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Judicial Protection of the Right to Health in Colombia: From Social Demands to Individual Claims to Public Debates

By Alicia Ely Yamin* and Oscar Parra-Vera**

I. Introduction

Even in a region characterized by a number of countries with robust constitutions and judicial enforcement of social rights, Colombia stands out as a striking example of judicial activism regarding health rights. Better known outside the region for its brutal fifty-year-old civil conflict, it seems startling if not paradoxical that the Colombian Constitutional Court (the Court) has developed some of the most progressive jurisprudence in the world with respect to economic, social, and cultural rights. The Colombian context indeed presents many contrasts: a long tradition of creating democratic institutions coexists with authoritarianism and alarming levels of political and social violence, and entrenched poverty persists despite years of strong economic growth.1 The extreme social inequality in Colombia is reflected in its health statistics, where national averages mask deep disparities that run along urban

* Joseph H. Flom Fellow on Global Health and Human Rights, Harvard Law School; Adjunct Lecturer, Harvard School of Public Health; and Senior Researcher, Christian Michelsen Institute (Norway).

** Senior Staff Attorney, Inter-American Court of Human Rights and Researcher, Group of Research in Contemporary Political Theory, National University of Colombia.

versus rural divides, as well as racial, ethnic and class lines.²

Nowhere has Colombia’s judicialization of social demands been more striking than in the health domain. According to a report by the Human Rights Ombudsman’s Office of Colombia, between 1999 and 2008, a stunning 674,612 actions for protection of constitutional rights were filed before the courts in relation to health issues; the Court itself has taken more than a thousand health cases since its formation.³ By 2008, it was clear that recourse to the courts had become an essential “escape valve” in a health system that was incapable of regulating itself; but the routinization of judicial intervention had created additional problems.⁴ In July of 2008, the Court issued a sweeping decision aimed at improving the equity and oversight of the health system and, in turn, stemming the tide of litigation.⁵ In that T-760/08 judgment, the Court examined systemic failures in the regulation of the health system, re-asserted the justiciability of the right to health, and called for significant restructuring of the health system based on rights principles.⁶ The extent to which the government will fully comply with the judgment, and the longer term impacts on health equity, are yet to be seen. Nevertheless, the manner in which the Uribe administration has responded to date, provides certain indications about the possibilities of and challenges to improving social justice in health in Colombia through court-centered strategies.

In this article, we first explore what factors led to the extraordinary level of judicial activism in health that Colombia has experienced. We then examine the evolving nature of the Court’s

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⁴ Procuraduría General de la Nación (PGN/Attorney General’s Office) and Centro de Estudios de Derecho, Justicia y Sociedad (Dejusticia), EL DERECHO A LA SALUD EN PERSPECTIVA DE DERECHOS HUMANOS Y EL SISTEMA DE INSPECCIÓN, VIGILANCIA Y CONTROL DEL ESTADO COLOMBIANO EN MATERIA DE QUEJAS EN SALUD (2008) [hereinafter PGN/Dejusticia].


⁶ Id. at sec. 3.
judicial intervention, culminating in Judgment T-760/08, and the impact that judicial intervention has had in terms of financial and policy impacts as well as equity. After describing how the Executive has responded to the T-760/08 judgment thus far, including the issuance of a declaration of emergency with respect to the health system, we offer some preliminary reflections on the potential impact of judicial intervention in terms of promoting the right to health in Colombia.

II. Factors Leading to the Judicialization of Health Rights in Colombia

The story of the Constitutional Court's role in enforcing health rights begins in the early 1990s, amid the conflicting aims of an aspirational Constitution, which enshrined broad social rights and set out a new vision for Colombian society, on the one hand, and a sweeping health sector reform based upon neoliberal principles on the other.7

The reforms implemented through Law 100 in 1993 were premised on the superiority of market-based allocation of health care. However, what Law 100 envisioned was far from an unregulated market. Unlike a normal private insurance scheme, Law 100 set up a hybrid scheme whereby private insurance companies did not set the capitation rates, did not define deductibles or premiums, did not set the content of benefits packages, and did not control whom to insure.8 Further, given the complex array of providers and insurers, the state also had a substantial role to play in regulation. Over time, the contradictions inherent within Law 100 produced fault lines which, together with regulatory failures, led to the crisis in the system.

Under Law 100, a managed care system was coupled with a defined benefits package to be provided under a national insurance scheme (Plan Obligatorio de Salud, or POS) through an individual capitation. Law 100 also introduced a two-tier system of benefits: (a) the contributory regime (POS-C) for those formally employed or earning more than twice the minimum wage; and (b) the subsidized regime (POS-S), which under Law 100 had a capitation set at one-

8. Interview with Juan Manuel Diaz Granados, President, ACEMI, in Bogotá, Colom. (Mar. 24, 2009).
half of that for the contributory regime and included approximately half the benefits.9

Although it has fallen short of the universal coverage called for under Law 100, insurance enrollment has quite steadily increased, as has health spending.10 In 2008, Colombia spent 7.8% of its GDP on the health sector, which is above average for the region, and substantially more than it did in 1993.11 In addition to public expenditure, the system is financed through payroll taxes, and there is a cross-subsidy from the contributory regime to the subsidized regime.12 This reliance on payroll taxes proved to be a fatal flaw in a country where increasingly workers were forced into the informal sector.

Since 1993, Colombia’s health reform has at times been cited as a success story in international circles.13 However, within Colombia

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10. Savedoff, supra note 9. By 2009, close to 90% of the population had health insurance, but the majority of the uninsured remain in rural areas and come from the lowest quintiles.


12. The 12.5% payroll tax, 4% of which is paid by the employee, is among the highest in the region, and is additional to payroll taxes for social security. Further, 1% of payments made within the contributory regime are used as a cross-subsidy for the subsidized regime. FROM FEW TO MANY: TEN YEARS OF HEALTH INSURANCE EXPANSION IN COLOMBIA (Maria-Luisa Escobar, Amanda Glassman, and Ursula Giedion, eds., 2009).

the system established under Law 100 has been criticized by actors from all sides of the political spectrum, both with respect to its original conception and its operation. A basic source of inequity lay in the design of the system itself. That is, although Law 100 called for the two schemes to be unified by 2001, in practice this had not occurred. While those who are able to pay participate in the contributory regime, those who are not are assigned to the subsidized regime, which provides far fewer benefits.

