DOI: http://dx.doi.org/10.12957/demetra.2014.11559

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Profile of lawsuits over the access to food formulas forwarded to the Brazilian Ministry of Health

Firstly, we would like to thank the discussants for their contributions, whose comments were extremely relevant to deepen reflections on the complex theme discussed in our article. Different views shared by diverse actors are valuable assets to the analysis of a problem, sometimes overlooked both in the field of health and food and nutrition security.

The article by Laura Araújo and Roseney Bellato brings the perspective of the right to health guaranteed by the Federal Constitution, with a focus on children under ten years of age, based on the high demand for the provision of nutrition formulas to this population, as demonstrated in our paper. In this sense, we reaffirm our recognition that judicialization is a legitimate way of claiming rights when the State does not provide inputs, actions and health services that are essential to the preservation of life. We agree with the authors' statements that both the children's parents and the Judiciary act to ensure this right. What we questioned in our article is the lack of rigor for the judicial decision-making and all other factors involved, such as conflicts of interest that may exist and are not considered in the legal proceedings.

So, we corroborate the points discussed by Clarice Petramale when she claims that the lack of documentation on the clinical case and its evidences prevent health managers from being certain about the existing benefits or possible harms

in using the requested product, and its provision based only on prescription and not on a whole care planning makes the control unfeasible with regard to the best therapy as well as any budgetary planning. Likewise, prescriptions for a given brand makes procurement much more difficult in terms of logistics and in obtaining the best purchasing prices and also leave doubts regarding the non-involvement of prescribers, lawyers, and associations of patients and inputs producers.

So, as claimed by Petramale, it is necessary to make sure that requests for nutrition formulas indicate scientifically what are the expected results with the use of the requested product, how long it will take to produce effect, and how the expected results will be monitored. Also, they should state clearly the criteria for discharge or suspension of treatment and include diagnostic tests and an assessment of the nutritional condition. As a result, it would be possible to give more certainty to the Judiciary to base its decisions, as well as to health managers, who will be able to assess the need and vulnerability of the patients and ensure that the provision of the nutrition formulas will not be eternized without justification. Thus, it will also contribute to the decision on whether include or not such nutritional input to the therapeutic supplies available at SUS, and in doing so alternative undesirable accesses to the products would be prevented.

Individualized decisions that disregard the collective aspects of allocating resources to health actions and services may be an evidence of a timid performance of the Judiciary in defense of SUS and its operationalization. It would also be worth questioning how well the Judiciary has been supporting the planning and assessment of public health policies in a collective level, not only on individual cases. So, we reaffirm our position in the article regarding the importance of an effective and continuous communication between the Judiciary and the Executive Powers, to which we would also add the need for support to the control instances and social participation.

Our reasoning about the lack of criteria for the Judiciary decision-making, with approval of 97.5% of demands, as demonstrated in various studies,[1-6] does not mean that we do not recognize that there also are tensions and conflicts, as well as the capture by private interests in the levels of the Executive branch. In the field of Food and Nutrition, it has been demonstrated that corporations use the most diverse strategies to influence public policies, from research funding to lobbying, and influence managers and professionals in the area. [7]

Brazil is one of the few countries that have a universal and free health system, but there are still financial and organizational limitations that impact the effectiveness of its principles of universal and equitable access and a full, comprehensive care. In this sense we agree that there are weaknesses in the Public Healthcare System (SUS), as pointed out both by Laura Araújo and Roseney Bellato, and Ligia Bahia.

It has been recommended that the system should be organized in Healthcare Networks (HCN), having primary care as the coordinator and organizer of care; however, what still prevails is the hospital-centered model. An example is in relation to nutritional therapy, where it has been observed that it is a practice historically recognized and performed in hospitals, where industrial nutrition formulas are usually prescribed. Such prescriptions are maintained after discharge for several reasons, among them: lack of organization for continuity of care in the HCN, such as nonexistent protocols and lines of care and unavailability of required therapeutic resources; uncertainty or lack of knowledge of professionals of other care units to re-evaluate the prescribed care and recommend interventions consistent with the living conditions of the individuals outside the hospital. Furthermore, there is a lack of scientific evidences to support the professionals' decision-making on the best dietary practice, whether with industrial nutrition formulas or formulas made from foods and food products.

In addition to a fragmented system, translated into the still little organized regional health services and lack of articulation between the HCN units, and the supremacy of the hospital-centered model, underfinancing, and fragility of SUS management are also issues to be tackled.

Although there are still many challenges, one cannot criticize the State for omission or lack of commitment in ensuring the right to health, once there has been considerable progress, as mentioned by Clarice Petramale in her article. In addition to the advances already pointed out by Petramale, we can cite the prioritization of primary care in recent years, also in financial terms, to ensure full access to the health system with quality and resolution. Accordingly, there has been an increase in the provision and qualification of health professionals, of home care, as well as of the primary care coverage to the population, especially the Household Health Strategy, which had impacts on the reduction of hospitalization and deaths caused by coronary heart diseases[9] and child mortality,[9] and so the Millennium Development Goal in relation to child mortality was achieved four years ahead of time.

Regarding child-oriented actions, Brazil has a number of initiatives that prioritize the provision of comprehensive care for children and include the guaranteed household minimum income and the access to health and education services. Thus, concerning children's health, the Ministry of Health and the State and Municipal Health Secretaries develop actions to train and qualify health professionals for the humanized care of newborns and improved practices of care at delivery and after childbirth, and so the Best Practices in Labor and Delivery, as recommended by the World Health Organization (WHO), are adopted. Also, actions to promote breastfeeding and healthy supplementary feeding, prevention and control of nutritional deficiencies, such as deficiency of vitamin A, anemia and malnutrition have been adopted, as well as incentives to carrying out actions to promote health and nutritional monitoring by the health staff of daycares and schools.

Finally, we agree with Araújo and Bellato, who brought to the debate that judicial demands serve as an alert for *the development of public policies and organization of practices that aim to promote, protect and recover the health of this population*. To this effect, based on the lawsuits and in the context of SUS improvements in recent years, the Ministry of Health brought to public consultation a proposed order that sets forth the guidelines for the organization of Nutritional Therapy in the Healthcare Network, and another one that updates the criteria for certification and eligibility of Nutritional Therapy services in hospitals. Still in discussion is the line of comprehensive care and the Clinical Protocol and Therapeutic Guidelines for children with Allergy to Cow's Milk Protein, a disease that accounts for the greatest demand for nutritional formulas via lawsuits, as shown in our paper.

In addition, the *Caderno de Atenção Domiciliar sobre Cuidados em Terapia Nutricional* (Handbook for Home Care Nutritional Therapy) will be published, aiming to support the primary care and home care teams, as well as SUS managers in the organization and provision of home care in Nutritional Therapy. Likewise, this thematic supplement "Care of Special Dietary Needs at SUS" contributes to the dissemination of scientific evidences and experiences on the theme, and assisting managers and professionals in the organization and provision of care to persons with special dietary needs at SUS.

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Received: July 10, 2014