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HEALTH AND PRIVATE INITIATIVE IN THE BRAZILIAN FEDERAL CONSTITUTION OF 1988: LEGAL PRINCIPLES

A saúde e a iniciativa privada na constituição federal de 1988: princípios jurídicos

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ABSTRACT

This study started from the following question: does the Brazilian Federal Constitution of 1988 point out the constitutional principles that should guide private activity in the health area in the country or is there a gap on the subject? To answer the question, a descriptive research of articles from 196 to 200 of the Constitution of 1988 was conduct in two stages. The methodology used in the first stage was the documentary survey based on the text of the minutes of the Subcommittee on Health of the Constituent Assembly, followed by reflection based on the theoretical framework of Martin Loughlin. The second stage was legal-doctrinal, with the search and selection of scientific articles in the databases Lilacs, Scopus, Web of Science and IUSData, the Library of the Faculty of Law of the *Universidade de São Paulo* (USP), as well as articles, dissertations and theses in the Bibliographic Database of USP (Dedalus) and material of the *Revista de Direito Sanitário*. It was concluded that the regulation of the State on the private initiative (supervision, regulation and control of private services) is guided by the general purposes of health, in constant dialogue with the guidelines of the Brazilian National Health System, in order to contribute and never jeopardize the implementation of the National Health System. Therefore, there are no gaps in the Federal Constitution. The private sector is inserted in the constitutional logic of Health Law, a new branch of law that emerges with the Federal Constitution of 1988.

Keywords

Brazilian Federal Constitution of 1988; Legal Principles of Health; Private Sector.

RESUMO

Este estudo partiu da seguinte pergunta: a Constituição Federal de 1988 aponta os princípios constitucionais que devem nortear a atividade privada na área de saúde no país ou há uma lacuna sobre o tema? Para responder à pergunta, foi realizada pesquisa descritiva sobre os artigos de 196 a 200 da Constituição de 1988 em duas etapas. A metodologia empregada na primeira etapa foi o levantamento documental a partir do texto da ata da Subcomissão de Saúde da Assembleia Constituinte, seguida de reflexão fundamentada no referencial teórico de Martin Loughlin. A segunda etapa foi de natureza jurídico-doutrinária, com a busca e a seleção de artigos científicos nas bases de dados Lilacs, *Scopus, Web of Science* e IUSData, da Biblioteca da Faculdade de Direito da Universidade de São Paulo, bem como artigos, dissertações e teses no Banco de Dados Bibliográficos da USP (Dedalus) e material da Revista de Direito Sanitário. Concluiu-se que a regulação do Estado sobre a iniciativa privada (fiscalização, regulamentação e controle dos serviços privados) é norteada pelas finalidades gerais da saúde, em diálogo constante com as diretrizes do Sistema Único de Saúde, no sentido de contribuir e jamais prejudicar a implementação do Sistema Único de Saúde. Portanto, não há lacunas na Constituição Federal. O setor privado está inserido na lógica constitucional do Direito Sanitário, novo ramo do direito que surge com a Constituição Federal de 1988.

Palavras-Chave

Constituição Federal de 1988; Princípios Jurídicos da Saúde; Setor Privado.

Introduction

Understanding the constitutional principles that guide the activity of the private health sector in Brazil is a necessary and important task. This study aimed to verify whether the Federal Constitution of 1988 (CF/88) points out the constitutional principles that should guide private health activity in the country or if there is a gap on the subject.

The first part of the study addressed the social and political context that led to the edition of articles 196 to 200 of CF/88. The methodology used in the first stage was the documentary survey based on the text of the Minutes of the Subcommittee on Health of the Constituent Assembly, followed by reflection based on Martin Loughlin's theoretical framework.

The second stage of the study had a legal-doctrinal nature. From the LILACS database, scientific articles were selected, using the descriptors of the subject "constitution and statutes" and "right to health", from the Integrated Search Portal using the words "constitution" and "right to health" (refined by "Articles" and "Peer-reviewed journals"), from the base *Scopus* using the words "constitution" and "right to health" and from the Web of Science database using the words "constitution" and " right to health." A search was also done in the IUSData database of the Library of the Law School of the *Universidade de São Paulo* (FDUSP), with the words "constitution" and "health". Finally, a search was carried out in the USP Bibliographic Database (*Dedalus*) and on the website of *Revista de Direito Sanitário*, with the terms "health and public relevance" and "health and private initiative". In the Dedalus, additional research was carried out with the words "health" and "private", and dissertations and theses were examined.

