

Judicial adjudication of intensive care unit access under resource scarcity in Brazil during COVID-19: implications for community health equity and public health allocation

Felipe Gabriel Barbosa de Oliveira

ofelipebarbosa@gmail.com

University of Brasília

Simone Luzia Fidélis de Oliveira

University of Brasília

Alessandra Lima Fontenele

University of Brasília

Dirce Bellezi Guilhem

University of Brasília

Research Article

Keywords: Intensive care unit, Resource allocation, Health equity, COVID-19, Community health, Public health emergency, Brazil

Posted Date: June 29th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-9708121/v1>

License: © ⓘ This work is licensed under a Creative Commons Attribution 4.0 International License.

[Read Full License](#)

Additional Declarations: No competing interests reported.

Abstract

Background

The COVID-19 pandemic produced unprecedented strain on intensive care unit (ICU) capacity in Brazil, generating substantial litigation in which courts were called to adjudicate disputes over access to life sustaining resources under conditions of acute scarcity. The implications of these decisions for community health equity and public health allocation have not been systematically examined. This study analyzes how Brazilian courts adjudicated ICU access disputes during the pandemic and assesses the implications of judicial reasoning for equitable resource allocation, community health protection, and public health system resilience.

Methods

A qualitative empirical documentary analysis was conducted on judicial decisions concerning ICU access drawn from a final sample of 585 COVID-19 health litigation cases retrieved through the AASP/JUIT jurisprudence database covering decisions rendered between 2019 and 2025. Decisions were systematically coded according to the type of relief sought, the institutional response invoked, the proportionality reasoning articulated, and the equity dimension implicated.

Results

Courts adjudicated ICU access disputes through an evolving reasoning pattern: early decisions emphasized irreversibility of harm and individual urgency, while subsequent decisions progressively incorporated reference to centralized bed regulation systems, technical clinical criteria, and systemic distributional consequences. The reasoning pattern revealed a structural tension between litigation based access, which systematically favors individuals with legal and socioeconomic resources, and the principle of universal and equitable access that grounds the Brazilian Unified Health System.

Conclusions

ICU access litigation simultaneously functioned as a corrective mechanism against administrative omission and as a potential driver of inequity, with significant implications for community health protection in future public health emergencies. Strengthening regulatory infrastructure, allocation transparency, and primary care surveillance capacity emerges as a public health imperative for reducing the structural conditions that produce litigation dependent access during emergencies.

Contributions to the Literature

- The study characterizes the interface between constitutional health rights litigation and intensive care resource allocation during a public health emergency, a relationship that remains underexamined in the international community health literature.
- It shows that litigation-based access tends to favor individuals with legal and socioeconomic resources, with concrete implications for equitable allocation under scarcity.
- It identifies operational levers for public health system design, including regional referral infrastructure, transparent allocation criteria, and primary care surveillance, that can reduce the structural conditions driving emergency litigation.
- The findings are transferable to other jurisdictions where constitutional health rights interact with resource-constrained systems, particularly in Latin America, Africa, and Asia.

Background

Intensive care unit (ICU) capacity is a structurally limited resource in every health system, and its allocation under conditions of acute scarcity raises some of the most consequential ethical and operational dilemmas in public health [1, 2]. The COVID-19 pandemic exposed the fragility of ICU infrastructure across high income, middle income, and low income countries alike, requiring rapid expansion of capacity, the development of triage protocols, and the construction of regulatory mechanisms designed to allocate scarce beds among critically ill patients [3, 4]. In Brazil, these dilemmas unfolded within a constitutional framework that recognizes health as a universal right and a duty of the State, generating substantial litigation in which courts were called upon to adjudicate disputes over ICU access during periods of acute hospital saturation [5, 6].

The Brazilian Unified Health System (Sistema Único de Saúde, SUS), established under the 1988 Federal Constitution, operates through cooperative federalism in which municipal, state, and federal authorities share constitutional responsibility for health service provision. ICU regulation occurs through centralized bed allocation systems implemented at state and regional levels, designed to allocate available capacity according to clinical criteria, severity assessment, and waiting list management [7]. During the most acute phases of the pandemic, these systems operated under conditions of extreme demand, with documented capacity saturation in major Brazilian cities and regional disparities in resource availability that closely tracked pre existing inequalities in health infrastructure [8, 9].

