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THE COLOMBIAN CONSTITUTIONAL COURT VERSUS THE INTERNATIONAL MONETARY FUND: ECONOMIC REFORMS, SOCIAL RIGHTS AND SOVEREIGNTY

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I. INTRODUCTION

One of the implications of the process of globalization concerns the diffusion of regulatory competences across governance levels and across state borders. New regulating actors have appeared on the scene, both externally (e.g. IMF, WTO) and internally (e.g. constitutional courts, mixed private-public entities). Especially in developing countries, the regulatory autonomy of the traditional actors (governments and parliaments) has further weakened and reaches sometimes worrying low levels.

This paper presents a case study of Colombia and builds further on an ongoing debate on the compatibility between the internationalization of the economy and macro-economic stability, on the one hand, and the recognition of the economic and social rights as fundamental rights, on the other, and on the implications of the growing complexity of the economic reality for constitutional case law with economic effects (Clavijo, 2001, 2004; Kugler and Rosenthal, 2005; Kalmanovitz, 2001, 2002; Uprimny, 2000, 2001, 2002; Alesina, 2002). This controversy is a local reflection of a debate that is also going on at the global level between, for example, the IMF that is regulating the global economy and the United Nations who are defending the right to development (cf. also Burgos, 2000; De Feyter, 2002).[1]

Defenders of the Constitutional Court (CC) in Colombia sustain that sentences should not take into account economic consequences; otherwise, it would become a politicized body (Uprimny, 2000a). Economists, however, consider that adjudications should be efficient and reflect the opinion of the majority (Kalmanovitz, 2001, 2002; Clavijo, 2001; Palacios, 2001:10-11; Kugler and Rosenthal, 2005). Moreover, the CC was accused of contributing to a sub-optimal allocation of scarce resources, solving problems for minorities but endangering rights and welfare of the citizens

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in general, and obstructing social policies of the State (Kalmanovitz, 2001:153-156; Palacios, 2001:10-11).

In Colombia, in the present situation, the CC is playing an active role in the process of economic regulation through the sentences of constitutional control (judicial review) which have *erga omnes* effects[2], but also through the action of protection of fundamental rights (A.P.F.R.) (*Acción de Tutela*).[3] It has also issued sentences which do not only establish the (un)constitutionality of a law but which give compulsory orientations to the legislator to produce norms to regulate certain sectors (in particular, financial and labor market regulations). In other cases, the CC explicitly stated that it will not necessarily follow the regulations in force (cf. health system) and decided to apply directly the constitutional principles even if these decisions have a negative impact from a macroeconomic point of view (Uprimny, 2000).

Simultaneously, the influence of the multilateral banks on the formulation of economic policies increased with the necessity to have access to external public credit and with the problems related to the generalized financial crises. As a consequence, the Colombian economic authorities signed three structural adjustment agreements with the IMF: an Extended Fund Facility (EFF) (1999-2002), a Stand-By Agreement (2002-2004) and a second Stand-By Agreement (2005-2006)[4]. All of them imposed institutional reforms to obtain macroeconomic stability. Some of these reforms were presented and, in some cases, approved by the Congress before the presentation of the IMF program. Other regulations were in accordance with the action plans of each economic sector that was targeted, although they were not part of the list of structural commitments in the agreements.

The interaction (and tensions) between these new "regulators" started when the CC modified or reversed some of the reforms enacted to comply with the IMF agreements. Although the CC declared the constitutionality of the articles of the IMF agreements and their amendments as valid and applicable international treaties, it did not attribute any normative value to the more specific structural adjustment agreements. The CC gave preponderance to the constitutional social rights, even if their accomplishment was not feasible from a budgetary point of view, and even if the proposed legal reforms did not directly violate any constitutional norm (Clavijo, 2001, 2004; Kalmanovitz, 2001). The economic authorities qualified these decisions as distortions of the institutional reforms which impeded obtaining certain macroeconomic goals of the agreements (Kalmanovitz, 2001:153).

The reasons behind the decisions of the CC are related to the fact that the legal status of the IMF adjustment programs is not very clear. The conditionality of the loans is rather seen as a political instrument (Sorel, 1996; Stiglitz, 2002:71; Direction du Trésor, 2002) because it is a discretional competence of the IMF.[5] It is mainly the guarantee which is backing the loans.[6] However, the legal source of this competence is not very clear in the Articles of Agreement or in the amendments. The current regulation of the conditionality, adopted by the Executive Board in September 2002, has no specific legal form either; it is an orientation which is similar to the one a private bank would follow with regard to its loans. The particularity is that this Guidance contains all the procedures for the negotiation, design and presentation of the economic policies that countries have to achieve. Through it, the IMF aims at making conditionality compatible with the competences of the national powers, and at coordinating the action of other Multilateral Organisms working in related fields.[7] This ambiguity is projected at the national level where not all the authorities recognize the normative character of the conditionality. In fact, the CC mentioned the IMF agreements in the sentences analyzing some structural reforms but gave more importance to the constitutional principles of the welfare state (cf. sentence C 931/04). In turn, the IMF expressly mentioned some of the rulings of the CC affecting economic and financial policies.[8]

