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Between justice and public management: interinstitutional collaboration in health litigation

Natalia Pires de Vasconcelos [1]

[1] Insper Instituto de Ensino e Pesquisa, São Paulo / SP – Brazil

The Brazilian justice system does more than simply review the legality of public policies and oversee their implementation. Looking at health litigation in Brazil reveals how judges, public lawyers, and prosecutors are increasingly involved in policy management, as they comprehend that the rising number of lawsuits seeking healthcare treatment requires management and inter-organizational coordination. This article explores this phenomenon by assessing initiatives of inter-institutional collaboration between actors in the justice and healthcare systems in four Brazilian states: São Paulo, Rio de Janeiro, Santa Catarina, and Rio Grande do Sul. By operationalizing the typology developed by McNamara (2012, 2016), this study compares the levels of integration in these responses and traces the collaborative "profile" of each state's approach to dealing with health litigation.

Keywords: health litigation; inter-organizational collaboration; public health; justice system.

Entre justiça e gestão: colaboração interinstitucional na judicialização da saúde

O sistema de justiça faz mais do que apenas "controlar" a legalidade de políticas públicas e sua execução. O caso da judicialização da saúde no Brasil ilustra como juízes/as, advogados/as públicos/as e promotores/as se envolvem cada vez mais ativamente com a gestão da política de saúde. Esse envolvimento resulta na reorganização da gestão pública assumindo as ações judiciais ajuizadas contra a administração do Sistema Único de Saúde (SUS) como um "problema social" que merece respostas organizadas e coordenação interinstitucional. Este artigo descreve tais respostas com base em padrões de colaboração interinstitucional entre atores do sistema de justiça e profissionais da gestão da saúde em 4 estados brasileiros: São Paulo, Rio de Janeiro, Santa Catarina e Rio Grande do Sul. A partir de tipologia de McNamara (2012, 2016), o texto compara os diferentes graus de integração dessas respostas entre órgãos e traça o "perfil" colaborativo do estado em relação à judicialização da saúde.

Palavras-chave: judicialização da saúde; colaboração interorganizacional; saúde pública; sistema de justiça.

Entre justicia y gestión: colaboración interinstitucional en la judicialización de la salud

El sistema de justicia hace más que simplemente "controlar" la legalidad de las políticas públicas y su implementación. El caso de la judicialización de la salud en Brasil ilustra cómo los jueces, los abogados públicos y los fiscales están cada vez más involucrados en la gestión de la política de salud. Esta participación resulta en la reorganización de la gestión pública. Las demandas presentadas contra la administración del Sistema Único de Salud se transforman en un "problema social" que merece respuestas organizadas y coordinación interinstitucional. Este artículo describe esas respuestas con base en estándares de colaboración interinstitucional entre actores del sistema de justicia y gestores de salud pública en cuatro estados brasileños: São Paulo, Río de Janeiro, Santa Catarina y Rio Grande do Sul. Operacionalizando la tipología de McNamara (2012, 2016) este estudio compara el grado de integración de las respuestas entre esos organismos y rastrea el "perfil" colaborativo de cada estado en relación con la judicialización de la salud.

Palabras clave: judicialización de la salud; colaboración interorganizacional; salud pública; sistema de justicia.

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1. INTRODUCTION

The relationship between the justice system and the executive branch is a central concern in empirical studies of law and political science around the world. In Brazil, the impact of litigation on social policies, such as education and public health, receives great attention from this literature, and scholars are already prepared to perceive the judiciary as a relevant actor in public policy cycles. This literature, however, has mostly ignored the importance of other justice organizations in the phenomenon while also oversimplifying the relationship between courts and policy, as if solely judges could exert only external control over policy decisions, leaving policymakers a single choice between compliance or not with judicial rulings.

The relationship between public policy and the justice system, however, happens between more actors than just policymakers and the judiciary, and involves responses beyond simply compliance. This study explores the creative and collaborative interactions between different organizations in the justice system and the executive branch through a qualitative study of health litigation in four states: São Paulo, Santa Catarina, Rio de Janeiro, and Rio Grande do Sul. As health litigation came to be considered not only a "social problem" (Dye, 2013) to be addressed through planning and governance, but a *wicked problem* that demands collaboration, this study maps the different institutional responses put in place to address the issue in each state.

As we will see, some responses are conceived and implemented unilaterally by policy officials attempting to mitigate the effects of health litigation over policy or to resolve conflicts before they are judicialized. But many other responses flourish from collaborations between policymakers and the justice system. By mapping these different answers and their degree of collaboration at the subnational level, this study helps to contribute to a better understanding of the interactions between the executive and judicial branches and to advance the field of studies of public policy and litigation.

2. JUDICIALIZATION OF PUBLIC POLICIES AND INTER-ORGANIZATIONAL COLLABORATION: THEORETICAL CONSIDERATIONS

Most studies on the "judicialization of public policies" focus on *command and control* explanations, seeking to verify if the performance of the executive branch within specific policies has complied with determinations from the justice system (Langford, Rodriguez-Garavito & Rossi, 2018). That is, to the extent that decisions of a given public policy are questioned before the judiciary, this literature focuses on whether public managers comply with these judicial determinations and the extent to which they impact the provision of a public service or the protection of a right. The judiciary — and, most frequently, constitutional or apex courts — is treated as an external reviewer of public policies that evaluates them only once they are being executed, acting to correct the application of an administrative decision in an individual case or the general directions of a policy after its implementation (Howlet, Ramesh & Perl, 2009; Kapiszewski & Taylor, 2013).

This traditional view has been challenged by works that identify the actions of a plurality of actors within the judicial system — such as public lawyers, prosecutors, private attorneys, and state attorneys general — and different organizations within the judiciary itself — such as subnational courts (Da Ros & Ingram, 2019) and the National Council of Justice (CNJ) (Ramos, Diniz & Madureira, 2015; Vasconcelos, 2020). All the organizations that make up the Brazilian judicial system are generally highly independent from each other and hold political power and procedural tools to act at different times during the public-policy cycle (Arantes & Moreira, 2019; Da Ros, 2014; Kerche, 2007). They might interfere with the formation of a policy agenda, with its planning and formulation, with the implementation phase, and at the evaluation and review stages. Thus, the judicialization of public policies cannot be seen only as a consequence of judicial decisions, but also as a result of the action, coordinated or not, of other institutions that make up "the gears" of the justice system and operate into different directions (Da Ros, 2014).

In addition to involving more actors from the justice system, the judicialization of public policies also involves a plurality of actors and organizations within the executive branch itself. In a governmental agency such as the healthcare department, for example, a lawsuit may require the work of different sectors — the offices of coordinators and legal advisors that work closely with the health secretary; the sector responsible for public purchases; the department in charge of regulating emergency and urgent healthcare cases; or the sector that plans the entire pharmaceutical assistance policy for the state (Vasconcelos, 2018). Even if less autonomous than the organizations of the justice system, these governmental agencies are, in general, dedicated to different aspects of policy provision.

In the phenomenon of judicialization of health, then, courts, defense attorneys, prosecutors, private lawyers, state attorneys, and different organs of the executive branch interact on similar health cases, over and over again, thousands of times every year, responding to more than 100,000 new health-related lawsuits filed in the country (CNJ, 2019). These repeated interactions encourage strategic behavior on the part of organizations — they are able to anticipate litigation and then structure more complex responses to the phenomenon than the mere resolution of each individual conflict.

