

Ordinary Crisis

Crisis. This was probably one of the most common words used by physicians and cancer patients when commenting about the current situation of the national health care system. Typically, this word refers to a time of difficulty or danger, an out-of-the-ordinary situation. In the context of medicine, it refers to the turning point of a disease when one must make a pivotal decision, indicating life or death. Dr. Artesano, a palliative care physician at HUV whose goal is to manage symptoms, usually at the end of life, likens a crisis to “an elephant in a cramped room; so obvious you couldn’t ignore it, so awkward and bizarre you wouldn’t get used to it.”

“Let me be clearer,” he said. “Think of pain. This is usually a visceral experience that may overwhelm us—physically, emotionally, mentally. In the case of most cancers, pain can be so intense that it can lead people to commit suicide. So my point is that pain—like the elephant in the cramped room—is nearly impossible to ignore. Most of us won’t get used to it—unless it is well controlled, of course.”

A crisis, hence, embodies a transformational event, an extraordinary moment when one must make a radical decision to change course. Yet it can also refer to a period of intense conflict that fails to reach a turning point.

In her *Anti-Crisis* manifesto, Janet Roitman (2013) has made a call to entertain crisis as a protracted and chronic condition, a bizarre yet ordinary situation. Consider the case of the Colombian health care system. Despite declaring bankruptcy, many public hospitals have figured out improvised and last-minute strategies to keep their doors open, albeit partially; while a number of EPSs have become insolvent and have been liquidated, new ones make it into the market as corporate mergers;¹ overworked physicians periodically protest on the streets because their salaries are not paid on time; low-income cancer patients wait, endure, and

die as they seek medical care. Most of the public anger triggered by these events have unfolded as hopeful mobilizations that rapidly dissolve into routine and dull expressions of frustration. Crises go from unique moments with transformational potential to ordinary events.

Oscillations like these—between indignation, disinterest, and resignation—after all, are typical of capitalism. Karl Marx ([1894] 1981, 357) 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.” For David Harvey (1982), the contradictions inherent to capitalism are expressed in “violent paroxysms” on which are imposed momentary solutions. Drawing inspiration from these thinkers, I discuss how the effects of Ley 100 and its neoliberal restructuring are expressed in social discontent, inequity, and protests (often violent), which have triggered policy transformations that temporarily restore the perception of equilibrium. Instead of analyzing the national health care crisis as an ongoing transformation or a turning point, I propose to approach it as a deadlock that has endured for nearly thirty years. As such, crisis becomes an ordinary and chronic condition or, as Roitman (2013, 16) has put it, “a persistent state of ailment and demise.”

“The worst part of the health care crisis,” according to Dr. Artesano, “is that we have no idea whether the required changes will ever be implemented by the government . . . or whether these will have enough momentum to unleash meaningful transformations.”

Although his words were spoken in 2012, they highlight the elusive nature of structural change in Colombia’s recent history and offer a cautionary tale about the latest health care reform project filed in Congress in early 2023.²

“Every time there is potential for structural transformation, people get killed,” Dr. Artesano told me. “There is a long list of social leaders, human rights activists and leftist politicians who have been assassinated because they represented a threat to the status quo. The case of the health care system is not the exception; hardly any of the laws and decrees promulgated over the years have resulted in meaningful changes. Rather, they have unleashed more social injustice, more death.”

When I asked him about the seemingly perennial state of health care crisis, Dr. Artesano resorted to the Spanish phrase, “lo mismo de siempre” (same old, same old). Things are the same again after all. “Lo mismo de siempre” reflects the perception of moving toward a turning point, the building of momentum, and the simultaneous impossibility of reaching it. It 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 state of *no change*, stasis.

Dr. Artesano used a military analogy: “Our health care system is like a time bomb without a detonator, ticking but not yet exploding.” Surprised by his words, I immediately asked for clarification. The physician paused for a few seconds before continuing.

“Well,” he said, “it’s a time bomb because the system was originally designed to respond to market forces rather than the needs of patients. After Ley 100 was implemented, inequality skyrocketed, corruption is now a rampant practice, and the violation of constitutional rights has become quotidian. But these conditions have yet to trigger widespread social unrest that could eventually result in major policy transformations, especially for the poor.³ 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 life defined by social *estratos* [strata].⁴ We all complain, yes—we love complaining, but at the end of the day we get used to the same conditions we criticize. It’s frustrating! Think about it. We want to change something that does not seem to be bothering us anymore.⁵ Unless there is a radical transformation in how we think and care for each other, not much will be achieved; everything will remain *lo mismo de siempre*.”

