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C. Marcela Vélez

The Health Care System in Colombia

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1. Country overview (latest data available)

Source: https://ontheworldmap.com/colombia/ (Accessed November 4, 2024)

- Sub-Region: South America
- Capital: Bogotá
- Official Language: Spanish
- Population size: 52,2155,503[1] (data October 2023)
- Share of rural population: 42.1%[1]
- GDP: 363,846,247.34 (data October 2023)[2]
- Income group: Upper-middle-income
- Gini Index: 55.5 (data 2022)[1]
- Colonial period and independence: Colombia was colonized by Spain between 1550 and 1810. The country became politically independent on July 20, 1810[3]

Sources: [1]DANE (2023), [2]IMF (2023), UNdata (2023), World Bank (2023), [3]Government of Colombia (2003)

2. Selected health indicators

Indicator	Colombia	Global Average
Male life expectancy in 2022 (years)	73.7	70.8
Female life expectancy in 2022 (years)	80	76
Under-5 mortality rate in 2021 (deaths per 1,000 live births)	13	38
Maternal mortality rate in 2020 (deaths per 100,000 live births)	66.7	223
HIV prevalence in 2021 (% of population ages 15-49)	0.7%	0.7%
Incidence of tuberculosis in 2021 (per 100,000 people)	22	134

Source: The World Bank (2023)

3. Legal Beginning of the System

Name and type of legal act	Decree 350 and Decree 056 of 1975
Date the law was passed	January 15 1975
Date of *de jure* implementation	1975
Brief summary of content	Through Decree 056 of 1975, the structural organization of the system began for the first time, among which the formulation of the country's health policy stands out, the issuance of standards that regulated the different aspects of the system, the formulation of the National Plan of Health, the surveillance and control of the entities that constitute the System, and the functions of sectional and regional organizations in the implementation of health programs and campaigns (Poder Ejecutivo Nacional 1975).
Socio-political context of introduction	The first conversations concerning the creation of a health care system in Colombia started at a meeting held by the Organization of American States in 1961 in Uruguay, in which relations between the Pan-American Health Organization and the countries of the region were reoriented. International cooperation projects were promoted, and the country progressively created laws that coordinated different aspects of health. In 1963, Law 12 created the "National Hospital Plan" and Decree 3224 restructured the Ministry of Health. In 1968, the Ministry was reorganized again (Hernández et al. 2002). Starting in 1966, the economy showed serious growth problems and proposals began to be made to modernize the state and create an integrated health system that would comprise all health care functions. In 1973, in the midst of a great political debate, the National Health System was created and then implemented through Decree 056 (Poder Ejecutivo Nacional 1975; Hernández et al. 2002).

4. Characteristics of the system at introduction

a. Organisational structure

The healthcare system uses a top-down approach that places the nation's Ministry of Health at the top, followed by regional (Departmental Directions), municipal (Sectional Direction) and local levels of the system. The system's governance and financing are centralized under the Ministry of Health. The system is decentralized for some administrative functions, such as for hiring of human resources and for the management of some institutions in sectional health services (at municipal level) (Hérnandez et al. 2002).

National level functions formulate the country's health policy, dictate the rules that regulate the different aspects of the system, formulate the national health plan, monitor and control the entities that provide health services, and supervise the operation of the organizations in the health system (Poder Ejecutivo Nacional 1975).

The functions at the departmental level adapt national health policy to the characteristics of each region, formulate local health plans and programs, supervise the operation of entities that provide health care services in the jurisdiction, and carry out the activities delegated to them by the Ministry of Public Health and its affiliated and linked entities (Poder Ejecutivo Nacional 1975).

The functions of the municipal level formulate regional plans and programs in accordance with the national health policy, supervise and coordinate the activities of local health organizations, carry out the activities delegated to it by the sectional health service, and apply to local health organizations the affiliation or connection regime established by law (Poder Ejecutivo Nacional 1975).

