Revista Jurídica vol. 02, nº. 64, Curitiba, 2021. pp. 489 - 514

THE RIGHT TO HEALTH AND ACCESS TO ICUs IN PANDEMIC TIMES: THE CASE OF THE MUNICIPALITY OF FORTALEZA (FIRST WAVE OF COVID-19)

O DIREITO À SAÚDE E O ACESSO ÀS UTIs EM TEMPOS DE PANDEMIA: O CASO DO MUNICÍPIO DE FORTALEZA (PRIMEIRA ONDA DA COVID-19)

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ABSTRACT

Objective: the article deals with the fundamental right to health and access to intensive care units – ICUs in the pandemic of COVID-19. The central core lies in the possibility of reconciling the right to equal treatment regarding the access to ICUs with the maximization of health benefits. The research has as its outline the city of

[Received/Recebido: Janeiro 19, 2021; Accepted/Aceito: Março 30, 2021]

Fortaleza, capital of Ceará, analyzing the period from March 1st, 2020 to June 19th, 2020 and the access criteria to ICUs adopted by the municipality.

Methodology: the research is descriptive and exploratory, with analysis of doctrinal texts, normative acts and empirical data and based on deductive reasoning.

Results: in Fortaleza, the criteria stipulated by CFM Resolution No. 2,156/2016 are applied, adapted to the structural aspects of the local health service. The disease causes more severe damage in neighborhoods with low HDI, as found. The option for a single line of access to hospital beds, public or private, in the experienced pandemic, reveals itself as a mitigating measure of the imposed social inequalities, however, there are great difficulties for its implementation.

Contributions: the main contribution of this study is to draw attention to the compatibility of the right to equal treatment and the access to ICUs with the maximization of health benefits, emphasizing the analysis of the criteria for access to ICUs adopted by the Municipality of Fortaleza during the pandemic and regarding the need to implement public policies that mitigate social inequalities.

Keywords: Right to health; Criteria for access to the ICU; Single line; COVID-19**.**

RESUMO

Objetivo: *o artigo versa sobre o direito fundamental à saúde e o acesso às unidades de terapia intensiva – UTIs na pandemia COVID-19. O núcleo central situa-se na possibilidade de compatibilização do direito ao tratamento igualitário ao acesso às UTIs com a maximização de benefícios em saúde. A pesquisa tem como recorte a cidade de Fortaleza, capital do Ceará, sendo analisado o período de 01 de março de 2020 a 19 de junho de 2020 e os critérios de acesso às UTIs adotados pela referida municipalidade.*

Metodologia: *a pesquisa é descritiva e exploratória, com análise de textos doutrinários, atos normativos e dados empíricos e baseada em linha de raciocínio dedutivo.*

Resultados: *em Fortaleza, aplicam-se os critérios estipulados pela Resolução CFM nº 2.156/2016, adaptados aos aspectos estruturais do serviço de saúde local. A doença ocasiona danos mais severos em bairros com baixo IDH, conforme constatado. A opção de fila única de acesso a leitos, públicos ou privados, na pandemia vivenciada, se revela como medida atenuante das desigualdades sociais impostas, todavia, constatam-se grandes dificuldade para sua implementação.*

Contribuições: *a principal contribuição do trabalho consiste em chamar a atenção para a compatibilização do direito ao tratamento igualitário o acesso às UTIs com a*

[Received/Recebido: Janeiro 19, 2021; Accepted/Aceito: Março 30, 2021]

maximização de benefícios em saúde, dando ênfase à análise de critérios de acesso às UTIs adotados pelo Município de Fortaleza durante a pandemia e à necessidade de implementação de políticas públicas que atenuem as desigualdades sociais.

Palavras-chaves: *Direito à saúde; Critérios de acesso à UTI; Fila única; COVID-19.*

1 INTRODUCTION

The classic dilemma of the lack of resources imposes its optimization, which becomes even more drastic once it affects a common good such as health. It is explicit that everyone has the right to health, as universally guaranteed in the Constitution, which implies the right to hospitalization in intensive care units – ICUs. During the pandemic resulting from the proliferation of COVID-19, in which the demand for ICUs exceeds the supply, the definition of objective criteria for its access becomes extremely necessary.

The article's central issue is to analyze how it is possible to merge the equal treatment to which everyone is entitled with the need to maximize benefits, due to the scarcity of intensive care units and the high demand for hospital beds experienced in the pandemic. There have been many proposals of criteria for the access to ICUs, some with an unapologetically utilitarian bias, which will be analyzed in the light of constitutionally elected principles.

The perspective will not be only theoretical, the criteria applied in the conceding of ICUs in the Municipality of Fortaleza will be examined. Capital of the State of Ceará, situated in the Northeast of Brazil, Fortaleza is a city of tourist calling, with approximately three million inhabitants, marked by a profound social disparity.

