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Article

The right to health in the Constitutions of Brazil (1988) and Ecuador (2008): a comparative analysis of its constitutionalization and development in public policies

El derecho a la salud en las Constituciones de Brasil (1988) y Ecuador (2008): un análisis comparado de su constitucionalización y desarrollo en políticas públicas

O direito à saúde nas Constituições do Brasil (1988) e Equador (2008): uma análise comparada da constitucionalização e desenvolvimento em políticas públicas

Luz Angela Tarazona Vélez[1]
Universidade Federal do Pará, Belém, PA.
https://orcid.org/0000-0003-0304-3906
luz.velez@icj.ufpa.br

Vladimir German Bazante Pita[2]
Instituto de Altos Estudios Nacionales, Equador.
https://orcid.org/0000-0001-6812-3697
vladimir.bazante@iaen.edu.ec

Eliana Maria de Souza Franco Teixeira[3]
Universidade Federal do Pará, Belém, PA.
https://orcid.org/0000-0002-7979-2404
elianafranco@ufpa.br

Abstract

Objective: to analyze, from a comparative perspective, the right to health in the Constitutions of Brazil, 1988, and Ecuador, 2008, examining how its normative configuration and projection into public policies impact the realization and guarantee of this right under the paradigms of the Social State and the Sumak Kawsay (Good Living). **Methodology:** it was a research with a qualitative and comparative law approach. The Constitutions of Brazil, 1988, and Ecuador, 2008, were analyzed as primary sources, along with indicators from government platforms and data from the Pan American Health Organization to evaluate the materialization of public health policies. **Results:** it was identified that the analyzed Constitutions establish health as a universal (Brazil) and decolonial (Ecuador) right. The implementation of public policies (Unified Health System and Intercultural) allowed for the realization of the right to health, reflected in the improvement of life indicators (mortality and life expectancy) and in the normative validation of ancestral knowledge. **Conclusion:** the constitutionalization of the right to health in Brazil, 1988, and in Ecuador, 2008, allowed for the overcoming of previous health models; transitioning in Brazil from a system based on labor contribution or charity to a universal right to be guaranteed by the State, and in Ecuador toward a transversal and intercultural approach. The realization in Brazil through the institutional strength of the Unified Health System and in Ecuador is achieved through the decolonization of medical

[1] PhD Candidate in Law, Universidade Federal do Pará, Belém, PA, Brazil.
[2] Master in Comparative Politics, Facultad Latinoamericana de Ciencias Sociales, Pichincha, Ecuador. Professor, Instituto Nacional de Estudios Superiores, Pichincha, Ecuador.
[3] PhD in Law, Universidade Federal do Pará, Belém, PA, Brazil. Professor, Universidade Federal do Pará, Belém, PA, Brazil.

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knowledge within the territories of ancestral peoples, and its sustainability depends on a political will that guarantees the proper budget allocation.
Keywords: Right to Health; Health Legislation; Public Policies; International Law; Brazil; Ecuador.

Resumo

Objetivo: analisar, sob uma perspectiva comparada, o direito à saúde nas Constituições do Brasil, 1988 e do Equador, 2008, examinando como sua configuração normativa e a projeção em políticas públicas incidem na efetivação e garantia desse direito sob os paradigmas do Estado Social e do Sumak Kawsay (Bem Viver). **Metodologia:** tratou-se de uma pesquisa com abordagem qualitativa e de direito comparado. Foram analisadas as Constituições do Brasil, 1988, e do Equador, 2008, como fontes primárias, juntamente com indicadores de plataformas governamentais e os dados da Organização Pan-Americana da Saúde para avaliar a materialização das políticas públicas em saúde. **Resultados:** identificou-se que as Constituições analisadas estabelecem a saúde como um direito universal (Brasil) e decolonial (Equador). A implementação de políticas públicas (Sistema Único de Saúde e Intercultural) permitiu a efetivação do direito à saúde, refletida na melhoria de indicadores de vida (mortalidade e esperança de vida) e na validação normativa dos saberes ancestrais. **Conclusão:** a constitucionalização do direito à saúde no Brasil, 1988, e no Equador, 2008, permitiu a superação de modelos de saúde prévios; transitando no Brasil de um sistema baseado na contribuição trabalhista ou na caridade para um direito universal a ser garantido pelo Estado, e no Equador para uma abordagem transversal e intercultural. A efetivação no Brasil mediante a fortaleza institucional do Sistema Único de Saúde e no Equador se alcança por meio da descolonização do saber médico nos territórios dos povos ancestrais, e sua sustentabilidade depende de uma vontade política que garanta a devida dotação orçamentária.
Palavras-chave: Direito à Saúde; Legislação da Saúde; Políticas Públicas; Direito Internacional; Brasil; Equador.

