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Colombia is an upper middle income nation of approximately 46 million which borders the Caribbean Sea and the North Pacific Ocean. Colombia's post-colonial history has been plagued by persistent civil conflict and social inequality, and the country has the world's seventh-highest Gini coefficient.<sup>1</sup>

Colombia's health outcomes are mixed with considerable progress in some areas (eg: infant mortality, under-five child mortality, acute respiratory infections) and little to no progress in other areas, such as maternal mortality which remains stubbornly high and is largely related to preventable causes.<sup>1</sup> A few areas of health have actually shown increases in prevalence and mortality in recent decades (e.g. congenital syphilis and dengue).<sup>1</sup>

As is the case in many Latin American and Caribbean countries, Colombia is experiencing a marked increase in non-communicable and chronic illness. This dual burden stresses the capacity of the health system.

Both access to healthcare and health outcomes vary widely between regions. Access issues are predominantly attributable to supply-side constraints. For example, 70% of health providers are the only providers available for Colombians enrolled in the nation's subsidized coverage regime in rural areas.<sup>1</sup> The government is attempting to resolve these issues through a health system overhaul focused on human resource issues (particularly outside of large metropolitan areas) and an improved finance and capitation system.



### Health Finance Snapshot

Total Health Expenditure (THE) as a share of gross domestic product (GDP) remained steady at between 6 and 7% from 1995 through 2012.

General Government Expenditure on Health (GGHE) as a percentage of THE, however, has increased by a net 21 percentage points in the same period with out of pocket spending (OOPS) decreasing proportionately.

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Table 1. Health Finance Indicators: Colombia

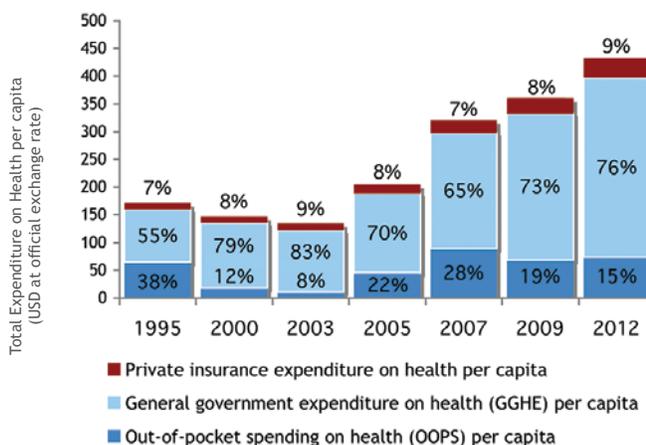
	1995	2000	2003	2005	2007	2009	2012
Population (thousands)	36,574	39,898	41,872	43,184	44,498	45,803	47,704
Total health expenditure (THE, in million current US\$)	3,442	4,678	4,637	6,147	9,199	11,998	25,275
THE as % of GDP	7	6	6	6	7	7	7
THE per capita at exchange rate	171	148	134	205	320	361	530
General government expenditure on health (GGHE) as % of THE	55	79	83	70	65	73	76
Out of pocket expenditure as % of THE	38	12	8	22	28	19	15
Private insurance as % of THE	7	8	9	8	7	8	9

Source: WHO, Global Health Expenditure Database; National Health Accounts, Colombia

▶ Out of pocket spending (OOPS) has fallen significantly, dropping 23 percentage points (as a % of THE) from 1995 through 2012 (Table 1, Figure 1).

- OOP costs are point-of-service fees (i.e.: copayments for consultations, medications, etc.).
- Those in Colombia's Subsidized Regime (SR) are largely exempted from point-of-service fees.
- However, those enrolled in the Contributive Regime (CR) through formal employment are subject to two different types of point-of-service fees, both assessed on a sliding scale based on income group.

Figure 1. Total Expenditure on Health per capita, Colombia



Note: Private insurance expenditure on health was below 1% before 2005.

Source: WHO, Global Health Expenditure Database; National Health Accounts, Colombia

## Health Status and the Demographic Transition

Non-communicable diseases are on the rise in Colombia with obesity rates, diabetes and cardiovascular conditions gaining in importance. High mortality from violence continues to be an important issue.

