UNIVERSITY OF MARILIA

LARA GUIMARAES PIACENTI

THE RIGHT TO HEALTH AND ALTERNATIVE DISPUTE RESOLUTION THROUGH THE BRITISH AND BRAZILIAN HEALTHCARE SYSTEMS

MARILIA, SAO PAULO
2023

UNIVERSITY OF MARILIA

LARA GUIMARAES PIACENTI

THE RIGHT TO HEALTH AND ALTERNATIVE DISPUTE RESOLUTION THROUGH THE BRITISH AND BRAZILIAN HEALTHCARE SYSTEMS

Dissertation presented to the Master's program in Law of the University of Marilia as a partial requirement for obtaining the Master's degree in Law, under the guidance of Prof. Emerson Ademir Borges de Oliveira, PhD.

MARILIA, SAO PAULO
2023

Piacenti, Lara Guimarães
P579r The right to health and alternative dispute resolution through the British and Brazilian healthcare systems / Lara Guimarães Piacenti. - Marilia: UNIMAR, 2023.
145f.

Dissertação (Mestrado em Direito – Empreendimentos Econômicos, Desenvolvimento e Mudança Social – Relações Empresariais, Desenvolvimento e Demandas Sociais) – Universidade de Marília, Marília, 2023.
Orientação: Prof. Dr. Emerson Ademir Borges de Oliveira

1. Alternative Dispute Resolution (ADR) 2. National Health Service (NHS) 3. Public Health 4. Sistema Único de Saúde (SUS) I. Piacenti, Lara Guimarães

CDD – 341.2

LARA GUIMARAES PIACENTI

THE RIGHT TO HEALTH AND ALTERNATIVE DISPUTE RESOLUTION THROUGH THE BRITISH AND BRAZILIAN HEALTHCARE SYSTEMS

Dissertation presented to the Postgraduate Program in Law of the University of Marilia, as a partial requirement to obtain the title of Master of Laws (LL.M.) for the area of concentration: Economic Enterprises, Development and Social Change, under the guidance of Prof. Emerson Ademir Borges de Oliveira, PhD.

Approved by the Examining Board on ________/________/________

____

Tutor: Prof. Emerson Ademir Borges de Oliveira, PhD

____

Guest 1: Prof. Johnathan Barros Vita, PhD

____

Guest 2: Prof. Melina Girardi Fachin, PhD

I dedicate this work to my admirable late grandmother, Carla Cecilia Ingegneri Piacenti, loving teacher, carer of the family, and favourite cook to all, with whom I share many likes, hobbies and traits. Even when I was living far away from her she would never fail to write me letters and send me gifts, a true sign that I was her favourite granddaughter. Unfortunately, she suddenly passed away in September of 2019 due to lung cancer at the age of 60. She will always be in my memory and in my heart.

I also dedicate this work to my boyfriend, Marcos Mesquita Serva Spressao, who has been there for me during the last three years, supporting me through my professional career and life in general. He has witnessed and been part of my struggles whilst finishing my Law degree, studying for the OAB examination, my whole Master’s degree, and finding a job – probably the most difficult, and, at the same time, rewarding time in my life. Needless to say, my love and gratitude towards him only grows.

I thank the University of Marilia for the academic knowledge I have obtained during my time there as an undergraduate and now as a postgraduate, especially the Law professors – Prof. Jonathan Barros Vita, PhD, Prof. Bruno Bastos de Oliveira, PhD, Prof. Marisa Rossignoli, PhD, Prof. Carlos Bittencourt Jorge, PhD, Prof. Walkiria Martinez H. Ferrer, PhD, Prof. Jefferson Aparecido Dias, PhD, Prof. Mariana Ribeiro Santiago, PhD, Prof. Maria de Fatima Ribeiro, PhD, Prof. Ricardo Pinha Alonso, PhD, Prof. Rafael de Lazari, PhD, and, finally, my tutor Prof. Emerson Ademir Borges de Oliveira, PhD, for the guidance and advice given during the last two years.

I would also like to thank my peers, especially Lucas Marinho and Leticia Lopes for the friendship that has blossomed from our course and will surely be for life.

Finally, I must thank the *Coordenação de Aperfeiçoamento de Pessoal de Nível Superior – CAPES*, for the opportunity and the grant I have received during my postgraduate course, which made it possible for me to complete my master’s degree and become a better professional and grow as a person.

ABSTRACT: This research aims to address the right to health through the universal Public Health systems, in particular the National Health Service (NHS), from the United Kingdom (UK), created in 1948 post-World War II, and the *Sistema Único de Saúde (SUS)*, or Unified Health System, from Brazil, created in 1988 along with the enactment of the present Brazilian Constitution. As both Public Health systems are mostly publicly funded and rely on the private health sector to provide complementary health services, and the SUS was created and inspired by the founding principles of the NHS, it is worth comparing them in order to discover if they are respecting the universal nature of their healthcare systems as a means of providing efficient access to healthcare services. A brief history of the evolution of the right to health in a global context and the evolution of the welfare state through the Poor Law in the UK, as well as the right to health through the Brazilian Constitutions is explored as a form of completely understanding the origin of the fundamental and social right to health. The study also outlines the Public Health policies and legislation which led to the creation and reforms of both systems, in addition to their funding and use of private healthcare, with the intention of understanding both systems as a whole. Lastly, the study explores the role of the Judiciary in guaranteeing the right to health as the Power that gives the last word when the Executive and Legislative Powers are inert and inefficient when creating and providing Public Health policies and access to healthcare services and medication through the SUS and the NHS. The NHS Resolution is used as a possible solution to the issues of judicial activism and judicialization of health which occurs in Brazil and is almost non-existent in the UK. The deductive methodology was used in this work with the aid of documental and scientific bibliographical research, as well as consultations of national and foreign legislation, with the purpose of producing a study in the scope of Comparative Law. It was concluded that the SUS has been drifting from the universal model inspired by the NHS, strongly depending on supplementary health, which is a market of privately funded health insurance and out-of-pocket family spending which is not approved by the World Health Organization (WHO) and decreases chances of achieving Universal Health Coverage (UHC). In addition, it was concluded that no comprehensive healthcare system is able to guarantee universal service and equitable access at all times, as unexpected sanitary complications can occur, such as the Covid-19 pandemic, which is responsible for the present crisis of the NHS. Furthermore, Alternative Dispute Resolution (ADR) through an independent administrative body is a more efficient form of resolving conflicts and claims within the Public Health system rather than litigating in the courts, providing benefits for both parties, as mediation is a faster way of guaranteeing the right to health for the claimant, and potentially reduces chances of the Government paying compensation, respecting the possible reserve theory.

KEYWORDS: Public Health; National Health Service (NHS); Unified Health System (SUS); Alternative Dispute Resolution (ADR); Comparative Law.

RESUMO: Esta pesquisa tem como objetivo abordar o direito à saúde por meio dos sistemas universais de Saúde Pública, em particular o *National Health Service (NHS)*, do Reino Unido, criado em 1948 pós-Segunda Guerra Mundial, e o Sistema Único de Saúde (SUS), do Brasil, criado em 1988 com a promulgação da atual Constituição Brasileira. Como ambos os sistemas de Saúde Pública são financiados com fundos públicos e dependem do setor privado de saúde para fornecer serviços complementares de saúde, e o SUS foi criado e inspirado nos princípios fundadores do NHS, vale a pena compará-los para saber se estão a respeitar a universalidade de seus sistemas de saúde como forma de acesso eficiente aos serviços de saúde. Explora-se um breve histórico da evolução do direito à saúde em um contexto global e da evolução do estado de bem-estar social através da Lei dos Pobres no Reino Unido, bem como do direito à saúde através das Constituições brasileiras como forma de entender a origem do direito fundamental e social à saúde. O estudo também traça as políticas e legislações de Saúde Pública que levaram à criação e reformas de ambos os sistemas, além de seu financiamento e uso da saúde privada, com a intenção de compreender os dois sistemas como um todo. Por fim, o estudo explora o papel do Judiciário na garantia do direito à saúde como o Poder que dá a última palavra quando o Executivo e Legislativo são inertes e ineficientes na formulação e execução de políticas públicas de saúde e em garantir o acesso a serviços de saúde e medicamentos por meio do SUS e do NHS. A Resolução do NHS é utilizada como uma possível solução para os problemas do ativismo judicial e da judicialização da saúde que ocorre no Brasil e que é quase inexistente no Reino Unido. A metodologia dedutiva foi utilizada neste trabalho com auxílio de pesquisa documental e bibliográfica científica, bem como consultas a legislações nacionais e estrangeiras, com a finalidade de produzir um estudo no âmbito do Direito Comparado. Concluiu-se que o SUS vem se distanciando do modelo universal inspirado no SUS, dependendo fortemente da saúde suplementar, que é um mercado de planos privados de saúde e de pagamentos diretos em serviços privados de saúde que não é aprovado pela Organização Mundial de Saúde (OMS) e diminui as chances de alcançar a Cobertura Universal de Saúde. Além disso, concluiu-se que nenhum sistema de saúde integral é capaz de garantir um atendimento universal e o acesso equitativo em todos os momentos, pois podem ocorrer complicações sanitárias inesperadas, como a pandemia de Covid-19, responsável pela atual crise do NHS. Além disso, a Resolução Alternativa de Litígios (ADR) através de um órgão administrativo independente é uma forma mais eficiente de resolver conflitos e demandas dentro do sistema de Saúde Pública ao invés de judicializar demandas, trazendo benefícios para ambas as partes, uma vez que a mediação é uma forma mais rápida de garantir o direito à saúde do autor, e potencialmente reduz as chances de indenização pelo Estado, respeitando a teoria da reserva do possível.

PALAVRAS-CHAVE: Saúde Pública; Serviço Nacional de Saúde (NHS); Sistema Único de Saúde (SUS); Resolução Alternativa de Litígios (ADR); Direito Comparado.

SUMMARY

INTRODUCTION

With the transition of the Liberal State to the Social State, several public policies aimed at healthcare were adopted by Western countries, especially after the Industrial Revolution, as a result of the concentration of workers in large urban cities that began to have medical care and more sanitary work conditions, as well as during and after World War II, due to the spirit of solidarity in the countries involved in the war and a need to care for wounded citizens and soldiers.

Soon after, the right to health appears as one of the Human Rights related to the principle of human dignity and the right to life. With the Universal Declaration of Human Rights (UDHR) in 1948, the right to health gains worldwide attention through its Article 25, as a means to guarantee the right to basic conditions of life and the so-called ‘existential minimum’. As a consequence of this Declaration, the National Health Service (NHS) was created in the United Kingdom, with the purpose of offering universal healthcare.

As history teaches, the right to health arises from the need to have healthy workers to operate factories and, in turn, improve the economy and society. However, without healthy workers, there is no work being done and, therefore, no profit. This similarity also appears in the evolution of the right to health in the Brazilian Constitutions, as we will see in the first chapter of this study, where the first mentions of health were introduced gradually in former Brazilian constitutions as a way of protecting workers’ health.

The same idea above applies for research and education, whereby Government intervention is needed, as if a researcher or a student is ill, it will not be possible to study or produce scientific research. Therefore, if an individual does not have the right to health guaranteed by the State, they are more likely to become ill and not be able to work or study, and, in turn, produce capital. That is, the economy and society as a whole will suffer, and, for this reason, it is the right to health, linked to life and dignity, the most important right of the second dimension.

The fundamental right to health is set out in Article 196 of the Brazilian Constitution and emphasizes that the State must ensure universal access to health for its citizens. Despite being declared a universal right, the Brazilian population faces several challenges in order to have the right to health guaranteed by the State, which is explored throughout this study.

Currently, a large part of the Brazilian population has had no alternative but to resort to privately funded health insurance due to the lack of efficient health service provided by the

Sistema Único de Saúde (SUS), or Unified Health System. The delay and inefficiency in the provision of health care violates the Brazilian Constitution, as it is the State's duty to guarantee this right.

Recently, the NHS has been facing similar issues regarding delay and inefficiency, suffering a sanitary crisis since the pandemic caused by Covid-19, meaning that the population also does not have proper access to health and has to contract private health insurance. Therefore, both publicly funded health systems have been challenged in guaranteeing universal healthcare and equitable access to health. Thus, the importance of this study is to understand the issues arising around the difficulties in insuring universal and equitable access to health.

It is important to say that most NHS funding comes from the public sector, mainly from general taxes (income tax and VAT) with the contribution from National Insurance (NI), which is roughly the same case of the SUS's funding. As both Public Health systems have the same type of funding, is the SUS not capable of meeting its demand and offering quality services across the country due to poor management of financial resources?

Through the history of Public Health policies in both countries, it is possible to understand that the NHS underwent reforms to adjust to constant demands in order to meet epidemiological and political needs, and its formation process was difficult and long. Furthermore, it will be possible to observe the evolution of these public policies according to the economic and political situation at the time, well before the creation of the NHS, with the formation of the welfare state and the Poor Law.

Moreover, Article 199 of the Brazilian Constitution states that it is constitutional for the private sector to explore the health insurance market and that private sector can complement the services provided by the SUS, through complementary and supplementary health.

Thus, the contribution of the private sector applies where the public sector is insufficient, which is a characteristic of a developing country. Furthermore, private participation contributes to increasing the capacity of the SUS to provide services without this implying an increase in public expenditure on health.

Supplementary health, on the other hand, has the role of relieving the SUS, because even with complementary health, that is, help with providing health services by the private sector, the system should be able to cover everyone. However, this is not the case, as the market for health insurance and out-of-pocket spending paid directly to self-employed health professionals is still necessary as an external form of health coverage. Therefore, does the NHS also make use of complementary and supplementary health? This question will be answered in chapter 2.

Governments intervene greatly in the market for healthcare. Not just in the UK and in Brazil, but globally, governments are involved in the financing and also in the provision of healthcare to their citizens. Although historically these systems have emerged through a variety of circumstances, there are a number of common problems that arise in the market for healthcare to which these government interventions provide a response.

In order to understand the role that the public and private sectors play in the UK and in Brazil and how other countries' systems compare, it is important to consider the role economics plays in this field, as it can relate to equity and market failures in the private healthcare market and, thus, calls for State intervention.

In order to seek answers for the economic and administrative challenges faced by the Brazilian healthcare system, it can be compared to the NHS, due to the public and universal character of both, in order to identify experiences and lessons from the NHS's history and health reforms, which may be useful to the process of improving the SUS.

At the same time, the NHS strategies should provide adequacy and viability of specific SUS strategies, seeking to guarantee the founding principles of the health systems. The study specifically does this in chapter 3 where the role of the Judiciary in guaranteeing the right to health and the increasing judicialization is explored, as well as the possible solutions that could be applied, based on the NHS Resolution.

The NHS Resolution is an administrative body within the Health and Social Care Department, which mediates conflicts related to healthcare services within the NHS, through Alternative Dispute Resolution (ADR), in order to reduce Government expenditure on unexpected compensation due to litigation. In other words, the NHS Resolution avoids litigation and provides a quick and efficient service.

The Judiciary in Brazil acts as a Power that guarantees the right to health when the Executive and Legislative Powers are inefficient. The inefficiency of these political Powers is one of the reasons for the increase of judicialization of health, as the Judiciary is called upon to intervene. The phenomenon of judicial activism is another consequence of this which will be outlined in chapter 3.

Finally, with regards to the methodology, the deductive method was used, through a general analysis of the Public Health systems, as well as the challenges faced by them, with the expectation to reach a conclusion. In addition, qualitative research was used as there is data that was analysed, as well as a bibliographical and documental review of works and scientific articles, as well as reports, bringing possible solutions to the problems found throughout the study based on Comparative Law.

It was found that through the comparison of Public Health systems and Comparative Law, it is possible to find ideas and solutions to issues regarding healthcare, especially in regard to litigation of healthcare, as the United Kingdom based its study and research on different healthcare systems globally in order to find solutions for the NHS Litigation Reform of 2022, which aims to reduce costs and litigation even further within the NHS.

1. THE RIGHT TO HEALTH IN A GLOBAL CONTEXT AND THE BRITISH HEALTHCARE SYSTEM

The first chapter of this study explores the right to health as an international right and how it emerged in history, with the passage of the Liberal State to the Welfare State, as well as the influences of the Industrial Revolution and World War II. All these historical events, as will be explored in the first part of this chapter, played an important role in the evolution of the right to health and the welfare state as we know it today.

It was not one specific historical event or piece of legislation that defined the crucial moment of the creation of the right to health or the welfare state, but rather many historical events and a diverse amount of public policies, sanitary reforms and legislation that managed to unite nations and guarantee the right to health in the Universal Declaration of Human Rights post World War II in 1948, and as a right for all and duty of the state in the Brazilian Constitution many years later with the enactment of the 1988 present Brazilian Constitution.

Before democracy, historically, people relied on the Gods, religion and the community for relief and health assistance, which was mostly voluntary. As we now know, the private sector and voluntary aid has never been enough to guarantee health coverage, and eventually the State had to intervene and provide Public Health, through Public Health systems, like the NHS and the SUS.

The first part of this chapter will briefly outline the evolution of the right to health internationally to give an overview of how Human Rights played a role in influencing Western countries to eventually create Public Health systems, followed by a more specific evolution of the right to health in the United Kingdom and the welfare state, through a timeline of the formation of the welfare state in the United Kingdom with the changes and reforms of the Poor Law.

Before starting this chapter, it is important to know that the NHS is mainly funded from taxation and National Insurance (NI) and is largely free at the point of delivery, meaning nationals in the UK are entitled to use the service, and contribution to funding is not directly linked to use of services for any individual.

At a national level, the Department of Health and Social Care work with NHS England, NHS Improvement and Clinical Commissioning Groups (CCGs). The Department is responsible for allocating funds towards the two NHS bodies mentioned, whilst NHS England is responsible for allocating funds to the CCGs and other British nations, such as Wales, Scotland, and Northern Ireland.

At a regional level, NHS England works with Care Quality Commissions (CQCs), whilst at a local level, many bodies work together to deliver healthcare according to the local community's needs, such as Sustainability and Transformation Partnerships (STPs), Integrated Care Partnerships (ICPs) or Integrated Care Systems (ICSs), as well as Primary Care Networks (PCNs) - all the functions of these bodies will be explored in this chapter.

This chapter will focus on the formative process of the National Health Service (NHS), which is related to the history of the formation of the welfare state, especially the financing aspect of this Public Health system and its Social Security.

Before going into detail about the NHS's financing and spending, the present work will go through the formative process of the NHS, as well as its founding principles. Lastly, this chapter will explore the private healthcare in the United Kingdom.

1.1. The birth of the right to health in a global context and the welfare state

It is necessary to consider that the importance given to health has grown over time in line with social needs and advances in medicine, science, and technology. According to Silva (2016, p. 06), "the concept of health reflects the social, economic, political, and cultural situation. That is: health does not represent the same thing for all people. It will depend on the time, place, social class. It will depend on individual values, scientific, religious, philosophical conceptions".

With this, it must be considered that there was a time when health was defined by the gods, and the mission of the first philosophers was to find non-supernatural explanations for health and illness. Therefore, "Hippocrates (6th century B.C.) established the man/environment relationship with the development of his Theory of Humours, according to which the elements water, earth, fire and air would affect the state of health and disease of human beings" (SILVA, 2016, p. 06).

Since the ancient Greeks, philosophers were already searching for a welfare state. According to the theory of Alcmaeon of Crotona on the state of health as the balance of powers: "Both the nature of the body and human action for the organization of the *polis*, according to Alcmaeon of Crotona, must be in balance, whether for the well-being of the body or for the city (*polis*)" (MORALES; VASCONCELLOS; MOTA, 2015, p. 98).

Nevertheless, it is necessary to mention the right to health during the Liberal State, because during this period, "the right to health was not part of the list of constitutional prescriptions, classifying itself as a private activity" (SCHIER; BEREJUK, 2016, p. 254). However, there were already advances in health in the West, mainly of a religious nature.

With the advances of industrialisation and the exploitation of workers, social and economic problems began to emerge, as a consequence of a concentration of the population in urban areas in search of work and housing. Therefore, "it was found that merely formal freedom and equality were not enough for citizens to live with dignity" (SCHIER; BEREJUK, 2016, p. 255).

With this scenario came the need to offer protection to workers and their families, mainly through health and hygiene, as a healthy worker working in adequate hygienic conditions could offer more labour to the industry and allow production to continue in factories, avoiding the transmission of diseases in that work environment (SCHIER; BEREJUK, 2016, p. 255).

Moreover, the State was pressured to take over the activities of restructuring the health infrastructure, especially in the period after the Second World War, there was a need to ensure rights to healthcare, education, and work, which resulted in social rights and began to be incorporated, in a meaningful way, into the Constitutions. It is emphasized that, "from the legal-constitutional point of view, what distinguishes liberal and social rights and marks the emergence of social rights, is not the date of their birth, but the differences in the nature of the law they promote" (SCHIER; BEREJUK, 2016, p. 256).

Furthermore, public administration has a crucial role in guaranteeing fundamental and social rights, which also marked the Welfare State, since "in the Liberal State, public services basically focused on the implementation of infrastructures - linking them to private interest in economic development" (SCHIER; BEREJUK, 2016, p. 265).

On this note:

> From the perspective of development, with regard to the implementation of public services in the democratization of the Brazilian State, public services began to be perceived as a set of basic and indispensable positive offers to society for a dignified life, taken over by the Public Power, linked the implementation of fundamental social rights, enshrined in the Constitution. *[translated by the author]* (SCHIER; BEREJUK, 2016, p. 266).

According to Silva, Bezerra and Tanaka (2012, p. 250), "the Rule of Law moves from the traditional model of the Liberal State of Law to the Democratic State of Law, resulting in a deepening of human and fundamental rights, which gain new values, and the performance of the State is claimed". According to the researchers mentioned above, "health as a right includes both individual aspects, prioritizing freedom, and social aspects, privileging the community". From this moment on, it is possible to speak of the welfare state in Common Law countries.

In this sense, with the end of World War II and with the transition of the Liberal State to the Social State, health began to be discussed in the perspective of a fundamental right, this historical fact being of crucial importance to understand the evolution of the right to health – a social right that became effective with the recognition of Human Rights regarding the principle of human dignity and the right to life (YAMADA, 2018, p. 02).

The Universal Declaration of Human Rights (UDHR) of 1948 mentions the right to health in its Article 25, as a means to guarantee the 'existential minimum' duly related to other rights:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, in particular food, clothing, housing, medical care and necessary social services, and has the right to security in the event of unemployment, sickness, disability, widowhood, old age or other cases of loss of livelihood due to circumstances beyond his control. (ONU, 1948, p. 06).

After the UDHR, countries began to give more importance towards the access to health and developed public policies for the provision of health services. For example, the United Kingdom created the National Health Service (NHS) which was founded in the same year as the Declaration in 1948.

Before the UDHR, as regards to social security, the International Labour Conference (ILC) of 1944 in Philadelphia created a report in 1950 stating that:

> The transformation of social insurance is accompanied by the absorption or coordination of social assistance, and there begins to emerge a new organization for social security, which we can describe only as a public service for the citizenry at large. This new organization now concerns society as a whole, though it is primarily directed to the welfare of the workers and their families. It tends, therefore, to become part of national government, and social security policy accordingly becomes coordinated closely with national policy for raising the standard of welfare and, in particular, for promoting the vitality of the population (BRIGGS, 2004, p. 18).

This played a role in what was known at the time as Labour Britain in 1945, with the term 'welfare state' beginning to be used not only in the United Kingdom, but in many other Western countries. Thus, even before the UDHR, the UK was already articulating and dreaming of a publicly funded healthcare system during World War II. This will be discussed further in the next part of the study.

Another international milestone was the first international conference on health promotion, held in Ottawa, Canada, in 1986, the Ottawa Charter was presented, as a document with intentions for health from the year 2000 onwards. This charter emerges as a need for a new Public Health, with intentions to seek the welfare state at a global level (MORALES; VASCONCELLOS; MOTA, 2015, p. 95).

In summary, on the evolution of Human Rights with regard to health from the 1960s onwards:

> The Lalonde Report (The new perspective for the Health of Canadians), of 1974 and the report of the missions sent to China between 1973-1974 referring to the activities for the improvement of the health since 1965 were two important bases for the formation of a new phenomenon, formalized at the Alma-Ata conference (1978), with the proposal of health for all in the year 2000 and the First International Conference on Health Promotion (1986) enacted in the Ottawa Charter *[translated by the author]* (MORALES; VASCONCELLOS; MOTA, 2015, p . 95).

In the same year, only after the 8th National Health Conference of 1986 that the right to health was properly discussed and implemented in the current Brazilian Federal Constitution of 1988, creating at the same time the SUS, inspired by the British NHS – indeed, a period of positive historical change for Brazil.

Thus, as fundamental rights were asserted, the Brazilian State, as a Democratic State of Law, seeks to guarantee these rights through the guarantee of the principle of human dignity. In other words, “the understanding is established that the State does not have fundamental rights, but rather, it is up to it to respect, guarantee, protect and promote development as a way of realizing the idea of a Republic based on human dignity” (SCHIER; BEREJUK, 2016, p. 257).

Since the principle of human dignity is the guiding principle of the Brazilian Federal Constitution of 1988, the right to health as a duty of the State starts to reflect on the public administration, through its health and social care policies, and, mainly, on the SUS itself. For this reason, it is worth exploring the evolution of the right to health in the Brazilian Constitutions and, subsequently, health as the right of all and duty of the State.

Before, though, and much earlier in history, the United Kingdom made its own influence on the world by starting a welfare state, which has ever since inspired many countries, including Brazil, to achieve this state. It was not easy, obviously, as no achievement or guarantee of a Human Right even has been, and the British have a long history in the field of Public Health policies.

It is appropriate to begin with a quote said by Aneurin Bevan in 1948 when the NHS was created, “we ought to take a pride in the fact that, despite our financial and economic anxieties, we are still able to do the most civilised thing in the world – put the welfare of the sick in front of every other consideration” (WEBSTER, 2002, p. 01).

In other words, “societies fail whenever someone who succumbs to a treatable illness causing pain, suffering, or premature death is unable to avail themselves of effective treatment because of the lack of money to pay for it” (HEATH, 2007). In the context of social solidarity after World War II, the UK created the NHS.

The NHS was recognized internationally as a form of ‘socialised medicine’ in the western world, especially by the Americans. However, according to the creator of the new service, Aneurin Bevan, the NHS was ‘the most civilised achievement of modern Government’ (WEBSTER, 2002, p. 01).

According to Maxwell (1992, p. 200), “Bevan's commitment to the values of the NHS was deep, personal, and romantic”. The wartime coalition Cabinet had publicly requested funded health services with universal access, however, the two Prime Ministers before Bevan failed to deliver this mission.

In Bevan's words:

> No society can legitimately call itself civilised if a sick person is denied aid because of lack of means. [...] Society becomes more wholesome, more serene, and spiritually healthier, if it knows that its citizens have at the back of their consciousness the knowledge that not only themselves, but all their fellows, have access, when ill, to the best that medical care can provide. (MAXWELL, 1992, p. 200).

Maxwell (1992, p. 200) believes that Bevan failed to recognise the public expenditure problems that were and have always been posed by the NHS. However, Bevan did insist that appointments throughout the NHS should be non-political and that generic drug equivalents be used, taking a more collective approach to healthcare.

Flinn (1976, p. 45) shares that, “sickness has always been a prime cause of poverty” Thus, ill health prevents workers from earning money and providing for their families, and as a consequence, calls for expenditure on medical services and medication. As he explains, “the more advanced the forms of social and economic organisation, the more acute the problems it raises”.

According to Flinn (1976, p. 45), the Industrial Revolution increased the population of the urban cities as demands for labour were higher, in turn having to make social and economic adjustments to accommodate so many newcomers. On the other hand, in rural areas, the population decreased and was left with no medical attention, as doctors moved to urban areas and the demand for medical attention was higher.

Flinn (1976, p. 45) explains that there were severe social inequalities when it came to health care during the Industrial Revolution:

> From the strictly economic point of view, sickness was never a problem for the wealthy. Doctors commonly adjusted their fees shrewdly to patients' incomes, and the middle and upper classes were usually comfortably placed to cope with the temporary cessation of earnings, if, indeed, sickness actually did lead to this. For the lower-income groups in society, however, sickness immediately created economic problems of immense, and often insuperable magnitude. Wages were so low that savings were out of the question, even to the extent of the few pence of weekly subscriptions to a 'club', the mutual health-insurance organization of the day: there was, therefore, an immediate problem of income, if the wage-earner's family was not to starve. The fees of doctors and nurses and the cost of drugs were beyond the pockets of all classes below the better-paid skilled workers, while the most effective cure was often the prescription of high-quality foods and stimulants whose price placed them even further from the workers' reach in times of sickness. Thus, if the sick poor were not to be deprived of even the little that the limited medical skill of the day could do for them, and their families were not to be allowed to starve, society must intervene and offer help.

From the 16th century this State intervention that was so necessary was officialised through the Poor Law, which was able to provide financial assistance and medical care to at least half of the population after it was enacted (FLINN, 1976, p. 46).

'The poor' according to this Law, "were those whose sources of livelihood were either so slender or so insecure as to oblige them, in situations of need, to turn to 'the parish' for assistance" (FLINN, 1976, p. 46). When 'the poor' who were not considered sick, old, or unemployed became independent from the parish, they became known as 'paupers', who were those given parochial relief and were also shamed for their economic situation.

The 'Old Poor Law' in question was a series of individual acts between 1572 and 1600, and formally codified in 1601 on what was expected to be temporary legislation and was extended to every part of the United Kingdom. This Law aimed at maintaining the parishes and giving them the duty to provide relief for the 'deserving poor', who were the sick, the old, and the unemployed who were willing to work, whilst those who were able to work but were unwilling, were considered the 'undeserving poor', and could be punished by the parish by Law (KING, 2000, p. 19-20).

This Law also intended to provide relief locally through local tax called the ‘poor rate’, based on property, as the communal or voluntary relief was to be the last resort, only to be called for when private help was not an option. According to King (2000, p. 20), “the necessity for kin to offer help to poor relatives was given legal force, allowing magistrates to compel relatives such as parents, children, grandchildren and grandparents (though not brothers and sisters) to offer monetary help to destitute kin when able to do so”. Thus, the family of the poor and the sick were obliged to help members in need, in order to relieve the State, and the Law was able to offer minimum levels of welfare to those in need.

With the Workhouse Act of 1723, relief was only given within a workhouse and only in return for labour. A parish could build a workhouse under act of parliament or share facilities with other workhouses. This Act maintained the locally provided aid for the poor, those with disabilities or too young to work, however, parishes would send those who were not ill or able to work to workhouses in order to reduce costs. Soon, a provision in the act made it possible for parishes and workhouses to contract care for the poor with farmers to provide food, and others to provide clothing, health services and accommodation in exchange for work (KING, 2000, p. 24).

The dynamic of workhouses in the 19th century can be understood by Charles’s Dickens classic novel, Oliver Twist, which was based on a fictional character called Oliver who was made orphan by the death of his mother at birth in a parish. Still as a young child, Oliver was sent to a workhouse and bought by different tradesmen to work in exchange for accommodation and food. The parishes and workhouses were generally overwhelmed with so many people needing relief and often sold children. These children overlooked by the parishes often suffered starvation and high mortality rates.

Another important piece of legislation is the Gilbert's Act of 1782, which made it possible for parishes and workhouses to come together as a union. According to King (2000, p. 25), “such measures encompassed considerable potential for humane treatment of the poor and by 1834 there were sixty-seven ‘Gilbert’ unions incorporating 924 parishes”.

In the late 1790s, relief expenditure was an issue during the Napoleonic Wars. In response to this crisis, the Sturges Bourne Act of 1818 attempted to correct the situation by modifying the voting system by which ratepayers determined local policy in an open meeting, as those who paid the rates were to have no votes. Thus, “individuals with property worth £50 were afforded one vote, while those with property worth £150 or more were afforded the maximum six votes” (KING, 2000, p. 26).

There were many initiatives asking for reform of the ‘Old Poor Law’ from 1810 to 1832, when, finally, parliament took the reform forward, via a commission of inquiry that was established to collect information on the state of the Poor Law, through questionnaires in parishes and witnesses’ help. This resulted in the formation of the ‘New Poor Law’ in 1834, with a few changes (KING, 2000, p. 27).

A few of the changes were as follows: the new legislation wanted to undo the link between local poverty and local administration through unionisation (which they managed to do successfully) and leave policy making to the central body of the Poor Law Commissioners until 1947. Therefore, “right from its inception the new poor law was a compromise between those who wanted no reform at all and those who wanted a national system of relief financed by a single tax” (KING, 2000, p. 33).

The advances that were in the provisions of the New Poor Law were already being put into action before it was sanctioned:

> Before 1834 there was no explicit legal justification for the overseers to provide medical relief, and yet large provincial towns had appointed dedicated poor law surgeons by the 1790s and most other parishes has at least an informal contract with a medical practitioner of some sort by the 1820s (KING, 2000, p. 33).

This shows that those who received local relief through parishes or workhouses began to receive medical treatments by the 1820s. Furthermore, the welfare state was far from becoming a reality, seeing as the New Poor Law was not much more successful than the Old Poor Law, as parishes and workhouses were under-resourced and could not attend to basic needs like enough food and sanitary accommodation, even though access to these relief facilities was rather high, despite them being small.

In King's conclusions regarding the growth and capacity of workhouses (2000, p. 39):

> By 1776 there were more than 1,900 workhouses in England, rising to almost 2,100 where we also include institutions established under individual acts of parliament. [...] by 1782 one-third of the 13,000 English poor law administration units would have had access to a workhouse [...] Moreover, it is important to be aware that most of these institutions were small and under-resourced. In 1776, less than 200 had a capacity of over 100 people [...].

In addition, King (2000, p. 40) concluded that during this period, too many complex and bureaucratic pieces of legislation that were related to the welfare of the poor were created, which made it difficult for local administration to understand and put into practice:

> [...] the sheer volume of the law (widely conceived to take account of statutes, case law and bylaws) in areas that were regulated created a considerable 'welfare baggage' which in turn gave local welfare practices a strong sense of inertia. It is perhaps for this reason that English poor law administrators consistently failed to address the causes rather than consequences of poverty, and in dealing with the latter came back over and over again to a limited field of remedies, some of which had no legal sanction at all.

It can be concluded here that quality is really better than quantity, in most things and apparently when it comes to legislation. In other words, more pieces of legislation do not necessarily mean better or more public policies related to the welfare of society, nor does it mean that there is more chance of these policies being successfully put into practice at a faster pace. Thus, it only means that parliament was not organised enough to create one efficient piece of legislation that was fit for local administration to work with and succeed in offering the best possible relief for the poor, in terms of health and other basic human needs, only delaying the process of reaching the welfare state.

Despite advances in England, the New Poor Law of 1834 did not apply to Scotland and only after a decade did the poor relief policies finally became recognised in the northern part of the United Kingdom. Only in 1845 an act for the amendment and better administration of the laws relating to the relief of the poor in Scotland came into force, and the new system introduced a Board of Supervision for local parishes until 1894 (PATERSON, 1976, p. 171).

The administration of the ‘poor fund’ in Scotland collected money at church services as well as taxes of compulsory poor rates charged to heritors within parishes. According to Paterson (1976, p. 172), this type of collection was done with suspicion, as “levying a poor rate meant taxing heritors who helped administer the poor fund, implying parsimony on the part of those who could afford and should have been willing to make adequate voluntary contributions towards the poor”. This theory is somewhat gullible, as it assumes that all those with funds are willing to help the poor. In other words, they are willing to wear the ‘badge of citizenship’. Furthermore, it assumes that the heritors who had access to ‘poor funds’ would not act corruptly and swipe money from the funds of the poor in order to pay their taxes or even other personal things.

Paterson (1976, p. 172) teaches that Dr Thomas Chalmers, a famous Presbyterian cleric of the 19th century, believed that “any form of regular income encouraged the poor to dependency by reducing their motivation towards self-help and that discrimination in the distribution of a small voluntary poor fund had a beneficial effect upon both donor and recipient". In other words, Dr Chalmers believed that public regular 'benefits' for the poor made them lazy and discouraged motivation to look for employment, whilst voluntary help had a beneficial effect for temporary relief.

As shown in King's findings above, solely voluntary help and communal relief was not enough to overcome the harsh conditions in which the poor who sought relief found themselves, as children were made orphan and left to starve, and workhouses were under-resourced. Therefore, private philanthropy was not greater than public welfare for the poor.

Furthermore, when the subject is welfare, or welfare state, people usually assume that the state is the protagonist provider and insurer of the wellness of its citizens, but history has shown that the state is not the only provider, as "the interplay between the state itself, the market, religious bodies in a variety of forms and what it has latterly been fashionable to call 'civil society' – have taken different shapes at different times and given rise to a wide variety of outcomes" (BRIGGS, 2004, p. 01). What needs to be questioned is how can the players provide welfare effectively? It is not a question of deciding which player is the most effective in providing welfare, as each player has their own values and political deficiencies in each society.

According to Briggs (2004, p. 04), "citizenship can be seen as merely a device for providing an entitlement to minimal support for those unfortunate (and deserving) enough to have earned the state's assistance". Therefore, as a citizen one is entitled to support from the state. Whereas, welfare can be seen as, "a public symbol of common membership in society". However, do those who do not fall into the category of a national citizen deserve support from the state? In other words, are convicted criminals and immigrants entitled to welfare?

