

“SUS is for everyone, for everyone who claims it”: managing health litigation in a time of crisis

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Abstract

The judicialization of health is a controversial topic. Some authors see it as the source of a series of problems in health policies that span from the disruption of waiting queues to shortages in drugs purchased by public administrations. For others, the recourse to legal action is a path taken to correct asymmetries in access to public services. Based on ethnographic research conducted between 2016 and 2017 in the Health Claims Resolution Chamber (CRLS), I compare these opposing stances and show how the requests for judicial and/or administrative intervention are to some extent incorporated into the ‘normal flow’ of the Unified Health System (SUS) in the context of a healthcare crisis in Rio de Janeiro. My central argument is that in a period of widespread precarity, the right to health is itself managed through the administration of litigation.

Keywords: Judicialization of health, Crisis, Management, Right to health, SUS.

“O SUS é para todos, para todos que reivindicam”: a gestão dos litígios de saúde em tempos de crise

Resumo

A judicialização da saúde é questão controversa. Para uns, ela gera uma série de problemas nas políticas de saúde que vão desde a desorganização de filas de atendimento até o desabastecimento de medicamentos adquiridos pelo poder público. Para outros, o apelo ao Judiciário é um caminho para corrigir assimetrias no acesso aos serviços públicos de saúde. Por meio de uma etnografia conduzida entre 2016 e 2017 na Câmara de Resolução de Litígios de Saúde (CRLS), busco relativizar esses posicionamentos dicotômicos e demonstrar como a demanda por intervenção judicial e/ou administrativa é, de certa forma, incorporada ao “fluxo normal” do Sistema Único de Saúde (SUS) em uma conjuntura de crise da saúde no Rio de Janeiro. Meu argumento central é que, em tempos de precariedade generalizada, é através da regulação dos litígios que se opera a gestão do direito à saúde.

Palavras-chave: Judicialização da saúde, Crise, Gestão, Direito à saúde, SUS.

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Introduction

This article is the result of ethnographic research undertaken over thirteen months between 2016 and 2017 at an institution called the Health Claims Resolution Chamber (*Câmara de Resolução de Litígios de Saúde*: hereafter the CRLS or simply the Chamber). Located in a three-storey building in the centre of Rio de Janeiro, the CRLS was created through cooperation agreements between various government bodies at municipal, state, and federal levels, designed to operate through the joint action of the Rio de Janeiro and Federal Public Defender's Offices (DPE-RJ and DPU, respectively), the Rio de Janeiro State and Municipal Attorney General Offices (PGE and PGM, respectively), the Municipal and State Health Secretariats (SMS and SES, respectively), the Department of Hospital Management of the Ministry of Health (DGH/MS), and the Rio de Janeiro State Court of Justice (TJ-RJ).

The people who work in the Chamber are divided among four sectors that correspond to the four phases involved in processing a claim: triage, user service, technical analysis, and analysis return sector. The teams are composed of professional graduates from middle and higher education – doctors, nurses, pharmacists, nutritionists, social workers, and lawyers. In addition, the CRLS's staff also includes interns from Law courses, who work on the customer service counters of the Public Defender's Offices, and outsourced workers who provide cleaning, reception, security, and maintenance services. The Chamber employs no staff of its own: all those working for it are linked to the aforementioned entities making up the institution.

The CRLS was created in 2012 in a setting of an alleged 'excessive growth' in the phenomenon of 'health judicialization.' Broadly speaking, this expression has been used to characterize the activities of members of the justice system in lower and higher court cases who litigate for the provision of a service and/or the availability of a particular asset perceived to be covered by the 'right to health.' These claims are generally addressed to the Unified Health System (*Sistema Único de Saúde*: SUS) but claims relating to private health plans also form part of the phenomenon. According to the most recent quantitative survey on the topic, court claims for the right to health grew 130% in lower courts between 2008 and 2017 (Azevedo & Aith, 2019). In the context of an ever larger volume of lawsuits filed in the Courts of Justice and, consequently, an increase in the amount of public funds allocated to comply with court rulings in favour of the claims made by citizens, the Chamber was designed with one main proposal: to settle health rights disputes out of court by offering 'administrative solutions' to the cases.

It is worth emphasizing that the Chamber was created as part of the + *Consenso* program of the Rio de Janeiro PGE (Attorney General Office). This program, in turn, is inserted in a broader context of promoting Extrajudicial Dispute Resolution Methods (*Métodos Extrajudiciais de Solução de Controvérsias*: MESC) and 'good practices' in public management, intended to reflect a "new stance in public advocacy with an emphasis on the administrative resolution of disputes" and "a change in posture of the public administration, no longer

stuck to an outmoded idea that an amicable solution to conflict is impossible.”¹ By encouraging reconciliation, mediation, and arbitration, the program’s objective is to encourage ‘dejudicialization’ and pave the way for other solutions in cases of litigation involving public bodies. Thus the concept of ‘management’ acquires an unavoidable centrality, making specific *management bodies* the main protagonists in the resolution of disputes between citizens and the Brazilian state, while *extrajudicial management practices* are converted into action models for diverse state actors and agencies.²

With the inauguration of the CRLS and the adoption of *management* as a paradigm for conflict resolution, the expectation was also for a reduction in the time taken to assess any health claims and for the demands to be answered by the public authorities. In a context marked by the contrast between the ‘vulgate’ (Lugones, 2012) that legal cases take years to reach a verdict because the Judiciary is so slow and the urgency of patients worried about the worsening of their medical condition, time becomes a crucial element in the dispute over the best path to take. In this sense, the speed of administrative responses – compared to the slowness of both the SUS queues and the court rulings – is presented as one of the most important results of the Chamber’s operation in the management of health litigation. In sum, the CRLS’s objective is to propose solutions that dispense with the involvement of members of the judiciary and that are also quick, efficient, and above all cheap. In practice, the institution seeks to manage the progress of health claims, reducing the number effectively brought to trial, lowering the costs of ‘health judicialization’, and speeding up the resolution of outstanding issues. In other words, by formulating administrative mechanisms for resolving claims, the CRLS was converted into an institution responsible, in some ways, for managing the flow of health judicialization.