Resumen

Objetivo: analizar, desde una perspectiva comparada, el derecho a la salud en las Constituciones de Brasil, 1988, y Ecuador, 2008, examinando cómo su configuración normativa y la proyección en políticas públicas inciden en la efectivización y garantía de este derecho bajo los paradigmas del Estado Social y el Sumak Kawsay (Buen Vivir). **Metodología:** se trató de una investigación con enfoque cualitativo y de derecho comparado. Se analizaron las Constituciones de Brasil, 1988, y Ecuador, 2008, como fuentes primarias, junto con indicadores de plataformas gubernamentales y los datos de la Organización Panamericana de la Salud para evaluar la materialización de las políticas públicas en salud. **Resultados:** se identificó que las Constituciones analizadas establecen la salud como un derecho universal (Brasil) y decolonial (Ecuador). La implementación de políticas públicas (Sistema Único de Salud e Intercultural) permitió la efectivización del derecho a la salud, reflejada en la mejora de indicadores de vida (mortalidad y esperanza de vida) y en la validación normativa de los saberes ancestrales. **Conclusión:** la constitucionalización del derecho a la salud en Brasil, 1988, y en Ecuador, 2008, permitió la superación de modelos de salud previos; transitando en Brasil desde un sistema basado en la contribución laboral o la caridad hacia un derecho universal a ser garantizado por el Estado, y en Ecuador hacia un enfoque transversal e intercultural. La efectivización en Brasil mediante la fortaleza institucional del Sistema Único de Salud y en Ecuador se logra a través de la descolonización del saber médico en los territorios de los pueblos ancestrales y su sostenibilidad depende de una voluntad política que garantice la debida asignación presupuestaria.
Palabras clave: Derecho a la Salud; Legislación de Salud; Políticas Públicas; Derecho Internacional; Brasil y Ecuador.

Introduction

After the Second World War, a repositioning of human rights occurs at the global level. Among these advances, the incorporation of a new view of the right to health as a human right stands out, driven by the creation of the World Health Organization (WHO) in 1946, which came into force in 1948. From that point onward, constitutions worldwide begin to recognize health as a human right. In Europe, the Constitution of Italy[4] of 1948[1] was one of the first constitutions to incorporate the right to health as a human right (Art. 32); followed by other European constitutions, such as those of Portugal and Spain, which deepened its protection within the framework of the social State[2].

Within the Latin American context, the Constitution of Brazil (CB) marks a milestone by incorporating recognition of health as a human right, with full possibility of being justiciable. Constitutionally, health is conceived as a right-duty: a citizen's right that must be guaranteed by the State. This constitutional responsibility has allowed Brazil to be internationally recognized as a reference in public health matters, by implementing an effective public health system called SUS (Unified Health System), a model of universal and comprehensive coverage that seeks to materialize the constitutional mandate in effective public policies, which pursue mitigation of social inequalities in access to life and well-being[3].

The approach to health within Brazilian constitutionalism develops within a justiciable health model that allows the population to demand its fulfillment through the courts[4]. This system contrasts with more recent models incorporated by New Latin American Constitutionalism (NCL), as in the case of the Constitution of Ecuador (CRE). Although the latter is also framed within contemporary Latin American constitutions, it incorporates a new decolonial perspective by incorporating the wisdom of Indigenous peoples and nationalities within a comprehensive and transformative health model, grounded in the Indigenous worldviews of Sumak Kawsay (Good Living).

Given these scenarios, this research has the general objective of analyzing, from a comparative perspective, the right to health in the Constitutions of Brazil of 1988 and Ecuador of 2008, examining how its normative configuration and projection into public policies affect the realization and guarantee of this right under the paradigms of the Social State and Sumak Kawsay (Good Living). Specifically, the intention is to identify, from the CB and CRE, the paradigmatic overcoming of previous health models; ascertain the materialization of constitutional precepts through analysis of Pan American Health Organization (PAHO) indicators; and finally, discuss the implementation, institutional, and normative mechanisms that allow the transition toward health with a social and intercultural approach.

In this way, the research seeks to answer the following question: In what way has the normative configuration of the right to health in the Constitutions of Brazil and Ecuador affected the realization of this right through their respective public health models?

This analysis allows a glimpse of the importance of different gnoseological constructions and experiences regarding the approach to the right to health. The exercise allows demonstration of how these two constitutional experiences enrich and strengthen the guarantee of the right to health through the realization of legal norms, with the concretization of public policies, allowing assessment of their effect on the advancement of health indicators according to PAHO standards.

[4] In Article 32, the Italian Constitution "The Republic protects health as a fundamental right of the person …"[1]

This research aims to analyze, from a comparative perspective, the right to health in the Constitutions of Brazil, 1988, and Ecuador, 2008, examining how its normative configuration and projection into public policies affect the realization and guarantee of this right under the paradigms of the Social State and Sumak Kawsay (Good Living).

