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Judicialization of health at the level of Brazilian treatment centers: is the allocation of public resources efficient?

Taíza CZORNEI[1], Inajara ROTTA[2], Juliane CARLOTTO[3]

[1]Instituto de Oncologia do Paraná; [2]Universidade Federal do Paraná. [3]Complexo Hospital de Clínicas da Universidade Federal do Paraná.

Corresponding author: Carlotto J, juliane.carlotto@hc.ufpr.br

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Abstract

Objectives: to describe the management process of judicialized drugs at the level of a tertiary hospital**,** evaluating their potential weaknesses and the need for interventions; 2) evaluate the sample of national scenario regarding the management of judicialized drugs, based on the aspects previously listed at the institutional level**. Methods:** In the institutional scenario, were analyzed the activities of provision and dispensing of these drugs, arising from 168 lawsuits, and interventions carried if there is detection of remaining vials or financial resources in the institution, through internal control spreadsheets, medical records and other institutional documents, from January 2017 to December 2018. The sample of national scenario was assessed by means of a questionnaire. **Results:** At the institutional level, 168 lawsuits were analyzed. The cost of medicines was US$ 5,493,361.83, and 17.3% remained in the institution as a residual of vials or financial resources related to the lawsuits of 104 patients (65.8%). A total of 116 interventions were carried out, highlighting the return to the provider source (US$ 409,701.70) and exchanges of vials to avoid loss due to expiration (US$ 140,349.24), saving public coffers US$ 853,374.04. At the national level, 80% of the centers reported the discontinuation of treatment with judicialized drugs, and all carried out actions to manage the excess of vials. **Conclusion:** This work demonstrated that the discontinuity or non-initiation of therapy with judicialized drugs is an important problem inherent to the judicialization of drugs in the institutional and national scenario, which generates remaining vials and/or financial resources in the institutions, contributing to the inefficient allocation of public resources.

Keywords: Health Management; Health's Judicialization; Drug Costs; Pharmaceutical Services; Resource Allocation

Judicialização da saúde a nível dos centros de tratamento brasileiros: a alocação de recurso público é eficiente?

Resumo

Objetivos: 1) descrever o processo de gestão de medicamentos judicializados a nível de um hospital terciário, avaliando suas potenciais fragilidades e necessidade de intervenções; 2) avaliar uma amostra do cenário nacional quanto à gestão de medicamentos judicializados, com base nos aspectos previamente elencados a nível institucional. **Métodos**: No cenário institucional, foram analisadas as atividades de provisão e dispensação destes medicamentos, advindos de 168 ações judiciais, e intervenções realizadas no caso de detecção de remanescente de frascos ou recursos financeiros na instituição, por meio de planilhas de controle interno, prontuários e demais documentos institucionais, no período de janeiro de 2017 a dezembro de 2018. A amostra do cenário nacional foi avaliada por meio de questionário com perguntas relacionadas ao sistema de gestão de medicamentos judicializados. **Resultados:** A nível institucional, foram analisadas 168 ações judiciais. O custo referente aos medicamentos foi de US$ 5.493.361,83, sendo que 17,3% permaneceram na instituição como remanescente de frascos ou recurso financeiro referentes às ações judiciais de 104 pacientes (65,8%). Foram realizadas 116 intervenções, destacando-se a devolução à fonte provedora (US$ 409.701,70) e trocas para evitar perda por expiração da validade (US$ 140.349,24), sendo economizado aos cofres públicos US$ 853.374,04. A nível nacional, 80% dos centros relataram a ocorrência de descontinuidade de tratamento com medicamentos judicializados, e todos realizaram ações a fim de gerir o excedente de frascos. **Conclusões:** Este trabalho demonstrou que a descontinuidade ou não início da terapia com medicamentos judicializados trata-se de um importante problema inerente à judicialização de medicamentos nos cenários institucional e nacional, que gera remanescente de frascos e ou recuros financeiros nas istituições, contribuindo para a alocação ineficiente de recursos públicos.

