FIOCRUZ | Brasília

ISSN: 2358-1824

Cadernos Ibero-Americanos de Direito Sanitário
Cuadernos Iberoamericanos de Derecho Sanitario

Article

Right to health and democratic governance in Northern Brazil: participation and social oversight in contexts of health vulnerability

Direito à saúde e governança democrática no Norte Brasileiro: participação e controle social em contextos de vulnerabilidade sanitária

Derecho a la salud y gobernanza democrática en el Norte de Brasil: participación y control social en contextos de vulnerabilidad sanitaria

Eduardo Alvares de Carvalho[1]
Tribunal de Justiça de Roraima, Boa Vista, RR.
https://orcid.org/0009-0001-7575-0880
eduardo.dsaude@gmail.com

Abstract

Objective: to understand the role of structured judicialization as a driver of democratic governance in contexts of state fragility, using Roraima as a case study. **Methodology:** qualitative and quantitative study based on documentary and empirical analysis of health-related judicial activity from 2020 to 2024. Judicial cases, technical reports, financial and administrative data, regulatory acts and institutional reports were examined using systematic documentary analysis, descriptive statistics and temporal comparison of decision-making patterns. **Results:** the 2020–2022 period revealed informational asymmetry, predatory practices and institutional fragility, with significant budgetary impact and limited social oversight. From 2022 onward, structural measures, judicial specialization, strengthening of technical advisory structures, accreditation of experts, procedural standardization and expanded transparency, produced more consistent decisions, substantial reduction of judicial blockings and greater social participation through broader access to public information. **Conclusion:** in regions marked by historical vulnerabilities and low state capacity, democratic health governance requires institutional arrangements that improve decision quality, reduce asymmetries and expand transparency. When guided by technical criteria and interinstitutional dialogue, judicial intervention can act as a catalyst for governance and enhance participation and social oversight in Northern Brazil.

Keywords: Right to Health; Health Governance; Community Participation; Health Judicialization; Public Health Policies.

Resumo

Objetivo: compreender o papel da judicialização estruturada como indutora de governança democrática em contextos de fragilidade estatal, tomando Roraima como estudo de caso. **Metodologia:** estudo qualiquantitativo baseado em análise documental e empírica da atuação judicial em saúde entre 2020 e 2024. Foram examinados processos judiciais, pareceres técnicos, dados financeiros e administrativos, atos normativos e relatórios institucionais, utilizando análise documental sistemática, estatística descritiva e comparação temporal de padrões decisórios. **Resultados:** o período 2020–2022 revelou assimetria informacional, práticas predatórias e

[1] Master in Judicial Administration and Human Rights, Universidade Federal do Tocantins, Palmas, TO, Brazil. Judge, Tribunal de Justiça de Roraima, Boa Vista, RR, Brazil

CC BY

OPEN ACCESS

fragilidades institucionais profundas, com forte impacto orçamentário e redução da capacidade de controle social. A partir de julho de 2022, a adoção de medidas estruturantes, como a especialização jurisdicional, o fortalecimento do Núcleo de Apoio Técnico do Poder Judiciário, o credenciamento de pareceristas, a padronização dos fluxos de cumprimento e a ampliação da transparência, resultou em maior racionalidade técnica das decisões judiciais, expressiva redução dos bloqueios judiciais e fortalecimento da participação social mediada por acesso ampliado a dados públicos. **Conclusão:** em regiões com vulnerabilidades históricas e baixa capacidade estatal, a governança democrática em saúde depende de arranjos institucionais capazes de qualificar decisões, reduzir assimetrias e ampliar a transparência. Quando orientada por critérios técnicos e diálogo interinstitucional, a judicialização pode atuar como catalisadora de governança e contribuir para o fortalecimento da participação e do controle social no Norte brasileiro.
Palavras-chave: Direito à Saúde; Governança em Saúde; Participação da Comunidade; Judicialização da Saúde; Políticas Públicas de Saúde.

Resumen

Objetivo: comprender el papel de la judicialización estructurada como inductora de gobernanza democrática en contextos de fragilidad estatal, tomando a Roraima como estudio de caso. **Metodología:** estudio cualitativo y cuantitativo basado en análisis documental y empírico de la actuación judicial en salud entre 2020 y 2024. Se examinaron procesos judiciales, informes técnicos, datos financieros y administrativos, actos normativos e informes institucionales, mediante análisis documental sistemático, estadística descriptiva y comparación temporal de patrones decisorios. **Resultados:** el período 2020–2022 mostró asimetría informativa, prácticas predatorias y fragilidad institucional, con notable impacto presupuestario y limitada capacidad de control social. A partir de 2022, la implementación de medidas estructurales, especialización jurisdiccional, fortalecimiento del asesoramiento técnico, acreditación de peritos, estandarización de procedimientos y mayor transparencia, generó decisiones más coherentes, reducciones significativas en los bloqueos judiciales y fortalecimiento de la participación social gracias al acceso ampliado a información pública. **Conclusión:** en contextos marcados por vulnerabilidades históricas y baja capacidad estatal, la gobernanza democrática en salud requiere arreglos institucionales que mejoren la calidad de las decisiones, reduzcan asimetrías y amplíen la transparencia. Orientada por criterios técnicos y diálogo interinstitucional, la judicialización puede actuar como catalizadora de la gobernanza y fortalecer la participación y el control social en el Norte de Brasil.
Palabras clave: Derecho a la Salud; Gobernanza en Salud; Participación Comunitaria; Judicialización de la Salud; Políticas Públicas de Salud.

