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Ordinary crisis: cancer care, *tutelas* and the outsourcing of ethics in neoliberal Colombia

There is no evil that can last a hundred years or any person that could endure it.
Miguel de Cervantes

Crisis consists precisely in the fact that the old is dying and the new cannot be born; in this interregnum a great variety of morbid systems might appear.
Antonio Gramsci

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Abstract. In this article I analyze how the financial inner workings of health insurances and the massive use of writs such as *tutela*, have transformed the national health care crisis into a protracted and ordinary event in neoliberal Colombia. To do so, I built on ethnographic research conducted during 2011-2012 with low-income cancer patients, physicians, and health insurance representatives in the city of Cali, Colombia. I argue that "anti-crisis" mechanisms such as *tutela* have paradoxically created the financial and ethical conditions that allow health insurance companies to systematically delay the provision of "high-cost'" treatments.

Keywords: Cancer, crisis, health insurance companies, tutela, neoliberalism, Colombia

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BOLETÍN DE
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Crises Ordinárias: cuidado do câncer, tutelas e a subcontratação da ética na Colômbia neoliberal.

Resumo. Em este artigo analiso como o trâmite financeiro interno das seguradoras de saúde e o uso massivo de ordens judiciais como a tutela, têm mudado a crise nacional da saúde em um sucesso lento e tardio na Colômbia neoliberal. Para fazê-lo, me baseio em uma pesquisa etnográfica realizada entre 2011 e 2012 com baixa-renda em pacientes com câncer, físicos, e representantes de seguros de vida na cidade de Cali. Eu discuto que mecanismos de "anticrese" como a tutela têm paradoxalmente criado as condições financeiras e éticas que permitem o negócio de seguros de saúde para, sistematicamente, atrasar o fornecimento de tratamentos de "alto costo".

Palavras-chave: Câncer, crise, companhias de seguros de saúde, tutela, neoliberalismo, Colômbia.

Crise ordinaire: soins contre le cancer, tutelles et sous-traitance de l'éthique en Colombie néolibérale

Résumé. Dans cet article, j'analyse la manière dont les rouages financiers des assurances-maladies et l'utilisation massive de brefs tels que la tutelle, ont transformé la crise nationale des soins de santé en un événement prolongé et ordinaire dans la Colombie néolibérale. Pour ce faire, je m'appuie sur des recherches ethnographiques menées en 2011-2012 auprès de patients atteints de cancer à faible revenu, de médecins et de représentants des assurances-maladies de la ville de Cali. Je soutiens que les mécanismes « anti-crise » tels que la tutelle ont paradoxalement créé les conditions financières et éthiques qui permettent aux entreprises d'assurance maladie de retarder systématiquement la fourniture de traitements « onéreux ».

Mots-clés : cancer, crise, compagnies d'assurance maladie, tutelle, néolibéralisme, Colombie

Introduction

Crisis, this is the most common word used by physicians and cancer patients when referring to the Colombian health care system. As explained by Dr. Masa[1] —a senior oncologist who works at several public hospitals in the city of Cali—, "Crisis is a severe, out of the ordinary situation. It is like an elephant in a cramped room; so obvious you couldn't ignore it, so awkward and bizarre you wouldn't get used to it. In the context of our healthcare system, however, this elephant has gone unnoticed; the crisis it represents became quotidian and bearable", the physician mused. Then, he concluded: "And guess what? This has been the state of affairs in Colombia for nearly 30 years and there aren't any signs of a potential change in the horizon". Puzzled by his words, I want to ask: How does the obvious become unnoticeable, and how does the bizarre turn ordinary in the Colombian health care system? In this article I analyze how the financial inner workings of health insurances and the judiciary system have transformed crisis into a protracted, seemingly ordinary[2] event in the context of neoliberal reforms.

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[1] All real names have been changed, except the author's.

[2] My understanding of this term is informed by Sharon Kaufman's work. In her book *Ordinary Medicine* (2015), she describes how rare and risky procedures suddenly become part of ordinary

In 1993, the Colombian government promulgated the '*Ley 100*' law to transform its health care system. According to the new law, people were required to establish contracts with insurance companies called *Empresas Promotoras de Salud* (EPS) [*Health-Promotion Companies]* while the state served the role of regulator and provider of funds, especially for the poorest sectors of the population (Abadia-Barrero and Oviedo, 2009; Giraldo, 2007; Hernandez, 2003). In addition, public and charity hospital institutions were transformed into for-profit corporations *Empresas Sociales del Estado (ESE)* [State's Businesses]. In sync with the neoliberal doctrine (Harvey, 2005; Kim *et al.,* 2000; Klein, 2007), '*Ley 100*' sought to create a health care market in which private and public actors would compete against each other and attract patients/enrollees. These new conditions —the rationale goes— would eventually bring down the costs of care and render the better positioned EPSs and hospitals for providing quality care for all Colombians —regardless of their capacity to pay.

Shortly after '*Ley 100*' was implemented, however, public hospitals were often at the verge of bankruptcy (see Abadia-Barrero, 2015a), increasing numbers of EPSs intervened and liquidated by the state after failing to provide medical services to patients. Overworked physicians witness how their medical practice and decision-making have been taken over by the EPSs profit-making goals while low-income patients —especially those who suffer from "high-cost" diseases such as cancer (Sanz, 2017)— are massively turning to the judiciary in order to protect their right to health and access prescribed treatments (Abadia-Barrero, 2015b; Defensoría del Pueblo, 2018).

If we follow the etymology of the Latinized form of Greek, *Krisis* refers to a moment when one must make a pivotal decision to change course. In her Anti-Crisis manifesto, Anthropologist Janet Roitman highlights that the crisis has often been conceived as a "turning point"; she writes: "Associated with the Hippocratic school as part of a medical grammar, crisis denoted the turning point of a disease, a critical phase in which life or death was at stake and called for an irrevocable decision" (Roitman, 2013: 15). Yet some of our contemporary crises, she argues, do not match this understanding; commonly a signifier for a critical moment, crisis seems to emerge as a rather protracted and chronic condition.

