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Research Article

Analysis And Reflections On The Health Model In Colombia: Is A Change Required?

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ARTICLE INFO	ABSTRACT

Health in Colombia is a fundamental right provided in the Constitution of the year 1991 and protected by the State. Based on the proposed analysis methodology, the shortcomings, strengths, and difficulties of the current health system are evident. They are contrasted with the bill approved by the House of Representatives and a rigorous analysis of the future of health in Colombia is carried out.

Keywords - Health reform, insurance, public health.

INTRODUCTION

Management models in health systems respond to political, social, and economic changes; they are adapted according to the countries that implement them (1). As health systems are dynamic and hypercomplex structures, it is not feasible to adopt a single model of care to be implemented in all countries, due to the diversity and socio-cultural characteristics (2).

Health systems can be classified, without claiming to be exhaustive or exclusive, into: segmented, integrated public systems and contract-managed public systems; also adding the model of regulated competition and the concept of structured pluralism (3,4).

In Latin America, these systems are structured around disease rather than health, based on medical knowledge, with disease as the central reference parameter, driven by the pharmaceutical industry and new technologies (5).

In Colombia, since the last decade of the past century, the National Health System has been reformed, seeking to guarantee universal coverage of the population's health care needs, adopting an insurance model with regulated competition and achieving an increase in coverage of over 95%; however, despite the progress made, major inequities persist and many people lack access to health care, especially in rural and dispersed populations (6-9).

WEAKNESSES IN THE CURRENT HEALTH CARE MODEL

Although the coverage of the health system is almost universal (over 95%) (10) and the participation of users is increasingly greater and more aware of their rights, with improvements reflected in lower disease burdens, longer life expectancy, with a low level of out-of-pocket expenses, major risks and important problems persist despite these achievements (11).

For the year 2006, Fedesalud (12) found that only 25% of patients with Diabetes Mellitus Type II received adequate treatment. The time elapsed between the diagnosis of diabetes and the development of chronic kidney disease does not exceed 13 years, when the estimated time usually is 20 to 30 years (13) and between the years 2010 and 2018 there were 58,123 deaths from kidney disease.

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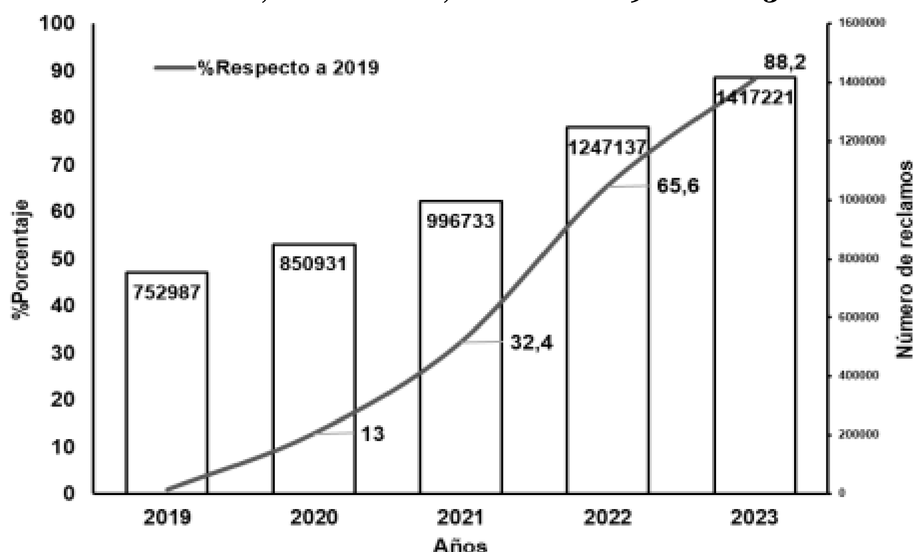
Complications of acute diarrheal disease and respiratory disease in children under 5 years of age are possibly associated with untimely or inadequate diagnosis and treatment (14). On the other hand, the increase in the number of observed cases of gestational syphilis in 2020 compared to the historical median 2016-2019 showed a significant increase of 68.4% (15). Likewise, a report by the Defensoría del Pueblo reported that health guardianships increased 58.31% in the monthly average as of September 2022 compared to the same period in 2021 (16).

The Contraloría General de la República reported that, during the last five years, 483,866 petitions were filed, of which 72.5% were granted. "The reasons contained in the rulings issued by the Constitutional Court indicated that the highest percentage (62.6%) were for deficiencies in care, corresponding mainly to outpatient services, hospital care, intensive care and treatments for different diseases" (17).

