JUDICIALIZATION OF HEALTH CARE IN COLOMBIA?

Insights of the role of Courts in the Political Dynamics of Social Provisioning

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List of Acronyms

CESCR	Committee on Economic, Social and Cultural Rights
ESCR	Economic, Social and Cultural Rights
EPS	Health Promoting Enterprise
FOSYGA	Solidarity and Guarantee Fund
HRBA	Human Rights Based Approach
ICESCR	International Covenant for Economic, Social and Cultural Rights
IPS	Health Service Provider
MCO	Managed Care Organization
MDGs	Millennium Development Goals
NPM	New Public Management
PND	National Development Plan
POS	Compulsory Benefit Package
POS-c	Compulsory Benefit Package for the contributory regime
POS-s	Compulsory Benefit Package for the subsidized regime
SGSSS	General System of Social Security in Health
SISBEN	Identification System for Potential Beneficiaries of Social Programs
TUTELA	Writ of Protection of Fundamental Rights
UCP	Unit of Capitation Payment
WB	World Bank
WDR	World Development Report

Abstract

The judicialization of social demands is a phenomenon that increasingly is becoming the pathway to access social goods such as health and education. With the incorporation of comprehensive bills of rights into states' constitutions, judges and courts in both the global North and South have become key actors in the distribution of resources through the protection of human rights. Judicial intervention as a distributive mechanism of social goods and its potential to bring social integration and challenge commoditized forms of social provisioning is a subject that still being studied today. This paper seeks to explore how the intervention of courts and judges are changing the political dynamics in social policy articulation in light of the political nature of social policy and its power to influence not only access to social goods but also social inequality and citizenship. The case of judicial decision T-760 of 2008 issued by the Colombia Constitutional Court to reform Colombia's health care system (Law No.100 of 1993) is used to reflect on the political importance of social policy choices and potential of judicial settings to address distributional conflicts.

Keywords

Social Policy, Inequality, Politicization, Rights, Courts

Chapter 1 Introduction

The neoliberal reforms of the 1990's, influenced by the 1993 World Development Report "Investing in Health", introduced highly liberalizing measures to the health care systems in most countries of Latin America, including Colombia. Currently, debates about the redistributive effects of health care policy inquire how commercialization processes of health care, which were intensified by these reforms, reinforces or breaks down structures of inequality and about its potential to bring social integration, citizenship and better wellbeing. At the same time, countries are facing an increasing demand from the international community and multilateral organizations, such as the United Nations, to strengthen the rule of law and set laws, policies and programs to contribute directly the realization of human rights. Countries have responded to this call, among other measures, with the constitutionalization of rights, the establishment of autonomous judiciaries (e.g. Constitutional Courts) and stronger judicial review procedures, in an attempt to robust their democracies. Within these two international projects, one that privileges the market as a mechanism for distribution and redistribution of social goods and wealth, and another that holds states accountable, as duty-bearers, for the integration human rights principles such as universality, equality, participation and inclusion and the realization of human rights, social policy is being articulated.

Additionally, debates on the potentials of social policy to distribute and redistribute resources and social goods, and its pivotal role in the reduction of poverty and addressing inequality, currently oscillate between two contending proposals. The first one neoliberal-oriented and sponsored by international financial institutions such as the World Bank (WB), which places social policy as a mechanism to correct or deal with failures of macroeconomic policies, hence mainly concerned with the eradication of income poverty and inequality by targeting the poor (Mkandawire 2005: 7). The second one which proposes a more universalistic view of social policy that raises questions regarding the basis of social entitlements and examines the underlying social processes which lead to poverty, vulnerability and inequality to address calls for social inclusion and social cohesion (Mkandawire 2005, Fischer 2012). Governments are then facing the challenges of developing policies and social provisioning systems within the continuum of these two extremes in search for a choice that better serves the poor, vulnerable and marginalized populations.

However, this process is not just a policy choice matter, i.e. a choice of institutional arrangements to distribute or redistribute resources considering the macroeconomic objectives, levels of social expenditure and power dynamics in a society, but rather a more deeply engrained *political* question because such choices will define what citizenship means, the degree of people's inclusion in the distributive or redistributive processes, social status and more directly well-being (Mettler and Soss 2004 in Mkandawire 2005, Fischer 2010). This is a strong reason why social policy choices and institutional arrangements should also be *politically bargained* and decided in participatory and democratic settings, which according to the tradition of representative democracies takes place in the bodies (government and legislative branch) that have been assigned the legitimate power to decide over collective interests.

The already contending political economy dynamics of social policy articulation are currently impacted by the involvement of judges and courts that are bringing into play the recognition of human rights. Parallel to the 1980s-1990s shift towards the neoliberal agenda, states were also experiencing a constitutional transformation in which judicial empowerment and the constitutionalization of human rights (including socio-economic rights) played a key role for the re-legitimation of democracy and the protection of people's basic needs. Today the judicialization of political agendas has come increasingly as a response to the failure of representative democracies and the loss of confidence in the government and the legislative branch to address social claims (Domingo 2004), consequently placing judges as "reputable, impartial, effective decision-making bodies" (Hirschl 2006: 744). Furthermore, the judicial protection of human rights has become one of the main mechanisms if not the principal today to vindicate the rights of and bring social justice to the poor and disadvantaged. However, in light of the political nature of social policy (due to its influence in processes of social integration and citizenship) and its redistributive effects, a debate is arising to question to what extent the intervention of judges and courts through human rights litigation is in reality favouring the poor and excluded populations and in a broader sense, is inquiring if the courts should be deciding these political issues in the first place (Brinks and Forbath 2010-2011, Hirschl 2006).

In this context, it is interesting what has happened with the involvement of Colombia's Constitutional Court (the "Court") in the reform of Colombia's health care system. The Court has stand out as one of the most progressive courts regarding the protection of human rights (Uprimny 2007, Yamin and Parra-Vera 2010). Regarding the protection of the right to health, one of the most invoked rights in Colombia, the failure of the health care system to provide comprehensive services to its beneficiaries left the "judicial recourse as the only escape-valve" (Yamin and Parra-Vera 2010). Such systematic failure has been partially attributed to the marketization of health care and the institutional arrangements of the adopted "managed competition" model of provision that ended up restricting even more the access to the poor while increasing the administrative costs of the system (Vos et al. 2006). This is why in 2008, the year where the number of writs of protection (*accion de tutela* in Spanish) of the right to health was the highest, the Court issued the decision T-760 in which it ordered the government to restructure the health care insurance scheme to address the structural barriers that were impeding or creating unequal access to health care services, in a way that realized people's right to health. Because of decision T-760 of 2008 and other set of decisions of this kind, it has been said this activism is an overstep of the Court's powers in matters seen as fundamentally "political" (Castaño et al. 2008) and claim the Court's decisions are provoking an institutional distortion because they drive the policy-making processes way from political debates where collective needs should be considered and assessed (Sotelo 2000).

How are courts then changing the dynamics of social provisioning in light of the political nature of social policy and its role in bringing social integration and citizenship-based entitlements? Because the distributive effects of judicial decisions in the context of social provisioning are still being explored, and given the reiterative claims that judges are helping bring social justice and social

inclusion for the poor and disadvantaged, it is important to continue to problematize their intervention to understand their potential to bring social transformation. To explore this, Colombia's health care system, the General System of Social Security in Health (SGSSS), put in place by the 1993 health care reform (Law No.100 of 1993) and the judicial decision T-760 of 2008 issued by the Colombia Constitutional Court, will be taken as a case study. In this judicial decision the Court ordered the government to restructure the SGSSS towards a more inclusive and universalized system, in order to effectively realize the right to health. In this ruling, the Court ordered the government, among others, to adopt the following actions: (i) update the Plan of Benefits affiliates of the system are entitled to (including, services, medicines and technologies); (ii) unify the contributory and subsidized regimes, and (iii) the adoption of the necessary measures to prevent rejection or delay in the provision of the service itself. This case will serve as a basis to first discuss whether or not judicial decision T-760 of 2008, using a rights-based approach for the realization of the right to health, helped bring social transformation by changing structures of polarization, segregation and stratification in the social order (considered indications of lower levels of social integration and more commoditized forms of entitlements). In doing so, the potentials of rights-based approaches in judicial settings to set in motion institutional reforms towards more universalistic ways of social provisioning will be examined.

The findings of this research suggest that although the intervention of the Court through its judicial decision T-670 of 2008 helped advance people's right to health and move the health care system towards one more right-oriented, its transformative potential was limited given that it failed to address more profound political questions regarding social inequality and citizenship-base entitlements. In this sense, restricting the cause of unequal access to "regulation failures" the Court did not addressed questions about how the model of health care provisioning reproduced inequality patterns of polarization, segregation and stratification. Furthermore, these limitations seem to be perhaps consequence of the role societies have traditionally given courts in their constitutions and other regulatory frameworks that confine the action of judges to the technical interpretation of the law, precluding them from discussing other issues such as how social policies and social provisioning systems reproduce social inequality and commoditized forms of entitlements, which are more political in nature. Although the findings of this research cannot be generalized, they give insights to broaden the debate about courts intervention in distributive conflicts.

To explore the above, a mix method approach is used. From a historical institutionalist perspective, the research will review the factors that shaped the 1993 health care sector reform in Colombia as well as those that lead the Court gain power to intervene in the distribution of social good such as health care. The analysis will also be guided by the debates in the literature around "universalistic social policy", its political nature, its potential to realized citizenship rights through less commoditized forms of social provisioning, as well as its power to change patterns of stratification and segregation. These debates will provide the conceptual framework to discuss the transformative potential of judicial interventions. Finally, document analysis of official government documents, constitutional judicial decisions, laws as well as the preparatory documents for each of

these, in addition to quantitative studies regarding the access of health care services, is used to provide evidence of the institutional changes brought to health care provision by the intervention of the Court through decision T-760 of 2008.

Following, Chapter 2 will discuss de debates around the role of social policy as a tool to bring social integration and materialized citizenship rights, contrasting mainstream approaches of targeting measures versus a more holistic views of social policy and linking this discussion with current debates in health policy. Chapter 3 will introduce debates around the incorporation of rights-based approaches to development outcomes, to later discuss the judicialization of politics and how judges and courts are increasingly intervening in the distribution of social goods through the protection of human rights. Chapters 4 and 5 will then enter in the discussion of the current patterns of segmentation, segregation and stratification in the structure of the 1993 health care sector reform to later assess how such structure has changed after the Court intervention. The conclusion will elaborate further on the role of courts and the judicialization of social demands in the articulation of universalistic social policies.

Chapter 2 Re-politicization of social policy debates: the power of social policy to bring social integration and citizenship

Debates around the impact of the Millennium Development Goals (MDGs) in the post-2015 development agenda pose some doubts around the impact of the MDGs in the reduction of poverty. For instance, as argued by Fischer (2010) there seems to be a risk of de-politicizing poverty and policy debates in the post-2015 development agenda because they do not consider how for example certain policy choices, such as targeting, can feed underlying processes of stratification and subordination, which have a direct impact on poverty given their impact on social mobility and social inclusion. It is also argued that the selection in the MDGs of absolute poverty targets and indicators, which implicitly indicate a preference for targeting modalities, might insinuate a choice in favour of a neoliberal agenda for poverty reduction. These discussions suggest a need to politicized debates regarding poverty itself and the social policy paths chosen to tackle it, because there is a latent risk they can be co-opted by agendas that privilege technocratic strategies that undermine the dynamics of social inequality structures in bringing about poverty.

The uncommon setting of courts and judges intervening in social policy areas through rights litigation calls for a revision of these same issues given their increasing intervention in the distribution of social goods such as health care and education. In Colombia, judicial decision T-760 of 2008 set the standards to restructure the health care system in order to effectively realize the right to health, attempting to help it move towards a more inclusive and universalized scheme. However debates of this intervention are still reduced to either considering it realises social justice for the disfranchised or is as a fundamental overstep of the Court's jurisdiction in matters that attaining the government. The redistributive power of this decision still needs to be reflected in light of the political importance of social policy choices and problematized in terms of its potential to address political questions regarding distributional conflicts.

There is a political sensitivity in the choice of a specific path for welfare reform. The choice of a particular social provisioning system reflects a preference in the path to access resources and social goods as well as in the foundations entitlements to such goods are based. These preferences are crucial because they go to the heart of how societies perceive dignifying livelihoods. The *political* importance of these social policy choices can be seen then on two accounts: First, on the understanding of what a secure livelihood is (i.e. notions of poverty, inequality, vulnerability and their root causes) and the basis on which entitlements to resources and social goods are founded (e.g. market-based, employment-based, citizenship-based), because these choices directly impact people's social status and wellbeing. Second, on the process through which these policy choices are made. Given that social policy defines people's citizenship status and influences the way wellbeing is enhanced, it is essential that such choices are politically bargained (Mettler and Soss 2004 in Mkandawire 2005), meaning they should be put forward in democratic and participatory settings where collective interests are represented and choices are debated collectively.

