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**Health Care as a Commodity
Contradictions in the Colombian Healthcare System**

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List of Acronyms

ADRES	Administradora de los Recursos del Sistema General de Seguridad Social en Salud
CHCS	Colombian healthcare system
CR	Contributory Regime
DNP	Departamento Nacional de Planeación (Nation Department of Planning)
EPS	Entidades Promotoras de Salud (Private Insurers)
ET	Entidades Territoriales (Local Governments)
FOSYGA	Fondo de Solidaridad y Garantía (Solidarity and Guarantee Fund)
IPS	Instituciones Prestadoras de Salud (providers and suppliers)
MIPRES	
PGN	General National Budget
POS	Plan Obligatorio de Salud (Basic Benefits Package)
SISBEN	Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales (Beneficiary Identification System)
SGSSS	Sistema General de Seguridad Social en Salud (General System of Social Security in Health)
SR	Subsidized Regime
UPC	Unidad de Pago por Capitación (capitated payment per enrollee)

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Abstract

The present study aims to address the following central question: why the Colombian Healthcare System has not accomplished its initial purposes of full coverage and equal service provision although institutional reforms have made it more integrated in terms of access, entitlements and funding management? Institutional approach is used as a method to determine if the healthcare system has attained its purposes of expanding coverage and equal quality services. Three main features have made the system more unified: equal and generous entitlements, measures regarding access and, finally, the centralized administration of the health care sources for one fund and conclusion. However, this system of commercial provisioning and commoditized pricing reinforces the idea of health care as a commodity. This may undermine government objectives in a context of cyclical fiscal constraints because the managed competence model can create incentives for commoditization of prices and yield high costs, thus jeopardizing the financial sustainability of the system

Relevance to Development Studies

This paper attempts to draw attention to aspects of health care that may be left overshadowed by the fact that health policy in Colombia received the international recognition as a “remarkable example of rapid progress toward universal health coverage.” For instance, although the OECD’s 2015 report recognizes that the system has serious problems, the proposed recommendations may introduce important changes yet do not challenge the chosen model and the principles that underpin it. Instead, it promotes changes that encourage competition and user’s free choice. Furthermore, the country’s entry into the OECD can reinforce the idea that the Colombian institutional arrangements for delivering health care can be considered as ‘good practices’. Unlike the OECD’s report, through the use of an analytical framework that conceives health as a fictitious commodity, this study attempts to show those aspects that are not quite right when, from the official perspective, greater attention is paid to the fact that there is a fiscal deficit, and less to the structural deficit causing it and its current consequences in terms of inequity, which can deteriorate in the coming years.

Keywords

Health Care, Healthcare System, Fictitious Commodity, Structured Pluralism, Managed Competence, Colombian Healthcare System Unification, Market Practices and Contestations in The Colombian Healthcare System

Chapter 1

Introduction: Contradictions of the Colombia Healthcare System

In the wake of economic liberalization and cyclical fiscal constraints, in 1993, Colombia adopted a health care system model called “managed competence” or “structured pluralism”. The right to health was deemed to be achieved through a model promoting competence in delivering within a public/private mix that seeks to expand the coverage and harmonize quality through commercial provisioning and commoditized pricing. In light of this, the initial structure of the Colombian Healthcare System (CHCS) permitted different entitlements for different groups, provided that such entitlements were to be equal within less than ten years. It also set up different mechanisms of funding which were administered by different channels: some public, as in the case of the subsidized regime (SR), and others by private insurers in the contributory regime (CR). Additionally, although this was not explicitly mentioned in the Law, it ended up delivering care through different providers. Evidently, at the time of implementation, the system was highly fragmented but sought to achieve full coverage and equal provision of benefits progressively.

This model has been recognized internationally for having accomplished significant outcomes. While at the time of the implementation of the healthcare system in 1993 just only 23% of the population had had health insurance, by 2016, approximately 95% of the population was covered either through contributory or subsidized means. Regarding out-of-pocket spending in health, the OECD’s report of 2016 highlighted that in 1993 it corresponded to approximately 52% of the national health expenditure, while it has since then decreased to approximately 15% in 2016. This factor is not only one of the lowest levels in Latin America, but also lower than the OECD average. The OECD’s report has also stressed that, in addition to the achievements in coverage and the reduction of out-of-the-pocket payments, fewer unmet health needs and greater satisfaction with health care has been reported in general. Finally, it has been emphasized that although a differentiated provision of services between the poor and vulnerable people (who are subsidized) and those who contribute at the time of the system implementation was permitted, currently, now the benefits seem equalized.

However, these indicators reflect only a partial reality of the provision of health care in Colombia. There are differences in the type of affiliation between urban and rural areas and among different regions. While coverage in rural areas and the poorer coastal regions is mainly carried out through the SR, in the wealthier regions and capital cities is implemented through the CR (Departamento Nacional de Planeación 2017). This is noteworthy because in rural areas and the poorer regions there is a lack of competent providers, a limited choice of insurers, and, hence, insufficient in quality services. Due to this fact, the Ministry of Health Care (2013) documented the geographical dispersion and the lack of health services in some regions. Moreover, many of the public hospitals are underfunded, which also undermines the quality of the services they can provide while lacking adequate infrastructure. Likewise, the differences exacerbated when compared to the provision of complex services mainly found in large cities. In this sense, although the fees may be lower for those covered under SR, the quality of service is less, accordingly.

In countries with high-income inequality, healthcare systems that do not manage to reduce the financial burden resulting from illness might promote inequality and reinforce the problem by widening the gap between the rich and the poor. Therefore, existing research recognizes the critical role universal health care can play in shaping more equitable outcomes, which explains the considerable attention it received in recent years. Much of the literature addresses the question of attaining it, granting that developing countries face fiscal constraints that make it difficult. Such approaches, however, have failed to address inequality by reproducing the idea that only those who have the means can access generous quality services. Conversely, others contend that universalism would become beyond reach in the South if the only way conceived for achieving it was through general taxes (Pribble 2013, Franzoni and Sánchez-Ancochea 2016). Therefore, the literature admits that different possible means can lead to significant and quality benefits, also highlighting that, in general terms, integrated systems can lead to more universal outcomes (Fischer, Andrew M. 2012, Franzoni and Sánchez-Ancochea 2016).

Last two authors focus their attention on the institutional arrangements designed for delivering health, thus allowing to see beyond the indicators that do not reflect the facts behind the figures. Indeed, these studies support the notion that profit-motive and marketization reinforce social and economic inequalities, which results in health care being conceived as a commodity that can benefit from market competence. Instead, health care may be better understood as a fictitious commodity; in other words, unlike commodities, when provided through ‘competitive markets’, it could cause detriment in life conditions of those who do not have the information (commonly, the patient) or the means to afford the services when the costs increase. According to Mackintosh (2006), commercialization jeopardizes the notions of health care as a right. The reason is that although it does not necessarily increase health inequalities in terms of access or outcomes, what it does is introduce certain forms of inequality in the health system through "legitimizing access to health care via the ability to pay." (Mackintosh 2006:397).

As mentioned above, the reform of the health care system in 1993 and its outcomes portrait the contradiction between health care as “right or as a commodity”. Healthcare commercialization in Colombia has created contradictions in different social spheres, and the reason behind this is that commercialization reshapes social and economic inequality. Therefore, these contradictions raise questions as to the validity of what is regarded as a constitutional right when compared to this service in practice (Cohn et al., 19991 in Mackintosh 2006). Specifically, the following research questions will be addressed: Why the CHCS has not accomplished its initial purposes of full coverage and equal service provision although institutional reforms have made it more integrated in terms of access, entitlements and funding management? Did the foundational architecture of the HCS allow to attain the proposed objectives? What reforms were necessary to meet the pressures resulting from judicialization in order to adjust the unsatisfactory outcomes of the health-care system? How have the reforms of the foundational architecture have contributed to approaching the objectives? Did these reforms suffice to fully meet the initial purposes of the System? If not, what are the reasons behind the unsatisfactory outcomes?

This essay will attempt to defend the view that the model of “managed competence” or “structural pluralism” is encourages the vision of health care as a commodity that can benefit from competence, thus resulting in its incapacity to produce universal outcomes. Although the institutional arrangements have been reformed, achieving an expansion of coverage and benefits that are supported in growth funding, the prices are commoditized, and the costs are high, which bring risk to the financial sustainability of the system. The presence of the

private insurers that purchase services without control has increased the prices, thus making the cost of the system unsustainable. The features of the model make the system fragmented, therefore, inhibiting it from achieving universal outcomes. Hence, the commercialization of health care is legitimating health inequalities and, as a result, exacerbates the persistent economic inequalities.

Methodology

In most recent studies, an institutional approach has been proposed to determine the presence or absence of universal principles underpinning healthcare systems. This institutional analysis goes in line with the working concept of universalism used in this research paper and inspired by Fischer's idea of being "an umbrella term that reflects guiding institutional principles." (Fischer, Andrew M. 2012: 3) This notion is useful, first, because it avoids dichotomies by allowing to map out universalism according to scales from strong to weak or absent; and second, because the dimensions on which he focusses (e.g., access/ coverage, funding and price/costs) are a crucial part of this study. For mapping out the system, in addition to the dimensions proposed by Fischer(2012), this study has considered some of the categories proposed by Franzoni and Sánchez-Ancochea(2016) (e.g., eligibility, benefits and the market outside option). This allows to have a broader perspective of the institutional arrangements that comprise the health care system. Unlike the study of Franzoni and Sánchez-Ancochea, this one considers the dimensions of funding and cost/ price separately. These cannot be conflated because while funding is about the insurance principle and risk pooling, cost/ price is about commoditization (Fischer, Andrew M. 2012). Hence, this study will mainly focus on the dimensions of funding and price/costs. Both works conceive that universalism implies generous, high in quality and equal services. Due to its limited scope, this study will focus on funding and cost/ prices.

For the purpose of this paper, the term of foundational architectures and policy architectures was adopted as used by Franzoni and Sánchez-Ancochea (2016). As institutional arrangements are dynamic, the first term allows one to differentiate the initial institutional design to deliver health from the more recent reforms and therefore, determine the events, actors and political determinants that encourage these reforms. Combining these terms has permitted the identification of barriers and opportunities for reaching universal health care. Additionally, the concepts of fragmentation, unification, and integration are essential in this paper. Fragmentation implies "the existence of diverse mechanisms of access, funding, entitlements, and providers, as well as the presence of a large outside market option." (Franzoni and Sánchez-Ancochea 2016: 19). Unification is understood as the process through which a health care system becomes more integrated, or when fragmentation is reduced, that is, permitting the delivery of health care be through similar channels and assisted by the state that plays a key role in this process.

Following these categories, two main phases of the healthcare system were identified. The first phase comprises the period between its implementation and T- 760 ruling, from 1993 to 2008. The first phase presented the foundational architecture and the constraints as well as the opportunities it creates for attaining universal health care. The second phase of the system comprises most of the reforms issued after the T-760 ruling, from 2009 to 2016. It identifies the events and circumstances that gave rise to these reforms as well as the effect concerning integration.

Furthermore, to identify if funding has been unified, it was necessary to carry out an exploratory inductive approach to quantitative analysis. Using this method was crucial because, due to the pressures implied by equalization and full coverage as well as due to the persistent deficit, the financial sustainability of the system has been one of the main concerns of both the Colombian government and of the international institutions. This topic will be expanded on in chapter 4. To develop the institutional analysis, data sources comprised statistics, newspapers, norms (e.g., laws, decree, and the document that contains the argument for its enactment), various rulings of the Constitutional Court of Colombia, and the financial reports from the Ministry of Health Care and Social Protection. These include both primary and secondary data.

The benefit of this approach is that it unveils the social dynamics related to the inequality, which remain invisible when focusing on certain indicators. The analysis of the proposed dimensions (e.g., eligibility, funding, entitlements, delivery, and regulation of the outside option) can depict a more transparent picture of their effects. For instance, this concerns the regressive fee payments resulting in the process of impoverishment, or the fragmentation institutionalizing segregated healthcare provision by reinforcing inequalities among the population, the rural and urban areas and even, among geographical regions. Alternatively, this method can assist in determining the public-sector capacity required to mitigate the prices or even, the ways in which this dimension can create incentives for profit. In order to examine this, the final section of the paper uses an analytical framework for the concept of health care as a “fictitious commodity” as previously used by Fischer (Fischer, Andrew M. 2012) and Mackintosh (Mackintosh 2006). This concept is useful in understanding the effects marketization has on attempts to achieve universal health care. This understanding of health care implies uneven commodities; health care may not benefit from market competence or managed competence because “ill-health is a fundamental human condition that is not produced for buying/selling on the market, that is not alienable and cannot be bargained; therefore, its commodification may reinforce vulnerability” (Fischer, Andrew M. 2012: 15). Furthermore, this perspective reproduces the practices of monopoly and information asymmetry embedded in the category. Needless to say, this perception reinforces inequalities and processes of exclusion that are magnified when materialized in countries with high levels of income inequality.

