COMPARATIVE ANALYSIS OF HEALTH LEGISLATION AND THE JUDICIALIZATION OF ACCESS TO HEALTHCARE IN BRAZIL AND PORTUGAL

ANÁLISE COMPARATIVA DA LEGISLAÇÃO SOBRE SAÚDE E JUDICIALIZAÇÃO DE SEU ACESSO ENTRE BRASIL E PORTUGAL

Gabriel Oliveira Silva[1]
Clemente Maia da Silva Fernandes[2]
Mônica da Costa Serra[3]

Abstract: This study proposes a comparative analysis of health legislation and the growth of the judicialization of access to healthcare in Brazil and Portugal, considering Comparative Law. It aims to understand the magnitude and the pace of this phenomenon in both countries, considering both the public and private sectors. The research involved an analysis of the Constitutions and related legislation, with the purpose of outlining their healthcare systems, as well as documentary research in official databases to survey the number of lawsuits related to access to healthcare. The results indicate that both the Brazilian Federal Constitution and the Portuguese Constitution guarantee the right to health protection. Regarding judicialization, Brazil shows an exponential increase in the number of cases, driven by the public sector and, above all, by the supplementary health sector. In Portugal, in turn, the increase is continuous but stable, with a significantly lower absolute volume.

Keywords: Health; Judicialization; Comparative Law; Portugal; Constitution**.**

Resumo: O estudo propõe uma análise comparativa da legislação sobre saúde e do crescimento da judicialização no Brasil e em Portugal, à luz do Direito Comparado. Busca-se compreender a magnitude e a velocidade desse fenômeno em ambos os países, considerando tanto o sistema público quanto o privado. A pesquisa envolveu a análise

[1] Advogado. Doutorando em Ciências Forenses pela Universidade Estadual Paulista – UNESP. Mestre em Direito e Gestão de Conflitos pela Universidade de Araraqura – UNIARA. ORCID: https://orcid.org/0000-0002-6843-4134. E-mail: g.silva02@unesp.br.

[2] Bacharel em Direito Cirurgião-dentista. Mestre e Doutor pela Universidade de São Paulo - USP. Pós-Doutor em Direito Internacional da Saúde (USP), em Antropologia Forense (Universidade de Coimbra) e em Ciências Forenses (Universidade Estadual Paulista - UNESP). Doutorando (2o doutorado) em Ciências Forenses (cotutela entre a UNESP e a Universidade de Alcalá, Espanha). Especialista em Odontologia Legal, em Cirurgia e Traumatologia Bucomaxilofacial e em Metodologia do Ensino de Anatomia Humana. Líder do Grupo de Pesquisa "Núcleo de Ciências Forenses, Bioética, Biodireito e Ética em Ciência e Tecnologia de Araraquara", cadastrado junto ao CNPq. ORCID: http://orcid.org/0000-0002-5401-6265. E-mail: cms.fernandes@unesp.br.

[3] Advogada. Cirurgiã-dentista. Licenciada em Letras. Pós-Doutora em Bioética pela Universidade Complutense de Madri, em Direito Internacional da Saúde pela Universidade de São Paulo - USP e em Antropologia Forense pela Universidade de Coimbra. Livre-docente em Odontologia Legal (Universidade Estadual Paulista -Unesp). Líder do Grupo de Pesquisa "Núcleo de Ciências Forenses, Bioética, Biodireito e Ética em Ciência e Tecnologia de Araraquara", cadastrado junto ao CNPq. Professora Titular da Faculdade de Odontologia de Araraquara-Unesp. Coordenadora da Pós-graduação stricto sensu, área de Ciências Forenses, Unesp. Coordenadora do Acordo de Cooperação Acadêmica entre a UNESP e a Universidade de Alcalá – UAH, Espanha. Professora e pesquisadora convidada da Universidade de Alcalá, Espanha, e da Universidade do Porto, Portugal. ORCID: https://orcid.org/0000- 0001-8820-2982. E-mail: monica.serra@unesp.br.

das Constituições e das legislações correlatas, com o objetivo de delinear seus sistemas de saúde, além de pesquisa documental em bases de dados oficiais para levantamento do número de ações judiciais relacionadas ao acesso à saúde. Os resultados indicam que tanto a Constituição Federal brasileira quanto a Constituição portuguesa asseguram o direito à proteção da saúde. No que se refere à judicialização, observa-se no Brasil um crescimento exponencial do número de processos, impulsionado pelo setor público e, sobretudo, pela Saúde Suplementar. Em Portugal, por sua vez, o aumento é contínuo, porém estável e com volume absoluto significativamente menor.

Palavras-chave: Saúde; Judicialização; Direito comparado; Portugal; Constituição.

Introduction

The Brazilian legal system establishes health as a central pillar of its system of social rights. The 1988 Federal Constitution enshrined, in Article 196, that health is a right of all and a duty of the State. This fundamental provision ensures universal and equal access to services and actions aimed at the promotion, protection, and recovery of health, with all levels of government responsible for structuring universal and comprehensive services. The healthcare model adopted in Brazil, the Unified Health System (SUS), is therefore predominantly public (Brazil, 1988).

As a result of this constitutional provision, the Federal Supreme Court (STF) has consolidated the understanding that the right to health, although established as a programmatic norm, must be guaranteed by the State in concrete cases, with joint responsibility shared by the Federal Government, States, and Municipalities. The Court's position seeks to ensure the effectiveness of this fundamental and human right, preventing the constitutional provision from becoming an "inconsequential constitutional promise" (Oliveira, 2013, p. 80).

On the other hand, while legal practitioners tend to understand health as an individual right, the State, as guarantor of this right, operates from a collective perspective, creating distortions between the public policies effectively implemented and the individual needs of a given citizen (Ribeiro; Lima, 2022, p. 22–23).

In this context, both legal doctrine and case law have engaged in a debate regarding the tension between two central premises in the realization of the right to health: the safeguard of the existential minimum and the "reserve of the possible" clause. On one hand, there is the argument that the State has a duty to provide the basic conditions indispensable to a dignified life, including unrestricted access to healthcare; on the other, it is argued that positive state obligations face factual and budgetary constraints, being

conditioned upon the actual financial capacity of the Public Administration. Notwithstanding this tension, higher courts and leading doctrine have consolidated the understanding that budgetary limitations do not constitute a legitimate justification for refusing essential services that ensure a basic level of human dignity, particularly regarding the fundamental right to health (Sarlet; Figueiredo, 2007, p. 183–184).

The divergence in perspectives also extends to the way public policies in this field are structured. One line of thought approaches health from an essentially public perspective, adopting the principle of equity as an indispensable guideline for the implementation of such policies. In contrast, another approach interprets the healthcare sector through an economic paradigm, advocating for the adoption of selectivity and rationalization criteria in State action within this domain (Nogueira; Pires, 2004, p. 758).

