

## Does the Colombian Constitutional Court undermine the health system?



*La Salud no es un favor, es un Derecho. Healthcare is a right, not a privilege.*  
Photo: Oisín Prendiville

Is right-to-health litigation a suitable strategy for advancing the right to health, or does it reinforce inequalities and undermine health authorities in their attempts to control costs and set fair priorities? Colombia has the highest number of right-to-health cases in the world. Its experiences illustrate how judicial claims can reflect structural problems of a health system. It also shows how, by exercising oversight and holding governments to their promises and obligations, courts can provide policy makers with evidence to evaluate current policies and to discover structural problems.

### **The Colombian health care system**

Within Latin America, Colombia has one of the highest investment rates in health as a percentage of the GDP. In 1993, an ambitious reform of the health system was adopted. The 1993 Health Act (Law 100) established market competition as a fundamental principle for improving the efficiency and financial security of the health system.

The Colombian Social Security System follows a dual market managed competition model, which means that there is one market for insurance plans and another market for health services. Private and public insurance companies (called EPS - Entidad Promotora de Salud) compete to

sell state-regulated insurance benefit packages (POS) to individual customers. The insurers receive a fixed premium for each insured person in exchange for a guarantee of delivery of the services included in the POS. There are two types of affiliation, each of one is bonded to different benefits package. The contributory scheme (POS-C) is for wage-earners earning more than twice the minimum wage and their families. The rest of the population is covered by the subsidised scheme (POS-S), which has less coverage. The goal of the reform was to progressively unify the two and achieve universal coverage by 2001. This did not happen.

Before the reform, the Colombian health system failed to cover the needs of the population, especially the poor and people in the rural areas. The Social Security system covered 23 per cent of the population while ten per cent had private insurance. In 1993, nearly 60 per cent of those who reported that they suffered from an illness requiring a visit to a health facility did not use these services because they were too expensive. After the reform, coverage increased significantly, especially among the poor. However, equal access to health care for all was still not achieved, and the Colombian health system had failed to secure its economic sustainability.

A rising tide of right-to-health litigation commenced, and between 1999 and 2008 674612 tutelas referring to their constitutional right to health were presented to the courts. The majority of these were claims that patients were being deprived of drugs and treatments

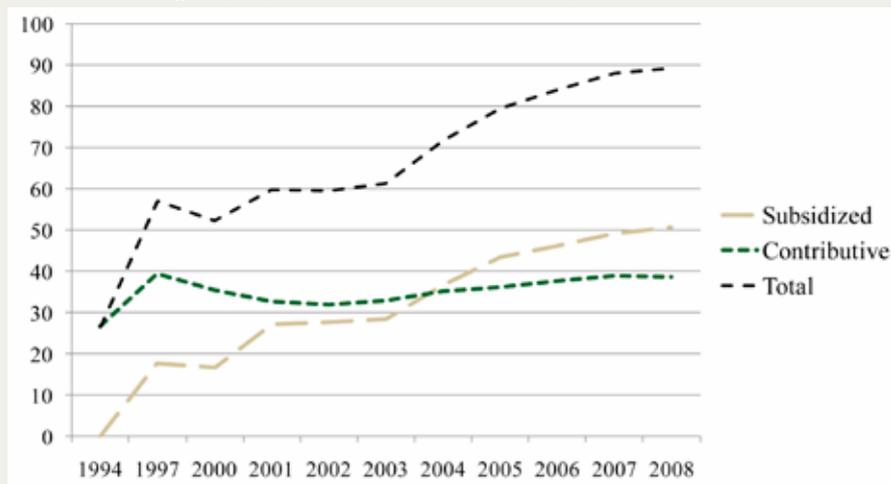
they were entitled to according to the POS. However, a substantial share of the claims were for (often expensive) medication and services not covered by the health plans. Most of these claims were granted, triggering additional state payments to the insurance companies.

**The Colombian Constitutional Court orders a reform of the health system**

Under the context of the staggering number of individual right-to-health claims, the Constitutional Court handed down a ruling in July 2008, ordering the Government to adopt measures to correct the deficiencies in the health care system violating Colombians' right to health (Decision T-760/2008).

