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HIV/AIDS in the Context of the Colombian Health Care Reform

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Case Study: HIV/AIDS in the Context of the Colombian Health Care Reform^α

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Abstract

Starting in the early nineties, Colombia, the third most populous country in Latin America, implemented a profound reform of its health system. A universal social health insurance system was created. The new system collects funds centrally, and allows for multiple competing plans that receive risk adjusted capitated payments and are responsible for delivering a basic and legally mandated basket of services. This case reviews how the HIV/AIDS epidemic has been managed in the context of this reform. The inclusion of Antiretroviral (ARV) in the mandated basic basket proved a powerful mechanism for ensuring access to care. Results are less clear, and to some extent disappointing, for prevention activities. A major policy concern with catastrophic illnesses including AIDS has been risk selection on the part of the competing plans. Recently, effective steps have been taken for its correction. The country has introduced innovation in the purchasing of care (different from fee for service) that seems to have improved outcomes and reduced costs. In recent years the judiciary has played an increasingly important role in the context of the health system, most notably by ordering the provision of services not included in the package for AIDS and other conditions. The financial sustainability of the health system is compromised. The case offers valuable lessons for the adequate management of chronic illness in other Low-and-Middle Income Countries (LMIC), especially those with a purchasing-provision split and/or competing health plans.

Key words: Colombia, Social Health Insurance, AIDS.

JEL Classification: H42, H51, I13, I18

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Caso de Estudio: VIH/SIDA en el Contexto de la Reforma a la Salud en Colombia^α

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Resumen

A comienzo de los noventa, Colombia, el tercer país con mayor población en Latinoamérica, implementó una profunda reforma de su sistema de salud. Se creó un seguro universal de salud. Este sistema recauda fondos de manera central, y paga una cantidad de dinero per-capita ajustada por riesgo a entidades que compiten entre sí por adiliados. Estas entidades privadas son responsables por asegurar acceso a un paquete de servicios de salud básico y definido por ley. El caso aquí presentado estudia cómo se manejó la epidemia de VIH/SIDA en Colombia en el contexto de la Reforma a la Salud. La inclusión de Antiretrovirales (ARV) en el paquete básico de salud se constituyó en un mecanismo poderoso para asegurar el acceso a tratamiento. Los resultados son menos claros y en cierta medida desesperanzadores en lo que corresponde a actividades de prevención. Una preocupación mayor de la política pública en enfermedades catastróficas, incluyendo el VIH/SIDA, es la selección de afiliados según su riesgo por parte de las entidades que compiten en el sistema. Recientemente se han tomado medidas para corregir este problema. El país ha introducido innovaciones en el sistema de compra de servicios de salud (diferentes a pago por evento) que parecen haber mejorado desenlaces y bajado costos. En años recientes, el sector judicial ha jugado un rol crecientemente importante en el sistema de salud, al obligar a las entidades del sector a proveer servicios de salud no incluidos en el paquete básico para VIH y otras patologías. Como consecuencia la sostenibilidad financiera del sistema se ha visto comprometida. Este caso de estudio ofrece lecciones para el manejo adecuado de enfermedades crónicas en otros países de niveles de ingreso bajo y medio, especialmente aquellos con planes de salud basados en competencia y/o separación entre quien paga y presta los servicios.

Palabras clave: Atención en salud, Sistema de salud, SIDA en Colombia.

Clasificación JEL: H42, H51, I13, I18

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1. Introduction

The advent of the HIV/AIDS epidemic prompted different policy responses around the world. In less developed countries with fragile health systems, prevention and care were organized in vertical programs that have tended to depend on international aid. In middle income countries, which already had functioning health systems, management of the disease was integrated to the institutions and schemes of their respective systems and, in general, care has been more reliant on local resources rather than international aid.

Integrating the management of HIV/AIDS to the institutions and schemes of publicly organized health systems has become an imperative, as it is increasingly clear that this condition is not an acute or episodic malady that can be “left behind” after timely care, but rather a chronic condition that poses long term challenges for patients, providers and the health systems as a whole.

The expansion of access to Antiretroviral (ARV) treatment has greatly increased life expectancy of patients. Recent estimations account for up to 35 years of additional life expectancy after being diagnosed with HIV/AIDS and treated with HAART (Atun et al, 2009). This success highlights the need to change the frameworks and assumptions with which this condition had traditionally been managed. A long term view for financing the management of HIV/AIDS has to be adopted. Sustainability of care is becoming a central concern. Moreover, continued access and long term care, as such, are important challenges for health service delivery models around the world, and in developing countries in particular.

