

*Challenges in Implementing the Colombian Constitutional Court's  
Health-Care System Ruling of 2008*

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## Abbreviations

A4R	Accountability for reasonableness
ACEMI	Association of Comprehensive Medicine Companies ( <i>Asociación Colombiana de Empresas de Medicina Integral</i> )
ACHC	Colombian Association of Public and Private Hospitals ( <i>Asociación Colombiana de Clínicas y Hospitales</i> )
CNSSS	National Council on Social Security in Health ( <i>Consejo Nacional de Seguridad Social en Salud</i> )
CR	Contributory regime
CRES	Commission on Health Regulation ( <i>Comisión de Regulación en Salud</i> )
EPS	Health insurers ( <i>Entidades Promotoras de Salud</i> )
ESCR	Economic, social, and cultural rights
FOSYGA	Solidarity and Guarantee Fund ( <i>Fondo de Solidaridad y Garantía</i> )
GDP	Gross domestic product
Gini	Income inequality index
HTA	Health technology assessment
IMF	International Monetary Fund
IPS	Health-care providing institutions ( <i>Instituciones Prestadoras de Servicios</i> )
Law 100	Law 100 of 1993 creating Colombia's comprehensive social security system and other provisions
POS	Colombia's health plan ( <i>Plan Obligatorio de Salud</i> )
POS-C	Health plan of the contributory regime
POS-S	Health plan of the of the subsidized regime
SIDBA	The government of Bogotá's health barriers reporting system
SISBEN	Beneficiary Identification System ( <i>Sistema de Identificación de Beneficiarios</i> )
SR	Subsidized regime
T-760/2008	Judgment T-760 of 2008 of the Constitutional Court
UPC	Fixed premium rate ( <i>Unidad de Pago por Capitación</i> )
UPC-C	Fixed premium rate of the contributory regime

UPC-S	Fixed premium rate of the subsidized regime
UN ESCR Committee	United Nations Committee on Economic, Social and Cultural Rights
WB	World Bank

## ***Scientific Environment***

The thesis is part of the research project “Right to health through litigation?” based at the Chr. Michelsen Institute (CMI) and financed by the Research Council of Norway’s GLOBVAC and FRIMUF programs. It was written at CMI between 2009 and 2012.

The thesis is presented through the Department of Health Promotion and Development (HEMIL), Faculty of Psychology at the University of Bergen. The supervisors are Elisabeth Fosse, professor at HEMIL, and Siri Gloppen, professor in the Department of Comparative Politics, University of Bergen, and researcher at CMI. Their comments throughout the process were key for the development of this thesis. They are also co-authors of article 2.

Members of the research group “Multicultural Venues in Health and Education” at HEMIL; the “Rights and Legal Institutions” cluster at CMI; and colleagues from the research project “Right to health through litigation?” donated their time and expertise by reading, commenting on, and discussing my work throughout the project. Their constructive and positive feedback has been much appreciated.

A concern during the writing of this thesis was how best to disseminate its findings. Articles allow for easier dissemination of the results, but being written in English and published in non-open-access journals creates access barriers to access. Hence, during my fieldwork in Colombia, I looked for alternative avenues for communicating the findings to relevant audiences. I participated in meetings organized at the University of Los Andes and the National University, and sent reports (in Spanish) to the Ethics Committee at the National University of Colombia and to the institutions that had provided information (including the Colombian Constitutional Court). One of the articles that I co-authored for the “Right to health through litigation?” project, which is not included in this thesis, was re-published in Spanish in *Cuadernos del Doctorado*, a journal of the National University. The book that resulted from the research project, in which I am co-author of the Colombia chapter, is currently being translated into Spanish. While I cannot guarantee that these dissemination activities have reached a large number of people, I would like to highlight my awareness of the importance of such spaces for disseminating the results of my work.

## *Acknowledgments*

Many people helped me complete this work. Firstly, I would like to thank the individuals in Colombia who generously took the time to speak with me. This research could not have been conducted without their openness.

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## *Abstract*

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? The answer depends, amongst other, on the nature of the judgments and how they are implemented. The latter is the main focus of this thesis.

The thesis presents an approach for evaluating the implementation of often complex judicial rulings calling for health system reform. Despite major developments providing conceptual clarity on the legal enforcement of economic social and cultural rights (ESCR), research analyzing the implementation processes of these rulings and their actual impact is scarce. Anecdotal evidence points to different conclusions. In some cases, legal enforcement of the right to health has been used to enhance the rights of vulnerable groups who face systematic and structural discrimination in national policies. In others, legal enforcement has been used as a strategy to claim the rights of individuals and groups who are not among society's most vulnerable (Ferraz, 2009).

This thesis aims to contribute to the development of a systematic understanding of the elements that affect the implementation of judicial rulings and how this shapes the effects of the litigation. It is based on an analysis of the implementation process of the Colombian Constitutional Court's decision T-760/2008, which ordered extensive reforms of Colombia's health system (Yamin, Parra-Vera, & Gianella-Malca, 2011).

Colombia has the highest number of right-to-health cases in the world per capita, and the intervention of the country's Constitutional Court has not been beyond criticism.

Taking the effects of right-to-health litigation as my departure point, I focus my analysis on the implementation process of some of the orders of decision T-760/2008, as well as on the contextual factors that influenced how these orders were satisfied by the competent authorities.

The three articles of this thesis address different elements of decision T-760/2008: (i) participatory processes in the implementation of the decision; (ii) the decision's impact on children's access to health care; and (iii) the fairness and legitimacy of the drugs priority setting in health care.

The results from the three articles are examined using an analytical framework for ESCR mobilization developed by a group of scholars linked to the "Right to Health Through Litigation" project of which this thesis forms part (Global Center for the Study of Law and Social Transformation, 2011). Together, the articles illustrate the importance of pre-existing contextual factors in the implementation of court rulings, particularly when it comes to complex judgments such as decision T-760/2008. The articles show how contextual factors have shaped the effects of the decision, and question the Constitutional Court's performance in the monitoring of key principles—most notably, participation—laid down in the decision.

### ***List of Publications***

- Article 1 Gianella-Malca, C. (2013). A Human Rights Based Approach to Participation in Health Reform: Experiences from the Implementation of Constitutional Court Orders in Colombia. *Nordic Journal of Human Rights* ©: forthcoming Vol 31, Issue 1. Published by Universitetsforlaget. All rights reserved.
- Article 2 Gianella-Malca, C., Gloppen, S., & Fosse, E. (2013). Giving effect to children's right to health in Colombia? Analysing the implementation of court decisions ordering health system reform. *Journal of Human Rights Practice* ©: forthcoming 2013. Published by Oxford University Press. All rights reserved.
- Article 3 Gianella-Malca, C., & Norheim, O. F. (2012). A fairer health system? Assessing Colombia's new health benefit packages. Submitted to *Revista Panamericana de Salud Pública/Pan American Journal of Public Health* November 7 2012.



## ***Contents***

Acknowledgments .....	iv
Abstract .....	v
Contents .....	vii
List of Tables .....	vii
Introduction .....	1
1. Background: Litigation of Economic, Social, and Cultural Rights .....	4
1.1 Proposed Framework .....	11
2.1 The Colombian Health System before Decision T-760/2008 .....	17
2.1.1 Colombia's Health System Reform .....	19
2.2 The Colombian Health System after Law 100: Universal Coverage, Solidarity, and Expenditure Effectiveness .....	26
2.3 Litigation of the Right to Health in Colombia .....	35
2.3.1 Constitutional Court Decision T-760/2008 .....	37
3. Research Questions .....	44
4. Methodology .....	45
4.1 Research Approach .....	45
4.2 Design .....	46
4.3 Data Collection .....	48
4.4 Data Analysis .....	52
5. Articles Summary .....	61
6. Discussion .....	66
7. Conclusions .....	73
References .....	76

## ***List of Tables***

<b>Table 1</b> Framework for analyzing the impact of judicial decisions .....	12
<b>Table 2</b> Health <i>tutelas</i> per year 2006–2011 .....	29
<b>Table 3</b> Departments with high transportation expenses as part of out-of-pocket health expenditure .....	31

## ***Introduction***

The expansion of the use of rights mobilization to enforce the right to health, as well as other economic, social, and cultural rights (ESCR),<sup>1</sup> has not led to a corresponding development of a systematic understanding of what affects rights mobilization and how this shapes policy formulation and implementation. This thesis aims to contribute to the development of a systematic understanding of the elements that affect the implementation of judicial rulings and how this shapes the effects of litigation. It does this by analyzing the implementation process of a particular decision from the Colombian Constitutional Court, decision T-760/2008, which ordered Colombian authorities to implement deep reforms to the country's health system. The thesis does not adopt a "for" or "against" position towards the use of legal strategies for rights mobilization. Rather, it aims to explore, describe, and understand the possible positive and negative effects of litigation on the right to health, and the factors that influence these effects.

This thesis is part of a larger project, "Right to health through litigation? Can court-enforced health rights improve health policy and priority setting in poor countries?"<sup>2</sup> Like the overall project, it is based on the premise that health is a matter of social justice; consequently, it does not question whether health should be considered a human right. The analysis is based on the conceptions and components of health outlined in General Comment 14 of the United Nations Committee on Economic, Social and Cultural Rights (UN ESCR Committee)<sup>3</sup> and embraced by the Colombian Constitutional Court in T-760/2008. In its decision, the Court explicitly adopted a "comprehensive human rights approach," as embedded in General Comment 14.

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<sup>1</sup> Such as the right to housing, the right to education, and the right to food.

<sup>2</sup> The project included six case studies: Argentina, Brazil, Colombia, Costa Rica, India, and South Africa.

<sup>3</sup> States that the right to health "...is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health" (Committee on Economic Social and Cultural Rights, 2000).

The thesis is complementary to the work performed for the Colombian case study under the “Right to health through litigation?”. In that case study, our analysis was able to include only a few years (mid-2008 to early 2011) (Gianella-Malca, Parra-Vera, Yamin, & Torres-Tovar, 2009; Yamin, et al., 2011), limiting our ability to perform an in-depth analysis of all elements considered significant for the implementation process. This thesis aims to provide a more inclusive examination of important elements of the implementation process. When we finished collecting data for the “Right to health through litigation?” case study, the Colombian Constitutional Court had not held yet any hearings on the judgment. By end-2012, the Court had organized two such hearings (in July 2011 and May 2012), which allowed different actors to present their views on the implementation process and the state of the health system.<sup>4</sup> These developments, analyzed in this thesis, changed the nature of the process from when our research for the “Right to health through litigation?” study was conducted.

At the same time, the dynamic and open nature of the implementation process of decision T-760/2008 means that this thesis faces similar limitations. Nevertheless, having a moving target as the object of one’s study can also be seen as an opportunity. It is my hope that the analysis provided herein can contribute to the ongoing monitoring of decision T-760/2008.

The first section of this thesis introduces the debate around ESCR litigation and presents an analytical framework for ESCR mobilization, developed by a group of scholars linked to the research team for the “Right to Health Though Litigation” project of which this thesis forms part (Global Center for the Study of Law and Social Transformation, 2011).

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<sup>4</sup> The videos of the public hearings are available at <http://www.corteconstitucional.gov.co/T-760-08/audiencias.php>.

The following section introduces the study context. It aims to provide a comprehensive description of the state of affairs within Colombia's health system at the time of decision T-760/2008, emphasizing elements that have had an impact on the aspects analyzed in this thesis (access to health care, particularly by vulnerable groups; institutional capacity to create a comprehensive and updated health plan; and participation). This includes health system organization, health insurance coverage, and corruption within the health system.

The methodology section describes the methods used in this thesis, including reflections on the role of a researcher in qualitative studies in contexts that are highly polarized. This section is followed by a summary of the articles that make up this thesis.

The thesis concludes with discussion and conclusion sections in which the main results of the three articles are integrated and organized according to the framework and research questions.

## ***1. Background: Litigation of Economic, Social, and Cultural Rights***

In the last decade, legal claims to secure the enjoyment of the right to health and access to health services have become an important phenomenon, including middle- and low-income countries (Gloppen, 2008; Yamin & Gloppen, 2011). This could increase even further once the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights enters into force, as this mechanism would enable individuals to bring cases, communications, and petitions concerning the violation of rights contained in Covenant to the attention of the UN ESCR Committee (United Nations General Assembly, 2008).<sup>5</sup>

This phenomenon of ESCR litigation has developed alongside theoretical attempts to solve the controversies regarding the justiciability, legitimacy, and legality of ESCR enforcement (Langford, 2009), including with regard to the right to health. These efforts have provided legal and philosophical grounds for the litigation of ESCR and the development of jurisprudence in different countries and legal systems, and at different levels (national courts and regional and international mechanisms). They have also “normalized” the use of litigation for the legal enforcement of ESCR. By “normalization,” I mean shared knowledge about the use of litigation as a strategy to force governments to comply with their national and international human rights obligations. There is still no general acceptance of ESCR justiciability. In many countries, ESCR are not justiciable rights, and in some countries where these rights are justiciable, courts are reluctant to intervene in such cases (Langford, 2009).

This thesis will not enter into the debate on whether ESCR should be justiciable, as I consider this question to have been forcefully answered by previous academic writings and Colombian Constitutional Court rulings (see, e.g., Corte Constitucional de Colombia, 2004, 2008;

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<sup>5</sup> Currently, the Optional Protocol is still in the ratification process; once it receives ten ratifications, it will enter into force. As of June 2012, eight countries had ratified the Optional Protocol. A complete list of the countries that had ratified as of this date can be found in Annex 1.1.

Courtis, 2008; Gargarella, Domingo, & Roux, 2006; Gauri & Brinks, 2008; Langford, 2008b). However, in the context of decision T-760/2008, the concerns and skepticism raised by the judicial enforcement of ESCR—particularly regarding the justiciability of the right to health—cannot be ignored, for they have appeared as a reaction to the decision and have influenced its implementation process.

These concerns can be divided into four groups: (i) those addressing the justiciability of ESCR; (ii) those addressing the democratic legitimacy of ESCR justiciability; (iii) those addressing the institutional legitimacy of ESCR justiciability; and (iv) those addressing the outcomes of ESCR justiciability.

*i) Are ESCR justiciable?* The first group of concerns stresses whether the “nature” of ESCR allows for judicial enforcement. Here, the traditional argument is that civil and political rights (such as the rights to vote, to freedom of expression, and to information) generate negative duties for the state. When a court requires respect for civil and political rights, it requires the state to refrain from and curb actions that limit the enjoyment of these rights. For example, in order to guarantee freedom of expression, the state must abolish policies that limit it. In contrast, ESCR (such as the rights to health and to education), generate positive duties for states and, as a consequence, are more resource dependent. For example, the right to education requires states to invest in hiring teachers, buying text-books, and building schools.

This traditional view has been criticized for adopting a narrow understanding of human rights. There is now broad consensus that all human rights involve both positive and negative duties (Courtis, 2008; Langford, 2008a). Guaranteeing the freedom of expression could involve the investment of public funds in the training of public servants or in the creation of ombudsman

offices. Ensuring the right to education could require the state to abolish legislation limiting certain groups' (such as women or undocumented immigrants) access to education.

ii) *Is the justiciability of ESCR legitimate?* This group of concerns stresses the perverse effects that the justiciability of ESCR could have on democratic systems. Under this conception, there is a separation of powers among the different branches of the state: the legislature has the responsibility to make laws, the executive to implement, and the judiciary to apply (Langford, 2008a). When the judiciary enforces ESCR, judges involve themselves in public policymaking, violating this separation of powers. Critics from this camp emphasize that judges do not have the (democratic) legitimacy to decide on policies.

In part the reply here is similar to that argued above: judges intervene in public policies not only in ESCR cases but also in civil and political cases. In a case regarding torture, for example, judges can order the state to implement measures to prevent this type of act from happening again, including by requiring changes at the public policy level. But there is also another aspect to this criticism : Is it true that when deciding cases involving public policies, judges are creating new obligations for the state? Are judges taking over responsibilities from other branches of government?

To address these concerns without underestimating their validity, it is necessary to contextualize ESCR justiciability. Judicial interventions are framed by a country's legal system, which consists of laws (national and international) accepted and adopted by the country. The legal system is the product of political processes, and it reflects societal values. A judge ordering compliance with this legal framework decides based on something that was already approved by the political process but has been systematically neglected. So when

deciding cases that involve ESCR and public policies, judges are reminding the state of its obligations, suggesting that the “judicial recognition and enforcement of such rights might be both effective in inducing better compliance with legal obligations and consistent with our structure of government” (Sabel & Simon, 2004 , p. 1016). In this sense, judges are not creating new obligations for the state.

It could be claimed that when developing new jurisprudence, judges are providing content to a right—new dimensions that were not initially “recognized” by the state—and thus enlarging state obligations. For example, for authorities, the right to health could be restricted to the right to life, without dimensions such as dignity, the quality of health care, and the right to die with dignity. However, when judges include these new dimensions, they are not necessarily enlarging the state’s obligations; rather, their intervention could be interpreted as a mechanism for clarifying the content of the right and, as a consequence, asking the state to pay attention to certain dimensions that it had previously neglected. The process of clarifying the content of rights is also developed within the legal framework recognized by the state.<sup>6</sup>

*iii) Are courts capable of deciding on social policy issues?* One dimension of this concern is that judges are deciding on social policy issues that often require a highly technical understanding. While it is true that many of these issues are complex, when judges intervene in ESCR cases, they are basing their decisions on existing rules within a system, thus limiting their discretion (Courtis, 2008). Nevertheless, it is also true that such regulated frameworks are not always in place. As described above, in ESCR cases, it is common for judges to remind the state to meet obligations that it has systematically neglected (Sabel & Simon,

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<sup>6</sup> For example, Colombian Constitutional Court decision T-760/2008 refers to the UN ESCR Committee’s General Comment 14, which states that the right to health is not merely the right to be healthy; rather, it contains the interrelated and essential elements of availability, accessibility, affordability, and quality of health services.



2004), and therefore judges face the challenge of monitoring the implementation of a policy that does not have a monitoring framework.

Courts have found different ways to deal with these challenges. As in civil and political rights cases, such as those concerning torture, extrajudicial killings, or gender violence, courts require opinions and reports from relevant authorities and experts (Gianella-Malca, 2012; César Rodríguez Garavito, 2010; Staveland, 2010). Certainly, expert opinions can be wrong and lead to inadequate judgments. For example, a doctor might recommend a treatment for a patient that is not the most indicated for the patient's condition. Courts must therefore have access to trustworthy sources that provide alternative opinions.

However, these experts, "reasonable people" can disagree on the best remedy. Furthermore, since ESCR affect people differently and involve different interests, we should expect diverging opinions on for topics such as what should be prioritized and included in a health plan. For some, this predictable disagreement is strong argument in favor for leaving all decisions that address ESCR to politicians. But leaving to the politicians the responsibility to decide over matters that are highly controversial in a society, as the access to health care, does not necessarily provide to the policy the expected legitimacy and sense of fairness, i.e does not guarantee the end of the dispute. These disputes between the different points of view, should be acknowledged, and consequently deliberations should be facilitated and mechanisms put in place to allow the presentation and discussion of these views. The deliberative process would not necessarily achieve a solution that would cover the expectations of the different parties. However, "even losers w(ould) know that their beliefs about what is rights were taken seriously by others" (Daniels, 2008 , p. 116), providing to the solution (such as a new health policy) the required legitimacy and sense of fairness.

Traditional procedural mechanisms such as judicial hearing, do not necessarily allow deliberative processes as the ones referred above. To address this, courts have developed mechanism such as monitoring groups and public hearings, to allow for and prompt dialogue among different actors. The monitoring spaces created by the Colombian Constitutional Court, for example, to follow up on its decision regarding internally displaced people not only acts as an accountability space for governmental actions but also allows different actors to gain a better understanding of problems that the “other” is facing.<sup>7</sup>

iv) *Is the justiciability of ESCR worthwhile?* Most of the scholarship regarding ESCR litigation addresses the concerns mentioned above, bringing conceptual clarity regarding the justiciability of ESCR and the increased use and promotion of legal strategies, such as strategic litigation, to advance the protection of ESCR by local and international actors.<sup>8</sup> The fourth set of critiques has to do with the outcomes of ESCR justiciability, raising doubts about the capacity of this type of intervention to genuinely improve policies (Rosenberg, 1991). These concerns not only highlight the possible perverse effects that judicial intervention can have on the equity of resource distribution; they also stress the need to develop an understanding of what happens after rulings are issued, what the levels of compliance with the court decisions are, whether authorities implement what the court ordered, and which factors could influence the level of compliance and implementation of the rulings.

This thesis primarily responds to this fourth group of concerns. It is not a pioneering work in this area; some scholars have already carried out studies of the implementation of ESCR rulings and on the assessment of their outcomes (e.g., Gauri & Brinks, 2008; César Rodríguez

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<sup>7</sup> Interview with member of the Colombian Constitutional Court, October 2009.

<sup>8</sup> See, e.g., Centro de Estudios Legales y Sociales, 2007; The Global Initiative for Economic Social and Cultural Rights 2012; Women’s Link Worldwide, 2010

Garavito & Rodríguez, 2010; Staveland, 2010; Yamin & Gloppen, 2011). These studies note the complexity of implementation processes and the key role played by contextual factors—such as the political orientation of the government and other political actors, the level of public debate, and social mobilization (see, e.g., Bergallo, 2011; Contesse & Lovera, 2008; Gauri & Brinks, 2008; César Rodríguez Garavito & Rodríguez, 2010).

Rodríguez Garavito distinguishes two main approaches to analyzing the impact of judicial decisions, framed in terms of “the type of effects on which they focus” (César Rodríguez Garavito & Rodríguez, 2010, p. 21). One approach is concentrated on the decision’s direct and observable effects on the target. This is usually measured using a positivist methodology prioritizing quantitative research methods and indicators. Right-to-health litigation has been studied, for example, in terms of impacts on health budgets, on measurable overall access to health care, and on the distribution of health services. The second approach is based on a constructivist perspective of law that presumes that judicial decisions may not only have an impact on their immediate targets but also generate other transformative effects. Decisions can, for example, shape how a problem is perceived in society in ways that have significant long-term consequences (César Rodríguez Garavito & Rodríguez, 2010). Indirect effects are potentially as important as direct effects and need to be included in the impact assessment. This approach combines quantitative and qualitative research methods, measuring direct and material impacts, as well as symbolic effects.

From a constructivist perspective, the implementation of judicial decisions is a process in which different elements interact to generate different effects. Judicial decisions are not linear processes, nor are they implemented in a vacuum, isolated from the context that generated the decision. Hence, health reform processes undertaken as a consequence of judicial decisions

will be influenced by the structures of the health system, which, in turn, are shaped by power relations in society. Consequently, analyses of the impact of judicial decisions should describe and analyze these contextual elements in addition to the various types of effects.

### ***1.1 Proposed Framework***

The framework for the analysis of judicial decisions (and legal strategies more broadly) presented in this thesis, outlined in Table 1 below, is the result of a collaborative effort among a group of scholars linked to the research project of which this thesis forms part (Global Center for the Study of Law and Social Transformation, 2011). Concordant with and complementing analyses by individual members of the group and others (Gauri & Brinks, 2008; McCann, 1992; César Rodríguez Garavito, 2011), the framework integrates the measurement of direct and observable effects of judicial decisions, with attention to transformative effects, such as the shaping of perceptions, that may have a long-term impacts. The framework aims to systematically incorporate key contextual elements into the analysis, building on existing work regarding how responses to judicial orders are influenced by social and political forces.

The framework does not conceptualize the use of legal strategies (such as litigation) as a closed and linear process, but rather encourages a broader understanding of the strategies used by different groups and of how contextual factors fit into the analyses, seeking to identify their various influences. Effects are here understood in terms of changes in goals and values, changes in decision-making processes, and concrete policy outcomes and material changes.

Besides enabling a more comprehensive approach to the type of effects—direct and indirect, symbolic, material, and political—resulting from judicial rulings, the framework contributes

to identifying the most relevant contextual factors influencing the legal enforcement of ESCRs, and understanding the processes resulting from such rulings.

**Table 1: Framework for analyzing the impact of judicial decisions**

Social, institutional, and political causes and challenges lead to ...	legal strategies ...	working through changes in intermediate mechanisms ...	to produce changes in:
	Legal reform	Institutional/organizational	Societal goals and values
	Legal mobilization (including litigation)	Actors and power relations	Decision-making processes
	Judicial decisions	Discourses and ideas	Policy outcomes, material changes in service delivery/uptake, sustainability

To apply this framework, the first step involves describing the context in which the legal strategies are taking place—in other words, analyzing and describing the social, institutional, and political causes and challenges. Another key issue to analyze is the opportunity structure, which “consists of the set of possible avenues for remedying the problem, including internal mechanisms to the health system; political mobilization; media pressure; Ombuds offices — and the courts” (Gloppen, 2008 , p. 27). The analysis of this structure is important because the choice of legal strategy might be influenced by the availability, accessibility, cost, perceived effectiveness, and normative acceptability of the set of possible avenues.

The second step of the framework requires analyzing and describing the legal strategies used by the different actors. The framework classifies various types of legal strategies: *legal reform*, typically top-down processes involving political decision-makers and bureaucrats; *legal mobilization*, typically bottom-up processes in which activists use law and legal arenas—such as litigation, “rights talk,” or advocacy directed at legal reform processes—in pursuit of social change, or individuals bring cases for private benefit without broader aims; and *court decisions*, which is the focus here, involving judges as central actors.

Legal strategies also generate different types of duties. Gauri and Brinks (2008) describe three types of duties produced by ESCR litigation: provisions (impose a duty on the state to provide a service to the claimant/recipients); regulations (create or remove regulation to facilitate the enjoyment of ESCR); and obligations (enforce private obligations established either in the regulatory framework or in the contracts between claimants/recipients and the providers).

In addition to the type of legal strategies and duties that these generate, it is also important to analyze the claimants (e.g., whether they are individuals, organizations, or corporations, and whether they are assisted by private or public interest lawyers), which legal strategies and arguments they use, and what remedies they seek.

The use of legal strategies is not a static and isolated process and another element to consider is whether the actors (claimants, defendants and courts) change their arguments over time.

To use an example from Colombia, a topic where the Constitutional Court has gradually changed its jurisprudence is access to safe abortion. In 1994, the Court upheld the criminalization of abortion, stating that legal existence starts at birth, but life starts at conception (Corte Constitucional de Colombia, 1994). By 1997, it allowed for abortion when a pregnancy is the result of a violent act, and in 2001 it held that a woman who becomes pregnant as a result of rape cannot be required to carry the pregnancy to term against her will (La mesa por la vida y la salud de las Mujeres, 2009). This judgment introduced a new aspect: the need to consider the effect of an unwanted pregnancy on the woman.

Over the years, the abortion debate intensified and the composition of the Court changed. In a 2006 landmark decision, the Court extended the grounds for legal abortion to three circumstances: when the continuation of pregnancy presents a risk to the life or health

(physical or mental) of the woman; when the pregnancy is the result of a criminal act of rape, incest, unwanted artificial insemination or implantation of a fertilized ovule; and when grave fetal malformation makes life outside the womb unviable (Corte Constitucional de Colombia, 2006).

The third step of the framework involves analyzing how these different legal strategies are working and what kinds of changes they produce. Regardless of the type of legal strategy, the framework suggests that in order to understand the impact, we must look for the *intermediary mechanisms* through which the strategy becomes operative. These may be at different levels: (i) institutional/organizational; (ii) actors and power relations; and (iii) discourses and ideas. At each of these levels, the effect could differ in “quality” (direct and indirect).

Direct changes refer to those changes produced in response to requirements from the legal strategies. At the institutional level, for example, if a court decision specifically requires improving the quality assurance system for health services, a direct effect would be the creation of a health quality-assurance body. At the power-relations level, if the claimants requested changes in the health priority-setting process that embrace the effective participation of affected sectors of society that are marginalized from the priority-setting process, a direct effect would be the establishment of effective participatory mechanisms guaranteeing the contribution of those traditionally excluded. Direct effects at the level of discourse and ideas refer to “ideological alterations with respect to the problems posed by the case” (César Rodríguez Garavito, 2011 , p. 1680). This could be reflected in how a problem is framed in public discourses and official documents—for example if, after a ruling on access to abortion, the government or the public starts referring to the right to safe abortion.

Indirect effects are those changes produced in the context of a decision's implementation but that were not specifically stipulated in the judgment. These changes derive from the legal strategies and affect not only the parties in the case but also other social actors (César Rodríguez Garavito, 2011; César Rodríguez Garavito & Rodríguez, 2010). Indirect effects could encompass a range of changes, such as the creation of policies or regulations to avoid similar cases in the future; changes in who is perceived as a key actor or reliable source of information; and the "routinization," or accumulation, of cases clustering around certain types of demands (Bergallo, 2011). Routinization could be as sign of inertia where the causes of the problems addressed by the legal strategies are not resolved – or of a perverse barrier effect whereby claimants' demands are not addressed unless they resort to a legal strategy—for example, providers of health services not providing treatment for costly diseases unless they are forced to through legal action.

The last step of the framework requires us to consider the effects of the measures resulting from the legal strategies (such as new laws, regulations, and judicial decisions) to answer a key question: does the implementation of these measures effectively correct the problems addressed by the legal strategy? This is a critical aspect. The framework can help us in analyzing the form and level of impact of the different measures and whether the expected effects of the measures at the level of intermediary mechanisms are achieved. It also provides a better understanding of the contextual factors that influence the implementation of the legal strategies and allows us to analyze the level of governmental commitment to human rights. To continue with the example of access to abortion, let us assume that, as a consequence of legal mobilization, access to safe abortion is recognized as a sexual and reproductive right. In addition to considering the legal context regarding abortion (step one), evaluating the legal strategies used by groups for and against the recognition of access to safe abortion services as



a sexual and reproductive right (step two), and analyzing the legislation, arguments, and discourses adopted to defend the right to access such services, as well as technical documents, such as clinical guidelines (step three), we must also assess the effects at various levels: (i) actual access to safe abortion (whether there are any barriers to accessing such services); (ii) measures taken by the government to implement relevant laws and regulations (e.g., budget allocations and training of health personnel); and (iii) measures taken to prevent and combat barriers to accessing safe abortion (e.g., supervision at health facilities and the use of sanctions against those who create barriers).

Thus, it is necessary to consider a wide range of evidence in order to establish whether the measures adopted to address the problems raised by the legal strategy in fact produced the desired outcomes. As in the analysis of intermediate mechanisms (step three), the effects resulting from the legal strategies are differentiated by their “quality” (whether direct or indirect) and by the “level” at which they take place (whether at the level of societal goals and values, decision-making and power relations, policy outcomes, or service delivery).

The case of access to safe abortion in Colombia, mentioned above, shows the major role played by political actors and ideologies. Decision C-355/2006 has not been enough to erode resistance among the political branches of government and health-care providers. Since the decision was handed down, both the Council of State and the Attorney General’s Office have issued regulations creating barriers to access safe abortion (see, e.g., Procuraduría General de la Nación, 2010). Providers have documented situations in which girls and women have been unable to access to safe abortion, despite fulfilling the criteria (Corte Constitucional de Colombia, 2011b; La Mesa por la Vida y la Salud de las Mujeres, 2011).

## ***2. Study Context***

This section describes the main structural characteristics of the Colombian health system, as well as the social, institutional, and political dynamics that operate within it. Since the aim of this section is to describe the context for the legal strategy (decision T-760/2008), the information is organized within the framework of Colombian national regulations and law.

This section also aims to provide a more comprehensive background to the articles that constitute this thesis. Through its analysis of contextual factors, the thesis stresses the role that social determinants of health play in the enjoyment of the right to health, as recognized by international agreements and Colombian legislation. The social determinants of health are affected by the distribution of power, income, goods, and services (Commission on Social Determinants of Health, 2008). Power in this context implies more than the power to decide when to visit health services; it also entails power dynamics within the health system that affect relations between different actors, from the individual level to the institutional level.

### ***2.1 The Colombian Health System before Decision T-760/2008***

Colombia is a middle-income country. Like other countries in the region, it exhibits great contrasts. Despite its economic growth—between 2006 and 2009, Colombia advanced five places in the United Nations Development Programme’s Human Development Index—it is also one of the most inequitable countries in Latin America and the world, with a Gini index of 58.5 (UNDP, 2011).<sup>9</sup>

These inequalities are reflected not only in income distribution but also in Colombian daily life and social relations. Ethnic groups and Afro-Colombian populations are victims of

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<sup>9</sup> The Gini index assesses the deviation of the distribution of income among individuals or households within a country. A value of 0 represents absolute equality and 100 absolute inequality. Colombia’s neighbors have the following rankings: Argentina, 45.8; Brazil, 53.9; Bolivia, 57.3; Ecuador, 49; Peru, 48; and Venezuela, 43.5.

structural inequities that have been neglected by Colombian authorities. Despite a constitutional framework that addresses the formal and material dimensions of equity, the development of cultural diversity, and the rights of indigenous populations, the actual enforcement of this legal framework is weak. Furthermore, Afro-Colombians enjoy very few legal frameworks granting them specific rights. Departments with higher concentrations of ethnic groups and Afro populations, such as Chocó, demonstrate serious deficiencies in the provision of health care, including lack of health services, lower insurance coverage, and poor health indicators (Observatorio de Discriminación Racial, Universidad de los Andes-Programa de Justicia Global, Comisión Colombiana de Juristas, Autoridad Nacional de Gobierno Indígena ONIC, & Proceso de Comunidades Negras, 2009). This inequity is critical in the context of ESCR litigation. As some scholars have pointed out, against such a backdrop, litigation strategies have been used to force Latin American governments to fulfill their promises and obligations to protect ESCR (Couso, 2006; César Rodríguez Garavito, 2011).

Another key characteristic of the Colombian context that has an effect at different levels is the country's ongoing internal conflict. Since the 1940s, Colombia has experienced an internal armed conflict with different manifestations and varying degrees of intensity. It has the second-highest number of internally displaced people in the world—approximately 5,200,000 in 2010 (Internal Displacement Monitoring Centre, 2011). This protracted conflict involves different actors: guerrilla groups, violent groups linked with the narcotics trade, paramilitaries, new armed groups emerging after the demobilization of paramilitaries, and state forces. However, throughout most of this period, the country has experienced a level of political stability (e.g., regular elections) and economic stability.

### ***2.1.1 Colombia's Health System Reform***

In 1993 Colombia undertook an extensive reform of the health system. This reform process is worth considering as it influenced subsequent debates on health reform, public trust and participation in policy processes, topics that are of main interest of this thesis work.

The 1993 health reform took place in a political context marked by deep economic crisis, internal conflict, and drug violence. The graveness of the situation led to a broad debate on the reforms needed to strengthen democracy and achieve peace in the country. The 1991 Constitution, and the reforms it called for were infused by the spirit of these debates, and a political vision that saw the recognition of social rights as part of the solution.

However, the health system reform was also influenced by the structural adjustments reforms promoted by multilateral financial institutions, such as the International Monetary Fund (IMF) and the World Bank (WB). At the end of the 1980s and the beginning of the 1990s, most Latin American countries faced economic crises. Governments were compelled to seek loans from multilateral financial institutions, to balance their payments. As part of the conditions of these loans, the IMF and WB required the governments to undergo structural adjustments to reduce their public debts, which were seen as partly to blame for the crises. These structural adjustments were rooted in neoliberal ideologies that required a restructuring of the state.

The restructuring promoted in Latin America followed a “liberal individualist” conception. According to this view, the market is a central instrument of social coordination, and state intervention should be kept to a minimum (Rodrigo Uprimny, Rodríguez Garavito, & García Villegas, 2006). State-owned enterprises are perceived as inefficient compared to the private sector. Consequently, creating a more efficient state (in order to prevent economic crises from

reoccurring) requires reducing the government's role, particularly through the privatization of state-owned enterprises (Homedes & Ugalde, 2005).

Colombia was not isolated from the regional “modernization” trend and the liberal ideologies were incorporated into the state's organization. It was this context that, in 1993, the Colombian government implemented a deep reform of the country's health-care system through the adoption of Law 100. Until this time, Colombia's health-care system had not managed to cover the needs of the population, especially those from the poorest sectors. Insurance coverage was minimal: social security covered 23 percent of the population, and private insurers covered 10 percent, concentrated mostly in urban areas. In 1993, nearly 60 percent of those who reported an illness requiring a visit to a health facility did not visit a facility because of the associated costs (Escobar, Giedion, Giuffrida, & Glassman, 2009).

Colombia's reform was led by a “change team” of professionals working under the leadership of Minister of Health Juan Luis Londoño. This team has been portrayed as consisting of members of the Colombian “policy elite” who were free of loyalties to particular groups and who based their legitimacy on technical and professional credentials. They were supported by the president and the governmental team responsible for implementing the structural reforms towards economic liberalization (González- Rossetti & Ramírez, 2000). Thus, although the change team perceived its role as entirely apolitical, it was a political actor that implemented political decisions according to the ongoing reforms. Its approach to the reform of Colombia's health system was neither universal nor value-neutral—it followed the neoliberal principles of the structural reforms adopted by the government and promoted by the IMF and WB.

The change team rallied support for the reform through alliances with legislators and key actors within the health system (Bossert et al., 1998). The health reform was for months subject to heated debates in Congress, but some see this as a mere formality designed to legitimate the real decisions – which were negotiated in closed spaces by the Executive and a small group of powerful actors (González- Rossetti & Ramírez, 2000). Fearing changes to the reform process by the newly elected presidential administration, promoters of the reform decided to hasten its approval. Law 100 “was pushed through the legislature shortly before the Christmas holiday and implemented as quickly as possible through decrees” (Yamin & Parra-Vera, 2010 , p.107). In seven months, the change team issued at least 25 regulatory decrees to entrench the reform. The decrees did not require Congressional approval were prepared in an almost secretive manner, and favoured the segmentation and creation of private organisations in the health system (González- Rossetti & Ramírez, 2000). The reluctance to debate the decrees created tension and discomfort towards the reform.

The objective of Colombia’s health system reform was to “improve equity through extending the coverage, facilitating access to health care and providing cross-subsidy mechanisms for the poor” (Bossert, et al., 1998 , p. 67). Its key principles were universal coverage, efficiency, and solidarity. The reform was financed through a combination of payroll contributions and general taxation. Users also have to pay co-payments at the point of service.

Law 100 created two types of insurance regimes: a contributory regime for formal workers earning more than twice the minimum wage and their families, and a subsidized regime for the population unable to pay. People covered by the subsidized regime are identified by a proxy means test called SISBEN (*Sistema de Identificación de Beneficiarios*, or Beneficiary

Identification System). This survey, which is performed by the local governments, assigns a poverty index score to each household. Households classified as poor must be included in the subsidized regime. Special regimes were also created for members of the armed forces, police, teachers, oil company workers, and pensioners (article 279). The two POSs (POS-S, for the subsidized regime, and POS-C, for the contributory regime) were initially designed by separate teams, following different criteria. The health plans differed in coverage and services. The contributory regime plan included approximately 60 percent more services than the plan from the subsidized regime (Yepes, Ramírez, Sánchez, Ramírez, & Jaramillo, 2010). Under Law 100, the regimes were to be progressively unified by 2001, but this goal was not achieved.<sup>10</sup> In addition, all citizens have the right to receive a public health intervention package, financed by a separate fund and administered by the local governments (Escobar, et al., 2009; Laurell & Herrera-Ronquillo, 2010).

The differences between the two regimes' coverage reflect an understanding of who is contributing to the system. People from the contributory regime are defined as “direct contributors” (through mandatory discounts to their salaries), while people from the subsidized regime are defined as “subsidized by the state”—for them, health is a “benefit” that the state provides. That they are also contributing through general taxes disappears from sight, what matter is that they are receiving a state subsidy. This approach does not reflect the idea of health as an acquired right and expression of citizenship (Hernández, 2010).

To improve the quality and efficiency of the health sector a dual-market “managed competition” model was adopted, consisting of an insurance plan market (private and public) and a health services providers market (Pinto & Hsiao, 2007). Under this model, individuals

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<sup>10</sup> As a response to Decision T-760/2008, by 2012 the plans were unified (Comisión de Regulación en Salud, 2010, 2011b, 2012a)

enroll with insurers (*Entidades Promotoras de Salud*, or EPSs) and have the right to a state-regulated health plan (*Plan Obligatorio de Salud*, or POS). To realize the expected positive effect of competition on the quality of these services, people in both schemes must be allowed to select their EPS. There are two types of fixed premium rates (UPC, for its Spanish acronym) that differ in monetary value<sup>11</sup> and structure. The UPC for the contributory regime was defined as a per capita tax adjusted by age and sex that functions as an “insurance premium” (independent of income) (Yepes, et al., 2010). The UPC for the subsidized regime did not have age or sex adjustment, but a percentage was added in the case of remote areas.<sup>12</sup>

Health care is provided by a mix of public and private institutions. The EPSs can provide services directly through their own provider network (vertical integration) or from public providers (*Empresas Sociales del Estado*) or private enterprises (*Instituciones Prestadoras de Servicios*, or IPSs). In the case of the subsidized regime, the law required that a mandatory percentage of the services be purchased within the network of public hospitals at the insured individual’s place of residence. For the contributory regime, EPSs can contract all of their services with private institutions. The health system’s resources are administered through the Solidarity and Guarantee Fund (*Fondo de Solidaridad y Garantía*, or FOSYGA), which finances and compensate entities in the distinct regimes.<sup>13</sup> By 2008, when the court issued decision T-760/2008, EPSs were allowed to purchase health-care services under three types of contracts (Decree 4747 of 2007).<sup>14</sup>

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<sup>11</sup> In 2007, the UPC-C was equivalent to US\$207 and the UPC-S to US\$117 (Escobar, et al., 2009 , p. 5).

<sup>12</sup> Such as some cities in the departments of Amazonas, Arauca, Casanare, Caquetá, Chocó, Guajira, Guainía, Guaviare, Meta, Putumayo, San Andrés, Providencia, Sucre, Vaupés, and Vichada Uraba .

<sup>13</sup> See Annex 1.2 for a graphic explanation of the Structure of the Colombian Health-Care System by 2008.

<sup>14</sup> The first type, *capitation*, consists of a fixed amount of per insured. The amount, services, and length of the contract is pre-negotiated by the EPS and the provider. In the second type, *event*, the payment is defined by the services and drugs provided to the insured in a certain period; often, the provision of services requires authorization from the EPS. In the third type, *case-by-case package of services provided by diagnoses*, groups of services are provided in response to a medical event or medical diagnosis. The payments are made on the basis of pre-agreed fares (Procuraduría General de la Nación, Agencia de Estados Unidos para el Desarrollo Internacional, & Centro de Proyectos para el Desarrollo – Cendex, 2012 , p. 15).



Law 10 from 1990, which was an antecedent for the 1993 health-care reform, recognizes the right of citizens and the community to participate in the assessment, formulation, and preparation of plans, programs, and projects; decision-making; and administration and management of health services (article 3). Social participation is also recognized in Law 100 as one of the guiding principles of public health-care services; article 153 calls for social participation in the organization and control of the institutions that are part of the health-care system, as well as in the system as a whole.

The reality, however, did not live up to these commitments. Regulations in practice limited citizens' participation to the client-provider relationship. The legal framework ordered the creation of citizen oversight committees and associations of users at the insurance companies, but in the case of community participation, the regulations stressed its local scope (see, e.g., Presidencia de la República de Colombia, 1994). At the national level, Law 100 created the National Council on Social Security in Health (CNSSS), responsible for making national-level decisions regarding the health-care system, such as what to include in the insurance benefit package. The CNSSS was composed of representatives of the state (presided over by the Ministry of Social Protection) and representatives of specific sectors (such as EPSs, providers, and unions). However, the CNSSS allowed only for limited participation of health-care users (Giedion, Panopoulou, & Gómez-Fraga, 2009). Furthermore, these various groups had unequal capacities to organize and participate at CNSSS sessions. Certain actors, such as the groups of EPSs represented by the Association of Integral Medicine Companies, and the Colombian Association of Hospitals and Clinics, enjoyed greater economic and human resources, including the ability to prepare technical studies to defend their proposals. Other

groups, such as pensioners, did not have the same capacity, and their arguments were often rejected for the lack of technical evidence.<sup>15</sup>

Implementation of the extensive health reform required by Law 100 has not been an easy task. More than 1,000 legal provisions have been approved to regulate and fix some of its “problems” (*Intervention of Senator Dr. Jorge Enrique Robledo Castillo. Audiencia Pública de Rendición de Cuentas en Salud. Bogotá, 2011*).

The reform was designed to achieve universal coverage and progressive equalization of the health plans, and to guarantee the economic sustainability of the system. These aims were conditioned on an increase in, and effective use of, health sector resources. The increase in economic resources was to be achieved through governmental allocations and a rise in contributions from the contributory regime (workers under the payroll regime and independent workers earning more than twice the minimum wage). But contributions from citizens with formal employment did not achieve their projected levels.<sup>16</sup> The financing model required that 70 percent of the Colombian population, including 85 percent of independent workers, needed to join the contributory regime—a target that, by 2008, had not been achieved (Barón, 2007; Clavijo, 2009; A. Gaviria, Medina, & Mejia, 2006; Guerrero, 2008).<sup>17</sup> At the same time Colombia’s health expenditure increased dramatically. Total health expenditure is composed of direct public expenditure (in Colombia, by the Ministry of Social Protection and local authorities), social security expenditure (contributions from the contributory regime), and private expenditure (private insurance and out-of-pocket expenditures). Between 1993 and 2003, total health expenditure as a percentage of GDP grew

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<sup>15</sup> Interview with former staff member of the Ministry of Social Protection, and CNSS November 2009.

<sup>16</sup> These contributions come in the form of mandatory discounts to payroll (since 2007, 8.5 percent is to be paid by the employer and 4 percent by the employee) or direct deductions to the income (12.5 percent) of independent/self-employed workers.

<sup>17</sup> As of December 2012, this goal had not been reached.

from 6.2 to 7.8, and direct public health expenditure grew from 1.4 percent to 3.1 (Barón, 2007). By 2008, the total health expenditure was 5.9 percent of GDP (Guerrero, Gallego, Becerril-Montekio, & Vásquez, 2011).

Law 100 (article 162) required that Colombia's health plan be designed and adapted to accommodate changes in the country's demographics, epidemiological profile, available technology, and financial conditions of the health system. However, no system for a regular and systematic review of the POSs was established. Despite the lack of a mechanism for a regular revision of the POSs, there were modifications (see Annex 1.3), but these did not follow a clear rationality, and did not lead to equalization of the POSs for the subsidized and contributory regime. In general, the inclusions focused largely on treatments for high-cost diseases, particularly HIV/AIDS and chronic renal failure. Scholars have argued that the modifications of the POS-S did not involve a comprehensive analysis of the needs and that it would have been better if they had started by, including the most important services from the POS-C (i.e., those with a higher demand) and then include more specialized treatments (Giedion, Panopoulou, et al., 2009).

## ***2.2 The Colombian Health System after Law 100: Universal Coverage, Solidarity, and Expenditure Effectiveness***

Based on this outline above of the main characteristics of the health system introduced by Law 100, this section assesses the health system's performance in terms of the principles set forth by Law 100: universal coverage, solidarity, and efficiency.

This thesis adopts a broad approach to health systems reform based on an understanding of the health system as a core social institution similar to the judicial system or the democratic

political system (Freedman, 2006; Freedman et al., 2005; Hunt & Backman, 2008; Yamin & Norheim, 2010). In this sense, health systems are not only providers of health and health care but also a vital part of the social fabric—structures where societal values and norms are communicated and reinforced. These societal values and norms influence how health systems are designed, as well as how the outcomes of health policies and interventions are assessed. Thus, the selection of criteria and indicators to assess the performance and outcomes of health systems and health interventions is contentious and embedded in normative judgments and moral considerations that are not value-neutral and that are often not explicitly presented by the literature (Harper et al., 2010).

This section presents an assessment of the reform based on its stated aims. It does not focus on health outcomes indicators—not because they are unimportant, but health outcomes are influenced by additional factors other than access to health care. It is difficult to extrapolate the impact of insurance coverage on a population's health conditions, and attempts in Colombia to measure the impact of insurance status on health status have been inconclusive (Agudelo, Cardona, Ortega, & Robledo, 2011; Giedion, Díaz, Alfonso, & Savedoff, 2009).

