



INNOVATIONS FOR SUCCESSFUL SOCIETIES

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

SYNOPSIS

In 2012, Colombia's public health system was headed for bankruptcy. The country had made significant progress on important public health priorities: 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 became minister of health and social protection amid that simmering crisis. To contain spiraling costs while enabling the sector to focus on some of its priorities, he worked to create new legislation that would limit the services the government would cover, regulate the drug market, and adjust an incentive structure that had lowered 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. In the end, some of Gaviria's efforts paid off and the ministry averted immediate insolvency, but as of 2018, the viability of Colombia's health-care system remained in doubt even as health indicators improved.

Gordon LaForge drafted this case study based on interviews conducted in Bogota, Colombia in September 2018. Case published November 2018.

INTRODUCTION

The Constitutional Court of Colombia in 2008 issued a ruling that threatened to break the country's universal health-care system. Health care, the court said, was a fundamental right administered at the discretion of physicians. The ruling cemented a judicial consensus: the government had to pay for health care—all of it. The decision triggered an explosion of individual demands for services outside a standard package of benefits, things like diapers, transportation to medical appointments, and even dolphin-assisted therapy for children with disabilities.

The decision highlighted the potential cost of an ambitious social agenda. Fifteen years earlier, after adopting its 1991 constitution, the government had passed Law 100, which charted a path to universal health coverage. In 1992, 20% of Colombians had health insurance, and by 2011, as many as 98% did. "This was without doubt the most important social achievement in Colombia in the past 50 years," said Augusto Galán, a physician who was minister of health from 1995 to 1996.

The health insurance system comprised two regimes. The *contributory regime*, mandatory for

formal workers—meaning, employees who paid taxes—and those with the ability to pay, was financed through a 12.5% payroll tax.¹ The *subsidized regime*, which covered more than 22 million poor and unemployed people, drew funds from more than a dozen sources, such as general taxes, consumption taxes, and special sin taxes on alcohol and tobacco products, some of which were collected by the nation’s 32 subnational governments, called departments. All health revenues flowed into a single account with five subaccounts managed by a consortium of fiduciary funds under the oversight of the health ministry. There was one subaccount apiece for the subsidized regime, the contributory regime, health promotion and prevention efforts, catastrophic auto accident insurance, and liquidity injections for service providers, called *guarantees*.

The population split between the contributory and subsidized regimes was roughly 50-50, save for a small percentage of people who enrolled in special social security schemes or paid for commercial health insurance. Health maintenance organizations were the main purchasers in the system and managed provision of the standard benefits package.² In addition to the subsidized regime, the government health budget paid for a small number of public health, disease prevention, and health promotion projects such as a public immunization program.

That system—already facing challenges because of rapid growth, high drug costs, and other factors—was buckling under the financial strain caused by the rapid expansion of government-funded services that the Constitutional Court decision had authorized. Domestic government health expenditure—roughly 70% of total health spending—accounted for 14% of general government expenditure and about 4% of the country’s gross domestic product. In per-capita terms, domestic government health expenditure had just about doubled in a decade, rising to US\$274 per person in 2010 from US\$106 in 2000 in constant terms. At a time when economic growth was beginning to slow and government debt was on the rise,

spiraling health costs presented a serious problem.

In 2012, President Juan Manuel Santos, two years into his first term, called Alejandro Gaviria and offered him the job of health minister, with a specific mandate to resolve the looming crisis. Trained as a civil engineer and then as an economist, Gaviria was dean of the economics faculty at the University of Los Andes, Colombia’s premier public university. He wrote columns for national newspapers and often served as an independent public commentator.

Gaviria wanted to decline the appointment. “I felt at the time that the health system was about to collapse, that this was an impossible job, that the system was doomed to fail, and that it was going to have terrible consequences,” he said. But a sense of ethical obligation gnawed at him. A government-provided scholarship had paid for his economics PhD at the University of California, San Diego. He recalled feeling compelled to give back, and he realized that as an academician, he had evidence-based knowledge and technocratic expertise that could benefit the country. He took the job.

The court ruling that the government had to pay for health services outside the package of benefits threatened the health system’s sustainability. To keep the system solvent, Gaviria and other government leaders would have to find ways of increasing revenue and reducing costs through better regulation and more-efficient financial management. Failure meant, at best, that the government would fall short in addressing the health priorities it had identified for action, which were (1) to improve access and quality of services, (2) to develop public hospitals, (3) to narrow gaps in coverage, (4) to reduce the incidence of communicable disease, and (5) to expand the public vaccination program. At worst, failure would mean collapse of the country’s health system.

THE CHALLENGE

The government’s non-finance-related health priorities reflected the stark reality of Colombia’s

health care system. Colombia was a unitary state but highly decentralized, diverse, mountainous, and unequal. Though, technically, everyone in the country's federal district and 32 subnational departments had coverage, access to health services was highly variable—especially for poor rural residents who could not afford to travel to hospitals in the capital. At least 30% of the country's 46 million citizens—some 14 million people—lived in rural areas with insufficient access to service providers. “In theory, everyone has access to MRIs and high-cost drugs, yet people lack basic health services in some regions,” said Aurelio Mejía, a Colombian health economist. At the time, about 15% of the population lived on the equivalent of less than US\$3.20 per day.³

Protracted conflict, which had only recently eased, worsened those inequalities. Many rural residents lived in areas emerging from a civil war that had left 220,000 people dead, 25,000 missing, and 5.7 million displaced since the early 1970s.⁴

When the Santos government took office in 2010, the proportion of children vaccinated against childhood diseases had only recently risen above 90%.⁵ Although the government estimated mortality among children younger than five years old had fallen from 35.13 per thousand live births in 1998 to 24.89 in 2010, the distribution of improvements was uneven.⁶ For instance, in 2008, Bogotá reported infant mortality was 16.9 per thousand live births, whereas the coastal department of Chocó reported 68 infant deaths per thousand live births. And malaria and other mosquito-borne diseases still posed threats.

The 2010 National Development Plan had highlighted a range of priorities, including (1) reducing infant mortality to 17.5 per thousand live births by 2014—a target under the United Nations' Millennium Development Goals, (2) reducing maternal mortality from 75.6 per 100,000 live births to 48.8, (3) expanding immunizations to 95%, (4) reducing the prevalence of HIV, and (5) increasing the prevention of kidney disease and high blood pressure. Ensuring the inclusion of all parts of the

country in such gains and sustaining improvement in those health benchmarks normally would be among a health minister's first responsibilities. But the Colombian government, in its rush to provide universal health coverage, had spawned an unsustainable system. The challenge to Gaviria's team was to guarantee that this system could meet its main obligations. “The limitations of budgets are no excuse to deny health services,” said Jaime Abril, deputy director of health and labor risks at the Directorate General for the Economic Regulation of Social Security in the finance ministry. “But because funds are finite, that forced us to constantly seek efficiencies in the system.”

