Judgment T-760/08 July 31, 2008
(Second Review Chamber of the Colombian Constitutional Court; Justice Manuel José Cepeda Espinosa authored the opinion)

Editor's Note

The Constitutional Court has the authority to hear actions of *tutela* ('protection writ,' a flexible jurisdictional action designed to protect fundamental rights), chosen by the Court from the decisions of all the judges of the Republic. Annually, the court reviews hundreds of *tutela* cases (which represent only a small fraction of the total number of cases decided by the system). A large number of these turn on the right to health. Judgment T-760 of 2008 collects 22 *tutelas* in total relating to systemic problems in the health system, most of which addressed issues that repeatedly had been decided by the Constitutional Court. In addition, the Court addresses the resolution of a series of structural flaws in the health system. A brief description of this system follows to help the reader understand the context for the Court's decision[1].

The current system is based on Law 100 of 1993, which was promulgated in a context of structural readjustment common to the region at the beginning of the 1990s. Law 100 created a managed care system based on market mechanisms, coupled with defined benefits schemes. The system offered subsidies for demand, in contrast to the old scheme that mainly provided subsidies to the supply side of the health market.

Under 100, Health Promoting Entities (Empresas Promotoras de Salud (EPS)), which can be public, private, or mixed ownership, administered two regimes of health coverage for their insured affiliates. The contributory regime is designed for users with capacity to pay – essentially the formal employees and their dependents- obligating a designation of 12.5% of their salary to health (8.5% from the employer and 4% from the employee, or the whole contribution when the member is independently employed). The subsidized regime provides coverage to those who do not have the capacity to pay, making use of public resources and a cross-subsidy from the contributory regime. Eligibility decisions for this latter regime are made through the System for Selection of Beneficiaries for Social Programs (el Sistema de Selección de Beneficiarios para Programas Sociales (SISBEN)). The funds for the subsidized regime are administered by the regional governments' health entities, which in turn contract with the private health industry. Additionally, there exists a third regime for linked participants (*participantes vinculados*) who do not have the capacity to pay and have not been included even in the subsidized regime. These people in theory should have access to subsidized

[1] For a detailed description of the system, consult the second chapter of "*The right to health from the perspective of Human Rights and the system of inspection, monitoring, and control exercised by the Colombian State in matters of health complaints*" Attorney General of the Nation and DeJusticia. Bogotá. 2008.

acre through the public network.

Under Law 100 users are free to affiliate with the EPS of their choice, resulting in competition amongst the providers. In the same way, the EPS's are free to contract with different Health Care Providing Institutions (Instituciones Prestadoras de Salud (IPS)) for services for their members. Benefits are defined according to an Obligatory Health Plan (Plan Obligatorio de Salud (POS)), and the Obligatory Subsidized Health Plan (Plan Obligatorio de Salud Subsidiado (POS-S)), for the contributory and subsidized regimes respectively. The POS-S contains approximately half the benefits of the POS.

Finally, the financing of the system as a whole is through a capitation scheme, (Unidades de Pago por Capitación (UPC)). The UPC corresponds to the value that is paid to the EPS for each user as an insurance premium for the POS coverage. The resources of the system are administered through the Solidarity and Guarantee Fund (el Fondo de Solidaridad y Garantía (FOSYGA)). This fund manages four independent sub-accounts, which serve to finance and compensate the entities in the distinct regimes. The users also pay copayments at the point of service.

Edited Judgment[2]

The present judgment consists of four principle parts. The first two relate to the proceedings in the individual cases collected in the present action, and the account of the evidence decreed by the Review Chamber appear in the annex, which constitutes an integral part of the present judgment. The other two parts [which are considered below] are (III) the *considerations and foundations* of the judgment, taken in light of the cases as considered individually and together; and (IV) the *resolutions* adopted.

(…)

In the present judgment, the Constitutional Court examines multiple cases that invoke the protection of the right to health –specifically, the access to needed health services–, whose solution has been clear and reiterated in the jurisprudence of this Court. These cases refer to diverse situations in which the access to the required health services was denied. These situations are the following: access to health services contemplated in the obligatory health plan, POS, dependent upon copayments; access to health services not included within the POS; access to health services required by a minor for his or her adequate development; recognition of the inability to work even when timely

[2] Note that most of the footnotes in the original judgment have been eliminated. Furthermore, the original judgment is 411 pages long; not all of the topics addressed by the Court could be covered here.

required payments are not made; access to health services in conditions of integrality; access to high cost health services and treatments of catastrophic illnesses, such as diagnostic exams; access to the health services required by those linked to the Health System, especially for minors; access to health services when they require travel and living in places distinct from that in which the person resides; freedom of choice of the '*entity charged with guaranteeing access to the provision of health services'* [health care provider], and doubt surrounding the inclusion of an intraocular lens in the POS and the appropriateness of recovery. Also presented before this Chamber were cases in which an EPS asked for timely reimbursement of the expenses for a medical service not covered by the POS.

(…)

All of the general problems can be joined in one particular problem: ¿Do the regulatory failures in the present judgment presented through the individual cases joined here and the evidence presented to this Chamber, represent a violation of the constitutional obligations of the competent authorities to *respect, protect, and fulfill* the right to health and its effective enjoyment? To this question, we respond affirmatively and we impart the orders necessary to overcome these detected failures of regulation. The orders that we impart are framed within the system conceived by the Constitution and developed by Law 100 of 1993 and its posterior norms, as it would exceed the competence of the Court to order the design of a distinct system, as that is a decision for the legislature. The orders will require the legally competent organs to adopt the determinations that will enable them to overcome the failures of the regulation that have resulted in failures to the protect the right to health, as evidenced by the actions of *tutela* that have been brought with increasing frequency for several years.

(…)

2.3. Structure of the Decision

To analyze and resolve the legal problems set forth, the present judgment tackles those problems in the following form. First, we point out that the right to health is a fundamental right, both as it is usually considered doctrinally in terms of a social right, and when considering its important *programmatic* dimension, which refers to its role in guaranteeing the provision of the health services. Second, we analyze the characteristics of this fundamental right and the pertinent rules that have been adopted by the jurisprudence to assure access to health services as a specific scope of protection. These rules are later applied to concrete cases. Third, we discuss the implications of the fundamental nature of the right to health in terms of the regulatory decisions adopted by the Court, and we impart the corresponding orders so that the competent authorities adopt the necessary measures.

3. The right to health as a fundamental right

The right to health is a fundamental constitutional right. The Court has protected it in three ways. The first has been to establish its connection with the right to life, the right to personal integrity, and the right to human dignity, which has permitted the Court to identify aspects of the essential nucleus of the right to health that are worthy of protection through the *tutela*. The second has been to recognize its fundamental nature in contexts in which the *tutela* claimant is subject to special protection, which has called for the Court to assure that a certain scope of required health services be effectively guaranteed. The third has been to affirm in general the fundamental nature of the right to health with respect to a basic set of services, which coincides with the services contemplated by the Constitution, the bloc of constitutionality, the law, and the obligatory health plans (with the necessary extensions to protect a life of dignity).

(…)

3.2. The Fundamental Right to Health

3.2.1 The Constitutional Court has recognized the fundamental nature of the right to health. In the present judgment, the Review Chamber does not analyze the concept of "*fundamental right.*" This category is the object of innumerable doctrinal and judicial debates, such that here we do not pretend to put an end to the discussion. As such, we do not seek to define what a fundamental right in general is, nor what criteria are used to identify its limits, among other matters. (…)

3.2.2. One of the aspects in which the constitutional jurisprudence has advanced is in signaling that recognizing the fundamental character of a right does not necessarily mean that all aspects covered by it are susceptible to protection through the *tutela*. This has two principle reasons. First, constitutional rights are not absolute, that is to say, they may be limited in accordance with criteria of reasonableness and proportionality as set by the constitutional jurisprudence. Second, the possibility of enforcing the obligations derived from a fundamental right, and the merits of doing so through the action of *tutela*, are distinct and separable issues.

(…)

3.2.4. The Constitutional Court initially held that the action of *tutela* was a tool aimed at ensuring the effective enjoyment of the rights to traditional freedoms and of other rights like the right to life. However, also since its inception, the jurisprudence understood that some of the obligations arising from the right to health, even though they had a *programmatic* character and realization was progressive, were directly susceptible to protection through the *tutela*, as they constituted obligations upon which the rights to life or personal

integrity, for example, depended. (…)

3.3.1. The right to health has a strong positive dimension, although it also has negative dimensions. Constitutional jurisprudence has recognized from the outset that the state, or its people, could violate the right to health, either by omission, such as by failing to provide a health service, or by an action, such as engaging in conduct which results in damage to a person's health. With respect to the negative dimensions of the right to health, from which the obligation for positive action is not derived but rather from which instead we derive obligations of abstention that do not imply that the state do anything, there is no reason whatsoever why there would be obligations whose performance is delayed until the State, person, or entity has sufficient resources and adequate administrative capacity.