As mentioned above, this paper attempts to draw attention to aspects of health care that may be left overshadowed by the fact that health policy in Colombia received the international recognition as a “remarkable example of rapid progress toward universal health coverage.” For instance, although the OECD’s 2015 report recognizes that the system has serious problems, the proposed recommendations may introduce important changes yet do not challenge the chosen model and the principles that underpin it. Instead, it promotes changes that encourage competition and user’s free choice. Furthermore, the country’s entry into the OECD can reinforce the idea that the Colombian institutional arrangements for delivering health care can be considered as ‘good practices’. Unlike the OECD’s report, through the use of an analytical framework that conceives health as a fictitious commodity, this study attempts to show those aspects that are not quite right when, from the official perspective, greater attention is paid to the fact that there is a fiscal deficit, and less to the structural deficit causing it and its current consequences in terms of inequity, which can deteriorate in the coming years.

This study consists of six chapters. Chapter 2 will consider the current debates around universalism in the south and acknowledging that while some define it as conflating the

means and the outcome, the others consider these separately. Chapter 3 is concerned with the foundational architecture of the CHCS, its constraints and opportunities to be more integrated in attaining universal health care. Chapter 4 analyses the gathered data, addresses the reforms and institutional pressures that have contributed to its integration, and shows how unification is portrayed in financial terms. The purpose of the final chapter is to reflect on the contradictions of the healthcare system and analyzes the facts leading to the current deficit and financial imbalances.

Chapter 2 Addressing Health Care as a Fictitious Commodity

A considerable amount of literature has been published on universal health care. It seems that there is a consensus regarding the reasons behind the provision of universal health care; though, in regard to other aspects, such as its significance and the methods necessary to attain it, there is less agreement. These studies have highlighted the essential role of health care at every stage of human life as well the need for universal accessibility to it. Its importance at all stages thus makes it a fundamental human right (Cotlear et al. 2015). The improving conditions and the emergence of a new middle class have justified the demand for increasing number of social services (Franzoni and Sánchez-Ancochea 2016:3). As mentioned above, there is not only humanitarian and ethical reasons that support the advancement of universal health care, but there are also political and economic ones. For instance, in a recent report from 2015 the World Bank stated, concerning the reasons behind the universal provision of health care financial burden caused for receiving the care required at a given moment is unacceptable (Cotlear et al. 2015). The fact that health care could lead to impoverishment, mainly among the poor and vulnerable. Therefore, attaining affordable health care is considered essential in advancing towards the reduction in poverty and inequality (Cotlear et al. 2015).

However, the meaning of universal health care is not very clear. Some studies emphasize that there is a difference between what is desirable and what is achievable given the available limited resources. In this sense, the World Bank presents a comprehensive definition of the universal health coverage (UHC): “UHC is about all people having access to the health care they need without suffering financial hardship.”(Cotlear et al. 2015: 21) That said, the World Bank makes it clear in this regard that “taking the concept literally, it could be said that no country has yet achieved UHC and that it is essentially *an aspirational goal*.(Cotlear et al. 2015: 21)” Hence, this organization highlights the dilemma of prioritizing different dimension - more people or larger packages- “given the inevitable trade-offs” (Cotlear et al. 2015). In the same vein, in its last special report about universal health care *The Economist* recognizes that although the argument for universal health care is clear, implementing it is difficult due to limited resources. Consequently, two options are presented: start by covering a small group of workers in-depth and, progressively add more and more workers from other sectors. Alternatively, they suggest a better solution, cover more people but limit the benefits (McDermott 2018).

A more solid approach to the longer-term significance of the universalistic principle in social policies and its capacity to bring about social integration can be found in Fischer (2012:). His study on the universalistic principle, although not specifically related to health care, shed the light on the different levels of the universalistic principle -from strong to weak- in which social provisioning including health care, is supported. The author also mentions the potential needed to reduce inequality and the presence of institutional barriers that can impede it. His study, built on the Mkandawire’s work, as he states, highlights the necessity to avoid approaches that consider universal and targeting as opposed. First, since it has been recognized that any welfare regime can be completely universal or entirely grounded on targeting (Mkandawire 2005:12) and second because some levels of targeting are necessary for recognizing differences within universalistic systems (Skchopol 1991 in Fischer, Andrew M. 2012). However, the distinction leads to literature appealing for universal social policies (in

particular, in the case of health care and education) based on the idea that the countries where universalistic policies are in place become more egalitarian than those that promote means-testing and other forms of selectivity (Mkandawire 2005:6)

This view is supported by Franzoni and Sánchez-Ancochea (2016: 31) who writes that Fischer's goals are similar to theirs and are meant to: "to separate the definition of universalism from specific historical experience, to establish the possibility of promoting universalism through different channels, and to consider different degrees of universalism." They argue that there are maximalist and minimalist approaches of universalism. The minimalist approach, such the one pictured in the Millennium Development Goals, pays attention to coverage and oversees aspects such as quality, generosity, and equity. The later combines into one the policy outputs and the policy instruments required to reach them. Therefore, their definition focuses on the outputs and mentions that these are desirable (similar, generous entitlements for all.), but warns us against excessive focus on "basic services for all can ultimately result in low-quality services only used by those who cannot rely on private options."(Franzoni and Sánchez-Ancochea 2016:33).

Despite, only in the past ten years have studies on universal health care started to address the attainment universal health care and the process required do so. To this effect, in 2010, The World Bank published *The World Health Report* (2010) which focused on the discussion of the broad approaches, as they later argue. When referring to methods, the organization highlighted three aspects namely: "the population (who is covered?), services (which are covered?), and cost sharing (what proportion of costs are covered)? Consequently, according to the World Bank, decisions had to be taken regarding these three dimensions by prioritizing between the services or the number of people covered, "given the inevitable trade-offs." The 2010 report by the World Bank was normative; it considered the barriers to achieving UHC as well as the instruments to overcome them. In this regard, three obstacles should be removed for reaching universal health care: availability of resources, overreliance on direct payments at the time of need and inefficient, inequitable use of resources. Accordingly, governments must raise resources, remove barriers to access (by extending coverage, by offering more services and/or paying a more significant part of the cost) and, finally, use the resources efficiently(Cotlear et al. 2015).

Additionally, direct payment is not considered an option; thus, there is a call for solidarity "between the sick and the healthy, or between the rich and the poor." (Cotlear et al. 2015)The report conceives risk-pooling or prepayment approach as the "only way to reduce reliance on direct payments." As the poor cannot contribute, pooled funds must be used to subsidize them (through government revenues). To assure sufficient funding and avoid the rich and the healthy to opt out, contributions should be compulsory. In this case, cross-subsidization was considered as an option, and multiple pools were possible if the political will and technical and administrative capacities allow it; in other cases, multiple pools were judged inefficient. According to the 2010 report by the World Bank, the figure illustrates the situation of a country and the features in which a government should centre their attention to moving towards universal coverage. Therefore, "to get closer to universal coverage, the country would need to extend coverage to more people, offer more services, and/or pay a greater part of the cost (World Health Organization 2010)."

The 2015 World Bank report entitled 'Going Universal' was presented as a follow-up to the 2010 report that had referred to broad approaches. Instead, Going Universal focused on

specific issues. By analysing the health care experience in 24 countries, it claims there is no unique method to attaining universal health coverage (UHC). Furthermore, the report stresses that the importance of objectives should not make us think there is such a thing as an instrument consistent with UHC; hence, it favours a wide range of approaches. The 2015 report goes beyond focusing on practical implementation issues which, as it explains, reach beyond the broad approaches that countries had already decided. Although it highlighted that there is not a pretence made to being normative and that they present a description of the choices each country has had to make, it emphasizes the commonly sound patterns. For instance, it talks about a bottom-up approach (different strategies carry out to attend different needs, such as targeting the poor and vulnerable), expanding the benefits (establishing waiting times and maximum financial risk). Additionally, it mentions improving provision (by providing managers with access to some “flexible” cash that can be rapidly allocated to operational needs or as incentives for staff and managers, this expanding their capacity to provide more and better services by engaging with private providers). Finally, it reports on strengthening accountability: delegation, output-based financing, information through data collection for UHC (Cotlear et al. 2015: 12-14).

Two important themes emerge from the World Bank’s and The Economist’s view on Universal Health Care. The first involves the idea that limited resources entail inevitable trade-offs between a massive coverage or generous benefits [since both are difficult to reach], especially in developing countries. The second centers around the idea that universal health care can be pursued through different instruments, and that nonspecific instrument is consistent with universal outcomes in health care. Regarding the first idea, what one can see is that fiscal constraints have been a long-standing argument for limiting social policy. Mkandawire (2005:6) explains that fiscal constraints underpinned the argument favouring means-testing instruments in the late 1970s, since they constitute a more efficient way to allocate resources. Indeed, he highlighted that, politically speaking, it is less convenient to dismiss the legitimacy of universalism than argue in favor of efficiency so as to deal with fiscal constraints. It would, therefore, be politically acceptable.

Furthermore, Mkandawire (2005:6) and Fischer(2012: 10), agree defending the idea of implementing universal social policies in developing countries. Mkandawire supports his argument not only on the idea that universal social policies have proved to be more effective in combating poverty but also, by pointing out the fact that targeting requires an administrative capacity to identify the poor which is unlikely to be found in developing countries (Srivastava 2004 in Mkandawire 2005: 9). Likewise, concerning this topic Fischer(Fischer, Andrew M. 2012) has argued that countries which are currently successful industrializers started implementing universal policies earlier, thus arguing that developing countries being unable to afford it goes against the historical experience.

Concerning the second idea, that there is not a unique and consistent instrument to advance towards universal health, it is necessary to be cautious. As mentioned above, the term universal health care has been widely accepted and adopted; yet, it cannot be said that its meaning is shared. Fischer (2012) issued a fair warning when referring to the consensus on the necessity to address inequality. He said that "recognizing the problem does not necessarily solve the question how to deal with it."(Fischer, Andrew Martin 2013:4) In his article, Fischer (2012: 4) states that inequality appears to have become one of the priorities among the mainstream multilateral institutions; however, as he shows, the proposed instruments to reduce inequality end up being criticized for reinforcing it.

Furthermore, there is a risk that inequality appears to be an issue solved through technical approaches, when its nature is political (Fischer, Andrew Martin 2013: 2). Similarly,

universal health care has become widely recognized as a desirable outcome; however, the instruments proposed to advance towards are the same that have reinforced segregation. For instance, the so-called "bottom-up approach" of the World Bank is based on the idea of efficiency and fiscal constraint endorsing the selectivity of the poor and vulnerable. The result is the policy options such as the ones proposed in the Universal Health Care special report published in *The Economist* (McDermott 2018). These are meant to create two separate health systems, for two different groups of the population: the poor and the non-poor; hence, these systems reflect incompatibly massive coverage and extensive benefits.

Unlike the World Bank's view of nonspecific instrument consistent with universal health care, Mkandawire (2005) highlights the importance of value judgments or ideologies when determining the instruments used to address poverty, inequality, and insecurity. For him, the chosen instruments reflect an ideological predisposition, reflecting the value one places, or the one assumes for a specific benefit. Therefore, for him what is at stake in the choice between universalism (in its maximalist view) or other policies "is the fundamental question about a policy values and its responsibilities to all its members." In this line, it may be assumed that not every type of social policy has the potential to reduce poverty and inequality and, hence, that not every instrument or health care system has the potential to advance towards UHC. Indeed, not all of the social policies are aimed at pursuing those objectives.

