Healthcare System Country Notes
South American Region

Colombia

The purpose of the IMSA National Health Insurance (NHI) web-site is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system in South Africa. This series of Country Notes is a collation of material submitted by independent researchers who are willing to place their research notes in the public domain. The collated notes, together with other studies found in the public domain are presented as a service to researchers, policy-makers and stakeholders who are looking at health reforms around the world.

A. Medi-Clinic Research Notes: "Progressive segmented health insurance: Colombian health reform and access to health services"

Paper: Ruiz F, Amaya L, Venegas S (2007) Progressive segmented health insurance: Colombian health reform and access to health services. *Health Economics* 16: 3 – 18

By 1993, the Colombian health reform addressed inequities in access to health services by establishing a segmented health insurance policy with solidarity financing – high income workers contribute a portion of their pay to the poor population. It consisted of the expansion of pay-roll linked insurance formerly limited to the worker to the entire family (**Contributive Regime - CR**), and the establishment of a subsidized health insurance for the poorest (**Subsidized Regime - SR**). **Special Regimes** were allowed to continue – privileged insurance schemes, mostly guaranteed through union arrangements or aimed at special groups: military personnel, petroleum industry workers, school teachers.

There are thus three types of SHI in Colombia. There is private health insurance available for those that want an expanded selection base of physicians and better in-patient accommodations.

CR health plan covered most outpatient and inpatient services, regardless of complexity – and a comprehensive medication list composed mainly of generic drugs. It has a co-payment rate depending on the individual's income.

Subsidized plan has similar coverage but does not cover most intermediate level surgery. Special plans have different health packages, but all at least have the CR package coverage, and have lower co-payments.

Financing of the health system is through government tax revenue, individuals' payroll contributions. CR is financed by 4% of salary; an additional 1% is solidarity contribution to the subsidised regime. Financial resources are managed through an equalisation fund (FOSYGA), which compensates adverse selection consequences among CR insurers based on gender and age group differences among the different risk pools.

The social health insurance initiative was intended as a progressive policy with sequential coverage of the population through rapid expansion of Subsidised and CRs. Objective: Universal coverage with benefit package at the level of CR.

Empirical evidence from analysis of household surveys suggests that insurance coverage increased from 15.7% to 57% in the first 7 years (from 1990). Expansion was due to both new family members affiliated to CR and to poor population covered by subsidised regime. Coverage was stagnant from 1998 – 2003 because of restrictions on health budget. Also, macroeconomic recession around that

time reduced formal employment, thus affecting the solidarity component to the subsidised regime (solidarity fund).

B. Medi-Clinic Research Notes: "Good practice in health financing; lessons from reforms in low and middle-income countries."

Paper: Good practice in health financing: lessons from reforms in low and middle-income countries. Edited by Pablo Gottret, George J. Schieber, and Hugh R. Waters, coeditors. World Bank 2008

The health system is largely public funded.

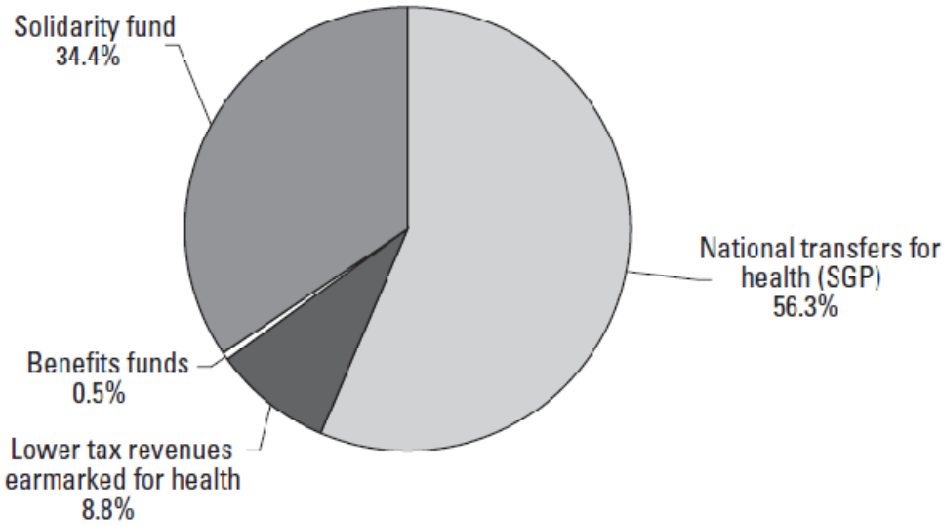
1991 constitution assigned the state the responsibility for directing, coordinating, and regulating a universal social security service, thus establishing a legal framework for National Social Health Insurance.

CR is mandatory insurance for the formally employed and self employed (who can pay) and pensioners. By 2006, 34% of population enrolled in CR. Individuals choose to enrol in health plans that serve the CR, called EPS – Health Promoting Companies. The EPSs collect wage contributions and transfers them to a central fund that pools and distributes revenues among sub-funds. This central fund is the Social Security and Guarantees Fund – FOSYGA).

SR subsidises individual insurance premiums for the poor according to proxy-means testing. Because of resource constraints, not all who are eligible for SR are given insurance. Priority enrolment is given to the poorest and vulnerable groups such as pregnant and lactating mothers, handicapped, under-5s, displaced populations etc.

SR is financed from:

- Government transfers (56.3%)
- 1% solidarity contribution from the CR (34.4%)
- Local tax revenues from "sin taxes" (8.8%)
- Family benefits funds (0.5%)



Source: Data from Grupo de Economia de la Salud 2006.