As will be discussed further, the Brazilian Constitution established a predominantly public model. During the drafting of the 1988 Constitution, social participation was particularly significant, especially regarding provisions related to the right to health. The coordinated action of civil society organizations, professionals in the field, and activists was decisive in consolidating the healthcare model that remains in force today. Since then, specialized literature has emphasized the imperative of materializing this right, assigning to the State the duty to adopt effective and comprehensive public policies. From this perspective, the realization of the right to health in Brazil cannot be subject merely to the discretion of public administrators (Dallari, 1988, p. 58). Despite this, there remains a profound gap between the normative framework established by the Federal Constitution and the factual reality of access to healthcare, a deficiency that more severely affects socially and economically vulnerable populations (Oliveira, 2013, p. 80).

Despite the legally established model, there is a significant gap between the ideal of universality provided for in the Constitution and the reality of access to healthcare in Brazil, especially for lower-income populations. This gap has led to the intense phenomenon of the judicialization of healthcare. Lawsuits are filed daily by citizens seeking to secure medical treatment through the Judiciary in the face of omissions by the Executive Branch (Oliveira, 2013, p. 87).

It is important to note, however, that specialized doctrine attributes a substantial portion of the increase in litigation to civic maturation and greater awareness among the population, especially its most vulnerable segments, regarding their constitutional and fundamental rights. The profile of litigants often indicates social vulnerability and

economic hardship, with many claimants represented by the Public Defender's Office. These lawsuits frequently seek medications not included in the official SUS list (Ferraz, 2019, p. 2).

A 2016 study showed that almost all lawsuits requesting medications obtain preliminary injunctions favorable to citizens (Catanheide; Lisboa; Souza, 2016, p. 1335). In the Federal District, between 2005 and 2010, most cases demanded access to ICU beds. Since a large portion of claimants were represented by the Public Defender's Office, it is evident that low-income individuals are those who most frequently resort to the Judiciary in such cases (Diniz; Machado; Penalva, 2014, p. 591–593). In Minas Gerais, although the Public Defender's Office acted in only 23.1% of the cases, most plaintiffs (retirees, homemakers, students, and unemployed individuals) also confirmed this profile of economic vulnerability (Machado et al., 2011, p. 592). Another study conducted in Pernambuco, Rio Grande do Sul, and Minas Gerais revealed that the Public Defender's Office participated in 71.5% of cases. Preliminary injunctions were granted in 91.2% of cases, and 97.8% of final decisions favored patients (Travassos et al., 2013, pp. 3419–3422). In Rio de Janeiro (2007–2008), cases were characterized by three main features: individual medical prescriptions, plaintiffs with limited financial resources, and urgency in the claims (Ventura et al., 2010, p. 79).

Generally, these lawsuits benefit only the individual claimant, without generating broader improvements for society (Freitas; Fonseca; Queluz, 2020, p. 5). Furthermore, many claims involve medications that are not included in the SUS list. In Rio de Janeiro, 80% of cases adjudicated at the appellate level required medications not provided by the government, a situation like that observed in Espírito Santo and Minas Gerais (Pepe et al., 2010, p. 2405–2412).

In order to deal with this high volume of cases, the National Council of Justice (CNJ) has adopted several measures to improve the efficiency of judicial decisions, such as issuing resolutions to guide judges, creating the Health Forum, and establishing Technical Support Centers (NATs), which provide medical opinions (Schulze, 2015, p. 4).

In contrast to the complex Brazilian scenario, Portugal also has a healthcare system structured on principles of universality, but with a different dynamic. The Portuguese Constitution of 1976 enshrines the right to health protection in Article 64. This right is implemented through a universal and general National Health Service (SNS),

which is predominantly free of charge. The Portuguese system emphasizes family-based intervention and a closer approach to disease management (Portugal, 1976).

The Portuguese healthcare system is characterized by the coexistence of three components: the National Health Service, linked to the Ministry of Health; public support subsystems; and private entities. The State has the duty to ensure access to preventive, curative, and rehabilitative care, guaranteeing adequate nationwide coverage of human resources and infrastructure. Law No. 95/2019, which established the new Basic Health Law in Portugal, reaffirms the central role of the SNS, while also providing for greater integration with private entities, provided that the public and universal nature of the service is not compromised (Portugal, 2019).

Considering the intensity of the judicialization phenomenon in Brazil and the sensitivity of the issue, this study is justified by the relevance of conducting comparative analyses. Examining solutions and dynamics adopted by other systems, such as the Portuguese one, may offer valuable contributions to addressing the complex issue of judicialization in access to public healthcare in Brazil.

Thus, this article specifically proposes a comparative analysis of health legislation and the growth of judicial actions concerning access to healthcare in Brazil and Portugal, focusing on the period from 2020 to 2023. The objective is to gather official data on the volume and pace of healthcare litigation in both countries (public and private/supplementary), to answer the central research question: What is the level of judicialization of access to healthcare in Brazil compared to Portugal?

1. Methodology

For the integrative literature review, works related to access to healthcare, judicialization, the judicialization of healthcare, and healthcare systems in Brazil and Portugal were selected.

Regarding the documentary research, data were collected on the number of judicial cases related to access to healthcare from official databases in Brazil and Portugal. The Constitutions and related legislation of both countries were also analyzed. The collected data were categorized and classified, including the number of cases filed per year and the proportion of cases relative to the population.

Specifically concerning Brazilian case data, these were obtained from the “Justice in Numbers” platform of the National Council of Justice (CNJ), by accessing the Health

Dashboard (https://justica-em-numeros.cnj.jus.br/painel-saude/). The filters "Health," "Public Health," and "Supplementary Health" were applied for the years 2020 to 2023. Brazilian population data were obtained from IPEA (https://www.ipeadata.gov.br/).

Data on cases in Portugal were collected through consultation of the Institute for Financial Management and Justice Infrastructure of Portugal (https://www.dgsi.pt/), with the search covering the following courts: Constitutional Court, Supreme Administrative Court, Court of Conflicts, Porto Court of Appeal, Lisbon Court of Appeal, Coimbra Court of Appeal, Guimarães Court of Appeal, and Évora Court of Appeal. The data collection in Portugal also presented limitations. Unlike Brazil, Portugal does not have a database specifically dedicated to cases concerning access to healthcare; therefore, the search is text-based, relying on the wording of judicial decisions issued by the courts.

.

2. Health legislation in Brazil

The legal architecture of healthcare in Brazil is deeply rooted in the project of a Democratic State governed by the rule of law, as outlined by the 1988 National Constituent Assembly. The 1988 Federal Constitution elevated healthcare to a unique status by recognizing it as a fundamental right. This recognition is not isolated, as Article 6 of the Constitution includes health among social rights, placing it alongside essential prerogatives for a dignified existence, such as education, housing, and work. The normative framework that follows details State responsibilities and the interaction between the public and private systems (Brazil, 1988).

The organizing principle of the system is established by Article 196 of the Constitution, which serves as the cornerstone of Brazilian health policy. This provision categorically declares that "health is a right of all and a duty of the State." This precept not only ensures universal and equal access to health services and actions but also determines that such actions must focus on the promotion, protection, and recovery of health, as well as on reducing the risk of diseases and other health hazards. The State's obligation goes beyond merely providing assistance, encompassing responsibility for the formulation of social and economic policies that directly affect the determinants of collective health (Brazil, 1988).

Furthermore, Article 197 establishes that health actions and services are of public relevance, assigning to the Public Authority the responsibility to regulate, supervise, and control them. Although the provision of these services may occur either

directly by the State or through third parties, such as private legal or natural persons, regulatory authority remains with the State (Brazil, 1988).

