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HEALTH POLICY STUDIES

Colombian Health System on its Way to Improve Allocation Efficiency—Transition from a Health Sector Reform to the Settlement of an HTA Agency

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ABSTRACT

Over the past 20 years, Colombia has invested major efforts in ensuring universal health care access to its citizens while facing epidemiological transition and demographic changes. The country, as any other region in the world, is challenged by financial constraints and market pressures for entry of new and frequently costly technologies. After the 1993 health sector reform, Colombian citizens are entitled to health care access via mandatory health insurance through a benefits plan. Inclusions to this plan were the first attempt to establish a formal methodology of health technology assessment. Later on, the dynamics of insurers, market pressure, reimbursement decisions, and judicial actions drove the government toward the formulation of an infrastructure to improve efficiency in the use of resources. This article accounts for the steps undertaken by the Colombian health system until the establishment of a health technology assessment body and outlines the most important issues that can be learned from this process.

Keywords: Colombia, health care sector, health care technology, health technology assessment, policy.

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Introduction

From 1993 Colombian citizens are entitled to health care access via mandatory health insurance through a benefits plan [1]. Health coverage as well as most performance indicators improved vastly, but the country faced the issue of needing a rational strategy to allocate resources. Between 2005 and 2010, the consumption of nonincluded technologies increased at rates as high as 855.89% [2]. Alongside, judicial interventions became the most common means for citizens to gain access to nonincluded technologies, a fact that has threatened the financial sustainability of the system in the midterm.

Various actions over these past two decades have been undertaken by current and past governments with the aim to control costs and strengthen the system's institutional capability to allocate resources. It is only in the last 2 years that the formal methods of health technology assessment (HTA) have seized the attention of policymakers. Last January 2011, Colombia enacted by law its own HTA agency, which is still under organizational design [3].

This article accounts for the steps undertaken by the Colombian health system to achieve its aim to improve the allocation of resources and describes how the health system reform (HSR) led to the creation of the agency.

Colombian Health System

Colombia is a middle-income economy with an estimated population of 46.581.823 million inhabitants (22.997.087 men and 23.584.736 women) for the year 2012 [4]. Over the last 30 years, Colombia has experienced demographic and epidemiological changes such as a rapid decrease in total fertility rates, a significant increase in life expectancy, and fast urbanization rates.

Before the HSR only a third of the population was covered by social insurance, and more than half of the total expenditure for health was attributable to out-of-pocket spending. In 1993, Colombia launched the HSR that replaced the previously segmented and low-coverage model. These changes prompted a competitive market that included insurers and health care providers. According to figures from the Ministry of Health and Social Protection , Colombia reached a health coverage of 96% in 2011 Figs 1-3 [5].

Law 100 of 1993 unified public and private health systems into one called the "General System of Social Security in Health" [1] .

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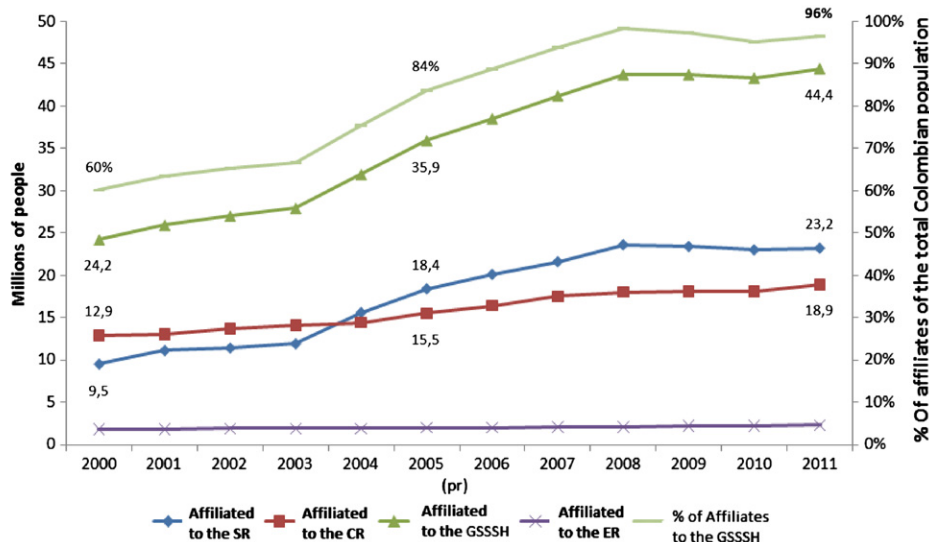

