PROFILE OF THE HEALTH SERVICES SYSTEM OF COLOMBIA

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PROGRAM ON ORGANIZATION AND MANAGEMENT OF HEALTH SYSTEMS AND SERVICES
DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT
PAN AMERICAN HEALTH ORGANIZATION

EXECUTIVE SUMMARY

Colombia is a decentralized unitary republic with a democratic government. In 2001 it had a land area of 1,138,910 kms^2 and a population of 43,070,703. In the 1990s, the country radically opened almost all sectors of its economy. The gross domestic product exhibited stable growth between 1991 and 1994, and inflation fell. In 1997, the economic growth came to a halt, and a deepening recession began that reached its lowest levels in 1998 and 1999. The GDP growth was –4.2 in 1999 and 2.8 in 2000. Inflation fell to 8.7% in 2000, with a rate of 8.0% projected for 2001.

The health situation of Colombia is in a transitional state marked by gradual but uneven improvement and the existence of communicable diseases side by side with chronic degenerative diseases, which most severely impact the poorest sectors of society, with manifest gender differences. Trauma and homicides have assumed major epidemiological proportions. The crude death rate for the year 2000 was 5.90. In 2000, the highest proportion of deaths was from causes related to the circulatory system, followed by external causes, tumors, communicable diseases, and disorders of the prenatal period.

Law 10/1990 on the municipalization of health marked the start of a transformation process aimed at strengthening the health sector through its territorial units. The process has been implemented slowly. By the year 2000, 25 departments and districts and 524 *municipios* had been certified for autonomous health management. The reform was further implemented by Law 60/1993, which decentralized the authority and resources in health and education, and Law 100/1993 creating the General Social Security System, both of them aimed at expanding public and private health coverage through the insurance system. Insurance is administered by the Health Promoting Enterprises in the contributory system and the by the Administrators of the Subsidized System in the subsidized system. The goal of universal coverage has yet to be achieved, and the low-income population that is not affiliated with the system receives health care through the network of public hospitals. The contributing population pays 12% of its income to subscribe to the Compulsory Health Plan; the subsidized population subscribes to the system through a premium paid by the State for the Subsidized Compulsory Health Plan. It was expected that the two packages would be identical by 2001, but unemployment and low economic growth have hindered the achievement of universal coverage and equalization of the plans as prescribed by Law 100/1993.

The system was originally based on the free choice of insurer and provider, but has been constrained by limitations in expanding coverage and difficulties in finding a competitive field of insurers and providers in many of the less-developed *municipios*.

In order to carry out the sectoral reform, a functional structure was created for the system consisting of: the National Social Security Health Board, which exercises the steering role in the system; and the Ministry of Health, which dictates policies (in the various territorial areas, it is represented by the Sectional Health

Services and Health Bureaus of the *Municipios*). System finances are handled through the Solidarity and Guarantee Fund. The National Health Authority is responsible for the oversight, surveillance, and control of the system.

In the year 2000, 13,245,465 beneficiaries were enrolled in the contributory system and 9,510,566 in the subsidized system (59.79% of the low-income population, measured by unmet basic needs), representing 53.76% of the Colombian population.

Health sector reform also involves the conversion of public hospitals into State Social Enterprises and the definition of institutional, legal, administrative, and operational mechanisms (Office of the Public Defender, National Health Authority, community oversight committees, legal guardianship, etc.) to bolster the participation of service users in sectoral management.

1. CONTEXT

1.1 Political Context: Colombia is a unitary republic governed constitutionally by three powers: the Executive Branch, represented by the President, who is elected for a four-year term and is assisted by 16 ministers he can designate and remove freely (executive powers in the Departments are exercised by the Governor and, in the *municipios*, the Mayor, both elected by popular vote for a three-year term); the Legislative Branch, made up of a bicameral Congress consisting of the Senate and the House of Representatives, with both senators and representatives elected by popular vote for a four-year term (the Legislative Branch in the Departments is represented by the Assembly of Representatives, and in the *Municipios* by the Municipal Council; the representatives and aldermen are also elected by popular vote every three years); and the Judicial Branch, represented at the national level by the Supreme Court, which is divided into four chambers: Penal, Civil, Labor, and Constitutional. In addition to the three powers described above, a branch of the Public Ministry is responsible for resolving conflicts between individuals and the State, or among the various State entities. The Public Ministry is represented at the national level by the Attorney General; at the Departmental level, by the delegated attorneys, and in the *municipios* by the municipal representatives. Under the Constitution of 1991, Colombia is divided administratively into 32 Departments, 1,076 *Municipios*, 2,029 Mayoral Districts, and 4,040 police precincts. The country's capital does not fall within the jurisdiction of any Department and is established as a Capital District.

Development planning and management are the responsibility of the National Planning Department (DNP), which follows a National Development Plan complemented at the territorial level by departmental and municipal development plans.

Within the context of the armed conflict that has engulfed the country for decades, forced displacement is a reflection of the humanitarian crisis, as is the limited access to basic services such as housing, drinking water, health, and social support or rehabilitation programs, and the fragility of basic rights and the judicial entities that enforce them. The displaced population lives in precarious conditions with little possibility of responding effectively to the situation. Accordingly, rural and urban gaps in education, basic services, and employment, coupled with gender inequalities and political and social violence (with its sequelae of injuries and homicides), are often cited as some of the main problems affecting health service performance. PROFAMILIA 2001 reports that displaced women become pregnant at double (8%) the national rate (4.7%), with 55% of their pregnancies unwanted. The pregnancy rate is particularly high among displaced adolescents.

1.2 Economic Context: The GDP exhibited satisfactory levels in the 1980s and stable growth from 1991 to 1994. Since 1994, inflation has slowly declined and in 1999 began to drop significantly.[1] In 1999, the GDP decreased by 4.2% in real terms and in 2000, grew by 2.8%. A 4.0% growth rate is projected for the year

2001. The inflation rate, as measured by the consumer price index (CPI), was 9.2% in 1999, 8.7% in 2000, and is projected at 8.0% for 2001.

Some Economic Indicators

INDICATOR	1995	1996	1997	1998	1999	2000
Per capita GDP in constant prices in US$	ND	ND	ND	2,420.1	2,038.4	1,920.1
Economically Active Population, in thousands	16,456	16,292	16,830	17,549	18,290	19,571
Public Health Expenditure / GDP	4.3	5.2	5.3	5.1	5.5	ND
Private Health Expenditure / GDP	3.2	3.6	3.9	4.2	4.5	ND
Total Health Expenditure / GDP	7.4	8.8	9.3	9.3	8.6	ND
Public social spending as a percentage of GDP	12.40	13.90	13.19	13.19	14.05	12.18
Annual Rate of Inflation%	19.46	21.63	17.68	16.70	9.23	8.75

Source: National Planning Department DNP. Economic Indicators. 2000. DANE 2000

Colombia increased its exports to the industrialized countries, Latin America, and the rest of the world between 1985 and 1995. A rapid opening of trade began in 1990 with significant tariff reductions at all levels, which has translated into a pronounced trade deficit. The most attractive export products include coffee, crude oil, coal, emeralds, bananas, flowers, textiles and clothing, chemical products, and leather goods.

The flow of direct foreign investment into the country increased gradually from 1985 to 1995, when it reached US$ 7,342 million. This figure excludes foreign investment in the mining-oil sector. In 1998, total foreign investment in Colombia was US$ 4,749.77 million. The total foreign debt of Colombia grew from US$ 17,000 million in 1992 to US$ 29,000 million in 1994 (34.5% and 30.7% of the GDP, respectively)[2]. In 1999, it rose to US$ 33,853 million and to $33,264 million in 2000.

1. 3 Demographic and Epidemiological Context

Colombia has experienced the demographic and epidemiological changes characteristic of transitional societies, such as aging of the population, a decline in fertility rates, and rapid urbanization. Life expectancy at birth rose to 71.2 years in 2000, and the fertility rate fell from seven children per woman in 1950-1955 to 2.7 children per woman in 1995-2000. Some 71% of the population is urban, with the consequent saturation of access to basic services in the cities. Life expectancy at birth has remained almost unchanged for the past three years; it was 68.2 years for men and 74.8 for women in 2000.

Annual population growth has remained between 1.6% and 1.8% in the past three years. The dependency ratio per 100 inhabitants has remained between 62.8 and 59.8 during the period. Forced displacement from the rural to the urban environment due to armed conflict is a serious problem. Over the past three years, some 580,000 people were displaced by violence. The *campesinos* are the most affected group; 82% of displaced persons come from rural areas, and out of the total population affected, 46% of households owned some land and 18% were day laborers or independent workers.

INDICATORS	YEARS		
	1998	**1999**	**2000**
Crude birth rate	23.2	23.6	23.4
Total fertility rate	2.7	2.7	2.7
Crude death rate	5.6	5.7	5.6
Maternal mortality rate	87	78.2	81.1
Annual population growth	1.6	1.8	1.8
Life expectancy at birth	71.0	71.0	71.2
Infant mortality rate	24.0	28.0	11.2

Source: *Situación de Salud en Las Américas. Indicadores Básicos* 2000, 1999, 1998.

As seen in the table above, the crude death rate has remained stable over the period 1998-2000. Underreporting of mortality is a significant problem. Diseases of the circulatory system are the leading cause of death in Colombia, followed by deaths from external causes, with rates ranging from 131.6 in 1998 to 131.5 in 2000, reflecting an upward trend (the rate was 107.7 per 1,000 population in 1995). In fact, this same trend was evident during the final quarter of the last century; approximately 25,000 homicides per year were recorded on average in the last decade, producing a total of nearly 500,000 dead in the last 20 years of the millennium. The National Institute of Forensic Medicine and Sciences reports figures of 36,947 violent deaths for 1999, 62% of which were homicides, 20% were from traffic accidents, and nearly 6% were suicides. The most affected population was men aged 25 to 34, followed by young people between the ages 18 and 24. The number of murders and the probability of being murdered have risen, reflecting the deterioration in the overall violence in the country. Tumors are the third leading cause of death, followed by communicable diseases, both showing a rather stable trend. The group of ill-defined signs, symptoms, and disorders shows the greatest variations, with a rate that fell from 27.4 per 100,000 population in 1995 to 13.1 in 1998.

