that are driving the violation of rights will remain intact. The defining undertone of the interventions of the CCC and the BFSC is that in some cases a merely individual, case-by-case approach to remedies would incentivize more litigation.

As a result of the shift in the approach to remedies, the CCC and the BFSC are now taking a harder look at the social, economic and institutional determinants of health-rights litigation. Just as Norman Daniels called attention to the tendency of bioethics and health reform to focus on health care only at the point delivery and to neglect an analysis of the determinants of health that lie upstream,[10] Colombian and Brazilian higher courts are now more inclined to analyze the upstream economic, social and institutional determinants of litigation. On several occasions the CCC and the BFSC have demonstrated that it is possible to combine individual remedies with structural remedies aimed at

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[10] Norman Daniels (2000), *Is Inequality Bad for Our Health?*, Boston, MA: Beacon Press.

correcting the health system's regulatory failures that are spurring the violation of rights and the surge of litigiousness.

Looking upstream for structural remedies that can prevent encroachment on the right to health is more demanding for courts than providing a remedy to a plaintiff whose rights have already been encroached upon. Even more difficult is handing down judicial orders that, on the one hand, avoid *command and control* mandates and are deferential to the elected branches of government, but that, on the other hand, can nudge governmental and regulatory agencies to comply with structural remedies.[11] As the CCC Opinion T-760 illustrates, striking a balance between those two poles becomes even more demanding when duty-bearers show low levels of compliance. The question of how to guide policymakers into compliance without exerting a disproportionate pressure on the separation of powers can become a major challenge for higher courts in Brazil and Colombia.

In sum, the results of the monitoring processes triggered by the CCC and the BFSC indicate that when courts embark on judicial experimentalism, they acquire a varied palette of strategies that they can deploy to instigate compliance. Some of the outcomes of the monitoring process carried out by the CCC and the BFSC suggest that by summoning public hearings and experts' groups, courts can destabilize government agencies and instigate them to comply with judicial orders.[12] These mechanisms are still nascent and must be refined to achieve better results. However, they have been instrumental in persuading government agencies that they have to take structural remedies and experimental judicial orders seriously.

D. COVID-19 AND THE EMERGENCE OF A NEW REGIME OF RESPONSIBILITY

The global spread of the COVID-19 virus poignantly demonstrates Henry Shue's contention regarding the interconnectedness of duties.[13] As the pandemic has profusely illustrated, in order to materialize complex socioeconomic rights such as the right to health, there must be a division of labor between a diverse set of interconnected duty-bearers: local, federal and foreign governments, private health providers, international institutions, non-profit organizations, pharmaceutical companies, technology firms, and organized communities, among others.

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[11] Charles F. Sabel and William H. Simon (2004), "Destabilization Rights: How Public Law Litigation Succeeds," *Harvard Law Review*, 117(4), 1015.

[12] Ibid.

[13] Henry Shue (1988), "Mediating Duties," *Ethics*, 98(4), 687–704.

Whereas some non-state actors can be considered as responsible parties on an equal footing with states, others act—in Shue's terms—as mediating institutions that help to amplify the impact of duty-bearers on distant right-holders. In both developed and developing countries, guaranteeing the basic right to health is an endeavor in which governments play a decisive, but not exclusive, role. Facing the surge of a global pandemic like COVID-19, an actual division of labor among states and non-state actors has proven necessary not only to vaccinate a sizeable part of the population, but also to treat patients, organize the delivery of health care, rearrange health insurance schemes, and implement measures aimed at preventing the spread of infection, among many other actions.

Furthermore, the global crisis prompted by COVID-19 offers the most striking example of why, facing a major threat to the life and well-being of the population at large, governments around the world fail to comply with their duties not only because they have limited state capacities, insufficient economic resources, or a lack of commitment to protect the right to health. In many regions around the world, but especially in the Global South, health systems fell short of guaranteeing even the most basic elements of the minimum core of the right to health—primary health care, vaccination, and essential medicines—because other stakeholders such as transnational pharmaceutical companies, foreign governments and international organizations, failed to act as duty-bearers and mediating institutions. The fact that those stakeholders refused or were unwilling to act as duty-bearers or facilitators of the duties of governments can be explained by the fact that they are not expected—neither by the academic literature nor by human rights bodies—to do so. On the contrary, according to our concentric, state-centered understanding of duties, only governments can be legitimately asked to undertake burdensome positive duties aimed at materializing the right to health.

