THE RIGHT TO HEALTH AND THE PANDEMIC IN COLOMBIA[1]

This document assesses Colombian governmental policy as relates to guarantees for the right to health during the first year of the pandemic. Considering available data, this document covers problems of access, working conditions, risk factors (such as access to drinking water) and structural problems in the healthcare system. To conclude, we offer some recommendations for the national government, healthcare personnel, human rights organizations, and society.

Debates about the healthcare sector, pandemic, structural problems rooted in Law 100, the working conditions of healthcare workers, and a long list of many others re-intensified and garnered concern during the pandemic and amidst the measures taken by the national government since March 2020.

For example, the national government's delay in closing airports, a decision that was highly criticized by society for favoring the airline market, permitted a gateway for the virus to enter the country despite media and social pressure. A second example was the disbursement of 17 trillion to banks[2] even before disbursements for the healthcare sector were defined, making the priorities of the national government clear.

From March 6th, when the first case was registered, until November 30th, 2020, more than 36,000 deaths and more than 1.3 million infected people were registered in Colombia. Moreover, a high level of under-reporting is presumed. Graphics from the first months[3] show an exponential rise without the achievement of the famous "flatten the curve" phenomenon, a goal repeatedly mentioned by the national government.

---

[1] Víctor de Currea-Lugo, PhD, MD. Text for the Plataforma Colombiana de Derechos Humanos, Democracia y Desarrollo. (Released April 19, 2021)

[2] "Banco de la República pone billonario respaldo a economía por covid-19" [Banco de la República Gives Billions in Economic Support for Covid-19]. *El Tiempo*, March 15, 2020. Available at: https://www.eltiempo.com/economia/sector-financiero/recursos-que-pone-el-banco-de-la-republica-para-enfrentar-el-coronavirus-472248

[3] Government of Colombia: "Comportamiento del Virus en Colombia" [Behavior of the Virus in Colombia]. November 30, 2020. Available at: https://coronaviruscolombia.gov.co/Covid19/estadisticas-covid-19/comportamiento-covid-19.html

1. ACCESS TO CARE WORSENS IN THE PANDEMIC

One central topic of discussion has to do with access to healthcare services. It is worth pointing out that access was already previously deficient, with gaps between rural and urban populations, peripheral and central areas, and between populations who are subsidized or contribute to the system. In addition to this, however, access is not only an issue of having a health insurance card or a general physician, but also, in our view, of having effective access to the specialists, treatments, and therapies merited by a case.

While it is true that access to basic health services is easier, there is also a great deal of concern about waiting lists for specialists and treatments, which are determinants between life and death in the event of cancer or other diseases. The pre-existing crisis in the healthcare sector, which is almost totally privatized, and the mismanagement of state resources deepened the impact of the pandemic on society.

Similarly, the high impact of the virus on remote areas, for example in Amazonas department, must be considered. In addition, these peripheral and impoverished regions have higher rates of under-reporting. This is observable, for example, in the DANE's (National Administrative Department of Statistics) distribution of Covid-19 mortality among different population groups.[4]

In reviewing the issue of access to healthcare by social strata, we see big differences among them. This is further aggravated by the impact of the pandemic, during which barriers to access to healthcare services[5] have increased.

A sample could be taken by analyzing the number of people lacking timely and specialized medical care. Such deficiencies show that most deaths occur without infected persons receiving care in an Intensive Care Unit (ICU).[6]

Almost 90 percent of pandemic deaths occurred among the first three social strata and about 67 percent of deaths occur among strata one and two. Therefore, it is not true that the virus, pandemic, and quarantine have affected all people equally; there is a clear socio-economic gap when examining actual impact. According to World Bank numbers, the rich

[4] Petro, Gustavo: "¿Un pacto histórico?" [A historic pact?]. *Cuarto de Hora*, 19 de julio de 2020. Available at: https://cuartodehora.com/2020/07/19/un-pacto-historico/

[5] "Pandemia del Covid-19 aumentó las barreras para acceder a la salud" [Covid-19 Pandemic Increased Health Access Barriers]. *El País*, Cali, April 28, 2020. Available at: https://www.elpais.com.co/colombia/pandemia-del-covid-19-aumento-las-barreras-para-acceder-a-la-salud.html

[6] Watch at: https://colombia.as.com/colombia/2020/06/19/tikitakas/1592566043_203159.html (data up to 19 June 2020).