As I explore later, a series of controversies and consensuses exist among the diverse specialists linked to the issue of health judicialization, including public managers, members of the executive, lawyers, public health experts, judges, prosecutors, public defenders, activists, health professionals, patients and so on. In general, the debate revolves around a central question: should litigation be seen as a ‘problem’ or a ‘solution’? On one side are those who accuse the judiciary of exceeding its powers by directly influencing the distribution of funds allocated to healthcare. On the other side are those who question the effectiveness of public administrators in allocating these funds appropriately, meaning that recourse to the courts is one of the few options available to ensure compliance with the constitutional obligation to guarantee the right to health. In all events, the steady increase in the number of legal cases has been seen as a problematic situation demanding intervention from the managers of public health policies and from the representatives of other bodies with stakes in the issue.

By articulating ethnographic accounts and data from the broader context of public health facilities and services over the second half of the 2010s, I seek to evade the dichotomous positions surrounding health litigation. My central argument is that far from being merely a ‘problem’ or a ‘solution’ – or, as I shall discuss over the course of the text, a ‘para- infrastructure’ (Biehl 2013, 2016) or a mere ‘undesired distortion’ (Ferraz 2009, 2021) – the request for administrative mediation and/or court intervention is routinized and contradictorily absorbed into SUS’s ‘normal flow of care’ in times of crisis. When the shortages and precariousness of the public health system reach alarming levels, the ‘target public’ of the judicialization of health ceases to be only those requesting treatment for rare and/or chronic diseases, as identified in other ethnographies on the topic (Biehl 2013, 2016; Aureliano & Gibbon, 2020; Flores, 2016; Pedrete, 2019). In other words, during widespread shortages, legal claims become an access route that *should* be mobilized by almost everyone dependent on the public health system, whether for the acquisition of basic items like adult diapers and drugs for high blood pressure, or for the realization of exams, consultations and/or other healthcare procedures.

1 Information taken from the pages of the + *Consenso* program and the CRLS on the PGE website: <https://pge.rj.gov.br/mais-consenso> and <https://pge.rj.gov.br/mais-consenso/camara-de-resolucao-de-litigios-de-saude-crls>. Consulted 6 June 2022.

2 One example of this dispersive effect was the creation of the Administrative Chamber for Conflict Resolution (*Câmara Administrativa de Solução de Conflitos*: CASC), another initiative of this same PGR-RJ program. The mission of the CASC is to administer claims in the area of education. Its foundation was described as an effect of the ‘efficiency’ and ‘good results’ of the CRLS.

However much the CRLS is mobilized by a lower-income population and users of SUS's basic healthcare services, though, a huge gulf still exists between those with the necessary means to seek assistance from the public defender's offices or the Chamber and those unable even to access public services and who remain excluded from the institutional mechanisms for claiming their rights. Hence the expression uttered by one of my interlocutors and included in the article's title – “SUS is for everyone, for everyone who claims it” – acquires a somewhat dramatic sense given the enormous contingent of people who require hospital treatment and public healthcare policies, yet are not even computed and are thus unable to be captured in an ethnographic study. Hence, the article examines the histories of those who try to circumvent the precariousness and shortages through litigation and/or the extrajudicial expedients of conflict resolution.

Judicialization of health: controversies, consensuses, and transformations amid the crisis

The judicialization of health represents one aspect of what various scholars of politics and the State have called the “judicialization of politics and social relations” (Vianna et al., 1999). This expression refers to a process involving a transformation in the political role of the judiciary and is linked to discussions of ‘legal activism’ and the ‘politicization of the justice system.’ As briefly mentioned in the introduction, the expression ‘judicialization of health’ is used both descriptively and conceptually/analytically to designate the activities of members of the justice system in lawsuits in the lower and higher courts demanding compliance with legal claims based on the constitutional right to health, whether these pertain to the public healthcare system or to supplementary private health plans.

For part of the literature on the theme, it is through the court rulings made in these cases and through ‘legal activism’ – and ‘activism’ here frequently appears as an accusation – that the judiciary becomes a kind of formulator and executor of public policies in the health sector, exceeding its powers and deciding on matters about which it possesses neither knowledge nor expertise (Silva & Jucatelli, 2017). Other authors argue that there is no necessary connection between legal activism and the judicialization of health since the judiciary does not violate its powers when ruling on these claims. Selayaran, Machado and Morais (2018) contend that to be understood as an expression of legal activism, the judicialization of health would have to be under the control of the judiciary and be an initiative of the magistrates themselves – which is not the case since the judiciary only acts when called upon.

For the many authors, institutions and organizations that debate the diverse topics relating to this issue, the judicialization of health is above all a complex and multifaceted *phenomenon* (Azevedo & Aith, 2019; Oliveira et al., 2015; Ferraz, 2009; Ventura et al., 2010; Ventura, Simas & Bastos, 2022; Messeder, Osorio-de-Castro & Luiza, 2005; among others). I stress the use of the word *phenomenon* – that is, an observable and delimitable event capable both of being explained and of receiving a supposedly scientific/legitimate solution – to characterize and categorize this type of legal procedure since this classification is a fundamental condition and, indeed, represents the first step for the judicialization of health to be subsequently treated as a kind of ‘State problem.’

As Biehl (2013, 2016) discusses, the judicialization of health is situated on the border between medicine and law, exposing issues of interest to Medical Anthropology, the Anthropology of Law and Political Anthropology. In addition to medicine and law, I would also include a third disciplinary field in the discussion of the theme: Public Administration, signifying that this issue can also be discussed from the perspective of the Anthropology of Administration and Governance (Teixeira & Souza Lima, 2010).

The emergence of this phenomenon is comparatively recent in Brazil, related to development of SUS itself and the conception of the democratization of the access to healthcare advocated by members of the Brazilian Sanitary Reform (RSB) movement. At the start of the 1990s, inspired by the right to health guaranteed under the 1988 Federal Constitution, professionals linked to non-governmental organizations (NGOs) specializing in

HIV-AIDS advocacy submitted the first lawsuits in Brazilian courts demanding the free supply of antiretroviral drugs from the State. In 1996, Law n. 9313 – which provides for the free distribution of medications for HIV-positive patients – was passed with the aim of reducing the discretionary nature of judicial decisions in such cases and, consequently, the ‘interference’ of the judiciary in the health sector (Oliveira et al., 2015).

The effect of the legislation was, however, precisely the opposite. In the following years, this type of lawsuit spread among movements of relatives and patients suffering from other chronic diseases or those requiring high-cost treatments. In many cases, the legal actions were promoted and financed by pharmaceutical laboratories looking to ensure approval for the commercialization of new drugs in the country (Chieffi & Barata, 2010) and/or manipulate the Brazilian legislation to consolidate a market for their products (Biehl 2013; Biehl & Petryna, 2013).