The Unified Health System (SUS) is formally established by Article 198 of the Constitution and is conceived as a regionalized and hierarchical network of public health services and actions. The SUS is organized under three crucial guidelines: decentralization (with a single direction at each level of government), comprehensive care (prioritizing preventive actions), and community participation. Its funding is tripartite, deriving from the budgets and social security resources of the Federal Government, States, the Federal District, and Municipalities (Brazil, 1988).

However, advances in healthcare and its recognition as a fundamental right were only consolidated in the Brazilian Constitution after a long period of political and legal struggles and debates. Until 1988, there were no constitutional provisions that expressly and comprehensively guaranteed the right to health for the entire population (Sturza; Lucion, 2022, p. 85).

From this perspective, the very phenomenon of the judicialization of healthcare in Brazil is relatively recent, both due to the recent inclusion of health among fundamental rights in historical terms and the increasing awareness of citizens regarding their own rights (Silva; Silva, 2018, p. 323).

The participation of the private sector in the system is strictly regulated by Article 199. This provision guarantees the freedom of private healthcare provision but limits its collaboration with the SUS to a strictly complementary role, carried out through agreements or public law contracts. The Constitution gives preference to philanthropic and non-profit entities and expressly prohibits the allocation of public resources to subsidize private institutions with profit-making purposes. It also establishes restrictions on foreign capital participation in healthcare, except in cases provided for by law (Brazil, 1988).

In this regard, there is a genuine paradox between the provision of private healthcare services and the universality of the SUS itself, insofar as the profit-driven nature of the private healthcare sector, although constitutionally defined as complementary, tends to be amplified by deficiencies in the public system (Dussel, 2023, p. 160).

Complementing this structure, Article 200 details the specific competencies of the SUS. These include the control and inspection of substances and products of health interest, the execution of sanitary and epidemiological surveillance actions, the

organization of human resources training for the sector, and collaboration in environmental protection (Brazil, 1988).

To implement these provisions, infra-constitutional legislation established Law No. 8,080 of 1990, known as the Organic Health Law. It regulates the conditions for promotion, protection, and recovery of health. This law reiterates health as a fundamental human right and reaffirms the duty of the State to ensure its full exercise, including through the formulation of economic and social policies aimed at reducing health risks (Brazil, 1990).

Law No. 8.080/90 also broadened the concept of health, recognizing that its determinants and conditioning factors are extensive, including crucial elements such as food, housing, sanitation, environment, work, and income. Under this legal framework, the SUS is defined as the organic set of health services and actions provided by public institutions at the federal, state, and municipal levels, whether under direct or indirect administration. Its scope of action is therefore comprehensive, encompassing workers' health, pharmaceutical policy, and the control of products relevant to health (Brazil, 1990).

The provision of services within the SUS whether carried out by public entities or contracted private providers, must adhere to a set of principles and guidelines set forth in Article 7 of the Organic Health Law. These pillars include universal access at all levels of care, comprehensiveness of care (integrating curative and preventive actions), equality of care (free from discrimination), community participation, and political-administrative decentralization. The system's management is hierarchical and regionalized, exercised by Health Departments at their respective levels of government, with intergovernmental commissions promoting federal cooperation (Brazil, 1990).

Parallel to the SUS, Brazil has developed a robust supplementary health sector. This market is subject to strict State regulation, primarily through Law No. 9,656 of 1998. This statute defines a "Private Health Care Plan" as the continuous provision of services or coverage of healthcare costs, aimed at ensuring medical, hospital, and dental assistance (Brazil, 1998).

Health insurance legislation establishes essential criteria for consumer protection. Among these is the requirement to offer a "reference plan," which serves as the minimum standard of coverage, including childbirth and treatment for all diseases listed in the World Health Organization's International Classification of Diseases (ICD). The law also prohibits the exclusion of coverage for pre-existing conditions after a

waiting period of 24 months. Furthermore, it forbids denying participation in health plans based on age or disability status (Brazil, 1998).

Finally, the regulation and supervision of this private sector are entrusted to the National Supplementary Health Agency (ANS), created by Law No. 9,961 of 2000. The ANS is an autonomous regulatory agency linked to the Ministry of Health, whose mission is to promote the public interest in supplementary healthcare. Its responsibilities include defining the list of mandatory coverage procedures, regulating reimbursement to the SUS for services provided to insured individuals, authorizing premium adjustments, and supervising health plan operators. In this way, the Brazilian State acts as a strong regulatory agent in the private market, ensuring sectoral balance and consumer protection (Brazil, 2000).

3. Health legislation in Portugal

The legal protection of health in Portugal is grounded in an articulated set of constitutional and infra-constitutional norms that shape the structure and functioning of the national healthcare system, as well as the content of the fundamental right to health protection. The starting point is the 1976 Constitution, which enshrines health as a social right and imposes on the State a set of positive obligations aimed at ensuring the material and institutional conditions necessary for its realization. From this foundation, a comprehensive body of legislation has developed, regulating services, stakeholders, financing mechanisms, and regulatory instruments within the sector (Portugal, 1976).

Article 64 of the Portuguese Constitution establishes that everyone has the right to health protection, while simultaneously recognizing an individual duty to promote it. The constitutional provision does not limit this right to mere access to clinical services; rather, it incorporates it into a broader conception of health that encompasses economic, social, cultural, and environmental factors. Accordingly, the State must adopt policies that promote adequate living and working conditions, health education, and healthy lifestyles. This reflects an integrated approach to the right to health, grounded in the understanding that health protection depends on multiple dimensions of social life (Portugal, 1976).

The same constitutional provision determines that the right to health is realized through a universal and general National Health Service (SNS), which is predominantly free of charge. This mandate binds the ordinary legislator and guides all administrative

action in the provision of care. The notion of "predominant gratuity," a typical feature of Portuguese social constitutionalism, rejects the idea of a fully free system, while requiring that any financial contributions by users be exceptional in nature, limited to mechanisms aimed at moderating service use rather than serving as structural funding for the SNS (Portugal, 1976).

Furthermore, the Constitution sets forth concrete obligations for the State: to guarantee access to preventive, curative, and rehabilitative care; to ensure adequate nationwide coverage of human resources and infrastructure; to socialize medical and pharmaceutical costs; to supervise the private practice of medicine and coordinate the private sector with the SNS; and to regulate the production and distribution of pharmaceutical and biological products. These provisions demonstrate a healthcare model in which the State plays a central role, not only as a provider but also as a regulator and supervisor of health-related activities (Portugal, 1976).

Another relevant constitutional provision is Article 59, which protects health within the context of labor relations. By establishing the right of workers to conditions of hygiene, safety, and health in the workplace, the Constitution integrates occupational health into the broader system of health protection. This reinforces the idea that the right to health extends beyond access to SNS, permeating various domains of social and economic life. This provision underpins specific public policies and employer obligations aimed at preventing occupational risks (Portugal, 1976).