Note: Total resources in 2005 = Col$3.2 billion (US$1,390,000,000); 1 billion = 1x1012.

For uninsured, public provider are allowed to charge user-fees, priced nationally on a sliding scale according to income. Uninsured can also pay OOP to private providers.

There is a defined benefit package for CR and SR. The benefit package (*Planes Obligatorios de Salud* – POS) of CR is the most comprehensive.

Private supplementary insurance policies can be purchased by individuals who want medical services not covered by the POS, or more amenities – about 5% of the population purchases these policies.

Reform organised the health delivery systems following a 2-market, managed-competition model that operates on 2 levels. On the 1st level, the insurance market, consumers have the freedom to choose from among a set of public or private health insurance plans offering services covered by the POS or POS-S (benefit package of the subsidised regime) in exchange for a fixed premium. Because the premium is fixed, theoretically, health plans should compete for enrolees not through price, but through their distinctive service and quality features. Health plans act as group purchasers for their enrolees by arranging a network of providers they select based on best price and quality.
On the 2nd level, the provider market, health care providers compete for inclusion in health plan provider networks and selection by enrolees on the basis of price and quality.

Health plans control demand (administratively) through the use of gatekeepers, and utilisation management for specialist, hospital and diagnostic care.

The reform: the goals were to improve access, efficiency, service quality and equity. The key strategy – NSHI

Before the reform: 3 tier system

- NHS, designed after the primary care model. Network of public facilities providing health care to about 50% of the population, financed through general taxes
- Mandatory social insurance for formal workers in the public and formal sector – covered about 20% of the population
- Private health insurance, upper income group

Rationale for reform

- Limited access to basic health care services for most of the population
- 75% of the population had no health insurance
- Huge financial barrier to health services for the poor
- Inequitable distribution of health financing incidence – 20% of population not reached by any health service

Target – Universal CR coverage for the 70% non-poor; Universal SR coverage for the poor 30%
As at 2005, 74% of population covered by CR and SR.

Lessons:

- *1991 constitution provided a legal framework for many of the strategies for the 1993 reform*
- *The NSHI was able to quickly sign up a large number of enrolees throughout the country because a reasonable number of private and public institutions already could meet the organisational requirements for delivering services under the managed competition model, or could adapt to fulfil this model*
- *Positive economic growth in the first 4 years, very helpful*
- *Good political support*
- *Existence of quality assurance regulations guaranteeing minimum safety and quality standards was one of the conditions that assisted Colombia in achieving positive gains from NSHI.*

C. Medi-Clinic Research Notes: "Colombia: In vivo test of health sector privatisation in the developing world"

Paper: De Groote T, De Paepe P & Unger J (2005) Colombia: In vivo test of health sector privatisation in the developing world. *International Journal of Health Sciences* 35 (1) 125-141

Nature of reform was influenced by international fad – increased privatisation within the health sector by World Bank and World Health Organisation.

Health sector reform started in the 1980s with a process of political, fiscal and administrative decentralisation

Reform proposal was made possible by petroleum discovery

Introduction of reform increased overall health expenditure – because of the demand-oriented health system. This increased cost not related to any increase in real access to health services or to improved disease control, hence doubts as to the efficiency of the social security system.

D. Medi-Clinic Research Notes: "Enhancing the political feasibility of health reform: The Colombian case"

Paper: Gonzalez-Rossetti A, Ramirez P (2000) Enhancing the political feasibility of health reform: The Colombian case

The reform was led by a team of economists from the more technocratic planning ministry; the emphasis was on bringing about change through regulation and to use market mechanisms to manage health funding and provision

