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Article

The role of the Federal Public Defender's Office in the fourth phase of the judicialization of health in the Federal Supreme Court: analyzing Topics 1,234 and 6

A atuação da Defensoria Pública da União na quarta fase da judicialização da saúde no Supremo Tribunal Federal: analisando os Temas 1.234 e 6

La actuación de la Defensoría Pública de la Unión en la cuarta fase de la judicialización de la salud en el Tribunal Supremo Federal: análisis de los Temas 1.234 y 6

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Abstract

Objective: to analyse the decision-making stages of the judicialisation of public health policy in Brazil based on the actions of the Federal Supreme Court, with emphasis on the role of the Federal Public Defender's Office and the recent decisions on Themes 1,234 and 6, through a critical analysis of the excessive judicialisation of health. **Methodology:** a narrative literature review was conducted, using data collected from the STF website based on the description of judicial decisions, as well as a bibliographic-doctrinal review. **Results:** there was an observed increase in technicality and obstacles to the right to health, hindering the work of the Federal Public Defender's Office. **Conclusion:** there

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should be a critical theory of Themes 1,234 and 6 of the STF that prioritises individuals in their collective struggle for the realisation of their rights.
Keywords: Public Defender's Office; Judicialization of Health; Right to Health.

Resumo

Objetivo: analisar criticamente as fases de decisão da judicialização da saúde no Brasil a partir da atuação do Supremo Tribunal Federal, com destaque para o papel da Defensoria Pública da União e as recentes decisões dos Temas 1.234 e 6. **Metodologia:** foi realizada revisão de literatura de tipo narrativa, utilizando-se coleta de dados no sítio eletrônico do STF a partir da descrição de decisões judiciais, assim como revisão bibliográfico-doutrinária assistemática. **Resultados:** observou-se uma crescente tecnicalidade e obstaculização ao Direito à Saúde, visto que a exigência de comprovação científica e a complexidade dos processos judiciais podem favorecer aqueles com maior acesso a recursos e a informações, perpetuando a exclusão dos mais vulneráveis e dificultando a atuação da Defensoria Pública da União. **Conclusão:** urge a necessidade de uma teoria crítica aos Temas 1.234 e 6 do STF, priorizando os indivíduos em sua luta coletiva pela efetivação de seus direitos com o papel fundamental da Defensoria Pública da União.
Palavras-chave: Defensoria Pública; Judicialização da Saúde; Direito à Saúde.

Resumen

Objetivo: analizar las fases de decisión de la judicialización de la política pública de salud en Brasil a partir de la actuación del Tribunal Supremo Federal, destacando el papel de la Defensoría Pública de la Unión y las recientes decisiones de los Temas 1.234 y 6, mediante un análisis crítico de la excesiva judicialización de la salud. **Metodología:** se realizó una revisión bibliográfica narrativa, utilizando datos recopilados en el sitio web del STF a partir de la descripción de decisiones judiciales, así como una revisión bibliográfica y doctrinal. **Resultados:** se observó una creciente tecnicidad y obstaculización del derecho a la salud, lo que dificulta la actuación de la Defensoría Pública de la Unión. **Conclusión:** debe existir una teoría crítica de los Temas 1.234 y 6 del STF que pueda dar prioridad a los individuos en su lucha colectiva por la efectividad de sus derechos.
Palabras clave: Defensoría Pública; Judicialización de la Salud; Derecho a la Salud.

Introduction

The judicialization of health in Brazil has become a multifaceted phenomenon, involving legal, political, economic, and social aspects. Since the promulgation of the Federal Constitution of 1988, which enshrined health as a right of all and a duty of the State[1], the Judiciary has been progressively called upon by citizens seeking the provision of medicines, treatments, and medical procedures. This movement has become especially relevant in light of the failures in the implementation of effective public policies and the structural underfunding of the Unified Health System (SUS)[2].

The evolution of the STF's jurisprudence on health matters can be understood in four phases[3]. The first, called "Non-Activism" (1988-1996), was dominated by the idea that constitutional norms related to health were programmatic in nature and had limited effectiveness. The second phase, "Absolutization of Health" (1997-2003), was marked by granting the right to health in an absolute manner, based on Article 196 of the Federal Constitution, which states that "health is a right of all and a duty of the State, guaranteed by social and economic policies aimed at reducing the risk of disease and other hazards and providing universal and equal access to actions and services for its promotion, protection, and recovery"[1].