in Colombia receive 55.7% of all national revenue, while nine million poor people share just 3.9% of total revenue.[7]

Two intertwined questions arise, one being whether the healthcare system was prepared to assume a response, universally and with solidarity, to this crisis and, second, whether the Colombian healthcare system corresponds to the country's reality: to its socio-economic needs, the promise of the right to health enshrined in the 1991 Constitution, the imbalances between rural and urban areas, the presence of tropical diseases, its severe problems of access, and the need for a more inclusive economic model contrary to neoliberal premises. In this sense, all the above cannot be considered independent or circumstantial findings. Problems in access to healthcare and food services and drinking water are not independent, nor are the poor working conditions of healthcare workers that have been exacerbated amid the pandemic.

The decisions of the national government to, for example, give priority to the financial system over hospitals during the first month of the crisis are not circumstantial either. Similarly, a series of resources were allocated to Health Promotion Companies (EPS) over direct allocation of resources to hospitals to provide health personnel with biosecurity equipment.

In other words, there were no erratic measures because of a lack of information or confusion over the novelty of the disease, but deliberate and systematic decisions made under the lens of the pre-existing healthcare and economic system: one that protects and promotes financial capital and market health rather than the rights of people.

As is well-known in Colombia, there exists a constitutional protection mechanism in which a constitutional judge can provide a writ of protection (*tutela*) for rights recognized by Colombian legislation.[8] One of these is the right to health, which is recognized as such, and not in connection with the right to life;[9] that is, it is a right with a life of its own. In order to protect this right, society has systematically and frequently made use of the constitutional writ of protection. It is not individuals who are responsible for the overuse of the writ, but institutions that do not comply with legal mandates.

Moreover, those who affirm that Law 100 is already an exclusionary system with limitations, gaps, and distortions, believe that the right to health goes far beyond what is currently

[7] Hernández, Gonzalo: "El dato de la desigualdad en Colombia" [Inequality Data in Colombia]. *El Espectador*, 5 March 2019. Available at: https://www.elespectador.com/opinion/el-dato-de-la-desigualdad-en-colombia-columna-843177/

[8] "Every person shall bring a writ of protection before the courts, at any time and in any place, by means of a preferential and summary procedure, by himself or by anyone acting on his behalf, for the immediate protection of his fundamental constitutional rights, where they are violated or threatened by the action or omission of any public authority." Article 86, Political Constitution of Colombia

[9] See: Full Chamber, Constitutional Court, Sentence SU-111 of 1997, MP: Eduardo Cifuentes Muñoz; and Constitutional Court, Sentence C-1204, 14 September 2000, MP: Alejandro Martínez Caballero.

recognized. Nonetheless, what stands out is that the vast majority of writs of protection are requested over treatments and therapies that are already recognized within the limited Law 100.[10] In this sense, what is therein being defended is only part of the right to health, deriving from a contractual regime based on the commodification of healthcare that is not even fulfilled by the institutions that ought to. In addition, the state does not assume a role of responsibility and leadership to ensure compliance with, at minimum, what is recognized by the norms.

According to the Defensoría del Pueblo (Ombudsman's Office), "every 3.5 minutes a health-related constitutional writ of protection is presented."[11] This data is relevant because it shows: a) a systematic violation of the right to health, b) that the healthcare system does not even fulfill its own offering, since the vast majority of writs of protection are for treatments already recognized by Law 100, c) that the state and, especially, the Ministry of Health do not fulfil its role of monitoring and guaranteeing the right to health, d) that a fundamental reform of the current system is urgently needed.

These severe restrictions forcing the use of writs of protection were also strongly observed during the pandemic. For example, the Cali Municipal Ombudsman's Office reported that the main complaints in April 2020 were over barriers at "Call Centers" to requesting Covid-19 tests (37.5%); difficulties in accessing medicines (35.9%); no access to medical procedures (7.6%), medical appointments (7.1%) and obstacles faced by some patients in accessing necessary supplies (4.9%).[12]

2. MORE PRECARIOUS WORKING CONDITIONS

A second element of the pandemic's management that requires in-depth analysis is related to the working conditions of health personnel. Generally speaking, the three things that stand out most are increased working hours, increased workload, and decreased wages.

