BY ANY MEANS NECESSARY? THE CONSTITUTIONALISATION OF HEALTHCARE IN THE UNITED STATES, UNITED KINGDOM AND BRAZIL

That healthcare reform involves a myriad of policy choices and complex trade-offs is, of course, a trite observation. The dilemmas that arise from trying to solve one important and challenging problem - bringing down the cost of healthcare whilst simultaneously improving the care offered - are all too familiar. We are accustomed to considering those dilemmas, and resultant trade-offs, in terms of expenditure, technological advances, fundholding, access, choice, coverage, efficiency, quality and so on, but other trade-offs occur which are not so well documented or discussed. These are the accommodations and compromises made at the constitutional level as a result of healthcare reform, and they raise important issues of constitutional identity and fidelity.

From decisions about constitutions and healthcare emerge systems which, ideally, form interlocking shapes, lending coherence, legitimacy and fit both to a jurisdiction’s healthcare policy and its constitution, which is the setting in which that policy must operate. As will be demonstrated, however, form and fit do not necessarily achieve this ideal symbiosis. Through an examination of three distinct approaches to healthcare reform in three different constitutional contexts – namely those of the United States of America (USA), the United Kingdom (UK) and Brazil – we reveal the ease with which a constitution may be undercut to achieve a particular policy aim. This outcome is at odds with the expectations liberal democracy attaches to a constitution and its role in ordering society but indicates that constitutional fidelity commonly yields to hard policy choices, and not just in America.

1. **The Relative Importance of ‘Form’, ‘Fit’ and Healthcare**

The jurisdictions examined here exhibit formal variety in healthcare and constitution but our interest is in ‘fit’ rather than what we consider the sideshow of ‘form’. As Bogdanor has noted, “[w]hether a country has a codified constitution is hardly something of great importance ... Whether it achieves the aims which constitutions are
intended to help achieve, is a matter of far greater moment."¹ The same might be said for healthcare systems. To demonstrate the point, both Brazil and the USA have codified constitutions, whilst the UK’s constitution is uncodified, yet Brazil and the UK maintain public healthcare systems whilst the USA traditionally favoured a privately funded model. Little can be drawn from that and, although we need briefly to address form, we will move quickly to examine how each jurisdiction has attempted to ensure that healthcare is constitutionally accommodated irrespective of form. Evaluating the jurisdictions’ approaches to fit is much more revealing since, for policymakers, judges, or both, confronting the issue is laborious and strained as it requires the examination and balancing of a jurisdiction’s constitutional history, philosophy and evolution – the components of fit² - with potentially progressive innovations in healthcare policy.

The difficulties engendered by attempting to map healthcare policy to constitution may lead to the issue of fit being bypassed, avoided or overlooked. Specifically in the UK and the USA, where no express right to healthcare exists, seeking equilibrium between free market autonomy and state-sponsored support in healthcare has generated these kinds of difficulties. The two jurisdictions’ reforms manifest an ideological shift from opposite ends of the healthcare spectrum towards the same point – the co-existence of public and private in a single system - but consideration for that kind of scheme’s fit with the constitution has been deficient or absent. Brazil, meanwhile, created an express, expansive sweep of a constitutional right to health whose practical realisation has been partial and problematic. In these deficient attempts to reconcile healthcare and constitution, three distinct approaches may be discerned: constitutional routing in the USA, procedural protection in the UK and substantive protection in Brazil. Yet in each jurisdiction a gap emerges between what is promised and what is delivered by the constitution, meaning that constitutional fidelity has been a subsidiary concern to the necessity of healthcare reform.