Palavras-chave: Gestão em Saúde; Judicialização da Saúde, Custos de Medicamentos, Assistência Farmacêutica; Alocação de Recursos

Introduction

The right to health in Brazil was included in the 1988 Federal Constitution, establishing health as a right for all and attributing the State the responsibility for maintaining and enforcing this right[1]. Despite the advances in access to the medications provided by the SUS, the phenomenon of judicialization of health has been growing at a dizzying pace. Expenses for court decisions increased from R$ 422.6 million (US$ 75,307.00) in 2012 to R$ 1 billion (US$ 178,200,000.00) in 2018[2]. The total annual SUS expenditure to comply with judicial decisions is estimated at R$ 7 billion (US$ 1,247,400.00)[3]. It is worth noting that cancer drugs have stood out in lawsuits both in terms of quantity and mean costs[4].

Despite the relevance of reflecting on the impact of the judicialization of health in recent years, and considering that legal demands can contribute to inefficiency of the SUS, thus hindering allocation choices in an already underfunded system[5-7], the literature is still scarce on the management of medications resulting from lawsuits in treatment centers. In addition to the already worrying scenario of implications for the SUS promoted by the phenomenon of judicialization of health, treatment centers are places where large amounts of public resources can be wasted in case of excess vials/financial resources from discontinued treatments, not initiated or received in quantities higher than required for the treatment. There is no systematized monitoring of the treatments provided through the courts by the Judiciary Power or the Ministry of Health. It is assumed that any and all medications delivered to the treatment centers are used by the patients, although this is not actually the case.

A previous paper conducted in our institution showed that 27.7% of the total amount made available (R$ 16,487,923.20 / US$ 2,938,147.91) for the anticancer therapy provided for the treatment of 119 patients remained in the institution, as 69.2% of the patients did not use all the financial resources/vials of medications made available[8]. Health systems, as well as all Public Administration, must be guided by the principle of efficiency. It is therefore necessary to seek to produce the maximum results with the resources allocated to health[9]. In this way, knowing the reality from the treatment centers' perspective is vital for defining strategies for an efficient allocation of resources available to lawsuits.

In this context, the objectives of this paper were as follows: 1) a detailed description of the process for the management of judicialized medications at the institutional level, highlighting the potential weaknesses in the judicialization process within a treatment center, due to the possibility of duplicity of supplying source and/or interruptions/non-initiation of treatments, and the potential interventions to deal with them; and 2) an assessment of potential weaknesses in the process for the management of judicialized medications at the national level, in public and private Brazilian institutions, through a questionnaire based on the aspects previously listed at the institutional level.

Methods

Stage 1

A descriptive and observational study was carried out, with data collection referring to the medication management process from the judicial route in a large tertiary-level public hospital, from January 2017 to December 2018. The study was based on the analysis of the data from the activities of provision and dispensing of judicialized medications, as well as interventions carried out when detecting excess vials or financial resources in the institution, identifying the reasons for the existence of the remaining stock. The study followed ethical principles that govern research studies with human beings, according to Resolution No. 466/2012, and was approved by the Institution's Research Ethics Committee (CAAE: 61351016.9.0000.0096).

The data for development of the research were obtained from the Institution's Hospital Information System (*Sistema de Informação Hospitalar*, SIH), internal control spreadsheets for monitoring provision and dispensing of medications, institutional documents and email messages referring to lawsuits and medical records. All the legal actions by patients that received judicialized medications during the period established were included.

Calculation of the cost of the medications was performed based on the purchase values made available by the SIH. When the values were not available, calculation was performed based on the CMED table, through the values of the Maximum Sales Price to the Government (*Preço Máximo de Venda ao Governo*, PMVG). The data were tabulated and expressed as medians, means, quartiles and deciles, or as frequencies and percentages.

Stage 2

A form developed through Google Forms was sent to Brazilian professionals involved in the judicialization process. Contacts were obtained from professionals associated with SOBRAFO (*Sociedade Brasileira de Farmacêuticos em Oncologia*) and pharmacists from the Ebserh network, as well as contacts through information from the Ministry of Health, the State Health Department of the State of Paraná and the 4th Federal Court of Curitiba/PR. The snowball method was also used, in which the previously selected professionals indicated other participants[10]. Email was used to contact the professionals.

The form was prepared using open and closed questions, subdivided as follows: a) Identification of the professionals, including name and institution in which they work; b) Characteristics of the judicialized medications; c) Occurrence of discontinuation of treatments with judicialized medications and remaining stock of vials; and d) Interventions carried out with excess vials and/or financial resources.