The political sensitivity around the choice of social policy paths can be seen in the broader context of the mainstream agendas for poverty reduction. After seeing the consequences of the Structural Adjustment Programs and the liberalization of the market on increasing poverty and inequality, the 1990 World Development Reports (WDR) on "Poverty" called for policies that were founded on the assumption that poverty was a result of market imperfections (Fischer 2010: 40), hence resting poverty reduction strategies on creating incentives for markets to include poor people in the productive processes in order to increase their income and consumption levels (World Bank 1990: 3). Further, it reiterated that poverty reduction could not be achieved without parallel economic growth and recognized that those who could not participate from the benefits of such economic growth needed to be reached using safety nets and targeted transfers (World Bank 1990: 4). The underlying neoliberal bias of the poverty reduction debates lead consequently to use welfare reforms as instruments to correct macroeconomic failures (Townsend 2004) and to redirect public spending way from the better-off and propose means-tested mechanisms to target the poorest (Mkandawire 2005: 3).

Mainstream approaches for poverty reduction have privileged policies and institutional modalities that are founded on limited notions of poverty and on a technocratic vision of poverty reduction. In this regard, mainstream institutional arrangements for poverty reduction and social protection have the rested, among others, in two mayor foundations: (i) targeting modalities to focalize social spending in a context of scares resources, and (ii) prioritization of the market as the mechanism for distribution of resources and social goods. The first foundation reflects a major shift in the understanding of poverty and insecurity which has impacted directly in the choice of policy strategies for poverty reduction and social protection. Neoliberal approaches to social protection have helped create the notion that poverty reduction is a matter of handling 'risks' and security as a matter of 'individual' responsibility, placing private actors in competitive markets as more 'efficient' actors to protect risks and provide social goods (Lavinas 2013: 5-7). In Latin America, for example, the focus on social policy reform during the 1990's was to change social provisioning institutions into individual savings schemes because there was a big influence from international policy makers to focus on more efficient ways to allocate financial resources, a need to reduce fiscal deficits, and an intention to expand the space for private providers (Barrientos et al. 2008: 760). In this context, as Chhachhi (2009) argued the new approach to security and poverty reduction implied: (i) poverty was rooted principally in shocks that affected household income, hence targeting programs such as microcredit, public employment schemes, conditional cash transfers, and social insurance schemes became suitable strategies to address income shocks (ii) competitive markets, specially financial markets, were the preferred mechanisms to manage those risk/shocks, due to their allegedly capacity to efficiently redistribute resources, thus reducing the role of the state just to enable their functioning through regulation, and (iii) entitlements to social goods to be mediated by market-based or means-tested mechanisms. The second of the foundations on the other hand, has become an entry point for the New Public Management framework (NPM) to take over reforms of social provisioning systems. The NPM in social provisioning brought the creation of "quasi-markets" (Dunleavy et al. 2006) in which states still play a role as regulators of the system but provisioning activities are ruled by market dynamics of privatization, competition, and commercialization of social goods. The health

care system reforms of the 1990's are an example of how public services adopted mix-market mechanisms for the provision of health care services. With the 1993 WDR "Investing in Health" setting the principles for the marketization of health care services, health sector reforms disaggregated provision between purchaser of services and providers, as well as within the state through decentralization, in addition to the creation of regulated markets where health services could be commercialized by profit seeking enterprises (Mackintosh 2003, Vos et al. 2006, Homedes and Ugalde 2005).

In the current context of the marketization of public services and the creation of quasi-markets, social inequality and commoditized forms of social provisioning work in particular ways. Social provisioning systems can a reproduce processes of social stratification, polarization, segregation between social groups as a result of the implementation of certain institutional modalities. For example, Fischer (2012) points out that segmentation in provisioning systems (e.g. differentiated organization channels in the provision of services) has the potential to segregate and stratify social groups, for example, if it separates provision of services between the middle income strata and the poor by organizing them according to means (e.g. fees, co-payments) instead of need. Welfare institutions are key players in "structuring class and social order" (Esping-Andersen 1990: 55) because they help shape divisions in class and status differentiation. In this sense, social inequality encompasses more than processes of social exclusion. A gendered analysis of mainstream social protection mechanisms also shows this special feature of social policy. Chhacchi and Truong (2009), for example, argue that failing to understand that welfare is underpinned by a gender order, can reinforce the subordinated status of women given how the "male bread-winner" model is integrated in the articulation of social protection programs and how care work is ignored, thus further enhancing the division between women and men in the access to resources and social goods. In the same way, commoditization is not entirely explained as per Esping-Andersen (1990) definition of the extent a persona can maintain a livelihood without the reliance on the market. It requires an analysis of the ways provisioning systems rely on market intermediation to provide services. For instance, if the system organizes prices of services according to market forces and financing of such services requires up-front payments the system can be considered more commoditized (Fischer 2012: 14-15). These form of social inequality and commoditization are being overlooked by the mainstream approaches to poverty reduction and social provisioning systems.

The health care mainstream policy choices for health sector reform are a good example of how commoditized forms of social provisioning impact social inequality. The 1993 WDR 'Investing in Health", the general framework for these reforms, conceptualized health care as a "private good" and opened the doors the creation of a "health care market" and the commercialization of health care services (Mackintosh 2003: 6). It proposed structural reforms that intended to improve government's spending on health, by for example reducing government expenditures on tertiary facilities, disaggregating management of government health services through decentralization, and financing of a package of essential clinical services to "leave the remaining clinical services to be financed privately or by social insurance" (World Bank 1993: 6). Equity was incorporated more in terms of targeting public funding on the poor (Mackintosh 2001: 176).

The organization of health care services through commercialization and privatization served as a way to influence socio-economic inequality in different ways: (i) the introduction of fees to rationalize service delivery and as a recovery cost mechanism generally impacts more out-of-pocket spending of the poor that people with different income levels, an usually exclude from services people that do not have the ability to pay, (ii) the creation of private insurances usually serves the middle income strata and pushes the poor to relay on public services, polarizing in this way people who can afford private health care from the rest, (iii) the privatization of secondary and tertiary care also serve the middle and high income strata (Mackintosh 2003: 15-18). The institutional arrangements of the health care reforms inspired in the 1993 WDR introduced then changes that first commoditized the system due to the creation of a market for health care and the introduction of user fees (direct financing), and second they helped reproduced social inequality by dividing the access to health care through the privatizing certain groups of services, which favoured the middle and high income strata.

Considering the discussion above, more universalistic approaches to social policy contribute to problematize the mainstream technocratic policy choices to poverty reduction and social protection by broadening the debate in terms of how to rearrange redistributive structures in order to bring social integration and realize citizenship rights. Coming back to Mkandawire (2005) the choice of a policy cannot be solely a technical one, but rather one that is based on an understanding that redistributive processes and redistributive choices are political because they have the power dismantle structures of inequality (e.g. stratification, segregation, polarization), by integrating different social groups and creating citizenship status with the setup of unconditional and untargeted access to social goods. Social provisioning systems are a good example of how more universal policy arrangements can contribute to this goal. Taking the case of education, integrated organizational channels that provide services to students based on equal access to all can contribute to dilute stratification structures among categories of students (e.g. girls, boys, rural, urban, economic stratus) (Fischer 2012: 12-13), because founding such access in unconditional arrangements has the potential construct both social integration and realize citizenship. The political importance of social policy calls then for a revision of redistributive institutions in terms of not only their potential to reduce poverty but also their potential to rearrange social order to counteract unequalizing processes and create true citizenship.

Chapter 3 Human rights approach and the judicialization of social demands

The emergence of human rights in the international regulatory frameworks has change the way states are approaching development outcomes. The integration of human rights and human rights discourses in the 2015 post-development agendas are clear examples of this. The rise of human rights frameworks and discourses started in the late 1980's with the third wave of democratization (after the fall of the Berlin wall) (Langford et al. 2013: 20) and in Latin America particularly, with the introduction of rights catalogues into state's constitutions (including economic, social and cultural rights - ESCR), to help secure a smooth transition to democracy and the rule of law, after the rights abuses of the previous authoritarian rulers (Domingo 2004: 105). International human rights law and other human rights instruments have been then developed on the basis that states have particular obligations in the realization of human rights, to *respect* (refraining from interfering), *protect* (ensure that people can exercise their human rights) and *fulfil* (adopt the necessary measures to realize human rights)[1]. The integration of human rights into development has then been on the basis that states are "duty-bearers" of these obligations and accountable for the realization of human rights. Failures in reaching right-based development outcomes are thus address by calling "the duty-bearer to change its behaviour, or action will be taken to ensure that the duty-bearer develops the necessary capacity to realize its duties" (Langford et al. 2013: 24).

Since the adoption of the MDGs, rights-based approaches to development are increasingly being incorporated in the discourse of poverty and inequality reduction. In 2003 the United Nations released the UN Common Understanding on Human Rights Based Approach (HRBA) which has served as a reference point to mainstream rights-based approaches into laws, policies and projects among states, UN agencies, NGOs, etc. In the case of health care, the adoption of a rights-based approach has meant for states the fulfilment of specific obligations regarding the setup of health care systems according to the standards determined by the Committee on Economic, Social and Cultural Rights (CESCR) in its General Comment No. 14 (2000) on the right to the highest attainable standard of health[2]. The General Comment established specific obligations for states to put in place health care systems that are: (i) *available* (facilities, goods, services and programmes) in sufficient quantity, (ii) *accessible* (physically, economically, non-discriminatory services), (iii) *acceptable* (appropriateness in terms of medical ethics, cultural tradition and sensitive to gender), and of *quality* (medically and scientifically accepted). This approach to the realization of rights, especially regarding ESCR, has been regarded as a neutral by the CESCR because its realization "neither requires nor precludes any particular form of government or economic system" (Committee on Economic, Social and Cultural Rights (CESCR) 1990: 2).

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[1] For further explanations on how these obligations are integrated in the different international treaties and human rights instruments please see http://www.ohchr.org/en/professionalinterest/pages/internationallaw.aspx

[2] See WHO and OHCHR information sheet on human rights based approaches to health care available in http://www.who.int/hhr/news/hrba_to_health2.pdf.

Supporters of right-based approaches for poverty and inequality reduction consider that a link between policies and human rights realization is positive and desirable. Critics express doubts regarding the operationalization of rights-based approaches when they are translated into policies, especially policies that have distributional purposes. Mclnerney-Lankford (2013), for instance, considers that rights-based approaches, founded on the human rights obligations to respect, protect and fulfil, have the potential to enhance states' accountability standards based on international treaty obligations. Hence, efforts to reduce poverty and inequality through the realization of rights can be strengthen by international legal accountability. Regarding the reduction of health inequality, Yamin and Norheim (2014) believe that human rights-based frameworks have the potential to highlight social inequality because they are concerned with protecting social groups that traditionally have been more disenfranchised because of their gender, race or cast. Then, human rights frameworks can widen the understanding of poverty and inequality by considering also how discrimination and disempowerment act as sources. Gauri (2004) on the other hand, argues that right-based approaches when applied to the provision of health care and education do not give "an explicit metric for making trade-offs" between (i) everyone having a right to health care or education and (ii) government's role to set priorities in contexts where resources need to be allocated to provide services. Then, it is very difficult to "realize" rights when it can range for example from access to basic primary health care to specific procedures like cosmetic surgery. Because such trade-offs are not resolved by merely appealing to the realization of rights, he argues they should be decided considering the political procedures for collective decision-making. Further, there might be a risk of rights-based approaches being co-opted because their operationalization into policies can lead to regressive outcomes given the degree of ambiguity of their content. In this regard, Fischer (2013) points out that for instance the principle of non-discrimination can imply both universalism and selectivity at the same time, either of which can pose problems when it comes to distributions of resources and social goods. Universalism because treating everybody equal can reinforce exclusionary or subordination processes founded on gender, race or ethnicity biases and selectivity of excluded groups can imply an agenda for targeting. The debates presented here show that somehow even though rights-based approaches can incorporate a desirable standard of human dignity into policies, their actual operationalization can present challenges in the process of making policy choices.

In this scenario, the intervention of courts and judges using rights-based approaches in policy matters has not come accidentally. It responds to the constitutional transformations states have been experiencing since the 1970s where the constitutionalization of rights (i.e. introducing comprehensive rights catalogues in states' constitutions) and the establishment of judicial review in states' regulatory frameworks have given judges greater power and independence from the government and the legislative branch. The convergence of states to constitutionalism, referred to as the New Constitutionalism phenomenon, has not had a unique origin, but rather responds to various reasons, which include: (i) the democratizations waves that took place in Europe in the 1970, in Latin America in the 1980s and in East Europe in the 1990s, where independent judges were viewed as a way to consolidate the separation of powers in representative democracies, and (ii) as a result of the prioritization of human rights after World War II, where signs of strong constitutional and democratic frameworks implied

the presence of robust bills of rights that gave legal protection specially to minorities (Hirschl 2004). Further, the judicialization of social demands has responded in many cases, to a loss of legitimacy of governments and parliaments, and particularly in Colombia, also due to the low levels of social mobilization (Uprimny and Villegas 2004, Uprimny 2007). Hence, people have turned to the judicial system to seek social goods and services they believe are entitled to, based on the rights incorporated in the constitutions, because the regular institutional channels do not respond to their demands and do not provide an effective way to voice their needs.

