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Article

Judicialization of health and sustainable development goals: Agenda 2030 and the role of the Brazilian judiciary in implementing the right to health

Judicialização da saúde e objetivos de desenvolvimento sustentável: Agenda 2030 e atuação do Poder Judiciário brasileiro na efetivação do direito à saúde

Judicialización de la salud y objetivos de desarrollo sostenible: Agenda 2030 y el papel del poder judicial brasileño en la implementación del derecho a la salud

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Abstract

Objective: This research analyzes the fundamentality of the right to health in the Brazilian Constitution of 1988 and the subsequent phenomenon of judicialization, covering the evolution of the concept of development and the Sustainable Development Goals (SDGs): the 2030 Agenda. The right to health is considered essential to guarantee dignity and quality of life for the population, so that the state's failure to comply with these ends up giving rise to recourse to the judiciary. **Methodology:** As a research strategy, a documentary and bibliographic survey was used, collected through selected sources, with analysis of decisions of the higher courts. The research also used articles published in journals and online publications, accessible free of charge and in Portuguese with high stratification, capable of studying the theme of the judicialization of health and development. **Results:** the incompleteness of the 2030 Agenda, legislative omission and difficulty in managing health on the part of the executive branch have led to an exponential growth in legal demands in health, and have begun to demand quick and efficient responses from the institutions of the justice system due to the very nature of judicialized law. **Conclusion:** It can be inferred that positive and/or negative provisions of the state's duty regarding the implementation of health, including compliance with international agreements such as the 2030 Agenda, are essential and the ineffectiveness of government action

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resulting from possible failures justifies access to the judiciary in order to ensure this fundamental right, providing the phenomenon of judicialization.
Keywords: Development; Right to health; Judicialization; Public policies.

Resumo

Objetivo: a presente pesquisa analisa a fundamentalidade do direito à saúde na Constituição Brasileira de 1988 e o posterior fenômeno da judicialização, perpassando pela evolução do conceito de desenvolvimento e os Objetivos de Desenvolvimento Sustentável: a Agenda 2030. O direito à saúde é considerado essencial para garantir dignidade e qualidade de vida da população, de modo que a omissão do Estado no cumprimento dessas acaba por ensejar recurso ao Poder Judiciário. **Metodologia:** Como estratégia de pesquisa, utilizou-se o levantamento documental e bibliográfico, colhido por meio de fontes selecionadas, com análise de decisões dos tribunais superiores. A pesquisa utilizou, ainda, artigos publicados em periódicos e publicações on-line, acessíveis gratuitamente e em língua portuguesa, com estratificação elevada, capazes de embasar o estudo do tema da judicialização da saúde e do desenvolvimento. **Resultados:** a inconclusão da Agenda 2030, a omissão legislativa e dificuldade de gestão da saúde por parte do Executivo acabam por gerar um crescimento exponencial das demandas judiciais em saúde, e passam a exigir das instituições do sistema de justiça respostas rápidas e eficientes em razão da própria natureza do direito judicializado. **Conclusão:** infere-se que prestações positivas e/ou negativas do dever estatal quanto à efetivação da saúde, inclusive para o cumprimento de acordos internacionais, como é o caso da Agenda 2030, são essenciais e a ineficácia da atuação governamental, decorrente de eventuais falhas, justifica o acesso ao Poder Judiciário a fim de assegurar esse direito fundamental, proporcionando o fenômeno da judicialização.
Palavras-chave: Desenvolvimento; Direito à saúde; Judicialização; Políticas públicas.

Resumen

Objetivo: esta investigación analiza la fundamentalidad del derecho a la salud en la Constitución brasileña de 1988 y el posterior fenómeno de judicialización, pasando por la evolución del concepto de desarrollo y de los Objetivos de Desarrollo Sostenible (ODS): la Agenda 2030. se considera fundamental para garantizar la dignidad y calidad de vida de la población, por lo que el incumplimiento por parte del Estado termina dando lugar al recurso al poder judicial. **Metodología:** Como estrategia de investigación se utilizó la investigación documental y bibliográfica, recopilada a través de fuentes seleccionadas, con análisis de decisiones de tribunales superiores. La investigación también utilizó artículos publicados en revistas y publicaciones en línea, accesibles gratuitamente y en portugués con alta estratificación, capaces de estudiar el tema de la judicialización de la salud y el desarrollo.. **Resultados:** lo incompleto de la Agenda 2030, la omisión legislativa y la dificultad en la gestión de la salud por parte del ejecutivo terminan generando un crecimiento exponencial de las demandas judiciales en salud, y comenzaron a exigir respuestas rápidas y eficientes de las instituciones del sistema de justicia debido a la naturaleza misma del derecho judicializado. **Conclusión:** Se infiere que los beneficios positivos y/o negativos del deber del Estado en materia de implementación de la salud, incluido el cumplimiento de acuerdos internacionales como la Agenda 2030, son esenciales y la ineficacia de la acción gubernamental derivada de posibles fallas, justifica el acceso al poder judicial. para garantizar este derecho fundamental, previendo el fenómeno de la judicialización.
Palabras clave: Desarrollo; Derecho a la salud; Judicialización; Políticas públicas.

Introduction

As a reflection of social transformation, the concept of development has evolved significantly over the decades. During the period of industrialization, it was a definition directly associated with the concept of economic growth. This is because it can be said that there was an initial focus on increasing production, employment and material prosperity, as these were believed to be the factors capable of

guaranteeing a better quality of life. However, with the emergence of new social, health and environmental issues and concerns, the inadequacy of this vision led to a new concept linked to the notion of justice, equity and sustainability.

Health, social, political and ecological crises, environmental degradation and other factors linked to the contemporary structuring of society have highlighted the need for an integrated notion of development, which has required the formulation of international agendas with the aim of reconciling economic growth, guaranteeing social and gender equity, as well as preserving natural resources, and dealing with crises generated by the globalization of risks and the globalization of capital.

It is against this backdrop that the United Nations (UN) 2030 Agenda emerged, establishing a series of 17 Sustainable Development Goals (SDGs) to guide global policies from a sustainable perspective. Among these goals, SDG 3 stands out, referring to health and well-being, recognizing both factors as fundamental to quality of life and progress. This goal seeks universal access to health care and the promotion of well-being for all, highlighting the reduction of financial difficulties in the health sector as a requirement for a more accessible and equitable system.

Despite the state's efforts to promote universal access to health and ensure that services are accessed equally by all, the reality has often been marked by inequality, revealing gaps in public policies and in the implementation of health services. As a result, judicialization has emerged as a mechanism for claiming the effectiveness of fundamental guarantees, while highlighting the failure of traditional systems to obtain medicines and treatments. This phenomenon reflects the level of complexity and the main challenges faced by public management and the justice system, considering the state's inability to meet all health needs.

