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Judicialização da saúde durante a pandemia de COVID-19 no Pará, região Norte do Brasil

Judicialization of health during the COVID-19 pandemic in Pará state, Northern region of Brazil

Judicialización de la salud durante la pandemia de COVID-19 en Pará, Norte de Brasil

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Resumo

No Brasil, o direito à saúde tem previsão constitucional e universal. No entanto, sua incompletude e a escassez de recursos humanos e estruturais levam as pessoas que necessitam

e se beneficiariam do acesso a bens e serviços de saúde específicos, principalmente as em necessidade de cuidados intensivos - como atualmente intensificado pela pandemia COVID-19 -, a recorrer à via judicial para obtê-los. Sendo assim, o objetivo deste artigo foi problematizar a relação entre a insuficiência do número de leitos de UTI com as atuais demandas por estes na pandemia de COVID-19 por meio da via judicial. Fez-se o confronto dos dados disponibilizados pelo Ministério da Saúde com a literatura sobre a judicialização no âmbito nacional, com atenção aos dados estatísticos do Tribunal de Justiça do Estado do Pará. Houve 14 ações visando garantir acessos aos leitos de UTI no período de 20/03/2020 a 25/05/2020 no estado do Pará. A disponibilidade destes no estado (1.718) representa 9% do total dos leitos existentes, abaixo da média nacional, ambas aquém da quantidade ideal traçada pela Organização Mundial de Saúde (Taxa ideal de 3 a 5 leitos de UTI para cada mil habitantes). Conclui-se que a judicialização da saúde pode ser um sinalizador de falhas na gestão e disfunções nos sistemas de saúde, evidenciadas pela pandemia COVID-19, podendo significar possibilidade de escassez de recursos em saúde no país.

Palavras-chave: Judicialização da saúde; COVID-19; Unidades de Terapia Intensiva.

Abstract

In Brazil, the right to health has constitutional universal provision. However, its incompleteness and the scarcity of structural and human resources leads people who would benefit from access to specific health services, mainly the ones in intensive care need - as currently intensified by the COVID-19 pandemic -, to appeal to judicial way to obtain access to them. The aim of this study was to problematize the relation between the insufficient number of ICU (Intensive Care Unit) beds at the current demands for them due to the COVID-19 pandemic through judicialization. The data from the Ministry of Health database were confronted with the literature on the judicialization of health within the national scope, with attention to the statistical data of Pará state's Court of Justice. There were 14 actions aimed at guaranteeing access to the ICU beds in the period from 03/20/2020 to 05/25/2020 in Pará state. The availability of these in the state (1,718) represents 9% of the total number of beds, below the national average, both beneath the ideal determined by the World Health Organization (ideal rate of 3 to 5 ICU beds for every thousand inhabitants). In conclusion, the judicialization of health can be a sign of dysfunctions and failures in the management of the health systems, evidenced by the COVID-19 pandemic, which could lead to the possibility of scarcity of health resources in the country.

Keywords: Health's Judicialization; COVID-19; Intensive Care Units.

Resumen

En Brasil, el derecho a la salud tiene disposición constitucional y universal. Sin embargo, su incompletitud y escasez de recursos humanos y estructurales lleva a las personas que se beneficiarían del acceso a servicios de salud específicos, especialmente aquellos que necesitan cuidados intensivos, como lo intensifica actualmente la pandemia COVID-19, para recurrir al sistema judicial. Por tanto, el objetivo de este artículo fue problematizar la relación entre el número insuficiente de camas de UCI y las demandas actuales de las mismas en la pandemia de COVID-19 a través del sistema judicial. Los datos proporcionados por el Ministerio de Salud se compararon con la literatura sobre judicialización a nivel nacional, con atención a los datos estadísticos de la Corte de Justicia del Estado de Pará. Se realizaron 14 acciones encaminadas a garantizar el acceso a las camas de UCI en el período del 20/03/2020 al 25/05/2020 en el Estado de Pará . La disponibilidad de estos en el estado (1.718) representa el 9% del total de camas existentes, por debajo del promedio nacional, ambos por debajo de la cantidad ideal determinada por la Organización Mundial de la Salud (tasa ideal de 3 a 5 camas de UCI por cada mil habitantes). Se concluye que la judicialización de la salud puede ser signo de fallas en la gestión y disfunciones en los sistemas de salud, evidenciado por la pandemia COVID-19, lo que podría significar la posibilidad de escasez de recursos de salud en el país.

