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Judicialization 2.0: Understanding right-to-health litigation in real time

João Biehl^{a,b}, Mariana P. Socal^c, Varun Gauri^d, Debora Diniz^{e,f}, Marcelo Medeiros^{g,h}, Gabriela Rondon^{e,f} and Joseph J. Amon^b

^aDepartment of Anthropology, Princeton University, Princeton, USA; ^bWoodrow Wilson School of Public and International Affairs, Princeton University, Princeton, USA; ^cDepartment of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA; ^dDevelopment Research Group and Mind, Behavior, and Development Unit, World Bank, Washington DC, USA; ^eLaw School, University of Brasília, Brasília, Brazil; ^fANIS – Institute of Bioethics, Human Rights and Gender, Brasília, Brazil; ^gDepartment of Sociology, University of Brasília, Brasília, Brazil; ^hIPEA – Institute for Applied Economic Research, Brasília, Brazil

ABSTRACT

Over the past two decades, debate over the whys, the hows, and the effects of the ever-expanding phenomenon of right-to-health litigation ('judicialization') throughout Latin America have been marked by polarised arguments and limited information. In contrast to claims of judicialization as a positive or negative trend, less attention has been paid to ways to better understand the phenomenon in real time. In this article, we propose a new approach—*Judicialization 2.0*—that recognises judicialization as an integral part of democratic life. This approach seeks to expand access to information about litigation on access to medicines (and health care generally) in order to better characterise the complexity of the phenomenon and thus inform new research and more robust public discussions. Drawing from our multi-disciplinary perspectives and field experiences in highly judicialized contexts, we thus describe a new multi-source, multi-stakeholder mixed-method approach designed to capture the patterns and heterogeneity of judicialization and understand its medical and socio-political impact in real time, along with its counterfactuals. By facilitating greater data availability and open access, we can drive advancements towards transparent and participatory priority setting, as well as accountability mechanisms that promote quality universal health coverage.

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Introduction

While the justiciability of socioeconomic rights is of increasing interest internationally, the high volume of individual right-to-health litigation (particularly over access to medicines) throughout Latin America stands out (Biehl et al., 2009; Biehl, Amon, Socal, & Petryna, 2012; Biehl, Socal, & Amon, 2016b; Dittrich et al., 2016; Gauri & Brinks, 2012; Pepe et al., 2010; Reveiz et al. 2013; Yamin & Gloppen, 2011). With the increasing number of cases has come controversy over the phenomenon and its consequences (Azevedo, 2007; Ferraz, 2009; Messeder, Osorio-de-Castro, & Luiza, 2005; Wang & Ferraz, 2013).

Over the past two decades, debates over the whys, the hows, and the effects of the ever-expanding phenomenon of the judicialization of the right to health have been marked by polarised arguments and limited information. A majority of judicialization studies have used imperfect data, focused on

short-term outcomes, and implicitly or explicitly advocated for the containment and management of the phenomenon (Borges & Uga, 2010; Campos Neto et al., 2012; Chieffi & Barata, 2009; Da Silva & Terrazas, 2008; Ferraz, 2009; Vieira & Zucchi, 2007). An alternative approach recognises that judicialization is an integral part of contemporary democratic life, something to be understood in its complexity and possibly tweaked or reoriented so as to promote substantive human rights.

In this article, we elaborate on such an approach that we call *Judicialization 2.0*. Drawing from our multi-disciplinary perspectives and field experiences in highly judicialized contexts, we describe a new multi-source, multi-stakeholder mixed-method framework that aims to capture the patterns and heterogeneity of judicialization and understand its medical and socio-political impact in real time, along with its counterfactuals. We are advocating for a change in perspective from one that focuses not only on the distribution of short-term costs and benefits to an understanding of judicialization as a localised and complex system in the making. At issue is not only the need to advance new methods but also to create new lines of inquiry, dynamic forms of collaboration among scholars and activists, along with new understandings of government obligations with respect to transparency. By facilitating real time data availability and open access, we believe we can promote more transparent and participatory priority setting, as well as accountability mechanisms that promote quality universal health coverage.