Arguably, such gaps might emerge in any given policy context but healthcare presents a particular challenge. Firstly, it bears enormous symbolic value.³ In each jurisdiction examined here, the promise of a peerless, universal healthcare system has loomed large in the political marketplace of ideas. Secondly, pressing practical

² Space constraints lead us to a broad-brush definition of fit, which we acknowledge as such.
considerations have begun to bite, principally the economic liability created by a failing healthcare system. In 2010, healthcare accounted for 17.6% of GDP in the USA, 9.6% in the UK and 9.0% in Brazil. The USA spent $8,233 per capita, the United Kingdom $3,433 and Brazil $1,028. The average cost of healthcare is rising, as are unusual costs and costs related to advances in diagnostics and treatment. Demography is also an economic driver as the healthcare needs of a growing, ageing population exert additional demands on resources. Failure to offer a workable solution to healthcare could, therefore, unsettle whole economies at both national and international levels. Indeed, it has been observed that, unless spending on healthcare is checked and managed, by 2015 the sovereign creditworthiness of G20 countries could be harmed.

The stakes are clearly high and, to that extent, perhaps invite policymakers to neglect the potential constitutional ramifications of reform, even where, in avoiding an unsettled economy, the alternative is to unsettle the constitution.

2. **USA: Constitutional Routing**

The Supreme Court (SC) has played an important role in ensuring that the USA's eighteenth century constitution, whilst difficult to amend through its own Article V procedures, remains relevant, applicable and fit for the modern world. The Constitution serves the principal purpose of dividing the powers of government, rather than expressing a commitment to rights. The Bill of Rights offers individuals protection from government interference with certain, primarily political, freedoms but features only negative rights (that cannot be denied to a person), rather than positive rights (that must be afforded to a person). Given its nature and principal purpose, it is not, therefore, surprising that the Constitution is silent on a right to healthcare: it is neither political nor negative and, as such, would not ‘fit’ the model. Nevertheless, healthcare, amongst other policy issues, has found its way into the canon of constitutional law. We are not concerned, here, with the Affordable Care Act's (ACA)

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constitutionality but rather how *NFIB* joins a long list of precedents in which constitutionality rests upon something other than the Constitution’s text, namely the SC’s interpretation of what that text now means.\(^8\)

To the extent that a constitution is neither an empty vessel nor a tablet of stone it is to be expected that, in adjudicating change, the SC creates a gap between the Constitution as written and as interpreted. Interpretation is, however, a matter of degree: too rigid an adherence to the text may thwart progress, too permissive an approach may vitiate the constitution. Aiming for fit, we argue, engenders considered interpretation which leads to minimal gapping between the written and interpreted constitution. What is noteworthy about *NFIB* is that, in paying scant attention to fit, the SC considerably widened that gap by routing the ACA’s constitutionality through Article I’s federal tax power.

The ACA’s individual mandate had been identified as being ‘enabled’ by no fewer than three of the Constitution’s clauses. Firstly, the President and Democrat-controlled Congress rooted the individual mandate in the Commerce Clause.\(^9\) Secondly, the federal government argued that, even if the Court interpreted the Commerce Clause narrowly, so as to deny authorisation for the individual mandate, it would be authorised by the Necessary and Proper Clause.\(^10\) Finally, Chief Justice Roberts identified Congress’s power to tax as the proper source of legislative authority.

Prior to *NFIB*, the main vehicle for constitutional routing had been the Commerce Clause\(^11\) but, in *NFIB*, no majority manifested to approve the legitimacy of routing mandatory federal health insurance through that clause. Instead, Chief Justice Roberts affirmed Congress’s power to mandate individuals to purchase healthcare insurance through the Taxing and Spending Clause, maintaining that “the mandate is not a legal command to buy insurance. Rather it makes going without insurance just another thing the Government taxes, like buying gasoline or earning income.”\(^12\) The Taxing and Spending clause has, of course, long been deemed to provide a foundation

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for welfare and healthcare legislation\textsuperscript{13} but not where the ‘tax’ concerned is, in reality, not a tax but a penalty for failure to enter the healthcare insurance market and where questions remain over further of its Article I credentials.\textsuperscript{14} \textit{NFIB} thus supplies Congress with a supplementary grounding for collective action problems needing federalisation - the tax power, broadly construed. This vastly expands the practice of, and possibilities for, constitutional routing by extending Congress's options in respect of the clauses to which it can bind a new policy, creating fresh rights in the process. As Justice Stone once quipped, the tax power is “sufficient for everything you want and need.”\textsuperscript{15} Indeed, in Barnett’s opinion, the upshot of \textit{NFIB} is that Congress will “be able to penalize or mandate any activity by anyone in the country, provided it limited the sanction to a fine enforced by the Internal Revenue Service.”\textsuperscript{16} On this view, the Chief Justice’s decision to hold the individual mandate constitutional via the tax power is a highly controversial departure. From the New Deal onwards, federal government has principally sought to establish the constitutionality of its actions through the Commerce Clause to the extent that the SC’s decisions regarding the Clause’s boundaries and outer limits have dominated federalism over the past twenty years. The power to tax may instead assume that role.