Countries have achieved different degrees of success in integrating and institutionalizing HIV/AIDS management in the context of their systems. Such integration is crucial for the sustainability of care and for adequately facing the new challenges that these conditions pose when viewed as a chronic illness.

The concrete ways in which HIV/AIDS has been managed in different countries depends, naturally, on contextual factors such as local capacity and the general level of development. Perhaps more importantly, features of the design of the health system are

also related to the extent to which this and other chronic conditions can be successfully managed in a sustainable way and integrated to the rest of the health system.

In this case study we consider the experience of Colombia, a middle income country with 45 million inhabitants. In the early nineties this country adopted a universal social health insurance system, with managed competition among multiple health plans and providers (public and private). The system includes a mandatory benefits package, which has been the main policy tool with which HIV/AIDS care has been organized and financed.

COLOMBIA

Country facts

- Population 46,044,601 (2011)
- Area: 1,141,748 km²
- GDP/PPP : \$ 404.9 billion (2010)
- GDP per capita (PPP) \$8,869 (2012)
- Real growth rate 2011: 5.9%
- Inflation: 3.2% (2011)
- Unemployment: 10.8% (2011)
- Life expectancy: 73 (2010)
- Infant mortality: 22 / 1.000 (2010)



Sources: DANE and World Bank

The experience of Colombia highlights important issues likely to be encountered by countries with similar design in their health systems when managing chronic conditions like HIV/AIDS, and other lessons that are pertinent for developing countries in general. The case is mainly focused on HIV/AIDS prevention and care. Some of the issues are common to other chronic conditions. Such more general issues will be highlighted and expanded from selected examples drawn from other conditions.

The next section after this introduction presents how the health system has been designed and implemented. The following one informs about the AIDS epidemic in the country.

Then, the policy response is presented and explained, emphasizing on three important health system functions: risk pooling, purchasing and service provision. The case of other chronic conditions, the judicial intervention in the health sector and the current financial crisis of the system are considered in the following section. The final section presents the lessons learned from this country case.

2. The Health Care Reform

Prior to 1993 Colombia had a health system with three components that functioned as “separated worlds”. The wealthiest 10% of the population was able to access private doctors and facilities paying either out of pocket or through private insurance. There were social security institutions for workers in the formal private and public sectors, and approximately 20% of the population was insured this way. These systems were financed with payroll based contributions and acted as vertically integrated monopolies that performed all the functions of the health system. Namely, stewardship, revenue collection, risk pooling, purchasing and provision. For the rest of the population (80%) there was a network of public hospitals funded through general tax revenues. Effective coverage of services tended to be very low and there were great disparities in spending¹. Exhibit 1, adapted from Frenk and Londoño (1997), shows this graphically.

The reform created a universal health insurance system. Workers and employers in the formal sector (public or private) contribute 12.5% of their wage earnings to a central fund called FOSYGA. Workers and their families choose a social health insurer among many public and private options. These are known as health promotion entities (EPS, by the acronym in Spanish). They play an insurance function that differs from passive payers of claims. EPS are involved with organizing the provision and some of them are themselves providers (vertically integrated)². The central fund then pays insurers (EPS) a risk adjusted per-capita rate, based on the population that chooses to enroll in each one of them.

¹ The ratio in health expenditure per capita between the province (department) that spent the most and the least was five to one (Ministry of Health, 1996).

² A law in 2007 limited the extent to which they can integrate vertically.

Exhibit 1. Functions of the health system

| FUNCTIONS | SOCIAL GROUPS | | |
|-------------|--|-------------------------|--|
| | Non-poor | | Poor |
| | Socially insured | Privately insured | Uninsured |
| Stewardship | ↓ Social security institution (s) | ↓ Private sector | ↓ Ministry of health/public Hospitals |
| Financing | | | |
| Purchasing | | | |
| Provision | | | |

Adapted from Londoño & Frenk 1997

For people in the informal sector without the ability to contribute, unemployed or poor, there is a subsidized scheme. For this population the contribution is fully subsidized. Municipal mayors make contributions to the insurers that people choose. Part of the funding comes from a solidarity contribution (1,5 percentage points of the 12,5% payroll based contributions in the formal sector goes to this account).