Methodology

This was exploratory and descriptive research with a documentary and bibliographic basis, using a qualitative and comparative law approach. Selection of these two constitutional texts responded to the relevance of these constitutions within the creative process of contemporary Latin American constitutionalism and the representativeness of their models (Social and Decolonial State). Likewise, the choice was grounded in the connection of the female researchers (Brazil) and the male researcher (Ecuador) with the object of study, as residents and users of the systems analyzed, which allows documentary analysis to be complemented with situated knowledge.

The research process developed in three stages: the first stage encompassed the qualitative aspect, in which comparative constitutional law analysis and bibliographic review were performed. Within comparative constitutional law analysis, five comparison indicators were established: the political paradigm, gnoseological scope, normative configuration, system model for public policy, and levels of realization (judicialization and interculturality). To address the study of Brazil, Title VIII concerning the Social Order was examined, in its Chapter II, Section II, On Health, concentrating the analysis on Articles 196 to 200, the constitutional Section dedicated to Health. To carry out the approach to Ecuador, the analysis concentrated on Articles 32 and 358 to 366, which integrate health under the paradigm of *Sumak Kawsay* (Good Living), which is recognized transversally in the Constitution of the Republic of Ecuador of 2008 and is expressed particularly in Title II, Second Chapter, "Rights of Good Living," where health is conceived in articulation with other fundamental rights, such as water, food, a healthy environment, education, habitat, and housing. The analysis concentrated mainly on Articles 32 and 358 to 366, which regulate the right to health from the vision of 'Good Living'[5].

The second stage encompassed analysis of public health indicators corresponding to each country, obtained from national government platforms and PAHO. The period between 2000 and 2024 was covered, selecting the indicators for assessment: infant mortality rate and life expectancy at birth to observe trends in effectiveness, assessed for the period after the constitutional texts came into force (CB/88 and CRE/08). Quantitative analysis is descriptive in nature and is limited to identifying temporal associations between normative frameworks and their realization, recognizing that data may be affected by other values that condition them. In the third and last stage, data triangulation was applied to contrast constitutional norms with the realization of public policies.

Because this research was based on publicly accessible documents and aggregated statistical data, the study did not require submission to a human research ethics committee, guaranteeing scientific rigor through systematic citation and critical analysis of the sources.

Results and Discussion

The analysis develops from the study of comparative constitutional law, in which the Constitution of Brazil of 1988 and the Constitution of Ecuador of 2008 are examined, with the

objective of identifying transformations in the conception of health in Brazil and its transition from predominantly assistance-based models linked to contributory coverage toward a social model under paradigms of health as a universal human right (Brazil), and the Ecuadorian health model that incorporates a new way of viewing health as a whole linked to the paradigm of Sumak Kawsay (Ecuador), allowing us to identify some of their innovations and impacts in these two models from PAHO indicators.

In this way, the right to health analyzed from these two experiences and Latin American comparative constitutional law allowed us to demonstrate two paradigmatic ways of constitutionally approaching the right to health: on the one hand, a social vision in the mission of guaranteeing the right to health that has yielded very favorable results in several indicators, and, on the other hand, an intercultural vision that seeks to recognize ancestral practices and knowledge in the territories of ancestral peoples.

The first, from the social vision that views health as a right to be guaranteed by the Brazilian State, with a biomedical model that addresses care for human ailments, conceives the body as a machine that must be adjusted or treated upon presenting an illness. Although it is true that the biomedical model has led to the advancement of science that has allowed a reduction in the incidence of death, cure or treatment of diseases, this model discards other variables that give rise to diseases (socioeconomic, affective, and psychological factors, among others), so within its approach there is a tendency to "fragment the patient" and distance itself from the patient-physician relationship[6].

Within constitutional theory in the region, Roberto Gargarella emphasizes, among the positive aspects of the emerging constitutionalism of the twentieth century, the incorporation and expansion of economic, social, and cultural rights[7]. The enshrinement of the right to health as a universal, free right and duty of the State in the Constitution of Brazil of 1988 did not constitute a mere declaration, but has been instituted as a serious normative commitment in favor of equality and social justice[8,9]. This constitutional recognition has allowed the implementation of public policies in favor of health, institutionally articulated through the SUS, which has served as a reference regarding its coverage, operating as a mechanism of social inclusion in Brazil that can be replicated in Latin America

The second modality, although retaining a biomedical aspect within medical care, incorporates a new vision of decoloniality and interculturality, Indigenous and community wisdom (Ecuador). This vision is framed in what may be called the philosophy of Sumak Kawsay. Sumak Kawsay, as Eugenio Zaffaroni tells us, "is a Quechua expression, which means good living or full living and whose content is nothing other than the ethics — not individual morality — that must govern the action of the state and in accordance with which people must also relate to one another and especially to nature" [5,10,11]. Recognition of an ethics different from those related to monocultural traditions marks an important paradigm shift regarding competing worldviews. Ecuador was deeply marked by practices expressed, as Marcelo Bonilla explains, in "schemes of action, thought, and perception directed toward consolidating the power of ordinary justice officials through their acts and decisions which enshrine a monocultural worldview — that of the Ecuadorian Nation State — which forms part of the dominant and majority culture" [12]. Although it cannot be affirmed that these practices have been banished after almost 20 years of the current Constitution's validity, it can be affirmed that its text made it possible to have other reference frameworks that translate, regarding this article, into

[5] Zaffaroni, 20[8].

various infraconstitutional normative developments that would be unimaginable with another constitutional text. In any case, recognition of otherness, of other ways of seeing and understanding the world, implies legitimization of ways of life and other orders, such as Indigenous justice[5,12], for example.

