Courts and Social Change: Lessons from the Struggle to Universalize Access to HIV/AIDS Treatment in Argentina

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The judicial enforcement of social rights has been a distinctive feature of the process of constitutionalization in Latin America over the last two decades.[1] By the late 1990s, in countries such as Argentina, Brazil, and Colombia, courts were already calling on governments and private actors to recognize and protect so-called second-generation rights.[2] In the face of this new phenomenon, scholars initiated a transnational dialogue that continues to this day. At the early stages of this conversation, critics of social rights constitutionalization, as well as supporters of the exclusive political enforceability of social rights, confronted a growing camp of advocates and scholars strongly committed to allowing courts to have a role in bringing social rights to bear.[3] While normative and doctrinal approaches shaped the initial exchanges, a new generation of studies has more recently invited a shift toward the empirical exploration of concrete and localized experiences.[4]

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1. Latin American and continental scholars have coined the term *neoconstitutionalism* to describe this process. *See generally* NEOCONSTITUCIONALISMO(S) (Miguel Carbonell ed., 2003).

2. Ángel Oquendo, *The Solitude of Latin America: The Struggle for Rights South of the Border*, 43 TEX. INT'L L.J. 185, 191 (2008) (characterizing second-generation rights as economic, social, and cultural rights, including "the right to work, to unionize, to subsistence, to housing, to health, to education, and to culture").

3. For an early version of this conversation, see generally VICTOR ABRAMOVICH & CHRISTIAN COURTIS, LOS DERECHOS SOCIALES COMO DERECHOS EXIGIBLES [SOCIAL RIGHTS AS REQUIRED RIGHTS] (2002); Fernando Atria, *¿Existen derechos sociales?* [*Do Social Rights Exist?*], 4 DISCUSIONES [DISCUSSIONS] 15 (2004) (Arg.), *available at* http://bib.cervantesvirtual.com/FichaObra.html?Ref=15570; Carlos Bernal Pulido, *Fundamento, concepto y estructura de los derechos sociales: Una crítica a "¿Existen derechos sociales?" de Fernando Atria* [*Foundation, Concept, and Structure of Social Rights: A Critique of "Do Social Rights Exist?" by Fernando Atria*], 4 DISCUSIONES [DISCUSSIONS] 99 (2004) (Arg.), *available at* http://bib.cervantesvirtual.com/FichaObra.html?Ref=15573; Carlos Rosenkrantz, *La pobreza, la ley y la constitución* [*Poverty, the Law and the Constitution*] (Seminario en Latinoamérica de Teoría Constitucional y Política [Latin Am. Seminar on Constitutional and Political Theory], Paper No. 15, 2002), *available at* http://digitalcommons.law.yale.edu/yls_sela/15.

4. *See generally* DERECHOS SOCIALES: JUSTICIA, POLÍTICA Y ECONOMÍA EN AMÉRICA LATINA [SOCIAL RIGHTS: JUSTICE, POLITICS, AND ECONOMICS IN LATIN AMERICA] (Pilar Arcidiácono, et al. eds., 2010).

The new works have shed increasing light on different dimensions of social rights justiciability, its effects and impacts, and the conditions for its compliance and implementation.[5] Diverse methodological approaches and theoretical frameworks have guided these contributions. In-depth investigations of single structural cases,[6] or of the judicialization of specific rights,[7] have resulted in more nuanced and less assertive claims about the legitimacy of courts and their capacity to generate social change. Ultimately, the new research has consistently shown mixed results depending on the type of social rights enforced, the style of the litigation (i.e., structural, collective, or individual), the litigants, the remedies ordered, and the political and institutional background against which the litigation took place. Findings suggest that while in some instances judicialization has fostered dialogue and inter-branch cooperation,[8] in other instances regressive effects may be surpassing the benefits of allowing courts a role in the enforcement of social rights.[9]

Recent works that have centered on the adjudication of right-to-health suits extensively illustrate these claims. Studies like the one conducted by Yamin and Parra on a case in the Colombian Constitutional Court,[10] and Ferraz's inquiries into the extent of the Brazilian individualized approach to

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5. *See, e.g.*, SIRI GLOPPEN ET AL., COURTS AND POWER IN LATIN AMERICA AND AFRICA 1 (2010) (examining the accountability function exercised by higher courts in Latin America and Africa). The new Latin American research contributed to the tradition of studies produced in the United States, such as MICHAEL W. MCCANN, RIGHTS AT WORK: PAY EQUITY REFORM AND THE POLITICS OF LEGAL MOBILIZATION (1994) and GERALD N. ROSENBERG, THE HOLLOW HOPE: CAN COURTS BRING ABOUT SOCIAL CHANGE? (1991).

6. CÉSAR RODRÍGUEZ GARAVITO & DIANA RODRÍGUEZ FRANCO, CORTES Y CAMBIO SOCIAL [COURTS AND SOCIAL CHANGE] 13 (2010) (discussing Judgment T-025, the Colombian Constitutional Court's 2004 landmark decision that declared a "state of unconstitutionality" regarding more than three million refugees displaced by the violence in the country).

7. Florian F. Hoffmann & Fernando R.N.M. Bentes, *Accountability for Social and Economic Rights in Brazil*, *in* COURTING SOCIAL JUSTICE 100, 119–32 (Varun Gauri & Daniel M. Brinks eds., 2008) (considering the judicialization of health rights and education rights in Brazil).

8. Rosalind Dixon, *Creating Dialogue About Socioeconomic Rights: Strong-Form Versus Weak-Form Judicial Review Revisited*, 5 INT'L J. CONST. L. 391, 402 (2007) (arguing that courts should have a role in the interpretation and enforcement of socioeconomic-rights guarantees because "[i]n cooperative constitutional understandings, majoritarian political processes are often subject to serious blockages, such that very strong judicial deference to the legislature . . . will tend to produce results that fall far short of a fully inclusive and responsive constitutional ideal").

9. *See, e.g.*, Hoffmann & Bentes, *supra* note 7, at 141–43 (discussing the recent success and prevalence of individual access-to-medicine and access-to-treatment cases, but noting an appreciable difference in access to justice between middle class and indigent plaintiffs and the phenomenon of successful litigants "queue-jumping" and thereby impacting vulnerable and indigent nonlitigants).

10. Alicia Ely Yamin & Oscar Parra-Vera, *Judicial Protection of the Right to Health in Colombia: From Social Demands to Individual Claims to Public Debates*, 33 HASTINGS INT'L & COMP. L. REV. 431, 432 (2010) (parsing the effects of Judgment T-760/08, a July 2008 Colombian Constitutional Court decision "examin[ing] systemic failures in the regulation of the health system, re-assert[ing] the justiciability of the right to health, and call[ing] for significant restructuring of the health system based on rights principles").

right-to-health claims,[11] exemplify the two extremes of a continuum in the judicialization of health policies with contrasting approaches and impacts: the structural case for comprehensive health-system reform on the one hand, and the accumulation of individual demands for varieties of health care supplies on the other.

This Article seeks to contribute to the dialogue inspired by these more contextualized and institutionally oriented works by evaluating them against the adjudication of health policies in Argentina. Moreover, the Article seeks to explore variations in the cooperative effects of domestic litigation by examining dimensions absent from recent regional studies on the right to health. With that aim in mind, the Article profiles fifteen years of right-to-health litigation about access to HIV/AIDS treatment in the Argentinian health care system, which combines public and private insurance and spending. In Argentina, national, provincial, and municipal health departments are in charge of public health services operating under a universal-access principle, but in practice, these services are used by poor uninsured patients.[12] A parallel contributory system is composed of a set of social health funds—known as *obras sociales* (OSSs)—organized by activity and run by unions,[13] and private health insurance funds—known as *empresas de medicina prepaga* (EMPs).[14] Because the litigation for enforcement of the right to health has been directed against public health services, OSSs, and EMPs, the HIV/AIDS treatment litigation offers an interesting setting for

11. Octavio Luiz Motta Ferraz, *The Right to Health in the Courts of Brazil: Worsening Health Inequities?*, 11 HEALTH & HUM. RTS., no. 2, 2009 at 33, 33 (analyzing the growing trend of Brazilian right-to-health litigation characterized by individualized claims to treatment).

12. These services are mainly supplied through public hospitals and, more recently, through primary care centers. *See* JAMES W. MCGUIRE, WEALTH, HEALTH, AND DEMOCRACY IN EAST ASIA AND LATIN AMERICA 128–48 (2010) (detailing the history of public health services and health care policy in Argentina).

13. There are different types of OSSs. National OSSs are run by unions with presence across jurisdictions. Armando Barrientos & Peter Lloyd Sherlock, *Reforming Health Insurance in Argentina and Chile*, 15 HEALTH POL'Y & PLAN. 417, 417 (2000); *Argentina—Empresas de Salud y Medicamentos* [*Argentinian Health and Drug Companies*], GOBIERNO DE LA REPÚBLICA DE ARGENTINA, http://www.argentina.gov.ar/argentina/portal/paginas.dhtml?pagina=614. Provincial OSSs are created for public provincial employees. Barrientos & Sherlock, *supra*, at 417. Other OSSs pertain to specific groups of public employees, including the army and the judiciary. WORLD BANK, ARGENTINA: FROM INSOLVENCY TO GROWTH 74 (1993).

14. EMPs offer private insurance plans. As of 2007, approximately 10% of the population made voluntary contributions to EMPs, either directly or by supplementing their OSS contributions. Ernesto Báscolo, *Características institucionales del sistema de salud en la Argentina y limitaciones de la capacidad del Estado para garantizar el derecho de la salud de la población* [*Institutional Characteristics of the Health System in Argentina and Limits on the Capacity of the State to Guarantee Health Rights of the Population*], *in* LAS CAPACIDADES DEL ESTADO Y LAS DEMANDAS CIUDADANAS: CONDICIONES POLÍTICAS PARA LA IGUALDAD DE DERECHOS [THE CAPACITY OF THE STATE AND CITIZEN DEMANDS: POLITICAL CONDITIONS FOR EQUAL RIGHTS] 95, 97 (Isidoro Cheresky ed., 2008), *available at* http://www.undp.org.ar/docs/Libros_y_Publicaciones/Capacidades%20del%20Estado%20y%20Demandas%20Borrador%20PNUD.pdf.

contrasting the policy impacts of vertical and horizontal applications of social rights.[15]

The research proposed in the following pages relies on several sources of empirical data. It is based, first, on a database of HIV/AIDS cases comprising all of the decisions published or referenced from 1995 to 2010 in Argentina's main national legal periodicals, court databases, and national newspapers (the Database).[16] Second, the data stems from congressional antecedents, news published from 1995 to 2010 in the three national newspapers regarding right-to-health claims for HIV/AIDS treatment, and a selection of court dockets. Third, for an anecdotal perspective on the effects of the litigation, the Article draws on twenty interviews conducted in winter 2009 with former directors of the *Programa Nacional de Lucha contra los Retrovirus Humanos* [The National Program for the Fight Against HIV/AIDS] (Program), lawyers and representatives of plaintiff nongovernmental organizations (NGOs), court officers and judges, and experts and social scientists specializing in the study of HIV/AIDS in Argentina.[17]

This Article begins by profiling fifteen years of HIV/AIDS treatment cases, distinguishing the effects of early litigation from the cases that followed from the increased institutionalization of policies mandating universal treatment for the disease. The distinctions between these two periods provide the matrix for framing the exploration of direct and indirect effects of the litigation vis-à-vis the political blockages and governance capacities and deficits that have characterized the expansion of access to HIV/AIDS medicines for the last fifteen years.

