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Claiming the Right to Health in Brazilian Courts: The Exclusion of the Already Excluded?

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The aim of this article is to test a widespread belief among Brazilian legal scholars in the area of social rights, namely, the claim that courts are an alternative institutional voice for the poor, who are usually marginalized from the political process. According to this belief, social rights litigation would be a means (supposedly "a better means") of realizing rights such as the right to health care, since supposedly both the wealthy and the poor have equal access to the courts. To probe the consistency of this belief, we analyzed the socioeconomic profiles of plaintiffs in the city of Sao Paulo (Brazil) who were granted access to specific medications or medical treatments by judicial decisions. In this study, the justiciability of social rights has not proven to be a means of rendering certain public services more democratic and accessible.

INTRODUCTION

There are certain widespread beliefs among Brazilian legal scholars, lawyers and judges concerning the implementation of the social and economic rights laid down in the Constitution. The most important for the purposes of this article is *courts are an alternative institutional voice for the poor, who are usually marginalized from the political process*. Representative of such beliefs is the statement of Piovesan, according to whom

> it is . . . essential that civil society, through its multiple organisations and movements, submits cases to the courts *with more frequency*, maximising the emancipatory and transformational potential for the justiciability and enforceability of socio-economic rights. . . . This is *the only way* to ensure greater transparency and accountability concerning the duties of the State to guarantee the rights to health and education. (Piovesan 2008, 191, emphasis added; see also Piovesan and Vieira 2006; Trindade 1997; Bonavides [1982] 1993; Bontempo 2005; Lima Jr. 2002; Olsen 2008; Duarte 2006; Frischeisen 2002; Mancuso 2001; Krell 2002)[1]

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1. For the Latin American context, see, for instance, Abramovich and Courtis (2002), Arango (2002), Bazán (2005), Feria Tinta (2007), García Ramírez (2003), and López Obregón (2005). For other contexts, see, for instance, Xianghe (2006), Jinrong (2006) and Ssenyonjo (2003). For examples of this type of belief in judicial decisions of the Brazilian Federal Supreme Court, see the decisions in the following cases: ADPF

This almost unconstrained faith in the social and distributive potential of courts frequently leads to the belief that by granting individuals rights that have been neglected by the political powers, courts function as an institutional alternative, fostering substantial equality among citizens. While one could argue that few people doing empirical research would share this belief,[2] in countries where legal studies are seen as synonymous with theoretical and doctrinal legal study (and this is not only the case for Brazil alone), and where academic research is not always clearly distinguished from human rights advocacy, courts are still regarded as the main—and often the best—arena for implementing social rights.

Contrary to this belief, our general perception of judicial activity in Brazil has always been that courts are rarely an institutional voice for the poor, who are marginalized not only in the political process, but also in their access to the judiciary. To test this perception within the so-called medication litigation, we carried out a case study in the city of Sao Paulo (Brazil) and analyzed the socioeconomic profile of plaintiffs granted access to specific medication or medical treatment by judicial decisions. By means of this case study, we wanted to test two interconnected hypotheses:

(1) Judicial decisions concerning the right to medications often do not benefit the less privileged;
(2) It is not possible to consider courts as an institutional voice for the poor without taking into account variables which are *exogenous* to judicial activity.

If these hypotheses are correct, it may be the case that when courts decide in favor of plaintiffs who request specific social goods (medicine or medical treatment), they are not actually encouraging equality between wealthy and poor by granting the latter access to the social goods from which they were excluded. On the contrary, such decisions often tend to benefit those in less need of assistance.

I. THE CONCEPT OF AN "INSTITUTIONAL VOICE FOR THE POOR"

The expression "institutional voice for the poor" may be understood in several ways, depending on which feature or outcome of the judicial process one chooses to focus upon. One may argue that being an institutional voice for the poor implies that courts are not only *formally* open to everyone, but the poor actually do have *effective*

45 (2004), AI 570.455 (2006), RE 271.286 (2000), RE 232.335 (2000), RE 297.276 (2004), RE 342.413 (2004), RE 353.336 (2005). In the case law of the State Court of Sao Paulo, see the decisions in the following cases: AI 291.732-5/8 (2002), AI 286.554.5/3 (2002), AI 291.816.5/1 (2002), AI 308.117-5/8-00 (2003), AI 306.778-5/9-00 (2003), AI 369.381-5/8-00 (2004), AI 375.351.5/0 (2004), AC 311.355-5/0-00 (2005). ADPF = Arguição de Descumprimento de Preceito Fundamental; RE = Recurso Extraordinário; AI = Agravo de Instrumento; AC = Ação Cautelar. In the cases cited in this article, these actions stand for different types of judicial procedures that can be used to challenge, in different moments and levels, the constitutionality of laws and administrative acts.

2. We would like to thank one of the referees for drawing our attention to the fact that different academic communities may have different perceptions of the outcomes of the judicial activity; thus the necessity of explaining that legal research, not only in Brazil in particular, but in Latin America in general, is above all theoretical and doctrinal legal research.

access to them. Another way to understand the concept of institutional voice stresses that no matter who benefits directly from judicial decisions in these cases, courts may *influence public policies*, thus enhancing the realization of social rights in general, which is also in favor of the poor. Finally, one could argue that courts are an institutional voice for the poor only if when deciding cases related to social and economic rights, courts must attempt to provide more egalitarian access to social goods, by treating poor and wealthy differently (that is, the poor are more frequently successful in lawsuits than the rich).

These and other differences are well illustrated using Gloppen's analytical framework (2006, 35). According to her,

> there are four main stages or variables in the litigation process that interact to determine the success or failure of social rights litigation: first, the extent to which people whose social rights are violated *voice* their claims in the courts; secondly, the courts' *responsiveness* to these claims; thirdly, the judges' *capability* to give legal effect to the social rights claims that are voiced; and fourthly, the authority of the courts' social rights decisions, seen in terms of *compliance* with the terms of the judgment, directly and in terms of subsequent legislation and policies. (Gloppen 2006, 42)

For our case study, neither the second (*courts' responsiveness*) nor the third (*judges' capability*) stages are the most relevant, since in Brazil courts respond (mostly positively) to the claims, and judges do provide binding legal effect to these claims. Problems arise when analyzing the first and the fourth variables (*voice* and *compliance*). Thus, in the case of medication litigation in Brazil, deciding whether courts are an institutional voice for the poor meant assessing the degree of realization of these two variables.

At this point it becomes clear that focusing on the realization of the variable "voice" implies emphasizing the first of the possible concepts of institutional voice presented at the beginning of this section ("courts are not only formally open to everyone, but the poor actually do have effective access to them"), whereas focusing on the realization of the variable "compliance" emphasizes the second concept of institutional voice ("no matter who benefits directly from judicial decisions in these cases, courts may influence public policies, thus enhancing the realization of social rights in general; that is, also in favor of the poor").[3]

In more general terms, one concept stresses the *direct* effects of judicial decisions (those who have access to courts and are the beneficiaries of their decisions) while the other emphasizes their *indirect* effects (for example, influence on public policies). Although both concepts are valid, our research can only assess the first one, since we dealt with the direct beneficiaries of judicial decisions.[4]

Hence, the concept of "institutional voice for the poor" referred to in this article should be understood as in the first meaning stated above. In order to be considered an

3. The other definition presented in the beginning of this section ("courts must try to provide more egalitarian access to social goods, by treating poor and rich differently; that is, the poor are more frequently successful in lawsuits than the rich") is simply too demanding, for it presupposes that, in order to say that someone has a voice somewhere, it is necessary that she has a louder voice than the others.