Thus, the aim of this research was, through the concept of development, considering the context of the 2030 Agenda, to address the judicialization of health as a tool capable of influencing the improvement of public management and the planning of public policies, promoting the realization of the right to health. From this study, it was possible to understand that the positive and negative provision of the state's duty to make health effective is essential, so that, in the event of any failures or omissions, it becomes acceptable for the Judiciary to go beyond its initial functions in order to ensure a fundamental right, a factor that justifies the exponential growth in demands on the subject.

Sustainable Development Goals: contextual analysis of the right to health

The definition of development is certainly complex, and its conception changes according to the historical context in which it is inserted. A major milestone linked to development was the First Industrial Revolution, which took place between the end of the 18th century and the beginning of the 19th century, with England at its epicenter thanks to the creation of the steam engine[(1)].

The idea of development at the time of the Industrial Revolution was associated exclusively with economic progress, and continued unabated in the post-war period, when the world lived in the dichotomy of capitalism *versus* socialism. On the western (capitalist) side, various theories and movements linked to development emerged[(2)].

The permanence of this idea consequently led the world to countless tragedies related to the abuse of natural resources and their limits. In fact, there was a need for a more holistic view of the world, and the perception of development began to change from 1960 onwards, with the emergence of various milestones, such as: the ten years for development, for the evolution of the content of UN development (1960); the Conference on Human Rights in Tehran (1968); the United Nations

Conference on the Human Environment - Stockholm Conference (1972); the General Assembly of the United Nations of November 23, 1979, which through Resolution 34/46 formally recognized development as a right, and the World Commission on Environment and Development (1987).

After this period, a new era of development began, linked to sustainability, which led to several other world conferences linked to the theme of sustainability and development (Rio 92, United Nations Millennium Summit (1994), Rio+10 (2002), Kyoto Protocol (2005), Rio+20 (2012)), currently culminating in concerns about various problems faced, such as unemployment, access to drinking water, human dignity, health, indigenous peoples, etc. It is therefore an important instrument for promoting sustainable development, and based on this new collaborative vision, since 2016 the UN has making efforts to implement the SDGs: the 2030 Agenda.

The main motto of the SDGs, as expressed by the UN(3), is that "[...] no one is left behind."(3, p. 1). This is why the 17 SDGs were established, which were designed for the 193 signatory countries that are members of the UN, regardless of their level of development, forming an integrated and indivisible set of global priorities, so it is up to governments to set their own targets according to national circumstances; it can't be any different in Brazil(4).

So, to get a better idea of the subject, we'll take a look back at history, starting with the Industrial Revolution in the 18th century, when humanity began to use natural resources as if they were inexhaustible. Factories were driven by steam engines, which were fueled by the indiscriminate burning of coal. This combustion generated a huge environmental impact, which still has repercussions today, as highlighted by Sachs(5), when he said that "[...] the burning of coal is both the emblem of the Industrial Revolution and the root of our current environmental crisis."[4](5, p. 10).

At that time, the concept of development was linked exclusively to the idea of economic growth, without any concern for any other aspect. Pearce(1) points out that "[...] the greatest phenomenon of vertiginous economic growth that the world has ever experienced was that of the Industrial Revolution to the present day."(1, p. 54).

For years afterwards, with the various phases of the Industrial Revolution, and the praise of the economic development it generated, the environment was totally neglected(1) . Thus, delving deeper into the subject, Goldemberg and Barbosa(6) reveal that "[...] the pollution and environmental impacts of disordered development were visible, but the benefits provided by progress were justified as a 'necessary evil', something we should resign ourselves to."(6, p. 1).

However, from the 20th century onwards, right after the Second World War, it became apparent that planet Earth was showing signs of being in danger. According to Barbieri(4), "[...] the surge in economic growth after the Second World War (1939-1945) would aggravate environmental problems, causing them to transcend national borders [...]." (4, p. 21). During this period, therefore, a large number of environmental disasters occurred in various parts of the world.

Many of these environmental disasters were caused by the indiscriminate use of natural resources, with the sole aim of generating wealth and growing the economy, a perspective used since the time of the Industrial Revolution(1).

Among the disasters that have gone down in history, the most emblematic are: The Great Smog in London, marked by severe air pollution, which caused the death mainly of children and the elderly who were more susceptible to diseases linked to the respiratory system (1952); the mercury

[4] "The burning of coal is both the emblem of the Industrial Revolution and the root of our current environmental crisis".

contamination of Minamata Bay in Japan (1956), due to waste produced and dispersed by the Chisso chemical industry, leading to the death of thousands of people[1, 7].

Pearce[1] also mentions another disaster that stands out in history, where in 1967 the first accident with an oil tanker occurred, causing the spillage of "[...] 121,000 tons of oil on the coast of England, causing the phenomenon of the 'black tide', killing the local fauna and flora and generating immense economic losses for the fishing sector."[1, p. 75].

Another important event for the detection of the environmental problem in this post-war period was the appearance, in 1962, of Silent Spring, written by biologist Rachel Carson. Pinato and Tavares point out[8] that "[...] this book was considered a milestone in the environmental movement [...]."[8, p. 24].

In Silent Spring, the author relates the disappearance of birds in a region of the United States of America (USA) to the use of the pesticide Dichloro-Diphenyl-Trichloroethane (DDT), concluding that all living beings are interconnected in the same ecosystem[1].

Thus, Silent Spring brought to light the scandal behind the excessive use of pesticides, even leading to the banning of DDT in the United States, but not only that, it gave rise to the environmental movement in that country[8].

Carson[9] points out that the degradation caused by humanity to the planet is gigantic, and warns of the irreversibility of these acts on the environment: It is only in the time sequence of the current century that one species - man - has acquired the considerable power to alter the nature of this world. In the last twenty-five years, this power has not only assumed a worrying scale, but has also changed form. The most alarming attack by human beings on the environment is the contamination of the atmosphere, soil, rivers and sea by dangerous and even fatal substances. This pollution is virtually without remedy, because it sets off a fatal chain of damage to the areas where life is nourished and to the living tissue itself.

It's easy to see from Carson's lesson[9] that environmental problems are interconnected and that there is no "out there", because all of humanity has a single home. The problems are no longer local but have international impacts, such as the deterioration of the ozone layer and global warming.

Faced with all this commotion, and the consequent concern arising from tragic events on a global scale linked to the environment, the need arose to create a forum to discuss the problem, culminating in the *United Nations Conference on the Human Environment* (UNCEDE), held in 1972 in Stockholm, the capital of Sweden.