I. Understanding the social and political context that led to the editing of these articles

From the 1970s, in parallel to the country's redemocratization movement, the health reform movement began to consolidate in Brazil. Around this movement, university professors, students, various popular sectors, workers and health professionals from the various regions of the country began the construction of a political thought that could break with the situation of the time. It is worth remembering that, before the CF/88, the population that did not have a formal employment relationship received care from philanthropic institutions (private entities), when existing or available. On the other hand, there were already private health plans that served the formal worker, through the welfare institutes.

In this context, the Brazilian Center for Health Studies (Cebes) was created in 1976 and, ten years later, with the conquest of democracy, the 8th National Health Conference was held, which brought together about 4,000 people – reflecting a

discussion process initiated in state and municipal preparatory conferences that produced texts, debates and round tables that culminated in a final report[1].

From the final report, it appears that the concept of right to health is broad and is related to the social determinants of health: education, work, housing, food, popular participation, universal and egalitarian access, among others.

The creation of a Unified Health System was advocated based on the structuring of the National Health System, totally separate from Social Security. Regarding the organization of services, it was advocated the

> decentralization in service management; integration of actions overcoming the preventive-curative dichotomy; unity in conducting sectoral policies; regionalization and hierarchy of service provider units; population participation through its representative entities, in the formulation of policy, planning, management, execution and evaluation of health actions; strengthening the role of the Municipality; introduction of alternative health care practices within the scope of the health service, allowing the user the democratic right to choose the preferred therapy[2].

On access conditions and quality, the final report of the 8th National Health Conference defended:

> universalization in relation to population coverage starting with needy or totally unassisted areas; equity in relation to access for those in need of attention; timely service according to needs; respect the dignity of users on the part of health service providers and servers, as a clear duty and commitment to their public function; quality care compatible with the stage of knowledge development and with available resources; right of follow-up to hospitalized patients, especially children; right of psychological assistance without the discrimination that currently exists[3].

The report documents the beginning of a broad campaign of popular mobilization to ensure that the Constituent guaranteed the universal right to health, against the commodification of medicine and the improvement of public services. In this context, the characterization of health services as public and essential was defended.

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[1] 8ª CONFERÊNCIA Nacional em Saúde, 17 a 21 de março de 1986. *Relatório final*. Brasília-DF: Ministério da Saúde-MS, Biblioteca Virtual em Saúde. Available at: http://bvsms.saude.gov.br/bvs/publicacoes/8_conferencia_nacional_saude_relatorio_final.pdf.

[2] *Id. Ibid., p.10-11.*

[3] *Id. Ibid., p.11.*

It was recognized, then, the impossibility of nationalization of the private sector, which would require non-existent financial resources, but there was a consensus on the need to expand and strengthen the public sector, making it clear that the participation of the private sector should occur through public service "granted" and the contract, governed by public law norms. Thus, it was defined that the SUS would be the main objective to be achieved, including through the control of private services:

> The main objective to be achieved is the Unified Health System, with expansion and strengthening of the state sector at federal, state and municipal levels, aiming at a progressive nationalization of the sector. Private service providers will now have controlled their operational procedures and directed their actions in the field of health, and abusive profits will be restraining. The private sector will be subordinated to the directive role of state action in this sector, ensuring control of users through its organized segments. In order to ensure the provision of services to the population, consideration should be given to the possibility of expropriation of private establishments in cases of non-compliance with the standards established by the public sector[4] .

The Report of the 8th National Health Conference served as the basis for the work of the 1988 Subcommittee on Health, Security and the Environment[5] of the Constituent Assembly. After the hearing of several entities representing health and population, the Subcommittee elaborated a proposal that mirrored much of the concepts defended at the 8th Conference.

Table 1 presents the text of the Subcommittee and the final text adopted in 1988, with amended order, to match similar devices.

The final text approved by the Constituent Assembly maintained the guiding thread of the proposal presented by the Subcommittee. Thus, the branch of Brazilian Health Law emerged, based on a broad concept of health that permeates several sectors (medicines, food, basic sanitation, environment and work, medical and hospital care), based on universal access, equality, integrality and social participation and, organized through a single health system, decentralized and regionalized.

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[4]8ª CONFERÊNCIA Nacional em Saúde, 17 a 21 de março de 1986. *Relatório final*, *cit*. p. 12.

[5]SENADO FEDERAL. Assembleia Nacional Constituinte. *Atas de Comissões. Subcomissão de Saúde, Seguridade e do Meio Ambiente*. Available at: http://www.senado.leg.br/publicacoes/anais/constituinte/7b_Subcomissao_De_Saude,_Seguridade_E_Meio_Ambiente.pdf. Accessed on: 10 Nov. 2020.

