EFFECTIVENESS OF THE RIGHT TO HEALTH IN BRAZIL IN A CONTEXT OF FINANCIAL AND CONSTITUTIONAL CRISIS

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ABSTRACT
The present research deals with the provision of the constitutional and social right to health, analyzing the role of the State in the implementation and availability of this fundamental social right, in a context of financial and constitutional crisis. An analysis of law no. With the analysis of the panorama of public health in Brazil between 2008 and 2013. Faced with the difficulty in effecting public health due to the insufficiency of public resources and the great demand for services, Solutions are proposed with the proposition of collective actions.

Keywords: Right to health; Reserve possible; existential minimum; weighting; Crisis.

RESUMO
A presente pesquisa aborda a prestação do direito constitucional e social à saúde, analisando o papel do Estado na efetivação e disponibilização deste direito fundamental social, em um contexto de crise financeira e constitucional. Faz-se uma análise da lei n. 8.080/90, conhecida como lei do SUS – Sistema Único de Saúde, com a análise do panorama da saúde pública no Brasil entre 2008 e 2013. Diante da dificuldade na efetivação da saúde pública pela insuficiência de recursos públicos e da grande demanda por serviços, aponta-se soluções com a propositura de ações coletivas.

Palavras chave: Direito à Saúde; Reserva do Possível; Mínimo existencial; Ponderação; Crise.

1. INTRODUCTION

The present research aims to address the effectiveness of the constitutional right to health in Brazil in a context of financial and constitutional crisis, with data analysis on the National Health Survey conducted by IBGE in the years of 2008 and 2013. In this sense, the problem that will guide this research will be: How to effect the social right to health in a context of economic and financial crisis?

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It is sought to answer the problem through an exploratory-explanatory bibliographic research, applying the deductive method.

For this, the research was divided into three titles, the first one to analyze the concept of health until we reach the right to health, the second one will be devoted to the analysis of the health panorama in the country, with verification of data from IBGE - Brazilian Institute of Geography and Statistics and the CNJ - National Council of Justice on the judicialization of health, and finally, in the third title, some alternatives are proposed to minimize the conflict involving health in the context of crisis.

2 FROM THE CONCEPT OF HEALTH TO THE RIGHT TO HEALTH

The notion that health is a fundamental human right, protected and protected by the State, is the result of a long evolution in the conception not only of law, but of the very idea of health itself considered.

Scliar (1987) argues that the literature indicates that the first conception of health appeared linked to a magical explanation of reality, in which the patient was a victim of demons and evil spirits.

Ancient Greece, through the studies of Hippocrates, questioned this conception, introducing environmental factors related to the disease, defending what could now be called an ecological-health-illness concept, emphasizing multi-causality in the genesis of diseases, not just being limited to the study of the patient (SCLIAR, 1987). The rituals gave way to the use of herbs and natural methods.

Platão brought the notion of internal balance between body and soul, then enlarged to affirm the balance of man with social organization and nature, taking from this context the concept of health (DALLARI, VENTURA, 2003).

The Middle Ages consolidated an immense retrocession in the health area, a period of epidemics and pestilences resulting from population movements, military conflicts, misery, promiscuity and lack of hygiene (FIGUEIREDO, 2007).

The disease was once again seen as a divine punishment, with health care being reduced to the concern of removing the patient from social life, to avoid contagion and the sight of the disease itself (Dallari, 1988). The only advance was with the emergence of hospitals, which functioned as real asylums or hospices (SCLIAR, 1987).

The Renaissance, as a restoration of Greco-Roman knowledge, was in the area of health a polarized period between Greco-Roman traditions, opposing medieval mysticism and

exoteric practices. This was a breakthrough in discoveries about the human body, thinking, and scientific methods (SCLIAR, 1987).

For Dallari and Ventura (2003) the current concept of public health would have emerged in the Renaissance, when the first concrete policies of what is known today by International Sanitary Law were established, which according to Soares (2000) began with the conclusion of the Treaty International between the Serene Republic of Venice and neighboring countries, still in the 14th century, related to the implementation of public policies for sanitary control of borders, with the aim of protecting the population against diseases that could come from merchant ships.

With the consolidation of the bourgeois Liberal State, from the end of the 18th century and during the 19th century, public assistance, encompassing social and medical assistance, no longer depended on neighborhood solidarity to include health protection among the range of activities typically even with legal-constitutional status (DALLARI, VENTURA, 2003).

The Industrial Revolution brought about a great urbanization movement, with population migration from the countryside to the city and the formation of belts around the factories, which, due to the spatial proximity and absolute lack of hygiene, allowed the rapid proliferation of diseases among the workers, relatives (FIGUEIREDO, 2007).

As in this period the State was nothing more than an instrument of entrepreneurship, it was relatively simple to transfer the claims for better sanitary conditions, assuming the State as a guarantor of public health (DALLARI, PILAU SOBRINHO, 2003). According to Schwartz (2001, p. 113) "capitalism, however paradoxical it may seem, has given rise to a social view of health."

In the 20th century, sanitary protection would finally be treated as social knowledge and government policy. Since World War II, this notion has been expanded, establishing the responsibility of the State for the health of the population, as well as reinforcing the economic logic, based on the evident interdependence between the health conditions of the worker and the productive activity (SCLIAR, 1987).

Affirms Silva (2010) that for long years health was understood as being the absence of diseases, thus having the power of public and private power when the knowledge of the various pathologies and endemias, in the sense of controlling the evolution of the picture and targeting the state absence of disease. It is only with the development of the social state of rights that the definition of health has broadened.