It is noteworthy that the time lapse analyzed by this study – March 1st, 2020 to June 19th, 2020 – is considered one of the most critical periods experienced in the pandemic by the city of Fortaleza, one of Brazil's most affected cities by COVID-19.

Initially, the access to ICUs will be characterized as a logical consequence of the right to health. Afterwards, the analysis will fall on their access criteria from a critical perspective, aiming to debate their democratization. Then, the situation of

[Received/Recebido: Janeiro 19, 2021; Accepted/Aceito: Março 30, 2021]

Fortaleza in the referred period will be analyzed. At the end, the conclusions will be presented.

The methodology is descriptive and exploratory, with the analysis of texts, especially doctrinal and normative acts, as well as empirical data. The data, indicators and information related to Fortaleza were obtained through the weekly epidemiological bulletin released by the Municipality of Fortaleza, as well as through the information request responded by the Municipal Health Department and the Report issued by the Center of Operations in Public Health Emergency (internal circulation document).

2 THE ACCESS TO ICUs AS AN EXPRESSION OF THE RIGHT TO HEALTH

Brazil's current Federal Constitution can be considered the most innovative and progressive regarding the guarantee of fundamental social rights and, especially, concerning the achievement of the right to health. According to Sarlet and Figueiredo (2013), before its promulgation, a "fundamental right to health" could not be recognized, since the previous provisions were limited to sparse norms, such as the guarantee to "public aid", inscribed in the 1824 Constitution, the inviolability of the right to subsistence and the imposition of the adoption of legislative and administrative measures to restrict child morbidity and prevent the spread of infectious disease, instituted by the Constitutional Charter of 1934.

The normative-constitutional model of 1988 broke previously reached paradigms to bring independence to the right to health, which was no longer necessarily correlated to the guarantee of social welfare. The breach with the established liberal normative tradition and the compliance, on the other hand, with the claims of the Sanitary Reform Movement, signed in the conclusions of the VIII National Health Conference, triggered new boundaries to the right to health in Brazil (SARLET; FIGUEIREDO, 2013).

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Another significant aspect that led to the installation of the new scenario, as emphasized by Hachem (2013), was the consolidation of the Constitution's idea of supremacy, which established validity parameters of the material content of all of the other norms of the legal system, and consolidated more relevant social values, whose compliance is mandatory not only to the legislator, but also to the judge and the Administration. The appreciation of the dignity of the human person and of the fundamental rights takes on new dimensions, making it possible to refer to a Constitutional Right of effectiveness, with concerns focused on the legal and social efficiency of the constitutional provisions.

The current constitutional order, therefore, recognized the right to health as a duty of the State, which became responsible for adopting measures to protect, promote and recover health, providing, if applicable, the most appropriate and effective treatment to fit the patients' need. Aiming to provide full physical, mental, and social well-being to all, it is determined that the State's actions and services must focus on protection (preventive health), promotion (promotional health) and health recovery (curative health), according to the international concept of health established by the World Health Organization (1946).

Despite the innovations, the constitutional order was not able to align itself with the reality of the Brazilian economy, where the scarcity of public resources prevails, especially regarding the funding and execution of several social rights. As time goes by, continuous advances occur both in scientific knowledge and in the cost of health assistance. However, unlike what usually happens in other sectors, technological advancement does not necessarily imply cost reduction, increasing the insufficiency. As concluded by Dworkin (2005), the rise of the prices in the health sector is not due to a more expensive traditional medicine, but to the advent of new medical treatments, since the technologies in this area are not substitutes, but cumulative, including in intensive care.

In fact, the increase in the demand for intensive care is a global phenomenon resulted from several factors, such as population growth and aging, an increase in the prevalence of comorbidities, etc. (RHODES; CHICHE; MORENO, 2011).

[Received/Recebido: Janeiro 19, 2021; Accepted/Aceito: Março 30, 2021]

However, it must be considered that after the declaration of the World Health Organization (ORGANIZAÇÃO DAS NAÇÕES UNIDAS, 2020) regarding the existence of a global pandemic, caused by COVID-19, on March 11th, 2020, there was an escalation of the situation.

The high rate of infection and the severe respiratory damage caused by COVID-19 culminated in the urgent need to expand access to ICU beds in many countries around the world, including Brazil, where an insufficient capacity in the care for patients in critical and unstable conditions was already verified.[1]

In this context, the importance of the access to ICUs in the realization of the fundamental right to health should be emphasized, considering that its primary goal is to aid critical patients, that present instability or risk of vital clinical instability and face the risk of death (CONSELHO FEDERAL DE MEDICINA, 2020).