The crisis I write about highlights the simultaneous need for structural change and the seeming impossibility of actualizing it. Building on Derrida’s *Aporias* (1993), I understand the Colombian 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” (8). It is a moment in which the legal dispositions, clinical expectations, and health policy regulations are planned but rarely actualized (Greenhouse 2006). For the past three decades, low-income patients have dwelled at a threshold of anticipation, hoping to access treatments on time and live longer—*what ought to be* according to Ley 100—and the sudden frustration of not being able to access them—*what is actually possible*. In other words, while the national health care system has undergone multiple policy transformations, it has fallen short of materializing the reforms needed by the less wealthy.

In this chapter I explore how the bizarre becomes ordinary. I analyze the contradictory relationship between the insurance companies’ practice of deferral, the rights to health and life, and the writ of tutela used to protect these fundamental rights. As discussed in chapter 1, deferrals are the EPSs’ practices of defaulting on salary payments for health care staff or hospital fees and delaying the provision of prescribed treatments for patients. To counter these deferrals and access their prescribed medical services, patients suffering from high-cost conditions have been resorting to tutela. This is an anti-crisis mechanism created in 1991 for imparting neoliberal justice and protecting fundamental rights, such as life.⁶ Filing a tutela is a simple and straightforward process. Patients can even file it on their own by downloading forms from the internet. Once a judge confirms that there has been a violation of a fundamental right, the tutela has immediate effects, and in no case can the period between the filing and the court ruling take more than ten working days.

While the tutela has allowed many Colombians to access medical services and protect their right to health, it has incentivized some high-cost patients to file it when their lives are threatened by waiting. At HUV, for instance, it was not uncommon to hear cancer patients suggesting they had better chances of getting

a favorable tutela ruling once they prove their cancers have become metastatic or terminal. As I show, the anti-crisis mechanism of the tutela has played a double role; while it has been a boon, especially for low-income Colombians who have been typically neglected by the state, it creates perverse financial incentives that encourage them to wait and deteriorate and EPSs to continue delaying the provision of high-cost treatments.

CARE DEFERRED

Throughout most of my ethnographic research, HUV became my fieldwork headquarters.⁷ Since it was founded in the 1930s, HUV has been a point of reference for working-class and poor Colombians living in the southwest. After the 1993 neoliberal reform, the hospital was transformed into an *empresa social del estado* (ESE), or state social enterprise. As a result, it is expected to deliver medical services directly or through contracts with individual providers and must compete for the preference of the purchasing organizations (EPSs). Hospitals like HUV “moved from a welfare-like system in which money was transferred directly from the state to a market competition model” (Abadía-Barrero 2022, 103). In this model, every medical service must be billed. And, of course, it becomes more preferable to sell specialists’ services like oncology or cardiology than do primary care.⁸ Selling more services—preferably high-cost ones—becomes the preferred business model for hospitals, while EPSs play the role of cost containment and financial vigilance, making sure health care funds are “responsibly” used and available to all Colombians who need them.

Like so many other public hospitals that were transformed into ESEs, HUV has struggled to maintain a permanent cash flow to fund its services and pay workers’ salaries on time. In addition, management inefficiency and rampant corruption have been ubiquitous throughout most of this hospital’s recent history.

I recall health care workers voicing their concerns about whether the next strike would finally force the hospital to close its doors for good. My main interlocutors on this topic were palliative care physicians. Led by Dr. Artesano, this group of doctors has been especially active in the hospital union for years, frequently standing behind the picket lines. During the longest stretch of my fieldwork (2011–13), they participated in the occupation of hospital aisles and administrative offices. According to Dr. Artesano, their motivation boils down to a set of perverse effects unleashed by the EPSs’ late payments of salaries and hospital fees. He explained, “The hospital already owes me around nine million pesos!⁹ That’s why I’m always trying to catch up in financial terms. But it’s difficult. The hospital has no money. Most EPSs pay late and rarely disburse the total amount they owe us. Whenever we complain to the hospital management, we are told these businesses are taking sixty to ninety days to pay for our services; that we should be patient and continue showing up for work and holding consultations as if nothing has happened.”

