"The Dual Manifestation of the Right to Health in Colombia and Its Challenges Arising from Post-Pandemic Crises*

La doble manifestación del derecho a la salud en Colombia y sus retos derivados de las crisis pospandémicas

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Abstract

The pandemic, declared in Colombia since March 2020, required a significant institutional and social effort to mitigate the effects of what was then an unknown disease. Although harm was suffered in multiple spheres —social, economic, political, and legal— such harm was justified by the need to protect a higher interest, namely, the health of the population in the face of an unknown and highly contagious virus. The aim was to prevent or reduce consequences that, in the short, medium, and long term, remained uncertain and could entail the

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deterioration of fundamental interests of the population.

Accordingly, measures were adopted such as restrictions on mobility, the closure of borders, and, as a consequence, the imposition of limits on the exercise of certain rights, including the right to health. In this regard, some decisions involved the closure of healthcare services to prioritize care related to COVID-19 in cases deemed non-urgent; the modification of care protocols to determine which patients would receive treatment in the event of insufficient ICU beds; and a general deficit in healthcare provision due to limited installed capacity, all of which placed the core of the right to health at risk, both in its manifestation as a social right and as a fundamental right.

As a result, we were compelled to confront a situation not foreseen in the legal system and for which the law had no definitive solution. This raises the need to examine how health should be conceived in light of these events, taking existing institutions as a reference and considering the challenges stemming from the pandemic in order to seek a definition of health that acknowledges the problems faced in recent years. In this regard, this study, framed within a qualitative methodological approach and employing descriptive and analytical methods, aims to analyze the legal relationships between the right to health following the end of the COVID-19 pandemic and the protection of the right to healthcare under conditions of timely, equal, and quality access to it, as recognized by Colombian constitutional jurisprudence.

Keywords:
right to health, fundamental right to health, health and COVID-19, right to health as a collective right, fundamental rights and social rights.

Resumen

La pandemia, declarada desde marzo de 2020 en Colombia, implicó un esfuerzo institucional y social enorme para reducir los efectos de la enfermedad, hasta ese momento desconocida. Aunque hubo perjuicios en todos los sentidos: social, económico, político y jurídico, los mismos estaban justificados en virtud de la protección de un interés superior, que no fue otro que la salud de la población ante un virus desconocido y altamente contagioso. Se buscaba prevenir o reducir las consecuencias que a corto, mediano y largo plazo eran ignotas y que podrían implicar una reducción de intereses fundamentales de la población.

Así las cosas, se tomaron medidas como la restricción de la movilidad, el cierre de fronteras y, por defecto, la imposición de límites al ejercicio de algunos derechos dentro de los que se encontraba el de la salud. En esta materia, algunas decisiones se relacionaron con el cierre de servicios de salud para la priorización de atención derivada del COVID-19 en eventos considerados no urgentes; la modificación de protocolos de atención para la escogencia de pacientes en caso de insuficiencia de camas UCI; el déficit de atención por la insuficiente capacidad instalada que pusieron en jaque el núcleo esencial del derecho a la salud, tanto en su manifestación como derecho social como fundamental.

Como consecuencia de ello, nos vimos avocados a enfrentar una situación no prevista dentro del ordenamiento jurídico y para el que el derecho no tenía solución definitiva, con lo que surge la cuestión de estudiar la manera en que debemos concebir a la salud a partir de lo acontecido, tomando como referencia las instituciones existentes y los retos derivados de la pandemia con el fin de buscar una definición de salud que tome nota de los problemas enfrentados durante los últimos años. Así las cosas, el presente trabajo inscrito dentro del enfoque metodológico cualitativo y a partir del método descriptivo y analítico, se plantea como objetivo analizar las relaciones jurídicas entre el derecho a la salud a partir de la terminación de la pandemia por COVID-19 y la protección del derecho de atención en condiciones de oportunidad, igualdad y calidad, tal y como ha sido reconocido por la jurisprudencia constitucional colombiana.

Palabras clave:
derecho a la salud, derecho fundamental a la salud, salud y COVID-19 , derecho a la salud como derecho colectivo, derechos fundamentales y derechos sociales.

1. Introduction: Justification and Problem Statement

Health, as a right, was initially classified as a social, economic, and cultural right in the original text of the 1991 Colombian Constitution, framed as a collective right with a service-based nature. This approach required the creation of a protection system covering healthcare services at all levels, including prevention, cure, treatment, and the alleviation of health conditions in their physical, social, and psychological dimensions. Article 49, paragraph 1, which remained unchanged by Legislative Act No. 2 of 2009, states: "Healthcare and environmental sanitation are public services under the responsibility of the State. Access to services for the promotion, protection, and recovery of health is guaranteed to all individuals." This demonstrates the intent of the Constituent Assembly, which was later implemented by the legislature through the enactment of Law 100 of 1993. This law established the General Social Security Health System and its various subsystems, including the healthcare subsystem.

However, its treatment within the Constitution has undergone fundamental transformations regarding its meaning and dimensions as a right. It could be said that, starting in 2006, the Constitutional Court began a shift that would be consolidated in 2008 with the issuance of Judgment T-760 of that year, which clarified the constitutional significance of the right to health within the Colombian legal framework:

> Ultimately, the landmark decision recognizing access to healthcare services as an autonomous fundamental right was Judgment T-760 of 2008. In this ruling, the Court relied on international developments and its own prior jurisprudence to transcend the purely service-based conception of the right to health and, in line with the Social Rule of Law, elevate it to the status of a fundamental right. In this regard, without disregarding its nature as a public service, the Court advanced

> the protection of health due to its essential role in guaranteeing other rights (CC, Decision T-171/18, Col.).