Briggs (2004, p. 04) believes that the inclusion of these outsiders should respect the fine line between achieving the sense of belonging through having their needs met by the state and the feeling of shame due to dependency. However, it is difficult to control this situation, as the will to become independent should come from each individual and it depends on how much this matters to them.

Moreover, those who were able to work were not always able to find themselves a job when trading conditions were poor. According to Briggs (2004, p. 10) these willing workers were known as the 'respectable unemployed' during the 1860s famine in Manchester. In contrast, "most of the poor turned out not to be able-bodied at all; being mostly too old or too young or else too sick or disabled (not least as a result of primitive industrial working conditions) to hold down a job even if it were available" (BRIGGS, 2004, p. 10).

Later, education, health and welfare services were being provided to natives in the colonies. Britain progressively extended the scope of unemployment insurance from 1921, after the National Health Insurance (NHI) created in 1911. However, it was really only after World War II that all social policy was uplifted and put into action, and the term ‘welfare state’ was first used to describe Labour Britain after 1945 (BRIGGS, 2004, p. 15).

According to Briggs (2004, p. 15), “from Britain the phrase made its way round the world. It was freely employed, usually but not exclusively by politicians and journalists, in relation to diverse societies at diverse stages of development”. Moreover, the term has been used to cover social and economic changes, more specifically, regarding the abolition of poverty and unemployment, overall, leaving the idea of *laissez-faire*.

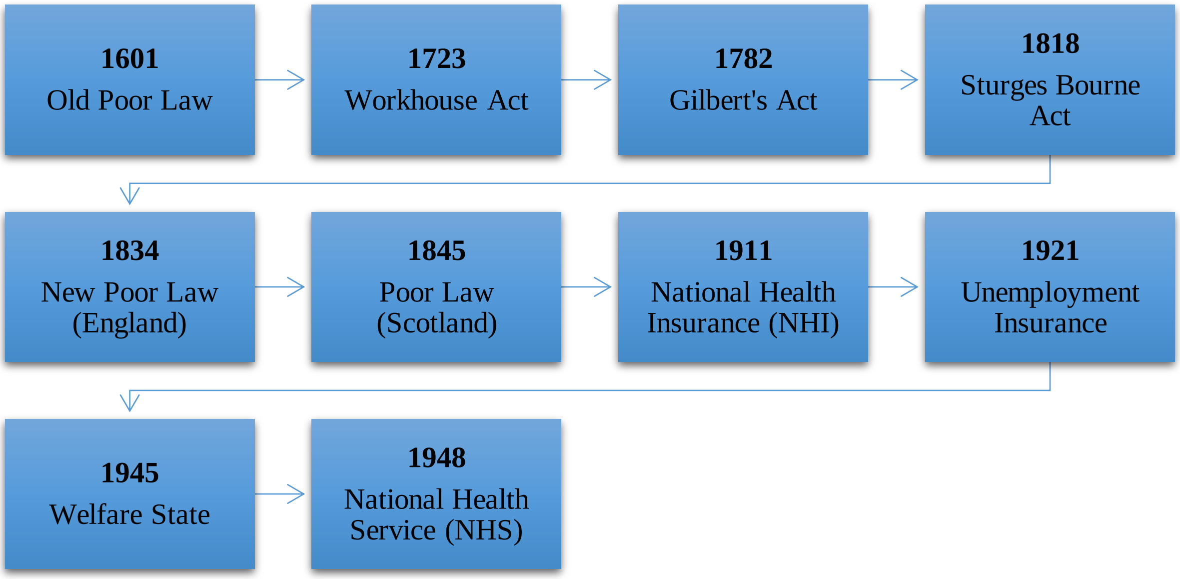
In contrast, nowadays, “comprehensive notions of a welfare state based on complete equality of citizenship no longer receive universal assent [...] against a background of recurring fiscal crises, paying for services has replaced fair shares for all as a current political slogan” (BRIGGS, 2004, p. 16). Thus, the states themselves have not been able to provide universal education and health care, in turn having to share the costs with those who can afford to pay, as we will see later in this study.

As Briggs (2004, p. 16) teaches that researchers in the field have resorted to limiting social service to those who need it most:

> On the other side, a number of writers, some of them influential, have reverted to older and more limited ideas of a 'social service state' where limited services are provided for a limited section of the population. That section is the least well-off section of the community. The state services liquidate themselves, it is claimed, as more and more people rise above the level of a minimum standard of living to reach 'freedom' to buy for themselves the services (health, education etc.) which they want.

Overall, the disassociation of welfare from Poor Law eventually allowed standards to be higher, and a concern for citizenship was elevated. In a sense, democratic demands were being valued through universal schemes and solidarity. According to Auerin Bevan, “homes, health, education and social security, these are your birth rights” (BRIGGS, 2004, p. 20).

Image 1 - A timeline of the advances regarding welfare in the UK up to the creation of the NHS.



Source: Created by the author.

From a perspective of economics and the need for Government intervention as a means of guaranteeing efficiency in the healthcare system, Emmerson, Frayne, and Goodman (2000, p. 15) explain that there are two types of healthcare market failure which are likely to occur and require State intervention; the first are known as ‘externalities’ and the second are ‘information failures’. As regards the ‘externalities’, they are based on the idea that there may be social and economic returns when individuals are healthy and not ill. As an example, curing infectious diseases involves social returns, as “the benefit of preventing or curing one person’s infectious illness extends beyond the private benefit to that individual and affects the community at large”. Therefore, the ‘externalities’ can be explained as the external consequences of an individual’s health to society.

Furthermore, other examples of externalities can be observed in the main welfare state reforms seen in this previous part of the study in Britain, that were driven by the need to have healthy soldiers to fight in war, as well as healthy workers for factory labour.

As Emmerson, Frayne, and Goodman (2000, p. 15) explain:

> It is often said that one of the driving factors behind some of the early welfare state reforms at the start of this century was the poor state of health revealed in the men who were conscripted in the First World War. Up to a third of conscripts were found to be medically unfit to join the forces, and as many as half of those who had volunteered to fight in the Boer War the previous decade was similarly found to be unfit. This is another example of the presence of externalities in the market for healthcare. Because they were needed to fight

> in the war, the benefit to society as a whole of the fitness of these men would have been greater than the sum of the private benefits to each of them individually.

Moreover, state finance and provision of health services is not the only way a government could intervene to address the presence of such externalities. Other forms of intervention could be regulation to guarantee that people are prone to specific diseases, such as "the selective provision of immunisation services, or subsidies to make prices seen in the market more fully reflect both private and social costs and benefits" (EMMERSON; FRAYNE; GOODMAN, 2000, p. 16). The 'information failures' aspect of the healthcare market failures will be discussed in chapter 4 of this study, as it involves the private sector.

The next part of the chapter shifts towards the NHS and outlines its formative process and its reforms since its creation, along with its founding principles, financing and spending, as well as an overview of the private healthcare in the UK.

1.2. The formative process of the NHS and its reforms since its creation in 1948

Before the creation of the NHS, many attempts to reform the British health system were made. One of the first pieces of evidence was the Royal Sanitary Commission Report of 1871, and the reformer Sir John Simon, author of the classic English Sanitary Institutions of 1891. However, this report and book were only published after the New Poor Law was enacted in 1834 and Britain began to think of Public Health and possibly a new health care system, with the evolution of the concept of welfare.

By 1909, Sidney and Beatrice Webb, through the Minority Report of the Poor Law Commissioners, "had attached high priority to the goal of unifying all state-provided health services in any one natural area of administration under a single agency of local government" (WEBSTER, 2002, p. 09).

From the mid-nineteenth century, state intervention in health care had steadily increased due to the advance in Western economies after World War II, whereby voluntary agencies and public authorities had built services covering the basic medical needs of the population. Soon after, the intervention of the public sector changed the need for voluntary agencies to provide health services.

During this time, "the UK accumulated a large body of legislation addressed to the control of Public Health, the regulation of the health care professions, and the provision of services to many different client groups” (WEBSTER, 2002, p. 02). Therefore, the UK was naturally following the pattern of other advanced European states.

Thus:

> Through the mechanisms of the poor law, public health, education, and health insurance, central and local government between them provided and financed an ever-increasing range of health services, until by 1939 a few of the more affluent and most progressive local authorities were within sight of providing a comprehensive health service (WEBSTER, 2002, p. 02).

Despite advances in medical research and other initiatives undertaken by the Government, during the inter-war period it was evident that the UK's health services were falling behind in comparison to other Western economies. In 1920 the Dawson Report exposed the areas of the UK that were denied the basic amenities of civilized life and lacked access to health services of minimum standards (WEBSTER, 2002, p. 04). Moreover, the Dawson Report was dismissed due to its, “oversimplifications and lack of political realism” (WEBSTER, 2002, p. 10).

According to Webster (2002, p. 04):

> The worst affected were working-class women. As dependents, they were even excluded from meagre National Health Insurance (NHI) medical provisions. They lacked the material resources adequately to support families and were therefore forced to deny themselves medical assistance or even an adequate diet. Their adversity was compounded by the absence of access to family-planning services.

The Local Government Act of 1929 attempted to control the health crisis during the inter-war period, as there was a sense of panic due to the economic and social crisis. Regarding the National Health Insurance (NHI), also known as Social Security in other countries, it was established in 1911, and its purpose was to aid with minimum financing for the poor through weekly income deductions (WEBSTER, 2002, p. 05).

During World War II, “all hospitals were coordinated together under civil defence regional administration” (WEBSTER, 2002, p. 06). In other words, the nation’s capacity to engage in warfare would be determined by its capacity to provide health care. At this time, the Emergency Medical Service, which later became the National Hospital Service, was created in order to support soldiers and the rest of the population affected by the disasters of war.

More on the ‘post-war reconstruction’ (WEBSTER, 2002, p. 07):

> The Emergency Medical Service and related support services demonstrated the remarkable capacity to make up for lost ground and prepare for a bombing catastrophe on a scale that mercifully failed to materialize. So impressive was the great constructive enterprise that PEP in common with many others called for the immediate conversion of the Emergency Hospital Scheme into a National Hospital Service. [1]

As difficulties in forming a new health service continued to increase, Sir William Beveridge, former Director of the London School of Economics (LSE) and President of the Royal Statistical Society, planned to create a scheme for reconstructing Social Security (MUSGROVE, 2000, p. 845) . The recommendations of the Beveridge Report (1942) would later serve as a basis for the creation of the NHS.

Thus:

> The report discusses the alternatives of financing by general taxation and by defined contributions and comes down squarely in favour of the latter. It admits that taxes may have to bear part of the cost of social insurance, to limit regressivity, but insists on the contributory principle as a significant source of finance (MUSGROVE, 2000, p. 846).[2]

The contributory principle for the British was: “payment of a substantial part of the cost of benefit as a contribution irrespective of the means of the contributor is the firm basis of a claim to benefit irrespective of means.” (MUSGROVE, 2000, p. 846). In other words, this allows the contributor to think of his payment as his own contribution and money, instead of Government money or public money, under the expectation that these contributors would be employed and that every household would contribute.

According to Musgrove (2000, p. 845), the Beveridge Report referred to potential moral hazards and adverse selection (those with lower health risks prefer to pay little as they use less services). However, it ignored any discrimination regarding health risks for certain groups, especially those who had unhealthful occupations.

Musgrove (2000, p. 845-846) believes that if this report was created in the 21st century, other risk factors would be considered:

> Nowadays, in contrast, anyone proposing the creation of a comprehensive, publicly financed health insurance would feel compelled to explain why

---

[1] The Political Economic Planning (PEP) body was the only one that produced a comprehensive review of the British health services undertaken before World War II (WEBSTER, 2002, p. 05).

[2] In a “regressive” insurance system, members with larger incomes pay smaller shares of their income the contributions to the system. The converse is a “progressive” system; in a “proportional” system all members contribute the same proportion of their income (MUSGROVE, 2000, p. 846).

> competitive markets are inefficient as well as inequitable as a way of financing and providing health care, and to review the reasons why the state must play a substantial role in the health sector, particularly in regulating and financing it.

This emphasizes that fact that competitive markets, that being health insurance providers, are not capable of providing health care to all, and that it is the Government's duty to provide this universal healthcare, as well as create bodies to regulate and supervise the private sector.

According to Brazier, Hutton, Jeavons (1990, p. 217), social security:

> Can be administered by a regional government, national government, or a quango[3], and enrolment may be compulsory or provide for opting out by those with private insurance. The premium is often directly ducted from employees' incomes and collected from employers in the form of a payroll tax. If funds collected in this way are used to provide health services free at the point of use, then there is little difference between social insurance and taxation-in effect the only difference is the tax-base. However, if the provision is organized so that consumers must pay for services and claim reimbursement, then the implications are rather different.

The social security systems of other Latin American countries have followed in the NHS's steps, as a means of including those without formal employment to have the right to health through a universal system. Some of these countries are Argentina, Colombia, Costa Rica, and Brazil (MUSGROVE, 2000, p. 846).

In addition to giving the Government a difficult challenge, the Report also suggested that private medical practice may disappear with the new system. However, this was not the case, as later when the NHS was formed, public money was paid to private providers (MUSGROVE, 2000, p. 846). Furthermore, as both private and public hospitals were used to charging for their services according to the patient's ability to pay, this was definitely a challenge for the Government.

The period of reform was of much conflict and uncertainty, as the parties were not flexible or forward-thinking, and the future of the NHS was overshadowed by ideologies and financial interests. Many negotiations during wartime were made by the Ministry of Health as a policymaker and the local government associations as providers of services (WEBSTER, 2002, p. 07-09).

---

[3] Quango (noun): a partly autonomous regulatory agency, especially one in Britain organised outside the civil service but financed and appointed by the government (MIRIAM-WEBSTER, 2023).

Later, the proposals of the Coalition Government (1943) were the first officially sanctioned scheme to the previous objective of Sidney and Beatrice Webb in the beginning of the 20th century. According to Webster (2000, p. 09), "this plan aimed to assemble all publicly funded health services under some forty bodies constituted from single local authorities or combinations of them. Voluntary hospitals constituted the only stumbling block to complete integration".

In other words, it was decided that a comprehensive health service would be established by extending the powers of existing local authorities, with the formation of joint bodies to overcome difficulties associated with the size of existing local government entities (WEBSTER, 2002, p. 09).

In addition, the new plan focused on Primary Care (PC) and General Practitioners (GPs), that would be employed directly by local authorities, thereby losing their autonomy associated with their status as independent contractors under the old National Health Insurance (NHI) system, to work in local health centres (WEBSTER, 2002, p. 09). However, neither voluntary hospitals, nor GPs wanted to be controlled by the unified system.

Thus:

> The voluntary hospitals sought guarantees to prevent local government exercising a strangle-hold over the public subsidies they were promised, while their staffs resented the prospect of being reduced to the rank of public-health employees. General medical practitioners insisted on continuing separate administration of their service and retention of their status as independent contractors (WEBSTER, 2004, p. 09).

In 1943, the White Paper known as A National health Service issued in February 1944, was heavily criticised, especially by medical organisations and the voluntary hospital lobby. In an effort to respond to the criticism, another White Paper was drafted by the Conservatives in 1945. For the purposes of national planning, it was proposed that regional bodies were to be created in councils and that medical schools would advise the Ministry of Health on the development of hospital specialities and appointments (WEBSTER, 2002, p. 10).

As regards to the worry surrounding GPs at the time, the second White Paper mentioned above took those worries into account and decided that:

> General medical practitioners were promised continuity of their existing arrangements for employment through a proposal to replace existing Insurance Committees by new 'local committees', fulfilling similar functions. Accordingly, general practitioners would remain as independent contractors;

> their payment would continue on the basis of capitation rather than salary; private practice would continue to be permitted (WEBSTER, 2002, p. 11).

Even though Government was able to make these changes, medical organisations and the voluntary hospital lobby still attempted to get further concessions, especially the British Medical Association (BMA). The negotiations during World War II were endless, and the dream of a unified health system felt far from becoming a reality, despite efforts from both leading parties (Labour and Conservative). Moreover, the Conservatives were still resistant to go forward with the proposal as it caused too much criticism, and only ambitious Labour was able to go forward with it in 1945 (WEBSTER, 2002, p. 12).

In Websters (2002, p. 12) words:

> The landslide victory obtained by Labour in the summer of 1945 presented an opportunity for decisive leadership on social policy; indeed, Labour was pledged to an ambitious welfare-state programme. Labour had long been committed to establishing a comprehensive health service and this pledge was reaffirmed in its policy document *National Service for Health*, published in April 1943, coinciding with the launch of the Coalition Government's similar plan. Within the Coalition, Labour ministers tried to force the pace of health-service reform. After the collapse of the 1943 plan, Labour only reluctantly accepted the 1944 White Paper.

According to Delamothe (2008), the NHS, “was the first health system in any Western society to offer free medical care to the entire population. It was, furthermore, the first comprehensive system to be based not on the insurance principle, with entitlement following contributions, but on the national provision of services available to everyone.”.

The founding principles of the NHS include integration, unification, and simplification in the organisation of health care to guarantee the protection of the health of all members of the community ‘from womb to grave’. According to Delamothe (2008), the NHS is “universal, equitable, comprehensive, high quality, free at the point of delivery, centrally funded”.

As stated in the NHS Act of 1946:

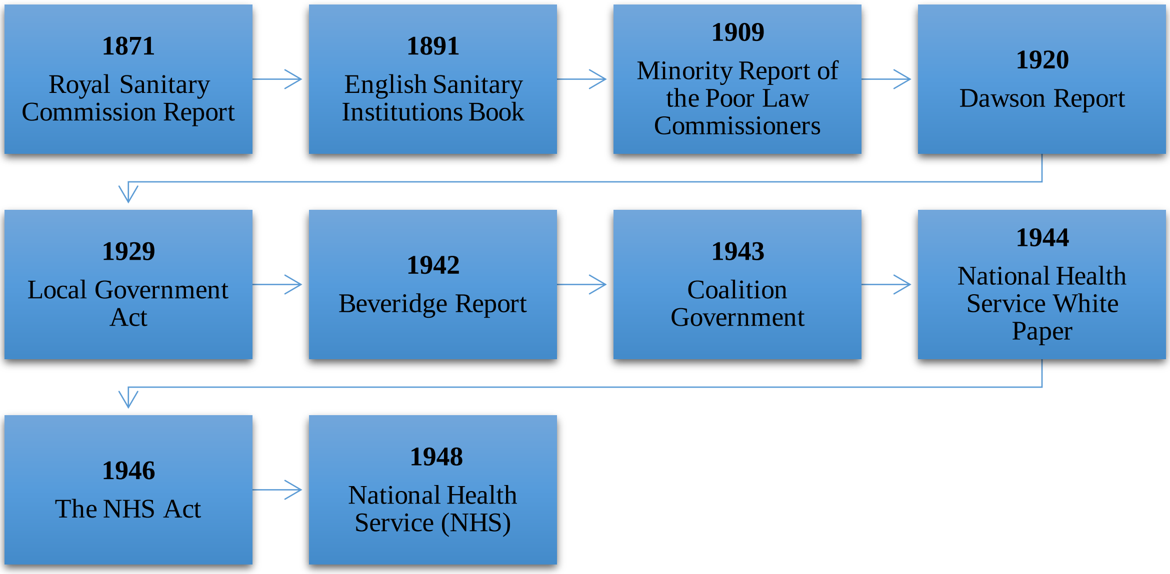
> It shall be the duty of the Minister of Health [...] to promote the establishment [...] of a comprehensive health service designed to secure improvement in the physical and mental health of the people [...] and the prevention, diagnosis, and treatment of illness [...]. The services so provided shall be free of charge, except where any provision of the Act expressly provides for the making and recovery of charges (HOWELL, 1992, p. 297).

As stated in Law, the NHS never promised to be all inclusive or completely free, as charges can and are made in very few cases. According to Howell (1992, p. 297), “a key word in the present context is ‘comprehensive’, which is sometimes assumed to mean all inclusive; but the definition of comprehensive is ‘comprising much; of large content or scope’”. This definition is key to understanding that the NHS never intended to provide every possible medical or dental care service, as it could not financially be possible.

When considering Government intervention in healthcare in order to guarantee the principle of equity and fairness, treatment must be available regardless of one’s ability to pay, something which the private sector obviously would not guarantee. Thus, the importance of Government intervention in ensuring services that the private health care market would not is essential in maintaining the welfare state.

Therefore, “the enshrining principles of the NHS set out in the 1944 White Paper, *A National Health Service*, included the aim that everyone ‘irrespective of means, age, sex, or occupation shall have equal opportunity to benefit from the best and most up to date medical and allied services available’” (EMMERSON; FRAYNE; GOODMAN, 2000, p. 14). The NHS does this by offering health services free at the point of delivery and available to all.

Image 3 - The formative process of the NHS.



Source: Created by the author.

Overall, the NHS manages to abide by its founding principles despite difficulties in controlling expenditure and meeting demands, in times of being under-resourced due to economic crisis.

It is also important to explore the reforms undergone by the NHS since its creation in 1948, up to 70 years later through the study of White Papers and other significant modifications to the Public Health system.

In 1953, the Guillebaud Committee was set up by the Conservative government after NHS expenditure had exceeded estimates. According to Powell (2018, p. 574), “this committee was similar in some ways to a Royal Commission in that it asked independent experts to examine the NHS”. In addition, the Committee was responsible for estimating the future funding of the NHS.

During this time, with all the advances in medicine and technology, an ageing population was evident, and it began to worry the Public Health system, as it could lead to further costs. Powell (2018) researched White Papers[4] published on NHS anniversaries for the last 70 years and found that there was no reason for this worry regarding the growing ageing population. Thus, “it cited the Registrar General's 1953 estimates: ‘there is no justification for the alarm that has been expressed about the impact of an ‘ageing population’ on the cost of the NHS” (POWELL, 2018, p. 575). The researcher claims that the Committee accepted that an ageing population had no effect on the future cost of the NHS.

In addition to analysing the costs of the NHS, the Committee was also responsible for managing the structure of the system, as pressures for adequate services increased with technological and medical advances. Powell (2018, p. 575) found that, “in the absence of an objective and attainable standard of adequacy the service must provide the best service possible within the limits of the available resources”. At this time, the NHS had only been operating for seven years.

The evaluation of the NHS on its 10th anniversary was the following: “despite certain weaknesses, the Service's record since 1948 had been one of ‘real and constructive achievement’” (POWELL, 2018, p. 576). With the first decade of the public health system being a success, the population was feeling positively about the following years.

During the next decade, the Hospital Plan of 1962 was created, whilst the nation saw a rapid growth in public expenditure. On the other hand, there was also a sort of reform in the NHS, targeting the organisational and administrative structure of the system. Thus, “in search of the organisational fix, Minister of Health Kenneth Robinson published the first consultative document on reorganisation in 1968, which was published to coincide with the NHS 20th anniversary” (POWELL, 2018, p. 576). This consultive document was known as a Green Paper.

---

[4] A 'White Paper' is an official document stating government policy (POWELL, 2018, p. 463).

The Ministry of Health at this time (1968) stated that, “the central theme of this Green Paper must be the unified administration of the medical and related services in an area by one authority, in place of the multiplicity of authorities concerned in the present arrangements” (POWELL, 2018, p. 576). This document, in summary, noted that hospital authorities were numerous, and that health and welfare services were divided by local authorities.

In 1973, the UK suffered an economic crisis which reduced the budget of the NHS, and by the second half of the 1970s, the nation witnessed a period of medical and trade union militancy, “for the first time in the history of the NHS, doctors took industrial action, resulting in ‘the politics of ideological confrontation’” (POWELL, 2018, p. 577). This crisis led to the creation of the Royal Commission of the NHS, and a Conservative government in 1979.

The Report of the Royal Commission on the NHS that year (1979) contradicted itself and stated that:

> The United Kingdom spent less than most other developed countries, and also performed relatively poorly in terms of indicators of health such as life expectancy, and perinatal and maternal mortality. It concluded ‘we need not seem ashamed of our health service and there are many aspects of it of which we can be justly proud’ (POWELL, 2018, p. 577).

The same Report also stated that the NHS was mostly known as a ‘sickness service’ rather than a health service, and made some recommendations:

> It stated that easily the most popular remedy for the failings of the NHS, especially and understandably with those working in it, was that much more money should be made available. Others included alternative methods of financing (e.g., charges); the NHS should be taken out of politics; integrating health and personal social services; and further NHS reorganisation (POWELL, 2018, p. 578).

The amount of funds available for healthcare generally seems to be an issue worldwide, and the temptations of the government to charge for services would remove the NHS, as well as other ‘free’ public health services, like the Brazilian SUS, out of the group of countries that offer universal health care.

This crisis led people to ask to save the NHS and spend more money, but the famous Margaret Thatcher had other plans. As “the Conservative Thatcher government introduced the ‘internal market’ or ‘purchaser/provider split’ which has been termed the biggest change in the history of the NHS and shaped the policy direction of the NHS for the next twenty-five years or so” (POWELL, 2018, p. 578).

During this period, the NHS Review (1988) and the Working for Patients (1989) documents were created.

The latter reaffirmed the principles of the NHS:

> The NHS is, and will continue to be, open to all, regardless of income, and financed mainly out of general taxation [albeit a minimalist interpretation]. Turning to finance, it was stated that total gross expenditure on the NHS increased from some £8 billion in 1978-79 to £26 billion in 1989-1990, an increase of 40% after allowing for general inflation (POWELL, 2018, p. 578).

According to James (2001, p. 463), palliative care did not attract attention or support before the 1980s, considering that only then did hospice care eventually get the attention of the Minister of Health at the time. Later, however, in 1978, “all authorities were required to draw up strategies and for several years from 1990 there was earmarked funding for hospices”. This means that there was specific funding for hospices, in other words, the funding was destined for that purpose.

On this note, the most important organisation regarding palliative care during this time was the National Council for Hospice and Specialist Palliative Care, which made all health authorities aware of palliative care in 1995 (JAMES, 2001, p. 463).

In the mid-1980s, another financially neglected health issue was AIDS, whilst all other health received funding for preventive work. Soon, national programmes to increase HIV/AIDS awareness, as well as support services were provided, and the transmission soon became low within European standards. Nowadays, most of the infections reported in the UK are acquired overseas (JAMES, 2001, p. 463).

Later, in 1997, “Labour Prime Minister Tony Blair stated that ‘creating the NHS was the greatest act of modernisation ever achieved by a Labour Government’” (POWELL, 2018, p. 578). Tony Blair wanted to modernise and improve the NHS, identifying issues that needed to be addressed:

> In short, he wanted the NHS to become a modern and dependable service that is once more the envy of the world. Problems included long waiting lists; variable quality; and an NHS that treated people when they were ill rather than one that worked with others to improve health and reduce health inequalities (POWELL, 2018, p. 578).

During this administration, the ‘The NHS. It's modern. Dependable’ (1997) White Paper stated that it had a 10-year-plan to improve the NHS, whereby, “the internal market would be replaced by a system of integrated care based on partnership and driven by performance, where cooperation would replace competition” (POWELL, 2018, p. 578). In addition, the report stated that new institutions such as new local commissioners of Primary Care Groups (PCGs) would be created, as well as the National Institute for Clinical Excellence, the Commission for Health Improvement, and National Service Frameworks.

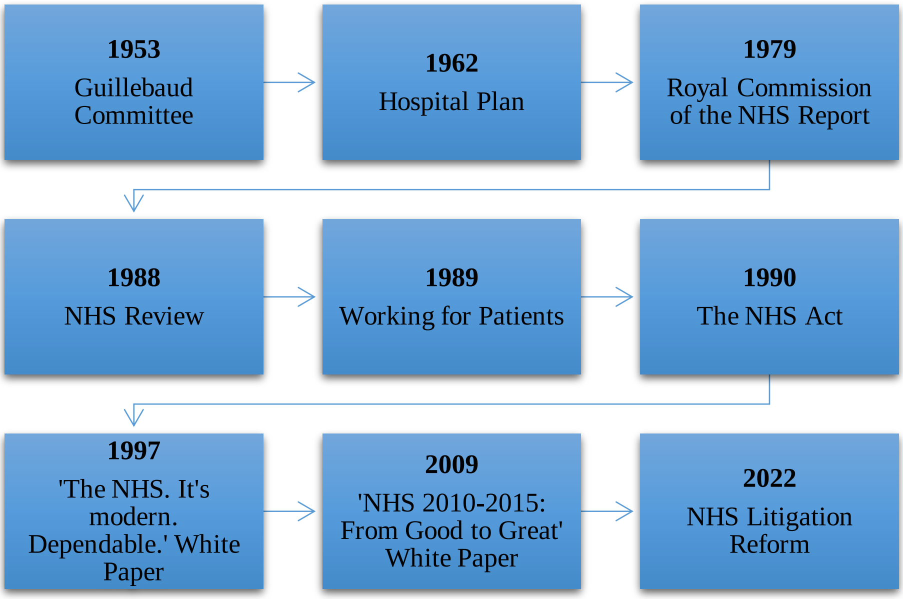
Furthermore, the government stated that it would spend more on health care every year as a change needed to be implanted for the new upcoming century. However, a government transition and a change of the Secretary of State made the promise of the NHS’s 2000 Plan vanish (POWELL, 2018, p. 578).

The ‘NHS 2010–2015: From Good to Great’ (2009) White Paper, “pointed to a decade of record, sustained investment which meant that funding doubled in real terms over the last 12 years and was almost exactly the average among the Organisation for Economic Co-operation and Development (OECD) countries” (POWELL, 2018, p. 578).

The NHS Resolution, which is a body within the Health and Social Care Department created to resolve claims in early stages to avoid litigation in the courts, is undergoing reform due to the NHS Litigation Reform of 2022. This will be discussed the last part of chapter 3.

Having studied the political and governmental changes to the NHS as a Public Health system over the years, it can be concluded that the improvements have been huge, and that the government reports overall satisfaction in delivering its missions, despite periods of national crisis.

Image 4 - The reforms and advances of the NHS since its creation in 1948.



Source: Created by the author.

In the next part of this chapter, the financing and spending of the NHS over the years will be discussed, as a means of understanding how the Government finances Public Health and what bodies are involved its financing, as well as to be able to evaluate if the spending of the NHS is in accordance with its founding principles and the rest of the OECD countries.

1.3. The financing and spending of the NHS

Funding for health services in England comes from the Department for Health and Social Care's budget. The majority of the Department's spending is passed on to NHS England and NHS Improvement for spending on health services. The remaining funds are allocated to other national bodies for spending on other health-related functions such as Public Health, training and development of the NHS staff and regulating quality of care (ANANDACIVA, 2023).

According to The King's Fund (ANANDACIVA, 2023):

> The Department's spending in 2020/2021 and 2021/2022 included funding to respond to the Covid-19 pandemic. This Covid-19 spending means the Department's budget grew rapidly between 2019/2020 and 2021/2022 before falling in 2022/2023. It is projected to increase by 1.2 per cent in real terms on average over the next two years.

The Annual Budget of 2022 informed that the “NHS England's budgets in future years have been adjusted downwards to remove compensation for the increased employer National Insurance costs that would have been incurred if the Health and Social Care levy had been maintained” (ANANDACIVA, 2023). In addition, the “NHS England's budget has also been adjusted upwards [...] because it will receive some additional funding through the increased Better Care Fund that was included as part of announcements around adult social care” (ANANDACIVA, 2023).

The funding, known as The King's Funding, flows through the NHS, starting with tax collection and National Insurance (NI) which based on the amount collected, sets a budget for each Government department. In 2018/2019 the Department of Health and Social Care spent the equivalent of £2,300 for every person in England (UK, 2020). In addition, Clinical Commissioning Groups (CCGs) also receives funding. The amount each CCG receives is based on the number of people in the local area and also factors of age and level of deprivation (UK, 2020).

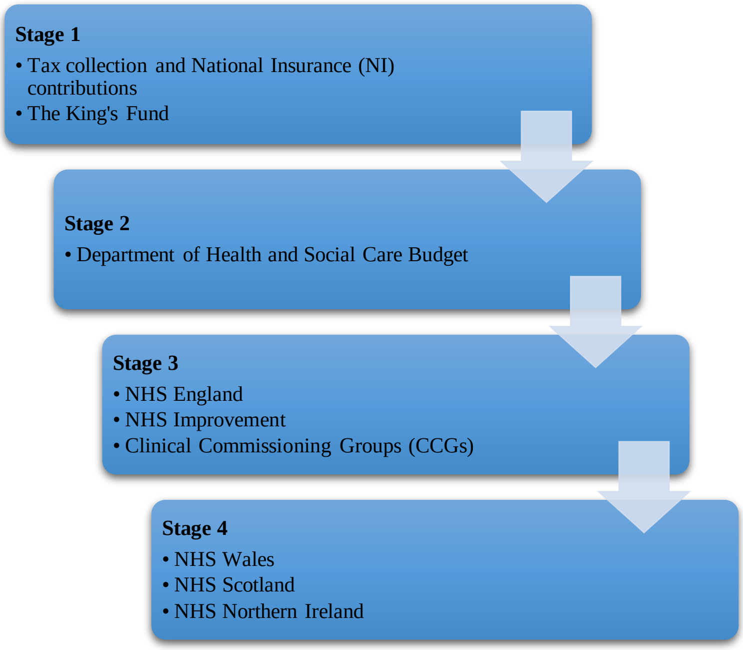
According to The King's Fund (UK, 2020), "CCGs assess the health needs of their local population to make decisions about the health and care services they need. They then buy as many of those services as their budget allows from providers like hospitals, GPs, mental health, community, and other providers". Moreover, providers can receive from other sources, including local authorities or people who pay privately for health care. Therefore, while there is a flow of funds from the Treasury to providers of services, not all NHS funding follows this path (UK, 2020).

The Government spending on health is quite flexible, as it can change throughout the year based on Public Health needs at specific times of the year. For example, during the winter months the Government usually spends more on health (UK, 2020). Thus, "it is not known how much of any reserves held back by NHS England will be allocated to each provider and commissioner". This means that it is difficult for local authorities to plan ahead as they do not know how much they will receive, but at the same time it is flexible.

In regard to how providers are regulated and commissioned, at a national level, the UK works with the NHS England and NHS Improvement team, as well as the Care Quality Commission (CQC). At a regional level, NHS England and the CQC also work. Moreover, it is really at the local level that the NHS has more specific services. For instance, the "Sustainability and Transformation Partnerships (STPs) bring organisations together to plan services around the long-term needs of local communities", whilst the "Integrated Care Partnerships (ICPs) are alliances of providers that work together to deliver care by agreeing to collaborate rather than compete" (UK, 2020).

According to The King's Fund (UK, 2020), "in some areas, Integrated Care Systems (ICSs) have evolved from STPs, taking on greater responsibility for managing local resources and improving health care for their populations", whereas "Primary Care Networks (PCNs) bring general practices together who may also collaborate with a range of other local providers to provide Primary Care at scale by using a wide range of professional skills and community services". In addition, other providers of NHS-funded care are GPs, the voluntary sector, social enterprises, and the private sector (UK, 2020).

Image 5 - The stages of the NHS funding in the UK.



Source: Created by the author.

A study of the NHS health and social care spending from 1949 to 2004, by Emmerson, Frayne, and Goodman (2000, p. 13), found that the largest part of spending was on acute hospital treatment, and increases in spending were also observed for mental health and those with learning disabilities (social care).

However, it was observed that less was being spent on the elderly, maternity care, and other areas of hospital community services, "it should be remembered that the elderly receive a large portion of spending through other parts of the health budget", and that "the reduction in share of spending on the elderly is potentially due to increases in other budgets — for example, in acute care or alternatively additional support from local authorities". Therefore, the highest spending is based on acute, community and mental health – the three parts of the NHS Trusts.

According to the Public Expenditure Statistical Analyses of 2019, in regard to the financing of local government expenditure, "central Government support for local government expenditure is provided in two main forms: capital and current grants and the redistribution of non-domestic rate payments" (UK, 2019).

In addition, the document explains that grants may be non-specific or dedicated to specific services, like health, for example. Furthermore, "a non-domestic rates retention scheme was introduced in England from April 2013, which allows local authorities to keep a proportion of the rates they collect, along with growth in the revenue that is generated in their area" (UK, 2019).

For most of the UK's history regarding government spending on health care, the numbers have been quite tight, as spending is lower relative to the Gross Domestic Product (GDP) than in most OECD countries. However, “for many years NHS spending was within the range 5.5-6.2% of GDP” (JAMES, 2001, p. 462).

These figures are relevant for the years prior to 1999, seeing as after March 1999, the government was committed to increase health spending during the next five years to meet the average for the European Union, in order to reduce waiting times for treatment, improve services and enhance patient experience.

According to the NHS Confederation (2018):

> Annual public spending on health didn’t reach £20 billion (in today’s prices) until the mid-1960s. It hit £40 billion in the mid-1980s, was at £80 billion by the turn of the century and now sits at £150 billion. Not only has spending risen in real terms, it has taken a bigger and bigger chunk of the national economy, rising from around 3% of GDP in the early 1960s to 4% during the 1970s and 1980s, 5% by the year 2000 and more than 7% by 2008. It represents 7.3% of national income today (CHARLESWORTH; JOHNSON, 2018, p. 11).

