Colombia

Area	1,141,748 km^2
Population[i]	45,012,096
Age structure	
0-14 years	29.6
15-64 years	65.1
65 years and over	5.4
Infant mortality rate (per 1,000 live births) both sexes[ii]	16
Life expectancy at birth (years) female	76.8
Life expectancy at birth (years) male	69.4
Maternal mortality ratio (per 100,000 live births)[iii]	130
GDP per capita	
Current USD[iv]	5,416
PPP (current international $)	8,797
Constant local currency	6,234,943
Total health expenditures (as % of GDP)	7.44[v]
Unemployment rate[vi]	12.2
Size of informal economy (%)	57[vii]
Poverty (% of population)	45.5[viii]
Extreme poverty (% of population)	16.4[ix]
Human development index (HDI) rank[x]	77
HDI poverty indicators – Human poverty index rank	34
Minimum monthly wage (in US$) 2010	221

The Subsidized Health-care Scheme in the Social Protection System

9

Colombia

Elisa Carolina Torrenegra Cabrera

Summary

- 1993 – Health-sector reform: converting a national health system into a system based on subsidizing demand (allocating money through subsidy to individuals, with administration by private insurance companies known as health-promoting entities (entidades promodoras de salud, EPSs) by assigning resources to the institutions in charge of health care, such as hospitals and clinics, from the nation's general budget;
- The General System of Social Security in Health (Sistema General de Seguridad Social en Salud, SGSSS) was created with two regimes: the contributive for those who can afford to pay and the subsidized for the poor;
- Objective: Universal health coverage - access to a variety of health services;
- Insures 41 million out of 46 million citizens;
- Beneficiaries of both the contributive and the subsidized regimes have access to a benefit package, but beneficiaries of the contributive regime enjoy additional services;
- Beneficiaries enrol with public or private insurers (health funds), have legal rights to an explicit package of health benefits, and receive care from a mix of public and private providers;
- Separation of the financing, stewardship and delivery functions within the health system;
- Introduction of a national equalization fund (Solidarity and Guarantee Fund (El Fondo de Solidaridad y Garantía, FOSYGA) to provide cross-subsidies between wealthy and poor, sick and healthy, old and young, and financing to shield health financing during economic crises;
- Establishment of the constitutional court and mechanisms to grant protection to individual rights, to enhance the public's access to the courts, and to help enforce the right to health;
- Financing: a mix of employer-employee contributions and general taxes;
- Results: increased public and private health expenditure and increased health insurance coverage.

Subsidized Health Insurance Scheme:

- Target group: Poor or informal workers;
- Selection of eligible poor and informal workers by the municipal authorities through a proxy means test;
- Financing: general taxes collected by the national government and transferred to the municipalities, reinforced by departmental and municipal contributions plus the transfer of 1.5 per cent of total collections from the contributive system.

Summary (cont'd.)

Contributive Health System:

- Target group: those who can afford to pay. Anyone with a labour contract or an income above two minimum salaries (if working independently) must be affiliated;
- Financing: wage contributions – 12 per cent of the declared income contribution, two thirds paid by the employer and one third by the employee.

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Economic and Social Context of the Subsidized Regime

Colombia's subsidized regime has its origins in the 1990s, a decade when international trends were based on the promotion of solidarity concepts, community participation, access to rural health services, self-management of health, health promotion and development through community participation, prevention in health care, and a focus on poor and vulnerable populations.

In Colombia, these global trends were consolidated through the establishment of the health plans serving the subsidized population (the Health Solidarity Organizations Programme (Programa de Empresas Solidarias de Salud, ESS). Established by the national government with support from the Inter-American Development Bank, these plans incorporated the public health policy concepts that were already accepted internationally and promulgated in the discussion, analysis and decision-making processes of health systems around the world. This programme improved the organizing of rural communities and communities with a lower socio-economic status, empowering and teaching them how to manage their health themselves and promoting the adoption of healthy lifestyles. These concepts initiated the establishment of a Colombian health system that would facilitate the improvement of the population's living conditions.

In the 1990s, the country had a total health expenditure of approximately 6.2 per cent of the integrated gross domestic product (GDP) (table 1), comprising mainly out-of-pocket expenditure, which accounted for more than 3 percentage points and had a significant impact on poverty levels (see also table 2 for per capita expenditure on health).

Table 1 | Total health expenditure as a share of GDP.

	1993	1997	2000	2003
% of total expenditure on health/GDP	6.2	9.6	7.7	7.8
% of total public expenditure on health/GDP	1.4	3.4	3.2	3.1
% of social security expenditure on health/GDP	1.6	2.8	3.0	3.5
% of private expenditure on health/GDP	3.3	3.4	1.5	1.2
% of out-of-pocket expenditure /GDP	2.7	2.9	0.9	0.6

Source: Barón, G. (2007). Cuentas de salud de Colombia 1993-2003: El gasto nacional en salud y su financiamento, Social Protection Ministry and National Planning Department.

Table 2 | Per capita expenditure on health.

	1993	1997	2000	2003
In current pesos	87,979	290,805	316,894	392,571
In constant pesos (2000 = 100)	255,717	403,147	316,894	320,074
In current dollars	112	255	152	136
In constant dollars (2000 = 100)	102	317	152	111

Source: Ibid.

The Gini concentration index for the second half of the 1990s was 0.56 (table 3).

After 2002, with the establishment of this programme and a combination of

Table 3 | Poverty statistics.

Year	GDP Growth (%)	Unemployment Rate	Gini Concentration Index	Income-Poverty Poverty Line (PL) (%)	Poverty Unsatisfied Basic Needs UBN (%)	Internally Displaced Persons (IDPs) per Year
1995	5.4	8.7	0.569	55.0	n.a.	89,000
1996	2.0	11.9	0.544	53.8	n.a.	181,000
1997	3.2	12.1	0.555	54.2	26.9	257,000
1998	0.57	15.7	0.563	55.7	26.3	308,000
1999	-4.20	22.0	0.556	60.1	26.1	225,000
2000	1.56		0.566			

Source: Sarmiento Anzola, Libardo, *Exclusión y Desarrollo Societal. Nov. Ed. Desde Abajo. Datos de Desplazamiento Forzado (Data on Forced Displacement)*: Codees Informa No. 26, p. 3.

other social assistance measures aimed at improving levels of poverty and equity in resource distribution, 2008 recorded a Gini index of 0.59. The poverty that had affected 55 per cent of the total population in the late 1990s fell 7 points, leaving 53.7 per cent of the total population in conditions of poverty in 2002 and dropping to 46 per cent in 2008. The level of indigence also declined from 19.7 per cent in 2002 to 16.4 per cent in 2008 at the municipal level. Indigence remained virtually unchanged in all other territories in the country.

A comparison of these figures with the health expenditures in 1993 calculated with the same methodology shows that the most evident change is the substitution of private expenditure (especially out-of-pocket expenditure) for insurance-financed expenditure (social security contributions): private expenditure on health (as a share of GDP) decreased from 3.3 per cent in 1993 to 1.2 per cent in 2003 (3.4 per cent in 1997) and out-of-pocket expenditure dropped from 2.7 per cent of GDP in 1993 to 0.6 per cent in 2003 and 0.38 in 2009. From 2002 to 2010, the Government defined and institutionalized social protection strategies to protect initially the economically active population and, for some risks, the poor and vulnerable populations (table 4).

Table 4 | Financial consolidation carried out by the guilds involved in the health sector regarding the money available for this sector, 2009.