This conference was also an opportunity for third world countries to fight for the right to economic growth and against poverty. Pearce[1] emphasizes that "[...] the Stockholm conference was thus first and foremost a space for global public deliberation in which those historically least heard found a window to shout out their desires and aspirations."[1, p. 96].

As far as the term "sustainable development" is concerned, it has been conceived since the 1970s, but was used publicly for the first time in August 1974, when Stockholm once again hosted the United Nations Symposium on the Interrelationship between Resources, Environment and Development[10].

In 1987, with the publication by the UN of the report Our Common Future, the concept of sustainable development took on global proportions and promoted the integration of environmental issues with economic development[10]. The document, Our Common Future, became universally known as the Brundtland Commission report, thanks to the efforts of the doctor and former prime

minister of Norway, Gro Harlem Brundtland, who was invited in 1983 to establish and chair the World Commission on Environment and Development (WCED)[4].

The idea of sustainability, as it is known today, was developed in the CMMAD report in Brundtland, 1987[11] and defines that "[...] sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs."[5][11, p. 41].

Since Brundtland, the idea of economic progress in many contexts has gradually been replaced by sustainable development, and this has become apparent even in professional and everyday language, which includes the three dimensions of this new concept of development: economic, social and environmental, as well as the requirement for their integration[12].

In 1992, based on these ideas, the United Nations Conference on Environment and Development, known as "Rio 92", had as its main objective to establish strategies and objectives for the implementation of the Brundtland Report, which gave rise to Agenda 21, however, no deadlines were set for its fulfillment[13].

In 2000, the UN held the United Nations Millennium Summit, which focused on solving social problems in developing countries[13]. This meeting gave rise to the Millennium Development Goals (MDGs), made up of eight thematic axes and targets to be achieved by 2015, which promised a global alliance for development[14].

It is undeniable that there has been significant progress in terms of development and sustainability. However, in the period covered by the MDGs, the situation has worsened and it has been possible to see trends of socio-environmental regression, demonstrating the fragility of the model, including dangerous climate change and global warming[15].

Soon after the lessons learned from the implementation of the MDGs, a new cycle in the history of development began with the implementation of the SDGs through the 2030 Agenda.

As mentioned above, with the end of the MDGs, the UN started a new set of actions to promote global development, called the Sustainable Development Goals (SDGs). The timeframe for implementing these new actions begins in 2016 and ends in 2030, which is why this new cycle is also called the 2030 Agenda.

In 2015, the United Nations Development Summit was held at UN headquarters in New York City, where the final document that gave rise to the SDGs, entitled: Transforming our world: The 2030 Agenda for Sustainable Development, was approved.

In the preamble to this inaugural document on the SDGs, the following UN definition is highlighted in the very first line[3] : "This Agenda is an action plan for people, planet and prosperity."[3, p. 1]. It is inevitable to see in this initial expression the first three axes on which the 2030 Agenda is based: People, Planet and Prosperity.

However, there are a total of five main axes or elements, called the "5 Ps", which structure the foundation of this global action plan: People, Planet, Prosperity, Peace and Partnership. In English, the initials are similar to those in Portuguese, i.e. *People, Planet, Prosperity, Partnership and Peace*[4].

With regard to the People axis, the idea is to enable the potential of each individual, with a focus on eradicating poverty and hunger. With regard to the Planet axis, the idea is sustainability as a way of guaranteeing the needs of the current generation as well as future generations. On the Prosperity

[5] Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs.

axis, it's about fostering economic, social and technological progress, but with access for all and in full compliance with the resources that exist in nature. The Peace axis is to raise awareness among global populations of the need to seek balance and the importance of harmonious, peaceful societies, to the detriment of conflict, as the only way of bringing about development among nations. Finally, the Partnership axis is intended to mobilize resources among all the participants in order to achieve the proposed goals[4].

From Barbieri's perspective[4] , "[...] the first three elements refer respectively to the social, environmental and economic dimensions of sustainable development; the last two, to the political and institutional dimensions that guide the governance of the 2030 Agenda."[4, p. 132] (Figure 1).

Figure 1. 5 Essential axes for the 2030 Agenda.

Source: National SDG Movement[16].

The authors Yamanaka[15] consider that the main tool for development promoted by the UN today "[...] is the 2030 Agenda, an action plan focused on eradicating poverty and promoting sustainable development based on the realization of human rights."[15, p. 10].

This global action plan was agreed by all 193 UN member countries and has 17 goals to be achieved, which in turn are broken down into 169 targets. The UN[3] defined the 17 SDGs as follows (Table 1):

Table 1. The 17 Sustainable Development Goals

Objective 1	End poverty in all its forms, everywhere;
Objective 2	End hunger, achieve food security and improved nutrition, and promote sustainable agriculture;
Objective 3	Ensuring a healthy life and promoting well-being for all, at all ages;
Objective 4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all;
Objective 5	Achieve gender equality and empower all women and girls;
Objective 6	Ensure the availability and sustainable management of water and sanitation for all;
Objective 7	Ensure reliable, sustainable, modern and affordable access to energy for all;
Objective 8	Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all;
Objective 9	Building resilient infrastructure, promoting inclusive and sustainable industrialization, and fostering innovation;
Objective 10	Reducing inequality within and between countries;
Objective 11	Making cities and human settlements inclusive, safe, resilient and sustainable;
Objective 12	Ensure sustainable production and consumption patterns;
Objective 13	Take urgent action to combat climate change and its impacts;
Objective 14	Conservation and sustainable use of oceans, seas and marine resources for sustainable development;
Objective 15	Protect, restore and promote the sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, halt and reverse land degradation and halt biodiversity loss;
Objective 16	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels;
Objective 17	Strengthen the means of implementation and revitalize the global partnership for sustainable development.

Source: UN[3].

The 17 SDGs include all the demands of years of struggle by the most oppressed and the maintenance of life on the planet, significantly translating the current idea of what development should be for human beings[13]. The SDGs include: poverty eradication; zero hunger and sustainable agriculture; health and well-being; quality education; gender equality; drinking water and sanitation; clean and affordable energy; decent work and economic growth; industry, innovation and infrastructure; reducing inequalities; sustainable cities and communities; responsible consumption and production; action against global climate change; life on water; life on land; peace, justice and effective institutions; and partnerships and means of implementation[17].

A very interesting strategy, which is worth highlighting, is that in the SDG implementation guideline, all the countries that make up the agreement are seen as developing countries, regardless of whether they are rich or third world countries[4].

The preamble to the *United Nations General Assembly*'s Agenda 2030 document states[17] that: "The 17 Sustainable Development Goals and targets are integrated and indivisible and balance the three dimensions of sustainable development: economic, social and environmental."[17, p. 1] . However, there is some criticism of this latter idea of integration and indivisibility[13]. For example, Pogge e Ladha[18] point out that some of the goals are difficult to reconcile and often even contradictory, which undermines the idea of integration and indivisibility.