Disorders of the perinatal period, with rates calculated on the basis of the number of expected births per year, show a dissimilar tendency, falling from 4.8 per 1,000 live births in 1995 to 2.4 in 1996, and increasing to 5.5 and 7.5 per 1,000 in 1997 and 1998, respectively.

Tuberculosis is a public health problem in Colombia. Its intensification is related to the growth of poverty and marginalized populations, the increase in migration, the weakness of control programs, poor access to services, and limited education. There had been a continuous decline in tuberculosis cases in Colombia, dropping from 58.6 per 100,000 population in 1970 to 26.5 in 1999; however, the reported incidence of tuberculosis has increased in the last three years, most likely due to improvements in the national program that resulted in a more active search for suspected cases and an increase in the number of positive cases

detected. In 1999, data on areas of the country with 31% of the population showed a 66.2% cure rate and a 78% rate of successful treatment.

The elimination of leprosy as a public health problem is national policy. The prevalence of active cases of the disease for the year 2000 was 0.5 per 10,000 inhabitants (2,124 cases). Although this indicator fell within the world parameters for eradication in 2000, the departments of César, Santander, Huila, and Norte de Santander presented prevalences of higher than 1 case per 10,000 population. Although the number of cases has been reduced, the percentage of new cases with disability due to late diagnosis has increased.

The infant mortality rate for the 5-year period 1995-2000 was 21 per 1,000 live births[3], with neonatal mortality of 15 per 1,000 and mortality in the first five years of life of 25 per 1,000. The lowest infant mortality was recorded in Bogotá (17 per 1,000), followed by the Central region (20 per 1,000), while along the coast it was 29 per 1,000. The Ministry of Health conducted a joint study with CIDER of the University of the Andes to adjust the infant mortality rate for underreporting and found that the adjusted figure should be on the order of 35 per 1,000 live births. To be sure, infant mortality of 21 is incongruous with the levels of maternal mortality recorded in Colombia[4]

The prevalence of chronic malnutrition or growth retardation was 13.5% among children under 5 and the prevalence of diseases in this age group was 13.9% for diarrhea and 12.6% for ARI. Thirty deaths occur daily in children under 5, 14% which is the result of ARI. Pneumonia is the leading cause of hospitalization and death, with a hospitalization rate of 20.1% in children under 1 year and 24.0% in children aged 1-4. This is followed by other causes of perinatal morbidity, enteritis, and other diarrheal diseases in children under 1, and by enteritis and bronchitis in the 1-4 age group. Morbidity from ARI has risen from 193.3 per 1,000 inhabitants in 1990 to 258.7 per 1,000 inhabitants in 1996.

Mortality from ADD in children under 5 was 45.4 per 100,000 in 1990, with the goal of lowering this rate to 22.7 by 2000. Between 1993 and 1997, mortality from this cause stayed below the expected levels, but has risen since 1997 to levels that exceed the proposed target for 1998. There is no mortality data available at this time for 1999 and 2000. Morbidity from ADD in children under 5 was 113.5 per 1,000 in 1990, with the goal of lowering this rate to 85.1 in 2000. The rates observed between 1991 and 1996 have been within the expected parameters. There has been no information on morbidity from ADD since 1997.

Acute respiratory infections are a significant public health problem and are the leading cause of morbidity and mortality in children under 5. Mortality from pneumonia has declined in recent years from 51.0 to 30.8 per 100,000 population between 1988 and 1996; however, it rose to 34.1 in 1998. Morbidity from ARI has increased from 174.0 to 214.0 per 1,000 inhabitants between 1991 and 1996. Mortality in children under 5 from ARI meets the targets of the goals set by the World Summit for Children; from a

starting point of 46.3 per 100,000 in 1990, mortality was projected to decline to 32.4 by the year 2000. In recent years combined (1997 and 1998), however, mortality from ARI has again risen.

Emerging and Reemerging Diseases. In 1999, 13 cases of cholera with no deaths were confirmed. This represents a considerable reduction over 1988, when 445 cases were reported, for an incidence of 1.04 per 100,000 inhabitants, and 7 deaths for a case-fatality rate of 0.01. Malaria, dengue, and other vector-borne diseases are serious public health problems in the country. An estimated 85% of the rural population living in areas below 1,800 meters (between 15 and 18 million people) may contract malaria, leishmaniasis, and yellow fever. Some 65% of the urban population has a high probability of contracting dengue/DHF, and an estimated 8 million people live in areas of Chagas' disease transmission. Colombia reported an annual average of 200,000 cases of malaria in the last decade, though for each recorded case two go unreported. Malaria reached epidemic proportions in 1998, with 240,000 confirmed cases, the highest peak in the country's history. A total of 141,047 confirmed cases were recorded in the year 2000, a 61% increase over 1999. This situation has been endemic since the 1990s.

The annual average for dengue cases is 30,000. However, 57,985 cases were reported in 1998, with 5,171 cases of dengue hemorrhagic fever. The disease exhibits an endemoepidemic pattern, given the simultaneous circulation of different serotypes and the high indexes of *Aedes aegypti* infestation.

With an average of 6,000 cases annually, leishmaniasis is a problem of major proportions and expense. In 1997, 51 cases of measles were reported; in 1998, 60 cases, and in 1999, 41 were confirmed. Vaccination coverage with trivalent viral vaccine is below 95% in a high percentage of *municipios*.

Rubella presented an endemoepidemic behavior, with rates ranging from 18.4 to 36.7 per 100,000 population, peaking in 1989 and again in 1994. In 1996, 6,302 cases were reported, with an overall rate of 17.1 per 100,000 population. Since 1997, the incidence of rubella has declined due as the result of vaccination with trivalent viral vaccine. During the years 1997, 1998, and 1999, a total of 1,901, 1,906, and 974 cases were detected, respectively, for a rate of 4.7, 4.7, and 2.3 cases per 100,000 population.. In 2000, rubella outbreaks in Bogotá, Norte de Santander, and Nariño were identified. The diphtheria rate declined with use of the DTP vaccine.

HIV infection and AIDS cases are reported in Colombia, which is an advantage for monitoring the epidemic. From 1983 through April 1999, 21,048 cases of HIV/AIDS were reported. Of these, 11,381 correspond to asymptomatic people and 5,782 to people with AIDS, for a cumulative total of 17,163, 85% of which are men. In the same period, 3,441 deaths from AIDS were reported, 90% of them men.

A national survey on psychoactive substance use among students aged 10 to 24 was conducted in 2001[5] in 27 capitals and three *municipios* of the country. Alcohol is the psychoactive substance most consumed by young people. The highest proportion of young alcohol consumers is found in Tunja and Bogotá, and the

highest levels of alcohol use occur among university students and men. New cases among women and secondary school students are becoming more common. Long-time users account for a high percentage of alcohol consumption, with few consumers having recently initiated their alcohol use.

Cigarette smoking is most prevalent in the cities of the interior among university students, and the majority of new cases occur among secondary school students. Most smokers are men. Alcohol and cigarette consumption begin most frequently between the ages of 10 and 14, with an average of 13.7 for smoking and 12.9 for drinking. The majority of young people begin smoking between the ages of 15 and 19.

Marijuana and cocaine are the most highly consumed illegal substances among young people. The greatest use of these substances and the greatest number of young people who tried them for the first time in the last year occurred in Medellín and the cities of the coffee belt (Manizales, Armenia, and Pereira). Cali is one of the cities with the highest incidence of cocaine use among young people. The highest use of marijuana and cocaine occurs among male university students, except in Arauca, where women's consumption of these substances is greater. In general, the use of basuco and inhalants is more common among students in secondary schools than in universities. Colombia is the world's leading producer of cocaine and heroin; coca is grown in an area equivalent to 103,000 hectares and poppy in an area measuring 9,000 hectares.

1.4 Social Context: The estimated population in 2001 is 43,070,703[6], with an annual growth rate of 1.77% and a population density of 37.8 pop./km^2. 49.5% are men and 50.5% women, with 71% located in urban areas and 29% in rural areas of the country.

The period between 1993 and 2001 was characterized by erratic levels of poverty, which improved between 1993 and 1997 and deteriorated in the subsequent years. According to the Quality of Life Survey of 1997, the percentage of the population under the poverty line, measured by unmet basic needs, fell from 32.7% in 1993 to 27% in 1997. In 1998 and 1999, 51.47% and 55%, respectively, of the population was under the poverty line. Inequity in the distribution of income, as measured by the Gini coefficient declined from 0.58 in 1993 to 0.53 in 1996; in 1998 and 1999, the Gini coefficient increased to 0.55, reflecting greater levels of inequity. According to the latest official DNP figures published, Colombia scored 0.85 on the Human Development Index and 0.75 on the Gender-Related Development Index.

In 2000, informal employment represented 54.9% of total employment (54.6% of the people employed in the informal sector were men and 45.4% women).[7] The informal subsistence economy prevails in Colombia. The production of goods and services within the informal sector is intended for domestic consumption. Three quarters of informal economic activity occurs in the commercial sector and other services.[8] In addition, temporary employment has increased in recent years.

The Government attempted to increase public social spending from 9.07 in 1990 to 15.14 in 1995 and to 16.2 in 1999, but inequalities between urban and rural areas are evident in education, basic services, and employment.[9] Colombia is a multicultural and multi-ethnic country with 81 different indigenous groups, as well as three Afro-American groups residing within its territory. The latest official figures indicate that the indigenous population of Colombia is 574,482[10] and the black population 502,343[11]. The following table shows the illiteracy rates between 1993 and 1999, which are low in the municipal capitals compared with other countries, but high in rural areas.