Although spending on health has risen greatly through the years, it still does not seem to be enough to tackle the Public Health systems issues. Moreover, it is wise to consider that public spending on health is different in all British countries, based on population size and their specific regional needs.

Thus, “funding for public services in Wales, Scotland and Northern Ireland is determined by the Barnett formula[5], whereby changes in public spending in England result in changes in public spending budgets in Wales, Scotland and Northern Ireland, based on population size” (CHARLESWORTH; JOHNSON, 2018, p. 12).

The Barnett formula mentioned above, is key in avoiding corruption and uneven distribution of funding between the British nations, as it makes it unnecessary for annual negotiations related to funding and ensures stability within the system. However, the formula also leaves space for flexibility, which is fundamental to ensure that each nation receives funding which is proportional to the present sanitary circumstances.

According to Cheung (2020):

---

[5] The Barnett formula is used by the UK Treasury to calculate the annual grants for the Scotland, Wales, and Northern Ireland and determines the funding available for public services such as healthcare and education in the British nations (CHEUNG, 2020).

> An advantage of this mechanistic formula is that it helps depoliticise the process of setting devolved budgets, removing the need for annual negotiations between Westminster and the devolved administrations. It also ensures relative stability and predictability for devolved budgets, as each year's budget uses the previous year's budget as a starting point. In addition, the lack of ringfencing within the block grants means that devolved administrations have the autonomy to choose their own spending priorities (although separate grants are given for resource and capital spending).

Furthermore, Public Health spending differs slightly among British nations, as "in 2015–16, it was highest in Scotland at £2,387 […] this compares with spending of £2,302 in Northern Ireland, £2,249 in Wales and £2,226 in England" (CHARLESWORTH; JOHNSON, 2018, p. 28).

Therefore, spending on health per person between 2015 and 2016 was lowest in England and highest in Scotland, although there was not a significant difference in spending, still meaning that allocation of resources should differ according to each nation and its specific needs. Thus, different countries spend varying amounts on healthcare, and this may reflect on the organisation of care, preferences for health, and variation in the overall levels of taxation and public spending in each country.

According to the NHS Confederation:

> While comparisons of spending do not necessarily reflect differences in the quality of care provided in different countries (with different costs of production and levels of health across countries), it is interesting to note that the UK has historically spent (and continues to spend) less on health than countries such as France and Germany. Indeed, these differences directly fed into policy in the 2000s when then Prime Minister Tony Blair promised to raise UK health spending to the European average by 2005. Following this pledge, while health spending rose as a share of GDP in most EU countries over the next decade, spending in the UK increased at a quicker pace. These increases were therefore broadly in line with this pledge, and they narrowed the gap in spending with France and Germany. While lower than in some countries, spending in the UK is now not low compared with that in other comparable countries on average (CHARLESWORTH; JOHNSON, 2018, p. 32).

As regards to sanitary crisis, the recent Covid-19 pandemic caused the UK to spend significantly higher in comparison to previous years. Therefore, during this economic and sanitary crisis in Britain, "instead of allocating additional money to the devolved administrations only after new spending was announced for England, the devolved administrations were each given a guaranteed minimum of additional spending to help them respond to the crisis" (CHEUNG, 2020). In other words, during this period, annual grants for Scotland, Wales and Northern Ireland did not depend on England's initial budget.

Another constant worry for the British is the possible increases in taxes in order to be able to finance the NHS, as "it is hard to imagine raising this kind of money without increases in at least one of the three biggest taxes – income tax, National Insurance and VAT[6]" (CHARLESWORTH; JOHNSON, 2018, p. 19). The NHS Confederation (2018) suggests that it would be possible to gradually increase taxes as the tax burden in the UK is significantly lower than many other European countries, such as Germany and France.

According to Doyle (2000, p. 563), "some private care is self-financed, and the NHS also contracts out to private providers – notably in the psychiatric services, care of elderly people, termination of pregnancy, and through waiting list initiatives". Thus, the NHS makes use of the private sector for providing specific services, like abortion and mental health services; whilst the elderly are more likely to have private health insurance.

Doyle (2000, p. 565) believes that, when possible, the NHS should work with the private sector, as "collaboration between public and private health care sectors, where it is sensible to do so, would serve the country better than continued isolation". This is the same as the Brazilian publicly funded health care system which also relies on the private sector's health services in order to complement its health care. However, as the study unfolds, it is possible to conclude that many researchers in Brazil believe that it would be best for a Public Health service to be independent.

Some researchers believe that the funding allocated for the NHS must be specifically prioritised for those who are already sick, that is, those in greater need, rather than the prevention of sickness, which overwhelms the system and is inevitable, as sickness and death is the natural ending of life.

In Heath's (2007) words:

> In the universal healthcare system, funded through taxation, can possibly pay for the pharmaceutical treatment of all risks to health. An excessive and unrealistic commitment to prevention of sickness could destroy our capacity to care for those who are already sick; everyone, in time, must become sick and die.

---

[6] Value Added Tax (VAT).

On the other hand, according to the NHS Confederation (2018), Primary Care, preventive care, as well as awareness campaigns, are key to avoiding health risks in the long term, and that the NHS plans to continue its mission on focusing on GPs and family physicians:

> The NHS Five Year Forward View in 2014 set out a vision for the future of the health service in England. In response to population ageing and the rising burden of chronic disease, it argued for the NHS to provide more care closer to people’s homes. It sought to shift care towards earlier diagnosis and more proactive management of health problems to prevent rather than simply manage ill health and hospitalisation. A sustainable, high-quality healthcare system is likely to involve more focus on supporting primary and community services, not less (CHARLESWORTH; JOHNSON, 2018, p. 12).

Some of these awareness campaigns include action against obesity, non-smoking, reduced alcohol consumption etc. This is crucial in avoiding overcrowding of the Public health system in the long-term, as “tackling chronic disease is not just an economic issue […] it has a substantial impact on quality of life and wider society” (CHARLESWORTH; JOHNSON, 2018, p. 15). Therefore, Primary Care, preventive medicine and awareness campaigns may be lest costly to the system overall than hospital care and more invasive treatments, like surgeries and palliative care.

As Howell (1992, p. 297) points out, “some people wait excessively long times for treatment”. However, “in comparison with the totality of care provided by the NHS these deficiencies are few and far between”. These issues are still being faced today in the NHS and also being observed in other publicly funded health systems, such as in Brazil.

In Howell's (1992, p. 297) words:

> Concern about providing an adequate health service is not limited to the United Kingdom. Similar concerns are being felt worldwide, ranging from those countries that have so little national and individual income that they can support only the most rudimentary of health services to affluent countries such as the United States, which despite spending more than 12% of its considerable gross domestic product on health does not provide care for millions of its citizens.[7]

Therefore, it is worth questioning whether the NHS can provide equitable access to healthcare; this was considered by the NHS Act of 1990. The Law considered that the NHS was under-resourced in a time of medical and technological advances, even though, “between 1948 and 1980 expenditure on the NHS in England (and presumably in Wales and Scotland also)

---

[7] This data is from the cited author’s findings in 1992.

increased on average by about 4% per annum after correction for the effects of inflation" (HOWELL, 1992, p. 297). During that time, the funds were enough to cover expenses, but more recently since 1990, Government has had trouble coping with the costs of health service.

One of the reasons for this is that between 1981 and 1985, the NHS suffered a reduction in the rate of increase in funding, which was consistent with the aims of Government to decrease public expenditure (HOWELL, 1992, p. 297). The NHS also suffered reorganisations of structure in 1974 and again in 1982, but there was not much improvement of its efficiency. The most significant change occurred in 1983, when the recommendation that general management should be substituted by clinical directorate systems that managed clinical resources of hospitals (HOWELL, 1992, p. 298).

The NHS Act of 1990 was the result of all these changes that occurred to the system over the years, especially the separation of the functions of purchasing health care from the provision of care by providers linked by contracts. According to Howell (1992, p. 298), "this has shifted some of the power to prescribe how resources will be allocated from doctors (and nurses) in favour of managers and health authorities, and this is widely accepted". Therefore, doctors and nurses participate in the management of resources as they are the ones who use them directly, creating a more efficient system.

According to Howell (1992, p. 298), 'consensus rationing' refers to prioritising funding of cost-effective treatments over other high cost and low effect treatments if resources are limited.

The advantages are as follows:

> One advantage of this form of 'consensus rationing' is that it removes from the individual doctor the possibility of conflict with his or her fundamental ethical responsibility of making decisions only in the interests of the patient once he or she has accepted responsibility for the patient's care; this is implicit in the Hippocratic oath. He or she does not have to worry whether the cost to benefit ratio is good enough – the community has already taken this decision and the doctor-patient relationship has not been directly compromised (HOWELL, 1992, p. 298).

At present, health authorities make decisions about the allocation of resources to different categories of care, whilst doctors decide on allocations based on each individual case, considering their personal medical history and circumstances with the pressure of local resources. Howell (1992, p. 298) emphasizes that, "as long as the gap between demand and resources is not wide, there is no inherent problem with this system".

However, the problem arises when patients are put on a waiting list to be treated if their case is not urgently considered by the doctor. Consequently, the health problem may become worse if it is not immediately treated and patients have to wait; this is why the doctor is given full autonomy to decide.

According to Dayan, Ward, Gardener, and Kelly (2018, p. 39), on the overall efficiency of the NHS despite its strict funding, “it provides unusually good financial protection to the public from the consequences of ill health; it appears to be relatively efficient; and it performs well in managing some long-term conditions”, furthermore, “it does all this with an unusually low level of staffing and, in at least some categories, equipment”. Thus, it is possible to say that even though the NHS has many responsibilities and tight funding, it manages to allocate its funds, accordingly, suggesting that its service is efficient and accessible.

In addition, it is important to consider that no health system can be efficient if there are great social inequalities, “one of the ambitions of preventive health care is that it will reduce the gap between rich and poor, but health inequalities reflect wider societal inequalities and cannot be solved by a health service operating within a persistently unequal society” (HEATH, 2007).

These findings can especially be applied to the Brazilian health care system, whereby the population presents huge levels of social and regional inequalities, and only the poor or unemployed use the SUS. In the UK, social inequality is especially observed with immigrants and refugees in comparison to the English and British citizens, whereby the is little or no social inequality, and everyone uses the NHS in the same way (JAMES, 2001, p. 463).

The next part of this chapter will outline private healthcare in the United Kingdom which, although scarce, still is used, especially when the NHS does not cover some treatments or during the NHS crisis being experienced since the Covid-19 pandemic.

1.4. Private healthcare in the United Kingdom

Before going deeper into this chapter, it is worth reviewing how insurance companies work, from the brief explanation given by Brazier, Hutton, Jeavons (1990, p. 217) below:

> Insurance companies charge a premium in return for a guarantee to cover an individual (or family) for the costs of treatment in the event of illness. Premiums may be averaged across a large group, for example a firm's workforce, or experience-rated, that is, based on the estimated risk of each person requiring treatment in the future. There is, therefore, the possibility of

> some link between utilisation of services and payments by individuals through variations of premiums. The extent of insurance cover is related to premium levels so individuals can choose the level of cover they wish, provided they can afford it.

According to Emmerson, Frayne, and Goodman (2000, p. 14-15), economics teaches us that Government intervention is needed when the private health care market is unable to provide coverage to those that cannot afford to pay for health plans or insurance in order to have access to health services. Thus, the Government guarantees the principle of equity and fairness by offering Public Health services that are free at the point of delivery regardless of one's ability to pay.

However, the amount of healthcare one will consume will vary, as "people with different incomes are likely to choose different levels of healthcare even if their medical conditions are the same", this is due to personal preferences and how one value's their own health and well-being and on what they prefer to spend their income on. Therefore, even when a Public Health service is available and efficient, one may still prefer to have private healthcare.

Emmerson, Frayne, and Goodman (2000, p. 14-15) explain that:

> Even with the same income, there are other reasons why people may buy different amounts of healthcare in the private health market. People may have varying preferences between spending their income on health and on other commodities, different degrees of risk aversion, with some willing to give up more income today for a certain future than others, or varying subjective discount rates, so that the trade-off between present and future consumption (and possibly health) will be higher for some than others. All these factors will result in different levels of treatment arising for people with identical medical need. In choosing different levels of healthcare, such people will be behaving in a manner that is rational and consistent with their preferences.

It is worth continuing the teachings of Emmerson, Frayne, and Goodman (2000, p. 15-16) on Government intervention and healthcare market failures, as seen in chapter 1, where the 'externalities' were discussed. In this chapter, the 'information failures' will be explored. The information failures can be considered as lack of information on the part of consumers about the healthcare they are purchasing, as well as "an asymmetry of information in the market for insurance between insurers, consumers and providers".

Thus, information failures are the consumers misunderstandings of the healthcare market due to misleading marketing of the services and/or lack of understandable information on part of the providers, which leads to health needs being unmet.

Emmerson, Frayne, and Goodman (2000, p. 16) believe that one cause of information failure is when consumers seek to contract health plans and insurance when they are ill. This means that they will probably not browse the market enough to find the best offer for their specific needs, as depending on the severity of their condition, they will be more desperate to find a deal quickly, especially if medical treatment is urgent. Thus, "the information that is required to make rational choices is often both highly technical and emotionally charged".

On the other hand, insurance companies also prefer not to insure the severely ill, especially the elderly who are more prone to illness, as ill consumers are seen as too costly. The aim of the insurance companies is to have as many healthy people insured as possible, and most people will contract health insurance when they are healthy, as prevention for future illnesses:

> In the case of major epidemics, each person's probability of getting ill will not be independent of the community at large, and these risks will be uninsurable. People born with certain conditions, or those looking to buy insurance after they have developed a chronic condition, will also be unable to buy insurance, as they are certain to require treatment. For many people, although not certain to require treatment, the probability may be sufficiently high that it will not be economical for insurance companies to provide insurance to them (this is likely to be the case for many elderly people). Major gaps in the market will develop (EMMERSON; FRAYNE; GOODMAN, 2000, p. 17).

Furthermore, self-employed professionals who perform badly develop poor reputations and loose patients, meaning that these professionals may not always give the best information in order for the patient to make the best choice, as poor choices in healthcare entail high costs and are generally irreversible. This is where Government intervention falls into place again, "at a minimum, some form of regulation of who is allowed to practise medicine; at a maximum, much fuller state involvement" (EMMERSON; FRAYNE; GOODMAN, 2000, p. 16).

Nonetheless, regulation can also be used to control a practise known as 'adverse selection', which occurs when neither the insurer nor the consumer knows enough about the risks of needing treatment. In other words, the future health of the consumer is a mystery to both parties, and so the insurance company will charge an average premium. However, those who are at lower risk of becoming ill, like those in their 20s-30s, may not consider this to be good value for money as opposed to those who are at higher risk of becoming ill.

As a consequence, "it will tend to mean that gaps in the market will appear as insurance providers try to avoid losing all their low-risk customers by refusing to cover those they can identify as being at highest risk" (EMMERSON; FRAYNE; GOODMAN, 2000, p. 17).

Therefore:

> Such problems provide the case for government intervention to prevent these kind of coverage gaps arising. At a minimum, this could involve regulation making coverage compulsory for all — preventing low risks dropping out and higher risks being refused coverage. Alternatively, it could involve a range of social interventions, from socially provided insurance to full public provision funded from taxation. Alternative private market solutions that have evolved as a response to such problems include employer-provided insurance, where risks are pooled across a range of employees. However, these schemes do not cover those who are not in work, such as the elderly, for whom gaps in coverage are most likely to arise (EMMERSON; FRAYNE; GOODMAN, 2000. p. 17).

Nevertheless, the private insurance market will always be subject to ‘moral hazard’, whereby insured consumers are more likely to visit doctors and take less care in becoming ill if they are insured. Therefore, “so long as the resulting condition is not expected to be too unpleasant, an insured person might take less care to prevent illness or injury or might visit their doctor more than they would in the absence of insurance” (EMMERSON; FRAYNE; GOODMAN, 2000, p. 18).

Overall, these are not the most equitable forms of overcoming healthcare coverage, and many healthcare systems have responded to the private healthcare markets, ranging from the predominantly market-based system in the US, which will be discussed in the next chapter, to the systems based on the Social Security model, such as Germany and Canada, to the universal tax-based systems such as the United Kingdom and Brazil.

Before the 21st century, about 10 million people in the UK were covered by private insurance, either employer-based or privately purchased. The people who sought private insurance were mostly employed people with families, mainly purchasing elective treatment and palliative care services (JAMES, 2001, p. 462).

According to Doyle (2000, p. 563), “the structured health insurance sector initially developed between 1940 and 1947 with the instigation of the London based Hospital Services Plan (now PPP Healthcare) and the amalgamation of several regional schemes into British United Provident Association (BUPA)”. This was before the UK had created the NHS in 1948.

Furthermore, in addition to Public Health financing, in the year 2000, “about two thirds of private medical insurance policies are paid for by employers, and one third are paid by individuals” (DOYLE, 2000, p. 563). This is similar to other countries data, like Brazil and the United States, whereby employers and employees finance a large part of the health system in order to provide health coverage. It is important to remember that it is in the employer’s interest that the employee has adequate access to health services in order to stay healthy enough to provide labour services.

Health care before the NHS was provided in many different ways:

> Before the NHS was set up in 1948 health care was provided by charities and voluntary hospitals, private medical clubs, occupational medical services and works clubs, fee for service insurance, friendly societies, public medical services (which were funded by subscription), and medical fees paid on an ad hoc basis (DOYLE, 2000, p. 563).

Since the creation of the NHS the private sector has viewed itself as complementary to the NHS. Like any universal health care system, if one has additional private care, one is still entitled to use the NHS. However, there is guidance for those who pay for additional private care, as they cannot be asked to pay towards NHS care, except where legislation allows charges, such as prescription charges (NHS, 2022).

In addition, the NHS cannot pay for or subsidise private hospital treatment, and there must be a clear distinction between one's private treatment and NHS treatment. Furthermore, one's position on an NHS waiting list should not be affected if one decides to have a private consultation (NHS, 2022).

When the NHS asks that patient's private treatment be separated from the NHS treatment, this means that one should receive their private care at a different time and place from their NHS treatment; this means that their care should be provided in separate buildings. However, if an NHS organisation also provides private care, this should be in a private room in a different part of the building or at a clinic run after NHS hours.

Moreover, “occasionally, a patient's doctor may agree they can receive their NHS and private treatment in the same place – for example, if the doctor decides the patient is too ill to be moved” (NHS, 2022).

On receiving private and NHS care at the same time, this means that it is not possible to join or divide different parts of the treatment between private and NHS care.

The NHS gives a good example of this:

> For example, you cannot have a cataract operation on the NHS and pay privately for special lens implants that are only normally available as part of private care. Instead, you either have to have both the operation on the NHS and standard NHS lens implants or pay for both the operation and implants privately. You should not need to have any of the same tests twice – for example, to diagnose or monitor your condition. In this case, the test will

> probably be part of your NHS care and the result will be shared with your private care provider if necessary (NHS, 2022).

One of the forms of privately funded health care is known as out-of-pocket spending, which in the UK, medication can be used as an example, as most prescription drugs are not covered by the NHS in England. A study on the effectiveness of the NHS in comparison to other developed countries found that:

> A breakdown of out-of-pocket spending by category suggests that the largest proportion went on pharmaceuticals, which in the UK accounted for a higher share of spending (42%) than in most countries. This may be due to prescription charges being one of the few areas where patients pay directly for NHS services, albeit only in England. Despite this, UK households spend a lower share of income on pharmaceuticals (0.6%) than all of the countries we compared except France and Germany (both 0.5%) and only half of the share spent in Australia, Sweden, and Spain (all 1.2%) (DAYAN; WARD; GARDENER; KELLY, 2018, p. 23).

As shown above, out-of-pocket spending on prescription drugs in the UK was one of the lowest in comparison to other countries, only losing to France and Germany. The issue with out-of-pocket spending is that it generally causes a strain on family’s income, causing financial hardship and eventually leading to poverty (DAYAN; WARD; GARDENER; KELLY, 2018, p. 22-23).

Furthermore, the UK seems to do rather well when it comes to comparing household incomes spent on health in different countries, with the UK being one of the nations which offers the most financial security:

> According to the World Bank, people in the UK were the least likely of all our comparison countries to spend more than a tenth of their income on the out-of-pocket costs of health problems […] The World Bank also looked at how many people had to pay more than a quarter of their income in health care charges. Again, the UK showed the highest degree of financial protection, with only 0.5% of people paying this amount. By contrast, in Portugal, 18.4% of the population spent more than 10% and 3.3% spent more than 25% (DAYAN; WARD; GARDENER; KELLY, 2018, p. 23).

Therefore, out-of-pocket spending does not seem to be common in the UK in comparison to other countries, except for when it comes to prescription drugs not covered by the NHS in England. As long as the user is a UK resident, they will not be expected to pay out-of-pocket for any general practice or hospital care through the NHS. However, “in England, Wales and Northern Ireland, only people who have both relatively serious needs and little money are eligible for state support for these services, which include residential care and help with everyday tasks for older people" (DAYAN; WARD; GARDENER; KELLY, 2018, p. 24).

According to The Guardian (DUCAN; CAMPBELL, 2022), "one in eight UK adults using private medical care due to NHS delays". In addition, "patients said delays had made their illness worse, with 20% currently waiting for an appointment, test or treatment". This is recent news that worries the nation, as this growth for private insurance has not been seen before. This is being seen as a consequence of the NHS post-pandemic crisis which has overwhelmed the NHS. With this scenario, if Britain does not overcome its crisis, it will soon leave its universal model and drift towards the American model, as Brazil has.

A former study on waiting times for emergency treatment by Dayan, Ward, Gardener, and Kelly (2018, p. 25) found that in 2018, "88% of people in the UK reported having been treated within four hours, a roughly average performance", and that "the data for the UK is broadly in line with NHS figures on how many people are admitted or discharged from A&E[8] within four hours – currently at around 88% in England and Scotland", whereas "the equivalent figures for Wales and Northern Ireland are 80% and 65% respectively". This data from 2018 before the NHS pandemic crisis in 2019 suggests an average normal waiting time for emergency services.

Moreover, waiting times for scheduled appointments considered not urgent were researched in a survey by The Commonwealth Fund (2016) and found that, "around half of people in the UK said they were treated within a month, similar to the average in other countries", however, "people in the UK were somewhat more likely to say they had to wait more than four months" (DAYAN; WARD; GARDENER; KELLY, 2018, p. 25). This waiting time is for specialised care or treatment, and the waiting times for the UK is an average of the other nations in the study.

The next chapter will take a similar path as this one, however, it will cover the Brazilian healthcare system, mainly the Public Health system, but also outline private healthcare, in order to have an idea of the healthcare system as a whole.

---

[8] A&E = Ambulance and Emergency.

2. THE RIGHT TO HEALTH THROUGH THE BRAZILIAN HEALTHCARE SYSTEM

The Brazilian health system is a universal one composed of Public Health institutions distributed throughout the national territory that operate based on the principles of universality, equity, and completeness, organised in a hierarchical and regionalised manner, composing the levels of Primary Care, secondary and tertiary care, in order to offer disease prevention actions, health promotion and protection, healing and rehabilitation.

For the SUS to be able to function properly, in accordance with its doctrinal and organisational principles, it is necessary that there be three divisions of administration, these being the municipal, state, and federal divisions. In addition, the systems structure includes health councils and committees, which means that the SUS establishes participatory administration.

At the municipal level, the Health and Social Care Department or the Town Hall, managed by the Health Secretary or the Mayor of the respective country deals with the systems administration, and responsibilities at the local level include programming, executing, and evaluating health promotion, protection and recovery actions and managing health facilities, such as test laboratories and blood centres, among others.

At the state level, a similar dynamic occurs, whereby there is a Department of health and Social Care and a Health Secretary, however, the responsibilities are greater, and include organising health promotion programs in the state, managing specific local and regional needs and executing matters in which towns are unable to do so. The funding for the towns is allocated by the state according to the population and specific needs of each town.

The last and main level is the federal one, in which the Ministry of Health, administered by the Minister of Health, must lead the set of actions for the promotion, protection and recovery of health, identifying risks and needs in the different regions, in addition to the control and supervision of health procedures, products and substances of interest to health, like medicines, for example.

Moreover, the SUS’s funding is public, and comes from federal, state, and municipal taxes and Social Security contributions. In addition, a subsystem of private institutions also integrates the system, known as complementary health, for the provision of services, through the establishment of public contracts and agreements.

However, the financing of the Brazilian health system as a whole, that is, not considering only the SUS, is mixed, and depends on supplementary health, which is a market of private health insurance providers, financed by families, as well as private employers.

This chapter will outline the right to health through the Brazilian Constitution, the formation of the SUS and its founding principles, as well as the financing and spending of healthcare and the complementary and supplementary health of the healthcare system.

2.1. The right to health in the context of the Brazilian Constitution

In order to understand the evolution of the right to health in Brazil, it is necessary to highlight its timid appearance in previous Brazilian Constitutional Charters, as it was only in the 1988 Constitution that the right to health actually gains confidence and appears in various moments of the constitutional text.

The 1824 Constitution made the first mention of the right to health, in its Article 179, Item XXIV, in the sense of protecting the worker, so that no work activity could harm the health of the worker. In the same sense, the 1934 Constitution, a decade later, in its Article 121, Paragraph 1, “h”, also mentioned health as protection for the worker, guaranteeing medical and sanitary assistance (SILVA, 2016, p. 11). It can be seen that the first mentions of the right in question were related to health care for workers in the work environment.

Still in the 1934 Constitution, in its article 10, item II, there is an advance in the sense of entrusting care and public assistance to the Federal Government and the states. However, it was the 1937 Constitution that showed progress in health protection, in its Article 16, Item XXVII, regarding the competence of the Federal Government to legislate on fundamental norms for the defence and protection of health (SILVA, 2016, p. 11).

It is important to highlight that in the same Constitution there was mention of the ‘*casas de saúde*’ or ‘health houses’, which would delegate competence to the states in the absence of a federal law on these health institutions. Therefore, “the so-called ‘health houses’ were considered as private entities that provided ‘luxury hospitalization’, which was still a reality of little accessibility to the population at the time, due to its commercial nature, thus being the first institutions for profit, that is, of private nature” (YAMADA, 2018, p. 04).

In this sense, there were no relevant advances in the Brazilian Constitutions not mentioned in this topic. Therefore, before the 1988 Constitution, there was no significant evolution towards guaranteeing the right to health in Brazil, that is, people who did not fulfil the requirements demanded by public entities in order to have access to health were dependent on the private sector. Thus, “access to health services in Brazil were restricted to formal workers and those who could pay for care. The others were left with Public Health, whose performance was restricted to targeted preventive actions” (SILVA; BEZERRA; TANAKA, 2012, p. 250). However, with the 1988 Constitution, health is no longer a moral value and becomes an obligation of the State.

With regard to the classification of the right to health in the present Constitution of 1988, immediate effects apply in accordance with Article 5, Paragraph 1, as it is considered a fundamental right. Moreover, it is a second dimensional right, as it is a social right provided for in Article 6, which lists social rights.

Thus, it is important to highlight the role of the State regarding social rights:

> Social rights are included among second-generation fundamental rights, demanding positive action from the public authorities, as an indispensable measure so that the constitutional norms that enshrine them can fully trigger the effects desired by the original constituent legislator, essentially, the provision of minimum material conditions for the poor. *[translated by the author]* (MOTTA, 2021, p. 412).

It is important to comment that there was historical incompatibility with Brazilian society in the 1980s and the 1988 Constitution:

> It is about the fact that our Constitution was idealised and made in a moment of democratic rescue and recovery of social guidelines, in a certain way in an environment of political euphoria, which resulted in the formal implementation of many rights and guarantees, as well as in guidelines, conceptions and principles, somewhat “strange” to the historical moment, and of institutional and cultural maturity that Brazilian society was experiencing in 1988. *[translated by the author]* (SENA, 2007, p. 372).

Therefore, there was not the necessary social and cultural maturity at the time of the enactment of the Constitution and all the social rights that came with it, to provide the basis for the achievement of these rights, in particular for the eradication of poverty and social inequality, one of the main goals listed in the Constitution, and which could be achieved through the right to health (SENA, 2007, p. 372).

In Article 196 of the Constitution, health is presented as a right of all Brazilian nationals and foreigners in the country and a duty of the State. Thus, the State must provide health services to individuals through Public Health policies, in order to materialize this fundamental right and guarantee the universal access to health, preserving the principle of equality.

However, even with the enactment of the 1988 Constitution and the right to health guaranteed by it, according to Silva, Bezerra & Tanaka (2012, p. 249), “although declared as a constitutional right, the Brazilian population faces several challenges to have health guaranteed by the State” - these challenges will be explored in the course of the study.

In this sense, it is important to understand the principle of completeness, which aims at full health care for each individual, according to their individual needs, and not generic care for the population as a whole. Thus, “the principle of completeness represents the awareness of the complexity and needs of each individual, demonstrating that the right to health in Brazil is not restricted to basic services, but must include the essentials for health care with dignity” (SILVA; BEZERRA; TANAKA, 2012, p. 249).

According to the aforementioned principle, the objective would be to offer a type of personalized health care to each user of the Public Health system, as a means of guaranteeing the principle of human dignity. Thus, the State would not only fulfil its duty to guarantee access and the right to health, but it would also go further. Overall, with guaranteed access to health and provision of health services, it is possible to think about the principle of completeness.

It is important to emphasize that, with the creation of the 1988 Constitution, with all its fundamental and social rights, it became known as the ‘Citizens Constitution’. In this context, it is worth thinking about citizenship and its relationship with the right to health, more specifically the participation of citizens in the process of achieving their right and the challenges that come with it.

On this note:

> This was intended to broaden the concept of citizenship, qualifying the Brazilian people as citizens, and thus enabling their participation in the political decision-making process. However, in the face of so many proposed reforms and amendments aimed at reducing guarantees that would enable greater participation by the people, it is difficult to perceive this desired increase in citizenship in the country. The limited exercise of citizenship is also influenced by the population's restricted perception of their instituted rights. An ambiguous relationship is established between citizens and the government: rights are seen as a favour in exchange for which gratitude and loyalty are owed, resulting in a passive and receptive citizenship, rather than an active and demanding one. *[translated by the author]* (SILVA; BEZERRA; TANAKA, 2012, p. 250).

It can be said, then, that the enactment of the 1988 Constitution was an achievement for the Brazilian people, however, it does not fully guarantee the constituted rights and duties therein. As seen above, citizens should preferably participate in the political decision-making process, especially when it comes to health and social care. However, social, and economic inequalities in Brazil hinder this social participation and even the interest of individuals on the subject.

Thus, according to Silva, Bezerra & Tanaka (2012, p. 251) in their study on the challenges of guaranteeing the principle of completeness, they concluded that the Public Health policies that caused more pressure from middle-class social groups, obtained improvement and quality in the provision of services:

> The participation of individuals in the process of claiming rights is fundamental for the implementation of the SUS, however, the existing social and economic inequality differentiates the forms of organization for the conquest of rights. This is what happens, for example, in the segmented health system in the United States, where the public sector is organized into two systems: Medicaid, exclusively for the poorest, and Medicare, intended for elderly people from different social classes. The qualitative differences between them are quite significant. The first has worse quality compared to the second, since the latter is more susceptible to pressure from more organized social groups, especially middle-class segments. This scope favours the strengthening of demands for improvement in the quality of services *[translated by the author]*.

Overall, social participation is essential in this process of guaranteeing rights enshrined in the Constitution. Article 196 of the Brazilian Constitution emphasizes that health is a right for all and a duty of the State, and that it must provide health services to individuals through Public Health policies, in order to materialize this fundamental right and guarantee access to health universally, preserving the principle of equality. According to Silva, Bezerra & Tanaka (2012, p. 250), “the responsibility of the State for the lives of its citizens is the result of the awareness of social and health problems in the scope of the production and reproduction of Labour power during the Industrial Revolution”.

It is possible to argue that, in reality, Public Health in Brazil is based on ‘selective welfare policy’, and not on ‘universal welfare policy’, since the SUS is unable to offer services to the entire Brazilian population and foreigners residing in the country, and, in reality, is only able to attend to those in need, while a large part of society is forced to contract private health insurance. However, as there is no criterion of need to become a SUS user, the system is classified as universal (CALIENDO, 2009, p. 142).

Taxes can differ in terms of their use in the implementation of public welfare policies as follows regarding state action:

> Taxes are aimed at financing general and universal activities of the State, with payment by everyone in a society. Fees, in turn, are intended to finance specific services, which are enjoyed by individual beneficiaries, but which correspond to public interest services. Social contributions, in turn, are aimed at financing a certain indivisible group, that is, incapable of allowing the individualization of beneficiaries, but which represents a needy sector, as in the case of health (CALIENDO, 2009, p. 143).

With regard to the duties of the State, it is possible to mention the principle of neutrality, which represents, in the legal sphere, the attempt to balance equity and efficiency in the economy, which usually come into conflict, being one of the greatest challenges of the State. Therefore, “the State must implement its policies with a minimum loss to society” (CALIENDO, 2009, p. 103).

Another important principle that the State must consider when fulfilling its duties is the principle of universality, in which fair taxation must reach the maximum of the taxpayer's economic capacity. In this sense, “taxation without limitations, without respect for basic principles (predictability, legality, ability to contribute and fairness) is not the application of justice, but its violation.” (CALIENDO, 2009, p. 109).

Knowing that it is the duty of the State to institute tax impositions as a form of state intervention to guarantee access to health care and social services, it is necessary to deal with the social use of taxes, which aim at the application of taxes for the improvement of the economy and society as a whole. This is known as ‘*extrafiscalidade*’ in Brazilian Tax Law.

Therefore, the ‘*extrafiscalidade*’ of taxes, that is, the tax used in order to obtain positive effects in the economic and social area, go beyond the mere collecting function to cover State expenses, known as taxation (BUFFON, 2010, p. 558). It is found in Article 153, paragraph 3, Item I and in Article 155, paragraph 2, item III, of the Constitution, which establish that the rates of the Goods and Services Tax (GST) will be selective depending on the need of the product, aiming at adapting this tax to the contributory principle.

In order to obtain tax relief for social purposes, the constitutional requirements for granting tax benefits through the reduction of rates and exemptions must be observed. However, it is not possible to consider the contributory principle to its fullness when it comes to tax relief:

> However, these tax benefits cannot entail a total breach of the contributory principle, nor disregard this principle, as this means unjustified discrimination and an unacceptable exclusion of the fundamental duty to pay taxes [solidarity duty]. In this way, the fundamental duty to pay taxes cannot be unjustifiably waived, as this breaks the bonds of solidarity that presuppose citizenship, in its contemporary conception. Being a citizen means having duties – including that of paying taxes – but it also means having rights, especially that of

> demanding that there is no illegitimate waiver, by others, of the main duty of citizenship. *[translated by the author]* (BUFFON, 2010, p. 562-563).

In this sense, for the State to be able to offer a tax relief, the contributory principle must be considered, with the duties of solidarity and paying taxes as a form of citizenship, so that there is no illegitimate relief. Therefore, exemption should not be taken by private and political interests and must be constitutionally justified.

In an analysis of ‘public choices’ by Paulo Caliendo, it is possible to understand political interests and the importance of constitutional foundations by observing James Buchanan's ideas about the ‘rules of the game’. Thus, “the political game is played by rational political agents involved in a political dispute guided by interests. The solution to this dispute is resolved within the scope of an institutional arrangement in which constitutional rules play a fundamental role.” (CALIENDO, 2009, p. 24). Therefore, the choice of tax immunity must be constitutional.

With regard to tax immunity and fundamental social rights:

> The recognition of society's complementary action in the implementation of fundamental social rights must correspond to a positive action by the State in encouraging social self-organization through the implementation of benefits through the implementation of tax immunities, exemptions, and tax incentives. The recognition of the omnipotence of the State in promoting social well-being, as well as the necessary commitment to the realization of fundamental social rights, encourages the recognition of funding of fundamental rights through a complex and complementary tax system, with the use of tax immunities and exemptions *[translated by the author]* (CALIENDO, 2009, p. 149).

As for the right to health, there could be a reduction or total exemption of the tax burden on medicines and health services considered ‘essential’, as well as in relation to income tax, whereby expenses with medicines should be admitted as deductible, especially since it goes against the contributory principle.

In addition, the exemptions in favour of entities that offer protection to families, pregnant women, needy children and adolescents, the elderly, and the disabled, do not integrate health, both in the scope of taxes and social security contributions (JARDIM, 2019, p. 117). This is because health does not fit the constitutional definition of social care, in terms of Article 203, Items I to IV of the Constitution, which makes it clear that social care will be provided regardless of the contribution to social security. However, there are understandings contrary to the constitutional definition of social care, which understand that health services provided by hospitals or medical clinics would be entitled to tax exemption (HABER, 2012, p. 54).

On the other hand, the Brazilian Supreme Court understood that the rules for the procedures that give the right to tax exemption provided for in Article 195, paragraph 7 of the Constitution, are those established in Law 12,101 of 2009, which establishes that the absence of a specific certificate called the *Certificado de Entidade Beneficente de Assistência Social (CEBAS)* prevents the entitlement to tax exemption. Therefore, the entitlement to tax exemption relative to social care entities depends on understanding of the requirements of Article 14 of the Brazilian National Tax Statute (BRASIL, 2020).