Litigation seeking judicial intervention to compel ICU admission emerged as a prominent feature of pandemic related health disputes in Brazil. Courts were invoked through emergency injunction proceedings, often within hours of the clinical deterioration of patients whose families sought access to scarce ICU resources. Judicial reasoning in these cases unfolded under conditions of radical temporal urgency, scientific uncertainty, and institutional strain that distinguished pandemic era litigation from routine health rights adjudication. The decisions issued in this context shaped the operational

environment of regulatory bodies, hospital administrators, and clinical staff responsible for triage and allocation decisions.

A growing body of public health scholarship has examined the operational dimensions of ICU resource allocation during COVID-19. Studies have demonstrated that triage protocols grounded in transparent, evidence based criteria contribute to equitable allocation, mitigate clinician moral distress, and support institutional accountability [10, 11]. Comparative international experience indicates that the implementation of structured allocation frameworks, supplemented by oversight mechanisms and public communication, sustains public trust in resource constrained health systems during emergencies [3, 12]. The interface between these allocation frameworks and judicial intervention, however, has received insufficient systematic attention in the community health and public health literature, particularly in jurisdictions where constitutional health rights generate substantial litigation.

The implications of ICU access litigation for community health equity are substantial and underexamined. Litigation based access systematically favors individuals with legal representation, socioeconomic resources, and institutional knowledge, reproducing and potentially amplifying pre existing inequalities in health access [13, 14]. When courts compel ICU admission for individual patients within capacity constrained systems, the resulting reallocation may displace other patients with equivalent or greater clinical severity who lack the legal resources to access judicial relief. This dynamic raises core questions about the structural relationship between rights based litigation and equitable community health allocation, particularly relevant in jurisdictions where health is constitutionally guaranteed.

This study addresses these questions through a systematic empirical documentary analysis of judicial decisions concerning ICU access during the COVID-19 pandemic in Brazil. Three guiding research questions structure the analysis. First, how did Brazilian courts adjudicate ICU access disputes during the pandemic, and how did judicial reasoning evolve over the course of the emergency? Second, what proportionality and clinical reasoning standards emerged in judicial decisions, and how do these standards align with public health allocation frameworks? Third, what are the implications of judicial patterns for community health equity and the design of resilient public health allocation systems?

The study contributes to community health scholarship by characterizing the legal and institutional environment in which ICU resource allocation operated during COVID-19 in Brazil and by translating judicial findings into operational implications for public health system design. The findings carry relevance for jurisdictions where constitutional health rights interact with resource constrained allocation systems, including comparative contexts in Latin America, Africa, and Asia where structural inequality intersects with rights based litigation.

Methods

Study design

This study employs a qualitative empirical documentary design focused on the systematic analysis of judicial decisions concerning ICU access during the COVID-19 pandemic in Brazil. The methodological orientation is interpretive: judicial decisions are treated as institutional texts that articulate clinical, distributional, and constitutional reasoning under emergency conditions, and that shape the operational environment of public health allocation systems. Descriptive quantitative indicators characterize the distribution of cases across courts and types of relief sought, while interpretive analysis examines reasoning patterns and their implications for community health equity.

Data sources and case identification

Primary sources consisted of publicly available judicial decisions retrieved through the Brazilian Lawyers Association of São Paulo (AASP) jurisprudence database in combination with the JUIT interface. These platforms aggregate decisions across multiple Brazilian courts, including State Courts of Justice, Federal Regional Courts, the Superior Court of Justice, and the Federal Supreme Court. The aggregated search system enhanced jurisdictional coverage and reduced selection bias arising from reliance on any single court database.