At the infra-constitutional level, Law No. 48/90, known as the Basic Health Law, served for nearly three decades as the main legal framework for the organization of the Portuguese healthcare system. It established the general principles of health policy, defined shared responsibility among the State, citizens, and society, and regulated the structure of the SNS and its coexistence with the private sector. The law recognized that the State must ensure access to healthcare in accordance with available resources, governed the articulation between primary and specialized care, and provided for mechanisms of evaluation, efficiency, and quality in healthcare services (Portugal, 1990).

This law also detailed the rights and duties of users, including mutual respect, cooperation with healthcare professionals, and the payment of user charges in applicable cases. It further established guidelines regarding the status of healthcare professionals, covering training, professional ethics, mobility, and regulation. By defining these foundations, the 1990 statute played a structuring role in consolidating the SNS after the revolutionary and institutional reorganization period of the 1970s (Portugal, 1990).

However, demographic, technological, and organizational changes in the healthcare system over time made it necessary to update this legal framework. Accordingly, in 2019, Law No. 95/2019 was enacted, repealing Law No. 48/90 and establishing a new Basic Health Law. This new legislation reaffirms the right to health and the role of the State, while reorganizing principles of management, financing, participation, and system regulation. It reinforces the centrality of the SNS and provides for greater integration between public and private entities, ensuring that partnerships or management models do not compromise the public and universal nature of the service (Portugal, 2019).

The 2019 Basic Health Law also serves as a foundation for complementary legislation and for the revision of existing norms, aligning the legal system with the new regulatory framework. By modernizing concepts and redefining institutional roles, it seeks to address challenges related to financial sustainability, service quality, and the increasing technological complexity of the healthcare sector (Portugal, 2019).

In addition to the Basic Health Laws, other legal instruments play essential roles in the governance of the healthcare system. Decree-Law No. 82/2009 establishes the structure and competencies of the Health Authorities, responsible for epidemiological surveillance and public health actions (Portugal, 2009). Decree-Law No. 49/2016 regulates the National Health Council, a consultative body focused on social participation and strategic deliberation in the sector (Portugal, 2016). Decree-Law No. 127/2009 governs the Health Regulatory Authority (ERS), responsible for supervising the quality, safety, and legality of activities carried out by public and private providers (Portugal, 2009).

Taken together, this normative framework demonstrates that the right to health in Portugal is structured around a strong public model, comprehensively regulated and subject to mechanisms of supervision and social participation. The interplay between the Constitution, basic laws, and regulatory decrees reflects a systematic effort to ensure not only access to care, but also quality, safety, transparency, and sustainability.

Thus, the Portuguese legal system constructs health as a fundamental right whose realization requires broad public policies, a robust SNS, and effective mechanisms of regulation and evaluation. This normative structure not only defines rights and duties, but also organizes the entire functioning of the sector, constituting the legal foundation for State action and for the protection of citizens in the field of health.

4. Results and discussion

An initial analysis of the comparative data reveals a striking asymmetry in the volume of healthcare litigation between Brazil and Portugal, covering the four-year period from 2020 to 2023. In the Brazilian context, a sharp expansion in the number of lawsuits was observed. The increase occurred across all cases classified as "Health – General," which experienced a substantial rise, driven by significant growth in both the public healthcare sector and, more markedly, in the supplementary (private) healthcare sector.

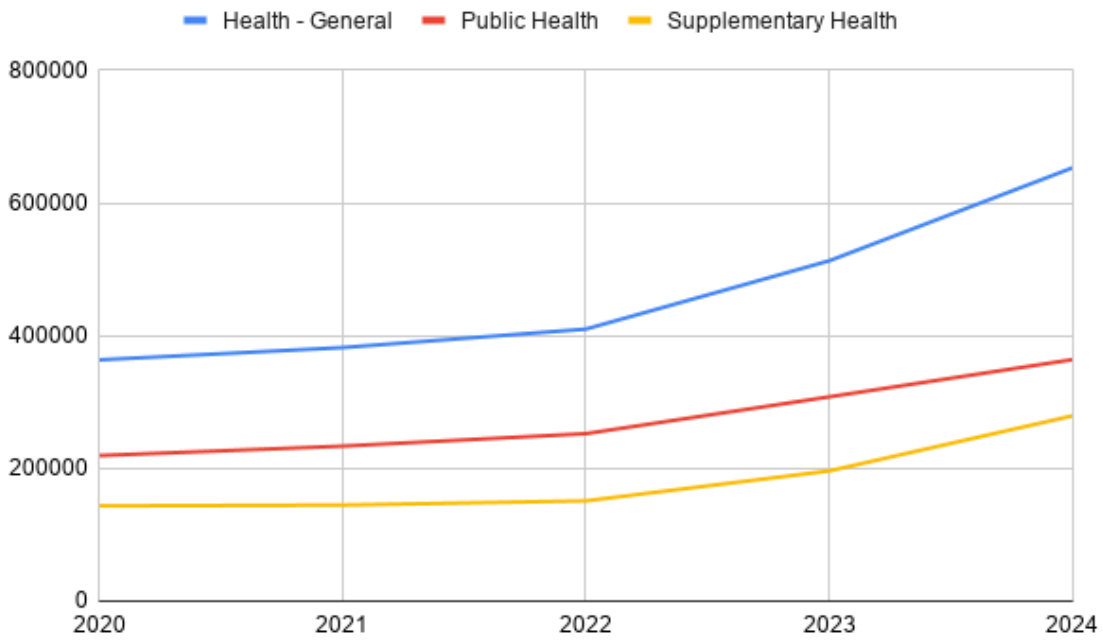

Figure 1 – Growth in healthcare-related litigation in Brazil: General Health, Public Health, and Supplementary Health.

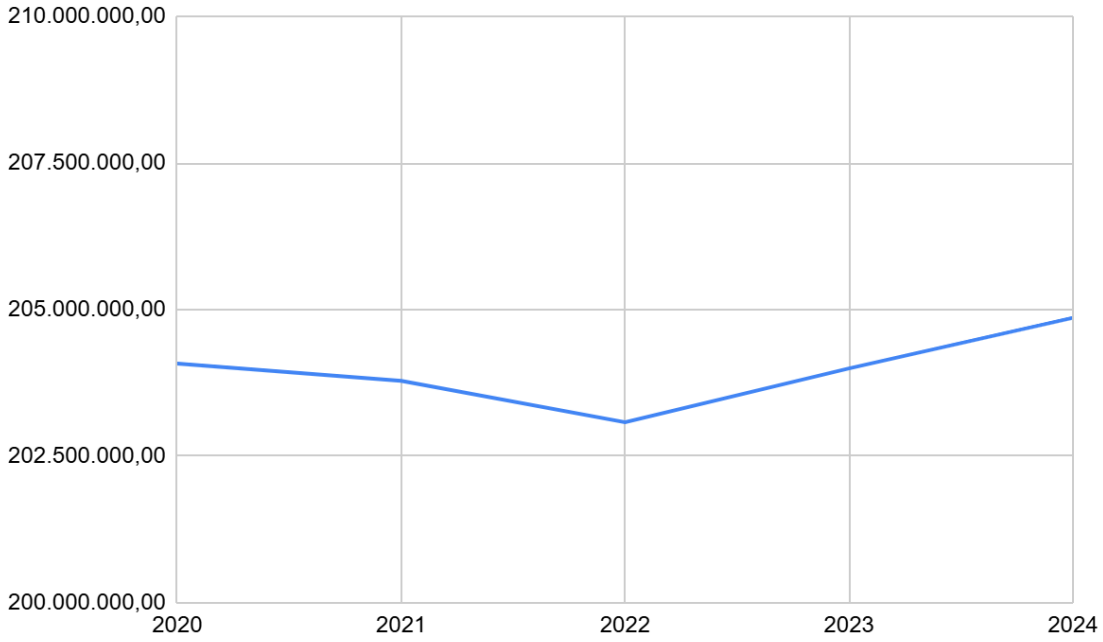

Figure 2 – Population growth in Brazil (2020–2023).