Results

Institutional setting

During the study period, medication supply data from 168 lawsuits for 158 patients were evaluated, as 6% of them received more than one judicialized medication. Most of the plaintiff patients were male (55.1%). The most frequent diagnoses were multiple myeloma (16.7%), lymphoma (12.5%) and breast cancer (11.3%). The most prevalent medications were bortezomib (27; 16.1%), rituximab (26; 15.5%), azacitidine (13; 7.7%) and mycophenolate mofetil (13; 7.7%), as shown in Table 1. Antineoplastics accounted for 72.8% of the total number of drugs received through judicial means. In addition, 64.9% of the judicialized medications belonged to the monoclonal antibody class.

Table 1 – Judicialized medications and their respective costs

Medication	No. of actions	Total value made available (US$)	Total value of the treatment actually provided to the patient (US$)	Mean cost of the treatment actually provided to the patient (US$)	Unused value – Excess vials or financial resources in the institution (US$)
ABIRATERONE	2	13,878.22	9,462.42	4,731.21	4,415.80
AFLIBERCEPT	1	1,369.87	1,369.87	1,369.87	0.00
ALBUMIN	1	1,738.16	1,000.77	1,000.77	737.39
ALEMTUZUMAB	1	52,281.96	38,023.25	38,023.25	14,258.72
ALGLUCOSIDASE ALFA	1	567,156.26	460,168.85	460,168.85	0.00
AZACITIDINA	13	244,603.79	193,564.42	14,889.57	51,039.37
BELIMUMAB	1	3,948.77	3,948.77	3,948.77	0.00
BEVACIZUMAB	7	104,833.88	89,880.47	12,840.07	13,851.08
BORTEZOMIB	27	339,494.23	243,316.97	9,011.74	63,224.09
BRENTUXIMAB	6	901,226.84	549,701.19	91,616.86	330,292.56
CABAZITAXEL	2	81,733.82	29,340.34	14,670.17	35,627.56
CETUXIMAB	3	31,343.74	20,187.49	6,729.17	11,156.25
ECULIZUMAB	8	1,523,427.64	1,014,122.67	126,765.33	157,054.40
ELOSULFASE ALFA	1	147,064.25	147,064.25	147,064.25	0
EVEROLIMUS	3	47,996.13	27,430.50	9,143.50	20,565.63
GALSULFASE	1	87,184.59	87,184.59	87,184.59	0.00
IBRUTINIB	1	42,008.01	21,004.01	21,004.01	21,004.01
ICATIBANT	2	9,237.35	4,619.75	2,309.87	0
MYCOPHENOLATE MOFETIL	13	41,154.91	23,651.64	1,819.36	17,058.49
NIMOTUZUMAB	1	15,205.91	13,576.70	13,576.70	1,629.20
NIVOLUMAB	3	132,935.00	122,423.86	40,807.95	4,328.12
OBINUTUZUMAB	1	2,291.21	763.74	763.74	0.00
OCTREOTIDE	3	24,044.22	8,014.74	2,671.58	15,228.01
OMALIZUMAB	3	45,895.77	39,011.40	13,003.80	0.00
PANITUMUMAB	4	57,879.36	39,631.68	9,907.92	17,392.32
PAZOPANIB	4	54,749.85	40,870.74	10,217.69	13,879.11
PEMBROLIZUMAB	1	17,226.45	15,073.15	15,073.15	0.00
PERTUZUMAB	7	214,123.05	185,472.78	26,496.11	27,142.36
PLERIXAFOR	1	8,908.94	0	0	0
RITUXIMAB	26	219,642.77	149,091.05	5,734.27	69,196.49
RUXOLITINIB	2	50,766.69	26,938.60	13,469.30	20,506.19
SORAFENIB	4	31,665.85	21,692.36	5,423.09	9,973.50
SUNITINIB	1	23,596.02	11,798.01	11,798.01	0
TEMOZOLAMIDE	3	4,563.70	3,855.80	1,285.27	0
TRASTUZUMAB EMTANSINE	1	22,934.34	22,934.34	22,934.34	0
TRASTUZUMAB	9	325,250.27	284,147.21	31,571.91	32,167.61
Total	**168**	**5,493,361.83**	**3,950,338.39**		**951,728.24**

