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Bureaucratic Itineraries in Colombia. A theoretical and methodological tool to assess managed-care health care systems

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ABSTRACT

Steady increases in the number of Colombians insured by the health care system contrasts with the hundreds of thousands of legal actions interposed to warrant citizen's right to health. This study aims to analyze the relationships among patients' experiences of denials by the system, the country's legal mechanisms, and the functioning of insurance companies and service providing institutions. We conducted a mixed-methods case study in Bogotá and present a quantitative description of 458 cases, along with semi-structured interviews and an in-depth illness history. We found that Colombians' denials of care most commonly include appointments, laboratory tests or treatments. Either insurance companies or service providing institutions use the system's legal structure to justify the different kinds of denials. To warrant their right to health care, citizens are forced to interpose legal mechanisms, which are largely ruled in favor, but delays result in a progressive and cumulative pattern of harmful consequences, as follows: prolongation of suffering, medical complications of health status, permanent harmful consequences, permanent disability, and death. We diagram the path that Colombians need to follow to have their health care claims attended by the system in a matrix called Bureaucratic Itineraries. Bureaucratic Itineraries is a theoretical and methodological construct that links the personal experience of illness with the system's structure and could be an important tool for understanding, evaluating and comparing different systems' performances. In this case, it allowed us to conclude that managed care in Colombia has created complex bureaucracies that delay and limit care through cost-containment mechanisms, which has resulted in harmful consequences for people's lives.

Introduction

Colombia Law 100: The new insurance-based health care system

Insurance-based Latin American Health Care reforms follow the Managed-Care model of the United States and were exported to this region to meet insurance companies' needs to expand their markets once they had reached saturation (Stocker et al., 1999). Thus, managed care has become the new paradigm in health care policy reforms (Iriart, Merhy, & Waitzkin, 2001), and the problems of deepening inequalities of the United States' market-based medicine (Rylko-Bauer & Farmer, 2002) have also started to be apparent in Latin America (Almeida, 2002; Armada & Muntaner, 2004; Armada, Muntaner, & Navarro, 2001; Homedes & Ugalde, 2005b), especially, in Colombia (De Groote, De Paepe, & Unger, 2005; De Vos, De Ceukeraire, & Van der Stuyft, 2006; Hernández, 2002; Homedes & Ugalde, 2005a). The majority of Latin American countries have implemented aspects of managed care, but only Chile and Colombia conducted full reforms (Homedes & Ugalde, 2005b).

Following the 1991 constitutional mandate that did not grant health care the status of a fundamental human right but regarded it as a public service, 1993's law 100 changed the way health care was conceived and practiced in Colombia by establishing the end of the former National Health System and the beginning of the current insurance-based General Health Social Security System. Arguing problems of fairness, corruption and inefficiency of public health care networks, the reformers attempted to transform the state's intervention, financing, and regulatory roles in health care. The proposed strategy, that was ruled without political consensus (Plaza, Barona, & Hearst, 2001), marked the end of the previous subsidies to supply approach (direct money transfers to public hospitals), and the beginning of subsidies to demand, in which local governments buy managed-care insurance for the poor from

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competing insurance companies (Gaviria, Medina, & Mejia, 2006; Plaza, Barona, & Hearst, 2001). The provision of services was to adopt a "structured pluralism" model, defined as an organizing structure with explicit rules and functions for the interactions of a choice exerting population, a modulating state, a financing social security network of institutions, and an increased pool of service providers (Londoño & Frenk, 1997). This structure, considered the first large-scale experiment with managed competition in the developing world, depended on the state's regulation of a market of new health care insurance companies *(EPS—Empresas Promotoras de Salud)*, service provider institutions (private clinics became *IPS—Instituciones Prestadoras del Servicio* and public hospitals were transformed into companies, *ESE—Empresas Sociales del Estado)*, and consumers, who would exert power by choosing the best services from different options, given that risk adjusted premiums are fixed by the state (Londoño & Frenk, 1997; Plaza, Barona, & Hearst, 2001).

By changing the financing of the health care services, the new system required definitions of levels of care to be provided according to the adjusted premium (Resolution 5261 of 1994), and stratification of users according to their payment capability with the intention of eliminating free of charge care, recovering costs, and earning money to pay foreign debt (OPS, 2002). Citizens with higher payment capability are required to purchase private health care insurance plans (11% of their income, Contributory Regime), which consists of a standard benefit package with three levels of care (I basic, II intermediate, and III complex) that are part of the Health Obligatory Plan (POS-Plan Obligatorio de Salud). In addition, 1.5% of their income is transferred to a fund that along with other sources of financing, such as taxes, is used by the state to pay subsidized policies for people without payment capability (Subsidiary Regime), who receive only the first level of care plus a few treatments included in levels II and III of the contributory regime (Resolution 306 of 2005) in a package known as Subsidized-Health Obligatory Plan (POS-S). Although these differences in what is covered by each plan were intended to be temporary, the discrepancies between the two systems have persisted, leading to a historical consolidation of class-based inequalities in regards to health care in Colombia (Hernández, 2002).