In Colombia, one of the main roles of the EPS is to connect the different actors in the health care market, the cogs in the machine—as Dr. Artesano would put it. These businesses are middlemen between patients and hospitals, physicians and patients.

“That is why we have taken over the hospital facilities,” Dr. Artesano 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.”

Certainly, Dr. Artesano was fed up with the current financial situation. He was onboard with the union’s plan to escalate its protest, even if that meant interrupting the provision of medical services to patients. He anticipated my questions about the repercussion of such actions: “They [referring to government officials and mainstream media] say that we should be held accountable for the hospital crisis; that the union is not allowing patients to access the oncology wards; that we are threatening their lives and violating their right to health care. These are all plain lies. Our fight is not against patients. It is against the whole *vagabundería criminal* [shameless criminal acts] that make a profit from physicians like ourselves and poor patients’ health.”

While protesters like Dr. Artesano were aware that blocking patients’ access to hospital services went against their medical ethics, they were nonetheless willing to do so in order to gain leverage with the hospital management and become visible before the state. A couple of weeks later, during a critical escalation of the protest, a temporary solution was suddenly reached. The municipality stepped in and disbursed emergency funds to ameliorate the financial crisis. In exchange, Dr. Artesano and his fellow protesters agreed to vacate the premises. The hospital doors reopened, but nobody knew for how long.

Several EPSs still owed money to the hospital. When their debt becomes unmanageable, EPSs default on their payments. Then the government steps in to either inject funds or liquidate the struggling businesses.¹⁰

Barely two months after the municipality disbursed funds to prevent the crisis from escalating further, social discontent was again coming to the surface. “Pa’lante y pa’trás [Back and forth],” said Dr. Artesano “While many EPSs still owe us money, the government looks the other way and thinks our situation can be fixed with palliative approaches.” “But palliation, by definition,” he explained, “is a practice that cloaks and manages symptoms. It does not seek to cure or treat the disease itself.”

Again, nurses and doctors found themselves standing behind picket lines, blocking Calle Quinta. This time, protesters carried wooden coffins on their shoulders to symbolize the death of the Colombian health care model. They shouted, “Health care is not a business! Save the public hospitals!” Protesters were especially upset because HUV was (once more) late paying their salaries.

This is what Dr. Artesano calls a delayed payment mind-set, or *mentalidad de pago atrasado*.¹¹ If insurance companies take too long to pay hospital fees, these

institutions may start running out of cash and incurring debts with health care providers. Following Abel Castaño (2023), this is partly due to EPSs lack of incentives to engage in long-term investments, particularly in early detection or screening for high-cost conditions such as cancer. First, according to him, a focus on early detection and screening may end up triggering a cascade of overdiagnoses and unnecessary treatments for slow-growing tumors that may never represent an actual threat to patients. Second, EPSs would not want to “invest” heavily in primary care and screening to prevent large claims in the future, largely because enrollees typically switch EPSs over time. Why would these businesses want to invest in people whose “good health” might end up benefiting direct competitors? And third, EPSs’ inability to engage in long-term goals is exacerbated when they are faced with financial difficulties and contractual requirements, such as paying providers’ salaries.

According to Dr. Artesano, the consultations he holds today are often translated into the salary EPSs will pay him over the next two to three months. “The problem is that most of us live paycheck to paycheck,” he said.

Failing to pay physicians’ salaries on time turns into a form of debt (and theft). Yet EPSs are not necessarily penalized for doing so. After all, an important number of EPSs—especially those in the subsidized regime—have found that the only way to stay competitive in the market is by delaying payments to hospitals and the provision of high-cost medical services.¹² In so doing, these businesses engage in the financial market and redirect resources to less risky investments (see Graeber 2014).¹³ As Marx ([1867] 1992) showed, the transformation of money to commodity to money (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. In other words, the EPSs’ money derived from circulation in the health care system must be greater than the money initially advanced to it (as UPC, for instance). And the most feasible route to do so—under the current health care model—is by delays in treatment provision.

Although some EPSs have made noticeable efforts to provide the best care possible for their enrollees, most insurance companies that I came across at HUV had resorted to creating money from debt, enabling capital to reproduce itself in a realm of pure promise and waiting (Marx 1992), that is, pledging to provide health care to all Colombians and pay health care workers’ salaries on time. For Melinda Cooper (2008), these practices may be understood as the “accumulation of biological futures.” This concept, she explains, includes business models in the life sciences that are based on financial speculation and debt creation—venture capital funding, stock markets, and so forth.