As well as being perceived as a phenomenon, there are also another two commonalities in how specialists from distinct fields of knowledge conceptualize the judicialization of health. The first is the perception that the increase in the number of legal cases over recent years represents a ‘real administrative and fiscal challenge’ for public healthcare in the country. However, the form taken by this ‘challenge’ is not even a consensus among academics from the same area. The perspectives of the specialists on the theme diverge considerably: on one side, SUS public managers, lawyers and academics in Public Health accuse members of the judiciary of exceeding their powers by directly influencing the distribution of the resources allocated to public healthcare; on the other side, prosecutors, public defenders and other agents question the efficiency of the administrators in optimizing the allocation of public resources and themselves assume the mission of ensuring that the right to health is made effective.

In the legal field, the controversies surrounding the theme concern issues like the separation of powers and the legitimacy of the judiciary’s actions in constraining or forcing the State to implement a given ‘right.’ Authors like Barroso (2009), Ferraz (2009, 2021) and Wang (2015, 2021) highlight a series of problems that may be directly caused by the growing number of healthcare claims. Prominent among these is the idea that judicialization has the potential to further exacerbate inequalities in healthcare provision since less needy people can mobilize the justice system to their own advantage, reducing the resources available for public health initiatives and policies. Meanwhile, authors like Pereira (2015) and Fortes (2021) argue that such criticisms exaggerate the ‘failures’ and negative effects of this mechanism, constituting certain ‘myths’ – a term used here in an explicitly pejorative rather than anthropological sense. According to the authors defending this stance, given the clientelism and patrimonialism that influence the distribution of public resources in Brazil, legal intervention is capable of reducing inequalities by “correcting asymmetries and opening channels blocked by the bureaucratic apparatus” (Pereira, 2015: 2083), promoting access to healthcare for a poorer and more needy section of the population.

The controversies surrounding the judicialization of health also extend to the area of public healthcare and administration. Pepe and other colleagues (2010) argue that three kinds of problems exist in relation to judicialization: ‘management problems,’ linked to economic costs and resource distribution; ‘medical/scientific problems,’ referring to the absence of evidence proving the therapeutic advances offered by medications not yet listed and/or registered; and ‘patient problems,’ which concern their need for treatment. The authors thus discuss how access to medications financed with public money through judicialization can generate imbalances in SUS’s pharmaceutical assistance policies by ‘disrupting’ the budgetary planning with unforeseen expenditures. As well as the problems for the management of pharmaceutical assistance, judicialization is also perceived to have other negative effects, such as worsening inequalities in access to health products and the compromising of the principle of integral care that governs SUS and the National Pharmaceutical Assistance Policy (*Política Nacional de Assistência Farmacêutica: PNAF*), as also discussed by Vieira and Zucchi (2007).

The situation becomes even more complicated when the legal claim refers to a drug not yet registered by the National Health Surveillance Agency (*Agência Nacional de Vigilância Sanitária: ANVISA*). In these cases, along with the question of the reorganization in the distribution of resources, the managers declare concerns with patient safety, since the long-term effects of using a new medication are frequently unknown (Pepe et al., 2010). Furthermore, as shown in Castro’s ethnography (2020), the resistance of the pharmaceutical laboratories to supplying the tested drugs after completion of the clinical trials contributes to increasing the number of cases of judicialization, since often the former participants decide to *entrar na justiça* (‘enter the justice [system]’: take court action) to obtain the medication, even in cases where the drug has yet to be approved for marketing in the country.

Oliveira and colleagues (Oliveira et al., 2015) consider the increase in the judicialization of the health sector to arise primarily from the discrepancy between what is guaranteed under the Constitution and what is actually provided to the population in terms of public health services and products. For the authors, this disparity is an outcome of ‘poor management’ by politicians, consultants and managers, forcing citizens to seek legal action for their right to be respected. Meanwhile Ventura et al. (2010) agree that despite being a legitimate strategy in diverse cases, judicialization by itself is insufficient to concretize a broad and collective right to health. In other words, one of the disruptions caused by healthcare litigation is the divergence between individual and public issues, or between what is seen as a *health demand* – a wish that may be perceived as legitimate or not – and what is considered to be a *health necessity* – something essential to a person’s well-being and/or survival – a distinction of central importance to the professionals working in the area of health planning and administration.

For Guimarães and Palheiro (2015), judicialization also poses other problems. Because products and medications purchased to comply with a court order are acquired in an emergency form, the procedure generates a higher cost for the public coffers: purchases are made on an individual basis on the retail market, significantly increasing the amount paid for particular items. The authors argue, therefore, that the application of large sums to pay for individual treatments causes difficulties for long-term planning, as well as shrinking the funds directed towards collective health policies, since the budget allocated to the sector is not adjusted by the court ruling. The authors also draw a correlation between judicialization and the potential for fraud, given that the need to respond promptly to a court order – especially when failure to comply can result in fines or the arrest of the managers concerned – means that these products are obtained without the usual tender process.

As well as the problem of the individualization of demand in detriment to collective planning, Chieffi and Barata (2010) identified another sensitive issue encompassed by the judicialization of health, namely the potential link between private lawyers and pharmaceutical laboratories. Analysing a set of almost 3,000 legal cases registered at the São Paulo State Court of Justice (TJSP), the authors perceived that more than 70% of lawsuits demanding a particular drug had been filed by the same lawyer. Their conclusion was that this was a strategy adopted by the pharmaceutical companies to introduce their products into the national market. In other words, the laboratories were hiring private lawyers and offering their services to patients with the aim of exploiting ‘loopholes’ in the Brazilian legislation so that their medications would be purchased by the public authorities and eventually added to the formulary of prescription drugs freely available from SUS.

The second understanding shared by the overwhelming majority of these authors concerns the budget available for public health. Most of them do not question – indeed even reinforce – the idea that public funds are limited or scarce, meaning that their proposals almost always set out from the necessity to establish priorities and balance their distribution. In Pereira’s aforementioned article, the author is categorical in arguing that “the challenge resides in defining the limits to the direct application of constitutional commands in the *context of limited material resources*” (2015: 2085, my italics).

The idea of a limitation on resources also appears in the book *Direito, Escassez e Escolha* (Law, Scarcity and Choice) by Gustavo Amaral (2001).³ In the author’s view, trial court judges, appeal court judges, prosecutors, lawyers and other legal actors must recognize that demands for rights always exceed the capacity of public authorities to meet them: in other words, there are no means to effectively satisfy all proposed rights, not even the most basic. Consequently, it is essential to address the difficult question of promoting a balance between the individual needs of litigious patients and the structuring of public health policies when judging cases, and establishing decision-making criteria on which claims will be met and which will be turned down.