According to Paulo Caliendo, "studies on the national tax burden demonstrate that in a Democratic State of Law, the tax burden represents the balance between the interests of different social groups, with conflicting views on the tasks of the State and its financing" (CALIENDO, 2009, p. 192). Therefore, the Brazilian tax structure, in theory, should be balanced and preferably have mostly progressive taxes, which does not occur in practice.

The main sources of Public Health revenue are those derived from Goods and Services Tax (GST) and social security contributions. Social security is funded by payroll taxes, often borne by both employers and employees. The respective sources of collection for financing Public Health comprise other revenues, as well as those collected with lotteries, donations, fines, fees, among others (BRASIL, 1991).

The promotion of social security, that is, health and social care and social security, according to Article 194 of the Constitution, are fundamental in income distribution, considering that this sector tends to prioritize the poor. Thus, "the search for ways to finance social security is among the main objectives of consolidating a Social State of Law" (CALIENDO, 2009, p. 192).

To complement this topic on health as a right of all and a duty of the State, it is worth remembering that the activities carried out by the public sector are subject to compliance with constitutional principles, especially those listed in Article 170 of the Economic Order:

> As a natural consequence of such fundamental guidance, it is concluded that any economic activity carried out in Brazil (including those performed by the Public Sector within the scope of state activities) is subject to the purposes and foundations established, naturally, in the constitutional text. In this sense, it can be said that the principles serve as normative-evaluative parameters for the achievement of these purposes and foundations. Some of these principles set out in Article 170 are even principles of the entire legal-constitutional system itself, and not only linked to the economic and financial order (SENA, 2007, p. 375).

The principles of Article 170 are also mentioned in the part of the foundations of the Republic, which are fundamental principles with values superior to the legal system. Therefore, “these higher order values are evaluative parameters (fundamental axiology) intended by the State, within a given legal order” (SENA, 2007, p. 375).

Thus, some can be mentioned on this occasion, being national sovereignty (Article 1, Item II, and Article 170, Item I), the reduction of regional and social inequalities (Article 3, Item III, and Article 170, Item VII), as well as economic competition and enterprise (Article 1, Item IV, and Article 170). The most relevant principle for this study on Public Health, is stated in Article 170, Item VII, which implies the reduction of social and regional inequalities.

Overall, it is emphasized that the State must comply with its duty to reduce social and regional inequalities through various sectors, including those of a social nature, such as education, food, and even health. However, “principles - it should be noted - are legal norms that impose a must-be.” (SENA, 2007, p. 376).

In addition, Article 174, Paragraph I, of the Constitution should be studied, which deals with state economic activity and the State's obligation to supervise, encourage, and plan these activities, *ipsis litteris*:

> Art. 174. As a normative and regulatory agent of economic activity, the State will exercise, under the terms of the Law, the functions of supervision, incentive, and planning, this being compulsory for the public sector and implied for the private sector. § 1 The Law shall establish the guidelines and bases for balanced national development planning, which shall incorporate and make compatible national and regional development plans. *[translated by the author]*.[9]

As noted, the State has the obligation to interact and intervene in the economy in order to comply with the Constitution, having, therefore, regulatory, and standardizing activity, with the purpose of guaranteeing development through balanced planning; this is the main role of the State regarding its constitutional duties.

As a definition of State planning, we have:

> The idea of a State planning function is related to the understanding that the State can and must select, among the various options and possible faculties, mechanisms and guidelines for public actions aimed at a given intended

---

[9] *“Art. 174. Como agente normativo e regulador da atividade econômica, o Estado exercerá, na forma da lei, as funções de fiscalização, incentivo e planejamento, sendo este determinante para o setor público e indicativo para o setor privado.” (BRASIL, 1988). § 1º A lei estabelecerá as diretrizes e bases do planejamento do desenvolvimento nacional equilibrado, o qual incorporará e compatibilizará os planos nacionais e regionais de desenvolvimento.”.*

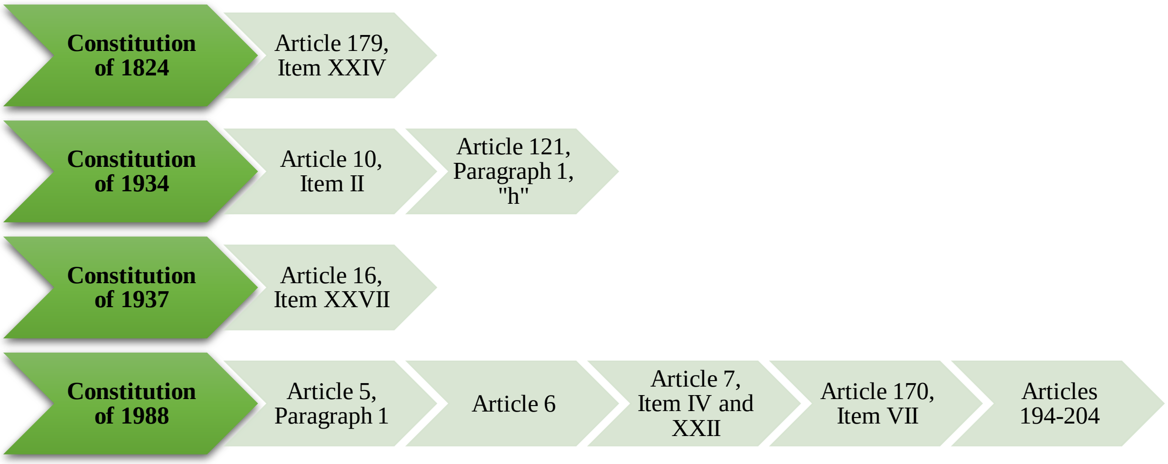
> objective. From this 'selection' of ideas and attitudes arises the idea that there will previously be an identification of what to do and how to do it. This is called planning. Planning means 'detailing' or, better yet, establishing what to do, when to do it and how to do it. The idea of planning comes from the very understanding of public efficiency *[translated by the author]* (SENA, 2007, p. 381).

In view of the above, it is possible to have an idea of the State's responsibility in encouraging planning aimed at public investment, especially in those situations in which the private sector remains inert and decides not to invest its capital, as, for example, is the case of the SUS, where users generally do not have enough income to cover the costs of the health services used, leaving the State responsible for reimbursing the private sector when complementary health (private sector) is used.

In any case, all parties are benefited, both the State that does not have the conditions to offer appropriate infrastructure to attend to the entire population and resorts to complementary health that helps the SUS, as well as the private sector, which will always earn money for the services provided, taking advantage of public sector's planning decisions. Finally, the users of the system should have their access to health guaranteed with these arrangements.

It can be concluded on this part that the State must act as an agent that encourages and executes planning and socioeconomic development, implementing strategies that make the complementary activity of the private sector based on administrative efficiency and constitutional principles possible, in particular the reduction of regional and social inequalities in the field of Public Health.

Image 2 - The mentions of the right to health and social security in Brazilian Constitutions.



Source: Created by the author.

The next chapter will discuss the formative process of the SUS and its founding principles – many inspired by the NHS universal model. The chapter will mainly outline the Public Health policies related to the formation of the Public Health system.

2.2. The formative process of the SUS and its founding principles

Throughout the history of Brazilian Public Health policies, there have been political, economic, and social transformations. In other words, the historical evolution of Public Health policies is related to the political and socioeconomic evolution of Brazilian society. Thus, Public Health policies can be defined as the set of decisions aimed at improving health, with the State having this commitment to society.

In order to be able to analyse and compare current health, it is essential to understand the main challenges and historical achievements related to health that have occurred in Brazil over the years, more specifically since the mid-1500s, during Brazil's Colonial Period when the nation still had no means of health care.

During the Colonial Period, between the years 1500 to 1822, natives and Indians depended on natural resources, including plants and herbs, as well as on their own faith and empirical knowledge for basic cures and pain relief, while Portuguese residents in Brazil were attended by physicians who were brought over from Portugal. The arrival of the Portuguese Royal Family boosted the need for basic health care in the city of Rio de Janeiro from 1808 onwards (NETTO; CARNEIRO, 2021, p. 13).

In the Imperial Period, which began with the Proclamation of Independence in 1822 and ended in 1889 with the Proclamation of the Republic, two medical schools were created. The first was the *Colégio Médico-Cirúrgico*, at the *Real Hospital Militar* in the city of Salvador, in the state of Bahia, and the second was the School of Surgery in Rio de Janeiro. These were the only government measures until the Proclamation of the Republic, due to the political organisation at that time, which was centralized and limited to the minimum sanitary control of ships and ports (NETTO; CARNEIRO, 2021, p. 13).

Later, with the arrival of several diseases, such as smallpox, malaria, yellow fever and the bubonic plague, foreign ships did not want to dock in the port of Rio de Janeiro, negatively affecting foreign trade. In this scenario, health became a priority for the government only at the beginning of the 20th century, with the aim of maintaining foreign trade in agriculture. At this time, Public Health policies began to emerge with the objective of the eradication of port diseases (NETTO; CARNEIRO, 2021, p. 13).

In the 1900s, Oswaldo Cruz was appointed General Director of Public Health. With the aim of eradicating the yellow fever epidemic. He instituted the mandatory smallpox vaccine throughout the national territory, through a Federal Law in 1904, which came to cause the Vaccine Revolt due to social dissatisfaction caused by the imposition of the vaccine. Despite the revolt, he was efficient in controlling the epidemic and eradicating yellow fever in Rio de Janeiro. In this sense, “the campaign model has become by far the best as a proposal for intervention in the field of health and social care” (NETTO; CARNEIRO, 2021, p. 14).

During this period, health care was limited to epidemiological control in order to maintain the country's economic interests. What did not exist was health care with an interest in maintaining the health of individuals in general, and, therefore, medical-hospital care depended on charitable and philanthropic entities. For this reason, Mutual Aid Societies were created in the 19th century, whereby people were in favour of better conditions for workers in the 20th century (NETTO; CARNEIRO, 2021, p. 14).

In 1908, the *Instituto Soroterápico Federal* became the *Instituto Oswaldo Cruz*, and, with the death of Oswaldo Cruz in 1917, Carlos Chagas took over the direction, innovating the campaign model through the introduction of propaganda and health education from 1921 onwards. Later, specialized bodies were created to fight specific diseases (tuberculosis, leprosy, venereal diseases), and health activities (child hospital care and industrial hygiene) expanded to other states besides Rio de Janeiro and São Paulo (NETTO; CARNEIRO, 2021, p. 14).

With the arrival of the Rockefeller Foundation in Brazil and its partnership with the Brazilian government from 1923, programs were established to eradicate epidemics, such as the yellow fever and malaria. Then, the Laboratory of the Special Service for the Prophylaxis of Yellow Fever was inaugurated by the Rockefeller Foundation within the Oswaldo Cruz Institute in 1937, currently responsible for 80% of the world production of this immunizer (NETTO; CARNEIRO, 2021, p. 14).

In addition, the Eloy Chaves Law of 1923 was sanctioned, as the initial milestone of social security in Brazil, along with the creation of Retirement and Pension Funds (*Caixas de Aposentadoria e Pensão – CAPs*) for employees of railway companies. However, the initiative depended on the mobilization of workers and the creation of a council composed of representatives of employees and employers, so that it would be possible to provide pensions, retirement, funeral services, and medical services to affiliated workers (NETTO; CARNEIRO, 2021, p 14).

With regard to funding CAPs:

> The State did not participate in the funding of the CAPs, which were maintained by employees (3% of their salaries), by the company (1% of gross income) and by service consumers. The companies themselves collected monthly contributions from all sources of income and deposited them in their CAPs bank account. CAP funding was not enough to build health services (such as hospitals and outpatient clinics) and provide them with equipment and human resources; in this way, they began to hire private health services, which kickstarted the privatisation of health in Brazil *[translated by the author]* (NETTO; CARNEIRO, 2021, p. 14-15).

According to the above, without State assistance to finance the CAPs, it was not possible to use this initiative as the main means of guaranteeing the health of workers, requiring the hiring of private health services, which, consequently, began the privatisation of health in Brazil.

The 1930 to 1945 period was characterised by social changes imposed by the Getúlio Vargas government, such as the Labour Laws Statute (*Consolidação das Leis do Trabalho - CLT*) and the nationalisation of social security. Social security benefits were extended to all workers and the CAPs system was gradually replaced by the Institute of Retirement and Pension (*Instituto de Aposentadoria e Pensão - IAPs*), where workers were divided into professional categories, making the State have administrative control over them (NETTO; CARNEIRO, 2021, p. 14).

Thus:

> The IAPs were created according to the organizational capacity, mobilization, and importance of the professional category, so the benefits and services provided were based on the category. The first institute created was the IAPM (Maritimes), in 1933, followed by the IAPC (Commerce) and the IAPB (Banking), in 1934, among others *[translated by the author]* (NETTO; CARNEIRO, 2021, p. 15).

Therefore, the benefits and services provided by each IAP were different and based on the category, making the new system more aware of the differences and needs of each professional category, being able to offer workers the appropriate benefits and assistance.

On the other hand, State interference in the administration of IAPs, “contributed to crystallize the centralized, bureaucratic and inefficient profile of Brazilian social security policy, to the extent that workers no longer had control over these institutions” (NETTO; CARNEIRO, 2021, p. 15). Despite the administration of the IAPs being the State, the system continued to be financed by employees and employers, and the provision of services remained private. Therefore, the State administered the IAPs but did not finance it, nor offered the provision of services.

In addition, another failure of the IAPs was that the new system only considered registered workers for the purposes of receiving benefits and providing health services. Thus, rural, and informal workers still did not have social security benefits or health care.

With State control and the centralisation of the IAPs, workers began to claim their administrative control. However, the State defended his permanence as administrator of the Institutions. However, "normative disparities between the IAPs contributed to the emergence of claims in favour of a unified and less unequal pension system, thus politicizing the pension issue" (NETTO; CARNEIRO, 2021, p. 15). It is possible to conclude that the new system had flaws, despite being a kind of advance in the field of Public Health policies.

In 1949, the ambulance service (*Serviço de Assistência Médica Domiciliar de Urgência - SAMDU*) was created, maintained by the IAPs and the remaining CAPs. The creation of SAMDU was an achievement for Public Health in terms of health care and universal care, even if limited to emergency cases and still financed by the IAPs (NETTO; CARNEIRO, 2021, p. 15). This ambulance service is known as SAMU today.

The Ministry of Health was created through Law 1,920 of 1953, which divided the Ministry of Education and Health into two. The Ministry of Health became responsible for organizing Public Health and the activities carried out by the National Health Department at the time (NETTO; CARNEIRO, 2021, p. 15). The division of the Ministry of Education and Health allowed the government's social work to be decentralised, giving special attention to education and health separately, which are two essential elements for the social development of a nation, in addition to being distinct.

The Social Security Law (*Lei Orgânica da Previdência Social - LOPS*) of 1960 was sanctioned, under civil pressure for medical care through institutes and medical-hospital complexes to provide care to public social security workers (NETTO; CARNEIRO, 2021, p. 15). The Law proposed standardizing the benefits provided by the IAPs and making social security responsible for the individual medical care of its beneficiaries. However, workers began to participate in the administration of the IAPs less.

With the beginning of the military government in 1964, extremely dictatorial, the social security system was used to gain social support and its legitimacy, guaranteeing its benefits for all workers and their dependents, since IAPs were limited to professional categories and not included medical-hospital assistance. Thus, the IAPs were unified in 1966 into the National

Institute of Social Security (*Instituto Nacional de Previdência Social - INPS*), with every formal worker automatically starting to contribute, generating capitalized financial resources:

> The increase in the contribution base, combined with the economic growth of the 1970s (the so-called Economic Miracle) and the small percentage of retirement and pension payments in relation to the total number of contributors, caused the system to accumulate a large volume of financial resources *[translated by the author]* (NETTO; CARNEIRO, 2021, p. 16).

According to Andrade & Andrade (2010, p. 66), about this transition:

> The INPS was the result of the merger of retirement and pension institutes (the so-called IAP) of different organized professional categories (banking, commercial, industrial, among others). INAMPS was responsible for providing health care to its members, which justified the construction of large outpatient and hospital care units, as well as the contracting of private services in large urban centres, where most of its beneficiaries were located *[translated by the author]*.

With the creation of the Rural Worker Assistance Program (*Programa de Assistência ao Trabalhador Rural - PRORURAL*) in the 1970s, which earmarked specific funds for the maintenance of the Rural Worker Assistance Fund (*Fundo de Assistência ao Trabalhador Rural - FUNRURAL*), other professional categories began to become beneficiaries of the social security system. In this sense, in 1974, the social security system left the Ministry of Labour and was separated, and became the Ministry of Social Security and Assistance, also creating the Social Development Support Fund (*Fundo de Apoio ao Desenvolvimento Social - FAZ*), which allowed the expansion of private hospitals (NETTO; CARNEIRO, 2021, p. 16).

In addition, the National Health System was established (1975), which established the role of the public and private sectors in promoting, protecting, and recovering health. More specifically, it established that curative medicine would be under the responsibility of the Ministry of Social Security and Assistance, while preventive medicine would be under the responsibility of the Ministry of Health (NETTO; CARNEIRO, 2021, p. 16).

According to Andrade & Andrade (2010, p. 66), regarding the role of the Ministry of Health in relation to the health care provided through the INPS, before the creation of the SUS at that time:

> The Ministry of Health operated only through a few specialized hospitals, in the areas of psychiatry and tuberculosis, in addition to the action developed by the Public Health Special Services Foundation (*Fundação de Serviços Especiais de Saúde Pública - FSESP*) in some specific regions, with emphasis

> on the interior of the North and Northeast. This action, also called medical-hospital assistance, was provided to the portion of the population defined as indigent, by some counties and states and, mainly, by philanthropic institutions. This population had no rights and the assistance they received was voluntary, as charity *[translated by the author]*.

In this way, the INPS transferred resources for health care to the states in proportion to the number of beneficiaries and funds raised. In this sense, “the more developed the state economy, with a greater presence of formal work relationships, the greater the number of beneficiaries and, consequently, the greater the need for resources to guarantee assistance to this population” (ANDRADE; ANDRADE, 2010, p. 66). Thus, the South and Southeast regions always received more financial resources for health.

According to Carvalho (2013, p. 07), the Special Public Health Services (*Serviços Especiais de Saúde Pública - SESP*), which was transformed into the Special Public Health Services Foundation (*Fundação de Serviços Especiais de Saúde Pública - FSESP*), was inspired by funding from the United States and emerged as a solution during the war for workers in the extraction of rubber and manganese.

On this note, regarding FSESP:

> It was the most complete health care program associated with sanitation in the country's history. The proposal was bold. It was, in almost all the places where it was implemented, the only existing health resource, mainly in the North and Northeast regions. Innovation was not only in the intervention proposal, but also in people management. We were already working with a multidisciplinary team within the availability of the time. It was organized from so-called mixed units where Primary Care, emergency and hospital admissions were carried out *[translated by the author]* (CARVALHO, 2013, p. 07).

Despite economic growth and an increase in social security contributions in the early 1970s, the economic model favoured by the military dictatorship entered a crisis in 1975, suffering from unemployment. In addition, the social security health model began to demonstrate:

> [...] inability to serve a growing population of marginalized people (without a formal contract and social security contribution); steadily rising costs of curative medicine; diversion of funds from the social security system to cover expenses in other sectors and execution of works by the Federal Government; collection system dependent on the number of taxpayers *[translated by the author]* (NETTO; CARNEIRO, 2021, p. 16).

As a result of the economic and social crisis, the Sanitary Movement emerged, with the aim of reforming health in Brazil. The main contribution of this movement was the proposal of the SUS as a national health system. Thus, “the Sanitary Reform in Brazil emerged from a social movement that claimed a profound change in the care model until then implemented in the country” (MELO, 2016, p. 09).

Furthermore, according to Silva Bezerra and Tanaka (2012, p. 250), “dissatisfaction with the accumulated neglect of the State, given the precarious living and health conditions of the population, resulted in the health reform movement in the 1970s, created in a context of social and political resistance to the authoritarian regime”. As a complement, the Brazilian Health Centre (*Centro Brasileiro de Saúde - CEBES*), founded in 1976, organized the Sanitary Reform and formed the Brazilian Association of Postgraduate Studies in Health and Social Care (*Associação Brasileira de Pós-Graduação em Saúde Coletiva - ABRASCO*).

Meanwhile, the military government allocated its resources to meet the need to expand the medical system, directing resources to the private sector, establishing agreements and contracts with physicians and hospitals. Soon, a medical-industrial system was formed, leading to the creation of the National Institute of Medical Assistance of Social Security (*Instituto Nacional de Assistência Médica da Previdência Social - INAMPS*) in 1978, where payments were made for services provided, making fraud easier. As a measure to combat fraud, the government created the Advisory Council for Social Security Administration (*Conselho Consultivo de Administração da Saúde Previdenciária - CONASP*), linked to the INAMPS, in 1981 (NETTO; CARNEIRO, 2021, p. 16).

In addition, in order to control public spending in the health sector, it created the Hospitalisation Authorization (*Autorização de Internação Hospitalar - AIH*), eliminating the transfer of funds to written hospitalisations. Thus, for each hospitalized patient, an AIH was issued, through which the hospitalisation would be paid to the hospital. Thus, the government began to control the private sector and the hospital began to reduce the length of stay of patients to free up beds and be able to issue more AIHs (NETTO; CARNEIRO, 2021, p. 17).

Another government strategy was the transfer of attributions and responsibilities from the federal level to the states and counties with the creation of Integrated Health Actions (*Ações Integradas de Saúde - AISs*), which became responsible for the individual medical care of the social security population.

According to Melo (2016, p. 08):

> In 1982, the PAIS – Integrated Health Actions Program was implemented, which emphasized Primary Care and had programmatic points that would be present in the SUS. It aimed, therefore, at the integration of Public Health institutions maintained by the different levels of government, in a regionalized and hierarchical network. Furthermore, its purpose was to create referral and counter-referral systems and assign priority to the Public Health services network, with complementation by the private network, after its full use; in the same sense, it also provided for the decentralization of resource management *[translated by the author]*.

With the New Republic, there was the expansion of AISs in 1985, and then, in 1986, the 8th National Health Conference, considered the most crucial moment of the Brazilian Sanitary Reform, where the concept of health as a citizen's right was approved and duty of the State, and the foundations of the Unified Decentralized Health System (*Sistema Único Descentralizado de Saúde - SUDS*) were created; these changes established the basis for the subsequent construction of the Unified Health System (SUS).

In other words:

> The Sanitary Reform Movement that resulted in the National Health Conference of 1986 proposed the unification of the health system and the universalization of its services, contrary to what the old regime for providing medical assistance, INAMPS, predicted. Through this institute, citizens would only enjoy the right to provide health services if they proved their status as insured. The breadth of coverage was still restricted to social security contributions *[translated by the author]* (MELO, 2016, p. 09).

These historical facts occurred concurrently with the election of the National Constituent Assembly in 1986, and the enactment of the Federal Constitution of 1988. Based on the proposals of the 8th National Health Conference, the Constitution established a section on health and in it Articles 196 to 200. More specifically, the SUS is conceived and defined in Article 198 of the Constitution, which emphasizes the following guidelines: decentralization, completeness and social participation.

According to Filho and Oliveira (1990, p. 139), on the Sanitary Reform:

> The formula “Health – A Right of Citizens, Duty of the State”, elaborated within the sanitarian movement and enshrined as a constitutional principle in 1988, admirably summarizes the conception that informed the first Brazilian experience of a universalizing social policy. The Sanitary Reform, notwithstanding its marches and counter marches, configures a pioneering break in the pattern of state intervention in the social field shaped in the 1930s and since then untouched in its essential traits. With it, the notion of a universal social right appears on the Brazilian political scene, understood as an attribute of citizenship without needing to be deserving, which must

> correspond, as a right, not as a concession, to a state action constituting the provision of services that are inherent to it *[translated by the author]*.

According to Carvalho (2013, p. 08-09), several forces contributed to the social struggle until the creation of SUS. Among them, civil movements, universities, progressive political parties, and town halls with progressive intentions. Firstly, among popular movements, it is possible to highlight community associations and churches in poor areas. Mainly, “the politicised citizen of poor neighbourhoods, mainly in Sao Paulo, who had no health coverage and lived with the consequences of being indigent.” (CARVALHO, 2013, p. 08).

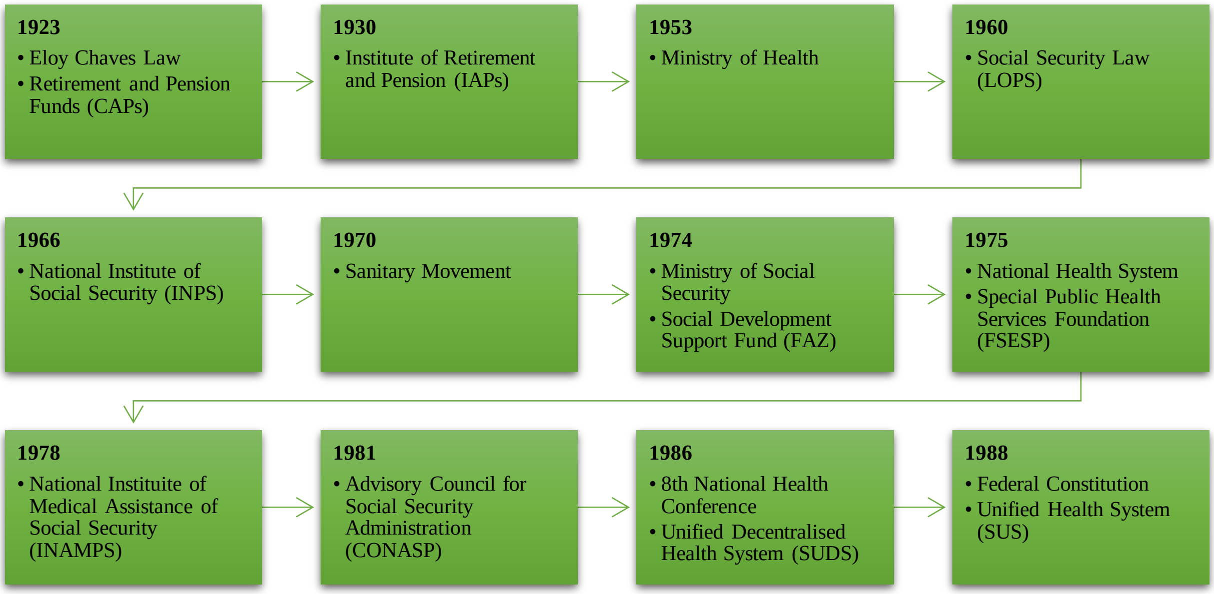
Secondly, medical schools began to place students in practice-oriented outdoor environments beyond hospitals, with universities developing outreach projects and departments of social medicine. This transformation of the medical course began to train professionals more connected with reality and social perspectives (CARVALHO, 2013, p. 08).

With regard to progressive political parties, the MDB party was a strong opposition and was the main resistance against the military dictatorship in the 1970s. Thus, “the MDB party sought to work together with the community on the outskirts of large urban centres and in some town halls” (CARVALHO, 2013, p. 09).

Finally, in relation to ‘progressive’ town halls, counties were more connected with local residents, compared to the states and the Federal Government. For this reason, town halls were more aware of the needs of their towns, and therefore knew about their sanitary issues. However, “Primary Care teams are born in counties, imitating what happened in the world, built by three professionals, mainly: the physician, the nurse and the new category called health agents” (CARVALHO, 2013, p. 09).

With all these political and social forces, including social participation, combined with pressure from social groups and universities, as well as the decentralization of health services through local administration, came the Sanitary Reform, which then brought the creation of the SUS in the current Brazilian Constitution, as we saw in the beginning of this chapter.

Image 6 - A timeline of the formative process of the SUS and social security in Brazil.



Source: Created by the author.

The construction of the SUS is guided by doctrinal and organizational principles established by Law 8,080 of 1990, the three doctrinal principles being: universality, equity, and completeness. The principle of universality refers to the guarantee of access to health for all residents and foreigners in Brazilian territory. This principle is important because, as seen above, only those who contributed to social security had access to the Public Health system.

The equity principle involves a dynamic of treating people unequally, to the limit of their inequalities, with the aim of minimizing disparities between Public Health users. According to Andrade and Andrade (2010, p. 61), “society will be fair when opportunities, wealth and respect are distributed to all equally or unequally when to equalize distortions and benefit the neediest”. A practical example of applying the principle of equity is priority care for the elderly, order of arrival in emergency services based on the severity of each case in emergency care in hospitals; all will be attended to, but the service order is defined according to agreed criteria.

In the first half of the 20th century, with the growth of public policies and health systems, the completeness principle emerged, broadly and significantly for the NHS creation process, which established the principle of collective responsibility for complete and free services for all the population. In Brazil, the completeness principle became part of the Health Reform proposals in the early 1980s (SILVA; BEZERRA; TANAKA, 2012, p. 252).

The Constitution of 1988 presents completeness in the sense of access and articulation of all actions and levels of health care, whether primary, secondary, or tertiary. According to Silva, Bezerra and Tanaka (2012, p. 525), “internationally, this principle seems to be related, above all, to the supply, organization and articulation of health services, in a perspective of complete care”.

In addition, this principle is aimed at the promotion, protection, prevention, and recovery of health. Some examples of promotion are awareness and education campaigns, while some examples of health protection and prevention are epidemiological and health surveillance, vaccinations, basic sanitation, and medical and dental examinations. Furthermore, an example of health recovery would be medical care and emergency care, as well as rehabilitation (NETTO; CARNEIRO, 2021, p. 23).

According to Silva, Bezerra and Tanaka (2012, p. 254), “the British health system, like the Brazilian one, provides universal coverage based on the principles of equity and completeness. The organization of systems through the purchase of services by basic care guarantees complete care for NHS users”.

The organisational principles establish how the SUS should be planned, encompassing the following principles: regionalisation, hierarchy, decentralization, and social participation. The principle of regionalisation arises from the need for the health system to adapt to the different epidemiological profiles in a continental country like Brazil. Therefore, the system is organised differently in each region of the country to meet different needs. (NETTO; CARNEIRO, 2012, p. 23).

It is worth mentioning that this principle of regionalisation is also directly linked to Article 170, item VII of the Constitution, which aims to eradicate regional and social inequalities:

> It is the formal and constitutional objective of the Federative Republic of Brazil to reduce regional and social inequalities, which means that any economic activity in Brazil implemented by the State must necessarily take into account the regional and local peculiarities of each economically considered, aiming at economic balance, throughout the Brazilian territory, either by executive public actions of strategic planning (carried out directly by the State as an encouraging agent), or by the intervening action of the State in the economic field, or within private activity, aiming to encourage the participation of this sector in regions and areas in need of such public policy *[translated by the author]* (SENA, 2007, p. 385).

In this way, every SUS activity, which is an activity implemented by the State, must consider regional and local differences. For example, there are still vaccination campaigns against yellow fever in the state of Amazonas – an endemic disease that covers the Amazon region, but which has been eradicated in the other states.

Moreover, Article 43 of the Constitution can be cited in this context, "for administrative purposes, the State may articulate its action in the same geoeconomic and social complex, aiming at its development and the reduction of regional inequalities" (BRASIL, 1988). However, public health policies, like any other, must be based on the Constitution and intended to provide useful services to society.

The hierarchy principle, linked to the regionalisation principle, by Article 198 of the Constitution, defines that services must be organised and hierarchised into three levels: primary, secondary, and tertiary care. The first level, that is, Primary Care, also known as basic care, must address 85% of the population's health problems, whereas if it is does not, it must be referred to secondary care, with outpatient centres of specialties, emergency care units, or to tertiary care, where hospitals are considered the last resort (NETTO; CARNEIRO, 2021, p. 23).

Nevertheless, decentralisation concerns the redistribution of responsibilities and financial resources for health actions between the levels of government, which are municipal, state, and federal, thus reinforcing municipal power in health administration. This transfer of responsibilities must be based on the constitutional concept of single authority, so that each level of government is autonomous and sovereign in its decisions and activities, provided that the general principles and participation of society are respected (NETTO; CARNEIRO, 2012, p. 24).

In this sense, by the social participation principle, it is understood that the population must participate in social public policies through representative entities, such as, for example, a municipal health council, which represents users, the county, health professionals and providers of services, or a health conference, which defines priorities for health actions. Thus, it is possible to guarantee social participation in the creation of Public Health policies and their execution (NETTO; CARNEIRO, 2012, p. 24).

Furthermore, these organisational principles of the SUS are found in the Federal Constitution, *in verbis*:

> Art. 198. Public Health actions and services are part of a regionalised and hierarchical network and constitute a single system, organized according to the following guidelines: I - decentralisation, with a single direction in each level of government; II - complete care, with priority given to preventive

> activities, without prejudice to assistance services; III - community participation *[translated by the author]*.[10]

Other organisational principle that should be mentioned are the principles of solvability and private sector complementarity. The first refers to the training of the health services provided, so that they must be sufficient to deal with health problems effectively, while the second principle concerns the contracting of private services for when public services are insufficient (NETTO; CARNEIRO, 2012, p. 24).

In the latter case, hiring must take place through the execution of a contract, in accordance with Public Law norms, and the contracted party must comply with the Public Health systems technical principles and standards. Finally, non-profit private services are preferred when it comes to complementing Public Health services, such as voluntary hospitals, as determined by the Constitution, in Article 199, paragraph 1.

Despite the principles of the SUS carved into the Brazilian Constitution, the Public Health system has had difficulties keeping these principles. According to Melo (2016, p. 11), there are several challenges that health administration has gone through to guarantee the effectiveness of the right to health, especially at the municipal level. The issues are, “insufficient resources; the low resolution of the basic network of services; the deficiency in the training of health professionals and the deficiency in the administration of local and regional health”. Therefore, the challenges to guarantee the right to health are present at all levels, especially the municipal one.

Furthermore, it is worth remembering that Article 37 of the Constitution expressly establishes that the Public Administration, both direct and indirect, of any of the Powers of the State, the states, the Federal District, and the counties, must obey the principles of legality, impersonality, morality, publicity, and efficiency in its administration. Again, it seems that the administration cannot always fully guarantee the Constitutions principles, but it works around them to attempt to deliver access to health.

Overall, according to the Ministry of Health (2009), “before 1998, 30 million people had effective access to Public Health services, and with the creation of SUS, it is estimated that 190 million Brazilians were attended to by this health system” (SCHIER; BEREJUK, 2016, p. 266), that is, access to health was significantly expanded between 1998 and 2009, considering

---

[10] *“Art. 198. As ações e serviços públicos de saúde integram uma rede regionalizada e hierarquizada e constituem um sistema único, organizado de acordo com as seguintes diretrizes: I - descentralização, com direção única em cada esfera de governo; II - atendimento integral, com prioridade para as atividades preventivas, sem prejuízo dos serviços assistenciais; III - participação da comunidade.”.*

that the SUS was created in 1990. Therefore, despite difficulties in administration, Brazil is certainly far better off with the Public Health system than without it.

The next part of the chapter will focus on the financing and spending of the SUS which we have explored in this part. Now that the history of the Public Health policies up to the creation of the SUS and its founding principles have been cleared, it is possible to go on to the next part of the study.

2.3. The financing and spending of the SUS

The constitutional provision for SUS funding is found in Article 198 and was initially regulated by Law 8,080 of 1990, which defines the importance of municipal health plans for planning and implementing initiatives in the field of health, and Law 8,142 of 1990, which deals with the conditions for receiving federal funds, both known as the Organic Health Laws.

Article 4 of Law 8,142 of 1990 points out that for counties, states and the Federal District to be able to receive resources, they must have a Health Fund, Health Council, Health Plan, management reports that allow for control, counterpart of resources for health in the respective budget, and a Commission for the elaboration of the Career, Jobs and Salaries Plan (*Plano de Carreira, Cargos e Salários - PCCS*), with an estimated period of two years for its implementation; if the counties and states do not meet the requirements of the Law, the resources are administered by the respective state or the Federal Government.

With the approval of the Constitutional Amendment 29 of 2000 by the National Congress, the financing of the health sector became stable and efficient, as it forced the three levels of government to allocate a portion of their resources to health, sharing responsibility for the financing of the SUS services, as the levels of government are subject to the sanctions of the Tax Responsibility Law (Complementary Law 101 of 2000).

According to the aforementioned Amendment, minimum percentages of health financing were defined for the Federal Government (amount of the previous year in addition to the nominal variation of the Gross Domestic Product (GDP)), the states (12% of Net Current Revenue (NCR), and counties (15% of NCR).

In addition, the Public Health Budget Information System was created in 1999, which was an important tool with regard to public spending, ensuring the expenditure of minimum resources for the promotion of health for the population (MELO, 2016, p. 15). Subsequently, there was a prediction of the inclusion of private services in health planning instruments, in addition to defining the form of organization, planning, assistance and articulation between federal entities, with Decree 7,508 of 2011.

