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Article

Judicialisation of medicines and health law: an empirical-jurisprudential study in the state and federal courts of Pará (Amazon)

Judicialização de medicamentos e direito sanitário: estudo empírico-jurisprudencial nos tribunais estadual e federal do Pará (Amazônia)

Judicialización de medicamentos y derecho sanitario: un estudio empírico-jurisprudencial en los tribunales estatales y federales de Pará (Amazonía)

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Abstract

Objective: to analyse case-law data concerning medicines and health law from the Court of Justice of the State of Pará (TJPA) and the Federal Regional Court of the First Region (TRF1) through the lens of the systems theories of Niklas Luhmann and Marcelo Neves. **Methodology:** quali-quantitative research on the costs and proceedings relating to the judicialisation of medicines. Data collection was carried out on the websites of the TJPA and the TRF1 using the descriptor "supply of medicines", between June and September 2025. Following reading and the application of exclusion criteria, procedural variables (medicine, disease and verdict) were extracted. Prices were benchmarked against Anvisa's PMVG, and the statistical data were analysed in the light of the scientific-legal literature. The analysed sample comprised 83 cases at state level and 310 at federal level (393 decisions). **Results:** the TJPA concentrates on primary care and infrastructure claims in Intensive Care Units (ICUs), with an average cost of BRL 9,041.38. The TRF1, by contrast, concentrates the demands of the "technological elite" (gene and oncological therapies), with an average cost of BRL 216,846.54. Furthermore, in 71 state cases, the thesis of federative solidarity was used to circumvent the jurisdiction rules laid down by Theme 1,234 of the Federal Supreme Court (STF). A profound functional asymmetry is thus revealed. **Conclusion:** judicialisation in Pará operates at "two speeds": one focused

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on survival at state level, and the other on high technology at federal level. In attempting to correct failures in the implementation of public policies through “selective inclusion”, the Law generates a tense structural coupling, in which guaranteeing individual rights disrupts collective planning, highlighting the legal limits in the face of economic scarcity in the Amazon.
Keywords: Judicialisation of Health; Case Law; Amazon; Brazilian Unified Health System; Health Law.

Resumo

Objetivo: analisar os dados de jurisprudência acerca de medicamentos e direito sanitário do Tribunal de Justiça do Estado do Pará (TJPA) e do Tribunal Regional Federal da Primeira Região (TRF1) sob a ótica das teorias sistêmicas de Niklas Luhmann e de Marcelo Neves. **Metodologia:** pesquisa qualiquantitativa acerca dos custos e dos processos de judicialização de medicamentos. A coleta ocorreu nos sítios eletrônicos do TJPA e do TRF1 com o uso do descritor “fornecimento de medicamentos”, entre junho e setembro de 2025. Após leitura e aplicação de critérios de exclusão, extraíram-se variáveis processuais (medicamento, doença e veredito). Os preços foram balizados pelo Preço Máximo de Venda ao Governo (PMVG), da Agência Nacional de Vigilância Sanitária (Anvisa), e os dados estatísticos analisados à luz da literatura científico-jurídica. A amostra analisada correspondeu a 83 processos na esfera estadual e a 310 na federal, totalizando 393 decisões. **Resultados:** o TJPA concentra-se nas demandas de atenção básica e infraestrutura nas Unidades de Terapia Intensiva (UTIs), com custo médio de R$ 9.041,38. Já o TRF1 centraliza as demandas da “elite tecnológica” (terapias gênicas e oncológicas), com custo médio de R$ 216.846,54. Além disso, em 71 processos estaduais, a tese da solidariedade federativa foi utilizada para contornar as regras de competência estipuladas pelo Tema 1.234 do Supremo Tribunal Federal (STF). Revela-se, assim, uma profunda assimetria funcional. **Conclusão:** a judicialização no Pará opera em “duas velocidades”: uma focada na sobrevivência no âmbito estadual e outra de alta tecnologia na esfera federal. O Direito, ao tentar corrigir falhas na execução de políticas públicas via “inclusão seletiva”, gera um acoplamento estrutural tenso, no qual garantir direitos individuais desorganiza o planejamento coletivo, evidenciando os limites jurídicos frente à escassez econômica na Amazônia.
Palavras-chave: Judicialização da Saúde; Jurisprudência; Amazônia; Sistema Único de Saúde; Direito Sanitário.

Resumen

Objetivo: analizar los datos jurisprudenciales relativos a medicamentos y derecho sanitario del Tribunal de Justicia del Estado de Pará (TJPA) y del Tribunal Regional Federal de la Primera Región (TRF1) a la luz de las teorías sistémicas de Niklas Luhmann y de Marcelo Neves. **Metodología:** investigación cualicuantitativa sobre los costes y los procesos de judicialización de medicamentos. La recogida de datos se realizó en los sitios web del TJPA y del TRF1 mediante el descriptor «suministro de medicamentos», entre junio y septiembre de 2025. Tras la lectura y la aplicación de los criterios de exclusión, se extrajeron variables procesales (medicamento, enfermedad y fallo). Los precios se ajustaron al Precio Máximo de Venta al Gobierno (PMVG) de la Agencia Nacional de Vigilancia Sanitaria (Anvisa), y los datos estadísticos se analizaron a la luz de la literatura científico-jurídica. La muestra analizada correspondió a 83 procesos en el ámbito estatal y a 310 en el federal (393 decisiones). **Resultados:** el TJPA se concentra en las demandas de atención primaria e infraestructura en las Unidades de Cuidados Intensivos (UCI), con un coste medio de 9.041,38 BRL. El TRF1, en cambio, concentra las demandas de la «élite tecnológica» (terapias génicas y oncológicas), con un coste medio de 216.846,54 BRL. Además, en 71 procesos estatales, la tesis de la solidaridad federativa se utilizó para eludir las reglas de competencia estipuladas por el Tema 1.234 del Supremo Tribunal Federal (STF). Se revela, así, una profunda asimetría funcional. **Conclusión:** la judicialización en Pará opera a «dos velocidades»: una centrada en la supervivencia en el ámbito estatal y otra de alta

tecnología en el ámbito federal. El Derecho, al intentar corregir los fallos en la ejecución de políticas públicas mediante la «inclusión selectiva», genera un acoplamiento estructural tenso, en el cual garantizar derechos individuales desorganiza la planificación colectiva, poniendo de manifiesto los límites jurídicos ante la escasez económica en la Amazonía.
Palabras clave: Judicialización de la Salud; Jurisprudencia; Amazonía; Sistema Único de Salud; Derecho Sanitario.

Introduction

The promulgation of the Federal Constitution of 1988 represented a paradigmatic rupture. By abandoning the insurance-contributory model, restricted to those formally inserted in the labour market, and establishing health as a "right of all and duty of the State" in Art. 196[1], the constituent assembly established a promise of universal access. However, the transposition of this norm to the reality of a country marked by profound socioeconomic and regional inequalities revealed a structural gap between the formally recognised right and the effective provision of health services. It is precisely in this gap that specialised literature locates the emergence and consolidation of the so-called "judicialisation of health" — understood as systematic recourse to the Judiciary to obtain medications, treatments, and other health supplies not made available in a timely manner through the administrative channels of the Unified Health System (SUS)[2,3,4]. Far from constituting a mere normative deviation, this phenomenon has become, in recent decades, an ordinary mechanism for access to essential health goods, whose determinants include failures in the implementation of public health policies, the expansion of the Judiciary's role in the realisation of social rights, and asymmetries in access to the justice system itself[2].

