



# Universal Health Coverage Assessment

## Colombia

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Global Network for Health Equity (GNHE)

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For the Global Network for Health Equity (GNHE)

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## Introduction

This document provides a preliminary assessment of the Colombian health system relative to the goal of universal health coverage, with a particular focus on the financing system and related aspects of provision.

In the 2010 World Health Report, universal health coverage is defined as providing everyone in a country with financial protection from the costs of using health care and ensuring access to the health services they need (World Health Organisation 2010). These services should be of sufficient quality to be effective.

This document presents data that provide insights into the extent of financial protection and access to needed health services in Colombia.

## Key health care expenditure indicators

This section examines overall levels of health expenditure in Colombia and identifies the main sources of health financing (Table 1).<sup>2</sup> In 2012, total health expenditure accounted for 6.8% of the country's Gross Domestic Product (GDP), an amount that was higher than the average of 6.1% for other upper-middle-income countries but below the global average of 9.2%.

Public allocations to fund the health sector (including social health insurance)<sup>3</sup> were 18.5% of total government expenditure. This percentage demonstrates the government's considerable commitment to funding the health sector. It was substantially higher than the average of 11.8% for other upper-middle-income countries. It was

**Table 1: National Health Accounts indicators of health care expenditure and sources of finance in Colombia (2012)**

Indicators of the level of health care expenditure	
1. Total expenditure on health as % of GDP	6.8%
2a. Per capita government expenditure on health at average exchange rate (US\$)	\$402
2b. Per capita government expenditure on health (PPP \$)	\$548
3. General government expenditure on health as % of GDP	5.2%
4. General government expenditure on health as % of total government expenditure	18.5%
Indicators of the source of funds for health care	
5. General government expenditure on health as % of total expenditure on health*	75.8%
6. Private expenditure on health as % of total expenditure on health	24.2%
7. External resources for health as % of total expenditure on health	0.7%
8. Out-of-pocket expenditure on health as % of total expenditure on health	14.8%
9. Out-of-pocket expenditure on health as % of GDP	1.0%
10. Private prepaid plans on health as % of total expenditure on health	9.5%

Notes:

\* This includes both tax-funded and payroll-funded health spending.

Source: Data drawn from World Health Organisation's Global Health Expenditure Database ([http://apps.who.int/nha/database/Key\\_Indicators/Index/en](http://apps.who.int/nha/database/Key_Indicators/Index/en)).

<sup>2</sup>The data quoted in this section all derive from the 2012 data in the World Health Organisation's Global Health Expenditure Database (<http://apps.who.int/nha/database/Home/Index/en>). Comparisons with other countries are based on figures expressed in terms of purchasing power parity. The country's income category is determined from the World Bank's classification for the same year (<http://data.worldbank.org/about/country-and-lending-groups>).

<sup>3</sup>Different countries use the terms 'national health insurance,' 'social health insurance' and 'social security' differently to describe different types of mandatory health insurance. In each country assessment in this series, the term applied is the one commonly in use in the country in question. In Colombia, the term 'social security' applies to those schemes that pre-dated reforms in 1993 and covered specific segments of the population (such as groups of formal sector workers, excluding their dependents). The term 'social health insurance' applies to the two large schemes (one contributory and one subsidized) that were introduced by the 1993 reforms and now cover the bulk of the population.

also above the 15% target set by the Organisation for African Unity’s 2001 Abuja Declaration (which was the same as the global average for 2012).

In fact, government health expenditure translated into 5.2% of GDP in 2012. This was considerably higher than the 3.4% average for upper-middle-income countries for that year, and around the global average of 5.3%.

Per capita government expenditure on health was as much as \$548 (in terms of purchasing power parity) in 2012, considerably higher than the upper-middle-income country average of \$371 and almost 85% of the global average of \$652.

As is the situation with most upper-middle-income countries, Colombia received very little donor financing (representing less than 1% of total financing sources for the health sector).

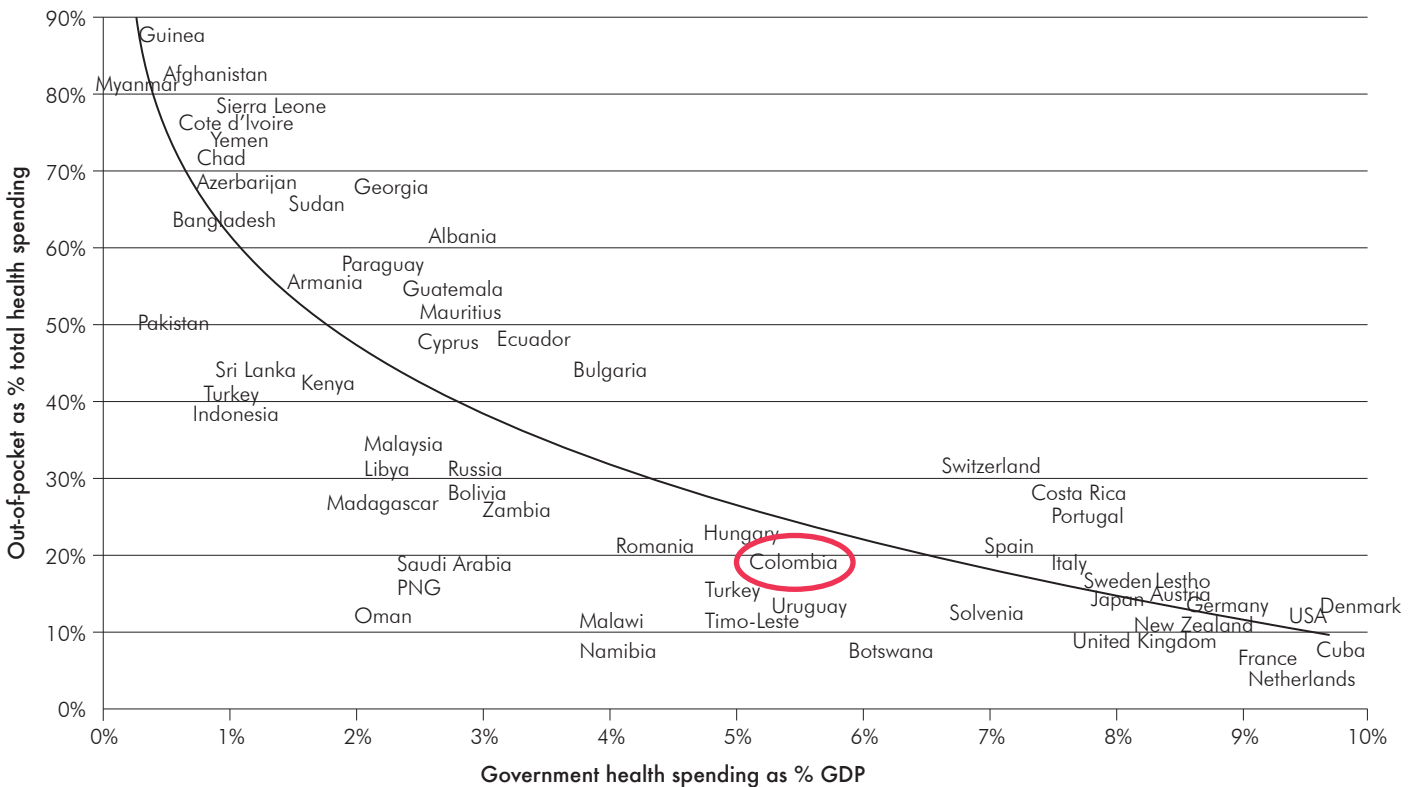
As would have been expected from the high levels of government expenditure, out-of-pocket payments played a small role in Colombia in 2012 (at about 15% of total financing). This was low in global terms (where the average was 21% for the same year). It was also well below the 20% limit suggested by the 2010 World Health Report to

