ISSN: 2358-1824

Cadernos Ibero-Americanos de Direito Sanitário
Cuadernos Iberoamericanos de Derecho Sanitario

Article

The (tacit) inclusion of the municipality in the legislative competence for the protection and defense of health: analysis under the binomial urgency and popularization

A inclusão (tácita) do município à competência legislativa para proteção e defesa da saúde: análise sob o binômio urgência e popularização

La inclusión (tácita) del municipio en la competencia legislativa para la protección y defensa de la salud: análisis bajo el binomio urgencia y divulgación

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Submitted on: 01/23/24
Revision on: 08/16/24
Approved on: 08/16/24

Abstract

Objective: this study analyzes the federalist decentralization materialized by decisions of the Brazilian Supreme Federal Court rendered during the SARS-CoV-2 virus pandemic. In this context, the aim is to consider the possibility of tacitly including municipalities within the concurrent legislative competence in the area of health, based on the elements of popularization and urgency. **Methods:** the study is based on bibliographic research – legal and public health doctrine – and legislative research, as well as ex post facto research, analyzing the causes and effects of Direct Action of Unconstitutionality 6.341, Allegation of Violation of Fundamental Precept 672, and Original Civil Action 3.451, all grounded in cooperative federalism. **Results:** as a result, the recognition of the municipality's duty to legislate in defense of health, especially in the inertia of other entities and limited only by regulatory agencies, and the existence of a delaying clash between legislative incompetence, urgency and popularization of the health system. **Conclusion:** it was concluded that the municipality was tacitly included in the legislative competence in the area of health by the decisions of the STF.
Keywords: Constitution; Jurisprudence; Municipality; Health policy.

Resumo

Objetivo: o presente estudo analisa a descentralização federalista materializada por decisões do Supremo Tribunal Federal proferidas durante a pandemia do vírus Sars-CoV-2. Com isso, objetiva-se considerar a possibilidade da inclusão tácita do município à competência concorrente legislativa na área da saúde, a partir dos elementos de popularização e urgência. **Metodologia:** o estudo pautou-se em pesquisa bibliográfica – doutrina jurídica e sanitária – e legislativa, além da pesquisa ex post facto, com a análise das causas e dos efeitos da Ação Direta de Inconstitucionalidade 6.341, da Arguição de Descumprimento de Preceito Fundamental 672 e da Ação Cível Originária 3.451, todas fundamentadas

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no federalismo cooperativo. **Resultados:** o reconhecimento do dever do município em legislar em defesa da saúde, especialmente na inércia dos demais entes e limitado apenas por agências reguladoras, e a existência do embate protelatório entre incompetência legislativa, urgência e popularização do sistema de saúde. **Conclusão:** concluiu-se pela inclusão tácita do município à competência legislativa na área da saúde pelas decisões do STF.
Palavras-chave: Constituição; Jurisprudência; Município; Política de Saúde.

Resumen

Objetivo: el presente estudio analiza la descentralización federalista materializada por decisiones del Supremo Tribunal Federal pronunciadas durante la pandemia del virus Sars-CoV-2. Con esto, se busca considerar la posibilidad de la inclusión tácita del municipio en la competencia legislativa concurrente en el área de la salud, a partir de los elementos de popularización y urgencia. **Metodología:** el estudio se basó en investigación bibliográfica – doctrina jurídica y sanitaria – y legislativa, además de la investigación ex post facto, con el análisis de las causas y efectos de la Acción Directa de Inconstitucionalidad 6.341, la Alegación de Incumplimiento de Precepto Fundamental 672 y la Acción Civil Originaria 3.451, todas fundamentadas en el federalismo cooperativo. **Resultados:** en consecuencia, el reconocimiento del deber del municipio de legislar en defensa de la salud, especialmente en la inercia de otras entidades y limitada solo por las agencias reguladoras, y la existencia del choque dilatorio entre la incompetencia legislativa, urgencia y popularización del sistema de salud. **Conclusíon:** se concluye que el municipio está tácitamente incluido en la competencia legislativa en materia de salud por las decisiones del STF.
Palabras clave: Constitución; Jurisprudencia; Municipio; Política sanitaria.

