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# Managed Competition in Colombia

***Aarushi Gupta & Anjali Nambiar****

**Abstract**

Colombia's healthcare domain, like many other sectors in the country, was completely overhauled as part of the country's sweeping reforms that followed the adoption of a new Constitution in 1991. The reforms introduced a mandatory social health insurance system, with many of its features designed in line with the theoretical principles of managed competition. The reforms, aimed at revamping and regulating the hitherto fragmented health insurance sector, concomitantly introduced a two-tier system — one for the formally employed and another for the low-income, informal sector workforce — with the broader objective of achieving universal health insurance. Almost three decades later, the verdict, on the impact of the reforms, varies across the system's stakeholders and therefore, remains ambiguous. While the reforms granted a constitutional right to healthcare, universal access in practice is yet to be achieved. Admittedly, the jury is still out on the optimality of the reform approach Colombia undertook, signalling the important lessons its case holds for developing countries like India. The embedment of managed competition principles in an environment characterized by low-state presence and weak rule of law makes Colombia an interesting setting to analyse, holding valuable lessons for policymakers seeking to adopt similar approaches in comparable jurisdictions.

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# 1 Introduction

Colombia is the fourth-largest economy in Latin America as measured by Gross Domestic Product (GDP). The economy is classified as upper-middle-income and between 2010 and 2019, its average annual GDP growth stood at 3.7% (The World Bank, 2020). Colombia has a population of approximately 48 million and as of 2019, about 36% of it lived below the poverty line, a figure comparable to that of many low-income economies (The World Bank, 2021). In terms of health indicators, Colombia enjoys a relatively low DALY rate[1] and over the last two decades, life expectancy has increased along with a decrease in infant mortality (Institute for Health Metrics and Evaluation, 2022). In 1993, the country embarked on a reform trajectory to restructure its healthcare system based on managed competition principles. Almost three decades later, the verdict, on the impact of the reforms, varies across the system's stakeholders and therefore, remains ambiguous. The reforms' politico-economic context coupled with their elaborate regulatory assemblage demand a closer analysis of the country's experience with managed competition.

[1] As of 2019, the figure stood at 24,211 DALYs per 100,000, lower than the OECD average of 29,600.

# 2 Health System Design: Tracing its Evolution

Colombia's healthcare system, along with its other sectors, underwent transformational changes in the 1990s. These reforms were part of the sweeping changes that were triggered by the adoption of a new Constitution in 1991. In 1993, its healthcare system was completely reorganized, following the introduction of mandatory social health insurance and the adoption of a "managed care"[2] approach. The reforms created a bifurcated system of insurance - one for the formally employed and another for the low-income, informal sector workforce - with the broader objective of achieving universal health insurance. Along with this, an elaborate regulatory framework was ushered in, to ensure competition in both insurance and the provision of care.

## 2.1 Pre-reforms Set-up (1950s-1993)

Prior to the introduction of a social health insurance set-up, Colombia's healthcare landscape was fragmented across three independent sub-systems, the public sector, the social security sector, and the private sector (Glassman et al., 2009). The public subsystem consisted of a network of regional hospitals and healthcare centres that were directly financed by government funds and primarily served the unemployed and the low-income groups, i.e., approximately 63% of the population (Shaw & Hsiao, 2007). The social security or the insurance subsystem consisted of a network of healthcare providers that covered the formally employed workforce. The formally employed workers made contributory contributions to closed pools. The erstwhile *Instituto del Seguro Social* (ISS or the Institute of Social Security) covered private-sector workers whereas public-sector workers were enrolled in funds exclusive to state-owned enterprises/public universities/government units (Castano & Zambrano, 2006). Only 23% of the population was enrolled under this insurance sub-system (Bauhoff et al., 2018). The private subsystem consisted of private institutions that mostly catered to the remaining 10-15% of the population, consisting of high-income groups that paid directly out of their pockets. Such a fragmented set-up was characterized by atomized risk pooling, consequent high levels of out-of-pocket spending, and inequality in access (Clavijo, 2009; Glassman et al., 2009). It resulted in limited access to even basic health services for a large proportion of the population, operational inefficiencies at all levels of care, and poor quality of services. All of these contributed to the low use and acceptance of the network of public providers (Shaw & Hsiao, 2007).

[2]Managed care refers to a variety of arrangements where insurers contract with providers to deliver comprehensive healthcare services (Ashraf, 2021).

## 2.2 The Reforms (1993)

### 2.2.1 Political Context

Colombia adopted a new Constitution in 1991. The constitutional reforms followed an official referendum that was held in May 1990, with an overwhelming majority voting in favour of adopting a new Constitution. In 1991, under the administration of President César Gaviria, the *Asamblea Nacional Constituyente de Colombia* (ANC or the National Constituent Assembly of Colombia) was formed to draft a new Constitution that could respond to the immediate political and social needs of the Colombian population. The ANC issued a comprehensive new Constitution that introduced a slew of radical institutional reforms, including the restructuring of Colombia's social security architecture (particularly for pensions and health).

The new Constitution underscored three key principles that were to define Colombia's social security system. These included universality, solidarity, and efficiency (The Constitute Project, 2022). It also stated that the system should include a plurality of public and private actors in an environment of financial sustainability (González-Rossetti & Ramírez, 2000). The operationalisation of these principles was set in motion by Law 100 of 1993, which introduced the framework for mandatory health insurance and laid down the key mechanisms that would govern this framework. It must be noted that the origin of Colombia's social security reforms can be traced back to the 1980s wherein two key trends, privatization and decentralization, dominated the discourse on public sector reforms. Law 10, 1990 initiated the municipalization of health, wherein sub-regional administrative units (departments and municipalities) were certified for autonomous health management. The operational authority for health care in the primary level was assigned to the municipalities, and for secondary- and tertiary-level hospitals, to the departmental governments (Pan American Health Organization, 1999). For instance, Law 12, 1986 helped establish a shared scheme for Value Added Tax (VAT) between local and central governments (González-Rossetti & Ramírez, 2000). This legislation introduced decentralization mechanisms that formed the core of Law 100, 1993. Moreover, the health system reforms in Colombia were informed by the lessons learnt from the Chilean health system reforms in the 1980s (C. Baeza, personal communication, June 14, 2022). Some features that were absent in the Chilean system were adopted in Colombia such as the establishment of a central risk adjustment fund and a single regulator for both the public and the private health systems.

