The Incomplete Symphony:
The Reform of Colombia's Healthcare System

Chernichovsky, Dov

Ben Gurion University of the Negev, Israel

Guerrero, Ramiro

Centro de Estudios en Protección Social y Economía de la Salud -- PROESA

Martínez, Gabriel

The Inter-American Conference on Social Security

Draft Final

The authors are indebted to The Inter-American Conference on Social Security (CISS) based in Mexico for initiating this report, and to the World Bank through its support of Centro de Estudios en Protección Social y Economía de la Salud (PROESA). The authors remain solely responsible for the views expressed in this paper.

Executive Summary

With the enactment of *Ley (Law) 100* in 1993, Colombia embarked on a bold reform of its healthcare system. In spite of the implied managerial, economic and political challenges, the country adopted a managed competition model of the Emerging Paradigm (EP) in modern healthcare systems. The implementation of the reform, scheduled originally to complete in 2002, is incomplete. This is evident in a segregated healthcare system comprising two major regimes: the Contributory Regime (CR) covering 40 percent of the population (2009) in the formal economy, and the Subsidized Regime (SR) covering 53 percent in the poorer less formal economy. The CR members are entitled to the benefits package stipulated by the Law: the *Plan Obligatorio de Salud*- POS. The SR members are entitled to a lesser package. The two regimes are also incompatible administratively. The CR has a national structure, decentralized to competing national plans or *Entidad(s) Promotora(s) de Salud* - EPSs. The SR has a Departmental ((Provincial/State) structure, decentralized to local authorities. This political economy reflects and enforces disparities to access to care as well as inefficiencies. These may help explain some of Colombia's relatively inferior health indicators.

The implied economic, managerial and political challenges notwithstanding, Colombia has a credible and visionary model. For one, the POS is not the poor men's (e.g. USA *Medicaid*) package. Hence, the Colombian model, if judiciously implemented, may hold more promise in the long term than those of other countries that may outperform health wise Colombia now. Creating an integrated national healthcare system in which all share the POS -- as opposed to only equalization of the POS in two regimes -- is the cornerstone for the integrated system along the lines of the EP and the Law.

Equalization of entitlement – not system integration -- is to be achieved now in 2012. But, the challenge is formidable, and state's credibility is at stake in this

Draft Final

regard, following a series of laws evidently not implementable, but legislated apparently as if they can substitute legislation.

The unified POS and an integrated system is to be mirrored also by a financial institution – a reformed current financing agency of the CR, *Fondo de Seguridad Social y Garantía*- FOSYGA -- that would pool all mandated contributions including taxes, and allocate them by a modified universal risk adjusted allocation mechanism used in the CR, the *Unidad de Pago por Capitación* – UPC. These institutions can signify a more efficient as well as more equitable healthcare system that the current semi-reformed system.

Resource-wise integration is a formidable task that needs to be planned and managed so as to be realistic, sustainable, and politically credible. Colombia spends on healthcare already an estimated 8 percent of its product, about 70 percent of which is public. These figures resemble parallel figures of developed countries with fully integrated systems. Consequently, financial sustainability of the system is yet another challenge, in view of the costly integration of the system and, not the least, the unparalleled flaw in the system's cost containment mechanism in the form of exception committee and court rulings (*Tutela*) that authorize extra-POS entitlement with dire financial consequences. To be sustainable, ultimately, the financial growth of the Colombia healthcare system must be aligned with the growth of the product, about 2 to 4 percent annually, and benefit from efficiency gains that can follow the completion of reform. That is, keeping the financial envelop of 8 percent of the GDP while raising the public share to about 80 percent, suggests reforming while "converting" some private funding into public. All additional public resources, from changing the public-private funding mix and product growth, should mostly be directed to bring the SR benefit package to that of the POS in the fully integrated system. Pressures to raise the POS, including court rulings, can be potentially answered by privately regulated private insurance.

Yet, Colombia may need to re-consider the managed competition model for peripheral areas where the non-competitive model is likely to be more efficient

Draft Final

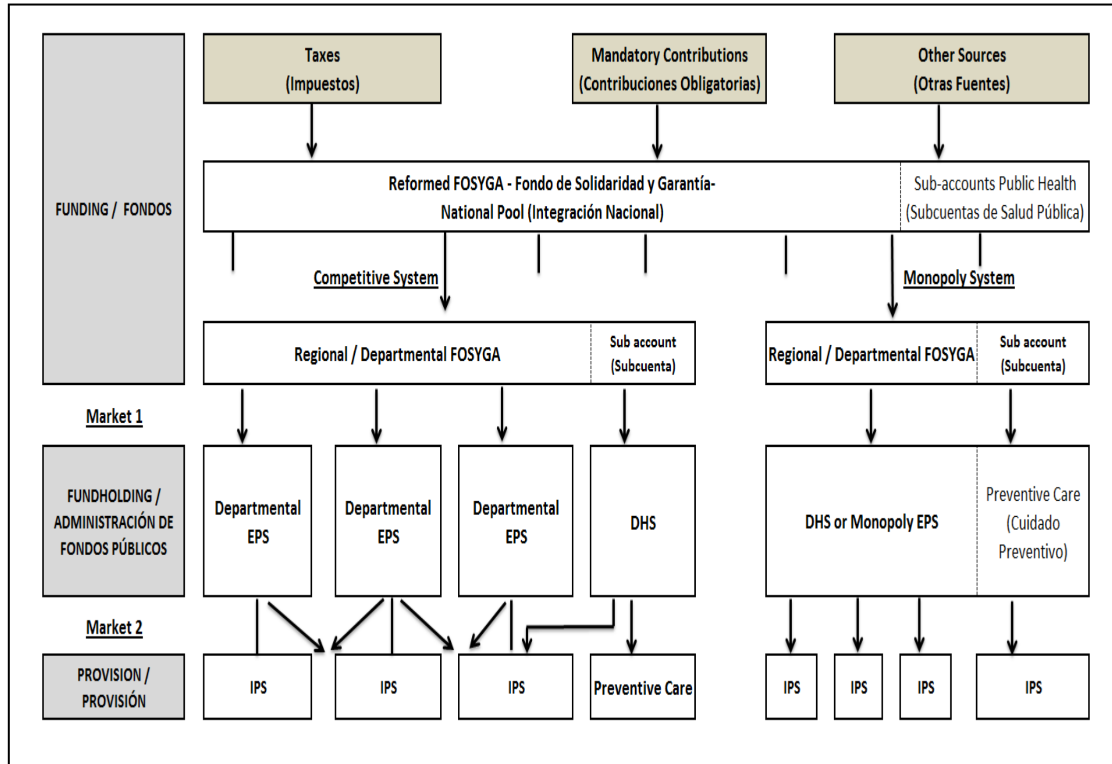
and equitable than the competitive model. For similar reasons, Colombia may wish to entrust health promotion and preventive care to local authorities or other entities with a territorial mandate while delegating all therapeutic care to EPSs, where they are viable. In addition, Colombia needs to consider carefully the options for vertical integration between plans and providers, probably disallowing such integration. The issues involve the financial viability of each institution while encouraging marginal costing, and securing maximum competition and choice in the system.

In general, Colombia may have yet to come to terms with the notion that managed competition is carefully regulated competition. Colombia has incomplete regulation in support of managed competition with regard to several key issues: prices of medical input, quality of care and service, and governance of EPS plans, to reflect the fact they are aims of the state and use public funds.

The fully reformed Colombian system should look as illustrated in the Figure below that is unified, but regionalized, and accommodates – per functionality in different regions – both competitive and non-competitive models.

Draft Final

Structure of Completely Reformed Colombian Healthcare System



a. Legend:

i. EPS – Entidades Promotoras de Salud – Plans (e.g. Organizaciones Para el Mantenimiento de la Salud)

ii. IPS – Instituciones Prestadoras de Servicios – Medical Care Providers.

iii. DHS – Autoridad de Servicios de Salud – Departamental Health Service (Autoridad Independiente)

Contents

1. Introduction 8
2. The Emerging Paradigm Principles and the *Ley 100* 11
~~3.~~ The Colombian Healthcare System – An Overview 14
  a. Coverage and Benefits 14
  b. System Funding and Organization 16
  a. Funding of Care 18
  b. Fund-holding 19
  c. Provision of Care 20
  d. Stewardship and Regulation 20
  e. Key Challenges 21
4. The Universal Coverage and the POS 24
  a. Gaps in Coverage 24
  b. Integration of the Excluded Regime 27
  c. Integration of the Privileged Regime 27
  d. The Universal POS 27
  e. POS Unification Challenge 29
  f. The Challenge of Real Resources 32
5. Funding of Care 34
  a. Integrated and Universal Fundraising 34
  b. Extra POS Funding 35
  c. Pooling public funds 35
  d. The Allocation Mechanism (UPC) 35
  e. Private Insurance 36
6. Health System Organization and management — the Fund-holding Perspective 37
  a. Resolving the National Decentralization Gridlock 37

Draft Final

b. Decentralization in the Healthcare system 38

c. Preventive Care and Health Promotion (PC&HP) 43

d. Vertical Integration between fund-holding and provision 44

7. Stewardship and Regulation 47

a. The Market of Medical Inputs 47

b. Quality of service and care 47

c. Governance of EPS 48

d. Stewardship 49

8. The Reformed System 50

9. References 51

Draft Final

The Incomplete Symphony:

The Reform of Colombia's Healthcare System[1]

Chernichovsky, Dov
Guerrero, Ramiro
Martinez, Gabriel

Draft Final

1. Introduction

With the enactment of the *Ley* 100 (hereafter referred to as the Law) in 1993 (Congreso de la República de Colombia [CRC], 1993b), Colombia embarked on a bold and visionary reform of its healthcare system.

The country – with a population of approximately 46.3 million (2010)[2] living on a land mass of 2,070,408 km^2 [3] — embraced the goals and related funding and organizational principles of the emerging paradigm (EP) in developed healthcare systems (Chernichovsky 1995a, 1995b; Frenk and Londoño, 1997). Colombia adopted the managed competition variant of this paradigm that is best represented by the healthcare systems of Germany, Israel and the Netherlands (Chernichovsky, Donato, Lebowitz et al., 2012). Contrary to these countries, however, whose systems evolved over decades, Colombia opted for "big bang" — an immediate sweeping institutional reform. Not surprisingly perhaps, the implementation of the reform, originally to end in 2002, remains incomplete.

