



Revista Eurolatinoamericana de Derecho Administrativo
ISSN: 2362-583X
editorial@unl.edu.ar
Universidad Nacional del Litoral
Argentina

RANADE, ARATI; MENDONÇA BERTOTTI, BÁRBARA
Implementation of the right to health in Brazil and India: a comparative study
Revista Eurolatinoamericana de Derecho Administrativo, vol. 8, núm. 2, 2021, Julio-Diciembre
Universidad Nacional del Litoral
Santa Fe, Argentina

DOI: <https://doi.org/10.14409/redoeda.v8i2.10652>

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REVISTA EUROLATINOAMERICANA DE DERECHO ADMINISTRATIVO

VOL. 8 | N. 2 | JULIO/DICIEMBRE 2021 | ISSN 2362-583X
SANTA FE | ARGENTINA | PERIODICIDAD SEMESTRAL

Revista oficial de la Red Docente Eurolatinoamericana de Derecho Administrativo
formada por las siguientes instituciones:



RED DOCENTE
EUROLATINOAMERICANA
DE DERECHO ADMINISTRATIVO



Implementation of the right to health in Brazil and India: a comparative study*

Concretização do direito à saúde no Brasil e na Índia: um estudo comparado

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Recibido el/Received: 11.09.2021 / September 11th, 2021

Aprobado el/Approved: 30.11.2021 / November 30th, 2021

RESUMEN:

Este artículo tiene como objetivo comparar los regímenes jurídico-constitucionales de Brasil e India con respecto a la realización del derecho a la salud. Por ello, en primer lugar, se presentará información general sobre los dos sistemas, en particular sobre aspectos de la fundamentalidad de este derecho, la garantía constitucional, la titularidad del deber de garantizarlo, la participación de los sistemas de salud público y privado (si los hubiere). Posteriormente, se contrastarán los objetos de estudio elegidos para identificar las proximidades. Se utilizará el

ABSTRACT:

The purpose of this article is to compare the legal-constitutional regimes of Brazil and India regarding the realization of the right to health. To this end, first, general information about the two systems will be presented, notably on the aspects of the fundamental nature of this right, the constitutional guarantee, the ownership of the duty to ensure it, the participation of the private sector and public health systems (if any). Then, the chosen objects of study will be contrasted in order to identify their proximities. The comparative method will be used, based on the thought disseminated by

Como citar este artículo | *How to cite this article:* RANADE, Arati; BERTOTTI, Bárbara Mendonça. Implementation of the right to health in Brazil and India: a comparative study. **Revista Eurolatinoamericana de Derecho Administrativo**, Santa Fe, vol. 8, n. 2, p. 27-46, jul./dic. 2021. DOI 10.14409/redoeda.v8i2.10652.

*This study was financed in part by the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior - Brasil (CAPES) - Finance Code 001.

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método comparativo, desde el pensamiento difundido por Pierre Legrand. Se concluye que en Brasil el derecho a la salud tiene mayor protección y densidad normativa, principalmente por ser un derecho fundamental garantizado constitucionalmente y por tener el Sistema Único de Salud como estructura pública de implementación. En India, sin embargo, por no estar constitucionalmente garantizado y por no contar con un sistema público estructurado a nivel nacional, el derecho a la salud se encuentra en un nivel inferior, y aún queda mucho por desarrollar.

Pierre Legrand. The conclusion is that the right to health has more excellent protection and normative density in Brazil, mainly because it is a constitutionally guaranteed fundamental right and because it has the Unified Health System as its public structure. In India, however, for not being constitutionally assured and not having a nationally structured public system, the right to health is at a lower level, and there is still much to be developed.

Palabras clave: derecho a la salud; Brasil; India; método comparativo; derecho constitucional.

Keywords: right to health; Brazil; India; comparative method; constitutional law.

CONTENTS:

1. Introduction; **2.** The Legal-constitutional regime of the right to health in India; **3.** India's public healthcare system; **4.** The Legal-constitutional regime of the right to health in Brazil; **5.** Brazilian public health system; **6.** A comparison between general aspects of the right to health in Brazil and India; **7.** Conclusions. References.

1. INTRODUCTION

Martin Luther King Jr. once stated: 'Of all the forms of inequality, inequality in healthcare is the most shocking and inhuman.'¹ The Covid-19 pandemic has reinforced the relevance of health issues around the world. But not only that. It also came as a litmus test to test and reveal the real situation of the health systems in each country.

In Brazil, the Unified Health System (called "SUS"), the public structure that materializes the right to health, guarantees universality, integrality, and gratuity to all the people who need it. About 75% of the Brazilian population depends entirely on SUS. In the face of the pandemic scenario, it has become a protagonist and has shown itself to be indispensable in the fight against the new Coronavirus. In reality, the way this system was thought and organized already announced its protagonism since always. And so it should be, were it not for the false ideas introduced by neoliberal thinking, where the inefficient State is opposed to the efficient private one. The dissemination of this thought brings to the population the idea that the SUS "does not work". In reality, SUS faces many problems, mainly related to its underfunding, management,² and substantial inequalities (both in relation to the territorial distribution of health services,

¹ Statement attributed to Martin Luther King Jr.

² BECHARA, Fábio Ramazzini; COSTA, Fernanda Soraia Pacheco. Eficiência na prestação de serviços de saúde: experiência brasileira do modelo gerencial e comparativo com os países da common law. **A&C – Revista de Direito Administrativo & Constitucional**, Belo Horizonte, ano 19, n. 75, p. 65-82, jan./mar. 2019.



facilities, and professionals and in relation to population distribution/dependence on services between SUS and private health care).

However, its structure, founded on the guidelines of decentralization, comprehensive care, encompassing from preventive to recuperative actions, and community participation, and on numerous principles (such as universality and equality), is highly complex and advanced, and the SUS is recognized as one of the largest public health systems in the world.

In India, the right to health is not recognized as a legal right in a statute. It is enforced through some Government implemented schemes which include free health centers in rural and urban areas, subsidized insurance coverage, the network of organizations spanning different states coming together known as Jan Swasthya Yojana (JSY)³. The two waves of the pandemic highlighted the healthcare system's inadequacies and demonstrated that there is still so much to be realized to bridge the inequality of healthcare services.

