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Judicialization of the right to health: (Un) compliance of the judicial decisions in Medellin, Colombia

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Summary

Introduction: The judicialization of health arose following the possibility of judicially demanding the right to health before national and international courts. In the case of Colombia, health litigation is done through a constitutional tool called the *tutela action*, which allows for the immediate protection of fundamental rights.

Methods: A retrospective cross-sectional study using a probabilistic stratified sample of 1031 users of the tutela actions, in Medellín, Colombia, between 2011 and 2014. Bivariate and multivariate analyses were performed, using statistical tests and multiple logistic regression models.

Results: According to the respondents, 95.9% of the tutela actions succeeded in favour of the applicant. On average, the judicial process took 10.96 days (SD = 8.09). After the favourable decision of the tutela action, access to health care followed in 76.2% of cases, partial access was found for 14.0% (median, 10 d), and in 9.8% of cases, claimants had not received access to the health care they sought.

Conclusion: The tutela action is an essential constitutional mechanism that guarantees the access to health services. However, it must be strengthened from the legal point of view through the implementation of monitoring and control actions and by imposing the sanctioning measures and deadlines established in existing legislation.

KEYWORDS

access to health care, Colombia, court decisions, judicialization of health, *tutela action*

1 | INTRODUCTION

The judicialization of health has created the possibility of demanding the right to health in national and international courts.[1] Judicial intervention can promote the right to health and encourage governments to fulfil their national constitutional obligations and their obligations outlined in regional and international treaties.[2] In addition, the judicialization of health highlights the limitations of health policies as well as the need to update health system programs and to change clinical guidelines.[3]

The right to health is enshrined in most constitutions of the Latin American countries. In Colombia, citizens can make claims to the right to health using a mechanism called the *tutela action* (*acción de tutela*)[4] and in other countries of the region is known as writ of *Amparo* (*recurso de amparo*).[5] In 1991, the tutela action was established in Article 86 of the Colombian Constitution as a mechanism for the immediate protection of fundamental rights. Court decision must be issued within a maximum of 10 business days and must be fulfilled within 48 hours. For urgent cases, such as when the patient's life is compromised, the judge can order a provisional measure of immediate compliance.[4] In case of noncompliance with the judgment, the litigant has the possibility of demanding an incident of contempt (*incidente de desacato*).[6]

As the tutela action may be seen as a way of protecting human rights, it is important to note that health is a right established in the Universal Declaration of Human Rights in 1948. In 1966, the International Covenant on Economic, Social, and Cultural Rights established it as a social right, reinforcing the State's commitment to achieving universal health care coverage and high levels of physical and mental health of the population.[7]

The right to health is a very broad concept that is strongly linked to other human rights and the social determinants of health. However, this work focuses specifically on access to medical care. The full protection of the right to health implies a health system that provides equal opportunities in access to health promotion programs, prevention and treatment of diseases, access to medicines, maternal and child health, and reproductive health.[7] People who are incorporated into the health system will have enough information to take care of their own health, but if they get sick, they can access quality medical care in a timely fashion.[8]

In Colombia, health care reform is a complex phenomenon.[9] The Social Security Health System (*Sistema General de Seguridad Social en Salud*-SGSSS) was created by Law 100 of 1993. In 2007 and 2011, two partial reforms were carried out through Law 1122 and Law 1438, respectively. Additionally, in 2015, Law 1571 aimed to guarantee the fundamental right to health. The SGSSS regulates basic public health services and access of the entire population to health care services through two main schemes. First, the *contributory* scheme includes the employed population, as well as those who are retired or self-employed. The second scheme is the *subsidized* regime, which includes poor people identified through the System of Selection of Potential Beneficiaries for Social Programs (*Sistema de Identificación y Selección de Potenciales Beneficiarios para Programas* Sociales-SISBEN), and it is subsidized by the State.[10] People who are not included in these two schemes are called the *uninsured poor*.[11] In 2016, according to the Quality of Life Questionnaire, 95.4% of the population was affiliated to the health system in the contributory and subsidized schemes and 4.6% belonged to the uninsured poor.[12]