For example, if a country sought to achieve the targets of SDG 1, “Eradicate poverty” in all its forms, everywhere, with a reduction in extreme poverty for all (target 1.1), it would be impossible to achieve SDG 10, "Reduce inequality within and between countries", as Pogge and Ladha explain[18] when citing research by economist David Woodward, who analyzes the two SDGs mentioned above:

> [...] David Woodward shows that in order to raise the number of people living below US$1.25 a day (in 'international dollars') above the official SDG poverty line, we would have to increase global GDP by 15 times - assuming the best case scenario - at the growth rates and inequality trends of the last 30 years. This means that the average global GDP *per capita* would have to rise to almost $100,000 in 15 years, three times the average US income at the moment. In a global economy that is so inefficient at distributing wealth, where 93 cents of every dollar of wealth created ends up in the hands of the richest 1%, more growth will only enrich the rich while destroying the planet in its wake.[18, p. 1]

This is cause for criticism, as it shows that this new idea of development has shortcomings due to its economic model, because for neoclassical economic theory, sustainable development is driven by economic growth, while disregarding the capacity limitations of life-supporting ecosystems[13].

Another important observation is that the 2030 Agenda is under no circumstances an exclusively governmental agenda, and emphasizes that national governments cannot carry out implementation alone. All stakeholders and all categories are encouraged to contribute. Here, a very important emphasis is placed on organized civil society and the third sector, which in Brazil has contributed greatly to monitoring and achieving the SDG targets[8].

According to Campos[13], another main challenge in meeting the SDG targets would be the difficulty of establishing suitable indicators for monitoring the targets, given the particularities of each country and methodological biases, "[...] particularly in countries lacking the infrastructure or institutions to collect and aggregate the necessary data and in those indicators anchored in the intention to implement them [...]."[13, p. 40].

Even though the implementation of the SDGs tries to respect the similarities and culture of the different cities in which they are implemented, whether with state support or not, as a way of making it feasible to be truly achieved, monitoring the implementation of the 169 goals, in the 193 countries with the most diverse cultures, is a Herculean task[4]. However, there is a special UN group that tries to monitor the programming, forming indicator frameworks, which are available to all actors, as a way of supporting the review and monitoring of progress[13].

Finally, despite the criticisms and shortcomings linked to the main economic theory guiding the 2030 Agenda, it cannot be denied that it is a global commitment ratified by almost 193 countries. It is a step forward and a global attempt with real objectives and targets to be achieved in order to build a better future for the next generations, while respecting rights in the present. The following are discussions on target 3.8, specifically on access to medicines.

SDG 3, “Health and Well-being”, aims to safeguard the sustainability of society, contributing to its well-being[4] . This SDG has 13 targets, target 3.8 of which is to: "Achieve universal health coverage, including financial risk protection, access to quality essential health services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”[3].

However, as mentioned above, “[...] it is well known that the challenges are different for each country, as it depends on its social development and vulnerability due to the economy, basic sanitation

and access to health [...]"[19, p. 36] and, to this end, the SDG targets may be adjusted to the reality of the country in their implementation. The Institute for Applied Economic Research explains[20] that, in Brazil, target 3.8 has been adjusted to better suit the Unified Health System (SUS), with the following wording:

> Ensure, through the Unified Health System (SUS), universal health coverage, access to essential quality health services at all levels of care and access to safe, effective and quality essential medicines and vaccines that are incorporated into the list of products offered by the SUS.[20, p. 37]

As for the indicators needed to monitor the targets, IPEA[20] mentions that target 3.8 has two indicators, namely: indicators 3.8.1 and 3.8.2, where the first, "Primary Health Care Coverage", is defined as:

> Average primary health care coverage measured by indicators relating to reproductive, maternal, neonatal and child health, infectious diseases, non-communicable diseases, and access to and capacity of services for the general population and the most disadvantaged populations.[20, p. 37]

Indicator 3.8.2 is defined as "Proportion of people in households with high health expenditure in relation to total household expenditure". This indicator 3.8.2 is about identifying people who spend out of pocket on health, exceeding their ability to pay, which can lead to cutting spending on other basic needs, such as education, food, housing and public services[21]. In this way, reducing financial difficulties in health is important in the global scenario for the development agenda, as well as a priority for the health sector in many countries, in all regions[21].

With regard to access to medicines, Brazil establishes, through the National List of Essential Medicines (RENAME), "[...] the medicines offered at all levels of care and in the lines of care of the SUS, providing transparency in information on access to medicines in the network."[22].

Despite this, taking into account that the SUS establishes the principles of universality and integrality, when there are medicines that are not incorporated by normative acts of the SUS, the Superior Court of Justice (STJ), in the judgment of the repetitive appeal, Repetitive theme 106, from the judgment of Special Appeal (REsp.) nº 1657156/RJ (2017/0025629-7), reported by Minister Benedito Gonçalves, which dealt with the requirements for supplying medicines outside the SUS list, establishing the thesis for guaranteeing the supply of these medicines. In this thesis, three requirements were established for granting these medicines, which are: i) Proof, by means of a reasoned and detailed medical report issued by a doctor who assists the patient, of the indispensability or necessity of the medicine, as well as the ineffectiveness, for the treatment of the illness, of the drugs provided by SUS; ii) financial inability to afford the cost of the prescribed medicine; iii) existence of registration of the medicine with ANVISA, observing the uses authorized by the agency.

These requirements of the STJ therefore help with access to medicines that are not on the RENAME list and are therefore denied administratively by the state (*latos sensu*), leading citizens to seek out the Judiciary in an attempt to guarantee their supply, from the point of view of the universalization of health, through Judicialization.

Judicialization of Health and Medicines: considerations for discussion

In judicialization, judges are bound by the dictates of the law, and in the case of health, the law that first binds these decisions is the country's highest law. From there, there are other normative instruments, such as: international treaties to which Brazil is a signatory, infra-constitutional norms and case law from the higher courts.

In order to understand the contours of the judicialization of health in Brazil, we first look at the concept of health and its interrelationships, according to some global and national perspectives, then move on to the framework of the right to health in the Brazilian legal system, and then define the panorama of this phenomenon.

The Constitution of the World Health Organization (WHO)[23] , in its preamble, defined health as "[...] a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity."[23, p. 1]. Along the same lines, the first International Conference on Health Promotion, held in the province of Ontario, Canada, in November 1986, drew up a letter of intent, the Ottawa Charter, which defined that "[...] the fundamental conditions and resources for health are: Peace - Housing - Education - Food - Income - Stable Ecosystem - Sustainable Resources - Social Justice and Equity."[24 p. 1].