In this sense, the firsts discussions about it were carry out considering social policies as a part of the broader debate of welfare regimes, which might help the reader to understand the purposes of the social policy. For instance, Esping Andersen (1999: 78) states that, while in liberal regimes social policy played a residual role "restricted to bad risks" and "disfavoring citizen entitlements", in social democratic regimes, social policy becomes crucial because this regime considers a wide range of risk coverage and generous entitlements in the quest for equality. On this basis, the definition of who was entitled to services and goods was narrow for the liberal regime so, it was based on need or an employment relationship approach. Contrarily, the social-democratic regime considers rights because of citizenship and, in that sense, striver to maximize equality (Esping-Andersen 1999: 78-79). According to Franzoni and Sánchez-Ancochea (2016:8), due to its significant contribution to the understanding of welfare policies, this approach has been useful for analytical purposes; however, Esping Andersen's typology has also resulted in oversimplification.

In this regard, the definitions of universalism provided by Fischer (2012:11) and Franzoni and Sánchez-Ancochea (2016:8) seek to avoid simplistic dichotomies between universalism and non-universalism as well as linking the concept to historical experience. Following from this approach, it is essential to recognize that although there might not be only one instrument consistent with UHC, as the World Bank states, there are instruments that create better conditions to achieve it than others. As Mkandawire (2005: 6) says: "The point is not that there is some functional relationship between universalist policies and redistributive policies in other areas, but that there is an elective affinity between the preference for universalism and other measures, such as high progressive taxes."

Hence, Fischer (2012: 11) proposes that universalism could be understood as guiding principles in three dimensions: access/coverage, cost/price, and financing. Each dimension reflects strong or weak forms of universalism and has "equalizing or disequalising potentials." In the same vein, Franzoni and Sánchez-Ancochea (2016: 16), attempted to qualify the concept of universalism focusing their attention on the ends -coverage, generosity, and equity- and consenting the possibility to achieve it through different means. They categorized as

minimalist the approaches that consider extensive coverage as equivalent to UHC and as maximalist, those normative ones that, through assimilating universalism to the Scandinavian experience, consider that the only way to advance toward universalism which is general taxes. Furthermore, they adopt the concept of policy architectures that comprises eligibility, funding, entitlements, delivery, and regulation of the outside option for specific social policies such as health care, education and pensions. In this sense, the work of Fischer (2012) and Franzoni and Sánchez-Ancochea (2016) shed light on the dimensions or components that can be analysed.

For instance, when referring to strong universalism concerning access/coverage, Fischer (2012: 12) highlights that it can be reached when the institutional structure of the system is more integrated. This permits access through the same channels and services of similar quality. Concerning the cost/price dimension, the author explains that the strong universalistic principle expects these to be decommodified, which implies that prices do not depend on the market forces (Fischer, Andrew M. 2012: 14). Regarding financing, what is meant to be a strong universalistic principle is that this is supposed to be indirect (i.e. that people do not have to pay at the time of need). In this sense, an integrated public system is preferable over social insurance (i.e. the other instrument that allows indirect funding) since the later tends to be more expensive and has a smaller pool of socializing the cost (Fischer, Andrew M. 2012 : 16).

To examine universalism meaning Franzoni and Sánchez-Ancochea (2016) compared the health care systems in four countries: Costa Rica, Mauritius, South Korea, and Uruguay. The study, as mentioned above, focuses on the question of achieving universal policies in the South. To answer this question, they adopted the concept of policy architectures and, based on it, the authors argue that the combination of instruments shapes affects how health care is delivered. Hence, these institutional arrangements allow to determine the different levels of universalism. In their comparative study (Franzoni and Sánchez-Ancochea 2016) they state that the more unified or integrated the systems, the more opportunities exist to achieve universal outcomes. In this regard, comparing the experiences of Costa Rica and Mauritius, they argue that contributory measures can advance to equal and generous access and that the use of general revenues does not necessarily assure universal outputs. Unlike the World Bank and The Economist, Franzoni and Sánchez-Ancochea (2016) have taken a broad approach by answering the question of how, but within a framework of services and transfers provided in a similar, high-quality and generous fashion. Therefore, the author state that "if everyone has access to some health care benefits, but only a few have their cancer treatment covered, there is no universalism to speak of." (Franzoni and Sánchez-Ancochea 2016: 6).

These institutional approaches allow to look beyond indicators that hardly reveal some facts behind the figures. For instance, the World Bank reports 2010 and 2015 take, as indicators for achieving universal health coverage the number of people covered, the extent of benefits provided and that amount of money pooled to expand coverage and services, as is the case with its "UHC cube." (Bump 2015: 12) These indicators tend to overlook the institutional processes behind them. As Fischer (2012: 22) reiterates concerning inequality indicators: "Inequality measures can mask stratification and segregation between poorer and middle social strata, or else exclusionary processes occurring among middle social strata that can have important implications for social mobility." In the case of health care systems, by paying attention to these three aspects the World Bank offers no explanation the effect that relying on profit has on healthcare systems.

Conversely, Franzoni and Sánchez-Ancochea (2016:19) make a case for fragmentation as the primary obstacle to universalism (Franzoni and Sánchez-Ancochea 2016, Agartan 2012, Stange 2009, Fischer, Andrew M. 2012).. In their view, a system is fragmented “when the provision of public social services varies in access and entitlements across groups of people and where there is a prominent outside market option.” Fragmentation can result from the manner in which the institutional arrangements are designed or from marketization. Moreover, in their study marketization and the existence of an outside option was considered as “the shared threat” for the analysed four countries. The reason being is that it negatively influences the other components (eligibility, funding, benefits, and delivery) negatively. For instance, fragmentation due to marketization can result from one access (i.e. when some can pay and other cannot). From funding (i.e. when the difference is that some are right bearers and others are purchasers); from the benefits (i.e. when some treatments are more lucrative than others) and finally; from the provision (i.e. when providers operate under different rules).

Combined, these studies support the notion that profit-motive and marketization has perverse effects on health care delivery. Health care plays a crucial role in human life, and that is the reason it must not be a threat as a commodity. Fischer (2012: 15) states that “given that the inevitable human condition of ill health debilitates bargaining power precisely at a time of greatest need, leading to a stark asymmetry between user and service provider.” The weak bargaining power leads to what the mainstream economics considers market failures; hence, healthcare provision is an appropriate arena for, if not monopolistic practices, then at least non-competitive markets and information asymmetries between the patient and the providers promoting in this way rent-seeking. Therefore, the provision of health care requires planning. Accordingly, prices are required to be determined by administrative means and not according to market forces, this means that the prices are decommodified, and the costs are internalized and socialized within the system.

Overall, these studies highlight the need for looking beyond indicators that misrepresent the reality. That is the reason behind the necessity to consider the methods, the institutional arrangements, affect the delivery of healthcare. Following this approach, theoretically speaking, this paper supports the notion of health care as a “fictional commodity.” This notion has been previously adopted by Mackintosh (2006: 402) and Fischer (2012: 14). The concept which originated in Karl Polanyi, allows for a better understanding of the reason behind the reinforcement of inequality and process of segregation are reinforced when health care is delivered through competitive markets and market forces.

This section has attempted to provide a summary of the literature relating the methods through which countries can achieve UHC. Four ideas have been identified as relevant. First includes the idea that universalism has a significant potential in promoting the reduction of inequality. Likewise, universalism carries significant potential in achieving universal outcomes in health if its principles are reflected in the institutional arrangements designed to deliver it. Second, in the same line, some instruments enhance these outcomes more than other. Third, health care should be understood as a fictitious commodity. Therefore, in health care, provision planning is required. Finally, the analysis of health care outcomes can be better understood if it is accompanied by the analysis of the impact the health system organization has on the distribution of health care-outcomes.

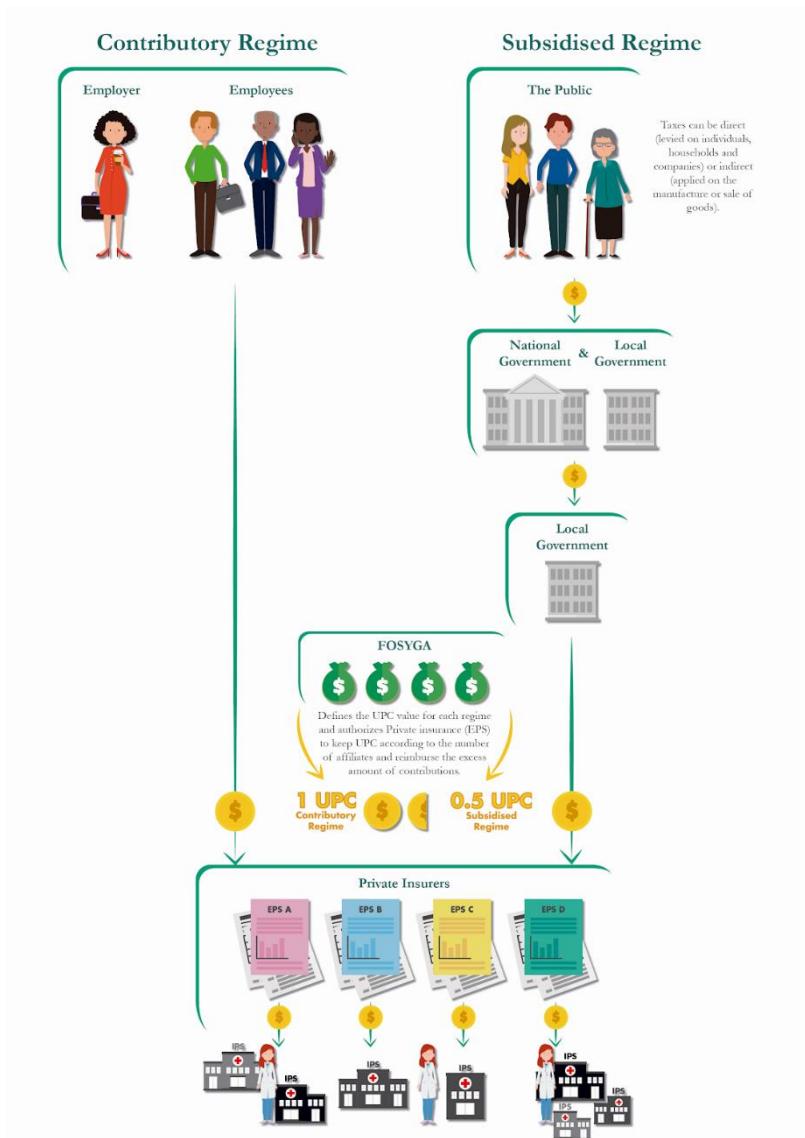
Chapter 3 The Healthcare System Foundational Architecture. The First Phase of the “Managed Competence Model”

Provision of healthcare services in Colombia was reformed in 1993 through Law 100, which envisaged the creation of the General System of Social Security in Health (*Sistema General de Seguridad Social en Salud* or *SGSSS*). The chosen model is called “structured pluralism” or “managed competence model” and is based on insurance, regulated competition, and market mechanisms ensuring that private companies can provide efficient health services (de la Nación, Procuraduría General 2008). By introducing a purchaser-provider split, law 100 sought to overcome the deficiencies of the previous model that was based on supply-side subsidies, considered uneven and deficiently regulated (OECD 2015:17)

The CHCS was founded on the idea of not only providing each individual the care they need but also recognizing the necessity of making the best use of limited resources. It would thus promote competency, solidarity, and presumably equality. In this regard, four of the principles underpinning the system are worth mentioning: universalism (especially regarding coverage), fiscal sustainability, progressiveness, and equity. Concerning universalism and equity, law 100 of 1993, set up two objectives which had to be achieved before the end of 2001. The first one involved the coverage of the entire population and the second, the equalization of healthcare benefits received within the contributory and the non-contributory scheme (de la Nación, Procuraduría General 2008) Regarding progressiveness and fiscal sustainability, the aim -in line with the Colombian Constitution- was to gradually advance in healthcare provision while bearing in mind that it comprised considerable investments (Durán and Uprimny Yepes 2014).

According to Law 100 (República de Colombia 1993), the Ministry of Health and Social Protection directs, coordinates and controls the healthcare system to which is mandatory for all the legal residents to be affiliated. Both employed and unemployed Colombian residents are affiliated through private insurances called Private Insurers (*Entidades Promotoras de Salud* or *EPS*) which they can choose freely thus promoting competence. These agencies oversee affiliation and administration of healthcare services provision (i.e. purchase of the healthcare services). Additionally, private insurers must receive their revenues through a capitated payment (UPC) per affiliate. Law 100 appointed the Solidarity and Guarantee Fund -*Fondo de Solidaridad y Garantía* FOSYGA- as the institution which would pool health funds accruing to the Contributory Regime (CR) while, in the Subsidised Regime (SR), health funds were to be pooled by local governments. Therefore, to guarantee healthcare services, private insurers must contract providers and suppliers (*Instituciones Prestadoras de Salud* IPS). Additionally, considering the existence of information asymmetries between the patient and the doctor, there was an acknowledgement of the need for vigilance and control by the state. Consequently, Law 100 established the National Health Superintendence, which is responsible for monitoring health actors, assessing providers and sanctioning those health actors not meeting the legal requirements (República de Colombia 1993; de la Nación, Procuraduría General 2008).