Reducing those inefficiencies would not be easy. Public expenditure on health care had grown 68% from 2002 to 2008, and even before the Constitutional Court ruling, it had increased further when, in a move to improve equity, the government brought the subsidized regime's benefits package in line with that of the more generous contributory regime. The result was a 45% increase in the amount of the premium the government paid on behalf of poorer residents. Projections indicated that expenditures would continue rising faster than revenues in the coming years.

An even greater difficulty was the overhaul of certain policy incentives that drove up those costs. The health ministry paid a per-capita sum to insurance companies to cover the premium for the package of benefits, called the Plan Obligatorio de Salud.⁷ “There are incentives for insurers to manage those funds efficiently, because they receive their money from the per-capita insurance premium the government subsidizes,” Abril said. But the Constitutional Court's ruling that the public system must also cover services outside that plan was subject to no such constraint. Though many out-of-package items were expensive, experimental, and, in some cases, unnecessary, doctors had greater incentive to prescribe them because they could do so directly through an online system rather than having to first request permission from the

insurance companies. “The out-of-package services [paid for directly by the government] are not managed by any insurer, and thus there are no incentives within the system to manage or control those expenses,” Abril said. If the government tried to refuse reimbursement for an out-of-package service, patients would file *tutelas*, fast-tracked civil lawsuits whereby a court forced the state to cover the cost. Although the expense was modest in comparison to the overall budget—about 3.1 billion pesos (Col\$), or about US\$1.6 million in 2013, which was roughly 8% of the total health budget—the amount was both likely to increase without a commensurate expansion of revenue and highly unpredictable. (Text box 1.)

Pharmaceuticals accounted for 85% of those out-of-package costs. The previous presidential administration had liberalized all drug prices, giving the industry free rein to charge whatever it wanted. “We were paying for all of these expensive medicines at probably the highest prices in the Americas, with the exception of the United States,” said Gaviria. “So you have a system where everything is included, and you

have to pay the price pharmaceutical companies want to charge. That’s a recipe for disaster.”

Unlike several of its neighbors in Latin America, Colombia had a record of fiscal prudence and macroeconomic discipline and had never suffered a major public-spending crisis. That was due in part to a powerful finance ministry as well as rigorous, codified planning and budgeting processes. Nonetheless, lack of accurate and timely data from insurers, doctors, and other providers together with poorly interconnected information subsystems made it hard to align yearly budget expenditures with longer-term targets and frameworks and thereby ensure adequate oversight. The division of the government health account into five subaccounts, managed under an independent fiduciary fund or public trust, proved not only cumbersome but also difficult to monitor. And in general, no performance indicators and metrics for health services were available. “When you look at the health budget, you can see many programs for which you don’t know whether the allocation is efficient or effective because you don’t have

Text box 1: The NoPOS and Tutelas

The essential benefits package called the Mandatory Health Plan (Plan Obligatorio de Salud, or POS) covered a raft of procedures, medicines, and health technologies for every Colombian. Anything outside that package (No Plan Obligatorio de Salud, or NoPOS) was an out-of-pocket expense—at least that was what the 2008 Constitutional Court ruling said the government had to cover. That created a major headache for insurers, which received a per-capita premium subsidy from the government to cover benefits package services up front but which would have to seek reimbursement from the government for out-of-benefits-package services. Some policy makers argued that the benefits package should simply expand to implicitly cover everything, except for a negatives list of explicit exclusions. Doing that, however, would have meant an increase in the per-capita insurance premium, which the finance ministry opposed.

In cases in which the government refused to cover out-of-benefits-package services, people seeking to receive those services might file *acciones de tutela* (guardianship actions) against the government. Arising from the 1991 Colombian Constitution, a tutela was a fast-tracked legal suit whereby a person claimed the government had failed to protect one of the fundamental rights enshrined in the law. After the court ruling affirmed that health care was one such fundamental right, the use of tutelas exploded. Advertisements for tutela lawyers were plastered on lampposts and walls across Bogotá. The suits confounded policy makers and budgeters, who began including a line item in each annual budget to project tutela expenses. And because of the court ruling, there was no way to stop them.

indicators for assessing those programs,” said Gilberto Barón, a longtime adviser to the health minister. Abril at the finance ministry echoed that point, saying the budget process should be formally tied to targets and measurements.

Further, Colombia’s 32 subnational governments (departments) and municipalities administered almost all government public health activities and programs. Around 30% of Colombia’s public budget went directly to them, and of that, 24% went to health, in 2013. Though that money was earmarked for health programs, such as those focused on reducing maternal mortality or addressing other Millennium Development Goals, it did not always reach those destinations. While health ministry officials developed biannual plans with health secretaries in the departments, they had no way to compel the departments and municipalities to follow those plans or to spend the money on what the money was earmarked for or to otherwise align their activities with national objectives. The comptroller general’s office reported that from 2011 to 2013, the national government transferred US\$242 million to 17 departments for the improvement of health facilities and hospitals, but those departments spent only US\$97 million of that total, about 40%.⁸ In some areas, limited capacity to absorb allocations—to carry out programs as intended—and poor expenditure control helped account for these results.

Corruption and abuse of the system abounded elsewhere—particularly at the insurance companies, which were relatively opaque and had the power to define and control their own provider networks. In 2011, the government seized SaludCoop, Colombia’s largest health insurer, whose managers had, according to the comptroller general’s office, committed financial and accounting fraud and embezzled 1.4 billion Colombian pesos (US\$740,448).⁹ Another insurer continued to receive government money to pay the premium for some 16,000 patients older than 100 years, who, oddly, never claimed any services.

FRAMING A RESPONSE

When Gaviria became health minister in 2012, he was eager to focus on the government’s public health priorities, such as improving rural access and public hospital infrastructure. But he had landed in the middle of a slow-burning financial crisis that was about to blow up. “As health minister, I wanted to tour the hospitals in the provinces and promote vaccines and talk about disease,” he said. “But every day, it was all just about the money.”