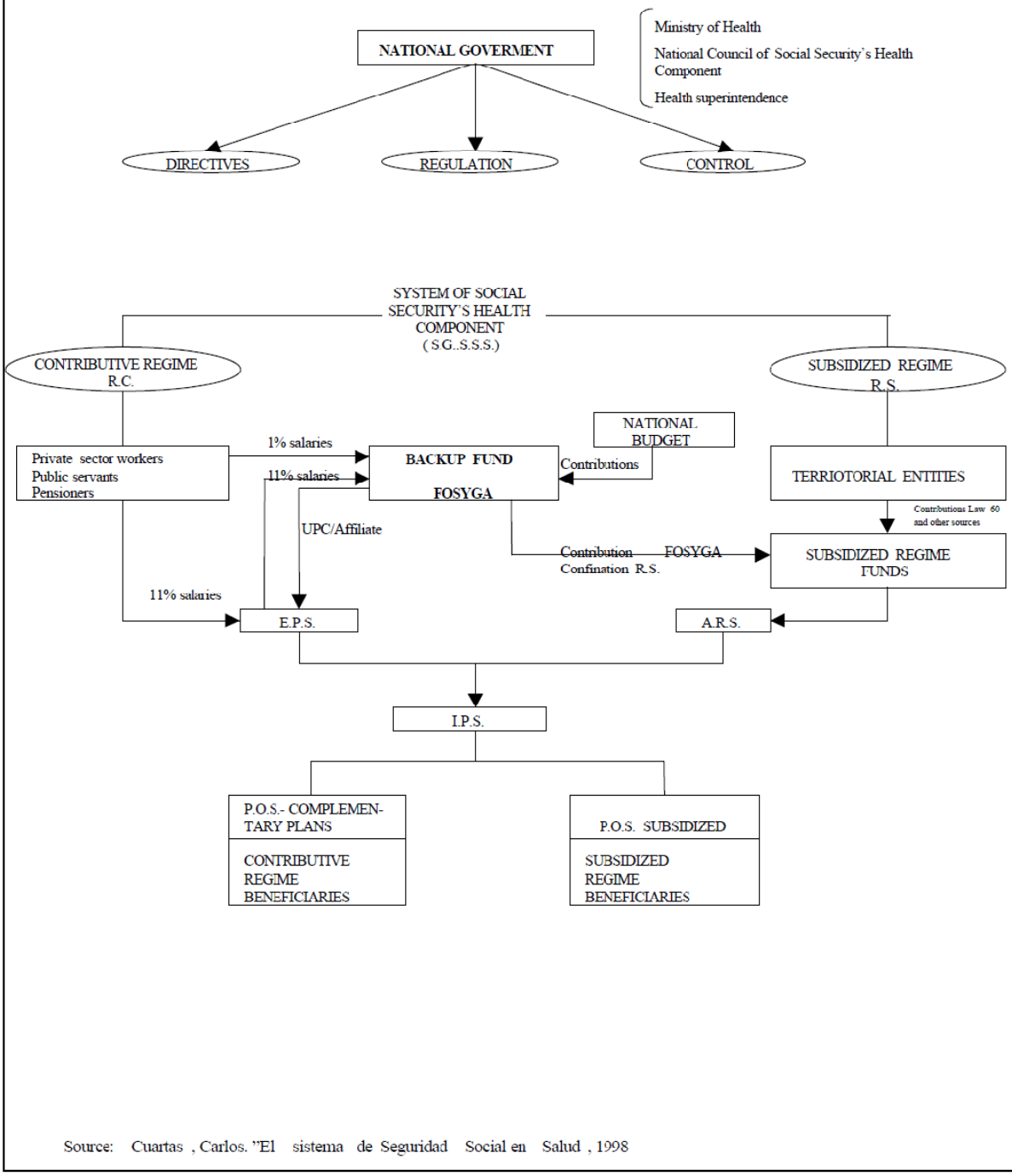
Access to the poor is still an objective that has not been adequately achieved

Central to the reform was a "health change team" that was created to be responsible for the reform. This team was very close to the "economic change team". The team's legitimacy came from its academic training, its previous work with government, international background, apolitical (none wanted to pursue a career in government); the team had joint expertise in health, economics, communications, law and public administration

Lots of changes in the 1980s can be viewed as the beginnings of the health reform – decentralisation of health expenditure (national hospital fund)

Chapter 2 - Diagram 1

SYSTEM OF SOCIAL SECURITY'S HEALTH COMPONENT
(S.G.S.S.S.)



Source: Cuartas , Carlos. "El sistema de Seguridad Social en Salud , 1998

E. Medi-Clinic Research Notes: "Evaluating the impact of health care reform in Colombia: From Theory to Practice"

Paper: Gaviria A, Medina C & Mejia C (2006) Evaluating the impact of health care reform in Colombia: From Theory to Practice

Problems with pre-reform health system:

- Low levels of insurance coverage
- Inequities in the access to health services and low levels of solidarity
- High inefficiency in the public sector

CR enrolees contribute 12% of their earned income (4% by employee and 8% by employer). The contribution is collected by the insurance carrier (EPS) that the contributor freely chooses. The EPS discounts from each contributor's contribution the value of the premium stipulated by the regulation (UPC) for the worker and his/her dependants, and transfers the difference to an equalization fund known as the *Fosyga* in the Colombian legislation. When the difference is negative, the Fosyga compensates the EPS with the corresponding value.

Coverage of the SR and CR had weaker than expected performance: CR only 54% of expected; SR on 40% of expected coverage. On the whole, coverage increased from 28% in 1992 to 42% in 2000. Reasons for SR are:

- Low solidarity contribution due to increase in unemployment
- Lower than expected funding from regions and national transfers

Major gap was the difficulty in converting subsidies of supply to subsidies of demand.

"initially, supply resources had to be maintained in order to assist the poor, uninsured population; which, in turn, diminishes available resources for subsidies to demand, which hinders the enrollment of new members, and which prevents the reduction in resources of supply, thereby deducting more resources from demand, and so on".

The political pressure exerted by inefficient public hospitals which were not able to attract resources through the sale of services, and therefore display a structural shortfall in their budgets, constituted the major bottleneck in accelerating the transition of subsidies to demand.

The introduction of the SR has been accompanied by both growth in the number of public hospitals and lower levels of occupation—a predictable result in the face of soft-budget constraints. Currently, resources are used not only in maintaining underused public hospitals, but also into subsidizing demand by the poorest citizens, who prefer to use private hospitals. In other words, the cost of subsidies to demand has been absorbed, but subsidies to supply have never been dismantled, which has implied a doubling of cost.

Lessons:
3 unanticipated results:

- *Duplicity in expenditure*
- *Perpetuation of inefficiencies in public supply*
- *Horizontal inequities generated by the lack of universal coverage of the SR*

F. Incentives in Colombia's Régimen Subsidiado

Paper: Grant Miller, Diana M. Pinto and Marcos Vera-Hernández (2010) High-Powered Incentives in Developing Country Health Insurance: Evidence From Colombia's Régimen Subsidiado. NBER Working Paper Series: Working Paper 15456. http://www.nber.org/papers/w15456

Despite current emphasis on health insurance expansions in developing countries, inefficient consumer incentives for over-use of medical care are an important counterbalancing concern. However, three factors that are more acute in poor countries (credit constraints, principal-agent problems, and positive externalities) result in substantial under-use and misuse as well. This paper studies Colombia's Régimen Subsidiado, the first major developing country effort to expand insurance in a way that purposefully addresses these inefficiencies. Using a regression discontinuity design, we find that Colombia's insurance program has provided risk protection while substantially increasing the use of traditionally under-utilized preventive services (with measurable health gains) through high-powered supply-side incentives.