Introduction

The Federal Constitution of 1988 established an innovative legal framework by enshrining the right to health as a fundamental right and by instituting the Unified Health System (SUS), structured on the principles of universality, comprehensiveness, and equity[1]. More than just an administrative arrangement, the System was conceived as an expression of a political and civilizational project that integrates social rights, citizen participation, and the democratization of public policies. However, the implementation of these principles is not uniform across Brazil. In the north of the country, especially in the Legal Amazon, vulnerabilities persist that strain the capacity to implement health policies and highlight the importance of democratic governance mechanisms to ensure comprehensive and equitable access to health services[2].

The state of Roraima occupies a unique position in this debate. Located on Brazil's northern border, with low population density, logistical challenges, a shortage of specialists and dependence

on the private sector for medium- and high-complexity procedures, it faces limitations that directly affect health governance and access to health services[3,4].

Low institutional capacity, combined with information asymmetry between the state and providers, fosters distortions and encourages predatory practices. This asymmetry arises because public authorities have less reliable data on prices, scientific evidence, and therapeutic alternatives than the providers and prescribers themselves. Without access to complete and verifiable information, the government is forced to make decisions based on information presented unilaterally by private actors, which increases the risk of overpricing, inefficient choices, and legal disputes based on partial information. This information imbalance creates an environment conducive to distorted decision-making and encourages economic strategies that deviate from the public interest, compromising equity and health planning[5,6,7].

In this context, the judicialization of health care plays an ambivalent role. Between 2020 and 2021, there was a significant increase in lawsuits regarding medications and procedures, often without scientific evidence to support them. Judicial injunctions totaled R$ 51,908,373.00 in 2021, compromising the pharmaceutical care budget and rendering planned actions within the SUS unfeasible[5].

The judicial process serves as a tool for guaranteeing rights, invoked by citizens in the face of state failures or omissions. However, when it is excessive, unregulated, or co-opted by private interests, it can cause collective harm, deepen inequalities, and undermine governance. In regions of structural vulnerability, such as northern Brazil, this ambivalence is accentuated: the fragility of mechanisms for social participation and the scarcity of reliable information hinder social control, while the State's limited regulatory capacity creates more room for predatory practices[8]. Given this scenario, there is a need to investigate institutional alternatives capable of streamlining legal claims in the health sector, reducing decision-making distortions, and curbing abusive practices. The research problem addressed in this article is to understand how structural mechanisms, triggered within the context of judicialization itself, can contribute to the democratic governance of health, particularly with regard to social participation, social control, the reorganization of relations between the state, society, and the justice system, and the institutional response to contexts of health vulnerability in northern Brazil.

The general objective is to understand the role of structured judicialization as a driver of democratic governance in contexts of state fragility, using Roraima as a case study. For the purposes of this study, the term "structured judicialization" is employed as an analytical category of the author's own construction, rather than as an autonomous theoretical category already established in the literature under that nomenclature. The formulation of the concept links the aforementioned democratic governance in health[2] with the judicial governance of the right to health examined in the work from which this article derives[5], the critique of fragmented and predatory judicialization[6] and consideration of the systemic, distributive, and budgetary effects of judicial decisions in health[7].

Structured judicialization refers to a systemic, technically oriented, and institutionally coordinated judicial approach, supported by the use of scientific evidence, the standardization of enforcement procedures, jurisdictional specialization, technical support from the Judiciary's Technical Support Center (NatJus), and ongoing interinstitutional dialogue. It is not, therefore, a well-established theory with this specific name, but rather an analytical framework used in this article to interpret the institutional experience in Roraima.

Methodology

This study is characterized as applied research with a quali-quantitative approach, of an exploratory-descriptive nature, and employing a single-case study design, with the state of Roraima as the unit of analysis. The choice of a case study is justified by the need to examine the judicialization of health within its real-world context, marked by territorial, health-related, institutional, and budgetary specificities. Based on the methodological principles of Robert Yin[9], the analytical design interprets the findings in light of local particularities, allowing for analytical generalizations about democratic governance in health, without claiming to produce statistical inferences that can be applied linearly to other states of the Federation.

The analysis presented here stems from empirical and documentary research consolidated in the work "Judicial Management of the Right to Health: The Strategic Role of the National Council of Justice and the National Judicial Forum for Health in the Governance and Sustainability of the Public Health System"[5], revisited in this article through a new analytical lens. The focus is on the relationship between the judicialization of health, democratic governance, social participation, and social control in Roraima. The logical structure of the procedures for data collection, selection, and validation of documents followed the methodological guidelines applied to social research techniques, as outlined by Gil[10].

Data collection was conducted through a documentary review of public and institutional sources. We consulted systems and records from the Roraima Court of Justice, data from NatJus, administrative documents from the Roraima State Department of Health, regulatory acts of the National Council of Justice, guidelines from the National Judicial Forum for Health, and documents related to the implementation of the Health Center 4.0, the accreditation of expert witnesses, and the standardization of procedures for complying with judicial decisions.

