# Colombian Health System Reform*

This case study outlines the main characteristics of the health system that was established in Colombia as a result reforms introduced in 1993. It also describes the effects of the reform on insurance cover, the distribution of social expenses for health, public health programs, and the State capacity to direct health public policies. After analyzing these aspects, we can conclude that the introduction of market mechanisms in 1993 marked the worsening of inequalities in the distribution of health resources, in access to health services and in the structure of social expenses. In addition, the reform allowed the development of the private sector, which undermined public institutions and the State capacity to direct health public policies.

## Economic and social characteristics of Colombia

Colombia is situated in the North West corner of South America; it has approximately 44.5 million inhabitants, 72% live in urban areas and 28% live in rural areas. The Human Development Index (HDI 2004) classifies Colombia as a country at a medium level of development, in the 73rd position. 10% of the population is illiterate and 90% of the population has access to potable water supply (DANE, 2002).

Two connected facts characterize Colombian society: social and political violence, which has worsened in the last few years; and huge inequalities in resource distribution. Violence in Colombia has multiple actors and forms of expression. The most significant contributor to violence in Colombia is the armed conflict involving guerrilla, paramilitary groups and the State army, which is supported by resources from drug trafficking. In recent years, the armed conflict has caused the displacement of approximately three million farmers (Codhes, 2004) who now live in the largest cities in miserable conditions, generating a human crisis of enormous magnitude.

The GINI index (a measure of inequality) in Colombia is 0.6 (on a scale from 0 to 1, 0 being total equality and 1 total inequality). An example of this inequality is the distribution of national resources: 77% of the population receives only 46% of GDP (Sarmiento, 2004).

In the last few decades, inequality has worsened as a result of the economic crisis the country is facing. This crisis is characterized by low rates of economic growth, the high percentage of the national budget paying for external debt and the closing of large national companies. The magnitude of the crisis can be observed in the HDI, which shows Colombia falling from the 50th position in 1990 to the 73rd position in 2004.

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In response to this crisis, the various governments of Colombia have applied a set of neo-liberal policies, which include privatization, a reduced role for the State, and the abolition of workers´ rights. These methods far from solving the crisis have worsened the economic and social problems. From 1997 to 2003, the percentage of the population surviving on three dollars a day rose from 55% to 66% (Gonzalez, 2004).

## Colombian health care system reform: the neo-liberal experiment

In 1993, in the middle of a delicate economic, political and social scene, the Colombian government, led by the current President Alvaro Uribe, proposed a reform of the health system, supported by what is called *¨structured pluralism¨.* The Colombian health reform was considered an absolute success and became symbolic in Latin America. It was claimed to be so successful that it was catalogued as the fairest in the world in according to the WHO (WHO, 2002). In the following paragraphs we will show how this was not the case.

### The Colombian Health System - pre-1993 reforms

To understand the reform of 1993, it is necessary to know how the preceding health system was structured. It was composed of three subsystems:

*a)* *The Public Subsystem*: a network of hospitals and health centers serving the unemployed and low income people, financed by state resources sent directly to health care delivery institutions;
*b)* *The Insurance Subsystem:* a network of health centers and hospitals covering employees, financed by contributions from employers and employees; and
*c)* *The Private Subsystem*: private institutions covering the high income population, who would pay for services out of their pockets.

This system was unfair because approximately 25% of the population (the poorest) was not covered, and personal income was used to determine access to health care services (Department of Health, 1991:64). Reform of the health system was promoted as a solution to the inequality problems.

### Characteristics of the Colombian Health Reform

- Reform ruled that the State relinquish its role in delivering health care, and that the health system be made self-sustainable by selling services;
- Reform ruled that individual insurance be defined as the mechanism of affiliation to the system. The new system is composed of two subsystems:
  - The Contributory Subsystem- covering employees and those who can afford to pay. Employees contribute 25% of the payment and their employers contribute 75%; and
  - The Subsidised Subsystem- Covering those who cannot afford cover. The state partially assumes the cost through a subsidy

It was expected that 70% of the population would be covered under the contributory subsystem and the remaining 30% under the subsidised subsystem.