### 2.2.2 Law 100, 1993

Law 100 of 1993 forms the fulcrum of Colombia's healthcare system and created the two-pronged insurance system consisting of the Contributory Regime and the Subsidized Regime. Individuals in the formal workforce or those who had the capacity to contribute towards health insurance were obligated to enrol themselves under the Contributory Regime (as was the case earlier in the insurance subsystem). Law 100 extended this coverage to first-degree family members (Bauhoff et al., 2018). The Subsidized Regime was designed to serve the remaining majority which was unable to contribute and primarily belonged to the informal (including self-employed), low-income group. The broad objective of the legislation was to provide universal health coverage through a compulsory social security system. It also stated that, by 2001 (eight years after the reform), both the regimes were to have the same package of basic services that would be provided through the *Plan Obligatorio de Salud* (POS or the Compulsory Health Plan) (González-Rossetti & Ramírez, 2000).

The law separated the two key functions of purchasing and provision of healthcare services — it distinguished entities that provided services from those that would finance or organise them. These are the *Instituciones Prestadoras de Servicios* (IPS or Health Service Providers Institutions) and the *Entidad Promotora de Salud* (EPS or Health Promoting Entities) respectively. EPSs can be public or private (for-profit or not-for-profit) (Bauhoff et al., 2018). They are responsible for enrolment, insurance, and the organization of service delivery (Puig-Junoy, 1999). It must be noted that in the Subsidized Regime, the role of insuring and organizing service delivery is performed by three different types of entities, together referred to as Subsidized Scheme Organizations (*Administradora del regimen subsidiado* or ARS) — a term that does not appear in Law 100 but was introduced later through Decree 2357 of 1995 (The Ministry of Health and Social Protection, 2002). There are different types of ARSs, (i) EPSs - that also serve the Contributory Regime, (ii) Family Compensation Funds - pre-existing institutions responsible for the administration of monetary and in-kind subsidies and were allowed to participate in the regime through Law 100 of 1993, and (iii) Solidarity Health Enterprises (*Empresas Solidarias de Salud* or ESS) – a special class of EPS that represented a network of community cooperative health organizations (Puig-Junoy, 1999).

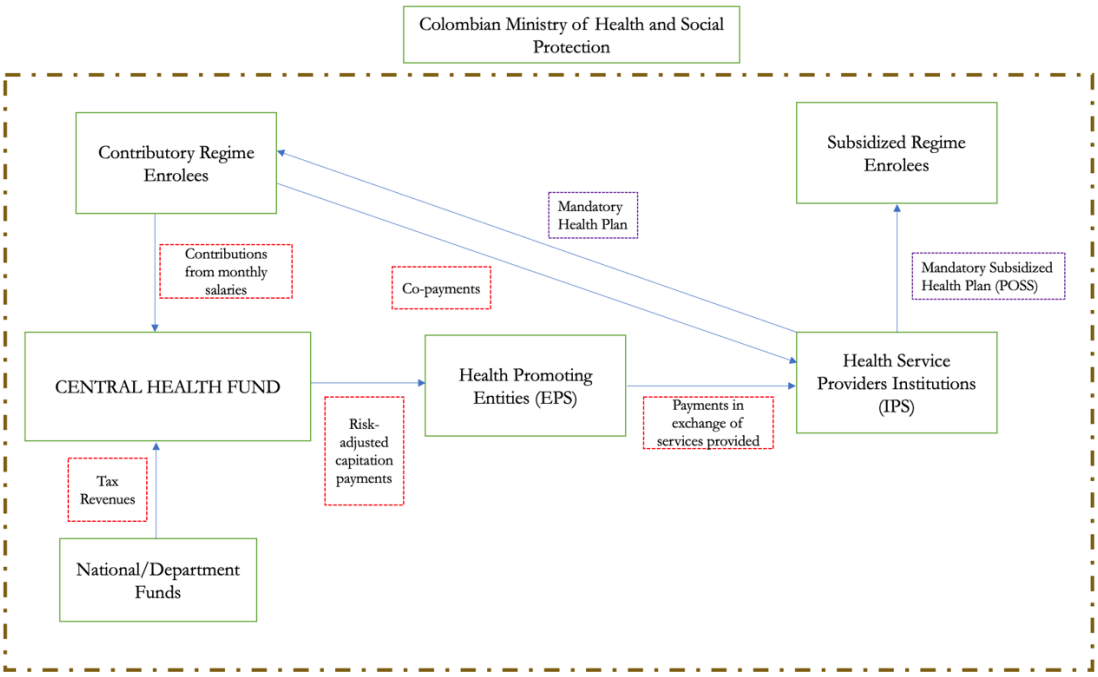
The law also introduced competition in both these domains, essentially establishing a dual market managed competition model (Shaw & Hsiao, 2007). The first of these markets is the insurance market, wherein citizens under each of the two regimes are free to enrol with any public or private EPS of their choice. Each EPS offers services included in a benefits package in return for a risk-adjusted premium

that is fixed at the national level. Both the contents of the benefits package and the quantum of premium are fixed at the national level through legislation. EPSs play a similar role to that of managed care organisations in the United States. Managed care refers to a model with certain core features such as alignment of incentives between the insurer and providers, coordination of care throughout the care continuum, provision of appropriate care and an emphasis on preventive care (Sekhri, 2000). EPSs in the Colombian health system create provider networks, purchase care through different payment mechanisms and employ gatekeeping at the primary care level (Vargas et al., 2013). The second market is that of the healthcare providers or IPS wherein the insurers or EPSs act as group purchasers on behalf of their enrolees and select a network of IPSs based on price and quality (Shaw & Hsiao, 2007). Not being able to compete on price or content of benefits, insurers can attract enrolees through the quality of their customer service and provider network (Bauhoff et al., 2018). The reforms mandated that public hospitals would make the transition from being state care providers financed through supply-side subsidies based on their historical budgets, to being state enterprises with autonomous governance structures remunerated for the services provided. Private health care providers were to compete with public providers for the provision of the mandatory benefit plan on the basis of quality and were to negotiate contracts with insurers (Glassman et al., 2009). The government's role is to facilitate and manage competition between EPSs (a) through the provision of information about price and quality and (b) by formulating, monitoring, and enforcing regulations concerning benefits, premiums, quality, enrolment, and standards (Shaw & Hsiao, 2007).

The law also introduced certain key mechanisms based on the principle of solidarity, one of the main tenets of the reforms. First, it established the *Unidad de Pago por Capitacion* (UPC or the Capitation Payment Unit) which is the per capita value that the system pays to EPSs for each enrolee. Second, the premium to enrol with an EPS under the Contributory Regime is calculated based on the payment capacity and not on the risk probability. Third, the law introduced a mechanism by which enrolees under the Contributory regime allowed 1% of their payment to flow to the Subsidized Regime, with this contribution being matched, by at least the same amount, from public sources (González-Rossetti & Ramírez, 2000).