Accessed March 2010.

G. The Economist: "Colombia's health reforms: Shock treatment"

President Uribe tries to push through some much-needed changes

4 February 2010 | BOGOTÁ | From The Economist print edition
http://www.economist.com/world/americas/displaystory.cfm?story_id=15469812

As allies of Barack Obama seek procedural tricks to slip his health reforms through a truculent Congress, his Colombian counterpart, Álvaro Uribe, is not bothering with such niceties. He has simply issued a set of decrees ordering a much-needed but equally controversial shake-up of his country's health service. The Constitutional Court, whose earlier rulings have added greatly to the health system's financial stresses, is examining the decrees. Mr Uribe has begun negotiating with doctors and other opponents over how they are implemented—but he remains determined to see them through.

There is little argument over the need to close the big deficit in the health service's budget. Mr Uribe's decrees include an increase in taxes on alcohol, cigarettes and gambling, and measures to cut losses from corruption and bureaucracy. But his critics accuse him of taking advantage of this financial emergency to make more profound changes to the way health care is provided, and with little public debate.

Doctors are especially angry at a decree limiting their autonomy to prescribe the best treatment for patients. Along similar lines to reforms introduced in Britain in the 1990s, it seeks to introduce a list of approved drugs and treatments. However, Mr Uribe at first sought to go further and impose fines of up to $13,000 for doctors who prescribe beyond what the list allows. Their strong objections prompted him to backtrack and promise that the new treatment standards will be only advisory, except in certain cases.

Another controversial decree, although unobjectionable in its fundamental aim, would equalise the benefits provided by Colombia's two parallel health systems. In one of these, salaried workers and the self-employed have to contribute 12% of their earnings to health plans run by managed-care organisations similar to those in the United States. The poor and unemployed get care from a second, subsidised system with fewer benefits and generally deficient service. A study in 2008 found that a quarter of those supposedly covered by the subsidised regime did not receive medical attention when they needed it.

Things were set up so that the premiums paid by those in the contributory system would eventually generate a surplus sufficient to subsidise the system for the poor. But this was based on over-

optimistic forecasts that unemployment would remain in single digits (it hit 12% in 2009) and the economy would grow by about 5% (economists expect 2.5% growth this year). Since the new taxes seem unlikely to raise enough money to fix the financial hole, the worry was that “equalising” the two systems would mean worsening the contributory system, not improving the subsidised one. Mr Uribe now says he is prepared to delay implementing this part of the reform if that is what it takes to maintain standards of care.

Besides the challenge in the Constitutional Court, Mr Uribe faces an attempt by two senators to block his reforms with a “patients’ bill of rights”. Trade unions are also planning to protest against them. The minister for social protection, Diego Palacio, says the president’s decrees have been “misunderstood”. But as Mr Obama could tell him, any health reform worth passing inevitably involves a struggle.

Accessed March 2010.

H. “From Few to Many -Ten Years of Health Insurance Expansion in Colombia”

Book edited by Glassman, Amanda L.; Escobar, María-Luisa; Giuffrida, Antonio; Giedion, Ursula
Dec, 2009 | ISBN: 9781597820738
Inter-American Development Bank - Co-published by The Brookings Institution
Available online at: http://idbdocs.iadb.org/wsdocs/getdocument.aspx?docnum=35026183

“ a comprehensive look at Colombia's 1993 health system reforms. It describes the implementation of universal health insurance, including a subsidized system for the poor, and examines the impact of this and other reforms during a time when Colombia experienced crushing recession and internal conflict that displaced half a million people

Prior to the reforms, a quarter of the Colombian population had health insurance. Subsidies failed to reach the poor, who were vulnerable to catastrophic financial consequences of illness. Yet by 2008, 85 percent of the population benefited from health insurance.

“...describes the challenges and benefits of implementing social health reforms in a developing country, exploring health care financing, institutional reform, the effects of political will on health care, and more. The reforms have provided important lessons not only for continued reform in Colombia, but also for other nations facing similar challenges....”

“Colombia: Approaching Universal Coverage”

Book review of “From Few to Many: Ten Years of Health Insurance Expansion in Colombia”. Review by Philip Musgrove, Health Affairs deputy editor, in Bethesda, Maryland.
Health Affairs, Supplement 2010; 29(4): 739-740. - doi: 10.1377/hlthaff.2010.0225
Website: http://content.healthaffairs.org/cgi/content/full/29/4/739?rss=1

“Much has been written in Colombia about this reform. However, as the authors of this most thorough and careful analysis point out, much of the discussion has been "based on limited data and inappropriate methods of analysis." It isn't easy to separate the effects attributable to the reform from those of economic changes, differences among population groups, policy fluctuations through several administrations, changes due to decentralization, and the reduction in violence in recent years as the country began to deal more effectively with rebel movements and drug trafficking. This book, therefore, has two main purposes: to make available to the rest of the world the large body of Colombian literature on the reform, and to provide analyses sophisticated enough for the complexity of this uncontrolled experiment to get beyond simple comparisons between before and after or insured and uninsured beneficiaries. It succeeds admirably on both counts.”