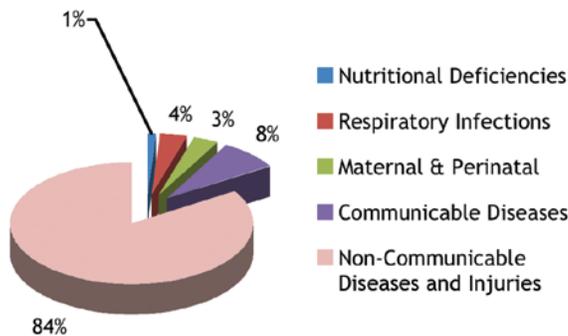
### Demographic Transition

- ▶ Birth rates are declining (figure 2).
- ▶ Life expectancy is increasing.
- ▶ The 'bulge' in the population pyramid is moving markedly upward (figure 3).
- ▶ The total fertility rate (TFR) has fallen from 3.1 in 1990 to 2.3 in 2011.

### Epidemiological transition

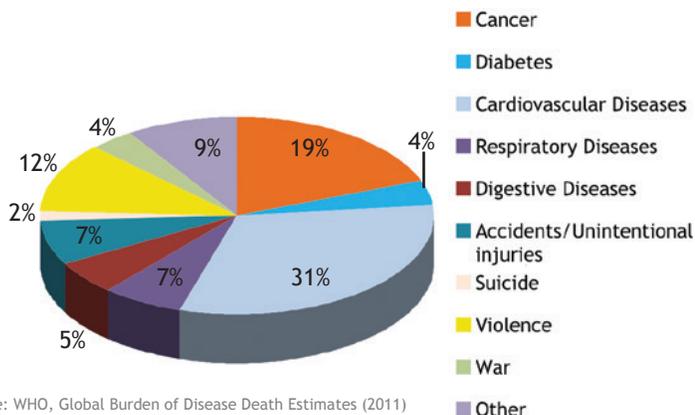
- ▶ Mortality from communicable diseases is low while non-communicable diseases, accidents/injuries and violence account for 84% of all mortality (Figures 4 and 5).

Figure 4. Mortality by Cause, 2008, Colombia



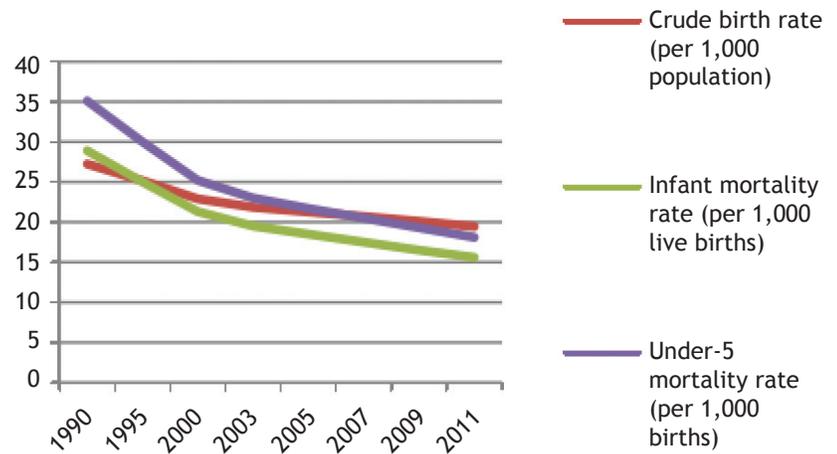
Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 5. Non-Communicable Disease, Accident & Injury Mortality, Colombia



Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 2. Demographic Indicators: Colombia