Whilst constitutional routing assists the SC and Congress in avoiding the Constitution’s formal amendment procedures,\textsuperscript{17} it also enables the ducking of substantive constitutional debate, creates second-class rights and rights protection, forces rights into the constitutional structure without proper consideration of their fit and, in this case, upsets the proper state-federal balance of power.\textsuperscript{18} Through routing, the SC has granted federal government an enhanced role in managing the country’s

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\textsuperscript{13} \textit{Helvering v Davis} 301 U.S. 619 (1937)
\textsuperscript{14} The SC declared that the penalty exhibited the “essential features” of tax but could not classify it as income tax, excise or direct tax. Arguably, the ACA falls foul of the Article I origination and uniformity clauses.
\end{flushleft}
economy, protecting workers rights,\textsuperscript{19} and preventing discrimination.\textsuperscript{20} Not once has a power so assumed by federal government been repatriated to state governments.\textsuperscript{21} Routing may be considered to protect rights because it prevents states from undertaking experimental action within a policy area by affording federal government the power to create a uniform national law but this frustrates one of federalism’s “happy incidents”, namely that “a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”\textsuperscript{22} Constitutional routing prevents state experimentation by reserving policy making to the federal government.\textsuperscript{23} State governments can no longer engage in a ‘race to the bottom’, when one state offers economic actors a more favourable set of laws, so that other states are forced to follow suit or suffer the economic consequences. Constitutionally routing protection of a policy to federal government may therefore place it beyond the kind of experimentation seen as a desirable by-product of the constitutional set-up. That the protection afforded by constitutionalisation comes not through a substantive safeguard but as a consequence of the SC’s reinterpretation of the constitution’s division of powers must beg questions about the sustainability of the federal model established by the Constitution.

By routing protection through Congress’s tax power the SC deemed constitutional federal legislation conferring an entitlement, standard, or regulatory benefit on the people. This tilts the constitutional structure, bypassing the states and granting individuals a right against deviation by state governments from the federal framework and standard, as approved by the SC.\textsuperscript{24} Consequently, federal government becomes the principal provider of second and third generation rights: states are constitutionally disabled since they cannot undercut the level of protection offered, granted or gained in that area of governance where their competence has just

\textsuperscript{19} NRLB v. Jones & Laughlin Steel Corp. (1937) 301 U.S. 1.
\textsuperscript{20} Heart of Atlanta Motel, Inc. v. United States (1964) 379 US 241.
been substituted by that of federal government.\textsuperscript{25} The role of state governments in healthcare is thus confined to ensuring that federal standards are met.\textsuperscript{26} If, however, federal policymakers decide to change tack or experiment, nothing may stop them.

The identification of a source of power for the regulation of healthcare gives national policymakers the freedom to decide which healthcare system should operate. Under \textit{NFIB}’s ruling, therefore, federal government has been constitutionally enabled to diminish or enlarge the scope of protection for healthcare, as expressed in policy rather than the constitution, as it wishes. Moreover, by creating structurally enforced rights, real debate concerning constitutional amendment and social welfare stagnates.\textsuperscript{27} Additionally, once undertaken, constitutional routing preserves the façade of the SC ostensibly remaining outside the politics of healthcare and respecting the Constitution’s separation of powers:

“We do not consider whether the Act embodies sound policies. That judgment is entrusted to the Nation’s elected leaders. We ask only whether Congress has the power under the Constitution to enact the challenged provisions … Resolving this controversy requires us to examine both the limits of the Government’s power, and our own limited role in policing those boundaries.”\textsuperscript{28}