### *Universal Coverage*

One of the most publicized outcomes of the Colombian health reform has been the increase in social security coverage (see, e.g., Glassman, Escobar, Giuffrida, & Giedion, 2009; Pinto & Hsiao, 2007; Savedoff, 2000). Different studies have shown that although universal coverage was not achieved by 2001, as was the aim of Law 100, coverage increased progressively, especially in the subsidized regime. According to the quality-of-life survey, by 2008, 84.6 percent of the population was covered by social security (DANE, 2009), showing a major advance compared with the 23 percent reported before the reform.

Universal coverage is recognized as a mechanism to secure access to health services, and consequently enjoyment of the right to health. This thesis adopts a definition of the right to health, that includes the access to health care, namely that listed in General Comment 14 and recognized by Colombia's Constitutional Court: i) accessibility; ii) availability; iv) quality; and iv) acceptability (ethically and culturally appropriate) (Committee on Economic Social and Cultural Rights, 2000).

The *accessibility* of health care has mainly been measured by an indicator of the use of health services when required. These assessments show that Colombians covered by the health system go more often to a health facility to receive care when required (Giedion, Díaz, et al., 2009; Guerrero, et al., 2011; SEI, CENDEX, COLCIENCIAS, & Ministerio de la Protección Social, 2009). However, this indicator does not allow us to infer the level of complexity of the health-care services accessed, or the levels of access by users from the different regimes to follow-up appointments or the continuation of treatment (Yepes, et al., 2010). This is highly relevant in the Colombian context due to the structural inequality of the system. While individuals under the POS-C have access to the full range of health care, individuals under the POS-S have access to a comprehensive package at the first level of attention and access to care at the fourth level (catastrophic diseases), but very limited access to services of medium complexity, including specialty care at outpatient and inpatient facilities (Giedion, Panopoulou, et al., 2009). This structure hinders the delivery of comprehensive care to people under the subsidized regime.

*Access to information* allowing patients to make informed decisions, such as which EPS or IPS to choose, is limited. The lack of information about user's rights, the system's functions,

and aspects of the quality of care has also been identified as a barrier to ensuring that competition within the system is driven by consumer choice, as originally planned by the reform (Pinto & Hsiao, 2007).

Another indicator of the accessibility of the health-care services is the number of claims presented for effective access to services recognized by the POS. Colombians have been systematically reporting serious failures in this regard, showing that the EPSs systematically deny users the access to drugs, services, and supplies included in the POS. As a result, many users are forced to resort to legal actions (in the form of *tutelas*) to protect their right to health. The majority of the health-related *tutelas* presented between 2003 and 2007 were for drugs, services, and supplies included in the POS.<sup>18</sup>

**Table 2: Health *tutelas* per year, 2006–2011**

	2006		2007		2008		2009		2010		2011	
	<i>Total</i>	%	<i>Total</i>	%	<i>Total</i>	%	<i>Total</i>	%	<i>Total</i>	%	<i>Total</i>	%
<b>POS</b>	76,719	60.89	60,178	50.72	75,774	49.29	103,041	68.25	89,762	65.40	131,077	67.81
<b>Non-POS</b>	49,275	39.11	58,480	49.28	77,956	50.71	47,937	31.75	47,498	34.60	62,225	32.19
<b>Total</b>	125,994		118,658		153,730		150,978		137,260		193,302	

Source: (Defensoría del Pueblo, 2009, 2010b, 2011, 2012)

Economic accessibility has been portrayed as one of the main achievements of the Law 100 reforms, through the role that access to health insurance plays in the financial protection of families (by limiting their out-of-pocket expenses) (Clavijo, 2009; Cubillos, Pulido, Alfonso, Bolivar, & Castrillón, 2009; Glassman, et al., 2009; World Health Organization, 2000). However, the parameters used by some scholars to assess financial protection (Flórez, Giedion, Pardo, & Alfonso, 2009) leave aside common expenses required to effectively access health care in Colombia, such as transportation, accommodation, and food for patients and their companions (SEI, et al., 2009 , p. 99). According to data collected by the 2007

<sup>18</sup> See Annex 1.7 for detailed figures on *tutelas* presented each year between 2003 and 2011.

National Health Survey, of the users who attended outpatient consultations that year, 46.6 percent paid for transportation, 27.7 percent paid for photocopies, and 11.9 percent paid for food. Transportation alone represents 19.1 percent of the monthly expenditure in outpatient consultations (SEI, et al., 2009 , pp. 99, 106).

Of these expenses, transportation is an important variable to consider in a context such as Colombia's, where the unequal distribution of health-care facilities forces users, especially the poorest ones, to travel long distances to access health care. This relates to another dimension of accessibility, which is *physical accessibility*. Under the Colombian health system, when a patient requires a consultation with a specialist, the EPS is not obligated to provide a service close to the patient's place of residence. Law 100 grants EPSs the authority to determine which health facilities within Colombia's territory its users can attend. This means, for example, that a user would not be able to go to the nearest second-level hospital if his or her EPS does not have a contract with that hospital.

Other expenses that can create economic barriers include co-payments (*copagos*) and "reasonable fees" (*cuotas moderadoras*). Co-payments are calculated as a percentage of the services provided and are charged for surgeries or costly treatments to help maintain the system's economic sustainability. In the contributory regime, users also pay a "reasonable fee" that aims to encourage the proper use of services and enrollment in comprehensive-care programs developed by the EPS (Ministerio de la Protección Social, 2009b). The 2007 National Health Survey showed that 40.9 percent of patients requiring a medical consultation paid either a co-payment or a reasonable fee. Users in the subsidized regime and those without insurance paid a higher amount than users in the contributory regime.

These economic barriers lead to, and exacerbate, other types of structural inequities. Due to higher rates of morbidity and the need to access reproductive health care, women use health care more frequently than men do, and have higher health expenses (Ewig & Hernández-Bello, 2009). In addition, gender inequalities within the labor market mean that women earn less than men—and thus feel the impact of health-care expenses more strongly. Many have also criticized the system for its failure to achieve financial equity. The contributory regime has a flat deduction rate that remains the same regardless of income or family structure (Procuraduría General de la Nación & Centro de Estudios de Derecho Justicia y Sociedad, 2008).<sup>19</sup>

The *availability* of health services is a major cause of out-of-pocket health-care expenditures in Colombia, particularly for people living in rural areas and in the poorest departments with most unmet health needs (see Table 2). A survey performed by Médecins Sans Frontières in rural and isolated areas found that the distance to health facilities—and, as a result, the cost of transportation—is a major barrier to accessing health services (Médicos Sin Fronteras, 2010). The types and level of services offered in the departments of Guainía, San Andrés, Arauca, Amazonas, and Guaviare, are extremely restricted (Defensoría del Pueblo, 2010a), meaning that their inhabitants must travel to other departments when they require specialized care.

**Table 3: Departments with high transportation expenses as part of out-of-pocket health expenditure**

Health expenditure: transportation	Annual health expenditure: transportation (Colombian pesos)	Times national average	% of the population with unmet basic needs
<b>National average</b>	<b>8,346</b>	<b>1</b>	<b>19.66</b>
Arauca	133,000	16	32.01
Caquetá	23,000	3	33.48
Casanare	44,600	5	26.16
Chocó	159,101	19	81.94
Putumayo	167,299	20	26.54
Vaupés	130,220	16	40.26
Vichada	206,204	25	42.94

Sources: (DANE, 2011; SEI, et al., 2009)

<sup>19</sup> The 12.5% deduction means that a family of five with a US\$1,000, monthly income pays US\$125 for health care and keeps US\$875 for the rest of its expenses. In contrast, a five-member family with a monthly income of US\$10,000, spends US\$1,250 on health care and keeps US\$8,750 for the rest of its expenses. While the percent deducted is the same, its impact is vastly different, depending on a family’s income.



*Quality* assurance has been another major challenge for the Colombian health sector. Even though Law 100 (article 153) states that the health system must progressively provide health services of equal quality regardless of users' ability to pay, the national system for quality assurance was not established until 2006 (Decree 1011 of 2006). This step, though late in coming, was a milestone. It was accompanied by other regulatory initiatives aimed to improve the quality of health services, such as the establishment of auditing and accreditation systems. Despite these initiatives, the dominant position in the health care market of the EPSs, the lack of information, and the weakness of the regulatory entities has allowed the quality of health-care services to be sacrificed for financial profitability (Molina, Muños, & Ramírez, 2009).

In term of the *cultural acceptability*, one major criticism in term of the cultural acceptability is that the Law 100 (and subsequent regulations) and consequently the POS do not include the cosmovision of indigenous population, not only in terms of the characteristics of the services, also in terms of their understanding of how health care should be organized and provided.<sup>20</sup>

### *Efficiency*

Competition between providers (insurers and health services) was conceived under Law 100 as the main mechanism for guaranteeing the efficient use of resources. However, various studies have showed that this “competition” has not been institutionalized throughout the country. Not all Colombians enjoy the possibility of choosing between more than one EPS. This means that sometimes EPSs and users alike have only one choice of health service providers.

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<sup>20</sup> Law 691 from 2001 regulates the participation of ethnic groups in the health system, but this does not adopt the cosmovision of indigenous population..

In addition, measures such as allowing EPSs to buy health services within their own health services network (known as vertical integration) have not achieved their expected outcomes in terms of expenditures (Restrepo, Lopera, & Rodríguez, 2007). Instead, these measures have produced a number of negative outcomes, such as (i) limiting the free exercise of the medical profession; (ii) creating opportunities to generate revenue by cutting costs without regard to quality; and (iii) giving more power to the EPSs to manage and control the cost of the services offered (Defensoría del Pueblo, 2007; Molina, et al., 2009; Restrepo, et al., 2007).

Another aspect of the efficient use of resources relates to transactions between different actors involved in the health system. Studies have shown that the structure of Colombia's health system, along with weak oversight mechanisms, has allowed practices to flourish that produce high transaction costs for the system (Barón, 2007; Ramirez, 2010; Semana, 2010). For example, the lack of an adequate information system has allowed EPS to claim pay for services without actual proof that the service was provided (including payment for non-POS services); deceased patients remain in the system and generate expenses (EPSs have been reported to request reimbursement for services ostensibly provided on behalf of these patients) (Pinto & Hsiao, 2007). The EPSs have also been able to establish anticompetitive practices, such as agreements on criteria to be used to deny certain services, drugs, and procedures, in order for the expenses to be recovered as "non-POS services" (Superintendencia de Industria y Comercio, 2011).

Corruption and clientelism have led to the misuse of resources. SISBEN, the surveys used to determine who qualifies for the subsidized regimen, has been used by national-level political authorities to obtain political support in two ways: by lowering the threshold to become eligible for social programs and by manipulating the timing of the survey so that it can be

used as part of election campaigns. SISBEN's methodology facilitates this manipulation; while the methodology requires the national government to instruct local authorities on how to apply the door-to-door survey, it grants local authorities discretion over the timing. This has allowed the survey to be conducted during electoral campaigns (Camacho & Conover, 2009).<sup>21</sup> In addition, authorities (such as mayors) have the capacity to manipulate the scores—a practice that different studies have shown to be widespread (Dinero, 2010; El Tiempo, 2008; A. Gaviria, et al., 2006; Sevillano, 2011). The national government's lack of control and monitoring has also contributed to this manipulation.<sup>22</sup>

As a result of these weaknesses and deficiencies, assessing the outcomes of the subsidized regime on the distribution and allocation of health care resources has not been an easy task, and different assessments have produced conflicting results. Some find that it has improved the distribution and allocation of the subsidies—in other words, the subsidies are being granted to those who need them (Yepes, et al., 2010). Other find that SISBEN has been providing subsidies to populations able to pay (Pinto & Muñoz, 2010).

The privatization of health services has created new paths for clientelism at the local level. Politicians can receive support from private health care enterprises for their campaigns. In exchange, authorities can use public funds to hire these enterprises' services. Public health-care resources have also been used to support illegal groups (paramilitaries and guerrillas) as a mechanism to obtain and maintain political power (López, 2010).

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<sup>21</sup> Due to continuous complaints about the survey being used for political purposes, in 2010, the government prohibited it from being conducted during the electoral campaign.

<sup>22</sup> Studies have found “suggestive evidence of less cheating during electoral periods when there is a stronger presence of monitoring institutions” (Camacho & Conover, 2009 , pp. 31–32)

Another source of resources misuse and lack of financial efficiency within the health sector has been the implementation of policies and regulations allowing increases in the prices of health services and supplies. One example is the drug pricing control system, implemented in 2006, which limited competition. As a result, the state has been paying exceptionally high prices for drugs (Health Action International, 2009; Vasquez, Cortes, & Rossi, 2010).

### *Solidarity within the Health System*

Despite increases in national health expenditure as part of the GDP, and an increase in contributions from the contributory to the subsidized regime (which rose from 1 percent to 1.5 percent in 2007) – there has not been a major increase in the fiscal effort to cover the health needs of the worst-off. Resources derived from the national budget to finance the health needs of the subsidized regime (i.e., the worst-off) fell by 5.5 percentage points between 2000 and 2007. While in 2000, 11 per cent of the tax revenue was directed to cover the health needs of the non-contributory population, by 2007 this was down to 6.5 per cent (Salud Colombia, 2009). This shows that despite the increase in coverage, the state has reduced the weight of public spending dedicated to cover the needs of the worst-off.

In conclusion, when analyzing the reform's outcomes against its aims of universal coverage, efficiency, and solidarity within the health system, the picture is grim. Serious deficiencies in the health system have prevented Law 100's aims from being realized.

### ***2.3 Litigation of the Right to Health in Colombia***

This section outlines the characteristics of the legal system in which litigation takes place, explaining the factors that shape the litigants' opportunity structure. In 1991, Colombia adopted a new Constitution that included major conceptual and structural innovations and

contributed to a rise in judicial interventions on social and economic rights, particularly the right to health. The new Constitution, which recognizes economic and social rights, includes a mechanism for the protection of fundamental constitutional rights, called *acción de tutela* (hereinafter *tutela*). This allows any citizen to demand immediate protection of his or her constitutional rights (González & Durán, 2011 , p. 54). The Constitutional Court was established “as a specialized tribunal overseeing a new ‘constitutional jurisdiction,’ which extended to all Colombian judges” (Yamin & Parra-Vera, 2010 , p. 109).

The Constitutional Court has protected the right to health in three ways. First, it has found the right to health enforceable when it is connected with the right to life, personal integrity, and human dignity, allowing Colombians to request procedures not included in the POS in a broader range of situations than just imminent death (Corte Constitucional de Colombia, 2008; Yamin, et al., 2011). Second, the Court has recognized the fundamental nature of the right to health in contexts in which the claimant is subject to special protection, such as the case of children, indigenous populations, or people with mental or physical disabilities. In these cases, the Court has called for ensuring that a certain scope of required health services be effectively guaranteed. Thirdly, the Court has gradually left the doctrine of connection (between health and life with dignity) to justify the enforceability of the right to health, and developed a third way, namely recognizing the right to health as a fundamental right. Yet, for the Court, constitutional rights are not absolute; they may be limited in accordance with criteria of reasonableness and proportionality. As with other constitutional rights, the Court recognizes that while the right to health have a programmatic character, it carries obligations that can require immediate fulfillment, either because they do not necessitate additional resources or because the severity and urgency of the case requires immediate action.

Other programmatic obligations are required to be carried out progressively; calling for complex actions and resource allocation. The progressive aspect of fundamental rights, such as the right to health, allows claimants to legally demand at least the existence of a public policy aimed at ensuring the effective enjoyment of the right, which includes mechanisms for stakeholders' participation.

In addition to the development of the Court's jurisprudence, systematic failures in the health system, have contributed to an exponential increase in right-to-health claims.<sup>23</sup> Although Law 100 (article 230) provides sanctions for practices such as the denial of services included in the POS, this has been a systematic problem, creating mistrust between the different actors of the health system. These systematic problems demonstrate the state's inability to fulfill its constitutional responsibilities of regulation, monitoring, and oversight of the health system.<sup>24</sup>

### ***2.3.1 Constitutional Court Decision T-760/2008***

In this context, with a staggering number of individual right-to-health claims, in July 2008 the Constitutional Court handed down decision T-760/2008, which ordered the Colombian government to adopt the necessary measures to correct deficiencies in the health-care system that, according to the Court, violated the right to health of Colombians. T-760/2008 is a "structural ruling," a type of judicial decision characterized by its (i) wide scope (affecting a large number of people whose rights are allegedly violated); (ii) systemic focus (involving several state agencies as defendants allegedly responsible for systematic failures of public policy); and (iii) complexity (involving orders of complex implementation, where various

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<sup>23</sup> The number of right-to-health claims rose from 21,301 in 1999 to 153,730 in 2008.

<sup>24</sup> Under the Constitution (article 49), the state is responsible for (i) organizing, (ii) directing, and (iii) regulating the provision of health services; (iv) establishing policies for the provision of services by private entities; exercising (v) monitoring and (vi) oversight; (vii) establishing the respective jurisdictions of the national and local authorities, as well as members of the public; and (viii) determining these actors' respective roles and responsibilities. Thus, in Colombia's managed competition model, the state is responsible for guaranteeing and facilitating competition between the EPSS

governmental entities are instructed to take coordinated actions to protect the entire affected population, and often with explicit requirements for participatory, dialogical policy processes) (César Rodríguez Garavito & Rodríguez, 2010).

Civil society organizations were not direct drivers of this decision; they were not plaintiffs in the case, and this decision did not result from strategic litigation. The Colombian legal system allows the Constitutional Court to accumulate and review individual cases and identify systematic and structural failures. In its preparation of decision T-760/2008, the Court carried out a research process, sending formal requests for information to actors and authorities within the health system and consulting officials from the Ministry of Social Protection, insurers, and providers.<sup>25</sup> The research allowed the Court to identify several problem dimensions reflected in the individual cases and to build one structural case. Decision T-760/2008 did not focus on one single problem of the health system; rather, the Court decided to address the whole system and to protect different rights (Cepeda-Espinosa, 2011). Decision T-760/2008 reflects the Court's understanding of the problems within Colombia's health system—it does not necessarily concur with the views of other Colombian actors.<sup>26</sup>

The Court's emphasis on addressing the health system as a whole increases the complexity of the ruling. One of the main characteristics of T-760/2008 is its scope. Unlike other structural rulings of the Colombian Constitutional Court addressing human rights violations faced by specific groups, such as inmates (T-153/1998) and internally displaced persons (T-025/2004), it involves the entire Colombian population and all actors in the health system. Thus, the

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<sup>25</sup> This research process was referred to in more than one of the interviews performed for this dissertation.

<sup>26</sup> For example, before decision T-760/2008, the Attorney General's Office issued, in collaboration with the non-governmental organization Centro de Estudios de Derecho, Justicia y Sociedad, a report analyzing the situation of the right to health in Colombia (Procuraduría General de la Nación & Centro de Estudios de Derecho Justicia y Sociedad, 2008). The report concluded that despite the major role performed by the Constitutional Court in protecting the right to health through decisions on *tutelas*, the situation of the health system and the increase in right-to-health *tutelas* showed the limitation of this legal mechanism to solve the health system's problems. The report recommended that the Court declare an unconstitutional state of affairs.

ruling's implementation requires tremendous commitment, participation, and coordination among public and private actors.

To illustrate the systematic problems within Colombia's health-care system, the Court selected and described 22 individual right-to-health claims (*tutelas*). For the Court, these cases represented a failure of competent authorities to meet their constitutional obligations to respect, protect, and fulfill the right to health, and, as a consequence, the Court decided to impart orders to overcome the detected failures of regulation. The ruling appointed responsible state bodies for the fulfillment of each of the orders.<sup>27</sup>

Persistent inequality was highlighted as one of the structural problems of Colombia's health-care system. The Court found that despite the government's commitment to unify the health plans by 2001, no program or schedule for this was in place. T-760/2008 thus ordered the updating, adaptation, and equalization of the health plans for adults and children (primarily through orders 16, 17, 21, and 22). The Court did not, however, order an automatic equalization. It called for a comprehensive process to identify the health needs of the Colombian population and to redesign a new and financially sustainable common health plan.

Decision T-760/2008, adopting a "comprehensive human rights approach" in line with General Comment 14 of the UN ESCR Committee, required that the reform process guarantee the direct and effective participation of the medical community and health service users, especially those affected by the policy changes. The Court explicitly defined participation as a mechanism to prevent those affected by decisions from being excluded from decision-making processes. In line with the right-to-health framework set out by the UN ESCR Committee,

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<sup>27</sup> A summary of the main orders can be found in Annex 1.4



decision T-760/2008 emphasized that the constitutional responsibilities regarding access to health care go beyond the issuing of regulations. It cited the conditions listed in General Comment 14—availability, non-discrimination, physical accessibility, economic accessibility (affordability), information access, acceptability (ethically and culturally appropriate), and quality—and stressed the state’s obligations to respect, protect, and fulfill the right to health (Committee on Economic Social and Cultural Rights, 2000).

The Court took into consideration the system’s economic sustainability, ordering “that whatever reform was adopted for the health care system to comply with the decision rendered by the court, it should be financially sustainable” (Cepeda-Espinosa, 2011 , p. 1701). The Court also showed its concern for cash-flow problems within the health system; it required the adequate and timely flow of resources to the health system and called for improving the system of verification, control, and payment performed by FOSYGA (mainly through orders 24 and 27).

The Court also stressed that its decision was framed within the existing legal framework conceived by the Constitution and developed by Law 100, emphasizing that it would exceed the Court’s competence to order the design of a distinct system, as that would be a decision for the legislature. In T-760/2008, the Court did not require a particular type of reform to the Colombian health system, for neither the Court nor its judges 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 , paragraph 3.3.15). However, the Court required that any measures taken to address the decision respect certain principles, including equality, financial sustainability, participation of users and medical associations in decision-making, to be based in evidence, and the protection

of vulnerable populations. These principles are recognized by the Colombian Constitution and Law 100.

Decision T-760/2008 did not generate a homogenous reaction in terms of wholesale support or rejection. Some criticized the Court's casting of T-760/2008 within the framework of Law 100. One aspect of this critique focused on the system's economic sustainability and on the impossibility of achieving the aims of equalization and universalization, expressed in Law 100 and required by the decision, under the current system of financing, which is based mainly on payroll deductions for formal employees and on state subsidies. According to this view, equalization would serve as a perverse incentive for people to return to the informal sector to avoid paying "more" (in deductions) for the same health-care services; it would thus create more problems for the system in terms of collecting the resources needed to finance the system (Santa María & Perry, 2008). Along the same lines, there were concerns regarding the use of *tutelas* for non-POS services, highlighting the need for a broader discussion on the availability of resources and the role of judges. (Santa María & Perry, 2008; Rodrigo Uprimny & Rodríguez, 2008).

A second set of responses reflected a more critical view of Colombia's health system, arguing that the Court, despite recognizing the structural problems of the Law 100 model, asked for solutions within a model that is incapable of guaranteeing the right to health in the terms defined by the Court. According to this view, the model created by Law 100 considers health as a good that can be purchased, resulting in a system where access to health depends on the purchasing capacity of individuals and where private actors such as EPSs are able to negotiate to obtain higher economic revenues, regardless of the quality of the services provided (Hernández, 2010; Malagón, 2010).

Other detractors, critical of the role of the Court and the judicialization of the right to health, focused on the decision's economic impact. According to their calculations, the requirements such as POS equalization were economically impossible to achieve (Caracol, 2008; Tsai, 2010). Without taking account of the structural problems of the system that motivated the ruling, they highlighted the scarcity of resources and disputed reports indicating that most *tutelas* concern services included in the POS, arguing that, in many cases, the EPSs do not deny services but rather (legitimately) ration the use of resources (Castaño, 2008).<sup>28</sup>

Yet other critics addressed the lack of a public health component within the decision (Rodrigo Uprimny & Rodríguez, 2008). This is not a minor point since, as recognized by the Court's own jurisprudence, health cannot be restricted to the absence of disease. Decision T-760/2008 neglected key components of health, such as preventive care and health promotion—areas that, as mentioned above, were already weakened after the implementation of Law 100.

#### *Monitoring of Decision T-760/2008*

Following the experience of decision T-025/2004, the Court invited different actors to constitute monitoring groups. The first call, in December 2008, was answered by a group of insurers and providers' associations and by an umbrella organization consisting mainly of academic organizations. The Court considered the composition of these groups (which included interest groups, such as insurers) a weakness for the process. Thus, in December 2009, it sent new invitations to a number of organizations from academia and civil society, and to a congressional commission (Corte Constitucional de Colombia, 2009). This invitation was accepted by some of the organizations (Confederación Colombiana de Consumidores;

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<sup>28</sup> This rationing could be interpreted as an action from the EPSs to increase their earnings in each transaction.

Movimiento Nacional por la Salud y la Seguridad Social; Asociación Colombiana de Facultades de Medicina; Centro de Estudios de Derecho, Justicia y Sociedad; and Asociación Médica Sindical). In May 2010, the Court resubmitted its invitation to those organizations that had not replied to the previous one (Corte Constitucional de Colombia, 2010a).

In addition, in 2010, organizations such as the *Mesa por la Vida y la Salud de las Mujeres* and *Comisión de Seguimiento a la Sentencia T-760 de 2008 y de Reforma Estructural al Sistema de Salud y Seguridad Social*<sup>29</sup> submitted a formal request to the Court asking to be part of the monitoring group; the Court accepted this request. It must be noted that these requests were presented in a tense political context. The government attempted to limit access to the *tutela* within the health sector through the implementation of legal limitation and fines to medical doctors. These measures, framed within the declaration of a state of social emergency in December 2009 (Ministerio de la Protección Social, 2009a), faced strong opposition from different sectors of society (El Espectador, 2010; El Tiempo, 2010) and, in April 2010, they were declared unconstitutional by the Court. For the Court, the government's reasons for declaring a state of social emergency were not sufficiently strong to justify the declaration. Since the situation motivating the state of social emergency was not an unforeseen event, the government should have used the traditional legislative channel, Congress, to pass health-care reforms such as the ones included in the social emergency decrees. The Court also found that

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<sup>29</sup> Its members consisted of ASALUD; ASSOSALUD; Academia Nacional de Medicina; Asociación Colombiana de Sociedades Científicas; Asociación de Pacientes de Alto Costo; Asociación Colombiana de Facultades de Medicina; Corporación Viva la Ciudadanía; Grupo Guillermo Fergusson; Movimiento Nacional por la Salud y la Seguridad Social; Universidad Javeriana, Facultad de Medicina, Dirección de Postgrados en Salud y Seguridad Social; Universidad Santo Tomás, Facultad de Economía; Universidad de Antioquia, Facultad de Derecho y Ciencias Políticas, Facultad Nacional de Salud Pública; Unión Temporal Universidad de Antioquia, Universidad Nacional; and Universidad Nacional, Facultad de Medicina, Doctorado Interfacultades en Salud Pública, Departamento de Salud Pública, Centro de Historia de la Medicina, Departamento de Salud Colectiva de la Facultad de Odontología, Programa de Doctorado en Salud Pública, Instituto de Desarrollo Humano, and Observatorio sobre Infancia.

the reforms included in the state of social emergency would not solve the underlying problems of Colombia's health-care system (Corte Constitucional de Colombia, 2010b).

This situation motivated some organizations to actively participate in monitoring the implementation process. The way in which the government initially responded to the decision, as well as the Court's response to these measures, created a context in which these actors recognized that the oversight of the implementation process provided an opportunity to participate in spaces where the structure and problems of the health system would be debated (see, e.g., Hernández, 2010; Malagón, 2010). In addition to creating these monitoring groups, in 2011, the Court invited groups of experts to discuss a number of topics related to decision T-760/2008. Five topics were assigned: (i) the comprehensive updating of the POS; (ii) the system's cash flow and financial sustainability; (iii) barriers to accessing the right to health; (iv) POS equalization and universalization; and (v) indicators and assessment benchmarks. The groups met an average of four times, and the results of their work were published by the Court (Corte Constitucional de Colombia, 2011a).

### ***3. Research Questions***

Regardless of whether one is “for” or “against” the Court's structural ruling in decision T-760/2008—and court involvement in ESCR matters more broadly—it is important to assess the effects of such judicial interventions. Do they produce the negative impacts predicted by detractors? And do they achieve the expected outcomes set by the courts?

The overall aim of this thesis is to provide practical evidence of the role that contextual pre-conditions play in the implementation of judgments addressing economic, social, and cultural rights. The research questions were as follows:

1. Did the implementation process for decision T-760/2008 change power relations between the actors involved in the design process for health policies? Articles 1, 2, and 3.
2. Did the implementation of decision T-760/2008 have an effect on the organization of the Colombian health system? Articles 2 and 3.
3. Did the implementation of decision T-760/2008 improve the fairness and legitimacy of the POS design? Article 3.
4. Did the implementation of decision T-760/2008 have an effect on the access to health care of vulnerable groups, such as children? Article 2.
5. How did contextual factors shape or hamper the implementation of decision T-760/2008? Articles 1, 2, and 3.

These questions are addressed in the three different articles that compose this thesis. Even though each article responds to different aspects of decision T-760/2008, they all harmonize with a common study design.

#### ***4. Methodology***

##### ***4.1 Research Approach***

For this thesis, the research strategy chosen was a single case study. This strategy allowed for the investigation of a contemporary phenomenon within its real-life context, which is important especially when the boundaries between the phenomenon and context are not clear (Yin, 2003). The case-study approach permits a detailed description of the context, as well as the use of multiple sources and the development or testing of a theory (VanWynsberghe & Khan, 2007). These characteristics were fitting for a research project such as this one, which involves the evaluation of ongoing processes and whose analysis seeks to address contextual conditions considered pertinent to the phenomenon in question (Yin, 2003).

## **4.2 Design**

This case study was a qualitative study that followed an interpretative, naturalistic approach: it was mainly (except for the analysis of some documentation) carried out on a real-world situation, without manipulation or control strategies. The information was analyzed following an inductive analysis (exploring open questions, no hypothesis test), and the interpretation of the phenomenon was concerned with understanding the meanings that people attach to this phenomenon within their social worlds (Patton, 1990; Snape & Spencer, 2003). I chose this approach because one of my methodological aims was to understand how the different actors involved in the implementation of decision T-760/2008 understand and interpret the decision and its implementation process.

The data collection methods involved close contact with research participants: interviews with actors involved in the implementation process, and the revision of documents produced by these actors. Some of the documents and data sources contained quantitative data (such as databases on services denied).

The field trips included visits to four cities in Colombia: Bogotá, Cartagena de Indias, Quibdó, and Medellín. Bogotá is the capital of Colombia, where the president, ministries, and Constitutional Court are located. Most of the meetings and public hearings organized by the Ministry of Social Protection (now Ministry of Health and Social Protection) and the Constitutional Court took place in Bogotá,<sup>30</sup> and all of the meetings and information sessions organized by the Commission on Health Regulation (CRES) included a session in Bogotá.

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<sup>30</sup> See Annex 1.5 for a complete list of the events organized by the Ministry of Social Protection, the CRES, and the Constitutional Court.

Cartagena de Indias is the capital of the department of Bolívar. At the beginning of 2010, the city's government decided to initiate, using its own resources, a pilot program for the equalization of the POS for all age groups.

Quibdó is the capital city of the department of Chocó, which is home to a high concentration of the country's vulnerable groups (82% of Chocó's population are Afro-descendants, 11.9% are indigenous, 25.5% are adolescents, 14.2% are under five years old, 51.4% live in rural areas, and 78.5% live in poverty). The region has been affected for years by the armed conflict. Chocó's health system has also been portrayed as heavily affected by corruption. Funds have been diverted to drug traffickers and to finance the campaigns of politicians involved in the drug trade. In 2007 and 2010, the system was declared bankrupt and required intervention by national authorities (*El Pulso*, 2008; López, 2010). This high level of corruption made research on Chocó's health system a sensitive issue. During the interviews, some of the key informants in Chocó required that I not take notes on sensitive issues (such as corruption), arguing that even if they trusted me as a researcher, my notes could be stolen by people who wanted to see what the interviewees were telling me. In June 2011, serious corruption was discovered in the department health office, Dasalud. The Attorney General's Office opened an investigation and ordered the detention of individuals involved in the fraud (Territorio Chocoano, 2011). Against this background, key informants from Chocó recommended against my visiting Quibdó, considering it unsafe to conduct research regarding health systems in a context where corruption cases were being revealed, and also that people would be reluctant to speak. Thus, my 2011 field work did not include a visit to Chocó.

Medellín is the capital of the department of Antioquia. For years, Antioquia has been home to the highest number of health *tutelas* per capita (Defensoría del Pueblo, 2010b, 2011). In 2011,



the health secretary from Medellín's local government presented a proposal to the national government for a progressive equalization of the POS. Medellín is also home to one of the country's best academic departments on public health, the Faculty of Public Health at the University of Antioquia. Researchers from this department have produced important investigations regarding the impact of health reform in Colombia (see, e.g., Arbelaez et al., 2004; M. B. Gaviria, Henao, Martínez, & Bernal, 2010; Molina, et al., 2009; Segura-C, Rey-S, & Arbeláez- M, 2005) and have been closely following the implementation of decision T-760/2008. This department, in collaboration with the legal department of the human rights office of Medellín (*Personería de Medellín*), has created a health observatory and a committee to follow up on the implementation of decision T-760/2008.

#### **4.3 Data Collection**

This study involved different sources of evidence: (i) semi-structured interviews of key informants from patients' organizations, non-governmental organizations, state bodies, regional-level health bodies, academia, and health providers (articles 1, 2, and 3); (ii) reports and official documents regarding the implementation of decision T-760/2008, mainly of its orders 17, 19, and 21, issued between July 2008 and March 2012, including electronic reports on health services denied (articles 1, 2, and 3);<sup>31</sup> (iii) the government of Bogotá's database on health barriers, SIDBA, from 2010 (article 2); and (iv) observations of meetings organized around the implementation of T-760/2008, such as meetings of civil society groups, public hearings (July 2011), and workshops during field work visits in 2009, 2010, and 2011. The data was collected between March 2009 and July 2012.

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<sup>31</sup> This included two sources of information, as described by Ying (2003): documentation and archival records.

For the selection of the respondents, a combination of theoretical sampling (Silverman, 2009) and snowball sampling was used. Individuals were identified according to their role in the implementation of decision T-760/2008. The sample included representatives from the following entities or groups: bodies in charge of implementing the decision, state institutions in charge of monitoring implementation, non-governmental monitoring institutions recognized by the Constitutional Court, users' groups working on the monitoring of the decision, civil society groups and experts who sent comments to the Constitutional Court and the Ministry of Social Protection regarding the implementation of T-760/2008, providers' associations, and minority and vulnerable groups (such as indigenous organizations in Quibdó and Bogotá, women's organizations, and organizations of patients with high-cost diseases).

Respondents were approached either through contacts in Colombia or directly (by phone or e-mail). The purpose of the interviews was explained to respondents, and all participants were asked for their oral consent to participate in the study. At the end of each interview, respondents were asked to share the names of other people or institutions that they considered crucial to be interviewed, as well as documents (such as reports) that they considered important to be reviewed. Access to files of the Constitutional Court and to the database of Bogotá's local government was acquired through letters of request. In these letters, the objective of the research was explained.

Ethical approval was obtained from the Norwegian Social Science Data Services Ombudsman for Privacy in Research and the Ethics Committee at the National University of Colombia (see Annex 2).

Certain limitations of this study and its data collection are worth mentioning because of their effects on the research. The first limitation is that I did not stay permanently in Colombia throughout the duration of this study. Although I made several trips to Colombia, which were planned to coincide with important activities of the Constitutional Court, the CRES, the Ministry of Social Protection (now Ministry of Health and Social Protection), and other actors connected with the implementation of decision T-760/2008, it was impossible to predict all of the reactions at the political level generated by the decision—which, in turn, had an effect on the dynamics of the implementation process. For example, at the beginning of my second field trip to Colombia (October–December 2009), officials from the Ministry of Social Protection, in interviews as well as in Congress, declared the impossibility of unifying the POS due to economic constraints, and criticized perverse effects of decision T-760/2008. Some civil society groups involved in the promotion and protection of the right to health criticized decision T-760/2008 for allowing the continuation of the model created by Law 100. Towards the end of my trip, in December 2009, the Colombian government declared a state of social emergency in the health sector (Ministerio de la Protección Social, 2009a). The emergency decree faced strong opposition from different sectors of society (see, e.g., *El Tiempo*, 2010b, 2010c; Jaramillo, 2010) and prompted protests in various cities at the beginning of 2010 (*El Espectador*, 2010).

Given that I had already left Colombia, I monitored from afar the sequence of events following the declaration of the state of social emergency. I did this through the media and through personal communications (mainly emails) with people I met during my previous field work. While following the process closely, I missed the opportunity to observe it in person.

The same happened with the process analyzed in article 3 (an analysis of the fairness and legitimacy of the system established to update the health plans). While having the opportunity to participate in some of the meetings organized by the CRES, following the debates, and collecting documents prepared by relevant actors, I did not attend most of the meetings that were organized, and consequently missed the debates that took place during these meetings.

Another limitation of this thesis is that it lacks the data and analysis to provide strong evidence regarding changes at the level of discourses and ideas, social goals, and values. Even if the thesis highlights decisions such as the adoption of a unified health plan (first for children and later for adults) as having major symbolic significance, as concrete and practical recognition of the equal rights of all Colombians, it does not analyze their effects on societal discourses regarding issues of equality within the health system. Time and resource constraints were the main barriers to developing an in-depth analysis and providing strong evidence regarding symbolic effects.

My analysis of the media coverage followed the methodology used by Colombian scholars (César Rodríguez Garavito, 2011; César Rodríguez Garavito & Rodríguez, 2010): I analyzed the discourse in two print media newspapers, *El Tiempo* and *Semana*. The strength of these two newspapers is that both have an online news archive that facilitates searching news items (i.e., it can be performed without being in Colombia). I performed an initial data collection of the news published in *El Tiempo*, but then started questioning whether *El Tiempo* was the best source. This newspaper belongs to one of the monitoring groups of decision T-760/2008, so its coverage on the issue (for example, the number of stories published) could be influenced by its work as a monitoring actor. This situation left me with one source, *Semana*, which I considered too limited to perform an analysis on the symbolic effect of decision T-760/2008.

Other sources of information were the laws and regulations issued after decision T-760/2008. An analysis of this issue is presented in the discussion section of this thesis.

#### ***4.4 Data Analysis***

One of the main challenges of this case study was that it was an ongoing process addressing a highly polarized topic in Colombia. Divergent opinions regarding the health system, as well as the disclosure during my data collection process of sensitive information, (such as the content of the Emergency Decrees, or databases on the denials of services) may have influenced the way in which I analyzed the data. As a researcher, I was requesting information from people who were participating in a debate; thus, what they disclosed to me was influenced by the position they were seeking to defend.

Since the start of Colombia's health system reform, polarized positions have developed among different sectors, including public authorities, health providers, insurance companies, scholars, users, and unions. Certainly, people can change positions, but in general, there appeared to be three distinct positions among stakeholders. One position supported the reform model and was skeptical of the Court's role. Within this camp, some had participated in programs to reinforce the Colombian health system, such as the Program for Supporting the Health System Reform (PARSALUD). During my first two trips (in 2009) to Colombia, I observed that among those in charge of the government's response to decision T-760/2008, including the social emergency decrees, many adopted this position (see, e.g., Centro de Gestión Hospitalaria, 2009a, 2009b; *El Tiempo*, 2010a). A second position was reflected by those who, despite having been supportive of the Law 100 model, were more open to speaking about its structural problems, as well as about the responsibility of Colombian authorities. Among these were insurers (from the contributory and subsidized regime) focused

on cash flow, the POS composition, and the calculation of the UPC (see, e.g., *Opinion y Salud*, 2011; *Portafolio*, 2009). A third position is represented by actors who, since the design of Law 100, have been critical of the model and the weight that it gives to private-sector actors, as well as of how the privatization of some hospitals has been carried out and of the repressive tactics deployed against union leaders. For years, Colombia has been home to the highest share of trade unionist homicides worldwide; it is estimated that 2,863 unionists were killed between 1986 and 2010 (Bolle, 2012; Escuela Nacional Sindical, 2010). Union leaders and workers in the health sector have also been victims of killings and brutal repression in the context of privatization (Yamin & Parra-Vera, 2010), reinforcing the polarization of positions regarding the country's health reform.

In addition to what can be described as political polarization regarding the Colombian health system model, distrust between suppliers and users was another key issue. Health system users expressed dissatisfaction with the information provided by their EPSs. They perceived that the EPSs did not provide them with enough information about their rights or about the providers' network hired by the EPSs (Defensoría del Pueblo, 2010a). This dissatisfaction reflected distrust concerning the information provided by the EPSs.

Another challenge was to follow an ongoing process that was a catalyst for changes in the health system and that uncovered corruption cases within the health sector. New regulations and disclosures of corruption cases not only generated more information for analysis but also produced changes in the discourses of different actors. For example, after the disclosure of corruption cases in 2011, the executive started to strengthen its position on the need to reduce the number of EPSs. Corruption cases also forced the resignation of ACEMI's president. The changes in the Ministry of Social Protection (now Ministry of Health and Social Protection)

were also significant. Since 2010, there have been three ministers of health (in comparison, their predecessor was in office for seven years). This has been interpreted as the political cost of the power purges within the health sector (César Rodríguez Garavito, 2012).

Against this background, characterized by distrust and opposing positions on the health system model, I used different strategies to ensure the rigor of my analysis of the qualitative and quantitative data collected. Rigor as used here refers to reliability and validity (Davies & Dodd, 2002). It implies a process that goes beyond the application of a set of methodological tools—it suggests an ethical component. Under this view, the data analysis acknowledges the location of the researcher during the research process, the presentation of the analytical framework (which reflects a value system), threats to the study’s validity, and analysis techniques employed (Whittemore, Chase, & Mandle, 2001). By making these elements explicit, the analysis covers the credibility requirement: it deals with the focus of the research and explores how well the data collection methodology and the analytical process address the intended focus.

### *Researcher Location*

Before embarking on my field work in Colombia, I studied decision T-760/2008, collected information regarding the organization of the Colombian health-care system, and discussed my questions regarding T-760/2008 and the Colombian health system with other members of CMI’s “Right to health through litigation?” team.<sup>32</sup>

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<sup>32</sup> Alicia Ely Yamin and Oscar Parra-Vera.

In March 2009, I traveled to Colombia with colleagues from the team. This visit allowed me to establish contact with different individuals and institutions involved in decision T-760/2008's implementation.

Having Spanish as a mother tongue facilitated my communication with respondents. It also proved an advantage in the analysis of documents and databases produced by Colombian authorities and organizations. Being a foreigner from a neighboring country (Peru), free from Colombian institutional affiliations in a highly polarized environment, also seemed to be a positive aspect. It allowed me to access different spaces and talk to people interested in explaining their points of view. Being a foreigner also helped in persuading people to describe their conceptions regarding the organization of Colombia's health system (which in itself reflects their position). Since I was a foreigner, they assumed that they needed to explain the organization of the health system—and I welcomed this, as it provided me with an explanation of the system and Law 100. I did not do this only to show empathy but also because I recognized that each interviewee had a unique understanding of the health system, sometimes shaped by personal experiences. This exposed me to new dimensions of the structure and problems within the system. For example, during some interviews in Bogotá, transportation of relatives was highlighted as an issue that creates problems for the EPSs (as it generates expenses not considered by the UPC), and for this reason, transportation cannot be considered under the POS. When another interviewee spoke about children with cancer who must travel to Bogotá, I discovered a new dimension of the problem. In these cases, should the transportation of the child's relatives be covered? Who pays for the accommodation of relatives during long-lasting treatments such as cancer? Should this be considered as part of health-care coverage?



In Quibdó, interviewees told stories about how hospitals in Medellín refused to receive patients transferred from Chocó, and how some patients had to be accompanied by police in order to receive treatment. In Medellín, interviewees described the huge debt that health authorities in departments like Chocó had with Medellín's hospitals, and how this situation was endangering the hospitals' finances. All of these elements were crucial to building my understanding of Colombia and informing my analysis.

Being identified as part of the same "reality" (i.e., Latin America) facilitated the communication. I felt that people found it easy to explain a reality that, in their opinion, I shared or at least was able to understand. On more than one occasion during the interviews, respondents made statements such as, "We Latin-Americans are alike . . . ," "As you know, we Latin Americans," or "I am sure that in Peru it is similar."

### *Analytical Framework*

This thesis applies an explicit framework for the analysis of legal strategies for the enforcement of ESCR, as described in section 1.1. However, in the assessment of the implementation process for decision T-760/2008, the analysis is also informed by the human rights based approach referred to in the Court's decision and uses the framework adopted by the Court in its decision as a benchmark for assessing the level of compliance. Thus, as will be discussed, in article 1, where participatory process are described, I do not argue that the human rights based approach to participation is the best approach for the development of participatory processes. Rather, I state that since the Court adopted a specific approach, the fulfillment of T-760/2008's participation component must be aligned with this framework.

The use of these frameworks has been critical in this thesis. During the interviews, I listened to strong opinions about decision T-760/2008 and the role of the Court—for example, that with T-760/2008, the Court destroyed the Colombian health system, or that the Court was interested only in reducing *tutelas* and not in solving the health system’s problems.

In addition, while I maintain the utmost respect for the Court as an institution, following its work has formed my opinions about its weakness and strengths, as well as about decision T-760/2008. While my opinions may have changed during this research project, I have sought to keep a firm focus for my analysis, stressing the main knowledge interest of this thesis—that is, an assessment of how contextual factors influence the implementation of rulings such as decision T-760/2008. To achieve this, I found that the best strategy was to be clear in the normative approach that I was adopting in the analysis – namely that of the Court itself.

### *Threats to Validity*

Two of the main threats of this study have been the reliability of the research and the credibility of the researcher (Patton, 1990). In qualitative studies, the researcher is an instrument, and in a highly polarized context such as the one studied here, it is easier to criticize the researcher for failing to be neutral. To prevent such criticisms, a number of measures were taken. As mentioned earlier, explicit frameworks were adopted for the data analysis, which respond to what was required by T-760/2008. Another principle followed was the use of multiple sources of information (Yin, 2003). The study’s design was explicit in its requirement to involve different actors with different opinions regarding the health system and to include all of these opinions and points of views in the analysis. In the case of quantitative data, the data were analyzed and the complete dataset was provided.

This study also followed the principle of maintaining the chain of evidence (Yin, 2003). The articles and reports were reviewed by external observers (e.g., supervisors and article co-authors) who were not directly involved in the data collection. These reviews were significant during the process of designing the study and writing the articles. They also required organizing the information in a way that allowed external observers to follow the chain of evidence from the conclusions back to the initial research questions, or vice-versa.

### *Analysis*

In the case of the recorded interviews (28), comprehensive data treatment and tabulations were used (Silverman, 2009). In other words, all of the interviews and materials were read, codified, and analyzed. This was done to increase the stringency of the analysis and to ensure that the findings were based on an analysis of all data and not on the selection of quotations that supported the researcher's assumptions. The analysis was conducted according to the following categories described by the human rights framework adopted by the Constitutional Court: (i) institutional mechanisms to ensure that people can participate; (ii) capacity building for participation (for health policymakers, individuals, and groups) that includes empowerment and an analysis of power relations; (iii) participation throughout the process (in setting the agenda for discussion, policy choices, implementation, monitoring, and evaluation; and (iv) accessible accountability and conflict-resolution mechanisms (Potts, 2008). *Triangulation of data* was used as a tool for checking the consistency of the information provided in documents and during the interviews (Patton, 1990; Yin, 2003).

For articles 1 and 2, the data was analyzed using the comprehensive human rights framework adopted by the Court, with the components of participation and the dimensions of availability, non-discrimination, physical accessibility, economic accessibility (affordability), information

access, acceptability (ethically and culturally appropriate), and quality being the main focus of the analysis (Committee on Economic Social and Cultural Rights, 2000; Potts, 2008).

In the case of the database of electronic reports submitted to the Court by the EPSs (article 2), two different report formats were used during 2011. Hence we decided to collect information from the three months – April to June 2011 – when most of the EPSs were sending information in the correct format (under Resolution 163/2011, approved in February 2011). However, it was still not possible to include all the data in the analysis, because the reports used different formats and did not contain the same information. In the case of one EPS, Salud Total, the codes used for the description of the service required were in the old format. As the report contains all the fields from the correct format the data was amended and included in the analysis.<sup>33</sup> The data set allowed for an analysis of information from 33,507 cases (27,535 from the subsidized regime and 5,972 from the contributory regime). The data was analyzed using PASW 18. Then, taking into consideration that T-760/2008 expressly addressed children’s right to health, the cases were divided into two age groups—individuals over and under 18 years old—and were reviewed and analyzed based on the reasons given for denying the service.

