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CHARACTERISTICS OF HEALTH JUDICIALIZATIONS IN HOME CARE

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ABSTRACT

The judicialization of health has gained strength in recent years, a theme that has generated several actions in the judiciary for characterizing the beneficiaries and the processes of judicialization of health in home care in a state agreement. Study based on a documentary of the patient's clinical condition and the reasons that led to the judicialization process of 80 injunctions evaluated were analyzed with quantitative approach conducted in Recife, Pernambuco from January 2010 to August 2018. It was observed that (62.5%) of the patients were females aged 80 years or older (43.7%). Regarding education, 48.7% had high school, 60% were married. The most frequent clinical diagnoses were stroke sequelae (38.8%) and Alzheimer's (17.5%). The clinical complexity of 33.8% of the patients, according to the parameters established by the Brazilian Association of Home Care Companies, was classified as medium complexity, but the court injunctions granted the classification was of high complexity to 87.5%. It was possible to know the characteristics of the beneficiaries analyzed and to perceive the discrepancy in the complexity of the patients given by the criteria defined by pre-established clinical parameters and the clinical complexity of the granted injunction.

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INTRODUÇÃO

Health is considered to be an individual right and an inalienable public good, granted by the Article 196 of Brazilian Constitution (BRAZIL, 1998). According to the law number 8080 of September 1990, Health is considered to be a fundamental right of the human being, having the State as the provider of the indispensable conditions to reach this position (BRAZIL, 1990). Although with this warranty, not always the citizen reaches the access to all the benefits, being many times obliged to claim for these rights through legal bodies.

For assistance to health of Brazilian population, one counts on Unique System of Health (SUS) represented by a set of actions and services guaranteed by the State and with the private sector Supplementary Health System (SSS), represented by agreements, health plans and cooperative of professionals, besides counting on autonomous services, corresponding to the classic liberal sector (BRAZIL, 2015). As health is considered a right for everyone (BRAZIL, 1990) it is not surprising that citizens require such conditions. One of the difficulties all over the world, in relation to medical services is their high cost.

It is known that there are not infinite resources to provide the services and actions available in the market for all beneficiaries of the system (CRUZ, 2014). Health Systems have, in their constitution, deficiencies and even gaps, both in public and private ones, making them liable to complaints from the beneficiaries for better equity and integrality of the service provided. One of the ways that people have to solve a part of these problems both from access and integrity of attention is through health judicialization (MARQUES; MELO; SANTOS, 2011). Health judicialization turns out, thus, the claim in courts for rights to health, expressed by court decisions, in order to carry out procedures not authorized by health services or plans that the beneficiary deems to be his own right (BAHIA; CASTRO; FARIA, 2015; CIRICO; RESNER; RACHED, 2015). These reinvindications may involve rights that fall into the so called gray areas, when beneficiaries fill lawsuits, due to lack of specifications about what is included in their contracts, (like prostheses, joint replacement surgeries, among other procedures). Or on other occasions, when authorizations are denied without any justification (YASMIN *et al.,* 2019). Generated from the health judicialization, actions start being deliberated by the judiciary, overlapping that

which is defined in the normative of the health system or plan considered. Based upon the statement that health is a fundamental right, the results of judicialization have kept the judiciary power decisions, rendered in favor of the beneficiaries (SIERRA, 2011). Sometimes, they are isolated decisions with great repercussions for all the system, which can lead to administrative disorganization and inefficient allocation of resources (TEMPORÃO, 2009). It became a political and social phenomenon, that has been growing as time passes by, with repercussions for public policies and economy (NAKAMURA, 2007). Health assistance by health plans will depend on the contract established between the user and the complementary system. Among the types of assistance provided by health plans one can have outpatient hospital and homecare, the latter of interest in this study. Homecare started in the United States in 1947, as an organized form of care. The initial motivation was to decongest hospitals in order to provide patients and families a more favorable psychosocial environment with the introduction of home visits by nurses to develop health actions. In the 1960's this kind of service started operating in Canada, oriented to precocious medical leave for surgical patients (LIMA; SPAGNUOLO; PATRÍCIO, 2013). In Brazil, since 1920, in Rio de Janeiro, there has been the Visiting Nurse Service with the aim of promoting health education for people in their homes. But the implementation of family assistance as an institutionalized activity only occurred a little over thirty years ago with the pioneering of dehospitalization service of the Hospital dos Servidores Públicos (Public Employees' Hospital) of São Paulo State, created for stable chronically ill patients (STULTZ, 2010). The term Home Service can be understood as basic nursing care up to advanced respiratory support at patients' homes (LEME, 2018).

