

## Colombia

### Progressing towards universal health protection

After two decades of development, the Colombian health insurance system exhibits very positive results. It is estimated that the rate of affiliation to the social health insurance schemes rose from 25 per cent in 1993 before the reforms to 96 per cent in 2014.

Out-of-pocket expenditures (OOP) fell to 15.9 per cent of national total health expenditures in 2011 (MSPS, 2014). According to the ILO's World Social Protection Report 2014/2015, per capita health expenditure not financed by OOP reached 358.5 US\$ and the share of live births attended by skilled health staff reached 99.2 per cent. Hence, Colombia is one of the most notable cases of recent progress in health protection in Latin America.

National Social Protection Floors (SPFs) guarantee access to essential healthcare and basic income security for children, persons of working-age and older persons.

185 countries have adopted the Social Protection Floors Recommendation, 2012 (no. 202) an approach to achieve universal social protection.

This brief presents a successful country experience of expanding social protection.

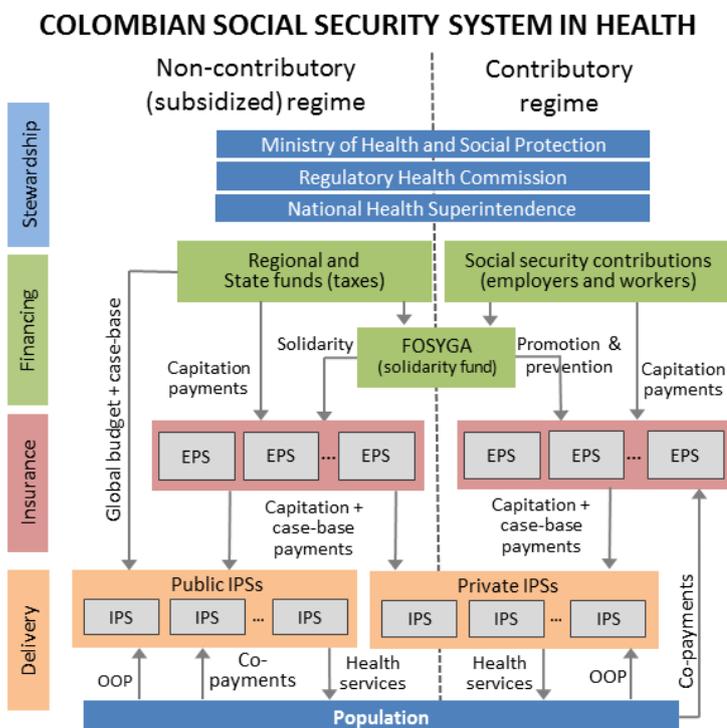


### Main lessons learned

1. Significant progress towards universal health protection is feasible and affordable for developing countries.
2. Colombia's FOSIGA solidarity and guarantee fund played a critical role in pooling funds from different sources and linking contributory and non-contributory schemes.
3. The creation of a single set of health services through the Mandatory Health Plan (POS), contributed to standardizing benefits across all insurers and providers, public and private.
4. It is possible to obtain highly successful results in terms of expansion of health coverage to rural populations and reduction of out-of-pocket expenditure payments by families.
5. The political economy of structural health reform is highly complex and may generate divergent views between stakeholders. Therefore, social dialogue is essential.

## 1. What does the system look like?

The Colombian health system is based on the principle of "universality", which means that all citizens are obliged to join one of two insurance schemes: a contributory plan for employees and self-employed workers with contributory capacity or a subsidized (non-contributory) scheme for informal workers and low-income self-employed workers.



**Benefit packages.** Members, either in the subsidized or the contributory scheme, are entitled to the same benefits. A single service package is defined by the Mandatory Health Plan (POS), which is composed of interventions aimed at health promotion, prevention, and medical care services, including pharmaceutical drugs for members and their families. The POS also includes cash benefits in case of illness and maternity leave. Public and private Health Promotion Entities (EPS), in their role as insurers, are responsible for ensuring citizens have access to POS entitlements.