Consider the Colombian health care system; despite declaring bankruptcy, for instance, most public hospitals have usually figured out improvised and last-minute strategies to keep their doors opened —albeit partially— while some insurance companies become insolvent and get liquidated each year, new ones make it into the market. Overworked physicians go out to the streets and protest against the

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life for patients in the U.S. Kaufman intended the term 'ordinary' partly ironically, for there is nothing usual or customary or inevitable about the developments in modern medicine by which more aggressive interventions —especially for older patients— become standardized, normal and ethically appropriate.

profit-making logic. Low-income cancer patients wait, endure and die as they seek medical care. Most of these critical situations, however, have often triggered social discontent that rapidly goes from hopeful mobilizations to routine and dull expressions of frustration.

Oscillations like these, after all, are typical to Capitalism. Karl Marx once wrote: "The crises are always but momentary and forcible solutions of the existing contradictions. They are violent eruptions which for a time restore the disturbed equilibrium" (Marx, 1981: 357). For David Harvey, the contradictions inherent to Capitalism are expressed in "violent paroxysms" which impose momentary solutions (1982). Drawing inspiration from these authors, I argue that the Colombian health care crisis illustrates how the side-effects of '*Ley 100*' are expressed in social discontent, inequality and protests (often violent), which usually trigger palliative measures that can only restore the perception of equilibrium.

In this article I seek to conceptualize the *crisis* by drawing on my 17-month ethnographic fieldwork during 2011-2012 (complemented by shorter visits to the field in 2016), with physicians, low-income cancer patients and EPSs representatives in the city of Cali. Inspired by *Anti-Crisis* by Roitman, I seek to argue that the national health care crisis cannot be analyzed in terms of an ongoing transformation or "turning point". Rather, it represents a deadlock that endures over time, a disaster that never ends. This perceived crisis, hence, becomes an ordinary and chronic condition or, as Roitman would have put it, "a persistent state of ailment and demise" (2013: 16).

According to another physician I call Dr. Artesano: "The worst part of the health care crisis is that we have no idea whether the required changes would be implemented by the government or whether these would ever trigger any meaningful transformation". Dr. Artesano is a senior palliative care giver who works at Hospital Universitario del Valle (HUV). He has been an active member of the hospital union and often stands behind the picket lines. Throughout my ethnographic fieldwork, he not only taught me about pain and cancer care but also discussed the financial and ethical challenges faced by health care workers in neoliberal Colombia.

When I asked him about the protracted crisis, Dr. Artesano resorted to the Spanish idiom *"lo mismo de siempre"* [Same old, same old]. *"Después de todo, las cosas vuelven a ser iguales"* (after all, things remain the same). Same old, same old reflects the perception of moving towards a turning point, the building of momentum, and the simultaneous impossibility of reaching it. Same old, same old, hence, signals a threshold, a decoupling of the link between action and reaction by which the latter fails to be in sync with the former. It refers to a *no-change* status, to stasis.

For Dr. Artesano, this phenomenon could be further illustrated by the following analogy:

> "Our health care system is like a time bomb without a detonator" he mused. Surprised by his words, I immediately asked for clarification: "What do you mean?"

Before answering my question, the physician closed his eyes for a couple of seconds, he opened them and stared at the wall behind me —as if carefully looking for the appropriate words:

> "Well, it's a time bomb because the system was originally designed to respond to market forces, not the need of patients. After '*Ley 100*' was implemented, inequality has skyrocketed, corruption is rampant and the violation of constitutional rights have become quotidian. But these conditions have yet to trigger a widespread social unrest that could eventually unleash major policy transformations —especially for the poor. Nothing has really happened as a result of this crisis, not even when patients die while waiting to be treated. We [Colombians] got used to living under these conditions, while at the same time complaining and hoping for a solution. Isn't this contradictory? We aspire to change something that isn't bothering us anymore". He further asked: "Is this the price we pay for a universal health care system in which every Colombian is a potential client, where every EPS is a potential investor?"

The crisis I write about signals the simultaneous coming of a change and the impossibility of actualizing it. Building on *Aporias* by Derrida, I propose to understand the health care crisis in terms of "a future advent which no longer has the form of the movement that consists in passing, traversing, or transitioning" (1993: 8). It is a split moment through which the legal dispositions, clinical expectations and health policy regulations are planned, but not actualized (Greenhouse, 2006). Crisis, hence, lies in a threshold of anticipation between the hopes for accessing treatments on time and living longer, *what ought to be* according to '*Ley 100*' and the sudden frustration for not being able to access them, or *what actually is* possible. In other words, while the national health care system dwells in a seemingly state of permanent transition, it simultaneously falls short to materialize the reforms needed by Colombians, especially the most vulnerable.

How does a threshold for bringing forth a transformation turn to be without passage, thus becoming a permanent and defining feature of the national health care system? In other words, how does an interval of time, just before the onset of something, become a windup? How do patients and physicians struggle to synchronize the time required by tumors to grow, the time of hospital bureaucracy and the time needed by health insurance companies to make profit?

To address these questions, I analyze the contradictory relationship between two seemingly opposite mechanisms: Health insurance deferrals and the writ of *tutela*. Deferrals are the EPSs practices of defaulting on salary payments for health care staff or hospital fees, as well as delaying the provision of prescribed treatments for patients (Sanz, 2017). To counter these deferrals and access their prescribed medical services, patients are overwhelmingly turning to *tutela*. This is an anti-crisis mechanism created in 1991 for imparting neoliberal justice and protecting fundamental rights, such as health and life. Filing *tutela* is a simple and straightforward process. Patients can even file it on their own by downloading formats that are available on the Internet. Once filed, Judges have up to 10 business days to provide a final ruling. *Tutela*, however, tends to make claimants especially visible before the state, often when their right to health has been systematically violated and their life threatened as a result of deferrals. In this article, I seek to argue, anti-crisis mechanisms such as *tutela* have set perverse financial incentives that encourage patients to wait and deteriorate, and EPSs to continue delaying the provision of "high-cost" treatments.

This article is not intended to be an *exposé* of EPSs inner workings, even less to offer solutions to the crisis. Rather, by drawing on my ethnographic research with physicians, cancer patients and EPSs representatives, my work seeks to discuss the conditions of (im)possibility that transformed the health care crisis into an ordinary becoming, a "blind spot" for social action and analysis —as Roitman would have put it.

