Medical Elective Report – Alastair Wright

OBJECTIVES:

1) Describe the pattern of disease/illness of interest in the population with which you have worked and discuss this in the context of global health.
2) Describe the pattern of health provision in relation to the country in which you have worked and contrast this with other countries, or with the UK.

Demographics

Colombia has a population of about 48m, of which 75% live in cities, and nearly 20% in the capital, Bogota, a city of 8-9m.[i] The median age in 2012 was 27.4,[ii] and life expectancy at birth was 76 for men, and 83 for women. The birth rate has fallen from more than 6 children per woman in the 1960's to just above replacement level currently.[iii]

Pattern of disease in Colombia

The pattern of disease in Colombia is in many respects similar to the UK, with ischaemic heart disease, cerebrovascular disease and diabetes related disease being major causes of mortality. Additional causes of death that are notably worse than the UK include road accidents - a significant cause of death amongst males - and violence. Levels of deaths due to violence have fallen significantly over the last decade however, being 82 per 100,000 in 2004,[iv] and 45 per 100,000 in 2011,[v] with violent deaths being almost exclusively confined to males. Major cause of morbidity include alcohol use disorders, cerebrovascular disease, diabetes, ischaemic heart disease, and disease of prematurity as well as road accidents and violence. Hypertension affects nearly 35% of the adult male population over 25,[i] and HIV prevalence is about 0.5%.[vi]

Healthcare Provision in Colombia

In 2010, there were 15 doctors per 100,000 population, and 62 nurses and midwives per 100,000.[vii] In 2012 there were 150 hospital beds per 100,000 population.[vii] The total healthcare spend per capita in 2011 was $618, representing in total 6.1% of GDP. Public expenditure on health as a percentage of total healthcare spend was 73% in 2010.

Healthcare access and insurance in Colombia

In 1993, law 100 was passed in Colombia. This created the General System of Social Security in Health (SGSSS), a system made up of two insurance schemes that support a managed competition model of healthcare involving private companies. One scheme is designed for those employed or with other wealth; the obligatory health plan (Plan Obligatorio de Salud - POS), and the other, the Obligatory Health Plan – Subsidized (POS-S), for those needing subsidies. A competition element was

introduced enabling competition, between the insurers who compete for customers, and between the medical service providers who compete for contracts with the insurers. Reflecting their Spanish language acronyms, the insurance companies are known as EPSes, and the healthcare providing companies as IPSes.
The government collects the money for the POS from employers at a rate of 12.5% of the employee's salary, and distributes it to the appropriate insurance companies. The POS-S is paid for by the government, and is funded from local and national taxes, oil and mineral taxes, and also includes 1.5% of the 12.5% paid by workers for the POS (i.e. workers pay 11% + 1.5% solidarity payment).
Approximately 44% of the population is covered under POS, and a further 51% by POS-S, with the result that by some measures about 96% of Colombians have medical insurance.[viii] This represents an approximate fourfold increase in numbers covered compared with the numbers before 1993.[ix]

Healthcare changes the original system

Following the introduction of the above healthcare model, access to healthcare improved, with those insured under the POS-S system about 40% more likely to have attended an outpatients visit as compared with the uninsured.[ix] Additionally, children suffering from cough or diarrhoea were more likely to be taken to a health care facility once they had insurance.[ix] Other benefits include a reduction in "catastrophic spending" on healthcare – that is, amounts above a specified proportion of nonsubsistence income. Additionally there was an increase in the percentage of those taking up services that were already free for all, such as immunization, indicating a health benefit to society beyond that anticipated.

As with any healthcare scheme, questions of allocation of resources and fairness arise, but these were particularly pertinent in Colombia as there were initially large differences in the healthcare provided depending on the patient's insurance cover, POS or POS-S. However in Colombia questions reflecting dissatisfaction with healthcare provision have increasingly been answered by the courts rather than the medical profession. Individuals in Colombia have a right to petition the constitutional court with a *tutela*, and many such petitions are received from individuals seeking access to healthcare as they have no other effective appeals mechanism. The numbers of such petitions rose from about 35,000 in 2006 to 142,000 in 2008.[x] This, together with the levels of corruption led to the government declaring a state of emergency in 2009. This was later declared unconstitutional, however, in the judgement, healthcare was enshrined as a legally enforceable right, and a deadline of one year given by which universal access to a basic care package was to be guaranteed.[xi] However it was noted that to universally bring the lower level scheme to the level of the higher would cost, by one estimate, nearly 20% of GDP.[xii]

Problems have also arisen as the insurance companies are owed large amounts of money the government has collected on their behalf, and in turn medical service providers are owed large amounts of money by the insurance companies. As a result, many insurance companies have been taken over by the government to prevent their collapse.