There are, of course, benefits to routing constitutional rights, not least the avoidance of the Constitution’s stringent Article V amendment procedure. Instead, the Constitution’s substance is altered by the SC through definitional changes to power-allocation structural clauses. This ‘fluidity’ facilitates constitutional change but leaves behind a false perception of a stable constitution and deferential Court\textsuperscript{29} whilst also embodying the idea that the constitution must be “living, adapting, and changing and, simultaneously, invincibly stable and impervious to human manipulation.”\textsuperscript{30}

\textsuperscript{27} Sunstein, "Social and Economic Guarantees”, 11-12.
\textsuperscript{28} \textit{NFIB}, 2577.
\textsuperscript{29} Bruce Ackerman, \textit{We the People: Transformations} (Cambridge: HUP, 1998), 29
It is also essential to note the quality of the right granted through routing. *NFIB* affords no substantive constitutional protection to healthcare.\(^{31}\) It does not bestow a ‘right’ to healthcare upon any citizen. In accordance with the black letter of the constitution, therefore, healthcare remains outside the scope of constitutional law. After *NFIB*, it is not the ACA’s healthcare policy that is protected but the vehicle upon which it hitched its ride, namely the Article I tax power employed by federal government to undertake the reforms. Since the New Deal, SC decisions interpreting congressional claims to power have led to the creation of a weak form of rights protection which has ultimately curtailed the need, or indeed desire, for formal constitutional amendment.\(^{32}\) Therefore, while the SC instigates constitutional routing to overcome rigid procedures of constitutional amendment, concomitantly it perpetuates the problem by remediaying, on the hoof, the constitution’s chief weakness - its inflexibility.\(^{33}\) Constitutional routing masks the Constitution’s often unattainable thresholds for amendment. ‘Rights’ created in this way may, however, be argued to be second-class rights. They do not bear the same hallmarks of legitimacy or visibility as rights created via constitutional amendment, are parasitic and, being creatures of SC rather than legislative majorities, offer a dilute level of protection.

Routing does not solve this predicament and is not the ideal form of rights protection since it evades the question of ‘fit’: the protection amounts to no more than federal government policy which, in the context of US constitutional history and philosophy, might be deemed ‘anti-fit’. Routing provides federal safeguards against the states and leaves individuals with the guarantee of a uniform set of expectations. It may thus be argued to create federal ‘rights’.\(^{34}\) Issues persist, however, in terms of what is acceptable in aiming for ‘fit’. Firstly, to the extent that the SC makes recourse to routing, it might be asked whether the Constitution’s formal amendment procedures are perhaps too restrictive? Secondly, a difficulty arises where constitutional routing, despite some apparent benefits, permits rights to be created, and powers expanded, where the high barrier set for formal constitutional amendment cannot be reached. Thirdly, routing may encourage the exploitation of the constitution by politicians and

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\(^{34}\) Swendiman, “Constitutional Rights and Legislative Powers”, 5.
judges putting policy aims before constitutional adherence and, in that sense, create a constitution that is arguably based as much in the political process as the constitution of the UK.

3. **UK: Procedural Protection**

Conflict between healthcare reform and constitutional fit is also evident in the UK where the Health and Social Care Act 2012 (HSCA) came under considerable scrutiny during its passage through Parliament, notably in the upper legislative chamber, the House of Lords. The House of Lords Select Committee on the Constitution (HLSCC) raised a number of concerns about the effect the HSCA would have on the relationship between the government-operated National Health Service (NHS) and Parliament. The Committee’s report questioned whether the HSCA conformed to established methods of accountability in the UK’s uncodified constitution.\(^{35}\) That concern was, we argue, symptomatic of the fact that, in passing the HSCA, constitutional actors in the UK demonstrated as little regard for fit when faced with the problem of healthcare reform as their American counterparts.

