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WHEN CURBING SPENDING BECOMES THE TOP PRIORITY: COLOMBIA TRIES TO BALANCE HEALTH NEEDS AND FISCAL CAPACITY, 2013–2017 (SHORT VERSION)

This summary draws on an ISS case study with the same title can be found on the ISS website. Gordon LaForge drafted the full case based on interviews conducted in Bogota, Colombia in September 2018. Case published November 2018. Summary published in May 2019.

BACKGROUND

In 2012, Colombia's public health system was headed for bankruptcy even though the country had made significant progress on important public health priorities by expanding immunizations, reducing infant mortality, and attaining near-universal insurance coverage. But a Constitutional Court ruling that the government had to pay for almost all health services and technologies for those it subsidized, combined with rising pharmaceutical prices, was pushing the budget into deficit.

Economist Alejandro Gaviria reluctantly became minister of health and social protection in the midst of that simmering crisis. To contain spiraling costs while enabling the sector to focus on some of its priorities, he worked to create legislation that would limit the services the government covered, that would regulate the drug market, and that would adjust an incentive structure that had reduced accountability and encouraged excess. In parallel, budget officials in the health ministry, the Ministry of Finance and Public Credit, and the National Planning Department tried to improve financial management of the system in order to increase efficiency and reduce costs. "As health minister, I wanted to tour the hospitals in the provinces and promote vaccines and talk about disease," Gaviria said. "But every day, it was all just about the money."

KEY ISSUES

- A court ruling that health care was a fundamental right administered at the discretion of physicians had triggered an explosion of individual demands for government health services outside the standard package of national health insurance benefits—including experimental drugs and treatments such as dolphin therapy—which led to an unsustainable rise in costs.
- Costs were already exceeding revenues because of a decision to align benefits for higher-income recipients paying into the contributory system with benefits for the roughly one-half of the population receiving subsidized care under Colombia's universal health insurance system.
- A previous presidential administration had liberalized all drug prices, giving the industry free rein to charge whatever it wanted, and as a result, Colombia's drug costs were among the highest in the hemisphere, adding to the health-care cost crisis.
- While the government was struggling to meet all of those costs, it faced the hazard of falling short in meeting its other health priorities. It was already confronting such challenges because the country's highly decentralized system had no authority over health spending by individual states. That lack of a centralized oversight led to inefficiencies and in some cases fraud.

REFORM STRATEGY

Gaviria's strategy for tackling the funding crisis had three main components: reform of an incentive system that had produced unsustainable spending and tempted insurers and providers to engage in corrupt practices; attempts to control spiraling costs under the government-run health insurance system by passing legislation that would define—and, more important, restrict—the right to health care; and regulation of drug prices. In short, Gaviria aimed to change the whole organizational culture surrounding health care in Colombia.

As part of the effort, the health ministry had to improve levels of efficiency in the areas of planning, budgeting, and financial management.

ACTIONS TAKEN

In seeking to reduce the impact of the court ruling requiring the government to cover all prescribed medical treatments (even unproven and exotic therapies) Gaviria saw—in a section of the ruling that called for the government to change the law to define the public right to health care—an opportunity to restrain spending. In 2012, he formed a team to draft two bills. The first, La Ley Estatutaria de Salud (the Statutory Law of Health), would define the right to health care and the government's obligation to provide it. The second, a health-focused Ordinary Law (Ley Ordinaria, one

level below a statutory law in Colombia's common law system), would include a variety of reforms to bring down costs and at the same time improve quality and access.

Gaviria's team also laid the groundwork for the incorporation of cost containment measures in the next National Development Plan, scheduled to begin in 2014. A key measure was the creation of a single account to gather and disburse all of the disparate revenues that went toward the financing of national health insurance premiums, which included funds from general, payroll, consumption, and sin taxes as well as about a dozen lesser sources. Before Gaviria's term in office, management of the bulk of those revenues had come under the trust of fiduciary funds: privately run health accounts that were opaque, prone to malfeasance, and sources of high administrative costs.

Following adoption of the plan for a unified account, a ministry-appointed committee established a semiautonomous statutory agency, the Administrator of the Resources of the General System of Social Security in Health (Administradora de los Recursos del Sistema General de Seguridad Social en Salud, or ADRES), to serve as a kind of bank for the government health system. ADRES built the largest database on health expenditure in the country, using the data it acquired to search for potential business process improvements, to evaluate potential savings, and even to identify abuses.