In our current pandemic context, we urgently need a polycentric theory of duties capable of describing how states interact with a web of duty-bearers and mediating institutions with the aim of materializing the minimum core of the right to health. Furthermore, Shue's idea of a web of interconnected state and non-state duty-bearers should be incorporated in a post COVID-19 concept of duties. Any polycentric concept of duties should also develop a new regime of responsibility capable of determining when state or non-state actors have breached the minimum core of the right to health and should be held accountable. Additionally, the extant literature has yet to reconsider, in the light of COVID-19, the role of courts and human rights institutions as enforcers of the minimum core of the right to health. More particularly, there is an urgent need to discuss what regime of responsibility courts and human rights bodies can apply to state and non-state actors whose actions and decisions are leading to a massive violation of the right to health around the world.

For instance, when non-state actors such as transnational pharmaceutical companies refuse to waive their patents and Global South countries are denied the possibility of producing cheaper generic versions of life-saving vaccines that could reach millions of vulnerable individuals, are they breaching a duty for which they can be held accountable? Or when a mediating international institution favors disproportionately the economic interests of pharmaceutical companies over the welfare of non-vaccinated individuals, is it breaching the minimum core of the right to health to a point where it can be held responsible?

Fortunately, international human rights law offers valuable tools that can be deployed to devise a new polycentric regime of responsibility that incorporates a wide array of interconnected stakeholders and mediating institutions. Although a polycentric regime of responsibility must reject a strong state-centered model of duties, it should recognize nonetheless that states have an undisputable obligation to be the main, but not the only, duty-bearers in charge of materializing the minimum core of the right to health. As the Committee on Social, Economic and Cultural Rights (CSECR) stated in reference to the COVID-19 pandemic, states have the obligation "to take all the necessary measures, as a matter of priority and to the maximum of their available resources, to guarantee all persons access to vaccines against Covid-19, without any discrimination."[14]

However, as a recent document from Amnesty International underscores, wealthy states should share duties with poorer states that are unable to guarantee the minimum core of the right to health to its citizens. According to the document,

> States in a position to provide technical or financial assistance must cooperate internationally and provide financial and technical support if needed to uphold the right to health, especially in the face of the global spread of disease. This may include the sharing of research, knowledge, medical equipment and supplies, as well as coordinated action to reduce the negative economic and social impacts of a health crisis and promote economic recovery globally.[15]

The idea of interconnectedness between duty-bearers also extends to the state duty to protect the minimum core of the right to health against abuses by third parties, including corporations. That state duty is already part of the UN Human Rights Guiding Principles, which determine that states have the obligation to take "appropriate steps to prevent, investigate, punish and redress

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[14] CESCR, Statement on universal affordable vaccination against coronavirus disease (COVID-19), international cooperation and intellectual property, 23 April 2021, available at: https://digitallibrary.un.org/record/3921880?ln=en.

[15] Shue (1988), "Mediating Duties."

such abuse through effective policies, legislation, regulations and adjudication." According to Amnesty International, that duty "extends extraterritorially where states can control or influence the conduct of corporations within their territory or under their jurisdiction." In the concrete case of the current pandemic, "States must therefore ensure that vaccine developers' operations extend access to Covid-19 vaccines and do not impede their own and other states' ability to ensure access for all."