3.3.2. The Court does not find that the positive aspects of a law are always subject to a gradual and progressive protection. "*When the failure to meet the minimum obligations places the holder of the right to health in imminent danger of suffering unreasonable harm*", such holder can immediately claim the judicial protection of the law. The approach suggested by the case law to determine when such a situation applies is one of *urgency* (...)

(...) Since its inception, the constitutional case law has indicated that while the *programmatic* character of constitutional rights is "closely" related to the economic, social and cultural rights, we are not presented with two identical categories, just two categories that overlap.

3.3.6. Some of the obligations that arise from a fundamental right and that have a *programmatic* character, are to becarried out *immediately*, either because they require a simple action of the State, which does not require additional resources (e.g., the obligation to provide information of their rights to patients before undergoing a medical treatment), or because, despite the need to mobilize resources required, the severity and urgency of the case requires an immediate state action (e.g., the obligation to take appropriate steps to ensure health care for every baby during his or her first year of life—art. 50, Political Constitution). Other obligations of *programmatic* character derived from a fundamental right are carried out *progressively*, because of the complexity of the actions and resources required to guarantee the effective enjoyment of these protective aspects of the right. (...)

3.3.7. Now then, the Court not only recognizes that the defense of many of the *programmatic* facets of a constitutional right require diverse and complex actions by the state. It also recognizes that the authorities constitutionally established for this labor have the responsibility to decide what actions and measures are necessary to guarantee the right of the claimant. (...)

3.3.9. In constitutional jurisprudence, when the effective enjoyment of a fundamental constitutional right depends on progressive realization, "*the least*

[the responsible authority] must do to protect a programmatic provision derived from the positive dimension of a [fundamental right] under the Rule of Law and in a participatory democracy, is, precisely, to have a program or a plan designed to ensure the effective enjoyment of that right. (...)"

As a consequence, the constitutional obligations of *programmatic* character, derived from a fundamental right, are violated when the entity responsible for guaranteeing the enjoyment of a right does not even provide a program or a public policy that would permit the progressive advancement in the fulfillment of its corresponding obligations. (…)

(…)

3.3.14. In conclusion, the *programmatic* and progressive aspect of a constitutional right allows its holder to legally demand at least the existence of a public policy, aimed at ensuring the effective enjoyment of the right, which includes mechanisms for stakeholder participation.

3.3.15. In the event that the *tutela* judge finds a violation of the *programmatic* facet of a fundamental right, he must protect that fundamental right by adopting orders to ensure its effective enjoyment. [But such orders should be] respectful of the process of public debate, decision and policy implementation, characteristic of a democracy. Therefore, it is not his duty to tell the responsible authority, specifically, what should be appropriate and necessary to ensure the effective enjoyment of the right, but rather he must adopt the decisions and orders to ensure that such measures are taken, promoting at the same time citizen participation. (...)

[Although the judgment has a complete annex describing the right to health under international law, the Court proceeds to set out the analytical categories through which the obligations arising from the right to health have been characterized under the International Covenant on Economic, Social and Cultural rights (ICESCR), as detailed by *General Comment* No. 14 (2000) of the UN Committee on Economic, Social and Cultural Rights (the Committee)]

(...) For the Committee, the ICESCR recognizes that states have three types of obligations derived from the recognized rights: obligations to *respect*, obligations to *protect* and obligations to *fulfill*.

(…)

The Review Chamber notes that there is now an open discussion in the jurisprudence and doctrine in relation to what are the obligations arising from a fundamental right. There is relative agreement as to which types of obligations would fall under the two initial classifications, the obligations to *respect* and to *protect*, but not the third. The obligations to *fulfill*, which some

authors call to *guarantee*, to *ensure* or to *satisfy*, have not been defined in a definitive way without disagreement. (...)

3.4.2.9.1. The Committee indicates that the obligation to *respect* "requires that States refrain from interfering directly or indirectly with the enjoyment of the right to health." (...)

3.4.2.9.2. The obligation to *protect* "requires that the States take measures to prevent third parties from interfering with the implementation of the guarantees provided for in Article 12" (ICESCR, 1966). (...)

3.4.2.9.3. The obligation to *fulfill* "requires States to take appropriate legislative, administrative, budgetary, judicial or other measures towards the full realization of the right to health." (I) For the Committee, the obligation to *fulfill* (*facilitate*) "in particular requires that the States adopt positive measures that permit and assist individuals and communities to enjoy the right to health." (ii) States are also obligated to *fulfill* (*provide*) a specific right enshrined in the Covenant "in cases where individuals or groups are unable, for reasons beyond their control, to exercise that right themselves by using means at its disposal." (iii) The obligation to *fulfill* (*promote*) the right to health "requires the States to undertake activities to promote, maintain and restore health to the population."

3.4.2.9.4. This classification of obligations arising from a right has various uses. It allows, among other things, the characterization of the type of violations of a law, distinguishing the legal implications in each case. In this way, for example, it can be argued that the fact that some of the duties of *protection*, that are costly and also progressive in nature, do not, in any way, impede the intervention of a constitutional judge in cases where the judge's duty is to avoid the disrespect of the law, removing the barriers to the effective enjoyment of the respective rights. (...)

(…)

3.5. Limits on the Right to Health. Examples of Limitation on access to services.

3.5.1. As the fundamental right to health is limited, the benfits plan need not be infinite but can be circumscribed to cover the health needs and priorities determined by the competent autorities in light of the efficient use of scarce resources. Consequently, the Constitutional court has on numerous occasions denied services solicited through *tutelas*. For example, the Court has denied cosmetic services. Although obesity can in the long run have consequences for the health of a person, every individual has the obligation of taking care of his own health and therefore trying to prevent the diseases that arise from being overweight. Only when obesity reaches a level where it poses definite and potentially irreversible dangers to a person's life and personal integrity does

the prescribed surgery aquire constitutional relevance which ahs led to tutelas being conceded. The same applies to dental care, as healthy and complete teeth are desirable but are far from necessary to preserve the life or personal integrity of a person or to permit a life of dignity. The Court has even agreed that the benefits plan can exclude fertility treatments. The list of examples of health services that the Court has agreed may be excluded from the POS--even when a doctor has prescribed them—could go on but it is unncessary to provide an exahustive list of all the caess where the Court had found thatthe right to health has reasonable and Constitutionally justifiable limits.

3.5.2. The Court lists some examples of cases in which treatments and services have been denied, including: (i) *cosmetic treatments and surgeries(...)*; (ii) *eyeglasses and refractive eye surgery(...);* (*iii*) *fertility treatments(...)* ; (*iv*) *Alcoholic rehabilitation/detoxification(...);* (*v*) *prostheses not included in the POS (...);* (*vi*) *gastric bypass surgery (...);* (*vii*) *dental services (...);* (*viii*) *certain Allergy treatments using vaccines (...).*

4. Access to quality, timely, and effective health services, guaranteed by the fundamental right to health

[Part 4 provides a summary of the rules of the Constitutional Court jurisprudence on the right to access quality health services in a timely and efficient manner. These rules are subsequently applied to the concrete cases resolved in the *tutela*. The formulation of the rules is accompanied by extensive case law that shows how they have been implemented.]

4.1. Existence of a health system that guarantees access to health services

(….)

4.1.3. In order for essentially everyone to access health services, the State is responsible, under the Constitution (art. 49 CP), to satisfy the following requirements: (i) *organize*, (ii) *direct* and (iii) *regulate* the provision of health services; (iv) establish policies for the provision of services by private entities, and exercise (v) *monitoring* and (vi) *oversight*; (vii) establish the respective powers of the national and local authorities, as well as members of the public, and (viii) determine their respective roles and responsibilities on such terms and conditions outlined in the law. (...)

[The Court then describes some examples of neglect and disregard of the right to health due to failures in oversight and regulation.]

4.2. Membership in the System and ensuring the provision of health services

(…)

4.2.2. Constitutional jurisprudence has recognized the constitutional right of everyone to have their employer ensure their affiliation under the social security system in health, in accordance with the Constitution (art. 48, 49 and 53) and the law (art. 152, num 2. and Art. 161, Act 100 of 1993). In cases where employers fail to fulfill their obligation to respect the right to health of their employees, by not ensuring their affiliation with the health system, case law has protected the rights of the employees, recognizing the responsibility of the employer under the law. (...)