The Colombian health system was created with the aim of improving access to medical care and is characterized as a model of regulated competition for insurers.[13,14] However, because this model is based on an insurance market, in which the insurers apply strategies to contain costs and increase microeconomic efficiency, the model can limit the realization of the right to health of the population.[15-18] In situations of failure, users of the health system are encouraged to demand access to health care through constitutional mechanisms such as the tutela action, described by

some authors as an immediate judicial protection of their fundamental rights. However, some authors disagree about the protective role of the tutela action. Some argue that the main beneficiaries are patients from high socio-economic strata, who have the ability to access the judiciary and request health services that are not covered by the health system. Others argue that the coverage of high-cost medicines and procedures generates exorbitant expenses and compromises the sustainability of health systems.[2,19-21] Biehl et al discuss some myths regarding the judicialization and anti-judicialization of health in Brazil, concluding that the beneficiaries are poor and older individuals who do not live in the main metropolitan areas of Brazil.[22]

Scientific studies on the judicialization of health are yet limited, but variations have been found both among and within Latin American countries. Many studies are based on secondary data, particularly from courts registers. The results are focused on the number and type of judicial decisions and the most requested types of health services. However, more studies that investigate the sociodemographic characteristics of the litigants, following the example of one study conducted in Brazil[22] are needed. Knowledge about the effectiveness and the impact of judicial decisions on access to requested health services is crucial to regulate the judicialization of health.[23-26]

In Colombia, the ability to file tutela actions does not require intermediaries. However, several institutions support patient-litigants in this judicial process. In Medellin, Colombia, the *Personería de Medellín* is one of these institutions. The *Personería* has administrative control in the municipality, with budgetary and administrative autonomy. The *Personero*, who heads the *Personería*, is responsible for carrying out duties related to the defence and promotion of human rights, the protection of the public interest, and the supervision of public officials.[27] This work, using primary data collected in Medellin, Colombia, aims to (a) summarize the sociodemographic characteristics of beneficiaries of the tutela action; (b) estimate the compliance rate with court rulings, including both compliance with the regulated times to receive a decision and with access to health care; and (c) explore factors that can affect the two types of compliance.

2 | METHODS

2.1 | Study design

A cross-sectional observational and analytical study was carried out. The study population corresponds to the users who presented tutela actions between 2011 and 2014 through the *Personería in* the city of Medellín, Colombia. A sampling frame of 25 890 records was provided. Using a stratified sampling procedure by year, a probabilistic sample was obtained, as described later.

Additionally, a retrospective substudy was performed, using the judicial website: http://procesos.ramajudicial.gov.co/consultaprocesos/ to obtain official data about the court decision, in order to compare the official data with the reported data. It should be noted that the site is freely accessible to the public, but it is very difficult to locate some judicial processes.

After ethical approval (IHMT—Decision No. 10-2015-TD), this study was implemented from September 2015 to September 2016.

2.2 | Sample size and sampling procedure

A proportional stratified sampling procedure was used, considering each year as a stratum.[28] This type of sampling was used for logistical reasons because the database was provided in different files correspondent to each year. The sample size was calculated with a margin of error of 3%, a confidence level of 95%, and using an estimate of 0.50 for a favourable decision to the claimant in the regulated time. Some studies indicated high values of a favourable decision (eg, 74%).[29] However, no studies were found that consider whether or not the decision was handed down in the regulated time. Thus, an estimate of 0.50 was fixed because it corresponds to a maximum sample size, which is also

desirable, taking into account several polytomous variables and the posterior use of logistic regression models. The resulting recommended sample size was 1025 individuals. In order to account for potential losses due to change of address, inactive contacts, omissions, or refusals to participate in the study, an additional 2% was added. At the end, by stratum, the sample size for each year was 311 claimants from 2011, 293 from 2012, 227 from 2013, and 200 from 2014. Overall, 1031 claimants participated in a survey questionnaire, which was elaborated in Spanish. A pretest of this questionnaire was applied to 50 claimants to improve and clarify questions and other logistic aspects.