As I further elaborate on in the Conclusion, the trajectory of access-to-HIV/AIDS-treatment litigation in Argentina could be seen as shifting from vertical suits, initiated in 1996 for direct provision of drugs by the federal government, to horizontal individual cases filed in the last decade seeking compliance with private duties to provide care. The case study suggests that early vertical–collective and horizontal–individualized enforcements of the right to health both inspired policy changes. As this Article shows, this early litigation promoted a cooperative style of judicial intervention where courts helped to foster tenuous forms of interbranch coordination of the regulation and organization of public and private treatment supply.[18] Similarly,

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15. For a discussion on the distinction between the horizontal and vertical effects of individual rights, see Stephen Gardbaum, *The "Horizontal Effect" of Constitutional Rights*, 102 MICH. L. REV. 387 (2003). Gardbaum explains that "[t]hese alternatives refer to whether constitutional rights regulate only the conduct of governmental actors in their dealings with private individuals (vertical) or also relations between private individuals (horizontal)." *Id.* at 388.

16. The only prior systematic gathering of data on HIV/AIDS treatment cases was published in 2005. Marta A. Macias et al., *VIH/SIDA en la jurisprudencia y en los medios de prensa* [*HIV/AIDS in the Jurisprudence and the Press*], Jurisprudencia Argentina [J.A.] (2005-IV-979).

17. Interviews are on file with the author. Where interviewees requested confidentiality, they will be identified using letters.

18. *See* J. MITCHELL PICKERILL, CONSTITUTIONAL DELIBERATION IN CONGRESS: THE IMPACT OF JUDICIAL REVIEW IN A SEPARATED SYSTEM 3 (2004) (supporting judicial review's role of

individual first-generation cases horizontally enforcing the right to health against private funds played a role as antecedents to important legislative reforms.[19] In the litigation that followed these initial claims, however, neither collective nor individualized demands for treatment supplies showed much capacity to generate greater interbranch coordination or effect deeper policy changes.[20] Moreover, given the shift in the litigation toward individual claims and the resultant need to relitigate the same rights, this second phase of judicial intervention leaves open questions about courts' capacity to correct beneficiary, interpolicy, and intrapolicy inequalities.

I. A Typology of the HIV/AIDS Treatment-Litigation

As illustrated by Figure 1 below, the prevalence of AIDS in Argentina increased between 1991 and 1997 and has gradually stabilized in recent years.[21] Pursuant to the reports of the National Health Department (NHD), by December 2009, there were a total of 29,886 patients under treatment.[22] Additionally, in the last four years, the NHD received approximately 5,000 reports annually of new diagnoses of HIV.[23] In 2008, the annual rate of HIV infection was 13 per 100,000 inhabitants.[24] For that same period, health services across the country received notice of about 1,700 new AIDS cases per year, resulting in an AIDS prevalence rate of 4.4 per 100,000 inhabitants.[25] The AIDS mortality rate also stabilized at 1,400 deaths annually.[26] The epidemic continues mainly to affect people in large urban centers with a male-to-female ratio of 1.7 HIV infections from 2007 to 2009.[27]

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furthering constitutional debate in the legislature and other forums); Daniel M. Brinks & Varun Gauri, *A New Policy Landscape: Legalizing Social and Economic Rights in the Developing World*, *in* COURTING SOCIAL JUSTICE, *supra* note 7, at 303, 343 (advocating an interbranch coordination process where courts advance social rights in the legislature by highlighting new concerns and goals in a judicial forum); Dixon, *supra* note 8, at 393 (applying a theory of dialogue between the courts and legislature to socioeconomic rights, and advocating that in this context, courts adopt only weak rights or remedies).

19. *See infra* Part II.

20. *See infra* Part III.

21. For a description of governmental and social reactions to HIV/AIDS between 1982 and 1990, see MÓNICA PETRACCI & MARIO PECHENY, ARGENTINA: DERECHOS HUMANOS Y SEXUALIDAD [ARGENTINA: HUMAN RIGHTS AND SEXUALITY] 215–26 (2006), *available at* http://www.cedes.org/descarga/CEDESArgentina_sexualidad.pdf.

22. MINISTERIO DE SALUD [MINISTER OF HEALTH], PRESIDENCIA DE LA NACIÓN [PRESIDENCY OF THE NATION], No. 27, BOLETÍN SOBRE EL VIH-SIDA EN LA ARGENTINA [BULLETIN ON HIV-AIDS IN ARGENTINA] 3 (2010).

23. *Id.* at 27.

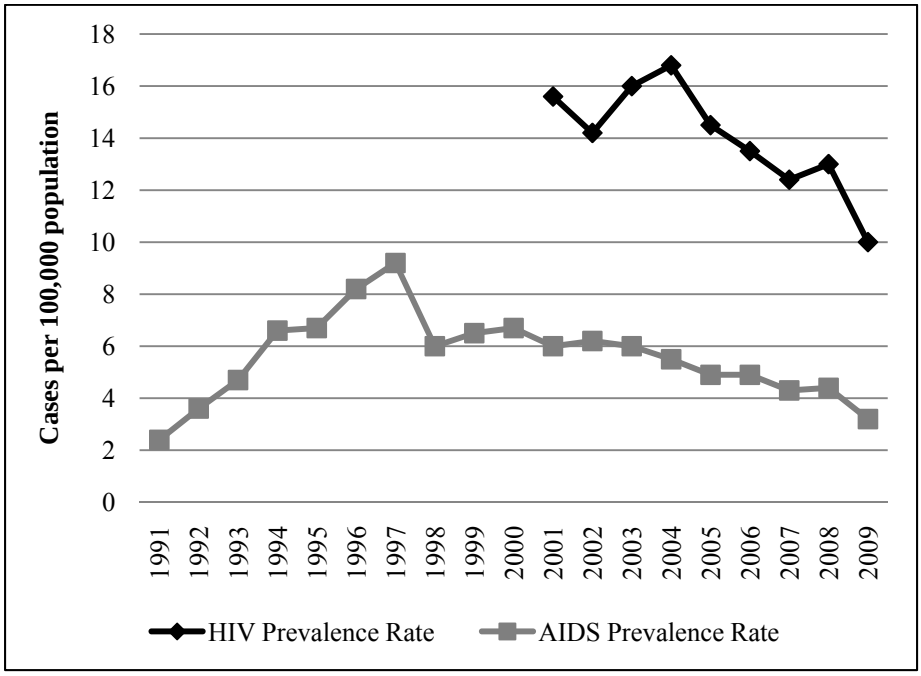
24. *Id.* at 3.

25. *Id.*

26. *Id.*

27. *Id.*

Figure 1. HIV/AIDS Prevalence Rates, 1991–2009



Source: MINISTERIO DE SALUD [MINISTER OF HEALTH], PRESIDENCIA DE LA NACIÓN [PRESIDENCY OF THE NATION], No. 27, BOLETÍN SOBRE EL VIH-SIDA EN LA ARGENTINA [BULLETIN ON HIV-AIDS IN ARGENTINA] 7 (2010).

Even if in hindsight the country's capacity to deal with the disease finally led to its stabilization, the history of the fight against HIV and AIDS has been a complex and relentless one. This was especially the case in the period from 1982, when the first cases of AIDS were reported,[28] to 1997, when the government changed its erratic approach to fighting the disease.[29]

Though the use of courts has been a latent resource for patients at different stages of this process, the literature often avoids it. The lack of official data on the numbers of right-to-health cases and the unavailability of information on the litigation brought by patients demanding HIV/AIDS medication also precludes an assessment of the extent of patients' reliance on courts for the adjudication of their demand for treatment.[30] However, upon

28. Mabel Bianco et al., Human Rights and Access to Treatment for HIV/AIDS in Argentina 14 (1998) (unpublished manuscript), *available at* http://www.aidslex.org/site_documents/T044E.pdf.

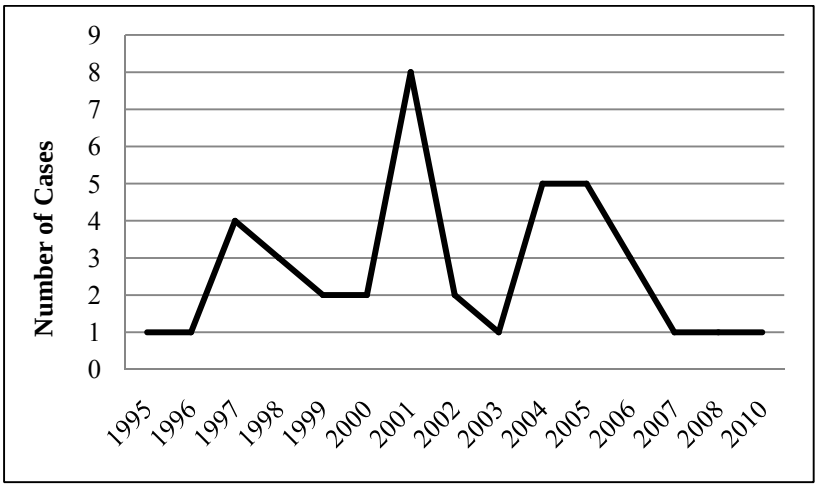
29. *See id.* at 7–11 (chronicling legislation affecting access to HIV/AIDS treatment in Argentina throughout the 1990s, and noting that "[i]n 1997 by virtue of Resolution 346, the Ministry of Health and Social Welfare changed the HIV/AIDS medicine purchase and distribution system," which "de-centralized the distribution of medicines" in the country).

30. I have attempted to profile the extent of this litigation in Paola Bergallo, *Courts and the Right to Health in Argentina: Achieving Fairness Despite Routinization in Individual Coverage*

examination of the secondary literature and the most publicized cases, I was able to build a Database with forty cases providing some indicia about the HIV/AIDS treatment claims that have reached the courts from 1995 to 2010.[31] In all of these cases, courts refused providers' attempts to reject coverage or recognized claimants' demands for treatment.

Even if the cases are just a piece of a larger phenomenon for which quantitative contours cannot be defined, Figure 2 shows the continuity over the last fifteen years of HIV/AIDS patients' recourse to federal and provincial courts in search of their treatment needs. Because the cases retrieved in the Database do not account for all cases filed, Figure 2 is not representative of the extent of the litigation. It suggests, however, a possible trend in the annual evolution of cases, which picked up during the 2001 crisis and has apparently fallen off since 2006.

Figure 2: Number of HIV/AIDS-Treatment Decisions or Cases, 1995–2010



The forty cases included in the Database were presented as individual or collective *amparos*[32] argued on a right-to-health basis. With the exception of

Cases?, *in* LITIGATING THE RIGHT TO HEALTH (Siri Gloppen & Alicia Ely Yamin eds., forthcoming 2011).

31. I generated the forty data points from a collection of all decisions or news about them included in EL DERECHO, REVISTA JURIDICA LA LEY , and LEXIS NEXIS JURISPRUDENCIA ARGENTINA from 1995 to 2010, the databases of selected precedents of the Cámara Nacional de Apelaciones Especial Civil y Comercial de la Capital Federal [National Court of Special Civil and Commercial Appeals of the Federal Capital], the database of the Corte Suprema de Justicia de la Nación [National Supreme Court of Justice], and the three main national newspapers (CLARÍN, LA NACIÓN, and PÁGINA/12). The Database is on file with the author.