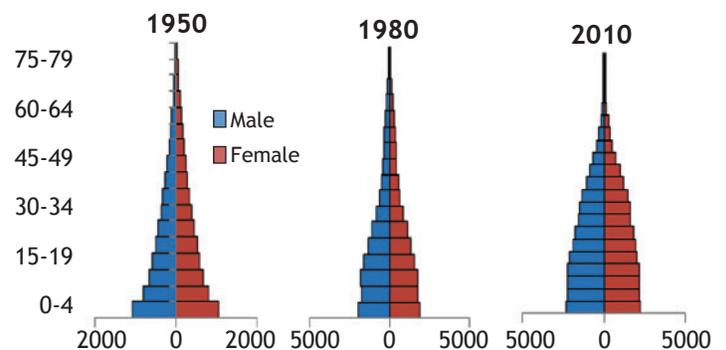
Source: World Bank: Health, Nutrition and Population Statistics

Table 2. International Comparisons: Health Indicators

	Costa Rica	Upper Middle Income Country Average	% Difference
GNI per capita (year 2000 US\$)	2,465.7	1,899.0	29.8%
Prenatal service coverage	97	93.8	3.4%
Contraceptive coverage	79.1	80.5	-1.4%
Skilled birth coverage	99.3	98.0	1.3%
Sanitation	78.1	73	5.1
TB Success	79	86	7%
Infant Mortality Rate	18.1	16.5	9.7%
<5 Mortality Rate	21.7	19.6	10.5%
Maternal Mortality Rate	92.0	53.2	72.8%
Life expectancy	73.4	72.8	2.2%
THE % of GDP	6.1	6.1	--
GGHE as % of THE	75	54.3	20.7%
Physician Density	0.1	1.7	-91.3%
Hospital Bed Density	1.4	3.7	-62.2%

Source: The World Bank, World Development Indicators database

Figure 3. Population Pyramids of Colombia



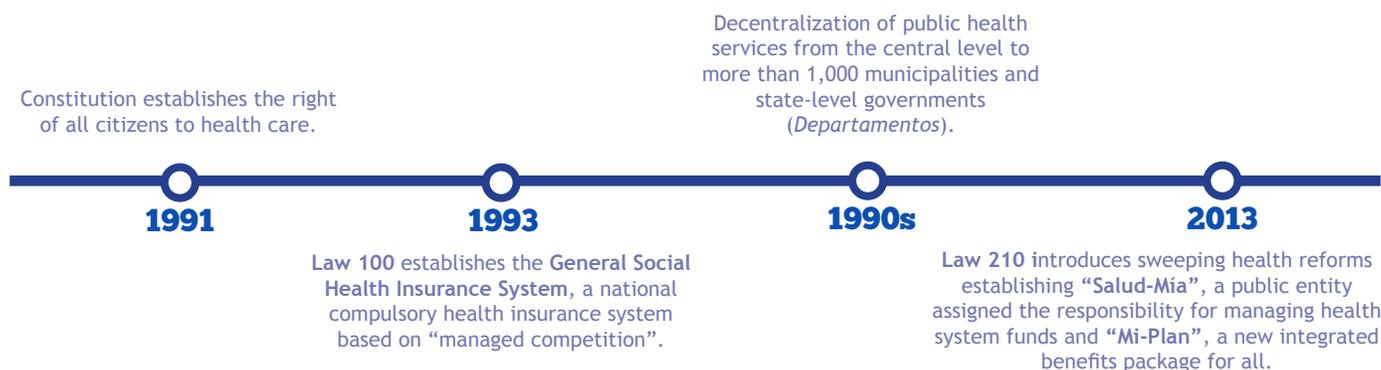
Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2010 Revision.

## Health System Financing and Coverage

Colombia's 1991 Constitution established the "Right to Health Care" for all. The operationalization of this concept began in 1993 with the establishment of the General Social Health Insurance System, a national compulsory health insurance system modeled after the Dutch system. The government established two health insurance regimes, a Contributory Regime (CR) for formal sector workers, and a Subsidized Regime (SR) for the

poor. The system embodied a separation of purchasing and provision of health services. Public funds were to be pooled into health plans (EPSs) to purchase services from regulated private and public-sector health care providers. Both service provision as well as financial pooling of public funds became the responsibility of municipalities and some *Departamentos* (state-level governments).

