

**Rapid Assessment  
of the purchasing arrangements in Colombia**

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## Executive Summary or Abstract

The purpose of this document is to outline and frame key policies issues and challenges that are considered critical to shift towards strategic purchasing in Colombian Health Care System. The short report summarizes and structures the issues emerging from the collected information through a rapid assessment tool applied in March 2018 in Colombian key policy responsible and stakeholders. The reports presents the opportunities and what needs to be done at country level to address reforms and dialogues on strategic purchasing as key health financing function to meet UHC by 2030, mainly regarding to: benefits plans, payment methods, information management and governance.

### 1. Introduction and objectives of the study

The strategic purchasing function has so far received relatively little attention in terms of reflection and action in many low- and middle-income countries. Too often, purchasing of health services, including medicines, is done in passive and non-strategic way (1). This can constitute a major obstacle in progressing towards Universal Health Coverage (UHC). The objectives of strategic purchasing are to enhance equity in the distribution of resources, increase efficiency (“more health for the money”), manage expenditure growth, and promote quality in health service delivery and it also serves to enhance transparency and accountability of providers and purchasers to the population (2).

The purpose of this document is to identify key drivers and policy implementation gaps regarding to strategic purchasing of health services in Colombian health care system. In order to achieve this overall aim, the following specific objectives were addressed:

- To analyze the country situation regarding to the purchasing function.
- To identify key areas of progress and gaps in the purchasing set up regarding to benefit design, payment methods, information management and governance.

### 2. Methodology

The assessment was guided by collecting information on how the purchasing function operates and how it is organized, using the rapid assessment guide. Additionally, the rapid assessment was complemented with i) literature review (Review of available documents on regulatory and legal provisions in the field); ii) Interviews and discussions with key stakeholders (among governance actors, purchasing agencies and providers); and iii) Quantitative data collection (exploring key and available data set sources).

### 3. Country setup

In 1993, the Law 100 transformed revenue collection, pooling, purchasing and service delivery arrangements in Colombia (3) (4). As a result, the health market has multiple purchasers and arrangements in place to purchase health services: i) Health insurance agencies in the contributory, subsidized and especial regimes (In Spanish: EPS), ii) Sub-national governments (33 Entidades Territoriales, which may comprise departments, municipalities, districts, indigenous territories and occasionally regions and provinces), each sub-national government is able to purchase health services to cover the needs of the poorer population; iii) Ministry of Health and Social Protection (MOHSP) is able to purchase through the Administrator of Resources of the

General System of Social Security in Health (In Spanish, Adres) and the Strategic Fund of the Pan American Health Organization; iv) The National Agency of Procurement (Colombia Compra Eficiente), and v) Voluntary health insurance agencies.

However, the main health services purchasers in the Colombia are 'Entidades Promotoras de Salud' (EPSs), which may be public and private and cover the 85% of health services. The EPS's contributory scheme covers 20.760.123 millions people (44%), EPS's subsidized scheme covers 22.882.669 millions people (46%) and special health insurance scheme cover approximately 2,226,973 million people (4%). In the other hand, the sub-national governments are principally responsible for carrying out public health actions, under the supervision of central government and cover the health needs of the 2,736,365 uninsured poor people (6%) (5).

In 1993, the benefit package for the subsidized scheme was more constrained than that for the contributory scheme (there were differences in access to treatments, procedures and medicines). Consequently, the subsidized regime's per capita cost was lower (3). The intention was to gradually expand the benefit package for the subsidized regime so that, when fully implemented, the content of the benefit package would be the same for all Colombians, whether in the contributory or subsidized scheme. However, achievement of this goal was delayed due to fiscal constraints and the content of the benefit package was standardized for both regimes only until 2012 (6). The EPSs are responsible to organize and manage the provision of the now benefit package called the 'Plan de Beneficios en Salud' (PBS) (7).

In 2017, the benefit package was reviewed to protect and advance the human right to health according the needs of the populations, to tackle problems of technological pressure and to resolved the judicial decisions with the incorporation of new health technologies, as a result the benefit package was move from positive list (what health services are covered) to negative list (what health services are not covered). In 2018, the benefit package covers 100% of the procedures; it is financed with different sources and covers the different phases of care of all pathologies, which one everyone may be entitled, including uninsured poorer people (8). Some exceptions are: aesthetic, sumptuary or cosmetic services, therapies, medications or experimental treatments whose effectiveness is not scientifically proven, or those offered abroad, bearing in mind that there are alternatives in Colombia.