The increasing intervention of judges and courts in these and other matters reflects an important change in the organization of traditional representative democracies. The rising reliance on courts and on judicial procedures to resolve policy choices and political controversies has become a world-wide phenomenon referred to as the "judicialization of politics" (Vallinder 1994, Hirschl 2006, Uprimny 2007). The definition of what *politics* means is still debated but in general terms has been defined as matters and procedures that traditionally have been assigned to be decided either by the government or the legislative, such as policy making, welfare provision, electoral processes, macroeconomic planning, national security, and nation building processes (Hirschl 2006: 724-728). Through the legal incorporation of rights and judicial review judges and courts have come to be involve in the determination of matters that either define polities or traditionally required collective decision-making processes. The result, as Hirschl (2006) has define it, is a slow transition from democracies to *juristrocracies*. The new role judges and courts are adopting has brought concerns that go beyond the separation of powers[3] principle (i.e. absence of jurisdiction of courts and judges to decide over these matters), to question if issues of political nature should be decided in spaces that are not democratic because collective interests cannot be bargained. In this sense, Vallinder (1994) pointed out that an important difference between judicial and political ways of conflict resolution is that judges and courts adjudicate according (i) to the claim (the facts) presented to them, which usually is enclosed in a controversy between two parties, (ii) to the regulatory framework that defines their jurisdiction and is applicable to the claim itself, (ii) normally on a case-by-case basis. Therefore, conflict resolution in the judicial setting presents limitations for processes of collective bargaining and the solution is confined to the boundaries set by the different regulatory frameworks that interplay. The main concern here is then that the judiciary lacks the legitimate authority to resolve these issues because it lacks democratic legitimacy since judges are not popularly elected and they lack the capacity to resolve trade-off because of the particular rules they need to oversee in their conflict resolution processes (Hirschl 2006, Cabrera and Ayala 2013). Further, judicialization has also the risk of politicising the resolution of judicial conflicts, which

[3] The separation of powers is a theory that has its origins in the work of Aristotle "*Politics*", in which he described three agencies that ruled the polities (general assembly, public officials and the judiciary). The checks and balances principle came in the time of the republic of Rome where the three branches were also separated to function as vigilants of each other in order to prevent the concentration of all the ruling power in one of the branches. The theory was refined in the 18th century by Montesquieu who based the separation of power and the checks and balances principle in the notion of liberty, according to which a life with liberty can only be lived if there is control over arbitrary power. For further discussions on the independence of judges please refer to Ervin, S.J. (1970) 'Separation of Powers: Judicial Independence', Law and contemporary problems: 108-127.

is portrayed as neutral precisely because it is shielded by the framework of the law, in terms of using the judicial setting by political actors to pursue particular agendas, especially when judicial systems are not so strong or independent (Domingo 2004, Uprimny 2007).

In this debate, supporters of the judicialization of social demands, an expression of the judicialization of politics, believe that their involvement actually reinforces democratic systems because they ensure accountability of the other branches, helps fill regulatory gaps (policy gaps as well) that are crucial for the legal protection and realization of rights and promotes equality by vindicating the rights of the disfranchised. Thus serving as democratic stimulators and vindicators of social justice claims. However, the distributional outcomes of judicial intervention using rights-based approaches vary and sometimes are inconsistent with these claims. Considering for example the advancement of health equity and the protection of the human right to health through the judicialization of health care claims, Brinks and Gauri (2012) found that rights litigation is not inherently regressive. Still, many factors such as who can access the judicial system, how broadly and to whom the court's decision is applicable (e.g. case-by-case basis mechanisms), and the level of implementation of the court's rulings play a role in determining how health benefits are redistributed, skewing in some cases the distribution towards the better-off. On this regard, Ferraz (2010) argued that the right to health litigation in the case of individual claims to medications not provided by the health care system actually had regressive effects because it did not benefited the poor but rather the social elites who had access to the judicial system. These studies challenge then the idea that socio-economic rights litigation can lead to better allocation of social goods and resources, hence better at bringing equity outcomes.

The missing link in the judicialization of social demands, besides how external factors such as the ones Brinks and Gauri mentioned interact to shape distributional outcomes, is how both the challenges of operationalizing rights-based approaches in addition to the special setting that confines judges in the resolution of conflicts play a role in the definition of welfare provisioning paths that, as discussed before, have a *political* nature themselves. These last factors should be considered to have a broader understanding of the potential of courts to resolve not only equity outcomes (e.g. who is being benefited in the distribution the social goods or resources claimed), but more importantly their potential to address the political predicaments that entails the definition of social provisioning paths in light of their power to either reinforce social inequality or bring social integration and citizenship.

Chapter 4 Health sector reform in Colombia: inequalities in health care access and judicial intervention

In 1993 the government of Colombia introduced one of the most important reforms to the health care system. Before the reform, access to health insurance coverage was dependant on people's employment status or income. Health care services were only guaranteed through social security schemes (public or private) if you were rich or belonged to the urban formal sector, i.e. formal workers, civil servants and military officials. These schemes left out of coverage the poor, unemployed populations and informal workers who had to seek at their own expense low quality care in public hospitals subsidized by the government (DNP Colombia 1998: 68-69). The principal aim of Law No. 100 of 1993, statute by which the SGSSS was incorporated, was then to expand coverage and incorporate these populations through a cross-subsidy system that changed government's financial support from the offer of health care services to their demand. This was part of a greater shift in health care provision that responded to the neoliberal tendencies of the macroeconomic context and the marketizised model proposed in the 1993 WDR "Investing in Health". The institutional arrangements proposed in the reform were therefore designed to universal health coverage by (i) reducing costs in order to release and allocate better resources to target the excluded populations and (ii) creating new opportunities for the private sector to commercialized health care services.

Portrayed as a "successful" reform in 2003 by the World Health Organization (World Health Organization 2003: 124), the health care system proposed in Law No. 100 has certainly helped increased health insurance coverage dramatically. In 1993, 23.7% of the total population was covered by the General System of Social Security in Health (SGSSS for its name in Spanish). By 2006 this number increased to 82.7% (Calderón et al. 2011: 3) and in 2013, over 90% of the population is enrolled in the SGSSS (DANE 2013). Still, this apparent success has been unmasked by the failure of the system to actually provide health care services to beneficiaries at the time of need. The government's aim to reach universal health coverage was equated mainly with the expansion in affiliation (GES 2011 in Ayala G. 2014). It turned out the reform created new barriers to access health care services that have resulted in unequal access among different social groups, affecting in particular women, black communities and the lower income strata. The intervention of the Court with decision T-760 of 2008 aimed to tackle unequal access to health care services due to failures in the structuration of the system.

4.1. Macroeconomic policy context of the 1993 health sector reform.

Law No. 100 was passed at a time where Colombia was shifting its macroeconomic policy framework from a closed and protectionist economy to one that pursued the liberalization of the commercial relations and seek the country's in-

tegration in the global market. Distancing itself from the previous import substitution industrialization model, the 1990-1994 National Development Plan (PND for its name in Spanish) introduced institutional reforms that appealed to many of the neoliberal policies, principles and assumptions proposed in the Washington Consensus (1990). Some of them were directed towards the flexibilization of labour market structures, the reduction of taxes and duties on imports, privatization of state-owned enterprises (which included the express authorization for the private sector to provide social good and services), reduction of public spending, liberalization of the financial market and decentralization (Orjuela 1998: 4). It was a classic attempt to reduce the powers of the state in the intervention of economic processes and clear a privilege of the market and the private sector as key actors.

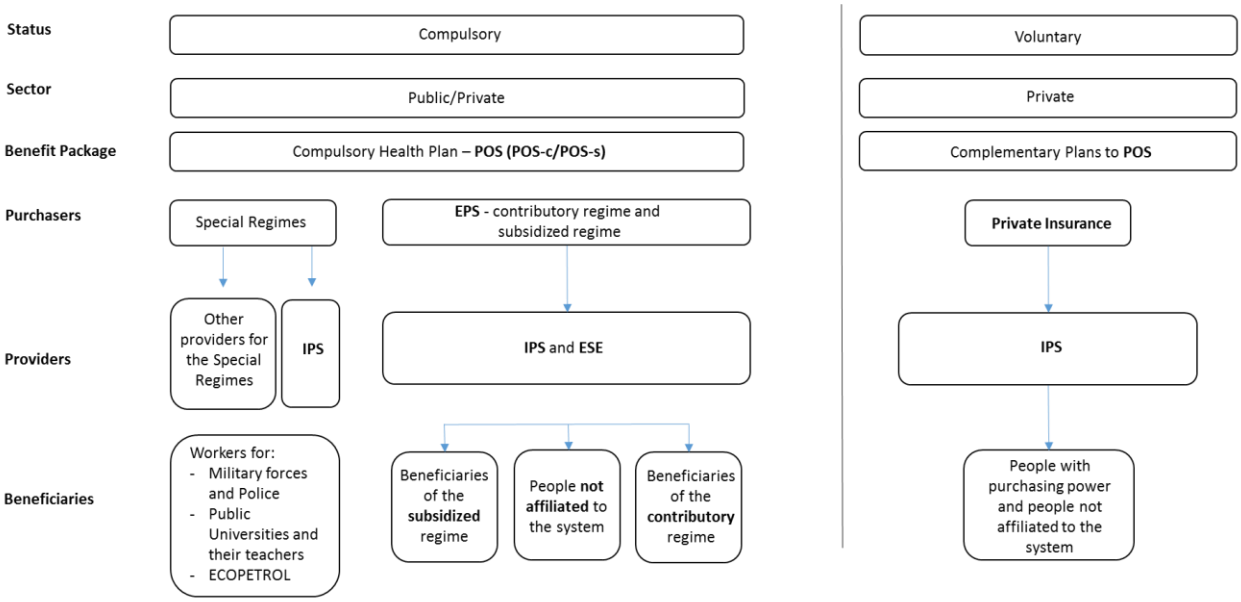
In this context, the 1993 health sector reform introduced the "managed competition" model. The opening of the markets and the liberalization of trade an investment led to the corporatization of health care services and the creation of a new niche market for foreign direct investment (Mackintosh 2003: 5). In the 1990's Colombia and many other Latin America countries imported from the United States a new model that promised to resolve problems of equity, cost and efficiency of health care systems (Iriart et al. 2001, Vargas et al. 2010). Founded in principles of efficiency, effectiveness, decentralization, privatization and freedom of choice the "managed competition" model rearranged the logic of administration and finance of the previous health care system by (i) reducing the government's intervention to the regulation, monitoring and inspection of the system, (ii) introducing enterprises (state owned, private or mixed) called managed care organizations (MCOs) that were responsible for affiliating the beneficiaries and arranging the provision of services and (iii) modifying its financial structure changing it to a capitated system (Waitzkin and Iriart 2000). It also introduced user fees and co-payments as a way to regulate service use and laid the foundations to finance the demand of services rather than the supply (Iriart et al. 2001: 1245). The model rested on the assumptions that a regulation of the market, as opposed to a complete liberalization, would correct past market failures (Vargas et al. 2010: 10) and that an atmosphere of competition and the power of free choice would force MCOs and providers to lower their costs but still offer higher quality services (Iriart et al. 2001: 3).

The adoption of the "managed competition" model in Colombia seemed to respond to many pressing issues of the previous health care schemes. It appeared to give a rapid solution to the problem of inefficient service delivery by allowing a specialized service unit, the MCOs, to control and oversee the provision of services at the lowest cost, still allegedly controlling for market co-option of social goods and low quality services with the introduction of strict standards and regulatory frameworks. However, the 1993 reform changed profoundly the perception of health care focusing more on economic sustainability, introducing arrangements that segmented and marketizised service delivery which contributed to reinforce commoditized forms of social provisioning and social inequality in the form of segregation, polarization and stratification of social groups, as explained further below.

4.2. Structure of the 1993 health sector reform.

The adoption of the "managed competition" model in the 1993 health sector reform was accompanied by a mixture of institutional arrangements. A market-oriented approach of the adopted model was levelled with progressive measures such as the integration of a cross-subsidy system intended to finance access and provide services for those who did not have the ability to pay for them. This created in Colombia a mixed system ruled by market-oriented institutional mechanisms for the supply of services but progressive measures to finance their demand. Within this mix, the 1993 reform established the following institutional arrangements, as shown in Figure No. 1[4].