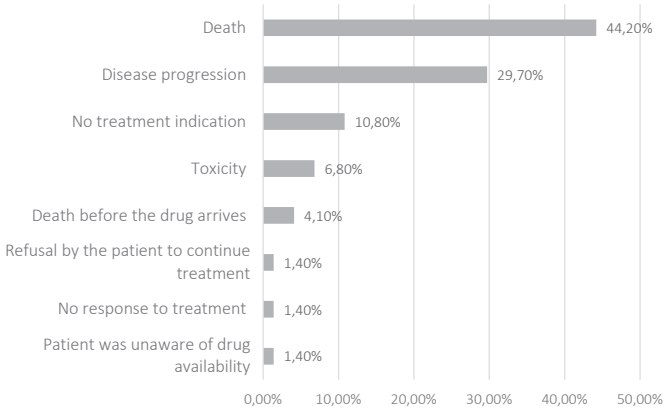
The time variation between arrival of the medication at the institution and the treatment initiation date was from 0 to 1,372 days, with 30% of the patients initiating their treatments on the same day, 50% within 1 day and 90% within 53 days from the moment the medication arrived at the institution. The mode (most frequent value in the dataset) observed for the period between arrival of the medication and treatment initiation was 0 days, in other words, the patients initiated their treatments on the same day that the medications arrived at the institution. Among the medications, bortezomib took the longest to be initiated (up to 1,372 days), with a median of11 days and 30% of the patients initiating their treatments on the same day, 50% within 15 days, and 90% within 573 days from arrival of the medication at the institution.

Regarding the supplying source, significant diversity of provision means was observed. Part of the medications (38%) were brought by the patients to the hospital (87% were provided by SESA/PR and the others by the MS). In addition to that, nearly 13% of the medications came directly via the MS; 9% via SESA/PR; 11% were purchased by the hospital through the provision of financial resources by the provider; and 3% came from judicially authorized relocation of other patients whose treatments were terminated. In 26% of the actions, more than one of the sources described above was involved in the provision process and, in 58% of the cases, there was duplicity of the supplying source, while in 42% there was complementarity between the supplying sources.

The amount made available to the institution by the supplying agencies, in the form of vials and/or financial resources, was US$ 5,493,361.83, and the medications that most contributed to this cost were eculizumab, brentuximab, alglucosidase alpha, bortezomib and trastuzumab (Table 1). The value referring to the cost of the vials actually dispensed to the patients was US$ 3,950,338.39 and the value referring to the cost of vials stored at the institution during the treatments was US$ 591,295.20. However, of the total financial resources made available for the treatments, US$ 951,728.24 (17.3%) were not used by the respective patients (Table 1). This is due to the fact that 104 patients (65.8%) presented excess vials or financial

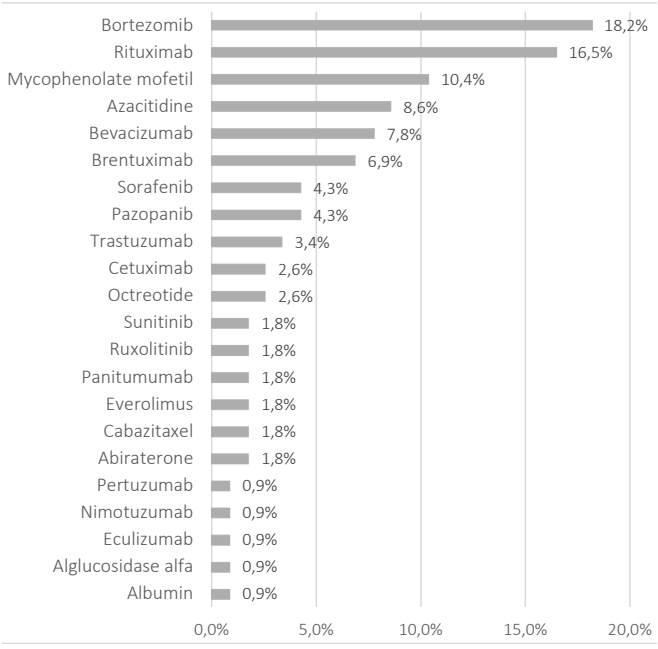
resources at the institution, due to discontinuation (59.7%; 62/104), non-initiation of treatment (11.5%; 12/104), or number of vials received higher than necessary for the treatment (28.8%; 30/104), this latter factor being mainly related to supplying source duplicity. The main reasons that led to discontinuation or non-initiation of the treatments were as follows: patient death (44.6%), disease progression (29.7%), lack of indication of therapy at the time of drug availability (10.8%) and toxicity (6.8%) (Figure 1).