Parliamentary sovereignty is the grundnorm\(^{36}\) of the UK constitution. It expresses the idea that Parliament may make or unmake any law and may not be bound in its actions by any previous Parliament.\(^{37}\) As a result of Parliament’s omnipotence, to all intents and purposes the constitution has no special ‘higher law’ status.\(^{38}\) In fulfilling its procedural role of assessing and scrutinising the proposed legislation, the HLSCC reviewed the HSCA to ensure that the doctrine of parliamentary sovereignty was not inadvertently undercut by the reforms contained in the Act.\(^{39}\) The Committee found that the Act made substantive changes to the scope of the government’s responsibility for healthcare, without giving due regard to the constitutional ramifications of reform.\(^{40}\)

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35 House of Lords Select Committee on the Constitution, *Health and Social Care Bill* (HL 2010-12, 197-I).
38 *Thoburn v Sunderland City Council* [2002] EWHC 195 (Admin)\(^{39}\)
40 HLSCC, *Health and Social Care Bill*, [4-5]
Central to the HLSCC’s concern was that the HSCA would weaken the constitutional convention of ministerial responsibility which ensures that government ministers are accountable for their decisions and remain subservient to Parliament.\textsuperscript{41}

Intrinsic to this convention is the idea that a minister is responsible for what happens in her department, and that Parliament acts as a watchdog of ministerial behaviour.\textsuperscript{42}

The convention of ministerial responsibility aims to ensure that the executive is accountable to Parliament for its actions.\textsuperscript{43} To ensure that parliamentary sovereignty is upheld, a Minister must maintain Parliament’s confidence by explaining and justifying her decisions in the deployment of powers delegated to her. The doctrine of ministerial responsibility is important because, apart from judicial review (where courts remain ostensibly subservient to Parliament by scrutinising only the executive’s implementation of parliamentary law), it is one of the only mechanisms or procedures through which members of the executive may be required to answer for their conduct.\textsuperscript{44} If the chain of responsibility is broken between a minister and Parliament, inhibitions on executive action are considerably weakened, Parliament’s sovereignty is undercut and the constitution loses democratic legitimacy because categories of government business fall outside its control. In its report on the HSCA, therefore, the HLSCC was concerned to ensure that the appropriate link was maintained between the actions of the executive and Parliament.\textsuperscript{45}

If parts of HSCA were exempted from the doctrine of ministerial responsibility, that would signify a yielding of constitutional principle to the practical desire for healthcare reform, providing a poor fit with the UK’s traditional constitutional model where parliamentary sovereignty is the primary, not secondary, concern.

The accountability gap identified developed through amendments to the National Health Services Act 2006 (NHSA). The Committee believed that the minister’s responsibility under the new Act would be considerably diluted\textsuperscript{46} and that

\begin{itemize}
\item \textsuperscript{41} Ibid, [18]
\item \textsuperscript{45} HLSCC, \textit{Health and Social Care Bill}, [18] “diluted”.
\item \textsuperscript{46} Ibid, [17-19]
\end{itemize}
Parliament had, thus far, failed to consider this consequence.\textsuperscript{47} The Committee pointed out a subtle, yet highly significant, modification in the duty owed by the Secretary of State for Health to the NHS between the NHSA and HSCA. The former imposed a duty on the Secretary of State to "provide or secure the provision of services in accordance with this Act"\textsuperscript{48}, while the latter simply requires that the Secretary of State uses his powers "so as to secure that services are provided in accordance with this Act."\textsuperscript{49} It was the HLSCC’s view that, this change meant "the chain of constitutional responsibility (between the NHS and Parliament) is severed."\textsuperscript{50} The difference was clear: under the NHSA a positive duty existed to provide or secure services, whereas the HSCA merely requires the Secretary of State to secure those services. The obligation to provide services was absent from the new legislation meaning that provision could occur in the private, rather than public, sphere. Removing this positive obligation from the Secretary of State meant that there would no longer be a governmental duty to offer certain treatments if they could not be sourced from the free market. If the Secretary of State was unable to secure a service from a provider, there would be no obligation then to provide that service.