(...) The Court has considered, for example, that the legislator disrespects the right to health by discriminating, in demanding from families formed by *de facto* marital unions an unreasonable requirement—that they have been in a two-year relationship—to access the Health System, which was not required of the families formed by legal marriage.

(…)

4.3. Judicial notice of the adequate and necessary information to access health services with freedom and autonomy

(…)

4.3.2. The EPS have the duty to give people the information necessary to enable them to know what health services they require, what are the chances of success and risks of the treatment, as well as how to access the required health services. The case law has indicated that an EPS does not violate the right to health when, through its affiliated doctor, the patient has been given simple, intelligible, accurate, and reliable information about the risks involved in the procedure or treatment that is to be carried out. The duty to inform and guide the patient with regard to the treatments to pursue and the institutions that provide such treatments, is also the responsibility of the IPS.

4.3.3. The information should provide people with the names of different actors within the health system (employers, the Superintendency of Health, EPS, IPS, and local governments' health entities) and should be delivered before the moment of affiliation. So that a person can exercise his freedom of affiliation (art. 153, Law 100 of 1993), he must have sufficient information to enable him to know (i) what options for affiliation are available to him, and (ii) the performance of each of the institutions, in terms of their respect for the effective enjoyment of the right to health. (...)

4.3.4. The EPS in the context of the subsidized regime have the obligation to provide the necessary information and support to individuals, including information regarding the health services that may be required which the institution is not obliged to guarantee. (...)

4.4. Right to have the responsible entities ensure access to efficient, timely and quality health care

(…)

4.4.1. *The right of access to services that are "necessary".*

Everyone has the constitutional right to be guaranteed access to the *required* services, that is, those services that are indispensable to maintain one's health when one's life, personal integrity or dignity is seriously threatened. The current constitutional order gaurantees every person at least access to services upon which his minimum level of subsistence (*mínimo vital*) and dignity as a person depend. The form in which a person's access to health services is guranteed depends upon the manner in which he is affiiated with the Health System.

(…)

4.4.2. *The scientific opinion of the physician is the main criterion to determine whether a health service is required, but is not the exclusive criterion.*

In the Health System, the person responsible for deciding when someone requires a health service is the physician, as the physician is able to decide based on scientific criteria and because he knows the patient. Constitutional jurisprudence has held that the relevant opinion to be used is that of the physician attached to the entity responsible for ensuring the provision of the service. Therefore, in principle, the protection of *tutela* will often be denied when it is invoked without such an opinion.

Constitutional jurisprudence has protected the right to health through the tutela when the service is required according to the attending physician, but not when the service is merely useful and the atttending physician recommends its use.

(...)

[The Court goes on to say that its jurisprudence has not been formalistic and EPSs should accept the opinions of outside physicians as "attending physicians" when they are the appropriately specialized practitioners in a given area or their expertise makes their opinions relevant]

4.4.3. *Access to required services, included and not included within the obligatory plans.*

(...) Currently, access to health services depends, in the first place, on whether the service is included in one of the obligatory health service plans to which the person is entitled to be affiliated. Thus, given the current regulations, the services required can be of two types: those that are included within the Obligatory Health Plan (POS) and those that are not. [The Court then describes the norms in which it has sought to establish mechanisms for access to health services not included in the POS.]

(…)

Currently, the jurisprudence reaffirms that the right to health of a person who requires medical services not covered by the obligatory health plan is violated, when "(i) *the lack of the medical service violates or threatens the rights to life and personal integrity of those who need it*, (ii) *the service can not be replaced by another that is included in the obligatory plan*, (iii) *the patient can not afford to directly pay for the service, nor the amounts that the health care provider is legally authorized to charge, and can not access the service by another different plan, and* (iv) *the medical service has been ordered by a doctor attached to the entity charged with ensuring the provision of the service to those requesting it.*" (...)

4.4.4. *Rule for resolving conflicts between the physician and the Scientific Technical Committee.*

(…)

4.4.4.2. [T]here also exists a gap in regulation with respect to the rules for resolving conflicts between the physician and the Scientific Technical Committee over whether or not a person requires a health service not included in the POS. In 2002, after confirming that there was a normative gap surrounding the issue, and that the gap represented an obstacle to the enjoyment of the right to health, the Constitutional Court decided that "*until we establish an expeditious procedure for resolving, based on clear criteria, the conflicts between the physician and the Scientific Technical Committee of an EPS, the decision of a physician to order a drug excluded from the POS, which he deems necessary to safeguard the rights of a patient, must prevail and be respected, unless the Scientific Technical Committee determines othwise based on (i) opinions of medical specialists in the field in question, and (ii) a full and sufficient knowledge of the specific case under discussion.*"

(…)

4.4.5. *Copayments, in addition to being reasonable, cannot constitute barriers to the accessing of health services for those who do not have the economic capacity to pay.*

(…)

4.4.5.1. *Copayments can not constitute barriers to accessing health services.*

4.4.5.1.1. Everyone has the constitutional right not to be denied access to health services, so the provision of the health services cannot be conditioned on the payment of a sum of money when the individual lacks the financial ability to pay. (...) [The Court describes in detail the regulation and jurisprudence related to the copayments.]

(…)

4.4.5.1.9. [T]he jurisprudence has held that it is constitutionally prohibited to make the provision of services contingent upon the payment of copayments for a child whose guardian does not have the resources to cover those costs. (...)

4.4.5.3. *Determination of the economic capacity, in each case. The concept of bearable burden.*

A person lacks the capacity to pay when he does not have the resources to cover a certain cost, or when it affects his "subsistence minimum" (*mínimo vital*). As the constitutional jurisprudence has reiterated in several cases, the right to the subsistence minimum is not a "*quantitative*" issue, but rather a "*qualitative*" one. The subsistence minimum of an individual depends on the specific socioeconomic conditions in which he finds himself, and the obligations that weigh on him. (...) [The Court describes several instances in which the jurisprudence has protected the rights of people with some capacity to pay to have access to free services, and some cases where people without much capacity to pay have been ordered to participate financially in the cost of a health service.]

4.4.5.5. *Rules regarding evidence to establish the economic capacity.*

Under the constitutional jurisprudence, it is not acceptable for an EPS to refuse to authorize the provision of a health service not included within the obligatory plan because the patient has not shown that he can assume the cost of the health services required. The EPS has information about the economic condition of the patient, allowing it to infer whether or not the patient can cover the cost. Therefore, one of the duties of the EPS is to assess whether or not, from the available information or the information requested from the person concerned, the patient lacks the means to bear the financial burden. (...)

4.4.5.7. *Entities in the health sector cannot impede access to health services, in an effort to obtain payment for the service.*

An entity responsible for ensuring the provision of a health service required by an individual, or an entity charged with such provision, cannot coerce a person

to sign any legal document to guarantee payment as a condition of access to health services, especially when the service is *required with necessity*. (...)

4.4.5.8. *An entity cannot deny access to a health service, based on the patient having failed to make certain contributions, when the entity is in part responsible for such failure.*

(...) when a health care promoter has not made use of different charge notification and recovery mechanisms that are within its power to secure payment of overdue contributions, it must accept some of the responsibility, and therefore, cannot use the non-payment or late payment of the contributions as justification for refusing to recognize the worker's incapacity to work.

4.4.5.9. *The duty of solidarity and of assuming bearable burdens.*

When a person with economic capacity has not paid the cost required to access a health service not covered by obligatory health plan, the barrier to access is imposed by that same person, not by the health entities. (...)

4.4.6. *The provision of the services must be timely, efficient and of quality. The principle of integral care.*

When the service included in the POS has been approved by the entity in question, but its provision has not been guaranteed in a timely manner, resulting in negative health effects, such as subjecting a person to severe pain, the right to health is also violated and should be subject to *tutela* by the constitutional judge. (...)

4.4.6.1. *The entities must integrally guarantee access to required health services.*

The principle of integral care has been applied by the Constitutional Court in situations in which required health services are split or separated in such a way that the entity authorizes only a part of what the individual must receive to regain his health and forces him to pay for the other part of the required medical service himself. (...)

This principle has been developed in the jurisprudence of the Constitutional Court, based on various legal norms and refers to the comprehensive care and treatment, as prescribed by the treating physician, to which the users of the social security system in health are entitled.