## 2.3 Post-reforms Set-up: Implementation of the Managed Competition Approach

Figure 1: Design of the Colombian Healthcare System




### 2.3.1 Administrative Structure

The 1993 reforms introduced a revamped administrative setup in the healthcare domain. The erstwhile Ministry of Social Protection (later divided into the Ministry of Labour and the Ministry of Health and Social Protection) was assigned the role of policymaking at the national level along with the mapping of the overall progress of the reforms. The monitoring, inspection, and sanctioning of EPSs was assigned to a regulatory body called the National Health Superintendency/National Health Authority (Shaw & Hsiao, 2007). A central health fund, called the *Fondo de Solidaridad y Garantıa* (FOSYGA or the Solidarity and Guarantees Fund), was established to pool the system's revenues and disburse them among EPSs in the two regimes. Broadly, it was responsible for managing the payment flows across the system. In 2017, FOSYGA was replaced by a new entity called *Entidad Administradora de los Recursos del Sistema General de Seguridad Social en Salud* (ADRES or the Administrator of the Resources of the General System of Social Security). This change is expected to simplify the collection processes, improve the

payments flow, and reduce the operating costs of the financing system (Bauhoff et al., 2018). Further, the National Council for Social Security in Health was created as a policymaking body with authority over various aspects of the health care system (Shaw & Hsiao, 2007). Its role was to determine the level of benefits citizens are entitled to and that of payments to EPSs. The Council had representatives from the government, insurers, providers, employers, and unions. However, this function was later passed on to a regulatory commission in 2009 and the Ministry of Health and Social Protection in 2012 (Bauhoff et al., 2018).

### 2.3.2 Benefits Package

Law 100 of 1993 mandates two standard health packages, the Mandatory Health Plan (*Plan Obligatorio de Salud* or POS) for the Contributory Regime and the Mandatory Subsidized Health Plan (*Plan Obligatorio de Salud Subsidiado* or POSS) for the Subsidized Regime. For the first two decades after the reforms, the POSS entailed a less comprehensive package than the POS. While both included health promotion and basic preventive care, POS also included curative and emergency services (Cabrera, 2011). Prior to 2012, the Subsidized Regimr benefits excluded secondary services, like access to certain specialties and diagnostic technologies (Bauhoff et al., 2018). The differences in the range of services offered under the two regimes were a matter of significant contention, with the Constitutional Court of Colombia finally intervening in 2008 to mandate the equalization of the benefits packages (*Sentencia T 760-2008*, 2008). Since the equalization of the benefits under the Contributory Regime and the Subsidized Regime in 2012, both regimes cover primary, secondary, and tertiary care, diagnostic and therapeutic services (both inpatient and outpatient), prescription drugs, and mental health. Other types of care, such as dental (with restrictions), palliative and home health care, and some indigenous traditional medicines are also covered with a list of exclusions. In 2015, a legal change facilitated shifting from an explicitly defined benefits package to an implicitly defined package with a negative list. This change was brought about by the Statutory Law on Health (Law 1751 of 2015), which also recognized health as a fundamental right (Quintero, 2019). In the new regime, individuals are entitled to most health services by default, with limits for only a few areas, such as medically ineffective and aesthetic services and treatments that are experimental, unapproved, or unavailable in Colombia (Glassman et al., 2009; Bauhoff et al., 2018). Except for emergency services, enrolees can only access the network of providers that has been contracted by their EPS, with no coverage of out-of-network spending (Bauhoff et al., 2018).

### 2.3.3 Switching

Enrolees in both regimes are free to choose their EPS and are allowed to switch between them after one year. In certain exceptional cases, they might even be allowed to switch to another EPS before the expiry of the one-year period. While there are switching mechanisms available, very few people have opted in for them. As of 2014, the switching rate was as low as 1% (Bauhoff et al., 2018). Earlier, Subsidized Regime enrolees who found a job in the formal sector were required to switch to an EPS in the Contributory Regime. However, since 2013, enrolees have been allowed to switch between the Contributory and the Subsidized Regimes (according to employment status) without having to change their EPS (Bauhoff et al., 2018).

### 2.3.4 Financing

Under the Contributory Regime, enrolee contributions flow directly into the central health fund administered by ADRES. These contributions do not vary across EPSs, eliminating any competition that is based on price. 12.5% of an enrolee's monthly income flows into the central fund. For the employed, 8.5% is paid nominally by the employer and the remaining 4% is deducted directly from the employee's salary. The self-employed pay the full 12.5% on 40% of their estimated gross income, but at least 12.5% on the full-time monthly minimum wage (approximately USD 230 in 2016) (Bauhoff et al., 2018). The employer contribution for private companies changed in 2012, wherein they were exempted from paying this contribution and were instead mandated to pay a corporate tax surcharge earmarked for health (Bauhoff et al., 2018). No such change was brought in for the public and not-for-profit sector employers.

1% of the contributions made by enrolees in the Contributory Regime are redirected towards enrolees in the Subsidized Regime and as stated earlier, are matched by equivalent funds ("solidarity matching funds") from public sources. The Subsidized Regime is, therefore, primarily financed through tax revenues from various sources and "social investment transfers" earmarked for health. Resources that were used for supply-side subsidies were also transformed into demand-side subsidies under this regime (Shaw & Hsiao, 2007).

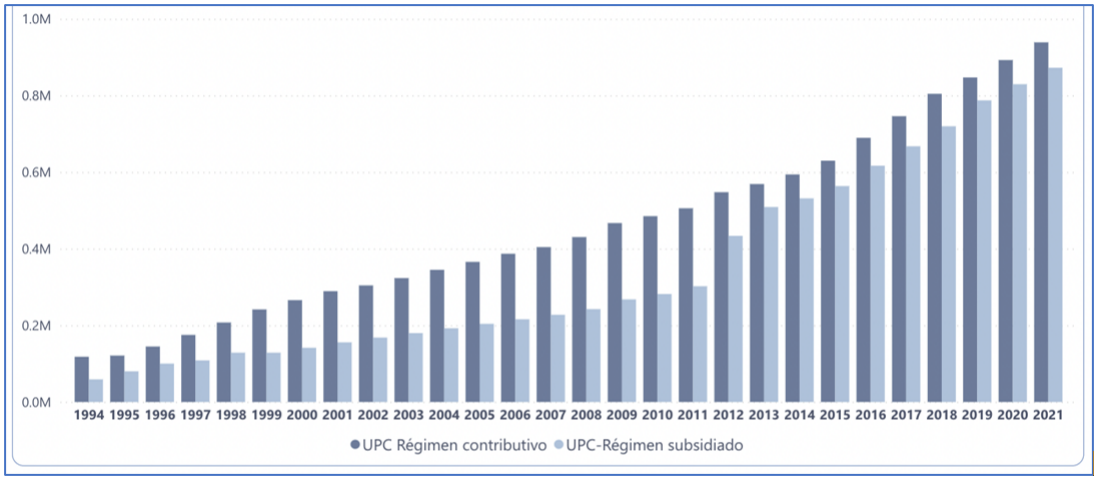
Approximately 80% of the funds collected (CR enrolee contributions + tax revenues + earmarked tax on employers) under ADRES are disbursed to EPSs in the two regimes. The remaining 20% is directed toward health initiatives outside of the insurance system. These include disaster relief, sick leave payments, maternity leave payments, etc. In addition to the funds flowing from the central fund, EPSs