".....During the past two decades, several middle-income countries have achieved universal health insurance coverage or made substantial progress toward that goal. The Colombian reform that began with Law 100 in 1993 is the most radical and interesting of these experiences. Instead of gradually adding beneficiaries to existing, small-scale insurance, as in Korea and Taiwan; creating a new scheme for the uninsured poor, as in China, Mexico, and Thailand; or making private insurance match public coverage, as in Chile, Colombia introduced a managed competition model in which for-profit and non-profit providers and insurers insure and deliver care."

"The intent was to move from the inefficiencies and inequity of budgeted funding of public providers—in effect, supply-side financing—to a form of demand-side financing in which money follows the patient, using both existing and newly created insurance organizations. The reform created a "contributory" program for those who could afford a reasonable premium and a subsidized program with half the premium and reduced benefits for those unable to pay. These changes were to occur simultaneously with a major decentralization of responsibilities to department and municipal governments for health care financing and delivery. ...."

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I. Econex Notes on Colombia

A formatted PDF note on Colombia, provided by Econex, is appended to this document from page 10 onwards.

Econex
Trade, Competition & Applied Economics

These notes have been collated for IMSA from submitted research material.
The material has not been independently reviewed, checked or verified.

Professor Heather McLeod
11 April 2010

1 Colombia

In 2002 the WHO termed Colombia's health system the fairest in the world (in terms of financial contributions specifically). Although this fact is much disputed in the literature, Colombia's national health system of managed competition provides an interesting and credible alternative to the way South Africa's proposed NHI is likely to be structured.

1.1 Historical Background

Before the introduction of Colombia's social health insurance scheme in 1993, the country had a three-tiered public health care system. The three levels were based on the type of services provided, as well as geographical areas it covered. The first level of care provided general medicine through various types of facilities, while the second level included hospitals that provided some speciality medical and other surgical care. The third level care included speciality care, subspecialty care and hospitalisation for complex cases. These three these levels of care were either financed by i) supply-side subsidies from the government budget (for the unemployed and low income population), ii) contributions from employers and employees (for employed persons only), or iii) private insurance.[1] "This system consisted of ... a mandated social insurance plan that financed and operated its own facilities for formal sector workers, and a system of private insurance and health care provision for those able to pay out-of-pocket. This system resulted in limited access to even basic health services for a large proportion of the population, operational inefficiencies at all levels of care, and poor quality of services. All these contributed to low use and acceptance of the network of public providers."[2] However, as mentioned above, the private sector also grew during this time. It had a similar structure, but targeted the part of the population able to pay; providing more and better quality services than the public sector.

1.2 Social Health Insurance – Overview

In 1993, the health system was completely reformed. The government opted for a more market-oriented system where medical insurance was separated from the provision of medical care and private insurers would compete with one another, thereby increasing efficiency, quality and service delivery. The state would only play a regulatory role, ensuring a level playing field by setting prices and standards, as well as providing information. Since both public and private providers of healthcare had to maintain the same standards, public providers now had to compete with private providers in terms of service delivery, quality, financing and administration.

Colombia's social health insurance scheme consists of two types of insurance. The Contributive Regime (CR) extends the previous employee insurance to formal workers earning more than twice the minimum

[1] Colombia Health System Reform
[2] World Bank 2007: 108

wage *and* their families. All tax-paying citizens contribute 12.5% of their salaries to social health insurance (the employer pays 75% and the employee 25% of this tax) and can then decide on the insurer of their choice. In other words, the government sets the price and minimum requirements for the benefit package, but insurers can still compete for enrolees "on the basis of the service and quality features of their benefits packages."[3] Insurers will thus buy services on behalf of their enrolees in the providers' market where public and private providers compete. The CR enrolees are entitled to a comprehensive benefits package covering most outpatient and inpatient care, as well as a comprehensive list of mainly generic drugs. Capped co-payments are also charged for people in the CR, depending on the individual's income and varying between 5-30%.[4] Additional private insurance covering private rooms and an extended choice of providers may also be bought.

The second type of insurance is the Subsidised Regime (SR) covering the poor. The SR is financed by general taxation and contributions from the CR. It only includes basic benefits, but the price of this benefits package is also determined by the government and insurers have to compete on the same basis as in the CR. A means test (SISBEN) is used to categorise the poor into six different levels with level 1 being the poorest. Health insurance is then subsidised for people in levels 1 and 2, with the other levels being eligible for subsidies only if the funding is available.[5] As a safety net for the uninsured and to fill the gap in services not provided by the basic benefits package, "the [SR] is complemented by services provided by public hospitals, financed through direct payments to providers, independent of what services they supply and of patients' insurance status."[6] The overall idea is however to transform all supply-side subsidies into demand-side subsidies (as the CR and SR are already doing) where beneficiaries instead of providers are subsidised. As more resources become available, insurance coverage by the SR was expanded by increasing the benefits, aiming to ultimately achieve universal coverage with the same benefits for the entire population. Initially the two regimes were expected to provide equal benefits by 2000, but, for various reasons, it was not achieved and the current aim is to have this implemented by 2010 – especially with the recent (2008) Constitutional Court ruling ordering the government to unify the benefits packages of the CR and SR, and to provide full health coverage to the Colombian population.