The survey was conducted through a telephone interview. The database contained a telephone number and/or mobile phone of contact of the claimant, who could be the beneficiary of the tutela action or a family member or a friend of the beneficiary. In all cases, the respondent gave (independently of whether she or he was the beneficiary of the tutela action or not) information about the beneficiary. The questionnaire was applied after oral informed consent.

For the retrospective substudy, 490 cases were selected randomly from the 1031 cases. From these 490 cases, there were 179 complete cases, which included the type of court that issued the decision of the tutela action (eg, criminal or civil), the date that the tutela claim was filed, and the date of the decision. Basically, with this information, the time between the filing of the claim and final decision on the tutela action was calculated and compared with the time reported by the respondent, to verify whether the official time of the decisions and the time indicated by the respondents were similar.

2.3 | Data analysis

Statistical analysis was performed using SPSS software version 24. Firstly, the data were analysed from an exploratory perspective. The absolute and relative frequencies for nominal or ordinal variables and means and standard deviations for symmetric variables were calculated.[30] For asymmetric variables, the median was accomplished by the interquartile range as measure of dispersion.[31]

Confidence intervals for proportions (eg, percentage of favourable decision in regulated time or access to health care) were estimated by Wilson method, using EpiTools.[32,33]

The normality of the distribution was tested with Shapiro-Wilk and Kolmogorov-Smirnov (with the Lilliefors correction) tests. The association of qualitative variables was carried out using chi-square or Fisher tests. A paired *t* test was used to compare official time and reported time.[31]

Logistic regression models were used to identify which explanatory variables were related to (a) whether or not the judge issued a decision in regulated time and (b) whether or not the access to health care was obtained after a favourable ruling.[34] These two dependent variables were dichotomized from the time that judge took to issue the ruling, according to Colombian law. In the first case, "compliance" corresponds to the decision being made in less than or equal to 10 days and "noncompliance" if the decision took more than 10 days (The 10 working days became 14 calendar days to include two weekends because the respondents reported values in calendar days). In the second case, "compliance" refers to obtaining access to health care in less than 2 days or "noncompliance" for more than 2 days.

Simple logistic regressions were performed using each independent variable. After, variables with $P < .10$ or with a relevant meaning (eg, sex and age) were included in multiple logistic regression models.

3 | RESULTS

3.1 | Sociodemographic characteristics of the beneficiaries of the tutela action

In 40.5% (n = 418) of the cases, the tutela action was filed by the beneficiary who responded to the questionnaire. In 59.5% (n = 613) of the cases, the tutela action was filed by a relative or friend who gave the information of the beneficiary of the tutela action. With few exceptions, we did not find any differences between these two groups of respondents.

According to the respondents, the average age of the beneficiaries was 48.7 years (SD = 23.7), and the median was 52 years (P25 = 31, P75 = 66).

Table 1 describes the sociodemographic characteristics of the beneficiaries of the tutela action. Predominantly, the beneficiaries were female (57.7% compared with 42.3% for male). Regarding marital status, most were single (42.9%), and 40.0% were married or in civil unions.

The education level was low, 42.3% of beneficiaries only had completed primary education, and 16% had completed less than that.

Socio-economic status is divided into six strata in Colombia, with one as the lowest and six the highest. In this sample, 87.5% of beneficiaries belonged to the three lowest strata, revealing that this judicial tool is primarily used by a poor population.

Table 2 shows the distribution of the beneficiaries by residence. Medellín is divided into six urban zones and one rural area. More than half (56.4%) of the beneficiaries of the tutela action live in zones 1 to 3, which are defined by low or medium-low socio-economic levels. Only 9.5% live in zone 4, which is characterized by medium to medium-high socio-economic status. Only 1.0% of beneficiaries reside in the richest part of the city (zone 5), with medium-

TABLE 1 Sociodemographic characteristics of the beneficiaries of the *tutela action*, Medellín 2011-2014