Based on this, the objective of this article is to compare general aspects of the normative realization of the right to health and public health systems in Brazil and India. To do so, first the legal-constitutional regimes of the right to health of the two countries and the operation of the two health systems will be presented. Finally, points of closeness and distance will be identified in order to make a comparison. The methodology used in the research is logical-deductive, through comparative procedures⁴ and bibliographic and documental research techniques. The functionalist approach is used.⁵

Still, it is essential to emphasize that for the proper use of the comparative method, we went through the steps proposed by Thiago Marrara, which are: (i) the choice of the objects of comparison (the legal-constitutional systems of Brazil and India); (ii) the presentation of the characteristics and legal functions of each object in the respective legal systems (items 2, 3, 4 and 5); (iii) the contextualization of each object from a macro-legal perspective and, when possible, from an extra-legal perspective (items 2, 3, 4 and 5); (iv) the comparison in the strict sense, when the chosen objects are contrasted, in item 6; (v) the examination of the differences and common points found throughout the comparison (item 6); and (vi) the elaboration of criticism of the objects studied and proposals for improving the systems based on the comparative conclusions, which is done in the conclusions.⁶

³ JAN SWASTHYA ABHIYAN. **People's Health Movement-India**. Available at: <<https://phmindia.org/about-us/>>. Access on: 31 jul. 2021.

⁴ We will use the ideas found in: LEGRAND, Pierre. **Como ler o Direito estrangeiro**. São Paulo: Contracorrente, 2018.

⁵ Through translation that does not seek full textual equivalence between words and expressions. LEAL, Fernando; JORDÃO, Eduardo. Quando a tradução também importa: problemas linguísticos de direito comparado. **Direitos Fundamentais & Justiça**, v. 8, n. 29, p. 86-104, out./dez. 2014. p. 102.

⁶ MARRARA, Thiago. Método comparativo e direito administrativo: breves reflexões por ocasião da criação da Associação Brasileira de Direito Público Comparado. In: BACELLAR FILHO, Romeu Felipe; HACHEM, Daniel



2. THE LEGAL-CONSTITUTIONAL REGIME OF THE RIGHT TO HEALTH IN INDIA

The Constitution of India, 1950 does not expressly codify a fundamental right to health. Various facets of the right⁷ have evolved through judicial decisions, expanding the scope of the pre-existing Fundamental Rights and Directive Principles of State Policy.

Articles 12 to 35 under Part 3 of the Constitution of India lay down enforceable fundamental rights, which broadly include the right to equality,⁸ life and personal liberty⁹ and rights against discrimination.¹⁰ Article 21, which upholds the right to life and personal liberty¹¹ is significant in the context of the right to health, as courts have upheld the right to health through the lens of the right to life under this provision.

Part 4 of the Constitution provides for the Directive Principles of State Policy (Directive Principles) which are non-enforceable welfarist obligations upon the State. The Directive Principles which indirectly recognize the right to health among other things include (i) formulation of policies to secure the health and strength of the working class and children¹², (2) providing just and humane conditions for work and maternity relief¹³ and (3) raising the level of nutrition and living standard and improving public health.¹⁴

Apart from the provisions mentioned above, the Constitution provides three lists comprising subjects of legislation falling under the domain of Centre and State, respectively.¹⁵ The subject “public health and sanitation; hospitals and dispensaries” is part of subjects to be legislated by the State government and therefore, the responsibility of legislating on health falls on the shoulders of the State governments.¹⁶ Thus the Constitution also envisages decentralization of health care to be implemented at the local level.

Wunder. (Org.). **Direito público no Mercosul: intervenção estatal, direitos fundamentais e sustentabilidade.** v. 1. Belo Horizonte: Fórum, 2013. p. 155-157.

⁷ For example, right to a pollution-free environment in *M.C Mehta v. Union of India* AIR; right against employing labor and providing in-human conditions in *Bandhua Mukti Morcha v. Union of India* AIR 1974 SC 102.

⁸ Constitution of India, Article 14. INDIA. **The Constitution of India.** Available at: <<https://legislative.gov.in/sites/default/files/COI.pdf>>. Access on: 31 jul. 2021.

⁹ Constitution of India, Article 21.

¹⁰ Constitution of India, Article 15.

¹¹ Constitution of India, n(7).

¹² Constitution of India, Article 39(e).

¹³ Constitution of India, Article 42.

¹⁴ Constitution of India, Article 47.

¹⁵ Constitution of India, Schedule VII.

¹⁶ Constitution of India, Schedule VII, Entry.



Violation of a right under Part 3 can be redressed by petitioning Constitutional Courts.¹⁷ for public law remedies.¹⁸ However, violation of a Directive Principle under Part 4 is not independently enforceable in a court of law, i.e. its breach cannot ground a legal claim. Over time, courts have recognized the importance of realizing Directive Principles and have held that Fundamental Rights are to be interpreted with the aid of Directive Principles.¹⁹ Owing to this interpretative technique, along with the express recognition of the broad ambit of Article 21 in *Shantisar builders v. Narayanan Khimalal Totame*²⁰ contributed by the activist approach of the Supreme Court beginning in the mid-1980s, the higher Judiciary upheld the citizen's fundamental right to health in different forms for example right to a clean environment,²¹ emergency healthcare services²² etc.

In 1987, the Supreme Court in *Vincent v. Union of India*²³ recognized the obligation of the State under Article 47 and held that "*maintenance and improvement of public health have to rank high as these are indispensable to the very physical existence of the community and on the betterment of these depends, the building of the society of which the Constitution makers envisaged. Attending to public health, in our opinion, therefore is of high priority perhaps the one at the top.*"

In 1989 in *Paramanand Katara v. Union of India*²⁴ held that failure on the part of a government hospital to provide timely medical treatment leads to violation of Article 21. The Court further directed the State to pay compensation to the victim. In conclusion,

¹⁷ The Constitutional Courts in India are the High Courts and the Supreme Court. India does have a separate system of courts for constitutional law cases.