In the reality of Pará, this equation acquires peculiarities that challenge public management. Amazonian geography imposes logistical obstacles frequently ignored by traditional legal doctrine. With a territorial area greater than that of entire European countries and restricted road infrastructure, decentralisation of care faces real physical barriers. The absence of high-complexity centres in the state's interior and the difficulty of retaining specialists outside the capital often turn the Judiciary into the main avenue of access to urgent treatments.

Furthermore, the bottlenecks in basic development are substantial. According to the United Nations Development Programme (UNDP)[5], of the 144 municipalities comprising the state of Pará, 87 have a low Municipal Human Development Index (MHDI) and 8 a very low one — representing approximately 65.9% of all municipal entities in a situation of socioeconomic vulnerability. Simultaneously, a large proportion of municipal administrations face budget deficits[6], a setting in which medication litigation begins to consume millions in slices of the local budget monthly[7].

The litigation phenomenon in Pará is not restricted to claims against public authorities. As will be demonstrated in the methodology section, a substantial proportion of the captured cases involves plan operators in the supplementary health sector, revealing that the crisis in access to medications extends beyond the state sphere and also reaches the private health market. The inclusion of these claims in the present research is justified by the need to understand the behaviour of Pará's courts in resolving health conflicts.

The year 2025 presented itself as a strategic temporal milestone for this analysis because it represented a period of intense institutional transition in the judicialisation of public health policies. Instead of a setting of settled rules, the courts were dealing with imminent structural changes. While Theme 793[8] of the Federal Supreme Court (STF) had already guided case law since 2019, crucial

theses were still undergoing modulation of effects. Theme 6[9] had its motions for clarification adjudicated throughout 2025, and the awaited Theme 1.234[10], which redefined Federal Court jurisdiction for medications not incorporated, had its agreement in the Tripartite Intermanager Commission (CIT)[11] approved with ex nunc effect only as of October 22, 2025.

This new arrangement operated by the STF finds support in the attempts at rationalisation promoted by the higher courts. Data from the National Council of Justice (CNJ)[12] indicate that the judicialisation of medications remained the second most frequent topic in the country's health claims. The Judiciary thus began to operate in a border zone between the unavoidable guarantee of fundamental rights and interference in the Executive Branch's exclusive administration, managing everything from beds to the distribution of high-cost drugs.

In this context, the present article formulates the following research problem: how do judicial claims for the supply of medications adjudicated by the Court of Justice of the State of Pará (TJPA)[13] and by the Pará Judicial Section linked to the Federal Regional Court of the 1st Region (TRF1)[14], from June to September 2025, differ regarding the epidemiological profiles of the actions, financial costs, and legal grounds adopted?

To answer this question, this study's main objective is to analyse empirically the case-law data from these two courts in the state. The choice aims to test the hypothesis that the litigation phenomenon operates at "two speeds": one focused on basic infrastructure claims and items of the National List of Essential Medications (RENAME)[15] at the state level, and another directed towards high technology, such as oncological treatments and rare diseases, at the federal level.

Methodology

To structure the analysis of the results, the study adopts an interdisciplinary theoretical framework anchored in the constitutional doctrine of Gilmar Mendes and Paulo Gonet Branco[16], combined with the structural legal sociology of Niklas Luhmann[17] and Marcelo Neves[18]. The study is characterised as documentary and empirical-jurisprudential research, adopting a qualitative-quantitative approach. The aim was to measure procedural and economic indicators, associating them with content analysis of judicial decisions.

The research was conducted by collecting primary data contained in publicly accessible cases made available on the TJPA[13] and TRF1[14] case-law websites. The temporal delimitation was between 1 June and 30 September, 2025, a period sufficient to ensure methodological data saturation, and strategically encompassing the complex interval preceding the full effectiveness of the jurisdiction rules of STF Theme 1.234[10]. The gross quantity collected was 95 cases at the state level (TJPA) and 330 at the federal level (TRF1). After applying the exclusion criteria, the net analysed sample corresponded to 83 state and 310 federal disputes, totalling 393 judicial decisions examined. The detailed results of this screening are presented and discussed in the "Results and Discussion" section.

The research steps followed this methodological flow:

1. Data search: the initial search was conducted in the TJPA[13] and TRF1[14] public case consultation repositories, using the term "supply of medications," excluding claims for ICU beds, supply of prostheses/orthoses, and other treatments.

2. Screening and exclusion criteria: after downloading case summaries and decisions, their contents were read. Exclusion criteria were applied to purify the sample and ensure thematic fidelity:

- **Death:** cases dismissed because of the plaintiff's death during the litigation were counted exclusively for mapping procedural outcomes, being excluded from effective cost analysis, since the state provision did not materialise financially.
- **Thematic deviation:** actions that, although containing the search terms, concerned medical errors, requests for ICU beds, supply of prostheses/orthoses and other treatments, compensation for purely nonpecuniary damages without a request for material health provision, or labour matters in a hospital setting were summarily discarded.
- **Duplicate records:** identical decisions and case summaries resulting from overlap or redundancy in extraction from case-law repositories (such as repetitions of the same case at different procedural stages, simultaneous appeals, or repeated files indexed with different identifiers), ensuring that each dispute was counted as a single unit of analysis in the net sample.

3. Systematisation of variables: the study's unit of analysis was the "judicial decision" (judgments on the merits, appellate decisions, or active urgent relief orders). For each valid unit, data were extracted and tabulated in an analytical matrix, comprising the following variables, in Microsoft 365 Excel[19]:

- Case number;
- Medication/Supply requested (active ingredient);
- Disease (International Classification of Diseases - ICD-11)[20];
- Verdict (Granted/Denied/Partial);
- Defendant entity (State, Municipality, Union, Health Plan Operators);
- Legal grounds (Precedent Statements, General Repercussion Themes, medical reports, technical notes from the Judiciary's Technical Support Centre (NatJus)[21], etc.).

4. Grouping diseases into categories: diseases were grouped into categories based on their chapter in the 11th International Classification of Diseases (ICD-11)[20], and its scientific criteria for division into chapters by groups of illnesses.

5. Methodological criteria for the economic stratification of medications: to assign economic value to the data with scientific precision, prices were surveyed based on the Maximum Sale Prices to the Government (PMVG) table of the Drug Market Regulation Chamber (CMED/Anvisa)[22]. To enable comparative analysis of the financial impact between courts, the study established its own methodological criterion for stratifying the values obtained through Anvisa's Average Government Value Price table[22] (0% Tax on the Circulation of Goods and Services). Medications subject to judicialisation were grouped into three main categories (low, medium, and high cost), with an analytical category (ultra-high cost) to isolate items that distort the federal sample's average. Range in reais (R$):

- Low cost: $X \leq 1{,}500.00$ (less than or equal to R$ 1,500.00).
- Medium cost: $1{,}500.00 < X \leq 10{,}000.00$ (greater than R$ 1,500.00 and less than or equal to R$ 10,000.00)
- High cost: $10{,}000.00 < X \leq 100{,}000.00$ (greater than R$ 10,000.00 and less than or equal to R$ 100,000.00)
- Ultra-high cost: $X > 100{,}000.00$ (greater than R$ 100,000.00).