Figure 6. Timeline of Colombia's Health Insurance System <sup>1,2</sup>



### General Social Health Insurance (SHI) Regimes<sup>1</sup>

#### Contributory Regime (CR)

- ▶ Financed mainly through earmarked payroll taxes pooled by the federal government into a national solidarity fund (FOSYGA). See Table 3.
- ▶ Approximately 21 Health Plans (EPSs) receive risk-adjusted capitation payments from the FOSYGA for a Mandatory Benefits Package (MBP) for CR beneficiaries.
- ▶ EPSs perform the purchasing functions for CR beneficiaries' MBP using public and private providers.

#### Subsidized Regime (SR)

- ▶ Close to 50 EPSs receive capitation payments from municipalities (and some *Departamentos*) and perform purchasing functions for services covered under the SR MBP.
- ▶ These capitation payments are financed by funds pooled at the municipal level consisting of revenues from general and earmarked taxes, and cross-subsidies from the FOSYGA. See Table 3.
- ▶ Municipalities (and some *Departamentos*) themselves perform purchasing functions through contracts with public health facilities for services not covered under the MBP.

Figure 7. SHI Enrolled by Regime, 2008-2011



Source: Ministry of Health, Colombia. "Coberturas del Régimen Subsidiado 2008-2011".

Table 3. Regimes and Coverage in Colombia's Social Health Insurance System

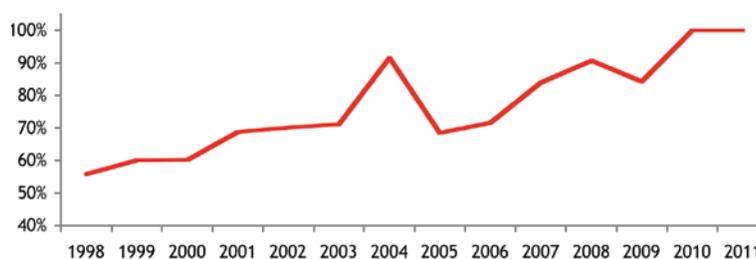
	Targeting/Enrollment	Health Services Covered	Provision and Financing Channels	Contributions and Payments
<b>Contributory Regime (CR)</b>	Formal sector workers + dependents as well as independent workers (non-indigent) with steady income.	A comprehensive 'Mandatory Benefits Package' (MBP) covering primary, secondary and tertiary services with exclusions mainly for aesthetic, elective and scientifically unproven procedures. <i>In 2012, the SR MBP was expanded to cover the same services as the CR MBP.</i>	FOSYGA makes capitation payments to EPSs for services covered under the MBP.	- FOSYGA is financed entirely from pooled payroll contributions (4 percent of salary from workers, 8 percent from employers). - Beneficiaries make co-payments for some services.
<b>Subsidized Regime (SR)</b>	Those not employed in the formal sector, members of low income and poor households, indigenous populations and vulnerable groups.	- Emergency care. - Services not covered by the MBP.	Municipalities and some <i>Departamentos</i> (state-level) use pooled funds to make capitation payments to EPSs for services covered under the MBP.	- Pooled funds at Municipal/ <i>Departamental</i> level are financed from: (a) general and earmarked federal taxes; (b) municipal (sometimes <i>Departamental</i> ) taxes; and (c) cross-subsidies from FOSYGA (no pre-pay contributions from beneficiaries). - Co-payments to health facilities apply in limited circumstances.
<b>Public Hospitals and outpatient facilities</b>	All citizens.		Municipal ( <i>Departamental</i> for tertiary care) fee-for-service contracts with public health facilities for non-MBP services.	Municipalities (and some <i>Departamentos</i> ) pool their own tax revenues and federal earmarked funds. No user payroll contributions.

Source: Montenegro Torres, F. and Acevedo, O.B. Colombia Case Study: The Subsidized Regime of Colombia's National Health Insurance System. The World Bank UNICO Studies Series No. 15, 2013.