The World Health Organization - WHO defines health as "the complete state of physical, mental and social well-being," and not simply the absence of disease. Encompassing thus the perfect personal well-being, which is only effective with its complete harmony. With this concept, WHO has taken up the idea of quality of life. The right to Health is established in arts. 196 and 197 of the Federal Constitution of 1988, which establishes the obligation of the State to provide health, prevention and protection conditions, that is, to reduce the risks of diseases by promoting preventive policies and actions, as well as to monitor their effectiveness.

For Araújo and Nunes Junior (2008) the Federal Constitution treats health as a social right and includes it in the list of Fundamental Rights. They also affirm that the right to health is an unfolding of the right to life itself and, consequently, a fundamental right of the individual.

According to Vasconcelos (2014, p. 1839), "health is the right of everyone and the duty of the State, and should be provided to those who need it". That is, it is the State's responsibility to provide it equally. However superficial the concept of health may be, any research on the right to health is enough to affirm the complexity and diversity of actions and benefits that make up the content of this fundamental right (FIGUEIREDO, 2007).

For Morais (2003, p. 23-24), the core of the concept of health would be in the idea of quality of life, which is related to contemporary political and legal theories, health being an element of citizenship, that is, a right to the promotion of people's lives, not only worrying about the diffuse and legitimate pretension to cure and avoid disease, but to have a healthy life.

Sarlet (2004, p. 2) equates a decent life with healthy life, bringing the concepts of quality of life closer to the dignity of the human person, affirming that complete physical, mental and social well-being strengthens the principle of human dignity, that unhealthy and inadequate living conditions are accepted as the content of a life with dignity.

The emergence of public health is therefore intrinsically related to the evolution of the modern state. At the beginning of the twentieth century, health protection was established as a public policy, reinforced with the advent of the Welfare State, where it becomes evident the interdependence between health and work conditions, whose new conception, revealed only from the last years of the twentieth century, implies the definition of public policies aimed at their care, defense and protection (CAVALHEIRO, 2013).

In addition, health is a right of all and an essential dimension of the growth and development of the human being, so all people, without distinction, have the right to a healthy

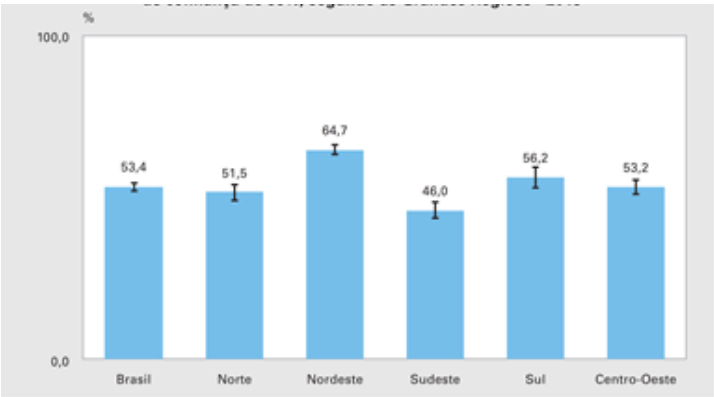
life and essential the complete well-being to reach the health condition. The health condition is produced in the relationships with the physical, economic and socio-cultural environment, identifying risk factors for personal and collective health present in the environment in which they live.

The debate on health and access to means of prevention and medical and therapeutic treatments has expanded greatly in the last decade in the country, incorporating new participants and placing doctors, managers and all involved in the process in a scenario where health, law, management and economics have been compelled to dialogue and build solutions.

3 HEALTH PANORAMA IN BRAZIL

According to the PNS - National Health Survey of 2013, 53.4% households were registered in the Family Health Unit (34.8 million households). The Northeast Region had the highest proportion (64.7%), while the Southeast Region had the lowest (46.0%). Considering the situation of the domicile, the urban area (50.6%) presented a lower proportion than that observed in the rural area (70.9%). As for people living in permanent private households, the survey estimated that 56.2% of the people were living in households enrolled in the Family Health Unit (IBGE, 2013):

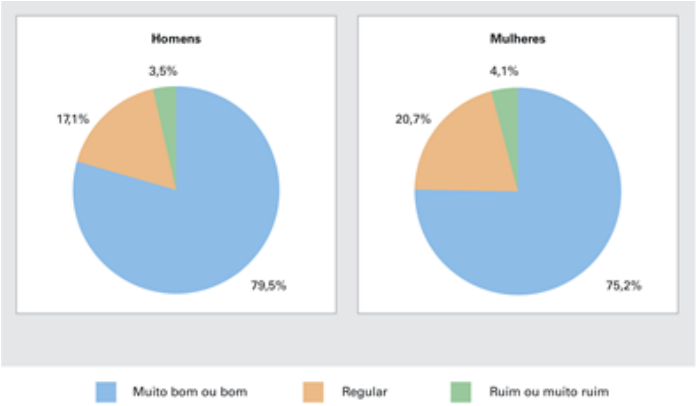
Figure 01 - Graph of Proportion of Households enrolled in family health unit



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

The National Household Sample Survey estimated, in 2008, about 190.0 million people living in Brazil. Of these, it was estimated that 77.3% self-rated their health status as "very good or good"; 18.9% as "regular" and 3.8% as "bad or very bad" (IBGE, 2008), according to the chart below:

Figure 02 - Graph of the distribution of the resident population, by sex, according to the self-health assessment 2008



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional por Amostra de Domicílios 2008.