The recent history of the Colombian healthcare system is well documented by Glassman, Escobar, Giuffrida and Giedion, (2009); Yepes, Ramirez, Sánchez, et al, (2010), and Bernal, Forero and Forde, (2012). Especially considering the country's level of development, even by today's standards as indicated by the

[1] We are indebted to Ms. Diana Isabel Osorio Cuevas for her helpful assistance.
[2] World Bank. Online at: http://data.worldbank.org/country/colombia. Accessed: 9 December 2011.
[3] ProExport Colombia. Online at: http://www.colombiaespasion.com/es/asi-es-colombia/26-colombia-en-cifras/284-superficie-y-poblacion. Accessed: 9 December 2011.

GDP per capita, about $8,487 in Purchasing Parity Power- PPP terms (2010)[4], one might have questioned the viability of the reform on several grounds. The first concerns the wisdom of launching a challenging, managed competition-oriented reform given the country's limited economic, medical, and managerial resources. The second involves the political *naiveté* about the sustainability of the political economy needed to see this reform through even in a decade. The third concerns the consistency of this reform with the parallel governmental and budgetary decentralization process initiated by the *Ley* 60 in 1993 (CRC, 1993a) about the same time *Ley 100* passed. The last but not least issue has been a lack of full realization in Colombia that managed competition is not free market competition.

These issues notwithstanding, the positives and lessons of the reform need to dominate Colombia's healthcare system policy today. The country has a clear and credible system design which is visionary, legislated already, and benefits from a political commitment. And, even if not fully implemented yet and beset by considerable challenges, the system has seen achievements in health as well as in income protection that run in tandem with practically universal coverage to basic care funded by tax and mandated non-tax contributions (Glassman, Escobar, Giuffrida and Giedion, 2009).

This paper examines the structural challenges Colombia needs yet to meet in order to complete the reform initiated two decades ago, by continued alignment with the fundamental features of a developed healthcare system, and its own law. Accordingly, the paper is organized as follows. In the next section we present the EP, the benchmark and framework for reviewing and studying the healthcare system. Then, in the third section, we introduce the Colombian system, and its general reform needs. The discussions of specifics follow, in order, in sections four through seven. These are organized by the functional grouping of the EP principles that concern entitlement, funding, fund-holding, provision of care and

[4] World Bank. http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.KD. Accessed: 9 December 2011.

Draft Final

stewardship. We summarize the discussion in section eight by suggesting a general implementation approach — the ‘next steps’ Colombia might follow.

Draft Final

2. The Emerging Paradigm Principles and the *Ley 100*

The Law aims to establish in Colombia an integrated healthcare system that is in line with the collective experience of developed healthcare systems, not including the United States (U.S). This experience is labeled here as the Emerging Paradigm (EP) (Chernichovsky,1995a,1995b, 2002; Chernichovsky, Donato, Leibowitz, et al 2012).

By this paradigm, developed systems optimize people's health and satisfaction with medical care subject epidemiological circumstances, sustainable resources, and medical technology. To this end, these countries attempt to advance and balance a set of intermediate, at times competing, proximate objectives: equity; cost containment; efficient delivery of quality care (as a condition for efficient production of health), a wide choice of care and providers. To achieve those, countries with developed healthcare systems adhere to a common set of entitlement and related funding and organizational principles. These are:

1. Universal entitlement to a common set of "core" medical benefits (CB).
2. Eligibility and the right of access to these benefits is based primarily on health and medical conditions and indications; it does not vary by work status, place of work, political affiliation, or the level of an individual's financial contributions or those made on his behalf.
3. Contributions to fund the CB are mandatory and commonly related to means or income, but do not necessarily take the form of state taxes; some or all contributions, including employers', may take the form of Social Health Insurance contributions, earmarked for healthcare. Like taxes, these contributions are universally mandatory, without opting out[5].

[5] Among developed healthcare systems, only Germany allows its upper-most income centile to "opt out".

Draft Final

4. Need-based entitlement is synchronized with the mandated contributions, which are unrelated to need,, through national pooling of these contributions.
5. The mandated pooled contributions comprise the healthcare budget to fund entitlement.
6. The employer's role in the context of the healthcare system is largely limited to that of a collection agent.
7. Private funding, out-of-pocket payments, and voluntary medical insurance, often regulated, are available to pay for extra benefits above CB.
8. The distribution of pooled funds is to fund holders, which can be either a non-competing monopsony state administration, or competing plans[6].
9. The distribution of pooled funds is commonly by a universal risk-adjusted (capitation) mechanism.
10. Medical care is supplied by public private, and not-for-profit providers who, depending on the arrangement, are contracted in different ways by the competing or non-competing fund-holders or a state administration in a fund-holding capacity. Participating providers must accept every patient, in accordance with the plans or fund-holders' provisions.
11. The state regulates the market, in addition to the implied above, mainly with regard to quality of care, medical input prices, and

Draft Final

[6] Fund-holding involves organizing and managing care consumption (OMCC) of entitled benefits for a defined population, and then purchasing or commissioning this care accordingly (Chernichovsky, 1995a, 1995b; Figueras, Robinson, Jakubowsky et al. 2005). Fund-holders also can perform an agency role for consumers by addressing information asymmetries between patients and providers, and acting as a countervailing power to providers' monopoly powers over patients (Chernichovsky, 2002; Frenk and Londoño, 1997). The common approach, associating just 'purchasing' with fund-holding is, therefore, simplistic.

> investments. A key regulation concerns open enrollment. Where applicable, the plans must maintain open enrollment; during set periods, they must accept every applicant who desires to change a plan.

Colombia adopted the “soft single payer” variant of the EP whereby the funding of entitlement combines earmarked mandated contributions with general tax revenues, and on fund-holding based on managed competition (Chernichovsky, Donato, Leibowitz, et al, 2012).

The countries that adhere to the EP have the highest health performing systems; by life expectancy on the one hand, and spending on the other (Chernichovsky, 2009). As for the latter, these countries, not including the USA, spend 8 to 9 percent of their GDP on healthcare, 70 to 80 percent of which is considered public, including earmarked mandated contributions (Chernichovsky, 2009). These percentages have emerged as rather common equilibrium shares.

Draft Final

~~3.~~ The Colombian Healthcare System – An Overview

The incomplete implementation of the reform of the Colombian system has resulted in a segregated healthcare system comprising two major regimes: the contributory regime (CR) covering 40 percent of the population (2009), and the subsidized regime (SR) covering 53 percent (Melo and Ramos, 2010). Two additional 'residual' regimes divide about evenly the rest of the population. The first comprises households not enrolled altogether in any social health insurance arrangement, the excluded regime (ER). The second comprises groups -- public school teachers, workers of public universities, military, and police officers that have their own social health insurance arrangements -- the special regimes (*Regímenes Especiales* or *Privileged Regime-PR*).

Affiliation with the contributory regime (CR) is mandatory for all formal sector workers, self-employed who are able to pay, and pensioners. Supplementary insurance is discretionary and cannot substitute mandated contributions (Guerrero, 2008).

Affiliation with the SR is based on a means test called SISBEN (*Sistema de Identificación de Beneficiarios*). In practice, this regime covers almost the entire population not enrolled in the contributory scheme or the SR and ER.

a. Coverage and Benefits

Enrollment in the SR has expanded gradually since the mid-nineties, reaching the percentages cited above. As of 2010, only 4 percent of the population was uncovered; these include those above the poverty line who cannot afford the contribution or who are self-employed who evade the system (Guerrero, Gallego, Montekio and Vásquez, 2011). Colombia has thus achieved almost universal coverage but in a segregated system, marked – among other things – by unequal benefit packages.

The Law stipulates a benefits package -- the *Plan Obligatorio de Salud* (POS) -- that lists three levels of care. The first includes preventive and emergency care, basic medical, dental, and diagnostic services. The second and third levels include specialized and rehabilitative care, hospitalization, and diagnostic tests.

Draft Final

The CR package covers all levels. The SR package covers catastrophic and primary care, but has limited coverage for hospital care (Glassman, Escobar, Giuffrida and Giedion, 2009). Catastrophic care is a separate category that covers all. Members of the ER are entitled to treatment in public hospitals.

The Law stipulates a gradual scaling up of all benefits to the more comprehensive CR POS package. Recently, the government has announced unification of the POS as of July 1st, 2012 (Comisión de Regulación en Salud [CRES], 2012). It should be emphasized that this unification in itself does not signify the integration of the system.

Separately from the POS, public health services delivered to the community (e.g. sanitation, vector control) are under the responsibility of municipalities.

Work-related accidents and diseases are covered separately from the POS by an insurance policy that employers are required, by law, to purchase. Medical care for road traffic injuries is taken care of by mandatory automobile insurance.

Occasionally, doctors prescribe care not included in the POS. In the Colombian Plans -- *Entidades Promotoras de Salud (*EPS)[7], there are exception committees called CTC (Comité Técnico Científico) that can authorize this care (CRC, 2011, Art. 26). In addition, citizens can claim this care in the courts invoking the right to health care, which is protected by the constitution. There is an expedited legal action, called *TUTELA*, to protect these fundamental rights, which has to be ruled within a few days. The Constitutional Court classified the right to health as fundamental and opened the door for the *TUTELA* to be used for claiming non-POS services.

Indeed, in 2008, a Constitutional Court (The Court) ruling ordered the government to update the content of the POS, and to do so with participation of stakeholders (Corte Constitucional, 2008). Although there have been inclusion of technologies, particularly after 2004. In December 2011, there was a significant

Draft Final

[7] EPS are defined more extensively in Section 3 .Basically the EPS are plans akin to American-type Health Maintenance Organizations (HMOs) and European-type sickness funds.