Palavras clave: Judicialización de la Salud; COVID-19; Unidad de Cuidados Intensivos.

1. Introduction

The rationalization of resources and inputs in health is a frequent reality in Intensive Care Units (ICUs). Researches in several countries show that it is common for ICU professionals to screen patients in a scenario in wich there are more people who could benefit from the treatment then the available vacancies (Sinuff et al, 2004; Oerlemans, 2016). Ramos (2017) considered Brazil this type of screen to be more common in public hospitals, considering clinical judgments about the viability or pertinence of intensive care (Wang & De Lucca-Silveira, 2020).

ICUs became a symbol of modern medicine and have a significant role in reducing population's mortality in the recent decades (Pollack et al, 1998). Thompson and Khot (1991) claim that despite investments aiming to expand hospital beds and increasing technology, demand continues to grow, whether in developed or in developing countries. Therefore, due to the intensive treatment demand expansion, the number of beds would

need to increase (Rhodes, Chiche & Moreno, 2011). On the other hand, as Eastman, Philips, Rhodes (2010) indicate in their research, without an increase that keeps up with the demand, deficit is installed, leading to need of pragmatic and rational screening in order to guarantee that patients who will benefit most from intensive care have access to it.

Such growing demand for beds in ICUs, overloaded by the COVID-19 scenario (coronavirus disease 2019), whose severe cases may need intensive care (Chen et al, 2020), generates impacts in health services. The new coronavirus, the cause of severe acute respiratory syndrome 2 (SARS-CoV-2), was initially reported in December 2019 in Wuhan, China (Zhu N, et al. 2020; WHO, 2020a). Patients often experience dry cough, headache, hypoxia, fever and dyspnoea, and deaths occur due to progressive respiratory failure caused by lung damage (Tsang et al, 2003; Drosten et al, 2003; Yang et al, 2020). Following the international interest decree of Public Health Emergency carried out by the World Health Organization (WHO) on January 30, 2020, a sequence of health devices followed until it culminated in global pandemic status, announced on March 11, 2020 (WHO, 2020b).

Moreira (2020) explains that spatial distribution of the disease has crossed national borders, leading several countries to declare states of emergency and of public calamity, with emphasis on a change in the disease epicenter from China to Europe, especially in Italy and Spain. Grasselli (2020) indicated that in Italy, given the current panorama of the COVID-19 pandemic, ICUs no longer absorb all the demand and doctors need to choose who to accept and who to let die (Lintern, 2020).

In Brazil, the first case was identified on February 26, 2020 in São Paulo state, and the first death on March 17, 2020, in the same state. Epidemic's progression are estimated to be exponential (Brasil, 2020) and to Brazilian researchers, if the current rate of contagion continues, it is possible that the national demand becomes similar to Italy's, whose system was overloaded (Wang & De Lucca-Silveira, 2020).

The first confirmed case of COVID-19 in the Pará state dates back to March 18, since when there has been a dizzying increase in the number of cases, with confirmed cases in over 100 of the 144 municipalities in the state. Despite the distribution, the capital, Belém, concentrates more than half of cases there (Rubiatti, 2020). According to Pará State Department of Public Health (2020) since the beginning of the pandemic (March 2020) until July 28, 2020, the state registered 150,616 confirmed cases, with 5,753 deaths by COVID-19.

Given this context, the doctor is autonomous to define the indicated treatment to the patient without need of proof that it will obtain the best result or need to justify the costs

that will be spent to achieve it (Carlini, 2017). However, no individual doctor can claim to have all medical knowledge about certain health situation, and may have his prescription questioned by another doctor, the patient and the judge, if happens specific health demand judicialization. It mainly occurs when the prescription is in disagreement with the principle of human dignity and high values, because even though the existence of high-tech medical resources to prolong life, these should only be used if they bring quality to human life and its benefit to the patient's treatment is proven (Carlini, 2017).