¹⁸ Article 32: Remedies for enforcement of rights conferred by this Part.

(1) The right to move the Supreme Court by appropriate proceedings for the enforcement of the rights conferred by this Part is guaranteed

(2) The Supreme Court shall have the power to issue directions or orders or writs, including writs like habeas corpus, mandamus, prohibition, quo warranto, and certiorari, whichever may be appropriate, for the enforcement of any of the rights conferred by this Part

(3) Without prejudice to the powers conferred on the Supreme Court by clause (1) and (2), Parliament may by law empower any other court to exercise within the local limits of its jurisdiction all or any of the powers exercisable by the Supreme Court under clause (2)

(4) The right guaranteed by this article shall not be suspended except as otherwise provided for by this Constitution.

¹⁹ In *Re: Kerela Education Bill* (AIR 1959 SCR 1 995) the Supreme Court of India held, "*The directive principles of State policy have to conform to and run as subsidiary to the Chapter on Fundamental Rights ... nevertheless, in determining the scope and ambit of the fundamental rights relied on by or on behalf of any person or body the court may not entirely ignore these directive principles of State policy laid down in Part IV of the Constitution but should adopt the principle of harmonious construction and should attempt to give effect to both as much as possible.*"

²⁰ In *Shantisar Builders* AIR 1990 SC 660, the Supreme Court has observed: "*the right to life under Article 21 would include the right of food, clothing, decent environment and reasonable accommodation to live in suitable accommodation which allows him to grow in all aspects-physical, mental and intellectual.*"

²¹ *M.C. Mehta v. Union of India* AIR 1987 SCR 819.

²² *Paramanand Katara v. Union of India* AIR 1997 SC 990.

²³ *Vincent v. Union of India* AIR 1997 SC 990.

²⁴ *Paramanand Katara v. Union of India* AIR 1997 SC 990.



the Court also held that it is obligatory for a doctor or hospital, both public and private, to provide immediate emergency medical aid to a victim of a road accident. Courts have also recognized international law obligations while upholding the right to health.²⁵ In the 2015 judgment in *Mohd. Ahmed v. State of Delhi*,²⁶ the Delhi High Court upheld the State's minimum core obligations to provide healthcare under the International Covenant of Economic, Social and Cultural Rights, 1966.²⁷ Recently, in 2021 during the devastating second wave during the COVID pandemic in India, the Supreme Court took *suo motu* cognizance of the oxygen shortage being experienced in the state of Delhi and issued a slew of directions to the state to ensure that oxygen tankers reach the requisite hospitals within a stipulated time.

However, without a law defining the right to healthcare, it has been argued that the right has been reduced to expressivist elaboration judged on a case-to-case basis without an effective enforcement mechanism.²⁸

3. INDIA'S PUBLIC HEALTHCARE SYSTEM

India has a mixed healthcare system, which includes public and private participation to provide affordable health care services focusing on the poor. In 2005, the Government of India launched the National Rural Health Mission (NRHM)²⁹ to provide accessible, affordable, and quality health care to the rural population, especially the vulnerable groups. The NHRM was subsequently subsumed within the National Health Mission (NHM)³⁰ which also encompasses the National Urban Health Mission (NUHM), which focuses on policies towards the urban poor. The public health care system under the NHRM in rural areas has been designed as a three-tiered system. Each tier is required to provide certain 'Essential Services' which are outlined in the Guidelines prescribed by the Ministry of Health and Family Welfare in 2012.³¹ States may also further provide services captioned as 'Desirable Services' depending upon their financial capability. The first tier under the NHRM comprises Primary Health Centres (PHCs) instituted as a first port of call to a qualified doctor of the public sector in rural areas.

²⁵ In *CERC Ltd. v. Subash Chandra Bose* (AIR 1992 SC 573,585) the Supreme Court relied on international instruments and concluded that the right to health is a fundamental right. It went further and observed that health is not merely the absence of sickness:

²⁶ *Mohd. Ahmed (Minor) v. Union of India and Ors.* (2014) 6 SCC Del 118 paragraph 67.

²⁷ CESCR General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant) Available at: <<https://www.refworld.org/pdfid/4538838e10.pdf>>. Access on: 30 July 2021.

²⁸ KHOSLA, Madhav. Making social rights conditional: Lessons from India. **International Journal of Constitutional Law**, v. 8, Issue 4, p. 739–765, October 2010.

²⁹ INDIA. Ministry of Health & Family Welfare Government of India. **National Health Mission**. Available at: <<https://nhm.gov.in>>. Accessed on: 30 July 2021.

³⁰ n(27).

³¹ n(27) These guidelines are applicable as on February 2021.



PHC is an essential wellbeing unit to provide rustic people coordinated, corrective, and preventive medical services. The services offered by the PHC include Out Patient Department Services (OPD), Emergency Services, maternity care which includes antenatal and post-natal care. Subordinate to PHCs are Sub-Centres from which severe cases are referred to the PHC.

At the secondary level, there are Community Health Centres (CHCs) and smaller sub-district hospitals. Cases from the PHCs are referred to the CHCs. The Community Health Centres (CHCs) comprise the secondary degree of medical services and provide expert medical care to the provincial populace. CHC also provides a 30-bed emergency clinic giving expert consideration in Medicine, Obstetrics and Gynecology, Surgery, Pediatrics, Dental, and AYUSH (give a complete form of AYUSH) he CHCs were intended to give reference medical care to cases from the Primary Health Centers level. 4 PHCs are incorporated under each CHC. The tertiary level of health care is provided by Medical Colleges/District Hospitals. District Hospital is a hospital at the secondary referral level is responsible for a district of a defined geographical area containing a defined population. Its objective is to provide comprehensive secondary health care services to the people in the district at an acceptable level of quality and to be responsive and sensitive to the needs of people and referring centers. Every district is expected to have a district hospital. The Indian Public Health Standards monitor the entire three-tiered system (IPHS), periodically revised.