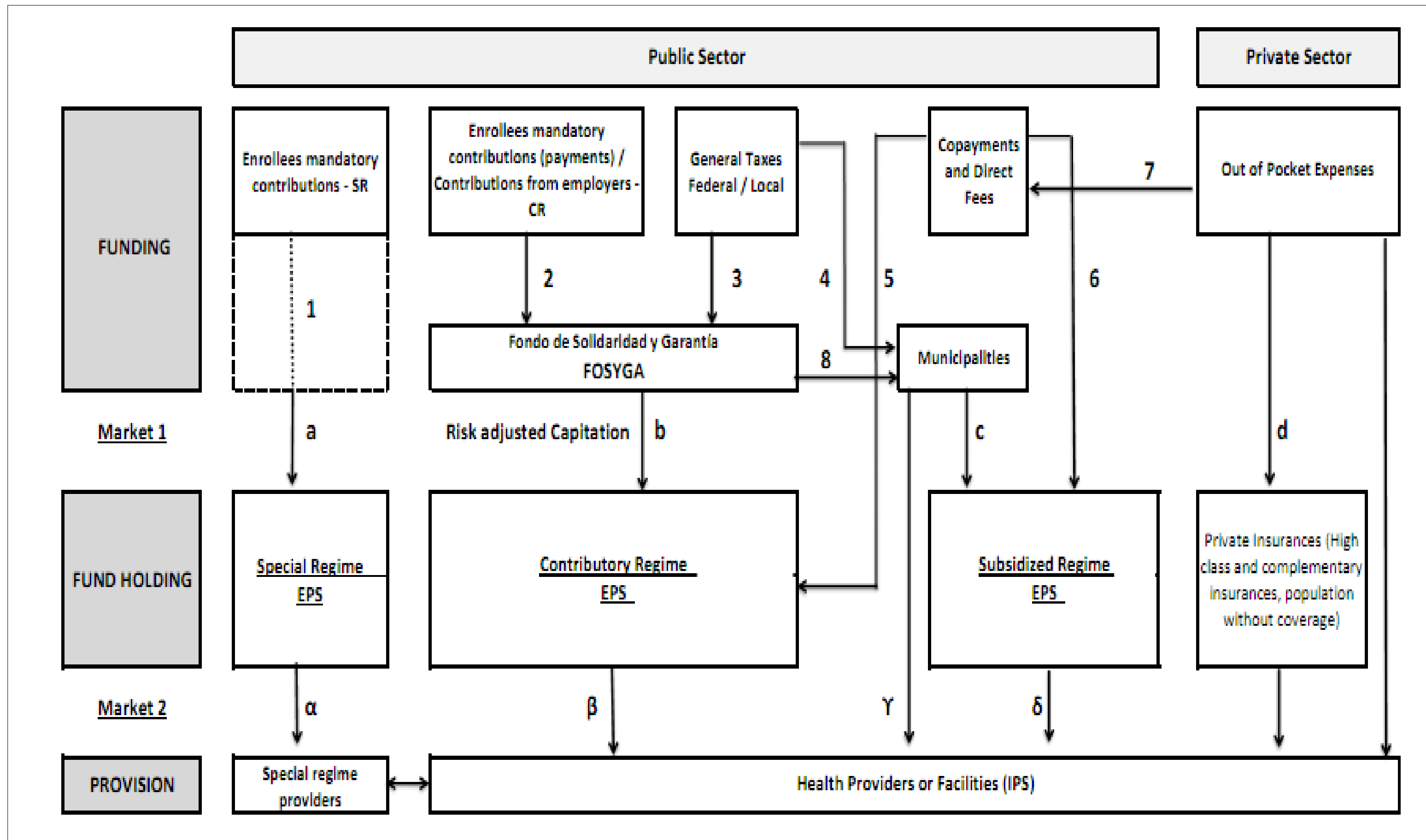
update, and it remains to be seen how it will be interpreted by the Court (CRES, 2011).

b. System Funding and Organization

The system is further discussed the aid of Figure 1 which portrays institutions by the basic functions of the system: funding -- fundraising, pooling, and allocation; budget-holding -- organization and management of care consumption (OMCC) and purchasing; and provision of care. The functions are separated by two potential internal markets (Chernichovsky 1995, 2002).Privately funded care — through private insurance and out-of-pocket pay (right panel of the Figure 1) — is, by and large, provided by the same institutions that provide entitled care. The discussion focuses on that part of the public system which is based on mandated contributions of all kinds, including the PR (on the left panel).

Draft Final

Figure 1. The Colombian Healthcare System



c. Funding of Care

Levels of public spending in Colombia (including mandatory payments) are well established at about 5.0 percent of the GDP (Melo and Ramos, 2010). At the same time, estimates of the levels of private spending are disputed. These range from 0.6 percent to about 4 to 5 percent of the GDP.[8] The lower estimate suggests that Colombia spends 5.6 percent of its GDP on healthcare, of which 90 percent is public. By the upper estimate, the corresponding figures are 10 of the GDP, of which 50 percent is public.[9]

For the discussion here, we assume that Colombia spends 8 percent of the GDP on healthcare. Sixty five (65) to seventy (70) percent of this is public. These shares are generally on par with the averages of the 22 developed countries identified with the EP (Chernichovsky, 2009).

Funding for the CR (top center panel) is from payroll contributions of employers and employees and general taxations (lines 2 and 3). The contributions are 12.5 percent of the wage bill (Clavijo, 2009). The self-employed pay the full 12.5 percent on 40 percent of their gross income. Regardless, however, the contribution has to be at least 12.5 percent of a full-time monthly minimum wage (in 2010, approximately US$260). Thus, self-employed workers earning a minimum wage cannot claim the aforementioned deduction, and for those working less than full-time or earning less than a monthly minimum salary contributions (as a share of income) can become very high or prohibitive. This

Draft Final

[8] Out-of-pocket (OOP) expenditures, according to estimates based on the LSMS survey, for the National Health Accounts (Barón, 2007), are only 0.6 percent of GDP. Estimates by Fedesarrollo in 2010, based on more recent rounds of the survey, are slightly over 1 percent of GDP. However, comparisons with other sources of data (Guerrero and Hails, 2008) suggest that the surveys might be seriously underestimating these expenditures. Work in progress by the World Bank estimates household expenditures in health in Colombia, which comprise not only OOP, but also insurance premiums, and arrives at figures that are 4 to 5 orders of magnitude higher (as a share of GDP). The OOP/GDP ratio estimated in the Colombian NHA is also extremely low when compared internationally.

[9] Either way, by the norms associated with the EP (Section 2), Colombia is in a financial bind. Either it spends too much publicly by the first estimate, or too much of the GDP by the second. And this is before the country has an integrated and unified system.

group probably includes the members of the ER who are not in the CR but may not qualify for the SR.

All CR funds are pooled by a central state fund, the *Fondo de Solidaridad y Garantía* (FOSYGA) . Most of these funds are allocated to EPS's or plans according to their membership through an age-gender risk adjusted capitation mechanism — *Unidad de Pago por Capitación* (UPC) as indicated by line b in the figure (Guerrero, 2008).

EPS's can receive additional revenue by charging co-pays for hospital and ambulatory care (lines 5, 6, 7). Such charges are based on rates regulated at the national level and are income adjusted. In addition, EPSs plans are reimbursed retroactively on a fee-for-service basis for all services approved exposed by *TUTELA* and the exception committees.

Funding for the SR is from general revenues (lines 4 and 8in figure 1) and the subsidy from the CR coming through the FOSYGA solidarity sub-account (line 8).

Funds for this regime are pooled mainly at the municipality level (line 4).[10] Ten percent of the funding is for public health activities (SGP).[11] The main item of funding here is for paying to plans (EPSs) that SR affiliates enroll with (line c).[12]

In the SR, the capitation rate that plans receive has been flat although it should also be risk adjusted. SR members bear copayments only for hospital care.

4. Fund-holding

Managed competition is a basic feature of the system. Consequently, beneficiaries in the different schemes select freely among competing plans, which may be managed and operated by public or private EPSs or plans.

Draft Final

[10] In some cases (especially small municipalities) the function of the municipality is fulfilled by the Department (provincial) government.

[11] Departamento Nacional de Planeación (DNP), República de Colombia. Online at: http://www.dnp.gov.co/Programas/DesarrolloTerritorial/FinanzasP%C3%BAblicasTerritoriales/Hist%C3%B3ricodeParticipacionesTerritoriales.aspx.Accessed 9 December 2011.

[12] Recent delays in the flow of SR funds have led to new regulations that allow for the direct transfer of resources to the plans and even the providers, skipping the municipalities.

Normally, enrollees must wait one year in an EPS before switching to another of their choice.

In the SR, local authorities are entrusted with budget-holding for the SR package as well as with the budget for public health and health promotion activities. While these authorities can contract with EPS's for the SR benefits, they can contract services directly with providers, some part of the same authorities.

5. Provision of Care

EPS may choose to deliver the services directly in their own facilities and by salaried staff (lines marked by Greek letters in Figure 1). By regulation they can do so with up to 30 percent of the value of services. Generally, EPSs select a network of providers, the *Instituciones Prestadoras de Servicios* (IPS), based on price and quality. Mostly, however, EPSs do not necessarily choose providers based just on price, but rather on the option for a network of providers offered.. Similar arrangements exist for the Special Regime.

Both public and private plans may select both public and private providers to be a part of their network. In the SR, the EPSs are obliged to contract at least 60 percent of the value of services with public providers if the latter comply with certain quality and capacity conditions.

There is a transitory system of public providers that provide care to the uninsured who are not yet part of the SR or CR. This system is financed primarily from national budgetary transfers.

6. Stewardship and Regulation

Colombia has opted for a managed competition EP model. The discussion thus far suggests substantial stewardship and regulatory powers by the central government that involves entitlement, funding, and system organization and management.

Draft Final

7. Key Challenges

Based on the discussion above, the Colombian healthcare system faces some key challenges to be addressed in order to align the system with the EP or, for that matter, with the principles of Ley 100. Table 1 provides a summary of these issues. Accordingly, Colombia needs to accomplish the following fundamental reform steps:

- Integrate the system by
  - making the POS universal
  - pooling all mandatory and tax-based contributions into a single reformed national FOSYGA fund.
- Reorganize its fund-holding functionally
- Establish a modern universal risk adjusted allocation mechanism.
- Regulate private insurance to complement entitlement.
- Strengthen a regulatory framework in support of the integrated system by regulate wages, prices, investments, and contracts mainly between EPS's and IPS's.