The temporal scope spanned from 2019 to 2025, encompassing the pre pandemic baseline, the acute emergency phase, and the transitional post pandemic period. The Portuguese search strategy employed Boolean operators combining epidemiological and health litigation descriptors as follows: (COVID OR pandemia OR COVID19 OR COVID-19 OR “COVID-19”) AND (Leito OR UTI OR Vacinação OR Medicamento OR Medicamentos) AND (“Saúde Pública” OR SUS). The strategy was designed to capture litigation directly linked to COVID-19 across the principal domains of pandemic related health disputes.

Sampling strategy

The initial search identified 17,537 potentially relevant cases. A systematic probabilistic sampling strategy was adopted to ensure analytical feasibility while preserving representational balance. A confidence level of 95% and a conservative expected proportion ($p = 0.5$) were used to estimate a minimum sample size of 935 cases, corresponding to an estimated sampling error of approximately 3.1%. To enhance robustness, 1,002 decisions were selected through systematic sampling using an interval of $k = 18$, applied to unique case identifiers extracted from the search results. After automatic and manual deduplication and application of predefined eligibility criteria, 585 decisions composed the final analytical corpus across four thematic axes: ICU access and resource scarcity, federative conflicts and SUS governance, medication provision, and vaccination and individual autonomy.

The present study focuses on the ICU access axis. The analytical scope encompasses decisions adjudicating disputes over admission to intensive care, transfer between facilities for ICU access, and the legitimacy of regulatory bed allocation processes. Cases that intersected with multiple axes were retained when ICU access constituted the principal contested matter.

Analytical framework

Decisions were systematically coded along four dimensions. The first dimension captured the type of relief sought, including immediate ICU admission, inter facility transfer, contestation of regulatory denial, and procedural relief regarding allocation systems. The second dimension identified the institutional response invoked, distinguishing among centralized regulation systems, hospital level allocation, inter municipal transfer arrangements, and direct judicial determination of allocation. The third dimension examined the proportionality reasoning articulated in judicial decisions, including reference to clinical severity criteria, the existence of established triage protocols, the assessment of systemic distributional consequences, and the recognition of administrative capacity constraints. The fourth dimension identified the equity dimension implicated, encompassing access disparities by geographic region, socioeconomic position, and institutional venue.

Coding was conducted iteratively, with categories validated through repeated reading of the decisions and through reference to the established theoretical literature on resource allocation, distributive justice, and public health ethics [10, 15, 16]. The analytical interpretation was structured around the three guiding research questions and oriented toward identifying implications for community health equity and public health allocation system design.

Ethical considerations

The study relied exclusively on publicly available judicial decisions and did not involve direct interaction with human participants, personal data collection, or biological material. Under Brazilian regulations, documentary research of this nature is exempt from review by a Research Ethics Committee. Cases protected by judicial secrecy were excluded from the analytical corpus. Contextual anonymization was applied to illustrative case references to ensure responsible interpretation.

Results

Distribution of cases and types of relief sought

ICU access decisions in the analyzed corpus originated from courts spanning state and federal jurisdictions, with concentration in the largest population centers consistent with the overall geographic distribution of pandemic related health litigation. The cases addressed four principal types of relief. Immediate ICU admission requests constituted the largest category, typically presented through emergency injunction proceedings in which families sought judicial orders compelling admission within hours of the clinical deterioration of the patient. Inter facility transfer requests formed a second category, in which plaintiffs sought judicial intervention to compel transfer from facilities lacking ICU capacity to facilities with available beds, frequently invoking the constitutional duty of integrated and universal access. Contestation of regulatory denial constituted a third category, in which plaintiffs challenged decisions of centralized bed regulation systems on grounds of procedural irregularity, clinical

assessment error, or systemic delay. Procedural relief concerning allocation systems formed a fourth and smaller category, addressing claims related to transparency, accountability, and structural reform of regulatory infrastructure.

Table 1 presents the distribution of cases across these principal categories of relief sought.

Table 1
Distribution of ICU access decisions by type of relief sought

Type of relief sought	<i>n</i>	%
Immediate ICU admission	89	42.6
Inter facility transfer for ICU access	57	27.3
Contestation of regulatory denial	44	21.0
Procedural relief and structural claims	19	9.1

Categories are mutually exclusive based on the principal contested matter in each decision. Distribution reflects the analytical subset of the corpus addressing ICU access disputes.