Figure 1. Reasons for discontinuity or non-initiation of the treatments



A total of 116 interventions were conducted during the period, when detecting excess vials or financial resources in the institution. Of the total interventions, 87.2% were related to antineoplastic medications. The main drugs involved in the interventions were bortezomib (18.1%), rituximab (16.4%), mycophenolate mofetil (10.3%); azacitidine (8.6%) and bevacizumab (7.8%) (Figure 2).

Figure 2. Medications involved in the interventions performed



A total of 89 requests were made to the competent bodies for the return of medication vials and/or financial resources, for temporary suspension of medication supply, or even for the relocation of vials between patients. The requests were made to the Judiciary Power (55%), SESA/PR (36%) and MS (9%). 25.6% and 16.7% of the requests to the Judiciary Power and MS, respectively, had to be reiterated due to non-return, with 12.8% of the actions to the Judiciary Power remaining without return.

In relation to the requests made to the Judiciary Power, it was observed that the period between the hospital's request and the response by the Court responsible for the lawsuit varied from 6 to 409 days, with 30% of the requests answered within 16 days, 50 % within 28 days and 90% within 214 days. In turn, regarding the requests made to SESA/PR, it was verified that the period between the request and the response varied from 0 to 51 days, with 30% of the requests answered within 1 day, 50% within 6 days, and 90% within 50 days. In addition, in relation to the requests to the MS, it was verified that the period between the request and the response varied from 1 to 98 days, with 25% of the requests answered within 1 day, 50% within 10 days, and 75% in 45 days.

Table 2 describes the interventions with their respective frequency and financial impact. The impact resulting from the interventions was US$ 853,374.04. Despite the interventions implemented, the value wasted due to expiration of the vials corresponded to US$ 61,874.68.

Table 2. Interventions performed

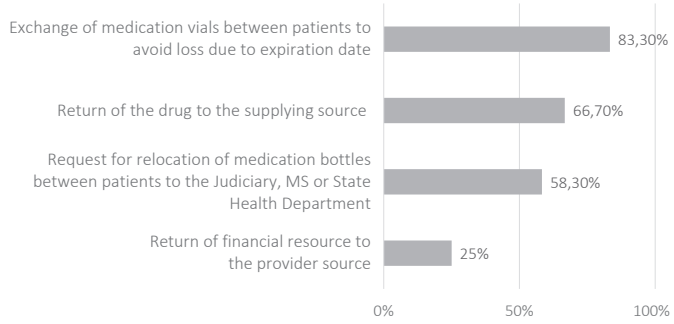
Intervention performed	Frequency n (%)	Cost of the medications involved ($)
Return of medication to supplying source	39 (33.6)	409,701.70
Vial exchange to avoid loss due to expiration	27 (23.3)	140,349.24
Relocation between patients	27 (23.3)	123,470.91
Return of resource to the supplying source	21 (18.1)	146,511.01
Request for temporary suspension of supply	2 (1.7)	33,341.17
Total	**116 (100)**	**853,374.04**

National scenario sample

It was possible to know the performance profile of treatment centers located in all Brazilian regions in the process for the management of medications from the judicial route. The form was answered by 22 professionals working in institutions that receive judicialized medications, 7 of which were excluded due to duplicity of answers by professionals from the same institution. Among the 15 professionals whose answers were included, 8 belong to centers located in the South region; 3 to the Northeast region; 2 to the Southeast region; 1 to the Midwest region; and 1 to the North region. Six institutions are of a public nature (40.0%), 5 are private (33.3%), 3 are of a combined nature (20.0%) and 1 is philanthropic (6.7%). On average, less than 10 patients with judicialized medications are seen per month in 7 centers (46.6%), from 10 to 30 patients in 4 centers (26.7%) and more than 30 patients are seen per month in 4 centers (26.7%). In 12 centers (80.0%), oncological drugs are the most judicialized; in the others (20.0%), monoclonal antibodies used in the treatment of autoimmune diseases are among the main medications resulting from lawsuits.