Social security funds (i.e., Social Security Institute, Provident Funds, and Compensation Funds) in addition to the private sector articulate with the National Health System (Hernández et al. 2002). Specifically, the Ministry of Health coordinates and articulates all entities attached and linked to the national health system, such as public and private healthcare organizations that provided health services to the community, whether or not they receive public funds (Poder Ejecutivo Nacional 1975).

b. Provision

Indicator	Value
Density of physicians (per 1.000 inhabitants) in 1977	0.5
Density of nurses (per 1.000 inhabitants) in 1990	0.3
Density of hospital beds (per 1.000 inhabitants) in 1980	1.6

Source: World Bank, 2023.

c. Regulation

Regulation of the system is shared by central government, regions, and municipalities. At the central level, the Ministry of Health is the main regulator of the system, overseeing regions and municipalities. At the regional level, Regional Health Units serve as the main actor responsible for regulation, with a homogeneous organization in technical and administrative aspects. The 33 jurisdictions are divided into Units that correspond to certain geographic areas, and are mostly responsible for hospitals. The Sectional Health Services carries out the regulation at the municipal level, being responsible for overseeing health centres and city hospitals (Poder Ejecutivo Nacional 1975).

5. Subsequent Historical Development of Public Policy on Health Care

a. Major reform I

Name and type of legal act	Law 100 of 1993 (Ley 100 -Sistema General de Seguridad Social en Salud)
Date the law was passed	December 23,1993
Date of *de jure* implementation	April 1, 1994
Brief summary of content	The law created a national social security system financed through payroll contribution. Introduced a private for-profit agent that managed the public insurance system (i.e., EPS for the Spanish acronym Empresas Promotoras de Salud, or Health Promotion Enterprises). Created three systems for (1) employed people (i.e., the Contributory scheme), (2) unemployed and poor people (i.e., the Subsidized scheme), and (3) unemployed and non-poor people (i.e., the transitory scheme of the uninsured population) (Colombia 1993). A third system was a transitory system for people not recognized as poor but unemployed. That system was planned to end when all people were assigned to either the subsidized or the contributory systems.

Socio-political context of introduction	The economic crisis of the 1980's played an important role since the government needed to use part of the gross domestic product to pay foreign debt commitments, and the social sectors became a source of savings that allowed the government to make the payments. Savings in the health sector emerged because, instead of providing healthcare services to all the population, the government targeted only the poorest people in the country. The external debt in Colombia was US $6.94 billion at the time; payment of debt services between 1980 and 1990 consumed between 35.1% and 59.4% of GDP, leading to an economic stagnation. The Government was pressured by international multilateral organizations to implement neoliberal measures in exchange for accessing international loans that would alleviate the crisis caused by those same loans. Neoliberal ideas focused on two main aspects: first, reducing social spending, and second, opening space for the private market (Vélez 2016). Before Law 100 of 1993, the country had a segmented system: a population from the upper-class receiving care through private health insurance, a population from the middle class and employed through social security, and those from the lower class through public hospitals.

6. Description of Current Health Care System[1]

a. Organisational structure

With Law 10 of 1990, all operational powers of the first level of care were assigned to the municipalities and the second and third levels of care to the departments. Subsequently, the Constitution endorsed decentralization and provided transfer of resources from the national budget to municipalities and departments (Articles 356 and 357); in this context, Law 60 of 1993 implemented the Constitution regarding decentralized powers and resources, particularly in the health sector.

The two schemes created by the Law 100 are public health insurance funds managed by for-profit insurance companies. Each scheme has specific for-profit insurance companies. in the first years of the Law 100 a single company could only belong to one scheme (this meant that a single company must chose if it wanted to work with the subsidized scheme or the contributory scheme). After some time, the government allowed for-profit insurance companies in both schemes.