Introduction

Brazil demarcates its territorial competence into three federal entities: the Union, the states and the municipalities [3]. The role of municipalities in health matters is set out in Law Nº. 8.080/90 (SUS Law)[(1)] and in articles 23 and 30 of the 1988 Federal Constitution (FC/88)[(2)], which set out issues of local interest - to the extent that it is only included in the common administrative competence of the entities. As a result, municipal power is not included in Article 24 of the Federal Constitution of 1988 (FC/88)[(2)], which sets out the list of entities competent to legislate in defense of health.

The municipality, however, has the administrative competence, provided for in art. 23, II, of the FC/88, to carry out what the legislation provides for in the health sphere. It is also up to the municipal authorities to take care of health, according to art. 23, II, of the FC/88[(2)], in keeping with cooperative federalism, which proposes replacing the predominance of the private competence of a single federal entity in favor of joint action by all entities[(3)].

Despite the absence of an express provision for the municipality in the text of concurrent competence, set out in art. 24, item XII, of the FC/88[(2)], recent jurisprudence, as a result of the outcome of the SARS-CoV-2 virus health crisis, demonstrates flexibility in the face of local competence, by allowing the municipality to legislate in the inertia of other entities, even though, before the pandemic, there was a centralization of legislative competence in favor of the Union, justifying the present study.

Among the case law, we highlight Direct Action of Unconstitutionality 6.341 (ADI 6.341), Original Civil Action 3.451 (ACO 3.451) and Arguition of Fundamental Presunption 672 (ADPF 672), which discussed, respectively, the legislative competence of each federal entity in combating the Sars-CoV-2 virus[(3)]; the competence of the federal entities to adopt immunization measures during the

[3] We are not ignoring the existence of the Federal District, which may be an exception to certain federal aspects, but in order to avoid lengthening the study, it is structured in line with the rule: Municipalities, States and the Union.

pandemic[4]; and the possibility of action by the federal entities in the event of inaction by the Union, in terms of health care[5].

When exploring the provisions of ADI 6.341, ACO 3.451 and ADPF 672, in exchange with the other judgments of the pandemic period, it can be seen that the Supreme Court has as peculiarities of health the popularization of health, through the concept of municipalization, and urgency, through the North American *presumption against preemption* clause[4].

Due to this legal logic intrinsic to health, this study analyzes the federalist decentralization materialized by decisions of the Federal Supreme Court (STF) handed down during the Sars-CoV-2 virus pandemic. The aim is to consider the possibility of the tacit inclusion of the municipality in the concurrent legislative competence in the area of health, based on the elements of popularization and urgency.

Methodology

The study, using a deductive methodology, made use of qualitative exploratory research by means of a bibliographical review[6], based on articles, dissertations, theses and books, both physical and virtual, authored by theoreticians of constitutional law, municipal law, administrative law, sanitary law and public health**.**

The selection of the texts analyzed was made possible through the use of virtual academic platforms, with emphasis on the Brazilian Digital Library of Theses and Dissertations (BDTD) which, by using the keywords “health”, “federalism”, “competence” and “pandemic”, made available several recent studies on the subject.

Also noteworthy is the *ex post facto* research[6], with an analysis of the causes and effects of case law. Due to the theoretical predominance of the topic - legal and health doctrine - there was no practical application apart from the analysis of the causes, terms and effects of Direct Action for Unconstitutionality 6.341 (ADI 6.341), the Argument for Non-Compliance with Fundamental Precept 672 (ADPF 672) and the Original Civil Action 3.451 (ACO 3.451).

Regarding the choice of decisions above, it was found that ADI 6.341, ADPF 672 and ACO 3.451 provided the basis for the other STF discussions by establishing elements used throughout the pandemic, such as urgency and municipalization, and thus considered paradigm decisions, as demonstrated by the multiple studies analyzed throughout the text. Among the other decisions handed down during the pandemic, the debate is more closely linked to each specific case. Therefore, if we chose to analyze them, the deductive methodology (starting from a whole towards the specific) would be invalid[6].

In the course of the study, documentary research[6] became essential to the factual analysis of the current legal interpretation, due to the gap between legislation and interpretation. With this in mind, the report of the 1992 National Health Conference was examined - as it was the forerunner of municipalization as a goal and objective of public health - which was placed in comparison with the 1988 Federal Constitution (CF/88), the National Health Plan in force from 2020 to 2023 and Law No. 8.080 of September 19, 1990 (SUS Law).

With the analytical-comparative aim of the three aspects of the subject, namely legislation, case law and doctrine, we sought to achieve the aforementioned research objective.

