State responsibility and right to health in Brazil: a balance of the Branches' actions

Responsabilidade do Estado e direito à saúde no Brasil: um balanço da atuação dos Poderes

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Abstract *The 1988 Federal Constitution set forth a new political-institutional moment in Brazil reasserting the Democratic State and defining a broad social protection policy including health as a social citizenship right. Since its promulgation, a great number of laws, ministerial decrees and administrative actions have attempted to make feasible the political project outlined in the Constitution. On the other hand, in the same period, the number of legal orders regarding health related demands has increased. Such a movement has revealed inconsistencies and contradictions in the legal and normative scope of SUS (Unified Health System), as well as problems not calculated by health policies, questioning the Executive Branch's actions and creating a new demand for legislation. This article discusses the role of the State in health as of 1990, considering the action of the Branches. The perspectives on the right to health in the construction of a democratic State oriented to social wellbeing, facing the challenges related to coordination mechanisms and balance among Branches in the health issue, are discussed.*

Key words *Health Policy, Right to health, Executive branch, Legislative branch, Judicial branch*

Resumo *A Constituição Federal de 1988 inaugurou um novo momento político-institucional no Brasil ao reafirmar o Estado Democrático e definir uma política de proteção social abrangente, incluindo a saúde como direito social de cidadania. Desde sua promulgação, um conjunto expressivo de leis, portarias ministeriais e ações de âmbito administrativo buscaram viabilizar o projeto político desenhado na Constituição. Por outro lado, no mesmo período, cresce o número de mandatos judiciais com demandas relativas ao direito à saúde. Tal movimento tem revelado inconsistências e contradições no âmbito legal e normativo do SUS, bem como problemas não equacionados pela política de saúde, questionando a atuação do Executivo e criando novas demandas por legislação. O artigo discute o papel do Estado na saúde a partir de 1990, considerando a atuação dos Poderes. Discutem-se as perspectivas da garantia do direito à saúde frente ao projeto de construção de um Estado democrático e orientado para o bem-estar social, em face dos desafios relativos aos mecanismos de coordenação e de equilíbrio entre Poderes na saúde.*

Palavras-chave *Política de saúde, Direito à saúde, Poder Executivo, Poder Legislativo, Poder Judiciário*

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Introduction

The 1988 Federal Constitution (CF88) set forth a new political-institutional moment in Brazil reasserting the Democratic State and defining a broad social protection policy. It recognized health as a citizenship social right and inscribed it in a list of integrated actions of the Public Branches' enterprise and of society aiming at asserting a new social order, whose essential objectives are social justice and wellbeing[1]. Since the CF88, the State is legally obliged to perform health actions and offer health services so as to build a new social order[2]. With the CF88, a great number of laws, ministerial decrees and administrative actions have made feasible the project designed. During the 1990s and 2000s, the number of legal orders with claims related to the right to health has progressively increased. The Judiciary Branch and the Public Prosecution (MP) have revealed inconsistencies and contradictions in the legal and normative scope of SUS (Unified Health System), as well as problems not calculated by the health policies, questioning the Executive Branch's actions and creating a new demand for legislation, which places the right to health issue in the agenda.

This article looks into a few challenges related to the performance of State duties in guaranteeing the right to health as of 1990, focusing on the operations of the Branches.

The text is based on the discussion about the CF88 and the SUS establishment context, highlighting the State reform agendas that have influenced the directions of national health policy as of 1990. In the subsequent topic, the action of the national Legislative and Executive Branches in health policy is evaluated considering their duties in the consolidation of SUS constitutional principles. The third item questions the action of the Executive and Legislative Branches in the legal phenomenon of health.

Finally, the perspectives on the right to health in the construction of a democratic State oriented by social wellbeing - considering the challenges related to coordination mechanisms and balance among Branches in the health issue - are discussed.

The 1988 Constitution and the SUS establishment context

The CF88 is considered one of the most progressive constitutions in the world because it comprehends a generous spectrum of civil, political and social rights[2,3]. In Brazilian history it is an important political and institutional benchmark, having been written in a context of transformations the State and society were going through, in a moment in which hope to build a new kind development - called "popular"[4] and "democratic"[5] - ruled and there were collective efforts to develop the economy, strengthen democratic values and social advancement.