Studies in the area have shown this pattern by looking at how health litigation extends the periods of interaction between agents from the executive branch and the justice system, an interaction that generates more permanent and comprehensive answers to health litigation than individual decisions and their compliance on a case-by-case basis (Chagas, Provin, Guimarães & Amaral, 2020; CNJ, 2019; Guimarães & Palheiro, 2015; Vasconcelos, 2018, 2020; Wang, 2015). One of these possible long-term

answers is the coordination of organs and agents into collaborative efforts. This answer is discussed in the present paper.

The literature on inter-organizational collaboration is helpful in understating the movement towards and the possible results of greater interaction between actors of different organizations. The works in the field deal with the difficult task of explaining in a dynamic way the multiple paths of interaction between agents and how collective action can occur in different contexts (Bryson, Crosby & Stone, 2006). The large number of explanatory variables and their many "potential combinations in dynamic interaction" (Williams, 2016, p. 26) favor case studies as a preferable research method, with special emphasis on qualitative work.

The emergence of collaborations would be especially associated with moments of increasing turbulence (Gray, 1989), when it seems clear to those involved that isolated action will not solve the problem, given its complexity or its polycentrism ([*wicked problems*] Gray, 1989). These moments also invite organizations to reflect and agree on the nature of the problem, the common objectives that would come from collaboration, and a possible division of tasks, costs, and responsibilities (Ansell & Gash, 2007).

Some studies have sought to identify the general conditions that affect and determine collaborations (Williams, 2016). In general, it is a literature that aims to explain the emergence of collaborations or their effects, placing greater emphasis on the independent variables that lead to or affect collaboration. Other studies seek to better characterize the dependent variable, concerned not only with theoretical uniformity but also with accuracy when determining what constitutes collaboration. This is the case of McNamara (2012, 2016), who catalogues the many works in the field of collaboration studies to typify the different forms of inter-organizational interaction. These different forms are arranged by the author into a continuum that goes from patterns of constant interaction towards greater and more established collaboration.

According to the author, in interactions defined as *cooperation,* the "participants with capabilities to accomplish organizational goals" "chose to work together, within existing structures and policies, to serve individual interests" (McNamara, 2012, p. 391). In this case, there would be no need for relevant organizational changes between organizations, such as modifying their missions or planning, since the focus of corporations is on delivering the best work among individuals who "communicating informally to help one another" (McNamara, 2016, p. 68) In general, interactions would also not involve leaders from high branches of each organization's hierarchy.

Coordination, in turn, moves these constant individual interactions towards more coordinated performance. It is characterized not only by greater formalization, with signed agreements and terms of cooperation, but organizations also join forces towards common goals in coordinative efforts.

These coordination processes can lead to collaboration, defined by the author as "an interaction between participants who work together to pursue complex goals based on shared interests and a collective responsibility for interconnected tasks which cannot be accomplished individually" (McNamara, 2012, p. 391). The key element of collaboration, which differentiates it in a continuum as the final stage after cooperation and coordination, is exactly the joint work that blurs the boundaries between organizations — it requires coordinated work and the development of closer relationships, in which resources, systems, information, and personnel are shared.[1]

[1] McNamara presents this continuum between cooperation, coordination, and collaboration in a 2012 paper but adds a fourth category — mandatory collaborations — in her 2016 piece. I agree with the author in 2012, however. The fact of a collaboration being made mandatory can be a trait of any inter-organizational relationship, especially if it involves public agencies.

3. METHOD

This article compares governance strategies of health litigation in four Brazilian states — São Paulo, Rio de Janeiro, Rio Grande do Sul, and Santa Catarina — by operationalizing the concepts described above based on McNamara's model (2012, 2016). These states were chosen because they are four of the states with the highest levels of health litigation in the country (CNJ, 2019; Tribunal de Contas da União [TCU], 2017) and have been systematically studied for their legal cases in healthcare and their impact over policy. Thus, this study assumes that public healthcare agents and members of the justice system in these states have elevated experience in facing health litigation cases unilaterally, making it more likely for them to see the issue as a *wicked problem*. All initiatives mapped here were observed until December 2017, except for the "Ser Saúde" Program, which, up until the end of data collection for this study, was called "Resolve + Saúde" and was still being negotiated. The initiative was signed in February 2020 and incorporated into this research project.

3.1 Method for Data Collection

Twenty-seven semi-structured interviews were conducted: twenty-five with healthcare policy officials and state attorneys from the four states, one with a member of the State Public Prosecutor's Office (MPE) of Santa Catarina, and one with a member of the Rio de Janeiro Federal Court. The interviews were conducted by telephone and in-person. All health department units responsible for compliance and management of judicial decisions were visited. State attorneys' offices were also visited. Such visits provided exposure to many of the initiatives described in this study.[2] The interviewees were chosen for their direct contact with legal healthcare cases. The choice to interview mainly policy officials and state attorneys is justified because these are the actors who, in all four states, centralize all information available on the existing governance initiatives for health litigation. These are also the agents in charge of defending the state in public health cases and complying with judicial decisions.

All the information collected through statements from interviews was triangulated between interviews until saturation was reached in relation to new information on all health-litigation governance initiatives ever created and in progress. The information obtained through interviews was also triangulated with: legal norms and terms of cooperation published in official state and judicial bulletins or available through official databases of the state administration and the justice system; articles from newspapers of large circulation or published as official communications, as long as publicly available; and publicly available reports from control agencies such as TCU and CNJ.[3]

All interviewees allowed their interviews to be recorded and used, including quotations. Consent was formalized by signature of consent and confidentiality forms in all face-to-face interviews and recorded in all interviews done by telephone. Only the author of this article and a research assistant listened to the recordings, which remain confidential.[4] All names were preserved, and the only information that was disclosed, with the consent of the interviewees, was their respective states, positions, and agencies

[2] It is an important part of qualitative work to know in person the realities discussed and narrated. In-person visits were not only opportunities for interviews, but they also allowed the snowballing of contacts and informal interaction, off-record, with healthcare policy officials and judicial agents.

[3] A list containing all reports, official documents, and publications used for triangulation are available in the electronic annex, retrieved from https://drive.google.com/drive/folders/1_5RrAhEKOCw_6uFSrx0s0muI57c_Atjp?usp=sharing

[4] The consent form used by this research is available in the electronic Annex, cf. n. 3.

(see Annex). The interviews were conducted between July and December 2017, lasted on average forty minutes, and followed a semi-structured questionnaire model in which twenty-two questions sought to map procedures and organizations involved in dealing health litigation and all the interaction processes in place with other agencies within the executive branch and the justice system (see Annex).

3.2 Method of Analysis

Through all the information collected, twenty strategies set in place to respond to health litigation were identified and listed — as can be observed in tables 2 to 5. As we will see in the results section, these strategies were divided into three groups: pre-procedural, procedural, and meta-procedural strategies to cope with the judicialization of health, depending on the moment they occur in relation to legal cases.

To assess the different degrees of collaboration, these strategies were broken down into seven of the ten dimensions proposed by McNamara (2012, 2016) through her literature review. The author catalogs ten relevant dimensions that would move interactions along a continuum that goes from cooperation to coordination to collaboration. They are: institutional design, formality of agreement, organizational autonomy, key personnel, information sharing, decision-making processes, dispute resolution, resource allocation, systems integration, and trust. Because it is a catalogue of dimensions, not all of them are present in all studies reviewed by the author. Moreover, some of these dimensions are intrinsically related to each other.

Thus, "conflict resolution" and "decision-making" were grouped here as overlapping dimensions titled "decision-making processes" — making decisions presupposes that conflicts are resolved in a collaborative interaction. Similarly, the "information sharing" and "systems integration" dimensions were also grouped as overlapping since the integration of systems is a stable and formalized version of information exchange processes.