Figure 1: 1993 Structure of Actors and Access to the Health Care System



Source: Guerrero et. al 2011. Modified by the author for the purposes of this paper

The reform created a compulsory health care scheme which obligated all citizens to be affiliate to either the contributory, subsidized regime or special regime, depending on which category of beneficiary people were classified in. It also allowed the creation of a voluntary insurance scheme free to choose from for everybody, if interested in having complementary health care benefits. In the compulsory health care scheme both public and private entities could participate either as purchasers (Health Promoting Enterprises – EPS) or providers (Health Service Providers - IPS), yet the benefit package (POS for its name in Spanish) offered was established by the government. The benefit package was set different in each regime, having then a POS for the subsidized (POS-s) regime only covering 55% of the services offered by the POS for the contributory regime (POS-c). The EPS were responsible for securing the provision of health care services by contracting/buying services from the providers. The reform allowed EPS to either vertically integrate with a provider to provide services within the same EPS or to contract such services from an independent provider. In the same way, EPS could offer complementary plans to the POS by way of private insurance packages regulated only by the market. On the other hand, IPS were in charge of the actual provision of services for beneficiaries of the contributory

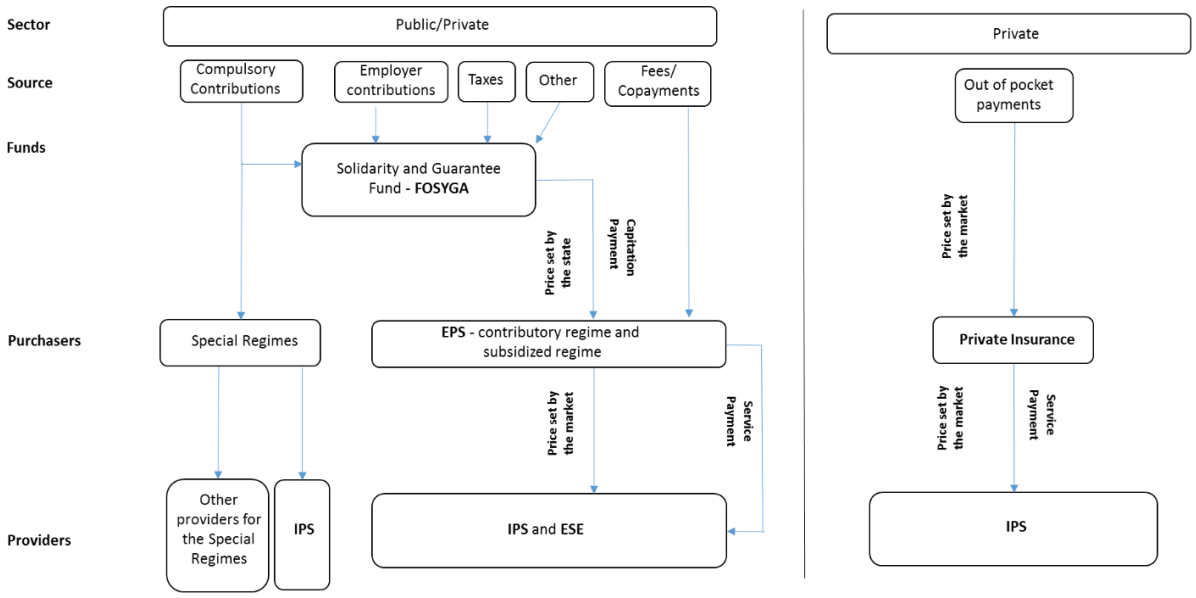
[4] Please refer to **Appendix I** to see a detailed description of the actors and access arrangements of the health care system introduced by Law No. 100 of 1993.

or subsidized regime, for people with private insurance and also for people not affiliated or covered by the SGSSS. They provide the services in the way they are contracted with the EPS and receive the corresponding payment as established in such agreements.

The regulation and monitoring of the SGSSS was assigned to the former Ministry of Health and Social Protection. This Ministry was in charge along with the Superintendence of Health of setting the rules that regulate the interactions between the all the actor of the system and the beneficiaries, as well as all the procedures to finance the system and access services. The system quickly grew to be dominated by the private sector and its competition dynamics. In 2010 for instance, the market was dominated by private EPS which had 81.6% of the enrolment, concentrated in 5 major private insurers that control 50% of the market share, and only approximately 30% of the IPS were public providers (Vargas et al. 2010: 2). Patients became clients and EPS compete among themselves for beneficiaries as well as with IPS for better and more profitable contracts.

Nonetheless, these dynamics co-exist with government led actions that aim to include the poor and unemployed populations. For example, targeting measures to ensure funds to finance service delivery for the previously excluded include the use of the Identification System for Potential Beneficiaries of Social Programs (SISBEN)[5] to target subsidies. If classified in levels 1 and 2 beneficiaries are granted with the full subsidy and if classified in level 3 the beneficiary is entitle only to a partial subsidy, which entitles them to access services included in the POS-s. Approximately 52.2% of the population is now benefited by the subsidized regime of the SGSSS (DANE 2013).

Figure 2: 1993 Finance and Cost Structure Health Care System



Source: Guerrero et al 2011. Modified by the author for the purposes of this paper

[5] The SISBEN is a system designed by the government to identify beneficiaries of public social expenditure, by elaborating socio-economic diagnosis using the concept of multidimensional poverty. Beneficiaries are then classified in one of the three level 1, 2 or 3, understanding that people classified in levels 1 and 2 are people below the poverty line.

The financial structure of the SGSSS in its compulsory scheme responds also to a mixture of market structures and government intervention. Figure No. 2[6] shows the basic financial arrangements of the system. The compulsory scheme is finance by both private (i.e. compulsory contributions, employer contributions and co-payments) and public funds (i.e. taxes and funds from the national and local government budgets. All the sources of funding of the compulsory scheme (leaving a side the special regime) go to a fund called the Solidarity and Guarantee Fund – FOSYGA. This fund is in charge of transferring the unit of capitation payment to the EPS to finance the services determined in the POS and contracted with the IPS.

An important feature of the financial structure is the combination of a capitated system[7] regulated by the government and a market-based relationship between EPS and IPS. The introduction of a capitated system in the SGSSS meant a transformation of the cost structure of the system, due to: (i) the creation of a global price per beneficiary (unit of capitation payment - UCP) calculated to cover the costs for the services, goods and procedures included in the POS and, (ii) a reduction of operational costs (e.g. fixed cost) since it transfers them the EPS and IPS in charge of arranging and delivering the service. The UCP is then transferred to the EPS which then uses it to pay for the services it privately contracts with the IPS[8]. The contracts between EPS and IPS are regulated by private law (the law only specified the payment mode), therefore arrangements regarding how to manage operational costs and profit are usually included (Perez C and Velazques A. 2008). The UCP is then impacted by a chain of intermediation arrangements. On the other side, a cross-subsidy system operates in tandem with the capitation system. This system works through the UCP of the subsidized regime which uses part of the contributions of beneficiaries affiliated to the contributory system to fund the subsidies. The system lays on the principle (solidarity) that those who have more should help pay for those who cannot.

As shown previously, the SGSSS established by the 1993 reform included both market-oriented mechanisms (with the introduction of a "managed competition" model) and direct government intervention (through regulation of the capitated system and the control of targeted subsidies) as instruments to provide health care services. Not completely driven by neoliberal principles of marketization and privatization, the reform opened the space also for progressive measures to co-exist with market oriented forms of service delivery. In this particular mixture some features, as discussed below, have contributed to shape unequal patterns of access to health care services which in turn have reinforced processes of segregation, polarization and stratification between different social groups. With the understanding that health care systems, considered as social settlements that reflect and at the same time create social inequality (Mackintosh 2001), the following section discusses how some institutional arrangements of the SGSSS established in the 1993 reform have contributed to maintain processes of social inequality and commoditization.

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[6] Please refer to **Appendix I** to see a detailed description of the finance and cost structure of the health care system introduced by Law No. 100 of 1993.

[7] Capitated systems are payment systems where payment is calculated per individual and not according to the service itself. The payment unit is called unit of capitation payment which is a single value calculated considering the cost, the risk and administrative operation cost to finance the services included in the benefit package.

[8] Does not apply to public EPS or IPS because their contract regime is determined by law.

4.3. Institutional modalities of the 1993 health care sector: segmentation and stratification.

An important challenge that governments face in the design and implementation of social provisioning systems is the creation of integrated schemes (as opposed to segmented provisioning arrangements) that at the same time serve the poor and excluded populations. In this struggle, targeting, market-oriented modalities and principles such as privatization and (profit-seeking) competition have been presented in international guiding policy documents like the WDRs as social policy mechanisms to reduce poverty and inequality, however not noting this measures can also feed underlying processes of segregation and stratification, due to the creation of segmented provisioning systems (Fischer 2012). In this context, certain features of the "managed competition" model plus the definition of differentiated types of regime (POS-c/POS-s) came to be sources of segmented organizational channels and commoditized forms of provisioning that have signified segregation, polarization and stratification of different social groups, such as the lower income strata, women and black communities.

4.3.1. Segmentation on the side of the offer: segregation and polarization processes.

Both the introduction of MCOs or EPS into the system as well as the privatization of managing and provisioning activities, contributed to separate the provision of services and created a division between the beneficiaries of the contributory and subsidized regimes in various ways. First, the institutional offer of EPS in the SGSSS compulsory scheme depends on the type of regime the beneficiary is affiliated to (MPS and SNS Colombia 2011). This means for example that beneficiaries from the subsidized regime cannot choose from the same group of EPS beneficiaries of the contributory or special regimes can. There is then a formal segregation of beneficiaries according to the type of regime they belong to.

Second, the division of provision activities between the EPS (management of service delivery) and IPS (actual delivery) and competition dynamics between and within EPS and IPS, has meant the fragmentation of contracts which results in deeper segmented channels to access health care services (Muñoz López 2001). How? since each EPS contracts services with IPS depending on the type of services they require and to the extent of what they can afford given the price of the service (set between them), the beneficiaries affiliated to a particular EPS can only use the services provided by the IPS which have been contracted (Perez C and Velazques A. 2008). Subcontracting between IPS is also possible (Muñoz López 2001). Furthermore, sometimes these contracts only include the provision of services for one of the three levels of care, usually fragmenting outpatient secondary care and tertiary care among different IPS according to the cost and the capacity of the IPS to deliver those services (Vargas et al. 2010: 4-5). This has meant that even within the same regime (contributory or subsidized) beneficiaries cannot access such services through the same organizational channels given that it depends on the contracts the corresponding EPS has arranged to provide health care services.

Third, competition and profit seeking dynamics among EPS and IPS have become incentives for risk selection of beneficiaries at the moment of seeking

care. For example, it has become a common practice to deny services to patients with costly illnesses due to the cost of medicines and the length of hospital stay (Vargas et al. 2010: 8). Authorizations, on the other hand, have become one of the main barriers to access health care and are used specially when there is a separation in the provision of services between EPS and IPS (when the EPS is integrated with the IPS – same economic group – risk selection comes in the form of controlling clinical practice), creating longer waiting times and additional paperwork to get appointments for secondary health care (Abadia and Oviedo 2009, Vargas et al. 2010, Garcia-Subirats et al. 2014). These barriers affect mostly beneficiaries in the subsidized regime, because they have to incur in additional costs in time and transportation to do the additional paperwork (Garcia-Subirats et al. 2014: 212, Vargas et al. 2010: 7). Here, the geographical distribution of the EPS play an important role because offer of services is also segmented between the contributory and subsidized regimes. EPS in the contributory regime are free to select the IPS they want to work with while EPS in the subsidiary regime are obligated to contract at least with public primary care centres which are managed by the local governments. The geographical access in the subsidized regime is better located than in the contributory regime, because competition and lower cost guide the selection of the places to provide services in the contributory regime (Garcia-Subirats et al. 2014: 212).

Segmentation of the side of the offer has meant in part segregation between the beneficiaries of the contributory, subsidized and the special regimes. In the same way, the introduction of the managed care mechanism such as authorizations, commercial relations between MCOs and actual providers and profit seeking interests product of privatization of health care services, have contributed to the creation of acutely fragmented organizational channels for service delivery, which in addition to a segmentation between regimes, has also meant polarization between the lower income strata and the middle income/ higher income strata. Low quality services partly due to their fragmentation have driven people with purchasing power to seek care in the voluntary/private insurance scheme and beneficiaries from the subsidized regime to stop seeking care due to lack of time (delay in the appointments) and lack of money (Garcia-Subirats et al. 2014: 208, 211).

4.3.2 Stratification on the side of the demand.

The definition of differentiated benefit packages (POS-c/POS-s) due to a differentiated value of the UCP for each regime plus the introduction of fees or co-payments to regulate the utilization of services have increased beneficiaries' out of pocket payments, impacting specially the lower income strata (beneficiaries of the subsidized regime), women and black communities, and driving them to either stop seeking healthcare or to face greater obstacles in accessing the services (Garcia-Subirats et al. 2014, Agudelo 2008, Ariza-Montoya and Hernández-Álvarez 2008). This is especially important given that health care markets are demand-inelastic (Fischer 2012: 15), which means that the liberty to change prices without a major risk of change in the demand can particularly restrain access from those who do not have the money to pay for services at the time of need. These type of arrangements are predicted of more commoditized forms of social provisioning because they require direct financing to access the services (Fischer 2012: 16).

The different POS for the contributory and subsidized regime were established as a result of calculating a different value for the UCP in each regime. The reform established that 55% of the UCP for the contributory regime was to be computed for the subsidized regime (Chicaiza 2002: 166). This meant that people from the lower income strata could only access about half of the services determined for the contributory regime, impacting as a result private health care expenditure in the form of out-of-pocket payments (Garcia-Subirats et al. 2014: 212, Vargas et al. 2010: 5). For instance, a regional study in the Department of Antioquia, based on the Quality of Life Surveys of 2003 showed that 46% of low income strata beneficiaries identified lack of money as the main barrier to access the services, compared to only a 26% of the people with better economic status and reiterated that out-of-pocket payments for medicines and hospitalization had a bigger weight in the expenses of people from the subsidized regime and people not affiliated to the system (Mejía-Mejía et al. 2007).