EPS deferral practices

During most of my ethnographic research, Hospital Universitario del Valle (HUV) became my fieldwork headquarter. This is one of the most important public hospitals in Cali. Since 1956 the HUV has been a point of reference for most working-class Colombians living in the south-west region of the country. After the neoliberal reform of 1993, the hospital was transformed into an ESE, as an *Empresa Social del Estado,* the HUV was expected to be financially sustainable and competitive in the newly created market. Like so many other public hospitals that were transformed into ESEs (see Abadia-Barrero, 2015a), the HUV has struggled to maintain a permanent cash flow to fund its services and pay salaries on time.

As a result, social discontent periodically builds. I recall health care workers being uncertain whether the next protest would finally force the hospital to close its doors for good. My main interlocutors on this topic were palliative caregivers, whose job is to provide symptom control —most often to cancer patients—. This group of doctors has been especially active in the hospital union, frequently standing at the picket lines. Several times during my research they took over the aisles and administrative offices located in the main building.

In the following vignettes, a palliative care physician describes the discontent and frustration I often encountered at HUV. Dr. Lucho is a junior doctor who was hired at this hospital after completing his residency in the pain clinic. His anger boils down to a set of perverse effects unleashed by the EPSs late payments of salaries and hospital fees. According to him:

"The hospital already owes me around 9 Million pesos![3] That's why I'm always trying to catch up in financial terms. But it's difficult. The hospital has no money.

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[3] Roughly USD $3,000.

Do you want to know why?" he rushed to ask me. Immediately I nodded my head, letting him know I was eager to find out. He carried on: "Most EPSs pay late and rarely disburse the total amount they owe us. Whenever we demand an explanation from the hospital manager, we are told these companies are taking 60-90 days to pay their debt. Still, the hospital management asks us to keep holding consultations and showing up for work. Sometimes I wish I could just quit and start my private practice. Unfortunately, this is not a viable option for me —at least for now—, if I quit, how would I get a good volume of patients to pay my bills?" he impatiently asked.

EPSs, after all, connect the different actors in the healthcare market, the cogs in the machine, as Dr. Lucho would have put it. These companies are middle-men, intermediators between patients and hospitals, physicians and patients.

"That is why we have taken over the hospital building", he felt compelled to clarify. "We want to make sure our demands are heard by the local government, the EPSs and the hospital administration. We have been systematically exploited".

My friend Dr. Lucho was not willing to be patient anymore with the current situation. He was onboard with the plan of the union for escalating the protest, even if that might affect the provision of medical services for patients. He further elaborated on his decision:

"They say [referring to government officials] we should be taken accountable for the hospital crisis; that the union is not allowing patients to access the oncology wards; that we are threatening their life and violating their right to health care. These are all plain lies. Our fight is not against patients. It is against the whole *vagabunderia criminal* (criminal, shameless actions) that makes profit from physicians, like ourselves, and poor patients' health".

While protestors like Dr. Lucho were aware that blocking the access of patients to hospital services could go against the *raison d'etre* of the union, they were nonetheless willing to do so in order to gain further leverage with the hospital management, and become visible before the state.

A couple of weeks later, during an escalation of the protest, a temporary solution was suddenly reached. The municipality intervened and pumped emergency funds to palliate the crisis. In exchange, Dr. Lucho and his fellow protestors agreed to vacate the premises. The hospital doors re-opened, yet nobody knew for how long. After all, the hospital debt had been growing out of control. The costs of care had risen exponentially over the last few months, turning HUV into a sort of financial black hole.

Barely two months after the municipality disbursed the promised funds, was social discontent on the rise again. *"Pa'lante y pa'tras"* (back-and-forth), said Dr. Lucho. "While many EPSs still owe us money, the government looks the other way and thinks our situation can really be fixed with *paños de agua tibia"* (lukewarm compresses).

Nurses and doctors stood behind their picket lines and blocked ‘Calle Quinta’. This time protestors were carrying wooden coffins on their shoulders to symbolize the death of the Colombian health care model. They were shouting: *“La salud no es un negocio”* (health care is not a business!), *“Viva el hospital público”* (save the public hospitals!). Physicians were especially upset because the HUV was (once more) behind with their salaries.

This is what Dr. Artesano calls *Mentalidad de pago atrasado,* or delayed payment mindset. If health insurance takes too long to pay hospital fees, these institutions may start running out of cash and incurring debts with providers and health care staff. According to Dr. Artesano, the consultations he holds today are often translated into the salary EPSs will pay him over the next 2-3 months: “The problem is that most of us live paycheck to paycheck”, he said.

Failing to pay the salaries of physicians on time turns into a form of debt (and theft). Yet, EPSs are not necessarily penalized for doing so. After all, EPSs make profit by delaying payments and the provision of medical services, especially those considered “high-cost” (Sanz, 2017). In so doing, these companies are able to engage in the financial market and redirect resources toward less risky investments[4] (see Graeber, 2014). As Marx showed, the transformation of money to commodity to money (diagrammatically represented as M-C-M´) would make no sense to capital unless that transformation was in fact M-C-M’, where M′ > M. Unless there is a constant potential for money returned through commodity exchange to be greater than money advanced, money is not capital (Marx, 1992). In other words, the EPSs money that emerges from the process of circulation in the healthcare system must be greater than the money initially advanced into it (for instance, Unidad de Pago por Capitación - UPC).[5]

The EPSs creation of money from debt, therefore, enables capital to reproduce itself in a realm of pure promise and waiting (Marx, 1992), that is, the promise of providing healthcare to all Colombians and paying the salaries of healthcare workers. For Melinda Cooper (2008) these practices may be understood as the ‘accumulation of biological futures’. This concept encompasses the many kinds of business models in the life sciences that are based on practices of financial speculation and debt creation —venture capital funding, stock markets and so forth.

This is partly why nurses and physicians go periodically on strike at HUV, block the main hospital entrance and march on the street, while medical appointments

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[4] In 2009, for instance, the Boston Consulting Group considered SaludCoop EPS as one of the five Colombian multinationals that were part of the top 100 enterprises in Latin America. In ten years, the small cooperative group had multiplied its capital almost a 100% and acquired other EPSs. In the end of 2006 SaludCoop had increased its capital to 362.000 million of pesos and sold for 1,3 billion pesos (Portafolio, 2013).