Figure 1 Foundational Architecture of the Colombian healthcare system



Source: the author's own collection based on Law 100 and an interview to the Legal Advisor of the Ministry of Health and Social Protection (conducted in 2018).

3.1. Foundational architecture component of the CHCS¹

The CHCS could be considered fragmented in terms of access due to three different affiliation regimes: one for those poor, one for the non-poor and a special one for teachers, state military employees and workers of the state petroleum company. It was also fragmented in terms of funding because each regime was not only funded through different resources but also its administration was attributed to different institutions. Furthermore, regarding entitlements it was fragmented too since the Contributory and Special Benefit Regime received more generous benefits than the subsidized regime. Finally, although the affiliation to

¹ A preliminary version of the information here mentioned has been written and incorporated in: *Universal Health Care in Colombia: Realisable?*. Unpublished work, 2017 María Alejandra Orjuela Ramírez

the general health care system was mandatory, the existence of private insurers and the possibility of acquiring complementary benefits was permitted (República de Colombia 1993).

Under what criteria do people benefit?

According to the Law 100, the SGSSS covers all Colombian residents in all periods of their lifetime. The obligatory affiliation to SGSSS is carried out through two regimes: contributory and subsidized. Although it is not regulated by Law 100, there is also the existence of the third special benefit regime. The latter provides health care for the armed forces, teachers, and the state-owned petroleum company. Moreover, migrant population is affiliated to SGSSS under the same conditions as Colombian residents. (República de Colombia 1993) Figure 1 illustrates the foundational architecture of the two-main regime as described in Law 100. Many reforms have changed this initial structure.

The contributory is arranged for people with payment capacity, including those individuals with employment contracts, receiving a pension or self-employed who earn no less than the minimum wage. The contribution depends on their income regardless of the risk or illness. Affiliate's family members are considered beneficiaries, and they include the spouse or the partner, children aged up to 18 or 25, if dependent economically on the affiliate, children without an age restriction if there is a proved incapacity. Likewise, a spouse's or partner's children are affiliated under the same requirements mentioned above. Affiliate's parents without pension and depending economically on her can be covered when in the absence of a spouse or a partner. The affiliation of the beneficiaries is carried out by handing the identification documents which prove the relationship with the contributor (Law 100 of 1993).

The subsidized regime is designed to guarantee affiliation for most vulnerable socio-economic groups that cannot afford health care through their own means. They have to first apply to Beneficiary Identification System -*Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales SISBEN*-, the national survey designed to identify the beneficiaries of social programs and to measure their socio-economic vulnerability (Martínez et al. 2011). After being categorized into levels 1 or 2, they can be affiliated to the subsidized regime.

Who pays and how?

Different sources finance the CHCS. For example, the financing sources of the CR came from the employer and employee payroll contributions. Additionally, the subsidized regime's financial sources came from national and local tax revenues, the cross-subsidization from the CR, and the resources of the subsidized regime affiliates, to the extent of their paying capacity (Law 100 1993).

In the contributory regime, while formal employees pay a portion of their wage, added to a percentage provided by the employer, the self-employed spend 5% of their contract fees. Contributions made by formal employees and their employers corresponds to 12 % of each worker's salary whose payment is distributed between the employer and the employee, the former paying 8% and the latter one 4% of their income. Similarly, self-employed individuals pay 12% out of their 40% per contract fees. (Durán and Uprimny Yepes 2014, OECD 2015),

According to Law 100, the above contributions flow to a common fund called FOSYGA (Solidarity and Guarantee Fund) and are then redistributed to the private insurers (EPS). However, Law 100 allows the delegation of the contribution collection to the EPS. This is the reason behind the fact that the funds go to the insurers directly in the CR as shown in Figure 1. As a result, FOSYGA is in charge of defining the UPC value for each regime and

authorizing the private insurers (EPS) in order to keep the UPC in accordance with the number of affiliates and give the extra money back to the SGSSS. In cases when the EPS has a negative balance, FOSYGA compensates the deficit (Plaza et al. 2001).

Finally, the subsidized regime is financed through the sources of the solidarity FOSYGA sub-account, which comprises 1.5% taken from the contributory regime, a contribution from the national budget, from oil exports and from the social aggregated value tax. These resources are transferred to local governments which contract EPS to attend the individuals affiliated to the subsidized regime (República de Colombia 1993). Since they are considered the most vulnerable individuals, the affiliates of the SR do not make co-payments for benefit if they belong to SISBEN 1. In the meanwhile, while those who belong to SISBEN 2 pay only a 5% co-insurance rate (OECD 2015)

The financial balance of the SGSSS is achieved through the capitated payment per enrollee (*Unidad de Pago por Capitación*, UPC), which is a fixed insurance value per person enabling the user to receive the health care required from the system. The UPC covers and unifies the costs of the essential services provided by the system through a benefits package (OECD 2015). At the time of the implementation of Law 100, the UPC value of the subsidized regime was 50% that of the contributory regime (República de Colombia 1993).

Through the FOSYGA, the government determines the "cross-subsidies," which allows to define how much should be assumed by the General National Budget (PGN), payroll contributions, co-payments (de la Nación, Procuraduría General 2008). It is claimed that the UPC is adjusted according to geographic, demographic and epidemiologic factors; however, according to the OECD (2014:61), it has been calculated by accounting available funds rather than health care needs. The UPC has a different value for the contributory and the subsidized regimes, the former being the larger of the two.

How are entitlements defined?

As subsidized scheme insurers started receiving 50% less than the UPC paid to contributory EPS per affiliate, the entitlements were not equal, and they had to be the same by 2001 (República de Colombia 1993). Moreover, the entitlements of both the subsidized and contributory schemes were unequal to those provided by the special regime. Not only did the special benefit regime have a larger package of services than the contributory, but also greater than that of the subsidized regime. Additionally, the former did not entail the obligation of making co-payment.² In the CR case, the individual who contributes does not have to make copayment, but it is mandatory for the contributor's family group or dependents, who have to partially bear the cost of certain services.

The provision: who does it?

Healthcare services are provided through health insurance agencies -EPS, which are chosen by users in order to promote competency (OECD 2015, Plaza et al. 2001, Londoño and Frenk 1997). These organizations are responsible for arranging individuals' affiliation, organizing and assuring the provision of health services and addressing health risk

² Co-payment is the additional payment of those expenses that are not covered by UPC. The affiliate must make it in proportion to her income.

population. In this sense, they must afford benefits included in the benefits package. The availability of services covered in the POS must be assured either through contracting service providers and suppliers (Instituciones Prestadoras de Salud IPS) or by offering health services directly, through their provider network.

The assurance must include health promotion, disease prevention, ambulatory, and inpatient services or rehabilitation. Additionally, EPS can select their healthcare providers (Instituciones Prestadoras de Salud or IPS) that can be either public or private (de la Nación, Procuraduría General 2008). They compete to provide healthcare service in what has been called a mixed public/private market; however, while private hospitals are considered as commercial entities and regulated as profit-making, public hospitals have the status of a state-owned enterprise (Londoño and Frenk 1997).

Local governments, namely departments, municipalities, districts, indigenous territories and occasionally regions and provinces, supervise public health arrangements and oversee the subsidized scheme administration. They bear the responsibility for monitoring and controlling the affiliation of those without payment capacity as well as the efficient provision of health services within their territory. Additionally, they allocate the financial resources within the subsidized regime and contract the EPS' healthcare provision (República de Colombia 1993).

Market-based alternatives

Those willing to pay extra can receive additional services through three mechanisms. First, paying additional services to those set forth in the POS. This was established as a complement to the services provided by the SGSSS, and it offers access to treatments excluded from the POS as an additional arrangement that must be financed entirely by the inscriber. Second, contracting prepaid medicine to enhance quality of care, which provides pre-hospital assistance and ambulances. These optional insurance plans are the complementary provision to the POS offered by EPS. Therefore, obtaining voluntary insurance requires previous affiliation and continuity on the payment made to the CR. The third option is to buy insurance policies administered by the insurance companies. These three voluntary health plans have become an option for those who have the means and need a rapid and more efficient response, thus avoiding the waiting list and low-quality treatments (Law 1438 of 2011).

3.2. Foundational architecture's components leading to opportunities and constraints

In regard to coverage and benefits, four features of the CHCS have contributed to the following expansion of health care. First, health was conceived as an inalienable resident's right, which reflects the change of values that have taken place in Colombia and in Latin America in general. Second, it started off by guaranteeing to the poor population half of the services that used to belong to the contributory regime, but with the promise that they will be equalized. Third, it reaches all workers, both employed and independent, pensioners and, in general, those who can afford to be insured, along with their families. Finally, the outside option is determined by the previous affiliation to the GHCS; hence, there is a possibility of acquiring complementary services or voluntary insurance for those willing to pay extra to receive additional or enhanced quality services, albeit it under restrictions.

On the other hand, five features have led to fragmentation and could negatively affect health care arrangements in long-term. First, the state involvement was restricted to regulating the sector while funding and service provision was kept as minimal as possible (Martínez et al. 2011). In this regard, public funding was directed only to the poor affiliated population or not registered in the system and to provision through public institutions, targeting the population not affiliated or whose services were not covered in the basic subsidized package. Second, administration of health funds was overseen by FOSYGA in the CR case; in the SR case, this duty was assumed by local governments. Although it was established that FOSYGA was to manage the CR funds by pooling them, it delegated this function to the insurers. Third, the lower value payment per affiliate discourages insurers to affiliate subscribers from the subsidized regime, thus promoting the creation of separate insurers for the SR and the CR. As a result, EPS became mere intermediaries collecting contributions and compensating providers but not managing clinic risk (OECD 2015:83). Fifth, not of all the insurers were under the same financial conditions.

Chapter 4 Taking a Path Towards Unification. The Second Phase of the “Managed Competence Model”

This chapter presents some of the challenges faced by the system, as well as the norms issued to address both the unresolved and unexpected outcomes of Law 100. Year 2008 was chosen as the starting point of the analysis because the first failures of the system were unveiled after judicialization of the “right to health”. This has become particularly relevant after the Constitutional Court’s ruling T-760 (2008), which put health care on the public agenda. Consequently, many rules were issued to comply with the court orders. Accordingly, this chapter will be divided in three main sections. The first will refer to T-760 ruling, its contributions -mainly in terms of entitlements- and some the recognized effects. The second section will refer to Law 1438/11, most of the reforms regarding funding and its administration through this Law. Finally, considering that the financial sustainability of the system has been one of the main concerns since the implementation of the system, the third part will provide a subsection of the system’s financial results from 2010 to 2016. The idea is to understand how the reforms adopted after the T760/2008 ruling have been materialized in financial terms. Overall, what can be observed is the unification across the architecture of the system, both legally and financially.

4.1. Unification regarding entitlements: a judicialization-driven effect

Regarding universal health care provision, what is desirable in terms of benefits and services is that these are generous, similar in quality, level, and provided to everyone (Fischer, Andrew M. 2012, Franzoni and Sánchez-Ancochea 2016). In this sense, state policies can promote fragmentation when institutional arrangements are designed in such a way that the provision of services is differentiated and ends up being more generous for those who have the means and less for those who do not (Stange 2009). The CHCS had been highly fragmented concerning entitlements because it defined a package of services for different segments of the population and, in some cases, involved co-payments. Moreover, the SR unit per affiliate paid to insurers cost 50% less than the one paid for contributory affiliates, which consequently entailed unequal access to benefits and services for those belonging to the SR. However, simultaneously, by establishing eight years for maintaining this differentiation, Law 100 recognized that this might have negative effects.

