

REACHING THE POOR WITH HEALTH SERVICES

2007

Colombia

Using Proxy-Means Testing to Expand Health Insurance for the Poor

Colombia's poor now stand a chance of holding off financial catastrophe when felled by serious illness. Sweeping health sector reform in 1993 brought health insurance to people never before covered. It used a proxy-means testing instrument, known as System for Selecting Beneficiaries of Social Spending (SISBEN, in Spanish) to assess the living conditions of individual families for targeting the poor people.

A Health System Built on Myths Pre-1993

Before the 1993 reform, although the Ministry of Health (MOH) was responsible by constitutional mandate for providing all Colombians with health care, inefficiency, badly targeted public subsidies, and fragmented markets were endemic. In reality, only one Colombian in five had any protection against the financial risk of health shocks due to serious illness, and only the better-off could afford to join social security schemes or pay out of pocket for health care.

Colombia's shaky health system was built on myths. Policy makers believed that Colombia's public health was well targeted to the poor; that public health services were free to all comers, but especially the poor; and that the poor did not have to go to private providers for health care. Public funds from the Treasury, raised through general taxation, supported a large network of public hospitals and clinics. In fact, a significant part of health care financing came from households spending out-of-pocket, and insufficient and inefficient social security schemes provided the rest. Faced with illness, the poor had three choices: i) to try to get treatment from public health services; ii) to pay private providers, or iii) to go without any medical care. Left with self-care as a last resort, the poor and less educated were at greater risk than the better off because quality control in the pharmaceutical

market is lax and medicine can be bought without a prescription in Colombia.

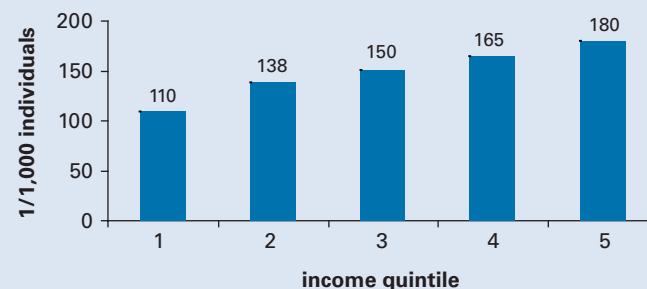
Differences between Rich and Poor

Cost was the most important barrier to health care before the 1993 reform (Figure 1). In the poorest group, quintile 1, only one individual in six who fell ill in 1992 sought medical care. The poor had less access to health care than the rich, paid out-of-pocket for public, as well as private health care services, and paid proportionately more of their income for any services they received.

The governmental health care delivery network did not serve the poor well, leaving already impoverished sick people with huge medical bills and the likelihood of abject poverty from which they couldn't recover.

The Colombian health care system before the 1993 reform allocated public subsidies directly to hospitals, rather than the users. Of patients treated in the public hospitals, only 20 per-

Figure 1. Individuals Obtaining a Medical Consultation in Month Preceding Interview



Source: Escobar 2005



cent came from the poorest income group and almost 60 percent from the upper- and middle-income groups (Figure 2). In 1992, 12 percent of hospitalizations and 20 percent of all surgeries done in the public sector were received by patients in the richest 20 percent of the population. Thus, middle- and higher-income individuals who could afford to use other private hospitals and medical services were crowding out the poor from public facilities. More importantly, the poor who could get into public hospitals more often incurred out-of-pocket expenses than did middle- and upper-income patients often covered by private insurance. Rarely did the poor receive free care in public facilities. In fact, 91 percent of the poorest inpatients incurred out-of-pocket expenses, while only 69 percent in the richest quintile did so.

The private sector was important in both financing and delivering health services before the reform. According to the government's National Household Survey in 1992, 40 percent of all health interventions and 45 percent of all hospitalizations were done in the private sector. At that time, only 20 percent of the Colombian population had health insurance.