Whereas, on one hand, the CF88 reflected the political-social advancements of the country, on the other, its text was full of contradictions, preserving characteristics of previous constitutions[6]. Next to political and social innovations, conservative propositions remained in the economic[5], tax[7] and administrative[5] areas of the State, as well as traces of conservativeness in the organization of the political system[8,9].

Nevertheless, the importance and the innovative character of the CF88 are unanimous. From its edition until December 2007, the Constitution suffered 56 amendments and the institutional rules have been constantly perfected, especially those which organize political institutions so as to meet the needs of a new democratic order. For these and other reasons -even if the levels of negotiation have multiplied, making the government's decisions more complex - the CF88 is far from constituting an obstacle for the governability of the country[10].

However, beyond the CF88, the structural problems of the State and of the Brazilian capitalist development system - the economic and social inequalities observed in the country are highlighted here[11-13] - have to be considered when one is seeking to understand the challenge of social protection and, particularly, the establishment of a health policy in the 1990s. The studies on the development of social policies in Brazil reveal limitations, especially due to its fragmented, stratified, unequal and ineffective character in a social perspective[14,15].

Thus, the establishment of a daring sanitary reform, conceived in the democratization context of the 1980's and consolidated by the acknowledgement of health as a citizen's right, demanded the confrontation of structural distortions in the health system and its main challenge was overcoming the serious inequality in the health scenario of the country. This would only become viable if included in a broader project to transform the development model and Brazilian society.

However, most of the constitutional conquests were hindered by the results of a conservative slant that reached its summit with the election of Fernando Collor de Mello as President of the Republic in 1989. The 1990s in Brazil were characterized by the coexistence of democratization and economic liberalism[5], with the preponderance of a State reform

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agenda that emphasized currency stabilization and inflation control; downsizing public structure and officialdom; restrictions to comprehensive social protection with restrictions in expenses and in the expansion of private offers of social services.

Therefore, the political and social protection model outlined found an unfavorable context to consolidate the constitutional principles in the 1990s. In health, even if there have been important advancements - such as the political-institutional changes related to the making of a decisive framework for SUS and the expansion of the public health actions and services in the national territory - the policies course has vigorously demonstrated the tensions between the sanitary reform project and the preponderant State reform agenda. Such agenda, neoliberally oriented, proved to be unfavorable to the expansion of State actions and imposed restrictions to the performance of duties to guarantee health as a citizen's right.

Such restrictions were strongly demonstrated especially in five fields: the obstacles to the consolidation of Social Security; the unstable contribution with financial resources; the insufficient supply of relevant health inputs such as medicine; the feebleness of human resources policies in health and the persistence of distortions in the relations between public and private in the area of health. The limitations were expressed in violation of rights and in the maintenance of severe inequality regarding health, giving rise to doubts regarding the possibility of a health system oriented by universality and comprehensiveness guidelines in Brazil.

The action of the Executive and Legislative Branches in the right to health

The reform project contained in the CF88 presupposed a new State intervention model regarding health and the reconfiguration of the role of the three government branches. In the scope of the federal Legislative Branch, such project meant the immediate definition of a legal basis for the organization of this system (regulating laws). In the federal Executive Branch's context, the project presupposed: institutional integration with the conformation of a single national health policy; a new inclusion of health policy in public policies; new relations between the federal manager of the policy and other governmental and non-governmental players, which could be sectorial and extra-sectorial; changes in the federal role and performance regarding health.

However, it is not only the reformist health project that influenced the action of the Legislative and Executive Branches in health in the 1990s. A broader set of factors, forces and political projects that influenced the State intervention standard as of that decade should be considered.

Thus, it is necessary to make explicit the consolidation of the health policy as of 1990 and how it expressed the contradictions among different reform agendas of the State.

The period between 1990 and 1994 was to define the institutional base of Social Security and SUS (Chart 1), but with no consensus for the creation of a regulating law for Social Security that would comprise social work, health and social assistance. Each area established its own legislation, in scenery of dispute over resources, reflecting the contradictions of the Social Security model designed in 1988 and the conflicts of interests of the three areas involved[16].

In the first years of the decade, the unfavorable scenario to consolidate protection policies was clear, with the reattachment of the Social Security to the Ministry of Labor in 1990; with the non-fulfillment of the CF88 temporary clauses for destination of health resources; with the linkage of Social Security to the discounts on workers salaries as of 1992; and with the inclusion of the Union Security Taxes (EPU) in the Social Security Budget (OSS)[16,17].