It is clear that the conflicts permeating the judicialization of health convert into a dispute over the distribution of scarce resources, the allocation of which depends on the definition of what is seen as a priority and which public services and policies can be cut, reduced and/or reorganized. A passage from the previously cited national survey coordinated by Azevedo and Aith (2019) provides a good insight into this point:

Considering that the provision of healthcare involves the *distribution of scarce resources* in a complex society with epidemiological patterns that approximate Brazil to developed and underdeveloped countries simultaneously, determining what is a *priority* and who should be the focus of these priorities is a theme that inevitably involves disputes. The so-called ‘judicialization of health,’ therefore, is an expression of this *structural dispute for resources*, but attains even higher levels than what would be expected from its relevance in the world of socioeconomic relations. (Azevedo & Aith 2009: 13, my italics)

It is the disputes surrounding the need to produce a ‘response to the judicialization of health’ that make it a provocative topic, the subject of intense production of data, interpretations, protocols, resolutions, norms and public policies. In the state of Rio de Janeiro, according to data from the National Justice Council (*Conselho Nacional de Justiça*: CNJ), court cases involving health claims leapt from 12,208 lawsuits in 2007 to 29,970 lawsuits in 2014. The combination of apparently scarce resources and a steady increase in the number of cases – and, consequently, in the number of decisions forcing governments to make unplanned disbursements – means that tensions between different public bodies have become ever greater. It is in this scenario of litigations that the alleged ‘excessive’ judicialization of health became seen as a problem requiring immediate intervention for its control. The State’s response to this ‘emergency situation’ was the creation of diverse mechanisms for the quantitative and qualitative regulation of the effectively prosecuted cases. In Rio de Janeiro, the accumulation of experiences of different initiatives for out-of-court resolution of health disputes culminated in the creation of the Health Claims Resolution Chamber (CRLS).

The CRLS began operating in September 2013. Around two months after its inauguration, the institution’s coordination team stated that on average about 60 people per day were attended and that the main demand of users was the supply of pharmaceutical drugs, comprising around 60% of total requests. During the first thirty days of operation, 511 demands were resolved ‘administratively,’ leading to a 37% reduction in the number of new court cases. Working with statistical data, Guimarães and Palheiro (2015) describe how the CRLS responded to about 9,000 users (*assistidos*)⁴ in its first year of activity. During this period, around 37% of the claims were resolved out of court. More than half of the total demands (54.33%) referred to drugs of various kinds.

It can be observed that between the start of its activities and mid-2015, the figures publicly presented by the Chamber sought to reflect the success of the initiative in terms of the administrative resolution of potential health litigation. During the period when I was conducting fieldwork, however, I witnessed numerous occasions when the staff expressed perplexity and/or indignation over the constant rise in the number of people waiting

3 Full title in Portuguese: *Direito, escassez e escolha: em busca de critérios jurídicos para lidar com a escassez de recursos e as decisões trágicas*.

4 Although the CRLS is an institution composed of staff coming from distinct government bodies and sectors, the public that seeks out its services are all called *assistidos*, a category designating people who receive assistance from Public Defender’s Offices.

to be attended and also over the types of ‘products’⁵ requested by users. It was common to hear remarks about how the consolidation of the idea that the ‘health crisis’ entailed new demands and generated unprecedented situations in the institution’s everyday running. The perception that something had changed – and for the worse – in public health facilities was shared by CRLS staff and users alike.

When the institution first began to operate, the most complex requests were related to pharmaceutical drugs not included on the public formularies, such as the National Formulary of Essential Medications (*Relação Nacional de Medicamentos Essenciais*: RENAME), the Specialized Component of Pharmaceutical Assistance (*Componente Especializado de Assistência Farmacêutica*: CEAF) and the Rio de Janeiro Municipal Formulary of Essential Medications (*Relação Municipal de Medicamentos Essenciais*: REMUME). But from the second half of 2015 and more intensely over the following years, lawsuits for the acquisition of drugs that were in short supply due to budget cuts and/or delays in the transfer of funds became increasingly common. In other words, the crisis occasioned a series of problems in the supply of basic supplies such as adult diapers, sterilized material, gauze, bandages and so on, as well as in the distribution of medications and equipment that form part of consolidated national health policies, including the supply of insulin, syringes, needles and glucometers used in the treatment and monitoring of the health condition of diabetic patients.

By making health services even more precarious, the worsening of the public healthcare crisis in Rio de Janeiro transformed how users resorted to the judiciary to prosecute the State’s failure to comply with their health rights. These alterations occurred in both a *quantitative* dimension – since there was a sharp increase in the number of new legal cases even after the development of mechanisms intended to reduce them – and a *qualitative* dimension – since the profile of the claimants and their claims have undergone significant modifications. In my ethnography, the crisis was vividly present when someone went to the CRLS to demand a medicine out of stock for five months, or complain that they had gone to the Family Clinic and their medication to control blood pressure was unavailable, or when they reported that a relative had been involved in an accident but there were no doctors to provide emergency care at the hospital, or when a patient requested to be transferred to another unit to undergo a surgery because the unit where they were hospitalized lacked the supplies needed to perform the procedure – to cite just a few of the particularly dramatic situations.

Although it is necessary to set out the controversies and consensuses involved in health litigations to contextualize the topic of the article, I emphasize that I have no intention to side with either of the two main positions in relation to the theme – that is, either ‘for’ or ‘against’ the judicialization of health demands. As I stated earlier, the healthcare crisis has inaugurated a new arena in the phenomenon of health judicialization in Rio de Janeiro that cannot be neglected, still less denied, since its effects are felt in devastating form by those who depend on SUS. Going beyond what was perceived as ‘habitual,’ judicialization became mobilized as a response to the impacts of the crisis. In sum, crisis and scarcity figure as inescapable descriptors of the institutional activities of the Chamber in the period when I conducted fieldwork and combine with the problem of ‘excessive judicialization’ with which the CRLS had already found itself dealing. Through the ethnography, therefore, my objective is to discuss what status can be attributed to the administrative resolutions and what role is played by resorting to judicial action in a period of crisis – that is, in a context of acute precarization in public health services.

⁵ In native terms, ‘product’ refers to any kind of demand made by a user, whether pharmaceuticals, supplies, consultations, surgeries, treatments or so on.