It's true that in the Brazilian legal system, the CF/88 deals exhaustively with the issue of health and spreads it out over various articles in the main part and in the Transitional Constitutional Provisions Act (ADCT), but there is none that explicitly describes its concept.

However, it is easy to see that health is examined in the same dimension as the concept of the WHO Constitution mentioned above, because when art. 196 of the Brazilian Constitution refers, in the final part, to "reducing the risk of disease" and "promoting, protecting and recovering" health, there is the possibility of deducing that it was the legislator's intention to encompass curative medicine and the other dimensions of human well-being (CF/88)[27].

In order to understand the contours of the judicialization of health in Brazil, we first look at the concept of health and its interrelationships, according to some global and national perspectives, then move on to the framework of the right to health in the Brazilian legal system, and then define the panorama of this phenomenon.

Therefore, this innovation in the CF/88's conception of health sought to give greater relevance to public policies for actions related to health, going beyond the restriction of issues linked only to the curative field, and broadening the focus to a broader horizon of the development of social, mental and physical well-being.

With this, the aim was to reach a wider range of actions, broadening the focus to a horizon of greater development in various areas of activity, such as in the field of health and environmental law. Also, if we turn to infra-constitutional legislation, Law nº 8.080, of September 19, 1990 "[...provides for the conditions for the promotion, protection and recovery of health, the organization and operation of the corresponding services and makes other provisions"[25], and it is possible to find as determinants and conditioning factors for obtaining health: food, housing, basic sanitation, the environment, work, income, education, physical activity, transport, leisure and access to essential goods and services[6].

[6] Law 8.080/1990, Art. 3: "Health levels express the country's social and economic organization, with food, housing, basic sanitation, the environment, work, income, education, physical activity, transport, leisure and access to essential goods and services being determinants and conditioning factors of health!". [27]

It comes as no surprise that the guiding principles of both the Federal Constitution (CF) and the SUS Law are aligned with the concept of health developed by the WHO, since this body was conceived at the suggestion of the Brazilian delegation, which in 1945 proposed the creation of an international public health organization with global reach[26]. The constitutionalization of health, this right of great importance, was introduced by the CF/88, making it possible to migrate access to health care to all people, previously limited only to workers with formal employment contracts.

One of the major milestones that gave rise to the right to health being elevated to the level of a fundamental social right in the Political Charter of 1998 was the health reform movement, especially the guidelines outlined by the 8th National Health Conference, held in Brasilia between March 17 and 21, 1986.

When carrying out the task of "georeferencing" the right to health in the Brazilian constitutional legal system, one must start with the foundations of the Republic, especially the core of values contained in art. 1[7] of the CF, pointing to the dignity of the human person as the cornerstone of the system. This is followed by Article 5, *caput*,[8], which guarantees the inviolability of the right to life, liberty, equality and security. This deductively gives rise to an assertion of the right to health, which is inseparable from all these rights.

The right to health first appears in art. 6[9] , which is located in Title II - Fundamental Rights and Guarantees - which leads to the obvious deduction that for the Brazilian constitutional system this right is formally considered a fundamental right. In the same vein, Mateus[28] states that:

> Despite the various theories on the subject, it is clear that the Brazilian legislator chose to consider social rights as fundamental rights, at least in terms of their spectrum of formal fundamentality, by providing for them in the list of Article 6 (at least most of them) within the catalog of fundamental rights and guarantees (Title II).[28 p. 57]

At this point, it is imperative to note that, according to the constitutional commandment of art. 5, §1[10] , the principle of maximum effectiveness of fundamental rights, the right to health, as it is a rule defining and guaranteeing a fundamental right and guarantee, has immediate application. Today, this is the majority interpretation, i.e. that this immediate application is applicable to social rights[29].

Promoting health in Brazil, given its continental dimensions and varied epidemiological patterns, certainly makes state provision a Herculean but necessary task. Guaranteeing the right to health, this fundamental social right, is unquestionable for the state and necessary for people's lives, as Barroso teaches:

> Qualifying a given right as fundamental doesn't just mean attributing it a merely rhetorical importance, devoid of any legal consequences. On the contrary, the constitutionalization of the right to health has led to a formal and material increase in its normative force, with countless practical consequences, especially with regard to its effectiveness, here considered as the materialization of the norm in the world of

[7] CF/1988, art. 1: "The Federative Republic of Brazil, formed by the indissoluble union of States and Municipalities and the Federal District, is constituted as a Democratic State of Law and has as its foundations: I - sovereignty; II - citizenship; III - the dignity of the human person; IV - the social values of work and free enterprise; V - political pluralism."[27]

[8] CF/1988, art. 5: "All are equal before the law, without distinction of any kind, and Brazilians and foreigners residing in the country are guaranteed the inviolability of the right to life, liberty, equality, security and property [...]".[27]

[9] CF/1988, art. 6: "Social rights are education, health, food, work, housing, transportation, leisure, security, social security, maternity and childhood protection, assistance to the helpless, in the form of this Constitution." (Edited by Constitutional Amendment 90 of 2015).[27]

[10] CF/1988, art. 5: "§1º The rules defining fundamental rights and guarantees have immediate application.".[27]

> facts, the realization of the right, the concrete performance of its social function, the approximation, as close as possible, between the normative should-be and the being of social reality.(30, p. 83)

Health therefore has both formal and material fundamentality. It has a direct and indirect connection with various rights that have constitutional protection, as is the case with the right to life, contained in the aforementioned art. 5, *caput*, or the right to have an ecologically balanced environment, contained in art. 225, *caput*[11] among others. Protecting health is paramount, otherwise these other rights, which are confluent, will be exhausted.

In the Federal Constitution, in chapter II - Social Security, section II is entitled Health - and begins with art. 196[12] , from which the first part can be extracted: "Health is the right of all and the duty of the State [...]"(27); the positive provision duty of the Public Power in the realization of this right. At this point, the positive provision of health is observed, but there are also several examples of negative provision in the legal system, with the aim of protecting the right to health, such as cases related to the physical and moral integrity provided for in the CF/88, art. 5, XLIX, in the case of prisoners under the custody of the State(27).

Another example of the right to non-intervention is the right provided for in the CRFB/88, art. 5, III[13], not to be subjected to torture or inhuman or degrading treatment. Also in infra-constitutional legislation, the Civil Code (CC)(31) and art. 13 of the CF[14], governs matters relating to the right to health to dispose of one's own body, when it entails permanent impairment of physical integrity, a legal command that seeks to protect the body and the physical and psychological structure of each individual.