The issues and potential solutions to achieve the above are outlined in the sections that follow.

Draft Final

Table 1. The EP Principles and Colombia's Deviation from Them

EP Paradigm Principle		Colombia's Deviation
1	Entitlement to a common set of "core" medical benefits (CB) is universal.	-Privileged regime is not integrated with the intended CR universal system. -Covered populations have uneven entitlement.
2	Eligibility and right of access to these benefits is based primarily on medical condition and indication, and does not vary by work status, place of work, political affiliation, or the level of an individual's contributions or those made on his behalf.	-Entitlement and eligibility varies by income /employment status as well as level and type of contribution.
3	Contributions to fund CB are mandatory and commonly related to income, but do not necessarily take the form of state taxes; some or all contributions, including employers', may take the form of Social Health Insurance contributions, earmarked for healthcare. The mandated contributions are universal, without opting out.	-Excluded Regime members opt out for a variety of reasons, including imperfect enforcement of the obligation to contribute for self-employed workers and wealthy individuals who choose not to work. More importantly, there might be many SR enrollees who would have the capacity to contribute and evade the system.
4	Need-based entitlement is synchronized with the mandated contributions, which are unrelated to need (actual or expected), through national pooling of these contributions that are, in turn, distributed nationally, commonly by a universal risk-adjusted capitation mechanism. National pooling can be virtual.	-The different sources of mandatory funding national and local taxes, plus employers' and employees' mandatory contributions are pooled nationally only for the CR, not the SR.
5	The mandated contributions comprise the healthcare budget to fund entitlement.	- *TUTELA* and other ruling reduce substantially cost containment efforts and budgetary discipline.
6	The employer's role in the context of the healthcare system is largely limited to that of a collection agent.	

Draft Final

7	Private funding, out-of-pocket payments, and voluntary medical insurance, often regulated, are available to pay for extra benefits, above CB.	-No regulation of private insurance as to complement public funding and entitlement (e.g. open enrollment and community rated premiums for cross subsidies).
8	The distribution of pooled funds is to fund holders, which can be either a non-competing monopsony state administration, or competing plans. The organization of fund holding reflects the system's philosophy about competition, viability of competition, healthcare policy and priorities.	-There are two basic types of fund-holders differentiated by the system´s regimes, not by functionality or by type of medicine or feasibility of managed competition.
9	The distribution of pooled funds is commonly by a universal risk adjusted (capitation) mechanism.	-Different allocation mechanisms are used for different regimes.
10	Medical care is supplied by public, private, and not-for-profit providers who, depending on the arrangement, are contracted in different ways by the competing or non-competing fund-holders or a state administration in a fund holding capacity. Participating providers must accept every patient, in accordance with the plans´ or fun holders´ provisions.	-Vertical integration between plans-EPS and provider-IPS remains an unresolved regulatory issue.
11	The state regulates the market (in addition to the implied above) mainly with regard to quality of care, medical inputs prices, and investments. A key regulation concerns open enrollment. Where applicable, the plans must maintain open enrollment; during set periods, they must accept every applicant who desires to change a plan.	- A lack of effective regulation of the medical input prices. - A lack of effective regulation of investments in the system - No clear regulation of providers on how they provide services to members of different regimes, to avoid discrimination and cost-shifting

Draft Final

8. The Universal Coverage and the POS

The Colombian approach to coverage and level of entitlement must be seen in perspective, for its uniqueness and vision. The Law stipulates the POS that is not a minimum poor man's package. Colombia did not opt for a "Medicaid" (USA) or a "Seguro Popular" (México) arrangement that would have meant that the entitlement of the SR regime is the universal package. Hence, Colombia assumed at the outset a formidable challenge: to provide the entire population with the package available to the formal sector or to the middle class and beyond.

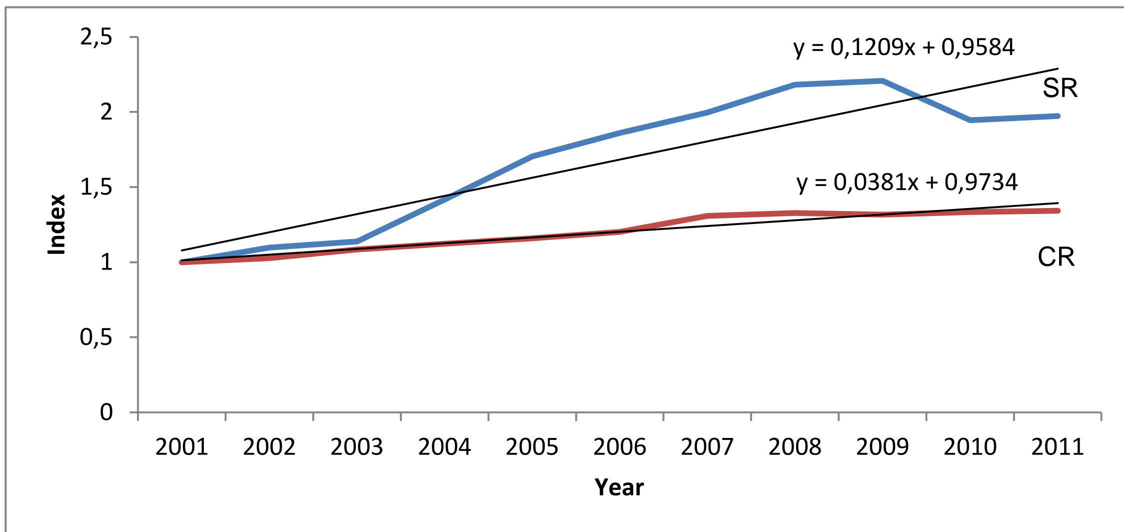
a. Gaps in Coverage

Colombia reached practically universal coverage by increasing membership in the SR by about 12.0 percent annually during the previous decade, while maintaining an average 3.8 percent growth rate for the SR (Figure 2). Simultaneously, it increased the value of benefits faster in the SR than in the CR, 11 percent as opposed to 8 percent (Figure 3).

Considering the situation and resource limitations, this policy is noteworthy by its consistency with the EP philosophy in that, by the fairness principle underlying universality, the policy has given preference to widening coverage and entitlement to the underprivileged regime (Chernichovsky, 2012a). The remaining challenges are, thus, to close marginal gaps in coverage, to include the PR in the universal system, and mainly to unify entitlement to the POS.

Draft Final

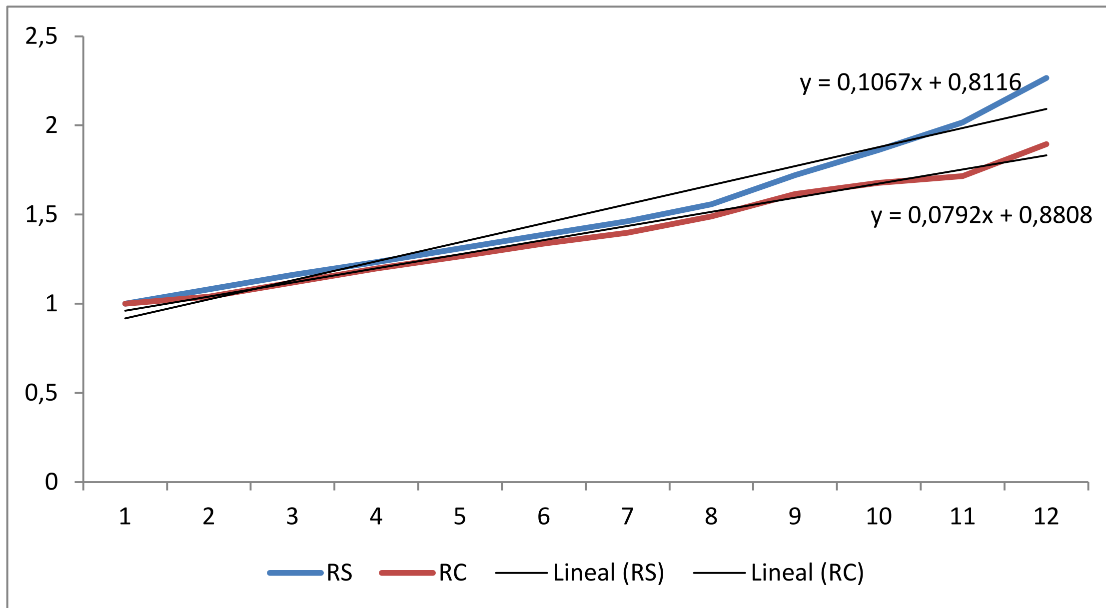
Figure 2. Index of Increase in Membership (Not Risk Adjusted) by Regime. 2001-2011



Source: Melo and Ramos (2010). Chart 1, page 4 and Chart 3, page 8, and ECV (2010 y 2011)

Draft

Figure 3. Index of Increase in Benefits by Regime. 2001-2012



Source: Melo and Ramos (2010). Chart 1, page 4 and Chart 3, page 8, and ECV (2010 y 2011)

Draft

b. Integration of the Excluded Regime

An estimated 4 percent of the population, about 2 million people, comprises the excluded Regime (ER)[13]. This group is outside the public system either by choice, by practically opting out, or by not qualifying for the SR because of informal employment and "insufficient poverty". Even for the short-term, a there is a need to enforce participation in the CR of those who can contribute bu opt out, and to make it possible to include those who are not poor enough but are at risk of poverty. Those groups should however be integrated in the CR and not the SR as an initial step in system unification and the integrating of the SR in the CR.. .

c. Integration of the Privileged Regime

Although allowed in the Law (see section 3), the arrangement for the privileged regime (PR) is not consistent with the principles of the EP as they defy equity and efficiency objectives.

As the arrangements of the PR imply privileges above the POS, the solution is to make members of these groups part of the CR. Extra contributions and benefits – above those stipulated by the CR arrangements -- can be turned into intra-group supplemental insurance managed at the groups' discretion.

d. The Universal POS

Colombia is beset by disagreement about the composition of the POS and its update. Clearly, the country needs to resolve this issue before proceeding to make the POS available to the entire population and proceeding with other aspects of reform. According to Melo and Ramos (2010), the SR package is valued at 57.3 percent of the POS as opposed to 53.7 percent in 2009.