An apparent failure to regulate the insurers, has meant that there aren't prescribed standards of healthcare with the results that the EPSes could pay for substandard care and claim they were meeting their obligations. One such EPS, SaludCoop, was taken over by the government after it was found to be paying executives huge salaries while denying services to their affiliates. Such corruption has been a major issue, with 14 of the 22 insurers in the POS system being sanctioned for collusion, and sentenced to multimillion dollar fines.[viii] Other charges against the insurance companies include conspiring to deny coverage to subscribers, and defrauding subscribers and government by altering information that determines subscriber premiums.

A further problem was that the prices that drug companies could charge for drugs was not regulated initially leading to high prices being charged, and the state and individuals losing out as a result. In response to this, a government led analysis of 240 drugs representing 30% of Colombian healthcare expenditure determined that prices for such drugs were higher in Colombia than in comparable countries and proposed maximum selling prices.[xiii]

Attempts to solve the healthcare crisis

In 2011, under the new government of Juan Manuel Santos, law 1438 was enacted, stating basic principles by which healthcare should be provided, and equalising the benefits under the POS and POS-S schemes. Payment by results was introduced with the aim of improving quality of care. Additionally new regulatory institutions were proposed.

Some problems remain however. The emphasis of the new law is on financial matters rather than on improved healthcare outcomes or patient experience, for example, doctors can be overruled by insurers. Regulation is fragmented between the Ministry of Health and other bodies at local and regional level leading to a lack of coherent implementation. There is still a lack of defined treatments and procedures that should be included in a basic package of care, and as a result the number of petitions made to the constitutional court is still high.

Notwithstanding the improvements in access to healthcare in the last few decades, inequalities exist, both for financial reasons and geographical ones. For example, in 2011 maternal mortality rates in Bogotá were about 45 per 100,000, but in Guainia in the Amazon region bordering Venezuela and Brazil the level is nearly 480 per 100,000. Underlying some of the differences in healthcare are differences in income, with poverty levels in Bogotá around 10% in 2013, while in Quibdo in the west they were about 50%.[xiv]

Conclusion

Overall Colombia has made great advances in access to healthcare of its people in recent decades as evidenced by the increase in life expectancy, however barriers to healthcare remain. Further challenges for the country reflect its position as a developing economy with a concomitant shift in the pattern of disease. Reflecting this, levels of children under 5 being underweight have fallen from 18.6% in 1966 to 3.4% in 2010, but by one estimate the burden of chronic disease has increased by 40%

between 1995 and 2005.[xv] Obesity levels were 16.5% in 2010, with over half the population, 51.2%, overweight.[xvi] It appears that just as Colombia deals with problems of underdevelopment, the pandemic of obesity and chronic disease of the developed world has already hit Colombia, and the consequences for the nation's health are, and will be, widely felt.

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[i] CIA World Factbook. https://www.cia.gov/library/publications/the-world-factbook/geos/co.html

[ii] WHO Global Health Observatory Data Repository. Accessed 7/5/14 available online at http://apps.who.int/gho/data/node.country.country-COL?lang=en

[iii] CIA World Factbook. Accessed 6/5/14 available online at https://www.cia.gov/library/publications/the-world-factbook/geos/co.html

[iv] http://www.quandl.com/colombia/colombia-mortality-and-disease

[v] http://www.worldlifeexpectancy.com/colombia-violence

[vi] WHO Dept of measurement and health information 2011

[vii] World Bank. http://data.worldbank.org/indicator/SH.MED.PHYS.ZS

[viii] Colombia: A Healthcare System in Crisis. Yepes, Fransisco. Medical Solutions, November 2012. www.siemens.com/healthcare-magazine.

[ix] Ursula Giedion and Manuela Villar Uribe, Colombia's Universal Health Insurance System. *Health Affairs*, 28, no.3 (2009): 853-863.

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[xi] Colombia's response to healthcare crisis. Oscar Bernal, Juan Camilo Forero, Ian Forde. BMJ 2012;344:e802.

[xii] J.C. Echeverry et al., "Monthly Report: Health System Crisis with Macro Consequences" (New York: Latin Source, 30 August 2008).

[xiii] Fijan precios máximos a 195 fármacos que tienen costos 'disparados'. El Tiempo, 25/6/13. http://www.eltiempo.com/vida-de-hoy/salud/fijan-precios-maximos-para-195-farmacos-_12948044-4

[xiv] POBREZA MONETARIA Y MULTIDIMENSIONAL 2013, DANE. http://www.dane.gov.co/files/investigaciones/condiciones_vida/pobreza/bol_pobreza_13.pdf

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[xvi] La obesidad y su concentración según nivel socioeconómico en Colombia Karina Acosta. Documentos de trabajo sobre Economia Regional. Banco de la Republica – Centro de Estudios Economicos Regionales – Cartagena. http://www.banrep.gov.co/sites/default/files/publicaciones/archivos/dtser_170.pdf