Is it a financial crisis or a management crisis? Evolution of the financial dynamic of the health sector from the perspective of territorial entities

¿Crisis financiera o crisis de gestión? Evolución de la dinámica financiera del sector salud desde la perspectiva de los entes territoriales

Crise financeira ou crise da gestão? Evolução da dinâmica financeira do sector da saúde a partir da perspectiva dos territórios.

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Reflective article

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Abstract

Traditionally, the problems associated with the health sector in territorial entities have been mainly outlined within a financial plane. Thus, efficiency problems have been treated with fiscal or financial measures. This article presents the financial situation of the health sector from the territorial entities perspective, and for this, the regulation and evolution of the main financial figures between 2010 and 2014 are studied. The surplus of departmental health funds in recent years suggests that public policy should transcend the financial sphere and concentrate on strengthening institutional and management tools in order to improve health results.

Keywords: health, territorial entities, crisis, management.

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Resumen

Tradicionalmente, los problemas asociados al sector salud en los entes territoriales se han enmarcado principalmente en un plano financiero. En esa línea los problemas de eficiencia se han venido tratando con medidas fiscales o financieras. El artículo presenta la situación financiera del sector salud desde los entes territoriales, para ello estudia la normatividad y la evolución de las principales cifras entre 2010 y 2014. El superávit de los últimos años de los fondos departamentales de salud sugiere que la política pública debería trascender de lo financiero y concentrarse en el fortalecimiento de herramientas institucionales y de gestión que permitan mejorar los resultados en salud.

Palabras clave: salud, entidades territoriales, crisis, gestión.

Resumo

Tradicionalmente os problemas associados ao setor da saúde nos territórios têm marcado principalmente um plano financeiro. Nessa linha os problemas de eficiência vêm tentando com medidas fiscais ou financeiras. O artigo apresenta a situação financeira do sector da saúde por parte das autoridades locais, para este estudo da regulação e evolução das principais figuras entre 2010 e 2014. O superávit nos últimos anos de fundos de saúde departamentais sugere que a política pública deveria transcender do financeiro e concentrar-se no fortalecimento de instrumentos institucionais e de gestão para melhorar os resultados de saúde.

Palavras-chave: saúde, territórios, crises, gestão.

INTRODUCTION

The reform made to the health sector in 2015, like the other reforms of recent years, seeks to address a problem in which the leading role is driven by financial aspects. The concentration on the financial is, in part, the result of a centralized point of view, in which the aggregate monetary variables stand out easily. The present work is based on the assumption that the view from the territorial entities allows a better understanding of the complexity of the flow of resources and identifies the problems that transcend the merely financial.

In order to understand the problem from a territorial perspective, it is necessary to begin with the Political Constitution of Colombia, which established two political changes of great historical importance: firstly, to establish the country as a social state of law and, secondly, regional decentralization. It is clear that decentralization has enabled subnational entities to have greater administrative and fiscal autonomy for resource management (Urrutia & Llano, 2012, Bonet, Pérez & Ayala, 2014). However, the combination of these constitutional principles has also framed two responsibilities for territorial entities: first, guaranteeing the supply of goods and services worthy of consideration for the population, which would include health, education, drinking water and basic sanitation; the second responsibility is to exercise its autonomy in accordance with the rules of fiscal

responsibility, whose macro objective is to achieve the fiscal sustainability of the territorial public finances.

It is questionable to frame a constitutional right such as health against an objective of fiscal sustainability. However, it is based on the economic premise that monetary and physical resources are scarce and, therefore, it is imperative to achieve the best possible results in the effective provision of this service (Stiglitz, 2000). In this measure, territorial entities in the full exercise of their autonomy must achieve efficiency in the management of resources allocated to this sector, a condition that implies legality and transparency in contracting, as well as quality and control in the execution of social investment.

In a decentralized institutional framework, the importance of the efficiency of territorial entities goes beyond being the basis of fiscal sustainability, because said entities manage public resources with a social destination. Therefore, the socioeconomic implications of their use could materialize in greater levels of health which, in addition to being an objective in itself, by increasing welfare directly, can also provide indirect support by allowing higher rates of productivity, growth and economic development.

On the other hand, after a little more than two decades of territorial decentralization, it is imperative that the analysis of the health sector situation does not focus on the debate about the scarcity of resources to finance the provision of services; as authors, such as Melo and Ramos (2010) have pointed out, there is also a need to make progress in assessing whether transferred resources are efficiently allocated. It is also important to establish if there is quality in the execution of those resources, and adequate access, so that services effectively reach the population and, therefore, are catalysts of greater social benefit.

The analysis of the health sector from the subnational level of government is important not only because of the role that the subsidized regime has had in the search for universal coverage, but also because it is considered that territorial administrations have a high impact on the design and execution of public health policies, and that they have the legal powers to carry out monitoring and control over the provision of services.

In this context, this article seeks to present an approximation to the background and current state of the health sector from the perspective of territorial entities. The methodology to be adopted will consist of two parts: firstly, the sector's regulatory review, which starts from the consideration that the health system in Colombia is characterized by its widespread and complex regulation; secondly, the state of the sector is analyzed based on its figures and the chronicle of the period 2010-2014.

Thus, the document is divided into five sections: the first presents a summary of the regulatory background of the health sector in the territorial entities; the second section outlines the situation of the sector, following the declared financial crisis of 2010; in the third, the sector's perspectives are shown from the subnational level of government; the fourth presents the budget balance of the departmental health funds for the year 2014; and in the fifth, by way of conclusion, the final reflections are presented.

NORMATIVITY IN CONTEXT

The National Government through Law 100 of 1993 regulated the General System of Social Security in Health (SGSSS by its acronym in Spanish), which is divided mainly into two types of schemes, which in principle are mutually exclusive: contributory and subsidized[1]. The contributory regime consists of all those individuals with the economic capacity to join the system through a periodic payment. For its part, the subsidized regime is composed of all the people who, because of their economic and social vulnerability, are not affiliated to the contributory regime and, therefore, the state links them by means of a subsidized contribution. The new regime was theoretically defended with the idea of structured pluralism (Londoño & Frenk, 1997)[2].