Similarly, co-payments have repetitively been identified as one of the major barriers for the beneficiaries of the subsidized regime to access health care in comparison to people with other levels of income (Vargas et al. 2010, Garcia-Subirats et al. 2014, Abadia and Oviedo 2009). Additionally, they have been shown to have also a regressive outcome when comparing their effects between women and men. A gender study done compering access between women and men to health care services before and after the implementation of 1993 health sector reform, found that after the 1993 reform women were less likely to be insured in a private insurance than men and their health care expenditure was more impacted by out-of pocket payments, because the system did not considered the structural restrictions women face particularly in the labour market (Agudelo 2008: 53-55). Furthermore, the organization and design of the system has also had effects in the access depending on your race. Ethnic groups[9], such as indigenous communities, people from the Rom community (gypsies) and black communities, who represent approximately 14% of Colombia' population. In general, for these ethnic groups seeking health care services usually comes as a second option mainly because they maintain their traditional ways of healing (Ariza-Montoya and Hernández-Álvarez 2008) However, the black communities face the biggest challenges to seek health care and are the least covered group in comparison to other ethnic groups because only indigenous and gypsies are recognized in the system as specially protected populations, which gives them an entry right to the subsidized regime and the possibility to organized themselves in particular EPS and IPS authorized to include their traditional ways of practicing medicine (Ariza-Montoya and Hernández-Álvarez 2008: 66). Hence, their health care expenditure is highly affected by these difficulties in access.

As a consequence of (i) the design and implementation of mechanisms that commoditize access to health care services, because direct financing to receive health care is required (ii) two differentiated benefit packages and (iii) special entry requirements, stratification according to income, gender and race can be found as underlying processes that affect particularly the poor population, women and black communities.

[9] For the purposes of this paper the black community is included in the category of "ethnicity' because the studies used as evidence here include this community in the definition of "ethnic group".

4.4. Decision T-760 of 2008: institutional reforms guided by a rights-based approach on the human right to health.

In 2008 the right to health became the most litigated right in Colombia, with a participation of 41.5% of all the rights litigated through *tutelas* (Defensoria del Pueblo Colombia 2013: 92). This was one of the reasons that indicated to the Court that there was a systematic failure in the protection and fulfilment of the right to health. Furthermore, the Court questioned if it was enough a judicial protection on a case-to-case basis or if given a pattern of systematic violations more structural changing measures were needed (Corte Constitucional Colombia 2008: 134). In this context, decision T-760 of 2008 was issued to help overcome what the Court identified as "structural regulation failures" in the health care system that led to a repetitive violation of people's right to health. Considering the above, the Court conditioned the fulfilment of the right to health, among other things, to an adequate regulatory framework which the state (in this case the government) was responsible for (Corte Constitucional Colombia 2008: 133). In addition, the Court framed the protection of the right to health applying directly the ICESCR and the CESCR's General Comment No. 14 (2000) on the right to the highest attainable standard of health, as authorized by article 94 of the Colombian Constitution[10], and circumscribed the requirement and orders to the government within the framework of "duty-bearers" responsibilities and "right-holders" claims of protection. On the basis of these foundations, the Court issued several orders to the government to fill the identified regulatory gaps in the system and to implement structural modifications in order to realize the right to health according to the international treaties referred, the national law and the applicable jurisprudence.

To define the nature of the right to health, the Court refers to art. 12 of the ICESCR and the CESCR´s General Observation No. 14 (2000), understanding that such right entitles people to claim for the 'highest attainable standard of health conducive to living a life in dignity'. The CESCR explains that this right is not a right to be healthy but a right to a series of entitlements such as facilities, goods, services and a system of health protection that provides health care equally for everyone, considering at the same time the state´s available resources (Committee on Economic, Social and Cultural Rights (CESCR) 2000: 4). Building on this definition, the Court again takes from the General Observation No. 14 (2000) the underlying determinants to realize the right to health, considering that such right is fulfilled when the government guarantees *availability*, *accessibility*, *acceptability* and *quality* of health care services as defined in this international instrument (Corte Constitucional Colombia 2008: 33). Regarding accessibility, the Court further established two guiding principles, the principle of "necessity" and the principle of "comprehensiveness" [11], on the basis of which the Court derived,

[10] Art. 94 of the Colombian Constitution allows the direct application of human rights international treaties such as the ICESCR, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC) regardless of their incorporation in the regulatory framework as national laws.

[11] The principle of necessity refers to the right to access health care services that are essential to preserve health, especially those that without can compromise physical integrity and a life with dignity. The principle of comprehensiveness refers to the access to all the services and goods required to treat an illness, in cases where the procedure included in the benefit package does not contemplate all the medicines and ancillary services required.

among others, the following constitutional rights, i.e. entitlements encompassed in the right to health (Corte Constitucional Colombia 2008: 194-196).

1. Access to health care services that are required with *necessity*, even if they are not included in the POS.
2. Access to health care services regardless of people's ability to pay. The inability to pay co-payments or contributions cannot be an obstacle to access services that are required with necessity.
3. Access to health care services without obstacles in the procedure of authorizations.
4. Access to *comprehensive* health care services that are required with necessity, regardless of their inclusion in the POS.

In addition to referring to an international human right instrument for the definition of the right to health, the Court complements its rights based-approach evaluating the barriers and unequal access to health care services from a "duty-bearers"/"right-holder" perspective. In this sense, the Court's orders to the government are founded on the human right principle of accountability and rule of law, according to which states are considered the natural duty bearers of the obligations to *respect*, *protect*, and *fulfil* human rights and are responsible and accountable to the people (right-holders) for the establishment of regulatory frameworks, policies and programmes that aim the realization of human rights. Consequently, when considering the systematic violation of the right to health and the root causes of the constant denials of EPS to deliver the health care services demanded, the Court concluded that the government as duty bearer of the obligation to fulfil the right to health was responsible for failing to regulate and apply the existing regulatory framework in sufficient manner in order to realized the right to health, as defined in the internationals human rights treaties and the jurisprudential rules set by the Court (Corte Constitucional Colombia 2008: 11). Therefore, the orders[12] presented in Table No. 1 were given to the government and further structural reforms were proposed (these also consider the entitlements defined by the Court when assessing the government's duty to guarantee health care *accessibility*) to advance the realization of the right to health and the universalization of health care services:

Table 1: Obstacles identified in decision T-760 of 2008 and orders to regulate "gaps"

Identified obstacle in access	Order given to the government
EPS denial of medicines, procedures or diagnostic tests because of unclear regulation on what is included or not in the POS.	Given that the government by law is required to update the health care benefit packages, the government is required to update them annually, explicitly mentioning what is included and what is not included in the POS applying the principle of *comprehensiveness.*
EPS denial of medicines, procedures or diagnostic tests to beneficiaries because of differentiated POS-c and POS-s.	Considering that Law No. 100 of 1993 stipulated that by 2001 both POS-c and POS-s were to be unified, the government is required to create a

[12] The orders presented in this section only include those that are relevant to the access of services that may have an impact in the patterns of segmentation, segregation, polarization and stratification identified in section 4.3. of this document.

	chronogram to unify both systems, however such unification is to be immediate for children.
EPS denial of health care services not included in the POS due to an unclear regulation to process the corresponding authorizations.	The government is required to regulate the internal procedure EPS need to follow to authorized services not included in the POS.
IPS denial of health care services of people not affiliated to neither regime of the SGSSS.	According to art. 48 Constitution, the state has to guarantee health care services to all citizens. The government is required to take all the necessary measures to include still unenrolled people in the system in order to fulfil its duty of reaching universal health coverage.

The Court´s overall assessment of the barriers people face to access health care services and the causes of EPS and IPS denials gravitate more around on the government's inability abide by the existing regulatory framework and delimit a clear regulatory framework for EPS and IPS to deliver the services. Equity is addressed only, on one hand, to reiterate the government´s responsibility to realized the right to health by providing a regulatory framework that allows EPS and IPS to adequately deliver services (Corte Constitucional Colombia 2008: 25) and on the other, to serve as an additional guiding principle, according which discrimination within the system based on people´s economic status creates unequal access to health care services. The delimitation of the structural problems of the health care system in term of 'regulatory failures', put the state as the main responsible and left out considerations of the model of provisioning, which as discussed before, adopted institutional arrangements that created not only unequal access to services but also reinforced social inequality structures.

Chapter 5 Universalization of health care system in Colombia?

The Court in decision T-760 of 2008 held the government accountable of rendering a clear and complete regulatory framework and to comply with the regulations already existing, as duty-bearer of the right to health. Furthermore, it helped align Colombia's health care law and policy with the international standards set in the ICESCR and the CESCR´s General Observation No. 14 (2000), as well as with the jurisprudence set by the Court regarding the realization of the right to health. However, access to health care services are still being denied by the EPS to beneficiaries, being 2013 the year were the use of *tutelas* for the protection of the right to health per 10.000 beneficiaries was the highest (Defensoria del Pueblo Colombia 2014: 7), and patterns of access to health care services seem not to have changed since the decision was issued, despite the effort the Court has put to monitor the way orders have been implemented. In general, denial and unequal access to health care services still remain the main reasons for people to either stop seeking health care or seek institutional support to access the services.

5.1. Changes in health care policy *versus* persisting problems in access to the health care system.

In 2013 the government presented to the congress a project to regulate the right to health, recognizing expressly that it was vital to incorporate the guidelines and orders given by the Court in order to help the health care system transit to one that effectively realized the right to health (Congreso de la República de Colombia 2013). This same year the congress adopted the Statutory Law for the Right to Health, in which it defined the nature, content and guiding principles of the right to health and other rights people have in relation to the access of health care services. A major progress has been made in relation to the embracement of human rights in Colombia's regulatory framework because for the first time with the mentioned law the right to health was given the status of "fundamental right", meaning it acquired a higher status than the one given to socio-economic rights in the constitution, settling all questions regarding the admissibility of *tutelas* for its protection[13]. Moreover, the law adopted almost in literal form the standards set in the CESCR´s General Observation No. 14 (2000), regarding the obligations of the state to *respect*, *protect*, and *fulfil* as duty-bearer as well as the content and guiding principles of the right to health of *availability*, *accessibility*, *acceptability* and *quality*. The statute also incorporated the Court's principles of "necessity" and "comprehensiveness" to extend the content of the right to health, granting for example the right to access hospital emergency services without requiring previous payment and to claim all the services and goods required to prevent or heal an illness regardless their status of inclusion in the benefit package[14]. Finally, there is a recognition of certain social groups such as children,

[13] According to art. 86 of Colombia's Constitution and Decree No. 2591 of 1991, *tutelas* for the protection of fundamental rights are only admissible for rights that have been expressly defined in the Constitution as "fundamental rights".

[14] Statutory Law for the Right to Health, Art. 8 and 10(b).

pregnant women, internally displaced people, indigenous communities, black communities and member of the ROM community, as especially protected subjects.

This advancements contrast with the still persisting difficulties in access to health care services. In this regard, Ayala (2014) performed a study to review the barriers to the access of health care services from both the demand and supply side concluded that: (i) people who belong to the high income strata have 12.9% more probabilities to receive health care than people in the low income strata, (ii) belonging to an ethnic groups lowers the chances to access health care services by 3 percentage points (iii) people who live in the rural areas have less probability to receive health care than those living in the urban areas in 3.8 percentage points, and (iv) beneficiaries of the contributory regime have in 5.9 percentage points more probabilities to access health care services than beneficiaries from the subsidized regime. Still, a positive change was found. Even though lack of money was still rated as the second most recurrent reason for not receiving health care, there was a substantial decrease in the number of people that did not receive health care because they could not pay for the services: from 42.3% in 1997 to 11.5% in 2012. The overall assessment indicated that there was a generalized decreased in actual access to health care services despite the increases in health insurance coverage and indicated that the main barriers to receive health services on the side of the offer are quality of the services, the bureaucracy and the distance to reach health care centres and on the demand side lack of money and mistrust towards doctors. The conclusion of this study can be complemented with others (Guzman F. 2014) that confirm (i) the health care market is still highly concentrated in both contributory and the subsidized regimen, with one or two EPS grouping between 70% and 100% of beneficiaries in 19 of the 32 regional departments, (ii) approximately 80% of the IPS have are private, and (iii) fragmentation in access considering levels of health care is still present nationwide.

What are the potentials of Statutory Law for the Right to Health to help advance the right to health considering how the health care system is functioning? It is a difficult question to respond especially since its implementation is so recent, however some limitations can be highlighted. First, although the law reiterates that the system should guarantee the access to health care services (art. 15), the law does not deal with the trade-offs between this and how such access can be financially sustainable. Moreover, the Court limited the interpretation of the principle of financial sustainability saying that this principle could not be an excuse not to provide services at the time of need (Corte Constitucional Colombia 2014: 6). Second, regarding the prohibition to deny services (art. 14), it limits such right only to hospital emergency services, leaving out primary, secondary and tertiary levels of care which actually have been identified as the services that are most denied. Third, despite the fact that there is a special protection to medical doctor's autonomy in prescribing medicines and procedures required to prevent or treat illnesses (art. 17), there is no mention of the direct responsibilities of EPS in not influencing medical staff decisions as also identified by studies that suggest clinical controls by EPS constitute a main barrier to the access of services (Vargas et al. 2010: 6). These issues may insinuate that a strict normative approach to solve the issues of unequal access to health care services, i.e. an almost literal adoption of the international instruments defining the standards on the realization of the right to health and the Court's rulings correspondingly,

could be restricting the space to question more profoundly the model of provisioning and the barriers that its structure is creating, as well as the responsibilities of other actors of the system (EPS and IPS) in also advancing the right to health and the universalization of services.