It was found that, as age increased, the estimate of the percentage of people who assessed their health status as "very good or good" decreased. Residents of urban areas presented a percentage (78.2%) of self-evaluation as "very good or good" higher than that of residents of rural areas (72.5%) (IBGE, 2008).

It was also found that the higher the monthly per capita household income, the higher the percentage of people who evaluated their health status as "very good or good". For those whose income was higher than 5 minimum wages, 87.9% self-rated under these conditions, against 74.9% for those with income up to a minimum wage (IBGE, 2008).

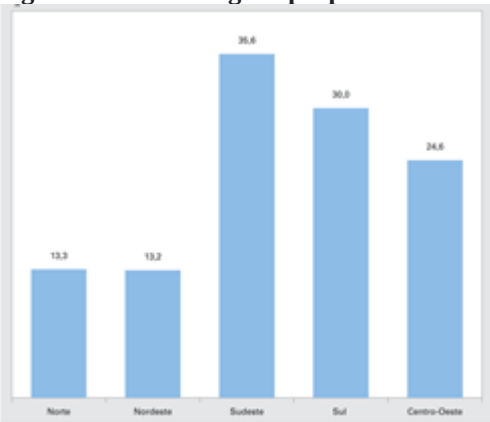
It is worth noting that, as the age group increased, so did the number of diseases declared by the people. Until the age of 14 to 19, the percentage of people who claimed to have three or more diseases was close to zero, for the 50-64 age group it grew to 17.1% and for those 65 years of age or older, reached 28.3%. For this last age group, considering only women, this percentage increased to 33.3%. Among people 65 years of age or older, 20.9% had no chronic disease (IBGE, 2008).

The relationship between monthly household income per capita and the existence of some chronic illness is positive; the higher the income, the greater the percentage of people who responded to have at least one disease. Among those with income of up to ¼ of the minimum wage, 20.8% had at least one disease, and among those with more than 5 minimum wages, the percentage reached 38.5% (IBGE, 2008). The chronic diseases identified by a physician or health professional most frequently reported were: hypertension (14.0%) and spine or back disease (13.5%).

The percentages for the other diseases were: arthritis or rheumatism (5.7%); bronchitis or asthma (5.0%); depression (4.1%); heart disease (4.0%) and diabetes (3.6%).

These percentages presented differences according to the analyzed age group. For example, when people 35 years of age or older were considered, 8.1% reported having diabetes. (IBGE, 2008) In 2008, 25.9% of the Brazilian population, or 49.2 million people, had at least one health plan. Of these, 77.5% were linked to plans of private companies and 22.5% to plans of assistance to the public servant. In addition, of the total number of persons covered by health insurance, 47.8% were holders of the sole or main health insurance plan they had. In urban areas (29.7%), the percentage of people covered by health insurance was higher than in rural areas (6.4%). The Southeast and South Regions registered percentages (35.6% and 30.0%, respectively), approximately three times higher than those for the North (13.3%) and Northeast (13.2%), according to data from the Brazilian Institute of Geography and Statistics (2008):

Figure 03 - Percentage of people with health insurance coverage in 2008

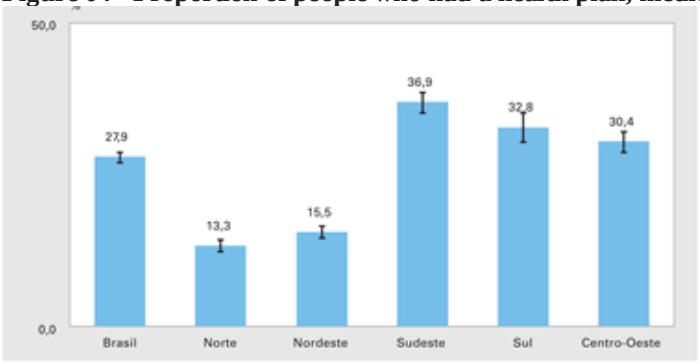


Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional por Amostra de Domicílios 2008.

In 2013, according to data from the Brazilian Institute of Geography and Statistics, published in PNS 2013, 27.9% of the population had some health plan (medical or dental). The Southeast, South and Central West Regions had the highest proportions (36.9%, 32.8% and 30.4%, respectively) and the North and Northeast Regions, the lowest (13.3% and 15.5% , respectively). The Southeast Region recorded a percentage almost three times higher than

that found in the Northern Region. In the urban area (31.7%), the percentage of people covered by health insurance was about five times higher than in the rural area (6.2%):

Figure 04 - Proportion of people who had a health plan, medical or dental, in 2013



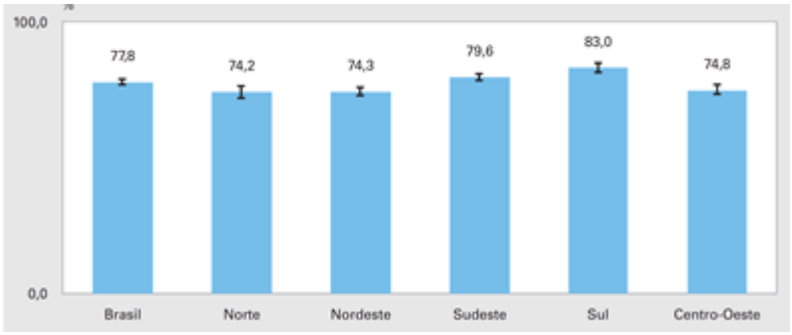
Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

The supplementary health survey of PNAD 2008 estimated that the total number of people who normally sought the same health service when it needed care was 139.9 million, corresponding to 73.6% of the population. By sex, 76.6% of women normally sought the same health service, among men, 70.5% did so (IBGE, 2008).