A second fundamental problem lay in the definition of the benefits packages themselves. They lacked clarity, an evidence base, and prioritization mechanisms. Although Law 100 was ostensibly intended to make social choices about health care explicit by establishing a defined benefits program, it left an inordinate number of what have come to be called “gray zones,” where it is unclear whether a given procedure, medication or service is covered. For example, in joint replacement surgery, it is uncertain whether the prosthetic joint is included in coverage for the procedure.

The operation of this system has been plagued by chronic problems as well. For example, when goods and services are not included in the POS, but are nevertheless ordered by a court, the government reimburses the Health Maintenance Organization (HMO) through a solidarity fund (FOSYGA, according to its Spanish acronym). However, such reimbursement has been

14. Indeed, the Court had heard abstract review cases questioning this division before T-760/08, in which it had deferred to the executive and legislature to determine when it would be financially feasible to unify the programs. *See infra* Part V; Boletín Estadístico Sectorial 2005, available at http://www.minproteccionsocial.gov.co/VBeContent/Estadistica/Boletin_Estadistico_2005/1_2%20%20AFILIACION%20C3%93N%20A%20SALUD.pdf (last visited Feb. 14, 2009).


16. *See infra* Part IV.

17. When goods and services are not included in the POS-C, but are nevertheless ordered by a court, a government solidarity and guarantee fund (Fondo de Solidaridad y Garantía, FOSYGA) reimburses the public or private insurance company providing such good or service. When goods and services are not included in the POS-S, but are nevertheless ordered by a court, the state government reimburses the HMOs providing such good or service if it is included in the POS-C. That is, the municipalities and regions cover the difference between the POS-C and the POS-S, if and when a service or medication is ordered through tutela, and the FOSYGA covers anything beyond the POS-C. Reimbursements from FOSYGA have been so inordinately slow that, according to the insurance
inordinately slow. Moreover, despite the existence of multiple oversight bodies, reports by the Human Rights Ombudsman’s Office and the Attorney General’s Office in conjunction with the non-governmental organization DeJuSticia documented virtually no capacity to address complaints in a uniform and systematic manner.

In short, by 2008, when the Court issued its decision in T-760/08, it had become clear that the system was incapable of regulating itself. In 2008 alone, over 142,000 claims of health rights violations were brought to the Colombian courts, and the majority related to goods and services that should have been provided by HMOs pursuant to the POS. As pointed out in the 2008 report from DeJuSticia and the Attorney General’s Office, the failure of systemic oversight left judicial recourse as “the only escape valve.”

A. Socio-political Context

In other contexts, widespread dissatisfaction with the health system would have led to political or social responses. Indeed, despite the state of the health system, the Constitutional Court might not have played the central role in enforcing health rights that

companies, the situation came to threaten their very economic viability. LEY 100. POR LA CUAL SE CREA EL SISTEMA DE SEGURIDAD SOCIAL INTEGRAL Y SE DICTAN OTRAS DISPOSICIONES (1993) (Colom.); LEY 715 (2001) (Colom.).

18. Reimbursements from FOSYGA have been so slow that, according to the insurance companies, the situation came to threaten their very economic viability. At the same time, Governors have indicated that they do not have funds to cover the non-POS care for the subsidized regime. El próximo año podrían desaparecer nueve EPS; Fosyga les debe más de $900.000 millones, EL TIEMPO (Colom.) (Nov. 12, 2009), available at http://www.portafolio.com.co/economia/pais/ARTICULO-WEB-NOTA_INTERIOR_PORTA-6567527.html (last visited Nov. 15, 2009); Interview with Juan Manuel Diaz Granados, supra note 8; see Jorge Correa, En riesgo salud de 3 millones de pobres por destinación de presupuesto a compras no incluidas en el POS, PORTAFOLIO (Colom.) (June 10, 2009), available at http://www.portafolio.com.co/economia/economiahoy/ARTICULO-WEB-NOTA_INTERIOR_PORTA5409214.html (last visited Dec. 15, 2009).


21. See PGN/DeJuSticia, supra note 4, at 147.
it has, but for the crisis in political representation.\textsuperscript{22} The enactment of Law 100 in 1993 has been cited as the paradigm of health reform by “change teams” — reforms that were rushed through the legislative process and defined and implemented by teams of technocrats, insulated from public debate and accountability.\textsuperscript{23} Although the enactment of Law 100 was highly controversial, it was pushed through the legislature shortly before the Christmas holiday and then implemented as quickly as possible through decrees before a change of presidential administration took place just months later. Similarly, despite the presentation of alternative proposals for the health system in 2007 when Law 100 was being reformed, the legislative debate regarding Law 1122 lasted literally only minutes before approval of the executive’s proposal.\textsuperscript{24}

If normal legislative and political channels for complaints regarding health care were blocked, so too were avenues for social mobilization.\textsuperscript{25} The armed conflict that has wracked the country for half a century, coupled with authoritarian repression of dissent, has had particularly devastating effects on the possibilities of social mobilization around health policy. Colombia is an excellent example of Asa Laurell’s insight that it is fallacious that the state “retracts” and merely allows the market to function when neoliberal policies are undertaken.\textsuperscript{26} Laurell argues, “on the contrary, the state plays a decisive and active role in dismantling its former institutions and functions.”\textsuperscript{27} In Colombia, labor leaders and workers in the

\textsuperscript{22} See, e.g., Eduardo Pizarro Leongomez, Giants with Feet of Clay: Political Parties in Colombia, in THE CRISIS OF POLITICAL REPRESENTATION IN THE ANDES 78, 78 (Scott Mainwaring et al., eds., 2006); David Landau, Political Institutions and the Judicial Role in Comparative Constitutional Law, 51 HARV. INT’L L. J. (forthcoming 2010); Rodrigo Uprimny, Judicialization of politics in Colombia: Cases, Merits and Risks, 6 SUR 49 (2007).

\textsuperscript{23} For a definition of change teams and discussion of Law 100 reform, see THOMAS J. BOSSERT, INTERNATIONAL HEALTH SYSTEMS GROUP, METHODOLOGICAL GUIDELINES FOR ENHANCING THE POLITICAL FEASIBILITY OF HEALTH REFORM IN LATIN AMERICA 38, 1 (2000).

\textsuperscript{24} Analysts have pointed to heavy lobbying from the pharmaceutical industry and insurance companies. Interview with Felipe Galvis Castro, human rights lawyer, in Bogotá, Colom. (Mar. 24, 2009).

