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Barriers in access to healthcare in countries with different health systems. A cross-sectional study in municipalities of central Colombia and north-eastern Brazil☆

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ABSTRACT

There are few comprehensive studies available on barriers encountered from the initial seeking of healthcare through to the resolution of the health problem; in other words, on access in its broad domain. For Colombia and Brazil, countries with different healthcare systems but common stated principles, there have been no such analyses to date. This paper compares factors that influence access in its broad domain in two municipalities of each country, by means of a cross-sectional study based on a survey of a multistage probability sample of people who had had at least one health problem within the last three months (2163 in Colombia and 2155 in Brazil). The results reveal important barriers to healthcare access in both samples, with notable differences between and within countries, once differences in sociodemographic characteristics and health needs are accounted for. In the Colombian study areas, the greatest barriers were encountered in initial access to healthcare and in resolving the problem, and similarly when entering the health service in the Brazilian study areas. Differences can also be detected in the use of services: in Colombia greater geographical and economic barriers and the need for authorization from insurers are more relevant, whereas in Brazil, it is the limited availability of health centres, doctors and drugs that leads to longer waiting times. There are also differences according to enrolment status and insurance scheme in Colombia, and between areas in Brazil. The barriers appear to be related to the Colombian system's segmented, non-universal nature, and to the involvement of insurance companies, and to chronic underfunding of the public system in Brazil. Further research is required, but the results obtained reveal critical points to be tackled by health policies in both countries.

1. Introduction

1.1. Healthcare reforms in Colombia and Brazil and the political background

Health system reforms were widespread worldwide with the stated goal of improving equity of access and efficiency; most have been spurred by a neoliberal agenda in the context of structural adjustment adopted by governments under the influence of international agencies, and focused on decentralization of public sector responsibilities to sub-national levels of government, the introduction of market and cost-control mechanisms, and

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privatization (Homedes and Ugalde, 2005). Colombia and Brazil have adopted different strategies to addressing social disparities through universal healthcare. The Colombian government, in which a number of top positions are held by individuals known to have neoliberal ideals, introduced a social security system based on the managed competition model, which has been increasingly exported from the USA to low and middle income countries (Waitzkin and Iriart, 2000). This reform received strong support from international organizations (World Bank, World Health Organization) and social sectors with a significant influence on state decisions, such as international health insurance companies, pharmaceutical companies and medical manufacturers (de Groote et al., 2005). Other social actors, such as AD-M19 and the Patriotic Union, were unsuccessful in their opposition of the reforms (Vega et al., 2012). In contrast, Brazil introduced a national health system supported by progressive political parties and social movements united behind a coalition commonly referred to as the Brazilian Sanitary Reform Movement, which opposes privatization (Ocke-Reis and Marmor, 2010). The Brazilian Sanitary Reform Movement identified democratization as central to the creation of an effective healthcare system, and promoted the construction of a political strategy that encouraged civil-society organizations to demand the universal right to healthcare as a duty of the state (Lobato and Burlandy, 2000). The universal health system began in an unfavourable political and economic climate, which promoted a neoliberal rather than universal approach.

Despite the gains made in the Gini index in both countries over the last decade, they still have the highest coefficients in Latin America (0.59–0.57 in Colombia, and 0.60 to 0.55 in Brazil between 1999 and 2009, respectively (The World Bank Group, 2013), indicating considerable inequalities in income distribution. As a percentage of GDP, public health expenditure increased from 3.7% to 4.6% in Colombia, and from 2.9% to 4.1% in Brazil between 1995 and 2011, respectively (The World Bank Group, 2013).

