EDITORIAL

Colombia's New Health Reform: Helping Keep the Financial Sector Healthy

Mario Hernández Álvarez and Mauricio Torres-Tovar

WHO's 2000 World Health Report proclaimed the Colombian health care system the highest performing system in Latin America.[1] This favorable assessment was based on Colombia's adoption of "structured pluralism," a model that had been promoted in the 1990's.[2] Colombia was seen as the panacea for what was wrong with the world's health systems.

Nothing could be further from reality. What Colombia does provide is the best example of a system providing curative services through private insurance within a regulated market that subsidizes care for the poor. The consequences of this model have been a consolidation of resources in the hands of the insurance companies, the widening of social inequalities, and the abandonment of public health. Even the results in terms of health are meagre.[3] Recent changes to the system, presented as a new "reform," do not attempt to resolve the problems created by regulated competition. On the contrary, they further consolidate the role of financial profit for all stakeholders involved in the insurance market. This further erodes the guarantee of a right to health for the Colombian people.

The big announcement

The passage of Law 1438 on January 19, 2011*, was presented as the long awaited "structural solution" to the problems created by the health care system established in 1993 by Law 100. There was talk of new health resources – 800 million dollars annually – to achieve universal insurance coverage, "national portability" of insurance coverage, special preferences for children and teenagers, and new monitoring and control mechanisms to avoid the loss of resources.

Unfortunately, as happens often in Colombia, disinformation fostered the illusion that problems have been fixed and that the government could be trusted without questioning. In reality, the problems remain and the proposed solutions are far from attractive.

A glance at history

To evaluate the new law, we need to go back to the controversial reorganization of the Colombian health care system in 1993 by Law 100. Congress discussed reforming the system in 2004, 2005, and again in 2006. Finally, in 2007 Law 1122 was passed. We were told that while Law 1122 was not *the* solution to the problems of the health care system, it would address the most problematic areas.

In 2009, the Uribe government declared a "Social Emergency" arguing that the financial crisis in the health care system had reached a

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Mario Hernández Álvarez. Physician, Specialist in Bioethics; Ph.D. History; Associate Professor, Department of Public Health, Universidad Nacional de Colombia, Bogotá; Member, Asociación Latinoamericana de Medicina Social (Latin American Social Medicine Association, ALAMES) and the Movimiento Nacional por la Salud y la Seguridad Social de Colombia (Colombian National Movement for Health and Social Security).
Email: mehernandeza@unal.edu.co
Mauricio Torres-Tovar. Physician, Specialist in Occupational Health; Master's Candidate in Political Sciences; Member of the Consultative Committee of ALAMES and the Movimiento Nacional por la Salud y la Seguridad Social de Colombia.
Email: maot99@yahoo.es

* "*Por medio de la cual se reforma el Sistema General de Seguridad Social en Salud y se dictan otras disposiciones*"" [For the reform of the Health Sector Social Security System and other provisions.]

breaking point. It implemented a series of austerity measures aimed primarily at the "most costly" patients and at those doctors who offered services and drugs which were not covered by the standard benefits package.[4] The Constitutional Court declared these measures unconstitutional because they involved alterations to the substance of the law. Such changes could only be made by Congress through the adoption of new legislation.

Before Uribe left office in 2010, Congress passed Law 1393 which increased taxes on beer, liquor, cigarettes, and gambling. Revenues from the government's role as "official bartender" thus allowed a temporary fix to the financial crisis. Funds raised through Law 1393 were also meant to finance the equalization of health care plan benefits which had been ordered by the Constitutional Court in 2008 by Judgment T-760.[†]

Three initiatives, one law

The government of Juan Manuel Santos proposed three legislative initiatives which clearly reflect his twin political intentions: assuring the financial sustainability of the system and complying with the court order:

1. A constitutional amendment – first proposed by the Uribe government – which would make "fiscal sustainability" a universal right. This is an attempt to limit the financing of social rights to what is left over after paying the government's debt and ensuring resources for public safety.[5]

2. A draft statute for the health sector which would, once and for all, define the "*core content of the right to health*." In practice this means establishing a benefit plan that is "cost-effective" and "economically viable." This would limit ability of citizens to request an order of protection or *tutela*[‡]. These *tutelas* have put the system at financial risk through the broad interpretations of the right to health that judges have adopted.[6]

3. The integration of several legislative proposals to reform the system, all of which propose to guarantee the financial sustainability of the insurance system.