People are allowed to choose insurer, and change after one year of enrollment. All insurers are obliged to offer the same benefit package, know as Mandatory Health Plan (the acronym in Spanish is POS). The average per-capita rate has increased over the past three years in an attempt to be equalized for both regimes from USD\$ 182 in 2009 to USD\$305,4 in 2012 (COL\$ 547.639,2)⁴ per year in the Contributory Scheme and, from USD\$ 105 in 2009 to USD\$ 241,8 (COL\$ 433.666, 8)in 2012 for the subsidized one

⁴ Currency exchange rate from <http://www.oanda.com/lang/es/currency/converter/> for July 31st 2012

(Giedion and Panopolou, 2009 and National Health Regulatory Commission- CRES 2011 and 2012).

The POS includes those services delivered to individuals, including a preventive component (e.g. child vaccination, cervical cancer screening). Services delivered at the community level are managed, according to the law, in a separate plan under the responsibility of municipal authorities. In 2001 a law took away the preventive component of the POS in the subsidized scheme and its corresponding funding from the EPS, and assigned that responsibility to municipal authorities. In 2007 the preventive component was restored back again to the social health insurers. Exhibit 2 illustrates the new health systems functions, and Exhibit 3 illustrates the flow of resources in the system.

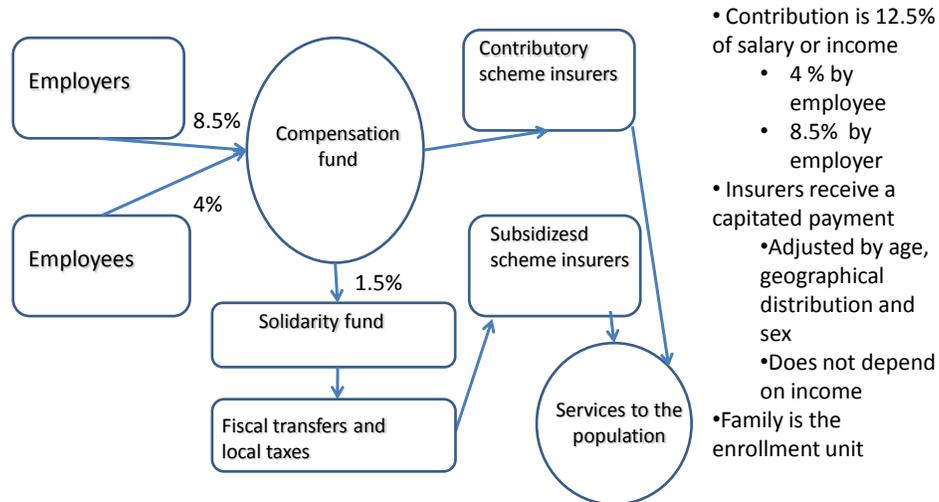
Exhibit 2. Functions of the health system after the reform

| FUNCTIONS | SOCIAL GROUPS | | |
|-------------|--|--------------------------------|------|
| | Non-poor | | Poor |
| | Socially insured | Privately insured Uninsured | |
| Stewardship | Ministry of health | | → |
| Financing | Social security (extended) | | → |
| Purchasing | Competing plans (structured choice) | | → |
| Provision | Public & private providers in plans networks | | → |

Adapted from Londoño & Frenk 1997

Exhibit 3. Financial Architecture and flow of resources

Financial Architecture

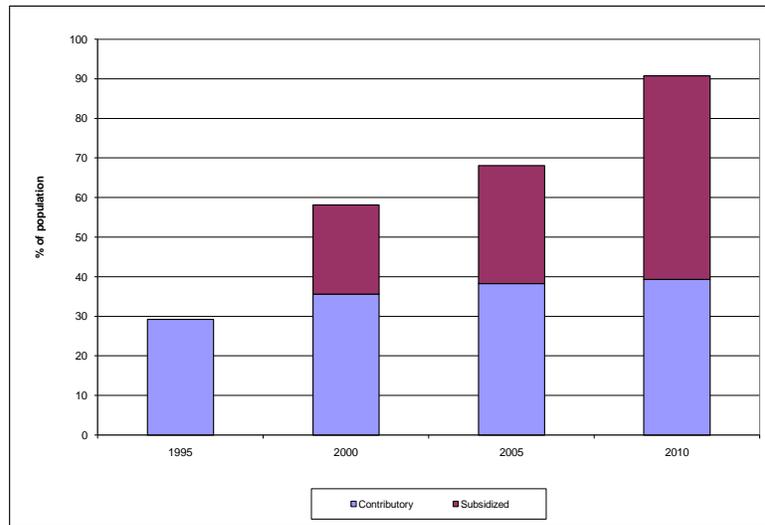


Implementation of the reform has been gradual. It was originally expected that approximately 70% of the population would enroll in the Contributory Scheme and the rest would be subsidized. After implementation the proportions were in fact inverted, due to structural informality in the labor market. Financing universal enrollment has meant a greater than expected effort for the public budget (Guerrero 2008) (See Graph 2 for details.)