The third phase (2004-2009), corresponding to the "Theory of the Costs of Rights"[4], introduced a balance between the minimum subsistence level and the reserve of the possible, presenting limits to

the indiscriminate granting of treatments and medications, balancing the scarcity of public resources with the need to guarantee the essential core of social rights.

Finally, the fourth phase (2009-2024), called "Evidence-Based Medicine" (EBM), which uses scientific and technical arguments based on medical technicality, aided by opinions from the Judicial Support Centers (NAT-JUS) and, currently, by the National Commission for the Incorporation of Technologies in the SUS (Conitec).

In this context of judicialization of the right to health, the Federal Public Defender's Office (DPU) emerges as a fundamental institution for access to justice by the most vulnerable, providing legal assistance to the vulnerable, mitigating the informational and procedural asymmetries inherent in the phenomenon of judicialization, and seeking to guarantee, ultimately, access to the right to health.

The Federal Public Defender's Office (DPU) plays a robust role in the judicialization of health, above all because it presents itself as a strong avenue of access to the judiciary for the vulnerable population. This institutional function, provided for in Article 134 of the Federal Constitution and regulated by Complementary Law No. 80/1994[5], gives it the mission of ensuring not only the procedural defense of the underprivileged, but also the protection and promotion of human rights, including collectively. However, the establishment of Themes 1.234[6] and 6[7] by the Federal Supreme Court in 2024, inaugurating the fourth phase of judicialization, introduced a new level of difficulties in accessing Constitutional Justice, which directly affects the practical effectiveness of the DPU's actions and, ultimately, hinders the vulnerable population's access to the human right to health.

The main objective of this study is to analyze the four decision-making phases of the Federal Supreme Court (STF) regarding the judicialization of public health policies, with special emphasis on the fourth phase, called Evidence-Based Medicine (EBM), permeating this analysis with the actions of the DPU.

Methodology

The methodology used was qualitative and descriptive in nature, through a narrative review of unsystematic doctrinal literature and analysis of case law[8,9]. Decisions of the STF published on its official website were consulted, as well as technical opinions, regulations of the National Council of Justice (CNJ), and scientific articles published between 2000 and 2025 on Google Scholar, Scielo, and the CAPES journal portal.

The analysis was based on the historical evolution of the four phases of the Judicialization of Health in the STF, culminating in STF Themes No. 1,234 and 6, always through a narrative review of the doctrinal literature and analysis of case law, in comparison with the Supreme Court's emblematic judicial decisions on the matter. It also sought to conduct an exploratory assessment of how the operative part of the judicial decision and its modulation of effects impacted the provision of legal assistance by the DPU in the context of the right to health.

Finally, an analysis is made of the interpretative distance between what would be a Constitutionalized Right to Health and a Judicialized Right to Health, in particular by systematizing a critical theory on Themes Nº. 1,234 and 6 of the STF, judged in 2024 and which became, respectively, Precedents 60[10] and 61[11], with significant impacts on the topic presented here.

Results and discussion

The right to health in the decision phases of the Federal Supreme Court (STF)

First decision phase in the STF: non-activism

The first decision phase of the STF on the realization of the right to health is classified as "Non-Activism" since the first ruling on the subject to appear on the Supreme Court's website was delayed by a jurisdictional vacuum of almost a decade after the 1988 Constitution.

Thus, the phase of non-activism lasted from the enactment of the Constitution of the Republic in 1988, with the promulgation of fundamental social rights, until 1997, when the STF ruled on Petition 1.246/SC, whose rapporteur was Minister Celso de Mello, on the case of a child with a rare disease – Duchenne Muscular Dystrophy[12]. In other words, it took almost ten years for a case involving the judicialization of health to reach the Supreme Court.

The main arguments put forward for the STF's non-activism phase in relation to the judicialization of health concern the persistent interpretation of the programmatic nature and limited effectiveness of recent constitutional norms related to the right to health. The STF's "non-activism" ended in the second half of the 1990s, in an attempt to find a solution for plaintiffs in the face of the Executive Branch's inertia in organizing and implementing public health policy and, above all, in the interest of filling the vacuum left by the Legislative Branch's failure to regulate the fundamental right to health[3].