ensure that financial catastrophe and impoverishment as a result of accessing health care become negligible (World Health Organisation 2010). In addition, the percentage for 2012 was part of a decline that started in 2009, following a period between 2002 and 2009 when out-of-pocket expenditure had more than doubled (Guerrero et al. 2012).

Finally, in 2012, private health insurance in Colombia accounted for almost 10% of total health sector financing. However, private expenditure – which includes out-of-pocket payments and voluntary prepaid plans – accounted for only a quarter of health financing in Colombia. The Colombian health system is therefore dominated by public sources.

Indeed, financial protection has been claimed by government authorities as well as academics as one of the biggest achievements of the Colombian health system. Figure 1 shows that, internationally, there is a strong correlation between government health expenditure as a percentage of GDP and out-of-pocket payments as a percentage of total health care spending. In this Figure, Colombia is located in that part of the graph indicating medium-to-high levels of government health spending and low out-of-pocket payments.

**Figure 1: Relationship between dependence on out-of-pocket payments and government spending on health care (2010)**



Source: Updated from McIntyre and Kutzin (2011)

## Structure of the health system according to health financing functions

Figure 2 provides a summary of the structure of the Colombian health system, depicted according to the health care financing functions of revenue collection, pooling and purchasing, as well as health service provision. Each block represents the percentage share of overall health care expenditure accounted for by each category of revenue source, pooling organisation, purchasing organisation and health care provider.<sup>4</sup>

### Revenue collection

Until the early 1990s, the Colombian health system was made up of three independent revenue collection ‘sub-sectors.’ First, Social Security schemes offered health insurance to groups of formal sector workers (but did not provide coverage to dependants). Second, private health insurance serviced those able to afford private contributions. Last, there was the tax-based financing system that serviced those who did not have health insurance cover.

Under this system, an estimated 20% of the population was enrolled in Social Security schemes and 10% was able to buy private insurance or pay directly for private

services. The remaining 70% had to rely on the public network of health facilities, which, in principle, provided services to poor people for free and charged only those with capacity to pay (Jaramillo 1994). In reality, the coverage of interventions delivered through the public network was inadequate because of the shortage of health care facilities in rural areas and overcrowding of urban facilities.

Two major changes to the Colombian health system were introduced in the 1990s. One was a process of decentralisation. This gradually transferred the responsibility (and the money) for delivering public health services to the 32 ‘departments’ (which are equivalent to states) and their constituent municipalities. The other change was a set of reforms falling under what is known as ‘Law 100.’ Law 100 transformed revenue collection, pooling, purchasing and service delivery arrangements.

With respect to revenue collection, Figure 2 shows that, now, there are two major schemes or regimes. The contributory regime is mandatory for formal workers and other people with the capacity to pay, and covers contributors as well as their dependants. The regime is financed by a total payroll tax of 12.5%, with formally employed workers originally contributing 4% and employers the remaining 8.5%. Independent workers pay the full 12.5%. Since 2014 employers have been exempted from contributing to the system for most employees. To offset this revenue loss, the government created an 8% tax on annual profits.

**Figure 2: A function summary chart for Colombia (2011)**

Revenue collection	General taxation	Social health insurance	Private insurance	Out-of-pocket
Pooling	Ministry of Health and Social Welfare		Special regimes	No pooling
Purchasing	Government*	Subsidised EPSs	Contributory EPSs	Individual purchasing
Provision	Public providers		Private-for-profit providers	

\*This includes spending on infrastructure (e.g. public hospitals), services and drugs not included in the benefit package, claims of the uninsured, public health campaigns (e.g. vaccination) and public health programmes (e.g. tuberculosis, HIV), among others.

Source: Developed by authors based on Ministry of Health statistics and Guerrero et al. (2011)

<sup>4</sup>The data quoted in this section are slightly different from the previous section because they are based on more detailed disaggregation by the authors of Ministry of Health statistics and Guerrero et al. (2011).

The subsidised regime is a mandatory scheme for the unemployed, informal sector workers and the poor (as determined by a means test),<sup>5</sup> including their dependents. Members of this regime do not make contributions to the regime, which is financed in a complex fashion through 17 different sources, mainly general taxes. There is a small cross-

subsidy from the contributory regime (equivalent to 0.17% of payroll, deducted from the total contribution of 12.5%).

People who have the means to do so are free to buy supplementary private health insurance, but are still required to enrol in the contributory regime (Jaramillo 1994).

**Table 2: Indicators of the source of funds for health care**

Health insurance	Nature of scheme and target beneficiaries	Financing mechanism	Benefit package
The contributory regime	Mandatory insurance for all formal sector workers and others with the capacity to pay (together with their dependants)	Payroll tax of 12.5%: <ul style="list-style-type: none"> <li>originally formal sector workers contributed 4% and employers 8.5%</li> <li>employers are now exempted but pay 8% tax on annual profits</li> <li>independent workers pay the full 12.5%</li> <li>0.17 percentage points of the payroll tax cross-subsidises the subsidised regime</li> </ul> Co-payments User fees	Comprehensive health care services (now called the 'Plan Obligatorio de Salud' (POS) or 'mandatory health plan') and maternity allowances <sup>6</sup>
The subsidised regime	Insurance for the unemployed, informal sector workers and the poor (together with their dependants)	No contributions from members 17 financing sources, mainly general taxes 1.5% of payroll of formal sector workers received from the contributory regime as a cross-subsidy Co-payments No user fees	Initially a smaller benefit package than the contributory regime but, since 2012, the full mandatory health plan (or POS)
Special Social Security schemes	Teachers in public schools and universities, the military and police officers, and workers of the national oil company (together with their dependants)	Payroll tax of 12.5%: <ul style="list-style-type: none"> <li>contributions by members and employers vary by scheme</li> <li>1.5 percentage points of the payroll tax cross-subsidises the subsidised regime</li> </ul> Usually no co-payments or user fees	Better benefit packages than the POS, including improved access to pharmaceuticals
Commercial health insurance	Voluntary insurance for those who have the capacity to pay (although these are still required to enrol in the contributory regime)	Contributions by members Co-payments User fees	Services that are not included in the mandatory health plan (e.g. private rooms)  Certain services in the mandatory health plan that have long waiting lists (e.g. certain specialist or laboratory services)  Services in the mandatory health plan that are provided by private providers that do not take POS clients

<sup>5</sup> This is standardized for the whole country but administered by local governments.