The substantial difference between these two regimes lay particularly in the formation of the Obligatory Health Plan (POS), since the state defined differential benefits plans, which led to important implications for their financing and, therefore, coverage of medical care and drug supply.

At the territorial level, Article 174 of the aforementioned law stated that the SGSSS integrates the management, promotion and service provision institutions of all territorial entities. In that sense, through Law 60 of 1993, the national government granted subnational governments jurisdiction in health matters, empowering them to organize the public health network and thereby signing contracts with the health promoting entities (EPS) within the subsidized regime, to guarantee the attention of the so-called poor and vulnerable population in their respective jurisdiction.

With the enactment of Law 100, the main objective was to expand the coverage of affiliation, in such a way that universal coverage in health was gradually achieved. This policy should be supported by a strategy of economic growth and the formalization of the labor market, which would increase the affiliation to the contributory system and, as a result, the progressive reduction of public funding to the subsidized system, so that in the medium term the health system would be financially self-sustaining.

Notwithstanding the above, at the end of the 1990s the territorial fiscal situation became financially unsustainable, due to the exorbitant growth of expenditures, especially those related to the operating sector, in proportion to their own resources generated by the territorial entity. In addition, there was a substantial increase in subnational debt, pension liabilities and an increase in fiscal dependence in relation to transfers from the *situado fiscal* (central government financing body) for the financing of social investment (Ministry

[1] It is necessary to specify that there is an exception regime, in which are found the military forces, the police, public servants of Ecopetrol and public universities, and teachers affiliated to the Fund of Social Benefits of Education.

[2] The Colombian reform was influential in other Latin American countries, such as Mexico, Argentina and the Dominican Republic (Frenk et al., 2006; Almeida, 2002; Bertranou, 1999; Castellanos, 2008). The case of Mexico is illustrative. The problem of territorial expenditure disparities has also appeared there (Knaul et al., 2012) but comparisons cannot be made directly because the institutional framework is different. Mexico has a federal regime, while Colombia has a centralist regime. Hence the importance of there being studies that explore the problem with regards to normativity.

of Finance and Public Credit, 2009, Urrutia & Llano, 2012, Directorate General of Fiscal Support, 2014).

Regarding the health sector, the legal framework was not clear regarding the assignment of powers for the different levels of government. This situation allowed the territorial administrations to use the resources without any technical criterion of rationality and efficiency, generating the accumulation of sectorial deficit at the central level, which was deepened with the deliberate creation of subnational decentralized entities (public hospitals comprised as social enterprises of the State and public establishments), whose regulatory framework allowed the territorial entities to set up an administrative structure without financial viability and without a solid legal defense, given the increase of the contingent obligations derived from the accumulation of judicial processes against the subnational entities that finally restricted the reorientation of resources in favor of social investment in health (Ministry of Finance and Public Credit, 2009, Nupia & Sánchez, 2001).

In response to this fiscal crisis, the central government established a set of norms of fiscal responsibility with the objective of: (I) adjusting public debt according to the financial capacity of the territorial entities - Law 358 of 1997; II) financing the pension liability through the creation of a common territorial fund - Law 549 of 1999; III) intervening financially in financially insolvent territorial entities through the signing of agreements for the restructuring of liabilities - Law 550 of 1999; IV) rationalizing operating expenses through the creation of budget categories with differential spending limits in proportion to the unallocated current revenue - Law 617 of 1900; and V) formalizing fiscal accountability and transparency norms, in particular it regulated the implementation of the medium-term fiscal framework for territorial entities - Law 819 of 2003 (Directorate General of Fiscal Support, 2014).

In the provision of public health and education services, among others, the government redefined the powers for both the nation and territorial entities through Law 715 of 2001[3]. Specifically, in the case of the health sector, the law granted departmental governments powers to guide sectorial policy, as well as to advise, coordinate and monitor the actions of municipalities within their jurisdiction.

As Bonet, Perez and Ayala (2014) have indicated, in order to guarantee the effective development of these powers, the law created the General Participations System (SGP, by its acronym in Spanish), whose framework defined the allocation of resources that the nation had to transfer to the territorial entities for the financing of the sectors of health, education, sports, culture, drinking water and basic sanitation, among others[4]. In this way, it

[3] ¨By means of which organic norms regarding resources and powers are dictated in accordance with articles 151, 288, 356 and 357 of the Political Constitution and other dispositions are dictated to organize the provision of the services of education and health, among others. ¨

4 It should be pointed out that, in view of the previous transfer regime, i.e. Law 60 of 1993, Law 715 of 2001 gradually disconnected territorial transfers from the current income behavior of the nation, mainly considering the problems of moral hazard presented at the subnational level, since improvements in the fiscal effort of the central national government were translated, through greater transfers, into increases in public territorial expenditure with few criteria for efficiency and quality in their execution. This situation contributed to the deepening of deficit fiscal results in both the territorial entities and the nation as a whole.

organized a sectoral distribution in which it established participation with a specific destination for the health sector equivalent to 24.5%, another for education corresponding to 58.5%, and 17% for those issues that were general purpose. For the latter, it should be noted that Law 1176 of 2007[5] defined the allotment for drinking water and basic sanitation at 5.4% and the remaining 11.6% for the other sectors that make up general purpose participation.

Regarding funds designated for health and in accordance with the powers defined by Law 715 of 2001, it was envisaged that the resources transferred to the sector would be used solely and exclusively for the financing of the following components: firstly, demand subsidies through the progressive affiliation of the poor population to the subsidized regime until universal coverage is achieved; secondly, it expressly provided for the financing of the provision of health services to the poor in what is not covered by demand subsidies; and finally, the investment in public health actions, according to the priorities defined in the National Public Health Plan of the Ministry of Health.

It should be noted that the aforementioned law established *a priori* powers for departments and districts regarding the administration, financing and co-financing of the three components in health: public health, subsidized regime, provision of services to the non-affiliated poor population. However, for the municipal area it only defined powers for the first two, so that the latter was left to the departmental administrations, except for those municipalities that had been certified in health[6] and that, therefore, were responsible for primary care and non-POS activities.

However, Law 715 of 2001 stipulated that departments should maintain coordination with the municipalities certified in their jurisdiction, in terms of health coverage of the population and the articulation of municipal hospital institutions with departmental networks.

