

The role of courts in defining health policy: The case of the Colombian Constitutional Court

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In July, 2008 the Constitutional Court of Colombia (the Court) handed down a decision (T 760/08) in which it ordered a dramatic restructuring of the country's health system. The judgment came as the culmination of a formidable wave of litigation to enforce the right to health, with tens of thousand of health rights cases before the Colombian courts each year. Since 1992, the Court has staunchly upheld rights to access and treatment in the context of a highly neoliberal state, and has not shied away from decisions with substantial resource implications.

Colombia is a striking example of broader regional and global trends relating to judicial enforcement of claims for health goods and services. However, there is a wide-ranging debate in public health circles about the appropriateness and impact of such judicial interventions on health policy and health equity. Critics question, for example, whether such judicial activism distorts priority-setting and undermines the role of administrative and legislative bodies.

Although it is too early to judge implementation of the July decision, the sweeping 411-page judgment reaffirms that courts can enforce access to health goods and services as a matter of fundamental rights, even when there are substantial resource implications. It further indicates that courts can creatively approach their role in health priority-setting.

Background

Colombia is a middle income country with a per capita GDP of \$7,304 (PPP 2005), and a GINI coefficient of 58.6, reflecting a level of economic inequality that is among the highest in the world. Almost two-thirds of the 46 million population lives below the poverty line. In Colombia, a tradition of creating democratic institutions has coexisted with a reality of authoritarianism and enormous political violence, notably the 50 year-old armed conflict.

The 1990's brought dramatic, albeit contradictory, changes to both the judicial and health systems. The 1991 Constitution created a Constitutional Court, together with mechanisms such as the *tutela* (protection writ) to protect individual rights, and greatly enhanced the public's access to the courts through unfettered standing and lack of procedural requirements.

In 1993, the Colombian healthcare system underwent a major reform, with the passage of Law 100. In keeping with neoliberal ideas for sectoral adjustment in the early 1990's, Law 100 shifted government subsidies from supply to demand and created a "competitive surrogate model" which used public and private insurers as surrogates to purchase health care for insured patients, with the goal of improving efficiency. It also established a two-tier

system of benefits: (i) the contributory regime (*Plan Obligatorio de Salud*, or POS) for those formally employed; and (ii) the subsidized regime (*Plan Obligatorio de Salud Subsidiado*, POSS), which includes approximately one-half of the benefits in the contributory regime.

History of judicial enforcement of the right to health

Although coverage has increased since 1993, the Colombian health system has been widely criticized; efficiency and quality gains have generally not materialized; and patients have increasingly turned to the courts to secure treatments and services. Between 1999 and 2005, the Human Rights Ombuds Office calculates that 328,191 *tutelas* were presented relating to the right to health; in approximately 80% of those cases the *tutela* was granted. Unlike the common law system, the vast majority of these cases resolve only the dispute in the individual case before the court. Nevertheless, the sharply increasing numbers of *tutelas* –approximately 90,000 per year by 2008--are alarming.

According to the jurisprudence of the Constitutional Court, which reviews *tutela* judgments from courts throughout the country, the right to health is enforceable for plaintiffs unable to afford care: (i) when there is an inextricable relationship with “fundamental rights,” including the right to life, such that if it were not protected immediately it would result in the violation of these latter rights; (ii) when the case involves a person or group of people in especially vulnerable circumstances, such as children, pregnant women, and the elderly; and (iii) when the health good or service at issue is included in the POS /POSS, which the Court has taken to define a minimum core content of the right to health.

Based on these criteria, the Court has ordered the provision of a wide range of goods and services, including viral load tests for HIV/AIDS as well as anti-retrovirals, costly cancer medications, and even the financing of treatment of patients abroad when appropriate treatment was unavailable in Colombia. Likewise, the Court has exercised judicial control over the procedures used to determine benefits in the POS as well as those used to determine beneficiaries of subsidized care. Compliance with individual judgments, as well as broader orders, has at times been slow and irregular. However, there is no question that the Court has had a dramatic impact on prospective health policy-making and budgeting and the enforcement of existing laws.

On the other hand, the overwhelming preponderance of cases in which courts have enforced the right to health in the country as a whole relate to health goods and services that the state had already agreed to provide. A prominent 2008 study found that between 1999 and 2005, approximately 89% of the surgeries, 93% of the treatments and 84% of the procedures that were petitioned for using *tutelas* were already included in the POS or POSS, suggesting a health system with little capacity for internal regulation, where judicial recourse has become a form of “escape valve.”