In the national normative scope, CFM Resolution No. 2.271, of February 14th, 2020, in its article 1, legally defines ICU as:

> [...] hospital environment with an organized system to offer high complexity vital support, with multiple modalities of monitoring and advanced organic support to preserve life during clinical conditions of extreme severity and risk of death from organ failure. This assistance is provided continuously, 24 hours a day, by a specialized multidisciplinary team (CONSELHO FEDERAL DE MEDICINA, 2020, s. p.).

Therefore, the existence of a multidisciplinary team specially trained and equipped, dedicated to the treatment and monitoring of patients facing the risk of death, as well as the existence of facilities to support vital functions, significantly favor the preservation of life and effective treatment of the ill (INTENSIVE CARE SOCIETY, 2013).

Although the Federal Constitution has not defined, specifically, the meaning of the right to health, it must be understood that it is linked, intimately, to the

[1] According to data from the Brazilian Intensive Care Association (2020), in a period prior to the pandemic, the World Heal Organization recommended that the ideal ratio of ICU beds would be 1 to 3 for every 10,000 inhabitants. However, with the outbreak of COVID-19, the number of beds recommended by the referred International Organization proved to be insufficient during the pandemic. Also, a discrepancy in the number of ICU beds in Brazil as early as 2019 can be noted, as shown bt data from the Brazilian Institute of Geography and Statistics (2019).

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protection of life, physical integrity, and the dignity of the human person, being directly connected to the existential minimum. According to Sarlet and Figueiredo (2013), a strong jurisprudential and doctrinal tendency regarding the recognition of subjective positions may be noted, as a result from the right to health in the condition of a right to material benefits, both in the hypothesis of the individual's risk of death, or even in situations in which the provision enables the concept of an existential minimum, that is, the guarantee of basic conditions of life with dignity and some quality.

It is worth highlighting that this minimum should not be limited only to preventative health actions, but also should include efforts related to curative health, such as the access to ICU beds, essential for maintaining the life of critically ill patients who are at risk or present vital clinical instability. Therefore, those who may need to be hospitalized in intensive care beds deserve legal safeguard, to achieve the right to health in a humanized, holistic, and safe way.

Facing the constant innovation and rising costs of health equipment, the state limitation for the accomplishment to the right to health is a recurrent theme in the contemporary debate (ALCÂNTARA, 2016). The deficit in the implementation has caused the phenomenon "judicialization of the right to health" (CONSELHO NACIONAL DE JUSTIÇA, 2019), resulting in deleterious effects on the organization of the health system (MATIAS; MUNIZ, 2015). The theme is beyond the scope of this article, but it is extremely important.

As seen, in an environment of scarcity, objective criteria of access to ICUs must be determined, which will be analyzed from now on.

3 BETWEEN ICU ACCESS EQUITY AND THE MAXIMIZATION OF HEALTH BENEFITS

Facing the scenario of tragic choices during the pandemic caused by COVID-19, although everyone has the right to effective treatment, access to ICUs has been

[Received/Recebido: Janeiro 19, 2021; Accepted/Aceito: Março 30, 2021]

restricted. The high global demand for health equipment and the lack of qualified human resources has banned the expansion of new ICU beds with the necessary survival equipment, especially ventilators.

So, the problem becomes the definition of parameters of choice, of electing criteria to define those who will have access to health equipment and, at last, will increase the chances of cure. Thus, it is necessary to establish a screening model balanced in the light of the universality of the right to health and the exceptional nature of the current situation.

3.1 THE CRITERIA CONSOLIDATED BY THE FEDERAL COUNCIL OF MEDICINE – CFM

The Federal Council of Medicine – CFM (2016), through CFM Resolution No. 2.156/2016, establishes parameters for prioritizing admission and discharge from the intensive care unit, which must take into account the resources available in the care unit, based on the patient's diagnosis and needs (accordingly justified by the requesting physician and registered in the medical record), on the clinical condition and on the potential benefit for the ill with the therapeutic interventions and prognosis.

Tuned with the constitutional text, specifically with articles 1st, III; 5th, I; and 196 of the Federal Constitution, criteria based on religion, ethnicity, sex, nationality, color, sexual orientation, age, social status, political opinion, disability or any other form of discrimination are ruled out (BRASIL, 1988).