Moving on, we find Article 198, which enabled the creation of what is considered by many to be the world's largest health plan: the SUS. Marked by gratuity, decentralization and universalization. Since the creation of the SUS and the possibility of the existence of supplementary medicine, there has been a mismatch in quality of care between the public and private networks, where those who can afford to pay for medical services have the upper hand.

Having made this introduction as a way of locating the right to health topographically in the constitutional order, from where the normative principle that guarantees judicialization comes, we will now investigate this institute within the scope of this right. The first judgment that had the line of argument used to this day, about the right to health being granted in an unrestricted manner, and with immediate application, was the precautionary measure in Petition nº 1.246 MC/SC(32). When judging the case on January 31, 1997, Justice Celso de Mello(33) argued that:

> [...] **the impossibility of complying with the political-constitutional duty imposed on the Public Power, in all dimensions of the federative organization, to ensure health protection for all (CF, art. 196)** and to provide special protection for children and adolescents (CF, art. 6, c/c art. 227, § 1) are factors which, associated with an imperative of human solidarity, disallow the granting of the request made by the State

[11] CF/1988, art. 225: "Everyone has the right to an ecologically balanced environment, which is a common good and essential to a healthy quality of life, and the public authorities and the community have a duty to defend and preserve it for present and future generations."(27).

[12] CF/1988, art. 196: "Health is the right of all and the duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other health problems and universal and equal access to actions and services for its promotion, protection and recovery." (27).

[13] CF/1988, art. 5º: XLIX: - "Respect for physical and moral integrity is assured to prisoners."(27).

[14] CF/1988, art. 5: III - "No one shall be subjected to torture or to inhuman or degrading treatment."(27).

> of Santa Catarina (folios 2/30). [...] **Between protecting the inviolability of the right to life, which qualifies as an inalienable subjective right guaranteed by the Constitution of the Republic itself (art. 5, caput), or making a financial and secondary interest of the State prevail against this fundamental prerogative, I understand - once this dilemma has been configured - that ethical-legal reasons impose on the judge only one possible option: the undeniable respect for life** [...].[33] (emphasis added)

One of the aspects that characterizes judicialization, as mentioned above, is the excess of lawsuits on a given topic, in the search for the realization of certain rights provided for in the legal system, compared to the volume of lawsuits filed on other topics. Thus, if we look at the information provided by the National Council of Justice (CNJ) on the subject of the right to health, we can say that the phenomenon of the judicialization of health in Brazil has been characterized.

The CNJ report, with the support of the Teaching and Research Institute[34], reports that there was "[...] a sharp increase of approximately 130% in the number of first instance lawsuits relating to the right to health from 2008 to 2017 [...]"[34, p. 46], compared to lawsuits involving other issues, which saw an increase of only 50% in the total number of lawsuits filed in the first instance, taking into account the same period[34].

Also taken into account is the data collected in the CNJ/PNUD survey[35], on the upward trend in the number of new health-related cases between 2015 and 2020, as shown in Table 1 below.

Table 1. Number of new health-related cases filed between 2015 and 2020 by court.

Court	2015	2016	2017	2018	2019	2020
Superior Court of Justice	6.953	8.116	9.764	10.250	147	7.608
Court of Justice	322.395	320.447	367.438	326.397	427.633	486.423
Federal Regional Court	36.673	47.139	40.730	40.357	41.795	58.774

Source: CNJ[35, p.27].

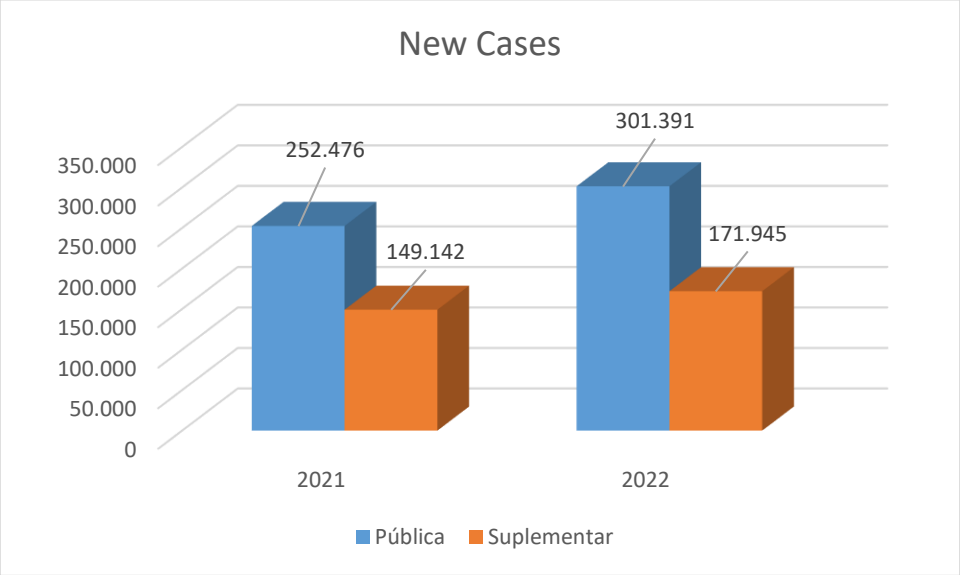
Another important fact that confirms the vertiginous growth of lawsuits related to the right to health is the data pointed out by Ramos[36], in which he considers that "[...] the Ministry of Healths spending on complying with court decisions, on the other hand, increased by 1,205% between 2010 and 2016."[36, p. 105].

The subject of the judicialization of health is so present in the day-to-day life of the judiciary that the CNJ recently launched the Health Law Procedural Statistics Panel[37], an indispensable tool for health law researchers, at the 5th National Health Law Conference, held on August 18 and 19, 2022. Through this statistical tool, it is possible to obtain information on lawsuits related to health, differentiating, for example, whether they are related to the public or private sphere. The data is valid from the National Database of the Judiciary (DataJud), and so far includes information for the years 2020 to 2022.

Considering the information on the website[37] of the 5th National Health Law Conference, on the recently launched panel on health-related lawsuits, which "[...] presents data on new, pending, judged and dismissed cases since 2020, with information on performance and productivity indicators, such as congestion rate, demand response index and case duration."[37].

From the data contained in the Health Law Procedural Statistics Panel, in the years 2021 and 2022, related to new cases, it is likely to observe that the upward trend in health-related lawsuits continues, as shown in Figure 2 below.

Figure 2. New health- related lawsuits in 2021 and 2021



Source: Adapted from the Health Law Procedural Statistics Panel[37].