In this first phase, the DPU's actions were incipient, as it had only been established on an emergency and provisional basis by Law Nº. 9,020 of March 30, 1995[13], reflecting the inertia of the Judiciary itself. Its activities were limited to specific cases, without a consolidated strategy for health litigation, which corresponded to the jurisdictional vacuum at the time.

Second phase of STF decision: absolutization of health

We characterize the second phase of the STF's decision as "Absolutization of Health"[14]. This name is due to the fact that the STF granted the vast majority or basically all legal claims regarding the constitutional right to health without limiting its scope, thus making Article 196 of the Federal Constitution absolute, removing it from the programmatic and limited effectiveness in which it was inserted. In other words, making health absolute meant granting the right to health in an absolute manner, without relativizing it, including the normative integrity of its objectives, principles, and guidelines constitutionalized in the 1988 Constitution.

The STF also decided at this stage that the realization of the right to health – whether it be the provision of high-cost drugs or treatment for a rare disease abroad – should be implemented as quickly as possible, regardless of the lack of financial resources to cover the respective costs, even if this meant increasing the cost of the entire bidding process for the delivery of drugs or the opening of highly complex treatment, for example.

It should be emphasized that these cases that reached the Supreme Court dealt only with microjustice – individual rather than collective claims[15] – and there was no concern on the part of the justices about their consequences for public policy and, above all, about the cost of realizing these rights to health, which is called the reserve of the possible[16].

The second phase coincided with the institutional consolidation of the DPU as one of the main actors in the judicialization of health. The favorable stance of the STF allowed the Public Defender's Office to succeed in a large number of individual lawsuits, becoming a crucial means of access to medicines and treatments for the low-income population. However, as Sant'Ana points[17], this action, although necessary, unintentionally contributed to the expansion of the microjustice model, focusing on individual cases, to the detriment of a collective and structural strategy.

Third phase of STF decision: cost of rights

In this third phase of the STF decision, the Supreme Court makes a radical shift in decisions relating to the right to health in order to weigh the importance of the cost of rights, especially those considered second-generation rights, i.e., rights that primarily require financial compensation from the State for their effective implementation, as is the case with the fundamental right to health[4]. Since 2004, with the judgment of the Fundamental Precept (Arguição de Descumprimento de Preceito Fundamental – ADPF) nº 45[18], there has been an institutional milestone on the legal-budgetary limit for granting health demands that reach the STF, especially in relation to high-cost drugs and highly complex treatments.

ADPF Nº. 45 is a leading case in the STF not only because it is the first decision on the theory of the costs of rights, but also because it discusses the issue of the Judiciary's involvement in the implementation of public policies, social rights, and expressly the reserve of the possible and the minimum existential.

The reporting judge for ADPF Nº. 45 – Celso de Mello – begins his vote by defending the STF's role in the implementation of public policies through the effective application of economic, social, and cultural rights, such as the fundamental right to health, when there is non-compliance on the part of the public authorities violating the Constitution not only intentionally, through positive action by the State, but mainly through governmental inertia. Celso de Mello argues in his decision that second-generation rights are fundamental rights and should be applied immediately[18].

Further on, the rapporteur considers that, for the State to implement economic, social, and cultural rights, such as the right to health, it would need an inescapable financial link subject to budgetary possibilities, as it is not possible for the public entity to finance and implement social policies without the appropriate budgetary allocation.

He notes, however, that for the State to give up on fulfilling its constitutional obligations, it must prove its argument based on the reserve of the possible, otherwise it will be considered a major fraud, illegitimately and arbitrarily denying the minimum health requirements for the citizens who are responsible for supporting the State through their taxes.

An important fact is that ADPF Nº. 45[18] was the first decision in the Supreme Court in which a minister of the Court explicitly developed a criterion for assessing the applicability of the principle of reservation of the possible. The suggested criterion was based on the combination of the reasonableness of the claim and the financial availability of the State. If both elements of the criterion suggested by the justice were affirmative, proven, and cumulative (reasonableness of the claim + financial availability of the State), the State would be obligated to enforce the right demanded. Otherwise, it would undermine the possibility of the public entity to practically enforce such rights, in this specific case, the fundamental right to health.