- Health insurance companies called Empresas Promotoras de Salud (EPS) were created in both subsystems.
- A basic benefit plan was drawn up which includes medical procedures, hospitalisation and medicines that insurance must cover. The medical procedures not included in the plan have to be bought in the market
- Reform ruled that public hospitals and health centres would not continue receiving financial resources directly from the state but they would compete with private institutions for contracts with insurance companies.
- Public health was confined to single issue programs such as vaccination and education which insurance companies and their affiliates would manage.

**Results of the neoliberal experiment**

1. Insurance Cover

According to government data, 42% of the population (17 million people) does not have health insurance and hence has no access to health services (National Quality of Life Survey, DANE, 2003).

| Contributory Population | | Subsidised Population | | Uninsured Population | |
|---|---|---|---|---|---|
| No. | % | No. | % | No. | % |
| 16 992 259 | 36 | 10 011 229 | 22 | 16 672 283 | 42 |

*National Quality of Life Survey, DANE, 2003*

When the reform was initiated, it was promoted as a solution to the inequalities of the Colombian health service, however the reform only made these inequalities worse. Sixty percent of the poorest quintile of the population is not insured while only 10% of the highest quintile is not insured. That last National Quality of Life Survey showed that 40% of those who felt sick did not seek medical attention because they could not afford it.

2. Social Expense for Health

After the reform, the proportion of GDP going to health has increased dramatically. Currently, expenditure on health constitutes 8.5% of the GDP compared to 4.5% before the reform in 1993 (Departamento Nacional de Planeacion, 2000:49 and Revista Salud Colombia, 2004). This increase comes mainly from out of pocket payments: the National Quality of Life Survey 2003 showed that 55% of people surveyed in the previous 3 months paid for health services out of their pocket. Furthermore, even though out of pocket payments have increased across the whole of the population, they have been more

frequent in the poorest quintile (90% of the poorest quintile paid out of their pocket compared to 70% in the highest quintile) (Castaño y col. 2001:20).

Insurance companies did not contract services with public hospitals but created their own clinics and health care delivery services. In rural and poor urban areas private services do not exist. Public hospitals situated in these areas continued for a while to satisfy the demand of the uninsured whom hospitals are obliged to give treatment to even though they can't afford it. In these cases patients sign forms to pay their debts which are rarely covered. With no resources public services are finding it more and more difficult to survive- five of the largest national public hospitals have closed and ten more are in liquidation (Paredes, 2004).

Health insurance has become one of the most profitable industries in Colombia and health insurance companies invest in other financial sectors in Colombia and abroad. Some insurance companies (that service the subsidised population) are now even the property of paramilitary groups and the money profiteered from these companies has been used to finance the war (El Tiempo, August 13, 2004).

3. Morbidity by immune preventable diseases

After the reform a number of previously controlled contagious diseases reappeared. According to the National Health Institute, in 2002 the incidence of malaria, yellow fever and measles increased compared to the 2001. This is a consequence of the reduction of public health programs and their replacement with individual programs for insured people.

4. Public health programs

Public health is probably the greatest victim of the reform. The majority of the budget was invested in individual health insurance, and resources assigned to health promotion were reduced. Furthermore, insurance companies refused to fulfil their obligations in public health (eg. health promotion and prevention programs for their affiliates) as these services increase the use of other clinical services such as preventive screening.

It is clear that the reform only strengthened the private sector. The role of the state as a regulator and leader of public health was lost in the national and municipal sphere. The neo-liberal model in Colombia not only did not address previous problems but had harmful consequences. The ten years since reform have shown that the strengthening of the private sector and market mechanisms have accentuated social inequality in Colombia.

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