Type	Source	US$
Contributory scheme	Contributions to Solidarity and Guarantee Fund (FOSYGA)	4,654,694,725
	FOSYGA Promotion and Prevention (PyP) – Health-promoting entities (EPSs)	141,671,029
	FOSYGA surplus	391,656,363
	Co-payments and moderation fees	122,835,717
	Total	**5,310,857,834**
Subsidized scheme	FOSYGA	1,218,053,089
	General Participation System (SGP)	1,351,633,716
	Others – Resources of territorial entities	312,022,433
	Surplus	278,249,561
	Total	**3,159,958,799**
The uninsured (Vinculados)	General Participation System (SGP)	517,779,685
	Transfers to departments	173,444,576
	Resources of territorial entities	520,862,032
	Catastrophic Risks and Traffic Accidents (ECAT), Mandatory Insurance for Road Accidents (Seguro Obligatorio de Accidentes de Tránsito, SOAT), Support to State Social Enterprise (ESE)	52,219,751
	Total	**1,264,306,044**

Table 4 | Financial consolidation carried out by the guilds involved in the health sector regarding the money available for this sector, 2009 (cont'd.).

Type	Source	US$
Special scheme	**Total**	**1,029,758,424**
Occupational risks	**Assistance coverage (25 per cent of the total accrued premium)**	**143,730,979**
SOAT (Mandatory Insurance for Road Accidents)	Assistance coverage (95% of net premium contributions)	290,724,014
	Road Accident Insurance Fund (As a result of the reform, the health subsidy received by the poorest segment of the population increased from 6.2 per cent in 1992 to 49.2 per cent in 2003 for quintile 1 of the population (table 8) (Fondo de Seguro Obligatorio de Accidentes de Tránsito, FONSAT)	79,487,131
	SOAT additional premium	143,991,233
	Total	**514,202,378**
Public health	General Participation System (SGP)	210,023,085
	FOSYGA	117,240,898
	National budget	70,109,747
	Territorial resources	246,363,858
	Fund for road safety	11,923,200
	Total	**655,660,788**
Other private resources	Pre-paid medicines, prepaid ambulance services (SAP) and complementary care plans (PAC)	747,345,662
	Personal health and accident insurance	411,736,652
	Expenditure in medicines trade channels	1,380,625,443
	Out-of-pocket expenditure	836,699,940
	Total	**3,376,407,697**
Total		**15,454,882,943**

The Social Protection System

Colombia's social protection system was established in order to achieve two main goals:

- to protect the population from economic risks whether they be individual or not; and
- to assist the poor in overcoming this condition.

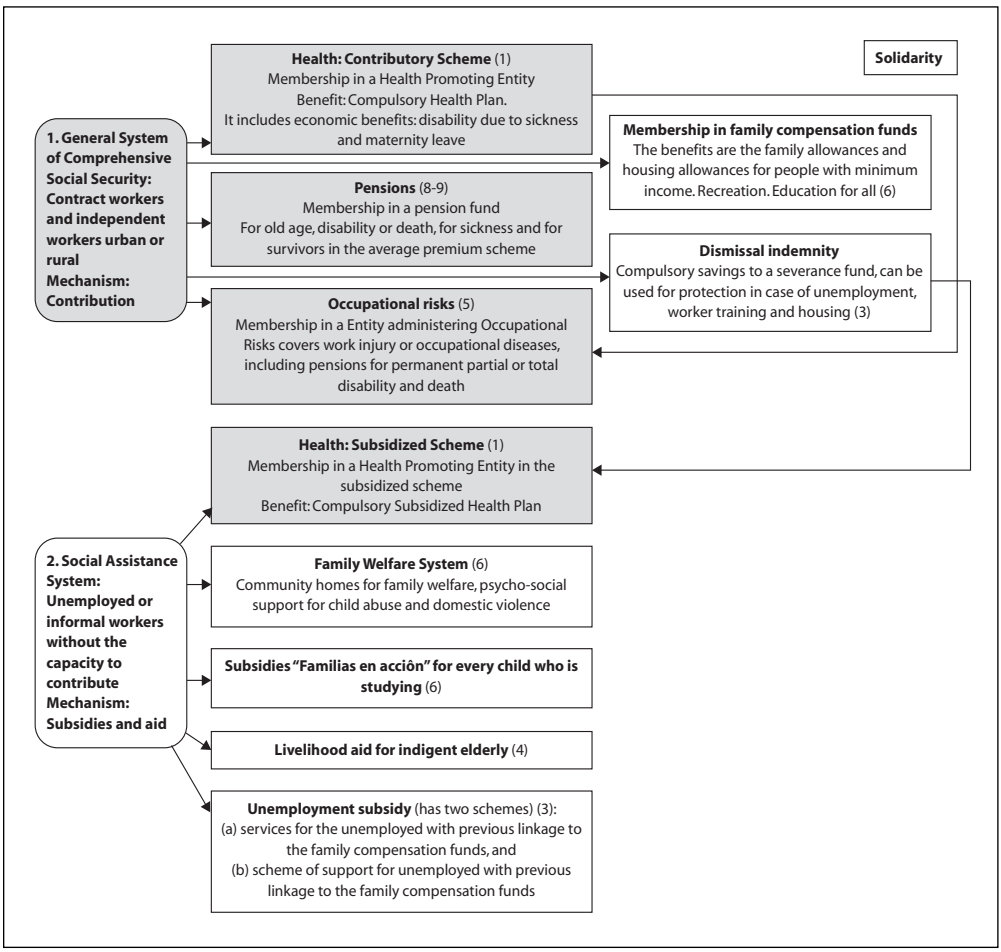
The General System of Comprehensive Social Security and all existing assistance to employees achieve the first goal. The second is reached by the establishment of the Social Assistance System, formed partly by the subsidized health scheme, the Red Juntos, Familias en acción, the National Vocational Training Service (Servicio

Nacional de Aprendizaje, SENA), and the programme of assistance to the elderly and the Colombian Family Welfare Institute (Instituto Colombiano de Bienestar Familiar, ICBF).

These various programmes or social assistance strategies cover the following risks: disease, nutrition, school dropout, capability to work, extreme poverty and old age. This list appears to cover all the life stages and all the conditions necessary for a person or family to be competent enough to enter the labour market, generate income and improve their quality of life in order to reach an optimal level of welfare. In reality, however, there is a lack of coordination of these efforts, a lack of comprehensiveness in the strategies defined to cover these risks, and a lack of intersectoral coordination, which reduces the efficiency of the social assistance system.

The social protection system has two components: the General System of

Figure 1 | Social Protection System of Colombia.



Comprehensive Social Security and the Social Assistance System. As a whole, the contents of each component respond to the call for new benefits contained in International Labour Organization (ILO) Social Security (Minimum Standard) Convention, 1952, as figure 1 shows, but they do not yet cover the entire population:

(1) medical care;
(2) monetary sickness benefit;
(3) unemployment benefits;
(4) old-age benefits;
(5) occupational risk and injury benefits;
(6) family benefits;
(7) maternity benefits;
(8) disability benefits; and
(9) survivor benefits.

A. The General System of Comprehensive Social Security

Established in 1993, the General System of Comprehensive Social Security aims to guarantee the inalienable rights of the individual and the community to a quality of life commensurate with human dignity by providing protection against various contingencies that arise throughout the life cycle (Article 1, Law 100 of 1993). It is based on the principles of (a) efficiency (the best use of resources), (b) universality (protection for all without discrimination), (c) integrality (coverage of all contingencies that affect health, economic capacity and general life conditions of the population), (d) solidarity (practice of mutual help between people, generations, economic sectors, regions and communities), (e) unity (articulation of policies, institutions, procedures and benefits in order to achieve the goals of social security), and (f) participation (the contribution of the community). The System includes four basic components: pensions, health, occupational risks and social assistance.