(…)

4.4.6.2. *Transport and accommodation as a means to access a service.*

(…)

The constitutional jurisprudence, based on the applicable laws and regulations, has stated several times that everyone has the right to access required health services, which may involve the right to means of transport and the costs of stay to receive the necessary attention . Thus, for example, the Court has noted that the obligation to bear the cost transportation is transferred to the health promoting entity only in the specific situations in which it can be shown that *"(i) neither the patient nor his relatives have sufficient financial resources to pay the value of the transfer; and (ii) the absence of treatment would threaten the life, physical integrity or health status of the user."* (...)

(...) The Court also has guaranteed the possibility of providing the means of transport and transfer of a companion when it is needed. (...)

4.4.6.4. *The principle of continuity; access to a health service must be continuous and can not be stopped suddenly.*

Since the beginning of its jurisprudence, the Constitutional Court has upheld the right of every person to the continuity of the health service, once it has been initiated. The Court thus guaranteed that the health service would not be interrupted suddenly before recovery or stabilization of the patient. (...) A health care provider may terminate the formal legal relationship with the patient in accordance with relevant standards, but that does not mean that it can immediately terminate the legal-material relationship, especially if the individual is guaranteed access to a health service. (...)

4.5. **Access to health services required by the subjects of special constitutional protection, such as children.**

4.5.1. The Constitutional Court has recognized the right to health of the subjects of special constitutional protection. Firstly, it has protected the children, whose right to health is expressly recognized as fundamental by the Political Constitution (art. 44 CP). [Reference is made to other subjects of special protection, such as pregnant women, the elderly and people with disabilities, those associated with the armed forces and those persons deprived of liberty.]

(...) The Political Constitution, to protect minors, recognizes the special status and value of their rights. For one part, those rights are considered to be *fundamental*, affecting both the content of the right and the acceptable mechanisms to claim their protection. For another part, the rights are given special value to indicate that "*children's rights take precedence over the rights of others*" (art. 44 Political Constitution) (...)

(…)

[In Part 5, the Court decides the 22 cases accumulated in the process of *tutela*.]

6. Recurrent problems illustrated by patterns of violations of the right to health. Orders to the regulatory bodies to ensure the effective enjoyment of the right to health.

The specific cases described in the preceding section reflect a structural problem with the Social Security System in Health generated by, among others reasons, various failures in regulation. (...) As the same situations continue to be repeated, the number of *tutelas* relating to access health services has increased strongly.

(…)

The Chamber wonders then if there is sufficient protection with a case by case approach, or whether, before a pattern of violation of rights, as in this case with health, the Chamber must make decisions that indicate that the bodies also overcome failures of regulation that have led to the repeated violation of the right.

… in this judgment the Court will adopt, in addition to the decisions taken to resolve individual cases, different measures destined towards the bodies responsible for regulating the health system intended to correct the flaws in the regulation, as well as the obstacles arising from the implementation of the existing regulations that affect the effective enjoyment of the fundamental right to health of the system's users. (...)

(…)

6.1. Orders relating to benefit plans

(…)

The health plan must be defined and updated[3] by the National Council on Social Security in Health. However, Law 100 of 1993 did not set deadlines for the update, an aspect of the law which will be discussed later.

The legislature established in Law 100 of 1993 that in the first seven years of the General Social Security System in Health, the obligatory health plan of the

[3] Law 100 of 1993 does not set a term in which the Obligatory Health Plan should be revised and/or updated by the National Council of Social Security in Health. In this regard, paragraph 2 of Article 162 of the Act states: "*The health services included in the Obligatory Health Plan will be updated by the National Council of Social Security in Health, in accordance with changes in the demographic structure of the population, the national epidemiological profile, the appropriate technology available in the country and the financial conditions of the system.*"

contributory regime would likely contain more health services than the obligatory plan of the subsidized regime. Starting from the seventh year of operation of this law (i.e., before 2001) all members of the General Social Security System in Health, regardless of the regime to which they belong, should have had access the same list of health services (Art . 162, incs. 2 and 3 of Law 100 of 1993). As such, it was established that those 'linked' members would progressively join the subsidized regime and its benefit plan, in a progressive manner until universal coverage is achieved in 2001.

(…)[The Court describes the rules governing the definition and content of the obligatory health plans.]

6.1.1. ***Measures to eliminate uncertainty about the content of benefit plans and to update them regularly.***

6.1.1.1. *Analysis of the problem and the current situation.*

6.1.1.1.1. Article 162 of Law 100 of 1993 which regulates the *Obligatory Health Plan*, orders in the second paragraph the update of the POS as follows: "The health services included in the Obligatory Health Plan will be updated by the National Council on Social Security in Health, in accordance with changes in the demographic structure of the population, the national epidemiological profile, the appropriate technology available in the country and the financial conditions of the system."

The authority to affect this update was assigned to the National Council on Social Security in Health[4] by the same norm: "*The National Council on Social Security in Health will have the following functions: 1. Define the Obligatory Health Plan for members according to the norms of the contributory and subsidized regimes, in accordance with the criteria of the third chapter of the first title of this book. (...) 5. Define the essential and generic drugs that will be part of the Obligatory Health Plan."* (Art.162, Law 100 of 1993).

[The court describes the norms which were adopted for the obligatory health plans since 1994 and the norms and court decisions that changed and added to those norms in later years.]

Making changes in the POS, albeit a measure that may eventually contribute to improving the coverage or the provision of health services within the Health System, does not correspond to an *update*, as required by the law. The *update* presupposes, more than just detailed adjustments. Rather, it requires a systematic review of the POS with regard to: (i) changes in demographic structure, (ii) the national epidemiological profile, (iii) appropriate technology

[4] The National Council on Social Security in Health has subsequently been replaced by the National Commission on Health Regulation

available in the country and (iv) the financial conditions of the system. (...)

Besides the problems associated with medical services excluded from the benefit plans and the absence of a comprehensive review, many of the *tutelas* that are brought requesting access to services have their origin in the existence of doubts about what is included or excluded from the POS and the absence of institutional mechanisms within the Health System to resolve this uncertainty.

[The Court transcribes some interventions that were sent to the Constitutional Court to illustrate the uncertainty facing the contents of the POS. These documents include excerpts of documents from the Ministry of Social Protection and Ministry of Finance which set out opposite positions with respect to the inclusion of the intraocular lens for cataract surgery. While the Ministry of Social Protection states that it is included, the Ministry of Finance says that is not included and is not funded in the UPC.]

6.1.1.1.3. Beyond any consideration of the arguments upon which each of these entities bases its interpretation of the inclusions and exclusions of the POS, this shows that there is no certainty about what inputs, procedures and interventions are included and which are not. (...)

The Health System, through regulation, does not provide a specific mechanism or criteria for interpretation, with some exceptions as indicated here and below, to resolve doubts about whether a health service is included, not included or affirmatively excluded. For its part, given this regulatory vacuum and the need to resolve cases in which there were disagreements about the inclusion of a health service in the POS, the jurisprudence has continued to note some criteria for interpretation that must be taken into account in these cases. (...)

(i) *The inclusions and exclusions of the POS should be interpreted according to relevant criteria, relating to the purpose of recovery of the health of the person concerned and the principle of integral care.* (...)

(ii*) In case of doubt about whether or not a health service is excluded from the POS, the Court should apply the interpretation most favorable to the protection of individual rights, in accordance with the principle 'pro homines'*. (…)

(…)

While the jurisprudence of the Constitutional Court has adopted the criteria above in resolving the questions raised as to the contents of the POS, there is an urgent need to determine, ultimately, what health services are included in the Obligatory Health Plan and what services are not. (...)

Besides the importance of clearly defining the content of the benefit plans for

purposes of protecting the right to health of the users, this aspect is essential to clarify the scope of financing of the UPC and the cases in which reimbursement is appropriate from the Fosyga, as these resources are provided only for cases in which the service is not included in the POS and the patients lack the resources to pay for the services themselves.
(…)

[The Court describes the regulation of per capita unit of payment, UPC, based on the criteria which must be defined and updated, and the norms through which these updates have been made. It notes that a comprehensive update of the POS and the POS-S must ensure that medical services are effectively financed through an updated UPC.]

(…)

6.1.1.2. *Specific orders to impart.*

(...) [The Court gives orders about the updating of the POS, periodic review of the POS and mechanisms to identify EPS that violate rights. See in the resolution portion of this judgment the sixteenth to the eighteenth orders.]