Finally, this research did not deal with the dimension "trust." This is a variable that is difficult to map in the relationships discussed in this work — these are interactions that presuppose litigation. This means that opposition, conflict, and asymmetry of power are issues that are at the birth of many of the collaborations discussed here.[5] Lack of trust is often confused with disagreement and opposition by being in different sides of the judicial procedure when this dimension appears in the speeches of the actors interviewed.

The remaining 7 dimensions received a score from 0 to 3, where 0 represents the *absence of any collaboration characteristic*; 1, when a particular dimension appears to be closer to what would be expected from a *cooperation*; 2, when it is closer to a *coordination*; and 3, when it is closer to a *collaboration* (Box 1). In the end, a simple average is calculated that indicates the final *score* of each strategy and the overall *score* for collaboration in the state.

[5] In the case of officials from the public health department (or "Secretaria Estadual de Saúde Publica," from here on SES) and from the state attorney general (or "Procuradoria Geral do Estado," from here on PGE), "confidence" may be a significant point for discussion, but any findings for this relationship could not be applied to interactions with other agencies. For example, while it is possible to define different degrees of trust for the relationship between SES and PGE, since they are "on the same side" of the judicial process, any other collaboration that involves public defenders (or members of "Defensoria Publica," from now on mentioned as DPE for state public defenders and DPU for federal public defenders), public prosecutors (or members of "Ministerio Publico," from now on mentioned as MPE for members of the state public prosecutor's office and MPF for members of the federal public prosecutor's office) or judges (from state courts, "Tribunais de Justiça," from now on referenced as TJ; and federal courts, "Tribunal Regional Federal," from now as TRF) would already start from points of distrust, given the position these actors occupy in legal cases, combined with power asymmetry — policy officials can be held personally liable in public health disputes.

BOX 1 VARIABLES AND SCORES FOR COOPERATION, COORDINATION, AND COLLABORATION

	Score 0	Score 1	Score 2	Score 3
Institutional Design	There is no structure for collaboration.	Structure for only informal collaboration.	Collaboration structure formalized by term and division of competencies.	Distinct, deliberative, and formalized structure for collaboration between organizations (such as Committees, Chambers, Councils, etc.)
Formality	There is no formal or informal cooperation agreement.	Informal collaboration agreement.	Formal cooperation agreement.	Formal and informal agreements in place.
Organizational Autonomy	There is not more than one organization involved.	Cooperation does not tie organizations together. No autonomous collaboration.	Coordination is semiautonomous to member organizations.	Collaboration creates an autonomous organization.
Key Personnel	There is no personnel involvement between organizations, only one organization.	Involves hierarchically low levels of member organizations and not leaders.	Intermediate and supervisory levels involved.	Hierarchically higher and/or leadership levels involved.
Information Sharing	Organization works alone with the information it has.	Information sharing is informal.	Sharing information is formalized by meetings and personnel exchanges.	Systems integration and creation of committees with access to information open to all members.
Decision-making	There is no interaction between organizations during decision making.	Interaction occurs, but decision making is made independently by each member.	Decision-making is centralized by some actors or the main member organization.	Collective decision-making that involves all member organizations.
Resource Allocation	There is no interaction. The organization invests its resources only in own its activities.	Only information is shared.	Physical and financial resources can be shared but collected and used to serve the interests of one or a few members.	Financial and physical resources are collected from everyone for collective purposes.

Source: Elaborated by the author based on McNamara (2012, 2016).

Assigning *scores* to qualitative variables allows a more direct comparison between experiences, summarizing many qualitative dimensions in some categories that can be laid out and form a collaboration scale.[6]

[6] Assigning *scores* (i.e., artificial values) in a scale, to summarize complex variables of the social world, is a research technique employed in studies of mixed methods that seeks to combine the different potentials of qualitative and quantitative research. This type of work, however, has limitations. As pointed out by one of the reviewers of this journal, there is a degree of subjectivity in the construction of categories that is reflected in how the *scores* are assigned. The discussion about subjectivity in qualitative research is largely discussed by the literature. Check, for example: King et al. (2014), Mahoney and Goertz (2006) an Onwuegbuzie and Leech (2005). To account for this subjectivity, the electronic annex presents exhaustively the reasons that led to the score of each dimension of this work.

4. RESULTS

4.1 Institutional Responses to Judicialization

The profile of health litigation in the four states is quite similar. There are mostly individual lawsuits that require, for the most part, drugs not standardized by clinical protocols from the Brazilian Unified Health System (or "Sistema Único de Saúde," from now on SUS). Judicial decisions, both before trial judges and courts of appeals, are largely favorable to the plaintiffs (Ferraz, 2011; Vasconcelos, 2018). An important difference, however, is the type of legal representation that is predominant in each state. While in São Paulo and Santa Catarina most of the lawsuits are filed by private lawyers (Chieffi & Barata, 2009), in Rio Grande do Sul (Biehl, Amon, Socal & Petryna, 2012) and in Rio de Janeiro cases filed by public defenders (DPE) are predominant (Ventura, 2012).

Responses to health litigation can be grouped in three major phases: pre-litigation, when organizations involved seek to avoid judicialization by addressing cases administratively; procedural, for responses that already happen at the litigation stage, such as legal defense or compliance with judicial decisions; and meta-procedural, for responses that involve broader monitoring and governance of litigation in the state. These strategies are summarized in Boxes 2, 3, 4 and 5.

BOX 2 RESPONSES TO THE HEALTH LITIGATION IN SÃO PAULO (SP)

	Strategy	Form	Designing actors	Implementing actors
Pre-Procedural	Administrative delivery of medicines and other products.	Drugs are individually required through an administrative procedure before the Pharmacology Commission of SES/SP.	SES-SP	SES-SP
Procedural	"Acessa SUS" — specialized screening of cases for Specialized Courts.	Agreement between organizations. Cases are screened for administrative resolution before any lawsuit. Non-legal-technical team provided by SES-SP works at AME Maria Zélia.	SES-SP, PGE-SP (helped drafting the agreement), MP-SP, DPE, TJ-SP	SES-SP, DPE, and TJ/SP
Procedural Strategies	Compliance with court decisions.	Drugs provided by judicial decisions are lined up for planned purchase. Process coordinated by CODES via S-CODES.	SES-SP and PGE-SP	SES-SP and PGE-SP
	Legal defense	CODES (SES) and PJ8 (PGE) prepare legal defenses via integrated system — S-CODES. Special treatment for high-impact demands. Weekly meetings, personnel exchange.	SES-SP and PGE-SP	SES-SP and PGE-SP

Continue

	Strategy	Form	Designing actors	Implementing actors
Meta-procedural	NAT	Issues technical opinions to assist judges. Used to mediate and issue opinions only for health insurance cases. Now follows general NAT model from CNJ.	Initially TJ-SP, ANS, ABRAMGE, FenaSaúde; currently CNJ, State Court, and Federal Court	TJ-SP
	Training and team-building sessions between PGE and SES in the countryside — "institutional marriage".	Promotes meetings between regional health directors and state attorneys from the countryside. Sessions meditated by coordinators from the main offices in São Paulo capital — PJ8 and CODES.	SES-SP and PGE-SP	SES-SP and PGE-SP
	CNJ State Committee.	Committee issues recommendations and promotes discussions and integration between healthcare officials, members of different agencies from the justice system, and civil society.	CNJ, JE, JF	SES, SMS-São Paulo; PGE-SP; MPE, MPF, DPE, DPU, AGU, JE, JF, COSEMS, CRM, CRF, CRA

Source: Elaborated by the author.