[5] This is the annual value recognized for each individual enrolled in an EPS.

get cancelled or postponed. In the process, the health conditions of patients keep deteriorating until they decide to file *tutela*. They sue the hospital and/or their EPSs, arguing that their right to health has been violated because physicians are not available to see them, or because of the time they wasted while trying to navigate the burdensome medico-insurance bureaucracy. Below, I discuss the financial incentives that have transformed these critical conditions into ordinary events.

Markets of crisis

Unlike other (so-called) third world countries, the health care crisis in Colombia can hardly be explained in terms of lack of technology or financial resources. Instead, the situation may be interpreted as a contradiction resulting from liberalization policies. As I have described elsewhere, while the state disburses large amounts of public funds to provide care for all Colombians, the same state forgoes control of the financial inner workings of the insurance companies (Sanz, 2017; 2019). There is no need to wonder why low-income cancer patients become “high-cost”; their bodily crises get transformed into business opportunities for EPSs.

In her book *Markets of Sorrow,* Vincanne Adams discusses this ethical transformation in the context of hurricane Katrina (2013). She unveils the effects of “privatizing the most basic social services and the failure of these services to respond to [north] Americans in need because they are tied to market forces guided by profit” (2013: 1). In the process, she argues, “the recovery that should have taken a few years was turned into what locals call a *funeral that would not end* [my emphasis]” (2013: 5). That is, post-Katrina became a stalled crisis that failed to reach a turning point. This *‘funeral-that-would-not-end’* highlights the underlying tendency of capitalism toward crisis and “the central role played by its own instability” (Marx, 1981).

Karen Ho (2009), for instance, has described this tendency in her ethnography of Wall Street. In her book *Liquidated,* she analyzed how investment bankers negotiate the relationship between massive downsizing, shareholder value, and the production of market crisis, which leads not only to the overhaul of mainstream business value but ultimately to the liquidation of Wall Street itself. In the period that has been called the greatest economic boom in the U.S history (early 1990s-2000), the economy experienced not only record corporate profits and the longest rising stock market ever, but also record downsizings and rampant job insecurity (O’Sullivan, 2000, in Ho, 2009).

In the context of Colombia, low-income cancer patients, bankrupt public hospitals and metastasized tumors, may be highly profitable, especially when neoliberal reforms have been intertwined with ‘*Ley 100’* and the biopolitical mandate to make patients live. In fact, I argue, EPSs systematic deferral —and the bodily deterioration that comes along with it— has been paradoxically reinforced by *tutela*; the same anti-crisis mechanism created to protect the citizen rights to health and life.

Tutela: 'Sin tropel no hay salud'

At the oncology ward, a woman in her 60s commented in a loud voice while pointing at the window: "Hey, hey… look at the doctors and nurses who are protesting outside. These folks know that the hospital management would only pay their salaries if they block the entrance to the out-patient facility. Health care workers are fighting for their salary, just as we [patients] file *tutelas* to protect our right to health. *¡Así le toca al pobre!* [This is what the poor have to do]".

While some patients nodded silently, the majority responded with energetic slurs against the government, EPSs and the hospital administration. One of them shouted: "That's right. *Sin tropel no hay salud, carajo!"* (No fight, no health).

In addition to their frustrating experiences with the health care system, these patients were dealing with the uncertainties of a partially-closed hospital. Nobody knew whether physicians would show up for consultations today —the same consultations patients had struggled to schedule for several months—. After all, part of the HUV medical staff was protesting outside, standing behind the picket lines.

A nurse who did not join the protest seemed overwhelmed by the patients frustration. Out of stress and exhaustion, she suddenly shouted in a cracking voice:

"Look, I am sympathetic with you all. But I am not willing to be the target of your anger. If you really want to complain and get things done, go to a courthouse and file a *bendita tutela.* C'mon, there is a rally going on outside! What do you want me to do?"

Over the years, *tutela* has become a popular "anti-crisis" mechanism used by patients to channel discontent and access treatments and medications. More than 70% of *tutelas* are usually filed against EPSs and hospital settings for not providing medical services (Defensoría del Pueblo, 2018; El País, 2013). The vast majority of these writs, however, have been filed to access treatments that are already legally covered in the Plan Obligatorio de Salud (POS)[6] (Defensoría del Pueblo, 2013; 2018). "Insurers argue that their refusal to provide these services conforms to the law, while patients use the same law to gain access to services denied" (Abadia-Barrero, 2015b: 63).

Because the majority of *tutelas* are relatively easy to file and judges usually approve them within 10 business days, these writs have swamped the judicial system, being almost 200.000 during 2018 (Defensoría del Pueblo, 2018). While health care is a fundamental right for all citizens, every 34 seconds a patient petitions the judiciary to issue a writ affirming their right to health care (Defensoría del Pueblo, 2019). The need for people to file these kinds of writs is not exclusive to Colombia,

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[6] Currently, Plan de Beneficios de Salud.

and it indicates the systematic problems in the functioning of health care systems elsewhere (Biehl *et al.,* 2012; Graham, 2016; Tichenor, 2017).

In this section I describe how low-income cancer patients seek to protect their right to health by resorting to the 'anti-crisis' nature of *tutelas*. The preposition 'anti' usually means to be opposed or against. In the case of *tutela*, however, its 'anti' character may turn out to reflect what it stands against. According to my dictionary definition, reflection indicates the return of light from a surface. Think about a mirror image, for instance; when an object is reflected on it, the resulting image is the return of light waves bouncing back from the object. This image becomes a duplication of the object that appears almost identical, yet it is reversed in the direction perpendicular to the mirror surface. Likewise, the divisions between crisis and anti-crisis become fuzzy, mostly because the latter is not necessarily an "opposite" of the former, but rather a reversed duplication. This poses the following question: Would not the "anti-crisis" nature of *tutela* end up reproducing (thus prolonging) the same crises it was designed to counteract? If so, how?

