DOI: 10.1590/1413-81232018246.08212019

Reflections on the judicialization of the right to health and its implications in the SUS

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Abstract *This paper presents the issue of judicialization of the right to health in Brazil. Data from the National Council of Justice evidence a substantial increase in the number of lawsuits concerning the right to health. We emphasize that the national doctrine exhaustively discusses ways to make the authority more effective, but it does not, as a general rule, discuss the economic aspect of health judicialization. Using the concept of opportunity cost extracted from economics science, it is shown that the judge, by deferring the lawsuit formulated by the plaintiff, automatically forces the Executive Branch to reduce the scope of other policies to generate resources to meet the court order. In specific contexts, this setting ends up favoring individual rights at the expense of the collective rights of SUS users, in violation of the principle of isonomy and efficiency. Finally, the case of the judicialization promoted by the hemophiliac patients in the Federal District is shown as a way of evidencing, at the factual level, the consequences of judicialization in the SUS policies.*

Key words *Judicialization, Right to health, Unified health system, Health policies, Opportunity cost*

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Introduction

The relationship between health and law gained prominence in Brazil with the 1988 Federal Constitution which stated in art. 196 that *health is the right of all and the duty of the State, guaranteed by social and economic policies aimed at reducing the risk of disease and other health problems, and the universal and equal access to actions and services for their promotion, protection, and recovery*[1].

Over the last 30 years, a growing judicialization of the right to health has been observed, under the constitutional rule. Data from the National Council of Justice (CNJ) show this increase, as per the Table 1.

Between 2016 and 2017, the number of cases addressing the right to health increased by almost 50%. In detail, CNJ data[2,3] only portray the demands that were submitted to the Judiciary. The table does not contain data concerning administrative requests made by citizens, the Public Prosecutor's Office, the Public Defender's Office, Health Councils, and other interested parties.

The fact is that matter is in the process of maturing through a broad discussion. The National Council of Justice itself recognizes that the issue requires attention and conveys, on its website, a report[4] pointing out that the judicialization of health is a matter of concern to the body, including justifying the establishment and maintenance of state health committees and the realization of public hearings to discuss the issue.

Debates on health judicialization usually focus on how to improve judicial performance, how to make court proceedings faster, how to make enforcement more productive, and the like.

Notwithstanding the importance of such debates, one must verticalize the analysis and discuss what is meant by the universal right to health and what are the costs that each understanding generates. This is because, in a scenario of scarce resources, one must consider the existing alternatives and adopt the one that best safeguards the public interest. This paper aims to promote this discussion.

The right to health and costs inherent to its implementation

The right to health, as well as social rights in general, are not self-enforcing. The creation of a standard providing rights for users of the Unified Health System (SUS) alone does not materialize the resources necessary for the implementation of such rights.

The discussion about the right to health and the limitation of state funds usually have an easy theoretical solution. The legal operators say that it is enough to withdraw funds from some other budget line to cover the implementation of the court order.

This understanding also gains importance when it is considered that the Judiciary decides on the duty to provide a particular treatment or

Table 1. Volumetry of lawsuits related to health law in the years 2016 and 2017.

Types of lawsuits	Justice Report in Numbers 2016 - CNJ	Justice Report in Numbers 2017 - CNJ	Increase (%)
Social control and Health Councils	1,468	2,008	37%
Medical agreement with the SUS	737	1,037	41%
Organ/tissue donation and transplantation	491	597	22%
Medical malpractice	38,810	57,739	49%
Supply of medicines	200,090	312,147	56%
Hospitals and other health facilities	5,642	8,774	56%
Health plans (labor benefits)	36,611	56,105	53%
Health plans (consumer law)	293,449	427,267	46%
Mental health	3,001	4,612	54%
Hospital medical treatment or drug supply	151,856	214,947	42%
Hospital medical treatment	60,696	98,579	62%
Total	*792,851*	*1,183,812*	*49%*

Source: National Council of Justice (CNJ).
Available from: http://www.cnj.jus.br/pesquisas-judiciarias/justicaemnumeros/2016-10-21-13-13-04/pj-justica-em-numeros

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not, but the Executive Power has the competence to pay and realize this determination.

In concrete terms, however, the issue does not find an easy solution. What seems to be evident is that health resources are scarce and that the implementation of health services determined by the Judiciary removes resources destined to other collective policies, as a general rule, is not taken into account at the moment of delivering the court order.

In the words of Professors Stephen Holmes and Cass Sunstein[5]: *the rights of Americans are neither divine gifts nor fruits of nature; they are not self-enforcing and cannot exist without a government with financial resources* [...] *This is true not only for social security, health and food rights but also for private property rights, freedom of communication, protection against abuse of authority.*

The jurisprudential understanding of the Brazilian Supreme Court of Justice (STF), a leading position for the entire Judiciary, is presented by Professor Reynaldo Mapelli Junior[6], citing the work of Daniel W. L. Wang. In his analysis, the author points out that the STF has revealed instability in the parameters adopted to rule on the rights to health lawsuits.