BOX 3 RESPONSES TO THE HEALTH LITIGATION IN RIO DE JANEIRO

	Strategy	Form	Designing actors	Implementing actors
Pre-Procedural	Health Dispute Resolution Chamber (CRLS).	Administrative screening with the possibility of judicialization via DPE and DPU offices on site.	PGE-RJ, SES-RJ, DPE, DPU	PGE-RJ, SES-RJ, DPE, DPU
Procedural	Compliance with court decisions.	Analysis, screening, and compliance with judicial decisions performed by a multidisciplinary team at CADJ (SES).	SES-RJ	SES-RJ
	Legal defense	SES-RJ technical team located within PGE-RJ prepares technical reports for legal defense.	SES-RJ and PGE-RJ	SES-RJ and PGE-RJ
	NAT	NAT issues technical opinions to assist judges.	SES-RJ and TJ-RJ	SES-RJ, TJ-RJ and JF-RJ
Meta-procedural	CNJ State Committee.	Committee issues recommendations and promotes discussions and integration between healthcare officials, members of different agencies from the justice system, and civil society.	CNJ, JE, JF	SES-RJ, SMS-RJ, PGE-RJ, PGM-RJ, MPE, MPF, DPE, DPU, JE, JF, municipal healthcare policy officials, academics

Source: Elaborated by the author.

BOX 4 RESPONSES TO THE HEALTH LITIGATION IN RIO GRANDE DO SUL

	Strategy	Form	Designing actors	Implementing actors
Pre-Procedural	"Ser Saúde". Agreement with DPE.	DPE refers patients to SES-RS before filing a lawsuit.	SES-RS and DPE	SES-RS and DPE
Procedural	Compliance with court decisions.	Agreement between courts and PGE to improve communication between SES and the judiciary and compliance with decisions. AME system is shared.	SES-RS, PGE, and TJRS	SES-RS, PGE, and TJRS
	Legal defense	Outsourced technical team, hired by SES-RS in partnership with PGE-RS, prepares technical defense.	SES-SP and PGE-SP	PGE-SP
Meta-procedural	CNJ State Committee.	Committee issues recommendations and promotes discussions and integration between healthcare officials, members of different agencies from the justice system, and civil society.	CNJ, JE, JF	SES-RS, PGE-RS, MPE, MPF, DPE, Federation of Association of Municipalities of RS (FAMURS), AGU, CREMERS

Source: Elaborated by the author.

BOX 5 RESPONSES TO THE HEALTH LITIGATION IN SANTA CATARINA

	Strategy	Form	Designing actors	Implementing actors
Pre-Procedural	NAT	CEOS system is fed by technicians. Available to members of the judiciary, public defenders, and public prosecutors. Consulting CEOS helps to avoid frivolous litigation.	SES-SC	SES-SC
Procedural	Compliance with court decisions.	Cases are registered into the system and assessed by a team of technicians. Coordinated by COMAJ and COJUR.	SES-SC	SES-SC and PGE-SC
	Legal defense	COMAJ and PGE-SC (NARAS) prepare technical opinions. Team acts on a case-by-case basis for high impact demands, in coordination with COJUR. Interaction between SES-SC and PGE-SC happens through PGE-Net, workshops, meetings, and phone calls.	SES-SC and PGE-SC	SES-SC and PGE-SC

Continue

	Strategy	Form	Designing actors	Implementing actors
Meta-procedural	CNJ State Committee.	Committee issues recommendations and promotes discussions and integration between healthcare officials, members of different agencies from the justice system, and civil society.	CNJ, JE, JF	SES-SC, PGE-SC, MPE, MPF, DPE, DPU, JE, JF, OAB, TCE, SMS-Florianópolis, CONASEMS, Federation of Municipalities and Municipal Health Council of Florianópolis

Source: Elaborated by the author.

4.2 Pre-Procedural Responses

The pre-procedural answers can be divided into two types: those in which health departments act alone in the analysis of administrative requests for drugs, services, and other products not covered by the policy, and decide these requests directly filed by claimants; and those responses structured over cooperation agreements between health departments and state and federal public defender's offices (DPE and DPU), whereby officials from all these organizations run a pre-litigation screening of all healthcare requests to prevent frivolous litigation.

São Paulo, for example, runs both strategies in an attempt to contain litigation promoted by public defense lawyers and private attorneys — an approach that is more decentralized (there is not one single firm or office) and more difficult to control.

"Access SUS" is the result of an agreement between SES, the State Attorney General's Office (PGE), the State Public Prosecutor's Office (MPE), DPE, and the State Court of Justice (TJ), whereby officials screen patients' requests administratively and attempt to solve the claim before litigation. This initiative is managed and funded by the state health department (SES-SP), and its technical team works in the primary healthcare unit, Maria Zelia, in the Belenzinho neighborhood in São Paulo city.

For administrative requests, SES assesses and can grant concession of demands for drugs and treatments that are already part of the policy basket, but also of out-of-policy drugs. The possibility of receiving from the health department a product that has not been incorporated into the general health policy is a feature that is not present in other states.

Like "Acessa SUS," the "Ser Saúde" project in Rio Grande do Sul involves DPE officials referring individual requests to SES before any lawsuit is filed. Implemented in February 2020, the project has expanded the agreement that already existed between SES and DPE from a small-scale operation in the municipality of Santa Maria to cover more judicial districts. In "Ser Saúde," triage officers do not have their own structure and workspace, as in the case of "Acessa SUS" and CRLS, but work at SES screening cases through a constant flow of communication between DPE and SES on a case-by-case basis.

The Chamber for Dispute Resolution in Healthcare (CRLS) in Rio de Janeiro is a similar strategy to Acessa SUS and Ser Saúde (Guimarães & Palheiro, 2015; Teixeira 2011; Souza, 2016, 2018). Its creation in 2012 was possible only through the alliance between[7] DPE, DPU, PGE, the Attorney General for the

[7] For all three strategies — Access SUS, Ser Saude, and CRLS — there were previous attempts of administrative cooperation between SESs and DPEs. For a brief history of these preexisting experiences in Rio de Janeiro, check Teixeira (2011) and Guimarães and Haystack (2015). For São Paulo, see Fanti (2010). For Rio Grande do Sul, see Vasconcelos (2018).

Municipality of Rio de Janeiro, SES, and the Rio de Janeiro Municipal Health Department (SMS). PGE played a fundamental role in this process, from the agreement's conception to its operationalization, mediating negotiations between all actors involved. PGE also provided the physical space where CRLS works and part of its staff. CRLS operates in downtown Rio de Janeiro, in a private building that was made public and given to PGE, which maintains the general administration of the building, providing cleaning, surveillance, and elevator services.

The Chamber began operating in September 2013, and, as reported by PGE, already in its first year solved 38% of the cases it received, preventing litigation. This number rose to 54% in 2016, with a total of 30,000 patients treated. In 2013, the CRLS was seeing 50 patients a day, a number that rose to an average of 100 visits in 2016. In the CRLS building, employees provided by SES, SMS, DPE, and DPU asses cases individually and, in dialogue, seeking to solve the patient's problem preferably through administrative resolution or, if not, through litigation. In total, in 2017, around 68 employees worked at CRLS, including policy officials, public defenders, technical advisors, and interns. The CRLS technical team also works as a point of contact between the Rio de Janeiro health department in the capital and its countryside offices, providing technical advice remotely.

4.3 Procedural Answers

Among the procedural strategies are the specialization and improvement of legal defenses and workflows for compliance with judicial decisions. For these purposes, health departments in three of the four states created specialized bodies, such as the Coordination Group of Strategic Demands of the SUS (Codes) in São Paulo; the Judicial Demands Service Center (CADJ) in Rio de Janeiro; and the Multidisciplinary Judicial Support Commission (COMAJ). These are multidisciplinary structures that hire their own technicians to answer legal cases or employ staff that have been relocated from other activities within the department to assist with litigation.