At the outset of the reform, for fiscal and political reasons, it was decided that the subsidized scheme would have a lesser benefits package, which would be gradually equalized to that of the contributory scheme. Such equalization has been delayed for fiscal reasons, which prompted new legal and judicial mandates for achieving it. The new government installed in 2010 promised to do so by 2014. In July 2012 equalization was achieved. Up to present the package in the subsidized scheme has covered primary care and low complexity interventions and a set of high complexity services for conditions

that would otherwise cause catastrophic expenditures. It has, however, a “hole” for secondary level care. Since the latter services are not assumed by insurers, people must seek them at public hospitals, which have special funding for them, although the switching of provider compromises continuity of care.

Graph 2. Historic evolution of enrollment rates within the Colombian health system



Source: Ministry of Health

After 15 years of implementation the country has achieved greater access and utilization of health services, particularly on the poor side of population. Gaps in access among wealth quintiles have been reduced across a wide set of services (Florez, 2007). Life expectancy has increased, although this does not automatically imply a causal relationship with the reform process. Coverage by the social health insurance scheme has been shown to protect households against catastrophic expenditures (Giedion and Villar, 2009). Information gaps make it difficult to establish what has happened with quality at population level. It was expected that efficiency would improve with competition, yet that remains to be proven. There are complaints about the complexity and transaction costs brought by the multiplicity of institutions.

The judiciary has become deeply involved in the health sector. Rulings have highlighted problems in the provision of services included in the package, like delays and denials. Judges have also pressed for the expansion of coverage within the package and, beyond that, ordered the provision of services not in the package at the taxpayer's expense. The extent to which this has happened has led to profound financial crisis.

The following sections present the AIDS epidemic in Colombia and the ensuing policy response in the context of the reformed health system.

3. The AIDS Epidemic in Colombia

HIV arrived to Colombia in 1983 according to official data. Every new case then was treated as a medical novelty capturing huge media attention, but ability to prolong the life of patients was very limited. Originally it affected high risk groups like sex workers, men that had sex with men and IV drug users (Castro, 2010). All cases during the first four years were reported as imported and only up to 1987 the ratio of imported vs. autochthonous infections was inverted (Galindo, 1989). Gomez in 1992 stated that during the early years and for a short period of time the disease affected mostly affluent population with the economic ability to cross borders, but then it spread to less affluent social classes rapidly. The ratio of *men:women* infection was by that time 11:1. Clinical diagnosis was made at late stages of infection, hence time survived after diagnosis was only 6.15 months on average.

During the 1980s HIV/AIDS was associated with stigma. No prominent consumer organizations (patients or their families) were visible in that decade. In 1986 and 1987 new laboratory techniques to detect antibodies against HIV-1 became available in Colombia. Earlier diagnosis became thus possible but screening did not become a wider practice until early 1990s. After a big scandal of newly infected hemophiliacs from infected blood transfusions, more stringent policies and regulation were introduced in 1993.

Health outcomes, up to the mid 1990s, were very poor since highly active antiretroviral therapy (HAART) had not been introduced and the only option offered consisted in supportive and palliative treatment (Carrasquilla, 1995). Resources for local research and

development were limited because of budget constraints of the former health system. During that decade the epidemic profile transitionally became more feminine and ratios of *men:women* went from 7:1 in 1995 to nearly 3:1 in 1999 (Galindo, 2000). Major technological advances entered the country in mid 1990s. More specific and sensitive techniques for CD4 count, viral load, better understanding of opportunistic infections and HAART became available, changing dramatically the life expectancy and quality of life of people living with HIV/AIDS.

The 2000's have brought more technology and new families of HAART. A shift in transmission patterns have made heterosexual transmission the predominant one; ratio *men:women* changed from 1:2.3 in 2005 to 1:1.8 in 2007 (UNAIDS, 2007). The risk of mother to child transmission represented 1,9% of total incidence (1085 cases) in 2008. A steady decrease in Men-who-have-sex-with men (MSM) rates from the late 1990s, a perceived reduction of infection rates of other risk groups and an increasing “feminization” since the mid 2000s have shaped the epidemic profile in Colombia (UNAIDS, 2005, Garcia et al, 2006).