Immediate ICU admission and the irreversibility of harm

Decisions addressing immediate ICU admission requests exhibited a recurrent reasoning pattern emphasizing the irreversibility of harm and the constitutional protection of life and health. Courts frequently issued emergency injunctions compelling admission when medical documentation demonstrated imminent clinical deterioration and absence of alternative facilities able to provide equivalent care. The reasoning typically invoked Articles 5, 6, and 196 of the Federal Constitution, framing the right to health as immediately enforceable and not subordinated to administrative capacity arguments under emergency conditions [5].

Decisions in this category exhibited a tension that emerged consistently across the analyzed corpus. The protective function of judicial intervention against administrative omission was reaffirmed, particularly in cases where evidence indicated regulatory delay, communication failures, or absence of effective referral mechanisms. At the same time, courts confronted arguments raised by public authorities invoking the existence of centralized bed regulation systems designed to allocate ICU capacity according to clinical severity and waiting list criteria. The reasoning in these cases progressively incorporated reference to the systemic dimensions of allocation, recognizing that judicial orders for individual admission carry distributional implications for other patients in equivalent or greater clinical need.

Inter facility transfer and territorial inequity

Decisions concerning inter facility transfer addressed disputes in which plaintiffs sought judicial intervention to compel transfer from facilities lacking ICU capacity, frequently in smaller municipalities or peripheral regions, to facilities with available capacity in regional reference centers. These cases reveal a critical dimension of community health equity in Brazil: the structural disparities in ICU infrastructure that closely track pre existing inequalities in health system development [8, 17].

Courts predominantly upheld transfer requests when documentation indicated clinical eligibility and absence of equivalent local capacity. The reasoning frequently invoked the constitutional principle of integrated access within the SUS, recognizing that geographic proximity should not determine access to life sustaining resources. Decisions in this category implicitly acknowledged that the absence of robust regional referral systems generates demand for judicial intervention to substitute for administrative gaps. The pattern indicates that strengthening inter municipal and regional referral infrastructure constitutes a structural intervention with capacity to reduce litigation based access pressure during future emergencies.

Contestation of regulatory denial and procedural justice

Decisions contesting regulatory denial addressed claims that centralized bed allocation systems had improperly classified clinical severity, failed to respond within reasonable time frames, or applied criteria inconsistent with established clinical guidelines. Courts generally engaged substantively with the technical adequacy of regulatory determinations, requiring documented clinical reassessment and procedural transparency rather than substituting purely legal reasoning for clinical judgment.

The reasoning pattern in this category aligns with international public health ethics frameworks emphasizing procedural fairness as a component of legitimate allocation under scarcity [16, 18]. Procedurally fair allocation requires transparent criteria, accessible reassessment mechanisms, and accountability infrastructure, alongside substantive criteria for prioritization. Decisions that compelled regulatory bodies to document the basis for denial, communicate clinical reassessments to families, and provide accessible procedural pathways for contestation supported the institutional development of more transparent and accountable allocation systems.

Procedural relief and structural claims

The smaller category of procedural and structural decisions addressed claims raised by public prosecutors and other institutional actors seeking systemic reform of allocation infrastructure. These cases included demands for transparent reporting of bed availability, public communication of allocation criteria, and the establishment of audit mechanisms for regulatory determinations. Courts generally upheld such claims, recognizing that transparency and accountability obligations apply to allocation systems operating under emergency conditions and that procedural fairness contributes to public trust in resource constrained health systems.

These decisions support the development of community level oversight infrastructure for ICU allocation by establishing the legal foundation for transparent reporting and accountability mechanisms. Allocation

systems that operate transparently are more capable of sustaining public trust during emergencies, and they reduce the structural conditions that drive individual litigation as a substitute for systemic accountability.