First generation studies of judicialization

Early studies of right-to-health litigation (particularly for access to pharmaceuticals) sought to assess the scope, magnitude, and main characteristics of cases and litigants. From these results, researchers and policy makers inferred (or speculated about) potential factors that influenced, or were driving, the judicialization of health (Borges & Uga, 2010; Chieffi & Barata, 2009; Messeder et al., 2005; Pepe et al., 2010; Yamin & Gloppen, 2011; Yamin & Parra-Vera, 2009). These studies faced enormous information-gathering challenges. Efforts to gather comprehensive or representative data on lawsuits have been elusive and, while large data repositories within public health administrations and the judiciary might have existed, they were not necessarily integrated and readily accessible. State actors were not always willing to allow access to information, and the data sources available – lawsuits and court rulings – did not contain enough information to provide a complete characterisation of plaintiffs' socio-medical needs and broader health and life circumstances. Without a broader picture, assessments of the effects of judicialization on individual welfare and social life were necessarily limited.

Most studies focused on collections of available lawsuits from a single city or region, single level of the judiciary, or single type of case. In addition, studies collected data from the limited information provided in the lawsuits or in legal or administrative registries. Lawsuits typically contained minimal information on plaintiffs aside from the requested treatment and perhaps the health condition that justified the request. Often only a lawyer's description of need was provided, without accompanying medical documents and without other health, demographic, or socio-economic information. Individual cases were studied more often than collective lawsuits.

Scholars had to use whichever information was available in order to conduct their analyses. Studies often resorted to proxies in order to fill in missing information – for example, using indicators for entire geographic areas as proxies for individual socio-economic status. In many cases, only aggregated data were available – for example budget line items reflecting resources being spent on court-obtained treatments. In addition, not only was evidence difficult to access, but also only certain types of evidence were examined. Studies largely focused on the substance of legal claims and did not seek the perspectives of the multiple actors involved in the process, such as patients, lawyers, judges, politicians, etc.

These early studies succeeded in demonstrating that judicialization of health increased significantly over time, both in terms of the number of lawsuits being filed and in terms of the amount of resources mobilised. Studies tended to agree on key points: that the phenomenon was growing

in all contexts where it was occurring; that multiple populations, and multiple state and legal actors were involved; that lawsuits originated in both private and public sectors but that the main target of the lawsuits was the government (overwhelmingly state governments); that the most frequent form of health care sought by lawsuits was access to medicines; that a wide range of different medicines were sought, from cheap, off-patent drugs that were part of government formularies to expensive, branded drugs that were sometimes not even approved for commercialisation; and that courts by and large sided with patient/litigants (Biehl et al., 2012; Biehl et al., 2016b; Borges & Uga, 2010; Campos Neto et al., 2012; Chieffi & Barata, 2009; Da Silva & Terrazas, 2008; Messeder et al., 2005; Pepe et al., 2010; Pereira, dos Santos, do Nascimento Junior, & Schenkel, 2010).

There has been disagreement, however, over some of the measurable attributes of cases that touched on issues of distribution. For example, studies diverged as to whether judicialization predominantly served better-off versus worse-off litigants; whether lawsuits predominantly sought expensive, off-formulary drugs or cheap, on-formulary drugs; whether cases were most often brought by private or public attorneys; and so on.

Some of the reasons for the divergence across studies were related to the selection of cases under study. Studies that collected information from cases under evaluation by higher courts, for example, might have been more likely to find that the treatments most often requested were expensive and off-formulary drugs. This might have been because requests for cheap and on-formulary drugs tend to be solved in lower courts, and complex and more questionable requests are more likely to be contested and progress to upper courts. Similarly, convenience samples of open legal cases might tend towards finding predominance of requests for complex and high-cost treatments, as these may be more subject to contesting and appeals from both sides. Lawsuits requesting cheap on-formulary drugs that should be provided by the state were more likely uncontested, more quickly resolved, and not picked up by investigations of ongoing cases (Pepe et al., 2010; Vieira & Zucchi, 2007). Some of these conflicts may have been resolved before becoming judicialized.

Other reasons for heterogeneity in findings may have been due to institutional variation. The availability of public defender offices and state laws allowing for private attorneys to be paid by the government provided means of legal representation for individuals without ability to pay; studies in locations with these resources may be more likely to find higher numbers of poor individuals filing health-related lawsuits than areas without such resources. Similarly, regions where the public health system is more successful in delivering on-formulary drugs may be less likely to have litigation for on-formulary drugs because of higher governmental administrative efficiency. The decentralised nature of public health and judicial systems makes it very likely that there may be true variation in the drivers and characteristics of judicialization across and within regions (Biehl et al., 2012; Biehl et al., 2016b; Chieffi & Barata, 2009; Diniz, Robichez de Carvalho Machado & Penalva, 2014; Messeder et al., 2005; Pereira et al., 2010).

