

E4 | COLOMBIA: SOCIAL STRUGGLES AGAINST THE COMMODIFICATION OF HEALTH¹

In Colombia, neoliberal reforms initiated in the 1990s began dismantling the edifice of the social security system. As part of these, reforms were initiated in the health system in 1993 through enactment of what is known as ‘Law 100’. The reforms sought to develop a healthcare model that was primarily based on individual private insurance. The Colombian ‘model’ was held out as a ‘success story’, and in fact was showcased as the model for achieving Universal Health Coverage (UHC) (see Chapter B1). However, the story told by the Colombian people is very different.

The reforms in the Colombian health system soon became an arena of struggle, revealing the disparity between those who defended the commercial model of healthcare and those who disputed this model from an understanding of health as a public good and a human right. During the last twenty years, this political contention around health policy has generated significant social mobilization against privatization of health, and has led to the emergence of a social movement for the right to health.

Law 100 and its impact on the right to health

Colombia was one of the most ‘faithful’ among Latin American nations in embracing and promoting the guidance provided by multilateral financial organizations. An adherence to this ‘guidance’ led to adoption of policies in the economic, social and political spheres. These policies (located within the logic of neoliberal globalization) promoted liberalization of markets and other standard measures that are the hallmark of ‘structural adjustment’ (see Chapter A1). A series of reforms were pushed through, in both the state apparatus (judicial and administrative reforms) and the economic and social sectors (tax, education, labour, social security and health reforms). These reforms were directed at bringing about a reorientation of the state. The state’s primary role was now seen as that of a ‘regulator’ instead of a direct provider of social services such as education, health, housing, etc. In the health sector, Colombia followed the prescriptions outlined by the World Bank in its 1988 document entitled *Financing health services in developing countries: an agenda for reform* (World Bank 1988).

The 1991 Constitution is in line with this new orientation. It does not define health as a human right but as a public service that can be provided by public or private institutions, thus establishing the basis for social security reforms through ‘Law 100 of 1993’. This led to the creation of the General



Image E4.1 National campaign for health and social security in Colombia (People's Health Movement)

System of Health Social Security (*Sistema general de seguridad social en salud*, SGSSS). SGSSS is a model based on individual insurance and regulation by market mechanisms. Health insurance companies (*Entidades promotoras de salud*, EPS) form the linchpin of this model.

Law 100 of 1993 is premised on an understanding of health as a 'private good'. It places responsibility on individuals to access health services from the market. In this system, the state addresses the needs of people who cannot pay through targeted subsidies. Through the operation of this law over the past twenty years, the concept of health as a commodity has been established, as opposed to an understanding of health as a human right and a duty of the State (Torres-Tovar and Paredes 2005).

The functioning of the SGSSS has led to a number of negative effects, and these have been the cause of the emergence of social struggles for the right to health. Some of these effects include:

- 1 the weakening of public institutions in social security and health leading to structural weaknesses in the development of policies and programmes for public health, health promotion and prevention, health surveillance and disease control;
- 2 the deterioration of the health status of the people and of conditions of employment of workers in the health sector;

- 3 increased barriers in accessing health services for almost the entire population, as evidenced by the high rates of legal action seeking protection by the state.

Collective social action for the right to health

Collective social action for the right to health over the past twenty years in Colombia can be divided into three phases. The first phase involved the articulation of demands. During this phase, in the period just after the implementation of Law 100, different sections of the population articulated sectional demands. Workers demanded protection of labour rights; students demanded increased budgets for education and health and for maintaining vocational training; users of health services demanded a better quality of services; groups of health professionals demanded the recognition of their social and employment status; and the indigenous peoples demanded a specific law that recognized their traditions and practices in health.

Each social group carried out its own analysis of the impact of the new law. They also, individually, sought legal recourse for protection of their rights. These separate strands of action were later to coalesce into a broad social movement.

A second phase, involving the politicization of the struggle, began in 2000. This phase commenced with preparation for and organization of the First National Congress for Health and Social Security. A collective called *Acciones Sociales Colectivas por el Derecho a la Salud* (Social Actions for the Right to Health – ASCDS) used this opportunity to provoke a broad public debate on the right to health.