32. The *amparo* is an injunctive procedure for the protection of constitutional rights. *See* GUSTAVO MAURINO ET AL., LAS ACCIONES COLECTIVAS: ANÁLISIS CONCEPTUAL, CONSTITUCIONAL Y COMPARADO [THE COLLECTIVE ACTIONS: CONCEPTUAL, CONSTITUTIONAL,

the *Hospital Británico* case,[33] the cases were demands for HIV/AIDS treatment brought by patients (thirty-three cases) or NGOs (six cases) against OSSs, EMPs, or the national or provincial programs for free treatment supply.

The cases can be classified following Gauri and Brinks's description of the relationships among the state, providers, and patients in social rights claims as "triangular."[34] As illustrated by Figure 3, different relationships connect (1) the state and patients, (2) the state and providers, and (3) the providers and patients. The cases in the Database reveal that, corresponding to Gauri and Brinks's model,[35] in the practice of enforcing legally mandated universal access to HIV/AIDS treatment, Argentinian courts have confronted three categories of cases. First, "Provision Cases" are those in which patients asked for the direct provision of treatment from state institutions. The Database reflects that these cases took two different forms during the given period: Federal Provision Cases against the Program, and Provincial Provision Cases against the provincial programs in charge of the primary free supply of HIV/AIDS treatment guaranteed by the federal government.[36]

A second category of cases connects patients and private providers: "Obligation Cases." These are instances of courts horizontally enforcing the right to health—what Clapham has called "the privatization of constitutional rights."[37] Against the backdrop of the two-tiered structure of the Argentinian

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AND COMPARATIVE ANALYSIS] 75–83 (2005) (discussing the *amparo* and recounting the process of adopting an *amparo* provision during the 1994 constitutional reforms).

33. The *Hospital Británico* case was filed by a group of private funds challenging the constitutionality of Law 24,754, which defined EMPs' duties to cover HIV/AIDS treatment. Corte Suprema de Justicia de la Nación [CSJN] [National Supreme Court of Justice], 13/3/2001, "Hosp. Británico de Buenos Aires c. M.S. y A.S. / acción de amparo," Colección Oficial de Fallos de la Corte Suprema de Justicia de la Nación [Fallos] (2001-324-754), slip op., *available at* http://www.csjn.gov.ar/cfal/fallos/cfal3/ver_fallos.jsp?id=131413&fori=RHH00090.340.

34. *See* Varun Gauri & Daniel M. Brinks, *Introduction: The Elements of Legalization and the Triangular Shape of Social and Economic Rights*, *in* COURTING SOCIAL JUSTICE, *supra* note 7, at 1, 9–11 (asserting that there are three groups involved in the distribution of social services—the state, service providers, and clients—and describing the legal relationships among these groups).

35. These relationships correlate to those identified by Brinks and Gauri. Brinks & Gauri, *supra* note 18, at 303, 307–08 ("[O]ne can usefully classify [social and economic] rights into those that relate to three sets of duties: *Provision*—imposing a duty on the state to pay for or provide a service directly; *regulation*—modifying the regulatory environment by imposing (or removing) state-enforced duties on providers; and *obligation*—modifying the provider–recipient relationship by imposing (or removing) a duty on the provider that the recipient herself must enforce.").

36. An example of a Federal Provision Case is CSJN, 1/6/2000, "Asociación Benghalensis y otros c. Ministerio de Salud y Acción Social—Estado Nacional / amparo ley," Fallos (2000-323-1339), slip op., *available at* http://www.csjn.gov.ar/cfal/fallos/cfal3/ver_fallos.jsp?id=117500&fori=RHA00182.340. An example of a Provincial Provision Case is Cámara 1a de Apelaciones en lo Civil y Comercial [CApel.CC] de Bahía Blanca, sala 2 [First Civil and Commercial Court of Appeals of Bahía Blanca, panel 2], 9/2/1997, "Hosp. Leónidas Lucero, C., C. y otros c. Ministerio de Salud y Acción Social de la Provincia de Buenos Aires," Revista Jurídica Argentina—La Ley [L.L.] (1997-LLBA-1122).

37. *See* Helen Hershkoff, *Transforming Legal Theory in the Light of Practice: The Judicial Application of Social and Economic Rights to Private Orderings*, *in* COURTING SOCIAL JUSTICE,

contributory health sector, these cases are brought against different types of OSSs and EMPs and compel courts to enforce private obligations established either in the regulatory framework defining OSSs' and EMPs' duties for coverage, or in the contracts between beneficiaries and their funds.

A third type of case, which in a few instances accompanied a right-to-health Provision or Obligation Case, corresponds to what Gauri and Brinks have identified as "Regulatory Cases."[38] In these cases, court intervention directly generates some form of regulation of public or private insurers and providers.[39] In the claims for HIV/AIDS treatment contained in the Database, however, there were no decisions exclusively demanding the regulation of insurers or providers. The parties requested that the court regulate PMO coverage duties to migrants in only one of the Provision cases.[40] That court granted coverage to the immigrant plaintiffs but refused to reach the issue of coverage duties to all immigrants.[41] The absence from the Database of Regulatory Cases seems to suggest that HIV/AIDS patients did not seek judicial recourse for more structural and systemic claims in this area.

supra note 7, at 268, 271 n.21 (citing Andrew Clapham for his use of the phrase "privatization of constitutional rights").

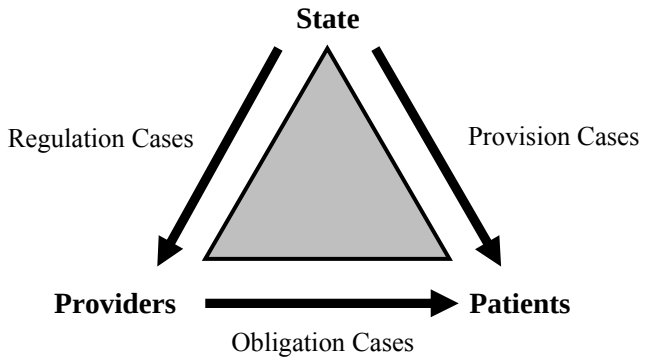
38. *See* Gauri & Brinks, *supra* note 34, at 10 (defining regulatory cases as those adjudicating duties between the state and service providers).

39. *Id.*

40. In the *EAG* case, the parties requested that the court clarify coverage duties, but the court declined to deal with the regulatory claim. CNCiv. y Com., sala III, 29/10/2002, "EAG y otros c. Ministerio de Salud de la Nacion / amparo," no. 8.972/01.

41. *Id.*; *cf.* Brinks & Gauri, *supra* note 18, at 331–32 ("[I]n many instances in which the courts are unwilling to impose new duties of provision on the state, they will still respond to demands that a particular policy (or its absence) unduly harms the protected interests of a particular group.").

Figure 3. Gauri and Brinks's Triangular Shape for Social Rights Litigation



Source: Varun Gauri & Daniel M. Brinks, *Introduction: The Elements of Legalization and the Triangular Shape of Social and Economic Rights*, *in* COURTING SOCIAL JUSTICE 100, 119–32 (Varun Gauri & Daniel M. Brinks eds., 2008)

II. The First Generation of HIV/AIDS Treatment Cases: From Legislative Promises to a National Policy for the Supply of HIV/AIDS Drugs

The roots of the litigation on access to HIV/AIDS treatment trace back to 1990 when, after several years of restrictive biosecurity policies, the congress adopted Law 23,798, the *Ley de Lucha contra el SIDA*,[42] a pioneer rule for Latin America. The new statute symbolized an important step away from prior blatantly discriminatory initiatives.[43] Among other things, it declared the fight against AIDS a national interest; mandated the establishment of a comprehensive national policy for its diagnosis, treatment, and prevention; and appointed the NHD as the body in charge of applying the law in coordination with provincial health authorities.[44]

The adoption of the new statute laid the groundwork for the implementation of a national policy to strengthen the erratic initiatives that preceded its passage. However, the institutionalization of a national policy to

42. Law No. 23798, Sept. 14, 1990, [26972] B.O. 2.

43. *See* Juan Carlos Tealdi, *Responses to AIDS in Argentina: Law and Politics*, *in* LEGAL RESPONSES TO AIDS IN COMPARATIVE PERSPECTIVE 377, 384 (Stanislaw Frankowski ed., 1998) (recounting a scandal resulting from news coverage of a policy of discrimination around the time of Law 23,798's passage); Organización Panamericana de la Salud, [OPdS] [Pan-American Health Organization], *Digesto de Leyes Nacionales y Provinciales de la República Argentina sobre VIH/SIDA* [*Digest of National and Provincial Laws of the Republic of Argentina about HIV/AIDS*], at 5, 68, OPdS Pub. No. 45 (1997), *available at* http://www.ops.org.ar/publicaciones/pubOPS_ARG/pub45.pdf (arguing that the purpose of Argentinean AIDS law is to protect the population against discrimination and to respect the confidentiality of those diagnosed with the disease).

44. Law No. 23798, arts. 1, 3, 4.

fight the disease was confronted with several challenges. Initial obstacles arose primarily from ideological tension from two strategies of the Menem administration—an alliance with conservative sectors of the Catholic Church and the broad reform agenda inspired by the Washington consensus—that pushed against the development of a robust national and universal policy against AIDS.[45]

A. Political Blockage and Implementation Gaps in the First Years of the Menem Administration

During the first three years of the Menem administration, the process of implementing a policy to combat AIDS and offer free treatment was marked by confrontations between two groups within the administration: those pushing to create a national policy and those fiercely opposing all legislation concerning the disease. In the beginning, opposition voices—primarily from conservative figures linked to the Catholic Church[46]—dominated the discussion; however, by April 1992, those awaiting the establishment of a national policy seemed to have something to celebrate. After a scandal involving the treatment of prisoners living with AIDS,[47] Menem replaced Avelino Porto and appointed César Aráoz the new head of the NHD.[48] In trying to show distance from his predecessor, Aráoz quickly promised to take AIDS seriously.[49] Among other measures, he announced a plan to introduce preventive initiatives (including mandatory sexual education in schools), discussed the free distribution of condoms, and launched a media campaign.[50] He also relaunched the Program with USD23 million in reserve funds.[51]

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45. *See* Carlos Santiso, *Gobernabilidad democrática y reformas económicas de segunda generación en América Latina* [*Democratic Governance and Second-Generation Economic Reforms in Latin America*], 8 REVISTA INSTITUCIONES Y DESARROLLO [INSTITUTIONS & DEV. REV.] 325, 343–45 (2001), *available at* http://ceder.ulagos.cl/gestiondesarrollo/gobernabilidadyreformas.pdf (describing the "important tension" between the neoliberal economic reforms of Carlos Menem under the Washington consensus and "political consolidation"); PETRACCI & PECHENY, *supra* note 21, at 172–73 (discussing Menem's conservative right-to-life policies associated with the Catholic Church).

46. Menem's commitment to the Church was epitomized by his alignment with the Vatican at United Nations' conferences in the 1990s. *See* PETRACCI & PECHENY, *supra* note 21, at 176–77 (describing the policies proposed by Menem at U.N. conferences and the relationship of those policies to the Church's positions).