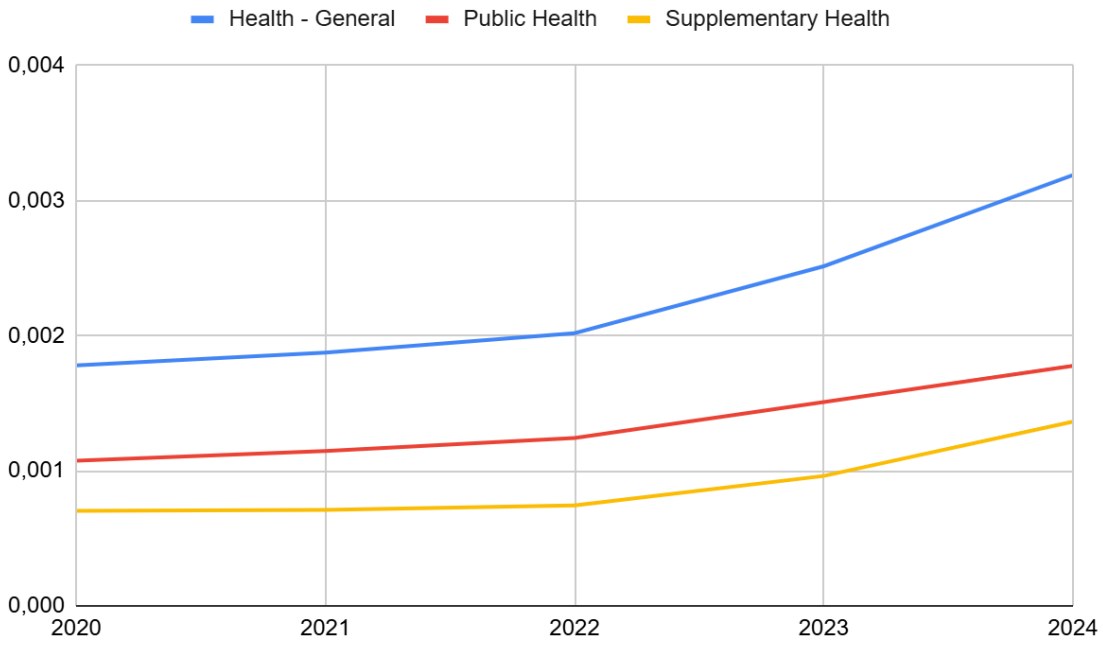

Figure 3 – Proportional relationship between healthcare-related lawsuits and the Brazilian population.

This Brazilian growth occurred within a demographic context of low variation. During the analyzed period (2020–2023), the country's population showed modest growth, remaining within the range of approximately 204 million inhabitants.

Consequently, the impact of litigation, when adjusted for population size, became significant: the proportion of lawsuits relative to the population tripled, rising from approximately 0.001 to over 0.003. As observed, the supplementary health sector was the segment that contributed most to this intensification, exhibiting both the highest and fastest-growing proportion. Brazil, therefore, demonstrates a disproportionate reliance on the Judiciary to resolve healthcare-related issues, even after adjusting for population.

In contrast, data from Portugal show continuous but stable growth in healthcare-related lawsuits between 2020 and 2023, both overall and within the public and private healthcare sectors.

A progressive increase is observed, although in relatively low absolute numbers when compared to Brazil. At the same time, Portuguese population growth shows minimal variation, with fluctuations of approximately one million inhabitants over the period, resulting in a stable and low-intensity ratio between lawsuits and population.

This finding suggests that the increase in judicial demands in Portugal is less associated with population growth and more related to internal factors within the healthcare system, such as funding patterns, administrative organization, and levels of user satisfaction, as well as increasing awareness of social and healthcare rights.

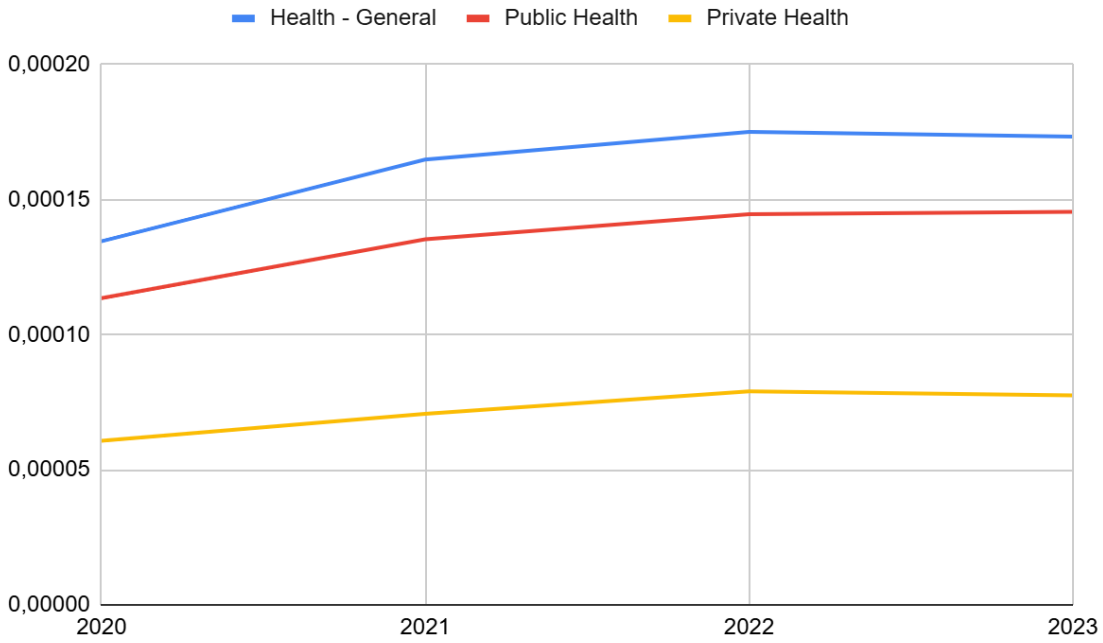

Figure 4 – Growth in healthcare-related lawsuits in Portugal: General Health, Public Health, and Supplementary Health.