PGEs are an important part of these strategies, working with the main partners of health departments in defense and in compliance with judicial decisions. Their performance is not limited to the legal and procedural *script* of acting as a lawyer or legal adviser, but also involve PGEs engaging in creative forms of interaction with health departments. They share electronic systems that help with workflow and communication, have regular meetings, and work cooperatively for the joint management of legal cases.

All states have also created PGE specialized units that work almost exclusively with healthcare cases. In São Paulo, the PGE's coordinator for health law cases and its special unit (PJ-8) organize the legal responses cases in the capital and in the countryside. Members of PGE also occupy key positions within the health department as legal advisers. The presence of state attorneys especially appointed to positions within the health department is a feature of litigation governance also found in Rio de Janeiro. São Paulo PGE and SES also exchange personnel, as staff from CODES and PJ-8 have periods of mutual internship. Another important feature of this joint work is a shared electronic system (S-Codes) that helps to manage all the case load while also providing relevant health policy information such as the epidemiological profile of cases, which doctors and legal practices are involved, and which drugs are being demanded.

In Santa Catarina, the Center for Repetitive Health Law Cases (NARAS) works in partnership with SES to develop legal defenses while managing compliance with judicial decisions. Similarly,

Rio Grande do Sul has twenty specialized state attorneys who concentrate most of health litigation cases. In order to strengthen PGE's legal defense in health litigation cases, SES-RS hires public health personnel to assist PGE remotely. To monitor compliance and avoid sanctions and judicial fines, SES and PGE have partnered with the state (TJ-RS) and federal courts (TRF) so that judges can access the Special Medicines Administration (AME) system which concentrates all the available information on the demand and stock of medicines and health products for SES. This partnership also sets clear commitments between all parties involved regarding deadlines for compliance with decisions and how the court system needs to inform PGE and SES in the case of pre-trial injunctions and sentences.

In Rio de Janeiro, PGE-16 concentrates all health litigation cases of Rio de Janeiro capital, assisted by officials from SES who work inside PGE-16 helping to write stronger technical defenses. PGE and SES also monitor compliance through the specialized work of CADJ. Moreover, the partnership between PGE and SES was also a precondition for CRLS's creation.

Another procedural initiative common to most states is the work of the Technical Support Centers ("Nucleo de Apoio Técnico" — NAT) that assist the judiciary in health litigation cases by providing technical advice. These centers are one of the many initiatives led by CNJ to address health litigation in the country. However, NATs assume very different formats from state to state. For example, in Santa Catarina, it works as an advisory body that assists the entire state justice system but works from within SES, where policy officials feed a comprehensive database (the Multidisciplinary Support Commission System, Siscomaj — CEOS) on drug safety, efficacy, and information on policy provisions. In Rio de Janeiro, NAT operates in offices lent by the Federal and State Courts with SES employees, a multidisciplinary team of more than seventy people on 24-7 duty to assist judges in technical decisions.

4.4 Meta-procedural Responses

Among the meta-procedural responses, the CNJ State Committees stand out. Recommended and then required by CNJ,[8] all states created some form of committee and, in the four states studied, they became spaces for the articulation of the largest number of organizations involved in health litigation. Interviewees from Rio Grande do Sul and Rio de Janeiro claimed that the initiative first took place in their respective states, arguing that it became a general recommendation by CNJ precisely because it had already successfully implemented in both states. The Santa Catarina version, the State Committee for Monitoring and Resolution of Healthcare Demands of Santa Catarina (Comesc), is identified by interviewees as the most productive space where health litigation can be discussed by different organization in the state. In São Paulo, the Committee was created only in 2017 but now manages the São Paulo NAT.

In addition to the Committee, an intense cooperation between PGE and SES in São Paulo happens at the meta-procedural phase. One of the initiatives that has resulted from this cooperation is the "institutional marriage," as named by the interviewees, where the head of the PJ-8, in partnership with the SES Codes, promotes meetings and workshops between countryside state attorneys and local health directors throughout the state so they can work together in health litigation cases outside São Paulo capital.

[8] Cf. Recommendation CNJ No. 31, of March 30, 2010, and, later, Resolution CNJ No. 238, 6 September 2016, both available at https://atos.cnj.jus.br/

5. COLLABORATION IN THE FOUR STATES

The *average scores* for the set of strategies mapped in each state are presented in the table below (Table 1). Rio Grande do Sul and Rio de Janeiro are the states with the most collaborative initiatives, with the highest averages and medians. Rio de Janeiro, however, occupies a clear first place. This is especially due to the design and dynamics of the state's NAT and the work of the CRLS. Santa Catarina is very close to Rio Grande do Sul — it loses out on second place because it does not have a pre-procedural initiative of administrative resolution via DPE, as present in all other states. São Paulo is found to be the least collaborative state, but with a standard deviation higher than all cases, indicating that there is much variation between the average *scores* of the state's initiatives. It is also the state with the most initiatives.

TABLE 1 FINAL SCORE BY STATE FOR COLLABORATION TYPES, CENTRAL TENDENCY MEASUREMENTS AND VARIATION

State	Average	Median	Standard Deviation	Number Actors	Result - Scores
SP	1.510	1.571	0.742	3.8	Cooperation-Coordination
SC	1.821	1.643	0.513	5	Cooperation-Coordination
RS	1.857	1.714	0.495	6	Cooperation-Coordination
RJ	2.143	2.429	0.670	5.4	Coordination-Collaboration

*The *scores* for each individual strategy are explained in the electronic annex (cf. note3).
Source: Elaborated by the author.

5.1 Information Sharing

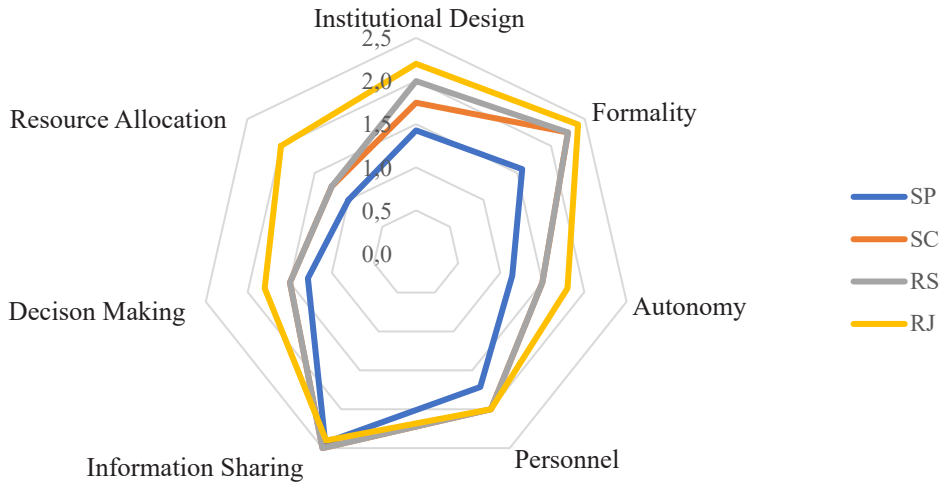
Graph 1 illustrates state *scores* for each of the seven dimensions. All initiatives have higher scores for "information sharing." According to the interviews, this is the main form of collaboration between organizations.

Health litigation is seen by most of the interviewees as a problem that can be solved only through better sharing of technical evidence among the organizations involved. Thus, access to sharing of systems is especially relevant for partnerships. This is even more important given the volume and pace of litigation, characterized by the frequency of pre-trial injunctions, compliance in short periods of time, and non-compliance penalties such as daily fines or the blockage and seizing of budget funds.