Five levels of hospitalization priority are established, opposite of the order of magnitude: Priority 1 - patients who need life support interventions, with a high probability of recovery and without any limitation of therapeutic support; Priority 2 - patients who need intensive monitoring, due to the high risk of needing immediate intervention, and without any limitation of therapeutic support; Priority 3 - patients who need life support interventions, with low probability of recovery or with limitation of therapeutic intervention; Priority 4 - patients who need intensive monitoring, due to

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the high risk of needing immediate intervention, but with limitation of therapeutic intervention; Priority 5 - patients with terminal illness, or dying, with no possibility of recovery.[2]

CFM Resolution No. 2,271, dated on February 14, 2020, besides defining intensive care units and intermediate care units according to their complexity and level of care, as well as determining the medical technical responsibility, ethical responsibilities, qualifications and obligations of the medical team that are necessary for its proper functioning, clearly states, in item 3.1, Annex I, that the criteria for admission and discharge from the ICU must be guided by CFM Resolution No. 2,156/2016 (CONSELHO FEDERAL DE MEDICINA, 2020). These parameters have been used in Brazil, in general, in the pre-pandemic phase and are still being used currently.

The assumption of a minimum standard of disease severity is established, which is used to give priority to patients that need life support interventions, with high probability of recovery and without any limitation of therapeutic support, a priority that decreases according to the reduction of the chances of recovery, which means that the privilege is guaranteed to those whose life is more likely to be saved.

Based on the general criteria of the situation's severity, an equitable parameter, the chance of recovery is privileged, without any distinction grounded on religion, ethnicity, sex, nationality, color, sexual orientation, age, social status, political opinion, disability, or any other form of discrimination. The discretion enshrines the option for the highest amount of lives susceptible of being saved, whether national or foreign, black or white, elderly or children, rich or poor. It is necessary that the indication of the priority degree results from a perfect analysis of the reality, with a precise justification of the clinical situation in the patient's medical report, to ensure transparency and eradicate influences from others, such as relatives.

[2] In general, patients with terminal illness or dying are not suitable for admission to the ICU (except if they are potential organ donors). However, their admission may be justified on and exceptional basis, considering the peculiarities of the case and conditioned to the discretion of the intensive care physician.

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With the severe crisis of access to health equipment nowadays, several parameters have been projected for its access, which will now be analyzed.

3.2 ADDITIONAL PARAMETERS TO ACCESS ICUS

Other criteria regarding the access to ICUs have been suggested, based on the conception that public policies must be economically efficient, understanding as such the prioritization of choices that benefit the highest number of people, considering that, at its core, it should be the greatest number of years of life or, even, the greatest number of years of life with quality. Tuned with utilitarian suggestions, the Brazilian Intensive Care Association – AMIB presented a Protocol regarding the allocation of scarce resource during the COVID-19 pandemic, in a purely suggestive manner.

In its initial version, suggested in April 2020, a criterion of prioritization to access ICUs based on the chance of benefit was proposed, equally applied to all the patients, regardless of subjective considerations concerning quality of life. It respected the equalization of the opportunity of individuals to go through the different cycles of life, which does not favor the elderly, even if healthy. It proposed tiebreaker criteria, sequentially, the score of clinical fragility, the total severity score of Sequential Organ Failure Assessment (SOFA), a criterion for checking the probability of survival proposed by professors of the University of Pittsburgh School of Medicine, with the title “Allocation of Scarce Critical Care Resources During a Public Health Emergency” (KRETZER *et al.*, 2020; WHITE, 2020), and the randomization. It is noticeable that the legal inadequacy of the document was clear.

In the version launched in the beginning of May 2020, it evolved to exclude the criterion of age group as an element to access treatment, since it is discriminatory and is not in line with the Federal Constitution. The inclusion of a functionality measure is the main difference between the two versions (KRETZER *et al.*, 2020).

On the other hand, there are criteria that are based on the factor of the number of years with life quality, which perpetuate previous existing disparities. The

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Quality Adjusted Life Years – QALY, suggested as a health parameter by the National Institute for Health Care Excellence – NICE (2020), public body of the English department of health, is an example.

In the last years, QALYs have become widely used indicators in health outcomes and this basically occurs due to three important factors: 1) they combine changes in morbidity (quality) and mortality (quantity) in a single indicator; 2) they are calculated through simple multiplication, although the previous estimate of utilities associated with certain health conditions is a complicating factor; 3) they are based on a peculiar economic analysis tool applied to the health area, in the analysis of cost-utility (DRUMMOND *et al.*, 1997).

QALY is centered on the objective of preserving as many years with quality as possible. Based on the determination of health conditions that would be preferentially understood as desirable, a perfectly healthy life parameter is established, assigning a perfectly healthy life unit (QALY) for each year of life in such circumstance. The same criterion, years of life with quality, results from the application of clinical scales of fragility (CECHINEL, 2015), in which clinical aspects that may compromise the capacity of recovery are indicated, drifting away the priority to the access of ICUs for the individuals that fit in them (NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE, 2020).