Illiteracy rate in the Population aged 15 and Over, by Gender and Area, 1993-1999.

	1993	1996	1997	1998	1999
TOTAL	**9.90**	**8.70**	**8.40**	**8.66**	**8.30**
CAPITALS	5.73	4.90	4.60	4.80	4.80
REST	20.33	19.40	19.40	19.70	18.20
MEN	9.86	8.80	8.60	8.83	8.10
WOMEN	9.82	8.60	8.30	8.52	8.50

Source: Social Mission, based on '93 census. DIOGS based on national Dane EH.

Average years of schooling for the population over 15 years of age is seven years in urban areas and 4.1 in rural areas, with no substantive gender-based differences.

Years of Schooling in Population aged 15 and Over, by Gender and Area, 1993-1999.

	1993	1996	1997	1998	1999
TOTAL	**6.2**	**6.6**	**6.8**	**7.0**	**7.0**
CAPITALS	6.9	7.7	7.9	8.1	8.1
REST	3.7	3.7	3.8	3.7	4.1
MEN	6.2	6.6	6.8	7.0	7.0
WOMEN	6.2	6.6	6.9	7.0	7.0

Source: Social Mission, based on '93 census and DIOGS calculations.

2. HEALTH SERVICES SYSTEM

2.1 General Organization: The Constitution of 1991 granted greater powers to the *municipios* and strengthened the role of the Departments; it furthermore regarded social security as an inalienable right of all inhabitants and a compulsory public service coordinated and controlled by the State, to be administered in a decentralized manner and by levels of care.[12] The system is organized by Law 10/1990, "Municipalization of Health"; Law 60/1993,[13] which establishes the authority and resources of the different territorial units; and Law 100/1993 creating the General Social Security System (SGSSS). Laws 10 and 60 (and currently Law 715) assigned the operational authority for health care in the primary level to the *municipios*, and for secondary- and tertiary-level hospitals, to the Departmental governments. Law 100 modified the health service delivery system, exchanging the supply subsidy for a demand subsidy,

with guaranteed universal coverage proposed as a goal for the year 2001. Law 100 created two systems of affiliation: one *contributory* and one *subsidized.* The poorest and most vulnerable population that cannot pay for services is assigned to the subsidized system. Those who are not affiliated with any system due to the lack of providers or resources are called *uninsured participants*, with the local government of each *municipio* taking responsibility for the delivery of health services to this population.[14] The guiding principles of the process are efficiency, universality, solidarity, comprehensiveness, unity, and social participation. Health Promoting Enterprises (EPS) were created for the contributory system and the Administrators of the Subsidized System (ARS) for the subsidized system. The Collective Health Companies are a form of ARS, created as cooperative associations. The EPS and ARS plan, organize, and carry out the activities necessary for controlling diseases and maintaining the health of the insured population. The two types of entities and the Municipal Ministry of Health contract IPS (Institutional Health Service Providers) and ESE (State Social Enterprises--formerly the public hospitals) for the delivery of services to beneficiaries. The new system divides responsibility for the various functions into: *Leadership* (National Social Security Board, Ministry of Health, Departmental and Municipal Directorates), *Financing* (FOSYGA, Solidarity and Guaranty Fund); *Administration* (EPS, ARS); *Service Delivery* (IPS, ESE), and *Surveillance and Control* (Health Authority). The system provides for a General Benefits Plan that includes a Basic Health Plan (PAB) and a Compulsory Health Plan (POS). The *municipios* administer the PAB, which includes surveillance in public health, and design a Local Health Plan to meet their responsibilities in promotion and prevention activities at the grassroots level. The EPS and ARS must provide diagnostic and treatment services, in addition to individual promotion and prevention activities, as defined in the POS and the Subsidized Compulsory Health Plan (POS-S).

2.2 System Resources

Human Resources: Laws 30 and 115/1994 gave educational institutions autonomy in creating programs. This has resulted in a chaotic proliferation of programs, especially private undergraduate and graduate programs at the advanced, technical, and auxiliary levels, without the concomitant regulation of the professional practice of these new workers. The trend toward privatization in the training of auxiliary workers is greater still with the elimination of the schools connected to the Departmental Health Services. The National Board for Human Resources Development in Health was created in 1997; comprised of representatives from the Ministries of Education, Health, and Labor, it has two operational entities, the National Executive Committee and the Departmental Committees, charged with formulating policies on the training, continuing education, distribution, and dynamics of human resources in health. Until late 1996, the National Council regulated the training of the following resources in the categories described as

nonformal education: health promoters, family health auxiliaries, oral health assistants, nursing auxiliaries, clinical laboratory assistants, administrative assistants, health statisticians, environmental care promoters, and pharmacy auxiliaries. In 1999, the Human Resources Bureau of the Ministry of Health was eliminated, leaving the Council in legal limbo. Nevertheless, it meets sporadically to approve proposals for the creation of nonformal education programs submitted by the Departmental Committees, which have proliferated in the last two years. In 2001, in response to the proliferation of health programs, the national government issued a Decree to guarantee the quality of training for professionals, since the voluntary accreditation system for quality control of higher education has not been implemented as quickly as desired. Educational facilities were granted a grace period until May 2002 in which to comply with the Decree. The educational programs are still found predominantly in the most developed regions of the country, and the cost of tuition remains high. The practice of lowering admissions requirements at institutions of higher education in order to maintain full enrollment is disturbing. Health care professionals look to continuing education as a means of acquiring additional skills to gain access to a very competitive labor market, leading to the inordinate proliferation of graduate programs of all types. A Compulsory Social Service Law applies to recent graduates in medicine, nursing, dentistry, and bacteriology. The Departmental Secretariats and the Ministry of Health had been responsible for creating these positions until decentralization gave the *municipios* the autonomy to exercise this function, causing the positions to be filled largely by professionals with greater experience and tenure. This, along with the greater number of professionals available as a result of the proliferation of academic programs, has forced the Ministry to hold periodic lotteries to allow professionals to be released from this responsibility. No official information system has been set up to collect and analyze data on human resources in health, and the official figures are only approximate, since they are not adjusted to account for the professionals who retire, die, or change jobs.

HUMAN RESOURCES IN THE HEALTH SECTOR[15]

TYPE OF RESOURCE	YEAR							
	1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Ratio of Physicians per 10,000 pop.	9	N/A	9.9	N/A	11.3	10.5	9.2	9.4
Ratio of Professional Nurses per 10,000 pop.	ND	4.83	N/A	N/A	N/A	4.8	N/A	5.7
Ratio of Dentists per 10,000 pop.	ND	4.03	N/A	N/A	N/A	N/A	N/A	8.0

Source (s): Superintendencia Nacional de Salud. Ministerio de Salud. El talento humano en salud. Segunda edición actualizada.1998.; WHO Estimates of Health Personnel http://www-nt.who.int/whosis/statistics; The World Bank, Health Nutrition and Population Statistics http://devdata.worldbank.org/hnpstats

Several recent studies evaluating the professional practice situation arising from the reform and decentralization processes and the trend toward the privatization of health care offer evidence of changes in occupational profiles: the work requirements for nurses show a greater emphasis on administrative

tasks at the expense of direct clinical work with patients; the private practice of physicians has clearly diminished (only 7.77% of professionals work outside the social security health system); and the work of specialists is mediated by referrals from general practitioners and must be performed within the framework of the restrictions imposed by the entities that control the health market. There is a troubling exodus of specialists toward the foreign labor market. The demand for specialists is critical in the case of dentists, therapists, and bacteriologists.

Four projects, contracted by the Ministry of Health and implemented in the past two years, together provide the information and proposals needed by the authorities to develop a Human Resources Development Plan for the sector. The human resources projections developed by one of the projects (CENDEX) in terms of professionals per 1,000 population are the following:

Year	Population	Physicians	Dentists	Nurses	Therapists	Bacteriologists Nutritionists
2000	40,836,901	1.32	0.74	0.53	0.43	0.58
2001	41,645,472	1.34	0.76	0.54	0.46	0.59
2002	42,471,718	1.35	0.78	0.55	0.50	0.60

The problems connected with human resources can be summarized as: a) imbalance between the supply in the various occupational categories and the demand for services, due to lack of planning and insufficient and unreliable information, as well as the lack of incentives for more equitable geographical redistribution of human resources; b) inconsistencies between the socioeconomic and epidemiological profiles of the population and the occupational profiles of human resources in health, and inconsistencies between the foregoing and teaching objectives, contents, strategies, and methods; these inconsistencies can be explained in part by the fact that models of care have been not defined or service networks reconstructed in conformance with the new social security health system; c) failure to recognize the importance of human resources management in the productivity and quality of care, in such critical areas as the introduction of labor flexibility, the trend toward the proliferation of external contracts for substantive activities (outsourcing), the lack of stability in working conditions, with the loss of job commitment and a deterioration in workplace morale and motivation (23% of professionals are working without steady work contracts - 33% in the case of physicians); d) lack of policies and strategies for performance evaluation and coherent plans for continuing education and training supervision.

***Drugs and Other Health Inputs*:** The National Drug Policy is not adequately enforced, even though Law 100 and its regulations contain well-defined provisions with regard to drugs, such as the coverage of essential drugs defined in the POS. Nevertheless, inequalities exist among contributors, subsidized beneficiaries, and the uninsured population, reflecting the differences in their respective financing sources. The use of the International Nonproprietary Names has also been established, along with

regulations on drug registration, good manufacturing practices (GMP), the essential requirements for pharmaceutical services, health surveillance, and drug surveillance. These policies have altered the structure of the market. Thus, while in 1995,[16] brand-name drugs claimed 70% and generics 15% of the market; in the year 2000, these figures were 41% and 37%, respectively. The percentage of public expenditure in health allocated to drugs was 7%-12% in 1995 and 13.17% in 2000, for a total of US$ 18.3. There are national protocols for the rational management of drugs for communicable diseases pertinent to public health. All pharmacies must have a pharmacist on the premises as a basic system requirement, but compliance has been low and this requirement is currently under review. Drug prices were deregulated in 1990. In 1998, the Price Liberalization regime was instituted by decree, except for POS drugs (essential drugs in Colombia), with fewer than three suppliers subject to direct control. This policy is estimated to have caused over 40% of drug prices to increase by more than the CPI (21.4%)[17].