The change in cultural visions inaugurated by the Constitution of 2008 therefore allows the value of otherness to be appreciated; Alejandro Medici emphasizes the value of the ancestral cultures of Andean communities, whose centrality relates to the inseparable duality of personal and social well-being, in which the person-society-nature relationship is included[13]. Evidence of this is precisely that the right to health is considered, by constitutional mandate, part of the rights of good living, that is, a transversal right whose exercise relates to the full exercise of other rights comprising Sumak Kawsay, and which, as will be seen below, also implies recognition of practices related to ancestral or traditional medicine and the ways in which they are carried out.

To facilitate understanding of the scope of the constitutionalization of health between both models, Table 1 summarizes the categories of analysis and pillars analyzed in the research:

Table 1. Fundamental constitutional pillars of the right to health

Comparison Criterion	Constitution of the Federative Republic of Brazil (1988)	Constitution of the Republic of Ecuador (2008)
Political Paradigm	**Social State under the Rule of Law.** Vision of social justice and redemocratization.	**Plurinational and Intercultural State.** Decolonial vision under *Sumak Kawsay*.
Concept of Health	**Universal Social Right.** Health as a "right of all and duty of the State."	**Right of Good Living.** Health as a transversal and interdependent right.
Specific Articles	Articles 196 to 200 (Section II: On Health).	Articles 32 and 358 to 366 (Regime of Good Living).
System Model– Public Policy (Realization)	**SUS (Unified Health System)**: Universal, decentralized, and free.	**National Health System**: Integrative, intercultural, and decolonial.
Gnoseological Scope	**Biomedical and Social**: Focus on universal provision and prevention.	**Intercultural and Ancestral**: Recognition of traditional knowledge and medicines.
Level of Application	**Direct Justiciability**: Strong tendency toward the judicialization of health.	**Infraconstitutional Development**: Focus on technical protocols and territorial respect.

Source: Own elaboration, based on analysis of the Constitution of the Federative Republic of Brazil (1988) and the Constitution of the Republic of Ecuador (2008).

The Federal Constitution of Brazil of 1988, known as the "Citizen Constitution" emerges within a scenario of redemocratization after decades of military dictatorship[4,14]. It positions itself within Latin American constitutionalism as the Constitution initiating the first advance toward the construction of innovative constitutionalism of its own; it incorporates important advances in favor

of citizens' rights and guarantees, consolidating the Democratic Social State under the Rule of Law[4,14]. Although the Constitution of Brazil remains within the liberal economic order, it breaks into some of its paradigms, such as the right to health as a moral duty governed by the policy of labor contribution. It transitions toward a universal, decentralized, and free right to health under State responsibility[4,9,14].

This paradigmatic transition was not a gratuitous concession by the State, but the result of the democratic conquest driven by the Health Reform Movement. This movement achieved that health ceased to be a benefit linked to the contributory social insurance of the extinct National Institute of Medical Assistance of Social Security (INAMPS), materializing the conception of health as a human and citizen's right, supported mainly within a new free public health structure called the Unified Health System (SUS), consolidated in Law No. 8.080/1990[15]. This represented an important advance in Latin America, making Brazil the first country in the region to declare health a human right guaranteed by the State[2,4,9].

Within the constitutional analysis, it stands out that the CB carries out a harmonious organization of social rights in favor of well-being and social justice. Among these, Chapter II enshrines the right to social security, integrated in a tripartite manner by the right to health, social insurance, and social assistance (Art. 194). Highlighting the right to health as a free and universal public service, constitutionally framed in Section II, the Constitution reserves an exclusive section dedicated to the right to Health (Articles 196-200), which evidences the importance given by the female and male constituents. On the other hand, social insurance is consolidated as an autonomous entity of a contributory nature for workers. A mixed security system thus emerges, in which universal state responsibility and individual contributory effort converge[8].

Articles 196 to 198 open the way to incorporation of the right to health as a human right, guaranteed through public policies and, in turn, delimit the principles that will govern this right, namely: universality, free provision, decentralization, community participation, and comprehensiveness. This articulation allows health to be displaced from a conception linked to contributory social insurance service policy and charity toward a scenario of a universal human right and State obligation with the possibility of justiciability[8].

Within the scenario of Brazilian health, although the State assumes responsibility for providing the service, health remains a market good, thus opening the way to private initiative so that those with economic capacity have other private alternatives, under the modality of supplementary health care. (Art. 199)[8,16].