The POS has been "discredited" for several reasons: i) The package is rightly or wrongly perceived as "outdated", considering available medical technology; ii) Rules about entitlement are controversial; and, hence, iii) Services are often

[13] The 2011 Living Standard Measurement Survey (LSMS) suggests that this group is 9 percent of the representative sample (Chernichovsky, 2012b)

Draft Final

denied by EPSs, but then successfully challenged by patients in the Exception Committee and the courts (the *Tutela*).

- Coverage in the population.
- Types or categories of included medicine.
- Forms of care or treatments within types of medicine.

The first refers to the size and nature population covered by publicly supported care. Even where there is real universal coverage, some segments of the population may not qualify for particular entitlement for reasons other than medical. This is the case for members not included in the CR and ER.

The second dimension concerns general categories of medicine such as elective cosmetic surgery, dental care, and long-term care, to mention several common cases excluded from medical entitlement in developed healthcare systems. In Colombia, elective cosmetic surgery, for example, is excluded from the POS.

The third dimension concerns specific broadly defined treatments or technologies. It may be the case that people qualify for general types of care or pathology, say, treatment of a particular cancer, but not for a specific technology or drug available for treatment. In fact, in 2011 the government announced that all pathologies will be included, implying that the limits to the content will not be by disease by kind of care or technology.

Colombia needs to adopt the practice common in developed healthcare systems to specify the positive / negative specification of entitlement concerns particular dimensions of coverage and entitlement (Chernichovsky, Donato, Leibowitz et al. 2012) in the following manner:

- Positive inclusion criteria for the first dimension, such as the qualifying criteria for the POS, eventually dismissing all non-medical criteria by principle No. 1 of the EP.

Draft Final

- Negative exclusion criteria for the second dimension as mentioned above, for example, with regards to elective cosmetic surgery.
- Positive inclusion lists for the third dimension, specifying rather explicitly the technologies and types of treatment in entitled categories of care.

Although the design of the POS has broadly followed these lines on paper, they have not been fully applied in practice because of the exception committees and judicial decisions.

Regardless, whether Colombian policymakers and administrators wish to examine the existing entitlement or are considering new entitlement, there is need a consensual institution and mechanism for prioritizing entitlement by all dimensions, and for deciding on exclusion and inclusion criteria that serve the goals and objectives of the healthcare system, and available budgets, including private insurance options.

To this end, if Colombia is to follow the other countries, the executive and the Judiciary need to take a snapshot of the CR at the end of 2012. Once the 2012 Package is defined, work should concentrate on the guidelines for updating this package, considering the implications from unifying the package, the growth of the economy, and the State budget as discussed below. By this strategy, as in other countries, over time a social basket evolves gradually from incremental decisions that shape a new whole.

e. POS Unification Challenge

Decisions about the three dimensions of entitlement mentioned above are usually subject to the same public budgetary envelope, and, therefore, need to be considered in tandem. Extending coverage and definition and unification of POS need to be part and parcel on one strategy.

The Government of Colombia announced unification of the POS in mid 2012, correcting a previous target date: the end of 2013. This ambitious target poses a

Draft Final

grave risk to the government with regards to the already tarnished legitimacy of rulings about the POS.

Table 2 shows the implied growth rate of the SR basket and the years needed for the SR basket to match the CR basket, when the latter is growing at selected annual rates. For example, if the SR grows at a 0 percentage rate, and unification is instant, one year, as proposed, the SR basket needs to grow by 56 percent per capita, Table 3 shows the corresponding implied annual growth rate per capita of entitlement for Excluded Regime (ER), if they are to be entitled to the unified package.[14]

Table 4 shows the budgetary implications of the simulated scenarios shown in Table 2 and 3 assuming an annual population growth rate of 1.6%. The simulation suggests that Colombia can achieve complete universal coverage with POS level entitlement in one year, provided the POS does not grow during this period, with a budgetary increase of 193 percent, or doubling the public budget.

Draft Final

---

[14] The computation is based on a 1 peso entitlement per capita today, and that entitlement to this group materializes on day of unification.

Table 2. Required Annual Increase in SR Basket per (not standardized) Capita by Annual Rate of Increase in CR Basket and Years to Unification of Baskets

Years to adjust	Percentage Change in Contributory Basket					
	0.0%	1.0%	2.0%	3.0%	4.0%	5.0%
1	56%	57%	58%	59%	60%	61%
2	28%	29%	30%	31%	32%	33%
3	19%	20%	21%	22%	23%	24%
4	14%	15%	16%	17%	18%	19%
5	11%	12%	13%	14%	15%	16%
6	9%	10%	11%	12%	13%	14%
7	8%	9%	10%	11%	12%	13%
8	7%	8%	9%	10%	11%	12%
9	6%	7%	8%	9%	10%	11%
10	6%	7%	8%	9%	10%	11%

Table 3. Required Annual Increase in ER Basket per (not standardized) Capita by Annual Rate of Increase in CR Basket and Years to Unification of Baskets

Years to adjust	Percentage Change in Contributory Basket					
	0.0%	1.0%	2.0%	3.0%	4.0%	5.0%
1	532%	533%	534%	535%	536%	537%
2	266%	267%	268%	269%	270%	271%
3	177%	178%	179%	180%	181%	182%
4	133%	134%	135%	136%	137%	138%
5	106%	107%	108%	109%	110%	111%
6	89%	90%	91%	92%	93%	94%
7	76%	77%	78%	79%	80%	81%
8	66%	67%	68%	69%	70%	71%
9	59%	60%	61%	62%	63%	64%
10	53%	54%	55%	56%	57%	58%

Table 4. Required Annual Increase in Total Public Budget for Unification of Baskets (including all mandated contributions)

Years to adjust	Percentage Change in Contributory Basket					
	0.0%	**1.0%**	**2.0%**	**3.0%**	**4.0%**	**5.0%**
1	193.7%	195.2%	196.6%	198.1%	199.6%	201.1%
2	140.3%	141.4%	142.4%	143.5%	144.5%	145.6%
3	126.0%	126.9%	127.9%	128.8%	129.8%	130.8%
4	119.4%	120.3%	121.2%	122.1%	123.0%	124.0%
5	115.6%	116.5%	117.3%	118.2%	119.1%	120.1%
6	113.2%	114.0%	114.9%	115.7%	116.6%	117.5%
7	111.4%	112.3%	113.1%	114.0%	114.9%	115.8%
8	110.1%	111.0%	111.8%	112.7%	113.5%	114.4%
9	109.2%	110.0%	110.8%	111.7%	112.5%	113.4%
10	108.4%	109.2%	110.0%	110.9%	111.8%	112.6%

Comments: It is assumed that the entire populations 0-18 and 65 and above already have access to the POS. The Specialized Regime is included in a "neutral" way; they are added to the population to be covered, but their POS budget is included in the public budget.

Draft

f. The Challenge of Real Resources

Availability of funding is a necessary but insufficient condition for unifying the packages. Increasing demands for care through widening entitlement that is not matched by adequate supplies of real resources will result in wasteful inflationary pressures on medical costs as well as deterioration of quality of care and service.

Assuming, quite simplistically, that all input increases proportionally to the budgetary requirements simulated in Table 4, Colombia will need in three years, with a zero growth rate of the CR package, a 26 percent annual increase in financial resources. This means an annual increase of about 17,000 in the number of MDs and about 11,000 in number of beds. While actual numbers may be considerably lower due to economies of scale and efficiency gains, the challenge is formidable.

In addition, the required quality of the additional services is higher since the aligning the SR with the CR means also a qualitative change because of the nature of services involved.

Draft Final

9. Funding of Care

Colombia has the financial profile of a developed healthcare system of the OECD.[15] It spends 8 percent of the GDP on healthcare, 65 -70 percent of which is estimated to be of public nature (Section 3).[16] Colombia does not look, however, like a developed OECD country by its health outcomes, level of economic development, and level of system integration.

For sustainability, Colombia should maintain healthcare spending at about 8-9 percent of GDP, and not exceed 80 percent of public funding.[17] That is, while maintaining the current percent of spending out of the growing GDP, Colombia should convert about 10- 15 percent, from 65-70 to 80, of private funding into public, and, at the same time, gain efficiency and equity in the system.

a. Integrated and Universal Fundraising

The reciprocal financial arrangements of a universal POS are universal contribution and allocation systems.

The first step toward universality in finance is the inclusion of the ER and PR in the FOSYGA funding arrangements. It is assumed that the net gain from inclusion of the poor of the ER with the well to do of the PR will yield a net financial gain to the unified system.

Second, the tax base for the contributions of the self-employed to the CR needs to be re-examined. Raising this base would be a net financial gain to the public system.

These two changes will clearly improve equity, and while not increase the total spending, and will convert some private finance into pubic.

Draft Final

[15] The U.S. is not included in this category. The U.S. has a developed medical system, but an underdeveloped healthcare system (Chernichovsky, 2009).
[16] The reader is reminded that these data are not well established. Thus, before embarking on policy based on these figures, further study of levels of private funding in Colombia are necessary.
[17] The reader is reminded that "public" in the context of the discussion concerns all mandated contributions.

Additional public funding would follow from financing additional benefits to the SR from the state budget--funded, however, from the growing national product.

b. Extra POS Funding

If extra-POS provisions, mainly *Tutela*, continue, an arrangement must be found to contain the implied cost explosion. This might be achieved by an a joint public –private insurance and risk sharing mechanism, combined with the abolition of fee-for-service arrangements for extra-POS entitlements,

c. Pooling public funds

The Colombian system is based on several mandatory financial sources: federal and local general tax revenues, employer and employee mandated contributions, and on levies on insurance and copayments (section 3). A critical element of Colombia's continued reform is to establish a national pool based on FOSYGA — with state/department or regional branches — of all public funds of a unified healthcare system.

The implementation process can be gradual and can be even notional through an accounting mechanism that pools all moneys under the reformed FOSYGA.