The post or health center was the most commonly declared site (56.8%), followed by private offices (19.2%) and the hospital outpatient clinic (12.2%). The other categories - pharmacy, clinic or company outpatient clinic, emergency room and community agent among others - accounted for 11.8% of the places sought. The health center was usually sought mainly by people belonging to the lower per capita household monthly income classes.

This number in 2013, according to the 2013 PNS, was 77.8% of people residing when they needed health care, they used to look for the same place, doctor or health service. The North Region (74.2%), the Northeast (74.3%) and the Center-West (74.8%) showed the lowest proportions of this indicator, while the South Region (83.0%):

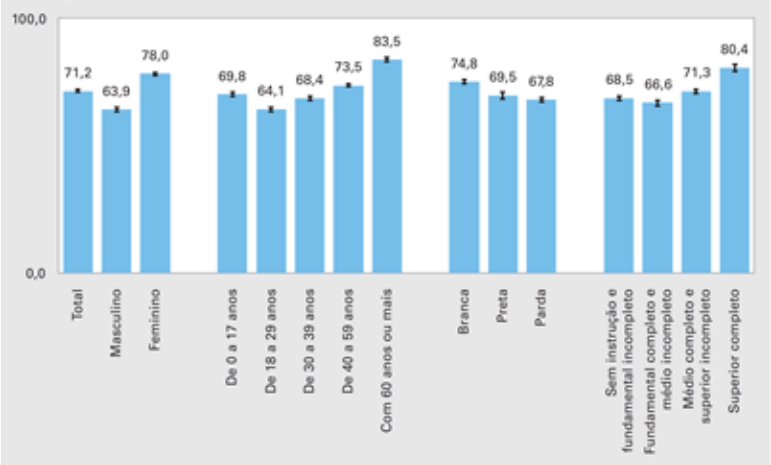
Figure 05 - Percentage of people who normally seek the same health service when they needed health care in 2013



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

In Brazil, among the 30.7 million people who sought health care in the last two weeks prior to the date of the interview, 97.0% reported having received care, and 95.3% were seen the first time they sought care. In the Great Regions, the percentage of services in the first time of demand fluctuated around the national average and ranged from 93.6% in the North to 96.3% in the Southeast and South Regions.

Figure 06 - Proportion of people who consulted doctor in the last 12 months in 2013



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

The 2013 PNS pointed out that 71.2% (142.8 million) of the residents of Brazil consulted in the last 12 months prior to the reference date of the survey. The North, Northeast and Central-West regions had lower percentages: 61.4%, 66.3% and 69.5%, respectively. The Southeast and South Regions presented estimates higher than the national average: 75.8% and 73.8%, respectively.

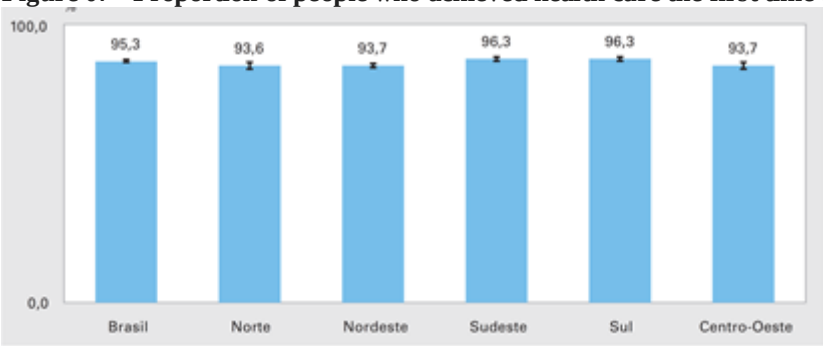
The 2013 PNS estimated that 7.0% of the population living in permanent private households (14.1 million people) stopped performing usual activities due to health reasons in the last two weeks prior to the survey. The South and Northeast Regions recorded the highest proportions (8.4% and 7.8%, respectively), and the North and Southeast Regions, the lowest (5.8% and 6.2%, respectively).

The proportion of people who stopped doing usual health activities was higher among women (8.0%) than among men (5.9%). Uneducated or incomplete people had the highest proportion of this indicator by level of education (8.3%). In relation to age, it was observed that the higher, the greater the proportion of the indicator, reaching 11.5% among people aged 60 years or older (IBGE, 2013).

The research also investigated the health reasons that prevented people from performing their usual activities: 17.8% cited a cold or flu and 10.5% reported back pain, neck or neck problems. The percentage of colds or flu was higher for people aged 0-17 years (39.8%) and decreased with increasing age (6.9% of those aged 60 years or over). Back pain, neck or neck problems were proportionally higher among people 40-59 years of age (16.5%). Reasons, such as: pain in the arms or hands; headache or migraine; asthma, bronchitis or pneumonia; diarrhea, vomiting, nausea or gastritis; and high blood pressure or heart disease reached percentages ranging from 4.1% to 5.5% of the total population (IBGE, 2013).