Gaviria’s strategy for tackling the problem had three main components: reforming an incentive system that produced unsustainable spending and tempted insurers and providers to engage in corrupt practices; passing legislation that would define—and, more important, restrict—the right to health care; and regulating drug prices. In short, Gaviria aimed to change the whole organizational culture surrounding health care. And as part of that effort, the health ministry would have to work with the finance ministry, the National Planning Department, and the subnational governments to improve levels of efficiency in planning, budgeting, and financial management.

Financial management practices and systems were already in place that would help the ministry of health develop and execute a reform agenda. Also, the finance ministry had rolled out a new, integrated financial management information system (IFMIS) that would facilitate improved execution and monitoring of the annual health budget. The creation of that budget followed a strictly structured process.

Because curbing costs would absorb nearly all of his time, Gaviria appointed Fernando Ruiz Gómez, a physician and public health expert, as the deputy minister of public health and provision of services to handle the government’s public health priorities. Gaviria’s team began devising a new health-care model in order to increase the ministry’s stewardship over primary care facilities in territories far from Bogotá. Faced with the

inability to compel departments and municipalities to enact programs that would improve prevention and address key public health priorities such as reducing communicable disease, they began to develop model protocols that would improve links between the insurance companies, providers, and the communities they served. The goals of the new approach—in the form of the Comprehensive Health Care Model (Modelo Integral de Atención en Salud) or MIAS—were to both meet national public health priorities and cut costs.

GETTING DOWN TO WORK

Maintenance of insurance coverage for the entire population was always the top priority at the country's health ministry. In 2013, more than 85% of government health expenditure, which totaled Col\$38 trillion (about US\$20 billion), went to per-capita insurance premiums. Programs for public health and promotion and prevention accounted for Col\$2 trillion (about US\$1 billion). And Col\$3.1 trillion (about US\$1.6 billion)—the second-largest expenditure—was for covering out-of-benefits packages and court-ordered settlements from tutelas, the civil suits. The government spent nearly one-third as much on those high-cost services as on all public health programs combined.

Planning and budgeting followed a strict calendar enshrined in law and mandated under the constitution (see figure 1.) The process typically yielded far too many proposed priorities, which senior officials then had to trim to manageable proportions.

Each new Colombian government developed a four-year plan—a concrete road map for that administration's policy agenda across all sectors. Working with each ministry and other stakeholders to set priorities and establish specific programs and projects to meet those priorities, the National Planning Department shepherded the process. Congress enacted into law the

resulting document, which was typically about a thousand pages and contained references to things the government might want to do. For the next four years, any program the government implemented had to align with one of the provisions in that law.

The process typically began in August, and during September and October, the National Planning Department asked each ministry and government agency for its ideas and then used the resulting information to build a rough draft. In mid November, it presented its proposal to an intergovernmental council on planning, then to another council focused on finance, and finally to a third group, the National Planning Council. A constitutionally established consultative body, the National Planning Council comprised as many as 18,000 civil society organizations across 24 sectors.

After another three months of consultations and revisions, the final plan went back to the finance council and National Planning Council for approval, after which the National Planning Department submitted it to Congress. During the next three months, the lawmakers converted the plan's goals and guidelines into a law.

Planners reported that the most difficult part of the process involved bringing the aspirational promises of a political campaign down to the hard, constrained realities of law and budgets. Government leaders usually struggled to keep the list of goals and targets manageable.

The priorities in the National Development Plan shaped the annual budget. The health ministry's planning office costed the programs and sent its proposed budget to the finance ministry, which submitted a prebudget—an early, pro forma draft—to Congress in March. In June, the ministry consulted intensively with the line ministries and public agencies to develop a final draft budget to send to Congress for deliberation in July. Negotiations between the finance ministry and Congress continued until October, the

deadline for final approval. The president then issued the budget in a December administrative decree.

The ministry of finance also used a medium-term expenditure framework to project and set ceilings on expenditure. In June, ministry of finance budget planners met with the various ministries, which made projections for the following four years. In practice, however, the medium-term expenditure framework played only a limited role. “To be honest, we mostly focus on the next year,” said Ana María Cadena, who worked on budgets for social sectors at the ministry of finance.

The National Planning Department analyzed each program in the annual budget to verify whether it aligned with the National Development Plan, as required by law. Moreover, each project had to have both general and specific objectives as well as activities and results linked to those objectives—a so-called value-chain approach. That framework helped inform investment programs and was the first step toward budgeting by results—an Organisation for Economic Co-operation and Development (OECD) best practice that Colombia was working toward.

Given the size of the subsidy for the insurance premium—which the budget had to cover, lest people lose access to services—there was little wiggle room in the budget. Of the 30% of all national income that went to departments and municipalities, nearly a quarter went to the health sector, yet just 10% of that amount was earmarked for public health programs that addressed priorities such as those related to the Millennium Development Goals. And in practice, there was little monitoring to ensure that departments and municipalities executed those programs or spent that money with fidelity.

To manage spending, ministry of health budget officials met every two months with the people who headed each internal directorate so they could make sure things were going smoothly. After he took office, Gaviria reviewed budget performance twice a year and intervened to

correct mismanagement. Gaviria’s top priority was to solve the financial problem the health sector faced. Gaviria’s team laid the groundwork for incorporating cost containment measures into the next national plan, scheduled to begin development in 2014. The process of building the 2014–18 plan was relatively frictionless because the government—continuing into its second term—was mainly updating existing priorities instead of creating new ones, save for the introduction of cost control measures.

For the health sector, the subdirectorate for health at the National Planning Department took the lead. Félix Nates, a regulation director in the ministry of health, ran the process for 2010–14, and Anwar Rodríguez of the National Planning Department led the effort for the 2014–18 plan. A 10-member team worked with officials from the ministry of health and other government agencies to develop objectives that aligned with the three overarching themes highlighted in the national plan: equity, peace, and education. Because public health also involved sanitation, nutrition, and family planning, the team also worked with other stakeholders, ranging from the agriculture ministry to the Colombian Family Welfare Institute to ensure support.

In the final document, the section on health focused on four broad goals that, to varying degrees, comported with the objectives: improvement of general health outcomes, reductions in inequality, improvement in levels of trust in the governance of the sector, and guarantees of financial sustainability. More-specific and more-detailed policy proposals followed each of those themes, along with targets. For example, one of the targets under improvement of general health outcomes was the improvement of urgent-care-patient average waiting time from 32 minutes in 2013 to 20 minutes by 2018 (See text box 2).