The following year, Complementary Law 141 of 2012 was sanctioned, which established the methodology for distributing Government resources to states and counties. Thus, the Law defined which health expenses could be declared as Actions and Public Services in Health (*Ações e Serviços Públicos em Saúde* - *ASPS*), in addition to establishing the obligation of federal entities to declare and ratify every two months the resources invested in health by the Information System on Public Health Budgets (*Sistema de Informações sobre Orçamentos Públicos em Saúde* - *SIOPS*).

However, in order to receive federal resources, according to Complementary Law 141 of 2012, the federal entities must regularly update the information systems that make up the national information base of the SUS, in addition to having a Health Council established and in regular operation, as well as a Health Fund established by law and categorised as a Public Fund, and, finally, a Health Plan with Annual Health Program (*Plano de Saúde com Programação Anual de Saúde* - *PAS*) and management report submitted to the respective Health Council; these requirements are similar to those of Article 4 of Law 8,142 of 1990 mentioned above.

For a better understanding, it is worth defining a Health Plan, not being the private plan contracted through health insurance providers such as *Unimed*, for example. The Health Plan discussed at this time, according to Netto and Carneiro (2021, p. 26):

> [...] is the instrument that presents the objectives, guidelines, and targets to be met in four years of administration. It must be prepared based on the perception of administration and the interests of society, in addition to having to be approved by the respective Health Council. It is from this plan that the budget proposal must be formulated in each of the system's administration levels *[translated by the author]*.

In this sense, it is important to understand the definition of an Annual Health Program (PAS), linked to the Health Plan and being another indispensable requirement for obtaining financial resources by federal entities:

> [...] it is the instrument that presents how the intentions expressed in the Health Plan should be operationalised. It must contain which actions will be carried out each year, in order to guarantee the achievement of the objectives of the Health Plan, which indicators will be used and the forecast of the use of budgetary resources *[translated by the author]* (NETTO; CARNEIRO, 2021, p. 26).

It is worth emphasizing the importance of the Health Councils, which approve Health Plans and are a fundamental requirement for states and municipalities to receive financial resources for health. Therefore, Law 8,142 of 1990 defines the Health Council and provides for its composition, in its Article 1, Paragraph 2, *in verbis*:

> Art. 1. [...] Paragraph 2. The Health Council, on a permanent and deliberative basis, a unified body composed of government representatives, service providers, health professionals and users, acts in the creation of strategies and in the control of the execution of health policies in the corresponding instance, including economic and financial aspects, whose decisions will be ratified by the legally constituted Head of power in each level of government *[translated by the author]*.[11]

As seen above, the Health Councils have a fundamental role regarding the participation of civil society in the field of health, being composed of health service providers and health professionals and users, contributing to the administrative policy of states and counties. Furthermore, the Health Councils will have their organisation and operating rules defined in their own regulations, approved by the respective council, guaranteeing more autonomy and control.

At the national level, the SUS has the National Council of Health Secretaries (*Conselho Nacional de Secretários de Saúde - CONASS*) and the National Council of Municipal Health Secretaries (*Conselho Nacional de Secretários Municipais de Saúde - CONASEMS*), which are represented on the National Health Council, in accordance with Paragraph 3 of Article 1 of the aforementioned Law.

With these points clarified, the next milestone in the area of the SUS funding was Constitutional Amendment 86 of 2015, which established that the minimum percentage of investment in health for the Government would be 15%. However, with the enactment of Constitutional Amendment 95 of 2016, which established the New Tax Regime within the scope of the Government's Tax Budget and Social Security, the Government's expenses and financial transfers were limited.

This measure limited federal spending on health for 20 years, so that it would now be corrected by inflation in the previous year, and no longer by NCR growth, that is, by the

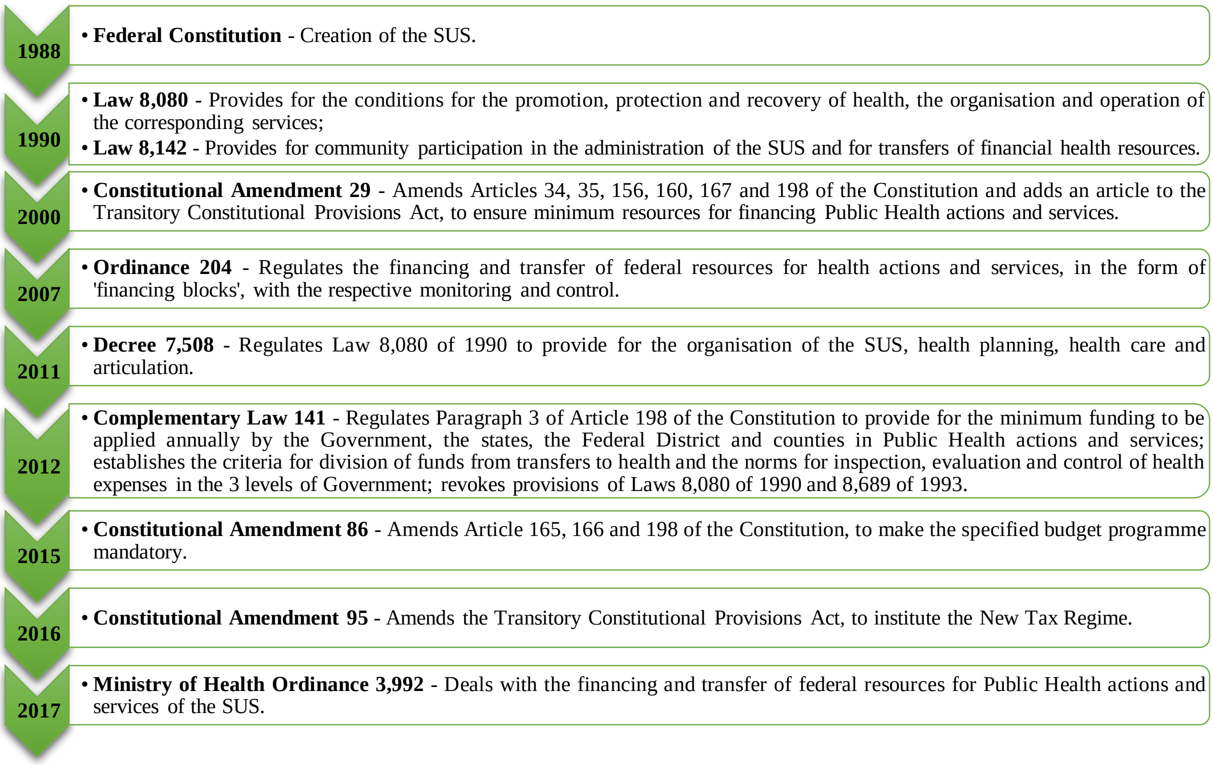
---

[11] *"Art. 1°. [...] § 2° O Conselho de Saúde, em caráter permanente e deliberativo, órgão colegiado composto por representantes do governo, prestadores de serviço, profissionais de saúde e usuários, atua na formulação de estratégias e no controle da execução da política de saúde na instância correspondente, inclusive nos aspectos econômicos e financeiros, cujas decisões serão homologadas pelo chefe do poder legalmente constituído em cada esfera do governo.".*

variation of the Extended National Consumer Price Index (*Índice nacional de Preços ao Consumidor Amplo - IPCA*) (NETTO; CARNEIRO, 2021, p. 26).

The following year, Ministry of Health Ordinance 3,992 was published in 2017, which changed the rules on funding, so that resources transferred to Health Funds, a transfer modality called ‘fund-to-fund’, as resources moved from the federal fund to state and municipal funds, they began to be organised into two financing blocks (BRASIL, 2017b), which will be discussed in the next part of this study.

Image 7 -The main legislative and executive advances in the financing of the SUS.



1988	• **Federal Constitution** - Creation of the SUS.
1990	• **Law 8,080** - Provides for the conditions for the promotion, protection and recovery of health, the organisation and operation of the corresponding services; • **Law 8,142** - Provides for community participation in the administration of the SUS and for transfers of financial health resources.
2000	• **Constitutional Amendment 29** - Amends Articles 34, 35, 156, 160, 167 and 198 of the Constitution and adds an article to the Transitory Constitutional Provisions Act, to ensure minimum resources for financing Public Health actions and services.
2007	• **Ordinance 204** - Regulates the financing and transfer of federal resources for health actions and services, in the form of 'financing blocks', with the respective monitoring and control.
2011	• **Decree 7,508** - Regulates Law 8,080 of 1990 to provide for the organisation of the SUS, health planning, health care and articulation.
2012	• **Complementary Law 141** - Regulates Paragraph 3 of Article 198 of the Constitution to provide for the minimum funding to be applied annually by the Government, the states, the Federal District and counties in Public Health actions and services; establishes the criteria for division of funds from transfers to health and the norms for inspection, evaluation and control of health expenses in the 3 levels of Government; revokes provisions of Laws 8,080 of 1990 and 8,689 of 1993.
2015	• **Constitutional Amendment 86** - Amends Article 165, 166 and 198 of the Constitution, to make the specified budget programme mandatory.
2016	• **Constitutional Amendment 95** - Amends the Transitory Constitutional Provisions Act, to institute the New Tax Regime.
2017	• **Ministry of Health Ordinance 3,992** - Deals with the financing and transfer of federal resources for Public Health actions and services of the SUS.

Source: Created by the author.

The investment and funding of the SUS are made with resources from the three levels of government, that is, there is a single fund called the National Health Fund, whose amount comes mainly from social security and other resources of the Government, contained in the Law of Guidelines Budget, approved annually by the National Congress.

According to Article 31 of Law 8,080 of 1990:

> Art. 31. The social security budget will allocate to the Unified Health System (SUS) according to the estimated revenue, the resources necessary to carry out its purposes, foreseen in a proposal prepared by its national direction, with the

> participation of the Social Security and Social Assistance bodies, bearing in mind the goals and priorities established in the Budgetary Guidelines Law *[translated by the author]*.[12]

Article 198, Paragraph 1 of the Constitution provides that the SUS will be financed, under the terms of article 195, with resources from the social security budget, the Federal Government, the states, the Federal District, and the counties, as well as specific sources of contributions, such as Social Contributions, being the main Contribution for the Financing of Social Security (*Contribuição principal para o Financiamento da Seguridade Social - COFINS*) and the Social Contribution on Net Income (*Contribuição Social sobre o Lucro Líquido - CSLL*).

Other sources of income include, according to Article 32 of Law 8,080 of 1990:

> Art. 32. Resources coming from: I – (Vetoed); II - Services that may be provided without impairing health care; III - help, contributions, and donations; IV - property disposals and capital income; V – fees and fines collected under the Unified Health System (SUS); and VI - possible rents, including commercial and industrial ones *[translated by the author]*.[13]

The resources managed by the Ministry of Health are divided into two parts - one part is retained for investment and funding of federal actions, while the other is passed on to state and municipal health secretaries, according to the needs of each region, considering criteria such as the epidemiological, demographic, socioeconomic, spatial dimensions and the ability to offer health actions and services (NETTO; CARNEIRO, 2021, p. 28).

In each state, the resources transferred by the Ministry of Health are added to those allocated by the state government itself, arising from the collection of its taxes. Of this amount, part is retained to fund state actions and services, while the other is passed on to counties, according to the same previous criteria (NETTO; CARNEIRO, 2021, p. 28).

At the municipal level, its own resources allocated for investment and funding of health actions and the federal resources transferred by the respective state are managed by the Health Fund. Between 2007 and 2017, that is, for 10 years, transfers took place within the ‘financing

---

[12] *“Art. 31. O orçamento da seguridade social destinará ao Sistema Único de Saúde (SUS) de acordo com a receita estimada, os recursos necessários à realização de suas finalidades, previstos em proposta elaborada pela sua direção nacional, com a participação dos órgãos da Previdência Social e da Assistência Social, tendo em vista as metas e prioridades estabelecidas na Lei de Diretrizes Orçamentárias.”.*

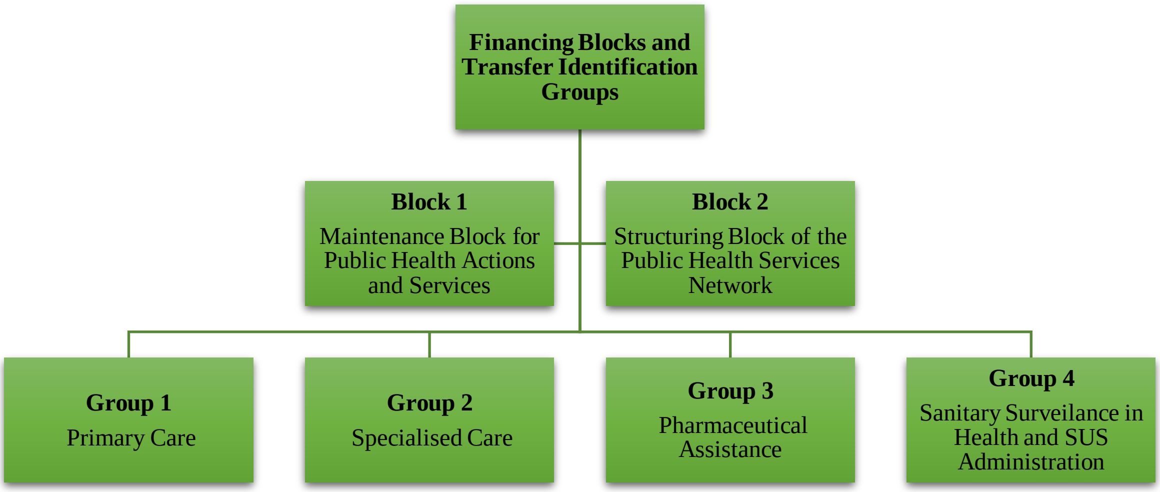
[13] *“Art. 32. São considerados de outras fontes os recursos provenientes de: I – (Vetado); II - Serviços que possam ser prestados sem prejuízo da assistência à saúde; III - ajuda, contribuições, doações e donativos; IV - alienações patrimoniais e rendimentos de capital; V - taxas, multas, emolumentos e preços públicos arrecadados no âmbito do Sistema Único de Saúde (SUS); e, VI - rendas eventuais, inclusive comerciais e industriais.”.*

blocks', with an account linked to each of them, with five funding blocks: 1. Primary Care; 2. Medium and High Complexity Outpatient and Hospital Care; 3. Pharmaceutical Assistance; 4. Sanitary Surveillance in Health and SUS Administration; and 5. Investment.

Ordinance 3,992 of 2017 redefined the form of transferring financial resources to health, reducing the blocks from five to just two, one of which was for funding, which united the first four blocks into just one, therefore, the current first block united Primary Care, Medium and High Complexity Outpatient and Hospital Care, Pharmaceutical Assistance, Sanitary Surveillance in Health, and SUS Administration, and the second current block is still Investment.

More recently, these two blocks had their names changed, according to Ordinance 828 of 2020, and are currently known as the Public Health Actions and Services Maintenance Block, and the Structuring Block of Public Health Services Network. In both blocks, the Transfer Identification Groups are currently: Primary Care, Specialised Care, Pharmaceutical Assistance, Sanitary Surveillance in Health, and SUS Administration.

Image 8 - The blocks and groups of the financing of the SUS.



Source: Created by the author.

With regard to the revenue passed on to health within the scope of the three levels of government, it is up to the Government to allocate a minimum of 15% of current net revenue for each financial year to health, while the states and the Federal District must pass on 12% of tax collection, and counties must allocate 15% of their tax collection.

Furthermore, Article 55 of the Transitory Constitutional Provisions Act must be observed in relation to the amount allocated to health, where it expressly states that 30% of the social security budget will be allocated to the health sector, until another percentage is established in the Annual Budget Law, which can be considered incompatible with the needs of the Public Health service (JARDIM, 2019, p. 44).

Researchers and scholars in the field of law and health report that there are challenges in guaranteeing the right to health through Brazilian public financing. In a study on the completeness of the right to health carried out by Silva, Bezerra and Tanaka (2012, p. 251), it was observed that there are insufficient funds for health, which prevents the guarantee of the principle of completeness, according to the research by Mendes and Marques (2009) at the National Meeting of Political Economy.

Thus:

> Mendes and Marques (2009) present the history of health financing in the post-constitutional period, demonstrating that the problems faced by the sector in the field of financing, notably the lack of resources, make it impossible to carry out a more effective policy. According to the authors, it was from the 1990s onwards that conflicts over financial resources for the implementation of a universal health policy intensified. One aspect that characterizes this conflict is the existence of two contradictory movements in the path of health financing: the ‘construction of universality’ and ‘cost containment’. In the logic of ‘cost containment’, the rights introduced by the Constitution are among the main reasons for imbalances in government accounts. Supporters of this movement propose a reduction in health spending and question the extent of service coverage *[translated by the author]* (SILVA; BEZERRA; TANAKA, 2012, p. 251).

According to the conclusions of 2009, about two decades after the enactment of the Constitution, the scarcity of resources for health remained, preventing the Government from guaranteeing a universal health policy. This, according to them, is due to the ‘construction of universality’ and ‘cost containment’, since the Brazilian State is apparently unable to offer universal healthcare completely free of charge, alongside other constitutional rights, such as free education up to university, among others. Therefore, it is not just the SUS that the State needs to finance.

However, the guarantee of the right to health in its entirety demands financial resources and is subject to the reserve of what is financially possible, which implies a limitation to the guarantee of fundamental social rights in the face of the financial possibilities of the Government (SCHIER; BEREJUK, 2016, p. 261) – this theory will be studied in chapter 3.

Another issue that will be discussed in chapter 3 but is worth mentioning here in terms of its financing, is medication. Ordinance 2 of 2017, presents the division of the list of medicines provided by the SUS into three groups and defines the financing responsibilities between the federal entities. The financing of these medicines is divided between the three levels of Government, however those of greater complexity, with a high financial impact, are acquired centrally by the Ministry of Health, or financed by it, through the transfer of resources to the states (NUNES; QUEMEL; ALEXANDRE et al., 2023, p. 68).

Still on investment in health in Brazil, in a 2015 study by Melo (2016, p. 18), it was found that, according to the ABRASCO, to overcome SUS underfunding with regard to complementary health (private sector), 75% of total health expenditure would be required, in line with the experience in other countries, while in Brazil health expenditure was 42%.

It was concluded that:

> In this sense, 9.7% of the per capita income of families, without considering the payment of taxes, is destined for health, among which 35.8% correspond to the cost of private health plans and 64.2% to direct payment. And in this context, Public Health funding has been below what is proposed by ordinary legislation and the Federal Constitution *[translated by the author]* (MELO, 2016, p. 19).

Still on studies referring to Brazilian spending on health, data from 2017 was presented by Bechara and Costa (2018, p. 11), in comparison with spending in the United Kingdom: “the United Kingdom spends 7 to 8% of GDP on health, while in Brazil, spending is 4% of GDP”. In addition, “according to information from the World Health Organization, Brazil annually spends between 300 and 1,000 dollars per person, while the United Kingdom invests from 1,000 to 5,000 US dollars”.

The conclusions about this data were the following:

> The difference is significant if we consider that the population of the United Kingdom is 64 million people and in Brazil there are more than 207 million inhabitants, that is, more than three times the amount of people, and that almost the entire British population uses the Public Health service; whereas we know that the public service in Brazil is avoided by those who can pay for health insurance *[translated by the author]* (BECHARA; COSTA, 2018, p. 11).

It is interesting to comment that even governments with campaigns focused on socialised public policies in Brazil do not spend enough on health. Regarding data on per capita health expenditures for 2003, which was the first year of President Lula's first term, are as follows:

> It is impossible not to point out that 2003, the first year of the Lula government, was the one in which fewer federal resources were spent on health, working with a per capita value. Above, this is definitely demonstrated: in 1997 it was R$ 294 per inhabitant. In 2003, the first year of the Lula government, it dropped to a minimum level, reaching R$234, and in 2008, R$289 *[translated by the author]* (CARVALHO, 2013, p. 22).

It is important to mention the fact that health education, as well as Primary Care, has a fundamental role in terms of reducing expenses with medium and high complexity medical care, something that the United Kingdom does very well, and that Brazil, despite its efforts, is insufficient at.

In that regard:

> From the details provided in the British system, it can be noted that Primary Care is privileged, with control of the users' medical records, avoiding the use of hospitals, which are known to be crowded with cases of little complexity in the Brazilian system. Health education should also be highlighted. In more developed countries, people are instructed to have preventive care, which is not the attention of local governments. This preventive care undoubtedly reduces the cost and facilitates the control of the type of diseases and Public Health policies *[translated by the author]* (BECHARA; COSTA, 2018, p. 12).

As a source of comparison in relation to health expenditures, the United States, whose supplementary health will be dealt with in chapter four of this study, is the country that spends the most on health compared to the other developed countries of the OECD, but does not have a Public Health system, only health coverage partially covered by the state, with most families and employers financing the health system through private services and insurance.

However, if the USA is considered the country that spends the most on health, spending was even greater under the Bill Clinton Government, whom, “promoted universalisation and emphasis on preventive measures, obtaining support for the approval of The American Health Security Act. During the Clinton administration, health spending consumed between 17 and 18% of GDP, much more than the UK and Brazil combined” (BECHARA; COSTA, 2018, p. 13).[14]

---

[14] Bill Clinton's government lasted 8 years and his mandate was between the years 1993 to 2001.

Regarding health spending, the same study compared the three countries, namely Brazil, the United Kingdom, and the United States, and concluded that although the US health system is mostly private, it is the State that spends the most with health, based on the WHO's data:

> Going back to the WHO's data, the United States of America spends more than 5,000 dollars per person in its health system. Admittedly, the population is over 300 million people, which is almost five times the population of the United Kingdom. However, the per capita expense is not justified if it is considered that the system is basically private, maintained by insurers, companies in favour of their employees, and also by policyholders, who bear high insurance premiums *[translated by the author]* (BECHARA; COSTA, 2018, p. 14).

Nonetheless, not in relation to funding specifically for the SUS, but relevant for raising awareness of the financing of the Brazilian health system as a whole, in addition to the funding for the SUS addressed in this chapter and on supplementary health that will be addressed in chapter four, there are the public servers, civil and military servers and their dependents, such as spouse and children, which is also financed with public resources, as well as by the beneficiaries themselves. As for the financing of independent private health providers with direct access, financing is maintained through direct payment at the point of service (MELO, 2016, p. 12).

With regard to self-employed professionals, according to Silva, Bezerra and Tanaka (2012, p. 254), "another difficulty is the secondary care funding policy based on individual payment for procedures, which leads to serious bottlenecks in the provision of specialised consultations and medium complexity exams". As a result, SUS users face long waiting times to access specialized services, which is a consequence of the financing system and an impediment to access to health in its entirety.

Still on the shortcomings in SUS care, Schier and Berejuk (2016, p. 267) states, "reality presents that the system is not sufficient to provide care as envisioned in the Constitution", because "when resorting to the Public Health system, whether in outpatient clinics or public hospitals, many times they are not attended to, or even, due to the waiting time, the measure becomes ineffective". It remains clear that the system is not able to meet the demand, because if it were, there would not be long waiting periods for medical care and all citizens would be willing to use the system instead of having no choice but to resort to private health insurance.

However, according to Schier and Berejuk (2016, p. 267), "reality has been demonstrating that meeting health needs does not keep up with demand, and this mismatch shows that the constitutional objectives of a just and balanced society are still far from becoming a reality". This scenario is not a surprise or an unprecedented discovery, as Brazilians have been living with this reality for a long time.

According to Silveira and Gaiger (2021, p. 170), the Brazilian model, that is, the mixed funding of the health system will probably continue, as a Health Reform would be necessary to reverse the situation:

> [...] the biggest issue of the Brazilian health system, which is the mixed funding of the public sector, will not be equated. That is, an insignificant share of public spending in total spending will be preserved, considering the level that expenditures have in relation to GDP. [...] Brazil will move further away from the transition that is observed in the evolution of health expenditure as income increases: the increase in its share in GDP is associated with the growth of the public pillar, which becomes dominant, with reduction in direct expenses and moderate increase in the share of expenses with voluntary health plans. In other words, the mixed character of the health system will be reinforced, with the public and private segments having similar importance *[translated by the author]*.

In conclusion, as public funding for health care is insufficient to meet the Constitutional requirements of the SUS and overall Public Health policies, the Brazilian health system will continue to make use of complementary health, that is, the private health sector, in order to attempt to meet the SUS's demands, as well as supplementary health, which is the market of health insurance providers and independent health professionals, financed directly by families and employers in favour of their employees and dependents, as a means of ensuring the maximum level of health care coverage.

In the next part of this chapter, the SUS's complementary health will be explained, as a form of understanding its important role in assisting the SUS to provide adequate health services and better infrastructure when the SUS is unable to do so or is overwhelmed. In addition, supplementary health will also be explained, as it is the third part of the Brazilian healthcare system and prevents the SUS from becoming overwhelmed.

2.4. The complementary and supplementary health of the SUS

The Federal Constitution of 1988 did not grant exclusivity to the State regarding the provision of health services, as it benefits from complementary health, which is the means by which private entities provide health services as an extension of Public Administration, in turn integrating the SUS and being linked to the guidelines and principles of this Public Health system when the provision of services by the State is insufficient.

Therefore, as the needs in healthcare are urgent and constant, and public resources for health are limited, there is a difficulty in guaranteeing this right universally (YAMADA, 2018, p. 07). For this reason, the participation of the private sector through complementary health and supplementary health is essential for the State to be able to guarantee the fundamental right to health.

In other words, the contribution of the private sector tends to be complementary in cases where there is insufficient installed capacity in the public sector in certain areas, according to Article 24 and its sole paragraph of the Organic Law of the SUS 8,080 of 1990:

> Art. 24. When its availability is insufficient to guarantee assistance coverage to the population of a given area, the Unified Health System (SUS) may resort to services offered by the private sector.
>
> Single Paragraph. The complementary participation of private services will be formalised by means of a contract or agreement, observing, in this regard, the norms of Public Law *[translated by the author]*.[15]

The State, in this case, does not explore economic activity, as it does not submit to the same rules and legal regimes as private sector companies competing on equal terms, nor does it explore economic activity through monopolistic means (both permitted by the Constitution).

Sena explains that (2007, p. 19):

> Competitive participation, as seen, comes into existence when the State acts in the economic domain, really supporting the productive segment, or rather, in the private economic scenario itself, as identified by the Federal Constitution in Article 173, which concludes that this action is a direct exploitation of economic activity. As a characterising element of this type of participation, the idea of competition between the State and the other agents of the economic sector in question, within that market under consideration, weighs heavily. Such a constitutional possibility can only exist if, at least, one of the two relevant conditions comes to exist nationally: the so-called 'national security imperatives' or 'relevant collective interest' *[translated by the author]*.

This economic-interventive role of the State does not apply to the case of the SUS, whereby in a complementary way, the private sector assists the Public Health system to offer quality health services, with due reimbursement, and without the State needing to spend more

---

[15] *"Art. 24. Quando as suas disponibilidades forem insuficientes para garantir a cobertura assistencial à população de uma determinada área, o Sistema Único de Saúde (SUS) poderá recorrer aos serviços ofertados pela iniciativa privada. Parágrafo único. A participação complementar dos serviços privados será formalizada mediante contrato ou convênio, observadas, a respeito, as normas de direito público.".*

for the SUS to function. In fact, it would be more costly for the State to invest in more hospitals and beds, in addition to hiring more health professionals, than reimburse the private sector for the services used.

The State and the private sector, in this case, are not equals, as the chosen private health service provider must follow the principles of the SUS and be a non-profit institution, according to Article 25 of the Organic Health Law: “philanthropic and non-profit entities will have preference to participate in the Unified Health System (SUS)”. In addition, as seen in the Single Paragraph of Article 24 of the aforementioned Law, complementary participation in health must observe the rules of Public Law.

Furthermore, Article 26, Paragraph 2 of the Law makes it clear that: “the contracted services will be subject to the technical and administrative norms, principles, and guidelines of the Unified Health System (SUS), maintaining the economic and financial balance of the contract”. Therefore, the contract or agreement entered into with the provider of complementary health services must follow, in addition to Public Law, the principles and guidelines of the SUS.

However, even if there is a condition of ‘relevant collective interest’ in the performance of the State, as the subject is collective health, there is no competition and neither does it aim for profits regarding the provision of health services, and the main purpose of the SUS is access to universal health.

In supplementary health, where there is a large market of private health insurers and self-employed professionals, there is competition and the pursuit of profit. However, even in this case, the private sector that explores economic activity is conditioned to the principle of reducing regional and social inequalities, as this principle is in Article 170 of the Constitution, in the section on the Economic Order; however, the public sector does not participate in this market of health insurers.

With regard to efficiency in providing the State's public service in terms of health, and the private sector as a participatory and supportive agent, this model does not seem to meet the needs of the population, nor does it respect the principle of efficiency in Public Administration. According to Bechara and Costa (2018, p. 15), “considering that efficiency aims at results and performance, as well as a balance between costs and benefits, it does not seem that administration inspired by the private sector is appropriate in all State services, especially in the health sector, which seems like a model to be rethought”. Furthermore, it must be considered that the principle of efficiency is not only aimed at saving and reducing expenses, but also at obtaining the best result with the least possible expenses, respecting the citizens taxes.

Therefore, according to Bechara and Costa (2018, p. 16), “the discourse of efficiency cannot be accepted just to justify the reduction of costs to the detriment of quality in the provision of services”, as well as “the privatising strategies are heading against the public interest”. Thus, the relevant collective interest must prevail, as a way to reduce regional and social inequalities.

Overall, complementary health plays an important part in delivering quality and efficient health services for the Public Health system when it cannot do so alone. It’s role, however, depends on being chosen by local authorities to provide health services without the intention of profit, and the service provider must assist the SUS’s users based on the systems principles and technical guidelines, in addition to following Public Law with local administration. Therefore, the private sector and public sector are not competing equally in the healthcare market.

On the other hand, there is a market composed of health plan operators and self-employed health professionals who also provide health services, known by the Brazilian healthcare system as supplementary health, authorized by Article 199 of the Constitution: “healthcare is economically explorable for the private sector”.

However, health plan operators do not have absolute freedom of action, being subject to supervision and regulation carried out by the National Supplementary Health Agency (*Agência Nacional de Saúde Suplementar - ANS*), created by Law 9,961 of 2000. The agency in question, linked to the Ministry of Health, is responsible for preparing the list of health procedures that should be covered by health providers, in addition to inspecting, regulating, and supervising health insurers.

It is worth remembering that private health insurance emerged in Brazil in the 1950s due to dissatisfaction with the care offered by the social security system at the time, the IAPs, which was partially financed by employees and employers, in addition to of the federal government (MACHADO, 2022, p. 54). Therefore, during this period, supplementary health was born, which was not yet subject to any form of regulation by the State, only to be regulated only in the year 2000, with the creation of the ANS.

The ANS is made up of beneficiaries, operators, and service providers, and currently has 726 healthcare operators and 265 exclusively dental operators, in addition to 174 benefit administrators. According to the ANS (2022, p. 32), “one in four inhabitants has a medical-hospital insurance plan”. Its mission is, “to promote the defence of the public interest in supplementary healthcare, to regulate operators, including their relationships with providers and consumers, and to contribute to the development of health actions in the country" (ANS, 2022, p. 32).

Regarding the growth of the health insurance market, Andrade and Andrade (2010, p. 67) teach that:

> In reaction to the growing power of group medicine, physicians reacted and formed a cooperative work system – *Unimed* – through which they sought to control the sale of medical work to companies interested in providing additional assistance to their employees. With this booming market, other economic agents directly linked to the financial area became interested in the business of selling health plans and created their products: *stricto sensu* health plans and health insurance, in an analogy with American HMO and PPO[16] *[translated by the author]*.

As seen in this chapter, the rapid growth of the supplementary health market in Brazil took place even with the existence of the SUS, as a consequence of the inefficient services provided, that is, the Public Health system has been excluding the middle- and working-class groups that are increasingly seeking private health insurance. Andrade and Andrade (2010, p. 68) state that, "currently, one of the objects of desire of the Brazilian citizen is to have a health plan. A job, nowadays, is valued not only for the value of the salary, but also for the offer of protection of this nature". In other words, one of the main advantages and perks of some jobs is that they offer private health insurance, mostly funded by the employer.

It is important to emphasize that individuals who have a health plan or health insurance are not prohibited from using SUS services, due to the principle of universality of the system. However, there is an obligation for insurers to reimburse the SUS for procedures performed by beneficiaries of private healthcare plans (YAMADA, 2018, p. 13).

Therefore, health in Brazil can be provided in three ways, namely: a) universal Public Health directed by the guidelines and principles established by the SUS; b) complementary health that acts as a third party through a legal entity governed by Public Law with the purpose of assisting the SUS; and, c) supplementary health, which consists of health services provided directly by self-employed health professionals or by operators of private healthcare plans and insurance (PEREIRA, 2020, p. 67).

The importance of supplementary health is given to the fact that the SUS is not able to meet the demands of universal health care alone, that is, in practice the system is not able to attend to all citizens, and those who have private health plans relieve the system. Furthermore,

---

[16] Health Maintenance Organization (HMO); Preferred Provider Organization (PPO).

supplementary health is not the solution for the health system, because, despite market regulation through Law 9,656 of 1998, there are still loopholes for operators to relieve themselves of providing full coverage to their users.

However, the regulation:

> [...] is strongly exclusionary when it creates the figure of pre-existing illness, as well as the deductibles and list of procedures as regulating elements of access to services. These situations, passed as mechanisms of contractual justice, actually function as dams preventing patients from accessing the necessary healthcare *[translated by the author]* (ANDRADE; ANDRADE, 2010, p. 68).

More recently, Law 14,454 of 2022 amended Law 9,656 of 1998, which provides for private healthcare plans and insurance to establish criteria that allow coverage of health tests or treatments that were not included in the list of procedures and supplementary health.

As a solution to the challenges presented, the ANS Strategic Planning 2021-2024 intends to abolish the weaknesses of the supplementary system, with the following objectives in relation to access to health: 1) improve care monitoring and guarantees of access; and 2) expand access to private healthcare plans (ANS, 2022, p. 42-43).

Regarding the first objective mentioned above, the ANS intends to guarantee the beneficiary's access to supplementary health services, through care monitoring and improved access guarantees, to improve the detection of risk of lack of assistance to beneficiaries, promoting an increasingly preventive action by the ANS to preserve access, continuity and quality of healthcare provided to beneficiaries (ANS, 2022, p. 42-43).

With this, the ANS expects an improvement in the access and quality of health care provided to beneficiaries, as well as an improvement in its performance in detecting administrative abnormalities of an assistance nature in the operators and in the assistance monitoring of the sector, in addition to optimising the process with cost reduction (ANS, 2022, p. 42-43).

Regarding the second objective, on expanding access to private healthcare plans, the ANS intends to guarantee consumer access to supplementary health services by easing the contracting of an expanded private healthcare plan. Thus, the Agency hopes to facilitate the contracting of a health plan with more flexibility, in addition to stimulating competition and efficiency in the sector (ANS, 2022, p. 42-43).

According to Andrade and Andrade (2010, p. 68), both the SUS and supplementary health leave their users without complete coverage. The former promises universality and does not deliver, due to lack of financial resources and mismanagement within local administration, whereas the second promises to offer the coverage that the SUS is not able to offer to the rest of the population, more efficiently and with better quality, but it does not deliver either, because if it offered access to all health services, it would not be able to achieve its desired profit and maintain itself as a successful market.

Moreover, the SUS is not ‘single’ (*único*), as it depends on complementary health, as well as supplementary health. The SUS is not universal either, as it is not able to attend to the entire population. In addition, the SUS does not guarantee the right to health in its entirety, failing to fulfil its constitutional duty.

Furthermore:

> The absurdity is greater when the government itself has supplementary health insurance for its employees, passively recognising the inefficiency of the SUS - not ideal, but real - to provide healthcare at least with the quality that its employees desire. Thus, we can conclude that the Brazilian health system, despite what the Federal Constitution says, is not single, neither complete nor universal, as it shares, consensually, space with a supplementary system; it restricts access to notoriously valid treatments and presents an excluding universality *[translated by the author]* (ANDRADE; ANDRADE, 2010, p. 71).

Given the above, the lack of financial resources for Public Health is not a completely plausible justification for the challenges of the SUS, when it is also added to poor management with public policies that encourage supplementary medical assistance with tax incentives (ANDRADE; ANDRADE, 2010, p. 71).

In a comparative study on the reform process of the Brazilian health system in the 1980s, by Faveret and Oliveira (1990), who are researchers from the Federal University of Rio de Janeiro, report that the Sanitary Reform had a ‘more residual than universal’ format, and the middle and upper classes stopped using Public Health and started using supplementary health. According to them, the financing mechanisms that emerged, such as health insurance and group medicine, “provide an increase in the financial autonomy of the private sector in relation to the public sector” (FAVERET; OLIVEIRA, 1990, p. 139).

Furthermore, the researchers concluded that:

> [...] the model of our Sanitary Reform, although inspired by the English system – universal access with predominance of the public sector in the provision of services – has been assuming features similar to the American one, in which the State's action is residual, reaching only those groups unable

> to access private health services through the market *[translated by the author]* (FAVERET; OLIVEIRA, 1990, p. 139).

Years after this study, researchers still believe that the Brazilian health system is increasingly leaving the universal model to approach the American model. According to Bechara and Costa (2018, p. 10), “Brazil is abandoning the constitutional model of universalisation, inspired by the British health system (NHS), with the segmentation model, from which the United States of America is a good example”.