Data on judicialization and the analysis of its impact and value have evolved, and a growing number of researchers are struggling with the assumptions and limits built into their methods and with the fraught quest for generalizability. As a result, the differences in results that emerged from the studies have been amplified by differences in the interpretation of their findings. In general terms, the debate has oscillated between two extremes. On the one hand, scholars have argued that judicialization is disruptive of public health policies and budgets, and by overruling the autonomy of the bureaucracy, it also reduces its efficiency. On the other hand, scholars have contended that judicialization corrects policy omissions and systemic failures and fulfils citizens' rights; by protecting patients in severe need, it addresses inequity and enhances accountability. There is no simple answer to what judicialization is and does, and cases supporting both views can be found. What seems clear is that a narrow view of the problem and the refusal to recognise its positive and negative effects do not contribute to the public interest (Biehl, Socal, & Amon, 2016a).

Dynamism and valence

Polarised debates of the judicialization of health ignore the complexity and dynamism of the phenomenon and reduce public attention to access to medicines and to a narrow view of individual right to health. However, there has been a dynamic evolution of right-to-health litigation and the role of diverse stakeholders and political actors. The recent case of the Zika epidemic in Brazil is illustrative. In 2015, the northeast of Brazil became the global epicentre of the Zika virus epidemic (Ventura, 2016). Transmitted by mosquitoes and sexual intercourse, the virus can cause fetal malformations, a syndrome of which the most well known sign is microcephaly, the small head circumference in the newborn. The northeast is one of the poorest regions in the country, and vulnerable families were the ones most severely affected (Diniz, 2017).

The impact of Zika on the region shows that the right to health is not only an individual right, but also a collective right, thus requiring a focus on population health and community interventions. It also reminds us that right to health is not only the right to treatment but also the right to prevention, supported by a broad range of social policies. Brazil once controlled the *Aedes* mosquitoes that carry the Zika (as well as dengue and chikungunya) virus, but years of neglect allowed their proliferation. An insufficient epidemiological surveillance system took too long to spot the epidemic. Long lines to access prenatal care delayed the identification of a link between the infection and fetal malformations. Lack of distribution of basic resources such as insect repellent, protective nets, and water collection and sanitation systems allowed the mosquitoes to spread (Diniz, 2017). The failure to fulfil the right to health in the case of Zika continues even after transmission has declined, as the health system is unable to provide appropriate and adequate care to babies affected by the Zika syndrome.

In 2016, a group of human rights activists (supported by the National Association of Public Defenders) petitioned the Brazilian Supreme Court, requesting both individual and collective remedies for those affected by Zika. The demands were simple: access to information, timely attention in health facilities, transportation to care centres for babies living in remote areas, and access to family planning, among others. A report prepared to give support to the court action shows that basic care was not being provided: anticonvulsants, mood stabilisers, diapers, early stimulation of children, long-acting reversible contraceptives, and the distribution of repellent against vector mosquitoes (Brazilian Supreme Court, 2016).

The example of Zika raises important questions about what drives judicialization on the ground and the impact of judicialization on the broader understanding of the state's obligation to fulfil the right to health in terms of both individual and collective rights. What appears superficially as individual vulnerability and demands for care reflect a collective condition of underlying structural precariousness of health systems. Similarly, what appears as individual responses – litigation – can also be seen as a collective movement to press for local and systemic change (Brinks & Gauri, 2014; Gauri & Brinks, 2012).

Meanwhile, the state too is evolving in response to judicialization. Over time, the growing impact of judicialization on the day-to-day operations and budgets of the public health administration and the judiciary has led to the creation of new structures in response to this phenomenon. Public health administrations designated staff and implemented software systems to manage court-obtained treatments. New public pharmacies were established to exclusively store and provide judicially obtained treatments, effectively creating parallel delivery systems of judicial and non-judicial drugs within the public health system. General attorneys' offices have organised task forces focused on health litigation, designating teams to work exclusively on health-related lawsuits. Medical consultants have been brought in to help prepare evidence-based defenses. Because health-related lawsuits inundated existing courts, specific jurisdictions were appointed to concentrate the health cases. In some cities, mediation courts have been created to resolve claims to medicines even before lawsuits were started (Vasconcellos, 2015).