Because all of the programs and projects the health ministry might want to initiate during the next four years had to explicitly connect to items in National Development Plan law, planners included a list of proposals lengthier than the

Text box 2: 2014–18 National Development Plan Priorities for Health

1. Increase effective access to services and improve the quality of care.
 - Consolidate universal coverage and unify insurance operations.
 - Generate incentives to improve quality.
 - Implement a comprehensive health-care-policy model.
 - Encourage investment in public hospitals to improve efficiency.
 - Develop alternative schemes for the operation of public hospitals.
 - Develop human talent in health policy.
 - Improve the diagnostic capabilities of laboratories at the national and regional levels.
 - Implement a national blood policy.
 - Implement an indigenous system of intercultural health.
2. Improve the population's health conditions and reduce disparities in outcomes.
 - Implement the Ten-Year Public Health Plan (2012–21) in the regions.
 - Encourage healthy lifestyle habits and reduce the adverse-lifestyle effects of noncommunicable diseases.
 - Prevent and control communicable diseases.
 - Promote social coexistence and improve mental health.
 - Improve nutrition.
 - Ensure sexual and reproductive rights.
 - Fully address the health of older people and encourage active lifestyles.
 - Improve the operation of the Expanded Immunization Program.
3. Restore trust in and the legitimacy of the health system.
 - Bring inspection, monitoring, and control closer to citizens.
 - Strengthen the institutional framework for administration of resources within the public health insurance system.
 - Simplify processes.
 - Consolidate the Integrated Information System of Social Protection.
 - Promote transparency, citizen participation, and accountability.
4. Ensure the financial sustainability of the health system.
 - Establish financial measures to restructure liabilities.
 - Obtain new revenue sources.
 - Generate financial stability and strong oversight.
 - Regulate the pharmaceutical market.
 - Reduce transaction costs.
 - Revise the mechanism for reducing risk.
 - Establish financing restrictions.
 - Define the technical mechanism for excluding services from the benefits package.

government could reasonably implement. In the list of goals for health, the most important item was the last one, which focused on curbing costs,

belying the actual priority for the sector. “If you read the document, it was very nice,” said Gaviria. “Up top, we talked about health inequalities in the

regions and problems of access, but the reality was that all of our time would go toward financial matters—dealing with a system that was on the brink of collapse.”

Implementing new information systems

In allocating and monitoring its budget, the health ministry benefited from steps other government officials had taken earlier—for example, the creation of an integrated financial management system, the IFMIS, which sharpened the usefulness of the budget as a management tool that helped the health sector achieve its priorities.

The reforms began in reaction to major gaps in the prior financial information system introduced in 2000. David Morales, a career public servant who led some of the changes, said budget officials in the finance and health ministries could see only in retrospect how money was spent, which meant ministry officials were slow to identify flagging projects and excess liquidity.

In 2003, Morales’s unit in the ministry of finance had begun building SIIF Nación, a new system for monitoring and controlling the national budget. The old system had been unable to link the budgets of the central government to the country’s 32 departments, many of which handled transactions through commercial bank accounts. Harmonizing that information required a structural change and therefore, completely new computer code. Morales’s team borrowed elements from commercial products to meet that need and moved the system from a local server into the cloud, thereby strengthening resiliency and facilitating real-time integration.

Expected implementation was in 2009, but the beta version failed initial tests. “The system wouldn’t operate properly for 40 users. We needed it to work for 10,000,” Morales recalled. He brought in international experts to troubleshoot. They found the code had been built in a way that precluded the system from functioning in every situation across all agencies.

“The scale of the problem was massive,” said Morales. During the next year, IT consultants rewrote the base code, and in 2010, Morales began new pilots, trial runs for learning how many users the IFMIS could handle, how to best order the actions required to issue a payment, and whether the panoply of pop-ups and filters would crash the system (they did). The trials also collected user feedback on the coloring of boxes and fonts. The results gave Morales the confidence to roll out the system, knowing his team would still have to correct minor issues.

The implementation, which extended into 2011, was grueling. Morales and a team of 50 finance ministry staff members had to train as many as 10,000 users and provide ongoing technical support. They went to other ministries and agencies to help train personnel. Users also came to the ministry for classes—sometimes for full, eight-hour days. The team built virtual tutorials, wrote user guides, and created channels for technical support. “We worked 16-hour days, seven days a week, for a year and a half. Nobody took vacation,” Morales recalled. “Thanks to the hard work and commitment of the team, we achieved our targets and implemented the system.”

The IFMIS led to better financial management. It enabled officials to see the funds they had available—with only a one-day lag. In many cases, via a smartphone app, leaders could check whether money was going toward priorities—without having to depend on reports from subordinates. The president could use his phone during a cabinet meeting to see how each ministry was executing its budget. And a website called the Economic Transparency Portal—launched in 2011—allowed the public to view how much the government was spending and on what.

The centralization and transparency of fund management reduced transaction costs, improved oversight, and enabled officials to identify corruption and malfeasance. Once trained in the system, civil servants at any agency could use it.

And ministries did not have to spend time and money developing their own financial management systems.

The finance ministry reported that the health ministry under Gaviria had achieved high levels of control over how it used its money. Budget execution scored 98.4% in 2015 and more than 99% in 2016 and 2017.

Changing the law

The new financial management tools available when Gaviria stepped in as health minister enabled him to focus on cost containment, knowing that his deputies could keep track of spending on vaccines and other priorities. A more immediate challenge was the effect of the Constitutional Court ruling requiring the government to cover all prescribed medical treatments. But Gaviria saw—in a section of the ruling that required the government to change the law to define the public right to health care—an opportunity to constrain spending. In 2012, he formed a team to draft two bills. The first, *La Ley Estatutaria de Salud* (officially, *Ley 1751*; in English, the *Statutory Law for Health*) defined 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.

The imperative for the Statutory Law was to reconcile a landmark 1993 law that had defined the state's responsibility to provide health care with the 2008 Constitutional Court ruling that annulled many of that law's provisions, including limits on covering the costs of services not included in the basic health package. To help draft the Statutory Law, Gaviria's team engaged one of the nation's preeminent constitutional law scholars, a former justice of the Constitutional Court who had not been involved in the ruling. "We had these incredible discussions about how to define the right to health," said Jaime Cardona, a senior health ministry advisor on the team.

"The bill covered all of it. It was awesome." The resulting draft contained 60 to 70 articles covering everything from birth control to dying with dignity.