According to the Ministry of Social Protection by the end of 2008 57,489 Colombians had been diagnosed as HIV positive. Colombia is the fourth Latin American country with the highest number of cases after Mexico, Brazil and Argentina. Even though the classification of levels of prevalence (suggested by the World Bank) states that Colombia has a concentrated prevalence (5% or greater prevalence rate in risk groups and less than 1% prevalence in general population), more than 180,000 persons (estimated prevalence of 0.67%) may be living with HIV/AIDS in the country. Each year about 4,200 new cases are reported.

The total cumulative incidence rate from 1983- 2005 has been 5.36 cases per 100,000 habitants, but the decade between 1995-2004 was comparatively higher than the total cumulative rate being 7.85 cases per 100,000 population (high rate of infection, driving average up), leading to concern about the effectiveness of preventive campaigns (UNAIDS, 2005).

4. Policy Response of the Health System

By the onset of the epidemic outbreak Colombia was still under the “old” health system described above. Although some public hospitals were subsidized by the government to cover vulnerable population’s health needs, most services were directly paid for by out-of-pocket in public and private facilities including those for HIV/AIDS and some other catastrophic conditions. Out-of-pocket expenditure was estimated as 43.7% of total private spending for the general population in 1993, the year the reform was approved (WHO, 2009).

At first, each case of HIV/AIDS was treated as a clinical novelty until 1987 when the government introduced the first national campaign to fight against AIDS and an official program of HIV/AIDS prevention. With an organized epidemiologic surveillance system, quality of data and reporting improved from year 1988 onwards.

When the reform was approved in the early nineties a set of conditions were classified as catastrophic⁵. They were explicitly included in the benefits package. Original regulation stated that some form of insurance should be used for them, and care should follow clinical guidelines. Except for initial and emergency care, treatment was conditioned to having contributed at least 100 weeks to the system⁶.

HIV/AIDS was classified as a catastrophic condition along with cancer, chronic renal failure, transplants, genetic disorders and severe trauma (Resolución 5261, 1994).

HIV/AIDS health care after diagnosis is exempted from copayments. In the paragraphs that follow we consider how each of three essential health system functions, namely financial risk pooling, purchasing and provision, have been performed in relation to HIV/AIDS.

Pooling

The Colombian health system pools all contributions centrally and, to that extent, achieves efficient pooling of financial risk across all population groups. Yet, in health systems with competing plans, there is the potential for risk selection on the part of

⁵ Defined then as having high cost, low occurrence, high complexity of treatment and low cost-effectiveness.

⁶ Of which at least 26 weeks during the last year.

insurers (Ellis and Van de Ven, 1999). Even though it is illegal to reject any request for enrollment, plans can find subtle ways of avoiding the most costly patients. If this happens, patients with catastrophic illnesses tend to concentrate in one or a few insurers, usually public ones, since the private counterparts have stronger incentives to select patients.

One mechanism by which this is partially controlled is by introducing risk adjustment in the capitation formulas. Colombia has done this only for the contributory scheme, and has approximated risk with demographic variables (age, sex and geographic distribution). Developed countries with similar health system design, such as the Netherlands, introduce clinical history in the formulas, which improves the match between expected costs and payments for each patient group. Yet even in the countries with the most sophisticated risk adjustment, other ex-post resource redistribution mechanisms have been implemented in order to control risk adjustment (Ellis & Van de Ven 1999).

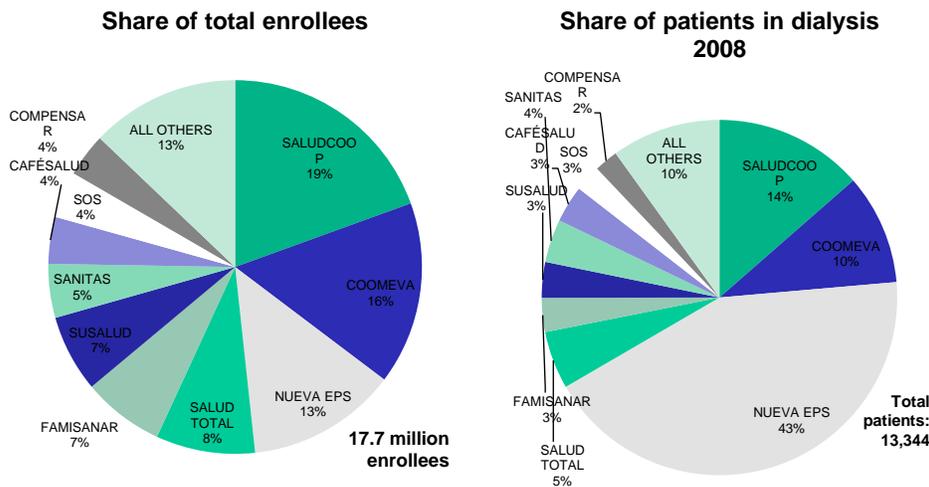
The potential problem of risk selection was foreseen at the beginning of the reform process in Colombia, and in 1994 the regulation established that 8% of the plans revenues (coming from capitated payments) should be set aside for a special reinsurance fund for these catastrophic conditions. This was scrapped a few months later on.