In this sense, Brazilian Medical Councils positioned according to Resolution No. 1.995 /2012, which addresses the new technological resources that allows adoption of disproportionate measures that prolong suffering of terminally ill patient without benefits, and that these measures may be rejected by the user (CFM, 2012). In the same interpretative field, there was an edition to No. 2,156/2016 Resolution, which establishes admission or discharge criteria for patients in ICUs. It aims to contribute to clinically unstable patients reception flow improvement, in view of the insufficient supply of ICU beds, especially in public services.

According to this resolution, ICU admissions should consider the following aspects: diagnosis and patient needs; prioritization based on clinical evidence; medical services available in the institution; availability of beds; and potential benefit for the patient with therapeutic interventions and prognosis. To Hermann Von Tiesenhausen, Coordinator of the Technical Chamber of Intensive Care Medicine, admission to the ICU should be primarily given to patients who need life support interventions with high probability of recovery and without any limitation to therapeutic support (CFM, 2016).

However, these criteria were not constructed in view to a pandemic, in wich there may be situations with several patients in the maximum priority category. Futhermore, social criteria can lead to different readings and prejudice, with an exception to health professionals, for the reasons already mentioned (Moreira, 2020).

According to the World Health Organization, the minimum number of ICU beds needed to ensure adequate care should vary between 3 to 5 beds per thousand inhabitants, value understood as the minimum recommended as a guideline in health policies (WHO, 2018). A large study carried out by the Federal Court of Accounts (TCU), analyzing the health situation in Brazil, pointed out that most Brazilian states do not have a number of beds per inhabitant in line with the recommended by WHO and face overcrowding in almost half of the health units visited in the survey (TCU, 2014), with an ICU rate of 2.19, according to a census conducted in 2016 by the Brazilian Association of Intensive Care Medicine (AMIB).

In May 2016, a Federal Concil of Medicine (CFM) survey based on information from the Ministry of Health identified the existence of 40,960 ICU beds across Brazil, of wich 20,173 beds were available in SUS to serve at least 150 million people who depend exclusively on this system. Supplementary or private healthcare, on the other hand, had 20,787 beds, to serve around 50 million people (CFM, 2016).

Analyzing data from the National Register of Health Establishments (CNES), that collects from all registered health establishments in Brazil, AMIB conducted a census for 2016 regarding the number of ICU beds in the country and measured the existence of 41,741 of these (AMIB, 2016).

To Ordacgi (2019), it clearly demonstrate that there are not enough ICU beds to meet the minimum demand and that among those, there is a high incidence of blockages. Such reality in the country is evidenced by the presented data and felt by the population within a common sense. Therefore, in addition to the number of existing ICU beds, it is necessary to check the number in operation. The scarcity of available beds, aggravated by the existence of blockages due to the lack of qualified personnel or equipment, make it necessary that public administration proceeds in a rational manner respecting the principle of proportionality and efficiency. For that, it is necessary to establish hospitalization criteria for intensive care units (Ordagci, 2019).

According to the information above, this study aimed to problematize the relation between the insufficient number of beds in Intensive Care Units with the current demands for beds in the COVID-19 pandemic in the national and also in Pará state scenario.

2. Methodology

Descriptive study, from the Ministry of Health through the secondary database of the Health Surveillance Secretariat (SVS): COVID-19 Epidemiological Surveillance Guide, which implemented a official vehicle panel for communicating about the epidemiological profile of COVID-19 in Brazil. All data are available on the internet by Ministry of Health webpage https://covid.saude.gov.br/.

It should be noted that the SVS, represented by five departments, is responsible for all actions of surveillance, prevention and control of communicable diseases, for the surveillance of risk factors for the development of chronic non-communicable diseases, environmental and worker health, as well as by analyzing the health situation of the Brazilian population. The

updating of data on cases and deaths confirmed by COVID-19 in Brazil is carried out daily by the Ministry of Health through official information provided by the State Health Departments of the 27 Brazilian Federative Units, and are consolidated and made publicly available, at around 7:00 pm.

As it is a public domain data collection, there was no need for evaluation by the Ethics Council and the National Research Ethics Committee CEP / CONEP, in accordance with resolution No. 510, of April 7, 2016. This research followed the Guidelines for the Transparent and Accurate Reporting of Health Estimates (GATHER Declaration), developed by the GARTHER group convened by WHO, in order to develop good practices in reporting global epidemiological estimates.