Another key matter was the cost of pharmaceuticals, which accounted for an estimated 25% of total public health expenditure in the country. The government before the administration of President Juan Manuel Santos, who appointed Gaviria, had deregulated the industry, leaving companies free to charge what they wanted. And with the Constitutional Court ruling, the government had to pay for whatever physicians prescribed—no matter the cost: even for unproven, experimental drugs.

The health ministry gathered a team of outsiders to decide how to regulate drug prices. In addition, the government created a National Commission for Medicine and Medical Device Prices. It concurred with the outsider team's recommendation to use international reference pricing—basically, to adopt prices from foreign markets and use them in Colombia.

The development of Excel spreadsheets for calculating the price of each drug helped overcome resistance to regulation. The spreadsheets were completely transparent; companies, hospitals, and any other stakeholders could see the exact formulas for determining prices. Also, the health ministry was aggressive in resisting multinational drug companies' resistance to price regulations, using public opinion to push back on pressure to rein in its efforts.

The health ministry's lack of oversight of public health programs and activities in the provinces posed yet another challenge for Gaviria. Colombia's 32 states, known as departments, and the country's municipalities administered almost all of the government's activities with regard to meeting

national public health priorities such as the United Nations Millennium Development Goals. And even though health ministry officials met with department health secretaries to develop plans for health programming, the ministry had no power to compel the departments to implement those plans with fidelity. Neither did it nor the finance ministry exercise oversight of department budgets. Audits conducted by accountability agencies in the Colombian central government, such as the office of the comptroller and the attorney general's office, often revealed gross mismanagement and fraud.

Starting in 2014, health ministry officials began devising a different blueprint for health care in remote departments so as to enable the ministry to exercise stricter stewardship. The officials engaged consultants and academicians and designed a model to enhance the provision of primary- and preventive-care public health in remote and rural areas. The Comprehensive Health Care Model sought to establish a holistic network tailored to an area's specific, primary health needs. The network comprised three main nodes: a single health insurer familiar with the area, service providers, and municipal health officials. The goal was to align the three so as to guarantee quality preventive health services to the entire population of a department.

RESULTS

By 2018, it remained unclear whether the government would meet the objectives outlined in the 2014–18 National Development Plan, and health outcomes still varied widely by department. There were, however, signs of progress: access to services had increased and out-of-pocket expenditures were comparatively low.

The planning, budgeting, and financial management of the system also had improved. Though barely a year old in 2018, ADRES—the de facto bank that centralized the health sector's financial functions—was improving health revenue management. From 2014 to 2017, the ministry of health had the best budget-execution rate of any sector in the government.

Gaviria and his team initiated additional reforms that helped corral some of the sector's runaway expenditure: The ministry regulated the prices of more than 1,800 pharmaceuticals. A lawyer who was on the minister's price regulation team estimated that since 2013, the measures had saved the country 4.2 billion Colombian pesos (about US$2 million). And the ministry's law reforms established a framework and a procedure for excluding certain health services from public provision despite strong pushback from the president's office and national medical board that limited their scope. "We were able to put some reasonable restrictions on the right to health care," said Gaviria, adding that although it didn't solve the problem, "the law has been instrumental for having a more reasonable debate about the inputs of the system."

Still, the health system was teetering on the brink of insolvency. And even though the government attempted to place caps on out-of-package

budget expenditure, spending on the services remained theoretically unlimited. "If you think of the system like a leaky bucket, there are two things you have to do: plug the leaks and add more water into the bucket," said Jaime Cardona, a senior health ministry adviser. "Under Gaviria, we did add more water—by reducing drug costs and adding more tax revenue—which was good. But we didn't plug the leaks."

LESSONS LEARNED

- The development of sources of clear and complete information about costs and spending was crucial to attempts to bring costs and spending under control.
- Health spending by Colombia's individual states—essential to improving health equity and outcomes—fell outside the health ministry's direct control, but the ministry's establishment of model protocols for the departments to follow in their budgeting helped bring some order to the system.
- The harnessing of public opinion was powerful. When the UK ambassador wrote to Colombia's health ministry, pressuring it to back off price regulation of a drug a British company manufactured, the ministry published the letter publicly, and the ambassador, under heavy criticism, issued an apology.