Informal communication mechanisms — such as emails, phone conversations, and especially messaging apps — are important avenues of exchange between all organizations involved in health litigation. They do not, however, replace access to official electronic systems that establish the organizational workflow between agencies (such as S-Codes in São Paulo, AME in Rio Grande do Sul, Siscomaj in Santa Catarina, or PGE-Net in all states). Rio Grande do Sul is the state that invests the most in sharing systems and information. The state has ceded access to its internal AME system to all organizations involved in health litigation, except private lawyers.

São Paulo, on the other hand, may have developed the system that is most desired among health departments, S-Codes, which, in addition to organizing in an industrial line all the stages and possible responses to lawsuits, also collects information about cases, generating reports and indicators that allow for health policy planning and strategic performance (Naffah, Chieffi & Correa, 2010; Toma, Soares, Siqueira & Domingues, 2017). This system, however, is shared only between PGE and SES in the state. In Santa Catarina, the system Siscomaj-Ceos, which serves the state's NAT, is managed by SES but used and shared with the entire justice system, thereby raising the state's *score*.

GRAPH 1 AVERAGES PER SCORE STATE FOR EACH COLLABORATION DIMENSION



*The *scores* for each individual strategy are set out in the electronic annex (cf. note3).
Source: Elaborated by the author.

5.2 Resource Allocation

For "allocation of resources," Rio de Janeiro stands out. This is explained by the experiences of CRLS and NAT. In each of these collaborations, resources and personnel are clearly shared between organizations from the justice system and SES. Low scores for the other three states point to the importance of discussing how most collaboration initiatives have so far been disproportionately funded and supported by single organizations, most often the executive branch.

5.3 Formality

Only four strategies reach *score* 3 on this dimension. They are the only ones that combine legal terms of cooperation or agreements formally signed by all the agencies involved with some form of informal arrangement, according to the interviews. These strategies are: the CNJ State Committees in Rio de Janeiro, Rio Grande do Sul, and Santa Catarina — at the time of data collection, the São Paulo Committee had been already formalized, but only began its activities — in addition to the CRLS.

An example of an informal arrangement that intensifies collaboration is the case narrated by a judge interviewed in Rio de Janeiro: within the CNJ State Committee, a WhatsApp group was formed in which member organizations are able not only to exchange general information but also to discuss concrete measures for ongoing judicial cases they need to handle. Apart from the administrative process of São Paulo *(score* 0) and the informal initiative for the "institutional marriage" (*score* 1), all other strategies have a formal term of cooperation and score 2 for this dimension.

5.4 Autonomy

For the "autonomy" dimension, CNJ State Committees received *score* 3. These are organizations that have become relatively autonomous structures in relation to their member organizations — even if there is some imbalance of powers and obligations between member organizations since the committee functions inside the judiciary and is an institution that originated from CNJ's recommendations to courts. CRLS received a score of 2 because, despite emerging from a partnership between PGE and SES, later joined by DPE, DPU, and SMS-Rio de Janeiro, almost all decisions and management are made by SES — that is, the final word for how the CRLS functions is made by SES, even though some deliberation involves the other organizations. The same is true for NAT in Rio de Janeiro, which, despite relative autonomy, is under coordination of the chief legal adviser for SES. All other strategies receive a score of 1 since there is no autonomous or independent structure to organization members.

5.5 Institutional Design

In institutional design, few initiatives are structured to become a separate entity to members. Thus, the four CNJ State Committees have score of 3 for this dimension, as well as the CRSL and Rio's NAT — these are collaborations that have their own physical space, a specific hierarchical organization that coordinates their activities, and there is clear distribution of roles and competencies between members. Acessa SUS, Ser Saúde, the partnership between SES, PGE and TJRS to comply with judicial decisions, and NATs from São Paulo and Santa Catarina received a score of 2. Although organized through formal agreements that consolidate the collaboration as something different from their members, these are strategies that depend almost exclusively on one of the members —TJSP for São Paulo's NAT and SES for all the others. In the case of SES, this member uses the collaboration to establish formal agreements with other organizations so that it can provide pre-trial screening services or technical advice during litigation. All other initiatives receive a score of 1.

5.6 Process of Decision

CNJ State Committees also *score* 3 in decision-making. Even if there is a power imbalance between member organizations, decision-making is indeed collective because recommendations and statements are issued after deliberation involving all members, a process through which different organizations seek to convince each other or end up making concessions. CRLS, Acessa SUS, and Rio de Janeiro's NAT receive score 2. There is some form of joint decision-making process in these initiatives, but normally one of the organizations has the final word — in this case, SES. All other partnerships receive a score of 1. These are non-deliberative decision-making processes between organizations, even if there is exchange of information. For example, PGE legal defense strategies might be drafted in communication with SES, but PGE decides on its own how it will run the process.

5.7 Staff

Finally, none of the strategies involve key personnel from the highest levels of organizational hierarchy, agents who could credibly make commitments on behalf of, or decide in name of, their entire institution. Apart from the São Paulo administrative procedure, which does not involve any other organization but SES, all nineteen initiatives score 2 in this dimension. They involve middle-ranked agents, in the case of SES, or judges and members of the justice system appointed by their organizations' presidents or chiefs of staff. Since functional autonomy is a major trace of justice organizations, those who are appointed and serve in these collaborations can hardly claim to represent their institutions, nor make decisions that bind other agents from the same organization.

Table 2 presents the average scores by strategy. The average score for São Paulo and its standard deviation can be explained by two factors. The first is the set of strategies for managing the health litigation in the state is larger than in the other three states. In addition to the CNJ State Committee and NAT, São Paulo also has two administrative pre-procedural strategies, Acessa SUS and a direct administrative procedure that scores 0 since it is a strategy that involves only health policy officials. The second reason is that the state appears to have relied on a close and cooperative partnership between PGE and SES as its predominant strategy. As discussed above, apart from the formal relationship between lawyer and client, this is a partnership that is specially structured through informal mechanisms of cooperation, such as the "institutional marriage."

TABLE 2 SCORES BY STRATEGY BY STATE

	SP		RJ		RS		SC	
strategy	average	median	average	median	average	median	average	median
Administrative procedure	0	0	-	-	-	-	-	-
SER Saúde	-	-	-	-	1.714	2	-	-
CRLS	-	-	2.571	3	-	-	-	-
Acessa SUS	1.857	2	-	-	-	-	-	-
Compliance	1.571	1	1.429	1	1.714	2	1.429	1
Legal defense	1.571	1	1.429	1	1.429	1	1.571	1
CNJ State Committee	2.492	2	2.571	3	2.571	3	2.571	3
"Institutional marriage"	1.429	1	-	-	-	-	-	-
NAT	1.714	2	2.429	2	-	-	1.714	2

Source: Elaborated by the author.

Rio de Janeiro is the state with the highest average. This result is mainly caused by the combination of CRLS, an active CNJ State Committee, and the state's NAT. These collaborations strongly connect organizations from the justice system to the executive branch. More than half of Rio's initiatives involve more than three actors, and such initiatives are designed to give a certain independence and "institutionality" to the collaboration, separating them from member organizations.

The high average of Rio Grande do Sul is not related to the state's pre-procedural strategy, more modest than the CRLS, but, above all, to the score of its CNJ State Committee. It is one of the first inter-organizational committees created in Brazil and, according to the interviewees, is a very collaborative space that functions specifically to govern health litigation in the state.

Finally, although Santa Catarina registers a higher average for collaboration than São Paulo, if one considers standard deviation and number of initiatives, it is the state with the smallest number of integrative initiatives. Moreover, it is the only state that does not have an administrative pre-procedural initiative that partners SES with DPE.