The General Pension System

General Features

The General Pension System seeks to ensure protection against the contingencies arising from old age, invalidity and death through the recognition of pensions and benefits determined by law, and progressively extends coverage to the segments of the population not yet covered (Article 10, Act 100 of 1993).

The System has both compulsory and voluntary membership. Mandatory members are all persons linked by an employment contract; civil servants; persons providing services directly under service provision contracts; and independent workers and public servants who entered Ecopetrol (a Colombian petroleum company) as of 29 January 2003. The volunteer members are the following: all natural persons residing in the country; Colombians living abroad who are not compulsory members and are not specifically excluded by law; and foreigners who, under an employment contract, can remain in the country and are not covered by any pension scheme in their country of origin and decide to contribute to a pension fund.

The Occupational Risks System

The Occupational Risks System covers occupational accidents and diseases (Atención en accidentes de trabajo y enfermedad professional, ATEP), including pensions for total permanent or partial permanent disability and death.

Membership in the System is compulsory for:

- dependent domestic or foreign workers, linked by contract or as public servants; and
- retirees or pensioners, except those receiving disability benefits, who rejoin the workforce as dependent workers, linked by contract or as public servants.

Employers are obliged to register their workers from the start of the employment relationship between them, employers being the only financiers in this system. This process produces an affiliation agreement for all employees with an entity administering occupational risks (administradora de riesgos profesionales, ARP). The ARP receives contributions from employers and covers the promotion, prevention and response to risks related to injury and occupational diseases (ATEP) as well as pension coverage for disability or death caused by or during work.

Additional Protection

Additional protection is provided through the following:

- **child benefit**: a social benefit payable in cash, in kind and in services to workers with medium and lower incomes in proportion to the number of dependents whom they support. Its main objective is to alleviate the financial burden of sustaining a family, which is considered a basic unit of society. Employers collaborate with the family compensation funds to collect the 4 per cent from the monthly salaries of their employees, which is part of the 9 per cent of revenues that companies must deliver as para-fiscal contributions. Employees with a monthly income that does not exceed four times the monthly minimum wage are entitled to the benefit, which is calculated by taking into account the income of the spouse or permanent partner and any other labour income;
- **dismissal indemnity**: savings to cover dismissal. This is a social benefit of a special nature, which generally corresponds to one month's salary for each year of service and proportionately for fractions of a year. The benefit is paid annually and is required by law to be entered into a severance fund. Each member is entitled to an individual account and the severance fund has a guaranteed minimum return. Under current legislation, partial withdrawals can be made for: (a) acquisition, improvement or to eliminate a mortgage on housing; (b) higher education in State-

recognized institutions for the member and his/her spouse or children; or (c) the purchase of State shares. Total withdrawals can be made only in cases of cancellation of the work contract.

The General System of Social Security in Health

Specific Goals

The specific goals of the General System of Social Security in Health (Sistema General de Seguridad Social en Salud, SGSSS) are as follows

- universal coverage for all Colombians;
- access to basic health services of a uniform quality for a fair contribution;
- efficiency: improve the health situation by reallocating resources towards preventive and primary care and into rural and poor areas; minimize losses in the provision of services;
- quality: ensure that the care provided to all meets the basic standards of quality and that the care given is of the highest possible quality given the available resources.

Central Policy Instruments

The General System of Social Security in Health aims to:

- enrol the population in health promotion entities and collect from those who must contribute;
- provide information to consumers about their rights, obligations and the quality of services in order for them to choose which health-promoting organization they want;
- establish reliable mechanisms for the monitoring and allocation of resources and ensure the financial stability of the system;
- specify the standard package of benefits to which each family is entitled – Mandatory Health Plan;
- establish the risk premium adjustment to pay these benefits – Risk Adjusted per capita Payment;
- define the appropriate payment systems to create incentives for efficiency and quality;
- develop institutions, processes and information to improve the quality of services;
- establish the legal basis for the system; and
- establish a dual policy for areas without sufficient market competition so as to improve efficiency and quality.

General Concepts and Principles

The General System of Social Security in Health is a solidarity system that aims to regulate the essential public health services and create conditions of access to all levels of care for all people.

In addition to the general principles enshrined in the Constitution, the concepts and principles guiding the System and the provision of public health services

are as follows: (a) equity, (b) obligation, (c) full protection, (d) free choice, (e) autonomy of institutions, (f) administrative decentralization, (g) social participation, (h) consultation, and (i) quality.

The System is managed by the Ministry of Social Protection, with the National Health Regulation Commission performing a regulatory role and the National Health Authority (SuperSalud) assuming a monitoring, inspection and control function.

The General System of Social Security in Health must ensure basic health benefits to the entire population present on the national territory in a gradual and permanent manner as well as economic benefits for people with employment contracts or independent workers who contribute to the System.

The System is based on insurance with the participation of public and private insurance entities, with State intervention, and is organized into two types of schemes: the contributory scheme and the subsidized scheme.

Administrative Agencies

The health-promoting entities (entidades promodoras de salud, EPS)[1] are responsible for recruiting and ensuring health care for the population, subject to the rules defined by the National Regulatory Commission and the Ministry of Social Protection.

The health-care providers (instituciones prestadoras de servicios de salud) are private and mixed public institutions attached to the Ministry of Social Protection, such as the National Institutes of Health and the National Cancer Institute.

The Solidarity and Guarantee Fund (FOSYGA) is a national fund with a legal personality established to raise solidarity funds for the General System of Social Security in Health. It consists of four subaccounts:

- the account for the distribution and compensation of resources of the contributory scheme;
- the solidarity account to cofinance the subsidized scheme;
- the account to cover catastrophic risks and traffic accidents; and
- the account for promotion and prevention for members of the contributory scheme.

Organization and Financing

1. The Contributory Health Scheme

The Contributory Health Scheme is comprised of people with the capacity to contribute to social security. Members of this system are entitled to a basic health-care plan (which conforms to the baseline for the entire population of Colombia) as well as economic benefits for incapacity and maternity leave. The

[1] To end the monopoly of the Social Security Institute on the administration of the obligatory health-care insurance, private enterprises (profit or non profit), cooperative enterprises and other public or mixed enterprises were allowed to compete. All these enterprises were called "health-promoting entities".

basic plan of this Scheme covers the interventions described in the mandatory health-care plan (more information is available at www.pos.gov.co). These benefits are guaranteed by the health-promoting entity, whose main functions are to manage the membership of people who freely choose to join the Scheme which is mandatory for employees, to collect the relevant contributions, to organize the delivery network to ensure the smooth operation of the basic health-care plan, to be an advocate for users and to provide mechanisms for user participation in the General System of Social Security in Health. This Scheme has national coverage, which means that enjoyment of the benefit is not tied to permanent residence in a particular municipality or geographic region.

Membership in the Scheme is by family, which means that the contribution of the member also benefits his/her spouse or long-term partner, children under 18 years of age, children over 18 years and up to 25 years who are financially dependent on their parents for their studies, and totally and permanently disabled persons.

Funding

The Scheme is financed by contributions from members, with the contribution base established at 12.5 per cent of the salary or monthly declared income, of which 8.5 per cent is provided by the employer and 4 per cent by the employee. Independent workers must pay 100 per cent of the contribution from the income reported at the time that they become members. In no event will the contribution base be less than the monthly minimum wage legally in force. The monthly contribution to the subsidized health scheme for pensioners and self-employed workers is set at 12 per cent of the income of the respective monthly pension; when accrued over 25 monthly legal minimum wages, the contribution base is limited to these percentages.

The contributions are paid to health-promoting entities, which are then responsible for transferring the funds to the Solidarity and Guarantee Fund (FOSYGA). In turn, FOSYGA remits a capitation payment unit (unidad de pago por capitación, UPC) back to the health-promoting entities to cover the premium of the insured. The capitation payment unit initially adjusted risk based on three variables: age, gender and geographic location.