In relation to discontinuation of treatments with judicialized medications, 12 centers (80.0%) reported that it occurs in their institution, which generates excess of medication vials and, in all of them, interventions are carried out in order to manage excess vials. The 3 centers (20.0%) without treatment discontinuation, and the consequent surplus of vials, are of a private nature, and the patients receive the medications in the exact amount for each treatment cycle. The interventions performed by all 12 centers to manage the surplus from the treatments are presented in Figure 3.

Figure 3. Interventions performed by other treatment centers in the management of judicialized medications.



Discussion

This study portrays the management of medications from the judicial route from the perspective of the treatment center, highlighting the weaknesses of the process. In view of the lack of studies of this nature, it was also proposed to know the reality of other Brazilian centers through answers to an elaborated form, obtaining an overview of a national scenario sample.

In the institutional scenario, antineoplastic drugs stood out both in cost and in number in lawsuits, as already reported by Vidal *et al*[11], with monoclonal antibodies being the most frequently judicialized. This reality was confirmed through the forms filled out by professionals working in public and private treatment centers in all Brazilian regions, as 80% of them reported that cancer drugs are the most judicialized.

Technological advances have led to the introduction of a variety of new treatments in Oncology, mainly based on the use of monoclonal antibodies[12]. Most monoclonal antibodies available on the market are used in the treatment of hemato-oncological diseases[13] and represent the main cause of the accelerated increase in cancer care costs worldwide. These high costs make these therapies inaccessible to users of the public health system, as most of them exceed the amount reimbursed to the treatment centers by the Authorizations for High Complexity Procedures in Oncology (*Autorizações de Procedimentos de Alta Complexidade em Oncologia*, APAC/ONCO), which advocate reimbursement of a mean monthly amount for each type of cancer in its various stages, leaving the patient to demand their treatment through judicial means[12,14,15].

In addition to neoplasms, monoclonal antibodies are also indicated for the treatment of other diseases, such as autoimmune, genetic and infectious ones[13]. In the institutional scenario, the most expensive medication was the eculizumab monoclonal antibody, representing 28% of the amount made available to the institution. Similar results were released by the Institute for Applied Economic Research (*Instituto de Pesquisa Econômica Aplicada*, Ipea), which showed that, in 2015, biological medications were among the most costly technologies for the MS through lawsuits, and that eculizumab was the item that generated the highest cost through this route in 2016[16].

The analysis of the medication supplying sources indicated that, in 26% of the actions, more than one source was involved in the supply process and that, for 58% of them, there was supplying source duplicity. This can be explained due to the solidarity condemnation of the Entities, which sometimes generates compliance with the decision by the municipal, state and federal spheres and, as the judicial control system does not cross the medication supply data by the different management spheres of the SUS, leading to supplying source duplicity[17].

Furthermore, it was observed that most of the medications were delivered to the institution directly by the patient, a fact that can compromise stability of thermolabile drugs, as it is not possible to guarantee that the patient had the necessary care in storage and transportation to preserve the medication, which can compromise safety and effectiveness of the therapy[17]. In addition to that, the inability to ensure that the medication stored and/or transported by a patient who had their treatment discontinued can be reincorporated to the supplying body's stock must be considered. According to RDC No. 304 dated September 17th, 2019, failure to ensure that the returned drug remains within its quality standards must result in rejection of its reincorporation the stock[18].

In relation to the time interval between arrival of the medication and its use, a large variation was observed, reaching 1,372 days and, in 11.5% of the actions, the treatments were not even initiated. This can be justified by the fact that, when a drug is made available through courts, the patient may no longer have an indication for its use since, in this paper, it was evidenced that death, disease progression and no indication of treatment with a judicialized antineoplastic medication were the main reasons for discontinuing or not initiating the treatments. If the medication can be used for disease relapse, it can remain stored in the institution. This explains the fact that bortezomib is the drug that took the longest to be initiated (up to 1,372 days). This medication is indicated for the chemotherapy treatment of multiple myeloma, both in the first line and in relapses[19].

It was verified that 65.8% of the patients presented excess vials or financial resources at the institution, mainly due to treatment discontinuation or non-initiation. The main reason listed was death of the patients. This result can be justified by the fact that most of the judicialized medications were anticancer drugs, and cancer is the second leading cause of mortality in the world, second only to cardiovascular diseases[20]. The high cytotoxicity and narrow therapeutic window of chemotherapeutics are responsible for the high rate of serious adverse events, also implying possible treatment suspensions[21].