All these criteria must be balanced in the light of the argument that the customary use of efficiency is not a value itself, but a mere instrument for the achievement of constitutionally foreseen purposes, in this case, the right to health. It should be noted that the legal order can use economic parameters, which lead to more objective analysis, as long as it does not use them to dismiss constitutionally elected values.

Therefore, legal efficiency, which means adequacy to constitutional values, can not be confused with economic efficiency, relevant to the optimization of resources. Although it may be influenced by the last one, in case there is a conflict, legal efficiency must prevail.

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3.3 THE SINGLE LINE AS A WAY TO DEMOCRATIZE ACCESS TO ICUS

In search of mechanisms that democratize the access to ICUs, intense has been the society's and scientific community's debate regarding the standardization and regulation of the single line. Facing the difficulties experienced and the lack of ICUs, aggravated by the serious respiratory complications caused by COVID-19 to thousands of individuals and, to a greater extent, to users of the Unified Health System – SUS, the debate on the adoption of a general single line to grant ICU beds in Brazil with the objective of democratizing the access has been nurtured.

The repercussions in favor and against the use of a single line to regulate ICU beds vary. In the social sphere, the Bed for All Manifesto (*Manifesto Leitos para Todos*) suggests that SUS should be responsible for controlling and coordinating of all the public and private beds in Brazil, through a unified regulation managed by the state departments, with no discrimination between the individuals that have a health plan and those that do not (SERRANO *et al.*, 2020).

Likewise, Recommendation No. 026 of the National Health Council (2020, s.p.) was issued, which: "recommends SUS managers, within their sphere of competence, to request private beds, when necessary, and to proceed with their unique regulation in order to guarantee equal care during the pandemic".

In the technical-scientific field, studies have supported the regulation and standardization of a single line by the Ministry of Health, along the terms of the National Transplant System, a model in which the state secretariats would also be responsible for the organization of a single hub of vacancies for each respective state (UNIVERSIDADE DE SÃO PAULO, 2020). In fact, a preliminary study carried out by the Getúlio Vargas Foundation (FGV EAESP) in a partnership with other institutions, points out that, besides social isolation measures, the unified line between public and private sectors could considerably mitigate the scarcity of ICU beds during the pandemic in various states (DANA *et al.*, 2020).

In the legal field, the debate got to the analysis of the Supreme Federal Court through the Failure to Comply with Fundamental Precept (ADPF) No. 671, filed by

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the Socialism and Freedom Party (PSOL). Through the referred action, it was claimed that SUS should regulate public and private ICU beds, while the COVID-19 pandemic lasts, through a single line of access, based on the guarantee of the right to health, of the dignity of the human person, of equality, of life and of equal access to health services (BRASIL, 2020).

However, the rapporteur, Minister Ricardo Lewandowski, deprived the action from moving forward, understanding that the ADPF would not be the appropriate way to guarantee the desired intention, being out of that Court's competence to replace the Public Administration, given that any entity of the federation would be able to require private goods and services related to health in the event of imminent public danger, according to the Federal Constitution (article 23, II), to the Organic Health Law (article 15, XIII of Law No. 8,080/1990) and to the Civil Code (article 1,228, §3º). Besides the referred provisions, the rapporteur also mentioned the administrative request, provided for by Law No. 13,979/2020, specially published for the battle against COVID-19 (BRASIL, 2020).

Against the aforementioned decision, PSOL filed an interlocutory appeal, which is still pending decision to date. Through a manifestation to the appeal, the National College of General Attorneys, representing the States of the Federation and the Federal District, made clear its understanding in favor of the administrative request, but demonstrated opposition towards a national single line to regulate ICU beds. Among the arguments raised, there is the disparity experienced by the States regarding the capacity of available beds, therefore, each state should adopt the best way to fight the pandemic. Also against the adoption of a single line was the manifestation of the Attorney General of the Republic (BRASIL, 2020).

In fact, the spread of COVID-19 has required quick and effective responses from health systems at national, state, and municipal levels. The identification of vulnerabilities and the measurement of needs are strategic actions in the management of responses to fight the disease.

Based on the proposed strategies, the single line of ICU beds must be considered as an option for coping with the health problem caused by COVID-19.

[Received/Recebido: Janeiro 19, 2021; Accepted/Aceito: Março 30, 2021]

Despite the contrary manifestations, the single line appears in the Brazilian scenario as an equal path for the democratization of health, given that most individuals affected by the disease are amongst the low-income population.

According to a study carried out by the Imperial College, in London, the most severe effects caused by COVID-19 are found in the most deprived strata of society, with a mortality rate 32% (thirty-two percent) higher when compared to wealthier classes (WINSKILL *et al.*, 2020).