This private provision of health services can also become an extending arm of SUS service through agreements with private entities that guarantee access to services unavailable in the public health service network; this allows even greater free coverage to be provided to the Brazilian health system. These services are decentralized and linked to the budgetary capacity of each municipality comprising the Federation, so care and effectiveness can vary from one municipality to another[8,9,16].

It must be considered that funds allocated to health, according to the CB (Arts. 195, 196), are not infinite and are limited by the budget allocated by social security, the Union, the states, the Federal District, the municipalities, and other sources[8].

Within the constitutional prerogatives regarding the right to health in the CB, lack of timely care may be the subject of a judicial claim. Nevertheless, these scenarios of judicialization have evidenced cases of overstepping by the judiciary that affect the public budget. Therefore, responsible

action by the judiciary, analysis of the consequences, and decisions based on evidence are necessary to avoid contradictions in state management[9].

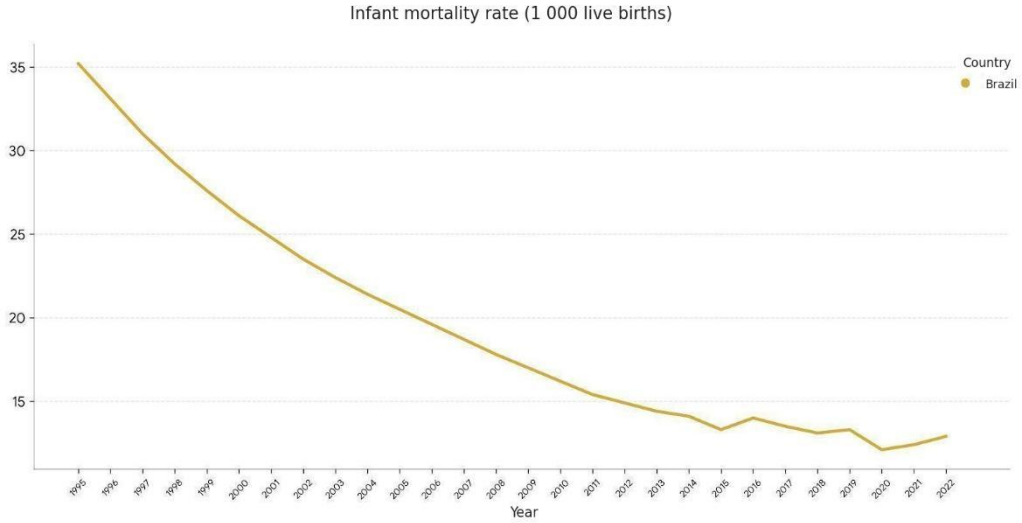
It was observed that this scenario of realization of the right to health, enshrined in the CB, is subjected to permanent tension between the expectation of fulfilling this constitutional guarantee and the limited real and budgetary possibilities available to the government for the actual safeguarding of this right. Therefore, judicialization proceedings present themselves as alternatives that on some occasions exceed budget projections[9,16].

Within these complex scenarios entailed by safeguarding the right to health, constitutionally contemplated by the CB, cases arise in which coverage is not provided in the SUS, resulting in judicialization proceedings to guarantee access to the right. This allows the right to health to face constant challenges as a consequence of its constitutional breadth[9,14,16].

Despite economic and/or budgetary limitations, the constitutionalization of the right to health as a human right and its realization through public policies (SUS) have allowed an improvement in PAHO indicators between 2000 and 2024. These advances, subsequent to the Constitution of 1988, are evidenced in variables such as infant mortality and life expectancy, whose behavior and analysis we present below:

Infant Mortality: Between 2000 and 2022, the infant mortality rate decreased from 26.10 to 12.90 per 1,000 live births. This decline (Graph 1) evidences the positive impact in favor of health after the transition from a previous exclusionary model. It demonstrates that the universal and free SUS system contributed to saving lives, favoring the effectiveness of the human right to health enshrined in the CB, with a reduction of more than fifty percent in infant mortality.

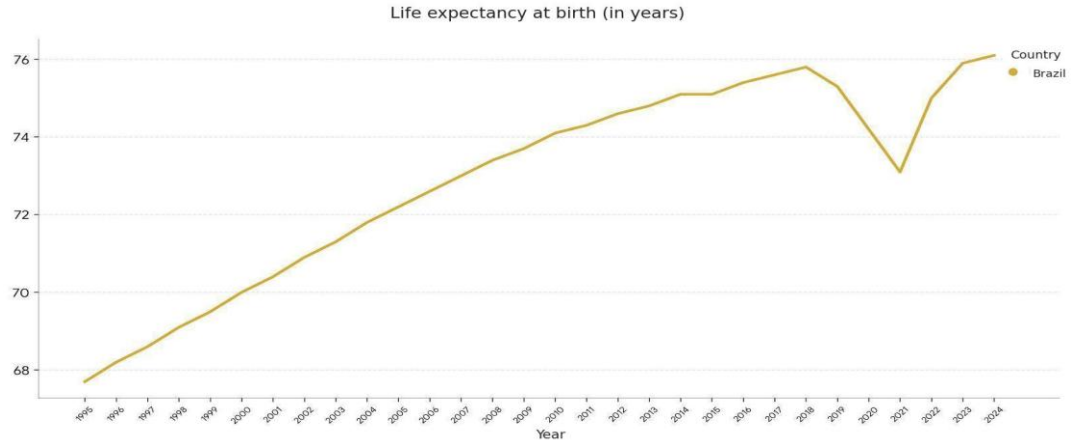
Graph 1. Infant Mortality per 1000 births. Brazil 1995-2022