[10] Defensoría del Pueblo: "La tutela y los derechos a la salud y a la seguridad social 2019" [Writs of Protection and the Rights to Health and Social Security, 2019], Bogotá, 2020. Avaliable at: https://www.defensoria.gov.co/public/pdf/Estudio-La-Tutela-Derechos-Salud-Seguridad-Social-2019.pdf

[11] "Cada 3,5 minutos se presenta una tutela por la salud" [Every 3.5 Minutes a Writ of Protection is Requested for Healthcare]. *El Tiempo*, Bogotá, December 25, 2016. Available at: https://www.eltiempo.com/archivo/documento/CMS-16780022

[12] "Pandemia del Covid-19 aumentó las barreras para acceder a la salud" [Covid-19 Pandemic Raises Barriers to Healthcare Access]. *El País*, Cali, April 28, 2020. Available at: https://www.elpais.com.co/colombia/pandemia-del-covid-19-aumento-las-barreras-para-acceder-a-la-salud.html

These three measures were continuously observed and documented by the group "Critical Monitoring of Working Conditions and Biosecurity of Health Personnel," comprised by 30 healthcare sector worker organizations, and published on August 18, 2020.[13]

The aforementioned report is not only about unfair working conditions, but the fact that more than 31% of health personnel experienced discrimination from society who considered them agents of contagion during the pandemic.[14]

These three findings in the context of the pandemic are part of the debate over working conditions, but they are only the tip of the iceberg of structural conditions such as the following: more than 43% of health personnel are indirect hires, meaning through third party contracts, which allows for greater infringement of labor rights. For this reason, during the pandemic hospitals (and IPS in general) often did not take necessary biosecurity measures and measures to challenge increased workloads or wage reductions were not effective, precisely because of the job flexibility to which they are subjected.

A pandemic is also a measure of a country's capacity to respond to social security in the face of a crisis, but the fact is that an effective response to such a challenge cannot be given if the number of people with indefinite contracts is just under 35%.

The national government, as well as Health Care Institutions (IPS), Health Promotion Companies (EPS), and Occupational Risk Administrators (ARL) passed off their responsibilities without anyone finally assuming them properly. As a result, within five months of the pandemic, 64 percent of healthcare workers said they had not received adequate personal protective equipment.[15] By then, the biosecurity statistics remained paltry, and by the beginning of December 2020, more than 170 people from the health sector had been killed by Covid-19.

3. RISK FACTORS: IS PREVENTION POSSIBLE WITHOUT DRINKING WATER?

The central question is why have other countries reported a lower impact in terms of mortality? And how has state response been in terms of subsidies and support for the most vulnerable people in the midst of the crisis? We know that the answer is not easy to come

[13] Full report available at: http://victordecurrealugo.com/wp-content/uploads/2020/08/boletin-n.3-17-agosto-2020.pdf

[14] Third bulletin on Critical Monitoring of Working Conditions and Biosafety of Health Personnel. August 18, 2020. Available at: https://www.oceinfo.org.co/difusion/noticias/324-monitoreo-critico-de-las-condiciones-de-bioseguridad-boletin-003

[15] Third bulletin on Critical Monitoring of Working Conditions and Biosafety of Health Personnel. August 18, 2020. Available at: https://www.oceinfo.org.co/difusion/noticias/324-monitoreo-critico-de-las-condiciones-de-bioseguridad-boletin-003

by because available information is not always conclusive and because epidemiological analysis contains many variables (from viral mutations to genetic characteristics of the affected population), but neither can we deny certain obvious facts.

This necessarily leads us to the discussion of a concept that, in terms of public health, is decisive in both pandemics and epidemics, and in general for the analysis of all diseases: "risk factors." According to the World Health Organization (WHO), "a risk factor is any trait, characteristic, or exposure of an individual that increases his or her probability of suffering an illness or injury. The most important risk factors include being underweight, unsafe sexual activity, hypertension, tobacco and alcohol use, unsanitary water, inadequate sanitation, and poor hygiene."

A widely discussed and accepted concept by all institutions is that the level of malnutrition of a population determines, in large part, its immune response. On this point, there are two observable, combined elements: the disease more seriously impacts people with malnutrition and, in addition, measures to contain the virus (quarantine and physical distancing) make access to food and work as a source of resources even more difficult.

It is also widely accepted that the right to health is closely related to other rights, such as the rights to food and drinking water, among others. In this sense, the nutritional obstacles faced by the population and low access to drinking water should be seen as determinants of social health.