6. Clinical and regulatory requirements (grounds on the merits): to deepen the qualitative analysis of the rationes decidendi (reasons for deciding) adopted by judges, specific variables were

extracted concerning fulfilment of clinical and regulatory requirements outlined in higher court case law. These criteria were coded in binary form (1 = Yes / 0 = No) to allow statistical cross-tabulation:

- Anvisa registration[23]: verification of explicit reference to the existence of valid health registration of the drug with the national regulatory agency.
- Off-label prescription: identification of cases in which the intended clinical use differed from the indications originally approved in the package insert.
- Financial incapacity (insufficient means): reference to fulfilment of the requirement of the patient's economic inability to pay privately for treatment.
- Reasoned medical report: verification of the requirement and acceptance of a detailed medical report attesting to the drug's clinical indispensability.
- Exhaustion of therapeutic alternatives: reference to ineffectiveness, intolerance, or impossibility of replacing the requested treatment with drugs already standardised in SUS clinical protocols.
- Scientific evidence: explicit reference to support for the claim in randomised clinical trials or Evidence-Based Medicine (EBM) guidelines attesting to the drug's safety and efficacy.

7. Administrative and evidentiary parameters: to map the preprocedural flow and technical support used in decisions, a group of variables directed towards administrative and expert conduct was established, categorised as follows:

- Prior Administrative Denial: documentary proof, coded in binary form (1 = Yes / 0 = No), that the State administratively refused supply before the judicialisation of the claim.
- Incorporation status in the National Commission for the Incorporation of Technologies into the Unified Health System (Conitec)[24]: assessment of the drug's situation before the responsible national commission. Categorically classified as: (1) Not assessed; (2) Negative recommendation; (3) Delay in administrative review; or (4) Incorporated into the SUS during the proceeding.
- Technical opinion (NatJus)[21]: verification of the issuance of an opinion by the Judiciary's Technical Support Centre, categorically coded by its impact on the decision: (1) Favourable to the plaintiff; (2) Unfavourable to the plaintiff; or (0) Nonexistent/Not consulted.

8. Enforcement and liability rules: finally, the study parameterised measures adopted for the material realisation of judicial relief and the accountability of public entities, using binary coding (1 = Yes / 0 = No):

- Joint and several liability (Theme 793/STF)[8]: identification of the recognition or exclusion of shared liability among the Union, States, and Municipalities for financing and supply.
- Application of astreintes (Theme 98/Superior Court of Justice)[25]: verification of the imposition of a coercive daily fine on the Public Treasury as a coercion mechanism for compliance with the court order.

It is pointed out that health plan operators belonging to supplementary health care, although not part of the SUS, were included in the sample for the following methodological reasons:

i. They represent a significant proportion of the litigation captured by the descriptor "supply of medications" in the TJPA and TRF1 repositories, corresponding to approximately 40% of the state cases analysed;

ii. Their exclusion would compromise the fidelity of the representation of the litigation phenomenon in Pará's courts, since the search descriptor does not distinguish, a priori, the public or private nature of the defendant side;

iii. Inclusion allows analysis of the courts' behaviour as a unitary system for resolving health conflicts, revealing interactions between judicialisation of the SUS and of supplementary health care. Data relating to operators are presented separately in the tables and analysis, to allow their identification and possible exclusion by readers interested exclusively in the SUS.

In cases of imported medications without registration in Brazil (such as certain cannabinoids), it was not possible to analyse them because their prices had not been determined by CMED. The methodology ensured that the values presented in this study reflect the budgetary impact as close as possible to the administrative reality faced by the public manager.

Finally, the final statistical data were subjected to an interpretive reading in light of systems theory[17,18, 26], constitutional doctrine[16,27], and analysed from the state of the art[28,29,30,31,32,33,34]. The aim was not only to describe how many cases exist, a task of descriptive statistics, but also why they exist and how the legal system justifies its interference in the health system. The categories of "autopoiesis," "structural coupling," "functional differentiation," and "symbolic constitution" were used to give sociological meaning to the numbers. Simultaneously, the categories of "existential minimum," "reservation of the possible," and "prohibition of social regression," explored by Gilmar Mendes and Paulo Gonet Branco[16], were applied to test the constitutional legitimacy of decisions, transforming raw data into indicators of institutional performance and social tension in Brazilian peripheral modernity.

Because this is empirical-jurisprudential research based exclusively on secondary data with public and unrestricted access, made available by the courts' electronic portals (TJPA and TRF1)[13,14], this study does not require submission to the System of Research Ethics Committees (CEPs) and the National Research Ethics Commission (Conep)[35], in accordance with applicable ethical principles and National Health Council resolutions for public-domain data.

In accordance with scientific activity integrity guidelines and CNPq Ordinance No. 2.664/2026[36], it is declared that this manuscript used the Google Gemini[37] Generative Artificial Intelligence tool, model 3.1 Pro, to assist with textual revision and support the structuring of data analysis, encompassing spelling and grammatical adequacy and preliminary statistical cross-tabulation of case-law variables. The authors confirm that no artificial intelligence-generated content attributed to human authorship was submitted and attest to having performed complete review and validation of all outputs generated by the tool. Thus, the authors assume full and unrestricted responsibility for the final content, accuracy of the data, and conclusions presented in the research.

Results and discussion

1. Macro contextualisation: the judicialisation scenario in the CNJ Dashboard

To understand the magnitude and nature of judicialisation in the state of Pará, it is imperative to situate the litigation phenomenon in its macro panorama. Data from the National Council of Justice (CNJ)[12] Right to Health Procedural Statistics dashboard, referring to 2025, reveal a structural

overload of the system: 6,924 new cases were recorded, with a congestion rate of 44.0% and an average pending time of 412 days. Table 1 details the procedural behaviour of this universe.

Table 1. Procedural data on the "health" topic in the Court of Justice of the State of Pará (TJPA) and the Federal Regional Court of the 1st Region (TRF1 – Pará Judicial Section), from 01/01/2025 to 31/12/2025