The information collected came from the data compiled from notifications regarding COVID-19 and all its consequences, contained in the panel mentioned above, located at the electronic address https://covid-insumos.saude.gov.br/paineis/insumos/painel.php. Among all the information available in the panel currently offered by the Federal Government, this research emphasized the search for data that refer to the total confirmed cases of the disease by region, total ICU beds also divided by region (belonging or not to the SUS), as well as the total number of ICU admissions and the mortality rate per inhabitant.

The studied population corresponded to a total of 391,222 people (total of confirmed cases) until May 26, 2020, since the panel update is carried out daily. Mortality per 100 thousand per inhabitants totaled 55.9, with 34,318 hospital beds belonging or not to SUS. The data were organized in absolute and relative frequencies and arranged in tables and graphs obtained using Microsoft Excel®. All the resources necessary for the production and submission of this research were financed by the authors themselves.

3. Results and Discussion

The judicialization of health is getting more present in Brazilian public health institutions and incorporated into the public debate. Despite this, it is still insufficiently explored, characterized as a theoretical-empirical gap that requires studies (Ramos, 2017).

In this panorama, table 1 shows the number of confirmed cases in Brazil from the beginning of the COVID-19 pandemic until May 26, 2020, the reference date for data collection. Of the 391,222 infected people, the South-East Region presents 144,446 cases and is the one with the highest number of infected people.

Table 1. Number of confirmed cases in Brazil. May, 2020 (n=391,222).

Brazil Regions	Confirmed cases	Mortality/100 mil inhabitants
North	81.231	26,6
North-East	135.623	12,9
Center-West	12.609	1,8
South-East	144.446	13
South	17.313	1,6
Total	391.222	55,9

Source: https://covid.saude.gov.br/.

International associations advocate that since the pandemic is a extreme exceptionality situation, it should be managed as a crisis situation, requiring measures of "disaster or calamity medicine". In this case, in order to best apply distributive justice in the appropriate allocation of resources, ethical precepts must be considered (Berlinger et al, 2020; Raccioni, et al, 2020).

The growing search for access to health through the courts, in Brazil, has promoted reflections on the country's use and budget availability, in addition to exposing the State difficulties in organizing and implementing public health policies (Machado, 2015). The combination of democratic failure that marks many countries in Latin America, associated with favorable opportunities in the courts (for example, the existence of constitutional protection resources, not stringent requirements for their legal processing and the speed of resolution) has led to an increase in the right to health judicialization (Silva & Baptista, 2014; Wang et al, 2014).

In addition, the judicialization of health in Brazil differs from the international framework, since while most countries that adopt the logic of a universal health system do not guarantee the right to health, but the right to health services, the Brazilian health system has protected the right to health (Diniz, Machado & Penalva, 2015; Yamin & Frisancho, 2015)

For Ramos (2016) universal access to health in Brazil, although constitutionally guaranteed, is not always fulfilled in all situations that require it, therefore more and more citizens turn to the judiciary to claim the health right and to guarantee access demands non-included to the system. In this context, the author states that resorting to legal entities to access what is constitutionally guaranteed, is configured as a great paradox when analyzing that health policy develops in a Rule of Law with democratic space, involving Civil Society and the Legislative, Executive and Judiciary Power in decisions and discussions on the direction of the Brazilian Health Policy.

From Table 1 it is possible to conclude the need to implement such measures, since the Mortality rate / 100 thousand inhabitants, in the Northern region, for example, reaches 26.6, followed by the Southeast Region with 13 and the North-East Region with 12.9. For Satomi et al (2020) the lack of antecipated planning in these situations of resources scarity risk can lead to waste of resources, inadvertent life and loss of trust from users and professionals.

Health care providers must be prepared to make the most out of limited resources and reduce damage to the patient, the health system and Society (Emanuel et al, 2020). In addition, decisions about the allocation of available resources, as established in Resolution 2,156 / 2016 CFM, should not fall on the professionals who are on the so-called “front line”, already overburdened by the current scenario, under stress, risk of illness and susceptible to errors. Futhermore, the integrity of health professionals must be protected in this process, since they are fundamental to facing the issue (Satomi et al, 2020).