in both regimes also collect co-payments that vary by income. For some services, enrolees are exempt from this amount. In 2021, the co-payment rate was 10% (of the value of service) for the Subsidized Regime, and for the Contributory Regime, depending on the enrolee's income bracket, the rate ranged anywhere between 11.5% and 23% (The Ministry of Health and Social Protection, 2021). Enrolees in the Contributory Regime also pay "moderating fees" which, as of 2021, ranged between 3,500 Colombian Peso (COP) and 36,800 COP, depending on the income bracket. Both these figures (co-payment rates and moderating fees) are revised every year by the Ministry of Health and Social Protection of Colombia. A total of 46% of payments in the Contributory Regime in 2011 were based on fee-for-service (FFS), while capitated payments accounted for 35% (Carranza, 2015). FFS payments are mostly used for specialty care while capitation payments are used for primary care. Diagnosis-Related Group (DRG) payments are also used in both regimes and constitute 2% of payments in the Contributory Regime (Bauhoff et al., 2018).

As mentioned earlier, the disbursement of money to the EPSs from the central fund is done through the 'Capitation Payment Unit' or UPC mechanism. UPC is a risk-adjusted per capita value wherein the risk adjustment is based on three factors, namely age, sex, and geographical location. For both the Contributory and the Subsidized Regimes, there are 14 age-sex groups and four geographical zones, resulting in a total of 56 cells for each regime — resulting in a total of 112 UPCs. The four geographical zones include regular areas, dispersed areas, cities, and remote areas. There are higher payments allocated to remote areas (to reduce access barriers) and to cities (to cater to the high demand) (Bauhoff et al., 2018). The UPC is calculated on an actuarial basis, through the estimation of demand for services included in the POS, given the characteristics of each cell. Notably, as seen in Figure 2, the UPC in the Subsidized Regime has been historically lower than that of the Contributory Regime. However, starting in 2012, with efforts underway to equalize the benefits basket under each of the regimes (discussed later), the values of the capitation payments have been gradually converging.

In addition to the UPC, an add-on payment is also made to EPSs that have a disproportionate share of the elderly insured. Some EPSs may also receive payments from a 'High Cost Account' for three conditions, including stage 5 kidney disease, HIV/AIDS, and haemophilia A (Bauhoff et al., 2018).

Figure 2: Differences in Values of the Capitation Payment Units under the Contributory and the Subsidized Regimes (1994-2021)




*Source: Asi Vamos en Salud (2021)*

### 2.3.5 Targeting

An important aspect of the bifurcated insurance system is the targeting mechanism through which citizens' eligibility for enrolment under the Subsidized Regime is determined. This is facilitated through a poverty-targeting index called *Sistema de Identificación de Beneficiarios* (SISBEN or the System for the Identification and Classification of Potential Social Programme Beneficiaries). The original SISBEN consisted of 14 components that acted as proxies for a household's well-being. These included housing type, access to public utilities, ownership of durable assets, demographic composition, educational attainment, and labour force participation, among others (Miller et al., 2013). The information collected for each of these components is used to determine a household's SISBEN score, which could range anywhere between 0 to 100 (with 0 being the most impoverished)[3]. Using these scores, households are classified into six strata. Households belonging to strata 1 and 2 are eligible to enrol under the Subsidized Regime (Miller et al., 2013). As of 2021, SISBEN-IV is being used to determine eligibility for the Subsidized Regime. Under this version, households are divided into four groups, Group A (extreme poverty), Group B (moderate poverty), Group C (vulnerable), and Group D (non-poor), with the first three groups eligible to enrol (National Planning Department, 2021). Recently, in April 2022, the Ministry of Health and Social Protection ex-

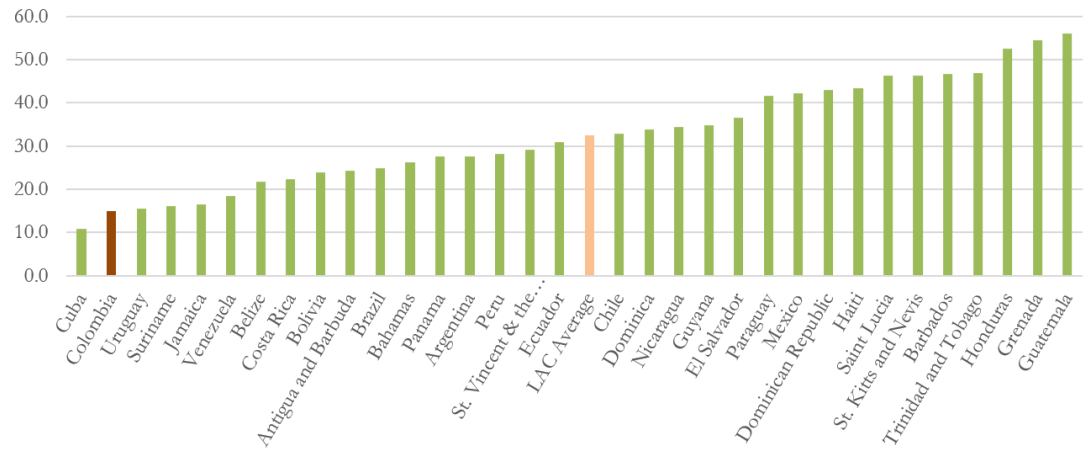
[3]It is worth noting that Camacho & Conover (2011) have documented patterns in the survey data that indicate strategic behaviour and manipulation during the implementation of the first Census of the Poor in Colombia.

panded the eligibility criteria, announcing that households which have lost their earning capacity and are classified in Group D are also eligible to enrol under the Subsidized Regime (News Beezer, 2022).

# 3 Performance of the Healthcare System

Since the inception of the 1993 reforms, there has been a dramatic increase in the proportion of the population formally insured. For instance, between 1993 and 1997, the coverage doubled from 23.7% to 57.2%, with the largest proportionate gains amongst the low-income population (Jack, 2000). As of 2014, about 96% of the population was estimated to be covered under formal insurance in the country (Bauhoff et al., 2018) and as per the latest figures announced by the Deputy Minister of Health and Social Protection in April 2022, around 99.19% of Colombia's population is formally insured (News Beezer, 2022). The achievement of near-universal coverage (even in nominal terms) by a developing country like Colombia has been cited as a remarkable success story. The 1990s reforms not only triggered an expansion in the number of people covered but also an expansion in the number of regions covered (González-Rossetti & Ramírez, 2000). In addition to high coverage rates, Colombia enjoys a relatively lower share of OOPE as a percentage of its total healthcare expenditure. As seen in Figure 2 below, OOPE share was about 15% of total health expenditure for Colombia in 2019 - the second-lowest and almost half of the average of the LAC region (32%) (World Health Organisation, 2022).