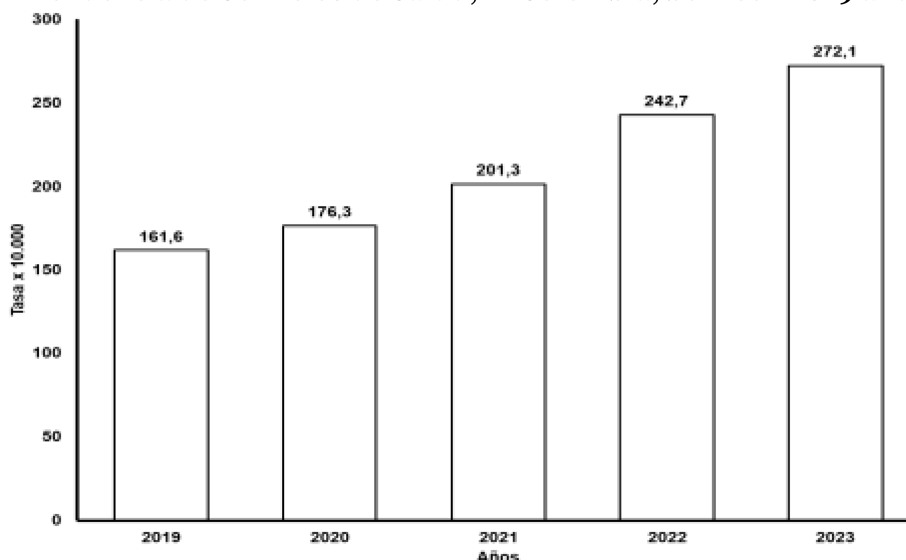
According to information from the Superintendencia de Servicios de Salud (18) claims for the provision of services have been increasing progressively (Figure 1), going from 752,987 in 2019 to 1,417,221 in 2023, which represents an increase of 88.2%; the rate of claims per 10,000 affiliates went from 161.6 to 272.1 (Figure 2), being clearly higher in the contributory regime compared to the subsidized regime (Figure 3), in the same period. The most frequent causes are: denial of appointments, lack of timeliness in consultations and denial of care in other health services (Table 1).

Figure 1. Number of claims for the provision of services to the Superintendencia de Servicios de Salud, in Colombia, between 2019 and 2023.



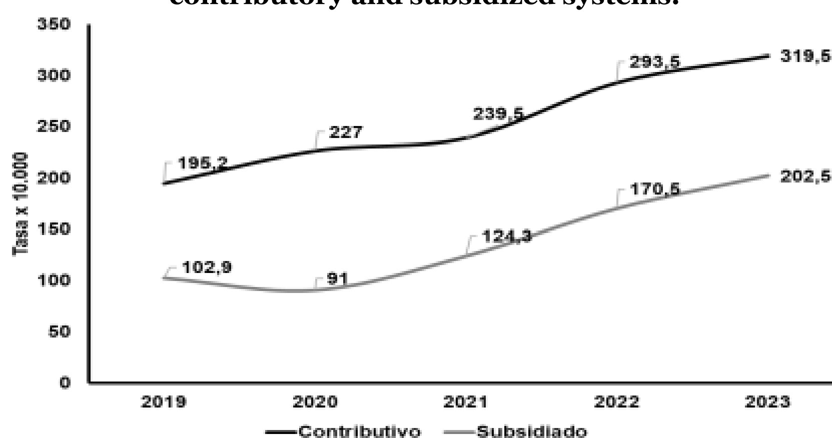
Source: Own elaboration based on open data from the Superintendencia de Servicios de Salud.

Figure 2. Rate of claims for the provision of services (per 10,000 affiliates), to the Superintendencia de Servicios de Salud, in Colombia, between 2019 and 2023.



Source: Own elaboration based on open data from the Superintendencia de Servicios de Salud.

Figure 2. Rate of claims for the provision of services (per 10,000 affiliates), to the Superintendencia de Servicios de Salud, in Colombia, between 2019 and 2023, in the contributory and subsidized systems.



Source: Own elaboration based on open data from the Superintendencia de Servicios de Salud.

Table 1. Health Claims by Specific Reasons (July to December 2023)

Motive	% (n=716,697)
Denial of appointments or consultations	22,77
Lack of timeliness of appointments or consultations	14,87
Denial of care in other health services	10,45
Denial for the delivery of health technologies and/or other authorized services	9,56
Lack of timeliness of care in other health services	8,96
Lack of timeliness in the authorization of other health services	6,02
Lack of timeliness in the delivery or incomplete delivery of health technologies and/or other services	5,62
Lack of timeliness in the authorization of health technologies and/or other services	3,38
Lack of timeliness in the authorization of consultation appointments	3,26
Non-recognition and/or payment of economic benefits	2,04
Other Reasons	13,08

Source: Own elaboration based on open data from the NSuperintendencia de Servicios de Salud

The deterioration of the capacity of local authorities to lead public health programs is reflected in the results of collective interventions that fail to have an impact on morbidity and morbidity (19).