The Compulsory Health Plan has a List of Essential Drugs with nearly 300 active ingredients and 435 dosage forms. By 1995, prescriptions for essential drugs in the public hospitals accounted for 70% of the drugs prescribed, and more than 60% of these prescriptions were filled with generics. That same year, Colombia adopted the GMP of WHO as the standard. The various quality control programs for the products on the market still yield rejection levels of close to 4%. Hospital Cooperatives, which account for nearly 80% of public hospitals, have been particularly effective and offer average discount levels of 79% on high-quality drugs. The General Social Security System guarantees access to essential drugs for beneficiaries of the contributory system, imposes restrictions on those affiliated with the subsidized system, and falls short in providing the uninsured population with access to the essential drugs system. Various studies conducted between 1995 and 1999 show an increase in the percentage of prescriptions for essential drugs. Access to essential drugs should increase by the same ratio as health system coverage, but several studies show inequities in this regard, relating principally to the dispensing of prescription drugs. The Office of the Public Defender reports an average failure to dispense the drugs of 39.8% and another study shows a rate of 56%, with significant variations among populations affiliated with the contributory and subsidized systems and the uninsured population[18].

Blood donations have not increased: in 1993, 300,000 units were collected; in 1997, 425,000; and in 2000, 400,000. Paid donations are prohibited and replenishment hospital donations comprise 80% of the total; 99% of blood is screened for the five markers required. Technical standards and control protocols exist, but no registry data is available to measure the degree of compliance with them[19]. Following the reinstatement of the National Blood Council in 2001, a group that was formed to set blood policy submitted a policy proposal to the Council for approval.

Equipment and Technology.

According to the National Census of Hospital Equipment, 41% of the 25,515 pieces of equipment inventoried in secondary- and tertiary-level facilities in 1997 functioned intermittently or were out of order. Expenditures for the maintenance of hospital equipment account for approximately 5% of public and private hospital budgets, although this figure is not audited by the National Health Authority during budget execution. There are regulations on the importation and marketing of medical equipment[20].

AVAILABILITY OF EQUIPMENT IN THE HEALTH SECTOR, 1997

Subsector	Clinical laboratory		Diagnostic imaging equipment	
	1st Level	2nd Level	1st Level	2nd Level
Public	649	135	N/A	N/A
Subtotal	649	135		
Private	1283	220	N/A	N/A
Subtotal	1283	220		
Total	**1932**	**355**	N/A	N/A

Source: Ministry of Health. National Census of Hospital Equipment, 1997.

2.3 Functions of the Health System:

Steering Role*:* The Ministry of Health dictates policy and is represented at the territorial level by the Sectional Health Services and Municipal Health Systems. By Law, the National Social Security Health Board (CNSSS) exercises the steering role in the system and manages the General Social Security Health System. This system is under the direction, regulation, supervision, monitoring, and control of the national government and the Ministry of Health, which dictates the government policies and plans, programs, and priorities that serve as the foundation for territorial plans under Law 715/2001. The CNSSS also functions as the Administrative Board of the FOSYGA and is responsible for regulating the contributory and subsidized systems, defining: the POS and the essential drugs that are part of it; contribution amounts and the value of the Capitation Payment Units (UPC), with their respective differentials based on the average for different populations by age, sex, and geographical location; the copayments and deductibles system; the system for determining eligibility for and payment of disability benefits and maternity leave; and measures to prevent discrimination in the selection of subscribers. The technical secretary of the CNSS, who is also the Director-General of Insurance of the Ministry of Health, submits the results of technical studies to the Ministry for its consideration in decision-making. The National Health Authority acts as the surveillance and control entity.

The functions of the Ministry of Health are: (i) to formulate and adopt the policies and strategies of the SGSSS in conjunction with the Ministry of Labor and Social Security, pursuant to the economic, social, and environmental development plans passed by the Congress of the Republic; (ii) to set the scientific

standards for the quality of services and the control of risk factors, which are mandatory for EPS, IPS, and territorial units (sectional, district, and local health bureaus); (iii) to issue administrative standards, which are mandatory for EPS, IPS, and territorial entities; (iv) to set the criteria for evaluating efficiency and apply them to EPS, IPS, and territorial entities.

The National Institute for Drug and Food Surveillance, headed by the Ministry of Health, executes policies governing sanitary surveillance and quality control of drugs, biologicals, food, beverages, cosmetics, medical and surgical devices, dental equipment, natural and biotechnology products, diagnostic reagents, and other products that impact individual and collective health.

Separation of Functions: The new system divides responsibility for the various functions into: *Leadership* (National Social Security Board, Ministry of Health, Departmental and Municipal Directorates); *Financing,* through the Solidarity and Guaranty Fund (FOSYGA), with four subaccounts for: internal compensation in the contributory system, support in the subsidized health system, health promotion, and insurance against catastrophic risks and traffic accidents; *Administration* (EPS, ARS); *Service Delivery* (IPS, ESE); and *Surveillance and Control* (Health Authority). Under Laws 10 and 715, the Departments, districts, and *municipios* are responsible for managing and organizing the health services to guarantee public health and the delivery of health services by public institutions, by contracting services or granting demand subsidies. The territorial entities organize the system of subsidies for the poorest and most vulnerable population, contracting with providers to provide care for EPS beneficiaries in their territory and promoting the creation of ESS.

Financing: The Solidarity and Guaranty Fund (FOSYGA) is an important source of financing for the General Social Security System and includes four major subaccounts for: internal compensation in the contributory system, support in the subsidized health system, health promotion, and insurance against catastrophic risks and traffic accidents. The capacity to collect sectoral data on sources of financing, utilization of financial resources, and analysis of gaps in sectoral financing between the contributory and subsidized systems has been developed on a national scale. The studies have used the methodological approach adopted for the Health Accounts System of Colombia[21], led by the General Insurance Bureau of the Ministry of Health with the participation of the National Planning Department and National Health Authority[22]. They also analyze the health expenditure of governmental, nongovernmental, central, and decentralized entities.

HEALTH PROMOTING ENTERPRISES–EPS
DIFFERENCES BETWEEN TOTAL INCOME AND PAYMENTS, 1995-1997
(million current pesos)

	1995	1996	1997	1998	1999	2000
TOTAL INCOME (1)	54,889.1	2,089,248	2,671,027	3,211,472	4,255,613	3,946,550
TOTAL PAYMENTS (2)	65,347.2	2,123,947	2,809,747	3,804,143	4,534,503	4,172,246
DIFFERENCE (1) - (2)	**-10,458.1**	**-34,699**	**-138,720**	**-592,671**	**-278,890**	**-225,696**
Private EPS		-53,329	-61,476	-61,899	-50,379	-30,927
Public EPS		42,649	-30,603	-68,280	-92,013	-48,407
ISS–EPS		-24,019	-46,642	-462,492	-136,498	-146,363

Source: Study of the financial balance of the SGSSS. Dec. 2001

SUBSIDIZED SYSTEM–SOURCES OF FINANCING
Annual rates of variation

SOURCES	1996/95	1997/96	1998/97	1999/1998	2000/99
Subsidy Payment			31.6	52.2	-4.1
ICN Share			0.1	30.7	-3.0
Self-help			4.4	-12.7	21.4
Compensation Funds	0.7	-47.4	64.6	2.9	17.4
FOSYGA	69.8	-12.9	42.0	-30.2	-8.9
Income Yielded				58.7	-42.7
Total resources	**57.2**	**66.0**	**28.1**	**-1.0**	**-4.7**

Source: Study of the financial balance of the SGSSS.2001. In constant pesos (1995=100).

COMPARATIVE FIGURES FOR PER CAPITA RESOURCES, COVERAGE, AND VALUES

	1997	1998	1999	2000	2001	2002
CONTRIBUTORY SYSTEM:						
Total EPS payments (millions curr. $)	2,809,746.8	3,804,143.1	4,534,502.8	4,172,246.0	4,549,069.5	4,835,517.3
Members	13,065,904	12,480,230	13,000,665	12,927,907	12,893,886	12,930,000
Total per capita expenditure $	215,044	304,814	348,790	322,732	352,808	373,976
Per capita POS cost $ (1)	121,569	164,303	195,428	247,412	271,888	288,201
UPC val. $ (2)	174,989	207,362	241,577	265,735	289,119	312,248
Difference (2)-(1)	53,420	43,059	46,149	18,323	17,231	24,047
Increase in coverage		-585,674	520,435	-72,758	-34,021	36,114
SUBSIDIZED SYSTEM						
Total ARS resources (millions curr. $)	747,987.7	1,119,165.2	1,210,679.8	1,254,295.7	2,064,331.4	2,169,082.5
Members	7,026,691	8,527,061	9,325,832	9,365,832	10,500,000	10,800,000
Per capita values $	106,449.5	131,248.6	129,820.0	133,922.5	196,603	200,841
Per capita POS cost $ (1)	69,965.0	97,626.0	100,866.0	113,387.0	126,362	171,823
UPC val. $ (2)	108,464.0	128,530.0	128,530.0	141,383.0	155,530	167,972
Difference (2)-(1)	38,499	30,904	27,664	27,996	29,168	-3,851
Increase in coverage		1,500,370	798,771	40,000	1,134,168	300,000
DELIVERY OF RESOURCES						
Total DSLS and ET (millions curr. $)	2,590,018.1	2,709,600.3	2,951,210.0	3,229,657.1	3,451,542.6	3,874,271.8
Affiliated population	14,673,109	14,949,624	15,230,488	15,509,252	15,798,424	16,092,987
Per capita values $	176,515	181,249	193,770	208,241	218,474	240,743