Figure 3: OOPE Shares (as % of Current Health Expenditure) for the LAC Region (2019)




*Data Source: World Health Organization - Global Health Expenditure Database (2022); Illustration: Author*

A possible explanation for this is the modest magnitude of cost-sharing in the system coupled with generous exemption rules. Enrolees in the Subsidized Regime

are exempt from paying moderating fees and the magnitude of moderating fees for the Contributory Regime is relatively small (OECD, 2015). Despite the success in expanding the extensive margins of insurance coverage and in controlling OOP spending, a range of issues continues to ail Colombia's health system. Over the last two decades, multiple scholars and international organizations have comprehensively documented and analysed these issues, creating a rich body of work that reflects the complexities associated with systemic reforms. A detailed overview of these issues has been provided below, along 4 key axes, (i) Access to and Quality of Care, (ii) Financial Stability, (iii) Monitoring and Accountability Mechanisms, and (iv) Degree of Competition.

## 3.1 Access to and Quality of Care

While overall access to healthcare services has improved since the initiation of the 1993 reforms (Glassman et al., 2009), the timeliness of such access continues to be a contentious topic in the scholarly literature on the reforms' impact. While many studies acknowledge that great strides have been made by the country's healthcare system, most of them also point toward systemic fault lines that have undermined the achievements made. Pre-existing interregional disparities in access seem to have persisted despite the reforms, indicating that the reforms are yet to crack the supply-side problem of inadequate infrastructure. Available measures for timeliness suggest low availability of specialized care providers in the public sector and rural facilities and for departments with higher rates of poverty (World Bank and International Finance Corporation, 2019). Profit-seeking EPSs generally flock to urban centres which have a higher proportion of enrolees from the Contributory Regime, resulting in poor availability of health centres and health professionals in remote areas or areas with a higher proportion of enrolees from the Subsidized Regime (C. Sanabria, personal communication, April 13, 2022). While EPSs are mandated to reimburse patients for the transportation costs incurred (the costs symptomatic of the EPS' failure in ensuring access close to the patient's residence), the rule has not been adequately enforced. Further, many patients, especially in the Subsidized Regime, are unaware of such mechanisms and do not get their costs reimbursed (D. Manrique, personal communication, April 20, 2022).

*Cost-cutting Mechanisms Deployed by EPSs*

One of the major reasons cited for delayed accessibility to healthcare services is the EPS's or the insurer's search for profitability (Vargas et al., 2013); C. Sanabria, personal communication, April 13, 2022). The government pays EPSs an annual fee per enrolee, called the UPC. With this amount, EPSs are expected to cover enrolees' annual examinations, treatments, and hospitalization costs. This fee is also

used to cover EPSs' own administrative and operational costs. However, many of these EPSs attempt to generate surpluses by causing delays in outgoing expenses. While insurance companies in Colombia are legally obliged to enrol patients regardless of their health care condition and capacity to pay, there are limited financial incentives to provide prompt and quality care (Sanz, 2017). Low-income patients have described the process of getting their access authorized by EPSs as exhausting and riddled with burdensome paperwork. Many patients have been subjected to lengthy, delay-causing administrative procedures or "bureaucratic itineraries" (Abadia & Oviedo, 2009) – resulting in multiple trips back and forth between the health insurance office, pharmacies, and the hospital (Sanz, 2017). Many EPSs tend to contract with different providers for different services, based on the terms they negotiate, resulting in a fragmented interface for the patient. Such fragmentation results in patients having to travel to multiple sites for different aspects of their diagnostic and treatment needs (World Bank and International Finance Corporation, 2019).

It has also been pointed out that while treatment rejection is not a legal option for insurance companies under Law 100 of 1993, these profit-seeking entities try to make money through treatment deferrals and by using UPC funds as financial capital (Sanz, 2017). EPSs have been frequently found to defer treatment authorizations to avoid spending money inefficiently on low-income/high-cost patients (Sanz, 2017; Vargas et al., 2013). The typical delays caused by EPSs in authorizing access to specialists[4], coupled with poor availability of healthcare infrastructure at the primary level (especially in rural areas), have crippled low-income households' accessibility to quality care.

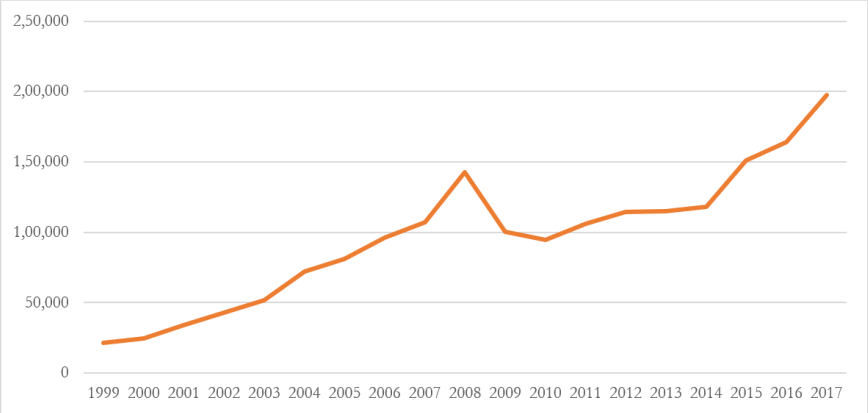
*Litigious Mechanisms for Accessing Care*

The 1991 Constitution created the Constitutional Court of Colombia (hereinafter referred to as "the Court"), the highest appellate authority in the country. It also introduced a mechanism called *tutela*, a writ designed to protect individual rights with fewer procedural requirements to bolster accessibility to courts. Between 1999 and 2005, approximately 3.2 million (Yamin & Parra-Vera, 2009) — symptomatic of the lack of timeliness and of quality in care provisioning offered by the system (OECD, 2015). Notably, this litigious mechanism has been used to gain access to services included in the POS, signalling important shortcomings in the system. These healthcare *tutelas* have increased sharply over time, with an average of 90,000 per year of these being filed until 2008. Interestingly, these

[4]There is a gatekeeper system wherein patients see specialists only through referral from primary care. See (World Bank and International Finance Corporation, 2019)