The author purports three conflicting understandings: a) the first relates to some moral debt feeling, in which the decision maker understands that he must save the author's life regardless of the procedure's cost (*rule of rescue*); b) the second is based on the analysis of the request considering the financial limitations of the state and the reasonableness of the demand; c) the third adds to the second understanding considerations on the consonance of the request formulated in court with the health policies of the state and the existence of scientific evidence regarding the effectiveness of the treatment sought.

The STF recognized that the judicialization of the right to health is an issue with a general repercussion in the context of RE 566471, which is still pending judgment. However, in the votes already presented, some arguments favor a patient-centered analysis (*rule of rescue*), or an analysis centered on health policy established by the SUS.

The fact is that the reserve for contingencies exists and it is a constraint for the implementation of public health policies. In the words of Caliendo[7]: *the reserve for contingencies (Vorbehalt des Möglichen) is understood as a limit to the power of the state to effectively realize fundamental rights to benefits, stemming from the German constitutionalist doctrine of limiting a student's access to university education (numerus-clausus Entscheidung). In that case, the German Constitutional Court (Bundesverfassungsgericht) held that there were factual limitations to meet all demands for access to a right.*

Therefore, the debate about the judicialization of health must consider the factual limitations. The sharp conflict in these actions is not between the right to health and the duty of fiscal responsibility of the state, but between the right to health of patients against the right to health of other patients.

The withdrawal of public resources to meet judicial orders in conflict with established health policies privilege the plaintiff and penalize the community dependent on the public health network.

Analyzing the consequences of the Supreme Court's court orders, Daniel W. L. Wang[8] found that not all patients can be saved by a factual limitation; the state does not have the financial and physical resources to save all patients. Thus, court decisions often introduce injustice into the health care system, as the expense and effort to save the plaintiff can often impact the health of tens, hundreds, thousands of other anonymous patients.

Tomake things worse, as a general rule, one must consider that the pre-trial phase of judicial processes involving the right to health is weak. In the words of Professor Mappelli Júnior[6], the production of evidence in these actions is generally not even admitted, since rulings are frequently issued by injunctions. The professor also maintains that the magistrates usually distrust the medical report of the referees linked to the SUS, while accepting, without question, the reports issued by private doctors.

In the study *Judicialization of the Public Health Policy in Brazilian Municipalities: a national portrait*[9], researchers from Fiocruz Brasilia (Prodisa) analyzed more than 12 thousand lawsuits and found that the main argument of the lawsuits is related to the risk of death and patient's lack of resources. The authors found that the court order is granted automatically in more than 80% of the cases, and they rarely bring proof of the drug's use by the plaintiff or even the proof of delivering the medication.

That is, the Judiciary decides on the right to health lawsuits on judicial cognizance and without considering the opportunity costs related to its decision. Spencer and Siegelmann[10] teach us that the opportunity cost *is the alternative cost that refers to the cost of the opportunities waived,*

or in other words, a comparison between the policy that was chosen and the one that was relinquished.

Decisions rendered by magistrates, when determining the provision of a welfare activity by the state, must consider the opportunity cost inherent to that decision. The state does not produce resources unlimitedly; the increased planned expenditure with judicialization will cause the elimination of other expenses to build cash to comply with the court order. This suppression is the opportunity cost not considered by the Judiciary.

However, it is recognized that the economic aspect of health judicialization and the empirical knowledge of its consequences remain unknown both for the judiciary and for the executive power, even though the latter has at least a notion of these consequences.

To illustrate what has already been said, we show below the case of the judicialization of coagulation factors in the Federal District.

The case of judicialization promoted by hemophiliac patients in the Federal District

The DF, following the national trend, also recorded an exponential growth of lawsuits related to the right to health. In 2017 alone, the DF was targeted by 2,722 new lawsuits, as per the Table 2.

The data show that the Federal District was subjected to approximately 11 new lawsuits per working day in 2017.

While alarming, this figure is far from portraying the total volume of lawsuits faced by that federative unit. This is because, besides having thousands of lawsuits filed before 2017 that did not finalize their proceedings, we still have *res judicata* decisions that determined the supply of medicines and medical supplies on an ongoing basis throughout the patient's needs. The execution of these continuous supply rulings lasts for decades.

In 2017 alone, the cost of the judicialization to the Federal District arrived at a total of R$ 29,276,530.52 (twenty-nine million, two hundred and seventy-six thousand, five hundred and thirty reais and fifty-two cents), as per the report prepared by the Health Fund of the Federal District from the proceeds allocation documents issued by the unit, included in the DF Transparency Portal (Available from: http://www.transparencia.df.gov.br/#/despesas/consulta-dinamica).