As COVID-19 spread around the world, it became clear that states, both wealthy and poor, were unable to guarantee the most basic elements of the minimum core of the right to health to millions of individuals who died or were critically ill because of governmental mismanagement and lack of state capacities. But even more troublingly, heads of state like Bolsonaro and Trump underestimated the threat of the pandemic and de-escalated the response of their countries' health systems, all of which had an enormous toll in human lives. A polycentric regime of duties should be able to answer whether actors like Bolsonaro or Trump can be held liable for their actions regarding COVID-19? Moreover, a polycentric regime of duties should be in the position to answer whether we can equate Bolsonaro and Trump's deeds with a crime against humanity that should be judged by an international court of human rights? In October 2021, Brazil's Congress addressed that question and indicted Bolsonaro for crimes against humanity, among other criminal charges.

However, the biggest challenge of a polycentric regime of responsibility is to incorporate non-state actors such as corporations into a scheme in which they can be considered as legitimate duty-bearers on the same footing as states. Although there is a growing body of human rights instruments that point to a nascent regime of human rights duties for corporations—the UN Guiding Principles on Business and Human Rights (UN Guiding Principles) and the OECD Guidelines for Multinational Enterprises (OECD Guidelines)—corporate responsibility in the field of socioeconomic rights is still incipient. For instance, the human rights community lacks reliable tools to assign responsibility to transnational pharmaceutical companies that, in the context of the COVID-19 pandemic, refused to waive their patents on coronavirus vaccines and, as a result, denied Global South countries the possibility of producing cheaper generic versions of life-saving vaccines that could reach millions of vulnerable individuals.

However, the international coalition that is building pressure on Big Pharma and some governments to waive patents on COVID-19 vaccines is also making important contributions to the emergence of a regime of responsibility that can be observed by non-state actors such as pharmaceutical companies. As Amnesty International argues, the regime of responsibility expected from pharmaceutical companies should require that corporations refrain from causing or

contributing to human rights abuses through their own business activities. Additionally, any regime of responsibility must require that Big Pharma companies prevent adverse human rights impacts linked to their operations, products, or services, even if the companies did not produce those impacts directly. Finally, facing the global emergency unleashed by COVID-19, a new regime of responsibility should demand that Big Pharma companies "remove all obstacles and refrain from any action that unduly impacts on states' ability to make Covid-19 vaccines available to all. Failures to take the steps needed to ensure fair and comprehensive vaccine roll-out may result in companies causing or contributing to human rights harms."[16]

As I discussed in this book, major public health crises such as the HIV/AIDS pandemic led Global South governments to demand the incorporation of human rights considerations into the global regime of intellectual property rights. Furthermore, in some critical junctures, Global South countries joined strategic coalitions with civil society organizations and transnational advocacy networks to contest the interests of pharmaceutical companies that were keeping vulnerable individuals from having access to life-saving drugs and medical treatments. It is conceivable that due to the scale and impact of the current COVID-19 pandemic there will be a window of opportunity to set the foundations of a new regime of responsibility in which non-state actors can be considered as duty-bearers in charge of assuming a bundle of responsibilities aimed at materializing the minimum core of the right to health.

E. A NEW CRITICAL JUNCTURE

As the writing process of this book unfolded during 2020 and 2021, the COVID-19 pandemic took over the world. The painful lessons left by COVID-19 transformed my own thinking about the right to health and forced me to reconsider some of the arguments that, initially, gave form to the main arguments presented in this book. Even the most abstract discussions about the minimum core of the right to health, included in the first section of the book, have been influenced by the pandemic. For instance, COVID-19 forced me to reassess my approach to the duties, attached to the right to health, held by non-state actors. More specifically, the debate about the waiving of patents on COVID-19 vaccines, formulated by Global South countries like India and South Africa, opened for me new paths to conceive an emerging global regime of responsibility where Big Pharma can be expected to hold burdensome positive duties aimed at guaranteeing the minimum core of the right to health

[16] www.amnesty.org/en/wp-content/uploads/2021/09/POL4046212021ENGLISH.pdf, at p. 17.

to millions of vulnerable people in the Global South. Additionally, the idea of a polycentric web of duty-bearers who share responsibilities geared toward the materialization of the right to health came from observing how governments and non-state actors—health providers, doctors, NGOs, international institutions, scientists, among many others—worked together to respond to the enormous challenges raised by the COVID-19 pandemic.