The growth in right-to-health litigation also motivated several initiatives such as meetings, conferences, and protocols within the judiciary, public health administrations, and academia (most

commonly in isolation from each other but also, in some cases, in cooperation). Interested in promoting debate and exchanging lessons across countries, international agencies such as the World Bank organised cross-national conferences, debates, and created platforms for shared resources (Reos Partners, 2013; SaluDerecho, 2017).

Judicialization 2.0

While there will continue to be a need to characterise trends in judicialization, we believe it is time to move towards a more systematic, comprehensive, and prospective analysis of the phenomenon that better addresses its effects on its multiple stakeholders, identifies new areas of human rights attention, and engages in alternative social and political theorising. By doing so we will be better equipped to examine not only budget allocation but also procedural justice and policy adjustments. We call this new framework 'Judicialization 2.0'. This framework proposes both conceptual and methodological changes to the current study of widespread right-to-health litigation (Tables 1 and 2).

The conceptual basis of the framework is a shift in the goals of judicialization studies (Table 1). While early studies of judicialization sought to characterise litigants and cases and identify factors associated with them, the new framework proposes that studies have broader and multi-dimensional aims: capturing patterns and the heterogeneity of judicialization; understanding its impact on multiple stakeholders, society, and health systems and on the conceptualisation of right to health;

Table 1. Judicialization 1.0 vs 2.0: conceptual aspects.

Characteristic	Judicialization 1.0	Judicialization 2.0
Goals of research	<ul style="list-style-type: none"> • Characterise readily observable characteristics of court cases: magnitude, trend, characteristics of plaintiffs, types of medicines sought, legal outcomes (and justification), costs. 	<ul style="list-style-type: none"> • Capture patterns and the heterogeneity of judicialization and understand its impact on multiple stakeholders, society and health systems and on the conceptualisation of right to health. • Understand how the new structures created in response to judicialization have in turn influenced its occurrence and outcomes. • Identify causal factors that can provide actionable targets to improve public policies.
Main focus Stages of the health litigation process addressed by the studies (Gloppen, 2008)	<ul style="list-style-type: none"> • Claims formation stage • Adjudication stage 	<ul style="list-style-type: none"> • Implementation stage • Social outcomes
Main actors Who is collecting and analyzing the data	<ul style="list-style-type: none"> • Academic scholars, or government officials, working independently from each other 	<ul style="list-style-type: none"> • Multiple stakeholders (scholars, executive, judiciary, civil society, international agencies) working in partnership
Generation of evidence	<ul style="list-style-type: none"> • By convenience • Fragmented • Unidimensional • Focuses on researchers' questions and priorities 	<ul style="list-style-type: none"> • Systematic • Integrated • Multi-dimensional • Reflects stakeholders' questions and priorities
From research to policy	<ul style="list-style-type: none"> • Retrospective data • Isolated efforts, not always resulting in directly comparable results 	<ul style="list-style-type: none"> • Real-time data • Tracking emerging and ongoing issues that are being judicialized and their respective responses • Transparency and participation in government • Inform policies to improve the responsiveness of the judiciary and the health system to the needs of the population

understanding how the new structures created in response to judicialization have in turn influenced its occurrence and outcomes; and, importantly, identifying causal factors that can provide actionable targets to improve public policies.

The analytical focus of Judicialization 2.0 extends beyond the claims formation and the adjudication stages of the phenomenon (what drives lawsuits and what is the judiciary's response) to its implementation stage and its social outcomes (to what extent does the state comply to rulings, and which structural changes are brought about as a result from litigation) to capture a more comprehensive picture of the phenomenon (Gauri, Staton, & Cullel, 2015).

Judicialization 2.0 also involves a more comprehensive set of actors. While early studies of judicialization were typically developed by academics or state officials (or both), the new framework proposes that multiple stakeholders partner in the development and use of the research. That includes legal scholars and practitioners in conjunction with medical and public health academics, state officials, and members of civil society and international organisations. Integration and collaboration among these multiple actors is a key component of Judicialization 2.0, responding to the need for a new form of evidence generation that focuses on producing systematic, integrated, and multi-dimensional information that reflects stakeholders' questions and priorities, addresses the nuanced aspects of the phenomenon, and produces actionable results. Ultimately, Judicialization 2.0 studies should seek to produce real-time data that can help inform policies to improve the responsiveness of both the judiciary and the health system to the needs of the population and promote increased transparency and participation in government.