The Health System in Brazil, including some plans, has faced in Justice some claims of their beneficiaries because of services and products not included in home care. Many times those claims are outside the list of procedures and pathologies in the contracts for this kind of assistance. Among products and services claimed are medicines, industrialized enteral diets, tests not indicated by attending physicians, dislocation for health services and personal hygiene products (CAVALCANTI, 2016; FELISBINO, 2014; ASENSI, 2010). Individual actions to obtain health rights at courts, can occur with certain ease, not only in Brazil but also in other countries (YASMIN *et al.,* 2019). In Brazil, in the last 30 years, judicialization of health has been growing, affecting the public area as well as the supplementary service. According to the National Council of Justice (CNJ) the number of actions in 2016, reached a million and three hundred thousand cases, having become a worrying theme for the control bodies, such as the state health committees, at stimulating this theme discussion in public hearings (BRAZIL, 2017). The growth of health litigation is added to the high success rate of claimants against the state. This phenomenon has been provoking a series of academic and legal debates, with challenges for both the legal and private systems (PAIXÃO, 2019). Faced with this context and in search of realizing the impacts of judicialization on health systems, as well as understanding not only what is being requested, but also who is claiming, that it was decided to carry out this research, in order to know the beneficiaries characteristics as well as those of the processes of judicialization of health on a home service in a state health plan.

MATERIALS AND METHOD

Study based on document analysis with a quantitative approach carried out in the city of Recife, Pernambuco referring to the period from January 2010 to August 2018, having as source the data base of the Health Assistance System of Servers of Pernambuco State (SASSEPE). SASSEPE is a state agreement with the function of carrying out preventive and curative medicine, outpatient and hospital actions, through accredited entities, professionals and hospitals. It offers home assistance programs with more than 100 (one hundred) interned patients. It was created based on Complementary Law number 30/2001, of which the first article establishes that the administration of the SASSEPE is under the responsibility of Human Resources Institute (IRH – PE) (INSTITUTO DE RECURSOS HUMANOS, 2018; PERNAMBUCO, 2001). To act on health care for its beneficiaries, SASSEPE has, in addition to its accredited network, its own network establishments in Pernambuco's capital, Recife, and in the countryside of the state. In 2015 it had 177.271 beneficiaries, of which 110.030 females and 67.241 males (INSTITUTO DE RECURSOS HUMANOS, 2015). It is a company considered to be as a self-managed one and carries out its activities through the (IHR) making them work by private health care plans, exclusively for its retirees, partners, administrators, employees, pensioners, and family groups of its beneficiaries, health services to family members up to the third degree (INSTITUTO DE RECURSOS HUMANOS, 2018). SASSEP offers to its members, among other modalities, home care with health services. Home care activities are developed by a multidisciplinary team, with doctors of several specialities, speech therapists, pharmacists, nurses, auxiliary nursing technicians, nutritionists, social workers, psychologists and physiotherapists (CORRÊA, 2018). Home Care is a modality destined to treatment and follow-up of patients with movement restrictions. To this kind of assistance the patient must meet the pre-established requirements from two instruments: 1. Evaluation Table of the Brazilian Association of Home Medicine Companies (ABEMID) and NEAD Score (Núcleo Nacional das Empresas de Serviços de Atenção Domiciliar). From this definition on, it is started the specification of the service structure to meet the therapeutic plan, designed to be followed at home, according to established technical criteria (NÚCLEO NACIONAL DE EMPRESAS DE SERVIÇOS DE ATENÇÃO DOMICILIAR, 2018). These criteria are: Being clinically stable, but in need of completing home care, under medical and nursing supervision, training the patient or caregiver in face of new conditions, limitations and clinical needs, patients with chronic diseases having a history of frequent readmissions, prolonged or recurrent infectious processes or palliative care (NÚCLEO NACIONAL DE EMPRESAS DE SERVIÇOS DE ATENÇÃO DOMICILIAR, 2018. These criteria are related to dependence degree, complication risks, morbidity and technical procedures. The punctuation of these criteria must be added to the NEAD Table, and together they can indicate one of the existing programs.

a) High Complexity: when it is used all the hospital technology compatible with the home environment – except for the intervention levels, which characterize procedures inherent to the hospital environment – and need permanent nursing services for 24 hours uninterrupted, with total dependency on care;
b) Medium Complexity: patient in a clinical condition which does not require invasive or non-invasive mechanical ventilation, continuous monitoring, intensive nursing care, continuous or complex application of medications. It is necessary nursing but just for 12 hours a day, with partial care dependency;
c) Low Complexity: patient needs medical and nursing care, due to nursing demands, requiring professionals to stay for, at least, six hours a day at his home;
d) Procedures: Patients who need palliative care like dressings, continuous positive airway pressing (CPAP), oxygen therapy or any other health care that needs medical supervision.