In Brazil, among the 30.7 million people who sought health care in the last two weeks prior to the date of the interview, 97.0% reported having received care, and 95.3% were seen the first time they sought care. In the Great Regions, the percentage of service in the first time of demand fluctuated around the national average and ranged from 93.6% in the North to 96.3% in the Southeast and South Regions:

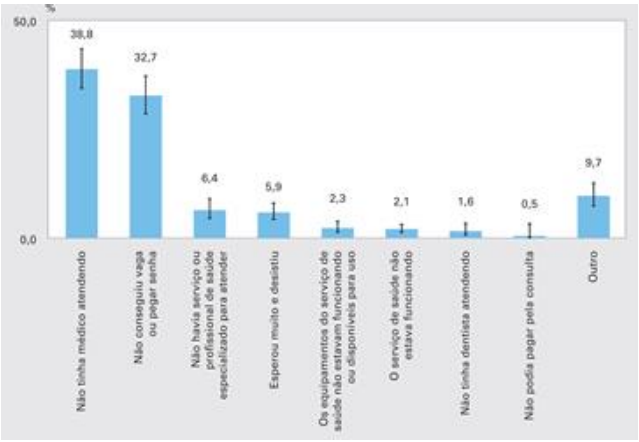
Figure 07 - Proportion of people who achieved health care the first time they sought in 2013



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

Here's a chart of why people could not get care the first time they got it:

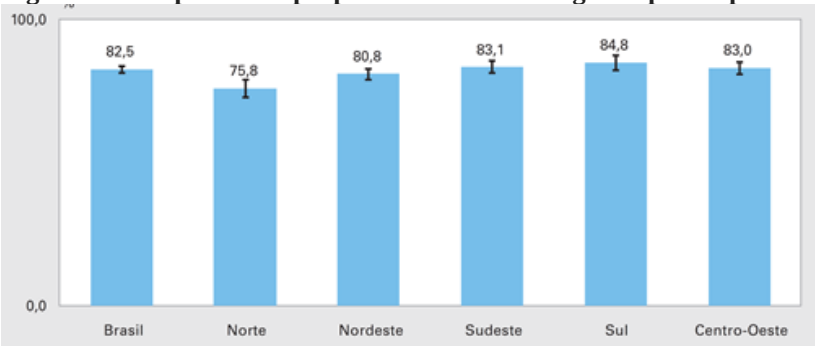
Figure 08 - Percentage of people who did not get care the first time they searched because they did not receive care



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

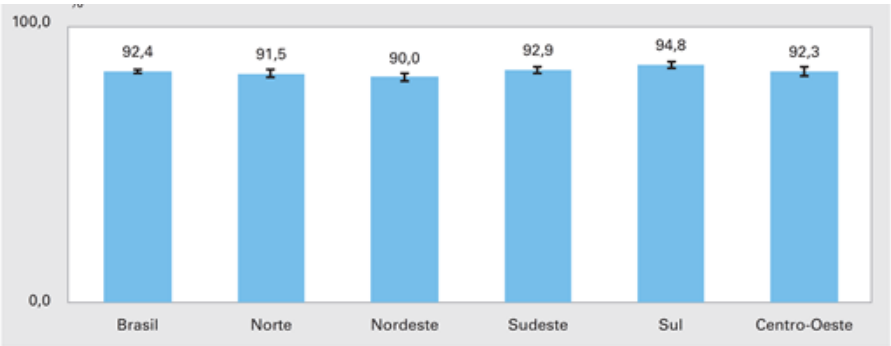
Of the people who had some prescription medicine in the last health care, 92.4% were able to obtain at least one of them. That estimate was about 10.0 percentage points higher than the proportion of people who were able to get all prescription drugs. The highest proportion was observed in the Southern Region (94.8%), and the lowest in the Northeast Region (90.0%):

Figure 09 - Proportion of people who were able to get all prescription drug



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

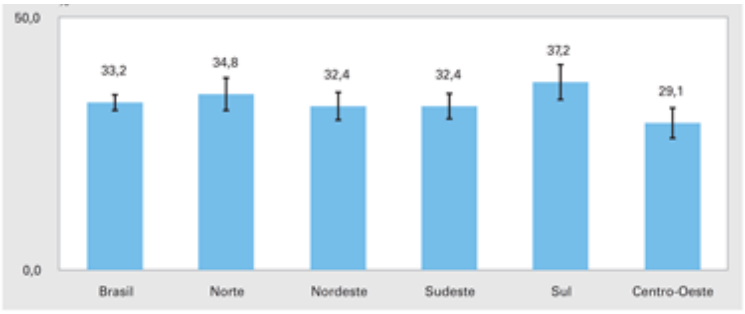
Figure 10 - Percentage of people who were able to obtain at least one of the prescribed medications



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

The proportion of people who managed to obtain at least one of the drugs prescribed in the public health service was 33.2% (6.4 million people), and there were no significant differences in the estimates by Major Regions of the Country:

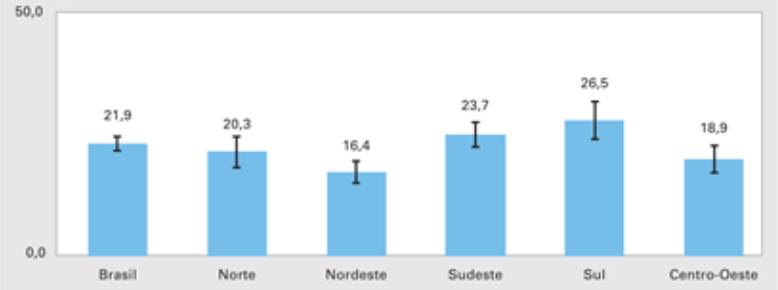
Figure 11 - Proportion of people who were able to obtain at least one of the prescribed medications in the public health servisse