In the case of the pandemic, what was observed, at least in Bogota, was a series of protests, demonstrations, and street blockades by some impoverished sectors facing severe food shortages and a direct relationship between the degree of poverty, absence of social protection, and number of people infected.

If we consider that more than two million people in Colombia do not have access to safe drinking water, compliance with general hygiene and sanitation measures is impossible, and the special recommendation to wash hands frequently cannot either be guaranteed. It should be remembered that this deficiency in access to drinking water is due in part to a state policy that was promoted by Alberto Carrasquilla Barrera, current Minister of Finance, whose "water bonds" policy generated a serious impact on drinking water services in many municipalities.

In Colombia in general the supply of drinking water in rural communities is insufficient. Historically discriminated populations are the most affected, among them those of Guainía, Amazonas, Guaviare, Vaupés, Chocó, and La Guajira. By means of example, see the

percentage of households with access to an aqueduct by department,[16] keeping in mind that access to safe drinking water is essential to prevent contagion.

4. THE SYSTEM, THE PROBLEM

In terms of the right to health, there were many evident effects of the pandemic. For example, the appalling attention provided to inmates in prisons, abandonment of migrants, especially Venezuelans, and neglect of people who were being treated for chronic diseases. There is also a serious decline in healthcare, which is partially explained by Covid-19, but also by the postponement of care of other diseases. In other words, other diseases and programs to which the healthcare sector should continue to respond appear to have been neglected under the excuse of Coronavirus care.

Another observation is the delay in the supply of drugs to chronic patients. An adequate service (a "call center" for example) would have sufficed to renew medical prescriptions so that people could access treatment requests without having to go to hospitals. Instead, what was observed was a marked delay in this procedure.

The pandemic once again showed that Law 100 impedes the autonomy of healthcare personnel. Medical decisions are, were, and continue to be subjected to administrative decisions and financial priorities rather than guaranteeing the human right to health. Delays in the processing of laboratory examinations and the subordination of medical criteria to administrative and financial criteria are so embedded within healthcare services, that many of the requests for examinations during the pandemic have been postponed or truncated under different arguments. Part of recovering medical autonomy will involve the possibility of ordering laboratory tests as the professional deems necessary to achieve a diagnosis, rather than limiting them for financial reasons alone.

It should also be stressed that the response to an epidemic depends on the strength of public healthcare systems and services, which were dismantled under Law 100.

Healthcare continues to be driven more by myth than by reality. For example, the idea expressed on social networks that doctors would charge up to 30 million pesos for each Covid-19 death or that there was a "Covid Cartel" are expressions that only contribute to

[16] DANE: “National Quality of Life Survey. ECV 2019”. Bogotá, July 2020.Available at: https://www.dane.gov.co/files/investigaciones/condiciones_vida/calidad_vida/2019/presentacion-ECV-2019-poblacion-campesina.pdf

distorting physician-patient relationships and that, above all, deviate from the central debate, which is about the healthcare model.

Let us take up some of the points already mentioned to orient a debate on the right to health beyond the pandemic. The Political Constitution of Colombia,[17] like international human rights law, clearly recognize health as a human right. Such recognition does not depend on whether a life is in danger, nor is it limited to the provision of healthcare services but understands health comprehensively and the duty of the state towards persons in its territory as a legal obligation. In other words, the right to health as such does not depend on whether a life is in danger nor on the limitations imposed by Law 100.

The guaranteed right to health is fundamental to the exercise of other rights, such as life, work, personal integrity, etc. Without prejudice to the universality of this right, there is a special legal emphasis on guaranteeing the right to health to persons in specific situations of vulnerability (children, pregnant women, immigrants, persons with disabilities, etc.).

Therefore, the right to health cannot be mediated by state charity (in the past, a very common practice), much less reduced to the logic of the service market (the prevailing logic in the region since the privatization of healthcare services by Augusto Pinochet in 1985 in Chile). There are a number of prevention and health promotion duties that go above and beyond medical care, but we also reject the use of the discourse on prevention as a pretext to evade the welfare duties of the state.