With more than 30 years of clinical experience under his belt, Dr. Masa is well aware of the seeming contradiction between the massive use of *tutela*, bodily deterioration and deferral practices by EPSs. He once told me: "To a great extent, the obsession with *tutela* explains why patients do not access medical services when they are still curable. When they get the favorable court ruling their bodies have deteriorated because of the long journey they had to endure with EPS bureaucracy".

"How's that?" I asked.

"It all boils down to the chain of financial incentives that encourages patients to wait and deteriorate before a *tutela* can actually protect their rights to health and life. For some of my patients, it doesn't really matter if this unlimited access is granted after their health has been seriously deteriorated. They still feel they have defeated the unjust system and made it pay for the wait and exhaustion".

Dr. Masa has just described a common situation I came across during fieldwork, in which low-income cancer patients may trade their curative chances in the present for future unlimited access to physicians, drugs and medical supplies. For most of the patients I talked to, becoming visible before the state and getting unlimited medical services, often in an uncertain future, is worth the bodily decay.

To illustrate this phenomenon, let me first introduce one of the patients I am deeply grateful with. I call him Mr. Alonso. He was a laryngeal cancer patient whom I met during my visits to the Oncology waiting room. I spent countless hours talking with him and his wife, Mrs. Luz. Due to his rapid deterioration, his wife had been doing all the hospital and insurance paperwork on his behalf. After several months caring for her husband, Mrs. Luz became an expert on navigating the health insurance bureaucracy and filing legal writs, such as *tutela*. During weekdays the couple would usually wake up at 3:30 a.m. and get to the hospital by 5:00 a.m. Getting early to the scheduling office usually allows Mr. Alonso to choose the soonest available oncology appointment.

Once they have been provided with the official appointment confirmation, Mr. Alonso and his wife pay a visit to the health insurance office —where they submit the prescription requests written earlier by the oncologist—. Today I followed them to a meeting with one of the insurance representatives. The office was crowded, as usual, and the long serpentine line did not seem to be moving. Only a couple of insurance representatives were at the counter reviewing clinical records, prescriptions and treatment application forms of the patients.

Mr. Alonso sat down on a plastic chair while Mrs. Luz and I kept waiting in line. Suddenly, he waved his hands at me. My friend grabbed a cloth from his pocket and placed it at the base of his neck, just inside the tracheotomy orifice. He then carefully dried the excess of saliva coming out from it and fitted a white plastic ring inside the orifice to prevent the still fleshy tissue from blocking the airway. In a barely comprehensible voice, he said: “So you want to learn about my medical journey, right? Take a look at these documents”. He carefully bent forward and grabbed a black plastic bag from underneath his chair. “This is where we keep all my medical records and any evidence that would allow us to prove that my right to health has been violated.”

After multiple enquiries and a legal petition, an insurance representative had informally told Mr. Alonso his prescribed Cetuximab was too expensive and would not be provided. “When the moment comes, my wife will go before a judge and use these documents to file a *tutela*. We will get medical service “By hook or by crook”he concluded.

Mr. Alonso had reached a tipping point in his frustrating relationship with the EPS. His struggle would soon be moving away from the hospital and health insurance office into the judiciary system, where a judge will review his case and decide whether the EPS has threatened his right to health (therefore, life). This encounter between medical and legal knowledge is known as the ‘judicialization of health care’, a term that refers to a “transfer of decision-making power from the Executive and Legislative to judges and courts” (Gonçalves and Machado, 2010: 39).

To initiate a *tutela* writ, patients are usually expected to attach detailed documentation that proves their prescriptions were denied, or their provision arbitrarily deferred by the insurance. It is worth noting that this document is furnished by EPSs themselves, which, over time, became standardized as a Service Denial Form (Abadia-Barrero, 2015b). After having endured systematic deferrals and burdensome bureaucracy, patients know that their wait and bodily deterioration may increase their chances for getting a favorable court ruling.[7]

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[7] Adriana Petryna (2003) uses the concept of Biological citizen to name the way that biology becomes a cultural resource through which citizens stake their claims for social equity in post Chernobyl

While Mr. Alonso kept discussing his clinical history with me, Mrs. Luz suddenly interjected: “Yes, we are taking legal actions as soon as the insurance representative provides us with the Service Denial Form. I am confident the judge will take this document as irrefutable evidence that my husband’s right to health has been threatened. The insurance company will then have to cover all his future treatments and drugs, regardless of costs”, she concluded with a tone of vindication.

Just as patient demands transition from the hospital to the legal system, physician expertise is being imbued by legal parlance and advice. While the doctors talk about exams, feel lumps, disinfect purulent tumors, for instance, they also spend time advising patients about *tutela*. Knowing how to file this ‘anti-crisis’ mechanism has become a common topic of conversation at examination rooms; doctors find themselves combining their medical practice with legal advice during their 15-minute consultations.

Please, do not get me wrong. *Tutela* has been a boon for patients, especially for those who are considered “low-income/high-cost”. Physicians are well aware of this fact; consider the following explanation given by Dr. Masa: “I really encourage my patients to file *tutelas.* I get a sense of relief when they get favorable court rulings. Caring for them becomes easier and less frustrating, and their prognoses usually tend to be better too. You don’t feel like wasting your time and energy with them. Besides, [as a doctor] you may even get to choose from the most cutting edge and ‘first line’ drugs on the market”.

Here Dr. Masa discussed how his medical knowledge about bodies got intertwined with knowledge about the judiciary system. He knows *tutela* has become a sort of lifeline for patients like Mr. Alonso. For many of them, getting access to most anti-cancer drugs is only possible if they waste time with EPSs bureaucracy and, most importantly, demonstrate that their bodies are incurable because of this wait.

In the next section I discuss the ethical implications of protecting a fundamental right when it has already been violated. To do so, I build on a conversation I witnessed between my friend, his wife, and an EPS representative. How do health insurance companies and patients negotiate *tutela*? How do patients make sense of the right to health and their deteriorated biology in neoliberal Colombia?