The EPSs can either provide services directly or contract with public or private providers. Moreover, EPSs and voluntary health insurance as health insurance agencies can negotiate contracts with individual providers. However, it is important to clarify that they have guidelines or a margin in which they can carry out negotiations that generate a return. In 2013, there were 51 EPSs, 14 in the contributory regime and 37 in the subsidized regime there are both public and private EPSs but in the contributory regime there are only private EPSs. Nevertheless, the number of EPSs within the health system has decreased by 40% in the last 6 years, as a result of the ranking of quality, efficiency and opportunity providing health services. Thus, inoperative EPSs have left the market.

At the provider payment mechanisms level, in 2017 the country has a blended payment system: 50% of all payments made were by activity, 40% by capitation and 10% by fixed payments. There are few processes that are paid by result. Still, many services are paid per activity. However, the tendency to move to prospective global budget in the future is clear. Overall, purchasing arrangements and outcome-based payments should provide the guarantee to pay for the services

and outputs. Yet in the practice these methods are not always well connected in the health financing policy arrangements.

However, it is worth to mention that the model of comprehensive health care in 2017 (in Spanish, MIAS), the regulation of drug prices since 2016 and the Health Statutory Law in 2015 have contributed to the increasing use of these methods. Output-based payments are not embedded and integrated within health system, except in the case of Chronic Kidney Disease, Sexual and Reproductive Health Care and HIV (currently it is exploring in cancer, hemophilia, rheumatoid arthritis), and recently through the strategic purchasing of Hepatitis C treatment, in which payment methods are oriented outputs due standardized clinical indicators that have been fully implemented in the contributory regime. Also, the hemophilia treatment offers a result-oriented example: If after 6 months the patient does not show favorable results, the provider can be changed. However, there is no additional economic benefit for good performance.

The types of providers from whom services are purchased may be public, private or mixed (in Spanish IPS). Colombia has 10.386 health services providers. The relationship between types of providers are 45% public, 54% private and mixed 1% IPS. The IPSs pay for activity carried out or for the availability of time of the professionals, while few IPSs pay for results. Recently, the network of private EPSs is implementing vertical integration, which has led to an increase in prospective global budgets. Regarding share of expenditure, between 30% and 35% are used to cover hospitalization services; between 18% and 20%, are used to cover ambulatory health services, and between 20% and 25% approximately are used to medicines.

#### 4. Results

We have identified keys areas of progress and challenges described as follows:

##### 4.1. Key areas of progress

###### *Benefit design*

- The Benefit Package revision process is based on exclusion list (what health services are not covered). In 2018, the benefit package covers 100% of the procedures; it is financed with different sources and covers the different phases of care of all pathologies, which one everyone may be entitled.
- Strengthened priority-setting process allowed improving benefit package review processes and clinical guidelines at all levels.
- The use of technologies platforms and channels has guaranteed to citizens the participation establishing the benefit package in high cost diseases (For example, Renal Chronic Disease, HIV, Hepatitis C).
- Benefit Package review has been based on a transparent, scientific-technical and participatory process.

###### *Payment methods*

- In 2017, in 2017, the payment methods most used by purchasers were mainly three: payment for activity (50%), payment by capitation (40%) and prospective global budgets (10%).
- The recent trend is to move to more prospective global budgets.

- The model of comprehensive health care (MIAS), the regulation of drug prices and the Health Statutory Law (2015) have contributed to the increasing the use of payment methods output oriented.

#### *Information management*

- The Information System for Social Protection (SISPRO) has implemented standards, the coding system of the International Classification of Diseases (ICD), interoperability processes with others data sources.
- The SISPRO allows setting up a productive interaction with health populations needs data and health system performance, but not completely.
- The government promotes the use of data, information and indicators for addressing the gap analysis at all levels of the health care system.
- The IPS provides the patients information to the EPS, such as the clinical history, such a as consultations, medications, treatments, and other supplies monthly, in order to facilitate to the follow-up committee of the IPS and EPS evaluate the patient's clinical history, validating information with the that the patient receives regarding health services and to review to perform the billing.
- EPS periodically report the information on high cost communicable and non-communicable chronic diseases of the contributory regime to meet national quality standards and requirements. In the other hand, subsidized patients data are collected partially. The health information system follows-up individually of Chronic Kidney Disease (3,055,568 cases), HIV/AIDS (53,408 cases), cancer (139,789 cases), hemophilia (3,501 cases), and Orphan Diseases (3,218 cases).

#### *Governance*

- Good governance (addressing regulation gaps, for example in the pharmaceutical market) has allowed better coordination to purchase health services and high cost medicines.
- Put in place the first national agency to manage funds for health (at country and sub-national levels) and purchase centralized health services, including medicines and supplies, which reduced operational cost.
- Put in place the Colombian Health Technology Assessment Agency (In Spanish IETS).