The research also shows that low-income people work in occupations that are often not compatible with social distancing measures, what reduces these individuals' ability to protect themselves against the infection. Besides, difficulties in accessing basic sanitary resources, such as water and soap, hospitals and housing that allows social isolation were considered (WINSKILL *et al*., 2020). The Brazilian scenario is not different, as demonstrated from a fragment of the reality extracted from the Municipality of Fortaleza, capital of the State of Ceará.

It is certain that, due to the current pandemic situation, it is necessary to adopt practical mechanisms that enable universal, equal, and democratic access to health services in Brazil, without distinction between users of SUS and health plans. The conception of a single line of severe cases of COVID-19 that require hospitalization and intensive care, updated and regulated by SUS, similar to the method used by the transplant queues, proposed by different segments of society, shows itself as an appropriate and democratic management route to handle COVID-19 and the scarcity of ICU beds.

However, since there are difficulties in its implementation, it is even more important to define criteria for care priorities, in order to guarantee an isonomic performance in the public and private spheres, emphasizing that the violation of these criteria may generate disastrous consequences, both for the patient and the functioning of the health system.

[Received/Recebido: Janeiro 19, 2021; Accepted/Aceito: Março 30, 2021]

4 THE COVID-19 PANDEMIC AND THE ACCESS TO ICU BEDS IN FORTALEZA/CE

The clipping of the article is directed to the Municipality of Fortaleza, capital of the State of Ceará, one of the most affected states by the COVID-19 pandemic. With an estimated population of approximately two million and six hundred thousand people and an area of 312,353 km², in 2019, the demographic density reaches 8,323hab / km², according to IBGE data. The female population is valued around 53%. In its metropolitan region, the population exceeds four million people, according to an estimate of 2019. The HDI of the Municipality is 0.754, in 2010 data (INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA, 2019).

As reported on the Weekly Report issued by the Municipal Health Secretariat of Fortaleza, confirmed deaths caused by COVID-19 have a close connection with the HDI of the analyzed neighborhood, with a higher number of deaths being found amongst residents of neighborhoods with a low and very low HDI. (FORTALEZA, 2020a).

According to data from the report published by the Center of Emergency Health Operations (COE-nCoV), within the scope of the public health service, until June 1, 2020, 97.7% of deaths were of individuals living in neighborhoods very low HDI, with only 3.3% and 2% of deaths of people living in high/very high and medium HDI neighborhoods, respectively. In the scope of the private service, the percentage of deaths of residents of neighborhoods with very low HDI was 78.2% (FORTALEZA, 2020b).

The city is divided into six health regions, segmented into neighborhoods. In each region, neighborhoods with higher and lower density of poverty, as measured by HDI, are found, however, it is certain that the poorest neighborhoods are concentrated in the west zone, composed by regionals I, III and V.

In global numbers of cases, the regionals in the western zone (I, III and V) are among those with the lowest number. The higher number of cases is found in regions II, IV and VI. However, the time series of confirmed deaths demonstrates the

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concentration of the number of deaths in the poorest areas, in neighborhoods embraced by Regional I (Arraial Moura Brasil; Barra do Ceará; Cristo Redentor; Pirambú and Vila Velha, among others) and Regional V (Bom Jardim; Canidezinho; Conjunto Ceará I and II; Genibaú; Granja Portugal; Granja Lisboa and Mondubim, among others (FORTALEZA, 2020b).

In the aftermath, there is a large number of deaths in some of the poorest neighborhoods of Regional II (Cais do Porto; Praia do Futuro I and Praia do Futuro II, among others), the area with the highest absolute number of cases in which the neighborhoods with the highest HDI in the city are concentrated, which also contributes to the incidence of a greater number of tests in the region (FORTALEZA, 2020b).

According to indicators of the Weekly Report, updated on June 19, 2020, the neighborhoods with the highest number of deaths were: Barra do Ceará (118), Vila Velha (91), Cristo Redentor (69) and Carlito Pamplona (51), located in Regional I; Granja Lisboa (77), Mondubim (71), Mayor José Walter (63), Bom Jardim (55) and Granja Portugal (49), located in Regional V; Vicente Pizon (80), Centro (59), Meireles (57) and Cais do Porto (42), located in Regional II; Bonsucesso (48), Pici (52) and Antônio Bezerra (49), located in Regional III; Jangurussu (53) and Messejana (52), located in Regional IV (FORTALEZA, 2020a).

It is also demonstrated that the lowest number of deaths is located within the districts that compose Regional IV (Airport; Benfica; Bom Futuro; Damas; Fátima; Gentilândia; Itaóca; Jardim América; José Bonifácio; Montese and Parangaba, among others) (FORTALEZA, 2020a), a middle class region, in which, besides houses, are located stores and educational institutions. The decree of social isolation, restricting commercial activities and face-to-face classes, was a very important factor in the control of the contamination and, consequently, in the reduction of the number of deaths.