II. BUILDING BLOCKS OF A THEORETICAL FRAMEWORK

The topic of this paper refers to new governance situations that were usually outside the reach of constitutional control, but in which the judiciary is now getting involved. These situations vary from country to country, but the growing importance of constitutional values and fundamental rights with regard to budget allocations and economic regulations seems to be a global tendency which is being analyzed in the literature on constitutional interpretation (Gargarella, 1997; Marmor, 2004; Ruiz Miguel, 2000). In some cases, jurisprudence has developed concerning the unconstitutionality by omission, when the legislative and/or the executive powers do not provide some goods and services. These changes have spurred growing criticisms of the excessive functions of the constitutional judges (Sagüés, 2004:6). The case study which is presented here is one of those situations: the allocation of scarce resources in order to reach universal coverage of constitutional social rights. The topic is not self-evident in developing countries, but it is of particular importance and complexity in countries where the rights discourse is politically important (Marmor, 2004:14).

The issue may be analyzed from different perspectives and an interdisciplinary approach seems suitable. A first perspective is the judge-made law approach, which tries to explain judges' behavior from the perspective of law and economics, may be useful.[9] The aim of this approach is to analyze how judges adjudicate and under which motivations they take judicial decisions. According to judicial incentives theory, judges try to impose to the society their preferences and personal values. However, if they do not adjudicate efficiently, legislators take over their field of action; this means that the use of discretionary competences by Courts may be limited by legislative power when it overrules an interpretation that not satisfies it (Posner, 1992; Rubin, 1999:504; Schneider, 2001; Cooter and Ginsburg, 2003). Other aspects are also relevant; the independence of Courts from the political process, for example, because politicians can influence judicial decisions more when they control factors such as budgets and promotions (Cooter and Ginsburg, 2003).

A second (complementary) approach is the legal theory analysis. Independence and impartiality[10] are considered as defining characteristics of the institutional position of judges with respect to the rule of law. The notion of independence is the negation of autonomy because they have to decide independently from their own beliefs. It does not signify sovereignty (meaning that they have the last word) neither, because they would be "out of institutional control". The independence of the judges guarantees the right to citizens to be judged according to the law and not under the influence of power relations or particular interests (Aguiló, 1997:74-79).

Third, the approach of "judicial accountability" sustains that judicial independence should not be seen as a "sufficient condition for the realization of the rule of law"; the concept of "judicial accountability" is presented as an incentive to make judges impartial. The term was defined as "the costs that a judge expects to incur in case her behavior and/or her decisions deviate too much from a generally recognized standard, in this case referring to the letter of the Law" (Voigt, 2005:4-5).

Fourth, these phenomena are also analyzed by the "judicialization of politics" approach, which refers to the fact that some policies are taken-over by the judicial branch (Uprimny, 2005). This is a complex issue, especially when the judiciary tries to control the other powers to protect individual rights (Couso, 2004:30). The scope of this judicialization of politics may improve the accountability among powers, but in democracies where the rule of law is weak, it may affect the independence of the judicial branch (Domingo, 2004:7; Couso, 2005:44-45). The judicial decisions have a political and economic impact, and in some cases the decisions of the Court could well be those that the Congress apparently did not want to take

(Palacios, 2001:8). As a consequence, despite the fact that the judicial review action seeks to protect the Constitution, some critical arguments arose against this constitutional control of laws. One of them is that judges legislate when they interpret the constitution, replacing the legislators and imposing their own positions (Gargarella, 1997:59-60).

In addition to these approaches, an additional dimension should be covered from the perspective of international and constitutional law: the legal nature and scope of the adjustment agreements. Clarification is needed about whether the duty to fulfill the structural reforms established by the IMF agreements concern all the authorities (including the judicial branch) or not. Clarification is also needed about the legal consequences of non-completion of the structural reforms, when the macroeconomic goals are totally or partially reached by other means. According to some opinions, those Agreements can be seen as instruments used by governments to impose unpopular policies (Przeworski, 2000).[11]

III. THE CASE OF HEALTH SECTOR POLICIES IN COLOMBIA

As mentioned before, a case study of the Colombian health sector allows showing the interactions between the two new regulatory actors very well. The discussion starts already with the classification of the health service as a private or public good (González, 2000:43-45). In Colombia, regulators seem to consider health as a merit good because its consumption is intrinsically desirable (Arias and Nuñez, 2002:287). According to the recommendations of the multilateral banks, legal reforms aim at a market-based scheme seeking a competitive system to supply efficient health services to the whole population. In contrast, the Court seems to be closer to those who consider health as a public good.