Contrary to what one might expect from the legislative bureaucracy, while the first two of these three initiatives continue their slow progress in Congress, the third – thanks to the strong leadership of Social Protection Minister Mauricio Santamaria[§] and the "message of urgency" - has become the new Law 1438.

Old wine in new bottles

Why isn't Law 1438 the much promised health care reform? The answer is that, as reiterated on many occasions by the Minister, it retains the fundamental structure of providing care through health insurance within a regulated market. This complex combination of state and market created in 1993 by Law 100 leaves us with two separate systems divided by the patient's ability to pay.

The new law seeks to curb the alleged misconduct of different actors in the system by asking them to contribute, through a "wise use of resources," towards making the system into a financially sustainable business. The law does not address the structural causes of the crisis; instead it tightens the screws. It is somewhat similar to Uribe's "Social Emergency" proposals, but the debate now is taking place within the Congress; this is a setting where the playing field is not level.

Depending on their relative economic, social, or political power, each actor is being offered either a bigger carrot or a bigger stick. For example, the initial proposal would have completely banned the vertical integration of the *Empresas Promotoras de Salud* (EPS, health insurance companies). By separating health care financing from health care delivery the proposal would have kept companies from increasing profits by transferring resources from one sector to

[†] Through Judgment T-760 (2008) the Colombian Constitutional Court established health as a fundamental and independent human right; this right is not included in the Colombian Constitution. The Judgment ordered the National Government to take a series of measure to ensure (among other things) that both private and subsidized health care plans provided universal and equal benefits. To date, most of these measures have yet to be implemented.

[‡] *Tutela* (guardianship or an order of protection) is the legal recourse of citizens to petition a judge to protect their fundamental rights. The national government and the union of health insurers attributed the financial problems of the system to the large number of tutelas granted by judges in favor of citizens. The truth is that the average annual number of *tutelas* in Colombia – about 80,000 – reflects the systematic violation of the right to health by the health care system.

[§] Current Minister of Social Protection; Colombia does not have a Minister of Health.

another. But this idea was withdrawn at the last moment and the vertical integration of EPS remains at the same levels (30 per cent) fixed by the Law 1122 (passed in 2007).

The new Law also leaves intact the separate financing of the private system and the subsidized public one. The Minister had wanted to eliminate any use of private funds for the public system, but as often happens, the final measure involved a compromise. Depending upon the financial condition of the private system, the government can use "*up to 1.5%*" of the private systems' resources to subsidize the public system.

Dubious improvements

Portability and global equity are still just promises; whether they happen or not depends on the financial sustainability of the system. There will be more resources thanks to the 2010 tax increases on the sale of beer, liquor, cigarettes, and gambling. In addition, there are new fees on the sale of weapons, ammunition, and explosives. But the health care market has proven difficult to regulate. Despite promises to the contrary, there have been increases in the prices of medicines and medical supplies. The much touted figure of "1.5 additional billion" in revenue (about 800 million dollars) is likely to be insufficient.

The "national right to portability," billed as a major strength of the new law, will only take effect after June 2013, when the EPS and the Ministry of Social Protection figure out how EPS will pay for services provided to members who go to a health care institution not part of their plan.

This will not be an easy task. The EPS compete among themselves. In their dealings with their in-network providers, they try to obtain the lowest possible cost. For their part, hospitals and clinics want to improve their incomes. The negotiations surrounding portability will be a good opportunity to increase their revenues. In the setting of such open competition one can ask: Is it possible to build lasting agreements that guarantee the portability?