Table 1. Evolution of the constitutional text

Subcommittee text	Text of the CF/88
Article 1. Health is a duty of the state and a right of all. §1 - The State guarantees to all decent living conditions and equal and free access to actions and services of promotion, protection and recovery of health according to their needs. §2 The Law shall provide for the summary rite by which the citizen will demand from the State the right provided for in this article.	Article 196. Health is everyone's right and a duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other health problems, and the universal and equal access to actions and services for its promotion, protection and recovery.
Article 2. The actions and public health services integrate a regional and hierarchical network, and constitute a Single System, organized according to the following guidelines: I - single administrative command at each level of government; II - integrality and continuity in the provision of health actions; III - decentralized management, promoting and ensuring the autonomy of States and Municipalities; IV – participation of the population through representative entities in the formulation of policies and control of actions at the federal, state and municipal levels, in health councils. Article 3. The Unified System is financed by the National Health Fund, with funds from tax revenue. §1 - The State and Municipal Funds are constituted with resources from these political-administrative units of the National Fund. §2 National expenditures for health shall not be less than ten percent of Gross Domestic Product.	Art. 198. The actions and public health services integrate a regional and hierarchical network, and constitute a single system, organized according to the following guidelines: I - decentralization, with a single management in each sphere of the government; II - comprehensive care, with priority to preventive activities, without loss of services of assistance; III - participation of the community. §1 - The single system shall be financed, in accordance with art.195, with resources from the social security budget, the Union, the States, the Federal District and the Municipalities, as well as other sources. §2 - The Union, States, the Federal District and Municipalities shall apply annually, in public health actions and services minimum resources derived from the application of percentages calculated on: [...] §3 Supplementary law, which will be reassessed at least every 5 years, shall establish: [...]

Continues

Continuation

Subcommittee text	Text of the CF/88
Article 4. Health actions are functions of a public nature, and the State is responsible for normalization, execution and control. §1 - The private sector providing health services may collaborate in the coverage of care to the population, under the conditions established in a Public Law contract, with preference and special treatment of non-profit entities. §2 - The Public Power may intervene and expropriate health services of a private nature; necessary to achieve the objectives of the sector's national policy. §3 - The direct or indirect exploitation by persons, companies and capital of foreign origin of health care services in the Country is prohibited. Article 6. The free exercise of liberal activity in health and the organization of private health services is ensured, obeying the ethical and technical precepts determined by the Law and the principles that guide the national health policy. Article 9. It is allowed the removal of organs from tissues of human cadavers for the purpose of transplantation, with no contrary disposition in life of the "*de cujus*" and nor prohibitive manifestation of the family. [...] §3 - Any type of marketing of human organs and tissues is prohibited.	Article 197. Health actions and services are of public relevance, and it is up to the Public Power to dispose, under the terms of the law, on their regulation, inspection and control, and their execution must be carried out directly or through third parties and, also, by natural or legal person under private law. Article 199 Health care is open to the private corporation. §1 Private institutions may participate in a way to complement the Unified Health System, according to these guidelines, by public law contracts or agreements, with preference being given to charities and/or non-profit organizations. §2 It is forbidden to allocate public funds to assist or subsidize for the private profit-making institutions. §3 Direct or indirect participation of foreign companies or capital in health care in the Country is prohibited, except in cases foreseen by the law. §4 The law provides for the conditions and requirements that facilitate removal of organs, tissues and human substances for transplantation, research and treatment, as well as the collection, processing and transfusion of blood and blood products, prohibiting all types of commercial transactions.

Continues

Continuation

Subcommittee text	Text of the CF/88
Article 5. The policies of human resources, basic sanitation, supplies, equipment and scientific and technological development in the health area are subordinated to the interests and guidelines of the Unified Health System. §1 - It is up to the Public Power to discipline and control the production and distribution of medicines, immunobiologicals, blood products and other materials, aiming to preserve national sovereignty. §2- It is the duty of the State to exercise the control of drugs of abuse and other intoxicating toxic products and to establish basic principles for the prevention of their use. [...] Article 11. The State is responsible, through a single health system, to monitor the quality of food, medicines and other products of consumption and human use, used in the National territory.	Article 200. The Unified Health System shall, in addition to other duties, in accordance with the law: I - to control and inspect procedures, products and compounds of interest to health and to participate in the production of medicines, equipment, immuno-biological products, hemoderivatives and other raw materials; II - to carry out sanitary and epidemiological actions, as well as actions related to work safety; III - organize the training of human resources in health area; IV - participate in the policy formulation and implementation of basic sanitation actions; V - increase in the scope of action, scientific and technological development; VI - supervise and inspect foods, including control of nutritional content, as well as liquids and water for human consumption; VII - participate in the supervision and control of production, transport, storage and use of psychoactive, toxic and radioactive substances and products; VIII - cooperate with the environmental protection, including that of work.