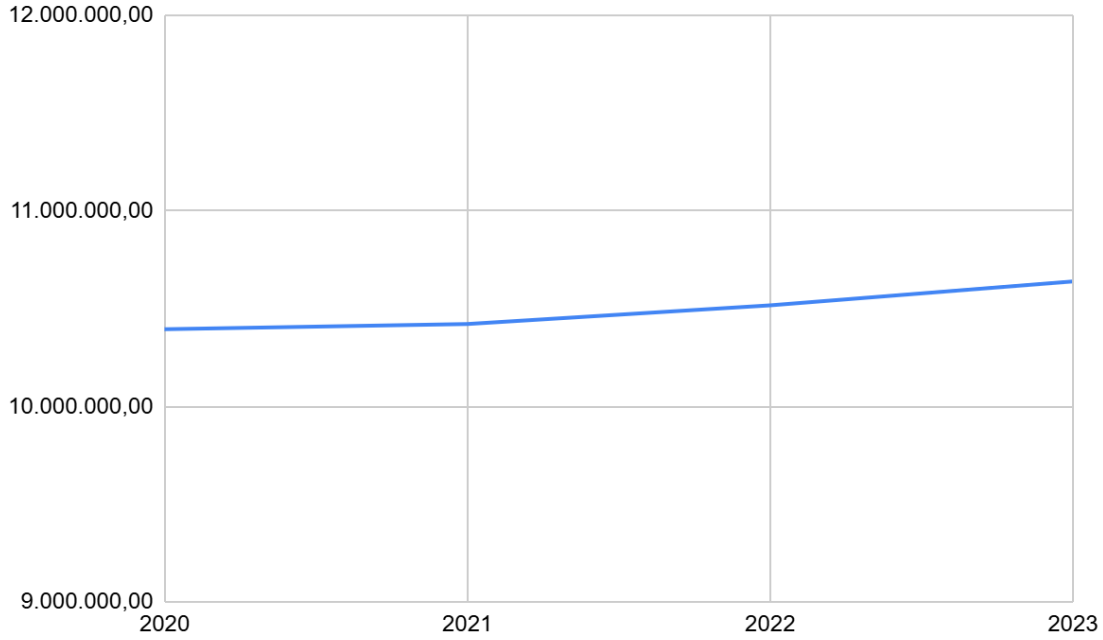

Figure 5 – Population growth in Portugal (2020–2023).

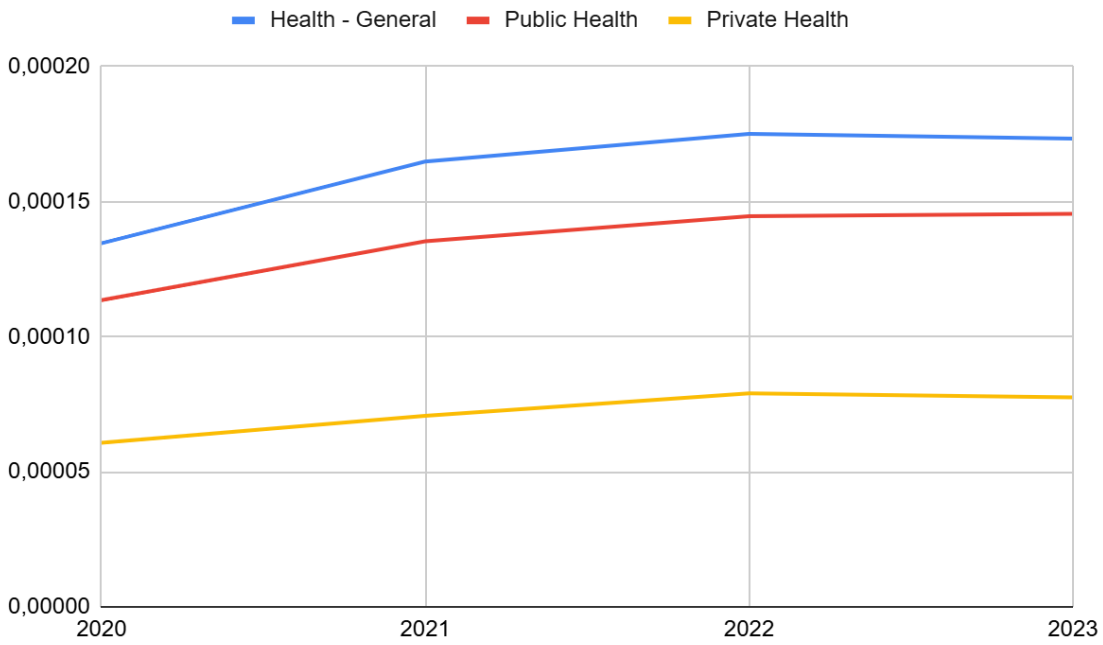

Figure 6 – Proportional relationship between healthcare-related lawsuits and the Portuguese population.

A direct comparison demonstrates that the phenomenon of judicialization in Brazil is not only greater in absolute numbers, but also disproportionately more intense when adjusted for population, indicating a higher reliance on the judicial system to resolve healthcare-related issues.

An analysis of the annual growth rates of lawsuits further deepens the understanding of the dynamics of this phenomenon in each country.

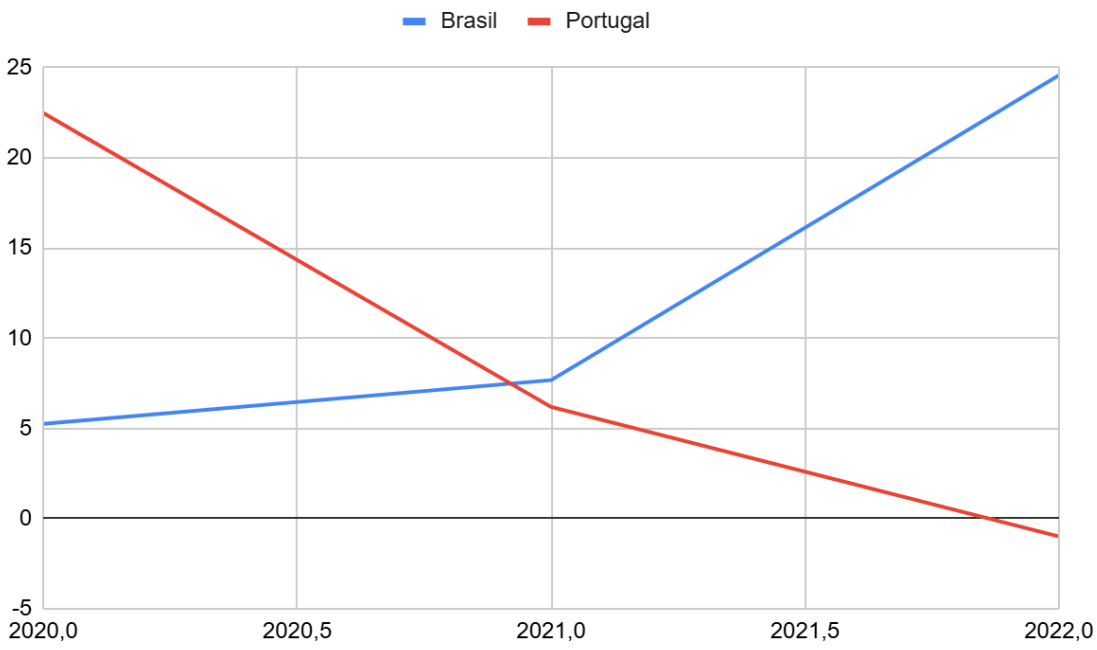

Figure 7 – Growth rate of healthcare litigation.