6.1.1.2.2. Likewise, the decision to eliminate services that were previously included in the POS can be based on technical reasons about the relevance of their provision, as well as on the fundamentals for the prioritization of health resources and the social impact assessment of the provision of various services. As long as the grounds upon which these services are removed are designed to protect the right to health according to the needs of the population, the Chamber considers that, *prima facie*, such elimination is not regressive. The same applies in the event that the benefit plan is conceived from a different perspective than the current one, e.g., by disease or another criterion for the inclusion of health services. Again, the right to health is not absolute but limited. However, the limitations on the right must be reasonable and proportionate. In other words, although the benefit plan does not contain an infinite selection of services, the limiting of included health services must respect the principles of reasonableness and proportionality in a context of allocation of resources according to health priorities. It is therefore essential to carefully justify each deletion as a measure that better allows for addressing new priorities in health, and not as a reduction in the reach of the right.

(…)

6.1.2. ***Unification of the Benefit Plan. Immediate unification in the case of children. Design of a program and schedule in the case of adults.***

6.1.2.1. *Analysis of the problem and the current situation*

While the regular updating of the benefit plan and its classification will reduce

the uncertainty that impedes access to health services and reduce the need for people to resort to *tutela* in order to effectively enjoy their right to health, these measures are insufficient as long as there persists differences in the benefits of the plan in the contributory scheme and those of the subsidized plan. (...)

6.1.2.1.1. The Court recalls that in addition to the regular updating of Benefit Plans, one of the obligations under Law 100 of 1993 was their progressive unification in the contributory and subsidized regimes, until full unification would be achieved in 2001. In effect article 157 of that norm states: "*From the year 2000, every Colombian must be linked to the System through the contributory or subsidized regimes, in which the health plans will be progressively unified so that all inhabitants of the national territory receive the Obligatory Health Plan referred to in article 162*."

In turn, Article 162 sets the year 2001 as the term to complete the unification. (...)

Despite these intentions, derived from clear legal mandates and explicitly endorsed by the National Council on Social Security in Health, to date there has been no program realized that defines specific goals for the progressive rapprochement of the two plans nor a timetable that would support such a goal, setting clear deadlines for the accomplishment of each step. In other words, there now exists a violation by the State of its constitutional obligation of progressive fulfillment consisting in the unification of the obligatory benefit plans to guarantee the right to health on equal terms. While it is an obligation of progressive fulfillment, the State currently violates the minimum degree of compliance as it has not adopted a plan, with its own timetable, to advance the unification of the benefit plans. (...)

It is not for the Constitutional Court to set goals or timetables for the unification of the benefit plans, but the Court must urge the competent authorities to act so that, based on epidemiological priorities, the health needs of those in the subsidized regime, and the relevant financial considerations, they design a plan that would allow for the real completion of this goal. (...)

[The Court describes bone marrow transplant and treatment for hemophilia as examples of omissions in the coverage of the POS-S, in comparison with the POS, which have been subject to *tutelas*.]

6.1.2.1.2. The need to unify the benefit plans is even more urgent in the case of children because, as noted in this order (see section 4.5.), the Constitution recognizes children as subjects of special protection and establishes in an automatic way their fundamental right to health (art. 44 Political constitution). [The Court describes some examples of health services to which children do not have access in the subsidized regime, including adequate psychiatric treatment] (...)

6.1.2.2. *Specific orders to impart.*

For the foregoing reasons, in the resolution portion of this order the Court will order the adoption of measures designed to unify the benefit plans, in relation to children in the short term, and for adults, at the moment when the competent authorities deem it feasible, but subject to a program and timetable to be adopted on the date indicated in the resolution part of this order. [See in the resolution portion the twenty-second and twenty-first orders.]

(…)

[T]he decision taken in the law, and whose fulfillment is ordered in this decision, to unify the benefit plans of the contributory and subsidized regimes, may generate perverse incentives in the collective action of the members. In effect, the fact that the benefit plans of the two systems would tend to be equal may discourage some individuals from belonging to a contributory system, bearing in mind that in the subsidized system they would "pay less."[5] To address this problem, so that the subsidized regime is only for those who do not have the resources to participate in the contributory regime, public solutions are required to be designed, implemented and evaluated by the competent authorities. These solutions may include, inter alia, sanctions for those who, by means of deceit, show lower earnings then they earn in reality, regulations aimed at the adoption of incentives to encourage the payment of contributions by those with economic capacity, and the appropriate dissemination of such policies. [6] In any event, these measures should provide the possibility of moving from one regime to another during the labor cycles and will not prevent people who are in the contributory regime from passing to the subsidized regime in those cases in which it is economically required.

6.1.3. Expanding the powers of the Scientific Technical Committee to also rule on requests for medical services other than drugs in any of the

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[5] One observes for example that the growth in the number of participants in recent years has been almost exclusively due to an increase in the number of members of the subsidized regime, while the number of members of the contributive regime has remained almost stable. This shows that even when the two systems provide different benefit plans, there is already a difficulty in getting people to contribute. According to a study in 2007 by the Corona Foundation, the University of the Andes, the National Planning Department, and the University of Rosario, "*the advances in the number of individuals covered that have been observed in the last five years are mostly through the subsidized regime, which rose from 22.5% to 29.8% while the contributory regime's membership increased only from 35.6% to 38.3%."* see C.E. Florez et al "Progress and Challenges of equity in the Colombian Health System," Working Paper No 15, p. 17.

[6] Ultimately, the problem of the stowaway ("free riders") is intrinsically related to the level of informality in the labor market, given that it is those workers who have no formal employment contracts who are more likely to enjoy the benefits of the subsidized regime, even when they have the possibility of paying contributions for the contributory regime. Therefore, the viable future of the contributory system depends largely on labor policies that facilitate the increase in the proportion of formal employment and work in safe and dignified conditions.

regimes.

6.1.3.1. *Analysis of the problem and the current situation.*

6.1.3.1.1. According to constitutional jurisprudence, an EPS violates the right to health of a person by denying a requested health service, saying only that it is not included in the obligatory health plan. (...)

If the service not included in the benefit plan is a medicine, the procedure to be followed by the attending physician is to request approval by the Scientific Technical Committee. But this is not the case for other required health services. The absence of regulation regarding the internal processing by the EPS of health services not included in the POS, other than medicines—procedures, activities and interventions—has increased the number of *tutelas*, as the *tutela* is the only mechanism through which the patients can ask to be protected in such cases. The EPSs see the *tutela* as the only means for the state to recognize the payment of the cost of the service in question, given that it is not included in the POS and therefore not funded through the UPC.

(…)

[The Court describes in detail the regulation of the Scientific Technical Committee]

(…)

6.1.3.2. *Specific orders to impart*

[The Court issues orders so that an internal process within the EPS is adopted to directly authorize health services. While this order is being implemented, the Court orders the EPS to adopt measures under the existing rules to present for consideration before the Scientific Technical Committee the approval of a medication not included in the POS, and the requests for approval of the health services not included in the obligatory health plan that are not medications. See the twenty-third order.]

In these cases, we apply the rule established in the judgment C-463 of 2008 in which the Court reviewed the constitutionality of Article 14j of Law 1122 of 2007, and in which the Court decided that "*whenever an EPS is obligated by an action of* tutela *to provide medicines and other medical services or health benefits prescribed by the attending physician, but not included in the benefit plan of any of the existing legal regimes*" the EPS will be reimbursed only by half of the costs not covered. That is to say, when the Scientific Technical Committee denies a medical service in accordance with the standards set by this order, and later the EPS is forced to provide the service through an action of *tutela*, only half of the costs not covered will be reimbursed [by the Fosyga].

(…)

6.1.3.2.2. [T]his ruling constitutes a full basis for action in the event that a civil servant is ordered to approve the payments for services outside the obligatory health plans, or to adopt the decisions that are not expressly or literally described in the respective manuals of functions. The same applies to individuals performing public functions who must comply with an order of *tutela*. However, without the need for orders of *tutela*, the Scientific Technical Committee can authorize services not covered by the POS. In this event, the Scientific Technical Committee will be in compliance with the judgment C-463 of 2008 and with this *tutela*. (…)

(…)

6.1.4. Measures to prevent the rejection or delay in the provision of medical services which are included in the POS.

6.1.4.1. *Analysis of the problem and the current situation.*

6.1.4.1.1. According to a study by the Ombudsman regarding the *tutela* and the right to health for the period 2003-2005,[7] it was found that the majority of the actions of *tutela* were brought to demand access to health services that were in fact included within the obligatory health plan. In fact, approximately 56.4% of the actions of *tutela* presented in the period studied demanded a service to which the patient had a right through the legal or regulatory framework and, therefore, which should be guaranteed without the need for any demand.