The National Urban Health Mission (NUHM) envisages meeting the urban population's needs, focusing on the urban poor by making essential primary health care services available and reducing their out-of-pocket expenses for treatment. This can be achieved by strengthening the existing health care service delivery system, targeting the people living in slums, and converging with various schemes relating to broader determinants of health like drinking water, sanitation, school education, etc. implemented by the Ministries of Urban Development, Housing & Urban Poverty Alleviation, Human Resource Development and Women & Child Development.

The Government also ties up with private players to provide affordable health care services. Under the Rashtriya Swasthya Bhima Yojana (RSBY) the Government sponsored insurance scheme.³² for the population falling under the Below Poverty Line (BPL). State Governments select insurance companies through an open tendering process, and the technically qualified lowest bid is selected.

However, the reality of the public health system in India paints a different picture from its theory. Amartya Sen and Jean Dréze highlight³³ the various challenges in the ef-

³² The insurance coverage is INR 30000 for a family of five. The Government pays the premium for RSBY. Central Government pays 75% of the total premium (90% in the case of Jammu & Kashmir and the North East States) while State Government pays the remaining premium. INDIA. **RSBY**. Available at: <http://www.rsbby.gov.in/how_works.html>. Access on: 30 July 2021.

³³ SEN, Amartya; DREZE, Jean. **An Uncertain Glory**. India and its contradictions. Penguin, 2013.



fective implementation of health care. These include issues about targeting, efficiency, vested interests of the private sector etc. A contributing factor for such callous attitude of the executive is also because the right to healthcare, unlike the right to food.³⁴ or education³⁵ has not translated into a comprehensive statutory right with independent legislation for the same. Such legislation imposes specific rights and obligations upon the executive along fostering legal accountability.

4. THE LEGAL-CONSTITUTIONAL REGIME OF THE RIGHT TO HEALTH IN BRAZIL

In Brazil, the 1988 Constitution of the Federative Republic of Brazil represents a landmark when it comes to the right to health. Before this Constitution, health was not considered a right for all, nor a duty of the State.

The 1988 Constitution met the demands of the Sanitary Reform Movement, especially with the discussions held during the VIII National Health Conference,³⁶ and broke with the previous model by attributing its contours to the right to health, correlating it to the guarantee of social assistance.³⁷

Thus, the right to health has passed to the category of fundamental social right, being inserted in Title II (Fundamental Rights and Guarantees), Chapter II (Social Rights), in Article 6 of the Federal Constitution: “education, health, food, work, housing, transportation, leisure, security, social security, protection to motherhood and childhood, and assistance to the destitute are social rights, in the form of this Constitution”.

This process of constitutional explicitness of the right to health gave origin to some of the main characteristics of its legal-constitutional regime, such as (i) health began to be understood as the state of complete physical, mental and social wellbeing, as the constitutional concept of health was adapted to the international conception established by the World Health Organization (WHO); (ii) the merely curative notion of the right to health was transcended and the scope of constitutional protection granted to

³⁴ The right to food has been codified under the National Food Security Act, 2013.

³⁵ The right to education has been codified under the Right to Education Act, 2005.

³⁶ The scope of the National Health Conferences is to facilitate the Federal Government’s knowledge about health-related activities in the country and guide the execution of local services - which was very evident in the VIII Conference, in 1986. RAEFFRAY, Ana Paula Oriola de. **Direito da Saúde de acordo com a Constituição Federal**. São Paulo: Quartier Latin, 2005. p. 260-262.

³⁷ The Federal Constitution of 1988 attributes ordinary competence to the federative entities (Union, States, Federal District and Municipalities) to take care of health and public assistance, protection and guarantee of people with disabilities, as provided in its article 23, item II. In turn, article 30, clause VII establishes the focus on the municipalized provision of health care services to the population, with technical and financial cooperation from the Union and the States. As for the legislative competence on the protection and defense of health, it is a concurrent competence among the Union, the States and the Federal District, according to article 24, clause XII. BRASIL. **Constituição da República Federativa do Brasil de 1988**. Available at: <http://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm>. Access on: 16 jul. 2021.



the right to health was expanded, to encompass the protective and promotional aspects of the due guardianship; (iii) a unique system was institutionalized, concomitantly marked by the decentralization and regionalization of health actions and services; (iv) the universality of health actions and services was assured, expanding the access that until then had only been guaranteed to workers with a formal contract and respective beneficiaries; (v) the public relevance of health actions and services was clarified.³⁸

Article 196 of the 1988 Constitution states: “health is a right and a duty of the State, guaranteed by social and economic policies aimed at reducing the risk of disease and other illnesses and at universal and equal access³⁹ to actions and services for its promotion, protection and recovery”. It is important to emphasize that health generates a corresponding duty of respect and even of protection and promotion also for private individuals in general, equally bound in the condition of recipients of the fundamental rights norms. Ingo Sarlet points out that “without the recognition of a corresponding legal duty on the part of the State and private individuals in general, the right to health would be weakened, especially about its effectiveness”.⁴⁰

The Federal Constitution of 1988 also determined that health care would be provided by private and public means. There are two provisions in the constitutional text that expressly provide for private participation: (i) article 197 provides that “health actions and services are of public relevance, and it is up to the Public Power to dispose, under the terms of the law, about its regulation, inspection and control, and its execution must be done directly or through third parties, and also by private individuals or legal entities”; (ii) article 199 states that “health care is free to private initiative”.

³⁸ RAEFFRAY, Ana Paula Oriola de. **Direito da Saúde de acordo com a Constituição Federal**. São Paulo: Quartier Latin, 2005. p. 260-262.