In the following years it became increasingly clear that catastrophic patients were disproportionately concentrated in the main public insurer (the former National Social Security Institute). The three main conditions for which this was reported to happen were chronic renal failure, cancer and HIV/AIDS. Graph 3 illustrates the extent to which patients with renal failure concentrate in the main public plan (now called “nueva EPS”).

Starting in 2001 several attempts were made to correct for this, firstly by mandatorily redistributing patients among insurers, and then by transferring resources between insurers. These were not successful mainly because of lack of good quality information and enforcement capacity on the part of the government. Regulators relied on information submitted by insurers that had strong incentives to distort it. The concentration of high risk contributed to a financial crisis in the main public plan, which was eventually liquidated in 2007 and replaced by a new institution (“nueva EPS”).

In 2007 the government mandated the creation of the so called high cost sub-account (HCA), which aims to pool and redistribute risk for catastrophic conditions, using the resources already allocated to insurers by the system. It is based on an externally audited database of patients, which is publicly available yet protects for privacy. This appears to have solved the main problem of prior attempts, which was reliable information, and HCA seems to be achieving its objective.

Graph 3. Risk selection share by insurer (Contributory scheme)



Harvard Global Equity Initiative

The HCA is managed collectively by all insurance funds from both regimens, Contributive Regime (RC) and Subsidized regime (RS), and under the oversight of government. After a successful pilot launched in 2008 that started operation focused on chronic renal failure⁷, additional high cost diseases have been considered to be managed through the HCA: Cervical, breast, stomach, colorectal and prostate cancers, acute lymphoid leukemia, acute myeloid leukemia, Hodgkin and no Hodgkin lymphomas, epilepsy, rheumatoid arthritis and HIV/AIDS. It was expected by 2011 to start risk pooling the population living with HIV/AIDS.

⁷ Resolution 321 of 2007.

Purchasing

Purchasing health services is a decentralized process made by each insurance fund. Retrospective fee-for-service (FFS) is the predominant mechanism to reimburse inpatient health care providers in Colombia (90% of contracts, according to ACEMI, 2008). FFS has been pointed out as major driver of the increase in health expenditures according to some international publications (EOHS-WHO, 2005) and associated to supplier induced demand (increase in volume of services).

Paying providers to treat chronic costly diseases during the last decade in Colombia has partially moved to fixed budgets emulating the Diagnostic Related Groups classification system (DRGs). The latter were firstly introduced in High Income Countries (HIC) during the 1980s. Some anecdotal evidence has described this migration in the payment mechanism for chronic renal failure under dialysis and HIV/AIDS under ARVT in Colombia.

For multiple sclerosis, rheumatoid arthritis and severe hemophilia, innovative incentive mechanisms have been developed for health providers. Based on case or disease management approaches health care professionals or groups of practice are allocated activity-based fixed payments to treat mostly in outpatient settings each case and reduce inpatient admissions, average stay, rate of complications and so on, but deeper research has yet to be implemented to account for overall economic impact and quality standards in such cases. In the case of cancer, a per-capita scheme trying to emulate the capitation schemes for primary health services was tried by a big insurer in 2009 without success.

In the case of HIV/AIDS health care services FFS was the predominant mechanism including medicines until late 1990s. After this period, purchasers introduced alternative mechanisms that mimic capitation or fixed budgets that after all became popular. Based on Yardstick competition and called “integral packages”, DRGs were introduced in the early 2000’s. They include a fixed monthly payment per case (prospective or retrospective) to cover outpatient care, medicines directly related to HIV/AIDS and sometimes inpatient health care derived from opportunistic HIV related infections after an initial period of compliance (usually 3 months).