The second bill, the Ordinary Law, included plans to, among other things, unite all fiduciary funds—the privately managed trusts—under a single, centralized account; impose capital requirements and liability ratios for insurance companies; divide the country into administrative health territories with a maximum number of insurers per territory so as to guarantee a risk pool sufficient to attract insurance providers; and allow hospitals, not just medical schools, to train specialists so as to make up for a shortage in the country's less-urbanized areas.

The proposed Ordinary Law faced stiff opposition from many fronts. Physicians' associations, which had intentionally restricted the supply of specialists in order to keep wages high, howled at the prospect of expanding hospital training. Insurance companies opposed the plan to limit the number of insurers in a territory. And lawmakers, responding to the opposition and recognizing the importance of the bill to so many interest groups, demanded sweeteners before passing it.

Nevertheless, work on both bills progressed—until the president summoned Gaviria to a meeting in 2013. When he arrived, Gaviria found in attendance an influential senator and the leaders of the *Gran Junta Médica Nacional* (Grand National Medical Board), a federation of the country's most powerful medical associations, who told him that, given the opposition, the proposed Ordinary Law could not move forward. Congress would fast-track a version of the Statutory Law, but in place of the version Gaviria's team's meticulously crafted legislation, the federation presented the health minister with a perfunctory list of bulleted items.

Gaviria designated Cardona and Marcela Montealgre, a legal advisor in the health ministry, to work with the federation to hammer those points into a new bill. The result was a far cry from the comprehensive draft. The new law

defined and restricted the right to health care but enumerated only four types of services the state could refuse to pay for: medicines not licensed in the Colombian market, cosmetic procedures, experimental technologies, and drugs proven to be ineffective. In its subsequent review of the law, the Constitutional Court enumerated further restrictions on those limits, such as that a doctor could overrule one of the limits by determining that a service was necessary for the health of a patient.

Regulating drug prices

Another key matter the health ministry sought to address was the cost of pharmaceuticals, which accounted for an estimated 25% of total public health expenditure in the country.¹⁰ The government before the Santos administration had deregulated the industry, leaving companies free to charge what they wanted. And with the court ruling, the government had to pay for whatever doctors prescribed no matter the cost. “Colombia was, for many pharmaceutical companies, a feeding frenzy. It was the place to be,” said Gaviria.

Pressure to control drug prices came from the public as well as the ministry. Óscar Andía, a prominent left-wing physician in exile to Colombia from Bolivia, led a highly visible popular movement decrying big pharma’s predatory behavior.

The health ministry gathered a team of outsiders to decide how to regulate drug prices. Gaviria gave Claudia Vaca, a pharmaceutical chemistry professor who had studied price regulation in her academic work and was already in the ministry as a senior adviser, a free hand to develop and implement a pharmaceutical pricing policy; Vaca then brought in Carolina Gómez, a lawyer at the government agency that regulated food and drugs; and the president’s office added a spot for an economist on the team, ultimately filling it with Andía’s daughter Tatiana, an assistant professor of sociology at the University of Los Andes, who had also written about the subject and agreed with her father on many,

though not all, issues. “We were all just visiting bureaucrats,” Gómez recalled. “We were there just for a mission and not for a career, so we could take risks. We didn’t care if we lost our jobs.”

The team’s first step was to develop a methodology for the pricing of medicines. The government created a National Commission for Medicine and Medical Device Prices, comprising the ministry of health; the Ministry of Trade, Industry and Tourism; and the president’s office. The commission also consulted with representatives of pharmacies, industry, medical associations, and advocacy groups such as the one Óscar Andía led. The commission agreed with Vaca’s team’s recommendation to use international reference pricing—basically, to adopt prices from foreign markets and use them in Colombia.

For the next four months, the commission met almost weekly to iron out the details. It met regularly with representatives from the pharmaceutical industry as well. Many sticking points emerged: (1) whether to regulate prices for the commercial market as well as for the public market (the commission decided yes); (2) level of transparency (the industry refused to release information on the prices it charged and how it set those prices, so the regulators, intent on being radically open in the whole process, used free, publicly available databases to gather the data they needed); (3) whether to base prices on generics or only on brand-name medications, as the industry wanted (the commission decided on generics pricing but only if the drugs were already being sold in Colombia); and (4) which international reference price to use (the 25th percentile, which was usually the third- or fourth-lowest price on the global market). The commission made decisions by majority vote, but the discussions were highly technical, and usually, a consensus emerged.

The methodology was in place by May 2013, and Gaviria’s team of so-called visiting bureaucrats began the painstaking, drug-by-drug work of determining and setting the new prices.

For that, they needed help. Gaviria, as former dean of the economics school at a prestigious university in Bogotá, tapped former and current students to help identify and analyze drug price information and then link the information to appropriate international reference prices. The team conducted the implementation in phases by, analyzing a set of around 500 drugs and setting prices for a few hundred.

At first, obtaining the necessary data posed a major challenge. In the health ministry, all of the information with regard to which medicines were prescribed and at what costs was under the purview of a single career civil servant who refused to share that data in its entirety—even with the minister. To circumvent the problem, the price regulation team tasked one of the students to befriend the man and gain access to the data. He succeeded—and used the information to create massive Excel spreadsheets for calculating the price for each drug. The spreadsheets were completely transparent; companies, hospitals, and any other stakeholders could see the exact formulas that had determined the prices.

The first medicines the team targeted were biologics—high-tech, expensive drugs used in the treatment of certain types of cancer and other, rare diseases. Though few people used them, the drugs cost the system dearly.

Resistance was stiff. Hospitals, which marked up the prices of medicines they bought, said they would go under if they lost that revenue. Such a claim was unverifiable because the hospitals refused to release information about their margins, so the National Commission for Medicine and Medical Device Prices decided to specify regulated markup prices for hospitals.

Unsurprisingly, the strongest opposition to implementation came from the pharmaceutical industry. Company representatives said the regulated prices were below their costs and that, if enacted, such regulation would cause shortages and massive layoffs. “This was all bluffing,” said Gómez. “These were the prices they sold the

drugs for in other countries. In fact, because we were using the 25th percentile, there were three or four countries where they sold the drug for *less*.”

When the companies themselves failed to move the regulators, they sought other channels. After the first phase of implementation, Gaviria received a letter from the UK ambassador to Colombia. AstraZeneca, a Cambridge, England–headquartered multinational with US\$22 billion in annual revenue, made an expensive antibiotic that was among the first drugs the commission regulated. Writing on behalf of the company, the ambassador politely urged the ministry to reconsider, citing AstraZeneca’s foreign investment in Colombia and local job generation.