³⁹ Carolina Zancaner Zockum points out that concerning universality, the public health service covers everyone indistinctly, since from the Federal Constitution of 1988 Brazilians and foreigners began to enjoy the public health system regardless of the payment of fees, demonstrating that the service, besides being universal, is also free. On the other hand, the aspect of equality concerns the fact that everyone, regardless of color, race, sex, religion, social or economic level, will receive the most appropriate treatment for the protection, promotion, and recovery of their health. For the author, “equity is nothing more than the consecration of the principle of impersonality, which must be obeyed by all entities of the Public Administration, by the provisions of art. 37, caput. ZOCKUN, Carolina Zancaner. **Da intervenção do Estado no domínio social**. São Paulo: Malheiros, 2009. p. 72. Daniel Wunder Hachem affirms that the Public Administration, in order to achieve equality, must, in its actions, surpass the existential minimum. This, as a criterion of justiciability of social rights, reveals a prioritization of equality of opportunities over equality of positions. The author, however, defends the prioritization of the latter since it is necessary to reduce disparities between social positions, allowing greater mobility of individuals. Equal opportunities, by themselves, do not equalize the initial stages of the search for individual life projects. HACHEM, Daniel Wunder. A maximização dos direitos fundamentais econômicos e sociais pela via administrativa e a promoção do desenvolvimento. **Revista de Direitos Fundamentais e Democracia da UniBrasil**, Curitiba, v. 13, n. 13, p. 340-399, jan./jun. 2013. p.375-377.

⁴⁰ SARLET, Ingo Wolfgang. Algumas considerações em torno do conteúdo, eficácia e efetividade do direito à saúde na Constituição de 1988. **Interesse Público – IP**, Belo Horizonte, ano 3, n. 12, p. 91-107, out./dez. 2001. p. 95.



Thus, the right to health can be realized either through private initiative, through health plans or private medicine;⁴¹ or through the public way, whose structure is the Unified Health System (SUS), which will be discussed in the next item.

Despite this hybrid system, the Brazilian State regulates all health activities. The activities it provides are called public health services, and it can use private agents, for-profit or not-for-profit, to execute the activities as delegates. This occurs because the first paragraph of Article 199 of the Constitution provides that “private institutions may participate in a complementary way in the single health system, according to its directives, through public law contracts or agreements, with preference given to philanthropic and non-profit entities.”⁴²

The private performance in health is connected to the constitutional right of freedom to explore economic activity. As a result, it is relevant to observe in which environment one is (public or private) when applying or interpreting the norms that regulate health, considering that the public law regime is different from the private one. One has the essence of a public function to meet the social right; the other is based on the free initiative of economic activity and, despite having as scope the health care of the individual, it does not concern the fulfillment of the social right to health. Therefore, the positive law system provides distinct normative environments for the solution of claims involving the provision of health services.⁴³

It is relevant to point out that “the Constitution establishes the general lines of public health policy for Brazil.”⁴⁴ The federal, state, and/or municipal legislator defines which material benefits are due to individuals, depending on the legislative competence, or the Public Administration, within its normative competence. The constitutional articles that deal with health are general, which was the original legislator’s option.⁴⁵

⁴¹ ABREU, Célia Barbosa; TIBÚRCIO, Dalton Robert. Oferta obrigatória de planos de saúde individuais e familiares: livre iniciativa e direito fundamental à boa regulação. **Revista de Investigações Constitucionais**, Curitiba, vol. 5, n. 2, p. 209-233, maio/ago. 2018; NÓBREGA, Theresa C. Albuquerque. A regulação da saúde no Brasil: o controle externo do Tribunal de Contas da União nas unidades do SUS geridas por instituições privadas. **A&C – Revista de Direito Administrativo & Constitucional**, Belo Horizonte, ano 19, n. 77, p. 101-119, jul./set. 2019; CORREIO, Felipe Dutra Asensi; PINHEIRO, Italo Jorge Bezzerá; MONNERAT, Diego Machado. Regulação em saúde: análise do impacto da atuação da ANS nas operadoras de planos de saúde. **A&C – Revista de Direito Administrativo & Constitucional**, Belo Horizonte, ano 21, n. 85, p. 139-160, jul./set. 2021.

⁴² On this subject, see: BERTOTTI, Bárbara Mendonça; PIVETTA, Saulo Lindorfer. A integração da iniciativa privada ao sistema público de saúde brasileiro: limites e possibilidades. **Revista Eurolatinoamericana de Derecho Administrativo**, Santa Fe, vol. 5, n. 2, p. 239-265, jul./dic. 2018.

⁴³ GUERRA, Alceni; BERTOTTI, Bárbara Mendonça; GUIDI, Silvío. **Comentários à Lei Orgânica da Saúde (LOS)**. Leis n. 8.080/90 e 8.142/90. Trinta anos da Lei. São Paulo: Quartier Latin, 2021.

⁴⁴ BITENCOURT, Caroline Müller; RECK, Janriê Rodrigues Democracia deliberativa, teoria da decisão e suas repercussões no controle social das despesas em saúde. **Revista de Direito Econômico e Socioambiental**, Curitiba, v. 8, n. 1, p. 121-147, jan./abr. 2017. p. 132; MARIANO, Cynara Monteiro; FURTADO, Emanuel Teófilo; ALBUQUERQUE, Felipe Braga; PEREIRA Fabrícia Helena Linhares Coelho da Silva. Diálogos Sanitários Interinstitucionais e a experiência de implantação do NAT-JUS. **Revista de Investigações Constitucionais**, Curitiba, vol. 5, n. 1, p. 169-188, jan./abr. 2018. p. 172.

⁴⁵ It is believed that the legislator’s choice was correct, considering that, as a result of the evolution of diseases



Based on this democratic option of public health policy in Brazil, it can be said that, in practice, a large part of the content of the right to health is materialized by the Clinical Protocols and Therapeutic Guidelines (PCDT), which are documents that establish criteria for the diagnosis of the disease or health problem; the recommended treatment, with drugs and other appropriate products, when applicable; the recommended dosages; the clinical control mechanisms; and the follow-up and verification of the therapeutic results, to be followed by SUS managers.⁴⁶ They serve as a decision-making tool for health managers in the three spheres of Government, making procedures available and acquiring and dispensing medications.