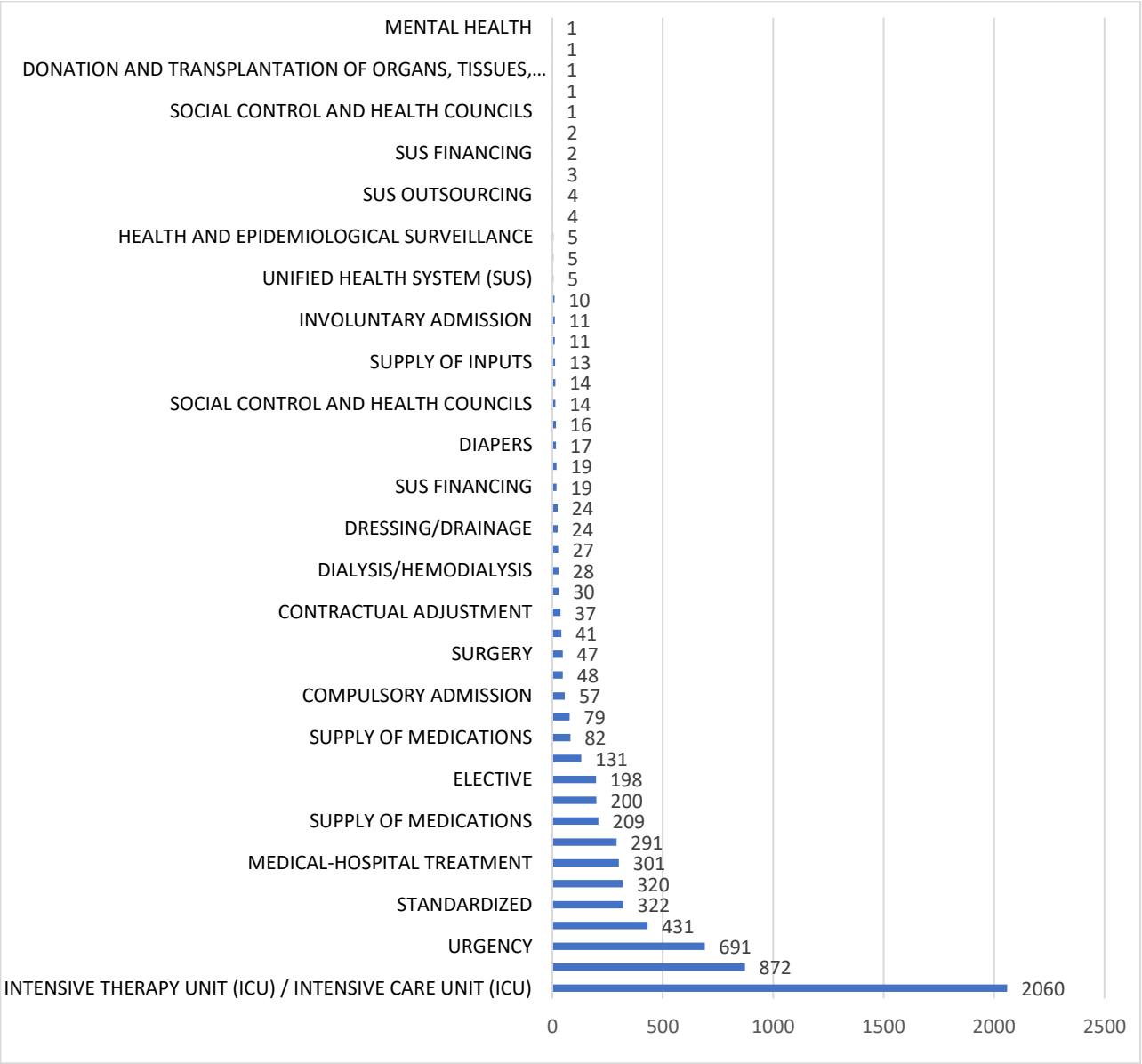
Indicator	Value
Entries in 2025 (new cases)	6,924
Pending on 31/12/2025 (total)	5,580
Pending on 31/12/2025 (net)	5,378
Average pending time (days)	412
Average net pending time (days)	346
Exits in 2025 (closed cases)	7,101
Average time to first closure (days)	313
Adjudicated in 2025	7,115
Average time to first adjudication (days)	234
Demand Satisfaction Index (IAD)	102.6%
Congestion rate on 31/12/2025 (gross)	44.0%
Congestion rate on 31/12/2025 (net)	43.1%
Preliminary injunctions granted in 2025	4,079
Preliminary injunctions denied in 2025	411
Adjudicated on the merits – favourable judgment/appeal granted	3,014 (42.36%)
Adjudicated on the merits – unfavourable judgment/appeal denied	449 (6.31%)
Adjudicated on the merits – approval of settlement	1,100 (15.46%)
Adjudicated on the merits – other	136 (1.91%)
Adjudicated without a decision on the merits	2,416 (33.96%)

Source: CNJ, Right to Health Procedural Statistics Dashboard[12], 2026.

Note: Data extracted from the CNJ Right to Health Procedural Statistics Dashboard, considering the joint universe (TJPA + TRF1 – Pará Judicial Section), for the period from 01/01/2025 to 31/12/2025. The Demand Satisfaction Index (IAD) corresponds to the ratio between adjudicated cases and new cases in the period.

Three findings deserve emphasis: the asymmetry between the levels reveals the nature of the claims: the TJPA concentrated 5,579 cases against only 444 in the Federal Courts (a ratio of approximately 12.5:1)[12], functioning as a "screening counter" for Pará's public health; the preliminary injunction granting rate reached 90.8% (4,079 granted against 411 denied), indicating that Pará's Judiciary operates as an instance of almost automatic acceptance of health claims; and finally, and sociologically most relevant, the taxonomy of subjects (Chart 1) demonstrates that the main cause of action in the state court is not a cutting-edge medication, but a hospital bed: ICU/ICU was the most recurrent topic, with 2,060 records plus 872 requests for ward/oncological beds and 691 generic urgent obligations to act[12].

Graph 1. Most frequent procedural subjects of the "health" topic in the Court of Justice of the State of Pará (TJPA) and the Federal Regional Court of the 1st Region (TRF1 – Pará Judicial Section), from 01/01/2025 to 31/12/2025



Source: CNJ, Right to Health Procedural Statistics Dashboard[12], 2026.
Note: Data refer to the universe of cases on the "health" topic recorded in the CNJ dashboard[12], and should not be confused with the research's empirical sample, comprising 393 decisions.

This macro scenario, dominated by the hospital infrastructure crisis, demonstrates that judicialisation in Pará transcends the pharmaceutical issue. However, this study delimits its empirical scope to the descriptor "supply of medications," to isolate and deepen the analysis of strictly pharmaceutical judicialisation. Even excluding the crisis in beds and procedures, the budgetary pressure imposed on both court levels remains substantial, as will be demonstrated from the sample of 393 decisions analysed. To interpret these data from a sociological and constitutional perspective, the theoretical framework that will guide the reading of the findings is presented in the following subsection.

2. Judicialisation as systemic noise and the reservation of the possible

From the Luhmannian perspective[17], judicial intervention operates as systemic "noise" or "irritation": when the political system fails to provide the health good, this environmental event "irritates" the legal system, which is operationally closed. To process this irritation and maintain its social relevance, Law translates the failure (a biological or medical demand) into its own binary code of lawful/unlawful. The problem arises because this translation frequently marginalises the economic system's codes of financial scarcity, demanding a theoretical framework beyond mere traditional doctrine to explain decisions that collide with the State's budgetary capacity.

In this translation process, the so-called structural couplings operate — mechanisms through which functionally differentiated systems reciprocally condition their operations without, however, merging or subordinating themselves[17]. The Constitution of 1988[1] constitutes the main structural coupling between the legal and political systems in Brazil, insofar as it programmes normative expectations binding both[18]. In judicial health practice, this coupling materialises through experts, medical reports, and technical notes, which function as "points of irritation" between Law, Medicine, and Economics[26]. The risk inherent in this dynamic, identified in Luhmannian literature as "dedifferentiation" or "corruption of the code"[17], occurs when the judge decides exclusively based on empathy, media pressure, or an individual moral sense, marginalising the logic of the economic system (resource scarcity) and the scientific system (clinical evidence). In this hypothesis, Law attempts to functionally dominate Politics and Economics, generating a collapse of rationality in which the judicial decision becomes an act of will disconnected from the real possibilities of the systemic environment[18].

From the perspective of Constitutional Law, Mendes and Branco[16] emphasise that the catalogue of social rights in the Constitution of 1988[1] created permanent tension between legal claims and the State's economic possibilities. The right to health, although endowed with legal effectiveness and generating subjective rights, depends on financial resources, which introduces the reservation of the possible, originating in German constitutional case law (numerus clausus), through which the individual claim to material provisions is limited to the availability of public resources, as Sunstein and Holmes[38] summarise: "taking rights seriously means taking scarcity seriously."