4. This will be explained in more detail below.

institutional voice for the poor, courts do not need to treat the wealthy and the poor differently (that is, in favor of the poor), nor is it sufficient that their decisions have some indirect effect—demonstrable or not—on public policies. Here, in order to consider courts an institutional voice for the poor, it is necessary that their decisions *directly* benefit the poor. This requires (1) that courts are formally open to everyone, (2) that the poor have *effective access* to them, and (3) that the judicial decisions *directly* and positively affect the poor.

II. THE JUSTICIABILITY OF SOCIAL RIGHTS: MYRIAD DEBATES

The role that courts have or should have in realizing social and economic rights may be discussed from several perspectives. While defining our hypotheses and our definition of an "institutional voice for the poor," we define the nature and the limits of our approach to this discussion. What is important for the goals of this article is to know who the beneficiaries of the so-called medication litigation are. In addition, our research is conditioned by the structure of the health care system in Brazil and by the peculiarities of Brazilian judicial procedures as well as by deep social inequalities within the country. Among other things, this means that we do not intend to draw conclusions that are valid for every social and economic right, in every country, at all times. Nevertheless, we argue that in the case of Brazil—which is also characterized by an extremely individualistic type of litigation, by judicial decisions whose effects are strictly limited to those who filed the lawsuits, and by social inequalities and a disparity in the access to information—our findings may to a great extent be generalized to the entire country, even though our research is limited to medication litigation in the city of Sao Paulo.

This having been said, and in order to avoid misunderstandings, it is important to stress that what is at stake is not a version of the debate "judicial activism *vs*. judicial restraint" (see Silva 2007, 176; Pieterse 2004). That is to say, the confirmation or rebuttal of our hypotheses has no necessary effects on this debate. Both judicial activism and restraint can foster social inclusion as well as social exclusion, and demonstrating that one specific type of activism has no positive effect on equality or social inclusion is not an argument against activism as such, nor an argument for restraint. In any event, we do not intend to engage in this debate.

Nor is it our goal to debate the nature of social rights themselves; that is, we do not intend to discuss either the widespread distinction between negative and positive rights or duties,[5] or the definition of these rights as human rights.[6] These debates, important as they may be, are not decisive to the purposes of this article. This is because, first of all, the justiciability of social rights does not depend on their definition as human rights. Moreover, this justiciability, however strongly influenced by the dichotomy between

5. See, for instance, Fried (1978, 110), Shue (1980, 35), Alston and Quinn (1987), Holmes and Sunstein (1999, 35), Abramovich and Courtis (2002, 21), Fredman (2008, 65).

6. For such a discussion see, above all, Cranston (1967) and Shue (1980). More recently, see Pogge (1995). For a good summary of the main arguments for and against the justiciability of social rights, see Gargarella, Domingo, and Roux (2006) and Nolan, Porter, and Langford (2007).

negative and positive duties, does not depend on the choice between either side of it. Therefore, it is irrelevant here to discuss whether social rights bring about more positive duties than civil and political rights, and whether this has any decisive (negative) impact on their justiciability, or whether all human rights (and not only social rights) give rise to positive duties.[7] These disputes, although of unquestionable importance in other contexts, are—for a trivial reason—not relevant here: All of them intend to reach normative conclusions concerning the possibility or the necessity of a judicial enforcement of social rights, whereas in our article, this justiciability is simply a matter of fact. It is its outcomes that we are concerned with here.[8]

III. HEALTH CARE SYSTEM AND JUDICIAL ORGANIZATION IN BRAZIL

As stressed above, and as will be argued throughout this article, the role courts may play in the realization of social rights in Brazil is conditioned by the structure of the health system and by the peculiarities of the judicial procedure. These two key variables are described in more detail in the following sections.

Health Care System

In 1988, the new Brazilian Constitution created the so-called Unified Health System (SUS—Sistema Único de Saúde), whose task is to serve the entire population, independent of an individual's ability to pay and regardless of whether those who use it have private health insurance. This means that everyone has free access to public hospitals in Brazil. Still, this is not to imply that there are no private hospitals or clinics. The Constitution created a unified public health system but did not abolish the private system. Both coexist.[9] Even though a robust private health system exists in Brazil, however, every citizen who cannot or does not want to pay for health care services is entitled to use the services of the public health system, which encompasses consultations with physicians, health exams, medical treatments, surgery or operations, etc.

In addition, the public health care system has a program that dispenses medication for free. This program grants everyone access to various types of drugs, also free of

7. Actually, it is even possible to accept—without affecting the purposes of our article—that implementing some civil and political rights may also be very expensive. Organizing elections, for instance, can be very costly. In fact, the budget provision for the organization of the 2008 local elections in Brazil is BRL 3.685 billion (~US$2.297 billion at the exchange rate of June 2008).

8. It is understood that our conclusions concerning these outcomes may be used as arguments for or against justiciability itself. But this is a step we do not intend to take here.

9. At this point it is important to briefly explain this coexistence. Even though it is the task of the public health system to serve the entire population, independent of individual payments and regardless of whether those who use its infrastructure have private health insurance or not, public hospitals are generally not used by the middle class and the upper-middle class (for reasons that range from comfort or waiting time to quality of the health care services). The costs for using the services of the private health system (consultation with physicians, health exams, medical treatments, surgery and operations) are covered either by a private health insurance or by the patients themselves.

charge. The Ministry of Health establishes a list, which is updated regularly, with available medications. This list includes medications ranging from basic drugs (such as analgesics and antibiotics) to very costly drugs against chronic diseases (such as hepatitis B and C, rheumatoid arthritis, etc.).

Judicial Procedure

Despite the existence of the above-mentioned free medication program, thousands of lawsuits are filed every year in Brazilian courts, requesting free access to specific drugs. The reasons for this will be analyzed below in this section, but first, it is necessary to explain briefly the effects of judicial decisions in this context.

Every single person we interviewed had made an *individual* claim to the court. As other studies indicate, this finding seems to be valid not only for lawsuits concerning the distribution of medication, but also for claims related to the right to health care in general (see, for instance, Hoffmann and Bentes 2008, 101, 114, 117). In Brazil, the number and the statistical significance of individual claims are clearly higher than those of collective claims (see Lopes 2006, 185; Ferraz 2009, 35).[10] The fact that all claims were individual ones is extremely important in understanding the findings of our research, as according to the Brazilian judicial procedure, only the person who filed a lawsuit may benefit from the effects of the judicial decision (the so-called *inter partes* effects), regardless of whether there are other people in the same situation as the plaintiff. In the context of the present study, this means that a successful lawsuit—for instance, one whose decision granted the dispensing of a specific drug—benefits only the person who filed it, no matter how many others are in the same situation, that is, no matter how many others have the same disease.