In a 2009 study by Silva, Bezerra, and Tanaka, these same findings about the distancing of the universal health model of the Brazilian Public Health system had already been raised, and, as it can be concluded, they remain relevant and current in 2023. They state that, “despite the advances achieved with the SUS, the scarcity of public resources and the dissemination of certain ideas make the system vulnerable to the risk of distancing itself from its original conception” (SILVA; BEZERRA; TANAKA, 2012, p. 251).

Given these observations, it is worth briefly mentioning the US healthcare system, as researchers have found that the Brazilian health system is becoming more and more similar to it. Thus, the US healthcare is one of the most modern and advanced in the world, however, it is also the most expensive healthcare in the world, whereby the government spending is absurd in comparison to other OECD countries. Surely, the amount of government spending on healthcare should be related to better healthcare, although that does not seem to be the case, as a large part of the population still does not have health coverage (ANDRADE; ANDRADE, 2010, p. 62).

In addition:

> […] rising costs have become an increasingly serious threat not only to the financial security of households, but also to the American economy itself. Relative to its Gross Domestic Product, the US spends more on health care than any other nation. Despite this, they still haven't been able to buy the one thing that health insurance is supposed to provide: efficient health. *[translated by the author]* (ANDRADE; ANDRADE, 2010, p. 63).

Health insurance is a means for financing a person's healthcare expenses and protecting their personal funds when expensive care is required. While the majority of people in the US have private health insurance, primarily through an employer, many others obtain coverage through programs offered by the government. Other individuals do not have health insurance coverage at all and have to pay expenses themselves without a sponsor; this is known as ‘out-of-pocket’ spending.

According to the WHO, “out-of-pocket spending is an inequitable and inefficient way to finance healthcare”. In addition, “globally in 2017, almost one billion people spent more than 10% of their household budgets on healthcare; among them, 290 million spent more than 25% of their budgets on health” (GHEBREYESUS, 2022, p. 67-68).

The Universal Health Coverage (UHC) is based on the 1948 WHO Constitution, “which declares health a fundamental human right and commits to ensuring the highest attainable level of health for all” GHEBREYESUS, 2022, p. 60).

As regards achieving Universal Health Coverage, WHO recommends that:

> Adequate and sustained health financing is a prerequisite for well-functioning health systems and for the achievement of UHC. Sustainable health financing entails having sufficient resources to fund the health system and to protect populations against financial hardship when they use health services. [...] Countries need to adopt strategies that increase resilience in health financing—that is, the ability to respond to health shocks and to safeguard or public spending on health. The countries that do so will be able to achieve the health financing arrangements that are strong enough to set them on the path to UHC (GHEBREYESUS, 2022, p. 67-68).

On the other hand, according to Dayan, Ward, Gardener, and Kelly (2018, p. 21):

> Being ‘covered’ does not necessarily mean that people are fully protected from the financial consequences of ill health. All countries rely to some extent on funding health care services through ‘out-of-pocket’ payments, where patients are required to pay a charge to access health services at the point of use. These charges, and other costs like transport, may cause people to skip consultations with a health professional or fail to take a prescription medicine, having an impact on health which disproportionately affects the poorest.

Furthermore, the Affordable Care Act (ACA) which is the Law regulating Medicare and Medicaid in the US, is somewhat limited in providing access to health because the middle-class citizens, who do not fit into the category of those who are eligible for government funded programmes, as Medicare is for the elderly and Medicaid is for the poorest (ROSENBAUM, p. 132, 2011).

This means that the remaining population are forced to contract a private health insurance plan if they do not have health insurance coverage provided by an employer or have access to health through out-of-pocket funding. Private health insurance plans funded privately are costly and violate the WHO's views that one should have access to healthcare without financial hardship.

In conclusion, United States healthcare system does not seem to be the ideal model of healthcare for a nation, as it does not achieve UHC. Moreover, the Brazilian healthcare system should remain loyal to its original founding principles of the SUS, based on the English universal model which created the NHS and does not rely heavily on supplementary health is recommended by the WHO as a means of achieving UHC and guaranteeing the right to health.

3. THE ROLE OF THE JUDICIARY IN GUARANTEEING THE RIGHT TO HEALTH AND ALTERNATIVE DISPUTE RESOLUTION

This final chapter will discuss the role of the Judicial Power in guaranteeing the right to health, as this work has already explored the role of the Executive and Legislative Powers in the previous chapters. The Judiciary is the Power that is able to guarantee the right to health when the other Powers are unable to do so, whereby an individual can resort to justice to obtain specific healthcare treatments and medications financed by the State.

In theory, this option ought to be the last resort for one to obtain specific healthcare when one is in face of a financial or administrative barrier. However, in Brazil this seems to be a common practice, that is, the phenomenon known as ‘judicialization of health’, in both public and private sectors. For this study, the judicialization of Public Health will be the focus.

As the Brazilian State has a fixed annual budget for health, different from the United Kingdom which has a more flexible budget, these unexpected costs paid directly to individuals personal healthcare needs when judicial battles are lost by the State, puts a heavy financial burden on public expenditure.

In addition, the Judiciary generally has a heavy workload, as it cannot manage so many litigation cases which pile up due to the lack of administrative bodies to deal with healthcare conflicts. In other words, the Judiciary has to solve the consequences of faulty public choice, which is unable to effectively allocate resources and guarantee access to health.

Moreover, as individuals needs are infinite and public resources are limited, the principle of the right to basic conditions of life (*mínimo existencial*) and the German theory of the reserve of the possible (*reserva do possível*) are often used as arguments against State provision of specific medical treatments and medication, especially if it is not provided by the SUS and the plaintiff is able to pay for it.

As seen in the last part of the previous chapter, on supplementary health, the judicialization of health comes largely from lawsuits related to the provision of specific treatments and medication not provided by health insurance operators. However, the main focus of the chapter is to explore the judicialization of health between users and the Public Health providers, such as the SUS and the NHS.

Although the phenomenon of judicialization comes from Brazil, the study uses the success of the United Kingdom in terms of the lack of litigation against the NHS to find a means of mediating the conflicts in faulty Public Health administration which overwhelms the Judiciary by studying the NHS Resolution.

3.1. The role of the Judiciary and judicial activism

In face of the inefficiency of the Executive and Legislative Powers in the provision of the UHC in its integrity, the Judiciary presents itself as the saviour of those who seek for their right to health to be met and guaranteed. As Silva and Gonçalves (2017, p. 18) put it: “the Judiciary Power has, in the past years, taken on the role of the protagonist on the provision of social rights, especially in the practice of judicial activism”.

According to Oliveira, Trovao, and Piacenti (2021, p. 169), on the inefficiency of the representative Powers in the provision of normative measures:

> Judicial orders imposed to the other Powers has been considered the newest cause of judicial activism in the scope of the Supreme Court, whereby the extraction of constitutional principles of concrete measures to be adopted by the Legislative and Executive Powers, especially to those measures where there is the investment of financial resources *[translated by the author]*.

In other words, the Judiciary, as a body that gives the last word and understanding of the law, in order for its application, ends up interfering with the other Powers autonomy, sometimes even disrespecting the principle of the separation of the Powers, many times disregarding its dialogical ability and the objectives of the Federal Republic of Brazil (OLIVEIRA; TROVAO; PIACENTI, 2021, p. 168).

One of the main issues of the Brazilian judicial system is the irresponsibility and inertia of the Legislative Power, which promotes judicial supremacy and triggers the Judiciary to solve constitutional conflicts, as well as those in society in general, mainly of healthcare provision, which is the focus of this chapter (OLIVERIA; TROVAO; PIACENTI, 2021, p. 171).

Oliveira, Trovao, and Piacenti (2021, p. 171) explain judicial supremacy and judicial activism:

> Judicial supremacy presupposes activism, whose opinions are divided regarding support for the movement, but touch on the recognition that the Judiciary should have the last word in the interpretation of laws and the constitutional text. The excess that characterizes activism, in order to be accepted as an interpretative jurisdictional activity resulting from the constitutional role given to the Judiciary, only requires balancing in the performance of judges and courts *[translated by the author]*.

Moreover, judicial activism is considered a contemporary phenomenon that is triggered when the State does not comply with its duties, in particular those relevant to this study, such as guaranteeing the right to health through decent medical services provided by the SUS, only possible through efficient Public Administration.

According to Justice Luís Roberto Barroso (2008, p. 78), "the idea of judicial activism means broader and more intense participation of the Judiciary in the implementation of constitutional values and purposes, with greater interference in the space of action of the other two Powers".

Although judicialization, which is the phenomenon, and judicial activism, which is considered a form of judicialization, go hand in hand, judicialization is a fact resulting from the adopted constitutional model, not representing mere willingness by the interpreter, because judicial activism is an attitude of choosing how to interpret the Constitution by expanding its meaning (BARROSO, 2010, p. 81).

According to Fachin and Schinemann (2018, p. 213):

> Although, at least from the first half of the 2000s, the doctrine has systematically taken a critical position in relation to the effects of the individual judicialization of the right to health, the budgetary impact resulting from decisions of this nature increases every year. In the same sense, the progressive increase of this judicialization indicates that the convictions suffered by the State do not necessarily influence the creation of public policies that are different from the condemnatory jurisdictional provisions *[translated by the author]*.

In other words, mass judicialization does not significantly seem to positively provoke the Executive and Legislative Powers to improve Public Health policies in order to avoid and decrease levels of judicialization, even though public expenditure continues to rise, and individuals generally have to wait long periods of time to have their rights guaranteed.

Fachin and Schinemann (2018, p. 213-214) argue that this happens because there are faults in Brazilian constitutional practice, "as case law does not always consider doctrine, in terms of parameters, possibilities, criteria, and potential of judicial protection, as well as how the Executive does not communicate with case law formation for the formation of public policies". Thus, it is important to emphasize that the three Powers need to improve communication between themselves to find effective solutions for the population.

Fachin and Schinemann (2018, p. 214) believe that the doctrine of 'structuring decisions'[17] could be applied in order to give better rulings. Thus, "judicial rulings are structuring in which, based on a dispute that transcends individual and private interest and, therefore, is of public interest, the restructuring of a certain social organisation or public policy is sought, with the aim of fulfilling socially relevant fundamental rights or interests".

The issue arises when one imagines how one could solve a conflict regarding the provision of constitutional fundamental rights, such as the right to health, particularly when controversial treatments or medication, such as medical cannabis is involved (recently legalised in the state of Sao Paulo through Law 17,618 of 2023). According to Oliveira, Trovao, and Piacenti (2021, p. 172), "the Supreme Court adjudicates for itself (after it is provoked), dictates the last word on a given subject, in order to summon society to stability".

In addition, many cases occur in face of the lack of dialogue between parties. When dialogue is not possible or sufficient, the Judiciary becomes the most sought body to decide on conflicting matters. Thus, "tension arises when giving the last word, which needs to be done with caution in regard to legal and constitutional norms, with the objective of guaranteeing the necessary effectiveness of the Law" (OLIVEIRA; TROVAO; PIACENTI, 2021, p. 172).

The Supreme Court has previously manifested itself with regards to the provision of measures in order to amend constitutional omissions: "The Judiciary, in exceptional situations, may determine that Public Administration adopt measures to ensure rights constitutionally recognised as essential, without this constituting a violation of the principle of the separation of Powers, inserted in Article 2 of the Constitution." (RE 669.635/sc AgR, rel. min. Dias Toffoli, j. 17.03.2015, 2ª T, DJe de 13.04.2015).

In other words, the interference of the Judiciary does not offend the principle of the separation of the Powers when it comes to guaranteeing constitutional rights. Thus, it is completely acceptable and constitutional in this case.

Nonetheless, the last three years has heavily burdened the Judiciary due to the Covid-19 pandemic, especially during 2020 and 2021. According to Oliveira, Trovao, and Piacenti (2021, p. 178), "the Supreme Court revealed that by the 26th of March 2021, it had given 9.500 rulings and had received about 8 million lawsuits related to Covid-19".

This data reflects not only inefficient administration of the pandemic, but also legislative failure, negligence, and politicization of health, especially during the recent pandemic. Thus,

---

[17] "The concept of 'structuring decisions' adopted here is the one developed by the doctrine of the United States from the 1960s onwards, specifically the one proposed by Owen Fiss and Abram Chayes." (FACHIN; SCHINEMANN, 2018, p. 214).

without the Judiciary, citizens would be left to fend for themselves and depend on administrative and State aid.

According to Silva and Gonçalves (2017, p. 22), "the Judiciary has been called to intervene with consistency in favour of the guarantee of rights in face of the control of constitutionality". Thus, the Judiciary has become an active participant in the creation of health policies in the democratic process, especially with its activist role over the fields normally occupied by the Legislative and Executive.

Fachin and Schinemann (2018, p. 223) argue that a notion of structuring decisions of social and economic constitutionalism is present in Latin American countries:

> There is a trend in Latin America and other regions of the Global South for the constitutional jurisdiction to act structurally in cases of violation of economic and social rights, with the aim of fulfilling the promises present in these Constitutions in the face of realities marked by massive violations of unacceptable rights and inequalities *[translated by the author]* (FACHIN; SCHINEMANN, 2018, p. 224).

Needless to say, "these decisions should not only aim at the solution of the specific case (direct material effects), but also indirect and symbolic effects resulting from disputes of this nature" (FACHIN; SCHINEMANN, 2018, p. 224). Therefore, an advanced and modern judicial system is able to analyse each individual case, awarding compensation according to each individual, and not based on fixed amounts, which is common to occur in Brazil and in the UK; more on this will be covered in the last part of this chapter.

Furthermore, decisions should create case law which can be used for other cases efficiently. Thus, the decisions should be detailed and, concerning collective health, should provide solutions and consider the Public Health system with the intention of avoiding future disputes related to the exact same issues, being able to be studied and learnt from.

Moreover, Fachin and Schinemann (2018, p. 226) understand that the current model of judicial protection of fundamental and social rights applied by Brazilian case law is insufficient, and in a comparative perspective, "it is possible to talk about the adoption of structuring decisions as a remedy in the face of repeated state omission". Therefore, how can structuring decisions help the Brazilian constitutional jurisdiction?

Fachin and Schinemann (2018, p. 226) argue that:

> The adoption of structuring decisions in the Brazilian constitutional jurisdiction would allow the restructuring of state institutes, giving meaning to constitutional values, especially from its use as an instrument that hinders

> the continuous and repeated omission of the State in the protection and promotion of rights *[translated by the author]*.

Nonetheless, two principles must be observed when applying structuring decisions in the Brazilian constitutional jurisdiction: subsidiarity and proportionality. Fachin and Schinemann (2018, p. 227) teach that "structuring decisions are an exception to the traditional regime of the separation of the powers and therefore must be seen in a subsidiary way" and that the principle of proportionality should always be considered in any decision-making process, as public money is involved.

Thus, it should be thought of as taxpayers money and not the State's money, as the case "takes place against the Public Power" and "the execution against the Treasury finds satisfaction in public money, the result of tax collection" (FACHIN; SCHINEMANN, 2018, p. 227).

Furthermore, the principle of subsidiarity implies and external aspect which involves the omission of the State and, ultimately, its failure:

> From an external point of view, provisions of this nature are sought only when ordinary political mechanisms repeatedly fail. Notably, when the promotion of rights through public policies coming from the Executive and Legislative branches does not work or when there is a lack of political will to implement them *[translated by the author]* (FACHIN; SCHINEMANN, 2018, p. 227).

Having understood the responsibilities of the State and its role in guaranteeing the fundamental right to health, as well as the issues involving this role, which include judicial activism and judicialization of health, and a possible solution, it is worth verifying the levels of confidence in the Brazilian judicial system, seeing as the population rely on it so much.

A study by FGV (2021, p. 12) called the Confidence in Justice Index in Brazil (*Índice de Confiança na Justiça no Brasil - ICJ*) found that "in 2021, confidence in the Judiciary reached 40%, a level rarely reached in recent surveys by ICJ Brazil", in other words, "four out of ten Brazilians said they trust or rely a lot on the Judiciary". This means that confidence in the Brazilian Judicial system is increasing, despite many issues already mentioned and that will be mentioned in this chapter.

According to FGV (2021, p. 14), the main issue that affects confidence levels in the Judiciary is the delay in the provision of claims. Thus, the institution found that "83% of the interviewees answered that the Judiciary resolves cases slowly or very slowly". Nonetheless, "the cost of access to justice was also mentioned by 77% of participants, and 73% of respondents stated that it is difficult or very difficult to use the Judiciary".

Based on the data presented above, even though there are Public Defenders available to offer judicial advice and representation to those with low income, and despite many other public policy efforts to increase access to justice, 77% of people said access to justice was costly and 73% said it was difficult to access the Judiciary. Therefore, the Judiciary disrespects Article 5, Item XXXV of the Constitution which mentions access to justice as a fundamental right.

In addition, Lima and Aguiar (2022, p. 05) explain that "access to jurisdiction, constitutionally guaranteed as a fundamental right, is understood as one of the possibilities of access to justice provided to the parties involved in legal-sanitary conflicts". Thus, citizens should not have access to justice with financial hardship, nor suffer inaccessibility.

Lima and Aguiar (2022, p. 05) believe that the delay in judicial conflict resolution relating to health cases "triggers a delay in the judgment of claims that deal with extremely delicate subjects and that, due to their peculiar nature and complexity, require maximum attention and analysis". In other words, the Judiciary must resolve claims quickly and effectively, however, due to the overwhelming caused by judicialization, this becomes difficult.

Another important finding from the FGV (2021, p. 14) report was in terms of honesty, competence, and independence levels in view of the population in relation to the Judiciary:

> The poor evaluation of justice also reflects the dimensions of honesty, competence, and independence. In 2021, 70% of those interviewed considered the Judiciary to be nothing or not very honest, that is, the majority of the population understood that this institution has a low capacity to resist bribery. In addition, 61% of respondents considered that the Judiciary is not at all or not very competent to resolve cases; and 66% believe that the Judiciary is not at all or little independent in relation to the influence of the other Powers of the State *[translated by the author]*.

This data contradicts the previous question in relation to population confidence in the Judiciary. Previously presented, 40% of the people surveyed said they trusted the Judiciary – even though this is less than half of the population it is still a significant amount. However, this piece of information stating that 70% believe the institution to not be honest is somewhat confusing. In other words, how can the population trust an institution, but at the same time not consider it to be honest?

Nevertheless, according to the FGV (2021, p. 14) "the percentage of respondents who believed that the Judiciary was little or not at all independent decreased in 2021, compared to

2017, from 73% to 66%". In other words, the percentage of people who believe that the Judiciary is independent of the influence of other Powers has increased.

In terms of confidence levels of the population in the Supreme Court, "forty-two percent of respondents said that the Supreme Court is a reliable or very reliable institution. This percentage was 24% in 2017". Also, the institution pointed out that "confidence in the Supreme Court does not vary significantly according to gender, education and work status" (FGV, 2021, p. 16).

Furthermore, rulings and understandings of the Supreme Court are coherent in the sense that all levels of State and Government are responsible for the provision of medical treatments and medication: "Government, states and local administration have common jurisdiction to respond to demands aimed at the free supply of medication, tests, or procedures, including surgeries. Joint liability of federal entities. Common jurisdiction expressed in Article 23, Item II of the Constitution *[translated by the author]*"[18] (STF - RE: 1370928 RS 0075012-15.2020.8.21.7000, Ricardo Lewandowski, Published: 14/03/2022).

In addition, the administration of the SUS between Government, states and local levels are linked and equal. Thus, "the operation of the SUS shares joint liability, so any of these entities have *ad causam* legitimacy to appear as defendants of the lawsuit that aims to guarantee access to medication for people lacking financial resources, which is why it is up to the plaintiff to choose which public entity he wants to litigate against *[translated by the author]*"[19] (TJ-CE - APL: 00503183520208060101 CE 0050318-35.2020.8.06.0101, Maria Iraneide Moura Silva, 2nd Court of Public Law, Published: 19/05/2021).

Therefore, the plaintiff seeking guarantee of their entitlements and damages can request the Judiciary to summon not only local administration, but also every other federal entity, as there is joint liability between all levels of Government.

Based on the case law understandings above, it is every level of administration's duty to guarantee Public Health, and, consequently, offer specific therapy, medical treatments, medication etc at no cost. In other words, federal entities must institute health policies for the

---

[18] *"União, Estados, Distrito Federal e Municípios ostentam legitimidade concorrente para responder às demandas que visam ao fornecimento gratuito de medicamentos, exames ou procedimentos, inclusive cirurgias. Responsabilidade solidária dos entes federativos. Competência comum expressa no art. 23, inc. II da CF/88.".*

[19] *"O funcionamento do Sistema Único de Saúde (SUS) é de responsabilidade solidária da União, Estados-Membros, Distrito Federal e Municípios, de maneira que quaisquer dessas entidades possuem legitimidade ad causam para figurar no polo passivo de demanda que objetive a garantia do acesso à medicação para pessoas desprovidas de recursos financeiros, razão pela qual cabe ao credor impetrante escolher contra qual ente público deseja litigar.".*

promotion, protection and recovery of health and social care, not only to avoid lawsuits against the Public Administration, but also to avoid unforeseen public expenditure due to inefficiency.

Lastly, according to Oliveira and Souza (2017, p. 123), “the possible reserve theory is one of the hindering processes of judicial activism”. In other words, when the Judiciary uses this theory in its decisions, it is acting in favour of the defendant (State), and not the plaintiff (individual), as it is taking into account the State’s best interest.

In the next part of this chapter, the study will explore the judicialization of health, specifically in the field of Public Health, and the use of the doctrine of the reserve of the possible, commonly used by judges to justify the refusal of judicial requests relating to healthcare in order to preserve the State’s resources.

3.2. The judicialization of Public Health

According to Lima and Aguiar (2022, p. 05) judicialization can be understood as “exercising the right of action based on a claim presented in court and, by virtue of this claim, obtaining a satisfactory and fair response through a judgment on the merits, via jurisdictional provision, regarding the exercise of a duty of the State”.

Considering the increase in the life expectancy of the population and the increase in judicial demands, along with new medical treatments and procedures that appear due to scientific and technological advances at higher costs, the issue of scarce public financial resources allows for the unquestionable conclusion that the right to health presents economic costs, and therefore higher transaction costs for the agents involved (the State and its citizens).

According to Silva and Gonçalves (2017, p. 23), “rights cost money, as this entitlement should become a reality in association with available public expenditure, otherwise the right will be deprived of effectiveness”.

The scarcity of public financial resources means that there is a need to balance choices in face of the possible alternatives and accept that one’s needs will not always be met, to allow better allocation of resources; this is known as ‘trade offs’ (*custo de oportunidade*). This scarcity being questioned throughout this study refers to the 1970 German doctrine of the possible reserve[20], whereby “the effectiveness of social rights and material benefits would depend on the financial possibility of the State” (SILVA; GONÇALVES, 2017, p. 23).

---

[20] The case which leads to the 1970s theory of the possible reserve was decided by the German Supreme Court, and was concerning the entitlement to higher education, from which the understanding remained in the sense that

According to Oliveira and Souza (2017, p. 114), the German Constitutional Court made it clear that resources would be limited if the claim were aimed at the entire community, although, in the practical case, it would be sufficient to meet those plaintiffs. For that reason, in many times some personal requests cannot be met in their fullness due to the principle of reasonableness. Thus, "the individual cannot claim anything beyond what is rational to expect".

In terms of a judicial analysis, what happens in practice is the constitutionalisation or legal definition of a right even before verifying whether that particular State will effectively be able to finance such a right to ensure it is met effectively, which is what happens with social and fundamental rights in Brazil (OLIVEIRA; SOUZA, 2017, p. 121).

Furthermore, the fulfilment of these rights will depend on the resources collected to be funded by the community and the Government. Although the total revenue is high, it will never be enough to ensure the fulfilment of all demands, which grow at a much higher rate than the growth in revenue. In Oliveira and Souza's (2017, p. 121) words, "some rights will have to be sacrificed so that others can be fulfilled".

Oliveira and Souza (2017, p. 122) citing Bonavides explain that "the sacrifice of constitutionally foreseen rights cannot be accepted, under any circumstances, as they possess an 'intangibility' such that it should lead the government to allocate, with priority, resources for its fulfilment".

Therefore, once a constitutional right has been given, there is no way of going back and revoking it. Thus, it should be made a priority, regardless of available resources, as this should have been considered before making it a constitutional right.

The Judiciary has been consistently ruling in favour of claimants and prioritising the guarantee of constitutional fundamental and social rights over considering the State's resources. According to Fachin and Schinemann (2018, p. 215), "data from July 2017 shows that, among 118,6 thousand claims that requested the State to supply medicines, only 474 claims were unsuccessful, which demonstrates a very low rate of 0.4%".

Furthermore, the rationalisation and material limitation of fundamental and social rights violates the Constitution, as well as Human Rights in general. Thus, Fachin and Schinemann (2018, p. 216) teach that "the rationalisation of a material limitation of the judicial protection of provisional rights, at the same time, would prevent an excessive intervention of the

---

the claimed benefit must correspond to what one can reasonably demand from the State (SILVA; GONÇALVES, 2017, p. 23). In other words, "the German Constitutional Court understood that such a requirement violated reasonableness in terms of what is expected of the State, in view of the impossibility of meeting any demands that had the same claim, which indirectly works with the scarcity of resources" (OLIVEIRA; SOUZA, 2017, p. 113).

jurisdiction on the decisions of resource allocation, but would also prevent the maintenance of a repeated omission and violation of Human Rights by the State".

The Supreme Court's understandings are in the sense that the State cannot wave its duty to guarantee the right to health solely due to financial limitations, as the life and dignity of its citizens should not be relativised.

According to Justice Carmen Lucia (STF - RE: 1347968 RS 0011370-34.2021.8.21.7000, Carmen Lucia, Published: 27/10/2021): "the budget forecast cannot limit the State's action in the provision of social and fundamental rights […] the right to health is directly related to the idea of an existential minimum, which constitutes the essential core of fundamental social rights *[translated by the author]*"[21].

Silva and Gonçalves (2017, p. 31) teach that in case law relating to the provision of specific treatments and medication, there are arguments for and against each case. The arguments in favour are generally as follows: 1) Law 8,080 of 1990 that regulates the actions and health services, by private and public entities, reaffirms Article 196 of the Constitution, in Article 2 of the aforementioned Law, that health is a fundamental right for all and a duty of the state; 2) the social character of Public Health should appreciate universality and equity; 3) since access to health is a universal and equitable right, it is not possible to relativise ones entitlement, regardless of one's economic status; and, 4) there should be accessibility to every available therapy, treatment and medication within the SUS.

On the other hand, the arguments usually found against the provision of health and social care are as follows: 1) one's economic status is relevant and proof of their socioeconomic background, along with spending within the household, should be requested and analysed, as the SUS does not have sufficient funding to provide every possible therapy, treatment and medication; 2) the lawsuits that request 'off label' medication funded by the SUS should be accompanied by proof of lack of personal financial resources; 3) for non-protocol therapies and supplies, other criteria must be met, including financial insufficiency (SILVA; GONÇALVES, 2017, p. 32).

Generally, there are two types of lawsuits related to the request of healthcare provision that calls for judicial intervention, the first are the ones that request health related treatments and medication included in the National List of Essential Medicines (*Relação Nacional de Medicamentos Essenciais - RENAME*), created by Ordinance 3,047 of 2019, that is, the list of

---

[21] *"A previsão orçamentária não pode limitar a atuação do Estado na efetivação dos direitos sociais e fundamentais. O direito à saúde está diretamente relacionado com a ideia de mínimo existencial, que constitui o núcleo essencial dos direitos fundamentais sociais.".*

medication provided by the SUS. The second type of lawsuit are those that request health related treatments and medication not on the RENAME list (SILVA; GONÇALVES, 2017, p. 32).

In the first case, the Judiciary should fulfil the plaintiff's request, based on the fundamental right to health and the possibility of the provision based on the protocols of the SUS, along with treatment and medication availability. Thus, there is no reason for the Judiciary not to make this request possible and guarantee ones entitled right to health.

Vast amounts of case law related to the provision of medical therapy and medication listed have come to an understanding that the socioeconomic background and financial income of an individual is absolutely irrelevant, as the fulfilment of the judicial request is merely a step forward in completing the health policy already created by the Executive in favour of society (SILVA; GONÇALVES, 2017, p. 33). Thus, the cost of therapy or supplies in face of individual and social health needs, especially the theory of the reserve of the possible should not be considered in these cases.

According to Silva and Gonçalves (2017, p. 32), the process to judicially request a therapy, supply, treatment, or medication is:

> To justify the lawsuit, it is sufficient for the plaintiff to attach the medical prescription indicating the specific disease and the need for its use or implementation (which may be from any professional within the public sector), as well as the demonstration of the failure of obtaining it through local administration (justifies the citizen's ability to act, similarly to what happens in Public Social Security, although without the need to complete all administrative requests) *[translated by the author]*.

The question is, however, why does one need to resort to the Judiciary to have basic health needs met, especially when the RENAME list already allows access to many types of medication?

Surely one should be given a prescription in order to have access to the medication prescribed or available treatment within the SUS directly, or, if not, at least through an administrative request. Therefore, for a lawsuit to be filed, one must have tried to receive treatment or medication within the SUS and failed, as well as made the same request to local administration and also failed.

Bearing in mind that, for citizens not part of Public Social Security, it is not a prerequisite to exhaust all administrative phases before resorting to the Judiciary, as seen above.[22] Therefore, it is possible to go straight to the Judiciary if one is not able to have specific treatment or medication through the SUS, although contacting local administration before filing a lawsuit is preferable. However, in case of emergency and life or death situations, taking the administrative route to obtain healthcare is not recommended, as filing an interim relief lawsuit is the fastest route.

Based on the previous question made, it is possible to answer that one of the reasons for which one resorts to the Judiciary is in desperate situations, whereby one is in special need of treatment or medication offered by the SUS but could not obtain it for some reason, or, in case of it not being listed, was obliged to judicially request it. However, this situation still does not answer why the SUS user would not be able to obtain specific treatment within the SUS or medication, even though it was listed.

In order to understand how and why medication is listed within the SUS, it is worth exploring this dynamic in an attempt to answer this question. Firstly, according to the Nacional Policy of Medication (*Política Nacional de Medicamentos – PNM*), "Brazilian states and local administrations must prepare their own lists of essential medicines, which strengthens the administrative decentralization process, and, as it defines needs, prioritizes and directs the application of financial resources from the three levels of government" (NUNES; QUEMEL; ALEXANDRE et al., 2023, p. 58).

Therefore, the principle of decentralisation, one of the main pillars which supports the SUS, comes into action even when defining essential medication to be provided publicly within the system. Moreover, the RENAME should serve as a foundation for the creation of state and local lists: "the national list should be adopted as a reference document in the construction of state and municipal lists of essential medicines" (NUNES; QUEMEL; ALEXANDRE et al., 2023, p. 58).

In addition, based on the constitutional principle of the reduction of social and regional inequalities, "it is important that the selection of drugs considers different clinical, epidemiological, demographic and technical aspects and includes the particularities and needs of each age group" (NUNES; QUEMEL; ALEXANDRE et al., 2023, p. 58). Thus, local administration has the autonomy and duty to create specific lists for the local needs of the community.

At the state level, Nunes, Quemel, Alexandre et al. (2023, p. 58) teach that:

---

[22] Theme 350 of the Supreme Court generally requires a previous administrative request to be made as a condition to access the Judiciary for cases involving Social Security (RE 631240, Jus. Luis Roberto Barroso, 2017).

> At the state level, the State List of Essential Medicines (*Relação Estadual de Medicamentos Essenciais - RESME*) is the standard document for planning actions, guides the selection of medicines and should serve as a basis for organising pharmaceutical assistance within the SUS in each state of the federation, it is based on the RENAME, and is updated periodically *[translated by the author]*.

At a municipal level:

> Locally, the Municipal List of Essential Medicines (*Relação Municipal de Medicamentos Essenciais - REMUME*) encompasses actions from the selection of pharmaceutical products to the moment of their use by the local user of the SUS and serves as a basis for guiding the acquisition of effective and safe products, the prescription and exemption constitute the best management for public resources that are limited *[translated by the author]* (NUNES; QUEMEL; ALEXANDRE et al., 2023, p. 58).

According to Nunes, Quemel, Alexandre et al. (2023, p. 59), there is the possibility of inclusions, exclusions, and substitution of medicines, through the request for alteration of the REMUME, through the National Therapeutic Form (*Formulário Terapêutico Nacional - FTN*), which are annually revised and analysed by the municipal secretary of health.

It is worth mentioning that those who make these requests are health professionals, and not citizens, and they must include the following information in order to be considered:

> The specialist must justify their request according to technical data such as: the extent of use, efficiency, side effects, precautions, toxicity, cost/benefit, average cost of treatment, and if possible, the justification needs to be accompanied by theoretical basis with bibliographical references, the inclusion, exclusion, or replacement *[translated by the author]* (NUNES; QUEMEL; ALEXANDRE et al., 2023, p. 59).

If the professional is able to meet all the request requirements and have their request approved, the list is altered, registered, and published, following the legal procedure of the local administration. However, if there are lists on federal, state, and local levels to meet the specific populations needs, why is judicialization still happening in Brazil? Is this form of administration and method of lists ineffective?

Nunes, Quemel, Alexandre et al. (2023, p. 60) argue that judicialization is common among cases involving “access to medication, consultations and procedures that have a high cost, as in the cases of chronic and degenerative diseases”, and that “judicialization deals with specific individual cases and treatments usually at a high price”.

Therefore, the real issue is the lack of accessibility to medication of high cost, which is generally in cases of chronic or rare disease – so are all lawsuits related to Public Health in the scope of obtaining high-cost medication or treatment?

Another question arises in the sense that: would the solution to this not be to just include high-cost medication or treatment in the provisions of the SUS, or not have a list? After all, only those in need of such medication or treatment would request it.

However, why would the State make it that easy and free, among all other benefits they already provide, if they can rely on the Judiciary to solve the matter and possibly be exempt from having to fund it? In other words, the State can save money if they relieve themselves from having to fund specific and expensive treatment or medication, deliberately creating a list to exclude these cases.

What is observed here is that when the State does this, they are disrespecting the SUS's principle of completeness, which aims to medically care and treat individuals – individually. This means that each person should be entitled to specific and complete treatment related to their illness without financial hardship and covered by the State.

Thus, when the State only focuses on collective health and social care and works with intention of only providing general care to the population, it is excluding those individuals with delicate needs and their right to health and dignity.

It is important to consider that the RENAME, RESME, and REMUME do not only include the medication provided by the SUS on all levels, but also other important information, such as medication classification organised by generic name, concentration/composition, pharmaceutical form, and description. Thus, the lists could not be disposed of due to the reasons mentioned in the previous analysis (NUNES; QUEMEL; ALEXANDRE et al., 2023, p. 68).

Another reason for the importance of these lists is that they are recommended by the WHO: "the WHO considers 'essential medicines' to be those that meet the priority healthcare needs of the population and are selected taking into account the prevalence and incidence of the health problems for which they are intended and have proven efficiency, safety, and cost-effectiveness" (NUNES; QUEMEL; ALEXANDRE et al., 2023, p. 60). Thus, even the WHO does not morally condemn a State that takes into account the financial aspects of providing healthcare.

In addition, regarding pharmaceutical assistance in Primary Care, the RENAME list of 2020[23] attempted to include specific medication in order to guarantee the principle of

---

[23] The RENAME 2020 list includes three lists within itself: 1) the National List of Basic Components of Pharmaceutical Assistance (*Relação Nacional de Componentes Básicos da Assistência Farmacêutica - CBAF*); 2)

completeness. Thus, the National List of Medicines of the Specialized Component of Pharmaceutical Assistance (*Relação Nacional de Medicamentos do Componente Especializado da Assistência Farmacêutica - CEAF*), “seeks to guarantee comprehensive drug treatment, on an outpatient basis, for clinical cases, especially chronic conditions with more complexity and higher treatment costs”.

In the second situation mentioned above, whereby one resorts to the Judiciary to request treatment or medication not provided by the SUS, that is, not listed, is more complex, as the requisites for filing a lawsuit include proof of the lack of financial resources to pay for it, as well as the demonstration of no public policy related to the therapy or medication (or inefficiency of an existing one), along with proof of the necessity through medical prescription or report (SILVA; GONÇALVES, 2017, p. 33).

According to Silva and Gonçalves (2017, p. 33), the principle of the existential minimum and the desirable maximum should be considered in these cases:

> The existential minimum concerns the fact of ensuring the basic conditions of a dignified life for human beings, while the desirable maximum refers to a horizon to be reached in the future, in which the State is obliged to create constant and gradual public policies, prospecting new solutions according to the advances in medicine and the riches of the country *[translated by the author]*.

In other words, when the requested therapy or medication refers to a disease for which there is no public policy and considering that this omission affects the principle of human dignity, to the extent that it is consistent with the basic principles of healthcare, one will be faced with one’s own entitlement to the existential minimum.

On the other hand, when there is a public policy making available a drug other than that legally pursued, or the absence of a policy is due to the fact that it is an experimental drug or pursues a high cost, the analysis must be deepened, because the decision will be directly influencing Public Administration, and therefore, the claim should be balanced with the reserve of the possible (SILVA, GONÇALVES, 2017, p. 33).