5.2. Advancing the universalization of health care services by filling the "gaps" in the regulatory framework of the health care system.

The Court has put great effort in monitoring the orders given to the government and follow up the advancements in the implementation of the existing regulation and the adoption of the new regulation required by the Court. In the last report presented to the Court the Ombudsman (Defensoria del Pueblo Colombia 2014) acknowledged the efforts the government has put to regulate the "gaps" identified by the Court as causes of barriers in the access of services, however presents deep concerns because still *tutelas* are the main recourse used by beneficiaries to access health care services. In 2013 the number of claims became the second highest in all the history of *tutelas* for the protection of the right to health and EPS continue to deny services (Defensoria del Pueblo Colombia 2014: 55-57). The following Table No. 2 presents the principal findings regarding the changes in access to health care services brought by the adoption of new regulation and its impact in the expected reduction of denials by EPS and *tutelas* for the protection of the right to health.

Table 2: Orders to regulate identified "gaps" compared to results in Ombudsman report 2013

Identified obstacle in access	Order given to the government	Observations in the Ombudsman monitoring report December 2013
EPS denial of medicines, procedures or diagnostic tests because of unclear regulation on what is included or not in the POS.	Given that the government by law is required to update the health care benefit packages, the government is required to update them annually, explicitly mentioning what is included and what is not included in the POS applying the principle of *comprehensiveness*.	In 2011 the government created a new methodology to update the POS with new medicines, technologies and services and its being implemented since. Other regulations regarding the control of the prices in medicines were also adopted. It has not reflected a decrease in the no. of *tutelas* for claims of services included or excluded in the POS (Pg. 5). Also, EPS denials increased 34.8% compared to 2012 (Pg. 8).
EPS denial of medicines, procedures or diagnostic tests to beneficiaries because of differentiated POS-c and POS-s.	Considering that Law No. 100 of 1993 stipulated that by 2001 both POS-c and POS-s were to be unified, the government is required to create a chronogram to unify both systems, however such unification is to be immediate for children.	In 2012 both POS-c and POS-s were unified, thus including the same goods, procedures and technologies for all groups of ages. However, in 2013 69.96% of *tutelas* for the protection of the right to health were to claim for services included in the POS, of which 75.63% came from the subsidized regime. It is noted that the unification of the POS

		shifted the denials of EPS in the subsidized regime from services not included in the POS to ones included in the POS. Hence, not having a significant decrease in denials compared to 2012 (70.93%) (Pg. 40)
EPS denial of health care services not included in the POS due to an unclear regulation to process the corresponding authorizations.	The government is required to regulate the internal procedure EPS need to follow to authorized services not included in the POS.	In 2008 and 2013 the government adopted a new regulation to set the internal procedure required, still in 2013 57.62% of denials of EPS are founded on the pertinence of the medicines and procedures ordered by the medical doctor, hence not authorizing the services (Pg. 31). In general EPS continue to deny services no included in the POS (Pg. 46)
IPS denial of health care services of people not affiliated to neither regime of the SGSSS.	According to art. 48 Constitution, the state has to guarantee health care services to all citizens. The government is required to take all the necessary measures to include still unenrolled people in the system in order to fulfil its duty of reaching universal health coverage.	In 2012 health insurance coverage reached 96.3% and the government plans for 2014 to reach 99.3%. For this it is appropriating the corresponding resources in the medium-term fiscal framework (Pg. 50). Reports on the health insurance coverage for 2014 are not available yet.

There are limitations to an approach that reduces to "structural regulation failures" the inability of the health care system to provide services to beneficiaries at the time of need. Furthermore, these limitations can be seen in two ways: (i) a limitation brought by the right-based approach used to analyse the issues and (ii) a limitation brought by the setting where the issues are being debated. The first limitation can be seen in the way the Court framed the judicial problem brought by the complaints. In this case the Court frame it in the following question "Do the regulatory failures identified in this judgment from the accumulated cases and evidence gathered by this Court, represent a violation of the constitutional obligations of the competent authorities to *respect*, *protect* and *fulfil* the right to health to ensure its realization?"[15](Corte Constitucional Colombia 2008: 11). In this way, the Court framed the analysis considering how the experienced barriers to the access of health care services were a violation of the right to health in terms of the obligation states have as duty-bearers to protect human rights. This puts at the centre the role of the state, however it leaves unquestioned the role of other actors and the dynamics of the system that as shown contribute to create such obstacles and reinforce inequality structures. The second limitation can be explained by the separation of powers theory, according to which the existence of three independent branches, executive, legislative and judicial, are essential to prevent the concentration of power in one

[15] Original in Spanish: "¿Las fallas de regulación constatadas en la presente sentencia a partir de los casos acumulados y de las pruebas practicadas por esta Sala, representan una violación de las obligaciones constitucionales que tienen las autoridades competentes de *respetar*, *proteger* y *garantizar* el derecho a la salud para asegurar su goce efectivo?"

ruling body, thus the each branch has its own role and cannot overstep its capacities. This is how the Court also framed its decision when it limited the orders given to the government in the following terms: "The orders to be imparted fall within the system conceived in the Constitution and Law No. 100 of 1993 and subsequent regulations, since it would exceed the jurisdiction of the Court to order the design of a different system, for that decision is to be taken by the legislative branch"[16] (Corte Constitucional Colombia 2008: 11)

The findings presented by the Ombudsman reveal overall that the orders to fill the "gaps" in the regulatory framework, identified as causes of unequal access to health care services, are not actually reducing the number of EPS denials and *tutelas* for the protection of the right to health. Even more, the unification of the POS for the contributory and subsidized regimes, one of the mayor reforms to the system and one that has demanded the most financial effort from the government, has had a neutral effect. Although the regulations referred above have certainly contributed to strengthen the health care system's regulatory framework and has helped set parameters of control and accountability for all the actors in the systems, major issues that incentive EPS and IPS to continue denying services are still untouched perhaps because certain structures of the provisioning model were not problematized by the Court. This could be because the discussion was confined under the framework of the state as the only duty-bearer of *respecting*, *protecting* and *fulfilling* the right to health.

Even though the Court identified a crucial aspect of the provisioning model which has been recognized as a mode of risk selection of beneficiaries, i.e. authorizations of medicines and procedures prescribed by medical doctors, its analysis referred to the "gaps" in the regulatory framework that impeded the EPS to authorize medicines procedures and technologies not included in the POS. Therefore, questions regarding how competition and profit seeking dynamics within EPS (an outcome of the marketization and privatization of health care provisioning) can create exclusionary structures in the access of services are not considered or debated. Moreover, although the Court reiterates the autonomy of the EPS and IPS medical staff, still EPS exert much control over authorizations, especially when there is a vertical integration between the EPS and IPS (same economic group), something which is allowed in the current regulatory framework. On the other hand, even though the order to unify of POS-c and POS-s certainly helped reduce the level of segmentation of health care provisioning, it has not prevented EPS to continue denying services included in the POS, thus raising questions on the potential of just analysing EPS service denials on the basis of further regulating the health care system. A complementary analysis regarding why EPS continue to deny services even when they are covered by the POS could have led to analyse for example the incentives brought by the combination of a capitated system with the marketization of health care provisioning (e.g. prices for health care services set in private contracts between EPS and IPS, competition between EPS for enrolments and with IPS for lower prices), to reduce service delivery costs. In this sense, because the UCP is diluted in the chain of intermediation arrangements between EPS and IPS, the system is prone to experience financial deficits that most likely incentive EPS and IPS

[16] Original in Spanish: "Las órdenes que se impartirán se enmarcan dentro del sistema concebido por la Constitución y desarrollado por la Ley 100 de 1993 y normas posteriores, puesto que excedería la competencia de la Corte ordenar el diseño de un sistema distinto, puesto que dicha decisión compete al legislador."

to reduce cost by denying services. As discussed before, this can have a greater impact in beneficiaries' out of pocket payments which usually affect vulnerable groups (lower income strata, women and ethnic minorities), and reinforces their position in the social ladder.

5.3. Representation in the judicial setting: who is being heard by the Court?

Debates around the effects of social and economic rights judicial enforcement in the distribution of social goods inquire what are the consequences of dealing with complex trade-offs between for example financial sustainability of social provisioning systems and the realization of people's rights. Some argue that these trade-offs are sometimes mediated by the case-by-case setting in which judges adjudicate social goods, thus having sometimes regressive effects because it directly or indirectly allocates resources to the middle income strata, as well as political and economic elites who have the opportunities and resources to access the judicial system (Ferraz 2010), and acknowledge that founding judgements on individual claims mechanisms could lead to greater inequality because litigation usually is more prevalent in the urban setting where access to the judicial system benefit more the wealthier populations (Brinks and Gauri 2012). In this sense, it is important to understand how representation works in the judicial setting because it may have the potential to influence the way judges adjudicate and resolve the claims presented to them. This is particularly important in the Colombian case because by law[17] judges can only adjudicate in the context of the claims presented in the lawsuit, even in constitutional cases like *tutelas*, notwithstanding of course the validity of the jurisprudence set by the courts as a criteria of interpretation for following cases.

Decision T-670 of 2008 has been distinguished for its broader scope of influence because it went beyond the limits of the individual claims to examine the structural failures of the health care system. It has then been characterized as a "systemic sectorial decision" (Cepeda-Espinoza 2010-2011) and part of the structural reform litigation movement (Rodriguez-Garavito 2011), thus affirming that its effects have gone beyond the people who presented the claims. As true as this may be, still the decision was influenced by issues of representation (i.e. the *type* claimant) in a way that has skewed its distributive effects in favour of the middle-high and high income strata. Since 1999, the Ombudsman has reported that approximately 60% to 80% of the claims have been presented either by beneficiaries from the contributory regime or against EPS from the contributory regime (Defensoria del Pueblo Colombia 2012, Defensoria del Pueblo Colombia 2013). This was also a finding in a study made in the city of Manizales in which 74% of the claimants in the period 2003-2004 belonged to the contributory regime (Vélez-Arango et al. 2007). This is in line with a study made by the Ministry of Health and Social Security in 2013 which measured the distribution of payments approved by FOSYGA for services not covered in the POS and claimed through *tutelas*, which revealed that 46.9% and 23.9% of those payments benefited the 5th and 4th quintiles of income per capita, respectively, compared

[17] Art. 230 of the Colombian Constitution says that judges can only rule according to the law. Further, the Court has set in its jurisprudence that the decision of *tutelas* for the protection of fundamental rights in can only be within the terms of the claim filed.

to 0.3% and 2.2% that benefited the 1st and 2nd quintiles (MSPS Colombia 2014: 6). Representation concerns are also present in terms of geographical distribution. For instance, Bogota D.C. (Colombia's capital city), Medellin (capital city of the department of Antioquia) and Cali (capital city of the department Valle del Cauca) have usually been the places were *tutelas* for the protection of the right to health are most concentrated (Defensoria del Pueblo Colombia 2012, Defensoria del Pueblo Colombia 2013). However Bogota D.C., Antioquia and Valle del Cauca have also been traditionally the regions where health care services are more available, but less demanded (Ayala G. 2014) and where poverty is less concentrated (Perez V. 2005). Finally, representation should also be evaluated considering how the health care system is functioning as a whole. The rate of people affiliated to the system that presented a *tutela* for the protection for the right to health compared to the total number of people affiliated to the system has oscillated since 2008 between 36% to 25%, meaning that around 70% of the people enrolled have not resorted to *tutelas* to access health care services (MSPS Colombia 2014: 3). In the same way, the percentage of health care services ordered by *tutelas* compare to the total number of services actually provided for instance in the period 2010-2012 represented 0.065% (MSPS Colombia 2014: 5).

Undoubtedly, the effects of decision T-760 of 2008 reached all the beneficiaries of the system, even though it was based on individual claims its effects have reached all the population, because it impacted structural arrangements of the health care system. However its distributive effects need to be carefully examined in light of how in the judicial setting adjudication is bounded by the claim itself, thus decision-making may be influenced directly or indirectly by the interest of the people who have the opportunity to access the judicial system. In this sense, considering the issues of representation in *tutelas* for the protection of the right to health, it is valid to ask if a judicial setting where adjudication is founded in individual case mechanisms is a scenario where collective interests are discussed or debated.