Furthermore, there is additional information related to the reasons underlying the filing of a lawsuit making claims on dispensation of medication that is crucial for understanding the conclusions of this article. When someone files a lawsuit, she may be pursuing two very different goals: either seeking to receive medication previously provided on the official list of the Ministry of Health or attempting to receive one that is not on the list. In the lawsuits of the first group, the plaintiff intends to ensure her medication against a possible shortage or delay in the distribution. Even in such cases, a judicial decision has only an *inter partes* effect. This means that if a shortage or a delay does occur, it would affect citizens to different degrees: those who had submitted a claim before the courts would not be affected by a shortage or delay, whereas those who did not (because they did not know of this possibility or because they thought it would not be necessary) must manage temporarily without the medication they need.

In the lawsuits of the second group—those aiming to receive a medication that is not on the official list, which corresponds to the majority of cases[11]—judicial decisions

10. The research carried out by Lopes within the Sao Paulo State Court of Justice found only fourteen collective lawsuits dealing with the right to health and sixteen dealing with educational rights between 1997 and 2003 (2006, 197).

11. In some cases, the most important one being the case of the lawsuits requesting an oncology drug, all the plaintiffs have requested a drug that is not provided on the official list, since the official list does not

also have only *inter partes* effects. This means that those who file a claim before the courts will receive medication that is possibly better than medication received by those who do not file a claim because they do not know of this possibility or because they do not have enough money to do so.

IV. METHODOLOGY

Legal study and research in Brazil are almost always considered synonyms for theoretical and doctrinal legal study. However, since in the realm of social and economic rights, protecting can only mean realizing those rights through public policies, it is impossible to discuss the role of the judiciary without knowing the real effects judicial decisions have on the allocation of the goods related to the satisfaction of those rights. For our goals, this means above all to find out who the beneficiaries of those judicial decisions are. Since we are convinced that this task cannot be accomplished through an exclusively theoretical study, we carried out the empirical research using the methodology explained in the following sections.

Gathering the Data

There were different means of gathering the necessary data used to analyze the socioeconomic profile of the beneficiaries of judicial decisions granting individuals the right to receive medication. We began by analyzing the files of the judicial proceedings in the State Court of Sao Paulo but soon realized that they did not contain sufficient data for our purposes.[12]

We then opted to directly survey the beneficiaries of these judicial decisions, since we believed that we could gather more information through this approach than by consulting the files of the judicial proceedings or even the databases of the State of Sao Paulo Health Department. The information we were searching for—mainly related to income and education—could only be reliably gathered by a direct survey. This direct survey was facilitated by the *Farmácia de Ação Judicial* (FAJ), a "Judicial Drugstore," where beneficiaries of judicial decisions granting direct distribution of a specific medicine must go to pick up their medication.[13]

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contain any oncology drugs. Unlike its regular policy, in the special case of cancer, the SUS offers treatment but does not dispense drugs directly to the patients. This means that those patients who are treated in a public hospital receive (or should receive) complete treatment ranging from diagnosis to surgery, radiotherapy, and chemotherapy. The dispensation of oncology drugs is thus included in this treatment. For more details on why there should not be direct dispensation of oncology drugs, see Vieira and Zucchi (2007, 220).

12. It is nevertheless possible to carry out empirical research only with the data found in such files. See, for instance, Vieira and Zucchi (2007, 214) and Lopes (2006, 185). For more comprehensive research, see also Hoffmann and Bentes (2008, 100). Their research, although based mainly on files of judicial proceedings, also included interviews with judicial and other relevant actors and a review of relevant literature.

13. The FAJ was created in 2005 for purely logistical reasons (in order to centralize the distribution of medicine to beneficiaries of judicial decisions). It is not part of the regular health system and there is nothing similar in other states in Brazil.

The FAJ

The State of Sao Paulo Health Department maintains an office where plaintiffs pick up the medicine provided by a judicial decision. This was very convenient for us, since all members of our target population[14] needed to be in the same place at least once a month. The FAJ, created exclusively for practical and logistical reasons, is not an independent administrative authority.

Population

The population of our research consisted of every plaintiff who obtained a favorable judicial decision against the State of Sao Paulo granting her the medication requested from a court located in the capital of the state (the city of Sao Paulo).

Questionnaire

The questions in the survey forms were related to (1) the age and gender of the beneficiary, (2) medicine requested, (3) where the medical prescription was issued, (4) the source of information through which the person interviewed had learned of the possibility of filing a lawsuit requesting medicine, (5) who filed the lawsuit, (6) the frequency with which the beneficiary uses public hospitals, (7) her occupation, (8) household income (per capita), (9) her educational level, (10) information about housing and neighborhood.

In this article, we reproduce only tables with data directly connected to our purposes. Tables with data on age or gender of the people surveyed, for instance, which might be important for other research purposes, are not reproduced here.

Surveys

The surveys were carried out from March 27 to April 26, 2007. The decision for this time span was based on the fact that beneficiaries must pick up their medication once a month. Thus, the population of one month is always the same as the subsequent months, and given that the surveys cover a thirty-day span, the initial date was irrelevant.

As a requirement of the ethics committee of the Health Department, before each survey, the purpose of our research was explained and the potential respondent was asked whether she agreed to be surveyed. If so, she had to sign a "term of consent." The survey began only after this form was signed.

14. Our target population consists of the plaintiffs who live in the city of Sao Paulo. People who live in other cities of the State pick up their medicines in the cities in which they live.

V. DATA

The basic information about our survey was (*a*) *Survey time span*: March 27 to April 26, 2007; (*b*) *Persons served at the FAJ during this period (population)*: 3,652; (*c*) *Persons surveyed (sample)*: 160 (selected at random); (*d*) *Sample size:* 4.38 percent.

With a sample of 160 people from a population of 3,652, we obtained a significance level of 95 percent and a margin of error of approximately 7.5 percent.[15] We are aware that defining the size of the sample, the significance level, and the margin of error has been, at least since Fisher (1935), subject to fierce disputes, but we do not intend to take sides here.[16] It does not seem meaningful for us to discuss either whether the margin of error should be 5 percent instead of 7.5 percent or whether it is necessary in social sciences that the size of the sample and the significance level follow the same benchmarks as in other sciences (see Gill 1999, 657; Hunter 1997, 3; Cohen 1994, 997). Although the acceptance of our conclusions may vary according to the statistical standards of those who read them, it does not appear to us that their validity is affected by a difference of 2.5 percent.

In addition to the debate over the representativeness of our sample for the population of Sao Paulo, one could ask what a survey conducted in only one city concerning only one type of litigation could be representative of. One could say that the city of Sao Paulo is not necessarily representative of Brazil, and Brazil is not representative of Latin America or the world, and that medication litigation is not representative of all health care rights litigation, and health litigation is not representative of all social rights litigation.