The 1993 Health Sector Reform

Law 100 of 1993 mandated the creation of a new national health care system with universal health insurance coverage and reorganized financing and delivery. Public subsidies would henceforth go directly to individuals, not institutions.

The reform introduced four main elements to reach the poor:

- A proxy-means testing index to target public health subsidies to the neediest (SISBEN, Selection System of Beneficiaries for Social Programs-Nunez 2004)
- Transformation of the traditional supply-side subsidies, which finance the public health care network, into demand-side subsidies, which subsidize individual insurance premiums for the poor
- An equity fund in which revenue from payroll contributions and Treasury resources cross-subsidize insurance premiums for the poor
- Contracting for health service delivery from both the public and private sectors.

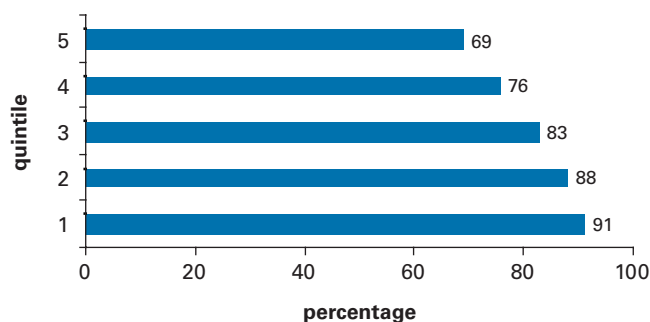
The new system is a universal health insurance coverage plan with two regimes:

- The Contributory Regime (RC) covers formally employed and independent workers who contribute to the scheme. Contributions are collected by the insurer of choice.
- The Subsidized Regime (RS) covers the poor and indigent individuals who cannot afford to make any insurance contribution.

SISBEN is a general purpose system for selecting beneficiaries for social programs in Colombia. It has a statistically derived proxy-means test index that serves as an indicator of household economic well-being. The variables that determine welfare include, availability and quality of housing and basic public services, possession of durable goods, human capital endowments and current income (this latter variable was excluded in the new revised SISBEN Index due to unreliability and lack of predictive power, as seen in Section 7). The system includes a set of norms and procedures defined at the central level and operated at the municipal level to gather information necessary to calculate the welfare index and select beneficiaries for the numerous social programs. The Subsidized Health Insurance Regime (SHIR) is one of the programs where benefit incidence has been the highest for those targeted with SISBEN, which was benefiting over 11.4 million poor and vulnerable people by end of 2002.

Payroll contributions go into a national health fund (Fondo de Solidaridad y Garantía, FOSYGA) with four separate accounts. The fund finances insurance premiums for all

Figure 2. Population Who Paid for Inpatient Care in Public Hospitals by Income Level. Before Law 100/93—CASEN 1993



enrolled in the RC. In the RC-RS cross-subsidization process, one point of the contributions is allocated to finance the RS, together with Treasury transfers to the territories. Individuals who are eligible for enrollment in the RS, but still are uninsured, are called *vinculados* and should rely on public hospitals for care.

Every insured individual is free to choose an insurer and consult any provider in the insurer's network. Both regimes have a basic benefits package, but the POS (Plan Obligatorio de Salud) for the contributory regime includes every level of care while the POSS (Plan Obligatorio de Salud Subsidiado) has to be complemented with services provided by public hospitals and financed through traditional supply-side subsidies. According to Law 100, those supply-side subsidies were turned into demand-side subsidies to achieve universal insurance coverage with the same POS in both regimes.

Although Colombia still faces important challenges in expanding health insurance coverage to all the poor, improving service quality, and providing a more complete benefit plan for the poor, some important accomplishments deserve attention.