Article 2 also analyzed the database provided by the government of Bogotá’s health barriers reporting system, SIDBA, using PASW 18. The database contained 6,305 cases of children. The analysis was performed using the categories created and applied by SIDBA, which incorporated the UN ESCR Committee’s right-to-health framework outlining the principles of availability, non-discrimination, physical accessibility, economic accessibility (affordability), information access, acceptability (ethically and culturally appropriate), and quality

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<sup>33</sup> A table describing the reviewed databases and quality of the information can be found in Annex 1.6

(Committee on Economic Social and Cultural Rights, 2000; Dirección de Participación Social y Servicio al Ciudadano. Alcaldía Mayor de Bogotá, 2010). The results of article 2 were organized following the structure proposed by the analytical framework outlined in section 1.1 (Global Center for the Study of Law and Social Transformation, 2011).

For article 3, five drugs were initially randomly selected from the list of technologies evaluated by the CRES in the prioritization process performed in 2011 (Comisión de Regulación en Salud, 2011a). As none of these drugs were subsequently included in the POS after the prioritization process, we decided to make a second random selection of five drugs, but this time from the list of drugs that were ultimately included in the POS (Comisión de Regulación en Salud, 2012b). This was performed with the aim of providing a better understanding of the possibilities provided by the template when the drug is prioritized.

For each of these ten selected drugs, we searched for published health technology assessments (HTAs) on the CRES website. The website contains two lists: (i) HTAs that recommended including the technology in the POS; and (ii) HTAs with other recommendations (such as to not include or to include with the caveat that an economic assessment be performed) (Comisión de Regulación en Salud, 2011c, 2011d). For seven of the selected drugs, we located one HTA for each. For two of the selected drugs, azithromycin and cefuroxime, we found two HTAs each (one for adults and one for children). Since esomeprazole did not have a HTA, we reviewed eleven HTAs in total. For the ten drugs, we also extracted information from the documents prepared by the CRES. This information included, among other things, the CRES's reasons for including or excluding a particular drug, and information on drugs included and excluded from the same pathology group. We also reviewed HTAs on insulin glargine and mycophenolate that were developed by the National University in 2010 in consultation with the CRES as part of the CRES's first exercise in developing a methodology

for health technologies assessments. The extracted information for each drug was used to complete the ethical template.

The results of the three articles were used to answer the questions presented in this thesis. The next section presents a description of each of the articles, including their main results and conclusions.

## ***5. Articles Summary***

### *Article 1*

Article one investigates how participation has been understood and practiced by the bodies in charge of implementing decision T-760/2008. As mentioned above, following a comprehensive human rights approach, the Court required this reform process to ensure the participation of the scientific community and users of health services. The article addresses the current debate regarding the application of participatory approaches to the development of health policies and programs. Using the example of decision T-760/2008's implementation, but also going beyond the Colombian context, the article analyzes the possibilities for and challenges to meaningful participation in health, and the role of courts in fostering deliberative processes.

As the article contends, despite widespread recognition of popular participation as a key aspect of the development of health policies and programs (Rifkin, 2009; World Health Organization & Office of the High Commissioner for Human Rights, 2010), scholars have raised concerns over the shortcomings of participatory approaches in genuinely empowering the people they ostensibly serve (Cooke, 2001), as well as over the lack of substantial evidence concerning the usefulness of participation (how it can really lead to better decision-making processes) (Church et al., 2002). In the article, I propose that such shortcomings can

be a signal of the resistance that some participatory initiatives produce, especially when their implementation entails a change in the relationship between citizens and authorities, such as when authorities provide agency to those usually ignored. The article argues that there are major differences between participatory approaches, especially regarding the role played by participatory spaces (e.g., whether they are informative, consultative, or decision-making spaces).

Since decision T-760/2008 adopted a specific approach, the evaluation of the participatory process under the decision's implementation process must assess whether the requirements of this approach have been fulfilled. According to the comprehensive human rights perspective adopted by T-760/2008, participation must guarantee the following: (i) institutional mechanisms to ensure that people can participate; (ii) capacity building for participation (for health policymakers, individuals, and groups) that includes empowerment and an analysis of power relations; (iii) participation throughout the process (in setting the agenda for discussion, making policy choices, implementation, monitoring, and evaluation); and (iv) accessible accountability and conflict-resolution mechanisms (Potts, 2008).

On the basis of these principles, I analyzed the implementation process for T-760/2008 during the three years following the decision. The article concludes that despite the implementation of participatory processes by Colombian authorities, the requirements of a comprehensive human rights approach to participation have not been fulfilled. Contextual factors, such as pre-existing power imbalances and traditions regarding how to implement policy reforms, influence the overall implementation process of judicial decisions, and, as consequence, the effects of these decisions. These are characteristics that must be considered in the assessment of participatory processes such as the one called for by the Court. However, this has been

neglected, even by the Court itself. The quality of the participation has not been a core element of evaluation and debate,<sup>34</sup> and there have been no spaces for agreeing on the parameters of participation alluded to in the Court's decision, as if participation had a universal and unique meaning.

Nevertheless, the approach adopted by the Court, calling for a broad democratic dialogue to define the new benefit plan (POS), constitutes a novelty in the Colombian context. This is so not because Colombia has never had participatory processes but because the country's experiences of such processes at the level required by the Court's decision (formulation of health public policies) have been traditionally implemented following an instrumental approach to participation.

### *Article 2*

This article assesses the implementation of one order of decision T-760/2008 relating to children's right to health. This article explores whether the reforms implemented allowed for a correction of the structural problems addressed by T-760/2008. It also explores whether these reforms have led to an improvement in the POS structure and in the effective enjoyment of the right to health by Colombian children.

Children's right to health was selected because T-760/2008 stressed that children are a group requiring special protection and because both the Colombian Constitution and the Court's jurisprudence expressly recognize children's right to health, in contrast to the general right to health, which the Court has derived from other rights, such as the rights to life and dignity.

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<sup>34</sup> This was an almost absent topic in the public hearing organized by the Constitutional Court on 7 July 2011 to evaluate progress in the implementation of orders 16, 17, 18, 21, and 22.



As a basis for the analysis, we outlined a theoretical approach for evaluating the implementation and effects of judicial rulings regarding health system reform.<sup>35</sup> The framework stressed the importance of including key contextual aspects in the analysis of legal strategies (such as judicial decisions) and of conceptualizing policymaking processes as highly influenced by contextual factors, such as power relations and political settings. In this sense, the framework differed from those approaches that conceptualize policymaking as a closed and linear process, and that characterize it as a technocratic challenge.

The article concludes that despite Colombian authorities' nominal compliance with the Court's orders, authorities have not fulfilled their constitutional responsibility to organize, direct, and regulate the provision of health services in a way that allows for the effective enjoyment of the right to health for all children.

### *Article 3*

Article 3 assesses the fairness and legitimacy of the system established to update Colombia's health plan, or POS, focusing its analysis on health technology assessments of the drugs.

Even if T-760/2008 did not provide an explicit framework to assess the fairness and legitimacy of the priority-setting process, the decision did require the POS update to (i) clearly define what health services are included in the benefit plans, (ii) establish what services are excluded, specifying those currently not covered under the benefit plans that gradually will be included, and indicating the goals and dates for expansion; (iii) decide what services should be removed from the benefit plans, justified in terms of health priorities, so as

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<sup>35</sup> This is the same framework as that presented in section 1.1.

to better protect human rights; and (iv) take into account the sustainability of the health system and the financing of the POS.

By adopting these principles, the Court explicitly required a prioritization process going beyond technical assessment and including public deliberation. This approach is in line with theoretical approaches to justice in health, one of the most prominent of which is called “accountability for reasonableness” (A4R), developed by Norman Daniels and James Sabin. According to A4R, prioritization processes must comply with four conditions: (i) publicity (public accessibility of rationales behind decisions); (ii) relevance (acceptance of evidence, reasons, and principles as relevant by fair-minded people); (iii) revision and appeals (institutionalization of mechanisms to challenge and dispute decisions and, more broadly, opportunities for revision and improvement of policies in light of new evidence or arguments); and (iv) regulation (public regulation of the process to ensure that the first three conditions are met).

In this article, we use an ethical template based on the A4R fair process principles (Daniels, Teagarden, & Sabin, 2003) to evaluate the drug prioritization process performed in Colombia in 2011 as part of the POS update. The ethical template organizes reasons regarding coverage and non-coverage of pharmaceutical products, and proposes a four-level hierarchy for decision-making about drug coverage. The template was used to analyze the prioritization process for ten randomly selected drugs performed by Colombian authorities during 2011.

The results show that the implementation of decision T-760/2008 has produced positive changes in the design of the decision-making process involved in health-care priority setting: in 2010, the CRES designed a methodology and a process by which this methodology would be approved by key Colombian actors (including civil society organizations, medical associations, and patients’ organizations).

However, despite this development, according to our analysis, implementation of the prioritization process has presented major weaknesses that undermine its fairness and legitimacy. These weaknesses are mainly associated with a lack of information and transparency in the decision-making process. This lack of information and transparency sometimes contradicts what was stated in the approved methodology.

## *6. Discussion*

The overall aim of this thesis is to contribute to the current debate regarding the strengths and limitations of economic and social rights litigation. The analysis focuses on the effects that contextual preconditions play in the implementation of judicial decisions aimed at protecting economic and social rights.

This section is organized following the framework adopted in this thesis (see section 1.1). As mentioned above, the three articles that make up this thesis address different aspects of this framework. The conclusions from each of the articles will be summarized and discussed in this section.

### *Legal Strategy*

As described in section 2.3, decision T-760/2008 is an ambitious ruling from the Colombian Constitutional Court that addresses the Colombian health system as a whole. Even for the preparation of its ruling, the Court consulted with different actors—an action that reflects the Court's approach to the health system's problems. Another main characteristic is that the decision did not create homogenous reactions of support or rejection from the various sectors of Colombian society. As mentioned earlier, while there are opposing positions regarding the health system's structure, decision T-760/2008 received neither clear and open support from

the sectors in favor of the structure created by Law 100 nor wholesale rejection from those more critical of it (see, e.g., Alzate, 2009; Castaño, 2008).

In this context, the Court, based on its experience from previous decisions (mainly decision T-025/2004), called on civil society organizations to form monitoring groups to oversee the decision's implementation. In addition to these monitoring groups, the Court invited a group of experts to discuss topics related to the decision (Corte Constitucional de Colombia, 2011a).

During the time period covered in this study, there were no legal attempts to overturn the decision, showing that despite the variety of positions towards T-760/2008, there existed a shared perception that the health system has structural problems that require intervention. Further, although the judicial intervention has been pointed out by some scholars as being one of the main factors responsible for the system's economic crisis (see, e.g., Guerrero, et al., 2011), Colombia "has a tradition of judicial independence and the Constitutional Court has built on this independence" (Cepeda-Espinosa, 2011, p. 1699).<sup>36</sup> The Court's role and authority is respected by organizations and authorities at various levels, proving the Court "social authority" to demand information from different state branches as well as private actors. This legitimacy also reflected on the events organized by the Court, such as public hearings.

### *Intermediary Mechanisms*

The articles that constitute this thesis analyze three intermediary mechanisms for the implementation of decision T-760/2008: (i) the parameters adopted by Court regarding

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<sup>36</sup> For example, in February 2010, the Court declared unconstitutional a law allowing for a third presidential term. This law would have allowed then President Uribe to run in the 2010 presidential elections. At the time, Uribe enjoyed citizens' support, and Congress had approved the law.

participation; (ii) the effects of the decision on the decision-making process and on power relations within decision-making spaces; and (iii) the effects on institutions.

In each of the three articles, it is possible to detect the same trend: authorities have only nominally complied with what was ordered by the Court. However, this nominal compliance should not be minimized. Institutions such as the CRES were created,<sup>37</sup> regulations were issued to improve the information system on health service denials, mechanisms were developed for public participation in the POS review process and equalization, and regulations were issued to equalize the POS. Nevertheless, these measures were insufficient in terms of fulfilling the Court's orders and providing solutions to problems within the health systems, beyond directly addressed by decision T-760/2008.

Indeed, the articles in this thesis demonstrate that these measures were not enough to challenge power relations within the health system. Power relations are a key element in health, as they shape social structures and processes (Commission on Social Determinants of Health, 2008). In the case study analyzed herein, power relations exist at the level of decision-making processes and at the level of accountability.

Regarding the decision-making process, the articles find that the shortfalls in fulfilling decision T-760/2008's requirements around participation were deeply influenced by different actors' varying perceptions of participation, which did not necessarily harmonize with what was required by the Court's framework. Articles 1 and 3 show how decision-making processes cannot be understood as linear processes, isolated from societal values and norms, where it is possible to go directly from problem identification to policy implementation

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<sup>37</sup> The CRES was liquidated in December 2012 (Ministerio de Salud y Protección Social, 2012). Its functions were transferred to the Ministry of Health and Social Protection.

(Freedman, 2006; Freedman, et al., 2005). Yet, in Colombia, decision-making processes within the health system have been dominated by an approach that sees participatory spaces merely as venues for information and consultation. In addition, policymaking processes have been controlled by the political elite.<sup>38</sup> The Court asked for a dramatic change to this approach, requiring a broader participatory process—but this request was not fulfilled.

One of the problems in this regard is that the Court has faced difficulties in creating benchmarks for participation. In 2011, the Court initiated a consultation process with experts in order to discuss and create benchmarks to assess the fulfillment of decision T-760/2008. The Court planned to include a group of civil society organizations in this process, with the aim of addressing the component of participation. While the Court organized a few meetings with these organizations, in the end, the results from these meetings were not included in the Court's report on the recommendations made by the group of experts.

This lack of clear benchmarks on what constitutes participation in the health system sheds light on the Court's capacity to monitor the implementation of participatory processes. Despite evidence of the Ministry of Social Protection and the CRES's poor compliance with the human rights approach, and the observations sent by different organizations to the Court highlighting the barriers to effective participation, the Court has not used the lack of participation as an argument to declare non-compliance (partial or total) with decision T-760/2008. This indicates that despite the adoption of a comprehensive human rights framework in T-760/2008 — and the fact that this is not the first decision of the Court that

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<sup>38</sup> For example, Diego Palacio, former minister of health, was part of the group in charge of the design of Law 100 and was the minister of social protection between 2003 and 2010. Teresa Tono was also part of the team in charge of designing Law 100, and was later hired by PARSALUD to support the implementation of the law. Nelcy Paredes Cubillo was also part of the same team, and later served as vice-president of the Association of Comprehensive Medicine Companies. Teresa Tono was hired by the Ministry of Social Protection, under the Palacio administration, to advise the ministry on how to respond to decision T-760/2008.

calls for broader participation of the people affected by the policies<sup>39</sup>—for the Court, there are other topics where it is easier to assess the level of compliance.<sup>40</sup>

Finally, the power imbalances challenged by T-760/2008 are not only at the level of the POS structure or between the actors directly involved in policy design. Corruption and clientelism have been common practices within the Colombia health system as a whole. They reflect a system of norms that must be changed if the health system reform is to be successful. However, as the implementation process of T-760/2008 shows, this is a complex task that requires political willingness and institutional capacity. These findings reveal a situation where some changes have been implemented but where the core sources of the problems remain unaffected. Our findings agree with the position presented by the Court in a public hearing in 2012, where the Court lamented the bleak situation of the health system—in contrast to the government’s reply, which stressed that all necessary measures to protect the enjoyment of the right to health had been taken. The Court identified structural problems that the governmental responses had not addressed, such as corruption, the dominance of private interests over public interests, and the inadequate administrative management of health resources. The Court ended by asking if it was perhaps time to re-assess the role of private insurers in the social security system in health (Corte Constitucional de Colombia, 2012).

### *Effects on Access to Health Care*

While it is too early to assess the decision’s effects on access to health care, after examining the shortfalls in addressing problems at the level of intermediary mechanisms, it is to be expected that the implementation measures have failed to achieve the decision’s expected outcomes. According to the data presented in article 2, despite the formal equalization of the

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<sup>39</sup> Such as decision T-025/2004.

<sup>40</sup> Such as in the case of the children’s POS, where the Court declared partial non-compliance, using an “objective” legal parameter (the age of 18).

children's POS, Colombian children continue to face barriers in accessing health care. Nevertheless, the government decided to move forward with the equalization of the adult population's POS before solving the problems already detected in providing equal access to children and in the equalization pilot programs in Cartagena and Barranquilla. Adults, too, continue to face barriers. For example, in the case of patients with mental health disabilities, prior to the equalization of the POS, their treatments were covered fairly effortlessly by the municipalities. After the equalization, their treatments became the responsibility of the EPSs, which denied the treatments (*El Tiempo*, 2012).

Another indicator of the problems faced by the population in accessing health care—and of the insufficiency of the government's measures—is the number of right-to-health *tutelas*. According to the most recent report from the Ombudsman's Office, an increase in *tutelas* was experienced in 2011, after a two-year decline; the majority of these claims (67.8%) were for services already included in the POS (Defensoría del Pueblo, 2012).

However, despite the perverse effects and shortfalls, some groups have experienced an increase in coverage. The equalization of the POS was a progressive process that started with the equalization of the children's POS in 2010, followed by the equalization of the POS for people over 60 years old in 2011, and ending with the equalization of the POS for all Colombians in July 2012. These changes should not be underestimated. They had a major symbolic effect in provided equal rights to the worst-off in terms of access to health care. However, that the worst-off must still prove their poverty status before they can enroll in the subsidized regime limits the symbolic effects of the equalization.

*Themes for Further Development*



Most of the findings presented in the three articles and in this section refer to what are categorized as direct and indirect material effects at the level of intermediary mechanisms. As mentioned in the methodology section, one of the main limitations of this dissertation has been the lack of data on symbolic effects. However, I will attempt to present some areas where, in my opinion, it is possible to find some symbolic effects, with the hope that these areas could be analyzed in future research.

One area for further research is on how the right to health is represented in legal documents, such as laws, and how T-760/2008 has influenced this representation. For example, when comparing Law 100 (1993), Law 1122 (2007), and Law 1438 (2011)—different texts that were created under the same Constitution—one can see major changes in how the right to health is identified and protected. While all three laws mention the right to social security in health, Law 1438 goes a few steps further by providing content on the right, as well as setting limits. It stresses the protection of vulnerable populations (such as pregnant women, children, and people with disabilities) and diseases (such as mental health), including the development of special measures to protect their health (articles 17–21 and 65–66). The law also provides a definition of integral care and stresses the need to strengthen the information system on the performance of insurers and providers as a key measure to guarantee users' right to free and informed choice (article 107). Law 1438 also differs from the previous laws in its emphasis on limiting individuals' access to treatments that could have a negative impact on the system's economic sustainability, and consequently on access to health care for the rest of the population (articles 3 and 104).

Another major development is the projects for a statutory law to regulate the right to health presented to the Congress in 2012 (Senado de la República de Colombia, 2012). This was a requirement from the Constitutional Court (Corte Constitucional de Colombia, 2010b).

One more example is the newly established National Pharmaceutical Policy, which was formulated within the right-to-health framework adopted by the Constitution. This represents a major departure from its predecessor from 2004, which did not mention the constitutional principle of the right to health (Departamento Nacional de Planeación, Ministerio de Salud y Protección Social, & Instituto Nacional de Vigilancia de Medicamentos y Alimentos, 2012; Ministerio de la Protección Social, 2004).

Another area for research could be to explore changes in the Court's discourse. For example, while in decision T-760/2008 the Court requested the implementation of changes within the framework created by Law 100, by May 2012, after seeing the difficulties faced by the government in controlling the health system, the Court changed its position. It asked the government whether it might be necessary, in order to guarantee the right to health of Colombians, to consider the need for private actors that act as intermediaries inside the health system (Corte Constitucional de Colombia, 2012).

## ***7. Conclusions***

The implementation process for decision T-760/2008 demonstrates several of the challenges involved in assessing judicial interventions, particularly in showing how the assessment of ESCR litigation can be context sensitive. This is not to say that it is impossible to assess litigation, but rather that it requires taking contextual factors into consideration. The analytical framework used in this dissertation provides consistency in its levels and variables, as well as

in the types of effects, allowing for a comprehensive analysis of the effects of decision T-760/2008. However, it is important to reiterate that the analysis was driven by normative premises regarding health, which led to the selection of certain facts over others.

This thesis raises a set of questions regarding the implementation process for decision T-760/2008 that are addressed in the three articles and in the dissertation's general discussion. According to my analyses, it is possible to argue that despite some important developments, there have not been major changes in the power relations within the health system, and that this is damaging to the trust that has been built around the reform process.

While it is not possible to prove that health regulations issued after 2008 are a direct consequence of decision T-760/2008, it is true that in order to respond to the Court's decision, Colombian authorities implemented a number of reforms affecting the organization of the country's health system. However, despite these efforts, the reforms did not lead to an improvement in the fairness and legitimacy of the POS design. The lack of transparency of some of the decisions raises serious doubts about the entire process. Furthermore, as has been demonstrated, people in Colombia still face serious barriers in access to health care.

Regarding the question of how contextual factors drive the implementation of decision T-760/2008, this thesis advocates for the inclusion of the social determinants of health in analyses of right-to-health litigation. The case study examined here shows how the health system is a marker of a government's performance.

The findings support the understanding of an intimate relationship between the economic impact of litigation and regulation within the health system (Yamin, 2011), and strengthen arguments for using comprehensive frameworks such as the one presented in this thesis.

Judicial decisions such as T-760/2008 are not the only path for contesting health inequities. Nevertheless, the evidence collected in this dissertation shows that this legal strategy has not harmed the authority of Colombian health institutions or damaged the system's economic sustainability, as some predicted when the decision was issued in 2008 (see, e.g., Caracol, 2008; Castaño, 2008; Tsai, 2010). Instead, during T-760/2008's implementation process, regulatory bodies within the health system have been strengthened, corruption cases have been uncovered, and measures to improve expenditures (such as prices controls for certain drugs) have been implemented. Despite its shortfalls, the implementation process could be argued to have produced positive direct effects at the level of the health-care system's organization.

My analyses allow me to conclude that despite the economic impact of right-to-health *tutelas*, these legal actions—and consequently the intervention of Colombian judges—have not been the main sources of the health system's economic crisis, as various scholars have argued (Guerrero, et al., 2011). The problems of Colombia's health system are more complex and are embedded in structural factors. The same structural factors have played a critical role in the implementation of decision T-760/2008, limiting the judgment's capacity to achieve its objectives and to secure equity in the provision of health services. These results show the importance of taking structural factors into account when analyzing the use of legal strategies.

## References

- Agudelo, C. A., Cardona, J., Ortega, J., & Robledo, R. (2011). Sistema de salud en Colombia: 20 años de logros y problemas. *Ciência e Saúde Coletiva* 16(6), 2817-2828.
- Arbelaez, M. P., Gaviria, M. B., Franco, A., Restrepo, R., Hincapié, D., & Blas, E. (2004). Tuberculosis control and managed competition in Colombia. *International Journal of Health Planning and Management*, 2004(19), S25-S43.
- Barón, G. (2007). Cuentas de la salud en Colombia 1993-2003: El gasto nacional en salud y su financiamiento. Bogotá: Ministerio de la Protección Social - Programa de Apoyo a la Reforma de Salud.
- Bergallo, P. (2011). Courts and Social Change: Lessons from the Struggle to Universalize Access to HIV/AIDS Treatment in Argentina. *Texas Law Review*, 89, 1611-1641.
- Bolle, M. J. (2012). U.S.-Colombia Free Trade Agreement: Labor Issues. Washington D.C: Congressional Research Service.
- Bossert, T., Hsiao, W., Barreda, M., Alarcon, L., Leo, M., & Casares, C. (1998). Transformation of ministries of health in the era of health reform: the case of Colombia. *Health Policy and Planning*, 13(1), 59-77.
- Camacho, A., & Conover, E. (2009). Manipulation of Social Program Eligibility: Detection, Explanations and Consequences for Empirical Research. In Centro de Estudios sobre Desarrollo Económico - CEDE (Ed.), *Documentos CEDE* (Vol. 19, pp. 37). Bogotá: Universidad de los Andes.
- Caracol. (2008). 'Se necesitan más de 6 billones de pesos para el nuevo POS': Gobierno. *Caracol Radio*, Actualidad. Retrieved from Caracol Radio website: <http://www.caracol.com.co/nota.aspx?id=657293>
- Castaño, R. A. (2008). La Sentencia T-760 de 2008 frente al conflicto entre el individuo y la colectividad. In M. L. Torres (Ed.), *Revisión de la Jurisprudencia Constitucional en Materia de Salud: Estado de las Cosas frente a la Sentencia T-760 de 2008* (pp. 107-120). Bogotá Universidad del Rosario.
- Centro de Estudios Legales y Sociales. (2007). Litigio Estratégico, from <http://www.cels.org.ar/cels/?info=detalleTpl&ids=33&lang=es&ss=47>
- Cepeda-Espinosa, M. J. (2011). Transcript: Social and Economic Rights and the Colombian Constitutional Court. *Texas Law Review*, 89, 1699-1705.
- Church, J., Saunders, D., Wanke, M., Pong, R., Spooner, C., & Dorgan, M. (2002). Citizen Participation in Health Decision-Making: Past Experience and Future Prospects. *Journal of Public Health Policy*, 23(1), 12-32.
- Clavijo, S. (2009). Social Security Reforms in Colombia: Striking Demographic and Fiscal Balances *International Monetary Fund Working Papers* (pp. 31): International Monetary Fund

- Acuerdo 011 de 2010: unifica el POS para los niños y adolescentes menores de 18 años (2010).
- Comisión de Regulación en Salud. (2011a). *Actualización Integral 2011. Plan Obligatorio de Salud. Sistema General de Seguridad Social en Salud. Tecnologías a ser Evaluadas*. Bogotá: Retrieved from <http://www.cres.gov.co/Portals/0/circulares%20externas/TECNOLOGIAS%20A%20EVALUAR%2021092011.pdf>.
- Acuerdo 027 de 2011: unifica el POS para los adultos de 60 y más años (2011b).
- Comisión de Regulación en Salud. (2011c). Consulta Ciudadana. Evaluaciones con otros conceptos Retrieved Last access April 5, 2012, from <http://www.cres.gov.co/consultaciudadana/Novedades.aspx>
- Comisión de Regulación en Salud. (2011d). Consulta Ciudadana. Tecnologías en Salud Evaluadas y Conceptuadas Retrieved Last Access April 5, 2012, from <http://www.cres.gov.co/consultaciudadana/tecnologias.aspx>
- Acuerdo 032 de 2012: unifica el POS para los adultos entre 18 y 59 años (2012a).
- Comisión de Regulación en Salud. (2012b). *Inclusiones y supresiones Plan Obligatorio de Salud 2012*. Bogotá: Retrieved from <http://www.cres.gov.co/ActualizaciónPOS2011.aspx>.
- Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva: World Health Organization.
- Committee on Economic Social and Cultural Rights. (2000). General Comment 14. Geneva.
- Contesse, J., & Lovera, D. (2008). Access to medical treatment for people living with HIV/AIDS: Success without victory in Chile. *Sur. International Journal on Human Rights*, 5(8), 142-161.
- Cooke, B. (2001). The Social Psychological Limits of Participation? In B. Cooke & U. Khotary (Eds.), *Participation: The New Tyranny?* (pp. 102 – 121). London- New York: Zed Books.
- Sentencia C-133 de 1994. Magistrado Antonio Barrera Carbonell (1994).
- Sentencia T-025 del 2004. Magistrado Manuel José Cepeda Espinosa. (2004).
- Sentencia C-355 del 2006. Magistrados Clara Inés Vargas Hernández and Jaime Araujo Rentería (2006).
- Sentencia T-760 de 2008. Magistrado Manuel José Cepeda Espinosa (2008).
- Auto S-34 del 2009. Magistrado Jorge Ivan Palacio Palacio (2009).
- Auto 094 del 2010. Magistrado Jorge Ivan Palacio (2010a).

- Sentencia C-252 del 2010. Magistrado Jorge Iván Palacio Palacio (2010b).
- Corte Constitucional de Colombia. (2011a). Seguimiento al Cumplimiento de la Sentencia T-760 de 2008. Bogotá.
- Sentencia T-841 de 11. Magistrado Humberto Antonio Sierra Porto (2011b).
- Corte Constitucional de Colombia. (2012). Cierre de la Audiencia Pública en Salud 2012.
- Courtis, C. (2008). *Courts and the Legal Enforcement of Economic, Social and Cultural Rights*. Geneva: International Commission of Jurists.
- Couso, J. (2006). The Changing Role of Law and Courts in Latin America: From an Obstacle to Social Change to a Tool of Social Equity. In R. Gargarella, P. Domingo & T. Roux (Eds.), *Courts and social transformation in new democracies. An institutional voice for the poor?* (pp. 61-79). Hampshire: Ashgate.
- Cubillos, L., Pulido, A., Alfonso, E., Bolivar, M., & Castrillón, J. (2009). Evaluación del plan obligatorio de salud de los regímenes contributivo y subsidiado en el sistema general de seguridad social en salud colombiano y lineamientos para su reforma. Bogotá: Ministerio de la Protección Social. .
- DANE. (2009). Encuesta Calidad de Vida 2008. Presentación de Resultados. Bogotá: Departamento Administrativo Nacional de Estadística - DANE.
- DANE. (2011). Necesidades Básicas insatisfechas - desagregada Retrieved June 21, 2012, from [http://www.dane.gov.co/index.php?option=com\\_content&view=article&id=231&Itemid=66](http://www.dane.gov.co/index.php?option=com_content&view=article&id=231&Itemid=66)
- Daniels, N. (2008). *Just health. Meeting health needs fairly*. New York: Cambridge University Press.
- Daniels, N., Teagarden, J. R., & Sabin, J. E. (2003). An Ethical Template for Pharmacy Benefits. *Health Affairs*, 22(1), 125-137.
- Davies, D., & Dodd, J. (2002). Qualitative Research and the Question of Rigor. *Qualitative Health Research*, 12(2), 279-289.
- Defensoría del Pueblo. (2007). Autonomía Médica y su relación con la prestación de los Servicios de Salud. Bogotá: Defensoría del Pueblo.
- Defensoría del Pueblo. (2009). La tutela y el derecho a la salud. Período 2006-2008. Bogotá: Defensoría del Pueblo.
- Defensoría del Pueblo. (2010a). Evaluación de los Servicios de Salud que brindan las Empresas Promotoras de Salud 2009. Bogotá: Defensoría del Pueblo,.
- Defensoría del Pueblo. (2010b). La tutela y el derecho a la salud 2009. Bogotá: Defensoría del Pueblo.

- Defensoría del Pueblo. (2011). *La Tutela y el Derecho a la salud 2010*. Bogotá: Defensoría del Pueblo.
- Defensoría del Pueblo. (2012). *La Tutela y el Derecho a la Salud 2011*. Bogotá.
- Departamento Nacional de Planeación, Ministerio de Salud y Protección Social, & Instituto Nacional de Vigilancia de Medicamentos y Alimentos. (2012). *Documento CONPES Social. Política Farmacéutica Nacional* Bogotá: Retrieved from <http://www.minsalud.gov.co/PoliticasyFarmaceuticas/Politica%20farmaceutica/Documentos%20soporte/23042012%20CONPES%20POLIITCA%20FARMACEUTICA%20PROYECTO.pdf>.
- Dinero. (2010). ¿Trampa o solución de pobreza? *Dinero*. Retrieved from Dinero.com website: <http://www.dinero.com/caratula/edicion-impresa/articulo/trampa-o-solucion-pobreza/95598>
- Dirección de Participación Social y Servicio al Ciudadano. Alcaldía Mayor de Bogotá. (2010). *Manual de Lineamientos Técnicos sobre el Sistema de Información Distrital y de Barreras de Acceso a los Servicios de Salud - SIDBA* Bogotá: Alcaldía Mayor de Bogotá.
- El Espectador. (2010). Miles de personas protestan en varias ciudades contra la Emergencia Social. *El Espectador*. Retrieved from El Espectador.com website: <http://www.elespectador.com/noticias/salud/articulo186238-miles-de-personas-protestan-varias-ciudades-contra-emergencia-social>
- El Pulso. (2008). Continúan dificultades de pago de Dasalud Chocó. *El Pulso*. Retrieved from El Pulso website: <http://www.periodicoelpulso.com/html/0805may/general/general-15.htm>
- El Tiempo. (2008). "Colados" en el Sisbén. 17.000 colombianos pudientes incluidos en el Sisbén pueden ser la punta del tímpano de una vasta red de corrupción. *El Tiempo*. Retrieved from El Tiempo website: <http://www.eltiempo.com/archivo/documento/CMS-4184148>
- El Tiempo. (2010). Iglesia pide que sean ajustados los decretos de la Emergencia Social. *El Tiempo*. Retrieved from El Tiempo.com website: [http://www.eltiempo.com/vidadehoy/salud/iglesia-pide-que-se-ajusten-los-decretos-de-emergencia-social\\_7146108-1](http://www.eltiempo.com/vidadehoy/salud/iglesia-pide-que-se-ajusten-los-decretos-de-emergencia-social_7146108-1)
- El Tiempo. (2012). Protestas por negación de servicios de salud mental. *El Tiempo*. Retrieved from El Tiempo.com website: [http://www.eltiempo.com/vida-de-hoy/salud/ARTICULO-WEB-NEW\\_NOTA\\_INTERIOR-10945713.html](http://www.eltiempo.com/vida-de-hoy/salud/ARTICULO-WEB-NEW_NOTA_INTERIOR-10945713.html)
- Escobar, M.-L., Giedion, U., Giuffrida, A., & Glassman, A. L. (2009). Colombia: After a Decade of Health System Reform. In A. Glassman, M. L. Escobar, A. Giuffrida & U. Giedion (Eds.), *From few to many: ten years of health insurance expansion in Colombia* (pp. 1-13). Washington DC: Inter American Development Bank - The Brookings Institution.
- Escuela Nacional Sindical. (2010). Informe nacional de coyuntura económica, laboral y sindical en 2010. Pese al crecimiento económico, no mejora la situación laboral del



país. Retrieved from Escuela Nacional Sindical website:  
<http://www.ens.org.co/index.shtml?apc=ba--;1;-;-;&x=20166447>

- Ewig, C., & Hernández-Bello, A. (2009). Gender equity and health sector reform in Colombia: Mixed state market model yields mixed results. *Social Science & Medicine* 68(2009), 1145 – 1152.
- Ferraz, O. L. M. (2009). The right to health in the courts of Brazil: worsening health inequities? *Health and Human Rights*, 11(2), 33-45.
- Flórez, C. E., Giedion, U., Pardo, R., & Alfonso, E. A. (2009). Financial Protection of Health Insurance. In A. Glassman, M. L. Escobar, A. Giuffrida & U. Giedion (Eds.), *From few to many: ten years of health insurance expansion in Colombia* (pp. 103-155). Washington D.C: Inter American Development Bank - The Brookings Institution.
- Freedman, L. (2006). Achieving the MDGs: Health systems as core social institutions. *Development* 48(1), 19-24.
- Freedman, L., Waldman, R., de Pinho, H., Wirth, M., Chowdhury, M., & Rosenfield, A. (2005). Who's got the power? Transforming health systems for women and children. London: UN Millenium Project. Task Force on Child Health and Maternal Health.
- Gargarella, R., Domingo, P., & Roux, T. (2006). *Courts and social transformation in new democracies. An institutional voice for the poor?* Hampshire: Ashgate.
- Gauri, V., & Brinks, D. (Eds.). (2008). *Courting Social Justice. Judicial Enforcement of Social and Economic Rights in the Developing World*. (First ed.). New York: Cambridge University Press.
- Gaviria, A., Medina, C., & Mejia, C. (2006). Evaluating The Impact Of Health Care Reform in Colombia: From Theory To Practice. Bogotá: CEDE - Universidad de los Andes.
- Gaviria, M. B., Henao, H. M., Martínez, T., & Bernal, E. (2010). Papel del personal de salud en el diagnóstico tardío de la tuberculosis pulmonar en adultos de Medellín, Colombia [The role of health care providers in the late diagnosis of pulmonary tuberculosis among adults in Medellín, Colombia]. *Revista Panamericana de Salud Pública*, 27(2), 83-92.
- Gianella-Malca, C. (2012). *Ready to respect the court ruling?* Paper presented at the European Network on Latin American Politics VI Annual meeting University of Bergen
- Gianella-Malca, C., Parra-Vera, O., Yamin, A. E., & Torres-Tovar, M. (2009). ¿Deliberación Democrática o Mercadeo Social? Los dilemas de la definición pública en salud en el contexto del seguimiento de la sentencia T-760 de 2008. *Health and Human Rights: An International Journal*, 11, 1-13.
- Giedion, U., Díaz, B. Y., Alfonso, E. A., & Savedoff, W. D. (2009). The Impact of Subsidized Health Insurance on Health Status and on Access to and Use of Health Services. In A. Glassman, M. Escobar, A. Giuffrida & U. Giedion (Eds.), *From few to many: ten years of health insurance expansion in Colombia* (pp. 47-74). Washington DC: Inter American Development Bank - The Brookings Institution.

- Giedion, U., Panopoulou, G., & Gómez-Fraga, S. (2009). Diseño y ajuste de los planes explícitos de beneficios: el caso de Colombia y México *Financiamiento del Desarrollo*. Santiago de Chile: Naciones Unidas-Comisión Económica para América Latina y el Caribe (CEPAL).
- Glassman, A., Escobar, M. L., Giuffrida, A., & Giedion, U. (Eds.). (2009). *From few to many: ten years of health insurance expansion in Colombia*. Washington DC: Inter American Development Bank - The Brookings Institution.
- Global Center for the Study of Law and Social Transformation. (2011). *Global Center for the Study of Law and Social Transformation Concept Note*. Paper presented at the Global Center Workshop, Chr. Michelsen Institute. Bergen. Norway.
- Gloppen, S. (2008). Litigation as a strategy to hold governments accountable for implementing the right to health. *Health and Human Rights*, 10(2), 21-36.
- González- Rossetti, A., & Ramírez, P. (2000). Enhancing the Political Feasibility of Health Reform: The Colombia Case. *Data for Decision Making (DDM) project: Latin America and Caribbean Regional Health Sector Reform Initiative*.
- González, A. C., & Durán, J. (2011). Impact of Court Rulings on Health Care Coverage: The Case of HIV/AIDS in Colombia. *MEDICC Review*, 13(3), 54-57.
- Guerrero, R. (2008). Financing universal enrollment to social health insurance: lesson from Colombia *Well- Being and Social Policy*, 4(2), 75-98.
- Guerrero, R., Gallego, A. I., Becerril-Montekio, V., & Vásquez, J. (2011). Sistema de salud de Colombia. *Salud Pública de México*, 53(Suplemento 2), s144-s155.
- Harper, S., King, N., Meersman, S., Reichman, M., Breen, N., & Lynch, J. (2010). Implicit Value Judgements in the Measurement of Health Inequalities. *The Milbank Quarterly*, 88(1), 4-29.
- Health Action International. (2009). Being sick and needing medicines is a costly misfortune in many countries. A one day snapshot of a medicine's price across 93 countries. Amsterdam: Health Action International.
- Hernández, M. (2010). ¿Derecho a qué?. El debate sobre la sentencia T-760/2008. *Cuadernos del Doctorado*.(11), 27-44.
- Homedes, N., & Ugalde, A. (2005). Why neoliberal health reforms have failed in Latin America. *Health Policy and Development*, 71(2005), 83-96.
- Hunt, P., & Backman, G. (2008). Health systems and the rights to the highest attainable standard of health *Health and Human Rights*, 10(1), 81-92.
- Internal Displacement Monitoring Centre. (2011). Current IDP figures Retrieved November 4 2011, from [http://www.internal-displacement.org/idmc/website/countries.nsf/\(httpEnvelopes\)/A7E1B7BD7528B329C12575E500525165?OpenDocument#expand](http://www.internal-displacement.org/idmc/website/countries.nsf/(httpEnvelopes)/A7E1B7BD7528B329C12575E500525165?OpenDocument#expand)

- Intervention of Senator Dr. Jorge Enrique Robledo Castillo. Audiencia Pública de Rendición de Cuentas en Salud. Bogotá, (2011).*
- La mesa por la vida y la salud de las Mujeres. (2009). *Un derecho para las mujeres: La Despenalización parcial del Aborto en Colombia*. Bogotá: La mesa por la vida y la salud de las Mujeres.
- La Mesa por la Vida y la Salud de las Mujeres. (2011). El acceso al aborto seguro y su impacto en la salud de las Mujeres en Colombia. Bogotá.
- Langford, M. (2008a). The Justiciability of Social Rights: From Practice to Theory. In M. Langford (Ed.), *Social Rights Jurisprudence. Emerging Trends in International and Comparative Law* (pp. 3-45). New York: Cambridge University Press.
- Langford, M. (2009). Domestic Adjudication of Economic, Social and Cultural Rights: A Socio-Legal Review *Sur. International Journal on Human Rights*, 11, 91-121.
- Langford, M. (Ed.). (2008b). *Social Rights Jurisprudence. Emerging Trends in International and Comparative Law*. New York: Cambridge University Press.
- Laurell, A. C., & Herrera-Ronquillo, J. (2010). La Segunda Reforma de Salud. Aseguramiento y compra-venta de servicios. *Salud Colectiva*, 6(2), 137-148.
- López, C. (2010). *Y refundaron la patria. De cómo políticos y mafiosos reconfiguraron el Estado Colombiano*. Bogotá Random House Mondadori.
- Malagón, R. (2010). La Sentencia T-760/2008: reseña crítica. *Cuadernos del Doctorado.*, 11, 13-26.
- McCann, M. (1992). Reform Litigation on Trial. *Law and Society Inquiry*, 17(4), 715-743.
- Médicos Sin Fronteras. (2010). Acceder a la salud es acceder a la vida: 977 voces. Bogotá: Médicos Sin Fronteras.
- Ministerio de la Protección Social. (2004). *Política farmacéutica nacional*. Bogotá: Retrieved from <http://apps.who.int/medicinedocs/documents/s18068es/s18068es.pdf>.
- Ministerio de la Protección Social. (2009a). *Decreto 4975 de 2009 por el cual se declara el Estado de Emergencia Social*. Bogota.
- Ministerio de la Protección Social. (2009b). Plan Obligatorio de Salud. POS Retrieved February 9, 2011, from <http://www.pos.gov.co/Paginas/preguntassobrecopagosycuotasmoderadorasycuotasdercuperacion.aspx#pregunta3>
- Decreto Número 2560 de 2012 Por el cual se suprime la Comisión de Regulación en Salud - CRES, se ordena su liquidación y se trasladan unas funciones al Ministerio de Salud y Protección Social y se dictan otras disposiciones (2012).
- Molina, G., Muños, I. F., & Ramírez, A. (Eds.). (2009). *Dilemas en las decisiones en la atención en salud. Ética, derechos y deberes constitucionales frente a la rentabilidad financiera*. Bogotá: Universidad de Antioquia, Procuraduría General de la Nación,

Instituto de Estudios del Ministerio Público, COLCIENCIAS, Universidad Industrial de Santander.

- Observatorio de Discriminación Racial, Universidad de los Andes-Programa de Justicia Global, Comisión Colombiana de Juristas, Autoridad Nacional de Gobierno Indígena ONIC, & Proceso de Comunidades Negras. (2009). Alternate Report to the Fourteenth Report presented by the Colombian State to the Committee for the Elimination of all Forms of Racial Discrimination. Executive Summary. Bogotá.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (Second ed.). California: SAGE.
- Pinto, D., & Hsiao, W. (2007). Colombia: Social health insurance with managed competition to improve health care delivery. In W. Hsiao, R. P. Shaw & A. Fraker (Eds.), *Social health insurance for developing nations* (pp. 105-131). Washington D.C: The World Bank, Wbi Development Studies.
- Pinto, D., & Muñoz, A. L. (2010). Colombia: Sistema General de Seguridad Social en salud. Estrategia BID 2011-2014 *Notas Técnicas*. Madrid: Banco Interamericano de Desarrollo.
- Potts, H. (2008). Participation and the right to the highest attainable standard of health. Essex: Human Rights Centre, University of Essex.
- Procuraduría General de la Nación, Agencia de Estados Unidos para el Desarrollo Internacional, & Centro de Proyectos para el Desarrollo – Cendex. (2012). *Financiamiento del Sistema General de Seguridad Social en Salud Seguimiento y control preventivo a las políticas públicas*. Bogotá.
- Procuraduría General de la Nación, & Centro de Estudios de Derecho Justicia y Sociedad. (2008). *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*. Bogotá: Procuraduría General de la Nación - Centro de Estudios de Derecho Justicia y Sociedad.
- Ramirez, J. (2010). La Emergencia Social en Salud: de las contingencias regulatorias a la desilusión ciudadana (*The healthcare social emergency: from regulatory contingencies to citizen disappointment*). *Revista Gerencia, Política y Salud, Sup* 9(18), 124-143.
- Restrepo, J. H., Lopera, J. F., & Rodríguez, S. M. (2007). La integración vertical en el sistema de salud colombiano. *Revista de Economía Institucional*, 9(17), 279-308.
- Rifkin, S. (2009). Lessons from community participation in health programmes: a review of the post Alma Ata experience. *International Health*, 1(2009), 31-36.
- Rodríguez Garavito, C. (2011). Beyond the Courtroom: The Impact of Judicial. Activism on Socioeconomic Rights in Latin America. *Texas Law Review*, 89, 1669-1698.
- Rodríguez Garavito, C. (2012). ¿Quién sacó a la ministra de Salud? *El Espectador*. Retrieved from El Espectador.com website: <http://www.elespectador.com/opinion/columna-375557-quien-saco-ministra-de-salud>

- Rodríguez Garavito, C. (Ed.). (2010). *Más allá del desplazamiento: políticas derechos y superación del desplazamiento en Colombia*. Bogotá: Universidad de los Andes, Facultad de Derecho, Centro de Investigaciones Sociojurídicas - CIJUS.
- Rodríguez Garavito, C., & Rodríguez, D. (2010). *Corte y cambio social: Cómo la Corte Constitucional transformó el desplazamiento forzado en Colombia*. Bogotá: Dejusticia.
- Rosenberg, G. (1991). *The Hollow Hope: Can Courts Bring About Social Change?* Chicago: University Of Chicago Press
- Sabel, C., & Simon, W. (2004). Destabilization Rights: How Public Law Litigation Succeeds. *Harvard Law Review*, 117(2004), 1015-1101.
- Salud Colombia. (2009). Editorial. Finanzas de la salud, un problema estructural. *Salud Colombia*, (December 2009). Retrieved from Salud Colombia website: <http://www.saludcolombia.com/actual/salud83/editor83.htm>
- Santa María, M., & Perry, G. (2008). El fallo de la Corte sobre salud: La Trinidad Imposible. *Economía y Política. Análisis de la Coyuntura Legislativa*, 46(October).
- Savedoff, W. D. (2000). Reaching the poor through demand subsidies: The Colombian health reform. Washington D.C.: Inter-American Development Bank.
- Segura-C, A. M., Rey-S, J. J., & Arbeláez- M, M. P. (2005). Tendencia de la mortalidad y los egresos hospitalarios por tuberculosis, antes y durante la implementación de la reforma del sector salud, Antioquia, 1985-1999. [Tuberculosis mortality and hospital discharge tendencies before and during the health sector reform, Antioquia, 1985-1999 ]. *Revista Facultad Nacional de Salud Pública*, 23(2), 83-89.
- SEI, CENDEX, COLCIENCIAS, & Ministerio de la Protección Social. (2009). Encuesta Nacional de Salud 2007. Resultados Nacionales. Bogotá.
- Semana. (2010). No todo fue malo en la Emergencia Social. *Semana*. Retrieved from Semana website: <http://www.semana.com/noticias-salud--seguridad-social/no-todo-malo-emergencia-social/137841.aspx>
- Ponencia Para Primer Debate al Proyecto de Ley Estatutaria Número 48 de 2012 Senado y Acumulados por la cual se regula el Derecho Fundamental a la Salud y se crean mecanismos adicionales para su protección. (2012).
- Sevillano, O. (2011). La paraeconomía ayudó al desfaldo de la salud. Retrieved from <http://comunidad.semana.com/t5/Blog-Corporaci%C3%B3n-Nuevo-Arco-Iris/La-Paraeconom%C3%ADa-ayud%C3%B3-al-desfalco-de-la-salud/ba-p/5899>
- Silverman, D. (2009). *Doing Qualitative Research* (Third ed.). London: SAGE.
- Snape, D., & Spencer, L. (2003). The Foundations of Qualitative Research. In J. Ritchie & J. Lewis (Eds.), *Qualitative research practice. A Guide for Social Science Students and Researchers* (pp. 1-23). London: SAGE.

