

New Ways of Corruption and the Colombian Health System Report

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Two categories of insurance coverage were defined in 1993 when the Colombian congress voted a structural reform of the national health system. One was the “contributive” regime, whose funding is provided by the periodical contribution of the employers and employees, the other was the “subsidized” regime, which is dually financed, first by government allocations from the national budget secondly by a portion of the higher income employees’ regular contribution. It was a tough challenge for government entities to deal with new interlocutors, particularly for the state departments of health, which had to switch public hospital’s bureaucrats to managers of privately owned insurance companies in charge of the subsidized regime. It was generally assumed that the new system conception, although complex, had the transparency and the right incentives for its optimum development.

Very soon reality proved these assumptions wrong. Lacking adequate information controls, the system was rapidly abused by users, insurers, public and private health practitioners and/or service suppliers, even official institutions. At the end of the nineties, Bogotá, the country’s capital, have one million of its inhabitants covered by the umbrella of the subsidized regime that was under direct responsibility of the city’s Health Secretary. A process was then initiated to deplete the available information by conforming the data bases of the subsidized regime insurers and afterwards of those of the contributive regime. All payments made by the Secretary of Health were based on the reported members of carnet holders therefore acknowledged as insured. However, it was found that several insurers had simultaneously affiliated the same person and others maintained the affiliation of persons for whom it was impossible to access health services as they had died, moved to a different region in the country, or became part of the contributing labor force. These frauds were meant to perceive the per capita contribution assigned by the system. This disruption caused millionaire losses and deprived the poorest population of substantial funds to get services for their most needed health demands.

From that moment on Bogotá devised additional producers for information data matching and payment controls that were later established throughout the country. Although new measures have been adopted, regulations are still weak and the capacity of the authorities to detect and sanction any violations is most limited.

Civil and penal law enforcing actions have been set forth. Unfortunately the judiciary system, besides being desperately slow and ineffective, ignores or has minimum knowledge of the specific and technical matters that arise from those institutional, financial or legal issues inherent to the reform. An abundant catalog of tasks is yet to be performed, while the definition of priorities and the creation of confidence among all the system actors still remains as the main challenges to be faced by this most difficult process of reforming the Colombian health system.