Rather than reply, the ministry of health, at the behest of the price regulation team, published the letter in full on its website. “We had a policy of absolute transparency,” said Gómez, whose team knew that public support was essential for pressing ahead with price regulation. And indeed, the press pilloried the UK ambassador, who requested a meeting with Gaviria and to the surprise of the regulators, apologized for attempting to influence a policy he acknowledged was well within Colombia’s sovereign right. “That sent a huge signal,” said Gómez. “We realized we could handle international pressure.” (See text box 3.)

The discussion had shifted. The question of whether to regulate prices was put to rest; instead, attention focused on the technical issue about what the prices should be. But the team’s method—setting rates in Colombia based on international reference pricing—did not cover all situations. Drugs new to the global market that did not yet have regulated international prices and those that public health systems did not usually purchase were harder to assess. So, later, in the 2014 National Development Plan, the ministry of health included a provision to regulate drugs based on assessments of their cost-effectiveness by the Instituto de Evaluación Tecnológica en Salud (Health Technology Evaluation Institute, or

Text box 3: The Minister versus Novartis

As Gaviria's team regulated drug prices, the minister himself fired a shot across the bow of the pharmaceutical industry. In 2012, Novartis, a Swiss multinational with US\$50 billion in annual revenue, won a Colombian patent for a leukemia treatment drug called imatinib, sold under the brand names Glivec and Gleevec. Before issuance of the patent, generic producers were selling the drug for nearly 200% less than the cost of Glivec/Gleevec. Now, Novartis had free rein to charge whatever it wanted for the drug.

Inspired by extraordinary cases in which governments had circumvented patents in the name of the public interest, such as when Brazil expropriated the intellectual property of HIV medicines during the 1980s epidemic, Gaviria in 2015 attempted to declare a compulsory license, which would override Novartis's patent and thereby permit other companies to sell generic versions of the drug. He argued that Colombia faced a financial crisis in health and that the public would benefit from market competition. "I wanted to send a message: that we are serious about this issue," said Gaviria. "If I showed them I was willing to take extraordinary measures, then abuses would become less prevalent."

The Colombian government's patent office and ministry of trade howled that Gaviria would turn the country into an international pariah. The president of Switzerland flew to Colombia expressly to complain about the policy. And a few US senators visited the Colombian ambassador in Washington to warn that if the government revoked Novartis's patent, it could forget about US aid for the peace process. After that, President Santos, who while preoccupied with FARC peace negotiations had given his blessing to Gaviria, told Gaviria to take a more moderate approach. So Gaviria left Novartis its patent but used the declaration of public interest to unilaterally fix the price for Glivec/Gleevec at US\$18.50 for a 400-milligram tablet—down from the US\$44 the company was charging.

IETS). Any drug to be sold on the Colombian market would have a value-based price. (See text box 4.)

The plan faced intense opposition from the pharmaceutical industry and commercial representatives from the United States, France, and Switzerland. After extensive lobbying through foreign commercial attachés and the World Trade Organization failed to deter the Colombian government, the industry finally found an effective lever: a roadblock to Colombia's OECD accession. Colombia was in the process of joining the international club of nations, which was one of President Santos's priority. Santos's office, confronted with threats by the United States that it would hamstring Colombia's OECD bid unless pricing policy changed course, forced the ministry of health to accept a version of the decree implementing value-based pricing that used language from the US Trade Representative.

The decree now allowed a drug to enter the Colombian market before undergoing a price-setting evaluation. But even that change didn't clear the way for the policy. When it came time to implement the decree, a government antitrust commission inexplicably delayed issuing approval. And as of 2018, the new pricing methodology had yet to go into effect. Meanwhile, the team of price-regulating visiting bureaucrats had, true to their moniker, moved on, leaving the future of price regulation in doubt.

Creating a unified account

Despite the fateful meeting in the president's office, some of the measures in the abandoned Ordinary Law achieved enactment as presidential decrees. One of them was the creation of a single account to gather and disburse all of the disparate revenues that went toward financing of insurance premiums. These included funds from general,

Text box 4: Evaluating Effectiveness

Another part of the government's strategy to rein in costs through regulation was the creation of the Instituto de Evaluación Tecnológica en Salud (IETS). Before his inauguration in 2010, President Santos met in England with former British Prime Minister Tony Blair, who said that one of the most important things his government had done was to create the National Institute for Health and Care Excellence, or NICE, which, among other things, evaluates which health technologies the public health system should cover. Blair urged Santos to do the same.

The Inter-American Development Bank began advising the health ministry on the creation of an institute capable of evaluating which medicines and technologies were effective and should be paid for with public funds. The bank brought Sir Michael Rawlins, inaugural chair of NICE, to Bogotá to help design what would become the IETS.

A presidential decree created the IETS in 2014, and though the health sector initially reacted with distrust, the organization quickly established a reputation for transparency and technical rigor. The IETS published every document it produced, and there were frequent public meetings and open and responsive channels for feedback from the industry and others in the health sector. The IETS began recommending, based on efficacy, which medicines and new technologies ought to be included in the government's package of benefits.

But the IETS stood on shaky ground: Though the Inter-American Development Bank had pushed to make the IETS a fully public institution, with a guaranteed annual budget, the government, pushed by the finance ministry in belt-tightening mode, made it a mixed, public-private institution that received grants from the health ministry.

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 came under the trust of *fiduciary funds*—the privately run health accounts that were opaque, prone to malfeasance,¹¹ and sources of high administrative costs. Ministry departments were responsible for gathering and disbursing about another 10% of the funding.

In the run-up to the new 2014 National Plan, officials at the health and finance ministries and the National Planning Department had agreed that the health system must adopt a single, unified account to handle all revenues in the system. Carmen Eugenia Dávila, then vice minister of health, took charge of designing a new vehicle for managing these resources. After the National Development Plan in 2014 incorporated a proposal for a unified account, she appointed a committee to assist in its implementation.

During the next two years, the 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. Some in the health ministry worried that the centralization of such a large budget in the hands of a single entity amplified the risks of possible mismanagement or malfeasance, yet with a board of directors exercising regular oversight of ADRES, opportunities for wrongdoing appeared scant.

There were bureaucratic birthing pains. The firms that had managed the fiduciary funds resisted losing their business. The finance ministry initially objected to allocating the capital necessary to launch a new organization that would end up costing Col\$120 billion (US\$37 million) annually to operate. Also, the health ministry had to close the directorate that oversaw the fiduciary funds and roll most of the employees into the new organization.