Finally, the minister concludes his vote by justifying the actions of the Judiciary in cases of inaction or non-compliance with constitutional norms – especially in relation to economic, social, and cultural rights – by members of the Legislature and the head of the Executive Branch, arguing that there is no absolute jurisdiction or monolithic interpretation of the theory of separation of powers, and that the Judiciary may act to prevent the most needy population from being deprived of a minimum standard of living that is fundamental to their existence[18].

The third phase forced the DPU to refine its legal argument. The institution, which expanded its staff with Provisional Measure Nº. 301 of 2006[19], began to incorporate into its requests the discussion of the minimum necessary for existence and the reserve of the possible, seeking to demonstrate the reasonableness of the claim and the budgetary availability of the public entity. During this period, the DPU's actions became more technical and strategic, developing expertise in the analysis of demands for high-cost drugs and their respective arguments in order to combat the idea of insufficient resources[20,21,22].

Fourth phase of decision in the STF: evidence-based medicine (EBM)

The fourth phase of the decision in the Federal Supreme Court began with the convening and respective debate between various actors in a public hearing led by Minister Gilmar Mendes in 2009, and also ends with the joining of various representatives of the Executive, Legislative, and Judicial branches, who consolidate Themes Nº. 1,234 and 6, judged in 2024, as Binding Precedents.

Initially, Minister Gilmar Mendes – in the Suspension of Anticipated Relief – STA 175-AgR/CE[23] in 2010, outlines five basic parameters for determining judicial decisions regarding the judicialization of health: 1) the existence of a division of powers among federal entities with the scope of dispensing medicines, relating them to the decentralization of pharmaceutical assistance policy; 2) if there is a public policy covering the health care requested by the party, the Judiciary must then intervene to ensure compliance in the event of omissions or inefficient provision; 3) if the non-provision results from a legislative or administrative omission to provide it, or from a legal prohibition on its dispensing, the following must be observed: if there is a legislative omission, registration with the National Health Surveillance Agency (Anvisa) is an essential condition for the supply of medicines; if there is an administrative omission, the judge must analyze whether the SUS provides alternative treatment, which will be privileged over other types available; 4) if the medications and treatments available to the patient are experimental, the State is not obliged to provide them; 5) in the case of incipient treatments and medications, which, because they are still very recent, have not yet been included in SUS protocols but are already provided by the private health network, treatments may be determined by the judicial authority, provided that they are followed by extensive evidentiary proceedings and with a reduced possibility of precautionary grants.

These five parameters have guided health law practitioners in all subsequent years in all instances of the Judiciary, reflecting on the following conduct of those who would need a medication that was not on the Unified Health System (SUS) list: a) mandatory presentation of an administrative refusal from a public pharmacy registered with the SUS; b) detailed completion of a medical certificate, report, or statement justifying the urgent need for the medication required for (un)certain survival; c) mandatory presentation of at least three updated quotes from private pharmacies or distributors to serve as a parameter for requesting the release of state funds to attempt to purchase the medication; and finally, d) an updated prescription.

These obligations became increasingly radical until they reached the height of technicality and requirements for filing a lawsuit, especially for obtaining high-cost medication that was proven to be off the Rename – National List of Essential Medicines (SUS) –, with the publication of recent Themes Nº. 1,234 and 6 of the STF, which were considered Binding Precedents, respectively Nº. 60[10] and 61[11].

Before delving further into the aforementioned Themes, it is important to note that the STF – by demanding greater parameters of analysis and requirements for judicialization – presents as its correct objective to undermine the lobbying of companies in the medical-pharmaceutical complex in public health policy. However, and here paraphrasing Paracelsus, the difference between medicine and poison lies in the dose applied[24].

Issue Nº 1,234[6] established that drugs not incorporated by the SUS, but registered with Anvisa, will be processed in Federal Court if the annual treatment is equal to or greater than 210 minimum wages; that the Judiciary may only formally review the act of rejection, and should not interfere in the merits of the administrative decision, in addition to confirming that the plaintiff is responsible for proving the efficacy and safety of the drug, as well as the lack of a therapeutic substitute in the SUS.