Notes: estimated values of UPC for contributory and subsidized systems for the year 2002, assuming an increase equivalent to the CPI of 6%

GENERAL CONSOLIDATED						
SOURCES AND USES OF SYSTEM RESOURCES						
(thousands of current pesos)						
	1995	**1996**	**1997**	**1998**	**1999**	**2000**
SOURCES/ USES						
SOURCES						
FAMILIES	73,499,707	1,548,400,587	1,156,910,377	1,444,369,515	1,796,875,643	1,857,677,803
COMPANIES	120,373,465	366,318,471	1,462,876,748	1,622,163,710	2,145,565,345	2,313,991,839
AGENT RESOURCES	**324,342,428**	**1,248,602,871**	**1,348,770,776**	**2,120,366,560**	**2,087,552,229**	**1,632,798,211**
EPS own funds	6,632,231	384,944,862	288,608,662	475,043,540	672,621,853	174,914,447
EPS equity	10,458,130	34,698,747	138,719,895	592,670,830	278,889,753	225,696,243
FOSYGA own funds	21,123,742	158,553,325	180,379,587	236,616,652	95,471,623	49,886,008
Sale of services (DSLS)	173,766,942	360,210,189	385,534,012	483,345,711	518,153,000	903,665,833
Capital resources (DSLS)	112,361,383	228,021,396	295,773,730	278,218,042	457,733,000	213,229,720
Others (DSLS)		82,174,352	59,754,890	54,471,786	64,683,000	65,405,959
GENERAL NATIONAL BUDGET P.G.N.	**801,115,398**	**1,021,864,209**	**1,493,837,849**	**1,820,845,591**	**1,987,408,522**	**1,982,937,404**
Budget allocation	33,568,737	13,860,738	389,589	60,877,100	42,918,436	60,297,001
Subsidy payment	471,692,101	699,761,407	812,644,150	918,880,888	1,063,534,000	1,018,956,698
ICN Share	20,762,600	32,536,255	234,817,375	338,659,292	483,522,086	509,967,486
Other allocations	275,091,960	275,705,809	445,986,735	502,428,311	397,434,000	393,716,219
BUDGETS TERRITORIAL ENTITIES	**282,845,614**	**500,692,847**	**685,356,948**	**625,163,299**	**678,990,766**	**868,792,587**
Departmental	282,845,614	368,530,748	438,315,828	361,704,214	345,511,000	413,575,438
Municipal		132,162,099	247,041,120	263,459,085	333,479,766	455,217,149
TOTAL RESOURCES		**4,685,878,985**	**6,147,752,698**	**7,632,908,675**	**8,696,392,505**	**8,656,197,844**
USES						
ADMINISTRATION	**207,928,897**	**997,259,737**	**1,189,943,715**	**1,225,148,163**	**1,410,109,045**	**1,331,725,777**
Personnel services	162,935,216	613,933,289	827,811,475	859,974,462	952,545,525	660,555,104
General expenditures	44,993,681	383,326,448	362,132,240	365,173,701	457,563,520	671,170,673
INVESTMENT	**125,605,600**	**276,787,255**	**163,413,206**	**242,429,612**	**154,307,951**	**134,807,770**
Infrastructure and equipment	125,605,600	276,787,255	163,413,206	242,429,612	154,307,951	134,807,770
HEALTH CARE	**899,433,619**	**2,471,251,617**	**4,131,106,579**	**5,003,264,316**	**5,686,170,123**	**6,310,464,465**
Outpatient	555,284,140	1,471,462,726	2,370,917,727	2,918,974,102	3,215,509,863	4,029,869,757
Hospital	172,616,764	590,572,042	1,045,967,125	1,443,587,038	1,678,847,425	1,623,675,395
Promotion and prevention	106,424,703	238,983,449	434,149,027	567,720,817	640,317,517	502,693,768
Basic health plan (PAB)	65,108,012	170,233,400	280,072,700	72,982,359	151,495,318	154,225,545
OTHER USES	**369,208,496**	**940,580,375**	**663,289,199**	**1,162,066,584**	**1,445,805,386**	**879,200,831**
TOTAL USES	#########	**4,685,878,984**	**6,147,752,699**	**7,632,908,675**	**8,696,392,505**	**8,656,198,843**

Source: Study of the financial balance of the SGSSS.2001

***Insurance*:** Social security coverage of 53.76% was attained in the year 2000. The subsidized system covers every *municipio* in the country through 214 ARS, bringing insurance to 9,510,566 people in the poorest sectors of the population, or 59.79% of the goal set for the quadrennium. The contributory system has 14,409,131 beneficiaries. The National Health Authority exercises budgetary and financial control over participating entities and monitors, ensuring compliance with the essential requirements of public

and private IPS and the appropriate use of financial resources by public and private insurers and system IPS. It is supported in these functions by the system's territorial entities.

2.4 Service Delivery

Population-based Health Services: The public benefits package is furnished by the Basic Health Plan (PAB) through health promotion and disease prevention activities. The SGSSS advanced mainly in regulation of the contents of the PAB, defining the Plan's specific areas of action in health promotion, disease prevention, and surveillance in public health; territorial authority; and the mechanisms for access to resources and their distribution, allocation, and administration. In 2000, the 32 departments and 4 districts had commenced activities under the Plan, and 10 departments were proceeding with technical assistance to *municipios* for preparation of the municipal PAB as well as with instruments and mechanisms for monitoring and surveillance of the municipal PAB. As a result of the PAB, surveillance and timely control of epidemics have improved and the warning system of the epidemiological surveillance network has been expanded, with a total of 1,200 reporting units in public and private IPS.

The PAB is a compulsory territorial plan that is provided free of charge and is the responsibility of the State under the authority of the *municipios*[23]. The environment and sanitation program is executed within this framework, along with some actions in food and nutrition for the prevention and control of micronutrient deficiencies, especially vitamin A, iron, and iodine. The PAB also includes interventions in the areas of public information, education, health promotion, control of tobacco and alcohol use and psychoactive substance abuse, nutritional supplementation, family planning, disparasitization of schoolchildren, vector control, and national campaigns for the prevention, early detection, and control of communicable diseases such as AIDS, tuberculosis, and leprosy, as well as tropical diseases such as malaria. It is guaranteed with national and territorial financial resources.

The individual package of benefits (under the contributory and subsidized systems) includes actions for early detection of cervical and breast cancer. The beneficiary population for cervical cancer screening consists of women between the ages of 25 and 69 or sexually-active women under 25 who are affiliated with the System, and for breast cancer screening, women over 50 years of age who are affiliated with the contributory and subsidized systems. These standards are promulgated in Ministry of Health Resolution 412/2000, which includes additional preventive interventions for the beneficiary population (visual acuity, precancerous lesions, domestic violence, hypertension, diabetes, and others). However, these interventions are not mandatory for private insurers and providers.

Health Services for Individuals: Law 100 established a scenario in which health service delivery is the responsibility of a series of public and private entities that compete for users in urban and rural settings, granting users free choice and promoting competition among EPS and IPS[24]. Law 100 required that public

hospitals become State social enterprises (decentralized autonomous public entities). Because the State is the sole provider of services in many locations and market conditions are unknown, some actors in institutions, territorial entities, academia, and civil society are reluctant to introduce intermediaries and demand subsidies into certain territorial situations[25]. Furthermore, the public IPS serve the unaffiliated population without receiving payment for the entire amount owed them[26] given the current public fiscal crisis. The EPS are the basic organizational unit of the SGSSS. Their function is to organize and directly or indirectly guarantee the delivery of the POS to beneficiaries, and to bill the FOSYGA for the difference between the income from subscriber premiums and the value of the corresponding Capitation Payment Units (UPC). The EPS are also responsible for organizing supplemental health plans. They offer their subscribers and beneficiaries a variety of alternative service providers to allow free choice, although this has been distorted, because the selection alternatives have been limited, in some cases, to the IPS organized by the insurer to cut POS production costs and increase profits. Sectoral Reform gave system institutions autonomy in the management of information on service delivery; this has had a negative impact on health information and surveillance systems, even though the Ministry of Health has established a series of basic indicators that must be reported. The Ministry has also prepared a uniform national list of procedures to facilitate the administrative processes for collections (RIIPS).

Primary Care Level: Nominal system coverage in 2000 is 53.76% (9.5 million in the subsidized system and 14.4 million in the contributory system)[27]. System affiliation is assumed to be synonymous with access to primary care levels, although this is not necessarily the case, since a beneficiary may not have regular access to health services for a number of reasons. Nevertheless, the key actors in the system (Ministry of Health, territorial entities, human resources training and research facilities, as well as Colombian civil society) consider primary health care to have deteriorated in the country[28]. House calls by health workers nearly always result from initiatives by insurers to offer inexpensive health care, with a lack of continuity in care at other levels of the system; this limits access to more complex and costly health care modalities. The five leading causes for outpatient consultation in all age groups in 2000 were, in descending order: acute respiratory infections, all other infectious parasitic diseases, diseases of the teeth and skeletal structures, diseases of the skin and subcutaneous tissue, and other diseases of the genital organs.

***Secondary Care Level*:** Many hospitals with more than 50 beds have computerized information systems to assist with administrative and clinical management. A government effort is underway to implement the RIIPS (Individual Registry of Health Service Delivery), but to date, the processing of this information is unreliable, and current data on service delivery does not exist for any level of care. The use of information for clinical management has been spearheaded mainly by private hospitals in the cities of Bogotá, Medellín, and Cali.