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

Of the estimated 19.3 million people who had prescribed medicine in the last health care, 21.9% (4.2 million) answered that they were able to obtain at least one of them in the Popular Pharmacy Program. The Northeast Region presented the lowest proportion (16.4%):

Figure 12 - Percentage of people who were able to obtain in the Popular Pharmacy Program at least one of the prescription drugs



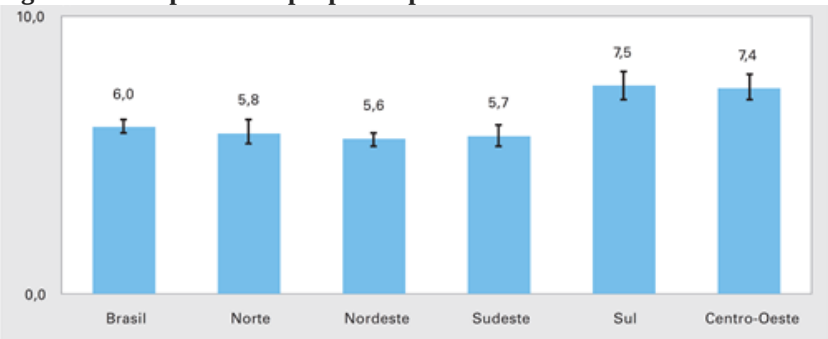
Fonte: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

According to PNS 2013, of the 200.6 million people living in Brazil, 6.0% (12.1 million) were hospitalized for 24 hours or more in the last 12 months prior to the date of the interview. The South and Center-West Regions presented proportions higher than the national average: 7.5% and 7.4%, respectively (IBGE, 2013).

Hospital admissions for 24 hours or more were higher than the national average for women (7.1%) and people aged 60 years or older (10.2%). There were no significant differences in the estimates of the proportions of this indicator, according to color or race and level of education. Clinical treatment and surgery were the two most frequent types of care in cases of hospitalization. In public health facilities, the proportions were 42.4% and 24.2%, respectively. In private health care facilities, the percentages were 29.8% and 41.7%, respectively. (IBGE, 2013)

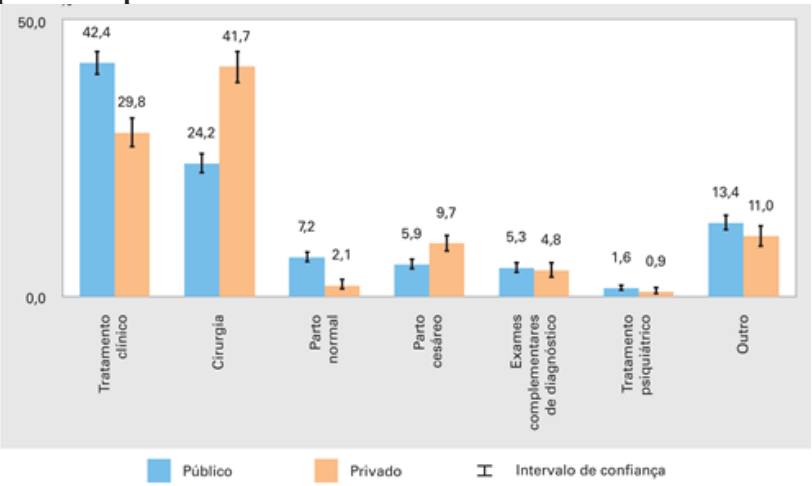
In public health facilities, normal births had a higher participation of hospitalizations (7.2%) than cesarean birth (5.9%). In private health care facilities, the opposite occurred: cesarean delivery (9.7%) exceeded the proportion of normal delivery (2.1%) (IBGE, 2013).

Figure 13 - Proportion of people hospitalized for 24 hours or more



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

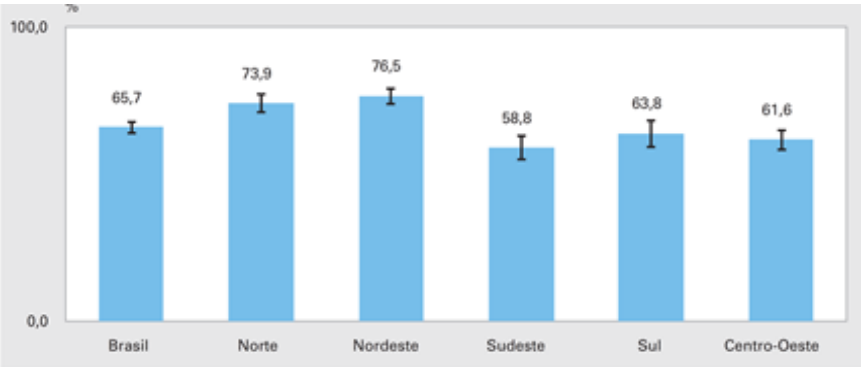
Figure 14 - Percentage distribution of people hospitalized in hospitals for 24 hours or more in public and private establishments