Regarding the subsidized regime, the national government, through Law 1122 of 2007[7], later made explicit the sources of financing of this regime for the territorial entities. For this purpose, the resources of the General Participations System, health, those from ETESA[8], specified the income assigned to the operation: income from a specific destination resulting from internal territorial effort, as well as the resources from the Solidarity and Guarantee Fund (FOSYGA, by its acronym in Spanish) and the family compensation funds.

In 2008, through Decree 028, the government established a strategy for the monitoring, follow up and comprehensive control of expenditures made by the territorial entities with

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5 "By which articles 356 and 357 of the Political Constitution are developed and other provisions are dictated."

6 Law 1176 of 2007 made express the possibility that those municipalities which upon issuance of Law 715 of 2001 did not have the health certification could acquire it in compliance with the regulations to that effect.

7 "For which some modifications are made in the General System of Social Security in Health and other provisions are dictated."

8 Currently Coljuegos.

the resources of the General Participations System. The framework of the strategy defined a total of seventeen events that could jeopardize the adequate provision of health services, education and other sectors that make up general purpose participation. To this end, it configured two types of intervention: the preventive measure and the corrective measure. The first refers to the signing of a performance plan that contemplates a series of obligations for the territorial entity in order to eliminate the identified risk events; the second includes stricter measures such as suspension of funds, direct sending of resources, temporary assumption of powers and suspension of contractual processes (Ministry of Finance and Public Credit 2011).

For the implementation of this strategy in the municipalities, the norm establishes that the departments will have the function of intermediation between themselves and the nation, in order to facilitate the development of the measures adopted in the territorial entities of their jurisdictions.

Under this framework, and especially in accordance with the objective of achieving universal health coverage, transfers from the General Participations System to finance the health sector have concentrated on securing the population to the subsidized regime, with the consequent gradual reduction of the resources that finance the provision of the service to the poor population in what is not covered by subsidies to the
demand (PPNA) and also finance, albeit to a lesser extent, the stabilization of resources earmarked for Public Health actions (see Figure 1).

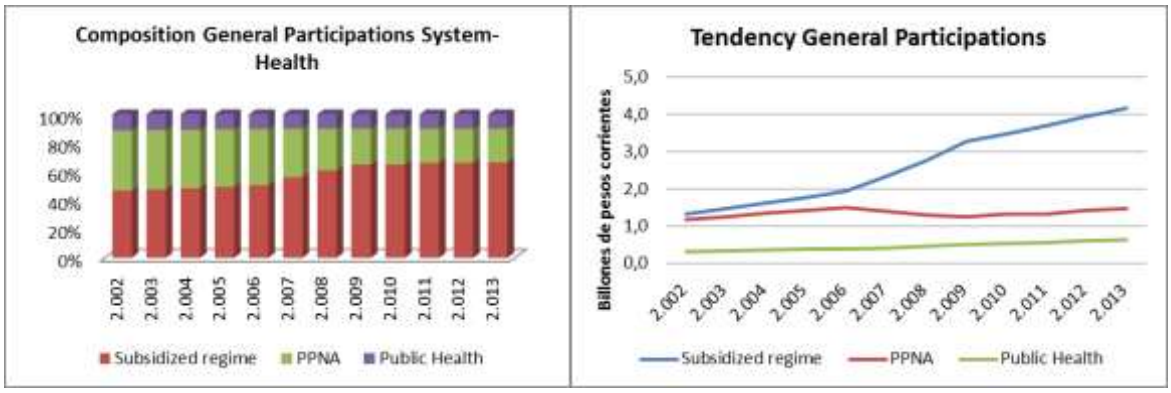

Figure 1. Composition and tendency General Participations System (SGP)-Health
Source: Elaborated by the author with data from the National Planning Department.

During the period 2002-2013, transfers recorded an annual average growth of 7.6%. This incremental trend is essentially explained by the provisions of Article 357 of the Political Constitution of Colombia, which initially determined an annual growth equivalent to the average percentage change in the current revenue of the nation of the last four years. However, the subsequent Legislative Act 04 of 2007[9] pointed out that from 2008 to 2016 it

[9] "By which articles 356 and 357 of the Political Constitution are reformed."

would increase by a percentage equal to the rate of inflation, plus a real growth rate expressly defined in the norm.

In general, in recent years there has been a growing trend in the resources transferred for insurance in Colombia, in particular by expanding coverage to the subsidized regime at the subnational level of government. In particular, municipal administrations have played a decisive role, since they have been acting as an insurer of the vulnerable population. The tool that has been used to identify the beneficiary population of the subsidized regime has been the System of Identification of Potential Beneficiaries of Social Programs (SISBÉN, by its acronym in Spanish), whose operation has been effective since the levels of health insurance are close to universal coverage.

However, in recent years, the performance of SISBEN as a targeting instrument for the subsidized regime has been questioned, since it has not been outside the political and clientelistic processes at the territorial level, thus promoting the growth of strategic biases of information presented in the surveys. In that sense, Bottia, Cardona-Sosa, and Medina (2012) present empirical evidence on the presence of households in Bogotá whose "strategic responses" have allowed them to be beneficiaries of the subsidized regime, even though their economic conditions are relatively better than those of the really vulnerable population. As a result, this situation has been generating higher costs for the health system and has encouraged SISBEN to begin to be seen as a regressive instrument.

FINANCIAL CRISIS OF THE HEALTH SECTOR: WHAT HAPPENED IN THE TERRITORIAL ENTITIES?

In 2010 the financial crisis of the health sector exploded. The crisis was triggered by the growing demand for services excluded from the mandatory health plan (POS), which was deepened when the Constitutional Court, through Judgment C-463 of 2008, forced FOSYGA to recognize the totality of the derived recoveries of non-POS events in the contributory regime, provided they had been approved by the so-called Scientific Technical Committee.

In the subsidized regime, the recoveries caused by these events had to be, for the most part, assumed by the departmental administrations, a situation that considerably affected the public finances, since a considerable portion of these liabilities did not have budgetary support and became a permanent source of fiscal deficit. Note that, in principle, this source of expenditure is not under the control of local authorities.