A specific case that is utterly subsumed in this paper is that of lawsuits for the supply of coagulation factors for DF hemophiliac patients.

The 71 court rulings that mandate the Federal District to provide hemophiliac patients with coagulation factors are subdivided into two groups: a) 62 court orders determining the supply of the Coagulation Factor VIII in quantity higher than that provided for in the protocol of the Ministry of Health; and b) 9 decisions determining the supply of the Recombinant Coagulation Factor IX, a drug that is not part of the protocol of the Ministry of Health and, therefore, purchased by the DF.

In the context of case No. 5129/2016[11], The Federal District Court of Accounts (TCDF) showed the mismatch between the amount of the coagulation factor provided by the DF compared to the national average and the world average. The findings evidenced that the consumption of coagulation factor VIII and coagulation factor IX in the Federal District is almost five-fold the

Table 2. Judicial claims cataloged by SES-DF in the year 2017.

Subject	Number of new lawsuits received in 2017
Supply of Medicines	815
Tests	159
Surgeries	473
Supply of Medical and Hospital Supplies	187
Compulsory hospitalization	41
ICU bed request	496
Medical visit	212
Performing various treatments (radiotherapy, hemodialysis, home care and others)	339
Total	2,722

Source: Report of the Judicialization Center of the Legal-Legislative Advisory Service of the State Health Secretary of the Federal District. Available for consultation at the Secretariat of Health.

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world average.The Court also showed that such mismatch is the result of court orders made by the Federal District Court and Territories in favor of hemophiliac patients based on a single doctor's report.

What is observed is that despite affecting the overall budget of the Unified Health System with millions of reais, the purchase of coagulation factor VIII is carried out by the Ministry of Health, and the drug is only dispensed by the Federal District. For this reason, court decisions dealing with this drug do not directly impact the DF budget.

On the other hand, the court orders that determine the supply of the recombinant coagulation factor IX, instead of the coagulation factor IX blood product, the latter provided by the Ministry of Health, significantly affect the budget of the local body.

In 2017 alone, the cost of supplying recombinant factor IX to the Health Secretariat of the Federal District was approximately R$ 5,000,000.00, as outlined in the statement of expenditure (QDD) included in the DF Transparency Portal.

So a question arises: what was the opportunity cost resulting from these court orders? The opportunity cost, in this case, should be understood as the services that the Federal District could have provided to the local population instead of purchasing the recombinant coagulation factor IX.

To make the example concrete, the Federal District has a list of almost one hundred patients waiting for an ICU bed vacancy and an even greater list of patients awaiting a vacancy in the hemodialysis program.

The nearly five million reais employed in the purchase of DF coagulation factor could have been used to pay more than 25,000 hemodialysis sessions in DF accredited clinics or to pay more than 800 ICU daily stay costs, as per the prices set in the SUS Price List and the SES/DF Contract No. 53/2018, respectively.

That is, one could have applied funds, for example, to pay for the treatment of patients requiring critical care, on pain of losing their lives, but this option was ripped from the Executive Branch due to court decisions anchored in medical report contrary to the current SUS protocol and without conclusive scientific evidence on the effectiveness of the treatment.

This hidden figure of people who are no longer assisted by the judicialization of health is not known but is probably much higher than the number of patients benefited by the judicialization, considering that the lawsuits, as a general rule, protect individual interests and the public policies of collective interests. As would professor Mapelli[6] say:

[...] *The lack of public resources makes unnecessary (there is therapeutic equivalent in the SUS), expensive (the pharmaceutical industry imposes the price it wants, when there is a court order) and illegal (lack of registration and importation represent a lack of therapeutic security, experimental treatments without minimum state control, the violation of human rights) health care divert public money from other public policies built to meet health demands according to epidemiological criteria. Contrary to health equity, those who lose out are the poorest people. By so doing, the Judiciary is not making judicial control of public policies (Grinover, 2010) and distorts its noble jurisdictional function by applying the right to serve a private interest, to the detriment of collective and common problems* [...].

What the case shows is that before proceeding to a court orderwithin the right to health, prudence recommends checking the impact of plaintiff's request on the rest of patients dependent on the SUS, to maximize the application of the already scarce public funds deliberately.

Final considerations

While already in vogue for more than a decade, the discussion on the judicialization of health still lacks maturity. It is necessary to include in the debate the factual and financial issues, as well as the consequences that the judicial decisions produce in the services provided by the Unified Health System.The case of the Federal District presented in this paper is only one among thousands of cases that exist in the country,in which a possible inefficient allocation of resources occurs due to judicialization.It is necessary to advance in the debate reflecting on the consequences of judicialization, under pain of the Judiciary, in the good intention to save lives, committing an injustice with the population and claiming more lives than it is saving.

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Article submitted 29/11/2018
Approved 06/02/2019
Final version submitted 26/03/2019

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