The resources collected by the health-promoting entities are included in the Solidarity and Guarantee Fund (FOSYGA) compensation subaccount by means of the compensation mechanism, with the purpose of recognizing the capitation payment unit for members and their beneficiaries according to their age and gender. This subaccount covers 1.5 per cent of the financing for the Subsidized Health Scheme.

2. The Subsidized Health Scheme

(a) Origins of the Programme

Before the 1993 reform in the 1980s, the coverage of the General System of Social Security in Health did not exceed 20 per

cent of the Colombian population and was only given to government employees affiliated with the Institute of Social Security (Instituto de Seguros Sociales, ISS), the local department provident funds, teachers and the military. The major problem with the System lay in ensuring access to health services for the poor and vulnerable segments of the population, given significant regional differences and the fact that there was no mutual help among members and much less of it among the poor.

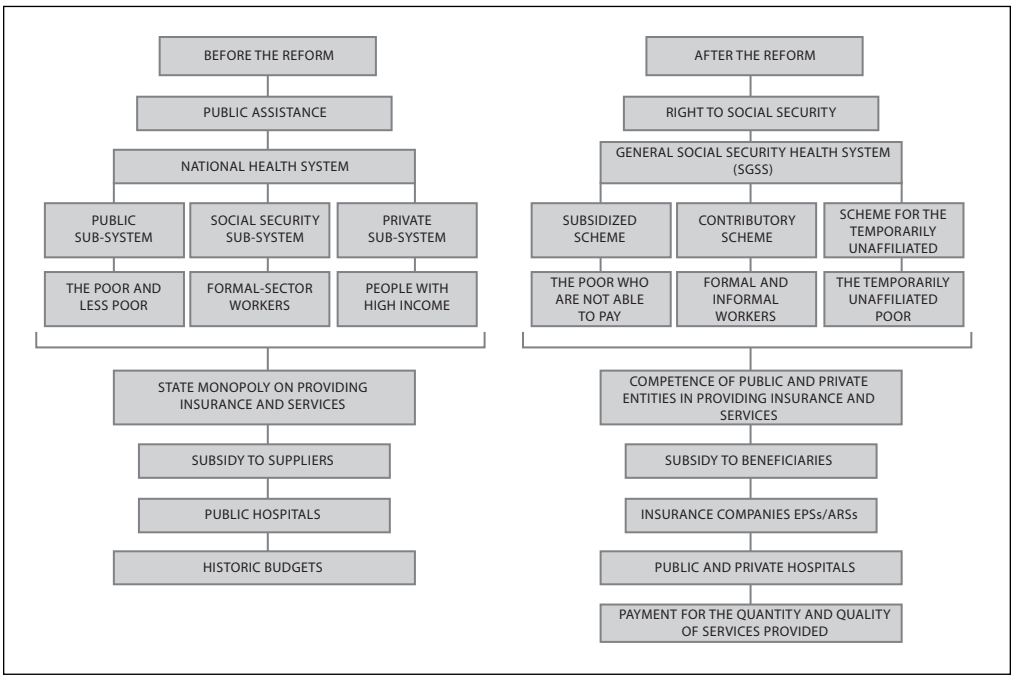
As stated in a March 1996 Harvard report,[xi] there was an inefficient institutional organization, which produced highly inadequate results considering the sector spending and which led to growing user dissatisfaction.

Before the reform, those not incorporated into the General System of Social

Legal Bases of the Subsidized Health Scheme

1. Constitution of Colombia, Articles 1 and 2, Title II and Chapter II.
2. Act 100 of 1993, which established the comprehensive social security system and enacted other provisions.
3. Act 715 of 2001, which sets out organic regulations regarding resources and duties in accordance with Articles 151, 288, 356 and 357 (Legislative Act 01 of 2001) of the Political Constitution and which enacts other provisions for organizing the provision of education and health services, among others.
4. Act 1122 of 2007, which makes some changes to the General System of Social Security in Health and enacts other provisions.
5. Decree 1011 of 2006, which establishes the Compulsory System of Quality Assurance for Health Care of the General System of Social Security in Health.
6. Decree 050, whereby measures are taken to optimize the cash flow of resources from the subsidized scheme of the General System of Social Security in Health and which enacts other provisions.
7. Resolution 415 of 2009 through which the shape and operating conditions of the subsidized scheme of the General System of Social Security in Health are defined and other provisions are enacted.
8. Decree 1965 of 2010 – New Resource Flow.
9. Order 2086 of 2010 – Accelerated Procedure for a Drugs Registry.
10. Resolution 2114 of 2010 – Transfer Procedures.
11. Resolution 1805 of 2010 – Amends master accounts.
12. Ministry of Finance External Circular 017 of 2010 – Contract Settlement.
13. Digital Signature Circular of 2010.
14. Decree 1964 of 2010 on Recruitment.

Figure 2 | Key differences between the national health system and the Social Security Reform of 1993.



Note: EPSs = Health-promoting entities; ARSs = Subsidized Scheme Administrators.

Security in Health could access health services through health centres and public hospitals under a "charitable" scheme, which effectively meant that better health care was available only to those who could afford to pay for it out of their own pockets. The limit to the amount of care provided was set by the public provider and varied between regions and between institutions. There was neither an integrated, coordinated audit system nor a reference system to adequately respond to existing health problems.

The leading causes of death or disease were those typical of developing countries and associated with deficiencies in basic sanitation and public services infrastructure. However, in addition to these, chronic and degenerative diseases began to appear – primarily those related to lifestyle and increased life expectancy such as diabetes, hypertension, cancer and chronic kidney disease. This reality required a shift in health-care approach, and specifically a greater involvement of society and a more preventive than curative approach. To achieve this goal, the Government of Colombia drew on the international trends of the 1990s, which thus affected the design and implementation of policy in Colombia.

(b) Description

Despite being part of the Social Assistance System, the Subsidized Health Scheme is considered a component of the General

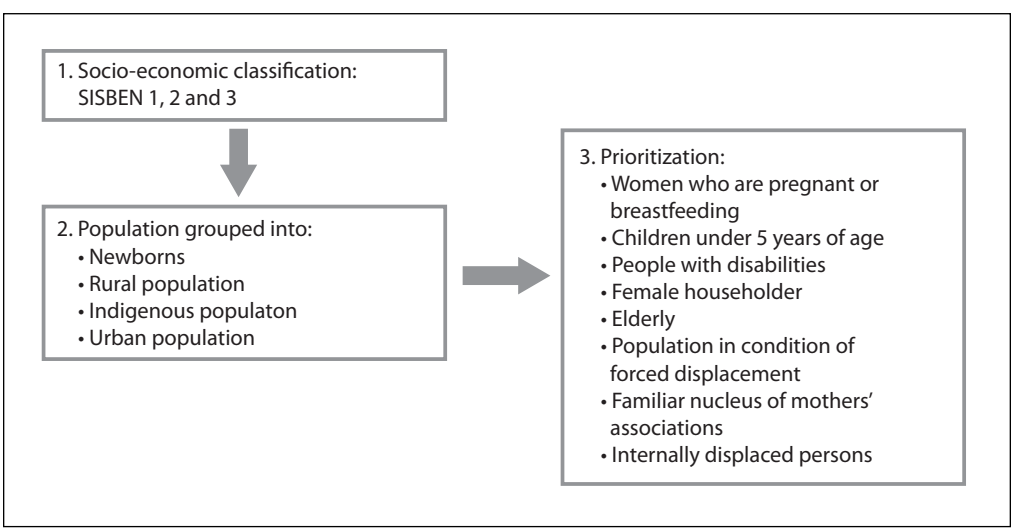
System of Social Security in Health because of its financing system. The Scheme was designed for the poor and the indigent. This target population must apply to their municipality and undergo a means test. If they are under a certain level of income, they qualify and are authorized to become affiliated. The number of poor affiliates authorized in each municipality depends on the resources available.