The main theme of this work is the judicialization of health with a focus on the demand for medicines, and it is precisely from the judgment of the leading case (RE n.º 271.286-8/RS), related to this theme, that the first steps of the judicialization of Brazilian health are drawn[38]. As Jobim and Sant'Ana say[39]:

> The first outlines of the judicialization of health in Brazil are attributed, by various researchers, to the movement to assert the rights of people with HIV, above all to guarantee access to medicines and the implementation of a pharmaceutical assistance policy for this segment of patients.[39, p. 160]

In the judgment of this AgRg in the RE, which was reported by Justice Celso de Mello[38], the Federal Supreme Court (STF) recognized the State's obligation to provide free medicines for the treatment of the Human Immunodeficiency Virus (HIV), and an important highlight of the judgment is the teaching that: "The right to health - in addition to qualifying as a fundamental right that assists all people - represents a constitutional consequence inseparable from the right to life."[38].

Since the STF's paradigmatic judgment on the supply of medicines for people with HIV/Acquired Immune Deficiency Syndrome (AIDS), many Brazilians have turned to the courts to obtain dignified treatment and access to new therapeutic procedures and drugs, even if they are not available from public bodies or are not *a priori* covered by health plans/insurance.

Over time, some adjustments have been made through administrative measures and/or the consolidation of case law on issues related to the supply of medicines. Thus, there are the judgments in theses with general repercussion by the STF in Extraordinary Appeal (RE), Leading Case. From then on, the thesis can be attributed to all cases with a similar theme that were suspended and awaiting judgment, as well as those that may be filed.

An example of this is the STF's judgment of RE nº 657.718/MG[40], which, in light of articles 1, III; 6; 23, II; 196, 198, II, § 2, and 204 of the Federal Constitution, discusses whether or not the state has a duty to supply medicines that are not registered with Anvisa. This case, RE nº 657.718/MG, was heard by Justice Marco Aurélio on November 17, 2011, and published in the Electronic Justice Gazette (DJe) on May 11, 2012, where the general repercussion thesis was established in Theme 500, which deals with the duty of the State to supply medicines not registered by Anvisa. According to this Thesis:

> 1 - The state cannot be forced to supply experimental medicines.
> 2 - The absence of registration with ANVISA prevents, as a general rule, the supply of medication by court order.
> 3 - It is possible, exceptionally, to grant a drug without health registration, in the event of an unreasonable delay by ANVISA in assessing the request (a period longer than that provided for in Law No. 13,411/2016), when three requirements are met: (i) the existence of an application for registration of the drug in Brazil (except in the case of orphan drugs for rare and ultra-rare diseases); (ii) the existence of registration of the drug with renowned regulatory agencies abroad; and (iii) the absence of a therapeutic substitute with registration in Brazil.
> 4 - Actions demanding the supply of medicines not registered with ANVISA must necessarily be brought against the Federal Government.[40, p.2]

Also noteworthy on the subject of the supply of medicines was the judgment in RE nº 566.471/RN[41], which sought to discuss, based on the constitutional parameters of arts. 2, 5, 6, 196 and 198, §§ 1 and 2, whether or not the state was obliged to supply high-cost medicines to people with serious illnesses who could not afford them. Justice Marco Aurélio was the rapporteur of RE nº. 566.471/RN, and the STF recognized the existence of general repercussion on the constitutional issue raised in the case in a judgment held on November 15, 2007, and published on December 7, 2007.

With regard to the claim for medicines not on the SUS list, the First Section of the STJ, in the judgment of Special Appeal (REsp.) nº 1657156/RJ (2017/0025629-7), which took place on April 25, 2018, with Justice Benedito Gonçalves as rapporteur, established the thesis that it is the duty of the Public Power to supply these medicines not incorporated by the SUS.

The judgment in REsp nº 1657156/RJ was assigned to a repetitive appeal under number 106 and has become the dominant case law, but in order for relief to be granted for the supply of these drugs, the following criteria have been defined cumulatively:

> 1 - Proof, by means of a reasoned and detailed medical report issued by a doctor who assists the patient, of the indispensability or necessity of the medication, as well as the ineffectiveness, for the treatment of the illness, of the drugs supplied by SUS;
> 2 - Financial inability of the patient to afford the cost of the prescribed medication; and;
> 3 - The drug has been registered with the National Health Surveillance Agency (Anvisa)[42].

Another interesting fact is that the STJ, in the judgment of REsp. nº 1657156/RJ, modulated its effects in the name of legal certainty and social interest, deciding that these aforementioned criteria will only apply from the date of this decision, i.e. it will only apply to cases that are distributed after this judgment. It should be noted that the judgment of a repetitive appeal is regulated in the Code of

Civil Procedure (CPC), in arts. 1.036 to 1.041[43] , and based on lawsuits that have similar disputes, a thesis is defined that will serve as a guideline to the other hierarchically inferior instances for the resolution of conflicts based on the same theme, including having an impact on the admissibility or not of the appeal before the STJ itself.

Currently, the issue of medicines is influenced in terms of their supply by a division agreed between the federated entities arising from decrees, resolutions and ordinances of the Ministry of Health (MS) and the State and Municipal Secretariats, although the central nucleus is the Federal Constitution, the SUS Law nº 8.080/90 and the Organic Health Law nº 8.142/90[44].

We must be diligent in observing that the infralegal norms instituted by the State (*lato sensu*), in the field of pharmaceutical assistance, with the aim of promoting government programs, should not be confused with the right to health itself. This is the warning made by Bucci[45], in relation to fundamental social rights, "[...] a frequent misconception is to take social rights, which are constitutionally based, and public policies designed to implement them as synonyms."[45, p. 254].

It is precisely because of this understanding, that public policy actions are not confused with fundamental rights, that lawsuits regarding access to medicines, i.e. judicialization to obtain drugs as a way of guaranteeing them, are so widespread. In relation to the legal and infra-legal norms that exhaust this list, it is possible to list several normative milestones that promote the policy of access to medicines, such as: Ordinance GM/MS nº 3.916, of October 30, 1998, which instituted the National Medicines Policy (PNM); Resolution of the National Health Council (CNS) nº 338, of May 6, 2004, which created the National Pharmaceutical Assistance Policy (PNAF)[46, 47].

The WHO encourages countries to create a NMP as a way of formally registering, defining national goals and objectives for the pharmaceutical sector, and fostering national discussions on the subject. According to the WHO[48]: "A national medicines policy is a commitment to a goal and a guide to action. It expresses and prioritizes the medium- to long-term goals set by the government for the pharmaceutical sector and identifies the main strategies for achieving them."[48, p. 4, our translation].

Thus, following this WHO guideline, Brazil created the RENAME. This publication is constantly updated through ordinances issued by the Ministry of Health, with the aim of guaranteeing pharmaceutical care and the responsible use of medicines in the country through action by the SUS.