From the whole context, the evidence extracted evinces that the disease had an initial impulse in the wealthiest neighborhoods, such as Meireles, and then expanded to the poorest areas, where it has caused the greatest impact. In the

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neighborhoods with the highest HDI, people have better original health conditions, due to a history of good nutrition and frequent medical care, as well as access to health plans, with the necessary equipment to cope with COVID-19.

The distribution of Municipal Emergency Care Units – UPAs in the Municipality of Fortaleza, in which the most urgent care occurs, obeys the logic of contemplating the most deprived areas (FORTALEZA, 2020c). However, the care provided by the UPAs is carried out in an initial way, being these units characterized as a gateway to the municipal health system, especially in the cases of patients affected by COVID-19. Then, through the regulation, the patients who need hospitalization will be directed to hospital beds (infirmary or ICU).[3]

According to data from the report issued by the Center for Emergency Health Operations (COE-nCoV), the contamination occurred more intensely among females. Featuring age groups, only in the range of 60 (sixty) to 79 (seventy-nine) years old, the infection was mostly in males (52%). In all other age groups, the female population exceeds half of the contaminations. However, when the analysis falls on the number of deaths by age group, it is noticed that there is an inversion, with the majority of deaths among males, in all age groups, except for the age group above 80 (eighty) years old, in which more women passed away. Nevertheless, in this age group, there are more women than men. The lethality rate by sex and age group indicates that males are more lethal in all age groups (FORTALEZA, 2020b).

The correlation of cases and deaths indicates that the age groups most affected were those that contemplate people between 60 (sixty) and 79 (seventy-nine) years old, in which 22% (twenty-two percent) of the cases occurred with 46% (forty-six percent) of deaths and people over 80 (eighty) years old, in which 7% (seven percent) of the cases occurred and 30% (thirty percent) of the deaths (FORTALEZA, 2020b).

This reality is added to a deprived population, that does not have health plans, already weakened by aspects resulting from low economic conditions, such as malnutrition, and there is a favorable scenario for more drastic effects of the

[3] Information provided in response to a formal request to the Municipal Health Secretariat.

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contamination. It is interesting to emphasize that there was no adoption of new screening criteria for the allocation of patients in the ICU in the city of Fortaleza. The criteria established by the Federal Council of Medicine – CFM (priority 1 to 5 – CFM Resolution No. 2,156 / 2016), which have already been analyzed, continue to be used. [4]

As highlighted, there is no preference based on criteria of religion, ethnicity, sex, nationality, color, sexual orientation, age, social status, political opinion, disability, or other forms of discrimination. Levelled by the health condition that imposes intensive treatment, the objective is to save the lives that have the best chance, according to their clinical conditions. The indication of the priority degree must result from a perfect analysis of the reality, with the precise justification of the clinical situation in the patient's medical record, ensuring transparency.

Amid a large number of cases of COVID-19 and the high demand for ICU and infirmary beds in the public health system, despite the expansion carried out by the Municipality of Fortaleza, with the creation of a parallel health system, operating in all levels of health care (primary, secondary and tertiary) in coping with the new coronavirus, at the municipal level, the disease reached its peak in May 2020, reaching 106 (one hundred and six) patients in nursing demands on May 14, and, on May 6, 32 (thirty-two) patients needing ICU beds (FORTALEZA, 2020b).

In the scope of primary care, the structural expansion was significant, which now has 113 beds, equipped with oximeter and laboratory. There was also an increase in the transport fleet, with the purchase of 7 (seven) units of advanced support, 6 (six) medical transports, 4 (four) ambulances from SAMU. Besides, there was a noteworthy growth in the number of medical professionals (173) through the programs Family Doctor Fortaleza and More Doctors Brazil, to work in basic health units. A digital tool “Atende em Casa” (“Home Care”) was also made available with the goal to guide citizens through initial screening based on online appointments (CABRAL, 2020).

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Within the scope of the secondary care system, the expansion of care was also verified, with a total of 791 (seven hundred and ninety-one) specific beds for COVID-19 in the pre-hospital and hospital systems. Also, the number of beds in Emergency Care Units (UPAs) was increased by 177% (one hundred and seventy-seven percent), as well as the construction of a campaign hospital (Hospital Presidente Vargas), specific for coping with COVID-19, with a total of 224 beds, being capable of having up to 336 inpatient units. In tertiary care, with the opening of the Dr. José Frota Institute 2 (IJF-2), the service capacity was expanded to 100 (one hundred) ICU beds and 50 (fifty) hospital beds (CABRAL, 2020).