In order to respond to the new conceptual aspects of Judicialization 2.0, the methodologies proposed by our framework address questions such as: what data are relevant? What types of cases should be studied? Which groups provide an adequate counterfactual? Which outcomes are relevant? These methodologies allow for an expansion of the scope of the studies by considering questions such as whether courts are accessible to all, and what types of challenges poor litigants face (questions addressed by the analysis of counterfactuals); whether there is compliance with court

Table 2. Judicialization 1.0 vs. 2.0: methodological aspects.

Characteristics	Judicialization 1.0	Judicialization 2.0
Data sources What are the main sources of data used in the studies	<ul style="list-style-type: none"> • Single-source • Available (existing) data: Lawsuits, legal, and health registries • Manual data collection (often convenience sampling) 	<ul style="list-style-type: none"> • Multiple sources • Data collection mechanisms deliberately incorporated into administrative and legal processes • Automated data collection (systematic sampling; big data)
Main information collected	<ul style="list-style-type: none"> • Aggregated information • Undimensional • Limited set of characteristics • Use of proxies and single-source 	<ul style="list-style-type: none"> • Disaggregated • Multi-dimensional • Comprehensive • Multiple data sources linked by area, jurisdiction, administrative division
Study design	<ul style="list-style-type: none"> • Single-method (qualitative or quantitative) • Cross-sectional analyses • Case series 	<ul style="list-style-type: none"> • Incorporating ethnographic insights and social theory • Mixed methods (qualitative and quantitative approaches) • Longitudinal studies (follow-up of cases over time) • Geospatial analyses • Simulation and modelling
Analytical perspective	<ul style="list-style-type: none"> • Single-context (one geographic location, judiciary level, or country) • Single-level (individuals, courts, or government budgets are independently examined) • Descriptive • Uncertain normative grounding 	<ul style="list-style-type: none"> • Comparative (across contexts: geographic areas, population groups, countries) • Multi-level (individual and geographic/system-level information are examined simultaneously) • Predictive • Grounded on social theory

rulings, and what institutional, social, attitudinal, and even electoral changes result from litigation; and others.

The methodological changes proposed by the new framework focus on four major areas: data sources, analytical perspective, study design, and information collected (Table 2). Judicialization 2.0 studies draw from multiple data sources, with automated data collection mechanisms deliberately incorporated into administrative and legal processes, and aiming to collect as close as possible a census or a representative sample of cases. The information collected is comprehensive, multi-dimensional and disaggregated, and the data from the multiple sources are linked by person, area, jurisdiction, administrative division, or other dimensions.

Open access data on lawsuits is not unheard of. In the United States, the ‘Public Access to Court Electronic Records (PACER)’ website provides electronic public access to case and docket information from federal appellate, district, and bankruptcy courts. Transparency promotes accountability: both are key principles of human rights. Public engagement also strengthens the process of priority setting and the effectiveness of a government’s policies, drawing upon the knowledge that is widely dispersed in society. It also increases the legitimacy of government actions. Ensuring real-time access also promotes accountability and good decision-making (United States Courts, n.d.).

Study designs in Judicialization 2.0 combine mixed methods (qualitative and quantitative approaches); incorporate insights from ethnographic studies; may have longitudinal approaches (follow-up of cases over time), implement simulation and modelling, geospatial analyses and other methodologies. Judicialization 2.0’s analytical perspective is grounded in social theory; is comparative (across geographic areas, population groups, countries, incorporating counterfactuals) and multi-level (individual and geographic/system-level information are examined simultaneously). Importantly, the analytical perspective goes beyond the description of the phenomenon to develop predictive models that can be used for priority setting and decision-making by the State or the judiciary. This is an ambitious proposal and will require potentially difficult deliberations among multiple stakeholders as well as new kinds of collaborations and funding.

Access to information, transparency, accountability, participation

Judicialization 2.0 is not intended to be simply a research endeavour but a laboratory of transparent and participative engagement between scholars, civil society and government officials, who together can benefit from an open-access set of cases (with appropriate protections of identifiable characteristics). This new approach, complemented by ethnographic methods and social theory, can investigate the impact of judicialization on the relationship between individuals and the state, the strength of health systems and the meaning – in practice – of the right to health (Biehl & Petryna, 2013). An open system will allow for individual inquiry as well as the creation of diverse partnerships among scholars, and among scholars and government officials and activists and other stakeholders, and – hopefully – a more robust and less caricatured dialogue, debate, and policy-making discussion.