47. Tealdi, *supra* note 43, at 384.

48. Carlos H. Acuña & Mariana Chudnovsky, *Salud: Análisis de la dinámica político–institucional y organizacional del área materno infantil* [*Health: Analysis of the Political–Institutional and Organizational Dynamics in the Area of Juvenile Pregnancy*] 24 (Centro de Estudios para el Desarrollo Institucional [CEDI] [Ctr. for the Study of Institutional Dev.], CEDI Working Paper No. 61, 2002), *available at* http://faculty.udesa.edu.ar/tommasi/cedi/dts/dt61.pdf.

49. Tealdi, *supra* note 43, at 385.

50. *Id.*

51. *See id.* at 385–86 (discussing Julio César Aráoz's announcement that he would start "the anti-AIDS campaign that was never carried out in the country"); *id.* at 387 (mentioning that the budget for the Program was USD23 million in 1993). Pursuant to Resolution 18/1992, the Program

Despite signs of an initial reformative promise, ideological tensions within the Menem administration came to a head in early 1993 when the Secretary of Health, Alberto Mazza, replaced Aráoz.[52] Mazza's appointment signaled the triumph of conservatives within the Menem Administration[53]—a turn with upsetting implications for health reforms and HIV/AIDS policies. A few months after Mazza replaced Aráoz, the Program established by the latter had already begun to encounter restrictions on financing for treatment supplies used in combatting opportunistic diseases affecting 1,200 AIDS patients.[54] Due to lack of payment, pharmaceutical companies began to discontinue their provision of drugs.[55] In September 1993, Mazza appointed a new director of the Program, Laura Astarloa, who headed it until December 1999.[56]

At this point, in addition to Church antagonism, another important source of ideological blockage had begun to hinder the implementation of Law 23,798. By the time of the statute's approval in 1990, former President Alfonsín's plans to integrate and nationalize the overfragmented Argentinian health system[57] had been defeated and were to be replaced by social-sector reforms promoted by the World Bank and the Inter-American Development Bank.[58] Those reforms led to fiscally oriented initiatives aimed at reducing public health expenditures and improving efficiency through competition

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would develop preventive and control measures while guaranteeing the provision of treatment to patients. Res. no. 18/1992, Oct. 1, 1992, [27526] B.O., *invalidated by* Res. no. 2145/2006, Oct. 12, 2006, [31016] B.O. 49, *available at* http://www.ops.org.ar/publicaciones/pubOPS_ARG/pub50.pdf.

52. *See* Juan Carlos Tealdi, *Las respuestas legales y políticas al sida en la Argentina* [*The Legal and Political Responses to AIDS in Argentina*], 2 BIOÉTICA Y BIODERECHO [BIOETHICS & BIOLAW] 41, 48–49 (1997) (Arg.) (describing Aráoz's difficulties with the Church's position against certain efforts to educate the public about the AIDS epidemic and his replacement in 1993).

53. *See id.* (recognizing political changes arising from pressure placed on political officials by religious groups and a belief that Mazza would not defend public sector interests).

54. *Id.* at 49.

55. *Id.*

56. *Id.*

57. For a discussion of President Alfonsín's proposal, see MCGUIRE, *supra* note 12, at 138. Actually, the first version of the original bill was approved by the House in September 1988—three months before congress passed Laws 23,660 and 23,661—and was the last legislative attempt to model a universal health insurance system. *Cf.* Guillermo Alonso, *Vida, Pasión y ¿Muerte? del Seguro Social de Salud Argentino* [*Life, Passion, and Death? of the Social Health Insurance System*], 11 PERFILES LATINOAMERICANOS [LATIN AM. PROFILES] 157, 161 (1997) (Mex.) (describing the elements of personal choice involved in the deregulation of the health insurance system, suggesting the failures of efforts to create a universal system). *See generally* Desarrollo local y regional: hacia la construcción de territorios competitivos e innovadores [Local and Regional Development: Toward the Construction of Competitive and Innovative Territories], July 10–12, 2002, *Descentralización fiscal en Argentina: Restricciones impuestas por un proceso mal orientado* [*Fiscal Decentralization in Argentina: Restrictions Imposed by a Misguided Process*], 18, U.N. Doc. LC/BUE/R.252 (Aug. 2002) (by Oscar Centrángolo & Francisco Gatto) (recounting the legislative history of creating a health system in Argentina).

58. Peter Lloyd-Sherlock, *Health Sector Reform in Argentina: A Cautionary Tale*, 60 SOC. SCI. & MED. 1893, 1894–96 (2005).

within the social-health sector.[59] With that aim in mind, the administration implemented reforms including privatization, decentralization, and the establishment of *Plan Médico Obligatorio* (PMO), a basic health plan defining coverage duties.[60]

The first years of Mazza's tenure were devoted to implementing these reforms, which meant clarifying contributory providers' HIV/AIDS treatment coverage duties.[61] To do so, at the behest of legislators from the opposing Radical Party, congress passed Law 24,455, in which congress articulated the duty of OSSs to cover treatment for HIV/AIDS as part of the PMO and established a federal government subsidy of such costs.[62] Additionally, those years were characterized by the almost total absence of national preventive policies, which many construed to be the result of the opposition successfully mounted by the Church.[63]

Despite the growing number of people contracting the disease, by 1996, the fight against HIV/AIDS clearly was not a priority in the shrinking public health agenda. The establishment of extended prevention policies through national information campaigns or sex education seemed unthinkable as Mazza even considered rejecting international funds offered to fight the disease.[64] Prospects for expanding the number of people that could now be treated with recently discovered antiretroviral drugs (ARVs) were bleak given the budgetary cuts suffered by the Program that year.[65] Moreover, coordination problems between national and incipient provincial programs

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59. *See id.* at 1897 (describing 1995 reform proposals that sought full competition in the health sector and enacted reforms that recognized workers' freedom to select their insurance).

60. Susana Belmartino, *Una Década de Reforma de la Atención Médica en Argentina* [*A Decade of Reform of Medical Care in Argentina*], 1 SALUD COLECTIVA [COLLECTIVE HEALTH] 155, 164 (2005).

61. *See* Enrique Visillac, *1983–2007: La salud en democracia* [*1983–2007: Health in Democracy*], BOLETIN DE TEMAS DE SALUD DE LA ASOCIACIÓN DE MÉDICOS MUNICIPALES DE LA CIUDAD DE BUENOS AIRES [NEWSLETTER OF HEALTH TOPICS OF THE ASSOCIATION OF DOCTORS OF THE CITY OF BUENOS AIRES] (Aug. 2007), http://www.medicos-municipales.org.ar/bts0807.htm#3 (describing the Argentinian health system and Mazza's role in defining coverage in the system generally).

62. Law No. 24455, Mar. 1, 1995, [28098] B.O. 1; *see* Bianco et al., *supra* note 28, at 10 (noting that the opposition party was the source of this legislation and the disagreements that emerged as to the scope of coverage—such as those involving mental health treatment for HIV/AIDS patients).

63. *See* Mónica Petracci et al., *A Strategic Assessment of the Reproductive Health and Responsible Parenthood Programme of Buenos Aires, Argentina*, 13 REPROD. HEALTH MATTERS 60, 62 (2005) ("The pressure from the Catholic Church . . . with regard to sexual and reproductive rights blocked any possibility of a national law being considered."); *see also, e.g.*, Tealdi, *supra* note 52, at 48, 49–50 (describing the Church's opposition to a video to educate children about sexual choices and potential health consequences).

64. *See* Tealdi, *supra* note 52, at 387 (discussing how Mazza refused to promote the use of condoms and clean syringes even though the World Bank offered to loan $20 million for AIDS prevention if the government accepted those conditions).

65. Interview with Interviewee A, Former Dir., Programa Nacional de Lucha contra los Retrovirus Humanos [The Nat'l Program for the Fight Against Human Retroviruses], in Buenos Aires, Arg. (June 4, 2009).

were gradually becoming more acute, resulting in restricted access to treatment for patients outside Buenos Aires.[66]

Compounding the problem were ideological and managerial shortfalls within the public programs and the OSSs' reluctance to cover treatment as mandated by Law 24,455.[67] The situation was even worse for patients of social funds not regulated by such law and for patients of EMPs left to the arbitrary coverage decisions of their unsupervised insurers.[68]

B. Litigation Enters the Scene: The First Cases

While the difficult process of implementing universal coverage unfolded, the constitutional reform of 1994 laid the foundation for the employment of a set of legal tools that would facilitate the use of new strategies by patients and their organizations. Indeed, the 1994 constitutional amendments provided the opportunity for the exercise of proactive initiatives by patients who could now resort to judicial enforcement of a constitutionally protected right to health.[69] The 1994 reforms included the expansion of social rights protections, in particular those corresponding to the right to health, through the incorporation of references to "a healthy and balanced environment fit for human development"[70] and consumers' rights "to the protection of their health, safety, and economic interests."[71] Moreover, article 75 defined congress's duty to legislate in keeping with a social justice agenda and to provide certain specific health protections on the basis of equality.[72] The right to health was further defined by several references to human rights treaties included under article 75(22).[73]

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66. *Id.*

67. *Id.*

68. *Id.*

69. *See* Enrique Peruzzotti & Catalina Smulovitz, *Social Accountability: An Introduction*, *in* ENFORCING THE RULE OF LAW: SOCIAL ACCOUNTABILITY IN THE NEW LATIN AMERICAN DEMOCRACIES 3, 14 (Enrique Peruzzotti & Catalina Smulovitz eds., 2006) (stressing the importance of the development and incorporation in constitutional reforms of new legal instruments to "improve the defense of the rights of ordinary citizens and their access to justice").

70. Art. 41, CONSTITUCIÓN NACIONAL [CONST. NAC.].

71. *Id.* art. 42.

72. *Id.* art. 75(19). Article 75(2) requires that the distribution of nationally levied taxes be "based on principles of equity and solidarity[,] giving priority to the achievement of a similar degree of development, of living standards and equal opportunities throughout the national territory." *Id.* art. 75(2). Article 75(8) mandates the annual allocation of the budget following the principles set forth in article 75(2). *Id.* art. 75(8). Article 75(19), known as the "progress clause," authorizes congress to take actions conducive to "economic progress with social justice." *Id.* art. 75(19). Article 75(23) lists among congress's powers the mandate "[t]o legislate and promote positive measures guaranteeing true equal opportunities and treatment, the full benefit and exercise of the rights recognized by this Constitution and by the international treaties on human rights in force, particularly referring to children, women, the aged, and disabled persons." *Id.* art. 75(23). The last paragraph of article 75(23) includes a reference to the country's commitment to maternal and infant health. It requires congress to create a special and integral social security system to serve this goal. *Id.*

73. *Id.* art. 75(22).

The reforms also introduced a number of new procedural resources, such as the *amparo colectivo*, a procedural mechanism for the collective enforcement of constitutional rights.[74] These and other legal enabling factors, extensively discussed in the literature on the transformation of the role of courts,[75] most certainly contributed to creating a context for the judicialization of disputes over access to HIV/AIDS treatment.