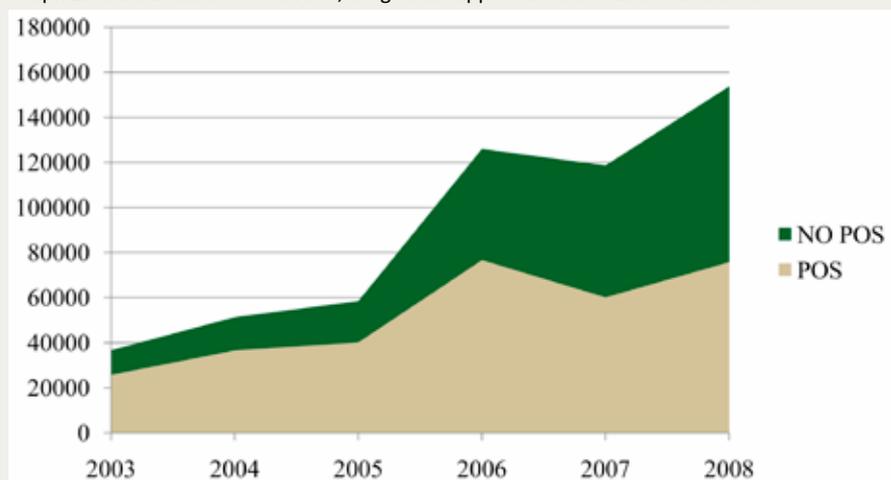
The Court selected and described 22 tutela cases that reflected structural problems in the health care system, and stated that the authorities were violating their constitutional obligations to respect, protect, and fulfill

Graph 1: Percentage of people covered by health insurance by scheme



Source: PAR S and Así Vamos en Salud.

Graph 2: Judicial Claims for services, drugs and supplies included and no included in the POS



Source: Colombian Ombudsman

people's right to health and to secure this right to be effectively enjoyed. In its decision the Court described in detail the regulatory shortcomings of the health system and ordered the government to take steps to overcome them. The Court did not ask for a new Health Act, nor did it specify a particular type of reform. The decision was thus framed within the existing legal framework and constitutional provisions, asking only the government to deliver on its promises. They emphasized that as judges they did not have the power "to tell the responsible authority, specifically, what should be appropriate and necessary to ensure the effective enjoyment of the right". (Colombian Constitutional Court Decisions T-760/2008)

#### Effects of the Court's decision (T-760/2008)

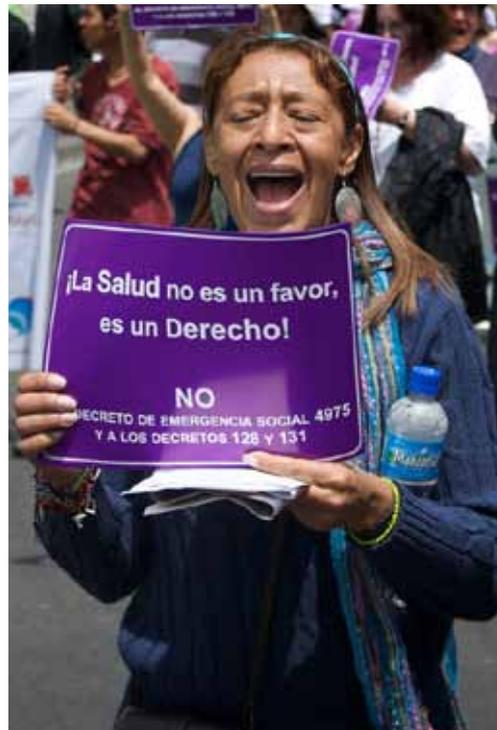
The implementation of the Court's decision is on-going, but some effects are already evident, especially at the level of regulation. However, it is difficult to establish a "clean" causal link to the Court's decision since a broader health policy process was initiated in Colombia subsequent to the Court ruling, influenced by social mobilisation and a new Government. Yet it is fair to argue that to comply with the Court's order, the government was forced to take measures to fulfil its obligations (stated in the Law 100). Decision T-760/2008 was a milestone and a catalyst for the ongoing health policy debate, and should be given considerable credit for its transformative effects.

#### Early reactions to the Court's Decision T-760/2008

One of the first measures adopted by the Colombian Government in order to comply with the ruling was to establish a Regulatory Commission of Health to ensure systematic updating of the health benefit plans in accordance with new medical developments and research.