The immediate gains from this move are several. First, the current multiple collections and allocation mechanisms are more costly than the proposed single integrated mechanism. Second, A unified pool helps national health policy that, through the universal allocation mechanism discussed below, can address issues of prevention and health promotion in conjunction with therapeutic medicine, on the one hand, and populations and regions that require specific attention, on the other .

d. The Allocation Mechanism (UPC)

Colombia employs three allocation mechanisms: direct budgeting, an age-gender risk adjusted resource allocation mechanism for the CR (UPC), and a flat per-capita rate in the SR. The funds from different sources often flow to the same EPS's or plans, for different types of entitlement and people. In addition to potentially serious accounting issues, this arrangement is a source for cost shifting and discrimination. The mechanisms need to be therefore integrated

Draft Final

and used for a coherent healthcare policy. Two allocation steps need to be taken at the outset.

First, following a national health policy, there is a need within FOSYGA, with the existing mechanism, to allocate funds for special programs not handled by the UPC -- mainly prevention and health promotion, ,

Second, the UPC need s to be modernized in several ways as follows:

a. Improve the UPC to included risk adjusters beyond age and gender
b. Include a regional adjustment mechanism, to overcome regional disparities in supply and demand for care
c. Provide a safety net for unusually costly services within the POS, — expensive cases that deviate substantially from the average in a potential risk adjusted category, and general conditions that affect average costs like increases in prices of medical inputs, on the one hand, and epidemics, etc, on the other.

These ex-post arrangements for the UPC — part of a reformed RA mechanism — aim to secure service to the population through the financial viability of plans/EPS, while reducing plans' incentives to save and, at the same time not sacrificing quality of service and care.

e. Private Insurance

To retain the financial envelope of about 8 percent of the Gross Domestic Product for Healthcare of which up to 80 percent is of public nature — Colombia may rely on private insurance, possibly regulated, to help with the system's goals and objectives.

Draft Final

Promotion of adequately regulated private insurance has two advantages. First, it will help reduce the growth target package for the unification both financially and practically while still signifying an improvement for the subsidized system. This insurance will provide an outlet for pressures to increase the POS. Second, it would not change the benefits for the contributory system (to become a combination of reduced public benefits and increased private benefits), thus making the unification politically more acceptable.

Such supplementary insurance, provided by EPSs as well as commercial insurers, considered insurance for “socially important care”, can be regulated to have community-rated premiums, which provide for cross subsidies and open enrollment arrangements.

10. Health System Organization and management — the Fund-holding Perspective

Colombia opted for managed competition or competitive fund-holding, but Colombia needs to resolve several functional issues with regard to the operation of this model. First and foremost is whether the model is nationally based or regional-departmental based. The second involves the viability of managed competition in peripheral areas. The third relates to the organization and management of preventive care and health promotion (PC&HP). The fourth concerns vertical integration, mainly between fund-holders and providers. The fifth involves the regulation of the system that is discussed separately below.

a. Resolving the National Decentralization Gridlock

Ley 100 reform of the healthcare system coincided with *Ley 60 (1993)* which marked a reform that devolved administrative and budgetary responsibilities to departmental (state) and local authorities. Consequently, by default, the state-based SR has become subject to the general administrative reform while the CR has been subject to the healthcare system reform. Colombia, thus, undertook simultaneously two decentralization processes affecting the healthcare system. One applies to the SR, devolving healthcare responsibilities (some funding +

Draft Final

some fund-holding + provision) to non-competing local authorities; and the second, for the CR, to the competing fund-holders (EPS) funded by the state.

As a result, by default, the SR has been subject to an administrative geographic decentralization, while the CR has been subject to national market decentralization. Colombia has created two separate healthcare systems based on different organizational and management principles. This separation does not reflect functionality or feasibility of managed competition. Worse, perhaps, as the situation created two basic institutions by the two regimes, the challenge of a unified system or POS is not just finance and resources, but organization and politics as well.

In addition, although the two regimes are funded differently by different pay and incentive mechanisms and serve different populations, at local level, the two may both compete for scarce providers and duplicate services.

To resolve this issue, Colombia may opt for a regional-departmental structure of the healthcare system, to be consistent with the general administration, and – not the least – to be able to address better the regional variations in health and medical services. This is not to say that EPSs need to be local entities. It merely suggests that that they need to be regional-departmental cost centers that get funding for regional populations,

b. Decentralization in the Healthcare system

The key feature separating developed healthcare systems adhering to the EP is the organization of Fund-holding. In general, countries can be grouped by two basic models.

The first is the state Direct Contracting Model (DCM). In this model, a state body is a single, non-competing fund-holder that engages in the organization and management of care consumption (OMCC) and in monopsony purchasing of entitled care, mostly from competing providers. This model is typical of Australia, Canada, France and the U.K., as key examples. By the original model, an independent state authority, as the National Health Service-NHS in the U.K., is the fund-holder.

Draft Final

The second model is a competitive Indirect Contracting Model (ICM). In this model, known as managed competition, the fund-holding responsibility is devolved to competing plans, Health Maintenance Organizations — HMOs, sickness funds, and their like, that can operate nationally and regionally, as in Germany, Israel, and the Netherlands, as key examples. These plans are contracted by the state to secure entitled care; the plans are essentially competing OMCC and purchasing arms of the state. In this case, for their entitled benefits, citizens enroll in a participating plan of choice that must accept them unconditionally, for securing core benefits.

In general, it is hard to point to the advantage of one model over the other in developed nations (Chernichovsky and Leibowitz 2010, and Chernichovsky, Donato, Leibowitz et al. 2012). Yet, from the Colombian perspective, some shortcomings for managed competition must be recognized.

As suggested above, the two models coexist in Colombia (Section 3). While the CR clearly adheres to managed competition, the SR is a confusing mix whereby local authorities purchase care for members of the SR either directly or through EPS. These authorities have also a clear role in at least coordinating PC&HP.

c. Functional Fund-holding

The two types of decentralization or fund-holding models can coexist in the same system, but they need be based on functional considerations, meaning that where competition is feasible, Colombia should retain competing EPS's for the two regimes (or with two benefit packages, for as long as they exist) until full unification or integration. Where these conditions for competition are not met, the non-competing arrangement should be considered.

Competitive principles can be impractical in "peripheral" regions and in populations that lack an infrastructure for competition (Chernichovsky, 2002). . The relevant situations are marked by the following conditions:

- Areas with low density and scattered populations that lead to natural monopoly situations whereby the needs and demands

Draft Final

for care are too small for efficient medical operations, especially those subject to increasing economies of scale.

- A relatively low supply of fund-holders and providers of care per population that leads to monopsony and monopoly situations.
- A relatively high prevalence of epidemiological and public health conditions that require centralized intervention at the community level because of externalities, such as eradication of communicable diseases and of economies of scale in public health and health promotion activities.
- A population not empowered enough socio-economically to choose care in an informed manner.

Usually, these different conditions are highly correlated as also suggested by the data in Table 5, indicating that low population density areas have above average infant mortality, and below average life expectancy, education, and supply of medical doctors.

The existence of all or even one of these conditions calls for a non-competitive fund-holding model. Consequently, even developed healthcare system that employs managed competition such as Germany, Israel, and the Netherlands, regulate heavily such situations.

Draft Final

Table 5. Colombian Departments (States) by Population Density, Infant Mortality, and MDs per 10,000 capita (2008).

Department	Population Density Per SqKM[a]	Infant Mortality Rate[b]	MDs Per 10,000 Population[c]
National Total	37.56	20.60	16.13
Antioquia	89.33	18.90	15.88
Atlántico	639.36	22.80	20.24
Bogotá, D. C.	4209.30	16.89	32.55
Bolívar	72.33	40.00	12.70
Boyacá	54.13	22.90	12.51
Caldas	122.81	14.50	7.30
Caquetá	4.72	38.90	4.45
Cauca	43.30	46.70	8.43
Cesar	39.44	38.30	14.74
Córdoba	58.67	34.90	8.80
Cundinamarca	100.86	23.30	6.97
Chocó	9.76	68.10	2.30
Huila	50.85	27.80	14.70
La Guajira	32.69	38.60	9.09
Magdalena	49.59	32.40	10.30
Meta	9.15	32.80	12.88
Nariño	46.35	41.60	8.94
Norte de Santander	57.44	24.10	11.66
Quindío	289.73	16.70	14.23
Risaralda	216.79	17.30	17.45
Santander	64.11	21.60	19.95
Sucre	70.72	27.60	10.03
Tolima	57.95	22.10	6.96
Valle del Cauca	187.96	16.50	17.08
Arauca	9.75	50.40	8.70
Casanare	6.62	37.30	9.98
Putumayo	12.47	33.00	7.87
San Andrés, Providencia and Santa Catalina	1603.50	17.80	11.91
Amazonía(1)	0.75	42.00	4.21

(1) Includes the Departments of Amazonas, Guainía, Guaviare, Vaupés y Vichada

Sources: a. DANE – Geoestadística y Proyecciones de Población por Departamento (2005). En Series de Población y Geoestadística; b. Jaramillo, Chernichovsky y Jiménez-Moleón (2012); c.Ministerio de Salud y Protección Social.

It is thus possible to envision the coexistence in Colombia of the U.K.-type Health Service Authority (HSA), a derivative of the current local authority arrangements, alongside EPS, depending on local circumstances in support of the competitive model. In either case, it is desirable that: (i) the HSA is not the state administration, but a separate statutory authority; and, (ii) that an HSA and plans do not operate in the same jurisdiction for securing identical benefits because the state administration may yield undue powers *vis-à-vis* non-state plans, and should oversee EPSs (see Section 3). As in developed systems, public health activity can stay, even where managed competition works, with centralized authorities such as the HSA (Chernichovsky, Donato, Leibowitz, et al. 2012).

An alternative option for the periphery is to charge a single EPS operating in "lucrative" area to be a regulated monopoly in a peripheral area as is common with public utilities. This option has several key advantages. It allows the EPS to use national infrastructure for the population in the periphery. In the long run, once the area develops and conditions are right, managed competition can be easily (re-) introduced, relatively speaking. The major drawback of this proposal may be political. It may face opposition from all local authorities who have fund--holding responsibilities.