\textsuperscript{25} Instituto de Estudios Políticos y Relaciones Internacionales, supra note 1, at 11-32.

\textsuperscript{26} Asa Cristina Laurell, Globalización y reforma de estado, in SAUDE, EQUIDADE E GÉNERO: UM DESAFIO AS POLÍTICAS PÚBLICAS 43 (A. M. Costa, E. Mércian-Hamann, & D. Tajer, eds., 2000).

\textsuperscript{27} Id.
health sector have been killed and brutally repressed in the context of the politics of aggressive privatization. Complaints allege that the government has deployed military units as well as death squads to harass dissident health workers and leaders, and to occupy public hospitals slated to be privatized or shut down. At the same time, especially in rural areas, attacks on medical facilities and personnel by illegal armed actors have been common, which has impacted access to care and vaccination in some cases. In some regions, paramilitary groups control and essentially manage the budgets for the subsidized regime, converting healthcare into another domain of so-called “armed patronage.”

At the same time that other avenues of recourse were closed to people with health claims, the legal opportunity structure created by the 1991 Constitution made seeking redress through the Colombian courts extremely appealing. In addition to a broad expansion of

28. For example, the Asociación Nacional de Trabajadores Hospitalarios de Colombia (ANTHOC) has reported that between 1996 and 2007, 132 of its members were killed. Moreover, ANTHOC has reported threats, burglaries, and several instances of arbitrary detention of its members. See Gilberto Martínez Guevara, Asociación Nacional de Trabajadores Hospitalarios de Colombia, ANTHOC ante el genocidio y la liquidación (2008), available at http://www.anthoc.org/index.php?option=com_content&task=view&id=216 (last visited Apr. 8, 2010).

29. Interview with Extrabajadoras and extrabajadores del Instituto Materno Infantil, in Bogotá, Colom. (Mar. 28, 2009).


rights in the 1991 Constitution to include economic and social rights, the Constitution enshrined various structural innovations. Among the most important innovations that explain the extent of intervention by the courts and the Court in particular in health are: (a) the establishment of the Court as a specialized tribunal overseeing a new “constitutional jurisdiction,” which extended to all Colombian judges; (b) the application of constitutional judicial review to specific cases through a protection writ (acción de tutela, or tutela); (c) the extension of abstract reviews of legislation through ex oficio and actio popularis, including the virtual abolition of standing requirements; and (d) reliance on expert opinions and outside evidence sources, including medical and scientific experts.

III. History of Judicial Enforcement of the Right to Health

Departing from the formal jurisprudence of the Supreme Court of Colombia, the Court determined that although not denominated as fundamental rights in the Constitution, social rights could become fundamental — and enforceable — by virtue of their connection to fundamental rights (doctrina de conexidad). That is, “when there is an intimate and inextricable relationship with other fundamental rights,” such that failure to immediately protect the social right would result in the violation these latter fundamental rights, the social right becomes fundamental. Thus, “in the case of health, even though it is not a fundamental right, it acquires this status when not providing care to the ill person would threaten his/her right to life.” A threat to life was interpreted broadly to mean jeopardizing a life of dignity (vida digna).

33. The tutela is analogous to the amparo in many other Latin American countries, but has taken on particularities in Colombia, which have made it pivotal in securing health and other social rights. See Manuel José Cepeda-Espinosa, Judicial Activism in a Violent Context: The Origin, Role and Impact of the Colombian Constitutional Court, 3 WASH. U. GLOBAL STUDIES L. REV. 529, 537 (2004), available at http://law.wustl.edu/wugslr/issues/volume3_spec/p529Cepeda.pdf.

34. Ex oficio review refers to types of norms subject to the Court’s jurisdiction; actio popularis permits reviews of legislation with broad collective effects.

35. Colombian Constitutional Court, Judgment T-406/1992 (tutela used to order sewage system within three months to avoid overflow of black waters because smell and contamination affected “life with dignity”).

36. Id.

In addition to the doctrine of “fundamental rights by virtue of connection,” the jurisprudence of the Court held the right to health enforceable when the case involved a person or group of people in especially vulnerable circumstances. For example, the Court has found special protection for the health rights of the displaced, pregnant women, children, and the elderly, among others.\(^{38}\) Moreover, the right to receive the health care defined in the POS was also considered an autonomous, fundamental right.\(^{39}\)

By finding the right to health enforceable when it was inextricably related not merely to preventing imminent death but to enabling a life of dignity, a wide range of goods and services excluded from the POS were conceded to petitioners.\(^{40}\) For example, the Court has ordered the provision of anti-retroviral drugs and costly cancer medications, treatment for severe psychiatric disorders, and even the financing of treatment of patients abroad when appropriate treatment was unavailable in Colombia.\(^{41}\) Although the great majority of cases resolved only the

\(^{38}\) See, e.g., Colombian Constitutional Court, Judgment T-025/2004 (deplorable conditions and lack of services for displaced persons violated right to health, among other rights, in the context of an “unconstitutional state of affairs”); Colombian Constitutional Court, Judgment T-1081/2001 (intraocular lens and medications related to eye surgery conceded as protecting right to health of elderly person); Colombian Constitutional Court, Judgment SU-225/1998 (meningitis vaccine for children is part of children’s fundamental right to health); Colombian Constitutional Court, Judgment T-850/2002 (sterilization of a disabled woman without provisions for her full informed consent affected her right to health).

\(^{39}\) See, e.g., Colombian Constitutional Court, Judgment T-261/2007 (denial of an intraocular lens in an intraocular lens implant procedure included in the POS violates the fundamental right to health); Colombian Constitutional Court, Judgment T-859/2003 (when there is a doubt about inclusion of a joint for joint replacement surgery under the POS, coverage should be interpreted in line with providing a functional life of dignity).

\(^{40}\) In assessing “medical necessity,” the Constitutional jurisprudence has placed extraordinary importance on the opinion of the attending, and sometimes other, physicians. When determining the patient’s needs for a given medication or service the Court repeatedly characterized the issues as a conflict between the physician, who is presumed to be able to make decisions “based on scientific criteria,” as well as his or her knowledge of the patient, and the HMO that was making decisions based on financial, bureaucratic, or other criteria. See, e.g., Colombian Constitutional Court, Judgment SU-480/1997 (‘unification judgment’ announcing general rule of denial of tutela without recommendation by an attending physician and concession of the same for treatment of HIV with anti-retrovirals with recommendation of attending physician).