In 1997, the five leading causes of hospital discharge in all age groups and sectors were, in descending order: normal childbirth, complications of labor, other problems in childbirth, complications of pregnancy, and pregnancy ending in abortion. A survey conducted by the Ministry of Health involving 151 secondary- and tertiary-level, mental, and pediatric hospitals yielded the following indicators for 1997: total number of discharges, 1,060; and occupancy rate, 76%.

***Technical Quality*:** Sectoral reform has sparked interest in quality programs. To this end, the Ministry of Health and the National Health Authority have developed quality standards in clinical and administrative services. These efforts have been supported by professional associations, such as the Center for Hospital Management and the Colombian Association of Clinics and Hospitals, and by individual providers, as in the case of the Social Security Institute (ISS) and the Family Compensation Funds (CCF). According to the Ministry of Health, 16,653 and the National Health Authority, 18,767 health institutions have met the basic requirements, including outpatient facilities, clinical laboratories, and physiotherapy centers. The Ministry of Health prepared guidelines and standards of care for priority national health problems, which were included in Resolution 412. Other system entities, such as the Social Security Institute, have developed evidence-based treatment protocols[29] that have been implemented in several insurance facilities and other institutions in the country.

***Perceived quality*:** The Office of the Public Defender conducted the "National Survey of Quality in Health as Perceived by Users", whose results are discussed in the section on Results.

3. MONITORING AND EVALUATION OF SECTORAL REFORM

3.1 Monitoring the Process.

Monitoring the Dynamics. The General Social Security System was created as a result of the confluence of Law 10/1990, the Political Constitution of 1991, Law 60/1993, and Law 100/1993. Accordingly, Sectoral reform is the product of State restructuring. The process was spearheaded by the Ministries of Health and Labor, with support from the National Planning Department (DNP) and the endorsement of Commissions VII of the Senate and House. A number of groups with an interest in health and pensions participated in its formulation. The studies were financed by these groups, international banking institutions (loans from the World Bank and IDB), and committed public institutions. The Health System Reform includes three different and complementary goals: decentralization in 1990, decentralization of authority and resources in 1993, and organizational financial restructuring with separation of functions and regulated competition for insurance and providers.

The new system was based on[30] the division between personal and population-based health services, with the former controlled by market principles with regulated competition and the latter managed by the State.

The structure of individual services followed the principles of the insurance market and incorporated aspects of the "managed competition" model. Compulsory insurance was proposed, as was the establishment of a single fund to amass resources (Solidarity and Guaranty Fund), the requirement of a basic benefits plan (Compulsory Health Plan), and the *capitation* payment of insurers with adjustment for risks (Capitation Payment Unit). The administration of insurance was separated from the delivery of services, and public and private institutions were expected to come together in a competitive environment. The State had to regulate the actors in the market and monitor their behavior, in addition to granting demand subsidies for the extremely poor. Transformation of the public sector began, moving from a supply subsidy to a demand subsidy; efforts were made to bring the poor into the insurance market through a direct subsidy. The coexistence of the contributory and subsidized systems was proposed, the former with a benefits plan for those able to pay and the latter offering 70% of the benefits[31] for those unable to pay. A package of services for catastrophic illnesses is financed with special funds[32], and the population with the ability to pay also subscribes to "supplemental plans." The population linked to the old public sector would subscribe to one of the two systems.

Goals, dates, and responsibilities were established for the three dimensions of the reform, but as of 2001, the country's political, economic, and social situation, as well as the complex and varied realities faced by the relevant institutions, have made it impossible to meet the goals of certifying decentralized *municipios* and expanding system affiliation.

Monitoring the Contents

***Legal Framework*:** The complexity of the system model has required that the regulations be adapted to reality, especially in areas relating to increased coverage, basic packages of services, health promotion, disease prevention, and financing. These legal frameworks continue to be supervised and evaluated by the various responsible entities, such as the Comissions VII of the Senate and House of Representatives. There is currently a heated debate going on in Congress about Law 100, focusing on its positive aspects and weaknesses in terms of achieving universal health coverage. Special attention has been focused on the economic and administrative aspects of the financial flows and balances of the health system, expanding coverage of the subsidized system, the crisis in public hospitals, administrative inefficiency, and equity, and their impact on the health situation.

***Right to Health Care and Insurance*:** The system currently covers 13,245,465 beneficiaries of the contributory system (or 31.3% of the population) and 9,510,566 beneficiaries of the subsidized system (or 22.47% of the population), for a total of 22,756,031 beneficiaries, or 53.76% of the population.[33]

***Steering Role*:** The essential public health functions were evaluated in September 2001, and the critical areas and institutional weaknesses of the General Social Security System in exercising its functions as the national health authority were identified. The SGSSS is accountable not only to the National Social Security Health Board, but also to the Congress of the Republic through reports submitted by the Ministry of Health in June of each year. Management information systems are a weak area, prompting the Ministry of Health to develop the Integrated Health Information System (SIIS) to process epidemiological data and data on health service production, financing, and human, material, and technology resources, making the use of health resources more efficient, effective, and equitable. The responsibility for policy-making and planning in the area of human resources was abandoned more than a decade ago; there has been no direction or management of human resources education in health for two years. Currently, a proposed Human Resources Development Plan, to be implemented by the health authority, is moving forward with the support of a loan from the IDB. Certification by the National Accreditation Board under the Ministry of Education applies only to professional education and voluntary under the Higher Education Law. The basic requirements in nursing, medicine, and dentistry have been defined slowly. Ministry of Health regulations govern the accreditation of health facilities,[34] which must meet the basic requirements established in 1995. The territorial health entities and the National Health Authority are responsible for monitoring fulfillment of these requirements; however, the Authority has neither sufficient resources nor the territorial representation necessary to meet this obligation, leaving accreditation inadequately supervised.

Decentralization Modalities: The current Colombian model transfers technical, administrative, and much of the financial responsibility to the territorial entities (Departments and *municipios*). The health structures are fully consistent with the political-administrative decentralization of the Colombian State. As of May 1999, the functions of 407 *municipios* in 20 Departments (or 37.9% of the *municipios*) had been decentralized. There are 693 small *municipios* that are limited by scale in their capacity to solve health problems without entering into partnerships with other *municipios* or the Department. The health facilities tend to operate in isolation, rather than networking. The decentralization of local and intermediate health systems resulted in autonomy, but the transfer of responsibilities and financial and technology resources was not accompanied by adequate management capacity. Lack of adequate knowledge and skills has been noted in the direction and management of networks in the territorial health systems, as well as weakness in the capacity to negotiate and coordinate performance commitments. The deterioration in the national health authority's ability to perform the essential public health functions creates a problem for health system coordination.

The decentralization of health as a function of the market is not always consistent with the country's political administrative structure, which is an obstacle to harmonizing the principles of democracy and

participation (based on *municipios* and Departments), epidemiology (based on population spaces), and services (based on articulated technology levels and economies of scale) with market principles (economic profitability). The EPS enhance their institutional net worth by adding new IPS to contain costs rather than meet needs. Some local levels have sought to restore the direction and management of health at the municipal and Departmental levels to promote processes based on primary health care, the complementarity of limited resources, health surveillance, patient referral and counterreferral, comprehensive health care, active social participation, and interaction between the health team and the community interaction. These processes have not been supported by the national health authority, and many difficulties have been encountered in their implementation.

***Social Participation and Control*:** Health service delivery is monitored by popularly-elected community oversight committees. When a subscriber encounters problems in health service delivery, he may file a complaint with the technical and scientific committee of the health institution with which he is affiliated or, in its absence, with the National Health Authority. Regulatory Decree 1757/1994 outlines the different forms of participation for citizens and users, such as the formation of EPS and IPS users' associations. Through legal advocacy groups (established in the Constitution of 1991), members of the public may file claims against providers and insurers before the constitutional court for health services not included in their benefits plan, which may be won based on right-to-life principles. It is important to note that the active mechanisms for participation in Colombia are mainly representative and nonparticipatory, with the exception of users' associations. These have minimal authority in practice, since they are limited to public EPS and IPS and exclude the private institutions[35].

Financing and Expenditure: The available information shows that the total expenditure of the nonfinancial public sector rose between 1994 and 2001. Income growth was concentrated basically in Social Security (increasing from 2.9% of GDP to 6.0%) and in the territorial public sector (increasing from 4.6 % of GDP to 8.3%). With regard to the financing of the operating system under Law 715/2001, financing from the *municipios* represents 24.5% of the total amount of the General System of Shares and is intended to support the population affiliated with the subsidized system, health service delivery for the unaffiliated poor, and public health actions. Other resources come from the income ceded by the National Government to the Departments, resources from ECOSALUD (gambling taxes, lotteries, etc.), the voluntary contributions of *municipios* and Departments, a share of the royalties from new oil wells, contributions from the Family Compensation Fund (CCF), the social VAT, the tax on firearms and munitions, and the copayments and deductibles of subscribers and their beneficiaries. In the year 2000, 7.7% of the national budget was allocated to health. In 1999, Colombians allocated 10% of GDP to health, of which 5.5% was public and 4.5% private expenditure[36,37]. Of the latter, approximately 40%

went for drugs, 14% for outpatient consultations, 20% for hospitalization, 5% for diagnostic tests, and 20% for other items. A challenge for the financial balance of the System is reducing contribution evasion: the EPS have no interest whatsoever in monitoring underpayment by higher-income subscribers, who accordingly will tend to declare lower income than they actually receive. The information systems on financing and expenditure are being improved to prevent the evasion of contributions to the SGSSS and to make the sector transparent in an effort to fight waste and corruption with respect to system funds.