For health, this meant the beginning of a period of financial frailty due to the non-fulfillment of the OSS[17,18], the instability of sources and the amount of resources[19], conflicts with the economic area, low federal[20] investments and restrictions related to the decentralization and distribution criteria of federal resources[7]. Not even the approval of a specific financing source for health in a subsequent moment (Temporary Contribution on Financial Transactions - CPMF in 1996) guaranteed a substantial increase and resource stability to the sector.

After the definition of the institutional basis there was a moment of great political and economical stability. The success of the Real Plan (1994) in controlling the currency allowed a political institutional rearrangement in the Brazilian State, reasserting a liberal perspective. As of 1995, the elected governors attempted to eliminate traces of the Vargas State and create new ways to regulate the market, having moderate economic liberalism[5] as the rule. The constitutional reforms became a central point in the government strategy and were almost completely approved by the Congress.

For the consolidation of social protection and right to health, the period from 1995 to 2002 expressed a reconfiguration of interests, with specific

Chart 1. Legislative Production in Health, per year and authorship.

Sus Institutional Basis - 1990-1994		
Documentation	**Year**	**Author**
Law 8080 - Fundamental Health Law	1990	Executive
Law 8142 - Complementary Law	1990	Executive
Law 8212 – Social Security Law	1991	Executive
Law 8246 - Institution of the Social Pioneers Association	1991	Executive
Law 8689 - Extinguishment of INAMPS	1993	Executive
Technical policies and specific health policies - 1995-1997		
Documentation		
Law 9005 - Obligates salt iodation	1995	Mixed committee
Law 9055 - Rules the use of asbesto/amianthus	1995	Legislative
Law 9313 - Defines the distribution of AIDS medicine	1996	Legislative
Law 9263 - Defines family planning	1996	Legislative
Law 9294 - Rules the use and advertisement of smoke, alcohol, medicine and others	1996	Legislative
Law 9311 - Institutes CPMF	1996	Executive
Law 9431 - Determines the Program to control hospital infection	1997	Legislative
Law 9434 - Rules the removal of organs, tissues and other parts of the human body	1997	Legislative
Law 9436 - Rules the working time for doctors	1997	Executive
Regulation of the health market and definition of specific actions - 1998-2002		
Documentation		
Law 9656 - Regulates private health insurance	1998	Legislative
Law 9836 - Regulates the subsystem of indigenous people's health	1999	Legislative
Law 9797 - Obliges restoring breast plastic surgery by the SUS	1999	Legislative
Law 9787 - Establishes generic medicine	1999	Legislative
EMC 29 - Guarantees minimal resources to finance health actions and services.	2000	Legislative
Law 9782 - Defines Sanitary Vigilance Systems and creates ANVISA	1999	Executive
Law 9961 - Created ANS	2000	Executive
Law 10289 - Establishes the Prostate Control Program	2001	Legislative
Law 10216 - Redirects the mental health model.	2001	Legislative
Law 10223 – Obliges restoring breast plastic surgery by health insurance	2001	Legislative
Law 10273 - Defines the inclusion of the message "safe sex" in videotapes	2001	Legislative
Law 10424 - Regulates home care by SUS	2002	Legislative
Law 10439 - Defines a day to fight High Blood Pressure	2002	Legislative
Law 10449 – Rules the commercialization of condoms	2002	Legislative
Law 10456 - Defines a day to fight Glaucoma	2002	Legislative
Law 10465 - Determines Oral Health day	2002	Legislative
Law 10507 - Creates the community health agent profession	2002	Executive
Law 10516 - Institutes the national health card for women	2002	Legislative