<sup>6</sup> Maternity benefits include: a) a prenatal subsidy consisting of a monthly food package of around 40 products, equivalent to one minimum salary, for all pregnant beneficiaries from the fifth month of pregnancy, b) a monetary payment equivalent to one minimum salary at childbirth and c) a postnatal or nursing subsidy of a monthly food package equivalent to a minimum salary until the child is one year old.



The only exceptions to mandatory enrolment in the contributory regime are for teachers in public schools and universities, the military and police officers, and workers of the national oil company, together with their dependants. These groups had their own special Social Security schemes before the reforms and these have been allowed to continue. This is because these schemes have better benefit packages (including pharmaceuticals) and the sectors that they serve have strong lobbying power. There is a cross-subsidy from these special Social Security schemes to the subsidised regime (equivalent to 1.5% of payroll, deducted from the total contribution of 12.5%).

In addition to the financing sources described above, government funds infrastructure (such as public hospitals), services and drugs not included in benefit packages, claims of the uninsured, public health campaigns (such as vaccination) and public health programmes (such as those for tuberculosis and HIV).

It was originally expected that universal health insurance would be achieved in 2001 but it was only achieved in 2011. In 2013 the contributory, subsidised and special regimes covered approximately 43%, 48% and 5% of Colombia's population, respectively (Gaviria 2014a). The remaining uninsured 4% of the population is made up of those people living in remote areas or not enrolled on government registers (such as the homeless).

The Colombian financing system includes cost-sharing mechanisms such as co-payments and user fees that are a source of dedicated revenue for health plans. These cost-sharing mechanisms are regulated by government and not by health plans and depend on the regime and on the individual characteristics of patients (such as income, whether the patient is a regime member or a dependant, health status and service type). In the subsidised regime there are no user fees but some services have co-payments, whereas in the contributory regime there are both user fees and co-payments. There are limits on co-payments per service and on how much money can be collected in one single year from each person. Special regimes make their own cost-sharing rules but typically do not charge user fees or co-payments on most of their services.

There are two mandated exemptions to these general rules. First, if the patient is part of programme designed to treat certain pathologies (defined by law), and adheres to its guidelines and treatment, no co-payments are charged (for example, cancer treatment). This is an economic incentive to promote integrated care programmes. Second, emergency room visits are exempt from co-payments, regardless of

affiliation to a financing regime or health care purchaser, as long as the visit is occasioned by a life-threatening condition (otherwise at the end of the visit the patient will be charged). Moreover, health plans are free to waive co-payments to incentivize the use of preventive services.

## Pooling

The Fondo de Solidaridad y Garantía (FOSYGA) pools all payroll-based contributions for health as well as other public sources earmarked for the sector. This fund is an account under the Ministry of Health and has four separate sub-accounts: Compensation, Solidarity, Prevention and Public Health, and Natural Catastrophe and Road Safety. The sub-accounts are kept separate because they are funded from different sources and each one has very specific items under which expenditure is allowed, as defined by law.

The Compensation Account funds the contributory regime. It receives contributions amounting to 11% of payroll and then distributes the money to health care purchasers or plans using a simple risk-adjusted capitation formula. The variables used are age, gender and location. Children, women between the ages of 15 and 45 (that is, of reproductive age) and the elderly are weighted more heavily than other demographic groups.

The Solidarity Account funds the subsidised regime and receives contributions from formal workers (1.5% of payroll) and 16 other sources, including national and local taxes.

The average per capita amount paid per year to health plans by these two accounts in 2013 was \$US 316 for the contributory regime and \$US 283 for the subsidised regime (Ministry of Health 2012).<sup>7</sup> The lower figure for the subsidised regime is because of government budget constraints.

This system achieves cross-subsidies because high-wage workers contribute an amount of money that is greater than the value the purchaser receives via the capitation formula for them, while low-wage employees pay less to the system than their purchaser receives. Thus, people with many children, women of reproductive age, the elderly and those with low incomes tend to be subsidised, while high-income, young single men tend to be subsidisers.

In 2007, the government mandated the creation of a high-cost sub-account to pool and redistribute risk retrospectively for catastrophic conditions across the entire population. Insurers with a relatively low prevalence of these conditions compensate those with a higher prevalence. This was in

<sup>7</sup> Estimated from Resolución 4480 of 2012 using an average nominal exchange rate for 2012 of 1,800 Colombian pesos per \$US.

response to a fiscal crisis in the system generated by the concentration of dialysis patients within the main public purchaser. To date this risk equalisation mechanism has been applied to chronic renal failure, but there are plans for expanding its scope to cancer and HIV/AIDS.

## Purchasing

The main health care purchasers or plans in the system are 'Entidades Promotoras de Salud' (or EPSs), which are akin to health maintenance organizations. In 2013, there were 56 EPSs, 19 in the contributory regime and 37 in the subsidised regime. In the subsidised regime there are both public and private EPSs, but in the contributory regime there are only private EPSs.

Law 100 stated from the outset that the benefit package for the subsidised regime would be more constrained than that for the contributory scheme (there were differences in access to treatment, procedures and pharmaceuticals). Consequently, the subsidised regime's per capita cost was lower. The intention was to gradually expand the benefit package for the subsidised regime so that, when fully implemented, the content of the benefit package would be the same for all Colombians, whether in the contributory or subsidised regime. However, achievement of this goal was delayed due to fiscal constraints and the content of the benefit package was standardised for both regimes only in 2012.

EPSs organize and manage the provision of the now standard benefit package called the 'Plan Obligatorio de Salud' (POS) or 'mandatory health plan.' The POS includes a comprehensive list of medical interventions and medicines, and also most public health activities that are carried out on an individual basis (e.g. immunizations, preventive visits and screening for certain diseases).<sup>8,9</sup>

EPSs can either provide services directly or contract with public or private providers. Under both the contributory and subsidised regimes, members are allowed to choose the EPS with which they want to enrol and, under certain conditions, are also able to choose providers within the network organized by the EPS. This means that EPSs compete for enrolees, and providers compete for inclusion in EPS networks. EPSs cannot reject applicants who wish to enrol with them, although there are rules that stop people from transferring from one EPS to another, to prevent risk concentration in a few EPSs. In more densely populated urban areas there is real competition between EPSs, but in rural areas there is effectively less choice as it is less profitable for EPSs to set up and compete.