“SUS is for everyone, for everyone who claims it”: administrative resolutions and state management practices

According to some of the staff of the CRLS, one of the main criticisms received by the institution from other State agents is that the Chamber allows people to ‘jump the SUS queue,’ creating a kind of ‘parallel queue’ that moves in accordance with ‘court orders and counter-orders.’ For these staff, these people have a mistaken view of the CRLS as an institution that provides ‘fixes’ and ‘workarounds’ to avoid court intervention in a given situation. Ultimately, these actors perceived the work of the Chamber as something that ends up reproducing what the health managers and professionals working in health facilities identify as one of the problems caused by the judicialization of health: the disruption of the flow of healthcare caused by the interference of outside agents and/or institutions who have little idea of how SUS functions ‘in practice.’ For the people who work in the Chamber, this criticism was not always made explicit or directly aimed at the institution. Very often the idea that outside agents saw the CRLS in this way was an interpretation made on the basis of the kind of responses received in their attempts to coordinate actions with other institutions – especially in situations where the conclusion of the Chamber’s analysts suggested the need for a reassessment of the ‘risk classification’ attributed to a particular request for consultation and/or examination registered in the National Regulation System (*Sistema Nacional de Regulação: SISREG*).⁶

On one occasion, this accusation turned into more than a veiled rebuke. In mid-July 2017, while I was accompanying the work of the technical analysis sector, the Chamber coordination team held a meeting with representatives from a local state body. As I had little direct contact with the coordinators, I did not attend the meeting or ask them directly about the reason for its realization, or indeed what it was about. However, talking with other staff, all of them said that the meeting had been tense, its objective having been to present how the Chamber operates to the agents concerned. The information that circulated was that they were members of the Public Prosecutors Office (PPO) – nobody knew for sure whether the State or Federal PPO – who had gone to investigate an anonymous denunciation that the Chamber’s intervention meant that some people ‘jumped the SUS queue.’

These kinds of views and criticisms are understood to result not exclusively from the work of the CRLS, but as a consequence – not necessarily foreseen and/or desired – of judicial or administrative intervention. In the qualitative segment of the national survey on the judicialization of health, the coordinators state that “the requests for hospital treatment granted by the courts may have the effect of ‘jumping the waiting queue’ for beds, which is not only potentially unfair to patients but also disrupts the regulation of hospital treatment in general” (Azevedo & Aith, 2019: 29). According to the authors, many of the interviewees understood judicialization to be a central element in the creation of ‘parallel queues,’ as they explain:

the interviewed managers see judicialization as an ‘unfair epidemic’ that jeopardizes the neediest portion of the population by unbalancing the system. One of the imbalances mentioned are waiting lists for surgeries. In their example, whenever there is a legal ruling to perform a surgery, those who enter through the courts ‘jump the queue,’ taking the place of patients who entered via SUS and have waited their turn normally. (Azevedo & Aith, 2019: 25)

⁶ SISREG is an online platform of the Ministry of Health created to manage flow control and optimize the use of resources in the health sector. All requests for outpatient consultations and exams are ‘regulated’ by their inclusion in this system. The risk classification table adopted by SISREG for outpatient regulation is organized by a colour code as follows:

Red = up to 30 days for attendance;

Yellow = up to 90 days for attendance;

Green = up to 180 days for attendance;

Blue = discretionary attendance / more than 180 days for attendance.

In this section of the article, I explore how the Chamber’s staff respond to this criticism and how they understand the recourse to judicialization as one of the few paths possible for guaranteeing health rights in a scenario of intensification of scarcity in healthcare facilities. In other words, while in ‘normal situations’ judicialization may ‘upset the system,’ when the ‘system is imbalanced,’ administrative or judicial interventions represent attempts to correct this ‘system’ and make it function at least minimally.

Slots, reservations and checking possibilities: an institutionalization of the ‘workaround’?

Jaime’s representative procured the CRLS at the start of July to request human immunoglobulin to control the symptoms of chronic inflammatory demyelinating polyneuropathy (CIDP), a degenerative disease that causes the progressive loss of reflexes and muscular strength. On this occasion, the patient’s documents were incomplete, meaning that he was asked to return another day with all the documents required for analysis of the case. At the start of August, he returned to the CRLS with the documentation. During the analysis it was observed that the patient was receiving treatment in a federal hospital in the Rio’s South Zone. Consulting the spreadsheet of medications made available by the Specialized Component of Pharmaceutical Assistance (CEAF),⁷ the professional from the Chamber noted that the medication is available through SUS but the International Classification of Diseases (ICD) code on the patient’s medical records was not included in the dispensing rules established by the Special Medications State Pharmacy (Riofarmes). According to the staff member, although not included, the indicated medication was prescribed by the contemporary medical literature as the appropriate treatment for the patient’s clinical condition. Given this situation, one of the possible paths would be to forward the case directly to the Public Defender’s Office. However, the analyst first attempted to find an ‘administrative solution’ instead. She contacted the hospital where the user was receiving treatment. During the phone call, she was informed that the unit stocked the medication, but its use is restricted to inpatients. The staff member asked to talk to the head of the pharmacy sector, arguing that were the patient to go to court, the hospital would be included in the lawsuit. During the conversation, the hospital employee said he was unaware of the case. In compiling her report, the analyst solicited a period of 15 days for the situation to be resolved and asked the patient or his representative to visit the hospital’s administration in the morning to explain the situation and try to resolve the issue without the need to take the matter to court.

Tales’ father went to the CRLS in August 2017 to request rescheduling of a paediatric consultation for his son at a federal hospital in the city. The request for a consultation had been made in July that year and scheduled for January 2018, which the father responsible for the patient considered too long to wait. Checking the boy’s medical documents, the CRLS analyst could not find any health condition justifying urgent consultation and, therefore, the need for the appointment to be brought forward. Nonetheless, she sent an email to the hospital explaining the situation and asking whether it would be possible to reschedule Tales’ appointment. In her report, the employee wrote: “To those concerned, SISREG does not permit consultations to be brought forward. Email sent to the hospital to verify the possibility of bringing the appointment forward. We advise you to await our contact within 15 working days.” Around a week later, an employee from the CRLS called Tales’ father telling him that a ‘slot’ had been obtained for his son and that his appointment could be made the following day. Next, she sent the report from the Chamber by email and informed him that the said document should be printed and presented at the consultation.