It has been used for carrying out this study, information contained in the files of the beneficiaries who have gone to court to obtain homecare previously denied, based on pre-established standards. These injunctions granted by the court are filled in the Legal Support Management (GAJ) sector of SASSEPE. This data were obtained by using a form with sociodemographic variables and the clinical complexity of the patient, following the criteria of the Brazilian Association of Home Medicines Companies (ABEMID) and the complexity given in the granted injunction and the reasons that led the the user to judicialization. Table 1 shows the studied variables and their definitions. All court injunctions were analysed, when referring to home admissions, in the studied period, making a total of 80 injunctions.

Table 1. Study Variables

VARIABLES	DEFINITION
Sociodemographic: • Age; • Sex; • Schooling; • Income; • Occupation.	 • Elapsed lifetime from birth; • Gender classification (female or male); • Years of study (Basic, High School, University); • Financial income reported; • Activity in which one works.
Complexity of the patient by ABEMID (general condition in which the patient fits): • High Complexity; • Medium Complexity; • Low Complexity; • For procedures.	 • 24 hours nursing; • 12 hours nursing; • 6 hours nursing; • Dressings, O_2, continuous positive pressure airway (CPAP).
Complexity of the patient given by injunction.	Considered classification given by justice, independent from ABEMID classification
Reasons for judicialization: • Medication; • Oxygen; • Outside the plan coverage area; • Physiotherapy and Speech Therapy out of medical prescription; • Probe diet.	 • solicitation of oral and intramuscular medication; • Oxygen request for permanent use through catheter or mask; • locations that exceed the maximum base mileage; • solicitation of physiotherapy and speech therapy for patients without strict indication; • solicitation of diet by enteral tube

SOURCE: Elaborated by the author, with research data.

Table 2. Sociodemographic characteristics of the pacientes who were admitted to Family assistance through legal actions in the period from January 2010 to August 2018. Recife PE, Brasil, 2018)

Variable	n = 80	%
Sex		
Male	30	37,5
Female	50	62,5
Age Range (years)		
Up to 69	19	23,8
70 to 79	26	32,5
80 years or older	35	43,7
Schooling		
Illiterate	1	1,3
Elementary (Basic)	13	16,2
Middle (High School)	39	48,7
Superior (University)	27	33,8
Marital Status		
Married	48	60,0
Single	6	7,5
Divorced	1	1,3
Widow(er)	25	31,3
Income (in minimal wages)		
1 a 2	29	36,3
3 a 5	45	56,2
6 a 10	6	7,5
Occupation		
Retired	48	60,0
Housewife	2	2,5
Professor	4	5,0
Pensioner	24	30,0
Others	2	2,6

Source: Elaborated by the author, by using research data.

The data were analysed descriptively through absolute frequencies and percentages for the categorical variables and measures: median, standard deviation and median age variable. The results were shown in an EXCEL spreadsheet. For statistical calculations it was used in the IBM SPSS program, version 23, used in tables and graphics. For data analysis on the complexity of the patients were used the parameters recommended by Brazilian Association of Home Medicine Companies (ABEMID) and the criteria for eligibility of home care concession. This study was approved by the Ethics Committee in Research of the University of Pernambuco, obeying resolution number 466/2012 of the National Health Council (CNS), regarding research involving human beings, under registration number 2.880.203 CAEE: 9653471. 07. 0000.5207.

RESULTS

The results showed that 58.8% of the processes have come from the capital, Recife, 68.7% of them were brought through private lawyers and most of the interments occurred with patients who were already at home. On table 2 it is possible to see the sociodemographic characteristics of the studied population. From the total of 80 analysed lawsuits against the SASSEPE, more than 40% were 80 years old or still older. There was a variation from 32 to 94 years old, with an average of 74.4 years of age and DP=14.35). The most prevalent patients were females (62, 5%) with high school (48,7%), married (60%) and widows (31.3%) According to monthly income, more than half (56.2%) had family income from 3 to 5 minimum

wages and 60% were retired. Table 3 presents the characterization of the analysed patients, as to ownership, complexity of the clinical aspect and outcome. It is noteworthy that most of them (76,2%) were composed of plan holders and the most frequent clinical diagnostics were sequelae of AVC(40,1%) and Alzheimer (22,5%) sequelae. As to the complexity of clinical conditions, according to ABMID, 33,8% were classified as medium complexity, and 18% had no indication for internment. However when qualified by the injunction, it was observed that 87,5% were of high complexity. At the moment of the analysis, 53,7 remained in home care and 46,3% had died.