<sup>8</sup> Other public health activities that are performed collectively, or that are done on an individual basis but have high externalities, like vector control, educational campaigns and control of environmental risk factors, are included in the Plan de Atención Básica (PAB). This is entirely financed and provided (or contracted) by local governments with money from general taxes or transfers from the central government.

<sup>9</sup> The POS insures health risks other than those resulting from occupational hazards. The latter are covered through a different insurance scheme.

<sup>10</sup> This is a calculation by the authors (total EPS expenditure on health services minus the total revenue of public hospitals).

EPSs pay providers in different ways. Typically, primary care services are capitated, secondary care services are paid under fee-for-service or bundled payments, and tertiary care is paid by event. There are some disease-specific programmes (such as diabetes) paid under capitation. How effectively different EPSs are able to influence providers through reimbursement mechanisms depends heavily on who has more market power.

## Provision

The private sector dominates provision in Colombia, accounting for two-thirds of health expenditure by EPSs in 2012.<sup>10</sup> In that same year, Colombia had 15.6 hospital beds per 10,000 people, and almost 58% were private (with an additional 2% a mixture between private and public). Only 40% of hospital beds were purely public (Registro Especial de Prestadores de Salud 2012).

Primary care providers vary in nature. There are private and public facilities, and there are comprehensive clinics as well as small outpatient facilities. EPSs are free to decide how to provide primary health care, although in rural areas there is usually only one health facility, a low-level local hospital.

The distribution of private and public providers is uneven around the country. In 2013, out of 1,122 municipalities, 469 did not have a private provider, 172 had 1 private provider and 66 had 2 private providers (Guerrero, Prada and Chernichovsky 2014).

According to a survey by the Ministry of Health (2014a), 71% of contributory regime enrolees felt that the quality of general health services was high, and only 6% felt that it was low. Similarly, in the subsidised regime 79% of enrolees felt that the quality was high and only 5% felt that it was low. These results changed under the contributory regime when the urgency of services was taken into account, with only 59% of the enrolees feeling that the quality was high, and 22% and 20% that it was middling or low, respectively.

## Financial protection and equity in financing

A key objective of universal health coverage is to provide financial protection for everyone in the country. Insights into the existing extent of financial protection are provided through indicators such as the extent of catastrophic payments and the level of impoverishment due to paying



for health services. This section analyses these indicators for Colombia and then moves on to assess the overall equity of the health financing system.

## Catastrophic payment indicators

Flórez et al. (2009a), using data from 2003, concluded that the reforms of the 1990s had increased financial protection for households, especially poor households. In this study, catastrophic expenditure was defined as any out-of-pocket payment that exceeded a threshold of 20% of non-food income (according to the methodology

proposed by the World Health Organization in 2005). According to the study, people insured under the contributory regime were significantly less likely to experience catastrophic expenses than those who were not insured.<sup>11</sup>

However, Figure 3 presents data from the same year showing that inequities persisted in Colombia, despite reductions in overall catastrophic expenditure. The Figure shows the percentage of households with catastrophic health spending by household-specific risk factor. As expected, catastrophic expenditures were mainly concentrated in the first quintile of income

**Table 3: Catastrophic payment indicators for Colombia in 2010\***

### Catastrophic payment headcount index

(the percentage of households whose out-of-pocket payments for health care as a percentage of household consumption expenditure exceeded the threshold) 4.6

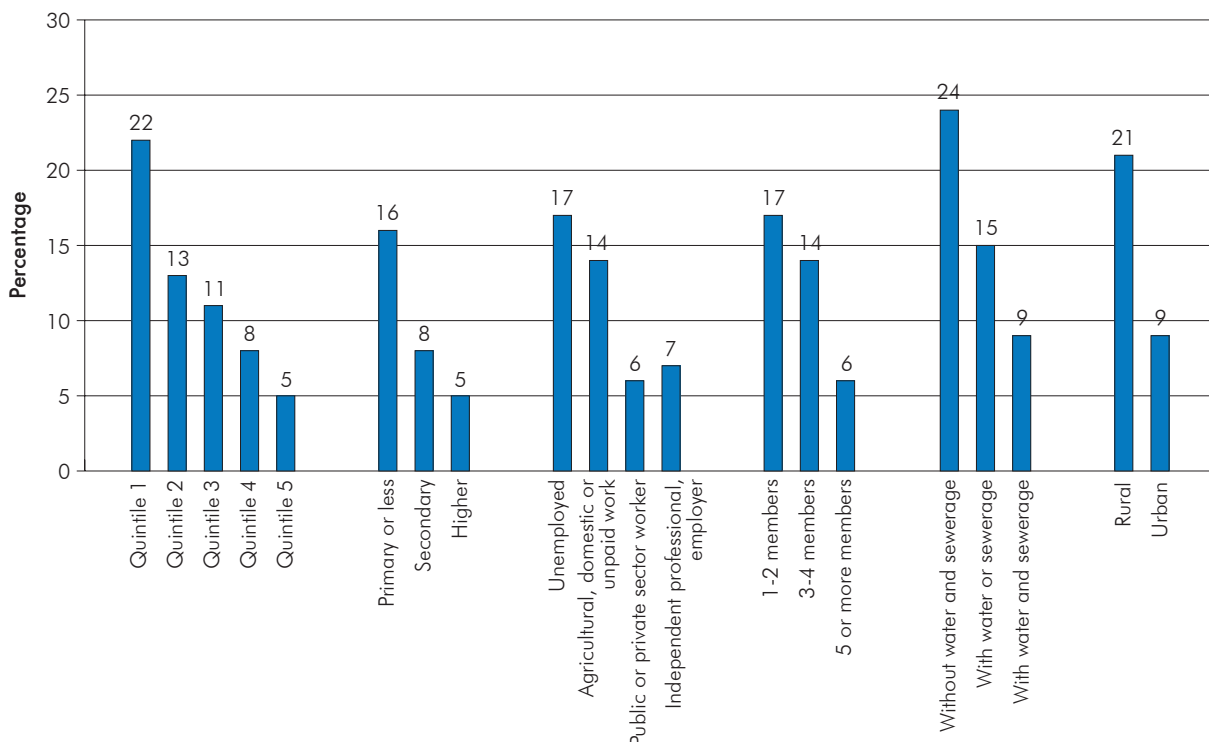
### Catastrophic payment gap index

(the average amount by which out-of-pocket health care payments as a percentage of household consumption expenditure exceed the threshold) -

Notes:

Financial catastrophe is defined as household out-of-pocket spending in excess of the threshold of 40% of household expenditure excluding food; '-' = 'not available'  
Source: Ruiz and Zapata (2013)

**Figure 3: Percentage of households with catastrophic health spending in Colombia, by income quintile, schooling, work situation, household size, access to utilities and geographic area (2003)\***



\*Catastrophic expenditure is defined as out-of-pocket payments exceeding a threshold of 20% of non-food income  
Source: Adapted from Flórez et al. (2009a)

<sup>11</sup> This study was conducted before universal health coverage was achieved.