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

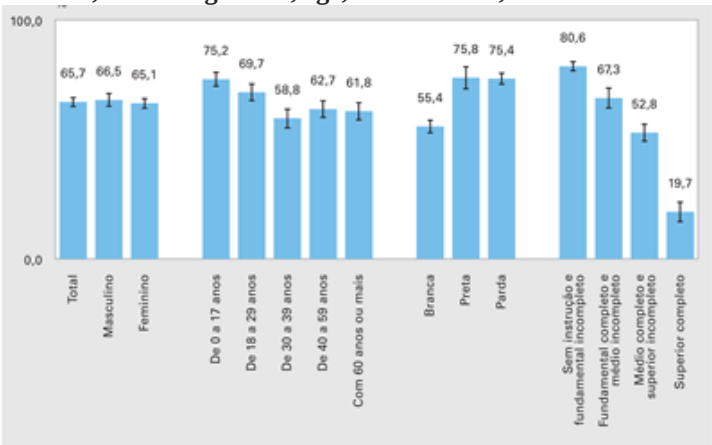
Of those hospitalized for 24 hours or more, 65.7% (8.0 million) had this care through the Unified Health System - SUS. The Northeastern and Northern Regions registered the highest proportions: 76.5% and 73.9%, respectively (IBGE, 2013):

Figure 15 - Proportion of people whose last hospitalization for 24 hours or more was through SUS – 2013



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

Figure 16 - Proportion of people whose last hospitalization for 24 hours or more was through the SUS, according to sex, age, color or race, and level of education



Source: IBGE, Diretoria de Pesquisas, Coordenação de Trabalho e Rendimento, Pesquisa Nacional de Saúde 2013.

The hospitalization rates in SUS hospitals were higher than the national average among people aged 0-17 years (75.2%) and people who declared themselves as black (75.8%) and brown (75.4% %), and did not present differences by sex. This proportion was also higher when the level of education was lower, ranging from 80.6% (uninstructed or with incomplete fundamental) to 19.7% (full superior) (IBGE, 2013).

The National Council of Justice published in October 2016 the 12th edition of the Justice in Numbers Report. This is the most important and complete diagnosis of the Brazilian Judiciary, since it includes statistics from all 90 Courts, as well as indicators on litigation, structure, investment, among other information.

Regarding the judicialization of health, considering the lawsuits filed up to 2015 and adding all the existing demands in the first degree, in the 2nd degree, in the Special Courts, in the Superior Court of Justice, in the Classes and in the Regional Classes of Uniformization, the following diagnosis:

Figure 17 - Judicialisation in Numbers in Brazil

SUBJECT MATTER	AMOUNT
Health services	61.655
Supply of medicines	200.090
Medical-hospital treatment hospital	60.696
Hospital medical treatment and / or supply of medicines	151.856
Agreement with SUS	737

Health plans (consumer law)	293.449
Health plans (labor benefits)	36.611
Organ / tissue donation and transplantation	491
Mental health	3.001
Social control and health advice	1.468
Hospitals and other health facilities	5.642
Medical error	38.810
ALL	**854.506**

Source: Conselho Nacional de Justiça. Justiça em números 2016[2].

In this sense, one can notice that the judicalization of health in Brazil presents frightening numbers, being one of the main reflections of the crisis, in several aspects, in which the country finds itself.

4 PREVENTION AND SOLUTION OF CONFLICTS IN PUBLIC HEALTH: SOME POSSIBILITIES

In the current Brazilian system, in which we have a financial and institutional crisis not seen in the last decades, where the Judiciary is insufficient, if not to say in bankruptcy, because it can no longer supply the demands that are proposed, one must try to find alternatives for the solution of social demands, especially in the social rights sphere. In this sense, the alternatives to be proposed should try to mitigate the judicialization of health.

If the increase of the judicialization is a concrete perspective, it is necessary that the alternatives can reduce the incidence of the phenomenon and at the same time awaken the Brazilian society to the search for solutions faster than the judicial one (CARLINI, 2014).

According to Carlini (2014), the solution of conflicts by non-judicial mechanisms is a sign of maturity of an organized society, which gives the dialogue and the weighing of arguments a greater weight than the solution dictated by a magistrate who will not always have objective conditions to take into account the impact of their decision on the social set.

[2] Disponível em http://www.cnj.jus.br/programas-e-acoes/pj-justica-em-numeros. Acesso em 23 de outubro de 2016.

Dialogue and debate on public issues are still precarious in the country, given the structure of the political organization that offers few spaces for the manifestation of active citizenship. There are numerous predictions in the Federal Constitution for the direct participation of the population, such as the Municipal Health Councils, however, the inheritance that the Authoritarian State model has left us is still very present, where the citizen is more motivated to seek the judiciary than to obtain the effectiveness of their rights through collective mechanisms of social participation.

Still, in Carlini's words (2014), Brazilian society has as its distinguishing feature individualism, resulting from the centrality of consumption, in the conception of family structure and as a consequence of the typical way of life of large urban centers that weakened community ties as much in which he subtracted free time from people's daily agenda.

In the imaginary of people, the solution of problems involved in public health issues is the exclusive role of governments, since citizens already pay taxes. People do not think that decisions can be taken together as the fruit of dialogue, debate and agreement. In this context, the search for collective solutions is evaluated as inefficient.

Carlini (2014) points out some suggestions to minimize judicalization: (i) Creation of Technical Chambers, which are multiprofessional groups that analyze judicial cases and provide technical reports to assist magistrates to provide technical arguments to be adopted in the solution of concrete cases ; (ii) Creation of Judicial Centers for Conflicts of Interest, with the objective of promoting litigation and social pacification actions through mediation and arbitration, including in the field of public health; (iii) Interposition of collective actions by the Office of the Public Defender and Public Prosecutor for the realization of the right to health, seeking to promote the realization of the right to medicines and medical treatment to all those who find themselves in a particular situation.