To some degree, this is of course true. However, given the formulation of our hypotheses, we consider this limitation (one type of litigation; one city) not decisive. Since our hypotheses do not state that courts cannot be an institutional voice for the poor under any circumstances, but only that some conditions, which are exogenous to the judicial activity, may affect the courts' "transformation performance" (Gloppen 2006), we argue that it is not necessary to demonstrate that courts are never an institutional voice for the poor. It suffices to show that there are cases in which "granting some neglected individual rights" do not imply "fostering substantial equality among citizens," meaning that the effects that judicial decisions have on fostering social justice may depend on several conditions that are exogenous to the judicial activity as such.

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15. In order to calculate these values, we used the following formula, frequently used to determine sample sizes in surveys:

$$n' = \frac{Z_a^2[p(1-p)]N}{Z_a^2[p(1-p)]+(N-1)I_c^2}$$

where N = population size; n' = sample size; a = significance level; I_c = margin of error; Z_a = value of Z for the confidence level; p = estimated proportion in the population (0.5 for the worst case scenario, that is, a 50–50 split).

16. For this discussion, see, for instance, Gill (1999), Rosnow and Rosenthal (1989), and Berger (2003).

TABLE 1.
Origin of the Medical Prescription

	no.	%
Private hospital or clinic	97	60.63%
Ordinary public hospital	21	13.12%
Reference public hospital	42	26.25%
Total	160	100%

Basic Data

In the following nine tables, we present and briefly comment on the basic results of our survey but do not analyze the data. This will be done in a section below.

Origin of the Medical Prescription

In Table 1 the results are quite clear: the absolute majority (60.63 percent) of those surveyed received their medical prescription in a private hospital or clinic. The division into two types of public hospitals is justified by the fact that in Brazil there is a significant difference (in terms of quality of the service offered) between public hospitals associated with a university and ordinary public hospitals. What we call "reference public hospitals" are those public hospitals considered "centers of excellence" within the public service, most of which are university hospitals or clinics. As will be shown later, access to a reference or ordinary public hospital is generally a matter of pure chance, related to place of residence. It is also important to stress that in Brazil, the public health system has a universal character; that is, everyone may use the services of a public hospital for free, even those with private health insurance.

Plaintiff's Source of Information about the Possibility of Filing a Lawsuit

Table 2 shows that the plaintiff's main source of information about the possibility of filing a lawsuit is the physician, rather than a lawyer. Quite often, physicians know beforehand that access to the medication prescribed by them will depend on a lawsuit.

Who Filed Lawsuits

Although the relative majority of the lawsuits were filed by a private lawyer, the difference compared to those filed by a public attorney is not very significant (see Table 3). As will be shown later, the task of classifying those lawsuits filed by associations or nongovernmental organizations (NGOs) is much more complex. The label "other" includes, for instance, lawsuits filed by the patient himself or a relative.

TABLE 2.
Source of Information

	no.	%
Private lawyer	3	1.81%
Public attorney	2	1.2%
Family / Friends	34	20.48%
Association / NGO	15	9.04%
Physician	92	55.42%
Other	20	12.05%
Total	166	100%

TABLE 3.
Who Filed Lawsuits

	no.	%
Private lawyer	62	38.75%
Public attorney	49	30.63%
Association / NGO	34	21.25%
Other	15	9.37%
Total	160	100%

TABLE 4.
Do Respondents Use the Public Health System?

	no.	%
Yes	64	40%
No	96	60%
Total	160	100%

Respondents Regularly Using the Public Health System

When defining what was meant by "uses the public health system," we excluded those who, despite being regular, only attend vaccination campaigns, which usually take place in public hospitals (see Table 4).

Occupation

In Table 5, the two most representative groups, which together represent the absolute majority of the persons surveyed—pensioners (35.63 percent) and formal (registered) workers (16.88 percent)—are predominantly composed of people with a

TABLE 5.
Occupation

	no.	%
Formal worker (registered worker)	27	16.88%
Informal (unregistered) worker	2	1.25%
Self-employed	20	12.5%
Civil servant	12	7.5%
Employer	4	2.5%
Pensioner	57	35.63%
Housewife	26	16.25%
Student	4	2.5%
Unemployed	5	3.12%
Others	3	1.87%
Total	160	100%

TABLE 6.
Household Income per Capita

	no.	%
Less than 0.5 times the minimum wage	23	14.37%
From 0.5 to 1 times the minimum wage	21	13.12%
From 1 to 1.5 times the minimum wage	22	13.75%
From 1.5 to 3 times the minimum wage	35	21.88%
From 3 to 5 times the minimum wage	17	10.63%
More than 5 times the minimum wage	19	11.88%
No response	23	13.75%
Total	160	100%

fairly stable financial status. However, this impression can be deceptive. In Brazil, many pensioners and formal (registered) workers have a very low income and, depending on the size of their families, this income may be insufficient to regard them as having a stable financial status. Such ambiguity is clarified in Table 6, related to the household income per capita.

Household Income[17]

Table 6 shows a fairly uniform distribution among the several levels of household income, with a slight majority situated within the range between one and a half and three times the minimum wage. The data summarized in Table 6 are based on spontaneous self-reporting. Our perception during the survey was that the income values were

17. The legal minimum wage valid at the time of the surveys was BRL 350 (~US$220—at the exchange rate of June 2008).

underestimated, especially in the higher income range. Many of the respondents at first declared a lower household income, and not until they were convinced of the anonymity and confidentiality of the survey did they correct the information and declare their actual (higher) income.[18] It is well known that when sensitive data are at stake, sometimes respondents choose what they think to be the best answer, and this best answer "depends on what the respondents presume to be the consequences of certain behavior or answers judging from visible or assumed features of their interview situations" (Schräpler 2004, 120). Therefore in a situation in which the legitimacy of a claim (in this case, a judicial claim) may be associated (or thought to be associated) with the capacity or incapacity of the respondent to pay for the goods she had requested, this type of behavior seems to be common.

Our perception that the values were underestimated was also supported by analyses made by other authors, who found even greater participation of the middle and upper-middle classes as beneficiaries of the medication litigation in the city of Sao Paulo. Based on the so-called map of social exclusion/inclusion in the city of Sao Paulo,[19] Vieira and Zucchi (2007, 219), doing research on medication litigation, report that, for instance, 63 percent of the plaintiffs live in the wealthiest areas of the city of Sao Paulo. Using another methodology—the *Index of Social Vulnerability in Sao Paulo* (IPVS)—Chieffi and Barata (2009, 1842) reported that 73 percent of the plaintiffs live in areas classified as low, very low or no social vulnerability.