[4] Presuption Against premption, i.e. presumption against the unrestricted preference of the federal rule.

Legislative competence in the area of health

Health is a field of rights implemented through public policies and should be studied from the perspective of interdependence[7]. Interdependence presupposes collective efforts and reciprocal duties; it is the responsibility of all federal entities to manage health, as the CF/88 states: "Art. 196. Health is the right of all and the duty of the State[5]"[2].

Municipalities have "(...) the capacity for self-organization, self-government, self-administration and self-legislation"[8, p. 3390-3392] and are entrusted with the duty to conduct public health in practice, under the terms of the common administrative competence of art. 23, item II, of the CF/88[2].

The legislation also provides for concurrent legislative competence - "in which the Union establishes the general rules, to be supplemented by the States, the Federal District and the Municipalities (BRAZIL, 1988, arts. 24 and 30, II)"[9]. It should be mentioned that art. 24 of the CF/88 binds the states to supplementary powers[6] and bridging powers[7] while it limits the municipalities to enacting non-competing rules that are subordinate to the general federal rules. Thus, if there is no general federal rule, the municipality is incompetent, with the exception of cases where the extraordinary rule of local interest applies[10].

However, even with the predominance of local interest, the existence of a federal rule establishing parameters for the municipality to legislate is mandatory. Therefore, the greatest contribution of the local interest provision is not the possibility of immediate action by the municipality (as occurs in Binding Precedents 38[8] and 42[9] of the STF), but rather its reflex effect: the political-administrative decentralization of the Health System, under the terms of art. 198 of the CF/88 and art. 7º of Law nº 8.080/1990 (SUS Law).

With the understanding that the municipality has the power and duty to execute health requirements - common administrative competence (article 23 of the CF/88) - the discussion in this study is formulated in the light of municipal competence in the concurrent legislative sphere (article 24 of the CF/88), given that the municipality does not, in theory, have legislative competence in defense of health. In dealing with legislation, the aim is not to engage in dialogue, but to encourage other studies to suggest changes in administrative powers, based on legislative changes, since material action lies within the limits of formal action.

The popularization of Heath

The social aims of health protection are built up through public policy councils, especially at municipal level. Councils make it possible for political decisions to follow the public interest and meet collective needs[13].

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[5] The concept of the state, when considering the constitutional provision listed, refers to all federative entities and determines a common duty, regulated mainly by Law 8.080/90, which states in Article 2: "Health is a fundamental right of the human being, and the state must provide the indispensable conditions for its full exercise"[1].

[6] Competence that allows the state to supplement particular rules, if the general rules have already been formulated by the Union[10].

[7] Competence that enables the state to establish general rules for the publication of particular rules that are only valid within its sphere of autonomy[10].

[8] It determines that it is up to the municipality to set the opening hours of commercial establishments, due to the existence of local interes[11].

[9] It establishes the unconstitutionality of linking the readjustment of salaries of state or municipal civil servents to gederal monetary correction indexes, due to the local interest and the resources available in each Municipality or State[12].

Post-positivist society resorts to popularizing public health through health councils and plenary sessions; it tends to prescribe the participation of civil society and practical citizenship as a social remedy[14]. It's a question of mitigating the state's material powers to the community, starting in the physical environments closest and most primary to citizens.

In this sense, municipalization emerged - the theme of the IX National Health Conference (IX CNS)[15] - a concept made concrete by Mário Magalhães da Silveira's "Sanitary Developmentism", which seeks to adapt a new sociability, with the aim of bringing health closer to democracy by facilitating access to a healthy system[16].

The conference set the goal of decentralization and local control of the Unified Health System, respecting regional autonomy. In the same vein, the SUS Law, art. 7, items VIII and IX, points "a" and "b", lays down the principles of community participation and political-administrative decentralization of health, with hierarchical and regionalized local command in each municipality[1].

These principles that govern the SUS Law are elements that originate in municipalization, which, from the outset, emphasizes decentralization to the municipality and the participation of citizens in health decisions.

Municipalization goes beyond the simple transfer of resources, as it defines the municipality as the legislator, manager and executor of health services. It involves the implementation of a "set of technical and administrative capacities of reasonable complexity so that the municipal authority can plan, evaluate, audit, finance and control the hospital network installed in the municipality"[17], as well as outpatient and preventive services.