(…)

6.1.4.1.2. In conclusion, the State fails to protect the right to health when it allows for the fact that the majority of violations show obvious disregard for said right, which impedes access to those services covered by the obligatory health plans that as such are already financed. Maintaining the incentives and disincentives that do not promote the effective enjoyment of the right and not adequately exercising the powers of monitoring and oversight, have allowed for the continuation of this unjustifiable situation of constant and repeated violations of the right to health of people on the part of many of the entities responsible for ensuring the provision of the services.

6.1.4.2. Specific orders to impart

[7] Ombudsman (2007): *The* tutela *and the right to health, period 2003-3005*. Study based on 5,212 *tutelas* selected through stratified random sampling.

[The Court imparts orders about reporting on the services that are denied by the EPS and the entities that most often refuse services. See in the resolution portion of this document the nineteenth and twentieth orders.]

6.2 Orders concerning the right to recover before the Fosyga or local governmental entities for medical services not covered by the benefit plan.

(…)

[There must be an] adequate guarantee of the flow of resources, which is necessary to ensure that everyone actually enjoys the *highest attainable standard of health*, given the budgetary, administrative and structural constraints that exist. (...) Regarding the flow of resources to the EPS, currently no measure has been adopted to ensure its timeliness, for example by ensuring the timely reimbursement of the resources that these institutions must invest to attend to their users when they authorize the provision of services not included in Benefits Plan but approved by the Scientific Technical Committee or ordered by decisions of *tutela*.

Given the rules of the current Health System, EPS have a constitutional right to recover the costs not financed through the per capita payment units (UPC). To guarantee the right to health of users, which depends on the timely flow of resources in the system, the reimbursement procedure must be clear, precise and agile.

(...) [The Court describes in detail the process of reimbursement from the Fosyga for health services ordered in actions of *tutela* or authorized by the Scientific Technical Committee.]

6.2.1. Order to expedite the execution of *tutela* judgments.

6.2.1.1. Analysis of the problem and the current situation.

(…)

As noted above, the Resolution 2933 of 2006 demands that among the requirements for submitting applications to recover funds based on decisions of *tutela* is a “copy of the decision of *tutela* with the final writ of execution (*consistencia de ejecutoria*)." (Article 11, paragraph b). In addition, the copy must be authentic. (...)

The requirement of submission of the final writ of execution of the decision of *tutela* becomes an obstacle for the recovery when it is interpreted as applying to a decision of *tutela* only when the Constitutional Court has excluded the decision from review, as the referral to the Constitutional Court, its exclusion from review, and the return of the decision to the respective judge of first instance, is a procedure that may take several months. This interpretation

contrasts with the immediate enforcement of orders of *tutela* and has become an obstacle that prevents the timely flow of resources to support effective access for users of health services.

(…)

6.2.1.1.4. Based on the above and taking into account that the Constitutional Court has repeatedly stated that "*the review must be process based on the principle of speed*" and that the flow of resources in the health system is to ensure protection of the right to health of users, as noted above, an interpretation of the requirement for the final writ of execution of the decision of *tutela*, *consistent with* the Constitution, must be directed to confirm that (*i*) all the instances have been exhausted, or (*ii)* if they have not been exhausted, the term has expired for challenging the ruling of first instance; and (*iii*) it is contrary to the Constitution to defer recognition of the right to recover until the Constitutional Court decides on whether or not to review the ruling that already granted the right of the *tutela* claimant to access the health service. And it is even more contrary to the Constitution if this leads to further delay in the approval and protection of the ordered health service.

6.2.1.1.5. [t]he determination of what is included in the benefit plan has also raised the recurring question of the difference between generic and brand-name drugs. It may be that the attending physician prescribes a brand name drug not included in the POS, while the generic name of that medicine itself is. (…).

[The Court describes the constitutional jurisprudence regarding orders on behalf of health professionals for the generic version of medications or the brand-name versions.]

[Currently] there is no rule to resolve how to repay an EPS that has authorized the provision of a brand name drug, which is usually more expensive than the corresponding generic. Until the regulator fills this void, the rules fixed by the jurisprudence must apply. These are, according to the jurisprudence described above: a) the attending physician must prescribe the medication under the common international name (generic), unless it has already proven that it is better for the user, from a medical point of view, to use the brand name medicine, b) if the physician prescribes a brand name drug, the medical need for this must be justified to the Scientific Technical Committee, c) the Scientific Technical Committee should analyze the application from the medical perspective, and, if it authorizes the brand name drug, it must include with the reimbursement request the appropriate justification. Additionally, d) given the presence of such a justification, the "Active Principle in POS" cannot be invoked and e) the amount to be repaid should correspond to the amount that the EPS is not legally and statutorily required to assume.

(…)

6.2.1.2. Specific orders to impart.

[The Court adopts orders regarding the requirements of the copy of the writ of execution, the explicit order of reimbursement, and generic drugs. See in the resolution portion of this document the twenty-fifth order.]

6.2.2. Order concerning the adoption of a contingency plan.

6.2.2.1. Analysis of the problem and the current situation.

In spite of the fact that the regulation has clearly established time limits within which reimbursement from the Fosyga should take place, it is clear that there are serious difficulties in ensuring that they are carried out satisfactorily. As a result, many requests for reimbursement have accumulated without the Fosyga executing them.

(...) [The Court describes some of the evidence showing the high number of applications not studied and the high amount of resources due.]

6.2.2.1.3. At the moment there is no certainty about the size of the backlog of late claims and payments of requested reimbursements (...) This indicates that there is a barrier to the flow of resources in the health system caused by the delay in reimbursements and the processing of applications for recovery from the Fosyga, which affects the enjoyment of the right to health of the users of the system. (...)

6.2.2.2. Specific orders to impart.

[The Court orders the adoption of the contingency plan for paying the late reimbursements and for processing applications. See the twenty-sixth order.]

6.2.3. Order to correct the obstacles in the system of reimbursements.

6.2.3.1. Analysis of the problem and the current situation.

The former also shows that there is a problem of resource flows in the system that has not been resolved with the current reimbursement mechanisms. Additionally, applications for reimbursement from the Fosyga have tended to grow and, consequently, so has the total amount to be paid to the insured for these claims according to a study conducted by the Ministry of social protection and the Program to support health reform.[8] According to the report,

[8] Cubillos Turriago, Leonardo MD. MPH. and Alfonso Sierra, Eduardo Andrés BA. *Preliminary descriptive analysis of recoveries in the General Social Security System in Health 2002 to 2005.* Technical Document. Final Report. Program of support for health reform. Crédito bid 910/oc-co

while in January 2002 the number of recoveries before Fosyga was less than 5000, by 2005 that number had risen to almost 30,000 (P. 29). Additionally, in the balance sheets for requests for recovery for 2006, of the money owed to the EPS, 73% corresponds to debts of the Fosyga.

(…)

The scenario described above shows the need for action to improve the current system of reimbursements with the aim of ensuring the timely flow of resources in the system. However, it is not for the Constitutional Court to establish the manner in which the system must overcome the flaws that prevent the public administration from having the institutional capacity that would enable it to take appropriate and necessary measures to guarantee the population a higher level of health, given the available resources. However, it is a function of the Constitutional Court to impart the orders necessary so that the competent bodies adopt these corrective measures, if they have not already done so or are not in the process of doing so, in accordance with the constitutional mandate, as soon as possible.

6.2.3.2. Specific orders to impart.

[The Court orders the adoption of measures so that the system of recoveries functions in an efficient manner. See the twenty-seventh order.]

6.3. Orders to protect the right to information in health, letter regarding rights and letter regarding performance.

6.3.1. Analysis of the problem and the current situation.

6.3.1.1. In addition to the aspects listed above related to flaws in the regulation of the POS and the recoveries before the Fosyga, other aspects of the system present some problems that deserve the attention of the Chamber with a view to identifying measures to help ensure the protection of the right to health.

(…)

In effect, the right to information must not only be guaranteed for those who already form part of the health system, but also for those who have not yet entered it. The information should serve this latter group in helping them choose in an informed manner the EPS and IPS to provide them with health services, according to their needs, and in addition, once inside the system, the information should assist them in the full exercise of their rights. As a minimum before making the decision to enter an EPS or choose an IPS, a person should know, in addition to his rights and duties, (i) what are the available options for affiliation, and (ii) the performance of each of these institutions, in terms of respect for the enjoyment of the right to health. Having reliable information about the behavior of EPS and IPS, in terms of

the fulfillment of their obligations and protecting the rights of their users, contributes to the informed decisions in the selection of entities. (...)