The document selection process took place in four structured stages. During the identification stage, regulatory, administrative, judicial, and technical documents related to the judicialization of public health in Roraima between 2020 and 2024 were collected. This time frame is justified by the inauguration of the Health Center 4.0 in mid-2022, when the binding precedents of the Federal Supreme Court (STF) and the recommendations of the National Council of Justice (CNJ) regarding the judicialization of health began to be systematically applied. Starting in 2023, the Center began to operate with exclusive jurisdiction over public health cases, which allows for a comparison of the situation before and after its implementation.

During the selection phase, documents were retained that directly addressed public health lawsuits, NatJus's activities, judicial injunctions, preliminary injunctions, institutional governance, compliance workflows, and measures to streamline the judicialization of public health issues. During the eligibility phase, records with no direct relation to public health, claims related to supplemental health care, duplicate documents, and materials lacking sufficient temporal or territorial context were excluded. During the inclusion phase, the documents and data sets capable of supporting the analysis of the institutional evolution of health-related litigation in Roraima were retained.

The quantitative component consisted of systematizing data on the number of cases, granted and denied preliminary injunctions, the volume of technical notes issued by NatJus, the average time taken to draft legal opinions, and the annual amounts of judicial injunctions. The analysis of these data was conducted using simple descriptive statistics and temporal comparisons across the years examined, without complex statistical modeling or any attempt at causal inference.

The qualitative dimension was developed through a systematic document analysis of normative acts, institutional reports, technical opinions, judicial decisions, and administrative documents included in the corpus. The analysis was guided by four analytical categories, presented in the same order as in the results and discussion section: the right to health in contexts of health vulnerability; institutional arrangements for streamlining judicial proceedings; the use of scientific evidence, transparency in decision-making, and the technical quality of decisions; and the budgetary, administrative, and democratic implications of the measures implemented.

We did not adopt categorical content analysis in the strict sense, but rather a systematic documentary analysis combined with descriptive statistics and a temporal comparison of institutional indicators. This methodological approach ensures internal consistency between the available empirical material, the article's objective, and the inherent limitations of the case study, relying on the triangulation of multiple sources of evidence and the appropriateness of the technique for exploratory-descriptive research[9,10].

Since this research is based exclusively on public documents, consolidated administrative data, and institutional records without patient identification or direct collection of information from human subjects it was not submitted to the CEP/Conep system. The limitations of the sources consulted were respected, so that the conclusions remain confined to the empirical scope of the analyzed case study.

Results and Discussion

The results section begins with a characterization of the documentary and quantitative corpus that underpinned the analysis and enabled the consolidation of a corpus comprising court cases, preliminary injunctions, NatJus technical notes, administrative records, normative acts, and institutional documents related to the judicialization of public health in Roraima. Table 1 summarizes the types of documents and data examined, their sources, and the quantities included in the study.

Table 1. Documentary and quantitative corpus analyzed based on the document search

Type of document or data analyzed	Time frame	Source consulted	Quantity included
Public health court cases	2020–2024	Consolidated data from the TJRR and the baseline survey	2,018 cases
Preliminary injunctions granted	2020–2024	Consolidated data from the TJRR and the baseline survey	935 decisions
Preliminary injunctions denied	2020–2024	Consolidated data from the TJRR and the baseline survey	304 decisions
Technical Notes NT1 issued by NatJus	2020–2024	NatJus/TJRR Panel and baseline survey	1,168 technical notes
Average time to issue technical notes	2020–2024	NatJus/TJRR Panel and baseline survey	5 annual reports
Amounts of judicial injunctions	2020–2024	Consolidated administrative and financial data	5 annual reports

Regulations, recommendations, and guidelines	2020–2024	CNJ, FONAJUS, TJRR, and SESAU/RR	Systematic analytical document corpus (qualitative)
Documents on Núcleo 4.0, NatJus, accreditation of legal advisors, and workflows	2020–2024	TJRR, NatJus, and institutional records	Systematic analytical document corpus (qualitative)

Source: own elaboration, 2026.

The empirical results, both quantitative and qualitative, are presented and analyzed in an integrated manner based on the categories defined in the methodology. This approach allows us to link the judicialization of health to democratic governance, social participation, and social control in Roraima, thereby avoiding a disconnect between the theoretical framework and the documented evidence examined.

With this framework, the theoretical foundations of democratic governance guide the interpretation of the empirical data examined. Democratic governance in health refers to the set of institutional practices that guide the management of the system according to criteria of transparency, technical rationality, social participation, public oversight, and accountability of the actors involved[11,12,13,14]. Three elements structure this arrangement: social participation, institutional transparency, and the use of scientific evidence as a basis for decision-making, operating in an interdependent manner[5,11,12,15,16].

The Right to Health in Contexts of Health Vulnerability

The challenges faced by the states of the Northern Region stem from structural conditions that affect the formulation, implementation, and evaluation of public policies: vast territorial dispersion, low population density, logistical precariousness, a shortage of specialized professionals, and heavy dependence on supplies from other regions. In states characterized by low administrative capacity, underfunding, and high dependence on private providers — as observed in Roraima — informational asymmetries between the state, prescribers, suppliers, and users are widening. This environment undermines health planning, hinders social oversight, and creates conditions conducive to predatory practices and disorderly judicialization[3,4,5,6,15,16].