Municipalization and, as a result, the popularization of health, was made a reality with the SUS Law, due to the public movements mentioned above that advocated the presentation of this concept to the legislator, despite the fact that it had been present since the first discussions of the health system.

However, in the legislative sphere, the local authority does not have the prerogative of the states to supplement particular rules or establish general rules that are valid within their sphere of autonomy[10]. The municipalities, despite the theorization of municipalization, remained at the mercy of the normative gap until the recent STF decisions - with a change from centralizing to decentralizing - based on the popularization of health and cooperative federalism.

The urgency of health: the right to life

Urgency and prevention are part of the nature of health, and are even one of the objectives of the SUS[1]. The slowness of public health affects the right to life; therefore, urgency is intrinsic to the health system. It is also possible to classify health as the incipient that perhaps questions the numerous formal requirements that prevent speed: the slowness of the health system affects the fundamental right to subsistence.

In a broad sense, with attention to speed, the National Health Plan (PNS), in force from 2020 to 2023, concurrently with the 16th National Health Conference, establishes the common competence of the entities, through a regionalized, decentralized and hierarchical management policy[18]. It is hoped that, given local governance, hospital administration, outpatient services and the whole health sector will be delivered quickly.

In the strict sense, urgency is presented by the US *presumption against preemption* clause, which prevents the presumption of prevalence of the federal rule over the others, except in cases of express

material contradiction between the rules[19]. It is understood that federal law should not prevent the enactment of state or municipal law in advance.

In federalism, there is no basis for the prior suppression of a rule, except in the case of constitutional control[20]. The rule seeks to avoid censorship by local citizens and, at the same time, to bring the system closer to the ideal of democracy, by allowing specific measures to be taken in certain places by a majority vote of the community[21].

Two principles emerge from "urgency": subsidiarity and proportionality. Based on both, the health system must allow all entities to legislate in order to define what is most capable of meeting the needs of the population. Only local or regional laws that expressly impose themselves against federal laws on the same subject are considered illegitimate[21].

According to Justice Carmem Lúcia's position in ADI 6.341, subsidiarity and urgency can be summarized as: "everything that the smaller entity can do more quickly, economically and effectively should not be done by the larger entity"[3].

Urgency, like popularization, predates the pandemic and has always been present in the health system, in moments of health crisis and normality, but only with the recent decisions of the STF has it been used as a basis for decentralization and cooperation between entities in the health system.

Supreme Court decisions

It can be seen from the STF justices' rulings during the SARS-CoV-2 pandemic that the landmark decisions (ADI 6.341, ADPF 672 and ACO 3.451) are based on two pillars: cooperative federalism and teleological interpretation. Both are considered pillars because they are listed frequently in the decisions and, as will be shown below, provide the basis for the discussion of legislative health competence.

Cooperative federalism, shaped by the co-participation of the entities, has been regularly considered since the federalist system was established, but only with recent precedents has the decentralization of health been guided.

The teleological interpretation mirrors the thinking of Rui Barbosa, who condemned the "hypertrophy of the powers of the Union"[22]. The legal system stipulates federal intervention as an exception, under the terms of articles 34 and 35 of the CF/88. Thus, teleology dissipates the prior censorship of local law by allowing the municipality to act, which, in large part, may be the most capable entity, as is the case in Rui Barbosa's example:

> In Pernambuco and Amazonas, Rui had no political or institutional interest, but he reacted to the subversion with the same energy. In the case of Amazonas, he analyzed and criticized the violence, in speeches and opinions, proving that "the bombardment of Manaus, the deposition of the Governor by federal weapons is an extreme of anarchy and savagery, whose unexpected explosion shocks us". After demonstrating that the legal solution lay with the local authorities, especially the legislature, he condemned the hypertrophy of the Union's powers, its "absorbing tendency" to "turn the Federal Government into a continuous intervener in the constitutional life of the State"[22, p. 9].

Even if there were no proof of greater capacity on the part of the local authority, the inertia and omission of other authorities are grounds for justifying local legislative initiative. A large proportion

of positive rights, realized through public policies, depend on government action. Therefore, "if one of the powers fails to play its role, it is up to the others to remedy its absence"[23].

Since federalism is a permanent clause (inalterable), according to article 60, § 4, I, of the FC, case law provides for the popularization and urgency of health without expansive changes, only as a practice of decentralized state action appropriate to all entities[24].

