Colombia: A Healthcare System in Crisis

By Francisco Jose Yepes Lujan, MD, PhD, Director, Graduate Studies in Health and Social Security Administration, Pontificia Universidad Javeriana, Bogota, Colombia

A 64-year-old woman I know who faithfully paid into the Colombian equivalent of an American Healthcare Maintenance Organization (HMO) for 20 years was rushed to a leading Bogota hospital in August 2012 in excruciating pain from what turned out to be an inflamed gall bladder. After waiting for four hours on an ambulance gurney parked in the emergency room hallway, she was finally examined. The doctor's diagnosis should have led to emergency surgery to prevent a ruptured gall bladder and the risk of fatal peritonitis. But the woman and her family were turned away, sent home. The reason? The hospital refused to authorize the surgery because her HMO had gone broke and for more than a year had not reimbursed this hospital or its doctors for medical services rendered. The woman survived, and her bladder's inflammation later subsided, and she was lucky.

Multiply this woman's experience hundreds of times per day in hospitals and clinics big and small across Colombia and you get an idea of the depths of this nation's medical care crisis. The system is, for all practical purposes, insolvent, and there are many expressions of what that means. In financial terms, the government-run Fosyga, the Spanish acronym for the Solidarity and Guarantee Fund that is responsible for distributing employer contributions to private health plans, owes billions of dollars to the various EPSes, which are the Spanish initials for insurance companies roughly equivalent to HMOs. The EPSes in turn owe $2 billion to the IPSes, the Spanish initials for the generic term for healthcare providers such as hospitals, clinics, laboratories doctors, and dentists that the insurers contract with. As a result, many of the EPSes have been taken over by the government in an effort to try to save them. Cities and townships, which are responsible for administering government-subsidized healthcare to the poor and indigent, have also incurred staggering levels of debt, and many are behind on payments they owe to IPSes.

The most important expression of the crisis is, of course, the decline in standards of healthcare, the congestion in emergency rooms (from which Colombians by law cannot be turned away), and the needless risks and delays that patients face when they become sick or need elective procedures performed. Although the crisis has worsened over time, it has reached a boiling point in recent months due to mounting protests by health professionals and patients and pressure on politicians. The Colombian congress is now considering a new legislative reform, after previous attempts in 2007 with Law 1122 and again in 2011 with Law 1438 failed to right the ship. As before, there is little agreement on how to fix the system, because it is so complicated that almost no one understands it.

What do I think is at the root of the crisis? The central problems are corruption, the failure of the government to adequately fulfill its regulatory function, and the inherent ideological conflicts embedded

Number of Physicians
per 10,000 Resident Population: 1.5 (2010)

Number of Hospital Beds
per 10,000 Resident
Population: 10 (2010)

Number of Nurses and Midwives
per 10,000 Resident Population:

6,2

Total Expenditure on Health
per Capita (2010): US$ 518

$$$$$

Government Expenditure on Health as % of Total Expenditure on Health (2010): 72.7%

Total Expenditure on Health as % of GDP (2010): 7,6

Male Life Expectancy
at Birth (2006):

73

Female Life
Expectancy
at Birth (2006):

80

Population in Thousands (2010): 46,295

Source: WHO Global Health Observatory Data Repository, http://apps.who.int/ghodata/. Last accessed Sept. 10, 2012

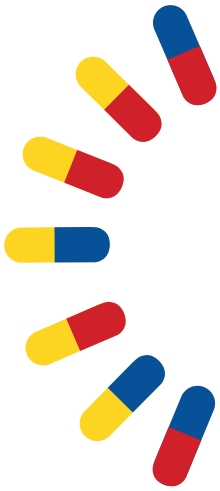
in the system, all of which I will discuss shortly. But first, I will outline the genesis of Colombia's current public healthcare system, which flows from the 1991 Constitution stating that all Colombians have a right to "social security." The so-called "Law" 100 passed by Congress in 1993 refined that right by creating National Obligatory Health Insurance, a system consisting of two regimens. One was called "contributive," for all employers and their formally contracted employees. Together, employer and employee contribute 12.5 percent of each worker's paycheck to the EPSes representing them. The EPSes then contract for services with IPSes – the 30,000 authorized hospitals, labs, clinics, doctors', and dentists' offices in Colombia.

Roughly 44 percent of Colombia's population is covered by 22 EPSes formed to insure "formal," or employed, subscribers in the system, which is a direct descendant of the healthcare insurance system that Bismarck's government designed in late 19th-century Germany.