(at 22%). The incidence decreased progressively to 5% in the wealthiest quintile.

More recent data from 2010, using the 40% threshold of non-food household expenditure for assessing catastrophic payments, show that 4.6% of the population incurred catastrophic spending as a result of accessing health care (see Table 3). Table 3 shows that, by 2010, 4.6% of the population incurred catastrophic spending in Colombia as a result of accessing health care.

It should be remembered, however, that estimates of catastrophic payments are difficult to interpret as they can underestimate the actual problem. This is because they may not capture the reality that there are people who do not utilize health services when needed because they are unable to afford out-of-pocket payments at all (Wagstaff and van Doorslaer 2003).

## Impoverishment indicators

While the extent of catastrophic payments indicates the relative impact of out-of-pocket payments on household welfare, the absolute impact is shown by the impoverishment effect. In Colombia, about 33% of the population lived below \$3.75 per day in 2012, representing a considerable improvement over the figure of 42% in 2008 (Departamento Nacional de Estadísticas 2012).

Table 4 looks at the impoverishing effects of health care use in Colombia in 2003, when impoverishment was around 39%. It shows that, when the national poverty line is used, an extra 3.7% of the population dropped into poverty as a result of paying out of pocket. For both poverty lines, the proportion of households that became

poor after the financial shock was highest for those belonging to the subsidized scheme. Those belonging to the contributory scheme experienced the least shock. It must be remembered, however, that these data are from well before the benefit package was standardised for both regimes in 2012.

## Equity in financing

Equity in financing is strongly related to financial protection (as described by the indicators above) but is a distinct issue and health system goal. It is generally accepted that financing of health care should be according to the ability to pay.

A 'progressive' health financing mechanism is one in which the amount richer households pay for health care represents a larger proportion of their income. Figure 4 provides some indication of the situation in Colombia in 2010 by revealing the distribution of different sources of health financing across different income quintiles. The wealthiest quintile financed 73% of total health expenditure, paying 87% of taxes, 61% of social health contributions and 63% of out-of-pocket payments. This suggests that health financing in Colombia is probably progressive.

This is confirmed by a more precise measure of progressivity, the Kakwani index. A positive value for the Kakwani index means that a financing mechanism is progressive; a negative value means that poorer households pay a larger proportion of their income and that the financing mechanism is therefore regressive. Table 5 provides an overview of the distribution of the burden of financing in the Colombian health system across different socio-economic groups (i.e. the financing incidence) as well as the Kakwani index for each financing mechanism.

**Table 4: Impoverishment indicators for Colombia using two different poverty lines (2003)**

	National poverty line*	Endogenous poverty line**
Pre-payment poverty headcount	39.3	17
Post-payment poverty headcount	43.0	20.3
Percentage point change in poverty headcount (pre- to post-payment) for the total population	3.7	3.3
Percentage point change in poverty headcount (pre- to post-payment) for beneficiaries of the subsidized regime	5.6	6.3
Percentage point change in poverty headcount (pre- to post-payment) for beneficiaries of the contributory regime	0.7	0.8

\* The national poverty line is \$3.8 and \$2.5 for urban and rural areas respectively

\*\*The endogenous poverty line is equivalent to \$2 per day

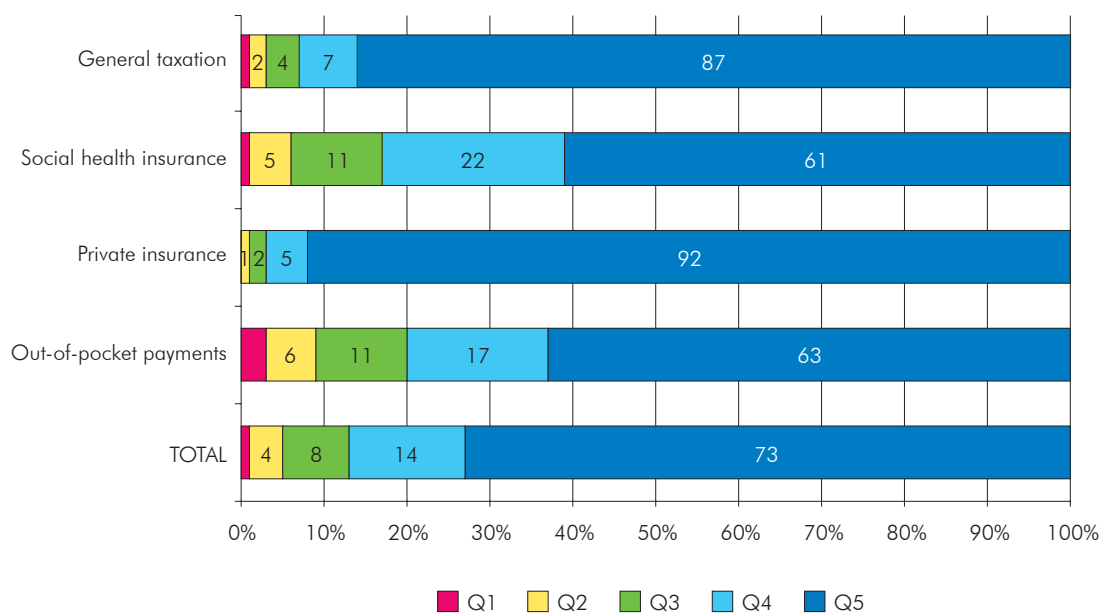
Source: Flórez et al. (2009b)

Table 5 shows that, in 2010, overall health financing in Colombia was progressive, meaning that individuals with higher incomes contributed relatively more (Ruiz and Zapata 2010). The most progressive source (with an index of 0.34) was private health insurance as it is largely purchased by higher income groups. The next most progressive source was general taxation (with an index of 0.27). Social health insurance was only mildly progressive (with an index of 0.05) which shows that this form of financing does not achieve substantial cross-subsidies between richer and poorer individuals.

## Equitable use of health services and access to needed care

The universal coverage goal of promoting access to needed health care can be interpreted as reducing the gap between the need for care and actual use of services, particularly differences in use relative to need across socio-economic groups. Figures 5 and 6 use data from the Demographic Health Survey to compare the distribution of health needs and benefits in the Colombian health system in 2005.