Source: Federal Senate, Subcommittee on Health, Security and the Environment.

Regarding the private sector, the final wording of the constitutional text has been modified at important points. The Minutes of the Subcommittee on Health, Security and the Environment of the Constitution of 1988[6] indicates that an active part of Brazilian society – such as representatives of philanthropic entities, "group medicine" companies, hospitals and health facilities - played an important role in the defense of health care during the work of the Constituent Assembly. As a result, the text of the Subcommittee – which attributed to the State the control of the private sector and defined that the private service would be public in nature and would be standardized, controlled and supervised by the State through a national health policy

[6]SENADO FEDERAL. Assembleia Nacional Constituinte. *Atas de Comissões. Subcomissão de Saúde, Seguridade e do Meio Ambiente, cit.*

and public law contracts – was not maintained by the Constituent Assembly. The consensus that remains established was that health actions and services are of "public relevance" and that the State's action on the private sector (regulation, supervision and control) should be defined by law.

From this context, it can be affirmed that the understanding prevailed in Brazilian society that health is a fundamental human right and, as such, it is guided by the constitutional values of dignity of life, equal access to health services, integrality and continuity in the provision of health actions and community participation. The idea that the public entity is responsible for the broad intersectoral systematization (environment, work, sanitary and epidemiological surveillance, assistance provided by the public and private sector, etc.), for the regulation, supervision and control of health actions and services, also prevailed. Finally, the idea that health care (medical and hospital) is free to private initiative, within the limits of state regulation, also prevailed. This consensus did not impose a specific model of public-private system, but provided guidelines for the establishment, operation and improvement of the system.

Therefore, the social and political context that culminated in 1988 confer important elements for the understanding of constitutional norms on health, including those that refer to the private sector.

It can be said that the then emerging branch of Health Law resulted from a process of broad participation and popular deliberation, carried out through municipal, regional and national health conferences in the 1970s and 1980s and also through a broad debate throughout the work of the Constituent Assembly.

The text resulting from the 8th National Health Conference underwent important changes, as indicated, but not in its structuring values. That is, what we want to emphasize is that, at least regarding health, the principles of law incorporated into the text directly reflected the values of society and, thus, it is possible to say that the 1988 Charter, regarding Health Law, consists of a true pact of Brazilian society.

As these values or principles reflect the will of various segments of civil society (health professionals, workers, university professors, entrepreneurs in the sector, etc.), based on Loughlin[7], it can be affirmed that they end up becoming legitimate limiters of the will of Brazilian governments and institutions. That is, these values or principles are prior and superior to the legal system and were constructed and recognized years before the formation of the Constituent Assembly. Therefore, the idea of "will of the people" here is neither an abstraction nor an ideal concept created from the need for consensus for the elaboration of a constitution[8].

[7]Para melhor compreensão deste tema, confira-se: LOUGHLIN, Martin. What is Constitutionalization? In: DOBNER, Petra; LOUGHLIN, Martin (Eds.). *The twilight of constitutionalism.* Oxford University Press, 2010.) (Chapter 3). (Oxford Constitutional Theory).
[8]LOUGHLIN, Martin. *op. cit.*

In contrast, however, it can be said that the idea of a Brazilian nation is not essentially based on these norms and values. Different norms and values existed in previous constitutions and, not for this day, the idea of a Brazilian nation had been questioned previously. In this sense, we agree with Loughlin[9] when differentiating modern constitutions from the ancient ones, indicating that they brought the idea of people as a "sacred" or "symbolic" element, on which the concept of nation was founded. In fact, the Constitution of 1988 does not carry this ancient symbolism, at least regarding the theme treated here, and can even be characterized as modern in the sense attributed by the author.

But it is possible to affirm that the idea of equality or equity and/or solidarity – central to health law and the security system as a whole – underlies a conception of nation to be built. In fact, the values of Health Law do not only reflect segmented interests of certain groups of civil society, victorious in certain circumstances. It is possible to say, thus, that the legal principles of Health Law are a reflection of the values of the Brazilian people or society in its broader conception, that is, they are values of a nation that intends to be more egalitarian. For these reasons, such values can be understood as being public, or of the entire Brazilian people, in the sense that it can be located between concrete and ideal, but which is not merely symbolic as something divine or transcendent.