Additionally, the Law 100 of 1993 delegated to the municipalities and departments the administration of the subsidized regime and created mechanisms to convert supply subsidies into demand subsidies (Jaramillo-Pérez 2009). This meant that public funds no longer would fund directly public hospitals (supply subsides) but progressively would fund subsidized health insurance. In other words, the hospitals would be funded when a person requested the health service (demand subsides).

b. Coverage

Universal coverage is one of the principles of the Colombian health system. Currently, there are two insurance schemes (the transitory one no longer existing) that aim to cover the entire population: the contributory scheme and the subsidized scheme, linked to each other through a common fund called the Solidarity and Guarantee Fund (FOSYGA). All employees or retirees and independent workers receiving income equal to or greater than the minimum wage are required to join the Contributory scheme. To do so, they can freely choose a public or private insurance fund (EPS for the abbreviation in Spanish). Each EPS are responsible for affiliating and registering users, collecting contributions, and organizing and guaranteeing the provision of health benefits.

The subsidized scheme is responsible for insuring all people without the ability to pay and who are not covered by the Contributory scheme. The identification of the poor population is a municipal responsibility and is carried out by applying the survey of the System for Identification and Classification of Potential Beneficiaries for Social Programs (SISBEN) (Guerrero et al. 2011).

1 At the time of writing this country brief (September 2023), there had been congressional debates on a potential healthcare reform in the country.

» Coverage (principal health insurance) for 2022

Indicator	Value
Percentage of population covered by government schemes (Subsidized scheme)	50.1%
Percentage of population covered by social insurance schemes (Contributory scheme)	49.5%
Percentage of population covered by private schemes	5.7%
Percentage of population uncovered	0.4%

Source: Colombia Ministry of Health (Ministerio de Salud 2022)

c. Provision

Indicator	Value
Density of physicians (per 10,000 inhabitants) in 2017	18
Density of nurses (per 10,000 inhabitants) in 2017	11
Density of public hospital beds (per 1,000 inhabitants)	1.7

Source: (Vivas 2018; Guzmán-Finol 2017)

The country has a total of 84,556 hospital beds for approximately 49 million inhabitants; of them, 39,961 are intended for adult care; 10,057, for paediatrics; 7,543, for obstetrics and 5,684, for intensive care (Vivas 2018). Data from 2013 showed that 3,888 institutions were public and 14,996 were private (with a very low participation of not-for-profit institutions) (Guzmán-Finol 2017).

» Importance of inpatient and outpatient sectors
Information from the database of authorized services of the Special Registry of Providers for 2015 show that in the country 66% of healthcare institutions primarily provide outpatient care, 17% for inpatient care, 11% for promotion and prevention centers, and 6% provide auxiliary services (Prada-Ríos et al. 2017).

» Benefit package
Until 2015, the country had a benefit package that explicitly defined the pharmaceuticals, treatments, and appliances to which each citizen was entitled. A health reform in 2015 changed this to a benefit plan based on an exclusion regime. The Government developed a mechanism to define the exclusions according to criteria established by the same law (resolution 5592 of 2015). This means that those affiliated with the health system have the right to all servives that doctors order, except for some elements that are explicitly outside the regime. These are the exclusions criteria defined in the statutory law (Law 1751 of 2015) for the benefit plan: a) the cosmetic and the luxurious; b) the experimental; c) treatments lacking scientific evidence; and d) treatments abroad that can be provided in the country (Ramírez-Ramírez et al. 2016). Although the benefits plan is comprehensive, the real problem is gaining access to what people are entitled to. The health system cannot cover everything, and therefore it only provides everything for those with the means to influence decisions, for most of the people in underserved areas or with a low capacity to influence decisions, the likelihood of even accessing simpler healthcare is low.

d. Financing

Indicator	Value
Total expenditure for health as a % of GDP (2020)	7.6
Domestic General Government Health Expenditure (GGHE-D) as % Current Health Expenditure (CHE) (2020)	71.6
Domestic Private Health Expenditure (PVT-D) as % Current Health Expenditure (CHE) (2020)	28.4
Out-of-pocket (OOPS) as % of Current Health Expenditure (CHE) (2022)	15
Voluntary Prepayments as % of Current Health Expenditure (CHE) (2022)	8.3

Source: (Gaviria-González 2022).

The mandatory contribution for employees is equivalent to 12.5% of labour income, but salaried workers or retirees only pay the equivalent of 4% of their salary, while the employer (or pension payer) is responsible for paying the remaining 8.5%. Self-employed workers must pay the entire contribution.