Theme Nº. 6[7] further tightened the requirements for legal action, determining that the plaintiff must prove that they do not have the resources to purchase the medication, that it cannot be replaced by another medication on the SUS list, that its effectiveness is based on evidence, and that its use is essential for treatment. And even if the plaintiff manages to prove this first stage to access their right, the National Commission for Technologies in the Unified Health System (Conitec) would evaluate the cost-benefit of the medication, that is, whether the amounts spent by the State would be in line with the calculation of the patient's survival. Therefore, specifically in this sense, human life has an established price, and judicialization can be hindered by the excess of obligations to be proven to the respective court.

This fourth phase represents the most complex challenge for the DPU. Themes No. 1,234 and 6 of the STF transferred to the active pole — and, consequently, to the DPU — a heavy technical-scientific burden of proof. Now, it is confirmed that it is not enough to demonstrate the need for treatment and the plaintiff's lack of financial resources; it is imperative to prove with robust evidence (meta-analyses, controlled clinical trials, and even statistics) the efficacy, safety, and cost-effectiveness of the requested medication, in addition to the lack of therapeutic alternatives in the SUS.

This requirement creates an almost insurmountable epistemological barrier for the average citizen. The DPU, therefore, assumes the role of mediator of scientific capital, needing to coordinate with hospitals and their respective attending physicians to produce the opinions and reports required by the new judicial paradigm. This requires a profound institutional rearrangement and the allocation of specialized resources that are often already scarce[20,21,22].

Faced with this challenge, the DPU, through Ordinance GABDPGF DPGU Nº. 1,698, of November 26, 2024[25], established the National Center for Health Interiorization (NNIS), with jurisdiction over health claims under the exclusive jurisdiction of the Federal Court in judicial subdivisions not yet served by DPU regional units or centers, precisely to act, in the literal sense of Article 8 of the aforementioned Ordinance:

> in administrative proceedings or in the first instance of judicial proceedings, in judicial sub-sections not yet served by DPU units, in health claims under the exclusive jurisdiction of the Federal Court, as defined in the STF decision in RE 1.366.243/SC (theme 1234 of General Repercussion), or in other binding precedents of higher courts[25].

After this descriptive analysis of the fourth phase of the judicialization of health and the role of the Federal Public Defender's Office, we will present a critical analysis of STF Themes Nº. 1.234 and 6.

Critical Analysis of Themes No. 1,234 and 6 of the STF

The recent Themes Nº. 1,234 and 6, decided and published in 2024 by the Federal Supreme Court and ending the fourth phase of the Judicialization of Health, are now Binding Precedents, that is, they are binding not only on the entire Judiciary, but also on the entire Public Administration.

In this sense, they guide the Evidence-Based Medicine (EBM) model at the legal and political level, requiring the plaintiff to bear the burden of producing advanced clinical reports, meta-analyses, controlled trials, or scientific statistics to claim the judicial provision of medical technology — elements of sophisticated cultural and financial capital[26].

The obligation — on the part of the plaintiff and main subject of the lawsuit — to produce robust scientific evidence represents a mechanism of procedural alienation: individuals with less access to cultural capital (rights, scientific networks, sponsorships) are systematically excluded from the judicial enforcement of the right to health, even if they are represented by robust institutions, such as Public Defender's Offices, which also do not have, specialists capable of producing documents that meet the requirements imposed by the aforementioned Precedents. Thus, instead of promoting equal protection, Themes Nº. 1,234 and 6 amplify legal inequality, favoring claims of high technical complexity and institutional cost.

Furthermore, the technical-legal model reinforced by the Themes analyzed reinforces the character of individualized microjustice, to the detriment of collective structural demands. This model fuels individual judicialization dissociated from the root causes—chronic underfunding of the SUS, unequal federal agreements, poor management, and empty talk of effectiveness without the necessary systemic transformation[2, 27].

It is also considered that the right to health (use value) comes into tension with the imperatives of budgetary sustainability and fiduciary criteria (exchange value)[28]. The legal system institutionalizes this tension as natural: judicial decisions require demonstrating cost-benefit ratios, converting human suffering into survival rates versus public spending — which reduces social rights to technical accounting logic, as attested by most of the conclusions reached by the Opinions and Technical Notes that validate or invalidate the provision of medications.