From that period onward, health has been consolidated as a right with two dimensions: first, as a social, economic, and cultural right from which public health policy derives, reflected in the creation of political, legal, and economic systems aimed at ensuring care under conditions of universality and timeliness; and second, as a fundamental right that guarantees timely and quality healthcare.

In the considerations of Decision T-760 of 2008, the Court clarified that there have been three stages in the protection of the right to health through the tutela action: first, as a fundamental right by connection (initial period); second, as an autonomous fundamental right in cases involving individuals entitled to special constitutional protection (second period); and third, as a fully autonomous fundamental right (third and final period). This leads us to understand that the dual dimension of the right to health, both as a social, economic, and cultural right (DESC) and as a fundamental right, also entails different representations.

Without disregarding that health continues to be a social, economic, and cultural right (DESC), it is worth noting that historically, four forms of manifestation of the right to health have been identified in relation to the theory of constitutional rights (Peces-Barba Martínez, 2004). However, at present, two of these manifestations coexist as a result of the influence of the theories of connection and fundamental rights for individuals entitled to special constitutional protection, alongside its recognition as an autonomous fundamental right of an unnamed nature; that is, both as a DESC and as an autonomous fundamental right. The latter condition is evidenced not only by the enactment of the Statutory Health Law as a consequence of the recognition made by the Constitutional Court, but also by the decisions and reiterations issued by the Court as the final authority on constitutional matters, which has stated: "Currently, there is no debate about the autonomous and inalienable nature of this right" (CC, Decision T-279/17, Col.). This decision was made in consideration of constitutional precedents and the constitutional block (Cárdenas Ramírez, 2013).

Furthermore, the public health policy, primarily composed of a general system known as the General Social Security Health System, aims to strengthen the coordination of regulations, policies, entities, and sectors to promote and ensure healthcare for individuals and the population. This highlights the complex and multidimensional nature of the health system. However, challenges such as universality, effective access, information transfer, and quality of care were the focus during the early years of the new system. Despite these efforts, the Covid-19 pandemic exposed areas where improvements are still necessary, both in the health system itself and in the protection of the right to health, understood as a right that applies both to individuals and to the institutional framework responsible for guaranteeing it.

The pandemic highlighted the need

to strengthen aspects such as territorial approaches, healthcare technology, public health, installed capacity, mental health, among others. Therefore, this article aims to analyze the legal relationships between the right to health following the end of the COVID-19 pandemic and the protection of individuals' autonomy as patients within the General Social Security Health System. Although the system faces numerous challenges, this study will focus on those related to the level of autonomy in the doctor-patient relationship. To this end, it employs the analytical and hermeneutic method to examine health and its recognition within Colombian law, identifying its perspectives and determining which aspects must be reinforced in order to ensure the protection of individuals' right to access healthcare services.

2. The Dual Dimension and Guarantee of the Right to Health

The starting point is the Constitution and the typologies of rights found in the 1991 Constitution. As noted by Peces Barba, within it we can identify various categories of rights, ranging from constitutional rights (those enshrined in the Constitution), fundamental rights, social, economic, and cultural rights (ESC rights), and collective rights, to political rights (as categories specifying types of constitutional rights). Doctrinally, there are also public freedoms (or liberty rights, generally associated with fundamental rights, although not all fundamental rights are strictly liberty rights), moral rights, generational rights, among others (Peces-Barba Martínez, 2004). For the purposes of this article, we are particularly interested in examining two types of rights in greater depth: social rights and fundamental rights.

First, we find social rights under the denomination of economic, social, and cultural rights (ESC rights). These rights exhibit a significant degree of indeterminacy due to the broad and open nature often found in their constitutional content, the multiplicity of denominations, or doctrinal trends (Arbeláez Rudas, 2006). Therefore, we adopt a general category, implying that these are rights (both negative and positive) aimed at satisfying the basic needs of individuals within a community and enshrined as such in Chapter II, Title II of the 1991 Political Constitution. According to Noguera Fernández, these rights are characterized by falling into one of three categories: those ensuring the economic stability of community members, those guaranteeing social services, and those aimed at "regulating relations in the labor market by recognizing and protecting workers' rights" (Noguera Fernández, 2010, p. 19).

Within the second approach or pillar are those rights guaranteeing housing, education, and addressing people's needs in situations that deteriorate their quality of life due to age, accidents, or illness — materialized in Colombia through the pension, occupational risk, and health systems, respectively. Another important aspect of ESC rights is their inherently solidaristic nature, which is reflected in the burdens —generally fiscal in nature— imposed to ensure their coverage

under conditions of accessibility, continuity, and universality. Furthermore, some authors situate them as rights of equality, as opposed to liberty rights, characterizing them as relative, corrective, and collective in nature (Arbeláez Rudas, 2006).

Based on this notion —guaranteeing interests to satisfy basic or primary needs— arises the condition of these rights as entitlements to provision. These are understood as

> programmatic rights, given that entitlements to provision require a budgetary and logistical effort from the State, which can only be carried out through proper planning and allocation of resources in accordance with the procedures established by the Constitution and the organic laws (Rosales, 2018, p. 365).