It is important to highlight the last suggestion mentioned, which concerns the proposition of collective actions, which correspond to social and economic relations between individuals belonging to the same group and having common interests. Such interests require joint action, that is, they need to be done collectively. In a collective action, the alignment of interests stems from the recognition that individuals have common needs, which will only be met through collective action (WOLFART, SILVA, SCHMIDT, 2014).

According to Ostrom (2007), the theory of collective action seeks to explain why individuals cooperate rather than seize the contributions of others. In his book The Logic of Collective Action, 1971, he analyzes what motivates individuals to act together instead of meeting their needs individually. Collective actions can be understood by various forms of

associativism, such as representation, purchase and sale, savings and credit entities, sales prospecting in foreign markets, quality control, among others. Generally, small companies have problems obtaining these aspects, which can be overcome through collective actions (SACHS, 2003). In this way, a collective action is a result of the union between agents who have common interests, believing that, individually, it is impossible or more difficult to obtain a certain objective than in a group. For Olson, collective action consists of joint pursuit of individual benefits. Thus, "the idea that groups always act to advance their interests is supposedly based on the premise that members of a group actually act out of personal, individual interest" (OLSON, 1999, p. 13).

Through collective actions, a general, global and impersonal effect is sought, often preventive, which seeks to prevent the occurrence of one or more grievances and not the reversal of its consequences. This does not prevent that certain actions understood as collective have particular effects, beneficial or not, on individuals.

The so-called collective actions in public health are a generic designation for measures taken aiming at not the particular instance of a given individual but a group of people. Durkheim's (1972) conceptualization of the social: the collective in public health is more than the sum total of individuals, without any professions of philosophical faith.

The participation of each individual in the total gain of the group depends on two factors: the size of the group and the individual benefit that the good provides in relation to the total group participants. These factors will determine whether the group will provide the collective good and its total gain (NASSAR, 2001).

Recognizing the existence of transindividual interests shared by several holders, the legal system began to admit the substitution of individual access to justice by a single collective process for the benefit of a whole group. The substitution of numerous individual actions pulverized by a single collective action represents undeniable procedural economy, in addition to avoiding contradictory decisions, which even contribute to the discredit of the administration of justice.

Collective action, as we know it in Brazil, was born in the class action of the American system, finding its antecedents in the Bill of Peace of Century XVII, that had as presupposition the existence of a large number of right holders who receive a single and simultaneous procedural treatment through a single exponent of the class (SÁ, 2013).

The Brazilian legislator, inspired by the American class action, created the public civil action, the popular action and the collective security order.

The public civil action is a civil liability action used to defend any transindividual interests, whether diffuse, collective or individual homogeneous, according to the provisions of art. 129, III of the Federal Constitution (BRAZIL, 1988). Although it has an essentially condemnatory nature, public civil actions have been admitted with a merely declaratory, constitutive or mandamental request, having as object of the condemnation an obligation to give, to do or not to do.

The legitimized assets are listed in art. 5 of Law 7,347 / 1985 - Law of Public Civil Action, being them, the Public Prosecutor; the Public Defender's Office; the Union, the States, the Federal District and the Municipalities; the municipality, public company, foundation or mixed-capital company; the association which, at the same time, has been established for at least one year under the civil law and includes, among its institutional purposes, the protection of public and social heritage, the environment, the consumer, the economic order, free competition , the rights of racial, ethnic or religious groups or the artistic, aesthetic, historical, tourist and landscape heritage; being obligatory the intervention of the Public Prosecutor in the case, if this is not the author.

In the case of public health, for the purpose of effecting this important right, it would be an interesting measure to file a Public Civil Action and other collective actions.

In 2011, in an attempt to incorporate mechanisms to minimize unrestrained health judicialization, Law 12,401, which amended Law 8,080 / 1990, was approved to provide therapeutic assistance and the incorporation of new technologies in the scope of the Unified Health System, adopting the definition of clinical protocol and therapeutic guidelines, determining the need for scientific evidence on the efficacy, accuracy, effectiveness and safety of the drugs, products or procedures that will be analyzed by the report of the National Commission for the Incorporation of Technologies in the SUS, that is, the incorporation of new technologies and medicines is conditioned by the existence of evidence and scientific research that proves that there will be efficacy and safety for patients, being extremely useful to the public health system.

5 CONCLUSIONS

From the research undertaken, it was verified that the right to health is directly related to the right to life, and inseparable from the Principle of Dignity of the Human Person. It has a constitutional provision, in the social right, with a privileged status, being the right of all, and must be effected through public policies issued by the State, encompassing in this term all entities of the Federation.

The right to health had great evolution over the years and with the need faced by the great pandemics that affected the population, which interfered in the social and economic order of the country, gaining space with public policies consolidated by the Federal Constitution of 1988 , the State was assured by the State that, in the face of the exhaustive demand and increase of health techniques, the State is not financially able to provide them, forcing the plaintiffs to bring the legal proceedings to ensure that this benefit is fulfilled, human dignity and life, the State seeks not to satisfy them.

The effectiveness of the right to health is far from being achieved in the face of the great demand for recovery and prevention assistance, the demand for the judiciary increases to compel the State to provide rights and guarantees already guaranteed, but not fulfilled by it, since we are experiencing a crisis context economic, social, political and institutional.

In this sense, another solution aimed at solving the existing problem in the realization of the Right to Health would be collective actions, such as Public Civil Action, which, unfortunately, depends greatly on the cultural maturation of the Brazilian population.

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