Supply of Services: The SGSSS has created new modalities of health care to expand service coverage. However, the referral and counterreferral processes were omitted from all planning and thus have been greatly hindered. Furthermore, the insurers created their own networks (vertical integration), which duplicated infrastructure in some areas and consolidated gaps in care in others. In some cases, vertical integration has provided an answer to the absence of adequate service supply. As to the supply of services, the model has ensured that the system operates on the basis of demand. Only care of the "linked" population functions through supply, which is usually provided through the ESE. The system also permits the targeting of actions to vulnerable groups through the System for the Identification of Beneficiaries (SISBEN), used to select the beneficiaries of the subsidized system. As a complement to the SISBEN, activities are also targeted to vulnerable groups, such as the elderly, children, victims of emergencies and disasters, etc.

Management Model: The EPS may be public, private, collective, or mixed, and thus compete for subscribers. Their essential function is risk management (guaranteeing the POS to their beneficiaries) and the organization and administration of health service delivery. Under Law 100, the Social Security Institute (ISS) will continue to exercise its functions as insurer and provider. The public sector social security funds and entities that provided health services or covered their members against the risks of general illness and maternity prior to the date Law 100 went into effect had two years to become health promoting enterprises, adapt to the new system, or go out of business. The reality, however, is different, as special systems have been established outside the SGSSS. Subscribers are authorized to organize for community oversight activities, group membership, and even the collective administration of health resources for the beneficiaries of membership subsidies.

Human Resources: The critical points in human resources development and the need for coordination with the education sector have been noted previously. However, thus far the initiatives have come autonomously and haphazardly from the education sector and have been characterized by the proliferation of educational institutions and programs, with no concern for their relevance or the subsequent employment opportunities they offer to graduates. A number of universities have instituted curriculum reforms to adapt their

programs to the new needs, but this has been done without coordination with employers. Continuing education has been weakened and some emerging needs, such as surveillance in public health, information systems, municipal management, and complex emergencies, require spatial attention. After a lengthy and difficult process, draft legislation has been submitted to regulate the practice of medicine and its specialties and replace a law that has been effect for 40 years.

In human resources planning and management, only isolated and uncoordinated actions appear to have been taken, determined more by the fiscal situation than authentic planning. Nevertheless, there have been some isolated successes in several regions such as Risaralda, Pasto, and the Special District of Bogotá. The private sector has made greater progress in management and planning.

Incentives are theoretically in place to improve the performance of personnel; however, they have not been applied, or the criteria have centered on the completion of specific tasks rather than the achievement of impact and teamwork. There has been greater progress in this direction in several private enterprises. The functions of general practitioners have been reclassified, with the expectation that they will exhibit a high degree of skill at problem-solving at low-tech care levels. The decentralization and reorganization of the hospital functions have caused uncertainty regarding the place of some traditional health workers in the health structure; for example, health promoters used to be hired by the hospitals but must now be hired by the municipal authorities. The occupational profile of the environmental health promoter has been redefined.

Continuing education in health has been implemented in recent years. Institutions of higher education or technical training in the field of health have been involved in this process in 13 Departments, with a view to forming intersectoral facilitator teams and stimulating the educational institutions' commitment to the development and implementation of programs. Professional accreditation is issued by the educational institutions. The country has no professional certification boards. On completing their university studies and receiving their degree, health professionals obtain provisional professional licenses from the health authority. This allows them to practice their professions with some restrictions while they fulfill their compulsory social service requirement. Once they have completed their service, they must obtain their definitive license in order to practice their profession independently. A registry of specialists has not yet been created. For some technical and auxiliary workers, there is still no compulsory registration with the health authorities; they are allowed to practice simply by presenting their academic credentials.

***Quality and Health Technology Assessment*:** A process to improve accreditation and quality assurance programs has been in place since 1990, supported by Decree 2174 establishing the Compulsory Quality Assurance System. Resolution 4242 of 1997 lays down the basic requirements for institutional health service providers. Health technology assessment has been strengthened by the activities of the Bureau of Science and Technology Development of the Ministry of Health; this office was eliminated with the

restructuring of the Ministry and its functions incorporated into the Bureau of Sectoral Planning and Analysis. Resolution 5039 of 1994 legislated on the importation and assessment of health technology.

3.2. Evaluation of Results

***Equity and Coverage*:** In the period 1993-2000, system coverage increased significantly from 22% in 1993 to 53.76% in 2000. Some 47.6% of the non-poor population is covered by the contributory system, 13.7% by the subsidized system, and 38.5% is unaffiliated. These figures are troubling, since there are at least 4 million subsidized beneficiaries among the non-poor. Furthermore, 35% of the poor population is covered by the subsidized system, while 10.7% is covered by the contributory system and 53.9% is unaffiliated.[38]

***In the Distribution of Resources*:** There are several different sources of information on the distribution of human, material, technology, and financial resources[39] within the Colombian health system. In the case of financial resources, the most reliable and current source is the National Planning Department (DNP), which has conducted studies of the national health accounts. The figures presented below are the most recent taken from the DNP and PAHO's Basic Health Indicators 2001.

Health System Resources, 1999-2001

Total Per Capita Expenditure in Health $ US (1)	216.83
Per Capita Public Expenditure in Health $ US (1)	126.61
Physicians per 10,000 population	9.3
Nurses per 10,000 population	4.3
Hospital beds per 1,000 inhabitants	1.5

Source: (1) DNP, 1999. Basic Health Indicators, 2001. PAHO

In Access: *Municipios* with lower levels of socioeconomic development and a higher prevalence of unmet basic needs are those with the highest percentages of deaths without diagnosis (or from ill-defined causes) as a result of inequities in access to health services, in contrast to the *municipios* with higher levels of development, where institutionally-certified mortality is more prevalent. Moreover, an analysis of the correlation between poverty and coverage by the subsidized system shows that of the 16 Departments with more than 50% of the population with unmet basic needs, only five have an affiliated population above the national median (40% of their poor population).[40] There are also problems with the affiliation of the poor; for example, half of those insured by the subsidized system are non-poor families, leading to doubt about the reasonable application of targeting criteria in the SGSSS.[41] In 1998, 8.5 million people were affiliated with the subsidized system and 16.6 million with the contributory system.[42] Insurance coverage increased until 1998, when it began to decline in the contributory system. The data may be interpreted as follows: those who were able to pay continued to do so, either through the contributory

system or prepaid medical plans, while only 9.7% of the poor (defined as the population with unmet basic needs) were covered.[43] On the other hand, the assumption that the number of registered beneficiaries represents actual coverage has been called into question. In fact, under the contributory system, the EPS are compensated by the FOSYGA for only 12.3 million people.[44] This means that, although more than 16 million people were registered in the system, 4 million of them stopped contributing or were dropped from the database of people for whom the EPS can collect Capitation Payment Units, making actual coverage much lower than indicated by the number of beneficiaries.

EVOLUTION OF CONTRIBUTORY SYSTEM MEMBERS

Year	Subscribers	Beneficiaries	Total	Dependent Family Members
1996	6,632,429	7,095,868	13,728,297	2.07
1997	6,991,962	7,977,316	14,969,278	2.14
1998	5,865,123	10,225,601	16,090,724	2.74
1999	5,631,268	8,021,610	13,652,878	2.42
2000*	5,363,181	7,882,656	13,245.836	2.47

Source: Resolution 2390 of 1998 and Circular Letter 2, DGSS, for Dec./99. * For the year 2000, information on compensated subscribers reported by FISALUD was used. The figures for beneficiaries are additional.

CONTRIBUTORY SYSTEM MEMBERS IN EPS OTHER THAN THE ISS (PRIVATE AND PUBLIC)

Year	Subscribers	Beneficiaries	Total	D. Family Member
1995	425,685	682,905	1,108,590	2.60
1996	988,000	1,578,900	2,566,900	2.60
1997	1,959,019	3,288,094	5,247,113	2.68
1998	2,101,454	3,420,380	5,521,834	2.63
1999	3,280,906	5,319,229	8,600,135	2.62
2000*	3,111,600	4,972,658	8,084,257	2.60

Source: Resolution 2390 of 1998 and Circular Letter 2, DGSS, Dec/99. * For the year 2000, information on compensated subscribers reported by FISALUD was used. Information on the ISS or adapted entities is not included. The figures for beneficiaries are additional.

Allocation of Resources: The Health System Reform appears to have substantially increased the financial resources available to the sector. This has ignited a major polemic, since under the system financial flows are mediated by the EPS, ARS, and ARP, which has led to serious problems related to high management costs and the sluggish flow of these resources. Sectoral Reform has had a positive impact in terms of the reallocation of resources, strengthening health promotion and disease prevention actions through the PAB.

Unfortunately, those resources have not been utilized effectively and efficiently because of problems related to the management capacity of the territorial entities, weak supervision and control, outsourcing of promotion and prevention services, local political influences, and other factors.