Regardless of the economic situation, countries around the world presented a demand for COVID-19 care greater than their medical-hospital capacity, mainly on admission to the ICU with intubation offer (Gruber & Sommers, 2020; Boccia, Ricciard & Ioannidis, 2020). In this sense, deaths could be avoided if we were ready to receive all patients, but this reality was not reliable in the number of cases of the disease that occurred in a short period.

According to data from Brazilian Institute of Geography and Statistics (IBGE), Brazilian population on July 1, 2019 was estimated at 210,147,125 million inhabitants. The ideal rate of ICU beds is 3 to 5 for every thousand inhabitants, so in the country there should be between 630,441 to 1,050,735, approximately. As seen in table 2, there are current 34,318 thousand ICU beds, below the minimum amount stipulated, just over 5%, according to the World Health Organization recommendation. It should also be noted that the Northern Region is the one with lowest absolute number (1,718) of beds within the total surveyed and corresponds to 9% of existing beds.

Table 2. Adult SUS' ICU beds and non-SUS ICU beds. Brazil, 2020.

Brazil Regions	SUS' ICU		NON-SUS ICU		Total
	N	%	N	%	
North	1.182	6%	536	3%	1.718
North-East	4.337	23%	2.643	17%	6.980
Center-West	1.413	8%	1.807	11%	3.220
South-East	8.201	44%	9.031	57%	17.232
South	3.431	18%	1.737	11%	5.168
Total	18.564	100%	15.754	100%	34.318

Source: https://covid.saude.gov.br/.

In the study led by TCU, 2,389 of the 23,755 reported beds from the units chosen for visit in different states of the federation were unavailable for use, corresponding to 10% of the total. When analyzing the different regions of the country, the North Region presented the highest percentage of blockade (15%), followed by the Southeast Region (14%). In the Southeast Region, a surprising 51% blockage of obstetric beds was reached. The most commonly cited cause of the blockage was the lack of professionals (TCU, 2014).

Furthermore, it is important to emphasize precaution when analyzing the total number of beds available. To Ordacgi (2019), most of them correspond to units of the complementary health system.

Belém Metropolitan Region (RMB) consists of 7 cities in Pará state (Ananindeua, Belém, Benevides, Castanhal, Marituba, Santa Bárbara do Pará and Santa Isabel do Pará), with a population around 2,459,321 inhabitants, according to 2019 IBGE data. CNES / DATASUS (2020) shows the RMB to have 4,383 hospital beds, between clinical, surgical and complementary beds (including ICUs). Therefore, the RMB has an average of 1.78 beds per thousand inhabitants, a number below the national mean, which is 1.95 beds per thousand inhabitants, according to the Brazilian Federation of Hospitals (FBH) and the National Health Confederation (CNS), while the world is estimated to have 3.2 beds per thousand inhabitants (OCDE, 2020).

A study of the spatiotemporal evolution of COVID-19 in Pará (Sousa Júnior et al, 2020), observed a progressive interiorization and peripherization in relation to RMB - related to interregional road and river flows -, consistent with the occurred in the other Brazilian

regions with a large population contingent (Fiocruz, 2020a). This is an alarm factor, since in the country there are high differences in the relation of capital and interiors availability of ICU beds, with an unfavorable contribution to the clinical outcomes of the disease by the coronavirus (Fiocruz, 2020b).

Taking this into account, in the Pará state, according to statistical data provided by the State Court of Justice (table 3) in the period between 03/20/2020 to 05/25/2020, a total of 14 actions were taken to guarantee access to ICU beds. It should be noted that in the North region, for example, the Mortality rate / 100 thousand inhabitants reaches 26.6, which corroborates with the increase in the judicial demand for access to beds, with the goal of maintenance of these patients' lives.

Table 3. Lawsuits initiated on the theme "Health Law" and "Issues of High Complexity, Great Impact and Repercussion" in Pará state, with process class, subject, date and instance - COVID 19.