The proxy means test designed to identify the most vulnerable members of a municipality is organized through a questionnaire that is called the National System for Identifying and Selecting Beneficiaries for Social Programmes (Sistema nacional de identificación de beneficiarios de programas sociales, SISBEN). The SISBEN index is calculated at the household level and has six score levels, 1 being the poorest. People scoring at levels 1, 2 and 3 qualify for the Subsidized Health Scheme.

Potential beneficiaries are selected from the list of prioritized individuals. The number of beneficiaries respects the established coverage goals and varies depending on the resources available for this purpose in each municipality. Ideally, family membership of prioritized populations is given precedence. However, this is not a necessary condition for membership. Thus individual membership may be granted if there are resource constraints and in particular if the case involves children under five years of age.

There also exist some special protection population groups, which are identified not through the SISBEN survey but through the census list prepared by the competent authority in each case. These groups are: (a) abandoned children; (b) indigent population; (c) population in conditions of forced displacement; (d) indigenous communities; (e) internally displaced persons; (f) abandoned and low-income elderly people; and (g) rural migrant populations.

Figure 3 | Beneficiary selection.



(c) Funding

Multiple funding sources and multiple organizations or agencies have been involved in order to achieve coverage of the entire population and ensure the provision of services originally chosen from the Basic Plan, which is offered to persons affiliated with the contributory Scheme. The three funding mechanisms for the Subsidized Health Scheme are national transfers from general taxation, solidarity contributions from the Contributory Scheme, and district and municipal efforts:

- the State through contributions from the national budget;
- 1.5 per cent of the contributions collected by the Contributory Scheme transferred by the Solidarity and Guarantee Fund (FOSYGA);
- the family compensation funds with 5 per cent or 10 per cent of child benefit receipts;
- territorial entities (departments, municipalities and districts) with resources that the nation transfers by means of the General Participation System (SGP) and resources from its own territorial efforts, which are the taxes taken from gambling and transfers for the Territorial Enterprise for Health (Empresa Territorial para la Salud, ETESA);

Table 5 | Coverage of the General System of Social Security in Health (SGSSS), 2009-2010.

	Value	% of Population
Country population*	**45,508,205**	**100%**
Contributory scheme members**	18,062,855	39.7
Employees, under contract, members of the subsidized scheme***	23,597,291	51.9
Members of Unique Affiliates Database (BDUA) subsidized scheme	20,772,333	45.6
Special schemes****	2,222,126	4.9
Total membership	**41,057,314**	**90.2**
Total funded	**43,882,272**	**96.4**
Unemployed population in the subsidized scheme	2,824,958	6.2%
Country population without funding	1,625,933	3.6%

**Source:* National Administrative Department of Statistics (DANE), *Population Projection* 2010.
***Source:* General Directorate of Policy Planning and Analysis (Dirección General de Planeación y Análisis de Política), until December 2009.
****Until 28 May 2010.*
*****Source:* General Directorate of Policy Planning and Analysis , until June 2010.

- departments and the capital district, with the transfer of resources to the departments;
- 15 per cent of the additional resources received by municipalities, districts and departments by way of income tax on the production of oil companies in the Cupiagua and Cusiana area; and
- financial performance of the resources described above.

Today, this combination of funding sources, the use of solidarity between those who have the ability to pay and those who do not, the contribution of general, departmental and municipal taxes and out-of-pocket expenditure has led to the collecting of US$3,159,958,799 in funds to meet the needs of the poorest and the most vulnerable populations. This has allowed the consolidation of an almost universal coverage, with more than 23 million poor and vulnerable people now having guaranteed access to health services.

(d) Membership

The membership process always requires: (a) the identification and prioritization of the population and the existence of resources to ensure the sustainability of membership; (b) the authorization of the National Health Authority (SuperSalud) for the health-promoting entities to operate the Subsidized Insurance Scheme in the region to which the municipality belongs, meeting the eligibility and/or permanence requirements; and (c) the registration and authorization for the health-promoting entities to operate the Subsidized Scheme, given by the municipal health administration.

Once the preconditions are met, districts and municipalities must organize a transparent call for tenders, where, previously, potential beneficiaries of the Subsidized Scheme were called, in the order specified and in numbers equal to the numbers of the funded quotas. At this public event, the health-promoting entities are called on to participate on equal terms in order to be chosen by the exercise of free choice to which individuals are entitled. The membership process lasts for six to seven months from the time that the lists of potential recipients are published (90-120 days before) and starts the public event. Individuals select their preferred health-promoting entity before a municipal public official, and this will is expressed on a single membership form, which the member takes to a point of care provided by the entity selected in order be enrolled and given a membership card.

The list of members of each health-promoting entity is consolidated with a defined structure entitled the Unique Affiliates Database (BDUA). This list is the central tool for the management and verification of rights and payments of the capitation payment unit for each participant entitled to insurance, as well as for system monitoring and statistics. This enables a monthly settlement, which in turn facilitates the liquidation of contracts at the end of each of their terms.

Membership in the Subsidized Scheme is municipal and is effective until a beneficiary changes municipalities. A member cannot retain membership beyond the contractual term; therefore, when people change their place of residence, they must report this change, exit the Scheme after completion of their contract, and then reapply as a potential beneficiary in the municipality that receives them.

There is also the possibility that Subsidized Scheme members change their income status or work activity at some time during the contract period, allowing them to contribute to the contributory regime. Therefore, the databases of the two Schemes need to be cross-checked every month in order to exclude temporarily or permanently all persons who meet this requirement.

These situations do not allow either adequate national portability, mobility within the territory with guaranteed access to health services, or adequate and timely mobility between Schemes – situations that are part of the great challenges faced by a system already accepted by the new Government. As a result of a recently established reform, the Unique Affiliates Database (BDUA) is managed by the Solidarity and Guarantee Fund (FOSYGA) and populated by the health-promoting entities through the presentation of monthly bulletins that report on membership retraction because of municipality change and on the transfer of health-promoting entities, among others.

Insurance Contract

Once the process takes effect, an insurance contract between the local entities and the health-promoting entity selected by the members is drawn up. This contract specifies the number of members that it covers, the value of the capitation payment unit (defined by the Regulatory Health Commission (Comisión de Regulación en Salud, CRES) for the corresponding period), the resources that finance the contract for each of the sources of funding, the database of members with the defined characteristics and the conditions set for this operation.

This recently modified contract has three features: it is electronic, standard within each municipality and multilateral. The real challenge, however, is standardizing the procedure with the Contributory Scheme in which there is no contract but rather a membership form between the health-promoting entity and the user and where the health-promoting entities support their members through the membership database and forms.

The local entity is responsible for monitoring and following up on the completion of the contract by the health-promoting entity operating within its territory. In order to achieve this goal, the local entity must have official supervision periodically and, as a condition for the periodic transfer of resources, must monitor compliance with agreed contractual obligations.

Another set of monitoring mecha-

nisms is the set of attention and user information mechanisms through which users can express dissatisfaction or make suggestions to ensure that the access to health services meets their needs.

(e) Health Insurance Management

Once the insurance contract is signed, the health-promoting entities guarantee access to the health services provided in the Mandatory Subsidized Health Plan (Plan Obligatorio de Salud Subsidiado, POSS), with the quality conditions agreed with the local authorities and accepted by the Quality Assurance System (Sistema Obligatorio de Garantía de la Calidad, SOGC).