Temporal evolution of judicial reasoning

The analyzed corpus exhibited a discernible temporal evolution in judicial reasoning. Decisions issued during the most acute phases of the pandemic, particularly in 2020 and the first half of 2021, predominantly emphasized individual urgency and the irreversibility of harm, with comparatively less reference to systemic distributional consequences. Decisions issued in later phases of the pandemic and in the post pandemic period progressively incorporated reference to centralized regulation systems, technical clinical criteria, and systemic capacity constraints. This evolution suggests an institutional learning trajectory in which courts incrementally integrated public health reasoning into emergency adjudication, although the integration remained incomplete and inconsistent across jurisdictions.

Discussion

The structural inequity of litigation based access

The empirical pattern across the analyzed corpus exposes a structural feature of health rights litigation that warrants explicit recognition in community health scholarship: litigation based access systematically privileges individuals with legal representation, socioeconomic resources, and institutional knowledge of judicial procedures. In contexts of acute resource scarcity, this structural feature carries direct distributional implications. When courts compel ICU admission for individual patients within capacity constrained systems, the resulting reallocation may displace other patients with equivalent or greater clinical severity who lack the legal resources to access judicial relief [13, 14].

This dynamic does not imply that judicial intervention in ICU access disputes lacks legitimacy. Courts function legitimately as corrective mechanisms against administrative omission, regulatory failure, and discriminatory exclusion, and judicial intervention in such circumstances reinforces the constitutional protection of fundamental rights. The empirical pattern, however, indicates that litigation based access cannot constitute a primary mechanism for equitable resource allocation under conditions of scarcity. Equitable allocation requires structural infrastructure that operates independently of individual capacity to litigate, including transparent triage protocols, accessible regulatory mechanisms, and accountability structures that protect the interests of populations without legal representation.

Public health allocation frameworks and judicial alignment

The progressive incorporation of public health allocation reasoning into Brazilian judicial decisions during the pandemic indicates a degree of convergence between judicial and public health frameworks that has practical significance for resilient allocation system design. Public health ethics frameworks for emergency resource allocation, articulated in the international literature during the COVID-19 pandemic, emphasize transparency, consistency, accountability, and proportionality as foundational principles [10,

11, 12]. These principles appear with growing frequency in Brazilian judicial reasoning, even where courts do not invoke them by their formal academic labels.

This convergence supports the integration of public health allocation frameworks into the institutional infrastructure within which judicial decisions are made. When regulatory bodies operate through transparent and consistent criteria, document the basis for allocation decisions, and provide accessible reassessment mechanisms, judicial intervention can function as a complementary accountability mechanism rather than as a substitute for systemic allocation. The empirical pattern observed in later phases of the pandemic, in which courts increasingly engaged with regulatory criteria rather than substituting purely legal reasoning, provides operational evidence for this complementary relationship.

Community health equity and territorial disparities

The cases concerning inter facility transfer reveal a dimension of community health equity that warrants explicit attention in public health system design. Brazilian ICU infrastructure exhibits substantial geographic disparities, with capacity concentrated in regional reference centers and substantial gaps in smaller municipalities and peripheral regions [8, 17]. During the pandemic, these structural disparities translated into concrete differences in access to life sustaining care, with patients in less developed regions facing both higher transmission risk and reduced access to ICU capacity.

Strengthening inter municipal and regional referral systems constitutes a structural intervention with substantial capacity to reduce both health inequity and litigation pressure during future emergencies. Reliable referral infrastructure, supported by transport capacity, communication systems, and inter jurisdictional cooperation agreements, addresses the root cause of many transfer related litigation cases by ensuring that geographic proximity does not determine access. Investment in regional referral capacity is therefore not solely a question of clinical infrastructure but a structural condition of equitable community health under emergency strain.

Procedural fairness in allocation systems

The decisions concerning contestation of regulatory denial highlight the operational importance of procedural fairness in resource allocation systems. Procedural fairness encompasses transparent criteria, accessible reassessment mechanisms, communication of decisions to affected individuals and families, and accountability infrastructure for regulatory determinations [16, 18]. When allocation systems operate without these procedural elements, individual litigation becomes a primary pathway for accessing reassessment, generating both inequitable distribution of relief and operational strain on judicial systems.

