COLOMBIA'S RESPONSE TO CRISIS

In 2009 Colombia declared a state of emergency in its healthcare system. **Oscar Bernal, Juan Camilo Forero,** and **Ian Forde** describe the origins of the crisis and explore the extent to which the reforms that followed are likely to secure better healthcare for the population

Colombia is struggling to provide an affordable and effective health system for its population. As in most of Latin America, its healthcare challenges include rising chronic diseases, persistent infectious diseases, and worsening inequity. More uniquely, around 3.4 million people are registered as internally displaced[1] and, although declining, murder and intentional injury remain major problems. Almost half (45.5%) of Colombians live below the poverty line, and the country's Gini coefficient, a measure of inequality, was 0.587 in 2009,[2] the highest in Latin America.

Colombia currently ranks 87 out of 187 on the United Nation's human development index with a per capita gross domestic product (GDP) of $9800.[3] Around 5.8% of GDP is spent on healthcare, infant mortality is 15.5 deaths/1000 live births, and life expectancy at birth is 73.7 years.[3 4] These statistics compare favourably with neighbouring countries, as the table shows. However, rising costs, waiting lists, and poor quality have left the system in disarray.

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Family planning on the move in Bogota

Origins of health sector crisis

Before 1993, healthcare was provided through a single public insurer. Planning was highly centralised and poorly responsive to changing needs; furthermore, 30% of Colombians were uninsured, and out of pocket payments made up 53% of total healthcare spending.[6] In 1993, Law 100 introduced private insurers under regulated competition. People in formal employment could opt to purchase health insurance through regular salary contributions, while those who were unemployed, informally employed, or very poor remained publicly subsidised.

The law specified a basic package of services to which members were entitled and expanded coverage to 90%,[7] but it resulted in a complex and conspicuously unequal, two tier system. Within contributory schemes, the average payment per person each year is 500 000 Colombian pesos (£170; €200; $260), roughly double that in publicly subsidised insurance schemes.[8] Consequently, the basic package is less generous in the public sector. Currently, healthcare is underwritten by more than 130 private and public insurers, with services provided in a mix of private and public hospitals; 70% of insurance companies manage their own facilities.[9]

Efforts to improve the system were made towards the end of the last decade. Law 1122, in 2007, aimed to strengthen regulation, clarify benefit packages, and stop people underdeclaring income to maintain publicly subsidised insurance. It also sought to improve financial flows by decentralising budget management and establishing deadlines by which insurers had to reimburse providers. In 2008, the constitutional court passed a judgment requiring that the publicly subsidised insurance offer the same level of care as contributory schemes, placing the sector under great financial strain.

The reimbursement deadlines specified in Law 1122, however, were ignored, and because the regulatory authorities lacked both the legal apparatus and the workforce to enforce them, huge financial deficits began to mount.

Health and development statistics for Colombia and neighbouring countries

Country	Human development Index[3]	GDP per capita, 2010[5]($Int)*	% of GDP spent on healthcare, 2008[5]	Life expectancy, 2011[4]	Under 5 mortality, 2009[4] (deaths/1000 live births)	Hospital beds, 2009[4] (per 10 000 population)	Gini index, 2009[2]
Colombia	87	8487	5.9	73.7	19	10	58†
Peru	80	8437	4.5	74.0	21	15	48
Venezuela	73	10 805	5.4	74.4	17	13	44†
Brazil	84	10 056	8.4	73.5	21	24	54
Chile	44	13 579	7.5	79.1	8	21	52

*Purchasing power parity for 2005 in international dollars.
†2006 data.

Furthermore, continuing evasion and high rates of informal sector employment meant that many fewer people subscribed to private health insurance than expected. The most recent figures show that around 40% of the population belong to contributory schemes, with 50% in the subsidised sector, and 10% uninsured.[7]