In the constitutional framework, social security and health were established as economic, social, and cultural rights (ESCR), as stated in articles 48 and 49 of the 1991 Constitution, respectively. As such, their content is defined as public services under the responsibility of the State (Cárdenas Ramírez, 2013). In the words of the author:

> [The] social nature of the State is reflected in its obligation to ensure the continuous and efficient provision of public services, the prioritization of social spending, and timely intervention to establish the necessary rules so that the various public and private entities and institutions can effectively guarantee the provision of services required by individuals within the Health System (2013, p. 203).

The discrepancy between the right to health and its manifestations stems from the difficulty of specifying its true content: whether it pertains to a service provision or to the implications of the concept of health in an individual's living conditions. This is clearly reflected in the discussion raised by Arbeláez, who notes the following:

> The right to health has been recognized by various doctrinal currents as one of the quintessentially service-based social rights to which we referred to the previous section. However, when it comes to establishing the legal nature of the constitutional provisions that, within the framework of social rights, enshrine the right to health or the protection or safeguarding of health, there is no clear consensus as to what exactly the constituent intended to address (Arbeláez Rudas, 2006, p. 55).

However, given its classification as a social, economic, and cultural right (SECR), its service-based nature has been prioritized. This is understood as the obligation of an authority, individual, or institution to carry out positive actions that progressively guarantee the right. In general, its enforceability stems from the duty of the authorities to promote, provide, facilitate, and increase access to and protection of this type of right.

For the time being, health must be recognized as a complex right, with distinct

levels, manifestations, and differentiated approaches (Bombillar Sáenz & Pérez Miras, 2015), which makes it difficult to define its essential core. As a social, economic, and cultural right (SECR), health focuses on the creation of public policies that involve the coordination of efforts, entities, resources, and processes aimed at ensuring the provision of healthcare services to the entire population (Camacho Nuñez & Montenegro Martínez, 2023). In turn, from the perspective of a public service, it entails that the duty to guarantee healthcare be fulfilled progressively, universally, and without interruption (Parejo Alfonso, 2011). Finally, as a public function, it must be carried out under the principles set forth in article 209 of the Constitution, particularly those of efficiency in the use of resources, equality in access, and equity (Turizo Tapias, 2019).

As a fundamental right, health was autonomously included in article 44 for children. In other cases, the text nominally included it as a social, economic, and cultural right (SECR). However, early on, the Constitutional Court established criteria for recognizing health as an autonomous fundamental right. Initially, during the Court's early years of jurisprudence, this recognition was granted to individuals under special constitutional protection, and later, from 2006 onwards, it was extended to all individuals. In the interim, the Court's criterion was based on the principle of connectedness.

The recognition of health as a fundamental right has two main effects. The first defines the core content of the right to health, and the second expands the limits of public intervention. Regarding the first, it focuses on achieving the realization of the principles of equity and social justice and promotes social equality (Grueso & Garcia, 2023a). This is particularly relevant from the perspective of access to healthcare services. However, it also has a practical effect: as a fundamental right, its essential core limits the regulatory powers of the legislative branch, as established in article 152.a of the 1991 Constitution. This is why the Congress of the Republic had to regulate the right to health through the statutory legislative procedure, resulting in Statutory Law 1751 of 2015, as provided for in Law 5 of 1992. In other words, it is not the Statutory Law that granted health its status as a fundamental right; rather, the Statutory Law on the Fundamental Right to Health is the result of the Constitutional Court's prior recognition of this fundamental nature. Contrary to what is often assumed, health is not fundamental because of the Statutory Law, but because the Court had already declared it so.

On this matter, it is important to highlight that article 152 of the Constitution establishes that Congress, through the statutory law procedure regulated by Law 5 of 1992, is responsible for regulating fundamental rights. However, this does not mean that Congress has the power to elevate a right to the status of fundamental if it was not previously recognized as such.

Thus, for example, statements such as "The fundamental fact is that, for the first time, health is enshrined as a fundamental right and elevated to constitutional status, as none of the previous constitutional charters of the country had included it" (Prieto

Villamil, 2015, p. 1); "This article examines the advantages and limitations of recognizing health as a fundamental right, as established by Statutory Law 1751 of 2015, a fundamental pillar of the health system in Colombia" (Grueso & Garcia, 2023b, p. 1); or from the Ministry of Health itself, which states on its website: "the country's history was split in two because the State elevated health to the status of a fundamental right, which means it will benefit from the protection and support of all governmental entities" (2015, para. 1), lack constitutional grounding, as the fundamental nature of the right to health was not established by the Statutory Law but by the prior recognition of the Constitutional Court.

If that were the case, it would constitute an overreach of the legislature's functions. Therefore, claiming that Law 1751 elevates health to the status of a fundamental right reflects a misunderstanding of the theory of rights, whether expressly named or unnamed. However, there may be some confusion in this regard, given that articles 1 and 2 of the aforementioned law provide as follows:

> Article 1. Purpose. The purpose of this law is to guarantee the fundamental right to health, regulate it, and establish its protection mechanisms. Article 2. Nature and Scope of the Fundamental Right to Health. The fundamental right to health is autonomous and non-waivable, both individually and collectively.