The scarcity structuring this tension is not merely theoretical. The Pharmaceutical Care in the SUS Survey[3], conducted by the Institute for Applied Economic Research (Ipea), in cooperation with the National Council of Municipal Health Departments (Conasems) and the National Council of Health Secretaries (Conass), showed that in 2023, medications subject to judicialisation corresponded, on average, to 8.4% of total medication spending in municipalities and 32.9% of spending in participating states, with judicial claims present in 58.7% of municipalities and all states[3]. In the same period, the federal share in pharmaceutical care financing decreased, while expenditure from states' and municipalities' own resources grew[3], shifting the burden of judicialisation to entities with lower fiscal capacity and further narrowing the margin between the existential minimum and the reservation of the possible.

However, the reservation of the possible cannot be absolute: the essential core of fundamental rights linked to human dignity — the existential minimum — is immune to budgetary restrictions[16], a thesis consolidated by the STF in the Claim of Noncompliance with a Fundamental Precept 45 (ADPF 45)[39], which prohibits invoking that clause to breach primary constitutional duties. Cunha[27] deepens the guideline by criticising its use as a "rhetorical shield" and warning that protection of the

existential minimum should not be exhausted in individualistic judicialisation, under penalty of perpetuating poor management and underfunding of the SUS.

Thus, the judicial avenue finds its constitutional legitimacy in protecting this existential minimum. The problem, however, arises when the judicial claim exceeds the "minimum" (basic treatment, vaccination, emergency care) and advances into the "maximum" (experimental treatments, high-cost medications, therapies abroad). In these cases, Mendes and Branco[16] warn of the risk of the Judiciary disorganising the health system, privileging individual interests to the detriment of the collective, violating the principle of equality and the very rationality of the public policy system.

3. Symbolic constitutionalisation and the galaxy of distinctions

Marcelo Neves[18], in critical dialogue with Luhmann[17], adapts systems theory to "peripheral modernity," in which continuous allopoietic interference between systems is observed. For this research, the reductionist meaning of "Politics" is set aside: Politics is understood in its three dimensions — polity (the institutional architecture of the State and SUS), policy (content, formulation, and implementation of health policies), and politics (negotiation and conflict between actors)[2]. In this two-way avenue, Politics transfers conflicts generated by its planning failures to the Judiciary, while Law, under the pretext of realising guarantees, advances into administrative governance and the budget[27] — a tension that Secchi[2] identifies between judicial logic (case by case) and managerial logic (universal and equal planning).

Neves[18] introduces the concept of "symbolic constitution": the constitutional text promises universal inclusion, but the peripheral reality, marked by scarcity, converts the norm into a symbol, since "symbolic legislation serves primarily to postpone the resolution of social conflicts, creating the illusion that enactment of the norm resolves the factual problem." In Pará, the theory explains overinclusion: the citizen with cognitive and financial means circumvents the SUS queue and obtains excellent treatment, draining collective resources, while the unassisted mass remains underincluded[26].

Ribeiro[26], in the thesis "Galaxy of distinctions," deepens the microphysics of the judicial decision: to reduce environmental complexity, judges create functional legal distinctions — urgent/elective, registered/unregistered (registration with Anvisa[23] presumes the right in place of efficacy analysis), and life/budget (a false dichotomy that excludes the reservation of the possible, ignoring that budget exhaustion produces loss of future lives). As the author summarises, "the judicial decision reconstructs the complexity of the concrete case, transforming scientific uncertainties into legal certainties ('clear and certain right'), ignoring the systemic consequences of this simplification"[26]. This "galaxy of distinctions" allows the court to function and issue judgments, but generates "systemic blindness" by focusing on the urgent/elective distinction, since the judge may order ICU admission of a terminally ill patient with no prognosis of recovery. Clinical bioethics calls the administration of measures that offer no physiological benefit or reasonable quality of life to the patient "therapeutic futility" or "therapeutic obstinacy"[40], consuming resources of treatable patients.

The STF, acting as the apex of the legal system, attempted to act as an instance of rational "recoupling." Theme 6[9] established that the State cannot be compelled to supply experimental medications or those without Anvisa registration, except for rare exceptions; Theme 793[8] sought to hold the entity responsible for financing accountable, and Theme 1.234[10] determined that the Union finance medications not incorporated, with Federal Court jurisdiction. These precedents constitute attempts to impose a logic of "conditional programmes." However, analysis of Pará's data

demonstrates that their full application at the first-instance level faces structural obstacles: not willful resistance, but factual impossibility — geographical distance, infrastructure scarcity, clinical urgency, and a legal culture forged in the immediate protection of the existential minimum override the doctrine of federative jurisdiction[26].

4. Empirical analysis of judicial decisions

Empirical analysis of the sample — comprising 393 judicial decisions (83 at the state level and 310 at the federal level) — reveals a scenario in which the judicial avenue in Pará has exceeded the nature of an "exceptional avenue" to become a structural, and deeply problematic, pillar of state health management. In contrast to the universe of the CNJ dashboard[12], in which hospital beds are the predominant demand, the empirical sample — delimited by the descriptor "supply of medications" — concentrates on drugs, demonstrating that, even excluding the infrastructure crisis, isolated pharmaceutical judicialisation already imposes substantial budgetary pressure on both court levels.

Before proceeding with the analysis, the flow of sample construction must be clarified to eliminate apparent divergences between manuscript sections. The quantities of 95 cases (TJPA) and 330 cases (TRF1) correspond to the gross universe captured by the descriptor "supply of medications." After reading the decisions in full and applying the exclusion criteria described in the Methodology (plaintiff's death, thematic deviation, and duplicate records), the net sample was consolidated into 83 state disputes (21.12%) and 310 federal disputes (78.88%), totalling 393 decisions analysed. It is this net sample — and not the gross quantity — to which all percentages and averages discussed below refer.

4.1) Sample composition and general overview of claims

As per the Methodology, the percentages and averages below refer to the net sample of 393 decisions (83 state; 310 federal), and not the gross quantity (Table 2). In the TJPA[13], 76 cases were granted (80.00%), 7 denied (7.36%), and 1 annulled/remitted (1.20%), and in the TRF1[14], 187 grants (56.67%), 119 denials (36.06%), and 4 annulments (1.21%). Regarding defendant sides, with sums exceeding 100% because of joinder of parties, in the TJPA, states (65.26%), municipalities (58.9%), and private operators (34.74%, predominantly Unimed Belém) stand out; in the TRF1, the Union accounts for 76.67%. Of the 135 medications (subject of a final state decision), 128 were granted (94.81%) and 7 denied (5.19%); joint and several liability (Theme 793/STF) appeared in 71 occurrences (55.46% of state grants). In economic stratification, the TJPA concentrated on low-cost (56.25%) and medium-cost (17.96%) ranges, totalling R$ 949,345.75 (average cost of R$ 9,041.38 per priced drug, calculated over the 105 items with available PMVG value, as per Note 9 of Table 2); the TRF1 concentrated on high cost (46.47%) and ultra-high cost (3.52%), totalling R$ 32,310,133.85 (average R$ 216,846.54), with the most expensive drug, Zolgensma (R$ 6,547,610.00; 3 occurrences), and, in the state sample, ravulizumab (R$ 77,271.91).