Direct Action of Unconstitutionality 6.341

Direct Action of Unconstitutionality 6.341, judged in a session held on April 15, 2020, presents itself as the link between the normative content and teleological interpretation, as Justice Luiz Fux[3] calls for. It is important to clarify that, with the analysis of the arguments made by the plenary of the court, teleology emerges in favour of the popularization and urgency of health, as will be seen below.

In the context of the decision lies the thesis of legislative communion. As a rule, municipal legislation is limited to the local interest. However, the STF affirms the subsidiarity of local interest by demonstrating that the municipal legislator is limited only by the technical knowledge of regulatory bodies, such as the National Health Surveillance Agency (ANVISA), in order to analyze the subject matter of the legislative act without proof of the predominance of interest[3].

This avoids the irregular application of the principle of the predominance of interests, which has been used as a basis for centralizing health to the federal power in some decisions and, in others, for decentralizing health to the single government of each entity[25].

Legislative formalities affect all entities: "The exercise of legislative activity materializes with the drafting of normative species that formalize parliamentary action and consolidate the political idea"[26]. Therefore, there is no way to prevent municipal action on the basis of the legislative process, as this is also a requirement for action by the states and the Union.

As for the screening of autonomous bodies, all entities are bound by the requirements stipulated by ANVISA, defined by Law 9.782/99. According to Justice Luiz Fux[3], regulatory agencies stand out for their *expertise* in the activity they manage, and should be taken as a basis for the conduct of any entity.

However, as has been decided, the inertia of one political entity cannot prevent the action of another. Justice Edson Fachin is in favour of municipalization, due to the protection provided for in article 7, IX, "a", of the SUS Law. The Justice reiterates that the hierarchization of healthcare lies in the fact that each entity has a single command in its territory, not in the assumption that the Union is above the state or municipality[3]. He also shows affinity with the *presumption against preemption* clause, due to the legislative cooperation promoted by federalism:

> In other words, in the organization of federal competences, the Union exercises pre-emption in relation to the attributions of the other entities and, in the silence of federal legislation, states and municipalities have the presumption against this pre-emption, the so-called "presumption against pre-emption" in US law. The National Congress may, if it sees fit, regulate a certain issue or public policy in a harmonized and national way. However, in its silence, the exercise of the competences of other entities in the promotion of fundamental rights cannot be hindered.[3, p. 38]

The plenary adds to the debate the very urgency (also dealt with during the study) as one of the specificities of health. In the words of Justice Fachin, the STF must analyze the subject matter of the rule under debate before judging the legislator to be incompetent. If the local rule does not offend the

constitutional content and fundamental rights, there is no need to declare it null and void, otherwise it would be limited to judging the entity, without considering the true purpose of monitoring the rule: to verify the principles on which it is based and its conformity with the legal system[3].

The judges describe the unity and diversity of the federation through the dynamism of federalism, which is historically rearranged in a unison or disharmonious way. By going beyond technical limits and seeking protective measures for health, federalism overcomes the idea of exclusive powers for each of the entities. The areas of private competence are changed to the cooperation model, as Karl Loewestein's studies show[3].

In keeping with Rui Barbosa's concept of evolutionary federalism, the ministers present a federative system that is cohesive, precise, cooperative and attentive to the matter. Unitary thinking and legislative permission for all entities, to the extent of their capacities and requirements, are laid out.

The plenary demonstrates a scenario of primacy of the matter, motivated by the popularization (municipalization) of health, together with the urgency summarized by Justice Carmem Lúcia: "the citizen, at the height of suffering, will knock on the door of the mayors, who will have to talk about what is necessary in specific contingencies and conditions'[3].

The decision, like the other STF rulings during the pandemic, is based on Cooperative Federalism, which is implicitly based on urgency and popularization to allow municipalities to act autonomously.

Fundamental Precept Argument (ADPF) 672

ADPF 672, with an injunction judged on April 8, 2020, also deals with the cooperation of the entities and the decentralization of the health system. Justice Alexandre de Moraes affirms the joint action of all federal entities as the only possibility of defending the public interest and the well-being of society[5]. The minister urges the Union not to intervene in state or municipal initiatives that comply with the regulations of technical bodies such as Anvisa, WHO and research institutes, due to the lack of constitutional grounds for intervention[5].