In response to these conditions, nurses and physicians at HUV frequently find themselves on strike, blocking the main hospital entrance and marching on the street while medical appointments are canceled or postponed. When the

government finally intervenes, hospitals have turned into a sort of financial black hole, a highly dense localization of financial need capable of engulfing any funds orbiting its vicinity. In the meantime, patients sue the hospital and/or their EPSs, arguing that their right to health has been violated because physicians are not available to see them. In what follows, I discuss the intersections of health care that have transformed these incarnations of crisis into ordinary becomings.

NO FIGHT, NO HEALTH

The crisis of the Colombian health care system cannot be explained exclusively in terms of lack of technology or financial resources.¹⁴ Instead, the situation may be the result of liberalization policies. As described elsewhere in this book,¹⁵ 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 health insurance companies. Consider the following ethnographic examples:

In her book *Markets of Sorrow* (2013), Vincanne Adams discusses the painstakingly slow rescue and reconstruction efforts in the aftermath of Hurricane Katrina. 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” (1). As a result, she argues, “the recovery that should have taken a few years was turned into what locals call a funeral that would not end” (5). That is, post-Katrina became a stalled crisis that failed to reach a turning point. This “funeral that would not end” highlights capitalism’s underlying tendency toward crisis and instability (Marx 1981).

Anthropologist Karen Ho provides another example. In *Liquidated* (2009), she has described this tendency for crisis during a period known as one of the greatest economic booms in the history of the US, the 1990s–2000. During this time, she writes, “the economy experienced not only record corporate profits and the longest rising stock market ever, but also record downsizings” (1–2). Ho analyzes how investment bankers juggled the relationship between massive downsizing and the production of a market crisis, which led to an increase in business value and the liquidation of Wall Street itself.

Likewise, in the context of Colombia, low-income cancer patients, bankrupt public hospitals, and metastasized tumors may turn out to be highly profitable after all—especially when neoliberal reforms get intertwined with the constitutional mandate to protect the rights to life and health. In fact, EPSs’ systematic deferral—and the bodily deterioration that comes with it—has been paradoxically reinforced by the tutela, the anti-crisis mechanism created to protect citizens’ rights to health and life.

Patients I met in Cali considered the tutela an especially effective mechanism when diseases were terminal or metastatic (El Espectador 2013). Under such conditions, thus, the state reemerges as a central figure in the management of patients’

bodies. Therefore, the expected separation between market and state under neoliberal conditions—as Dan Mains (2012) has noted for places like Ethiopia—may not always seem to be perceived as such by its citizens.

. . .

“Look!” shouted a woman at the oncology waiting room. “Look at the doctors and nurses who are protesting outside.” Eager to see people’s reactions, she turned around and said, “These folks know that the hospital management will only pay their salaries if they block the entrance to the outpatient facility.”

Several patients stood up and walked toward the window. They wanted to see for themselves the unfolding protest.

The woman continued, “Health care workers are fighting for their paychecks, just as we [patients] file tutelas to protect our right to health. ¡Así le toca al pobre! [This is what the poor must do]. Even if I die, I will do everything I can to make them pay. I have the right to do so.”

Her words reverberated around the waiting room. She had been able to tap into patients’ widespread frustration and harness its potential. Few individuals had remained indifferent to her speech. There was a loud murmur interwoven with slurs against the government and EPSs. “That’s right. ¡Sin tropel no hay salud, carajo! [No fight, no health, damn!],” responded a man who was standing next to her by the window. “We will have these *sinvergüenzas* [thugs] pay what they promised but never delivered.”

In Spanish, *tropel* means “crowd,” typically a chaotic throng. This word is often used to highlight mass mobilizations against social, political, or economic injustices, which often turn into violent clashes between protesters and the security forces of the state. In addition to experiences of *tropel*, many of the patients in the waiting room were dealing with the uncertainties of a partially closed hospital. Nobody knew whether physicians would show up for consultations that day—the same consultations they had fought to schedule for so long.

The atmosphere in the waiting room was especially tense that day. It felt as if any incautious interaction or loose comment would ignite a *tropel* inside the room. Nurses were not spared. “Hey, miss, I have an appointment today, not tomorrow,” a patient complained. “You better make sure a doctor sees me today, okay?” the patient uttered bitterly.