## 4.2. Challenges

#### *Benefit design*

- Benefit package review needs to be aligned with provider payment mechanisms. In the practice, this lack of alignment mainly with the separate funding flows affect most of the time the population under subsidized regime.
- To address technological pressure and the judicial decisions with the incorporation of new health technologies.
- To improve participatory dialogue with civil society and inter-sectoral coordination from the beginning of benefit package review process. In particular, involving decision-makers in overall planning, poverty reduction, climate action, water, sanitation and hygiene, labour, housing conditions, as key governments sectors which share common objectives in health equity.

### *Payment methods*

- Providers' financial management systems are highly fragmented, which limits the planning and assessment of population needs, the decision-making of what health services are being provided, where and with what outcomes.
- To align payment methods with PFM rules and processes in the whole health care system. Most providers manage several programs with funding flows and separate data management system. For example, data on provider payments systems in the contributory regime are not aligned with provider payment systems, which ultimately increase inequities, inefficiencies and gaps in quality of care.
- In the practice, benefit package review and provider payment methods reforms are not always well connected in health financing policy discussion. For example, there is a need to understand how effective provider payment methods can be drivers of positive health systems changes (improving efficiency, equity, health outcomes and overall performance).
- Existence of few incentives to improve productivity, which are sometimes translated into lower quality and rationing.
- Gap analysis in the field. There is an urgent to increase evidence using the available data on provider's payment methods.

### *Information management*

- Weaknesses in payment information systems in collecting data of the subsidized health insurance scheme.
- Financial information is hardly integrated into the National Information System of Social Protection (SISPRO). Thus, the information cannot be easily accessed and disaggregated by types of insurance schemes at the geographic level, resource flows.
- Information on the contributory regime is more available, although fragmented in several information systems within the Ministry of Health and Social Protection. While information of the subsidized, exceptional and special health insurance schemes, and uncovered poor population are not fully available.

### *Governance*

- The fragmentation and lack of coordination in the policy-making processes and health financing functions is a result of not-aligned purchaser's aspects across the different health insurance schemes with multiple purchasing markets (EPSs, Ministry of Health and Social Protection, Colombia Compra Eficiente, Sub national Governments, Strategic Fund).
- To strengthen the overseeing the purchasing function or a purchasing agencies.
- To gain better understanding and importance to interconnect clearly the set UHC objectives with set for the purchasing function.

## 5. Conclusions and proposed options

Considering that the experience of Colombia suggests that health system has made significant achievements, we identified six action areas due their political, technical and institutional feasibility which may help Colombia to move forward strategic purchasing for UHC by 2030:

- *Gain better understanding of strategic purchasing, driving forces and interest of stakeholders.* There is a need to understand the purchasing market structures, driving forces and the interest of involved stakeholders, in particular that of health workers both in the public and private health sector. Some of the key policies actions are: i) To implement the Office of Ministry of Health and to strength the Administrator of Resources of the General System of Social Security in Health (Adres) in place to negotiate and purchase health services and medicines (Art. 71, National Development Plan); and iii) To develop training and skills in health financing governance at all levels of the health system.
- *Effective design and implementation of payment systems, generation and use of new data to refine payment systems over time.* The country has the health information management architecture: National Information System of Social Protection (SISPRO), which may allow setting up a productive interaction of health populations and needs data with providers payment methods.
- *Effective aligning benefit package review needs with provider payment mechanisms.* Despite the Statutory Law defines equity and health as universal right, in the practice subsidized and uninsured people still facing gaps implementation due the separate funding flow of the health financing sources. This underperformance result in avoidable barriers, which in turn generate inequalities in the health care access and in the health coverage.
- *Adoption of international methodology System Health Account (SHA).* This in order to made health financing data comparable and to allow better disaggregation data and cross country and country comparisons. Moreover, the integration of health financing data to National Information for Social Protection (SISPRO) is a must.
- *Dynamic management of strategic purchasing into the health system building blocks.* Improving purchasing function is a constant challenge: needs, demands and priorities, funding levels, treatment options and technologies and medicines over time, as do provider and user behavior as result of adapting to provider payment methods. Therefore, a poorly understood or underdeveloped strategic purchasing function by some key actors (For example, the government itself, Entidades territoriales and health insurances agencies) can constitute a major obstacle in progressing towards Universal Health Coverage (UHC).
- *Development of training and skills in health financing governance at all levels of the health system.* This includes policy makers (Ministry and ADRES), responsible in EPS, IPS and sub national governments. Additionally, this will also require that national government and health agencies and partners (National Institute of Drug Surveillance, Colombian Health Technology Assessment Agency, Administrator of Resources of the General System of Social Security in Health) to continue aligning their objectives into a coordinated strategic effort and political commitment, which certainly will allow better capabilities and knowledge translation in purchasing arrangements.

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