1.3 Costs and Administration

The Colombian Ministry of Social Protection oversees the national health insurance system. "The monitoring, inspection, and sanctioning functions of health plans were entrusted to a regulatory body called the National Health Superintendency. A national health insurance fund, referred to as the Solidarity and Guarantees Fund (SGF) was created to pool the system's revenues and distribute them among regimes ... . The National Council for Social Security in Health was created as a policy-making body with

[3] World Bank 2007: 109
[4] The Impact of Subsidized Health Insurance 2005
[5] The Impact of Subsidized Health Insurance 2005
[6] Colombia's Universal Health Insurance System 2009

regulatory and policy making authority over various aspects of the health care system ..." The council was chaired by the minister of social protection. Members included the minister of finance and representatives of various stakeholders, such as employers and workers, public and private health plans, and public and private sector providers."[7]

As mentioned above, the flow of funds are administered by the SGF. This fund receives the contributions from employees in the formal sector and transfers 1.5% of the current 12.5% contributions to the solidarity fund that subsidises the contributions of the poor. Funds for both the SR and CR "are distributed to insurers based upon a risk-adjusted per capita capitation fee. The capitation fee is roughly equivalent to the value of the health package and its administrative costs. The fee was designed to avert adverse selection by providing higher compensation for higher risk clients, factoring in age, sex and geographic area to account for the higher costs of the elderly, women of reproductive age and distant clients."[8] A small fraction of the revenues also goes towards health promotion and prevention activities, as well as sick leave and maternity leave payments. "The remaining revenues were used to pay premiums to contributory regime health plans [as explained above] and claims for payments filed by health plans for medications and procedures not included in the benefits package. Surpluses were invested in government bonds and reserved for future contingencies." [9]

Turning to the structuring of health plans as such, we note that health insurance for employees were mainly provided by public insurers before the 1993 reforms. However, competition from private health plans available on the CR increased significantly over the years. The market share of private health plans increased from 11% to 30% of the population in the CR between 1995 and 1998 alone. By the end of 2004, CR enrolees had a choice between 40 health plans, of which 29 (72.5%) were private plans. Health plans on the CR are free to contract with any providers they prefer. It seems that first level care is mainly contracted with private providers; with a recent trend towards vertical integration where insurance plans own first-level providers of medical care.[10] Health plans in the SR are a bit more complex and experience some problems during the initial phases of the health system – these will be discussed in more detail in the following section.

Table 1 shows the composition and value of national health expenditure as a percentage of GDP for the years 1993, 1997, 2000 and 2003. Although the data is only presented up to 2003, total health spending have stabilised around 8% of GDP since that time.[11] While social security expenditure continually increased and became the largest financing source, private and out-of-pocket spending declined throughout this period. Out-of-pocket expenses decreased from 43.5% of total health expenditure in 1993

[7] World Bank 2007: 110-111
[8] Gender Equity and Health Sector Reform in Colombia 2009: 1147
[9] World Bank 2007: 111
[10] World Bank 2007
[11] World Bank 2007

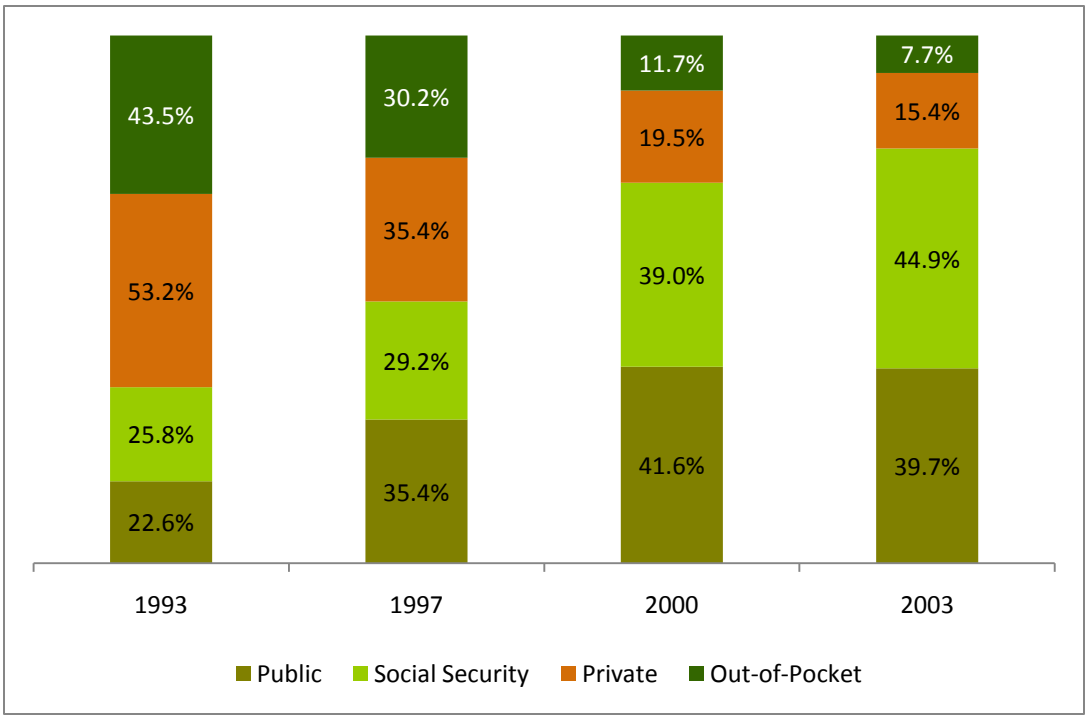
to 7.7% in 2003 (0.6% of GDP). Figure 1 depicts this changing composition of health care expenditure over the period under consideration.