Overwhelmed by these kinds of reactions, the nurse replied in a cracking voice, “Look, I am sympathetic with you all. But you must be patient. There is a rally going on outside! I am not willing to tolerate *groseria* [bad manners] and shouting. If you really want to complain and get things done, go to a courthouse and file a *bendita* [blessed] tutela. What else do you expect me to do?”

Over the years, the tutela has become a popular mechanism used by Colombians to channel social discontent and access treatments and medications (Ambito Jurídico 2012). In 2018, for instance, there were around 200,000 tutelas filed to

protect the right to health, most of which were directed against EPSs and hospitals (Defensoría del Pueblo 2018). According to Abadía-Barrero (2015a, 63), “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.” Lack of accountability becomes quotidian.

As an anti-crisis mechanism, the tutela was created to confront the violation of fundamental rights, yet it has the potential for becoming an extension of the same problems it seeks to counter. “To a great extent,” mused Dr. Artesano, “the overreliance on tutelas may explain why certain patients do not access medical services when they are still curable. Waiting to get worse may pay off in the long run—or so they think. But waiting is a risky strategy. When they eventually get a favorable court ruling, their bodies have often deteriorated due to a lack of timely treatment.”

“How’s that?” I asked.

“For many of my patients, for instance, it doesn’t really matter if tutelas grant them access to medical services that won’t ever cure them. What really matters to them,” he emphasized, “is seeking justice against some of the most visible faces of the health care system—like hospitals, EPSs, the government. Patients want to make sure they get what they are entitled to. They have been repeatedly promised health care, so they have decided to claim it.”

Dr. Artesano’s words point to a phenomenon I frequently came across at HUV: low-income cancer patients were trading their chances to be cured in the present for the possibility of exercising their rights in the future—when their bodies are too sick and deteriorated for most oncological interventions. Under this logic, becoming visible before the state and making sure it fulfills its promises is worth the bodily decay, an irrational decision from the point of view of biomedicine and economics. Thus the point of care for many of these patients is not cure, as my colleague Misha Klein made me realize, but having the rare opportunity to become visible before the state.

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Here I turn to Alonso, a stage III laryngeal cancer patient I met during my visit to one of the EPS offices located near HUV. Due to his rapid physical deterioration, his wife, Luz, had been doing all the hospital and insurance paperwork on his behalf. After several months of caring for her husband, she became an expert in navigating the health insurance bureaucracy. On weekdays the couple would wake up at 3:30 a.m. and get to the hospital by 5:00 a.m., just to be told the oncologist’s planner was full. “It’s a disrespect with patients,” Luz complained. “We show up at the hospital hoping for some sort of miracle,” she said, while making the sign of the cross on her chest.

Today, against all odds, Alonso and Luz managed to get a same-day appointment. Waking up early and skipping meals to pay taxi fares had finally paid off.

"I persevered. I stood by the nurse at the front desk and never moved an inch from her," Luz explained to me. "At some point the nurse told me that someone else had missed their scheduled appointment. So we got assigned their spot. That's how we managed to see the oncologist the same day. But don't be fooled. Our real goal is to file a tutela. That's why we are here today."

When I ran into the couple at the insurance office, they were standing in a long serpentine line that did not seem to be moving anywhere. The office was packed, as usual. When I looked toward the front of the room, hoping to get a sense of how long they would be waiting, I realized there was only one representative behind the customer service desk, just one person in charge of processing all these patients' paperwork.

"Esto va para largo [This will take a long time]," I said to them.

Frustrated, Alonso stepped out of the queue and sat down on a plastic stool. I took his place in line, next to Luz, who began telling me about Alonso's journey with cancer. When I mentioned I was conducting research to understand how patients manage to access their medical services via EPSs, Alonso waved his hands at me. He grabbed a cloth from his pocket and placed it at the base of his neck, just inside the tracheotomy opening. He then carefully dried the excess saliva coming out of it and fitted a white plastic ring inside the opening to prevent the still fleshy tissue from blocking his airway. In an aspirated voice, he asked, "So you want to learn about my medical history, right? Look at these documents." He carefully bent forward and grabbed a black plastic bag from underneath his plastic stool. "This is where we keep my medical history and the evidence that would allow us to prove that my right to health has been violated."