In the 1970s neoliberal policies were formulated to fundamentally reduce the role of the state to its minimum expression, and to allow services (such as healthcare) to be governed by the law of supply and demand. It is in the Chilean context, as a result of Pinochet's military coup, that economists from the Chicago School implemented their recommendations. The Chilean healthcare model was thus modified in 1985 to include new elements, including financial intermediation.[18]

[17] "Health care and environmental sanitation are public services provided by the state. All persons are guaranteed access to health promotion, protection, and recovery services. It is the responsibility of the state to organize, direct, and regulate the provision of healthcare services and environmental sanitation to its inhabitants in accordance with the principles of efficiency, universality, and solidarity. Also, to establish policies for the provision of healthcare services by private entities, and to exercise oversight and control over them..." Article 49, Political Constitution of Colombia.

[18] For a thorough debate, the following book can be downloaded for free: De Currea-Lugo, Víctor. Salud y neoliberalismo [Healthcare and Neoliberalism]. Universidad del Bosque, Bogotá, 2010. Available at: http://victordecurrealugo.com/salud-y-neoliberalismo/

Fiscal intermediaries (ISAPRE in the Chilean context and EPS in the Colombian context) were a mechanism that would apparently seek the efficiency and effectiveness of healthcare services. In both cases, what has been found is that the fiscal intermediary by its very nature obeys other logics: a) as a private actor it seeks to obtain profits that are not returned to the population, b) its management model seeks the highest profitability and, therefore makes use of expenditure rationalization policies, c) the power of lobbying by healthcare entrepreneurs enables them to interact with elites to ensure legal developments to their benefit, and d) the adoption of such a brokering model (and its imposition on the poorest countries) by the World Bank and the International Monetary Fund have resulted in the dismantling of public hospitals and, in general, the reduction of services in national healthcare systems.

Former World Bank Vice President Joseph Stiglitz acknowledges that in such negotiations "countries were set strict targets (...) in some cases the agreements established *which laws* the country's parliament had to pass to meet the IMF's requirements or 'objectives.'"[19] His examples illustrate that the failures of such measures are manifold: slashed food subsidies in Indonesia only exacerbated the crisis and slashed health programs in Thailand meant the reversal of some of the best AIDS measures in the world. Conversely, when the IMF's recommendations to cut education spending in Uganda and Jordan were flouted, there were huge benefits.[20]

In the case of Colombia, the EPS were created primarily by financial capital and managed with the aim of accumulating private capital. Their search to rationalize expenses meant abusing their condition as intermediary between the patient and healthcare service, trimming everything possible from the patient (formulation of health plans to reduce the number of medical procedures, as well as lists of medicines), increasing payments to the EPS (monthly contributions, plus copayments, plus moderating fees), and evading adequate payment to healthcare services (delaying transfers, rejecting service charges).

Unfortunately, hospitals were absorbed into that market logic, believing that their survival could be found in neoliberal management models: hiring for short periods of time, decreasing wages, applying pressure to avoid laboratory examinations, and putting pressure on patients to pay for services (withholding patients against their will, even delaying the release of corpses).

The rejection of patients, limited procedures and medical materials, the creation of requirements that are non-existent by law, an increase in the number of patients per hour

[19] Stiglitz, Joseph: *El malestar en la globalización [Globalization and its Discontents].* Taurus, Madrid, 2002*,* p. 71

[20] Stiglitz, Joseph: *The discomfort in globalization [Globalization and its Discontents].* Taurus, Madrid, 2002*,* pp. 106-111.

per doctor, persecution of health unions, the great diversion of health system efforts to administrative tasks, and forms of short-term contracting, are precisely the (practically) inevitable consequences of a healthcare system based on the laws of the market.

What healthcare service users in Colombia highlight are the consequences of this set up, but they are not always aware of their origin. This perverse logic has led some patients to believe that responsibility lies with the doctor on duty, and some doctors to believe that the responsibility lies with the patient, without realizing that the problem transcends them. These situations are caused by the surrender of healthcare to private capital, its management as a commodity, and the progressive withdrawal of the state from its functions as regulator of the healthcare system.

On the matter of the model itself, let us remember that one of the arguments health market advocates use is limited availability of resources. While this limitation is true, the real debate has two facets:

a) the amount of budget allocated by the state to the healthcare sector vis a vis the total national budget, meaning, how much of a priority is the health of the population to the state? For example, if we compare war and health budgets, we can conclude that our country prioritizes death over life; and
b) the distribution of resources within that healthcare system. For example, the percentage allocated to administrative expenditure is very high compared to other systems.