It was at this point that litigation began to play a role in the fight for universalizing treatment. The first individual case seeking access to medicines publicized in legal periodicals was litigated in 1995.[76] Even though the opinion contained no citations to the constitution or its legal framework and did not reveal much about the court's reasoning, courts began to invoke it as precedent to protect privately insured patients who, at the time, were often denied treatment based on the alleged absence of a general legal duty to treat HIV/AIDS patients.[77]

The following year, 1996, marked an important point in the struggle against AIDS, as a group of activists from the main civil-society organizations working to combat HIV/AIDS began to coordinate strategies to foster universal access to ARVs for patients.[78] One of the proactive strategies in which some members of the group were involved consisted of the promotion of legislation clarifying the duty of private funds to cover HIV/AIDS treatment.[79] Interestingly enough, the resulting bill, which would become

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74. GUSTAVO MAURINO ET AL., LAS ACCIONES COLECTIVAS: ANÁLISIS CONCEPTUAL, CONSTITUCIONAL, PROCESAL, JURISPRUDENCIAL Y COMPARADO [COLLECTIVE ACTIONS: CONCEPTUAL, CONSTITUTIONAL, PROCEDURAL, JURISPRUDENTIAL AND COMPARATIVE ANALYSIS] 77 (2005).

75. *See, e.g.*, Catalina Smulovitz, *Judicialization in Argentina: Legal Culture or Opportunities and Support Structures?*, *in* CULTURES OF LEGALITY: JUDICIALIZATION AND POLITICAL ACTIVISM IN LATIN AMERICA 242–43 (Javier A. Couso et al. eds., 2010) (discussing *amparos* as one of the changes that modified the institutional structure to promote judicialization).

76. Juzgado Nacional de Primera Instancia [1a Inst.] [National Court of First Instance], 25/9/1995, "T.C.A. c. Promed S.A. / amparo," J.A. (1996-I-405).

77. *See* Sandra M. Wierzba, *Protección de datos de salud en procesos judiciales* [*Protection of Health Data in Judicial Processes*], 22 REVISTA JURIDÍCA: ÓRGANO INFORMATIVO DEL PODER JUDICIAL DEL ESTADO DE NAYARIT [LEGAL J.: INFO. OFF. JUD. POWER ST. NAYARIT] 15, 19 & n.20 (Mex.), *available at* http://www.tsjnay.gob.mx/tribunal/revistas/revista22.pdf (citing *T.C.A. c. Promed S.A.* as one of the many cases that effectively ordered hospitals to provide care and medicine to AIDS patients).

78. Interview with Mabel Bianco, Former Dir., Programa Nacional de Lucha contra los Retrovirus Humanos [The Nat'l Program for the Fight Against Human Retrovirus], in Buenos Aires, Arg. (May 29, 2009); Interview with Interviewee B, Att'y, in Buenos Aires, Arg. (June 17, 2009). Participants in the meetings included prominent advocates from the gay and women's movements and lawyers with human rights and health backgrounds. Interview with Interviewee B, *supra*.

79. María del Carmen Moreau de Banzas, Silvia Vazquez, and Cristina Guevara, three house members of the Radical Party then leading the opposition, initially conceived of the project. The legislators sought the opinions of members of the group and collaborated with lawyers in the design of the statute. Interview with Mabel Bianco, *supra* note 78; Interview with Interviewee B, *supra* note 78. *See also* C.D. Rep. 18, 46a. Reu.—20a Ses. D.S. 11/20–21/87 (identifying legislative supporters of the measure).

Law 24,754,[80] was the first bill to be passed by congress regulating the coverage duties of EMPs, to that point an extremely underregulated subsector of the health care system.[81] It should be noted that despite the isolation and lack of elaboration in the *T.C.A.* case discussed above, interviewees claimed that the case played an important role in the passage of Law 24,754.[82]

C. First-Generation Provision Cases: The Benghalensis[83] *Litigation*

Even if the approval of Law 24,754 did not end the debate over private funds' duty to cover treatment, by the end of 1996, it represented a major victory for the advocates finally beginning to put in motion more proactive initiatives. The second litigation-based strategy developed by activists in spring 1996 resulted in the *Benghalensis* case—a pioneer Provision Case, not only for what it meant for the expansion of access to HIV/AIDS treatment, but also for its innovative approach to a type of problem not seen at the time as judicially actionable.[84]

During 1996, troubles accessing free treatment from the Program intensified.[85] Meanwhile, the number of patients had doubled and the budget had been reduced by two-thirds.[86] After several meetings and discussions among advocates and lawyers, on November 29, 1996, the group finally filed suit against the NHD and the Program, requesting compliance with Law 23,798, the constitution, and human rights treaties recognizing a right to health.[87] The case was filed by eight organizations but excluded the

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80. Law No. 24754, Dec. 23, 1996, [28555] B.O. 1.

81. Paul M. Rodriguez & Daniela A. Arnus, *Judicial Protection Against Health:* Femeba Quilmes *Medical Circle "Can Defend,"* JADDREAMER.COM (Nov. 17, 2005), http://www.jadeddreamer.com/judicial-protection-against-health-femeba-quilmes-medical-circle-can-defend/index.html. The bill extended to EMPs the duty to cover HIV/AIDS treatment for social funds, as specified in Law 24,455, and was passed by the house and the senate in less than ten days, when it become Law 24,754. *Cf.* S. Rep. 14, 78a. Reu.—31a Ses. D.S. 11/28/96 (identifying date of senate consideration of the legislation and scope of coverage). It was directly considered on the floor of the house on November 20 and 21, 1996 and defended by the informant member on the grounds that it was going to reduce public spending, ultimately providing treatment for unprotected patients of EMPs. C.D. Rep. 18, 46a. Reu.—20a Ses. D.S. 11/20–21/87. The senate, which also considered it on the floor, rapidly approved the bill. S. Rep. 14, 78a. Reu.—31a Ses. D.S. 11/28/96. For a discussion of the current state of regulation and recent efforts to reform EMPs, see "*Las prepagas tienen privilegios excepcionales," sentenció el moyanista Plaini*, LA NACIÓN (Arg.), Apr. 18, 2011, http://www.lanacion.com.ar/1366581-las-prepagas-tienen-privilegios-excepcionales-sentencio-el-moyanista-plaini.

82. Interview with Mabel Bianco, *supra* note 78; Interview with Interviewee B, *supra* note 78.

83. CSJN, 1/6/2000, "Asociación Benghalensis y otros c. Estado Nacional / amparo," Fallos (2000-323-1339).

84. Despite its relevance in the configuration of a new style of litigation, the case has been scarcely studied. As an exception, see Bianco et al., *supra* note 28, at 13 (discussing the *Benghalensis* litigation in the context of the development of the right to HIV/AIDS health care in Argentina).

85. *See id.* at 12 (chronicling indicia of worsening conditions for AIDS patients in 1996, including budget cuts and rising rates of infection).

86. *Id.*

87. Bianco et al., *supra* note 28, at 13.

Comunidad Homosexual Argentina, which, though part of the group, could not join in the suit because it lacked authorization to operate.[88]

In less than a week, Judge Rodríguez de Vidal granted a preliminary injunction ordering the NHD to supply viral-load tests, Vademecum, and ARVs.[89] The following year, on November 19, 1997, the judge signed her decision confirming the terms of the preliminary injunction and ordering the NHD once more to comply with Law 23,798 and the constitution.[90] The decision was appealed by the NHD, but a few months later, on March 5, 1998, the court of appeals upheld the judgment of the lower court.[91] Finally, on June 1, 2000, the supreme court also found for the plaintiffs.[92] In drafting the opinion adopted by the majority of the court four years after the filing of the suit, the attorney general recognized the fundamental character of the right to health.[93] He also acknowledged the interconnectedness of the right to health and the right to life.[94] The decision cited several constitutional clauses and grounded its conclusions in references to international human rights treaties that provide for the duty to respect, protect, and fulfill the right to health.[95] Additionally, the court relied on the international commitments assumed by Argentina upon the signing of these human rights instruments.[96]

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88. *Benghalensis*, Fallos (2000-323-1339). The Argentinian supreme court upheld the denial of the organization's petition to be registered as a nonprofit organization in 1991. CSJN, 22/11/1991, "Comunidad Homosexual Argentina c. Resolución Inspección General de Justicia / personas jurídicas," Fallos (1991-328-1491).

89. Interview with Judge Rodríguez Vidal, Presiding Judge, *Benghalensis* Litigation, in Buenos Aires, Arg. (June 3, 2009). Judge Vidal's decision on December 5, 1996 granted a preliminary injunction ordering the provision of (a) the supplies needed to test patients, (b) all of the drugs provided for in the basic Vademecum established on May 13, 1994, and (c) all the drugs approved by the ANMAT between 1995 and 1996, even if they had not been incorporated into the 1994 Vademecum. This was specially to address the supply of ARVs. *Id.*

90. *Id.* *See also* Opinión del Procuración General de la Nación [Op. of the Nat'l Att'y Gen. Office], "Asociacion Benghalensis y otros c. Estado Nacional / amparo," 22/2/1999, pts. II to IV, *adopted by Benghalensis*, Fallos (2000-323-1339) (discussing the granting of the injunction and subsequent attempt to enforce compliance); *El Estado, obligado a atender el SIDA* [*The State is obligated to pay attention to AIDS*], LA NACIÓN, June 2, 2000, http://www.lanacion.com.ar/nota.asp?nota_id=19161 (Arg.) (reporting on the supreme court's decision in *Benghalensis* and providing the history regarding Judge Rodriguez de Vital's granting of a preliminary injunction).

91. Cámara Nacional de Apelaciones en lo Contencioso Administrativo Federal [CNFed.] [National Court of Appeals on Federal Administrative Litigation], sala I, 5/03/1998, "Asociación Benghalensis y otros c. Ministerio de Salud y Acción Social—Estado Nacional / amparo," no. 33.629/96.

92. *See* Victor Abramovich & Laura Pautassi, *Judicial Activism in the Argentine Health System: Recent Trends*, 10 HEALTH & HUM. RTS., no. 2, 2008 at 53, 57, 65 n.25 (discussing the history of the *Benghalensis* case).

93. Opinión del Procuración General de la Nación [Op. of the Nat'l Att'y Gen. Office], "Asociacion Benghalensis y otros c. Estado Nacional / amparo," 22/2/1999, pt. V, *adopted by Benghalensis*, Fallos (2000-323-1339).

94. *Id.*

95. *Id.*

96. *Id.* pt. V (acknowledging that the National Court of Appeals in Federal and Administrative Litigation had expressed that the state had an obligation to combat AIDS per various constitutional mandates, pacts with constitutional status, and statutes).

Finally, the court laid out the grounds for developing an interpretation of federal rules in the realm of health and defined the government's duty to coordinate policies between the national and provincial governments.[97] Even though the judgment specifically concerned the enforcement of Law 23,798, it was an important precedential step in the development of the court's doctrines regarding federalism and health policies.[98] The court expressly considered the NHD's allegations that courts could not review the administrative decision to reassign budgetary lines.[99] In doing so, the court found that both the constitution and Law 23,798 required the allocation of resources to meet the commitments set forth therein and that the breach of this duty represented a violation of the constitution.[100] From a remedial point of view, the order was simple. It mandated the supply of treatment without distinguishing patients covered under the Program from those not yet covered by it. The court assessed neither the criteria used by the existing Program to allocate resources among patients nor the criteria used to distribute certain types of drugs.

The case remained opened from 1996, when the judge granted the first preliminary injunction, to 2001, when she issued the last individual injunction.[101] During that period, the judge received several petitions directly from patients seeking access to ARVs, and she included them as parties to the case.[102] Similarly, lawyers and advocates of NGOs involved in the case helped file claims from patients around the country,[103] and advocates in Buenos Aires referred local patients searching for treatment to local lawyers.[104]

D. Impacts of the Benghalensis *Litigation*

In the process being implemented, the *Benghalensis* litigation impacted several dimensions of public policy regarding provision of free treatment.