The provisions addressing the universal character of health insurance didn't arise from a political decision to ensure real access to needed services. Instead they make enrollment into the system compulsory at the time someone seeks services. The intention – and the new Law has yet to be implemented – is the following: when someone gets sick and presents for care, a large integrated national database, available at all health care institutions, will use the patient's national ID number to determine whether he or she is affiliated with a health plan. If the patient is enrolled in a plan, services will be provided according to the plan's benefits.

Insurance plans will be updated every two years using criteria of "cost-effectiveness," "resource availability" and the financial "equilibrium" of the *Unidad de Pago por Capacitación* (UPC).[**] The law does not address the Court's order that the private and public health systems be unified. Hence we continue to live with the injustice of a two-tiered health care system.

More red tape

If a patient needs a service not covered by his or her own plan, he or she can appeal to a Comité Técnico Científico (CTC, Technical/Scientific Committee) composed entirely of physicians employed by the EPS. These supposedly "objective" judges determine if the service is justified or not.

If the CTC rules against the request, the patient can to appeal to another group of doctors: the *Junta Médica de Pares* (Medical Peer Review Board), this time employed by the *Superintendencia Nacional de Salud* (SINS, National Health Regulatory Agency). The peer review board will examine the case in light of the scientific evidence, the "cost-effectiveness" of the procedure, and the norms and recommendations of the newly created *Instituto de Evaluación de Tecnologías Médicas* (IETM Institute of Medical Technology Assessment). Only if rejected by the peer review board does the patient have the right to seek redress in the courts. If the non-covered service is authorized, its costs will continue to be covered by the *Fondo de Solidaridad y Garantias* (FOSYGA, Solidarity and Guarantee Fund).[††]

To avoid this entire process, individuals can purchase a supplemental "voluntary health insurance" plan which covers services outside the standard EPS Plan. This is an additional profit-center for the EPS which the government is seeking to promote.[7] Lacking this supplementary

[**] The UPC is the capitated amount paid to the EPS for each member.

[††] FOSYGA is financed through public tax revenues.

insurance, the patient must work their way through the bureaucracy and remains subject to the availability of resources within the public system.

If a patient is not insured, the clinic or hospital will see whether or not he or she has the ability to pay. If not, the patient will be temporarily enrolled in an EPS within the public system, which will cover the costs of treatment. But the EPS will be required to verify the patient's inability to pay. The national health insurance database will be linked with information on property ownership, income, payroll deductions, and taxes, in order to determine "objectively" if a patient can pay or not. Patients with resources will be required to cover the costs of care and enroll in the private system. This entire structure is designed to ensure more resources for the financial health of the system.

Protecting resources

The new law presents a series of detailed procedures for payment, resource flow, and conflict resolution between all parties involved in the regulated market. It mandates rigorous surveillance and control measures, penalties, fines, and all kinds of deterrent mechanisms to prevent the misappropriation of resources.

Included are the principles of shared responsibility and the "duty of self care." Users are responsible for caring for themselves, their families, and their communities. They are particularly responsible for any children and elderly family members with incapacitating or unusual diseases. Apparently, all players are equal and this includes the users of the system. They are expected to do their part to help make the system work. The law ignores the enormous inequalities of power between these "agents" as well as the vulnerability of people when they become ill and are in need.

A few flowers for the opposition

In order to address criticisms from health professionals, and medical/academic organizations, the law includes a number of fashionable buzzwords. It talks of Primary Health Care (PHC, recently rediscovered by the WHO), of health equity, and of the social determinants of health (two other WHO favorites). The law is in favor of (the oft touted) "comprehensive" care of pregnant women, children, the disabled, victims of domestic violence, people with mental illness, and older adults.

Of course, these types of explicit goals can be later used by citizens to exert pressure for their fulfillment. But the fact is that their appearance in the law guarantees nothing. On the contrary, under the new law it will not be easy to develop the promised PHC strategy. PHC requires a territorial and hierarchical organization of services according to the health care needs of the population. This, in turn, requires a good information system which would allow government institutions to work with communities to change the living conditions which cause disease.