This problem is susceptible, given that the enormous controversy over which protections would be legally required from the State has culminated in the phenomenon of judicialization.⁴⁷ Due to benefits not met by the Public Administration or not foreseen in the legislation, the issue is taken to the Judiciary.⁴⁸ This is also due to the scarcity of resources faced by the Brazilian state.

and treatments, the population's needs change. Ligia Melo and Thanderson Pereira point out that "the Administration has the power to conform the right to health, and if it has the power, it has the duty to act so that access to public health actions and services are guaranteed in a collective and egalitarian way, always guided by the principles that govern the administrative activity: legality, impersonality, morality, publicity, and efficiency (art. 37, caput)". CASIMIRO, Ligia Maria Silva Melo de; SOUZA, Thanderson Pereira de. A tutela do direito à saúde pela Administração Pública: delineando o conceito de tutela administrativa sanitária. **Revista de Investigações Constitucionais**, Curitiba, vol. 7, n. 2, p. 601-629, maio/ago. 2020. p. 610.

⁴⁶ Article 19-N, item II, of Law 8.080/1990. BRASIL. **Lei 8.080 de 19 de setembro de 1990**. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Available at: <http://www.planalto.gov.br/ccivil_03/leis/l8080.htm>. Access on: 16 jul. 2021.

⁴⁷ Leandro Ribeiro and Ivar Hartmann indicate that the main characteristics of judicial claims in healthcare are: "Judicial claims are individual, not collective; Most cases request the provision of drugs through SUS; Claims have a success rate of 90%; Favorable rulings are not based on independent medical assessments, but rather on prescriptions of the plaintiffs' personal physicians. Such prescriptions may contain drugs that have not even been approved for commercialization in Brazil. What is more, a large part of rulings are preliminary injunctions, which require immediate delivery of drugs". RIBEIRO, Leandro Molhano; HARTMANN, Ivan Alberto. Judicialization of the right to health and institutional changes in Brazil. **Revista de Investigações Constitucionais**, Curitiba, vol. 3, n. 3, p. 35-52, set./dez. 2016. p. 39. Concerning the authorization for use of medicines that have as active ingredient proscribed substances in Brazil, see: GABARDO, Emerson; CABRAL, Rodrigo Maciel. Autorização para uso de medicamentos com princípios ativos proscritos no Brasil. **Revista de Investigações Constitucionais**, Curitiba, vol. 7, n. 2, p. 473-515, maio/ago. 2020.

⁴⁸ PIVETTA, Saulo Lindorfer. **Direito fundamental à saúde**: regime jurídico, políticas públicas e controle judicial. São Paulo: Revista dos Tribunais, 2014. p. 34. On judicialization of healthcare, see also: AVILA, Ana Paula Oliveira; MELO, Karen Cristina Correa de. Separação de poderes e diálogos institucionais nos litígios envolvendo o direito à saúde. **Revista de Investigações Constitucionais**, Curitiba, vol. 5, n. 1, p. 83-108, jan./abr. 2018; MASCARENHAS, Caio Gama; RIBAS, Lídia Maria. Materializando diálogos institucionais na judicialização da saúde pública – propostas de convenções processuais coletivas, LINDB e transparência. **Revista de Investigações Constitucionais**, Curitiba, vol. 7, n. 1, p. 285-317, jan./abr. 2020; DAL POZZO, Emerson Luís; MION, Ronaldo de Paula. Controle jurisdicional das políticas públicas de saúde através da inclusão de medicamentos na relação de medicamentos essenciais do Sistema Único de Saúde. **A&C – Revista de Direito Administrativo & Constitucional**, Belo Horizonte, ano 19, n. 77, p. 199-228, jul./set. 2019;



Research by the National Council of Justice for the year 2019 indicated that until that year there were more than two million lawsuits about health. A large part involved requests for access to procedures and medicines, many of them provided for in the Unified Health System (SUS) lists, but not provided by the state.⁴⁹

5. BRAZILIAN PUBLIC HEALTH SYSTEM

In Brazil, the public structure for realizing the right to health is called the Unified Health System (SUS). Article 198 of the Federal Constitution of 1988 states that: “public health actions and services integrate a regionalized and hierarchical network and constitute a single system, organized according to the following guidelines: I- decentralization, with single direction in each sphere of government; II - comprehensive care, with priority for preventive activities, without prejudice to care services; III - community participation”.

The SUS was regulated by Law number 8.080/90.⁵⁰ Despite not having its own legal personality, it articulates the health actions and services provided at all levels of the federation and coordinates the various actors and structures involved in health policies. Thus, it integrates a complex legal structure, which involves the participation of various agencies of the direct public administration (such as the Ministry of Health, State and Municipal Secretariats), of entities of the indirect administration (such as the National Health Surveillance Agency, the university hospitals linked to public universities), of private law entities (such as Social Organizations and philanthropic hospitals), and the Health Councils and Conferences, which enable the community participation in the formulation and management of health policies. These actors act in a harmonized way, based on the same guidelines and with objectives linked.⁵¹

The regionalized performance of the SUS allows for the adaptation of health actions and services to the local epidemiological profile. Therefore, municipalization is the main way to densify the decentralization and regionalization guidelines of the SUS,

⁴⁹ CONSELHO NACIONAL DE JUSTIÇA. **Soluções construídas pelo CNJ buscam reduzir judicialização da saúde**. Available at: <<https://www.cnj.jus.br/solucoes-construidas-pelo-cnj-buscam-reduzir-judicializacao-da-saude/>>. Access on: 15 jul. 2021.

⁵⁰ For more information on the articles of the Law, see: GUERRA, Alceni; BERTOTTI, Bárbara Mendonça; GUIDI, Silvio. **Comentários à Lei Orgânica da Saúde (LOS)**. Leis n. 8.080/90 e 8.142/90. Trinta anos da Lei. São Paulo: Quartier Latin, 2021.

⁵¹ PIVETTA, Saulo Lindorfer. **Direito fundamental à saúde**: regime jurídico, políticas públicas e controle judicial. São Paulo: Revista dos Tribunais, 2014. p.124-125.



even though improvements and adjustments are always necessary.⁵² Law 8.080/90 establishes that SUS planning will be ascending, from the local to the federal level.⁵³

The “hierarchical” network is elaborated from a succession of three levels of care: primary care, secondary care, and tertiary care. This model is recommended by the Pan-American Health Organization and the World Health Organization, since it enables adequate planning and greater efficiency in managing public resources.