It is apparently serious that the inaction of the federal and state governments prevents municipalities from implementing essential public policies, or that the Union fails to finance and provide full logistical support to other entities, as it is the most common and broadest sphere in the country[5].

Interconnected with the other decisions, Original Civil Action 3.451 (ACO 3.451), discussed in detail below, ratifies the need for mutual support between the federative entities, precisely because it is the duty of each entity to "make the population's right to health effective within their territories"[4, p. 5].

Therefore, although the municipality does not have the original power to legislate in defense of health - a fundamental right - case law grants it to the municipality, with the aim of preventing death or serious suffering caused by its violation or by the inaction of other entities[27].

Original Civil Action nº 3.451

In order to remedy possible omissions by the federal entity, and based once again on cooperative federalism, the STF, in the person of Justice Ricardo Lewandowski, provided in a precautionary

measure in ACO 3.451, with judgment in a virtual session on April 23, 2021, the active legislative action of all entities, including the municipality, in defense of health[4].

As with the decisions listed above, ACO 3.451 demonstrates a strong attachment to the popularization and urgency of health, elements that, among other fundamental rights, guide a different stance in the field of health, focused on speed. However, with the precautionary decision, one of the main objectives of the health system is also presented: prevention.

The STF recognizes preventive medicine and reaffirms community participation in the field of health, with political-administrative decentralization, given that preventive measures are determined locally by the entity closest to the population and based on general rules and standards[4]. The Court has also ruled that health is a social and collective right and therefore precedes the authority of the elected government, being an intrinsic duty of the State (Union, states, Federal District and municipalities), separate from any political-electoral agenda.

Justice Edson Fachin's position is identical to the one mentioned above, as he affirms the existence of state obligations, which are to respect, protect and fulfill fundamental rights, including health. Thus, the exclusive existence of government obligations, such as the fulfillment of electoral promises, is ruled out. On the contrary, state obligations, as a unity of all entities, are independent of the elected government and must be prioritized by all entities together[4].

As a result, decisions are based on urgency and popularization, which are always present in the health sphere, due to the notion that social rights are popular because they are intended for and promoted by everyone, and urgent, due to preventive medicine and curative medicine: both required for well-being before and after the disease is identified[28].

Tacit inclusion of the municipality in legislative competence

It is consistent for a municipality not to legislate for citizens in another territory. However, local law reveals peculiarities that can aggregate in various spheres of action, even if they are not covered by local interest. The reprimand of the municipal legal provision, prior to the implementation of its own legislation, allows for regional discrepancies that are contrary to national peculiarities and municipal heterogeneity, in all areas[29].

Through municipal participation, democracy is more fully realized, which takes shape in its territory and induces state and federal development through autonomous local initiatives. It is municipal participation that makes it possible to see a path towards popularization and urgency.

The permissibility of local legislation, in other words, adapts to the specificities of health. By applying urgency and popularization, the STF's jurisprudence sets up a scenario of power for local entities and allows authorities to implement policies according to the capacity of each municipality:

> In other words, the local interest clause should restrict the scope of action of the municipality when its particularities hinder the enjoyment of public policies by its citizens, and should support bolder public policies for those local entities that can effectively implement them.[30, p. 262]

Preventing the municipality from legislating, especially in cases of federal inertia, means reducing the possible ways of achieving the health system's objectives, at least legislatively.

The system analyzed is designed to transfer power from the central to the peripheral levels[27], in order to comply with the specificities of health, but it does not presuppose, on the merits, reversing

any governmental collapse: the inclusion of the municipality is not intended to solve complications inherent in the system of government, but it is reprehensible to allow the inertia of the entities to undermine municipal action.

Local interest, inertia and municipal comparison

It is credible to question whether decentralization is applied to the detriment of the constitutional basis of eradicating regional inequality, laid down in Article 3, III of the FC/88(2). It is clear that the Constitution refers to municipal and regional heterogeneity when dealing with this foundation, since the polarization of regions attracts investment to the more developed localities and fails to favour developing regions[31].

Lucas Verderosi states that regional omission should not limit local action, since areas of local impact always fall within the sphere of local interest, which must avoid the legal uncertainty caused by the omissions of other entities[32].

The contrary view is that municipalities can implement policies according to their own capacities. Therefore, it is not appropriate to demand that one municipality be limited based on the momentary situation of another[30].