Table 3. Patients' characterization who were admitted to home care through legal actions at SASSEPE as to ownership, complexity of the clinical condition and outcome, in the period of January 2010 to August 2018. (Recife-PE, Brasil, 2018)

Variable	n = 80	%
Condition in relation to SASSEPE		
Holder	61	76,2
Dependent	19	23,8
Diagnosis		
Alzheimer	18	22,5
Aneurysm	4	5,1
Sleep Apnea	4	5,0
Câncer	2	2,6
Convulsive Seizures	1	1,3
Encefalopathy	3	3,8
Hematoma Drainage	1	1,3
Myositis	1	1,3
Parkinson	3	3,8
Schistosomiasis	1	1,3
Femur Fracture	1	1,3
Urinary Tract Infection	1	1,3
Respiratory Failure	3	7,8
Neurological Injury	1	1,3
Stroke Sequel	32	40,1
Radicle Sequelae	1	1,3
Complexity of the clinical condition according to ABEMID*		
High	17	21,3
Medium	27	33,8
Low	14	17,5
Interned for procedures (dressings, antibiotic therapy)	07	8,8
No indication for medical internment at home care	15	18,8
Complexity of the clinical condition according to injunction		
High	70	87,5
Medium	3	3,8
For use Continuous Positive Airway Pressure (CPAP)	4	5,0
For use Oxigen by catheter	3	3,8
Outcome		
Still interned	43	53,7
Death	37	46,3

Source: Elaborated by the author with research data.
Notes:
*ABEMID: Evaluation Table of the Brazilian Association of Home Medicine Companies
**INJUNCTION: Judicial Decision on the Brought Action.

Table 4 shows that diet was one of the most requested reasons for medical internment (61,3%) followed by medication (51,2 %) and (41,3%) requested 24-hour nursing follow-up Acquisition of materials for hygiene occupied (28%) of the requests and (23,8%) asked for motor, respiratory physiotherapy and speech therapy.

DISCUSSION

Results have shown that from the eighty analysed injunctions, most newcomers were from Recife, females, with high school level, married, with income from 3 to 5 minimal wages and over 80 years old. Most of them used private law service, that can show greater access to justice, an indication of greater economic power, coinciding with the results of Ventura et al (2010) in a similar study carried out in Rio de Janeiro, Brazil. It can be noticed that most lawsuits were filed by females, similar results to those found in other studies, which can suggest greater attention from women to health treatment, in addition to more extended longevity of them in society (MACHADO *et al.*, 2011; MARÇAL, 2012).

Table 4 . Judicialization reasons which led to medical internment in the home care program of SASSEPE, in the period of January 2010 to August 2018. (Recife, PE, Brasil, 2018)

Variable	n = 80	%
Medication	41	51,2
Oxygen / CPAP	5	6,3
Being outside the coverage area	12	15,0
Not to have ABEMID indication for home service by ABEMID	2	25
Needing 24-hour nursing follow-up	33	41,3
Motor Physiotherapy /Respiratory Physiotherapy /Speech therapy	19	23,7
Quantity of hygiene material needed, besides the standardized	8	10,0
Not to have coverage for industrialized enteral diet at home service	49	61,3
Request for diapers	14	17,5

Source: Elaborated by the author by using research data.

It is also possible to realize that the majority of people were elderly, over 80 years old, demonstrating a greater aging of the population which corroborates the fact that most of them are retired. The population aging is one of the problems to be faced by society, considering that the older the population the greater its needs (MIRANDA; MENDES; SILVA, 2016). From 40 years old, strokes have a high prevalence in the population (WANG *et al.*, 2017). A study carried out in Santa Maria, Rio Grande do Sul, Brazil, corroborates the results of the present study, when it shows that the majority of patients had a diagnosis of stroke, also verifying that women are the most affected, mainly over 70 years old (ROSA; MORAES; TREVISAN, 2015). In a certain way, home service was thought to assist patients with chronic health problems as stroke patients and Alzheimer sufferers, among other pathologies that affect elderly population (SILVA *et al.*, 2013). It was observed a non-agreement between the judicial decisions and the pre-established technical parameters for the classification of the clinical complexity of the patients. While by the parameters only 21,3 % were classified as high complexity, in the injunctions, granted by the court, the percentage reached 87,5%. One realizes an enormous discrepancy between these two classifications. From such results it is inferred that there is a need for wider knowledge on the part of the judiciary in decision –making for these actions, since the absolute majority of requests were attended as being of high complexity, regardless the existing parameters for this clinical classification.