Before 1993, the Colombian health system was composed by three sectors: the public sector aimed at the population not included in the social security system and representing approximately 70% of the population; the social security system covered 15% of the population and the rest used private providers (Zukin, 1985; quoted by World Bank, 2003:657). The system had low levels of coverage and access to the services; 45% of urban population and 80% or rural population did not belong to any insurance system (Molina et al., 1993; quoted by Guigale et al., 2003:657).

The Political Constitution of 1991 (P.C.) introduced specific rules for the Colombian health system. They can be summarized as: special protection of the weak (children, elderly and disabled); consideration of the social security system as an obligatory "public service[12]" to be supplied under the regulation of the State; sharing of the responsibility to increase coverage between public and private sector; prohibition to decrease the

share of social investment expenditure in the national budget in time. In the nineties, health reforms appeared as a conditionality of the IMF and World Bank lending policies. The main policies suggested by the World Bank were: decentralization, privatization and the improvement of the "equity and allocative efficiency through guaranteeing universal access to a basic package of services, determined according to what each country could afford and based on cost-effectiveness principles. Governments and the rest of the population would subsidize the provision of the services included in the basic package" (Homedes et al., 2005:84).

These policies were presented in the World Development Report of 1993. While decentralization was applied in almost all the Latin American countries, the guidelines to improve the system of universal coverage with the participation of private sector was applied more rigorously in Colombia (Homedes et al., 2005:83-86). Two legal reforms implemented the recommendations: the decentralization of competences and resources to supply health services (Law 60/93 reformed by Law 715/03)[13] and the reform of the health system (Law 100/93).

The first reform regulated the intergovernmental transfers, to finance vertically the supply of health and education services (mainly) through the sub-national levels, according to policies fixed at the national level. The main goal was not the transfer of competences, but the reduction of expenditures of the central government.[14] This process has been considered as a de facto privatization, because the central government diminishes or suspends funding whereas, as a result, the fees for health provision paid by the population increase (Homedes et al., 2005:87).

The second reform transformed the health system in order to reach universal coverage, solidarity and efficiency with quality. It introduced two regimes of affiliation: the contributory regime, covering people that are able to pay a monthly contribution, and the subsidized regime, covering the poor.[15] People that should be in the second system, but are not (yet), can benefit from health services in the public hospitals. The municipalities provide subsidies to the poorest population living in their regions, whereas the departments provide the subsidies to the public hospitals to provide health services to the poor population that is not (yet) in the system. The most notorious change was the scheme of subsidies; the demand side (poorest population) is privileged instead of the supply side (public hospitals). Public hospitals should act as any other health service provider in the market, in order to make them competitive and efficient; as a result, their subsidies were planned to be eliminated and their management aimed at technical and financial autonomy (CONPES, 2002).[16]

The contributory regime is managed by the Health Promotion Enterprises (*Empresas promotoras de salud* - EPS) and they offer the Obligatory Health Plan (*Plan obligatorio de salud* - POS). The subsidized regime is offered by the Subsidized Regime Administrating Enterprises (*Empresas administradoras de régimen subsidiado*) and they offer also the Obligatory Health Plan for this regime (*Plan Obligatorio de Salud del Régimen Subsidiado*). At the national level, the Solidarity Fund (Fondo de Solidaridad y de Garantía –FOSYGA-[17]) plays the main role and manages the contributory and subsidized regime, the promotion of public health and the payment of health care in case of traffic accidents and catastrophic and terrorist events.

IV. The Implementation of the Reforms

The constitutional (L.A. 01/01) and legal (Law 715/2001) reforms were included in the first agreement with the IMF. Although these reforms have not been evaluated yet, a new proposal of constitutional and, by consequence, legal revision is in the 2006 recommendations of the IMF, to further reduce the growing transfers (IMF country report 06/234). The goals of Law 100/93 were not reached. In theory, the provision of universal health care depends on the public expenditure capacity to subsidy the part of the population that is not able to pay for these services. Social security contributions should therefore be sufficient to maintain the whole system; otherwise, it is impossible to protect the right to health for everybody. In practice, the prolongation of subsidies to the supply side doubled the expenditure and obstructed the extension of the coverage to the poorest population by the subsidized demand system (Table 1). Also, the coverage of the contributive regime had a weaker than expected performance and public hospitals increased their inefficiency (Gaviria, 2005:14-16; Acosta et al., 2005).[18]

The economic crisis at the end of the nineties worsened the rising deficit of the sector. Some irregularities were highlighted in 1999: 30% of the population that should be beneficiary was not and 31% of the actual beneficiaries were not poor (González, 2000, quoted by Homerde, 2005:91). As a consequence, the decrease in the number of affiliated persons in the contributive regime, the unemployment levels, and the delays in the payment of the contributions, obliged the State to a larger coverage of health expenditures. In 2001, 19.5 million of people were not affiliated; of these, 8.1 million were potential candidates for the subsidized regime, 2.5 million for the contributive regime, and 8.8 million were not classified as poor but they suffered income problems which impeded them to pay the contributions (Acosta et al., 2005:43). In 2002, 18.6 million

people did not belong to the social security system in health (Arias et al., 2002:288-289); however, most of the people that used the judiciary to obtain a health service, did not belong to this category (García and Rodríguez, 2001:436-438).[19]