Thus, when claiming the right to specific therapy or drugs not listed by SUS protocol, among the requisites mentioned above, it is important for the judge to separate cases involving requests related to the existential minimum, and those related to the desirable maximum:

---

the National List of Drugs of the Strategic Component of Pharmaceutical Care (*Relação Nacional de Medicamentos do Componente Estratégico da Assistência Farmacêutica*); and 3) the National List of Medicines of the Specialised Component of Pharmaceutical Assistance (*Relação Nacional de Medicamentos do Componente Especializado da Assistência Farmacêutica - CEAF*).

> In lawsuits aimed at basic healthcare and life, linked to the notion of human dignity (existential minimum), justification is unnecessary [...] in cases clearly aimed at achieving the desired maximum, it is necessary to apply the methodology of balancing fundamental values, weighing up any collision of antagonistic principles (proportionality *strictu sensu*) and factual circumstances of each case (necessity and adequacy), in addition to the reserve of the possible *[translated by the author]* (SILVA; GONÇALVES, 2017, p. 33).

Therefore, in cases where the plaintiff judicially requests medical treatment or drugs that are not part of the SUS's list and protocols but has been advised by a doctor due to unquestionable need and urgency to protect and preserve the patient's life or significantly improve one's life, that is, to ensure basic health and guarantee the existential minimum, the Judiciary has an obligation to guarantee the right to health. In other cases, such as those involving the desired maximum, the Judiciary will analyse each case individually and consider the possible reserve theory.

According to Silva and Vita (2014, p. 251), the existential minimum is not expressively mentioned in the Constitution but should be understood through the principles of human dignity, liberty, the due process of law, among others, as it is linked to absolute poverty and should be overcome by the State. In other words, "without the existential minimum, there is no social freedom and/or social equality, since human dignity is the foundation and starting point for the fulfilment of any fundamental right".

In addition, "the existential minimum must be ensured to every citizen, not individually, but rather as an object of well-defined public policies that are in harmony with the notion of a Democratic State based on the rule of law" (SILVA; VITA, 2014, p. 252). When public policies fail or are insufficient or inefficient, the Judiciary assumes its role of guaranteeing the existential minimum.

Therefore, the existential minimum "requires specific content and may cover any right, such as the right to health", and is "a right to the minimum conditions of dignified human existence that cannot be the object of State intervention and that still requires positive state benefits" (SILVA; VITA, 2014, p. 251).

For these reasons, when a lawsuit is received and analysed to be a case of providing the existential minimum, the Judiciary acts in favour of the plaintiff, regardless of whether specific treatment or medication is in the SUS's provision or listing.

In summary:

> In this weighing of values, it is essential to invoke the principle of proportionality to safeguard the balance between the reserve of the possible and the existential minimum, thus preventing the setback in social conquests. Finally, the faithful fulfilment of the provision of social rights still depends on a fixed standard of action by the state Powers, so that the inertia of the Public Power and the adoption of partial measures do not end up producing different categories of benefits of a universal nature *[translated by the author]* (SILVA; VITA, 2014, p. 252).

Fachin and Schinemann (2018, p. 216) cite Ana Paula de Barcellos on the existential minimum, and explain that:

> The content of the existential minimum, according to Ana Paula de Barcellos, is built from an objective and preferential role established by the Constitution itself. The right to education, basic health, assistance to the homeless and access to justice would be part of the existential minimum, because its densification is normatively foreseen in the constitutional text *[translated by the author]*.

However, Fachin and Schinemann (2018, p. 216) teach that this definition is problematic, as it considers “to conceive the existential minimum from a list of its content”, which means that the concept is not flexible, and potentially limited. In other words, the definition of the existential minimum according to Ana Paula de Barcellos is objective and does not account for individual subjective ideas of what is considered to be minimum.

This understanding has two issues, explained by Fachin and Schinemann (2018, p. 217-218). The first is the obstacle of the fulfilment of rights beyond the existential minimum in the Constitution itself. However, given its express provision, the judicial protection of these rights must be given in a broad way.

The second obstacle is the maximum effectiveness of fundamental rights and the jurisdiction. Thus, “the hermeneutical criterion of maximum effectiveness advocates that the interpretation that recognises greater effectiveness of fundamental rights should be preferred” (FACHIN; SCHINEMANN, 2018, p. 217-218).

Overall, Fachin and Schinemann (2018, p. 2018) concluded that “it is not possible to define, *a priori*, what is the material content of this existential minimum; and even if it were, this classification would be insufficient, as it is not possible to restrict, in advance, judicial protection to the existential minimum”.

One of the issues within the Judiciary, according to Silva and Gonçalves (2017, p. 34) is that “this situation creates a limitation in the fulfilment of the right by the State, creating individuals with an absolute right to health and individuals with a relative right”.

Moreover, if a nation guarantees the right to health in the Constitution and adopts a universal model of public healthcare, then surely one's financial income should not be an issue when granting judicial healthcare requests, and there should not be a list of treatments and medication provided by the SUS.

As a list exists to exclude people's access to certain therapy, medical or dental treatment and medication not provided by the SUS and depends on judicial analysis on one's need and financial income, then one's health is directly relativised and hindered by the possible reserve theory, possibly putting in question the principles of morality and efficiency.

As Silva and Vita (2014, p. 254) teach, the main idea of the doctrine of the reserve of the possible is "the allocation of everything possible to meet the fundamental rights of the individual, however, whilst avoid putting the public budget at risk". It is not, therefore, the State's refusal to fulfil fundamental rights, but rather to limit what it is unable to be met based on the State's revenue.

Silva and Vita (2014, p. 255), referring to Canotilho, explain that "the tasks constitutionally imposed on the State for the fulfilment of rights must be translated into the issue of concrete and determined measures and not into vague and abstract promises". Therefore, is it possible for the State to call its system universal if it relativises the right to health and considers one's finances in the provision of healthcare?

Here is where the British NHS can answer this question, in terms of the NHS's founding principles. One of the most important principles of the NHS is that it is 'comprehensive'. This principle sometimes gives the idea that it is all inclusive, but actually it is the key to understanding the nature of a Public Health system, which really includes treatments and medication to a large extent, but not completely, as it would be financially impossible. This understanding has already been reached in chapter 1 of this study. However, it is important to be reminded of it throughout the study.

Furthermore, Silva and Vita (2014, p. 255), citing Ingo Wolfgang Sarlet, explain that the possible reserve theory does not violate the principles of morality and efficiency, as the Judiciary is effective in balancing the scarcity of public resources and one's right to health and the existential minimum by considering social rights.

Therefore, the possible reserve theory is conditioned by Article 5, Paragraph 1, of the Constitution, which states that the burden of effectively proving the total or partial unavailability of resources and the non-waste of existing resources rests with the public authorities.

However, with regard to the funding of drugs or medical treatments at a high cost provided by the State, if one type is already indicated for a certain disease and is provided free of charge by the SUS, there is no reason to compel the State to pay more to obtain the same result through a different brand, for example.

Therefore, such an obligation regarding the provision of medication, and in the specific manner intended by the plaintiff, even though similar medication or treatment is provided by the SUS, can only be excluded in case of documentary proof by the State that the other medication supplied by the SUS has the same efficacy and purpose (SILVA; VITA, 2014, p. 259).

It should also be noted that if there is more than one medication indicated for a given type of pathology, the State's duty is to provide the most effective one, regardless of availability or price. This is as a form of fulfilling its constitutional duty to implement the right to health of its citizens by adopting the best and necessary measures (SILVA; VITA, 2014, p. 259).

As far as the data about access to medication and hospitalisation through Public Health, the Brazilian Institute of Geography and Statistics (*Instituto Brasileiro de Geografia e Estatística – IBGE*) published a report in 2020 on the access to Public Health services and indicators, as well as private healthcare statistics. The report found that within Public Health, the proportion of people who obtained at least one prescribed medicine was inferior to those who were covered by private health insurance (IBGE, 2020, p. 48-49).

Therefore, in 2019, “only 30.5% (6.2 million) of people managed to obtain, in the Public Health service, at least one of the drugs prescribed in the last healthcare appointment, especially in the Midwest (24.9%) and Northeast (28.9%) with the lowest proportions, while the Southern region, with the highest (36.2%)” (IBGE, 2020, p. 48-49). Needless to say, the Government still has a long way to go in terms of reducing social and regional inequalities in terms of healthcare services.

In addition, the report also found that education levels seem to play a role in obtaining medication within the Public Health system. Thus, the proportions of people who obtained at least one of the drugs prescribed in the Public Health service showed significant differences, according to the level of education, “ranging from 38.7%, among those with no education or with incomplete primary education, to 12.5%, among those with complete higher education” (IBGE, 2020, p. 48-49). Therefore, those with lower levels of education are more likely to be able to find ways of obtaining prescribed medication within Public Health.

In terms of racial and social differences, the report also found that “the proportion of black people (34.4%) was higher than that observed among white people (27.9%) regarding this aspect" (IBGE, 2020, p. 48-49). In other words, it is more likely for black individuals than white individuals to obtain at least one medication prescribed in a consultation with a medical or dental professional within the Public Health system. However, the difference is only 6,5% between white and black people, whereas the difference is higher when considering education levels (26,2%).

The final conclusions on access to medication within the SUS found that:

> *Per capita* household income and household situation showed an inverse relationship with the proportion of people who obtained, at the public health service, at least one of the drugs prescribed in the last healthcare visit. The lower the *per capita* household income range, the higher the indicator: 42.3% of people without an income of up to ¼ of the minimum wage obtained at least one medication from the Public Health service, while only 7.1% of those in the income range more than 5 minimum wages achieved it. People residing in rural areas also had a higher proportion of success than those in the urban area (36.8% and 29.6%, respectively) *[translated by the author]* (IBGE, 2020, p. 48-49).

This last piece of data shows that poor individuals, that is, those with the lowest income, especially those living in the countryside, that is, far from the city or town centre, are more likely to access free medication within the Public Health system, as opposed to those considered as middle-class. Therefore, middle-class individuals are potentially more likely to seek judicial aid in order to obtain medication, as only 7.1% are able to obtain it through the SUS.

In terms of hospitalisation, in 2019, of the people who were hospitalised for 24 hours or more, "64.6% (8.9 million) received this care through the SUS - the Northeast and Northern regions had the highest proportions (77.8% and 76.2%, respectively), while the Southeast region had the lowest (56.4%)" (IBGE, 2020, p. 50-52). In other words, most hospitalisation is carried out through the SUS, as 64.6% of those who were hospitalised were Public Health users - mainly of the Northeast and Northern regions.

The proportion of hospitalisations in SUS hospitals was higher among men (65.4%), young people aged 18 to 29 years old (72.0%), as well as among black and brown people (75.9% and 73.6%, respectively)" (IBGE, 2020, p. 50-52). Therefore, hospitalisation within the SUS is most common among young black and brown men.

The report also concluded that "the lower the level of education, the greater the proportion of the indicator, varying strongly from 79.6% among people with no education or with incomplete primary education to 21.1% among those with complete higher education" (IBGE, 2020, p. 50-52). This information is consistent with the previous data gathered from access to medication within the SUS and education levels.

Finally, the report concluded that:

> The differences are significant when considering the *per capita* household income of people who were hospitalised for 24 hours or more, in the 12 months prior to the date of the interview and the last hospitalisation was through the SUS. This indicator reveals a clear dependence of economically vulnerable people on the SUS. According to 2019 estimates, 95% of people without an income of up to ¼ of the minimum wage and 89.8% of those in the range of more than ¼ to ½ of the minimum wage were in this condition. Contrary to what was observed in these initial groups, only 6.8% of people with a *per capita* household income of more than 5 minimum wages had their last hospitalisation through the SUS. In rural areas, hospitalisations via SUS were also more frequent (85.9%) than those registered in urban areas (61.4%) *[translated by the author]* (IBGE, 2020, p. 50-52).

From this data from the 2020 IBGE report, it is possible to conclude that white individuals with higher levels of education, considered to be middle-class and be from the Southeast and Southern regions of the country, living in urban areas, are more likely to seek guarantee of their right to health judicially when it comes to obtaining medication, as the data shows that they are not successful in obtaining it through the SUS.

In terms of hospitalisation, it has been observed from the data that it is not likely for this type of individual to be hospitalised within the SUS, as those more likely to make use of this health service are black and brown individuals, with little or no education levels, considered to have low-income and be from the Northeast and Northern regions of the country, also from rural areas; these individuals are also the ones who are more likely to obtain free medication within the SUS.

Therefore, as the first group, considered to be more privileged than the last, does not generally make use of hospitalisation services within Public Health, they are probably hospitalised through private health insurance in private hospitals. Thus, judicialization is potentially more likely to occur in claims regarding hospitalisation against private insurance operators than the SUS.

Ribeiro (2018, p. 65) confirms that “in the perception of the Brazilian citizen, justice in Brazil is considered below average”. However, he argues that his findings “confront a contradictory situation in the country, because on the one hand, social perception demonstrates the poor confidence in the country’s Courts to resolve conflicts, on the other hand, a growing judicialization of public rights and policies has been verified”. Therefore, due to the reasons explored in this chapter, individuals are obliged to seek judicial intervention as a last resort.

According to the Getulio Vargas Foundation (FGV, 2021, p. 02), an issue that profoundly affects the economic and social development of a country is the ability of the Judiciary to present itself as a legitimate Power in resolving conflicts that arise in all areas of society. Thus, “one way to measure this legitimacy is through the motivations that lead citizens to use (or not) the Judiciary and to trust (or not) it, in terms of efficiency (speed), responsiveness (competence), impartiality, honesty and access (ease of use and costs)”.

A study by FGV (2021, p. 10) mentioned previously, called the Confidence in Justice Index in Brazil (*Índice de Confiança na Justiça no Brasil - ICJ*) found that “we asked the interviewees if they would resort to the Judiciary to request high-cost medicines that are not available in the Unified Health System (SUS), reinforcing the so-called judicialization of health: 85% of respondents said yes”. Thus, people in general are not resistant to resort to the Judiciary, despite previous data shown in this study relating to high cost of judicialization and access issues.

In Lima and Aguiar’s (2022, p. 05) view, “despite such efforts, the lawsuits directed at the Judiciary are not adequately supplied and answered, in quantitative and qualitative terms, nor in a quick, accessible and economical way”. This confirms that the Judiciary is slow and costly, and even so, does not seem to be efficient.

According to Lima and Aguiar (2022, p. 06), “numerous problems are caused and/or enhanced, such as disbelief in the justice system and the possibility of worsening the health condition of the parties claiming guarantee of their right to health”. Therefore, “emerging alternative/complementary paradigms can guarantee an adequate response”. These alternatives emerge in the form of mediation and arbitration and will be discussed next.

Now that the study has covered the role of the Judiciary and its duties, judicial activism and judicialization of health in Brazil, the study, finally, attempts to bring a solution to these issues surrounding the Brazilian judicial system and the Public Health system through the British conflict resolution model, which rarely relies on the Judiciary to guarantee the right to health or resolve internal conflicts.

3.3. Non-judicial conflict mediation and resolution in Public Health

This part of the chapter addresses the institutional use of mediation and conflict resolution in the field of healthcare. According to Ribeiro (2018, p. 63), “mediation and conflict resolution has been used in a number of countries indicating a worldwide trend in different topics, including healthcare access". In Brazil there have been studies of some initiatives aimed at using mediation as a means of resolving controversies in the field of healthcare, whilst in the United Kingdom, the NHS Resolution body within the Public Health system deals with conflicts of interest between users and the NHS.

Ribeiro (2018, p. 66), citing Cappelletti and Garth, explains that access to the Judiciary can be discussed in the perspective of three different positions. The first position is characterised by the access to legal assistance aimed at individual claims, whilst the second position is identified by the access of collective claims and class actions.

Thirdly:

> The third position would seek a broad approach, centred on the notion of access to justice and, in addition to including advances arising from previous positions, propose to go beyond and discuss forms of access to justice more generally, articulated and understanding. In line with this third position, the creation of specialised bodies and the institutionalisation of alternative ways to the traditional Judiciary for conflict resolution *[translated by the author]* (RIBEIRO, 2018, p. 66).

In addition, Lima and Aguiar (2022, p. 07) also have a view on the third position on access to the Judiciary:

> Known for being part of the third wave of the main procedural movements for access to justice, self-composition is a notably articulated, complete and autonomous tool for administration or conflict management, in which the parties, through dialogue and consensus, seek more lasting and viable solutions, other than, for example, a mere transaction (agreement), withdrawal (waiver of right) or submission (legal recognition of the request) *[translated by the author]*.

The term Alternative Dispute Resolution (ADR) is used in Common Law countries to refer to the alternative methods of conflict resolution.[24] Moreover, mediation and arbitration have advantages that are not merely limited to the question of the speed in resolving the conflict, since the slowness of the Judiciary is often one of the main issues, but also include pros in reducing costs, as well as the maintenance of relationships between the conflicting parties (RIBEIRO, 2018, p. 69).

---

[24] According to Ribeiro (2018, p. 68), "ADR entered as a US movement in the 1970s as a way to solve social disputes involving civil rights and as an alternative to the overcrowded legal system. In 1990, many US courts institutionalised some type of ADR with the objective of reducing the cost and time of legal cases, which also resulted in a large increase in the number of law firms that started offering ADR services.".

According to Parisi and Silva (2018, p. 32), mediation promotes dialogue, which is encouraged by the mediator. Also, "the mediation of conflicts in health work, by proposing understanding, acceptance of diversity and dialogue, acquires a sense of transformation of subjectivities and resistance to the propositions of exclusion and utilitarianism".

Furthermore, the National Council of Justice approved Resolution 107 of 2010 which created the National Judiciary Forum for Monitoring and Resolution of Healthcare Claims (Health Forum), "considering the high number of lawsuits related to healthcare and the consequent need to deepen studies with a view of preventing litigation and the proper management of ongoing cases" (LIMA; AGUIAR, 2022, p. 05).

Lima and Aguiar believe that it is necessary that the current jurisdictional model as the only means for conflict management be broken so that other mechanisms are legitimised, not necessarily "with the focus of decreasing or "drying out" the cases of judicialization, but, mainly, to materialise fundamental rights".

Thus, the objective of ADR is not simply to relieve the workload of the Judiciary and save money, as that will be a consequence of the main goal, which is to simplify the process in general by resolving conflicts before reaching the Judiciary, in order for the individual to have their needs and rights met quickly and effectively, rather than having to depend on the Judiciary.

Therefore, "health mediation can be understood as one of these paths, given that it is based on replacing the culture of litigation with a culture of dialogue and consensus, offering a harmonious, democratic, participatory and responsible treatment" (LIMA; AGUIAR, 2022, p. 06). In addition, "access to justice through self-composition, such as mediation, conciliation and negotiation, can be a very effective mechanism for dealing with disputes outside the judicial sphere" (LIMA; AGUIAR, 2022, p. 07).

Resolution 125 of 2010 created by the National Council of Justice ensures access to justice through ADR, and is related to Article 5, Item XXXV of the Constitution, which "implies access to a fair legal system and effective solutions, with mediation being one of the conducive instruments for social pacification, the solution and prevention of disputes" (LIMA; AGUIAR, 2022, p. 07). Needless to say, it is the State's duty to "improve, encourage and establish public policies for adequate treatment of legal problems and conflicts of interest", mainly by improving ADR.

Moreover, Law 13.140 of 2015 provides for mediation as one of these instruments, considering it as a technical activity guided by principles, such as the impartiality of the mediator, equity, orality, informality, autonomy of the will of the parties, search for consensus, confidentiality, and good faith. Another advantage to this form of ADR is that decision-making belongs to and is constructed by the litigants themselves, which gives a sense of autonomy (LIMA; AGUIAR, 2022, p. 07).

Lima and Aguiar (2022, p. 08) explain that conflicts can either be “internal and/or external to the system, such as disputes between professionals, between doctors and patients, between doctors and hospitals/clinics, between patients and health plans”. The method to be used can, therefore, directly involve local administration, that can also involve the SUS and its managers.

In a study by Ribeiro (2018, p. 71-72), three institutionalised initiatives for the application of mediation in healthcare were found. The first was sanitary mediation promoted by the Public Prosecution Service of the state of Minas Gerais, through the Operational Support Center for the Prosecutors of Justice and Health Defense (*Centro de Apoio Operacional das Promotorias de Justiça e Defesa da Saúde - CAO*).

It was found that:

> The idealisation of health mediation starts from the perception of two political-institutional situations: (a) the negative impact of health judicialization on budget and collective health planning; and (b) the need for the reorganization of health actions and services, in the regionally and collectively, with democratic participation, aiming at the elaboration of this same health planning from an integrated and regional perspective *[translated by the author]* (RIBEIRO, 2018, p. 71-72).

Secondly, in the Federal District, the District Health Mediation Chamber (CAMEDIS) established by joint action of the State Secretary of Health and the Public Defender’s Office of the Federal District, responsible for mediation regarding the demands for health services or products offered by the SUS in the Federal District, aims to “seek solution to the demands for health services and products in order to avoid lawsuits and propose solutions for those in process” (RIBEIRO, 2018, p. 71-72).

Thirdly, the Interinstitutional Committee on Administrative Resolution of Health Demands (CIRADS), in the state of Rio Grande do Norte, which aims to resolve conflicts between the SUS and its users, have also been extended to the states of Bahia and Para. According to Ribeiro (2018, p. 71-72), “CIRADS seeks the administrative solution of conflicts in health, through the analysis of conflicts in which the citizen failed to resolve directly with the SUS”. Thus, CIRADS seeks to give administrative support to issues that can be resolved non-judicially, avoiding judicialization and offering alternatives to those already judicialized conflicts.

The benefits of these initiatives are as follows: “some benefits are cited: the high rate of resolution of demands at the administrative level; reducing the number of lawsuits; immediate and individualised response to demands; and consensual and participatory solutions” (LIMA; AGUIAR, 2022, p. 08).

Lima and Aguiar (2022, p. 09) argue that for this to work, “changes need to come from both users of the justice system and legal professionals and public institutions”. Basically, all federative entities (Government, states, and local administration), as well as the other parties involved (SUS users, lawyers, health service providers, the Judiciary) must collaborate and find alternative means to overcoming the conflict. This usually will come from within the SUS and local administration, as well as the lawyers who give legal advice, as the Public Health user generally does not have knowledge on this subject and relies on their representative to take their best interests into consideration.

In regard to the current NHS Resolution, formerly known as the NHS Litigation Authority (NHSLA), is an extension of the Health and Social Care Department and provide expertise to the NHS on resolving concerns and disputes fairly. According to the NHS Resolution, “on the whole, NHS healthcare is generally very good, and most people don’t experience any difficulties, but occasionally things can go wrong” (NHS, 2023).

The NHS Resolution is formed of four key services: 1) claims management; 2) practitioner performance advice; 3) Primary Care appeals; and 4) safety and learning (NHS, 2023a). Claims management will be outlined in this chapter in order to develop a broader understanding of this mediation extension service within the Health and Social Care Department.

The claims management handles negligence claims on behalf of the members of indemnity schemes, that is, NHS organisations and independent sector providers of NHS care in England. The majority of claims received are resolved without formal court proceedings and more claims are resolved without payment of damages if they are still in the early stages (NHS, 2023a).

The statistics regarding the success of this conflict resolution model is outstanding and efficient in comparison to Brazil, whereby the phenomenon of litigating to resolve healthcare claims is so common that it is even known as ‘judicialization’, as seen in the previous part of this chapter.

In the UK litigation levels are almost non-existent, and the courts are more likely to rule in favour of the NHS when a conflict is not resolved through NHS Resolution and does reach the courts:

> In 2017/18, just under one third of claims ended up in litigation with fewer than 1% going to a full trial (where most end in judgment in favour of the NHS). Claims resolved without the need for formal court proceedings are managed by our in-house teams. The overwhelming majority were resolved by negotiation in correspondence, in meetings between the parties, or using some form of alternative dispute resolution, including formal mediation (NHS, 2023a).

This could mean that judicialization in the UK is almost non-existent due to the fact that lawyers are more likely to advise clients to make a deal and mediate, rather than seek litigation, mainly because the courts seem to rule in favour of the NHS. In Brazil, the courts generally rule in favour of the claimant rather than the SUS and local administration (this is also motivation for individuals to seek litigation) and are more likely to claim damages in further stages of litigation.

The NHS Resolution gives advice to claimants and takes into consideration their mental health and well-being, considering that litigation is not generally peaceful and not always has positive outcomes. According to the NHS Resolution “making a claim can be an expensive, stressful and potentially a lengthy process” (NHS, 2023a). Therefore, it is important to be aware that even though one may be able to claim more compensation if they go through the entire litigation process, their health is potentially at risk whilst waiting. Thus, ADR seems to be the most sensible approach to resolving healthcare conflicts.

In other words:

> When considering the reason for your claim, it is important to note that the process of taking legal action is only about claiming compensation, the court can’t discipline healthcare practitioners, force a hospital or individual healthcare practitioner to change how they work or make a healthcare practitioner say sorry (NHS, 2023a).

As seen above, the Judiciary is not responsible for interfering with the NHS administration and training of healthcare professionals, and the aim of litigation is solely to claim compensation if injury was suffered due to negligent healthcare treatments that could have been avoided or less severe if the individual had received the correct treatment (NHS, 2023a).

In addition, in order to receive compensation, the claimant will have to show that both ‘breach of duty of care’ and ‘causation’ has taken place (NHS, 2023a). According to the NHS

Resolution, the former means that the healthcare professional must have acted below acceptable professional standards.

In this case, it is necessary to follow the ‘Bolam’ principle:

> Known as the ‘Bolam’ principle, this tests whether the actions of the health professional in question could be supported by a ‘responsible body of clinical opinion’. This test is not about what ‘could have been done’ – that other health professionals might have done something differently, but whether it ‘should have been done’ – would a ‘responsible body’ of health professionals support the action taken? (NHS, 2023a).

In addition, there is also another test known as the ‘Bolitho’, “this means that the court should not accept a defence argument as being ‘reasonable’, ‘respectable’ or ‘responsible’ without first assessing whether such opinion is susceptible to logical analysis” (NHS, 2023a). Therefore, the court will analysis each individual case in order to verify whether the healthcare professional acted against NHS principles and acceptable professional standards, based on the specific situation.

The second requisite for a claimant to be entitled to receive compensation is ‘causation’, which means that “the harm suffered must be shown, on the balance of probabilities, to be directly linked with the failure of the health professional to meet appropriate standards” (NHS, 2023a). For example, if the courts decide that the injury suffered was likely to occur even if the health professional had acted differently, then the claimant will be unlikely to receive compensation.

The NHS Resolution warns claimants that injury claims are subject to a limitation period of three years, which means they must issue their claim within three years of the alleged negligence, or within three years of becoming aware of it. On the other hand, in Brazil, claimants have up to five years to issue a claim. Moreover, the longer the limitation period, the more time individuals have to seek compensation; this could also be another reason for the judicialization in Brazil.

Although the NHS recommends one hires a lawyer to issue a claim, it is also possible for claimants to issue their claim themselves, without legal representation. In this case, individuals must complete a ‘letter of claim’ through a template provided on the NHS Resolution website. The letter should include 1) the precise nature of the allegations of breach of duty being made, against which clinician and on what date; 2) the nature and extent of the symptoms caused by the breach in duty; and 3) the level of compensation they are seeking (NHS, 2023a).

There are also two types of damages one can be entitled to in these cases, being ‘general damages’ and ‘special damages’. The former “includes compensation for both the pain suffered and loss of amenity you have incurred”, whereas the latter “includes any additional losses you may have incurred such as loss of earnings, additional care requirements, medical expenses, funeral expenses (in cases of bereavement) and other expenditure” (NHS, 2023a).

When the court is considering the claim and analysing the specific situation, guidelines must be followed based on the Judicial Studies Board and previous awards by the court in similar cases. Later, a ‘condition and prognosis report’ is written for the claimant either by an expert chosen by them or on their behalf by the defendant NHS trust, to accurately evaluate what the claimant is entitled to receive (NHS, 2023a).

Regarding ADR, specifically mediation, the NHS Resolution currently has four different services available. The Centre for Effective Dispute Resolution (CEDR) and Trust Mediation Limited are two services that mediate disputes related to personal injury and clinical negligence incidents and claims. The Costs Alternative Dispute Resolution (CADR) and St. John’s Buildings Limited are two more services which mediate disputes arising from recoverability of legal costs (NHS, 2023a).

The NHS Resolution explains the purpose of these services:

> Our new claims mediation service has been designed to support patients, families, and NHS staff in working together towards the resolution of incidents, complaints, legal claims, and costs disputes – avoiding the unnecessary expense, time, stress, and potential emotional distress of going to court. The service will provide access to an independent and accredited mediator, selected from a panel drawn from a wide range of backgrounds (NHS, 2023a).

The NHS Resolution claims management resources has kept databases of healthcare related compensation claims, practitioner performance concerns and the causes of contracting disputes on Primary Care over the last 25 years; they use this information to positively improve the early resolution of contracting disputes (NHS, 2023a).

The data analysed below is from period 2006/07 to 2021/22, which includes the Annual Report Statistics (2021/2022) which concerns the volume of claims notified and settled, and the provision for financial liabilities. The data also includes Supplementary Account Stats (2021/2022) which shows payments made in each year for damages and legal costs, as well as the average damages and legal costs, along with time from incident to notification of claim and from notification to settlement (NHS, 2023a).

According to the Annual Report Statistics (2021/2022), in 2019/2020 there were 11,677 total claims, in 2020/2021 there were 13,351 total claims, and in 2021/2022 there were 15,078 total claims (NHS, 2023a). This shows that healthcare claims within the NHS Resolution have been increasing during the last three years, which could be due to the Covid-19 pandemic which began in March 2020.

Image 9 – The total number of NHS Resolution claims and settlements in the last decade (2012-2022).

Year	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**
Total claims received	10,129	11,945	11,497	10,965	10,686	10,672	10,678	11,677	13,351	15,078
Total claims settled	8,922	10,348	10,493	11,334	12,478	11,896	11,417	11,359	12,079	13,070

Source: Adapted from the Annual Report Statistics 2021/2022 (NHS, 2023a).[25]

Based on the last ten years of new claims made to the NHS Resolution, it is possible to calculate that the average number of claims received is 11,668 for non-judicial conflict resolution. In addition, from 2012/2013 to 2019/2020, the number of claims received by the NHS Resolution did not differ significantly. However, from 2020/2021 to 2021/2022 there was a greater difference and increase in the total number of claims.

It is also important to observe the amount of settled claims received by the NHS Resolution, to analyse whether ADR is effective and if it is delivering its mission by avoiding litigation. Moreover, the data collected from the Annual Report Statistics confirms that the mediation services are efficient, as most claims are settled directly through the NHS Resolution. Therefore, it is possible to calculate that the average number of claims settled by the NHS Resolution is 11,340 cases. The remaining cases not settled within the NHS Resolution go to the courts.

The Department of Health and Social Care published an NHS Litigation Reform Report on the 28th of April 2022 with the explanation that every year in England the NHS spends over too much money compensating patients who suffered harm during their treatments and is in urgent need of a reform (UK, 2022).

---

[25] The numbers marked in red are total claims settled which are higher than the total number of claims received. This is due to an error in the 2015/16 to 2017/18 data in the Report which failed to record some claims received in the previous years.

More specifically, “ten years ago the NHS paid £900 million in damages; last year it was £2.17 billion - equivalent to the annual running costs of the biggest hospital Trust in England or four average sized hospitals”. It is also predicted that the spending is going to double over the next decade and “the English NHS spends 2% of its total income on clinical negligence compared to half that level in New Zealand or Sweden”. Furthermore, “around a quarter of such costs go not to families but to lawyers” (UK, 2022).

According to UK Parliament, litigation does not always deliver what is it supposed to:

> A process that is supposed to deliver justice and incentivise improvements fails to do either: lessons are rarely learned and for families accessing compensation is slow, adversarial, stressful, and often bitter. Those who are most in need usually wait the longest and the system often appears arbitrary - based not on need but on whether clinical negligence can be proved (UK, 2022).

In other words, sometimes the length of time waiting for low compensation is not worth the stress of the whole litigation process. Also, clinical negligence must be proved in order to receive compensation, and the courts generally rule in favour of the NHS, as this is difficult and costly to prove. In addition, litigation is often bitter, and parties fail to maintain relationships, meaning that this conflict can also affect users’ relationship with the NHS services.

The NHS Litigation Reform Report of 2022 explains that advocates of the reform have argue that the best way to reduce costs is for the NHS to reduce harm and improve patient safety, which is one of the four parts of the NHS Resolution. According to this Report, the significant increase in compensation costs is a “result of a growth in claims and steep increases in the value of awards and claimant legal fees”. In addition, the court does not review cases “in a way which accounts for context and system failure”, but rather “a system focused on clinical negligence by definition seeks out individual failings” (UK, 2022). This is also a form of reducing the responsibility of the NHS as an institution and blaming the health professional as independent service providers.

On this note, the NHS created a statutory body called the Health Service Safety Investigations Body (HSSIB) as an incentive to reduce harm and improve patient safety:

> Maintaining a costly and adversarial litigation system is evermore at odds with our understanding of how the NHS should respond to failures in care. England’s system of clinical negligence stands in stark contrast to international best practice in terms of patient safety. In other countries, gains are made by careful system-wide analysis rather than an insistent search for individual error. The creation of the Health Service Safety Investigations

> Body (HSSIB) as a statutory body to undertake no-blame safe-space investigations maps out the direction of travel for reducing harm and improving patient safety (UK, 2022).

The HSSIB will be an independent administrative body responsible for investigating cases and deciding on eligibility for compensation, instead of litigating through the courts. In addition, “reconstituting the new Special Health Authority, which will take over maternity investigations from HSSIB, would be an efficient way for the Government to implement our recommendation”. According to the recommendations, “this would be the most effective long-term way to reduce both the number of tragedies and the cost to the NHS” (NHS, 2022).

In order to make these changes, there needs to be a change in the law so that “access to compensation is based on agreement that correct procedures were not followed and the system failed to perform, rather than the higher threshold of clinical negligence by a hospital or clinician”. According to the Report, comparative studies in other countries have shown that whilst this broadens entitlement to compensation, overall costs are lower (NHS, 2022).

Furthermore, the reform intends to make ADR compulsory in all stages of the litigation process:

> Before any court case there should be compulsory use of alternative dispute resolution mechanisms (ADRs). This often happens before the start of a trial but should happen before the issuing of any court proceedings. The Government should consult on the format of ADR and whether ADR should include mediation or be an inquisitorial, ombudsman-style process.[26]

In regard to the waiting of litigation and conflict resolution, the Report recommends that cases should be resolved within six months and should include the following elements “an independently led investigation involving both families and the Trust; implementation of any safety recommendations made; and communication of such lessons to the wider NHS” (NHS, 2022).

Finally, what was continuously emphasized in the Report was that: 1) harm needs to be reduced and patient safety needs to be improved within the NHS; 2) responsibility needs to be taken collectively as the NHS institution itself and not individually aimed at healthcare professionals; 3) the courts need to provide better explanations to victims as well as solutions

---

[26] Ombudsmanship: A government official (as in Sweden or New Zealand) appointed to receive and investigate complaints made by individuals against abuses or capricious acts of public officials (MERRIAM-WEBSTER, 2023).

for the NHS to avoid reoccurring claims, as a form of learning from mistakes instead of simply verifying clinical negligence (NHS, 2022).

One important factor to take into consideration is that the UK values Comparative Law and inspire themselves in other nations systems for change and improvement. Therefore, in the same way that the Brazilian Public Health system was inspired to create the SUS based on the NHS, it can also be inspired in other systems for the creation of an independent administrative body to resolve conflicts through ADR before claims becoming litigation and reaching the Judiciary.

In other words, “administrative compensation systems have been adopted with great benefits in New Zealand, Japan, Florida, Virginia and across Scandinavia, where both cost savings and safety improvements have proved possible”. In addition, “the most complex and expensive cases are those related to birth injuries which leave children seriously disabled so it may be appropriate to pilot new changes in this area as has happened in Japan” (UK, 2022).

Even though the UK has created the NHS Resolution within the Health and Social Care Department, considered to be efficient as it is able to resolve most claims in early stages, generally without having to pay compensation and without litigating, the British still are not content and are always searching for improvement, so that it is possible to avoid overspending. Due to these reasons, through the NHS Litigation Reform of 2022, the Public Health system created the HSSIB and the Special Health Authority as additional administrative bodies to resolve conflicts as peacefully, quickly, and less costly as possible.

Regardless of the attempts to reduce litigation, it will still always exist and sometimes it may be necessary in specific cases if there is not a quicker administrative route, which is apparently preferable:

> Although the system would be no less generous in its awards than the courts, patients would always retain the option of pursuing clinical negligence cases and seeking redress via litigation. Evidence from abroad, however, indicates that, when given the choice, patients and families prefer the simpler administrative process and, in the system we recommend, the new body would be the mandatory first port of call for anyone who thinks they are entitled to compensation (UK, 2022).