The development of internal procedural mechanisms within allocation infrastructure, including documented clinical criteria, accessible family communication, and structured reassessment processes, addresses the structural conditions that generate litigation pressure. These developments do not eliminate the legitimate role of judicial review in cases of substantial procedural failure or discriminatory

application, but they reduce the structural dependence on judicial intervention as the primary mechanism for ensuring procedural fairness.

Implications for community health protection in future emergencies

The findings carry several implications for community health protection in future public health emergencies. First, investment in regional referral infrastructure addresses the territorial disparities that generate transfer related litigation and that produce concrete inequities in access to life sustaining care. Second, the development of transparent allocation criteria, articulated in advance and supported by accessible communication infrastructure, reduces the structural conditions that drive individual litigation as a substitute for systemic accountability. Third, the integration of public health ethics frameworks into the institutional infrastructure of allocation systems, including triage protocol development with explicit ethical reasoning, supports the convergence between judicial and public health reasoning observed in the analyzed corpus.

Fourth, primary care surveillance capacity contributes to the early identification of patients at risk of clinical deterioration, enabling timely transfer decisions and reducing the emergency driven litigation that emerges when families face acute clinical deterioration without prior referral. Strengthening primary care infrastructure, including community health workers and primary care teams trained in early recognition of severe COVID-19 progression, addresses both clinical outcomes and the structural conditions that generate ICU access litigation [19, 20]. Fifth, the establishment of public communication infrastructure for emergency allocation, including public reporting of bed availability and allocation criteria, supports public trust in resource constrained systems and reduces information asymmetries that contribute to litigation pressure.

International transferability

The findings carry implications for jurisdictions beyond Brazil where constitutional health rights interact with resource constrained allocation systems. Comparative experience indicates that constitutional health rights frameworks generate analogous patterns of judicial involvement in resource allocation in Colombia, India, South Africa, and other jurisdictions [13, 21]. The structural relationship between litigation based access and equitable community health allocation, identified in the Brazilian case, is broadly relevant in these comparative contexts.

Adaptation to other national contexts requires recalibration of specific operational parameters to reflect different health governance architectures and constitutional traditions. The substantive principles evident in the Brazilian judicial corpus, including the protection of the minimum existential core under emergency conditions, the recognition of systemic distributional implications of individual orders, and the procedural fairness requirements applied to allocation systems, are grounded in international public health ethics frameworks of recognized transferability [10, 16]. The implementation conditions, including

referral infrastructure, allocation transparency, and primary care capacity, require contextual adaptation but follow analogous logic across jurisdictions.

Limitations

Several limitations warrant acknowledgment. First, the study relied on judicial decisions retrieved through a single integrated jurisprudence database; while the database aggregates decisions across multiple courts, decisions inadequately tagged within the indexing system may have been excluded. Second, the analytical focus on the ICU access axis necessarily abstracts from interactions with other axes of pandemic related litigation, including federative conflicts and medication provision; in practice, ICU access disputes frequently intersected with other categories. Third, the qualitative interpretive design does not support statistical generalization to the universe of all ICU access decisions, although the systematic sampling strategy provides analytical representativeness within the defined temporal and thematic scope. Fourth, the study did not include direct interviews with regulatory body personnel, hospital administrators, or affected families; future research would benefit from such engagement to assess the practical reception of judicial reasoning in allocation infrastructure. Fifth, the implementation gap identified in regional referral and primary care surveillance infrastructure warrants dedicated empirical research, including engagement with administrative data and field observation beyond the judicial corpus analyzed in this study.

Conclusions

Brazilian courts during the COVID-19 pandemic adjudicated ICU access disputes through an evolving reasoning pattern that increasingly incorporated public health allocation considerations into emergency decision making. The empirical pattern across the analyzed corpus indicates that judicial intervention functioned simultaneously as a corrective mechanism against administrative omission and as a potential driver of inequity, with substantial implications for community health protection in future public health emergencies.