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Chart 1. continuation

Government project and health policy - 2003-2007		
Documentation	**Year**	**Author**
Law 10651 - Controls the use of thalidomide	2003	Legislative
Law 10708 - Defines the psycho-social rehabilitation support	2003	Executive
Law 10741 - The Elderly's Law	2003	Legislative
Law 10778 - Defines the compulsory notification in case of violence against women	2003	Legislative
Law 10835 – Rules basic citizenship income	2004	Legislative
Law 10972 - Authorizes the Executive branch to create the state company of Hemoderivative and Biotechnology	2004	Executive
Law 11123 - Creates, in the career of Social Security and Work, at the Ministry of Health, the jobs it mentions	2005	Executive
Law 11129 - Institutes the National Program for inclusion of youths - Projovem	2005	Executive
Law 11104 - Defines the compulsory creation of toybraries	2005	Legislative
Law 11255 - Defines the guidelines for the protection policy and health care for people with hepatitis	2005	Legislative
Law 11350 - Rules article 198 of the CF88 and determines the utilization of personnel - EC51 - Agents	2006	Executive
Law 11346 - Creates the National System for Food and Nutrition Safety - SISAN	2006	Executive
Law 11344 - Defines new structures for careers	2006	Executive
Law 11355 - Defines the creation of careers in Social Security, Health and Labor	2006	Executive
Law 11387 - Authorizes the Union to contribute with the WHO in order to make possible the International Center to buy medicine against AIDS, malaria and tuberculosis	2006	Executive
Law 11303 - Institutes the National Day for awareness of Multiple Sclerosis	2006	Legislative
Law 11347 - Defines the free distribution of medicine and necessary materials to apply and monitor capillary glycemia in diabetic people enrolled	2006	Legislative
Law 11373 - Institutes the National Day to Fight Psoriasis	2006	Legislative
Law 11265 - Rules commercialization of food for lactants and infants, as well as related products for children	2006	Legislative
Law 11445 - Sanitation Law	2007	Legislative
Law 11506 - Creates the National Day for the Ostomized	2007	Legislative
Law 11520 - Defines the granting of pensions for people affected by Hansen's disease who were compulsorily isolated and kept in hospitals	2007	Legislative
Law 11585 - Creates a National Day for the Community Health Agent	2007	Legislative
Law 11584 - Creates the National Day for Organ Donation	2007	Legislative
Law 11605 - Creates the National Day for the Guthrie Test	2007	Legislative

Source: SICON. Federal Senate. Creation based on the legislation approved.
Attention: Budgetary laws, administrative laws on the creation of jobs and careers and the laws that make changes to other laws were not included.

demands and new problems to be faced. The period comprises two governments of President Fernando Henrique Cardoso and reveals a certain mode of directing social and health policies in an administrative reform context that was oriented to reduce the size of the State and the changes in its role.

In the analysis of the legal production in health from 1995 to 2002 it is possible to identify at least two sub-periods (Chart 1), which correspond to the moments of variation in the governmental health policy: a first moment in which there was the expansion of specifically health policies (1995-1997), when the direction was facing dilemmas in

operating SUS, aiming at the development of technically based policies and addressing claims of certain groups or organized social movements; and a second moment when the emphasis was on the regulation of the health market (1998-2002), according to the government's style of "regulating interventionism" by the Executive Branch through controlling offices[21].

The analysis of ministerial policies and the legal production of the period[22] allow us to visualize tendencies in the debate about right to health that characterized the health decision process and that remained constant in the following moment. In general, three trends in the approach to right to health in the laws were settled in the beginning of the 1990s, especially as of 1995, expressing contradictions and dilemmas to guarantee the right to health:

- Laws that reaffirm the right to health comprised in its reach, as determined in the CF88. This is the case of laws that: advance on sanitary control and production of healthy environments (salt iodation, asbestos/amianthus control, use and advertisement of tobacco, sanitary vigilance); promote the regulation of strategic areas of health care (hospital infection control, organ, tissue and body part removal); meet demands of specific areas (family planning, native Brazilian subsystem, psychiatric care), usually the result of a debate with the social movement and responding to its demand.

- Laws that segment right to health, discriminating rights to certain groups, such as the law that guarantees medicine for AIDS.

- Laws that introduced changes in the conception of rights, including other views such as consumer rights. This is the case for the law which regulates health insurance, the law which created the Supplementary Health National Agency (ANS) and the generic medicine law.

All the laws promoted advances in the establishment of the right to health, however, a change in the emphasis of what is legislated can be noticed, which also reflects the movement of the Ministry of Health in the definition of policies in this period. From the first subperiod (1995-1997), when the technical and social demands were buzzing, aiming at improving the rights determined constitutionally, there was a shift to an emphasis in the regulation of the consumer logic (as of 1998)[22]. The approval of the AIDS law in 1996, in a different perspective, denotes the frailty of the State in responding to a health need - medicine supply - and represented a path used by specific groups seeking to assert of their constitutional rights.