Table 2. General dashboard of medication supply cases: quantities collected and analysed, verdicts, defendant sides, and economic stratification of drugs, according to the PMVG/Anvisa table, in the TJPA and TRF1 – Pará Judicial Section), from 01/06/2025 to 30/09/2025

General Procedural Dashboard		
X	**TJPA**	**TRF1**
Total cases[1]	95 (100.00%)	330 (100.00%)
Cases analysed	83 (87.37%)	310 (93.94%)
Excluded	12 (12.63%)	20 (6.06%)
Lawful (granted)[2]	76 (80.00%)	187 (56.67%)
Unlawful (denied)	7 (7.36%)	119 (36.06%)
Annulled/Remanded[3]	—[4]	4 (1.21%)
Union[5]	0 (0%)	253 (76.67%)
State[5]	62 (65.26%)	89 (26.97%)
Municipality[5]	56 (58.9%)	35 (10.61%)
Health plan[5][6][7]	33 (34.74%)	1 (0.30%)
Total medications[8]	128 (100%)[8]	170 (100%)
Low cost (X ≤ 1,500.00)	72 (56.25%)	6 (3.52%)
Medium cost (1,500.00 < X ≤ 10,000.00)	23 (17.96%)	65 (38.23%)
High cost (10,000.00 < X ≤ 100,000.00)	11 (8.59%)	79 (46.47%)
Ultra-high cost (X >100,000.00)	0 (0.00%)	6 (3.52%)
Not listed[9]	22 (17.18%)	14 (8.23%)
Total value (PMVG)	R$ 949,345.75	R$ 32,310,133.85
Most expensive medication	Ravulizumab R$ 77,271.91	Zolgensma R$ 6,547,610.00[10]
Average	R$ 9,041.38[11]	R$ 216,846.54

Source: Own elaboration, 2026.

Notes: **[1]** Percentages calculated over the total cases collected (95 and 330); the sum of verdicts and exclusions equals 100% of the total. **[2]** Joint and several liability (Theme 793/STF) was identified in 71 occurrences in cases against public entities, corresponding to 55.46% of state grants. Cases involving supplementary health operators were not counted in this parameter. **[3]** Decisions annulled or returned to the court of origin (lack of jurisdiction, revocation of relief, or reopened evidentiary proceedings), without a usable verdict on the merits in the analysed period. **[4]** At the state level, one case (0009457-27.2018.8.14.0045) had 1 (one) drug (Methotrexate) remitted to the Federal Courts. The case remains counted as granted regarding the other drugs. **[5]** The sum exceeds 100% due to joinder of defendants (multiple defendants). **[6]** Supplementary health operators included because the search descriptor captures the repositories' overall health litigation and exclusion, a priori, would compromise representativeness of the phenomenon. Data are presented separately to allow specific SUS analysis. **[7]** The quantity of 33 cases involving operators refers to disputes in which the operator is on the defendant side as sole defendant or joined defendant. The collection spreadsheet records 52 mentions of operators, since the same case may contain multiple drugs or multiple co-defendant operators. **[8]** Medications contained in decisions favourable to the litigant. **[9]** Excluding prostheses, surgeries, tests, and other items not included in the PMVG/Anvisa. **[10]** Zolgensma had 3 occurrences in the TRF1 sample. **[11]** Medications without a PMVG price (n = 22) and 1 (one) drug remitted to the Federal Courts (Methotrexate) were excluded from the average calculation, totalling 105 items for the TJPA and 149 for the TRF1.

Analysis of the 83 state cases with decisions on the merits or active preliminary injunctions reveals massive acceptance of plaintiffs' claims: of the 135 medications subject to a final decision at the state level, 128 were considered lawful (94.81%) and only 7 denied (5.19%). In cases against the state and municipalities, the argument of "joint and several liability"[8] was identified in 71 explicit occurrences (55.46% of state grants). A substantial portion of the state sample — 33 cases (34.74% of the gross total; 39.76% of analysed disputes) — has health plan operators as defendants, notably Unimed Belém. In these cases, the grounds migrate to Consumer Law (Precedent Statement 608/STJ)[41].

4.2) Disease category and economic impact of claims

Data on the frequency of disease groups among litigants are summarised in Table 3.

Table 3. Frequency of disease groups (ICD-11 chapters) among litigants in medication supply claims in the TJPA and TRF1 – Pará Judicial Section, from 01/06/2025 to 30/09/2025

ICD-11 classification	TJPA	TRF1[1]
Chapter 01: Certain infectious or parasitic diseases	0 (0.00%)	2 (0.65%)
Chapter 02: Neoplasms	38 (28.15%)	99 (31.83%)
Chapter 03: Diseases of the blood or blood-forming organs	2 (1.48%)	18 (5.84%)
Chapter 04: Diseases of the immune system	29 (21.48%)	6 (1.95%)
Chapter 05: Endocrine, nutritional, or metabolic diseases	7 (5.19%)	29 (9.42%)
Chapter 06: Mental, behavioural, or neurodevelopmental disorders	3 (2.22%)	5 (1.62%)
Chapter 07: Diseases of the nervous system	14 (10.37%)	28 (9.09%)
Chapter 08: Diseases of the visual system	2 (1.48%)	8 (2.60%)
Chapter 10: Diseases of the circulatory system	2 (1.47%)	7 (2.27%)
Chapter 11: Diseases of the respiratory system	13 (9.63%)	44 (14.15%)
Chapter 12: Diseases of the digestive system	0 (0.00%)	6 (1.95%)
Chapter 13: Diseases of the skin	6 (4.44%)	9 (2.92%)
Chapter 14: Diseases of the musculoskeletal system or connective tissue	8 (5.93%)	4 (1.30%)
Chapter 15: Diseases of the genitourinary system	0 (0.00%)	3 (0.97%)
Chapter 19: Developmental anomalies or congenital anomalies	0 (0.00%)	4 (1.30%)
Chapter 21: Injury, poisoning, or other consequences of external causes	0 (0.00%)	2 (0.65%)
No Information (N/A)[2]	11 (8.15%)	37 (11.90%)
Total	135 (100%)	311 (100%)

Source: Own elaboration, 2026.

Notes: **[1]** The total of the TRF1 column (311 cases) exceeds the number of analysed cases (310) by one unit, since one (1) case contains two diseases classified in different ICD-11 chapters. **[2]** No mention of the disease type in the procedural text.

Complementing Table 3 and giving greater parsimony to the presentation, ICD-11[20] chapters with no occurrences in the sample were excluded from tabulation. Thus, it is recorded that no cases were identified in either court concerning Chapters 09 (diseases of the auditory or vestibular system), 16 (pregnancy, childbirth, or puerperium), 17 (conditions related to sexual health), 18 (certain conditions originating in the perinatal period), 20 (symptoms, signs, or clinical and laboratory findings, not elsewhere classified), 22 (external causes of morbidity or mortality), 23 (factors influencing health status or contact with health services), 24 (codes for special purposes), 25 (extension codes), and 26 (conditions related to traditional medicine). At the state level (TJPA)[13], there were no records in Chapters 01 (certain infectious or parasitic diseases), 12 (diseases of the digestive system), 15 (diseases of the genitourinary system), 19 (developmental anomalies or congenital anomalies), and 21 (injury, poisoning, or other consequences of external causes), whose occurrences were restricted to the federal sample.

Combined analysis of the epidemiological profile (according to ICD-11[20]) and economic stratification reveals that the category of the pathology subject to judicialisation acts as the main determinant of the budgetary impact imposed on each court level. Financial quantification, guided by the PMVG/Anvisa table[22], with a 0% ICMS rate, confirms substantial financial asymmetry, in which the TJPA[13] absorbs mass claims and the TRF1[14] absorbs extremely high-value disputes.