For 2011, the departments registered a deficit for services of approximately $ 591.126 billion COP. Of this figure, 84% ($ 496.345 billion COP) corresponded to billing for services rendered without budgetary support, and the remaining 16% ($ 94.781 billion COP) corresponded to recoveries. Including the accumulated deficit of previous years, the departments presented a budget deficit for services provision of $ 976 billion COP (Directorate General of Fiscal Support, 2015a).

In addition, the Constitutional Court's ruling T-760 of 2008 had ordered the approval of the benefit plans of the subsidized and contributory regime, whose financial model forced the

territorial entities to concentrate their institutional capacity to control the problems of adverse selection and moral hazard, given that with the unification of the insurance plans there were incentives for taxpayers from the contributory regime to pass to the subsidized and thereby obtain salary savings under an equivalent level of health care. A situation such as this could generate problems in the financing of the subsidized regime, since reducing the contributions of the contributory regime would simultaneously reduce the resources coming from the FOSYGA solidarity sub-account (Núñez, Zapata, Castañeda, Fonseca & Ramírez, 2012).

In this context, the crisis in the sector made structural flaws evident, the causes of which were mainly attributed to a financial problem, but with significant repercussions on the principles of efficiency, quality and equity in the delivery of health services. One of the measures taken by the National Government was to increase the resources allocated to the sector. An example of this was the declaration of a social emergency (which was later declared to be unenforceable), whose framework extended the resources for the sector, in particular from taxes on gambling, as well as cigarette and liquor consumption, among others. These were rents of specific destination that were later regulated and declared permanent by Law 1393 of 2010[10].

With the enactment of Law 1438 of 2011[11], the national government ratified the powers of local and regional authorities to monitor and control the insurance of affiliates to the subsidized regime, but modified the powers regarding the administration of resources. From this law, the former Ministry of Social Protection[12] would be responsible for directly paying, on behalf of local authorities, the resources to finance the unit of payment for capitation to health promoting entities and / or services provided by health care institutions.

This would mean that subnational governments should now concentrate their institutional capacity on the identification, updating and registration of affiliates to the subsidized regime, so that such information would allow the national government to make direct payments. Thus, despite the fact that resources would not enter the territorial treasury, regional autonomy over the administration of the subsidized regime would be preserved[13].

It is important to clarify that the direct payment did not seek to inject capital into the health system, but rather to streamline the flow of resources that were part of it, particularly because there were high levels of indebtedness, mainly originating from the administration contracts of the subsidized regime that had been signed between the territorial entities and

[10] "By which specific income for health is defined, measures are taken to promote activities that generate resources for health, to avoid evasion and avoidance of health contributions, resources are redirected into the health system and other provisions are issued".

[11] "By means of which the General System of Social Security in Health is reformed and other dispositions are dictated".

[12] That changed its name to that of the Ministry of Health and Social Protection with the passing of Law 1444 of 2011.

[13] For this particular case, it is worth specifying the dimensions of decentralization, since territorial entities retained administrative autonomy for monitoring and controlling the subsidized regime, but the degree of freedom over financial autonomy was reduced.

the health promoting entities. This situation generated illiquidity events, vicious inter-institutional circles and finally affected the access of members to health services.

In addition to the above and in light of the conditions of financial unsustainability presented by a large number of public hospitals formed as state social enterprises, the national government, through Law 1438 of 2011, established the criteria and conditions for the adoption of fiscal and financial consolidation programs under the supervision of the departmental or district health directorates.

Thus, it was determined that all social enterprises of the state that, according to the evaluation of the Ministry of Health and Social Protection, presented weak market conditions, balance, financial viability and low health indicators, and were therefore categorized as medium or high risk, should adopt a fiscal and financial consolidation program[14].

According to the norm, the breach of the program could generate actions of mediation by the national government that range from the signing of an agreement for the restructuring of liabilities, or the intervention by the National Superintendence of Health, to the liquidation or merger of the entity.

For the year 2013, out of 967 state social enterprises evaluated by the Ministry of Health and Social Protection, 540 (56%) were categorized as a risk[15], of which 412 (76%) were at high risk and 128 (24%) were medium risk. In 2014, 42 more hospitals were categorized as a risk[16], reflecting a 10% increase over the previous year's report. Of the latter, 31 were classified as high risk (74%) and 11 as medium risk (26%). In sum, 454 social enterprises of the State had to adopt a Program of Fiscal and Financial Consolidation in the terms defined by the Ministry of Finance and Public Credit[17].

In order to finance consolidation programs in public hospitals, the national government authorized[18] the use of the surplus of the master accounts by the territorial entities[19], allocating approximately $ 379 billion COP (equivalent to 27% of the surpluses).

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[14] Subsequently, article 8 of Law 1608 of 2013 defined Fiscal and Financial Consolidation Programs as "an integral, institutional, financial and administrative program that covers the State Social Enterprise, whose purpose is to restore the economic and financial soundness of these companies, with the purpose of ensuring continuity in the provision of the public health service. The Fiscal and Financial Consolidation Program shall contain measures for administrative reorganization, rationalization of expenditure, debt restructuring, consolidation of liabilities and strengthening of the revenues of State Social Enterprises; that allow their proper operation, in order to guarantee access, opportunity, continuity and quality in the provision of health services to the user population. "

[15] According to Resolution 1877 of 2013 of the Ministry of Health and Social Protection, "By means of which the categorization of the risk of State Social Enterprises of the territorial level for 2013 is implemented."

[16] According to Resolution 2090 of 2014 of the Ministry of Health and Social Protection, "By means of which the categorization of the risk of State Social Enterprises at the territorial level for the 2014 term is implemented and other provisions are dictated."

[17] By means of Decree 1141 of 2013, the national government established the general parameters of the viability, monitoring, follow up and evaluation of Fiscal and Financial Consolidation Programs to be adopted by State-owned Social Enterprises at the territorial level, categorized as medium or high risk.

[18] Article 2 of Law 1608 of 2013.

In addition, it allocated $ 645 billion COP (46% of the surpluses) for infrastructure financing and public hospital network endowment, whose redesign and modernization was already a necessity since the enactment of Law 1438 of 2011.

Similarly, although Law 1438 had ordered the liquidation of subsidized regime contracts and implemented direct transfer, the territorial entities still had high levels of indebtedness due to insurance, since part of this regime was financed with internal resources. The government allocated $ 103 billion (7% of the surpluses) to finance the commitments acquired between the 2011 and 2013 periods.