Primary care is the first level of health care, the “entrance door” to the system. The population has access to basic specialties: clinical medicine (general practice), pediatrics, obstetrics, and gynecology. Studies show that primary care is capable of solving about 80% of health needs and problems. If necessary, the patient is “referred” to more complex levels (secondary or tertiary).⁵⁴

Important to noting that, despite the use of the term “hierarchical”, there is no hierarchy among the Union, states, and municipalities, but rather competencies for each of these three SUS managers.⁵⁵ Article 200 of the 1988 Constitution establishes the competencies and attributions of the SUS.

It is a list of examples, and there may be others. These are control and inspect procedures, products, and substances of health interest and participate in the production of drugs, equipment, immunobiologicals, blood derivatives, and other inputs; perform sanitary and epidemiological surveillance actions, as well as worker health; organize human resources training in the health area; participate in the formulation of policy and execution of basic sanitation actions; increase scientific and technological development in its area of operation; to increase, in its area of operation, scientific and

⁵² The municipality is the main one responsible for the public health of its population. As of the Health Pact, signed in 2006, the municipal manager begins to assume immediately or gradually the complete management of health actions and services offered in his territory. Moreover, as of the pact mentioned above, states and municipalities can receive federal resources through five financing blocks: (i) primary care; (ii) medium and high complexity care; (iii) health surveillance; (iv) pharmaceutical assistance; and (v) SUS management. Before the pact, there were more than 100 forms of transferring financial resources, which caused some difficulties in its application. BRASIL. Ministério da Saúde. **Cartilha “Entendendo o SUS”**. Available at: <<http://portalarquivos.saude.gov.br/images/pdf/2013/agosto/28/cartilha-entendendo-o-sus-2007.pdf>>. Access on: 15 jul. 2021.

⁵³ Article 36 of Law 8.080/1990. BRASIL. **Lei 8.080 de 19 de setembro de 1990**. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Available at: <http://www.planalto.gov.br/ccivil_03/leis/l8080.htm>. Access on: 16 jul. 2021.

⁵⁴ In the Unified Health System, there is called “referral”, a strategy of care where, for each type of illness, there is a place of reference for the service. BRASIL. Ministério da Saúde. **Cartilha “Entendendo o SUS”**. Available at: <<http://portalarquivos.saude.gov.br/images/pdf/2013/agosto/28/cartilha-entendendo-o-sus-2007.pdf>>. Access on: 15 jul. 2021.

⁵⁵ The legislator uses the “cooperation” modality to distribute the competencies among the federated entities. This modality differs from coordination, which allows the federated entity to act autonomously or separately in achieving the constitutionally established objective. In cooperation, decisions on health policies must be made jointly by all federated entities, although the execution can often be carried out by only one entity. BERCOVICCI, Gilberto. A descentralização de políticas sociais e o federalismo cooperativo. **Revista de Direito Sanitário**, vol. 3, n. 1, p. 13-28, mar. 2002. p.15.



technological development and innovation; to inspect and inspect food, including the control of its nutritional content, as well as beverages and water for human consumption; to participate in the control and inspection of the production, transport, storage, and use of psychoactive, toxic, and radioactive substances and products; to collaborate in the protection of the environment, including the work environment.⁵⁶

In addition to these three guidelines, SUS also operates based on the following principles: universality of access to health services at all levels of care; integrality of care, understood as an articulated and continuous set of preventive and curative actions and services, individual and collective, required for each case at all levels of complexity of the system; preservation of people's autonomy in defense of their physical and moral integrity; equality of health care, without prejudice or privilege of any kind; Right to information about one's health to the assisted people; dissemination of information regarding the potential of health services and their use by the user; use of epidemiology to establish priorities, resource allocation, and program orientation; community participation; political-administrative decentralization, with single direction in each government sphere: a) emphasis on decentralization of services to the municipalities; b) regionalization and hierarchization of the health services network; integration at the executive level of health, environment, and basic sanitation actions; combination of financial, technological, material, and human resources of the Union, states, Federal District, and municipalities in the provision of health care services to the population; organization of public services in such a way as to avoid duplication of means for identical ends; and the organization of specific and specialized public services for women and victims of domestic violence in general, which guarantee, among other things, care, psychological support, and reparative plastic surgeries.⁵⁷

Despite its extraordinarily organized and complex structure, the SUS faces numerous problems, mainly related to underfunding,⁵⁸ inequalities and resource management. This imposes the need for investments in human resources training, the modernization of work processes, information systems, and technological infrastructure.⁵⁹

⁵⁶ BRASIL. **Constituição da República Federativa do Brasil de 1988**. Available at: <http://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm>. Access on: 16 jul. 2021.

⁵⁷ Article 7º of Law 8.080/90. BRASIL. **Lei 8.080 de 19 de setembro de 1990**. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Available at: <http://www.planalto.gov.br/ccivil_03/leis/l8080.htm>. Access on: 16 jul. 2021.

⁵⁸ Critical of the underfunding of the SUS can be found in: MARIANO, Cynara Monteiro; PEREIRA, Fabícia Helena Linhares Coelho da Silva. Mais um obstáculo ao SUS: o caso dos planos de saúde populares. **A&C – Revista de Direito Administrativo & Constitucional**, Belo Horizonte, ano 18, n. 72, p. 115-132, abr./jun. 2018. p. 117 e ss.

⁵⁹ On a discussion of the incorporation of new technologies in the SUS, see: BLANCHET, Luiz Alberto; BERTOTTI, Bárbara Mendonça. **Perspectivas e desafios à implementação de Saúde Digital no Sistema Único de Saúde**. Unpublished.