Chapter 6 Concluding remarks: the role of Courts in advancing social integration and citizenship

The judicialization of social relations through the litigation of human rights (especially of social and economic rights) is bringing together fields that traditionally were studied separately: the political organization of states based on the separation of powers and the assignation of specific roles and functions for each branch (legislative, executive and judicial) and the political nature of social organization through welfare policies and provisioning systems. The increasing intervention of courts and judges in the allocation of resources and the distribution of social goods such as health care, has brought new debates around the role of judges in the choice of welfare provisioning policies and its effects in the social order and in the institutional order. From the political organization of the states' perspective (judicialization of politics phenomenon) it is argued that this intervention of judges brings institutional instability and undemocratic processes of decision-making because they do not have the legitimate authority to address these political issues. From a policy perspective it is argued that the distributive potentials of judicial intervention through social rights litigation has had mix effects in equity outcomes (e.g. distribution of health care benefits amongst different social groups), sometimes being sceptic about their positive intervention because such outcomes can be skewed towards the wealthier and privileged social groups. However, considering that social policy and the choice of social provisioning systems have power to affect the organization of the social order by enhancing social integration and bring human dignity by creating citizenship-based entitlements, it is important to broaden these debates further questioning to what extent judicial intervention, as an institution through which now social policy is working, has the potential to bring social transformation, meaning the potential to influence processes of segmentation, segregation or stratification and change the processes by which people access resources and social goods.

The case of Colombia's health care system put in place by the 1993 health care reform (Law No.100 of 1993) and the judicial decision T-760 of 2008 issued by the Colombia Constitutional Court, can give us some insights of these new dynamics. The diagnosis the Court did of the unequal access to health care services, even though it was address as a "structural" failure of the system, was limited to "regulation failures", hence making the state responsible of the failures of the system to provide services. This delimitation of the problem was strongly mediated by the use of a rights-based approach for the protection of the right to health, which as discussed before, delimits rights violations as either omissions or transgressions of states, given that they are the duty-bearers of the obligations to protect, respect and fulfil human rights. In a marketizised and segmented health care system, due to the influence of neoliberal and NPM arrangements in the 1993 health sector reform, the orders of the Court to further regulate the "gaps" of the system helped only to reinforce the neoliberal model of social provisioning that reduces the power of the states to control distributive outcomes because the preferred distributive mechanism is the market (the role of the state is only to allow the market to function by correcting market failures

through regulation). This framing of the problem did help advanced the regulation of the system towards a one more in line with the protection of human rights, according to the international standards (General Observation No. 14 of 2000), however its transformative potential was limited because it did not open the space to question de model of provisioning or the marketization of health care services themselves, which as shown had important effects in sustaining commoditized forms of social provisioning and social inequality structures of segregation, polarization and stratification of social groups. Moreover, their intervention had either a neutral effect, like with the unification of the POS-c and POS-s, or regressive effects considering that people belonging to the 4th and 5th quintiles of income are benefiting more form the outcomes of the Court's intervention through the litigation of the right to health. There is a real incorporation of human rights approach in the system (from a regulatory point of view), however it seems not enough to change social inequality or discriminatory structures.

Why this mixed social outcomes in judicial interventions? An explanation to this could be given referring to the *political* importance in the choice of a specific path for welfare provisioning. As discussed earlier, distributive and redistributive institutions or mechanisms of resources and social goods not only affect people's material wellbeing (e.g. high or low health status), but also the way they are integrated in the social order (e.g. integrated horizontal vs. segregated, polarized or stratified social structures). Diverse factors in the judicial setting restrict the potential of courts and judicial decisions to reflect and address these distributive conflicts. First, considering that these conflicts are mainly brought to the courts through the litigation of rights, there is a major challenge in the operationalization of the right-based standards into social policies and provisioning systems. This because they either do not give space to address the trade-offs faced in policy decision-making processes (like when the Court limited the principle of financial sustainability of the system not to be an excuse to limit service delivery) or do not provide concrete guiding parameters to address such trade-offs given they appeal to ethical principles. Second, rights-based approaches usually address the realization of those rights through the modification of the behaviour of the duty-bearers, meaning states. This has important effects as seen in the Colombian case, because it can on one hand, reinforce social policies and provisioning models that continue to reproduce social inequality structures and commoditized entitlements and on the other, limit the inclusion of other actors, their roles, and responsibilities in the understanding and solution of the conflict (e.g. not considering the role of EPS in the failure of the system to provide services). Third, conflict resolution in judicial settings is ruled by norms and principles that confine judges to the technical interpretation of the law, even when they introduce more progressive views of social conflicts like with the incorporation of human rights norms and standards. In the Colombian case, the Court framed its orders within the understanding that it had no jurisdiction to interfere with the government's role of policy making, which resulted in putting forward solutions that referred only to the existing legal framework, either to ask for further regulation or to order its application. This is not accidental, given that judges in Colombia can only refer to the law to solve judicial conflicts. The special characteristics of judicial interventions through rights-based approaches then pose several challenges to solve distributive conflicts because they are mediated by factors that tend to limit the understanding of distributive problems and the outcomes of such processes lose their transformative

power because they fail to address important political questions regarding social integration and citizenship.

This brings us back to the important proposition of politicizing distributive and redistributive institutions or mechanisms by placing them in the broader context of universal social policy, because among other things it rescues its transformative potential by integrating an understanding of their political nature and the importance of bargaining policy choices in democratic and participatory settings. Although rights-based judicial intervention can enhance other democratic processes through the strengthening of state accountability and humanize social relations with the integration of human rights standards, the judicial setting is not a space where collective interest can be bargained. Thus, this increases the probabilities of biasing the understanding of distributive conflicts, for example by framing the problems according to the view of the people who can access the judicial system. Judicial decision T-760 of 2008 is an example of this, as discussed previously.

These reflections are not to say that the intervention of courts and judges in protecting and advancing human rights is in vain or has no positive effect in problematizing debates about distribution of social goods. In spite of the challenges judicial intervention faces in serving as a distributive mechanism of resources and social goods, their role in placing unequal distribution in the public debate is of most important value. Their intervention has serve as a catalyser of the political processes that need to take place in order to debate and bargain the way resources and social goods are being distributed. This is what is currently happening in Colombia. After decision T-760 of 2008 was issued, the Court has helped place in the public debate the still persisting problems of access to health care services to the point that today the Congress in debating a new law, Protect No. 210 of 2013, that takes as a reference the issues identified by the Court as a starting point to question the problems that the model of provisioning itself poses to health care access. Hence, the role of courts should be to problematize debates about distribution of social goods, rather than become rectors of distributive processes given the challenges they face in addressing distributive conflicts.

References

Abadia, C.E. and D.G. Oviedo (2009) 'Bureaucratic Itineraries in Colombia. A Theoretical and Methodological Tool to Assess Managed-Care Health Care Systems'*, Social science & medicine* 68(6): 1153-1160.

Agudelo, C.C.G. (2008) 'Equidad De Género En El Acceso a Los Servicios De Salud En Colombia (Gender Equity in the access to Health Care Services in Colombia)'*, Revista de Salud Pública* 10(1): 44-57.

Ariza-Montoya, J.F. and M.E. Hernández-Álvarez (2008) 'Equidad De Etnia En El Acceso a Los Servicios De Salud En Bogotá, Colombia, 2007 (Ethnic Equity in the Access to Health Care Services in Bogota, Colombia, 2007)'*, Rev.salud pública* 10(supl. 1): 58-71.

Ayala G., J. (2014) 'La Salud En Colombia: Mas Cobertura Menos Acceso (Health in Colombia: More Coverage Less Access)'*, Documentos de Trabajo Sobre Economia Regional* (204): 1-42.

Barrientos, A., J. Gideon and M. Molyneux (2008) 'New Developments in Latin America's Social Policy'*, Development and Change* 39(5): 759-774.

Brinks, D.M. and W. Forbath (2010-2011) 'Social and Economic Rights in Latin America: Constitutional Courts and the Prospects for Pro-Poor Interventions. (Symposium: Latin American Constitutionalism)'*, Texas Law Review* 89(7): 1943-1955.

Brinks, D.M. and V. Gauri (2012) 'The Law's Majestic Equality?: The Distributive Impact of Litigating Social and Economic Rights'*, World Bank Policy Research Working Paper* 5999: 1-40.

Cabrera, O.A. and A.S. Ayala (2013) 'Advancing the Right to Health through Litigation', in J.M. Zuniga, S.P. Marks and L.O. Gosta (eds) *Advancing the Human Right to Health,* pp. 1-18. Oxford: Oxford University Press.

Calderón, C.A.A., J.C. Botero, J.O. Bolaños and R.R. Martínez (2011) 'Sistema De Salud En Colombia: 20 Años De Logros y Problemas (the Colombian Healthcare System: 20 Years of Achievements and Problems)'*, Ciênc.saúde coletiva* 16(6): 2817-2828.

Castaño, R.A., D. Pinto, E. Restrepo and J. Ramírez (2008) 'Las Limitaciones Financieras Del Sector Salud: ¿Cuáles Deben Ser Los Principios y Criterios Para Asignar Los Recursos Para Lo no Cubierto Por Le Plan De Beneficios? (the Financial Limitations of the Health Sector: Which should be the Criteria and Principles to Allocate Resoruces for what is Not Covered in the Benefit Packages?)', Debates de Conyuntura Social, No. 26, pp. 1-80. Bogota D.C.: Fundacion para la educación Superior y el Desarrollo - Fedesarrollo.

Cepeda-Espinoza, M.J. (2010-2011) 'Transcript. Social and Economic Rights and the Colombian Constitutional Court'*, Texas Law Review* 89(7): 1699-1705.

Chhachhi, A. (2009) 'Democratic Citizenship Or Market Based Entitlements?: A Gender Perspective on Social Protection in South Asia'*, International Institute of Social Studies Working Papers* (No. 486): 1-39.

Chhachhi, A. and T. Truong (2009) 'Gender, Poverty and Social Justice'*, International Institute of Social Studies Working Papers* (No. 482): 1-28.

Chicaiza, L. (2002) 'El Mercado De La Salud En Colombia y La Problemática Del Alto Costo (the Health Care Market in Colombia and the Problems of High Costs)'*, Problemas del desarrollo* 34(131): 163-187.

Christiansen, E.C. (2006) 'Adjudicating Non-Justiciable Rights: Socio-Economic Rights and the South African Constitutional Court'*, Colum.Hum.Rts.L.Rev.* 38: 321-386.

Committee on Economic, Social and Cultural Rights (CESCR) (2000) United Nations Economic and Social Council. 'General Comment no. 14 (2000) on the Right to the Highest Attainable Standard of Health '. Geneva: .

Committee on Economic, Social and Cultural Rights (CESCR) (1990) United Nations Economic and Social Council. 'General Comment no. 3: the Nature of States Parties' Obligations'. Geneva: .

Congreso de la República de Colombia (2013) 'Proyecto De Ley Estatutaria 209 De 2013 Senado (Project of Statutory Law 209 of 2013)'. Proyect of Statutory Law, .

Corte Constitucional Colombia (2014) 'Comunicato De Prensa no. 21 Revision De Constitucionalidad Proyecto De Ley 209 De 2013 Senado (Press Release no. 21 Constitutional Review of Project of Law 209 of 2013)'. Colombia: .

Corte Constitucional Colombia. (2008) T-760 at 1-304.

DANE (2013) 'Encuesta Nacional De Vida 2012 (Boletin de Prensa) (National Quality of Life Survey 2012 (Press Release))'. Colombia: Departamento Administrativo Nacional de Estadistica.

Defensoria del Pueblo Colombia (2014) 'Informe De Cumplimiento Sentencia T-760/08 (Monitoring Report Judicial Decision T-760/08)', pp. 1-60. Colombia: Defensoria del Pueblo Colombia.

Defensoria del Pueblo Colombia (2013) 'La Tutela y El Derecho a La Salud 2012 (Tutela and the Right to Health 2012)', La Tutela y el Derecho a la Salud en Colombia, pp. 1-247. Bogotá D.C.: .

Defensoria del Pueblo Colombia (2012) 'La Tutela y El Derecho a La Salud 2011. 20 Anos Del Uso Efectivo De La Tutela 1992-2011 (Tutela and the Right to

Health 2011: 20 Years of Effective use of Tutela 1992-2011)', La Tutela y el Derecho a la Salud en Colombia, pp. 1-171. Bogotá D.C.: .

DNP Colombia (1998) 'Informe De Desarrollo Humano Para Colombia (Report on Human Development for Colombia)', pp. 1-169. Colombia: TM Editores: Departamento Nacional de Planeacion Mision Social.

Domingo, P. (2004) 'Judicialization of Politics Or Politicization of the Judiciary? Recent Trends in Latin America', *Democratization* 11(1): 104-126.

Dunleavy, P., H. Margetts, S. Bastow and J. Tinkler (2006) 'New Public Management is dead—long Live Digital-Era Governance', *Journal of public administration research and theory* 16(3): 467-494.

Ervin, S.J. (1970) 'Separation of Powers: Judicial Independence', *Law and contemporary problems* : 108-127.

Esping-Andersen, G. (1990) *The Three Worlds of Welfare Capitalism: Gøsta Esping-Andersen.* Cambridge: Polity Press.

Ferraz, O.L.M. (2010) 'Harming the Poor through Social Rights Litigation: Lessons from Brazil', *Tex.L.Rev.* 89: 1643-1668.

Fischer, A. (2013) 'The Political within the De-Politicised: Poverty Measurement and Implicit Agendas in the MDGs', in M. Langford, A. Summer and A.E. Yamin (eds) *The Milleniun Development Goals and Human Rights. Past, Present and Future,* pp. 119-142. United States of America: Cambridge University Press.