Critical theory applied to public health — present in the approach of the Social Determination of Health[29] and historical-dialectical materialism[30] — identifies technified and individual judicialization as part of a model that rationalizes rights and restricts access to those with greater cognitive and institutional capital, as we see in Themes Nº. 1,234 and 6 of the STF. In this sense, judicial technification functions as an ideological apparatus of the State[31], reproducing a technical rationality that naturalizes state austerity and legitimizes fiscal control as a parameter of justice.

To overcome these inequalities, the proposed critical health theory addresses the following points: a) expansion of collective organizing power: encouragement of structural or collective litigation involving broad representation, as opposed to individual judicialization; b) democratization of cognitive capital: institutional strengthening of Public Defender's Offices and Legal Support Centers at Universities and Community Organizations for access to the required scientific evidence; c) resistance to technical naturalization: the Judiciary must critically evaluate the logic of Themes No. 1,234 and 6, recognizing their exclusionary potential and seeking to construct inclusive legal techniques; d) redistributive policies and public financing to counteract the effects of budgetary austerity regimes that reduce the universality, comprehensiveness, and equity that are the cornerstones of the Unified Health System (SUS).

By requiring technical evidence that is difficult for the underprivileged to produce, Themes No. 1,234 and 6 of the STF operate a class selection within the judiciary, reproducing inequality under the cloak of legality. This is a case of legal fetishism[32], in which material relations of domination are hidden under abstract forms of formal equality.

In this context, judicialization must be understood as a response to the failure of the constitutional health pact. The STF's actions in the fourth phase shift the focus from the subject of law to technical rationality, promoting a reversal that threatens the democratic core of the 1988 Constitution. Judicialization ceases to be an instrument of emancipation and becomes a mechanism for legitimizing scarcity, reproducing inequalities in the name of science. It is proposed that overcoming this scenario requires a recomposition of the role of the State in guaranteeing the right to health, with the resumption of universal and structuring public policies, as in the advent of the Health Reform with the consolidation of the SUS[33].

Therefore, the criteria of high medical proof requirements and cost analysis of human life imposed by the STF in Themes Nº. 1,234 and 6 introduce a biopolitical logic[34] into the field of health justice. Life is now managed based on calculations of productivity and survival, which reveals a form of neoliberal governmentality[35]. In this model, the poor become disposable if their treatment is considered uneconomical.

A critical analysis of Themes Nº. 1,234 and 6 must consider the dual role of the DPU: on the one hand, as an institution that operates the law and must follow the new guidelines; on the other, as an institution that guarantees fundamental rights and must criticize and seek to overcome the obstacles imposed by them.

Themes Nº. 1,234 and 6 deepen the distinction between those who have and those who do not have access to “scientific capital”. The DPU is at the forefront of the fight against this inequality, despite its lack of structure and personnel, especially with technical expertise in health matters. Its work goes beyond procedural representation; it is a counter-majoritarian action, challenging the pure and simple application of a precedent that, under the argument of rationality, can produce serious injustices. The DPU has the legitimacy to litigate in order to modulate the effects of these issues in specific cases where the requirement for technical evidence makes access to the law impossible, arguing for the primacy of human dignity over extreme economic rationality[20,21,22].

The excessive technicality of individual claims means that the DPU needs to rethink its strategy. The solution pointed out by the most recent doctrine is the migration from a model of individual litigation to a model of structural or collective litigation, or the establishment of mechanisms that do

not abandon individual protection, but that specialize in collective action, with the strengthening of the system of regional human rights defenders.

Thus, while filing hundreds of individual lawsuits with a high burden of proof, the DPU should also seek: a) collective protection: to impose on the State the duty to incorporate essential medicines and treatments into SUS protocols, based on scientific evidence; b) strengthen intervention in public policies: act extrajudicially and in social control, participating even more incisively in the discussions of Conitec and the Health Councils; c) strengthen partnerships with specialized centers: the DPU needs to strengthen its own specialized health centers and establish permanent partnerships with universities and teaching hospitals; d) Criticizing technical and judicial fetishism: in its oral arguments and briefs, the DPU should avoid uncritical adherence to the Evidence-Based Medicine (EBM) paradigm. It is its doctrinal role to unveil the legal-technocratic fetishism[32] present in the aforementioned themes, showing that behind seemingly neutral concepts such as "cost-effectiveness" and "scientific evidence" lie political choices that prioritize cost containment at the expense of human lives. The argument must always re-inscribe the discussion in the field of fundamental rights, questioning when technicalities serve as a veil for the denial of a right[20,21,22], which is the essential role of an institution dedicated to the protection of human rights.