In addition, the use of $ 263 billion COP (19% of the surpluses) was approved to cover the services rendered to the uninsured poor and for the payment of services not included in the subsidized scheme's benefit plan.

The Ministry of Health and Social Protection was also allowed to allocate FOSYGA resources to municipalities in categories 4, 5 and 6 up to an amount equivalent to $ 150 billion COP to cover the debts recognized by the subsidized regime[20]. By the end of 2014, the Ministry had made direct payments of about $ 112 billion COP[21].

As a measure to temporarily solve the problems of liquidity suffered by the health system, the Ministry of Health was authorized to purchase a portfolio recognized by institutions providing health services with health promoting companies both contributory and subsidized, operations that would be financed with the resources of the FOSYGA sub-account securities. According to Ministry figures, by the end of 2014, 900 portfolio purchase operations had been carried out for a little more than $ 1 trillion COP, of which approximately 46% were made with institutions providing public or mixed capital health services.

Finally, considering that the health system not only required the capitalization of new sources of financing, but also improving the flow of resources that were part of the system, the national government created the Fund for the Rehabilitation and Guarantees for the Health Sector (Fonsaet)[22], which would finance the obligations that could not be canceled by the state social enterprises which intervened or that were categorized as medium or high risk. In addition, it allowed the fund to purchase and commercialize the portfolio of institutions providing public health services.

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[19] At the end of 2012 municipalities had surpluses in the master accounts of the subsidized regime amounting to 1.4 trillion, according to the report of the Ministry of Health and Social Protection on the implementation plan and execution of the surplus of the master accounts of the subsidized regime.

[20] According to Law 1608 of 2013, the beneficiary municipalities will have to return the resources in no more than 10 years by increasing their own effort in the co-financing of the subsidized regime.

[21] According to the resolutions of the transfer of resources FOSYGA operation 2013 and 2014 of the Ministry of Health and Social Protection.

[22] It was created by Law 1438 of the year 2011 and later modified by Law 1608 of the year 2013.

With all of the above, the sector figures do not seem to show the magnitude of the problem, for although the measures of the national government have mainly concentrated on the financial, the balance of departmental health funds showed a surplus of approximately $ 1.08 trillion COP in 2013 (Directorate General of Fiscal Support, 2015a).

The expectations are set in the statutory reform presented by the national government, which promises to guarantee health as a fundamental right and proposes a new scheme or model that is essentially based on the creation of two entities: Salud-Mía, a public entity that will have administrative and budgetary autonomy and independent assets, and that will manage the resources of the health system; and health service managers, public and private entities that should be assigned to a health management area and form networks for the provision of health services (Sarmiento et al., 2005)

In addition, according to the reform, the Obligatory Health Plan will be eliminated to give way to a new comprehensive benefit plan called Mi-Plan, which must include all pathologies so that it is not necessary to return to the old technical-scientific committees. Nevertheless, it defined a list of exclusions of services, procedures and medicines, whose function will be exclusively cosmetic or luxury, such as health technologies that do not have scientific evidence of their safety and effectiveness.

Thus, Salud-Mía will verify that the managers are guaranteeing the provision of services to the population and will make direct payments to the institutions providing health services based on the affiliation data that will be administered. In that sense, it is necessary to specify that the reform foresees the transformation of health promoting entities, since those who are up to date with their obligations may be managers, in conjunction with the territorial entities.

WHAT WAS THE BALANCE OF DEPARTMENTAL HEALTH FUNDS IN 2014 AFTER THE FINANCIAL MEASURES?

The following is an overall approximation of the budgetary results of departmental health funds at the end of 2014, considering an analysis of sources and uses.

Sources

In 2014 departmental health funds received revenues of $ 4.36 trillion COP, equivalent to 0.6% of GDP. The composition by source of the sector showed in that year, 22% corresponded to tax revenues that by legal provision had to be destined to the financing of the sector[23]; on the other hand, 39% originated from transfers, particularly from the central level through the so-called General Participations System; and 31% to extraordinary income, mostly composed of balance sheet resources[24] (see Figure 2).

[23] These include national revenues, such as VAT on liquors, beers and cigarettes; as well as resources of the fiscal effort of the departments that by ordinance must be invested in the health sector.

[24] It groups the surpluses of previous years, the cancellation of budgetary reserves and the resources that finance budgetary reserves established at the end of fiscal year 2013.

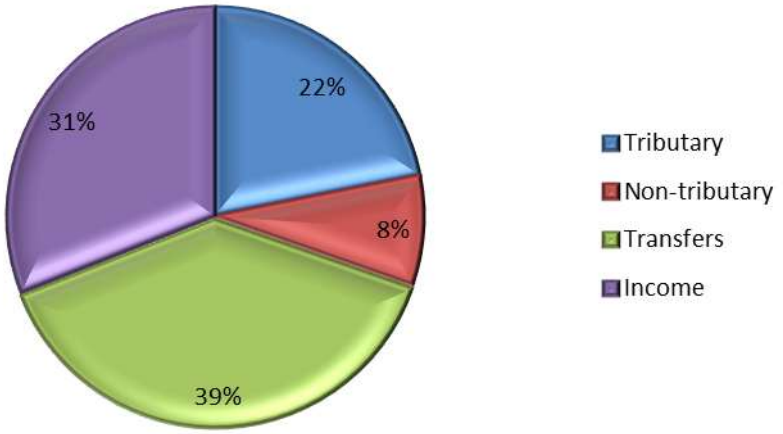

Figure 2. Distribution of departmental sources of funds for health 2014
Source: elaborated by the author with data of the Consolidator of Hacienda and Public Information (CHIP, by its acronym in Spanish)

In general, the sources of financing of the health sector in the departments were concentrated in transfers and capital revenue, which shows a significant level of fiscal dependence at the central level. This is due to a health decentralization scheme that is essentially based on the distribution of powers and, hence, the strict definition of the rules of the execution of resources that have finally made the budget of subnational governments more inflexible.

The departments of Antioquia, Valle del Cauca and Cundinamarca were the ones that received the most resources for the financing of the sector, with a third of total revenues. Meanwhile, the lowest budget entities were San Andrés and the old departments[25], whose revenues were mainly transfers.