The resources for financing the Subsidized scheme are gathered through FOSYGA and are equivalent to one and a half percentage points from 12.5% of the contribution of the Contributory scheme, which is added to funds from other fiscal and parafiscal sources.

e. Regulation

The contributory scheme regulation establishes that payroll contributions paid by the worker and the employer must be deposited into the EPS account that the worker freely choses (Colombia 1993). The EPSs are responsible for affiliating and registering users, as well as organizing and guaranteeing the provision of the benefit package. The Ministry of Health and the Fund that administer the public health insurance (i.e., FOSYGA), every year determine the capitation unit payment, which is a sum that indicates how much money is assigned monthly to cover the health of each person (that sum varies according to demographic characteristics). Through a technical and financial procedure, each month, each EPS receives from the payroll taxes the amount necessary to cover all the capitation unit payments for the population affiliated (Colombia 1993).

The Health Directorates of the municipalities hire the EPSs that work for the Subsidized regime and pay them through the per capita unit payment of the Subsidized regime. These EPSs can be of three types, EPSs of the Contributory regime working for the Subsidized regime, Family Compensation Funds or Solidarity Health Companies, which are community organizations. All EPSs contract healthcare services with healthcare institutions in either the private or public sector.

In 2007, Law 1122 further regulated the EPS and incorporated a rule to limit vertical integration (Congreso de la República 2007). Vertical integration means that an EPS can provide healthcare services, which is an extra function to the original conceived in Law 100 that only considered the EPS as intermediary between the public health insurance and the healthcare institution. This means that an EPS manages and hires healthcare institutions, but also can hire itself to provide healthcare services (therefore it can be a for-profit insurance intermediary as well as healthcare institution)(Vélez 2016).

Finally, in the case of special regimes, EPSs have retained their own mechanisms for financing, administration and, in some cases, also for providing services.

As of August 2023, there were 19 EPSs in the contributory regime, four EPSs in the subsidized regime, and four Family Compensation Funds.

7. Co-existing systems

There is no co-existing statutory system; however, there is an important role for voluntary private health insurance (duplicated in nature). The Law 100 from 1993, primarily financed through mandatory contributions from employers and employees, allows citizens to purchase Voluntary Private Health Insurance (VPHI), also known as prepaid medicine in Colombia, while continuing to contribute to the public system. VPHI can be classified into three types: complementary, which covers costs such as co-payments; supplementary, which covers additional benefits that are not included by the public system; and duplicate, which aims to provide faster access to specialists and services available in the public system (OECD 2021). These three types apply in the case of Colombia. In Colombia, there are health providers that exclusively offer services to those who have VPHI. The percentage of citizens who have VPHI (principal and duplicate schemes) has increased from 4.8% to 8.2% between 2008 and 2017. Data from 2018 shows that private insurance accounted for 13% of the total health expenditure (Patiño-Lugo and Vélez 2023).

8. Role of global actors

There is the presence of international investors in some EPSs and in some healthcare institutions but they are not important donors or big healthcare providers (Semana 2018). Pharmaceutical companies and device companies are the most prominent international private actors in the country. Recently, international investors purchased Banmédica – owner of Colmédica and Aliansalud. Banmédica is a Chilean company focused on health care insurance and clinical services, with a presence in Chile, Colombia and Peru. Investments in the health sector by Banmédica have been identified in Bogotá, Medellín and Cali (the three big cities in Colombia). According to data from the Cooperation and Investment Agency of Medellín and the Metropolitan Area, the total amount of foreign investment in the health sector registered between 2008 and 2017 was US$37.19 million (Semana 2018).

Churches or other charity organizations play basically no role in the Colombian health systems. Catholic church lost participation after Law 100 of 1993, in this moment they do not have a role in healthcare provision or in financing.

9. List of additional relevant legal acts

Law 1122 of 2007 (Congreso de la República 2007)

Sentence T-760 of 2008 of the Constitutional Court (Corte Constitucional 2008)

Law 1438 of 2011 (Congreso de la República 2011)

Law 1751 of 2015 (Congreso de la República 2015)

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