To test the accuracy of the spontaneous responses received in our survey, we decided to use a procedure similar to that employed by Vieira and Zucchi and applied a spatial pattern called "social exclusion/inclusion index (*IEx*)," used in the above-mentioned "map of social exclusion/inclusion in the city of Sao Paulo." Câmara et al. (2004, 226) explain the meaning of *IEx* as follows: There is

> a *reference value* that marks the attainment of a *basic standard of inclusion*. Areas that achieve such levels are assigned a value of 0 (zero), whereas areas with values above such reference are mapped linearly to a positive [0 to 1] scale, and areas below such reference are assigned negative values on a [–1 to 0] scale. Therefore, each of the components has a range between –1 (total exclusion) and 1 (total inclusion).

Using their map of the city of Sao Paulo and the information we had about the neighborhood of the plaintiffs, we obtained the information shown in Table 7.

Almost half of the respondents[20] live in areas considered above the basic value of inclusion, indicating that they belong to the middle or upper-middle classes. Nevertheless, since we wanted to remain consistent with the methodology of our survey, based on

18. For the effects of the assurance of confidentiality when the data asked about are sensitive, see Singer, von Thurn, and Miller (1995, 66).

19. The so-called map of social exclusion/inclusion in the city of Sao Paulo aims to map social exclusion and inclusion in urban areas in developing countries. In order to express social exclusion as a spatial pattern, Câmara et al. (2004) created a social exclusion/inclusion index (IEx), aggregated by areal units, with four components: income, quality of life, human development and gender equality.

20. The difference between this sample (140 respondents) and the general sample we used in the other tables (160 respondents) is explained by the fact that 20 respondents do not live in areas covered by the map of social exclusion/inclusion.

TABLE 7.
Social Exclusion/Inclusion Index

	no.	%
From –1 to –0.4	41	29.29%
From –0.4 to 0	35	25,00%
From 0 to +1	64	45.71%
Total	140	100,00%

TABLE 8.
Education Level

	no.	%
Elementary school (4th grade)	30	18.75%
Middle education (8th grade)	23	14.37%
High school	58	36.25%
Undergraduate study	40	25%
Postgraduate study	9	5.63%
Total	160	100%

spontaneous responses, we did not take this apparent bias (underestimated income responses) into account in our findings. Since both the above-mentioned studies (Vieira and Zucchi 2007; Chieffi and Barata 2009), as well as the application of the exclusion index to our sample, show much greater participation of the relatively financially well off in the medication litigation than our regular sample, we felt certain that if we strictly considered this sample alone, we would be working with the best case scenario for the widespread belief we wanted to question. That is to say that if there is a bias, this bias runs not favorable to, but against our hypotheses. The data from this table will be analyzed in much more detail in a section below.

It is also important to stress that we asked about household income per capita. In doing so, we wanted to prevent anyone with a higher salary but also with a larger family from being considered more privileged financially than someone who, even though earning a smaller salary, lives alone.

Education

The people surveyed generally had a high level of education relative to most Brazilians (see Table 8). As will be analyzed later in greater depth, this factor (education) plays a central role in the chance of success in obtaining the most expensive medication.[21]

21. See also Hoffmann and Bentes (2008, 111), who make a clear link between the level of education and litigiousness.

TABLE 9.
Medication Requested

	no.	%
Oncology	32	20%
Arthritis	29	18.13%
Diabetes	38	23.75%
Heart diseases	7	4.38%
Diabetes/Heart diseases	10	6.25%
Osteoporosis	8	5%
Over-the-counter goods	9	5.62%
Synages	5	3.12%
Others	22	13.75%
Total	160	100%

Medication Requested[22]

As shown in Table 9, not surprisingly, the three most frequently requested types of medication are extremely expensive.

Crossing Data

After an initial analysis of information gathered in surveys, we decided to analyze cases involving requests for oncology drugs separately (see Tables 10 through 12). This decision was made for three main reasons, which will be explored below: (1) since oncology drugs are extremely expensive,[23] we could assume that both the poor and the wealthy alike are willing to receive them free of charge; (2) oncology medications are for a disease not related to variables such as the socioeconomic condition of the patient, access to information on health issues, housing conditions, or access to services such as running water or a sewage system; and (3) since all claims for oncology drugs are necessarily claims for medication not on the official list (see note 11), we were able to achieve an important type of parity among the plaintiffs: all of them had requested a medicine that was not directly distributed to anyone, and we would not have been able to obtain a similar sample if our analysis had focused on other types of medication.

22. Some of the people surveyed requested more than one type of medicine. In these cases, we classified the request according to the medicine the person considered the most important.

23. The average cost for this type of drug amounts to US$5,500 per month. Some of the oncology drugs granted are as expensive as US$14,500 per month. Source: http://www.pregao.sp.gov.br (accessed October 23, 2010).

Household Income of Respondents Requesting Oncology Drugs

TABLE 10.
Income of Respondents Requesting Oncology Drug

	no.	%
Less than 0.5 time the minimum wage	2	6.25%
From 0.5 to 1 time the minimum wage	0	0%
From 1 to 1.5 times the minimum wage	4	12.5%
From 1.5 to 3 times the minimum wage	7	21.88%
From 3 to 5 times the minimum wage	6	18.75%
More than 5 times the minimum wage	8	25%
No response	5	15.62%
Total	32	100%

Origin of Prescription in Judicial Requests for Oncology Drugs

TABLE 11.
Issuers of Prescriptions for Oncology Drug

	no.	%
Private hospital or clinic	27	84.38%
Ordinary public hospital	1	3.12%
Reference public hospital	4	12.5%
Total	32	100%

Drugs Requested in Lawsuits Filed by Civil Associations or NGOs

During the surveys, we noticed that the lawsuits filed by civil associations or NGOs were much more often related to medications for certain diseases than others. Therefore, we also decided to analyze these cases separately. A brief analysis of the results in Table 12 can be found in a section below.

VI. ANALYSIS

Those Benefiting from Judicial Decisions

One important finding of the survey (see Table 1) is that the majority of medical prescriptions (60.63 percent) used in the judicial requests were issued in a private hospital or clinic. This is the first piece of evidence indicating that the judicial activity

TABLE 12.
Drugs Requested by Civil Association/NGO in Lawsuits

	no.	%
Oncology	5	14.71%
Arthritis	23	67.65%
Diabetes	0	0%
Heart diseases	0	0%
Diabetes/heart diseases	0	0%
Osteoporosis	0	0%
Over-the-counter goods	0	0%
Synages	3	8.82%
Other	3	8.82%
Total	34	100%

concerning the right to medications especially benefits higher-income individuals who can afford private health insurance, since they are the ones using private hospitals and clinics. This means that such judicial decisions to a greater extent benefit the middle class and the upper-middle class or, at the very least, workers employed in large companies, which usually provide health insurance for their employees.

We understand that lower-income individuals increasingly have health insurance. One could therefore argue that our data are not conclusive, since it is not possible to claim that all those "having health insurance" in fact "belong to the middle or upper-middle class." While we do not wish to make such an absolute claim, we wish to point out that, on the other hand, 40.8 percent of the inhabitants of the city of Sao Paulo still do not have private health insurance (ANS 2007). Hence, it is possible to suppose that the fact that someone does or does not have health insurance generally remains a strong indicator of her socioeconomic status (Neri and Soares 2002, 77).