When considering the tax revenues of the sector, selective excise taxes were the most important resources for the departments, specifically taxes on alcoholic beverages, cigarettes and tobacco which grouped together amounted to 44% of tax revenues; while VAT on alcoholic beverages and stamps accounted for 34% and 10%, respectively (see Table 1).

Table 1. Departmental tax revenue destined for the health sector (figures in billions of pesos)

Concept	2014	%
Tax on ordinary and extraordinary lottery winners	18.585	2 %
Tax on foreign lotteries	16.964	2 %
Tax on liquors, wines, aperitifs and similar	64.372	7 %
Disaggregation liquors, wines, aperitifs and similar	321.891	34 %

[25] That is, Vaupes, Vichada, Guainía, Amazonas and Guaviare.

Tax on beer	259.804	27 %
Tax on cigarettes and tobacco	97.487	10 %
Tax on gambling	118	0 %
Stamps	91.555	10 %
Other tax revenues	83.153	9 %
Total	**953.929**	**100 %**

Source: elaborated by the author with information of the CHIP

Of the transfers to the sector, resources received from the General Participations System accounted for 83% of total transfers; meanwhile, the resources of FOSYGA and of the former royalties regime[26] had a small share, with 0.4% and 1%, respectively.

Capital revenues constituted an important portion of the sector's sources, a situation that is unfortunate if it is considered that approximately 80% corresponded to surpluses from previous years, which translates into the availability of resources close to $ 1 trillion COP that were not invested in the sector during the fiscal period in which the budget was allocated.

Uses

In 2014 the departments invested $ 3.48 trillion COP[27] in the health sector, equivalent to 0.5% of GDP. Of this amount, 22% was used in the insurance of the subsidized system, 12% in public health actions, 38% in the provision of services to the poor and 28% in other health expenditures.

Of all the components of the subsidized regime, the most important item was health insurance coverage with 67% ($ 517.280 billion COP). In public health, the main investment accounts were the treatment of contagious diseases and zoonosis (22%), health and environmental security (16%), and management of the operational development of the National Public Health Plan (20%).

In relation to the service delivery component, the most representative investment items were health services to the uninsured poor (67%) and services not included in the POS of the subsidized regime (17%).

Per capita spending on health departments was approximately $ 87,130 COP. Smaller entities in population terms had higher per capita investments, as was the case in the old departments and San Andres (see Figure 3); nevertheless, entities such as Cundinamarca[28] and Antioquia, which have the highest population levels in the country, also show per capita expenditure above the departmental indicator. This situation may reflect the concentration of more complex health services in these geographical areas.

[26] Established by Law 141 of 1994. Currently the royalties are administered by the new General System of Royalties, according to the provisions of Law 1530 of 2012 and other statutory decrees.

[27] 2014

[28] Not including the Bogotá Capital District.

In contrast, the Bolivar and Atlantic departments had the lowest levels of per capita investment in the country despite having population sizes similar to Cundinamarca and Santander.

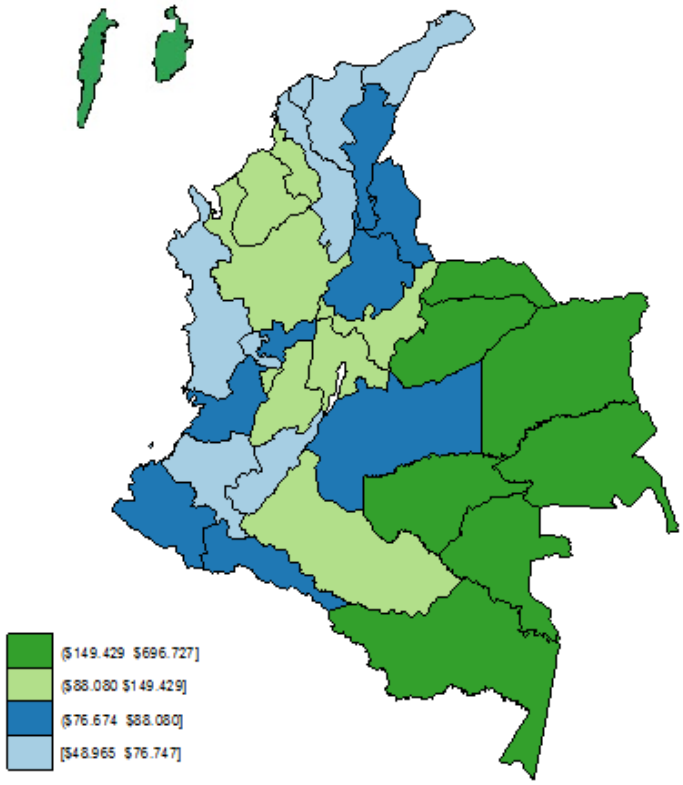

Figure 3. Per capita expenditure of departmental funds on health 2014
Source: elaborated by the author with data from the CHIP and DANE

Budget balance of the departments

At the end of the fiscal year of 2014, departmental health funds presented a surplus of $ 889.198 billion COP (see Table 2), equivalent to 0.1% of GDP. Although this result reflects a nominal reduction of 21% compared to 2013, it shows that the health sector at the departmental level has not shown structural financial problems. On the contrary, it has been characterized by the availability of the budgetary resources of previous years, without its due implementation during the fiscal period in which the investment was scheduled.

Table 2. Consolidated result – health departmental funds year 2014
(Millions of pesos**)**

Concept	2014
Total revenue	4.364.388
Total expenditure	3.475.189
Budgetary surplus	**889.198**

Source: elaborated by the author based on CHIP

In general, the departments did not show a tendency of budgetary balance, curiously, not through a bias towards the deficit, but because of significant surpluses of resources that demonstrate the management capacity of territorial entities of investing resources allocated to the health sector.

This is reaffirmed by the fact that only the departments of San Andrés and Antioquia exhibited budget deficits, while Valle del Cauca and Atlántico contributed significantly to the consolidated surplus (see Figure 4). This situation contrasts with spending on health per capita, noting that Atlántico, Magdalena and Chocó had the lowest indicators in the country, even though their budget balances were positive.