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97. *Id.* pt. XI.

98. *See* Walter F. Carnota, *Rights and Politics in Argentine Social Security Reform*, 44 AUSTRALIAN J. POL. SCI. 115, 122 (2009) (stating that the Argentinian supreme court "became sensitive to issues relating to a right to health" evidenced by *Benghalensis*); *see also* Maria Gracia Andia, Disadvantaged Groups, the Use of Courts, and Their Impact: A Study of Legal Mobilization in Argentina Through the LGBT Movement 15 (Aug. 23, 2010) (unpublished manuscript), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1664178 (stating that *Benghalensis* "is extremely central because the Court's decision states that the National State is the guarantor of the country's population health").

99. Opinión del Procuración General de la Nación [Op. of the Nat'l Att'y Gen. Office], "Asociación Benghalensis y otros c. Estado Nacional / amparo," 22/2/1999, pt. XII, *adopted by Benghalensis*, Fallos (2000-323-1339).

100. *Id.*

101. In June 2001 alone, the judge granted 11 individual preliminary injunctions to provide treatment. Interview with Judge Rodríguez Vidal, *supra* note 89.

102. Interview with Mabel Bianco, *supra* note 78; Interview with Judge Rodríguez Vidal, *supra* note 89.

103. Interview with Interviewee B, *supra* note 78.

104. *Id.*

As suggested by Mæstad, Rakner, and Ferraz's impact matrix, the effects of the right-to-health litigation can be observed at the individual, policy, and societal levels.[105] The impact of the case on the individuals that joined the collective litigation was clear, since receiving an order from the judge implied that treatment would be provided within the following forty-eight hours.[106] Moreover, interviewees pointed to the significant expansion during 1997 of the number of patients covered under the national Program as a direct effect of the case.[107] For that year the number of patients receiving free treatment escalated from 400 in July to 1,413 by November.[108]

However, the effects of *Benghalensis* extended beyond the patients actually involved in the case and those incorporated into the Program as a result of its expansion during 1997. As described below, together with the 1997 receipt of international funds used to set up the LUSIDA program,[109] the litigation represented an important tool to confront the ideological blockage that had complicated the implementation of Law 23,798; contributed to the transformation of the political agenda regarding treatment for HIV and AIDS previously plagued by administrative inaction; and significantly redefined the Program and its coordination with its provincial counterparts.

First, according to the director of the Program, the litigation was key to dismantling the internal ideological blockage within the NHD cultivated earlier by Mazza.[110] As stated by one interviewee working for the NHD at the time, once the case and the subject were in the media, the Ministry began to yearn for "a week without having to hear about AIDS."[111] The media's coverage of the litigation may have contributed to expanding public awareness of the NHD's deficient policies. Indeed, press coverage of the HIV/AIDS litigation in Argentina began with *Benghalensis* and was repeated each time an access-to-treatment case was at stake.[112]

Second, the case impacted policy priorities within the Program and set in motion several initiatives that redefined its existing rules, scope, design, and operation, both at the national level and in coordination with provincial

105. Ottar Mæstad, Lise Rakner & Octavio Ferraz, *Assessing the Impact of Health Rights Litigation: A Comparative Analysis of Argentina, Brazil, Colombia, Costa Rica, India, and South Africa*, *in* LITIGATING THE RIGHT TO HEALTH, *supra* note 30.

106. What is more, in other cases, the press has reported that judges had to travel to providers' facilities to demand compliance with the court orders. Mónica Galmarini & Fabián Debesa, *Un juez reclamó personalmente drogas antisida para una mujer* [*A Judge Personally Asked for Anti-AIDS Drugs for a Woman*], CLARÍN.COM, Mar. 2, 2005, http://edant.clarin.com/diario/2005/03/02/sociedad/s-02601.htm.

107. Interview with Mabel Bianco, *supra* note 78; Interview with Interviewee A, *supra* note 65.

108. Bianco et al., *supra* note 28, at 21.

109. Interview with Mabel Bianco, *supra* note 78; Interview with Interviewee A, *supra* note 65.

110. Interview with Interviewee A, *supra* note 65.

111. *Id.*

112. *See, e.g.*, *El Estado, obligado a atender el SIDA* [*The State, Obligated to Attend to AIDS*], LA NACIÓN, June 2, 2000, http://www.lanacion.com.ar/19161-el-estado-obligado-a-atender-el-sida (reporting on the *Benghalensis* case).

policies. During 1998, the Program experienced an important increase in the allocation of financial resources, USD19 million to USD70 million.[113] These budgetary changes were accompanied by other reforms, including the creation of a new system for the decentralized delivery of drugs through hospitals.[114]

From a policy-making perspective, *Benghalensis* not only reduced political blockage within the NHD, but also helped strengthen the institutional design and the organization of a policy for the free supply of ARVs to patients from different jurisdictions of the country. Ultimately, as an interviewee put it, the litigation helped to turn a unitary program operating exclusively in Buenos Aires into a federal one with increasing presence across several jurisdictions.[115]

Lastly, the case was relevant for its innovative use of legal tools that would continue to forge significant changes in the system. To begin with, the case helped define the contours of the still unregulated *amparo colectivo*. The court's recognition of standing for a group of NGOs that was not accompanied by an "affected" individual as a party to the case represented a true experiment. In that sense, the decision in November 1996 to bring a collective case without including a single individual claimant was itself a risky idea. Moreover, the *amparo colectivo* was only a two-year-old tool, and there were few precedents to predict what courts would do with the device. Even more uncertainty surrounded the estimation of the final costs of litigation in the case of a defeat, an important concern for recently created NGOs experiencing resource constraints. The case was litigated when the public-interest litigation movement was still in its infancy.[116] From a doctrinal standpoint, the supreme court's decision was also relevant because the decision was one of the first to establish acceptance of the justiciability of the right to health.

Table 1 sums up the effects discussed above and includes examples of concrete impacts that together exemplify instances of interbranch cooperation (instilled by the *Benghalensis* litigation) between the courts and the administration.

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113. Bianco et al., *supra* note 28, at 13.

114. *See id.* at 13, 21 (reporting that "the supply of medicines was largely regularized" after the 1998 budget increase, and detailing the subsequent distribution of drugs through multiple channels, including several hospitals).

115. Interview with Interviewee A, *supra* note 65.

116. For a comprehensive description of the evolution of the use of courts as instruments of reform in the context of one of the main human rights organizations, see generally CENTRO DE ESTUDIOS LEGALES Y SOCIALES [CTR. FOR LEGAL & SOC. STUDIES], LA LUCHA POR EL DERECHO: LITIGIO ESTRATÉGICO Y DERECHOS HUMANOS [THE FIGHT FOR RIGHTS: STRATEGIC HUMAN RIGHTS LITIGATION] (2008) (analyzing many of the more than 100 cases tried by the Center).

Table 1. The *Benghalensis* Litigation and Its Effects

Effects / Case	Individual	Policy	Political and Ideological	Legal
***Benghalensis* Case**	Increased litigants' access to ARV. Increased number of individuals covered by the Program.	Regulatory gaps: Incorporated ARV into the Program's Vademecum. Coordination gaps: Resolution768/1998 defining the coordination of national and provincial policies. Budgetary gaps: Increase in the budget to USD70Million. Managerial gaps: Resolution 346/1997 changed the procedure for the purchase of ARVs.	NHD: Dismantled internal ideological blockages. Media: Dissemination of information on public policies.	Right to health, a fundamental right. International commitments. Federalism and coordination. Right to health is justiciable. Broad standing for *amparo colectivo*.

As a final point, the *Benghalensis* case represented the first instance of a strand of Provision Cases that would be litigated at least partly on the grounds defined by the supreme court's decision in *Benghalensis*.[117]

III. A Second Generation of Right-to-Health Claims for HIV/AIDS Treatment

As of 1997, both newspapers and legal periodicals reflected the emergence of new cases demanding the continued supply of free ARVs that both public and contributory providers had begun to limit for different reasons.[118] According to the Database, the number of published cases

117. *See* CSJN, 24/10/2000, "Campodónico de Beviacqua, Ana Carina c. Ministerio de Salud y Acción Social—Secretaría de Programas de Salud y Banco de Drogas Neoplásicas," Fallos (2000-323-3229), slip op. at 7, *available at* http://www.csjn.gov.ar/cfal/fallos/cfal3/ver_fallos.jsp?id=125162&fori=RHC00823.352 (citing *Benghalensis* as affirming the state's obligations concerning the right to health).

118. *See, e.g.*, *Ordenan normalizar la entrega de medicamentos a enfermos de SIDA* [*Court Orders Normalization of Provision of Drugs to AIDS Patients*], LA NACIÓN, July 13, 2001, http://www.lanacion.com.ar/319516-ordenan-normalizar-la-entrega-de-medicamentos-a-enfermos-

including parties seeking or disputing access to treatment from 1997 to 2010 totals thirty-eight. Provision Cases after 1997 are part of a new generation of litigation because they evolved against the backdrop of a Program that was already implementing important institutionalization efforts, inspired by the *Benghalensis* litigation, to offer free ARVs.[119] Second-generation Obligation Cases can be considered part of a new cohort of cases because, after the passage of Laws 24,455 and 24,754, cases were litigated against the background of legal rules defining contributory funds' duties for coverage.

A. Second-Generation Provision Cases

The Provision Cases included in the Database total fourteen, nine of which were Provincial Provision Cases and five of which were Federal Provision Cases. In all of these cases, plaintiffs successfully sought the satisfaction of their right to access ARVs from publically run programs. Second-generation Provision Cases were filed either by individuals or groups as a reaction to the discontinuation of treatment.

These cases are associated with concrete deficits in the operation of national and provincial policies supplying free ARVs, which would result in a breach of provision duties. Such policy gaps emerged, first, from the budgetary constraints affecting the Program beginning in 1997, before the changes from the *Benghalensis* injunction led to the increase of financial resources.[120] At this point, some of the cases, such as *A.C.*[121] or the *Leónidas Lucero*[122] litigation, reflect basic coordination problems between national and provincial administrations that became apparent with the increase in the number of patients and the insufficient allocation of resources during early 1997.[123]

Second, beginning in 2000, Provision Cases also emerged in the context of continuity and adaptability deficits experienced by the Program that led to difficulties in the purchase of drugs.[124] These cases coincided with a new

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de-sida (Arg.) (discussing a court order to normalize drug delivery to members of the Welfare Projects of the City of Buenos Aires (OSBA) suffering from HIV); *SIDA: otra prepaga es obligada a cubrir los gastos de un paciente* [*AIDS: Another Health-Care Provider Is Required to Cover the Cost for a Patient*], LA NACIÓN, Oct. 31, 1998, http://www.lanacion.com.ar/116162-sida-otra-prepaga-es-obligada-a-cubrir-los-gastos-de-un-paciente (Arg.) (discussing a case where the court ordered a health-care provider to cover the costs of treatment for an AIDS patient).

119. Interview with Interviewee A, *supra* note 65.

120. Interview with Mabel Bianco, *supra* note 78; Interview with Interviewee A, *supra* note 65; Interview with Interviewee B, *supra* note 78.