Facing the structural reality of fighting the pandemic in Fortaleza, considering the structural aspects and the high demand, it is clear that the criteria established by the CFM, if considered isolated, are no longer enough in the scope of regulation, requiring the observance of some practical parameters to optimize the allocation of patients, among which are considered: (i) analysis of the clinical profile of the patient and the available ICU; (ii) entry order; (iii) profile of transport conditions; (iv) infrastructure offered and (v) administrative issues. [5]

Therefore, it is necessary to verify the best suitability of the patient's clinical profile and its classification in the available ICUs. For example, patients with COVID-19 combined with other comorbidities such as tuberculosis, HIV and viral hepatitis, have a specific adequacy profile, being ideal to allocate these patients in ICUs or wards available at the São José State Hospital, since, besides the existence of professional, technical and structural support suitable for the treatment of COVID-19 and other associated pathologies, it is a reference hospital in infectious diseases.[6]

The suitability of the clinical profile is an extremely important measure to increase the patient's chances of survival and should be adopted whenever possible. However, in the absence of ICU or infirmary beds specific to the clinical picture presented, the patient may be allocated to more inclusive health units, such as

[5] Information provided in response to a formal request to the Municipal Health Secretariat.
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campaign hospitals, in order to avoid the worsening of the clinical conditions and, consequently, the death of the patient.[7]

The order of admission for all who are in similar conditions, that is, the single line of UNISUS has been obeyed.[8] It is an equal form of access, in which the order of priority of hospitalization is followed, after due adjustment to the criteria abstractly suggested.

Often, the single line suffers interference from the Judiciary, with the determination to include patients, which creates great disorder in the administration of the beds. Another aggravating factor in the regulation process during the pandemic in Fortaleza was the high degree of destabilization of the patient, which occurred between regulation and the acquisition of beds. Frequently, patients with a clinical profile of an infirmary worsened significantly and started to demonstrate a clinical condition that required a spot in the ICU.

Still in the allocation of patients in ICUs, the available transport profile has also been considered. Transport can lead to instability and risks for the patient, and it is necessary to define strategies to ensure safe transport and, consequently, the reduction of risks and complications. Often, the ill does not have transportation conditions and, therefore, cannot access ICUs that are unoccupied, making it necessary to allocate the bed to another patient.[9]

Structural and administrative issues are also taken into consideration. The lack of updating of the patient's clinical situation is a recurring impediment for the allocation of individuals who need ICU beds. Not knowing the current clinical situation, the regulating physician will not be able to indicate the bed, since the patient may have died or even had changes in his clinical profile.[10]

[7] Information provided in response to a formal request to the Municipal Health Secretariat.
[8] Information provided in response to a formal request to the Municipal Health Secretariat.
[9] Information provided in response to a formal request to the Municipal Health Secretariat.
[10] Information provided in response to a formal request to the Municipal Health Secretariat.

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5 FINAL CONSIDERATIONS

The right to health is universally guaranteed in the Federal Constitution of 1988, which includes the right of access to Intensive Care Units – ICUs. Facing the scarcity of ICUs, which was aggravated by the pandemic triggered by COVID-19, in which the demand for beds far exceeds the supply, a balance is required between equity of access and maximization of benefits, a balance that can only be established through objective criteria to access ICUs.

Tuned with the Federal Constitution, criteria based on religion, ethnicity, sex, nationality, color, sexual orientation, age, social status, political opinion, disability, or any other form of discrimination should be drifted away. Among the various proposals for setting criteria, the criterion defined by CFM Resolution No. 2,156/2016 must prevail, since it is synchronized with constitutional values.

In the Municipality of Fortaleza, capital of the State of Ceará, over the period from March 1st to June 19th, 2020, the time period in which the research was focused, the criteria for access to ICUs stipulated by CFM Resolution No. 2,156/2016 were applied, adapted to structural aspects of the local health service, such as: analysis of the profile of the patient and the available ICU; entry order; profile of transport conditions; infrastructure offered and administrative issues.

It was found that the disease is perverse and its effects are more intense in neighborhoods with a lower HDI, which concentrate the majority of deaths, despite not having the largest number of cases (what demonstrates a lower number of tests in poorer areas in the investigated time lapse). Despite the efforts of public agents, the Unified Health System – SUS has presented difficulties to support the exceptional demand for ICU beds due to the pandemic. The single national line of access to beds, public or private, would mitigate the effects of the pandemic among the poorest, but there are complex obstacles to its implementation.

Therefore, it can be realized that social inequality is a nuclear factor and antecedent to all the problems potentialized by the pandemic, such as the lack of basic sanitation, adequate food and minimum hygiene conditions. Perhaps, a

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possible result from this extremely difficult moment is the arise of the perception that policies for inclusion and the reduction of inequalities can no longer be delayed.

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