Variables	n (%)
Gender	
Female	595 (57.7)
Male	436 (42.3)
Civil status	
Single	442 (42.9)
Married/union	413 (40.1)
Widower	109 (10.6)
Divorced	67 (6.5)
Education level	
Without studies	165 (16.0)
Primary education	436 (42.3)
Secondary education	288 (27.9)
Technical/technological studies	76 (7.4)
Bachelor's degree	57 (5.5)
Postgraduate	7 (0.7)
No information[a]	2 (0.2)
Socio-economic level	
One (low-low)	198 (19.2)
Two (low)	445 (43.2)
Three (medium-low)	259 (25.1)
Four (medium)	45 (4.4)
Five (medium-high)	22 (2.1)
Six (high)	6 (0.6)
No information	56 (5.4)

[a]In these two cases, a friend who provided the information of the beneficiaries of the *tutela action* did not have the knowledge of their education levels.

TABLE 2 Residence zone of the beneficiaries of the *tutela action*, Medellín 2011-2014

Zone	Number of Communes	Socio-economic Level That Predominates	n (%)
Zone 1 (Northeast)	4	Low and medium-low	254 (24.6)
Zone 2 (Northwest)	3	Low and medium-low	197 (19.1)
Zone 3 (Central-Eastern)	3	Low and medium-low	131 (12.7)
Zone 4 (Central-Western)	3	Medium and medium-high	98 (9.5)
Zone 5 (Southeast)	1	Medium-high and high	10 (1.0)
Zone 6 (South West)	2	Medium-low and medium	87 (8.4)
Rural area	NA	NA	39 (3.8)
Municipalities metropolitan area	NA	NA	112 (10.9)
Other municipalities of Colombia	NA	NA	103 (10.0)
Total			1031 (100)

Abbreviation: NA, not apply (there is no information about the neighbourhood).

high and high socio-economic levels; 3.8% of the beneficiaries live in the rural area outside of Medellín (where socio-economic status was not defined), and 20.9% reside in other municipalities of the country.

3.2 | Social security scheme

Regarding the social security scheme of the beneficiary of the tutela action, the most beneficiaries belonged to the contributory regime (53.4%), while 40.6% belonged to the by the subsidized scheme. Only 2.5% belonged to the special regime, and 3.4% did not have any scheme (uninsured poor). Only 3.4% reported having prepaid health plans or special health plans.

3.3 | Characteristics of the tutela action

Table 3 shows that two-thirds of respondents (66.7%) did not know which court issued the decision on their tutela action. Respondents indicated the civil court (11.4%), the criminal court (11.7%), the family court (4.9%), the labour court (2.7%), and the administrative court (2.4%).

Given this lack of knowledge about the type of court, the substudy of the official data obtained from the judicial website (n = 179) was particularly important. This substudy revealed that decisions were given by the criminal court (35.9%), the civil court (23.9%), the administrative court (19.6%), the labour court (13.0%), and the family court (7.6%) (data not shown).

In our sample (n = 1031), only 21 (2.0%) of the respondents did not know the decision of the judge. Our findings indicate a high percentage of judgments decided in favour of the beneficiary in the tutela action—95.9% (95% CI, 94.5-97.0). Of these 21 decisions against the beneficiary, two (9.5%) were under appeal, waiting for a new decision.

3.4 | Waiting time for the decision of the tutela action

According to respondents, the decision of the tutela action was given in a mean of 10.9 days (s = 8.0) and median of 10 days. The minimum number of days was 0.04, and the maximum was 90 days. The official time registered on the judicial website—calculated using the registration date and the date of the judgment (n = 179)—indicated that the decision was given in a mean of 15.2 days (s = 15.2) and median 13 days, with a minimum of 0.05 days and maximum

TABLE 3 Features of *tutela action*, Medellín 2011-2014

Variables	n (%)
Court that issued the judgment of the tutela action	
Civil	118 (11.4)
Penal	121 (11.7)
Family	51 (4.9)
Administrative	25 (2.4)
Labour	28 (2.7)
Not know	688 (66.7)
Total	1031 (100)
Decision of the judge	
In favour	989 (95.9)
Against	21 (2.0)
Not know	21 (2.0)
Total	1031 (100)
Legal process contesting (n = 21)	
Not	19 (90.5)
Yes	2 (9.5)
Total	21 (100)

of 158 days. Therefore, for this paired subsample, significant differences were found ($P < .001$), with a higher mean waiting time in official registers compared with reported time by beneficiaries.