Despite those challenges, ADRES opened for business in August 2017. From its brand-new 18th-floor offices overlooking the sprawling southern section of Bogotá, ADRES's staff of

220—under oversight by a board of representatives from the president’s office, the ministries of health and finance, and the National Planning Department—would manage all of the funds that went toward the country’s insurance system: around Col\$40 trillion (US\$12.6 billion).

The single, centralized account enabled ADRES officials to better monitor and allocate funds. Previously, when the money going to pay insurance premium and to cover other health expenditures was in five different accounts, planners seeking to shift money to cover a deficit in one of those accounts would have to get congressional approval and take out a high-interest loan from another account—even though all of it was public money. Under the unified single account, planners could perform what Marcela Brun, inaugural director of ADRES’s financial health resources management directorate, called “budget gymnastics”: quickly shifting money from one fund to another.

ADRES also enabled the central government to oversee revenues for the first time. The agency designed and developed software that enabled subnational departments to deposit through one single system the taxes and fees they collected electronically rather than have to account for them with paper receipts, as had been prior practice. The ADRES staff trained local budget officials to use the new software, and despite some initial resistance, the officials took to the system because it greatly simplified their work.

The agency built the largest database on health expenditure in the country. “I see ADRES as more than a bank. Its real importance comes from the information it can gather,” said Gaviria. ADRES used the data it acquired—on subjects including insurance company rosters, pharmacies, patients, and what doctors were prescribing—to conduct cost–benefit studies, to search for potential business process improvements, to evaluate potential savings, and even to identify abuses. “We saw that a doctor had prescribed 66,000 cans of Ensure [a nutrition supplement] to one patient,” said Brun. “If we see that kind of

behavior, we report it to the hospital, insurance company, or even the media to discourage these acts.”

That collection and dissemination of data on the health sector aligned with Gaviria’s objective to change the culture surrounding health care. “This wasn’t the main purpose of ADRES, but it has proved very powerful. We can inform the public debate with this information,” he said.

Delivering health priorities in the provinces

The health ministry’s lack of oversight of public health programs and activities in the provinces was yet another challenge for Gaviria. The subnational departments and municipalities administered almost all of the government’s activities focused on meeting national public health priorities—such as the Millennium Development Goals. And though health ministry officials met with health secretaries in Colombia’s 32 departments to develop plans for health programming, the ministry had no power to compel the departments to implement those plans with fidelity. Nor did it or the finance ministry exercise oversight over departmental budgets. Audits 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 from the Inter-American Development Bank 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 (Modelo Integral de Atención en Salud, or MIAS) 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. And the goal was to align the three actors so as to guarantee quality preventive health services to the entire population of a department.

In late 2015, the ministry of health launched a pilot of the MIAS in Guainía, a department on the border of the Amazon with a dispersed, rural, and large indigenous population. Ministry officials and Inter-American Development Bank experts consulted with local community leaders, municipal governments, and health officials to design the components of a primary care model for the department. The model's major elements were the existence of a single insurer, the improvement of health posts and facilities, the deployment of health managers to communities to provide maternal-care and childhood-care services, and participation by the indigenous community in decision-making processes. The health ministry provided technical assistance to guide implementation.

After 18 months, Guainía showed positive results. According to the health ministry, access to primary services increased to 79% of the population from 17%; there were no maternal mortalities during the pilot period; and the department reported one of the lowest rates of neonatal death in the country.¹²

The MIAS had showed promise. But Guainía was only one department; the health ministry lacked the capacity to implement the model in multiple departments simultaneously. As of 2018, there was no clear course of action for expanding the MIAS across Colombia.

OVERCOMING OBSTACLES

In addition to the resistance Gaviria faced in implementing reforms, he was dealing day-to-day with an ongoing financial crisis that he would later equate to being in charge of the US treasury after the collapse of Lehman Brothers—the US investment bank whose 2008 failure triggered the global financial crisis. “It’s hard to be health minister,” said Tatiana Andía, the professor who worked on price regulation at the health ministry. “I would say it’s the hardest job in Colombia right now.”

Starting in 2015, the health budget slipped into deficit. Faced with a growing shortfall and shrinking revenues, health budget managers had to find new, often creative ways to fill the gap. “We were constantly looking for money,” said Gaviria. “This was tough and not sustainable.” Gaviria was able to generate some new revenue by getting Congress to pass a tobacco tax increase of nearly 200%, earmarked for health. He tried to pass a similar tax on sodas, but the industry, which had substantial media interests in the country, killed the effort with a public campaign that attacked Gaviria personally.

Another problem was the finance ministry’s reluctance to disburse funds to the health ministry from the general account—especially for covering the potentially limitless out-of-benefits-package expenditures mandated by the Constitutional Court ruling. From 2015 to 2017, the health ministry drew money from FONPET, a pension fund from the municipalities and departments that had a surplus, to cover the gap in the per-capita premium, a solution the finance ministry deemed necessary at the time. “We don’t budget for the health system like we do for roads or education, where you have a number of buildings and teachers and you know the costs and then you cut investments if you can’t meet certain costs,” said Cardona, who moved to the finance ministry from the health ministry after helping draft the laws limiting the health costs the government would cover. “In health, you have to pay the per-capita insurance premium, calculated through an actuarial model, because if you don’t, people won’t get services, and health outcomes will suffer.”

Difficulty in calculating the premium exacerbated the shortfall. Planners attempted to estimate at the beginning of the budget process what the premium would have to be for the next year. But information from the insurers about the actual costs of services consumed by patients did not become available until much later. “We have a mismatch in the information we need in order to calculate the per-capita insurance premium and the budget process.” Diana Cardenas, who

became vice minister at the ministry of health in 2018, said. “We work hard to put forward an aggressive projection for health expenditure, but we just don’t have enough information.”

Other uncertainties also afflicted budgeting. Throughout the year, some of the sources of revenue that went toward financing the premium came from locally collected taxes,¹³ but there were two problems with that revenue: it arrived variably, because much of it came from taxes on liquor, gambling, and other seasonally affected consumption items; and the departments failed to collect or share good information about that revenue. In addition, unknowable out-of-benefits-package expenditures and tutelas—the civil suits filed by claimants for noncovered health services—haunted budget managers. “We always set aside money to pay for tutelas, but we get sued a lot,” said Brun, the finance director at ADRES. “Suddenly, late in the year, I could get a large tutela and then have to move money very quickly to cover it because if we don’t pay, I personally could go to jail.”