It is important to notice that the HSA as a state body cannot offer supplemental insurance for supplemental benefits (SB). This means that an HSA arrangement requires other insurers for the SB and complicated arrangements to supervise providers. This may, however, not be a substantial issue in peripheral areas where the population might be poor. It may not be an issue at all where an EPS is charged as a local fund-holding monopoly.

The proposed arrangement can have considerable efficiency and equity gains by reducing potential duplications of service and making services available to relatively remote populations that are unlikely to be served by competitive arrangements.

Draft Final

d. Preventive Care and Health Promotion (PC&HP)

The organization and management of preventive care and health promotion is a common challenge, especially in systems of managed competition. It is generally believed, although not proven, that competing EPS or plans may not have the incentives to invest in prevention and health promotion of their membership because they risk of losing this investment in prevention as members move from one plan to another (Chernichovsky and Leibowitz 2010).

The challenge in Colombia may be relatively greater than in other places. Plans under financial pressures as the case may be in Colombia (because of unregulated medical input prices) are willing to take lesser risk, and may indeed forgo prevention and health promotion of no “immediate gains”. [18]

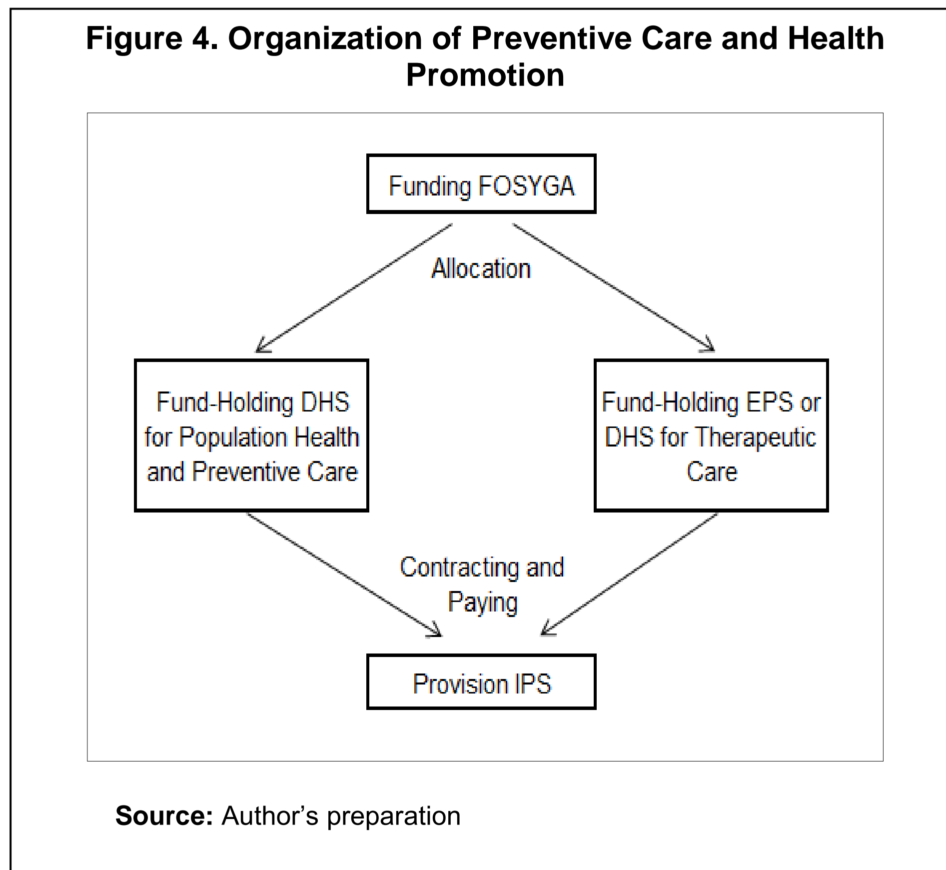
To deal with plans’ apparent relevant disincentives, the system can be organized as follows (Figure 4). Although financed by common public sources (e.g. a reformed FOSYGA) the responsibility for fund-holding or budget execution and implementation for general curative medicine and PC&HP is delegated to separate authorities. And needed care (e.g. vaccinations) can be given by providers who supply the two types of medicine.

This is the common solution in the relevant European experience. While plans handle general medicine, state and local authorities, handle PC&HP. This can be a realistic solution for Colombia, given the existing budgeting arrangements for PC&HP, and the substantial role of local authorities in the oversight and fund-holding of PC&HP. This solution can be efficient for the production of health and medical care and improve harmonization between different types of care as well as institutions (Chernichovsky and Leibowitz 2010).

Draft Final

[18] The discussion disregards issues of financial mismanagement and corruption that has been leveled with some EPSs.

Figure 4. Organization of Preventive Care and Health Promotion



Source: Author's preparation

e. Vertical Integration between fund-holding and provision

Vertical integration under managed competition, such as in Colombia's case, concerns the integration fund-holding, the key function of EPS plans, and provision of care, the key function of care suppliers — IPS.

This kind of integration is common in state institutions, in Colombia as well, that may integrate the function of finance as well, to become fully vertically integrated bureaucracies of the kind managed competition attempts to dissolve. Indeed, in the spirit of managed competition, Colombia has made a deliberate; though not fully successful, effort to rid the state of owing and running institutions, notably state hospitals that sell services to EPS plans. The fact that the state still owns hospitals led it to mandate that EPS plans purchase minimal amounts of care form state hospitals, in defiance of managed competition principles.

In general, vertical integration of fund-holding and provision is not for several key reasons. First, non-integrated plans can pay the marginal cost of care provision

Draft

rather than assume liabilities of fixed capital and semi-fixed labor costs (such as those associated with unionized labor) . Such plans do not expose themselves to investments in medical facilities, notably hospitals. Second, from the plan's perspective, no-integrated plans can use marketing strategies that permit their membership a wide choice of providers, not necessarily those owned and employed by the plan. Thereby, where there is an infrastructure for managed competition, non-integrated plans can be more responsive to clients. Third, related to the second, but from the public's perspective, non-integrated institutions have fewer powers to exploit the client. Fourth, from the same perspective, non-integrated plans assume less financial and managerial responsibilities and risk that go with them.

For these key reasons in the highly competitive markets of the USA, plans, with the notable exception of Kaiser Permanente, avoid so-called vertical integration. It may exist to an extent, with regard to a referral system, to have gatekeepers who manage patients for quality of care but mainly to save on costs.

While Israel allows plans or sickness funds to organize care as they wish, the integration is discouraged in Europe..

As vertical integration efforts can be motivated by efforts to create monopolies, even localized. Such efforts, when sanctioned, need careful regulation of provider prices, of free choice of and access to care, and state responsibility of securing investments as suggested further below.

Indeed, two common complaints in Colombia about vertical integration are that integrated plans have the means to follow the incentive for risk selection and quality skimping in order to save money, and can divert resources away from clients more easily than when vertically integrated. However, the first is generally attributable to the capitation as an allocation mechanism, not to vertical integration. Many providers are in fact paid by plans of EPSs through capitation and, thus, face those same incentives. The second complaint is more about non transparent accounting and corporate governance practices than about integration. In the absence of clear accounting and good governance, diversion

Draft Final

of resource can, in principle, occur at the plan or provider level without integration. These issues can be resolved by viable competition, on the one hand, and regulation, on the other.

Draft Final

11. Stewardship and Regulation

Managed competition is regulated competition; although not directly run by the state, the internal market where the EPSs operate needs to be fairly tightly regulated[19]. And, Colombia appears lagging in this regard.

a. The Market of Medical Inputs

Control of input prices -- wages and fees of medical personnel and cost of technology, mainly pharmaceuticals -- is a key to successful operation of a managed competition under the fixed budget allocated through a risk adjusted mechanism.

Contrary to a budget-holder which is non-competitive state monopsony, competing budget-holding EPSs cannot control efficiently input prices. Price increases of medical inputs that are not anticipated undermine the operations of the system. Unless, adjusted in the budget and the allocation mechanisms, such prices produce pressures on EPSs to cream skim (select good or favorable risks, the relatively healthy upon the sick), to reduce quality of service and care, and even to resort to questionable financial practices, including delayed payments to providers.

b. Quality of service and care

Assuring quality of care in particular is a challenge, especially in a non-competitive environment with a population of a relatively low socio-economic profile that may not be knowledgeable and powerful enough to exercise informed choice and insist on rights.

Therefore, Colombia needs in place an effective quality assurance system, mainly to help EPSs deal with quality of care while assisting the population with informed choice.

Colombia passed a law to this effect in 2006, but the law has not been effectively implemented (CRC, 2007).

[19] This concept should not be confused with managed care.

Draft Final

c. Governance of EPS

Even when for-profit, EPS are arms of the state since they use public funds and are secured demand for their services. This situation calls for tight state control over at least the management of the financial affairs of the EPS (Chernichovsky, Frenkel and Mizrahi 2009).

Colombia appears to treat EPSs like regular insurers. This is most apparent in the regulation requiring EPSs, for example, to hold financial reserves. One might question the rationale for regulating such reserves because at the end of the day they are at the taxpayer's expense, and may only slow down the need for a state bailout when and an EPS is in financial trouble.

Especially in the case of for profit EPSs, the following regulation can guide their finances:

- Operation on a cost-plus basis in regulated medical input prices.
- Holding limited financial reserves in the form of state-approved financial instruments
- Strict payment terms to providers
- Reserves, including those of owners, should be available to the state for timely pay to providers when EPSs fail to do so
- Disallow vertical integration between EPSs and providers.

These call for a presence of societal stakeholders, including the funding State as well as membership, on the boards of EPS, and for a close monitoring of their affairs.

Draft Final

d. Stewardship

In the context of the proposed reform above and regardless of other changes, the federal and departmental (state) governments will remain generally responsible for:

- Formulating and implementing policy. This includes instituting, regulating and enforcing standards and establishing criteria for allocation, and providing guidelines for contracts, including setting the mechanism for price formation, reimbursement schedules, and procedures.
- Regulate natural monopolies and monopsonies and the important investments.
- Monitor and evaluate as well as promote competition and consumer choice. This includes the task of safeguarding public monies and the supervising affiliates/patients, as well as collecting information on an ongoing basis to ensure that the players in the system comply with the regulations and disseminate relevant information of the citizens and patients.
- Coordinate activities regarding environment, sanitation, public health, including those who have long-term implications (particularly preventative care), medical education and training, research, and the adoption of new technology.