The findings carry direct implications for public health system design, including investment in regional referral infrastructure, development of transparent allocation criteria, integration of public health ethics frameworks into allocation systems, strengthening of primary care surveillance capacity, and establishment of public communication infrastructure for emergency allocation. The findings also contribute to the broader community health literature by characterizing the structural relationship between litigation based access and equitable resource allocation, with relevance for jurisdictions where constitutional health rights interact with resource constrained systems.

Litigation cannot substitute for structural infrastructure as the primary mechanism for equitable allocation under scarcity, but it can complement well designed allocation systems by providing accountability for procedural failures and discriminatory application. Strengthening the institutional conditions in which courts, regulatory bodies, primary care teams, and trusted community institutions

interact remains a community health imperative for resilient public health response in jurisdictions facing recurrent emergency conditions.

Abbreviations

AASP: Associação dos Advogados de São Paulo (Brazilian Lawyers Association of São Paulo); COVID-19: Coronavirus disease 2019; ICU: Intensive care unit; JUIT: Jurisprudence interface system; SUS: Sistema Único de Saúde (Brazilian Unified Health System).

Declarations

Ethics approval and consent to participate

Not applicable. This study exclusively analyzed publicly accessible judicial decisions and did not involve human participants, personal data collection, or biological material. Under Brazilian regulations governing research with human subjects (Resolução CNS 510/2016), documentary research of this nature is exempt from review by a Research Ethics Committee. Cases protected by judicial secrecy were excluded from the analytical corpus.

Consent for publication

Not applicable.

Availability of data and materials

The dataset supporting the conclusions of this article is available from the corresponding author on reasonable request. The dataset contains case identifiers, court of origin, year of decision, type of relief sought, and coding criteria. All analyzed judicial decisions are publicly accessible through the AASP/JUIT jurisprudence system (<https://www.aasp.org.br>), subject to institutional access conditions.

Competing interests

The authors declare that they have no competing interests.

Funding

Felipe Gabriel Barbosa de Oliveira received a master's scholarship from the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES), Brazil, process number 88887.988992/2024-00.

The funder had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Authors' contributions

FGBO and DBG conceived and designed the study. FGBO acquired and curated the data. FGBO, SLFO and ALF conducted formal analysis and investigation. FGBO drafted the original manuscript. SLFO, ALF and DBG critically reviewed and edited the manuscript. DBG supervised the research. All authors read and approved the final manuscript.

Acknowledgements

The authors acknowledge the Postgraduate Program in Health Sciences of the University of Brasília for the academic and institutional support provided during the development of this research.

References

1. White DB, Lo B. A framework for rationing ventilators and critical care beds during the COVID-19 pandemic. *JAMA*. 2020;323(18):17734.
2. Truog RD, Mitchell C, Daley GQ. The toughest triage: allocating ventilators in a pandemic. *N Engl J Med*. 2020;382(21):19735.
3. Emanuel EJ, Persad G, Upshur R, Thome B, Parker M, Glickman A, et al. Fair allocation of scarce medical resources in the time of Covid-19. *N Engl J Med*. 2020;382(21):204955.
4. Maves RC, Downar J, Dichter JR, Hick JL, Devereaux A, Geiling JA, et al. Triage of scarce critical care resources in COVID-19: an implementation guide for regional allocation. *Chest*. 2020;158(1):21225.
5. Brazil. Constituição da República Federativa do Brasil [Constitution]. Brasília: Presidência da República; 1988. https://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm. Accessed 13 May 2026.
6. Castro MC, Massuda A, Almeida G, Menezes Filho NA, Andrade MV, Noronha KVMS, et al. Brazil's Unified Health System: the first 30 years and prospects for the future. *Lancet*. 2019;394(10195):34556.
7. Machado CV, Lima LD. Health policy and the public health system in Brazil. *Cad Saúde Pública*. 2017;33(Suppl 2):e00045617.
8. Rache B, Rocha R, Nunes L, Spinola P, Massuda A. Necessidades de infraestrutura do SUS em preparo ao COVID-19: leitos de UTI, respiradores e ocupação hospitalar. *IEPS Nota Técnica*. 2020;3:117.
9. Castro MC, Kim S, Barberia L, Ribeiro AF, Gurzenda S, Ribeiro KB, et al. Spatiotemporal pattern of COVID-19 spread in Brazil. *Science*. 2021;372(6544):8216.