SOURCES AND USES OF SYSTEM RESOURCES

(thousands of current pesos)

	1995	1996	1997	1998	1999	2000
SOURCES						
FAMILIES	73,499,707	1,548,400,587	1,156,910,377	1,444,369,515	1,796,875,643	1,857,677,803
COMPANIES	120,373,465	366,318,471	1,462,876,748	1,622,163,710	2,145,565,345	2,313,991,839
GENERAL NATIONAL BUDGET (P.G.N.)	**801,115,398**	**1,021,864,209**	**1,493,837,849**	**1,820,845,591**	**1,987,408,522**	**1,982,937,404**
BUDGETS TERRITORIAL ENTITIES	**282,845,614**	**500,692,847**	**685,356,948**	**625,163,299**	**678,990,766**	**868,792,587**
Departmental	282,845,614	368,530,748	438,315,828	361,704,214	345,511,000	413,575,438
Municipal		132,162,099	247,041,120	263,459,085	333,479,766	455,217,149
TOTAL RESOURCES	#########	**4,685,878,985**	**6,147,752,698**	**7,632,908,675**	**8,696,392,505**	**8,656,197,844**
USES						
ADMINISTRATION	**207,928,897**	**997,259,737**	**1,189,943,715**	**1,225,148,163**	**1,410,109,045**	**1,331,725,777**
Personnel services	162,935,216	613,933,289	827,811,475	859,974,462	952,545,525	660,555,104
General expenditures	44,993,68	383,326,448	362,132,240	365,173,701	457,563,520	671,170,673
INVESTMENT	**125,605,600**	**276,787,255**	**163,413,206**	**242,429,612**	**154,307,951**	**134,807,770**
Infrastructure and equipment	125,605,600	276,787,255	163,413,206	242,429,612	154,307,951	134,807,770
HEALTH CARE	**899,433,619**	**2,471,251,617**	**4,131,106,579**	**5,003,264,316**	**5,686,170,123**	**6,310,464,465**
Outpatient	555,284,140	1,471,462,726	2,370,917,727	2,918,974,102	3,215,509,863	4,029,869,757
Hospital	172,616,764	590,572,042	1,045,967,125	1,443,587,038	1,678,847,425	1,623,675,395
Promotion and prevention	106,424,703	238,983,449	434,149,027	567,720,817	640,317,517	502,693,768
Basic health plan (PAB)	65,108,012	170,233,400	280,072,700	72,982,359	151,495,318	154,225,545
OTHER USES	**369,208,496**	**940,580,375**	**663,289,199**	**1,162,066,584**	**1,445,805,386**	**879,200,831**
TOTAL USES	#########	**4,685,878,984**	**6,147,752,699**	**7,632,908,675**	**8,696,392,505**	**8,656,198,843**

Sources: Study of the financial balance of the SGSSS.2001

***Management of Resources*:** In the initial implementation phase of the Health Sector Reform, there was an expansion in infrastructure and equipment, chiefly in the private sector. Public institutions at the secondary and tertiary levels of care received support from the hospital improvement program (through an external loan) to upgrade their equipment and management (benefiting 140 secondary- and 31 tertiary-level hospitals). With regard to management commitments, a total of 413 institutions have been converted to ESEs to date.

Effectiveness and Quality: Technical norms and quality standards were established under the Compulsory Quality Assurance System (Decree 2174/1996): basic requirements, the design and execution of a quality improvement plan, and medical audits. A number of decrees and resolutions were issued to measure the level of user satisfaction and the response to complaints and suggestions: Resolution 03165/1996, on health care for disabled and handicapped persons; Decree 2240 and Resolutions 4445 and 5042 of 1996, on basic requirements for the health services infrastructure; and other legal measures such as manuals on scientific, technical, and administrative standards, blood banks, information, and care for users.

Technical Quality: No systematic effort has been made to monitor institutional quality processes, although isolated examples of high-quality care exist, particularly in institutions that provide highly complex care. Legislation requires institutions to establish nosocomial infection committees, but hospital quality evaluation committees are not operating systematically, nor are they evaluated or supervised periodically by the territorial entities or Ministry of Health. Medical ethics committees have been formed at the territorial level.

Perceived Quality: According to the results of the National Health Survey, 67.4% of Colombians consider their health to be very good or good and 32.6% moderate or poor. Among the members of a health services system, 13.1% consider their health to be very good, compared to 9.5% of the unaffiliated population. 46% of subscribers consulted a physician or dentist each year for preventive check-ups, compared to only 32.1% of the unaffiliated population, with hospitalization rates of 8.4% for the former and 5.3% for the latter. Some 72.1% of subscribers with chronic illnesses make periodic visits to a physician, as opposed to 55.6% of the "linked" population. A greater proportion (80.7%) of subscribers visits health facilities than nonsubscribers (66.9%).

In the year 2000, the Office of the Public Defender[45] conducted the "National Survey of Quality in Health as Perceived by Users" with a stratified, multistage representative sampling of all *municipios*, in which 2,365 users participated. The following results were reported: (i) 1,628 users are affiliated with some system and 737 do not have any type of affiliation; (ii) 75.3% consulted a general practitioner and 24.7% did not. Of those who did, 4.1% were not examined and 95.9% were; 63.6% were given laboratory tests and 78.2% were prescribed drugs; (iii) the number of days between the appointment request and the consultation: 42.7% of consultations occurred on the first day, 8.7% the following day, and 6% on the third day; (iv) general consultations: 91.4% of those surveyed indicate that their clinical history was taken, 80.4% had the nature of their medical problems explained to them, and a change in lifestyle was recommended for 52% of them; (v) on a scale of 1 to five, the quality of care in terms of treatment, facilities, and information was rated as follows: 36.5% of respondents rated general care at 4 and 34.9% at 5; 7.6% of the ratings were below 3; (vi) specialized medical service: 42.5% of respondents were able to choose their specialist, while the remaining 57.5% were not. Of these, 81% would return to the same specialist; 8.3% would not; and 10.7% did not respond. A full 49% rate the services of specialists at 5 and 27.6% at 4; (vii) perception of health entities: 88.5% of the affiliated users who responded to the survey report that the institution has made access easier for them. Some 18.55% of the affiliated population have considered changing health institutions, and 81.5% have not. The primary reason given for changing institutions was poor service (33.9%), followed by lack of reliability of or dissatisfaction with care provided (29.4%), and delays in care (9.1%). Some aspects of the professional relationship with users are troubling, for example the fact that clinical histories are not taken for all people; or that one fifth of all

users leave the consultation without being told the nature of their medical problem; or that half leave the services without obtaining adequate information; or that the promotion and prevention services are the most negatively perceived of all. The survey results belie the operational, credibility, and legitimacy crisis in the health system.

Sustainability: The financial sustainability of the system has been threatened by the country's economic crisis[46], the evasion of contributions by beneficiaries, corruption in the management of certain administrative institutions of the subsidized system, and the inaccuracy of the economic predictions of 1993 on which the financing of expanded coverage was based (for example, income from oil production and the privatization of certain State investments). The main difficulty is with financial stability. The macroeconomic projections made in 1993 were not met: the recession and the expansion of unemployment, underemployment, and the informal job sector, added to the fiscal crisis, frustrated attempts at universal coverage and threaten the financial future of the system. Although coverage in the contributory system has been maintained, the numbers of subscribers and income-based wage premiums have declined, increasing the number of dependent beneficiaries and family density. This makes the system unsustainable[47].

There are major difficulties in financing health care for the poor and vulnerable population: first, because the reduction in the number of subscribers and income-based wage premiums has reduced the collective contribution (1 peso out of every 12 pesos paid by a subscriber to the contributory system is allocated to financing the subsidized system); second, because of the difficulty in ensuring timely management of "semifiscal" resources (income from the support contribution and the Family Compensation Funds, when they decide not to administer the subsidized system directly), since these resources are passed on to the General National Budget, with the rigidities and delays that this implies; and third, because of the reduction and delay in the State's *pari passu* contribution since 1995[48]. Furthermore, financing of "catastrophic" or high-cost events (cancer, chronic renal insufficiency, AIDS, and organ transplants) threatens the financial stability of the FOSYGA and several EPS, such as the ISS, in which most of these risks are concentrated. Also threatened is the financial stability of important Administrators of the Subsidized System (ARS), such as the Family Compensation Funds and Departmental and District Funds, which are responsible for treating these events among the poor not affiliated with the SGSSS. This situation is exacerbated by the impact of legal advocacy groups, which have pushed many hospital facilities of high complexity to the brink of closure, as they are unable to collect for the services provided, and have caused Departments and Districts without the resources for specialized care to execute their annual budget in only seven months. Furthermore, service providers do not diagnose or register occupational illnesses, which further exacerbate the financial crisis of the Health System, as the

Occupational Hazards System does not assume responsibility in these cases. There are also difficulties in recognizing the causality of occupational illnesses, which makes payment by the Occupational Hazards Administrators uncertain and creates a disincentive for the providers to report these events accurately. The most serious consequence of this situation is that workers lose economic benefits if they become unemployed due to disability.

The special systems created under Law 100 have contributed to an imbalance in the compensation account. For example, the public university health system has kept over 10,000 million pesos from being contributed to the compensation subaccount of the FOSYGA this year. If no special systems existed, the SGSSS would be more collective and universal and the contributory system would be more profitable, guaranteeing the financial sustainability of the system, since the average system density has declined to 2.0 current monthly minimum wages per subscriber and the special systems have a wage density of over 4.0.

Despite CNSSS and Ministry of Health management, an obstacle to the flow of resources toward the Subsidized System have limited effective access by the population to services and has caused the greatest public hospital crisis in the country's history. In short, although total expenditure and public spending in health have increased, compensation costs continue to be insufficient to achieve the goal of the law: "universal coverage and equality in the Compulsory Health Plans[49]."

Social Participation: No in-depth studies have been conducted to verify the effects of sectoral reform on social participation in health. Law 100 provided for the creation of citizen oversight mechanisms, users' associations, and social health enterprises to increase citizen participation in the evaluation of health activities and the overall social control of management. The community is represented on every ESE governing board, as well as at the different levels of system management, up to the CNSSSS. The ESS encountered serious difficulties in their economic viability, since they were not able to manage risk adequately due to population numbers. The financial difficulties of the SGSSS have severely reduced the possibilities of social participation that were conceived for the system.

* The second edition of the profile was prepared by a group of 40 professionals and national policymakers from the Ministry of Health, the National Health Institute, the National Institute for Drug and Food Surveillance (INVIMA), the National Health Authority, the National Administrative Department of Statistics, the National Planning Department, the National University, Javeriana University, the University of Antioquia, and PAHO/WHO. Technical coordination of the national group was the responsibility of the PAHO/WHO Representative Office in Colombia. The external review was commissioned to the Foundation for the Development of Health Education in Colombia (FUNDESCO). Final review, editing, and translation are the responsibility of the Program on Organization and Management of Health Systems and Services of the PAHO/WHO Division of Health Systems and Services Development.

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