*tutelas*, filed by patients aggrieved by the cost-cutting tactics of EPSs, have also been cited as one of the key factors responsible for the financial instability of the system (Alvarez-Rosete & Hawkins, 2018). In cases where the Court ordered the provisioning of services not included in the Mandatory Health Plan or the POS, the central health fund was required to reimburse the provider for expenses incurred, which resulted in most of the fund's expenditure being dedicated to the fulfilment of the Court's orders. It is amidst this context that the Court issued a landmark judgment, T-760 of 2008, and ordered a "dramatic restructuring" of the country's health system. T-760 collected 22 *tutelas* that comprehensively illustrated the systemic problems in the healthcare system. These included restrictions on access to care stemming from inappropriate transfers of administrative costs to patients and failures to make access effective (e.g., by ignoring transportation needs) (Yamin & Parra-Vera, 2009). The Court also reiterated the need to implement measures that would reduce the usage of *tutelas* as a recourse and recognized health as a fundamental right (Quintero, 2019). Most importantly, it ordered the appropriate executive agency to standardise the benefits packages across the two regimes without compromising the financial stability of the system. It also set various deadlines by which the government was to comply with the judgment (Yamin & Parra-Vera, 2009). Interestingly, as seen in Figure 4 below, the number of *tutelas* addressing access to health care decreased after the passing of the T-760 judgment in 2008. However, this fall was only temporary and starting in 2010, the number of healthcare *tutelas* started increasing again, plateauing between 2012 and 2014, a period marked by the standardization of benefits across regimes. Two more spikes in the number of healthcare *tutelas* seem to have taken place in 2014 and 2015 respectively. In these years, the benefits package was being transformed from an explicitly defined list of healthcare services to an implicit one. However, this legislative change was not accompanied by a proportionate increase in fiscal resources, resulting in inadequate UPCs being disbursed (Quintero, 2019). This, in turn, led to deferred/denied access to care, as reflected in the exponential rise in the number of *tutelas* that have been filed since then.

Figure 4: Number of Healthcare *Tutelas* (1999-2017)



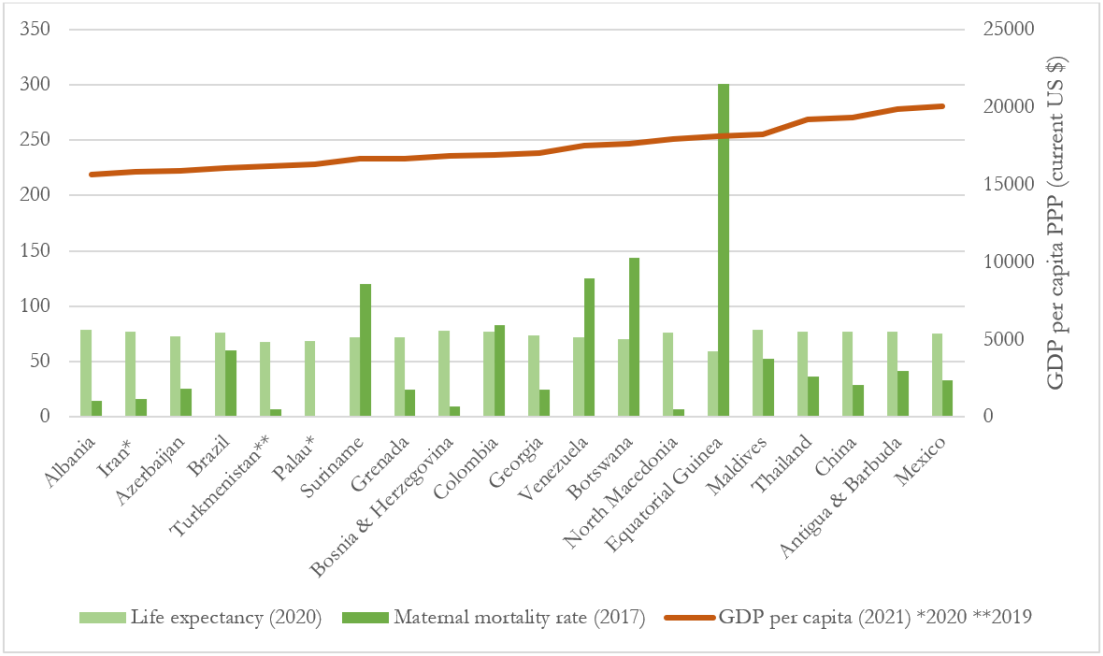

*Data Source: The Constitutional Court of Colombia; Illustration: Author*

In terms of quality of care, assessments have been limited due to a paucity of data (C. Sanabria, personal communication, April 13, 2022). While mechanisms for data reporting exist[5], many health institutions struggle to report valid (or any) data (OECD, 2015). A recent study estimates that approximately 33,917 deaths per year in Colombia can be attributed to the health care system, with 65% (22,080 deaths per year) of these resulting from the use of poor quality of care while the other 35% (11,836 deaths per year) caused due to non-utilization of or poor access to health facilities (World Bank and International Finance Corporation, 2019). However, the number of deaths per 100,000 people due to poor quality of care in Colombia (46) is much lower than that in Brazil (74) and Mexico (56) (World Bank and International Finance Corporation, 2019). Colombia has achieved mixed health outcomes. Figure 5 below illustrates the life expectancy and maternal mortality of Colombia in the background of countries with similar per capita GDP.

While the life expectancy in Colombia falls below the OECD average, it is higher than a few OECD countries such as Latvia, Lithuania and Mexico (World Bank and International Finance Corporation, 2019). When compared to countries with similar GDP per capita, the life expectancy at birth in Colombia (77 years) is better than most (Figure 5). In terms of health status, the maternal mortality rate (MMR) in Colombia 2016 wasis not only higher than the OECD average (World Bank and International Finance Corporation, 2019) but also higher than

[5]Recent efforts by the Government of Colombia have resulted in the creation of digitized information systems with respect to the health systems. One such database is called the Comprehensive Social Protection Information System or SISPRO (*Sistema Integrado de Información de la Protección Social*), a tool to collect nationwide information on the health system.

Figure 5: Comparison of Health Outcomes in Colombia with that of Similar Countries




*Data Source: The World Bank; Illustration: Author*

OECD countries like Mexico and Brazil that have comparable GDP per capita (Figure 5). Hence, in terms of MMR it performs worse than most except a few countries like Botswana and Venezuela. Lastly, per-capita allocations to EPSs are not adequately adjusted for risk, creating a disincentive for insurers to invest in quality improvements that will attract high-risk, high-cost patients (World Bank and International Finance Corporation, 2019).The profit-seeking activities of the insurers are also symptomatic of the inadequacies in the existing risk adjustment mechanisms.