However, despite their wording, these two articles serve a theoretical function and enhance legal certainty by codifying what had already been established in general-effect constitutional rulings. Although article 49 (which nominates the right to health) exists, its recognition as a fundamental right remains unnamed. Both legal scholarship (Quinche Ramírez, 2020; Rodríguez Villabona, 2020) and the Constitutional Court's case law have acknowledged the existence of both named and unnamed fundamental rights (CC, Decision SU-146/20, Col.; Decision C-030/23, Col.). The defining feature of the latter lies in their formal content, which is not explicitly found in the Constitution, although their material content can be inferred from it.

3. Guaranteeing the Constitutional Right to Health

Regarding the guarantee of the right to health, when it is understood as a social, economic, and cultural right (ESC right), its protection is ensured through the mechanisms provided for social and collective rights under article 88 of the Constitution, as it is linked to a right of a service-providing nature. These mechanisms include popular and group actions; however, it is also possible to seek its enforcement through a compliance action when there are applicable but unenforced regulations within the General Social Security Health System.

Since the Constitutional Court early on recognized a close relationship between health and other fundamental rights—particularly human dignity and life, and to a lesser extent, the free development of personality, as well as due process and the right to petition—the mechanisms of protection through collective and compliance actions

gradually gave way to the tutela action, primarily through the application of the theory of conexity. This theory, which is still employed in constitutional matters to analyze other legally significant issues (CC, Decision C-471/16, Col.), was used to protect the right to health for individuals who, prior to 2008, were not covered by the recognition of health as an autonomous fundamental right.

For this reason, in the early stages of constitutional jurisprudence, the protection of health was granted through tutela on the condition that it was closely connected to a named fundamental right, under the assumption of a close relationship by virtue of conexity (CC, decision T-760/08, Col.). In this ruling, the Court upheld the theory of conexity by stating that "the obligation arising from a constitutional right is enforceable through tutela if it is connected to the effective enjoyment of a fundamental right." Similarly, the Court addressed conexity as follows:

> However, alongside the placement of a right within the constitutional text as a criterion for establishing its fundamental nature—and, therefore, the admissibility of the tutela action for its protection—there is also the criterion of conexity. This criterion allows for the protection of rights that are, in principle, not judicially enforceable, provided that such protection is necessary to uphold a right that is unquestionably fundamental (CC, Decision T-010/99, Col.).

From this perspective, it is clear that health remains, by its nature, a social, economic, and cultural right (DESC) and, therefore, a service-based right whose protection, unlike that of expressly named fundamental rights, is not immediate. In this regard, the Court recognizes the connection between an individual's health status and the promotion of other rights, such as life or personal integrity. By adopting the criteria of the gradual realization of the right to health, its differentiated nature, and the impact on an individual's rights and interests that prevent them from developing within a framework of physical, psychological, or social normalcy, the Court has affirmed this position (CC, Decision T-760/08, Col.).

Another scenario for protection employed by the Constitutional Court was through the possibility of granting autonomous protection to the right to health, provided that its violation or the risk of its violation was demonstrated, especially in cases involving individuals entitled to special constitutional protection, such as children and adolescents, the elderly, patients with serious, catastrophic, or incurable diseases, indigenous, Afro-Colombian, Palenquero, and Raizal communities, persons with physical disabilities, and pregnant women (CC, Decision T-760/08). On this matter, the Court stated:

> The Court had also explicitly held that the right to health is fundamental and subject to protection through constitutional actions in cases where the person requiring health services belongs to a group entitled to special constitutional protection. This

> position has been reaffirmed in the Court's case law, for example, in relation to elderly individuals (CC, Decision T-527/06, Col.).

This marked the constitutional shift established by Decision T-760 of 2008, which allowed for the direct protection of health as an autonomous fundamental right and endowed it with a minimum essential content under two dimensions: positive and negative. The negative dimension requires actors within the healthcare system to refrain from imposing limits or barriers that may worsen the quality of healthcare services provided to patients: "The Colombian State must refrain from using any mechanism that restricts access to basic guarantees for preserving the dignity of a sick person and must remove barriers for individuals with pathological conditions (…)" (CC, Decision SU-508/20, Col.).

The positive dimension, in turn, requires the adoption of measures aimed at ensuring effective access to healthcare services under conditions of timeliness, universality, and quality: "The State must also fulfill its political commitment through the adoption of public policies that give effect to legal provisions guaranteeing access to and the quality of services necessary to ensure the right to health" (CC, Decision SU-508/20, Col.).

For now, it is important to clarify that, despite common belief, health has not ceased to be classified as a social, economic, and cultural right (DESC), as also reaffirmed by the Constitutional Court in Decision T-171 of 2018. In that ruling, the Court stated that health is both a fundamental right and an essential public service; however, it is in its public service facet that it operates as a benefit-based right, meaning one that must be provided under conditions of equality, timeliness, and quality. In that decision, recalling the content of Statutory Law 1751 of 2015, the Court referred to its dual nature:

> (i) As an autonomous and inalienable fundamental right, which entails access to healthcare services in a timely, effective, and high-quality manner for the preservation and promotion of health; and (ii) as a mandatory essential public service, whose efficient, universal, and solidarity-based provision is carried out under the non-delegable responsibility of the State (CC, Decision T-171/18, Col.).