Table 4 shows compliance with the legal deadline to issue a tutela action—within a maximum of 10 business days—considering the social security scheme and year. Similar percentages of compliance of the legal deadline were found among users of the different schemes ($P = .490$). More than 70.0% of the users of the subsidized and the contributory schemes received a decision in the regulated time. In the smallest group, the uninsured poor (n = 26), noncompliance with the judgement was highest (42.3%), however, without statistically significant differences.

TABLE 4 Compliance with the term of the decision of the *tutela action* by social security scheme and by year, Medellín 2011-2014

	Compliance With the Deadline to Issue the Court Decision		
Variables	Compliance n (%)	Noncompliance n (%)	*P* Value
Social security scheme			
Contributory	355 (71.0)	145 (29.0)	
Subsidized	277 (71.2)	112 (28.8)	.490
Special	16 (66.7)	11 (33.3)	
Any (poor uninsured)	15 (57.7)	11 (42.3)	
Year			
2011	189 (65.9)	98 (34.1)	
2012	193 (72.6)	73 (27.4)	
2013	138 (67.0)	68 (33.0)	.009
2014	143 (79.4)	37 (20.6)	

Analysing compliance rates by year, differences were significant (P = .009) and revealed an improvement over time. Even with an exception in 2013, from 2011 to 2014, the compliance rate varied from 65.9% (95% CI, 60.2-71.1) to 79.4% (95% CI, 73.0-84.7).

Based on official data, considering 14 calendar days, the compliance rate was 76.0% (95% CI, 69.2-81.6).

In terms of compliance with regulated time to take the decision of the tutela action (10 d), several multiple logistic regression models were explored to identify related factors. Table 5 suggests a borderline improvement in 2012, considering as a reference year 2011 (OR = 1.47; P = .050). A statistically significant higher chance of compliance with the regulated time was found for patients receiving the judicial decision in 2014 (OR = 1.95, P = .005), compared with 2011. Regarding the location of residence, taking the Northeast (zone 1) as the reference group, the model suggests that the residents of the rural area (OR = 0.30; P = .003) and residents of municipalities of the

TABLE 5 Multiple logistic regression to fit the decision variable of the judge in the time foreseen by the law adjusted for age and gender, Medellín 2011-2014

Variables	OR	CI 95%		*P* Value
		Lower	Upper	
Year of the *tutela action*				
2011	Reference			
2012	1.47	1.00	2.16	.050
2013	1.00	0.66	1.50	1.000
2014	1.95	1.22	3.12	.005
Residence zone				
Zone 1 (Northeast)	Reference			
Zone 2 (Northwest)	1.31	0.82	2.10	.257
Zone 3 (Central-Eastern)	0.88	0.52	1.48	.633
Zone 4 (Central-western)	0.73	0.40	1.33	.312
Zone 5 (Southeast)	1.36	0.22	8.33	.733
Zone 6 (South West)	0.63	0.34	1.13	.126
Zone 7 (Rural)	0.30	0.14	0.66	.003
Municipalities metropolitan area	0.55	0.32	0.96	.035
Other municipalities	0.71	0.38	1.32	.289
Socio-economic level				
One	Reference			
Two	0.54	0.35	0.85	.008
Three	0.60	0.36	0.99	.048
Four	1.51	0.58	3.89	.394
Five and six[a]	0.49	0.17	1.37	.177
Health care requested				
Surgical procedures of low complexity				
No	Reference			
Yes	0.42	0.21	0.83	.013

[a]Levels 5 and 6 (medium-high and high) were grouped by statistical reasons, because some numerical instabilities were found in the process of obtaining the coefficient estimates of the model.

metropolitan area (OR = 0.55; *P* = .035) are less likely to get a decision in less than 10 business days. In terms of socio-economic status, taking the lowest stratum as the reference group, this model indicated that patients from levels 2 (OR = 0.54; *P* = .008) and 3 (OR = 0.60; *P* = .048) had less chance of obtaining a decision of the tutela action in the regulated time.