Nevertheless, in 2001, health became subject to litigation on account of persistent problems of provision, failure to comply with the full coverage and equal provision of services to the population (Durán and Uprimny Yepes 2014, Rodríguez 2012). This was even though health care had been constitutionally recognized as a right of all residents. Subsequently, those who thought that health care services were denied unfairly and whose provision could be a determining factor in maintaining one’s life, started bringing lawsuits against insurers or providers to meet their demands for health care access. Some of the services were included in the benefits package while others were not (Duran & Uprimny 2014). *Tutela* was the litigation mechanism used to make these claims and had been designed to guarantee the immediate protection of civil and political rights. However, from 1993 to 2008, the number of

tutelas issued to guarantee economic and social rights such as healthcare, grew significantly. While in 2000, 24.843 health care tutelas were issued, in 2014 their number increased to more than three times, reaching 117.746, according to the OECD (2014:16,78).

Furthermore, as most of the cases tended to address concrete situations of either one individual or a family, the Colombian Constitutional Court decided to expand the scope of its decisions and gather various cases in which the right to health had been demanded (Rodríguez 2012, Uprimny and Durán 2014). Moreover, through the T-760 ruling of 2008, the Court identified structural problems in the design and implementation of Law 100 and found that the government had not acted following the mandate of guaranteeing health progressively, as a social and economic right. In doing so, the court issued orders of mandatory compliance to the government: it ordered to actualize and unify the basic package of services or POS (*Plan Obligatorio de Salud*) for the two regimes and the acceleration of universal coverage before 2010 (Rodríguez 2012). In this light, with a broader idea of health care enforceability, the system had to be adapted to the orders issued by the Constitutional Courts. After 2008, the government has continued promoting universal coverage, which, as a result, has been increasing since the Law 100 implementation. Additionally, following the court's orders to gradually equalize the benefits between regime, three acts were enforced: Act 004 of 2009 equalized the benefits for children aged 12 and under; Act 11 of 2010 made equal health services accessible for people of sixty years and over; and, finally, Act 32 of 2012 equalized all the services for the two regimes (Uprimny and Durán 2014). As shown below, the benefits equalization has been concomitant with increments in the revenues of the system; however, it seems that this increase in revenues has not materialized in practice.

To sum up, judicialization has paved the way for unification, especially in terms of entitlements. First, this is evident from the orders related to the continuous actualization of the service package and the request to the government for a plan that equalize the services. Second, as some of the services were not included in the service package, judicialization has ended up widening the range of the provided services. Yet, in this regard, it has been acknowledged that judicialization might have a segmentation effect in the sense of litigation being a resource primarily used by affluent and informed people, hence, benefiting those who have the chance to dispute (Ferraz 2010, Rodríguez 2012). Other researchers, however, highlighted that decisions with structural effects, namely the T-760 case, have the capacity for breaking the deadlock and benefitting those who do not have the capacity to litigate (Uprimny and Durán 2014). This was carried out by changing the behavior of the involved parties (government, services providers, insurers and civil society) and by making current problems of the system both transparent and subject to debate, focusing mostly on government's action (Uprimny and Durán 2014).

As far as benefiting those who cannot or do not have the capacity to litigate, it is important to mention that equalization of the benefits basket included in the CR and SR, as announced in 2012, has led to accelerating the respective increment in the SR UPC paid to the insurers. Hence, in recent years, the UPC in the SR has increased to match with that of the CR (OECD 2015, en Salud 2016). This implies that services are equally provided between the CR and the SR.

4.2. Unification driven by Law 1438

This section will refer to the changes promoted through the Law 1438 reform, which have resulted in a more unified system. First, this will be done in terms of access and, then, in terms of funds administration. In 2011, reforms such as Law 1438 were implemented to pursue the strengthening of the health care system by addressing persistent failures demanding urgent reform. The core objectives of Law 1438 were in line with the court orders whose focus had been the healthcare system outcomes: reach the equalization of health care services between the regimes, the universal coverage and guarantee of the possibility to receive health care across the entire country. All of this shall be implemented within a framework of financial sustainability (República de Colombia 2011). The means to achieve these objectives have been considered insufficient to resolve fragmentation in the health care system, thus limiting the action of the Health Care and Social Protection Ministry to guarantee the laudable purposes set out by the Laws 100 and 1438, and the Constitution.

4.2.1. Access

Fragmentation driven by Law 100 created repercussions concerning access by setting a marked distinction between regimes, one for those who can contribute to social insurance and the other for those who cannot. In total, three kinds of fragmentation effects were identified. First, although the purpose had been universal coverage, there was a population excluded from the system. Second, there were target errors type I. Third, two main kinds of insurers were in place: some that affiliate users to the CR, and others that affiliate to SR. Each of these problems was attempted to be solved by applying one or two measures.

First, after establishing two eligible forms -one for the non-poor and one for the poor- the system excluded those who cannot afford an affiliation to the CR but who, at the same time, are not categorized as level-1 or level-2 by the SISBEN and, hence, could not be affiliated to the SR. This situation has been defined as targeting error type I, “which occur when someone who deserves the benefits is denied them” (Mkandawire 2005: 15). Law 1438 established two measures that attempt to solve this issue. It insisted on the need to affiliate the whole population to the health care system; hence, it established the capacity payment presumption and guaranteed the portability of the insurance. This means it has ensured the provision of health care across the entire country. This resulted in the fact that insurers must create agreements with healthcare providers to assure that provider will deliver the care. Additionally, Law 1438 established an unemployment health care insurance for those who have been contributing for at least one year to the compensation funds (meant for providing education, rent allowance and other subsidies for low-income family groups)(República de Colombia 2011). This may lead to solving, at some point in the future, the problem of having excluded a significant part of the population. Finally, it also created a partial subsidy as contribution for those who have not been affiliated.

Second, the system led to discourage individuals to do activities that may improve their incomes because, if they do so, they were not longer eligible for public support. In this regard, Mkandawire (2005: 15) suggests that “the high marginal effective tax rate can act as disincentive to getting out of the “poverty trap”. Therefore, by trying to be efficient in the allocation of resources to the needy, the system ends up being inefficient and, instead, creates the undesired effect of dependency (van Oorschot 2002:178 in Mkandawire 2005: 21). Due to this fact, two measures were set up. The first one, was to permit a rate proportional to the income of those who earned less than the minimum wage. For instance, an affiliate to SR that start working per hour but would not want to be affiliated to CR because of her casual

employment relationship, the employer and the employee could pay proportional contribution to the SR. Second, Law 1438 and then a decree issued in 2013 updated affiliation criteria facilitating the “mobilization” between regimes, without interruption of the affiliation. In this way, if someone belonged to the subsidized regime and started being employed formally hired, he or she could remain affiliated through the same insurer but receiving economic benefits such as parental leave, sickness leave and other, when necessary. In the case when someone was affiliated to the contributory scheme but lost her payment capacity, she had to first apply to the national survey designed to identify the beneficiaries of social programs (SISBEN) and, unless previously categorized, be categorized in level one or two (this is if she had not been categorized before)(República de Colombia 2011).

Third, a more generous payment per affiliate to the CR encouraged the creation of companies as EPS to exclusively assure those who could pay for health care. This reinforced fragmentation in a double sense. On the one hand, by creating a noticeable division between insurers for the SR and insurers for the CR and, on the other, by promoting the existence of multiple insurers, which made it difficult to compare and guarantee similar treatment and quality of services. Therefore, Law 1438 attempted to reduce this fragmentation and enhance the continuity by establishing that insurers could offer package services for both regimes, which was still different at the time of the law enactment). One of the consequences of this measure affecting the mobility between the regimes was that the line dividing the insurers for both regimes was blurred. That is, while before Law 1438 of 2011 it was easily identifiable which insurers were for the contributory scheme and which for the subsidized during the first years, once the legal reform was implemented, the mobilization of users imposed on insurers the obligation to provide services irrespective of the affiliation of their patients.

4.2.2. A significant change: centralization of the health care funding administration

One of the factors that contributed to the fragmentation of the Colombian health care system was the fact that there were two different institutions in charge of pooling and redistributing the resources to the insurers in each regime. In the SR case, the local governments were responsible of the affiliation and contracting the SR – insurers, while in the CR, FOSYGA was the institution that was supposed to pool the contributions. In the latter case it transpired that this function was delegated to the EPS. The manner in which pooling, and resources were administered created perverse incentives for both the local governments and insurers in the CR.

According to a recent report of the OECD (2015), Law 100 had assigned responsibilities to actors who were not completely capable to assume them. Hence, there was a contradiction between policy and practice. For instance, misuse of the funds was found within the public and the private sector. In the case of local governments, municipalities’ duties concerning the administration of the SR (e.g., affiliation, pooling revenues and purchasing services) were influenced by the relations of patronage and clientelism. Moreover, increasing coverage was not proportionally compensated; hence, public hospitals saw their revenues decrease.

Therefore, concerning funding and, specifically, the administration of the SR, Law 1438 established that Local Governments (*Entidades Territoriales -ET*) shall continue oversee the

subsidized scheme administration regarding affiliation; however, the central government is the one accountable for transferring the UPC directly to the EPS or the IPS. This is notwithstanding the fact that ET are still responsible for conducting healthcare services for those who are not affiliated neither to CR nor SR. This implies that since 2011, FOSYGA, and then ADRES (*Administradora de los Recursos del Sistema General de Seguridad Social en Salud*), starting in 2015, pools the financial sources of the SR as illustrated in figure 2. This was an important reform because the administration of the funds in charge of FOSYGA in the CR case and the ETs in the SR case was one of the features that had made the system fragmented.

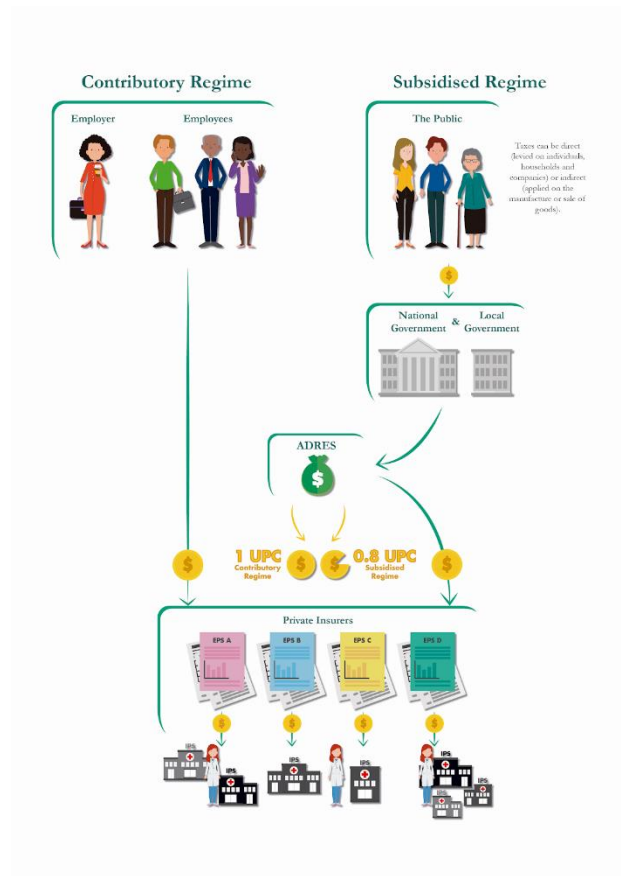
Table 1 illustrates the reformed features that led to a more unified system, and figure 2, depicts the way in which reforms have changed the financial structure of the CHCS. Three main features have made the system more unified: equal and generous entitlements, measures regarding access and, finally, the centralized administration of the health care sources for one fund -the ADRES.

Table 1: Reforms leading to a more unified system

Driver	Criteria unified	Content
Judicialization	Entitlements	<ul style="list-style-type: none"> • Equalization of benefits • Generous entitlements, such as those excluded of the services package (POS) • MIPRES
Law 1438, Decree 2353 of 2015.	Access	<ul style="list-style-type: none"> • Portability • Continuity (Same insurers from different regime) • Unemployment insurance • Proportional contribution in case of a remuneration inferior to the minimum wage • Mobility within regimes (reduce segregation)
	Funding	<ul style="list-style-type: none"> • Centralized administration of funds for the subsidized regime • Direct payments from the FOSYGA, (currently ADRES) to providers

Source: the author's own collection based on Cifras del sector Salud. Ministerio de Salud y Protección Social (2013, 2014, 2016)

Figure 2 Taking the path to unification



Source: the author's own collection based on Law 100 of 1993, Law 1438 of 2011 and an interview conducted with a Health and Social Protection Ministry's legal adviser (2018)

4.2.3. Financial effect of the institutional reforms

The reforms mentioned in this section share the feature of requiring the financial support of the government. Not only would equalizing the benefits imply the rise in the SR-UPC and, hence, in revenues, but also the measures related to access require extremely high administrative costs. For instance, the mechanisms for guaranteeing portability and even continuity within the regimes (i.e., when affiliates change regime from SR to CR and vice versa) will entail articulation among the insurers, providers and those local governments recognized as poor in the 2014 report of the health care system.