**Figure 4: Distribution of different health financing sources in Colombia by income quintile (2010)**



Source: Ruiz and Zapata (2010)

**Table 5: Incidence of different domestic financing mechanisms in Colombia**

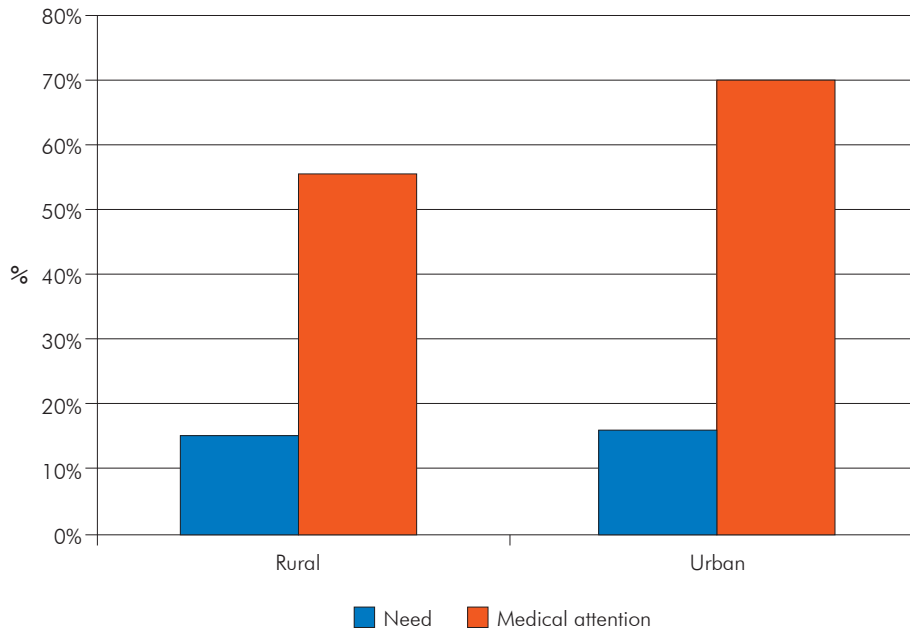
Financing mechanism	Percentage share (2011)	Kakwani index (2010)
General taxes	34.1%	0.27
Mandatory health insurance contributions (Social Health Insurance)	39.2%	0.05
<b>Total public financing sources</b>	<b>73.3%</b>	<b>-</b>
Commercial voluntary health insurance	9.6%	0.34
Out-of-pocket payments	17.1%	0.03
<b>Total private financing sources</b>	<b>26.7%</b>	<b>-</b>
<b>Total financing sources</b>	<b>100.0%</b>	<b>0.15</b>

Note: Estimates are based on per adult equivalent expenditures; '-' = not available  
Source: Ministry of Health (2013, 2014b), Ruiz and Zapata (2010)

It is clear from both Figures 5 and 6 that urban areas and wealthier populations had better access to health services in 2005. The discrepancy between need and access for poorer populations is likely to have been more exaggerated than shown in the Figures because rural and poorer populations are likely to have had greater health care needs, whereas the graphs estimate need to be roughly equivalent across all rural-urban and income quintile categories.

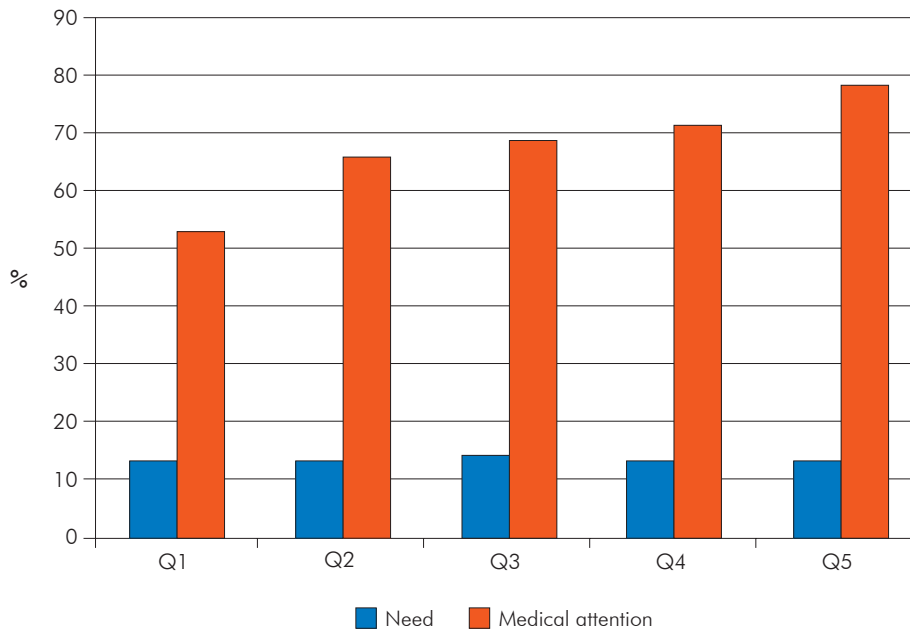
When comparing the 2005 data from the Figures below with data from a similar survey in 2000, it becomes apparent that there was a very slight change in the relative utilization of health services by the highest and lowest income groups (see Table 7). Thus, in 2000 the wealthiest income quintile utilized health services 1.6 times more than the poorest, whereas it used health services 1.5 times more in 2005. These data show a tentative movement in

**Figure 5: Distribution of need and benefits in rural and urban areas of Colombia (2005)**



Source: Adapted from Flórez and Soto (2007)

**Figure 6: Distribution of need and benefits across wealth groups in Colombia (2005)**



Source: Adapted from Flórez and Soto (2007)

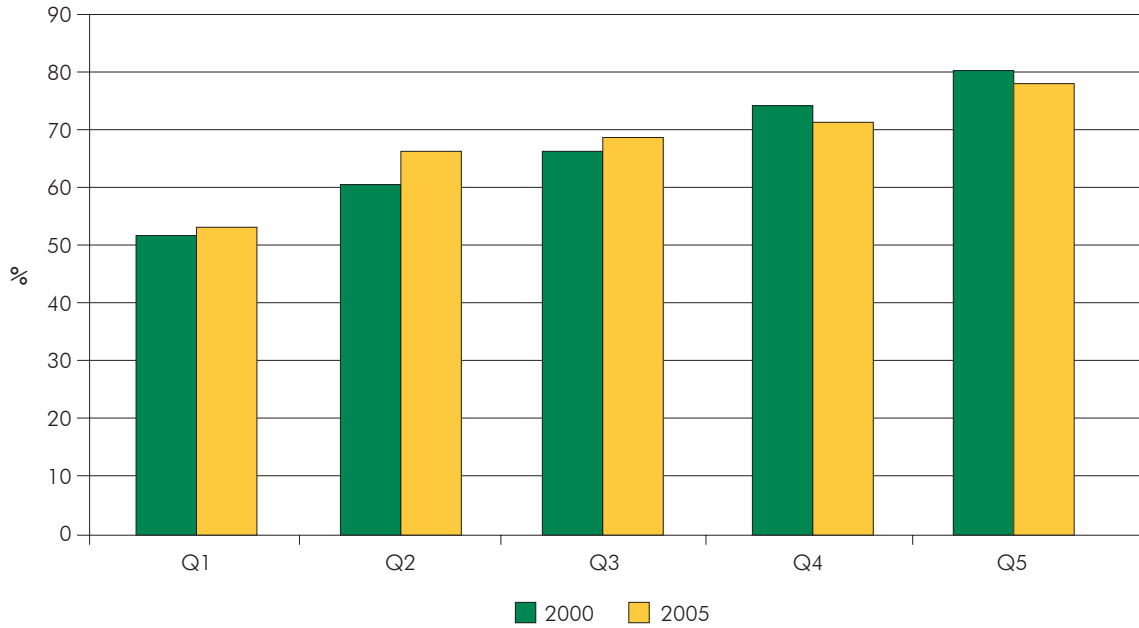
the Colombian health system in the direction of greater equity. In addition, Gaviria (2014b) found that, in 1993, 30% of people from the poorest quintile had no access to health care when they were seriously ill, but that this figure had dropped to 3% twenty years later.