After two requests and a legal petition, insurance representatives had told Alonso that his prescribed Erbitux would not be provided. "When the moment comes, my wife will use these documents to file a tutela on my behalf. If we cannot get medical service *por las buenas* [the nice way], we will get it *por las malas* [the tough way]," he asserted.

Alonso had reached a tipping point in his frustrating relationship with the EPS. His fight 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 and life.

To file a tutela aimed at protecting the right to health, patients must include detailed medical insurance evidence to support their requests. Most of the time, patients are expected to provide a document that is furnished by EPSs themselves, which "has been standardized as a Service Denial Form" (Abadía-Barrero 2015a, 68). This is an official document that confirms the status of the request made by patients and details the reasons for denying or delaying the provision of a treatment.

While Alonso was attempting to discuss his clinical history with me, Luz interjected, "Indeed, we are pursuing legal actions as soon as the insurance representative provides us with the letter."

“The letter?” I asked.

“Yes, the Service Denial Form,” she replied. “I am confident the judge will take this document as solid 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.”

This intersection of medical and legal practices 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). For patients like Alonso, getting access to high-cost cancer drugs is possible if they have previously wasted time with the EPS bureaucracy and, most importantly, demonstrated that their bodies are incurable because of the wait.

Physicians also play a role in this increasingly frequent practice. Their expertise often is infused with legal parlance and advice during their fifteen-minute consultations. While doctors talk about exams, feel lumps, and disinfect purulent tumors, they also spend time advising patients about *tutelas*. “I encourage my patients to file *tutelas*,” said Dr. Artesano. How else are they supposed to access their treatments? Even though some of them may be terminal, I often feel relieved when they get a favorable court ruling. It feels like a form of revenge, you know, against an unjust system. And it gives me some peace of mind. Besides, favorable *tutelas* may even allow oncologists to prescribe cutting-edge drugs on the market that would have been impossible to access otherwise.”¹⁶

What are the ethical implications of protecting a fundamental right when it has already been violated? How do patients make sense of the right to health and their deteriorated biologies in neoliberal Colombia?

(IM)POSSIBLE RIGHTS

Rights are commonly understood as inalienable conditions that confer inherent protections and privileges on recipients. In “Who Is the Subject of the Rights of Man?” (2004), however, Rancière argues that human rights are often applicable when individuals can demonstrate they are being deprived of those rights. 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 understanding has been fueled by “disagreements around the idea of justice in terms of how much social harm is morally acceptable when granting people’s individual petitions” (Abadía-Barrero 2015a, 75). In the case of cancer patients I worked with, prompt access to medical services often became a reality when their right to health had been systematically violated and their life threatened as a result, that is, when patients could demonstrate they were deprived of the rights they have.

Hoping to illustrate how low-income patients in Colombia may often find perverse incentives to waste time, Dr. Artesano sought to activate the power of

imagination: “Picture a bullet-proof vest. This piece of military equipment is used to protect people from getting injured or killed by gunfire. In the context of Colombia, however, this imaginary vest tends to stop bullets after bodies have been previously shot at. Only then the vest magically becomes bullet-proof—protecting its user 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. “This is how our health care system works.”

Dr. Artesano’s words highlight the bizarre relationship between *tutelas* and the right to health I frequently encountered during fieldwork. The cases I witnessed at HUV suggest that *tutelas* tended to be especially effective after diseased bodies were “wounded” by the bullets of inequality, time, and burdensome bureaucracy. This is when a right becomes inalienable.

Miriam Ticktin (2006) has examined a similar phenomenon in which biological deterioration becomes an asset. In her fieldwork with undocumented immigrants in Paris, she showed how these individuals were relying on physical injuries or HIV infections to claim the basic “rights” supposedly granted to “human beings.” Ticktin saw this phenomenon as an “ethical configuration in which people trade in biological integrity for political recognition” (33). The state renders sick bodies visible (over laboring bodies)—as long as they remain sick from life-threatening pathologies. 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, following Ticktin, entails selling one’s suffering, bartering for membership with one’s life and body. “Although driven by the ethical imperative of relieving suffering” (34), she writes, this form of humanitarianism may have discriminatory and violent consequences.

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

BACK AT THE EPS OFFICE

The following vignette illustrates how a *tutela* ruling granted Alonso access to Erbitux but also transferred the EPS’ financial risks associated with his large claim back to the neoliberal state.