Since the aim of this section is to show the financial consequences stemming from judicialization and legal reforms after the T760/2008 ruling in terms of the increase or decrease of revenues and expenditure for both regimes, the considered period will start after the unification of the benefit package across the SR and CR. Equalization took place from 2010 to 2012; therefore, this period and the subsequent years between 2013 and 2016 will be analyzed. The purpose is to establish whether there has or has not been an increase in the 2012 revenues and expenditures between the regimes. Moreover, this study will analyze the period from 2010 to 2016. Ideally, the years 2008 and afterwards would have to be presented and compared to the financial situation of the system before 2008; however, the data

available online only shows information from 2010 onward. In table 3, the sources of financing allocated to the CR and SR.

Four sources of information were used in developing this section: three reports entitled Financial Data of the Health Sector published by the ministry of Health Care and Social Protection bulletin number 1 (November to December 2013), bulletin number 10 (May to June 2015) and bulletin number 13 (2016), as well as a fourth document entitled Sources and Uses of the Health Care System. These bulletins compile budget execution reports from FOSYGA, the Ministry of Healthcare and Social Protection as well as the National Department of Planning (DNP). Although it is intended to be a bimestrial publication, the ministry's web page has only published annual reports from 2013, 2014 and 2016. Evidently, each of these publications collect information from preceding four to five years. For instance, the 2013 bulletin provides information about years 2010 to 2013, the 2014 bulletin for years 2010 to 2014 and, finally, 2016 bulletin from 2012 to 2016. These bulletins are aimed at governmental offices, health care sector professionals, experts, researchers, students, and the civil society.

The document presents the description of the financing sources (revenues) and the uses (expenses) of the healthcare system as well as its analysis. The bulletins also show data on the amount of money devoted to each of the system's financial sources: contributions, national and local taxes. The 2013 bulletin comprises two parts, first, it explains the financial sources of each scheme separately, indicating which sources finance the CR and which the SR. In the second part, it compiles the figures in a table titled "Sources of the healthcare system resources 2010-2013 (2013=100)". Unlike the 2013 bulletin, the 2014 and the 2016 bulletins show the data related to sources and uses (expenditure) of the healthcare system without discriminating which sources of finance fund each scheme.

While the 2014 bulletin refers to the financial healthcare structure presented in the 2013 bulletin, the 2016 bulletin must be accompanied of a second document that presents the financial structure of the healthcare system in more detail. This is important, since from 2011, ADRES is the institution in charge of redistributing the resources between the SR and the CR. As mentioned above, before 2011, funds for the subsidized regime were pooled at the local level. However, Law 1438 relieved the local governments from the responsibility to pool and manage the resources; ADRES assumed that function instead.

In order to use the most recent data, the scope of this study was limited to bulletins 2014 and 2016. The analysis of these two bulletins has allowed to scrutinize a wider range of years. The data from years 2010 and 2011 was updated to 2014, while the data of 2012 to 2015 was updated to 2016. As the bulletins do not refer to the utilized price index, which is not mentioned in the bulletins, to present accurate information, it was decided not to update the information related to years 2010 and 2011.

In order to gain a better understanding of the figures, table 2 illustrates the financial structure of the healthcare system. It is evident that the CR and the special benefit regimes are funded through payroll contributions and the SR through national and local taxes. As of 2014, the financial structure of the system was modified, and an equity tax known as CREE substituted some of the employer contributions. Consequently, a new column has been added to denote this change. Evidently, the subsidized regime is funded through national, local and other sources. National sources comprise the share of cross-subsidization raised from the CR, sources from family subsidy fund and taxes raised by central government (the

sale of alcohol and casinos). Additionally, local sources come from local taxes and revenues ceded by the national government to municipalities.

Table 2 : Financial structure of the healthcare system

Regime	Source	
Contributory regime	Contributions	Employee (4%) and employer (8,5%) Dependent and independent workers 12,5% IB
		Pensioners 12%
		Exception regime and special regime 12%
		Since 2014 CREE
Subsidized regime	Central Sources	1.5% of the cross subsidization (contributory and special regime)
		Family subsidy funds
		Sources of the national budget -Law 1122/2007
		Taxes for the sale of alcohol and casinos
	Local Sources (Municipalities and Departments)	Ceded revenues (<i>Sistema general de participaciones</i>)
		Other Revenues ceded by the national government to municipalities
		Local resources
		Financial returns
	Sin taxes (alcohol, cigarette, tobacco)	

Source: the author's own collection based on Cifras del sector Salud. Ministerio de Salud y Protección Social (2013, 2014, 2016)

The analysis of the data comprises four stages. The first stage identifies which resources were allocated to each regime and which to the uninsured the low-income population. Although Law 100 is clear in establishing the financing sources of the contributory regime, the same does not occur for the SR. The reason is that funding for the SR comes from various sources of financing some of which have a share allocated to finance the provision of healthcare to the impoverished uninsured population. The second stage presents the information from 2010 to 2016 and identifies the resources per regime. These were added separately to establish the total amount per regime in a single table (see table 3). In this table, the graph only shows information about the health care resources directed to the SR and the CR. The first graph illustrates revenues per regime and the second one the resources per regime per capita. Finally, the fourth stage identifies the expenditures per regime which could be easily identified when compared to the revenues because they were separated in advance. The figures were also plotted on two graphs: one for the expenditures by regime and other for each regime and per capita.

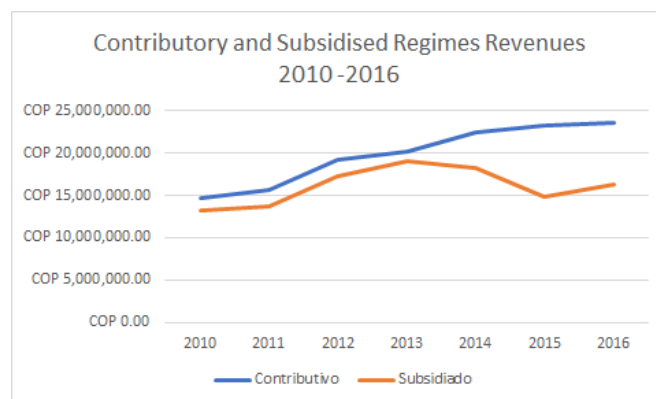
Table 3: Financial resources of the healthcare system per regime

Revenues	2010	2011	2012	2013	2014	2015	2016
CR	COP 14,608,872.86	COP 15,682,515.96	COP 19,129,304.8	COP 20,122,958.0	COP 22,484,551.7	COP 23,289,058.3	COP 23,621,380.5
SR	COP 13,219,169.1	COP 13,730,193.0	COP 17,197,576.2	COP 18,993,583.0	COP 18,228,305.3	COP 14,896,688.7	COP 16,260,804.5

Source: the author's own collection based on Cifras del sector Salud. Ministerio de Salud y Protección Social (2013, 2014, 2016)

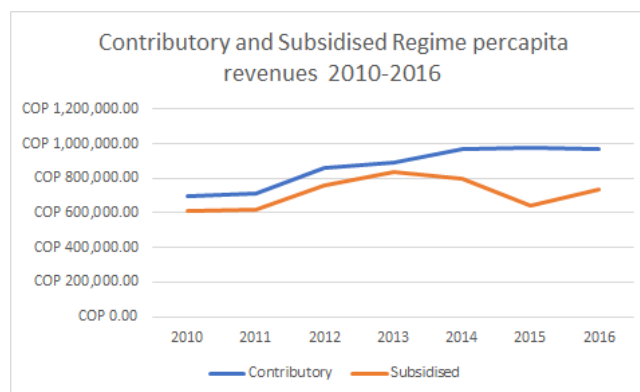
Figure 4 illustrates a stable growth of the financial sources in the contributory scheme during the period between 2010 to 2016. In the case of the subsidized scheme, there was a gradual increase between 2010 and 2014. In 2014, there was a slight decrease in the financial sources until 2015, followed by a slow recovery. This was mainly due to reductions in financial return from FOSYGA and, in less proportion, family subsidy funds, and local revenues. Evidently, between 2014 and 2016, the difference in the revenues of the contributory and subsidized scheme increased. However, revenues from the CR comprise the contributory UPC as well as employees' economic benefits such as sick leave, parental leave and others. Likewise, figure 5 shows an overall increase in the expenditure per capita for both schemes, which is significant because there was an important reduction in the population not covered by either of these schemes. While the expenditure per capita in the contributory scheme grew steadily, the subsidized scheme decreased slightly between 2010 and 2011. After 2011, there was a significant rise until 2013, which was largely due to the Constitutional Court orders. In its wake, the unification of the benefits package has started progressively in 2010, with the equalization of the benefits provided to children under 14 years and the adults over 60 years. These results coincide with the increase in the UPC per affiliate in the SR as shown in figure 1.

Figure 3 Contributory and Subsidised Regimes per capita revenues 2010-2016



Source: the author's own collection based on Cifras del sector Salud. Ministerio de Salud y Protección Social (2013, 2014, 2016)

Figure 4 Contributory and Subsidised Regime per capita revenues 2010-2016



Source: the author's own collection based on Cifras del sector Salud. Ministerio de Salud y Protección Social (2013, 2014, 2016)

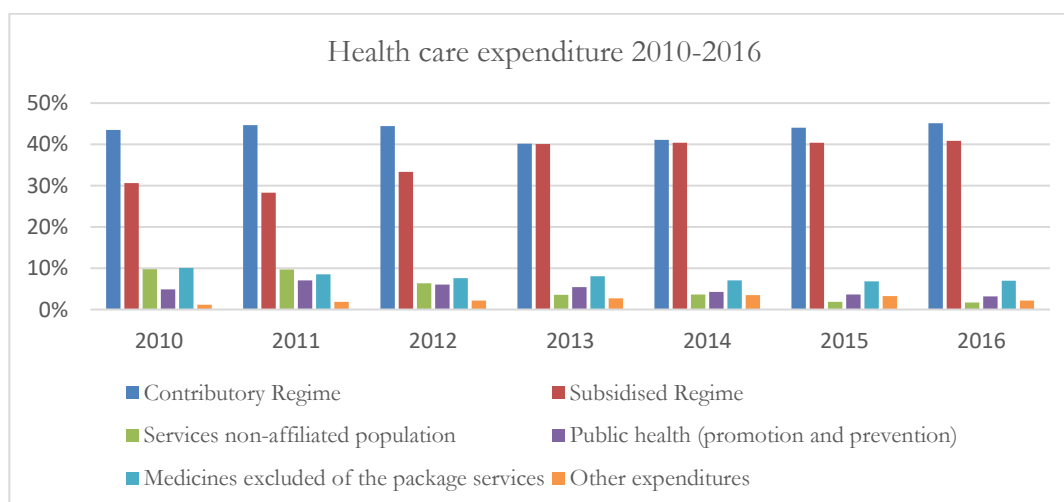
Healthcare expenditure is illustrated in table 4 and figures number 6, 7 and 8. Table 4 and figure 6 show the amount per item. The expenditure in the CR and the SR are the most important as both are approximately 40% of each one's expenditure. The next one is services provided to the unaffiliated population and services excluded from the benefit package which can be recognized through tutela and, currently, through the mechanism known as MIPRES. Other expenditure includes operating costs and SOAT –an insurance covering traffic accident.