Discontinuation of treatments with judicialized medications and the consequent generation of excess stocks was cited by 80% of the professionals who answered the form prepared, showing that this is a national reality, especially within the scope of public institutions. All 3 institutions (20%) in which such discontinuity does not occur are of a private nature and the treatments are available in sufficient numbers to meet each treatment cycle, with greater control of the medications used.

Facing this scenario of high rates of treatment discontinuation, it becomes indispensable that the treatment center acts in the management of judicialized medications, monitoring dispensations and taking actions to return vials or financial resources, as well as relocations between patients. The financial impact of the interventions performed during the period was US$ 853,374.04. When these interventions were not possible before expiration of the medications, considering the long period for response, which reached 409 days, and also the possibility of non-return from the competent bodies, as 12.8% of the requests to the Judiciary Power remained unanswered, actions are necessary for relocation of vials, both internally and with other treatment centers, in order to

avoid loss due to expiration. This intervention was mentioned by most (83.3%) of the treatment centers included in the research. In addition, return of the medication to the supplying source and request for relocation between patients were actions adopted by more than half of the centers included.

In this way, strategies that bring together the main actors of the judicial process (Judiciary Power, Ministry of Health, State and Municipal Health Departments, and treatment centers), facilitating the flow of information, are fundamental, highlighting the use of integrated computerized systems to control the lawsuits. Yamauti *et al.*[22] reported that, in Brazil, several public institutions have implemented strategies that address the phenomenon of increasing judicialization, focusing on the organization and improvement of this form of drug provision in the country. Among the 82 strategies listed, 8 (9.8%) referred to the use of computerized systems, which are indispensable tools for management, as they simplify many administrative tasks, assist in inventory control and user data monitoring along with their history of consume, and facilitate communication.

The benefits contributed by judicialization to many people and the legitimacy of certain legal demands arising from failures in the health system cannot be denied[5]. However, as widely described in the literature, judicialization can generate inequality and inefficiency in the SUS, as it hinders allocation choices in an underfunded system, forces the provision of technologies that have not yet been proven effective and safe, and does not consider the opportunity costs related to the judicial decisions, characterized by majority attendance to individual demands, contributing to inequality in the population's access to public health as a whole[5-7,23-27]. Added to this panorama of potential harms to public health, this paper presents alarming data regarding the possibility of wasting financial resources invested in the acquisition of medications, indicating inefficient allocation of public resources.

As a limitation of this study, there is lack of an in-depth evaluation of the process for the management of judicialized medications by other treatment centers, not allowing comparisons to be made with the process carried out at the institutional level in relation to the forms of medication supply and the existence of duplicity of these sources, time spent between arrival of the medications and their effective use by the patients, reasons for discontinuation or non-initiation of the treatments, and the financial impact resulting from the interventions performed. In addition, the number of centers evaluated was reduced, considering that, according to the National Cancer Institute, there are currently 317 care units and centers qualified in the treatment of cancer in Brazil[28]. Finally, the evaluation of the national scenario sample took place through the professionals' answers to the forms, subjected to biases, which may not correspond to what actually occurs in these places.

Conclusion

In this paper, it was evidenced that discontinuity or non-initiation of treatments with judicialized medications is an important problem inherent to such judicialization in the institutional and national scenarios, which generates excess vials and/or financial resources in the institutions, contributing to inefficient allocation of public resources. This makes it indispensable for treatment centers to be prepared to efficiently receive and manage lawsuits, centralizing the diverse information related to the processes and intervening for the return or relocation of vials or financial resources. It also shows the need for actions to systematize monitoring of the lawsuits, integrating all the agencies involved and stages of the process, from granting of the lawsuit to the end of therapy by the patients.

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Collaborators

TC participated in conception of the study, data collection and analysis, writing and final version of the article. IR supervised all study stages and participated in data analysis, critical review of the article and validation of the final version. JC supervised all study stages and participated in data analysis, critical review of the article and validation of the final version. All the authors approved the final version and are responsible for all the aspects of the paper, including guarantee of its accuracy and integrality.

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Conflicts of interest's statement

The authors declare no conflicts of interest regarding this article.

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