The judicialization of health care is a complex and ambivalent phenomenon[7,17]. An analysis of the period from 2020 to 2022 shows that the judicialization of health care in Roraima developed within an environment marked by these structural vulnerabilities, which directly influenced the relationship between the public system, private providers, and the judiciary. The fragility of public management was evident in the absence of consistent planning and the lack of reliable information on prices, which compromised transparency and limited social control[13].

The data analyzed indicate that, in 2020, 307 health-related lawsuits were filed[5]. In 2021, the situation became even more critical. A total of 487 lawsuits were filed, and the total amount of funds frozen reached R$ 51,908,373.00 — nearly ten times the amount from the previous year. This sharp increase resulted in severe budgetary disorganization and highlighted the fragility of administrative response mechanisms.

Institutional vulnerability was also evident in the procurement patterns determined by court decisions, in which the prices charged often did not comply with public pricing parameters: in the

case of medications, the Maximum Government Sales Price (PMVG), applicable to public procurement; and, in the case of procedures and services provided by private facilities to SUS users in compliance with a court order, the criterion defined by the Federal Supreme Court in Precedent 1,033, according to which reimbursement must follow the same parameters used to compensate the SUS for care provided to health insurance plan beneficiaries[5,6,7,15] .

This set of factors created a context of profound institutional instability. Thus, the period from 2020 to 2022 represents the critical phase preceding the institutional turning point, during which the fragility of administrative governance and the absence of consolidated judicial governance instruments combined, fostering predatory practices and deepening inequalities in access to public health policies[5,6,15].

From 2020 to 2022, Roraima witnessed a scenario of unstructured judicialization, characterized by a high number of preliminary injunctions granted, heavy reliance on private prescriptions as evidentiary basis, insufficient prior technical analysis, low standardization of judicial decisions, and recurrent use of judicial freezes as an enforcement mechanism. This environment has widened the imbalance between litigants, providers, prescribers, and public administrators, favoring economic practices organized around the expectation of immediate judicial enforcement. Although aimed at protecting the individual right to health, decisions rendered without adequate technical mediation can produce adverse systemic effects, with budgetary impacts and the risk of deepening health inequalities[5,6,15,18].

In peripheral, border, and historically underfunded states, judicialization tends to compound preexisting administrative weaknesses and, when lacking technical criteria, can become a factor in the disorganization of public health policy and lead to budgetary unpredictability, the reallocation of resources intended for class-action lawsuits, the widening of information asymmetries, and the deepening of inequalities in access to health services.

Institutional Arrangements to Rationalize Judicialization

Beginning in mid-2022, a process of institutional transformation began at the Court of Justice of Roraima that sought to reconfigure the relationship between the justice system and public health policy. The inaugural milestone of this change was the establishment of the Health Center 4.0, conceived as a specialized structure for processing, analyzing, and adjudicating cases. The Center's operations took place in two phases: the redistribution of approximately half of the cases in July 2022 and, in January 2023, the assignment of exclusive jurisdiction over all public health cases. This centralization led to standardized decision-making, streamlined procedural workflows, and greater legal predictability[5,6].

The most decisive change was the technical restructuring of judicial support. Given the structural inadequacy of the local NatJus system, an unprecedented measure was implemented: the official accreditation of external expert advisors, a practice aligned with the recommendations for technical strengthening issued by the CNJ and the National Forum of the Judiciary for Health (FONAJUS), thereby expanding the number of specialists available to the judiciary[5,19].

Another key pillar was the implementation of CNJ Recommendation No. 146/2023[20], aimed at standardizing the process for enforcing judicial decisions in the health sector. The adoption of this standard helped discourage the use of judicial freezes as a routine enforcement mechanism, reestablishing the primacy of in-kind compliance and imposing strict economic parameters on court-

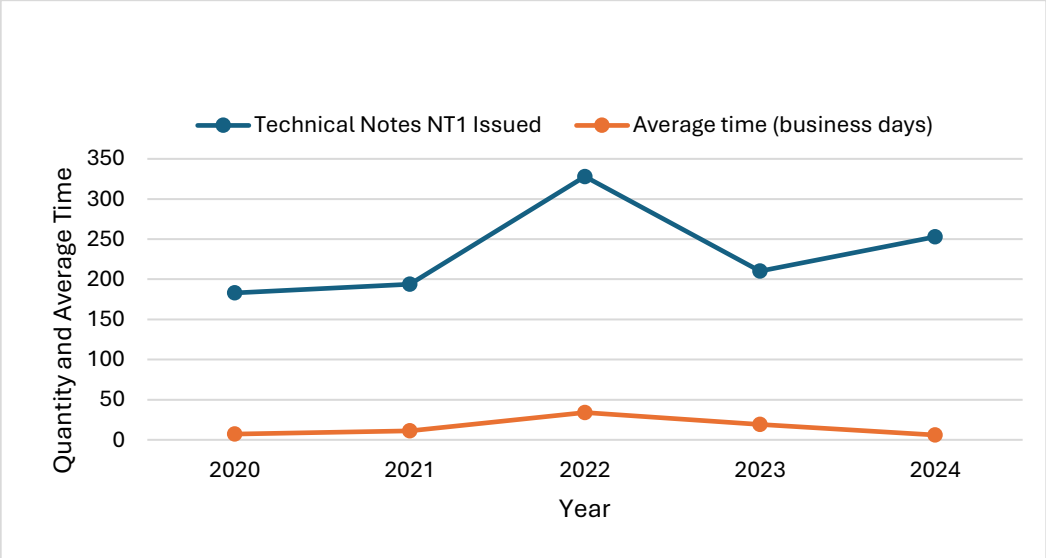
ordered procurements[5,13]. Thus, the period from 2022 to 2024 represents an experience of structured judicialization, guided by jurisdictional specialization, standardization of procedures, and interinstitutional dialogue[5,6,15,16].