“We should be getting called any time soon,” mused Luz, Alonso’s wife.

“Called soon? When?” Alonso replied in exasperation, while placing a finger on his tracheotomy. “We should probably go back home,” he shrugged.

"If you leave, we will accomplish nothing. We have expected the most, we can expect the least. Please hang on," urged his wife, visibly upset.

Not much time had passed when an insurance representative gestured, asking them to step forward. The couple had finally made it to the customer service desk—arguably their final destination.

The representative greeted them with a smile. I call her Amparo. "What can I do for you today?"

"My husband [pointing at Alonso] has cancer. He has been requesting his Erbitux for more than two months."

Luz 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 numerous documents, until she came across a small wrinkled paper. She carefully unfolded it and placed it on Amparo's desk.

"Take a look at my husband's Erbitux prescription," she said. "It turns out his application was denied twice by this EPS. So it's time for us to file a tutela. We are here to request the official rejection letter from you."

The EPS representative took her glasses off and looked at the prescription. She then turned to the computer and typed Alonso's last name into the database.

There was a prolonged silence.

Amparo mused, "I wish I could help you get the much-needed drug, but unfortunately it does not seem our EPS will authorize it anytime soon. It is considered expensive. I mean, it is expensive if we compare it to generic bioequivalents like cetuximab, which can be as effective as Erbitux."

"Yes, I get that," said Luz. "But what else are we supposed to do? We come here and get told the physician should prescribe something different. We go to see the physician, and then he tells us Erbitux is the only option—which you guys should provide." "Who should I listen to?" Luz said, raising her voice.

Visibly irritated, she uttered words that sounded more like a warning than a mere plea: "Please pay attention to what I am going to say. My husband has a metastatic cancer. Is this clear enough for you?" "We have to move forward with a tutela," she told her.

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

Amparo turned back to the computer screen. She checked Alonso's full name against his cédula and reentered it in the database. "I will need to consult something with my supervisor. Would you mind giving me a moment?" she asked. Luz and Alonso nodded.

Only a few minutes had passed when she was back at her desk. This time she was holding a white envelope with a document inside. "Here you have it, the official letter. It explains why your treatment wasn't approved. It has the EPS's seal stamped at the bottom. Please keep it in a safe place and attach it to your tutela paperwork. This [pointing at the document] is the most important piece of

evidence for your writ. As soon as you get a favorable court ruling [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.”

Given the severity of his cancer, Luz was confident the judge would rule in Alonso’s favor and override the EPS decision. Arguably, the incurable cancer had given him the edge he needed.

And Luz was right. The judge who reviewed the tutela request took less than six days to arrive at a favorable ruling, and Alonso’s EPS was forced to provide the prescribed medication. Two months later, Alonso died at home, next to his wife, when his body could not take it anymore. Alonso’s case shows how financial resources and legal mechanisms are usually activated in situations of bodily crises—not before. Alonso’s medico-bureaucratic journey illustrated how the tutela becomes an ordinary mechanism that ends up reproducing and sustaining crisis itself.

OUTSOURCING OF ETHICAL LIABILITY AND FINANCIAL RISK

Alonso’s legal determination came with a catch. The same court ruling that sought to protect him against the EPS’s inaction, released this business from the financial costs associated to his Erbitux claim. Even though EPSs are usually presented as the main “targets of complaints,” a ruling against them authorizes these companies to access public funds (Abadía-Barrero 2015a).

This financial twist was rendered possible through a mechanism known as *recobro*, “recovery” or “reimbursement.”¹⁷ Until 2020, *recobro* was a financial request by which EPSs charged previously uncovered medical care to the Fondo de Solidaridad y Garantía del Sistema General de Seguridad (FOSYGA).¹⁸ Over time, *recobro* became a popular mechanism by which EPSs transferred their financial accountability back to the government, which highlights the fusion of the welfare state and the corporation (Lamphere 2005; Adams 2013).

To analyze the financial twist rendered possible through *recobro*, I now turn to a conversation I had with Amparo, the same EPS representative who met with Alonso and Luz. Two days later, when I returned to the EPS office, I asked her whether she wouldn’t mind chatting with me as part of my research. This time our conversation would take place at a small restaurant next door.