Table 1- Distribution of Intergovernmental Transfers for Health. Millions of Colombian pesos

Year	Subsidized regime	Public Health	Supply subsidies	Total
2002	1.207.542	290.874	1.093.059	2.591.475
2003	1.453.555	337.649	1.243.177	3.034.382
2004	1.609.641	359.695	1.363.470	3.332.807
2005	1.765.826	379.758	1.440.908	3.586.493
2006	1.940.245	398.372	1.497.019	3.835.637

Source: Ministry of Social Protection (2006).

Another problem that was identified was the evasion in the contributory regime; in 2000 it represented 2.75 % of the 2000 GDP (World Bank, 2003:675). During the crisis years, administrative failures (i.e. a lack of a performing information system) and the constitutional case law in health matters complicated the situation. One of the issues raised in the A.P.F.R. referred to the delay in the payments of the contributions by employers, but it was also used to obtain health services avoiding social security contributions (see below). The government shows figures that do not confirm this appreciation. The report of Uribe's government indicates an extraordinary increase in coverage, but it points also to some failures in the collection of the figures. In fact, a closer look shows that the increase is mainly due to the correction of the population figures (Table 2).

Table 2 - Total Number of Affiliated People in both Regimes[1]

Year	Contributive regime	Subsidized regime	Total affiliated	Total population	Coverage as %
2002	13.165.463	11.444.003	24.609.466	43.834.117	56,14%
2003	13.805.201	11.867.947	25.673.148	44.531.434	57,65%
2004	14.857.250	15.553.474	30.410.724	45.325.261	67,09%
2005	15.533.582	18.581.410[2]	34.114.992	41.242.948	82,72%

[1] In 2005, active and suspended affiliates were included. Dirección General de Seguridad Económica y Pensiones and Dirección General de Gestión de la Demanda en Salud

[2] At the end of 2005 16.483.662 were full subsidies and 2.097.748 partial subsidies.

Source: Dane and Subsistema de Información del FOSYGA y BDUA[20] quoted by the Ministry of Social Protection.

V. THE ROLE OF THE CONSTITUTIONAL COURT

The Court has been influencing the economic situation of the sector through its judicial review[21] but also through the A.P.F.R. which has been creating one of the largest numbers of adjudications. As Cepeda confirms,

the "vast majority of cases analyzed by way of the [A.P.F.R.], concern social rights, and among these, the right to health is in the first place" (Cepeda, 2004:620). Moreover, the Court has been "regulating" the health provision through this action, which was established for concrete cases. Its argument is the omission of the legislator, who has not enacted the statutory law to regulate the scope of social rights. It considers that constitutional regulations cannot be ignored and imposes therefore its own equality criteria (García Villegas et al., 2002). This way, it helps to correct the redistributive competence of the State (Arango, 2001; Cepeda, 2004; Uprimny, 2003).However, some studies argue that the judiciary is not the best public authority to correct the redistribution of scarce resources, because it does not study all the cases but only those presented to judges (Posner, 1998; Rubin, 1999; Bouckaert, 2002). Furthermore, if the Court orders an expenditure not covered by the planned budget, the State will be forced to use other resources to accomplish the adjudication, at the cost of the poorest, the disabled or the children. The activism of the CC is considered as producing inefficiencies when it stimulates contract breach or obstructs the use of production factors in optimal ways (Palacios, 2001:7). To evaluate these criticisms, its case law should be analyzed from the perspective of the discretionary use of the judicial interpretation (Buscaglia, 2005; Voigt, 2005).

Concerning the enforcement of the right to health through the A.P.F.R., the Court admitted its lawfulness when it is necessary to protect a minimum quality of life, i.e. when it is linked to the rights to life and/or personal integrity. In the period January 1992 – December 1996, the CC conceded, as a percentage of total demands, more A.P.F.R. than any other judicial instance (García and Rodríguez, 2001:432-436). This situation contrasts with the opinions of other courts, as e.g. those of the Council of State where 92.5% of these actions are denied because of procedural reasons or the Supreme Court of Justice that denies 93.7% of the cases, of which 56% have also been denied due to procedural reasons (García and Rodríguez, 2001: 445). In the period that was analyzed, it was concluded, first, that judicial decisions are not effective to change the future conduct of the State, given that 80 % of the A.P.F.R. is presented against its institutions (García and Rodríguez, 2001:429); and second, that the absence of procedural unification criteria creates the over-utilization of this action, not considering its constitutional goals.[22] The possible reasons are, on the one hand, that the CC bases its competence on the open model of fundamental rights of the P.C., which allows it to define their limits and scope; and on the other hand, that the effectiveness of fundamental rights

produces a big judicial liberty without the duty to respect precedents (García and Rodríguez, 2001:453-454).