The law stipulates all of these things, but the reality is different. EPS compete amongst themselves and have no interest in generating profits for their competitors. They are more concerned with lowering health care bills than providing care. The struggle for profit has impeded the development of a genuine health information infrastructure. Municipalities and states don't have sufficient institutional capacity to coordinate and enforce these commitments. The state sector will be even further weakened by the mandate that the Ministry of Social Protection turn over the resources of the public system to the EPS.

More consumers, fewer citizens

The new reform furthers the process begun by Law 100 of stripping Colombians of their rights as citizens and turning them into consumers of health services. Health care becomes ever more the province of the technocrats as users lose any voice in the bodies which make the real decisions. The CTC are emblematic of the hegemony of the "experts."

Consumers are expected to behave certain ways. They should take care of their health, pay their bills on time, not withhold information, contribute according to their ability to pay, and be vigilant. They are not expected to participate in the key arenas where important decisions are made on national health policies and the composition of the health care system.[8]

Backroom dealings

We are witnessing another chapter in the backroom negotiations between the various actors of the health care system, the politicians and the

government. Those most affected by the debate – the citizens of Colombia – are hardly involved. The EPS will remain the dominant force in health care, widening their influence through the introduction of supplemental policies. The State will continue its efforts to get everyone to behave so the system doesn't go bankrupt. But it's doubtful that more of the same will resolve the system's problems.

Colombian society should not be satisfied with empty promises. We must continue to criticize this law. In fact, we must sharpen our critique. Although we are told this is the best option, this is not a health care model that will work in Colombia or anywhere else.

References

1. World Health Organization. World Health Report 2000. Health Systems: Improving Performance. Geneva, WHO 2000.
2. Hernández M. El enfoque sociopolítico para el análisis de las reformas sanitarias en América Latina. *Revista Facultad Nacional de Salud Pública*, 19 (1), January-June, 2001: 57-70.
3. Yepes F, Ramírez M, Sánchez LH, Ramírez ML, Jaramillo I. *Luces y sombras de reforma a la salud en Colombia. Ley 100 de 1993*. Bogotá: IDRC, Assalud, Facultad de Economía, Universidad del Rosario, 2010.
4. Hernández M. ¿Emergencia social o emergencia financiera? *UNPeriódico*, N° 130, February 15, 2010: 15.
5. Proyecto de Acto Legislativo N° 016 de 2010, Cámara, "*por el cual se establece el derecho a la sostenibilidad fiscal para alcanzar los fines del Estado Social de Derecho*"[‡‡]. [see Justifications for the Bill].
6. Proyecto de Ley N° 186 de 2010, Senate, *"Por el cual se regula parcialmente el derecho a la salud y a la igualdad en salud en los regímenes contributivo y subsidiado del Sistema General de Seguridad Social en Salud y los principios de prioridad en los afiliados, promoción de la salud y prevención de la enfermedad, igualdad, solidaridad, equidad, universalidad, calidad, eficiencia, sostenibilidad, progresividad, participación social, corresponsabilidad y transparencia en el acceso a los servicios de seguridad social en salud, así como el deber de procurar el cuidado integral de la salud".*[§§] [see Justifications for the Bill].
7. Torres M. Legislar para el negocio. Ahora "los planes voluntarios de salud". *Desde Abajo*, N° 164, diciembre de 2010: 2-3.
8. Torres M. ¿Y cómo va el tema de participación en la reforma de salud? *Participación Al Día*, N° 32, February 2011:7

[‡‡] "[I]n order to create the right to fiscal sustainability as a means of achieving a society based on social rights."

[§§] "[I]n order to partially regulate the right to health, the equality between the state and private components of the General System of Social Security for Health, the prioritization of health needs among participants, health promotion and disease prevention, equality, solidarity, equity, universality, quality, efficiency, sustainability, progressiveness, social participation, shared responsibility, and transparency in the access to the health services of the social security system, as well as the duty to provide comprehensive health care."