services in 2005, as studied by Flórez and Soto (2007). As the Figures show, lack of money and lack of available services were relatively more important reasons for the lower income quintiles, and for rural areas. In rural areas the lack of supply was a key deterrent to access.

Figures 8 and 9 seek to understand why Colombians who needed health care in the previous 30 days did not access

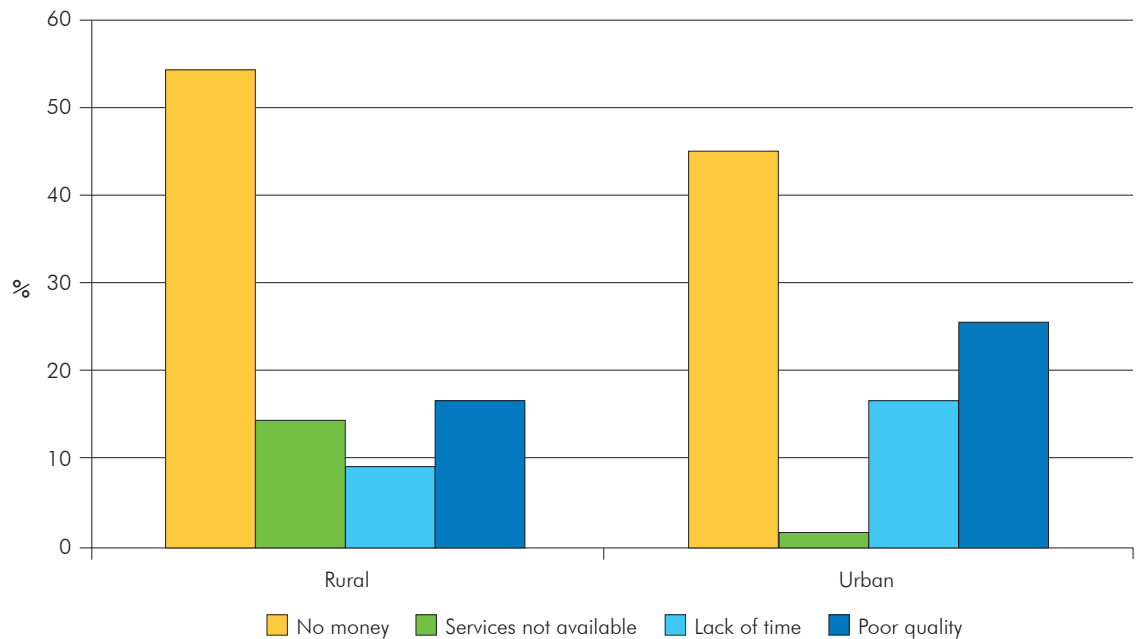
These data corroborate that problems with financial protection and geographic access remained in 2005 (although new data

**Figure 7: A comparison of the distribution of health care benefits across wealth groups in Colombia in 2000 and 2005**



Source: Adapted from Flórez and Soto (2007)

**Figure 8: Reasons why people did not use health services in rural and urban Colombia (2005)**

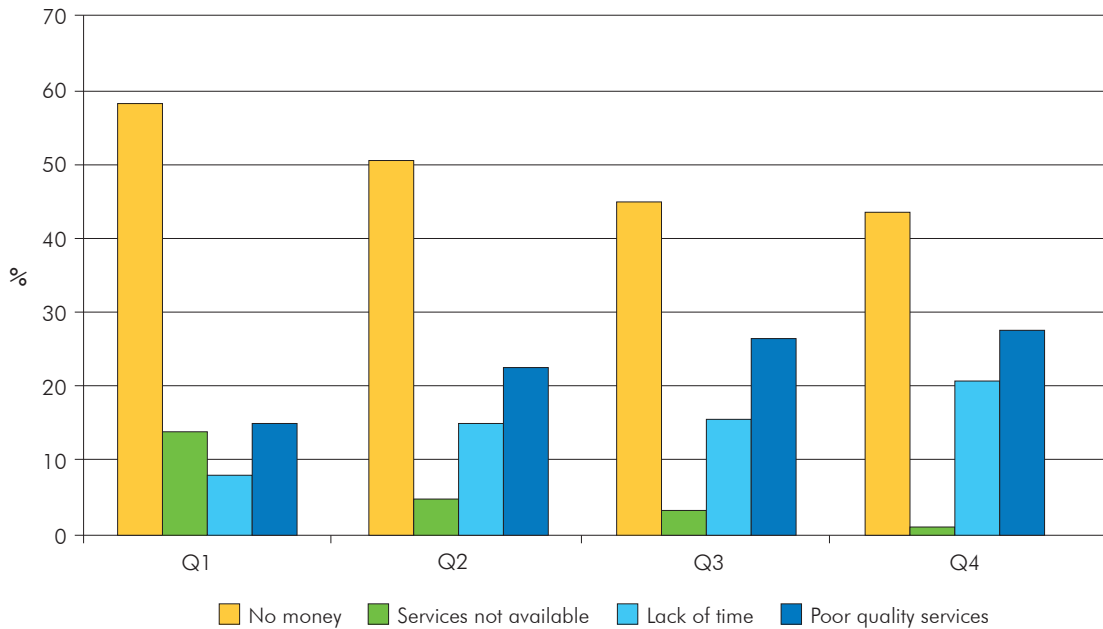


Source: Adapted from Flórez and Soto (2007)

are required to assess how the situation may have changed over the past decade). It is important to note, though, that, by 2005, lack of money had become a less important reason for the lack of access: 49% of all respondents cited this as a