In the present study, in order to quantify the volume and potential fiscal impact of case law, sentences deciding A.P.F.R. and involving the supply of a health service, were considered.[23] A.P.F.R. against private persons were considered too, because in many cases, the CC orders to supply the service even when the employer did not pay the social security contributions, and in many cases, the EPS demanded were also private enterprises. In the period that was analyzed (2000-2004), the Court adjudicated 240 health rights on average per year, representing 25% of the total number of A.P.F.R. adjudications, and on average 18% of the total number of sentences (including judicial review).[24] A further analysis would reveal whether these proportions are representative for the whole country or whether they reveal the preferences of the CC. The percentage of conceded sentences (i.e. the supply of a health service), is almost constant: 67% on average. The negative decisions are apparently slightly diminishing in numbers.

Two additional types of decisions are present; and although they represent only a small minority of cases, they are relevant. First, there are cases where the CC declares that the petition lacks an object, mostly because the solicitor died during the procedure of the action. This type represents around 4% of the total number of decisions. Second, there are cases where the petitions have overcome facts (i.e. health services that have been provided before the end of the judicial procedure); they represent 8% of the cases on average. This last figure could partly reflect the impact of the A.P.F.R. on the efficiency of the health service provision, because in a number of cases, the provider, knowing the tendency of the Court case law, might want not to wait until the final decision of the CC requiring the provision of a service, being afraid of administrative and economic sanctions. The probabilities of obtaining a favorable decision using the A.P.F.R. are high, which can explain one of the reasons for its over-use. While a general regulation concerning the scope of this right is not enacted, many people will prefer to use this instrument rather than to pursue the accomplishment of regulations in force. The correction of the administrative inefficiency in the sector seems to be very small and does not show signs of improvement.

A further analysis was made: the identification of the reasons used by the CC to concede or deny the A.P.F.R. This allows identifying how far the Court goes as a regulator in this sector, respecting or replacing general regulations. From this exercise, some preliminary conclusions were drawn: First, the activism of the CC is clear; the figures corroborate the

conclusions of previous studies: 36% of the total A.P.F.R. adjudications refer to situations that order the provision of a health service not included in the POS, i.e. it orders the non-application of the legal rules and instead compel the provision of the service based on the constitutional rights and principles. The Court, acting as a regulator, indicates the cases in which these people have the right to get a subsidy that is not foreseen in the national budget. To this type of decisions, cases of lacking minimum contributions (8%), the absence of economic capacity (6%), and state responsibility (3%), should be added, because all of them imply cases in which legal and administrative procedures to obtain a subsidy are not followed, and the A.P.F.R. is used instead. Summing up, this totalizes more that 50% of the A.P.F.R. decisions in health matters. The budgetary burden is important, the more because many of these cases include the so-called "catastrophic" illnesses. The cost of these decisions has to be paid by the FOSYGA, because the EPS request the difference. It constitutes a new way to obtain subsidies not included in legal regulations. However, the recovery of the costs is not automatic and mainly public hospitals are affected. This situation influences the apparent inefficiency of the public hospitals because these debts are increasing dramatically their deficit.[25]

Second, cases in which people use the A.P.F.R. as a way to avoid arbitrariness and inefficiency of the health service providers represent 19% of the total number. These situations imply the non-compliance of contracts and regulations by private or public suppliers who deny health care, and should indeed be addressed with this instrument. As explained before, these percentages do not necessarily apply to the rest of the country, because the selection of the cases by the CC is discretionary and not necessarily proportional with respect to the distribution of the cases countrywide.[26] A previous study showed that most of the presented A.P.F.R. demanded a health service included in the POS, and 71% were caused by administrative failures (Defensoría del Pueblo, 2004). Third, the category referring to the delay of the payment of the employers' contributions (14%) illustrates the economic crisis at the end of the decade. Whereas in 2000, they represented 26% of the total cases, they dropped to 2% of the total A.P.F.R. in health matters in 2003. These cases correspond also to a typical judicial controversy, namely whether the Court should accept that the problem can be solved through the A.P.F.R. instead of the ordinary jurisdiction, in order to protect urgent health rights.

The Ministry of social protection presented striking figures of the recovery of the A.P.F.R. More than 52% are recoveries of expenditures related with non POS treatments demanded from the State. The causes of the other recoveries were not specified. These figures show that, despite the

surmounting of the economic crises at the end of the nineties, the use of this action continues to growth for other reasons. A probable reason is that it is easier to obtain subsidies this way, than by following the administrative procedure. Moreover, it is also a new way to obtain subsidies for people who are in the contributive regime but ask for treatments or medicines not included in the POS. This implies that subsidies are given to the population not classified as poor.