Colombia also allows individuals to petition the constitutional court, a process known as a *tutela*. Within healthcare, the court receives petitions across the spectrum of activity, including for the right to drugs, imaging, procedures, and specialist consultation. The petitions are partly driven by the fact that the basic package of care has not been substantially revised since 1993.[10] Additionally, nearly two thirds relate to long waiting times imposed by insurance companies after agreeing a clinical need.[11] Patients have no other mechanism to claim redress and, until recently, the costs of treatment resulting from successful petitions were paid from public funds, creating a perverse incentive for contributory insurance schemes to exploit them. Rapid increases in the number of successful petitions (from around 35 000 in 2006 to 141 800 in 2008[11]) made the arrangements increasingly untenable, as did endemic corruption. Recent auditing by the Presidential Office estimates 2.5bn pesos to have been illegally diverted from public funds, roughly equal to the sector deficit.[12] Well publicised cases include an insurance company spending part of its funds to build a golf course and luxury hotel[13] and government officials taking bribes from insurers to waive through selected petitions or reimburse fictional ones.[14]

By the end of the decade, the health system was in deep crisis. Health costs and the sector deficit were rising unsustainably, some health indicators were worsening (figure), and the quality of health services was deteriorating: 2010 saw 1776 inquiries by the health regulator into healthcare institutions—1617 fines were imposed and 33 institutions were taken over.[15] The government declared a state of emergency in 2009. This triggered an automatic inquiry by the constitutional court, which reasoned that the crisis was foreseeable and declared the state of emergency unconstitutional. The same judgment enshrined healthcare as a legally enforceable right, and set a deadline of one year by which universal access to a basic package of care had to be guaranteed.

New law to improve healthcare

In 2010 President Juan Manuel Santos was elected with a promise to undertake major health system reform. Financial sustainability was a key priority, alongside reorganisation of the ministries responsible for health and social care. To find a way forward President Santos convened a series of roundtable discussions, inviting patient associations, clinicians, providers, and insurance and drug companies to put forward their views (box).

The outcome of this process was Law 1438, enacted in January 2011. The government stated that the law sought to improve healthcare based on principles of universality, equity, solidarity, quality, transparency, participation, and sustainability by improving governance and interministerial coordination, placing greater focus on prevention and health promotion, offering the same level of coverage in the publicly subsidised and private contributory schemes, and providing universal coverage.

There was a commitment to unify employment based and publicly subsidised health plans by 2011, offering the same level of coverage in each and allowing users to access health services nationally. Performance indicators and quality rankings will be published so that insurers and providers can compete for patients, with digital health records mandated by 2013. Capitation payments are retained for straightforward services such as cervical cancer screening or family planning, but payment by results was introduced for more complex services such as cancer care or HIV management with the aim of improving the performance of providers and ensuring adequate reimbursement; providers had previously lost money on such care, which was funded under outdated block contracts. Additionally, new institutions such as a national health observatory and institute for the evaluation of new technologies were proposed to inform regular revision of the benefit package, mandated biennially.

Financial sustainability was sought through placing limits on the overheads for which insurers could charge (although "overheads" is vaguely defined); introducing new mechanisms to control drug prices (such as reference prices and centralised purchasing); seeking additional revenue through new taxes (such as a tax on private guns); and authorising an increase in the proportion of national tax revenue available for healthcare. Renewed efforts were made to speed up reimbursement from insurers to providers and, in order to strengthen governance and clarify responsibilities; additional budgetary competencies were devolved to regional governments.

Uncertain future

Although it is still early to assess the effect of the new legislation, it is a promising attempt at reform. Nevertheless, some concerns and inconsistencies remain to be resolved.

Firstly, the primary emphasis of the new law

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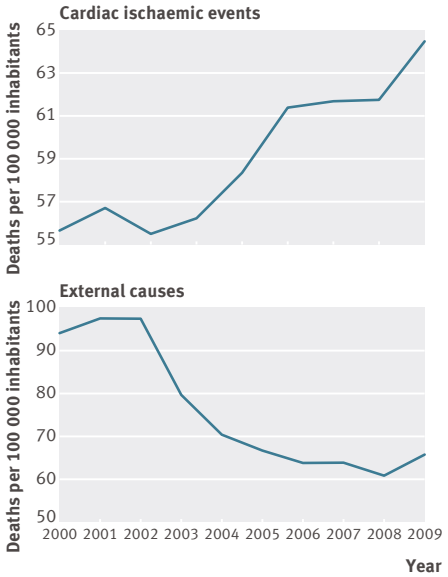

Deaths from cardiac ischaemic events and external causes, Colombia 2000-9[16]