What is intended to be emphasized, then, is that the legal principles of Health Law are not only rational legal instruments far from the will of Brazilian society. They are not mere arguments of technicians or a legal elite. They originated in broad deliberation and popular consensus and are the legitimate parameters both for the elaboration of infra-institutional norms and for the conduct of the actions of society and rulers.

II. Doctrine on constitutional articles

As seen, the final text approved in 1988 recognized the freedom of initiative in the health sector, with restrictions and controls that would be established by law, as will be seen from the systematic analysis of the articles from 196 to 200 of the CF/88.

Today it is clear that a huge challenge has been established for the country: to create and consolidate a public health system alongside an existing private system, based on the constitutional principles of the right to health, which will be dealt with later.

Article 196 of the CF/88 provides:

> Health is everyone's right and a duty of the State, guaranteed through social and economic policies aimed at reducing the

[9] *Id. Ibid., p.49; 55.*

> risk of disease and other health problems, and the universal and equal access to actions and services for its promotion, protection and recovery.

This provision defines that, in Brazil, all citizens have the right to health and that for this reason, it is up to the State to conceive social and economic policies in order to achieve two objectives: reduction of the risk of disease and other injuries, and universal and equal access to actions and services for their promotion, protection and recovery.

The state obligation imposed by the article in reference is therefore of two types, as explained by Aith:

> obligations related to public health and obligations related to the individual health of each citizen. With regard to the former, the State must adopt in advance all the necessary conducts for the promotion, prevention and recovery of the health of the population. We are in the field of preventive, active actions, express obligations of the State that can be identified, planned and required. When we refer to individual health, there is no way to demand that the State give health to everyone. The State must ensure access to the actions and services necessary for the prevention, promotion and recovery of health, when this is possible and necessary[10].

Article 196 gives specific guidelines for the entire health sector. It dialogues and influences both articles 198 and 200, which deal with the actions and public health services and the attributions of the SUS, as well as articles 197 and 199, which deal with health actions and services performed by third parties and by individuals or legal entities under private law. Therefore, the duty of the State is: 1) in the direct provision of public health actions and services, embodied in Articles 198 and 200 of the CF/88; 2) in the regulation, supervision and control of private health actions and services provided for in Article197; and 3) the limitations imposed in the paragraphs of Article 199. We are interested in directly analyzing articles 197 and 199.

Article 197 of the CF/88 provides:

> Health actions and services are of public relevance, and it is up to the Public Power to dispose, under the terms of the law, on their regulation, inspection and control, and their execution must be carried out directly or through third parties and, also, by natural or legal person under private law.

[10] AITH, Fernando. *Curso de direito sanitário*. São Paulo: Quartier Latin, 2007. p. 85.

And Article 199 provides:

> Health care is open to the private corporation.
>
> §1 Private institutions may participate in a way to complement the Unified Health System, according to these guidelines, by public law contracts or agreements, with preference being given to charities and/or non-profit organizations.
>
> §2 It is forbidden to allocate public funds to assist or subsidize for the private profit-making institutions.
>
> §3 Direct or indirect participation of foreign companies or capital in health care in the Country is prohibited, except in cases foreseen by the law.
>
> §4 The law provides for the conditions and requirements that facilitate removal of organs, tissues and human substances for transplantation, research and treatment, as well as the collection, processing and transfusion of blood and blood products, prohibiting all types of commercial transactions.

It turns out, then, that the private initiative is free to provide health actions and services. But such performance is always of "public relevance" (197), is marked by the public authorities (197 and 199, §1º) and is limited and/or prohibited in certain situations (art.199, §§2º to 4º).

On the beaconing by the public power, it is worth making a distinction. When private institutions participate in a complementary way to the Unified Health System, through a public law or agreement, such participation will have to follow both the Guidelines of the SUS – that is, those indicated in Article 198 of the CF/88 – and the guidelines of Article 196, which apply to all actions and all health services. In other cases, the actions and health services provided by private institutions should also follow the two major guidelines of the system, contained in Article 196 of the CF/88.

As for SUS guidelines, a weighting should be considered. In the final wording of the CF/88, the content of Article 198 came after Article 197. We chose to distinguish two types of service: the public (art. 198) and the public relevance (art. 197). Article 198 *caput* deals only with public services, and Article 197 deals with actions and services of public relevance. In a first analysis, it seems that public relevant services would not apply to article 198 guidelines, restricted to public services. It happens that services of public relevance must be not only monitored, but also regulated and controlled by the public authorities. Now, if at the same time the Federal Constitution defines the creation of a public system, unique, with clear operating guidelines,

it can be deduced not only that the general guidelines of article 196 must dialogue with the specific guidelines of article 198 in the construction of the public health system, as well as that the general guidelines of article 196 must dialogue with the specific guidelines of article 198 to guide the inspection, regulation and control of the private system (provided for in article 197). In other words, the SUS guidelines (art. 198) are a condition for the effectiveness of the general guidelines of the health system (art. 196), since the opposite would lead to the possibility of a health system that promotes aggravation of risks and access segmented or unequal, that is, the impossibility of realizing the general guidelines of article 196.