With the establishment of the municipality, when the North American model was adapted to Brazil, the local entity was established with great value for federalism. Therefore, local interest is a favorable institute for the municipality, to the extent that it strengthens its action at times of legislative competition, as well as prioritizing its action when it is essential that the community participates in the legislative process, and thus should not be limited except by legislation.

Decentralization and the STF's new understanding

In the form of a dialog with recent studies, it is imperative to mention the contribution of Miguel Gualano de Godoy and Renata Naomi Tranjan[25], who discussed the change in paradigms of the STF, by analyzing the decisions handed down before and during the Sars-CoV-2 pandemic.

The study concludes that, before the pandemic, the STF established the paradigm of centralizing legislative acts related to health in favor of the Union, based on the predominance of powers. However, in times of the pandemic, the paradigm has been reversed towards the decentralization of legislative acts, now in favor of local entities, based on cooperative federalism and the elements mentioned above, with the summary transcription of ADI 6.341 and ADPF 672[25].

Jeison Heiler, Lucas Busemayer and Patrick Kaminski[33] also conclude that the federalism adopted by Brazil was efficient in combating Sars-Cov-2, due to the autonomy of the federal entities. The researchers understand that ADI 6.341 and ADPF 672 - analyzed in this study - are not isolated, but are symbolic decisions of the parameters applied by the STF during and after the pandemic.

Studies based on these spheres analyze these fundamentals, especially decentralization. Even though they are old, the urgency and popularization are only carried out with recent decisions, both in favour of decentralization and the principles of subsidiarity and proportionality.

The conclusion is that the municipality was tacitly included in the legislative competence, due to its collective duty to provide health care. The practical explanation for the inclusion was the change in the STF's paradigm, based on cooperative federalism; however, implicitly, the possibility was realized due to popularization and urgency.

Conclusion

The solution may lie with the local authorities. It is shown that case law recognizes the material capacity of the municipality, albeit tacitly, and that the limitation of local legislation lies only in relation to validity - compliance with formal and material constitutional requirements - and the expertise of autonomous technical bodies, such as ANVISA and research institutes.

As a material capacity, we have the idea that the municipality obeys the specificities of public health presented since the developmental health movement: urgency and popularization, known by the application of presumption against preemption and municipalization. Federalist decentralization has been guided by these in the STF's decisions.

When comparing the STF's positions prior to the pandemic - based on the studies referenced - and the paradigm decisions listed above, we see not only the ratification of common and concurrent competences, but the classification of the municipality's actions, together with the other entities, as a form of materialization of Cooperative Federalism: a conclusion that was unnoticed before the pandemic.

The aim of including the municipality in the concurrent legislative competence is to enable the community to have quick access to a healthy sanitary system, with close access to health, as well as local clarity when managing this right: the local legislator has, in theory, the will of the community as a primary and immediate factor.

From a municipalism perspective, there are new ways of thinking about cooperation between entities, in line with the evolutionary federalism developed by Rui Barbosa. In raising collective rationality, the Judiciary does not go beyond its typical role, but merely interprets cooperative federalism in the appropriate way.

In conclusion, there are different views on the inclusion of local legislators in the sphere of legislative competition in defense of health. However, the authors' points of synthesis, complemented by contemporary case law, indicate that, theoretically, there is an opportunity to include the local vision in the sphere of concurrent constitutional competence or, alternatively, to expand the sphere of local interest.

It is unreasonable to conclude categorically that including the municipality is the solution to the health system's shortcomings. The inclusion of the municipality resides tacitly in the current legal logic, but its empirical analysis is necessary: a process through which inexhaustible theoretical and practical gaps are expected.

This is a decentralization process that is only just beginning, but with or without municipalization, it is the mayor who is waiting at his or her door for citizens who are crying out for help from the health system.

At the present time, there are constitutional precedents for the government, in its three spheres, to reaffirm the model of decentralized cooperative federalism, with the inclusion of all entities in the legislative process, including the Municipality, due to the consequences of inattention to the popularization and urgency of health.

Conflict of interest
The authors declare that there is no conflict of interest

Thanks
To Prof. Dr. Phillip Gil França, for his initial guidance in my course work.

Authors' contribution

Denner Pereira da Silva contributed to the critical review of its content and approval of the final version. Lucas Gabriel Martins de Lima contributed to the conception/design and writing of the article, as well as data analysis and interpretation.

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Como citar

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