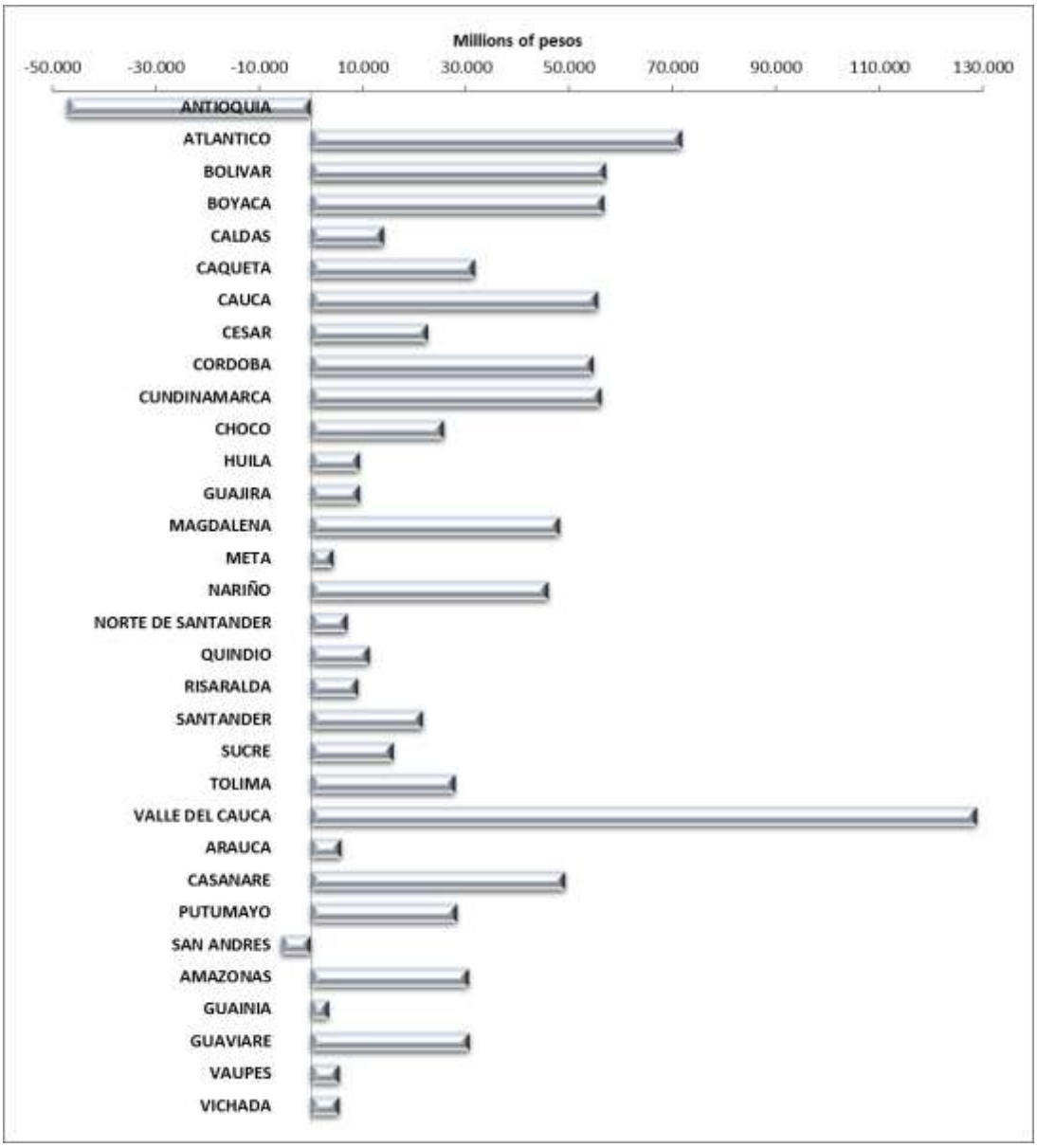

Figure 4. Budgetary result – health departmental funds for 2014
Source: elaborated by the autor based on CHIP

FINANCIAL CRISIS OR MANAGEMENT CRISIS?

Initially services not included in the POS were claimed through the mechanism of constitutional rights protection, a situation that generated high levels of fiscal deficit in the territorial entities. Subsequent to the homologation of the POS, ordered by the Constitutional Court, a good part of the deficit was conserved, since there was a delay[29] between the inclusion of health services in the scheme of benefits of the subsidized regime and the equalization of the unit of Payment By Capitation (UPC) with the contributory regime.

[29] The unification of the POS effectively began in July 2012.

According to a report by the Ombudsman's office (2014), in 2013, 454,500 claims were filed, of which 25.33% (115,147) claimed health services, a figure that represented an increase of 0.73% compared to the previous year. In addition, at the time of the unification of the POS, the percentage of applications through claims for services included in the POS was not reduced and was more representative in the subsidized regime than the contributory system (75.63% and 64.90%, respectively), a situation that shows that there were still access barriers for some services, despite the homologation of the POS.

In contrast to the non-POS, it should be noted that in the subsidized regime, constitutional rights protection rates have not been observed at levels as high as those in the period between 2006 and 2008[30]; However, there was an increasing tendency, at the end of 2013 with 24% of requests that claimed services not included in the POS.

This demonstrates that, following the homologation of the benefit plans, requests have been transferred that were made in the subsidized non- POS to the unified POS (Ombudsman´s office, 2014). This situation explains to a large extent the deficit of $ 433.781 billion COP for services rendered by the departments at the end of the 2013 term (Directorate General of Fiscal Support, 2015a).

Thus, one of the challenges of health reform will then be to put into practice the unification of the benefits plan, as well as the equalization of the financing mechanisms of the services, in a way that eliminates the pressure that has come from exercising non-POS expenses on subnational public finances.

As shown in Figure 2, Colombia has made significant progress in the goal of universal health coverage; nevertheless, this has been achieved with a significant portion of affiliation to the subsidized regime[31], a situation that must be permanently evaluated, since the health system financing model promoted by Law 100 of 1993 has required that territorial entities move towards a sustainable path of economic growth, with the benefit of generating employment and the formalization of labor, so that financing mechanisms through salary contributions, ceded income and transfers from the national government allow the cross-subsidy scheme to be maintained (Salazar, 2011).