At the state level (TJPA)[13], the illness profile concentrates mainly on neoplasms (28.15%), immune system pathologies (21.48%), diseases of the nervous system (10.37%), and of the respiratory system (9.63%). Consequently, economic stratification demonstrates that approximately 74.2% of requested medications fall within the low-cost (56.25%, with values up to R$ 1,500.00) and medium-cost (17.96%, up to R$ 10,000.00) ranges. Comparatively, in the TRF1[14], the illness profile remains predominantly composed of neoplasms (31.83%), but with a greater presence of diseases of the respiratory system (14.15%) and nervous system (9.09%), and with most medications concentrated in the high-cost range (46.47%, with values between R$ 10,000 and R$ 100,000), followed by a minority portion, but financially substantial, of ultra-high cost (3.52%, above R$ 100,000).

The average value of medications granted in the TJPA[13] was R$ 9,041.38, characterising widespread judicialisation directed at logistical failures in pharmaceutical care; outliers, however, destabilise the model: Ravulizumab (R$ 77,271.91/unit) was added to the mass of low-value claims (R$ 949,345.75), suffocating public entities' planning and operators' actuarial provisions. In the TRF1[14], the 6 ultra-high-cost items (3.52%) concentrated almost the entire financial volume granted (R$ 32,310,133.85), raising the average to R$ 216,846.54 — more than 23 times the state average.

4.3) Clinical, regulatory, and procedural parameters of decisions

Data on the parameters sought in judicial decisions are summarised in Table 4.

Table 4. Clinical, regulatory, and procedural parameters of judicial medication supply decisions, according to the verdict (unit of analysis: medication), in the Court of Justice of the State of Pará (TJPA) and the Federal Regional Court of the 1st Region (TRF1 – Pará Judicial Section), from 01/06/2025 to 30/09/2025

Parameters of judicial decisions[1]				
Claim	**Lawful (granted)**		**Unlawful (denied)**	
Parameter	**TJPA (n=128)**	**TRF1 (n=170)**	**TJPA (n=7)**	**TRF1 (n=119)**
Anvisa registration	42 (32.81%)	34 (20.00%)	1 (14.28%)	21 (17.64%)
Off-label	14 (10.93%)	4 (2.35%)	0 (0.00%)	0 (0.00%)
Insufficient means	19 (14.84%)	32 (18.82%)	0 (0.00%)	69 (57.98%)
Medical report	107 (83.59%)	35 (20.58%)	5 (71.42%)	69 (57.98%)
Exhaustion of therapeutic alternatives	12 (9.37%)	13 (7.64%)	2 (28.57%)	7 (5.88%)
Scientific evidence	13 (10.15%)	43 (25.29%)	0 (0.00%)	80 (67.22%)
Prior administrative denial	37 (28.90%)	27 (15.88%)	3 (42.86%)	71 (59.66%)
Incorporation status in Conitec (Negative recommendation; Incorporated during the proceeding)	1 (0.78%); 2 (1.56%)	21 (12.35%); 28 (16.47%)	0 (0.00%); 0 (0.00%)	67 (56.30%)[2]; 13 (10.92%)
Technical opinion NatJus (Favourable; Unfavourable)	1 (0.78%); 0 (0.00%)	21 (12.35%); 0 (0.00%)	0 (0.00%); 2 (28.57%)	51 (42.85%); 10 (8.40%)
Joint and several liability (Theme 793/STF)[3]	71 (55.46%)	46 (27.05%)	1 (14.28%)	11 (9.24%)
Application of astreintes (Theme 98/STJ)	37 (28.9%)	15 (8.82%)	0 (0.00%)	4 (3.36%)[4]

Source: Own elaboration, 2026.

Notes: **[1]** This table's unit of analysis is the medication (and not the case), since the same case may contain multiple drugs and multiple decision-making parameters. The "n" refers to the total medications whose decisions were classified as lawful (granted) of unfawful (denied) in each court: TJPA lawful (n = 128 medications granted); TRF1 lawful (n = 170 medications

granted); TJPA unlawful (n = 7 medications denied); TRF1 unlawful (n = 119 medications denied). Decisions encompass judgments on the merits, appellate decisions, and active urgent relief orders, as defined in item 3 of the Methodology. Each parameter's percentage corresponds to the ratio between the number of parameter occurrences and the "n" of the respective column. **[2]** In the TRF1 (unlawful column), the category "Incorporation status in Conitec (Negative recommendation)" (67; 56.30%) represents the main technical ground for denial, revealing institutional deference to the assessments of the National Commission for the Incorporation of Technologies into the SUS. **[3]** Cases involving health plans are not included in this parameter. **[4]** Percentages were calculated by dividing the number of occurrences of each parameter by the total medications in the respective column (n), and not by the total cases.

5. The "two speeds" and the opportunity cost of macroallocation

In the TJPA[13], the concentration of low- and medium-cost drugs (74.2%) and granting of 94.81% of requests reveal a Judiciary acting as a corrector of logistical failures in pharmaceutical care (authorising the supply of insulins, anticoagulants, and standardised drugs that should be dispensed by the network), in line with the characterisation of judicialisation as a symptom of failure in the implementation of basic policies[28] and with the coexistence of the "judicialisation of misery" and the "technological elite" described in the literature[33,34,42]. In the TRF1[14], the predominance of gene therapies and rare diseases confirms the high-technology pole of the hypothesis[29]. Results confirm the migration of grounds to Consumer Law (STJ Precedent Statement 608)[41] in disputes against operators, revealing that the access crisis is double: the State fails in the existential minimum and the Market fails in supplementary health contracts.

The decision-making contrast is equally substantial. The TJPA[13] grounds grants in the medical report (83.59%) and federative solidarity (55.46%), with marginal reference to scientific evidence (10.15%); the TRF1[14], conversely, conditions granting on technical-regulatory criteria and denies based on the absence of evidence (67.22%), lack of a detailed report (57.98%), and negative Conitec[36] recommendations (56.30%), demonstrating adherence to Health Technology Assessment (HTA)[24] reports and NatJus[21] opinions. At the federal level, 187 (56.66%) grants were observed against 119 (36.06%) denials on the merits and 4 (1.21%) annulments. The framework of these denials consisted of lack of scientific evidence and absence of institutional deference to Conitec's prior negative recommendations, while state decisions were based almost exclusively on tacit trust in the prescription of the plaintiff's private physician.

In sum, the overall financial figure summarises the disparity between levels: the amount granted in the federal sample was R$ 32,310,133.85, and the average expenditure per case in the TRF1[13] (R$ 216,846.54) represented an impact more than 23 times greater than state litigation (R$ 9,041.38). This distortion is mainly caused by ultra-high-cost medications — Zolgensma, with 3 occurrences (~R$ 19.6 million), and, at a subsequent level, Eculizumab and Trikafta, both with permanent annual costs in the hundreds of thousands of reais per litigating citizen[14].

Zolgensma summarises the opportunity cost of macroallocation: ~R$ 19.6 million for three patients, an amount capable of suppressing the annual primary care budget of dozens of Pará municipalities. The incidence of ultra-high-cost technologies in the TRF1 inserts the legal system into the bioethical and constitutional debate on resource macroallocation: judicial granting of treatments costing millions of reais for a single patient creates tension in the principle of human dignity in its transindividual dimension, since allocation of public funds is a zero-sum game, since diverting substantial budget shares to extraordinary individual claims passes over preventive policies and established treatments, violating the dignity of the unassisted collective.