But not only was my theoretical approach to the right to health transformed by COVID-19. As I wrote the chapters devoted to the case studies of Brazil and Colombia included in Part II, I came to the realization that COVID-19 was also a large-scale experiment that tested not only the judicialization of the right to health in both countries, but also the institutional capabilities of Brazil and Colombia's health systems. Facing the immense death toll left by COVID-19, I grasped some of the implications of having a deeply individualized, routinized and pharmaceuticalized notion of the right to health in both countries.

More concretely, I realized that the judicialization of health care, as it is currently conceived and practiced in the two neighboring South American nations, did not offer any real safeguards against the threats of the virus, nor did it offer effective tools to demand that the Brazilian and Colombian governments fulfill their duties aimed at protecting the minimum core of the right to health of the population. On the contrary, the spread of the virus proved that the legal mechanisms to demand brand-name drugs and health services were mostly useless to obtain COVID-19 vaccines, oxygen, ICUs and hospital beds.

As I have shown in this book, during the past two decades thousands of Colombian and Brazilian litigants have obtained costly brand-name drugs and health services thanks to the orders of judges. Yet, the escalating litigiousness failed to strengthen primary health care, preventive medicine, and public health policy, which proved to be the key elements to mitigate the effects of COVID-19. The shortcomings of a deeply individualized, routinized and pharmaceuticalized judicialization of health care proved that in Brazil and Colombia there is an urgent need to reconceive the notion and practice of the right to health.

The pandemic also put in the foreground that in a country like Colombia the government was at the mercy of large pharmaceutical companies, who, invoking their patents, could unilaterally set the prices of life-saving vaccines and define the conditions to deliver the shots to millions of Colombians. Additionally, the shocking mishandling of Brazil's response to COVID-19 offered support to the argument according to which public officials should be held accountable for failing to guarantee the right to health of citizens. Moreover, Brazil's case proved that a head of state's decision to de-escalate the public response to the virus—based on a disgraceful refusal to recognize the nature of COVID-19—brought as a result thousands of deaths which were preventable. On this point, the indictment against Bolsonaro for crimes against

humanity, handed down by Brazil's Congress in October 2021, showed that COVID-19 was ushering in a new regime of responsibility. Based on that new regime, judges and international human rights institutions could make accountable public officials who willingly refuse to protect the right to health of citizens. The dawn of a new era of responsibilities could, eventually, pave the way for the emergence of an enforceable minimum core of the right to health that governments and non-state actors like Big Pharma can be expected to guarantee to all citizens.

But despite the shortcomings of the judicialization of health care evinced by COVID-19, it became increasingly evident to me that the Brazilian and Colombian health systems were now more resilient and humane thanks to the extended judicialization of health care. As the magnitude of the pandemic became frightfully evident, I realized that the human scale of the right to health in both countries should not be overlooked, especially in a context in which politicians and scholars criticize the judicialization of health care based on its negative impact on health budgets and on the distribution of scarce resources. Limiting or removing the legal means to litigate the right to health would not improve the lives of the most vulnerable Brazilians and Colombians, I concluded. On the contrary, it would divest citizens of one of the few effective mechanisms that allow them to demand the materialization and enforcement of a key socioeconomic right.

However, recognizing that the right to health is now deeply ingrained in Brazil and Colombia's legal conscience should not obscure the fact that it needs an urgent rekindling. Making the right to health a collective entitlement, bolstering its transformative potential with an emphasis on public health concerns, looking upstream for the determinants that are creating the conditions for the violation of the right to health in thousands of individual cases, incorporating non-state actors as duty-bearers in charge of materializing the minimum core of the right to health, de-escalating the pharmaceuticalization of health care, and searching for global remedies when trying to solve the local maladies that affect the judicialization of health care in countries like Brazil and Colombia, should guide the research, policymaking, litigation and adjudication on the right to health across the Global South in the years to come.