In a more specific analysis of the role of the Ministry of Health in the direction of the national policy in the period from 1990 to 2002, Machado[23] showed that the limits in two important action fields for the development and consolidation of the right to health become obvious: human resources (professional education and management of work in the area of health) and the relevant input for health.

In the direction of a human resource policy in health, at least two important aspects should be considered. First, the difficulty to politically calculate the conflicts of interest among health professionals who came from varied contractual regimes, resulting from the merger of INAMPS and the Ministry of Health, and from the decentralization/municipalization. The Fundamental Health Law from 1990 (Law 8080) suffered important vetoes in its regulation of the human resources policy and did not have political support to recover such aspects in Law 8142, leaving all policies related to SUS career plans, jobs and salaries undefined; this is still an issue to be resolved nowadays.

Second, the general context of the State reform in the federal level which was unfavorable to the expansion of officialdom and personnel expenses and led to a downsizing of the Federal Public Administration never seen before[24]. Such agenda generated intense pressure on states and municipalities so that they carried out restricting measures, making it difficult to hire, offer adequate work conditions and pay public health professionals in the other levels of the government, which many times turned to outsourcing and other uncertain or legally doubtful ways to retain SUS professionals. The context was also unfavorable to seek more integration among social policies, in the 1990s there was no significant articulation between the Ministries of Health and Education to discuss the education of health professionals.

In the area of health input development and supply, there were important gaps in the actions of the Ministry of Health, partly due to the deficiencies in the national industrial policy of the 1990s, the limited articulation among public policies in federal level[25] and the strong private interest in the area. This hindered the expansion of the population's access to necessary inputs in health care, which is evident in pharmaceutical care. Thus, even if the federal expenses on exceptional medicine and AIDS treatment have increased in the 1990s, since the federal government gave priority to strategies aimed at specific groups, the access to medication and others remained a problem, including the ones to control diseases under vigilance and the ones needed for people in the first level of care. It is also

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essencial to point out the importance of the generic medicine policy on the federal agenda.

In this scenario, the highlight is the creation of the National Sanitary Vigilance Agency (ANVISA) in 1999, which set forth the model for a regulating agency in the country - responding to the State reform - and also had an essential role in controlling the production, commercialization and consumption of products and inputs that affect human life.

A summary of the period 1995-2002 reveals important changes in the direction of the health policy, in the reach of the Legislative and Executive Branches, in view of the reform project designed in 1988. The conformity of the policies designed by both Powers is startling. The Executive was responsible for 89% of the legislative subjects approved and the main laws written by the Legislative expressed interests of policies directed by the Ministry, as in the case of AIDS medicine policy, the salt iodation policy, the control of tobacco advertisements or the hospital infection control program, among others[22]. The analysis of the legal production and ministerial policies of the period revealed a strong presence of the Executive agenda in the scope of the Legislative, gathering elements for us to think about the relation between Branches in health.

A third moment in the consolidation of the health policy can be located as of 2003, in the beginning of Lula's government and the political project to change the role of the State, emphasizing the recovery of long term policies and reduction of inequalities. Beginning on 2003, the ongoing concern with the economic stabilization and the gradual feasibility for the creation of a development strategy, especially as of Lula´s second administration, with the presentation of the Plan to Accelerate Development (PAC), are witnessed. In the social scope, the direction towards policies for groups that were set aside from society and penalized by the situation of social inequality interfering in some degree with the asseverative health agenda.

In the direction of the health policy, some important tendencies can be observed, such as the beginning of a human resources policy for SUS; the origin of a policy to guide the input production according to the health needs; and the search for a better integration with other public policies.

In a different perspective, the Ministry of Health established as of 2004 the "Popular Drugstore" Program to offer basic and essential medicine subsidized by the Federal Government and sold at inexpensive prices in state drugstores or private ones that are part of the program. Such policy sets forth the utilization of SUS resources for programs and actions that are not necessarily attached to the development of the guarantee to the universal and comprehensive right to health and, to some extent, can compete with the medicine supply in the public health system.

In the legal production of health, the strong presence of the Executive agenda can be noticed, as in the previous period. Since 2003, laws related to policies of social inclusion and assistance to segregated groups or minorities have been approved (the law for the elderly, social rehabilitation support, basic income for citizenship, family grant) as well as laws that reinforce the science and technology policy in health (hemoderivative and biotechnology state company).