The Quality Assurance System selects and hires the network of health-care providers who meet the enabling conditions defined by standards and negotiates the purchase prices of services and mechanisms of monitoring and follow-up, auditing, recognition and payment of services, and settlement. A contract sets out the agreed conditions between the health-promoting entities and the health-care providers (instituciones prestadoras de servicios de salud, IPSs) and provides, in the annex, the databases of members covered by said contract.

The health-promoting entity can use only 8 per cent of revenues from the capitation payment unit for administrative expenses; the 92 per cent left is to ensure access to health services and to guarantee the health of members. Of this 92 per cent, 60 per cent must be contracted and executed with public institutions from the region.

Additionally, the health-promoting entities guarantee the reference and counter-reference system that enables users to access service at all levels of care. They also ensure participation in health care through partnerships and user associations to guarantee that users' voices are heard and appropriate adjustments are made to improve health care overall.

The health-promoting entities undertake a diagnosis of both the demography and the health risks of the populations that they cover to offer a wide range of covered risks. They then develop a health-care plan under the Mandatory Subsidized Health Plan and define the model of care that ensures access to initiatives of health promotion, prevention and early detection, health recovery and rehabilitation.

The health-promoting entities are also responsible for the regular monitoring of health-care indicators and health outcomes, as required by the Quality Assurance System and those contractually agreed, and for reporting to the authorities any deficiencies and improvement plans agreed on with the health-care providers in the monitoring of contractual obligations. Table 6 shows the results of the measurement of quality indicators from 2007 to 2009.

Table 6 | Quality indicators of the health-promoting entities, 2007-2009.

Indicator	2007-1	2007-2	2008-1	2008-2	2009-1	2009-2
Timely referral to a general practitioner (for general check-ups) (in days)	2.8	3.1	2.6	2.3	2.8	2.6
Timely referral to a medical specialist (in days)	6.6	7.3	7.5	7.4	7.3	8.8
Number of *tutelas* (court order/protection writ for the satisfaction of fundamental rights) for not receiving a service from POS* or POSS*	8,960	66,645	307,690	7,358	4,034	4,262
Timely delivery of medications, POS (%)	85.5	86.8	87.6	93.5	90.4	90.2
Timely action in carrying out planned surgery (in days)	12.8	13.9	15.4	15.6	14.2	11.8
Timely referral to general dentistry (in days)	3.7	4	3.9	3.4	3.8	4
Timely referral for medical imaging (in days)	4.1	4.2	4.1	4	3.6	3.1
Timely referral to an EPS, ARS, CCF, EA, MP (in hours)	3.7	2.2	2.3	2.6	4.5	5
Proportion of appropriate vaccination schemes in children under one year of age (%)	54	45.5	66.5	51.8	50	64
Timely detection of cervical cancer (%)	48.1	44.1	58.8	59.4	69.5	59.8
Mortality rate from pneumonia in elderly over 65 years of age (rate x 1,000)	13	10.5	14.6	7.2	8.7	12.2
Mortality rate from pneumonia in children under 5 years of age (rate x 1,000)	4.4	2.1	3.5	2.8	2.6	3
Maternal mortality rate (x 1,000)	51.9	40.6	47.1	41.3	53.2	44.6
Overall satisfaction rate (%)	71.2	78.7	81.5	81.8	87.1	91.1
Proportion of complaints resolved within 15 days (%)	83	84.3	74.2	73.5	83	80.4
Rate of transfers from EPS*, ARS*, CCF*, EA*, MP* (%)	0.8	0.4	0.6	1	1.2	0.8

*ARS: Subsidized Scheme Administrator (Administradora del regimen subsidiado)
*CCF: Family Compensation Fund (Caja de Compensación Familiar)
*EA: Administering entity (Empresa administradora)
*EPS: Health-promoting entity (Entitade promodora de salud)
*MP: Prepaid medicine (Medicina pre-pagada)
* POS: Mandatory Health Plan, for the employed (Plan Obligatorio de Salud)
* POSS: Mandatory Subsidized Health Plan (Plan Obligatorio de Salud Subsidiado)

(f) Benefit Plan

The Mandatory Subsidized Health Plan (POSS) corresponds to a selection of activities of the Mandatory Health Plan (Plan Obligatorio de Salud, POS, which is for the employed) defined for the Contributory Scheme. However, it lacks a comprehensive range of services and

benefits and therefore needs to be updated and approved.[2]

The contents of the Mandatory Subsidized Health Plan are as follows:

(a) comprehensive care for women during pregnancy, birth and the postpartum period for less than one year;

(b) issues of a low level of complexity: health promotion and disease prevention as well as health recovery measures that are covered by general practitioners, other non-specialized health professionals and support staff and/or paramedics, and radiology services and low-complexity clinical laboratory work;

(c) concerns of medium complexity: ophthalmology and optometry consultations for people below the age of 20 and over 60, strabismus care for children under five years of age, cataract treatment, orthopedics and trauma treatment, including magnetic resonance imaging (MRIs) and surgeries (appendectomy, hysterectomy, cholecystectomy, inguinal hernia, crural herniorrhaphy and umbilical herniorrhaphy, male and female surgical sterilization);

(d) highly complex cases: heart diseases, thoracic and abdominal aorta, vena cava, pulmonary and renal vessels, surgical care for central nervous system disorders, acute or chronic renal failure, care for burn victims, HIV and AIDS patient care, cancer patient care, partial or total hip or knee joint replacement, and intensive care.

The greatest challenge facing the country in terms of health content is to ensure updated and equal benefit plans for all people regardless of their employment situation. In light of this, the Regulatory Health Commission (Comisión de Regulación en Salud, CRES) is developing updated technical guidelines for the different diseases to be covered, and the new government has defined strategies to reach the financing goals that will allow the standardization of the benefit plans for all Colombians by 2014 at the latest.

(g) Capitation Payment

The capitation payment unit (unidad de pago por capitación, UPC) is the annual value of the health subsidy, which is set by the Regulatory Health Commission. It is the same amount for all members of the Subsidized Scheme and it is transferred periodically from the various funding sources to a master account to which municipalities, districts and departments must conform. These funding sources are combined into a common fund, with the resources from the funding coming from municipalities, districts and departments – available in the master account – and

[2] Law 100 mandates two standard health packages: the Mandatory Health Plan (Plan Obligatorio de Salud, POS) for the contributing population and the Mandatory Subsidized Health Plan (Plan Obligatorio de Salud Subsidiado, POSS) for the subsidized population. The POSS entails a less comprehensive package than the POS (initially); however, both include health promotion and basic preventive care while the contributory scheme includes curative and emergency services.

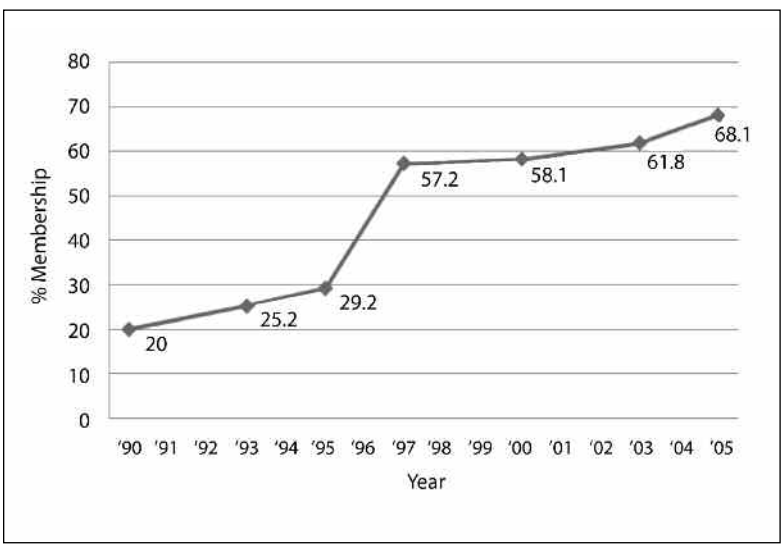
they must be turned over to the health-promoting entities two months in advance. This flow of resources has led to delays and to the loss of resources. Hence, another challenge for the new government is to shift resources directly to the health-promoting entities, enabling these resources to "follow" members in case they move or in case their socio-economic status changes.