The institutional shift that began in 2022 suggests that the Judiciary can play a significant role in driving institutional improvements when it operates with specialization, technical support, and inter-institutional dialogue. The creation of Núcleo 4.0, the strengthening of NatJus, the accreditation of legal advisors, alignment with national guidelines, the standardization of compliance workflows, and the expansion of active transparency have altered the decision-making and administrative dynamics of health litigation in Roraima. The reduction in the average time taken to issue expert opinions, the reorganization of workflows, and the more systematic use of technical and scientific criteria have contributed to decisions that are more predictable, consistent, and compatible with the public policies of the SUS.

Use of Scientific Evidence, Decision-Making Transparency, and Technical Quality of Decisions

To ensure the systematic use of evidence, NatJus underwent an internal reorganization, which included a review of workflows, an expansion of the technical staff, and an improvement in the criteria used in NT1 Technical Notes. The impact of this reorganization is directly reflected in the technical capacity to respond. The issuance of NT1 opinions, which had an average turnaround time of 34 business days in 2022 due to an increase in submissions, showed a marked improvement. In 2024, following the accreditation of physicians and pharmacists, the volume reached 253 opinions, with the average processing time reduced to six business days, approaching the statutory deadline of five days, as shown in Figure 1[5].

Graph 1. Evolution of Technical Notes NT1 and Average Processing Time (2020–2024)



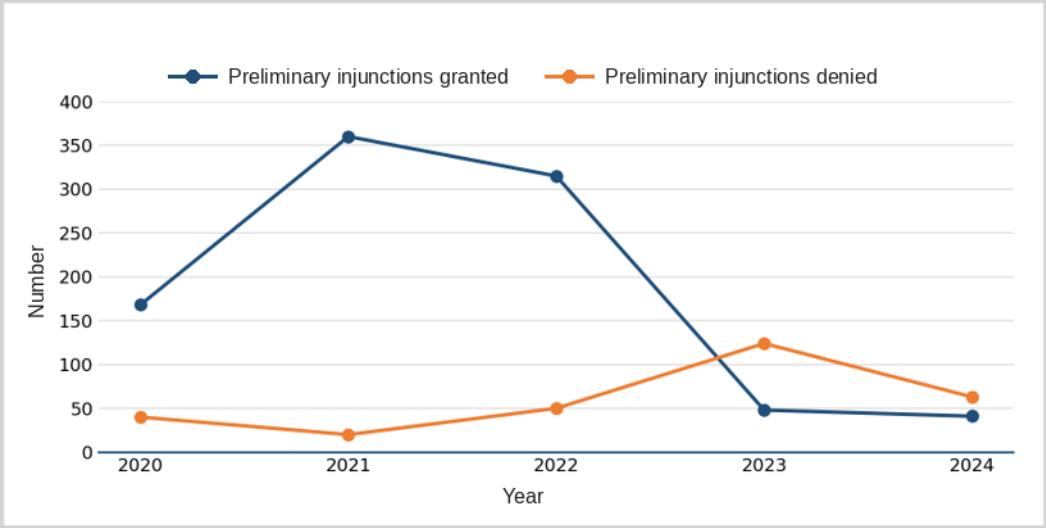
Source: own elaboration, 2026.

This increased capacity of NatJus contributed to a shift in the decision-making dynamics of emergency injunctions, with a reversal in the pattern of approvals and denials beginning in 2023. nalyzing the historical trend of these cases highlights this shift: with 2021 marking the peak at 360

grants, the drop to 48 grants in 2023 represents a significant decrease, while the level of 41 grants in 2024 confirms that the new pattern has held, as shown in Figure 2[5].

The significant increase in denials (124 in 2023; 63 in 2024) does not reflect a restrictive stance toward access to the judiciary, but rather greater technical rigor, the systematic incorporation of technical notes, adherence to Clinical Protocols and Therapeutic Guidelines, and a more thorough analysis of medical urgency[5].