Regarding the role of health in the context of the government's project, some old frailties persist. The sectorial efforts undertaken - from the beginning of the government - to locate health as an important productive sector of the State (health productive complex) were not enough to guarantee a change in the sectorial financing standard.

As already pointed out, the health sector financing revealed it had been fragile since the beginning of the SUS establishment. In 2000 there were advances in the definition of a constitutional amendment (EC29) determining rules for the minimum application of resources in health by the three government levels, however, the amendment still needs regulation. In 2008, the issue remained in the agenda and the lack of regulation allowed the Executive Branch to manipulate the application of what was determined by the law and hindered the Judiciary control over its enforcement. The Legislative became the stage for this negotiation between the government and the health sector, which, to some extent, reflects the position financing has in the government's projects.

The analysis of the actions of Executive and Legislative Branches in the 20 years after the CF88 leads to a harsh conclusion on the role of health policy in the Brazilian State agenda. The scenario of the project guaranteeing universal and comprehensive right to health is presently very different from the one that defined the project. The 1990s produced a shattered, privatized State with a low response capacity. In the social scope, inequalities have been emphasized. In health, two strong health systems compete: SUS and the private system. Even though there have been important changes in federal performance, during this whole period, there was no definition of a broad positive project for the Ministry of Health, guided by objectives that are coherent with the Sanitary Reform guidelines, which should at least be: the insertion of health in

a new development model and in a broad social protection logic; the search for consolidation of SUS principles and guidelines in the national territory and the reduction of health disparities.

In the Legislative Branch, the private interests of professional corporations, service provider representatives, health productive sector and several social movements prevail in the present debate ,harming public interests. The right to health is discussed as the right to free choice, as a possibility to have access to health services and inputs, be it by public or private means, it doesn't necessarily matter whereas there is a Unified Health System that is good, egalitarian, universal and comprehensive. For these interest groups, all that matters is that the State provides for a large part of this care and that it finances the productive sector attached to it. No wonder the health financing issue is an agenda that gathers several groups representing public or private interests.

While the Executive and Legislative Branches delay effective responses to social demands, the number of legal orders increases, resuming the debate on this right.

The guarantee of the right and the judicialization of health

As from the end of the 1990s the number of legal orders has increased exponentially, most of which attempt to guarantee people's access to medicine, diagnostic and therapeutical procedures.

Some studies show[26-30] that the Courts have been acting in areas not considered by national health policy, such as medicine supply. It is pointed out that the object of the legal orders are frequently medicines that have not been proven to be efficient and that are not registered in the country, but a great number of court orders have been used as a resource to allow access to medicines under the responsibility and duty of the State and listed by the Ministry of Health, such as medicines from the Basic Pharmaceutical Care Program, drugs considered strategic for the control of certain diseases and damages or those to be used in rare and exceptional cases[27,30].

Thus, it becomes clear that the increase of judicial activity is at least in part due to the deficiencies of Public Administration, having a beneficial effect when it renders the State responsible for developing adequate procedures to incorporate, buy and distribute therapeutic procedures by the public system. However, this practice risks developing the judicial path as the main means to guarantee access to medicine, which is contradictory to say the least when health is considered a social right of a citizen.

The use of court orders also alludes to the broader discussion about the origin of the suits and the variety of interests at stake which, most of the time, exceeds the individual situation presented. Thus, the court system has been the preferred path used by the HIV/AIDS carriers' movement in Brazil, in the 1980s, having been an important means to guarantee medicine and exams to treat and control the disease in programs controlled nationally by the Federal Executive Branch during the establishment of SUS[28]. However, marketing and pressure from the pharmaceutical industry over doctors, NGOs, institutions and HIV/AIDS carriers to incorporate new medications and exams must be considered the origin of many of these suits, no matter the issues related to the rational use of medical procedures and the possible damage associated to inadequate prescription and misemployment. This same situation can be applied to present orders in other conditions such as neoplasia and rare diseases with experimental or expensive treatments.