Source: Pan American Health Organization Source: Pan American Health Organization [17]

Life Expectancy at Birth: An increase of 6.4 years was recorded compared with the figures for 2000 (69.6), reaching a life expectancy of 76 years in 2024[17]. This increase in longevity reflects the impact of the SUS, and the importance of sustainability in access to free health services affects an improvement in quality of life.

Graph 2. Life Expectancy at Birth in Brazil 2000-2024



Source: Pan American Health Organization Source: Pan American Health Organization [17].

As observed, recognition of the right to health in the CB represents a constitutional advance of great importance within Latin American constitutionalism, which allows the overcoming of precepts that projected health as viewed from contribution or charity, moving toward a vision of the right to health as a right to be guaranteed by the State through public policies, and with the possibility of its being judicially demanded by citizens if necessary.

Within the scenarios of Latin American constitutionalism, NCL breaks in, from the constitutions of Venezuela, of 1999, Ecuador, of 2008, and Bolivia, of 2009[4]. NCL incorporates into constitutional texts new paradigms that make ancestral wisdom visible in all areas of the human sciences, especially in the field of Health. Thus, in the CRE, traditional biomedical scenarios are transcended toward comprehensive perspectives where health is viewed as a whole, in harmony with nature and the community, to achieve *Sumak Kawsay* (Good Living).

Health in Ecuador is constitutionally enshrined as a transversal right that must be guaranteed by the State. This transversality implies, as will be seen shortly, a strong contingent of constitutional provisions that relates or conditions the exercise of the right to health with the rights of good living. This meant overcoming the notion of the Constitution of 1998, which contained limitations regarding free provision of what was considered a public service, since it stipulated that these health services would be public for those who needed them, and that financing of entities would come from those using their services and having the capacity for economic contribution[18].

These economic limitations on access to the right to health were corrected by the CRE, which changed the approach based on economic differentiation of those needing medical care to a fully universal one, but not only regarding care *per se*, rather to a more harmonious approach recognizing diverse ways of understanding health. This approach is called the rights of Good Living or *Sumak Kawsay*, insofar as it is considered a "system of life that allows harmony with nature" [5,11] and integrates several principles, among which belonging to a community stands out, since in the Andean world the human being as an individual does not exist except insofar as integrated into the community[11].

Taking this into account, it is understood why the CRE established that rights, including health, cannot be realized in isolation, but require an interrelated set of actions in various areas. The

constitutional text itself attests to this by stating that all rights and principles are inalienable, unrenounceable, indivisible, interdependent, and of equal hierarchy[5].

The CRE dedicates an entire chapter (Title II, Chapter II) to developing the specific rights required to achieve Good Living, among them water and food, a healthy environment, communication and information, culture and science, education, habitat and housing, health, and work and social security[5].

This explicit change in the reference frameworks for conceiving rights, from strictly individual to relational and interdependent, is appreciated when it is established that health, like the other rights detailed above, is a condition of people's dignified life[5], that water is essential to life[20], that the population has the right to a healthy and balanced environment[5], that education constitutes a guarantee of equality and inclusion[12], or that health, in particular, is a right linked to the exercise of the rights to water, food, or education[5], for example; all indispensable for achieving *Sumak Kawsay*.

Nevertheless, the relationship and interdependence of the good living model are not circumscribed solely to the health field with the characteristics indicated, but, in the Ecuadorian case, imply recognition of "other" knowledge in medicine and its incorporation into the so-called "regime of good living," through which institutions and programs are articulated to put the statements indicated above into practice.

This "other" knowledge of medicine translates into recognition and the state obligation to guarantee "ancestral and alternative health practices," respecting and promoting the "use of their knowledge, medicines, and instruments"[5,19]. Ancestral medical knowledge, mainly, had important infralegal normative development when, in 2017, Ministerial Agreement number 0082-2017 was issued, regulating the "application of the intercultural approach in health establishments"[19]. This is important normative development considering that it stipulates that administrative personnel and health professionals know basic words, phrases, and expressions of the language used in the area where the health service is located[19], that if communication is not possible, the presence of an interpreter must be requested[19], or that signage be implemented with translation into the language of the nationalities or peoples present in the territory[19].