Given this scenario, there is an urgent need for a necessary and profound reflection on the constitutionalized right to health, anointed with popular participation, financing, and universalism, and the judicialized right to health, which — contradictorily — individualizes and restricts the achievements of the Constitutional SUS.

The constitutionalized right to health and the judicialized right to health: a tense and necessary relationship

The concept of the right to health in its constitutional sense — constitutionalized — was the result of a movement of democratic participation in the ratification and normative implementation of the right to health for the entire Brazilian population, the Health Reform Movement, which, together with the Constituent Assembly, inserted the objectives, principles, and guidelines, such as universality and comprehensiveness, into a universal health system — the Unified Health System (SUS). The aim was to serve the community with public funds secured by a civilizational pact guaranteed by the Social Order in the context of the consolidation of Social Security in our Federal Constitution[33].

On the other hand, over the past thirty years, we have witnessed the formation of public health policy surrounded by advances, setbacks, and contradictions, moving from its comfort zone in the constitutional text to the clashes of the courts, especially the STF, the highest court that influences direct and indirect administrative bodies, as well as the entire Judiciary and the Justice System. This resulted in the four phases of decision-making shown above, which function as a kind of conceptual benchmark for a judicialized right to health.

In this scenario, the role of the Federal Public Defender's Office (DPU) stands out. This institution is essential to the jurisdictional function of the State[1] and acts to defend the fundamental rights of the needy, with special attention to health. The DPU has established itself as a bridge between microjustice and macrojustice: while promoting individual actions to ensure medication, treatment, or hospitalization for low-income individuals, it also uses collective protection instruments — such as public civil actions, recommendations, and structural litigation — that seek to align individual protection with the strengthening of the SUS. In this way, its actions prevent the judicialization of

health from being limited to a technical and fragmented model, redirecting it toward the constitutional perspective of universality and comprehensiveness, in addition to lending greater rationality to the demands before the STF[20,21,22].

On the one hand, we have a concept formulated with democratic participation encompassing values such as universality, comprehensiveness, and equity, which reveal the intention to reach as many people as possible – macrojustice – through compliance with the objectives, principles, and guidelines of the constitutional SUS. On the other hand, we have a concept formulated based on restrictive and technical criteria, serving only the underprivileged individual demanding a subjective public right – microjustice – backed by medical-scientific documents guided by institutions that have enjoyed supra-constitutional importance in relation to the realization of the right to health.

In this sense, Lima[36] points out, when revisiting the right to health between the ideals of the 1988 Federal Constitution and the current legal drama:

> The factor that is most interesting here is that this subjective right, in the context of justice as a virtue, uses instruments of particular commutative (or retributive) justice, in which distribution is equal only among individuals involved in the exchange of goods or commodities, and which directs the so-called "zero-sum games", that is, those in which the result belongs entirely to a winner, and the decision is primarily binary in nature (lawful-unlawful; granting of medication-non-granting) and tends to decree orders whose fulfillment is all or nothing, which evaluate, in short, only two alternatives. Thus, subjective rights are asserted independently of particular duties, which would generate a disconnect between benefits and burdens – and, thus, a character of potential irresponsibility. **The consequence is perverse: the subject of a fundamental subjective right can exercise it against the world, without their right being conditioned by the social reach of its exercise; in this context, the judicial resolution of conflicts is shifting from its collective essence to a form of private justice** (emphasis added)[36].

The risk that could arise from the fusion of the two concepts structured here is made explicit in a possible departure from the judicialized concept of the right to health in relation to the constitutionalized concept, especially after the publication of Themes Nº. 1,234 and 6 of the STF.

This is because fundamental social rights, such as the right to health, are understood and interpreted as distributive rights, rights belonging to a community. Thus, when compared to subjective rights, they are distinct in nature and, therefore, use equally diverse legal remedies, which require mediation and negotiation.