The fact is that in a context of restriction and low capacity of the State (on the three levels of the government) to respond to health problems, the Judiciary Branch and the Public Prosecution's action stood out. Thus, the lawsuits are frequently against state, municipal and public service officers, especially in areas in which national policy expresses greater gaps and contradictions. For example, officers are pressured by the legal system and by the Public Prosecution to carry out immediate public contests after years of being submitted to restrictive policies to hire personnel and being subordinate to the limits imposed by the Fiscal Responsibility Law. Another example is the demand to buy certain medicines in dubious situation or contradicting policies in force, such as: for people assisted in the private sector; when the efficiency of the drug is not clear, or in the case of essential medications that are missing from the basic services system, occasionally available as generic drugs in regular drugstores or in stores linked to the Popular Drugstore Program.

The action and the orders of the Court or the Public Prosecution end up bringing about issues of a different nature. What are the criteria used by these Powers in their directions? It can be noticed is that the Judiciary and the prosecuting lawsuits are fragmented among thousands of authorities, who - in view of the lack of objective parameters given by Executive Branch and even by the law - usually define their own criteria to decide and judge.

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The frailty and deficiencies in the relationship among the Branches concerning the right to health are then revealed. Within the perspective of the Executive and the Legislative Branches, the growing feeling is that, considering the expenses imposed to public money; it is necessary to establish a new legal benchmark that will regulate, for example, the exemption of medication and the performance of other medical procedures.

An example is Bill n. 219 of 2007, which has responded to demands from SUS officials attempting to restrict the actions of the Judiciary and the MP so as to limit the guaranteed access only to therapeutic procedures in clinics and hospitals listed in the tables prepared by the Ministry of Health. Besides limiting the comprehensive concept of SUS, this bill does not consider the importance of the organized civil society's conquests through court to expand access to news technologies that are relevant for the treatment and control of certain diseases. On the other hand, in the Judiciary Branch, the autonomization and insulation movement is growing and if not mediated by information and knowledge about the rules that condition the actions of the Executive and Legislative in the health sector, may generate an even greater disorder of health service and actions offered to the population.

Perspectives to guarantee right to health in Brazil

CF88 established, in the scope of social protection, the extension of a series of rights, especially Social Security and the acknowledgment of health as the social right of a citizen and the State's duty. Regarding the political system, guidelines were defined to reach a greater balance among the Branches and to reestablish the democratic process in the political and institutional scope.

The content of the Fundamental Health Law, product of the debates between the Executive and the Legislative Branches, is very comprehensive and positive as to the guarantees of rights, especially when reasserting the universality and comprehensiveness guidelines and the definition of the Executive responsibilities in the three government levels. Even with the political administrative decentralization guideline, a series of competencies are asserted for the national management of SUS, represented by the Ministry of Health. The National Executive would be responsible for the necessary regulation in order to lead the policy according to SUS principles and a series of assignments in strategic areas. What could be observed in subsequent years, however, was that fragmentation in the direction of policies and the excessive federal normatization in some areas harmed the understanding of the direction of national policy. Moreover, there are significant gaps in the performance of the Ministry of Health in the field of human resources and inputs, which are revealed in the state and municipal levels and harm health care in its universal and integral perspective.

The Legislative action during the establishment of SUS expresses on one hand, an agenda in total accordance with the Executive demands. The Legislative in the past twenty years has been the main voicer of policies defined by the Ministry of Health, even those which, to some extent, oppose to the right to health principles and guarantees. Within another perspective, the Legislative also expresses a sharp fragmentation, predominantly responding to legitimate demands, though specific to certain groups. Such demands gain space and become specific laws as the Constitution's guidelines and the LOS aren't completely fulfilled. On the other hand, they generate contradictions regarding a broader and more universal conception of a right.

The performance of the Judicial Branch and the Public Prosecution, - oriented as of 1988 by new constitutional rules that changed and expanded their attributions - bring out contradictions and dilemmas to the right to health in Brazil, questioning not only the Executive, but the balance made by the Legislative. Acting as an intervener and defender of the rights and putting in practice its autonomy and insulation, the Judiciary itself can be questioned because it leads determinations that sometimes collide with the right to health.

The disruption between Branches reveals how important it is to improve checks and balances mechanisms and dialog among public institutions that operate guaranteeing the SUS principles. Even if there have been advancements, it is still the State's great challenge, as a whole, to guarantee democracy and perform the role of mediator of interests and demands, establishing priorities and acting in a balanced manner, considering collective wellbeing and not only responding to the interests of specific groups.

Collaborators

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