When revenues flagged or projections proved out of sync with fiscal reality, midyear budget revisions were often necessary. Budget managers at the ministries of finance and health met monthly to consult on whether programs would have to be delayed or trimmed. Below-projection fiscal conditions sometimes resulted in cuts to programs that proved effective and that targeted specific health outcomes, such as the country’s vaccination program or grant funding for medical students pursuing specialist training.

In addition to the dynamics of the system, changing fiscal conditions would undermine longer-term planning frameworks, such as the National Development Plan and the medium-term expenditure framework. For example, oil had accounted for roughly 5% of government revenue, so when the price cratered in 2015, the budget suffered; and annual investments in public health projects had to be cut below what the plan had envisioned.

ASSESSING RESULTS

By 2018, it had become unclear whether the government would meet the objectives outlined in the 2014–18 National Development Plan. For instance, in 2016, the most-recent year for which the Colombian statistics agency had data, infant mortality had fallen to 16.8 per thousand live births, which was well above the plan’s target of 14.5 by 2018.¹⁴ Health outcomes still varied widely by department. There were, however, signs of progress. Access to services increased, as the use of services per capita went from 1.2 visits per year in 2010 to more than 2 by 2017. Out-of-pocket expenditures were comparatively low, amounting to only 15.4% of total expenditure in 2017—a level on par with many western European countries. And no one went bankrupt from health expenses, because the system protected families from poverty.

The planning, budgeting, and financial management of the system had also 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. “ADRES frees the ministry of health to focus on regulation, stewardship, and its mission, leaving operational and financial management of the system to be done by a specialized entity,” said Abril at the finance ministry.

Separately, the integrated financial management system gave budget officials closer oversight of execution with regard to whether units spent their funds for the purposes and in the amounts intended. The measures Gaviria’s team implemented would pay off: from 2014 to 2017, the ministry of health had the best budget-execution rate of any sector in the government.¹⁵

Health minister 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. Gómez, the lawyer who was on the minister’s price regulation team, estimated

that since 2013, the measures had saved the country Col\$4.2 billion (about US\$2 million). And the ministry's law reforms established a framework and a procedure for excluding certain health services from public provision. "We were able to put some reasonable restrictions on the right to health care," said Gaviria. "The immediate impact of the law was small. It didn't solve the problem," he said, but it did represent a symbolic change. "The law has been instrumental for having a more reasonable debate about the inputs of the system."

Still, the health system teetered on the brink of insolvency. As of 2018, the government had excluded only around 80 technologies under the Statutory Law; 18,000 drugs remained unregulated. And though the government attempted to place caps on out-of-package budget expenditure, spending on the services was still 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 Cardona. "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" (i.e., the out-of-package services and the incentives that drove them).

The ministry of health was seeking to introduce co-pays and other mechanisms to limit out-of-package services. "Even so, all we can do is stop the growth," said Cardenas, vice minister of health. "We can't reduce the spending."

In 2018, the health budget was in debt by Col\$10 billion (US\$3.3 million). Planners were anticipating spending on out-of-package services, which was around Col\$3 billion (US\$1million) in 2017, to be Col\$5 billion (US\$1.7 million) in 2018. And the insurance companies owed an estimated Col\$12 billion (US\$4 million) to hospitals. "I'm afraid the system is going to break because the insurers are gradually going under," said Tatiana Andía, the sociologist who worked on price regulation. "We've done some great things, but the system is neither sustainable nor equitable."

REFLECTIONS

At the end of his tenure, economist Alejandro Gaviria, who became Colombia's minister of health, admitted that the health system was still out of control and that his efforts to control expenditure had been limited. He considered his greatest achievement to have been building both cultural awareness in the health sector and an intergovernmental architecture to handle the problem. Just as his drug price regulation team had shifted the paradigm from a question of whether to regulate prices to one of how to regulate them, policy makers and stakeholders were now focusing not on whether to rein in costs but on how to do so.

But the shift in the public's attitude toward health care Gaviria had hoped to instill seemed a long way off. Colombians expected the state to pay for their health care, and many sued to demand that it do so; yet tax revenue was only 20% of GDP—well below Organisation for Economic Co-operation and Development and Latin American averages. "There is a huge problem in the way Colombians think about health care," said assistant professor of sociology at the University of Los Andes Tatiana Andía, who helped work on drug price regulation at the health ministry. "Sometimes the attitude is, 'Get everything you need, not only because you deserve it, but because this is the most effective way to get it.' Changing that culture is hard."

Meanwhile, though health coverage was technically universal, access and quality would remain glaringly unequal. Improving rural access to health care and exercising better control of departmental budgets to ensure service delivery were projects that went far beyond the health sector. "We are a postconflict country. It will take decades for the Colombian state to function effectively in the provinces," said Gaviria.

After five high-stress years as health minister, Gaviria received a cancer diagnosis in 2017, and a year later, his term ended. Still, he was optimistic about the future. "I thought the system was about to fail in 2012. Six years later, it still has a lot of problems, but I don't think it's going to collapse."

There is greater awareness among all of the participants that we have to work together to preserve what I believe is the most important

social change the country has achieved since 1991: universal health care.”

Conversions of Colombian pesos to US dollars based on yearly average rates. There is considerable volatility within a given year.

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- ¹ The employer paid 8.5%; the employee, 4%. The self-employed paid the entire 12.5%. See https://www.icesi.edu.co/proesa/images/GNHE%20UHC%20assessment_Colombia%204.pdf.
- ² People could choose their HMO, and the HMOs chose their providers. There were different HMOs for the subsidized regime and for the contributory regime and different benefits packages for each regime until 2012.
- ³ World Development Indicators. Note that reference years vary slightly and that income inequality data are not available for each year.
- ⁴ Council on Foreign Relations. Background briefing, p. 1. Accessed at <https://www.cfr.org/backgrounder/colombias-civil-conflict>.
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- ¹⁰ The pharmaceutical industry disputes this and claims it is only 12%.
- ¹¹ For example, insurance companies that had relationships with funds were more likely to get reimbursed—and more quickly—than those that lacked such relationships.
- ¹² <https://www.minsalud.gov.co/English/Paginas/The-Successful-Results-of-MIAS.aspx>.
- ¹³ Ninety percent of funding for the UPC came from the national level; 10% was collected locally.
- ¹⁴ <https://www.dane.gov.co/index.php/estadisticas-por-tema/salud/nacimientos-y-defunciones>.
- ¹⁵ Official budget execution numbers from the ministry of finance: 2015, 98.4%; 2016, 99.5%; 2017, 99.7%.



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