121. CSJN, 24/10/2000, "Campodónico de Beviacqua, Ana Carina c. Ministerio de Salud y Acción Social—Secretaría de Programas de Salud y Banco de Drogas Neoplásicas," Fallos (2000-323-3229), slip op. at 7, *available at* http://www.csjn.gov.ar/cfal/fallos/cfal3/ver_fallos.jsp?id=125162&fori=RHC00823.352.

122. CApel.CC de Bahía Blanca, sala 2, 9/2/1997, "Hosp. Leónidas Lucero, C., C. y otros c. Ministerio de Salud y Acción Social de la Provincia de Buenos Aires," L.L. (1997-LLBA-1122).

123. Interview with Interviewee A, *supra* note 65.

124. Interview with Mabel Bianco, *supra* note 78.

shortage of the medicines provided by the Program that originated around the time of the presidential succession from Menem to De la Rúa in December 1999.[125] That year, after Menem lost the election, the NHD was virtually paralyzed.[126] The bids that should have been organized to sustain treatment and supplies were delayed,[127] and by early 2000 the shortages were already severe in spite of the fact that the Program had more financial resources than ever, with a total budget of $70 million.[128] These obstacles, which resulted in part from a lack of foresight within the former administration, were compounded later by the failure of the administration to anticipate the cost consequences of the first year of enforcement of new patent regulations scheduled for 2000.[129] Once the new intellectual property framework went into effect, the cost of patented ARV drugs skyrocketed.[130] When health officials opted for the purchase of generics, new confrontations arose between the administration and patients.[131] Moreover, as evidenced in the filings within the *Benghalensis* docket, some patients' organizations went back to court that same year to guarantee access to the brand-drug Kaletra, which had been replaced by generics purchased by the NHD.[132]

Third, beginning in 2001, another set of Provision Cases reached the courts in the context of the unfolding deep economic crisis that culminated later that year in the resignation of President De la Rúa.[133] At this point, new

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125. *See* MARCOS NOVARO, ARGENTINA EN EL FIN DE SIGLO: DEMOCRACIA, MERCADO Y NACIÓN (1983–2001) [ARGENTINA AT THE END OF THE CENTURY: DEMOCRACY, MARKET, AND NATION (1983–2001)] 555 (2009) (describing the shortage of medicine during the presidential transition).

126. Interview with Mabel Bianco, *supra* note 78.

127. *Esta semana pueden agotarse los medicaentos para enfermos de sida* [*This Week May Exhaust Drugs for AIDS Patients*], PÁGINA 12 (Arg.), Dec. 1, 2000 (describing the failure of the Memem administration to organize bids for the purchase of AIDS medication).

128. *See Argentina: AIDS Treatment Interrupted*, INT'L GAY & LESBIAN HUMAN RIGHTS COMM'N (Sept. 18, 2000), http://www.iglhrc.org/cgi-bin/iowa/article/takeaction/partners/793.html (considering problems that arose in 2000 related to public access to drugs in Argentina, even though the budget for "AIDS-related expenditures" was approximately $70 million at the time); Marta García Terán, *Reclaman por el costo del tratamiento* [*Reclaiming the Cost of Treatment*], LA NACIÓN, Dec. 1, 2000, http://www.lanacion.com.ar/43136-reclaman-por-el-costo-del-tratamiento (Arg.) (referring to instances of shortages of treatment supplies in local markets).

129. Gabriela Navarra, *Marca registrada* [*Trademark*], LA NACIÓN, Mar. 22, 2000, http://www.lanacion.com.ar/221228-marca-registrada (Arg.) (discussing the impact on prescription drug prices of the implementation of patent regulations).

130. *Id.*

131. *See Argentina: AIDS Treatment Interrupted*, *supra* note 128 ("Activists are demanding that the Argentinian government take immediate action to resolve the irregularities in drug delivery, guarantee and standardize the quality of ARV medication . . . and stop compromising the health and lives of some of its most physically vulnerable inhabitants.").

132. *Id.*

133. *See* Patrice M. Jones, *Leadership Crisis Adds to Argentina's Misery: Country Already Struggling Through Economic Turmoil*, CHI. TRIB., Dec. 1, 2002, *available at* http://articles.chicagotribune.com/2002-12-01/news/0212010457_1_peronist-party-buenos-aires-argentine-president-carlos-menem (summarizing the situation in Argentina that led to the resignation of President De la Rúa).

individual and collective Provision Cases grew out of financial cuts to the public health sector as a whole. As suggested by the number of cases filed during 2001, the decision to suspend the provision of ARVs was the rule rather than the exception within the different subsectors of the health system.[134] Moreover, toward the end of 2001, in the face of monetary devaluation, drug prices soared and purchasing treatment became even more difficult for providers.[135]

The national chaos that began in December 2001 significantly altered the supply of public health services in the following months. By February 2002, when the new head of the NHD took control of the Program, the shortage of drugs was intensifying and the need to organize new bids was urgent.[136] However, the *Sindicatura General de la Nación* [National General Syndicate] in charge of internal-accounting supervision would not authorize the acquisition of drugs at the prices available in March 2002.[137] Under these circumstances, a few days before the declaration of a national health emergency on March 13, a group of patients accompanied by the lawyers at the Center for Legal and Social Studies (CELS) filed suit, demanding the continued supply of ARVs for patients with HIV/AIDS.[138]

The *A.V.*[139] litigation, as it was called, was introduced on behalf of a number of patients,[140] and CELS was also a party.[141] The judge immediately granted an injunction ordering the NHD to continue provision of treatment.[142] With the NHD's new purchases, the provision of treatment gradually improved.[143] However, in spite of the commitment shown by the NHD, the first months of the case were difficult. Shortages continued throughout the

134. The Database shows nine cases in 2001.

135. *See* Patrice M. Jones, *Argentine Leader to Devalue Peso: Duhalde Seeks to Reform Banks, Regulate Prices*, CHI. TRIB., Jan. 5, 2002, *available at* http://articles.chicagotribune.com/2002-01-05/news/0201050150_1_devaluation-resignation-of-president-fernando-peso (describing the impact of currency reform on drug prices).

136. Interview with Carolina Fairstein, Att'y, Centro de Estudiados Legales y Sociales [CELS] [Ctr. of Legal and Soc. Studies], in Buenos Aires, Arg. (June 3, 2009).

137. *Id.*

138. For a detailed account of the background of this case, see CENTRO DE ESTUDIOS LEGALES Y SOCIALES, EL DERECHO A LA SALUD EN LA LUCHA CONTRA EL VIH-SIDA: UN EXAMEN DE LA POLÍTICA PÚBLICA Y LOS RECURSOS PRESUPUESTARIOS [THE RIGHT TO HEALTH IN THE FIGHT AGAINST HIV/AIDS: AN EXAMINATION OF PUBLIC POLICY AND BUDGETARY RESOURCES] 28–29 (2005).

139. 1a Inst., 27/2/2004, "A.V. y otros c. Ministerio de Salud de la Nación / amparo," Expte. No. 3223/02, slip op.

140. *See* CENTRO DE ESTUDIOS LEGALES Y SOCIALES, *supra* note 138, at 28–30 (explaining that the suit was brought based on the complaints of two beneficiaries of the National Program, but because of the effect of the situation on all beneficiaries, it was brought as a class action).

141. Interview with Carolina Fairstein, *supra* note 136.

142. *Id.*

143. *Id.*

end of the year, and CELS moved for the judge to fine culpable officers of the NHD, a motion the judge granted on December 2, 2002.[144]

As the months passed, patients began to arrive at CELS in search of new court orders for the continuation of treatment. According to the lawyers, patients were apparently receiving the recommendation to go to CELS directly from officers in charge of the supply of treatment.[145] In the chaos that hit the country during the first months of 2002, obtaining a court order became a prerequisite to continued treatment under Argentina's free public programs.[146] Between that time and late 2003, CELS filed, in this same case, petitions for court orders for treatment for forty-nine individuals with different needs ranging from ARVs to special imported drugs for opportunistic diseases.[147]

The *A.V.* case was widely covered by the press and remained open until 2005, when the court of appeals ratified the lower court's judgment, a decision challenged by the NHD and still pending before the supreme court.[148]

Finally, the Database includes four Provincial Provision Cases decided since 2002, where patients have had to litigate to obtain free treatment under provincial programs in Córdoba and Buenos Aires. In those cases, judges issued injunctions for the continued supply of medicines where logistical problems had arisen in the purchase of drugs.[149] The last of these claims, filed in 2010, requested treatment, food, and housing services for a girl with the disease.[150] There, courts construed the injunction to include the plaintiff's demands.[151]

B. Second-Generation Obligation Cases

Obligation Cases, brought against different contributory providers by plaintiffs seeking horizontal enforcement of the right to health, represent twenty-five out of the forty cases in the Database. While seven cases were brought against private funds, seven cases were litigated against the national OSS; six against provincial OSSs; three against the Programa de Atención

144. *Id.*

145. *Id.*

146. *Id.*

147. *Id.*

148. *Id.*

149. *See* Cámara Federal de Apelaciones [CFed.] de Córdoba [Federal Court of Appeals of Córdoba], sala A, 10/05/2006, "F Maca 250171," L.L. (2007-A-255); CFed. de Rosario, sala B, 16/05/2006, "Fernández, Germán v. Ministerio de Salud," no. 874/92, slip op.; Cámara Nacional de Apelaciones en lo Civil y Comercial Federal [CNApel.CC] [National Court of Federal Civil and Commercial Appeals], Sala 1, 10/05/2005, "Chianalino Marina Lorena c. Estado Nacional / amparo," no. 16.507/04, slip op.; Tribunal Familia [Trib. Fam.] de Mar del Plata [Family Court of Mar de Plata], 28/05/2010, n. 2, "G. G. / medidas cautelares," Lexis no. 70061224, slip op.

150. *G.G.*, Lexis no. 70061224, slip op.

151. *Id.*

Médina Integral (PAMI)—the functional equivalent to Medicaid; and two against other OSSs.

The Obligation Cases examined usually alleged a failure to comply with statutory duties to provide coverage. These cases represent a reaction to three situations: the first group of cases, litigated from 1997 to 1998, emerged because EMPs disputed the constitutionality of Law 24,754, opposing congress's mandate that the EMPs honor claims for ARVs.[152] In all of these cases, judges upheld the mandate based on the recognition of a constitutional right to health.[153]

A second group of claims involved the national OSSs' parallel legal obligation to cover treatment, which the government would reimburse through the subsidies established in a redistributive fund pursuant to Law 24,455. The litigants demanded OSS compliance with a legal duty that, in some cases, OSSs were failing to satisfy due to financial constraints or mismanagement of resources. Cases within these categories include, for instance, *NN v. OSDE y Ministerio de Salud*,[154] decided in 1997, and *R.D., J.S. v. Obra Social de la Unión Obrera Metalúrgica*,[155] with EMP and OSS defendants, respectively. These cases emerged where alternative supervising mechanisms under which patients could claim treatment were unavailable or not working properly.

In a third group of Obligation Cases, patients sought horizontal enforcement of the right to health when rules were either absent or unclear in scope. Specifically, where provincial OSSs or other OSSs were excluded from the social health sector regulated by Law 24,455, social funds had often denied their duty to cover or continue treatment.[156] Courts reacted by applying the rules for national OSSs to provincial OSSs by analogy, grounding their reasoning in the constitutional protection of the right to health.[157]

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152. Estudio Ymaz Abogados, *Sida, droga y prepagas. Inconstitucionalidad de la ley 24.754* [*AIDS, Drugs, and Prepayment Plans: The Unconstitutionality of Law 24.754*], BOLETÍN INFORMATIVO, No. 8, July 1999, at 4 (summarizing EMPs' argument that Law 24,754's mandate to cover AIDS treatment unconstitutionally interfered with the private health insurers' autonomy).