In relation to the distribution of resources within the healthcare system (for the sake of debate, considering for a moment the existence of EPS alone) the percentage of resources that ends up in the hands of private capital is shameful. In fact, bill 010 of 2010 (and other proposals) precisely sought to increase financial capital's control over healthcare resources. Healthcare reforms have been essentially cosmetic over the last 26 years, and all current bill 010 proposes is a mere name change from EPS to Health Insurers (AS).

However, the healthcare system would remain intact (its types of recruitment, forms of payment, financial intermediation, the capitation payment unit, drug regimens and limitations, etc.), and along with it, all deriving violations to the right to health would also persist.

To date, this transfer from the public to the private partially explains limited benefit plans and medicines lists, double payment (premiums and copays) systems, delays in treatment, exclusions, precarious working conditions for health workers, evasion, and corruption. All of this is what was laid all the more bare during the pandemic. The policies developed by EPS during the pandemic also demonstrate the same behavior of appropriating resources

without redistributing to IPS and without assuming biosecurity priorities. What more evidence do we need?

5. THE PROPOSAL: RECOVER THE ROLE OF THE STATE

As has been observed since 1993, administrative gymnastics and wage cuts have failed to ensure the dignified survival of healthcare hospitals. The depressingly infamous "*paseo de la muerte"* or "death crawl" is a daily occurrence that precisely reflects the triumph of the market over the right to health. We believe that neither palliative nor temporary measures can provide a just response to the health needs of Colombians.

Since the greatest evil is fiscal intermediation, a tool applauded by both national elites and international banks, dismantling the EPS is fundamental. International experiences have shown, both in Tanzania and Spain, in Cuba and Sweden, that the adoption of IMF measures has seriously impaired equity in healthcare services. The debate is not, therefore, one of limited resources, as we mentioned above, but of public policy being at the service of the EPS, reducing or restricting the state's work to legislating according to the wishes of the EPS lobby.

The state must regain its role as regulator of health services. With the formulation of Law 100 of 1993, the state relinquished part of its functions, handing them over to healthcare fiscal intermediaries. For years, the former Consejo Nacional de Seguridad Social en Salud (National Council for Social Security in Health) assumed leadership tasks that should be the responsibility of a Ministry of Health that prioritizes the public, while in fact the Council regulated in favor of the market.

The public hospital must be defended as a lynchpin for the population's health, not only as a provider of healthcare services, but also as a space for community participation, disease prevention, and health promotion, as demonstrated by various national and international experiences. The social purpose of this public enterprise must be a priority that cannot be diminished under the pretext of effectiveness and efficiency. Indicator formulation and healthcare services evaluations should be based on the effective satisfaction of health needs and not on the accounting of service sales.

Equity in healthcare services: the current health model is structurally designed in such a way that it is impossible to apply principles of justice and equity in daily practice. A differential approach to services must be offered by providing greater services to those who need them most, not to those who have greater capacity to pay.

Universality and comprehensiveness of services: it is urgent that therapeutic limitations (both medicines and procedures) be dismantled and replaced by a population-based,

territorial care model, deploying the APS (primary health attention) strategy. In the current model it is impossible to practice medical ethics because the health professional has become an alienated worker at the service of the financial capital of the EPS and the international capital of pharmaceutical companies.

Transnational company control of drugs: it is surprising that medicines produced in Colombia can be bought more cheaply than in the countries to which Colombia exports. The pharmaceutical industry is known to lobby the Ministry of Health to guarantee the profitability of its products, which seriously affects patient access to treatments. We want a Ministry of Health capable of regulating transnational pharmaceutical capital, as well as the financial capital represented in the EPS.

We reject the EPS that is representative of an intermediary model. We believe that the duty of care should reside in the state. EPS have private capital and take resources from the health sector, impregnating all actions of the healthcare system with the logic of the market. The right to health is affected by its desire for profit.

Public health institutions should be the backbone of the national healthcare system. We reject any closure or sale of public hospitals or clinics. Their ability to survive cannot be based on their service sales, but on their social value.

The National Health System must provide a universal service. Health protocols should be based on medical-health needs and not on a cost-cutting policy. The notion of compulsory healthcare plans, medicine lists, procedure lists, etc. are contrary to universal coverage and compatible with the logic of the marketization of health.

The prices of medicines should, without exception, be determined by the national government, both for wholesalers and retailers. We reject the determination of drug prices by the pharmaceutical lobby.