Instead of addressing the structural problems pointed out by the ruling, the Government decided to limit physician's capacity to prescribe drugs and treatments not included in the POS, as well as people's right to file right-to-health claims (*tutelas*). This was done despite a lack of methodology to guarantee a comprehensive POS updating, and despite a general decrease in health *tutelas* (from 153,730 in 2008 to 150,978 in 2009) and the fact that a larger share of the *tutelas* addressed regulatory failures. *Tutelas* requesting drugs and treatments already included in the health benefit plans rose from 75,774 in 2008 to 103,041 in 2009 (Defensoría del Pueblo de Colombia: 2010)

The public and the associations of health professionals strongly opposed the emergency decrees issued by the government in late 2009/early 2010. One of the arguments against it was the intention to limit the access to health *tutelas*. In April 2010 the Court declared the decrees unconstitutional.



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#### First attempts to correct structural problems: Drug price controls

The Government, in an attempt to control "health system bleeding", initiated regulations to control drug prices. Drug price controls had been almost absent following the 2006 New Price Control regulation, which relied on the competition strategy to control the prices. The result was that drug price in Colombia were much higher than elsewhere in the region.

The first measures attempting to reduce the cost of drugs with a heavy budgetary impact through "parallel import" had limited impact. Pharmaceutical companies already apply sales controls to ensure that their products are marketed through authorized agents in the country.

#### Steps to equity: Unification of child POS and pilot experiences of the unified adult POS

An important aspect of the Court's decision was that all should have the right to the same benefit plan, whether they were in the contributory or subsidized scheme. Since January 2010, in accordance with the Court decision, Colombian children have the right to the same benefit plan.

In 2010, the government initiated two pilot programmes to supply the same POS for adults. These pilot experiences have revealed several shortcomings: the lack of an adequate information system, resource flows and availability of health infrastructure. However, as in the case of the child POS, they represent important steps towards the fulfillment of the State's obligations to equity under Law 100, and by implication towards realization of the right to health.

Project: Right to health through litigation? Can court enforced health rights improve health policy?  
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### **New measures to control the activities of health insurance companies**

In June 2010, Juan Manuel Santos was elected President of Colombia, and Diego Palacio Betancourt left as Minister of Social Protection after seven years in office. The new government was a more attentive one, taking note of the criticism from civil society organizations such as the Colombian Medical Federation. The focus of attention was no longer exclusively on the tutelas. Rather, the authorities started to examine causes related to regulation, oversight and control mechanisms.

### **Examples of fraud and corruption cases uncovered and accepted by the Colombian authorities since 2010:**

- EPS were charging drugs included in the POS as “No POS”. Just for Antihemophilic Factors VIII and IX they irregularly charged an approximate amount of 13,000 million pesos (7.2 million USD) in 2009.
- Public servants were involved in acts of corruption in complicity with officials of some EPS, stealing 4.5 billion pesos (approximately 2.5 billion USD) from the health system

This shift, in line with the approach recommended and ordered by the Court in decision T-760/2008, enabled the Colombian health authorities to discover serious irregularities in the management of the public funds. Even if the Colombian authorities have not yet complied with all the Court’s orders, the measures taken so far have reaffirmed the importance of improving health system regulations and control mechanisms.

The new Government’s approach to the health system crisis looks towards stronger regulation, information systems, control and accountability mechanisms. The regulatory authority budget (Superintendence on Health) is doubled, and the government plans a new National Drug Policy.

### **Conclusions**

The Colombian Constitutional Court has been criticized for ignoring the economic constraints of the Colombian health system in its enforcement of the right to health. Critics argue that the Court jurisprudence and the tutelas destabilise the Colombian health system and create inequalities in resource allocations. While it is too early to conclude, a preliminary analysis of the impact of the health tutelas and the Court’s decision T-760/2008 shows that Colombian authorities were forced to improve oversight mechanisms and the management of the health sector. As a result, extensive corruption and misappropriation of funds were uncovered, and sanctions were imposed.

The analysis also shows the importance of taking the context into account when assessing the effects of courts’ enforcement of the right to health, and in particular the nature of the health system. As the Colombian case shows, what may seem as a negative economic impact of judicial decisions could also be a product of the lack of regulation and control mechanisms in the health system.

The Colombian case illustrates how right-to-health litigation can have positive impacts on a health system. The accountability-role of courts does not imply that they become “policy makers”. Rather, by exercising oversight and holding governments to their promises and obligations, courts can provide a space for policy makers to evaluate current policies and to mend structural problems.