Via Law 100 (República de Colombia, 1993) Colombia created the General System of Social Security in Health (SGSSS in Spanish), composed of two insurance schemes, the contributory scheme for formal sector employees and people of means, and the subsidized scheme for people without ability to pay; each scheme has a different benefit package, the Obligatory Health Plan (POS in Spanish) for the contributory system, and the Obligatory Health Plan – Subsidized (POS – S) for the subsidized system. Competition was introduced between insurers – Health Promotion Entities (EPS in Spanish) – for the enrolment of the population and between public and private healthcare providers for contracts with the insurers. Insured patients make a copayment according to income and the uninsured pays a percentage of the service according to an income classification system, except for indigenous and indigents, who are exempt from payment. The SGSSS co-exists with other special insurance schemes for workers in certain sectors, such as education, the military and the police, and the petroleum sector (Guerrero et al., 2011). In its 1988 Constitution (Presidência da República, 1988), Brazil formulated its Unified Health System (SUS in Portuguese), funded by taxes, and characterised by universal coverage, free at point of delivery, and decentralized to the federation, states and municipalities, according to the country's political structure. Care is provided by public or contracted private providers.

Both reforms share the stated aim of achieving equity in access to healthcare, although they differ markedly in their approach, reflecting these countries' distinct ideologies. While Colombian reform focuses on universal insurance coverage based on managed competition, the Brazilian system offers universal access to integral care by means of a national health.

Both processes are still far from universal; in Colombia, 12.1% of the population remained uninsured (Profamilia, 2010) and the benefits package of the subsidized scheme was greatly inferior to that of the contributory scheme – while funding increased progressively from 2008, the benefits packages of each system were not matched until the end of 2012 (República de Colombia, 2012). Furthermore, while public spending on health (70.7% of total expenditure) has increased significantly since the reform (Barón-Leguizamón, 2007), around 17% is devoted to administrative costs, of which more than 50% is spent on daily operations and enrolment processes (Cendex, 2000). In Brazil, the SUS is mainly used by lower and lower-middle income strata, who also use private health services, and the middle and high income populations have private insurance and use the SUS for high cost services (Ocke-Reis and Marmor, 2010). Thus the level of private spending, which represents 56.4% of total spending on health, is one of the highest in the region (World Health Organization, 2012). Studies have evaluated the effects of the reform in both countries, focussing on health services utilization as a proxy for healthcare access. These studies show the persistence of inequalities in the use of health services related to SGSSS enrolment in Colombia (Ruiz et al., 2007), to private insurance in Brazil (Paim et al., 2011), and to income and education in both countries.

1.2. The evaluation of access to healthcare in the broad domain in Colombia and Brazil

To analyse care access one may consider the *narrow domain* – from the moment the patient seeks care to the moment attention is first received – or the *broad domain* – from perceiving the need for healthcare through to the use of services, including all contact throughout the episode (Frenk, 1985). Some authors extend the latter to include satisfaction with the care received and incorporate aspects of quality and health outcomes (Andersen, 1995). Studies on access barriers tend to focus on initial contact and on a specific type of barrier related to the services or the population.

One approach used with increasing frequency to analyse access is to assess unmet need, in other words, the persistence of need as a result of not receiving adequate treatment (Allin et al., 2010). This is divided into different types including not perceiving a need for care when there is an objective need for it (unperceived unmet need), not seeking attention when a need is perceived (subjective, chosen unmet need), and inadequate treatment when care is received (subjective, non-chosen unmet need). While an analysis of different unmet needs and their causes would allow us to identify access barriers throughout the care trajectory, most existing studies do not distinguish between types (Allin et al., 2010). Quantitative studies, in Colombia and Brazil, which analysze access barriers in the broad domain for the general population based on population surveys, are not available. There is only one available study on unmet needs, which is limited to Brazil (Osorio et al., 2011). Existing studies apply qualitative methods based on one type of care or vulnerable population (Souza et al., 2008; Vargas et al., 2010) and few make reference to barriers across the care continuum for the general population (Cunha and Vieira da Silva, 2010; Vargas et al., 2010). These identify structural service-related barriers to access (insufficient physical and human resources and supplies) and organization (waiting times), which especially affect outpatient secondary care in Colombia and primary care in Brazil. In Colombia, moreover, some studies highlight access barriers related to insurance companies, such as control mechanisms for services utilization (Abadia and Oviedo, 2009; Vargas et al., 2010).

The aim of this study is to contribute to our understanding of the factors that influence access to healthcare, through a comparative analysis of barriers from the initial moment care is sought through to resolution of the problem in selected municipalities of Colombia and Brazil, countries with distinct health systems but common stated principles.