6. EPILOGUE: PLAYING MONOPOLY WITH HEALTHCARE

The state of healthcare is serious, on that there is consensus. Where consensus is lacking is on the causes and responsible parties. Everything began with the enactment of Law 100 in 1993, sponsored by Álvaro Uribe Vélez. There was nothing original in this model: it copied the ISAPRE model (our EPS) established by Pinochet in Chile, applied the World Bank's recommendations to make healthcare profitable, and built itself on healthcare economics analyses designed at Harvard, such as its "Global Burden of Disease" report.

The above, well-packaged and availing of certain guiding principles (that do not extend beyond formulation) allowed the imposition of a model that, in the long run, is simple: have an intermediary charge the users of the system (converted into customers) and hire service providers (hospitals). The deal established by these rules is simple: the profit of private

intermediaries depends on their seeking to reduce the services provided to clients and reducing the costs of healthcare institutions, while the state is responsible for non-profitable tasks.

This system, with its market rules, is reminiscent of the Monopoly board game. In this game it is not possible to act in solidarity, because the nature and rules of the game do not aim to distribute wealth or benefit participants, but to have some win and others lose. Donating a house or a hotel does not alter the consequences of capital accumulation through the exchange, sale, auction, and wagering of property.

In the healthcare sector, the existence of medicine and procedure lists, medical check-ups that avoid certain exams or dodge the prescription of expensive treatments, the proliferation of all kinds of trickery to avoid paying hospitals, and an ad nauseum etcetera, demonstrate the consequence of subjecting healthcare to the market economy. Law 100 is the cause of such practices.

To further secure the model, a series of myths are created: medical spending must be rationalized by accounting, even for gauze (paradoxically, the military does not have limited spending, which shows that the country has limitations in saving lives, but not in killing), when the problem is not only limited resources, but the distribution of resources in the public sphere and the surrender of healthcare resources to the private sector.

There is an assumption that hospital administration can save Colombian hospitals economically, when their survival really means that that they can "sell health profitably"; that is, through patient selection, reducing the costs of care, and decreasing the salaries of employees.

Curiously, those who have overseen the healthcare system seem to be participating in a revolving door between the EPS and the Ministry of Health and vice versa, without any hesitation.

The only option is for the state to resume its functions as guarantor of healthcare, as demanded by the Constitutional Court. But a Ministry of Health at the service of the EPS and pharmaceutical companies cannot offer a way out of the health crisis due to the business relationships they have fortified since 1993. It is for this reason that we continue to play Monopoly.

7. RECOMENDATIONS

For the Colombian state:

- Recognize its governing role as guarantor of the right to health, including the interdependent rights to food and drinking water.

-Review policies on access to safe drinking water to enable disease prevention measures.

-Address problems of malnutrition, especially in vulnerable areas of the country that overlap with the development and prevalence of diseases.

- End intermediation between the state and companies that turn healthcare into a business and violate the fundamental rights of people.

-Increase the health budget and ensure its proper use, especially for vulnerable and resource-poor areas, as they are the most affected by Covid-19.

For human rights organizations:

- Contribute to the promotion and guarantee of the right to health, in terms of access, service availability, quality, and acceptability.

-Document and make public the structural consequences of the pandemic response.

-Implement a national advocacy campaign based on the negative consequences of the current health model.

-Develop mechanisms to monitor the use of healthcare resources.

-Strengthen discussions on the formulation of alternative models to the current Colombian healthcare model.

For healthcare personnel:

-Work towards the unity of healthcare personnel to defend decent working conditions and the right to health, generally.

-Promote wage and gender equity among healthcare workers.

-Report on irregularities in the delivery of healthcare by EPS and IPS in a timely fashion.

-Based on their experience, contribute to the formulation of alternative models to the current Colombian healthcare model.

For Colombian society:

-Maintain media and social pressure to put an end to Law 100.

-Support policies and projects to move towards legislation that can provide real protections for healthcare for society and the working conditions of healthcare personnel.

-Join observatories on the right to health and contribute from their experience to the formulation of alternative models to the current Colombian healthcare model.

Plataforma Colombiana de Derechos Humanos, Democracia y Desarrollo
www.dddhhcolombia.org.co plataformaco@gamil.com calle 54 No. 10-81 Cuatro Piso
Bogotá - Colombia