Therefore, from the systematic interpretation of articles 196 to 200 of the CF/88, especially considering articles 196, 197 and 198, it follows that the obligation attributed to the public power to regulate, supervise and control health actions and services (whose execution may be carried out by third parties or by the private sector) is constitutionally parameterized by the two general health purposes, indicated in article 196 - (i) aiming at reducing the risk of disease and other diseases and (ii) aiming at universal and equal access to actions and services for their promotion, protection and recovery - and also through a dialogue with the guidelines of SUS[11], which should contribute to the effectiveness of such objectives and never jeopardize their reach

A clear example of regulation applied to the private sector with the objective of aiming at universal and equal access to health actions and services is in article 32 of Law n. 9.656/1998[12]. This provision corroborates the thesis presented so far in determining that health plan operators will reimburse SUS for services provided by SUS to beneficiaries who, by contract, would have the right to have received such services from the contracted operator's network. Several objectives stem from this standard, including: (i) preventing the public network from serving "indirect" support to private health operators, encouraging the development of an efficient, economically and financially self-sustaining private sector that maintains a compatible service structure with the demand of its users, effectively expanding access to health; (ii) ensure that as many Brazilian citizens as possible have access to public health actions and services, especially the portion of the Brazilian population that does not have a health plan, considering that the public resources allocated to the sector are insufficient for the entire population; and (iii) organize a data and information

[11] PINHEIRO, Maria do Carmo Gomes; ROMERO, Luiz Carlos. Saúde como matéria de Direito Constitucional no Brasil. *Cad. Ibero-Americano de Direito Sanitário*, Brasília-DF, v. 1, n. 2, p. 64, jul./dez. 2012. Available at: https://www.cadernos.prodisa.fiocruz.br/index.php/cadernos/article/view/45/90. https://doi.org/10.17566/ciads.v1i2.45.

[12] BRASIL. *Lei n. 9.656, de 3 de junho de 1988*. Dispõe sobre os planos e seguros privados de assistência à saúde. Available at: http://www.planalto.gov.br/ccivil_03/leis/L9656compilado.htm. Accessed on: 14 Oct. 2020.

network on public services provided to users of health plans, in order to constantly improve the regulation, inspection and control of health plan operators.

And what would be the distinction between the private sector and third parties? According to José Afonso da Silva:

> In administrative law, when it is said that a service can be provided or performed by the Administration or by third parties, "third party" means a private person to whom the provision or performance of the service is delegated. But the clause under examination distinguishes between third parties and private individuals and legal entities. The "and, also" is a composite sign that indicates the separation between the antecedent and the consequent, and it does so, by means of a reinforced addition, "and" with "also". So "third parties" can only refer to autonomous public or parastatal entities, in such a way that the understanding of the text is: "the execution of health actions and services can be done by the direct Administration (Ministry, etc.), by entities of indirect Administration and other autonomous services to which it is delegated and, also, by individuals and legal entities under private law"[13].

In addition, and before that, Article 197 of CF/88 determines that health actions and services are of "public relevance". And, from reading article 129, II of CF/88, it appears that services of "public relevance", alongside public authorities, are on the list of those who must be "cared for" by the Public Ministry:

> Article 129. Institutional functions of the Public Ministry are:
>
> [...]
>
> II - to ensure the effective respect of the Public Authorities and services of public relevance to the rights enshrined in this Constitution, promoting the measures necessary to guarantee them. Thus, it follows that it is up to the Public Ministry to promote all the necessary measures to ensure that services of public relevance (and public authorities) respect and guarantee the rights enshrined in the Federal Constitution of 1988.

So far, it remains clear, therefore, that the performance of the private sector in health (except for the cases referred to in §1 of art.199 above) is permitted (alongside the state entities of direct and indirect administration), but it is regulated, inspected and controlled by the public authorities, with the objective of promoting the reduction of the risk of disease and other diseases and of guaranteeing universal

[13] SILVA, José Afonso da. *Comentário contextual à Constituição.* 4. ed. São Paulo: Malheiros Editores, 2007.

and equal access to actions and services for the promotion, protection and recovery of health. In addition, the performance of the private sector in health is regulated, supervised and controlled by the government in order to contribute to (and never harm) the implementation of SUS guidelines; and, finally, such action is found in the list of activities that must be taken care of by the Public Ministry.