## 3.2 Financial Stability

The first significant setback to the system occurred in the period 1998-2001. This period was marked by an economic recession and an intensification of internal armed conflict. The healthcare reforms set out in Law 100 of 1993 had only been partially implemented by then and the health system faced a "severe and generalized financial crisis" (Glassman et al., 2009). The recession had revealed the system's fault lines. Prior to 1993, public hospitals had relied upon direct funding from the government, but, after the reforms, they were required to contract

with EPSs that invariably delayed the payments due. The EPSs demanded lesser services from public providers. The public hospitals were unable to adjust their cost structures in response to this limited purchasing from the EPSs (C. Baeza, personal communication, June 14, 2022). Further, the lack of compliance on the government's part to contribute the solidarity matching funds and/or funnel tax revenues from oil, resulted in a poorly funded public hospital network. This crisis also led to the closure of many public hospitals that had initially been transformed into autonomous companies competing with private counterparts. While such a crisis unfolded in the public sector, private EPSs continued to grow (Uribe Gómez, 2009).

In December 2009, almost a year after the T-760 judgement, Colombia's President declared a "State of Social Health Emergency" and stated that the exponential increase in demand for services outside of the POS had threatened the liquidity of many EPSs and IPSs, resulting in a precarious scenario for the entire health system. The decree also stated that the system's current deficit had doubled over a period of one year from 409.18 million COP in 2008 to 885.23 million COP in 2009. It also cited the T-760 judgement as one of the factors exacerbating the system's financial imbalance, specifically its provisions related to the universalization of coverage and the standardisation of benefits across regimes (The Administrative Department of the Presidency of the Republic, 2009). The declaration made it possible for the government to issue decrees that would implement cost-cutting mechanisms to ration healthcare. One such reform introduced pertained to the conduct of physicians in the health system, whereby any physician who was found prescribing services disproportionate to the patient's condition (and therefore violating widely acceptable protocols in the medical community) would be held personally liable to pay for the services rendered (D. Manrique, personal communication, April 20, 2022). Such reforms generated a strong public opposition with healthcare providers engaging in widespread protests. The Emergency was finally declared to be unconstitutional in April 2010 by the Court, which also annulled the Emergency decrees that had been issued (Alvarez-Rosete & Hawkins, 2018).

One of the most pivotal assumptions of the architects of Law 100 of 1993 was that unemployment and the proportion of informal labour would decrease over the following decade, resulting in the Contributory Regime growing faster than the Subsidized regime. Under this assumption, it was expected that the "solidarity mechanism," whereby the formally employed contribute 1% of their salary, would become the financial bedrock of the Subsidized Regime. This forecast proved to be wrong, and informal labour and unemployment rose. Between 1993 and 2013,

the subsidized population grew faster than the contributory population, and as a result, the government had to invest heavily to finance the expansion of health care coverage among the subsidized population (García et al., 2016). It has also been observed that the broad expansion of government-provided health insurance in Colombia inadvertently contributed to increasing informal employment (Camacho et al., 2014) as well as false reporting of informality and poverty (C. Baeza, personal communication, June 14, 2022).

Financial sustainability continues to be one of the key challenges for the system (OECD, 2015), its deficits being frequently cited by the government as the key contributing factor to poor accessibility. Any delays caused by the central health fund in paying the EPSs naturally cascade into delayed payments to hospitals, doctors, and laboratories, which in turn, are forced to turn away patients. Financially troubled EPSs also tend to not have contracts with a healthcare provider for specialty care, and then the primary healthcare provider must resort to referring the patient to the nearest emergency department for treatment (World Bank and International Finance Corporation, 2019).

Even in cases wherein EPSs have received adequate funds in a timely manner, various instances of misappropriation of the UPC funds have been reported (Lujan, 2012; OECD, 2015). Some of these examples include the investment of state funds received in foreign real estate and the establishment of clinics (thereby violating the rules related to vertical integration of insurance and provisioning[6] (Lujan, 2012). These instances have also resulted in the closure of many EPSs, effectively diluting the degree of competition in the insurance market (D. Manrique, personal communication, April 20, 2022). As of 2012, many of the EPSs had also been taken over by the government to avoid complete insolvency. According to the latest financial estimates from June 2021, the Contributory Regime reported net losses amounting to 324.5 million COP while the Subsidized Regime reported a net income of 62.7 million COP — indicating net margins of -1.6% and 0.8% respectively. Further, the operating margins of both the regimes are negative, -2.1% and -2.4% respectively (PROESA, 2022). This is interesting because EPSs' cost-cutting mechanisms, coming as they do at the cost of accessibility, have been quite pervasive and one would assume that such mechanisms would have, at least, enabled them to break even. This, however, is evidently not the case – indicating a double failure in the system in terms of both accessibility and efficiency, two metrics that typically share a trade-off relationship. The insurers' search for profitability leads them to deploy cost-cutting or cost-efficient protocols that typically

[6]In 2007, EPSs were to contract with their own providers for up to 30% of their total expenditure only. See (Bauhoff et al., 2018)

entail either the rejection of a particular treatment requested or authorization of a cheaper alternative. Both these protocols impede the ease with which a patient accesses the healthcare system. However, in the case of Colombia, such cost-cutting mechanisms have not necessarily led to any improvements in the financial state of many insurance companies.

## 3.3 Monitoring and Accountability Mechanisms

### 3.3.1 Switching as an Accountability Tool

While enrolees in both the regimes are allowed to switch between EPS, the actual switching rate was as low as 1% as of 2014 (Bauhoff et al., 2018). A managed competition system depends, in theory, on the public availability of quality data to support user choice of insurer and provider and spur quality-driven competition. However, the disclosure of the system's performance indicators is not timely and is not tailored to the needs of the enrolees it seeks to serve. Uneven data quality has led to the limited use of data for quality assessment, benchmarking and quality improvement. Furthermore, the lack of guidance by the government in interpreting data on healthcare quality limits the ability of patients to choose their EPSs (World Bank and International Finance Corporation, 2019). Therefore, switching between EPSs as an accountability tool is not a frequent phenomenon (Prada-Ríos, 2016) and must be proactively encouraged by the government for improving the system's governance mechanisms.

### 3.3.2 State Capacity and Motivation

The Ministry of Health and Social Protection is responsible for the framing of regulatory policies for the healthcare system. One of the key provisions available for monitoring the quality of healthcare is the accreditation process, introduced to encourage providers to adhere to quality standards above the minimum threshold. However, the accreditation process is voluntary with nearly zero incentives to catalyse its take-up by providers — largely due to the lack of actual user choice of provider based on quality indicators (OECD, 2015). The lack of actual choice, in part, is a product of poor information dissemination and paucity of infrastructure in the last mile (limiting patients' options even when they have enough information on quality). With regard to the monitoring of EPSs, the regulatory architecture has been widely criticized for foregoing control over public monies once they enter the private-sector domain (Sanz, 2017). Regulators have little visibility with respect to the financial management of EPSs, indicating a major failure of its capacity to "manage" the system. The Colombian state's adequacy in effectively regulating its healthcare system has been called into question on multiple occa-

sions. Many scholars have cited it as an example of the practical difficulties low-income/middle-income countries' regulation schemes face while correcting market failures and safeguarding patients' rights (Vargas et al., 2013). The evidence of such practical difficulties is clearly illustrated by the degree of non-compliance that exists in the EPS domain. It must be added that while most international organizations such as The World Bank, The Inter-American Development Bank have cited the failure of regulation as the system's Achilles' heel, other scholars and organizations are of the view that it is the system's design (in particular, its incentive and accountability structures) and not its regulation that is to be blamed for its sub-optimal outcomes.