Practices such as "traditional ancestral midwifery" must also be highlighted, set out in a text that is "a resource for cultural understanding in health" called the Code of ethics of the men and women of wisdom of ancestral-traditional medicine of the nationalities and peoples of Ecuador," issued in 2020, detailing various procedures and specialties of ancestral medicine; or also the Technical guide for culturally appropriate childbirth care, which, although preceding the Constitution of 2008, details the rituals, positions, appropriate clothing at the time of giving birth, and the meaning of delivery of the placenta after childbirth[20,21].

However, the most prominent aspect relates to the implementation of boundaries between traditional medicine and ancestral medicine, considering that they form part of the same National Health System. Thus, the obligation of knowledge and respect is developed through "articulation with the men and women of wisdom of ancestral medicine," requiring health professionals to pass a Virtual Course on Health and Interculturality[19]; or the obligation to respect patients' wishes to be treated with ancestral medicine, allowing the man or woman of wisdom of ancestral medicine to enter health establishments[19,20].

As can be appreciated, the figure of the men and women of wisdom of ancestral medicine, and their various characterizations[21], is central to the configuration of the right to health and the healing

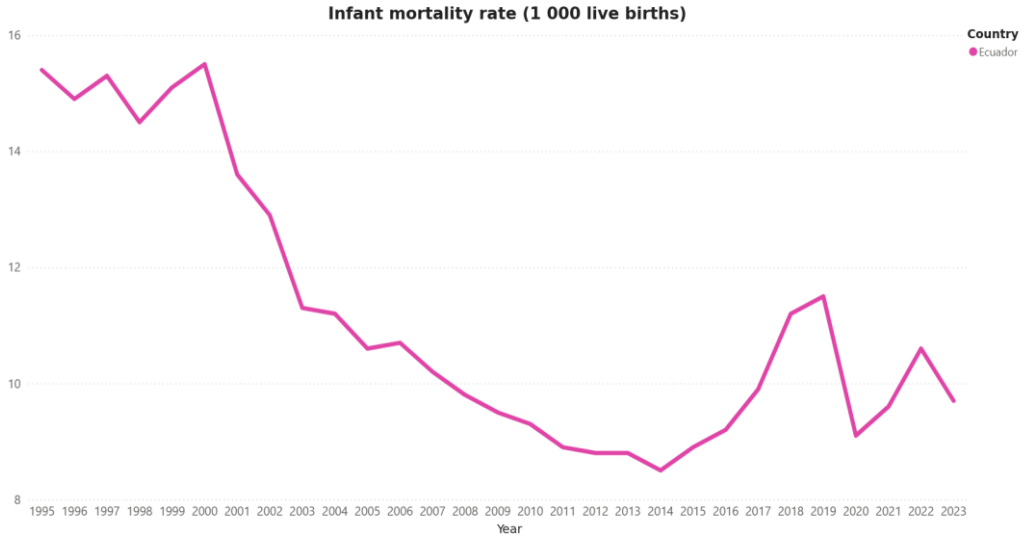
of community members. Nevertheless, the Ministry of Public Health, in exercising stewardship of the system, also established boundaries related to patients' "voluntary discharge" when there are risks to public health for sanitary reasons, or risks to patients' physical or psychological integrity[19].

In any case, recognition of ancestral medicine by the Constitution of 2008 has enabled respect for and practice of ancestral knowledge within health establishments located in the territories of ancestral nationalities and peoples, with the issuance of eminently practical norms that contribute to improving interculturality relations.

Although what has been indicated thus far shows the ideal normative aspect around the interdependent nature of the right to health and the deeply decolonial meaning implied by recognition, respect, and guarantee of ancestral medicine, this does not necessarily have an effective translation in the daily practice of those seeking health care, and questions the possibilities of realizing health in a transversal sense according to the current constitutional regime. With this clarification, it is possible to observe PAHO indicators on Infant Mortality and Life Expectancy and compare them with the periods of the CRE's validity.

In the Infant Mortality variable, a consistent decline is observed since 1995, experiencing the lowest infant mortality point in 2014 with 8.50% per 1000 live births; however, this decrease cannot be associated with the CRE's entry into force. The rise in infant mortality from 2016 had its highest peak in 2019, experiencing 11.50% deaths per 1000 live births; subsequently a drastic decrease in 2020, coinciding with confinement policies resulting from the Covid 19 pandemic.