6. DISCUSSION

The results of this research show that there is, in general, convergence among the states in their different institutional responses to health litigation and their patterns of collaboration. The differences, however, are relevant to future studies since they provide clues to explain the emergence and durability of collaborations or even their impact on health litigation.

6.1 Strengthening the Administrative Process and Partnerships with the Public Defender's Office

In three of the four states there is some procedure prior to litigation that aims to resolve conflicts administratively through screening of cases and partnering with public defenders. The commitment to strengthening administrative procedures as a way to reduce litigation has been documented in the literature for health law cases (Silva, Petramale & Elias, 2012; Teixeira, 2011; Wang, 2015) as well as for other highly litigated public policies, such as social security (CNJ, 2020) and early childhood education (Ximenes, Oliveira & Silva, 2019).

In the cases studied here, the typical form of legal representation is an essential information for initiatives like this to emerge. Santa Catarina, for example, is the only one of the four states that has not structured an administrative procedure to address litigation. It is no coincidence, however, that most lawsuits in the state are filed by private law firms (Pereira, Santos, Nascimento & Schenkel, 2010; Vilvert, Buendgens, Campos & Oliveira, 2019), while the state's DPE is a young and small organization (Moreira, 2019). São Paulo has a similar legal-representation profile — most of the state's litigation is also brought by private firms, but DPE-SP is a much older organization (Moreira, 2019) that has become a relevant actor in terms of the number of health lawsuits filed every year (TCU, 2017).

For the two states, however, partnership and joint work between PGE and SES are more aligned with the profile of their local litigation. When working together, these two organizations can present better legal defenses to the large volume of cases being brought by a private law firm. Moreover, even the possibility of bringing these cases to an administrative procedure would happen only if the legal case is already a reality.

In Rio de Janeiro and Rio Grande do Sul, by contrast, litigation is mostly driven by public defenders (Pepe et al., 2010; Travassos et al., 2013). This makes CRLS and the SES-RS partnership with the DPE-RS desirable and potentially effective tools for litigation management. The health department can negotiate with only one organization, the public defender's office, instead of hundreds of private

lawyers. This allows for the prevention of most lawsuits while converting them into administrative requests before they are judicialized.

6.2 Specialization

Another common feature among states is the specialization of state attorneys and policy officials to specific subdepartments created to issue better legal defenses or manage compliance with judicial decisions. As with other Brazilian social policies, such as social security (CNJ, 2020), the volume of lawsuits and the risks of sanctions and penalties in the case of non-compliance require the executive branch to respond quickly and effectively. This encourages specialization in administrative sectors that can concentrate all the responses to lawsuits. This not only includes drafting better and more technical defenses, but also providing strategic advice to the healthcare department on the risks of justice-system interference at each stage of the public-policy cycle.

Specialization helps to translate the language of public policy into the language of law. As has been highlighted by scholars many times before, judicial interference in health policy can ignore important technical aspects of policy and problematically brush off decisions made by very specialized state bureaucracies (Wang et al., 2020). This lack of deference can generate undesirable consequences, such as the inefficient and potentially regressive allocation of public resources (Chieffi & Barata, 2009; Ferraz, 2011; Wang, 2015). Policy officials and state attorneys have responded to this lack of deference by improving legal defense, translating highly technical health-policy decisions, and the allocation dilemmas that they entail, into legal language that can be understood by agents of the justice system.

This effort, however, can also be seen as a potentially inefficient allocation of resources caused by litigation because, in order to structure these highly specialized subdepartments, healthcare departments need to transfer staff and financial resources from important health policy tasks to health-litigation governance.

6.3 Measures taken by the National Council of Justice

Another common characteristic among all states is the presence of initiatives related to CNJ recommendations and resolutions since 2009: the State Committees and NATs. CNJ can be considered one of the most relevant actors to promote collaboration between policy officials and the justice system, especially the judiciary (CNJ, 2019; Vasconcelos, 2020; Wang, 2015).

After the Supreme Court public hearing in 2009, when the Court heard from specialists in public health and health litigation, CNJ worked intensely to set a truly parallel arena for discussion and decision-making in health policy. This set of organizations is made of the National Health Forum, the National Executive Committee and 26 State Committees (Tullii, 2017), four of which studied here. Alongside these deliberative spaces, CNJ also recommended and now imposes that all courts, federal and state, create a NAT in their respective states. All these initiatives set a clear agenda for CNJ that encourages greater collaboration between all different organizations involved in litigation (Vasconcelos, 2020).

It is not clear how effective these initiatives are. If the creation of Committees and NATs was made mandatory for all courts, attendance at meetings is voluntary and decisions need not be made in accordance with these organs' guidelines and recommendations (Ventura, 2012). What the interviews

and the literature suggest, however, is that NATs and especially State Committees can serve as spaces in which policy bottlenecks and inefficiencies are brought before policy officials, helping them review policy decisions and correct mistakes (Vasconcelos, 2018, 2020).

6.4 More actors, more collaboration?

The results of this research indicate that the more actors there are in an initiative, the more collaborative the strategy will be. The most collaborative initiatives in all states — Accessa SUS, CRLS and State Committees — are also the initiatives with the largest number of organizations involved (see the electronic annex, cf. note 3). Meanwhile, the least collaborative state, São Paulo, is also the one that involves, on average, the smallest number of organizations per strategy — an average of 3.8 — while in other states, on average, this number is between 5 and 6 organizations per initiative (Table 1).

This result is particularly counterintuitive, as it would be logical to expect the opposite: the more organizations involved in strategy, the higher the transaction costs of a collaboration will be, implying that collaboration is less likely to occur. The literature on judicialization of politics and inter-organizational collaboration, however, provides clues to what may be behind this puzzle.

First, one possible explanation to this finding is that it reflects the very nature of the problem of litigating public policies: it is a phenomenon that becomes a problem only because it is caused by a plurality of actors — officials from the executive branch and the justice system (Da Ros, 2014; Lima & Vasconcelos, 2019) — acting interdependently. The judicialization of health, like any judicialization of public policies, is not caused only by the actions of judges and courts; it also depends on what triggers the justice system and the actions of the health policymakers who give rise to these lawsuits, consciously or not. That is, all actors are potentially interdependent veto points (Ansell & Gash, 2008; Bryson et al., 2006) on the judicialization of health, so it is logical that initiatives that seek to address the phenomenon also seek to bring all these veto actors to the table.

A second explanation might rely on the distribution of costs and benefits for all the collaborations studied here. For organizations from the justice system, the costs to participate in partnerships such as the CNJ State Committees, CRLS and Acessa SUS are relatively low, while the gains are potentially high (Ansell & Gash, 2008). That is, for almost all actors in the justice system, participating in these strategies does not significantly alter how they normally perform their activities. However, if successful, these strategies can reduce their workload: public defenders would have fewer lawsuits to file and judges would have fewer cases to judge.

This also explains why it is less likely to see private lawyers represented in these forums.[9] The costs to coordinate the performance of all lawyers is very high — or even prohibitive, considering that professional organizations, such as the Brazilian Bar Association (OAB), do not have the power to control the performance of all private lawyers — and the benefits would be negative to this group, since they would lose clients or receive very small compensation if they are acting only at the administrative stage.