The scope of the Secretary of State’s responsibility to Parliament would be reduced under the new law because a large part of the NHS would now be placed beyond her control, resulting in much of the functioning and performance of the NHS lacking any form of accountability.\textsuperscript{51} Moreover, it was unclear who would be accountable for the NHS services provided, if not the Secretary of State. No longer would Members of Parliament be able to ask questions of the Secretary of State regarding the government’s failure to provide constituents with healthcare. Their remit would be limited to inquiring about the services the government had secured or could secure.\textsuperscript{52} Furthermore, the NHS does not possess the governance structures associated with private market accountability, such as shareholders and stakeholders. In this light, it can be seen that the desire to reform the NHS caused potential questions

\textsuperscript{47} Ibid, [19] “[I]t is not self-evident that the proposed changes are a necessary component of the Government’s reform package.”
\textsuperscript{48} NHSA s1(2). Emphasis added.
\textsuperscript{49} HLSCC, Health and Social Care Bill, s1(2). Emphasis added.
\textsuperscript{50} House of Lords Select Committee on the Constitution, Health and Social Care Bill Follow Up (HL 2010-12, 240-I), [9]
\textsuperscript{51} Ibid, [1]
\textsuperscript{52} HLSCC, Health and Social Care Bill, [13-14]; Follow Up [6], [10].
of constitutional fit to be ignored and the practical need for change put first. That had two major constitutional impacts. First, the removal of the Secretary of State’s responsibility upset the pertaining constitutional balance. King has identified this as part of a trend which is “subverting the traditional constitution.” When responsibility is removed from the Minister the traditionally “clear-cut line of authority becomes a scramble”, with accountability becoming lost amongst the private sector, quangos and civil servants. Second, the impetus to achieve the desired reforms to healthcare blinded the government to the poor fit within the UK’s constitutional framework of the market’s new regulatory structure.

In response to the HLSCC’s highlighting of the possible dilution in ministerial responsibility, the government inserted the following into the HSCA:

“The Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England.”

This provision aims to reassure and confirm that the Secretary of State remains responsible to Parliament for her department’s operation. Nevertheless, the substantive, statutory duty of the Secretary of State remains merely to secure rather than provide services. The HLSCC was unsuccessful in altering this. Whether or not a future court will read the word provide into secure as a result of the provision remains to be seen but, given the courts’ deferential posture, this seems unlikely.

When evaluated against other constitutions, the UK’s overarching commitment to parliamentary sovereignty could appear retrogressive, not least because it leaves control over the constitution in the hands of the political class. Nicol identifies a silver lining, however, in claiming that parliamentary sovereignty makes the UK constitution ideologically neutral by not crystallising and embedding specific ideological beliefs. Democracy is maintained through the constitution’s direct link to swings in political opinion. As we will soon see, this is in complete contrast to the Brazilian constitution.

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54 Ibid.
56 Section 1(3) HSCA
Through leaving the task of definition to politics, the UK constitution does not mandate pre-emptive and substantive policy choices. Nor does it force politicians, judges and academics to work around any entrenched provisions in order to accommodate policy reform as does the constitution of the USA. Parliamentary sovereignty means that no political alternative, policy idea, or economic decision, is ever pre-ordained, barred, or outside the realm of possibility. This does not mean, however, that ‘fit’ with the constitution is a given for the policy choices of politicians: it is neutral, not empty.

The procedural mechanisms within a parliamentary democracy’s constitution must be adhered to for that constitution to maintain its legitimacy. The HSCA’s modification of statutory language created an accountability gap between the new NHS governance model and the constitution. In striving for a more flexible NHS, with free market sensibilities, government placed adherence to constitutional principles second. This means that, in the UK, the desire to find a workable solution to healthcare reform has led to a gap between accepted constitutional principles and the practical desire for a workable healthcare system. While the nature of this gap differs from those in the USA and Brazil, it is clear evidence of an emerging theme, namely that healthcare reform may require policy makers to overlook ordinary principles of constitutionalism to overcome the problems healthcare reform poses. Brazil is our final case in point.