Table 4 Expenditure of the healthcare system (2010-2016)

Expenditure item	2010	2011	2012	2013	2014	2015	2016
Contributory Regime	11,768,059	12,272,490	14,593,160	15,490,444	16,085,481	17,392,360	18,480,184
Subsidized Regime	8,298,631	7,762,743	10,944,959	15,465,973	15,833,210	15,928,281	16,736,998
Services for non-affiliated population	2,644,780	2,670,144	2,087,182	1,366,551	1,433,964	745,374	694,419
Public health (promotion and prevention)	1,328,958	1,930,789	1,990,635	2,098,948	1,670,465	1,437,249	1,310,421
Medicines excluded from POS	2,726,978	2,332,255	2,496,892	3,100,637	2,771,884	2,680,824	2,846,968
Other expenditures	312,942	500,373	721,798	1,052,040	1,368,652	1,286,317	871,040
Total	27,080,348	27,468,794	32,834,626	38,574,593	39,163,656	39,470,405	40,940,030

Source: the author's own collection based on Cifras del sector Salud. Ministerio de Salud y Protección Social (2013, 2014, 2016)

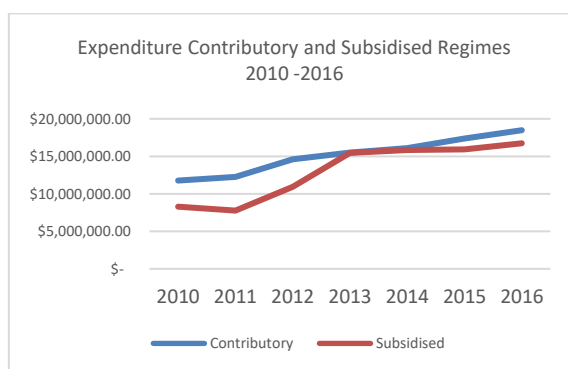
Figure 5 Healthcare expenditure 2010-2016



Source: the author's own collection based on Cifras del sector Salud. Ministerio de Salud y Protección Social (2013, 2014, 2016)

Figures 7 and figure 8 illustrate the health care expenditure in the CR and the SR. Both graphs show and overall increase in the expenditures in the two regimes between 2010 to 2016. From 2010 to 2013, the growth is gradual; in 2013, the expenditure of SR reached that of CR; from 2013, there is a steady increase. Figure 8 shows a per capita similar expenditure in both regimes, also coinciding with the rise in the UPC of the CR and the SR showed in graph 1.

Figure 6 Healthcare expenditure Contributory and Subsidised regimes 2010-2016



Source: the author's own collection based on Cifras del sector Salud. Ministerio de Salud y Protección Social (2013, 2014, 2016)

These findings suggest that, in general, there has been unification in four of the analyzed components. Benefits are being equalized in legal terms; measures have been implemented to widen access and reduce segregation; the financial structure of the system has been reformed as well, thus allowing just one institution pool and administering the health care resources. Finally, as shown in the third section of this chapter, the expenditures have become more equal than the revenues. This is what should be expected from a more universalistic system. In other words, the wealthier part should be subsidizing the less affluent part, which is evident not only because the subsidized expenditures are more significant than revenues but, more importantly, because they are lower for the contributory part.

Chapter 5 The Double Movement in the Colombian Health Care System. Market Practices and Contestations

In Colombia, the healthcare system remains fragmented and may be far from reflecting principles of strong universalism³ because health care has been regarded as a commodity. The universalistic principles established in the Constitution are in contradiction with those market elements of the system that have not been reformed. The problem with health care perceived as a commodity is that it reinforces social and economic inequalities (Mackintosh 2006), thus, inhibiting the realization of the universal policies' broader aim.

This chapter is subdivided into three sections. The first section will refer to the contradictions of the so-called "structured pluralism model". Second with focus on, market practices within the health care system and the contestation it has created, and finally, on the commercialization consequences.

5.1. The structured pluralism model: can health care benefit from managed competence?

As long as health care is perceived as a commodity, health care system remains far from attaining its initial purposes. The economic liberalization of developing and transitional countries brings about the commercialization of health care as one of its common patterns (Mackintosh 2006:394) The fiscal constraints that arose in late 1970's justified the quest for budgetary restrictions as well as a more "efficient" allocation of the available resources. Therefore, there was a shift in the way social policies were conceived. As there were fiscal limits to universal policies, privatization of health care and other social services such as education was considered as an appropriate solution. While the state did not have to bear the "heavy fiscal burden" of those who have the means, it would "redistribute" the available sources by identifying those who required them (Mkandawire 2005:3). Health care commercialization is being implemented in different forms: private provision, investment, trade-to-payment in health care. However, what asserts attention are the contradictions that healthcare commercialization creates in different social spheres. Namely, it reshapes social and economic inequality and makes it very difficult to understand that what is regarded as a right in the constitutions it is a service in practice (Cohn et al., 19991 in Mackintosh 2006).

The reform of the health care system in 1993 is an example of this contradiction. The right to health was deemed to be attained through a model that promotes competence in delivering within a public/private mix. With the framework of economic liberalization, under the guidance of the International Monetary Fund and the World Bank, it was proposed structural adjustments in health provision but also in other services. The CHCS adopted a model called "structured pluralism"(de la Nación, Procuraduría General 2008). The model was regarded as innovative by Londoño and Frenk (1997:17) because it would stimulate more choice that stemming from the state-centered administration and prevent the fragmentation

³ Understood as extensive and equal benefits that can be better attained through unified instruments (Fischer, Franzoni)

resulting from information asymmetry, which occurs when healthcare services are provided by solely private sector.

These authors (1997) proposed to organize healthcare systems according to functions instead of by segregating different social groups in a different segment. While the Ministry of Health tended to serve the poor, social security agencies served the formal sector workers and the private sector among the rest of the population. Therefore, the authors proposed a change in the way systems work. As all the functions (i.e. modulation, funding, articulation and delivering) used to be performed by different organizations (The Ministry of Health, the social security agencies, and the private sector) for a determined social group. Under the new proposal these functions would be divided, and each institution would be in charge of a different one (Londoño and Frenk 1997). Consequently, "the health system would no longer be organized by social groups, but by functions," and the Ministry of health would be responsible for the direction of the system (i.e. modulation). The enrollment and the organization of providers as well as financing would oversee the "organizations for health services." Finally, the public and private providers would deliver health care, hence, creating a wide range of choice to the "consumers."

The model, as explained in Chapter 3, created fragmentation in access, funding, entitlements, and providers. Although institutional reforms have been implemented to correct the fragmentation (see Chapter 4), the system is insufficiently unified and is in fact, reinforcing social and economic inequalities. This persisted fragmentation is a symptom that will remain as long as health care is being treated as a commodity. Paradoxically, it is important to mention that, currently, more than twenty years after of the implementation of this "innovative model," the Colombian healthcare system is considered, according to the OECD (2015), as a successful case. This was mention in a recent document entitled "OECD Reviews of Health Systems: Colombia 2016" and prepare as a part of the process for Colombia's accession to the OECD. According to this report: "Colombia offers a remarkable example of rapid progress toward universal health coverage that deserves to be better known internationally"(OECD 2015:11). The record in extending health insurance and health services to its population is considered impressive, as is the equal access to services even if Colombia remains a country with high rates of income inequality (OECD 2015).

However, such expositions are unsatisfactory because they reflect only a partial reality of the provision of health care in Colombia. Furthermore, indicators beyond the coverage or the equal services promised to be offered and the growth in the allocated resources were considered, the conclusions would have been different. For instance, although the healthcare insurance covers 95% of the population and has increased in all regions, it is not evenly distributed among them. There are differences in the type of affiliation between urban and rural areas and among regions. While coverage in rural areas and the poorer coastal regions is mainly carry out through the SR, in wealthier regions and capital cities it is implemented through the CR (Departamento Nacional de Planeación 2017). This is particularly important because in rural areas and the poorer regions there are insufficient numbers of providers, lack of competence or limited choice of insurers, and hence, of similar services.

Moreover, many of the public hospitals are underfunded, which likely to undermine the quality of the services that are provided without adequate infrastructure. Similarly, the differences are exacerbated when comparing the provision of complex services which are mainly found in large urban areas. In this sense, although the fees may be lower for those cover

under the SR, the quality of the services deteriorates accordingly. These differences were recognized in a reform announced in 2013. In the first case, the Ministry of Health (Gaviria 2013) documented the geographical dispersion and the lack of supply among health services in some regions. For instance, according to the ministry, in 2011, 16% of the rural population did not have access to healthcare services due to the considerable distance they had to travel to the healthcare centers, while the same figure was only 2,6% in the urban areas.

According to Mackintosh (2006:396), notions of health care as a right are frequently jeopardized by commercialization. The reason is that although it does not necessarily increase health inequalities in access or outcomes, what it does is introduce certain forms of inequality in the health system through "legitimizing access to health care via the ability to pay." (Mackintosh 2006:397). The following section discusses the evidence of health care being perceived as a commodity in the CHS.

5.2 Market practices and contestation

The creation of a 'health market' has resulted in contestation, which can be seen in the reforms established to restrict the healthcare actors and their practices. Three main facts reveal that health care may be conceived as a commodity. First, consider that insurers' management of funds; second, consider the increasing entitlements and the incentives for profit; and, finally, last but not least, include the weaker capacity for cost control and prices.

5.2.1 The insurer's management of funds: providing services or rights?

The insurers' management of funds has reflected that their main concern has been the maximization of financial gains rather than the provision of public service. Multiple private insurers prioritize their role as managers of financial risk (i.e., implying purchasing of health services) over their task as managers of clinical risks (i.e., comprising prevention, early diagnosis, and supervision of health care providers' quality). This is evident in the case of vertical integration which had led to the institutional reform in 2007. Between 1993 and 2007, insurers opted for providing services directly, through their provider network. This situation created incentives not only for increasing the prices of some services, especially those not included in the essential service package obtained via tutela, but also for reducing costs by delivering less expensive in cost and fewer in number quality services included originally in the package. In monetary terms, Law 1122 of 2007 limited the vertical integration to 30% of their total activity. However, as stated by the OECD(2015:90), there is insufficient evidence that this limit has been met. In the same line, one other situation identified by the Ministry of Health was that EPS, in search of lower prices occasionally ends up changing providers, does affecting the continuity of the patient care.

Healthcare funds misuse by the insurers represents another example of the aim gain maximization. In this sense, according to the Comptroller General's Office, administration cost in fact have been higher than 50% although the insurers officially reported it between 6 and 8% (Contraloría 2013). This practice was restrained by limiting the administration expenditure up to 10% and Law 1438 of 2011 prohibited the insurers to acquire capital assets unrelated to the provision of health services. Many of these cases are still being investigated by the respective authorities. However, what the news reported was that the president of one of the most important insurers, Saludcoop, had invested the health care resources in a business that does not relate to health care providers, that it seems there were also misreported

affiliates, such as men reported as women or people with identifications of those who had died.

Evidently, insurers have assumed the action of market players, first by seeking to reduce the costs, then by expanding their profit margin and charging higher rates for intermediation. Take for example the use of the resources of the health care system for investing into capital to generate profit.

5.2.2. More entitlements and incentives to profit

Concerning entitlements, as reported in Chapter 4, judicialization allowed individuals in need to receive the services included and excluded in the basic package. This meant that there was a pressure to expand the provided services. Over time, this situation transformed the system into a more generous one by expanding the range of services. In this regard, the Constitutional Court established that high-cost illnesses could not be excluded from the services of insurance companies. Although at the beginning only the individuals who use “*tutela*” were the beneficiaries of this expansion, through the creation of the administrative mechanism MIPRES this possibility was then extended to all the other affiliates of CR who require medication and other initially excluded services. Currently, this mechanism is being implemented for the SR as well.

As such, harmful practices of insurers and providers have been identified, especially those where there was evidence of vertical integration. On the one hand, current practice was that in seeking additional profit, insurers started covering services excluded from the services package instead of those that were included. Initially, when the Constitutional Court and the local judges dictated healthcare delivery, insurers could ask for the total amount reimbursement of the provided service price, which was paid by FOSYGA retroactively. In this respect, in 2013 the Ministry of health denounced that according to a survey conducted in 2008, 63% of the affiliates reported that they had not received a complete treatment of prescribed medication. As the EPSs were indifferent about the price of pharmaceuticals outside of the services package, this resulted in a significant increment in reimbursements for drugs excluded from the POS. According to Nuñez et al. (2012), these rose by a factor of 19 000, reaching COP 1 billion, USD 345 000 or EUR 314 000, from 2001 to 2008. Figure 6 (pg. 27) illustrates that the payment for medication excluded from the package services had been between 5 and 7% of healthcare expenditure.

The government is seeking to reduce the negative consequences of judicialization adopted through law 1122 of 2007. It created a fund for high-cost illnesses in order to guarantee access to healthcare services of those patients suffering from chronic kidney disease, several cancers, epilepsy, rheumatoid arthritis, and HIV/AIDS (OECD 2015). Then the government also imposed limits on the reimbursement of the standard drugs obtained via *tutela* in 2011 and included some of the medication in that package of service together with maximum reimbursement prices.