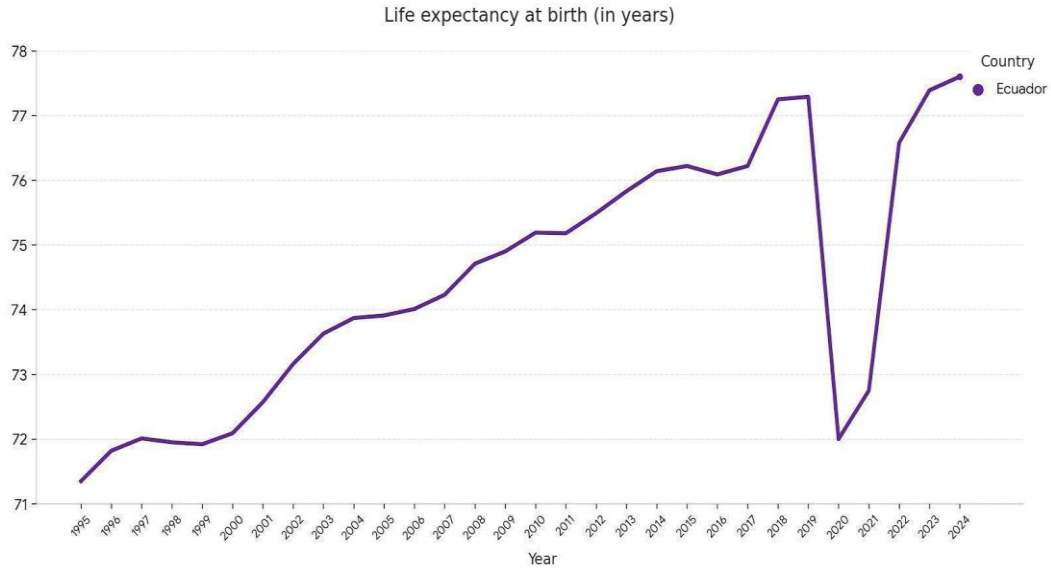
Graph 3. Infant Mortality per 1000 births. Ecuador 1995-2023



Source: Pan American Health Organization Source: Pan American Health Organization [17].

The Life Expectancy at Birth variable also shows an upward trend in this area. When the CRE came into force in 2008, life expectancy at birth averaged 74.71 years. Whereas in 2019 it stood at 77.29 years, experiencing a sharp decline in 2020 on the occasion of the Covid 19 pandemic, when life expectancy at birth decreased to 72.00 years. In 2024, life expectancy stood at 77.58 years.

Graph 4. Life Expectancy at Birth in Ecuador 1995-2024



Source: Pan American Health Organization [17].

Although the indicators presented do not show significant ruptures associated with the CRE's validity, they do show variations that can be associated with existing political changes. Nevertheless, the main achievement of recognition in the CRE of rendered-invisible knowledge and traditions, which have been indicated in part in this article, consists of the infraconstitutional development of those provisions, because in that space the actors and criteria used by ancestral medicine, and the changes in the care regime that this implies, are recognized in greater detail. Although this is a strictly normative assessment, it allows the new reference frameworks of the right to health and its development in an intercultural key to be taken into account.

Final Considerations

The constitutionalization of the right to health in Brazil, of 1988, and Ecuador, of 2008, represents a significant advance within contemporary Latin American constitutionalism. In the CB, health has been elevated to the category of fundamental right and duty of the State, transitioning from a health system sustained by labor contribution and assistance viewed as charity toward one of a human, universal, and justiciable right. In the CRE, a constitutional advance is made by conceiving health as a comprehensiveness, interconnected with other rights that must be guaranteed, such as the rights of Good Living, among them water, a healthy environment, a safe habitat, and food. This integration of knowledge, which overcomes the exclusivity of the monocultural model, is decolonial in nature. Recognition of health as a component of *Sumak Kawsay* (Good Living) transcends the biomedical vision and integrates ancestral wisdom into the National Health System.

In Brazil, data show the favorable impact from incorporation of the SUS in key indicators such as reduced infant mortality and increased life expectancy at birth. Although there are differentiating features in access, as indicated in this article, referring to private medical care for those who can access it, implementation of this system is strongly related to the guarantee of the right to health for the population in a majority manner.

Data show a similar panorama in Ecuador, although with more evident setbacks in periods when the Covid 19 pandemic was present, which coincided with important political changes. However, the most significant aspect regarding the transversalization of the right to health consisted of recognition by the State of the "other" knowledge of medicine practiced in the territories of Ecuador's ancestral peoples. Such recognition, although of constitutional rank, required infraconstitutional norms to operationalize the use of that knowledge, the medicines, and the corresponding instruments.

Finally, the success of the SUS and recognition of ancestral knowledge and practices in the field of medicine constitute hopeful aspects for people's health. However, this is not sufficient. In the Ecuadorian case, recognition of ancestral knowledge and practices, for the moment, is territorialized, and this does not necessarily influence the health system practiced in the rest of the country, in which patients' needs and pain are very pressing. For better or worse, the success of a system depends on the policy adopted by a State, and the crisis can be resolved with adequate management.

In conclusion, the comparative analysis allows affirmation that the normative configuration of both States has positively affected the realization of health. While Brazil consolidates this right through the institutional strength of the SUS and justiciability, Ecuador does so through the decoloniality of ancestral knowledge and the intercultural approach to health. Nevertheless, beyond normative advancement, the guarantee of the right to health will depend on political will allowing the budget allocation to be ensured, making the provision of supplies and hiring of medical personnel possible, so that the constitutional mandate is truly realized.

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