> It is worth investigating, then, what is the nature of health services and actions provided by private entities. The term "service of public relevance" gives public connotation to a category of actions and services provided by private entities, that is, which are organized under private law. One of the ways to understand the term would be the search for the meaning of "public service", although this definition helps little in this task, since currently the safest criterion for defining an activity as a public service is its prediction as such in the Federal Constitution.

Anyway, the doctrine that deals with the topic contributes to reflection. For Eros Grau,

> we can adopt the following notion of public service: public service is the activity explicitly or supposedly defined by the Constitution as indispensable, at a given historical moment, for the realization and development of social cohesion and interdependence (Duguit) - or, in other words, activity explicitly or supposedly defined by the Constitution as an existential service in relation to society at a given historical moment (Cirne Lima)[14].

And, when dealing specifically with the concept of "public relevance" of health in CF /88, Eros Grau[15] concludes that "the only function fulfilled by the concept of public relevance in the constitutional framework seems to be to enable the Public Ministry to act [...] under the terms of article 129, II of the Federal Constitution" (a topic that has already been addressed above).

Luiz Alberto David Araújo, when dealing with the theme, also explains the role of the Public Ministry in relation to health actions and services ("public relevance"):

> Among the necessary measures to guarantee the fulfillment of services of public relevance, there is the possibility of filing lawsuits against the public bodies themselves, either for the fulfillment of constitutional mandates, or for the correction of activity when

[14] GRAU, Eros Roberto. Constituição e serviço público. In: GRAU, Eros Roberto; GUERRA FILHO, Willis Santiago (Orgs). *Direito constitucional*: estudos em homenagem a Paulo Bonavides. 1. ed. 2. tir. São Paulo: Malheiros Editores, 2003. p. 267.

[15] GRAU, Eros Roberto. O conceito de "relevância pública" na Constituição de 1988. *Revista de Direito Sanitário*, São Paulo, v. 5, n. 2, p. 68-76, jul. 2004. Available at: http://www.revistas.usp.br/rdisan/article/view/80683. https://doi.org/10.11606/issn.2316-9044.v5i2p68-76.

> deviated from the constitutional vector. The review, however, is not limited to illegality (non-compliance with an infraconstitutional legal standard). The Public Prosecutor's Office also has the role of inspecting whether the infraconstitutional rule (which may be a service order, an ordinance and even a law) fulfills the role established by the Constitution. There is a need to control, in addition to legality, the observance or not of government actions in relation to constitutional programs. Often, the public administrator, understanding correct such behavior, mortally hurts the Federal Constitution, without, at least immediately, injuring any immediate higher norm[16].

What is apparent from such statements is that the private regime of health actions and services does not remove their public relevance, i.e., such activities are considered indispensable for social cohesion, either when provided by the private law regime or when provided by the public law regime.

The idea that health has a public connotation or importance is consistent with the essentiality of health services and actions and its close relationship with the constitutional principles of the protection of life and dignity of the human person, gravitational centers of CF/88. That is why such activities remain under the tutelage of the State, so much so that they are subject to regulation, inspection and control by the public authorities with specific objectives, as well as they are subject to the inspection of the Public Ministry over the performance of public authorities in relation to these objectives. expressly defined.

Thus, the Constitution ends up giving the State real responsibility for the actions and health services provided by both the public and private sectors. This is the understanding of Sueli Dallari and Vidal Serrano, who cite Antonio Augusto Mello de Camargo Ferraz and Antonio Herman de Vasconcellos e Benjamin on the subject. See below:

> In this same line of understanding, it should be added that state responsibility, in relation to health, is not limited to the provision of public services, but also to its regulation, supervision and control, pursuant to art.197 of the Major Law, which classifies health actions and services as of public relevance, either when provided directly, or when performed by third parties or by a natural or legal person under private law. Elucidative, in this sense, the conclusions reached by Antonio Augusto Mello de Camargo Ferraz and Antonio Herman de Vasconcellos e Benjamin:

[16] ARAÚJO, Luiz Alberto David. O conceito de "relevância pública" na Constituição Federal de 1988. *Revista de Direito Sanitário*, São Paulo, v. 5, n. 2, p. 90-97, jul. 2004. Available at: http://www.revistas.usp.br/rdisan/article/view/80686. https://doi.org/10.11606/issn.2316-9044.v5i2p90-97.