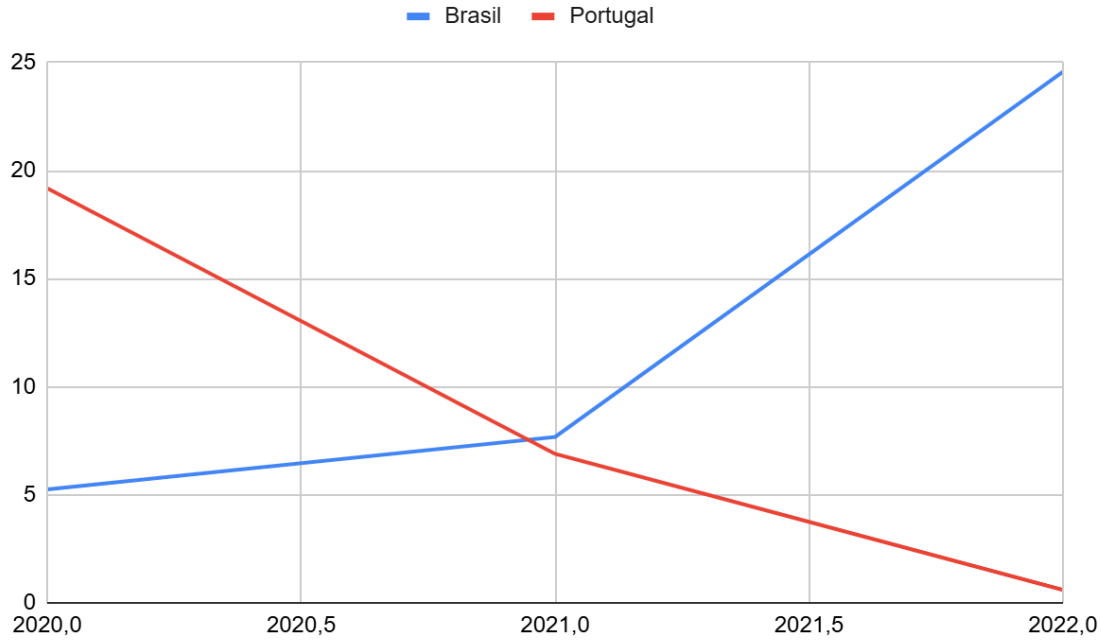

Figure 8 – Growth rate of public health litigation.

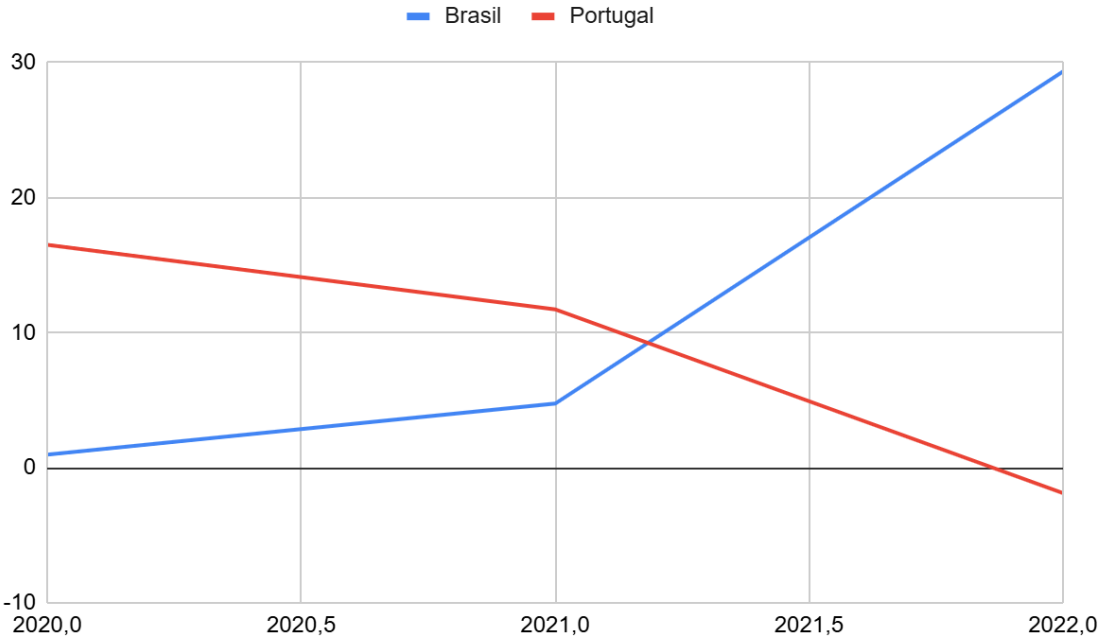

Figure 9 – Growth rate of private and supplementary health litigation.

The analysis of the growth rates of judicial actions highlights relevant structural differences between the two countries in the way health judicialization develops and interacts with their respective social protection systems. In the comparative graphs, Brazil

exhibits significantly more pronounced variations than Portugal between 2020 and 2022, both in overall healthcare and within the public and supplementary sectors. Such fluctuations reflect an internal dynamic characterized by greater volatility and high sensitivity to conjunctural factors.

In Portugal, in contrast, the behavior of the curve indicates a relative reduction in judicialization when considered in relation to population growth. The growth rates of lawsuits remain within narrow intervals, even in the face of significant external pressures, such as those arising from the COVID-19 crisis. This pattern suggests lower permeability of the Portuguese healthcare system to judicialization, as well as greater institutional predictability and administrative stability. Factors such as centralized management, a smaller population size, and reduced segmentation between public and private sectors may contribute to containing litigation.

Thus, the comparison of growth rates goes beyond merely quantifying differences between the two countries, revealing how institutional, normative, and social elements shape the population's strategies for accessing the judiciary. The data indicate that, while in Portugal judicialization evolves in a more controlled and predictable manner, in Brazil it intensifies more abruptly, functioning as a recurring mechanism for claiming rights, compensating for systemic failures, and exerting pressure on public health policies.

Conclusion

The present study proposed a comparative analysis of the legislation and the intensity of the judicialization of access to healthcare in Brazil and Portugal, focusing on the period from 2020 to 2023. The research encompassed both the public and the private/supplementary healthcare systems in both countries.

The analysis of the legal frameworks demonstrated that the Constitutions of both nations enshrined the right to health protection. In Brazil, the 1988 Federal Constitution establishes health as a fundamental right and a duty of the State, structuring the Unified Health System (SUS) as a universal and comprehensive model. Additionally, Brazil has strong regulation of the supplementary health sector, grounded in Law No. 9,656/98. Similarly, in Portugal, Article 64 of the 1976 Constitution guarantees the right to health protection, implemented through the National Health Service (SNS), which is universal, general, and predominantly free of charge.

However, the comparison of empirical data on the volume of litigation between 2020 and 2023 revealed a marked disparity in the intensity of the judicialization phenomenon. Brazil exhibited exponential growth in the number of lawsuits. With the Brazilian population remaining around 204 million inhabitants, the proportion of legal actions relative to the population tripled, with the supplementary healthcare sector showing the highest and fastest-growing proportion.