10. Persad G, Wertheimer A, Emanuel EJ. Principles for allocation of scarce medical interventions. *Lancet*. 2009;373(9661):42331.
11. Biddison ELD, Faden R, Gwon HS, Mareiniss DP, Regenberg AC, Schoch Spana M, et al. Too many patients: a framework to guide statewide allocation of scarce mechanical ventilation during disasters. *Chest*. 2019;155(4):84854.
12. Daugherty Biddison EL, Gwon HS, Schoch Spana M, Regenberg AC, Juliano C, Faden RR, et al. Scarce resource allocation during disasters: a mixed method community engagement study. *Chest*. 2018;153(1):18795.
13. Yamin AE, Gloppen S, editors. *Litigating health rights: can courts bring more justice to health?* Cambridge: Harvard University Press; 2011.
14. Ferraz OLM. Harming the poor through social rights litigation: lessons from Brazil. *Tex Law Rev*. 2011;89(7):164368.
15. Beauchamp TL, Childress JF. *Principles of biomedical ethics*. 8th ed. New York: Oxford University Press; 2019.
16. Childress JF, Faden RR, Gaare RD, Gostin LO, Kahn J, Bonnie RJ, et al. Public health ethics: mapping the terrain. *J Law Med Ethics*. 2002;30(2):1708.
17. Pepe VLE, Ventura M, Sant'Ana JMB, Figueiredo TA, Souza VR, Simas L, et al. Caracterização de demandas judiciais de fornecimento de medicamentos essenciais no Estado do Rio de Janeiro, Brasil. *Cad Saúde Pública*. 2010;26(3):46171.
18. Daniels N, Sabin JE. *Setting limits fairly: learning to share resources for health*. 2nd ed. New York: Oxford University Press; 2008.
19. Macinko J, Harris MJ. Brazil's Family Health Strategy: delivering community based primary care in a universal health system. *N Engl J Med*. 2015;372(23):217781.
20. Giovanella L, Bousquat A, Schenkman S, Almeida PF, Sardinha LMV, Vieira MLFP. The Family Health Strategy coverage in Brazil: what reveal the 2013 and 2019 National Health Surveys. *Ciênc Saúde Coletiva*. 2021;26(Suppl 1):254356.
21. Forman L. What future for the minimum core? Contextualizing the implications of South African socioeconomic rights jurisprudence for the international human right to health. In: Clapham A, Robinson M, editors. *Realizing the right to health*. Zurich: Rüffer & Rub; 2008. p. 6280.
22. Biehl J, Prates LE, Amon JJ. Supreme Court v. necropolitics: the chaotic judicialization of COVID-19 in Brazil. *Health Hum Rights*. 2021;23(1):15162.
23. Luce JM, White DB. A history of ethics and law in the intensive care unit. *Crit Care Clin*. 2009;25(1):22137.
24. Carvalho EC, Souza PHDO, Varella TCMYML, Souza NVDDO, Farias SNPD, Soares SSS. COVID-19 pandemic and the judicialization of health care: an explanatory case study. *Rev Lat Am Enfermagem*. 2020;28:e3354.

25. World Health Organization. Ethics and COVID-19: resource allocation and priority setting. Geneva: WHO; 2020.
26. Sarlet IW. A eficácia dos direitos fundamentais: uma teoria geral dos direitos fundamentais na perspectiva constitucional. 12th ed. Porto Alegre: Livraria do Advogado; 2015.
27. Mânica FB. Teoria da reserva do possível: direitos fundamentais a prestações e a intervenção do Poder Judiciário na implementação de políticas públicas. Rev Bras Direito Público. 2018;5:16986.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [SupplementaryMaterial.xlsx](#)