\(^{41}\) See, e.g., Colombian Constitutional Court, Judgments T-409/2000 (concession of tutela for treatment of severe depression which included suicide attempts); Colombian Constitutional Court, Judgment SU-819/1999 (minor who suffered from
instant case, the Court’s jurisprudence led to changes in health policies as well. For example, after repeated cases, the state responded by including viral load tests within the POS, as well as other diagnostic tests, such as biopsies, given that treatment for HIV/AIDS and other conditions is dependent upon an accurate diagnosis.42

Not all of the decisions of the Court have had direct financial implications; the Court has also issued judgments where there have been normative and regulatory vacuums.43 Moreover, the jurisprudence of the Court has denied tutelas when attending physicians’ recommendations have not been present, as well as in relation to claims for cosmetic procedures, eyeglasses and certain kinds of eye surgery, fertility treatments, drug and alcohol rehabilitation, certain prosthetics, gastric bypass operations, dental services, and allergy treatments when the underlying allergies do not pose life threatening conditions.44

Nevertheless, the “fundamental rights by virtue of connection” doctrine proved inherently subjective. Penile enlargement and Viagra were conceded by the courts as necessary for a “life of dignity” while fertility treatments for women, a prosthetic leg and oxygen tubes (pipetas de oxígeno) were not.45 HMOs argued that the unpredictable intervention of the courts undermined the stability of

42. See, e.g., Colombian Constitutional Court, Judgment T-500/2007 (fundamental right to diagnosis in case where HMO had classified patient’s skin problem as cosmetic before diagnostic tests were performed); Colombian Constitutional Court, Judgment T-654/2004 (Uprimny, J., concurring).

43. See e.g., Colombian Constitutional Court, Judgment C-463/2008 (when petitioners are forced to seek tutelas for Non-POS care because of arbitrariness or negligence of HMO’s scientific-technical committees, only 50% of reimbursement will be effected). See generally Rodolfo Arango, El derecho a la salud en la jurisprudencia constitucional, TEORÍA CONSTITUCIONAL Y POLÍTICAS PÚBLICAS: BASES CRÍTICAS PARA UNA DISCUSIÓN (Manuel José Cepeda & Eduardo Montealegre eds., 2007; Aquiles Arrieta, Comentarios a la creación de jurisprudencia constitucional: El caso del acceso a los servicios de salud, REVISTA TUTELA, ACCIONES POPULARES Y DE CUMPLIMIENTO 1773-1777 (2002).

44. See Colombian Constitutional Court, Judgment T-760/2008, at sec. 3.5.2 (summarizing all denials).

insurance contracts with patients. Other critics pointed to a perverse alliance between pharmaceutical companies, doctors, and judges in “judicially-stimulated corruption” that led to expensive pharmaceuticals being conceded to patients. For example, some laboratories have provided financial incentives to individual doctors or to HMOs to use brand-name drugs rather than generics.

More recent jurisprudence from the Court has attempted to respond to all of these critiques. Beginning in 2007, the Court progressively abandoned the doctrine of fundamental rights by virtue of connection, considering it “artificial” and erroneous to conceive of certain categories of rights as purely positive and programmatic, given that all rights have positive, programmatic facets to them. In T-760/08 the Court made clear once and for all that it was setting aside the doctrine of fundamental rights by virtue of connection and that, in turn, the doctrine of “special protection for vulnerable groups” was no longer relevant in determining that the right to health was indeed fundamental.

Thus, rather than determining whether the right to health is susceptible to protection through the tutela in a given case, the relevant inquiry became the extent to which aspects of the fundamental rights to health were enforceable immediately and which were subject to progressive realization. The benefits contained within the POS, as well as “other required services” established through jurisprudence, were immediately enforceable. With respect to progressive realization, jurisprudence from the Court has established that although the State can allege a lack of resources to implement a specific obligation, it needs to outline its plan to obtain the necessary resources, and the respective policies that such a plan will entail developing, which should in all cases

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46. Interview with Juan Manuel Diaz Granados, supra note 8.
47. Interview with Oscar Andia, director, Observamed, in Bogotá, Colom. (Mar. 24, 2009).
48. See Medina, supra note 19, at 42-48; Interview with Oscar Andia, supra note 47; Interview with Juan Manuel Diaz Granados, supra note 8.
49. Colombian Constitutional Court, Judgment T-760/2008, at sec. 3.2.5.
50. Id.
51. Contrast this approach to the “reasonableness” approach taken by the Constitutional Court of South Africa. See, e.g., Minister of Health v. Treatment Action Campaign 2002 (5) SA 721 (CC) (unreasonable for government not to extend Nevirapine treatment past 18 pilot sites).
include opportunities for public participation and deliberation.\(^{52}\)

**IV. Context for T-760/08**

Between 1999 and 2008 the number of *tutelas* filed regarding health claims has increased continuously.\(^{53}\) Most of these *tutelas* have been to enforce treatments and services that the insurance companies should have been covering. For example, between 2006 and 2008, 75% of the surgeries, 63% of the exams, 67% of the treatments, and 78% of the procedures sought through *tutela* were all part of what petitioners had a right to under their respective POS-C and POS-S coverage.\(^{54}\) Thus, with respect to the majority of the cases filed, it is misleading to talk about judicial activism. Judges were merely enforcing pre-existing legal obligations, laid out in policies designed and enacted by the political branches of government.\(^{55}\)

Another substantial percentage of the reimbursements from the government solidarity fund, FOSYGA, were due to the so-called "gray zones" in the POS, together with the systematic failure on the part of the HMOs to take into account constitutional jurisprudence that attempted to make those gray zones less gray. For example, the Human Rights Ombudsman’s office documented that in relation to surgeries, between 2006 and 2008, “the principal source of denials are surgeries that require some additional input or added material in order to be realized, such as lenses for cataract surgery, stent implants [for cardiac catheterization], and orthopedic surgeries requiring joint replacements.”\(^{56}\)

Yet, since 2003 the jurisprudence of the Court has been consistent in asserting that materials necessary to carry out a covered procedure should be considered as included within the POS, unless expressly excluded.\(^{57}\) Thus, as pointed out by both the Human Rights Ombudsman’s Office and the Attorney General’s Office in separate reports, the insurance companies have been

\(^{52}\) Colombian Constitutional Court, *Judgment T-595/2002* (addressing plan for needs of disabled in public transport system, including ramps); see also Colombian Constitutional Court, *Judgment T-760/2008*, at sec. 3.3.2.