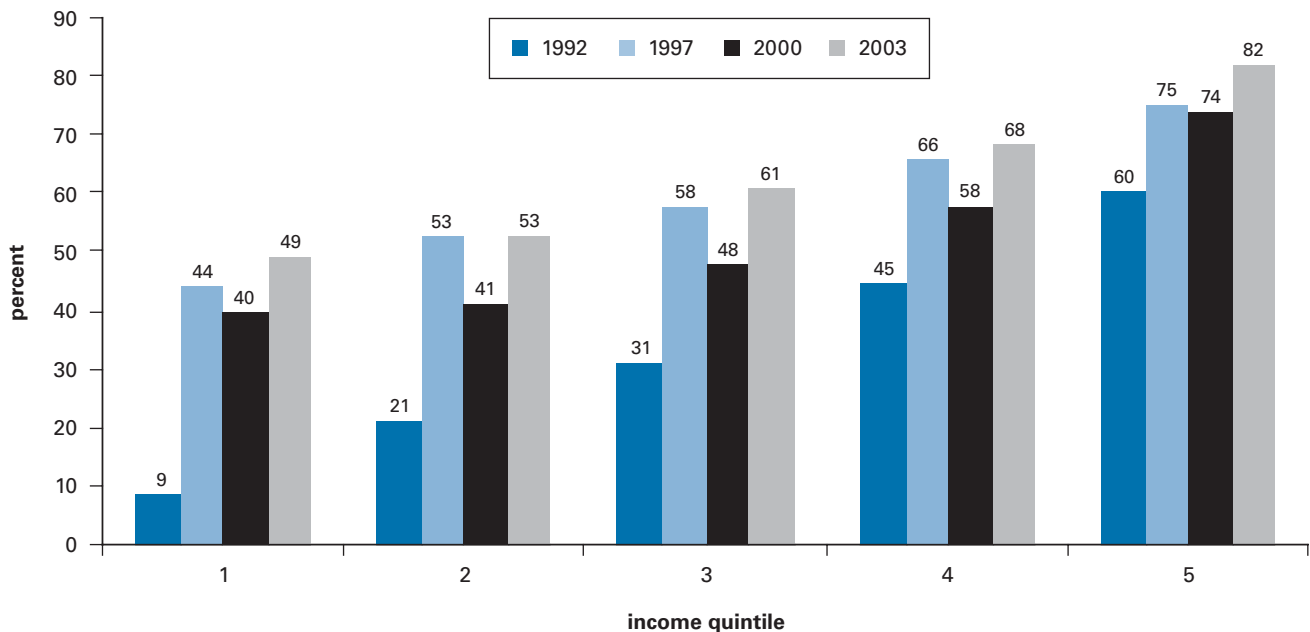
The Results

SISBEN has established a technical, objective, equitable and uniform mechanism for selecting beneficiaries of social spending to be used by all government levels. It classified applicants to social programs in a rapid, uniform and equitable way. It strengthened institutional development of municipalities with the establishment of a modern social information system and supported inter-institutional coordination within the municipality to improve impact of social spending. It avoided duplication and concentrated efforts on the poorest. It elaborated socioeconomic diagnostics of the poor population to better prepare the social insurance programs for the poor, and facilitated attainment of targeting goals for the various levels of governments.

The reform brought more opportunities for access to health care for the poor. Still, differences persisted between the insured and the uninsured. The insured still were more frequently treated than the uninsured in both the urban and rural areas and they also used more preventive care services.

The reform of 1993 increased financial protection for all, but especially for the poor and rural population. Before

Figure 3. Insured Population, by Income Status



1993, 23 percent of Colombians were financially protected against the risk of health shocks. Ten years later, 62 percent of the population had access to health insurance, an impressive change when compared with all Latin American countries that had health care systems similar to Colombia's before 1993.

The reform improved equity in the system by introducing to the poor financial protection instruments previously available only to the formally employed and the better-off (figure 3). Insurance coverage among the wealthiest group increased modestly with the reform, from 60 percent in 1992 to 82 percent in 2003, while insurance coverage among the poorest group increased from 9 percent in 1992 to 49 percent in 2003. With the introduction of the subsidized insurance regime, access to health insurance was delinked from formal employment and income.