4. **Brazil: Substantive Protection**

The drafting and ratification of Brazil’s 1988 constitution occurred almost immediately after two decades of military dictatorship and was a highly transparent and inclusive process. As such it recognisably represents a progressive advancement of democratic and liberal ideals, bearing the title ‘Citizen Constitution’ (Constituição Cidadã). Its 245 articles, authored out of broad participation and compromise, cover nearly every aspect of daily life, protecting not only an array of first generation rights but also second and third generation rights. A right to health is explicitly guaranteed under Article 6.58 It is not merely *healthcare* to which the Brazilian citizen is entitled, therefore, but an altogether broader right to ‘health’, as confirmed by Article 196 which

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58 “Education, health, work, habitation, leisure, security, social security, protection of motherhood and childhood, and assistance to the destitute, are social rights, as set forth by this Constitution.”
provides explicit direction to policymakers, constraining policy choices and, ultimately, the legislative function as a result.59

The democratic character of the Constitution is mirrored in Brazil’s healthcare system which emerged from the Sanitary Reform movement (Movimento Sanitarista) of the 1970s and 80s. Partly as a resistance to dictatorship, the movement, comprising an informal coalition of health professionals, academics, and activists, lobbied for a universal and constitutionally protected public health system. Its efforts brought forth important health sector reforms which, at least on paper, contrasted with the more market based reforms occurring in other jurisdictions in the 1990s. The resulting public Unified Health System (SUS) is declared to be based on the principles of universality, equity, public financing, decentralisation, popular participation and integrated service provision.

Ferraz argues that the high level of prescription in the Brazilian constitution, rather than establishing an enhanced range of rights and entitlements and ensuring that power is bounded, may in fact promote inertia. From one perspective, he states, constitutions “should establish only the abstract principles, and leave the rest for the field of ordinary politics”60 because “the more specific a constitution becomes, the more it reduces the scope for institutions of state to achieve the constitution’s goals”61 and, consequently, the harder it is to secure and manage the fit between policy initiatives and constitutional guarantees. It is, therefore, clear that highly specific constitutional provisions may undercut the purpose of the constitution itself since, “if the legislature and public administration decide ... that the detailed constitutional provisions are impossible to implement, or cannot be implemented in the near future ... there is the risk of debasing the constitutional document”62 and, by implication, what it establishes, including institutions of state, divisions of power, forms of democracy, and important rights. Where, therefore, da Silva and Terrazas maintain that “in the

59 “Health is the right of all and the duty of the State, granted by means of social and economic policies that aim at reducing the risk of disease and of other maladies, and at providing universal and equal access to the actions and services that promote health, protection and recovery.” Articles 198 and 200 impose further constraints.
61 Ibid.
62 Ibid.
area of social and economic rights, protection of rights can only mean the real implementation of such rights”63 the opposite may, in fact, occur.

It is probably fair to say that the problem of ‘fit’ in the Brazilian context relates to fitting the promise of the constitution to the reality of what politicians are willing, or able, to deliver. The Constitution’s health provisions make high demands of Brazilian state institutions, political processes, policy-making and budgets and the promised access to, promotion and protection of health has not materialised despite the constitutional guarantees. Alves and Timmins claim that, in reality, a two-tiered system persists where “[t]hose with sufficient means have access to a private system of healthcare that provides quality treatment on demand, while the remainder of the country relies on an overburdened system of public clinics and hospitals.”64 This gap between the aspirations of the Constitution and the reality of SUS is one that has needed to be plugged through litigation since the constitution’s health provisions automatically give rise to court-enforceable rights.65 That enforceability arises on two different planes. The first is that the right to health may be asserted by each and every citizen. The second is that the Constitution obliges the state – the sphere of public power in the broadest sense – to promote, protect and defend health. Ostensibly, therefore, when called upon to adjudicate constitutional rights, Brazilian courts cannot duck the issue of fit, even if policymakers have done so.

Ferraz notes an “explosion of litigation”66 in Brazilian courts, in particular in the areas of medicine and treatment provision. The judicialisation of health has necessitated Brazilian courts’ involvement in interpreting policy - including the finer details - allocating resources and ensuring that state provision complies with healthcare’s fundamental principles as set out in the Constitution. This means that explicit constitutional protection for health, whilst attractive in theory, may be argued to foster an undesirable level of judicial intrusion into the political arena, especially if,

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66 Ferraz, “Right to Health”, 1
as Ferraz contends, Brazilian judges have been “not at all deferential to the decisions of the political branches about social policy and resource allocation in health.”