**Financing.** The Contributory Scheme is financed by compulsory contributions from employers, employees, the self-employed, and pensioners. Participants contribute according to their payment capacity. The Subsidized Scheme is financed by taxes and transfers from the Contributory Scheme. A per capita payment to deliver the POS —the Capitation Payment Unit (UPC)— is transferred by the Government to the Health Promotion Entities according to the number of enrolled members in each EPS. Thus, EPSs compete for the enrolment of new members in order to maximize their revenue. A Solidarity and Guarantee Fund (FOSYGA) was created to provide cross-subsidies between schemes and finances promotion and prevention interventions.

**Legal aspects.** The health system was created in 1993 by Law 100. Several reforms have been introduced over time in order to correct problems. In 2007, the Government approved a legal reform to improve stewardship functions, the financing, the financial balance, and the quantity and quality of current services. In 2011, further reforms were introduced to create a single POS for all residents (the former POS provided lower standards for the Subsidized Regime), reach universal coverage, and ensure territorial portability of benefits. Other reforms are currently under debate and highlight the divergent views on the health system among stakeholders. An element of concern is the increasing “judicialization” of the system, whereby the constitutional court has adopted several resolutions to guarantee to the whole population effective access to the POS.

**Institutional arrangements for delivery.** EPS insurers in the contributory and subsidized schemes purchase services from health provider institutions (IPS), which may be either public or private entities. Public hospitals became State-owned social corporations with legal personality, equity capital, and administrative autonomy. Thus, the system has public and private provision of health-care services. Regulation and oversight of health insurers and providers is under the responsibility of a public entity called SuperSalud. Only people identified through SISBEN, a system for identifying social assistance beneficiaries, are entitled to non-contributory coverage (subsidized scheme).

## 2. How was this progress achieved?

The current situation of the Colombian health system is the result of a long process of major structural reforms led by the Government with both proponents and opponents. Reforms involved the discontinuation or transformation of old social insurance institutions. One of the more debated topics among stakeholders is the importance given to the private sector in the newly managed competition model. Critics of private participation in health care provision and insurance functions insist on the high intermediation costs generated by private insurers (financial intermediation costs, excessive profits, etc.) as well as the problems of lack of competition, low quality of services, and patient refusal. Proponents highlight the results so far achieved: the strong expansion of coverage increased supply of health services, and the commitment of the Government in financing health for the low-income population.

### 3. What are the main results in terms of impact on people's lives?

**Outcomes** High levels of affiliation (coverage) rates achieved by the Colombian social health insurance system have had positive implications for the well-being of the population. OOP fell dramatically from 43.7 per cent of national health expenditures in 1993 to 15.9 per cent in 2011 (MSPS, 2014), generating a considerable reduction in vulnerability for many Colombians. Thanks to the strong expansion in financing, total health expenditures financed with public resources reached 73.8 per cent in 2011 (MSPS, 2014), one of the highest rates in Latin America.

**Impacts on people's lives.** One of the most remarkable achievements of Colombia is the extension of health protection and effective access to health services to rural and poor populations. Several studies now show significant increases in the use of health services in rural areas. As a result, since the introduction of the health care reform in 1993, the number of infant and maternal deaths has fallen by 40 per cent and prenatal care has increased by 17 percentage points, with significant improvements in immunization rates for children under the age of 2, according to World Bank figures.



**Impacts on the economy.** It is recognized that investments in the health sector generate multiplier effects and linkages with other economic sectors. For example, medical tourism is a developing industry in Colombia as a result of the sustained increase in the quality of medical services.

### 4. What's next?

Despite its accomplishments, the Colombian health system is not free of problems and criticisms, including divergent views on the direction of future reforms. Among the many challenges that remain to be addressed are:

1. Complete universal access to health protection and effectively equalize the POS across schemes.
2. Close the gaps in the availability of health care particularly in rural areas through the provision of a sufficient number of health workers to ensure that all in need have effective access to quality health care.
3. Enhance efficiency and effectiveness of the overall health system
4. Improve scope and quality of health services and reduce denial of treatment by insurance companies.
4. Strengthen social dialogue as a part of the current model.
5. Increase membership in the contributory scheme in order to enhance fiscal sustainability through increased social contributions.
6. Improve national health account data and quality of information on health in order to strengthen government monitoring, planning and decision-making capabilities.
7. Improve the procedures for beneficiaries to appeal in case of denial of treatment, in order to reduce the use of the constitutional channel to appeal.
8. Reduce intermediation costs generated by EPSs.
9. Improve the regulatory framework and increase regulatory capacity of the State.

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