Table 3 - Number of A.P.F.R. Recovered from the State (FOSYGA)

	Number of recoveries presented		
Year	Non POS treatment	A.P.F.R.	Total recovery
2002	35.185	33.801	68.986
2003	86.267	46.903	133.170
2004	90.853	65.935	156.788
2005	139.603	144.411	284.014
2006	49.170	74.043	123.213
Total	401.078	365.093	766.171

Source: Data base of the Fidufosyga trust (2006), quoted by the Ministry of Social Protection.

VI. The Parameters of the IMF Structural Adjustment Agreements

References to the health sector reform can be identified in the IMF Staff Country Reports produced during the period analyzed (Table 4). Provisions refer, first of all, to the control of intergovernmental transfers and, second, to the financial deterioration of the health system within the Social Security Institute (ISS). The former issue was one of the main benchmarks of the first Agreement (EEF) while the latter topic was not presented; only since December 2001 (Country Report (CR) 01/12) it was mentioned, and it was the only subject in health matters since the Stand-By Agreement (2002-2004). In 2001, the imminent restructuring of the ISS was presented as a serious fiscal problem; simultaneously, the IMF mentioned decisions of the CC from as early as 1996 as one of the causes of this problem (cf. CR 01/168). The social safety net program as well as the enlargement of the coverage of the social security system to the elderly was mentioned, but not developed explicitly by the IMF.

Table 4- Provisions Related to the Health System Included in the IMF Country Reports.

IMF Staff Country Report	Provisions related to health system.
99/149	The freezing of intergovernmental transfers was one of the targets in order to reduce the Non financial Public Sector deficit of 2000 (Point 22). The increase of the enrolment of the elderly in the health insurance system (Point 21).
00/12	The central government kept much of the spending responsibilities while intergovernmental transfers rose constantly (Point 2).
01/12	Restructuring the provision of health services due to the financial deterioration of the health system under the ISS (Point 26).
01/64	Reforms of sub national public expenditure control, constitutional reform on transfers and reform of lotteries were presented as a concrete result (point 13). The health system of the ISS showed a rapid financial deterioration because of an increase in costs. An organizational reform was planned by 2001(point 28). The cash deficit of the ISS health system would be eliminated in the medium term. (Point 38).
01/168	Decisions of the Court affecting health financing policy (P12-13.): Sentence C579/96: unconstitutionality of L100/93 (235) and DL 1651/77 (3). ISS' employees must be granted the same collective bargaining rights as employees of public enterprises. IMF sustained that these sentences impeded competence with private sector. C1165/00: unconstitutionality of Law 344/96 (34). The central government cannot limit transfers to a subsidized health plan for people outside the labor market.
02/15.	The increased purchases of security equipment and the rising costs of the public health system were presented as causes of the non accomplishment of the NFPS spending program by which exceeded by 0.5 percent of the GDP in 2001 (Point 10) Reform of the ISS health service initiated in July 2001: - Restructuring health service provider's debt. – Renegotiation of the collective bargaining agreement with health workers; - Lifting of the ban on increasing the number of affiliates in the ISS health Plan. - New regulations to financing high cost medical treatments. These measures will save 0.2 % of the GDP annually (Point 34).
03/19.	The costs overrun by the ISS health service was one of the major causes of the adverse economic situation. (Point 3) Reform plan for the public health service because it posted a deficit in 2002 despite measures mentioned to reduce operating costs. (Point 23). Result: the approval by CONPES of the ISS financial sustainability plan for its health service. The elimination of the fiscal deficit by 2007 was the goal (P40).
03/181.	The program of CONPES was complemented with a credit with the IDB to make public hospitals financially viable by 2007[27]. This restructuring was presented as possibly inconvenient for the targets of the CPS deficit. (Point 19).
04/15.	The 2004 budget included restructuring of the public health service
04/199.	Progress in health sector is not mentioned.
05/154.	Additional evaluation over D 1750/03 and a full implementation of CONPES plan to eliminate deficit of the ISS by 2007 were planned (p57).

Source: http://www.imf.org/external/country/COL/index.htm.

From a combined analysis of the reforms enacted during the period of the IMF agreements and the corresponding judicial review sentences of the CC, it is possible to identify the interference of the Court in the reform process. One constitutional reform and nine legal reforms contain regulations concerning health topics referred to in the IMF agreements. Four legal reforms refer to public expenditure control, two laws and the constitutional amendment reformed the intergovernmental transfers and other resources, and two legal reforms, one through legislative delegation, modified the structure of the ISS. Eight of the judicial review sentences that analyze the reforms may affect the IMF structural programs. These sentences declared the unconstitutionality or conditioned constitutionality of some reforms. Most of the laws deal with public expenditure control (L547/99, L617/00 and L812/03) and one relates to intergovernmental transfers (L715/01). Decisions concerning the reform of the ISS were all declared as constitutional.