A transitioning period was proposed with the goal of universal coverage in 2000. When people are outside of the two regimes, that is when they have proven that they cannot afford private insurance and subsidized insurance companies also do not affiliate them arguing lack of expanding-users capability, they are called, paradoxically, insiders *(vinculados).* Insiders receive care in public hospitals in an event by event basis through funds that health care secretariats allocate to the hospitals. All people, however, according to income and type of affiliation to the system, including insiders, are asked to pay a fixed amount for each consultation, exam or prescription, or a percentage of the particular service or event they require.

Evaluations of the reform

After 15 years of the reform, there are two opposing sets of results, analyses and arguments. For reformers, the fact that the number of people with insurance increased from 13.4% in 1993 to 82.7% at the end of 2005 is an irrefutable success (Londoño, 2002; Ministerio de Protección Social, 2006). However, critics of the reform argue that official numbers are biased, and that whether enrollment in insurance equates access to services or higher quality of care is highly debatable (De Vos, De Ceukeraire, & Van der Stuyft, 2006; Hernández, 2002; Plaza, Barona, & Hearst, 2001).

The system's performance and promotion of equity have also been a disputed topic. In 2000, the WHO ranked health care systems based on a new indicator of performance, which was claimed to be a step towards evidence-based health policy (Murray & Frenk, 2000). The Colombian health care system ranked as best in the Americas in overall performance and first in the world in fairness in financial contribution, measured as households' contribution to the system's financing (WHO, 2000). These results that were claimed to be indicative of the country's improvement in equity (Londoño, 2002) were highly criticized, not only because of the measurement's technical problems, but also because the WHO, by using these new indicators, was favoring private interests at the expense of peoples' health (Almeida et al., 2001; Navarro, 2000; Waitzkin, 2003). In fact, other studies of equity have found that, in Colombia, the poor have increased their health care expenses while the rich have reduced them (Homedes & Ugalde, 2005a, 2005b). The International Society for the Equity of Health ISEH (2006) presents a summary of mixed results with more poor people being insured as a significant step towards equity, and increases in out of pocket expenses as a sign of increased inequity. In addition, ISEH finds that many Colombians remain uninsured, that the significant increases in the country's total expenditures in health care cannot be continued for much longer, and that the inequities between subsidiary and contributory regimes have not been resolved.

According to official data from the Ministry of Social Protection (in charge of health and labor) and some scientific studies, the reform has been successful given that the country is closer to universal insurance coverage; quality and efficiency are improving, and users' satisfaction is increasing (Ministerio de Protección Social, 2006). Yet, other studies argue that not only have health care costs for both the state and the citizens escalated, but that traditional public health indicators, such as mortality rates, also show significant setbacks (Gómez, 2006). Failures of the system have been related to several factors, including increases in preventable diseases associated with a decline in vaccination rates, the end of prevention and public health programs, the collapsing of the public health care networks represented by the closing of many public hospitals, the revoking of the right to adequate labor for health care workers, and the promotion of a market mentality that has shifted the focus away from health care (Acosta-Ramírez, Durán, Eslava, & Campuzano, 2005; Homedes & Ugalde, 2005a; OPS, 2002; ISEH, 2006; Velez, 2008). Some studies have begun to show that, when the insurance-based system transforms the hospitals to for-profit institutions with managerial mentality, problems in denial, access and quality of care start to be evident (Abadía-Barrero et al., 2007; De Groote, De Paepe, & Unger, 2005; De Vos, De Ceukeraire, & Van der Stuyft, 2006; Defensoría del Pueblo, 2007b; Homedes & Ugalde, 2005a; Velez, 2008).

Citizenship and health care in Colombia

Although the constitution did not identify health care as a fundamental human right, it provided legal mechanisms that any citizen can implement when they feel any cultural, social, political, or health right has been violated. *Tutelas* (writ for the protection of constitutional rights) are the most common legal action used by citizens to ask the judiciary system to protect their rights. Of the 1,067,070 writs initiated by Colombians between 1999 and 2005 (most current data), 30.76% (328,191) asked to grant the right to health specifically (Defensoría del Pueblo, 2007b). Right to health writs are increasing every year (21,301 in 1999, 42,734 in 2002, and 81,017 in 2005), both in numbers and as a percentage of total writs (Defensoría del Pueblo, 2007b; Vélez-Arango, Realpe-Delgado, Gonzaga-Valencia, & Castro-Castro, 2007). This may reflect the international literature that reports that the system is based on failed policies that deepen inequalities and access problems (De Groote, De Paepe, & Unger, 2005; De Vos, De Ceukeraire, & Van der