- Staveland, K. (2010). *Litigating the right to a healthy environment. Assessing the policy impact of "The Mendoza Case*. Master in comparative politics, Bergen University, Bergen.
- Superintendencia de Industria y Comercio. (2011). Informe Motivado. Bogotá: Superintendencia de Industria y Comercio.
- Territorio Chocoano. (2011). Primeras capturas por desfalco a la salud en el Chocó *Territorio Chocoano*. Retrieved from Territorio Chocoano website: <http://www.territoriochocoano.com/secciones/orden-publico/1682-primeras-capturas-por-desfalco-a-la-salud-en-el-choco.html>
- The Global Initiative for Economic Social and Cultural Rights (2012). Strategic Litigation and Legal Advocacy, from <http://globalinitiative-escr.org/strategic-priorities/strategic-litigation-and-legal-advocacy/>
- Tsai, T. C. (2010). Second chance for health reform in Colombia. *The Lancet*, 375, 109-110.
- UNDP. (2011). International Human Development Indicators, from <http://hdr.undp.org/en/data/profiles/>
- Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (2008).
- Uprimny, R., & Rodríguez, D. (2008). Aciertos e insuficiencias de la sentencia T-760 de 2008: implicaciones para el derecho a la salud en Colombia. *Observatorio de la Seguridad Social*, 7(18), 12-16.
- Uprimny, R., Rodríguez Garavito, C., & García Villegas, M. (2006). *¿Justicia para todos? Sistema judicial, derechos sociales y democracia en Colombia*. Bogotá: Grupo Editorial Norma.
- VanWynsberghe, R., & Khan, S. (2007). Redefining Case Study. *International Journal of Qualitative Methods*, 6(2), 80-94.
- Vasquez, M. D., Cortes, M. E., & Rossi, F. (2010). Precios de medicamentos en el mercado privado colombiano: en gasto injustificado en marcas comerciales. Bogotá: IFARMA.
- Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research*, 11(4), 522-537.
- Women's Link Worldwide. (2010). Strategic Litigation, from [http://www.womenslinkworldwide.org/what\\_cases.html](http://www.womenslinkworldwide.org/what_cases.html)
- World Health Organization. (2000). The World Health Report 2000. Health Systems: Improving Performance. Geneva: World Health Organisation.
- World Health Organization, & Office of the High Commissioner for Human Rights. (2010). A Human Rights-Based Approach to Health
- Yamin, A. E. (2011). Power, Suffering and Courts: Reflections on Promoting Health Rights through Judicialization In A. E. Yamin & S. Gloppen (Eds.), *Litigation Health Rights*.

- Can Courts Bring More Justice to Health?* (pp. 333-372). Cambridge MA: Harvard University Press.
- Yamin, A. E., & Gloppen, S. (Eds.). (2011). *Litigating Health Rights: Can Courts Bring More Justice to Health?*. Cambridge MA: Harvard University Press.
- Yamin, A. E., & Norheim, O. F. (2010). *Health care priority-setting: The definition of a new benefits scheme; public deliberation; and the Constitutional Court's follow-up with respect to its orders concerning prioritization*. Paper presented at the Paper prepared for seminar to the Constitutional Court Bogotá.
- Yamin, A. E., & Parra-Vera, O. (2010). Judicial Protection of the Right to Health in Colombia: From Social Demands to Individual Claims to Public Debates. *Hastings International and Comparative Law Review*, 33(2), 101 – 129.
- Yamin, A. E., Parra-Vera, O., & Gianella-Malca, C. (2011). Judicial Protection of the Right to Health in Colombia: An Elusive Promise? In A. E. Yamin & S. Gloppen (Eds.), *Litigating Health Rights, Can Courts Bring More Justice to Health?* (pp. 103-131). Massachusetts: Harvard University Press.
- Yepes, F. J., Ramírez, M., Sánchez, L. H., Ramírez, M. L., & Jaramillo, I. (2010). Luces y sombras de la reforma de la salud en Colombia. Ley 100 de 1993. Bogotá: Assalud, Universidad del Rosario, Facultad de Economía and Mayol Ediciones S.A.
- Yin, R. K. (2003). *Case Study Research. Design and Methods* (Third ed. Vol. 5). California: SAGE.





*Research Articles*



## **Article 1**

**A Human Rights Based Approach to Participation in Health Reform:  
Experiences from the Implementation of Constitutional Court Orders in  
Colombia.**



# A Human Rights Based Approach to Participation in Health Reform: Experiences from the Implementation of Constitutional Court Orders in Colombia

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**Abstract:** This paper analyses how participation was understood and put in place by the bodies in charge of implementing the Colombian Constitutional Court's Decision T-760/2008, which ordered extensive reforms of the health system. Following a comprehensive human rights approach, the Court required this process to ensure the participation of the scientific community as well as users of health services. The decision should be seen in the context of Colombian politics, where issues concerning the health system are highly polarised. The aim of this paper is to describe and analyse the process of implementation of T-760/2008 during the three years following the decision. The use of the comprehensive human rights framework, adopted by the Court itself, as an analytical tool brings to the analysis some elements needed to evaluate the extent to which the process was participatory, and to describe the reasons for this.

**Keywords:** Participation; Healthcare Reform; Colombia; Decision T-760/2008; Participation and Human Rights.

## I. Introduction

Despite the widespread recognition of popular participation as a key aspect of the development of health policies and programmes,<sup>1</sup> scholars have raised concerns over the shortcomings of participatory approaches in genuinely empowering the people that they ostensibly serve.<sup>2</sup> A concern has also been raised about the lack of substantial evidence regarding the usefulness of participation, that is, how it can lead to better decision-making processes.<sup>3</sup>

This article analyses how participation has been understood and practised by the bodies in charge of implementing the Colombian Constitutional Court's Decision T-760 from 2008, which ordered extensive reform of Colombia's health system. The Court required the process to follow a comprehensive human rights approach, ensuring the participation of the scientific community as well as users of health services. The article aims to highlight the importance of contextual preconditions for effective participation of relevant stakeholders in the implementation of such reforms. It demonstrates how these preconditions can be decisive in the results achieved, and argues that contextual preconditions must be included in any assessment of participatory processes.

The implementation of Decision T-760/2008 offers an interesting opportunity to analyse the possibilities for, and challenges to, meaningful participation in health, and the role of

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<sup>1</sup> See Susan Rifkin, 'Lessons from community participation in health programmes: a review of the post Alma-Ata experience' (2009) 1 *International Health* 31; World Health Organization and Office of the High Commissioner for Human Rights, *A Human Rights-Based Approach to Health* (2010).

<sup>2</sup> Bill Cooke, 'The Social Psychological Limits of Participation?' in Bill Cooke and Uma Khotari (eds), *Participation: The New Tyranny?* (Zed Books 2001).

<sup>3</sup> John Church and others, 'Citizen Participation in Health Decision-Making: Past Experience and Future Prospects' (2002) 23 *Journal of Public Health Policy* 12, 14.

courts in fostering deliberative processes. It must be noted that, while the article analyses implementation of the Decision between 2008 and 2011, this is still an on-going process.<sup>4</sup>

The article begins by describing the approach to participation adopted by the Colombian Constitutional Court in its Decision, placing this into the framework of different approaches to participation. It then highlights some key characteristics of Colombia's health-care system and the "participatory approach" within this health-care system. Finally, the article addresses the process of implementing the orders regarding participation within the context of the overall implementation of T-760/2008. The analysis is informed by the human rights approach referred in the Court's decision.

## **II. Understandings of Participation**

Scholars have shown that participation has different meanings for different people and that it 'doesn't embody a set of values in and of itself'.<sup>5</sup> To recognise this is to acknowledge that, when assessing a particular participatory process, the scope for participation provided must be carefully described.

The manner in which participation is conceived is not "value neutral"—it is rooted in both normative and theoretical approaches. These approaches determine the level of influence that decisions taken in "participatory spaces" have on the final decisions (policies).<sup>6</sup>

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<sup>4</sup> The article is based on interviews conducted in Colombia between March 2009 and August 2011 and also on a review of documents and reports produced by Colombian authorities, civil society organisations, academia, and private enterprises regarding the implementation process of Decision T-760/2008.

<sup>5</sup> Richard Ballard, 'Between the Community Hall and the City Hall: Five Research Questions on Participation' (2008) 66/67 *Transformation: Critical Perspectives on Southern Africa* 168.

<sup>6</sup> See for example the classifications and differences highlighted by Mario Bronfman and Marcela Gleizer, 'Participación Comunitaria: Necesidad, Excusa o Estrategia? O de qué Hablamos Cuando Hablamos de Participación Comunitaria' (1994) 21 *Cad Saúde Pública* 111; Roberto Briceño-León, 'El Contexto político de la participación comunitaria en América Latina' (1998) 14 *Cad Saúde Pública* 141; Alicia Ely Yamin, 'Suffering

The various perspectives regarding participation can be described as occurring on a continuum. At one extreme are conceptions that define participation as an issue of social justice and empowerment. Here, participation has an ideological dimension, or intrinsic value (social transformation and building new social relationships), as well as a strategic, or instrumental dimension (methodologies and tools to achieve policy goals). The core aim is to provide agency to the individuals so that they can actively drive changes within their daily lives and within society.<sup>7</sup> This conception is inspired by Paulo Freire and his analysis of the structures of oppression.<sup>8</sup>

The approach analysed in this article—which can be described as a “comprehensive human rights approach”—is found on this side of the continuum. According to this approach, effective participation can challenge political and other forms of exclusion that prevent people from exercising power over the decisions and processes affecting their lives.<sup>9</sup> According to the comprehensive human rights perspective, participation must guarantee the following:

This perspective coincides with social justice and empowerment approaches in emphasising the need to analyse power structures in society (eg, who is consulted, who is perceived as a valid interlocutor, and how decisions are normally made), as well as capacity building for participation (providing agency).

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and Powerlessness: The Significance of Promoting Participation in rights-based approaches to health’ (2009) 11 Health and Human Rights.

<sup>7</sup> Pablo Alejandro Leal, ‘Participation: the Ascendancy of a Buzzword in the Neo-Liberal Era’ (2007) 17 Development in Practice 539; Joel Martí, *La realidad que se percibe, se mide y se transforma: métodos y técnicas para la participación social* (Centro de Estudios Sociales Construcción Crítica, n.d).

<sup>8</sup> Paulo Freire, *Pedagogía del oprimido* (Tierra Nueva 1970).

<sup>9</sup> Yamin (n 6).



At the other end of the continuum, participation is conceived as a strategy or tool, with instrumental and discretionary use of participatory tools and methods.<sup>10</sup> The main objective of participation is to improve decision-making processes and their products (such as policies or programmes) in order to address the needs of the community or target population.

This conception is reflected in approaches to development in which participation is highlighted as a key to ensure the sustainability and efficiency of interventions.<sup>11</sup> Under this view, involvement of the target population in the design of policies and programmes allows for improved resource allocation, thereby increasing the efficiency and efficacy of public expenditures.<sup>12</sup> Participation has an instrumental value: by allowing for a better understanding of reality, it provides valuable information that can improve policies and programmes. In addition, since the target population is informed from the outset when policies and programmes are designed, participation helps to build the legitimacy of such policies and programmes. All of this is expected to have a positive impact on the final product, making the intervention as a whole more efficient in economic terms. Therefore, the ultimate belief is that a more informed policy design will increase the effectiveness of a given development intervention.<sup>13</sup>

This approach is rooted in a normative and theoretical position in which empowerment is understood according to the logic of free-market relations. The poor and marginalised must

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<sup>10</sup> Mario Mosquera-Vasquez and others, 'Strengthening User Participation through Health Sector Reform in Colombia: A Study of Institutional Change and Social Representation' (2001) 16 Health Policy and Planning 52; Eduardo Cáceres, *Participación ciudadana desde un enfoque de derechos* (Cuadernos Descentralistas 2004).

<sup>11</sup> Sam Hickey and Giles Mohan, 'Relocating Participation within a Radical Politics of Development: Citizenship and Critical Modernism. Draft working paper' (2005) 36 Development and Change 237.

<sup>12</sup> ISALUD, *Participación ciudadana en salud en el Mercosur. Marco conceptual y metodológico sobre participación ciudadana en el Mercosur ampliado. Primer informe de avance* (ISALUD, 2005).

<sup>13</sup> See for example Inter-American Development Bank, *Strategy for Promoting Citizen Participation in Bank Activities* (Report) (Inter-American Development Bank, 2004); Carmen Malena, Reiner Forster and Janmeja Singh, *Social Accountability. An Introduction to the Concept and Emerging Practice*. (Social Development Papers 2004).

be empowered in order to ‘become clients who are capable of demanding and paying for goods and services from government and private sector agencies.’<sup>14</sup> This approach does not link empowerment with the idea of social transformation. This is not a minor difference. It frames participation in a client-provider relationship, where clients have the right to and role of improving providers’ performance when delivering specific services, including health services, but without questioning the broader premises. As most of these services are provided with public resources, a main function of participation in this perspective is also to ensure the proper use of public funds.

A comprehensive human rights approach, on the other hand sees participation as a citizenship right. In this sense, the notion of citizenship goes beyond legal obligations and entitlements, and becomes a means of challenging subordination and marginalisation.<sup>15</sup> Participation not only refers to local projects and programmes; it also entitles citizens to participate in broader debates, including debates on national policies.

This notion of citizenship harmonises with deliberative democracy models, which propose that ‘in addition to a well-functioning electoral system, citizens should have opportunities to challenge and debate policies and their implementation on an on-going basis’.<sup>16</sup> Another characteristic of these models is that democracy goes beyond the election of representatives, implying an ‘ongoing participation of citizens in the deliberative processes that determine policy and resource allocation’.<sup>17</sup> Deliberative democracy does not imply a transfer of power from the electorate to representatives, where citizens unconditionally accept

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<sup>14</sup> The World Bank, *The World Bank Participation Sourcebook* (The World Bank 1996).

<sup>15</sup> *Hickey and Mohan* (n 11) 239.

<sup>16</sup> *Ballard* (n 5) 169- 170.

<sup>17</sup> *Ibid* 170.

being governed (in a vertical hierarchical structure). Rather, it entails horizontal socio-political relationships in which representatives continuously receive guidance from the people—relationships that in turn reinforce the legitimacy of the democratic process.

Despite the differences between the two conceptions, both (and positions between the two) require a degree of institutionalisation in the form of rules that define how participation is comprehended, channels for its implementation, and human and financial resources.

This wide range of normative and theoretical approaches demonstrates that the widespread use of the term “participation” masks substantial differences in the understanding and meaning of participatory processes—and the manner in which such processes are implemented. This does not mean that “anything goes” or that it impossible to evaluate the quality of participation. On the contrary, the awareness enables better and more nuanced assessment of participatory processes.

Spelling out the content of the participatory approach under scrutiny allows us to assess whether weaknesses found in the particular case are a reflection of problems inherent to participation as such; whether they should be ascribed to the particular normative and theoretical approach by which the participatory process has been designed; or stem from implementation failures.

In the process analysed in this article, the Colombian Constitutional Court explicitly framed the scope of the participation process to be undertaken as part of the implementation of T-760/2008. Hence, when assessing the implementation of this process, cognisance must be given to the Court’s participatory approach. It must also be understood against the particular social and political context in Colombia.

### III. Participation in the Colombian Health System

Colombia is a middle-income country. However, like other countries in the region, it shows great contrasts. Despite economic growth – Colombia advanced five places in the United Nations Development Programme’s Human Development Index between 2006 and 2009 – it remains one of the most inequitable countries in Latin America (and the world), with an income Gini coefficient of 58.5.<sup>18</sup> The high level of economic inequality has implications for social and political relations and is an important contextual factor for understanding the importance – and challenges - of participation in health reform.

Equally important is the civil war. Since 1940, Colombia has experienced an internal armed conflict with different degrees of intensity and had the second-highest number of internally displaced people in the world: approximately 5,200,000 in 2010.<sup>19</sup> The conflict involves different actors: guerrilla groups, violent groups linked with the narcotics trade, paramilitaries, new armed groups emerging after the demobilisation of paramilitaries, and state forces. Some of these groups also have vested interest in the health system, politicising and militarising struggles over health policy.<sup>20</sup>

Colombia also has a significant history of health reform. In 1993, through the adoption of Law 100, the Colombian government implemented a deep reform of the country’s health-care system. Up until this time, Colombia’s health-care system had not managed to cover the

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<sup>18</sup> UNDP, ‘Colombia. Country Profile. International Human Development Indicators’ (UNDP 2011) <<http://hdrstats.undp.org/en/countries/profiles/COL.html>> accessed 4 November 2011. UNDP income Gini coefficient assess the deviation of the distribution of income among the individuals or households within a country, a value of 0 represents absolute equality, and value of 100 absolute inequality.

<sup>19</sup> Internal Displacement Monitoring Centre, ‘Current IDP figures’ (2011) <[http://www.internal-displacement.org/idmc/website/countries.nsf/\(httpEnvelopes\)/A7E1B7BD7528B329C12575E500525165?OpenDocument#expand](http://www.internal-displacement.org/idmc/website/countries.nsf/(httpEnvelopes)/A7E1B7BD7528B329C12575E500525165?OpenDocument#expand)> accessed 4 November 2011.

<sup>20</sup> Oscar Sevillano, ‘La paraeconomía ayudó al desfalco de la salud’. (Corporación Arco Iris, 2011) <<http://www.nuevoarcoiris.org.co/sac/?q=node/1173>> accessed July 20 2011

needs of the population, especially not those from the poorest sectors. Insurance coverage was minimal and mostly concentrated in urban areas: social security covered 23 % of the population and private insurers 10 %. In 1993, nearly 60 % of those who reported an illness that required a visit to a health facility did not visit a facility because of the costs associated with seeking care.<sup>21</sup>

Some features of this reform process are worth considering due to its influence on subsequent debates on health reform, and on public trust and participation in policy processes.

The 1993 health reform took place in a political context marked by deep economic crisis, internal conflict, and drug violence. The graveness of the situation led to a broad debate on the reforms needed to strengthen democracy and achieve peace in the country. The 1991 Constitution, and the reforms it called for were infused by the spirit of these debates, and a political vision that saw the recognition of social rights as part of the solution.

However, the reforms were also influenced by the structural adjustment reforms promoted by the International Monetary Fund and the World Bank in the early 1990s, in which state owned enterprises were perceived as inefficient.<sup>22</sup> A reduced role for the government – entailing privatisation of state-owned enterprises such as hospitals – was seen as key to building a more efficient state.<sup>23</sup> The reform process was characterised by a heated

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<sup>21</sup> María-Luisa Escobar and others, 'Colombia: After a Decade of Health System Reform' in Amanda Glassman and others (eds), *From Few to Many: Ten Years of Health Insurance Expansion in Colombia* (Inter American Development Bank - The Brookings Institution 2009).

<sup>22</sup> John Williamson, 'A Short History of the Washington Consensus', (Conference "From the Washington Consensus Towards a New Global Governance" Fundación CIDOB).

<sup>23</sup> Núria Homedes and Antonio Ugalde, 'Why Neoliberal Health Reforms have Failed in Latin America' (2005) 71 *Health Policy and Development* 83.

debate between ‘those who advocated solidarity and a predominant role for the state (...), and those who advocated competition, efficiency, and a stronger role for the private sector’.<sup>24</sup>

The reform process was led by a “change team” of professionals working under the leadership of the Minister of Health. They rallied support for the reform through alliances with legislators and key actors within the health system.<sup>25</sup> Thus although the health reform was subject to heated debate in Congress for months, some have seen this as a mere formality designed to legitimate the real decisions – which were in fact negotiated in closed spaces by the Executive and a small group of powerful actors.<sup>26</sup>

Fearing changes to the reform process by the newly elected presidential administration, promoters of the reform decided to hasten its approval. Law 100 ‘was pushed through the legislature shortly before the Christmas holiday and then implemented as quickly as possible through decrees’.<sup>27</sup> In the course of seven months, the change team issued at least 25 regulatory decrees to entrench the reform. These decrees did not require Congressional approval, and were prepared in an almost secretive manner, isolated from debate. Critics have argued that they favoured the creation and consolidation of private organisations in the health system and the segmentation (inequality) of the system. The reluctance to debate the decrees created tension and discomfort towards the reform.

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<sup>24</sup> Alejandra González-Rossetti and Patricia Ramírez, *Enhancing the Political Feasibility of Health Reform: The Colombia Case*. (Data for Decision Making (DDM) project 2000) 38.

<sup>25</sup> Thomas Bossert and others, ‘Transformation of Ministries of Health in the Era of Health Reform: the Case of Colombia’ (1998) 13 *Health Policy and Planning* 59.

<sup>26</sup> *González-Rossetti and Ramírez* (n 24).

<sup>27</sup> Alicia Ely Yamin and Oscar Parra-Vera, ‘Judicial Protection of the Right to Health in Colombia: From Social Demands to Individual Claims to Public Debates’ (2010) 33 *Hastings International and Comparative Law Review* 101, 107.

The result of the 1993 reform was a “structured pluralism” model, financed through a combination of payroll contributions and general taxation. Under this model, individuals enrol with insurers (*Entidades Promotoras de Salud*, or EPSs) and have the right to a state-regulated insurance benefit package (*Plan Obligatorio de Salud*, or POS). Healthcare is provided by a mix of public and private institutions.

Law 100 created two types of insurance regimes: a contributory regime (CR)<sup>28</sup> for formal workers and those earning more than twice the minimum wage and their families, and a subsidised regime (SR) for the population unable to pay.<sup>29</sup> The health plans of each regime differed in coverage and services. The plan from the contributory regime (POS-CR) included approximately 60 % more services than the plan from the subsidised regime (POS-SR).<sup>30</sup> However, according to Law 100, the regimes were to be progressively unified by 2001. By 2008 this goal was still not achieved. This was the context in which the Constitutional Court issued decision T-760/2008.

Regarding the legal framework for participation, the 1991 Constitution specifies that one of the essential purposes of the state is to facilitate the participation of the population in decisions that directly affect it, as well as in the economic, political, administrative, and cultural life of the nation (article 2). It recognises the scope of participation at both the local and national levels. The Constitution describes the mechanisms for democratic participation as including voting, the holding of a referendum, popular consultation, public hearings,

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<sup>28</sup> In addition to general taxes, they “contribute” to the health system through mandatory discounts: to the payrolls (since 2007, 8.5 % paid by the employers and 4 % by the employees) or via direct deduction to the income of independent/self-employed workers (12.5 % of the income).

<sup>29</sup> People covered by the subsidised regime are identified by a proxy means test survey called SISBEN (Sistema de Identificación de Beneficiarios - Beneficiary Identification System). The survey assigns a poverty index score to each household; the households classified as poor must be included in the subsidised regime.

<sup>30</sup> Francisco J Yepes and others, *Luces y sombras de la reforma de la salud en Colombia. Ley 100 de 1993* (Assalud, Universidad del Rosario, Facultad de Economía and Mayol Ediciones SA 2010).

popular legislative initiatives,<sup>31</sup> and the possible removal of public servants should they misuse their office.

The participatory framework developed in the health-care sector harmonises with these constitutional principles. Even before the adoption of the 1991 Constitution, participation was considered one of the guiding principles of the public health system. Law 10 from 1990, which was an antecedent to the health-care reform implemented in 1993, recognises the right of citizens and the community to participate in the processes of assessing, formulating, and preparing plans, programmes, and projects; in decision-making; and in administration and management of health services (article 3). Law 100 also states that social participation is one of the guiding principles of public health-care services. Article 153 states that the health-care system must promote social participation in the organisation and control of the institutions that are part of the health-care system, as well as in the system as a whole.

While recognising the importance of participation, the regulations resulting from Law 100 in effect provided limited scope for citizens and local communities to participate in any meaningful way in health policy processes. Citizens' participation was limited to the client-provider relationship—stressing the importance of citizens' control and supervision over the services provided. In the case of community participation, there were regulations providing for the creation of citizen oversight committees and associations of users at the insurance companies, albeit stressing its local scope.<sup>32</sup>

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<sup>31</sup> Can be presented by a group of citizens equal or more than the 5 % of the current electoral census.

<sup>32</sup> See for example Presidencia de la República de Colombia, *Decreto 1757. Por el cual se organizan y se establecen las modalidades y formas de participación social en la prestación de servicios de salud, conforme a lo dispuesto en el numeral 1 del artículo 4 del Decreto-Ley 1298 de 1994* (1994).



At the national level, Law 100 created the National Council on Social Security in Health (CNSSS) to make decisions with national impact, for instance regarding the inclusion of new drugs and technologies in the insurance benefit package (hereinafter POS). The CNSSS was presided over by the Ministry of Social Protection and composed of representatives of the state and different sectors (such as EPSs, providers, unions, and representatives of health professionals as well as user organisation from rural areas). However, in practice this allowed only limited participation by citizens, and then only in the capacity of health-care users.<sup>33</sup> The various groups – representing different interests – had very unequal capacity to organise and participate at CNSSS sessions. While the EPS group, represented by the Association of Insurers from the contributory regime (ACEMI), and the Colombian Association of Hospitals and Clinics (ACHC) had economic and human resources to prepare technical studies to defend their proposals, other groups, such as pensioners, lacked such capacity, and their arguments were often rejected due to lack of technical evidence.<sup>34</sup>

Some scholars have highlighted this model of social participation as one of the biggest contributions of Law 100.<sup>35</sup> Others do not share this enthusiasm. In addition to the limited space for participation, the implementation of the participatory process has been cited as a drawback. Critics have also described the complexity of the process as a barrier.<sup>36</sup> The

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<sup>33</sup> Ursula Giedion, Giota Panopoulou and Sandra Gómez-Fraga, *Diseño y ajuste de los planes explícitos de beneficios: el caso de Colombia y México* (Financiamiento del Desarrollo, 2009) [75].

<sup>34</sup> This was the opinion of a key actor, former staff at the Ministry of Social Protection and CNSSS member, interviewed in Bogotá in November 2009, thus agreeing with the analysis of scholars such as Jairo Humberto Restrepo, '¿Qué cambió en la seguridad social con la Ley 1122?' (2007) 25 *Revista Facultad Nacional de Salud Pública* 82.

<sup>35</sup> *Escobar and others* (n 21); Rocío Carvajal, Gustavo Alonso Cabrera and Janeth Mosquera, 'Percepciones de los efectos de la implementación del Sistema General de Seguridad Social en Salud sobre las acciones de control de tuberculosis en el Valle del Cauca, Colombia' (2004) 35 *Colombia médica* 179.

<sup>36</sup> Ofelia Restrepo-Vélez and Paola Andrea Mosquera-Méndez, 'Participación y empoderamiento comunitario: tareas pendientes de la Atención Primaria de Salud' in Román Vega Romero and others (eds), *Atención Primaria Integral de Salud Estrategias para la transformación del Sistema de Salud y el logro de la equidad en salud* (Alcaldía Mayor de Bogotá. Secretaría Distrital de Salud 2009).

participatory system involves several spaces: users associations at health-centres and hospitals, as well as community committees, each different in scope. To actively participate in the various spaces requires resources, such as time and money to attend the meetings that are often limited, especially for the poorest. Users also cite scarcity of information about the different participatory mechanisms, and fear of service providers' reprisals as other important barriers.<sup>37</sup> There are also formal requirements to participation, such as being an organisation with legal standing.

Another weakness is that the participation mechanisms were not accompanied by policies to regulate and implement them. This is a key issue because, although some have seen the scope as too limited, Law 100's participatory approach was an innovation that should have challenged the traditional way of making decisions. However, in the absence of effective policies, doubts and mistrust between the actors, and lack of initiative from the authorities prevented the consolidation of the participatory spaces conceived by the law.

The challenges involved in implementing Law 100's participatory approach should not be underestimated. A predominant complication was the polarisation of positions regarding the reform and the health model adopted. While supporters of the "managed competition" model have defended the Law 100,<sup>38</sup> others have, as discussed earlier, been critical to the power it gave to private sector actors, as well as the structural inequality of the system, and the lack of adequate initiatives to adapt the public health institutions to the new model.<sup>39</sup>

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<sup>37</sup> Ibid; María Delgado-Gallego and Luisa Vázquez-Navarrete, 'Barreras y Oportunidades para la Participación Social en Salud en Colombia: Percepciones de los Actores Principales' (2006) 8 *Revista de Salud Pública* 128; *Mosquera and others* (n 11).

<sup>38</sup> Amanda Glassman and others (eds), *From Few to Many: Ten years of Health Insurance Expansion in Colombia* (Inter American Development Bank - The Brookings Institution 2009).

<sup>39</sup> Amparo Hernández -Bello and Román Vega-Romero, 'El sistema colombiano de seguridad social en salud: desigualdad y exclusión' (2001) 1 *Gerencia y Políticas de Salud* 48; *Homedes and Ugalde* (n 24);

These opposing forces led to public debate, as well as to the development and discussion of legislative initiatives to reform the health system.<sup>40</sup> In 2007 a reform law (Law 1122) was passed. However, despite the doubts regarding the achievements of Law 100, the executive constrained the debate and ‘the legislative debate regarding Law 1122 lasted literally only minutes before approval of the executives’ proposal’.<sup>41</sup>

Among public hospitals, the reforms led to privatisation and closure of hospitals, and dismissal of workers.<sup>42</sup> Protests by health workers unions resulted in brutal repression and the killing of several union members.

Furthermore, actors at the central level (such as health authorities, insurance company and provider representatives) were not entirely convinced of the potential of Law 100’s participatory policies. Recognising the asymmetry of information, the limited capacity of users to guide or be part of the decision-making process, was used as an argument against participation. Providers also cite some civil society actors’ lack of (political) “independence” as an argument against participation.<sup>43</sup> This reflects an understanding of legitimate participation as politically neutral. When stakeholders are critical to public policies, they are viewed as political and suspicious and thus discredited, marginalised or repressed, even by

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Mario Hernández-Álvarez and Mauricio Torres, ‘Colombia’s New Health Reform: Helping Keep the Financial Sector Healthy’ (2010) 5 *Social Medicine* 177; *Restrepo* (n 36).

<sup>41</sup> Alicia Ely Yamin and Oscar Parra-Vera (n 27) 107

<sup>42</sup> See for example Mario Hernández-Álvarez, ‘Neoliberalismo en salud: desarrollos, supuestos y alternativas’ in Dario Restrepo (ed), *La falacia neoliberal: crítica y alternativas* (Ediciones Antropos 2003); María Patricia Arbelaez and others, ‘Tuberculosis Control and Managed Competition in Colombia’ (2004) *International Journal of Health Planning and Management* S25.

<sup>43</sup> *Delgado-Gallego and Vázquez-Navarrete* (n 38); *Mosquera-Vasquez and others* (n 10).

those who promote participatory processes. As Ugalde (1985) observes, this is not particular to Colombia, but has been a common practice in Latin-American countries.<sup>44</sup>

As result of these various factors, what was intended as participatory spaces ended up being conceived by users as a channel for complaints rather than spaces in which to influence decisions regarding the services organisation or health policies.<sup>45</sup>

It is against this backdrop that the Colombian Constitutional Court decision T-760/2008 must be interpreted.

#### **IV. Evaluating the Participation Set in Motion through the Colombian Constitutional Court Decision T-760/2008**

Decision T-760/2008 is a landmark decision with special characteristics. Unlike many structural judgements elsewhere, it did not result from mobilisation by civil society organisations. The plaintiffs were individuals seeking health services for themselves, who neither acted jointly, nor were backed by organisations acting in the public interests. Colombian law allows very easy access for individual *tutelas* - legal recourse to protect constitutional rights, hence this has become a main channel for the voicing of complaints and dissatisfaction with government. Health claims account for a large and growing share. Between 1999 and 2008 the judiciary received a total of 674,612 health *tutelas*. In a vast majority of these, the claim was granted, casting the judiciary in the role of public protector, while also being vilified as the cause of runaway health expenses.

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<sup>44</sup> Antonio Ugalde, 'Ideological Dimensions of Community Participation in Latin American Health Programs' (1985) 21 *Social Science & Medicine* 41.

<sup>45</sup> *Delgado-Gallego and Vázquez-Navarrete* (n 37); *Mosquera-Vasquez and others* (n 10).

Besides ruling in individual cases, the Constitutional Court may accumulate and jointly review individual cases, and identify systematic and structural failures. In Decision T-760/2008, the Court identified several problematic dimensions reflected in the overwhelming number of individual right-to-health *tutelas* presented to the courts. Against this background, it constructed a decision articulating its understanding of the problems of the Colombian health system.<sup>46</sup>

In the Decision, the Court selected and described 22 individual right-to-health claims to illustrate the systematic problems within Colombia's health-care system. For the Court, these cases demonstrated a failure of competent authorities to meet their constitutional obligations to respect, protect, and fulfil the right to health, and, consequently, the Court decided to impart orders to overcome the detected regulatory failures. The ruling identified the state bodies responsible for the fulfilment of each of the orders.

In T-760/2008 the Court decided that, rather than focussing on a single problem within the health system, it would address the system as such, and include orders addressing the range of problems identified in the review of the individual right-to-health claims – such as freedom to choose among providers, regulations regarding reimbursements to the insurers, universal coverage, and the unification of the POS.<sup>47</sup> Given the complex structure of the

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<sup>46</sup> However, in several interviews respondents from different sectors, such as civil society, insurance companies, academia, as well as from the Ministry, referred to having been interviewed by representatives of the Constitutional Court, while it was working on the decision.

<sup>47</sup> Manuel José Cepeda-Espinosa, 'Transcript: Social and Economic Rights and the Colombian Constitutional Court' (2011) 89 Texas Law Review 1699. Unlike previous decisions of the Court, T-769/2008 did not focus on one specific group (such as inmates or internal displaced people) but simultaneously addressed problems faced by actors throughout the system: the users –and the EPS – in the subsidised- and in the contributory regime, as well as particular problems faced by vulnerable groups within the health system (children, patients with high-cost diseases).

Colombian health system, with a mix of private and public actors playing different roles, the decision to address the whole system increased the complexity of the ruling.

Among its orders, the Court requested the updating, adaptation, and unification of the benefit plans (POSSs) for adults and children (primarily through orders 16, 17, 21, and 22). Decision T-760/2008 also adopted a “comprehensive human rights approach”, embedded in General Comment 14 of the United Nations Committee on Economic, Social and Cultural Rights, and required the process to guarantee the direct and effective participation of the medical community and health service users, especially those who stood to be affected by the policy changes. The explicit adoption by the Court of an approach defining participation as a mechanism to prevent those affected by decisions from being excluded from decision-making processes should be seen in the light of the Court’s role as recipient of public grievances, and of the structural inequalities in Colombian society.

When evaluating to what extent Colombian authorities complied with the Court’s orders regarding participation, the criteria laid out in the comprehensive human rights approach should be applied and consequently fulfil the comprehensive human rights approach principles: :

1. institutional mechanisms to ensure that people can participate;
2. capacity building for participation;
3. participation throughout the process;
4. accessible accountability and conflict resolution mechanisms.<sup>48</sup>

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<sup>48</sup> Helen Potts, *Participation and the Right to the Highest Attainable Standard of Health* (Human Rights Centre, University of Essex 2008).

The following sections examine to which degree each of these criteria have been met in the participatory processes designed and implemented by the Ministry of Social Protection (August 2008–November 2009) and the Health Regulation Commission<sup>49</sup> (December 2009–August 2011) in response to decision T-760/2008.

### **Institutional Mechanisms**

According to the comprehensive human rights approach, participation requires regulated and operative institutional mechanisms to ensure that people can participate. In the context of Decision T-760/2008, the Ministry and the Commission were responsible for identifying and putting in place mechanisms (such as public meetings), as well as for developing an accessible and inclusive methodology for participation.

The Court did not specify the organisations and institutions entitled to participate in the implementation of the reforms. Emphasising that as judges they do not have the power ‘to tell the responsible authority, specifically, what should be appropriate and necessary to ensure the effective enjoyment of the right’,<sup>50</sup> they left it to the Government to invite stakeholders and manage the process. Yet, the Court retained authority to evaluate whether the process fulfils the requirements of the Decision.

To oversee the implementation of Decision T-760/2008 the Court formed a review panel that receives and analyses reports and documents from the following bodies:

- I. the bodies in charge of implementing the orders (the Ministry, the CNSSS, and the Health Regulation Commission);

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<sup>49</sup> The CRES (Regulatory Commission in Health) is composed of the Minister of Social Protection (chair), the Minister of Economy, and five commissioners.

<sup>50</sup> Corte Constitucional de Colombia, *Sentencia T-760 de 2008. Magistrado Manuel José Cepeda Espinosa* (2008)

- II. governmental bodies responsible for monitoring the implementation of specific orders from the Decision (the Ombudsman Office, the Attorney General's Office, and the Colombian Family Welfare Institute); and
- III. non-governmental monitoring groups that formally expressed their interest and requested to be recognised as such.<sup>51</sup>

Initially, Colombian authorities expressed their commitment to implement an inclusive process in accordance with the Constitutional Court's requirements. In its design of the process, the Ministry's acknowledged the importance of inclusion and the need for participatory mechanisms in order to guarantee the legitimacy and social acceptance of its decisions.<sup>52</sup>

The Ministry's participatory process was designed to guarantee spaces for deliberation and for setting up social and political agreements, and identified the need for representative, qualified, and deliberative participation. Participation was to occur in spaces for technical decisions, in spaces for public consultation (mainly the internet), and through information campaigns.<sup>53</sup>

Between 2008 and 2010 the Ministry organised seminars with international experts, and discussion workshops on the criteria for POS update and on the equalisation of the Child POS, in addition to an internet-based consultation process on the criteria for POS update.

Major weaknesses in the process designed and implemented by the Ministry included:

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<sup>51</sup> In December 2008 two groups presented a request and were recognised by the Constitutional Court as monitors, one consisted of insurer and provider associations, the other was a consortium of academic and civil society organisations. In December 2009 and May 2010 the Court invited additional organisations in academia and civil society to form monitoring groups. Six organisations – two NGOs, one user organisation, two medical associations, and one civil society movement (constituted of scholars, grassroots representatives, patient organisations and NGOs) – expressed their interest in creating a monitoring group.

<sup>52</sup> Ministerio de la Protección Social, *Informe con destino a la Honorable Corte Constitucional Unificación Gradual y Sostenible de los Planes Obligatorios de Salud – POS. Sentencia T 760 de 2008. 30 January 2009* (2009).

<sup>53</sup> Ministerio de la Protección Social, *Mecanismos e instrumentos para la información, participación y comunicación de los procesos de actualización de los Planes Obligatorios de Salud POS: Hacer público lo que es público* (2008).



1. Lack of clarity regarding the who, when and how. That is, on the selection of organisations invited to workshops and meetings (for example whether there would be a quota for each group of stakeholders – insurers, health professionals organisations, patients associations, etc); when in the process there would be room for participation; and how the actors would participate.
2. Lack of an inclusive methodology for participation, that is, strategies to guarantee the accessibility and adaptability of the information, particularly to vulnerable groups (priority was given to internet-base consultations in a country with major regional and income differences in internet access).<sup>54</sup>
3. Lack of a strategy to ensure broad participation and representation in the process, including of groups entitled to special protection, such as the indigenous population.
4. Absence of estimates concerning the resources (human and financial) required to implement the process and how these would be secured.

Although these weaknesses may in part be ascribed to lack of resources or time, critics argue that it was a process led by “second level officials” and that Ministry did not have ‘a true interest’ in the process.<sup>55</sup>

When the Commission took over responsibility for the implementation of the reform, some of the shortcomings of the previous process were addressed. Resources were allocated to design and implement participatory mechanisms, and there was a genuine effort to decentralise the process, for example, by organising meetings outside of Bogota. In addition to internet-based consultations, the Commission organised meetings in several cities around the country, including seminars on the methodology of UPC calculation; workshops for civil society representatives selected to participate in the POS update process; and an information session on the evaluation criteria for POS update.

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<sup>54</sup> Camila Gianella-Malca and others, ‘¿Deliberación Democrática o Mercadeo Social? Los dilemas de la definición pública en salud en el contexto del seguimiento de la sentencia T-760 de 2008’ (2009) 11 *Health and Human Rights: An International Journal* 1.

<sup>55</sup> Interview with a representative of the Colombian civil society organisation, Bogota, October 2009.

However, the process as designed by the Commission repeated a mistake of previous participation processes in Colombia, namely complexity. There was, for example, a series of formal requirements to participate in the workshops (such as belonging to an organisation with legal standing). Not all organisations were able to qualify and some interviewees cited the requirements as a barrier to participation. Moreover, the prioritisation of the internet for the broader participatory processes resulted in participation predominantly from cities with higher internet access.<sup>56</sup>

Most importantly, as for the Ministry, the Commission's participatory activities were defined as mechanisms for consultation and not as decision-making spaces. It is interesting to note that the Spanish term used by the Commission to refer to the meetings is *socialización* (socialization)—a term that does not normally imply decision making, but rather a space for information sharing. This is incompatible with what was required by the Constitutional Court.

In summary, despite the state's efforts to institutionalise participatory spaces, particularly since 2010, the requirements outlined in the Court's decision have yet to be fulfilled.

### **Participation Throughout the Entire Process**

The comprehensive human rights approach does not provide a “fixed formula” (eg, in terms of methodology or number of meetings) for implementing a participatory process—indeed, this would go against its core principles. The process must be built by the actors themselves. However, the human rights framework does require that those who stand to be affected by the decisions play an active role throughout the entire process. This does not necessary imply that

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<sup>56</sup> For example, the process for evaluating the inclusion of three drugs into the POS showed a regional imbalance again. Of the 3,664 interventions submitted online, 42.8 % came from the capital city, Bogota.

users must take part in all technical deliberations, but a participatory process must at least allow people to be part of the process of identifying priorities and developing benchmarks.<sup>57</sup>

As discussed above, the process designed by the Ministry included two types of participatory spaces: one where policy decisions would take place (such as defining priority setting criteria for the POS design), and another for wider consultation and information about the decisions (mainly via internet). A weakness of this process was that it failed to make clear how participants in the “decision-making spaces” would be selected. The spaces were called spaces for qualified, representative and deliberative participation, but in fact the Minister controlled who would be invited.

The Minister also kept control over the focus of the workshops – and the final decisions. The workshop on the Child POS equalizations was in fact a pure information exercise. Participants received information and instructions about the POS equalisation, but key points, such as why the Minister and the Commission decided to restrict the equalisation to children up to the age of 12 years, were not discussed. Workshop assistants were of the view that the organisations were invited mainly to legitimise decisions already taken.<sup>58</sup>

With regard to the spaces for general consultation, the Ministry did not consider how to enable the participation of people who did not have internet access or who could not fill out an internet survey. It was also unclear how the information from the general consultation would be included in the decision-making process.

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<sup>57</sup> Potts (n 48).

<sup>58</sup> Interviews with assistants to the workshop Developments for the Child POS Equalization, Bogota November 2009.

The Commission, in its process, kept the format of two spaces (decisions and broad consultation). However, in contrast to the Ministry, it established clear (albeit demanding) criteria for the selection of participants to workshops and expert meetings. Another major change was that while the internet remained a key mechanism for broad participation, direct spaces (such as workshops) were now among the main activities, and were developed in cities outside Bogota.

Still, the Commission maintained firm control over the process – with regard to the agenda and methodology, concerning whether to accept suggestions made by citizens, and over the evaluation process. Again, workshop assistants saw this primarily as an invitation to help legitimise decisions already taken, rather than to contribute to the decisions as such.<sup>59</sup> With regard to the broad, internet-based consultation process, the Commission, like the Ministry, failed to address how to enable participation by people who lacked internet access or skills.

### **Capacity Building for Participation**

Capacity building for participation in this context involves making the information, including technical terms, accessible and available, enabling all participants to understand the information circulating during the discussions. This is key to transparency and to building confidence in the process.

The design adopted by the Ministry in response to decision T-760/2008 did not consider capacity building. This is noteworthy in light of the fact that national-level actors in charge of the design and implementation of the process recognised the need for capacity building - and

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<sup>59</sup> See for example Hernando Gúzman, ““La CRES no nos quiso escuchar”: Sociedades Científicas”” *El Pulso* <<http://www.periodicoelpulso.com/html/1202feb/debate/debate-06.htm>> accessed February 23 2012.

that the staff hired to design and implement the process acknowledged that differences between stakeholders in terms of knowledge and resources did not allow for equal participation. While this was an accepted weakness, it was not identified as a potential delegitimising factor.

For some workshop participants, the Ministry's technical format was a barrier 'to giving an opinion or providing realistic input according to the needs of the patients' thus turning the participatory process into a mere "formality."<sup>60</sup> For the actors in charge of the process at the Ministry, a key lesson learnt was the need to build a broader understanding among participants of the entire health system, including how the financing of the system operates, in order to avoid opinions expressed only reflecting narrow group interests.

Capacity building is also about creating conditions for real participation, which includes building trust, both in the process and between the actors. Central level officials in charge of developing the participation strategy acknowledged that the debate over the Colombian health system has been very harsh and confrontational, creating polarised positions, distrust, and a lack of legitimacy. However, the manner in which the Ministry's process was implemented did not contribute to trust building.

The Commission expected its informational sessions to have a positive effect on building trust. However, although the Commission's participatory process included a training component, participants complained about the material's complexity and the lack of tools and time to analyse the documents. In a letter to the Commission and the Court, representatives of civil society organisations complained that the Commission 'gave us five hundred pages to

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<sup>60</sup> Interview with member of high cost disease patient organisation, Bogota November 2009.

read, in two parts, on December three and December six, [and] the meeting was on December seven.’ Hence, lack of effective capacity building remained a major barrier to meaningful participation.

### **Accessible Accountability Mechanisms**

The fourth criterion of the human rights based approach, refers to mechanisms for accountability and conflict resolution. A participatory process involves making difficult choices, for example, decisions to exclude treatments for certain diseases considered too costly to the system. This is likely to produce disputes and disagreements.<sup>61</sup> In a field such as health care, the development of new technologies and discoveries, fluctuating prices of treatments and new knowledge regarding their effectiveness, add extra challenges. This makes it imperative to establish a body to enforce accountability and provide space for conflict resolution. The Ministry did identify the need for a body to review decisions, and initially proposed this as a separate entity (ie, not the Commission). However, such a body was never created.

While there were no formal process for POS revision, major mistakes in the first POS update, performed in August 2009 led to severe criticism from different organisations and forced the Ministry and the Commission to undertake a new review of the POS. Members of the organisations that had openly criticised the process, saw the willingness, on the part of the Ministry and the Commission to review the “new” POS as a response to the protests over the errors made in the first round, not as reflecting new openness to a more participatory

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<sup>61</sup> Alicia Ely Yamin and Ole Frithjof Norheim, ‘Health care Priority-Setting: The Definition of a New Benefits Scheme; Public Deliberation; and the Constitutional Court’s Follow-up with Respect to its Orders Concerning Prioritization’ (Paper prepared for seminar to the Constitutional Court, 2010); *Potts* (n 48)

process.<sup>62</sup> This bred doubts concerning the possibilities for a real debate on the health system structure in the reforms initiated by decision T-760/2008.

The distrust in the authorities' commitment to openness, were reinforced when the Ministry – soon after the criticised POS updating process – declared a state of social emergency in the health sector. Their justification was that the financial crisis stemming from the increases in non-POS expenditures was at breaking point, putting the provision of health care to the population at risk. This demanded the adoption of extraordinary measures to rationalise, redistribute and allocate the resources within the health system.<sup>63</sup> The state of emergency was accompanied by thirteen decrees aimed (amongst others) at reducing the number of right-to-health claims presented to the courts by imposing a legal limitation as well as by fining medical doctors for supporting unwarranted claims. To reduce the cost of non-POS procedures granted through right-to-health claims, the government ordered that patients had to first exhaust their savings and pension funds to pay for these. As with the decrees issued shortly after the Law 100, the state of emergency decrees were issued by a team of consultants hired by the Ministry, isolated from the public debate and in near secrecy.