As a fundamental right, its guarantee is provided through the tutela action when it is linked to its minimum essential content. Meanwhile, as a social right, it compels the State to design public policies aimed at ensuring access to the prevention, treatment, and palliation of circumstances that may harm the physical, emotional, and social health of the population (CC, Decision T-171/18, Col.). In this regard, institutions at all levels and branches are required to comply with constitutional, legal, and regulatory mandates concerning protection, access, and care for the promotion of health, the prevention of disease, and the alleviation of harm. Likewise, there is an obligation to make investments aimed at securing access to healthcare services, injecting resources into the system's financing, and

expanding coverage, particularly for the poorest populations, in accordance with the principles of universality, continuity, progressivity, and non-interruption. Finally, the State is required to establish mechanisms for quality assurance and oversight to improve the standards of the healthcare services provided, among other measures.

The categorization of rights in the 1991 Constitution is not arbitrary; rather, it aligns with legal doctrine, which regards rights as protected interests that can be guaranteed through judicial actions. In this sense, the division into classes, categories, or generations of rights is linked to the immediacy and inalienability of their judicial protection.

In its dimension as a social right, it is characterized by the allocation of resources, procedures, regulations, and institutions that oversee its provision as a public service through a health system, regardless of its specific designation. Conversely, when recognized as a fundamental right, it is linked to timely, high-quality, and equitable access to services that promote health in the areas of prevention, recovery, and the alleviation of physical, psychological, and social health conditions. This was affirmed by the Constitutional Court in Decision T-121 of 2015:

> The right to health entails timely, effective, high-quality, and equitable access to all services, facilities, establishments, and goods necessary to guarantee its protection. Likewise, it encompasses the fulfillment of other rights closely connected to its effective realization, such as basic sanitation, access to potable water, and adequate nutrition. Therefore, according to the Statutory Legislator, the health system is understood as: The coordinated and harmonious set of principles and norms; public policies; institutions; competencies and procedures; powers, obligations, rights, and duties; financing; controls; information and evaluation, established by the State to guarantee and materialize the fundamental right to health. (CC, Decision T-121/15, Col.)

In this regard, it can be concluded that health, as an autonomous fundamental right, becomes materialized in both theoretical-practical and procedural dimensions. In the first, it is recognized for its intrinsic connection to human dignity, which serves as the foundation for recognizing first-generation fundamental or human rights (CC, Decision T-760/08, Col.; Decision T-171/18, Col.). As a theoretical-practical right, its core is embodied in the right to the provision of health services, as the Court pointed out in Decision T-171 of 2018, emphasizing that every fundamental right inherently includes a service-oriented dimension. Finally, from a procedural standpoint, it enables the protection of health through the tutela action, which serves as an immediate, summary, and effective mechanism for safeguarding fundamental rights. In practice, this reduces the claimant's argumentative burden, as it is no longer necessary to demonstrate or justify the connection between health and other expressly recognized fundamental rights. A simple allegation supported by summary

evidence of the impairment of health, in any of its dimensions, suffices to obtain a ruling from the tutela judge.

4. The Health Crisis Due to the COVID-19 Pandemic

However, like many other rights, the right to health has undergone transformations, particularly as a result of the challenges arising from the circumstances brought about by the COVID-19 pandemic. Even prior to the pandemic, the existing healthcare infrastructure was not only insufficient but also posed risks to the population (Martínez et al., 2022). This situation led to complex decisions, such as limiting the provision of medium- and low-complexity healthcare services, the closure of operations by certain healthcare providers, and the strengthening of health promotion and disease prevention systems focused specifically on the virus.

All of this highlights the need to analyze the challenges currently facing the right to health, particularly in a context shaped by the impacts on health economics, the provision of care for non-urgent conditions, the emergence of debates focused on mental health, and the modernization of healthcare systems. All these efforts aim to strengthen the essential purpose of the right to health: to ensure access to care at all levels and in all its dimensions.

Firstly, it is important to note that the inclusion of human dignity and the right to life among the purposes of the State positions dignity as the starting point for the protection of rights, regardless of whether they are categorized as fundamental, social, economic, cultural, or collective (Fonseca-Ortiz & Sierra-Zamora, 2022), as was the case in the early stages of protecting the right to life through the tutela action. In the case of fundamental rights, this has been acknowledged by the Constitutional Court in various decisions linking health to the protection of human dignity, as noted in Decision T-171 of 2018, which states:

> The Court held in this ruling that the understanding of individuals and society, within the framework of the Social Rule of Law, must revolve around human dignity rather than primarily around freedom. In other words, freedom is placed at the service of human dignity as the supreme goal of both individuals and society. In this context, health acquires a fundamental connotation as an essential right to ensure people a dignified and quality life that allows for their full development within society. Therefore, economic, social, and cultural rights are not to be seen merely as complementary to rights of freedom but are, in themselves, genuine fundamental rights (CC, Decision T-171/18, Col.).

Based on the above, it is important to recall that the right to life can be understood within three key dimensions or scenarios: living well, living as one wishes, and living without humiliation (C. Correa Martínez, 2022a). Health, in this sense, is connected to all these dimensions. Living well entails enjoying physical, mental, and socio-environmental conditions that enable

the normal development of any human being's capacities. Living as one wishes requires the ability to make autonomous decisions, to self-govern, and to enjoy freedom in both its positive and negative senses—conditions that are intrinsically linked to adequate well-being as encompassed by the concept of health (C. A. Correa Martínez et al., 2022). Finally, living without humiliation requires ensuring equitable and non-discriminatory access to healthcare services whenever needed, whether in the stages of prevention, recovery, or palliative care.