Regarding the content of requests for health care, patients who requested low-complex surgical procedures were less likely to obtain a decision in the regulated time (OR = 0.42; *P* = .013) compared with patients who did not request this type of health care procedure.

3.5 | Access to health care after the decision of the tutela action

After the favourable decision of the tutela action, access to health care followed in 76.2% of cases, according to respondents. Partial access was found for 14.0%, and in 9.8% of cases, claimants had not received access to the health care they sought, at least by the time of the interview. The median number of days until the patient received access to health care was 10 days (P1 = 3 and P3 = 20). The minimum waiting time was 0.13 days (approximately 3 h), but the maximum was very high (730 d) for one patient.

According to Decree-law 2591 of 1991, after issuing the decision of the tutela action, access to health care must be provided within 48 hours. For the 989 patients with a favourable decision of the tutela action, only 17.9% (95% CI, 16.2-21.3) reported access to health care in regulated time. There are even cases where access to health care, for example, took more than 2 years.

Table 6 shows a multiple logistic regression model for compliance in terms of the access to health care in regulated time. This model suggests a higher chance for accessing health care in less than 2 days for patients who had been hospitalized in the last 5 years (OR = 1.93; *P* = .000) and patients requesting medicine (OR = 1.45; *P* = .047).

Patients who requested a hospital referral had five times the likelihood of accessing health care in the regulated time (OR = 5.00; *P* = .009). This situation can be explained because of the day the tutela action was filed, the patients were hospitalized, and therefore, they urgently needed a hospital change.

4 | DISCUSSION

Scientific studies based on primary data are scarce in Colombia and also in other Latin American countries, where the phenomenon of health judicialization is common.

The findings of this study showed that 64.8% of the tutela action beneficiaries lived in the poorest areas of the city of Medellín and only 1.0% lived in richest zone. Most of the beneficiaries of the tutela action also presented a low socio-economic status. This suggests that citizens of the lowest socio-economic status are those who most need this type of judicial tool. However, it is important to make clear that the *Personería de Medellín* advises approximately 50.0% of the tutela actions in the city of Medellín. The remaining 50.0% correspond to other institutions such as universities, the Office of the Attorney General, the *Defensoria del Pueblo*, foundations, NGOs, and private lawyers. Thus, the overall socio-economic status of all tutela users may be different. Patients with high socio-economic status are more likely to use the private sector because they can afford an additional health insurance.[35,36]

Some Brazilian studies have found that inhabitants of the richest regions and members of the middle class benefit most from lawsuits because they have greater access to the judicial system because in Brazil, legal representation is compulsory, which increases the inequities of the health system.[20,37,38] However, in Colombia, the access to tutela action does not require intermediaries. In fact, our findings suggested that tutela actions were requested mostly by patients of a low socio-economic status and from vulnerable areas of the city of Medellín. A study focused on Brazil showed that the judicialization of health was used by patients with a better socio-economic status[39] and that 60.6% of patients requested medicine from private health services. This suggests that they had a health plan or they can pay

TABLE 6 Multiple logistic regression to fit the access to health care in the time foreseen by the law after the favourable decision, adjusted by age, Medellín 2011-2014

Variables	OR	95% CI		*P* Value
		Lower	Upper	
Gender				
Male	Reference			
Female	0.64	0.45	0.91	.014
Previous hospitalization in the last 5 y of the interposition of the *tutela action*				
No	Reference			
Yes	1.93	1.34	2.79	.000
Requests in the *tutela action*				
Medical consultation				
No	Reference			
Yes	0.61	0.37	0.99	.047
Medicines				
No	Reference			
Yes	1.45	1.00	2.09	.047
Medical products				
No	Reference			
Yes	0.35	0.19	0.65	.001
Referral services				
No				
Yes	5.00	1.50	16.6	.009

for private services.[39] However, using primary data in the state of Rio Grande do Sul, Brazil, Biehl et al found that the majority of patient-litigants in this state is poor, older individuals, living in outside major metropolitan areas and who depend on the state to provide their legal representation.[22] Thus, geographic variations and different critical or favourable narratives around judicialization are expected in different settings.[18,20,22,40-44]

In our study, 95.9% of decisions had been decided in favour of users. This may suggest that the judges tend to protect the right to health in their decisions regarding tutela actions.