Rename is considered a strategic axis in both the PNM and the PNAF, but its structure follows GM/MS Ordinance nº 204 of January 29, 2007[45]. This ordinance "[...] regulates the financing and transfer of federal resources for health actions and services [...]"[49], and in its article 24, there is a well-defined division of the three components of Pharmaceutical Assistance, namely: "I - Basic Component of Pharmaceutical Assistance; II - Strategic Component of Pharmaceutical Assistance; and III - Specialized Component of Pharmaceutical Assistance."[49].

Each component has its own regulation by autonomous ordinances, which are modified from time to time, for example: the Basic Component of Pharmaceutical Assistance (CBAF) is regulated by Ordinance GM/MS nº 1,555 of July 30, 2013[50]; the Strategic Component of Pharmaceutical Assistance (CESAF); the Specialized Component of Pharmaceutical Assistance (CEAF) is regulated by Ordinance GM/MS nº 1,554[51].

The CBAF is made up of medicines aimed at addressing the population's main health problems and conditions in primary care. This component is financed by the three federated entities, but storage and dispensing logistics are the responsibility of the States, Federal District and Municipalities[22].

The Federal Government's financial transfer to fund the CBAF for the current 5,568 municipalities is based on the criteria set out in item I of article 537[26] of the Ministry of Health's Consolidation Ordinance nº 6 of September 28, 2017, stipulated on the basis of each municipality's Municipal Human Development Index (MHDI).

The CEAF has medicines linked to the impacts of endemic and neglected diseases, related to the precarious socio-economic conditions of a given population (*e.g.* tuberculosis, leprosy, toxoplasmosis, filariasis meningitis, leishmaniasis, Chagas disease, cholera, schistosomiasis, hepatitis, dengue, systemic mycoses, lupus, spotted fever and brucellosis). This component also includes the control of smoking, influenza, HIV/AIDS, and issues related to nutrition, vaccines and serums. This component is fully funded by the Union[22].

Lastly, there is the CEAF, which has the strategy of providing medicines for Chronic Degenerative Diseases (CDD), including rare diseases, whose treatment is carried out comprehensively in outpatient clinics, in the lines of care defined in Clinical Protocols and Therapeutic Guidelines (PCDT)[22].

Both Ordinance GM/MS nº 1,554/2013, art. 3, and Consolidation Ordinance GM/MS nº 02/2017, Annex IV, Title IV, Chapter I, art. 49, provide for the distribution of medicines belonging to the CEAF in three groups. The financing of group 1, subdivided into "1A and 1B", is the responsibility of the Ministry of Health, therefore the Federal Government; in group 2, the financing is the responsibility of the Health Secretariats of the States (SES) and the Federal District; and in group 3, the financing is the responsibility of the SES of the Federal District and the Municipalities.

There is Law nº 12,401, of April 28, 2011, which amended the content of Law nº 8,080/90: "[...] to provide for therapeutic assistance and the incorporation of health technology within the scope of the Unified Health System - SUS [...]"[52] , in which according to its art. 19, in the absence of a clinical protocol or therapeutic guideline, medicines will be supplied "[...] based on the lists of medicines instituted by the federal manager of the SUS [...]"[52], which will be agreed by the Tripartite Inter-Managerial Commission (CIT).

It is also possible to cite Decree nº 7.508, of June 28, 2011, which "Regulates Law nº 8.080, of September 19, 1990, to provide for the organization of the Unified Health System - SUS, health planning, health care and inter-federative coordination, and makes other provisions"[54]. In this decree, art. 26, sole paragraph[53], states that the RENAME must be updated every two years.

As can be seen, there is extensive legislative production in the field of pharmaceutical assistance by the Ministry of Health of ordinances and resolutions with low technical quality, as there is no orchestrated concatenation between these norms, which Jorge[44] understands to be: "[...] a reflection of governmental disarticulation and administrative discontinuity, generating a lack of cohesion in the normative basis of the right to health and a plurality of interpretations, factors that favor excessive judicialization of health policy reflections of governmental disarticulation and administrative discontinuity, generate a lack of cohesion in the normative basis of the right to health and a plurality of interpretations, factors that favour the excessive judicialization of the pharmaceutical assistance policy."[44, p. 469] (emphasis added).

Finally, with regard to the defense of the actions that deal with pharmaceutical care, the main defense of the bodies, whether municipal, state or federal, involves the second part of art. 196 of the CF, since, right after the comma, one can read "[...] guaranteed through social and economic

policies".[27]. In this way, its defenders proclaim that the right to health should be applied programmatically.

One of the main arguments in this regard is the use of the reserve of the possible, since the existence of budgetary limits has been the main defense argument. It is also claimed that often meeting individual demands, in the face of collective needs, ends up hindering the very effectiveness and implementation of the actions of the public authorities[54]. Global assistance, in terms of access to medicines, precedes, by virtue of the legislation in force, the planning of the Public Authority to orchestrate the bidding process, culminating in the acquisition of these drugs[55].

In this way, the judicialization process can also be an ally, an indicator for public planning, when it is possible to determine which medication is most in demand, and what their quantities are by searching the courts' *websites*, thus creating intelligence that will help the manager in annual planning, or even anticipating its inclusion, for example, in the Multi-Year Plan (PPA)[55].

Conclusions

Far from offering definitive solutions on the subject, the aim of this research was to address the importance of the right to health, outlining the concept of development and its evolution. It also aims to identify how the Brazilian state has acted to guarantee the implementation of SDG 3.

From this, it was possible to see that the complexity of social reality meant that the concept of health had to be improved so that it could encompass human needs in a broad way, as required by the new concept established by the WHO, which now overcame the dichotomy according to which health is the absence of disease.

This new concept, which requires a perspective of universal access and a reduction in inequalities, has become the subject of international action, such as the 2030 Agenda, in order to develop a better response to health issues. Despite this, the state's efforts have not proved sufficient. This is because the judiciary has become more involved in making health more effective, since the state's omission, failure or non-compliance with its social and institutional promises has pushed the realization of citizens' health care to the judiciary.

As a result, legal demands in the health sector have grown exponentially and have demanded quick and efficient responses from the institutions of the justice system, due to the very nature of the right being judicialized.

In this sense, it is possible to state that the phenomenon of the judicialization of health can function as an effective instrument to ensure access to health. It is considered that, in the absence of the Legislative and Executive branches, the Judiciary can act to guarantee the realization of fundamental rights, allowing more equitable and effective access for society.

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

Authors' contribution
Author Fabrício Alberto Lobão de Oliveira was in charge of outlining and analyzing the content. Authors Edith Maria Barbosa Ramos and Natalie Maria Oliveira de Almeida contributed to the interpretation and construction of the content. It should be noted that all the authors participated jointly in the writing of the manuscript and its revision, including the intellectual critique presented, and finally declare that they jointly decided positively on the version to be published.

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