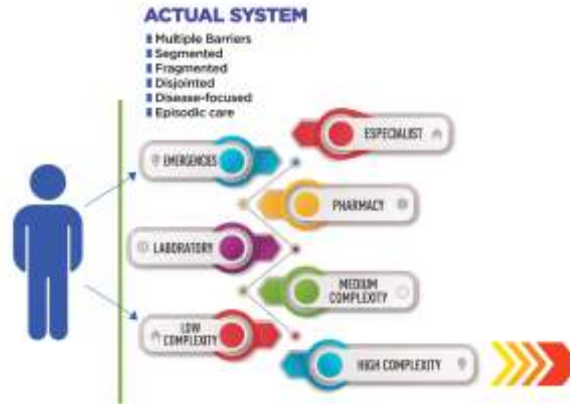
According to the Superintendencia de Servicios de Salud (20), as of May 1, 2023, 190 territorial entities (municipalities and departments) recorded non-compliance in the timeliness of the contracting of the Collective Interventions Public Health Plan (Plan de Salud Pública de Intervenciones Colectivas-PSPIC); 49 municipalities were prioritized to be subject to specific scope audit and some of the findings documented were: failure to carry out contracting to ensure the continuity of human talent, failure to include social participation actions and contracting through the abbreviated selection modality with a private entity, without justifying in the contracting process financial, technical or operational reasons why contracting was not carried out with a public institution.

The medical act requires total autonomy in accordance with risk management and cannot be interfered with by third parties outside the doctor-patient relationship (21). The fractioning of care is a structural problem, where the first level is managed on a capitated basis and the more complex services are attended and billed by events (22). Payment per event may lead to an increase in the volume of activities or services provided and capitation may reduce the capacity of care, prolonging the time required to access services (23-25).

On the other had, when there is a predominance of economic incentives without a counterbalance of stimuli for positive health outcomes, the effect can be unfortunate for all levels (26). The pressure for the billing of services and the production of economic returns induces the practice of cost controls such as the establishment of quotas for diagnostic procedures and drugs to be prescribed (27) and incentives for health professionals, depending on whether they adhere to the established quotas, affecting the quality of care and even altering the veracity of the clinical history. All the above leads to the provision of a poor-quality service (28).

Other factors currently affecting service delivery include: problems in the flow of funds, lack of governance, fiscal pressures derived from non-UCP spending, the Covid-19 pandemic, Venezuelan migration, and expenses derived from the End Point Law (29) among other factors that if adequately addressed will improve the health system (30) (Figure 4).

Figure 4. Benefit scheme Model of Law 100 of 1994



Source: Prepared by the authors based on the outline of Law 100 of 1993.

PROPOSALS FOR CHANGE

Is it necessary to carry out modifications in the Colombian health system? This has been suggested in different countries, which have found the need to focus on prevention and at the community level, with principles of equity, as fundamental pillars (31, 32).

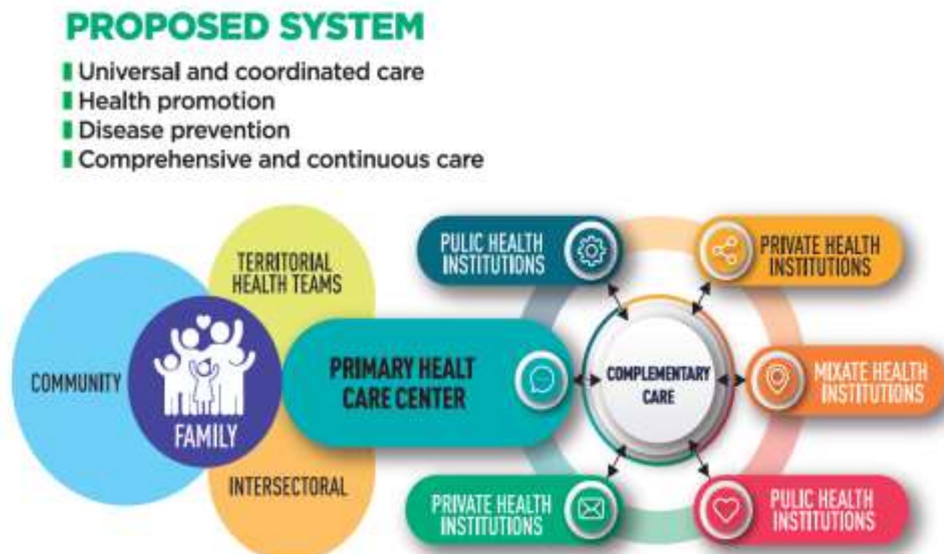
Recently, a Bill to Reform Health, strengthening primary health care, was presented, and disapproved in the Congress of the Republic (33) (Figure 5). It described that each health center would oversee 25,000 people, depending on their place of residence or work, and would have a multidisciplinary team of health professionals, being these centers the gateway to the system with the capacity to solve most of the people's health needs.