The emergency decrees faced strong opposition from different sectors of society and, in April 2010, the Court declared them unconstitutional, finding that the reasons for declaring a state of "social emergency" were too weak to justify the decrees. As this was not an unforeseen event, the government should have passed healthcare reforms, such as those included in the social emergency decrees through Congress (the traditional legislative

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<sup>62</sup> As one interviewee declared referring to this process '*they have recognised all their errors, or horrors, rather, because some of them are shocking. Over there we have a list in the POS in which there are some products that are completely out-dated*'.

<sup>63</sup> Ministerio de la Protección Social, *Decreto 4975 de 2009 por el cual se declara el Estado de Emergencia Social* (2009).

channel). The Court also found that the reforms ordered by the decrees failed to address the structural problems identified by T-760/2008 and would not solve the underlying problems of Colombia's health care system.<sup>64</sup>

Consolidation of the Commission as the entity in charge of the POS revision and update also puts it in charge of solving disputes arising from the process. In other words, the Commission is in charge of reviewing controversies raised by its own decisions. Moreover, while the Commission is transparent with regard to the number of objections and comments received regarding the decisions, it is not transparent concerning whether or how they are taken into consideration.

How the lack of an independent reviewing body creates problems of trust between the actors becomes clear if we examine the Commission's role in the process of the child POS equalisation. In 2009 the Commission and the Minister decided that the newly equalised child POS would only cover children of twelve years of age and below, excluding minors from thirteen to eighteen years. The argument used to justify this age parameter was that the Code of Children and Adolescent defined people between zero and twelve years old as "children", while people between the ages of twelve and eighteen were defined as "adolescents". Hence, the Ministry and the Commission concluded that the state would fulfil its responsibilities under Order 21 by granting the POS update to children up to twelve years of age. According to participants in meetings organised by the Commission and the Ministry in September 2009, resource constraints were also cited to justify the age limit on the POS equalisation.

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<sup>64</sup> Corte Constitucional de Colombia, *Sentencia C-252 de 2010*. Magistrado Jorge Iván Palacio Palacio (2010).



As one of the monitoring bodies for the implementation of T-750/2008, the Ombudsman, pointed out, according to the Colombian Constitution everyone under eighteen years of age are considered to be children. This did not move the Commission to reconsider. Only after the Constitutional Court issued an order specifying that under Colombian law a child is a person between nought and eighteen years old did the Commission expand the POS-equalisation to children of all age groups.

With regard to the POS update, the Commission, as discussed earlier, changed its decision after severe criticism. However, some of the mistakes remained in the 2011 version of the POS, including ones regarding drug coding and inclusion of drugs without a valid health registration. Following new rounds of criticism, the Ministry admitted that there were flaws and promised to review the POS once again. In this third review process, the Commission opened up for comments, but some workshop participants complained that the Commission ignored their proposals without any clear reason. They pointed to the need for other complaint channels besides the Commission, and decided to present complains to the General Attorney Office, and court petitions requesting information on the criteria for prioritising and including drugs into the new POS.

## **V. Conclusions**

Our analysis of the participatory process implemented by the Colombian Ministry of Social Protection and the Health Regulation Commission shows that – despite formal commitments to participation and establishment of participatory mechanisms – participation in the sense required by the Court in Decision T-760/2008 was not achieved.

The participatory approach adopted by the Court, calling for a broad democratic dialogue to define the new benefit plan (POS), constituted a novelty in the Colombian context. Not because Colombia lacked prior experience with participatory processes, but because the level and form of participation in the formulation of health policies required by the Court represented a breach with the traditional, instrumental approach to participation.

Decision T-760/2008 came after more than half a million Colombians had presented right-to health claims to the Colombian courts. The Court's review of this wave of legal actions, and its own jurisprudence, pointed to a range of structural problems faced by individuals vis-a-vis the health system, sometimes even resulting in death due to the lack of medical attention.<sup>65</sup>

The legal actions also demonstrated an ongoing - and unavoidable - conflict between the health system users and the health system (authorities and service providers) over resource allocation. As shown above, the definition of benefit plans is a difficult process, where it is almost impossible to generate universal agreements between the different actors. Some treatments will be prioritised over others, creating discomfort among those negatively affected. In this context, transparency around the priority-setting decisions, allowing people to know and understand (although not necessarily agree with) the rationale behind them, is crucial for the legitimacy of the decisions and for the health system as such.

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<sup>65</sup> So-called death itineraries. See for example Cecilia López, 'El Paseo de la Muerte' <[http://www.cecilialopezcree.com/k\\_OldTopics/b\\_Prensa/2006/b\\_Febrero/d\\_Paseo.html](http://www.cecilialopezcree.com/k_OldTopics/b_Prensa/2006/b_Febrero/d_Paseo.html)> accessed November 4, 2011; Observatorio Interinstitucional de Cáncer Infantil, 'Urge reglamentar la ley de protección a niños con cáncer' <<http://oicicancerinfantil.blogspot.com/2011/12/urge-reglamentar-la-ley-de-proteccion.html>> accessed December 8 2011.

The participatory approach ordered by the Court provided a valuable opportunity to build trust between the different parties involved. By creating spaces for inclusive participation throughout the process, investing in capacity building, and securing transparency and communication of the rationale behind the decisions, it could have improved the outcome by building trust in the decisions taken by the Colombian health authorities.

However the measures taken by the Ministry in response to the Decision, contributed very little to trust building. Workshops presenting decisions already taken, and the declaration of a state of social emergency created widespread discomfort among the Colombian population. The Commission faced the challenge of demonstrating that its approach was different from that of the Ministry – and it undoubtedly made important improvements. Not least by organising workshops and sessions outside Bogota, the Commission signalled an interest in broadening participation. However, the Commission also failed to be transparent in their decision-making, creating a sense of discomfort among people who actively followed and participated in the POS update process.<sup>66</sup>

While recognising the limitations of the processes implemented by the Ministry and the Commission, it should be noted that institutions overseeing the process, such as the Ombudsman and the Constitutional Court itself, provided important feedback on shortcomings and thus contributed towards a gradual improvement of the participatory process.

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<sup>66</sup> The same type of discomfort found in the interviews was detected by the Colombian media, see for example Hernando Gúzman, 'En actualización del POS "El Ministerio y la CRES perdieron transparencia": Ifarma' (El Pulso February 1st, 2012 <<http://www.periodicoelpulso.com/html/1202feb/debate/debate-03.htm>> accessed February 23 2012; *Gúzman* (n 59).

Given that the participatory approach adopted by the Court represents a novelty in the Colombian health system, it would be naive to expect that one decision alone would correct problems that had been ignored for years. The question is whether the Decision advanced the understanding. Unfortunately, the quality of the participation process has not been a central issue in the evaluation and debate on the health reform.<sup>67</sup> Furthermore, there has been no space to deliberate on the participation parameters themselves, as laid out by the Court, as though participation had a universal and unique meaning.

Decision T-760/2008 was not the first structural decision in which the Colombian Constitutional Court required the implementation of a comprehensive participatory process.<sup>68</sup> Yet, in the three years following the decision, the Court has done little to follow up on the lack of compliance with its orders regarding participation, with the partial exception of criticism levied during the state of social emergency. Orders relating to other decisions taken by the Ministry and the Commission, have not commented on weaknesses in the form or scope of participation. The lack of oversight over the participation component of decision T-760/2008 has allowed Colombian authorities to maintain, and act in accordance with, their own instrumental conceptions of participation throughout the reform process – regardless of the fact that this approach to participation is in stark contradiction with the orders given by the Court in its decision.

The evidence presented here allows us to argue that the shortcomings of the participatory processes implemented in Colombia in response to Decision T-760/2008 are not

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<sup>67</sup> This was an almost non-existent topic in the public hearing organised by the Constitutional Court on July 7 2011, to evaluate the advances in the implementation of orders 16, 17, 18, 21, and 22.

<sup>68</sup> The main prior experience was from decision T-025/2004, which declared an unconstitutional state of affairs regarding the situation for Colombia's millions of internally displaced people.

rooted in the limitations of the comprehensive human rights approach. Indeed, such an approach has not been applied, despite being called for by the Court's decision and different sectors of Colombian society.



**Article 2**  
**Giving effect to children's right to health in Colombia? Analysing the implementation of court decisions ordering health system reform.**





# **Giving effect to children's right to health in Colombia? Analysing the implementation of court decisions ordering health system reform**

## **1. Introduction**

Health systems have been recognized as key determinants of health and it is essential to ensure that they are 'designed and financed to ensure equitable, universal coverage, with adequate human resources' (Commission on Social Determinants of Health 2008 : 94). To comply with the requirements, health systems in different parts of the world have been, or are currently under reform. These reforms are a central topic in the agenda of multilateral agencies and donors such as the Inter-American Development Bank, the World Health Organization, the World Bank, and USAID.

Despite the widespread promotion of health system reforms as a key strategy for the improvement of social determinants of health, there is no general consensus on how this should be addressed, or on which parameters to evaluate health system reform processes. This complicates the evaluation of judicial rulings that call for changes in health systems, and the implementation of court-initiated reform processes. In the last decade, legal claims to secure the enjoyment of the right to health and access to health services have become an important phenomenon, including in middle and low income countries (Gloppen 2008; Yamin and Gloppen 2011). This could increase further as a consequence of the recent adoption of the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, which may prompt more domestic courts to adjudicate these rights in order to avoid cases being appealed internationally (ESCR-Net, DeJusticia et al. 2010). In a situation where courts are becoming more central initiators of health system reform, it is important to gain a better understanding of the effects of such rulings.

Despite major developments to provide conceptual clarity to the legal enforcement of economic social and cultural rights (ESCR), research analysing the implementation of the rulings and their actual impact is scarce. This is a sensitive issue and existing evidence regarding the effects of such judgments point in different directions. In many cases legal enforcement of the right to health has

aimed at improving the rights of vulnerable groups who face systematic and structural discrimination in national policies, such as children living under poverty, or people subjected to forced displacement (Corte Constitucional de Colombia 1998; Corte Constitucional de Colombia 2008). However, legal enforcement has also been used as a strategy to claim the right of individuals and groups who are not among the most vulnerable in the society (Ferraz 2009).

This paper argues that when evaluating court judgments calling for health system reform, we should highlight the importance of contextual pre-conditions for the implementation of such judgments. In many cases, discriminatory or neglecting behaviour is driven by 'structural forces that constrain national policymaking' (Meier and Yamin 2011 :83). Health systems reproduce these structural forces, such as power structures or societal values. Legal rulings aiming to address situations of structural inequity or discrimination into the health system thus also have to address these variables.

These reflections are based on an analysis of the implementation of the Colombian Constitutional Court's decision T-760/2008, which ordered extensive reforms of Colombia's health system (Yamin, Parra et al. 2011). To give effect to the constitutional protection for children's fundamental right to health, the decision T-760/2008 includes separate orders explicitly addressing children's right to health. The article focuses on the implementation of the orders related to children's access to health care.

The article first describes the Court's decision regarding children's rights to access health care. Then it outlines the proposed analytical framework, which is subsequently used to analyse the implementation of the Court's decision. The parameters for the analysis of policy outcomes are based on the comprehensive human rights approach referred to by the Court in its decision.

## **2. Background**

### **2.1 Understandings of health system reforms**

The lack of consensus on how health system reforms should be addressed or assessed stems partly from diverging conceptions of the relationship between health and development. Freedman (2005) identifies two main rationales traditionally used to define this relationship. The first conceives health as an intrinsic aim, as a dimension of development, and a key element of a life with dignity. This conception is similar to the human rights approach that conceives health as a ‘fundamental human right indispensable for the exercise of other human rights’ (Committee on Economic Social and Cultural Rights 2000).

A second rationale considers health as a tool for economic growth and therefore development. Health is defined as a resource and a commodity hence the lack of health has a negative impact on individuals’ economy, obstructing income generation (to them and the society) and generating expenditures (to them, their families and the societies).

Freedman proposes a third rationale, focused on health systems as core social institutions (Freedman, Waldman et al. 2005 :20). Under this approach, the health system is conceived as a core social institution, similar to the judicial system or the democratic political system (Freedman 2006; Hunt and Backman 2008; Yamin and Norheim 2010). In this sense, health systems are not only providers of health and health care, but also a vital part of the social fabric of any society. They are not simply mechanical structures used to deliver technical interventions, they are structures where societal values and norms are communicated and reinforced.

This understanding of the rationale of the health system adds new dimensions to the relationship between poverty and health. If health systems involve fundamental social relations between individuals, and between individuals and the state, then health system reforms have to address these relations.

A technocratic approach, addresses health and poverty as states of being. Health system reforms are here conceived as technical challenges, isolated from societal values and norms. This allows health

system reforms to be represented as linear processes that go from the problem identification, to policy implementation (Freedman, Waldman et al. 2005; Freedman 2006). The implicit premise is that reform processes are based on objective scientific evidence, and that the impact of the processes can be objectively evaluated with a set of value neutral tools.

While recognizing the importance of using evaluation tools to follow up advances and setbacks resulting from the implementation of health reform processes, it is also necessary to be aware of the limitations of evaluations purely based on so called objective scientific evidence. They only evaluate specific elements of the health system against specific expected outcomes. For a more comprehensive view that also can provide insights into how other societal factors influence the outcomes, we need approaches that consider the structural societal factors that play a role in the health systems, and influence the reform processes.

## **2.2 Health System Reform in Colombia and Children's Right to Health**

Colombia is a middle-income country. Like other countries in the region, it shows great contrasts. Colombia is also one of the most inequitable countries in Latin America (and the world), with an income Gini coefficient of 58.5 (UNDP 2011).

In 1993, through the adoption of Law 100, the Colombian government radically reformed the country's health-care system. Up until this time, Colombia's health-care system had not managed to cover the needs of the population, especially not the poorest sections. Insurance coverage was minimal: social security covered 23 per cent of the population and the private insurers 10 percent, concentrated mostly in urban areas. In 1993, nearly 60 percent of those who reported an illness that required a visit to a health facility did not go because of the costs associated with seeking care (Escobar, Giedion et al. 2009).

The reform adopted the “structured pluralism” model, financed through a combination of payroll contributions and general taxation. Under this model, individuals enrol with insurers (*Entidades Promotoras de Salud*, or EPSs) and have the right to a state-regulated insurance health plan (*Plan Obligatorio de Salud*, or POS). Health care is provided by a mix of public and private institutions.

Law 100 created two types of insurance regimes: a contributory regime (CR) for formal workers earning more than twice the minimum wage and their families, and a subsidised regime (SR) for the population unable to pay. The health plans of each regime differ in coverage and services. The plan from the contributory regime (POS-CR) included approximately 60 percent more services than the plan from the subsidised regime (POS-SR) (Yepes, Ramírez et al. 2010). According to Law 100, the regimes were to be progressively unified by 2001. This goal was not achieved. By 2008, when the Constitutional Court issued decision T-760/2008, the dual structure was still in place.

A central characteristic of Colombia’s 1993 health-sector reform is its technocratic approach. The reform was driven by a “change team” of “apolitical” technocrats working in isolation from public debate, relying on consensus within a small group from the different political clans (Bossert, Hsiao et al. 1998). Colombia’s technocratic approach to health reform has been viewed as a success by national and international organizations (González- Rosseti and Ramírez 2000).

This conception of reform and its rationale of health and development have also influenced the evaluation of the reform process. When Colombia’s health reform is portrayed as a success story internationally (World Health Organization 2000; Glassman, Escobar et al. 2009), it is based predominantly on indicators assessing the reform in terms of objective outcomes (such as coverage among the poor), without considering societal factors affecting the health system, such as corruption. Such “other societal factors” profoundly affect the relationship between individuals and the health system, they facilitate or create barriers to access health care, and are among the drivers of the crisis in Colombia’s health sector (El Tiempo 2008; Procuraduría General de la Nación and Centro de Estudios

de Derecho Justicia y Sociedad 2008; Sevillano 2011; Superintendencia de Industria y Comercio 2011).

The inequity of the Colombian health system is widely recognized as a weakness. But for some it is merely a shortcoming – due to economic constraints – of an otherwise sound system (i.e. poor have less coverage but are covered) (Castaño, Arbelaez et al. 2001; Glassman, Escobar et al. 2009). We will argue that it should be understood as an expression of structural inequalities within the Colombian society, systematically neglected by authorities and power elites. Access to health care for the poor has been categorized as a “benefit” that the State provides to those who do not contribute to the system (through deduction in the pay-roll). This approach does not reflect the idea of health as an acquired right, and expression of citizenship (Hernández 2010).

The structural inequity of the health system profoundly affects Colombian children. Studies show that children from the poorest areas score poorly on national health indicators. Regions with higher levels of poverty, such as Chocó, have higher infant mortality (29.4 per thousand live births - almost twice the national figures of 15.3), higher under five years mortality for acute diarrhoea (39 per thousand, three times the national figures of 11.8), and high under five year mortality for respiratory diseases (40.5 thousand compared to 24 nationally) (Departamento Administrativo de Salud y Seguridad Social del Chocó, Gobernación de Chocó et al. 2008): 72). There are also significant differences by income level. Iron deficiency is twice as high in poor children between one and four years old and 1.8 times higher for those between five and twelve years, compared to children from the richest income quintile.

Fifty-six per cent of Colombian children are from households categorized as poor (Comisión Económica para América Latina y el Caribe, Centro Latinoamericano y Caribeño de Demografía et al. 2010 : 82). Before the Constitutional Court’s handed down its decision T-760/2008, these children only had access to the most limited health plan, the POS–SR. The structure of the health system – stratified and based on managed competition between insurance companies and health providers – has also led to a fragmentation of responsibilities and created barriers to access health care. Studies show

barriers against access to integral treatment, prevents adequate care for patients suffering from diseases such as cancer. The lack of integral treatment for children has been highlighted as a principal factor contributing to the low survival rate of 50 per cent for children with cancer in Colombia. With conditions enabling early diagnoses and adequate treatment, it is estimated that survival rates could reach 90 per cent (Observatorio Interinstitucional de Cáncer Infantil 2011).

This situation of inequity has resulted in legal claims to secure the enjoyment of the right to health. Already prior to the decision T-760/2008, the Colombian Constitutional Court affirmed the right to health of groups entitled to special protection, such as children, pregnant women, the elderly, people with disabilities, people associated with the armed forces or deprived of liberty. The Court underscored that the Colombian Constitution expressly recognizes children's right to health – in contrast to the general right to health, which the Court has derived from other rights such as the right to life and dignity (Corte Constitucional de Colombia 1998; Corte Constitucional de Colombia 2004; Corte Constitucional de Colombia 2008). With the decision T-760/2008 the Court, among others, ordered the Colombian health authorities to restructure the health care system to provide all children with access to the same health plan, regardless of the family's ability to pay. However, what can court enforcement of children's right to health in practice achieve? Before examining the implementation and effects of this ruling, we outline the analytical framework structuring our assessment, which we believe is useful generally for assessing court induced social reform, and health system reform specifically.

### **3. Analytical Framework**

Rodriguez Garavito (2011) distinguishes two main approaches towards analysing the impact of judicial decisions, framed in terms of *the type of effects on which they focus*. The first concentrates on the direct and observable effects of the judicial decision on the target, usually measured following a positivist methodology prioritizing quantitative research methods and indicators. Access to right-to-health litigation has here been studied, for example, in terms of impacts on health budgets, on measurable overall access to health care, and on health services distribution.

The second approach is based on a constructivist perspective of the law, which presumes that judicial decisions not only have an impact on their immediate targets, but also may generate other transformative effects. It can for example shape how the problem is perceived in the society in ways which may have significant long term consequences (Rodríguez Garavito and Rodríguez 2010). A potential indirect effect of health rights litigation could be that health is perceived as a right, rather than a commodity or benefit provided through social programs. This, in turn could influence policy. Indirect effects are potentially as important as direct effects, and need to be included into the impact assessment. This approach combines quantitative and qualitative research methods, measuring direct and material impacts as well as symbolic effects.

From a constructivist perspective the implementation of judicial decisions are processes where different elements interact to generate different effects. Judicial decisions are not linear processes, nor are they implemented in a vacuum, isolated from the context that generated the decision. As indicated earlier, we understand health systems as core social institutions that are socially and culturally embedded. In this perspective, reform processes undertaken as a consequence of judicial decisions will be influenced by the structures of the health system, which in turn are shaped by power relations in society more broadly. Analyses of the impact of judicial decisions should thus, in addition to measuring various types of effects, also describe and analyse these contextual elements.

The framework for the analysis of judicial decisions (and more broadly, legal strategies) presented in this paper and outlined in Table 1 below, is a collaborative effort of a group of scholars with the Global Centre for the Study of Law and Social Transformation (Global Center for the Study of Courts and Social Transformation 2011). Concordant with, and complementing analyses by other scholars (McCann 1992; Rodríguez Garavito and Rodríguez 2010), it integrates measurements of direct and observable effects of judicial decisions, with attention to transformative effects, such as the shaping of perceptions which may have a longer-term impact. The framework aims to systematically include key contextual elements into the analysis, building on existing work on how responses to judicial orders



are influenced by social and political forces – for example the political orientation of the government and other political actors; public debate; and social mobilization (see for example Contesse and Lovera 2008; Gauri and Brinks 2008; Keck 2009; Rodríguez Garavito and Rodríguez 2010; Bergallo 2011; Rodríguez Garavito 2011).

The framework does not conceptualize policy making as a closed and linear process, but rather encourages a broader understanding of the strategies used by different groups and how contextual factors fit into the analyses, seeking to identify their various influences. Effects are understood in terms of changes in goals and values, and in decision-making processes, as well as concrete policy outcomes and material changes in health service delivery and uptake.

Besides enabling a more comprehensive approach to the types of effects – direct and indirect, symbolic and instrumental – resulting from judicial rulings, the framework contributes to understanding what are the most relevant contextual factors influencing legal enforcement of health rights (and ESCRs more generally), and the processes resulting from such rulings.

The framework classifies various types of legal strategies: *legal reform*, typically top-down processes involving mainly political decision-makers and bureaucrats; *legal mobilization*, typically bottom up processes with activists using law and legal arenas for purposes of social change – through litigation, “rights talk”, or advocacy directed at legal reform processes; and *court decisions*, which is our focus here, involving judges as central actors. The court case may be the result of legal mobilization, be initiated by individuals bringing cases for private benefit without broader aims, or, in some cases initiated by the judges themselves.

Regardless of the legal strategy, the framework suggests that in order to understand the impact, we need to look for the *intermediary mechanisms* through which it becomes operative. These may be at different levels: it could be i) institutional/organizational changes, ii) changes in actors and power relations; and iii) changes at the level of discourses and ideas.

<b>Social, institutional and political causes and challenges lead to...</b>	<b>legal strategies ...</b>	<b>working through changes in intermediate mechanisms ...</b>	<b>to produce changes in:</b>
	1. Legal reform	a. Institutional/ organizational	i. Societal goals and values
	2. Legal mobilization (including litigation)	b. Actors and power relations	ii. Processes of decision-making
	<b>3. Judicial decisions</b>	c. Discourses and ideas	iii. Policy outcomes, material changes in service delivery/uptake, sustainability

When analysing judicial decisions, the framework requires that we, in addition to describing specific and objective measures ordered by the court, are concerned with their effects at different levels. Thus it is relevant to consider a wide range of evidence regarding whether the measure achieved its aim, as well as possible unintended effects. Changes resulting from court decisions are differentiated by their ‘quality’ (instrumental or symbolic, direct or indirect), as well as the ‘level’ at which they take place (whether at the level of societal goals and values, in processes of decision making, or in policy outcomes, service delivery and sustainability).

**4. Study design and methodology**

The design chosen was the single case study. This design was selected because it allows researchers to investigate contemporary phenomena within its real life context, especially when the boundaries between phenomenon and context are not clearly evident (Yin 2003). This is important in this case, where the research involves the evaluation of ongoing processes and the analysis is deliberately aimed at covering contextual conditions considered pertinent to the phenomenon of study (Yin 2003).

*Data collection:*

This qualitative case study includes qualitative and quantitative data. The analysis is based on information collected between March 2009 and August 2011. The main sources are: i) court decision

T-760/2008; ii) reports and official documents regarding the implementation of the Court decision; iii) a 2010 database from Bogota county government's health barriers report system (SIDBA); and iv) reports to the Constitutional Court on health services denied by the insurers (EPSs).

To ensure that the analysis includes all the material produced and sent to the Constitutional Court regarding the decision T-760/2008, we made formal requests to the Court and were granted access to the documents filed in the Court. The files were reviewed and data was collected on two occasions, December 2009 and August 2011.

A major weakness of the Colombian health system is the lack of an information system for systematic monitoring of EPSs. However, there are some initiatives to follow up health system performance. One of these is SIDBA, the Bogota County's health barriers report system, which contains information from patients in the Bogota area on health services denied by the insurance companies and providers. From the 28,694 cases recorded by SIDBA in 2010, 22 percent (6,305 cases) referred to children. After sending a formal request we obtained access to this database. This article only includes the information from 2010 after the POS unification.

Other sources of information regarding health system performance are reports from the EPSs. Decision T-760/2008 requires the EPSs to submit reports on services denied to the Constitutional Court. We made a formal request to the Court and were granted access to these. The database obtained contained reports received and filed at the Court up to 19 August 2011. However we could not include all the data in the analysis, because the reports use different formats and do not contain the same information. We decided to use data from April, May and June 2011, the period in which most EPSs submitted information in the correct format (subsequent to resolution 163/2011 approved in February 2011). In this period, twenty six EPSs complied with the obligation to report to the Constitutional Court. One EPS, Salud Total, used codes from the old format, but since the reports contains all the necessary information, the data was amended and included in the analysis.

*Data analysis:*

This article focuses on the implementation of the order addressing the unification of the Child POS (Order 21). A challenge for the study was that the process was on-going. To overcome this, the research strategy chosen was to provide a clear study frame.

Rigor is a notion that refers to reliability and validity (Davies and Dodd 2002). This is met through the use of a framework (presented in the previous section) which makes explicit the techniques employed in the data analysis, and acknowledges the researchers location (Whittemore, Chase et al. 2001).

The decision T-760/2008 and the reports filed in the Constitutional Court were reviewed, summarised, and analysed using the framework. For example, in the case of a report by the Ministry of Social Protection of 13 March 2009, we refer to how the Ministry was planning to perform the Children POS Unification, mainly providing information about changes in the intermediation mechanisms of the institutions.

Similarly, regarding an August 5 2008 letter from Gestarsalud, describing technical problems with the database registering the denial of services by the EPS's, we provide information about the process of change in the intermediation mechanisms of the institutions. This exercise was performed with all the reviewed documents.

We then evaluated whether the expected outcomes at the level of policy were achieved (as described in the parameters of the Court decision).

For the analysis of the SIDBA database we used the categories created and used by the SIDBA. Their indicators incorporate the right-to-health framework set out by the United Nations Committee on Economic, Social and Cultural Rights (ESCR Committee) that includes the conditions of i) availability; ii) non-discrimination, iii) physical accessibility, iv) economic accessibility (affordability), v) information access, vi) acceptability (ethically and culturally appropriate); and

quality (Committee on Economic Social and Cultural Rights 2000; Dirección de Participación Social y Servicio al Ciudadano. Alcaldía Mayor de Bogotá 2010).

These conditions were also used for the analysis of the database on services denied. The reasons for denial registered in the database were classified according to these conditions. For example, if the database registers that the reason for treatment denial was that the medical doctor was late in sending the information to the Scientific Committee for its evaluation (extemporary), this was recorded as an accessibility barrier resulting from errors performed by health system actors (administrative barriers).

Regarding researchers' location, in qualitative studies, the researcher is an instrument. Different measures were taken to enhance the rigor of the study from the design phase, via data collection and data analysis. As mentioned, explicit frameworks were adopted for the data analysis, reflecting the requirements of the Court's decision T-760/2008. Another principle followed was to use multiple sources of information (Yin 2003), and explicitly including all the reports sent by different organizations into the analysis. Similarly, with regard to the quantitative data, we analysed the complete dataset provided.

The analysis follows the principle of maintaining the chain of evidence (Yin 2003). The data was collected by the principal author, a Spanish speaking PhD student at the University of Bergen and affiliated to the Chr Michelsen Institute. She was also in charge of developing the first analysis. This was reviewed several times by the other two co- authors, acting as external observers. These reviews were critical for organising the information in a way which allows external observers to follow the chain of evidence, from the conclusions back to the initial research questions, or vice-versa.

## **5. Results**

The results have been organized following the categories proposed by the framework:

### Strategies

The Court decision was not the result of a litigation strategy developed by specific actors seeking social change. It was rather the response to years of staggering numbers of individual right-to-health claims. In 2008 only, more than 40,000 right-to-health claims were presented to the Colombian courts (Defensoría del Pueblo 2010).

T-760/2008 is a “structural ruling”, a type of judicial decisions characterised by i) wide scope (affecting a large number of people whose rights allegedly are violated) ii) systemic focus (involving several state agencies as defendants to be responsible for systematic failures of public policy) and iii) complexity (involving orders of complex implementation, where various government entities are instructed to take coordinated actions to protect the entire affected population, and often with explicit requirements for participatory, dialogical policy processes) (Rodríguez Garavito and Rodríguez 2010).

T-760/2008 is not the first structural ruling from the Colombian Constitutional Court that addresses economic, social, and cultural rights, or that creates mechanism inside the Court to follow up the implementation process of the decision. The principal precedent for the structural ruling T-760/08 is a ruling from 2004, the decision T-025 in which the Court declared the existence of an “unconstitutional state of affairs” in relation to the situation of the millions of internal displaced people (IDPs) in the country. But in contrast with previous decisions that addressed a particular group of people, T-760/2008 covers the whole Colombian population and the whole health system.

However, in decision T-760/2008, the Court also emphasises the rights of vulnerable groups. In the case of children, the Court saw a particularly urgent need for a unification of the health plans. As children are considered subjects of special protection, with explicit constitutional protection for children’s fundamental right to health, T-760/2008 included a separate order (Order 21), explicitly addressing the unification of the Child POS. This order required Colombian authorities to take measures to unify the Child POS by the 1<sup>st</sup> of October 2009.

Another effect of T-760/2008 at the level of legal strategies is that the decision explicitly adopted the right-to-health framework set out by the United Nations ESCR Committee. The decision emphasizes that the constitutional responsibilities regarding access to health care go beyond the issuing of regulations, and describes the conditions listed in General Comment 14: i) availability; ii) non-discrimination, iii) physical accessibility, iv) economic accessibility (affordability), v) information access, vi) acceptability (ethically and culturally appropriate); and quality (Committee on Economic Social and Cultural Rights 2000). The Court also emphasised, in line with the ESCR Committee's approach, that the right to health requires a broad participatory process in the formulation and implementation of the reform.

So, even if T-760/2008 is not the first "structural judgment" from the Colombian Constitutional Court, it does constitute a milestone in the Court's approach to: national public policies (addressing problems concerning a whole institution and the whole population); to the implementation of national public policies (adopting a the right-to-health framework set out by the United Nations ESCR Committee); and to the protection of children's right to health.

*Effect at the level of intermediate mechanisms:*

At the institutional level, decision T-760/2008 created some spaces at governmental and civil society levels for engagement with the implementation of the decision. A review panel in the Court oversees the decision, receiving and analysing reports and documents from:

- (i) bodies in charge of implementing the orders (the Ministry of Social Protection, the National Council on Social Security in Health (CNSSS), and the Health Regulation Commission (CRES));
- (ii) governmental bodies responsible for monitoring the implementation of specific orders from the decision (the Ombuds Office, the Attorney General's Office, and the Colombian Family Welfare Institute); and
- (iii) formally recognized non-governmental monitoring groups. At the time of data collection, there were two such monitoring groups, one was composed by insurers and providers

associations, and the second by a consortium of academic and civil society organizations. Both presented a request to the Constitutional Court in December 2008 and were recognized as monitoring groups. In December 2009 and May 2010 the Court invited different organizations from academia and civil society to constitute monitoring groups (Corte Constitucional de Colombia 2009; Corte Constitucional de Colombia 2010).

Until the appointment of CRES (hereinafter “Commission”) commissioners in June 2009, the main body responsible for implementing T-760/2008 was the Ministry of Social Protection (hereinafter “Ministry”). The process of transition and consolidation of the Commission took several months and in this period the Commission organised activities with the Ministry

As described, civil society organisations were not direct drivers or plaintiffs in T-760/2008. However, different actors such as insurers, pharmaceutical industry organizations, medical associations, unions, patient organizations and academic organizations have been following the implementation process of T-760/2008, and formally requested the right to participate and be recognised as “follow-up groups”.

This has not led to immediate changes in the relations between actors. Despite the Court’s participation requirement, Colombian authorities have generally approached the implementation of T-760/2008 as a technocratic challenge, limiting the space for broader debate on the health care system.

The Courts Order 21 on unification of the Child POS required that a first report on compliance be sent to the Constitutional Court by March 15, 2009. The report should also be communicated to the Colombian Family Welfare Institute and the Ombudsman, who were tasked with the responsibility of monitoring the implementation of this order (Corte Constitucional de Colombia 2008).

In the first months after the ruling, the Ministry worked to demonstrate compliance with the Court’s decision and time-line. A document outlining the methodology for unification of the Child POS was sent to the Court. It included a participatory mechanism, but did not specify how participants would be



selected. Nor did it include a schedule of activities or assign specific responsibilities. In the document the Ministry also indicated that it was in the process of reviewing the age limits for using the concept “children” (Ministerio de la Protección Social 2009).

At the end of July 2009, the Ministry presented to the Court a new document. This explained the methodology used to calculate the cost of the Child POS unification (Ministerio de la Protección Social 2009) and limited the age of children to twelve years.

The argument used by the Ministry, and later by the Commission for this age parameter was that the Code of Children and Adolescent defined “children” as people between zero and twelve years old while people between the ages of twelve and eighteen were defined as “adolescents” (Congreso de la República 2006 Article 3). Following this line of argument, the Ministry and the Commission concluded that the state would fulfil its responsibilities under Order 21 by granting the POS update to children up to twelve years of age (Ministerio de la Protección Social 2009). According to participants in meetings organised by the Commission and the Ministry in September 2009, resource constraints were also cited to justify limiting the POS equalization to children of twelve years and below.

The Ombudsman office pointed out that according to the Colombian Constitution everyone under eighteen years of age are considered to be children (Defensoría del Pueblo 2009). They and others also voiced concern regarding the government’s focus of attention, which they saw as centred on the economic impact of the order and not on how to safeguard children’s right to health. The Ombudsman also highlighted the lack of information on morbidity and mortality, which is required for a comprehensive POS update (Defensoría del Pueblo 2009).

Despite not having filled the requirement to undertake a comprehensive review of the POS prior to unification, Colombian health authorities decided to merge the Child POS from October 1<sup>st</sup> 2009. The Commission justified this with the Constitutional Court’s refusal to allow more time (Comisión de Regulación en Salud 2009). There is some merit to their argument, however, reports sent by the

Ministry prior to July 2009 did not indicate need for extra time. It can thus be argued that Colombian authorities only nominally complied with the decision and the timeframes.

The fusion of the Child POS failed to fulfil the participation requirements given in the Court's decision. The Ministry and the Commission merely organized two meetings in Bogota where the participants were informed about the decision to fuse the POS from October 1<sup>st</sup> 2009, and the challenges of this in terms of logistic and economic resources.

Despite the lack of participatory spaces, various actors criticized the unification process and the inadequate amount designated to cover the cost of the unified Child POS. On December 15<sup>th</sup> 2009, the Constitutional Court issued an order specifying that under Colombian law a child is a person between zero and eighteen years old. It ordered the expansion of the POS-equalization to children of all age groups. The Court also criticized the passive role of the Colombian Family Welfare Institute, requiring it to fulfil its obligations to monitor the implementation of Order 21 (Corte Constitucional de Colombia 2009). In January 2010 the Commission recognized that all children under 18 years have the right to the same POS (Comisión de Regulación en Salud 2010).

With the poorly organized participatory process, the ability of civil society to influence the process was very uneven. Civil society organizations not only represent different interests but also have unequal resources and capacity to organise. Certain actors, such as the insurers represented by the Association of Integral Medicine Companies (ACEMI, for its Spanish acronym) have the benefit of far greater economic and human resources than most other interest groups. Since the beginning of the process, they have demonstrated capacity to follow up, present proposals, and even invest in technical studies to defend their interests. Other civil society organisations, users, and patients' organisations have also done important work in following up on the activities of the Ministry and the Commission, but these organisations do not have the same level of resources to invest in the process.

It should be noted, however, that in parallel to the implementation of T-760/2008 some organisations, especially those concerned with high cost diseases, such as child cancer organisations, continued with their advocacy work to secure integral care for these diseases. As a result, Congress approved a law specifying the care that children with cancer must receive. Failure to pass required regulatory decrees has, however, delayed the implementation of the law (Observatorio Interinstitucional de Cáncer Infantil 2011).

#### *Changes at the level of output and policy outcomes*

The unification of the Child POS is undoubtedly a step forward in the protection of Colombians' right to health. By showing that this was possible to achieve without financially breaking the system, it also provided legitimacy to claims for a more equal health care system in Colombia. And it demonstrated that with political will, it is possible to achieve more equality in the Colombian health system.

An important symbolic impact of the Court's judgment has been the recognition of the right to health. This contributed towards changing the focus of the debate regarding POS equalization from arguments presenting it as a financially impossible goal, to that of a right that can and must be achieved.

It also helped uncover problems in the health system. After the unification of the Child POS, the government has been forced to take on structural problems within the health system causing financial constraints, such as corruption and overpricing of drugs. This has also changed the understanding of the problems and the focus of attention regarding health system financing.

After T-760/2008, the number of right-to-health claims before the courts have dropped (to 142,957 in 2008 to 100,490 in 2009 and 94,502 in 2010) (Defensoría del Pueblo 2011 : 22). However, this in itself does not necessarily imply an improvement of health system performance. The *tutelas* have been replaced by an increase of cases evaluated by the Scientific Technical Committees, so the structural problems have not really been addressed (Comisión de Regulación en Salud 2010; Defensoría del Pueblo 2011). EPSs continue to deny patients services that are included in the POS, and when patients

are granted these, the EPSs claim them refunded as non-POS costs, which means that the state pays twice and the EPSs receive extra income.

What about the “objective and direct impacts” of the judgment? We have analysed two databases providing information on Colombian children’s access to health care after the POS unification, using the parameters established in the Court’s decision. We find that, despite the formal commitments, Colombian children still face serious barriers to the enjoyment of their right to health-care. The reports on services denied sent by the EPSs to the Constitutional Court in April, May and June 2011; show that children do not always have access to the services included in the unified Child POS. In the majority of the cases the barriers are administrative (referred to as “bureaucratic barriers” by the providers) including cases where the information provided is insufficient. Sometimes users are punished for mistakes performed by other system actors (including physicians who fill forms incorrectly, or send them late). This concurs with findings from earlier studies regarding the systemic barriers in the Colombian health care system (Abadía and Oviedo 2009).

The results also show that EPSs have failed to recognize the acquired rights. We found 145 cases where EPSs ignored the POS equalization (see Table 2), denying access to services for poor children from the subsidized regime.

**Table 2: Reason for service denial April, May and June 2011 as reported by the HMOs**

Reasons for denial	Number of cases	Percentage
Accessibility. Administrative/bureaucratic barriers (i.e. late submission, forms incomplete, sent to the wrong institution)	559	38,34
Accessibility: Economic Barrier (i.e. non-POS intervention such as transport, delays on payments)	272	18,66
Accessibility. Administrative Evaluation by peers (i.e. lack of evidence, drug is not authorised in the country, life is not at risk)	248	17,01
Accessibility. Administrative barrier: service is considered non POS-SR	145	9,95
Availability of the treatment prescribed (i.e. health certificate expired, the product is not register in the country)	79	5,42
Others	20	1,37
No Information (missing cases)	135	9,26
<b>Total</b>	<b>1458</b>	<b>100,00</b>

When comparing the data provided by the suppliers (EPSs reports to the Court) with the claims presented by the users (in the SIDBA database), we found similarities. The majority of the SIDBA claims regarding children refer to suppliers' administrative barriers as the main problem (2,083 cases, 33.56 percent).

**Table 3: Barriers for children to access health care in Bogota (SIDBA 2010)**

<b>Barrier</b>	<b>Number of cases</b>	<b>Percentage</b>
Accessibility (administrative) Problems with the databases	2083	33,04
Accessibility (administrative): Problems that generate delay in the attention i.e. delays appointments with specialist, to provide priority care, transfer to other services)	1380	21,89
Accessibility (administrative): Problems in the supply of POS services (except drugs)	1341	21,27
Access to information and quality of the services (i.e. deficient information regarding procedures, mistreatment)	917	14,54
Availability and geographic accessibility of the services (i.e. emergency services, service is far from the place of residence)	403	6,39
Accessibility (economic)	181	2,87
<b>Total</b>	<b>6305</b>	<b>100,00</b>

As the aim of the SIDBA database is to assess the enjoyment of the right to health, its indicators provide more detail on the relationship between users and providers. These components, such as geographical barriers, barriers created by opening hours, or mistreatment by the providers, go beyond the formal access to the service and they detect other dimensions of health care access – dimensions that were included in T-760/2008, but that the fusion of the POS did not address.

## **6. Conclusions**

This paper aims to provide practical evidence of the major role that contextual pre-conditions play in the implementation of judgments addressing economic, social and cultural rights. This is also highlighted by other researchers, but we find that there is a need for methodological developments enabling a better understanding of the role of contextual pre-conditions.

In this article we applied a framework where effects of legal strategies (here a court judgment), are understood in terms of changes in goals and values, and in decision-making processes, as well as in concrete policy outcomes and material changes in health service delivery and uptake. The framework was used to analyse the implementation of a Colombian Constitutional Court ruling from 2008. The characteristics of the ruling (a structural ruling addressing the whole Colombian health system) and the process (currently ongoing) created major challenges for the impact evaluation. The paper thus focuses on one of the orders (unification of the health plan for children), within a restricted timeframe (July 2008 – August 2011). The analyzed impacts are mainly in intermediate mechanisms (at the institutional/organizational level; regarding actors and power relations), but we also seek to assess changes at the level of decision making processes, policy outcomes, and material changes in services delivery.

A major limitation of the article is that it lacks the data and analysis to provide strong evidence regarding changes at the level of discourses and ideas, social goals and values. Even if we highlight that the adoption of a unified health plan is of major symbolic significance per se, as it implies concrete and practical recognition of the equal rights of all Colombians, we do not analyze the effects of this on societal discourses, or on public opinion regarding issues of equality within the health system.

While we cannot project effects of these symbolic effects on future service delivery, the article, and the framework used do provide key evidence regarding the importance of contextual pre conditions on the implementation process. A main finding of our work is that contextual conditions often are overlooked in practice. Even organizations in charge of monitoring the implementation of judgments as T-760/2008, over-focus on “nominal” compliance measures, such as the issuing of new regulations, without taking account how they will be implemented.

With regard to the characteristic of the legal strategy, that is, judgment T-760/2008, we show how the Court identified structural problems in the Colombian health system and presented its views as to how these problems could be addressed to fulfill the constitutional duties regarding the right to health.

In the ruling, the Court adopted the right to health framework (which informs our analytical approach). This framework conceives health as an intrinsic aim, and emphasizes the need to analyze the functioning of the health systems in light of the broader power structures in society, incorporating into the assessment dimensions such as i) availability of services; ii) non-discrimination, iii) physical accessibility, iv) economic accessibility (affordability), v) information access, vi) acceptability (ethically and culturally appropriate); and quality.

Decision T-760/2008 called for a broad democratic dialogue, in a context in which this method of policy making is not the norm. The Court also ordered the government to address structural problems of equality within the Colombian society that were neglected by the authorities for many years. The reform processes thus represented a radical novelty in the Colombian context - not because Colombia lacked experiences of health reform, but because previous processes were implemented following a narrow technocratic approach.

The Court's ordering of the adoption of comprehensive measures to ensure that Colombians from all classes have equal access to health services, requires equality in a country where public policies generally allow inequality, not only in the access to health care. Colombia is the country in South America with the highest levels of income inequality, and among the most unequal countries in the world. The Court's decision thus requires a broader debate, a national debate that goes beyond the provision of health care. It concerns the distribution of national resources, and challenges power structures, societal values and norms that allow structural inequalities, within the health system and outside it.

The responses at the level of the intermediate mechanism to the Court's decision, such as the establishment of the Health Regulation Commission, and the adoption of concrete measures such as the unification of the Child POS undoubtedly represents important steps towards protection and recognition of children's' right to health.

However, nominal compliance with the Court's orders is not enough. The data analyzed in this article shows that the state has not fulfilled its constitutional responsibility to organize, direct and regulate the provision of health services in ways that allow the effective enjoyment of the right to health for all children. The weakness of the state's regulatory capacity was highlighted also prior to the Court decision, and has not shown major improvements.

The Colombian government's own assessment of its compliance with the Court's decisions, has mainly followed a traditional, linear understanding of policy reform, and relied on objective indicators (such as the enactment of regulations to unify the Child POS) (Ministerio de la Protección Social 2010). If we recognize that health systems are more than simply mechanical structures used to deliver technical interventions, that they are also institutions where societal values and norms are communicated and reinforced, efforts should be made to undertake a more comprehensive assessment of the policy reform process.

As shown in the analysis of the implementation process of Order 21, it is necessary to not only assess the process with regard to objective measures, but also to look at how it has affected conceptions of the problems in the health system. The monitoring of the compliance and effects of legal mechanism also has to consider interactions between a particular reform and the social and institutional context in which it is embedded. In our case, this includes analysing how the implementation of Order 21 is affected by the other twenty-nine orders in the Court's decision. This still remains to be done.

This article presents evidence demonstrating that the health reform process undertaken in Colombia in response to the Constitutional Court's decision, cannot be isolated from structural problems in the



health system (Procuraduría General de la Nación and Centro de Estudios de Derecho Justicia y Sociedad 2008). This has, however, been neglected. On July 7 2011, at a Public Hearing organized by the Constitutional Court, the Ministry of Social Protection accepted that the health system still faces some of the problems addressed by the Court's decision, including insufficient POS updates, exponential growth in non-POS reimbursements, unnecessary intermediaries and delayed resource flows, poor inspection, supervision and control (fuelling corruption); and poor quality in service delivery (Ministerio de la Protección Social 2011). In this context, it would be naïve to expect that the sole enactment of a new regulation is enough to secure the right to health of Colombian children.

Perhaps the most significant achievement of the Constitutional Court's decision is the legitimization of the claim for a more equal health-care system in Colombia. And the unification of the Child POS shows – despite the shortcomings – that, with political will, it was possible to make considerable gains in a short time.

In light of the findings of this article, we recommend that efforts to follow up the implementation of judgments must make explicit the arguments and frameworks adopted by the court, and include them as criteria in the evaluation of the implementation of the legal strategy. In the case of decision T-760/2008, where the Court explicitly adopted the right-to-health framework, the evaluation of the implementation process must take into consideration whether the conditions listed by this framework are fulfilled. Doing so would not only provide information about the fulfillment of the decision, it would also provide evidence regarding to what extent the diagnosis and approach adopted by the Court was the most adequate, and thus would provide a better understanding of the potential impact of ESCR litigation.

This analysis shows the importance of projecting potential challenges that the context could have on processes of implementing court judgments (including the structural causes that forced the use of legal strategies), and to go beyond a monitoring of nominal compliance to an analysis of how the formal measures (such as the enactment of new regulations) are implemented.