\(^{54}\) Id. at 64-77.

\(^{55}\) PGN/DeJuSticia, *supra* note 4, at 155-56.

\(^{56}\) Defensoría del Pueblo 2006-08, *supra* note 3.

“double dipping” — charging patients through premiums and charging the government again through reimbursements from FOSYGA. Nevertheless, a number of economists in Colombia have argued that the judicial concession of benefits not explicitly foreseen in the POS financially destabilizes the system.

More fundamental concerns have been raised with respect to the equity impacts of judicial interventions of conceding treatments that could not be universalized. In effect, Colombian courts have been awarding health benefits based on the morally irrelevant criterion of who has access to justice. This inequity has been exacerbated greatly by the fact that those who have historically benefited from the tutelas are the better off classes, who have a greater defined benefits package. Studies carried out by the Human Rights Ombudsman’s Office and the Attorney General’s Office/DeJuSticia indicated that over half of claims have been brought by individuals in the contributory regime. In contrast, fewer than 20% have been brought by individuals in the subsidized regime. Based on the numbers of affiliated persons in the regimes, the Attorney General’s Office/DeJuSticia report calculated that in 2003, rates of the use of tutelas for enforcing health claims were almost six times higher for the contributory regime than the subsidized regime (184/100,000 v. 33/100,000). Moreover, between 2006 and 2008, Bogotá (24.9%), Antioquia (20.1%), Valle (10.1%) y Atlántico (5.4%) — that is, la capital three of the wealthiest departments of the country, represented more than 60% of the tutelas. By contrast, Vaupés, Guainía, Vichada and Chocó, which are among the poorest departments, did not together total even 1% of the tutelas during the period.

In addition to fostering this inequity, some studies indicate that

58. Id.; see also PGN/DeJuSticia supra note 4. Similarly, the Court had repeatedly made it clear that patients could not be denied coverage for catastrophic conditions on account of, e.g., not having paid premiums for a sufficient length of time. See Colombian Constitutional Court, Judgment C-463/2008. Yet, patients continued to have to seek redress through the courts.


60. Colombian Constitutional Court, Judgment T 654 /2004 (Uprimny, J., concurring).

61. PGN/DeJuSticia, supra note 4, at 173.

the funds disbursed by the FOSYGA for non-POS benefits would have been better applied to expand coverage, particularly in the subsidized regime, or fund crucially needed public health measures. As noted earlier, the extreme inequality in Colombia is reflected in its health statistics, where some parts of the country have undergone an epidemiological transition while others continue to face problems relating to basic sanitation and health infrastructure. For example, while 99% of the urban population had access to improved drinking-water sources by 2006 and 86% to adequate sanitation facilities; these numbers were only 71% and 54%, respectively, for the rural population.

In short, by 2008, not only the health system, but the role of the courts in the health system, had come to be highly controversial in Colombia. The structural orders in T-760/08 were a response to the Court’s own diagnosis of the situation.

V. T-760/08: A Landmark in Health Rights Protection or a ‘Hollow Hope’?

In July of 2006, the Court began gathering information from governmental and non-governmental sources, together with illustrative individual cases in order to inform its structural approach to violations in the health system. Aquiles Arrieta, the auxiliary magistrate for Justice Manuel José Cepeda, alluding to Brown v. Board of Education, noted that “we were the NAACP and the Warren Court wrapped into one.”

T-760/08 selected twenty-two tutelas in order to illustrate

63. Diana Pinto and María Isabel Castellanos, Caracterización de los recobros por tutela y medicamentos no incluidos en los planes obligatorios de salud, 3 REVISTA GERENCIA Y POLÍTICAS DE SALUD 56 (2004). According to these authors, approximately 199,000 additional individuals in 2002 and 327,000 additional individuals in 2003 could be insured using the revenues from the contributory regime and their associated administrative costs in 2002 and 2003.


66. PGN/DeJuSticia, supra note 4, at 57.


68. Interview with Aquiles Arrieta, auxiliary magistrate, Colombian Constitutional Court, in Bogotá, Colom. (Mar. 25, 2009).
systemic problems in the health system that have led to the overuse of the *tutela*. The Court did not declare the health system to be in an "unconstitutional state of affairs," as many activists and analysts had recommended.\(^6^9\) However, it did call for a significant restructuring of the health system in addition to resolving the individual cases. The Court asserted this structural approach was necessary because "the organs of government responsible for ... the regulation of the health system have not adopted decisions that guarantee the right to health without having to seek recourse through the *tutela*.\(^7^0\)

Twenty of the twenty-two illustrative cases analyzed under T-760/08 involved principles that the Court has repeatedly established, but that HMOs had failed to assimilate into their policies due to a failure of oversight and regulation.\(^7^1\) The remaining two cases, taken from HMOs, related to reimbursement for services not included in the POS and adjustments in the regulations regarding reimbursements.\(^7^2\)

In one of its structural orders, the judgment directed the Commission on Health Regulation (CRES, by its acronym in Spanish) to immediately and on an annual basis comprehensively update the benefits included in the POS through a process that included "direct and effective participation of the medical community and the users of the health system,"\(^7^3\) in particular those who would be most affected by policy changes.

Law 100 established the aim of unifying the two benefit

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69. According to Manuel José Cepeda, the author of the judgment, a declaration of an unconstitutional state of affairs would have allowed the government a long period to analyze the flaws in the system and come up with proposals to address them, which in this case would have merely led to greater delays. Interview with Manuel José Cepeda Espinosa, former Justice, Colom. Constitutional Court, in Bogotá, Colom. (Mar. 27, 2009).


71. Among those cases were restrictions on access to care stemming from inappropriate transfers of administrative costs to patients and failures to make access effective (e.g., by ignoring transportation needs), as well as restrictions on access to care “necessary for the adequate development of a child” (e.g., cochlear implant), and care for catastrophic conditions. Some cases also addressed the freedom to choose among providers and the process for determining whether a given service was included in the POS. Colombian Constitutional Court, *Judgment T-760/2008*, supra note 44, at sec. 2.