While having coffee, I asked her, “I am curious about your meeting with Alonso, the cancer patient who has a tracheotomy and requested the treatment denial form. His visit to the EPS office puzzled me. And I apologize if I misunderstood what really happened that day, but his visit was not about requesting access to treatments. He was exclusively interested in collecting the EPS documents needed to file a tutela against your EPS, which the insurance provided swiftly. How

common it is for patients to request these denial letters and for representatives to advise patients on filing a tutela against the same EPS they work for?”

Amparo took a sip of hot coffee and shook her head. “It is rather common. From time to time, I do encourage patients to sue us.” She took another sip. “Most of us do it. It does not mean we are betraying 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. The tutela allows us to do both things at the same time.”

I asked, “Could you elaborate on how a tutela, which is commonly filed against an EPS, suddenly becomes favorable—even desirable—for these businesses?”

“Well, it all starts with something called a reinsurance 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 to increase our premiums in the long run.”

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 Alonso who 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 is taking seemingly unethical decisions in the health care system.

Sergio Sismondo has written about this ghostly phenomenon in the context of pharmaceutical marketing in the US. In *Ghost-Managed Medicine* (2018, 9), he argues that “the work to coordinate the production and circulation of knowledge is performed by invisible hands.” These invisible hands represent middlemen or middle managers who 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” (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,” Sismondo writes. This makes it difficult to identify who is unethical.

In Colombia, ghostly practices are incarnated in the reinsurance policies EPSs purchase from other insurance companies. These policies have allowed many EPSs to outsource ethics 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 missing.

"I wonder about the seeming incompatibility between tutelas and reinsurance policies," I said to Amparo. "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 explain how EPSs manage the associated costs? Wouldn't these companies pass these costs on to their enrollees?"

"Not necessarily," she replied. "Remember that health care is a 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 must be passed somewhere else."

"Where?"

"To the government. The government chips in through FOSYGA. That is how we can provide universal health care without increasing our premiums and still be competitive on the market."

To make her point clearer, Amparo resorted to the following example: "Do you know something about the corn industry in the US?"

"That corn is everywhere," I said. "It is a cheap ingredient used in most processed foods."

"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 costs of production. 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 a profit—even when there are huge financial risks associated with large claims from catastrophic diseases."

Her words made me realize that the ethical responsibilities taken away from the welfare state in 1993 were being transferred back to it via the *tutela*. This was a seeming paradox: the *tutela* does not only seek to protect fundamental rights such as health (ensuring patients access to their prescribed treatments and drugs); it also, and crucially, seeks to safeguard insurers' capital by transferring part of their financial burden to the state and outsourcing their ethical responsibility to reinsurance companies.

This is the corporate-state fusion common to neoliberalism. In her ethnography about post-Katrina New Orleans, Adams (2013) has shown how the two entered a new form of relationship: capitalism making money on the welfare state. She described the phenomenon in which the same agents that produce disasters often manage to capitalize on the aftermath of such calamities. In Colombia, the anti-crisis mechanism of the *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 effect may have occurred in two ways: first, by the growth of EPSs that find ways to provide health care

for low-income and working populations while also making profits; and second, by desperate and exhausted patients (and their families) “who must resort to the judiciary to avail themselves of their constitutional right to health care” (Abadía-Barrero 2015a, 63).

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In this chapter I discussed how the national health care crisis has become a stubbornly protracted event fueled by EPSs’ deferral practices and their relationship with anti-crisis mechanisms such as the *tutela*, which has often encouraged low-income cancer patients to let their bodies deteriorate. These patients are often caught between a simultaneous impossibility of getting cured and the possibility of accessing virtually unrestricted and immediate medical care—the same care that was so elusive prior to a favorable *tutela* ruling. The relationships I described between the *tutela* and EPS treatment deferrals seem to have created the financial incentives that transformed the health care crisis into a chronic condition, a disaster that never ends.

In chapter 3 I offer a contrast with the previous two chapters. There I discuss the health insurance regime for the wealthier population. The chapter teases out the ontological indeterminacy of cancer and its relationship to high-end hospitals and a patient who could, albeit not without effort, pay for the treatment. I analyze how dermatologists, pathologists, and oncologists studied a patient’s skin biopsy and enacted two seemingly contradictory diagnoses: a lethal melanoma and a benign dysplastic nevus, commonly known as mole. Because their differences under the microscope or through dermatological goggles may be subtle, physicians often disagree on what they see.