> "When the Federal Constitution states that 'health is the right of all and the duty of the State' (art. 196), being 'of public relevance health actions and services, it is up to the Government to dispose, under the law, on its regulation, supervision and control' (art. 197) and that 'health care is free to private initiative' (art. 199, *caput*), several conclusions can be drawn from this:
>
> Health is a subjective public right chargeable against the State and against all those who, even if private entities, with the authorization of the state, guarantee it;
>
> Health is always ensured through the performance of a state public function, even when provided by individuals, and only its 'actions and services' do not have exclusive exercise of the State; for this very part, they are considered of public relevance;
>
> As a state civil service, the State is responsible for providing health services and actions, and must establish the guidelines and parameters for the exercise of these; with this it can be said that the freedom of private providers is limited;
>
> The non-conformities in the services and actions allow the State to exercise all its 'munus', including with the use of the institute of expropriation;
>
> As a subjective public right, health creates a series of interests in its materialization, interests that are now typically public, now diffuse, now collective, individual homogeneous or simple individual;
>
> Such interests, when contradicted, give legitimacy to a number of subjects, public and private, to seek, judicially, their protection (for these purposes, law 7347/85 and the Consumer Protection Code can be used)"[17].

Therefore, the private health sector is also regulated by Health Law. It is worth noting that this debate already has an important doctrinal basis. According to Aith,

> Health Law is the branch of Law that regulates public and private actions and services of interest to health, formed by the set of legal norms – rules and principles – which aims to reduce the risks of diseases and other injuries and the establishment of conditions

[17] DALLARI, Sueli Gandolfi; NUNES JÚNIOR, Vidal Serrano. *Direito sanitário*. São Paulo: Ed. Verbatim, 2010. p. 70-71.

> that ensure universal and equal access to actions and promotion services, health protection and recovery[18].

In this sense, the author also clarifies that the principles of Health Law apply to all legal norms valid in Brazil aimed at the realization of the right to health:

> [...] any legal rule valid in Brazil and whose purpose is to assist the State in achieving the objectives provided for by the Federal Constitution, notably in articles 196 to 200, may be considered as belonging (or of direct interest) to Health Law. The legal norms of Health Law, directly aimed at the realization of the Right to Health, must be interpreted taking into account the specific principles that govern it. Also subject to the legal principles of health law are legal norms that, although not directly aimed to the protection of health, deal with issues related to the determinant factors of health. The only difference in this case, is that the interpretation will be more complex, as it should consider the other objectives contained in the legal standard in reference. Once health has been identified as a direct or indirect object of protection, its interpretation must be in accordance with the legal regime of Health Law, its objectives, principles and guidelines that organize this field of legal science[19].

State action regarding private services (supervision, regulation and control) is governed by the constitutional principles provided for in Article 196 of the CF/88. Moreover, such action must constantly dialogue with the constitutional principles provided for in Article 198 of the CF/88, in order to contribute and never harm the implementation of the SUS. The Federal Constitution does not present gaps, therefore, regarding these principles. Therefore, the private sector is inserted in the constitutional logic of Health Law, a new branch of law that emerges with the Federal Constitution of 1988.

Finally, Minhoto, when dealing with the paradoxes of legal protection of health, explains that, in strictly legal terms:

> [...] the new law aims to overcome the old liberal conception of contract, expressed in the ideal of commutative justice derived from the supposed equivalence of the terms of exchanges that take place on the market, by a new conception of contract, based on the ideal of solidarity. And what exactly can the passage of the typical civil law contract to the new solidarity contract mean?

[18] AITH, Fernando. *op. cit*., p. 92.
[19] *Id. Ibid.,* p. 137.

> First, a contractual modality that focuses on fair redistribution, equitable allocation of benefits, costs and social risks[20].

It is necessary to reflect, then, on the pertinence of a regulation that has an egalitarian or distributive purpose for the private health sector and that, in this sense, contributes to the purposes of the Unified Health System. But this a different matter altogether.

Final considerations

This study pointed out the constitutional principles that should guide the private health activity in the country, based on a descriptive research on articles 196 to 200 of the CF/88 that considers both the social and political context that led to the issue of these devices, as well as the legal doctrine built on them.

It is concluded that the consensus established through these articles does not impose a specific model of public-private system. On the other hand, these articles provide guidelines for the establishment, functioning and improvement of the health system as a whole. State action regarding private services (supervision, regulation and control) is based on the constitutional principles provided for in Article 196 of the CF/88 and by the constant dialogue with the constitutional principles provided for in Article 198 of the CF/88, in order to contribute and never harm the implementation of the Unified Health System.

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