In December 2009, the Colombian government decreed a state of emergency adducing that “in the CR and in the SR, some regulators and agents of the SSSH encourage the demand or offer of health services outside of those included in the POS” resulting in “an accelerated increase in the demand for services and medicines not included in the POS and the ostensible increase in system costs” (Corte Constitucional 2013). The decree was declared unconstitutional by the Constitutional Court arguing that the problems that supported the measures

were structural and not supervening; hence, these must be resolved via the legislative debate (Corte Constitucional 2013).

In 2013, the government presented a “structural reform” of the system, but the opposition impeded its enforcement. The reform did not bring significant changes. In fact, it pretended to create a single national fund and unique benefit plans, which were supposed to be in place after the pressure coming from judicialization and the laws 1122 of 2007 and 1438 of 2011. It also proposed that service was divided into the following categories: basic, specialized and special. Hence, providers were also categorized according to the complexity of services division. One of the main criticisms against the reform was that it let almost intact the intermediation of insurers, which had been identified in the document containing the motives exposure as one of the main promoters of the problems in the system. The way that profit-motive would be corrected was by relieving them from the responsibility for managing financial risk but letting them manage the clinical risk and continue receiving UPC. Likewise, it was also problematic that the municipalities and other local governments considered that the reform would decrease municipal and departmental autonomy due to the centralization of healthcare resources. However, the Ministry of Health had issued decrees addressing the specific elements of the system.

5.3. The weaker capacity for cost control and prices

A lack of regulation on the price of medicines excluded from POS has been a challenge in Colombia. As shown in the previous section of this chapter, incentives were created for private insurers to purchase services without control, which ended in increasing the prices, thus making the cost of the system unsustainable. The consequence of this is that Colombia has one of the higher prices for health care of the region. In fact, according to the OECD(2015), the price of medications in Colombia could reach three or four times the prices in the rest of the world. Attempts to control prices have been made during the recent years; however, these have only had a partial effect.

In this regard, it has been found that at the beginning of this year (2018), the Ministry of Health has issued a decree to implement a new mechanism to evaluate the entry of medications into the country without harming the system's finances. The idea behind the decree has been to control false innovation. This includes medications presented as innovative and more effective than those already on the market which did not bring about significant improvements and could be justified paying high prices. The reform proposes that before granting a sanitary registry for a new medication by the institution in charge of this function, the INVIMA, the Institute of Technological Evaluation in Health, should first evaluate and define its therapeutic value. The decree has led to strong resistance from the pharmaceutical sector because if it were implemented as initially planned, the Ministry of Health would take control over the prices of the medication before they entered the market as opposed to leaving it to the pharmaceutical companies.

AFIDRO, the association that brings together pharmaceutical multinationals, opposed the decree by suing it, but the Constitutional Court ruled in favor of the decree. Subsequently, discussions were held between the different actors and the Ministry of Health trying to reach consensus. However, according to El Espectador(2018), an additional difficulty arose during the admission process to the OECD. The news media found that Pharma, which represents the interests of the laboratories in the United States, exerted pressure on the government to modify the decree. It seems that Pharma was

lobbying the Colombian government by asserting that, had the decree been implemented, the United States would not vote in favor of the Colombian admission into the OECD.

The Colombian case illustrates the problems that commoditized prices and high cost can bring to health care systems. It is evident that the strong resistance by pharmaceutical companies to protect their interest have jeopardized shifts towards the more progressive and indirect forms of financing. As Fischer warned, a situation like this shows that “the huge challenge in social policy reform towards more universalistic principles is found in this need for systemically-coordinated changes, which at heart is a fundamentally political issue, not a technical one.” (Fischer, Andrew M. 2012: 16).

5.2. Consequences of health care regarded as a commodity: the debt and bankruptcy of providers and insurers

In Chapter 4, it was shown that there had been a steady increase in the revenues of the healthcare system. Likewise, according to the OECD, the levels of health funding are aligned with those of the countries that belong to the OECD. The average health expenditure in Colombia is 6,7% of its GDP; nevertheless, Colombia is experiencing financial strains. There is a deficit in the healthcare sector, and there has been cases of over-indebtedness and bankruptcy among many providers and insurers. These factors jeopardize the availability of resources required to meet not only the equalization of the benefits, but also puts at stake the quality of the provided services and in fact, the access to health care.

Both the insurers and provider have reported financial losses. The case of the CR insurers illustrated in table 5, is less acute than the SR case. Additionally, according to the OECD(2015), at the time of the report publication, twenty-one insurers had filed for bankruptcy (nine serving the CR, eleven serving the SR and one serving both the CR and the SR).

Table 5 Consolidated net financial results of public and private providers, Dec 2015

Type of Insurer		Gains		Loses		Net financial results
		Number of insurers	Million COP	Number of insurers	Million COP	
SGSSS	EPS CR	6	58,31	7	(670,63)	(612,32)
	EPS SR	8	28,06	23	(1636,00)	(1,607,94)
	Subtotal	14	86,38	30	(2306,63)	(2,220,25)
Additional services	Ambulances	8	39,53	1	(0.10)	39,43
	Prepaid	7	136,88	1	(1.23)	135,65
	Subtotal	15	176	2	(1.33)	175,08

Resource: Superintendence of Health Care, July 2017(2017)

The providers' case is not very different; according to the OECD (2015: 84), public hospitals have reached a deficit of approximately \$ 62 million in 2012. They also found that in an assessment done of the financial conditions of 955 public hospitals by the Health care Superintendence concluded that “45% of public hospitals were at high risk of financial breakdown in 2014 – compared to 32% in 2012 and 42% in 2013 – and a further 14% were at moderate risk” (OECD 2015: 84). The causes were the delays in the payment by the insurers,

the defaults of the payments due to insurers' bankruptcy as well as pressures for an increase in demand without respective financial support.

Table 6 Consolidated net financial results of public and private providers, Dec 2015

Provider	Gains		Loses		Net financial results
	Number of insurers	Mil-lion COP	Number of insurers	Mil-lion COP	
Private providers	5765	2131	1008	447	1684
Public providers	716	786	247	376	410
Total	6482	2917	1255	823	2094

Resource: Superintendence of Health Care (2017)

5.4. Conclusion

As discussed above, the system was categorized as a “structured pluralism” or “managed competition” model. This means that individuals enrol into an EPS of their choice; these EPS have a provider network accessible in time of need. This model conceives health care as a commodity that can benefit from managed competence and could operate according to a profit motive. As a result, it has created incentives for commoditization of prices and generated high costs. Consequently, attempts to regulate them have encountered strong resistances from pharmaceutical companies which, attempting to protect their interest, have acted at the expense of the health care system. This confirms the argument of being a political issue rather than a technical one (Fischer, Andrew M. 2012).

To sum up, neither all the insurers nor all the providers have the same financial conditions. This is evident from both the persistent deficit of the system and the debt among the government, EPS and providers. Therefore, insurers and providers are not under the same conditions when it comes to providing equal and quality services, especially in the poorer regions. Even though indicators suggest an expansion of coverage and equal access to services, scepticism arises as to whether these paint the true picture of the system. This does not mean that these sustainability issues can be resolved through increasing funding, In fact, it is the model itself which by enhancing profit motives has made it difficult to regulate costs and prices as well as socialize costs, hence, “less efficient, more costly, and more risk-prone than integrated public systems” (Fischer 2012: 15-16).

Chapter 6 Conclusion

This conclusion will sum up the reasons that rendered the Colombian healthcare system unable to accomplish its initial purposes of full coverage and equal service provision, even if institutional reforms have made it more integrated in terms of access, entitlements and funding management.

The study set out to establish whether the foundational architecture of the HCS allowed to attain the proposed objectives (Chapter 3). This study has identified that the foundational architecture of the system made it difficult to attain the pursued objectives because all of its components were highly fragmented. Regarding access, three different affiliation regimes were established: one for the poor, one for the non-poor and a special one for teachers, the state military employees and workers of the state petroleum company. While an individual with payment capacity was affiliated through the insurers, those without payment capacity were affiliated through the local government. This created a noticeable division between the insurers for the SR and those for the CR. The existence of multiple insurers within the regimes made it challenging to compare and guarantee similar treatment and quality of services. The providers of the SR were mostly public hospitals, while those in the CR were both private and public.

Each regime received differentiated services concerning quantity and quality. For instance, the contributory and special benefit regime received more generous benefits than the subsidized regime. The SR affiliates included prevention and primary care as well as medication for these services. Finally, although the affiliation to the general health care system was mandatory, the existence of private insurers and the possibility of acquiring complementary benefits was permitted, thus resulting in the fact that those whose means allowed had better quality service. It was also fragmented concerning funding because, although there is a presence of subsidization across both systems, the functions of pooling and the resource administration were attributed to different institutions.

The second purpose of this paper was to examine what reforms were necessary to adjust the unsatisfactory outcomes of the health-care system, and how the reforms of the foundational architecture have contributed to approaching the objectives (Chapter 4). In general terms, it can be concluded that judicialization paved the way for unification, especially in the case of entitlements. First, this is evident from the orders related to the continuous actualization of the POS and the request to the government for a plan that equalizes the services. Second, as some of the services were excluded from POS, judicialization has widened the range of the provided services. As announced in 2012, the equalization of the POS included in the CR and SR, has led to the acceleration of the corresponding increment in the SR UPC paid to the insurers.

Law 1438 was one of the reforms intended to adjust the unsatisfactory outcomes of the system due to its fragmentation. This reform has had influenced regarding two aspects: access and funding. Concerning access, various mechanisms were deemed necessary. One was the insistence on the need to affiliate the whole population to the health care system; hence, the law established the capacity payment presumption and has guaranteed the portability of the insurance. This means it has ensured the provision of health care across the entire country. Additionally, Law 1438 established an unemployment health care insurance for those

who have been contributing for at least one year to the compensation funds. This may lead to solving, at some point in the future, the problem of having excluded a significant part of the population. It also introduced a rate proportional to the income of those who earn less than the minimum wage. Finally, Law 1438 and then a decree issued in 2013 updated the affiliation criteria by facilitating the “mobilization” between the regimes, without interrupting the affiliation. One of the positive consequences of this measure affecting the mobility between the regimes was that the line dividing the insurers for both regimes was blurred.

Regarding funding, after 2011, the law centralized the administration of the healthcare sources in one fund. Currently, ADRES formerly known as FOSYGA, pools the financial sources of the SR as illustrated in figure 2. Furthermore, to identify if funding has been unified, it was necessary to carry out an exploratory inductive approach to quantitative analysis. Using this method was crucial because the financial sustainability of the system has been one of the main concerns of the government and of the international institutions. This was due to the pressure caused by the equalization and full coverage as well as due to persistent fiscal deficit. This has shown that the expenditures have become more equal than the revenues, and this is exactly what should be expected from a more universalistic system. In other words, the wealthier part is subsidizing the less affluent part, which is evident not only because the subsidized expenditures are more significant than revenues but, more importantly, because they are lower for the contributing part.

In Chapter 5 the main concern was to assess if the mentioned reforms sufficed to fully meet the initial purposes of the System and if not, what were the reasons behind the unsatisfactory outcomes. It has found that, despite the satisfactory results concerning the access equalization, entitlements and funding management, certain factors stemming from the foundational architecture and the institutional reforms make it less likely for the reforms to attain the initial purposes of the system. The latter was built upon the principle of “managed competence” and “free choice”, which has led to lacking control over the price of medications and excessive vertical integration. As a result, the system has become riddled by indebtedness and bankruptcy of insurers and providers. First, the outcomes show that the idea of conceiving health care as a commodity is still driving the system and, second, that this idea may encourage its actors to seek profit instead of providing high-quality of services, thus making less likely to leave up to the true purpose of the system.

Returning to the question posed at the beginning, it is now possible to state that although there has been accomplished relevant outcomes concerning coverage, equity of the provided services, and the reduction of the out-of-pocket payments, this system of commercial provisioning and commoditized pricing reinforces the idea of health care as a commodity. This may undermine government objectives in a context of cyclical fiscal constraints because the managed competence model can create incentives for commoditization of prices and yield high costs, thus, jeopardizing the financial sustainability of the system. However, this conclusion has limited scope and cannot be extended to other cases, even similar, since the outcomes of the system are also mediated by other factors (i.e., the population’s health condition, policy legacies, corruption, to name but a few) different from the institutional arrangements that were not covered by this study. Further studies need to be carried out to paint the whole picture.

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