Draft Final

12. The Reformed System

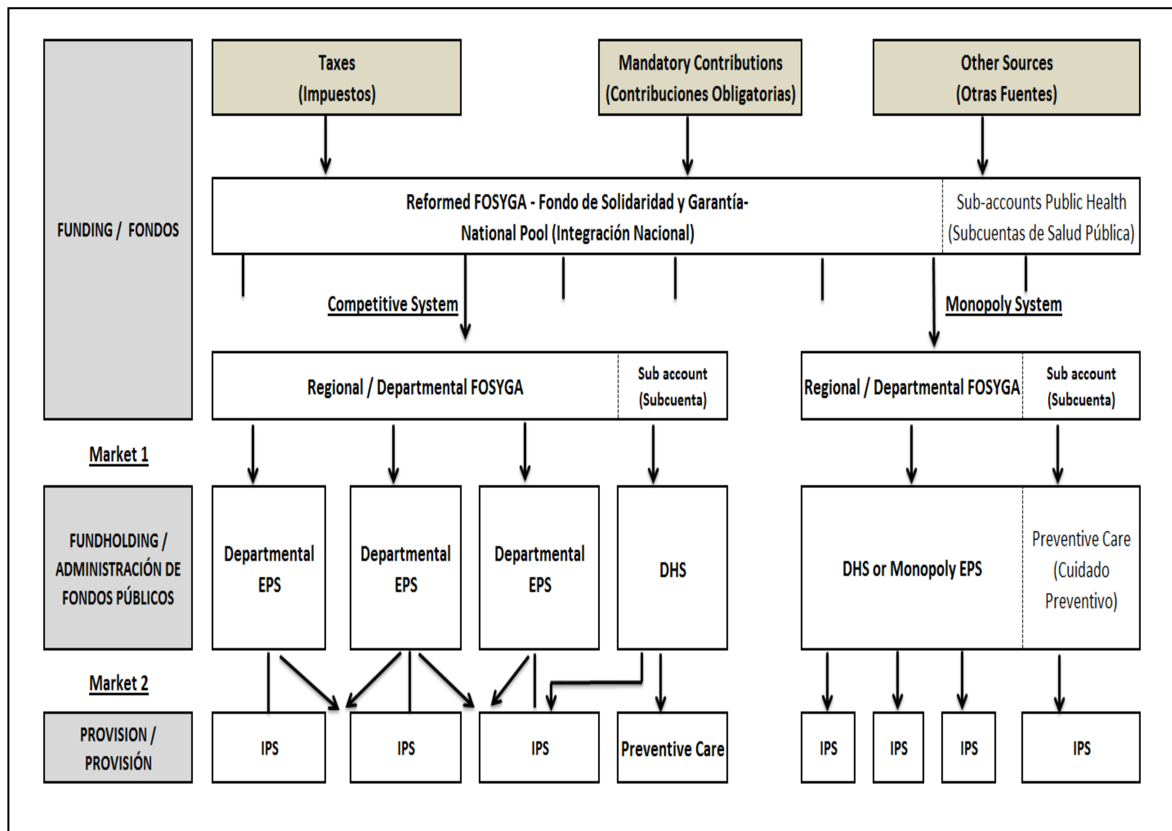
In sum, the reformed integrated Colombian system, by the philosophy and principles of the Law, should be portrayed as in Figure 5. The system would be national but regionally or departmentally organized. All funding of the system would be pooled by the National Fosyga, which has regional branches.

Depending on local circumstances, there can be competitive EPSs that operate as regional/departmental cost centers, or a monopoly authority – Departmental Health Service --DHS (or a chartered monopoly EPS for therapeutic care). Such a DHS should exist for managing population health and preventive care (PH&PC) in each region/department.

Funds would be allocated to regions/departments by a revised RA - UPC mechanism as well as a by budget for PH&PC. These will take into account regional differences in health and medical conditions.

Draft Final

Figure 5. Structure of Completely Reformed Colombian Healthcare System



b. Legend:

i. EPS – Entidades Promotoras de Salud – Plans (e.g. Organizaciones Para el Mantenimiento de la Salud)

ii. IPS – Instituciones Prestadoras de Servicios – Medical Care Providers.

iii. DHS – Autoridad de Servicios de Salud – Departamental Health Service (Autoridad Independiente)

13. References

Barón, G. (2007). Cuentas de Salud de Colombia 1993-2003: El Gasto Nacional en Salud y su Financiamiento. Bogotá: Ministerio de la Protección Social. Ladiprint Editorial.

Bernal, O., Forero, J. C.,Forde, I. (2012). Colombia´s Response to Healthcare Crsis. In BMJ. No. 344.

Clavijo, S. (2009). Social Security Reforms in Colombia: Striking Demographic and Fiscal Balances. In IMF Working Paper vol. 58: 1-33.

Chernichovsky, D. (1995a). Health System Reforms in Industrialized Economies; An Emerging Paradigm. In The Milbank Quarterly vol. 73: 339-372.

Chernichovsky, D. (1995b). What Can Developing Economies Learn from Developed Economies? In Health Policy vol. 32: 79-91.

Chernichovsky, D. (2002). Pluralism, Choice, and the State in the Emerging Paradigm in Health Systems. In The Milbank Quarterly vol. 80: 5-40.

Chernichovsky, D. (2009). Not Socialized Medicine-An Israeli View of Health Care Reform. In New England Journal of Medicine vol. 361, No. 21: e41.

Chernichovsky, D. and Leibowitz, A.A. (2010). Integrating public health and personal care in a reformed US health care system. En American Journal of Public Health vol. 100, No. 2: 205-211.

Chernichovsky, D., Donato, R., Leibowitz, A. (2012). What Can the U. S. Learn from it Allies?. (Processed)

Chernichovsky, D., Mirzrahi, S., Frankel A. (2008). The Public Supervision Funds in Israel. Taub Center for Social Policy Studies in Israel.

Chernichovsky, D. (2012a). Disaggregation Private Spending on Medical Care for Improved Policy Making. (Processed)

Chernichovsky, D. (2012b). Private Household Spending in Colombia- An indication to System Performance. (Processed)

Chernichovsky, D., Martinez, G., Aguilera, N. (2012). The Mexican Healthcare System-Time for Further Structural Reform. (Processed)

Comisión de Regulación en Salud (2011). Acuerdo 029 de 2011, "*Por el cual se sustituye el Acuerdo 028 de 2011 que define, aclara y actualiza integralmente el Plan Obligatorio de Salud".* Diciembre 28 de 2011. Bogotá, Colombia.

Comisión de Regulación en Salud (2012). Acuerdo 032 de 2012, *"Por el cual se unifican los planes de salud para las personas de dieciocho (18) a cincuenta y nueve (59) años de edad y se define la Unidad de Pago por Capitación UPC del Régimen Subsidiado".* Mayo 17 de 2012. Bogotá, Colombia.

Congreso de la República de Colombia (1993a). Ley 60 de 1993, *"Por la cual se dictan normas orgánicas sobre la distribución de competencias de conformidad con los artículos 151 y 288 de la Constitución Política y se distribuyen recursos*

según los artículos 356 y 357 de la Constitución Política y se dictan otras disposiciones”. Agosto 12 de 1993. Bogotá, Colombia.

Congreso de la República de Colombia (1993b). Ley 100 de 1993, *“Por la cual se crea el sistema de seguridad social integral y se dictan otras disposiciones”.* Diciembre 23 de 1993. Bogotá, Colombia.

Congreso de la República de Colombia (2007). Ley 1122 de 2007, “*Por la cual se hacen algunas modificaciones en el Sistema General de Seguridad Social en Salud y se dictan otras disposiciones”.* Enero 9 de 2007. Bogotá, Colombia.

Congreso de la República de Colombia (2011). Ley 1438 de 2011, *“Por medio de la cual se reforma el Sistema General de Seguridad Social en Salud y se dictan otras disposiciones”. Enero 19 de 2011. Bogotá, Colombia.*

Corte Constitucional (2008). Sentencia T-760 de 2008. Julio 31 de 2008. Bogotá, Colombia.

Figueras, J., Robinson, R., Jakubowsky, E. (2005). Purchasing to improve health systemas performance. Europe: Open University Press. European Observatory on Health Systems and Policies. 298 p.

Glassman, A.L., Escobar, M.L., Giuffrida, A., Giedion, U. (2009). From Few to Many: Ten Years of Health Insurance Expansion in Colombia. Washington D.C. The Brookings Institution.

Guerrero, R. (2008). Financing Universal Enrollment To Social Health Insurance: Lessons Learned From Colombia. In Well-Being and Social Policy vol. 4: 75-98.

Guerrero, R. and Hails, P. (2008). Method for Estimating the National Health Accounts in the Case of Colombia.Harvard Initiative for Global Health. (Processed)

Guerrero, R., Gallego, A.I., Montekio, V.B., Vásquez, J. (2011). Sistema de Salud de Colombia. En Salud Pública de México (Suplemento 2): S144-S155.

Jaramillo, M.C., Chernichovsky, D., Jiménez-Moleón J.J. (2012) Resolving the Enigma of Infant Mortality Rate in Colombia. Working Papers Series. Social Science Research Network [online]. Published June 30, 2012. URL Available from: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2096901

Londoño, J. L. and Frenk, J. (1997). Structured Pluralism: Towards an Innovative Model for Health System Reform in Latin America. In Health Policy: 1-36.

Melo, L. A. and Ramos, J. E. (2010). Algunos Aspectos Fiscales y Financieros del Sistema de Salud en Colombia. En Borradores de Economía No. 624.

Pinto, D. (2008). Colombia: Good Practices in Expanding Health Care Coverage. In Good Practices In Health Financing. Washington, World Bank**:** 137-183.

Yepes, F.J., Ramirez, M., Sanchez, L.H, Ramirez, M., Jaramillo, I. (2010). Luces y Sombras de la Reforma de la Salud en Colombia: Ley 100 de 1993. Ottawa ON: Centro de Internacional de Investigaciones para el Desarrollo.

Draft Final