(Im)possible rights and Minimal Health

Rights are commonly understood as unalienable conditions or legal statuses that entitle the recipients with inherent protections and privileges. In *Who is the subject of the right of man* (2004), however, Ranciere argues that human rights are often applicable

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Ukraine. She traces the claims to health services and social support of those who were exposed to the radiation effects of the nuclear explosion in Chernobyl, in the name of their exposure to radioactivity.

when individuals can demonstrate they are being deprived of the rights they had. His work puts together a relation of inclusion and a relation of exclusion. Similarly, access to health care in Colombia is inscribed in conditions in which rights are presented as a function of deservedness versus finances. This, of course, has been fueled by "disagreements around the idea of justice in terms of how much social harm is morally acceptable when granting individual petitions of people" (Abadia-Barrero, 2015b: 75). In the case of the cancer patients I worked with, their prompt access to medical services often became a reality when their right to health has been systematically violated —and their life threatened as a result—. That is, when patients are able to demonstrate they have been deprived of the rights they have. What does *'Sin tropel no hay salud'* [no fight, no health] tell us about universal health care, *tutela* and crisis in neoliberal Colombia?

Dr. Masa resorted to one of his pedagogical analogies to illustrate the paradox of the right to health in Colombia. While placing his hands on his chest, he uttered: "Imagine a bullet-proof vest. This piece of military equipment is used to protect people from getting injured or killed by gunfire, right? In the Colombian context, however, it only stops bullets after your body has been previously shot. Only then the vest magically becomes bullet-proof —protecting you from future shots— but what's the point of wearing a bullet-proof vest if it only protects you after your body has been injured?" he questioned.

His analogy highlights the bizarre relationship between *tutela* and fundamental rights in my home country. While *tutela* seeks to protect rights such as health and life, it actually does so after diseased bodies have been 'wounded' by the bullets of inequality, time and burdensome bureaucracy. This is when a right becomes unalienable. Not in vain patients often wait and allow their bodies to reach what I call 'minimal health'.

'Minimal health' is a concept I developed from Agamben's 'Bare life' (1998). For him, Bare life is the life that has been stripped of its political and social qualities. It refers to those who are abandoned outside the polis, such as the asylum seeker, for instance. Agamben outlines this foundation of sovereignty through a figure he derived from archaic Roman Law: Homo Sacer, "This is a person whom one could kill with impunity, since he was banned from the politico-legal community and reduced to the status of his physical existence" (Agamben, 1998: 181). Building on his work —while departing from it—, in this article I utilize 'minimal health' as a concept that helps me think about a life that is managed once it has deteriorated beyond a curable point. Yet it is not a life technically destined to die. Rather, it is expected to endure until it is nearly exhausted. Cancerous bodies, for instance, are expected to persist until the chemotherapy *pharmakon* —once considered therapeutic— turns into poison (Derrida, 1981).

Reaching this state of 'minimal health', after all, allows low-income cancer patients to maximize their chances for getting unlimited and prompt access to medical services via *tutela* ruling. Myriam Ticktin has examined a similar phenomenon in which bodily deterioration became an asset. In her work on HIV illegal migrants (2012), she showed how decaying and incurable patients become visible before the French state. She examined the role of humanitarianism and compassion in the development of an ethical configuration that has made illness a primary means to obtain papers in France. Ticktin explained how the state renders sick bodies visible (over laboring bodies) —as long as they remain sick from life-threatening pathologies—. By getting infected with HIV, illegal immigrants to France were able to acquire citizenship and health care treatment. This phenomenon is based on engaging other people in relationships of empathy and in this way demonstrating their common humanity; this is an ethics that, when taken to the extreme, entails selling suffering, bartering for membership with life and body (Ticktin, 2012).

In the case of cancer care in Colombia, 'minimal health' makes possible the disbursement of millionaire public funds into the health care circuit, allowing cutting edge (often high-cost) chemotherapy regimens and low-income conditions to cohabit in the same body. This means that EPSs often leave small tumors untreated until they grow and metastasize. While the state does not question the legitimacy of treatments and payment deferrals by EPSs, it intervenes legally to grant low-income cancer patients their right to health when their bodies and tumors are necrotic (Sanz, 2017).

The following vignettes illustrate how a *tutela* ruling not only granted Mr. Alonso access to Cetuximab, but also transferred the EPS financial risks —associated to his large claim— back to the neoliberal state.

Back at the EPS office

I looked at my watch and it was almost 3:00 p.m. Mr. Alonso was getting frustrated and could not find a comfortable position on the plastic chair. I could hear the heavy breathing through his tracheotomy. "I might need some fresh air", he said. "A little stretching would help". He grabbed my arm and slowly stood up. "Don't go too far", asked his wife, "We should get called any time soon". But Mr. Alonso was exhausted, since 5:00 a.m. he had taken buses, stood in line, felt impatient and thirsty. "I am not sure I can take it anymore. We should probably go back home", he mused while placing a finger on his tracheotomy.

"If you leave, we would accomplish nothing. *Hemos esperado lo más, podemos esperar lo menos* [Because we have already waited for so long so, we can certainly wait a little more]. Please hang on", his wife begged him while at the verge of crying. Time kept passing, frustration kept mounting.

Finally, an insurance representative made a gesture with her hands, asking them to step forward. After a long wait, my friends had finally made it to the customer service desk. The representative —whom I will call Mrs. Amparo— greeted them with a smile: "Please sit down. What can I do for you today?" she kindly asked.

Mrs. Luz said "My husband [pointing at Mr. Alonso] has been requesting his Cetuximab for more than 2 months". She opened the black plastic bag and grabbed a bunch of documents held together by an elastic band. She wetted her index finger with saliva and quickly skimmed through the many documents, until she came across a small wrinkled paper. She carefully unfolded it and placed it on the desk.

Mrs. Luz then said, "Take a look at my husband's Cetuximab prescription. It turns out his application was denied by your EPS. So, it's time for us to file *tutela*. We are here to request the official rejection letter from you", she said while Mr. Alonso kept listening.

The EPS representative took her glasses off and looked at the prescription. She then turned to the computer and typed Mr. Alonso's last name into the on-line database. There was a prolonged moment of silence. Then she mused: "I wish I could help you get the much-needed drug, but unfortunately the CTC (Comité Técnico Científico) won't allow it. It's too expensive".

Mrs. Luz replied, "Yes, I get that. But what else are we supposed to do? I've been told Cetuximab is his only option in the market right now. If we keep waiting, my husband will die. Look at him! We need to move forward with *tutela*".