## References

- Abadía, C. E. and D. Oviedo (2009). "Bureaucratic itineraries in Colombia: a theoretical and methodological tool to assess managed-care health care systems." *Social Sciences & Medicine* **68**(2009): 1153-1160.
- Bergallo, P. (2011). "Coorts and Social Change: Lessons from the Struggle to Universalize Access to HIV/AIDS Treatment in Argentina." *Texas Law Review* **89**: 1611-1641.
- Bossert, T., W. Hsiao, et al. (1998). "Transformation of ministries of health in the era of health reform: the case of Colombia." *Health Policy and Planning* **13**(1): 59-77.
- Castaño, R. A., J. Arbelaez, et al. (2001). Evolución de la equidad en el sistema colombiano de salud. Santiago de Chile, CEPAL. Unidad de Estudios Especiales. Secretaria Ejecutiva.
- Comisión de Regulación en Salud (2009). Acuerdo 004. Comisión de Regulación en Salud.
- Comisión de Regulación en Salud (2010). Acuerdo 011. Comisión de Regulación en Salud. Bogotá
- Comisión de Regulación en Salud (2010). La CRES y la coyuntura actual del Sistema General en Seguridad Social y Salud. *IX Congreso Gobernar Salud "Hacia la cobertura y atención integral en salud"*. Medellín, COSESAM.
- Comisión Económica para América Latina y el Caribe, Centro Latinoamericano y Caribeño de Demografía, et al. (2010). Pobreza infantil en América Latina y el Caribe. Santiago de Chile, United Nations: 208.
- Commission on Social Determinants of Health (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva, World Health Organization.
- Committee on Economic Social and Cultural Rights (2000). General Comment 14. Geneva.
- Congreso de la República (2006). Código de la Infancia y Adolescencia (*Code of Children and Adolescents*). Bogotá D.C. Colombia.
- Contesse, J. and D. Lovera (2008). "Access to medical treatment for people living with HIV/AIDS: Success without victory in Chile." *Sur. International Journal on Human Rights* **5**(8): 142-161.
- Corte Constitucional de Colombia (1998). Judgment SU-225 of 1998. Justice Eduardo Cifuentes Muñoz.
- Corte Constitucional de Colombia (2004). Sentencia T-217/04. Justice Eduardo Montealegre Lynett.
- Corte Constitucional de Colombia (2008). Auto N° 251 de 2008. Sala Segunda de Revisión.
- Corte Constitucional de Colombia (2008). Judgment T 760 of 2008. Justice Manuel José Cepeda. C. C. d. Colombia. Bogota.
- Corte Constitucional de Colombia (2009). Auto S-34 of 2009. Justice Jorge Ivan Palacio Palacio. Corte Constitucional de Colombia.
- Corte Constitucional de Colombia (2009). Order 342A. Justice Jorge Ivan Palacio. Corte Constitucional de Colombia.

- Corte Constitucional de Colombia (2010). Auto 094 de 2010. Justice Jorge Ivan Palacio
- Davies, D. and J. Dodd (2002). "Qualitative Research and the Question of Rigor." Qualitative Health Research 12(2): 279-289.
- Defensoría del Pueblo (2009). Cumplimiento Auto de fecha 13 de Julio de 2009. Sentencia T-760 de 2008. Oficio OPTB 207/209. Corte Constitucional de Colombia. Bogotá.
- Defensoría del Pueblo (2009). Cumplimiento Auto de fecha 13 de Julio de 2009. Sentencia T-760 de 2008. Oficio OPTB 207/209. Corte Constitucional de Colombia. Bogotá.
- Defensoría del Pueblo (2010). La tutela y el derecho a la salud 2009. Bogotá, Defensoría del Pueblo: 91.
- Defensoría del Pueblo (2011). La Tutela y el Derecho a la salud 2010. Bogotá, Defensoría del Pueblo: 93.
- Departamento Administrativo de Salud y Seguridad Social del Chocó, Gobernación de Chocó, et al. (2008). Indicadores Básicos en salud 2007 Chocó.
- Dirección de Participación Social y Servicio al Ciudadano. Alcaldía Mayor de Bogotá (2010). Manual de Lineamientos Técnicos sobre el Sistema de Información Distrital y de Barreras de Acceso a los Servicios de Salud - SIDBA A. T. S. a. Ciudadano. Bogota, Alcaldía Mayor de Bogotá.
- El Tiempo (2008) ""Colados" en el Sisbén. 17.000 colombianos pudiesen ser incluidos en el Sisbén pueden ser la punta del témpano de una vasta red de corrupción." El Tiempo.
- Escobar, M.-L., U. Giedion, et al. (2009). Colombia: After a Decade of Health System Reform. From few to many: ten years of health insurance expansion in Colombia. A. Glassman, M. L. Escobar, A. Giuffrida and U. Giedion. Washington DC, Inter American Development Bank - The Brookings Institution: 1-13.
- ESCR-Net, DeJusticia, et al. (2010). Enforcement of ESC Rights Judgments. International Symposium, Bogota, Colombia 6-7 May 2010. Analytical Report, ESCR-Net, DeJusticia, Norwegian Centre for Human Rights: 20.
- Ferraz, O. L. M. (2009). "The right to health in the courts of Brazil: worsening health inequities?" Health and Human Rights 11(2): 33-45.
- Freedman, L. (2006). "Achieving the MDGs: Health systems as core social institutions." Development 48(1): 19-24.
- Freedman, L., R. Waldman, et al. (2005). Who's got the power? Transforming health systems for women and children. London, UN Millenium Project. Task Force on Child Health and Maternal Health.
- Gauri, V. and D. Brinks, Eds. (2008). Courting Social Justice. Judicial Enforcement of Social and Economic Rights in the Developing World.. New York, Cambridge University Press.
- Glassman, A., M. L. Escobar, et al., Eds. (2009). From few to many: ten years of health insurance expansion in Colombia. Washington DC, Inter American Development Bank - The Brookings Institution.
- Global Center for the Study of Courts and Social Transformation (2011). Global Center for the Study of Courts and Social Transformation Concept Note. Global Center Workshop. Chr. Michelsen Institute. Bergen.Norway.

- Gloppen, S. (2008). "Litigation as a strategy to hold governments accountable for implementing the right to health." Health and Human Rights **10**(2): 21-36.
- González- Rosseti, A. and P. Ramírez (2000). Enhancing the Political Feasibility of Health Reform: The Colombia Case. . Data for Decision Making (DDM) project, Latin America and Caribbean Regional Health Sector Reform Initiative: 111.
- Hernández, M. (2010). "¿Derecho a qué?. El debate sobre la sentencia T-760/2008." Cuadernos del Doctorado,(11): 27-44.
- Hunt, P. and G. Backman (2008). "Health systems and the rights to the highest attainable standard of health " Health and Human Rights **10**(1): 81-92.
- Keck, T. (2009). "Beyond Backlash: Assessing the Impact of Judicial Decisions on LGBT Rights." Law & Society Review **43**(1): 151-185.
- McCann, M. (1992). "Reform Litigation on Trial." Law and Society Inquiry **17**(4): 715-743.
- Meier, B. M. and A. E. Yamin (2011). "Rights to Health Litigation and HIV/AIDS Policy." Journal of Law, Medicine and Ethics(Spring 2011): 81-84.
- Ministerio de la Protección Social (2009). Informe con destino a la Honorable Corte Constitucional unificación gradual y sostenible de los Planes Obligatorios de Salud – POS de los niños y niñas. Sentencia T 760 de 2008. Marzo 13 de 2009. Bogota.
- Ministerio de la Protección Social (2009). Respuesta Auto Remitido con Oficio No OPTB-206/2009 del 23 de Julio de 2009 Corte Constitucional – Sala Seguimiento. Seguimiento a la Vigésima Primera Orden de la Sentencia T-760 – 2008. Bogota.
- Ministerio de la Protección Social (2010). Informe a La Honorable Corte Constitucional. Oficio 001507 del 17 de Marzo del 2010. Bogotá
- Ministerio de la Protección Social (2011). Audiencia pública de rendición de cuentas ante la Honorable Corte Constitucional. Audiencia pública de rendición de cuentas en el seguimiento a las órdenes 16 (adopción de medidas necesarias para superar fallas de regulación), 17 (actualización integral del Plan Obligatorio de Salud), 18 (periodicidad en la actualización), 21 (unificación de planes de beneficios para niñas y niños de regímenes contributivo y subsidiado) y 22 (adopción de programa y cronograma para unificación de los planes de beneficios de regímenes contributivo y subsidiado) de la sentencia T-760 de 2008. Bogotá.
- Observatorio Interinstitucional de Cáncer Infantil (2011) "Urge reglamenta la ley de protección a niños con cáncer."
- Procuraduría General de la Nación and Centro de Estudios de Derecho Justicia y Sociedad (2008). 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. Bogotá, Procuraduría General de la Nación - Centro de Estudios de Derecho Justicia y Sociedad.
- Rodríguez Garavito, C. (2011). "Beyond the Courtroom: The Impact of Judicial. Activism on Socioeconomic Rights in Latin America." Texas Law Review **89**: 1669-1698.
- Rodríguez Garavito, C. and D. Rodríguez (2010). Corte y cambio social: Cómo la Corte Constitucional transformó el desplazamiento forzado en Colombia. Bogotá, Dejusticia.
- Sevillano, O. (2011). "La paraeconomía ayudó al desfalco de la salud." Corporación Nuevo Arcoiris <http://www.nuevoarcoiris.org.co/sac/?q=node/1173> 2011.

- Superintendencia de Industria y Comercio (2011). Informe Motivado. Bogotá, Superintendencia de Industria y Comercio.
- UNDP. (2011). "Colombia. Country Profile. International Human Development Indicators." Retrieved November 4, 2011, 2011, from <http://hdrstats.undp.org/en/countries/profiles/COL.html>.
- Whittemore, R., S. K. Chase, et al. (2001). "Validity in qualitative research." Qualitative Health Research **11**(4): 522-537.
- World Health Organization (2000). The World Health Report 2000. Health Systems: Improving Performance. Geneva, World Health Organisation: 215.
- Yamin, A. E. and S. Gloppen, Eds. (2011). Litigating Health Rights: Can Courts Bring More Justice to Health?. Human Rights Program Series. Cambridge MA, Harvard University Press.
- Yamin, A. E. and O. F. Norheim (2010). Health care priority-setting: The definition of a new benefits scheme; public deliberation; and the Constitutional Court's follow-up with respect to its orders concerning prioritization. Paper prepared for seminar to the Constitutional Court Bogotá.
- Yamin, A. E., O. Parra, et al. (2011). Judicial Protection of the Right to Health in Colombia: An Elusive Promise? Litigating Health Rights, Can Courts Bring More Justice to Health?. A. E. Yamin and S. Gloppen. Massachusetts, Harvard University Press: 103-131.
- Yepes, F. J., M. Ramírez, et al. (2010). Luces y sombras de la reforma de la salud en Colombia. Ley 100 de 1993. Bogotá, Assalud, Universidad del Rosario, Facultad de Economía and Mayol Ediciones S.A.
- Yin, R. K. (2003). Case Study Research. Design and Methods. California, SAGE.



**Article 3**  
**A fairer health system? Assessing Colombia's new health benefit packages.**





# A fairer health system? Assessing Colombia's new health plans

Camila Gianella-Malca<sup>a</sup>, Ole Frithjof Norheim<sup>b</sup>

## Introduction

This article assesses the fairness and legitimacy of the system put in place to update the health plans of Colombia's health-care system. Around the world, how priorities are set within health-care systems is a critical and highly controversial topic, and the definition of health plans is at the core of this debate. This is also true in Colombia, where health plans are among the main drivers of health expenditure.

Since 2008, Colombian health authorities have worked to institutionalize priority-setting processes and mechanisms, including criteria for updating the country's health plans (hereinafter POS). This was done to implement Constitutional Court decision T-760/2008, which ordered extensive reforms to the health system.

The prioritization of drugs has been at the core of the debate following the Constitutional Court's orders for a comprehensive review and update of the health plans (Andia, 2009; Arboleda, 2010; Gúzman, 2012). This article analyzes the process and methodologies developed by the Colombian authorities, using an approach that considers legitimacy and fairness in the distribution of health resources. Focusing on one component of the POS—drugs—it aims to demonstrate the advantages of adding fairness considerations to health technology assessments.

In analyzing the drug prioritization process performed in Colombia between 2009 and 2011, this article also aims to contribute to the fairer prioritization of drugs in the country and to build on the work already done by Colombian authorities.

The article begins by describing the prioritization initiatives implemented in Colombia since the adoption of the POS in 1994 until the issuing of decision T-760/2008 in 2008. It then describes the methodology for the analysis of the prioritization process that was undertaken within the context of the implementation of T-760/2008. The methodology follows the ethical template for pharmacy benefits developed by Norman Daniels, Russell Teagarden, and James Sabin (2003).

## 1. Background: The definition of the Colombian health plans (POS)

In 1993, the Colombian government implemented a deep reform of the country's health-care system (Law 100). Until then, the system had failed to cover the needs of the population, especially those from the poorest sectors. Insurance coverage was minimal. Social security covered 23 percent of the population, and private insurers 10 percent, mostly in urban areas.

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By 1993, nearly 60 percent of those who reported an illness requiring a health facility visit did not seek care due to the associated costs (Escobar et al., 2009).

The 1993 reform adopted the “structured pluralism” model, financed through a combination of payroll contributions and general taxation.

Two types of insurance regimes were created by the reform: a contributory regime (CR) for formal workers earning more than twice the minimum wage, and a subsidized regime (SR) for those earning less than this. The health plans of each regime differ in coverage and services. The contributory regime plan (POS-CR) included approximately 60 percent more services than that of the subsidized regime (POS-SR) (Yepes et al., 2010).

The initial POS-CR and POS-SR of 1994 were designed by separate teams, following different criteria, but both regimes were positive lists with a number of explicit exclusions. The structure resembles a “shopping list,” mentioning drugs, procedures, and supplies without giving precise guidance on when and under what conditions they are indicated.

While the two POSs were later modified to include some additional drugs and technologies, an institutionalized priority-setting process for regular and comprehensive revisions (as required by Law 100) was lacking (Giedion et al., 2009 : 79-81). The inclusion of new drugs and technologies was done in a piecemeal fashion and was focused mainly on high-cost diseases (e.g., HIV/AIDS and chronic renal failure) (Giedion et al., 2009 : 54). Some of these inclusions came in response to judicial orders—sometimes contrary to the opinion of the Technical Advisory Committee (Giedion et al., 2009 : 83).

Between 2006 and 2008, Colombian courts received 81,065 right-to-health claims (*tutelas*) seeking the provision of drugs (19.2 percent of all right-to-health claims presented in that period). Of these, 76.5 percent were for drugs not included in the health plans (non-POS) (Defensoría del Pueblo, 2009). Some of the services provided through judicial decisions were later included in the POSs. For other services the rulings established precedent, encouraging demands from those similarly situated. The financial implications were considerable (Giedion et al., 2009; González & Durán, 2011).

### ***The Constitutional Court’s requirement for a new approach to prioritization***

In July 2008, the Colombian Constitutional Court handed down decision T-760/2008, which ordered the government to correct the deficiencies in the health-care system that were violating Colombians’ right to health. In one of the orders, the Court requested systematic updating of the POS, specifying that the health plans should be defined in a way that respects the principle of comprehensive medical treatment. In concordance with the Constitution and Law 100, the Court also required that the measures developed respect certain principles, including equality and financial sustainability; that decisions be evidence based and protect vulnerable groups, such as children; and that the process be inclusive, allowing the participation of users and medical associations. Furthermore, the Court specified that the POS updating should do the following: (i) clearly define what health services are included in the benefit plans; (ii) establish what services are excluded, specifying those currently not covered under the benefit plans that gradually will be included, and indicating the goals and dates for expansion; (iii) decide what services should be removed from the benefit plans, justified in terms of health priorities, so as to better protect the rights of users; and (iv) take into account the sustainability of the health system and the financing of the POS.

By adopting these principles, the Court explicitly required a prioritization process that goes beyond technical assessment and includes public deliberation. This was no novelty. In jurisprudence around the right to health (and economic, social, and cultural rights generally), it is increasingly common for judicial interventions to promote deliberative processes shaped by the participation of different sectors of society in order to guarantee collective and inclusive discussions (Gargarella, 2006, 2011).

## 2. Methods

### 2.1 Methodological approach

The approach adopted by T-760/2008 is in line with theoretical approaches to justice in health, one of the most prominent of which is called “accountability for reasonableness” (hereinafter A4R), developed by Daniels and Sabin. According to A4R, prioritization processes must comply with four conditions: (i) publicity (public accessibility of rationales behind decisions); (ii) relevance (acceptance of evidence, reasons, and principles as relevant by fair-minded people); (iii) revision and appeals (institutionalization of mechanisms to challenge and dispute decisions and, more broadly, opportunities for revision and improvement of policies in light of new evidence or arguments); and (iv) regulation (public regulation of the process to ensure that the first three conditions are met).

A4R has been embraced by different organizations that perform health technology assessments, such as NICE in the UK, and has been influential in the prioritization processes developed in countries like Mexico, Canada, Sweden, and Norway (Kapiriri et al., 2007; Yamin & Norheim, 2010). It was also quoted by Colombian authorities as one of the frameworks to be followed in the design of the prioritization process under the implementation of decision T-760/2008 (Ministerio de la Protección Social, 2008).

Using A4R fair process principles, Daniels, Teagarden and Sabin developed a template for organizing the reasons behind the coverage or non-coverage of pharmaceutical products (Daniels et al., 2003 : 128). The template was created as a guide to evaluate the benefits of various pharmaceutical products. It proposed a “four level hierarchy for decision-making about drug coverage,” as described in Table 1 below.

**Table 1: Ethical template for pharmacy benefits**

Allocation decision level	Coverage policy question	Central ethical issues	Relevant rationales
Level 1: Drug categories included	Which categories of drugs to include?	Giving priority to important health needs	Appeal to acceptable, general priority principles; facts about effectiveness, risks, and cost-worthiness
Level 2: Drug selection within category	Which drugs from category to include?	Gaining cost advantage without undue burden on or risk to patients	Facts about interchangeability; facts about costs; fair exceptions process
Level 3: Drug indication	Which uses of the drugs are covered?	Giving priority to important health needs	Appeal to acceptable, general priority principles; facts about effectiveness, risk, cost-worthiness

Level 4: Drug use coverage limitations	How many can be covered? Where and how can they be purchased?	Gaining cost advantage without undue burden on or risk to patients	Reasonableness of coverage limitations; facts about costs; fair exceptions process
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Source: (Daniels et al., 2003 : 128)

This article used this template to analyze the prioritization process for ten randomly selected drugs performed by Colombian health authorities in 2011. It must be noted that the 2011 process was part of the work started in 2009 by the Commission on Health Regulation (hereinafter the Commission) to develop a methodology for evaluating both the drugs already included in the POS and new drugs. To accomplish this task, the Commission hired a team from the National University of Colombia. This methodology was presented in 2010 to different actors (such as scientific organizations and patients organizations) to explain how it would be used in the process for reviewing and updating the POS.

To identify the new technologies to be evaluated, the Commission used different sources (Comisión de Regulación en Salud, 2011d : 40-41).

- National Guidelines, list of prioritized diseases, burden of disease studies, laws ordering the comprehensive treatment of certain diseases
- Analysis of the technologies provided as non-POS as a result of Scientific Technical Committees and *tutelas* decisions
- Formal requests from system actors
- Suggestions from Scientific Technical Committees
- Analysis of judicial claims
- Early warning identification system (innovation of health technology)

Based on the information it collected, the Commission decided in 2011 to evaluate 359 technologies, of which 274 (76.3 percent) were drugs (Comisión de Regulación en Salud, 2011a). Interestingly seven drugs (atorvastatina, bosentan, caspofungina, cefepime, esomeprazole, milrinone and zoledronic acid for osteoporosis treatment were not in this list but were added to the POS anyway ("Personal communication (email) with Luz Marina Umbacía ", 2012).

The selected technologies were grouped according "pathology" groups: developmental disorders, nutritional disorders, priority attention, cardiovascular disease, congenital diseases, metabolic diseases, infectious diseases, inflammatory diseases, mental health, neurological diseases, oral health/dentistry, ophthalmology, kidney and urologic diseases, respiratory diseases, and cancer.

The methodology included two types of evaluations for these new technologies: (i) effectiveness and safety evaluations; and (ii) economic evaluations.

## **2.2 Case selection**

Initially, we randomly selected five drugs from the list of technologies evaluated by the Commission in its 2011 prioritization process (Comisión de Regulación en Salud, 2011a).

**Table 2: Drugs selected for the analysis**

Drug	Pathology Group	Included in 2011 POS
Azithromycin	Respiratory diseases: pneumonia	Yes
Bupropion	Mental health: psychosis	No
Cefuroxime	Respiratory diseases: pneumonia	Yes
Esomeprazole	Not listed among the drugs to be evaluated	Yes
Insulin glargine	Metabolic diseases: diabetes	Yes
Mycophenolate	Kidney and urologic diseases: transplants	Yes
Paliperidone	Mental health: schizophrenia	No
Pediatric enteral feeding	Developmental disorders: management of malnutrition in hospitalized pediatric patients	No
Valdecoxib	Inflammatory diseases: arthritis	No
Valsartan	Kidney and urologic diseases: chronic renal failure	No

As none of the first randomly selected drugs were subsequently included in the POS, we decided to make a second random selection of five drugs, but this time from the list of drugs included in the POS (Comisión de Regulación en Salud, 2012). This was performed with the aim of providing a better understanding of the possibilities provided by the template when the drug is prioritized (see Table 2).

For each of the ten drugs, we searched for published health technology assessments (hereinafter HTA) on the Commission's website. The website contains two lists, published in 2011: (i) HTAs that recommended including the technology in the POS; and (ii) HTAs with other recommendations (such as to not include or to include with the caveat that an economic assessment be performed) (Comisión de Regulación en Salud, 2011b, c). Two of the selected drugs, azithromycin and cefuroxime, each had two HTAs (one for adults and one for children). Esomeprazole did not have an HTA. Thus, we reviewed eleven HTAs in total.

In addition, for the selected drugs, we extracted information from documents prepared by the Commission. This information included, among other things, the Commission's reasons for including or excluding a particular drug (see Table 3).

We also reviewed HTAs on insulin glargine and mycophenolate that were developed by the National University in 2010 in consultation with the Commission as part of the Commission's first exercise in developing a methodology for health technologies assessments.

The extracted information for each drug was used to complete the ethical template (see Table 3).

### 3. Results

Our results are organized into two parts: (i) results from the use of the ethical template with the group of ten drugs; and (ii) results from the use of the principles of the ethical template for the analysis of the institutional decision-making process performed by the Commission.

#### 3.1 Ethical template

The rationales for the inclusion and exclusion of the ten drugs are summarized in Table 3. In this section, we present the results organized according to the levels (1, 2, 3, and 4) of the ethical template.

TABLE 3

*Level 1: Drug categories included*

*L1.1. Which categories of drugs to include?* The first step was to identify the rationale behind the identification and selection of the drugs to be evaluated. This task was the Commission's responsibility. There is no publicly available information on why and how the Commission selected the drugs for evaluation. According to the methodology developed for the evaluation of new inclusions in the POS, each evaluation must start with a "weighting" to assess the relevance of the health technology and to consequently establish the order and priority in which technologies should be subject to the assessment process (Comisión de Regulación en Salud, 2011d).

None of the 2011 HTAs evaluated in this article mentioned the weighting matrix. However, insulin glargine and mycophenolate, which also have HTAs from 2010, have their weighting matrices from 2010.

Seven of the drugs were evaluated along with other drugs that address the same disease/condition.

*L1.2. Giving priority to important health needs.* Despite their lack of information regarding selection criteria, nine of the 2011 HTAs reviewed included descriptions of the disease's impact on the Colombian population and the importance of providing treatment.

*L1.3. Appeal to acceptable, general priority principles; facts about effectiveness, risks, and cost-worthiness.* The effectiveness, safety, and economic impact of eight of the drugs were compared with technologies already included in the POS. In the case of pediatric enteral feeding, the POS did not have a comparable treatment; and esomeprazole did not have an HTA.

The eleven HTAs followed a standard methodology and included a systematic review of scientific evidence, based mainly on searches from MEDLINE and Cochrane for evaluations of effectiveness and safety evidence, and from MEDLINE and EconLit for economic evaluations.

The methodology presented in 2011 not considered the antiqueness of the evidence as a criteria for the inclusion and exclusion of studies, however the Commission's methodology presented in 2010, which was validated by civil society organizations, established as an exclusion criterion articles older than five years. Nevertheless, the HTAs for azithromycin, cefuroxime, insulin glargine, and mycophenolate cited articles more than five years old.

"Financed by the pharmaceutical industry" was also a reason to exclude studies, according to the methodology developed by the Commission in 2010 (Castillo, 2010). However, this was not applied in the HTAs analyzed. For example, the HTA for paliperidone included studies (clinical evidence and economic evaluations) financed by the pharmaceutical industry, and the HTA for insulin glargine failed to mention that two of the three studies quoted to provide

evidence on the drug's effectiveness in preventing nocturnal hypoglycemia (Eliaschewitz et al., 2006; Fritsche et al., 2003) were financed by the drug manufacturer.

Despite these issues, the HTAs did all follow some exclusion criteria, such as the following: (i) if the study did not fulfill the quality criteria established by the HTA; (ii) if the study was repeated; (iii) if the article did not correspond to the topic under evaluation; (iv) if the language of the article was neither in English nor in Spanish; and (v) if the article was not available.

### *Level 2: Drug selection within category*

*L2.1. Which drugs from category to include?* In the case of four of the non-prioritized drugs, the new POS included some of the drugs evaluated in the same category (that in some cases shared the same HTA). Only in the case of pediatric enteral feeding is it unclear whether there are other treatment possibilities.

*L2.2. Gaining cost advantages without undue burden on or risk to patients.* This point is not addressed by the HTAs analyzed, and it is unclear whether it was a criterion for including or excluding the drug. However, in some cases, the HTA recommend exercising caution in the use of the drugs (insulin glargine) or explicitly stated that it found no evidence on the drug's safety (cefuroxime for the treatment of child pneumonia).

*L2.3. Facts about interchangeability; facts about costs; fair exceptions process.* According to the HTAs, in the case of cefuroxime, insulin glargine, and mycophenolate, the POS already contained cheaper options with similar effects, meaning that the POS already addressed the health needs identified by the Commission. The inclusion of these drugs was conditioned on an economic evaluation in Colombia and/or regulation of the drugs' prices.

In the case of esomeprazole, according to some experts, the POS already included cheaper options (such as omeprazole) for the management of the same conditions (Gúzman, 2012).

### *Level 3: Drug indication*

*L3.1. Which uses of the drugs are covered?* Esomeprazole and insulin glargine do not have clear indications (When can they be prescribed? Are they first- or second-line treatments?). In two cases, the drug's indication is broader than the one mentioned in its HTA: (i) cefuroxime is recommended for the treatment of pneumonia in all age groups, while the HTA recommended its use in adults only, stating that there is no evidence for pediatric use; and (ii) mycophenolate is recommended for the management of heart, kidney, and liver transplants, while the HTA recommended its use only for kidney and liver transplants.

*L3.2. Giving priority to important health needs.* As mentioned above, for four of the non-prioritized drugs, the new POS included drugs evaluated within the same category, the only exception being pediatric enteral feeding.

*L3.3. Appeal to acceptable, general priority principles; facts about effectiveness, risk, and cost-worthiness.* The HTAs provided information primarily on drugs' effectiveness and safety. Due to the lack of information on the cost of these drugs in the Colombian context, the HTAs of the four drugs included in the new POS highlighted the need to perform—prior to including the drug—an economic assessment in the Colombian context. We did not find

evidence allowing us to determine whether these studies were performed before the drugs' inclusion in the POS.

#### *Level 4: Drug use coverage limitations*

*L4.1. How many can be covered? Where and how can they be purchased?* For three of the prioritized drugs, the POS stated limitations for the drugs' coverage: azithromycin and cefuroxime are covered only for pneumonia treatment, and mycophenolate is covered only for the management of heart, kidney, and liver transplants.

In none of the cases examined did the POS state a limit for the treatment length nor provide information regarding how the drugs shall be purchased.

*L4.2. Gaining cost advantages without undue burden on or risk to patients.* We found no consistent information on these points. As mentioned above, some drugs were included despite being more expensive and having marginal benefits compared with other drugs already included in the POS.

*L4.3. Reasonableness of coverage limitations; facts about savings; fair exceptions process.* We found no consistent information on these points. The HTAs for cefuroxime, insulin glargine, and mycophenolate recommended that—in light of these drugs' high prices and marginal benefit compared with the ones already included in the POS—their inclusion be conditioned on the regulation of their prices in Colombia. There is no evidence on the implementation of the recommended price control measures.

### **3.2 Final decision-making process**

Levels 3 and 4 of the template refer to the final stage of the prioritization process (see Table 3). The prioritization process that we analyzed was the responsibility of the Commission.

Decision T-760/2008 required that the prioritization process of health technologies include the effective participation of both the scientific community and users of the health-care system. This participation was made up of two elements: (i) meetings to discuss the methodology for updating the POS; and (ii) social validation of the proposals for inclusion and exclusion.

The first element was carried out through the organization of regional meetings, defined as spaces for allowing interaction with the decision-making process. However, the term used in Spanish to label the meetings (*socialización*) could indicate merely a space for information sharing and does not necessarily imply decision making.

One barrier to stakeholders' participation in these meetings, especially for organizations with less academic training, was the use of technical language. While the process included a training component, participants complained about the complexity of the material and the lack of tools and time provided for analyzing the documents.

Despite this barrier, for the Commission, these regional meetings were the spaces for sharing and approving—in other words, providing legitimacy to—the methodology and the priority-setting process performed in 2011.



The second element of the process was the social validation, which was conducted online. Before the publication of the final version of the new POS in January 2012, the Commission launched a broad citizens' consultation via internet. For this online consultation, the Commission prepared a chart regarding the proposed POS that included a column for citizens' observations.

The HTAs and the results from the public participation constitute inputs that the Commission considered before making its final decisions. However, how these inputs were weighted and used is not clear, as there is no publicly available information regarding the rationale behind the Commission's final decisions.

#### **4. Discussion**

The first objective of this article was to assess the fairness and legitimacy of the POS prioritization process performed in Colombia between 2010 and 2011. The article used a framework, developed by Daniel et al. (2003), that addressed these two elements.

Therefore, this article did not engage with or respond to positions criticizing the current health system structure and asking for a different organization of the Colombian health system. Instead, the framing of this article was based on the current structure of the Colombian health system and its health plans.

Our analysis considered Colombian authorities' attempts to design a fair and legitimate process. In 2010, the Colombian Commission on Health Regulation designed a methodology and a process by which this methodology would be approved by key Colombian actors (including civil society organizations, medical associations, and patients' organizations).

Despite the Commission's efforts, according to our analysis, implementation of the prioritization process has presented major weaknesses that undermine its fairness and legitimacy. These weaknesses are mainly associated with a lack of information and transparency in the decision-making process. This lack of information and transparency sometimes contradicts what was stated in the approved and socialized methodology.

The methodology adopted by the Commission for the health technology assessment emphasizes the importance of tangible evidence for decision making. However, there have been some decisions clearly not based on such evidence. Firstly, the rationale behind the selection of the 359 evaluated technologies is not clear, nor is it clear how they were ranked in comparison with those excluded from the evaluation.

Further, some of the decisions have been made without fulfilling the observations included in the HTAs (such as economic impact assessments within the Colombian context), and our analysis detected the case of one drug that was included in the POS without an HTA.

Despite the public availability of the HTAs and the documents regarding the methodology for the prioritization process in Colombia, we found no information regarding why some of the criteria presented and approved in the methodology developed in 2010 were not followed by the HTAs performed in 2011, such as the exclusion of studies performed by the pharmaceutical industry and studies older than five years. The pharmaceutical industry's participation in clinical trials as a strategy to advocate for the use of certain manufactured drugs is a concern not only in Colombia but around the world (Bosch et al., 2012); that is why

decisions allowing the inclusion of studies financed by the pharmaceutical industry in the HTAs must be clearly explained.

This is not a minor observation, because deciding not to limit the searching period or to accept studies performed with the support of the pharmaceutical industry could change the results of the HTA, as described above in the case of insulin glargine and mycophenolate.

These observations do not imply that the Commission made these changes to its methodology without valid arguments. Rather, they highlight the fact that the rationale for changing the methodology has not been explicit, thus undermining the process's legitimacy.

These observations concur with the opinions raised by Colombians regarding the updating of the POS, which have stressed the lack of transparency in how the technologies were selected, as well as how the final decisions were made.

These weaknesses reflect negatively not only on the process's legitimacy but also on its perceived fairness. Our analysis detected that in three of the four prioritized drugs with available HTAs, the recommendation was to condition the drugs' inclusion on the implementation of price regulation measures in the country. There is no evidence regarding the implementation of these measures.

This is a major issue in the Colombian context, where debate about the impact of drug price deregulation is a sensitive issue. In 2006, Colombia implemented an entire reform of the system of price regulation that reduced the government's control over drug prices. The new control regimen applied only to those products for which no competition exists in their therapeutic class. This characteristic affects very few products and made most pharmaceutical products in Colombia immune to price control.

Deregulation has had a negative impact on the financial state of Colombia's health system. The state has been paying overly high prices for drugs. In addition, the lack of oversight of expenditures in pharmaceutical products has allowed corrupt practices within the pharmaceutical market that in turn had a major negative impact on the health system (Access to medicines project, 2009; Corte Constitucional de Colombia, 2012; Departamento Nacional de Planeación et al., 2012; Observatorio del Medicamento Colombia, 2012).

The lack of transparency about the rationale behind the prioritization of drugs, as well as the lack of economic analysis, raises doubts concerning the process's fairness (Are the resources invested in the best way?) and concerning the state's capacity to cover the expenses of the new POS. The HTAs highlighted the need to perform economic evaluations in the Colombian context before the drugs' inclusions; however, there is no evidence that these were performed. It is worth noting that in T-760/2008, the Court ordered the reforms to be undertaken in consideration the economic sustainability of the system (Cepeda-Espinosa, 2011).

The second objective of this article was to contribute, through the adoption of the ethical template, to a fairer and more legitimate priority-setting process in Colombia. The results show that an ethical template such as the one proposed by Daniel et al. (2003) could contribute to making decisions more explicit, thus strengthening the transparency of the process. The framework requires making information on the rationale behind the decisions publicly available, in turn creating the possibility for debate on the fairness and legitimacy of the process.

**Table 3: Using the ethical template**

<u>Allocation decision level</u>	<u>Coverage policy question</u>	<u>Central ethical issues</u>	<u>Relevant rationales</u>
<b>Level 1: Drug categories included</b>	<i>L1.1. Which categories of drugs to include?</i>	<i>L1.2. Giving priority to important health needs</i>	<i>L1.3. Appeal to acceptable, general priority principles; facts about effectiveness, risks, and cost-worthiness</i>
<b><u>Azithromycin</u></b>	Treatment of children. Community-acquired pneumonia. HTA included macrolides (azithromycin, clarithromycin, roxithromycin) and ketolides (telitromycin).	Pneumonia causes 12% of reported deaths among children under 5 years in Colombia. Burden of disease in terms of DALYs among children aged 0–4 years is 12.5, and children aged 5–14 years 1.22.  In Colombia, pneumonia is the fourth leading cause of hospitalization for people over 60 and is responsible for more than 70,000 annual hospitalizations in all age groups.  Mental health diseases are the leading cause of adults' burden of disease in Colombia.  The prevalence of schizophrenia in Colombia is 1.4% and is higher among the female population. Most of the reported cases are from the poorest sectors of society.	Clinical evidence was searched at MEDLINE, Cochrane, SciELO, and LILACS (children: 2794 found, 6 included; adults: 2794 found, 35 included).  For children, economic evaluations were searched at MEDLINE, EconLit, and HTA (4 found, 1 included); for adults, MEDLINE, EconLit, NHS, and ISPOR (48 found, 11 included).
<b><u>Bupropion</u></b>	Antidepressants as adjuncts in antipsychotic therapy. HTA included bupropion, duloxetine, venlafaxine, mirtazapine, paroxetine, sertraline, rivastigmine, and ziprasidone.	Same as azithromycin	Clinical evidence was searched at MEDLINE, Cochrane, NICE, SIGN, and Instituto de Salud Carlos III (98 found, 2 included).  Economic evaluations were searched at EconLit, Health Business Fulltext Elite, HTA, Instituto de Salud Carlos III, ISPOR, and NHS EED (141 found, 0 included).
<b><u>Cefuroxime</u></b>	HTA included second-generation cephalosporins (cefuroxime, cefprozil) and third-generation cephalosporins (cefotaxime).	Same as azithromycin	Clinical evidence was searched at MEDLINE, Cochrane, SciELO, and LILACS (children: 97 found, 2 included; adults: 97 found, 5 included).  For children, economic evaluations were searched at MEDLINE, EconLit, and NHS (31 found, 1 included); for adults, MEDLINE, Cochrane, EconLit, AEA, and Google Scholar (186 found, 6 included).
<b><u>Esomeprazole</u></b>	No information available. Drug not among the list of drugs to be evaluated	No information available	No information available

<b><u>Insulin glargine</u></b>	HTA included 2 long-acting basal insulin analogues (glargine, detemir) and 3 rapid-acting insulin analogues (lispro, aspart, glulisine).	Diabetes is among the 5 leading causes of death in Colombia.	No information available regarding how many studies were analyzed for this specific drug. For the whole group, clinical evidence was searched at MEDLINE and Cochrane (823 found, 24 included).
<b><u>Mycophenolate</u></b>	Immunosuppressant for the prevention of transplant rejection in kidney or liver transplants	Not clear. HTA mentioned an increased number of kidney and liver transplants in Colombia.	For the whole group, economic evaluations were searched at MEDLINE and Cochrane (186 found, 7 included). Clinical evidence was searched at MEDLINE and Cochrane (1026 found, 12 included). Economic evaluations were searched at PubMed, BVSALUD, and ISPOR (382 found, 3 included).
<b><u>Paliperidone</u></b>	HTA included 5 last-generation antipsychotic drugs (olanzapine, quetiapine, risperidone, aripiprazole, paliperidone).	In Colombia, schizophrenia causes 2.65 DALYS.	No information available regarding how many studies were analyzed for this specific drug. HTA indicated that for the five drugs evaluated, evidence was searched at NICE, SIGN, Instituto de Salud Carlos III, LILACS, MEDLINE, PubMed, Google Scholar, and Pharmaceutical Industry (863 found, 8 included). Information searched at NICE, INHATA, HTA, Pharmaceutical Industry, WHO, and NHS EED (90 found, 6 included). Clinical evidence was searched at MEDLINE, PubMed, LILACS, and Cochrane (65 found, 3 included).
<b><u>Pediatric enteral feeding</u></b>	Pediatric enteral feeding	No data available for the prevalence of hospitalized pediatric patients in Colombia. However, evidence shows that nutritional status plays a key role in the recovery of hospitalized children, and that sick children are at higher risk of malnutrition.	The analysis also included the consensus documents on pediatric enteral nutrition access, document approved by SENPE/SEGHNP/ANECPN/SECF.
<b><u>Valdecoxib</u></b>	HTA included 2 non-steroidal anti-inflammatory drugs for rheumatoid arthritis (etoricoxib, valdecoxib).	No data available regarding the prevalence/impact of the disease (inside or outside Colombia).	Complete economic evaluations and comparative cost-effectiveness analyses were searched at ISPOR, HTA-HEED, NHS, EconLit, LILACS, PubMed, EBSCO, ScienceDirect, and Cochrane (2835 found, 1 included). Valdecoxib is not licensed in Colombia.
<b><u>Valsartan</u></b>	HTA included 7 angiotensin II receptor antagonists (candesartan,	Chronic renal failure is described as one of the main public health problems worldwide.	No information clinical evidence searched . No economic evaluations were searched. Clinical evidence was searched at MEDLINE, Cochrane, PubMed, and LILACS (66 articles found, 0 included).

<p>eprosartan, valsartan, telmisartan, losartan, olmesartan, irbesartan) and quinapril combined with hydrochlorothiazide for the treatment of chronic renal failure.</p>	<p>In Colombia, the management of chronic renal failure is estimated to account for about 2% of national health expenditure and 4% of social security expenditure on health. According to the national guidelines, all patients with diabetic nephropathy (with or without hypertension) should be treated with an inhibitor of converting enzyme or angiotensin II receptor.</p>	<p>Due to the lack of clinical evidence, HTA incorporated the Colombian clinical guidelines for the management of patients with chronic renal failure.</p> <p>Economic impact studies were searched at PubMed, ScienceDirect, EBSCO, LILACS, Cochrane, ISPOR, HEED, EconLit, and NEEED (128 found, 0 included).</p>
<p><b>Level 2: Drug selection within category</b></p>	<p><i>L2.1. Which drugs from category to include?</i></p>	<p><i>L2.3. Facts about interchangeability: facts about costs; fair exceptions process</i></p>
<p><b><u>Azithromycin</u></b></p>	<p>Azithromycin and clarithromycin were included.</p> <p>As safe and effective as other drugs included in the POS</p>	<p>HTA highlighted the drug's effectiveness and safety; however, it requires an economic evaluation for Colombia.</p> <p>By 2009, it was calculated that in one year 1,918,747 units of 500 mg were sold, and that the brand presentation was 6.5 times more expensive than the generic, and 20.1 than the pioneer 20.1 (Vásquez et al., 2011).</p> <p>HTA did not find evidence of the use of bupropion as adjunct in antipsychotic therapy.</p>
<p><b><u>Bupropion</u></b></p>	<p>Despite HTA's conclusion and recommendation, rivastigmine and sertraline were included.</p> <p>Not addressed by the evaluation</p>	<p>Despite the HTA's conclusion that there was not enough evidence to recommend the drug's inclusion, rivastigmine and sertraline were included in the POS.</p> <p>For adults, the HTA recommended that the drug's inclusion in the POS be conditioned on its economic evaluation and the establishment of a favorable price.</p> <p>No information available</p>
<p><b><u>Cefuroxime</u></b></p>	<p>Cefuroxime and azithromycin were included.</p> <p>No information available</p>	<p>According to the HTA, this is the most expensive insulin. Its inclusion was conditioned on a price regulation.</p>
<p><b><u>Esomeprazole</u></b></p>	<p>Esomeprazole was included.</p>	<p>Effectiveness and safety is similar to cheaper options included in the POS (azathioprine) in the management of patients with lung and liver transplants. HTA conditioned its inclusion on price regulation.</p>
<p><b><u>Insulin glargine</u></b></p>	<p>Insulin glargine, detemir, lispro, aspart, and glulisine were included.</p> <p>Not clear. Studies reported minor benefits and suggested being cautious in the use and promotion of this type of insulin until data on the drug's long-term efficacy and safety become available.</p>	<p>In cases of kidney transplants, drug does not have an effect on mortality or kidney loss, and increases the chances of diarrhea, opportunistic infections, and infections by cytomegalovirus.</p>
<p><b><u>Mycophenolate</u></b></p>	<p>Mycophenolate was included.</p>	<p></p>

				Mycophenolate was among the top 10 drugs reimbursed from the Colombian health system in 2009. In 2010, it was removed, with other 9 drugs from Roche, from the list of drugs that should reduce their price by the mechanism of parallel imports.
<b><u>Paliperidone</u></b>	Olanzapine and risperidone (restricted to schizophrenia treatment) were included.	Not clear with respect to risperidone; this is the most expensive within the group of evaluated drugs, and, according to the studies, does not provide major gains.	Not addressed	The rationale for selecting risperidone is unclear.
<b><u>Pediatric enteral feeding</u></b>	None	Not addressed	Not addressed	
<b><u>Valdecoxib</u></b>	Included new combinations, such as aspirin + codeine, lefunomide, etanercept, and rituximab.	No economic analysis was performed with Valdecoxib.	Not addressed	
<b><u>Valsartan</u></b>	Losartan was included	No economic analysis was performed.	No	
<b><u>Level 3: Drug indication</u></b>	<i>L3.1. Which uses of the drugs are covered?</i>	<i>L3.2. Giving priority to important health needs</i>	<i>L3.3. Appeal to acceptable, general priority principles; facts about effectiveness, risk, and cost-worthiness</i>	
<b><u>Azithromycin</u></b>	Pneumonia treatment. POS includes 3 presentations.	Yes	No information about the economic evaluation recommended by the HTA	
<b><u>Bupropion</u></b>	None	Drug not included	Drug not included	
<b><u>Cefuroxime</u></b>	Pneumonia treatment. POS includes 3 presentations.	Not clear. POS includes cheaper options with similar effectiveness and safety.	Drug not included	Despite the HTA's recommendation, the POS allows the use of this drug among all age groups.
<b><u>Esomeprazole</u></b>	Use not specified. POS includes 4 presentations.	No. POS includes cheaper options with similar effectiveness and safety (such as omeprazole).	No information about the economic evaluation recommended by the HTA	No. Despite the fact that esomeprazole was not included in the list of drugs to be evaluated and that it does not have a HTA, it was included in the POS.
<b><u>Insulin glargine</u></b>	Use not specified	Not clear. POS includes cheaper options with similar effectiveness and safety.	No information about the economic evaluation and price control regulation recommended by the HTA	No information about the economic evaluation and price control regulation recommended by the HTA
<b><u>Mycophenolate</u></b>	Heart, kidney, or liver transplant	Not clear. POS includes cheaper options with similar effectiveness and safety.	No information about the economic evaluation and price control regulation recommended by the HTA	No information about the economic evaluation and price control regulation recommended by the HTA
<b><u>Paliperidone</u></b>	None	Drug not included	Drug not included	
<b><u>Pediatric enteral feeding</u></b>	None	Drug not included	No. The HTA argued that the evidence shows that pediatric enteral feeding could have a positive impact. However, because of the lack of information in the Colombian context, it did not provide a final recommendation.	
<b><u>Valdecoxib</u></b>	None	Drug not included	The argument for excluding valdecoxib was that it has not been licensed in	

	Colombia due to safety.	
<b><u>Valsartan</u></b>	None	Drug not included
<b>Level 4: Drug use coverage limitations</b>	<i>L4.1. How many can be covered? Where and how can they be purchased?</i>	<i>L4.2. Gaining cost advantages without undue burden on or risk to patients</i>
<b><u>Azithromycin</u></b>	Not addressed	Not addressed
<b><u>Bupropion</u></b>	Drug not included	Drug not included
<b><u>Cefuroxime</u></b>	Not addressed	Not addressed despite HTA recommendation
<b><u>Esomeprazole</u></b>	No information available	No information available
<b><u>Insulin glargine</u></b>	Not addressed	No. Effectiveness is similar to cheaper options already included in the POS.
<b><u>Mycophenolate</u></b>	Not addressed	No. Effectiveness is similar to cheaper options already included in the POS. In cases of kidney transplants, the management of side effects could generate higher costs to the system.
<b><u>Paliperidone</u></b>	Drug not included	Drug not included
<b><u>Pediatric enteral feeding</u></b>	Not addressed. Lack of information for Colombian setting	Not addressed
<b><u>Valdecoxib</u></b>	Drug not included	Drug not included
<b><u>Valsartan</u></b>	Drug not included	Drug not included
Sources: (Unidad Administrativa Especial Comisión de Regulación en Salud, 2011a, b, c, d, e, f, g, h, i, j, k)		

## References

- Access to medicines project. (2009). Colombia Sets Price Ceiling on Important HIV/AIDS drug. Access to medicines project.
- Andia, O. (2009). Sentencia T-760/2008 y Acceso a Medicamentos “aciertos, desaciertos y repercusiones”. La Corte, las cuentas y la salud. ¿Cómo reformar el sistema de salud en Colombia? Universidad de los Andes. Bogotá.
- Arboleda, J.C. (2010). Desangre financiero del sistema de salud por medicamentos lo propició el gobierno. El Pulso. Medellín.
- Bosch, X., Esfandiari, B., & McHenry, L. (2012). Challenging Medical Ghostwriting in US Courts. *Plos Medicine*.
- Castillo, J.S. (2010). Evaluación de novedades POS. Bogotá: Universidad Nacional de Colombia.
- Cepeda-Espinosa, M.J. (2011). Transcript: Social and Economic Rights and the Colombian Constitutional Court. *Texas Law Review*, 89, 1699-1705.
- Comisión de Regulación en Salud. (2011a). Actualización Integral 2011. Plan Obligatorio de Salud. Sistema General de Seguridad Social en Salud. Tecnologías a ser Evaluadas. Bogotá.
- Comisión de Regulación en Salud. (2011b). Consulta Ciudadana. Evaluaciones con otros conceptos. Bogotá.
- Comisión de Regulación en Salud. (2011c). Consulta Ciudadana. Tecnologías en Salud Evaluadas y Conceptuadas. Bogotá.
- Comisión de Regulación en Salud. (2011d). Metodología para la Actualización Integral del Plan Obligatorio de Salud del Sistema General del Seguridad Social en Salud. Documento para Socialización. Bogotá
- Comisión de Regulación en Salud. (2012). Inclusiones y supresiones Plan Obligatorio de Salud 2012. Bogotá.
- Corte Constitucional de Colombia. (2012). Intervención Contralora General de la República Sandra Morelli. Audiencia T-760-08 part2/4. Bogotá.
- Daniels, N., Teagarden, J.R., & Sabin, J.E. (2003). An Ethical Template for Pharmacy Benefits. *Health Affairs*, 22, 125-137.
- Defensoría del Pueblo. (2009). La Tutela y el Derecho a la Salud. Período 2006-2008. Bogotá: Defensoría del Pueblo.
- Departamento Nacional de Planeación, Ministerio de Salud y Protección Social, & Instituto Nacional de Vigilancia de Medicamentos y Alimentos. (2012). Documento CONPES Social. Política Farmacéutica Nacional (p. 71). Bogotá.