DRGs were promoted by insurers due to the high levels of financial uncertainty with disease, high prices of newly discovered medicines and social pressure via judicial intervention surrounding HIV/AIDS during the late 1990s (to be commented below). DRGs aim to introduce incentives for the provider to adhere to guidelines, follow up and control the highest number of patients, control for adverse events and complications, minimize hospitalizations and improve health outcomes. DRG and FFS still share the market for HIV provision, the former operates in urban areas focused on insured population and the latter for those living in rural areas where numbers of patients are not enough to control for provider's risk pooling, or for those still without insurance facing out of pocket expenditure. Complementary and voluntary private insurance (PHI) that covers affluent population is mainly dominated by FFS to provide health care, including those for HIV/AIDS not excluded at enrollment.

DRGs are usually payments for multidisciplinary groups which are to provide clinical follow up, guideline's routine testing, HAART and supportive activities for patients with clinical indications of ARVT (psychology, nutrition, social work and so on). The first "integral packages"⁸ cost around COL\$1.500.000 (USD\$ 750) per patient per month, but over the last three or four years cost has gone down to COL\$750.000 (USD\$ 350) or less per patient per month, probably related to economies of scale and scope achieved by providers, some price regulation of medicines and the entrance of generics and, hopefully not, from quality skimming or cream skimming.

According to a recent economic evaluation made with Colombian figures DRGs are cost effective mechanisms to reimburse health care providers to treat HIV/AIDS when compared to FFS, but early diagnosis and classification of disease are key elements in order to efficiently allocate resources (Castro, 2010). For each five cases of HIV/AIDS diagnosed and treated at an early stage, at least one extra case could be treated with the same amount of resources under the DRG scheme.

⁸ "Integral packages": comprehensive health care, including outpatient care, medication, and supportive therapy provided by the same healthcare organization.

Although drug costs have tended to go down, they continue to be a major concern. In recent years the government has regulated the price of a number of monopoly drugs including ARVs. One of the most visible cases was that of Kaletra.

Government initiatives to unify report mechanisms of new HIV cases and the introduction of clinical guidelines in the mid 2000s aimed at homogenizing clinical practice, have made it possible to oversee and regulate the quality of service, since it provided a nationally accepted gold standard to provide health care.

Provision

Personal health services:

The provision of health care for people living with HIV/AIDS in Colombia has evolved over time from segmented facilities in the early stages of the epidemic (mostly hospitals) to concentrated services where medical and paramedic specialized supportive staff and equipments are available for diagnosis and disease/case management (mostly outpatient services), perceived as specialized centers of excellence. Most of these facilities are private (or mixed public private) organizations, either for profit and non for profit, registered as NGOs or independent health care providers that contract out with third party payers (mainly EPS). Some others are vertically integrated facilities owned and managed by insurance funds and although the majority are focused exclusively on HIV/AIDS treatment, some of them provide services for cancer or hematology outpatient controls. Inpatient health care services for people living with HIV/AIDS are still mostly provided by hospitals or clinics.

In an attempt to standardize quality of provision, in 2003 the National Council of Social Security and Health (CNSSS), mandated the national adoption of evidence based guidelines for HIV/AIDS. These were later published in 2005 and fully implemented in 2007.

Nowadays patients entering the health system are seen by a general practitioner that acts as a gatekeeper. When a patient is diagnosed as being HIV positive, confirmatory tests are performed and referral is made to more specialized level of care for clinical classification to be made by specialists or sub specialists (Internal Medicine or

Infectology) and ARVT is started if needed. If the patient is stable and does not require ARVT yet, health care is usually provided in primary care facilities where a physician in charge (usually a GP) follows up and controls each case and counter refers only when needed. New cases, severely ill, first presenting with complications are referred to acute inpatient care to be provided in clinics and hospitals attempting to stabilize them.

All para-clinic and laboratory tests to diagnose or follow up clinical status of infection were included in the basket of benefits since late 1990s (Elisa test, IFI, Viral load ultrasensitive techniques, CD4, CD8 and other sub populations of lymphocytes count). Gen-typification for HIV1 to account for viral resistance (and decide further clinical options) and additional screening tests for co morbidities are also included. Although 2005 national clinical guidelines consider the combination Lamivudine + Zidovudine + Efavirenz as first line treatment, second line options and even new generations of HAART are included in the package⁹.