Mrs. Amparo: "I completely understand. And I am here to help. Let me look for the denial form".

The insurance representative turned to the computer, she double checked the full name of Mr. Alonso against his cédula (ID card) and re-typed it into the database. After a prolonged silence, she said with a tone of relief: "I found it, I'll print out the form for you." She grabbed an insurance stamp from a drawer and stood up: "My supervisor has to sign it. I'll be right back".

When she returned to her desk, the representative was holding an empty envelope in one hand, and the denial form on the other: "Well, here is the official letter. It clearly explains why your treatment wasn't approved. It has the EPS stamp on it and my supervisor's signature at the bottom. Please keep it in a safe place and attach it to your *tutela* dossier. This is the most important piece of evidence for your writ. As soon as you get a favorable court ruling, *Dios mediante* [she crossed her fingers], come back to our office. We should then be able to coordinate the delivery of the drug to the HUV oncology department".

The representative was hopeful about Mr. Alonso's *tutela*: "Based on the time you have waited for the drug, and given the severity of your cancer, I am pretty confident the judge will rule in your favor and override our CTC's decisions". Mrs. Amparo made sure the couple had read the letter and understood the next steps moving forward with *tutela*. She gave them a final advice: "You may find free *tutela* forms on-line or at the courthouses. Social workers at the hospital should be able to help with these, too".

At the end, putting together the paperwork and filing the *tutela* was a rather straightforward process. The judge who reviewed Mr. Alonso's case took less than 6 days to come up with a favorable ruling. His EPS was finally forced to provide the prescribed medication. The cancer, unfortunately, had long ago found its way into his liver because Mr. Alonso had wasted so much time struggling with burdensome bureaucracy, his treating oncologist did not have the chance to order standard blood and imaging exams to monitor the tumor. Standing in line, hopping on buses, talking to insurance representatives, going to courthouses; the journey to access oncology treatments becomes a journey of *vueltas* and wasting time (Sanz, 2017).

Two months later my friend died at home —next to his wife— when his liver could not take it anymore. The case of Mr. Alonso shows how financial resources and legal mechanisms are activated in situations of bodily crises, not before. His decision to reach 'minimal health' reflects how rights become unalienable only when they have been violated. In addition, his medical-bureaucratic journey illustrates how *tutela* —as anti-crisis— becomes such an ordinary mechanism that it ends up reproducing and sustaining the crisis itself.

Outsourcing of ethical liability and financial burden

The legal determination for Mr. Alonso came with a catch. The same court ruling that sought to protect him against the EPS inaction, released this company from the financial costs associated with his Cetuximab claim. Even though EPSs are usually presented as the main targets of complaints (Defensoría del Pueblo, 2018), a ruling against them authorizes these companies to access public funds (Abadia-Barrero, 2015b).

This financial twist is rendered possible through a mechanism known as Recobro[8] or Reimbursement, which highlights the welfare state and corporate fusion (Adams, 2013; Lamphere, 2005). Recobro is a request by which EPSs charge previously uncovered[9] medical care to the Fondo de Solidaridad y Garantía del Sistema General de Seguridad (FOSYGA).[10] This is a public fund ascribed to the Ministry of Health, which was created to manage and oversee the financial resources of the national health care system.

To analyze the financial twist rendered possible through Recobro, I now turn to a conversation I had with Mrs. Amparo —the same EPS representative who met with

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[8] Through a controversial move in early 2020, the Ministry of Health derogated the mechanism of Recobro (decrees 205 and 206). In doing so, the government seeks to accomplish three main goals: (1) To provide EPSs with more funds, stream the process through which denied or NO POS medications were accessed by patients; (2) render more transparency and accountability in the management of these funds; and (3) reduce the numbers of *tutela*s patients file to access medical services.

[9] Usually considered 'too expensive' or not included in the POS, Plan Obligatorio de Salud.

[10] Nowadays, Administradora de los Recursos del Sistema General de Seguridad Social en Salud (ADRES).

Mr. Alonso and his wife—. When I approached her, I made it clear I wanted to learn about EPSs inner workings and the mechanism of *Recobro*. Fortunately, a colleague of hers had introduced us when I was still in the first months of fieldwork. Since then, we came across several times and had sporadic —yet fruitful— conversations.

"Sure. I'd be happy to help with your research" she mused, "Today I might have some time to talk, right after work. Would you mind waiting for a couple of hours or so?" She asked. "Once I am done, we could look for a place to chat outside". I went back to the waiting room and worked on my field notes of the day. A while later Mrs. Amparo stood up from her desk, slid insurance forms into manila envelopes and turned off her computer. She looked at me and waved her hands. She was getting ready to leave.

While having a coffee at a *corrientazo* next door,[11] I asked: "I am curious about your meeting with Mr. Alonso. You know, the patient with the tracheotomy you met today. Could you talk more about his case? Please correct me if I misunderstood what happened earlier, but did you encourage Mr. Alonso to file a *tutela* against the same insurance company you work for?"

Mrs. Amparo took a sip of hot coffee and nodded: "Yes, from time to time I do encourage patients to sue us". She took another sip "We [insurance reps] all do it. It does not mean we are being disloyal to our company or doing unethical stuff. In fact, I would say, this is a quotidian part of our job. While we help patients access medical services, we also seek to ensure our company stays financially fit. *Tutela* allows us to do both things at the same time".

Camilo: "Could you please elaborate further more? I am struggling to understand this seemingly win-win situation".

Mrs. Amparo: "Well, it all starts with something called re-insurance policy. This is a policy we get from another insurance company. It allows the EPS to be protected against large claims. Let's say my company buys a policy and insures treatments that go beyond 15 million pesos per patient. In other words, we have a deductible of 15 million per patient. Any claim beyond this amount would automatically be covered by our reinsurance policy. But it does not mean we should go beyond the deductible every time someone files a "high-cost" claim. Doing so has the potential for increasing our premiums in the long run".