Table 1: Total Health Expenditure as a Proportion of GDP 1993, 1997, 2000, 2003

Spending	1993	1997	2000	2003
% Total expenditure on health / GDP	6,2	9,6	7,7	7,8
% Total public expenditure on health / GDP	1,4	3,4	3,2	3,1
% Social security expenditure on health / GDP	1,6	2,8	3,0	3,5
% Private expenditure on health / GDP	3,3	3,4	1,5	1,2
% Out-of-Pocket expenditure / GDP	2,7	2,9	0,9	0,6
Per capita expenditure				
In current US dollars	112	255	152	136
In constant US dollars (2000 = 100)	102	317	152	111

Source: Adapted from Baron 2007

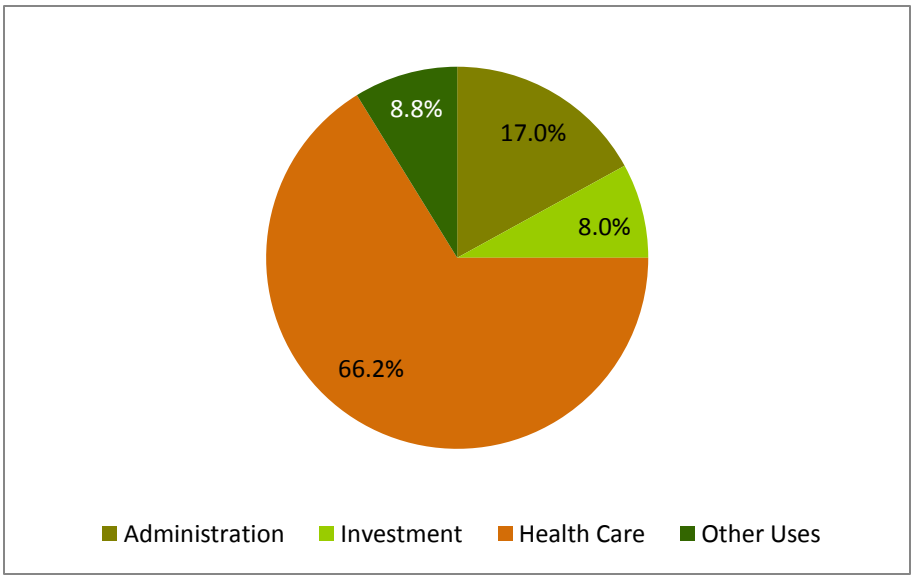
Figure 1: Types of Spending as Proportion of Total Health Expenditure 1993, 1997, 2000, 2003



Source: Adapted from Baron 2007

Important also, is to consider the way health expenditure is used and how exactly the SGF allocates the funds. Figure 2 shows the average share per use of total health expenditure over the period 1996-2003. Even though more than two thirds of the funds are spent on health care, administration costs are very high (17% of the total) and Colombian citizens would definitely benefit from more efficient administration practices, decreasing these costs to the economy.

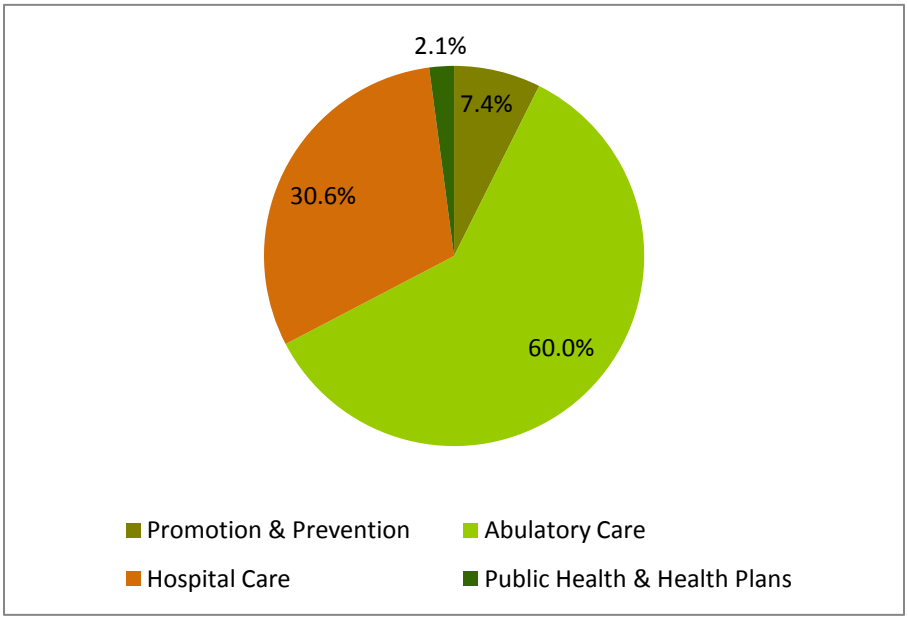
Figure 2: Resource uses, 1996-2003 (average share)



Source: Baron 2007

The following graph (Figure 3) further divides the 66.2% of total health expenditure that is spent on health care, into its different uses.