Furthermore, according to the Report, the system needs to rethink how it awards compensation, not always with the intention to reduce this by all means so as to not stimulate litigation, as in specific cases it is necessary, and the most evolved judicial systems are able to provide compensation accordingly to victims needs, which means compensation should not be based on fixed or defined amounts, but rather change and adapt over time.

In other words:

> At present compensation is awarded on a 'once and for all' basis, but we recommend that awards be made with periodical review built in so that they can become responsive to the changing needs of patients. The requirements of a child with birth injuries, for example, can evolve over time and the most effective system would be one that can provide initial compensation within weeks of a claim and then be adapted to meet the individual child's requirements as they grow and develop (UK, 2022).

Needless to say, the SUS can inspire itself on the NHS Resolution body and the NHS Litigation Reform in order to create independent administrative bodies to resolve healthcare claims and reduce judicialization, as in Brazil, healthcare related claims are the fourth most common cause of judicialization (FGV, 2023); bearing in mind that, not all healthcare related claims that become litigation are against the SUS – many seek the provision of healthcare services and compensation against private health insurance providers.

It is important to consider that some local authorities in Brazil have attempted to reduce judicialization, such as the '*SUS COM VC*' or 'SUS WITH U' attempt by the county of Jundiai in the state of Sao Paulo, known as the Guidance and Mediation Center of the SUS: an experience of coping with the Judicialization of Health in the County of Jundiai (*Centro de Orientação e Mediação do SUS: uma experiência de enfrentamento da Judicialização da Saúde no Município de Jundiaí*), created in 2017, which successfully was able to reduce judicialization by 43% with health mediation practices, as well as reduce the amount of lawsuits filed by the State Public Defenders Office by 58% (COSEMS, 2018).

In addition, the three states that have been studied by other researchers due to successful institutionalisation of sanitary mediation and were mentioned in this chapter are Minas Gerais, Distrito Federal, and Rio Grande do Norte. This represents a larger attempt to reduce judicialization at a larger level.

Despite efforts of local authorities and states in Brazil attempting to create independent administrative conflict resolution bodies, it is still not enough to reduce judicialization nationally, which means the Executive and Legislative Powers will need to make more efforts to increase attempts, as a few local authorities alone are not enough to abolish a national phenomenon.

However, it could be the first steps to achieving this goal if other local authorities and states inspire themselves on those that have been successful, as the benefits for locals, as well as public expenditure itself are high. In addition, Public Health policies related to a SUS reform should take into consideration other Public Health systems and Comparative Law for inspiration and ideas, similarly to what the UK has done in relation to its recent NHS Litigation Reform of 2022.

CONCLUSION

As studied in this work, the right to health was born in a global context with the Universal Declaration of Human Rights (UDHR), which led to the foundation of many Public Health systems around the world, mainly the immediate creation of the National Health Service (NHS) in 1948, as well as the inclusion of the right to health in many Constitutions, such as the Brazilian 1988 Constitution.

Long before the appearance of the right to health and the UDHR, welfare was on a long journey to becoming reality in Great Britain. The first piece of legislation that had anything to do with welfare was The Poor Law of 1601, and Britain took over three centuries to be recognised as a welfare state in the late 1940s with Labour Britain and the creation of the NHS.

The formation process of the NHS was largely based on externalities, as the nation needed a publicly funded health service in order to attend to wounded soldiers and civilians during World War I and II. Another externality was the fact the industrialisation and urbanisation in larger cities needed healthy labourers and had more citizens to attend to.

The United Kingdom, despite its post-Covid-19 pandemic crisis, has maintained its universal model since it was created post-World War II. The NHS Act of 1946 states that the Public Health system is ‘comprehensive’, which means it is free at the point of use and covers most services. It can be concluded that those services will, on occasions, struggle to respond to rapid changes in demand, as seen during the 2020 Covid-19 pandemic recently, and some groups will not always receive equitable access.

A universal service will not always guarantee universal and equitable access, and the right to health will not always be met, not necessarily because of negligence or bad administration of the government, but because some health situations are unpredictable and there may not be enough income to finance health care services.

It was possible to conclude that after 75 years of the NHS, the system continues to serve almost the entire population, around 80% to be more precise, with the exception of a small group that has private health insurance to cover specific treatments not covered by the NHS. On the other hand, in Brazil, after 34 years of the creation of the SUS, one in four people have private health insurance according to the ANS.

With the enactment of the Federal Constitution of 1988, health becomes a right for all and a duty of the State, and universal access is established with the creation of the SUS. The provision of the Public Health service since then would not be restricted to the formal worker, but to all Brazilian citizens and foreigners in Brazilian territory, regardless of employment or nationality.

The SUS, despite providing access and health coverage to a large part of the population, seems to be focused on delivering healthcare services to the poor with low income or the unemployed, since the middle and working class usually prefer to have private health insurance, as the services of the SUS are limited and lack quality and efficiency.

It is possible to confirm that the universal character of the SUS in Brazil is based on the fact that any individual is free to use the service, without discrimination or need to prove financial income, rather than that the service covers the entire nation, and everyone uses it - which is not the case.

The SUS also relies heavily on complementary health. As Brazil is a developing country, it does not have the best infrastructure and most up to date technology in public hospitals and walk-in clinics, let alone enough hospital beds and health professionals to attend to all its users. Therefore, the private sector acts as a crucial health agent assisting the SUS and making this Public Health service possible.

It was possible to conclude that both systems maintain the private sector as a complementary provider of health services and that the trend is to continue with this model. However, the UK makes use of the private sector only for the provision of specific services, such as abortion services and mental health services or elderly care, while Brazil makes general use of the private sector for various services.

The NHS and the SUS are based on the principle of decentralisation, which means local administration has the largest role in attending to the population’s health needs based on specific regional needs. The model of decentralisation of public policies gives greater autonomy to local administration, which results in an increase in actions aimed at promotion of healthcare.

In the 1988 Constitution, the constitutional principle of reducing regional and social inequalities is an informing principle of all economic activity. This means that all economic activity must act to help reduce both regional and social inequalities, that is, both the State and private companies must be in line with public policies to reduce regional and social inequalities.

This constitutional principle must be observed mainly by supplementary health, which operates aiming at profits in a competitive market of private health plans. To ensure that these constitutional duties are respected and fulfilled by health plan operators, the ANS acts to define the list of procedures offered by operators, in addition to regulating and supervising this sector.

In addition to the principle of reducing regional and social inequalities being a mandatory principle to be observed by the State and the private sector in the exploration of economic activity, the principle is also found in the fundamentals of the Federative Republic of Brazil, which gives this principle an even greater relevance - not only guiding economic activity.

The quality of health care services in both countries seems to be a matter of public resource allocation, and, in the case of Brazil, a combination of this problem and mismanagement of resources. This malice must be seen as a serious challenge towards Public Administration, which disrespects the principle of efficiency, in addition to ignoring the constitutional commandment of the right to health as a duty of the State.

The financing of the British healthcare system is greatly similar to the Brazilian healthcare system, whereby general taxation, such as income tax, VAT, and other small contributions such as fees and fines, especially Social Security, finance the system. In addition, employers, and employees, as well as families finance private health insurance, and individuals use private healthcare services paid directly through out-of-pocket spending.

Those that are not Public Health users, that is, are not users of the NHS or the SUS, neither have private health insurance, in other words, those individuals that use private healthcare services through out-of-pocket spending are not considered to be covered. The WHO condemns out-of-pocket spending and recommends that people should have access to health services without financial hardship, and that countries must work to achieve UHC.

The excess levels of litigation in Brazil related to the provision of healthcare services and medication from the SUS and private healthcare insurance providers is known as ‘judicialization’ – a phenomenon that causes overwhelming of the Brazilian Judiciary. Judicialization is also accompanied by ‘judicial activism’ another Brazilian phenomenon considered to interfere with the Executive and Legislative Powers.

Claims related to healthcare in Brazil are the fourth leading causes of judicialization, whilst in the UK only 1% of claims reach the courts. This is because the UK has created an efficient body within the Health and Social Care Department called the NHS Resolution, which has been able to resolve claims in initial stages through independent mediation services.

While the Judiciary in Brazil plays an important role in guaranteeing the right to health of individual claims through the provision of healthcare services and medication, the process of litigation is often slow, costly, and conflicting. It was found that based on other countries experiences, a quicker and cheaper administrative route would be preferable.

The NHS Resolution is crucial in guaranteeing the right to health in the United Kingdom, through ADR such as mediation, and has been successful in avoiding the payment of compensation. In order to avoid compensation, which puts a heavy strain on public expenditure, as it is seen as an unforeseen cost, the conflict must be resolved within the early stages.

The possible reserve theory is heavily used by the Brazilian Judiciary when considering the provision of healthcare services and medication through the SUS, when the specific treatment or medication is not found on the RENAME list and when the claimant is able to pay for it, based on analysis of financial income and household situation.

It was found that the possible reserve theory hinders the right to health through a system which is allegedly universal and should not discriminate based on individuals' financial income, as it is expressed in the Constitution that health is a right for all and a duty of the State. At the same time, it is also the Judiciary's duty to find a balance and consider public expenditure.

It was concluded that although some Brazilian states and local authorities have created sanitary mediation bodies to reduce judicialization, as well as the National Council of Justice with Resolution 107/2010, it is far from the necessary incentive to reduce judicialization at a larger scale. The Executive and Legislative Powers must make an effort to seek appropriate Public Health policies, or else the Judiciary will have to continue intervening.

Efforts to reduce judicialization are scarce and could benefit from Comparative Law and studying other Public Health systems and how they deal with conflict, similarly to this study and the NHS Litigation Reform of 2022, which sought how other healthcare systems dealt with specific conflicts in order to find solutions and improve NHS Resolution performance.

REFERENCES

ANDRADE, Elizabeth Nogueira de; ANDRADE, Edson de Oliveira. O SUS e o direito à saúde do brasileiro: leitura de seus princípios, com ênfase na universalidade da cobertura. **Revista Bioética**, vol. 18, n. 1, p. 61-74, 2010.

ANS. Agência Nacional de Saúde Suplementar. **Boletim informativo**: utilização do sistema único de saúde por beneficiários de planos de saúde e ressarcimento ao SUS. 10 ed. Rio de Janeiro: ANS, jun. 2020. Disponível em: https://static.poder360.com.br/2020/10/boletim-informativo-ressarcimento-edicao-10.pdf. Acesso em: 01 fev 2023.

ANS. Agência Nacional de Saúde Suplementar. **Elaboração das Normas da Saúde Suplementar**. Rio de Janeiro, 2023. Disponível em: http://www.ans.gov.br/legislacao/elaboracao-das-normas-da-saude-suplementar. Acesso em: 01 fev 2023.

ANS. Agência Nacional de Saúde Suplementar. **Relatório Anual de Gestão e de Atividades 2021**. Gerência de Planejamento e Acompanhamento. Rio de Janeiro: ANS, abr. 2022, p. 106-110. Disponível em: https://www.gov.br/ans/pt-br/acesso-a-informacao/transparencia-e-prestacao-de-contas/prestacao-de-contas/Relatrio_Anual_de_Gesto_e_de_Atividades__RAG_2021_2_ed_Alterado_082022.pdf. Acesso em: 01 fev 2023.

ANANDACIVA, Siva. The King's Fund. **The Autumn Budget 2022**: what was announced and what does it mean for health and care spending? United Kingdom, 2023. Available in: https://www.kingsfund.org.uk/blog/2022/11/autumn-budget-2022-announced-what-does-it-mean-health-and-care-spending. Accessed: 06 Feb 2023.

BARROSO, Luís Roberto. **Curso de Direito Constitucional contemporâneo**: os conceitos fundamentais e a construção do novo modelo. São Paulo: Saraiva, 2010.

BARROSO, Luís Roberto. **Fundamentos Teóricos e Filosóficos do Novo Direito Constitucional Brasileiro (pós-modernidade, teoria crítica e pós-positivismo).** A Nova Interpretação Constitucional: ponderação, direitos fundamentais e relações privadas. Rio de Janeiro: Renovar, 2008.

BARROSO, Luís Roberto. **Judicialização, Ativismo Judicial e Legitimidade Democrática.** Disponível em: http://www.oab.org.br/oabeditora/users/revista/1235066670174218181901.pdf. Acessado em: 13 mar 2023.

BECHARA, Fabio Ramazzini; COSTA, Fernanda Soraia Pacheco. Eficiência na prestação de serviços de saúde: experiência brasileira do modelo gerencial e comparativo com os países da common law. **Revista de Direito Administrativo e Constitucional**, Belo Horizonte, n. 75, p. 65-82, jan/mar 2019.

BRASIL. Supremo Tribunal Federal. **Sessão virtual do Plenário Analisa processos sobre Covid-19**. Disponível em:

http://portal.stf.jus.br/noticias/verNoticiaDetalhe.asp?idConteudo=441447&ori=1. Acesso em: 11 mar 2023.

BRASIL. Supremo Tribunal Federal. Notícias. **STF reconhece Competência concorrente de estados, DF, municípios e União no combate à Covid-19**. Disponível em: http://portal.stf.jus.br/noticias/verNoticiaDetalhe.asp?id-Conteudo=463079&ori=1. Acesso em: 11 mar 2023.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Constituição da República Federativa do Brasil de 1988.** Disponível em: http://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm. Acesso em: 20 set 2021.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Lei nº 9.961, de 28 de janeiro de 2000.** Cria a Agência Nacional de Saúde Suplementar – ANS e dá outras providências. Brasília: Diário Oficial da União, 28 jan. 2000a. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/l9961.htm. Acesso em: 17 out 2021.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Lei nº 10.185, de 12 de fevereiro de 2001.** Dispõe sobre a especialização das sociedades seguradoras em planos privados de assistência à saúde e dá outras providências. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/leis_2001/l10185.htm. Acesso em: 12 set 2021.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Lei nº 9.656, de 3 de junho de 1998.** Dispõe sobre os planos e seguros privados de assistência à saúde. Brasília: Diário Oficial da União, 3 jun. 1998. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/l9656.htm. Acesso em: 11 out 2021.

BRASIL. **Lei nº 14.454, de 21 de setembro de 2022.** Altera a Lei nº 9.656, de 3 de junho de 1998, que dispõe sobre os planos privados de assistência à saúde, para estabelecer critérios que permitam a cobertura de exames ou tratamentos de saúde que não estão incluídos no rol de procedimentos e eventos em saúde suplementar. Brasília: Diário Oficial da União, 21 set. 2022. Disponível em: http://www.planalto.gov.br/ccivil_03/_Ato2019-2022/2022/Lei/L14454.htm#art2. Acesso em: 19 jan 2023.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Medida Provisória nº 2.177-44, de 24 de agosto de 2001.** Altera a Lei no 9.656, de 3 de junho de 1998, que dispõe sobre os planos privados de assistência à saúde e dá outras providências. Brasília: Diário Oficial da União, 27 ago. 2001. Disponível em: http://www.planalto.gov.br/ccivil_03/mpv/2177-44.htm. Acesso em: 13 out 2021.

BRASIL. Ministério da Saúde. Gabinete do Ministro. **Portaria nº 2.979, de 12 novembro de 2019.** Institui o Programa Previne Brasil, que estabelece novo modelo de financiamento de custeio da Atenção Primária à Saúde no âmbito do Sistema Único de Saúde, por meio da alteração da Portaria de Consolidação nº 6/GM/MS, de 28 de setembro de 2017. Brasília: Diário Oficial da União, 12 nov. 2019. Disponível em: https://www.in.gov.br/en/web/dou/-/portaria-n-2.979-de-12-de-novembro-de-2019-227652180. Acesso em: 28 set 2021.

BRASIL. Ministério da Saúde. Gabinete do Ministro. **Portaria nº 3.947 de dezembro de 2017.** Atualiza a base populacional para o cálculo do montante de recursos do componente Piso da Atenção Básica Fixo PAB Fixo da Portaria 1.409/GM/MS, de 10 julho de 2013 e do

Anexo I: e altera o Anexo II. Brasília: Diário Oficial da União, 28 dez. 2017a. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt3947_28_12_2017.html. Acesso em: 28 set 2021.

BRASIL. Ministério da Saúde. Gabinete do Ministro. **Portaria nº 3.992, de 28 dezembro de 2017.** Altera a Portaria de Consolidação nº 6/GM/MS, de 28 de setembro de 2017, para dispor sobre o financiamento e a transferência dos recursos federais para as ações e os serviços públicos de saúde do Sistema Único de Saúde. Brasília: Diário Oficial da União, 29 dez. 2017b. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt3992_28_12_2017.html. Acesso em: 28 set 2021.

BRASIL. Ministério da Saúde. Gabinete do Ministro. **Portaria nº 828, de 17 de abril de 2020.** Altera a Portaria de Consolidação nº 6/GM/MS, para dispor sobre os Grupos de Identificação Transferências federais de recursos da saúde. Brasília: Diário Oficial da União, 24 abr. 2020. Disponível em: https://www.in.gov.br/web/dou/-/portaria-n-828-de-17-de-abril-de-2020-253755257. Acesso em: 28 set 2021.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Lei nº 12.401, de 28 de abril de 2011.** Altera a Lei nº 8.080, de 19 de setembro de 1990, para dispor sobre a assistência terapêutica e a incorporação de tecnologia em saúde no âmbito do Sistema Único de Saúde - SUS. Brasília: Diário Oficial da União, 29 abr. 2011a. Disponível em: http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2011/lei/l12401.htm. Acesso em: 04 ago 2021.

BRASIL. Ministério da Saúde. Secretaria de gestão estratégica e participativa. **Decreto nº 7.508, de 28 de julho de 2011.** Regulamenta a Lei nº 8.080, de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde – SUS, o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências. Brasília: Diário Oficial da União, 28 jun. 2011b. Disponível em: http://www.planalto.gov.br/ccivil_03/ato2011-2014/2011/decreto/d7508.htm. Acesso em: 08 out 2021.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Lei Complementar nº 141, de 13 de janeiro de 2012.** Regulamenta o § 3º do art. 198 da Constituição Federal para dispor sobre os valores mínimos a serem aplicados anualmente pela União, Estados, Distrito Federal e Municípios em ações e serviços públicos de saúde; estabelece os critérios de rateio dos recursos de transferências para a saúde e as normas de fiscalização, avaliação e controle das despesas com saúde nas 3 (três) esferas de governo; revoga dispositivos das Leis nº 8.080, de 19 de setembro de 1990, e 8.689, de 27 de julho de 1993; e dá outras providências. Brasília: Diário Oficial da União, 13 jan. 2012. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/lcp/lcp141.htm. Acesso em: 12 set 2021.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Emenda Constitucional nº 86, de 17 de março de 2015.** Altera os arts. 165, 166 e 198 da Constituição Federal, para tornar obrigatória a execução da programação orçamentária que especifica. Brasília: Diário Oficial da União, 17 mar. 2015. Disponível em: http://www.planalto.gov.br/ccivil_03/constituicao/emendas/emc/emc86.htm. Acesso em: 17 jan 2023.

BRASIL. Ministério Da Saúde. Gabinete do Ministro. **Portaria nº 204, de 29 de janeiro de 2007.** Regulamenta o financiamento e a transferência dos recursos federais para as ações e os serviços de saúde, na forma de blocos de financiamento, com o respectivo monitoramento e controle. Brasília, 29 jan. 2007a. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2007/prt0204_29_01_2007_comp.html. Acesso em: 18 jan 2023.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Emenda Constitucional nº 29, de 13 de setembro de 2000.** Altera os arts. 34, 35, 156, 160, 167 e 198 da Constituição Federal e acrescenta artigo ao Ato das Disposições Constitucionais Transitórias, para assegurar os recursos mínimos para o financiamento das ações e serviços públicos de saúde. Brasília: Diário Oficial da União, 14 set 2000b. Disponível em: http://www.planalto.gov.br/ccivil_03/constituicao/emendas/emc/emc29.htm. Acesso em: 12 set 2021.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Lei Complementar nº 101, de 4 de maio de 2000.** Estabelece normas de finanças públicas voltadas para a responsabilidade na gestão fiscal e dá outras providências. Brasília: Diário Oficial da União, 4 de mai. 2000c. Disponível em: https://www.planalto.gov.br/ccivil_03/leis/lcp/lcp101.htm. Acesso em: 17 jan 2023.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Emenda Constitucional nº 95, de 15 de dezembro de 2016.** Altera o Ato das Disposições Constitucionais Transitórias, para instituir o Novo Regime Fiscal, e dá outras providências. Brasília: Diário Oficial da União, 15 dez 2016. Disponível em: http://www.planalto.gov.br/ccivil_03/constituicao/emendas/emc/emc95.htm. Acesso em: 14 set 2021.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Lei nº 8.080, de 19 setembro de 1990.** Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Brasília: Diário Oficial da União, 20 set. 1990a. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/l8080.htm. Acesso em: 03 ago 2021.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Lei nº 8.142, de 28 de dezembro de 1990.** Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS) e sobre as transferências intergovernamentais de recursos financeiros na área da saúde e dá outras providências. Brasília: Diário Oficial da União, 28 dez. 1990b. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/l8142.htm. Acesso em: 17 jan 2023.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Lei nº 8.213, de 24 de julho de 1991.** Dispõe sobre os Planos de Benefícios da Previdência Social e dá outras providências. Brasília: Diário Oficial da União, 25 jul. 1991. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/l8213cons.htm. Acesso em: 07 ago 2021.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Lei nº 8.383, de 30 de dezembro de 1991.** Institui a Unidade Fiscal de Referência, altera a legislação do imposto de renda e dá outras providências. Brasília: Diário Oficial da União, 31 dez. 1991. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/l8383.htm. Acesso em: 08 out 2021.

BRASIL. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. **Lei nº 13.427, de 30 de março de 2017.** Altera o art. 7º da Lei nº 8.080, de 19 de setembro de 1990, que "dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências", para inserir, entre os princípios do Sistema Único de Saúde (SUS), o princípio da organização de atendimento público específico e especializado para mulheres e vítimas de violência doméstica em geral. Brasília: Diário Oficial da União, 31 mar. 2017. Disponível em: http://www.planalto.gov.br/ccivil_03/_ato2015-2018/2017/lei/L13427.htm. Acesso em: 19 out 2021.

BRASIL. **Portaria nº 3.916, de 30 de outubro de 1998.** Aprova a Política Nacional de Medicamentos. Brasília: Ministério da Saúde, 1998. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/1998/prt3916_30_10_1998.html. Acesso em: 15 mar 2023.

BRASIL. **Relação Nacional de Medicamentos Essenciais Rename 2020.** Brasília: Ministério da Saúde, 2019. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/relacao_medicamentos_rename_2020.pdf. Acesso em: 15 mar 2023.

BRAZIER, J.; HUTTON, J.; JEAVONS, R.. Evaluating the Reform of the NHS. Competition in Health Care. **Economic Issues in Health Care,** p. 216-236, London, 1990.

BRIGGS, Asa. **Welfare and the State**: Critical concepts in political science. 2nd Ed. Routledge, Taylor & Francis Group: London, 2004.

BUFFON, Marciano. A tributação como instrumento de concretização dos direitos fundamentais. **Revista da Faculdade de Direito de Uberlândia**, v. 38, n. 2, p. 555-579, 2010.

CALIENDO, Paulo. **Direito Tributário e Análise Econômica do Direito**: Uma análise crítica. Editora Elsevier: São Paulo, 2009.

CARVALHO, Gilson. A saúde pública no Brasil. **Revista Estudos Avançados**, Saúde Pública, vol. 27, n. 78, 2013.

CNM, National Confederation of Municipalities. National Council of Municipal Health Secretariats. **Changes in health funding.** Brasilia, 2018, 40 p. Available in: https://www.cnm.org.br/cms/biblioteca/Mudan%C3%A7as%20no%20Financiamento%20da%20Sa%C3%BAde.pdf. Accessed: 22 Oct 2021.

CHARLESWORTH, Anita; JOHNSON, Paul. **Securing the future**: funding health and social care to the 2030s. Institute for Fiscal Studies. The Health Foundation. NHS Confederation, May 2018.

CHEUNG, Aron. Institute for Government. **Barnett formula.** England, 2020. Available on: https://www.instituteforgovernment.org.uk/article/explainer/barnett-formula. Accessed: 14 Feb 2023.

COSEMS. Conselhos de Secretarias Municipais de Saúde do Estado de São Paulo. **SUS COM VC – Centro de Orientação e Mediação do SUS**: uma experiência de enfrentamento da Judicialização da Saúde no Município de Jundiaí (SP). Publicado: 14 ago 2018. Disponível em: https://www.cosemssp.org.br/noticias/premiados-sus-com-vc-centro-de-orientacao-e-mediacao-do-sus-uma-experiencia-de-enfrentamento-da-judicializacao-da-saude-no-municipio-de-jundiai-sp/. Acesso em: 20 mar 2023.

DAYAN, Mark; WARD, Deborah; GARDENER, Tim; KELLY, Elaine. **How good is the NHS?** The Health Foundation. Institute for Fiscal Studies. The King's Fund. Nuffield Trust, 2018.

DELAMOTHE, Tony. NHS at 60: Founding principles. **The British Medical Journal**, 2008. Available on: https://doi.org/10.1136/bmj.39582.501192.94. Accessed: 06 Feb 2023.

DIAS, Leticia Lucia dos Santos; SANTOS, Maria Angelica Borges dos; PINTO, Cláudia Du Bocage Santos. Regulação contemporânea de preços de medicamentos no Brasil - uma análise crítica. **Revista Saúde Debate**, Rio de Janeiro, v. 43, n. 121, p. 543-558, 2019.

DOYLE, Yvonne. Role of private sector in United Kingdom healthcare system. **The British Medical Journal**, vol. 321, p. 563-565, 2000.

DUCAN, Pamela; CAMPBELL, Denis. **One in eight UK adults using private medical care due to NHS delays**. The Guardian, Dec 15. 2022. Available on: https://www.theguardian.com/society/2022/dec/15/one-in-eight-uk-adults-using-private-medical-care-due-to-nhs-delays. Accessed: 06 Feb 2023.

EMMERSON, Carl; FRAYNE, Christine; GOODMAN, Alissa. **Pressures in UK Healthcare**: Challenges for the NHS. Institute for Fiscal Studies, London, May 2000.

FACHIN, Melina Girardi. SCHINEMANN, Caio Cesar Bueno. Decisões estruturantes na jurisdição constitucional brasileira: critérios processuais da tutela jurisdicional de direitos prestacionais. **Revista Estudos Institucionais**, vol. 4, n. 1, 2018.

FAVERET, Paulo F. Filho; OLIVEIRA, Pedro Jorge de. A universalização excludente: Reflexões sobre as tendências do sistema de saúde. **Revista Planejamento e Políticas Públicas**, nº 3, p. 139-162, jun. 1990.

FLINN, M.W.. **Medical services under the New Poor Law.** The New Poor Law in the Nineteenth Century. Problems in focus, p. 45-46, United Kingdom, 1976.

FGV. Fundação Getúlio Vargas. **Relatório ICJ – Brasil 2021.** FGV Direito, São Paulo. Disponível em: https://bibliotecadigital.fgv.br/dspace/bitstream/handle/10438/30922/Relato%cc%81rio%20ICJBrasil%202021.pdf?sequence=1&isAllowed=y. Acesso em: 16 mar 2023.

GHEBREYESUS, Adhanom Tedros. **Health is a fundamental human right.** Human Rights Day 2017. World Health Organization (WHO). Available on: https://www.who.int/news-room/commentaries/detail/health-is-a-fundamental-human-right. Accessed: 30 Aug 2022.

GHEBREYESUS, Adhanom Tedros. **World Health Statistics 2022**: Monitoring health for the Sustainable Development Goals (SDGs). World Health Organization (WHO). Available: https://www.who.int/data/gho/publications/world-health-statistics. Accessed: 10 Oct 2022.

HABER NETO, Michel. A tributação e o financiamento do direito à saúde no Brasil. 2012. Dissertação (Mestrado em Direito Econômico e Financeiro) - Faculdade de Direito, **Universidade de São Paulo (USP)**, 2012.

HEATH, Iona. In defence of a National Sickness Service. **National Library of Medicine**, 2007. Available on: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1764107/. Accessed: 11 Jan 2023.

HOWELL, J. B. L.. Re-examining the fundamental principles of the NHS. **The British Medical Journal**, vol. 304, p. 297-299, 1992.

IBGE. Instituto Brasileiro de Geografia e Estatística. **Pesquisa Nacional de Saúde 2019**: informações sobre domicílios, acesso e utilização dos serviços de saúde. Disponível em: https://biblioteca.ibge.gov.br/visualizacao/livros/liv101748.pdf. Acesso em: 16 mar 2023.

JAMES, John H.. Healthcare financing for the under-served: UK. **Journal of the Royal Society of Medicine**, vol. 94, p. 462-465, 2001.

JARDIM, Eduardo Marcial Ferreira. A Constituição Federal e a saúde pública no Brasil: visão crítica sob a óptica tributária e financeira. Constituição, Economia e Desenvolvimento: **Revista Eletrônica da Academia Brasileira de Direito Constitucional**, v. 11, n. 20, p. 111-153, 2019.

KING, Steven. **Poverty and welfare in England 1700-1850**: A regional perspective. Studies in modern history. Manchester University Press, 2000.

LIMA, Luiza Beattrys Pereira dos Santos; AGUIAR, Marcus Pinto. Mediação sanitária como instrumento de efetivação do direito fundamental à saúde. **Revista Direito Sanitário**, São Paulo, v.22 n2, ed. 0015, 2022.

MACHADO, Ana Luisa Araújo. Os impactos da declaração de taxatividade do rol da Agência Nacional de Saúde pelo Superior Tribunal de Justiça no Ecossistema da saúde suplementar. **Revista Caderno Virtual (Direito, Cultura e Literatura)**, v. 1 n. 53, 2022.

MORALES, Milton Filho; VASCONCELLOS, Cidia; MOTA, Andre. A Carta de Ottawa e a medicina grega antiga: breve reflexão sobre dois momentos históricos e a mudança nos paradigmas de definição de saúde. **Revista Internacional de Humanidades Médicas**, vol. 04, n. 02, p. 95-100, 2015.

NETTO, Fernanda; CARNEIRO, Jeane Lima e Silva. **Saúde Coletiva.** Vol. 1. São Paulo: Editora Medcel, 2021.

NHS. National Health Service. **If I pay for private treatment, how will my NHS care be affected?** England, 2022. Available on: https://www.nhs.uk/common-health-questions/nhs-services-and-treatments/if-i-pay-for-private-treatment-how-will-my-nhs-care-be-affected/. Accessed: 06 Feb 2023.

NHS. National Health Service. **Claims management.** England, 2023a. Available on: https://resolution.nhs.uk/services/claims-management/. Accessed: 19 mar 2023.

NUNES, Ketlen Dalalba; QUEMEL, Franciele da Silva; ALEXANDRE, Monica Micheli; CEBRIAN, Rosinéia Aparecida Vilela; BOLETA-CERANTO, Daniela de Cássia Faglioni; LOURENÇO, Emerson Luiz Botelho; HOSCHEID, Jaqueline; ZARDETO, Giuliana. Políticas públicas de medicamentos e a relação de Medicamentos essenciais. **Arquivos de Ciências da Saúde da UNIPAR**, Umuarama, v.1, n.1, p. 50-72. 2023.

MAXWELL, Robert. Aneurin Bevan on the NHS. **The British Medical Journal**, vol. 304, p. 200, 1992.

MELO, Daniela Vieira de. Considerações sobre análise econômica do Direito e a efetividade: direito fundamental à saúde no Brasil. **Revista Digital Constituição e Garantia de Direitos**, vol. 9, n. 1, 2016.

MERRIAM-WEBSTER. **Quango.** Merriam-Webster Dictionary. Available on: https://www.merriam-webster.com/dictionary/quango. Access: 02 Feb 2023.

MERRIAM-WEBSTER. **Ombudsman**. Merriam-Webster Dictionary. Available on: https://www.merriam-webster.com/dictionary/ombudsman. Access: 20 mar 2023.

MOTTA, Sylvio. **Direito Constitucional.** 29ª ed. Grupo GEN: Rio de Janeiro, 2021.

MUSGROVE, P. Health insurance: the influence of the Beveridge Report. **Bulletin of the World Health Organization**, vol. 78, n. 6, p. 845-846, 2000.

OLIVEIRA, Emerson Ademir Borges de. **A Constituição brasileira ao alcance de todos.** Editora D'Placido: São Paulo, 2020.

OLIVEIRA, Emerson Ademir Borges de; TROVAO, Lidiana Costa de Sousa; PIACENTI, Lara Guimaraes. Diálogos institucionais, teoria da última palavra e supremacia constitucional no ativismo judicial dialógico do Supremo Tribunal Federal. **Revista dos Tribunais**, n. 110, vol. 1034, pgs. 165-180, dez 2021.

OLIVEIRA, Emerson Ademir Borges de; SOUZA, Alessandro de Almeida Santana. Teoria da reserva do possível: a escassez de recursos como limitação para a concretização de direitos fundamentais. **Revista da Toledo Prudente**, vol. 22, p. 110-125, 2017.

ONU. Organização das Nações Unidas. **Declaração Universal dos Direitos Humanos (DUDH)**. Publicado em: 10 dez 1948. Disponível em: https://brasil.un.org/pt-br/91601-declaracao-universal-dos-direitos-humanos. Acesso em: 09 ago 2022.

PATERSON, Audrey. **The Poor Law in nineteenth-century Scotland.** The New Poor Law in the Nineteenth Century. Problems in focus, p. 171-193, 1976.

PARISI, Luciana; SILVA, Jandira Maciel da. Conflict mediation in SUS as a transformative political action. **Revista Saúde Debate**, Rio de Janeiro, v. 42, n. especial 4, p. 30-42, dez 2018.

PEREIRA, Daniel de Macedo Alves. **Planos de Saúde e a Tutela Judicial de Direitos**: Teoria e Prática. Saraiva: São Paulo, 2020.

POWELL, Martin. Exploring 70 Years of the British National Health Service through Anniversary Documents. **International Journal of Health Policy and Management**, National Library of Medicine, p. 574–580, 2018. Available on: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6037491/. Accessed: 17 Jan 2023.

RIBEIRO, Wesllay Carlos. Mediation as a means of resolution of conflicts in the health area. **Revista de Direito Sanitário**, São Paulo, v.18, n.3, p. 62-76, dez 2018.

ROSENBAUM, Sara. The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice. Public Health Reports. **Law and the Public's Health**, v. 126, p. 130-135, 2011.

ROSSI, P.; DWECK, E. Impactos do Novo Regime Fiscal na saúde e educação. **Cadernos de Saúde Pública**. Rio de Janeiro, v. 32, n. 12, 2016.

SCHIER, Adriana da Costa Ricardo; BEREJUK, Léa Maria Massignan. O direito fundamental social à saúde e a administração pública. **Revista em tempo**, Marília, v. 15, p. 250-272, 2016.

SENA, Oswalter de Andrade Sena Segundo. O princípio constitucional da redução das desigualdades regionais e sociais e sua efetivação jurídico-política na ordem econômica. **Revista Direito e Liberdade**, v. 7, n. 3, p. 371-400, jul/dez 2007.

SILVA, Michelle Emanuella de Assis. Direito à saúde: evolução histórica, atuação estatal e aplicação da teoria de Karl Popper. **Revista Digital Constituição e Garantia de Direitos**, v. 9 n. 2, 15ª ed., p. 04-22, 2016.

SILVA, Marco Aurélio Souza da; GONÇALVES, Everton das Neves. Direito e economia na consecução de políticas públicas para saúde no Brasil. **Revista de Direito, Economia e Desenvolvimento Sustentável**, n. 2, vol. 3, p. 17-39, jul/dez 2017.

SILVA, Karina Zanin da; VITA, Jonathan Barros. O princípio da reserva do possível e o direito fundamental à saúde. **Revista Jurídica Cesumar**, v. 14, n. 1, p. 241-264, jan/jun 2014.

TANAKA, Oswaldo Yoshimi; BEZERRA, Adriana Falangola Benjamin; BRITO-SILVA, Keila. Direito à saúde e integralidade: uma discussão sobre os desafios e caminhos para sua efetivação. **Revista Interface – Comunicação, Saúde, Educação (UNESP)**, vol. 16, n. 40, 2012.

UK. United Kingdom. HM Treasury. **Public Expenditure Statistical Analyses (PESA) 2019.** England, 2019. Available on:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/818399/CCS001_CCS0719570952-001_PESA_ACCESSIBLE.pdf. Accessed: 14 Feb 2023.

UK. United Kingdom. The King's Fund. **How is the NHS structured?** England, 2020. Available on: https://www.kingsfund.org.uk/audio-video/how-is-nhs-structured-funding-flow. Accessed: 06 Feb 2023.

UK. United Kingdom. **NHS Litigation Reform**: Report Executive Summary. UK Parliament. Published: 28 Apr 2022. Available on: https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/740/summary.html. Accessed: 20 mar 2023.

WEBSTER, Charles. **The National Health Service**: A political history. Oxford University Press: London, 2002.

YAMADA, Marco Aurélio Franqueira. A Efetividade do Direito à Saúde Através da Iniciativa Privada no Estado Social de Direito. **Revista Eletrônica do Curso de Direito das Faculdades OPET**. Curitiba-PR. Ano XI, n. 19, jul-dez/2018.