72. Id. at sec. 8.2.

73. Id. at sec. 6.1.
regimes. In 2006, the Court issued a judgment that considered the differentiation in schemes based on ability to pay permissible, but added that the government should, in keeping with its own stated objectives, formulate a plan for unification to occur within a specified time frame.\textsuperscript{74} Citing the government's failure to take any steps toward a unification of plans since the adoption of Law 100, the Court in T-760/08 ordered the CRES to unify the benefit plans (POS-C and POS-S), initially for children and later for adults. The plans were to be unified for adults progressively while taking into account financial sustainability. The process of devising a unification plan was to be participatory, transparent, evidence-based, and inclusive of relevant indicators and benchmarks.\textsuperscript{75}

Furthermore, noting that achieving universal insurance coverage was an established public policy goal under both Law 100 and subsequent legislation, the judgment called on the government to adopt deliberate measures to progressively realize universal coverage and set a 2010 deadline. Additional compliance deadlines were set for 2008 and 2009.\textsuperscript{76}

The Court's decision is notable for, among other things, the explicit adoption of the right to health framework set out by the United Nations Committee on Economic, Social and Cultural Rights (UN ESC Rights Committee).\textsuperscript{77} For example, in keeping with the UN ESC Rights Committee's interpretation of the right to health, the Court: (a) elaborated on the multiple dimensions of state obligations that flow from the right to health, including the role of oversight and regulation of a market-based scheme to protecting the right to health; (b) reiterated that the state is responsible for adopting deliberate measures to achieve progressive realization of the right to health and that retrogression is generally impermissible; and (c) asserted that the right to health calls for transparency and access to information, as well as for evidence-based planning and coverage decisions based on participatory processes.

The Court reiterated that the right to health contains an

\textsuperscript{74} Colombian Constitutional Court, \textit{Judgment C-1032/2006} (finding Constitutional the two-scheme health system under Law 100).
\textsuperscript{75} Colombian Constitutional Court, \textit{Judgment T-760/2008, supra} note 44, at sec. 6.1.
\textsuperscript{76} \textit{Id}.
essential core content or nucleus (nucleo esencial) which should be guaranteed immediately to all persons, as well as other elements subject to progressive realization. In addition to what is defined through the government benefits scheme, care that falls outside the POS can be immediately enforced through tutelas when (a) the lack of the medical service threatens a patient’s minimum level of subsistence (mínimo vital); (b) the service cannot be substituted by one contained within the POS; (c) the patient cannot afford to pay the price of the required treatment or medication and cannot obtain said treatment or medication through any other healthcare regime such as insurance plans provided by employers, pre-paid complementary plans, etc.; and (d) the service has been ordered by an attending physician.78 The Court attempted to establish a minimum core as distinct from any particular set of interventions that might be legislated through the POS. However, other than what had already been excluded, such as cosmetic procedures, the Court did not firmly define the limits of an immediately enforceable right to healthcare.79

Instead, the Court called for a broad public dialogue about the content of the new POS, and by extension the dimensions of the right to healthcare in Colombia. The Court did not assume it knew best what benefits should be included under the POS, nor did it set out ethical grounds for making those determinations. Instead it called upon the CRES to fulfill its legal obligations pursuant to prior legislation. The Court did stipulate that the process might well result in exclusions from the current POS, and that it would prima facie consider that such elimination was not regressive so long as each elimination was justified.80

Although the Court was criticized for its failure to “limit the right to health in a constitutionally permissible and financially sustainable manner,” the justice who authored the opinion, stated in an interview that such a definition of the scope was neither politically practicable, nor appropriate for the Court to undertake.81

78. See Colombian Constitutional Court, Judgment T-760/2008, supra note 44, at sec. 3; see, e.g., Colombian Constitutional Court, Judgment SU-480/1997, supra note 39.

79. Colombian Constitutional Court, Judgment T-760/2008, supra note 44, at sec. 3.5.2.

80. Id. at sec 6.1.1.2.2.

81. For this critique of the Court, see Rodrigo Uprimny and Diana Rodriguez Franco, Aciertos e insuficiencias de la sentencia T-760 de 2008: implicaciones para el
In general, the Court's approach to a remedy can be seen as consistent with theories of "experimentalist regulation" and "dialogical justice." As Charles Sabel and William Simon have written, an experimentalist regulation regime "leaves the parties with a substantial range of discretion as to how to achieve [the goals set out by the court]. At the same time, it specifies both standards and procedures for the measurement of the institution's performance." Although the Court has yet to set out clear standards and procedures for the measurement of the health system's performance, as it did with respect to a previous decision related to internally displaced persons (T-025/04), Roberto Gargarella has described T-760/08 as a positive example of judicial contribution to deliberative democracy. Gargarella argues that the Court strove to ensure that political decisions setting health priorities responded to an exchange of arguments in public forums, rather than to the pressure of interest groups. The Court pushed for consideration of structural problems that the Colombian legislature had not addressed, which consequently resulted in the systematic violation of fundamental rights. Gargarella also supports the Court's call "for public audiences in order to ensure that difficult constitutional problems [such as the scope of the right to health] are properly discussed by all those potentially affected."

T-760/08 can also be seen as consistent with proposals for ethical healthcare priority-setting, such as Norman Daniels's "accountability for reasonableness." Daniels argues that we do not have fine-tuned principles that tell us how to meet health needs fairly - what priority to place on the worst off, etc. - when we cannot meet them all. Therefore, he asserts that we need to fall


85. See generally DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY, supra
back on a fair process, that is (a) transparent, in that the grounds for
decisions are made public; (b) based on relevant reasons (i.e.,
appropriate patient care versus racial or gender stereotypes, etc.); (c)
revisable through some kind of appeals procedure because there
will always be new factors to consider as well as atypical cases; and
(d) enforceable.86 As a general matter, T-760/08 called for just such
processes to define the updated benefits packages as well as the
unified benefits schemes for children and adults.

VI. Implementation of T-760/08

In March of 2009, the Court's composition changed
substantially, partly due to the departure of the justice who drafted
the opinion, Manuel José Cepeda.87 Nevertheless, the new Court
oversaw the implementation of the judgment's complex structural
orders by way of a special "Review Panel." This action
demonstrated a continued commitment to the judgment.