The other half of the system is the so-called "subsidized" regimen, which provides health insurance for the poor, unemployed, and indigent who cannot contribute. This welfare portion is funded by national and local taxes, royalties from oil and mineral sales, and also a 1.5 percent slice of the 12.5 percent taken from formal workers' paychecks as a "solidarity" gesture. The subsidized system is also supposed to receive any surpluses from Fosyga that are left over from the contributive plan. This half of the public health system covers 51 percent of Colombians and involves 44 EPSes. Taken together, the two regimens were meant over time to give all Colombians, now numbering just over 46 million, access to healthcare, and, so far, 96 percent of the population is at least nominally covered.

The system has worthy social goals, including guaranteeing every Colombian the right to free birth control, including vasectomies and tubal ligations. But there were also some absurd inequalities built into it by which contributive plan members were initially entitled to 40 percent more reimbursements than subsidized affiliates. For example, a poor female participant in a subsidized EPS may have gotten a preliminary diagnosis of cervical cancer, but not the coverage to pay for follow-up procedures to confirm it. That same woman was likely to be denied reimbursement for a mammogram initially, although many of these coverage holes have been filled.

But there are even more critical omissions that have not been corrected. At the top of my list is the government's failure to enforce its regulatory power, evidence of which is very clear in the freedom of the EPSes to commit abuses. Fourteen of the 22 insurers in the contributive system have been sanctioned for collusion, and have been sentenced to pay multimillion-dollar fines. Among the charges against insurers is conspiring to deny coverage and to defraud their affiliated subscribers, and the state as well, by altering information that determines insurance premiums.



> "The central problems are corruption, the failure of the government to adequately fulfill its regulatory function, and the inherent ideological conflicts."
>
> Francisco Jose Yepes Lujan, Director of Graduate Studies in Social Security and Health Administration, Pontificia Universidad Javeriana, Bogota, Colombia

The Office of the General Controller is investigating the EPSes and has found numerous incidences of insurers misappropriating employee contributions, which technically are state funds, and investing them in foreign real estate, in clinics they should not have built, and even in a tourist resort in Villavicencio. So when you talk about this crisis, you have to look at what these insurers have done with the funds that were supposed to go into health services.

The scale of corruption we see is due in part to the fact that regulators have never developed minimum rules and standards for the economics of healthcare delivery,

Facts and Figures

Life expectancy: This figure was 80 years for females and 73 years for men in 2010. That tracks almost exactly with averages in the region, and it has been steadily rising in recent decades with better healthcare penetration, particularly since social security was guaranteed by the 1991 Colombian Constitution. The increases are due partly to the dramatic improvement in infant mortality, as Colombia's under-five mortality rate has dropped from more than 40 per 1,000 births in 1990 to 20 as of 2010. Maternal mortality, however, remains alarmingly high at 92 per 100,000 live births, far above the Latin American average of 63.

Medical care: Colombia has a bifurcated national health insurance system. The "contributive" half covers all employees with formal jobs. They and their employers contribute 12.5 percent of gross paychecks into a national fund that then distributes premiums to the 22 insurers (resembling HMOs) that contract with health service providers. The poor, indigent, and unemployed are covered by the "subsidized" health insurance program funded by national and local taxes, royalties from oil and mining, and a "solidarity" portion of 1.5 percent of the 12.5 percent paid in by "contributive" plan subscribers. Those funds are channeled to cities and townships, which then contract with 44 insurers. When the national health plan was launched in the early 1990s, the aim was to cover all Colombians over time, and currently about 96 percent of the country's 46 million inhabitants participate. Contributive plan participants receive on average about 40 percent more in annual reimbursements than subsidized members, meaning the former are entitled to procedures that the latter are not. Eventually, the gap in reimbursements is supposed to narrow.
Healthcare spending in Colombia is far below the regional average, with US$569 per capita spent in 2009, compared with more than US$3,000 per capita in the rest of Latin America. Total national expenditure on health in 2010 was 7.6 percent of gross national product. Colombia also ranks low as far as medical professionals per capita. There are only 1.5 physicians and 6.2 nurses and midwives per 10,000 inhabitants – considerably fewer than the 20 doctors and 72.5 nurses and midwives averaged in the rest of the region. Colombia ranks close to regional averages in contraceptive prevalence (78 percent), prenatal care (4+ visits: 89 percent), and measles inoculation of one-year-olds (88 percent).

Morbidity and Mortality: The main health risk factor in Colombia is high blood pressure, which afflicts 34.3 percent of the male population over 25, compared with 26.3 percent of men in Latin America generally. Hypertension is diagnosed in 26.5 percent of women, above the 19.7 percent average across the region. But Colombian men are far less vulnerable to diabetes than elsewhere in the hemisphere, with inhabitants having about two-thirds the incidence of raised blood glucose and half the obesity rate seen regionally. Women are also under the regional rate in both diagnoses.