Moreover, every right, and especially fundamental rights, possesses a dual connotation concerning capacity and will: enjoyment and exercise. The first refers to the effective entitlement to the right, while the second concerns the personal experience of the right or the actual possibility of its realization (García Toma, 2018).

Regarding rights, the notion of limitation is inherent to their very nature, as the exercise of a right requires the effort not to harm others who enjoy the same entitlement. Isaiah Berlin aptly describes this through the concept of negative liberty, understood as the obligation to avoid unjustifiably harming others (Berlin, 2017), or, as Alexy defines it, as the duty of abstention (Alexy, 2017). Likewise, there exists legislative authority to delimit (and reasonably and justifiably limit) the exercise of rights (García Toma, 2018), as well as to establish restrictions in the face of exceptional circumstances, such as those recognized in articles 212, 213, and 215 of the Constitution. Interestingly, the different types of states of exception (foreign war, internal unrest, and disruption of the economic, social, or ecological order or public calamity) contain specific rules regarding the limitation of rights. In the first two cases, it is stated that neither human rights nor civil liberties may be suspended, whereas in the third, the ninth paragraph merely provides for the possibility of limiting social rights, but not fundamental rights. This distinction becomes particularly relevant when considering the ongoing debate on the classification of health as a right.

This is significant because the declaration of the state of emergency through Decree 417 of 2020 established a state of economic, social, and ecological emergency throughout the national territory. In this regard, the Constitutional Court set forth the criteria distinguishing between the notions of deprivation, suspension, and limitation of (fundamental) rights:

> There is a distinction between the concepts of deprivation, suspension, and limitation of fundamental rights. The deprivation of a right can only occur in a specific and personal manner as a consequence of a sanction, which can only be imposed by a judge. Suspension, on the other hand, allows the right to be exercised against parties other than the State, and any suspended right must be surrounded by certain guarantees to prevent abuse or suspension without due cause. Limitation of a right presupposes the possibility of exercising the right, albeit subject to restrictions; while it may involve certain burdens or conditions, the exercise of the

> right cannot be outright prevented. In this sense, limitation presumes the exercise of the right, which remains possible but subject to conditions—it cannot be entirely impeded. (CC, Decision C-136/09, Col.).

It is noteworthy, however, that with regard to the regulation of states of exception, Statutory Law 137 of 1992 established specific provisions concerning the limitation and suspension of rights deemed intangible. Article 4 lists these intangible rights and explicitly prohibits any form of suspension or limitation. Meanwhile, article 6 provides that any limitation imposed during states of exception must not affect the essential core of the right in question.

Therefore, if, as previously discussed, the essential core of the right to health is tied to access to healthcare services under conditions of quality, equality, timeliness, and universality, it becomes necessary to examine the legality of the suspension of its exercise through the legal and administrative measures adopted in the country to address the health crisis—regardless of their factual justification. Rather, the aim here is to offer a critical reflection on the gap between what the legal norms prescribe and the actual needs that expose their limitations.

On the one hand, there are the guidelines set forth in article 3 of Decree 457 of 2020, which states that, in order to guarantee "the right to health in connection with the right to life [sic]", measures would be taken to ensure access to healthcare services (Article 3.1). Despite this provision, for example, the Bogotá District Health Department issued several circulars addressed to healthcare providers, which effectively restricted access to non-urgent or non-priority healthcare services for the general public. These include Circulars 029, 036, and 048 of 2020, which set forth recommendations for the operation of healthcare services. These so-called recommendations ultimately became de facto orders suspending access to certain healthcare services, such as non-urgent dental care, non-therapeutic cosmetic procedures, procedures with an unfavorable cost-benefit ratio for the patient, non-urgent procedures for patients presenting respiratory symptoms or with a history of respiratory illness, and any procedures deemed suitable for rescheduling.

Upon reviewing the material content of these circulars, it becomes clear that they amounted to actual suspensions of the right to access healthcare services. One of the outcomes of these suspensions was the widely reported decrease in tutela actions between 2019 and 2020 by 58 %, according to official reports—a decrease that had a particularly significant impact on actions seeking protection of the right to health.

On the other hand, the pandemic exposed the country's insufficient healthcare infrastructure, with Colombia falling below the global average in most key indicators, such as the number of hospital beds across all levels of care, as well as medical and specialized healthcare personnel (Martínez et al., 2022). This study highlighted that the State's limited response capacity undermined the effective enjoyment of the right to health, as it failed to act promptly on global warnings, which reached Colombia with a delay of

approximately two months compared to healthcare systems like Spain's. This lack of preparedness was further exacerbated by the repeated warnings issued by the WHO since the 1990s, consistently alerting States to the potential occurrence of a pandemic (Martínez et al., 2022). Additionally, healthcare services during the COVID-19 crisis were prioritized based on utilitarian criteria, further impacting access.

> It is necessary to review or at least reflect on whether the measure of prioritizing ICU admissions violated the United Nations Human Rights Charter and the international treaties signed and ratified by Colombia. For example, the Inter-American Convention on the Protection of the Human Rights of Older Persons, approved through Law 2055 of 2020 and declared constitutional by the Colombian Constitutional Court in Decision C-395 of 2021, establishes the obligation to promote, protect, and ensure the recognition and full enjoyment, on equal terms, of all human rights and fundamental freedoms of older persons. Moreover, it explicitly prohibits discriminatory treatment, particularly on the basis of age (Martínez et al., 2022, p. 149).