In light of Mendes and Branco[16], granting ultra-high-cost drugs not incorporated must be subjected to the three-phase proportionality test - suitability (proven therapeutic adequacy), necessity

(absence of an equally effective incorporated alternative), and proportionality in the strict sense (weighing cost against clinical benefit) - because treatments of extreme cost and marginal benefit violate equality and unbalance the system. From Luhmann's perspective[17], the conflict between the codes of scarcity (economics), truth (science), and lawful/unlawful (Law) explains the judicial tendency to ignore economic restriction. The TRF1's restrictive stance materialises institutional self-restraint and the premise that "rights cost"[16,38], while state approval of prescriptions illustrates the "systemic blindness" of the "galaxy of distinctions"[26], including the risk of therapeutic obstinacy[40]. By denying 119 requests, federal judges exercise control of systemic rationality, preventing the Union's budget from being captured by extremely high-cost individual claims and preserving the SUS's collective and universal character — deference to the limits of state planning (polity), which avoids the financial collapse of public collective health policy (policy).

6. Instrumental federative solidarity, exhaustion of the model, and institutional perspectives

Federative solidarity, applied in 71 state cases to order the State and Municipalities to provide drugs not incorporated, functions as an instrumental mechanism of effectiveness, but contradicts the jurisdiction rule of Theme 1.234[10] and creates tension in the federative pact. The apparent local resistance to jurisdictional reorganisation is explained by the ex nunc modulation of the CIT agreement[11]; even so, the distinction between who can pay quickly (Municipality/State) and who must pay legally (Union) transfers insolvency to the local political system, in line with Cunha's criticism[27] of using solidarity as a release from responsibility.

Mendes and Branco[16] emphasise that Brazilian federalism, although cooperative, presupposes a rational division of powers and resources. Solidarity cannot mean release from responsibility or administrative chaos. When the Judiciary imposes on a Pará municipality — frequently characterised by a low Municipal Human Development Index (MHDI)[5] and a high degree of dependence on constitutional transfers such as the Municipal Participation Fund (FPM)[43] — the financing of an ultra-high-cost medication, whose financing and incorporation fall within the Union's responsibility, it severely compromises the viability of local health management and creates tension in the federative pact.

This local federative tension is not an isolated phenomenon, but reflects structural exhaustion of national scope. Findings converge with Ipea's portrait[3]: in 2023, medications subject to judicialization corresponded, on average, to 8.4% of total medication spending in municipalities and 32.9% of spending in participating states, with claims present in 58.7% of municipalities and all states. Furthermore, the reduction in federal participation in financing, combined with growth in expenditure from states' and municipalities' own resources[39], aggravates pressure on entities with lower fiscal capacity[44]. The literature converges in diagnosing exhaustion of the model[28,29,30,31,32,33,34], updating Neves's thesis of the symbolic constitution[18].

In Pará's context, this explains the observed dichotomy: in the TJPA[13], judicialisation of basic items reflects what Leal and Ribeiro[28] call failure in the implementation of basic social policies; in the TRF1[14], granting million-real drugs (such as Zolgensma) exemplifies Silva and Severino's concern[29], identifying high-cost medications as the main vector of financial imbalance, in which the individual right absolutely overrides the collective.

If systems theory points to "irritation" between Law and Politics, the most robust institutional response came with STF Theme 1.234[10]. Nascimento and Hirsch[31] emphasise that this precedent,

consolidated between 2024 and 2025, changes the "physics" of the judicial health proceeding. The authors[31] explain that Theme 1.234[10] not only defined Federal Court jurisdiction for medications not incorporated, but also imposed a rigorous administrative filter: the need for prior administrative denial and the prohibition on the Judiciary replacing Conitec's technical assessment[24] without a basis in robust scientific evidence.

Santos[32], in his monographic analysis, reinforces that the STF's new understanding seeks to end the "overriding" of powers. Creation of a national litigation platform and the requirement that the plaintiff prove the ineffectiveness of SUS drugs are attempts at systemic "recoupling." However, when we cross this theory with TJPA practice[13] in the analysis period from June to September 2025, it is perceived that application of Theme 1.234[10] still faces resistance: state judges' insistence on applying unrestricted solidarity — ordering the State/Municipality to provide medications not incorporated — directly contradicts the thesis that such claims should fall within the Union's responsibility, as outlined by Santos[32].

Galvão Junior[33], through an integrative review, deconstructs the myth of judicialisation as a democratic access tool: although many actions are brought through the Public Defender's Office (suggesting insufficient economic means), the object of the request often reveals a "technological elite." Prudêncio, et al.[34] reinforce that judicial requests for high-cost medications create "health at two speeds": while ordinary users await in the administrative queue, users resorting to judicialisation access treatments that do not even have consensus in the international scientific community.

This literature corroborates the distinction found in this research between the "judicialisation of misery" (TJPA) and the "judicialisation of the elite" (TRF1). As Silva and Severino[29] point out, the contemporary challenge is not merely legal, but bioethical: to what extent should the State finance an individual's "last chance" if this costs the "first chance" (vaccination, sanitation) of thousands?

Joint reading of these studies allows Marcelo Neves's criticism[18] to be updated: the litigation phenomenon, as described by Martins[30], Leal[28], and Nascimento[31], has ceased to be "course correction" to become a parallel and unregulated public policy — a "selective solidarity," financially unsustainable and socially unjust. Mitigating allocative disorganisation therefore requires prospective observance of the jurisdiction and financing rules of Theme 1.234[10] and managerial, logistical, and infrastructure improvement of the Executive, maintaining the administrative avenue as the priority for equitable access in the Amazon.

Final Considerations

Empirical analysis of the judicialisation of health in the state of Pará during the period examined in 2025, reveals asymmetric institutional dynamics and distinct litigation profiles between the State and Federal Courts, challenging the premise that this procedural phenomenon is homogeneous.

Within the Court of Justice of the State of Pará (TJPA)[13], data reveal the prevalence of claims directed towards filling structural deficits, evidenced by the high demand for ICU beds and primary care medications. The state Judiciary supplements the Executive's infrastructure and logistical failures, presenting a decision-making pattern of high granting. This case law is grounded mainly in the immediate guarantee of the existential minimum and the instrumental application of federative solidarity, reflecting the operational limitations of local public health policies.

In contrast, the Judicial Section linked to the Federal Regional Court of the 1st Region (TRF1)[14] processes disputes concentrated on innovative technologies of high financial impact, notably gene

therapies, rare disease treatments, and oncological drugs not incorporated by the SUS. In this court, judicial activity is observed to be guided by greater technical-expert scrutiny and adherence to the Federal Supreme Court's (STF) binding precedents. Such a stance results in stricter control regarding the reservation of the possible clause, weighing opportunity cost and budgetary impact on the collective.

From the systemic and constitutional perspective, it is inferred that the current litigation model accentuates tensions in the structural coupling between Law and health Politics. Continuous judicial intervention, by enabling the selective inclusion of litigants in treatment access, resolves the individual factual conflict, but frequently disorganises the rationality of budgetary planning and the administrative regulation queue.

It is concluded, from the collected evidence, that mitigating allocative disorganisation requires profound institutional realignment. Stabilisation of the health arrangement in Pará depends on rigorous observance of the jurisdiction and financing rules stipulated by the STF (notably in the prospective consolidation of Theme 1.234)[10], with this observance inseparable from imperative managerial, logistical, and infrastructure improvement by the Executive Branch. Administrative strengthening of the Unified Health System remains the priority avenue for ensuring equitable access, reducing dependence on the judicial avenue for realisation of the right to health in the Amazonian region.

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