⁶⁰ This presupposes sufficient and stable financial resources, which are allocated from political decisions.⁶¹

6. A COMPARISON BETWEEN GENERAL ASPECTS OF THE RIGHT TO HEALTH IN BRAZIL AND INDIA

Comparative law research aims to investigate foreign legal experiences, their evolution, and verify the characteristics of the various legal systems. In the field of constitutional law, one should identify networks of influence and collaboration between legal systems, analyzing approximations, divergences, and feedback.⁶²

For Pierre Legrand, the comparison must involve the basic and fundamental investigation of difference. Comparative law studies can promote understanding of other peoples by shedding light on how they understand their law.⁶³

Michele Carducci, on the other hand, believes that *“en realidad, la comparación conlleva la conciencia de observar la complejidad, y manifiesta siempre la exigencia de un camino crítico marcado por continuas preguntas acerca de la doble dimensión del sujeto - el jurista que observa - y los otros - los sujetos y los ordenamientos observados y confrontados”*.⁶⁴

In this sense, based on the comparison between the two legal-constitutional systems, Brazil and India, it was possible to identify to what extent the two systems are similar or different, by analyzing the characteristics related to whether the right to health is considered fundamental, its constitutional recognition, the ownership of the duty to guarantee this right, the role of the private sector in the realization of the right, and the presence of a public health system.

(i) *Fundamentality of the right to health*

In India, the recognition of the fundamental right to health came from the Supreme Court in the mid-1980s in the case of *Shantisar Constructors v. Narayanan Khimalal Totame*, which upheld the citizen's fundamental right to health in different forms, for

⁶⁰ On how the fostering of Information and Communication Technologies (ICTs) by the Public Administration can bring significant development impacts, see: REIS, Camille Lima; CARVALHO, Fábio Lins de Lessa. O fomento às novas tecnologias na Administração Pública como direito ao desenvolvimento. **International Journal of Digital Law**, Belo Horizonte, ano 1, n. 3, p. 11-28, set./dez. 2020.

⁶¹ BERTOTTI, Bárbara Mendonça. **Sistema Único de Saúde: estrutura, financiamento e cobrança**. Curitiba: Íthala, 2021.

⁶² DIMOULIS, Dimitri. Objetivos e métodos do direito comparado e peculiaridades do direito constitucional comparado. **Revista Brasileira de Estudos Constitucionais – RBEC**, Belo Horizonte, ano 10, n. 35, maio/ago. 2016. p. 77 e 85.

⁶³ LEGRAND, Pierre. A impossibilidade de “transplantes jurídicos”. **Cadernos do Programa de Pós-Graduação em Direito – PPGDir./UFRGS**, Porto Alegre, v. 9, n. 1, p. 11-39, jan./jul. 2014. p. 35-36.

⁶⁴ CARDUCCI, Michele. Crítica de la comparación constitucional “ad hoc”. **A&C – Revista de Direito Administrativo & Constitucional**, Belo Horizonte, ano 14, n. 55, p. 13-22, jan./mar. 2014. p. 21.



example right to a clean environment, emergency health services, etc. In Brazil, the Federal Constitution of 1988 expressly brings the right to health as a fundamental right of the human person.

(ii) Legal-constitutional recognition

A significant starting point of difference between the two jurisdictions is within the legal-constitutional recognition of the right to health. While the 1988 Constitution of the Federative Republic of Brazil explicitly recognizes the right, such recognition is missing Indian Constitution. Therefore, in India, the Judiciary has imported the right through an expanded reading of the already existing Fundamental Rights and Directive Principles of State Policy provided thereunder. Due to such a method of recognition, and without a statute to govern the right to health in India, it has been observed that the Judiciary adjudicates the right on a case-to-case basis. The explicit recognition of the right to health in the Brazilian Constitution provides for legal certainty and accountability.

(iii) Guarantee competence

In Brazil, guaranteeing the right to health is the State's competence and its title is expressed in article 196: "health is everyone's right and the State's duty". Since there is no constitutional recognition of this right in India, there is also no express title. The Supreme Court recognized this in *Vincent v. Union of India*, where it recognized the State's obligation under Article 47. The responsibility to legislate, however, lies with the state. Thus, the Constitution also provides for the decentralization of health care to be implemented at the local level.

(iv) Role of the private

India has a mixed health care system, which includes public and private sector participation to provide affordable health care services focusing on the poor. In Brazil, the system is also hybrid, and the private sector can participate in health care delivery through the market and by complementing the Unified Health System.

(v) Public health system

While Brazil has the SUS, which was foreseen by the 1988 Constitution and regulated by Law 8.080/1990 and is responsible for realizing the right to health for all, India has no constitutionally organized public structure for this purpose.



7. CONCLUSIONS

From the above, it can be concluded that, as for the realization of the right to health in the two countries, Brazil is well ahead of India for some reasons: (i) it expressly recognizes health as a fundamental social right; (ii) the ownership of the right to health is of all Brazilians and foreigners, resident or not in Brazil; (iii) it has the SUS, a complex, advanced and organized public structure that guarantees from preventive actions to highly complex actions; (iv) it has dense normatization, with emphasis on Laws No. 8.080/1990 and No. 8.142/1990; (v) it attributes to the State, with possible complementation of the private, the duty to ensure the right to health. Not that the Brazilian public health system is perfect, on the contrary, it faces serious problems related, above all, to inequalities and underfinancing.

However, India is behind because health has not yet been elevated to a constitutional right. Although it has achieved significant advances in health care through some state policies and Supreme Court interpretations, it still has tremendous challenges, related to high maternal and infant mortality rates, poor immunization coverage, inactive nutritional status of children, and significant levels of mortality from communicable diseases. In addition, it has a poor budget allocation, lack of advocacy by the poor, and the persistence of dysfunctional and low-resolution health services due to the diffusion of unregulated markets. The low utilization of public health services in rural areas is also due to doctors' unwillingness to work in rural areas without adequate infrastructure. There are also geographical and regional disparities in the distribution and quality of health services and social inequalities that impact health indicators.⁶⁵

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⁶⁵ ABROL, Dinesh; SUNDARARAMAN, T.; MADHAVAN, Harilal; JOSEPH, K. J. A criação de sistemas inclusivos de inovação em saúde: lições da Índia. **Cadernos de Saúde Pública**, Rio de Janeiro, n. 32, suplemento 2, 2016. p. S2.



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