## Targeting and Enrollment<sup>1,4</sup>

- ▶ In 2008, the federal government abandoned targeting mechanisms previously used to enroll SR beneficiaries in order to increase enrollment and coverage. See Figure 8.
- ▶ This particularly increased enrollment of the poor from 47% in 2003 to 98% in 2010.
- ▶ Population coverage (total in the SR and CR) has increased from 83.2% in 2008 to 90.9% in 2010.

Figure 8. Percentage of Eligible Population Covered by the SR



Source: Ministry of Health, Colombia. "Histórico Cobertura del Régimen Subsidiado Año 1998 - 2010".

## Financial Sustainability

- ▶ There has been an increasing share of enrollees in the SR relative to the CR. See Figure 7.
- ▶ In 2012, the MBP of the SR was expanded to match the MBP of the CR.
- ▶ This increase in the SR MBP was not matched by an increase in capitation payments from the government to EPSs serving SR beneficiaries leading to widespread bankruptcy of EPSs.
- ▶ Both the increase in SR enrollees as well as the expansion of the SR MBP have highlighted the seriousness of supply-side factors that constrain access for SR beneficiaries, particularly in rural areas.

## Point-of-Service Fees<sup>3</sup>

- ▶ Some SR beneficiaries may face a co-payment for services at public health facilities.
  - This co-payment is a maximum of 10% of the cost of all services rendered per health event in a limited number of cases.
  - NO copayments for infants under 1 year of age, indigenous populations, displaced populations, rural migrants, and the indigent, elderly or disabled.
  - NO copayments for mother and child health care (including prenatal care, deliveries and potential complications), health prevention and promotion services, communicable disease programs, high-cost and catastrophic services, medications, urgent consultations, and many specialist services.
- ▶ CR beneficiaries may face two types of point-of-service fees. Only one may be assessed for any given health event. Both are assessed on a sliding scale based on the beneficiary's income group.
  - Co-payments are assessed as a percentage of the cost of services rendered for a particular health event.
    - Co-payments are often charged for complex and high-cost services.
  - A flat fee (referred to as a "moderator fee") is assessed in other instances.
    - The flat fee is often charged for primary care and lower-cost services.

## Challenges and Pending Agenda<sup>2</sup>

Many see Colombia's health system as being in a deep financial and institutional crisis. The pending agenda aims to<sup>2</sup>:

- ▶ Increase capitation payments to EPSs for SR beneficiaries to match the higher levels paid for CR beneficiaries following the 2012 reforms that expanded the MBP for SR beneficiaries to match that of CR beneficiaries. The expanded SR coverage without sufficiently increased capitation payments has led to bankruptcy of many SR EPS institutions and an unwillingness of CR EPSs to accept SR beneficiaries.
- ▶ Move from managing inputs to managing for results with proactive resolution mechanisms that avoid current perverse incentives for physicians to prescribe medicines that do not follow international medical guidelines for evidence-based interventions.
- ▶ Restructure SHI debts particularly those involving bankrupt SR EPSs and those requiring urgent intervention to avoid bankruptcy.
- ▶ Increase health system capacity, particularly through enhanced focus on human resources outside of large metropolitan centers, one of the greatest supply-side challenges in the nation and a significant barrier to access.

## References

- 1 Montenegro Torres, F. and Acevedo, O.B. Colombia Case Study: The Subsidized Regime of Colombia's National Health Insurance System. The World Bank UNICO Studies Series No. 15, 2013.
- 2 Ministry of Health and Social Services, Colombia. "Hacia un nuevo modelo de salud". 2013. Accessed at <http://www.minsalud.gov.co/Documents/Ley%20Reforma%20a%20la%20Salud/ABC-nuevo-modelo.pdf>
- 3 Ministry of Health and Social Services, Colombia. "Cuotas Moderadoras y Copagos 2013". Accessed at [http://pospopuli.minsalud.gov.co/LinkClick.aspx?fileticket=IE\\_hkW-3wQS8%3D&tabid=737&mid=1819](http://pospopuli.minsalud.gov.co/LinkClick.aspx?fileticket=IE_hkW-3wQS8%3D&tabid=737&mid=1819)
- 4 Ministry of Health and Social Services, Colombia. "Coberturas del Régimen Subsidiado".

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