- Eliaschewitz, F.G., Calvo, C., Valbuena, H., Ruiz, M., Aschner, P., Villena, J., et al. (2006). Therapy in Type 2 Diabetes: Insulin Glargine vs. NPH Insulin Both in Combination with Glimepiride *Archives of Medical Research*, 37, 495-501.
- Escobar, M.-L., Giedion, U., Giuffrida, A., & Glassman, A.L. (2009). Colombia: After a Decade of Health System Reform. In A. Glassman, M.L. Escobar, A. Giuffrida, & U. Giedion (Eds.), *From few to many: ten years of health insurance expansion in Colombia* pp. 1-13). Washington DC: Inter American Development Bank - The Brookings Institution.
- Fritsche, A., Schweitzer, M.A., Häring, H.-U., & 4001 Study Group (2003). Glimepiride Combined with Morning Insulin Glargine, Bedtime Neutral Protamine Hagedorn Insulin, or Bedtime Insulin Glargine in Patients with Type 2 Diabetes. A Randomized, Controlled Trial. *Annals of Internal Medicine*, 138 952-959.
- Gargarella, R. (2006). Theories of Democracies, the Judiciary and Social Rights. In R. Gargarella, P. Domingo, & T. Roux (Eds.), *Courts and social transformation in new democracies. An institutional voice for the poor?* pp. 13-34). Hampshire: Ashgate.
- Gargarella, R. (2011). Dialogic Justice in the Enforcement of Social Rights: Some Initial Arguments. In A.E. Yamin, & S. Gloppen (Eds.), *Litigating Health Rights. Can Courts Bring More Justice to Health*. Cambridge MA: Harvard University Press.
- Giedion, U., Panopoulou, G., & Gómez-Fraga, S. (2009). Diseño y ajuste de los planes explícitos de beneficios: el caso de Colombia y México. *Financiamiento del Desarrollo*. Santiago de Chile: Naciones Unidas-Comisión Económica para América Latina y el Caribe (CEPAL).
- González, A.C., & Durán, J. (2011). Impact of Court Rulings on Health Care Coverage: The Case of HIV/AIDS in Colombia. *MEDICC Review*, 13, 54-57.
- Gúzman, H. (2012). En actualización del POS “El Ministerio y la CRES perdieron transparencia”: Ifarma. *El Pulso*. Medellín.
- Kapiriri, L., Norheim, O.F., & Martin, D.K. (2007). Priority setting at the micro-, meso- and macro-levels in Canada, Norway and Uganda. *Health Policy*, 82, 78-94.
- Ministerio de la Protección Social. (2008). Mecanismos e instrumentos para la información, participación y comunicación de los procesos de actualización de los Planes Obligatorios de Salud POS: Hacer público lo que es público. (p. 9). Bogotá.
- Observatorio del Medicamento Colombia. (2012). Federación Médica Colombiana denuncia a ex-ministro Palacio por omisión de su deber de defender los recursos del sistema de salud y presunto favorecimiento a la multinacional Roche. *Boletín Informática & Salud*. *Boletín del Consumidor de Medicamentos*. Bogotá.
- Personal communication (email) with Luz Marina Umbacía (2012).
- Unidad Administrativa Especial Comisión de Regulación en Salud. (2011a). Informe Técnico 2. Efectividad, seguridad y análisis económico de bupropion, duloxetine, venlafaxina, mirtazapina, paroxetine, setralina, rivastigmina y ziprasidona inyectable en psicosis. Bogotá: Comisión de Regulación en Salud.

- Unidad Administrativa Especial Comisión de Regulación en Salud. (2011b). Informe Técnico 23. Efectividad, seguridad y análisis económico del uso de alimentación enteral como manejo de desnutrición en pacientes pediátricos hospitalizados. Bogotá: Comisión de Regulación en Salud.
- Unidad Administrativa Especial Comisión de Regulación en Salud. (2011c). Informe Técnico 78. Efectividad, seguridad y análisis económico de de los antagonistas de los receptores de la angiotensina II y quinapril combinados con hidroclorotizada en pacientes con insuficiencia renal crónica. Bogotá: Comisión de Regulación en Salud.
- Unidad Administrativa Especial Comisión de Regulación en Salud. (2011d). Informe Técnico 107. Efectividad, seguridad y análisis económico de etoricoxib y valdecoxib para el tratamiento de pacientes con artritis reumatoidea. Bogotá: Comisión de Regulación en Salud.
- Unidad Administrativa Especial Comisión de Regulación en Salud. (2011e). Informe Técnico 26. Efectividad, seguridad y análisis económico de roxitromicina, telitromicina, azitromicina y claritromicina en neumonía en adultos. Bogotá: Comisión de Regulación en Salud.
- Unidad Administrativa Especial Comisión de Regulación en Salud. (2011f). Informe Técnico 27. Efectividad, seguridad y análisis económico de roxitromicina, telitromicina, azitromicina y claritromicina en neumonía en niños. Bogotá: Comisión de Regulación en Salud.
- Unidad Administrativa Especial Comisión de Regulación en Salud. (2011g). Informe Técnico 28. Efectividad, seguridad y análisis económico de cefotaxima, cefuroxima y cefprozil en neumonía en adultos. Bogotá: Comisión de Regulación en Salud.
- Unidad Administrativa Especial Comisión de Regulación en Salud. (2011h). Informe Técnico 29. Efectividad, seguridad y análisis económico de cefotaxima, cefuroxima y cefprozil en pacientes pediátricos con neumonía. Bogotá: Comisión de Regulación en Salud.
- Unidad Administrativa Especial Comisión de Regulación en Salud. (2011i). Informe Técnico 62. Efectividad, seguridad y análisis económico de micofenolato en el manejo de pacientes transplantados. Bogotá: Comisión de Regulación en Salud.
- Unidad Administrativa Especial Comisión de Regulación en Salud. (2011j). Informe Técnico. Efectividad, seguridad y análisis económico del uso de antipsicóticos de segunda generación olanzapina, quetiapina, risperidona, aripiprazol y paliperidona en el manejo de esquizofrenia. Bogotá: Comisión de Regulación en Salud.
- Unidad Administrativa Especial Comisión de Regulación en Salud. (2011k). Informe Técnico. Seguridad, eficiencia, efectividad y evaluación económica de las insulinas análogas (lispro aspart, glulisina, glargina y detemir) para el tratamiento de la diabetes mellitus. Bogotá: Comisión de Regulación en Salud.
- Vásquez, M., Miguel, C., & Rossi, F. (2011). Efectos de las marcas comerciales en medicamentos. Buscando Remedio. Bogotá: IFARMA.
- Yamin, A.E., & Norheim, O.F. (2010). Health care priority-setting: The definition of a new benefits scheme; public deliberation; and the Constitutional Court's follow-up with

respect to its orders concerning prioritization. Paper prepared for seminar to the Constitutional Court Bogotá.

Yepes, F.J., Ramírez, M., Sánchez, L.H., Ramírez, M.L., & Jaramillo, I. (2010). Luces y sombras de la reforma de la salud en Colombia. Ley 100 de 1993. Bogotá: Assalud, Universidad del Rosario, Facultad de Economía and Mayol Ediciones S.A.



*Annex 1*  
*Complementary information*

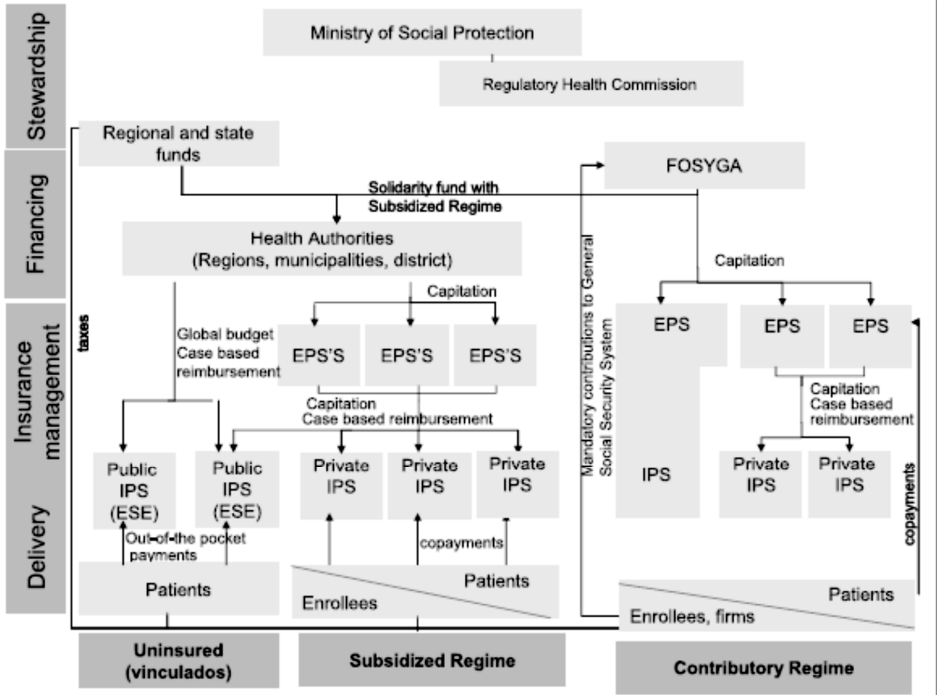


*Annex 1.1: States That Have Signed and Ratified the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights as of June 2012*

State	Date Signed	Date Ratified	Human Development Index Quartile	Human Development Index Rank
Argentina	24 Sept. 2009	24 Oct. 2011	Very high	45
Armenia	29 Sept. 2009		High	86
Azerbaijan	25 Sept. 2009		High	91
Belgium	24 Sept. 2009		Very high	18
Bolivia (Plurinational State of)	12 Feb. 2010	13 Jan. 2012	Medium	108
Bosnia and Herzegovina	12 July 2010	18 Jan. 2012	High	74
Cape Verde	26 Sept. 2011		Medium	133
Chile	24 Sept. 2009		Very high	44
Congo	25 Sept. 2009		Medium	137
Costa Rica	28 Apr. 2011		High	69
Democratic Republic of the Congo	23 Sept. 2010		Low	187
Ecuador	24 Sept. 2009	11 June 2010	High	83
El Salvador	25 Sept. 2009	20 Sept. 2011	Medium	105
Finland	24 Sept. 2009		Very high	22
Gabon	24 Sept. 2009		Medium	106
Ghana	24 Sept. 2009		Medium	135
Guatemala	24 Sept. 2009		Medium	131
Guinea-Bissau	25 Sept. 2009		Low	176
Ireland	23 Mar. 2012		Very high	7
Italy	28 Sept. 2009		Very high	24
Kazakhstan	23 Sept. 2010		High	68
Luxembourg	24 Sept. 2009		Very high	25
Madagascar	25 Sept. 2009		Low	151
Maldives	21 Sept. 2011		Medium	109
Mali	24 Sept. 2009		Low	175
Mongolia	23 Dec. 2009	1 July 2010	Medium	110
Montenegro	24 Sept. 2009		High	54
Netherlands	24 Sept. 2009		Very high	3
Paraguay	6 Oct. 2009		Medium	107
Portugal	24 Sept. 2009		Very high	41
Senegal	24 Sept. 2009		Low	155
Slovakia	24 Sept. 2009	7 Mar. 2012	Very high	35
Slovenia	24 Sept. 2009		Very high	21
Solomon Islands	24 Sept. 2009		Low	142
Spain	24 Sept. 2009	23 Sept. 2010	Very high	23
Timor-Leste	28 Sept. 2009		Low	147
Togo	25 Sept. 2009		Low	162
Ukraine	24 Sept. 2009		High	76
Uruguay	24 Sept. 2009		High	48
Venezuela (Bolivarian Republic of)	4 Oct. 2011		High	73

Sources: UNDP (2011a); United Nations (2012)

*Annex 1.2: Structure of the Colombian Health-Care System in 2008*



*From: Vargas, Vásquez, Mogollón Pérez, & Unger (2010, p. 2)*



**Annex 1.3: Inclusions to the POS-S and POS-C, July 1994–July 2008**

Year	POS-S	POS-C
<b>July 1994 – Definition of the contents of the POS-S and POS-C</b>		
1995	Inclusion of high-cost diseases (e.g., cancer and renal failures). Inclusion of ophthalmology and optometry services, as well as glasses frames and lenses for patients over 18 and under 60 years old.	
1996	Inclusion of treatment for some high-cost diseases.	
1996	Inclusion of appendectomy, hysterectomy, cholecystectomy, female sterilization (tubal ligation and Pomeroy).	
1997	First update of the list of medicines. Inclusion of 15 drugs for HIV treatment.	
1997	Increased coverage for high-cost diseases. Inclusion of treatment for strabismus in children under five years old, and for cataracts in patients of all ages.	
1997	Inclusion of herniorrhaphy and functional care services.	
1997	Second update of the list of medicines.	
1998	Third update of list of medicines.	
2002	Inclusion of linear accelerator for photon teletherapy (cancer treatment). <i>Agreement No. 226 of the CNSSS.</i>	
2002	Fourth update of the list of medicines..	
2002		Inclusion of zoledronic acid for cancer treatment.
2003		Inclusion of conventional uncoated coronary stents and HIV viral load test.
2004	Inclusion of zoledronic acid for cancer treatment.	
2005	Inclusion of conventional uncoated coronary stents and HIV viral load test.	
2005		Inclusion of liver transplant.
2005	Inclusion of 16 drugs for treatment of high-cost diseases.	
2005	Inclusion of meshes for herniorrhaphy.	
2005	Inclusion of laparoscopic cholecystectomy.	
2006	In base of the clinical guidelines inclusion of genotyping, formula, microalbuminuria for HIV patients.	
2006	On the basis of clinical guidelines, inclusion of new drugs for HIV and chronic kidney disease.	
2006	Inclusion of voluntary interruption of pregnancy.	
2007	On the basis of clinical guidelines, inclusion of new drugs for HIV/AIDS (lopinavir/ritonavir).	
2007	Inclusion of vasectomy.	
2008	Inclusion of five hormonal contraception drugs and the male condom.	
2008	On the basis of clinical guidelines, inclusion of ambulatory services for hypertension and diabetes mellitus type 2.	
<b>July 2008 – Decision T-760/2008</b>		

Sources: Giedion, Panopoulou, et al. (2009); Ministerio de la Protección Social (2010)

## Annex 1.4: Summary of main Orders of Decision T-760/2008

Order	Main Entity Responsible
<p><b>Sixteen.</b> Take the necessary steps to overcome the failures of regulation in the POS, ensuring that its contents are (i) defined in a clear way; (ii) fully up to date; (iii) unified for the contributory and subsidized regimes; and (iv) timely and effectively delivered by the EPSs.</p> <p>This regulation shall also (i) encourage the EPSs and regional entities to ensure access to health services to those who are so entitled and (ii) discourage the denial of health services by the EPSs and regional entities.</p>	<p>Ministry of Social Protection, CRES, and CNSSS</p>
<p><b>Seventeen.</b> Integral update of the POS. To fulfill this order, the CRES must ensure the direct and effective participation of the medical community and users of the health system.</p> <p>This integral update must (i) clearly define what health services are included in the POS, evaluating the legal criteria and the jurisprudence of the Constitutional Court; (ii) establish what services are excluded, as well as those that are not covered under the benefit plans but will gradually be included, indicating the goals for expansion and the dates by which they will be satisfied; (iii) decide what services should be deleted from the benefit plans, indicating the specific reasons for such decisions according to health priorities, so as to better protect rights; and (iv) take into account, in decisions to include or exclude a health service, the sustainability of the health system and the financing of the benefit plans by the UPC and other funding sources.</p>	<p>CRES</p>
<p><b>Eighteen.</b> Update the POS at least once a year, based on criteria established by law.</p> <p>The CRES shall submit an annual report to the ombudsman and the attorney general indicating, for the respective period, (i) what is included; (ii) what is not included from the requests by the medical community and users; (iii) what services were added or deleted from the benefit plans, indicating the specific reasons for each service or illness; and (iv) the justification for the decision in each case, with reasoning based on medicine, public health, and financial sustainability.</p>	<p>CRES</p>
<p><b>Nineteen.</b> Take steps to ensure that all EPSs in the country send a quarterly report to the CRES, the National Health Superintendent, and the ombudsman. The report should include (i) medical services ordered by the attending physician that were denied by the EPS and that were not processed by the Scientific Technical Committee; (ii) medical services ordered by the physician that were denied by the Scientific Technical Committee of the EPS; (iii) reasons for the refusal or lack of a decision in each case.</p>	<p>Ministry of Social Protection</p>
<p><b>Twenty.</b> Take appropriate steps to identify which EPSs and IPSs frequently refuse to allow timely health services included in the POS or <i>required with necessity</i>. With this aim, the Ministry of Social Protection and the National Health Superintendent shall report the following to the ombudsman, the attorney general, and the Constitutional Court: (i) which EPSs and IPSs most frequently engage in practices that violate the right to health; (ii) what concrete and specific measures in relation to these entities were adopted in the past and are currently being advanced, if any; and (iii) what concrete and specific measures have been taken to ensure the effective enjoyment of the right to health of persons who are affiliated with the EPSs and IPSs identified.</p>	<p>Ministry of Social Protection and the National Health Superintendent</p>
<p><b>Twenty-one.</b> Unify the benefit plans for children of the contributory and subsidized regimes. This must take into account the necessary adjustments to the subsidized UPC for children to ensure the financing of the expansion in coverage. If by that date the necessary measures are not adopted for the equalization of the benefit plan for children, it is understood that the POS-C will cover children from both regimes.</p>	<p>CRES</p>
<p><b>Twenty-two.</b> Adopt a program and timetable for the gradual and sustainable consolidation of the POS, taking the following into account: (i) the priorities of the population according to epidemiological studies and (ii) the financial sustainability of the expansion of coverage and its funding by the UPC and other sources of funding for the existing system.</p> <p>This should (i) provide the definition of mechanisms to streamline access to health services for users, ensuring that the needs and health priorities are met without impeding access to required health services; (ii) identify the disincentives for the payment of contributions by users; and (iii) plan for the necessary measures to encourage those with economic capacity to actually contribute and to ensure that those who move from the subsidized regime to the contributory regime can return to the subsidized regime swiftly when their income decreases or their socioeconomic situation deteriorates.</p> <p>The implementation process must provide sufficient opportunity for effective and direct participation by the medical community and the organizations representing the interests of health system users.</p>	<p>CRES</p>
<p><b>Twenty-three.</b> Take the necessary measures to regulate the internal procedure that the treating physician must perform so that the respective EPS directly authorizes both POS and non-POS health services.</p> <p>Until this internal process is developed, the Court orders the Ministry of Social Protection and the CRES to take the necessary steps to ensure that the EPSs extend the existing rules for the submission for consideration by the Scientific Technical Committee of a medication not included in the POS, where such medication is ordered by the attending physician, taking into account the parameters set by the Constitutional Court.</p> <p>When the Scientific Technical Committee denies a medical service in accordance with the competence laid out in the present ruling, and is later obliged to provide such a service by means of a <i>tutela</i>, only half of the costs not covered will be reimbursed, in accordance with what is said in this ruling.</p>	<p>Ministry of Social Protection and CRES</p>

Order	Main Entity Responsible
<p><b>Twenty-four.</b> Take measures to ensure that the process of reimbursement to the EPSs by FOSYGA and the regional entities is agile and to ensure the adequate and timely flow of resources to the health system to finance the health services, whether the request for a health service originates via <i>tutela</i> or via an authorization of the Scientific Technical Committee.</p> <p>To comply with this order, at the very least, the measures contained in orders 25 through 27 of the resolutions section must be adopted.</p>	<p>Ministry of Social Protection and FOSYGA</p>
<p><b>Twenty-five.</b> When FOSYGA deals with health services whose practice is authorized pursuant to a <i>tutela</i>, it must act as follows: (i) an EPS may start the recovery process once the order is final, whether because the decision of first instance was not challenged or because the order comes from the decision of second instance, without the authorization or recovery procedure for the health service being hindered based on the pretext of any review process that may reach the Constitutional Court; (ii) the presence of an express authorization for recovery before FOSYGA or the regional entity in the resolution portion of the <i>tutela</i> decision cannot be established as a condition for recognizing the right to recover the costs that the entity had no legal or regulatory obligation to assume. It will be sufficient to find that the EPS has no legal or regulatory obligation to assume the cost under the scope of the relevant benefit plan funded by the UPC. And (iii) the repayment should take into account the difference between generic drugs and brand-name drugs, but should not be refused with recourse to the "Active Principle in POS" when the brand-name drug is formulated under the terms specified in section 6.2.1. of this order.</p>	<p>Ministry of Social Protection and FOSYGA</p>
<p><b>Twenty-six.</b> Devise a contingency plan to (1) advance the processing of applications for recovery that are late and (2) expedite payment of recoveries for claims in which compliance with the requirements of the existing resolutions was verified, but in which payment has not yet been made, in accordance with this order. At the very least, this plan must contain the following: (i) specific targets for compliance with this order; (ii) a timetable for meeting the goals; and (iii) actions to be undertaken to meet the goals, specifying in each case the officer responsible for compliance.</p>	<p>Ministry of Social Protection and FOSYGA</p>
<p><b>Twenty-seven.</b> Take the necessary measures so that the system of verification, control, and payment of claims for recovery operates efficiently, and so that FOSYGA promptly disburses funds related to applications for recovery. The Ministry of Social Protection may define the type of measures necessary.</p> <p>The Ministry of Social Protection may also redesign the system of recovery in the manner it deems most appropriate, taking into account the following: (i) ensuring the timely and effective flow of resources to finance health services; (ii) the definition of a smooth and clear procedure to audit applications for recovery without the duration of the procedure impeding the flow of resources; (iii) transparency in allocation of FOSYGA's resources; and (iv) the allocation of resources to deal effectively with the needs and priorities of health.</p>	<p>Ministry of Social Protection</p>
<p><b>Twenty-eight.</b> (1) Take the necessary steps to ensure that when joining an EPS, whether contributory or subsidized, each person receives the following information in simple and accessible terms: (i) a letter with the patient's rights and (ii) a letter regarding institutional performance.</p> <p>(2) Take appropriate steps to protect those who have had their right of access to adequate and sufficient information impeded to enable them to exercise their freedom of choice in deciding among the entities responsible for ensuring access to health services.</p>	<p>Ministry of Social Protection and CNSSS</p>
<p><b>Twenty-nine.</b> Take the necessary measures to ensure sustainable universal coverage of the General Social Security System in Health. The reasons for failing to achieve this goal should be given, and a new goal should be set and duly justified.</p>	<p>Ministry of Social Protection</p>
<p><b>Thirty.</b> Submit an annual report to the Second Review Chamber of the Constitutional Court, the attorney general, and the ombudsman, which includes the number of <i>tutelas</i> that resolve the legal issues raised in the ruling and, if the number has not diminished, an explanation of why not.</p>	<p>Ministry of Social Protection</p>

*Annex 1.5: Meetings and Public Hearings Organized by the Ministry of Social Protection, the CRES, and the Constitutional Court*

<b>Meeting</b>	<b>Organizer</b>	<b>City</b>	<b>Date</b>
<i>2008</i>			
International exchange seminars	Ministry of Social Protection	Bogotá	9–14 Nov.
<i>2009</i>			
Discussion workshops on criteria for the POS update	Ministry of Social Protection and CRES	Bogotá	23 and 27 July
Workshop: Developments regarding equalization of the children's POS	Ministry of Social Protection and CRES	Bogotá	21–22 Sept.
<i>2010</i>			
Seminar: Methodology for the UPC calculation	CRES	Bogotá	8–9 Mar.
Workshop: Monitoring of the observatories in implantable medical devices and new procedures	CRES	Bogotá	24 May
Thematic roundtables: Social security system reform process	Ministry of Social Protection	Bogotá	21–30 Sept.
Workshop: Selection of civil society representatives for POS update process	CRES	Bogotá	20 Oct.
Workshop: Selection of civil society representatives for POS update process	CRES	Bucaramanga	26 Oct.
Workshop: Selection of civil society representatives for POS update process	CRES	Pereira	28 Oct.
Workshop: Selection of civil society representatives for POS update process	CRES	Cali	3 Nov.
Workshop: Selection of civil society representatives for POS update process	CRES	Barranquilla	9 Nov.
Workshop: Selection of civil society representatives for POS update process	CRES	Medellín	11 Nov.
Workshop: Selection of civil society representatives for POS update process	CRES	Villavicencio	17 Nov.
Workshop: Training and information on POS update methodology	CRES	Bogotá	6–7 Dec.
Workshop: Training and information on POS update methodology	CRES	Cali and Pereira	9 Dec.
Workshop: Training and information on POS update methodology	CRES	Barranquilla and Bucaramanga	13 Dec.
Workshop: Training and information on POS update methodology	CRES	Villavicencio	14 Dec.
Workshop: Training and information on POS update methodology	CRES	Valledupar	15 Dec.
Workshop: Training and information on POS update methodology	CRES	Medellín	17 Dec.
<i>2011</i>			
Workshop: Training and information on POS update methodology	CRES	Bucaramanga and Pereira	13–14 June
Workshop: Training and information on POS update methodology	CRES	Valledupar and Barranquilla	16–17 June
Workshop: Training and information on POS update methodology	CRES	Medellín	20–21 June
Workshop: Training and information on POS update methodology	CRES	Cali	23–24 June
Workshop: Training and information on POS update methodology	CRES	Bogotá	28–29 June
Public hearing: Accountability orders 16, 17, 18, and 21	Constitutional Court	Bogotá	7 July
Information session: Evaluation criteria for POS update	CRES	Barranquilla	10 Aug.
Information session: Evaluation criteria for POS update	CRES	Cali	17 Aug.
Information session: Evaluation criteria	CRES	Bogotá	23 Aug.

<b>Meeting</b>	<b>Organizer</b>	<b>City</b>	<b>Date</b>
for POS update			
Information session: Evaluation criteria for POS update	CRES	Pereira	26 Aug.
Information session: Evaluation criteria for POS update	CRES	Bucaramanga	26 Aug.
Information session: Evaluation criteria for POS update	CRES	Valledupar	29 Aug.
Information session: Evaluation criteria for POS update	CRES	Medellín	31 Aug.
Information session: Agreement proposal for comprehensive POS updating and presentation of HTA evaluations	CRES	Cali	8–9 Nov.
Information session: Agreement proposal for comprehensive POS updating and presentation of HTA evaluations	CRES	Barranquilla	8–9 Nov.
Information session: Agreement proposal for comprehensive POS updating and presentation of HTA evaluations	CRES	Pereira	10–11 Nov.
Information session: Agreement proposal for comprehensive POS updating and presentation of HTA evaluations	CRES	Medellín	10–11 Nov.
Information session: Agreement proposal for comprehensive POS updating and presentation of HTAs evaluations	CRES	Villavicencio	15 Nov.
Information session: Agreement Proposal for comprehensive POS updating and presentation of HTA evaluations	CRES	Valledupar	15–16 Nov.
Information session: Agreement proposal for comprehensive POS updating and presentation of HTA evaluations	CRES	Bogotá	17, 18, and 23 Nov.
Information session: Agreement proposal for comprehensive POS updating and presentation of HTA evaluations	CRES	Bucaramanga	22 and 23 Nov.
<i>2012</i>			
Workshop: POS equalization	CRES	Bogotá	20 Mar.
Public hearing: Accountability orders	Constitutional Court	Bogotá	10 May

*Annex 1.6: Electronic Reports Filed Before the Colombian Constitutional Court*

EPS	Submission of April 2011 Report	Submission of May 2011 Report	Submission of June 2011 Report	Which reports were included in article 2's analysis?
Aliansalud	4 May Uses format from Resolution 163/2011	3 June Uses format from Resolution 163/2011	5 July Uses format from Resolution 163/2011	Apr., May, June  All according resolution (detail with the code of the service, doses)
Ambuq	4 May Uses format from Resolution 163/2011  Does not include description of medicines (variable 11)	7 June Uses format from Resolution 163/2011	5 July Uses format from Resolution 163/2011	Apr., May, June  Information regarding services codes but details are missing
Anas Wayuu	18 May Uses format from Resolution 3821/2009, which was replaced by 163/2011	21 June Uses format from Resolution 3821/2009, which was replaced by 163/2011	22 July Uses format from Resolution 3821/2009, which was replaced by 163/2011	None
Asmet Salud	4 May Uses format from Resolution 163/2011	2 June Uses format from Resolution 163/2011	Not submitted	Apr., May
Caja de Compensación Familiar de Nariño	15 June  Uses format from Resolution 163/2011 to send quarterly report for Mar.–May		Not submitted	Apr., May
Colsubsidio	16 May Uses format from Resolution 3821/2009 to send the quarterly report for Mar.–May  Indicates that it has had problems in adding the database to the Supersalud website because the online format has not been updated according to Resolution 163/011  Report for Feb.–May 2011 resent according to Resolution 163/2011, but the information is still in in the old format		Uses format from Resolution 163/2011	June
Caja de Compensación familiar de Boyacá (Comfaboy)	5 May Uses format from Resolution 163/2011	4 June Uses format from Resolution 163/2011	4 July Uses format from Resolution 163/2011	Apr., May, June
Caja de Compensación Familiar de Córdoba (Comfacor)	15 July Reports for Jan.–June 2011 resent using format from Resolution 163/2011 format, responding to a communication from the CRES sent on 30 June 2011			Apr., May
Caja de Compensación Familiar de Huila (Comfamiliar)	Reports for Jan.–June 2011 resent using format from Resolution 163/2011			Apr., May, June
Caja de Compensación Familiar de Sucre (Comfasucre)	Reports for Feb.–May 2011 resent using format from Resolution 163/2011		Not submitted	Apr., May
Comfenalco Antioquia	5 May	1 June	6 July	Apr., May, June

EPS	Submission of April 2011 Report	Submission of May 2011 Report	Submission of June 2011 Report	Which reports were included in article 2's analysis?
	Uses format from Resolution 163/2011	Uses format from Resolution 163/2011	Uses format from Resolution 163/2011	
Comfenalco Santander	14 July Quarterly report quoting decision T-760/2008 sent using format from Resolution 163/2011			Apr., May, June
Comfenalco Valle	5 May Uses format from Resolution 163/2011	7 June Uses format from Resolution 163/2011	6 July Uses format from Resolution 163/2011	Apr., May, June
Compensar	5 May Uses format from Resolution 163/2011	7 June Uses format from Resolution 163/2011	6 July Uses format from Resolution 163/2011	Apr., May, June
Cóndor	30 May Reports for Jan.–Apr. 2011 resent using format from Resolution 163/2011	7 June Uses format from Resolution 163/2011	1 July Uses format from Resolution 163/2011	Apr., May, June
Convida	25 May Uses format from Resolution 3821/2009	Not submitted	Not submitted	None
Ecoopsos	24 May Uses format from Resolution 3821/2009	16 June Report for Feb.–May 2011 resent using format from Resolution 163/2011	1 July Uses format from Resolution 163/2011	Apr., May, June
Emdisalud (The government took control of the EPS in Dec. 2010)	Not submitted	3 June Information is inconsistent, cannot be trusted (e.g., on 4 May, there are 19 cases, of which 17 are procedures; 16 correspond to the same user who, according to the database, requested the same procedure more than once. The entire database is organized in this way.)  All cases indicate the same reason for rejection	3 July Same problem as for May data	None
Emssanar	4 May Uses format from Resolution 163/2011  Reports problems in obtaining data from physicians  IPS does not provide the information	2 June Damaged CD  Uses format from Resolution 163/2011	5 July Uses format from Resolution 163/2011	Apr., June
Manexka	13 May Uses format from Resolution 3821/2009	8 June Responding to a letter from the CRES, reports for Feb.– May 2011 resent  Uses format from	26 July Uses format from Resolution 3821/2009  Notes that the format of Supersalud's database is not updated	Apr., May

EPS	Submission of April 2011 Report	Submission of May 2011 Report	Submission of June 2011 Report	Which reports were included in article 2's analysis?
		Resolution 163/2011  Does not report on reasons for rejection  Information resent on 26 July, but using the old format	in accordance with Resolution 163/2011	
Mutual Ser	3 May Uses format from Resolution 163/2011	1 June Damaged CD	1 July Uses format from Resolution 163/2011  Contains three requests from a person born on 1 January 1900	Apr., June
Nueva EPS		8 June Uses format from Resolution 3821/2009	2 Aug.  CD was not in the file	No
Red Salud	5 May Uses format from Resolution 163/2011	3 June Uses format from Resolution 163/2011	3 July Uses format from Resolution 3821/2009	Apr., May
Salud Total	5 May Uses format from Resolution 163/2011  Codes of the type of service requested are in the old format	8 June Uses format from Resolution 163/2011  Contains information only on contributory regime  Codes of the type of service requested are in the old format	6 July Uses format from Resolution 163/2011  Codes of the type of service requested are in the old format	Apr., May, June
Sanitas	2 May Report for Jan.–May 2011 sent in response to communication 055 of 24 June 2009  Uses format from Resolution 3821/2009	24 June Reports for Apr.–June 2011 sent in response to communication 055 of 24 June 2009  Uses format from Resolution 3821/2009	No	No
Sura	4 May Uses format from Resolution 163/2011	3 June Uses format from Resolution 163/2011	5 July Uses format from Resolution 163/2011	Apr., May, June  All according resolution (detail with the code of the service, doses)



**Annex I.7: Number of Tutelas, POS and non-POS, by Year and Type of Request**

	2003	% from the annual total	% from the category	% from POS or non-POS	2004	% from the annual total	% from the category	% from POS or non-POS	% increase in relation to previous year	2005	% from the annual total	% from the category	% from POS or non-POS	% increase in relation to previous year
Year POS	25776	N/A	70.04	N/A	36624	N/A	70.93	N/A	42	40180	N/A	68.26	N/A	10
Year non-POS	10857	N/A	29.50	N/A	14676	N/A	28.42	N/A	35	18253	N/A	31.01	N/A	24
<b>Year</b>	<b>36804</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>51634</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>40</b>	<b>58865</b>	<b>N/A</b>	<b>73.04</b>	<b>N/A</b>	<b>14</b>
Exams POS	7800	21,19	67,12	30,26	12212	23,65	79,24	33,34	57	11380	19,33	73,04	28,32	-7
Exams non-POS	3309	8,99	28,47	30,48	2075	4,02	13,46	14,14	-37	3109	5,28	19,95	17,03	50
<b>Total exams</b>	<b>11621</b>	<b>31,58</b>	<b>17,78</b>	<b>7,01</b>	<b>15412</b>	<b>29,85</b>	<b>18,90</b>	<b>7,48</b>	<b>52</b>	<b>15581</b>	<b>26,47</b>	<b>11,29</b>	<b>26,47</b>	<b>1</b>
Drugs POS	1806	4,91	17,78	7,01	2739	5,30	18,90	7,48	52	2133	3,62	11,29	5,31	-22
Drugs non-POS	7356	19,99	72,41	67,75	10276	19,90	70,90	70,02	43	14674	24,93	77,65	80,39	43
<b>Total drugs</b>	<b>10159</b>	<b>27,60</b>	<b>N/A</b>	<b>27,60</b>	<b>14493</b>	<b>28,07</b>	<b>N/A</b>	<b>28,07</b>	<b>40</b>	<b>18897</b>	<b>32,10</b>	<b>N/A</b>	<b>32,10</b>	<b>30</b>
Surgeries POS	9224	25,06	91,96	35,79	11830	22,91	88,07	32,30	28	12730	21,63	87,88	31,68	8
Surgeries non-POS	757	2,06	7,55	6,97	1556	3,01	11,58	10,60	106	1756	2,98	12,12	9,62	13
<b>Total surgeries</b>	<b>10030</b>	<b>27,25</b>	<b>N/A</b>	<b>27,25</b>	<b>13433</b>	<b>26,02</b>	<b>N/A</b>	<b>26,02</b>	<b>34</b>	<b>14486</b>	<b>24,61</b>	<b>N/A</b>	<b>24,61</b>	<b>8</b>
Treatments POS	5651	15,35	93,16	21,92	7733	14,98	93,59	21,11	37	11031	18,74	91,96	27,45	43
Treatments non-POS	391	1,06	6,45	3,60	530	1,03	6,41	3,61	36	965	1,64	8,04	5,29	82
<b>Total treatments</b>	<b>6066</b>	<b>16,48</b>	<b>N/A</b>	<b>16,48</b>	<b>8263</b>	<b>16,00</b>	<b>N/A</b>	<b>16,00</b>	<b>36</b>	<b>11996</b>	<b>20,38</b>	<b>N/A</b>	<b>20,38</b>	<b>45</b>
Prosthesis POS	2689	7,31	44,93	10,43	4940	9,57	57,42	13,49	84	5803	9,86	52,19	14,44	17
Prosthesis non-POS	3296	8,96	55,07	30,36	3663	7,09	42,58	24,96	11	5316	9,03	47,81	29,12	45
<b>Total prosthesis</b>	<b>5985</b>	<b>16,26</b>	<b>N/A</b>	<b>16,26</b>	<b>8603</b>	<b>16,66</b>	<b>N/A</b>	<b>16,66</b>	<b>44</b>	<b>11119</b>	<b>18,89</b>	<b>N/A</b>	<b>18,89</b>	<b>29</b>
Appointments POS	2383	6,47	95,17	9,25	5018	9,72	99,07	13,70	111	5196	8,83	95,69	12,93	4
Appointments non-POS	121	0,33	4,83	1,11	0	0,00	0,00	0,00	-100	140	0,24	2,58	0,77	140
<b>Total appointments</b>	<b>2504</b>	<b>6,80</b>	<b>N/A</b>	<b>6,80</b>	<b>5065</b>	<b>9,81</b>	<b>N/A</b>	<b>9,81</b>	<b>102</b>	<b>5430</b>	<b>9,22</b>	<b>N/A</b>	<b>9,22</b>	<b>7</b>
Procedures POS	2201	5,98	89,07	8,54	2686	5,20	77,47	7,33	22	4182	7,10	86,21	10,41	56
Procedures non-POS	270	0,73	10,93	2,49	734	1,42	21,17	5,00	172	669	1,14	13,79	3,67	-9
<b>Total procedures</b>	<b>2471</b>	<b>6,71</b>	<b>N/A</b>	<b>6,71</b>	<b>3467</b>	<b>6,71</b>	<b>N/A</b>	<b>6,71</b>	<b>40</b>	<b>4851</b>	<b>8,24</b>	<b>N/A</b>	<b>8,24</b>	<b>40</b>

	2006	% from the annual total	% from the category	% from POS or non-POS	% increase in relation to previous year	2007	% from the annual total	% from the category	% from POS or non-POS	increase in relation to previous year	2008	% from the annual total	% from the category	% from POS or non-POS	% increase in relation to previous year
Year POS	76719	N/A	60,89	N/A	91	60178	N/A	49,28	N/A	-22	75774	N/A	49,29	N/A	33
Year non-POS	49275	N/A	39,11	N/A	170	58480	N/A	50,71	N/A	19	77956	N/A	50,71	N/A	26
<b>Year</b>	<b>125994</b>	N/A	N/A	<b>27,60</b>	<b>114</b>	<b>118658</b>	N/A	N/A	<b>27,60</b>	<b>-6</b>	<b>153730</b>	N/A	N/A	<b>27,60</b>	<b>30</b>
Exams POS	21100	16,75	70,69	27,50	85	16062	13,54	62,42	26,69	-24	19615	12,76	55,90	25,89	22
Exams non-POS	8749	6,94	29,31	17,76	181	9669	8,15	37,58	16,53	11	15473	10,07	44,10	19,85	60
<b>Total exams</b>	<b>29849</b>	<b>23,69</b>	<b>23,69</b>	<b>23,69</b>	<b>92</b>	<b>25731</b>	<b>21,69</b>	N/A	<b>21,69</b>	<b>-14</b>	<b>35088</b>	<b>22,82</b>	N/A	<b>22,82</b>	<b>36</b>
Drugs POS	12139	9,63	33,10	15,82	489	6519	5,49	18,41	10,83	-46	7720	5,02	19,33	10,19	18
Drugs non-POS	24534	19,47	66,90	49,79	67	28882	24,34	81,59	49,39	18	32227	20,96	80,67	41,34	12
<b>Total drugs</b>	<b>36673</b>	<b>29,11</b>	<b>29,11</b>	<b>29,11</b>	<b>94</b>	<b>35401</b>	<b>29,83</b>	N/A	<b>29,83</b>	<b>-3</b>	<b>39947</b>	<b>25,99</b>	N/A	<b>25,99</b>	<b>13</b>
Surgeries POS	17715	14,06	79,89	23,09	39	17233	14,52	75,38	28,64	-3	21341	13,88	70,63	28,16	24
Surgeries non-POS	4459	3,54	20,11	9,05	154	5628	4,74	24,62	9,62	26	8875	5,77	29,37	11,38	58
<b>Total surgeries</b>	<b>22174</b>	<b>17,60</b>	<b>17,60</b>	<b>17,60</b>	<b>53</b>	<b>22861</b>	<b>19,27</b>	N/A	<b>19,27</b>	<b>3</b>	<b>30216</b>	<b>19,66</b>	N/A	<b>19,66</b>	<b>32</b>
Treatments POS	8390	6,66	72,05	10,94	-24	3512	2,96	69,22	5,84	-58	3935	2,56	56,52	5,19	12
Treatments non-POS	3254	2,58	27,95	6,60	237	1562	1,32	30,78	2,67	-52	3027	1,97	43,48	3,88	94
<b>Total treatments</b>	<b>11644</b>	<b>9,24</b>	<b>9,24</b>	<b>9,24</b>	<b>-3</b>	<b>5074</b>	<b>4,28</b>	N/A	<b>4,28</b>	<b>-56</b>	<b>6962</b>	<b>4,53</b>	N/A	<b>4,53</b>	<b>37</b>
Prosthesis POS	7322	5,81	52,76	9,54	26	9086	7,66	47,39	15,10	24	12223	7,95	46,44	16,13	35
Prosthesis non-POS	6557	5,20	47,24	13,31	23	10087	8,50	52,61	17,25	54	14096	9,17	53,56	18,08	40
<b>Total prosthesis</b>	<b>13879</b>	<b>11,02</b>	<b>11,02</b>	<b>11,02</b>	<b>25</b>	<b>19173</b>	<b>16,16</b>	N/A	<b>16,16</b>	<b>38</b>	<b>26319</b>	<b>17,12</b>	N/A	<b>17,12</b>	<b>37</b>
Appointments POS	7887	6,26	87,05	10,28	52	6134	5,17	73,72	10,19	-22	9473	6,16	71,55	12,50	54
Appointments non-POS	1173	0,93	12,95	2,38	738	2187	1,84	26,28	3,74	86	3767	2,45	28,45	4,83	72
<b>Total appointments</b>	<b>9060</b>	<b>7,19</b>	<b>7,19</b>	<b>7,19</b>	<b>67</b>	<b>8321</b>	<b>7,01</b>	N/A	<b>7,01</b>	<b>-8</b>	<b>13240</b>	<b>8,61</b>	N/A	<b>8,61</b>	<b>59</b>
Procedures POS	2167	1,72	79,76	2,82	-48	1632	1,38	77,75	2,71	-25	1469	0,96	74,80	1,94	-10
Procedures non-POS	550	0,44	20,24	1,12	-18	467	0,39	22,25	0,80	-15	495	0,32	25,20	0,63	6
<b>Total procedures</b>	<b>2717</b>	<b>2,16</b>	<b>2,16</b>	<b>2,16</b>	<b>-44</b>	<b>2099</b>	<b>1,77</b>	N/A	<b>1,77</b>	<b>-23</b>	<b>1964</b>	<b>1,28</b>	N/A	<b>1,28</b>	<b>-6</b>

	2009	% from the annual total	% from the category	% from non-POS	% increase in relation to previous year	2010	% from the annual total	% from the category	% from POS	% increase in relation to previous year	2011	% from the annual total	% from the category	% from non-POS	% increase in relation to previous year
Year POS	103041	N/A	68,25	N/A	-36	89762	N/A	65,40	N/A	-13	131077	N/A	67,81	N/A	46
Year non-POS	47937	N/A	31,75	N/A	-39	47498	N/A	34,60	N/A	-1	62225	N/A	32,19	N/A	31
<b>Year</b>	<b>150978</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>-2</b>	<b>137260</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>-9</b>	<b>193302</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>41</b>
Exams POS	10493	6,95	89,91	10,18	-47	10237	7,46	96,79	11,40	-2	2421	1,25	17,71	1,85	-76
Exams non-POS	1177	0,78	10,09	2,46	-92	340	0,25	3,21	0,72	-71	11249	5,82	82,29	18,08	3209
<b>Total exams</b>	<b>11870</b>	<b>7,73</b>	<b>N/A</b>	<b>7,73</b>	<b>-67</b>	<b>10577</b>	<b>7,71</b>	<b>N/A</b>	<b>7,71</b>	<b>-9</b>	<b>13670</b>	<b>7,07</b>	<b>N/A</b>	<b>7,07</b>	<b>29</b>
Drugs POS	10206	6,76	28,12	9,90	32	13388	9,75	34,92	14,91	31	15275	7,90	35,65	11,65	14
Drugs non-POS	26086	17,28	71,88	54,42	-19	24954	18,18	65,08	52,54	-4	27573	14,26	64,35	44,31	10
<b>Total drugs</b>	<b>36292</b>	<b>24,04</b>	<b>N/A</b>	<b>24,04</b>	<b>-9</b>	<b>39342</b>	<b>27,93</b>	<b>N/A</b>	<b>27,93</b>	<b>6</b>	<b>42848</b>	<b>22,17</b>	<b>N/A</b>	<b>22,17</b>	<b>12</b>
Surgeries POS	18070	11,97	87,68	17,54	-15	18517	13,49	84,92	20,63	2	20840	10,78	80,56	15,90	13
Surgeries non-POS	2538	1,68	12,32	5,29	-71	3289	2,40	15,08	6,92	30	5029	2,60	19,44	8,08	53
<b>Total surgeries</b>	<b>20608</b>	<b>13,65</b>	<b>N/A</b>	<b>13,65</b>	<b>-32</b>	<b>21806</b>	<b>15,89</b>	<b>N/A</b>	<b>15,89</b>	<b>6</b>	<b>25869</b>	<b>13,38</b>	<b>N/A</b>	<b>13,38</b>	<b>19</b>
Treatments POS	29062	19,25	86,46	28,20	639	9002	6,56	60,58	10,03	-69	47500	24,57	88,59	36,24	428
Treatments non-POS	4551	3,01	13,54	9,49	50	5858	4,27	39,42	12,33	29	6120	3,17	11,41	9,84	4
<b>Total treatments</b>	<b>33613</b>	<b>22,26</b>	<b>N/A</b>	<b>22,26</b>	<b>383</b>	<b>14860</b>	<b>10,83</b>	<b>N/A</b>	<b>10,83</b>	<b>-56</b>	<b>53620</b>	<b>27,74</b>	<b>N/A</b>	<b>27,74</b>	<b>261</b>
Prosthesis POS	3472	2,30	25,80	3,37	-72	2248	1,64	19,21	2,50	-35	2421	1,25	17,71	1,85	8
Prosthesis non-POS	9984	6,61	74,20	20,83	-29	9456	6,89	80,79	19,91	-5	11249	5,82	82,29	18,08	19
<b>Total prosthesis</b>	<b>13456</b>	<b>8,91</b>	<b>N/A</b>	<b>8,91</b>	<b>-49</b>	<b>11704</b>	<b>8,53</b>	<b>N/A</b>	<b>8,53</b>	<b>-13</b>	<b>13670</b>	<b>7,07</b>	<b>N/A</b>	<b>7,07</b>	<b>17</b>
Appointments POS	17017	11,27	94,55	16,51	80	20341	14,82	97,07	22,66	20	18115	9,37	76,88	13,82	-11
Appointments non-POS	981	0,65	5,45	2,05	-74	615	0,45	2,93	1,29	-37	5448	2,82	23,12	8,76	786
<b>Total appointments</b>	<b>17998</b>	<b>11,92</b>	<b>N/A</b>	<b>11,92</b>	<b>36</b>	<b>20956</b>	<b>15,27</b>	<b>N/A</b>	<b>15,27</b>	<b>16</b>	<b>23563</b>	<b>12,19</b>	<b>N/A</b>	<b>12,19</b>	<b>12</b>
Procedures POS	2612	1,73	74,50	2,53	78	1568	1,14	73,58	1,75	-40	1891	0,98	85,68	1,44	21
Procedures non-POS	894	0,59	25,50	1,86	81	583	0,41	26,42	1,19	-37	316	0,16	14,32	0,51	-44
<b>Total procedures</b>	<b>3506</b>	<b>2,32</b>	<b>N/A</b>	<b>2,32</b>	<b>79</b>	<b>2131</b>	<b>1,55</b>	<b>N/A</b>	<b>1,55</b>	<b>-39</b>	<b>2207</b>	<b>1,14</b>	<b>N/A</b>	<b>1,14</b>	<b>4</b>

Sources: Defensoria del Pueblo (2003, 2009, 2010b, 2011, 2012)



*Annex 2*  
*Project Documentation*





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Camila Gianella  
Chr. Michelsen Institute  
Postboks 6033 Postterminalen  
5892 BERGEN

Vår dato: 19.08.2009

Vår ref:22372 / 2 / JSL

Deres dato:

Deres ref:

## TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 03.08.2009. Meldingen gjelder prosjektet:

22372

*Analysis of the Consequences of Health Rights Litigation on Access to the Right to Health in Colombia*

Behandlingsansvarlig  
Daglig ansvarlig

Universitetet i Bergen, ved institusjonens øverste leder  
Camila Gianella

Etter gjennomgang av opplysninger gitt i meldeskjemaet og øvrig dokumentasjon, finner vi at prosjektet ikke medfører meldeplikt eller konsesjonsplikt etter personopplysningslovens §§ 31 og 33.