In sharp contrast, Portugal showed continuous but stable growth in healthcare-related lawsuits, with a relatively low absolute volume. Given that Portugal's population growth exhibited minimal variation (fluctuations of approximately one million inhabitants over the period), the proportion of lawsuits per capita remained stable and low in intensity. The analysis of annual growth rates revealed that Brazil experienced significantly more intense and volatile variations. In Portugal, the trend curve indicated a decrease in judicialization when compared to population growth, suggesting greater institutional predictability and lower permeability to judicial claims.

In conclusion, the phenomenon of judicialization in Brazil is disproportionately more intense and accelerated than in Portugal. The data demonstrate that, while in Portugal litigation expands in a controlled and predictable manner, in Brazil it intensifies more abruptly, functioning as a continuous channel for claiming rights, compensating for systemic failures, and exerting pressure on public health policies. These findings reinforce the importance of comparative studies, as solutions identified in more stable systems may contribute to mitigating the growing complexity of judicialization in Brazil.

References

BRASIL. Constituição Federal da República Federativa do Brasil. 1988.

BRASIL. Lei nº 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. Brasília, DF: Presidência da República. Publicado no DOU de 20 set. 1990.

BRASIL. Lei nº 9.656, de 3 de junho de 1998. Dispõe sobre os planos e seguros privados de assistência à saúde. Brasília, DF: Presidência da República. Publicado no DOU de 4 jun. 1998.

BRASIL. Lei nº 9.961, de 28 de janeiro de 2000. Cria a Agência Nacional de Saúde Suplementar – ANS e dá outras providências. Brasília, DF: Presidência da República. Publicado no DOU de 29 jan. 2000, Edição Extra.

CATANHEIDE, Izamara Damasceno; LISBOA, Erick Soares; SOUZA, Luis Eugenio Portela Fernandes de. Características da judicialização do acesso a medicamentos no Brasil: uma revisão sistemática. **Physis: Revista de Saúde Coletiva**, Rio de Janeiro, v. 26, n. 4, p. 1335-1356, 2016.

DALLARI, Sueli Gandolfi. O direito à saúde. **Revista de Saúde Pública**, São Paulo, v. 22, n. 1, p. 57-63, 1988.

DINIZ, Debora; MACHADO, Teresa Robichez de Carvalho; PENALVA, Janaina. A judicialização da saúde no Distrito Federal, Brasil. **Ciência & Saúde Coletiva**, v. 19, n. 2, p. 591-598, 2014.

DUSSEL, Enrique. O princípio da vida contra o princípio da morte: os direitos humanos e o neoliberalismo. **Revista Culturas Jurídicas**, Niterói/RJ, v. 10, n. 27, p. 155-164, set./dez. 2023.

FERRAZ, Octávio Luiz Motta. Para equacionar a judicialização da saúde no Brasil. **Revista Direito GV**, São Paulo, v. 15, n. 3, e1934, set./dez. 2019.

FREITAS, Beatriz Cristina de; FONSECA, Emílio Prado da; QUELUZ, Dagmar de Paula. A Judicialização da saúde nos sistemas público e privado de saúde: uma revisão sistemática. **Interface - Comunicação, Saúde, Educação**, Botucatu, v. 24, e190345, 2020.

MACHADO, Marina Amaral de Ávila et al. Judicialização do acesso a medicamentos no Estado de Minas Gerais, Brasil. Revista de Saúde Pública, v. 45, n. 3, p. 590-598, 2011.

NOGUEIRA, Vera Maria Ribeiro; PIRES, Denise Elvira Pires de. Direito à saúde: um convite à reflexão. **Cadernos de Saúde Pública**, Rio de Janeiro, v. 20, n. 3, p. 753-760, maio/jun. 2004.

OLIVEIRA, Maria dos Remédios Mendes. A judicialização da saúde no Brasil. **Tempus - Actas de Saúde Coletiva**, v. 7, n. 1, p. 79-90, 2013.

PEPE, Vera Lúcia Edais *et al*. A judicialização da saúde e os novos desafios da gestão da assistência farmacêutica. **Ciência & Saúde Coletiva**, v. 15, n. 5, p. 2405-2414, 2010.

PORTUGAL. Constituição da República Portuguesa: de 2 de abril de 1976. Aprovada pela Assembleia Constituinte, reunida na sessão plenária de 2 de abril de 1976.

PORTUGAL. Decreto-Lei n.º 82/2009, de 2 de abril. Estabelece as regras de designação, competência e funcionamento das entidades que exercem o poder de autoridade de saúde. Publicado no Diário da República, 1.ª série, n.º 65, de 2 de abril de 2009.

PORTUGAL. Decreto-Lei n.º 49/2016, de 23 de agosto. Estabelece o regime jurídico do Conselho Nacional.

PORTUGAL. Lei n.º 48/90, de 24 de agosto. Lei de Bases da Saúde. Aprovada em 12 de julho de 1990. Promulgada em 31 de julho de 1990.

PORTUGAL. Lei n.º 95/2019, de 4 de setembro. Aprova a Lei de Bases da Saúde e revoga a Lei n.º 48/90, de 24 de agosto, e o Decreto-Lei n.º 185/2002, de 20 de agosto. Publicada no Diário da República, 1.ª série, n.º 169, de 4 de setembro de 2019, p. 55.

RIBEIRO, Krishina Day Carrilho Bentes Lobato; LIMA, Leandro Cavalcante. Judicialização da saúde e teoria dos sistemas sociais: revisão narrativa. **Revista Culturas Jurídicas**, v. 9, n. 22, p. 48-72, jan./abr. 2022.

SARLET, Ingo Wolfgang; FIGUEIREDO, Mariana Filchtiner. Reserva do possível, mínimo existencial e direito à saúde: algumas aproximações. **Direitos Fundamentais & Justiça**, n. 1, p. 171-213, out./dez. 2007.

SCHULZE, Clenio Jair. O papel do Conselho Nacional de Justiça na judicialização da saúde. In: CONSELHO NACIONAL DE SECRETÁRIOS DE SAÚDE (CONASS). **Direito à Saúde** (Coleção Para Entender a Gestão do SUS). Brasília: CONASS, 2015.

SILVA, Paulo Henrique Tavares da; SILVA, Suely Coelho Tavares da. Judicialização da saúde no Brasil: um diálogo a partir da metódica estruturante de Friedrich Müller. **Revista Culturas Jurídicas**, v. 5, n. 10, p. 314-340, jan./abr. 2018.

STURZA, Janaína Machado; LUCION, Maria Cristina Schneider. Retornando ao passado para compreender o presente: a trajetória de reconhecimento da saúde como direito e importante elemento de cidadania e inclusão social. **Revista Culturas Jurídicas**, v. 9, n. 22, p. 73-98, jan./abr. 2022.

TRAVASSOS, Denise Vieira *et al*. Judicialização da Saúde: um estudo de caso de três tribunais brasileiros. **Ciência & Saúde Coletiva**, v. 18, n. 11, p. 3419-3429, 2013.

VENTURA, Miriam *et al*. Judicialização da saúde, acesso à justiça e a efetividade do direito à saúde. **Physis: Revista de Saúde Coletiva**, Rio de Janeiro, v. 20, n. 1, p. 77-100, 2010.