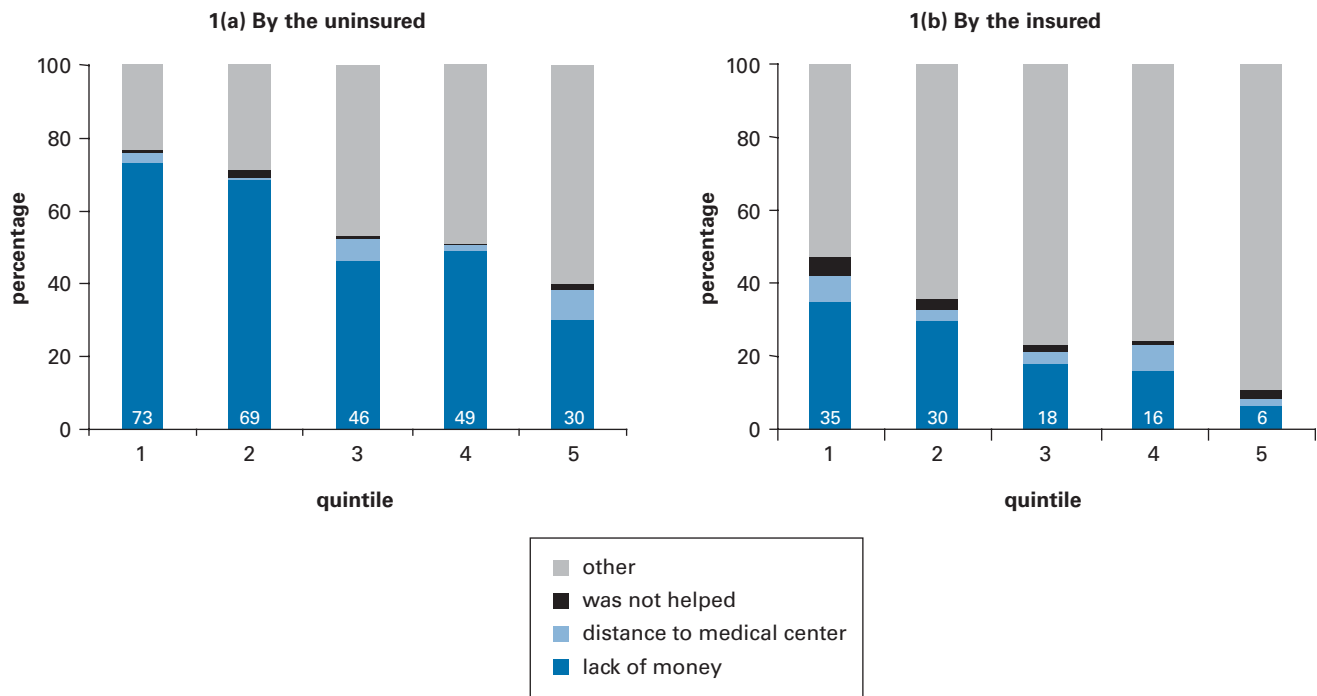
The reform reduced economic barriers to health care use for all income groups, but particularly for the poor. Lack of money was still the reason most often given by the poor, both insured and uninsured, for not seeking medical care (figures 4a and 4b). The economic barrier to health care access was

more than twice as high for the uninsured poorest group as for the insured poorest.

Health care expenditure as a percentage of income is much larger for the uninsured than for people in either the contributory or the subsidized regimes. Formal insurance in Colombia reduced out-of-pocket expenditures on ambulatory care between 50 and 60 percent. The poor in the RS spent around 4 percent of their income on ambulatory care, but the uninsured poor more than 8 percent. Out-of-pocket expenditures on hospitalization among the uninsured poor absorbed more than 35 percent of their income in 2003. The poor in the RC spent a smaller proportion of their income on inpatient care than the poor enrolled in the RS. However, a health shock requiring hospitalization pushed 14 percent of those hospitalized and uninsured below the poverty line while that fate only befell 4 percent of inpatients covered by the subsidized regime (Table 1).