The National Council of Justice (CNJ) proposes that judges have support from pharmacy and medicine specialities , so that they can access technical information and be instructed by specialists in each area, since this theoretical apparatus is not part of their training (BRAZIL, 2017). Still thinking of the aspect of subsidizing the decision-making of the judiciary, it was approved the recommendation number 31, from March 30, 2010, which recommends the courts the adoption of measures with the objective of giving greater support to the judges and other law operators in order to guarantee more security in deliberations. It still recommends incorporating the medical health law for training judges and conducting seminars to incorporate members and managers of the Public Ministry, with the aim of improving knowledge on the subject (BRAZIL, 2010). Although one cannot deny the importance of incorporating support to pharmacy and medicine areas to subsidize the judiciary, one perceives that the instruction does not make any reference to other health areas, what can keep distortions or misinformation about treatments, since these professionals are not responsible for the knowledge of other areas such as nursing, nutrition and physiotherapy. When one analyses the reasons that have most demanded home care actions, it calls for our attention requests for industrialized enteral diets occupying the first place, and soon

after, the requests for medicines. Another study (SOUZA; PIRES, 2008) saw diets as one of the greatest reasons for the lawsuits as well as diapers and hygiene materials. This demand for diets is justified by the fact that sick individuals, restricted to home care, need nutritional special items, due to the dietary changes caused by pathologies, difficulty of swallowing and, often, the restriction to the use of probes (GONÇALVES; MATTOS, 2008). It was proven in a study on dietary costs that diets represented 35,47% of the total hospital bills, and the internal modality reached 59,8% of the total diet costs. In other words this treatment item has a huge impact on individual and family expenses, stimulating the requests for coverage by health plans in home care (HYEDA; COSTA, 2017). In Rio Grande do Sul, Brazil, state champion in judicial processes related to health, it was found out that the most frequent request was for medications, having occupied more than half lawsuits, mainly caused by high-cost medications (RAYMUNDY, 2014), a different datum from the present study, where medications occupied only the second place. The whole world faces this obstacle in relation to health service, the high-cost medications and procedures (CRUZ, 2014). The judicialization of health access generates many controversies, both in the plan of discussion of the public power and in the doctrinal one, according to the National Council of Justice (CNJ) There are doubts if this judiciary intervention hurts the principles of separation of powers. The problem, in this last aspect, often consists of what is pleaded and granted, without a detailed analysis of the case by the judge, since this is an emergency protection, clinging to an unavailable right for an immediate decision (BRAZIL, 2017). Some scholars and public policy makers state that judicial decisions of health rights have possibilities of doing harm to health equity and universality, according to the objectives of sustainable development (RUMBOLD *et al.*, 2017). It is necessary to consider, of course, the existing limitations such as finite budgets, having in mind that the divergence present in these actions does not occur between the right to health of some individuals in opposition to the health right of others (PAIXÃO, 2019). The judicial application of such rights can function more as an "escape valve", perpetuating the regulatory function in the system (YASMIN *et al.*, 2019). The causes for judicialization of assistance in home care are several, because of many actions necessary to different health conditions, making the deficiency of public policies noticeable in this context.

CONCLUSION

By using the results of this study, it has been possible to know the patients' characteristics in the lawsuits, granted in the studied complementary health system, the complexity of the patients and to observe the existence of incoherence between the criteria defined by pre-established clinical parameters and the complexity given in the injunction granted by the judiciary. Besides this, it was possible to identify the motivations for entering the actions, and cases outcome. It is easily observed that there is a necessity for debates, and wider knowledge of the theme, because on one hand, it is essential to protect the right to health, and, on another hand one realizes that there are difficulties, faced by the health plans and the State. All of us hope that these results can contribute to further research on the topic to be carried out, in order to seek more advanced knowledge, facilitate the understanding of the phenomena related to health judicialization and evaluate the way in which they have made progress.

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