Figure 3: Distribution of Health Care Expenditure, 1996-2003 (average share)



Source: Baron 2007

1.4 Transition Issues / Growing Pains

As mentioned before, the structuring of health plans serving the SR (called subsidised regime administrators (SRAs)) were somewhat problematic. SRAs, which included non-profit and for-profit private, public and community based non-profit insurers, started operating in 1995. By 1999 there were 239 registered SRAs insuring 22% (9 million) of the population. "The large number of SRAs did not permit adequate risk pooling and generated large inefficiencies, caused primarily by large transaction costs. This motivated the government to issue Decree 1804, which required SRAs to have a minimum of 200,000 enrolees and led to a wave of mergers that reduced the total number of SRAs to 43 by December 2004. Of this total, 45 percent were private, 42 percent were community based, 6 percent were public, and the remainder were health plans for indigenous populations."[12]

Another challenge was the economic recession at the end of the 90's which caused many job losses. This of course decreased contributions to the SGF, while increasing the demand for subsidised health care on the SR. Funds were quickly depleted and benefits on the SR could not be expanded as initially planned. The SGF's balances are further affected by evasion of wage contributions and underreporting of income. "Estimates for 2000 indicated that only 65 percent of potential contributors were actually paying their obligations, and furthermore, those who did contribute paid much less than they should. This could be decreasing the contributory regime's revenues by 35 percent."[13]

Additional problems include the absence of a quality assurance system and insufficient capacity to oversee the quality of service and facilities. Risk pooling in certain less-populated areas is another problem. The transformation of supply-side subsidies into demand-side subsidies has also not gone completely according to plan, and only 50% of what had initially been estimated was achieved by 2000. A host of administrative problems further complicate the efficient working of the health system.

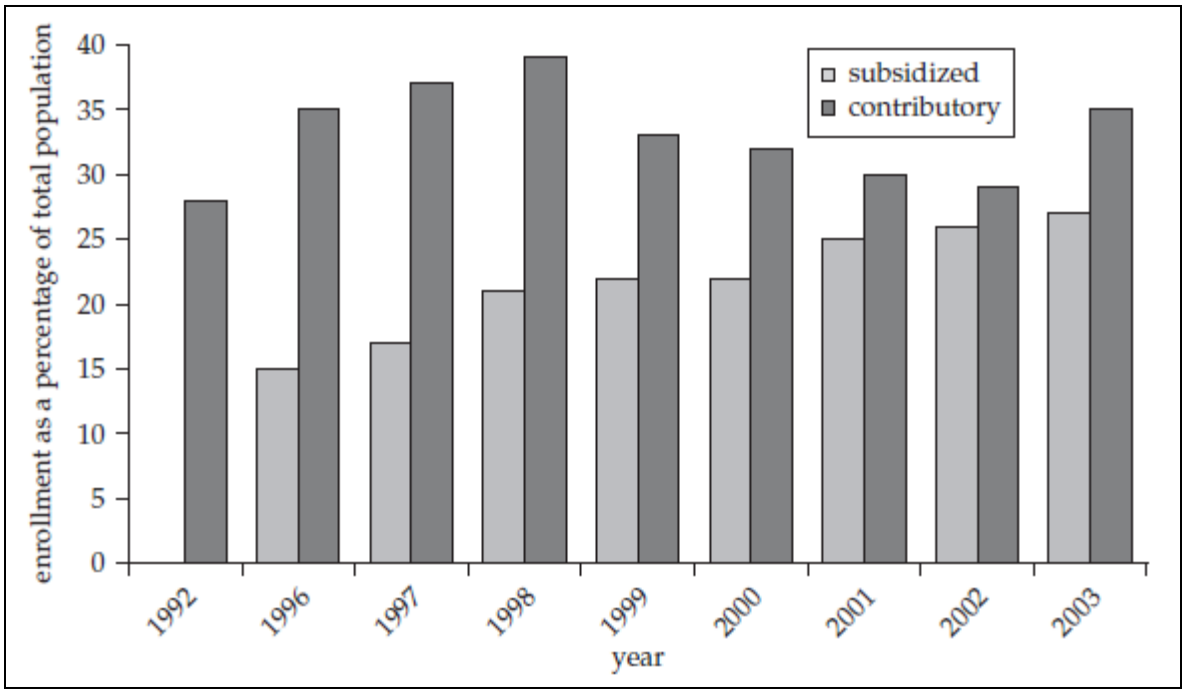
1.5 Coverage and Utilisation

Figure 4 below shows the expansion of coverage from 1992, split between the two regimes. Total coverage increased from 27% of the population in 1992 to more than 63% by 2003.[14] Currently (2009), coverage is estimated to be between 80% and 90% of the population. Especially among the lowest quintile of the population, health insurance coverage have increased dramatically – with 6% covered before the reform to more than 70% being covered by 2007.[15] Giedion & Uribe (2009: 857) confirms that the SR has definitely improved access for the poor over the 10 years before and up to 2005. "Those insured by the SR are approximately 40 percent more likely to have used outpatient visits in the past year

[12] World Bank 2007: 120
[13] World Bank 2007: 126
[14] World Bank 2007
[15] Colombia's Universal Health Insurance System 2009

... and almost have as likely to have experienced barriers to access when needing care ...” They also find that the SR is reducing equity gaps in both insurance coverage and access to services.

Figure 4: Expansion of Insurance Coverage by Regime, 1992 and 1996-2003



Source: World Bank 2007: 114

Ruiz et. al. (2007: 15) also analyse coverage and utilization of Colombia’s health system. They find that “social insurance increases the likelihood of using medical care and reduces the financial burden of health utilization for all studied populations.” They find further that, as expected, access to all types of medical care and services are much better for those insured by the SR, than the non-insured population.