Dersom prosjektopplegget endres i forhold til de opplysninger som ligger til grunn for vår vurdering, skal prosjektet meldes på nytt. Endringsmeldinger gis via et eget skjema, [http://www.nsd.uib.no/personvern/forsk\\_stud/skjema.html](http://www.nsd.uib.no/personvern/forsk_stud/skjema.html).

Vedlagt følger vår begrunnelse for hvorfor prosjektet ikke er meldepliktig. Prosjektet kan settes i gang.

Vennlig hilsen

Bjørn Henriksen

Juni Skjold Lexau

Kontaktperson: Juni Skjold Lexau tlf: 55 58 26 35

Vedlegg: Prosjektvurdering







UNIVERSIDAD NACIONAL DE COLOMBIA  
VICERRECTORIA DE INVESTIGACION

VRI-2449

Bogotá D.C., 19 de Noviembre de 2009

Señora

**CAMILLA GIANELLA**

**Estudiante de Doctorado**

Instituto Michelsen de la Universidad de Bergen en Noruega

Respetada señora Gianella:

El Comité Nacional de Ética en Investigación en sesión del 9 de noviembre de 2009, evaluó la propuesta de investigación titulada "Right to health trough litigation? Can court enforced health Rights improve health policy and priority settings in poor countries".

El Comité realizó un análisis colegiado en torno a los principales aspectos que aborda el proyecto en especial los relacionados con la reglamentación y determinaciones de la Sentencia 760 de 2008 y las repercusiones que ello tiene en los escenarios asistenciales colombianos ratificando la salud como Derecho Humano. Los miembros del Comité consideran que el abordaje y estudio de las condiciones de aplicación normativa mencionada expresan una condición de protección a los más vulnerables, especialmente a los grupos minoritarios nacionales por lo que será un aporte determinante para el sistema colombiano el que se consiga con ésta investigación. Constituirá además un mecanismo de retroalimentación sobre determinaciones fundamentales de los derechos ciudadanos por lo que será muy importante el desarrollo de este proyecto y su publicación amplia para que los resultados lleguen a todos los niveles tanto de decisión como de aplicación. El Comité reconoce que aunque la formulación de la propuesta es adecuada no permite conocer los criterios de selección e inclusión o exclusión de los entrevistados por lo que se recomienda que se tenga en cuenta los principales protagonistas de la definición de la política así como los actores encargados de su evaluación cotidiana.

Se sugiere incluir dentro de los encuestados a los grupos de Salud Pública nacionales como el del doctorado de Salud Pública de la Universidad Nacional de Colombia y el grupo de Salud Pública de la Universidad de Antioquia. Igualmente miembros de los Observatorios de Salud.

El comité Nacional de Ética en Investigación da el aval para iniciar el proyecto y le solicita a la investigadora, una vez finalice el proceso, hacer llegar un resumen de los resultados.

Cordial saludo,

**RAFAEL MOLINA GALLEGO**

Vicerrector

Presidente del Comité

Ana Carolina

Ciencia y tecnología para el país

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Bogotá Colombia, Sur América





**CORTE CONSTITUCIONAL  
SECRETARIA GENERAL**

Bogotá D. C., diez (10) de diciembre de dos mil nueve (2009).

**Oficio N° OPTB-415/2009 (Al responder cite el número del oficio y del expediente)**

Señora

**CAMILA GIANELLA MALCA**

Camila.gianella@cmi.no

**REFERENCIA: SENTENCIA T-760/2008. EXPEDIENTE T-1.281.247  
ACCIÓN DE TUTELA INSTAURADA POR LUZ MARY OSORIO PALACIO  
CONTRA SALUD COLPATRIA Y OTROS.**

Respetada señora:

Para dar cumplimiento al Auto S-40 de fecha primero (1) de diciembre de dos mil nueve (2009), proferido por el H. magistrado doctor **JORGE IVÁN PALACIO PALACIO**, me permito solicitarle el envío a esta Secretaría General (Calle 12 No. 7- 65. Piso - 2. Fax No. (091) 3 36 75 82. Palacio de Justicia), de lo ordenado en el proveído atrás descrito, cuya parte pertinente dice así:

***PRIMERO.** Por intermedio de la Secretaría General de esta Corporación, expídanse copias a costa de Camila Gianella Malca, de los siguientes documentos:*

- *Copia de los documentos con las respuestas que no sean de carácter reservado enviadas por el Ministerio de la Protección Social y la Superintendencia de Salud a la sala de seguimiento de la Sentencia T-760 - 2008 sobre la implementación de las ordenes de la Sentencia T-760 - 2008.*
- *Copia de los documentos con los informes de seguimiento enviados por Así vamos en Salud y ACEMI y otros a la Sala de seguimiento de la Sentencia T-760 - 2008 sobre la implementación de la Sentencia T-760 - 2008.*
- *Copia de los documentos con los informes de seguimiento enviados por la Defensoría del Pueblo de Colombia y la Procuraduría General de la Nación a la Sala de seguimiento de la Sentencia T-760 - 2008 sobre la implementación de la Sentencia T-760 - 2008.*
- *Copia de los documentos con las respuestas que no sean de carácter reservado enviadas por el Ministerio de la Protección Social y la Superintendencia de Salud a la Sala de seguimiento de la Sentencia T-760 - 2008 sobre los 26 Autos de Salud emitidos por la Corte Constitucional en Julio de 2009.*

*Para tal fin, las copias que contienen los documentos quedarán en la Secretaría General de esta Corporación a disposición del solicitante.*

**SEGUNDO.** Con fundamento en los argumentos presentados en este Auto, no acceder a la petición de copia electrónica de la base de datos de tutelas de salud del 2008. En su lugar, a través de Secretaría General, (i) remitir copia de la solicitud presentada por Camila Ginealla Malca a la Presidencia de esta Corporación para que allí sea atendida e (ii) informar de lo aquí resuelto al peticionario.

**TERCERO.** Prevenir al solicitante que la información que se le suministre debe ser consultada y utilizada con especial cuidado, por cuanto la ejecución y el cumplimiento de la sentencia T-760 de 2008 se encuentra en una etapa preliminar, consistente en la gestión, seguimiento y corrección de todos los informes para garantizar el goce efectivo del derecho a la salud.”

Atentamente,

  
**MARTHA VICTORIA SÁCHICA DE MONCALEANO**  
Secretaria General

**MVSM/asf/jtq**

REPÚBLICA DE COLOMBIA



CORTE CONSTITUCIONAL  
SECRETARIA GENERAL

Bogotá, D.C., catorce (14) de junio de dos mil once (2011).

Oficio 385/2011

Señora

**CAMILA GIANELLA MALCA**

Camila.gianella@cmi.no

Bergen - Noruega

**REFERENCIA: SENTENCIA T-760/2008. EXPEDIENTE T-1.281.247  
ACCIÓN DE TUTELA INSTAURADA POR LUZ MARY OSORIO PALACIO  
CONTRA SALUD COLPATRIA Y OTROS.**

Respetada señora:

En cumplimiento de lo dispuesto por el magistrado doctor **JORGE IVÁN PALACIO PALACIO**, en auto de fecha junio 10 del presente año, procedo remitirle copia del auto para su conocimiento.

Para lo pertinente, le agradecemos autorizar a una persona en Colombia para hacerle entrega de las copias solicitadas, ya que algunos de los documentos no están en medio magnético.

Atentamente,

**MARTHA VICTORIA SÁCHICA DE MONCALEANO**

Secretaria General

Anexo copia del auto en 1 folio.

MVSM/mbv/jtq



## CORTE CONSTITUCIONAL

### AUTO

Referencia: expediente T-760 de 2008

Solicitud de copias de Camila Gianella Malca, recibida el 9 de junio de 2011, Bergen.

Magistrado Ponente:  
**JORGE IVÁN PALACIO PALACIO**

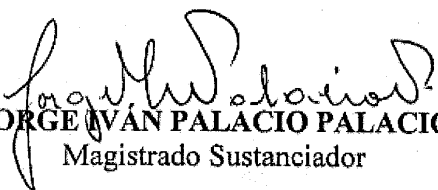
Bogotá, D.C., diez (10) de junio de dos mil once (2011).

El Magistrado Sustanciador considerando que mediante escrito recibido el 9 de junio del presente año, la señora Camila Gianella Malca solicita copias de los documentos relacionadas en su escrito, se

### RESUELVE:

Expedir las copias requeridas a costa de la interesada, bajo las limitaciones propias de la documentación reservada y su manejo confidencial. Proceda la Secretaría General de esta Corporación a comunicar esta determinación a la peticionaria en el correo electrónico suministrado.

Comuníquese y cúmplase.

  
**JORGE IVÁN PALACIO PALACIO**  
Magistrado Sustanciador

  
**MARTHA VICTORIA SÁCHICA MÉNDEZ**  
Secretaría General



PARTICULAR  
De: SECRETARIA DE SALUD  
R:92302 02/08/2011-09:45  
Folios:0 Anexos:1  
OFICIO  
-RESPUEST

120

Doctora  
CAMILA GIANELLA  
[Camila.gianella@cmi.no](mailto:Camila.gianella@cmi.no)  
Investigadora  
Chr. Michelsen Institute – CMI de Noruega  
Doctorante  
Universidad de Bergen.

Asunto: Información sobre el Sistema de Información Distrital y de Barreras de Acceso – SIDBA de la Secretaría Distrital de Salud. – R.92302 01-07-2011.

Estimada doctora Gianella:

Reciba un cordial saludo. Atentamente en respuesta al Rad. 92302 01-07-2011, le adjunto un CD con la información que le relaciono a continuación, solicitada en el marco del desarrollo del Proyecto de Investigación sobre la Judicialización del Derecho a la Salud en Colombia.

Los documentos remitidos son:

1. Matriz Excel: que contiene una Base de Datos sobre casos de barreras de acceso, con datos exportados de las diferentes variables capturadas a través del SIDBA "Sistema de Información Distrital y de Barreras de Acceso a los servicios de salud", correspondientes al año 2010.

OBSERVACIÓN: Por protocolo de seguridad y confidencialidad del manejo de la información, el grupo de investigadores se obliga a hacer uso de la información suministrada, solo para fines exclusivos de la investigación.

2. Criterios de homologación de algunas variables SIDBA: que fueron ajustadas a través del año 2010, para facilitar la consolidación de la información.
3. Manual de Motivos de Orientación e Información y Motivos de Barreras de Acceso.





ALCALDÍA MAYOR  
DE BOGOTÁ D.C.  
SALUD

Secretaría de Salud

4. Manual Técnico SIDBA.
5. Instructivo de Operación del SIDBA.
6. Presentación sobre el Proyecto SIDBA.
7. Informes Estadísticos SIDBA-SQS años 2009 – 2010 -2011.

Cordialmente,

LUZ DARY CARMONA MORENO  
Directora de Participación Social y Servicio al Ciudadano.

Anexo. 1 CD.

Proyectó: Alix Moreno Addie /Revisó: Luzmila Buitrago Jaime.









**Doctoral Theses at The Faculty of Psychology,**  
**University of Bergen**

<b>1980</b>	Allen, H.M., Dr. philos.	Parent-offspring interactions in willow grouse ( <i>Lagopus L. Lagopus</i> ).
<b>1981</b>	Myhrer, T., Dr. philos.	Behavioral Studies after selective disruption of hippocampal inputs in albino rats.
<b>1982</b>	Svebak, S., Dr. philos.	The significance of motivation for task-induced tonic physiological changes.
<b>1983</b>	Myhre, G., Dr. philos.	The Biopsychology of behavior in captive Willow ptarmigan.
	Eide, R., Dr. philos.	PSYCHOSOCIAL FACTORS AND INDICES OF HEALTH RISKS. The relationship of psychosocial conditions to subjective complaints, arterial blood pressure, serum cholesterol, serum triglycerides and urinary catecholamines in middle aged populations in Western Norway.
	Værnes, R.J., Dr. philos.	Neuropsychological effects of diving.
<b>1984</b>	Kolstad, A., Dr. philos.	Til diskusjonen om sammenhengen mellom sosiale forhold og psykiske strukturer. En epidemiologisk undersøkelse blant barn og unge.
	Løberg, T., Dr. philos.	Neuropsychological assessment in alcohol dependence.
<b>1985</b>	Hellesnes, T., Dr. philos.	Læring og problemløsning. En studie av den perseptuelle analysens betydning for verbal læring.
	Håland, W., Dr. philos.	Psykoterapi: relasjon, utviklingsprosess og effekt.
<b>1986</b>	Hagtvet, K.A., Dr. philos.	The construct of test anxiety: Conceptual and methodological issues.
	Jellestad, F.K., Dr. philos.	Effects of neuron specific amygdala lesions on fear-motivated behavior in rats.
<b>1987</b>	Aarø, L.E., Dr. philos.	Health behaviour and socioeconomic Status. A survey among the adult population in Norway.
	Underlid, K., Dr. philos.	Arbeidsløse i psykososialt perspektiv.
	Laberg, J.C., Dr. philos.	Expectancy and classical conditioning in alcoholics' craving.
	Vollmer, F.C., Dr. philos.	Essays on explanation in psychology.
	Ellertsen, B., Dr. philos.	Migraine and tension headache: Psychophysiology, personality and therapy.
<b>1988</b>	Kaufmann, A., Dr. philos.	Antisocial atferd hos ungdom. En studie av psykologiske determinanter.

	Mykletun, R.J., Dr. philos.	Teacher stress: personality, work-load and health.
	Havik, O.E., Dr. philos.	After the myocardial infarction: A medical and psychological study with special emphasis on perceived illness.
<b>1989</b>	Bråten, S., Dr. philos.	Menneskedyaden. En teoretisk tese om sinnets dialogiske natur med informasjons- og utviklingspsykologiske implikasjoner sammenholdt med utvalgte spedbarnsstudier.
	Wold, B., Dr. psychol.	Lifestyles and physical activity. A theoretical and empirical analysis of socialization among children and adolescents.
<b>1990</b>	Flaten, M.A., Dr. psychol.	The role of habituation and learning in reflex modification.
<b>1991</b>	Alsaker, F.D., Dr. philos.	Global negative self-evaluations in early adolescence.
	Kraft, P., Dr. philos.	AIDS prevention in Norway. Empirical studies on diffusion of knowledge, public opinion, and sexual behaviour.
	Endresen, I.M., Dr. philos.	Psychoimmunological stress markers in working life.
	Faleide, A.O., Dr. philos.	Asthma and allergy in childhood. Psychosocial and psychotherapeutic problems.
<b>1992</b>	Dalen, K., Dr. philos.	Hemispheric asymmetry and the Dual-Task Paradigm: An experimental approach.
	Bø, I.B., Dr. philos.	Ungdoms sosiale økologi. En undersøkelse av 14-16 åringers sosiale nettverk.
	Nivison, M.E., Dr. philos.	The relationship between noise as an experimental and environmental stressor, physiological changes and psychological factors.
	Torgersen, A.M., Dr. philos.	Genetic and environmental influence on temperamental behaviour. A longitudinal study of twins from infancy to adolescence.
<b>1993</b>	Larsen, S., Dr. philos.	Cultural background and problem drinking.
	Nordhus, I.H., Dr. philos.	Family caregiving. A community psychological study with special emphasis on clinical interventions.
	Thuen, F., Dr. psychol.	Accident-related behaviour among children and young adolescents: Prediction and prevention.
	Solheim, R., Dr. philos.	Spesifikke lærevansker. Diskrepanskriteriet anvendt i seleksjonsmetodikk.
	Johnsen, B.H., Dr. psychol.	Brain asymmetry and facial emotional expressions: Conditioning experiments.
<b>1994</b>	Tønnessen, F.E., Dr. philos.	The etiology of Dyslexia.
	Kvale, G., Dr. psychol.	Psychological factors in anticipatory nausea and vomiting in cancer chemotherapy.

	Asbjørnsen, A.E., Dr. psychol.	Structural and dynamic factors in dichotic listening: An interactional model.
	Bru, E., Dr. philos.	The role of psychological factors in neck, shoulder and low back pain among female hospitale staff.
	Braathen, E.T., Dr. psychol.	Prediction of exellence and discontinuation in different types of sport: The significance of motivation and EMG.
	Johannessen, B.F., Dr. philos.	Det flytende kjønnnet. Om lederskap, politikk og identitet.
<b>1995</b>	Sam, D.L., Dr. psychol.	Acculturation of young immigrants in Norway: A psychological and socio-cultural adaptation.
	Bjaalid, I.-K., Dr. philos	Component processes in word recognition.
	Martinsen, Ø., Dr. philos.	Cognitive style and insight.
	Nordby, H., Dr. philos.	Processing of auditory deviant events: Mismatch negativity of event-related brain potentials.
	Raaheim, A., Dr. philos.	Health perception and health behaviour, theoretical considerations, empirical studies, and practical implications.
	Seltzer, W.J., Dr.philos.	Studies of Psychocultural Approach to Families in Therapy.
	Brun, W., Dr.philos.	Subjective conceptions of uncertainty and risk.
	Aas, H.N., Dr. psychol.	Alcohol expectancies and socialization: Adolescents learning to drink.
	Bjørkly, S., Dr. psychol.	Diagnosis and prediction of intra-institutional aggressive behaviour in psychotic patients
<b>1996</b>	Anderssen, N., Dr. psychol.	Physical activity of young people in a health perspective: Stability, change and social influences.
	Sandal, Gro Mjeldheim, Dr. psychol.	Coping in extreme environments: The role of personality.
	Strumse, Einar, Dr. philos.	The psychology of aesthetics: explaining visual preferences for agrarian landscapes in Western Norway.
	Hestad, Knut, Dr. philos.	Neuropsychological deficits in HIV-1 infection.
	Lugoe, L.Wycliffe, Dr. philos.	Prediction of Tanzanian students' HIV risk and preventive behaviours
	Sandvik, B. Gunnhild, Dr. philos.	Fra distriktsjordmor til institusjonsjordmor. Fremveksten av en profesjon og en profesjonsutdanning
	Lie, Gro Therese, Dr. psychol.	The disease that dares not speak its name: Studies on factors of importance for coping with HIV/AIDS in Northern Tanzania
	Øygaard, Lisbet, Dr. philos.	Health behaviors among young adults. A psychological and sociological approach
	Stormark, Kjell Morten, Dr. psychol.	Emotional modulation of selective attention: Experimental and clinical evidence.

- Einarsen, Ståle, Dr. psychol. Bullying and harassment at work: epidemiological and psychosocial aspects.
- 1997**
- Knivsberg, Ann-Mari, Dr. philos. Behavioural abnormalities and childhood psychopathology: Urinary peptide patterns as a potential tool in diagnosis and remediation.
- Eide, Arne H., Dr. philos. Adolescent drug use in Zimbabwe. Cultural orientation in a global-local perspective and use of psychoactive substances among secondary school students.
- Sørensen, Marit, Dr. philos. The psychology of initiating and maintaining exercise and diet behaviour.
- Skjæveland, Oddvar, Dr. psychol. Relationships between spatial-physical neighborhood attributes and social relations among neighbors.
- Zewdie, Teka, Dr. philos. Mother-child relational patterns in Ethiopia. Issues of developmental theories and intervention programs.
- Wilhelmsen, Britt Unni, Dr. philos. Development and evaluation of two educational programmes designed to prevent alcohol use among adolescents.
- Manger, Terje, Dr. philos. Gender differences in mathematical achievement among Norwegian elementary school students.
- 1998**
- V Lindstrøm, Torill Christine, Dr. philos. «Good Grief»: Adapting to Bereavement.
- Skogstad, Anders, Dr. philos. Effects of leadership behaviour on job satisfaction, health and efficiency.
- Haldorsen, Ellen M. Håland, Dr. psychol. Return to work in low back pain patients.
- Besemer, Susan P., Dr. philos. Creative Product Analysis: The Search for a Valid Model for Understanding Creativity in Products.
- H Winje, Dagfinn, Dr. psychol. Psychological adjustment after severe trauma. A longitudinal study of adults' and children's posttraumatic reactions and coping after the bus accident in Måbødalen, Norway 1988.
- Vosburg, Suzanne K., Dr. philos. The effects of mood on creative problem solving.
- Eriksen, Hege R., Dr. philos. Stress and coping: Does it really matter for subjective health complaints?
- Jakobsen, Reidar, Dr. psychol. Empiriske studier av kunnskap og holdninger om hiv/aids og den normative seksuelle utvikling i ungdomsårene.
- 1999**
- V Mikkelsen, Aslaug, Dr. philos. Effects of learning opportunities and learning climate on occupational health.
- Samdal, Oddrun, Dr. philos. The school environment as a risk or resource for students' health-related behaviours and subjective well-being.
- Friestad, Christine, Dr. philos. Social psychological approaches to smoking.

	Ekeland, Tor-Johan, Dr. philos.	Meining som medisin. Ein analyse av placebofenomenet og implikasjoner for terapi og terapeutiske teoriar.
H	Saban, Sara, Dr. psychol.	Brain Asymmetry and Attention: Classical Conditioning Experiments.
	Carlsten, Carl Thomas, Dr. philos.	God lesing – God læring. En aksjonsrettet studie av undervisning i fagtekstlesing.
	Dundas, Ingrid, Dr. psychol.	Functional and dysfunctional closeness. Family interaction and children's adjustment.
	Engen, Liv, Dr. philos.	Kartlegging av leseferdighet på småskoletrinnet og vurdering av faktorer som kan være av betydning for optimal leseutvikling.
<b>2000</b>		
V	Hovland, Ole Johan, Dr. philos.	Transforming a self-preserving "alarm" reaction into a self-defeating emotional response: Toward an integrative approach to anxiety as a human phenomenon.
	Lillejord, Sølvi, Dr. philos.	Handlingsrasjonalitet og spesialundervisning. En analyse av aktørperspektiver.
	Sandell, Ove, Dr. philos.	Den varme kunnskapen.
	Oftedal, Marit Petersen, Dr. philos.	Diagnostisering av ordavkodingsvansker: En prosessanalytisk tilnæringsmåte.
H	Sandbak, Tone, Dr. psychol.	Alcohol consumption and preference in the rat: The significance of individual differences and relationships to stress pathology
	Eid, Jarle, Dr. psychol.	Early predictors of PTSD symptom reporting; The significance of contextual and individual factors.
<b>2001</b>		
V	Skinstad, Anne Helene, Dr. philos.	Substance dependence and borderline personality disorders.
	Binder, Per-Einar, Dr. psychol.	Individet og den meningsbærende andre. En teoretisk undersøkelse av de mellommenneskelige forutsetningene for psykisk liv og utvikling med utgangspunkt i Donald Winnicotts teori.
	Roald, Ingvild K., Dr. philos.	Building of concepts. A study of Physics concepts of Norwegian deaf students.
H	Fekadu, Zelalem W., Dr. philos.	Predicting contraceptive use and intention among a sample of adolescent girls. An application of the theory of planned behaviour in Ethiopian context.
	Melesse, Fantu, Dr. philos.	The more intelligent and sensitive child (MISC) mediational intervention in an Ethiopian context: An evaluation study.
	Råheim, Målfrid, Dr. philos.	Kvinnerens kroppserfaring og livssammenheng. En fenomenologisk – hermeneutisk studie av friske kvinner og kvinner med kroniske muskelsmerter.
	Engelsen, Birthe Kari, Dr. psychol.	Measurement of the eating problem construct.

	Lau, Bjørn, Dr. philos.	Weight and eating concerns in adolescence.
<b>2002</b>		
V	Ihlebak, Camilla, Dr. philos.	Epidemiological studies of subjective health complaints.
	Rosén, Gunnar O. R., Dr. philos.	The phantom limb experience. Models for understanding and treatment of pain with hypnosis.
	Høines, Marit Johnsen, Dr. philos.	Fleksible språkrom. Matematikk læring som tekstutvikling.
	Anthun, Roald Andor, Dr. philos.	School psychology service quality. Consumer appraisal, quality dimensions, and collaborative improvement potential
	Pallesen, Ståle, Dr. psychol.	Insomnia in the elderly. Epidemiology, psychological characteristics and treatment.
	Midthassel, Unni Vere, Dr. philos.	Teacher involvement in school development activity. A study of teachers in Norwegian compulsory schools
	Kallestad, Jan Helge, Dr. philos.	Teachers, schools and implementation of the Olweus Bullying Prevention Program.
H	Ofte, Sonja Helgesen, Dr. psychol.	Right-left discrimination in adults and children.
	Netland, Marit, Dr. psychol.	Exposure to political violence. The need to estimate our estimations.
	Diseth, Åge, Dr. psychol.	Approaches to learning: Validity and prediction of academic performance.
	Bjuland, Raymond, Dr. philos.	Problem solving in geometry. Reasoning processes of student teachers working in small groups: A dialogical approach.
<b>2003</b>		
V	Arefjord, Kjersti, Dr. psychol.	After the myocardial infarction – the wives' view. Short- and long-term adjustment in wives of myocardial infarction patients.
	Ingjaldsson, Jón Þorvaldur, Dr. psychol.	Unconscious Processes and Vagal Activity in Alcohol Dependency.
	Holden, Børge, Dr. philos.	Følger av atferdsanalytiske forklaringer for atferdsanalysens tilnærming til utforming av behandling.
	Holsen, Ingrid, Dr. philos.	Depressed mood from adolescence to 'emerging adulthood'. Course and longitudinal influences of body image and parent-adolescent relationship.
	Hammar, Åsa Karin, Dr. psychol.	Major depression and cognitive dysfunction- An experimental study of the cognitive effort hypothesis.
	Sprugevica, Ieva, Dr. philos.	The impact of enabling skills on early reading acquisition.
	Gabrielsen, Egil, Dr. philos.	LESE FOR LIVET. Lesekompetansen i den norske voksenbefolkningen sett i lys av visjonen om en enhetsskole.
H	Hansen, Anita Lill, Dr. psychol.	The influence of heart rate variability in the regulation of attentional and memory processes.



	Dyregrov, Kari, Dr. philos.	The loss of child by suicide, SIDS, and accidents: Consequences, needs and provisions of help.
<b>2004</b>		
V	Torsheim, Torbjørn, Dr. psychol.	Student role strain and subjective health complaints: Individual, contextual, and longitudinal perspectives.
	Haugland, Bente Storm Mowatt Dr. psychol.	Parental alcohol abuse. Family functioning and child adjustment.
	Milde, Anne Marita, Dr. psychol.	Ulcerative colitis and the role of stress. Animal studies of psychobiological factors in relationship to experimentally induced colitis.
	Stornes, Tor, Dr. philos.	Socio-moral behaviour in sport. An investigation of perceptions of sportspersonship in handball related to important factors of socio-moral influence.
	Mæhle, Magne, Dr. philos.	Re-inventing the child in family therapy: An investigation of the relevance and applicability of theory and research in child development for family therapy involving children.
	Kobbeltvedt, Therese, Dr. psychol.	Risk and feelings: A field approach.
<b>2004</b>	Thomsen, Tormod, Dr. psychol.	Localization of attention in the brain.
H	Løberg, Else-Marie, Dr. psychol.	Functional laterality and attention modulation in schizophrenia: Effects of clinical variables.
	Kyrkjebø, Jane Mikkelsen, Dr. philos.	Learning to improve: Integrating continuous quality improvement learning into nursing education.
	Laumann, Karin, Dr. psychol.	Restorative and stress-reducing effects of natural environments: Experiential, behavioural and cardiovascular indices.
	Holgersen, Helge, PhD	Mellom oss - Essay i relasjonell psykoanalyse.
<b>2005</b>		
V	Hetland, Hilde, Dr. psychol.	Leading to the extraordinary? Antecedents and outcomes of transformational leadership.
	Iversen, Anette Christine, Dr. philos.	Social differences in health behaviour: the motivational role of perceived control and coping.
<b>2005</b>	Mathisen, Gro Ellen, PhD	Climates for creativity and innovation: Definitions, measurement, predictors and consequences.
H	Sævi, Tone, Dr. philos.	Seeing disability pedagogically – The lived experience of disability in the pedagogical encounter.
	Wium, Nora, PhD	Intrapersonal factors, family and school norms: combined and interactive influence on adolescent smoking behaviour.
	Kanagaratnam, Pushpa, PhD	Subjective and objective correlates of Posttraumatic Stress in immigrants/refugees exposed to political violence.

	Larsen, Torill M. B. , PhD	Evaluating principals` and teachers` implementation of Second Step. A case study of four Norwegian primary schools.
	Bancila, Delia, PhD	Psychosocial stress and distress among Romanian adolescents and adults.
<b>2006</b>		
V	Hillestad, Torgeir Martin, Dr. philos.	Normalitet og avvik. Forutsetninger for et objektivt psykopatologisk avviksbegrep. En psykologisk, sosial, erkjennelsesteoretisk og teoriehistorisk framstilling.
	Nordanger, Dag Øystein, Dr. psychol.	Psychosocial discourses and responses to political violence in post-war Tigray, Ethiopia.
	Rimol, Lars Morten, PhD	Behavioral and fMRI studies of auditory laterality and speech sound processing.
	Krumsvik, Rune Johan, Dr. philos.	ICT in the school. ICT-initiated school development in lower secondary school.
	Norman, Elisabeth, Dr. psychol.	Gut feelings and unconscious thought: An exploration of fringe consciousness in implicit cognition.
	Israel, K Pravin, Dr. psychol.	Parent involvement in the mental health care of children and adolescents. Emperical studies from clinical care setting.
	Glasø, Lars, PhD	Affects and emotional regulation in leader-subordinate relationships.
	Knutsen, Ketil, Dr. philos.	HISTORIER UNGDOM LEVER – En studie av hvordan ungdommer bruker historie for å gjøre livet meningsfullt.
	Matthiesen, Stig Berge, PhD	Bullying at work. Antecedents and outcomes.
<b>2006</b>		
H	Gramstad, Arne, PhD	Neuropsychological assessment of cognitive and emotional functioning in patients with epilepsy.
	Bendixen, Mons, PhD	Antisocial behaviour in early adolescence: Methodological and substantive issues.
	Mrumbi, Khalifa Maulid, PhD	Parental illness and loss to HIV/AIDS as experienced by AIDS orphans aged between 12-17 years from Temeke District, Dar es Salaam, Tanzania: A study of the children's psychosocial health and coping responses.
	Hetland, Jørn, Dr. psychol.	The nature of subjective health complaints in adolescence: Dimensionality, stability, and psychosocial predictors
	Kakoko, Deodatus Conatus Vitalis, PhD	Voluntary HIV counselling and testing service uptake among primary school teachers in Mwanza, Tanzania: assessment of socio-demographic, psychosocial and socio-cognitive aspects
	Mykletun, Arnstein, Dr. psychol.	Mortality and work-related disability as long-term consequences of anxiety and depression: Historical cohort designs based on the HUNT-2 study
	Sivertsen, Børge, PhD	Insomnia in older adults. Consequences, assessment and treatment.

**2007**

V

- Singhammer, John, Dr. philos. Social conditions from before birth to early adulthood – the influence on health and health behaviour
- Janvin, Carmen Ani Cristea, PhD Cognitive impairment in patients with Parkinson's disease: profiles and implications for prognosis
- Braarud, Hanne Cecilie, Dr.psychol. Infant regulation of distress: A longitudinal study of transactions between mothers and infants
- Tveito, Torill Helene, PhD Sick Leave and Subjective Health Complaints
- Magnussen, Liv Heide, PhD Returning disability pensioners with back pain to work
- Thuen, Elin Marie, Dr.philos. Learning environment, students' coping styles and emotional and behavioural problems. A study of Norwegian secondary school students.
- Solberg, Ole Asbjørn, PhD Peacekeeping warriors – A longitudinal study of Norwegian peacekeepers in Kosovo

**2007**

H

- Søreide, Gunn Elisabeth, Dr.philos. Narrative construction of teacher identity
- Svensen, Erling, PhD WORK & HEALTH. Cognitive Activation Theory of Stress applied in an organisational setting.
- Øverland, Simon Nygaard, PhD Mental health and impairment in disability benefits. Studies applying linkages between health surveys and administrative registries.
- Eichele, Tom, PhD Electrophysiological and Hemodynamic Correlates of Expectancy in Target Processing
- Børhaug, Kjetil, Dr.philos. Oppseding til demokrati. Ein studie av politisk oppseding i norsk skule.
- Eikeland, Thorleif, Dr.philos. Om å vokse opp på barnehjem og på sykehus. En undersøkelse av barnehjemsbarns opplevelser på barnehjem sammenholdt med sanatoriebarns beskrivelse av langvarige sykehusopphold – og et forsøk på forklaring.
- Wadel, Carl Cato, Dr.philos. Medarbeidersamhandling og medarbeiderledelse i en lagbasert organisasjon
- Vinje, Hege Forbech, PhD Thriving despite adversity: Job engagement and self-care among community nurses
- Noort, Maurits van den, PhD Working memory capacity and foreign language acquisition

**2008**

V

- Breivik, Kyrre, Dr.psychol. The Adjustment of Children and Adolescents in Different Post-Divorce Family Structures. A Norwegian Study of Risks and Mechanisms.
- Johnsen, Grethe E., PhD Memory impairment in patients with posttraumatic stress disorder
- Sætrevik, Bjørn, PhD Cognitive Control in Auditory Processing

	Carvalhosa, Susana Fonseca, PhD	Prevention of bullying in schools: an ecological model
<b>2008</b>		
<b>H</b>	Brønneck, Kolbjørn Selvåg	Attentional dysfunction in dementia associated with Parkinson's disease.
	Posserud, Maj-Britt Rocio	Epidemiology of autism spectrum disorders
	Haug, Ellen	Multilevel correlates of physical activity in the school setting
	Skjerve, Arvid	Assessing mild dementia – a study of brief cognitive tests.
	Kjønniksen, Lise	The association between adolescent experiences in physical activity and leisure time physical activity in adulthood: a ten year longitudinal study
	Gundersen, Hilde	The effects of alcohol and expectancy on brain function
	Omvik, Siri	Insomnia – a night and day problem
<b>2009</b>		
<b>V</b>	Molde, Helge	Pathological gambling: prevalence, mechanisms and treatment outcome.
	Foss, Else	Den omsorgsfulle væremåte. En studie av voksnes væremåte i forhold til barn i barnehagen.
	Westrheim, Kariane	Education in a Political Context: A study of Knowledge Processes and Learning Sites in the PKK.
	Wehling, Eike	Cognitive and olfactory changes in aging
	Wangberg, Silje C.	Internet based interventions to support health behaviours: The role of self-efficacy.
	Nielsen, Morten B.	Methodological issues in research on workplace bullying. Operationalisations, measurements and samples.
	Sandu, Anca Larisa	MRI measures of brain volume and cortical complexity in clinical groups and during development.
	Guribye, Eugene	Refugees and mental health interventions
	Sørensen, Lin	Emotional problems in inattentive children – effects on cognitive control functions.
	Tjomsland, Hege E.	Health promotion with teachers. Evaluation of the Norwegian Network of Health Promoting Schools: Quantitative and qualitative analyses of predisposing, reinforcing and enabling conditions related to teacher participation and program sustainability.
	Helleve, Ingrid	Productive interactions in ICT supported communities of learners
<b>2009</b>		
<b>H</b>	Skorpen, Aina Øye, Christine	Dagliglivet i en psykiatrisk institusjon: En analyse av miljøterapeutiske praksiser
	Andreassen, Cecilie Schou	WORKAHOLISM – Antecedents and Outcomes

	Stang, Ingun	Being in the same boat: An empowerment intervention in breast cancer self-help groups
	Sequeira, Sarah Dorothee Dos Santos	The effects of background noise on asymmetrical speech perception
	Kleiven, Jo, dr.philos.	The Lillehammer scales: Measuring common motives for vacation and leisure behavior
	Jónsdóttir, Guðrún	Dubito ergo sum? Ni jenter møter naturfaglig kunnskap.
	Hove, Oddbjørn	Mental health disorders in adults with intellectual disabilities - Methods of assessment and prevalence of mental health disorders and problem behaviour
	Wageningen, Heidi Karin van	The role of glutamate on brain function
	Bjørkvik, Jofrid	God nok? Selvaktelse og interpersonlig fungering hos pasienter innen psykisk helsevern: Forholdet til diagnoser, symptomer og behandlingsutbytte
	Andersson, Martin	A study of attention control in children and elderly using a forced-attention dichotic listening paradigm
	Almås, Aslaug Grov	Teachers in the Digital Network Society: Visions and Realities. A study of teachers' experiences with the use of ICT in teaching and learning.
	Ulvik, Marit	Lærerutdanning som danning? Tre stemmer i diskusjonen
<b>2010</b>		
<b>V</b>	Skår, Randi	Læringsprosesser i sykepleieres profesjonsutøvelse. En studie av sykepleieres læringserfaringer.
	Roald, Knut	Kvalitetsvurdering som organisasjonslæring mellom skole og skoleeigar
	Lunde, Linn-Heidi	Chronic pain in older adults. Consequences, assessment and treatment.
	Danielsen, Anne Grete	Perceived psychosocial support, students' self-reported academic initiative and perceived life satisfaction
	Hysing, Mari	Mental health in children with chronic illness
	Olsen, Olav Kjellevoid	Are good leaders moral leaders? The relationship between effective military operational leadership and morals
	Riese, Hanne	Friendship and learning. Entrepreneurship education through mini-enterprises.
	Holthe, Asle	Evaluating the implementation of the Norwegian guidelines for healthy school meals: A case study involving three secondary schools
<b>H</b>	Hauge, Lars Johan	Environmental antecedents of workplace bullying: A multi-design approach
	Bjørkelo, Brita	Whistleblowing at work: Antecedents and consequences

Reme, Silje Endresen	Common Complaints – Common Cure? Psychiatric comorbidity and predictors of treatment outcome in low back pain and irritable bowel syndrome
Helland, Wenche Andersen	Communication difficulties in children identified with psychiatric problems
Beneventi, Harald	Neuronal correlates of working memory in dyslexia
Thygesen, Elin	Subjective health and coping in care-dependent old persons living at home
Aanes, Mette Marthinussen	Poor social relationships as a threat to belongingness needs. Interpersonal stress and subjective health complaints: Mediating and moderating factors.
Anker, Morten Gustav	Client directed outcome informed couple therapy
Bull, Torill	Combining employment and child care: The subjective well-being of single women in Scandinavia and in Southern Europe
Viig, Nina Grieg	Tilrettelegging for læreres deltakelse i helsefremmende arbeid. En kvalitativ og kvantitativ analyse av sammenhengen mellom organisatoriske forhold og læreres deltakelse i utvikling og implementering av Europeisk Nettverk av Helsefremmende Skoler i Norge
Wolff, Katharina	To know or not to know? Attitudes towards receiving genetic information among patients and the general public.
Ogden, Terje, dr.philos.	Familiebasert behandling av alvorlige atferdsproblemer blant barn og ungdom. Evaluering og implementering av evidensbaserte behandlingsprogrammer i Norge.
Solberg, Mona Elin	Self-reported bullying and victimisation at school: Prevalence, overlap and psychosocial adjustment.
<b>2011</b>	
<b>V</b>	
Bye, Hege Høivik	Self-presentation in job interviews. Individual and cultural differences in applicant self-presentation during job interviews and hiring managers' evaluation
Notelaers, Guy	Workplace bullying. A risk control perspective.
Moltu, Christian	Being a therapist in difficult therapeutic impasses. A hermeneutic phenomenological analysis of skilled psychotherapists' experiences, needs, and strategies in difficult therapies ending well.
Myrseth, Helga	Pathological Gambling - Treatment and Personality Factors
Schanche, Elisabeth	From self-criticism to self-compassion. An empirical investigation of hypothesized change processes in the Affect Phobia Treatment Model of short-term dynamic psychotherapy for patients with Cluster C personality disorders.
Våpenstad, Eystein Victor, dr.philos.	Det tempererte nærvær. En teoretisk undersøkelse av psykoterautens subjektivitet i psykoanalyse og psykoanalytisk psykotterapi.

	Haukebø, Kristin	Cognitive, behavioral and neural correlates of dental and intra-oral injection phobia. Results from one treatment and one fMRI study of randomized, controlled design.
	Harris, Anette	Adaptation and health in extreme and isolated environments. From 78°N to 75°S.
	Bjørknes, Ragnhild	Parent Management Training-Oregon Model: intervention effects on maternal practice and child behavior in ethnic minority families
	Mamen, Asgeir	Aspects of using physical training in patients with substance dependence and additional mental distress
	Espevik, Roar	Expert teams: Do shared mental models of team members make a difference
	Haara, Frode Olav	Unveiling teachers' reasons for choosing practical activities in mathematics teaching
<b>2011</b>		
<b>H</b>	Hauge, Hans Abraham	How can employee empowerment be made conducive to both employee health and organisation performance? An empirical investigation of a tailor-made approach to organisation learning in a municipal public service organisation.
	Melkevik, Ole Rogstad	Screen-based sedentary behaviours: pastimes for the poor, inactive and overweight? A cross-national survey of children and adolescents in 39 countries.
	Vøllestad, Jon	Mindfulness-based treatment for anxiety disorders. A quantitative review of the evidence, results from a randomized controlled trial, and a qualitative exploration of patient experiences.
	Tolo, Astrid	Hvordan blir lærerkompetanse konstruert? En kvalitativ studie av PPU-studenters kunnskapsutvikling.
	Saus, Evelyn-Rose	Training effectiveness: Situation awareness training in simulators
	Nordgreen, Tine	Internet-based self-help for social anxiety disorder and panic disorder. Factors associated with effect and use of self-help.
	Munkvold, Linda Helen	Oppositional Defiant Disorder: Informant discrepancies, gender differences, co-occurring mental health problems and neurocognitive function.
	Christiansen, Øivin	Når barn plasseres utenfor hjemmet: beslutninger, forløp og relasjoner. Under barnevernets (ved)tak.
	Brunborg, Geir Scott	Conditionability and Reinforcement Sensitivity in Gambling Behaviour
	Hystad, Sigurd William	Measuring Psychological Resiliency: Validation of an Adapted Norwegian Hardiness Scale
<b>2012</b>		
<b>V</b>	Roness, Dag	Hvorfor bli lærer? Motivasjon for utdanning og utøving.
	Fjermestad, Krister Westlye	The therapeutic alliance in cognitive behavioural therapy for youth anxiety disorders

	Jenssen, Eirik Sørnes	Tilpasset opplæring i norsk skole: politikeres, skolelederes og læreres handlingsvalg
	Saksvik-Lehouillier, Ingvild	Shift work tolerance and adaptation to shift work among offshore workers and nurses
	Johansen, Venke Frederike	Når det intime blir offentlig. Om kvinners åpenhet om brystkreft og om markedsføring av brystkreftsaken.
	Herheim, Rune	Pupils collaborating in pairs at a computer in mathematics learning: investigating verbal communication patterns and qualities
	Vie, Tina Løkke	Cognitive appraisal, emotions and subjective health complaints among victims of workplace bullying: A stress-theoretical approach
	Jones, Lise Øen	Effects of reading skills, spelling skills and accompanying efficacy beliefs on participation in education. A study in Norwegian prisons.
<b>2012</b>		
<b>H</b>	Danielsen, Yngvild Sørebo	Childhood obesity – characteristics and treatment. Psychological perspectives.
	Horverak, Jøri Gytre	Sense or sensibility in hiring processes. Interviewee and interviewer characteristics as antecedents of immigrant applicants' employment probabilities. An experimental approach.
	Jøsendal, Ola	Development and evaluation of BE smokeFREE, a school-based smoking prevention program
	Osnes, Berge	Temporal and Posterior Frontal Involvement in Auditory Speech Perception
	Drageset, Sigrunn	Psychological distress, coping and social support in the diagnostic and preoperative phase of breast cancer
	Aasland, Merethe Schanke	Destructive leadership: Conceptualization, measurement, prevalence and outcomes
	Bakibinga, Pauline	The experience of job engagement and self-care among Ugandan nurses and midwives
	Skogen, Jens Christoffer	Foetal and early origins of old age health. Linkage between birth records and the old age cohort of the Hordaland Health Study (HUSK)
	Leveresen, Ingrid	Adolescents' leisure activity participation and their life satisfaction: The role of demographic characteristics and psychological processes
	Hanss, Daniel	Explaining sustainable consumption: Findings from cross-sectional and intervention approaches
	Rød, Per Arne	Barn i klem mellom foreldrekonflikter og samfunnsmessig beskyttelse
<b>2013</b>		
<b>V</b>	Mentzoni, Rune Aune	Structural Characteristics in Gambling



Knudsen, Ann Kristin	Long-term sickness absence and disability pension award as consequences of common mental disorders. Epidemiological studies using a population-based health survey and official ill health benefit registries.
Strand, Mari	Emotional information processing in recurrent MDD
Veseth, Marius	Recovery in bipolar disorder. A reflexive-collaborative exploration of the lived experiences of healing and growth when battling a severe mental illness
Mæland, Silje	Sick leave for patients with severe subjective health complaints. Challenges in general practice.
Mjaaland, Thera	At the frontiers of change? Women and girls' pursuit of education in north-western Tigray, Ethiopia
Odéen, Magnus	Coping at work. The role of knowledge and coping expectancies in health and sick leave.
Hynninen, Kia Minna Johanna	Anxiety, depression and sleep disturbance in chronic obstructive pulmonary disease (COPD). Associations, prevalence and effect of psychological treatment.
Flo, Elisabeth	Sleep and health in shift working nurses
Aasen, Elin Margrethe	From paternalism to patient participation? The older patients undergoing hemodialysis, their next of kin and the nurses: a discursive perspective on perception of patient participation in dialysis units
Ekornås, Belinda	Emotional and Behavioural Problems in Children: Self-perception, peer relationships, and motor abilities
Corbin, J. Hope	North-South Partnerships for Health: Key Factors for Partnership Success from the Perspective of the KIWAKKUKI
Birkeland, Marianne Skogbrott	Development of global self-esteem: The transition from adolescence to adulthood