## 3.4 Degree of Competition

The change in subsidies allocation from a supply-driven process to a demand-driven process was implemented only partially. Vertical integration was permitted in the healthcare system in the 1990s. While the reform allowed EPSs to create their own provider networks and reimburse providers based on the healthcare provided, there were still provisions which guaranteed contracts to public providers. EPSs have to mandatorily allocate 60% of their expenditure to public providers. This provision has created distortions in the market and impedes the realisation of quality-based competition between providers (D. Bardey, personal communication, June 4, 2022).

Starting in 2007, EPSs were to contract with their own providers for up to 30% of their total expenditure only (Bauhoff et al., 2018). The cap on vertical integration prevents EPSs from establishing clinics in areas where the government has not instituted adequate healthcare infrastructure (A. Galan, personal communication, May 29, 2022). Despite this regulation, EPSs have operated their own set of providers (hospitals, clinics, and laboratories), frequently flouting the rules pertaining to limited vertical integration. Regulatory loopholes have also effectively allowed insurers to impose contracts with exclusivity clauses (OECD, 2015). Insurers can opt for greater vertical integration in some local markets or regions as opposed to others while still meeting the ceiling of 30% for their overall expenditure (Bardey & Buitrago, 2016). Vertical integration, in this context, has also acted as an entry barrier, especially in an environment characterized by a scarcity of providers like the rural areas in Colombia. When an exclusive contract is signed by an EPS with, for example, the only hospital operating in an area, it makes the provider unavailable to potential entrants — essentially establishing the contracting EPS' monopoly (OECD, 2015). As stated earlier, the degree of competition in the insurance market has increasingly diluted, in part, due to the closure of many EPSs for non-compliance (D. Manrique, personal communication, April 20, 2022).

Despite these concerns, vertical integration has some efficiency-enhancing benefits and should be managed by the Colombian Competition office or *Superintendencia de Industria y Comercia*, for better outcomes (D. Bardey, personal communication, June 4, 2022). Bardey & Buitrago (2016) recommend the prohibition of vertical integration in rural areas where there is a dearth of healthcare providers but easing the restriction in urban areas where the efficiency enhancing benefits of vertical integration can be leveraged.

## 3.5 Regulation of Drug Prices

According to Law 100, essential generic drugs were included as one of the basic healthcare benefits to be provided to the population. Subsequently, multiple policies have been introduced to regulate the pharmaceutical sector (Mendoza-Ruiz et al., 2017). In 2008, a National Pharmaceutical Policy (NPP) was published by the MoHSP but not officially adopted. Later, a second NPP was introduced and approved for 2012-2021 which sought to ensure equitable access to good quality medicines through shared responsibility between stakeholders.

The inclusion of drugs in the benefits package and coverage through health insurance has two implications (Romero, 2017). Firstly, this reduces the out-of-pocket (OOP) expenditure that consumers incur on pharmaceutical purchases causing a decrease in price sensitivity for drugs. This could result in consumer-led moral hazard and increasing prices if the suppliers enjoy market power. This is especially the case in the pharmaceutical sector since suppliers are usually granted temporary monopolies to develop a drug. Secondly, the drugs listed in the benefit plan become close substitutes for other drugs in the market, prompting increased competition and leading to reduced prices. The net effect, however, is unclear (Romero, 2017).

The Colombian health system has implemented negligible cost-sharing fees reducing OOP expenditure to a large extent. Instead, it has relied only on price-cap regulations. In 2009, Colombia had the most expensive drugs in the region, in response to which it implemented two overall price cap regulations (Bardey et al., 2021). The Maximum Price for Sale to the Public (*Precio Máximo de Venta al Público* or PMVP) was introduced for the drugs included in the SHI benefits plan and the Maximum Recovery Value scheme (*Valor Máximo de Recobro* or VMR) for other drugs in the market. While the latter is primarily applicable to privately sought care, it also applies to drugs which can be retrospectively reimbursed under the SHI system. Prada et al. (2018) document a significant decrease in drug prices by 43% immediately following the implementation of the price cap regulations. However, at the same time, the sale of drugs almost doubled during the period

under study (2011-2015). They deduce that this could be a result of increased access to drugs or more worryingly, induced demand and consequent oversupply of drugs. To address this issue, there is a need for periodic monitoring and regulation of the quantity of drugs sold in addition to the application of price caps (Prada et al., 2018).

# 4 Conclusion

The embedment of managed competition principles in an environment characterized by low-state presence and weak rule of law makes Colombia an extremely interesting setting to analyse. The scale and the intensity of the reforms it embarked on in the 1990s remain unprecedented among developing countries. The verdict on the impact of these reforms, however, varies not just across the system's stakeholders but also across scholars with opposing methodological inclinations. Most quantitative studies on Colombia's healthcare, invariably, depict the system as having achieved enviable goals related to access to and quality of care. However, it has been pointed out that most of these studies treated insurance as a simple, independent, binary variable - failing to capture the influence insurers have on access to healthcare through their power to define provider networks and conditions of access in a managed competition set-up (Vargas et al., 2013). On the other hand, qualitative research, which has documented the impact through ethnographies and reasoned argumentation, has mostly delivered a less-generous verdict on the reforms.

In nominal terms, Colombia's healthcare system has made considerable progress, as reflected in its low share of OOP spending and high rates of coverage. While Glassman et al. (2009) highlight that the reforms have not only dramatically increased health insurance coverage among the poor but have also improved access to and use of key health services, Vargas et al. (2013) summarise the various access barriers that have been instituted by the same reforms. These include (i) authorizations resulting in the delay of access to specialist care, (ii) capitated payments leading to denial of patient care and to referrals to other levels of healthcare to avoid the costs of the treatment, and (iii) fragmented contracting of medical care resulting in high transaction costs for the patient, among others. These barriers also underscore how managed care may exacerbate the negative impact of supply-side barriers that are either way common in most developing countries, through an increase in indirect costs (time and travel) and delay in care Vargas et al. (2013). These debates indicate that the jury is still out on the optimality of the reform approach Colombia undertook in 1993, signalling the important lessons its case holds for developing countries like India.

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