The introduction of health insurance improved access to preventive care. While 65 percent of the insured saw a physician or a dentist at least once for preventive reasons and without being sick in 2003, only 35 percent of the uninsured did so.

Figure 4. Reasons for Not Seeking Health Care, 2003



Source: Escobar 2005

Table 1. Individuals Pushed below Poverty and Indigence Lines by a Health Shock (percent)

Health shock	Uninsured		Insured subsidized regime	
	Poverty	Subsistence	Poverty	Subsistence
Ambulatory care	5	6	4.1	3
Hospitalization	14	18	4.2	11

Source: Escobar 2005

Regulation gave preference to children, single mothers, the elderly, the handicapped, and the chronically ill for priority access to insurance enrollment in the RS. Empirically, those poor and insured were less healthy than their uninsured counterparts, which could be confused with adverse selection. In reality, however, individuals did not decide when to enroll in the RS, because annual extension of coverage depended on the availability of financial resources.

No longitudinal data existed to see whether access to health insurance among the poor affected their overall health status. However, some inferences could be made from data on infant mortality, institutional delivery, and prenatal care.

Consistent with findings in other countries, insured Colombians sought health care more often and faster than the uninsured. This activity was especially important in the cases of child birth and child and maternal health. Lower infant mortality rates were observed among children of women who had access to medical care during pregnancy, used prenatal care, and had a medically assisted delivery. Colombia’s Demographic and Health Surveys (DHSs) indicated a big improvement in access to those services, particularly in the rural areas. According to the DHS (1986, 1990, 1995, and 2000), the following increases occurred in: physician-assisted child delivery, 66 percent; institutional delivery, 18 percent; and prenatal care use among rural women, 49 percent. Changes after 1993 were influenced by improved access to health care services by the insured.

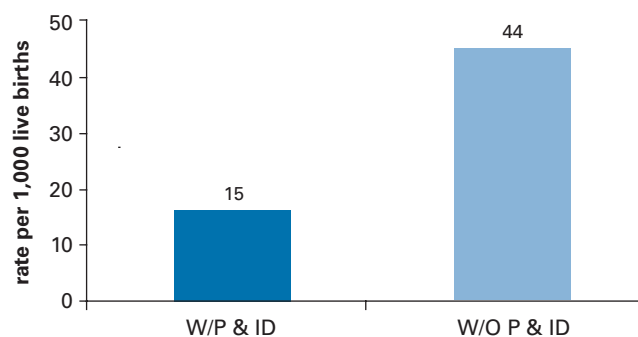
The DHS 2000 indicated that access to prenatal care and to institutional delivery reduced child mortality. Figure 5 shows a truly astonishing difference between infant mortality rates among children whose mothers had access to prenatal care (P) and to institutional delivery (ID) with those whose mothers did not have access to such services.

The Challenges Ahead

Despite positive results, the Colombian social insurance scheme has been criticized for not having achieved universal coverage and for financing a less comprehensive benefits package for the poor (RS) than for the wealthier (RC). The slower than planned transformation in supply-side subsidies, which finance public hospitals, into demand-side subsidies to finance health insurance for the poor, has also come under fire for slowing down the expansion of the RS benefits package.

Several attempts have failed to introduce legislation to change the present system back into a government-owned and government-delivered health care system like the one in 1992. However, Colombia still has many challenges to surmount to complete the consolidation of the social insurance scheme, not only to cover the entire population, but also to improve the efficiency and quality of health care. The changeover to the new, insurance-based system has been dif-

Figure 5. Impact of Institutional Delivery and Prenatal Care on Infant Mortality Rate



Source: Escobar 2005

difficult politically, administratively, and technically. The decentralization process begun in the early 1990s has brought with it disadvantages as well as advantages for the implementation of the 1993 health reform.

This brief is intended to summarize good practices in Health, Nutrition, and Population. It was edited from María-Luisa Escobar, "Health Sector Reform in Colombia," *Development Outreach* 7 (2 May 2005): 6–9, 22. The views expressed in this note do not necessarily reflect those of the World Bank.