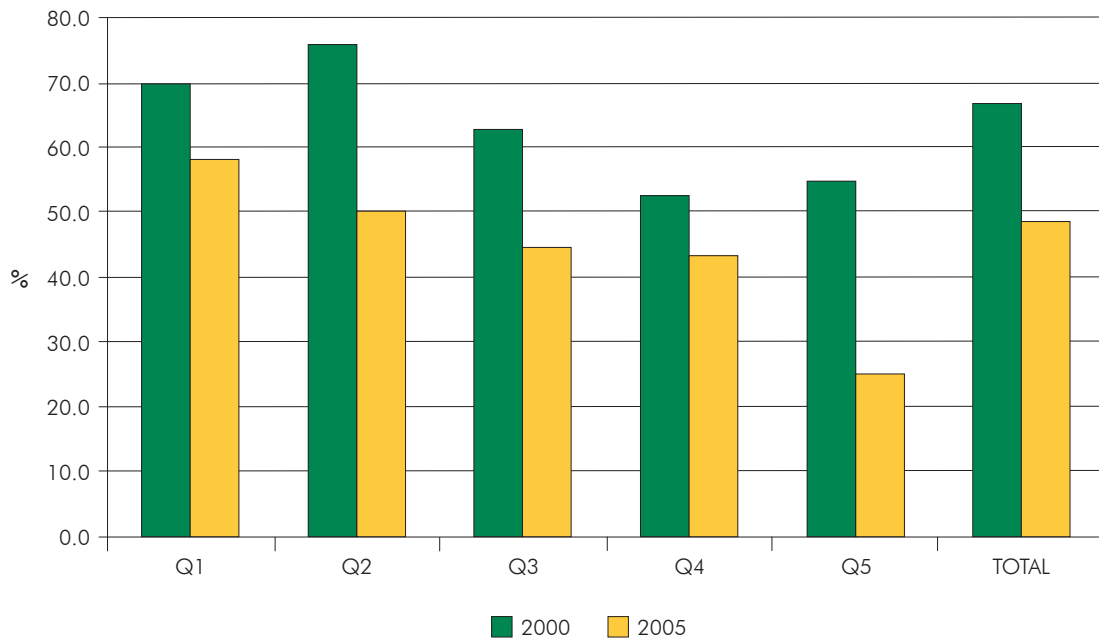
reason compared to 67% in 2000 (Figure 10). On the other hand, by 2005 equitable access to services seems to have worsened, and concerns with the quality of care, and lack of time to visit health services, had increased (Figure 11).

**Figure 9: Reasons why people did not use health services in Colombia, by income quintile (2005)**



Source: Adapted from Flórez and Soto (2007)

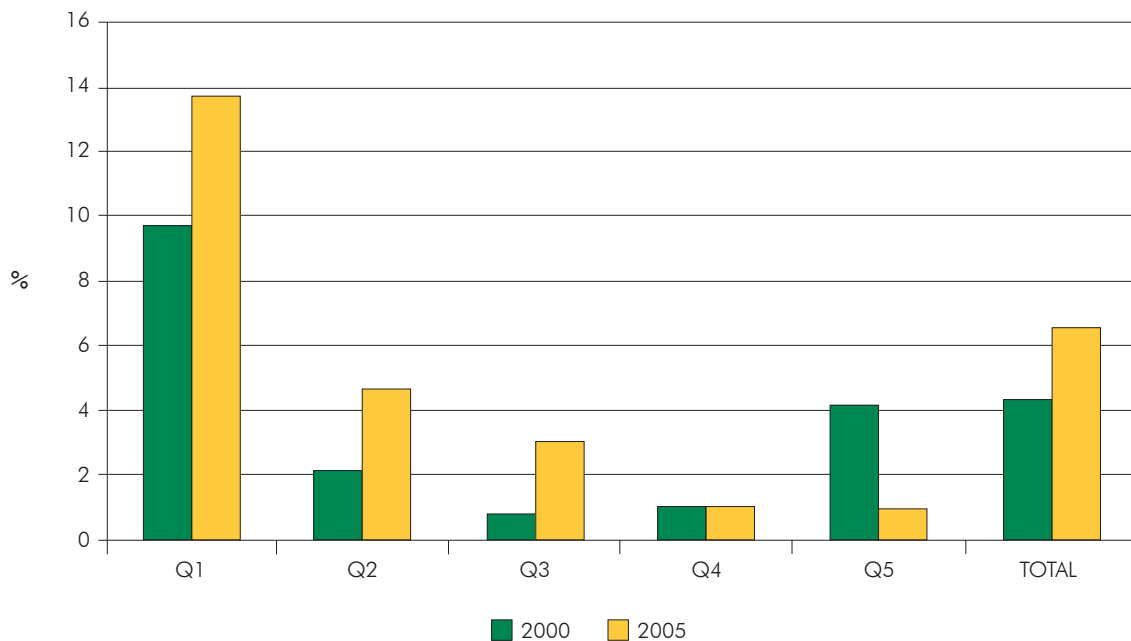
**Figure 10: The percentage of people citing lack of money as a reason for not accessing needed health services in Colombia, by year**



Source: Adapted from Flórez and Soto (2007)



**Figure 11: The percentage of people citing poor availability as a reason for not accessing needed health services in Colombia, by year**



Source: Adapted from Flórez and Soto (2007)

## Conclusion

The Colombian health system has two major health insurance schemes. The contributory regime is mandatory for formal workers and other people with the capacity to pay. The subsidised regime is for the unemployed, informal sector workers and the poor.

The Colombian health system has made big efforts to fulfil the goal of universal health coverage. Since 2000, health expenditure as a percentage of GDP has been around 6.8% and government health expenditure as a percentage of total health expenditure has been almost 80%. In 2010 all health system financial sources were progressive, meaning that higher-income individuals contributed relatively more towards the health system.

In 2013 the contributory and subsidised regimes covered approximately 96% of Colombia's population, and more than half the population was completely subsidised. There is a common mandatory benefit package.

The structure of the health system pools all resources into a common fund that is distributed on a risk-adjusted, capitation basis to a range of public and private health maintenance organisations. People are allowed to choose their health maintenance organisation, and health maintenance organisations are able to choose the providers with which they contract.

However, 4.6% of households in 2010 incurred catastrophic expenditure (measured using a 40% threshold of non-food household expenditure). Although this was an improvement from 2008, the intensity of catastrophic expenditures is still concentrated in low-income households. Data also suggest that the households that became poor after a financial shock were predominantly those in the subsidised regime and the uninsured.

In summary, Colombia has made important progress towards universal health coverage but attention still needs to be paid to the differences in access to health care for those with lower incomes and living in rural areas.

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GNHE is a partnership formed by three regional health equity networks – SHIELD (Strategies for Health Insurance for Equity in Less Developed Countries Network in Africa), EQUITAP (Equity in Asia-Pacific Health Systems Network in the Asia-Pacific, and LANET (Latin American Research Network on Financial Protection in the Americas). The three networks encompass more than 100 researchers working in at least 35 research institutions across the globe.

GNHE is coordinated by three institutions collaborating in this project, namely: the Mexican Health Foundation (FUNSALUD); the Health Economics Unit of the University of Cape Town in South Africa; and the Institute for Health Policy based in Sri Lanka.

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