Graph 2. Decisions on preliminary injunctions (2020–2024)



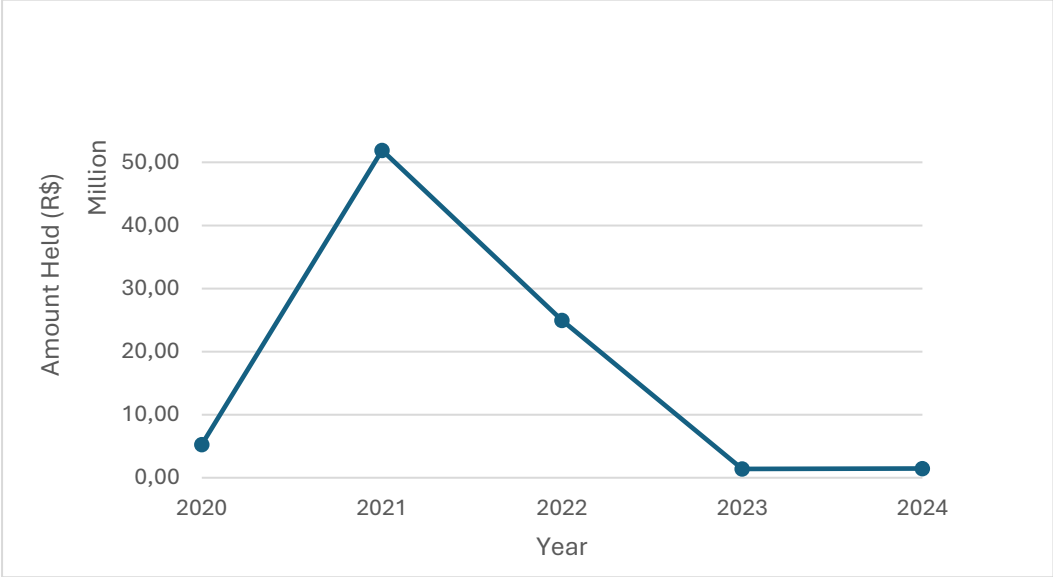
Source: own elaboration, 2026.

The increase in denials of preliminary injunctions beginning in 2023 should not be interpreted as an abstract restriction on the right to health, but rather as an indication of a shift in the rationale behind judicial decisions. Urgency is now examined with greater attention to the existence of scientific evidence, available therapeutic alternatives, administrative parameters, and the collective impact of decisions. This change reinforces the idea that structured judicialization does not eliminate individual judicial protection but seeks to reconcile it with criteria of equity, sustainability, and democratic governance.

Budgetary, administrative, and democratic implications of the implemented measures

The adoption of these structural measures has had measurable impacts on the financial sustainability of the public health system. The figures for court-ordered freezes show the most significant change. In 2021, the figure peaked at R$ 51,908,373.00 (4.30% of the state health budget). Following the structural intervention, the amount decreased sharply, reaching R$ 1,396,909.93 in 2023. In 2024, the amount frozen remained at a similarly low level, totaling R$ 1,529,266.79, as shown in Figure 3[5].

Graph 3. Amounts frozen by year (2020–2024)



Source: own elaboration, 2026.

The substantial drop in frozen amounts (a 97.05% reduction compared to 2021) demonstrates that the freezing of public funds is no longer a routine mechanism for budget execution but has taken on an exceptional and technically justified character[16,21]. The budgetary savings resulting from this reduction allowed the Executive Branch to resume collective projects and strengthen strategic areas of the public sector. The restoration of administrative predictability reduced tensions between the branches of government and contributed to greater systemic efficiency[22].

Another measurable impact was the reorganization of the distribution of legal claims, with a reduction in predatory practices and a gradual increase in the participation of the Public Defender's Office[6]. Public policy governance was also bolstered by the adoption of active transparency measures, including the systematic disclosure of data on preliminary injunctions, judicial freezes and statue of limitations patterns. By continuously disclosing these indicators, the Judiciary has expanded institutional monitoring and academic research, improving the conditions for citizen participation and strengthening social control against the lack of transparency that has historically fostered distortions in the Amazonian context[5,13,17].

Furthermore, increased transparency regarding preliminary injunctions, judicial freezes, statute of limitations patterns, and the origin of lawsuits represents a significant advance for social control. By making visible the flows, costs, and actors involved in judicialization, the systematic disclosure of data reduces the informational opacity that fosters predatory practices and enables greater oversight by regulatory bodies, researchers, health councils, and civil society. Transparency, in this sense, is not merely an administrative tool but a democratic requirement for public oversight of health policy[14,17].

Final Considerations

The analysis of the judicialization of health in Roraima, situated within the framework of democratic governance and the structural specificities of the Brazilian Amazon, shows that the effectiveness of the right to health in contexts of low state capacity depends not only on

constitutional norms, but also on the existence of institutional arrangements capable of reducing information asymmetries, improving the quality of decisions, and increasing public transparency.

The combination of judicial specialization, technical support from NatJus, standardization of workflows, institutional transparency, and inter-institutional coordination was associated with the reorganization of the judicialization of health care in Roraima between 2022 and 2024. These mechanisms contributed to greater predictability in decision-making, a reduction in information opacity, technically sound decisions, and the streamlining of compliance with court orders, without supplanting the administrative authority of SUS managers or traditional spaces for social participation.

The experience in Roraima demonstrates that, in contexts of health vulnerability, structured judicialization, understood as technically oriented, transparent, standardized, and institutionally coordinated judicial action, can contribute to strengthening democratic governance. The case analyzed indicates that the Judiciary, when supported by scientific evidence and aligned with SUS guidelines, can act as a catalyst for administrative rationality, the reduction of disparities, and the rebuilding of institutional capacities, without replacing public management or the mechanisms for social participation.