Bianca’s husband visited the CRLS for the first time in January 2017 to complain about the delay in scheduling an MRI pelvis scan for his wife, who, according to the medical documents, suffered from constant episodes of acute and debilitating pain. On this first occasion, the CRLS analyst verified that the request had already been registered in SISREG

⁷ The National Pharmaceutical Assistance Policy (Política Nacional de Assistência Farmacêutica: PNAF) is divided into three components: basic, specialized and strategic. The specialized component (CEAF) centres on the dispensation of exceptional drugs for rare diseases or diseases that are prevalent but whose one-off or chronic treatment is considered high cost. The dispensation of medications by the CEAF is linked to the Clinical Protocols and Therapeutic Guidelines (Protocolos Clínicos e Diretrizes Terapêuticas: PCDT) defined by the Ministry of Health (Ministério da Saúde: MS), which establish the pathologies for which specific drugs are recommended and the standard order of therapeutic strategies that should be adopted by the health professionals.

as ‘blue risk’ [least urgent]. Since requests whose deadline has not yet expired are not transferred to the Public Defender’s Office, the CRLS employee reforwarded the user to the Family Clinic concerned and asked the professional health carers there to reassess the patient’s risk category. In April 2017, he returned to the Chamber to inform them that the exam had still not been performed. Consulting SISREG again, the employee responsible for producing the report noted that the request had been altered at the start of February, around a week after the first visit to the CRLS, and that the risk category attributed to the new consultation was ‘red’ [most urgent]. Since the deadline for the performing the exam had expired more than two months previously, the analyst contacted the employee responsible for the regulation – also called “regulator” – who asked the Chamber employee to wait a short while, the exam would be authorized that same day. Around an hour later, the CRLS doctor updated Bianca’s SISREG page and the exam had not only been authorized but also scheduled at a private laboratory that same week. In his report, he advised that the user should arrive at the lab an hour before the scheduled time to have the procedure explained by a health professional and that she could not fail to turn up on the scheduled date, or else risk of request being cancelled and the need to make a new request in SISREG, reinitiating the process.

Based on these ethnographic vignettes, we can note that the procedures adopted by the CRLS resulted in situations like the ‘reservation’ of a medication for a specific person; the possibility of bringing forward a consultation and finding a ‘slot’ for a patient in the schedule of a doctor working at a public hospital; or the alteration of the ‘risk category’ of someone treated at a Family Clinic. In this sense, the *interinstitutional dialogues* – that is, the interaction between CRLS staff and employees from other institutions and public health facilities – undertaken to reach administrative resolutions configure particular *institutional arrangements*. At first glance, these arrangements could be read as a paradox: a kind of officialization or bureaucratization of the Brazilian *jeitinho* or ‘workaround’ as a mode of managing conflicts over health rights. However, as mentioned earlier, my intention is to offer another reading of the situation by demonstrating how judicialization has been incorporated into the ‘normal flow of SUS’ during a period of crisis and widespread shortages in the public health sector.

In Weber’s formulation of the ideal type, the efficiency of bureaucracy resides in principles like rationality, neutrality, impersonality, regularity, technicism, mechanism and transparency (Weber, 1982). In the Weberian view, bureaucracy became indispensable to modern societies and its development was intertwined with the growth of the capitalist market economy, which required a rapid, constant, precise and impersonal administration. In Weber’s conception, bureaucratic government and patrimonialism comprise opposite poles of the state administration, such that the bureaucratic rules emerged as a way to eliminate arbitrary personal authority. The comparison between the Weberian ideal type and the findings of a broad set of ethnographic research on how subjects deal with the law and with bureaucratic apparatuses in their own particular and creative ways in everyday practice has produced contributions to anthropological debates on the State, administration and bureaucracy for decades. Stoler (2004), for example, is one of the authors who discusses how bureaucratic rationality does not represent a separate and sterilized administrative domain, meaning that there is no effective separation between ‘emotion’ and ‘politics.’ According to her, the State’s unity is established through a moral education that produces not only the feeling of belonging to the nation – or a sentimental collectivity – but also sensibilities, aspirations and affective dispositions in the nation’s citizens.

Herzfeld (1993), for his part, concludes that the functioning of the bureaucracy in the nation state is analogous to the ritual system of a religion and is founded on a principle of identity, whether personal, social or national. In this sense, *bureaucratic indifference* is the outcome not of rational practices of an egalitarian and democratic form of management, but of the distinction between ‘us’ and ‘them,’ which implies a frontier between those on this side – who are able to manipulate, broaden and interpret the forms of bureaucracy to their own benefit – and those on the other side – who are left only with the indifference of strict and disembodied rules and laws.

In Brazil, *Carnavais, Malandros e Heróis* by Roberto DaMatta (1997) was one of the first works to discuss the topic in national anthropology. For the author, the dilemma of Brazilian society rests on the distinction between *individuals* – people governed by formal regulations and by the equal treatment of everyone – and *persons* – people with relations of proximity, kinship and/or intimacy who demand a treatment in accordance with the social position they occupy – in a universe in which the dynamics and practices of social relations bear no relation to the world envisaged in laws. DaMatta (1984) also explores the origins of ‘Brazilianess’ and the characteristics that make Brazil the country it is. Along these lines, he identifies the *jeitinho* (workaround), *malandragem* (street smart) and *você sabe com quem está falando?* (do you know who you’re talking to?) as intrinsic characteristics of the ‘Brazilian mode of social navigation.’ The ‘workaround’ is a form of resolving a dispute between the interests of distinct parties in a harmonious and conciliatory way, while the question ‘do you know who you’re talking to?’ is a more conflictual way of achieving the same result by invoking a hierarchical principle in which the person claiming is perceived to be in a more favourable position.

Although important to discussions of how subjects mobilize positions of authority and deal with bureaucracy in Brazil, the reasoning developed by DaMatta in his differentiation of *individuals* and *persons* produces something of a culturalist interpretation of what he calls *brasilidade* (Brazilianess). Thinking about the activities of the employees and the role of the CRLS among the set of institutions and processes that compose the State along these lines would lead to an understanding of the Chamber as a public space that itself comprises a *jeitinho*, created by the State to cover over its own ‘failures’ and/or ‘absences’ in assisting a portion of the population. In other words, the creation of the CRLS and the establishment of its mode of operation based on ‘good management practices’ would represent a kind of officialization of a strictly ‘informal’ practice of conflict resolution based on specific powers and authorities derived from the posts occupied by particular State agents. This is not the analytic path I intend to follow, as I discuss below.