In geographically remote areas and in big cities and nearby urban centres, in which the population requires a greater and more complex range of health-care services and has a higher concentration of diseases that are expensive to treat, the capitation payment unit is adjusted to take these risks into account.

(h) Impact of the Subsidized Scheme

Access

The study of the progress and challenges of achieving health equity in Colombia demonstrated that, as a result of 1993 reform, access to the General System of Social Security in Health increased from 20 per cent in 1990 to 68.1 per cent in 2005 (graph 1).



Graph 1 | Membership in the General System of Social Security in Health, 1990-2005.

There have been membership increases in all dimensions: in area of residence, region, gender or level of wealth, with progress being greatest in the poorest groups (graph 2).

Coverage data as of March 2010 (table 7) shows that 89.8 per cent of the Colombian population has effective health coverage. In addition, there are a number of funded quotas for membership to the Subsidized Scheme, which, once assigned, will raise the health coverage to 95.1 per cent of the population.

Graph 2 | Membership in the General System of Social Security in Health, by wealth quintile, 1995-2005.

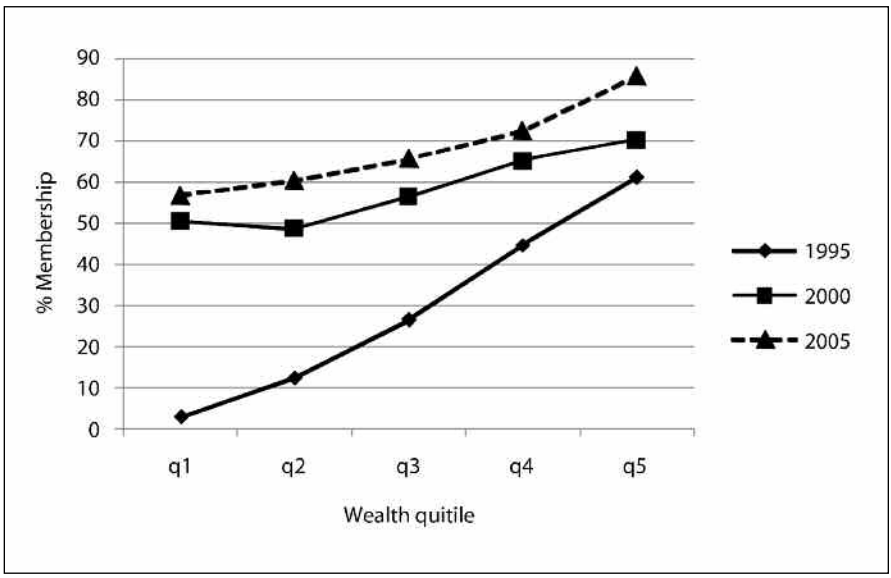


Table 7 | Population covered by the General System of Social Security in Health, 2009.

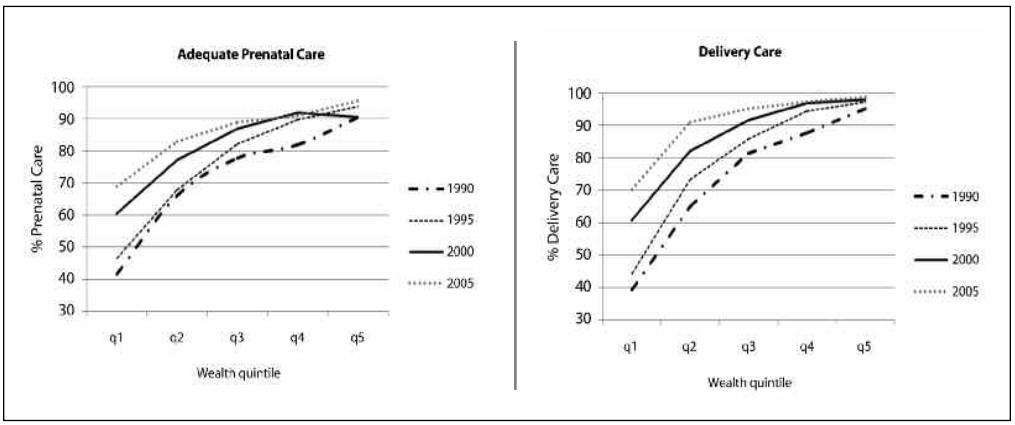
	Value	%
Country population*	**45,399,789**	**100.0**
Contributory scheme members**	17,687,031	39.0
Subsidized scheme members under contract	23,300,617	
of which BUAD subsidized scheme members	20,888,536	46.0
Special schemes***	2,192,197	4.8
Total members	**40,767,764**	**89.8**
Total financed	**43,179,845**	**95.1**
Unemployed population in the subsidized scheme	2,412,081	
Country population without financing	2,219,944	4.9

* Source: National Administrative Department of Statistics (DANE), Population projection, until March 24.
** Source: General Directorate of Planning and Policy Analysis, Average of members by compensation period.
***Source: Ministry of Social Protection, until December 2009.

Use of the Services: Professional Care

The Subsidized Scheme has facilitated the use of health services, especially among the poorest population and the rural population, which use 50 per cent more health services than the uninsured. Although inequities in the use of services have declined, there were still cases of inequity in 2005 –primarily cases relating to the level of wealth (graph 3). Progress in terms of equity is related to the health system reform, and in particular to the Subsidized Scheme, since membership in the Scheme facilitates the use of health services by the poor.

Graph 3 | Adequate prenatal care and delivery care, by wealth quintile, 1995-2005.



Equity

As a result of the reform, the health subsidy received by the poorest segment of the population increased from 6.2 per cent in 1992 to 49.2 per cent in 2003 for quintile 1 of the population (table 8).

Table 8 | Transfer as a proportion of income.

	1992 (Molina, Giedion, 1995)[xii]	2003 (This Study)			
Quintile	Total Population	Total Population	Members Contributory Scheme	Members Subsidized Scheme	Unaffiliated Population
1	6.2	49.2	20.9	120.1	45.4
2	3.7	16.2	7.5	40.4	13.4
3	1.8	8.7	2.7	24.4	7.0
4	1.0	3.7	-1.3	15.3	4.1
5	0.1	-2.9	-4.8	7.1	1.3
Average	1.2	1.9	-1.2	18.2	4.7

In 2003, the transfer of resources to the poorest segment of the population through the allocation of public resources and the solidarity of the overall system represented a 50 per cent increase in the income of these families.

Effects of the Scheme on Poverty

The net transfers made by the General System of Social Security in Health to provide health services have reduced poverty by more than two percentage points and inequality by more than three points. These results improve the level of equity since benefits are higher for the poorest segment of the population. The three measures of poverty (incidence, intensity and severity) decreased as a result of the transfers made by the System, with greater benefits for the poorest segment of the population.

(i) Degree of Coordination with Other Programmes

All programmes or systems seek to prevent, mitigate and overcome social and occupational risks, which as a whole are responsible for the greater or lesser degree of vulnerability of families and individuals and provide protection against the loss of employment, health, work capacity, a breadwinner, etc. There are direct interactions with the Contributory Scheme for the mobility of members between the two Schemes and the 1.5 per cent solidarity contribution. It is therefore essential to safeguard the existence of social protection programmes for all people, even those who have the ability to pay, to ensure that they do not fall into poverty as they grow older and/or if their social or economic conditions deteriorate.