This percentage was higher, comparing with national level reported by Defensoría del Pueblo, which found that 85.46% of the tutela actions were decided in favour of the users. Some regional variations were found. For example, 87.1% was found in Antioquia (Colombia).[45-47] Other research in Colombia confirms the tendency of judges to issue favourable judgments to patients.[18,29,48] In Brazil, lawsuits are also favourable in a percentage of 90.0%.[22,24] By contrast, in Argentina, 75.0% of decisions were favourable, according to Gotlieb et al.[49] In Costa Rica, another study found 60.0% of favourable judgments.[50]

Regarding the regulated time for court decision, using secondary data, a study conducted in the city of Manizales-Colombia found a percentage of 74.0% of compliance with the regulated time.[29] In 2011, the *Personería de Medellín* analysed 384 cases of the different courts in the city of Medellín. In 25.2% of cases, the date of the decisions was not found. In the remaining cases, the average time to issue the decision was 13.2 days.[51] Our findings revealed a lower mean value (10.9 d), considering the self-reported data by participants. However, using the substudy of official case data, the mean was higher (15.2 d). The *Personería de Medellín*[51] found a compliance with the time established by law in 77.3% of the cases studied (this calculation was based on 14 calendar days). The

present study found compliance rates based on respondents' reports (70.6%) and on official data (76.0%) that are very similar to the previous study.

In about one-quarter of the cases, there was noncompliance with regulated time. This may be due to several reasons. For example, an overuse of courts or the absence of an information system or a specialized consultation mechanism that allows judges to easily access information for decision making could explain this noncompliance. Judges must resort to the patient's medical history based on the documentation attached in the *tutela action*. Further, judges might need to use the jurisprudence from similar cases (if applicable), research on the internet, and advice from nearby doctors (such as family and friends), among other sources, in order to decide the case. To understand the patient's situation, judges need medical advice to understand the technical-scientific details and clarify their doubts.[52] In addition to information gaps on health and administrative procedures, insurers also contribute to these failures. Rivera and Álvarez point out that insurers often do not respond or do not respond within the deadline, forcing judges to take longer time to make a decision.[52]

Despite a high percentage of the decisions of the tutela actions that were in favour of the users, according to the respondents, 23.8% of the users of the sample were not able to access health care or only had a partial access to health care. Regarding the temporal issue, the law in Colombia establishes that after a decision has been handed down, access to health care must be granted within 2 days. In our study, compliance with law was only observed in 17.9% of the cases studied. Thus, both those in charge of the health system and judicial system need to rethink how the tutela mechanism is used and develop other tools to promote compliance with judgments and the effective protection of the right to health.

During 2015 and 2016, the number of tutela actions in Colombia has increased significantly, particularly in Medellín, Antioquia.[47] In 2008, the Constitutional Court established that health is a fundamental right, and Law 1751 of 2015 further regulated the fundamental right to health. However, it seems that this legislation is still insufficient to guarantee the right to health of the Colombian population, as citizens have been forced to go to court to try to access health care.

The violation of the right to health may be also a consequence of the weak role of the National Health Superintendence in the inspection, surveillance, and control of health insurances in Colombia.[46,47] Colombian citizens continue to face significant barriers to obtaining basic health care and, therefore, as Nussbaum (2001) states, there is an absence of social justice and minimal social rights protections.[53]

5 | CONCLUSION

The judicialization of the right to health has allowed Colombian citizens to use the *tutela action* to try to gain access to health care; however, the issue of timely access to health care continues to be a challenge in the city of Medellín. Several issues upstream and downstream continue to be the major concerns in this country. The design and implementation of effective health policies that protect and guarantee the right to health of the Colombian population, avoiding or at least minimizing the use of this judicial tool, is crucial. Until a radical change occurs, downstream issues of the *tutela action* must be monitored and controlled in order to effectively comply with regulated times in law. Coordination between the health and judicial sectors should be improved.

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