This phase of activity promoted public debates that shaped the proposal to build a social movement for health and a process of political mobilization. The contours of a new model of health were agreed at the Second National Conference on Health in 2004. Key elements of the proposal for a new health system include that it should:

- 1 be based on an understanding of health as a human right linked to well-being and quality of life;
- 2 be universal, equitable, solidarity based and cognizant of differences (cultural, gender, age);
- 3 be administered with a public ethos, without insurance companies functioning as intermediaries;
- 4 be financed from the national budget, through a national public fund and regional funds;
- 5 prioritize health promotion, prevention and education;
- 6 implement a national system of health information;
- 7 respond to people's needs and include technological developments (equipment, medicines, etc.);



Image E4.2 Health professionals march in Bogotá against the reforms (Mauricio Torres)

- 8 incorporate the cultural and intellectual heritage of indigenous medicine and medicine of other ethnic groups;
- 9 be subject to social surveillance and control with a high participation of citizens.

Over a period collective actions grew and there was a greater politicization of the movement. This was based on the realization among different partners in the movement that the structural causes of state policy needed to be countered by collective action. Thus, while actions on specific demands continued, different sections opposing the reforms began working together in a coordinated manner.

A significant development in this phase was the election of a non-neoliberal government in the city of Bogotá. The new government of the city sought the help of ASCDS and this enabled district-level public health policy to be designed from the perspective of human rights. It was also possible to incorporate some elements of the proposal described earlier (Vega-Romero et al. 2008). Valuable experience was gained regarding challenges that exist, at the local level, to the reorientation of state policy (away from the premises of Law 100).

Since early 2011, a third phase of the struggle has been taking shape. This phase of the movement has progressed in shaping a collective identity of the struggle and has also accomplished further concretization of the alternative proposals. Through years of working together in the common struggle, different sections that are active have developed common positions on many issues. Consequently, the movement is much less fragmented now.

The progress in shaping a collective identity for the struggle has been very valuable in channelling the collective outrage of the people against measures by the national government to forcibly implement a system that helps the insurance companies. These measures are clearly against the interests of the people, as well as of health workers and professionals (Torres-Tovar 2010). Two processes are now taking place simultaneously: convergence of a movement around health as a right, and a conceptual clarity against an insurance-based model of healthcare that is represented by the model promoted by Law 100.

Protests in Colombia escalated in 2013, brought on by the condition of the health system and outrage in the face of the Bill introduced by the national government. This Bill is designed to further deepen the impact of Law 100 and will exacerbate the health crisis in Colombia. Protests are taking place in various ways: blockades, marches, pot-banging, permanent assemblies, public discussions, information dissemination through social networks, rejection letters through virtual platforms, etc. The streets are filling up with protesters, many of whom are medical students and young graduates.

Looking forward

The experience gained in the past twenty years has sharpened the understanding that there is a need to confront a political class, a national government and a parliament that do not represent the interests and needs of society. The movement for better healthcare is also now a movement for increased political participation of the people in the shaping of policies.

This implies that all social, academic, legal, technical and political efforts must be continuously directed at increasing people's dissatisfaction with the present system. The movement has the task of channelling people's anger and their growing consciousness to build a political platform for the right to health. Such a platform would not just seek a new healthcare system, but would also demand initiatives around health promotion, prevention and rehabilitation.

Note

¹ This chapter is based on research conducted by the 'Social Collective Action for the Right to Health in Colombia' from 1994 to 2010, published as *Lucha social contra la privatización de la salud*, Ediciones Cinep, Bogotá, 2013.

References

- Torres-Tovar, M. (2010) 'Colombia: declaratoria de emergencia social. Salvavidas para el negocio de la salud', *Le Monde Diplomatique*, 86: 2-3, Bogotá.
- Torres-Tovar, M. and N. Paredes (2005) 'Derecho a la salud. Situación en países de América Latina. El caso colombiano, "El mercado no es para todos y todas"', *Gerencia y Política de Salud*, 4(8): 169-85.
- Vega-Romero R. et al. (2008) 'Health policy in Bogotá (2004-2008): an analysis of the experience with primary health care', *Social Medicine*, 3(2).
- World Bank (1988) *Financing health services in developing countries: an agenda for reform*, Policy study, Washington, DC: World Bank.