On the other hand, public policy officials (and state lawyers) bare almost all the costs of these collaborative initiatives — for example for CRLS and Acessa SUS — since they are the ones that establish

[9] As stated in an interview with a federal judge from Rio de Janeiro, OAB was often invited to take part on the State Committee's meetings, but it has never participated.

and monitor workflows between all organizations, develop and make information systems available, and fund and manage the physical structure that makes these partnerships happen. But the benefits are also perceived as potentially higher to these organizations than their costs — if successful, they would spend less on out-of-planning purchases of drugs and health products, as they are normally out-of-policy and out-of-SUS protocols, or save resources that would otherwise be spent on paying judicial fines or budget seizure.

In the case of CNJ State Committees and NATs, there are some organizational costs shared between policy officials and the judiciary. But there are also more benefits to the courts. They can not only rely on constant technical advice to support their work in difficult cases, but also retain great power over policy officials and the executive branch though State Committees by steering their decisions even if not related to specific judicial cases.[10]

Finally, it is likely that all organizations involved in these collaborations perceive them as beneficial. The actors interviewed often framed them as spaces for joint work and dialogue between policy officials and different organizations from the justice system. From the interviews, it is possible to identify a change in mentality over how to deal with health litigation: it appears to move away from adversarial models, currently in force, to favoring collaborative solutions (Da Ros, 2014).

7. CONCLUSION

Health litigation has been a reality of Brazilian public-health policy for almost 20 years, and according to current data (CNJ, 2019) there is no indication that it will cease to exist in the short term. This phenomenon creates incentives for collaboration. It is a complex and polycentric problem that involves a plurality of organizations and for which a solution could not be conceived or implemented through the unilateral action of a single body.

This does not mean that collaboration is "the holy grail" that must be pursued at all costs to confront litigation (Bryson et al., 2006; Peters, 1998). As shown in the cases studied here, the type of litigation matters and collaboration between organizations is not always a viable or desirable option.

This study presents an initial effort to map and analyze strategies for litigation governance, opening a research agenda that combines the literature on health litigation and public-policy litigation with the literature on inter-organizational collaboration. The next steps to understand health litigation in Brazil need to explain how each of these collaborations came to be in each state and to determine their effects on litigation as a whole.

However, even without looking at the causes and effects of collaborations, the present work advances the literature on public-policy litigation by developing a comparative and dynamic study of the phenomenon through the inclusion of its plurality of actors. This study also helps to strengthen a research agenda on the aspects of judicialization of politics happening at the subnational level. By applying the same data collection and analysis methodologies to litigation in four states while proposing a replicable way to measure inter-organizational collaboration, future studies can advance the work on other state initiatives and thus allow for a better understanding of the phenomenon in Brazil.

[10] The balance between costs and benefits varies from initiative to initiative, but, as we have seen, it is, disproportionately borne by the executive branch. This unbalance might compromise, in the long run, these collaborations' stability (Ansell & Gash, 2008; Bryson et al., 2006).

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Natalia Pires de Vasconcelos

https://orcid.org/0000-0002-0309-6904

Ph.D. in Law from the University of São Paulo; assistant professor at Insper; Senior research fellow at the Solomon Center for Health Law and Policy, Yale Law School. E-mail: nataliapv1@insper.edu.br

ANNEX

BOX 6 **INTERVIEWEES BY STATE, ORGANIZATIONS, POSITIONS, AND PROFESSIONAL BACKGROUND.**

Rio de Janeiro				
State	Organization	Position	Form of Interview	Training
RJ	PGE-RJ	PG-16 State Attorney	In person	Law
RJ	JUD/NAT	Federal Judge for the specialized court for health law cases; Coordinator of the CNJ State Committee - RJ	In person	Law
RJ	SES-RJ	Legal Consultant at SESDEC-RJ	In person	Law
RJ	SES-RJ	Coordinator of NAT-JUS RJ	In person	Pharmacy
RJ	SES-RJ	Coordinator of CRLS	In person and phone	Nursing
RJ	PGE-RJ	Chief Attorney of PG16, specialized in health law	In person	Law
RJ	CADJ/SES-RJ	Coordinator of CADJ (Center for Legal Claims), SES-RJ	In person and phone	Law
Rio Grande do Sul				
State	Organization	Position	Form of Interview	Training
RS	PGE-RS	Member of the Superior Council of the State Attorney General's Office, former attorney of NARAS-RS, Capital	Phone	Law
RS	SES-RS	Coordinator of the Legal Counsel Office at SES-RS	Phone	Law
RS	PGE-RS	State Attorney for countryside health dept.	Phone	Law
RS	PGE-RS	State attorney of PGE-RS, one of the coordinators of "+Saúde" Project	Phone	Law
RS	SES-RS	Deputy Coordinator of the Pharmaceutical Assistance Department (CPAF)	In person and phone	Pharmacy

Continue

Santa Catarina				
State	Organization	Position	Form of Interview	Training
SC	SES-SC (COJUR)	Technical Assistant at COJUR-SES/SC	In person	Law
SC	SES-SC (COMAJ)	COMAJ coordinator for 2017 - SES/SC	In person	Law
SC	PGE-SC	Former SES/SC legal adviser until June 2017	In person	Law
SC	SES-SC	COMAJ official, technical team	In person and phone	Nutrition
SC	SES-SC	Director of the Dept. of Pharmaceutical Assistance	In person	Pharmacy
SC	MP-SC	Public Prosecutor Coordinator for the Center of Operational Support in Human Rights and Third Sector	In person	Law
SC	SES-SC	COMAJ official, technical team	In person and phone	Pharmacy
SC	PGE-SC	Chief Attorney for PGE-SC, Criciúma, NARAS Criciúma	Phone	Law
SC	PGE-SC	Public Prosecutor NARAS Team	Phone	Law
São Paulo				
State	Organization	Position	Form of Interview	Training
SP	SES-SP	Former coordinator of CODES	In person	Pharmacist
SP	PGE-SP	Chief Attorney of PJ8, PGE/SP	In person	Law
SP	CODES-SESSP	Coordinator of CODES-SES/SP	In person	Nursing and Law
SP	CODES-SESSP	Technical Director of CODES-SES/SP	In person	Pharmacy
SP	CODES-SESSP	Technical Advisor of CODES/SES-SP	In person	Medicine
SP	PGE-SP	PJ8 Attorney - specialized in health law	In person	Law

Source: Elaborated by the author.

BOX 7 SEMI-STRUCTURED INTERVIEW QUESTIONNAIRE

SEMI-STRUCTURED INTERVIEW QUESTIONNAIRE

* Indicative questions: the script can be adapted according to the interviewee's organization.

About the interviewee

1. What is your position in your organization? How long have you been in that position? What do you do in this job?
2. Could you tell us a little bit about your trajectory? How did you get to the position you are in today?
3. What was your first contact with healthcare lawsuits?
4. What is your perception of healthcare lawsuits? Do lawsuits affect your work? How is that?

About internal processes and workflow

5. How does your organization work?
6. Do you deal with administrative or judicial health proceedings? If so, how?
7. How does your organization respond to lawsuits? Could you give details about the workflow and sectors involved?
8. What are your organization's possible responses to litigation?

About lawsuits

9. Could you give me a general sense of what kinds of lawsuits your agency deals with (if it does)?
10. For the most part, are these individual or collective cases?
11. What treatments are most required? Are they part of SUS lists or clinical protocols?
12. What are the most common diseases in these cases?
13. Does your organization act to comply with court decisions? If so, how? If not, who does?
14. Which sanctions are most often imposed by judges? What are their effects on your organization's functioning?
15. Does your organization struggle to comply with decisions? If so, why?

Inter-organizational interaction

16. Does your agency interact with other organizations in the executive branch? What about the justice system?
17. How does that interaction occur?
18. Is this a formal or informal interaction? Does it occur within any organization or committee?
19. Is there any periodic or systematic information exchange between these agencies?

Source: Elaborated by the author.