Two sentences refer to the calculation of the intergovernmental transfers (C 1504/00 and C 568/04.) Three refer to limits imposed by the central government to the sub national entities to manage their budget (C540/01, C 579/01 and C837/01) and four refer to the regulations of the supply of health services (C 540/01, C 615/02, C974/02 and C305/04). Sentences that refer to intergovernmental transfers declared the unconstitutionality mainly because the law did not respect the parameters to transfer the resources to the sub-national entities. Sentences related to the limitations of the budget management relate to the violation of the autonomy of sub-national entities.

The last group is probably the most interesting: the Court did not accept the limits imposed by the State to the investment projects of private entities that provide health services, because it violates the principle of freedom of enterprise. The aim to rationalize the supply of services in the territory is not sufficient to allow limiting this right and the competence of the market. Another surprising result was that the CC did not authorize to liquidate public hospitals when they do not produce utilities during a period of three years. The reason is related to the aim of these entities; they have to provide social welfare and not economic utilities. This position may obstruct the restructuring of public hospitals, but until now, any of these measures have been declared as unconstitutional. Finally, it is notorious that despite the fact that the CC protects the right to health through the A.P.F.R., in the judicial review case law, fundamental rights are not the main basis of its argumentation when it declared an economic reform as unconstitutional. The violation of the economic regulations (general

economic principles, norms regulating intergovernmental transfers) is the most used argument.

VIII. CONCLUSIONS

Based on the Colombian case, this article has shown that in a context of globalization, a tense relationship can emerge between IMF-supported government policies and actions, on the one hand, and Constitutional Court rulings, on the other. Whereas national regulators and the IMF are focusing on the reduction of the fiscal deficit, the Court tends to concentrate on the insufficient health services coverage. In the period under analysis, the legal reforms in Colombia dealt with the resources assigned to the health sector and their distribution, but not with systematic reforms concerning the provision of the service. It is this vacuum that the Court fills through its A.P.F.R. case law. However, even if jurists would like to give absolute value to social rights, public expenditure restrictions are more than obvious. In addition, economic studies show that budget restrictions are also due to the bad implementation of legal reforms and to not accomplishing legal parameters by some actors (public hospitals, contributors to the system). As a consequence, the health system is not very likely to reach the goal of universal coverage. But at the same time, specific decisions taken by the Court do not necessarily help with the rational development of the system; on the contrary, these decisions may well help some people but may damage the system as a whole.

From an analysis of the A.P.F.R. case law, it has been shown that the Court uses this action to act as a sort of super-regulator, disregarding general regulations and procedures. Although the Congress and the government disagree with this situation, until now they have not taken any measure to limit the discretionary action of the Court which has been qualified as arbitrary. The Court defends itself arguing that they are trying to apply the justice of the constitutional rights. However, the beneficiaries of this failure of the State are those with enough capacities to present the action, but not necessarily the most needed. For them, it seems easier to obtain subsidies following the judicial way instead of following the political or administrative way (Uprimny, 2005:17). Although the increase of the use of the A.P.F.R. in 1999 was interpreted as a consequence of the economic crisis, reality shows that after the crisis, the use of the action continues to grow. According to some studies, despite the fact that Colombia followed the World Bank and IMF guidelines and increased considerably health public expenditure, a large number of citizens are (still) not covered by the system. Moreover, many of those that are in one of the systems cannot pay the co-payments. Administrative and medical services

are not efficient and public health and health equity have deteriorated. (Homedes et al., 2005:91). Regarding the sector deficit and its institutional capacity, nor the government or the IMF make a systematic effort to improve the efficiency of the sector. Measures suggested and /or put in action were just aimed at solving the short term distresses but not at improving the quality and coverage of the health sector. The judicial review sentences that analyzed those measures did not go against the IMF recommendations. On the contrary, all of them defended the policies of decentralization of the services and freedom of market in the provision of health services.

A curious result is that the A.P.F.R. is the action of the judiciary that influenced most the health market. It has a non negligible impact on the deficit of public hospitals but it is not mentioned at all in the Structural Adjustment Agreements. Only the restructuring of the sector (through the reduction of the rights of the health workers) is mentioned, whereas debts of the state (FOSYGA) with the health providers are very important and are not considered by the IMF analysis. Tackling the absence of a legal framework for the scope of social rights and the discretionary competences used by the Court has to be a priority of the reforms, as well as the requirement towards the actors of the system (health service providers and contributors) to comply with the law. The IMF, however, seems not to focus on this situation nor did the government mention the problem.

Finally, the case of the Colombian health sector shows that in the new globalized context, new regulating actors have emerged on the Latin American scene. On the one hand, international actors like the IMF, reduce apparently the regulatory autonomy of the traditional regulators (governments and congresses), whereas on the other hand, new regulatory actors (like the Constitutional Courts) attempt to fill certain regulatory gaps that emerge and re-conquer lost spaces of sovereignty through the protection of constitutional rights. Our case shows, however, that although the role of the Court is certainly essential to protect fundamental rights of citizens in a sovereign country, the Court is not best placed to regulate particular socio-economic sectors and that its intervention, can also produce dysfunctional and counterproductive effects. It also shows that the normative character of the recommendations of the IMF structural agreements should not be overestimated.