A not-so-parallel infrastructure: recourse to the justice system in a time of crisis

Júlio’s daughter visited the CRLS on 19 May 2017 to request the scheduling of an exam for her father, who was extremely weak with a suspected metastatic cancer in different parts of the body. The request had been registered as ‘red risk’ but, according to the “regulatory doctor”, would not be able to be performed within this deadline at any public health facility. Authorization was given, therefore, for the exam to be performed at a private laboratory that had an agreement with the public authorities to cover demands that SUS was unable to accommodate. However, though authorized, the exam had not been specifically ‘regulated,’ that is, actually scheduled. Contacting the clinic’s exam booking centre, the Chamber analyst described the situation and said that the case could already go to court. The conversation was over quickly. Soon after completing the phone call, the employee began to write his report informing that the exam had been scheduled by telephone with an employee from the laboratory and that Júlio should attend the facility to perform the exam the next day, at 9.30 am, taking his documents.

Francisco headed to the CRLS at the beginning of September 2017. Affected by a chronic health condition, he needed continuous medication supplied by Riofarmes through the state exceptional medications program; the stock was down to zero and restocking uncertain. Around midday, one of the professionals from the technical analysis sector began to undertake the procedures to decide how to resolve the case. Consulting a table listing the situation of the CEAF medications shared among the Chamber’s employees, the analyst noted that the last time that availability of the medication requested by Francisco had been checked was a little over a week previously. So he called Riofarmes and explained the situation. The person on the telephone replied that the medication in question had arrived that morning and that at the end of the day they would check the shipment and begin dispensing the drug the day after. The Chamber employee stated that Francisco had gone to Riofarmes

three times already and each time been unable to obtain the medication, which had led him to seek CRLS's help. A short while later he finished the call and said that Francisco's medication would be 'reserved': the user should go first thing the next day to ensure he obtained the drugs. In his report, the employee not only wrote that the medication had recently been restocked but also stressed that it was essential for Francisco to go the next day to withdraw it and, were he unable, for him to return to the CRLS as soon as possible.

Edna was a 42-year-old woman, diagnosed with Systemic Lupus Erythematosus (SLE), a chronic inflammatory and autoimmune disease that causes the body's immunological system to attack its own healthy tissue. In August 2017 she turned up at the CRLS to report that she was not receiving Rituximab, one of the drugs included in her treatment regimen. The user received outpatient treatment at a university hospital and obtained the medication at another health facility, which told her that the drug had been out of stock since the start of the year. Edna said that she had been told by the pharmacy's employees that the hospital management had set new criteria for dispensing the drug due to the intermittent supply and the possibility that the stock would run out. Since it is also used to prevent rejection of transplanted organs, the drug had been reserved by the managers for patients in post-operative care. The hospital employees suggested to Edna that she should seek help from the Chamber, since if she had a court order, they would be unable to refuse her the medication. Armed with this information, the user went to the CRLS. In the technical analysis sector, one of the Chamber professionals contacted the hospital pharmacy, which denied what the user had related. The analyst said that the case could go to court and that he was proposing an administrative solution that would result in less work for the hospital, for Edna, for the Chamber, for the Public Defender's Office and for the Court of Justice. After some minutes, the analyst put down the telephone and said that the person on the other end of the line had been unyielding and claimed various times that the drug Rituximab was out-of-stock and the institution's dispensation had been paused. Without any administrative solution possible, the CRLS analyst wrote his report and sent Edna's case to the Federal Public Defender's Office for a lawsuit to be filed.

In his own research, Biehl (2013, 2016) describes judicialization as a kind of para-infrastructure for accessing the right to health. In his words: “the judicialization of health has become a para-infrastructure through which the chronically ill and various public and private actors come into contact, face off, and enact ‘one by one’ rescue missions” (Biehl, 2016: 100). In other words, for the author, the emergence of this ‘para-infrastructure’ relates to the efforts made by diverse subjects to confront a series of obstacles in assuring the right to health, posed by ‘infrastructural problems,’ ‘inadequate public institutions’ and the ‘inefficiency of drug distribution programs.’

The jurist Octavio Ferraz (2021), for his part, develops his analysis of the topic setting out from a central question: does the health right matter? This relates not to the right to health in the abstract but to its legal formulation, meaning that the question concerns whether the legally established right to health is effective or merely a ‘ghost right.’ Taking statistical data as a synonym for ‘empirical evidence,’ the author positively evaluates the constitutionalization of the right to health for reducing the persistent inequality in access to services and technologies and contributing to an overall improvement in the population's health. However, in Ferraz's view, this also generated negative and undesirable effects such as ‘distortions’ to the health budget and policies caused by the judicialization of health. As he writes:

Litigation in the field of health, in contrast, has on balance produced regressive effects, a conclusion I had already reached in my earlier work and have confirmed here based on more extensive empirical evidence. It has by and large diverted an increasingly larger amount of the already severely limited health budget to health treatments of dubious effectiveness and priority (mostly expensive new medicines) to a minority of people who are capable to litigate (Ferraz, 2021: 2-3)

I agree with Biehl and Ferraz that structural problems exist in terms of the adequate and effective formulation and implementation of public health policies in Brazil. However, rather than taking the budget limitation as a given – as Ferraz does in the passage cited above – I believe that we should think of this chronic scarcity as a *mode of government*, a management tool and a form of operation of the State that induces, produces and reproduces social inequality through the creation, reform and/or closure of ‘inadequate public institutions’ and ‘inefficient programs’ at different moments and in distinct political and economic settings in Brazil. In this sense, my aim is not to understand these situations as signs of lacunas in the legislation, or as products of ‘errors’ or ‘defects’ in the design of policies, or as consequences of a supposed ‘absence of the State’ that leaves certain territories and/or populations unassisted.

In a scenario of deepening precarity like that of the health crisis in Rio de Janeiro, *entrar na justiça* (‘entering the justice [system]’: taking legal action) represents neither a parallel infrastructure for accessing health services and technologies (Biehl 2013, 2016) nor an alternative mobilized exceptionally by a group of persons with the capital necessary to litigate (Ferraz, 2021). On the contrary, supported by ethnographic data, I argue that the request for legal aid is perversely incorporated as part of the ‘normal flow of SUS’ in this context. As a consequence, the recourse to the CRLS becomes just one more stage in the therapeutic itinerary (Augé, 1986) of those seeking free healthcare. An inclusion of this kind amounts to a considerable distortion of these itineraries since patients are put in situations where access to health services, technologies, supplies and drugs depends on shuttling public institutions that vary from hospitals to the waiting rooms of public defender’s offices. In other words, people are forced to circulate not only between health facilities but also between bureaucratic and administrative bodies that operate according to logics previously unknown to them – and most of the time not even recognized as legitimate – and that above all appear to make no sense, disorienting those dependent on SUS.