30 On average, 69% of the guardians requested services not included in the POS.

31 According to the statistics of affiliation of the Ministry of Health and Social Protection, as of December 2014, 45,492,407 people were enrolled, of whom 50% belonged to the subsidized regime, 46% to the contributory and 4% to the exception.

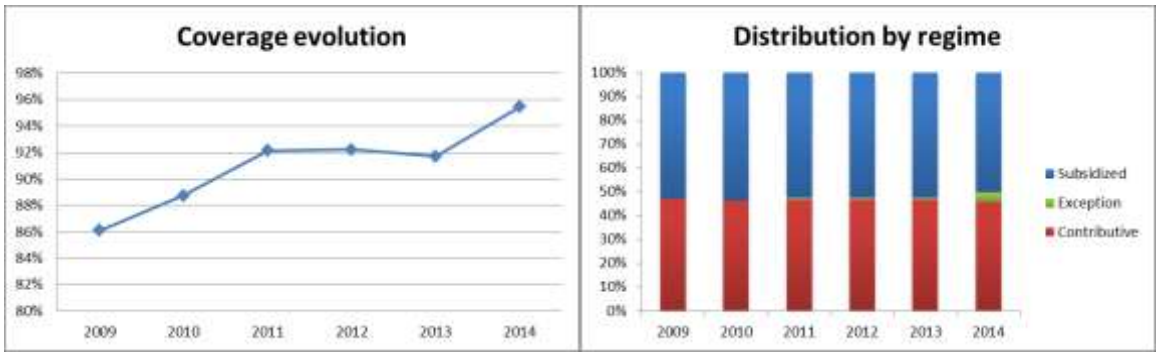

Figure 5. Evolution and distribution of insurance
Source: elaborated by the author based on information from the Ministry of Health and Social Protection and DANE

Although the health system has received significant injections of resources, the sector will not see substantial improvements in terms of medium and long term financial sustainability, unless a process of strengthening of the institutional capacity of the territorial administrations optimizes the allocation and interinstitutional flow of resources, guarantees quality in the execution of the investment, reorganizes and articulates the service delivery networks from a regional perspective and with facilities for the population to access, and improves local information systems in a way that facilitates the coordination of public policy between the national and subnational government and makes the instruments of monitoring and control of the provision of health services more effective.

On the other hand, the effectiveness of programs aimed at achieving the fiscal and financial consolidation of state social enterprises will not only be measured by the correction of liabilities of the sector, but also by the continuity in time of quantitative fiscal rules that have been established according to the conditions of each hospital, so that it is feasible to project a sustainable financial framework in the public networks of health services.

The large resources that have been capitalized for the sector and the surplus recorded by departmental health funds in recent years suggest that it is no longer a financial crisis, but a crisis of management and confidence in the institutionality of the system, which has generated efficiency problems with implications for the delivery of health services. In that sense, the sector crisis is not resolved from a solely financial perspective, but with measures that strengthen the management capacity of each of the actors of the system, including the territorial entities.

CONCLUSIONS

The review made here of the evolution of the sector shows that, today, the financial problem has lost importance. The health system in Colombia has antagonistic characteristics: on the one hand, the Colombian health system is one of the programs with the most resources in their coffers for financing, as Nuñez et al. (2012), Barón (2007) and Orozco (2015) point out. However, in turn it has significant weaknesses and limitations in its financial structure, which have negatively affected the provision of health services. An example of this is the budgetary surplus of departmental health funds in 2013, compared to the deficit in the service delivery component in the same year.

On the other hand, the most politically significant result is health insurance, currently very close to universal coverage (95%), but this indicator has been supported by a significant rate of affiliation to the subsidized regime, as by 2014 approximately 50% of the insured population belonged to the program. This fact makes the financial sustainability of the system more vulnerable, given the economic context of low prospects for economic growth[32] and, consequently, the risks of consolidating a formal labor market that will allow the contributory regime to be strengthened and, with that, to maintain the cross-subsidies programs in health care.

Finally, Colombia is still in the process of consolidating decentralization. Therefore, statutory health reform has major challenges, particularly in relation to the administrative and financial centralization plan which is outlined, and the restrictions that this creates regarding the autonomy and the powers that the territorial entities have in health matters (Fedesarrollo, 2013).

In any case, the health system requires structural reforms. However, unlike the current common discourse, reforms should not only be framed in the financial sphere, but especially in the redesign of their institutional structure. The objective should be to strengthen the management capacity of each of the actors in the system, while facilitating the coordination of national and regional public policy in order to ensure that resources in the sector are properly managed and that the entire population has access, without distinction, to health services.

One point that may be relevant in this context is that policies such as primary health care (PHC) could provide adequate management models at the municipal level. This, together with the treatment of those economic variables that affect the health of the community, as well as the so-called social determinants of illness (De Santis & Villagra, 2014) can be more easily managed at the level of the territorial entities due to the size of the population. Alternatives of this type could contribute to better management of these types of entities.

It is worth noting that the elements found here refer to health, but they coincide with what has been found by other authors in territorial tax matters. Chamorro and Urrea (2016), in a study on the incidence of fiscal rules at the territorial level, found an interesting fact: that the deficit trend in the territorial entities has been reversed. Although during the 1990s, expenditures grew faster than revenues, since 2000 the finances of local authorities have recovered and become more closely linked to the political cycle. It is possible that what happened in the health sector will help to explain this phenomenon.

Although this situation can be explained by the application of the fiscal responsibility framework, the fact is that the health sector has been accumulating a significant amount of resources that have not been implemented. The report of the Fiscal Support Directorate of the Ministry of Finance (2015b) shows that in 2014, the departments reported an

[32] In particular by the impact of the dynamics of royalties on territorial budgets.

accumulated balance of net availabilities for the general participations system[33] for the health sector corresponding to approximately 557 billion pesos. Although these are resources with a specific destination established by Law 715, these amounts contribute to the aggregate with the goals of fiscal responsibility.

Considering the reform of the General Participations System, the advisability of maintaining the inflexible scheme of specific destinations or the need to make more general distributions that allow the territorial entity to have discretion over the spending of health resources, taking into account their needs, should be discussed.

In any case, aspects related to the territorial fiscal situation and health management deserve to be further studied in detail.

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[33] The net availabilities correspond to the difference between the assets of easy realization and the liabilities and budget reserves.

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