On the other hand, the judicial role as guardian of the constitution may mandate such intrusion and, if seeking fit is both desirable (as we claim) and a constitutionally mandated judicial enterprise (as appears to be the case) it might be viewed as the only legitimate and sustainable position for the courts to adopt. Michelman states that, in these circumstances, the judiciary is faced with a “hapless choice between usurpation and abdication” which means either that judges must make a “pretentious, inexpert, … resented attempt to reshuffle … basic resource-management priorities … against prevailing political will” or “debase dangerously the entire currency of rights and the rule of law by openly ceding to executive and parliamentary bodies an unreviewable privilege of indefinite postponement of a declared constitutional right.”

The Brazilian approach draws judges into the political arena by requiring them to determine the contours of the Constitution’s right to health and, initially, in the Brazilian Federal Supreme Court (BFSC) this engendered a highly proactive approach. Wang notes the BFSC’s declaration that a lack of resources could not restrict the right to health and often repeated mantra that the constitution must be:

“completely respected and fully complied with, especially in cases where a right – such as the right to health – entails a judicial prerogative to ensure the right of the citizen to demand positive action from the State … The judiciary’s action in those situations is legitimized where the State refuses to respect the constitutional commandment, whether by arbitrary and intolerable default, or by any other form of governmental deviant behaviour.”

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68 Article 102
71 Ibid, 78
72 Ibid, 77
Despite its apparent determination to ensure healthcare’s fit with the Constitution, the BFSC soon concluded that its approach was unsustainable. Neither it, nor the government, was a Sorcerer’s Apprentice: resources could not be created out of thin air. The BFSC’s principled approach to fit had, therefore, to give way to practicalities and the recognition of a rather more limited right to health than that detailed in the Constitution:

“The fulfilment of social and economic rights depends on financial resources that are subject to the government’s available budget … [O]nce it is objectively shown that the State does not have the financial capacity, it cannot be obliged to fulfil these constitutional duties.”

The BFSC’s fluctuating deference to the realities of healthcare provision might have suggested that assertions of the right to health at first would always, and subsequently would never, prevail but many Article 6 claims have succeeded. It might also have suggested that, irrespective of a written constitutional guarantee, the BFSC had adopted the kind of model that emerged in both the USA and UK, whereby the constitution would be fitted to policy rather than vice versa, but that is not the case either. What the BFSC opted for was an approach mediated via public consultation, echoing both the drafting of the Constitution and the creation of SUS. In 2009, the BFSC held a public hearing to invite opinion, information and input from laymen and experts, to discuss access to health care and to consider the judicialisation of the right to health. In subsequent case law, this democratic glossing of the BFSC’s involvement in policy determinations and striving for fit resulted in a set of guidelines and criteria for a “refined and realistic interpretation” of the right to health. The approach is clearly premised on rationing and, in practice, falls woefully short of the Constitution’s promise but it does, at least, constitute judicial acknowledgement of the need to consider, openly and explicitly, apparent departures from constitutional fit.

5. **Conclusion**

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73 Ibid, 79; (2006) ADPF 45
74 Ibid, 79-81
75 Ibid, 82
In the context of healthcare reform, it is apparent that maintaining constitutional fidelity is difficult. What is clear is that the unstoppable force of healthcare policy does not, in fact, meet the immovable object of the constitution, as might be imagined, but, instead, encounters something altogether more malleable. In the USA and Brazil respectively, the judiciary proved instrumental in fitting and bending the constitution to healthcare, rather than the other way round, whereas, in the UK, alerting Parliament to healthcare’s uncomfortable constitutional fit was a matter of pre-legislative scrutiny undertaken by members of the legislature. In all three jurisdictions, on the basis of economic necessity, healthcare reforms ultimately trumped prevailing constitutional norms. In no instance was constitutional fidelity fully maintained. That might be a concern for those who exhibit a preference for principled, as opposed to practical, fit.