Therefore, social rights — such as the constitutional right to health — were conceived as interests to be enjoyed or exercised not only individually, but primarily in a collective sense, and, as a rule, are realized through the provision and sharing of common goods or scarce goods—hence the importance of the issue of the costs of rights between the reserve of the possible and the minimum existential. Furthermore, their effectiveness depends on the concrete actions of the executive and legislative branches, as they are characterized by generality and publicity, which, in the case of health, takes on the contours of universality and comprehensiveness, and cannot simply wait for the possibility of legal action[36, 37].

With the systematic demonstration of the trajectory of the concept of the right to health, both from a constitutional and judicial perspective, we hope that the Justice System and the Health System can refine their agreements on the subject, since its implications directly affect the Brazilian

population, bringing the two concepts closer together with the aim of strengthening and consolidating the SUS. The objective is that: a) individual microjustice be inserted in a context of collective justice, in which individual rights are judged to be inherent to the achievement of collective demands; b) the criteria of commutative justice be brought closer to the criteria of distributive justice; c) the concepts of universality, comprehensiveness, and equity — elements that characterize the right to health via the Constitutional SUS — are respected; d) the concepts stipulated by the Brazilian Health Reform Movement serve as a parameter for subsequent debates through complaints, doctrine, and jurisprudence post-Themes No. 1,234 and 6, aiming at hermeneutic stability.

In the same vein, as stated by Lima[36] in the aforementioned work on the relationship between the concept of constitutionalized and judicialized health rights:

> [...]**although it has the individual as its guiding core, it manages to perceive rights in a collectivist manner, [...] which would require reflection not only on the practical consequences of judicial decisions on individualized demands, but also a hermeneutic effort by the Court to try to define which values currently contextualize the right to health, so that the equality between the recipients of the norm is not tarnished** (emphasis added)[36].

Therefore, the surrender of the Judicialized Right to Health – which unfortunately was lost with the radicalization of the technicality of Themes Nº. 1,234 and 6 of the STF – will only occur with epistemological and progressive hermeneutic reconciliation with the Constitutionalized Right to Health, as we warned in the critical analysis of the fourth phase of the STF decision. In this process, the role of the DPU is central, as it enables individual defense to be understood in a collective key, rescuing the ideals of Health Reform and promoting a hermeneutics that reaffirms the SUS as an expression of the constitutional civilizational pact.

Final Considerations

Judicialization is evident as a response to state inefficiency, that is, the population resorts to the Judiciary to guarantee access to treatments not available in the SUS, highlighting flaws in public health policy. We can also consider it as a control over the influence of the medical-industrial complex. However, judicial decisions can also reinforce inequalities: the requirement for scientific proof and the complexity of judicial proceedings can favor those with greater access to resources and information, perpetuating the exclusion of the most vulnerable, even when they are represented by the Federal Public Defender's Office.

The STF's decision-making trajectory in the field of the right to health illustrates the profound challenge of reconciling fundamental guarantees with the budgetary and administrative reality of the State. The transition to an evidence-based phase, radicalized by Themes Nº. 1234 and 6, reflects an institutional effort toward greater rationality and predictability. However, its concrete implementation, without the necessary compensation mechanisms, runs the risk of converting judicialization from an instrument of emancipation into a mechanism of exclusion and legitimization of inequality.

In this complex and challenging scenario, the Federal Public Defender's Office (DPU) reaffirms its role as a national human rights institution that is indispensable to the realization of the democratic rule of law. Its work is no longer limited to mere individual procedural representation; it now requires multidimensional action involving: (1) strategic individual and collective litigation; (2) the mediation

of scientific and technical capital; (3) coordination with academic and civil society support networks; and (4) well-founded legal criticism of technocratic excesses.

The future of access to justice in health will depend, to a large extent, on the DPU's ability to adapt to this new paradigm, fighting within it to mitigate its most perverse consequences and, at the same time, litigating against it when necessary, to reaffirm the primacy of life and human dignity over any economic calculation. Overcoming the challenges outlined here therefore requires not only a more sensitive judiciary, but also institutional strengthening of the Public Defender's Office, providing it with the resources, expertise, and legitimacy to continue to be the voice of those who would otherwise be silenced by the technicalities of the law.

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