Fischer, A. (2012) 'Inequality and the Universalistic Principle in the Post-2015 Development Agenda', *Institute of Social Studies (The Hague), Erasmus University Rotterdam.* : 1-28.

Fischer, A. (2010) 'Towards Genuine Universalism within Contemporary Development Policy', *Institute of Development Studies* 41(1): 36-44.

Fredman, S. (2008) *Human Rights Transformed: Positive Rights and Positive Duties.* Oxford University Press Oxford.

Garcia-Subirats, I., I. Vargas, A.S. Mogollón-Pérez, P. De Paepe, da Silva, Maria Rejane Ferreira, J.P. Unger et al. (2014) 'Barriers in Access to Healthcare in Countries with Different Health Systems. A Cross-Sectional Study in Municipalities of Central Colombia and North-Eastern Brazil', *Social science & medicine* 106: 204-213.

Gauri, V. (2004) 'Social Rights and Economics: Claims to Health Care and Education in Developing Countries', *World Development* 32(3): 465-477.

Gloppen, S. and V. Gauri (2012) *Human Rights Based Approaches to Development: Concepts, Evidence, and Policy.* Vol. 5938. Washington, D.C: The World Bank.

Guerrero, R., A.I. Gallego, V. Becerril-Montekio and J. Vásquez (2011) 'Sistema De Salud De Colombia (Colombia's Health Care System)', *salud pública de méxico* 53: s144-s155.

Guzman F., K. (2014) 'Radiografia De La Oferta De Servicios De Salud En Colombia (Radiography of Health Care Service Supply in Colombia)', *Documentos de Trabajo Sobre Economia Regional* (202): 1-63.

Hirschl, R. (2006) 'The New Constitutionalism and the Judicialization of Pure Politics Worldwide', *Fordham Law Review* 75(2): 721-754.

Hirschl, R. (2004) 'The Political Origins of the New Constitutionalism', *Indiana Journal of Global Legal Studies* 11(1): 71-108.

Homedes, N. and A. Ugalde (2005) 'Why Neoliberal Health Reforms have Failed in Latin America', *Health policy* 71(1): 83-96.

Iriart, C., E. Elías Merhy and H. Waitzkin (2001) 'Managed Care in Latin America: The New Common Sense in Health Policy Reform', *Social science & medicine* 52(8): 1243-1253.

Langford, M., A. Summer and A.E. Yamin (2013) 'Introduction: Situating the Debate', in M. Langford, A. Summer and A.E. Yamin (eds) *The Milleniun Development Goals and Human Rights. Past, Present and Future,* pp. 1-36. United States of America: Cambridge University Press.

Lavinas, L. (2013) '21ST Century Welfare', *New Left Review* (84): 5-40.

Mackintosh, M. (2003) 'Health Care Commercialisation and the Embedding of Inequality', *RUIG/UNRISD Health Project Synthesis Paper* : 1-40.

Mackintosh, M. (2001) 'Do Health Care Systems Contribute to Inequalities?', in D.A. Leon and G. Walt (eds) *Poverty, Inequality, and Health: An International Perspective / Edited by David A. Leon and Gill Walt,* pp. 174-193. Oxford [etc.]: Oxford University Press.

McInerney-Lankford, S. (2013) 'International Development Actors and Human Rights', in M. Langford, A. Summer and A.E. Yamin (eds) *The Milleniun Development Goals and Human Rights. Past, Present and Future,* pp. 160-206. United States of America: Cambridge University Press.

Mejía-Mejía, A., A.F. Sánchez-Gandur and J.C. Tamayo-Ramírez (2007) 'Equidad En El Acceso a Servicios De Salud En Antioquia, Colombia (Equity in the Access of Health Care Services in Antioquia, Colombia)', *Rev.salud pública (Bogotá)* 9(1): 26-38.

Mkandawire, T. (2005) *Targeting and Universalism in Poverty Reduction: Thandika Mkandawire.* Vol. 23. Geneva: UNRISD.

MPS and SNS Colombia (2011) 'Situacion Actual De Las EPS De Los Regimenes Contributivo y Subsidiado En Colombia (Current Situation of EPS in the Contributory and Subsidized Regimes in Colombia)', pp. 1-324. Colombia: Ministerio de la Proteccion Social y Superintendencia Nacional de Salud.

MSPS Colombia (2014) 'Presentacion Ministerio De Salud y Proteccion Social. Tutela y Los Derechos a La Salud y a La Seguridad Social 2013 (Presentation Ministry of Health and Social Protection. Tutela and the Rights to Health and Social Security)', pp. 1-6. Colombia: Ministerio de Salud y Proteccion Social.

Muñoz López, O.L. (2001) 'Doble Intermediacion. Yo Contrato, tú Contratas, Él Contrata, Nosotros Ganamos, Ellos Pierden (Double Intermediation. I Contract, You Contract, He Contracts, we Win, they Lose)', *El Pulso*(3): October 2014<http://www.periodicoelpulso.com/html/jun01/general/general-09.htm>.

Orjuela, L.J. (1998) 'El Estado Colombiano En Los Noventa: Entre La Legitimidad y La Eficiencia (the Colombian State in the Nineties: Between Legitimacy and Efficiency)', *Revista de Estudios Sociales* 1: 56-60.

Perez C, M.M. and A.M. Velazques A. (2008) 'Modelos De Contratacion En El Sistema De Salud En El Marco De Las Relaciones Entre Prestadores y Aseguradores (Models of Contrating in the Health Care System within in the Relations between Providers and Insurers)', Post Graduate Degree in Social Security Management. Colombia: CES Unversity.

Perez V., G.J. (2005) 'Dimension Espacial De La Pobreza En Colombia (Spacial Dimension of Poverty in Colombia)', *Documentos de Trabajo Sobre Economia Regional* (54): 1-51.

Rodríguez Tejada, C.M., G. Molina Marín and S.A. Jiménez (2010) 'Características De Las Tutelas En Salud Tramitadas En Medellín, Colombia (Features of the Protective Actions Related to Health Processed in Medellin, Colombia)', *Invest.educ.enferm* 28(1): 92-100.

Rodriguez-Garavito, C. (2011) 'Beyond the Courtroom: The Impact of Judicial Activism on Socioeconomic Rights in Latin America', *TEXAS LAW REVIEW* 89(7): 1669-1698.

Sotelo, L.C. (2000) 'Los Derechos Constitucionales De Prestación y Sus Implicaciones Económico- Políticas. Los Casos Del Derecho a La Salud y De Los Derechos De Los Reclusos (the Constitutional Rights of Provision and their Political-Economic Implications. The Case of the Right to Health and the Rights of Inmates)', Archivos de Macroeconomia - Departamento Nacional de Planeación Republica de Colombia, No. 133, pp. 1-70. Bogotá D.C.: Departamento Nacional de Planeacion.

Townsend, P. (2004) 'From Universalism to Safety Nets : The Rise and Fall of the Keynesian Influence on Social Development', in T. Mkandawire (ed.) *Social Policy in a Development Context,* pp. 37-62. Basingstoke: Palgrave Macmillan.

Uprimny, R. and M.G. Villegas (2004) 'Corte Constitucional y Emancipación Social En Colombia (Constitutional Court and Social Emancipation in Colombia)', *Emancipación social y violencia en Colombia* : 463-514.

Uprimny, R. (2007) 'Judicialization of Politics in Colombia: Cases, Merits and Risks', *Sur* 6(4): 49-66.

Vallinder, T. (1994) 'The Judicialization of Politics—A World-Wide Phenomenon: Introduction', *International Political Science Review* 15(2): 91-99.

Vargas, I., M.L. Vazquez, A.S. Mogollon-Perez and J.P. Unger (2010) 'Barriers of Access to Care in a Managed Competition Model: Lessons from Colombia', *BMC health services research* 10: 297-6963-10-297.

Vélez-Arango, A.L., D. Cecilia Realpe, J. Gonzaga-Valencia and A.P. Castro-Castro (2007) 'Acción De Tutela, Acceso y Protección Del Derecho a La Salud En Manizales, Colombia (Tutela, Access and Protection of the Right to Health in Manizales, Colombia)', *Rev.salud pública* 9(2): 297-307.

Vos, P.D., W.D. Ceukelaire and P.V.d. Stuyft (2006) 'Colombia and Cuba, Contrasting Models in Latin America's Health Sector Reform', *Tropical Medicine & International Health* 11(10): 1604-1612.

Waitzkin, H. and C. Iriart (2000) 'How the United States Exports Managed Care to Third-World Countries', *MONTHLY REVIEW-NEW YORK-* 52(1): 21-35.

World Bank (1993) 'World Development Report 1993: Investing in Health (Overview)', World Development Reports, pp. 1-16. New York: Oxford University Press.

World Bank (1990) 'World Development Report 1990: Poverty (Overview)', World Development Reports, pp. 1-6. New York: Oxford University Press.

World Health Organization (2003) 'World Health Report 2003: Shaping the Future', World Health Reports, pp. 1-193World Health Organization.

World Health Organization and The Office of the High Commissioner for Human Rights 'Information Sheet on a Human Rights-Based Approach to Health (HRBA)'. WHO; OHCHR.

Yamin, A.E. and O.F. Norheim (2014) 'Taking Equality Seriously: Applying Human Rights Frameworks to Priority Setting in Health', *Human Rights Quarterly* 36(2): 296-324.

Yamin, A.E. and O. Parra-Vera (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): 431-460.

Appendices

Appendix 1: Further description of the Structure of the 1993 Health Sector Reform

Status: The reform created a compulsory health care scheme which obligated all citizens to be affiliate to either the contributory, subsidized regime or special regime – depending on which category of beneficiaries the citizen was classified. The reform also allowed the creation of a voluntary insurance scheme free to choose from for everybody, if interested in having complementary health care benefits.

Sector: In the compulsory health care scheme the both public and private sector can participate either as purchasers or providers, yet the benefit package offered is required to be the one established by the government. The voluntary scheme is free to be organized by the private sector. The sector can also be identified considering the origin of the sources of finance. The compulsory scheme is financed by both private and public sources in the form of private contributions, employer contributions, co-payments or public funds coming mainly from taxes. The voluntary scheme is financed entirely by out of pocket payments of individuals.

Benefit package: The compulsory health care scheme included a compulsory benefit package (POS for its name in Spanish) designed according to countries epidemiological profile, its demographic structure and the available technology. The POS for the contributory regime (POS-c) was different from the POS for the subsidized regime (POS-s). The latter only covers about 55% of the POS-c.

Purchasers: The MCOs in the reform are the EPS or health promoting enterprises. They are responsible for securing the provision of health care services by contracting/buying those services from the providers and to administer the unit capitation payment transferred by the government for each beneficiary according to the regime he/she belongs to. The reform allowed EPS to either vertically integrate with a provider to provide services within the same EPS or to contract such services from an independent provider. In the same way EPS could offer complementary plans to the POS by way of private insurance packages regulated only by the market, which in such case the EPS becomes a private insurer. EPS can take the form of private enterprises, be state-owned or mixed. The special regime conserves its own MCOs.

Providers: The providers in the system are the responsible for the actual provision of health care services. The IPS or health service provider is in charge of providing services for beneficiaries of the contributory or subsidized regime, for people with private insurance and also for people not affiliated or covered by the SGSSS. They provide the services in the way they are contracted with the EPS and receive the corresponding payment as established in such agreements. For people not affiliated to the SGSSS the government is obligated to finance

directly those services. IPS can take the form of private enterprises, be state-owned or mixed.

Beneficiaries: Law No. 100 established different categories of beneficiaries that determine the type of regime they belonged and the type of POS they were entitled to:

Special Regime	Contributory Regime POS-c	Subsidized Regime POS-s
Workers for: - Military Forces and Police. - ECOPETROL. - Teachers in public schools and universities.	People with the ability to pay: - Workers with formal labour contracts. - Independent workers who earn more than minimum monthly wage. - Pensioners	People without the ability to pay - People identified in levels 1 and 2 SISBEN - Level 3 SISBEN (partial benefits)

Either of these beneficiaries can access the voluntary scheme if interested in complementary benefits to the POS in the form of health insurance plans and through the IPS contracted by the private insurers.

Source: The compulsory scheme is finance by both private and public funds. Private origin funds can come in the form of compulsory contributions from the beneficiaries affiliated to the contributory regime, employer contributions and co-payments. These last ones are payments that the EPS receive at the time people seek the service or medicine and are paid by all beneficiaries. Public funds are directed to partially finance the subsidized regime and come from taxes and from the national and local government budgets. The main source of finance in the voluntary scheme is out of pocket payments in the form of premiums.

Funds: All the sources of funding of the compulsory scheme (leaving a side the special regime) go to a fund called the Solidarity and Guarantee Fund – FOSYGA. This fund is in charge of transferring the unit of capitation payment to the EPS to finance the services determined in the POS and contracted with the IPS. The unit of capitation payment is set by the government considering the cost of the services included in the POS, plus administration cost and is adjusted with the risk. This payment is transferred per each beneficiary and in the case of the subsidized regime is partially funded by part of the compulsory contribution set for the contributory regime.