DCP3 Volume 6, Chapter 15 Supplement: Financing Cancer Care and Control in Colombia

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In the early nineties, Colombia adopted a universal social health insurance system and introduced a mandatory benefits package (1, 2, 3, 4, 5, 6). Implementation has been gradual, and universal enrollment was achieved in 2011 (7). Overall, insurance has protected households against catastrophic expenditures, and improvements in access and utilization of health services, particularly among the poor, have been documented (8).

Colombia has a contributory scheme (RC) for workers and employers in the formal sector, and a subsidized plan (RS) for the informal sector, the unemployed and the poor. The average per capita rate in 2013 was $US 284 per year in the contributory plan, and $US 254 in the subsidized plan (9). RC covers approximately 39.4% of Colombia’s population and is financed by a total payroll tax of 12.5% of wages, with salaried workers paying 4% and employers paying 8.5%, while independent workers pay the full 12.5% (10). Beginning in 2014, for-profit employers will be exempt from the 8.5% tax and will replace their contribution with an income tax surcharge. The RS, which covers approximately 51.4% of the population, is financed by a cross-subsidy from RC and general taxation (10). The National Fund (FOSYGA) pools these varying funding sources and pays competing insurers through Risk Adjusted Capitation. The Health Maintenance Organizations pay cancer care providers by fee-for-service (10). These insurers deliver the legally stipulated package of services, which include child vaccination, cervical cancer screening, hospitalization, chemotherapy, radiotherapy, and most cancer drugs (11).

This financing reform has been implemented in the context of a growing NCD and cancer epidemic. Prior to the reform, most services for catastrophic illnesses were paid out-of-pocket in both public and private facilities. When the content of the insurance package was first defined in 1994, coverage was mandated for a series of basic interventions. Cancer was classified as a catastrophic disease along with HIV/AIDS, chronic renal failure, transplants, genetic disorders, and severe trauma in the contributory plans. This classification is noteworthy considering the high prevalence and mortality associated with the disease in Colombia. Cancer accounted for 17% of total mortality in Colombia in 2008 (12). In 1995, some coverage for high-cost catastrophic diseases like cancer was also included in the basic plan for the subsidized scheme.

Coverage of catastrophic illness has expanded gradually. In 2000, screening interventions were included for breast, cervical, prostate, and colorectal cancers. Radiotherapy treatment with linear accelerators was included in the package for both plans in 2002, while mammography and breast biopsies were included for both regimes since 2012.81 Cancer, HIV/AIDS, chronic

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renal failure, transplants, genetic disorders, and severe trauma were all categorized as catastrophic diseases and thus included in the RC package in 1994 and the RS plan in 1995. The subsidized plan had a smaller benefits package until 2012, when its content was then equalized with that of the contributory scheme. Now, surgery, chemotherapy, and radiotherapy for cancers, as well as some drugs (such as tamoxifen and paclitaxel, and more recently Rituximab and Trastuzumab, in accordance with Acuerdo 029 of 2011) have been included in the equalized insurance package (13).

Still, certain exclusions remain, especially of last generation technologies. Geographical disparities and barriers in access to prevention and care also persist. More than 77.8% of breast cancer patients are diagnosed when breast cancer has reached advanced stages.82

In the courts, patients often successfully challenge the denial of services and drugs, even those that are not included in the package. The number of such legal claims has grown explosively, as have costs fueled by the resulting inefficient, ad hoc procurement and payment methods for judicially granted benefits.84 In this context, substantial amounts of resources are devoted to very expensive drugs that are given to patients who sue, often after late diagnosis, when treatment is not very effective. Meanwhile, prevention and detection remain underfunded.

In 2007, the government mandated the creation of a high-cost sub-account to pool and redistribute risk for catastrophic conditions across the entire population. Insurers with relatively low prevalence compensate those with a higher one. This was a response to a fiscal crisis in the system generated by the concentration of catastrophic patients - predominantly beneficiaries suffering chronic renal failure, cancer, and HIV/AIDS - in the main public insurer (11). Based on a successful pilot of the sub-account for chronic renal failure, several cancers have been selected for being added to the scheme. These would include cervical, breast, stomach, colorectal, prostate, acute lymphoid leukemia, acute myeloid leukemia, Hodgkin and non-Hodgkin lymphomas, along with epilepsy, rheumatoid arthritis, and HIV/AIDS. However, more sophisticated risk sharing mechanisms between insurers are still needed to better manage financial risk and compensate the costs of high cost conditions. Potential innovative methods such as bundles of services and performance related measures have been used in Colombia for such conditions as HIV and may be applied to cancer (11).

While these developments in cancer care and control may inform policies in other low and middle income countries, significant challenges remain in the delivery of services across the country. Coordination between payers and providers in the system is lacking, thus compromising the quality and continuity of care. Supply side bottlenecks inhibit access to care, due to inadequate human resources and infrastructure outside the main urban centers. Nonetheless, Colombia’s progress in improving financial risk protection may serve as a model for other low and middle income countries with similar burdens of chronic and catastrophic illness.

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