The study, however, has limitations. The research was based exclusively on documentary sources, consolidated administrative data, and institutional records, without interviews with managers, judges, users, health advisors, or other involved actors. Furthermore, as this is a single-case study, the results do not allow for statistical generalizations to other states in the Northern Region or the country. The conclusions remain confined to the empirical context of Roraima and should be understood as analytical generalizations regarding governance mechanisms in a context of health vulnerability. Nor is the intention to establish a direct causal relationship between each institutional measure and each observed outcome, but rather to identify temporal and institutional associations consistent with the documented reorganization process.

Therefore, the right to health in northern Brazil requires institutional responses that are sensitive to the region's territorial, logistical, and administrative inequalities. Democratic governance emerges as an indispensable pillar for addressing historical vulnerabilities, and the Judiciary, when structured to operate with technical expertise, transparency, and predictability, can contribute to more rational, equitable, and sustainable public policies.

References

1. Brasil. Constituição (1988). Constituição da República Federativa do Brasil [Internet]. Brasília: Presidência da República; 1988 [cited Nov 17, 2025]. Available from: https://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm

2. Marques RM, Piola SF, Carrillo Roa A, organizadores. Sistema de saúde no Brasil: organização e financiamento [Internet]. Rio de Janeiro: ABrES; Brasília: Ministério da Saúde; OPAS; 2016 [cited Nov 17, 2025]. 260 p. Available from: https://pesquisa.bvsalud.org/portal/resource/pt/biblio-999082

3. Instituto Brasileiro de Geografia e Estatística. IBGE Cidades: Boa Vista [Internet]. Rio de Janeiro: IBGE; [s.d.] [cited Nov 17, 2025]. Available from: https://cidades.ibge.gov.br/brasil/rr/boa-vista/panorama

4. Scheffer M, coordenador. Demografia médica no Brasil 2025 [Internet]. Brasília: Ministério da Saúde; Faculdade de Medicina da Universidade de São Paulo; Associação Médica Brasileira; 2025 [cited Set 23, 2026]. 446 p. Available from: https://amb.org.br/wp-content/uploads/2025/04/DEMOGRAFIA-MEDICA-DO-BRASIL-2025_versao-online.pdf

5. Carvalho EA. Gestão judicial do direito à saúde: o papel estratégico do CNJ e do FONAJUS na governança e sustentabilidade do sistema público de saúde. São Paulo: Dialética; 2025. 152 p.

6. Silva MAS. Judicialização predatória da saúde e falhas de governo: levando a sério a teoria da escolha pública. Economic Analysis of Law Review [Internet]. 2022 [cited Nov 17, 2025];13(2):262-81. Available from: https://portalrevistas.ucb.br/index.php/EALR/article/view/13416 doi:10.31501/ealr.v13i2.13416

7. Wang DWL, Vasconcelos NP, Oliveira VE, Terrazas FV. Os impactos da judicialização da saúde no município de São Paulo: gasto público e organização federativa. Revista de Administração Pública [Internet]. 2014 [cited Nov 17, 2025];48(5):1191-206. Available from: https://www.scielo.br/j/rap/a/5YcctKRJTVmQnp5mRHkBBcj/?lang=pt

8. Gondim DAD, Campos MR, Castanheira D. Avaliação de estrutura da atenção primária à saúde materno-infantil. Roraima, região Norte e Brasil, 2012-2017 [Internet]. Ciência & Saúde Coletiva. 2024 [cited Nov 17, 2025];29(10):e03462023. Available from: https://www.scielo.br/j/csc/a/9jRPBGmTMbjKGXjq4K4Fqrb/?lang=pt

9. Yin RK. Estudo de caso: planejamento e métodos. 5ª ed. Porto Alegre: Bookman; 2015.

10. Gil AC. Métodos e técnicas de pesquisa social. 7ª ed. São Paulo: Atlas; 2019.

11. Brasil. Conselho Nacional de Secretários de Saúde (CONASS). As Conferências Nacionais de Saúde: evolução e perspectivas [Internet]. Brasília: CONASS; 2009 [cited Nov 17, 2025]. 100 p. (CONASS Documenta, 18). Available from: https://www.conass.org.br/conassdocumenta/cd_18.pdf

12. Matta GC. Princípios e diretrizes do Sistema Único de Saúde. In: Matta GC, Pontes ALM, organizadores. Políticas de saúde: organização e operacionalização do Sistema Único de Saúde [Internet]. Rio de Janeiro: EPSJV/Fiocruz; 2007 [cited Nov 17, 2025]. p. 61-80. Available from: https://www.arca.fiocruz.br/handle/icict/39223

13. Costaldello AC, Lacerda Rocha VM. A contribuição do Fórum Nacional do Judiciário para a Saúde (FONAJUS) para a democratização dos processos de saúde. Revista de Direito da Saúde Comparado [Internet]. 2023 [cited Nov 17, 2025];2(2):61-79. Available from: https://periodicos.unisa.br/index.php/direitosaude/article/view/487 doi:10.56242/direitodasaudecomparado;2023;2;2;61-79

14. Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI, organizadores. Políticas e sistemas de saúde no Brasil [Internet]. 2ª ed. Rio de Janeiro: Editora Fiocruz; 2012 [cited Nov 17, 2025]. 1100 p. Available from: https://books.scielo.org/id/c5nm2