Fig. 1 – Colombian health system coverage. Source: Fedesarrollo, Ministry of Health, and Fund of Solidarity and Guarantees.

Legislation aligned the system into functions and responsibilities rather than into groups of populations [6]. There is a contributive regimen for those with ability to pay and a subsidized one for those without it. The population covered by the subsidized regimen (mostly unemployed) is selected on the basis of a survey performed by the government. Funding of the system is based on a combination of social security and payroll taxes of formal employees.

Health care providers are both public and private in this system, and all affiliates have access to a benefits plan defined by the government periodically. Alongside the official list of benefits, the system also reimburses more than 700 nonincluded drugs and technologies that are claimed by patients through exceptional mechanisms (judicial actions).

Insurers play a very important role by administering these benefits plan to patients. At this moment, concentration is taking place in the health sector and the smaller and less efficient insurers are being absorbed by stronger competitors. Insurers operate with an insurance premium known as the Capitation Payment Unit, an amount of money transferred by the government for each individual enrolled in each company. In 2012, there was a differential unit between the two regimens: $304.24 USD per year for the contributive regime and $240.94 USD per year for the subsidized regime, a fact that contributed to inequity within the system. This premium is adjusted against epidemiological variables and geographical differences [7].

There are also supplementary (voluntary) health insurances known as prepaid medicine, all of which offer additional coverage to the basic benefits plan. These plans are completely funded from private spending [1]. The system also comprises coverage for special populations such as military forces, public education workers, and the national oil company employees, all of whom have different benefits plans and do not pool their resources within the system.

Finally, there is a Basic Health Plan that addresses public health issues and covers all citizens regardless of their insurance status. Municipalities and local health authorities provide health promotion and disease prevention programs through the BPH. BPH is funded from alternative sources than those of the general system. There are two complementary plans that cover health care services derived from road accidents and natural disasters.

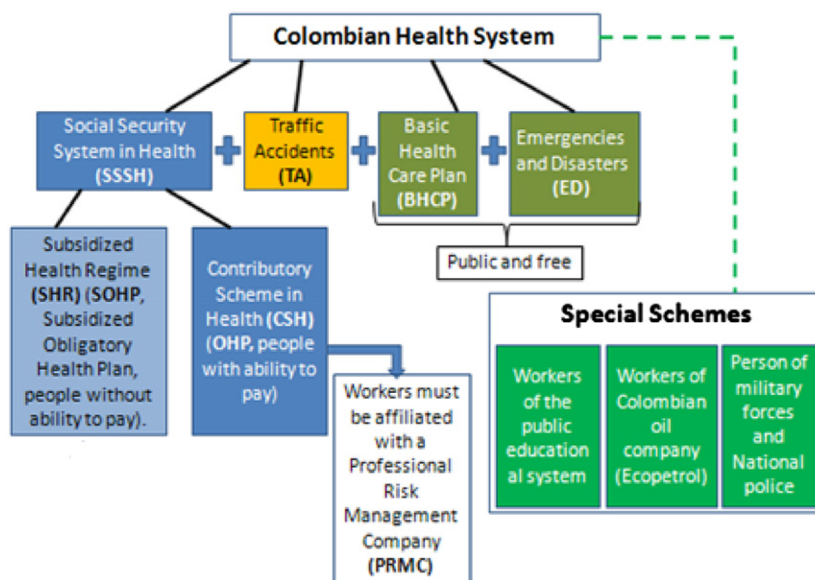

Fig. 2 – Colombian health system composition.

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