From the outset, however, the Uribe administration resisted
genuine implementation of the T-760/08 judgment. For example, in
August of 2008, shortly after the judgment was issued, Minister of
Social Protection (MSP) Diego Palacio estimated it would cost as
much as Col. 6.5 trillion (approximately U.S. $3.25 billion) to unify

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86. Id.
88. In July of 2009, this special Review Panel issued 16 orders (autos)
requesting information regarding the implementation of the judgment. In some cases, the
Court returned the information proffered by the MSP and clarified that the
responsibility of the Ministry was to provide "qualitative and quantitative
parameters that enable assessments of follow-up on the problems identified. See
Colombian Constitutional Court, Judgment T-760/2008 (July 13, 2009) (Order related
to presentation of quarterly report by the EPS). Other orders warned the MSP
regarding the imminent approach of deadlines set in T-760/2008 and the need to
comply with the judgment or request new deadlines based upon clearly justified
and reasoned arguments and specific plans. A number of the orders sought
information regarding the methodologies being used to implement the judgment,
regarding for example the calculation of the capitation rate for the subsidized
regime, and the process for selecting that methodology. See Colombian
Constitutional Court, Judgment T-760/2008 (July 13, 2009) (Order related to
comprehensive actualization of POS). Still others requested information regarding
the number of tutelas that had been ordered which were related to issues in T-
(Order related to measuring the number of tutelas).
the benefit plans, which he asserted “the State does not have.”

Whether the state has the resources is arguable. Nor has there been any debate about the meaning of scarcity of resources in a country in which military spending is similar or superior to that of education and health combined. However, it may indeed be the case that the unification of benefit schemes is not compatible with the current financing scheme for health insurance, which is based upon payroll taxes. As the Court itself acknowledged in the opinion, the financing system has become increasingly precarious, given the reduction in formal employment. That is, the percentage of insured in the contributory regime has remained relatively stable, but the percentage in the subsidized regime rose from 16% to 53% between 1993 and 2009. Without addressing the underlying trend toward labor flexibilization, universalization will increase payroll taxes on the formal sector for those in the contributory regime, which will likely lead to people transferring to the informal sector and the POS-S, which will again increase payroll taxes on the formal sectors.

In addition to claiming a lack of resources, the government has largely ignored the Court’s emphasis on reasoned public debate. Serious deficiencies in creating a meaningful participatory process

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92. Natalia Millan, FEDESARROLLO, presentation at the University of the Andes (Mar. 25, 2009).


have related to a lack of information and transparency with regard to fora for participation and criteria for decisionmaking, as well as lack of access to public consultations organized by the MSP.95 On repeated occasions, the CRES issued accords immediately before court-set deadlines without substantive input from different stakeholders, and without setting forth meaningful methodologies for its determinations of treatments and services to be included in coverage schemes.96

However, the most telling response of the government to T-760/08 was President Uribe’s "Declaration of a Social Emergency" in December 2009.97 Pursuant to this Declaration, the Executive moved swiftly to issue a series of decrees that circumvented any popular discussion whatsoever. Some of these decrees were aimed at injecting resources into the health system through centralizing reimbursements, eliminating fraud and corruption, and imposing new taxes on beer, cigarettes and gambling.98 Notably, efforts to control costs did not attempt to re-regulate the pharmaceutical industry, which was largely deregulated under President Uribe.99
Nor were emergency powers used to attempt to combat price-fixing and other anti-competitive practices relating to excluding services among HMOs.100

Other decrees limited patients' rights to certain care — in particular specialized care — under the POS, as well access to *tutelas* through the courts.101 The decrees created a technical body to regulate POS and non-POS care, which will determine medical necessity rather than leaving those decisions to attending physicians. Pursuant to the decrees, payments for "exceptional services" — those outside the POS — could only be provided when the petitioner demonstrated an absolute lack of resources.102 Thus, whereas in the past the courts had considered whether paying for a medical service would affect a petitioner's "minimum level of subsistence,"103 under the new decrees pensions and other assets can (and must) be liquidated to pay for medical costs.104

Critics of the Declaration of a State of Emergency asserted that the FOSYGA has close to 5 trillion pesos (approximately U.S. $2.5 billion) invested in public bonds and certificates of deposit, which would be sufficient to cover the debts in the system.105 Others point to the fact that the HMOs, which are among the largest and most profitable businesses in Colombia, are the principal beneficiaries of the emergency decrees while already struggling public hospitals are

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100. *See* A la Supersalud le llegó la hora de ajustar a las Clínicas de EPS, *EL TIEMPO* (Colom.), Apr. 27, 2009; Cuestionan a Saludcoop por uso de recursos, *PORTAFOLIO* (Colom.), July 7, 2009. According to the media, the Superintendencia de Industria y Comercio was investigating the 15 HMOs that constitute the Association of HMOs, ACEMI, in relation to agreements to restrict free competition and to exclude certain services from the POS. *See* Quince EPS en la mira del Gobierno Nacional, *LA LIBERTAD* (Colom.), June 9, 2009.


102. *Id.*

103. *See supra* Part III.


left worse off.\textsuperscript{106}

Criticism of the decrees was not limited to academic fora; they created a furor among patient and medical associations.\textsuperscript{107} By February 2010, mass protests were taking place across Colombia using the slogan “health is not a favor; it’s a right.”\textsuperscript{108} Presidential candidates, academics, members of Congress, and even representatives of the Catholic Church in Colombia publicly denounced the government’s attempts to restrict the right to health.\textsuperscript{109}

In the next few months, the Court will have to take a position on the legality of decrees issued by the Executive. Until now, the Court has merely requested information but has not issued any orders with respect to the emergency decrees.\textsuperscript{110} It is foreseeable that the Court will declare these decrees unconstitutional. The jurisprudence is clear in stating that a state of emergency requires more than an assertion of economic, social or environmental conditions that might disturb public order; it requires a

\begin{itemize}
\item \textsuperscript{110} In particular, they requested “studies or supporting material that led them to conclude that the facts set out in the declaration of emergency surpassed the capacity of existing mechanisms, sanctioning ability and mandate of the system of inspection, regulation and oversight of the health sector.” Congreso y Corte Constitucional revisarán emergencia social, SEMANA (Colom.), Feb. 2, 2010, available at http://www.semana.com/noticias-salud-seguridad-social/congreso-corte-constitucional-revisaran-emergencia-social/134188.aspx (last visited Feb. 13, 2010).
\end{itemize}
demonstration that the emergency does not stem from chronic and foreseeable structural problems, and that normal institutional mechanisms are inadequate to resolve the crisis.111

VII. Implications for Dialogical Justice

Much of the literature regarding the role of the judiciary in the enforcement of social rights places great importance on the process of deliberation set into motion by the courts.112 This public deliberation and the continued scrutiny of public values it entails can shape how we assess justice — and the need for equality — in health and other spheres.113 Yet meaningful deliberative discussion is contingent on the context in which it occurs and what is up for contention.114 As Nancy Frazer has argued about the preconditions for effective participation in other contexts, “it does require the sort of rough equality that is inconsistent with systemically-generated relations of dominance and subordination.”115 Frazer argues that in “stratified societies” — i.e., societies whose basic institutional framework systematically generates unequal social groups — “full parity of participation in public debate and deliberation is not within the reach of possibility.”116

Not only does the Colombian context present extreme social inequalities, but certain interest groups — such as HMOs — are extremely well organized and exercise great economic clout in contrast to unorganized patients who have little or no economic means. Thus, the “rules of the game” for democratic deliberation

111. See, e.g., Colombian Constitutional Court, Judgment C-136/2009 (Feb. 25, 2009) (finding constitutional the declaration of a state of emergency based on the grave and imminent threat to the social order posed by certain unauthorized activities that were using up public resources).