In addition, considering that the percentage of people surveyed whose medical prescriptions were issued by physicians in private hospitals (60.63 percent) is very similar to the percentage of people surveyed who do not usually use the services of public hospitals (60 percent; see Table 4),[24] it becomes even clearer that these people belong at least to the middle class and are not poor in the Brazilian context. The services provided by public hospitals in Brazil are generally used by the lower-income individuals, with the very few exceptions of public hospitals considered centers of excellence, especially those belonging to public universities. This also explains why there are more medical prescriptions issued in such hospitals (26.25 percent) than in ordinary public hospitals (13.12 percent), even though there are more of the latter in the city of Sao Paulo.

At this point one could argue that the proportion of cases originating in public hospitals and the proportion of respondents using the public health system exactly

24. In fact, among those who had a medical prescription issued in a private hospital or a clinic, less than 10 percent (eight persons) had declared themselves to be occasional users of the public health system, and most of them (five persons) use only the services of university hospitals.

TABLE 13.
Respondents Who Have Prescriptions from Public Hospitals

	no.	%
Use the public health system	55	87.3%
Do not use the public health system	8	12.7%
Total	63	100%

mirror the proportion of the population that does not have private health insurance. In other words, one could argue the poor and the wealthy, those who use public or private health care, find a voice in the courts that is exactly proportional to their representation in the general population. However, this would be true only if those who have a medical prescription issued in a public hospital frequently use the public health system. However, this is not exactly the case, as shown in Table 13.[25]

However—and more importantly—even if one discerns in our sample a mirror of the general patterns of wealth and health of the city of Sao Paulo (since the deviance shown in Table 13 could be interpreted as nondecisive), one still needs to determine what this finding means for the interpretation of the courts as an institutional voice for the poor. In the next section, we further analyze this coincidence between some patterns of our sample and patterns of the city of Sao Paulo.

Household Income, Hospital, Lawyer, and Oncology Drugs

There is a fairly uniform distribution among the six categories concerning the household income (per capita) of those surveyed (although with a slightly higher concentration in the category *1.5 to 3 times the minimum wage*; see Table 6).

This distribution across the six categories of income does not significantly differ from the general distribution of the population of the city of Sao Paulo in the same income categories, as shown in Table 14, below.[26]

At this point, one could argue that the information about household income of the persons surveyed mirrors the patterns of household income of the city of Sao Paulo and that this finding shows not only that the judiciary is open to everyone, but also that wealthy and poor have effective access to courts. However, the finding that both patterns of household income (from our sample and from the city of Sao Paulo) are similar may be interpreted quite differently if one bears in mind that the objects of the judicial decisions we are discussing are drugs and medical products whose prices vary

25. The existence of persons who have a medical prescription issued in a public hospital, but who otherwise do not use the public health system, is due to the belief that a prescription of a public hospital has a stronger persuasive impact on judges.

26. For detailed information on this issue, see http://www.seade.gov.br/produtos/msp/ren/ren2_001.xls (accessed October 23, 2010).

TABLE 14.
Household Income—City of Sao Paulo

	%
Less than 0.5 time the minimum wage	8.89%
From 0.5 to 1 time the minimum wage	12.27%
From 1 to 1.5 times the minimum wage	12.6%
From 1.5 to 3 times the minimum wage	25.35%
From 3 to 5 times the minimum wage	15.05%
More than 5 times the minimum wage	25.84%

from US$48 (diapers) to US$14,500 (MabThera, an oncology drug) per month, and that it is possible to assume that the poor need assistance in buying every item (from diapers to oncology drugs), and the wealthy only need assistance in buying the more expensive drugs or medical products.

We clearly identified two distinct groups of plaintiffs. The first consisted of people with a low income, whose medical prescriptions were issued at an ordinary public hospital, and whose lawsuits were filed by a public attorney. People in this group usually requested simple over-the-counter goods or less expensive drugs.[27] The other group consisted of individuals with a higher household income, whose medical prescription was issued at a private hospital, and whose lawsuits were filed by a private lawyer. Individuals of this second group usually requested (very) expensive drugs.

A very good test for this division into two groups is provided by a separate analysis of the cases involving oncology drugs, which are usually extremely expensive. While the global results of our research show that 60 percent of the people surveyed had medical prescriptions issued in private hospitals, focusing only on the cases involving oncology drugs, we determined that in those cases 84 percent of the prescriptions were issued by private physicians (see Table 11).

Moreover, distribution according to household income also changes.[28] While the global results show a predominance of plaintiffs whose household incomes (per capita) were located somewhere between one and a half and three times the minimum wage, the narrowed sample (only the oncology drug cases) shows a predominance of plaintiffs from the category *above 5 times the minimum wage*. Only one of the people surveyed had a medical prescription for an oncology drug issued by a physician from a public, nonuniversity hospital. However, she not only belonged to the category *3 to 5 times the minimum wage*; she also declared that she otherwise never uses the services of public hospitals.

27. The average cost of the drugs requested in the lawsuits filed by a public attorney amounts to US$88. Source: http://www.pregao.sp.gov.br (accessed October 23, 2010).

28. Compare Tables 6 and 10.

Who Filed Lawsuits? Deconstructing the Civil Society Mobilization Argument

The lawsuits of 60 percent of the people surveyed were filed by a private lawyer, who had been hired either by the plaintiffs themselves (38.75 percent) or by some civil association or NGO (21.25 percent) (see Table 3).

At first sight, one could imagine that the large number of suits filed by an association or an NGO indicate that citizens are gradually joining together in civil associations or NGOs in order to fight for their right to health. However, most individuals who said that their requests were filed by an association or a NGO acknowledged either that they did not even know the name of the association or that, although they knew its name, they did not know where it was located. In addition, they were not asked to pay for the services of the associations that sponsored their requests: the association paid the costs of the lawsuit.

Comparing the information concerning the lawsuits filed by associations and NGOs with the information on the type of drug requested (see Table 12), in 67.65 percent of these lawsuits, the plaintiffs requested drugs for rheumatoid arthritis. Coincidentally, these were precisely the plaintiffs who did not know the name of the association that helped them with the judicial request. This suggests that the citizens are not in fact joining together to fight for their right to health care, but rather that someone is sponsoring these civil associations and NGOs to file lawsuits. According to Hoffmann and Bentes (2008, 114–15), "NGOs are not always immune to overtures from the pharmaceutical industry, and some openly admit that they are co-sponsored by private sector health companies" (see also Scheffer, Salazar, and Grou 2005, 63 ff.).