Since the early years of the 2000 decade there have been no important differences in the content of the benefit packages of the contributory and subsidized schemes in what has to do with HIV/AIDS.

Judicial rulings ordering the provision of services not included in the package are a major issue in the Colombian health care system. They were frequent for AIDS in the late 1990's and early 2000's. The courts favored the expansion of the benefits package to include more HIV/AIDS services. The package has been expanded to cover the newest

⁹ The basket of benefits explicitly covers three groups of ARV agents: Protease Inhibitors, Nucleoside Reverse Transcriptase Inhibitors and Non Nucleoside Reverse Transcriptase Inhibitors and implicitly the group of Fusion and Entry Inhibitors and Integrase inhibitors. The current ARVT included in the basket of benefits are: Protease Inhibitors (Atazanavir, Fosamprenavir, Indinavir, Nelfinavir, Ritonavir, Saquinavir), Nucleoside Reverse Transcriptase Inhibitors (3TC Lamivudine, Abacavir, Zidovudine, Stavudine, Didanosine), and Non Nucleoside Reverse Transcriptase Inhibitors (Efavirenz, , Nevirapine) and the combination tablets (Combivir [AZT+3TC], Kaletra [Lopinavir +Ritonavir], Kivexa [3TC+ Abacavir], Trizivir [AZT+3TC+Abacavir]; The ARVT non explicitly included in the basket of benefits, but reimbursed via CTC or Tutelas (judiciary) are: Protease Inhibitors (Darunavir), NRTI (3TC Tenofovir CTC administrative tramits , NNRTI (Etravirine), Fusion and Entry inhibitors (T-20 Fuzeon, Maraviroc) and Integrase inhibitors (Raltegravir) as well as the Combinations Truvada [FTC+Tenofovir] which is newly entering the market and expected to be reimbursed via CTC or tutelas (judiciary entitlement) too. From the PI (Tripranavir), NRTI (Emtriva FTC No invima) and the combination Atripla [Efavirenz+Tenofovir+FTC] are not yet approved to be commercialized in the Colombian market."

drugs and technologies. After these expansions ARV drugs have not been among the “off package” ones that judges usually grant, because most (if not all) are in the package.

Non personal health services

Defined as those collective interventions including education and prevention campaigns, these are mostly delivered by the public sector.

Some of these campaigns have not been very clear or specifically targeted to risk groups. These have not had a remarkable impact, since according to UNAIDS 2010 the incidence of new HIV cases remains substantial in this country. Even now the use of condom reflects misinformation and is frequently more associated as a contraceptive method than protective mechanism for STD including HIV/AIDS as has been described elsewhere (Ali et al, 2004).

Heterosexual sex transmissions is currently the main infectious mechanism in Colombia, recent figures of new reported cases do not support the efficacy of preventive campaigns. Late diagnosis of disease (70% according to UNAIDS) does not support either the efficacy of efforts invested in promoting patient’s initiated health care.

5. Lessons learned

Colombia implemented a sweeping health reform that introduced powerful “horizontal” tools, like the mandated benefits package, for guaranteeing the provision of priority health services.

The country was successful at integrating the vertical programs for AIDS treatment in the basic package, thus guaranteeing its sustainable financing and provision. While treatment appears to have been successfully institutionalized within the health system, HIV/AIDS prevention has underperformed.

This could bear some relationship to certain features of the design of the health system. To the extent that people are free to change insurer, the latter have weak incentives for long term investments in prevention (because they have no guarantee of receiving the rewards of such investments). Public health services delivered to the community, on the

other hand, have not been coordinated with personal services, nor delivered in way that is considered effective.

Colombia has innovated in the way care is purchased. A lesson learned from this is that the way care is purchased matters greatly in terms of the quality, sustainability and cost effectiveness of care.

Predictably, the country has had serious problems of risk selection on the part of competing insurers. While the technical solutions to this problem are well know (albeit imperfect), their implementation requires greater regulatory capacity and stronger stewardship. It is crucial to obtain reliable information on morbidity and service coverage. This proves especially difficult in a context in which insurers and providers have strong incentives to distort such information.

The fact that in recent years HIV/AIDS drugs and services are not among the “off package” ones granted judicially suggests that the package is comprehensive and up to date for this condition.

While it is positive that countries introduce certain universal entitlements in the context of health care, they need to be cautious in their expansion in order to avoid compromising sustainability. This ultimately speaks to the need for stronger stewardship, for being able to balance the need for greater coverage and the necessary limits for sustaining essential services in the long term.

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