Mrs. Amparo explained that reinsurers handle risks that are usually too large for EPSs to handle on their own. These companies help EPSs get protected from the risk of a major claim event; that is, from cancer patients like Mr. Alonso who (often) require expensive chemotherapy. This is a form of outsourcing that imbues health insurance practices with a ghostly attribute, and makes it more difficult to know who

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[11] A "corrientazo" is a corriente (common, ordinary) type of restaurant that offers inexpensive lunch menus, usually for the busy working class.

is taking seemingly unethical decisions in the health care system.[12] In other words, the outsourcing of ethics is further outsourced so that no one is unethical.

Sergio Sismondo has written about this phenomenon in the context of pharmaceutical marketing in the U.S. In his book *Ghost-Managed Medicine* he argues that "the work to coordinate the production and circulation of knowledge is performed by invisible hands" (2018: 9). These invisible hands would represent middle-men or middle managers that work backstage. They are either invisible or look as though they are doing something else. As ghosts, "we can't quite see them or can't see them for what they are" (2018: 14). The visible ones, on the other hand, may truly believe their jobs are helping patients. Pharma representatives and Key Opinion Leaders (KOLS,) for instance, are generally fully committed to what they are doing. And they do it "for the sake of patients". This makes it difficult to identify who is 'unethical'.

Similarly, Anthropologist Sharon Kaufman has written about a chain of invisible health care drivers[13] that has heavily influenced "health care policy, the development of biomedical technologies and how evidence about treatment is produced and employed in clinical care" (2015: 8). The intimate articulation of these health care drivers, she argues, has made it difficult to see the line between *enough and too many* treatments —especially for the elderly.

In Colombia, following the explanation given by Mrs. Amparo, ghostly practices are incarnated in the outsourcing of ethics from EPSs to reinsurances. This mechanism has allowed EPSs to dilute their ethical liability to a point where no one is seen as unethical, where EPSs representatives themselves can actually "help" and guide patients through legal suits against their own company.

There was, however, another piece of the puzzle I was still hoping to understand. It has to do with the widespread use of *tutela* and its potential financial effects on reinsurance premiums. If *tutela* has become the ordinary means by which most 'low-income/high-cost' patients access medical services, would not reinsurance deductibles be constantly maxed out by EPSs? I end this article with a brief discussion on how EPSs may manage to abide by the staggering numbers of *tutela* rulings without increasing premiums of their enrollees, and still obtaining large profit margins.

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[12] This is a titration mechanism used to reduce the number of large claims. This is the secret process that Blue-Cross Blue Shield had regarding breast cancer treatments in California in the early 2000s; it secretly had a policy that they had to sue and then they would provide the treatment. They got caught as this was seen as unethical.

[13] There are four invisible health care drivers in the U.S. according to Kaufman: Biomedical industry and its clinical trials that produce facts about medical treatments; private insurance and Medicaid committees that determine what is reimbursable and transform treatments into standards of care; physicians who prescribe these treatments, most of which are now seen as ethically necessary and difficult to refuse (2015).

At the *corrientazo* I rephrase this question for Mrs. Amparo:

"I wonder about the seeming incompatibility between *tutelas* and reinsurance policies. How does the massive use of *tutelas* impact the reinsurance premiums? After all, when a judge rules in favor of a claimant, the EPS is forced to provide the medications it was sued for. Could you please comment on how EPSs manage the associated costs? Would these companies pass these costs on to their enrollees?"

Mrs. Amparo: "Not necessarily. Remember that healthcare is a fundamental right in Colombia. All Colombians, regardless of their capacity to pay should be able to access medical services. So, passing these costs on to patients —especially the less wealthy— would be problematic. The costs associated with larger claims have to be passed somewhere else".

Camilo: "Where?"

Mrs. Amparo: "To the government. The government chips in. That is how we are able to provide universal health care without increasing our premiums and still be competitive on the market".

To make her point clearer, Mrs. Amparo resorted to the following example:

"You mentioned you have lived in the U.S. Do you know something about corn in that country?"

Camilo: "Well, I know corn is present throughout the food industry and it is often a key ingredient in most processed foods, which are usually the cheapest".

Mrs. Amparo: "For sure. That's because corn production is highly subsidized by the gringo government. As far as I know, this subsidy allows farmers to stay competitive in the market. It allows them to sell their corn at incredibly low prices way below the production costs. Similarly, EPSs in Colombia stay competitive, partly thanks to Recobro. Think of it as a form of government subsidy that allows us to provide universal health care while making profit even when there are huge financial risks associated with large claims".

The conversations I had with Mrs. Amparo made me realize that the ethical responsibilities taken away from the welfare state in 1993 are now being transferred back to it through *tutela*. This is the seeming paradox: *Tutela* does not only seek to protect fundamental rights such as health (ensuring patients access to their prescribed treatments and drugs) but also, and crucially, to protect insurance capital by transferring part of their financial burden to the state and outsourcing their ethical responsibility to reinsurance companies.

Vincanne Adams has extensively written about this corporate/state fusion that is so common to neoliberalism (2013). As mentioned earlier, her story about post-Katrina New Orleans is a story about how the two have entered into a new form of relationship: capitalism making money on the welfare state. She describes the phenomenon in which the same agents that produce disasters are often involved in capitalizing on spoils in the aftermath. In Colombia, the anti-crisis mechanism of *tutela* allows EPSs to apply for *Recobro* and further capitalize on their failure to provide prompt care to all patients.

The Colombian health care system is an example of a ghostly market-driven, publicly funded bureaucratic failure. This trickle down may have occurred in two ways: first by the growth of EPSs businesses that find ways to provide healthcare for low-income and working populations while also making profits; and by desperate and exhausted patients (and their families) "who must resort to the judiciary to avail themselves of their constitutional right to health care" (Abadia-Barrero, 2015b: 63).

In this article I have discussed how the national health care crisis became ordinary, protracted, and fueled by EPSs deferral practices and their relationship with anti-crisis mechanisms such as *tutela*, which has encouraged many Colombians to let their biologies deteriorate. This is what I have called 'minimal health', a simultaneous impossibility for getting cured and the possibility for accessing virtually unrestricted and immediate medical care —the same care that was elusive prior to a favorable *tutela* ruling—. The relationships I described between *tutela* and EPSs deferrals seemed to have created the financial incentives that transformed the healthcare crisis into a chronic condition, a disaster that never ends.

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