Lifestyle Risk Factors: Recent figures show that 21 percent of Colombian girls younger than age 20 are having babies, up from 13 percent in 1990. In Latin America, Colombia's teenage birthrate is exceeded only by Nicaragua (25 percent), Venezuela and El Salvador (21.6 percent), and Honduras (21.5 percent). By comparison, recent figures for the United States, tallied in 2006, show about seven percent of U.S. teenagers gave birth that year. Colombia also ranks high in landmine victims, with 512 in 2010 (including 54 killed), due to the ongoing armed conflict between leftist rebels, drug gangs, and government forces. The 2010 toll continued a declining trend seen since 2005 and 2006, when about 1,200 were killed and wounded in each year.

Sources: World Health Organization (WHO), Colombian Health Ministry, Guttmacher Institute, Colombian Campaign Against Landmines

which should be their job. Because health services is an imperfect market, regulators need to act as honest brokers of information that some actors in the health market have and that others do not have. The absence of those standards gives the EPSes enormous latitude to commit abuses. A very well-known example is one involving the SaludCoop EPS, which was taken over by the government after it was revealed that its executives were paying themselves enormous salaries while denying services to their affiliates. Another crucial mistake in the system was in not controlling prices that pharmaceutical companies charge for drugs. As a consequence, drug companies are about the only actors, except for corrupt EPSes, that have benefitted from this system. The fact that the drug companies are collecting exorbitant prices for medications is something all critics agree on, and I blame the lack of vigilance by the Colombian state.

The bottom line is that the system gives all the financial incentives to extract money, but absolutely no incentives to promote good health results. There are no standards of health outcomes, and no minimum results for which EPSes and healthcare providers can be held accountable. If an expectant mother dies or someone does not recover from a sickness that we have a cure for, the EPSes, the hospitals, and the municipalities should be responsible for those results. The 2007 law ordered the Health Ministry to come up with those standards within six months, and we are still waiting for them – so we cannot demand them from the actors in the system.

Colombia still has not resolved the inherent clash of interests between those who see healthcare in purely business terms as a commercial asset, and those who feel it is a fundamental human right. One's ideology is bound to affect how one views the crisis and how to fix it, and consensus still seems far away. The government, the World Bank, the Inter-American Development Bank, and a respected think tank in Bogota – Fedesarrollo – think it is a problem of regulation. Others, including many universities, the major medical associations, and big hospitals, think the entire system has to be restructured.

For example, a recent study by Fedesarrollo determined that the current system is salvageable if more resources can be invested. I do not agree. I think it is impossible to determine whether the system as it stands today can be adequately funded while there is so much corruption, when there are so many actors stealing the money. You have to have a system working in an orderly fashion, without the distortions caused by corruption, before you can determine its financial sustainability.

I think the only way out of the mess is to form a new national health system, learning from other experiences like those in the United Kingdom, Brazil, Costa Rica, or Canada. This system would not copy any of those plans, but rather would take elements from each and do away with distinctions between employer-financed and public-financed healthcare insurance systems. Healthcare would be made available to anyone with a Colombian identity card. That approach was the basis of a proposal put forth by a commission on which I participate and which was presented to Colombia's Congress at the end of August 2012. This proposal is based on every citizen's fundamental right to healthcare and the state's duty to respect, protect, and warranty its fulfillment.

The opinions reflected in this article are those of the author and do not necessarily reflect those of Siemens Healthcare.

Francisco Jose Yepes Lujan is Director of Graduate Studies in Social Security and Health Administration at Pontificia Universidad Javeriana in Bogota, Colombia. He earned his medical degree (1964) and his master's degree in public health (1967) at Universidad de Antioquia in Medellin and a master of science degree in health administration (1971) and a doctorate in public health (1979) at Harvard University. Prior to his current academic post, he was a professor at Universidad del Valle Medical School, and a visiting professor at the School of Public Health in the National Institute of Public Health in Cuernavaca (Mexico) and at the Department of Preventive Medicine at the Harvard Medical School. He has held numerous government posts, including Head of Human Resources and Secretary General at the Colombian Ministry of Health and Vice President of the Institute of Social Security, as well as adviser to several health ministers. He also has held several international posts, including consultancies with WHO, PAHO, World Bank, IADB, IDRC, Kellogg Foundation, and several Latin American and African governments. He is the author of numerous articles that have been published in Health Policy and Planning, Cadernos de Saude Publica, and national journals. He has published, with other collaborators, several books on Colombian healthcare reform. The most recent, Luces y sombras de la reforma colombiana de la salud (Highlights and Shadows of Colombian Healthcare Reform) was published in 2010 by Mayol Ediciones and IDRC. He is currently a member of the Commission for the Follow-up of Ruling T-760, which advises Colombia's Constitutional Court, and he has helped prepare a proposal to reform the current healthcare system that is currently being considered by the Colombian Congress.