ADRIAN OHRN JOHANSEN

The outskirts of Bogota have many cramped homes, many without electricity or clean drinking water

What stakeholders wanted from health reform[17]

Private health insurers—To maintain the status quo (although they were open to some simplification through takeover of smaller insurers); exclusion of high cost and rare diseases from basic package of guaranteed healthcare

Private providers—To contract directly with government avoiding private insurers, whom they saw as inefficient intermediaries

Public insurers—Introduce a not-for-profit model across the entire health insurance system and expand their membership to include private contributory members

Public providers—National insurance system, predicated on health as a human right with emphasis on primary healthcare and provision according to need rather than through a defined package

Local government—Resist recentralisation and win stronger support for local public health facilities, especially in isolated areas

Doctors—To secure better salaries and working conditions, within single national insurance system

Patients—Greater participation in decision making

is financial sustainability rather than improved outcomes or patient experience. Although financial restructuring is undoubtedly needed, reforms should be driven by, and their results measured in, health not financial terms. Doctors were particularly dismayed that the law makes provision for clinical opinion to be overruled by the insurer.

A focus on quality will be hampered by a continued lack of effective regulation. Although responsibility for quality of staff and facilities was devolved to regional health boards, financial regulation was recentralised. Hence, regulatory capacity remains scattered incongruously across the Ministry of Health, the central regulator, and the regions, complicating implementation. Furthermore, although funding for regulation was increased, it may still be insufficient because of the administrative burden arising from the closure and takeover of numerous hospitals that have been judged of poor quality.

A related concern is the proliferation of new bodies such as the National Health Observatory and Institute for the Assessment of New Health Technologies (modelled on the English National Institute for Health and Clinical Excellence). Although these are necessary, their mandates overlap with those of pre-existing bodies. The role of the existing institutions is now unclear, and it is unfortunate that legislators missed the opportunity to improve them rather than create new agencies. For example, confusion over relative institutional roles meant that unification of the private and public benefit packages was two years late and restricted to children and elderly people.

The second important failing relates to managing *tutelas,* which cause substantial instability. The government's original intention was to formulate a law that recognised healthcare as a fundamental right—fulfilled through a defined benefit package, with any services outside this financed through other means. However, lack of political will meant that attempts at a constitutional amendment foundered. To reduce the number of *tutelas,* the government needs to strengthen national priority setting and conduct a thorough revision of the care included in the basic package. Although 163 treatments and procedures have recently been added,[18] the process was not transparent, an explicit list of excluded treatments was not specified, some included drugs are not even marketed in Colombia, and disparate packages remain for subsidised and contributory schemes in adults.

The new law also does little to deal with the fundamental roots of the financial crisis—that is, high levels of informal employment, failure of the formally employed to enrol in contributory schemes, and corruption. Although various incentives to encourage formal employment have been created, Law 1438 allows citizens to remain in the subsided system even if they are formally employed. This is because formal contracts often last just a few months. Given that high levels of informal employment are likely to persist for some time, it may be appropriate to link individuals' insurance contributions to income rather than employment status, with greater penalties for under-declaring income. Other revenue streams, such as an increase in point of sale tax (VAT), may need to be considered, although this could be regressive and the tax is also widely evaded.[19] The government has recently hardened penalties for institutional corruption, an important first step to deal with this problem.

All these changes require strong leadership, the apparent lack of which is perhaps the most worrying feature of Colombia's recent reforms. At a recent audience summoned by the constitutional court to review progress, the minister of social protection (who was responsible for health at the time) denied any crisis in the healthcare sector, referring instead merely to issues that needed "adjustment," such as improving financial flows, updating the benefit package, and reducing inequalities.[20]

Other countries have moved quickly from fragmented and inefficient healthcare systems to constitutionally mandated healthcare and steadily improving outcomes. Turkey achieved reductions in infant and maternal mortality and greater patient satisfaction by investing in public hospitals and prioritising family medicine. Strong political leadership, simplification of ministerial responsibilities, and outcome based financial incentives (both to physicians and patients) were seen as key.[21] Ongoing debate, scrutiny, and accountability are now necessary to ensure that Law 1438 achieves similar goals for Colombia.

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