Expanding technological and computing power should allow for the collection of information that allows for the detection of heterogeneity across locations and juridical levels. Complementary research methodologies should be employed to capture those individuals who might have judicialized but did not. Multi-level information that combines characteristics of the individuals initiating health litigation with the resources available to them at the area level should be analyzed in order to help devise better policies.

Judicialization 2.0 should go beyond measuring trends and examining potential drivers and aim to capture broader questions of societal changes brought about by judicialization, and the impact it may have on the development and implementation of public health policies. Importantly, this approach should seek to represent the multiple narratives reflecting the disaggregated experience of diverse patient/litigant groups from different geographic locations, socio-economic backgrounds, health needs, and legal representation, accounting for counterfactual cases and scenarios.

The principles of open access to health litigation and participation in health policy decision-making are well grounded in international human rights law. For example, access to information is protected by both the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (ICESCR) (UN General Assembly, 1966; UN General Assembly, 1976). Access to information on health litigation can also be understood as a part of the requirement to provide information on the main health problems in the community and more broadly to assess government responses to those health issues. Human rights related to access to information have been emphasised in international agreements related to environmental protection and health, such as the Convention on Access to Information, Public Participation in Decision-Making and Access to Justice in Environmental Matters, known as the Aarhus Convention (Wates, 2005).

In some countries, such as Ecuador, Israel, Mexico, India, and Panama, freedom of information legislation explicitly applies to at least some types of information held by the judiciary (Open Society Justice Initiative, 2009). However, in most countries, the degree of access to judicial records and information is left to the courts and can be highly variable. National courts have recognised these rights in their jurisprudence as well. As Yamin and Parra-Vera note in the case of Colombia:

In keeping with the UN ESC Rights Committee's interpretation of the right to health, the Court ... asserts that the right to health calls for transparency and access to information, as well as for evidence-based planning and coverage decisions based on participatory processes. (Yamin & Parra-Vera, 2009)

Access to information on right to health litigation can be understood as consistent with the same principles, and where courts are intervening to address perceived state failures, such as in the provision of access to medicines, transparency can promote legitimacy.

Despite these precedents, information on judicialization remains restricted. While government officials blame judicialization for disrupting health policies, public administrators often do not release data that would allow an open examination of how judicialization is being conducted and who benefits from it. In some cases, agencies are increasing barriers to data access instead of reducing them.

Does it matter? Yes it does, and for a clear reason: a claim about the costs and benefits of judicialization, and its relationship to equity in health, requires an analysis of procedural justice as well as human capabilities, and such analyses require detailed data.

For courts as well as for ministries of health, autonomy does not preclude transparency and accountability. It would be better if no one needed to resort to courts to obtain treatment, but in modern democracies courts are the legitimate institutions for challenging policies and administrative decisions. It is unrealistic to believe that citizens will not press their health demands by all possible means. The judiciary will be used to contest the allocation of resources in any domain, and health policies are not an exception. The less accountable bureaucracies and courts remain, the easier it will be to manipulate judicialization for private interests and drive the policies away from the objectives of equity and efficiency.

Conclusion

Any study of judicialization—from start to end—entails normative choices and is deeply public. What drives our choice of data, the compromises we make to access it, what our methods address or exclude, what is made visible and what remains invisible in our results, the values we sponsor in our interpretations, and the benefits we garner from the uptake of our work—all this is, or should be, subject to challenge and material for critical inquiry. Debates often use apparently objective concepts, such as efficiency, autonomy, and fiscal space that have implications for what counts as evidence and who is able to participate in discussions and policy-making. Shining a light on how judicialization affects bureaucratic autonomy or public sector budgets, for example, tends to leave community engagement and rival understandings of justice in the shadows. Attention is often drawn to what is most prominent, and whatever is in the background is easily overlooked.

As we critically reflect, at every step, on the publicness of our studies of judicialization and the political work they do, we might become better equipped to meaningfully retrofit current and future research, thus keeping our research ever ‘more realistic,’ as the political economist Albert O. Hirschman would put it, and ‘hopefully better’ (Hirschman, 1998). Judicialization 2.0 seeks just that: to understand right-to-health litigation as a localised, complex and dynamic system in the making and as a critical dimension of democratic life, and to create socially meaningful and actionable evidence. Our goals should be a partnership among multiple democratic stakeholders to produce real-time, comprehensive data, which can be analyzed through multiple methods over the short- and medium-term, with the normative ambition of achieving transparent, accountable, and participatory priority setting that promotes substantive human rights.

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