At this point, one could argue that if a pharmaceutical company decides that it is in their interest to fully fund an extensive litigation campaign for their latest-generation medications, and if this leads to the inclusion of such medication in the public program of free dispensation of medicines, which also benefits the very poorest of the poor, this would mean that courts would have ultimately increased health care for the poor. Plausible as it may be, this argument, as an argument associated with an indirect effect of litigation, is neither valid nor invalid as such. Just as it is the case for other indirect effects, its evaluation depends on several other variables. Since we decided—for reasons explained before, which are reiterated in the section below—that it is not our goal to assess the indirect effects of medication litigation, and because this assessment would require the evaluation of other variables (such as price of medication, existence of alternative, less expensive, generic drugs, etc.[29]), we do not think it is appropriate to engage in this debate here. In any event, for the purposes of this section—that is, to analyze the argument concerning the civil society mobilization—it is enough to show that the lawsuits filed by civil associations or NGOs are not necessarily the expression of such mobilization.

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29. For a simulation of what would happen if the Brazilian government decided to include the most recent drugs for only two diseases (hepatitis C and rheumatoid arthritis), which are constantly granted to individuals by judicial decisions, in its program of free dispensation of medicines, see Ferraz and Vieira (2009, 235–38). According to their calculation, although these drugs would attend to only 1 percent of the Brazilian population, it would cost ca. BRL100 billion, which is more than the budget of the whole health system in 2007 (BRL85,7 billion).

Direct and Indirect Effects of Medication Litigation

First of all, and independently of any other variable, it is possible to argue that the people who benefit from a judicial decision granting them direct access to a certain drug through the FAJ may be considered privileged citizens relative to other Brazilians, since they not only have access to medication and treatments often not available to the users of the regular public health services but also are guaranteed that such medication will never be out of stock (which is very common in ordinary public hospitals) because they are protected by a judicial decision.

Moreover, as has been already mentioned, courts often are very distant from the poor, despite the formal possibility of resorting to a public attorney. Those already marginalized on economic grounds usually have little or no access to information and are not aware of the possibility of bringing a request before the courts for the medication they need.[30]

Thus, it may be argued that they are twice excluded: In the first place, although access to the judiciary branch is formally open to every person, lower-income individuals are often blocked from this access for economic reasons, especially when associated with a lack of information (see Junqueira 2003, 182; Hoffmann and Bentes 2008, 105, 113). In the second place, they are excluded from receiving the most modern and effective medication and medical treatment, which, despite being publicly funded, are accessible only to those who overcome the first hurdle, that is, to those who have obtained access to the judiciary (since the type of judicial decision we are dealing with here benefits only those involved in the case).

Accordingly, if we return to Gloppen's analytical framework, it becomes even clearer what we meant by courts not being an institutional voice for the poor, as in the meaning defined in the beginning of this article. Concerning the first variable of her model, *voice*, our results show not only that the practical barriers (especially costs of litigation and lack of information) mentioned by Gloppen (2006, 46) are present, but also that the victim's voice, when actually channeled into the judicial system, is individualistic and fragmented, which clearly undermines the courts' transformation performance.

If this is true, one has to rely primarily on the courts' *passive potential* to act as an institutional voice for the poor. This is related partially to the fourth variable, *compliance*, concerning the possible influence courts may exert on legislation and policies by passively "serving as a public platform where claims can be articulated," having "important political effects even in the absence of a judgment acknowledging the claim" (Gloppen 2006, 38; Gargarella 2006, 28), regardless of who benefits directly from each individual judicial decision (see, for instance, Goldstone 2008, ix-x; Gauri and Brinks 2008, 6; Roesler 2007, 571).

In addition, it has frequently been argued that this type of positive indirect effect could in many cases be amplified by the media (Contesse and Lovera Parmo 2008, 150).

30. However, there are some people who succeed in being part of this privileged group of plaintiffs even though they have no privileged economic status or previous access to information. These are the patients of the so-called reference public hospitals and are privileged due to pure luck, primarily because they live close to such hospitals.

In fact, in the Brazilian context, the most frequently used example of positive indirect effects is the well-publicized case of public policies combating AIDS. Among developing countries, Brazil has one of the best policies in this domain, and it is common to attribute this success at least partially to intense judicial litigation during the late 1990s (see, for instance, Piovesan 2008, 189; and Novogrodsky 2009).[31] Even though it is not possible to measure the exact contribution of this type of litigation to the success of this public policy in Brazil, it is possible to acknowledge that it may have had positive indirect effects. However, this does not alter the findings of our research. At most, these indirect positive effects could be used to identify the judiciary as an institutional voice for the poor in the second sense defined at the beginning of this article: "No matter who directly benefits from judicial decisions in these cases, courts may influence public policies, thus enhancing the realization of social rights in general (that is, also for the poor)." Yet, as has been previously argued, we do not intend to define which concept of institutional voice for the poor is the best for all imaginable circumstances. Given the nature of our research and the peculiarities of the Brazilian judicial and health care systems, we were able to measure the possibilities of being an institutional voice for the poor in only one of its many possible meanings. Moreover, given that we decided—for reasons explained at the beginning of this article—on a concept of institutional voice that could be empirically evaluated with the available data,[32] it did not seem appropriate to include unintended and indirect consequences in our analysis, except for cases in which these consequences, even though unintended and indirect, could be empirically assessed.[33]

CONCLUSION

In conclusion, we wish to begin by revisiting the hypotheses formulated in the opening of this article, which contrasted with the widespread belief also stated in the beginning of this article. This belief is "Courts are an alternative institutional voice for the poor, who are usually marginalized from the political process," and our hypotheses were "(1) Judicial decisions concerning the right to medications often do not benefit the

31. Similarly, for the Chilean context see Contesse and Lovera Parmo (2008).

32. We do not intend to take sides in the dispute concerning the possibility of empirically measuring the indirect effects of social rights litigation at all; thus the qualification "*with the available data*." This is to say that it is not at stake whether a concept of institutional voice for the poor based primarily (or solely) on the indirect effects of the judicial decisions may be sound or would often be too diffuse to be empirically demonstrated (see, for instance, Scheingold [1974] 2004; McCann 1994; Rosenberg [1991] 2008, 2004; Klarman 2004).

33. And in our case study the only indirect effect we were able to assess in these terms was a negative one. This negative indirect effect could be summed up as follows: Judicial decisions in the field of social rights imply the reallocation of scarce resources, which could otherwise be invested in collective and more equitable public policies, exclusively in favor of individuals who succeed in their judicial claims. In fact, in 2006 those judicial decisions granting medicine to individuals implied, in the city of Sao Paulo alone, the reallocation of BRL65 million (~US$40 million) and attended approximately 3,600 people. In the same year, the State of Sao Paulo spent BRL817 million (~US$510 million) on the acquisition of expensive medicine and attended 280,000 people (see Terrazas 2008; Chieffi and Barata 2009). In short, an individual who has a favorable judicial decision costs six times more annually than other individuals who use the services of medicine distribution in public hospitals in the state regularly.

less privileged; (2) It is not possible to consider courts as an institutional voice for the poor without taking into account variables which are *exogenous* to judicial activity."