In matters related to the right to health, there are countless situations that justify its limitation, ranging from installed capacity (as it is a progressive right), scientific limitations in providing effective treatments, the availability of resources and personnel, to considerations of the patient's best interest. Based on reasonable justifications, as has been shown, it is possible to limit individuals' rights (García Toma, 2018), not only in catastrophic situations such as the pandemic but also in everyday circumstances, such as the prioritization of emergency care.

With the declaration of the pandemic, limitations on access to healthcare services became more evident for certain individuals who, under normal circumstances, require priority care due to their health conditions, such as the elderly, individuals with obesity, or patients with underlying or autoimmune diseases. These limitations were justified by the need to ensure the availability of resources for the care of individuals infected with the SARS-CoV-2 virus. This is reflected in the issuance of guidelines and the adoption of protocols for prioritizing admission and care in Intensive Care Units, favoring patients with no prior health conditions over those with comorbidities.

Care protocols, as instruments for standardizing healthcare in accordance with advancements in medical best practices (lex artis sanitaria), establish mechanisms for accessing and receiving care within the healthcare system based on scientific and social criteria, such as the progression and severity of the illness and the patient's biological conditions, among others. Although these protocols serve to rationalize resources and improve care processes, during the pandemic and the state of emergency, certain protocols were implemented that restricted access to Intensive Care Units for individuals under special constitutional protection due to their age or health conditions. This

was because priority was given to the adoption of measures outlined in the London Protocol on Active Failure and the standards and recommendations manual issued by Spain's Ministry of Health and Social Policy (Ministry of Health and Social Protection, 2020).

Regarding resources, access to healthcare—understood as the right to receive services under conditions of equality, quality, and timeliness within the General System of Social Security in Health—is subject to certain criteria aimed at rationalizing healthcare resources. Among these, for example, the healthcare system is funded through contributions from both employed and self-employed workers, which are mandatory under the contributory regime, as well as through other financing mechanisms established by Law 100 of 1993 for the subsidized regime (resources from the General System of Participation, VAT taxes, allocations from the national budget, among others). However, the country's circumstances led to the enactment of additional sources of funding for both the contributory and subsidized regimes through Laws 715 of 2001 and 1122 of 2007.

Today, discussions on social containment measures are more feasible, as these measures have already been surpassed. Political decisions—ranging from mass vaccination campaigns and mobility restrictions to the implementation of limited healthcare access criteria—enabled a return to normalcy, albeit with a clear warning about the need to overcome the shortcomings revealed during the crisis to be better prepared for future events.

5. Challenges for the Effective Protection of the Right to Health in the Post-Pandemic Era

The world turned a blind eye to the arrival of the pandemic. Now, the experience of recent years has revealed that the tools to address the crisis brought about by COVID-19 are not solely medical, but also require participation in the legal sphere. In February 2021, the first vaccines against the disease that shook humanity were developed and made available, prompting debates about the progress of vaccination efforts and raising concerns about healthcare capacity, particularly with regard to the duty to be vaccinated and the right to refuse vaccination, grounded in personal autonomy. This situation must be examined, as it highlights the ongoing tension between personal freedom and solidarity. It also underscores the need to strengthen the notion of patient autonomy in its broadest sense (Ángel, 2016; Puyol González, 2014).

Various states announced mobility restrictions for those who refused vaccination, basing these measures on the need to protect public health. In Colombia's case, such measures align with the constitutional duty to safeguard both individual and collective health. This has reignited the debate between personal freedom and social duty in the field of public health. Autonomy, grounded in freedom —both to project one's desires and to act accordingly— is expressed through the capacity for self-legislation and self-governance (Puyol González, 2014). However, this freedom carries public responsibilities,

which may justify measures such as mandatory disclosure of health information or non-waivable treatments (C. Correa Martínez, 2022b). Patient autonomy within the doctor-patient relationship is supported not only by legal and normative principles but also by ethical ones, as it prescribes actions, their grounds, and consequences within spheres where state intervention should be limited.

For this reason, it is essential to reaffirm the concept of autonomy of will in its four dimensions: as freedom, as self-governance, as dignity, and as self-affirmation (Arrieta Valero, 2016). This ensures individuals' comprehension, personal reflection, and reasoned assessment of the benefits and consequences of their decisions (Robert B et al., 2016). Moreover, it is necessary to educate the public on the duties of solidarity and responsibility, particularly in matters of public health (Allen et al., 2016). As previous studies have shown, these values entail certain limits on individual autonomy (C. Correa Martínez, 2022b).

Due to the challenges and reflections prompted by the pandemic, certain circumstances have become evident and must be addressed by healthcare systems, institutions, and patients in order to strengthen interaction, protection, care, and the prevention of conditions affecting the population's well-being. In this context, the voice of healthcare professionals is particularly relevant. As reported by El País, in 2020 there were instances of chaos, fragility of the healthcare system, and unfulfilled promises, among other issues, which revealed conditions of uncertainty and social inequality. The article highlights the need to promote closer ties between the healthcare system and the public, to strengthen health sovereignty, and to avoid losing the momentum of the investments made in 2020 and 2021, which more than doubled the country's installed capacity, particularly in hospital beds and intensive care units (Stacey, 2025).