For the poor and vulnerable segments of the population, it is necessary to ensure that social assistance programmes (see the next section) are coordinated according to the health outcomes of the population and that they complement specific health measures in order to effectively influence health determinants and achieve better results in poverty reduction. Health measures should be the gateway to a social protection system guaranteed by the social assistance component.

(j) Situation of Beneficiaries after Passage through the Programme

The main contribution of the Subsidized Scheme is the reduction of poverty of its members through assuming out-of-pocket expenditures and thus enabling members to cover other necessary expenses, improve their socio-economic status and be eligible to enter the labour market.

When there are articulation and coordination between social assistance programmes, there are a greater increase in work capacity and a sharper decline in poverty levels as a result of the introduction of health measures.

Similarly, ensuring mobility between schemes, continuing to guarantee social protection benefits to workers, and progressing in the extension of income protection and better health benefits for the poor will ensure that beneficiaries progress

towards the improved living conditions that are vital for the entire population.

B. The Social Assistance System

The Social Assistance System has various mechanisms to provide subsidies to those who do not have the capacity to contribute and help them to lead a dignified life, especially during the critical life stages:

- **work training.** The system provides, through the National Training Service *(Servicio Nacional de Aprendizaje, SENA)*, technical training to employees or the underemployed to enable them to enter the labour market. It also conducts business, community and technology development activities. The National Training Service is funded with the 2 per cent of revenues that constitute the fiscal contributions made by firms;
- **strengthening the family and protection of minors.** The Family Welfare System (Servicio Público de Bienestar Familiar, SPBF) is defined as a public service under the responsibility of the State and it is subject to a legal regime established by law.

  The Family Welfare System strengthens family ties, enables families to access ongoing training and education on the rights and responsibilities of its members, and provides children and young people with support on an ongoing and permanent basis for comprehensive development with the help of the family and the community.

  The Family Welfare System gives priority to poor urban areas, rural areas, the most vulnerable, and the high risk of neglect, malnutrition, physical danger and/or psychological risks in children and young people;
- **"Familias En Acción" Programme.** This is an initiative of the national government to deliver nutrition or education subsidies to children from the poorest families, displaced families or families from indigenous communities. The Programme involves providing monetary support directly to the beneficiary mother, subject to commitments by the family in terms of education (i.e., ensuring school attendance) and health (i.e., guaranteeing that children will be taken to the scheduled medical check-ups for physical growth and development);
- **protection scheme for the unemployed.** Created as a mechanism for intervention in the critical times of economic cycles, this scheme consists of a temporary subsidy administered by the Ministry of Social Protection. It is distributed only when specified by the Government and after approval by the National Economic and Social Policy

Council. The financial resources of the scheme come from: (a) contributions allocated from the national budget; (b) resources given by local authorities for social protection plans, programmes and projects; (c) donations received; (d) financial returns generated by investing the resources mentioned above; and (e) financial yields on their excess liquidity and, in general, all other funds received in any capacity. These resources are deposited into the Employment and Unemployment Subsidy Fund, which is considered a special account under the responsibility of the Ministry of Labour and Social Security.

The programme offers services for unemployed workers who have previous links to the family compensation funds, which entitle them and their dependents or beneficiaries to the same access to education, training, and recreation and social tourism programmes (supported by the family compensation funds) as they had had before they left the scheme. This is valid for one full year from the time that workers are declared unemployed by the last fund with which they were affiliated.

In addition, workers who have contributed to the family compensation funds for 25 years or more and are pensioners are entitled to training and recreation and social tourism programmes at the lowest rates of each family compensation fund. There are also two schemes for the unemployed, one of which is the support system for the unemployed with previous links to the family compensation funds. Under this scheme, the heads of households who find themselves unemployed after having been in the system of family compensation funds for no less than one of the three years preceding the request for support, are entitled – covered by the resources of the fund for employment promotion and unemployment protection – to the following benefits on a one-time basis until the resources are exhausted:

(a) a subsidy equivalent to the amount of one and a half months of the statutory minimum wage, which is divided and paid out in six equal monthly instalments. These may be made effective through contributions to the health system and/or food stamps and/or education, depending on which one the beneficiary chooses. For this purpose, the funds reserve a maximum of 30 per cent of the resources that they manage for the promotion of employment and unemployment protection; and

(b) training for the job placement process. For this purpose, the funds reserve a maximum of 25 per cent of the resources that they manage for the promotion of employment and unemployment protection;

- **support system for the unemployed without previous links to family compensation funds.** Through 5 per cent of the fund for the promotion of employment and unemployment protection, the family compensation funds have established a scheme of support and promotion of employment for heads of households without previous links to the family compensation funds. This takes the form of a subsidy equivalent to a monthly statutory minimum wage, paid out in six equal monthly instalments, which may be made effective through contributions to the health system and/or food stamps and/or education, depending on which one the beneficiary chooses. Priority is given to artists, writers and athletes who affiliated with the corresponding associations or who can prove that they hold one of these occupations. To access this benefit, one must prove that he or she lacks the capacity to pay in accordance with the terms and conditions set out in the regulations.

  Out of the parafiscal contributions intended for the National Training Service, 25 per cent of the resources that the Service receives from contributions is reserved for the training of the unemployed population, as set out in the terms and conditions determined by the Government for the management of these resources as well as the content of these programmes.

  The largest problem with these so-called "other protections" destined to provide assistance to poor and vulnerable populations is their lack of internal coordination, which makes it difficult for beneficiaries to access these protection measures.

Future Improvements and Challenges

The challenges facing the General System of Social Security in Health (SGSSS) are to:

- ensure its sustainability by finding mechanisms to shield resources from the instability of the economy. Currently, each of the capitation payment units is supported by three sources that must be sustainable in the long run: solidarity resources from the contributing population; the General Participation System from national taxes; and the funding from local and provincial taxes. When assumptions of employment growth are not satisfied, the second-largest source of financing, the Solidarity and Guarantee Fund (FOSYGA), is threatened;
- guarantee the portability of the subsidized insurance scheme in order for people to be able to exercise their right to protection regardless of their movement between areas;
- implement automatic mechanisms

that enable people to switch from one type of membership to another should they lose or gain the ability to contribute to the social security system; this requires that the modus operandi of the schemes be very similar; and

- recognize and publicly disseminate results of the progress and achievements of the System since it is necessary to build and strengthen it through a solid health communication strategy designed to improve people's sense of belonging to the System and enhance communication with users about decision-making processes.

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[i] World Bank, *World Development Indicators* 2008.

[ii] WHO, Global Health Observatory, 2008.

[iii] WHO, UNICEF, UNFPA and World Bank, Global Health Observatory, 2005.

[iv] World Bank, *World Development Indicators* 2008 and *Global Development Finance* 2008.

[v] Intergremial Commission, 2009.

[vi] National Administrative Department of Statistics (*Departamento Administrativo Nacional de Estadística*, DANE), 2010.

[vii] DANE, 2009.

[viii] National Planning Department, 2009.

[ix] Ibid.

[x] UNDP, *Human Development Report* 2009.

[xi] Colombia Health Sector Reform Project, *Report on Colombia Health Sector Reform and Proposed Master Implementation Plan*, Harvard School of Public Health, Boston, 1996.

[xii] Molina, C. G., Giedion, U., Rueda, M. C. and Alviar, M., "El Gasto Público en Salud y Distribución de Subsidios en Colombia", *Estudio de Incidencia del Gasto Público Social*, FEDESARROLLO, Departamento Nacional de Planeación, Santafé de Bogotá, 1994.