A landmark decision

There are at least three key aspects of the T 760/08 holding that demonstrate the potential for courts to play a constructive role in health policymaking. First, with the aim of providing clear guidelines for policymaking, the Court not only reiterates but substantially clarifies its ample

jurisprudence regarding the enforceability of the right to health, stating that there is an actionable claim in the circumstances described above as well as, *inter alia*: (i) when access to care is impeded by the imposition of fees which the plaintiff cannot afford; (ii) when the responsible health sector entity fails to provide the information, guidance and follow-up necessary to secure an important health service; and (iii) when affordable access to services is impeded by transferring administrative costs to the user that should be assumed by the provider.

Second, the Court calls for the restructuring the benefit plans themselves. The judgment orders the National Commission for Health Regulation to immediately and on an annual basis comprehensively update the benefits included in the POS/POSS through a process that includes “direct and effective participation of the medical community and the users of the health system.” The Court further orders the appropriate executive agencies to unify the benefit plans (POS and POSS), initially for children and later for adults, in the latter case progressively and taking into account financial sustainability, as well as the epidemiological profile of the population. The process of devising a unification plan is to be participatory, transparent, and evidence-based, and must include relevant indicators and benchmarks.

Third, the Court calls for measures to reduce recourse to *tutelas* both in relation to care included in the POS /POSS, and regarding the inclusion of additional services. It further calls for: (i) measures to facilitate execution of *tutelas* by both private and public entities; and (ii) the adoption of a contingency plan to ensure appropriate and timely reimbursement from the government’s social solidarity fund (*Fondo de Solidaridad y Garantía*) to insurance companies in the event of costs associated with services not covered under the POS/POSS.

The judgment calls upon the government to adopt deliberate measures to progressively realize universal coverage by 2010, and sets various compliance deadlines in 2008 and 2009.

Discussion

The Court’s decision is notable in many respects, not least of which is its explicit adoption of the right to health framework set out by the United Nations Committee on Economic, Social and Cultural Rights (UN ESC Rights Committee) and clarified through the work of the first Special Rapporteur on the Right to Health. In keeping with the UN ESC Rights Committee’s interpretation of the right to health, the Court: (i) elaborates on the multiple dimensions of state obligations which flow from the right to health, and how monitoring and oversight are essential to protecting the right to health and accountability; (ii) reiterates that the state is responsible for adopting deliberate measures to achieve progressive realization of the right and that retrogression (backsliding) is generally impermissible; and (iii) asserts that the right to health calls for transparency and access to information, as well as for evidence-based planning and coverage decisions based on participatory processes.

Further, the Court reaffirms its jurisprudence distinguishing an essential minimum core of the right to health based on the POS/POSS, which is immediately enforceable, and other elements that are subject to progressive realization taking into account resource constraints. This

approach contrasts with e.g. the South African Constitutional Court, which has rejected the notion of a minimum core that can be enforced without regard to resources, and has instead focused on “reasonableness.”

In the past, the considerable economic impact of the Court’s decisions has sparked controversy regarding the appropriate role of the judiciary in setting spending priorities in health, leading it to oscillate between judicial deference and activism. Although no information about how the July decision has actually played out is yet available, the structural approach adopted by the Court suggests that it may avoid some of the pitfalls associated with prior decisions, as well as with the judicialization of health policy-making in general.

For example, the Court does not assume it knows best what benefits should be included under the POS/POSS, nor the precise ethical grounds for making these determinations. Rather, in keeping with recent proposals in health ethics, the decision calls for a participatory process that is transparent, based on relevant reasons and current epidemiological information, subject to revision, and enforceable. As it did in a similar structural order related to internally displaced persons (T 025/04), the Court appears likely to adopt creative mechanisms for the supervision of this judgment including public hearings with multiple stakeholders from government as well as civil society. However, next year the Court’s composition will change substantially, and it is unclear whether the new Court will assume the same degree of responsibility for overseeing the implementation of the judgment’s complex structural orders.

Further, this decision, like most of the Court’s other decisions, is directed at enforcing access to services, treatments and medications. In the past, the Court has adopted some sweeping decisions with regard to public health measures, such as vaccination campaigns for poor children (SU 225/98). Yet, paradoxically, the overall trend in judicial activism may in fact reinforce the effects of the 1993 health reform, which invested the majority of the health budget in individual insurance at the expense of public health promotion and prevention. Empirical investigation is needed to determine whether health resources are increased or merely shifted, what the effects on equity are, and whether the overall health system’s infrastructure and workforce, as well as health promotion and prevention activities are neglected as a result of policies stemming from the decision.

Yet, the impacts of Court’s activism in relation to the right to health should not be evaluated in isolation from its consideration of other economic and social rights, including housing and education, which are critical social determinants of health, as well as its progressive treatment with respect to gender and ethnic discrimination. Further, grass-roots groups have found in the Court’s jurisprudence a political banner that inspires them to use legal strategies to vindicate rights and seek social change. Nonetheless, Colombia remains a profoundly unequal society and there are clearly limits to the role of the Court in restructuring the fundamental social disparities that underlie many health inequalities.