In order to achieve the objectives based on the principles of healthcare, the right to health, and the doctor-patient relationship, while simultaneously strengthening the healthcare system without undermining the rights already acquired by patients, it is recommended —in addition to the proposals previously discussed— to adopt certain regulatory guidelines aimed at preventing future crisis scenarios. These include: increasing installed capacity and corresponding investment in healthcare; standardizing specific protocols with a social approach tailored to Colombia's realities, thereby avoiding the adoption of foreign protocols that respond to different contexts; strengthening the training of healthcare professionals and ensuring minimum guarantees in ethical-clinical and labor matters; promoting the digital transformation and interoperability of the healthcare system to better address social inequalities between central and peripheral regions; and, finally, reinforcing citizen participation with an intersectoral approach.

Firstly, the direct consequence in measurable terms shows that Colombia ranked 22nd out of 187 countries with reliable and comparable data regarding the total number of COVID-19 deaths per 100,000 inhabitants (Prada et al., 2022). It

should also be noted that the pandemic triggered an unprecedented social and economic crisis, the effects of which are still visible today. In response to COVID-19, investments were made in installed capacity and human resources, which during the first two years of the pandemic resulted in the acquisition of at least 6,000 ventilators, an increase in the number of intensive and intermediate care beds from 133 % to 150 %, and an approximate 20 % increase in hospital beds. Additionally, the training of healthcare professionals was strengthened, along with the implementation of the national vaccination policy (Prada et al., 2022).

In a broader sense, strengthening the healthcare system to ensure an expanded and autonomous right to health —focused on addressing the country's specific challenges— requires the adaptation of protocols to the particular needs of the population. As previously discussed, one of the issues during the pandemic response was the wholesale adoption of foreign protocols, particularly those from Spain and the United Kingdom. However, the study conducted by Gutiérrez Cortés (2022) highlighted the lack of adequate care for the elderly population. For this reason, it is crucial for the state to promote documentary autonomy by developing care protocols tailored to emergency situations, high levels of medical care, and problem-solving during crises, all of which should be aligned with national living standards, social determinants of health, care pathways, and participatory frameworks (Gutiérrez Cortés, 2022).

In this way, citizen participation is strengthened through an active, rather than merely reactive, population. A citizenry that is aware of its rights and engages with the healthcare system not only for the prevention or treatment of illness but also to support decision-making on structural matters. Thus, the purpose of the right to health, both as a social and fundamental right, is expanded towards a conception of the right to health rooted in policies grounded in participatory democracy.

6. Conclusions

Health was constitutionally enshrined as a social right of a service-based nature, subject to the principle of progressivity and linked to public policies, fiscal resources, and the guarantee of basic services. However, jurisprudential developments —particularly those of the Constitutional Court— have also recognized its status as an autonomous fundamental right, initially for subjects of special constitutional protection and later extended to the entire population. This recognition of health as a fundamental right was not created by Statutory Law 1751 of 2015; rather, it had already been established through constitutional jurisprudence. Its status as an unnamed fundamental right does not stem from legislative provisions but from constitutional developments and the material content of the right itself.

The recognition of health as an autonomous fundamental right imposes more stringent duties of protection on the state and limits its regulation through statutory laws, in accordance with article 152 of the Constitution. This has implications not only for equitable access to healthcare services

but also for ensuring the ethical, legal, and material conditions necessary for its effective realization. Moreover, it provides greater clarity regarding the essential core of the right to health and strengthens its enforceability in cases of omissions or structural failures within the healthcare system.

The tutela action has become the primary mechanism for protecting the right to health, allowing for its immediate enforceability without requiring the petitioner to demonstrate its connection to other fundamental rights. This has reduced the argumentative burden on claimants and reinforced the state's obligation to ensure timely, universal, continuous, and high-quality access to healthcare services through public policies, investments, and oversight mechanisms, in accordance with the constitutional principles of human dignity, equality, and solidarity.

The COVID-19 pandemic exposed the structural shortcomings of Colombia's healthcare system, such as its limited installed capacity and shortage of medical personnel. These deficiencies forced the adoption of measures that restricted access to healthcare services, particularly non-urgent care. Although these decisions were justified by the public health emergency, they created tensions with the constitutional guarantees of the right to health, as they affected its exercise under conditions of equality, quality, and timeliness.

The right to health, being closely linked to human dignity and the right to life, must be recognized as a fundamental right that cannot be suspended or restricted beyond what is strictly necessary, even in exceptional circumstances. The measures adopted during the pandemic, which prioritized certain patients over others or limited access to specific services, require critical review to ensure that in future emergencies, practices that undermine the core essence of this right are not repeated.

The pandemic revealed that the effective protection of the right to health cannot depend solely on medical infrastructure; it requires a comprehensive approach that integrates legal, ethical, and social dimensions. This entails balancing personal autonomy with the duties of solidarity and collective responsibility, especially in public health contexts such as vaccination and pandemic management, where the general interest may come into tension with individual freedoms.

Moreover, there is an urgent need to structurally strengthen Colombia's healthcare system through sustained investments, the adaptation of protocols to local conditions, professional training with a social focus, digital transformation, and active citizen participation. Only through these measures can the right to health be truly guaranteed as universal, dignified, and equitable, and the system be adequate.

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