Accounts like those of Francisco and Edna exemplify this point. Their narratives are permeated by episodes in which the managers of public pharmacies and health facilities condition the distribution of a drug on presentation of a court order or legal document – a practice that became increasingly common over the period when I was accompanying the day-to-day workings of the Chamber. As diverse employees of the CRLS remarked, the crisis profoundly exacerbated the chronic issue of *shortages* in public hospitals. This means that ‘everything is judicialized,’ from procedures seen as more complex such as prosthetic implants or neurosurgery, to items taken as basic and trivial, such as adult diapers, baby formulas and drugs for high blood pressure.

The alleged generalization of recourse to the judiciary was made explicit on other occasions during my fieldwork. One day while I was accompanying the work of the technical analysis sector, one of the employees told his team colleagues that the most recent attempts to resolve requests where the main issue was a lack of catheters⁸ had proven unsuccessful. According to him, thenceforth the standard procedure for this type of demand should be judicialization rather than any more attempts to resolve the problem administratively. The reason: managers were only purchasing supplies for cases where there was an express court order. Hence it becomes clear that when there is ‘a shortage of everything,’ one of the few paths available to resolve the deficit is to ‘judicialize everything.’ In this kind of context, judicialization is transformed into a routine and becomes part of the flux of SUS, figuring as one more stage – or, to be more precise, one more bottleneck – in people’s access to the right to health. As the employee said on the occasion cited above, “with this present crisis, it seems like SUS is only *operating through judicialization*.”

As I mentioned earlier, according to some of the professionals who work in the Chamber, the doctors from the Family Clinics and the Municipal Health Centres perceive the requests to alter the ‘risk category’ attributed to exams and/or consultations as a form of interference by the CRLS in their professional autonomy.

⁸ A catheter is a thin flexible tube used in different diagnostic or therapeutic surgical procedures. They are generally inserted in blood vessels and can be used to drain fluids, inject drugs, insert surgical instruments and so on.

The CRLS staff do not necessarily disagree with this interpretation but understand their actions – and, by extension, judicial or administrative intervention itself – as a sort of ‘necessary evil,’ principally in the context of the crisis and deepening scarcity in public health services.

This idea of the routinization of judicialization in the normal flow of SUS was encapsulated by one of the technical analysis staff – who had also occupied various managerial positions in the Municipal Health Secretariat for over a decade – in one of our conversations. As we discussed the topic, she stressed that the crisis did not affect and was not felt in all parts of the city in the same way, since there was a huge inequality in the distribution of SUS resources between the administrative regions of the municipality, meaning that health facilities located in the South Zone possess better equipment, more health professionals and so on. In her opinion, beyond the question of income, this inequality mainly derives from the level of education and ability of the residents of this wealthier region to pressurize the public authorities and demand that the State meets its obligations. She then drew an analogy between this capacity for mobilization and the guarantee of the right to health at more basic levels. For her, the advent of the crisis meant that access to public health services was becoming ever more difficult and dependent on the work of agents and/or institutions from the justice system. The employee concluded her line of reasoning with a rhetorical question: “and who are the people who matter to the justice system and who are capable of making sufficient noise for them to intervene in the situation?” At the end of our dialogue, she uttered a fairly sarcastic and deeply significant phrase, chosen for the title of this article: “SUS is for everyone, for everyone who claims it.”

Final remarks: management of and through health litigation

Over the course of this article, my aim has been to consider the place occupied by health litigation in a period of acute precarization. I have also sought to show how the consolidation of Extrajudicial Dispute Resolution Methods work to equalize the actions of *managing* and *resolving*, such that management is not just a *function* of the public apparatuses, but also a *method* of conflict resolution between citizens and the State. Initially, therefore, I described the main divergences and convergences on the theme among specialists from areas like Law, Public Health and Public Administration and state agents like health secretariat managers, magistrates, lawyers, public defenders and others. Next, I sought to eschew the dichotomous positions surrounding the judicialization of health and demonstrate how, in the ethnographic universe to which I had access, litigation and extrajudicial mediation were incorporated into the therapeutic itinerary (Augé, 1986) of those who depend on free healthcare. To conclude this text, I wish to underline how the management of litigation is also a form of management *through* litigation.

Observing the way in which ‘macro’ issues of a public health crisis are manifested locally in the everyday life of a significant portion of the population, as well as apprehending the ways in which users and professionals try to circumvent the effects of this precarity, are both tasks for which qualitative research – especially ethnographic – offer important contributions. In this sense, the analyses of health judicialization made solely through a quantitative/statistical approach are problematic for two reasons. Firstly, they transform the question into an urgent problem by highlighting the impacts and supposed distortions caused by litigation. Secondly, this data is incapable of capturing the nuances and concrete conditions that lead people to turn to the judiciary, very often overlooking how this is one of the few means available to guarantee the right to health. As becomes clear from the vignettes presented here, people face exceptionally dramatic situations in contexts involving a severe shortage of medications, supplies and health professionals. However, neither can the questions and inequalities revealed by judicialization be seen as merely the mistakes, failures or neglect of state management where judicial intervention functions as a kind of panacea.

Someone able to pay for a private lawyer can *entrar na justiça* (take legal action) to resolve a health claim whenever they wish. But those dependent on free legal aid from the Public Defender’s Offices have fewer options, given that ever since the CRLS was created and administrative solutions prioritized, public defenders have had less autonomy to prosecute health claims. In the past, someone could head to the nearest DPE-RJ or DPU office and receive help to file a lawsuit. From the moment CRLS began its activities, it was stipulated that public defenders could only file suits after the failure and exhaustion of all possible administrative solutions to the question – a decision that ultimately falls to the Chamber staff themselves.

The management of the flow of the judicialization of health encompasses what I have called the *pace of management* (Freire, 2019), that is, the speed of case processing imposed by the procedures executed by CRLS staff. The imposition of this pace involves a series of determinations and measurements such as the ‘risk’ to which a person is exposed, which establishes how long they can tolerate a given health condition without leading to serious consequences or death. This pace of management regulates the time taken and the promptness with which a user demand can be forwarded to the Public Defender’s Offices if and when it cannot be resolved administratively.

In sum, during the crisis that marked the second half of the 2010s when SUS “was only functioning through judicialization” and where the possibility of taking legal action with the aid of the Public Defender’s Office was conditional on the CRLS’s decisions, control of the progress of administrative and judicial proceedings dictated who had their right to health safeguarded. Considering this scenario, then, I argue that in the ethnographic universe under study, the management of health litigation ultimately entails the administration of access to public health services *through* the regulation of opportunities and of the viability of litigation.

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