6.3.2. Specific orders to impart.

[The Court imparts orders about the provision of a bill of rights of the patient and the bill of performance. See the twenty-eighth order.]

6.4. Orders about universal coverage

6.4.1. Analysis of the problem and the current situation.

(…)

The existence of these cases makes it clear that the health system in the country still does not conform to the principle of universality, one of the basic principles of social security specified in Article 48 of the Constitution, which states that the social security "*will be under the direction, coordination and control of the State, subject to the principles of efficiency, universality and solidarity, in the terms established by law.*"

[The Court describes the considerations of the National Constitutional Assembly in adopting the constitution of 1991.]

In light of the above, Law 100 of 1993 incorporated the universality as one of the principles that should guide the action of the State with respect to the provision of the service of social security in health.[9] Therefore, the Act established that the overall Social Security System in Health would have universal coverage. In the first paragraph of Article 162, the law sets a deadline for achieving this objective, in the following terms: "*The General Social Security System in Health creates the conditions for access to an Obligatory Health Plan for all inhabitants of the territory before the year 2001*."

(…)

6.4.1.3. Despite this, the deadline set by Law 100 of 1993 for universal health coverage has passed without the goal achieved.

(…)

[9] Article 2 of Law 100 of 1993 states that the essential public service of social security "will be subject to the principles of efficiency, universality, solidarity, integrity, unity and participation ..." Universality was defined as "the guarantee of the protection of all persons, without any discrimination, at all stages of life ..."

> The reform [of Law 100 of 1993] was approved through Law 1122 of 2007, "*which makes some changes to the General Social Security System and Health, and makes some other orders.*" Consistent with the discussion in Congress, Article 9 of the Law sets a new deadline for achieving universal insurance coverage: "*The General Social Security System in Health will meet, in the next three years, the insurance coverage at levels I, II and III of Sisben of people who meet the requirements for membership in the System.*"
>
> The target set by Law 1122 of 2007 was confirmed in the National Development Plan, passed by Law 1151 of 2007. (...)
>
> (…) given that there has already been a breach of the term specified in Law 100 for the universalization of social security in health, the Court emphasizes the need to comply with the new term that the legislature has set for achieving the goal of universal coverage.
>
> (…)
>
> [See the twenty-ninth order in the resolution portion of this document to take necessary measures to ensure sustainable universal coverage.]
>
> [In part 7, the Court refers to some issues which, while noting their importance, are not the subject of specific orders. Specifically, the Court describes in detail the public health situation and recent changes, and notes, in conclusion, new measures that have been introduced to tackle public health problems of the country, which have been operating for just a few months, and as such do not warrant the adoption of measures by the Court.]
>
> [In part 8, the court reviews the decisions adopted.]
>
> **9. The reduction of the filing of actions for *tutela* to gain access to health services as an indicator of compliance with this ruling**
>
> [F]or over a decade people have had to resort to the action of *tutela* to resolve disputes so that the judiciary resolves disputes that could have been heeded off in a general way by the competent regulatory bodies. This is a clear indication about the flaws in the regulation of the health system, which in turn is the basis for general orders we adopt to correct such problems. For this reason, the decisions of regulatory bodies to comply with this ruling must necessarily lead to a result that will facilitate people's access to health services and eventually reduce the proportion of *tutelas* filed.
>
> (...) Therefore, without prejudice to the autonomy of the authorities of the sector charged with designing and implementing indicators which it believes are most appropriate, the Court orders the Ministry of Social Protection to report to the Second Review Chamber and the Attorney General of the Nation

and the Ombudsman, on the number of actions of *tutela* brought in order to protect the right to health, specifically concerning the legal issues described in this order. Over time, if the actions of regulatory bodies are ideal, people will not be forced to seek the actions of *tutela* and its proportion will be reduced.

(…)

III. Decision

In view of the foregoing, the Constitutional Court, administering justice on behalf of the people, and mandated by the Constitution,

Resolves:

[Orders regarding the concrete cases.]

(…)

Sixteenth.- To order the Ministry of Social Protection, the Regulatory Commission on Health and the National Council on the Social Security in Health to take the necessary steps, within their powers, to overcome the failures of regulation in the benefit plans, ensuring that their contents (*i*) are defined in a clear way, (*ii*) are fully up to date, (*iii*) are unified for the contributory and subsidized regimes, and (*iv*) are timely and effectively delivered by the EPS.

This regulation also shall (*i*) encourage the EPS and the regional entities to ensure access to health services to those who are so entitled and (*ii*) discourage the denial of health services by the EPS and regional entities.

To comply with this order, the authorities shall at least adopt the measures described in the seventeenth to twenty-third orders.

Seventeenth.- **To order** the National Commission on the Regulation in Health to integrally update the Obligatory Health Plans (POS). To fulfill this order the Commission must ensure direct and effective participation of the medical community and the users of the health system, as described in section (6.1.1.2.). This integral review must: (*i*) clearly define what health services are included in the benefit plans, evaluating the legal criteria and the jurisprudence of the Constitutional Court, (*ii*) establish what services are excluded and those which are not covered under the benefit plans but will gradually be included, indicating what are the goals for expansion and the dates by which they will be satisfied, (*iii*) decide what services should be deleted from the benefit plans, indicating the specific reasons for such decisions according to health priorities, so as to better protect the rights, and (*iv*) take into account, for the decisions to include or exclude a health service,

the sustainability of the health system and the financing of the benefit plans by the UPC and other funding sources.

The definition of the contents of the POS should respect the principle of integral treatment in terms of the ordered health services and the attention required to treat the diseases covered.

The new benefit plans, in accord with what is stated above, shall be adopted before the first of February, 2009. Before that date the plans will be submitted to the Constitutional Court and will be communicated to all the Health Care Promoting Entities to be implemented by all the Scientific Technical Committees of the EPS. This period may be extended if the Regulatory Commission on Health, CRES, explains the reasons that prevent compliance with this date, which in no case can be extended beyond August 1, 2009.

(…)

Eighteenth.- To order the Regulatory Commission on Health to update the Obligatory Health Plan at least once a year, based on criteria established by law. The Commission shall submit an annual report to the Ombudsman and the Attorney General of the Nation indicating, for the respective period, (*i*) what is included, (*ii*) what is not included from the requests by the medical community and users, (*iii*) what services were added or deleted from the benefit plans, indicating the specific reasons for each service or illness, and (*iv*) the justification for the decision in each case, with reasons based on medicine, public health and financial sustainability.

(…)

Nineteenth.- To order the Ministry of Social Protection to take steps to ensure that all Health Care Promoting Entities in the country send to the Regulatory Commission on Health, the National Superintendence of Health and the Ombudsman, a quarterly report which includes: (*i*) medical services ordered by the attending physician that were denied by the Health Care Promoting Entity and which were not processed by the Scientific Technical Committee, (*ii*) medical services ordered by the physician that were denied by the Scientific Technical Committee of each entity, (*iii*) indicating in each case the reasons for the refusal, and with respect to the former, the reasons there was no decision by the Scientific Technical Committee.

The first report should be sent on February 1, 2009. A copy must be sent to the Constitutional Court before the same date.

Twentieth.- To order the Ministry of Social Protection and the National Superintendence of Health to take appropriate steps to identify the EPS and IPS that frequently refuse to allow timely health services included in the POS or those that are *required with necessity*. To this end, the Ministry and the

Superintendent shall report to the Ombudsman, the Attorney General of the Nation and the Constitutional Court (*i*) which are the EPS and IPS that most frequently engage in practices that violate the right to health; (*ii*) what are the concrete and specific measures in relation to these entities that were adopted in the past and are currently being advanced, if any, and (*iii*) what are the concrete and specific measures that have been taken to ensure the effective enjoyment of the right to health of persons who are affiliated with the EPS and IPS identified.

This report should be presented before October 31, 2008.

Twenty-first .- To order the Regulatory Commission in Health to unify the benefit plans for the boys and girls of the contributory and subsidized regime through measures to be taken before October 1, 2009, and to take into account the necessary adjustments to the subsidized UPC for children to ensure the financing of the expansion in coverage. If by that date the necessary measures are not adopted for the unification of the benefit plan for the children, it is understood that the obligatory health plan of the contributory regime will cover children from the both the contributory and subsidized regimes.

A report on the compliance with this order must be forwarded to the Constitutional Court before March 15, 2009 and be communicated to the Colombian Family Welfare Institute and the Ombudsman.