113. Id.


115. Id. at 65.

116. Id. at 66.
about the parameters of the right to health might only be expected to entrench profound imbalances in power. Indeed, during the first fifteen months after the decision, this is exactly what seemed to occur, as the CRES seemed incapable of real implementation and effective oversight of the powerful interest groups.\textsuperscript{117}

Moreover T-760/08, in contrast with the aforementioned structural decision regarding internally displaced persons, was not linked with a strong social movement struggling for implementation of the decision.\textsuperscript{118} Indeed, some members of the national movement for health argued that the decision was not worth supporting because it distracted attention from the structural failings of a health system predicated on the fundamental assumption that healthcare was a commodity rather than a public good.\textsuperscript{119}

However, while the initial implementation of the judgment seemed to entrench rather than destabilize steep asymmetries of power in the Colombian health care context, the government’s declaration of a state of emergency has changed the dynamic for a variety of interest groups, as well as for the legislature and the Court itself.\textsuperscript{120} Indeed, as of this writing, the effect of T-760/08 may well have been to create what Sabel and Simon refer to as “destabilization rights”:

\begin{itemize}
  \item \textsuperscript{120} The state of emergency permits Executive decrees to take effect for a year and afterward, legislative action will be required to enact permanent laws. POLITICAL CONSTITUTION OF COLOMBIA, art. 215 (1991).
\end{itemize}
claims to unsettle and open up public institutions that have chronically failed to meet their obligations and that are substantially insulated from the normal processes of political accountability.... The effect of the court’s initial intervention is to destabilize the parties’ pre-litigation expectations through political, cognitive, and psychological effects that widen the possibilities of experimentalist collaboration.\textsuperscript{121}

That is, for the first time, the right to health is a matter of broad public debate in Colombia and the design and feasibility of the entire health system are being actively discussed. The Executive’s initial inaction has given way to dramatic measures by the Uribe Administration, and crucially, the non-left middle classes and social leaders.\textsuperscript{122} Based on U.S. public law litigation experiences, Sabel and Simon write that after the initial destabilization, “the regimes of standards and monitoring that commonly emerge from remedial negotiation allow this destabilization, and the learning it generates, to continue within narrower channels.”\textsuperscript{123} We will soon see whether this proves to be the case in the Colombian context.

\textbf{VIII. Conclusions}

The judicial protection of programmatic dimensions of the right to health has steadily increased in Colombia since 1992, and jurisprudence regarding the enforceability of the right to health is perhaps the most progressive in the world. Yet the overall trend in judicial activism and the T-760/08 judgment may in fact reinforce the effects of the 1993 health reform, which invested the majority of the health budget in individual insurance, and thereby neglected public health promotion and prevention plans that might have provided a greater benefit to a larger population (see, e.g., vaccination programs). Further empirical investigation is called for to assess what the effects on equity are, and whether the overall

\textsuperscript{121} Sabel & Simon, supra note 82, at 1020.

\textsuperscript{122} Miles de personas protestan en varias ciudades contra la Emergencia Social, El Espectador (Colom.), Feb. 6, 2010, available at http://www.elespectador.com/noticias/salud/articulo186238-miles-de-personas-protestan-vari

\textsuperscript{123} Id.
health system’s infrastructure and workforce, as well as public health promotion, is neglected as a result of policies stemming from the decision.124

Importantly, in T-760/08 the Constitutional Court acknowledged the limitations of individual concession of health benefits and attempted to foster a public dialogue among different actors regarding constitutionally permissible limitations on the right to health that might guide discussions. However, the Colombian healthcare context presented profound challenges for such “dialogical” judicial activism, in that steep social and power inequalities, coupled with low social mobilization around health care, made, and continue to make it extremely difficult for a dialogue to be held on equal terms. Nonetheless, T-760/08 unleashed a dramatic response from the government in the form of a series of emergency decrees relating to health care financing and regulation, which in turn destabilized the interests of some of the formerly insulated institutions within the Colombian health system.

The story of the Constitutional Court’s role in the judicial protection of health rights is not over. As of this writing, it is unclear what the ultimate impact of the T-760/08 decision will be. On February 26, 2010, the Constitutional Court rejected as unconstitutional a referendum law that would have allowed Uribe to attempt to run for a third term as president, thereby promising a new administration and the possibility of a new approach to implementing the right to health.125

If the emergency decrees are held to be unconstitutional, the next administration will have to determine how to respond to the structural orders in T-760/08, as well as the underlying crisis in the health system. In the wake of the government’s emergency decrees, the Colombian public seems, on the one hand, to have suddenly recognized the right to health as a fundamental claim of citizenship under the 1991 Constitution. In the best case scenario, this may open up new spaces for negotiation and produce a highly salutary debate about the kind of health system that Colombian society

124. The Declaration of a State of Emergency called for the prioritization of preventative public health measures but how this would be implemented is entirely unclear.

125. Colombian Constitutional Court, Judgment C-141/2010 (finding unconstitutional legislation that would have allowed a referendum to approve the possibility of a third presidential re-election).
Judicial Protection of the Right to Health in Colombia requires. On the other hand, should the new administration attempt to push through reforms that only nominally address the regulatory, financing and structural defects in the health system, it will surely provoke a continuing institutional crisis. Much will depend upon the level of scrutiny the Court exercises over the degree of implementation of T-760/08, and whether it actively engages with a wide range of citizens through public hearings and follow-up committees (comités de seguimiento), as it has in an earlier structural judgment involving internally displaced people.\footnote{Canadian Constitutional Court, \textit{Judgment T-025/04}.} The coming months will reveal whether and to what extent the Court can facilitate meaningful democratic deliberation about the scope and permissible limitations on a constitutionally recognized right to health in Colombia.