153. *See, e.g.*, Cámara Nacional de Apelaciones en lo Civil de la Capital Federal [CNCiv.] [National Court of Civil Appeals of the Federal Capital], sala F, 23/10/1997, "S/N c. Tecnología Integral Médica / amparo," El Derecho [E.D.] (1997-177-144).

154. CNCiv., 23/12/1997, "s/n c. OSDE s/ amparo-sumarísimo," E.D. (1997-176-483). In 2001, the supreme court considered a case on this subject. CSJN, 13/3/2001, "E., R.E. c. Omint S.A. de Servicios / recurso extraordinario," Fallos (2001-324-677), slip op., *available at* http://www.csjn.gov.ar/jurisp/jsp/fallos.do?usecase=mostrarHjFallos&falloId=67212.

155. 1a Inst., 8/9/1999, "R.D., J.S. v. Obra Social de la Unión Obrera Metalúrgica / medida autosatisfactiva," J.A. (2001-II-452).

156. *See, e.g.*, CNCiv., *OSDE*, E.D. (1997-176-483) (recognizing the duty to cover costs for AIDS treatment and finding that the OSS denied that treatment).

157. *See id.* (noting that national law requires the provision of medical treatment for AIDS patients, and applying that law to the OSS defendant).

C. The Effects of Second-Generation Cases

While *Benghalensis* represented a turning point in expanding access to HIV/AIDS treatment for patients in the public health system, none of the subsequent cases resulted in similarly significant policy impacts. Even though courts continued to cooperate in fostering access to HIV/AIDS treatment until recently, the cases initiated after 1997 have not been linked by interviewees or secondary sources to the promotion of relevant reforms.[158]

In any event, the cases in the Database show that the recourse to courts continued after 1997, even in a context of higher budgets, better defined rules, and less flawed policies than a couple of years earlier. Moreover, the cases in the Database expose the need to relitigate certain claims more than once and show courts repeating the argumentative and remedial style of the early decisions, without much innovation.

Second-generation cases are also characterized by patients and their representative organizations filing simple compliance Provision Cases requesting coverage and seeking the enforcement of existing legislation. Second-generation litigation was less often caused by ideological blockage and incomplete commitments to universalize treatment—common features of first-generation cases. In addition, judges exclusively mandated the provision of treatment for an individual or a group of patients in these cases, while avoiding recognition of the collective dimensions of the right to health at stake in each.[159]

An overview of second-generation cases further shows the absence of demands for more structural or systemic approaches to health system deficits or, more specifically, to the multiple policy and regulatory gaps that gave rise to the persistent need for litigation. With the exception of Provision Cases such as *A.V.*, second-generation suits share some traits with right-to-health litigation demanding other drugs and treatments, which has increasingly reached the courts since the late 1990s. Furthermore, in the very few instances in which litigants individually or collectively formulated an aggregate demand concerning the management of health services, the courts never abandoned their practice of adjudicating these demands as simple individual claims for breach of statutory and constitutional duties, thereby avoiding recognition of the collective and aggregated potential effects of the cases.

Perhaps because these cases were ostensibly about enforcing simple coverage rules, judges never reached the causes behind administrative inaction or the violation of the right to health. This is epitomized by the cases

158. As we shall see, the *A.V.* litigation might be an exception to this claim.

159. This type of dynamic is not unique to Argentinian health law. *See* William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497, 502 (2008) (characterizing U.S. health law in general as having developed around private interactions, and "public health law" as having little connection to the institutions that supply or fund the medical profession).

adjudicated around the time of the deep crisis of 2001–2002, where litigation accumulated with other demands in the context of a national health emergency. In their decisions in these cases, judges either avoided referring to the emergency or referred to it only to emphasize its inadequacy as an excuse for the failure to comply with a fundamental constitutional right.[160] Lastly, judges seldom discussed the disparate enforcement of right-to-health claims inherent in a horizontal approach to their adjudication, nor did they consider the systemic deficits inspiring noncompliance—namely, regulatory, coordination, monitoring, management, and budgetary gaps. In fact, that courts failed to recognize their responsibility to mediate access to treatment for HIV/AIDS was symptomatic of the problems within the Argentinian health system as a whole, and seemed to be a striking feature of courts' enforcement of these and other right-to-health claims from 1997 to 2010.[161]

IV. Lessons from Fifteen Years of HIV/AIDS Treatment Litigation

The prior Parts profiled the different stages of litigation by HIV/AIDS patients and their representative organizations over the course of the last fifteen years. I have distinguished the two eras of right-to-health litigation in both Provider and Obligation Cases. Beyond the concrete individual effects of the cases, I have also offered evidence of the broader policy and legal impacts of the litigation—effects that, while clearly acknowledged in a few initial cases, seem harder to identify in those filed after 1997.

With respect to their content, the judgments retrieved in the Database suggest that in both stages of the litigation, courts relied on similar reasoning and simple remedies, such as injunctions, to order the supply of treatment for individuals or groups. In none of the cases did the parties or the courts discuss the lack of preventive or promotional policies within the public health system. Moreover, decisions in second-generation cases do not show much change in terms of courts' express articulation of, or reference to, the collective dimensions of the right to health, its content, or the budgetary constraints under which it operates within different subsectors of the health system. Nor did the cases contemplate the broader background of systemic failures of the health institutions and policies from which the Provision and Obligation Cases emerged. With very few exceptions, such as the *Benghalensis* or the *A.V.* cases brought by NGOs as part of broader strategies—and to a certain extent, even in those cases—judgments have maintained a simple structure limited to ascertaining the violation of a right, without defining its minimum content or a rationality test for administrative conduct. Furthermore, courts have only developed jurisprudence on the coordination duties of the federal

160. *See, e.g.*, CENTRO DE ESTUDIOS LEGALES Y SOCIALES, *supra* note 138, at 30 n.103 (explaining that the court in *A.V.* rejected the government's argument that an emergency could justify its public health failings).

161. For a profile of the litigation for other health services, see generally Bergallo, *supra* note 30.

and provincial authorities in a small number of cases. Finally, as we have seen in the second generation of the litigation, judges have almost never made reference to the types of treatment prescribed, their absolute or relative costs, effectiveness, or quality; nor do they reference the need to import expensive drugs not available in the country. It is particularly telling that in neither generation did decisions allude to political blockage or to any of the regulatory, monitoring, coordination, or managerial gaps that provided the need to resort to courts.

Table 2. Effects of HIV/AIDS Litigation in Argentina by Type of Litigation

Effects / **Type of Litigation**	**Political Blockage**	**Governance Capacities**
Horizontal 2nd Generation Cases	N/A	(−) Regulatory Gap (−) Monitoring Gap
Vertical 2nd Generation Cases (*A.V.*)	N/A	(−/+) Coordination Gap
Horizontal 1st Generation Cases (*T.C.A.*)	(+) Congressional Action	(+) Regulatory Gap (+) Monitoring Gap (OSS, not EMP)
Vertical 1st Generation Cases (*Benghalensis*)	(+) NHD Reactions	(+) Regulatory Gap (+) Coordination Gap (+) Monitoring Gap (+) Managerial Gap (budgetary and organizational gaps)

Table 2 and the preceding Parts suggest that cases have had varied impacts at different points over the fifteen-year span examined. Both individual and collective cases, as well as vertical and horizontal cases, have shown variations in their capacity to surmount political blockage and governance incapacities in the realization of the commitment to guarantee universal access to treatment. This finding clearly supplements available comparative research contrasting structural with individual cases in right-to-health litigation,[162] revealing that impacts can vary within the same family of

162. *See, e.g.*, Mæstad, Rakner & Ferraz, *supra* note 105, at 10 (offering "plausible explanations for this apparent discrepancy in enforcement between collective (including structural) and individual cases").

cases, depending on the time and the institutional background against which plaintiffs resort to courts.

In the concrete case of HIV/AIDS treatment, the first generation of vertical enforcement litigation, namely the *Benghalensis* case, helped dismantle the prevalent ideological blockage behind the postponement of serious policies addressing AIDS. *Benghalensis* also contributed to the confrontation of the public administration's governance incapacities in the exercise of its stewardship functions, inspiring significant changes in national coordination with the provinces and the logistics for the delivery of treatment, among others. Prior to *Benghalensis*, individual cases such as *T.C.A.* and the work of groups of advocates had also inspired legislative reforms defining private funds' duties.

However, after 1998, when the initial barriers behind administrative and legislative inaction finally began to come apart, both individual and collective recourse to the courts in vertical and horizontal Provision and Obligation Cases limited the efficacy of curtailing discontinuities of drugs by public and contributory providers. At this point, recourse to courts somehow lost its cooperative potential beyond the mere order to supply treatment, without significantly affecting the more systematic problems causing the shortages. Neither interviewees nor secondary sources recognized these cases as major instruments that inspired larger reforms. Instead, most of the reforms adopted in the last decade have been attributed to other factors.

On the other hand, while second-generation cases unquestionably contributed to the expansion of access to treatment both from the individual standpoint and from the point of view of certain groups of patients participating in the cases, the effects of courts' intervention remained confined to the situation of the particular plaintiffs, as in the traditional bipolar style of private law cases. As one of the interviewees put it, at this point the litigation caused the Program to function as no more than a "drugstore," and the perpetuation of this litigation may have exacerbated intrapolicy inequalities. In other words, the reinforcement of a curative impulse potentially generated less efficient and equitable results.[163] If one takes into account Gauri and Brinks's warning,[164] this litigation may have fostered interpolicy inequities

163. Interview with Mario Pecheny, Soc. Scientist, in Buenos Aires, Arg. (June 2, 2009). Concentration on the fight for access to treatment may have shifted the allocation of resources and the focus of state policies to the delivery of drugs, to the detriment of prevention and promotion interventions necessary to counteract the progress of the disease. *See* Laura Rocha, *Polémica por el fin del proyecto Lusida* [*Controversy Over the LUSIDA Project*], LA NACIÓN, Dec. 10, 2001, http://www.lanacion.com.ar/nota.asp?nota_id=357997 (Arg.) (describing the four-year history of the LUSIDA program and its possible shutdown). In practice, for several years these interventions remained the sole competence of LUSIDA, a program established thanks to donors' funding. *See Promueven la detección precoz del virus del SIDA* [*Promote Early Detection of AIDS Virus*], LA NACIÓN, Apr. 29, 1998, http://www.lanacion.com.ar/95046-promueven-la-deteccion-precoz-del-virus-del-sida (Arg.).

164. *See* Brinks & Gauri, *supra* note 18, at 336, 340 (stating that private and individual litigation, like the medication litigation occurring in Brazil, "carr[ies] greater risk of producing

affecting the prioritization of public investment in other diseases impacting less privileged groups. These groups' demands may have thus received less attention and resources as a result of the bias towards the better resourced, better publicized struggle at issue in this Article. Finally, in the context of the massive inequalities that result in the disparate situation of patients within different subsectors of Argentina's health care system, the litigation may have also intensified pervasive inequalities in benefits.

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beneficiary inequality" and "operates at times as a rationing device, in which claims are denied to all except those who have the resources to retain a private lawyer").