(…)

Twenty-second.- To order the Regulatory Commission in Health to adopt a program and timetable for the gradual and sustainable consolidation of the benefit plans of the contributory regime and the subsidized regime taking into account: (*i*) the priorities of the population according to epidemiological studies, (*ii*) the financial sustainability of the expansion of coverage and its funding by the UPC and other sources of funding for the existing system.

The program of unification should additionally (*i*) provide the definition of mechanisms to streamline access to health services for users, ensuring that the needs and health priorities are met without impeding access to required health services, (*ii*) identify the disincentives for the payment of contributions by users and (*iii*) plan for the necessary measures to encourage those with economic capacity to actually contribute, and to ensure that those who move from the subsidized regime to the contributory regime can return to the subsidized regime swiftly when their income decreases or the socioeconomic situation deteriorates.

The Regulatory Commission in Health shall submit to the Constitutional Court, before February 1, 2009, the agenda and timetable for the unification of the benefit plans, which must include: (*i*) a program, (*ii*) a timetable, (*iii*) measurable goals, (*iv*) mechanisms for monitoring progress and (*v*) the

justification for why there was a decline or stagnation in the expansion of the scope of the right to health. Copies of the report shall be submitted to the Ombudsman on said date, and then progress reports must be submitted on the implementation of the program and timetable every six months from the date indicated.

In implementing the program and timetable for the unification of the benefit plans, the Commission will provide sufficient opportunity for effective and direct participation by the medical community and the organizations representing the interests of the users of the health system. (…)

Twenty-third.- To order the Regulatory Commission in Health to take the necessary measures to regulate the internal procedure that the treating physician must advance so that the respective EPS directly authorizes both non-medication health services not covered by the obligatory health plan (contributory or subsidized), and medications for the attention of the activities, procedures and interventions explicitly excluded from the Obligatory Health Plan, when these are ordered by the treating physician.

Until this internal process of the EPS is regulated in a definitive way, the Court orders the Ministry of Social Protection and the Regulatory Commission in Health…to take the necessary steps to ensure that the EPS extend the existing rules for the submission for consideration by the Scientific Technical Committee of a medication not included in the POS, or the non-medication health services not included in the obligatory health plan, such as activities, procedures and interventions explicitly excluded from the Obligatory Health Plan, where they are ordered by the attending physician, taking into account the parameters set by the Constitutional Court. This order must be implemented within five (5) days of the notification of this ruling.

When the Scientific Technical Committee denies a medical service, in accordance with the competence laid out in the present ruling, and then is obliged to provide such a service by means of an action of *tutela*, only half of the costs not covered will be reimbursed, in accordance with what is said in this ruling.

The Ministry of Social Protection shall present, before March 15, 2009, a report on compliance with this order to the National Superintendence of Health and the Ombudsman, with a copy to the Constitutional Court.

Twenty-fourth .- To order the Ministry of Social Protection and the trustee of the Fosyga to take measures to ensure that the process of recovery for the EPS before the Fosyga, as well as before the respective regional entities, is agile and ensure the adequate and timely flow of resources to the health system to finance the health services, both in the event that the request originates in *tutela* or when it comes from an authorization of the Scientific Technical Committee.

To comply with this order, at least the measures contained in the twenty-fifth through twenty-seventh orders of the resolutions section must be adopted.

Twenty-fifth.- To order the trustee of Fosyga, from the date of notification of this ruling, and when dealing with health services whose practice is authorized pursuant to an action of *tutela*, as follows: (*i*) an EPS may start the recovery process once the order is final, whether because the decision of first instance was not challenged or because the order comes from the decision of second instance, without the authorization or recovery procedure for the health service being hindered based on the pretext of any review process that may reach the Constitutional Court, (*ii*) the presence of an express authorization for recovery before the Fosyga or the regional entity in the resolution portion of the *tutela* decision cannot be established as a condition for recognizing the right to recover the costs that the entity had no legal or regulatory obligation to assume. It will be enough that it is found that the EPS has no legal or regulatory obligation to assume the cost under the scope of the relevant benefit plan funded by the UPC. And (*iii*) the repayment should take into account the difference between generic drugs and brand name drugs, but should not be refused with recourse to the "Active Principle in POS" when the brand name drug is formulated under the terms specified in section (6.2.1.) of this order.

The Ministry of Social Protection and the trustee of Fosyga must submit a report on the compliance with this order before November 15, 2008 before the Constitutional Court.

Twenty-sixth .- To order the Ministry of Social Protection and the trustee of Fosyga, if they have not already done so, to devise a contingency plan to (*1*) advance the processing of applications for recovery that are late and (*2*) expedite payment of recoveries for claims in which the compliance with the requirements of the existing resolutions was verified, but in which payment has not yet been made, in accordance with this order. This plan must contain at least: (*i*) specific targets for compliance with this order, (*ii*) a timetable for meeting the goals and (*iii*) actions to be undertaken to meet the goals, specifying in each case, the officer responsible for compliance.

The plan must be submitted before November 15, 2008 before the Committee on Verification established by the State Council and the Constitutional Court and shall be fully implemented before March 15, 2009. In the case that by this date (March 15, 2009) repayment has not been made in at least 50% of recovery applications from the process from September 31, 2008, independent of the glosses placed on the applications, a compensation mechanism will operate for these 50%. The remaining 50% must have been paid in full before the first (1) of July 2009. In the event that it is latter verified that the Fosyga was not required to make certain repayments, measures should be adopted to compensate those resources, with the corresponding EPS.

The Ministry of Social Protection and the trustee of Fosyga shall submit a report on the implementation of the Contingency Plan every two months to the Committee on Verification.

Twenty-seventh.- To order the Ministry of Social Protection to take the necessary measures so that the system of verification, control and payment of claims for recovery operates efficiently, and so that the Fosyga promptly disburses funds related to applications for recovery. The Ministry of Social Protection can define the type of measures necessary.

The Ministry of Social Protection may also redesign the system of recovery in the manner it deems most appropriate, taking into account: (*i*) ensuring the timely and effective flow of resources to finance health services, (*ii*) the definition of a smooth and clear procedure to audit applications for recovery without the duration of the procedure impeding the flow of resources (*iii*) transparency in allocation of the resources of the Fosyga and (*iv*) the allocation of resources to deal effectively with the needs and priorities of health.

On 1 February 2009, the Ministry of Social Welfare shall submit to the Constitutional Court the regulation by which the new system is adopted. The new system should begin to be implemented in the third quarter of 2009, on the date indicated in the regulation.

Twenty-eighth.- To order the Ministry of Social Protection, if it has not already done so, to take the necessary steps to ensure that when joining an EPS, contributory or subsidized, every person is delivered in simple and accessible terms, the following information,

> (i) *A letter with the patient's rights*. This must contain at least the rights contained in the Lisbon Declaration of the World Medical Association (adopted by the 34th Assembly in 1981)[10] and those contemplated in the portion of this judgment laying out the reason for this decision, especially *Chapters 4 and 8*. This *Letter* shall be accompanied by indications about which of the institutions provide assistance for the enforcement of rights, and which of the resources can be used to seek and access that help.
>
> (ii) *A letter regarding institutional performance*. This document must contain basic information about the performance and quality of the different EPS to which the individual can enroll in the respective system, as well as similar information about the IPS that belong to the network of each EPS. The document should provide the information necessary to properly exercise the freedom of choice.

[10] Resolution 13437 of 1991, Ministry of Health (today of Social Protection).

The Ministry of Social Protection and the National Council on Social Security in Health shall take appropriate steps to protect those who have had disrespected their right of access to adequate and sufficient information to enable them to exercise their freedom of choice in deciding amongst the entities responsible for ensuring access to health services. These measures must be taken before the first (1st) of June 2009 and a report must be submitted to the Constitutional Court.

Twenty-ninth.- To order the Ministry of Social Protection to take the necessary measures to ensure sustainable universal coverage of the General Social Security System in Health, by the date fixed by the Law—before January 2010—. Should it be impossible to achieve this goal, the reasons for this failure should be given and a new goal set and duly justified.

Thirtieth.- To order the Ministry of Social Protection to submit an annual report to the Second Review Chamber of the Constitutional Court, the Attorney General of the Nation and the Ombudsman, which includes the number of actions of *tutela* that resolve the legal issues raised in this ruling, and if they have not diminished, an explanation for why not. The first report should be submitted before the first (1) of February, 2009.

(...) To be notified, communicated, and published in the Gazette of the Constitutional Court.