With respect to the Single Affiliation System, it was proposed to eliminate the carnets and, without intermediaries or access barriers. The Administrator of the Resources of the General Social Security Health System (dministradora del recurso del Sistema General de Seguridad Social en Salud-ADRES) would be in charge of paying the service providers directly, without the intermediation of the Health Promotion Companies.

A single national fund would be created to receive fiscal, parafiscal and contributory contributions and distribute resources according to territorial and population needs. In addition, the role of the Ministry of Health as the governing body would be strengthened. And the Superintendencia de Salud as a control entity, presenting the transfer of insurance and financial risk management functions to ADRES and other state entities.

In this point, it is emphasized that, by dispersing a high percentage of health insurance functions to the state institutions, as well as among several state entities of the new institutional structure proposed in the Reform Bill, without the prior development of capacities, it represents a high risk of collapse of the health system and ignores the technical and institutional capacity that the Health Promotion Companies have developed throughout the 30 years of development of the system, particularly in the management of financial, operational and health risks. Faced with this scenario, families could be faced with the materialization of financial risk and consequently an increase in out-of-pocket expenses, because of an increase in the barriers to access to the provision of services.

Figure 5. Outline of the system proposed in the Health Reform Project 2023



When comparing the current model with the proposed model, the following aspects are found (Table 2):

Table 2. Inventory of changes and their potential impact

Dimension	Current	Reform proposal
Financial	Severe and frequent problems in financial flows, high transaction costs and breakdown of risk pooling through recoveries to the system for services not included in the benefit plan.	No scenario is proposed to define the sustainability of the proposed model. The model envisages a single national fund that would receive the fiscal, parafiscal and contributory contributions, who would collect and pay for the services (ADRES).
Effective access	Barriers to access to health services are a sensitive issue for users, especially when emergency care is required, and to a lesser degree in actions aimed at health promotion and prevention, the failure to perform these actions in a timely manner generates higher costs and impacts. The negative results that are manifested on the users generate multiple complaints and guardianships.	Creation of a network of primary care centers (CAPS) to provide comprehensive and preventive services to the population, with emphasis on rural and marginalized areas.
Basic health equipment	Not defined in model.	They are primary care teams. They would perform general outpatient services in the extramural modality, for medical, nursing, dentistry, and psychology professionals.
Transition	The process of adjustment and implementation of Law 100 lasted approximately 10 years.	The reform proposes two years. It is one of the most controversial points
Human Talent	Increase in outsourcing contracts, untimely payments to health personnel, hasty closures of services, thus increasing the instability of health personnel.	The quantitative and qualitative requirements of the Human Health Talent (HRH) and the impact that the changes in the Health System would have on them are not stated.

Under a social project analysis approach, it is necessary to review the financial criteria, effective access, the creation of basic health teams, the transition process and the impact on human talent. It is important to highlight that the content of the Health Reform proposal did not allow identifying that there are sufficient conditions to support a reasonable political and economic feasibility for the approval and effective implementation of the new model.

Health, together with education, is one of the basic pillars that determine a country's competitiveness (34). Having a solid health system is a precondition for promoting development, since a healthy population is more productive, which translates into greater returns for the economy.

The design of a new system requires the contributions of academia and transdisciplinarity to relate scientific knowledge, extra-scientific experience and the practice of problem solving oriented towards improving the health system (35,36).

Some specific provisions could be taken up again, including the one that orders the transfer of a high percentage of the invoiced amount to the providers and that the remaining amount is to be paid once the audit is performed. Likewise, it is necessary to clarify the doubts regarding the functions of the territorial entities in the system, as well as the adequate articulation of the control entities to carry out the inspection, surveillance and control of the execution of these resources.

It is necessary to reach a consensus, to build on what has been built, to clarify the medium term fiscal framework for the Public Treasury, and to include all stakeholders in the system, especially academia, in the dialogues.

CONCLUSIONS

The need for a structural reform of the health system in Colombia is evident, imminent and a priority. Social challenges worldwide, coupled with demographic changes and advances in technology, pose the need to develop new knowledge and transform methods to achieve solutions that will have a positive impact on society.

The greatest challenge lies in solving health problems through a comprehensive health care model that responds to the needs of people in the territories, without destroying the achievements of the current system. The proposal presented generates gaps that should be reviewed, to ensure that the proposal is not a setback that affects the most sensitive actors of the model, patients and health care workers.

On the other hand, there are many issues to be resolved, such as coverage, improvement of primary care without affecting comprehensive care in chronic patients and in cases requiring high complexity, sustainability in the medium and long term, and improvement of the working conditions of health professionals.

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