Notes

[1] Decision of the Economic and Social Council 1998/249.

[2] Abstract constitutional control refers to a control in the absence of a concrete controversy concerning the application of the law to a specific case. The action can be presented by any citizen and the procedural conditions are very simple and short; a second instance is not allowed.

[3] It was created by the Political Constitution of 1991 as an expedite way to protect constitutional rights when they have been violated or when there is a menace that cannot be avoided by other means. Any person can ask to any judge, in any moment, through a preferential and summary procedure and without the intervention of a lawyer, the immediate protection of her/his rights. The decision can be appealed and revised by the Constitutional Court. It is a subsidiary action because it can only be used when the plaintiff does not have any other legal way to project his/her rights, or when he/she uses this action as a transitory mechanism to avoid an irremediable damage. It represents more than 70% of the total number of decisions of the CC.

[4] This last agreement is not analyzed in the case study.

[5] cf. Second reform of the articles of understanding of the I.M.F.art.V§4.

[6] The IMF explains the conditionality of the support as follows: "The policies to be adopted are designed not just to resolve the immediate balance of payments problem but also to lay the basis for sustainable economic growth by achieving broader economic stability-for example, measures to contain inflation or reduce public debt. Policies may also address structural impediments to healthy growth-like price and trade liberalization, measures to strengthen financial systems, or improvements in governance. Together, these policies constitute a member country's "policy program", which is described in a letter of intent (which may or may not have a memorandum of economic and financial policies attached to it) that accompanies the country's request for IMF financing. The specific objectives of a program and the types of policies adopted depend on a country's circumstances (…)" (IMF, 2002:1).

[7] These guidelines were revised in the 2004-2005 conditionality review (IMF, 2005:35).

[8] Sentences related to labor market reforms as a consequence of the restructuring of the State; reform of housing credits; the slowdown of the central governments transfers, and public wages indexation (cf. country report 01/168, pp. 12-13.)

[9] The pioneer argument concerning utility maximization by judges was developed by Posner (1992).

[10] The independence principle tries to control the motivations of judges vis-à-vis external influences from the social system into legal regulations; and the impartiality principle tries to control the motivation of judges from external influences in the process (i.e. independence from the procedural parties and from the object of the process) (Aguiló, 1997:74).

[11] In Colombia, the IMF did not make a detailed evaluation of the accomplishment of the agreement and, as said before, many reforms were proposed before the signature of the agreements and others were not completed.

[12] This term corresponds to the French theory of "service public" later renamed as public interest services.

[13] Law 60/1993 developed articles 356 and 357 of the P.C. Then, Law 715/03 developed the constitutional amendment (L.A. 01/01) of these articles. The reform aimed to diminish in real terms the transfers as a percentage of the current revenues of the central government and to make flexible the use of these resources by the sub national governments.

[14] The IMF made an in depth analysis of the intergovernmental transfers after the P.C. of 1991. Cf. Ahmad et al 1995, 457-503.

[15] It is designed similarly to the American Medicaid: targeted programs with limited coverage by the resources and not constituting entitlements (Gaviria et al., 2005).

[16] National Council of Economic and Social Policies.

[17] This is a count linked to the budget of the Ministry of Social Protection and administered by a trust.

[18] Despite the fact that 44% of the population were treated by public hospitals before 1993, only 15% of the subsidized regime continued been treated by the public net and 29% passed to the private sector (Acosta et al., 2005). Moreover, the labor cost of public hospitals increased 40% since 1995 (World Bank, 2003:672).

[19] Some analyses conclude that the lack of resources hinder compliance with the contracts in force because resources allocated have to be used to accomplish the A.P.F.R. sentences. Examples of decisions that do not consider legal regulations of health service are: Sentences SU 819/99 and SU 562/99 (Restrepo, 2003:202-208). Cf. also López M. (2003: 292-294) and García and Uprimny (2002).

[20] In 2005, active and suspended affiliates were included. Dirección General de Seguridad Económica y Pensiones y Dirección General de Gestión de la Demanda en Salud Corte Contributivo y Subsidiado 31/12/05 incluye subsidios parciales.

[21] Judicial review will be presented with the IMF conditions, because it is linked directly to the reforms.

[22] There are many recurrent conflicts because a large number of actions have the same causes.

[23] A.P.F.R. classified as social but involving freedom and collective rights were excluded.

[24] Own calculations based on: www.constitucional.gov.co

[25] As an example, between January and June 1999 The ISS spent $col 15.878.683.984 and FOSIGA reimbursed only $ 10061642 (0.063%).Cf. Sotelo (2000:42).

[26] The total number of A.P.F.R. revised by the CC during the years 1992-2003 represented 2.81% of the total actions presented countrywide (cf. www.constitucional.gov.co).

[27] During the period 2002-2005, 128 public hospitals were restructured. The cost amounted to $ 483.830 mln.

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