As we have seen, the classification based on household income (per capita) does not substantially differ from the distribution of the entire population of the city of Sao Paulo. However, these similarities between the patterns of our sample and the general patterns of household income in the city of Sao Paulo do not necessarily rebut our first hypothesis. An important reason for this is the clear divide between the two groups of plaintiffs, as explained before: The former consists of people with a low income, with medical prescriptions from public hospitals, and whose lawsuits have been filed by a public attorney; the latter group consists of people with a higher household income, with medical prescriptions from private hospitals, and whose lawsuits have been filed by a private lawyer. People in the first group usually requested simple, less expensive over-the-counter pharmaceutical goods, such as gauze, diapers, etc., or even less expensive drugs, whereas people in the second group usually requested (very) expensive drugs.

An illustrative example of this divide was provided by narrowing our sample only to the cases involving the request for oncology drugs. Since these drugs are extremely expensive, it might be expected that the requests for them might be made by plaintiffs of any socioeconomic background—oncology drugs are expensive for everyone. However, this was not the case. As a matter of fact, only 6.25 percent of the requests came from plaintiffs with a household income (per capita) under one time the minimum wage, although 27.51 percent of our sample population was included in this income category. And although only 22.51 percent of our sample population belong to the category *over 3 times the minimum wage per capita household income*, 43.75 percent of the requests for oncology drugs were made by plaintiffs from this category. Therefore, we believe that comparing the data may indicate a very important finding: Whenever both the poor *and* wealthy need assistance from the judiciary, there is a clear advantage for the latter.[34]

Nevertheless, the results indicate that "less privileged" cannot be understood exclusively in terms of income. Since the data concerning the household income (per capita) of the respondents does not substantially differ from the distribution of the entire population of the city of Sao Paulo, concluding that the judiciary benefits the wealthy does not hold (at least not for our case study). However, the hypothesis still holds if "less privileged" is understood as a more complex concept. The key factor here is *access to information*.

Privileged access to information (including medical and legal advice) is a crucial variable, and this access is exponentially increased by other variables such as access to better hospitals, health insurance, a higher level of formal education, a private lawyer, etc. If we take these variables into account, we realize how different the socioeconomic

34. Of course, it could be the case that the distribution of oncology drugs is concentrated within the category *over 3 times the minimum wage per capita household income* because only people from this category request this kind of drug. Unfortunately, we do not have enough data to test this hypothesis. But even if we assume this alternative hypothesis to be true, this would not necessarily lead to the rebuttal of our original hypotheses, as we explain in the continuation of the text.

TABLE 15.
Comparison of Variable

Variable	Our Sample Population (Oncology Drugs)	City of Sao Paulo
Education: university degree	50.01%	Less than 13.4%
Health: private insurance	84.38%	59.2% (ANS 2007)

profile of the plaintiffs requesting very costly medicines is from the general socioeconomic profile of the population of the city of Sao Paulo. In Table 15, we compare two variables.[35]

If our conclusion regarding our first hypothesis is correct, that is, if the judicial decisions concerning the right to medications often do not benefit the less privileged (but rather those who have better access to information, including better access to health, education, and legal services), then it is plausible to suppose that our second hypothesis is also correct, that is, that to a great degree, courts are not an institutional voice for the poor (at least not a current one). The justiciability of social rights, at least in our case study, has fallen short as means of rendering certain public services more democratic and accessible. On the contrary, the benefits of such justiciability are mostly enjoyed by those whose interests are already at least partially considered in the political process and who simply use the judiciary as an additional forum to better protect these interests.

However, it is very important to stress that we are not arguing that the courts treat wealthy and poor *differently* (i.e., that the wealthy win more often than the poor). This is not what is meant in our first hypothesis by "judicial decisions concerning the right to medications often do not benefit *the less privileged*." Actually, since most of the cases brought before the courts are successful (see Ferraz 2009, 35), it is possible to state—without affecting our hypotheses—that judges treat wealthy and poor fairly *equally*. However, since access to courts presupposes financial resources as well as access to information and since the poor in Brazil have both limited financial resources and highly limited access to information, the judiciary remains far from being an institutional voice for the poor.

This means that our hypotheses are not affected by the possibility that poor plaintiffs succeed at slightly higher rates than upper class plaintiffs. Due to the high rate of general success, the ratio between requests presented and requests granted is not

35. *Education*: The data available about the educational level of the population of Sao Paulo are unfortunately not conclusive, for they give information only about the time of study (in years) but not the degrees obtained by the inhabitants of the city. Since only 13.4 percent studied fifteen years or longer, we at least know that the number of citizens with a university degree cannot be higher than this. See ftp://ftp.ibge.gov.br/Indicadores_Sociais/Sintese_de_Indicadores_Sociais_2007/Tabelas/Educacao.zip (table tab2_14.xls) (accessed October 23, 2010). *Health insurance*: We assumed that every medical prescription issued by a private physician is related to a plaintiff who has private health insurance. Actually, it is possible to suppose that the number of people surveyed who have private health insurance is even higher, since some people have a medical prescription issued by a physician at a public hospital, but nevertheless have private insurance.

decisive. Hypothetically, even if every lower-income plaintiff is granted her request and only 75 percent of upper-class plaintiffs win theirs, this would not alter the assessment that courts are not currently an institutional voice for the poor, because what is decisive is who benefits from the allocation of resources implied by judicial decisions.

One final objection could be raised here, namely, that a single piece of research in a single city is insufficient to demonstrate that courts are not, as a whole, an institutional voice for the poor. As has been already stressed, our goal was not to demonstrate that courts are incapable of being, under any imaginable circumstances, a forum for the poor. Our primary goal was to rebut the widespread belief in Brazil in particular and in Latin America in general, particularly among authors not doing empirical studies on courts and among human rights lawyers, that whenever courts grant individuals rights that have been neglected by the political powers, they are functioning as an efficient alternative to foster substantial equality among citizens. As stressed above, to rebut this thesis, it is sufficient to show—for instance, through a case study such as ours—that this belief does not hold in at least some cases. In other words, if we demonstrate that there are cases in which "granting some neglected individual rights" does not imply "fostering substantial equality among citizens"—as we have argued—this means that the effects that judicial decisions have on fostering social justice may depend on several conditions that are exogenous to judicial activity as such. Moreover, although the results of our research are limited to a single case in a single city, we consider our sample to have adequate explanatory capacity, particularly if one bears in mind that the city of Sao Paulo is not just another city in Brazil, but rather its most important city, with a population that amounts to more than 10 percent of the population of the entire country. If, as has been shown, economic issues and, more importantly, access to information are the main variables that render access to courts difficult, one could expect that at least in the wealthiest city of the country, where the educational level is above the average, these external variables would be less decisive. However, this was not consistent with our findings. This is why we are convinced that even though courts may be an additional forum of debate, this can only be true under certain circumstances, which were shown to be highly limited in our case study.

Finally, it is important to stress that our conclusions are not intended to have a normative character. That is, at least in this article, we did not aim to determine the role courts *should play* when the right to health care or medication is at stake. Our goal was rather descriptive and limited to empirically testing one of the many widespread beliefs in this area, namely, that courts are an alternative institutional voice for the poor, who are marginalized from the political process. As far as we could see, at least in our case study, this belief had weak explanatory ability.

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