CLASS	SUBJECT	DATE	INSTANCE
Antecedent Anticipated Guardianship	COVID-19	2020/05/01	1st Degree
Antecedent Anticipated Guardianship	COVID-19	2020/05/03	1st Degree
Grievance Procedure Instrument	Hospital bed/ Oncology bed | COVID-19	2020/04/29	2nd Degree
Public Civil Action	Hospitalization/ Hospital Transfer | COVID-19	2020/05/15	1st Degree
Public Civil Action	Hospitalization/ Hospital Transfer | COVID-19	2020/05/01	1st Degree
Grievance Procedure Instrument	Hospitalization/ Hospital Transfer | COVID-19	2020/05/22	2nd Degree
Public Civil Action	Abuse of Power | Hospitalization/ Hospital Transfer | COVID-19	2020/05/06	1st Degree
Public Civil Action	Hospitalization/ Hospital Transfer | Intensive Care Unit /COVID-19	2020/05/15	1st Degree
Public Civil Action	Hospitalization/ Hospital Transfer | Intensive Care Unit /COVID-19	2020/05/20	1st Degree
Public Civil Action	Hospitalization/ Hospital Transfer | Intensive Care Unit /COVID-19	2020/05/20	1st Degree

Public Civil Action	Hospitalization/ Hospital Transfer | Intensive Care Unit /COVID-19	2020/05/20	1st Degree
Public Civil Action	Hospitalization/ Hospital Transfer | Intensive Care Unit /COVID-19	2020/05/22	1st Degree
Public Civil Action	Hospitalization/ Hospital Transfer | Intensive Care Unit /COVID-19	2020/05/22	1st Degree
Public Civil Action	Injunction | Obligation to do / not to do| Hospitalization/ Hospital Transfer | Intensive Care Unit /COVID-19	2020/05/15	1st Degree

Compilation: Statistics Coordination Counting Period: 2020/03/20 to 2020/05/25. All matters related to the topic were investigated: "Health Law" and "Issues of High Complexity, Great Impact and Repercussion", according to the unified procedural table management system CNJ - https://www.cnj.jus.br/sgt/consulta_publica_assuntos.php
Source:“O judiciário não Para” Panel.

In a study developed in the Federeal District (DF) carried out at the Second Public Finance Court, aimed to study the scenario of the lawsuits related to the request for access to ICU beds, found that 66% of the 385 cases analyzed, between 2005 and 2010, referred to this theme (Diniz, Machado & Penalva, 2015). Another research that sought to know the panorama of the judicialization of health in DF in 2015 found that 34.7% of the 375 actions analyzed had this objective (Nascimento, 2015).

The adequate provide of social assistance services, for example, is essential for the quality of practically all lines of care, even in the most complex treatments, as is the case of admission to the Intensive Care Unit (Pessoa et al, 2016). In sum, the limited view on health is reflected in obstacles to accessing it, especially by individuals from the popular lower classes.

4. Final Considerations

The problem of insufficient number of Intesive Care Units beds is perceived not only through the data raised by this study, but also in view of all the circumstances that surfaced during the COVID-19 Pandemic, therefore demonstrating the reality of the country, as well as in the tertiary healthcare services, whether in the public or private sector. The burden involved is on the users, who need this service in particular.

Since there is a high cost involved, ICUs are not services of interest to the private sector, thus, the public system has been facing difficulties including contracting ICU from the

private system. In this sense, taking in consideration the essentiality of the right to health, private system include beds available to SUS through contracts, certainly less than the SUS hiring potential, precisely because the commercialization of health is a decisive factor for the insufficient ICU beds, given that the services with the greatest financial return are targets of the powerful interests and action of monopoly capital.

Therefore, it is concluded that the judicialization of health can point out flaws in the management and dysfunctions in the health systems, which presents an insufficient supply of the necessary health apparatus in a crisis situation, in relation to proposed by the WHO. Legal actions allow managers to outline health profiles and problems, generating information that can assist local managers in understanding problems related to management, care management, and possible reorientations of health practices.

It is also necessary to make efforts to promote the strengthening and enrichment of the discussion about the guaranteeing strategies for universal access to health actions, involving professionals both in the health area and in the judiciary area, as well as users and researchers of the theme. Based on evidence, it will be possible to reflect on proposals for the resolution of demands, especially the most recurring ones, thus enabling the advance of democracy and citizenship, thus improving universal access and coverage within the scope of SUS.

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