15. Vieira FS. Direito à saúde no Brasil: seus contornos, judicialização e a necessidade da macrojustiça [Internet]. Brasília: Instituto de Pesquisa Econômica Aplicada (IPEA); 2020 [cited Nov 17, 2025]. (Texto para Discussão, n. 2547). Available from: https://repositorio.ipea.gov.br/bitstream/11058/9714/1/TD_2547.pdf

16. Souza KAO, Souza LEPF. Incorporação de tecnologias no Sistema Único de Saúde: as racionalidades do processo de decisão da Comissão Nacional de Incorporação de Tecnologias no Sistema Único de Saúde. Saúde em Debate [Internet]. 2018 [cited Nov 17, 2025];42(Suppl 2):48-60. Available from: https://www.scielo.br/j/sdeb/a/B5SF5XcgGVhVznDbNpVpPJQ/?lang=pt doi:10.1590/0103-11042018S204

17. Bahia L. Judicialização da saúde e democracia. Demetra: Alimentação, Nutrição & Saúde [Internet]. 2014 [cited Nov 17, 2025];9:215-8. Available from: https://www.e-publicacoes.uerj.br/index.php/demetra/article/view/11749 doi:10.12957/demetra.2014.11749

18. Ventura M, Simas L, Pepe VLE, Schramm FR. Judicialização da saúde, acesso à justiça e a efetividade do direito à saúde. Physis: Revista de Saúde Coletiva [Internet]. 2010 [cited Nov 17, 2025];20(1):77-100. Available from: https://www.scielo.br/j/physis/a/35xXdQXR9JrdvpPmtkktL9F/?lang=pt

19. Conselho Nacional de Justiça (Brasil). Resolução nº 238, de 6 de setembro de 2016. Dispõe sobre a criação e manutenção, pelos Tribunais de Justiça e Regionais Federais, de Comitês Estaduais da Saúde, bem como a especialização de vara em comarcas com mais de uma vara de Fazenda Pública [Internet]. Brasília: CNJ; 2016 [cited Jul 7, 2026]. Available from: https://atos.cnj.jus.br/atos/detalhar/2339

20. Conselho Nacional de Justiça (Brasil). Recomendação nº 146, de 28 de novembro de 2023. Dispõe sobre estratégias para o cumprimento adequado das decisões judiciais nas demandas de saúde pública [Internet]. Brasília: CNJ; 2023 [cited Jul 7, 2026]. Available from: https://atos.cnj.jus.br/atos/detalhar/5360

21. Conselho Nacional de Secretários de Saúde. Para entender a gestão do SUS [Internet]. Brasília: CONASS; 2003 [cited Jul 7, 2026]. 248 p. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/para_entender_gestao.pdf

22. Miranda GMD, Mendes ACG, Silva ALA. O desafio da organização do Sistema Único de Saúde universal e resolutivo no pacto federativo brasileiro. Saúde e Sociedade [Internet]. 2017 [cited Nov 17, 2025];26(2):329-35. Available from: https://www.scielo.br/j/sausoc/a/89Dyb8NphHWYmPhnzNnnTGG/?lang=pt doi:10.1590/S0104-12902017168321

Editorial Information

History

Received: November 19, 2025
Reviewed: July 29, 2026
Accepted: July 30, 2026

Review Process

Double-blind peer review.

Open peer review

Options for an open peer review process, including the publication of reviews, the disclosure of identities, and interaction between authors and reviewers, were not available for this article.

Preprint

The manuscript is not a preprint.

Similarity check

This article underwent a textual similarity check using CopySpider software.

Authors' Contributions

E.A. Carvalho: conception/design of the article, to the critical review of its content, and to the approval of the final version of the article.

Conflict of Interest

The authors declare that they have no personal, commercial, academic, political, or financial conflicts of interest regarding this article.

Funding

Not applicable.

Source of Research

Not applicable.

Ethical Approval of the Research

Not applicable.

Availability of Research Data

Not applicable.

Declaration of use of Artificial Intelligence (AI) tools

Not applicable.

Editorial Team

Editor-in-Chief: Sandra Mara Campos Alves
Guest Editors (dossier): Eliana Franco, Krishina Day Ribeiro
Assistant Editor: Amanda Nunes Lopes Espiñeira Lemos
Editorial Assistants: Danilo Silva Santos Rocha, Daphne Sarah Gomes Jacob Mendes, Maria Ester Simões Nogueira
Copy Editor: Mirna Barcelos
Translator: David Elias Cardoso Câmara

Publisher

Fundação Oswaldo Cruz, Fiocruz, Health Law Program, Brasília, Federal District, Brazil.

Copyright

The authors retain the copyright to their works and grant the Cadernos Ibero-Americanos de Direito Sanitário (CIADS) the right of first publication.

Open Access

This article is published under an Open Access model, providing immediate, free, and permanent access to its content, with no fees charged for reading, downloading, or sharing.

License of Use

Copyright © 2026 Eduardo Alvares de Carvalho. This article is licensed under the Creative Commons Attribution 4.0 International (CC BY 4.0) license, which permits use, distribution, and reproduction in any medium, provided that the original authorship and source of publication are properly cited.



How to Cite (Vancouver)

Carvalho EA. Right to health and democratic governance in Northern Brazil: participation and social oversight in contexts of health vulnerability. Cad. Ibero-Am. Direito Sanit. 2026;15:e2026036. doi: 10.17566/ciads.e2026036